

**TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
February 28, 2019 – 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	<p>Public Comments – Announcement</p> <p>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.</p> <p>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.</p>	2 min.	Standard
12	Report from TCHD Foundation – Jennifer Paroly, Executive Director	10 min.	Executive Dir./Foundation
13	January 2019 Financial Statement Results	10 min.	CFO
14	<p>New Business</p> <p>a) Consideration to approve an Independent Physician Recruitment Agreement with Dr. Morgan Silldorff, Orthopedic Surgeon</p>	10 min.	Senior Director/Busi. Development
15	Old Business - None		
16	<p>Chief of Staff</p> <p>a) Consideration of February 2019 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on February 25, 2019.</p> <p>b) Consideration of Revised Rules & Regulations:</p> <ol style="list-style-type: none"> 1) Anesthesiology 2) Radiology 3) Pathology <p>c) Consideration of Revised Privilege Cards:</p> <ol style="list-style-type: none"> 1) Anesthesiology 2) Neonatology 3) NP-Interventional Radiology 4) OB/GYN 5) Orthopedic Surgery 6) Pathology 7) Pediatrics 8) Radiology 	10 min.	Chief of Staff
17	<p>Consideration of Consent Calendar</p> <p>Administrative & Board Committees</p> <p><i>(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.</i></p> <p><i>(2) All items listed were recommended by the Committee.</i></p> <p><i>(3) Requested items to be pulled <u>require a second.</u></i></p> <p>(1) Administrative Committee</p>	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	<p>a) Patient Care Policies & Procedures</p> <ol style="list-style-type: none"> 1) Automated Dispensing Machine Pro 2) Blood Products Administration Procedure 3) Diabetes Education Procedure 4) Discharge Planning Policy 5) Discharge Planning, Homeless Patient Policy 6) Lift Team Policy 7) Point of Care New Test Method Request and Implementation Policy 8) Preceptor Program Procedure 9) Provision of Education for Adolescents During Hospitalization 10) Sponge, Sharps and Instrument Counts Prevention of Retained Surgical Objects <p>b) Cardiology</p> <ol style="list-style-type: none"> 1) 2D Echo with Conventional & Color Flow Doppler and M Mode Procedure 2) 12 Lead EKG Procedure 3) 24 Hour Holter Monitor System Hook Up and Initiate Recording Procedure 4) 24 Hour Holter Monitor System -- Scanning Analysis Procedure 5) Critical Results Reporting for Electrocardiogram Procedure 6) Echocardiogram - Contrast Bubble Study (Agitated Saline Contrast Injection) Procedure 7) Stress Echocardiogram Procedure 8) Tilt Table Test Procedure 9) Transesophageal Echocardiogram (TEE) <p>c) Engineering</p> <ol style="list-style-type: none"> 1) 6000 Infection Control <p>d) Food & Nutrition</p> <ol style="list-style-type: none"> 1) Emergency Preparedness – Meals for All Nutricopia 2) Nutrition Assessment and Care for Adult Geriatric Patients 3) Nutrition Assessment BHU <p>e) Medical Staff</p> <ol style="list-style-type: none"> 1) Credentialing Policy, da Vinci Robotic-Assisted Surgery 8710-563 2) Medical Record Documentation Requirements 3) Standards for Seed Implants in the OR <p>f) Patient Care Management</p> <ol style="list-style-type: none"> 1) Discharge Planning Policy (DELETE) <p>g) Formulary Requests</p> <ol style="list-style-type: none"> 1) Ceftazidime/Avibactam (Avycaz) 2) Infliximab-dyyb (Inflectra) <p>(2) Board Committees</p> <p>A. Community Healthcare Alliance Committee Director Chavez, Committee Chair <i>(No meeting held in February, 2019)</i></p> <p>B. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 1</p>		
			CHAC Comm.
			FO&P Comm.

	Agenda Item	Time Allotted	Requestor
	<p><i>(Committee minutes included in Board Agenda packets for informational purposes)</i></p> <p>1) Approval of an agreement with nThrive for a term of 36 months, beginning March 1, 2019 through February 28, 2022, for an annual cost of \$120,000 and a total cost for the term of \$360,000 for patient accounting.</p> <p>2) Approval of an agreement to add Dr. Hussna Wakily to the currently existing Panel Agreement for ED On-Call Coverage-General Surgery for a term of 17 months, beginning February 1, 2019 through June 30, 2020.</p> <p>C. Professional Affairs Committee Director Reno, Committee Chair <i>(No meeting held in February, 2019)</i></p> <p>D. Audit, Compliance & Ethics Committee Director Schallock, Committee Chair <i>(Committee minutes included in Board Agenda packets for informational purposes)</i> Open Community Seats – 1</p> <p>1) <u>Compliance Policies & Procedures</u></p> <ul style="list-style-type: none"> a) Compliance Officer – 535 b) Compliance Program Overview – 532 c) Disclosure of Protected Health Information – 513 d) HIPAA Mitigation e) Duty to Report Suspected Misconduct; Potential Compliance Irregularity e) Monitoring Compliance – Auditing & Reporting; Introduction; General Policies – 551 (DELETE) f) Notice of Privacy Practice – 518 9) Use and Disclosure of Protected Information for Fundraising – 525 h) Verification of Identity and Authority of Persons Requesting Protected Health Information (PHI), including Personal Representatives - 593 <p>(3) Minutes – Approval of:</p> <ul style="list-style-type: none"> a) Regular Board of Directors Meeting – January 31, 2018 <p>(4) Meetings and Conferences – None</p> <p>(5) Dues and Memberships - None</p>		<p>PAC</p> <p>Audit, Comp. & Ethics Comm.</p> <p>Standard</p>
18	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
19	<p>Reports (Discussion by exception only)</p> <ul style="list-style-type: none"> (a) Dashboard – Included (b) Construction Report – Included (c) Lease Report – (January, 2019) (d) Reimbursement Disclosure Report – January, 2019) (e) Seminar/Conference Reports – None 	0-5 min.	Standard

	Agenda Item	Time Allotted	Requestor
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20	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
21	Comments by Chief Executive Officer	5 min.	Standard
22	Board Communications (three minutes per Board member)	18 min.	Standard
23	Report from Chairperson	3 min.	Standard
24	Total Time Budgeted for Open Session	2 hours	
25	Adjournment		



FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: February 21, 2019
Physician Recruitment Proposal – Orthopedic Surgeon

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

Physician Name: Morgan Silldorff, M.D.
Areas of Service: Orthopedic Surgery (Total Joint Specialist)

Key Terms of Agreement:

Effective Date: August 1, 2019, or the date Dr. Silldorff becomes a credentialed member in good standing of the Tri-City Healthcare District Medical Staff

Community Need: TCHD Physician Needs Assessment shows significant community need for Orthopedic Surgery (Total Joint Specialist)

Service Area: Area defined by the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients

Income Guarantee: \$800,000 NTE (\$400,000 annually - for a two-year income guarantee, with a three-year forgiveness period)

Sign-on Bonus: \$25,000

Relocation: \$10,000 (Not part of the Loan)

Loan Amount: \$825,000

Total Not to Exceed: \$835,000

Unique Features: Dr. Silldorff will practice at Orthopedic Specialist of North County

Requirements:


Business Pro Forma: Must submit a 24 month business pro forma for TCHD approval relating to the addition of this physician to the medical practice, including proposed incremental expenses and income. TCHD may suspend or terminate income guarantee payments if operations deviate more than 20% from the approved pro forma and are not addressed as per agreement.

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

Document Submitted to Legal 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: Jeremy Raimo, Sr. Director Business Development / Scott Livingstone, Chief Operating Officer

Motion:

I  that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the public health of the communities served by the District to approve the expenditure, not to exceed \$835,000 in order to facilitate, Morgan Silldorff, M.D., Orthopedic Surgeon practicing medicine in the communities served by the District. This will be accomplished through an Independent Physician Recruitment Agreement (not to exceed a 24 month income guarantee with a three-year forgiveness period) for a total not to exceed \$835,000.



TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
February 13, 2019

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 03/01/2019 - 02/28/2021)

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 03/01/2019 through 02/28/2021:

- ALARCON, Anthony MD/Anesthesiology (ASMG)
- CHOI, Scott MD/Anesthesiology (ASMG)
- CORNELISSEN, Christopher DO/Anesthesiology (ASMG)
- CRANDALL, Geoffrey MD/Anesthesiology (ASMG)
- PANICKER, Harish MD/Teleradiology (StatRad)
- PANZER, Glenn MD/Family Medicine (Elizabeth Hospice)
- TOOHEY, Tara MD/Psychiatry (Vituity)



TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 5
February 13, 2019

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 03/01/2019 –02/28/2021)

Any items of concern will be “red” flagged in this report. The following application was recommended for reappointment to the medical staff office effective 03/01/2019 through 02/28/2021, 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:

- ANDRADE, Kristine, MD/Teleradiology/Active Affiliate
- ASSELIN, Lynette, DO/Pediatrics/Active
- BARAGER, Richard, MD/Nephrology/Active
- BARCO, Eric, MD/Internal Medicine/Active
- BURZYNSKI, Margaret, MD/Anesthesiology/Active
- CHOW, Chien-Hsiang, MD/Anesthesiology/Provisional
- EBRAHIMI ADIB, Tannaz, MD/Obstetrics & Gynecology/Active
- FREDERIKSEN, Ryan, MD/Teleradiology/Active Affiliate
- FURUBAYASHI, Jill, MD/Teleradiology/Active Affiliate
- GOELITZ, Brian, MD/Interventional Radiology/Active
- GRANT, Colette, MD/Pediatrics/Provisional
- GREIDER, Bradley, MD/Ophthalmology/Active Affiliate
- HELTON, Derek, MD/Oncology/Active
- IBRAHIM, Nagi, MD/Internal Medicine/Refer and Follow
- JACOBS, Karl, MD/Psychiatry/Provisional
- KALOOGLIAN, Harold, DPM/Podiatric Surgery/Active
- KURIYAMA, Steve, MD/Infectious Disease/Active Affiliate
- LEAN, Eva, MD/Radiation Oncology/Active



TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 5
February 13, 2019

Attachment B

- LUSCHWITZ, Brian, MD/Pediatrics/Active
- MacEwan, Jennifer, MD/Otolaryngology/Provisional
- MCGAHAN, Michele, MD/Diagnostic Radiology/Provisional
- MELLS, Cary, MD/Emergency Medicine/Active
- MUHTASEB, Talal, MD/Obstetrics & Gynecology/Active
- NEWMAN, Jeffrey, MD/Family Medicine/Active
- NGUYEN, Christine, MD/Internal Medicine/Refer and Follow
- ONAITIS, Mark, MD/Cardiothoracic Surgery/Provisional
- POUNTNEY LEVESQUE, Marlene, MD/Obstetrics & Gynecology/Active
- QUAN, Maria, MD/Obstetrics & Gynecology/Provisional
- SAHAGIAN, Gregory, MD/Neurology/Active
- SERDAREVIC, Hanna, MD/Anesthesiology/Active
- SHAFQAT, Jon, DDS/Oral & Maxillofacial Surgery/Active Affiliate
- SMITH, Mark, MD/Ophthalmology/Active
- SMITH, Richard, MD/Infectious Disease/Active
- SMITH, Ryan, DO/Emergency Medicine/Active

RESIGNATIONS: (Effective date 02/28/2019 unless otherwise noted)

Automatic:

Voluntary:

- ANAKWENZE, Okechukwu, MD/Orthopedic Surgery
- BLAKE, Patrick, MD/Dermatology
- DOAN, Michael, MD/Anesthesiology



TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 5
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Attachment B

- KANEL, Jason, MD/Anesthesiology
- KIM, James, MD/Anesthesiology
- LIU, David, MD/Anesthesiology
- PATEL, Lance, MD/Anesthesiology
- ROSS, Richard, MD/Emergency Medicine
- WANG, Huan, MD/Anesthesiology
- ZHU, Shiyin, MD/Anesthesiology



TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
February 13, 2019

Attachment B

EXTENSION OF PROCTORING

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 **August 31, 2019** would result in these privileges automatically relinquishing.

- | | |
|-----------------------------------|-------------------------------------|
| • <u>CLARKSON, Chunjai, MD</u> | <u>Obstetrics & Gynecology</u> |
| • <u>DHILLON-ASHLEY, Tina, MD</u> | <u>Obstetrics & Gynecology</u> |
| • <u>GANDHI, Dhruvil, MD</u> | <u>General and Vascular Surgery</u> |
| • <u>GROVE, Jay, MD</u> | <u>General Surgery</u> |
| • <u>NGUYEN, Vu, MD</u> | <u>Dermatology</u> |
| • <u>PENRY, Jackson, MD</u> | <u>Radiology</u> |
| • <u>RUELAZ, Robert, MD</u> | <u>Cardiology</u> |
| • <u>URBANIC, James, MD</u> | <u>Radiation Oncology</u> |

AUTOMATIC EXPIRATION OF PRIVILEGES

The following practitioners were given 14 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and therefore the listed privileges will automatically expire as of February 28, 2019.

- | | |
|------------------------------------|-------------------|
| • <u>PASHMFOROUSH, Mohammad MD</u> | <u>Cardiology</u> |
|------------------------------------|-------------------|

STAFF STATUS CHANGE

- | | |
|-------------------------|----------------------|
| • <u>HAAK, Logan MD</u> | <u>Ophthalmology</u> |
|-------------------------|----------------------|



TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
February 13, 2019

Attachment C

PROCTORING RECOMMENDATIONS (Effective 2/28/2019, unless otherwise specified)

- | | |
|----------------------------------|------------------------------------|
| • <u>BUL Hanh, MD</u> | <u>Cardiology</u> |
| • <u>CATTAFL Paul DO</u> | <u>Anesthesiology</u> |
| • <u>DANG, Christopher DO</u> | <u>Emergency Medicine</u> |
| • <u>FISHER-GAMEZ, Lori RNFA</u> | <u>Allied Health Professionals</u> |
| • <u>MOUSSAVIAN, Mehran MD</u> | <u>Cardiology</u> |
| • <u>PAVEGLIO, Kathleen, MD</u> | <u>Cardiology</u> |
| • <u>RYEL, Justin, MD</u> | <u>Emergency Medicine</u> |
| • <u>SAMANI, Pargol, MD</u> | <u>Cardiology</u> |
| • <u>SCOTT, Katie PAC</u> | <u>Allied Health Professionals</u> |

TRI-CITY HOSPITAL DISTRICT

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I. MEMBERSHIP

As part of the Department's goal to ensure that its physicians meet high standards of clinical quality, the Department has determined that Board Certification is an important indicator of quality. Therefore, the Department of Anesthesiology consists of physicians who are at all times and remain Board Certified by the American Board of Anesthesiology (ABA), or are a candidate in the ABA examination system, as determined by the American Board of Anesthesiology. Department members with time-limited certificates must participate in the ABA's Maintenance of Certification in Anesthesiology (MOCA) program in order to maintain their certification. For those members who have non-time limited certificates, the Department recommends participation in the MOCA program.

II. FUNCTIONS OF THE DEPARTMENT

The general functions of the Department of Anesthesiology shall include:

- A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Department and develop criteria for use in the evaluation of patient care;
- B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;
- C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Department clinical practices;
- D. Review and evaluate Department member adherence to:
 1. Medical Staff policies and procedures;
 2. Sound principles of clinical practice;
- E. Submit written minutes to the QA/PI/PS Medical Quality Peer Review Committee and Medical Executive Committee concerning:
 1. Department review and evaluation activities, actions taken thereon, and the results of such actions; and
 2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital;
- F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;
- G. Take appropriate action when important problems in patient care, safety and clinical performance or opportunities to improve patient care are identified;
- H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);
- I. Approve On-Going Professional Practice Evaluation Indicators; and
- J. Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. DEPARTMENT MEETINGS

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

Twenty-five percent (25%) of the Active Department members, but not less than two (2) members,

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shall constitute a quorum at any meeting.

IV. DEPARTMENT OFFICERS

The Department shall have a Chair who shall be a member of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in the clinical area of Anesthesiology. The Department Chair shall be elected every two (2) years by the Active members of the Department who are eligible to vote. Vacancies for any reason shall be filled for the unexpired term through a special election. The Chair shall be elected by a simple majority of the members of the Department. The Department Chair shall serve a two-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Department. Department officers shall be eligible to succeed themselves. The Vice Chair will be the prior Chairman and a Quality Review Committee Chairman will be appointed.

V. DUTIES OF THE DEPARTMENT CHAIR

The Department Chair shall assume the following responsibilities:

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

VI. PRIVILEGES

- A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.
- B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.
- C. Requests for privileges in the Department of Anesthesiology shall be evaluated on the basis of the member's education, training, experience, demonstrated current professional competence and judgment, clinical performance, and the documented results of patient care and proctoring.
- D. Practitioners shall practice only within the scope of their privileges as defined within the respective Department rules and regulations. Recommendations for privileges are made to the Credentials Committee and Medical Executive Committee.

COGNITIVE PRIVILEGES	Initial	Proctoring	Reappointment every two years
Consultation	N/A	N/A	N/A
Perform history and physical examination	N/A	N/A	N/A
Evaluate and treat patients with	N/A	N/A	N/A

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COGNITIVE PRIVILEGES	Initial	Proctoring	Reappointment every two years
anesthesia-related problems			
CORE PROCEDURAL PRIVILEGES	Initial	Proctoring	Reappointment every two years
General Anesthesia	Training	3	20
Regional Anesthesia	Training	2	5
Invasive Monitoring, including: Arterial line Central line Pulmonary Artery Catheter	Training	N/A	5

Cardiac Anesthesia Criteria – Cardiac anesthesia privileges are considered for applicants who fall under one of the following two categories:

Category 1:

Successful completion of cardiac anesthesia fellowship OR completion of six months of focused cardiac anesthesia training during third year of residency OR documentation of current activity managing cardiopulmonary bypass cases.

Category 2:

Completion of approved anesthesia residency training program that included three (3) months of cardiac anesthesia with additional proctoring: 1) Five (5) cases will be proctored via direct observation; and 2) Twenty-five (25) prospectively reviewed cases where the plan for anesthesia is discussed with an eligible proctor and the proctor reviews the case retrospectively.

SPECIAL PROCEDURES	Initial	Proctoring	Reappointment every two years
Cardiac anesthesia	See above.	See above.	5
Transesophageal echocardiography (TEE)	1. Cardiac fellowship training, or 2. Documentation of recent training program where TEE was part of training, or 3. Six (6) months Cardiac Anesthesia residency	3	None
Coronary sinus catheter placement	Successful completion of all privileging criteria for Cardiac Anesthesia (Category 1 or 2), and current fluoroscopy license, and Transesophageal echocardiography	2	None

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OTHER PRIVILEGES	Initial	Proctoring	Reappointment every two years
Admit patients	Training	N/A	N/A
Fluoroscopy	Refer to policy 8710-528 and 8710-528A	N/A	N/A
PAIN MANAGEMENT PROCEDURES	Refer to policy 8710-541		

VII. REAPPOINTMENT

Procedural privileges may be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. For Anesthesiology Procedural Privileges, 25% of the overall case-specific volume requirement(s) must have been performed at an acute care hospital. If the minimum number of cases is not performed, the physician will be required to undergo proctoring for all procedures that were not satisfied. The physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. PROCTORING OF PRIVILEGES

- A. Each Medical Staff member granted initial, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privileges status is established by a recommendation from the Department Chair to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.
- B. All Active staff members of the Department will act as proctors to monitor quality of performance.
- C. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.
- D. Blank forms will be available from the ~~Operating Room Supervisor~~ OR Medical Director and/or the Medical Staff Office.
- E. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.
- F. Evaluation of the Medical Staff member by the proctor will emphasize concurrent or retrospective chart review and include direct observation of procedural techniques. The Medical Staff member must notify his proctor at the time a procedure is scheduled or planned. If the proctor is not available, the applicant must notify another anesthesiologist. If the procedure must be done as an emergency without proctoring, the proctor must be informed at the earliest appropriate time following the procedure.

IX. DEPARTMENT QUALITY REVIEW AND MANAGEMENT

The Department of Anesthesiology will have a Quality Review Committee (QRC) comprised of no less than four (4) Department members. The committee chairman is the Department's representative to the Medical Quality Peer Review Committee. Committee members are able to succeed themselves. The QRC will meet a minimum of four (4) times per year to review cases in a timely manner.

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A. General Function

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

B. Specific Functions

The QRC is established to:

1. Identify important elements of anesthesia care in all areas in which it is provided;
2. Establish performance monitoring indicators and standards that are related to these elements of care;
3. Select and approve their performance monitoring indicators;
4. Integrate relevant information, as indicated, and review quarterly;
5. Formulate thresholds for evaluation related to performance monitoring indicators.
6. Review and evaluate physician practice when specific thresholds are triggered;
7. Identify areas of concern, opportunities to improve care and safety, and educate Department members based on these reviews;
8. Highlight significant clinical issues and present the specific information regarding quality of care to the appropriate Department member, in accordance with Medical Staff Bylaws;
9. Request Focused Professional Practice Evaluation when/if questions arise regarding a physician's practice;
10. Monitor and review the effectiveness of any intervention and document any change.

C. Other Functions

1. Assist in the reappointment process, through retrospective review of charts;
2. Review any issues related to anesthesia that are forwarded for review by other departments;
3. Assist in the collection, organization, review, and presentation of data related to anesthesia care and safety;
4. Review the cases involving an anesthesia related death.

D. Reports

Minutes are submitted to the ~~Medical Staff QA/PI/PS Committee~~ Medical Quality Peer Review Committee and the MEC.

X. EMERGENCY WEEKEND AND NIGHT CALL

Individuals administering twelve (12) or more anesthesia cases in a year must maintain their active medical staff membership. Active medical staff members shall participate in anesthesia emergency, weekend, and night call as determined by the Department.

Approvals:

Department of Anesthesiology — ~~05/21/2015~~ 1/31/2019

Medical Executive Committee — ~~06/22/2015~~

Governance Committee - ~~07/07/2015~~

Board of Directors — ~~07/30/2015~~

TRI-CITY HOSPITAL DISTRICT

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I. MEMBERSHIP

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

II. FUNCTIONS OF THE DEPARTMENT

The general functions of the Department of Radiology shall include:

- A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Department and develop criteria for use in the evaluation of patient care;
- B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;
- C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Department clinical practice;
- D. Review and evaluate Department member adherence to:
1. Medical Staff policies and procedures;
 2. Sound principles of clinical practice.
- E. Submit written minutes to the Medical Quality Peer Review Committee and Medical Executive Committee concerning:
1. Department review and evaluation activities, actions taken thereon, and the results of such actions; and
 2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.
- F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;
- G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;
- H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);
- I. Approve On-Going Professional Practice Evaluation Indicators; and
- J. Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.
- K. Establish protocols for the supervision of Physician Assistants.

III. DEPARTMENT MEETINGS

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

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

IV. DEPARTMENT OFFICERS

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

TRI-CITY HOSPITAL DISTRICT

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Section: Medical Staff

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

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

V. DUTIES OF THE DEPARTMENT CHAIR

The Department Chair shall assume the following responsibilities:

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

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

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

VII. PRIVILEGES

- A. Request for privileges in the Department of Radiology shall be evaluated on the bases of the member's education, training, experience, demonstrated professional competence and judgement, clinical performance and documented results of patient care and monitoring.
- B. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Department.

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- C. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.
- D. Sites:
 - 1. All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.
 - 2. Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside, CA 92056.

VII. REAPPOINTMENT OF CLINICAL PRIVILEGES

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

VII. PROCTORING OF PRIVILEGES

- A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Department Chair to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.
- B. All Active members of the Department will act as proctors.
- C. Additional cases may be proctored as recommended by the Department Chair. It is the responsibility of the Department Chair to inform the proctored member whose proctoring is being continued whether the deficiencies noted are in: a) preoperative, b) operative, c) surgical technique and/or, d) postoperative care.
- D. Supervision of the member by the proctor will include concurrent review for invasive cases or retrospective chart review of cognitive processes for noninvasive cases and direct observation of procedural techniques. The monitor must be present in the Procedure Room for a sufficient period of time to assure himself/herself of the member's competence.
- E. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).
- F. The member shall have free choice of suitable consultants and assistants. The proctor may assist the member.
- G. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.
- H. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Medical Staff Department.
- I. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Department.

VIII. EMERGENCY DEPARTMENT CALL

Active department members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. The Department Chair will be responsible for maintaining

TRI-CITY HOSPITAL DISTRICT

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adequate coverage of the Emergency Department. Refer to Medical Staff Policy and Procedure 8710-520.

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

APPROVALS:

Department of Radiology:

~~10/17/2017~~ 2/5/2019

Medical Executive Committee:

~~3/26/2018~~

Board of Directors:

~~3/29/2018~~

TRI-CITY HOSPITAL DISTRICT

Rules & Regulations

Section: Medical Staff

Subject: Department of Pathology

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I. MEMBERSHIP

The Department of Pathology consists of only physicians who have a contractual relationship with the existing pathology group and are board certified by the American Board of Pathology, or who are actively progressing towards certification during the first five years of eligibility. Physicians who are actively progressing towards board-certification must attain certification within the first two (2) years of being on staff.

II. FUNCTIONS OF THE DEPARTMENT

The general functions of the Department of Pathology shall include: the provision of comprehensive medical direction of all aspects of the Clinical Laboratory and its branches, and anatomic pathology, clinical pathology, and laboratory medicine services to the patients and physicians of the Tri-City HealthCare District (TCHD).

- A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Department and develop criteria for use in the evaluation of patient care;
- B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;
- C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Department clinical practice;
- D. Review and evaluate Department member adherence to:
 1. Medical Staff policies and procedures;
 2. Sound principles of clinical practice.
- E. Submit written minutes to the QA/PI Medical Quality Peer Review Committee and Medical Executive Committee concerning:
 1. Department review and evaluation activities, actions taken thereon, and the results of such actions; and
 2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.
- F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;
- G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;
- H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);
- I. Approve On-Going Professional Practice Evaluation Indicators; and
- J. Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. DEPARTMENT MEETINGS

The Department of Pathology shall meet as often as necessary to perform quality assessment, at the discretion of the Chair, but at least annually or upon request of two or more department members. The Department will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the QA/PI Medical Quality Peer Review Committee, and then to the Medical Executive Committee.

TRI-CITY HOSPITAL DISTRICT

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

From time to time, other laboratory professionals may be invited to participate in the discussions and deliberations in a non-voting capacity.

IV. DEPARTMENT OFFICERS

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

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

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

V. DUTIES OF THE DEPARTMENT CHAIR

The Department Chair shall assume the following responsibilities:

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

VI. PRIVILEGES

- A. All privileges are accessible on the ~~TCMC TCHD~~ Intranet and a paper copy is maintained in the Medical Staff ~~Office~~Department.
- ~~B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.~~
- C. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.

TRI-CITY HOSPITAL DISTRICT

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- D. Privileges shall consist of the full breadth of anatomic and clinical pathology services, including surgical pathology, cytopathology, and autopsy pathology, as well as all the disciplines of laboratory medicine.
- E. The role of the individual physician with clinical privileges will be:
1. the expert provision of all anatomic and clinical pathology services to patients and physicians of Tri-City HealthCare District;
 2. providing appropriate consultations to members of the Medical Staff on a timely basis;
 3. participating in suitable teaching activities and patient management conferences; and,
 4. contributing to uninterrupted on-call coverage to the District and the Medical Staff.

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Anatomic Pathology	Training	Blend of ten (10) representative cases	Ten (10) cases
Laboratory Medicine (Clinical Pathology)			As attested by the Department Chair or designee.

VII. REAPPOINTMENT OF CLINICAL PRIVILEGES

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

VIII. PROCTORING OF PRIVILEGES

- A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Department Chair to the Credentials Committee and to the Medical Executive Committee, with final approval by the Board of Directors.
- B. All Active members of the Department ~~will~~ may act as proctors and the Department Chair will make proctoring assignments. Additional cases may be proctored as recommended by the Department Chair. It is the responsibility of the Department Chair to inform the monitored member whose proctoring is being continued whether the deficiencies noted are on current clinical competence, practice behavior, or the ability to perform the requested privilege(s).
- ~~C. THE MONITOR MUST BE PRESENT FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE PRACTITIONER'S COMPETENCE.~~

TRI-CITY HOSPITAL DISTRICT

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- D-C. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.
- E-D. A form shall be completed by the proctor, and should include comments on procedural technique, and overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Medical Staff ~~Office~~Department.
- F-E. Forms will be made available to the member.
- G-F. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff ~~Office~~Department.

IX. PERFORMANCE IMPROVEMENT FUNCTIONS

In selecting performance improvement monitoring priorities, high-volume, high-risk, and problem-prone diagnoses and procedures are identified and considered as the foci of more intensive review.

The current primary performance improvement foci for this service include at least the following evaluations, some of which are interdepartmental and/or interdisciplinary in nature. Additional team members are involved in the improvement process as are deemed appropriate to the process(es) being reviewed, evaluated and addressed so the most knowledgeable participants related to the focus are involved in its review and improvement.

The Department will maintain at all times a Quality Improvement Plan, which complies with the requirements of applicable accrediting and licensing agencies.

Performance Measure	Function
• Malignant Diagnosis Retrospective Review	Rec credentialing, Competency/Proficiency, Improving Organizational Performance
• Non-Malignant Diagnosis Retrospective Review	Rec credentialing, Competency/Proficiency, Improving Organizational Performance
• Tissue Review As Determined by the Pathologist	Improving Organizational Performance, Assessment Of Patients, Regulatory Requirement, Education
• Blood Usage Review – Usage Appropriateness, Informed Consent, Utilization, Outcomes	Improving Organizational Performance, Assessment Of Patients, Regulatory Requirement, Education
• Autopsy Review – See criteria below	Regulatory Requirement, Outcomes, Education

X. AUTOPSIES

Autopsies are secured pursuant to the guidelines outlined in the Medical Staff Rules and Regulations, and Patient Care Services Policy "Autopsy, Authorization of", IV.P.4.

XI. AUTOPSY NOTIFICATION GUIDELINES

~~The pathologist shall perform the autopsy in a timely manner. Before beginning an autopsy, the attending physician and pathologist should confer to achieve a maximum~~

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~~interchange of knowledge and to assure optimum results from the clinical history and histological examination. The requesting physician should be present at the autopsy. The pathologist performing the autopsy shall notify the requesting physician when an autopsy is to be performed. As relevant to their educational need, other providers may be requested or permitted to observe the gross examination.~~

APPROVALS:

~~Department of Pathology: 8/19/2015~~ 2/11/2019

~~Medical Executive Committee: 8/24/2015~~

~~Governance Committee: 9/01/2015~~

~~Board of Directors: 9/24/2015~~

Tri-City Medical Center
Delineation of Privileges
 Anesthesiology - (Revised ~~3/17~~1/19)

Provider Name:

Request	Privilege	Action
		MSO Use Only

CRITERIA FOR OBTAINING PRIVILEGES BASIC QUALIFICATIONS: As part of the Department's goal to ensure that its physicians meet high standards of clinical quality, the Department has determined that Board Certification is an important indicator of quality. Therefore, the Department of Anesthesiology consists of physicians who are at all times and remain Board Certified by the American Board of Anesthesiology (ABA), or are a candidate in the ABA examination system, Board Eligible as determined by the American Board of Anesthesiology. Physicians who make an initial application to join the Department after January 1, 2013, must become Board certified within five (5) years of joining the Department. Department members with time-limited certificates must participate in the ABA's Maintenance of Certification in Anesthesiology (MOCA) program in order to maintain their certification. For those members who have non-time limited certificates, the Department recommends participation in the MOCA program.

SITES:

All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.

Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056.

COGNITIVE PRIVILEGES

- Consultation including via telemedicine (F)
- Evaluate and treat patients with anesthesia related problems
- Perform history and physical examination, including via telemedicine (F)

CORE PROCEDURAL PRIVILEGES

- General Anesthesia
 Initial: Training
 Proctoring: Three (3) cases need to be proctored
 Reappointment: ~~Twenty (20)~~en (10) cases required per two year reappointment cycle
- Regional Anesthesia (Epidural, Spinal ~~and nerve block~~)
 Initial: Training
 Proctoring: Two (2) cases need to be proctored
 Reappointment: Five (5) cases required per two year reappointment cycle
- Invasive Monitoring (Includes: Arterial line, Central line, Midline, and Pulmonary Artery catheters)
 Initial: Training
 Reappointment: Five (5) cases required per two year reappointment cycle.

SPECIAL PROCEDURES

- Cardiac Anesthesia
 Initial: Cardiac anesthesia privileges are considered for applicants who fall under one of the following two categories:
 Category 1:
 Successful completion of cardiac anesthesia fellowship OR completion of six-months of focused cardiac anesthesia training during third year of residency OR documentation of current activity managing cardiopulmonary bypass cases.
 Category 2:
 Completion of approved anesthesia residency training program that included three (3) months of cardiac anesthesia with additional proctoring: 1) Five (5) cases will be proctored via direct observation; and 2) Twenty-five (25) prospectively reviewed cases where the plan for anesthesia is discussed with an eligible proctor and the proctor reviews the case retrospectively.
- Transesophageal Echocardiography (TEE)
 Initial:

Tri-City Medical Center
Delineation of Privileges
 Anesthesiology - (Revised ~~3/17/19~~)

Provider Name: _____

Request	Privilege	Action MSO Use Only
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1. Cardiac fellowship training, or
 2. Documentation of recent training program where TEE was part of training, or
 3. Six (6) months Cardiac Anesthesia during residency
- Proctoring: Three (3) cases
 Reappointment: ~~Ten (10)~~Five (5) cases required per two year reappointment cycle

— Coronary sinus catheter placement
 Initial: Successful completion of all privileging criteria for Cardiac Anesthesia (Category 1 or 2) and Transesophageal Echocardiography
 Proctoring: Two (2) cases

— **PAIN MANAGEMENT CORE PRIVILEGES** - Per Medical Staff "Criteria for Pain Management Privileges" Policy 8710-541

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.

Initial Application: See required qualifications for Pain Management privileges. Current certification required for fluoroscopically-guided procedures

Proctoring: Five cases (of core pain management privileges) should be proctored, which should include at least three spinal (thoracic or lumbar) cases; with the exception of cervical cases, which would require an additional three cases be proctored.

