TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
December 13, 2018 – 2:30 o'clock p.m.
Classroom 7 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 1, 2 & 3
4002 Vista Way, Oceanside, CA 92056

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

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	Public Comments – Announcement 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	1 Hour	
	a. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) 2 (1 Matter)		
	b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	c. Approval of prior Closed Session Minutes		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)		
10	Roll Call / Pledge of Allegiance	3 min.	Standard

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
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	Welcome and Introduction of New Board Members: 1) Rocky Chavez 2) George Coulter 3) Tracy Younger	5 min.	Chair
13	Special Award Presentation: a) Honoring James J. Dagostino, DPT, PT and Laura E. Mitchell, RN for their service on the TCHD Board of Directors	5 min.	Chair
14	Report from TCHD Foundation 1) Diamond Ball 2) Employee Giving Campaign	10 min.	Acting Foundation President
15	October 2018 Financial Statement Results	10 min.	CFO
16	New Business 1) Consideration and possible action to elect Board of Director Officers for calendar year 2019: 1) Chair 2) Vice Chair 3) Secretary 4) Treasurer 5) Assistant Secretary 6) Assistant Treasurer 7) Board Member	10 min.	Chair
	2) Consideration to certify a recognized Employee Organization as the exclusive bargaining representative	10 min.	Sr. Dir. H/R
	3) Consideration to nominate Board Member to serve on the San Diego Local Agency Formation Commission (LAFCO) as a Regular Special District Member or Alternate Special District Member whose term will expire 2023.	10 min.	Chair
	4) Consideration of proposed 2019 Board Meeting Schedule	5 min.	Chair
17	Old Business – None		
18	Chief of Staff a) Consideration of November 2018 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on November 26, 2018 b) Rules & Regulations: 1) AHP	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	c) Privilege Card: 1) Cardiology		
19	Consideration of Consent Calendar **Administrative & Board Committees** ***(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.*** ***(2) All items listed were recommended by the Committee.*** ***(3) Requested items to be pulled require a second.*** **(1) Administrative Committee** **a) Patient Care Policies & Procedures** 1) Code Adam 369 Policy 2) Micromedex Carenotes Procedure (DELETE) 3) Skills Lab, Annual Interdisciplinary Policy 4) Stryker Glide Lateral Air Transfer Device Procedure 5) Volunteers, Patient Care Services Department Policy **b) Administrative Policies & Procedures** 1) Authorized Access Medications 298 2) Severance Plan – 454 **c) Infection Control** 1) Management of Patients with Multi-Drug Resistant Organisms (MDRO) and/or C,Difficile Infection **d) NICU** 1) Criteria for Case Referrals to Morbidity and Mortality 2) Education Plan, NICU 3) NICU Placement; Overflow to Alternate Location (Temporary Overflow) (DELETE) **e) Pharmacy** 1) Antimicrobial Stewardship Program Policy (DELETE) 2) Bedside Medication Storage (DELETE) 3) Controlled Substances – Pharmacy 4) Discharge Prescriptions 5) Drug Compounding for Medication Not Commercially Available 6) Drug Product Procurement and Inventory Management 7) Unusable Medications 8) Verbal and Written orders – General (DELETE) **f) Rehabilitation** 1) Physical Plant – 105 **g) Pre-printed Orders** 1) Adult Parenteral Nutrition Orders 2) Wound V.A.C. (Vacuum Assisted Closure) Orders 8711-4026 (DELETE) **h) Formulary Requests**	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	1) Cangrelor 2) Disopyramide phosphate (Norpace CR®) 3) On-Q Pumps		
	(2) Board Committees		
	A. Community Healthcare Alliance Committee Director Nygaard, Committee Chair *(No meeting held in November-December, 2018)*		CHAC Comm.
	B. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 0 *(Committee minutes included in Board Agenda packets for informational purposes*		FO&P Comm.
	1) Approval of a global agreement with Beckman Coulter for a term of 42 months, beginning January 1, 2019 through June 30, 2022, for an annual cost of $609,240 and a total cost for the term of $2,132,340.		
	2) Approval of an agreement with BD Diagnostics for two Phoenix M50 Instruments, and associated consumables, for a term of 84 months, beginning January 1, 2019 through December 31, 2025, for an annual cost of $736,968 and a total cost for the term of $5,158,776.		
	3) Approval of an agreement with San Diego Blood Bank for blood products and immunohematology reference laboratory services for a term of 60 months, beginning January 1, 2019 through December 31, 2023, for an annual cost of $1,890,000 and a total cost for the term of $9,450,000.		
	4) Approval of an agreement with Dr. Anitha Rajamanickam as the Cardiac Rehabilitation Services, On-Site and Wellness Center Coverage Physician, for a term of 36 months, beginning January 1, 2019 through December 31, 2021, not to exceed an average of 39 hours per month or 458 hours annually, at an hourly rate of $148.30 for an annual cost of $69,404 and a total cost for the term of $208,213.		
	5) Approval of an agreement with Dr. Jeffrey Ferber as the Medical Director for Employee Health Services Department for a term of 24 months, beginning January 1, 2019 through December 31, 2020 for a total cost for the term not to exceed $76,800.		
	6) Approval of an agreement with Dr. James Johnson as the Physician Chairperson of MDQA/Peer Review/QAPI for a term of 18 months beginning January 1, 2019 through June 30, 2020, not to exceed an average of 33 hours in total per month or 400 hours annually, at an hourly rate of $155 for an annual cost of $62,000 and a total cost for the term not to exceed $108,000.		

	Agenda Item	Time Allotted	Requestor
	C. Professional Affairs Committee Director Grass, Committee Chair *(No meeting held in November-December, 2018)* **D. Audit, Compliance & Ethics Committee** Director Schallock, Committee Chair Open Community Seats – 0 *(No meeting held in November-December, 2018)* (3) Minutes – Approval of: a) Special Board of Directors Meeting – November 15, 2018 b) Regular Board of Directors Meeting – November 8, 2018 (4) Meetings and Conferences – None (5) Dues and Memberships a) 2019 California Special District's Association Renewal - $6,647.67		PAC Audit, Comp. & Ethics Comm. Standard
20	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
21	Reports (Discussion by exception only) (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (October, 2018) (d) Reimbursement Disclosure Report – October, 2018) (e) Seminar/Conference Reports – None	0-5 min.	Standard
22	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
23	Additional Comments by Chief Executive Officer	5 min.	Standard
24	Board Communications (three minutes per Board member)	18 min.	Standard
25	Report from Chairperson	3 min.	Standard
26	Total Time Budgeted for Open Session	2 hours	
27	Oral Announcement of Items to be Discussed During Closed Session		
28	Motion to Return to Closed Session (if needed)		
29	Open Session		
30	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
31	Adjournment		

LAFCO

San Diego Local Agency Formation Commission

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

November 28, 2018

TO: Independent Special Districts in San Diego County

FROM: Tamaron Luckett, Executive Assistant
San Diego Local Agency Formation Commission

SUBJECT: **Call for Nominations | San Diego Local Agency Formation Commission**

This notice serves as a call to nominations pursuant to Government Code Section 56332(1) to solicit two special district members – (a) one regular and (b) one alternate – to serve on the San Diego Local Agency Formation Commission (LAFCO).

San Diego LAFCO Commissioners serve four-year terms. The term of the incumbents – regular district member (Ed Sprague)[1] and alternate district member (Judy Hanson)[2] – expires May 2019.

- The new term of the regular district member expires May 2023.
- The new term of the alternate district member expires May 2023.
- Candidates eligible for election must be members of the legislative body of an independent special district who reside within San Diego County, but may not be members of the legislative body of a city or county.

State law specifies only the presiding officer or their alternate as designated by the governing board must sign the nomination form. Attached is nomination form for the LAFCO regular and alternate special district member **(Attachment A)**. Nominations and a limited **two-page** resume indicating the candidate's District and LAFCO experience must be returned to San Diego LAFCO **no later** than **Monday, January 7, 2019**. Nominations and resumes can be emailed to tamaron.luckett@sdcounty.ca.gov, if necessary to meet the submission deadline, but the original form must be submitted.

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[1] The term of the regular member position expires on May 6, 2019, but will be extended to 2023 if approved by a majority of special districts.
[2] The term of the alternate member position expires on May 6, 2019, but will be extended to 2023 if approved by a majority of special districts.

Please send nominations and resumes to:

Tamaron Luckett, Executive Assistant
San Diego Local Agency Formation Commission
9335 Hazard Way, Suite 200
San Diego, California 92123

After nominations and resumes are received it is anticipated a candidates' forum will be held in conjunction with the California Special Districts Association Quarterly Dinner with confirmation being provided under separate/future cover. All nominations and resumes received will be reviewed by a nominating committee. The nominating committee's report and copies of all nomination forms and resumes submitted will be included with the ballots and voting instructions. These materials will be mailed on **Wednesday, February 20, 2019.**

Should you have any questions, please contact Executive Assistant Tamaron Luckett at (858) 614.7755.

Attachments:
1) Nomination form – LAFCO regular and alternate special district member
2) Acknowledgement receipt form

ATTACHMENT A

NOMINATION OF THE SPECIAL DISTRICT REPRESENTATIVES
LAFCO REGULAR AND ALTERNATE
FOR THE SAN DIEGO LOCAL AGENCY FORMATION COMMISSION

The _____ is pleased to nominate _____ as a
(Name of Independent Special District) (Name of Candidate)

Candidate for the San Diego Local Agency Formation Commission as a regular or alternate special district member.

Please check one box.
Refer to the List of Incumbents.

[ ] **Regular Special District Member** (Term expires 2023)
[ ] **Alternate Special District Member** (Term expires 2023)

As presiding officer or his/her delegated alternate as provided by the governing board, I hereby certify that:

- The nominee is a member of a legislative body of an independent special district whom resides in San Diego County.

_____
(Signature)

_____ _____
(Print Name) (Date)

_____
(Print Title)

PLEASE ATTACH RESUME FOR NOMINEE
- Limit two pages
- Must be submitted with Nomination Form

TCHD BOARD OF DIRECTORS
MEETING SCHEDULE
CALENDAR YEAR 2019

Regular Board of Directors Meetings – Open Session to begin at 3:30 p.m. Closed Session to begin at approximately 1:30 p.m. (depending on agenda items) and again immediately following Open Session, if needed

- January 31, 2019 (Last Thursday)
- February 28, 2019 (Last Thursday)
- March 28, 2019 (Last Thursday)
- April 25, 2019 (Last Thursday)
- May 30, 2019 (Last Thursday)
- June 27, 2019 (Last Thursday)
- July 25, 2019 (Last Thursday)
- August 29, 2019 (Last Thursday)
- September 26, 2019 (Last Thursday)
- October 31, 2019 (Last Thursday)
- No meeting in November due to Thanksgiving holiday
- December 12, 2019 (Second Thursday in December)

Special Board of Directors Meeting – April 2, 2019 – 1:00 p.m.
Closed Session to review biennial quality reports

Special Board of Directors Meeting – June 20, 2019 – 6:00 p.m.
Budget Meeting

Special Board of Directors Meeting – September 12, 2019 – 1:00 p.m.
Closed Session to review biennial quality reports

2019 Dates to Note:

- AHA Annual Meeting – April 7-10, 2019

Proposed Schedule: December 13, 2018
Approved by BOD:

Tri-City Medical Center
MEDICAL STAFF

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

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 12/14/2018 – 10/31/2020)

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 12/14/2018 through 10/31/2020:

- AL-BALAS, Hassan MD/Teleradiology (StatRad)
- BADIEE, Behyar DO/Family Medicine
- CHAUHAN-JAMES, Jaimini MD/Psychiatry (Vituity)
- DANG, Christopher DO/Emergency Medicine (TeamHealth)
- HARMAN, Herbert MD/Psychiatry (Vituity)
- HIDY, Benjamin MD/Psychiatry (Vituity)
- JOHN, Katrina MD/Emergency Medicine (TeamHealth)
- MOLL, Angela MD/Ophthalmology (Rady Children's Hospital San Diego)
- RANDALL, Penny MD/Psychiatry (Vituity)
- RAMEZANI, Roshanak MD/Psychiatry (Vituity)
- WAKILY, Hussna MD/Surgery (Coastal Surgeons)

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 4
November 14, 2018

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 01/01/2019 –12/31/2020)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 01/01/2019 through 12/31/2020, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- **AMBO, Stanley, MD/Pediatrics/Active**
- **CHO, Aaron, MD/Radiology/Active Affiliate**
- **FRISHBERG, Benjamin, MD/Neurology/Active**
- **GERBER, Michele, MD/Obstetrics & Gynecology/Provisional**
- **KATO, Kambrie, MD/Teleradiology/Provisional**
- **KHAWAR, Osman, MD/Nephrology/Active Affiliate**
- **KORABATHINA, Kalyani, MD/Neurology/Provisional**
- **KYAW, Naing, MD/Nephrology/Active**
- **MAYBERRY, Jennifer, MD/Radiology/Active**
- **MCWHIRTER, Robert, MD/Emergency Medicine/Active**
- **MILLER, Jason, MD/Pain Medicine/Active Affiliate**
- **MOSTOFIAN, Eimaneh, MD/Obstetrics & Gynecology/Active**
- **NGUYEN, Minh, MD/Internal Medicine/Active**
- **NOLAN, Frank, MD/Rheumatology/Refer and Follow**
- **POP, Simona, MD/Family Medicine/Refer and Follow**
- **PRINCE, Jennifer, DO/Pediatrics/Provisional**
- **SHAD, Javaid, MD/Gastroenterology/Active**
- **SINGH, Himani, MD/Oncology/Provisional**

Attachment B

- WINE, David, MD/Internal Medicine/Refer and Follow

CHANGE OF STATUS:

- MARCISZ, Thomas, MD/Neurosurgery/Active

RESIGNATIONS:

Automatic: (Effective date 11/30/2018 unless otherwise noted)

- BENNETT, John, MD/OB/GYN
- LONGACRE, Brett, NP/Allied Health Professional
- OJA-HAMMAD, Anita R., MD/Internal Medicine

Voluntary: (Effective date 12/31/2018 unless otherwise noted)

- IUREWITZ, William, MD/OB/GYN
- HOOPES, David, MD/Radiation Oncology
- POWELL, Carl, DO/General/Vascular Surgery
- PROCHERA, Ann Marie, MD/Anesthesiology
- RICHTAND, Neil, MD/Psychiatry
- WISEMAN, Stephen, MD/Anesthesiology

Tri-City Medical Center
MEDICAL STAFF

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

Attachment B

ADDITIONAL PRIVILEGE REQUEST (Effective 12/14/2018, unless otherwise specified)
The following practitioners requested the following privilege(s) and met the initial criteria for the privilege(s)

- RAJAMANICKAM, Anitha, M.D. — Interventional Cardiology

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by **May 31, 2019** would result in these privileges automatically relinquishing.

- AHMED, Mohammed, MD — Psychiatry
- BEN-HAIM, Sharona, MD — Neurosurgery
- EIKERMANN, Eric, MD — Anesthesiology
- KELLY, Jon, MD — Orthopedic Surgery
- MADANI, Michael MD — Cardiothoracic Surgery
- MITCHELL, Charles, MD — Radiology
- PERRICONE, Anthony, MD — Cardiothoracic Surgery
- PONEC, Donald MD — Radiology
- PRETORIUS, Gert, MD — Cardiothoracic Surgery
- REEN, Sandeep, MD — Family Medicine
- SHABANIAN, Leila, MD — Internal Medicine
- THISTLETHWAITE, Patricia MD — Internal Medicine

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given six months from the last reappointment date to complete their outstanding proctoring, and given an additional six month period after that one. These practitioners failed to meet the proposed deadline and are approved for an additional 3 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by ***February 28, 2019*** would result in these privileges automatically relinquishing.

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

- **PASHMFOROUSH, Mohammad MD** — **Cardiology**
- **SHAHIDI-ASL, Mahnaz MD** — **Pathology**

Tri-City Medical Center
MEDICAL STAFF

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

Attachment C

PROCTORING RECOMMENDATIONS (Effective 12/14/18, unless otherwise specified)

• BAJA, Diosdado Jr., MD	Anesthesiology
• CHIAO, Hellen, MD	Gastroenterology
• DALLA BETTA, Michael, DO	Emergency Medicine
• FISCHER, Andrew, MD	Emergency Medicine
• MEMEO, Kelly, NP	Allied Health Professional
• NELSON, Jesse, DO	Anesthesiology
• ONIVEROS RAMIREZ, Jorge, MD	Emergency Medicine
• RAJAMANICKAM, Anitha, MD	Cardiology
• SHABRANG, Cyrus, MD	Radiology
• VASHISHTA, Rishi, MD	Anesthesiology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – 1 of 1
November 2018 – *Electronic Approval*

Attachment B

REINSTATEMENT: **(Effective dates 12/14/2018 - 07/31/2020)**

Any items of concern will be "red" flagged in this report. The following application was recommended for reinstatement to the medical staff office effective 12/14/2018 through 07/31/2020, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- **WEICHERT, Rachel, AuD/Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

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

ANNUAL EVALUATIONS: The following providers have received annual evaluations and have been recommended for continued AHP membership.

- Kimber, James PA-C
- King, John AuD
- Miller, Cortney FNP
- Myers, Shannon E. AuD

I. **DEFINITIONS:**

A. Allied Health Practitioner (AHP) means a health care professional, other than a physician, dentist or podiatrist, who holds a license or other legal credential, as required by California law, to provide certain professional services and who, pursuant to the terms of the Medical Staff Bylaws, are not eligible for Medical Staff membership, but have been granted clinical privileges to provide certain clinical services.

B. Clinical Privileges (or Privileges) means the permission granted to an AHP to provide specified patient care services within his or her qualifications and scope of practice.

II. **QUALIFICATIONS:**

A. An AHP is eligible for clinical privileges at Tri-City Medical Center (TCMC) if he or she:

1. Holds a license, certificate, or other legal credential in a category of AHPs which the Board of Directors has identified as eligible to apply for clinical privileges; and
2. Meets the qualifications described in these Rules and Regulations; and
3. Documents his or her education, experience, background, training, current competence, judgment, and ability with sufficient adequacy to demonstrate that any patient treated by the practitioner will receive care of the generally recognized professional level of quality established by the Medical Staff; and
4. Is determined, on the basis of documented references to adhere strictly to the lawful ethics of his or her profession, to work cooperatively with others in the hospital setting so as not to affect adversely patient care, and to be willing to commit to and regularly assist the Medical Staff in fulfilling its obligations related to patient care, within the areas of the practitioner's professional competence and credentials; and
5. Agrees to comply with all Medical Staff and Department and Division bylaws, rules and regulations, policies and procedures, and protocols to the extent applicable to the AHP; and
6. Maintains professional liability insurance, or is covered by the terms of their employer's insurance, with an insurer meeting the requirements specified in Medical Staff Policy 8710-558 (Liability Insurance Requirements), with minimum limits in the amount of $1 million per occurrence and $3 million per aggregate.

B. More specific qualifications may be established by Departments and/or Divisions as stated in their respective rules and regulations and/or other privileging documents.

III. **CATEGORIES OF AHPs ELIGIBLE TO APPLY FOR CLINICAL PRIVILEGES:**

A. The following categories of Allied Health Professionals have been approved by the Board of Directors:

1. Audiologist
2. Certified Nurse Midwife
3. Clinical Psychologist
4. Marriage and Family Therapist Intern
5. Medical Physicist/Radiation Physicist
6. Nurse Practitioner
7. Orthopedic Surgery Technician

8. Physician Assistant
9. Registered Nurse First Assist

B. The Board of Directors shall review the designation of categories at least annually and at other times within its discretion or upon the recommendation of the Medical Executive Committee (MEC).

IV. **PROCEDURE FOR GRANTING CLINICAL PRIVILEGES:**

A. An AHP whose scope of practice allows independent practice must apply and qualify for clinical privileges and, at the time patient care services are rendered, must designate a physician member of the active medical staff who is responsible, to the extent necessary, for the general medical condition of the patient for whom the AHP proposes to render services in the hospital. This provision currently only applies to clinical psychologists. Each AHP who practices independently must maintain communication with the relevant physician in order to enable the physician to assume responsibility, to the extent it is indicated, for the general medical condition of the patient.

B. An AHP whose scope of practice does not allow independent practice must apply and qualify for clinical privileges and must provide services under the supervision of an active Medical Staff member. An AHP under this subsection may apply to work under the supervision of one active Medical Staff member or a group of medical staff members. Such supervision must be in strict accordance with any hospital-developed standardized procedures and with any rules and regulations or other policies developed by the appropriate department/division and approved by the MEC, and does not replace any supervision requirements mandated under state law.

C. All AHP applications for initial granting and renewal of clinical privileges shall be submitted to the Interdisciplinary Practice Committee (IDPC). All such applications shall be processed in a parallel manner to that provided in Articles IV (Membership and Membership Renewal) and V (Clinical Privileges) of the Medical Staff Bylaws, except that the Interdisciplinary Practice Committee shall review all AHP applications prior to the Credentials Committee review, and except that any reference in the Bylaws to hearing rights shall not apply to any AHP except clinical psychologists.

D. AHPs shall not practice within the hospital until requested privileges have been granted. Temporary privileges may be granted. Granting of temporary privileges shall follow a similar process as prescribed by the Medical Staff Bylaws, Section 5.5 and in Medical Staff Policy 8710-515 (Temporary Privileges).

E. Except as is provided below, an AHP who (a) has received a final adverse decision regarding his or her application for clinical privileges, (b) withdrew his or her application for clinical privileges following an adverse recommendation by the IDPC or MEC, (c) after having been granted clinical privileges, has received a final adverse decision resulting in termination of clinical privileges or (d) has relinquished his or her clinical privileges following the issuance of a IDPC, MEC, or Board of Directors recommendation adverse to his or her clinical privileges, shall not be eligible to reapply for clinical privileges affected by such decision or recommendation for a period of at least 18 months from the date the adverse decision became final, the application was withdrawn, or the AHP relinquished his or her clinical privileges. An AHP who reapplies after the waiting period must

provide evidence demonstrating to the Medical Staff's satisfaction that the factors that led to the adverse recommendations or actions have been resolved. The waiting period described in this Section shall not apply to an AHP whose application was deemed withdrawn as incomplete, whose application was denied for failing to meet the Specific Credentialing Criteria found in Section XIV, or whose privileges were automatically terminated under Section IX.

F. AHP categories identified as eligible for clinical privileges are identified above. Practitioners who are not in one of those categories may not apply for clinical privileges, but may submit a written request to the IDPC, requesting that the Medical Staff and the Board of Directors consider adding an additional category of AHPs eligible to apply for clinical privileges.

1. Upon receipt of such a request, the IDPC shall obtain the recommendation of any affected department or division in order to determine if there is a need for an additional category of AHP and shall forward the recommendation from the respective department or division to the Credentials Committee. The recommendation of the Credentials Committee is then forwarded on to the MEC.
2. The MEC makes the final recommendation to the Board of Directors. The Board of Directors shall consider the recommendation of the MEC, as well as the recommendation of any affected department or division, either before or at the time of its annual review of the categories of AHPs. If the requested category of AHP fulfills a patient service need as identified by the Board of Directors, the category will be added to the recognized categories of AHP.
3. Once added, the appropriate department/division, IDPC and Credentials Committee (as appropriate), and MEC shall establish clinical privilege requirements, scope of service, and monitoring mechanisms. After approval by the Board of Directors of these requirements, the AHP may apply for clinical privileges.

G. Each AHP who is granted clinical privileges shall be assigned to the department/division appropriate to his or her occupational or professional training. Although AHPs may not be Medical Staff members, they shall, unless otherwise specified in these rules and regulations, be subject to the Basic Responsibilities of Medical Staff Membership and the prohibition against harassment specified in Article II (Membership) of the Medical Staff Bylaws, as they may logically apply to AHPs and may be appropriately tailored to the particular category of AHPs. In addition, each AHP must adhere to the terms and conditions as delineated in their delegation of services agreement, standardized procedures, protocols, job description, and clinical privileges.

H. If a service provided by a category of AHP is no longer a service that is being provided by TCMC, the category may be eliminated without affording the process described in section VIII of these rules and regulations to those AHPs affected.

V. PREROGATIVES:

A. The prerogatives which may be extended to a member of a particular category of AHP shall be defined in the applicable privilege/prerogatives cards reviewed by the Department/Division Chief and the IDPC, and approved by the Medical Executive Committee. Such prerogatives may include:

1. Provision of specified patient care services consistent with clinical privileges granted to the AHP and within the scope of the AHP's licensure or certification.
2. Service on Medical Staff and hospital committees except as otherwise expressly provided in the Medical Staff bylaws, rules and regulations. An AHP may not serve as chair of Medical Staff committees.
3. Attendance at meetings of the Department/Division to which he or she is assigned, as permitted by the department/division rules and regulations, and attendance at Medical Staff educational programs in his or her field of practice. An AHP may not vote at department/division meetings.

B. AHPs may not:
1. Admit or discharge patients from the hospital .
2. Give orders, verbal or written, unless they are authorized by the Medical Staff and unless it is within the AHP's scope of licensure.
3. Give telephone orders.
4. Act as a first assistant at any surgical, diagnostic or therapeutic procedure for which the Medical Staff requires the presence of an assisting physician.
5. Inhibit or in any way interfere with the responsibilities of employees of the hospital.

VI. RESPONSIBILITIES:

A. Each AHP shall:
1. Meet those responsibilities required by the Medical Staff bylaws, rules and regulations, policies and procedures and TCMC policies and procedures.
2. Retain appropriate responsibility within his/her area of professional competence for the care of each patient in the hospital for whom he/she is providing services.
3. Participate, when requested, in patient care audit and other quality review, evaluation, and monitoring activities required of AHPs, in evaluating AHP applicants, in supervising initial AHP appointees of his/her same occupation or profession or of an occupation or profession which has a more limited scope of practice, and in discharging such other functions as may be required by the Medical Staff from time to time.
4. Prepare and complete, in a timely manner, any documentation relevant to patient care provided.
5. Abide by the ethical and moral principles of their respective profession.

VII. DEFINITION OF PHYSICIAN SUPERVISION:

A. Level of Physician Supervision -
1. Each AHP shall be supervised by their supervising physician(s) in a manner consistent with the requirements of the California scope of practice statutes and regulations, as well as in a manner consistent with these Rules and Regulations, the Medical Staff Bylaws, and the applicable privileging forms, standardized procedures, delegation agreements, and policy and procedures.
2. Each supervising physician must sign a medical staff-developed form acknowledging his or her responsibilities as a supervising physician.
3. Each supervising physician must be available in the manner detailed by the applicable privileging forms, standardized procedures, delegation agreements, and policy and procedures,

4. The supervising physician shall always be available by electronic communication whenever the AHP he or she is supervising is practicing at the hospital.
5. The following additional supervision requirements apply to the following units and situations:
   i Medical/Surgical Units: Documentation of an examination of the patient by the supervising physician(s) every third day if care is given by the AHP.
   ii ICU/Telemetry Units: Examination of the patient by the supervising physician(s) the same day as care is given by the AHP.
   iii Non-Scheduled Admission(s): Examination of the patient by the supervising physician(s) the same day as care is given by the AHP.

B. Podiatrists may not supervise physician assistants unless the podiatrist also holds a M.D. or a D.O. license.

C. Physician Co-signature:
1. Order(s), verbal or written, may be immediately implemented. Physician co-signature is required within 48 hours of AHP's order excluding those covered under an already approved standardized procedure.
2. Any medical record of any patient cared for by an AHP for whom the physician's prescription has been transmitted or carried out shall be reviewed and countersigned and dated by the supervising physician within 48 hours.
3. The H&P must be co-signed by the supervising physician(s) within 48 hours.
4. The supervising physician must review and authenticate any progress note within the medical record of any patient(s) documented by an AHP within 48 hours.

D. Each time an AHP provides care for a patient and enters his/her name, signature, initials, or computer code on a patient's record, chart, or order, the AHP must also enter the name of his/her supervising physician who is responsible for the patient. When a physician assistant transmits an oral order, he/she must also state the name of the supervising physician responsible for the patient (16 C.C.R. §1399.546.)

VIII. TERMINATION, SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES:

A. PROCEDURES FOR AHPS WHO ARE NOT NURSE PRACTITIONERS, CERTIFIED NURSE MIDWIVES, REGISTERED NURSE FIRST ASSISTS, OR PHYSICIAN ASSISTANT

1. For the purposes of Section VIII.A. only, the term "AHP" applies only to those professionals who are not nurse practitioners, certified nurse midwives, registered nurse first assists, or physician assistant.

2. At any time, the Chief of Staff or Chair/Chief of the Department/Division to which the AHP has been assigned may recommend to the MEC that an AHP's clinical privileges be terminated, suspended or restricted. After investigation (including, if appropriate, consultation with the Interdisciplinary Practice Committee), if the MEC agrees that corrective action is appropriate, the MEC shall recommend specific

corrective action to the Board of Directors. A Notification Letter regarding the recommendation shall be sent by certified mail to the subject AHP. The Notification Letter shall inform the AHP of the recommendation and the circumstances giving rise to the recommendation.

3. Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an AHP, other than a clinical psychologist, to the hearing rights set forth in Bylaws Articles VI and VII. However, an AHP shall have the right to challenge any recommendation which would constitute grounds for a hearing under Section 7.2 of the Bylaws (to the extent that such grounds are applicable by analogy to the AHP) by filing a written objection (i.e., a letter objecting to the recommended action and requesting an interview) with the MEC within fifteen (15) days of receipt of the Notification Letter. Upon receipt of an objection, the MEC or its designee shall afford the AHP an opportunity for an interview concerning the objection. Although such interview shall not constitute a "hearing" as established by Article VII of the Bylaws, and need not be conducted according to the procedural rules applicable to such hearings, the purpose of the interview is to allow both the AHP and the party recommending the action the opportunity to discuss the situation and to produce evidence in support of their respective positions. The MEC shall have sole discretion in determining what evidence may be permitted and how it may be presented. Minutes of the interview shall be retained.

4. Within fifteen (15) days following the interview, the MEC, based on the interview and all other aspects of the investigation, shall make a final recommendation to the Board of Directors, which shall be communicated in writing, sent by certified mail, to the subject AHP. The final recommendation shall discuss the circumstances giving rise to the recommendation and any pertinent information from the interview. Prior to acting on the matter, the Board of Directors may, in its discretion, offer the affected practitioner the right to discuss the recommendation with the Board or with a subcommittee of the Board, in a manner and at a time determined by the Board. The Board of Directors shall adopt the MEC's recommendation, so long as it is reasonable and appropriate under the circumstances. The final decision by the Board of Directors shall become effective upon the date of its adoption. The AHP shall be promptly provided with notice of the final action, sent by certified mail.

B. **PROCEDURES FOR AHPS WHO ARE NURSE PRACTITIONERS, CERTIFIED NURSE MIDWIVES, REGISTERED NURSE FIRST ASSISTS, OR PHYSICIAN ASSISTANTS:**

1. AHPs who are nurse practitioners, certified nurse midwives, registered nurse first assists, or physician assistants shall be entitled to the AHP limited-hearing procedures detailed below:

Purpose

This Appendix A to the Allied Health Practitioner Rules and Regulations provides the process by which certain Allied Health Practitioners subject to the Allied Health Practitioner Rules and Regulations of the Tri-City Medical Center Medical Staff can challenge adverse actions or adverse recommendations against their practice privileges.

Scope/Coverage

This policy applies only to nurse practitioners (NP), certified nurse midwifes (CNM), certified registered nurse anesthetists (CRNA), registered nurse first assists (RNFA), and physician assistants (PA).

Definitions

1. **Adverse Action and Adverse Recommendation** mean actions and recommendations, respectively, that constitute grounds for a hearing, as described in the AHP Rules and Regulations.

2. **Allied Health Practitioner (AHP)** for the purposes of this Appendix, means only NPs, CNMs, RNFAs, CRNAs, and PAs.

3. **Limited Hearing** means the process by which AHPs may challenge an adverse action or an adverse recommendation, and is not a hearing that is described in the Medical Staff Bylaws.

Policy

Nothing contained in the Medical Staff Bylaws or this Appendix shall be interpreted to entitle an AHP covered by the scope of this Appendix to the hearing rights set forth in Bylaws Articles VI and VII. However, an AHP covered by the scope of this Appendix shall have the right to challenge any recommendation which would constitute grounds for a hearing under Section 7.2 of the Bylaws (to the extent that such grounds are applicable by analogy to the AHP) as set forth here.

Procedure

1. At any time, the Chief of Staff or Chair/Chief of the Department/Division to which the AHP has been assigned may recommend to the Medical Executive Committee (MEC) that an AHP's clinical privileges be terminated, suspended or restricted. After investigation (including, if appropriate, consultation with the Interdisciplinary Practice Committee), if the MEC agrees that corrective action is appropriate, the MEC shall recommend corrective action and send a Notification Letter to the AHP. The Notification Letter shall inform the AHP of the recommendation and the circumstances giving rise to the recommendation.

2. An AHP may request a limited hearing by filing a written objection (i.e., a letter objecting to the recommended action and requesting review) MEC no later than 15 days after receipt of a Notification Letter. Failure to submit a letter within 15 days shall result in a waiver of the right to a limited hearing.