Reappointment Criteria: Documentation of twenty (20) cases within the previous two (2) years and ongoing CME in pain management are required to maintain clinical competency.

Admit Patients

Chemo-Denervation (i.e. Stellate Ganglion block, peripheral nerve block, Botox injections, Intra-muscular phenol injections)

Epidural procedures (i.e. Translaminar and transforaminal epidural injections (cervical, thoracic, lumbar), and epidural blood patch)

Joint Injections (i.e. Facets, SI joint)

Sympathetic Blocks

— **PAIN MANAGEMENT SPECIAL PROCEDURES** - Per Medical Staff "Criteria for Pain Management Privileges" Policy 8710-541

Discograms

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

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

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

— Radiofrequency Thermocoagulation Lesion Ablation (RFTC)

Initial Application: See required qualifications for Pain management privileges. Must provide documentation

Tri-City Medical Center
Delineation of Privileges
 Anesthesiology - (Revised 3/17/19)

Provider Name: _____

Request	Privilege	Action MSO Use Only
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of training in "RFTC" in Residency of fellowship, or provide documentation of a hands-on training course in RFTC.

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

Reappointment Criteria: Satisfaction of the reappointment criteria for the Core Procedures will automatically satisfy reappointment criteria for this procedure.

— Intradiscal Electrothermal Annuloplasty —

Initial Application: See required qualifications for Pain management privileges. Must provide documentation of training in Intradiscal Electrothermal Annuloplasty in residency or fellowship, or provide documentation of a hands-on training course in Intradiscal Electrothermal Annuloplasty.

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

Reappointment Criteria: Satisfaction of the reappointment criteria for the Core Procedures will automatically satisfy reappointment criteria for this procedure.

— Implantables (i.e. intrathecal or epidural infusion pumps with tunneled catheter, spinal cord stimulator) —

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

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

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

— Cranial nerve blocks - All types —

Initial Granting: Five cases within two years of Residency

Proctoring: Two (2) cranial nerve blocks – all types

Reappointment: One (1) per year (two per reappointment cycle)

OTHER PRIVILEGES

— Fluoroscopy in accordance with hospital policy (Refer to Medical Staff Policy #528 and 528A) —

 Print Applicant Name

Tri-City Medical Center
Delineation of Privileges
Anesthesiology - (Revised 3/17/19)

Provider Name: _____

Request	Privilege	Action MSO Use Only
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Applicant Signature

Date

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

Date

Tri-City Medical Center
Delineation of Privileges
 Neonatology - (Revised ~~2/17/19~~)

Provider Name:

Request	Privilege	Action
		MSO Use Only

~~CERTIFICATION~~BASIC QUALIFICATIONS: The Division of Neonatology consists of physicians who are board certified in Neonatal-Perinatal Medicine by the American Board of Pediatrics or are 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 Neonatology and must become board-certified within four (4) years of the initial granting of medical staff membership, unless extended for good cause by the Pediatrics Department.

Neonatologists (Pediatric Cardiologists have separate criteria as outlined in the Pediatric Cardiology Procedures section)

Initial: Training and evidence of current NRP certification

Proctoring: Six (6) admissions or consultations

Reappointment: Evidence of current NRP certification

SITES:

All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.

Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056.

- Admit patients
- Consultation, including via telemedicine (F)
- Perform medical history & physical examinations, including via telemedicine (F)
- Attendance at C-Sections and vaginal deliveries, including newborn resuscitation
- Newborn care, Level 2 and Level 3
- **INVASIVE PROCEDURES** - By selecting this privilege, you are requesting the Invasive Procedures privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Invasive Procedures Category Criteria:

Initial Criteria: Evidence of current NRP Certification

Proctoring: Five (5) cases from Invasive Procedures Category

Reappointment: Five (5) Cases from a blend of the privileges listed below and maintain a current NRP Certificate (Successful completion of the six proctoring reports for Invasive Procedures satisfies proctoring requirement for Non-Invasive Procedures, Admissions and Consultations.

Arterial puncture

Central vessel catheterization

Intubation/Thoracentesis/Thoracostomy, Infant

Exchange transfusion of neonates

Interosseous needle insertion

Lumbar puncture

Peripheral arterial catheterization and umbilical catheterization - artery

Tri-City Medical Center
Delineation of Privileges
 Neonatology - (Revised 2/17/19)

Provider Name: _____

Request	Privilege	Action MSO Use Only
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Peripheral I.V. cutdown

Suprapubic aspiration

Umbilical catheterization - vein

— **NON-INVASIVE PROCEDURES** - By selecting this privilege, you are requesting the Non-Invasive Procedures privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want. —

Non-Invasive Procedures Criteria:

Initial Criteria: Evidence of current Neonatal Resuscitation Program (NRP) certification

Proctoring Criteria: Three (3) cases from Non-Invasive Procedures category

Reappointment Criteria: Five (5) cases from a blend of the privileges listed below and maintain a current NRP certificate

Care of ventilated patients

Cardiac defibrillation

Delivery Room newborn resuscitation

Echocardiography

Elective cardioversion

Electrocardiography (EKG/ECG)

Parenteral hyperalimentation

Pericardiocentesis

— **Pediatric Cardiology Procedures** —

By selecting this privilege, you are requesting the Pediatric Cardiology Procedures privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Initial: Successful completion of a fellowship training program in Neonatology or Pediatric Cardiology

Proctoring: Two (2) cases from this category

Reappointment: Ten (10) cases from this category

Cardiac defibrillation

Consultation, Pediatric Cardiology

Echocardiography

Elective cardioversion

Electrocardiography (EKG/ECG)

Pericardiocentesis

OTHER:

— Moderate Sedation (special credentialing required - Refer to Medical Staff policy 8710-517 and evidence of current NRP certification) —

Tri-City Medical Center
Delineation of Privileges
Neonatology - (Revised ~~2/17~~1/19)

Provider Name:

Request	Privilege	Action MSO Use Only
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Print Applicant Name

Applicant Signature

Date

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

Date

Tri-City Medical Center
Delineation of Privileges
 NP - Interventional Radiology - 1/19

Provider Name: _____

Request	Privilege	Action MSO Use Only
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Criteria:

The nurse practitioners must have the following:

1. Valid, California Registered Nurse license;
2. Successful completion of a Board of Registered Nursing approved Nurse Practitioner program;
3. Certification by the State of California, Board of Registered Nursing as a Nurse Practitioner;
4. Successful completion of the Family, Geriatric, or Adult Nurse Practitioner Credentialing examination or equivalent national specialty certification (preferred);
5. If furnishing drugs and devices, the Nurse Practitioner must possess a furnishing license;
6. Nurse Practitioners wishing to furnish Schedule II controlled substances are required to complete a Board of Registered Nursing approved three (3) hour continuing education course as well as possess a current, valid DEA certificate to prescribe Schedule II-V drugs.

The following privileges may be performed by the Nurse Practitioner in accordance with standardized procedures and protocols.

Proctoring: Ten (10) cases (proctoring for Therapeutic Procedures may be used towards fulfilling this general proctoring requirement.)

Reappointment: Satisfactory evaluation by supervising physician.

General Patient Care Privileges:

By selecting this privilege, you are requesting the General Patient Care privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Perform history and physical exam

Furnish drugs consistent with the TCMC Formulary and as outlined in the standardized procedures and protocols.

Furnish Schedule II-V controlled substances per the patient specific protocol and per the standardized procedures and protocols. Physician consultation and approval will be obtained prior to furnishing medication.

General evaluation of health status, including but not limited to ordering laboratory procedures, x-rays, respiratory therapy, rehabilitation therapies (physical therapy, occupational therapy, and speech therapy)

Recommend therapeutic diets and exercise

Provide patient education and counseling

Refer to physician or specialty clinic when the diagnosis and/or treatment are beyond the scope of the nurse's knowledge and/or skills, or for those conditions that require consultation

Therapeutic Procedures: A supervising physician must be physically present in the Radiology Department before therapeutic procedures can be carried out.

By selecting this privilege, you are requesting the Therapeutic Procedures privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Abscess drainage tube manipulation / resuturing

Bone marrow biopsy, image guided

Proctoring: Five (5) cases

Central line insertion: Jugular line insertion

Tri-City Medical Center
Delineation of Privileges
 NP - Interventional Radiology - 1/19

Provider Name: _____

Request	Privilege	Action MSO Use Only
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Proctoring: Three (3) cases
 Central line insertion: PICC line insertion
 Proctoring: Three (3) cases
 Chest tube removal
 Keo feeding tube insertion/Nasogastric tube insertion
 Lumbar puncture
 Proctoring: Three (3) cases
 Paracentesis/Arthrocentesis (i.e. hip injections)/Thoracentesis
 Proctoring: Three (3) cases
 Peripheral IV line insertion
 Removal of drains and tubes
 Removal of tunneled catheter
 Removal of venous port (Mediport)
 Subcutaneous local anesthesia
 Suturing and suture removal

Moderate Sedation: Refer to Medical Staff policy 8710-517

APPLICANT:

I agree to exercise only those services granted to me. I understand that I may perform any functions within Tri-City Medical Center that are not specifically approved by the appropriate Department/Division and the Interdisciplinary Practice Committee.

 Print Applicant Name

 Applicant Signature

 Date

*Note - Applicant is responsible for obtaining Sponsoring Physician's Signature and completion of below:

SPONSORING PHYSICIAN:

As sponsoring physician of this Allied Health Professional, I agree to be held responsible for his/her performance while providing services at Tri-City Medical Center

Tri-City Medical Center
Delineation of Privileges
NP - Interventional Radiology - 1/19

Provider Name:

Request	Privilege	Action MSO Use Only
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Print Name of Sponsoring Physician

Sponsoring Physician Signature

Date

Approval:

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

Date

Provider Name:

Request	Privilege
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BASIC QUALIFICATIONS: The Department of Obstetrics and Gynecology consists of physicians who are board certified or actively progressing towards certification by the American Board of Obstetrics and Gynecology and have successfully completed an ACGME/AOA-accredited residency training program in Obstetrics and Gynecology.

SITES:

Privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.

Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056.

All practitioners who currently hold the privilege to "consult" and/or "perform a history and physical examination" may also perform these privileges via telemedicine

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.

- ☐ Admit Patients
- ☐ Consultation, including via telemedicine (F)
- ☐ Perform history and physical examination (includes pelvic exam and cultures), including via telemedicine (F)

BASIC OBSTETRICS:

Initial Criteria: In order to obtain this privilege bundle, must have completed an accredited residency program and show competency criteria of 12 procedures for the previous two years.

Proctoring Requirements: A minimum of six representative cases must be presented for consideration to the Credentials Committee.

Reappointment Criteria: In order to maintain this privilege bundle, competency criteria of 6 procedures for the past two years is required.

☐ **Procedures:**

LABOR TECHNIQUES

Amnioinfusion, Amniotomy
 Application of Fetal Monitor/Internal
 Application of Uterine Monitor/Internal
 Pudendal Anesthesia
 Induction of Labor

PROCEDURES

Episiotomy and Repair
 Suction Dilation and Curettage
 First Trimester Abortion
 Noninstrumented Vaginal Delivery

Provider Name:

Request	Privilege

 Postpartum
 Dilation and Curettage

ADVANCED OBSTETRICS

Initial Criteria: In order to obtain this privilege bundle, must have completed an accredited residency program and show competency criteria of 12 procedures for the previous two years.

Proctoring Requirements: A minimum of 6 representative cases must be presented for consideration to the Credentials Committee. Successful completion of six proctoring reports for Advanced Obstetrics satisfies observation requirements for Basic Obstetrics.

Advanced Obstetrics bundle qualifies physician for Basic Obstetrics bundle.

Reappointment Criteria: In order to maintain this privilege bundle, competency criteria of 6 procedures for the past two years is required.

Procedures:

Conization in Pregnancy
 Ovarian Cystectomy in Preg.
 Appendectomy in Pregnancy
 Postpartum Hysterectomy
 Postpartum Exploratory Laparotomy
 Postpartum Abdomen Tubal
 Operative Vaginal Deliveries
 C-Section: Emergency & Elective
 C-Section: Subtotal Hysterectomy
 C-Section: Total Hysterectomy
 Paracervical Anesthesia
 Mgmt. Shoulder Dystocia
 Repair 3-4 Degree Laceration
 Manual Removal of Placenta
 Second Trimester Medical Termination of Pregnancy
 Excision Vulvar/Vaginal Lesions During Pregnancy
 Cervical Ripening
 Repair Cervical/Vaginal Laceration
 Vaginal Breech Delivery
 Cerclage
 Evacuation of Hematoma
 Uterine Inversion
 Uterine Packing
 External Version
 Maturity Amniocentesis
 Twin Vaginal Delivery
 Hypogastric Artery Ligation
 Level I Ultrasound/Interpretation

BASIC GYNECOLOGY/ENDOSCOPY:

Provider Name:

Request	Privilege

Initial Criteria: In order to obtain this privilege bundle, must have completed an accredited residency program and show competency criteria of 12 procedures for the previous two years.

Proctoring Requirements: A minimum of 6 representative cases (3 Vaginal and 3 Endoscopy procedures) must be presented for consideration to the Credentials Committee.

Reappointment Criteria: In order to maintain this privilege bundle, competency criteria of 6 procedures for the past two years is required, OR meet the criteria to be granted Advanced Gynecology privileges.

Basic Procedures:

Culdocentesis
 Marsupialization: Bartholin cyst
 Dilation and curettage
 Diagnostic Hysteroscopy

Vulvovaginal Procedures:

Colpotomy
 Hymenotomy
 Conization of cervix
 Excision: Bartholin cyst
 Ablation or Destruction of Condyloma

Basic Endoscopy Procedures:

Cystourethroscopy
 Aspiration of ovarian cysts
 Fulguration of implants
 Diagnostic Laparoscopy
 Lysis of adhesions
 Laparoscopic Tubal Sterilization
 Ovarian/Peritoneal Tissue Bx.
 Laparoscopic Oophorectomy/Salpingectomy/Tubovarian Surgery
 Laparoscopic Ovarian Cystectomy
 Operative Hysteroscopy (incl. all hysteroscopic procedures i.e., myomectomy/polypectomy, etc.)
 Hysteroscopy Endometrial Ablation

ADVANCED GYNECOLOGY:

Initial Criteria: In order to obtain this privilege bundle, must have completed an accredited residency program and show competency criteria of 12 procedures for the previous two years.

Proctoring Requirements: A minimum of 6 representative cases must be presented for consideration to the Credentials Committee. Successful completion of six proctoring reports for Advanced Gynecology satisfies observation requirements for Basic Gynecology.

Reappointment Criteria: In order to maintain this privilege bundle, competency criteria of 6 procedures for the past two years is required.

Provider Name:

Request	Privilege
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Procedures:
ADVANCED VAGINAL PROCEDURES

Closure: cervicovaginal fistula
 Vaginal repair: cystocele
 Closure: rectovaginal fistula
 Vaginal repair: enterocele
 Closure vesicovaginal fistula
 Vaginal repair: rectocele
 Closure urethrovaginal fistula
 Vesical neck suspension
 Colpocleisis (JeForte procedure)
 Vaginal urethral suspension (Stamey, Pereyra)
 Drainage of pelvic abscess
 Vaginal Hysterectomy Transvaginal Suburethral Sling Procedure (TVT)
 Transobturator Suburethral Sling Procedure (TOT)
 Paravaginal Repairs (open and laparoscopic)

VULVOVAGINAL PROCEDURES

Simple vulvectomy
 Skinning vulvectomy

ABDOMINAL PROCEDURES

Appendectomy
 Repair rent in urinary bladder
 Hypogastric artery ligation
 Hysterectomy: Subtotal Abdominal
 Hysterectomy: Total Abdominal Hysterotomy
 Repair small bowel laceration
 Repair large bowel laceration
 Minilaparotomy tubal sterilization
 Myomectomy
 Retropubic urethropexy
 Metroplasty
 Salpingectomy
 Microtuboplasty
 Salpingostomy
 Ovarian surgery, cystectomy, wedge resection, oophorectomy
 Umbilical hernia repair
 Uterine suspension
 Presacral neurectomy
 Plastic repair, Fallopian tubes
 Panniculectomy

ADVANCED ENDOSCOPY:

Initial Criteria: In order to obtain this privilege bundle, must have completed an accredited residency program and show competency criteria of 12 procedures for the previous two years.

Provider Name:

Request	Privilege
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Proctoring Requirements: A mix of 6 representative cases must be presented for consideration to the Credentials Committee. (At least 4 of these must be as the primary surgeon; and 2 can be as the assistant surgeon.) Successful completion of six proctoring reports for Advanced Endoscopy satisfies observation requirements for Basic Endoscopy.

Reappointment Criteria: In order to maintain this privilege bundle, competency criteria of 6 procedures for the past two years is required. (At least 4 of these must be as the primary surgeon; and 2 can be as the assistant surgeon.)

Procedures:

Laparoscopic Pelvic Lymphadenectomy
 Laparoscopic Myomectomy
 Laparoscopic Retropubic Urethropexy
 Laparoscopic Correct Vaginal Floor Defects
 Laparoscopic Assisted Vaginal Hysterectomy
 Laparoscopic Vaginal Vault Suspension
 Laparoscopic Hysterectomy
 Laparoscopic Cerclage

URO-GYNECOLOGY:

Initial Criteria: To obtain this privilege bundle, must have completed an accredited Uro-Gynecology fellowship program or submit documentation of training/experience for a specific procedure. In addition must show competency criteria of 12 procedures for the previous two years. (At least 6 of these must be as the primary surgeon; and 6 can be as the assistant surgeon.)

Proctoring Requirements: 6 cases (At least 4 of these must be as the primary surgeon; and 2 can be as the assistant surgeon.)

Uro-Gynecology privilege bundle qualifies the physician for Basic Gynecology and Advanced Gynecology bundles.

Reappointment Criteria: To maintain this privilege bundle, competency criteria of 6 procedures for the past two years is required. (At least 4 of these must be as the primary surgeon; and 2 can be as the assistant surgeon.)

Procedures:

Abdominal Vesicovaginal fistula repair
 Cystotomy and Repair
 Cystoscopy -- Ureteral stenting
 Excision Urethral Caruncle
 Non-Burch Type Urethropexies (Example: Capiro CL Device)
 Paravaginal Repairs (open and laparoscopic)
 Pubovaginal sling w/autologous, cadaveric or synthetic material
 Retro-Rectal Analplasty
 Sacral Nerve Stimulation w/Interstim System
 Transvaginal Suburethral Sling Procedure (TVT)
 Suprapubic Catheter, open or closed
 Urethral Meatoplasty
 Urethral Diverticulum Excision, Marsupialization

Provider Name:

Request	Privilege
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URO-GYNECOLOGY SPECIAL PROCEDURES

Initial Criteria: To obtain this privilege bundle, must be Board Certified/Admissible in Obstetrics/Gynecology; must have completed an accredited Fellowship program or submit documentation of training/experience for a specific procedure, with competency criteria of 6 procedures for the previous two years. (At least 3 of these must be as the primary surgeon; and 3 may be as the assistant surgeon.)

Proctoring Requirements: 4 cases

Reappointment: To maintain this privilege bundle, competency criteria of 4 procedures (At least 2 of these must be as the primary surgeon; and 2 may be as the assistant surgeon.) over the previous two years is required.

- ___ Abdominal Sacrocolpopexy
- ___ Laparoscopic Sacral Colpopexy
- ___ InterStimTherapy (Requires a training certificate)
- ___ Use of C-Arm (Requires current fluoroscopy certificate)

GYN ONCOLOGY:

Initial Criteria: Must have successfully completed an ACGME/AOA accredited Gyn/Oncology fellowship program and must be ABOG/AOBOG certified or admissible. Must provide documentation of 10 cases, representing a mix of procedures in the past two years.

Proctoring Requirements: A mix of 6 representative cases (At least 4 of these must be as the primary surgeon; and 2 can be as the assistant surgeon.) Successful completion of six proctoring reports for Gyn/Oncology satisfies observation requirements for this bundle as well as Basic and Advanced Gynecology.

Reappointment Criteria: Documentation of a mix of six cases for the past two years.

 ___ **Procedures:**

Colostomy
 Radical Vulvectomy with or without Lymph Node Resection
 Exenteration: Anterior
 Exenteration: Posterior
 Exenteration: Total
 Ureteral Reanastomosis
 Ureteral Reimplantation
 Urethral Diverticulum Excision & Marsupialization
 Ileal Conduit
 Indiana Pouch
 Interstitial Implant
 Radical Abdominal Hysterectomy with or without Lymph Node Resection
 Sigmoidoscopy

Provider Name:

Request	Privilege
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Vaginal Reconstruction (Absent Vagina)
 Conization in Pregnancy
 Ovarian Cystectomy in Pregnancy
 Central Venous Catheter Placement
 Appendectomy in Pregnancy

BASIC REPRODUCTIVE ENDOCRINOLOGY/INFERTILITY PRIVILEGES:

Initial Criteria: Must have successfully completed an ACGME/AOA accredited reproductive endocrinology/infertility fellowship program and must be ABOG/AOBOG certified or admissible. Must provide documentation of 12 procedures for the previous two years.

Proctoring Requirements: 4 cases

Reappointment Criteria: 4 cases for the past two years is required.

Procedures:

Dilation and Curettage
 Diagnostic Hysteroscopy
 Aspiration of Ovarian Cysts
 Fulguration of Implants
 Diagnostic Laparoscopy
 Lysis of Adhesions
 Laparoscopic Tubal Sterilization
 Ovarian/Peritoneal Tissue Biopsy
 Laparoscopic Oophorectomy/Salpingectomy/Tubovarian Surgery Basic Endoscopy Procedures
 Laparoscopic Ovarian Cystectomy
 Operative Hysteroscopy (incl. all hysteroscopic procedures i.e., myomectomy/polypectomy, etc)
 Hysteroscopy Endometrial Ablation

ADVANCED REPRODUCTIVE ENDOCRINOLOGY/INFERTILITY PRIVILEGES:

Initial Criteria: Must have successfully completed an ACGME/AOA accredited reproductive endocrinology/infertility fellowship program and must be ABOG/AOBOG certified or admissible. Must provide documentation of 12 procedures for the previous two years. Advanced REI bundle qualifies physician for Basic REI bundle.

Proctoring Requirements: A mix of 6 cases. Removal from proctoring for Advanced REI bundle qualifies physician removal from proctoring for Basic REI bundle.

Reappointment Criteria: A mix of 6 cases for the past two years is required.

Procedures:

Abdominal Myomectomy
 Abdominal Metroplasty
 Abdominal Salpingectomy
 Abdominal Microtuboplasty

Provider Name:

Request	Privilege
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Abdominal Salpingostomy
 Abdominal Ovarian Surgery, Cystectomy, Wedge Resection, Oophorectomy
 Abdominal Plastic Repair, Fallopian Tubes
 Laparoscopic Myomectomy

OTHER:

_____ Moderate Sedation - Refer to Medical Staff policy 8710-517 for Initial, Proctoring, and Reappointment credentialing criteria.

INTRA-ABDOMINAL LASER SURGERY:
Initial:

1. Documentation of completion of laser training for each wavelength requested
2. Documentation of clinical experience with specialized laser surgery or hands-on laboratory experience for each wavelength requested

Proctoring: One (1) case per wavelength

Reappointment: One (1) case per wavelength

_____ CO2 Laser

_____ Nd Yag Laser

Robotic Surgery Bundle (da Vinci) (Refer to Credentialing Policy, Robotic Assisted Surgery #8710-563 for Initial, Proctoring, and Reappointment criteria)

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.

_____ Robotic surgery (da Vinci) - Multiple Port

_____ Robotic surgery (da Vinci) - Single Port

_____ Xi Robotic Privileges

Initial Criteria: Must meet initial and reappointment for Core Robotic assisted privileges and provide certificate of training for Xi Robotic from Intuitive prior to case

Proctoring: Must meet proctoring criteria for Da Vinci Robotic Surgery

_____ Assist in robotic surgery (da Vinci)

_____ Assist in Xi Robotic

Initial Criteria: Must meet initial and reappointment for Core Robotic assisted privileges and provide certificate of training for Xi Robotic from Intuitive prior to case

Proctoring: Must meet proctoring criteria for Assisting in Da Vinci Robotic Surgery

Provider Name:

Request	Privilege

Print Applicant Name_____
Applicant Signature_____
Date_____
Division/Department Signature (By Signing this form I agree with the granting of these privileges indicated above.)_____
Date

Tri-City Medical Center
Delineation of Privileges
 Orthopaedic Surgery ~~4/131/19~~

Provider Name:

Request	Privilege
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~~**CRITERIA FOR OBTAINING PRIVILEGES**~~**BASIC QUALIFICATIONS:** Must be Board Certified within the first 36 months of Board Eligibility, actively pursuing certification by the American Board of Orthopedic Surgery, or able to demonstrate comparable ability, training and experience. Documentation of training must be provided for additional privileges requested and proctoring of the additional privileges will apply as stated under each privilege.

SITES:

All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.
 Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056.
 All practitioners who currently hold the privilege to "consult" and/or "perform a history and physical examination" may also perform these privileges via telemedicine.

- ☐ Admit Patients
- ☐ Consultation, including via telemedicine (F)
- ☐ Perform History & Physical Exam, including via telemedicine (F)

BASIC ORTHOPEDIC PRIVILEGES:
Initial Criteria: See Basic Qualifications

- ☐ Repair Lacerations (F)
- ☐ Foreign Body Removal (F)
- ☐ Manipulation Joints
- ☐ Tendon Surgery
- ☐ Biopsy (Bone / Soft Tissue)
- ☐ Soft Tissue Management (Debridement) (F)
- ☐ Peripheral Nerve Surgery
- ☐ Skin Grafts
- ☐ Chymopapain

ADVANCED ORTHOPEDIC PRIVILEGES
For Initial, Reappointment and Proctoring criteria see above privilege requested.

Initial: Prerequisite would include evidence of training in residency and/or fellowship of arthroscopic experience, documented by Director of Program and/or documented past case experience, including operative reports and/or documentation of continuing education course in arthroscopic surgery including motor skill which is approved for CME Credit and 20 cases submitted from the last 12 months.

Proctoring: Two (2) cases

Reappointment: Four (4) cases per two year reappointment cycle

- ☐ Arthroscopy Surgery for Knee, Shoulder, Elbow, Hand, Ankle, Wrist & Hip Joints
Initial: Prerequisite would include evidence of training in residency and/or fellowship of arthroscopic experience, documented by Director of Program and/or documented past case experience, including operative reports and/or documentation of continuing education course in arthroscopic surgery including motor skill which is approved for CME Credit and 20 cases submitted from the last 12 months.

Tri-City Medical Center
Delineation of Privileges
 Orthopaedic Surgery 4/131/19

Provider Name:

Request	Privilege
	<p>Proctoring: Two (2) cases Reappointment: Four (4) cases per two year reappointment cycle</p>
==	-Tendon Surgery
==	-Biopsy (Bone / Soft Tissue)
==	-Soft Tissue Management (Debridement) (F)
==	<p>-Arthrodesis of Extremities Initial: Criteria as stated above Proctoring: (2) cases must be proctored Reappointment: (4) cases are required per every two year reappointment cycle</p>
	<p>Initial: Criteria as stated above Proctoring: (2) cases must be proctored Reappointment: (4) cases are required per every two year reappointment cycle</p>
—	<p>-Ligament Reconstruction Initial: Criteria as stated above Proctoring: (2) cases must be proctored Reappointment: (4) cases are required per every two year reappointment cycle</p>
	<p>Initial: Criteria as stated above Proctoring: (2) cases must be proctored Reappointment: (4) cases of a compilation of bone grafting and/or arthrodesis of extremities are required per every two year reappointment cycle</p>
—	-Bone Grafting
—	<p>-Arthrodesis of Extremities Initial: Criteria as stated above Proctoring: (2) cases must be proctored Reappointment: (4) cases are required per every two year reappointment cycle</p>
	<p>Initial: Criteria as stated above Proctoring: (2) cases must be proctored Reappointment: (4) cases are required per every two year reappointment cycle</p>
—	<p>-Osteotomy Initial: Criteria as stated above Proctoring: (2) cases must be proctored Reappointment: (4) cases are required per every two year reappointment cycle</p>
==	-Peripheral Nerve Surgery
==	-Skin Grafts
==	-Chymopapain
	<p>EXTREMITY FRACTURES: Initial: Criteria as stated above Reappointment: A total of (4) procedures from this category are required for recredentialing of the entire category of procedures.</p>
—	Internal Fracture Fixation (includes joint hemiarthroplasty for fracture repair)

Tri-City Medical Center
Delineation of Privileges
 Orthopaedic Surgery ~~4/131/19~~

Provider Name:

Request	Privilege
<input type="checkbox"/>	External Fracture Fixation (includes joint hemiarthroplasty for fracture repair)
<input type="checkbox"/>	Fracture Treatment of hand (Required for Ortho-ED Call participants)
<input type="checkbox"/>	Pelvic Fracture Care (Open / Closed)
<input type="checkbox"/>	EXTREMITY DISLOCATION: Initial: Criteria as stated above
<input type="checkbox"/>	Internal Fixation, Dislocation
<input type="checkbox"/>	External Fixation, Dislocation
<input type="checkbox"/>	AMPUTATIONS: Initial: Initial criteria as stated above and (5) cases within the last 12-24 months or a list from Residency program.
<input type="checkbox"/>	Elective amputation
<input type="checkbox"/>	Traumatic amputation
<input type="checkbox"/>	TOTAL JOINT ARTHROPLASTY Initial: Initial criteria as stated above and (10) cases within the last 12-24 months or a list from Residency program. Proctoring: (2) cases from each type of arthroplasty this category need to be proctored Reappointment: A total of (4) procedures from this category are required for recredentialing of the entire category of procedures.
<input type="checkbox"/>	Ankle, Arthroplasty
<input type="checkbox"/>	Hip, Arthroplasty
<input type="checkbox"/>	Knee, Arthroplasty
<input type="checkbox"/>	Shoulder, Arthroplasty
<input type="checkbox"/>	Wrist, Arthroplasty
<input type="checkbox"/>	BLUE BELT NAVIO PFS (BBN) GUIDED KNEE ARTHROPLASTY Criteria: BBN Primary Surgeon Initial: The surgeon must be currently privileged to perform underlying procedure without BBN guidance, <u>AND</u> have <u>one</u> of the following: a. Documentation of training in residency/fellowship and log of ten (10) cases; OR b. Certificate of completion of BBN or comparable hands-on training program and documentation of ten (10) cases beyond proctoring from another institution; OR c. Certificate of completion of BBN or comparable hands-on training program. Proctoring: a. & b. One (1) case concurrently proctored by a BBN credentialed/experienced/faculty physician c. Three (3) cases concurrently proctored by a BBN credentialed/experienced/faculty physician Reappointment: Four (4) cases per two-year reappointment cycle BBN Assistant Initial: <u>One</u> of the following: a. Currently privileged to perform BBN-guided knee arthroplasty; OR b. Currently privileged to assist in surgery <u>AND</u> documentation of completion of BBN or comparable hands-on training program. Proctoring: One (1) case concurrently proctored by a BBN credentialed/experienced/faculty physician. If the assistant is privileged to perform BBN-guided knee arthroplasty and has been released from proctoring in the surgeon role, no additional proctoring is required in the assistant role.

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Delineation of Privileges
 Orthopaedic Surgery ~~4/131/19~~

Provider Name:

Request	Privilege
	Reappointment: Four (4) cases per two-year reappointment cycle
—	Blue Belt Navio PFS (BBN) guided knee arthroplasty
—	Assist in Blue Belt NavioPFS (BBN) guided knee arthroplasty
—	-MINOR TOTAL JOINT ARTHROPLASTY Initial: Criteria as stated above Proctoring: (2) cases from each type of arthroplasty need to be proctored Reappointment: A total of (4) procedures from this category are required for recredentialing of the entire category of procedures.
—	Fingers, Arthroplasty
—	Toes, Arthroplasty
—	-HAND SURGERY: Initial: Initial criteria as stated above and (10) cases within the last 12 months or a list from Residency program. Proctoring: (2) cases from this category need to be proctored Reappointment: A total of (4) procedures from this category are required for recredentialing of the entire category of procedures.
—	Microvascular Replantation (Hand)
—	Microvascular / Tissue Transfer (Hand)
—	Nerve Repair of hand (Required for Ortho-ED Call participants)
—	Tendon Repair (flexor & extensor tendon repair hand) (Required for Ortho-ED Call participants)
—	Vascular lesion repair of extremities (Hand)
—	Vein graft to vascular lesion in extremities (Hand)
—	-SPINE: Initial: Initial criteria as stated above and (10) cases within the last 12-24 months or a list from Residency program. Proctoring: (2) cases from this category need to be proctored Reappointment: A total of (4) procedures from this category are required for recredentialing of the entire category of procedures.
—	Cervical Discectomy
—	Implantables (i.e. spinal cord stimulator)
—	Laminectomy
—	Pedicle Screw
—	Percutaneous and subcutaneous implantation of neurostimulator electrodes and pulse generator
—	Plating
—	Spinal Fixation
—	-SPINAL ARTHRODESIS: Initial: Initial criteria as stated above Proctoring: (2) cases from this category need to be proctored Reappointment: A total of (4) procedures from this category are required for recredentialing of the entire category of

Tri-City Medical Center
Delineation of Privileges
 Orthopaedic Surgery 4/13/19

Provider Name:

Request	Privilege
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	procedures.
—	Cervical, Spinal Arthrodesis
—	Lumbar, Spinal Arthrodesis
—	Thoracic, Spinal Arthrodesis
—	-FRACTURE TREATMENT OF THE SPINE: Initial: Initial criteria as stated above
—	Open Fracture Treatment of the Spine
—	Closed Fracture Treatment of the Spine
—	-CERVICAL FRACTURE TREATMENT: Initial: Initial criteria as stated above
—	Open Cervical Fracture Treatment
—	Closed Cervical Fracture Treatment
—	-MAZOR ROBOTIC SURGERY:
—	Mazor robotic surgery - Refer to Credentialing Policy, Mazor Robotic Surgery #8710-566
—	Assist in Mazor robotic surgery - Refer to Credentialing Policy, Mazor Robotic Surgery #8710-566
—	-OTHER:
—	<p>Initial: 1. MD or DO 2. Complete ACGME/AOA accredited residency program and board certified/eligible in Orthopedic Surgery, Neurosurgery, Neuroradiology, or Radiology AND one of the following: a. Fellowship training in Spine Surgery or Interventional Radiology or; b. Current Competence in spine surgery or interventional spine procedures (10 cases in past two years without significant complications) 3. Valid Fluoroscopy Supervisor and Operator permit. 4. Completed training in vertebral augmentation. Evidence of training may be provided via either a certificate of completion from the applicant's vertebral augmentation training program or letter of reference from the director/chief of spine surgery or interventional radiology where applicant currently or most recently has practiced.</p> <p>Proctoring: Five (5) cases performed during the first twenty-four (24) months after granting of the privilege by a member of the medical staff with unsupervised vertebral augmentation privileges.</p> <p>Reappointment: Ten (10) vertebral augmentation procedures performed during the reappointment cycle with acceptable success and complication rates.</p>
—	-Vertebral Augmentation (Policy #534)
—	<p>Initial: 1. MD or DO 2. Complete ACGME/AOA accredited residency program and board certified/eligible in Orthopedic Surgery, Neurosurgery, Neuroradiology, or Radiology AND one of the following:</p>

Tri-City Medical Center
Delineation of Privileges
 Orthopaedic Surgery 4/131/19

Provider Name:

Request	Privilege
	<p>a. Fellowship training in Spine Surgery or Interventional Radiology or; b. Current Competence in spine surgery or interventional spine procedures (10 cases in past two years without significant complications) 3. Valid Fluoroscopy Supervisor and Operator permit. 4. Completed training in vertebral augmentation. Evidence of training may be provided via either a certificate of completion from the applicant's vertebral augmentation training program or letter of reference from the director/chief of spine surgery or interventional radiology where applicant currently or most recently has practiced.</p> <p>Proctoring: Five (5) cases performed during the first twelve (12) months after granting of the privilege by a member of the medical staff with unsupervised vertebral augmentation privileges.</p> <p>Reappointment: Ten (10) vertebral augmentation procedures performed during the reappointment cycle with acceptable success and complication rates.</p>
—	Moderate Sedation - Refer to Medical Staff policy 8710-517
—	Fluoroscopy in accordance with hospital policy (Refer to Medical Staff Policy #528 and 528A)
==	<p>-LASER PRIVILEGES: Physicians applying for privileges to use the laser in surgery must submit:</p> <p>*Copy of certificate of completion of course specific to type of laser and copy of course outline required.</p> <p>*The American Society for Laser Medicine and Surgery (ASLMS) recommends: 1.) The physician have interventional privileges in their specialty before (or in conjunction with) requesting laser privileges. 2.) Training in respective Residency Program (competency verified by Program Director) or completion of an appropriate course, eight to ten hours in length ("40% of the course time allocated to practical sessions"). Longer courses / additional practical sessions may be indicated for different wavelengths, different applications, or delivery instruments.</p>
==	<p>-CO2 Laser Initial: Copy of certificate of completion of course specific to type of laser and copy of course outline required. Proctoring: (1) case must be proctored Reappointment: (2) cases required per every two year reappointment cycle.</p>
==	<p>-Argon Initial: Copy of certificate of completion of course specific to type of laser and copy of course outline required. Proctoring: (1) case must be proctored Reappointment: (2) cases required per every two year reappointment cycle.</p>
==	<p>-KTP Initial: Copy of certificate of completion of course specific to type of laser and copy of course outline required. Proctoring: (1) case must be proctored Reappointment: (2) cases required per every two year reappointment cycle.</p>
	-Forensic Site Specific Privileges
==	-Implant removal, small (i.e. K-wires) (F)
==	-Injections into joints or tendon sheaths (F)

Tri-City Medical Center
Delineation of Privileges
Orthopaedic Surgery ~~4/13~~1/19

Provider Name: _____

Request	Privilege
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==	-Aspiration of joints (F)
==	-Minor I&D abscess or hematoma (F)
==	-Closed reduction of fractures using local anesthesia (F)
==	-Casting and splinting (F)

Print Applicant Name

Applicant Signature

Date

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

Date

Tri-City Medical Center
Delineation of Privileges
 Pathology 6/072/19

Provider Name:

Request	Privilege	Action
		MSO Use Only

~~CERTIFICATION~~ **BASIC QUALIFICATIONS:** Only physicians who are certified by the American Board of Pathology, or who are recently Board-eligible, may be members of the Division, except in the circumstance of special skills or other attributes offered by a candidate that are necessary for the proper functioning of the Division. Physicians who are Board-eligible must attain certification within two years, unless this requirement is waived by the Division. All pathologists applying for Medical Staff membership or practicing in the Division must have a contractual relationship with the existing pathology group at that time.

GRANTING OF PRIVILEGES: Specific clinical privileges will be recommended for an applicant by the Pathology Division only upon providing, in the opinion of the Division, satisfactory evidence of appropriate training and / or experience. The awarding and continued exercise of such privileges shall be based upon the scope and currency of training and experience, demonstrated competence and sound professional judgement. Such recommendations shall be made to the Medical Executive Committee and the Governing Body of the District.

Initial Criteria: Must provide proof of training for privileges requested

Proctoring: 15 cases based on privileges requested

Reappointment: 5 Cases required per every two year cycle

— Surgical Pathology, Cytopathology

~~Initial: Training~~

~~Proctoring: (15) cases must be proctored~~

~~Reappointment: (5) cases required per every two year reappointment cycle~~

== ~~Cytopathology~~

~~Initial: Training~~

~~Proctoring: (10) cases need to be proctored~~

~~Reappointment: (3) cases needed per every two year reappointment cycle~~

== ~~Postmortem Examination~~

~~Initial: Training~~

~~Proctoring: (1) case needs to be proctored~~

~~Reappointment: N/A~~

== ~~Fine Needle Aspiration Interpretation~~

~~Initial: Training~~

~~Proctoring: (2) cases need to be proctored~~

~~Reappointment: N/A~~

— Hematopathology

— Serology

— Immunopathology

— Hematology

— Venipuncture

== ~~Arterial Puncture~~

— Clinical Chemistry

— Clinical Microbiology

— Immunohematology

— Bone Marrow Interpretation

Tri-City Medical Center
Delineation of Privileges
Pathology ~~6/072/19~~

Provider Name:

Request	Privilege	Action
		MSO Use Only

~~==~~ ~~Apheresis~~
— Skin Testing

Print Applicant Name

Applicant Signature

Date

Division/Department Signature

Date

Tri-City Medical Center
Delineation of Privileges
 Pediatrics - (Revised 8/17/19)

Provider Name: _____

Request	Privilege	Action MSO Use Only
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CERTIFICATION BASIC QUALIFICATIONS: The Department of Pediatrics consists of physicians who are board certified by the American Board of Pediatrics or are board-eligible, having completed an ACGME approved residency in Pediatrics, and who are actively progressing towards certification.

Pediatricians who admit and care for neonates in the Neonatal Intensive Care Unit (NICU) must be members of the Division of Neonatology.

SITES:

All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.

Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056.

Level 1 and Level 2 Newborn Criteria:

Initial: Training and evidence of current NRP/NALS or PALS certification

Proctoring: Six (6) cases (Any combination of proctoring from Admit patients, Consultation, Newborn Care, or H&P)

Reappointment: Evidence of current NRP/NALS or PALS certification

— Newborn care, Level 1 and Level 2

— Admit patients, Level 1 and Level 2 newborns

— Perform medical history and physical examination (newborn), including via telemedicine (F)

— Consultation, including via telemedicine (F)

— Refer and follow

Physicians with this privilege may refer patients to the hospital and follow their progress, but an attending physician would provide necessary care. This privilege will allow the physician to visit patients, read records, and refer patients to specialists. SELECTION OF THIS PRIVILEGE IS EXCLUSIVE. NO OTHER PRIVILEGES MAY BE REQUESTED IN CONJUNCTION WITH THE REFER AND FOLLOW PRIVILEGE. *REFER AND FOLLOW IS NOT A CLINICAL PRIVILEGE*

— **PEDIATRIC CARDIOLOGY PRIVILEGE CATEGORY** - By selecting this privilege, you are requesting the Pediatric Cardiology privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Pediatric Cardiology Procedures Criteria:

Initial: Successful completion of a residency in Pediatrics and a fellowship training program in Neonatology or Pediatric Cardiology

Proctoring: Two (2) cases from this category

Reappointment: Ten (10) cases from this category per two-year reappointment cycle

Cardiac defibrillation, to include neonates

Consultation, Pediatric Cardiology, to include neonates

Echocardiography, to include neonates

Elective cardioversion, to include neonates

Electrocardiography (EKG/ECG), to include neonates

Pericardiocentesis, to include neonates

— **PEDIATRIC SURGERY PRIVILEGE CATEGORY** - By selecting this privilege, you are requesting the Pediatric Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Tri-City Medical Center
Delineation of Privileges
Pediatrics - (Revised 8/17/19)

Provider Name: _____

Request	Privilege	Action
		MSO Use Only

Pediatric Surgery Privilege Criteria:

Initial: Board certified by the American Board of Surgery in Pediatric Surgery

Proctoring: One (1) cases from this category

Reappointment: Evidence demonstrating activity performing pediatric surgery at another healthcare facility

Consultation, Pediatric Surgery, to include neonates

____ Moderate Sedation _____

Moderate Sedation Criteria:

Initial and Reappointment - Refer to Medical Staff policy 8710-517 and evidence of current NRP/NALS certification

Print Applicant Name

Applicant Signature

Date

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

Date

Tri-City Medical Center
Delineation of Privileges
 Radiology - (Revised ~~11/14~~1/19)

Provider Name:

Request	Privilege	Action MSO Use Only
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~~CRITERIA~~ BASIC QUALIFICATIONS:

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

SITES:

All privileges may be performed at:

- 4002 Vista Way, Oceanside, CA
- 2095 W. Vista Way, Suite 111, Vista
- 2095 W. Vista Way, Suite 101, Vista

Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056.

- ___ Admit Patients
- ___ Consultation, including via telemedicine (F)
- ___ History and physical examination, including via telemedicine (F)
- ___ Proctoring: Six (6) cases

General Diagnostic Radiology and Fluoroscopy (All Diagnostic Radiologists may remotely interpret (teleradiology) diagnostic images.) - 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.

Initial - Board certification or board eligible and actively progressing towards certification

Proctoring - Twenty-five (25) representative blend of cases

Reappointment - Fifty (50) representative blend of cases

- Arthrography/Arthrocentesis/Injection
- Breast biopsy
- Computed tomography
- General diagnostic/fluoroscopy
- Hysterosalpingography
- Lymphocintigraphy
- Magnetic resonance imaging/spectroscopy
- Mammography
- Nuclear medicine (all routine)
- Positron Emission Tomography (PET)
- Radionuclide cysternography and shunt studies

Tri-City Medical Center
Delineation of Privileges
 Radiology - (Revised ~~11/14~~1/19)

Provider Name: _____

Request	Privilege	Action MSO Use Only
	Sialography	
	Ultrasonography/hysterosonography	
	Vascular duplex ultrasound	
	Venography	
	Lumbar or C1-2 puncture/myelography	
—	Special Nuclear Medicine Procedures:	
	Initial - Board certification or board eligible and actively progressing towards certification	—
	Proctoring - Three (3) representative blend of cases	
	Reappointment - Five (5) representative blend of cases	
—	I-131 Therapy for thyroid cancer or for hyperthyroidism	—
—	Radionuclide therapy low dose < 33 mCi	—
—	Radionuclide therapy high dose > 33 mCi	—
—	P-32 Intravenous or intracavitary	—
—	Immune imaging (Zevalin, etc.)	—
—	Teleradiology (for Stat-Rad only; all non-Stat-Rad practitioners use General Diagnostic Radiology and Fluoroscopy privileges.) - 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.	—
	Initial - Twenty-five (25) cases General Radiology and ten (10) ultrasound, ten (10) tomography, ten (10) MRI, and ten (10) nuclear medicine.	
	Proctoring - Twenty-five (25) representative blend of cases	
	Reappointment - Fifty (50) representative blend of cases	
	Computed tomography	
	General radiology	
	General nuclear medicine	
	Magnetic resonance imaging	
	Ultrasound	
—	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 privilege(s) you do not want.	—
	Carotid	
	Cerebral	
	Extremity	

Tri-City Medical Center
Delineation of Privileges
 Radiology - (Revised ~~11/14~~1/19)

Provider Name: _____

Request	Privilege	Action
		MSO Use Only

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

Chemoembolization

Drug infusion

Embolization

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)

Transjugular Intrahepatic Portosystemic Shunt (TIPS)

Venous Access Procedures (Ports, Tunneled Lines, Midline catheters)

Venous Sampling

Venous Thrombolysis

INTERVENTIONAL PROCEDURES:

Unless specified by policy, the following criteria shall apply for the following interventional procedures:

Initial - Completed fellowship training in interventional radiology or diagnostic radiology with appropriate experience and acceptable outcomes.

Proctoring - See below

Reappointment - Twenty (20) representative blend of cases

Endovascular AAA Repair
 (Refer to Medical Staff Policy # 8710-503 for Initial, Proctoring, and Reappointment Criteria)

Vertebral Augmentation
 (Refer to Medical Staff Policy # 8710-534 for Initial, Proctoring, and Reappointment Criteria)

Endovascular (Catheter Based) Therapy for Cerebrovascular Disorders (including: Coil Occlusion of intracranial aneurysms, treatment of AV Malformation or Fistulas)
 (Refer to Medical Staff Policy # 8710-530 for Initial, Proctoring, and Reappointment Criteria)

Tri-City Medical Center
Delineation of Privileges
 Radiology - (Revised ~~11/14/19~~)

Provider Name: _____

Request	Privilege	Action MSO Use Only
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- | | | |
|-------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> | Genito-Urinary Intervention (includes Nephrostomy, Ureteral Stent, Stone Removal, Tract Dilation, Endopyelotomy, etc.)
Proctoring: Two (2) cases | <input type="checkbox"/> |
| <input type="checkbox"/> | GI/Biliary Intervention (includes Gastrostomy/Enterostomy, GI Stent, Biliary Drain/Stone removal, Dilation, Stent, etc.)
Proctoring: Two (2) cases | <input type="checkbox"/> |
| <input type="checkbox"/> | Biopsy/Drainage Intervention (includes all biopsy, aspiration and drainage procedures)
Proctoring: Two (2) cases from either this privilege or Tumor Ablation Intervention | <input type="checkbox"/> |
| <input type="checkbox"/> | Tumor Ablation Intervention (includes ablation by injection or Radiofrequency probe, Brachytherapy with implantable seeds)
Proctoring: Two (2) cases from either this privilege or Biopsy/Drainage Intervention | <input type="checkbox"/> |
| <input type="checkbox"/> | PAIN MANAGEMENT CORE PRIVILEGES - Per Medical Staff "Criteria for Pain Management Privileges" Policy 8710-541
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.

Epidural Procedures (i.e. Translaminar and transforaminal epidural injections (cervical, thoracic, lumbar), and epidural blood patch)

Joint injections (i.e. Facets, SI joint)

Sympathetic blocks

Chemo denervation (i.e. Stellate Ganglion block, peripheral nerve block, Botox injections, Intra-muscular phenol injections) | <input type="checkbox"/> |
| <input type="checkbox"/> | PAIN MANAGEMENT SPECIAL PROCEDURES - Per Medical Staff "Criteria for Pain Management Privileges" Policy 8710-541 | <input type="checkbox"/> |
| <input type="checkbox"/> | Discograms | <input type="checkbox"/> |
| <input type="checkbox"/> | Implantables | <input type="checkbox"/> |
| <input type="checkbox"/> | Intradiscal Electrothermal Annuloplasty | <input type="checkbox"/> |
| <input type="checkbox"/> | Radiofrequency Thermocoagulation Lesion Ablation (RFTC) | <input type="checkbox"/> |
| <input type="checkbox"/> | SEDATION PRIVILEGES: (Per Medical Staff policy #8710-517 for all initial, proctoring, and reappointment credentialing criteria) | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> | Deep Sedation | <input checked="" type="checkbox"/> |
| <input type="checkbox"/> | Moderate Sedation | <input type="checkbox"/> |

Print Applicant Name _____

Tri-City Medical Center
Delineation of Privileges
Radiology - (Revised ~~11/14~~1/19)

Provider Name: _____

Request	Privilege	Action MSO Use Only
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Applicant Signature

Date

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

Date

ADMINISTRATION REVIEW CONSENT AGENDA

January 31st, 2019

CONTACT: Scott Livingstone, COO

Policies and Procedures	Reason	Recommendations
<u>Patient Care Services Policies & Procedures</u>		
1. Automated Dispensing Machine Procedure	Practice Change	Forward to BOD For Approval
2. Blood Products Administration Procedure	Practice Change	Forward to BOD For Approval
3. Diabetes Education Procedure	Practice Change	Forward to BOD For Approval
4. Discharge Planning Policy	Practice Change	Forward to BOD For Approval
5. Discharge Planning, Homeless Patient Policy	NEW	Forward to BOD For Approval
6. Lift Team Policy	3 Year Review, Practice Change	Forward to BOD For Approval
7. Point of Care New Test Method Request and Implementation Policy	2 Year Review, Practice Change	Forward to BOD For Approval
8. Preceptor Program Procedure	3 Year Review, Practice Change	Forward to BOD For Approval
9. Provision of Education for Adolescents During Hospitalization Policy	3 Year Review, Practice Change	Forward to BOD For Approval
10. Sponge, Sharps and Instrument Counts Prevention of Retained Surgical Objects Procedure	Practice Change	Forward to BOD For Approval
<u>Cardiology</u>		
1. 2D Echo with Conventional & Color Flow Doppler and M Mode Procedure	NEW	Forward to BOD For Approval
2. 12 Lead EKG Procedure	NEW	Forward to BOD For Approval
3. 24 Hour Holter Monitor System Hook Up and Initiate Recording Procedure	NEW	Forward to BOD For Approval
4. 24 Hour Holter Monitor System -- Scanning Analysis Procedure	NEW	Forward to BOD For Approval
5. Critical Results Reporting for Electrocardiogram Procedure	DELETE	Forward to BOD For Approval
6. Echocardiogram - Contrast Bubble Study (Agitated Saline Contrast Injection) Procedure	NEW	Forward to BOD For Approval
7. Stress Echocardiogram Procedure	NEW	Forward to BOD For Approval
8. Tilt Table Test Procedure	DELETE	Forward to BOD For Approval
9. Transesophageal Echocardiogram (TEE) Procedure	NEW	Forward to BOD For Approval
<u>Engineering</u>		
1. 6000 Infection Control Policy	3 Year Review, Practice Change	Forward to BOD For Approval
<u>Food & Nutrition</u>		
1. Emergency Preparedness - Meals for All Nutricopia Policy	Practice Change	Forward to BOD For Approval
2. Nutrition Assessment and Care for Adult Geriatric Patients Policy	Practice Change	Forward to BOD For Approval
3. Nutrition Assessment BHU Policy	DELETE	Forward to BOD For Approval
<u>Medical Staff</u>		
1. Credentialing Policy, da Vinci Robotic-Assisted Surgery Policy 8710-563	3 Year Review, Practice Change	Forward to BOD For Approval
2. Medical Record Documentation Requirements Policy 8710-518	Practice Change	Forward to BOD For Approval




ADMINISTRATION REVIEW CONSENT AGENDA

January 31st, 2019

CONTACT: Scott Livingstone, COO

Policies and Procedures	Reason	Recommendations
3. Standards for Seed Implants in the OR Policy 8710-524	3 Year Review, Practice Change	Forward to BOD For Approval
<u>Patient Care Management</u>		
1. Discharge Planning Policy	DELETE	Forward to BOD For Approval
<u>Formulary Requests</u>		
1. Ceftazidime/Avibactam (Avycaz)	Add to Formulary	Forward to BOD For Approval
2. Infliximab-dyyb (Inflectra)	Add to Formulary	Forward to BOD For Approval

PATIENT CARE SERVICES

 Tri-City Medical Center		Patient Care Services change to policy
PROCEDURE:	AUTOMATED DISPENSING MACHINE	
Purpose:	To define the operation of the Automated Dispensing Machine (ADM), roles of the personnel authorized to access the ADM, resolution of discrepancies and analysis of the medication usage through the ADM.	
Issue Date:	06/00	

ISSUE DATE: 06/00 **SUBJECT:** Automated Dispensing System

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

Patient Care Services Content Expert Approval:	12/17/01/19
Clinical Policies & Procedures Committee Approval:	04/18/01/19
Nurse Executive Committee Approval:	04/18/01/19
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	04/18/01/19
Medical Executive Committee Approval:	02/18
Administration Approval:	08/15/01/19
Professional Affairs Committee Approval:	03/18 n/a
Board of Directors Approval:	03/18

A. POLICY

1. Automated Dispensing Systems (ADS) are used for medication dispensing and control in accordance with state and federal regulations and accreditation standards.
2. The pharmacy system administrator, in collaboration with hospital leadership, is responsible for ensuring the safety and security features of the ADS are properly configured and enforced.
3. The safe use of the ADS is a collaborative multidisciplinary process requiring appropriate use by all disciplines.
4. User groups and privileges are defined to control access to medications for specific practitioners and patient care areas.
5. Only Information Technology (IT) and authorized pharmacy personnel may activate a new user or renew a user's access code in the system.
6. Biometric user ID is utilized, or at minimum, passwords are changed every six (6) months.
7. Sharing of user names and passwords is *prohibited*. All users are expected to follow hospital policies regarding confidentiality and passwords.
8. Medication removal, return, or waste under an invalid patient account is *prohibited*.
9. Automated dispensing cabinets (ADCs) are considered secured areas for medication storage.
10. ADCs are placed in areas that have minimal distractions, allowing staff to concentrate on the task of selecting medications from the cabinet.

Patient Care Services Pharmacy Content Expert	Clinical Policies & Procedure	Nurse Executive Committee	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
10/02, 11/03, 07/06, 05/15, 12/17, 04/19	04/18	04/18	n/a	07/05, 07/06, 07/09, 01/12, 05/15, 01/18	07/05, 07/06, 07/09, 01/12, 07/15, 02/18	08/15	03/18	07/05, 07/06, 07/09, 01/12, 03/18

A.B. PROCEDURE:

1. System Access:

- a. Nurse Directors or their designees, and Credentialing Staff from the Medical Staff Office are authorized to submit a **Pyxis System Access Request** form to request access to the Automated Dispensing System Machine (ADSM).
- a.b. ~~The Designated Pharmacy staff pharmacists, Medstation System Specialist, Pharmacy Technician Supervisor, and Controlled Substance Technician have the privileges to enter assign access a permanent user into the ADSM (See Pyxis System Access Request Form).~~
- b.c. The User identification (ID) and initial password will be assigned by IT the first three (3) letters of the last name followed by the first three (3) letters of the first name (e.g. Mary Smith SMIMAR). If that user name is taken, a single numeric digit will be added starting with one (1).
- d. First time users will be prompted to change their password the first time they sign onto the system. Passwords must be five (5) to eight (8) characters long (may be alpha or numeric or alpha-numeric). After selecting a permanent password, the user will register a fingerprint for the "Bio ID" Pyxis-function. Thereafter, the user will log onto the ADS Pyxis Medstation with the User ID and fingerprint.
- e.i. All users are set up for Bio ID which is the preference, but may be switched to password ID if problem arises with Bio ID.
- d.e. Users who forget their passwords will need to contact IT or use recovery system as available report to the pharmacy in person with their hospital ID badge.
- e.f. ADSM privileges, areas of the hospital, security groups, override capabilities and console privileges are defined by the user's job title and role.
- f.g. Access to ADSMs will be assigned by work areas. These will be:
 - i. ~~Users~~ Nurses who float outside their normal areas shall have their permanent password visitor access granted activated at the new ADSM by the Assistant Nurse Manager (ANM) or Relief Charge Nurse, Administrative Supervisor (AS) or pharmacist.
 - ii. Travelers nurses will be granted access a permanent password for assigned unit with locations and a thirteen (13) week expiration date, unless their until the end of contract or term date is less than thirteen (13) weeks.
 - iii. Registry nurses will be granted access assigned a permanent password with no ADSM locations assigned. They will be granted visitor access activated at the station each time they work. The temporary activation remains in effect for fourteen (14) hours.
 - iii.iv. Registry staff other than nursing will be granted access appropriate to their role.
- g.h. Human Resources will notify IT the Pharmacy Manager, Medstation System Specialist, and Controlled Substance Technician via email when a nurse has separated from the hospital.
- h.i. Medical Staff Office will notify IT via email to the Pharmacy Manager when a physician is separating from the hospital.
- i. ~~The Medstation System Specialist is the primary person responsible for deleting users from the system. The Pharmacy Manager and Controlled Substance Technician serve as an alternate in the event the Medstation System Specialist is not available.~~
- j. Periodically, and no less often than quarterly, Pharmacy will review user lists on the Server. Users without activity will be inactivated. Local users with Active Directory accounts will be inactivated. In addition to the Human Resources notifications, ADM users are routinely reviewed to ensure only current Tri City Healthcare District (TCHD) employees, Anesthesiologists, Nurse Travelers, Nurse Instructors, and Registry Staff have privileges to access to the system. This is done

- ~~monthly by comparing the ADM user list against a current list of TCHD active employees, Traveler, Anesthesiologist, and nurse instructors.~~
- k. Nursing personnel shall notify the Pharmacy Department when a unit which contains an ADCSM is closing. Once notification is received, the ADCMC shall be de-activated. De-activation of the ADM will prevent utilization of the system. When the unit is reopening, nursing personnel shall notify the Pharmacy and the ADCMC shall be reactivated.
2. **Medication Access: Dispensing, Returning and Wasting**
- a. **Removal of medications from the ADM: Profile dispense**
- ~~i. Sign onto the ADM, go to the "Patient Care" section of the main menu.~~
- i. Medication orders are reviewed by a pharmacist prior to administration of the first dose. Following the pharmacist's review/verification of the medication order, the medication is available for selection on the ADC patient profile.
- ii. Obtain medications from the ADC one patient at a time. Medications should not be obtained for multiple patients during a single ADC session.
- iii. Review each medication selected with the patient's medication administration record (eMAR).
- iv. Verify the inventory count when prompted.
- v. Administer the medications as soon as possible after removal from the ADC.
- ~~ii.vi. Select "Remove" button.~~
- ~~iii. Select a patient. Scroll using arrows on the side of the screen or type in the first three (3) letters of the patient's last name.~~
- ~~iv. Using the patient's medication administration record (MAR) as the reference, search for the medication by type in the first three (3) letters of the drug name. If the medication is gray, it means the pharmacist has reviewed the order but the medication is not loaded or is out of stock in the ADM.~~
- ~~v. Select the quantity to be removed. This must be accurate for billing and inventory purposes.~~
- ~~vi. If more than one (1) med is to be removed for this patient press 'Select Next Med' and repeat the process.~~
- ~~vii. Press the 'Remove Now' button.~~
- ~~viii. Verify beginning med count if prompted.~~
- ~~ix. All ADM stored controlled substances have the 'Blind Count' option activated that required the user to enter the correct beginning count of a medication before removal. The system does not display the expected beginning count. The user is given two (2) attempts to enter the correct beginning count. If an incorrect quantity is entered on the first try, a second attempt is permitted and a warning banner is displayed that informs the user that a discrepancy is about to be created. If an incorrect quantity is entered on the second attempt, a discrepancy is created as the transaction is completed, and a discrepancy slip is printed for incorrect quantity as well as for the removal.~~
- ~~x. For controlled substances, there is an option of wasting part of the dose upon removal (see waste section)~~
- ~~xi. Remove the med from the correct pocket.~~
- ~~xii. Conclude the removal process by verifying the patient name, medication and remove quantity on this final screen against the MAR, then shut the drawer.~~
- ~~xiii. Press the 'Exit' button to log off the system.~~
- b. **Clinical Data Screens: Override dispense**
- i. **Override Dispense'** function may be used to access select hospital-approved medications that may be needed to treat an urgent/emergent clinical situation
- ii. When using the 'Override Dispense' function the user determines, and a witness (if required) confirms:

- 1) An urgent situation exists, such that a delay may cause harm.
- 2) The medication order is a valid order.
- 3) The patient is not allergic to the medication ordered.
- 4) The correct medication, dose and dosage form are being removed from the aADC
- iii. Override reports are routinely reviewed to identify and address reasons for overrides.
- i. ~~Clinical Data Screens appear between the select quantity screen and the opening of the drawer. These are intended to alert the practitioner about some aspect of the medication (e.g. Coumadin has significant drug-nutrient interactions which require patient/family education). The practitioner may be required to select a response and press the 'Accept' button before the drawer will open.~~
- c. **Patients:Returns**
 - ~~Under no circumstances are medications returned to the active directory drawer and pocket.~~
 - i. Medications must be returned promptly to the ADC when it is discovered that the medication will not be administered.
 - ii. Unopened medications removed from the ADC that are not used are returned to the ADC return bin unless otherwise indicated by the ADS.
 - iii. A witness is required when returning Class II-V controlled substances to the bin.
 - iv. If the medication is not intact, follow the procedure for wasting medications.
 - ii. ~~When the patient has not been officially admitted or transferred to the nursing unit by the hospital admission, discharge, and transfer (ADT) system, (s)he will not appear in the ADM (e.g. when Affinity is down). Patients added at the ADM without the billing number will not have a Pyxis Profile available. To add a patient:~~
 - 1) ~~From the list of patients press the 'Add Patient' button.~~
 - 2) ~~Type in the patient's last name, first name and patient ID if known. If the patient's name is not known, type in 'Dee' for the last name and 'Jane or John' for the first name. If the patient ID is unknown, leave blank.~~
 - 3) ~~The patient added at the MedStation will show for 24 hours. Once the ADT information comes across to Pyxis, that patient will show up twice in the ADM. Only the patient entry from the ADT system (usually the one with the proper account number) will have the profile of medications. The patient manually entered at the ADM will not have a medication profile.~~
 - 4) ~~Billing for patients manually entered at the ADM will be done by the pharmacy.~~
 - 5) ~~Press the 'Exit' button to log off the system.~~
- d. **Wasteage:**
 - i. Medications are wasted as close to the ~~Wastage can be done at the time of removal as possible~~, or after the removal transaction. If a witness is required, the person witnessing the wastage shall confirm the correct medication and amount wasted in addition to documenting the transaction in the ADC system.
 - ii. See Tri-City Medical Healthcare District Center (TCHDMC) Waste Disposal Guidelines for appropriate disposal of medication that is being wasted including controlled substances.
 - iii. ~~To waste at time of removal~~ Medication waste is documented in the ADC station at the time the medication is actually wasted.
 - 1) ~~After the quantity is selected, press the 'Remove Now' button.~~
 - 2) ~~The next screen that appears will ask if a full dose will be administered. If yes, the drawer opens and you proceed to remove the medication. If no,~~

- the system will identify the medications that require a witness for waste, press 'Accept'.
- 3) Another licensed person will be required to enter their user ID and password to document as a witness.
 - a) Approved licensed health care professional
 - i) Anesthesiologist
 - ii) Registered Nurse
 - iii) Licensed Vocational Nurse
 - iv) Respiratory Care Practitioner
 - v) Radiology Technician
 - vi) Pharmacist
 - vii) Pharmacy Technician
- 4) Enter the amount to be given and the amount wasted is automatically calculated.
- 5) Press the 'Accept' button.
- 6) Press the 'Exit' button to log off the system.
- iv. To waste after removing:
 - 1) From the main menu select 'Waste'.
 - 2) Select the patient by typing in the first three (3) letters of the patient's last name. A list of medications removed in the past 24 hours will appear.
 - a) If the patient you want is not listed, select 'Add Patient' and manually enter the patient (see adding patients at the station).
 - 3) Select the medication to be wasted from the list.
 - a) If the medication does not appear on the list, select 'All Meds'.
 - i) Use for wasting controlled substances that were not removed from same Pyxis
 - b) For multiple wastes, press 'Select Next Med', make multiple selections if needed.
 - 4) Once all medications have been selected, press 'Waste Now'.
 - 5) The system will identify the medications that require a witness for waste, press 'Accept'.
 - a) When the witness screen appears then have the witness enter their User ID and Password.
 - b) Upon completion of documentation, both staff signing for waste must properly dispose of excess medication based on the current TCMC Waste Disposal Guidelines.
 - c) When wasting PCAs, drips or epidurals the waste amount will be in milliliters
 - d) Narcotic PCA syringes will be wasted using the same procedure as above.
 - e) Morphine drips will be wasted using the Narcotic Drip entry.
 - f) To waste a fentanyl patch, estimate the amount used and document in Pyxis then fold the patch so that the adhesive side adheres to itself, then discard in the appropriate container per TCMC Waste Disposal Guidelines.
 - 6) Enter the amount given; the system will calculate the waste. If the entire dose is wasted and the patient needs to be credited, press the 'Credit Patient' button.
 - 7) Press the 'Accept' button.
 - a) Press the 'Exit' button to log off the system.
- e. Returns:
 - i. From the Main Menu, select the 'Return' button.
 - ii. Select the patient. Scroll using arrows on the side of the screen or type in the first three (3) letters of the patient's last name.