3. Upon receiving the request, the MEC shall make arrangements to convene a limited hearing. The limited hearing shall not constitute a Medical Staff

hearing as established in the Hearings and Appellate Review Article of the Bylaws and need not be conducted according to the procedural rules applicable to such hearings.

4. The parties to the limited hearing shall be the MEC and the AHP subject to the adverse recommendation or action. The MEC may select an individual to serve as its representative at the limited hearing; however, that person shall not be an attorney.

5. The Chief of Staff shall appoint at least three unbiased Medical Staff members or AHPs, or a combination of the two, who are in good standing and of good ethics, along with the appointment of at least one member to serve as an alternate, to serve on a review committee. Such appointment shall include designation of the chair. When feasible, at least one member shall hold the same type of license as the AHP party. The review committee members shall gain no direct financial benefit from the outcome of the limited hearing, and shall not have acted as accusers, investigators, fact finders, initial decision makers or otherwise actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude an individual from serving as a member of the review committee. Employers, supervisors, or co-workers of the AHP are not eligible to serve on the review committee.

6. The Chief of Staff may appoint a hearing officer, who shall have the same qualifications described for hearing officers in the Medical Staff Bylaws.

7. The chair of the review committee or hearing officer, if any, shall schedule the limited hearing, with the goal to for the limited hearing to occur no sooner than 30 days, and no later than 60 days, of the request for limited hearing.

8. No later than 20 days prior to the limited hearing, each party shall submit to the review committee a written statement of the party's own position. The written statement should be supported by proposed evidence, which may include, but is not limited to, declarations from witnesses and relevant portions of medical records. Each party must supply a copy of its written statement and the proposed supporting evidence to the other party. No later than 10 days before the limited hearing, each party may submit a rebuttal to the other party's written statement, with proposed supporting evidence. Each party must supply a copy of its rebuttal and proposed supporting evidence to the other party. The hearing officer, or if none is appointed, the review committee, may impose limits as to the length of the written submissions, and decides whether proposed evidence shall be included in the record of the limited hearing proceedings. An AHP applicant shall not be permitted to introduce information requested by the Medical Staff, but not produced during the application process, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

9. At the limited hearing, each party may make an oral argument addressing the issues raised by the adverse action or recommendation; however, neither party shall present evidence during the limited hearing that had not been presented with the written statement or rebuttal or that had been rejected by the hearing officer or review committee. The Hearing Officer or, if none appointed, the chair may impose appropriate time limits to the oral statements and to the limited hearing as a whole. The review committee may interview or question either party and may invite witnesses to attend the limited hearing in order to be questioned by the committee. No party may question a witness directly, though the parties may submit questions to the chair, which the chair, in his or her discretion, may ask the witness. Neither party may be represented by an attorney at the limited hearing. Minutes of the limited hearing shall be retained.

10. At the conclusion of the limited hearing, the review committee shall meet and deliberate. If a preponderance of the evidence supports the adverse action or recommendation, then the review committee shall recommend to the MEC that it be upheld. An AHP applicant shall bear the burden of persuading the review committee, by a preponderance of the evidence, of his/her qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her current qualifications for membership and privileges.

11. Within seven days of the review committee's deliberations, the committee shall submit a written decision to the parties and to the MEC regarding its recommendation, including facts and conclusions supporting the recommendation.

12. Within 14 days following receipt of the decision, the MEC will consider the review committee's decision and make a final recommendation to the Board of Directors. The MEC, in its discretion, may adopt the review committee's decision as its own, or may modify or reject the recommendation. The MEC shall deliver to each party a copy of its recommendation.

13. AHP shall have the right to appeal the MEC's recommendation to the Board of Directors.

14. The affected AHP shall be informed in writing of his or her right to appeal the final recommendation. The affected AHP shall have ten (10) days after being informed of his or her right to appeal to request an appeal review. The request for appeal shall state with specificity the basis for the appeal.

15. The appeal review shall be conducted within thirty (30) days of the request. The parties to the appeal shall be the MEC and the AHP.

16. Each party shall have the right to present a written statement in support of his, her or its position on appeal. The Board of Directors Chair shall appoint an Appeal Board of up to three people, including at least one Board member. Each party may submit a written statement in support of its position to the Appeal Board within thirty (30) days of the Board's acceptance of the appeal. No party has the right to personally appear and make oral argument, though the Appeal Board, in its discretion, may allow oral argument by both parties. In such cases, neither party shall have the right to representation by counsel at oral argument. The Appeal Board may then, at a time convenient to itself, deliberate outside the presence of the parties.

    i The Appeal Board shall issue written recommendations to the Board of Directors within fifteen (15) days of the conclusion of the appellate review. The Board of Directors shall issue a final decision at its next regular meeting, which shall be delivered to the parties by hand delivery, courier delivery service with confirmed delivery (such as Federal Express or UPS), or certified mail.

C. **SUMMARY SUSPENSION:**

1. Notwithstanding any other provision in Section VIII, an AHP's clinical privileges may be immediately suspended or restricted where the failure to take such action may result in an imminent danger to the health of any individual. Such summary suspension or restriction may be imposed by the Chief of Staff, the MEC, or the Chair/Chief of the Department/Division to which the AHP has been assigned (or his/her designee). Unless otherwise stated, the summary action shall become effective immediately upon imposition and the person responsible for taking such action shall promptly give written notice of the action to the Board of Directors, the MEC, and the Chief Executive Officer. The notice shall also inform the practitioner of his or her right to file an objection if the suspension is imposed for more than 14 days. The practitioner's right to file an objection and subsequent interview procedures shall be in accordance with Section VIII.A and B, except that all reasonable efforts shall be made to ensure that the practitioner is given an interview or limited-hearing as expeditiously as possible and that final action is taken within (15) days or as promptly thereafter as practicable.
2. Within three (3) working days of the summary action, the affected practitioner shall be provided with written notice of the action. The notice shall include the reason(s) for the action and that such action was necessary because of a reasonable probability that failure to take the action could result in imminent danger to the health of an individual.
3. Within five (5) working days following the action, the Interdisciplinary Practice Committee shall meet to consider the matter and make a recommendation to the MEC as to whether the summary suspension should be vacated or continued pending the outcome of any interview with the affected practitioner. Within eight (8) days following the imposition of the action, the MEC shall meet and consider the matter in light of any recommendation forwarded from the Interdisciplinary

Practice Committee. Within two (2) working days following the MEC's meeting, the MEC shall provide written notice to the affected practitioner regarding its determination on whether the summary action should be vacated or continued pending the outcome of any interview proceeding.

IX. **AUTOMATIC SUSPENSION, TERMINATION OR RESTRICTION:**

A. Notwithstanding subsection VIII.A, above, an AHP's clinical privileges may be subject to automatic suspension or termination as set forth in this Section IX.

B. An AHP's clinical privileges shall be subject to automatic suspension in the event that:

1. the AHP's license or other legal credential expires. The automatic suspension will continue until proof of renewal is received.
2. With respect to an AHP who must have a physician supervisor:
   - i The medical staff membership or privileges of the supervising physician is terminated, whether such termination is voluntary or involuntary; or
   - ii The supervising physician no longer agrees to act in such capacity, or
   - iii The relationship between the AHP and the supervising physician is otherwise terminated, regardless of the reason.

   In any of these cases, the automatic suspension will be lifted if the AHP finds a supervising physician within 30 days of the suspension being imposed.
3. The AHP fails maintain professional liability insurance, if any is required.
4. The AHP fails to complete medical records as required by policy and procedure.
5. The AHP fails to provide documentation of Tuberculin testing in accordance with applicable medical staff policy.
6. If the AHP's DEA certificate is revoked, limited or suspended, the AHP shall automatically and correspondingly be suspended of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
7. The AHP fails, without good cause, to appear at a meeting called by the AHP's department chair or section chief or a medical staff committee or officer to discuss a suspected deviation from standard clinical practice, if the AHP has been given at least seven days' written notice of such meeting.

C. Notwithstanding subsection VIII.A, above, an AHP's clinical privileges shall automatically terminate in the event that:

1. The AHP's privileges have been automatically suspended for more than 30 continuous days.
2. The AHP's certification, license, or other legal credential is not renewed, is revoked, or is suspended.

D. In the event that the AHP's certification, license, or DEA certification is restricted or made the subject of an order of probation, the AHP's corresponding clinical privileges shall automatically be subject to the same restrictions or conditions of probation.

E. Where the AHP's privileges are automatically terminated, suspended, or restricted pursuant to this subsection, the notice and interview procedures under subsection VIII shall not apply and the AHP shall have no right to an interview. The MEC, within its discretion, may, upon the AHP's request, invite the AHP to a meeting to discuss any

factual dispute over whether or not the circumstances giving rise to the automatic termination, suspension, or restriction actually exist. Such a meeting shall not be a hearing under the Medical Staff Bylaws or an interview or AHP limited-hearing under Section VIII, above.

X. **APPLICABILITY OF SECTION VIII:**

A. The rights afforded by Section VIII shall not apply to any decision regarding whether a category of AHP shall be eligible for clinical privileges or the terms or conditions of such decision.

XI. **REAPPLICATION:**

A. Initial and renewal of clinical privileges shall be for a period of up to two years. Each AHP must reapply for renewed clinical privileges in accordance with Section IV.

XII. **ON-GOING PROFESSIONAL PRACTICE EVALUATION (OPPE):**

A. AHPs are subject to the provisions of the Medical Staff's OPPE process outlined in Medical Staff Policy 8710-509.

XIII. **FOCUS PROFESSIONAL PRACTICE EVALUATION (FPPE)/PROCTORING:**

A. AHPs are subject to the provisions of the Medical Staff's FPPE process outlined in Medical Staff Policy 8710-542 and the applicable Department/Division Rules and Regulations.

B. In addition to what is specified in the applicable Department/Division Rules and Regulations, all AHPs shall be proctored (i.e., initial FPPE) for a minimum of six (6) cases of patient contact.

XIV. **SPECIFIC CREDENTIALING CRITERIA** (in addition to documentation of current competence in scope of privileges and other documentation as requested in accordance with Medical Staff Bylaws and applicable Department/Division requirements):

A. Audiologist:
   1. Current, valid Audiologist license issued by the California Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.
   2. Masters or doctorate degree in audiology (AuD)
   3. Documentation of participation in relevant continuing education activities.
   4.

B. Certified Nurse Midwife (CNM)
   1. Current, valid RN license issued by the California Board of Registered Nursing
   2. Current, valid NM certificate issued by the California Board of Registered Nursing
   3. Current Furnishing Number issued by the California Board of Registered Nursing
   4. Current certification (or actively pursuing certification; must be certified within one year of initial appointment) by the American Midwifery Certification Board (formerly the ACNM Certification Council, Inc.) College of Nurse Midwives
   5. Current, valid NRP certificate

6. Current, valid DEA registration
7. Documentation of participation in relevant continuing education activities.

C. Clinical Psychologist
1. PhD or PsyD degree
2. Current, valid Clinical Psychologist license issued by the California Board of Psychology
3. Documentation of participation in relevant continuing education activities.

D. Marriage and Family Therapist Intern
1. Masters or doctorate in counseling psychology
2. Registered with the California Board of Behavioral Sciences as an MFT Intern
3. BLS or ACLS
4. Documentation of participation in relevant continuing education activities.

E. Medical Physicist/Radiation Physicist
1. Masters of Science in medical physics or physics; or PhD in related field
2. Certified by the American Board of Medical Physics, the American Board of Radiology, or in the process of obtaining certification.
3. Documentation of participation in relevant continuing education activities.

F. Nurse Practitioner (NP) (Non-surgical)
1. Current, valid RN license issued by the California Board of Registered Nursing
2. Current, valid NP certificate issued by the California Board of Registered Nursing
3. Current, valid Furnishing Number issued by the California Board of Registered Nursing
4. Current, valid DEA registration issued by the United States Drug Enforcement Administration.
5. Documentation of participation in relevant continuing education activities.
6. BLS or ACLS

G. Nurse Practitioner (NP) (Surgical)
1. Current, valid RN license issued by the California Board of Registered Nursing
2. Current, valid NP certificate issued by the California Board of Registered Nursing
3. Current, valid Furnishing Number issued by the California Board of Registered Nursing
4. Current, valid DEA registration issued by the United States Drug Enforcement Administration.
5. Documentation of participation in relevant continuing education activities.
6. BLS or ACLS
7. Documented completion of a formal Registered Nurse First Assistant training program.

H. Orthopedic Surgery Technician
1. Certified by the National Board for Certification of Orthopedic Technologists
2. Documentation of participation in relevant continuing education activities.
3. BLS or ACLS

I. Physician Assistant (PA)
1. Graduate of an accredited physician assistant education program

2. Current, valid PA license issued by the California Physician Assistant Board.
3. Certified by the National Commission on Certification of Physician Assistants
4. Current, valid DEA registration issued by the United States Drug Enforcement Administration.
5. Documentation of participation in relevant continuing education activities.
6. BLS or ACLS

J. Registered Nurse First Assist (RNFA)

1. Current, valid license issued by the California Board of Registered Nursing
2. Current CNOR certification
3. Documentation of successful completion an AORN-approved RNFA course
4. Documentation of participation in relevant continuing education activities.
5. ACLS

APPROVALS:

Interdisciplinary Practice Committee:	~~2/17~~10/18
Medical Executive Committee:	3/17
Board of Directors:	3/17

Tri-City Medical Center

Delineation of Privileges

Cardiology - 11/18

Provider Name:

Request	Privilege	Action MSO Use Only

Please check the box next to the privilege bundle(s) you wish to request. Please strike through any procedure within your requested bundle that you do not wish to request.

CRITERIA: The Division of Cardiology consists of physicians who are Board Certified in Cardiovascular disease by the American Board of Internal Medicine or are actively progressing toward certification.
Applicants who are progressing toward Board Certification must complete formal training prior to applying for medical staff membership in the Division of Cardiology and must become Board Certified within five (5) years of the initial granting of medical staff membership, unless extended for good cause by the Medical Executive Committee.

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

COGNITIVE PRIVILEGES:

Initial Requirement: Must meet basic qualifications as outlined above.
Proctoring Requirement: A minimum of 6 cases proctored resulting in any combination of H&P'sand/or Consultations.
Reappointment Criteria: Documentation of 6 cases within the past two years is required.

___ Admission of a Patient to Inpatient Services

___ Performance of a History and Physical Examination, including via telemedicine

___ Performance of a Cardiac Consultation, including via telemedicine

___ Operation of Fluoroscopy Equipment
Prerequisite Criteria: Requires Current Fluoroscopy certificate.

ALLIED HEALTH PRACTITIONER SUPERVISOR PRIVILEGES

___ Supervision of an approved category of Allied Health Practitioner

SEDATION/ANALGESIAPRIVILEGES:

___ Moderate Sedation/Analgesia

Initial/Reappointment Criteria: Per Medical Staff policy 8710-517

___ Deep Sedation Sedation/Analgesia
Initial/Reappointment Criteria: Per Medical Staff policy 8710-517

BASIC INVASIVE PROCEDURES:

Initial Criteria: Must meet basic qualifications as outlined above and have performed at least four (4) of each privilege requested within the previous 24 month period is required.
Proctoring Requirements: One(1) of each privilege requested.
Reappointment Criteria: In order to maintain this privilege bundle, competency criteria of four (4)cases of each procedure requested within the previous 24 month period is required.

___ Venous cut-down & Percutaneous Central Venous Pressure Catheters

___ Insertion of Temporary Transvenous Cardiac Pacemaker

___ Elective Cardioversion

Printed on Wednesday, November 14, 2018

Provider Name:

Request	Privilege	Action MSO Use Only
___	Swan-Ganz Catheter Insertion & Monitoring	___

CARDIAC CATHETERIZATION PROCEDURES

Initial Criteria: Must meet basic qualifications as outlined above and provide training and show current competency of have performed at least three-hundred (300) cases; if more than 12 months since completion of training, documentation of forty (40) cases within two (2) years prior to application is required.
Proctoring Requirements: Five (5) cases
Reappointment Criteria: In order to maintain this privilege bundle, competency criteria of forty (40)cases within the previous 24 month period is required.

___	RIGHT Cardiac Catheterization	___
___	LEFT Cardiac Catheterization	___
___	Coronary Arteriography	___

SPECIAL PROCEDURES

Initial Criteria: Must meet basic qualifications as outlined above and the specific criteria indicated below.

Permanent Pacemaker Insertion (single/dual/biventricular chamber) and/or intra-cardiac defibrillator (ICD) (single/dual/biventricular chamber) requires proof of completion of fellowship training or twenty-five (25) cases.
Percutaneous Angioplasty (PTCA) requires training & two-hundred fifty (250) cases; if more than 12 months since completion of training, documentation of seventy (75) cases within the two years prior to application.
Pericardiocentesis: Requires a Fluoroscopy Certificate
Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation requires completion of accredited fellowship in Clinical Cardiac Electrophysiology, Board Certification or eligibility & twenty (20) cases within the past 12 months prior to application.
Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation requires completion of accredited fellowship in Clinical Cardiac Electrophysiology, Board Certification or eligibility & twenty (20) cases within the past 12 months prior to application.
Rotational Atherectomy requires meeting PTCA criteria and Boston Scientific Certificate documenting training (FDA requirement).
Transesophageal echocardiography (including passing the probe) requires documentation of training or a course.

Proctoring Requirements:

Permanent Pacemakers/ICDs: two (2)
Percutaneous angioplasty (PTCA):five (5)
Pericardiocentesis: one (1)
Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation: two (2)
Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation: two (2)
Rotational Atherectomy: three (3)
Transesophageal echocardiography: two (2)

Reappointment Criteria:

Permanent Pacemaker/ICD cases: ten (10)
Percutaneous Angioplasty (PTCA): seventy five (75) cases of which twenty (20) must be done at TCMC
Pericardiocentesis: one (1)
Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation: Twenty (20)

Provider Name:

Request	Privilege	Action MSO Use Only

Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation: Twenty (20)
Rotational Atherectomy: six (6)
Transesophageal echocardiography: ten(10)

___ Permanent Pacemaker/ICD Insertion ___

___ Percutaneous Angioplasty (PTCA) ___

___ Pericardiocentesis ___

___ Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation ___

___ Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation ___

___ Rotational Atherectomy ___

___ Transesophageal echocardiography ___

NON-INVASIVE PROCEDURES:

Initial Criteria: Must meet basic qualifications as outlined above and be a cardiologist with fellowship training and is an active reading panel participant and has sufficient case volumes to fulfill reappointment volume requirements as outlined below for each procedure requested.

Proctoring Requirements:

EKG: twenty five (25)
Stress ECHO: two (2)
Thoracic ECHO: two (2)
Holter Monitor: two (2)
Treadmill: two (2)

Reappointment Criteria:

EKG: five hundred (500) or active reading panel member as attested by Division of Chief or designee.
Stress Echo: five (5) Documentation of Stress Echos performed at other facilities (including the physician's office) will count towards this requirement.
Thoracic Echos: two hundred (200) or active reading panel member as attested by Division of Chief or designee.
Holter Monitor: forty (40), of which ten (10) must be performed at TCMC or active reading panel member as attested by Division of Chief or designee.
Treadmill: fifty (50) or active reading panel member as attested by Division of Chief or designee.

___ EKG ___

___ Stress Echo ___

___ Thoracic Echo ___

___ Holter Monitor ___

___ Treadmills ___

___ **PERIPHERAL VASCULAR INTERVENTIONAL PROCEDURES** (Refer to Medical Staff Policy # 8710-504 for Initial, Proctoring, and Reappointment Criteria) ___

___ Peripheral Angiography - By selecting this privilege, you are requesting the core privileges listed immediately below. If you do not want any of the core privileges below, strikethrough and initial the ___

Provider Name:

Request	Privilege	Action MSO Use Only

privilege(s) you do not want.

Carotid

Cerebral

Extremity

Pulmonary

Thoracic

Visceral

___ Peripheral Intervention - By selecting this privilege, you are requesting the core privileges listed immediately below. If you do not want any of the core privileges below, strikethrough and initial the privilege(s) you do not want.

Angioplasty

Drug infusion

Stent graft

Stent placement

Thrombolysis

___ Venography and Venous Intervention - By selecting this privilege, you are requesting the core privileges listed immediately below. If you do not want any of the core privileges below, strikethrough and initial the privilege(s) you do not want.

IVC filter

Stent

Tissue plasminogen activator (tPA)

Venous Sampling

Venous Thrombolysis

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

Tri-City Medical Center
Delineation of Privileges
Cardiology - 11/18

Provider Name:

Request	Privilege	Action MSO Use Only

Division/Department Signature (By Signing this form I agree with the granting of these privileges indicated above.)

Date

ADMINISTRATION REVIEW CONSENT AGENDA
December 3rd, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Code Adam 369 Policy	3 Year Review, Practice Change	Forward to BOD for Approval
2. Micromedex Carenotes Procedure	DELETE	Forward to BOD for Approval
3. Skills Lab, Annual Interdisciplinary Policy	DELETE	Forward to BOD for Approval
4. Stryker Glide Lateral Air Transfer Device Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
5. Volunteers, Patient Care Services Departments Policy	3 Year Review, Practice Change	Forward to BOD for Approval
Administrative Policies & Procedures		
1. Authorized Access Medications 298	3 Year Review, Practice Change	Forward to BOD for Approval
2. Severance Plan - 454	3 Year Review, Practice Change	Forward to BOD for Approval
Infection Control		
1. Management of Patients with Multi-Drug Resistant Organisms (MDRO) and/or C. Difficile Infection	Practice Change	Forward to BOD for Approval
NICU		
1. Criteria for Case Referrals to Morbidity and Mortality	2 Year Review, Practice Change	Forward to BOD for Approval
2. Education Plan, NICU	2 Year Review, Practice Change	Forward to BOD for Approval
3. NICU Placement: Overflow to Alternate Location (Temporary Overflow)	DELETE	Forward to BOD for Approval
Pharmacy		
1. Antimicrobial Stewardship Program Policy	DELETE	Forward to BOD for Approval
2. Bedside Medication Storage	DELETE	Forward to BOD for Approval
3. Controlled Substances - Pharmacy	3 Year Review, Practice Change	Forward to BOD for Approval
4. Discharge Prescriptions	3 Year Review, Practice Change	Forward to BOD for Approval
5. Drug Compounding for Medication Not Commercially Available	Practice Change	Forward to BOD for Approval
6. Drug Product Procurement and Inventory Management	3 Year Review, Practice Change	Forward to BOD for Approval
7. Unusable Medications	3 Year Review, Practice Change	Forward to BOD for Approval
8. Verbal and Written Orders - General	DELETE	Forward to BOD for Approval
Rehabilitation		
1. Physical Plant - 105	3 Year Review, Practice Change	Forward to BOD for Approval
Pre-Printed Orders		
1. Adult Parenteral Nutrition Orders	3 Year Review, Practice Change	Forward to BOD for Approval
2. Wound V.A.C. (Vacuum Assisted Closure) Orders 8711-4026	DELETE	Forward to BOD for Approval

ADMINISTRATION REVIEW CONSENT AGENDA
December 3rd, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Formulary Requests		
1. Cangrelor	Add to Formulary with Restrictions	Forward to BOD for Approval
2. Disopyramide phosphate (Norpace CR®)	Remove from Formulary	Forward to BOD for Approval
3. On-Q Pumps	Remove from Formulary	Forward to BOD for Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 6/97	**SUBJECT: Code Adam**
REVISION DATE(S): 12/98, 5/03, 10/04, 12/05, 10/10, 5/14, 09/14	

Patient Care Services Content Expert Approval:	**08/18**
Clinical Policies & Procedures Committee Approval:	**~~09/14~~09/18**
Nurse Executive Committee Approval:	**10/14**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee:	**n/a**
Medical Executive Committee Approval:	**~~10/14~~ n/a**
Administration Approval:	**12/18**
Professional Affairs Committee Approval:	**~~11/14~~ n/a**
Board of Directors Approval:	**12/14**

A. **PURPOSE:**

1. ~~To provide a systematic method for responding to the report of a missing infant/child.~~**To ensure that all hospital personnel and outside agencies are notified appropriately of a missing infant or child, with the goal being to locate, return and reunite the infant/child with family as quickly as possible.**

B. **POLICY:**

1. When staff ~~concludes~~ **has a suspicion** that an infant or child is missing, the staff member will immediately call a CODE ADAM by dialing "66". An **overhead** announcement will be made over the **Public Broadcasting Exchange** (PBX~~A~~) system by the operator, "Code Adam location," such as Women and Newborn Services **(WNS)** or Neonatal Intensive Care Unit (NICU). This will be repeated three times.
2. ~~Response Team members (Security, Lift Team, Emergency Medical Technician, Environmental Services),~~ **All available Tri City Medical Center (TCMC) staff members** will immediately go to **a nearby** ~~their predetermined area and~~ **to** secure ~~the~~ **all** exits.~~. Any available staff member not involved in direct patient care should secure the closest exit.~~ Any person carrying an infant, wrapped bundle, car seat, **stroller, large cart** or large carryall bag will **attempt to** be detained and Security will be called STAT. All other ~~Response Team members~~ **TCMC staff** will ~~report to the location identified by PBX for further instructions from the security supervisor.~~ **remain in their place until cleared by a PBX overhead announcement.**
3. ~~2.~~ **WNS, including NICU, will check the unit to ensure that all babies are accounted for.**
4. ~~3.~~ Any employee witnessing a suspicious activity or, situations involving an infant/child will notify PBX immediately by dialing "66" and PBX will notify Security.
5. ~~4.~~ Security will notify:
   a. -Director of Women and Newborn Services
   b. Security Supervisor
   c. Oceanside Police Department dial: 80-911
   d. Administration (after hours, the Administrator On-Call)
   e. Director of Engineering
   f. Environment of Care/Safety Officer
   g. Director of Risk Management
   h. Public Information Officer.
6. ~~5.~~ Security Department Officer will recall additional Security Officers as needed.

7. The ANM **or designee** of the department involved will compile a complete written description of the missing **infant/**child, including any available photos. The description/photo will be given to Security.

~~6.~~**8.** The medical records of the infant/child will be secured in Medical Records.

~~7.~~**9.** The Director of ~~Women and Newborn Services~~ **WNS**, the Administrative Supervisor or designee, will relocate the parents of the infant/**child** to a private location within the unit (as available) and remain with them at all times to support and protect them from any additional stressful interference. Social Services or Chaplaincy Services may assist in this service.

~~8.~~**10.** The Security Supervisor will immediately organize an expanded search of the hospital, using all available **TCMC staff.** ~~Security, Environmental Services and Engineering, and Lift Team personnel.~~ This search will **also** include the exterior of the Medical Center **and grounds area** (per Administrative Policy #305, Missing Person).

a. ~~The Security Supervisor will allocate their office to the local police, or other law enforcement agency.~~ **A Command Center shall be established where TCMC Administrators, local law enforce agencies and Public Affairs personnel can congregate as needed.**

b. The first Security Officer on the scene will secure the crime scene. Nothing should be moved or removed from the area until the senior law enforcement officer releases the area.

c. Police Officer from the Oceanside Police Department, or other law enforcement agencies, ~~will be in~~ **shall take** charge of the situation upon arrival to TCMC.

~~c.~~**d.** **The CEO or designee, will develop a plan that meets the specific needs of this incident and act as the facility liaison with the Oceanside Police Department to ensure cooperation with any needed activities, i.e. complete hospital search, questioning of staff and visitors.**

~~9.~~**11.** ~~The TCMC Administrator on Call (AOC) or designee will be in charge of the overall situation.~~

~~10.~~**12.** Interviews will be conducted with everyone on the unit at the time of the incident. This will include names, addresses, and phone numbers of employees, patients, visitors, etc.

~~11.~~**13.** Security Department personnel will be assigned to check and verify all persons leaving or entering the unit.

~~12.~~**14.** All employees are not to make statements to patients, visitors or other employees to ensure patient confidentiality.

~~13.~~**15.** The Public Information Officer or designee will prepare all community/media communication.

C. **PRESUMED KIDNAPPED:**

1. Security Department
   a. Assist all law enforcement agencies.
   b. Monitor visitor control to critical areas of the hospital.
   c. Provide necessary security personnel to affected nursing unit or department.
   d. Provide parking escorts and parking location as needed.
   ~~d.~~**e.** **Obtain all pertinent information such as, description, clothing, vehicle license (if applicable) and direction of any person or persons observed fleeing the facility. This information shall be forwarded to local law enforcement agencies immediately.**
   ~~e.~~**f.** Document all pertinent activity in security log, commence case report, and document on Quality Review Report.
2. Departments
   a. Continue to provide care to patients.
   b. Assist Security in visitor control and identification.
   c. Reassure patients of their safety.
3. Chaplaincy Service/Social Service
   a. Provide continuous support to the family of the missing **infant/**child.
   b. Provide assistance and support to patient and family.

4. Marketing
   a. Designate an area for the press to use.
   b. Select a spokesperson for the Medical Center (confer with the Administrator on Call).
   c. Schedule press conferences.
   d. Consult with legal staff and hospital management concerning patient confidentiality.
   e. All contact with the media will be conducted only through the Public Affairs.
   ~~e.~~

D. **RECOVERY/EVALUATION:**
1. Security Department
   a. Provide a complete case report to Risk Management.
   b. Determine how the infant/child was taken and take immediate steps to correct any deficiencies.
   c. Review all security policies and instructions relating to abductions.
   d. Assist law enforcement agencies as needed.
   e. Review operational plan relevant to this incident.

E. **DEPARTMENT:**
1. Review all policies and instructions relating to infant/children (i.e., visiting hours, screening of employees).
2. Make appropriate changes that are deemed necessary after review.

F. **RELATED DOCUMENT(S):**
1. **Patient Care Services Policy: Missing Patient ~~Person Administrative Policy~~ #305**
2. **Administrative Policy: Mandatory Reporting Requirements ~~Administrative Policy~~ #236**

~~F.~~G. **REFERENCE(S):**
1. **Guidelines for Perinatal Care 8th Edition. (2017). American Academy of Pediatrics and The American College of Obstetricians and Gynecologists.**
~~1. Reporting to California Department of Public Health et al.,~~
2. ~~Mandatory Reporting Requirements Administrative Policy #236~~**Rostant, D.M., Cady, R.F. (1999). Liability Issues in Perinatal Nursing. New York, New York.**

Tri-City Medical Center	Patient Care Services	DELETE: No longer have Carenotes
PROCEDURE:	**MICROMEDEX CARENOTES**	
Purpose:	To define the procedure for accessing Micromedex patient and/or family education handouts via Tri-City Medical Center (TCMC) Intranet.	
Supportive Data:	CareNotes are patient education instructions accessed via TCMC intranet on a variety of healthcare topics to provide information to patients and/or their caregivers on individual health care needs. The CareNotes may also be assessed to assist TCMC staff when providing education to patients and/or their caregivers..	
Equipment:	Computer with access to TCMC Intranet Printer linked to computer	

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

~~1. Micromedex CareNotes may be used with other printed patient education to provide education information for patients and their family on diseases, surgical procedures, diets, medications laboratory information.~~

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

~~1. CareNotes Patient Education Handouts: Patient education handouts which provide disease, treatment, dietary, medications and laboratory information.~~
~~2. Drug Information: Patient education medication handouts.~~
~~3. Keyword Search Tab: allows the user to search disease, medication, treatment, dietary, and laboratory handouts by relevant terminology. Options are limited by the topic selected.~~
~~4. Care and Condition Titles: an alphabetical categorized list of education handouts.~~
~~5. Drug Titles: allows the user to use an alphabetical list to search for medication handouts.~~
~~6. Lab Titles: allows the user to use an alphabetical list to search for selected laboratory and diagnostics handouts.~~
~~7. Hot List: A unit specific department customized lists of Micromedex handouts. The handouts are specific to physician instructions and/or to standards of practice.~~
~~8. Customizing: Allows end users to insert patient specific text in CareNotes which contain blanks.~~
~~9. Conversion Calculator: A calculator used by healthcare workers to convert different units of measurements.~~

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

~~1. Double click on the TCMC Icon of the main screen of a computer.~~
~~2. Select Micromedex.~~
~~3. Select CareNotes.~~
~~a. Select the appropriate Topic tab. The Topic tabs include the following:~~
~~i. Keyword Search~~
~~ii. Hot Lists~~
~~iii. Care & Conditions Titles~~
~~iv. Drug Titles~~
~~v. Lab Titles~~
~~4. Keyword Search:~~
~~a. Type a key word of the education topic i.e., disease, diet or condition name, then select (click) Search.~~
~~b. Select the appropriate CareNote(s) from the Care and Condition Titles list then select (click) Select Titles.~~
~~c. Select the CareNote language from the Document Type. The Document Types vary based on the topic selected. The available Document Types are as follows:~~
~~i. General Information~~

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
08/03, 04/09, 09/18	12/11, 02/16, 10/18	12/11, 02/16, 11/18	n/a	n/a	n/a	12/18	2/12, 04/16, n/a	2/12, 04/16

ii. Inpatient Care
iii. Ambulatory Care

d. Review the selected CareNote(s) by selecting (clicking) Print or Add to Print List.
e. Print the CareNote(s)

5. Care & Conditions Titles:
   a. Select the Care & Conditions category
   b. Select the desired CareNote
   c. Select the CareNote language for the Document Type.
   d. Review the selected CareNote(s) by selecting (clicking) Print or Add to Print List.
   e. Print the CareNote(s)
6. Drug Titles:
   a. Select the alphabet corresponding to the desired Drug Title i.e., medication
   b. Select the medication from the Drug Titles list
   c. Select the CareNote language from the Document Type list
   d. Review the selected CareNote(s) by selecting (clicking) Print or Add to Print List.
   e. Print the CareNote(s)
7. Lab Titles:
   a. Select the lab or diagnostic from the Browse Tests List or type the lab or diagnostic in the Jump to: box
   b. Click the Select button
   c. Select the CareNote language from the Document Type list
   d. Review the selected CareNote(s) by selecting (clicking) Print or Add to Print List
   e. Print the CareNote(s)
8. Hot Lists: Department specific procedures may require the use of a specific type of document and limits may restrict access to certain document types.
   a. Select the Hot List tab
   b. Select your department, then select (click) GO
   c. Select the Hot List topic
   d. Select the CareNote language from the Document Type list
   e. Review the selected CareNote(s) by selecting (clicking) Print or Add to Print List.
   f. Print the CareNote(s)
9. Customizing:
   a. Customizing of CareNotes is not allowed at TCMC.
10. Conversion Calculator:
    a. Select (click) Conversion Calculator
    b. Enter the unit of measure requiring conversion
    c. Select (click) Convert

D. **DOCUMENTATION:**

1. Document patient and/or family receipt of the handouts on the Education All Topics powerform.
2. Document as appropriate for Behavioral Health Unit (BHU) or Neonatal Intensive Care Unit (NICU).