- iii. ~~Select 'Remove Meds' to view previously removed meds or select 'All Meds' to view a complete list of meds.~~
- iv. ~~Search for the medication using the first three (3) letters of the drug name and select.~~
- v. ~~Verify or enter the number of meds returning.~~
- vi. ~~Select 'Return Now' or for multiple returns select 'Select Next Med'.~~
- vii. ~~Press the 'Exit' button to log off the system.~~
- viii. ~~Medication removed from the ADM not administered and still intact, shall be returned to the ADM 'Return Bin' with the exception of refrigerated and some designated controlled substance medication. If the medication is a controlled substance and is too large to fit in the return bin slot, it must be wasted through Pyxis and the patient credited by touching the 'credit' button or by contacting the pharmacy for immediate pick up. For non-controlled medications that are too large, place into the 'Return to Pharmacy' bin.~~
- f. ~~Override Process:~~
 - i. ~~When overriding a medication which has not been reviewed by the pharmacist, the nurse is responsible for screening allergies, appropriate dose/route/frequency and all other relevant clinical criteria.~~
 - ii. ~~The ADM utilizes an override feature whereby a nurse may obtain a newly ordered medication not yet entered into the system by the Pharmacy.~~
 - iii. ~~The Pharmacy Department will manage the list of medications that may be overridden in the ADM based on their use in emergent/urgent situations. Not all medications are eligible for override.~~
 - iv. ~~Medications shall be removed through override access only if the indication is deemed by the healthcare provider to be urgent or emergent. All healthcare providers that use the override function are expected to use professional judgment to determine appropriateness.~~
 - 1) ~~Urgent Indications: include those in which significant patient harm could result from a delay secondary to a pharmacist's review of the order.~~
 - 2) ~~Emergent Indications: include situations in which life, limb or eyesight is threatened.~~
 - 3) ~~In each individual case, the need for the override must outweigh the risk of omitting the pharmacist's review of the order.~~
 - v. ~~To access a medication through the override function:~~
 - 1) ~~At the ADM Profile Screen, press the override button at the bottom of the screen.~~
 - 2) ~~Type in the first three (3) letters of the medication.~~
 - 3) ~~Select the medication.~~
 - 4) ~~Proceed as instructed above to remove the medication.~~
 - vi. ~~If the medication does not appear on the Pyxis override screens, the nurse does not have access to the medication and must call the pharmacist or Administrative Supervisor.~~
 - vii. ~~An override report is generated on a daily basis and includes the patient name, drug, strength, amount taken, date/time and name of the nurse withdrawing the medication. A pharmacist reviews this report and reconciles override medications with physician orders. Any overrides without orders will be brought to the attention of a Nurse Manager for follow up. Should the pharmacist require assistance in following up on any overrides without orders, they may contact the Pharmacy Director or Clinical Manager.~~
 - viii. ~~Critical Override gives the nurse the ability to override for any medication currently located in the ADM. This function will be turned on at each station during emergencies such as network failure.~~
- g.e. ~~Controlled Drug Discrepancy:~~

- i. Nursing is responsible for reconciling all ADMC discrepancies prior to the end of a shift per the Patient Care Services Policy: Controlled Substance Management. Pharmacy staff can be utilized to run reports and assist with resolution.
- ii. If the discrepancy was caused by pharmacy personnel, then Pharmacy is responsible for resolving the discrepancy.
- iii. The pharmacy monitors for open discrepancies that have been unresolved for greater than 24 hours. The Controlled Substance Technician will contact the Nurse Manager or Charge Nurse to make them aware of the need to resolve the discrepancy immediately. If no action is taken, the matter will be escalated to the ~~Medication Safety Officer~~ **Pharmacy Director, or designee.**
- iv. Documented Discrepancies are reviewed daily to ensure all documented discrepancies have been resolved accurately and confirm no controlled substances are unaccounted for.
- v. If during the course of a discrepancy investigation controlled substances are unaccounted for, further appropriate action shall be taken. This could include an audit of individuals and reporting to appropriate agencies.
- vi. Nurses shall perform a physical inventory of all controlled substances as stated in Patient Care Services Policy: Controlled Substance Management.

3. ~~ADM Inventory and Formulary:~~

- a. ~~The Pyxis Console automatically prints refill lists, stock outs and new loads for each MedStation.~~
- b. ~~Pharmacy technicians will refill and load the ADMs with stock from the main pharmacy inventory.~~
- c. ~~Medications that need to be refilled or have stocked out, shall be verified and initialed by two (2) technicians or technician and a pharmacist prior to leaving the pharmacy.~~
- d. ~~New loads will be verified and initialed by a technician and pharmacist prior to leaving the pharmacy.~~
- e. ~~Licensed pharmacy personnel will load or refill the medication(s) in the correct pocket(s) of the appropriate ADM.~~
- f. ~~The Medstation System Specialist in conjunction with a pharmacist will review the usage of medications for each ADM on an ongoing basis and adjust minimum/maximum levels, establish new standard stock medications if indicated, and remove medications that have not been used recently and are not standard stock.~~
- g. ~~When medication stock outs occur, the pharmacy technician is encouraged to look at the present minimum and maximum levels and adjust if needed, using the following table as a guideline:~~
 - i. ~~Inventory Max and Min Levels (10-day usable inventory with a max/min ratio of 50%)~~

Max Level	Min Level
100	50
80	40
60	30
50	25
40	20
30	15
20	10
10	5
Patches	
6 (every day)	3
3 (every week)	4

- h. ~~Pharmacy personnel are responsible for utilizing the outdated med tracking function any time a medication is placed in the ADM.~~

- i. ~~An Outdated Inventory Report is run daily and pharmacy technicians shall utilize this report to remove all medications that are expiring in the near future.~~
4. ~~Narcotic Vault (C-II Safe):~~
 - a. ~~All controlled substances (C-II through C-V) will be managed through the C-II Safe. Controlled substances which require refrigeration shall be placed in locked containers within a refrigerator. All other controlled substances shall be secured in the C-II Safe.~~
 - b. ~~Only Pharmacy personnel will have access to the C-II Safe.~~
 - c. ~~Controlled substances received from the drug wholesaler will be received into the C-II Safe by the Pharmacy Technician Supervisor or designee.~~
 - d. ~~All CII Safe receive reports are compared against the invoice by the Pharmacy Buyer.~~
 - e. ~~All controlled substances sent to a nursing floor will be placed in the ADM. Controlled substances removed from the Nursing Unit ADMs will be immediately returned into the C-II safe.~~
 - f. ~~All controlled substances used for compounding in the intravenous (IV) room will be managed through the C-II Safe.~~
 - g. ~~An inventory of the CII Safe shall be done monthly by the Controlled Substance Technician and a witness which may be any pharmacy personnel.~~
 - h. ~~Expired controlled substances that are awaiting pick up from a reverse distributor shall be placed in the expired/waste bin of the CII Safe and kept segregated from the rest of the inventory.~~
5. ~~Downtime Procedures:~~
 - a. ~~All ADMs, the C-II Safe and the Pyxis Console will be plugged into red emergency plugs. Nursing shall contact the Pharmacy when an ADM is not functional.~~
 - b. ~~When facing the back of the MedStation:~~
 - i. ~~Key PL085 will unlock the left side and the refrigerator units.~~
 - ii. ~~Key PL081 will unlock the right side.~~
 - iii. ~~Key 6234 will unlock the computer lid.~~
 - iv. ~~There is one set of back panel keys in the C-II Safe at all times which can be accessed by pharmacy personnel.~~
 - v. ~~If the hospital emergency power is not functioning the pharmacy has enough back panel keys for every Pyxis MedStation. These extra keys along with the keys to unlock the doors to the C-II Safe will be kept in the Director of Pharmacy's office. The Director of Pharmacy or Pharmacy Technician Supervisor will need to be called to access these keys.~~
 - c. ~~All medications removed from the ADM will be accounted for in the patient's chart as soon as chart is accessible.~~
 - d. ~~Two (2) licensed personnel will perform controlled substance counts upon initiation of the ADM downtime procedure and at the end of each shift. The initial controlled substance count and all subsequent controlled substance activities will be recorded on a Daily Audit and Disposition for Controlled Drugs Form. Discrepancies will be resolved before any staff members are allowed to leave the unit.~~
 - e. ~~Once the MedStation becomes functional, pharmacy personnel will update the inventory counts and capture charges. Two (2) nurses will inventory all controlled substances, reconcile against the Daily Audit and Disposition for Controlled Drugs Form and resolve any discrepancies.~~
 - f. ~~When interface communication is lost between the Pharmacy Computer System and ADM or the ADM console and the ADM, all new orders, changes in orders, admits, transfers and discharges will not be updated. If this condition lasts for more than three (3) hours, the ADM will be set to Critical Override so the licensed personnel can override any medication available in the ADM.~~
- 6.3. Reports:
 - a. Override Reports are run daily.
 - b. All C-II Safe Events - Ran daily and kept on file for three (3) years. Fulfills Board of Pharmacy requirements.

- c. Charges and Credits- Run daily, billing is processed by the Medstation System Specialist for patients manually entered at the ADMC. These billing adjustments are made directly into the hospital host computer system.
 - d. Documented Discrepancy Report- Run daily
 - e. C-II Safe vs. Pyxis MedStation Compare- Run throughout the day by staff accessing the CII Safe and reviewed by the Controlled Substance Technician.
 - f. C-II Safe Activity Log- Run daily and reviewed by the Controlled Substance Technician for unusual occurrences. This report is kept on file for three (3) years.
 - g. C-II Safe Open Discrepancy- Run daily (Monday through Friday) and reconciled by the Controlled Substance Technician.
 - h. Suggested Reorder Report- Run every Monday and Thursday by Pharmacy Buyer or designee.
- 7.4. Data Archival:
- a. A redundant copy of all information is automatically stored on a hard drive within the C-II Safe.

B.C. FORM(S):

- 1. ~~Pyxis~~ System Access Request Form (SAR) – Non-Provider
- 4.2. System Access Request Form (SAR) – Provider/Provider Office
- 2.3. Tri-City Medical Center Daily Audit and Disposition for Controlled Drugs-~~Form~~

G.D. RELATED DOCUMENT(S):

- 1. Patient Care Services (PCS) Policy: Controlled Substance Management
- 2. TCMC Waste Disposal Guidelines

TRI-CITY HEALTHCARE DISTRICT

System Access Request Form (SAR)

Select one:

<input type="checkbox"/> Employee	<input type="checkbox"/> Traveler	<input type="checkbox"/> Registry	<input type="checkbox"/> Volunteer
<input type="checkbox"/> Student	<input type="checkbox"/> Instructor	<input type="checkbox"/> Contract/Vendor	<input type="checkbox"/> Temp/Non-District Employee

Select New Account or Modify Existing Account:

<input type="checkbox"/> New Account	Start Date	End Date (if applicable)
Requestor Name:		Email:
- OR -		
<input type="checkbox"/> Modify Existing Account	End Date (if applicable)	
Reason:	<input type="checkbox"/> Transfer	<input type="checkbox"/> Position Change
	<input type="checkbox"/> Extension	<input type="checkbox"/> Return
<input type="checkbox"/> Other		
Requestor Name:		Email:

Account User Information: * Required Fields

*First Name:	*Middle Initial:	*Last Name:
Role/Position:	Job Code:	Job Title:
Cost Center:	Department Name:	
Nurse Units (Required for Staff Assignment):		
Company/Practice/Vendor Name (if applicable):		

Access Requested for the following:

<input type="checkbox"/> Affinity (Patient Accounting) <input type="checkbox"/> Cerner <input type="checkbox"/> Email <input type="checkbox"/> Internet <input type="checkbox"/> Kronos (Manager/Supervisor) <input type="checkbox"/> Lawson (Finance/HR) <input type="checkbox"/> Other:	<input type="checkbox"/> PACs - Radiology <input type="checkbox"/> PACs - Cardiology <input type="checkbox"/> Pyxis Med Station <input type="checkbox"/> Remote Access <input type="checkbox"/> Report Writing (Power Insight) <input type="checkbox"/> RL Solutions File Management Access <input type="checkbox"/> Other:
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E-Mail Distribution – please list email distribution groups to assign:

1.
2.
3.
4.
5.

TRI-CITY HEALTHCARE DISTRICT System Access Request Form (SAR)

I am aware of and agree to abide by the privacy and security policies of Tri-City Healthcare District and its affiliates as it applies to the protected health information as well as organizational information. I understand that I must only access that information which is the minimum necessary for me to carry out my duties within the organization and any other access is strictly forbidden.

- Never share my password or access information that is not required for my assigned duties.
- Always log in and off appropriately when using a workstation.
- Never access or disclose organizational or protected health information except within the scope of my position.
- Only copy information from the organizational data bases as authorized.
- Always take reasonable precautions when originating, receiving or transferring database information (virus).
- Never remove organizational or protected health information from the organization (paper or electronic) unless authorized.

I understand that violations of Tri-City Healthcare District (TCHD) privacy and security policies are grounds for disciplinary action to include, but **not limited to** loss of privileges, termination, or possible criminal prosecution.

Account User Signature _____ Date _____

Manager/Supervisor Approval of Request

I authorize the above named individual to have access to the information. Additionally I have reviewed with this individual organizational privacy and security policies and the consequences of failure to comply.

Signature _____ Date _____

Print Name _____

PLEASE EMAIL THE COMPLETED FORM TO: SARIT@TCMC.com

Information Systems Review & Implementation of Request

Implemented by: (IT Representative) _____ Date _____

Staff Member Notified/Educated as to Log in Process/Password Selection

IT USE ONLY:

Initial User Login Name and Password _____ Entered by _____ Date _____



TRI-CITY HEALTHCARE DISTRICT System Access Request Form (SAR)

Please check one:

☐ Provider

☐ Provider Office Staff

☐ New Account

☐ Modify Existing Account

Requestor
Name:

Phone:

Start
Date:

Account User Information:

Last Name: _____

Middle Initial (Required or NA): _____

First Name: _____

Access Start Date Requested: _____

Business Name: _____

Contact Information: _____

Job Title: (Office Staff) _____

Dictation Code (Required for Staff Physicians): _____

Physician Specialty _____

eMail: _____

Access Requested for the following System Modules/Position	YES	Access Requested for the following System Modules/Position	YES
Remote Access		PACs	
Cerner		Mailbox Account (MD only)	
Powerchart Touch		MedStaf	
Dragon			
Comments:			

I am aware of and agree to abide by the privacy and security policies of Tri-City Healthcare District and its affiliates as it applies to the protected health information as well as organizational information. I understand that I must only access that information which is minimum necessary for me to carry out my duties within the organization and any other access is strictly forbidden

- Never share my password or access information that is not required for my assigned duty
- Always log in and off appropriately when using a workstation
- Never access or disclose organizational or protected health information except within the scope of my position
- Only copy information from the organization data bases as authorized
- Always take reasonable precautions when originating, receiving or transferring database information (virus)
- Never remove organizational or protected health information from the organization (paper or electronic) unless authorized

Print Name: _____ Date: _____

Signature: _____

For Office Staff Access Requests, someone in an authoritative position, must sign below:

Name: _____ Title: _____

Signature: _____ Date: _____

IT USE ONLY:

Initial User Login Name and Password _____ Entered by: _____

Date: _____

PLEASE EMAIL THE COMPLETED FORM TO: SARIT@TCMC.com or FAX to: (760)-940-4038
One User/Account per SAR

TRI-CITY MEDICAL CENTER DAILY AUDIT AND DISPOSITION FOR CONTROLLED DRUGS

UNIT:

DATE:

MORPHINE 2MG INJ 68943

MORPHINE 4MG INJ 75179

MORPHINE 10MG INJ 08745

MORPHINE PCA 74057

DEMOROL 50MG INJ 06877

DEMOROL 75MG INJ 07339

DEMOROL 100MG INJ 06885

DEMOROL PCA 74065

VALIUM 10MG/2ML INJ 04435

ATIVAN 2MG/ML INJ 33269

ATIVAN 4MG/ML INJ 69158

VERSED 1MG/ML 5ML INJ 47939

VICODIN TABS 31768

TYLENOL #3 TABS 12701

PERCOCET TABS 14862

DARVOCET N100 TABS 01167

RESTORIL 15MG CAPS 28764

ATIVAN 1MG TABS 06638

ATIVAN 2MG TABS 06646

RN Signature:

BROUGHT FORWARD



time

patient

account #

nurse








SHIFT CHANGE INVENTORY

SHIFT CHANGE INVENTORY

SHIFT CHANGE INVENTORY

Nurses Signature Nurses Signature

TCMC Waste Disposal Guidelines

						
Regular Waste	Biohazardous Waste	Sharps	Pharmaceuticals	Controlled Substances	RCRA Pharmaceuticals	Chemo/Hazardous Waste
NO NEEDLES	NO NEEDLES	NEEDLES OK	NEEDLES OK	NO NEEDLES	NO NEEDLES	NEEDLES OK IN BIN, NOT BAG
<ul style="list-style-type: none"> Empty IV bags, Piggyback bags/tubing without PHI or PHI covered Empty medication vials without PHI or PHI covered Trash Dressings Chux Diapers Sanitary napkins Gloves Empty foley bags and other drainage bags Disposable patient items Empty irrigation syringes Empty syringes (without needles) 	<ul style="list-style-type: none"> Blood and all OPIM (<u>O</u>ther <u>P</u>otentially <u>I</u>nfectious <u>M</u>aterial) Blood tubing/bags/hemovacs/pleurevacs Intact glass or plastic bottles with bloody fluid or OPIM Suction liners with bloody fluid or OPIM Soaked/dripping bloody dressings All disposable items soaked or dripping with blood or OPIM <p>When in doubt, use red bag.</p>	<ul style="list-style-type: none"> All sharps <i>Example: needles (including needles from insulin pens), lancets, broken glass vials, ampules, blades, scalpels, razors, pins, clips, staples</i> Trocars, introducers, guide wires, sharps from procedures etc. 	<ul style="list-style-type: none"> Syringes, needles, tubexes, carpuejts with pourable medication (pourable means there is enough liquid to pour it out, not just residual amount) Partially used or wasted prescription or over-the-counter medication <i>Examples: vials, tablets, capsules, powders, liquids, creams/lotions, eye drops, suppositories, patches (fold in half)</i> Inhalers with no propellants <i>Examples: Advair, Foradil</i> 	<p>ALL Controlled Substances and propofol ONLY</p> <ul style="list-style-type: none"> Solid controlled substances -Tablets, capsules, suppositories, lozenges, and patches. Fold patch in on itself prior to disposal Liquid controlled substances -Intravenous & oral Propofol <p>No needles, syringes, ampules, vials, bottles, or tubing</p>	<p>EPA designated R.C.R.A. Pharmaceuticals only:</p> <p><i>Examples:</i></p> <ul style="list-style-type: none"> Insulin/Insulin Pen (needles removed) Inhalers -only those w/ propellant e.g Ventolin, Atrovent, Flovent, Symbicort Warfarin /Coumadin Used & Unused nicotine gum or patches, (include empty wrappers) Silver sulfadiazine cream Silver nitrate applicators (unused) Selenium sulfide shampoo Multiple trace elements Unused& residual alcohol/acetone/acetic acid <p>No Needles NO PHI</p>	<p>Trace Chemo: All supplies used to make and administer chemo medication <i>Example: tubing, empty bags/ bottles/ vials, syringes, needles, pads, wipes, contaminated gloves, gowns, masks etc.</i></p> <p>Hazardous Waste: All supplies used to make and administer hazardous meds.</p> <p>Bulk Chemo: Return to pharmacy all unused bulk chemo in original pharmacy bag for disposal into RCRA container</p> <p>NO PHI</p>

All bins picked up on regularly scheduled basis. Chemo/Hazardous Bin supplied by Materials (X3330). RX Destroyer and all other bins supplied by EVS (760-644-6973) If additional pick up is needed: M-F 0600-1100 page 760-926-0972. At all other times: call EVS at 760-644-6973

References: <http://cwea.org/p3s/documents/DHS%20Guidance%20Pharmacy%20Waste%20from%20Hospitals.pdf>; County of San Diego Department of Environmental Health Hazardous Materials Division; Stericycle Healthcare Environmental Resource Center, Epinephrine Fact Sheet http://www.dhs.ca.gov/LawsRegsPolicies/Title22/upload/Ch11_Art4.pdf

Revised Date: 04/2017 pharmacy

**PROCEDURE: BLOOD PRODUCTS ADMINISTRATION**

Purpose:	To outline the nursing care and management of adult/adolescent/pediatric/newborn patients receiving blood or blood products. This includes, but not limited to , packed-red blood cells (PRBCs), irradiated blood products, platelet pheresis concentrates (PLPH), and thawed fresh frozen plasma (TP) and cryoprecipitate.
Supportive Data:	Blood and blood products are unlike other intravenous medications administered due to the human/organic nature of the substance. Special precautions and timeliness are required for proper management of the patient receiving a transfusion.
Equipment:	Blood Product Blood Administration Set with a 170 micron filter Normal Saline Intravenous (IV) Electronic Infusion Pump Automatic Blood Pressure (BP) machine Pressure pump bag (if indicated)

A. DEFINITION(S):

1. Qualified transfusionists are:
 - a. Registered Nurses (RN) who have completed annual/ongoing competency in blood/blood product administration
 - b. Anesthesiologists
 - c. Perfusionists in surgery-

B. PROCEDURE:

1. Refer to ~~Mesby's~~ **Online Skills Nursing Skills** procedure: Blood Products: Administering for complete information.
2. Confirm patient identity using two-identifier system. Refer to Patient Care Services Policy: Identification, Patient.
3. Verify order and complete a Transfusion Request Form
 - a. A nurse will verify that patient has received, read and understands, "A Patient's Guide to Blood Transfusions". The nurse will also verify that the patient has had opportunity to discuss this process with their physician.
 - i. After reviewing the copy of "A Patient's Guide to Blood Transfusions" if the patient, parent, conservator or guardian refuses to permit the use of blood or blood derivatives in their care or the care of the patient, the patient will date, time and sign the refusal section of the consent.
 - ii. When a patient is a minor or physically or mentally incapable of understanding and signing the consent, a parent, conservator or guardian may sign. Check the box which indicates the relationship of the signature for consent.
 - b. Obtain patient's signature on consent form, if not previously signed, for all blood products from Transfusion Service.
 - i. Notify the physician- ~~who order~~ **ing the blood product** if patient has not received informed consent regarding blood administration.
 - ii. ~~Record ID number from the Transfusion Service identification band on Transfusion Request Form~~
 - c. **Take the pre-transfusion vitals and only continue if the vitals are not significantly different than the most recently recorded on the chart.**
4. Obtain blood products from the Transfusion Service:
 - a. **Send the Transfusion Request Form with a** ~~Only~~ **Tri-City Healthcare District (TCHD)**

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Blood Utilization Review Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/94, 07/09, 10/10, 05/12, 12/17, 07/18	05/12, 03/13, 01/15, 11/18	05/12, 03/13, 02/15, 11/18	04/17, 11/18	n/a	06/12, 06/13, 08/17, 01/19	01/19	07/12, 07/13, 09/17, n/a	07/12, 07/13, 09/17

- employees ~~to~~may pick up blood products from the **Blood Bank** in lab.
 - b. Transfusion Services will use a dual bag system to protect patients' privacy and contain possible spillage of blood products not transported in a cooler. Single and double units will be placed in a re-closable clear plastic bag. This clear plastic bag will be placed in a white bag labeled "Handle with Care: Human Blood".
 5. Initiate the transfusion within 30 minutes of obtaining ~~component~~it from the Transfusion Service
 - a. It is permissible to start the transfusion even if it is delayed more than 30 minutes from issue as long as the entire unit can be infused within 4 hours of issue. After 4 hours the remainder of the unit must be discarded. **The time issued is recorded on the Transfusion Request Form.**
 - i. Blood and blood products that are not going to be transfused should be returned to the Transfusion Service immediately, as they are temperature sensitive.
 - ~~ii. Any unused blood or blood product unit, if not transfused should be returned to the Transfusion Service.~~
 - ii. **If the patient has received any of the blood productproducts, discard the remainder of unused blood in biohazardous waste if the transfusion is discontinued unless there is a transfusion reaction.**
 - iii. Do not store blood products in any refrigerator outside of the Transfusion Service.
 - b. Exception: Areas designated by the laboratory may be issued ~~ice chest~~coolers to store blood while waiting to be transfused. ~~ice blocks~~blocks are good for 6-9 hours, after which they must be switched for fresh ~~ice blocks~~blocks. The blood bank monitors the time limit of the ~~ice~~ blocks. Any remaining units of blood in the ~~ice chest~~cooler at the conclusion of the procedure must be returned to blood bank in their original cooler.
 6. **Verify blood product and patient information**
 - a. Verify the following information from blood products, unit tag, ~~transfusion record~~patient chart, and patient information from attached armbands with another RN (in Operating Room may verify information with a Perfusionist/Anesthesiologist **whenever possible**).
 - ~~6-i.~~ The RN /perfusionist/anesthesiologist (**whenever possible**) administering the blood products must participate in the verification process.
 - a-b. Unit tag, armband number highlighted on forms must match the number on the Transfusion Service identification band attached to the patient.
 - i. Return blood product to Transfusion Services if number does not match.
 - b-c. Patient's name and medical record number on hospital armband with unit tag and Transfusion Record form.
 - e-d. Type of blood product issued matches blood product ordered by Physician.
 - d-e. Blood group and Rh type on blood product label matches blood group and Rh type on unit tags and for red cell products ~~are~~is compatible with patient's blood group and Rh type on the unit tags.
 - i. Platelet and cryoprecipitate ABO/Rh types may not match the patient's blood ABO/Rh but are compatible to be transfused. Call the Transfusion Service with questions concerning ABO/Rh compatibility.
 - e-f. Donor unit number (**Blood Unit ID#**) on blood product label matches donor unit number on unit tag and Transfusion Record form.
 - f-g. Expiration date/time on blood product label has not elapsed. **Record the expiration date/time on the Transfusion Record Formen the left hand side.**
 - i. If the expiration date is the current calendar day, the blood products must be infused by midnight or the remainder discarded at midnight (23:59).
 - ii. **If the expiration date includes a specific time that time is the expiration time rather than 23:59 as above.**
 - g-h. Compatibility status if blood product is red blood cell unit.
 - i. Document verification on Transfusion Record form and Blood Administration Powerform.
 - ~~h-i.~~ **Anesthesiology documents on anesthesia record**
 7. All non-autologous PRCs and all platelet pheresis products used at this hospital are leuko-

- reduced.
8. Pressure Pump/Bag may be used if blood needs to be infused at a rapid rate.
 - a. Use only external pressure devices equipped with a pressure gauge, and that exert uniform pressure against all parts of the blood container.
 - b. Maintain 300 mmHg or less when pressure transfusing blood components as higher pressures may cause bag rupture or hemolysis through small-gauge lines.
9. Blood may be infused using an electronic infusion device.
10. Blood warmer may be used. Use only equipment specifically designed to warm blood product and maintain blood warmer temperature at specified temperature for equipment used throughout transfusion.
11. Document temperature of blood warmer on Transfusion Record form.
12. **Medications may not be given in the same Intravenous (IV) line while blood is transfusing.**
 - 12.a. ~~Intravenous (IV)~~ push medication may only be given via the lowest injection port while the normal saline is infusing immediately before or after transfusing the blood product.
13. Change the blood administration set after 4 hours. Up to 2 units may be given with each set if the total infusion time is less than or equal to 4 hours.
14. Assess and document vital signs (including blood pressure, heart rate, respiratory rate, and temperature) on Blood Administration Powerform:
 - a. Pre-transfusion
 - i. It is recommended that vital signs be obtained immediately prior to **sending for blood and** initiating a transfusion not to exceed 1-2 hours prior to the transfusion initiation
 - b. 15 minutes after blood product initiated
 - c. 1 hour after blood product initiated
 - d. Every 1 hour until blood product infused
 - e. Immediately post transfusion.
15. A patient receiving blood must be accompanied by a nurse when leaving the nursing floor.
16. Complete Transfusion Record and Blood Administration Powerform including documentation of amount of blood product infused and any adverse reactions and place the chart copy of the Transfusion Record in the laboratory section of the patient's chart. Return the Blood Bank copy to the Lab.
 - a. Document any adverse reactions on the Transfusion Reaction section of the Blood Administration Powerform.
 - b. A form must be completed for each unit of blood product transfused.
17. Upon discharge of Outpatients, provide patient with an "Outpatient Post Transfusion Reaction" information sheet.
18. Initiate Blood Transfusion Reaction process for suspected transfusion reaction.
 - a. Check unit and patient information to verify that the unit was started on the correct patient.
 - b. See **Mesby's Online Skills Nursing Skills Transfusions: Reaction Management**
 - c. Complete Reaction section of the Blood Administration Powerform and the Transfusion Record form.
 - d. Send blood product with attached blood administration set, the printed Blood Administration form, the Blood Bank Transfusion Record, record forms and first void urine specimen to Transfusion Service.
19. Dispose of blood product containers, and administration sets in red bags, if no transfusion reaction.

C. SPECIAL CONSIDERATIONS FOR: PEDIATRIC/NEONATAL:

1. A nurse will verify that patient/parent/legal guardian has received, read and understands a patient guide to blood transfusion. The nurse will also verify that the patient/parent/legal guardian has had opportunity to discuss this process with their physician. Obtain consent for blood and blood products administration from parents.

2. Verify Newborn Screening has been obtained prior to the first PRC transfusion providing Hct greater than 25 or as ordered by the physician.
3. Ensure that all cellular blood products are **Cytomegalovirus (CMV) negative, leukoreduced and irradiated** for newborns or per physician order.
4. Consult with physician regarding the use of ~~irradiated blood and donor specific blood~~.
5. **"Double-check" As above a second qualified transfusionist must verify** all blood products prior to administration to ensure that the proper blood is administered to the infant in the Neonatal Intensive Care (NICU).
6. Administer all blood products via an Alaris pump except with exchange or emergency transfusions.
7. Prime tubing with blood product and attach to T-connector or double or triple lumen connector tubing.
8. Administer blood products through largest bore catheter available (24 gauge minimum recommended).
9. Transfuse PRCs per physician order.
10. Allow blood products to warm to room temperature (approximately 20 minutes) prior to administration to reduce thermal stress.
11. Transfuse blood over time specified by physician order, but not more than 4 hours. If transfusion orders require infusion greater than 4 hours, request smaller aliquots from the Transfusion Service.
12. Use a controlled blood warmer when performing large volume transfusions (exchange transfusions).
13. Document, to the nearest tenth of an mL, the amount of blood product infused in the electronic health record (EHR).

D. SPECIAL CONSIDERATIONS FOR: INTRAOPERATIVE REINFUSION OF PROCESSED BLOOD:

- ~~1. Processed units will use a new set each time.~~
- 2-1. Label each unit with patient's full name, Medical Record Number, date, time of start of collection, time of expiration and for "Autologous Use Only", at time of collection.
- 3-2. Reinfusion of intra operatively processed blood must begin within 6 hours of end of collection.
- 4-3. Blood collected intra operatively is to be transfused to the donor only.
- 5-4. Contraindicated in cases of sepsis or malignancy.

E. FORM(S):

1. Authorization for Consent to Blood Transfusion or Blood Refusal 7420-4004 - English Sample
2. Authorization for Consent To Blood Transfusion or Blood Refusal - Spanish - Sample
3. Blood Bank Transfusion Record 7500-5006 - Sample
4. Outpatient Post Transfusion Reaction Information Sheet 7725-1003 - Sample
5. Transfusion Request Form 7500-1009 - Sample

E.F. RELATED DOCUMENT(S):

1. A Patient's Guide to Blood Transfusion – English (external link [http://www.mbc.ca.gov/Publications/Brochures/blood transfusion english-print.pdf](http://www.mbc.ca.gov/Publications/Brochures/blood%20transfusion%20english-print.pdf))
- 4-2. A Patient's Guide to Blood Transfusion – Spanish (external link [http://www.mbc.ca.gov/Publications/Brochures/blood transfusion spanish-print.pdf](http://www.mbc.ca.gov/Publications/Brochures/blood%20transfusion%20spanish-print.pdf))
- 2-3. Patient Care Services Policy: Identification, Patient
4. Patient Care Services Procedure: Constavac, Reinfusion of Blood-Procedure

F.G. REFERENCE(S):

1. Transfusion Therapy Guidelines for Nurses, National Blood Resource Education Program, Public Health Service of National Institutes of Health, U.S. Department of Health/Human Services.

2. Stryker Constavac Blood Conversion (CBC) System Operating Instructions, 98. See TCHD Equipment Manual.
3. Technical Manual, American Association of Blood Banks, ~~17th~~ current Edition, ~~2011~~. Bethesda, MD ~~20814-2749~~
4. TCMC Blood Utilization Review Committee. Chair, Gary Wilcox, M.D., 2000.
5. AWHONN Core Curriculum for Neonatal Intensive Care Nursing, Deacon, J, and O'Neil, P (Eds), 5th Edition, W. B. Saunders, Philadelphia 1999.
6. American Association of Blood Banks Association, Standards for Blood Banks and Transfusion Services, ~~27th~~ current Edition: Bethesda, AABMD, ~~20814-2749~~ ~~2011~~
7. Merenstein, G.B., Gardner, S.L. (2011). Handbook of neonatal intensive care, 7th Edition. Mosby-Elsevier: Philadelphia, PA.

SAMPLE

CONSENT TO BLOOD TRANSFUSION

My signature below indicates that: (1) I have received a copy of the brochure, "If You Need Blood: A Patient's Guide to Blood Transfusions," (2) I have received information concerning the risks and benefits of blood transfusion and of any alternative therapies, (3) I have had the opportunity to discuss this matter with my physician, including pre-donation, (4) subject to any special instruction listed below, my consent to such blood transfusions as my physician may order in connection with the operation or procedure described in the "Consent For Operative Or Other Procedures," (5) I have read and understand the information in the "Blood Transfusion and/or Refusal of" section provided on this form, (6) I have received all of the information I desire concerning the procedure(s), and (7) I authorize and consent to the performance of the procedure.

[Describe here any specific instructions for patient's blood transfusion, e.g., pre-donation, directed donation, etc.]

Name: Patient/Representative	Signature: Patient/Representative	Date	Time	AM/PM
If signed by a person other than the patient, indicate relationship to patient: _____				
Examples: Spouse, Partner, Legal Guardian				
If patient is unable to sign, state reason: _____				
Witness - TCHD Representative (print name)	Signature - Firma	Date - Fecha	Time - Hora	AM/PM

REFUSAL OF BLOOD TRANSFUSION

My signature below indicates no blood derivatives be administered during this hospitalization. I hereby release the hospital, its personnel, and the attending physician from any responsibility whatsoever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or its derivatives. The Possible risks and consequences of such refusal on my part have been fully explained to me by my attending physician and I fully understand that such risks and consequences may occur as a result of my refusal, even if this results in my death.

Name: Patient/Representative	Signature: Patient/Representative	Date	Time	AM/PM
If signed by a person other than the patient, indicate relationship to patient: _____				
Examples: Spouse, Partner, Legal Guardian				
If patient is unable to sign, state reason: _____				
Witness - TCHD Representative (print name)	Signature - Firma	Date - Fecha	Time - Hora	AM/PM

INTERPRETATION (Complete if Interpretation provided)

Interpretation provided in preferred language: _____ ☐ Telephonic ☐ VRI
☐ Face-to-face: ☐ I have accurately and completely reviewed this document in patient/patient's legal representative preferred language with: _____ ☐ Patient ☐ Patient's legal representative

Interpreter ID number or Name: _____ Interpreter Signature (if present): _____ Date: _____ Time: _____ AM/PM
☐ Patient refuses TCHD's interpretation services and selects as interpreter: _____ Name and relationship to patient: _____



Tri-City Medical Center

4002 Vista Way • Oceanside • CA • 92056




7420-4004
(Rev. 10/17)

**AUTHORIZATION FOR CONSENT
TO BLOOD TRANSFUSION OR
BLOOD REFUSAL**

White - Chart Yellow - Patient

Affix Patient Label

BLOOD BANK TRANSFUSION RECORD <small>Form 7500-5006 (Rev. 8/10)</small>	TRI-CITY MEDICAL CENTER OCEANSIDE, CA Pathologists: M. Contardo, M.D., M.P.H. Director B. Bobzien, M.D. J. Kao, M.D. M. Myrsiades, M.D. M. Shahidi-Asl, M.D. W. Snider, M.D.		SAMPLE		DELETE – see new form					CHART COPY  <small>7500-5006</small>	
	I HAVE IDENTIFIED INTENDED RECIPIENT BY ARMBAND AND COMPARED THIS WITH BLOOD LABEL, WITH THE UNIT IDENTIFICATION AND WITH THE PHYSICIAN'S ORDERS. I CERTIFY THESE TO BE CORRECT.		NAME _____								
	CHECKED BY _____		MEDICAL RECORD NO. _____								
	TRANSFUSION STARTED BY _____		ACCOUNT NO. _____								
	DATE _____ TIME _____		PATIENT'S LOCATION _____								
	TIME COMPLETED _____ AMOUNT TRANSFUSED _____		ARMBAND NO. _____								
	DISCONTINUED BY _____		PATIENT'S TYPE _____								
	ADVERSE REACTION <input type="checkbox"/> NO <input type="checkbox"/> YES DOCUMENT VITAL SIGNS ON BLOOD ADMINISTRATION POWER FORM		UNIT / POOL / LOT NO. _____								
	BLOOD WARMER TEMP. _____		CROSSMATCH _____								
			COMMENTS _____				COMPARE TO WRISTBAND				
		DONOR TYPE _____			COMPONENT _____			UNITS IN POOL _____		VOLUME _____	
					TECH _____		DATE _____				

TRI-CITY MEDICAL CENTER		SAMPLE													
OCEANSIDE, CA															
Pathologists: M. Contardo, M.D., M.P.H. Director B. Bobzien, M.D. J. Kao, M.D. M. Myrsiades, M.D. M. Shahidi-Asl, M.D. W. Snider, M.D.															
<div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <p>I HAVE IDENTIFIED INTENDED RECIPIENT BY ARMBAND AND COMPARED THIS WITH BLOOD LABEL WITH THE UNIT IDENTIFICATION AND WITH THE PHYSICIANS ORDERS. I CERTIFY THESE TO BE CORRECT</p> <p>CHECKED BY _____</p> <p>TRANSFUSION STARTED BY _____</p> <p>DATE _____ TIME _____</p> <p>TIME COMPLETED _____ AMOUNT TRANSFUSED _____</p> <p>DISCONTINUED BY _____</p> <p>ADVERSE REACTION <input type="checkbox"/> NO <input type="checkbox"/> YES DOCUMENT VITAL SIGNS ON BLOOD ADMINISTRATION POWER FORM</p> <p>BLOOD WARMER TEMP. _____</p> </div> <div style="width: 60%;"> <p>NAME _____</p> <p>MEDICAL RECORD NO. _____</p> <p>ACCOUNT NO. _____</p> <p>PATIENT'S LOCATION _____</p> <p>ARMBAND NO. _____</p> <p>PATIENT'S TYPE _____</p> <p>UNIT / POOL / LOT NO. _____</p> <p>CROSSMATCH _____</p> <p>COMMENTS _____</p> </div> </div>		<div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <p>ACCESSION NO. _____</p> <p>BIRTHDATE _____ SEX _____</p> <p>PHYSICIAN _____</p> <p>DONOR TYPE _____</p> </div> <div style="width: 60%;"> <p style="text-align: center;">COMPARE TO WRISTBAND</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 33%;">COMPONENT</th> <th style="width: 33%;">UNITS IN POOL</th> <th style="width: 33%;">VOLUME</th> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table> </div> </div>		COMPONENT	UNITS IN POOL	VOLUME									
COMPONENT	UNITS IN POOL	VOLUME													

BLOOD BANK TRANSFUSION RECORD




Form 7500-5006 (Rev. 8/10)


DELETE – see new form

BLOOD BANK COPY

8005-0057

BLOOD BANK COPY

SAMPLE		Perfusion TRI-CITY MEDICAL CENTER OCEANSIDE, CA Pathologist: M. Centardo, M.D., M.P.H. Director B. Bobben, M.D., J. Kao, M.D., M. Myrasiades, M.D. M. Shallick, Aet, M.D., W. Sander, M.D.		DELETE – see new form		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">NAME</td> <td colspan="2">ACCESSION NO.</td> </tr> <tr> <td colspan="2">MEDICAL RECORD</td> <td colspan="2">BIRTHDATE</td> </tr> <tr> <td colspan="2">ACCOUNT NO.</td> <td colspan="2">SEX</td> </tr> <tr> <td colspan="2">PATIENT'S LOCATION</td> <td colspan="2">PHYSICIAN</td> </tr> <tr> <td colspan="2">ARMBAND NO.</td> <td colspan="2" style="text-align: center;">▶ COMPARE TO WRISTBAND</td> </tr> <tr> <td colspan="2">PATIENT'S TYPE</td> <td colspan="2">DONOR TYPE</td> </tr> <tr> <td colspan="2">UNIT / POOL / LOT</td> <td>COMPONENT</td> <td>UNITS IN POOL</td> <td>VOLUME</td> </tr> <tr> <td colspan="2">CROSSMATCH</td> <td colspan="3">TECH DATE</td> </tr> <tr> <td colspan="2">COMMENTS</td> <td colspan="3" rowspan="2"> <div style="text-align: right;"> UNIT TAG  505-7057 </div> </td> </tr> <tr> <td colspan="2"></td> </tr> </table>				NAME		ACCESSION NO.		MEDICAL RECORD		BIRTHDATE		ACCOUNT NO.		SEX		PATIENT'S LOCATION		PHYSICIAN		ARMBAND NO.		▶ COMPARE TO WRISTBAND		PATIENT'S TYPE		DONOR TYPE		UNIT / POOL / LOT		COMPONENT	UNITS IN POOL	VOLUME	CROSSMATCH		TECH DATE			COMMENTS		<div style="text-align: right;"> UNIT TAG  505-7057 </div>				
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<div style="text-align: center;">  SAMPLE </div> <p>ABBREVIATED INSTRUCTIONS: READ BEFORE ADMINISTERING (Complete Instructions in Nursing Manual)</p> <ol style="list-style-type: none"> 1. Read label and unit tag carefully to assure that blood type on unit label matches blood type on unit tag. Donor type and patient type should be compatible for red cell products. 2. Check patient's identification bands. Name and numbers on arm bands must match name and numbers on unit tag. 3. Fill in signatures after verification. 4. Record Vital Signs. 5. Mix thoroughly and gently before administering. 6. Always administer through appropriate filter. 7. NO Medication is to be added to blood or component. <p>If there is a reaction: A. Stop Transfusion Immediately.</p>	
<div style="border: 2px solid black; padding: 5px; font-weight: bold; font-size: 1.2em;">DELETE – see new form</div>	
<p style="text-align: center;">With the Transfusion Reaction Form and post-transfusion urine specimen.</p> <ol style="list-style-type: none"> 8. Upon completion of transfusion, fill in volume, check appropriate adverse reaction box and sign form. 9. Place Chart Copy in patient's chart. 10. If NO adverse reaction, discard bag in appropriate Bio-Hazard waste container. <p>NOTE: DO NOT store blood in ward refrigerator. Unused blood must be returned to Blood Bank refrigerator within 30 minutes.</p>	
<div style="text-align: right; padding-right: 10px;">Perforation</div>	

SAMPLE

BEDSIDE VERIFICATION

Before administering this unit, we the undersigned licensed personnel, have verified the following items:

- Physician's order verified, component matches the order & Informed Consent documented
- Name, medical record number (MRN), and Blood Bank (BB) Armband Number are identical on patient's BB Blood Bank armband, patient identification (ID) Hospital Armband, Transfusion Record and Unit Tag.
- Unit number, Unit ABO Rh, Component type and Expiration date/time are identical on the Unit product label, the Transfusion Record and Unit Tag.
- Patient Transfusion Requirements (Irradiated, CMV Neg.) for RBC and Platelets are verified on Unit product label, Transfusion Record and Unit Tag. For RBC: Crossmatch compatibility is verified on Transfusion Record and Unit Tag.
- The Unit is normal in appearance.
- Unit has not expired.



Checked by:			
Transfusion Started By:		Date:	Time:
Completed:	Date:	Time:	Amount Transfused:
Discontinued By:	Blood Warmer Temp (if used):		
Transfusion Reaction:	<input type="checkbox"/> No <input type="checkbox"/> Yes, follow direction on back		

EMERGENCY DISPENSE:

☐ Due To Critical Condition Of Patient, Accept Unit Without Crossmatch: _____ MD

Document Vital Signs in IV/Anesthesiologist/Perfusionist Record. Use this section for Downtime Only:

	Pre	Start + 15 min.	Start + 1hr	Start + 2hr	Start + 3hr	Start + 4hr	1 hr. post
TIME							
INITIALS							
TEMP							
PULSE							
RESP							
BP							

 Tri-City Medical Center 4002 Vista Way • Oceanside • CA • 92056 Medical Director: M. Contarino, MD, MPH Section Designer: M. Sepkowitz, MD		Label size 3 1/2 inch by 4 inch PATIENT: TEST, SIMON MRN: 0000000 FIN#: 000000000 LOC: ARMBAND#: 33333333333 PATIENT TYPE XX-XXX UNIT TYPE XX-XXX UNIT#: W044216504728 UNIT EXPIRATION: 04/15/16 CROSSMATCH: COMPUTER XM OK	
 7500-5005		BLOOD BANK TRANSFUSION RECORD	
(Rev. 10/2011)		Internal Encounter Number	

SAMPLE

READ BEFORE ADMINISTERING, ABBREVIATED INSTRUCTIONS:

(Complete Instructions in Patient Care Services Procedure: Blood Products Administration)

1. Record/upload vital signs in IView. Follow current timing policy for documenting vitals during product administration in IView. See Below for Surgery or Downtime Manual Form.
2. Read unit label and unit tag carefully to assure that blood type on unit label matches blood type on unit tag. Donor type and patient type should be compatible for red cell products.
3. Check patient's identification bands Name and numbers on armbands must match name and numbers on unit tag
4. After verifying patient, sign BB transfusion Record above as having verified information and/or verified information and started the product administration.
5. Mix unit thoroughly and gently before administering, especially RBC.
6. Always administer all blood products through appropriate administration set with filter.
7. No Medication is to be added to blood or blood components.
8. Return any unused product to the blood bank if the patient has ~~does~~ not received any of the unit (even if unit has been spiked but patient has not received product) as soon as possible.
9. Product Administration: Should be completed within 4-hours of release from the Transfusion Service. The time released is recorded stamped on the Transfusion Request Form. If problem at bedside occurs delaying starting unit, keep unit at bedside if administration can be completed within 4-hr. limit.
10. DO NOT store blood or blood components in any of the floor's refrigerators.

IF THERE IS NO REACTION:

1. Upon completion of transfusion, fill in volume, check No- adverse reaction box and sign form.
2. Place this form in patient's chart.
3. If there is not an adverse reaction, discard bag in appropriate bio-hazard waste container

IF THERE IS A REACTION:

1. Stop Transfusion Immediately. Maintain venous access with normal saline.
2. Call patient's MD STAT, determine if they want to discontinue the transfusion and want to workup the suspected transfusion reaction. If decision is made, to discontinue unit, and do workup, hold bag and attached administration set and saline (unit) at bedside (hold for phlebotomist secured in sealed ~~able~~ bag).
3. Call Transfusion Service STAT at ext. 7394.
4. If the symptoms are LOCALIZED URTICARIAL ONLY, no blood sample or urine is collected. After reporting urticaria to MD and Transfusion Service, the transfusion may continue if directed by MD.
5. Document Vital Signs in IView.
6. Complete the Transfusion Reaction section of the Blood Products Administration ~~powerform~~
7. Transfusion Reaction Report will print automatically in the Transfusion Service when the ~~powerform~~ is signed.
8. Make a copy of this Transfusion Record to send to the Transfusion Service.
9. Collect the first voided or catheter urine after reaction. Phlebotomist who responds for workup sample collection will bring the Transfusion Record copy, the urine and the unit when they return to the Lab.

File 1/4 1 3/8 c-to-c

SAMPLE

The transfusion of blood and its components is, ordinarily, a safe and temporarily effective way to correct hematologic problems. However, some adverse effects may occur. The following is a list of symptoms that can be associated with transfusion reactions. Your illness may already cause some of these symptoms before the transfusion. If you notice any of your current symptoms rapidly increasing, or any new symptoms listed below, consult your physician immediately.

1. Fever
2. Dark or red-colored urine
3. Back pain
4. Nausea, vomiting, abdominal cramps or diarrhea
5. Increased or decreased urinary output
6. Acute shortness of breath (difficulty breathing)
7. Chills
8. Severe headache
9. Swollen extremities
10. Coughing
11. Rash, hives or itching
12. Jaundice and/or fatigue 2-4 weeks following transfusion

Care of Site

1. Leave dressing on for 24-hours.
2. If bleeding at the infusion site, use pressure with two fingers for 10 minutes. If bleeding continues, call the physician.

At the time of discharge:

Temperature _____ Pulse _____ Blood Pressure _____

I have read and understand these instructions.

Signature of Patient

Signature of Nurse

Date

Date



Tri-City Medical Center

4002 Vista Way • Oceanside • CA • 92058



7725-1003
(Rev 06/02)

OUT PATIENT POST TRANSFUSION INSTRUCTIONS

White - Medical Records Yellow - Patient

Affix Patient Label

SAMPLE

TRANSFUSION REQUEST FORM

Physician ordering transfusion: (Last name, first name)

_____, M.D.

SPECIAL PATIENT REQUIREMENTS: ☐ IRRADIATED

OTHER: _____

Product ordered for transfusion and quantity to be dispensed now:

Product (check)

Quantity

☒ **O-NEG UNCROSSMATCHED RED BLOOD CELL (RBC)'S** _____

☐ **EMERGENCY RELEASED BLOOD CELLS (RBC)** _____

☐ **RANDOM RBC'S, LEUKOPOOR** _____

☐ **PLATELET PHERESIS (PLPH), LEUKOPOOR** _____

☐ **THAWED PLASMA (TP)** _____

☐ **CRYOPRECIPITATE** _____

☐ **AUTOLOGOUS RBC'S** _____

☐ **DONOR SPECIFIC RBC'S, LEUKOPOOR** _____

☐ **OTHER BLOOD COMPONENT:** _____

ADDITIONAL ORDER NOTES: _____

☐ **Massive Transfusion Protocol (5 RBCs:5FP:1 PLPH) until ordering physician discontinues/stops**

Transfusion Service Identification Band Number: _____

Order verified by: _____, R.N.

Date: _____

Time: _____

Dispensed:

Date: _____

Time: _____

DO NOT WRITE IN THIS SPACE



Tri-City Medical Center

4032 Vista Way • Oceanside • CA • 92055



7500-1309
Rev. 2/14

TRANSFUSION REQUEST

White-Chart Yellow-Blood Bank

SAMPLE

Guidelines for Completing Transfusion Request Form (Add to back of page 1)

1. Attach a current patient chart label to each copy of the form.
2. Record the name of the physician ordering the transfusion on the corresponding line.
3. Check the type of product requested and indicate the number required for the current transfusion.
4. Record the Transfusion Service ID band (BBID) number in the corresponding area on the form. Use the current band number verified from the patient's BBID armband.

SAMPLE

TRANSFUSION REQUEST FORM

Physician ordering transfusion: (Last name, first name)

M.D.

SPECIAL PATIENT REQUIREMENTS: ☐ IRRADIATED

OTHER: _____

Product ordered for transfusion and quantity to be dispensed now:

Product (check)

Quantity

- ☒ ~~NEG UNCROSSMATCHED RED BLOOD CELL (RBC)'S~~ _____
- ☐ EMERGENCY RELEASED RED BLOOD CELLS (RBC) _____
- ☐ RANDOM RBC'S, LEUKOPOOR _____
- ☐ PLATELET PHERESIS (PLPH), LEUKOPOOR _____
- ☐ THAWED PLASMA (TP) _____
- ☐ CRYOPRECIPITATE _____
- ☐ AUTOLOGOUS RBC'S _____
- ☐ DONOR SPECIFIC RBC'S, LEUKOPOOR _____
- ☐ OTHER BLOOD COMPONENT: _____

ADDITIONAL ORDER NOTES: _____

☐ Massive Transfusion Protocol (5 RBCs:5FP:1PLPH) until ordering physician discontinues/stops

Transfusion Service Identification Band Number: _____

Order verified by: _____, R.N.		Date: _____	Time: _____
Dispensed:	Date: _____	Time: _____	
To: _____	Loc: _____	Cooler ID: _____	By: _____



Tri-City Medical Center

4002 Vista Way • Oceanside • CA • 92058



7500-1009
(Rev. 2/14)

TRANSFUSION REQUEST

White - Chart Yellow - Blood Bank

Attn: Patient Lab

SAMPLE

References:

- Circular of Information for the Use of Human Blood and Blood Components. AABB. Nov 2013 (revised April 2014)
- AABB Technical Manual. 18th Edition.



This brochure was developed by the California Department of Public Health, Laboratory Field Services (850 Marina Bay Parkway, Richmond, CA 94804)

In partnership with the Medical Technical Advisory Committee of the Blood Centers of California.

For information about brochure contents, please call Laboratory Field Services: (213) 620-6574

This brochure is provided as a source of information and is not considered a replacement for the Informed Consent process prior to the transfusion of blood.



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Revised 05/2018

A Patient's Guide to Blood Transfusion



California
Department of Public Health

June 2018

SAMPLE

This document provides written information regarding the benefits, risks, and alternatives of transfusion of blood products (including red blood cells, plasma, platelets, or others) collected from the patient (autologous) or another person. This material serves as a supplement to the discussion you have with your physician. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your physician prior to consenting to receive a transfusion.

■ Information about the treatment

Transfusions of blood products are provided to increase the amount of blood components in your body when they are below a reasonable level for your health. The transfusion may be made up of red blood cells, plasma, platelets or other specialized products made from blood. Your physician will decide on the right amount and type of blood product based on your medical condition or diagnosis.

■ Potential benefits of the treatment

Transfusion of blood products may be necessary to correct low levels of blood components in your body, and may also make you feel better. In some cases, failure to receive transfusion(s) may result in death.

■ Risks of the treatment

Known risks of this treatment include, but are not limited to:

- Irritation, pain, or infection at the needle site
- Temporary reaction such as a fever, chills, or skin rashes.

Other rare but more serious complications include severe allergic reactions, heart failure due to fluid overload, acute pulmonary edema (fluid leaking into the lungs), hemolysis (destruction of red blood cells), shock, or death.

Transfusion of blood products carries a very small risk of transmission of infectious diseases such as HIV (about 1 in 1.5 million), Hepatitis C (about 1 in 1.2 million), and Hepatitis B (about 1 in 1 million). Other significant infections may also be transmitted by transfusion, but overall this risk is low.

■ Treatment Options/Alternatives

If you need blood you have several options. Most patients requiring transfusion receive blood products donated by volunteer community donors. These donors are extensively screened about their health history and undergo numerous blood tests as mandated by state and federal regulations in order to ensure the safest possible blood supply. Alternatives to transfusion with blood products from volunteer community donors include:

- Pre-operative autologous donation (using your own previously donated blood), see below for more information
- Directed donation (blood donated by people who you have asked to donate for you), see below for more information
- Intra-operative autologous transfusion/Hemodilution (collecting your own blood during surgery to be given back to you)

- Medications (certain medications may increase blood volume prior to surgery or reduce active bleeding to lessen the need for transfusion)

These options may be available only if your health, time, and procedure permit. They may not be available at all locations or for all patients. You may also choose not to receive blood transfusion; however this decision may hold life-threatening consequences.

Pre-operative autologous donation is not appropriate for all patients. Autologous donation involves collecting your own blood prior to a planned surgery for storage in the hospital blood bank. It is important to discuss with your physician if it is safe for you to donate and the likelihood of needing a transfusion based on your surgery and current transfusion guidelines. Receiving your own blood may reduce, but will not eliminate, the risk of transfusion-related complications. Insurance company policies may vary regarding reimbursement for this service. Overall, although autologous donation is an option to consider for those who qualify, the number of autologous donations in the United States has significantly decreased in the last few decades mainly due to major advances in blood safety and efforts to decrease unnecessary blood transfusions.

Directed donation refers to blood collected from "directed donors" who are donating blood for a specific patient by request. Directed donors are often family and friends of the patient. Directed donors go through the same qualification process as volunteer donors. Directed donations are not considered to be safer than the general blood supply.

SAMPLE

Referencias:

- Circular de información para el uso de sangre humana y componentes sanguíneos. AABB. Noviembre de 2013 (revisada en abril de 2014).
- Manual técnico de AABB. 18ª edición



Este folleto fue desarrollado por el Departamento de Salud Pública de California, Servicios de Laboratorios (850 Marina Bay Parkway, Richmond, CA 94804).

En asociación con el Comité de Asesoría Técnica Médica (en inglés, Medical Technical Advisory Committee) de los Bancos de Sangre de California.

Para más información sobre el contenido del folleto, llame a Servicios de Laboratorio al (213) 620-6574

Este folleto se proporciona como fuente de información y no se considera un reemplazo del proceso de Consentimiento Informado previo a la transfusión de sangre.



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Transfusions.aspx](http://www.mbc.ca.gov/Publications/Brochures/Blood_Transfusions.aspx)

Revisado el 06/2018.

Una guía para el paciente sobre la transfusión de sangre



Departamento de Salud Pública
de California
Junio de 2018

SAMPLE

Este documento proporciona información escrita sobre los beneficios, riesgos y alternativas de la transfusión de productos sanguíneos (incluyendo glóbulos rojos, plasma, plaquetas u otros) que hayan sido extraídos del paciente (transfusión autóloga) u otra persona. Este material es complementario a la conversación que usted tiene con su médico. Es importante que comprenda totalmente esta información, por lo que debe leer este documento a fondo. Si tiene alguna pregunta con respecto al procedimiento, consulte con su médico antes de firmar el consentimiento para recibir la transfusión.

■ Información sobre el tratamiento

Las transfusiones de productos sanguíneos se proporcionan para aumentar la cantidad de componentes sanguíneos en su cuerpo, cuando estos se encuentran por debajo del nivel razonable para su salud. La transfusión puede estar compuesta de glóbulos rojos, plasma, plaquetas u otros productos especiales de la sangre. Su médico decidirá la cantidad y el tipo de productos sanguíneos correctos basándose en su diagnóstico o estado de salud.

■ Beneficios potenciales del tratamiento

La transfusión de productos sanguíneos puede ser necesaria para corregir niveles bajos de componentes sanguíneos en su cuerpo y también puede hacerlo sentir mejor. En algunos casos, no recibir una transfusión puede causar la muerte.

■ Riesgos del tratamiento

Los riesgos conocidos de este tratamiento incluyen, entre otros:

- Irritación, dolor o infección en el sitio de inserción de la aguja; y
- Reacciones temporales como fiebre, escalofríos o erupciones en la piel.

Otras complicaciones raras pero más serias incluyen reacciones alérgicas graves, insuficiencia cardíaca debido a la sobrecarga de fluidos, edema pulmonar agudo (fluido en los pulmones), hemólisis (destrucción de los glóbulos rojos), estado de shock o la muerte.

La transfusión de productos sanguíneos conlleva un riesgo muy bajo de transmisión de enfermedades infecciosas, como VIH (alrededor de 1 en 1,500,000), Hepatitis C (alrededor de 1 en 1,200,000) y Hepatitis B (1 en 1,000,000). Otras infecciones importantes también se pueden transmitir a través de la transfusión sanguínea, pero el riesgo general es bajo.

■ Opciones de tratamiento/ Alternativas

Si necesita sangre, tiene varias opciones. La mayoría de los pacientes que requieren una transfusión reciben productos sanguíneos de donantes voluntarios de la comunidad. Estos donantes son evaluados en profundidad acerca de su historia clínica y pasan muchos exámenes de sangre, de conformidad con las normas estatales y federales, para así garantizar un suministro sanguíneo lo más seguro posible. Las alternativas a la transfusión de productos sanguíneos donados por voluntarios de la comunidad incluyen:

- Donación de sangre autóloga preoperatoria (utilizar su propia sangre previamente donada), vea abajo para más información.
- Donación dirigida (sangre donada por personas a quienes usted le pidió que le donen sangre), vea abajo para más información.
- Transfusión autóloga intraoperatoria/ Hemodilución (extraer su propia sangre durante la cirugía para que le sea suministrada nuevamente).

- Medicación (ciertos medicamentos pueden aumentar el volumen sanguíneo antes de una cirugía o reducir el sangrado activo para disminuir la necesidad de transfusiones).

Estas opciones pueden estar disponibles para usted solo si su salud, el tiempo y el procedimiento así lo permiten. Puede que no estén disponibles en todas las ubicaciones o para todos los pacientes. También podrá elegir no recibir una transfusión sanguínea. Sin embargo, esta decisión puede tener consecuencias que pongan en peligro su vida.

La donación autóloga preoperatoria no es apropiada para todos los pacientes. Este método requiere extraer su propia sangre antes de una cirugía planeada para que sea almacenada en el banco de sangre del hospital. Es importante que discuta con su médico si es seguro para usted donar y las probabilidades de que necesite una transfusión según la cirugía y los manuales de transfusión actuales. Recibir su propia sangre puede reducir, pero no eliminará, el riesgo de complicaciones relacionadas con las transfusiones. Las pólizas de las compañías de seguros pueden variar con respecto a los reembolsos por este servicio. En general, aunque la donación autóloga es una opción a considerar para quienes califican, el número de donaciones autólogas en los Estados Unidos ha aumentado significativamente en las últimas décadas principalmente debido a los grandes avances en la seguridad sanguínea y los esfuerzos para disminuir las transfusiones de sangre innecesarias.

La donación dirigida refiere a sangre extraída de "donante directo" que donan sangre para un paciente específico por solicitud. Los donantes directos por lo general son familiares y amigos del paciente. Estos donantes directos pasan por el mismo proceso de cualificación que los donantes voluntarios. Las donaciones dirigidas no se consideran más seguras que el suministro general de sangre.

**PROCEDURE: DIABETES EDUCATION AND DISCHARGE PLANNING**

Purpose:	To outline Nursing's responsibility for providing survival skill diabetes self-management education
Supportive Data:	American Diabetes Association (ADA), American Association of Diabetes Educators (AADE) guidelines and The Joint Commission Certification Compliance/Standards.
Supplies	Diabetes Patient Education Booklets, selected medication education leaflets, blood glucose meters with test strips.

A. DIABETES EDUCATION:

1. It is not necessary to obtain an order for Diabetes Education from the physician.
2. All inpatients patients with diabetes should be assessed for diabetes self-management deficits deemed to be survival skills by the Joint Commission's education compliance standards.
 - 3-a. This includes patients who are newly diagnosed or patients who have a history of diabetes whether it is Type 1, Type 2, Gestational Diabetes, or pre-diabetes.
- 4-3. The required elements of education are all included in the **Tri-City Medical Center Diabetes Patient Education Booklets**.
 - 5-a. ~~The Tri-City Medical Center (TCMC)-Type 1 Diabetes Booklet~~ should be used for patients newly and previously diagnosed with **Type 1 Diabetes**. Patients admitted with diabetic ketoacidosis (DKA) will most likely, though not always, fall into this category.
 - b. ~~The TCMC-Type 2 Diabetes Booklet~~ should be used for patients newly and previously diagnosed with Type 2 Diabetes, and pre-diabetes, ~~and Gestational Diabetes~~.
 - 6-c. **Education for the Patient with Diabetes: An Antepartum and Postpartum Guide book or the Education for the Intrapartum Patient with Diabetes flyer** should be used for pregnant or postpartum patients.
- 7-4. Every patient admitted to TCMC with a diagnosis of diabetes as an inpatient is ~~assessed~~ **screened for nutrition risk** by a Registered Dietitian (RD) and **will be assessed as needed**. Education on meal planning ~~is~~ may be provided by the RD, depending on the circumstances of admission to the hospital, e.g. DKA. The content in the Patient Diabetes Education Booklets serves as the basis for meal planning education by the RDs. This same content is used by the Registered Nurse.
- 8-5. Each diabetic patient or at risk patient should have an A1c done on admission. If the A1c is not done, obtain order from physician.
 - a. An A1c greater than 8% warrants a change in medication and/or better self-management.
 - a-b. **Exception: gestational diabetes**
6. The Interdisciplinary Plan of Care (IPOC) should include **diabetes related goals and interventions (for example initiating "Adult Diabetes Endocrine" or Obstetric Diabetes During Pregnancy IPOC)** from which all education elements can be accessed for documentation.
- 9-7. **A Diabetes Learning Needs Assessment (LNA) is completed on admission to identify knowledge and self-management deficits a patient may have. The completed assessment is the basis for which education topics are provided to the patient and/or family/caregiver(s). The LNA is documented on either the PowerForm or in IView. It need only be completed once.**
- 40-8. All education is documented on in the electronic health record (EHR) (for example on either the Education All Topics Ad Hoc Form or in IView). ~~If documented on the PowerForm, the information will populated to IView, but IView documentation will not populated to the PowerForms.~~

Department ReviewPatient care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Diabetes Task Force	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
02/06, 01/10, 02/13, 07/18	01/06, 03/09, 02/10, 03/13, 10/16, 08/18	02/06, 05/09, 02/10, 03/13, 10/16, 09/18	12/16, 12/18	n/a	02/06, 05/09, 03/10, 01/14, 01/17, 01/19	01/19	03/06, 06/09, 04/10, 02/14, 02/17, n/a	03/06, 06/09, 04/10, 02/14, 02/17

B. TEACHING SUPPLIES:

1. Supplies should be obtained as soon after admission as possible so that there is enough time for learning.
2. The Diabetes Education Booklets contain all of the topics required for teaching in an inpatient setting.
3. The Inpatient Diabetes Educator is available to all nursing staff for complex patient education and management. **The primary nurse should be specific about the reason the consult was requested.** Examples include:
 - a. **Blood glucose management assistance**
 - b. **Complex learning needs**
 - a-c. Repeated hypoglycemic episodes
 - b-d. Persistent hyperglycemia
 - e-e. Patients with insulin pumps
 - d-f. Patients with frequent readmissions
 - e-g. Patients with learning difficulties
4. The Diabetes Task Force is a multidisciplinary committee that generally meets every ~~other month~~ **quarterly**. Diabetes care issues may be brought to this committee for discussion and resolution.

C. DIABETES DISCHARGE PLANNING:

1. Prior to discharge for patients meeting the following criteria, a diabetes care follow-up appointment is made with the provider who cares for the patient's diabetes:
 - a. ~~An~~ **HbA1c equal to or greater than 9% and/or**
 - b. ~~A~~ **New diagnosis of diabetes and/or**
 - c. ~~An~~ **Order for insulin at discharge in which the patient is new to insulin**
 - d. The appointment is documented in the ~~electronic health record (EHR)~~ including the provider, date and time.
 - i. If unable to schedule an appointment document reason in EHR.
2. Outpatient Diabetes Self-Management Education classes are encouraged. Registration information is found in the Diabetes Education Booklets.
3. The A1c is shared with the patient and documented in EHR.
4. The Family Risk Assessment (found on the back cover of the Diabetes Education Booklets) is provided to the patient with an explanation that siblings and children of the patient assess their risk for diabetes.
5. Prescriptions for diabetes supplies should be written for patients as needed, especially patients who are newly diagnosed with diabetes. These include:
 - a. Glucose meter, lancets, and strips
 - b. Glucagon emergency kit if patient is prone to severe hypoglycemia
 - c. Ketone test strips for patients admitted for DKA
 - e-d. **Glucose tablets**
 - d-e. Syringes and/or pen needles

PATIENT CARE SERVICES

ISSUE DATE: 12/01 **SUBJECT:** Discharge Planning, Inpatient

REVISION DATE(S): 6/03, 7/05, 02/10, 04/11 **POLICY NUMBER:** ~~VI.E~~

Patient Care Services Content Expert Approval:	08/18
Clinical Policies & Procedures Committee Approval:	12/14 09/18
Nurse Executive Council Approval:	12/14 11/18
Utilization Review Committee Approval:	11/15 12/18
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	01/16 01/19
Administration Approval:	01/19
Professional Affairs Committee Approval:	02/16 n/a
Board of Directors Approval:	02/16

A. DEFINITION:

1. Discharge Planning: A systematic, multidisciplinary and coordinated process that begins upon admission to the facility and continues throughout the patient's stay. It is an integral part of the inpatient Care Management process and serves to identify those patients who require continued healthcare services after acute hospitalization. The Interdisciplinary Team may be composed of the Physician, Case Manager, Social Workers, Nursing, Dietary, Physical, Occupational and Speech Therapy, Pulmonary Therapists, wound care staff, and any other staff that would be able to contribute to the development of a comprehensive discharge plan.

B. PURPOSE:

1. To collaborate with patient and/or family and/or their representative(s) to assess, facilitate, plan and advocate for the patients' ongoing needs on an individual basis. Through collaboration with the multidisciplinary team members as needed, the Case Manager shall initiate and implement an individualized **transition plan** (discharge plan) as necessary, through monitoring and re-evaluation to accommodate changes in treatment or progress.
- ~~1-2.~~ **The discharge planning process applies to all Inpatients; discharge planning is not required for outpatients.**
- ~~2-3.~~ To provide a comprehensive and safe discharge plan that strives to meet each patient's present needs.