E. **LIMITATIONS:**

1. 3000+ CareNotes in several categories are available.
2. Department and/or location may limit limitations on access, customization, and printing. The Department Director has reviewed these limitations.
3. Physicians and Educators may request additions to the unit specific Hot Lists.
4. Educators, Shift Supervisors, and managers may customize CareNotes as needed.

F. **REFERENCE(S):**

1. Truven Health Analytics, Inc. (2016). Micromedex CareNotes system. Retrieved from Tri-City Medical Center intranet.

Tri-City Health Care District
Oceanside, California

DELETE – follow Administrative Policy: Competency 458

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 03/09	**SUBJECT:** Skills Lab; Annual Interdisciplinary
REVISION DATE: 07/10; 12/11	**POLICY NUMBER:** I.U

Patient Care Services Content Expert Approval:	07/18
Clinical Policies & Procedures Committee Approval:	~~12/11~~10/18
Nurse Executive Committee:	~~12/11~~11/18
Medical Staff Department or Division Approval:	n/a
Pharmacy &Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	12/18
Professional Affairs Committee Approval:	~~02/12~~ n/a
Board of Directors Approval:	02/12

~~A. PURPOSE:~~

~~1. Define the process for the Annual Interdisciplinary Skills Lab to meet regulatory requirements and cover high risk and/or low volume skills~~

~~B. POLICY:~~

~~1. Attendance at Skills Lab annually is a mandatory requirement for all clinical staff including but not limited to the following departments:~~

~~a. Acute Care Services~~
~~b. Cardiac Cath Lab~~
~~c. Emergency Department~~
~~d. Forensics~~
~~e. Home Care~~
~~f. Hospice~~
~~g. Intensive Care Unit~~
~~h. Interventional Radiology~~
~~i. Lift Team~~
~~j. Inpatient Behavioral Health Unit~~
~~k. Neonatal Intensive Care Unit~~
~~l. Radiology~~
~~m. Resource Pool~~
~~n. Respiratory Services~~
~~o. Surgical Services~~
~~p. Telemetry~~
~~q. Women and Children Services~~
~~r. Wound Care Center~~

~~2. Staff hired the first 6 months of the fiscal year (July through December) are required to attend Skills Lab. Staff hired the second 6 months of the fiscal year are not required to attend, but is optional per department.~~

~~a. Registered Nurse (RN) travelers are not required to attend Skills Lab, but it is optional per department.~~

~~3. The Skills Lab consists of stations and electronic exams. These are assigned for staff to complete based on job category and department. The content is determined annually by the Education Department in collaboration with the Clinical Educators.~~

~~4. Skills Lab is held annually at least four times per year.~~

a. Each employee required to attend will sign-up for one of the scheduled Skills Lab days via Netlearning. This is considered scheduled time.
b. Each employee will have the ability to reschedule their selected Skills Lab date in Netlearning until 2 days before the scheduled Skills Lab.
c. If an employee cannot attend the Skills Lab they have scheduled, the employee needs to notify by telephone the employee's immediate supervisor/department manager in accordance with specific departmental policy.
    i. If an employee does not attend the scheduled Skills Lab and fails to notify their immediate supervisor/department manager it is considered no call, no show according to Administrative Policy 408 Absences and Tardiness.

5. If an employee attends a Skills Lab but does not complete all the station(s)/exam(s), the employee must complete the incomplete station(s)/exam(s) by the next Skills Lab or within 30 days from the last Skills Lab.
6. Each department is responsible for ensuring all required employees complete the annual Skills Lab.
    a. If an employee was on an approved leave of absence (LOA) during the designated Skills Lab, the department is responsible for completing the Skills Lab at the department level within 30 days of the employee return from LOA.
    b. If an employee was not on an approved LOA and failed to attend the Skills Lab, the employee is responsible for completing the Skills Lab at the department level within 30 days of the last Skills Lab. Failure to do so will result in termination.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**HOVERMATT AIR TRANSFER SYSTEM ~~STRYKER GLIDE LATERAL AIR TRANSFER DEVICE~~**
Purpose:	To outline staff responsibilities **and patient safety** in the use of a lateral air transfer device.
Supportive Data:	Lateral air transfer devices assist with safe patient mobilization and movement techniques to ensure patient safety and reduce risk of injury to staff from patient mobilization tasks.
Equipment:	**HoverMatt Air Transfer Mattress and HT-Air 1200 Air Supply**~~Stryker Glide mattress and blower power unit.~~

A. INTENDED USE AND PRECAUTIONS:

1. **Intended Use**
   a. **The HoverMatt Air Transfer System is used to assist caregivers with patient transfers, positioning, turning and proning. The HoverTech Air Supply inflates the HoverMatt to cushion and cradle the patient, while air simultaneously escapes from the holes on the underside, reducing the force needed to move the patient by 80-90%.**
2. **Indications**
   a. **Patients unable to assist in their own lateral transfer**
   b. **Patient whose weight or girth poses a potential health risk for the care givers responsible for repositioning or laterally transferring the patient**
3. **Contraindications**
   a. **Patients who are experiencing thoracic, cervical or lumbar fractures that are deemed unstable, unless using in conjunction with a spinal board on top of the HoverMatt**
4. **Precautions with HoverMatt**
   a. **Caregivers must verify that all brakes have been engaged prior to transfer.**
   b. **For safety, always use two people during patient transfer.**
   c. **Additional caregivers are recommended when moving a patient over 750 lbs/340kg.**
   d. **Never leave patient unattended on an inflated device.**
   e. **Never attempt to move a patient on an uninflated HoverMatt.**
   f. **Only use attachments and/or accessories that are authorized by HoverTech International.**
5. **Precautions with Air Supply**
   a. **Not for use in the presence of flammable anesthetics or in a hyperbaric chamber or oxygen tent.**
   b. **Route the power cord in a manner to ensure freedom from hazard.**
   c. **Avoid blocking the air intakes of the air supply.**
   d. **When using the HoverMatt in the MRI environment, a 25 ft. specialty MRI hose is required.**

~~A.~~B. PROCEDURE:

1. Selecting the appropriate ~~mattress~~ **HoverMatt** size:
   a. **HoverMatts are available in 34 inch, 39 inch and 50 inch widths. The 34 inch width is the standard.**
   ~~1.~~b. **All sizes have a weight capacity of 1200 pounds.**
   ~~a. 32" mattress is appropriate for patients up to a weight of 700 pounds and a maximum~~

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/13, 11/17	06/13, 10/18	06/13, 11/18	n/a	n/a	11/18	12/18	07/13, n/a	07/13

~~width of 32".~~

~~b. 46" mattress is appropriate for patients up to a weight of 1000 pounds and a maximum width of 46".~~

~~c. The width of the patient shall not exceed the width of the deflated mattress at any point along its length.~~

2. **Instructions for Use**

   a. **A minimum of two (2) caregivers are required when transferring a patient. Caregivers need to be positioned so they can control patient positioning.**

~~2.~~3. Positioning the ~~mattress~~ **HoverMatt** underneath the patient:

~~a. A minimum of two (2) caregivers are required when transferring a patient. Caregivers need to be positioned so they can control patient positioning.~~

~~b. Place a sheet on top of the Glide mattress before the device is positioned underneath the patient. If soiling is possible add disposable under pads as needed.~~

~~c. Roll the Glide mattress lengthwise towards the center from one side, so that the side with the perforations is against the patient support platform, not the patient.~~

   a. **Patient should preferably be in a supine position.**

~~d.~~b. Place the ~~Glide mattress~~ **HoverMatt** under the patient using a "log-rolling" technique.

   i. Make sure that the patient's head is located at the same end as the "HEAD" label on the ~~Glide mattress~~**HoverMatt** topside.
   ii. Roll the patient onto their side towards the staff member.
   iii. Place the rolled edge of the ~~Glide mattress~~ **HoverMatt** against the patient.
   iv. Roll the patient back towards the opposite side enough to unroll the ~~Glide mattress.~~ **HoverMatt.**
   v. Center the patient on the ~~Glide mattress.~~ **HoverMatt.**

~~e.~~c. Attach the two **(2)** safety patient straps **over** ~~in gentle contact with~~ the patient.

   i. Straps ~~do~~ **should be loose** ~~not need to be tight~~.
   ii. Do not pull on the safety straps to transfer the patient.

~~3.~~4. Connecting the blower unit to the ~~mattress~~**HoverMatt:**

   a. The patient must be secured on the ~~mattress~~ **HoverMatt** before starting the inflation process.
   b. Make sure that the ~~On/Off (I/O) switch on the~~ blower is ~~positioned to~~ **off by** **off by seeing the standby light on** ~~(O)~~.
   c. Plug the power cord of the blower unit into the electric outlet on the wall.
   d. Fully insert the other end of the flexible air hose into the ~~mattress~~ **HoverMatt** sleeve ~~under the label flap.~~ **into either two hose entries** ~~entires~~ **at the foot end of the HoverMatt and snap buckle into place.**
   e. ~~Wrap~~ **Close** the Velcro ~~strap~~ **flap** around the ~~mattress~~ **HoverMatt** sleeve.
      ~~i. The Velcro strap must be fastened around the flexible air hose, the hose cuff.~~
   f. Use the air hose retention straps to secure the air hose to the ~~mattress~~**HoverMatt**.

~~4.~~5. Transfer of patient from one patient support platform to another:

   a. Position one patient support platform alongside the other patient support platform as closely as possible.
   b. Set the brakes to "ON" for both patient support platforms. Only use ~~Glide~~ for patient transfers between fixed patient support surfaces that are level with one another.
   c. Raise the patient support platform side rail located opposite the patient transfer.
   d. If the space between the two patient support platforms is greater than three inches, use the transfer bridge to fill the gap.
   e. Before turning the blower unit on, verify that the:
      i. Side rails, accessories, or sharp object are not obstructing the path of the ~~mattress~~**HoverMatt.**
      ii. Air hose is free to travel with the ~~mattress~~**HoverMatt.**
      iii. Patient support systems, such as IV lines or oxygen tubing, are free to travel with the patient.
      iv. Staff are positioned in the direction of the patient transfer, one on each side of

the patient.

v. Never leave the patient unattended when the ~~mattress~~ **HoverMatt** is inflated and the blower power unit is on.

f. ~~Press On/Off (I/O) switch to the On (I) position.~~ **To turn on, press the button corresponding to the HoverMatt size (size is printed at the bottom on the matt).**

~~f.~~**i. The "Adjustable" setting is a safety feature that can be used to ensure the patient is centered on HoverTech air-assisted devices and to gradually accustom a patient who is timid or in pain to both the sound and functionality of the inflated devices.**

g. Wait approximately 10-15 seconds for the ~~mattress~~ **HoverMatt** to fully inflate.

h. After the ~~mattress~~ **HoverMatt** is fully inflated, grasp the extended pull handles of the ~~mattress~~ **HoverMatt** while keeping your back in the neutral, ergonomic upright posture.

i. Push HoverMatt at an angle, either headfirst or feetfirst. Once half-way across, opposite caregiver should grasp closest handles and pull to desired location.

~~i.~~**j.** ~~With one firm continuous pull, move the patient towards the staff member to the desired surface.~~ Patient must be centered on the new surface.

~~j.~~**k.** Press the ~~On/Off (I/O) switch to the off (O) position.~~ **"Standby" button to turn off.**

~~k.~~**l.** Unplug the power cord from the wall and the blower unit.

~~5. Removing patient from mattress:~~

~~a. Once mattress is fully deflated log-roll patient off of the mattress using a minimum of two staff members.~~

~~b. Discard any linens/chucks used is the appropriate receptacle.~~

~~c. Clean mattress after use with hospital approved disinfectant.~~

~~i. Dispatch wipes are preferred for cleaning Glide mattresses following patients with a Clostridium difficile diagnosis. If visible soiling is noted on the Glide mattress it should be sent out to be laundered.~~

~~ii. Grossly soiled mats should be placed in designated receptacle for laundering.~~

~~d. Return Glide mattress and blower unit to designated area.~~

~~i. Lift team members will be responsible for monitoring equipment in designated areas and serve as a resource for staff.~~

~~B. RELATED DOCUMENT(S):~~

~~1. Infection Control Policy IC.5~~

~~C. FORMS:~~

~~1. Stryker Glide Helpful Hints~~

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

~~Stryker. (2009). Glide lateral air transfer system operation/maintenance manual.~~

1. **HoverMatt Air Transfer System Use Manual (2018).**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**12/01**	**SUBJECT:**	**Volunteers, Patient Care Services Departments**
REVISION DATE:	**03/03, 06/03, 08/05, 01/09**	**~~POLICY NUMBER: IV.E~~**	
Patient Care Services Content Expert Approval:		**09/18**	
Clinical Policies & Procedures Committee Approval:		**~~09/15~~10/18**	
Nursing Executive Council Approval:		**~~09/15~~11/18**	
Medical Staff Department or Division Approval:		**n/a**	
Pharmacy & Therapeutics Committee Approval:		**n/a**	
Medical Executive Committee Approval:		**n/a**	
Administration Approval:		**12/18**	
Professional Affairs Committee Approval:		**~~11/15~~ n/a**	
Board of Directors Approval:		**12/15**	

A. **POLICY**:

1. Volunteers at Tri-City Medical Center are available to assist patients, families, and healthcare providers in the Patient Care Services Units/Departments.
   ~~1.~~a. Volunteers may not enter isolation rooms.
2. Services that may be provided by Patient Care Services volunteers may include but are not limited to the following:
   a. Intensive Care Unit (ICU): Assist, screen, and comfort visitors. Watch for the arrival, or transfer out, of patients and assist in record keeping of these arrivals and transfers. Escort visitors to the patient's room according to the guidelines of the ICU.
   b. Courtesy Shuttle: Drive a covered vehicle around the hospital campus to assist people who want a ride to or from their car or the bus stop.
   c. **Surgery Check-in**Customer Relations: Assist in checking in patients for surgery; **do not address any medical questions. Escort patients to preop hold area, ask families to wait in the main hospital lobby. Facilitate communication between preop hold, recovery room (PACU), operating rooms, and surgeons.** ~~answer no medical questions, greetescort patient and family into Pre-Op Hold area. Keep track of where the family can be located during the surgery process.~~
   d. Surgery: Escort patients and families, store personal effects, prepare gurneys, stock blanket warmers, **prepare preop kits,** clean equipment as directed, order linen and supplies, discharge patients in wheelchairs, pick up/deliver paperwork, serve food/drinks, and assemble blank patient packets.
   e. Emergency Department: Act as liaison between visitors, patients, and the medical staff. Offer non-medical assistance to the medical staff, assist the medical secretaries and clerical staff in registration area, change gurneys, keep supplies on hand, make quantities of coffee, assemble medical and surgical packets, assist in taking patients to their rooms, and stand by for any errands.
   f. Employee Health Office: Fill out and file receipts, log over-the-counter medications to employees and volunteers, stock supply cabinets, and open and check in the new merchandise.
   g. Escort Service: Escort patients to the proper departments, ~~deliver documents to various areas of the hospital, keep the waiting area neat~~, interact with patients in the waiting room and when assisting to appropriate areas of the hospital **and discharge patients when requested**.
   h. Gift Shop: Assist all customers in the sale of gift shop items.

i. Imaging: Liaison between staff, families, and patients. Receive patients as they arrive for procedures, escort patients to the dressing room, see to patient comfort while they are waiting or recovering from imaging procedures, assist with paperwork for the radiology staff and follow department and Health Insurance Portability and Accountability Act (HIPAA) guidelines for checking-out films.

j. Laboratory: Assist nursing units with a pick-up and delivery service and make rounds as requested. Dispense specimens from the lab triage tubs. Assist with paperwork at the laboratory front office and the triage unit.

k. Women~~'s~~ **and Newborn** ~~& Children's~~ Services: Hand out juice or food trays, fill water pitchers, strip or make beds, watch/rock newborns, run errands, make up home packets when patients discharged, and push mothers and babies in a wheelchair to front door.

l. Pulmonary Rehabilitation: Assemble new patient orientation packets; assemble Asthma and Chronic Obstructive Pulmonary Disease (COPD) education packets; assemble new patient class notebooks. Help with answering phones and simple clerical duties.

m. Information Desk: Relay hospital information to the public in accordance with HIPAA guidelines, assist security in providing visitors badges, give directions to visitors, receive patient mail and assign room numbers, deliver mail to patients, receive and deliver floral arrangements, and answer questions.

n. Registration: Serve as liaison with the Admitting Office, assist incoming patients with completion of information form, and **interact with patients relaying concerns when necessary** ~~monitor patients for signs of undue discomfort or acute illness and report to Control Desk~~.

~~o. Telecare: Daily calls as support service to those who live alone (retired persons, widows/widowers, those convalescing from an illness).~~

~~p.~~**o.** Rehabilitation Services: Office clerical making up charts and/or patient packets, filing, restocking linens, transport, using a copier, make phone calls to patients and process surveys.

~~q.~~**p.** Women's' Diagnostic Center: Clerical services to make and distribute packets to patients. Mail computer generated positive letters to patients.

~~r.~~**q.** Cardiac Rehabilitation: Provide both clerical and operational support as directed by staff

r. Acute Care Services & Telemetry: Assist with delivery of trays as instructed by nursing staff, visit with patients, assist with transporting discharged patients and transporting specimens to the lab. Answer the phone and call lights during nursing rounds.

s. Greeter Service: Welcomes patients and their families who enter the hospital. Greeters direct individuals to registration and other service areas of the hospital. Help with obtaining wheelchairs when necessary.

~~s.~~**t. Advocacy Service: Visit patients on day one or two. Give them a copy of "A Patient & Family Guide". Encourage participation in any surveys received on discharge. Arrange for Social Service visits, therapy dog visits, or chaplain visits. Distribute activity packets, library books, or magazines. Listen to and provide comfort to patients.**

3. Workshop members make **toys**~~puppets~~ for children admitted to the hospital, tray favors for holidays, ~~corsages for prospective mothers attending the Maternity Teas~~, stuffed toys for Emergency Department, **red stocking for babies born in December** and lovey dolls for the Neonatal Intensive Care Unit infants.
   a. Volunteers may be assigned tasks by the Assistant Nurse Managers/designee.
4. Off Campus volunteer support
   a. Tri-City Wellness Center Carlsbad Physical Therapy and Cardiac Rehabilitation: Assist in clerical duties as directed by staff.
   ~~Tri-City Wound Care and Occupational Therapy Carlsbad: Meet and greet new patients and maintain lobby area.~~
   b. Outpatient Rehab, Oceanside
   ~~b.~~**c. Outpatient Behavioral Health, Vista**

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY
DISTRICT OPERATIONS

ISSUE DATE: 02/15 **SUBJECT: Authorized Access - Medications**

REVISION DATE(S): **POLICY NUMBER:** 8610-298

Administrative District Operations Content Expert Approval:	**08/18**
Administrative Policies & Procedures Committee Approval:	**~~11/14~~09/18**
Pharmacy &Therapeutics Committee Approval:	**~~01/15~~11/18**
Medical Executive Committee:	**n/a**
Administration Approval:	**12/18**
Professional Affairs Committee Approval:	**~~02/15~~n/a**
Board of Directors Approval:	**02/15**

A. **PURPOSE:**

1. To define categories of personnel who have authorized access to secure medication storage areas.

B. **DEFINITION(S):**

1. Secure Area: a secure area means that drugs and biologicals are stored in a manner to prevent unmonitored access by unauthorized individuals. Drugs and biologicals must not be stored in areas that are readily accessible to unauthorized persons. Areas where patients and visitors are not allowed without the supervision or presence of a health care professional are considered secure. Areas restricted to authorized personnel only are generally considered "secure areas".

C. **POLICY:**

1. Medications and biological are stored in a secure environment:
   a. Controlled substances are locked.
   b. Both controlled substances and non-controlled medications are locked when a patient care area is not staffed.
2. Only authorized personnel have access to secure areas where medications and biologicals are stored.
3. Categories of personnel are authorized access to secure medication areas based on the organization's need for individuals to perform their assigned duties and in accordance with federal, state and local regulations.
4. Non-licensed authorized personnel are identified by job classification and job description with competencies related to their specific role.

D. **PROCESS:**

1. The following personnel are authorized by licensure, certification, or policy to have responsibilities within the medication use system as defined by their regulating boards or agencies and hospital policy:
   a. Registered Nurses (RN)
   b. Licensed Practical Nurses (LPN)
   c. Graduate Nurses (GN)
   d. Physicians (MD, DO)
   e. Pharmacists and Pharmacy Technicians
   f. Respiratory Therapists (RT) (RT related medications only)
   g. Radiology and Interventional Radiology Technologists (Radiology related medications only including contrast).

h. Cardiac Catherization Lab Technician.
i. Operating Room Technicians.
j. Anesthesia Technicians.
k. Physical Therapists (PT) (PT related medications only)
l. Speech Therapist (ST) (ST related medications only)
m. Materials Management Staff (IV fluids, skin antiseptics, etc.)
n. Transporters (transfer of medications from licensed professional to licensed professional- transfer only).
o. Physician's Assistant (PA)
p. Nurse Practitioner (NP)
q. Doctor of Podiatric (DPM)
r. Doctor of Dental Science (DDS)
s. Doctor of Dental Medicine (DMD)
t. Certified Nurse Midwife (CNM)
u. Medical Assistants (MA)

E. **REFERENCE(S):**

1. CMS State Operations Manual- Appendix A Interpretive Guidelines for Hospitals §482.25(b)(2)(i)
1. The Joint Commission Standards MM 03.01.01 EP 6
2. CMS Conditions of Participation §482.25(b)(2)(iii)
3. Healthcare Facilities Accreditation Program (HFAP) 25.01.03
4. DNV National Integrated Accreditation for Healthcare Organizations MM.1 SR.4b

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY
HUMAN RESOURCES

ISSUE DATE: 07/96 **SUBJECT:** Severance Plan

REVISION DATE(S): 09/12 **POLICY NUMBER:** 8610-454

Administrative Human Resources Content Expert Approval:	~~08/15~~08/18
Administrative Policies & Procedures Committee Approval:	09/18
~~**Human Resources Committee Approval:**~~	~~08/15~~
Administration Approval:	12/18
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/15

A. **PURPOSE:**

1. To provide continued compensation for a specified period of time to eligible Tri-City Healthcare District (TCHD) employees whose employment is affected when a separation occurs as a result of reduction in force; business decline; department, program or hospital reorganization; or other business reason.

B. **ELIGIBILITY:**

1. Benefited Employees - All benefited employees may be eligible for a severance benefit under this policy.
2. Temporary or per diem employees shall not be eligible for severance benefits under this policy.
~~1.~~3. Employees with signed employment agreements that include a severance arrangement shall be subject to the terms of those agreements in lieu of the provisions of this plan.
~~2.~~4. Subject to ~~B.4.~~ below, eligible employees ~~(as described in B.1., above)~~ shall be entitled to severance pay when:
   a. Their employment is not terminated for cause but for reasons beyond their control due to reduction of work force; business decline; department, program or hospital reorganization or other business reason; or
   b. They elect to participate in and are selected for a voluntary reduction-in-force.
~~3.~~5. Severance shall not be payable under this plan in any of the following circumstances:
   a. Where an employee who has had his/her position eliminated is offered and declines alternative benefited TCHD employment that is not less than **seventy percent** (70%) of his/her current base hourly compensation and scheduled pay period hours .
   b. Where an employee who is terminated by TCHD due to the outsourcing or transfer of operations is offered and declines benefited TCHD employment at a facility which is not more than **thirty-five** (35) miles farther from the employee's residence than the site of his/her present employment.
   c. Where an employee has been terminated for cause.
~~4.~~6. TCHD will require as a condition for payment to an otherwise eligible employee, that he/she execute and deliver a Settlement Agreement and General Release ~~in a~~ form acceptable to TCHD.

C. **PAYMENT OF SEVERANCE:**

1. Payment of severance will begin on the first pay date following separation or following the execution and non-revocation of the Settlement Agreement and General Release ~~described at B.4., above,~~ or as otherwise provided in such Settlement Agreement and General Release.
2. Amount and distribution of severance payment for benefited employees:

a. An eligible employee will receive a severance at his/her final base rate of pay, less applicable required withholding and deductions as identified in the ~~attached~~ Severance Schedule set forth below.

b. For non-exempt employees, a "week's salary" shall be defined as an amount equal to the product of the employee's final base hourly rate of pay, multiplied by the number of hours the employee was regularly scheduled to work each week at the time of his/her termination of employment with ~~the District~~**TCHD**.

~~b.~~**c.** For exempt employees, a week's salary shall be determined by multiplying his/her monthly salary by twelve **(12)** and dividing that number by fifty-two **(52)**.

~~c.~~**d.** The severance payments provided under this Plan will be paid out in equal installments consistent with TCHD's normal pay dates. Lump sum payments, if applicable, will be made at the end of the severance period.

~~d.~~**e.** TCHD will pay the cost of COBRA (medical, vision and dental) benefits for one **(1)** month for the employee only. Such coverage shall be effective the first day of the month following the employee's termination date and shall cease at the end of the last day of that month.

D. **DISCONTINUANCE OF SEVERANCE PAYMENTS:**

1. Severance benefits under this plan are not available to an employee's beneficiaries or to his/her estate.
   a. Employees who are rehired by TCHD in a regular position before receiving all their severance payments will not receive their remaining severance payments.

E. **CHANGES TO ~~TRI-CITY HEALTHCARE DISTRICT~~TCHD SEVERANCE PLAN:**

1. This Plan is entirely voluntary on the part of TCHD, which has the right to and may terminate or amend it at any time, with or without notice to employees.
2. Plan variations, amendments or the decision to terminate the Plan can be made only by either the TCHD Board of Directors **(BOD)** or the ~~TCHD~~ Chief Executive Officer **(CEO)** or his/her designated representative.
3. If the Plan is amended or terminated, all employees' rights under this Plan, except for those who were terminated and had already begun receiving payments under the Plan, will be governed exclusively by the new plan document or will cease to exist in the case of a plan termination.

F. **ATTACHMENT(S):**

~~4.~~**1. Severance Schedule**

SEVERANCE SCHEDULE:

Number of Years of Service	Number of Weeks		
	Non-Exempt Exempt Non-Manager	Manager	Director
Less than 1 Year	2	3	4
1	2	3	4
2	2	3	4
3	3	4	5
4	4	5	6
5	5	6	7
6	6	7	8
7	7	8	9
8	8	9	10
9	9	10	11
10	10	11	12
11	10	11	12
12	10	11	12
13	10	11	12
14	10	11	12
15	10	11	12
16	10	11	12
17	10	11	12
18	10	11	12
19	10	11	12
20+	10	11	12
Other	1 month COBRA paid by TC~~MC~~**HD** for single coverage.		

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL ~~Manual~~

ISSUE DATE: 03/16

SUBJECT: Management of Patients with Multi-Drug Resistant Organism (MDRO) and/or C. Difficile Infection

REVISION DATE(S):

Infection Control Department Approval:	**~~10/15~~09/18**
Infection Control Committee Approval:	**~~10/15~~10/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/16~~10/18**
Administration Approval:	**12/158**
Professional Affairs Committee Approval:	**~~03/16~~ n/a**
Board of Directors Approval:	**03/16**

A. **DEFINITIONS:**

1. Multi-drug resistant Organism (MDROs) and Clostridium Difficile are organisms of epidemiological significance in the health care setting. MDROs are defined as microorganisms that are resistant to one or more classes of antimicrobial agents. The clinical manifestations are often similar to infections caused by susceptible pathogens; however the options for treatment are limited. MDROs and C. Difficile infection increase the length of stay, costs and mortality of patients. The MDROs of significance are:
   a. Vancomycin Resistant Enterococci (VRE)
   b. Methicillin Resistant Staphylococcus aureus (MRSA)
   c. Resistant Acinetobacter baumannii
   d. Carbapenem- resistant Enterobacteriaceae (CRE)
      i. Klebsiella pneumonia
      ii. Escherichia coli
   e. Extended Spectrum beta Lactamase Producers (ESBL)
      i. Klebsiella pneumonia
      ii. Escherichia coli
   f. Other MDROs as identified by Laboratory identification and/or Physician
2. The risk factors for obtaining an MDRO (Infection or colonization) include those with severe disease, ICU stay, compromised host defenses, recent surgery or indwelling medical devices.
3. The risk factors for obtaining C.difficile infection are: antimicrobial exposure, acquisition of C.difficile, advanced age, underlying illness, immunosuppression, tube feeds and gastric acid suppression. The purpose of this policy is to prevent the transmission of MDROs and C.Difficile Infection.
4. C.Difficile Infection: This policy applies to patients who have active C.difficile Infection as defined by those with a recent positive test for C.diff during current admission or recent positive test and still has active diarrhea.
5. Cohorting is the placement of patients with the same microorganism in the same room. Usually done when private rooms are not available.
6. Recommendations for MRSA active surveillance culturing are focused on high-risk populations and the delay inherent in identifying MRSA in clinical cultures makes it impossible to know the MRSA status of every patient when they are admitted. The use of Standard Precautions and most importantly hand hygiene will reduce the risk of cross transmission from unknown cases. Please note: Routine screening for other types of MDROs is not recommended.

B. **POLICY**

1. Transmission:
   a. Transmission may occur through direct contact with a MDRO carrier and ineffectively disinfected equipment. The use of Standard and Contact Precautions to break the chain of transmission is recommended in the acute care hospital.
2. Strategies To Reduce Risk Of Cross Transmission:
   a. Because of the difficulty in treating MDRO infections, it is imperative that health care workers prevent the transmission of MDRO from colonized or infected patient to other patients or personnel.
   b. Compliance with Standard Precautions and Contact Precautions will reduce the risk of transmission between patients.
   ~~b.~~**c.** Place patients in C~~c~~ontact P~~p~~recautions in the following cases :
      i. **Active** MRSA, **ESBL, VRE,** ~~or~~ **CRE/other MDRO infections. Active infections include positive cultures from blood, urine, respiratory or wound.**~~,~~ **These will be noted in the patients Problem List in Cerner.**
      ii. **Patients with a history of** -ESBL **or CRE. The history can be found in the patients Problem List in Cerner.**
      iii. ~~, VRE, and~~ **Patients with active** C.difficile **infection.**
      ~~i. positive tests trigger an auto order in the Cerner record for Contact Precautions as recommended by CDC HICPAC. Electronic methods for identification of patients with MDRO history are available to the Infection Control Department.~~
      ~~ii. Patients with a history of ESBL and VRE are placed in Contact precautions by entering an order for Isolation – Contact precautions. The history can be found in Cerner- Patient Problem List.~~
      ~~iii. MRSA perform the following in addition to above.~~
      ~~1) Unresolved History of MRSA: All patients with an unresolved history of MRSA infection or colonization on the problem list are placed in Contact Precautions by entering an order for Isolation – Contact Precautions for duration of hospitalization or if readmitted within ≤ 29 days of discharge. This information can be found in Cerner Patient Problem List.~~
      ~~2) Resolved history of MRSA: Do not need to be placed into Contact precautions unless there is a new MRSA positive culture~~
   ~~c.~~**d.** Perform hand hygiene before and after gloving. Hands of health care workers can become transiently colonized which is the most common mode of transmission of healthcare associated MDROs.
      i. Wear gloves for contact with membranes, damaged skin, or with any moist body substance (i.e., oral secretions, sputum, blood, urine, feces, and vomitus).
      ii. Change gloves between patients and on the same patient when an episode of care has multiple components such as care at different anatomical sites involving moist body substances or mucous membranes.
         1) Wearing gloves does not take the place of hand washing. Perform hand hygiene after removing gloves.
      iii. Wear a new pair of gloves with each patient. Failure to change gloves between patient contacts is an infection control hazard.
      iv. Wear a plastic apron or a gown if it is likely that clothing will be soiled. Change aprons/gowns between patients.
   ~~d.~~**e.** Remove gloves and gown before leaving the patient's room. Ensure that after glove and gown removal ~~and~~ hand hygiene **is performed. Ensure that**~~,~~ clothing and hands do not come in contact with environmental surfaces (doorknobs and curtains).
   ~~e.~~**f.** Follow Standard Precautions and wear face protection if it is likely that eyes, nose or mouth will be splashed with moist body substances or secretions (e.g. during wound care or suctioning an intubated patient).