C. POLICY:

1. The hospital will utilize an "8-Point Risk Assessment Tool" (Adapted from BOOST) that herein after is identified as "Risk Tool" to identify those patients at high risk for readmission. Inpatients who score six (6) or higher on the "Risk Tool", will be considered at high risk for readmission and "at risk of adverse health consequences post-discharge if they lack discharge planning".
2. Physicians, patients or their identified representative(s) may ask for discharge planning assistance. Assistance will be provided as available and/or appropriate regarding the availability of community resources and how those resources may be accessed and utilized to provide the most effective transition of care for those patients identified as having discharge planning needs.
3. Patients and/or their identified representative(s) will be asked for input into the transition of care plan (discharge plan) and will be kept informed of discharge plans throughout the transition of care process.

D. PROCEDURE:

1. Initial Patient Assessment:

- a. Initial Screening: All patients admitted to an Inpatient level of care will be screened by a Case Management representative for assessment of the patient's risk for readmission or "risk of adverse health consequences post-discharge" ~~not later than 48 business hours from admission~~. Assessment shall be documented in ALLSCRIPTS using the "8-Point Risk Assessment Tool.
 - b. Inpatients identified as being at High Risk for Readmission will receive an "evaluation of the post-discharge needs of inpatients identified in the first stage, or of inpatients who request an evaluation, or whose physician requests one."
 - c. This evaluation will be documented in the "Care Management Assessment" Section of ALLSCRIPTS.
 - i. The "Care Management Assessment" should consider the patient's illness, psychosocial, educational needs, and care and treatment required upon discharge as appropriate (this is not intended to be an all-inclusive list).
 - ii. The patient and/or designated representative(s) may also be interviewed as indicated to assure appropriate identification of; and coordination of necessary after-hospital services.
 - d. The Care Management Assessment shall be updated and re-evaluated as needed and documented appropriately to adequately reflect appropriate discharge planning and collaboration with other disciplines as required; which may include but not be limited to: Social Services and Physical Therapy for example.
 - i. ~~Timeliness of Initial Care Management Assessment:~~
 - 1) ~~Every reasonable effort shall be made to perform-~~ An initial discharge planning assessment will be performed when assessment criteria is met within 48 business hours of inpatient admission to TCMC or upon within 24 business hours of receiving receipt of an electronic health record (EHR) generated Consult (Referral) for Case Management intervention.
 - 2) Referrals for Discharge Planning may be initiated by physicians, patients and/or their designated representative(s), families, nursing staff and other ancillary staff as indicated.
 - ii. ~~Timeliness of Initial Social Worker Assessment:~~
 - 1) Social Service Assessments shall be initiated on a referral basis.
 - 2) ~~Every reasonable effort will be made to complete-~~ The Initial Social Service Assessment within 24 business hours of **will be performed upon receipt of receiving a an-EHR generated Consult (Referral) for Social Services intervention** and as needed thereafter in order to identify potential psycho-social needs that may adversely impact the discharge plan.
 - 3) Social Work Initial Assessment will be documented in ALLSCRIPTS: "Care Management Assessment".
2. Provision of Post-Hospital Services (Home Health, Hospice & SNF, etc.)
- a. The Case Manager and or Social Worker may collaborate with the physician, patient, family and other pertinent health care providers (that may include but not be limited to the RN caring for the patient at any given time) in an attempt to determine a patient's individual needs.
 - b. If the Case Manager / Social Worker assesses a need for home health care but there is no order, the Case Manager / Social Worker will suggest these services to the physician.
 - c. The Hospital identifies patients requiring post-hospital services and informs the patient and/or family and/or their representative(s) of their right to choose post-hospital services among Medicare providers for Home Care, Hospice & Skilled Nursing Facilities that serve the geographic area requested by the patient and/or family and/or their representative(s).
 - i. The Hospital shall maintain and make available a list of
 - 1) Medicare Certified Agencies that provide Home Health services
 - 2) Hospice services and
 - 3) Skilled Nursing services, that serves the geographic area in which the patient resides.

- ii. In the case of Home Health Agencies (HHA) the geographic area served is defined by the HHA.
3. Patient Choice of After Care Providers:
 - a. The Case Manager will ascertain whether the patient has had home health services in the past and confirm agency of preference.
 - b. The Hospital shall document the patient's choice and that the appropriate list was provided to the patient and/or the patient's designated representative(s) in the patient's medical record, using the appropriate Case Management charting system.
 - i. Patient, families and/or their representative(s) should be informed of possible issues that may limit patient choice that may include but not be limited to:
 - 1) Insurance Coverage issues or
 - 2) Provider Capability (for example: bed availability or inability of HHA or Hospice to meet patient needs or limited service area).
 - c. Post-Acute Care provider / agency of choice will be notified of referral with specific orders and other pertinent patient information, utilizing the Appropriate Referral Management System.
 - d. The Hospital discloses any financial interest Hospital (or Hospital's parent corporation) has in any Post-Acute Care Provider(s).
 - i. This disclosure is identified by BOLD FONT on list provided to patient.
4. Provision of Durable Medical Equipment (DME)
 - a. If the Case Manager/Social Worker identifies a need for DME and if there is not a physician order, the Case Manager/Social Worker may make a recommendation to the physician.
 - b. When an order for DME is received, the Case Manager shall provide DME provider choice to the patient, family and/or their representative(s) in keeping with patient's preferred providers and providers as directed by payer contract.
 - c. Case Manager / Social Work will make every reasonable effort to coordinate delivery of DME with patient, and/or their designated representative(s).
5. Provision of Weekend & Holiday Case Management & Social Service Coverage
 - a. Case Management & Social Service are available Monday-Friday, 0830 -1700 and ED Case Management coverage available until 0300
 - b. Case Management & Social Work will be onsite in a reduced number on weekends and holidays 0830 - 1700.
6. Transfer or Referral of Patients for Post-Hospital services
 - a. The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.
 - b. Upon creating a referral for post-hospital service(s) – hospital will endeavor to provide clinical information to the post-hospital provider necessary to make a clinical determination as to the appropriateness of the patient.
 - c. Clinical information accompanying a referral to post-hospital provider may include but not be limited to:
 - i. Patient diagnosis
 - ii. Dictated physician reports, when available
 - 1) History and Physical (H&P), Operative Reports, Consultations for example
 - iii. Therapy notes / assessments when available & appropriate
 - 1) Physical Therapy (PT)
 - 2) Occupational Therapy (OT)
 - 3) Speech Therapy (ST)
 - iv. Most recent Medication Administration Record (MAR) appropriate lab results
 - v. Advance Directive, when available for patients transferring to another facility
 - vi. Treatment Plan
 - d. Transition of Care Document includes but is not limited to:
 - i. Reason for hospitalization (Patient's Diagnosis/Problem List)

- ii. Hospital Course & Treatments(s)
- iii. Treatment Plan
- iv. Pain Treatment and Management
- v. Medication List
- vi. Dietary Requirement
- vii. Rehabilitation Potential
- viii. Known Allergies
- ix. Medical History & Physical
- x. Medical Discharge Summary

E. RELATED DOCUMENT(S):

- 1. ~~TCMC maintained Resource Lists: Home Health Care Agencies, Hospice Agencies & Skilled Nursing Facilities.~~

F.E. REFERENCE(S):

- 1. 42 CFR Ch, IV §482.43; CMS State Operations Manual Appendix A
- 2. The Joint Commission, Hospital: PC 04.01.01, PC 04.01.03 & PC 04.02.01
- 3. Health and Safety Code, 1262.5 "Discharge Planning"
- 4. CADPH, AFL 09-09, Subject: Hospital Discharge Policies, Senate Bill: (SB) 633. Letter pertains to "Discharge planning policy and process requirements pursuant to Health and Safety Code (HSC) 1262.5."

PATIENT CARE SERVICES

ISSUE DATE: NEW

SUBJECT: Discharge Planning, Homeless Patient Policy

REVISION DATE(S):

Patient Care Services Content Expert Approval:	12/18
Utilization Review Committee Approval:	12/18
Clinical Policies & Procedures Committee Approval:	12/18
Nurse Executive Committee Approval:	12/18
Medical Executive Committee Approval:	01/19
Administration Approval:	01/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. DEFINITION(S):

1. A homeless patient is an individual who:
 - a. Lacks a fixed and regular nighttime residence, or
 - b. Has a primary nighttime residence that is a supervised publicly- or privately-operated shelter designed to provide temporary living accommodations, or
 - c. Is residing in a public or private place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.
2. Residence: the location identified to the hospital by the patient as his or her principal dwelling place.

B. POLICY:

1. The purpose of this policy is to help prepare the homeless patient for return to the community by connecting him or her with available community resources, treatment, shelter, and other supportive services.
2. Nondiscrimination policy: Housing status will not be used to discriminate against a patient or prevent medically necessary care or hospital admission.
3. This policy applies to patients discharged from **Tri-City Medical Center** ~~an inpatient unit, emergency department, and acute rehabilitation facility.~~
4. All information about discharge will be provided to the homeless patient in culturally competent manner.
5. A homeless patient log will be available via the electronic health record.

C. PROCEDURE:

1. Patient Access Registrar will screen the patient to determine if homeless criteria are met.
 - a. The Patient Access Registrar will document the patient's answer or refusal to state by entering into the electronic health record.
2. The social worker, case manager, nurse and/or attending physician assigned to the patient will do further assessment to determine if the patient is homeless.
3. The social worker, case manager, and/or nurse will prepare an individual discharge plan for each homeless patient.
 - a. Discharge planning will be guided by the best interests of the homeless patient, his or her physical and mental condition, and his or her preferences for placement.
4. A post-discharge destination will be identified for each homeless patient, which may be:
 - a. A social services agency, nonprofit social services provider, or governmental services provider that has agreed to accept the patient.

- i. The social worker, case manager, and/or nurse must document the name of person at the receiving agency or shelter who agreed to accept the patient.
 - ii. The social worker, case manager, and/or nurse must send the receiving entity electronic information (depart) about the patient's post-discharge health and behavioral health needs.
 - b. The homeless patient's residence.
 - c. An alternative destination, as indicated by the homeless patient.
5. The hospital will not "cause the transfer" of a homeless patient to another county for the purpose of receiving supportive services from a social services agency, health care service provider, or nonprofit social services provider in the other county, unless the hospital has received prior authorization from the receiving entity to accept the specific patient.
6. Each homeless patient will be offered the following services prior to discharge:
 - a. The patient will be offered a physical exam and the physician will determine the patient's stability for discharge.
 - b. The patient will be given referrals for any needed follow-up care, both medical and behavioral, as determined by the treating physician. Referrals will include: the provider's name, address and phone number to make an appointment, other information as needed. If follow-up behavioral health care is recommended, the psych liaison will contact the patient's health plan or primary care provider or other provider (including entry into coordinated entry system), if applicable.
 - c. The patient will be offered a meal. This will be an inpatient tray or "to-go-meal" (bagged lunch).
 - d. If the patient's clothing is not weather-appropriate, the patient will be offered weather-appropriate clothing. Clothing available through social work, and also in specified patient care areas.
 - e. The patient will be provided discharge medications as determined by the treating physician via prescription (will need to provide medication supply when outpatient pharmacy is licensed during business hours).
 - f. The hospital will offer homeless patients when appropriate or refer homeless patients for infectious disease screening.
 - i. Infection Control is mandated to report all reportable diseases and conditions based on Title 17 to CDPH.
 - ii. All patients are "screened" for infectious diseases and reportable conditions based on signs and symptoms, lab tests, and risk factors.
 - g. The patient will be offered vaccinations appropriate to his or her presenting medical condition, as determined by the treating physician.
 - h. Hospital personnel will offer the patient transportation to his or her chosen discharge destination, if that destination is within 30 miles or 30 minutes of the hospital via appropriate transportation for the patient's condition.
 - i. The patient will be screened for, and helped to enroll in, any affordable health insurance coverage for which he or she is eligible by the hospital approved MediCAL screener.
 - j. Document homeless patient discharge plan in electronic health record.
7. A written plan for coordinating services and referrals for homeless patients is available including the following:
 - a. County behavioral health agencies
 - b. Healthcare and social services in San Diego County
 - c. Other healthcare providers
 - d. Nonprofit social services providers.
8. The plan will include a list of homeless shelters including:
 - a. Their hours of operation
 - b. Admission procedures/requirements
 - c. Population served
 - d. General scope of medical and behavioral health services available
 - e. Contact information for intake coordinator
 - f. Referral procedures

- g. Training protocols for discharge planning staff.

D. **REFERENCE(S):**

1. California Hospital Discharge Planning for Homeless Patients: Understanding the law on preparing to return homeless patients to the community
2. SB 1152, Hernandez. Hospital patient discharge process: homeless patients.

PATIENT CARE SERVICES

ISSUE DATE: 04/00 **SUBJECT:** Lift Team Technician

REVISION DATE(S): 06/03, 09/05, 6/08, 08/11, 05/15 **POLICY NUMBER:** VI.J

Patient Care Services Content Expert Approval:	11/18
Clinical Policies & Procedures Committee Approval:	04/15 12/18
Nurse Executive Committee Approval:	04/15 12/18
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Administration Approval:	01/19
Professional Affairs Committee Approval:	05/15 n/a
Board of Directors Approval:	05/15

A. POLICY:

1. Tri-City Healthcare District (TCHD) is committed to providing a safe environment for patients and staff. To minimize the risk of workplace injuries associated with the handling of patients, TCHD shall implement and maintain a safe patient handling policy for all patient care units.
2. This will include a lift team and safe patient handling procedures with mechanical lifting devices for every total body lift of non-ambulatory patients weighing more than 50 pounds.
 - a. TCHD personnel shall not be required to lift non-ambulatory patients weighing more than 50 pounds by themselves, except in an urgent or emergent situation.
3. Lift Team Technicians (LTT) are available for lifting assistance in the hospital.
 - a. When a LTT is not available on a unit or outpatient area, the Assistant Nurse Manager (ANM)/Relief Charge Registered Nurse (RN) or Supervisor shall obtain assistance with lifts from other patient care areas as well as other unit staff.
 - b. LTT duties in Women and Newborns Services and Surgical Services are provided by the peri-operative aides as well as other unit staff.
4. LTT shall remain on their designated units during working hours unless instructions are received from the unit's leadership team Clinical Manager (CM), ANM, Relief Charge RN, or Supervisor.
5. LTT shall remain in their designated areas during respond to all Rapid Response (RR), Code Blue, and Dr. Strong alerts to assist as needed.
 - 5-a. **At the scene of the emergency event, LTT will be released to regular duty by an ANM/Relief Charge RN or Administrative Supervisor (AS) if not needed**
 - 5-b. LTT assigned to the Intensive Care Unit shall accompany the RR or Code Blue RNs, and released to regular duty when as directed.
6. RNs and Advanced Care Technicians (ACTs) are expected to assist in the transfer and repositioning of ambulatory patients not requiring full body lift (i.e., bed to chair/wheelchair, bed to commode, or floor to bed.)
7. A RN or ACT shall be present when patients require repositioning by a LTT
8. LTTs shall follow the practices of their unit for the following:
 - a. Change of shift task
 - i. Obtain a brief shift hand-off to identify the patient's requiring repositioning
 - ii. Assist with answering telephones and call lights during the RN and ACT shift hand-off on Acute Care Services and the Telemetry unit
 - b. Patient rounding times
 - i. Scheduled rounds shall occur at least every two hours on assigned units
 - ii. ~~Write your initials on~~ Initial the patient education/rounding board in the appropriate time space after repositioning a patient

- c. Floor assignments when a unit is comprised of more than one floor
 - i. Womens and Newborn Services
 - 1) Assist with the transport of patients from the Emergency Department when notified per department practices i.e., pager system
 - ii. Acute Care Services (ACS)
 - 1) One LTT will be assigned to 4 Pavilion (4P) and One LTT will be assigned to 1 North (1N) on the day shift.
 - 2) One LTT will be assigned to 2P and One LTT will be assigned to 1N on the night shift.
 - a) Both LTTs will alternate tasks on the floor without an assigned LTT.
 - iii. Intensive Care Unit:
 - 1) One LTT will be assigned to the 1East and One LTT will be assigned to 1West when rounds are completed
 - 2) LTTs shall work together as needed
 - iv. Telemetry Unit:
 - 1) One LTT will be assigned to the second floor
 - 2) One LTT will be assigned to the fourth floor
 - 3) Both LTT will collaborate to assist with task on the third floor
 - d. Break and meal times
 - i. Follow unit practices
 - ii. Acute Care Services
 - 1) LTTs will sign up for their lunch/break times on the LTT logs at the beginning of the shift
 - 2) LTTs will notify all ACS floors of their lunch/break times
 - iii. Telemetry
 - 1) Sign-up for break by documenting your name in an allotted time on the break sheet.
 - 2) One LTT will be on the unit all times
9. The LTT personnel shall use a mechanical lifting device, when available, for every total body transfer. Equipment available may include:
 - a. Mechanical vertical or horizontal lifts
 - b. Full Length Slide Boards
 - c. Gait Belts
 - d. Mechanical Weighing Devices
 - e. Glide mat
 10. The Lift Team shall be called for all lifts as specified in this policy on their assigned units.
 - a. Lifts are defined as total body transfers to and from:
 - i. Bed to chair/wheelchair
 - ii. Bed to gurney
 - iii. Bed to commode
 - iv. Floor to bed
 - v. Bed or chair to scale
 - vi. Any other lift where total body movement of the non-ambulatory patient is required.
 11. Patient Safety
 - a. Prior to leaving a patient's room ensure the following:
 - i. Patient's room is clean and uncluttered
 - ii. Bedside tray within patient's reach
 - iii. Call button, television remote control and patient's other personal items are within their reach
 - iv. Patient's bed is in low position with upper side rails in the up-raised position
 - v. Patients are covered with a blanket or per their preference
 - vi. Ask if there is anything they can get for the patient

12. Performs the following task as directed by an RN and assist ACTs as directed by RN:
 - a. Assist ACTs and RNs with the following:
 - i. Admission and daily weights
 - ii. Positioning patients during baths
 - iii. Ambulating patients to bathroom that are potential risk for falls and the patient requires more assistance than one RN or ACT
 - b. Answers telephones and patient call lights during the RN shift hand-off, Protected Time, Quiet Time and PRN as directed by RN or per unit practices
 - c. Answers patient's call lights and relays message to RN or ACT
 - d. Transport specimens to the lab
 - e. Transport patient belongings or equipment to other nursing departments
 - f. Pick up medications (not controlled substances) from the pharmacy department and transport to nursing unit as directed by a RN
 - g. Obtain blood products from Transfusion Services
 - h. Transfers inpatients to other inpatient nursing departments
 - i. Transports discharged patients to personal vehicles
 - j. Keeps halls free from clutter and equipment and ensures equipment is not placed ~~near~~ or ~~blocks~~ blocking fire doors or entrance to patient's room
 - k. Assist with positioning patients during bedside procedures and treatments as delegated by RNs
 - l. **Assist with stocking supplies as directed by RN**
 - ~~k-m.~~ **Assist with inventorying supplies and equipment as directed by RN**
 - ~~l-n.~~ **Other duties as assigned by RN/AMN**
13. The Lift Team shall respond to a priority lift (in their designated area or when delegated by a CM, ANM/Relief Charge or Supervisor) immediately or as soon as it is safe to leave their current patient assignment.
14. Personnel who do not comply with this policy may be subject to discipline under Administrative Policy, Employee Health and Safety.

B. RELATED DOCUMENT(S):

1. Lift Team Helpful Hints (ICU, Telemetry, and ACS)

Lift Team Helpful Hints (ICU, Telemetry, and ACS)

TIME	TASKS	HELPFUL HINTS
0700-0759 And 1900-1930	<ol style="list-style-type: none"> 1. Obtain Shift Hand-off <p>Remain near nurses' station during RN shift hand-off to assist with answering telephones and patient call lights</p>	<p><u>Breakfast</u></p> <p>➤ Ask patients the following questions prior to leaving their rooms:</p> <ol style="list-style-type: none"> 1. Would you like to sit in the chair or dangle on the side of the bed for breakfast? 2. Can I get you anything before I leave? 3. Ensure patients are covered with a blanket
0800- until 1900 And 2000-0700	<ol style="list-style-type: none"> 1. Begin Rounding (round every 2 hours) 2. Note the patients who will require assistance with repositioning every two hours 3. Note the patients who will require assistance ambulating 4. Knock prior to entering a patient's room 5. Introduce yourself to patient 6. Write your name on patient's education board 7. Assist ACT with weights, repositioning patients. 8. Assist ACT as directed by RN with: <ul style="list-style-type: none"> • Assisting patients to chairs for meals • Repositioning positions for meals • Assist with repositioning for hygiene care 9. Perform duties assigned by RNs 10. Assist with discharges, transfers, and admissions 	<p><u>Lunch and Dinner</u></p> <p>➤ Ask patients the following prior to repositioning or assisting or leaving room:</p> <ol style="list-style-type: none"> 1. Would you like to be repositioned? 2. Would you like to sit in the chair or dangle on the side of the bed for lunch? Dinner? 3. Would you like to take a walk before or after lunch? Dinner? 4. Can I get you anything before I leave? <p>➤ Rapid Response (RR), Code Blue, Dr. Strong</p> <ul style="list-style-type: none"> • All LTTs shall respond, and either assist or return to regular duties as directed.
Breaks	<ol style="list-style-type: none"> 1. Take breaks as assigned 2. Inform RNs and ACTs prior to leaving the floor for break 3. Inform 2nd LTT, if applicable 	
PRN Task examples	<ol style="list-style-type: none"> 1. Assist with answering call lights and telephones during Protected Time and Quiet Time 2. Remove unused equipment from halls, ensure fire doors are not blocked with equipment 3. Ensure halls are free of clutter 4. Ask RNs or ACTs if new admissions or transfer patients require assistance with repositioning or ambulating 	

PATIENT CARE SERVICES

ISSUE DATE: 12/11

SUBJECT: Point of Care (POC) New Test/Method
Request and Implementation

REVISION DATE:

POLICY NUMBER: IV.BB

Patient Care Services Content Expert Approval:	04/15/10/18
Clinical Policies & Procedures Committee Approval:	05/15/11/18
Nurse Executive Committee Approval:	05/15/11/18
Department of Pathology Approval:	03/16/01/19
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	01/19
Professional Affairs Committee Approval:	04/16 n/a
Board of Directors Approval:	04/16

A. PURPOSE:

1. To ensure that:
 - a. POC testing meets the needs of the patients served, is performed correctly by non-laboratory staff, and is cost effective.
 - b. POC testing is approved by the appropriate committees at a hospital level before implementation.
2. Devices, tests, and analytes available as POC testing are continually improving and expanding. However, POC testing is not appropriate for use in all situations. New test and method requests must be evaluated before implementation.

B. POLICY:

1. POC testing is under the direction, authority, jurisdiction and responsibility of the Laboratory Medical Director.
2. Any patient testing, including testing that is performed outside of the clinical laboratory by non-clinical laboratory personnel, must conform to state and federal regulations. The **Product Standards Committee (PSC)** ~~Clinical Value Analysis Team (CVAT)~~ reviews all requests for new testing. Once approved by the **PSC** ~~CVAT~~, the ~~laboratory~~ **Laboratory and POC Department** will establish standards for POC testing, evaluate POC devices or tests before implementation, and monitor all POC testing sites for compliance.
3. Requestors must complete and submit the form "Request for Approval of New POC Test/Method" to POC Coordinator (POCC) and/or Lab Leadership Team.
 - a. The front of the form explains the extent and use of desired testing, and must be filled out in full by the requesting department.
 - b. The back of the form evaluates the financial impact of testing. This can be completed with assistance from the POCC, but the requesting department must be fully aware of all costs involved.
4. Requestors must then submit to the Clinical Value Analysis Team according to current **PSC** ~~CVAT~~ policies. **PSC** ~~CVAT~~ reviews all requests for new POC testing taking into consideration the following aspects:
 - a. Medical need for decreased turn around time
 - b. Procedure complexity
 - c. Regulatory compliance
 - d. Ongoing competency

- e. Cost
5. Following approval for consideration, the POCC and Lab Leadership Team assigns oversight to the appropriate personnel who will:
 - a. Assess available technology for the requested test by contacting vendors.
 - b. Evaluate and make recommendations to the ~~POC Committee~~ **Laboratory Leadership and Medical Director**.
 - c. Perform test method validation according to regulatory requirements and obtain approval by the Laboratory Medical Director.
 - d. Create written policies/ procedures that are clear to users and meet all regulatory requirements.
 - e. Establish quality control policy to be followed by testing personnel with regular review of data by responsible staff.
 - f. Enroll in appropriate proficiency testing or establish alternative proficiency testing if needed.
 - g. Ensure testing personnel are trained and demonstrate competency prior to performing patient testing.
 - h. Request Lab Information System or Information System input, if needed.
 - i. Communicate to physicians new test availability.
 - j. The Laboratory Medical Director and POCC review and approve all data for test implementation prior to patient testing. The Lab Medical Director is involved in the selection of all equipment and supplies, in accordance with College of American Pathology (CAP) regulations.
6. CAP requirements for POC testing ~~include including but not limited to the following general items. Refer to the POCC and current CAP POC testing checklist for specific requirements.~~
 - a. Proficiency testing is performed at intervals determined by the subscribed survey, in a timely manner, as similar to patient testing as possible, by personnel who perform patient tests, and rotated among all testing personnel.
 - b. Testing Personnel must adhere to manufacturer instructions and written procedure.
 - c. Results are reported in the medical record. Critical Results are handled appropriately.
 - d. Reagents are stored properly. New lots and shipments are evaluated appropriately before use.
 - e. Equipment maintenance is performed and documented to meet manufacturer requirements.
 - f. Personnel must be trained and competency assessed according to the ~~current Patient Care Services Procedure:~~ **Point of Care Testing Competency Assessment Policy**
 - g. Quality Controls are performed and documented at required intervals.
7. Managers overseeing departments performing POC testing must ~~complete the Request for Approval of New Point of Care Test/Method understand and support the Federal/ State/ Agency/ and Organizational standards. The following statement must be read and agreed to, and signed on the form 'Request for Approval of New POC Test/Method:~~
 - a. ~~I have read and understand the "POC New Test/Method Implementation" Policy and the CAP requirements for POC testing. I am qualified as a manager and will assume responsibility for testing, including all aspects of training and certification of personnel, quality controls, proficiency testing, competency checks, routine instrument maintenance, recording of all test results and all other required documentation. I also understand that all supplies are the responsibility of the performing department. The privilege to perform testing will be removed if requirements are not met and maintained.~~

C. **FORM(S) ATTACHMENTS:**

1. Request for Approval of New Point of Care Test/Method
2. ~~Refer to current forms required by CVAT.~~
- 3.2. Request for Clinical Product Review

4.D. **RELATED DOCUMENTS:**

- 5.1. Patient Care Services Procedure: Point of Care Testing Competency Assessment

D.E. REFERENCE(S):

1. College of American Pathology. CAP Accreditation Program. Point of Care Testing Checklist Tri-City Medical Center, CAP Number: 2317601. Version: ~~04.21.2014~~**08.22.2018**.
2. College of American Pathology. CAP Accreditation Program. Team Leader Assessment of Director and Quality Checklist Tri-City Medical Center, CAP Number: 2317601. Version: ~~04.21.14~~**08.22.2018**.

Tri-City Medical Center		Distribution: Point of Care Quality Management	
FORM: REQUEST FOR APPROVAL OF A NEW POINT OF CARE TEST / METHOD			
Purpose:		To ensure that, <ol style="list-style-type: none"> 1. Point of Care testing meets the needs of the patients served, is easily performed correctly by non-laboratory staff, and is cost effective. 2. Point of Care testing is approved by the appropriate committees at a hospital level before implementation. 	
Supportive Data:		Refer to the Policy: POINT OF CARE NEW TEST/METHOD REQUEST AND IMPLEMENTATION The Clinical Value Analysis Team (CVAT) reviews all requests for new testing. Once approved by the CVAT, the Lab Point of Care Coordinator (POCC) and Leadership Team will evaluate further to assess Accuracy, Precision, and added value of the new testing. To expedite your request, complete the form in full and submit one copy to the CVAT and one to the Lab POCC.	
Test Requested:	Date request submitted:	Requestor (name, title, department, phone, email):	
Name of Manager for requesting Department: Manager's certification: I have read and understand the 'Point of Care New Test/ Method Implementation' Policy and the CAP requirements for Point of Care testing. I am qualified as a manager and will assume responsibility for testing, including all aspects of training and certification of personnel, quality controls, proficiency testing, competency checks, routine instrument maintenance, recording of all test results and all other required documentation. I also understand that all supplies are the responsibility of the performing area. The privilege to perform testing will be removed if requirements are not met and maintained. Signature: _____ Date: _____			
How did you learn about this test? <input type="checkbox"/> Contacted by Vendor (Company/Name) <input type="checkbox"/> Journal (citation) <input type="checkbox"/> Conference/Seminar (Title/date) <input type="checkbox"/> Recommended by colleague (Name/contact info) <input type="checkbox"/> Physician Request (Name/phone) Info: _____ _____ _____		Purpose for requesting test: <input type="checkbox"/> Patient care goals <input type="checkbox"/> Provides greater benefit than current system <input type="checkbox"/> Shorter TAT or reduced cost <input type="checkbox"/> New technology or new test to this institution <input type="checkbox"/> Replacement for test or instrument Explain: _____ _____ _____	
How will test results be used? (Screening, Monitor, Diagnosis)		Where will this test be used? Patient population: Nursing Units/Departments:	
Algorithms: <u>Diagnosis and Screening:</u> -What (if any) clinical findings should be present prior to performing the test? - What is the follow-up for a positive test? - What is the follow-up for a negative test? <u>Monitoring:</u> -What will the frequency of monitoring be? Dependent on clinical findings or time? -Does monitoring need to occur at a specific point in time (e.g. post therapy)? -Does the test have important decision levels? -Critical Values? Relate to lab? Actions to be taken? -Repeat values?		Who will perform this test? Job description: Approx # of operators: Advantages/Disadvantages to testing in central lab: (Method/ Accuracy/ Sensitivity/ Value added?) Test requirements: Quantitative or Qualitative? Analytical Range? Low end sensitivity? Accuracy/Precision? Will follow up testing be required?	
Statement of Clinical Justification:		Estimate annual test volume:	Estimate annual cost: (see pg.2)
Statement of Clinical Justification:		Statement of Cost Justification:	

FINANCIAL ANALYSIS / COST ESTIMATION:

Equipment:

___ # Instruments x \$ ___ each = Total Capital Cost \$ ___ / ___ yrs Life of Instrument = **1**\$ ___ Capital/yr

Reagents and Disposables:

Test/Reagent: \$ ___ Cost per kit / ___ # tests/kit = \$ ___ Cost per test
 Supply A: \$ ___ Cost per box / ___ # per box = \$ ___ Cost per test
 Supply B: \$ ___ Cost per box / ___ # per box = \$ ___ Cost per test
 Supply C: \$ ___ Cost per box / ___ # per box = \$ ___ Cost per test
 Supply D: \$ ___ Cost per box / ___ # per box = \$ ___ Cost per test
 Supply E: \$ ___ Cost per box / ___ # per box = \$ ___ Cost per test
 Total Cost Reagents/Disposables per test: **2**\$ ___ Cost / patient test
 (- any disposables not used for QC testing) **3**\$ ___ Cost / QC/PROFICIENCY test

Proficiency Testing:

CAP Survey: **4**\$ ___ Cost per year

User Training / Competency:

users ___ x # training tests/ year ___ x **5**\$ ___ Cost / QC/prof test = **5**\$ ___ Training Cost/year

Annual Volume:

___ Number of Patient Tests x **2**\$ ___ Cost per patient test = **6**\$ ___ Annual Cost Patient Test
 Number of QC Tests: # ___ Days of testing x # ___ Instruments x # ___ levels of QC = # ___ QC Tests
 Number of Proficiency Tests: # ___ Surveys per year x # ___ Samples per survey = # ___ Prof. Tests
 # QC ___ + # Prof. ___ = # ___ Total QC/Prof x **3**\$ ___ Cost / QC/prof test = **7**\$ ___ Cost QC/Prof.
 Total Annual Cost for testing: **1**\$ ___ + **4**\$ ___ + **6**\$ ___ + **3**\$ ___ + **7**\$ ___ = \$ ___ Total Cost /year

Other Costs/ Capital Costs:

Software: ___ Interface: ___ Total other/capital: \$ ___
 Hardware: ___ Other not listed above: ___

**** Point of Care Committee Use Only ****

CAP Activity Menu updated?	Yes	No	N/A	Notes:
Included in POC QM Plan	Yes	No	N/A	
Proficiency Test Ordered?	Yes	No	N/A	
Procedure Approved?	Yes	No	N/A	
Competency Written?	Yes	No	N/A	
Competency Checklist updated?	Yes	No	N/A	

0 1 2 3 4 5 6 7 8 9 10



Tri-City Medical Center

Request for Clinical Product Review

The purpose of this form is to request review and evaluation of a new or alternate product. Please complete this form and submit to Supply Chain Management. All requests will be reviewed by the Clinical Value Analysis Team.

Date of Request: _____

Requestor: _____ Product Name: _____

Department: _____ Sales Rep Contact Name: _____

Extension: _____ Sales Rep Contact #: _____

Vendor: _____ Manufacturer Rep: _____

Manufacturer: _____

Reason for Request:

☐ Regulatory Requirement

☐ Patient Safety

☐ Improves Quality / Outcomes

☐ Improve Efficiency

☐ Cost Savings

☐ Other: _____

Product description and function: _____

Please explain the improvements noted above (attach literature, if appropriate): _____

Indicate anticipated usage per month: _____

Indicate areas to use this product:

☐ Acute Care Services

☐ Critical Care Services

☐ WCS

☐ Ancillary Services

☐ Emergency Services

☐ Surgical Services

☐ Other: _____

Will this product replace a currently used product? ☐ Yes ☐ No

Current Product: _____ Manufacturer: _____ Manufacturer Item No.: _____

To be completed by Supply Chain Management

Current Product: _____ MMIS Item No: _____

Cost \$ _____ Packaging: _____ Monthly Usage: _____ GPO Contract: _____

Proposed Product: _____

Cost \$ _____ Packaging: _____ Monthly Usage: _____ GPO Contract: _____

ECRI Cost Range: _____



Tri-City Medical Center

Request for Clinical Product Review - CHECKLIST

The purpose of this form is to request review and evaluation of a new or alternate product. Please complete this form and submit to Supply Chain Management. All requests will be reviewed by the Clinical Value Analysis Team.

PRODUCT NAME: _____

REQUESTOR: _____ EXT: _____

DEPARTMENT: _____

In order to facilitate this request for the Clinical Value Analysis Committee, the items below need to be reviewed and approved by the appropriate department

Has the product been assessed/reviewed by:

- ☐ GAP Analysis performed for tubing misconnection
- ☐ Infection Control
- ☐ IT (computer/software related)
- ☐ Risk/Patient Safety
- ☐ Engineering (room modification/air handling)
- ☐ SPD

Is this new product disposable or reusable? _____

Does the new product require any additional consumable to utilize it? _____

If yes, provide product information: _____

Will this product require educational training? _____

What resources will the vendor provide for product education and final implementation? _____

**FOR ALL REQUESTS SUBMITTED FOR CLINICAL VALUE ANALYSIS PLEASE ATTACH BROCHURE,
PRODUCT RESEARCH AND ANY EVIDENCE BASES ARTICLES / WHITE PAPERS**

**PROCEDURE: PRECEPTOR PROGRAM**

Purpose: To outline the procedure for Preceptor Program at Tri-City Healthcare District (TCHD).

Supportive Data: Education Department Policy & Procedures: Preceptor Role

A. DEFINITIONS:

1. Preceptors are Registered Nurses (RN) that have successfully completed the **Tri-City Healthcare District (TCMCHD)** Preceptor training and have been endorsed by management with their signature on the Preceptor Application Form (~~Attachment A~~).
2. Precepting consists of **one to one (1:1)** training of new employees to the department during the official orientation period per Administrative Policies: **8640-457 "New Hire Orientation"** and **#458 "Competency"**.
3. ~~The Preceptor Program applies to precepting RN New Graduates during orientation. Upon completion of Orientation the RN New Graduate is supported by a "Mentor" until completion of the first year per Education Department Procedure RN New Grad Mentor Program.~~
4. The Preceptor Program does not apply to working with students; please refer to **Patient Care Services Policy: VIII.M Nursing Students in Patient Care Areas**.

B. PROCESS TO BECOME A NEW PRECEPTOR:

1. ~~All RN's who meet the following qualifications may apply to become a Preceptor for new hires.~~
 - a. ~~At least Six (6) months experience at Tri-City Medical Center as an RN in the clinical area where precepting will occur.~~
- 2.1. The RN must demonstrate effective qualities of precepting in daily clinical performance such as:
 - a. Demonstrated willingness to share information and teach others as seen in patient family education, working with students in clinical rotations and working with all members of the Healthcare team.
 - b. Consistency in demonstrating TCMCHD Service Standards with all members of the healthcare team, patients, families and visitors.
 - c. Clinical knowledge and practice in accordance with TCMCHD Policies and Procedures.
 - d. Not on a performance action plan within the past six (6) months.
- 3.2. If the above qualifications have been met the RN may request endorsement on a preceptor Application Form (~~Attachment A~~) from the department Management team (Manager-/Assistant Nurse Manager [ANM]).
- 4.3. Once the Preceptor Application Form is signed by the Manager-/ANM, the RN must take the form to the department Clinical Educator- /Clinical Nurse Specialist (CNS) to be enrolled into the Preceptor Training module in Net-Learning.
- 5.4. Upon successful completion of the Preceptor Training Module in Net-Learning, the RN must take one copy of their transcript (proof of completion) to their Clinical Educator-/CNS and one copy of their transcript (proof of completion) to the Manager/ANM to begin preceptor assignments.
5. In order to become eligible for "Preceptor Differential" Pay in accordance with the **Certified Nursing Assistant/CNA contract** and ~~this Patient Care Services Preceptor procedure~~, the RN must successfully complete both:
 - a. ~~Application process components (Endorsed Preceptor Application — Attachment A) and completion of~~
 - b. ~~preceptor training~~ **Preceptor class**. If a preceptor class is not offered the nurse must complete the following:
 - i. ~~(Net-Learning transcript with proof of completion of Preceptor Training-Net Learning module).~~
 - 6.ii. **One on one training with Clinical Educator/CNS or Manager**

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
12/12, 01/17, 03/17	12/12, 02/17, 11/18	12/12, 11/18	n/a	n/a	01/13, 01/19	01/19	02/13, n/a	02/13

C. PROCESS FOR PRECEPTORS WHO TRANSFER TO A DIFFERENT DEPARTMENT:

1. When an RN who has completed the preceptor training, and transfers to a different department, they will not be required to re- take the preceptor training.
2. The Manager-/ANM-/Clinical Educator-/CNS will determine when an RN will be assigned as a preceptor based upon the RN demonstrated Preceptor qualities-per PCS Preceptor Procedure.

D. PRECEPTOR ASSIGNMENTS:

1. Manager is responsible for designating and communicating the process within the department for Preceptor assignments, monitoring and evaluation for continued Precepting.
2. Manager is responsible for determining duration of training and orientation for new hire RN's and transfers to the department. ~~In general, orientation duration may follow these timeframes:~~
 - a. ~~Experienced RNs (generally 2 weeks)~~
 - b. ~~RN New Graduates (generally 10-12 weeks)~~
 - c. ~~Travelers (generally 2 shifts)~~
3. Preceptor Performance Evaluation Forms (~~attachment C~~) can be utilized by all staff working directly with Preceptors to evaluate performance as needed. It is the responsibility of the Preceptor to utilize the feedback to improve skills and performance.
4. All Performance Evaluation Forms are the responsibility of the Manager and will be kept in the employee file in the department.

E. ESSENTIAL PRECEPTOR DUTIES AND RESPONSIBILITIES:

1. Function as a clinical role model for Nursing knowledge, practice and technical skill.
2. Orient and train new staff using the department skills checklist.
3. Provide written documentation of the orientee's skills and progress on the skills checklist.
4. ~~Demonstrate~~ Demonstrate positive service standards in the delivery of care with the orientee.
5. Provide a rich learning environment with effective communication and feedback.
6. Complete the Orientation Performance Evaluation Form (~~Attachment B~~) with the orientee, providing effective feedback on their performance while continuing to motivate a positive attitude towards orientation and the department.
7. Provide written documentation of the orientees performance on the orientation performance evaluation form for each orientee daily/weekly according to department guidelines.

F. PRECEPTOR FLOATING:

- ~~F.1.~~ 1. If it is the primary preceptor's turn to float and there is another RN on the unit who is a designated "preceptor", the orientee assigned to the preceptor may- stay and orient with that other preceptor. If there is not another "preceptor" on that shift, then the primary preceptor would skip that float.

G. PRECEPTOR PAY:

1. RN Preceptor is eligible for "Preceptor Differential" when orienting new RN's to the department.
2. Preceptor is responsible for identifying the shift and hours they are available for precepting.
3. Float staff, per-diem registry, students are considered part of the RNs professional responsibility and as such are not compensated with a preceptor differential.

H. FORM(S) AVAILABLE ON THE INTRANET:

1. ~~Annual Preceptor Status Form~~
- ~~2.1.~~ 2. Case Management Orientation Performance Evaluation Form
2. Circulating Case Evaluation Tool
3. ~~Preceptor Performance Orientation~~ Evaluation of Preceptor Form ~~—Sample~~
4. Preceptor Application Form ~~—Sample~~
5. RN Orientation Performance Evaluation Form ~~—Sample~~
- ~~5.6.~~ 6. Scrubbing Case Evaluation Tool

B. RELATED DOCUMENT(S):

1. Administrative Human Resources Policy: New Hire Orientation 8610-457

2. **Administrative Human Resources Policy: 458-Competency 8610-458**
- 6.3. **Patient Care Services Policy: Nursing Students in Patient Care Areas**

Employee ID # _____

Name _____

Annual Preceptor Status Form

DEPARTMENT _____ Status: ☐ Active ☐ Inactive ☐ Termed

Manager/Assistant Nurse

1. Manager/Assistant Nurse establish a new preceptor and complete assessment and complete assessment.
2. Manager/Assistant Nurse evaluation.

DELETE – no longer needed

Educator / CNS to complete annual evaluation review in active status. Preceptor at annual evaluation.

Please complete the following

		Disagree	Agree	Strongly Agree
Provides consistent clinical supervision		2	3	4
Submits in a timely manner documentation of orientee's performance on the Orientation Performance Evaluation forms	1	2	3	4
Provides a supportive learning environment for orientees	1	2	3	4
Uses effective communication to provide constructive feedback to orientees	1	2	3	4
Acts as a role model for department/organization as demonstrated by:				
Assessment Skills	1	2	3	4
Clinical and Technical Skills	1	2	3	4
Knowledge of Standards & Policies	1	2	3	4
Service Excellence Skills	1	2	3	4

Date: _____

Manager/Assistant Nurse Manager (print name) _____ (signature) _____

Date: _____

RN Preceptor / Employee (print name) _____ (signature) _____

Please turn-in completed form to the Preceptor Program Coordinator, Education Department

Employee ID # _____

Orientee Name _____

Dept _____

Case Management Orientation Performance Evaluation Form

- Orientee complete self evaluation column and develop orientation goals to discuss with Preceptor.
- Preceptor complete Preceptor evaluation column
 - ✓ Review form and discuss orientation performance with orientee before signing form.
 - ✓ Complete one orientation performance evaluation each shift OR each week per your department guidelines.

Date(s): _____ **of shift(s) worked with orientee during the week**

Standard	Orientee Self Evaluation of Performance			Preceptor Evaluation of Orientee Performance			Scoring: 2 Requires Assistance 3 Performs Independently Not Observed - Did not perform during shift, no opportunity
	2	3	Not Obs	2	3	Not Obs	
Performs an Accurate Assessment of Patient's Needs.							Performs Patient Assessment within Standard of Care for dept. Collaboration with multi-disciplinary team members as needed.
Comment:							
Initiate and implement an individualized transition plan							Coordination of discharge planning with patient/family, Provide Patient Choice for any applicable needs. Send referrals to appropriate providers. Performs accurate documentation in EMR per Dept specific process.
Comment:							
Integrates transition/discharge plan into the patient specific Cerner Depart.							Updates Discharge Plan/Depart as needed Notification to MD/Nursing Staff Notification to patient/family
Comment:							
Case Management Assessment/Ongoing Note(s) is Accurate and Appropriate, including using SBAR							Report is accurate and timely Follows Dept process for Hand off Communication using Allscripts Case Management Census
Comment:							
Utilizes InterQual for Severity of Illness/Intensity of Service (SI/IS) guidelines to perform and document clinical reviews.							Performs InterQual Review to identify appropriateness of Level of Care (ICU/CCU, DOU/Telemetry, Med/Surg, etc).
							Performs Continued Stay, Retroactive, and Discharge Reviews as per Dept Policy (Pt Care Mgmt Utilization Review Process).
							Appropriately identifies admission criteria for Observation vs Inpatient status.
Comment:							

Standard	Orientee's Self Evaluation of Performance			Preceptor Evaluation of orientee's performance			Scoring: 2 Requires Assistance 3 Performs Independently Not Observed - Did not perform during shift, no opportunity
	2	3	Not Obs	2	3	Not Obs	
Workflow Prioritization							Appropriately prioritizes work flow based on discharge needs. Referrals made to other disciplines as needed.
Comment:							
Professionalism TCMC Service Standards							Professional with patients, family, and visitors. Demonstrates effective interpersonal skills with the health care team and coworkers
Comment:							
Physician Orders							Verbal orders (V.O.) are only during an emergency. Telephone orders (T.O.) are only when an MD can't enter an order into Cerner. Patient class/status (INPT vs OBS, SDS, etc) orders need to be written by the MD in Cerner before patient is discharged. Do not take V.O. or T.O. from MDs/NPs for pt class changes. Follows Physicians Orders PCS Policy IV.M
Comment:							
Goals for next week							

Orientee's Printed Name: _____ **Signature:** _____

Preceptor's Printed Name: _____ **Signature:** _____

CIRCULATING CASE EVALUATION TOOL

Date: _____

Employee: _____ Preceptor: _____

Procedure #1: _____ Procedure #2: _____

Procedure #3: _____ Procedure #4: _____

1=Observation Only; Did Not Perform

2= Requires Assistance Inconsistent performance often not meeting expectations; rarely demonstrates desired behaviors without prompting or directions.

3=Performs Independently Generally meets most expectations; demonstrates desired behavior without prompting; recognizes own limitations and seeks guidance appropriately.

4=Can Teach Others Consistently meets or exceeds all expectations; demonstrates desired behaviors independently and possesses knowledge base sufficient to share knowledge and skills with others.

PRE-OPERATIVE PHASE	SELF EVALUATION OF PROCEDURE #				PRECEPTOR EVALUATION OF PROCEDURE #			
	1	2	3	4	1	2	3	4
Room organization								
Reviews and follows preference card								
Patient assessment and documentation								
Pre-procedure verification/documentation								
Patient and family education								
Communicates patient changing status								
Able to organize patient care while remaining flexible to changing needs of the patient								

INTRA-OPERATIVE PHASE	SELF EVALUATION OF PROCEDURE #				PRECEPTOR EVALUATION OF PROCEDURE #			
	1	2	3	4	1	2	3	4
Assist with anesthesia induction								
Knowledge of instruments and procedure								
Positioning the patient								
Prepping the patient								
Documentation & Lab forms								
Specimen handling procedures								
Aseptic technique								
Medications and solutions properly labeled								
Participates in Time Out								
Rapport with staff and MD's								

POST-OPERATIVE PHASE	SELF EVALUATION OF PROCEDURE #				PRECEPTOR EVALUATION OF PROCEDURE #			
	1	2	3	4	1	2	3	4
Reporting skills: change of shift/PACU/ICU								
Room turnover								

Comments: _____

TIME IN	TIME OUT	TIME IN	TIME OUT
---------	----------	---------	----------

Employee Signature: _____ Date: _____

Preceptor Signature: _____ Date: _____

Employee ID # _____

Preceptor Name _____

Orientation Evaluation of Preceptor Form

Orientees Instructions:

1. Please complete evaluation form on your preceptor.
2. Please return to your Clinical Educator who will forward to the Clinical Manager.

Name of Orientees Completing Form: _____

Department: _____

Date: _____

Name of Preceptor Being Evaluated by Orientees: _____

	Strongly Disagree	Disagree	Agree	Strongly Agree
My preceptor:				
Worked with me on my goals for the day	1	2	3	4
Assessed my skill level before introducing new learning experiences	1	2	3	4
Acted as a role model for:				
Assessment Skills	1	2	3	4
Clinical and Technical Skills	1	2	3	4
Knowledge of Standards & Policies	1	2	3	4
Clinical documentation (Cerner)	1	2	3	4
Service Excellence	1	2	3	4
Provided instructions and explanations for:				
Procedures & tasks	1	2	3	4
Clinical documentation (Cerner)	1	2	3	4
Nursing Practice	1	2	3	4
Provided supportive learning environment	1	2	3	4
Used effective communication to provide constructive feedback	1	2	3	4

Please turn-in completed form to the Clinical Educator/CNS/Manager
Coordinator, Education Department _____



Employee ID # _____ Dept: _____

New Preceptor Name

Preceptor Application Form

RN Instructions:

1. Review PCS Procedure [Preceptor Program] to ensure you meet the qualifications for participation.
2. Obtain endorsement of your application with evaluation and signature by your Manager/ ANM.
3. Take signed application to your Clinical Educator / CNS for enrollment into the Preceptor Training net learning module (TCMC Librarian will only grant access to module upon receipt of this application).
4. Upon completion of the module notify your Manager/ANM and Clinical Educator/CNS to begin receiving preceptor assignments.

Nurse Name: (Printed)	Strongly Disagree	Disagree	Agree	Strongly Agree
Provides consistent clinical documentation in a timely manner	1	2	3	4
Provides a supportive learning environment for staff, students	1	2	3	4
Demonstrates the ability to teach and evaluate clinical performance of students in clinical rotations within the dept	1	2	3	4
Uses effective communication with all members of the healthcare team, patients, visitors and families	1	2	3	4
Has completed Department specific skills checklist and demonstrates ability to teach to the skills checklist				
Assessment and Care of Patients admitted to Dept	1	2	3	4
Operation and Troubleshooting of Dept Equipment	1	2	3	4
Knowledge of Nursing Standards, Policies & Procedures	1	2	3	4
Professionalism and Service Standards	1	2	3	4
Total Score (must be ≥ 24) to participate in Preceptor Program	Total Score = _____			

1. This Nurse has at least 6 months experience at TCMC in this department.
2. I support this Nurse (RN) participating in TCMC Preceptor Program:

_____/_____
Manager / ANM (print name) (signature) Date: _____

Department: _____ Cost Center: _____

RN Orientation Performance Evaluation Form

Instructions:

1. Orientee:

- a. Score each standard you demonstrate during the shift(s), to reflect the level of support you need. (2) or (3)

2. Preceptor:

- a. Reviews orientee's self assessment scores and provide preceptor scores for each standard you observe performed during the shift. Mark not observed for the items you do not have a chance to perform.
b. Review and discuss orientation performance with orientee and plan goals together, then both sign completed form.
c. Forward the completed "orientation performance evaluation form" to your department Clinical Educator/CNS.
d. Please complete one orientation performance evaluation each shift OR each week per your department guidelines

Orientee Name: _____ Mentor/Preceptor Name: _____
Date(s): _____ Number of shifts worked with orientee: _____ Orientation Week # _____

Place checkmark where applicable: 2 Requires Assistance 3 Performs Independently

Standard	Orientee Self Evaluation			Preceptor Observed Evaluation			
	2	3	N/A	2	3	N/A	
Performs an Accurate Patient Assessment.							Performs Patient Assessment within Standard of Care for Department.
							Recognizes Normal and Abnormal findings on exam.
							Comments:
Recognizes change in patient's condition.							Changes recognized and appropriate intervention taken.
							When calling a Physician, communicates accurate patient information and is able to anticipate needed orders for patient.
							Comments:
Seeks out, reviews and interprets lab results.							Obtains lab/test results in timely manner in Cerner/ Medical Record.
							Reports Critical Values Accurately and timely.
							Correlates labs and diagnostics to the patient's clinical picture.
							Comments:
Nursing Report is Accurate and Appropriate.							Report is accurate and timely.
							Procedural Hand off communication process is accurate.
							Comments:
Delivery of Care / Workflow Priorities in Patient Care.							Appropriately identifies priorities of care for patients according to unit specific standards of care and appropriate to each patients level of acuity.
							Delegates to healthcare team appropriate to their scope of practice.
							Comments:

Standard	Orientee Self Evaluation			Preceptor Observed Evaluation			
	2	3	NA	2	3	NA	
Integrates Patient Assessment and Patient information into the Nursing Care Plan.							Completes a Patient Admission accurately and timely.
							Updates Care Plan in accordance with unit specific guidelines.
							Patient teaching is accurate.
							Comments:
Professionalism Service Excellence							Provides emotional support to patients, family, and visitors.
							Demonstrates effective interpersonal skills with the health care team.
							Comments:
Medication Administration							Follows rights before administering medications.
							Demonstrates understanding of meds action, onset-duration, indications for use, side effects, anticipated prn response
							Documents in barcode medication administrator device correctly including prn response.
							Patient teaching for medications, indications, side effects is accurate.
							Comments:
Physician Orders							Notes and implements Physician's orders accurately and in a timely manner.
							Repeats back all telephone orders including medications.
							Comments:

Preceptor Feedback to Orientee	Comments:
Goals for next week:	1. 2.
Number of patients	Patient(s) Acuity

Updated Skills Checklist _____ (initial)

Orientee's Signature: _____ Preceptor's Signature: _____

SCRUBBING CASE EVALUATION TOOL

Date: _____

Employee: _____ Preceptor: _____

Procedure #1: _____ Procedure #2: _____

Procedure #3: _____ Procedure #4: _____

1=Observation Only; Did Not Perform

2= Requires Assistance Inconsistent performance often not meeting expectations; rarely demonstrates desired behaviors without prompting or directions.

3=Performs Independently Generally meets most expectations; demonstrates desired behavior without prompting; recognizes own limitations and seeks guidance appropriately.

4=Can Teach Others Consistently meets or exceeds all expectations; demonstrates desired behaviors independently and possesses knowledge base sufficient to share knowledge and skills with others.

PERFORMANCE CRITERIA	SELF EVALUATION OF PROCEDURE #				PRECEPTOR EVALUATION OF PROCEDURE #			
	1	2	3	4	1	2	3	4
Demonstrates knowledge of case								
Reviews and follows preference card								
Demonstrates knowledge of equipment/instruments								
Uses strict aseptic technique in opening of supplies								
Performs proper surgical scrub								
Correctly gowns and gloves self								
Correctly gowns and gloves other team members								
Demonstrates knowledge and ability of draping								
Demonstrates knowledge of instrument set-up								
Medications & Solutions properly labeled								
Participates in Time Out								
Demonstrates organizational skills								
Attempts to anticipate needs of surgeon								
Demonstrates knowledge and ability in handling suture								
Demonstrates accuracy of sponge, sharps & instrument counts								
Demonstrates knowledge & proper application of Standard and Isolation precautions								
Performs thorough and efficient post-operative case clean-up/turnover								

Comments: _____

TIME IN		TIME OUT		TIME IN		TIME OUT	
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Employee Signature: _____ Date: _____

Preceptor Signature: _____ Date: _____

PATIENT CARE SERVICES
Administrative Policy Manual

ISSUE DATE: 04/06

SUBJECT: Provision of Education for
Adolescents during During
Hospitalization

REVISION DATE(S): 02/09, 02/11

POLICY NUMBER: ~~8610-391~~

Patient Care Services Content Expert Approval:	12/18
Clinical Policies & Procedures Committee Approval:	12/15 01/19
Nurse Executive Committee Approval:	01/16 01/19
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	01/19
Professional Affairs Committee Approval:	03/16 n/a
Board of Directors Approval:	03/16

A. PURPOSE:

1. To address the specific academic education needs of adolescents by supporting continuity of education during hospitalization.

B. POLICY:

1. Parents will be informed upon admission that assistance in communicating with the adolescent's school during hospitalization will be provided after the 14th day of hospitalization.
2. Collaboration with the adolescent's school will be facilitated upon parental request and permission.
3. The Case Manager will:
 - ~~3-a.~~ eCommunicate with the adolescent's school regarding coordination of appropriate educational services to meet both the adolescent's academic and medical needs during hospitalization.
 - ~~4-b.~~ The Case Manager will fFacilitate coordination of educational services provided by the school district.
 - ~~5-c.~~ The Case manager will eContact the school district representative/ adolescent's teacher to assist with transition upon the adolescent's return to regular school or for home follow-up after discharge.

**PROCEDURE: SPONGE, SHARPS & INSTRUMENT COUNTS, PREVENTION OF RETAINED SURGICAL ITEMS**

Purpose: To outline nursing responsibilities and accountability regarding sponges sharps, and instrument counts in the surgical/procedural areas.

Supportive Data: Sponges, sharps, and instrument counts are performed during surgery/invasive procedures to provide for safe patient care and prevent retained surgical items. Counts for sponges/soft goods, sharps, and instruments are performed to account for all items used on the surgical field and to lessen the potential for injury to the patient as a result of a retained surgical item. All items are to be counted except those used for storage or disposal of items.

Equipment: White Board, White Board Marker, Count Sheet(s), Sponge holders

A. POLICY:

1. Sponges, sharps, and miscellaneous item counts are required on all procedures except eyes and cystoscopies.
2. All counts shall be conducted both audibly and visually.
 - a. Counted items shall be visualized by both the scrub person and circulator/designee.
 - b. At time of permanent relief of either the scrub or circulating Registered Nurse (RN), direct visualization may not be possible; the team shall account for all items.
3. In surgery/obstetric operating room (OB-OR), one of the counting team members must be an RN.
4. A count may be initiated by any member of the perioperative team.
5. Unnecessary activity and distractions should be omitted during the counting process.
6. To the extent possible, the initial count shall be completed before the patient is brought into the **Operating Room (OR)**.
7. Counts may be omitted in an emergency.
 - a. The emergent nature of a procedure or an unexpected change in the condition of the patient may necessitate omission of counts to preserve patient life or limb. In such cases, counts may be waived on order of the surgeon. The surgeon will document the omission of the count and rationale for the practice variation in the medical record.
 - b. If counts were omitted due to an emergency, ~~fluor~~**fluoro image**~~x-ray~~**x-ray** shall be performed and read prior to the completion of skin closure.
 - i. Document events regarding the nature of the emergency.
 - ii. Document the name of physician reading the ~~fluor~~**fluoro image**~~x-ray~~**x-ray** and the ~~fluor~~**fluoro image**~~x-ray~~**x-ray** results.
 - iii. **The ~~fluor~~**fluoro image**~~x-ray~~**x-ray** must be saved in the patient's electronic health record (EHR).**
 - iv. Complete an incident report.
8. If a patient is transferred to another department for completion of the procedure (i.e., transferred from OR to Interventional Radiology or transferred from Labor and Delivery to OR), an ~~fluor~~**fluoro image**~~x-ray~~**x-ray** must be performed and read for retained surgical items prior to the completion of skin closure.
9. Sponge, sharps, and miscellaneous item counts shall be written on the white board. Instrument counts shall be recorded on the instrument count sheet(s).

B. PROCEDURE:

1. Surgical counts are classified as:
 - a. Initial count: count before the procedure begins to establish the baseline and identify

Patient Care Services Content Expert	Operating Room Committee	Clinical Policies & Procedures Committee	Nurse Executive Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/03, 04/06, 08/09, 05/12, 01/13, 05/14, 04/15, 09/15, 10/17, 06/18	06/14, 01/16, 12/17, 07/18, 10/18	06/12, 07/13, 05/14, 11/15, 02/16, 01/18, 12/18	06/12, 02/13, 05/14, 02/16, 01/18, 12/18	07/12, 07/14, 09/16, 02/18, 01/19	01/19	08/12, 10/14, 10/16, 03/18, n/a	08/12, 11/14, 11/16, 03/18

- 132

- e. Inform a member of the department's leadership team ~~Assistant Nurse-Manager (ANM)/charge nurse/designee~~ of count discrepancies.
12. ~~Fluor~~**Fluoro imageX-rayX-ray** interpretation for incorrect counts, emergencies, and ~~fluor~~**fluoro imageX-rayX-ray** in lieu instrument counts:
 - a. When possible, it is highly recommended that a radiologist read the ~~fluor~~**fluoro imageX-rayX-ray** before the skin is closed and the results of the reading, along with the name of the person who read the ~~fluor~~**fluoro imageX-rayX-ray**, are documented.
 - b. At a minimum, the surgeon must interpret the film intraoperatively.
 - ~~b.c.~~ **The ~~fluor~~fluoro imageX-ray must be saved in the patient's EHR.**
13. If an item is used to occlude the colpotomy during a da Vinci hysterectomy (i.e., asepto or glove), it becomes a countable item and must be accounted for at the end of the case.

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

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

D. SHARPS AND MISCELLANEOUS ITEMS COUNTS:

1. The following counts are required for sharps and miscellaneous items:
 - a. Initial count
 - b. Add count
 - c. Relief count
 - d. Cavity count
 - e. Closing count
 - f. Final count
2. Packaged needles containing an incorrect number shall be removed from the room.
3. All used needles are to be placed in a puncture-proof needle counter box.
 - a. Place one needle in each numbered slot; do not double-up needles in a numbered slot.
 - b. Obtain an additional needle counter box if the initial needle counter box is full.
4. Counting number of needle packages may not be used to reconcile an incorrect needle count.

E. INSTRUMENT COUNTS:

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

- recorded and retained.
- vii. When possible, it is highly recommended that a radiologist read the ~~fluorofluoro imageX-rayX-ray~~ before the patient leaves the OR and the results of the reading, along with the name of the person who read the ~~fluorofluoro imageX-rayX-ray~~, are documented. At a minimum, the surgeon must interpret the film intraoperatively.
- e. Reverse total shoulder replacements: the surgeon shall announce when the humeral protector is placed into the wound and when it is removed and the RN circulator shall record it on the whiteboard.

F. DOCUMENTATION:

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

G. REFERENCE(S):

1. ~~AORN Guidelines for Perioperative Practice, 2017 Edition.~~ Conner, R. (2018). Guidelines for Perioperative Practice, 2018 Edition. Denver, CO: Association of PeriOperative Registered Nurses.
2. Verna Gibbs, MD. NoThing Left Behind®: Prevention of Retained Surgical Items Multi-Stakeholder Policy (2015).

**PROCEDURE: 2-D ECHOCARDIOGRAPHY WITH CONVENTIONAL & COLOR FLOW DOPPLER AND M-MODE**

Purpose: Cardiovascular technologists (CVT) shall be knowledgeable in performing a 2-D echocardiogram using the Philips ~~IE33 and Siemens Sequoia~~ **Cardiac Sonography** ultrasound machines, **to identify and quantify pathology and hemodynamic function of the heart and to improve patient outcomes.**

Supportive Data: Current **American Society of Echocardiography(ASE)** and **American Registry of Diagnostic Medical Sonography (ARDMS)** accepted guidelines

Equipment: Philips ~~IE33 and Siemens Sequoia~~ **Sonography** ultrasound machines

A. POLICY

1. Confirm physician's order.
2. In-patient verbal stat ~~echo's~~ **echocardiograms (echo)** ordered by an ~~cardiologist MD~~ is sufficient but ~~the cardiologist MD~~ must **enter the order** ~~echo~~ in Cerner ASAP. If order is not in chart at time of the exam, then the CVT will ask the attending nurse to put ~~the echo order~~ into Cerner using the proper protocol.
3. All echocardiograms should contain ~~the~~ images, Doppler, and measurements. ~~listed under "Exam Procedure"~~. Modified views may be necessary ~~and as~~ some views and measurements may not be available. Attempts must be documented.
4. All echocardiograms will be performed, optimized, measured, calculated, and analyzed according to the ASE and the ARDMS accepted guidelines.
5. Images will be captured digitally and stored in the CPACS/McKesson digital system.
6. Machine settings, transducer selection, and patient position will be adjusted as needed to optimize all captured images including Doppler display.
7. Introduce yourself and use (2) patient identifiers to verify correct patient.
8. CVT will explain the test to patient.
9. Perform "Standard Precautions" at all times.
10. Maintain patient privacy.

B. PROCEDURE:

1. Daily Preparation:
 - a. Check for previous echo exam for each patient. If ~~previous-echo exam~~ is less than 1 year (or use your best judgement), direct patient's nurse to contact ordering physician to verify ~~if echo is needed~~ **needed echo**. Print previous report and ~~keep with~~ **add to** patient folder.
 - i. ~~For inpatients -~~
 - 1) Obtain the code status, contact precautions status, fall risk, height & weight, applicable medical history, and patient cardiologist, if any.
 - 2) Triage patient exams according to: Cardiologist, diagnosis, critical care units, chronological order, discharge status, etc.
 - 3) When ready, call patient's nurse to confirm if patient is available for exam ~~rew.~~
 - 4) ~~Call tech aide to transport patient to echo lab~~ **Use Aionex transport system to request the patient** or go portable as appropriate.
 - ii. ~~For out~~ **Out-patient's - Registered in CVI** **Obtain scheduled patients from CVHI secretary. Echo's usually performed in the Institute.**
2. Patient Preparation:
 - a. Establish indication for exam and whether the patient has a current Cardiologist. Obtain brief cardiac history from patient.
 - b. Enter patient information into sonography machine and select appropriate settings.

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- c. Use towel and or patient gown to cover female chest area at all times.
 - d. Connect ECG to patient. Use ultrasound gel as appropriate.
3. Performing the Procedure:
 - a. For each view stated below, when indicated, obtain additional 2-D images, Doppler spectral tracings, color flow images, and utilize the measurement packages for additional quantitative assessment, such as for pericardial and valvular disease, chamber size analysis, diastolic function analysis and other assessments when indicated. The following order is preferred; however patient access and cooperation may require a different order.
 - i. Parasternal (PLAX, RA/RV) long axis with M-Mode, color flow and PW/CW Doppler when indicated.
 - 1) LV with visualization of RVOT, LV, AO, LA, CS, DA.
 - 2) RV inflow with visualization of RV, RA, CS, IVC
 - ii. Parasternal short axis (PSAX) with M-mode, color flow and PW/CW Doppler when indicated
 - 1) LV apex
 - 2) Papillary muscles (midlevel)
 - 3) MV (basal level)
 - 4) AV with visualization of SVC, RA, TV, RV outflow, PV, PA, AV, LA
 - iii. Apical (AP4CH, AP2CH, APLAX) with color flow and PW/CW Doppler when indicated
 - 1) Four-chamber
 - 2) Four-chamber with AV (AP5CH)
 - 3) Two-chamber
 - 4) Long axis
 - iv. Subcostal (SUBC) with M-mode, color flow and PW/CW Doppler when indicated
 - 1) Four-chamber
 - 2) Atrial view with emphasis on IAS with color flow Doppler
 - 3) Short axis (if the PSAX views were suboptimal)
 - 4) IVC and hepatic vein with demonstration of respiration (sniff)
 - v. Suprasternal notch long axis of the aorta with Doppler, when indicated
 - vi. Right parasternal area view (RLD) of the aortic valve with CW, when indicated
 - vii. Miscellaneous imaging plus color flow, pulsed wave and/or continuous-wave Doppler of other sites when clinically indicated.
4. Evaluation:
 - a. 2-D Echo and M-mode evaluation:
 - i. LV, RV wall motion characteristics. Is wall motion normal? Normal wall motion is uniform contractility throughout systole and diastole. Abnormal wall motion is defined as global or segmental abnormalities (hypokinesis, akinesis, dyskinesis)
 - 1) Systolic excursion
 - 2) Systolic thickening
 - 3) Timing
 - 4) Segmental approach (base, mid, apical) in each view
 - 5) Ejection fraction
 - 6) Fractional shortening
 - 7) IVS and PW thickness/mass
 - ii. Chamber/vessel size, volumes and characteristics
 - 1) LV, LA, RV, RA, IVC (with sniff), Aorta, LVOT
 - 2) LV aneurysm (true, false)
 - 3) Thrombus
 - 4) Mass
 - 5) Pacemaker wires, catheters, other

- iii. Valve appearance and morphology (thickened, prolapse, flail, mass, vegetation)
 - 1) MV, chordae, papillary muscle, annulus (calcification, prosthesis, ring)
 - 2) Aortic root and aortic valve appearance (calcification, prosthesis)
 - 3) Tricuspid and pulmonary valve appearance
 - iv. Pericardial effusion/pleural effusion
 - b. Color and Spectral (Pulsed and Continuous wave) Doppler evaluation, when indicated:
 - i. Mitral and annulus velocities: E, A, E/A ratio, E/E', IVRT, DT, mean gradient, pressure half time and MVA (MS)
 - ii. Mitral regurgitation jet: velocity, quantitative assessment
 - iii. Pulmonary venous flow: systolic, diastolic, atrial reversal wave velocity/duration
 - iv. Tricuspid inflow & regurgitation jet: velocity, quantitative assessment (including RVSP)
 - v. Left ventricular outflow tract velocity, peak gradient
 - vi. Aortic velocity: Velocity, mean and peak gradients, AVA, quantitative assessment. Aortic stenosis the highest systolic velocity from multiple views (apical, suprasternal, right parasternal, subcostal). When indicated, a non-imaging Doppler transducer (Pedoff) should be used.
 - vii. Aortic regurgitation jet: velocity, quantitative assessment
 - viii. Pulmonary artery flow velocity/regurgitation: acceleration time, PR end diastolic jet velocity
 - ix. Atrial and ventricular ~~septa~~-color Doppler and PW/CW screening for defects.
 - c. Bubble study (agitated saline) when ordered by a physician.
 - i. Attending ~~cardiologist~~ **Cardiologist** or cardiac nurse will inject agitated saline into an IV access, according to lab protocol, followed by acquisition of echo images.
 - ii. Contrast study (Definity) when ordered by a Cardiologist/ **Physician/physician extender**.
 - 1) Attending cardiologist or cardiac nurse will inject Definity contrast agent according to the manufacturer's and the lab protocol, followed by acquisition of echo images.
 - d. At the conclusion of the test:
 - i. Patient is wiped clean of gel, transducer is cleaned and linens are changed. ~~and supplies~~ **Supplies** are re-stocked.
 - ii. Transfer images to CPACS digital workstation.
 - iii. Complete the CVT preliminary report and place patient folder in ~~cardiologist's~~ **Cardiologist's** in-box.
 - iv. Record the exam information on the CVT log.
 - v. CVT will process the billing charges for the inpatients. The scheduler will process charges for the outpatient's.