~~f.~~**g.** Environmental cleaning is an important measure to reduce risk of transmission.

~~g.~~**h.** Use of dedicated non-critical patient care equipment is recommended. Reusable equipment must be disinfected before being used on another patient.

~~h.~~**i.** **Patients with** C.difficile ~~i~~Infection, perform the following in addition to above:

i. Wash hands with soap and water after removing gloves.

ii. Ensure purple "D" sign is posted along with the contact precautions sign outside patient room

iii. Room is cleaned with bleach product by EVS staff

iv. Reusable equipment is cleaned after patient use by bleach product (if product tolerates bleach product otherwise utilize hospital approved disinfectant)

3. Cohorting:

a. Single patient room preferred.

b. Cohorting (patients with same MDROs sharing a room) is permitted for the following:

i. MRSA: Cohort patients with current ~~or past history of~~ **MRSA infection**~~unresolved history of MRSA (not cleared by screening culture or previously resolved on problem list).~~

ii. VRE: Cohort patient with current ~~or past history of~~ VRE **infections**

iii. ESBL, CRE, or C. Difficile: Do not cohort patients without consulting Infection control for the following organisms (past or current history).

c. When a private room is not available and cohorting is not achievable, consider the epidemiology of the microorganism and the patient population when determining patient placement. First try to select someone with no invasive lines (IV, central line, foley, trach, etc.) or open wound. If this is not possible, then select someone with an invasive line that carries a low risk of infection, such as a peripheral IV or NG tube. Consult with infection control staff when there are questions about patient placement. Also consider the conditions of the individual patients and the ability to transmit the infection in giving them priority for single room placement, for example stool incontinence and/or uncontained drainage.

4. Discharge, Transfer, And Transport Of Patient:

a. Isolation Signs communicate isolation status to visitors and ~~Healthcare~~ **healthcare** workers when entering the room. **A** "D" Sign is placed **on the outside of a patient room** to communicate to ~~Healthcare~~ **healthcare** workers if a patient has C.difficile infection.

~~b. The Corner problems list communicates MDRO status across admissions for ESBL, VRE and "unresolved" MRSA.~~

~~i. MRSA patients with a "resolved" history of MRSA do not need to be placed in contact precautions unless a new MRSA culture is identified.~~

~~ii.~~**i.** C.difficile infection is not placed on the problem list since past history does not define isolation in future admissions.

~~c.~~**b.** Hand off communication includes isolation information to receiving unit and transporters.

~~d.~~**c.** Patient Transfer: try to cover or contain potentially infectious body fluids prior to transport. The transporter should discard contaminated PPE before transport. Perform good hand hygiene. Don clean PPE at destination to handle the patient.

~~e.~~**d.** When arranging transfer, communicate information to nursing home, home health agency or other hospital receiving patient

~~f.~~**e.** Infection Control communicates final lab results to receiving facilities if they are not available until after discharge in the following situations:

i. Positive MDRO culture known after the patient was discharged to another healthcare facility and the patient had no history of the same MDRO

ii. Positive C.difficile tests known after the patient was discharged to another healthcare facility.

5. Discontinuation of Contact Precautions:

~~5.~~**a.** **Active MRSA infection: remain in Contact Precautions for duration of stay**

b. **Active** ESBL~~,~~ **& CRE: remain in Contact Precautions for duration of stay**~~, and other MDROs are not able to be discontinued from Contact precautions.~~

~~a.~~**c. Active** VRE **infection**: Isolation may be discontinued after obtaining three consecutive negative stool, rectal or peri-rectal cultures one or more weeks apart.

~~b.~~**d. Active** C.Difficile ~~Infection~~**infection: remain in Contact Precautions for duration of stay**~~This policy applies to patients who have active C.difficile Infection should stay in isolation~~ for duration of ~~their~~ stay.

~~c. MRSA: Patient with a history of MRSA may be discontinued from contact precautions:~~

~~i. If readmitted with a prior unresolved history and discharged ≥30 days- Screen nares and review any cultures ordered by the physician. Maintain Contact Precautions until culture results are known. Discontinue Contact Precautions if screening and clinical cultures are MRSA negative (See Patient Care Services: Standardized Screening Procedure: MRSA Screening~~

6. Patient Education:
   a. Patients discovered to have MRSA, VRE or ESBL colonization or infection, or C.difficile ~~Infection~~ **infection** is given pre-printed educational handouts provided through Micromedex. Micromedex: CareNotes Procedure

C. **RELATED DOCUMENT(S)**

1. Infection Control **Policy:** ~~Manual~~ Standard and Transmission Based Precautions.
2. Patient Care Services Standardized Procedure: Methicillin Resistant Staphylococcus Aureas (MRSA) Screening Procedure
3. ~~Infection Control Manual Disease Index:~~ Type and Duration of Precautions – **Disease Specific (FKA Short Sheet)**

D. **REFERENCE(S):**

1. APIC Guide. (2010) Guide to the Elimination of Methicillin Resistant Staphylococcus aureus (MRSA) transmission in Hospital Settings, 2nd edition.
2. APIC Text of Infection Control and Epidemiology Fourth edition 2014.
3. Centers for Disease Control and Prevention. Guidance for Control of Carbapenem-resistant Enterobacteriaceae 2012. Available at http://www.cdc.gov/hai/pdfs/cre/CRE-guidance-508.pdf
4. Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007 *http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf*
5. Management of Multidrug-Resistant Organisms In Healthcare Settings, Healthcare Infection Control Practices Advisory Committee (HICPAC) 2006 Jane D. Siegel, MD; Emily Rhinehart, RN MPH CIC; Marguerite Jackson, PhD; Linda Chiarello, RN MS; the Healthcare Infection Control Practices Advisory Committee

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES
NEONATAL INTENSIVE CARE UNIT (NICU)

ISSUE DATE: 8/06

SUBJECT: Criteria for Case Referrals to Morbidity and Mortality (M&M) Meetings

REVISION DATE(S): 4/09, 8/12, 09/15,03/18

Women and Newborn Services Department Approval:	~~02/15~~ 03/18
~~**Division of Neonatology Approval:**~~	~~04/15~~
Perinatal Collaborative Practice:	05/18
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~08/15~~10/18
Administration Approval:	12/18
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**
1. To facilitate discussion for educational purposes and to improve the outcomes of newborns.

B. **POLICY:**
1. It is the policy of Tri-City Medical Center to have a minimum of quarterly Morbidity and Mortality (M&M) review meetings.

C. **PROCEDURE:**
1. The ~~n~~Neonatologist/Allied Health Professional **(AHP)** in collaboration with the ~~o~~Obstetrician identifies neonates that meet the criteria for the M&M meeting.
2. These criteria include, but are not limited to ~~any~~:
   a. Death;
   b. Transfer out;
   c. Birth that requires extensive resuscitation;
   d. Major birth trauma (i.e., neonatal respiratory depression);
   e. IVH 3 & 4;
   f. ROP requiring laser surgery;
   g. Complications from procedure resulting in the prolongation of hospital stay or disability;
   h. Major congenital abnormalities; or
   i. Apgar scores of less than 5 at 1 minute and 5 minutes of age
3. The team consists of all disciplines involved in the decision making and care for mom and baby, i.e., genetics; lab; ~~clinical~~ **Clinical N**~~n~~urse ~~s~~Specialist; ~~s~~Social ~~w~~Worker; performance improvement representative; ~~ne~~Neonatologist; ~~o~~Obstetrician; NICU and OB nurses; ~~u~~Ultrasound technician; and/or ~~p~~Pathologist.
4. The M&M is held quarterly.
5. Team members are invited to participate **in person, or** through email and/or telephone calls.

D. **SUPPORTIVE DATA:**
1. Collaborative aims of M&M are to improve the health of pregnant women, infants and children by collecting high quality information on perinatal outcomes and research utilization, which then allow for performance improvement and bench marking processes in perinatal care and neonatal intensive care units.

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

1. CCS Manual of Procedures, Chapter 3.25, CCS Standards for Neonatal Intensive Care Units; Chapter 3.25-29. 1999

Tri-City Medical Center
Oceanside, California

WOMEN'S & NEWBORN~~CHILDREN'S~~ SERVICES ~~MANUAL~~
NEONATAL INTENSIVE CARE UNIT (NICU)

ISSUE DATE: 08/12 **SUBJECT: Education Plan, NICU**

REVISION DATE(S): 03/18

Women & Newborn Department Approval:	**~~02/15~~04/18**
Perinatal Collaborative Practice Approval:	**~~n/a~~11/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**12/18**
Professional Affairs Committee Approval:	**~~03/15~~ n/a**
Board of Directors Approval:	**03/15**

A. **PURPOSE:**

1. To determine educational needs of NICU staff members and to develop an education plan based on the identified needs.

B. **DEFINITIONS:**

1. Educational Needs Assessment Survey: A survey to determine staff areas of interest and needs in learning and preferred methods to meet new learning needs.
2. Education Plan: A formal written description of the education goals derived from the needs identified in the survey and the yearly plan for meeting those objectives.
3. Education Calendar: A schedule that contains the educational activities planned for the ~~fiscal~~ **calendar year.**~~year July 1 – June 30.~~

C. **SCOPE AND RESPONSIBILITY:**

1. Scope: this policy applies to the Neonatal Intensive Care Unit of Tri-City Medical Center.
2. Responsibility: it is the responsibility of the ~~c~~Clinical N~~n~~urse ~~S~~Specialist **and NICU Leadership**, ~~assistant nurse manager(s) and clinical operations manager~~ to implement ~~this policy in~~ the process of development, review, revision, approval and communication of the education plan as identified. ~~within the policy.~~

D. **POLICY:**

1. **Either an**~~A~~**n** educational needs assessment survey **or a skills proficiency self-assessment tool** will be developed and conducted annually. ~~by the CNS and the professional practice council and will be~~
~~1.~~**2. These tools, combined with leadership assessment of visualized unit-based care, incident event reports and chart audits, will be** used in developing an education plan for NICU nursing staff.
~~2. The educational needs assessment survey evaluates nursing staff input on areas of interest in learning, preferred methods of learning and preferred times for educational activities.~~

E. **PROCEDURE:**

1. The CNS will develop a yearly staff educational needs assessment survey **or RN skills proficiency self-assessment.**~~:~~
2. The **results of the** educational needs assessment **survey, leadership assessment of incident event reports, and chart audit** reviews **will be used in developing an education plan for NICU nursing staff.**

~~2. The results of the needs assessment and the education plan are presented to the nursing staff.~~

3. The CNS in conjunction with ~~the professional practice committee~~**NICU leadership** will ~~write~~ **develop** an education plan to address the staff learning needs.~~.~~

~~4. Using the results of the survey, the CNS in conjunction with the professional practice committee will develop an educational calendar to start July 1 and finish June 30 of the next year.~~

4. The educational calendar will be posted in the NICU to assure accessibility for staff.

5. In-house **hospital educational offerings** and applicable external educational opportunities will **be posted and available to NICU staff.**

F. **REFERENCE(S):**

1. CCS Manual of Procedures, Chapter 3.25, CCS Standards for Neonatal Intensive Care Units; Chapter 3.25-30-33. (1999)

Tri-City Medical Center	Women and Newborn Services Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**NICU PLACEMENT: OVERFLOW TO ALTERNATE LOCATION (TEMPORARY OVERFLOW)**
Purpose:	To define the circumstances, criteria and process us Care Unit (NICU) is at or near peak capacity and ov outside the NICU.
Supportive Data:	California Code of Regulations Title XXII, #70483 #[illegible] #70507, CCS Manual of Procedures Chapter 3.25.1/G.
Equipment:	See Equipment List for NICU Patients in Alternate Areas

DELETE: No longer needed.

A. **POLICY:**

1. When NICU census nears peak capacity, Tri-City Medical Center **NICU** management, in collaboration with NICU physician/licensed independent practitioner**Allied Health Professional (LIPAHP)**, will evaluate options for placement of NICU patients in alternate locations where appropriate licensed beds are available.
2. Appropriate space, equipment and supplies for NICU patients will be provided as specified by the CCS Manual of Procedures pages 17-21.
3. Rooms will be appropriately supplied and equipped prior to moving patients.
4. NICU nursing ratios will be maintained and medical management procedures followed.
5. A minimum of 2 RNs will be present when NICU patients are placed in the assigned area.
6. NICU patients placed in the temporary location outside the NICU will remain under NICU medical and nursing care and supervision.
7. A member of the NICU Leadership team/Relief charge nurse, in collaboration with physician/LIP **AHP** as needed, are responsible for the identification of patients who may be appropriate for alternate patient placement.
8. Eligibility criteria includes:
   a. Levels 1-6 as described in Patient Classification in the NICU.
   b. No pending surgery procedure.
   c. Determination of the attending Physician/LIP **AHP.**
   d. Infusing intravenous fluids via peripherally inserted venous (PIV) and peripherally inserted central catheters (PICC). Maximum in these criteria will not exceed 50% of the patient population.
9. Exclusion criteria
   Oxygen delivery**Receiving oxygen therapy.**
   a. via nasal cannula, CPAP, hood or ventilatory device
   b. Determination of the attending Physician/**LIPAHP.**
10. Quality Assurance
    a. NICU patients placed in the temporary location outside the NICU will receive the same standard of nursing and medical care as patients cared for in the NICU.
       i. The NICU relief **C**charge nurse will round hourly in the overflow area and be immediately available by **cell** cell phone.
       ii. All equipment/supplies will be the same in the main NICU and the temporary location. The designated temporary location will meet Title XXII requirements for Newborn Intensive Care Nursery.
       iii. Random assessments will be performed by the NICU leadership to assure the quality of the clinical medical and nursing care of the NICU patient placed in the temporary location outside the NICU**NICU.**

B. **PROCEDURE:**

Department Review	Department of OB/GYN	Division of Neonatology Perinatal Collaborative Practice	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration Professional Affairs Committee	Board of Directors
1/15, 03/18, 07/18	n/a	1/15, 05/18, 07/18	n/a	n/a	3/15, 06/18, 10/18	4/15, 12/18	8/12; 4/15

1. When bed space in the NICU nears peak capacity, the NICU will begin the process of identifying appropriate locations for patient placement outside the NICU as follows:
   a. A member of the NICU Leadership team/Relief cCharge nurse will alert the NICU Nurse Manager of increasing census.
   b. The NICU Manager will alert the Director of Women's and Newborn's Services and the Director of Regulatory Compliance of the imminent need for the NICU to locate alternate bed space outside the NICU.
   c. Alternate location for NICU patient placement will be in the designated NICU Overflow.
   d. /Relief cCharge nurse of the alternate areas will arrange for terminal cleaning of the rooms.
2. Relief cCharge nurse will identify patients to be moved in collaboration with the Physician/LIP as needed.
3. The following steps will be implemented to ensure a safe move into an environment that is consistent with NICU standards
   a. The Relief cCharge nurse will ensure that the NICU Overflow is ready.
   b. Pharmacy, Materials, and Respiratory Therapy will be notified of the move by a member of the NICU leadership team/Relief cCharge nurse.
   c. The Relief cCharge nurse will notify the Unit Secretary of the patients to be moved and their destination.
   d. An RN will move the first patient in its own bed to the prepared room into the assigned area and will reconfirm that the appropriate equipment is in place, plugged in, and functioning appropriately.
      i. The NICU technician may be utilized to help move beds/equipment. An RN must accompany all NICU patients.
   e. The RN will then ensure that the patient is connected to the appropriate monitors (cardio-respiratory and/or pulse oximeters) with the appropriate alarm limits set.
   f. The RN will remain with the patient until appropriate transfer with handoff is made to the assigned RN.
   g. Additional patients will be moved according to the procedure described above.
   h. The Relief cCharge nurse in conjunction with the NICU staff will notify families of the move as soon as possible.
4. When the NICU census is no longer near peak capacity, NICU patients will return to the NICU following the steps described in #3 a-h.

C. **RELATED DOCUMENTS:**
1. Equipment List for NICU Patients in Alternate Area

D. **REFERENCES :**
1. California Code of Regulation, Title 22: Social Security, Volume 28, Revised, November 29, 1996. Barclays Law Publishers, South San Francisco, CA.

Tri-City Medical Center
Oceanside, California

DELETE – follow Patient Care Services Policy: Antimicrobial Stewardship

PHARMACY ~~MANUAL~~

ISSUE DATE: 10/10	**SUBJECT:** Antimicrobial Stewardship Program
REVISION DATE(S): 05/15	

Pharmacy Department Approval:	~~03/15~~09/18
Pharmacy & Therapeutics Committee Approval	~~10/10, 3/15~~09/18
Medical Executive Committee Approval:	~~10/10, 4/15~~10/18
Administration Approval:	12/18
Professional Affairs Committee Approval:	~~05/15~~ n/a
Board of Directors Approval:	05/15

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

~~1. To provide a process in order to promote judicious use of antimicrobials~~

~~2. The goals of the Antimicrobial Stewardship Program (ASP) include, but are not limited to:~~

~~a. Minimize adverse effects and events secondary to the use of antimicrobial agents~~

~~b. Reduce, minimize, and/or prevent the emergence of resistant microorganisms~~

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

~~1. A physician supervised multidisciplinary antimicrobial stewardship workgroup shall evaluate the judicious use of antimicrobials in accordance with guidelines established by the federal government and professional organizations.~~

~~2. Antimicrobial stewardship activities, outcomes, and all quality indicators shall be reported quarterly by the Infectious Disease physician or pharmacist to the Pharmacy & Therapeutics Committee and Infection Control.~~

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

~~1. Antimicrobial Stewardship Workgroup:~~

~~a. Clinicians~~

~~i. A single physician leader, knowledgeable in the area of infectious diseases, responsible for program outcomes~~

~~ii. A pharmacist leader, knowledgeable in the area of infectious diseases, will co-lead the program~~

~~b. Infection Control~~

~~i. Infection Control Activities~~

~~ii. Quality indicators (*C. difficile*, MDRO, device related infections, procedure related infections, etc)~~

~~c. Information Systems~~

~~i. Computerized alerts & warnings~~

~~ii. Data generation and reporting~~

~~d. Microbiology~~

~~i. Culture and sensitivity reporting/alerting~~

~~ii. Annual antibiogram~~

~~e. Administration~~

~~i. Financial support of program~~

~~2. Antimicrobial Stewardship Activities:~~

~~a. Prospective audit and feedback conducted by pharmacist leader in conjunction with physician leader~~

i. This process involves prospectively reviewing the use of antimicrobial agents and contacting the prescriber with recommendations for optimizing current antimicrobial therapy on an individual patient.

b. Development and implementation of a restricted antibiotic policy (Refer to Pharmacy policy "Restricted Antimicrobials")

c. Surveillance and trending of antimicrobial use patterns and quality indicators

d. Education to clinicians and staff
   i. Development of evidence based, institution-specific guidelines for the treatment of common infections

e. Other activities:
   i. IV to Oral route conversion program
   ii. Renal dose adjustment of antimicrobials
   iii. Preparation of retrospective reviews (i.e. Medication Use Evaluation)

Tri-City Medical Center
Oceanside, California

PHARMACY MANUAL

DELETE – content contained in Patient Care Services Policy: Medication Administration

ISSUE DATE: 09/91

SUBJECT: Bedside Medication Storage

REVISION DATE(S): 01/97, 07/00, 02/03, 04/05, 07/06, 07/09, 01/12

Pharmacy Department Approval:	~~03/15~~07/18
Pharmacy & Therapeutics Committee Approval:	~~02/03, 04/05, 07/06, 07/09, 01/12, 03/15~~09/18
Medical Executive Committee Approval:	~~02/03, 04/05, 07/06, 07/09, 01/12, 04/15~~10/18
Administration Approval:	12/18
Professional Affairs Committee Approval:	~~05/15~~ n/a
Board of Directors Approval:	~~02/03, 04/05, 07/06, 07/09, 01/12,~~ 05/15

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

~~1. Medications shall not be stored at bedside.~~

~~a. Exception: as delineated in Patient Care Services Policy Self-Administered Continuous Subcutaneous Infusion of Insulin (Insulin Pump Therapy) for the Acute Care Patient~~

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 09/90

SUBJECT: Controlled Substances - Pharmacy

REVISION DATE(S): 01/97, 12/97, 02/03, 06/05, 07/06, 07/09, 01/12

Pharmacy Department Approval:	~~03/15~~09/18
Pharmacy & Therapeutics Committee Approval:	~~02/03, 06/05, 07/06, 07/09, 1/12,~~ 09/18
Medical Executive Committee Approval:	~~02/03, 06/05, 07/06, 07/09, 1/12, 06/15~~10/18
Administration Approval:	12/18
Professional Affairs Committee Approval:	~~07/15~~ n/a
Board of Directors Approval:	~~02/03, 06/05, 07/06, 07/09, 1/12,~~ 07/15

A. **POLICY**:

1. The Pharmacist in Charge (PIC) is responsible for the proper safeguarding of controlled substances within the Hospital.
2. The PIC is responsible for the purchase, storage, accountability and proper dispensing of controlled substances.
3. All applicable state and federal laws governing the handling of controlled substances will be enforced.
4. The Pharmacy Department utilizes a perpetual inventory system for all Schedule II-V controlled substances. The PIC is responsible for assuring the accuracy and completion of the perpetual inventory system.

B. **PROCEDURE:**

1. Registration:
   a. The hospital will hold current registration with the Drug Enforcement Administration (DEA) and appropriate state licensure.
   b. The individuals authorized to sign the DEA Form 222 and Controlled Substance Ordering System (CSOS) will include the Director of Pharmacy, Pharmacy Buyer, and anyone else deemed appropriate and necessary.
   c. Only physicians with valid registration numbers may prescribe controlled substances.
2. Pharmacy Receipt of Controlled Substances:
   a. The receipt of all Schedule II-V controlled substances is documented in the perpetual inventory system in the CII safe.
   b. Upon receipt of controlled drugs, the count, condition and identification of the drugs are verified by a pharmacist.
   c. The Pharmacy Buyer shall fill out the retained copy of the DEA Form 222 for all Schedule II drugs, indicating the amount received and date.
   d. For Schedule II, a copy of the wholesaler's invoice, CII Safe Receive Log Sheet, and copy of DEA 222 will be filed separately in a readily retrievable manner and will be maintained for the period required by law.
   e. For Schedule III-V, a copy of the wholesaler's invoice and CII Safe Receive Log Sheet will be filed in a readily retrievable manner and will be maintained for the period required by law.
   f. Discrepancies in shipment that cannot be resolved immediately with the wholesaler shall be reported to the PIC.
3. Pharmacy Storage and Security:

a. All Schedule II-V drugs are stored in the Pyxis cabinet (C-II Safe) or locked cabinet in the refrigerator.
b. Only licensed personnel shall have access to controlled drugs with the hospital.

4. Dispensing and Distribution:
   a. All Schedule II, III, IV and V drugs are dispensed to the patient care units and stored in an automated dispensing machine. Exceptions: See Pharmacy Policy Floor Stock.
   b. Par levels for controlled substances are automated utilizing the C-II Safe and the Pyxis Medication Stations. The Pharmacy Department will re-stock and fill orders on a daily basis.
   c. The Pharmacy Technician fills the order and the order is checked by a second technician or a pharmacist prior to delivery to the nursing unit. Upon refill, a perpetual inventory is updated with the refill amount. Activity reports are generated and reviewed for audit purposes.
   d. Controlled substance discrepancies will be resolved according to Patient Care Services Policy Controlled Substances Management Policy and Pharmacy Policy Automated Dispensing Machine.
5. Inventory System:
   a. In the CII Safe a physical inventory is done monthly and is compared to the computed balance in the perpetual inventory system. Any discrepancy that cannot be resolved will be reported to the PIC immediately.
      ~~a.~~i. **A physical inventory will be compiled of all Class-II substances stored in the Pharmacy at least every 3 months as required by the California Board of Pharmacy. The Inventory Reconciliation report should be readily available for up to 3 years.**
   b. Every two (2) years a complete inventory count of all controlled drugs will be conducted and kept on file in the pharmacy department pursuant to state and federal laws.
6. Destruction:
   a. Destruction of all controlled substances within the pharmacy must be done in the presence of two (2) licensed individuals, one of which must be a pharmacist.
   b. Destruction of patient's own controlled substances left behind after discharge must be wasted in the presence of two (2) pharmacists.
7. Suspected Tampering/Loss:
   a. If tampering with or loss of a controlled substance is suspected the PIC shall be notified immediately and an investigation shall be initiated. (See Employee Theft or Impairment Policy)
   b. All unauthorized losses shall be reported to the appropriate state and federal authorities.

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 01/98 **SUBJECT: Discharge Prescriptions**

REVISION DATE(S): 02/03, 06/05, 07/06, 07/09, 01/12

Pharmacy Department Approval:	~~03/15~~07/18
Pharmacy & Therapeutics Committee Approval:	~~02/03, 06/05, 07/06, 07/09, 1/12,~~ 09/18
Medical Executive Committee Approval:	~~02/03, 06/05, 07/06, 07/09, 1/12, 04/15~~10/18
Administration Approval:	12/18
Professional Affairs Committee Approval:	~~05/15~~ n/a
Board of Directors Approval:	~~02/03, 06/05, 07/06, 07/09, 1/12,~~ 05/15

A. **POLICY**:

1. The hospital does not provide discharge medications, unless an extreme emergency exists. Discharge prescriptions may be an important component of the continuum of the patient's care. This hospital is committed to assisting the patient/family in obtaining access to appropriate pharmaceutical care during the discharge process.
2. If an emergency exists, no drugs supplied by the hospital shall be taken from the hospital unless a prescription or medical record order has been written for the medication. The medication must be properly labeled and prepared by the Pharmacist in accordance with state and federal laws, for use outside of the hospital.
3. The patient may be provided printed material describing the effects of the discharge medications ordered by the physician. Drug leaflets for discharge information may be accessed at nursing units using the Micromedex system.
4. Depending on risk and other factors, the patient and/or family may receive education about anticipated discharge medications prior to the day of discharge. Such education will be provided by either the nurse or Pharmacist. Documentation of such education will appear in the discharge instructions area of the medical record.
5. The Hospital may assist in extraordinary cases, hardship cases or when the medication is difficult to obtain elsewhere. It should be noted however, that discharge prescriptions are not a payable benefit of most health care insurance plans. The patient/family holds the financial responsibility for discharge prescriptions.
6. No person other than a pharmacist or an individual under the direct supervision of a pharmacist shall dispense medication for use beyond the immediate needs of the patients.

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 01/85

SUBJECT: Drug Compounding for Medication Not Commercially Available

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

Pharmacy Department Approval:	~~10/17~~09/18
Pharmacy & Therapeutics Committee Approval:	~~11/17~~09/18
Medical Executive Committee Approval:	~~11/17~~10/18
Administration Approval:	12/18
Professional Affairs Committee Approval:	~~01/18~~ n/a
Board of Directors Approval:	01/18

A. **POLICY:**

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

B. **PROCEDURE:**

1. The Pharmacy Department may procure compounded drugs from a contracted Compounding Pharmacy in situations where drug products are not commercially available and/or a suitable alternative does not exist.
   a. The following includes, but may not be limited to reasons for ordering and/or preparing compounded drugs:
      i. The drug required is not manufactured in the needed strength.
      ii. The prescriber requests a different form of the drug to improve patient compliance with prescribed drug therapy (for swallowing or taste purposes, etc.).
      iii. The prescribed drug needs to be combined in forms not available from the manufacturer to improve patient response to prescribed drug therapy.
      iv. The patient is allergic to inactive ingredients (dye, lactose, etc.) in the manufactured form of the drug.
      v. The prescribed therapy requires tailoring to the individual patient (intravenous feeding solutions, chemotherapy, etc.).
   ~~vi.~~**b. Before outsourcing sterile compounding, the pharmacy department will confirm that the vendor to be used can provide evidence of the following:**
      ~~vii.~~**i. State pharmacy and/or wholesaler licensure and other appropriate licenses**
      ~~viii.~~**ii. Licensure documents if the compounding facility is registered with the FDA as a drug manufacturer or device manufacturer**
      ~~ix.~~**iii. Current DEA registration as a manufacturer or wholesaler**
      ~~x.~~**iv. Stability and sterility documents and clinical references, as well as any materials that are used to determine beyond-use date**
2. The Pharmacy Department shall not prepare high-risk compounded sterile products which utilize non-sterile ingredients or devices. Refer to Pharmacy Policy Sterile Product Preparation section on High-Risk Level CSPs.

3. Extemporaneously prepared products by the Pharmacy Department must be supported by evidence-based literature and a recipe must exist for the preparation of the product.
4. The drug to be compounded must be individually prescribed for an identified patient.
5. A bulk drug substance (the chemical that becomes the drug's active ingredient) qualifies for use in compounding when:
   a. It is found in a FDA-approved drug.
   b. It is listed in a book of widely used drug substances published by the United States Pharmacopeial Convention (authoritative body).
   c. It is listed in a FDA rule as acceptable for pharmacy compounding.
6. Previously marketed drugs found to be unsafe or ineffective and removed from the market shall not be compounded.
7. If inclusion criteria are met and no exclusion criteria exist, prior to preparing the compounded drug, the Pharmacist will review the medical record of the patient. The risks of the patient receiving compounded drug, along with the benefits, will be weighed in the context of a specific patient's medical condition. If the Pharmacist, in his/her clinical expertise feels the risks outweigh the benefits, the prescriber will be contacted for revision of the order.
8. If the prescriber has ordered a compounded drug that is either found to be unsafe or ineffective and removed from the market, or is listed in the FDA's regulations as difficult to compound the prescriber will be contacted for discontinuation of the order.
   a. If the prescriber refuses to discontinue the order and insists on preparation of the compounded drug, the Pharmacist will contact either the Pharmacy Clinical Manager or Pharmacy Director.
   b. The Pharmacy Clinical Manager or Director will contact the Chairperson of the Pharmacy and Therapeutics Committee to resolve the situation with the prescriber.

C. RELATED DOCUMENT(S):

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

D. REFERENCE(S):

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

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 09/90

SUBJECT: Drug Product Procurement and Inventory Management

REVISION DATE(S): 09/91, 01/97, 02/03, 01/05, 07/06, 07/09, 01/12
~~**REVIEW DATE: 02/03, 01/05, 07/06, 07/09, 1/12, 05/15**~~

Pharmacy Department Approval:	~~05/15~~09/18
Pharmacy & Therapeutics Committee Approval:	~~07/15~~09/18
Medical Executive Committee Approval:	~~08/15~~10/18
Administration Approval:	12/18
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **POLICY:**

1. The Pharmacy Department shall be responsible for the procurement, distribution, and control of all drug products used in the hospital for inpatient and ambulatory patients.

B. **PROCEDURE:**

1. Medication Acquisition:
   a. Pharmacy or Designee (i.e. Materials Management) shall ensure the highest quality of and the best price for drug products through careful consideration and selection of drug product manufacturers and suppliers.
   b. Only those medications approved for formulary use will be procured and stored as delineated in Pharmacy Policy Formulary System.
   c. Whenever possible, only those medications which are commercially available and/or in single-unit packages and in ready-to-administer form shall be procured.
   d. Procurement of medications during emergencies shall be determined and performed as delineated in Pharmacy Policies Medication Shortages and Loaning and Borrowing of Medications for Emergency Purposes.
   e. Antidote medications will be procured and stocked in accordance to Pharmacy Policy Antidote Stocking.
   f. Orders will be made by the Pharmacy Buyer or designee and prepared daily using the wholesaler computerized ordering system or ordered directly from the manufacturer.
   g. After the product is delivered directly to Pharmacy or via Materials Management, the order will be checked against the packing slip and invoice.
      i. If the items received were not accompanied by an invoice, drug products will be put aside until an invoice is obtained and the items are entered into inventory.
      ii. Upon arrival of the order from the wholesaler the pharmacist will confirm the shipment container quantities match the expected quantities.
      iii. If the order is complete, the pharmacist checking the order must initial and date the packing slip as an indication the products were received.
      iv. If the order is incomplete, the Pharmacy Buyer will be notified and shall contact the appropriate wholesaler for rectification.
         1) Receipt of controlled substance medications shall be checked against the controlled substance packing slip for quantity and accuracy, signed and dated by a pharmacist.
         2) Any discrepancies shall be noted and referred to the appropriate person.

3) The CII Safe Receive Report is compared to the invoice to ensure all ordered products are accounted for and placed in the CII Safe.

h. A copy of each invoice will be forwarded to Accounts Payable.

i. A copy of Schedule II invoices shall be kept with the DEA order form filed for three years. Copies of Schedule III, IV, V invoices shall be kept in a separate file for three years.

2. Storage:

a. Medications shall be received, stored, and prepared under proper conditions in accordance with State and Federal Regulations, governing agencies, and manufacturer recommendations to ensure medication integrity, safety and security.

b. Storage of medications outside of the pharmacy shall be done in a secure manner, utilizing automated dispensing devices whenever possible.

c. Unusable drugs will be removed from stock as delineated in Pharmacy Policy Unusable and Outdated Drugs.

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 04/77 **SUBJECT: Unusable Medications**

REVISION DATE(S): 06/05, 07/06, 07/09, 01/12

Pharmacy Department Approval:	~~03/15~~07/18
Pharmacy & Therapeutics Committee Approval:	~~06/05, 07/06, 07/09, 1/12, 03/15~~09/18
Medical Executive Committee Approval:	~~06/05, 07/06, 07/09, 1/12, 06/15~~10/18
Administration Approval:	12/18
Professional Affairs Committee Approval:	~~07/15~~ n/a
Board of Directors Approval:	~~06/05, 07/06, 07/09, 1/12,~~ 07/15

A. **PROCEDURE**:

1. All medication storage areas of the hospital will be inspected for outdated, contaminated improperly stored medications and containers with worn, illegible or missing labels. The Pharmacy staff member conducting the inspection will remove all of these types of medications from the area.
2. The medication storage areas will be inspected by a pharmacist, pharmacist intern, or pharmacy technician on a monthly basis.
   a. The nurse manager or designee will be notified of the inspection findings at the time the inspection is complete.
   b. If the inspection is performed by a pharmacist intern or pharmacy technician, any irregularities found during an inspection will be reported to the Director of Pharmacy or designee within 24 hours.
3. Nursing, or other staff approved by license to administer medications, who note outdated, contaminated, improperly stored medications or containers with worn, illegible or missing labels, will contact the Pharmacy Department to notify them of the drug's existence on his or her unit. Pharmacy personnel will remove the medication from the unit.
   a. Patient specific medications that are used should be placed in the appropriate waste bin on the nursing unit at the time of patient discharge or discontinuation of the physician order.
4. Unusable medications shall be stored in an isolated area within the Pharmacy Department that has been designated for the storage of such unusable drugs. The drugs shall remain there until they can be returned to the manufacturer or picked up by the pharmaceutical reverse distribution company.
5. A record of medications returned to the manufacturer or pharmaceutical reverse distribution company will be maintained. Documentation will include the name of the receiving company, the name, strength and quantity of medications, and the date the medications were removed from the Pharmacy Department.
6. Medications that are to be disposed of within the pharmacy department will be done according to current regulations.
7. Disposal of controlled substances within the pharmacy department must be done in the presence of two (2) witnesses, one of which must be a pharmacist. A record of all controlled substances that are disposed of within the Pharmacy Department will be maintained for three (3) years. The record will consist of the name and strength of the medication, quantity, signatures of witnesses, and date of destruction.
8. Medications from outside the hospital brought in by patients and left in the Pharmacy Department for storage greater than 30 days:
   a. Will be destroyed in accordance with current regulations.

b. A record of disposal will be noted on the "Patient's Own Medication Record".
c. Upon destruction, the information on the "Patient's Own Medication Record" will include the name of medication, strength, quantity if a controlled substance, patient's name, date of destruction and signature of person(s) disposing of the medication(s).
d. Controlled substances shall be destroyed in the presence of two (2) pharmacists. .
e. The records shall be kept for three (3) years.

DELETE – incorporated into Patient Care Services Policy: Physician/Allied Health Professionals

Tri-City Medical Center
Oceanside, California

PHARMACY ~~POLICY MANUAL~~

ISSUE DATE:	**12/01~~, 01/05~~**	**SUBJECT:**	**Electronic, Verbal and Written Medication Orders — General Prescribing**
REVISION DATE(S):	**10/02, 05/03, 06/05, 09/04, 01/12**	**POLICY NUMBER:**	**8390-3003**

Pharmacy Department Approval:	**~~05/15~~08/18**
Pharmacy & Therapeutics Committee Approval:	**~~03/02, 06/05, 7/09, 01/12~~09/18**
Medical Executive Committee Approval:	**~~03/02, 06/05, 7/09, 01/12~~10/18**
Administration Approval:	**12/18**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**~~03/02, 06/05, 7/09, 01/12~~**

~~**DEFINITION(S):**~~

~~**A Verbal Order: (noted in the chart as V.O) is defined as an order communicated by oral, spoken, face-to-face communication between the prescriber and authorized hospital personnel.**~~

~~**A Telephone Order: (noted in the chart as T.O.) is defined as an order communicated by telephone when the prescriber is not physically present (face-to-face) with the authorized personnel.**~~

~~**Titrating Orders: orders in which the dose is either increased or decreased in response to the patient's clinical status. See Patient Care Services (PCS): Titrating Medications, Adult Patient Policy.**~~

~~**Taper Orders: orders in which the dose is decreased by a specified amount with each dosing interval.**~~

~~**Hold Orders: order for discontinuation of the medication (refer to PCS Automatic Stop Orders Policy).**~~

~~A.~~ ~~**Range Orders: Medication orders in which the dose or dosing interval varies over a prescribed range, depending on the patient's status.**~~

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

~~1.~~ ~~Tri-City **Healthcare District (TCHD)**Medical Staff may order **medications for** inpatient/outpatient treatment and diagnostic studies. Non-physician members and non-members of Tri-City Healthcare District**TCHD** medical staff may only order diagnostic, imaging, therapeutics, laboratory tests, and rehabilitation services within their scope of practice for outpatient services.~~

~~All Medical Staff orders **Medication orders will be entered electronically via CPOE or written** recorded (written) legibly in the patient's **medical** record.~~

~~**A Physician's Assistant who has been appropriately credentialed through the Medical Staff may transmit orders from the physician given verbally, via telephone, or in writing.**~~

~~**Orders must be co-signed by the Physician's Assistant and supervising physician or attending physician within 48 hours for medication orders and 14 days post discharge for all other orders.**~~

~~**Registered Nurses (RN) or other designated personnel may accept and implement a medication order which is transmitted by a designee of the Medical Staff member to the RN after determining that the order is being transmitted and not initiated by the Medical Staff member's designee, that the order is appropriate for the patient's condition and is**~~

in his or her best interest, and that the order is in compliance with applicable statutes, regulations, and hospital policies.

- Orders must be co-signed by the physician within 48 hours for medication orders and 14 days post discharge for all other orders.

- Medical Staff members covering for another Medical Staff member may sign his/her order.
- Only medications needed to treat the patient's condition are ordered.
  - Diagnosis, condition, or indication for use must be documented for each medication ordered within the patient medical record
- Required elements of a medication order include:
  - Drug name
  - Dosage form
  - Drug strength or concentration
  - Dosage
  - Administration route
  - Frequency
  1. Duration, see PCS:harmacy Policy Automatic Stop Orders Policy All medication orders are to be timed, dated, and signed by the Medical Staff member who gave the order or the physician who was the patient's attending physician at the time the order was given. These orders must be authenticated within 48 hours. Non- medication orders are to be signed and dated within 14 days of discharge.

a. Other essential elements of a written medication order include:
   i. Name of Patient
   a. Age, height and weight with appropriate
      ii. Drug Name
      iii. Dose, frequency and route of administration, if other than oral
   iv. Purpose or indication of PRN medication
   b. Date, Time and signature of prescriber

- Pediatric Orders:
  - Physician/provider orders for pediatric populations shall contain weight-based dosing (i.e. mg/kg), calculated dose, and the patients current weight except for the following defined medication classes:
    - Medications not determined by the patient's weight (i.e., iron sulfate)
    - Vaccines
  - Ensure the weight-based dose does not exceed the recommended adult dose
- Orders that do not contain the required elements or entered incorrectly shall be considered incomplete and shall not be implemented until clarified. If the prescriber cannot be reached and the intervention is urgently needed, the appropriate on-call physician/provider shall be contacted to clarify the order.
- The pharmacist shall review all medication orders for appropriateness before dispensing the first dose and prior to administration as delineated in Pharmacy: Policy Pharmacisty Order Verification Policy and Patient Care Services PolicyPCS: Medication: Administering Medications per Scope of Practice Policy.ration
- Physician/provider "PRN" medication orders shall specify an indication or symptom unless only one indication exists for the medication.
  - If an order is written without an indication, the use of the "PRN Medication Default Reasons" will auto-populate for select medications on the MAR.
  - Multiple orders for the same PRN reason will not be accepted unless one of the following criteria are met:
    - Order clarifies the sequence of administration. Example: Percocet 5/325 1 tab PO Q4H PRN severe pain (7-10) Morphine 2 mg IV Q4H PRN severe pain not relieved by Percocet
    - Order specifies different, non-overlapping ranges for the symptoms. Example: Percocet 5/325 1 tab PO Q4H PRN moderate pain (scale)

- ~~Morphine 4 mg IV Q4H PRN severe pain (scale)~~
- ~~Any order with the same PRN reason as a previous order will supersede the previous order. The pharmacist will automatically discontinue the previous order.~~
- ~~If the indication entered does not reflect the patient's condition or if there are any questions concerning the appropriate indication the physician/provider shall be contacted for clarification.~~

- ~~Range Orders may only contain one set of ranges (dose or frequency).~~
- ~~If orders are received with more than one set of ranges, then the healthcare provider must contact the physician/provider to change the order unless a policy or protocol is in place for interpretation of range orders (i.e. sliding scale insulin order, PACU opiate orders).~~
- ~~Range orders for a dosage that is more the double than smallest dose shall not be accepted by pharmacy and shall be clarified with the physician by pharmacy~~
  - ~~Example Morphine 2-8 mg IV every 4 hrs PRN will be clarified by pharmacy~~
  - ~~Acceptable orders include: Morphine 2-4 mg IV every 4 hrs PRN or Morphine 4-8 mg IV every 4 hrs PRN after speaking with the physician~~

- ~~"Blanket orders" for medication, treatments, procedures, and laboratory tests (i.e. "continue previous medications," "resume all pre-op medication, labs or treatments," "resume all PT therapy," or "discharge on current medications") will not be accepted.~~
- ~~Titration medication orders must include the rate of infusion and instructions for titration with goal parameters, unless part of an approved protocol. See Patient Care Services PolicyPCS: Titration of Medications, Adult Patients Policy~~
- ~~Taper orders must include a detailed taper/wean schedule, including specific dose reductions per specified dosing intervals, unless they are part of an approved protocol specified by the prescribing physician.~~
- ~~Any medications put on "hold" by the physician shall automatically be discontinued by the nurse and Pharmacy and must be reordered by the physician if and when the medication is resumed.~~
- ~~Medication orders will be renewed in a timely manner and in accordance to Patient Care ServicesPCS: Automatic Stop Orders Policy.~~

b. ~~A Physician's Assistant who has been appropriately credentialed through the Medical Staff may transmit orders from the physician given verbally, via telephone, or in writing. Orders must be co-signed by the Physician's Assistant and supervising physician or attending physician within 48 hours for medication orders and 14 days post discharge for all other orders.~~

c. ~~Registered nurses or other designated personnel may accept and implement a medical order which is transmitted by a designee of the Medical Staff member to the RN after determining that the order is being transmitted and not initiated by the Medical Staff member's designee, that the order is appropriate for the patient's condition and is in his or her best interest, and that the order is in compliance with applicable statutes, regulations, and hospital policies. Orders must be co-signed by the physician within 48 hours for medication orders and 14 days post discharge for all other orders.~~

d. ~~Medical Staff members covering for another Medical Staff member may sign his/her order.~~

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

1. ~~Elements of Written Orders:~~

a. ~~These shall be filled when written as stated above and signed by the practitioner.~~

i. ~~Name of Patient~~
ii. ~~Age and weight with appropriate~~
iii. ~~Drug Name~~
iv. ~~Dose, frequency and route of administration, if other than oral~~
v. ~~Purpose or indication of PRN medication~~
vi. ~~Date, Time and signature of prescribe~~

2. A Verbal Order: (noted in the chart as V.O) is defined as an order communicated by oral, spoken, face-to-face communication between the prescriber and authorized hospital personnel.
3. A Telephone Order: (noted in the chart as T.O.) is defined as an order communicated by telephone when the prescriber is not physically present (face-to-face) with the authorized personnel.

Telephone/Verbal medication orders are to be used infrequently, only to meet the care needs of the patient when it is impossible or impractical for the ordering physician/provider to write/enter the order without delaying treatment. Every effort is to be made by the ordering physician/provider to enter orders into Cerner or in writing when they are on the unit. Verbal medication orders will only be accepted in emergency situations by a registered nurse or licensed pharmacist.

c. **Telephone orders/verbal medication orders shall be entered directly into the EHR and signed, dated, and timed by the individual who received the order.**
d. **Telephone/verbal orders will not be accepted for antineoplastic agents.**
   Exceptions: See PharmacyPCS: Policy Chemotherapy Prescribing, Processing, and Preparation Policy
a. Verbal orders given during patient procedures are to be recorded by the circulating nurse and signed by the ordering physician immediately following the procedure.

4. Telephone medication orders may be received by a registered nurse or licensed pharmacist. Verbal orders for drugs shall be given only to a registered nurse or licensed pharmacist by a person legally authorized to prescribe and shall be recorded in the patient's medical record, noting the name of the person giving the verbal order and the signature of the individual receiving the order. The prescriber or attending physician shall countersign the order within 48 hours.
   a. Elements of a telephone medication order that should be documented include:
      i. Name of patient
      ii. Age and weight of patient when appropriate
      iii. Drug name
      iv. Dose, frequency and route
      v. Quantity and duration
      vi. Purpose or indication
      vii. Name of prescriber, and telephone number when appropriate
      viii. Name of individual transmitting order, if different from the prescriber. All entries into the medical/clinical/case record must be complete, accurate, and timely
      ix. Complete medication orders contain the name of the drug, strength, dosage form, route of administration if other than oral, dosage regimen and preferably indication
      b. All telephone orders must be documented immediately in writing and signed by the individual who received the order.
   c. Telephone orders for antineoplastic agents are not permitted.
   5. Preprinted Order:

a. Preprinted orders will be accepted if they have been approved by the Pharmacy and Therapeutics Committee.

6. New **Transfer Medication** Orders:

When a patient is transferred from one level of care to another the physician/provider updates the orders and completes medication reconciliation per medical staff policy

e. **When a patient undergoes a surgical procedure, all previous orders shall be discontinued and post-operative orders implemented.**

Discharge Medication Orders: See Pharmacy: Policy Discharge Prescriptions Policy.

a. When transferring a patient from one level of care to another, reviewing of orders will go as follows:
   i. All patients transferring from one level of care to another will have current orders reviewed as the physician will document any changes to previous orders that

would be pertinent upon transfer within the physician transfer orders, to include but not be limited to: from ACCU to IMC, IMC to ACCU, ACCU to Pavilion, IMC to Pavilion. See following examples:

1) Physician documents patient to be transferred, "orders have been reviewed and no changes to be made." Physician times, dates and signs the order.

2) Physician documents patient to be transferred, with appropriate order(s) to be changed, an example such as: "orders have been reviewed, diet advanced to Soft Diet." Physician times, dates and signs the order.

Minor invasive procedures, such as Endoscopy Procedure(s), Interventional Radiology Procedure(s), Lumbar

ii. Puncture(s), PICC Line Insertion(s), tracheotomies and Central Line Insertion(s) do not demonstrate transfer of the patient to new level of care.

iii. If patient is transferring emergently to a different level of care to stabilize an EMC, the transferring physician will review, time sign and date all transferring orders within twenty four hours.

7. Blanket Orders Prohibited:

a. It is unacceptable to use "blanket orders" for medication, treatments, procedures, lab tests (such as "continue previous medications, resume all pre-op medication, labs or treatments", such as "resume all PT therapy, or discharge on current medications").

b. Resume orders from floor

c. Discharge on current medications

c. All orders for treatment or medications for discharge must be rewritten in their entirety by the prescribing LIP.

RELATED DOCUMENT(S):

Patient Care Services: Automatic Stop Orders Policy

Patient Care Services: Chemotherapy Prescribing, Processing, and Preparation Policy

Patient Care Services: Medication: Administering Medications per Scope of Practice Policy

Patient Care Services: Titrating Medications, Adult Patient Policy

d. **Pharmacy: Discharge Prescriptions Policy**

1. **Pharmacy: Pharmacist Order Verification Policy**

SUBJECT: ~~Physical Plant~~Service Locations

ISSUE DATE: 7/91
REVISION DATE(S): 1/94, 4/97, 10/00, 1/09, 3/12, 09/15

Department Approval Date(s):	~~07/15~~10/18
Department of Medicine Approval Date(s):	n/a
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	n/a
Administration Approval:	12/18
Professional Affairs Committee Approval Date(s):	~~09/15~~ n/a
Board of Directors Approval Date(s):	09/15

A. **POLICY:**

1. This Policy / Procedure applies to the following Rehabilitation Services' locations:
   a. Rehabilitation Services is located in 1 North wing of Tri-City Medical Center.
   b. Outpatient Rehabilitation Services is located at 2124 El Camino Real Suite 100, Oceanside, CA 92054.
   c. Tri-City Wellness Center is located at 6250 El Camino Real, Carlsbad, CA 92009.

Orders Required

1. **Hang time will be at 2100 for all TPN and fat emulsions**
2. **Orders written after 1400 may not be ~~incorporated~~ initiated until the following day**
3. **Hang 10% Dextrose in Water at same rate as TPN if TPN infusion is stopped or runs out before new bag available**
4. **Insulin will not be added to any TPN per policy**
5. **All changes must be done with use of pre-printed orders set**

☐**CLINICAL PHARMACY SERVICES NUTRITION CONSULT PER DR.** _____

☐**CENTRAL LINE::** _____ ☐ **PERIPHERAL LINE** ~~Cyclic TPN~~ _____

INFUSION VOLUME _____ (mL/24 hrs) **OR** **INFUSION RATE** _____ mL/hr

CYCLIC TPN (enter all rates/durations): _____

Standard Central TPN (Clinimix-E) 5/20
Rate: _____ mL/hr

Contents:
Dextrose 20%
Amino Acid 5%
Sodium Chloride 10mEq/L
Sodium Acetate 25mEq/L
Potassium Phosphate 15 mM/L
Magnesium Chloride 5 mEq/L
Calcium Chloride 4.5 mEq/L

ADDITIVES:

☐ 10 mL Adult Multi-Vitamin **(contains 150 mcg Vitamin K) Daily**
☐ 1 mL Trace Elements-5 Concentrate **Daily**— OR
☐ 10 mL Addamel N daily (Call MD if liver disease)
~~☐ Cyanocobalamin 1000 mcg/month(1st day of Month)~~

☐ **RENAL FORMULA Central TPN (Clinimix) 5/20**
Rate: _____ mL/hr

Contents:
Dextrose 20%
Amino Acid 5%
**** No electrolytes are in this bag****
Sodium Chloride may be added if severe hyponatremia is present (≤130 mg/dL) 75 to 150 mEq Sodium recommended
☐ _____ mEq/Liter **Sodium Chloride**

☐ _____ mEq/Liter **Sodium Acetate**

ADDITIVES:

☐ 10 mL Adult Multi-Vitamin **(contains 150 mcg Vitamin K) Daily**
☐ 1 mL Trace Elements-5 Concentrate MWF OR

☐ 10 mL Addamel N MWF (recommended dose)
~~☐ Cyanocobalamin 1000 mcg/month(1st day of month)~~

LABORATORY MONITORING (with AM labs)

☐ CHEM-7 ☐ CHEM-12 ☐ Phosphorus

☐ Magnesium ☐ Calcium ☐ Amylase ☐ Lipase

☐ Triglyceride ☐ Pre-Albumin ☐ Ionized Calcium
☐ Accuchecks Q6H (while on TPN)

FAT EMULSION 20%

RATE: Infusion via "Y" site at 25 mL/H

☐ No change to prior order

Volume: ☐ 100 mL (200 Kcal) ☐ 250 mL (500Kcal)

Frequency: ☐ Daily ☐ Every other day ☐ M-F

☐ 3x per week on days _____

☐ Read Back all T.O./V.O.orders

Nurse's – Signature Date Time

Physician's – Signature Date Time

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ADULT PARENTERAL NUTRITION ORDERS
Page 1 of 5

Day #_____

CUSTOM TPN

INFUSION VOLUME _____ (mL/24 hrs) **OR** **INFUSION RATE** _____ mL/hr

Cycle TPN _____

AMINO ACID FINAL CONCENTRATION:	**FAT EMULSION 20%**
Amino Acid _____ gm/24 H **OR** ☐ 4.25% ☐5% ☐ 7.5% ☐ Other _____%	**RATE: Infusion via "Y" site at 25 mL/H** ☐ No change to prior order
DEXTROSE FINAL CONCENTRATION: Dextrose _____ gm/24 H **OR** ☐10% ☐ 20% ☐25% ☐ Other:_____ %	**Volume:** ☐ 100 mL (200 Kcal) ☐250 mL (500 Kcal) **Frequency:** ☐ Daily ☐Every other day ☐M-F ☐ 3xper week on days _____

ADDITIVES:		**Average daily maintenance requirements:**
Calcium Gluconate	mEq/Liter	• Sodium: 60-150 mEq • Potassium: 60-120 mEq • Chloride: 60-150 mEq • Acetate: 80-120 mEq • Calcium: 10-15 mEq • Phosphorous: 20-40 mM • Magnesium: 8-23 mEq
Magnesium Sulfate	mEq/Liter	
Potassium Acetate	mEq/Liter	
Potassium Chloride	mEq/Liter	
Potassium Phosphate	mM/Liter	
Sodium Acetate	mEq/Liter	
Sodium Chloride	mEq/Liter	
Sodium Phosphate	mM/Liter	
Multi-Vitamin-12 **(includes 150 mcg Vit K)**	☐ 10 mL/day	
*Trace Elements-5 ☐ 1 mL daily *Addamel N ☐ 10mL daily	☐1mlMWF (renal diseas ☐ 10mL MWF (renal)	
~~Cyanocobalamin (1st day of month)~~	~~☐ 1000 mcg/month~~	

LABORATORY MONITORING (with AM labs) ☐ **Accu-checks Q6H (while on TPN)**

☐ CHEM-7 ☐ CHEM-12 ☐ Phosphorus ☐Magnesium ☐Calcium

☐ Triglyceride ☐Pre-Albumin ☐ Amylase ☐Lipase ☐ Ionized Calcium

☐ Read Back all T.O./V.O.orders	
Nurse's – Signature Date Time	Physician's – Signature Date Time
Tri-City Medical Center 4002 Vista Way • Oceanside • CA • 92056 **ADULT PARENTERAL NUTRITION ORDERS** **Page 2 of 5**	Affix Patient Label

STANDARD TPN AND RENAL FORMULATION MACRONUTRIENTS

Amino Acid 5% and Dextrose 20%

Rate (mL/hr)	24-hour volume (mL)	Protein (grams)	Protein (Kcal)	Dextrose (grams)	Dextrose (Kcal)	Total Kcal
30	720	36	144	144	490	634
35	840	42	168	168	571	739
40	960	48	192	192	653	845
42	1000	50	200	200	680	880
45	1080	54	216	216	734	950
50	1200	60	240	240	816	1056
55	1320	66	264	264	898	1162
60	1440	72	288	288	979	1267
65	1560	78	312	312	1061	1373
70	1680	84	336	336	1142	1478
75	1800	90	360	360	1224	1584
80	1920	96	384	384	1306	1690
84	2000	100	400	400	1360	1760
85	2040	102	408	408	1387	1795

TPN ORDERING INFORMATION

INFUSION RATE	• Initiate at slow rate (approx. 40-50 mL/hr) • Usual goal rate 65-85 mL/hr • To discontinue TPN, decrease rate by 50% every 2 hours until 40 mL/hr then discontinue
DEXTROSE	• For custom TPN start with 10-15% dextrose • Maintain blood sugars less than 180 mg/dL before increasing rate of TPN or percent dextrose • Do not exceed 5 mg/kg/min
PROTEIN	• For custom TPN in non-acutely ill patients start with 4.25% amino acids • For critically ill patients or nutritionally depleted use 5-6% amino acids
ELECTROLYTES	Average daily maintenance requirement: • Sodium: 60-150 mEq • Potassium: 60-120 mEq • Chloride: 60-150 mEq • Acetate: 80-120 mEq • Calcium: 10-15 mEq • Phosphorous: 20-40 mM • Magnesium: 8-24 mEq

GUIDELINES FOR INTIATION OF TOTAL PARENTERAL NUTRITION

CALORIC AND FLUID REQUIREMENTS	1. **Calculate dosing body weight** a. Ideal body weight (IBW) i. Men: 50kg + 2.3 (Height in inches – 60) ii. Women: 45.5kg + 2.3 (Height in inches – 60) b. If ~~actual~~ **total body** weight (TBW) is 20% below IBW, use TBW c. ~~Use IBW for obese patients 18-22 Kcal/kg IBW or~~**If obese: Use total body weight and adjust daily requirements as below**~~11-14 Kcal/kg TBW~~ 2. **Estimate daily caloric requirement in normal patients** a. 20-35kcal/kg i. Consider lower range in elder (greater than 65 Y/O) ii. Generally, critically ill patients require 25-30 kcal/kg daily iii. Consider higher range for nutritionally depleted ~~iii.~~**iv. Reduce calculated daily requirment by 50-70% in obese patients (and pair with increased protein intake as below)** 3. **Estimate daily fluid requirement in normal patients** a. 30-40 ml/kg OR 1 mL/Kcal **b.** Account for fluid intake from other sources including maintenance fluids and intravenous-medications
MACRONUTRIENT REQUIREMENTS	1. **LIPIDS (20%, 2 kcal/mL)** a. Dedicate 20-30% of total caloric needs to lipids ~~b. *Intralipids 20%*® contains 2 kcal/ml~~ ~~c.~~**b.** In critically ill septic patients, limit to 20% of total calories ~~d.~~**c.** *Intralipids 20%*® approximately 250ml twice weekly is needed to prevent essential fatty acid deficiency ~~e.~~**d.** While considering caloric needs, *Intralipids 20%*® should not exceed 5-12.5 ml/kg/d to minimize metabolic adverse consequences 2. **PROTEIN (4 kcal/g)** **a. Maintenance or elective surgery: 0.8–1 g/kg/day** **b. Minor infection or surgery: 1.2–1.5 g/kg/day** **c. Malnourished, nutritionally depleted: 1.5 g/kg/day** **d. Medical ICU patients: 1.5–2 g/kg/day** **e. Major surgery/trauma/sepsis: 2–2.5 g/kg/day** **f. Renal failure** **i) AKI: 0.6–1 g/kg/day** **ii) CKD: 0.6–1 g/kg/day** **iii) Hemodialysis: 1–1.5 g/kg/day** **iv) CRRT: 2–2.5 g/kg/day** **g. Obese (and receiving 50-70% of calculated daily caloric needs)** **i) 1.2 g/kg/day (TBW) OR use BMI** **ii) BMI less than 40: 2 g/kg/day (use ideal body weight)** ~~a.~~**ii. BMI of 40 or greater: 2.5 g/kg/day (use ideal body weight)**~~Determine requirement based on metabolic and disease state conditions as follows:~~ ~~i. Maintenance: 0.8-1 g/kg~~ ~~ii. Catabolic patients: 1.2-2 g/kg~~ ~~iii. Chronic renal failure (renal replacement therapy): 1.2-1.5 g/kg~~ ~~iv. Acute renal failure + catabolic: 1.5-1.8 g/kg~~ ~~b. Protein provides 4 kcal/g~~ 3. **Dextrose (3.4 kcal/g)** a. Use dextrose to meet remainder caloric needs ~~b. Dextrose provides 3.4 Kcal/g~~ ~~c.~~**b.** For glucose intolerant patients, start with maximum of 150g/day ~~d.~~**c.** While considering caloric needs, dextrose should not exceed 7g/kg/day to minimize adverse metabolic consequences Consider all sources dextrose when calculating total goal

Example Calculation

1. Calculate caloric goal (20-35 kcal/kg/day): 70kg x 30 kcal = 2100 kcal/day
2. Calculate protein goal (Catabolic 1.2-2 g/kg): 70 kg x 1.4 kcal = 98 g
3. 98 g protein x 4 kcal/g = 392 kcal
4. Calculate lipid goal (20-30% of caloric goal): 2100 kcal x 25% = 525 kcal
   525 kcal x (ml/2 kcal) = 262 ml
   Use 250 ml since this size is available
5. Meet remaining caloric needs with dextrose: 2100 – 392 – 525 = 1183 kcal
   1183 kcal x (g / 3.4 kcal) = 348 g
6. Goal TPN **approximately** = 348 g dextrose, 98g protein, Intralipids 20% 250 ml

DELETE- Approved for retirement in PPO committee 2/13/17. Approved for deletion at P&T 07/17.

~~**PROCEDURE:** Place Wound V.A.C.~~

~~**WOUND TYPE AND LOCATION:**~~

~~**ALLERGIES:**~~

~~**PRE-MEDICATION (If indicated) (CHOOSE ONE):**~~

- ☐ ~~OxycoDONE 5 mg / acetaminophen 325 mg (Percocet) 1 – 2 tablets PO, give 60 minutes prior to dressing changes~~
- ☐ ~~Morphine 2 – 4 mg IV, give 30 minutes prior to dressing changes~~
- ☐ ~~HYDROmorphone (Dilaudid) 0.5 – 1 mg IV, give 30 minutes prior to dressing changes~~
- ☐ ~~Other:~~

~~**V.A.C. PRESSURE SETTING:**~~

- ☐ ~~Start at 125 mmHg for the first 48 hours. (After the first 48 hours pressure settings may be titrated up or down by 25 mmHg)~~
- ☐ ~~May titrate down in 25 mmHg increments (minimum pressure is 50 mmHg) for the following situations:~~
  - ~~Wound is very painful~~
  - ~~Elderly patient~~
  - ~~Nutritionally compromised patient~~
  - ~~Patient on anticoagulants~~
  - ~~Patient with compromised circulation~~
  - ~~Excessive granulation tissue~~
  - ~~Periwound or wound bed ecchymosis~~
- ☐ ~~May titrate up in 25 mmHg increments (maximum pressure is 175 mmHg) for the following situations:~~
  - ~~Excessive amount of drainage~~
  - ~~Large wound~~
  - ~~V.A.C. Vers Foam is in the wound~~
  - ~~Difficulty maintaining the seal~~
- ☐ ~~Other:~~

~~**THERAPY SETTINGS:**~~

- ☐ ~~Continuous~~
- ☐ ~~Intermittent (First 48 hours on continuous)~~

~~**DRESSING CHANGES:**~~

- ☐ ~~Every 24 hours (if infection present)~~
- ☐ ~~Every 72 hours~~
- ☐ ~~Other:~~

8711-4010

☐ Read Back all T.O./V.O orders					
Nurse's – Signature	Date	Time	Physician's – Signature	Date	Time

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8711-1111

WOUND V.A.C. (VACUUM ASSISTED CLOSURE) ORDERS

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Affix Patient Label

Cangrelor (Kangreal)

Drug Class: Cardiovascular Agent – Antiplatelet

FDA Approval: 2015

Indication: Adjunct to percutaneous coronary intervention (PCI) to reduce the risk of periprocedural myocardial infarction (MI), repeat coronary revascularization, and stent thrombosis (ST) in patients who have not been treated with a P2Y12 inhibitor and are not being given a glycoprotein IIb/IIIa inhibitor.

Manufacturer: The Medicine Company

Dosage Form: Supplied as a sterile lyophilized 50mg powder in single use 10mL vial

Recommendations:
As TCMC rarely pre-loads with an oral P2Y12 inhibitor, recommend restricting cangrelor use in patients who require immediate inhibition of platelet reactivity and where there is a contraindication to both an oral $P2Y_{12}$ inhibitor (cardiogenic shock with presumed gut malabsorption) and intravenous GP IIb/IIIa inhibitor.

Also recommend restricting cangrelor to use as bridging therapy for patients requiring short-term antiplatelet therapy prior to cardiovascular procedures with history of coronary stent placement in the past 12 months.

- Add to TCMC formulary
- Restrict to Cardiothoracic Surgery and Cardiology for above indications

Background:
Almost a million percutaneous coronary interventions (PCI) are performed annually in the United States.[3] As part of an invasive strategy for the treatment of moderate to high-risk acute coronary syndrome, PCI reduces mortality and major cardiovascular events.[4,5] PCI may be complicated by adverse ischemic events including death, myocardial infarction (MI), a need for coronary revascularization, and stent thrombosis, making antithrombotic therapy an important adjunct to PCI.[6]

National practice guidelines recommend antiplatelet and anticoagulant therapy. Antiplatelet therapies include use of both aspirin and a $P2Y_{12}$ inhibitor such as clopidogrel. Clopidogrel, when added to aspirin, reduces events in patients undergoing PCI and has been the standard antiplatelet therapy for more than a decade. Given its need for hepatic activation through CYP2C19 metabolism, clopidogrel's pharmacokinetic and pharmacodynamic profile is significantly influenced by genetic polymorphism. Interpatient variation in platelet response leaves 25% to 30% of patients unprotected from clopidogrel's antiplatelet effects and therefore such patients are considered "non-responders."[7] The use of 600 mg

loading dose of clopidogrel over 300 mg achieves greater platelet inhibition, reducing the incidence of non-response, and has become the new dosing standard.[6]

Second generation oral $P2Y_{12}$ inhibitors, prasugrel (a thienopyridine) and ticagrelor (a direct-acting, non-thienopyrdine adenosine diphosphate [ADP] receptor antagonist), have less interpatient variability and more potent anti-platelet aggregation effects than clopidogrel.[8,9] Both prasugrel and ticagrelor, when compared to clopidogrel, reduce the risk of ischemic events including stent thrombosis while increasing the risk for bleeding. Furthermore, ticagrelor (but not prasugrel) has demonstrated cardiovascular and all-cause mortality benefit over clopidogrel. Based on this data, the 2014 non-ST-segment elevation myocardial infarction (NSTEMI) guidelines suggest the use of either ticagrelor or prasugrel over clopidogrel in patients undergoing PCI.[5]

Use of oral $P2Y_{12}$ inhibitors during PCI becomes problematic when the coronary anatomy necessitates revascularization with coronary-artery bypass grafting (CABG) since irreversible $P2Y_{12}$ inhibition increases risk of perioperative bleeding. For this reason, many physicians choose not to load patients with an oral $P2Y_{12}$ inhibitor until coronary anatomy is delineated. In unstable angina (UA)/NSTEMI patients with high risk features (e.g., elevated troponins) not treated with bivalirudin and not adequately pretreated with an oral $P2Y_{12}$ inhibitor, national guidelines strongly recommend use of IV GP IIb/IIIa inhibitors with unfractionated heparin (UFH) at the time of PCI to reduce peri-procedural ischemic events. Once discontinued, IV GP IIb/IIIa inhibitors continue to inhibit platelet aggregation for hours.

Given intravenously and with a short half-life of 3-6 minutes, cangrelor is a new $P2Y_{12}$ inhibitor that produces rapid onset of platelet inhibition and normalized platelet activity within 30-60 minutes after discontinuation. Similar to ticagrelor, cangrelor is a nonthienopyridine adenosine triphosphate analogue that provides direct and reversible $P2Y_{12}$ inhibition. Without the need for hepatic activation, cangrelor's activity is not subject to variations in genetic polymorphism of hepatic enzymes. The effects of cangrelor's pharmacokinetic and pharmacodynamic advantages on periprocedural thrombotic complications as compared to clopidogrel were examined in the CHAMPION phase III clinical trials.

In addition to its use during PCI, IV cangrelor may have a role in reducing thrombotic events and minimizing bleeding prior to open-heart surgery in patients who require interruption of $P2Y_{12}$ inhibitor therapy. Patients are at risk of thrombotic events following acute coronary syndrome or placement of coronary stents and, therefore, require dual antiplatelet therapy with aspirin and $P2Y_{12}$ inhibitor. To minimize the risk of perioperative bleeding during CABG, the oral $P2Y_{12}$ inhibitor is routinely discontinued 5 to 7 days prior to CABG; however, there is also an increased risk of thrombotic events with this practice. Strategies that minimize bleeding and thrombotic events around CABG are needed. IV cangrelor's short half may be potentially beneficial in patients requiring $P2Y_{12}$ inhibition but requiring normalization of platelet aggregation immediately prior to surgery. It is unknown whether the use of a cangrelor bridge over no bridging would lead to fewer thrombotic and bleeding events in patients who require PY_{12} inhibition and CABG surgery.

Dosing:[1]

- Recommended dose is 30 mcg/kg intravenous bolus followed by 4 mcg/kg/min for duration of PCI or at least 2 hours, whichever is longer. Initiate the bolus infusion prior to PCI.

Transitioning to Oral $P2Y_{12}$ Therapy

To maintain ADP mediated platelet inhibition after discontinuation of cangrelor infusion, an oral $P2Y_{12}$ platelet inhibitor should be administered.

- Ticagrelor: 180 mg at any time during cangrelor infusion or immediately after discontinuation
- Prasugrel: 60 mg immediately after discontinuation of cangrelor. Do no administer prasugrel prior to discontinuation of cangrelor
- Clopidogrel: 600 mg immediately after discontinuation of cangrelor. Do not administer clopidogrel prior to discontinuation of cangrelor.

No dosage adjustment is required for severe renal (estimated glomerular filtration rate [eGFR] < 30 mL/min/1.73 m^2) or hepatic impairment.

Table 1 contains pharmacodynamic and pharmacokinetic data pertaining to cangrelor.

Table 1. Pharmacodynamics/kinetics

	Parameter
Absorption	Cmax reached within 2 minutes
Distribution	3.9 L
Protein Binding	97%
Half Life	3-6 minutes
Metabolism	Dephosphorylation to non active metabolite
Excretion	58% urine 25% fecal

CONTRAINDICATIONS:[1]

- Cangrelor is contraindicated in patients with significant active bleeding.
-

WARNINGS/PRECAUTIONS:[1]

- Cangrelor increases the risk for bleeding.

DRUG INTERACTIONS:[1]

Clopidogrel/Prasugrel: The expected antiplatelet effect of a 600 mg loading dose of clopidogrel or a 60 mg loading dose prasugrel was blocked when clopidogrel or prasugrel was administered during a cangrelor infusion. In contrast, the antiplatelet effect of a 180 mg ticagrelor loading dose was not altered significantly when ticagrelor was administered during cangrelor infusion.

MONITORING:[1]

- Signs and symptoms of bleeding

- Signs and symptoms of hypersensitivity: anaphylactic reactions, anaphylactic shock, bronchospasm, angioedema, and stridor.
- Dyspnea

PREGNANCY and LACTATION CONSIDERATIONS:[1]

Pregnancy Category C: There are no well controlled studies of cangrelor in pregnant women.

SAFETY:[1]

Cangrelor was associated with an increase in minor bleeding events compared to clopidogrel when using the GUSTO, TIMI and ACUITY bleeding definitions. **When using the ACUITY definition, major bleeding was increased with cangrelor.** (see Table 2 for bleeding definitions)

Table 2. Bleeding definitions[12]

GUSTO	**Severe or life-threatening** - Intracerebral hemorrhage - Resulting in substantial hemodynamic compromise requiring treatment	**Moderate** Requiring blood transfusion but not resulting in hemodynamic compromise	**Mild** Bleeding that does not meet other criteria
TIMI	**Major*** - Any intracranial bleeding (excluding microhemorrhages <10 mm evident only on gradient-echo MRI) - Clinically overt signs of hemorrhage associated with a drop in hemoglobin of ≥5 g/dL		**Minor** Clinically overt (including imaging), resulting in hemoglobin drop of 3 to <5 g/dL
ACUITY	**Major** - Intracranial or intraocular hemorrhage - Access-site hemorrhage requiring intervention - ≥ 5-cm hematoma - Retroperitoneal - Reduction in hemoglobin concentration of ≥4 g/dL without an overt source of bleeding - Reduction in hemoglobin concentration of ≥3 g/dL with an		**Minor** Bleeding that does not meet major criteria.

	overt source of bleeding - Reoperation for bleeding - Use of any blood product transfusion		

* Non-CABG related bleeding

Phase III Clinical Trials

Cangrelor was studied in three randomized, controlled, double dummy phase III trials in patients undergoing PCI. In the first study, CHAMPION PLATFORM, cangrelor infusion administered at the beginning of PCI was compared to placebo infusion. Cangrelor infusion (or placebo) was continued throughout the procedure or for 2 hours (whichever was longer) and was followed by clopidogrel 600 mg administered immediately after discontinuation of cangrelor infusion. Given the lack of superiority of cangrelor compared to placebo in reducing the primary composite endpoint of death, MI, and ischemia driven revascularization, PLATFORM was prematurely discontinued for futility. In this study, an increase in stent thrombosis and all cause death was observed in the placebo arm. Using GUSTO and TIMI defined bleeding; cangrelor did not increase major bleeding when compared to clopidogrel. However an increase in ACUITY defined major bleeding was observed with cangrelor which was driven primarily due to groin site hematoma size > 5mm. Cangrelor did increase minor bleeding across all bleeding definitions.

The second study (CHAMPION PCI), designed to determine if cangrelor infusion administered 30 minutes before PCI would be superior to pretreatment with clopidogrel 600 mg, was also terminated early as it failed to show a reduction in the primary composite endpoint of death, MI, and ischemia driven revascularization at 48 hours. An increase in minor and major bleeding events was observed using all bleeding definitions; however, only increases in minor ACUITY and GUSTO defined bleeding were statistically significant.

Despite the apparent lack of superiority of cangrelor in the CHAMPION PCI and PLATFORM trials in reducing the composite endpoint of death, MI, and ischemia-driven revascularization, the investigators observed a reduction in stent thrombosis, a sensitive measure of antiplatelet efficacy. The investigators proposed that the benefit on the primary outcome was diluted because of the inability of the trial definition of periprocedural myocardial infarction (which relied primarily on biomarker elevation) to differentiate between ischemia present prior to randomization versus ischemia that developed after randomization (true outcome events).

In response to the findings and limitations in CHAMPION PCI and PLATFORM, the third phase III clinical trial, CHAMPION PHEONIX, was designed to determine the efficacy of cangrelor given prior to PCI and followed by clopidogrel 600 mg compared to placebo infusion and clopidogrel given at anytime during or after PCI at a dose of 300 mg or 600 mg. The trial increased the sensitivity of defining myocardial infarctions using angiographic data in order to capture true ischemic events after PCI in patients who had biomarker elevations prior to randomization. After using a more sensitive definition of MI, expanding the composite endpoint to include stent thrombosis, and allowing for a potentially inferior

comparator group (lower loading dose of clopidogrel and variations of clopidogrel timing), CHAMPION PHEONIX demonstrated cangrelor superiority on the primary endpoint of death, MI, and revascularization or stent thrombosis at 48 hours compared to clopidogrel (4.7% vs. 5.9%, OR 0.78; 95% confidence interval [CI], 0.66 to 0.93; p=0.005).

Although not a phase III clinical trial, the BRIDGE trial is relevant in this discussion about the clinical use of cangrelor. The BRIDGE trial was a pharmacodynamic evaluation of IV cangrelor to maintain platelet inhibition in patients at risk for thrombotic complications (e.g., stent thrombosis) when oral $P2Y_{12}$ inhibitors are discontinued prior to surgery. Stage 1 of this trial identified a dose necessary to produce at least a 60% platelet inhibition in at least 80% of samples as measured by the VerifyNow $P2Y_{12}$ assay. In stage 2, patients maintained on a thienopyridine for prevention of thrombotic complications from acute coronary syndrome or placement of coronary stent who required interruption of therapy due to nonemergent cardiac surgery were randomized to receive either IV cangrelor as a bridge therapy or placebo. A greater proportion of patients receiving IV cangrelor maintained low platelet reactivity (below 240 platelet reactivity units measured by VerifyNow $P2Y_{12}$) compared to placebo (98.8% [83 of 84] vs 19.0% [16 of 84]; relative risk [RR], 5.2 [95% CI, 3.3-8.1]) . There was no difference in major CABG-related bleeding or major bleeding prior to surgery; however, numerically, minor bleeding rates were almost doubled in the cangrelor group (17.9% vs 9.9%). The study was not powered to detect statistically significant differences in bleeding.

A summary of the Phase III clinical trials along with relevant pooled analyses is reported in Table 3.

Table 3. Efficacy and Safety Data

Indication	Evidence-Based Statement	Key Points	References

Unstable Angina or Non ST-segment elevation myocardial infarction (NSTEMI)	Periprocedural cangrelor and post-procedural clopidogrel compared to post procedural clopidogrel alone in patients having PCI for acute coronary syndrome **may not reduce death, myocardial infarction or revascularization rates, but is associated with increased major ACUITY defined bleeding**	• Based on randomized trial with premature trial termination
		• 5,362 patients (median age 63 years) having PCI for acute coronary syndrome (non-ST-elevation myocardial infarction or unstable angina) were randomized to cangrelor 30 mcg/kg bolus plus 4 mcg/kg/minute infusion vs placebo bolus and infusion IV for duration of PCI procedure
		• All patients received clopidogrel 600 mg orally [after cangrelor infusion or at end of procedure in placebo group]
		• > 90% patients had unstable angina or NSTEMI
		• Trial terminated early due to unlikelihood of cangrelor superiority (98.9% completed trial)
		• Comparing cangrelor vs. placebo (in intention-to-treat analysis) during PCI
		  ○ Primary endpoint (death from any cause, MI, ischemia-driven revascularization at 48 hrs): 6.9% vs. 8% (not significant)
		  ○ Death from any cause in 0.3% vs. 0.7% (p = 0.04, NNT 250 [not significant at 30 days])
		  ○ Myocardial infarction in 6.6% vs. 7.2% (not significant)
		  ○ Ischemia-driven revascularization in 0.7% vs. 1% (not significant)
		  ○ Stent thrombosis in 0.2% vs. 0.6% (p = 0.02, NNT 250)
		  ○ Stroke in 0.3% vs. 0.2% (not significant)
		  ○ Q-wave myocardial infarction in 0.1% vs. 0.3% (not significant)
		  ○ Blood transfusion in 1% vs. 0.6%
			CHAMPION PLATFORM trial (N Engl J Med 2009 Dec 10;361(24):2330)
			
			Editorial N Engl J Med 2009 Dec 10;361(24):2382
			
			Commentary Hosp Pract (1995) 2010 Feb;38(1):109,
			
			N Engl J Med 2010 Mar 18;362(11):1048

Indication	Evidence-Based Statement	Key Points	References

		(not significant)
		• Cangrelor associated with increased risk of (in modified intention-to-treat analysis)
		  ○ Dyspnea (1.4% vs 0.5%) (p = 0.002, NNH 111)
		  ○ Minor bleeding (12% vs. 9.3% with clopidogrel, p = 0.001, NNH 37)
		  ○ Major bleeding on 1 of 3 scales (5.5% vs. 3.5% with clopidogrel, p < 0.001, NNH 50)
		• Other antithrombotic treatments included
		  ○ Aspirin 75-325 mg for all patients
		  ○ Clopidogrel or other $P2Y_{12}$ inhibitor (at investigator discretion) after 48 hours
		  ○ Choice of periprocedural anticoagulant (bivalirudin, unfractionated heparin, low-molecular-weight heparin, or fondaparinux) at discretion of investigator
		  ○ Glycoprotein IIb/IIIa inhibitors allowed only as rescue therapy during PCI
		• 5.2% had stable angina, 35.4% unstable angina (UA), 59.4% NSTEMI. ST-segment elevation myocardial infarction (STEMI) patients were excluded.	

Indication	Evidence-Based Statement	Key Points	References

Stable angina, Unstable angina, NSTEMI and STEMI undergoing PCI	Cangrelor before PCI **may not reduce death or myocardial infarction compared to clopidogrel**, and cangrelor is **associated with increased major (ACUITY defined) bleeding**	• Based on randomized trial with premature trial termination
		• 8,877 patients (median age 62 years) with stable angina or acute coronary syndrome randomized to 1 of 2 treatments before PCI (with or without stenting)
		  ○ Cangrelor 30 mcg/kg bolus plus 4 mcg/kg/minute infusion IV plus placebo orally
		  ○ Clopidogrel 600 mg orally plus placebo bolus and infusion
		• 8,716 (98%) had PCI
		• Trial terminated early at 70% interim analysis due to estimated low conditional power to demonstrate superiority of cangrelor
		• No significant differences with pre-procedural cangrelor vs. clopidogrel in
		  ○ Primary endpoint (death from any cause, MI, ischemia driven revascularization at 48 hrs): 7.5% vs. 7.1%
		  ○ Death from any cause 0.2% vs. 0.1%
		  ○ Myocardial infarction 7.1% vs. 6.6%
		  ○ Ischemia-driven revascularization 0.3% vs. 0.6%
		  ○ Stent thrombosis 0.2% vs. 0.3%
		  ○ Stroke 0.2% vs. 0.2%
		  ○ Q-wave myocardial infarction 0.1% vs. 0.3%
		  ○ Serious adverse events 2.7% vs. 2.7%
		• Cangrelor associated with increased risk of
		  ○ Dyspnea (1% vs 0.4% p = 0.001)
		  ○ Minor bleeding (17.6% vs. 15.2% with clopidogrel, p = 0.003)
		  ○ Major (ACUITY defined) bleeding
			CHAMPION PCI trial (N Engl J Med 2009 Dec 10;361(24):2318)
			
			Editorial N Engl J Med 2009 Dec 10;361(24):2382
			
			Commentary N Engl J Med 2010 Mar 18;362(11):1048

Indication	Evidence-Based Statement	Key Points	References

		(3.6% vs. 2.9% with clopidogrel, p = 0.06)
		• Other antithrombotic treatments included
		  ○ Aspirin 75-325 mg for all patients
		  ○ Clopidogrel or other $P2Y_{12}$ inhibitor (at investigator discretion) after 48 hours
		  ○ Choice of periprocedural anticoagulant (bivalirudin, unfractionated heparin, low-molecular-weight heparin, or fondaparinux) per treating physician
		  ○ Procedural glycoprotein IIb/IIIa inhibitors use per treating physician
		• 15.1% had stable angina, 24.7% unstable angina, 49.2% NSTEMI, 11% STEMI	

Urgent or elective PCI	Periprocedural cangrelor IV followed by post procedural clopidogrel orally is **associated with decreased risk of procedural complications (such as stent thrombosis and biomarker-defined myocardial infarction) [lacking direct evidence] but increases risk of bleeding [reliable evidence]** compared to	• Based on randomized trial without statistically significant differences in clinical outcomes
		• 11,145 patients (median age 64 years) having urgent or elective PCI randomized to 1 of 2 interventions (with matching placebos to maintain blinding)
		  ○ Cangrelor 30 mcg/kg IV bolus then 4 mcg/kg/minute for at least 2 hours and for duration of procedure, then clopidogrel 600 mg orally, then clopidogrel 75 mg orally within 48 hours
		  ○ Clopidogrel (600 mg or 300 mg at physician discretion) orally, then clopidogrel 75 mg orally within 48 hours
		• Other antithrombotic treatments included
		  ○ Aspirin 75-325 mg for all patients
			CHAMPION PHOENIX trial (N Engl J Med 2013 Apr 4;368(14):1303)
			
			Editorial N Engl J Med 2013 Apr 4;368(14):1356
			
			Commentary Ann Intern Med 2013 Jun 18;158(12):JC5
			
			N Engl J Med 2013 Jul 25;369(4):393

Indication	Evidence-Based Statement	Key Points	References
	perioperative clopidogrel orally in patients having PCI	○ Clopidogrel or other $P2Y_{12}$ inhibitor (at investigator discretion) after 48 hours ○ Choice of periprocedural anticoagulant (bivalirudin, unfractionated heparin, low-molecular-weight heparin, or fondaparinux) at investigator discretion ○ Glycoprotein IIb/IIIa inhibitors allowed only as rescue therapy during PCI • 56% had stable angina, 26% had acute coronary syndrome, and 18% had STEMI at baseline • Primary outcome was composite of death, myocardial infarction, ischemia-driven revascularization, or stent thrombosis at 48 hours • Myocardial infarction defined as creatine kinase-myocardial band (CK-MB) ≥ 3 times upper limit of normal on postprocedure testing and did not require symptoms or clinical manifestations for outcome definition • 2% did not receive PCI and/or study medication and were excluded from analyses • Outcomes at 48 hours: Comparing cangrelor followed by clopidogrel vs. clopidogrel ○ Primary outcome (death, MI, revascularization, stent thrombosis) 4.7% vs. 5.9% (p = 0.005, NNT 84) ○ Myocardial infarction 3.8% vs. 4.7% (p = 0.02, NNT 112) ○ Stent thrombosis 0.8% vs. 1.4% (p = 0.01, NNT 167)	

Indication	Evidence-Based Statement	Key Points	References
		○ All-cause death 0.3% vs. 0.3% (not significant), all deaths were cardiovascular-related ○ Ischemia-driven revascularization 0.5% vs. 0.7% (not significant) ○ Major bleeding (ACUITY criteria) 4.3% vs. 2.5% (p < 0.001, NNH 55) ○ Minor bleeding (ACUITY criteria) 11.8% vs. 8.6% (p < 0.001, NNH 31) ○ Severe bleeding (GUSTO criteria) 0.16% vs. 0.11% (not significant) ○ Moderate bleeding (GUSTO criteria) 0.4% vs. 0.2% (not significant) ○ Procedural complications (such as intraprocedural stent thrombosis or use of rescue therapy) 3.4% vs. 4.5% (p = 0.002, NNT 91) ○ Treatment-related adverse events in 20.2% vs. 19.1% (not significant) ○ Transient dyspnea 1.2% vs. 0.3% (p < 0.001, NNH 111)	
Urgent or elective PCI	IV cangrelor followed by oral clopidogrel may **decrease risk of myocardial infarction and stent thrombosis but increase risk of minor bleeding** compared to clopidogrel alone in patients having PCI	• Based on prespecified pooled analysis of CHAMPION trials • 24,910 patients having PCI (98.1% of total randomized) who were randomized to cangrelor followed by clopidogrel vs. clopidogrel alone were evaluated • Primary outcome was composite of death, myocardial infarction, ischemia-driven revascularization, or stent thrombosis at 48 hours • Bleeding assessed by GUSTO criteria • Comparing cangrelor followed by clopidogrel vs. clopidogrel alone at 48 hours ○ Primary outcome 3.8% vs. 4.7% (p = 0.0007, NNT 112)	Lancet 2013 Dec 14;382(9909):1981 Editorial Lancet 2013 Dec 14;382(9909):1960

Indication	Evidence-Based Statement	Key Points	References
		○ Myocardial infarction 3.1% vs. 3.6% (p = 0.0182, NNT 200) ○ Ischemia-driven revascularization 0.5% vs. 0.7% (p = 0.0363, NNT 500) ○ Stent thrombosis 0.5% vs. 0.8% (p = 0.0008, NNT 334) ○ Death in 0.3% vs. 0.4% (not significant) ○ Mild bleeding in 16.8% vs. 13% (p < 0.0001, NNH 26) ○ Severe or life-threatening bleeding 0.2% vs. 0.2% (not significant) ○ Moderate bleeding 0.6% vs. 0.4% (not significant) ○ Transfusion 0.7% vs. 0.6% (not significant)	
Urgent or elective PCI	Comparative efficacy of $P2Y_{12}$ inhibitors: Newer $P2Y_{12}$ inhibitors (cangrelor, ticagrelor, elinogrel, and prasugrel) **associated with decreased mortality, major adverse cardiac events, and stent thrombosis** after PCI compared with clopidogrel in patients with STEMI	• Based on systematic review with incomplete assessment of trial quality • Systematic review of 8 randomized trials comparing $P2Y_{12}$ inhibitors cangrelor, ticagrelor, elinogrel, or prasugrel with clopidogrel in 48,599 patients scheduled for PCI • PCI performed in 84% • In patients with acute coronary syndrome, newer $P2Y_{12}$ inhibitors (cangrelor, ticagrelor, elinogrel, and prasugrel) associated with decreased mortality, major adverse cardiac events, and stent thrombosis but increased major bleeding compared with clopidogrel • In patients with STEMI, newer $P2Y_{12}$ inhibitors (cangrelor, ticagrelor, elinogrel, and prasugrel) associated with ○ Decreased mortality in analysis of 4 trials with 13,028 patients ▪ Odds ratio (OR) 0.78 (95% CI 0.66-0.92)	J Am Coll Cardiol 2010 Nov 2;56(19):1542

Indication	Evidence-Based Statement	Key Points	References
		▪ NNT 58-248 with 5.3% mortality in patients taking clopidogrel o Decreased major adverse cardiac events in analysis of 4 trials with 13,028 patients ▪ OR 0.82 (95% CI 0.73-0.92) ▪ NNT 37-126 with 11.1% major adverse cardiac events in patients taking clopidogrel o Decreased stent thrombosis in analysis of 3 trials with 12,958 patients ▪ OR 0.66 (95% CI 0.53-0.83) ▪ NNT 68-189 with 3.2% stent thrombosis in patients taking clopidogrel o No significant difference in major bleeding in analysis of 3 trials with 12,032 patients	
Coronary artery bypass graft (CABG) surgery	IV cangrelor **may be effective in achieving and maintaining platelet inhibition after stopping thienopyridine therapy** in patients having CABG	• Based on nonclinical outcome from randomized trial • 210 patients (≥ 18 years old) with acute coronary syndrome or treated with coronary stent and having CABG randomized to IV cangrelor 0.75 mcg/kg/minute vs placebo o All patients were taking 1 of 3 thienopyridines (ticlopidine ≥ 500 mg, clopidogrel ≥ 75 mg, or prasugrel ≥ 10 mg) prior to starting cangrelor or placebo o Thienopyridines were stopped and cangrelor or placebo administered for ≥ 48 hours o Cangrelor or placebo discontinued 1 to 6 hours before CABG	BRIDGE trial (JAMA 2012 Jan 18;307(3):265)

Indication	Evidence-Based Statement	Key Points	References

		• Primary efficacy end point was proportion of patients with platelet reactivity of < 240 $P2Y_{12}$ reaction units (PRUs) for all samples assessed during study drug infusion prior to surgery
		• Excessive CABG-related bleeding defined as occurrence of ≥ 1 of following 3 components during CABG procedure through hospital discharge
		  ○ Surgical re-exploration
		  ○ 24-hour chest tube output of > 1.5 L
		  ○ Packed red blood cell transfusion of > 4 units
		• Comparing cangrelor vs. placebo
		  ○ Platelet reactivity < 240 PRU 98.8% vs. 19% (p < 0.001, NNT 2)
		  ○ Excessive CABG-related bleeding 11.8% vs. 10.4% (not significant)	

Cost Impact:

The cost impact of cangrelor depends on the antithrombotic strategy employed by the interventional cardiologist. If patients are routinely pre-loaded with clopidogrel (administered at least 6 hours prior to PCI), then the cost impact will be driven by the additional cost of cangrelor, as the clopidogrel loading dose are required at completion of the cangrelor infusion. See Table 4a for the cost impact of cangrelor when a used in place of a pre-loading with clopidogrel strategy.

When a deferred clopidogrel strategy is preferred, clopidogrel is not administered until after coronary anatomy is delineated (i.e. after angiography) and a glycoprotein IIb/IIIa inhibitor is typically infused during PCI to inhibit platelet aggregation. In this case, the cost impact of cangrelor depends on the cost of the GP IIb/IIIa used. See Table 4b for the cost impact of cangrelor when a delayed clopidogrel strategy is used.

Table 4a Cost Impact in context of Pre-loading clopidogrel strategy-

	Cangrelor 50 mg/10 mL	**Comparator: No infusion**
Based on 90 kg or less	1 vial= $708	0

Table 4b: Cost impact in context of deferred clopidogrel strategy-

	Cangrelor 50 mg/mL 30 mcg/kg bolus + 4mcg/kg/min x 2 hours	**Comparator:** Eptifibatide 20mg/10 mL 75 mg/100 mL 180 mcg/kg bolus x 2 2 mcg/kg/min x 12 hrs
Based on 90 kg or less	1 vial = $708	2 bolus vials =60.88 2 infusion vials = 229.9 total cost =

Summary:

When compared to clopidogrel given during PCI, pretreatment with intravenous cangrelor decreases the composite endpoint of death, MI, revascularization, and stent thrombosis without increasing the risk for severe or life threatening GUSTO defined bleeding at 48 hours. The composite endpoint reduction was driven by the significant reduction in stent thrombosis and periprocedural MI. Mortality as a single endpoint did not differ between groups.

Critical Considerations/Questions:

- The comparator arm in the CHAMPION PHOENIX trial was potentially inferior by design.
    - Patients in the control arm received a placebo infusion without routine clopidogrel pretreatment, while cangrelor was administered 30 minutes prior to PCI. By study protocol, clopidogrel or placebo was not administered until coronary anatomy was established. Less than two-thirds of the patients received the clopidogrel loading dose before PCI. Loading doses of clopidogrel, when given prior to PCI, had a median time of less than 5 minutes in acute coronary (ACS) patients.
    - When patients referred to PCI are not adequately pre-treated with clopidogrel and not receiving bivalirudin, clinical guidelines recommend intravenous GP IIb/IIIa inhibitors use in UA/NSTEMI. In CHAMPION PHOENIX, patients were not routinely pre-treated with clopidogrel and over 75% of patients did not receive bivalirudin; however, routine GP IIb/IIIa

inhibitor use was prohibited. GP IIb/IIIa inhibitors were permitted only for rescue therapy during PCI to treat new or persistent thrombus formation. Based on the pharmacokinetic and pharmacodynamic profile of clopidogrel, administration of clopidogrel at the beginning of PCI without use of an IV GPIIb/IIIa inhibitor in the placebo arm left patients unprotected. The recommended time frame between clopidogrel loading to PCI is 6 to 15 hours. The minimum time to achieve platelet inhibition of at least 20% after a loading dose of clopidogrel 600 mg is 2 hours.[10]

- The loading doses of clopidogrel used in the comparator arm were 300 mg or 600 mg while clopidogrel 600 mg was used consistently in the cangrelor arm at the end the of the infusion. A little over 25% of the patients received the 300 mg loading dose rather than the 600 mg dose.
- The authors concluded that the relative efficacy of cangrelor was maintained in patients throughout various subgroup analyses: those who received a clopidogrel 300 mg and 600 mg dose and patients who received the clopidogrel loading dose prior to PCI or after. However, an analysis performed by the FDA showed that the 300 mg dose was predominately administered prior to PCI, the 600 mg loading dose has a bimodal distribution with modes both prior to start and after the PCI. Logistic regression of the sponsor's primary endpoint at 48 hours in the clopidogrel arm of PHOENIX by the FDA reviewer showed that both the use of 600 mg loading dose and earlier timing of clopidogrel administration are associated with better outcomes, although the association is stronger for the 600 mg loading dose.[11]
- The authors of the CHAMPION studies also observed that based on the examination of secondary composite endpoints, it appears that the 600 mg loading dose of clopidogrel may provide incremental benefit when given at the start of the procedure versus only at the end, though this conclusion remains speculative.

- The benefit of cangrelor over clopidogrel on the primary composite endpoint identified in PHOENIX was driven by the reduction in periprocedural MI. Is a reduction in periprocedural MI clinically relevant when there is no reduction in death or ischemia driven revascularization?
- When ACS patients are not adequately pretreated with clopidogrel due to concerns for high risk coronary anatomy, IV GP IIb/IIIa inhibitor is routinely recommended for immediate anti-platelet effects. It is unclear if there is a benefit of using cangrelor over an IV GP IIb/IIIa inhibitor strategy.
- In addition to cangrelor, prasugrel and ticagrelor have established superiority over clopidogrel on composite endpoints of death, MI, stroke, and revascularization. Ticagrelor, but not cangrelor, has also demonstrated a mortality benefit over clopidogrel. For interventionalists that are already using prasugrel or ticagrelor after coronary anatomy is established, it is unclear what benefit, if any, cangrelor offers over those agents.

Conclusions:

- ✓ When a deferred oral $P2Y_{12}$ inhibitor treatment strategy is employed (i.e., withholding oral $P2Y_{12}$ until after coronary anatomy is established), it is unclear what benefit, if any, cangrelor offers over the use of a periprocedural intravenous GP IIb/IIIa inhibitor.

- ✓ When a pretreatment strategy with loading doses of oral $P2Y_{12}$ inhibitors prior to PCI is employed, it is unclear what benefit, in any, cangrelor offers over ticagrelor or prasugrel as both these oral agents have demonstrated superior efficacy over clopidogrel. Furthermore, it is also unclear if cangrelor is superior to clopidogrel 600 mg loading doses given 6 to 15 hours prior to PCI.
- ✓ Although IV cangrelor, when given after thienopyridine discontinuation and in anticipation of cardiac surgery, maintains low platelet reactivity to levels associated with reduced thrombotic events, it is unclear if a bridging strategy with cangrelor will actually reduce thrombotic events over placebo.

References:

1. Kengreal [package insert]. Parcippany, NJ: The Medicines Corporation; June 2015.
2. FDA News Release-FDA approves new antiplatelet drug used during heart procedure. June 22nd 2015. http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm452172.htm Accessed August 10th, 2015.
3. Mozaffarian D, Benjamin E, Go AS et al, for the American Heart Association Statistics Committee and Stroke Statistics Subcommittee. Heart disease and stroke statistics – 2015 update: a report from the American Heart Association. Circulation 2015;131:e29-e332
4. O'Gara, Kushner FG, Ascheim DD et al. 2013 ACCF/AHA Guideline for the management of ST-Elevation myocardial infarction. J Am Coll Cardiol 2013;61:e78-140.
5. Amsterdam EA, Wenger NK, Brindis RG et al. 2014 AHA/ACC Guideline for the management of patients with non-ST elevation acute coronary syndrome. J Am Coll Cardiol 2014;62(24):e139-e228.
6. Levine GN, Bates ER, Blakenship JC et al. 2011 ACCF/AHA/SCAI Guideline for percutaneous coronary intervention. J Am Coll Cardiol. 2011;58(24):e44-e122.
7. Mega JL, Close SL, Wiviott SD et al. Cytochrome P-450 polymorphisms and response to clopidogrel. N Eng J Med 2009;360:352-62.
8. Wiviott SD, Baunwald E, McCabe C et al, for the TRITON-TIMI 38 Investigators. Prasugrel versus clopidogrel in patients with acute coronary syndromes. N Engl Med 2001 2007;357:2001-15.
9. Wallentin L, Becker RC, Budaj A et al, for the PLATO Investigators. Ticagrelor versus clopidogrel in patients with acute coronary syndromes. N Engl J Med 2009;361:1045-57.
10. Montalescot G, Sideris G, Meuleman C et al. A randomized comparison of high clopidogrel loading doses in patients with non-ST segment elevation acute coronary syndromes: the ALBION (assessment of the best loading dose of clopidogrel to blunt platelet activation, inflammation and ongoing necrosis) trial. J Am Coll Cardiol 2006;48(5):931-938.
11. FDA briefing document for the cardiovascular and renal drugs advisory committee. Cangrelor Injection. Meeting date February 12, 2014. http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/CardiovascularandRenalDrugsAdvisoryCommittee/UCM385234.pdf Accessed July 14, 2015
12. Mehran R, Rao SV, Bhatt DL et al. Standardized bleeding definitions for cardiovascular clinical trials. Circulation 2011;123:2736-2747.

Disopyramide phosphate controlled release (Norpace CR®): Recommendation for formulary removal

Requestor: Tori Hong, PharmD

Declared conflicts of interest: None

Situation: Disopyramide phosphate (Norpace CR®) is an antiarrhythmic drug primarily used for ventricular arrhythmias or atrial fibrillation. It has not been ordered or dispensed in the last two 2 years.

Background: Disopyramide phosphate (Norpace CR®) was previously on a long term backorder. Now it is available again but the cost of this medication has risen (around $40 per tab).

Assessment:

- There were 0 orders in 2017 and 2018. However, there were 3 patients with orders for disopyramide phosphate in 2016 and 4 patients in 2015.
- Currently, there are newer antiarrhythmic agents with fewer side effects available.

Recommendation(s):

- The Pharmacy Service recommends that disopyramide phosphate CR be removed from the formulary at this time due to lack of use.

On-Q Pumps

Recommendation for formulary removal

Requestor: Michael Montoya, Pharm.D., BCPS

Declared conflicts of interest: None

Situation: On-Q pumps are infusion devices typically used for continuous peripheral nerve blocks in post-operative pain management

Background: Usage for On-Q pumps has decreased significantly with changes in post-operative pain management.

Assessment: Anesthesia has stated they are no longer placing these types of blocks at TCMC. Last order for an On-Q pump was May of 2017

Recommendation(s):

- Remove On-Q pumps from formulary secondary to lack of use and anesthesia recommendation

Community Healthcare & Alliance Committee (No meeting held in November/December, 2018)

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
December 4, 2018

Members Present	Director Julie Nygaard, Dr. Marcus Contardo, Dr. Mark Yamanaka, Dr. Jeffrey Ferber, Wayne Lingenfelter, Jack Cumming, Dr. Gene Ma (*joined the meeting at 12:32 pm)*
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, CFO, Scott Livingstone, COO, Sharon Schultz, CNE, Susan Bond, General Counsel
Others:	Tom Moore, Jane Dunmeyer, Aaron Byzak, Maria Carapia. Cristina Barrera, Eva England, Sherry Miller, Tara Eagle, Jennifer Paroly, Barbara Hainsworth
Members Absent:	Director Cyril Kellett, Director Leigh Anne Grass, Carlos Cruz, CCO

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Nygaard called the meeting to order at 12:30 pm.		Chair
2. Approval of Agenda		**MOTION** **It was moved by Dr. Yamanaka, Dr. Ferber seconded, and it was unanimously approved to accept the agenda of December 4, 2018.** **Members:** **AYES: Nygaard, Contardo, Yamanaka, Ferber, Lingenfelter, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: Kellett, Grass, Ma**	
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.		Chair
4. Ratification of minutes of October 16, 2018	Director Nygaard advised that some minor verbiage changes had been made to section number 10 of the minutes. a revised version was distributed to the Committee members.	Minutes were ratified. **MOTION** **It was moved by Dr. Ferber, Mr. Cumming seconded, and the revised minutes of October 16, 2018 were**	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	After a brief opportunity to review the changes, the revised minutes were ratified.	**unanimously approved.**	
5. Old Business	None		
6. New Business			
a. Finance, Operations & Planning Meeting Dates - 2019	Director Nygaard encouraged the members of the Committee to note the 2019 Finance, Operations & Planning Committee meeting dates on their respective calendars.		
7. Consideration of Consent Calendar:		**MOTION** **It was moved by Mr. Cumming to approve the Consent Calendar, Dr. Yamanaka seconded.** **Members:** **AYES: Nygaard, Contardo, Yamanaka, Lingenfelter, Cumming** **NOES: None** **ABSTAIN: Ferber** **ABSENT: Ma**	Chair
a. Beckman Coulter Proposal		**Approved via Consent Calendar**	Tara Eagle
b. BD Diagnostics Phoenix M50 Instrument Proposal		**Approved via Consent Calendar**	Tara Eagle
c. Blood Bank Proposal • San Diego Blood Bank		**Approved via Consent Calendar**	Tara Eagle
d. Physician Agreement for Cardiac Rehabilitation Physician Supervision • Anitha Rajamanickam, M.D.		**Approved via Consent Calendar**	Eva England
e. Medical Directorship Agreement for Employee Health Services Department • Jeffrey M. Ferber, M.D.		**Approved via Consent Calendar**	Sharon Schultz / Scott Livingstone
f. Physician Agreement for MDQA – Peer Review &		**Approved via Consent Calendar**	Sherry Miller

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
QAPI Committees Proposal • Dr. James L. Johnson (Manta Med)			
8. Financials:	Ray Rivas presented the financials ending October 31, 2018 (dollars in thousands) **TCHD – Financial Summary Fiscal Year to Date** Operating Revenue $ 118,267 Operating Expense $ 120,455 EBITDA $ 4,942 EROE $ (225) **TCMC – Key Indicators Fiscal Year to Date** Avg. Daily Census 153 Adjusted Patient Days 34,382 Surgery Cases 2,221 Deliveries 745 ED Visits 19,050 **TCHD – Financial Summary Current Month** Operating Revenue $ 29,558 Operating Expense $ 29,796 EBITDA $ 1,561 EROE $ 254 **TCMC – Key Indicators Current Month** Avg. Daily Census 150 Adjusted Patient Days 8,277 Surgery Cases 590 Deliveries 187 ED Visits 4,590 **TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R Avg. (in millions) $ 42.4 Days in Net A/R Avg. 49.8		Ray Rivas

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Graphs: • TCMC-Net Days in Patient Accounts Receivable • TCMC-Average Daily Census, Total Hospital-Excluding Newborns • TCMC-Acute Average Length of Stay		
9. Work Plan:			
a. Wellness Center	Scott Livingstone gave a brief PowerPoint presentation on the following elements pertaining to the Wellness Center: • Current Membership • Financial Performance, FYTD • Membership Costs • Medically Integrated Programs In addition, he detailed other opportunities that are being evaluated: • Increasing Membership Dues • Increasing Add-On Fees • Implementation of Productivity Model • Obtaining Supplies through TCMC's GPO • Focusing on Wellness vs. Fitness • Class Schedule Modifications		Scott Livingstone
b. Dashboard	No discussion		Ray Rivas
10. Comments by committee members	Mr. Lingenfelter conveyed a message of praise he'd received from an acquaintance, pertaining to care rendered at TCMC. Director Nygaard expressed her appreciation to both the Administration		

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	and staff for their devotion to ensuring that TCMC continues to move in a very positive direction.		
11. Date of next meeting	Tuesday, January 22, 2019		Chair
12. Community Openings (0)			
13. Adjournment	Meeting adjourned 12:49 p.m.		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 4, 2018
Beckman Coulter Proposal

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

Vendor's Name: Beckman Coulter

Area of Service: Laboratory - Hematology, Urinalysis, and Chemistry

Term of Agreement: 42 months, Beginning, January 1, 2019 – Ending, June 30, 2022

Maximum Totals:

Current Monthly Cost	Current Annual Cost	Total Term Cost
$50,770	$609,240	$2,132,340

Description of Services/Supplies:

- Beckman Coulter has been a partner with our laboratory for over 30 years. They understand today's healthcare climate and financial challenges and are willing to continue to partner with us using innovative financial strategies in order to deliver quality results for patients.
- Current utilization statistics: 1.8M chemistry tests/yr.; 30K urinalysis tests/yr.; 15K blood and body fluid differentials/yr.
- This proposal renews our current agreements in mid-term, caps our costs at current rates, and renews them until July 2022.
- The current instrument roster is three platforms consisting of four automated chemistry analyzers (2 DxC and 2 DxI) and one automated urinalysis analyzer (iQ200). At the inception of this new agreement, we will have four platforms consisting of our existing DxCs and DxIs, a new urinalysis analyzer (iQ200 Elite) and a new "digital cell morphology" analyzer (CellaVision DM1200) that will be used to study body fluids and peripheral blood.
- Thus, we will bring for the first time into TCMC laboratory new and enhanced capabilities in Hematology and Body Fluid analysis (the CellaVision DM1200), replace our existing (12 years) iQ200 to a state-of-the-art urinalysis analyzer, and continue the support of our existing four Chemistry analyzers.

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

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

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the global agreement with Beckman Coulter as described above for a term of 42 months, beginning January 1, 2019 and ending June 30, 2022 for an annual cost of $609,240, for a total cost for the term of $2,132,340.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 4, 2018
BD Diagnostics Phoenix M50 Instrument Proposal

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

Vendor's Name: BD Diagnostic Systems
Instruments to be acquired: Two Phoenix M50 Diagnostics Instruments

Area of Service: Laboratory – Microbiology

Term of Agreement: 84 months, Beginning, January 1, 2019 – Ending, December 31, 2025

Maximum Totals:

Current Monthly Cost	Current Annual Cost	Future Monthly Cost	Future Annual Cost	Term Cost
$60,217	$722,604	$61,414	$736,968	$5,158,776

Description of Services/Supplies:

- The BD Diagnostics Phoenix M50 instruments are our choice for microbial identification and antibiotic susceptibility testing. They produce indispensable information that is critical to the management of infections in our patient population.
- These two new replacement instruments are made by the same manufacturer, BD Diagnostics (Becton-Dickinson), as our current instrument, the M100. Our current unit is at the end of its operational life, and is a sole-source instrument for this type of information. We are requesting replacement of the M100 with two smaller but functionally identical units, the M50s, in order to process the same specimen volume, but mitigate the risk of instrument failure by one instrument serving as backup to the other. If one instrument goes down, the other can maintain operation while repairs are effectuated. Relying on a single instrument entails excessive and undesirable risk to timely clinical management decisions, and adverse delays in patient care.
- This proposal includes the two replacement instruments, warranties, consumables, and the required Cerner interfaces. Service is additional, as it is today.

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

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

Motion: I move that the Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with BD Diagnostics for two Phoenix M50 Instruments, and associated consumables, for a term of 84 months, beginning January 1, 2019 and ending December 31, 2025 for an annual cost of $736,968, and a total cost for the term of $5,158,776.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 4, 2018
Blood Bank Proposal

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

Vendor's Name: San Diego Blood Bank

Area of Service: Laboratory – Transfusion Service

Term of Agreement: 60 months, Beginning, January 1, 2019 – Ending, December 31, 2023

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$157,500	$1,890,000	$9,450,000

Description of Services/Supplies:

- San Diego Blood Bank is our vendor of choice for blood products and immunohematology reference laboratory services. We have a long-standing relationship with the Blood Bank dating back more than 20 years.
- An assured supply of human blood, and products derived from blood, are the *sine qua non* of an acute care hospital. Criteria for the ideal provider of such services include the longevity of the entity; its commitment to its medical customers and the at-large community; the quality, safety, and reliability of the supply; service levels appropriate to the need; consistency of supply compatible with its supply chain; and cost-effectiveness.
- In addition to an inventory of almost 25 types of blood products, the Blood Bank of choice also provides TCMC with highly technical reference lab backup support for compatibility testing.

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

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

Motion: I move that the Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with San Diego Blood Bank for blood products and immunohematology reference laboratory services for a term of 60 months, beginning January 1, 2019 and ending December 31, 2023 for an annual cost of $1,890,000, and a total cost for the term of $9,450,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 4, 2018
Physician Agreement for Cardiac Rehabilitation Physician Supervision

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

Physician's Name: Anitha Rajamanickam M.D.
Area of Service: Cardiac Rehabilitation Services, On-Site and Wellness Center
Term of Agreement: 36 months, Beginning, January 1, 2019 – Ending, December 31, 2021
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Adding physician to existing Cardiac Rehab services coverage, no increase in expense

Rate / Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	36 month (Term) Cost
$148.30	39	468	$5,784	$69,404	$208,213

Position Responsibilities:

- Cardiac rehabilitation Wellness Center Supervising Physician in accordance with CMS 42 CFR 410.49 (Direct supervision of the Cardiac Rehabilitation program by a physician is a requirement).
- Maintain cardiac rehabilitation program as a physician directed clinic.
- Providing medical supervision of patients receiving services in the Department, and clinical consultation for the Department as requested by attending physicians including, without limitation, daily review and monitoring of patients receiving services in or through the Department.
- Ensuring that all medical and therapy services provided by the Department, Program or Service are consistent with Hospital's mission and vision.
- Supervising the preparation and maintenance of medical records for each patient receiving services in or through the Department.
- Evaluation of all Phase 2 patients enrolled in the Cardiac Rehabilitation Program and ongoing supervision and evaluation of monitored exercise sessions.
- Attend meetings with Hospital administration, Hospital's medical staff as required by Hospital and/or Dept
- Participate in and otherwise cooperate with continuing education and in-service training of Department Personnel and others working in Department.
- Assure that adequate medical coverage is provided for Cardiac Rehabilitation clinical services activities performed within Department during hours of operation.

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

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

Motion:

Move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Anitha Rajamanickam as the Coverage Physician for a term of 36 months, beginning January 1, 2019 and ending December 31, 2021. Not to exceed an average of 39 hours per month or 468 hours annually, at an hourly rate of $148.30 for an annual cost of $69,404, and a total cost for the term of $208,213.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 4, 2018
Medical Directorship Agreement for Employee Health Services Department Proposal

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

Physician's Name: Jeffery M. Ferber, M.D.

Area of Service: Employee Health Services Department

Term of Agreement: 24 months, Beginning, January 1, 2019 – Ending, December 31, 2020

Maximum Totals: Within Annualized Fair Market Value: YES (MD Ranger)

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	24 Month (Term) Cost
$160	20	240	$3,200	$38,400	$76,800

Position Responsibilities:

- Physician will be the Medical Director of the Employee Health Services Department to manage, generally supervise and direct the medical administrative operations of the Department
- Provide medical direction and services for Employee Health Services Department
- Physician is responsible for oversight of the Nurse Practitioner of the Department

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

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive / 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. Jeffery Ferber as the Medical Director for Employee Health Services Department for a term of 24 months beginning January 1, 2019 and ending December 31, 2020, for a total cost for the term not to exceed $76,800.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 4, 2018
Physician Agreement for MDQA - Peer Review and QAPI Committees Proposal

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

Physician's Name: Dr. James L. Johnson (Manta Med)
Area of Service: MDQA/Peer Review/QAPI Committees
Term of Agreement: 18 months, Beginning, January 1, 2019 – Ending, June 30, 2020
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Rate/Hour	Average Hours per Month	Hours per Year Not to Exceed	Monthly Cost	Annual Not to Exceed	Term Cost Not to Exceed
$155	33	400	$5,167	$62,000	$93,000
Education Hours & Travel Stipend				$10,000	$15,000
			Total Cost:	**$72,000**	**$108,000**

Position Responsibilities:
Chairperson MDQA-Peer Review and QAPI Committees:
• Promote initiatives for improving quality of patient care, and services within TCHD

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

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

Person responsible for oversight of agreement: 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 agreement with Dr. James L. Johnson as the Physician Chairperson of MDQA/Peer Review/QAPI for a term of 18 months beginning January 1, 2019 and ending June 30, 2020. Not to exceed an average of 33 hours in total per month or 400 hours annually, at an hourly rate of $155 for an annual cost of $62,000 and a total cost for the term not to exceed $108,000.

Professional Affairs Committee
(No meeting held in November/December, 2018)

Audit, Compliance & Ethics Committee
(No meeting held in November/December, 2018)

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

November 15, 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 10:00 a.m. on November 15, 2018.

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

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

Absent were Director Leigh Anne Grass and Director Cyril F. Kellett, M.D.

Also present were:

Sharon Schultz, Chief Nurse Executive
Scott Livingstone, Chief Operations Officer
Susan Bond, General Counsel
Dr. Victor Souza, Chief of Staff
Dr. Jamie Johnson, Medical Director, Quality
Jaclyn Hunter, Clinical Quality Manager
Teri Donnellan, Executive Assistant
Jonathan Ingram, Security Supervisor

1. The Board Chairman, Director Dagostino, called the meeting to order at 1:05 p.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Mitchell 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 Schallock to approve the agenda as presented. Director Mitchell seconded the motion. The motion passed (5-0-0-1) with Directors Grass and 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 November 15, 2018 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees.

6. Motion to go into Closed Session

It was moved by Director Mitchell and seconded by Director Schallock to go into Closed Session at 1:10 p.m. The motion passed (5-0-0-2) with Directors Kellett and Grass 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 5:05 p.m.

_____
James J. Dagostino
Chairman

ATTEST:

_____
Leigh Anne Grass
Secretary

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

November 8, 2018 – 2:00 o'clock p.m.
Classroom 7 – 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 2:00 p.m. on November 8, 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 Larry W. Schallock

Absent was Director RoseMarie V. Reno

Also present were:

Colin Coffey, Board Counsel (via teleconference)
Steven Dietlin, Chief Executive Officer
Susan Bond, General Counsel
Sharon Schultz, Chief Nurse Executive
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 2:00 p.m. in Classroom 7 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

   Director Mitchell noted a minor correction on the wording of a policy.

   It was moved by Director Schallock to approve the agenda as amended. Director Mitchell seconded the motion. The motion passed unanimously (6-0-0-1) with Director Reno absent.

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the November 8, 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 November 8, 2018 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter of Potential Litigation, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committee, approval of Closed Session Minutes and Reports Involving Trade Secrets with various disclosure dates.

5. Motion to go into Closed Session

It was moved by Director Nygaard and seconded by Director Kellett to go into Closed Session. The motion passed unanimously (6-0-0-1) with Director Reno absent.

6. The Board adjourned to Closed Session at 2:05 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, M.D.
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
Aaron Byzak, Chief Governmental Officer
Susan Bond, General Counsel
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairman Dagostino reported no action was taken in closed session.

10. Director Kellett 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. Chairman Dagostino requested that speakers adhere to the three minute time allotment.

12. Special Recognitions:

a) Recognition of former Board Committee Community Members on Board Committees that have been dissolved.

Chairman Dagostino stated it is a great honor to recognize the community members who have volunteered their time to serve on our Board committees. He stated, in an effort to be more efficient some of our Board committees were dissolved and as a result some of our volunteers no longer have the opportunity to serve. Chairman Dagostino recognized the following individuals who have served and volunteered their time on the following committees and presented them with a Certificate of Appreciation:

1) Employee Fiduciary Committee –

   a) Gwen Sanders

2) Human Resources Committee –

   a) Gwen Sanders

   b) Joe Quince

3) Governance & Legislative Committee -

   a) Dr. Paul Slowik

   b) Robin Iveson

Dr. Paul Slowik and Mr. Joe Quince were unable to attend today's recognition.

Director Grass expressed her appreciation to the volunteers for their time and their energy and for orienting her to their respective committees as a new Board member.

Director Reno expressed her appreciation to Ms. Sanders and Ms. Iveson. She stated they have been active community members of this hospital for many years and she appreciates their input and loyalty.

Chairman Dagostino recognized Ms. Gwen Sanders. Ms. Sanders stated it has been a privilege to serve and she would love to have the opportunity to continue to be able to serve this Board and the hospital staff and our community. Ms. Sanders stated she is very knowledgeable and active in our community and would like to continue to contribute to Tri-City Medical Center.

Director Kellett expressed his appreciation to Ms. Sanders, Joe Quince, Ms. Iveson and all the community members who have served on committees. He stated it is a great contribution and an opportunity to hear from community members.

Chairman Dagostino recognized Ms. Robin Iveson. Ms. Iveson expressed her appreciation to Director Kellett personally as he was the first Chair on the committee she first served on. She wished Director Kellett good luck.

b) Dr. Gene Ma and Emergency Department Recognition

Ms. Sharon Schultz, CNE reported a former patient, Mr. Larry Hall reached out to her and wanted to share his experience and story and thank the team and the physician who cared for him.

Mr. Larry Hall stated he is a recent stroke survivor and wanted to express his appreciation to Dr. Ma and the team who cared for him in the Emergency Department. He stated he has done miraculously well thanks to Dr. Ma and the tPA drug and would like to be proactive in the stroke community to help others.

Ms. Schultz invited Dr. Ma, along with the Stroke Team to the podium to be recognized. Ms. Schultz stated the stroke team is comprised of staff from the Emergency Department, 4 Pavilion, ICU and Telemetry who come together every day to take care of our stroke patients.

No action taken.

13. Educational Presentation

a) "Speak up" Culture – Carlos Cruz, CCO

Mr. Carlos Cruz presented a brief Compliance Program Plan Update. He stated a new Values Line upgrade was implemented which will allow us to benchmark ourselves against other organizations. The noted the Values Line phone number had to be updated and all staff were informed of the new hotline number via e-mail, posters, etc.

Mr. Cruz also commented on Auditing & Monitoring EMR access reviews which identified an educational opportunity related to staff's access of their own medical records.

Mr. Cruz also provided an educational presentation on Building a "Speak Up Culture. He explained the goal is to present this training to management and all levels of staff. The presentation described the False Claims Act and the definition of a "Whistle Blower". The five steps to reinforce the "Speak Up Culture" included the following:

- Communicate – employees are the real eyes and ears of the organization
- Reinforce – take time to promote avenues of reporting that might include internal sites, newsletters, informal meetings
- Integrate – the "speak up" concept should be integrated in the organization's standards of behavior
- Train Leaders and Staff – train management on whistleblowers and non-retaliation; train staff on the importance of reporting concerns
- Evaluate Program Regularly- track issues reported to compliance and Human Resources; conduct staff surveys.

The presentation emphasized that the "tone" starts with Leadership who must cultivate an environment where employees feel safe/empowered to raise concerns Board members asked questions of Mr. Cruz related to the Values Line, Confidentiality, compliance office location and consistency with Joint Commission standards.

No action taken.

4. Report from TCHD Auxiliary – Mary Gleisberg, President

Ms. Mary Gleisberg, Auxiliary President provided a brief report on the activities of the Auxiliary. She stated there are currently 469 active volunteers who serve in 29 departments throughout the hospital.

Ms. Gleisberg stated JV Orientation has been completed with 34 new Junior Volunteers.

Ms. Gleisberg reported on Saturday, October 20th the Pet Therapy Department Dogs and Handlers gathered at a local park for an annual refresher for our dogs. The training included a lot of fun activities for the dogs and handlers alike.

Santa's Elves led by volunteer Lynn Fisher will be decorating the lobby the weekend of December 1st in preparation for our annual tree lighting by Mr. Dietlin on December 3rd.

Ms. Gleisberg reminded everyone to remember our wonderful Gift Shop for your holiday shopping needs. The 2019 Pet Therapy Calendars are available in the Gift Shop for an $8 donation and feature our Pet Therapy dogs and volunteers as well.

Lastly, Ms. Gleisberg invited Ms. Judy Howard Jones to the podium. Ms. Jones will be honored by the North County Philanthropy Counsel as Volunteer of the Year. Ms. Gleisberg stated the Auxiliary Board enthusiastically supported nominating Ms. Jones for this award as she has not only been a volunteer for 34 years but is Chair of the Escorts and has volunteered a total of 14,748 hours of service to Tri-City Medical Center.

Ms. Jones expressed her appreciation to everyone for their warmth and kindness over the past 34 years. She commented that Tri-City is like a second home to her and she has loved every minute of it.

Director Grass questioned how many Junior Volunteer applicants that we could not accommodate. Ms. Gleisberg explained the openings fill up extremely fast. She explained that the majority of the junior volunteers are only available on Saturdays, Sundays and after school, thus we are limited to those departments that are open during those hours.

No action taken.

15. Report from Chief Executive Officer CEO

Mr. Steve Dietlin, CEO expressed his appreciation to today's presenters and guests including former patient Larry Hall, Dr. Gene Ma, the Stroke Team and the Auxiliary.

Mr. Dietlin also acknowledged the community members who were recognized today for their service on Board committees.

Mr. Dietlin commented that the membership of the Board of Directors will likely be changing soon. He expressed his appreciation to the Board for their deep

commitment and collaborative efforts to advance the mission of this hospital and this community.

In closing, Mr. Dietlin shared a letter from a patient who spoke of the excellent care she received as a patient.

No action taken.

16. Report from Chief Financial Officer

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

- Net Operating Revenue – $88,709
- Operating Expense – $90,659
- EBITDA - $3,381
- EROE – ($479)

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

- Average Daily Census – 154
- Adjusted Patient Days – 26,105
- Surgery Cases – 1,631
- Deliveries – 558
- ED visits – 14,460

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

- Operating Revenue - $28,950
- Operating Expense - $29,304
- EBITDA - $1,417
- EROE –$119

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

- Average Daily Census – 146
- Adjusted Patient Days – 8,361
- Surgery Cases – 512
- Deliveries – 170
- ED Visits – 4,647

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

- Net Patient Accounts Receivable - $42.7
- Days in Net Accounts Receivable - 44.8

No action was taken.

17. Report from Chief Government and External Affairs Officer

No report.

18. New Business

1) Consideration to approve a Physician Recruitment Agreement with Dr. Hussna Wakily, General Surgeon

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors find it in the best interest of public health of the communities served by the District to approve the loan amount not to exceed $670,000 and a total expenditure of $680,000, in order to recruit Hussna Wakily, M.D. as a General Surgery Physician practicing medicine in the communities served by the District. This will be accomplished through a Group Physician Agreement (not to exceed a two-year income guarantee with a three-year forgiveness period) with Coastal Surgeons. Director Mitchell seconded the motion.

Chairman Dagostino stated Dr. Wakily is a young, bright, talented surgeon who is interested in practicing in this community and joining the Coastal Surgeons group.

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**

20. Old Business - None

21. Chief of Staff

a. There was no Chief of Staff Report.

22. Consideration of Consent Calendar

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

Director Nygaard stated she would be abstaining from the vote on the minutes.

It was moved by Director Reno to pull item D. 1) Approval to appoint Kathryn Fitzwilliam to the role of "Subject Matter Expert".

The vote on the main motion was as follows:

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

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

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

23. Discussion of items pulled from Consent Agenda

Director Reno, who pulled item 22. D. 1) Approval to appoint Kathryn Fitzwilliam to the role of "Subject Matter Expert" questioned why we are deviating from current practice and allowing Ms. Fitzwilliam to serve as a subject matter expert. Director Reno commented that all committee members are expected to have expert knowledge in the respective committees on which they sit. Director Schallock explained that often times there is difficulty finding an individual with Ms. Fitzwilliam's high level of expertise. Director Schallock reviewed Ms. Fitzwilliam's background beginning as an auditor with Deloitte & Tusche. Ms. Fitzwilliam also worked for the Walt Disney Company worldwide, Gateway and Life Technologies. Director Schallock further explained that when the committee drafted changes to the Charter last year they specifically put in language that provides for a subject matter expert who would be a non-voting member of the committee. Director Schallock clarified that we will attempt to fill the vacancy on the committee and will advertise such in January. Director Reno questioned why Ms. Fitzwilliam would not have a vote. Ms. Donnellan explained that if the subject matter expert were to vote the community members would outnumber the Board members on the committee and that is not appropriate.

Director Reno also expressed concern that the current Chair of the Finance Operations & Planning Committee also sits on the Audit Committee and she believes that is a conflict. Ms. Donnellan stated the Board Chair will take her comments into consideration when committee members are appointed.

It was moved by Director Nygaard to appoint Katheryn Fitzwilliam as a subject matter expert on the Audit, Compliance & Ethics Committee.

The vote on the motion was as follows:

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

24. Reports (Discussion by exception only)

There were no comments or questions on the reports.

25. Comments by Members of the Public

There were no comments from members of the public.

26. Additional Comments by Chief Executive Officer

Mr. Dietlin had no additional comments

27. Special Recognition

Cyril F. Kellett, M.D. – for dedication, commitment and service on the Tri-City Healthcare District Board of Directors over the past 29 years

Chairman Dagostino presented Director Kellett with a plaque honoring him for this dedication, commitment and service on the Tri-City Healthcare District Board of Directors over the past 29 years. Chairman Dagostino stated our community was fortunate to have Dr. Kellett not only a Board member but as a dedicated surgeon who was a member of this Medical Staff for many years and at one time served as the Chief of the Medical Staff. Chairman Dagostino stated Dr. Kellett believed in his oath of office and his oath as a physician and will be personally missed.

28. Board Communications

Reports from Board Members

Director Schallock stated as a former employee and Board member he has had the opportunity to see Dr. Kellett's work and dedication for his patients, the organization and the facility. Director Schallock commented that Dr. Kellett provided expertise and guidance to all Board members and he wishes Dr. Kellett and wife Joanne the very best in their retirement.

Director Reno stated she has known Dr. Kellett since he arrived first as a physician and then a Board member. She commented on his tenure as Chief of Staff. Director Reno stated Dr. Kellett is a faithful, loyal Board member who cannot be replaced however the hope is to get a physician on his Board with Dr. Kellett's caliber of knowledge and dedication. She expressed her appreciation to Dr. Kellett for his years of service.

Director Nygaard stated Dr. Kellett is an amazing mentor and has been the "reasonable voice" on this Board for a very long time and will be missed immensely. Director Nygaard wished Dr. Kellett a pleasant retirement.

Director Grass stated in the two years she has been on this Board she has appreciated Dr. Kellett's comic relief as well as his desire to stay "on task". Director Grass stated Dr. Kellett has a beautiful spirit and will be greatly missed.

Director Mitchell expressed her appreciation to Director Kellett not only for his years of service on the Board but for his service to his patients.

Director Mitchell also expressed her appreciation to Administration and the staff for their hard work and dedication and stated it has been an honor and a privilege to serve on the Board.

On behalf of the Medical Staff, Dr. Souza acknowledged Dr. Kellett's many years of service at the hospital and on the Tri-City Healthcare District Board. He appreciated Dr. Kellett's efforts and commitment to the community and is very grateful for everything Dr. Kellett has done. Dr. Souza stated it has been a privilege to have Director Kellett on the Board during his tenure as Chief of Staff and wished him good luck in his retirement.

Director Kellett stated it has been a great honor to serve on the Tri-City Healthcare District Board of Directors and expressed his appreciation to fellow Board members, the Administration, the physicians, the patients and the public for their support.

29. Report from Chairperson

Chairperson Dagostino did not have any additional comments.

34. There being no further business Chairman Dagostino adjourned the meeting at 4:52 p.m.

James J. Dagostino, DPT, PT
Chairman

ATTEST:

Leigh Anne Grass, Secretary

California Special Districts Association
Districts Stronger Together

California Special Districts Association
1112 i Street, Suite 200
Sacramento, CA 95814
Phone: 877.924.2732 Fax: 916.520.2470
www.csda.net

2019 CSDA MEMBERSHIP RENEWAL

To:

Tri-City Healthcare District
4002 Vista Way
Oceanside, CA 92056

Membership ID: 1590

Issue Date October 1, 2018

Due Date: December 31, 2018

RM-Regular Member	$6,647.67
Optional Purchases	
$25 2019 Required State & Federal Labor Law Poster	$
$225 CSDA Sample Policy Handbook	$
Total	$
PAYMENT (Credit card payments may be made online at www.csda.net, by fax or phone)	
Account Name:	Account Number:
Expiration Date	Auth Signature

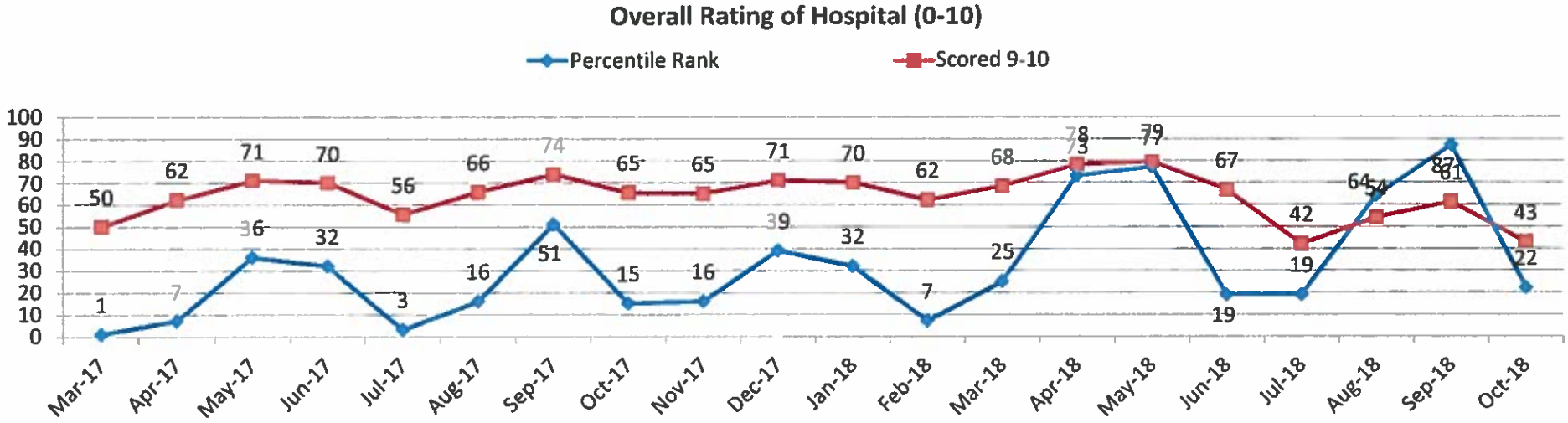
Please return this form with payment to CSDA Member Services, 1112 I Street, Suite 200, Sacramento, CA 95814, fax: 916.520.2470, or email cassandras@csda.net.

OBRA 1993 prohibits taxpayers from deducting, for federal income tax purposes, the portion of membership dues that are allocable to the lobbying activities of trade organizations. The nondeductible portion of your dues is estimated to be 8%. To view dues categories, please visit the CSDA transparency page at www.csda.net

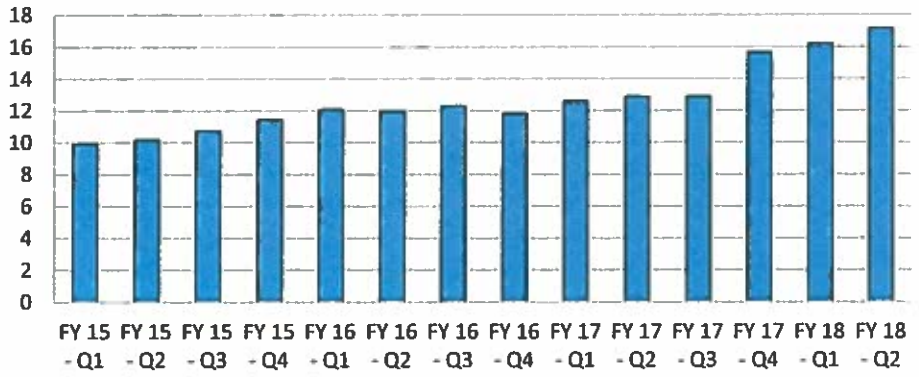
Thank you for being a CSDA Member!

Stakeholder Experiences

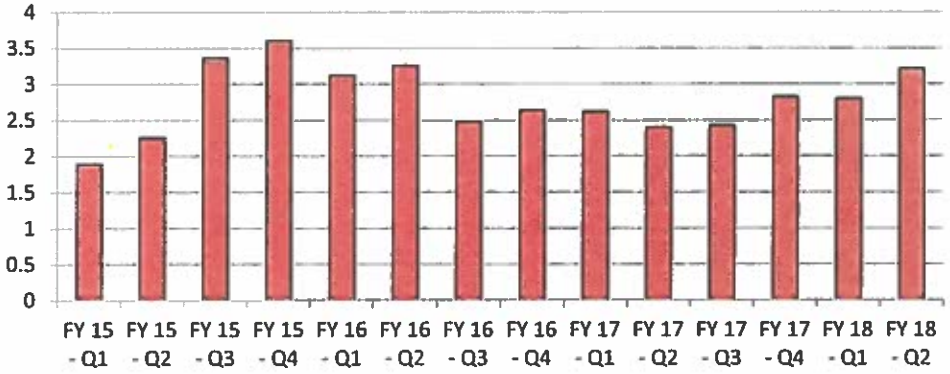
Overall Rating of Hospital (0-10)



Voluntary Employee Turnover Rate



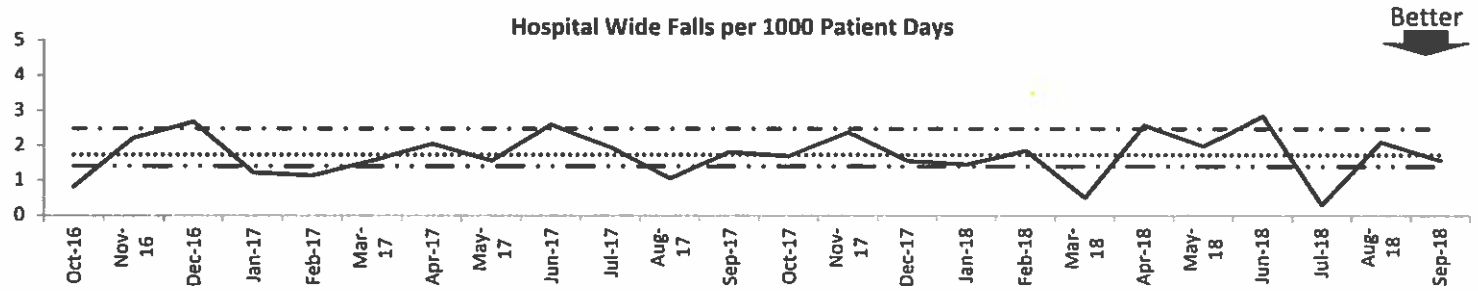
Involuntary Employee Turnover Rate



Current Trending Measures

TCMC Rate — Mean — CA Mean — TCMC Target

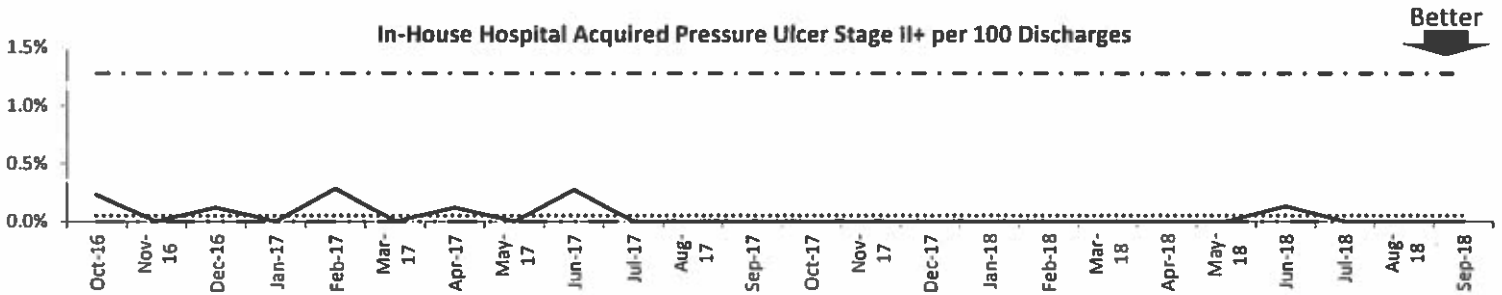
Hospital Wide Falls per 1000 Patient Days



Action Plan

Continue to increase fall awareness and monitor hourly rounding compliance. September rate is at is between our mean and target. Performance is better than state mean. No action necessary at his time. Continue to monitor.

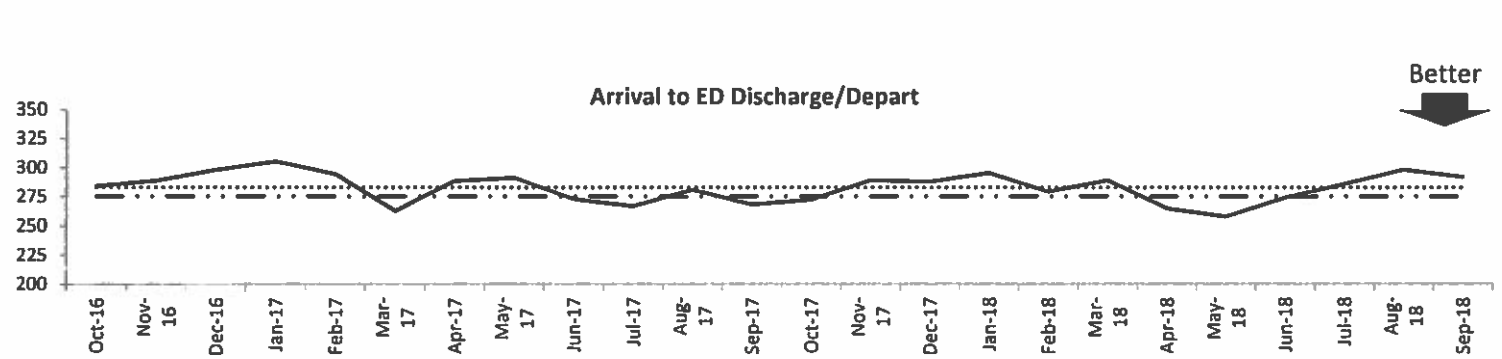
In-House Hospital Acquired Pressure Ulcer Stage II+ per 100 Discharges



Action Plan

Performance below goal. No action plan necessary. Continue to monitor.

Arrival to ED Discharge/Depart



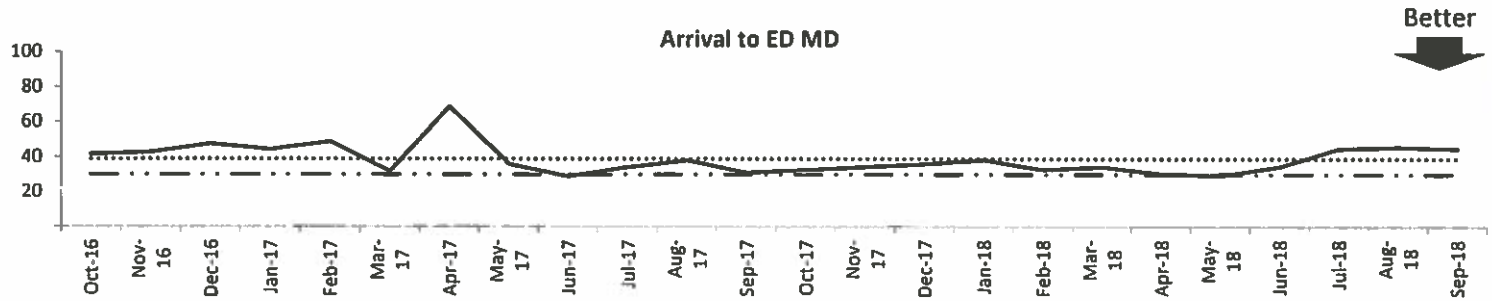
Action Plan

MD coverage reduced due to ED volume decrease. Admits and discharges continue taking longer as each provider has more patients. Adding doctor hours at peak times being assessed.

Current Trending Measures

TCMC Rate ····· Mean - - - - CA Mean —·—·— TCMC Target

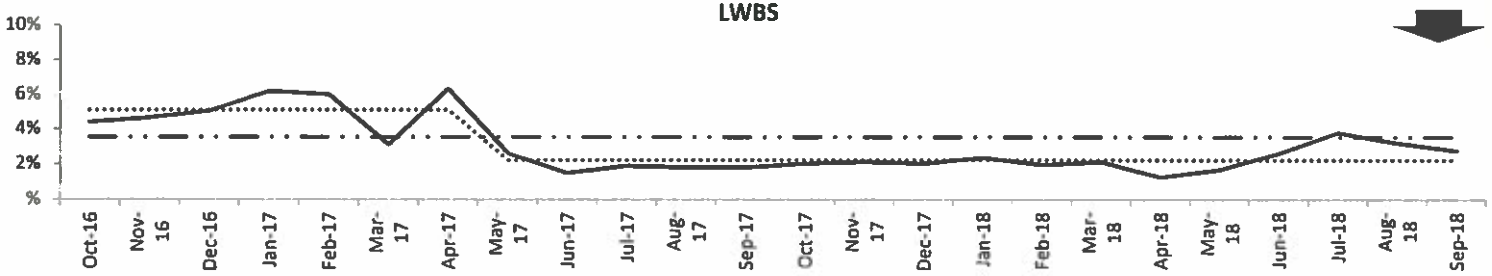
Arrival to ED MD



Action Plan

Triage MD hours reduced causing longer waiting times to be seen and in the main ED. Earlier MD coverage was expecte dto be added by 10/1. Too early to determine if change will affect the times.

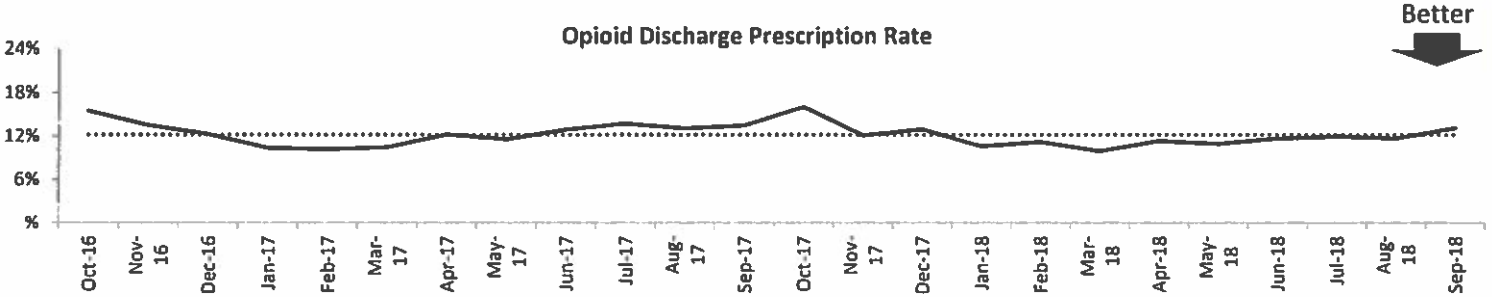
LWBS



Action Plan

LWBS were previously increased due to longer waits and increase in ED Psych volume. Station F opened and more MD hrs added. September data shows a decrease from July and August. Continue to monitor.

Opioid Discharge Prescription Rate

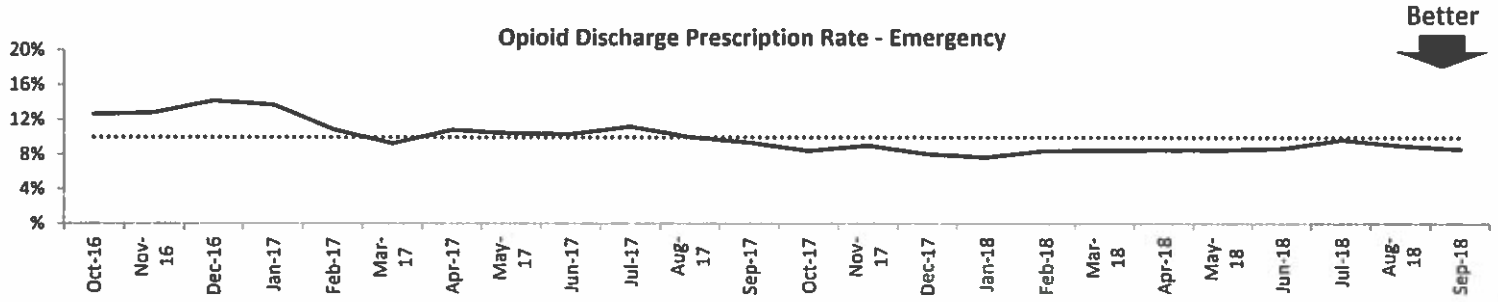


Action Plan

Performance continues to be consistant with the mean. No action necessary at this time. Continue to monitor

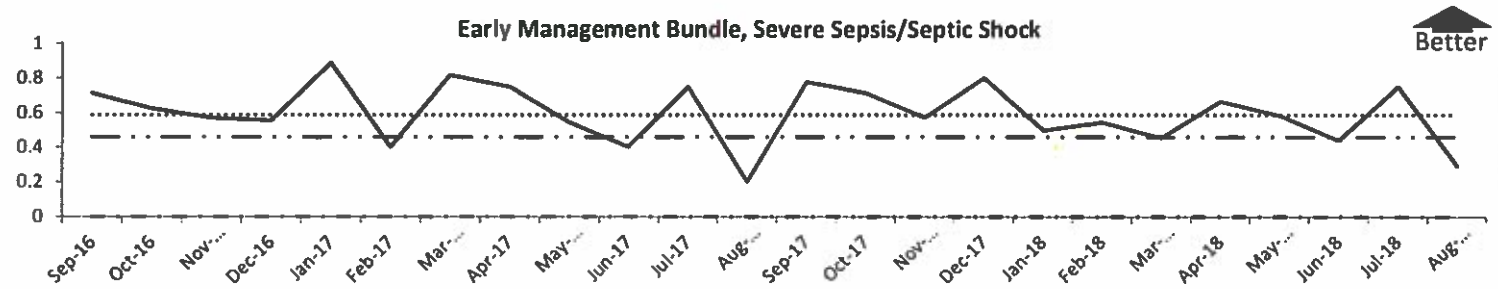
Current Trending Measures

TCMC Rate — Mean — CA Mean — TCMC Target



Action Plan

Performance continues to be better than the mean. No action necessary at this time. Continue to monitor.

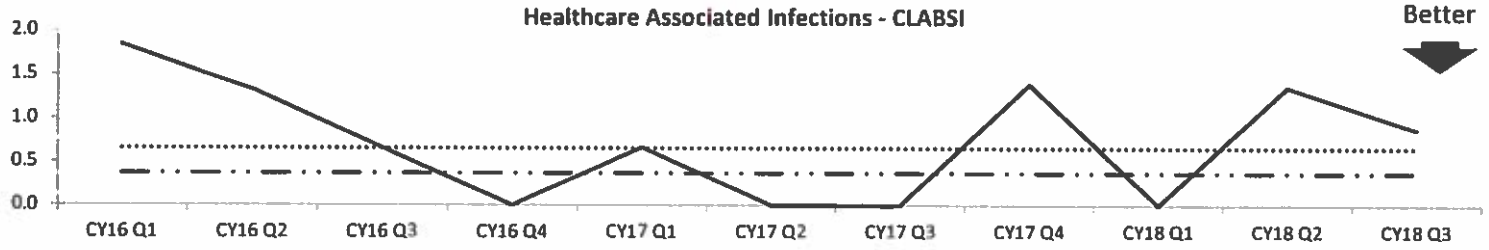


Action Plan

Sepsis Predictive Platform Go-Live anticipated early Oct 2018. All sepsis resources have been allocated to this project. Implementation on MedTele live 10/2018 to determine roll-out plan. Data remains above the state and national averages. Continue to monitor.

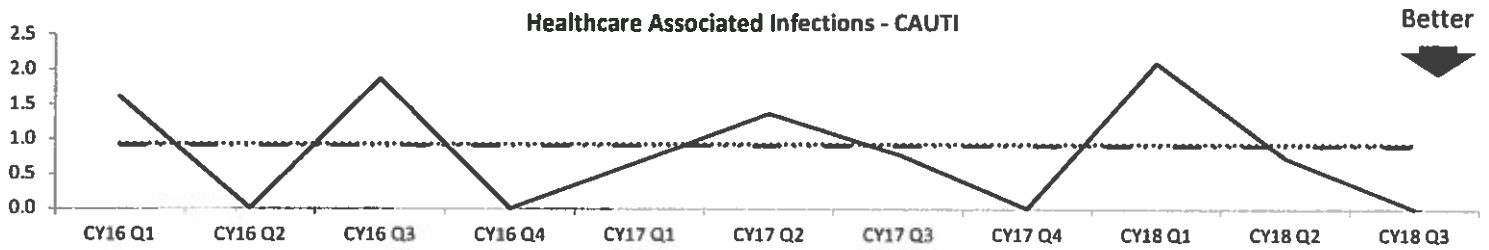
Current Trending Measures

TCMC Rate Mean CA Mean TCMC Target



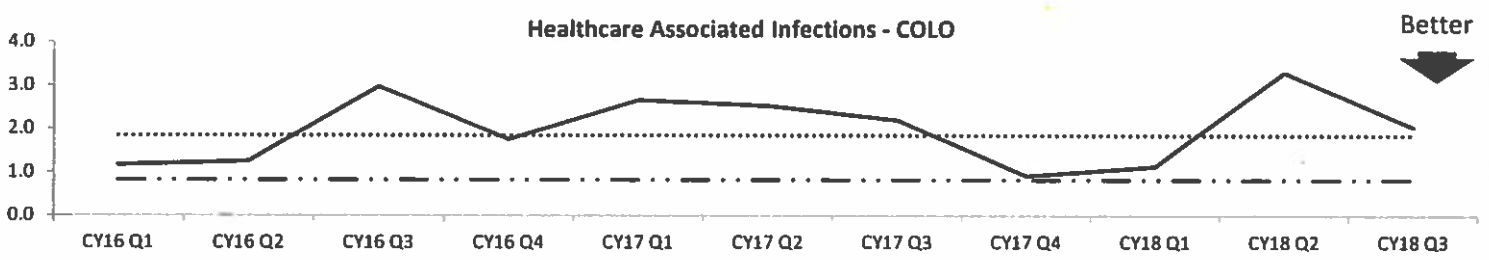
Action Plan

Continue CLABSI bundle. Real time feedback for new cases.



Action Plan

No CAUTI's indentified in CY18 Q3- continue real time feedback for new cases.

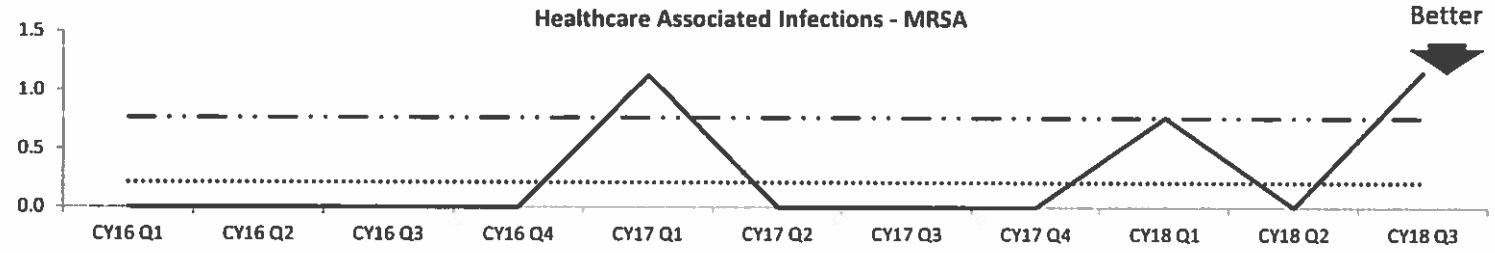


Action Plan

Create audit tool for drill down & follow up. Peer review of all COLO Cases.

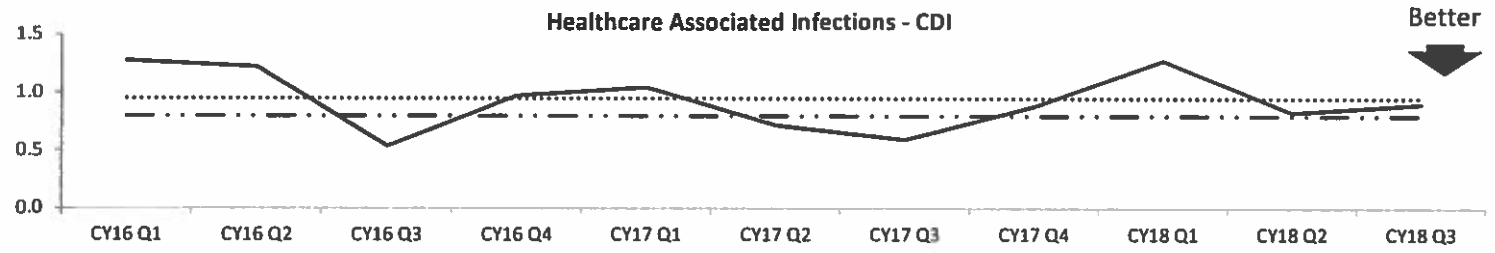
Current Trending Measures

TCMC Rate Mean CA Mean TCMC Target



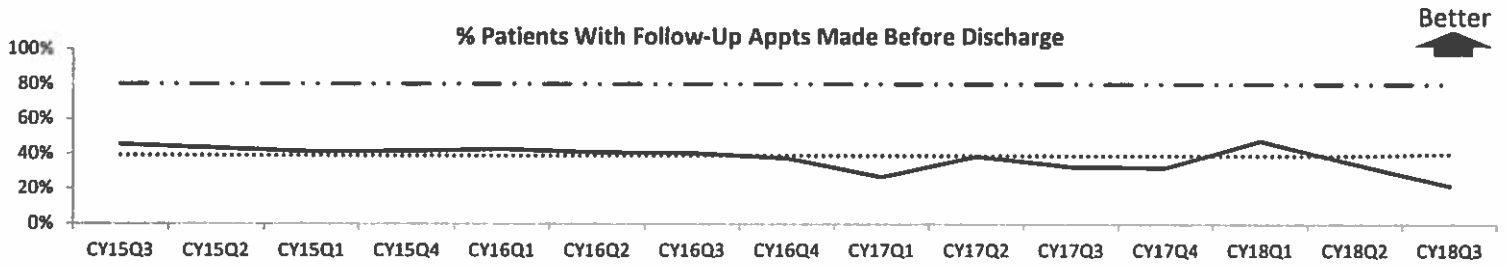
Action Plan

Continue Contact precautions and environmental cleaning.



Action Plan

Antimicrobial stewardship, Contact precautions, Hand soap & water, realtime feedback & deep dive of positive HO cases.



Action Plan

CY 18 Q3 the metric changed within to only include A1c>9. Updating the graph back to original A1c>7 for data capture and break out in a separate graph A1c>9 for a focus area to drive improvement for the new metric.

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
FY19	18	29	19	27									93
FY18	26	23	23	20	27	27	22	23	24	20	20	28	92

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	10	12	3	7									32
FY17	14	6	7	13	7	15	14	8	12	7	10	6	40

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	19	16	12	16									63
FY18	11	12	12	14	16	18	23	12	15	15	16	20	49

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	20	23	18	22									83
FY18	15	20	20	16	23	15	15	19	23	11	20	17	71

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	31	31	27	35									124
FY18	48	37	33	32	26	38	29	24	30	38	33	38	150

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
FY19	10.8	11.3	9.7	-									10.6
FY18	15.7	14.5	16.2	16.3	9.9	14.2	16.7	12.5	13.7	13.8	13.0	11.9	15.5

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	7.4	9.1	6.5	4.7									6.9
FY18	9.0	6.7	6.2	9.5	8.3	7.3	7.2	8.7	7.5	7.1	6.6	4.8	7.9

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	11.4	9.8	10.0	11.0									10.6
FY18	11.3	16.4	12.4	13.9	13.5	10.5	12.5	12.7	12.4	11.5	12.2	13.5	13.5

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	160.3	155.9	146.4	149.6									153.1
FY18	169.7	181.9	163.4	173.4	160.9	172.5	210.7	185.8	186.4	163.2	161.9	165.9	172.2

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	186	202	170	187									745
FY18	210	222	194	206	184	166	209	169	186	156	163	188	832

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	8	10	6	8									32
FY18	12	11	11	11	11	18	16	5	7	16	15	20	45

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
FY19	3	4	3	13									23
FY18	4	7	7	3	4	3	2	4	8	2	7	8	21

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	8	8	6	8									30
FY18	8	7	7	11	3	14	11	10	4	10	8	5	33

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	1.79	1.83	1.9	1.78									1.82
FY18	1.75	1.80	1.81	1.80	1.83	1.72	1.64	1.77	1.78	1.85	1.86	1.79	1.79

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
FY19	51.0	48.5	50.3	49.5									49.8	48-52
FY18	47.7	47.8	48.9	50.8	49.6	49.5	49.8	47.2	46.8	47.0	46.6	45.8	48.8	

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
FY19	84.9	86.5	90.2	91.4									88.2	75-100
FY18	82.1	79.1	78.8	83.4	87.7	81.3	82.9	85.2	78.8	83.2	89.2	83.0	80.8	

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
FY19	($478)	($121)	$119	$254									($225)	($810)
FY18	($394)	($429)	($224)	($171)	($2,571)	($383)	($1,242)	($542)	($337)	($679)	($408)	$3,118	($1,219)	

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
FY19	-1.64%	-0.39%	0.41%	0.86%									-0.19%	-0.71%
FY18	-1.33%	-1.39%	-0.76%	-0.55%	-9.47%	-1.26%	-3.94%	-1.86%	-1.09%	-2.31%	-1.31%	9.07%	-1.00%	

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
FY19	$796	$1,168	$1,417	$1,561									$4,942	$4,484
FY18	$898	$864	$1,091	$1,146	($1,288)	$908	$81	$751	$963	$571	$900	$4,407	$3,999	

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
FY19	2.73%	3.81%	4.90%	5.28%									4.18%	3.93%
FY18	3.03%	2.80%	3.69%	3.66%	-4.74%	2.99%	0.26%	2.57%	3.13%	1.95%	2.90%	12.82%	3.30%	

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
FY19	6.73	6.70	6.75	6.98									6.79	6.58
FY18	6.51	5.92	6.90	6.26	6.50	6.43	5.95	5.99	5.86	6.29	6.43	6.43	6.38	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY19	$50.0	$49.5	$49.3	$48.1									
FY18	$58.5	$49.8	$42.3	$48.2	$58.6	$54.5	$54.7	$53.1	$49.4	$42.7	$41.5	$52.8	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending October 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	$3.59	(a)	45,637.80	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	$2.47	(a)	5,029.28	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	$1.91	(a)	11,056.71	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	$2.58	(a)	27,111.35	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	$2.58	(a)	15,640.35	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	$2.62	(a)	9,867.81	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)	10,599.16	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	$4.24	(a)	27,379.00	10/01/12	10/01/22	**Chemotherapy/Infusion Oncology Center** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056
Total				**$ 182,962.47**			

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending October 2018

Cost Center	Description	Invoice #	Amount	Vendor #	Attendees
6183	2018 PERIOPERATIVE QUALITY & ENHANCED RECOVERY	101518	1,010.22	80084	COURTNEY NELSON
7320	ASSESS & TREAT SUICIDAL RISK TRAINING	101518	135.00	80740	HOLLY HAMILTON
8390	CSHP SEMINAR PHARMACY	102218	497.33	79349	TORI HONG
8480	CERNER HEALTH CONFERENCE 2018	101518	1,595.01	83340	REBECCA KREIDER
8480	CERNER HEALTH CONFERENCE 2018	101618	1,622.96	65505	KIMBERLY QUINN
8510	ADVANCED EXCEL TRAINING	24446103	199.00	37911	JESSICA GODFREY
8510	ADVANCED EXCEL TRAINING	101518	199.00	83339	CARLI COVEY
8610	CERNER COMMUNITY WORKS	82718	1,012.81	80739	SCOTT LIVINGSTONE
8610	HASD & IC ANNUAL MEETING	M00211	1,990.00	34627	BOARD MEMBERS & CHIEFS
8650	EMPLOYMENT LAW 2019 SEMINAR	101918	149.00	83278	ELLIOT STEIN
8650	SOCIETY FOR HR MANAGEMENT	82718	192.00	43185	ANNA AGUILAR
8650	CCP CERTIFCATION	4504508	1,283.00	74956	ANNETTE MORRIS
8650	AM SOCIETY FOR HEALTHCARE RISK MANAGEMENT	91718	2,223.98	83312	MICHAEL D LEVINE
8723	DISCHARGE PLANNING FOR HOMELESS PATIENTS	HOMWB10201856745864	246.00	14365	LISA STROUD
8740	OPTIMAL OUTCOME IN BREASTFEEDING	101218	100.00	78644	CYNDI OZBUN
8740	LEAD EKG INTERPRETATION COURSE	92118	100.00	83346	KYUNGHEE KIM RUETTEN
8740	ORTHOPEDIC NURSING SYMPOSIUM	100518	110.00	77871	MING YIN
8740	AGING FEMALE/MALE URINARY SYSTEM	92818	120.00	54954	LINDA M BOESS
8740	AM SOCIETY OF RADIOLOGIC TECHNOLOGISTS	101218	125.00	82343	MIKE TRACEY
8740	NRP PROVIDER COURSE	100518	145.00	81376	KIMBERLY LEMIEUX
8740	PALS RENEWAL	101918	150.00	80314	SARA SMITH
8740	ORTHOPEDIC & SPINE SYMPOSIUM	100518	170.00	27009	JUDITH FARR
8740	NUTRITION & FEEDING INFANTS & TODDLERS	101218	180.00	81649	BENILDA MILAN-AGLUGUB
8740	2018 WACHSA MULTIDISCIPLINARY HEALTHCARE CONFERENCE	101218	180.00	82051	MARY JENNIFER CATACUTAN
8740	CA LEGAL & ETHICAL ISSUES FOR MENTAL HEALTH	100518	199.99	82946	SUDABEH ZARIFIFAR
8740	ADVANCED DIALECTICAL BEHAVIRO THERAPY	101918	200.00	28745	CATHERINE FISHER
8740	GERIATRIC PHYSICAL THERAPY	101918	200.00	49111	ELLEN W. O'CONNOR
8740	CASE MANAGEMENT CERTIFICATION	100518	200.00	82189	JOCELYN GUERRA
8740	PALS COURSE	101218	200.00	83345	TONYA LEROY
8740	MASTER OF SCIENCE NURSING	92118	755.00	77556	HEATHER HUNTER
8740	BACHELORS OF SCIENCE NURSING	92818	2,500.00	69613	KACIE ROBINSON
8740	MASTER HEALTH ADMINISTRATION	92118	4,989.56	82653	DANIEL BARNES
8756	HSAG HIIN CALNOC	102918	264.47	83102	JACLYN HUNTER
8758	LIGATURE & SELFHARM RISKS	100218 WELLS	135.00	14365	KELLY WELLS
8758	CDPH UPDATES	CDPHWB10201856685858	185.00	14365	KELLY WELLS
8790	PERINTAL ORIENTATION & EDUCATION	101018	4,950.00	77316	LABOR & DELIVERY STAFF

**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.