**PROCEDURE:** 12-Lead EKG Procedure

Purpose: All EKG technicians will be knowledgeable in obtaining a 12-lead EKG, to evaluate the electrical impulses generated by the heart during the cardiac cycle to assist with diagnosis of cardiac arrhythmias, blocks, damage, infection, or enlargement.

Supportive Data: ELI 350Marquette Manual and National Patient Safety Goal (2005)

Equipment: 12-lead EKG MachineMarquette EKG Machine

A. POLICY:

1. Once ordered, an EKG will be performed. Stat EKG's will be done in 10 minutes or EKG's are to be performed in 10 minutes or less once ordered less. Notification of a patient's MD or RN if the following automated EKG interpretation appears in the execution of electrocardiogram tracings when automated interpretations are read from the EKG tracing, notification of the patient's immediate caregiver must be made when the following EKG interpretations are made:
 - a. Ventricular Tachycardia.
 - b. Ventricular Fibrillation.
 - c. Complete heart block.
 - d. Marked sinus bradycardia.Pause >3 seconds
 - e. Acute MI.
2. In the Emergency Department, the technician will personally hand the ECG preliminary tracing to the patient's physician or primary RN.
3. In the inpatient units, the technician will personally hand the ECG preliminary tracing to the patient's nurse.

B. PROCEDURE:

1. Introduce yourself and explain procedure. Inform patient of who you are and what you will be doing.
2. Identify the patient by using two (2) patient identifiers.
3. Enter patient information into cart.
 - a. Enter F1 key "PatInfo". Turn machine on
 - b. Enter patient last name (return). Work list (password EKG1), OK
 - c. Enter patient first name (return) Download MWL.
 - d. Enter patient medical record number (return). Query code (OK)
 - e. Enter age (return). WiFi connection for patient list
 - f. Enter gender (return). Highlight (patient name).
 - g. Enter physician (return). Load ID
 - h. Enter test indication — diagnosis (return). Patient Information (OK)
 - i. Enter tech I.D. number (enter). Run EKG for (10 seconds).
 - j. Enter patients FIN number (enter). Auto (ready to print), next enter
 - k. Enter location number (return). Print (EKG)
 - l. Enter room number (return). XMT transmission status (OK)
4. Apply electrodes using correct lead placement.
 - a. V1 and V2 on either side of sternum, 4th intercostal space.
 - b. V4 at the mid clavicular line, 5th intercostal space.
 - c. V3 halfway between V2 and V4.
 - d. V5 and V6 on same level with V4 in the anterior and mid axillary lines.
 - e. LL on the left leg, RL on the right leg, LA on left arm and RA on right arm.
5. Record 12-lead EKG. Ensure a good baseline, i.e. without artifact, somatic tremor or wandering baseline and save on diskette.
 - a. Artifact: an artifact is anything on the EKG that is not caused by the currents

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generated during the cardiac cycle. Artifacts include interference, 60 cycle, somatic tremor and wandering baseline.

- b. 60 cycle: caused by leakage of the electrical power.
 - i. To correct change the "short wire with the alligator clip" (the electrode lead adapter) in the lead showing the 60 cycle. Other attempts can include changing the plug, unplug the bed when able, and ensure proper electrode contact with patient. If continued issues, have machine inspected by BioMed and utilize other machine.
- c. Somatic Tremor: caused by tense muscles. Ask the patient to relax. Make sure all extremities are on the bed, hands unclenched and patient lying flat if possible.
- d. Wandering Baseline: An artifact in which all the complexes are present, but not "isoelectric" (not straight baseline).

C. CRITICAL RESULTS REPORTING

- 1. Diagnostic procedures within the department of cardiology/catheterization lab are reviewed and evaluated by the cardiologist. Departmental staff is not responsible for interpreting or evaluating test results to determine whether a test result is critical.
- 2. STAT ECG constitutes a critical test.
- 3. The following ECG tracings, as read from the ECG report, are consider a critical result.
 - a. Ventricular Tachycardia
 - b. Ventricular Fibrillation
 - c. Complete Heart Block
 - d. Marked Sinus Bradycardia
 - e. Acute Myocardial Infarction
 - f. STEMI
 - g. Code Blue
 - h. Rapid Response
- e.4. Upon verification of the above critical results, the technician must follow the 12-Lead EKG procedure, which outlines the communication procedure.
- 6. ~~Transmitting an EKG (performed by AM admit)~~
 - a. ~~Hook EKG machine to modem.~~
 - b. ~~Turn machine on.~~
 - c. ~~Press Δ Button with F1 button.~~
 - d. ~~Menu will appear. Press F2 "Storage".~~
 - e. ~~Press F2 "Directory". Run a directory before transmitting.~~
 - f. ~~Check the directory with the name and medical record number against patient for accuracy prior to transmitting.~~
 - g. ~~Fax the directory to cardiology services at 940-4040.~~
 - h. ~~Press F4 "Transmit".~~
 - i. ~~Press F1 Phone programmed # in the machine (will hear ringing).~~
 - j. ~~Press F1 "Enter".~~
 - k. ~~Screen will reveal "Select Patient ID, Yes or No" Select NO.~~
 - l. ~~Continue to bypass every name, Press F1.~~

**PROCEDURE: 24 HOUR HOLTER MONITOR SYSTEM HOOK UP AND INITIATE RECORDING**

Purpose: Cardiovascular technologist (CVT) shall be knowledgeable in performing a hook-up for a 24-hour holter monitor study. A physician's order is required before initiation of a ~~holter~~ **Holter** hook-up. The CVT performs the procedure with the cardiologist interpreting the data.

Supportive Data: ~~Mortara~~ Manuals (**Holter**)

Equipment: ~~Mortara H3+ digital holter~~ **Holter** recorders with patient cable and accessories, ~~Holter Analysis System~~ **H-Scribe Holter** ~~Holter Analysis System~~

A. POLICYDEFINITIONS:

1. Used for the purpose of arrhythmia analysis.
2. Recording ECG data of patients requiring ambulatory (Holter) monitoring over a 24 hour or 48 hour period.
3. The 3 channel, 5-wire patient cable records 24 hours of data and displays channel I, II, and V. The 2-channel, 5-wire patient cable records up to 48 hours of data and displays channel 1 and channel 2.
4. Stored ECG data will be downloaded for analysis to the ~~H-Scribe~~ **Holter Analysis System** with a USB interface cable after the ~~H3+ recorder~~ has been disconnected from the patient cable. After the data is downloaded, the memory can then be cleared and the ~~H3+recorder~~ is ready for use on the next patient.

B. POLICY:

- ~~1-5.~~ Confirm physician's order
- ~~2-6.~~ Introduce yourself and use (2) patient identifiers to verify correct patient.
- ~~3-7.~~ CVT will explain the test to patient.
- ~~4-8.~~ Perform "Standard Precautions" at all times.
- ~~5-9.~~ Maintain patient privacy.

C.B. PROCEDURE:

1. Prepare the Recorder:
 - a. Connect recorder to USB interface cable on the ~~H-Scribe~~ **Analysis System**
 - b. Select "Enter ID" from the "Patient List" page
 - c. Select "OK" to "Set time"
 - d. Select last 7 days-Query (or use last name) from "Work List" page. (may need to hit Query a few times)
 - e. Hi-light patient
 - f. OK - puts MR # onto recorder box
 - g. Save
 - h. Remove recorder // USB cable
2. Prepare the patient and initiate the recording:
 - a. Identify the (5) electrode sites on the torso by referring to the ~~Mortara~~ user manual
 - b. Shave (if needed), wipe oils from the electrode sites with alcohol prep pad and lightly use sandpaper strip on electrode sites to remove any dead skin. Use sween, if needed
 - c. Attach lead wires to electrodes. **Select either 3 channel (24hr) or 2 channel (48hr) set of wires.**
 - d. Attach the electrodes to the proper electrode sites.
 - e. Attach the patient cable to the ~~H3+recorder~~
 - f. Remove the battery door of the ~~H3+recorder~~, insert a new ~~AAA battery~~ **bateries**, and close the battery door
 - g. Press the "Enter" button to move through the menu displays

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- h. Verify the current time setting, Press Enter
 - i. Verify the ID number, Press Enter
 - j. Verify the ECG signal quality, Press Enter x 3 (Check all (3) channels for good QRS, minimal artifact and avoid big T waves)
 - k. The time shows, Press Enter
 - l. To begin recording, press and hold the "Enter" button for a period (3) seconds. An R indicates ~~Recording~~**recording** mode and displays the current time
 - m. Entering optional diary events - To mark an event, press the "Enter" button.
 - n. Place tape over each electrode snap to ensure electrode attachment throughout the recording
 - o. Insert recorder into the disposable pouch and arrange the pouch on the patient's torso securely
 - p. Fill out the necessary information on the front of the diary.
 - q. Explain to the patient:
 - i. How to use the event button, if applicable. (Same "Enter" button)
 - ii. How to use the diary and to return the diary with the recorder
 - iii. Continue with normal activities, as directed by their physician
 - iv. **Do not** get the recording device, electrodes and wires **wet**.
 - v. Allow patient to dress and instruct them to return in 24 hours for removal of the device
3. Documentation:
- a. Write on the patient's facesheet the date, recording device number and the time that the recorder began recording
 - ~~b. Record the exam information on the CVT log~~
 - ~~c.b.~~ Place the patient folder ~~next to the Mortara Holter Analysis System in the locked cabinet~~ for return follow up and analysis
 - ~~d.c.~~ The scheduler will process billing charges for the outpatient's. The CVT will process billing charges for the (rare) inpatient ~~halter~~**Holter**
4. Ending a recording session:
- a. At the end of a 24 or 48 hour period, the time is cleared from the ~~LCD-screen~~**device**. ~~and the ID is displayed in A~~ reversed color to indicate the recording period has ended and that the ~~H3+recorder~~ is full
 - b. Remove the battery door of the ~~H3+device~~ and remove the ~~battery~~**batteries**. Replace the battery door
 - c. Dispose of the battery properly
 - d. Remove the electrodes, the lead wires and the tape from the patient and retrieve the patient diary. Allow the patient to dress and inform them that the interpreted report will be sent to their referring doctor in approximately (2 - 3) working days
 - e. Remove the patient cable from the recorder
 - f. Place the recorder in the proper patient folder for system analysis
 - g. Clean the exterior surfaces of the ~~H3+~~recorder, the patient cable and the lead wires with an approved sanitary cloth

**PROCEDURE: 24 HOUR HOLTER MONITOR SYSTEM – SCANNING ANALYSIS**

Purpose: Cardiovascular technologists (CVT) shall be knowledgeable in performing a ~~Holter~~ **Holter** monitor scanned analysis on adults. The Cardiologist interprets the results and prepares the final report.

Supportive Data: ~~H Scribe Mortara manual~~ **Manuals (Holter)**

Equipment: ~~Mortara H3+ digital holter~~ **Holter recorders and the H Scribe-Holter Analysis System**

A. POLICYDEFINITIONS:

1. Used for the purpose of arrhythmia and pacemaker analysis.
2. ~~H Scribe holter~~ **Holter** system is intended to automatically acquire, analyze, edit, review, report and store prerecorded ECG data of patients that have been connected to the ~~H-3+ a digital recorder.~~

B. POLICY:

- 1.2. This acquired cardiac data and analysis is reviewed, edited, saved and printed by the CVT.
- 2.3. The printed data is analyzed, interpreted and signed by a Cardiologist who also creates the final and signed report for the referring physician.

G.B. PROCEDURE:

1. Acquire a recording:
 - a. Remove ~~battery~~ **batteries**, if not already done.
 - b. Connect recorder to USB interface cable on the ~~H Scribe~~ **Holter** Analysis System
 - c. Select an "Empty" line on list
 - d. Select "Connect To"
 - i. Shows ID, recording length, etc.
 - ii. Select "Start"
 - e. Highlight "Patients Name" from list (if name not on list, try a Query, or re-order – see notes)
 - f. Select "OK" and fill in:
 - i. Indications
 - ii. Medications
 - iii. Referring MD
 - iv. Reviewing MD
 - v. Tech
 - vi. Analyst
 - g. Select "Auto Scan", "OK"
 - h. **If 48hr recording (2 channel):**
 - i. **After acquiring, select no to review day 2?**
 - ii. **The program will move to Day 1.**
 - iii. **Complete day 1 and mark as reviewed**
 - iv. **The program will ask to review day 2, reply yes**
 - g-v. **Day 1 must always be completed before day 2**
2. Patient Diary Symptoms
 - a. Select "Edit", "Diary Entry List", "Enter", "OK"
3. Choose best leads for analysis (zoom to 40 seconds)
 - a. Review at least the first ten minutes of recording on all 3 leads (I, II, V)
 - b. Determine which 2 leads are the clearest and have the 2 best defined QRS complexes.
 - i. If lead II & V, then go to step 4.
 - ii. If lead I is better than either lead II or V, then go to "Patient>Rescan". Select "Autoscan" and answer yes to selecting new channel combination for analysis. Select best leads.

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4. Mark Artifact (zoom out to 600 seconds)
 - a. Zoom out all the way and view all 3 leads. Page down through entire recording marking as artifact large sections of artifact (half a line or more).
5. Review Templates (zoom to 40 seconds)
 - a. Review "Ventricular" first, then "Normal", then "Supraventricular"
 - i. WARNING! Use tab button to review at least the first dozen beats in any bin over 50 before relabeling. DO NOT relabel a bin just because how the first few beats appear.
 - b. Select "Templates & ECG". Go to "Format>Ventricular"
 - i. In ventricular templates relabel as artifact any small template bins that are not "Wide and Bizarre". Label larger bins as necessary". If shaped like normal beats, then label "Normal".
 - c. In "Normal" templates, find the first template bin that has just 1 sample. Right click and select "Label All Following as Artifact". Then go back to page 1 of "Normal" templates, highlight the whole page and label "Normal". If prompted, click "Proceed".
 - d. In "Supraventricular" first relabel any bins that do not resemble "Normal" shaped beats. SVT should be normal shape but early. Refresh screen by turning on, then off again the split screen. Then go back to page 1, highlight the whole page and label "Normal". If prompted, click "Proceed".
6. Review "Auto Strips" (zoom to 40 seconds)
 - a. Turn on split screen and select "Profile & ECG".
 - b. Move along the Summary row and confirm "Auto Strips".
 - i. Min HR, Max HR, Supra 3+ if any, Vent +3 if any, Pause (Max R-R). If samples are incorrect, mark as artifact then hit the backspace button. Add page strips if needed.
 - c. Edit>Strip List>click on "Add Auto Strips"
 - i. Click on "Time" column and delete duplicates except if HR or long RR strips. Click "OK".
7. Review other events
 - a. Profile & ECG
 - b. Move along Summary Row adding samples of diary events. Supraventricular & Ventricular (from TOTAL columns), AFIB and pauses as necessary. Add a few samples of each and Page Strips if there are a high number of samples.
 - c. Edit>Strip List. Click on TIME column and delete duplicates, except if HR or long RR strips.
 - i. Click on DURATION column, then "OK"
8. Report Preview
 - a. View>Report Preview
 - i. Page down through report and verify for accuracy and completeness.
 - b. Report Options>
 - i. Select best lead, Select 24 hours, OK , Print (prints full disclosure)
 - ii. Choose cardio printer when available or back room ECG printer.
 - c. View>Report Preview
 - i. Select "Load Defaults">OK
 - 1) This resets full disclosure and prevents sending it to Cerner – the file is too big!)
 - d. Close> tab to close report (not red X)
 - i. Patient>Open Patient>Select YES to "send to Dicom?"
 - 1) This sends a report to Cerner, but not full disclosure.
9. Clear recorder
 - a. Patient List>"Erase">OK (erases data and resets time)
 - i. If this is not completed, it will clear itself when initiated for next hookup, but if not initiated with next hook up, then recorder will not record)
10. Note Do not use red X box in upper right corner to close windows

11. Complete charges in Cerner
 - a. Go to CARDIOVASCULAR tab using "completed" filter
 - b. Click on patients name
 - c. At bottom of screen
 - i. Right click on 1st line> OK
 - ii. Right click on 2nd line>select reviewing physicians name>OK
 - d. Can do preview to confirm strips are in patients chart.
12. Place the printed full disclosure, final report summary and patients demographic paperwork in a folder and place in the reviewing Cardiologists in-box for final report processing.



Tri-City Medical Center

Cardiovascular Services

Delete- content contained
in Critical Results
Reporting were added to
EKG Policy/Procedure

PROCEDURE: Critical Results Reporting

Purpose: To clarify the process for critical results reporting after a diagnostic procedure.

Supportive Data: National Patient Safety Goals (2005)

Equipment: N/A

A. DEFINITIONS:

B. POLICY:

C. PROCEDURE:

1. ~~Diagnostic procedures within the department of cardiology/catheterization lab are reviewed and evaluated by the cardiologist. Departmental staff is not responsible for interpreting or evaluating test results to determine whether a test result is critical. (See "12-Lead EKG Procedure")~~

2. ~~STAT ECG constitutes a critical test.~~

3. ~~The following ECG tracings, as read from the ECG report, are considered a critical result.~~

a. ~~Ventricular Tachycardia~~

b. ~~Ventricular Fibrillation~~

c. ~~Complete Heart Block~~

d. ~~Marked Sinus Bradycardia~~

e. ~~Acute Myocardial Infarction~~

f. ~~STEMI~~


g. ~~Code Blue~~

h. ~~Rapid Response~~

Upon verification of the above critical results, the technician must follow the 12-Lead EKG procedure, which outlines the communication procedure.

4.

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 Tri-City Medical Center		Cardiologyvascular Services
PROCEDURE:	ECHOCARDIOGRAM - CONTRAST BUBBLE STUDY (Agitated Saline Contrast Injection)	
Purpose:	<p>4. Cardiovascular Technologist (CVT) shall be knowledgeable in performing an Agitated Saline Contrast (ASCI) Exam. Contrast Echocardiogram—ASCI. The ordering physician must consult with a cardiologist prior to scheduling an outpatient study. The echo tech (sonographer) CVT performs the echocardiogram acquires the images and the cardiologist an MD or registered nurse RN performs the contrast injection.</p> <p>A contrast bubble study is used to identify shunt abnormalities, especially in the setting of a CVA or TIA.</p>	
Supportive Data:	ASE 2013 "Detection of Right-to-Left Atrial Communication Using Agitated Saline Contrast Imaging"	
Equipment:	Cardiac ultrasound machine, (2) 10 ml syringes (leur lock tip); (1) three-way stopcock; (2) Vial Access Cannulas; (1) Extension Set (short tubing); (3-4) 30 ml Bacteriostatic Water 0.9% Sodium Chloride vials, for injection; alcohol swabs	

A. **POLICY:**


1. Confirm physician's order.
2. Use two (2) patient identifiers to verify correct patient.
3. CVT will explain the test to patient.
4. Perform "Standard Precautions" at all times.
5. Maintain patient privacy.

B. **PROCEDURE:**

1. Preparation:
 - a. Perform **color flow imaging (CFI)**. Need to see flow clearly passing directly across the atrial septum. ASCI may not be needed if clear CFI demonstrates an intraatrial communication.
 - ~~b. Obtain Doppler derived assessment of LA pressure by E/E' (Chronically elevated LA pressure can prevent ability to visualize atrial shunting).~~
 - ~~c.b.~~ The ~~cardiologist~~MD/RN will verify an IV is patent, preferably in the antecubital vein. If using another IV site, the site must have an 18 gauge or larger cannula and must be able to accommodate a 10ml rapid bolus. If the IV is not patent or is not adequate for this procedure, restart an appropriate IV.
 - ~~d.c.~~ Attach the three-way stopcock to the IV hub.
2. Performing the Procedure:
 - a. Connect patient to ECG on the echocardiography machine.
 - b. The CVT will: obtain the optimal 2D echocardiographic view (4CH most common and occasionally PSAX or SUBC), optimize settings and patient position.
 - c. MD or RN will attach the three way stopcock to the nearest port to the IV site.
 - d. MD or RN will attach one (1) leur lock syringe to the stopcock port. **MD or RN will draw 8.5 mL of 0.9% sodium chloride and add 1.5 mL of air. Attach a pre-filled syringe to the remaining stopcock port.** Shuttle 8.5ml sodium chloride between the two syringes rapidly three or more times to agitate.
 - e. On the CVT cue, the ~~cardiologist~~MD/RN will turn the stopcock and inject the entire contents of the syringe rapidly
 - f. As soon as **the MD/RN begins pushing the contrast is seen entering the RA**, acquire ~~4-6-8-12~~ **sec** digital loops.
 - g. If competitive flow from IVC causing loss of contrast along the RA side of atrial septum, then perform manual compression of the liver to suppress IVC flow.

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- (Need to differentiate IVC flow from negative contrast flow from an ASD.)
- h. Obtain images with normal respiration and with provocative maneuvers **(PM)**.
 - i. Use ~~provocative maneuvers (PM)~~ to increase the RA pressure above the LA pressure.
 - i. Use Valsalva, sniff or cough.
 - ii. Should see complete opacification of RA and leftward bowing of the atrial septum to the LA.
 - iii. Repeat if not successful.
 - j. Minimum of **4- 5** injections if negative study.
3. Positive Study
- a. Any number of bubbles seen in LA or LV within 5 seconds of initial entrance of contrast into RA.
4. Negative Study
- a. **4-5** injections, full opacification of RA and evidence of bowing into the LA and no left heart contrast seen within 5 beats after successful PM or at rest
5. Indeterminate Study
- a. Non successful in full opacification of RA along atrial septum and/or could not demonstrate bowing into the LA and no left heart contrast seen within 5 beats.
 - b. Image quality suboptimal.
6. The CVT will view the images and determine diagnostic value.
7. Transfer the exam images to CPACS workstation. Complete the CVT preliminary worksheet and place folder in cardiologist box.
8. Record the exam information on the CVT log.
9. CVT will process the appropriate billing charges for inpatients through Cerner. Scheduler will process charges for outpatients.
10. ~~Supportive Data:~~
- a. ~~PFO's exist in about 25% of population. A shunt only exists if/when the RA pressure is greater than LA.~~
 - b. ~~95% sensitive after just a single injection with complete opacification of RA adjacent to IAS at the time of transient leftward IAS bowing (PM correctly implemented).~~
 - c. ~~Bubbles seen after 5 beats are assumed transpulmonary transit.~~
 - d. ~~Color flow signals along the R & L surface of the septum, but not seen to cross, are not diagnosed as a PFO, because this most likely venous flow.~~
 - e. ~~Color flow imaging using PM has low sensitivity because image quality deteriorates with PM; degree of R-L shunting is usually small and distinguishing flow along versus flow across IAS.~~
 - f. ~~TEE gold standard for defining IAS anatomy however, not always appropriate due to availability, cost and patient risk.~~
 - g. ~~On report, state the PM that was used.~~
~~On report, suggest using descriptives: trivial, mild, large shunting, etc~~

 Tri-City Medical Center	Cardiologyvascular Services
PROCEDURE:	STRESS ECHOCARDIOGRAM
Purpose:	Cardiovascular technologists (CVT) shall be knowledgeable in performing a Stress Echocardiogram. The CVT performs the echocardiogram. A Cardiologist or a physician extender under the supervision of a Cardiologist, and an EKG tech performs the treadmill exercise test.
Supportive Data:	Current American Society of Echocardiography (ASE) and American Registry of Diagnostic Medical Sonography (ARDMS) accepted guidelines
Equipment:	Mortara X-Scribe Stress System, Philips IE33 Ultrasound machine, Horizon Cardiology di ital digital workstation

A. POLICYDEFINITIONS:

1. **A stress echocardiography is a procedure that determines how well the heart and blood vessels are working.**
- A.2. **A patient is expected to exercise on a treadmill or stationary bike while a Cardiologist or physician extender monitors the blood pressure and heart rhythm.**

B. POLICY

- 1.3. ~~Cardiologist's~~ **Physician** written order is mandatory.
- 2.4. ~~The attending cardiologist~~ **A Cardiologist or physician extender** must be present during the exercise portion of the exam.
- 3.5. The echocardiogram should contain the images, Doppler, and measurements. ~~listed under "Procedure".~~ **Modified views may be necessary as some views and measurements may not be available. Attempts must be documented.**
4. ~~Modified views may be necessary and some views and measurements may not be available for all patients. Attempts must be documented.~~
- 5.6. Images will be captured digitally in a quad format and stored on the Horizon Cardiology digital workstation.
- 6.7. Machine settings, transducer selection and patient position will be adjusted as needed to optimize all captured images, including Doppler display. ~~if indicated.~~
- 7.8. Check the ECG signal for a well-defined R wave on both the ultrasound machine and the exercise stress system before beginning the examination.
- 8.9. If necessary, ECG electrodes can be repositioned to ensure "window" access.
- 9.10. The resting echo window positions can be marked on the patient's chest for post stress references; however, remember that the window can change after exercise.
- 10.11. Perform a pre exercise echo to help determine that a contraindication to stress testing does not exist.
- 11.12. Maintain a uniform depth setting throughout the exam. Generally, the depth should be no more than 16cm.
- 12.13. Be certain to position the apical views correctly within the quad screen so that the apex of the heart is visible.
- 13.14. After acquiring resting images, a reference mark can be placed on the exam table so the patient can return to the best place and position on the exam table after exercise.
- 14.15. Apply gel to the transducer during patient exercise to save valuable seconds after exercise.
- 15.16. Introduce yourself and use (2) identifiers to verify correct patient.
- 16.17. CVT will explain the test to patient.
- 17.18. Perform "Standard Precautions" at all times.
- 18.19. Maintain patient privacy.
- 19.20. Contraindications:
 - A.a. Severe aortic stenosis
 - B.b. Severe left atrial enlargement
 - C.c. Severe mitral regurgitation

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- D-d. Moderate to severe left ventricular systolic dysfunction
- e. ~~E.~~ Not a contraindication, however significant mitral annular calcification, sclerosis, diastolic dysfunction should be commented on in the Summary of the report.
- f. **In certain instances or contraindications, a Cardiologist may override a contraindication but must be present for the procedure.**

20-21. Reason For Termination Of The Treadmill Exercise:

- A-a. Target heart rate achieved
- B-b. Wall motion abnormalities that correspond to two or more coronary territories
- C-c. Wall motion abnormalities associated with ventricular dilation and/or global reduction of systolic function
- D-d. Significant chest pain and/or ECG changes consistent with an ischemic response
- E-e. A decline in blood pressure
- F-f. Patient is unable to continue due to fatigue or excessive shortness of breath
- G-g. Significant arrhythmia

G.B. PROCEDURE:

1. Daily Preparation:
 - A-a. Check for prior exam for each patient. Print previous report and ~~keep with~~ **add to patient** folder.
 - B-b. Connect dedicated black cable from back of treadmill system to the front of the ultrasound machine
2. Patient Preparation:
 - A-a. Establish indication for exam. Obtain brief cardiac history from patient.
 - B-b. Enter patient data into ultrasound machine and select appropriate settings.
 - C-c. Enter patient data into the exercise treadmill system and select appropriate settings
 - D-d. Obtain signed consent form for treadmill exercise exam
 - E-e. Prepare the skin area and connect the ECG leads to patient in appropriate modified positions.
 - F-f. Place blood pressure cuff on patient's arm, preferably the right arm
 - G-g. Obtain resting blood pressure and print a resting ECG.
3. Performing the Procedure:
 - A-a. Use ultrasound gel as appropriate
 - b. Perform pre-exercise echo to assist in evaluating for any contraindications; attending **Cardiologist or physician extender's** ~~cardiologist's~~ determination. Transfer exam to CPACS and prepare preliminary report for attending **Cardiologist or physician extender's** ~~cardiologist's~~ review, analysis and signature.
 - B-c. **If baseline ECHO windows are poor, consider using Definity contrast for rest and exercise images.**
 - C-d. Preset/Protocol
 - D-e. Select "Stress Echo" - Begin with trim knob turned to AP4CH
 - E-f. Begin with **"Resting" Stress Echo** -
 - 4-i. "Acquire" loops: 4Ch, 2CH, Apical LAX (if needed), PLAX, SAX and select image for the (4) quad views
 - 2-ii. Observe the view icon and stage to ensure correct labeling (look at monitor screen trim knob)
 - 3-iii. May have to acquire additional "off axis" and "foreshortened" views to have available to correlate w/ impost images
 - 4-iv. Select "Accept Stage"
 - 5-v. To show **a Cardiologist or physician extender the images** ~~cardiologist~~ selected resting images - "Review", "Shuffle View", then "Shuffle Stage"
 - F-g. Ready for **"Impost" Stress Echo** -
 - 4-i. Put gel on transducer
 - 2-ii. Press "Review" to turn review off and to show ROI box
 - 3-iii. Patient is instructed on how to walk on the treadmill and the need to safely

and quickly return to the bed and assume the same left decubitus position post exercise.

- 4-iv. Patient performs exercise according to conventional exercise protocol
- 5-v. Press "Timer" when treadmill belt stops
- 6-vi. "Acquire" loops: 4CH, 2CH, Apical LAX (if needed), PLAX, PSAX
- 7-vii. Acquire images within 60 - 90 seconds
- 8-viii. May push "Enter" on keyboard or turn "trim knob" when changing from one view to another - will label view automatically
- 9-ix. Push "Acquire" on keyboard when you want to stop acquiring images
- 10-x. Select "End Acquisition" on screen - all "impost" images will appear
- 11-xi. Select image for the (4) quad views (cardiologist may select final impost images at this time)
- 12-xii. Select "Accept Selected" (each view)
- 13-xiii. Select "Accept Stage"
- 14-xiv. Select "Shuffle View", then "Shuffle Stage" - Cardiologist analyzes and reviews side-by-side images (Resting images side-by-side with Impost images)
- h. Serial blood pressures, pulse and ECG recordings are obtained in the recovery period according to ~~cardiologist~~ **the Cardiologist or physician extender. request/direction and patient** Patient monitoring is terminated and patient is released from the echo lab upon the attending **Cardiologist or physician extender.**~~cardiologist's instruction.~~
- 4. At the conclusion of the test:
 - A-a. Patient is wiped clean of and supplies are re-stocked.
 - B-b. Proper infection control measures are taken to clean room.
 - C-c. Transfer images to CPACS digital workstation.
 - C-d. Complete the CVT preliminary report for the pre-exercise echo and place patient folder in cardiologist's in-box.
 - D-e. Stress echo exam is dictated by attending ~~Cardiologist~~ **Cardiologist or physician extender.-**
 - E-f. Record the exam information on the CVT log.
 - F-g. CVT will process the appropriate billing charges through Compass.



PROCEDURE:	TILT TABLE TEST
Purpose:	Cardiovascular technologists (CVT) will be knowledgeable in assisting with the performance of the Tilt Table test. A Cardiologist must consult with the patient prior to scheduling. A Cardiologist, CVT, and a RN (needed when medications are planned) perform the test.
Supportive Data:	"Tilt Table Testing for Assessing Syncope" JACC Vol. 28, no. 1 July 1996:263-75. "Getting a Slant on Syncope" Nursing 99, Vol. 29, number 9. "Safety and Tolerability of an aggressive tilt table test protocol in the evaluation of patients with suspected neurocardiogenic syncope" Pacing Clinical Electrophysiology 2000 Apr. 23 (4 part 1)
Equipment:	Tilt Table bed; stress testing EKG module; automatic blood pressure equipment; crash cart; The following equipment needed when medications are planned - (2) intravenous infusion pumps; IV starter kit; 20G/22G needle; 250 ml D5W or sodium chloride solution; 500 ml sodium chloride solution; (3) IV solution sets; (3) needleless adaptors; 10 ml leur lock syringe; Brevibloc pre-mixed drip solution; Isuprel ampule 1mg.

A. DEFINITIONS:

1. ~~Assessing syncope and dizziness.~~
 - a. ~~To diagnose vasomotor depressor syndrome in patients with syncope, pre-syncope without significant structural heart disease, documented ventricular tachycardia, bi fascicular block, or documented bradycardia after negative monitoring and/or electrophysiology study.~~
 - b. ~~To determine which patients may benefit from dual chamber pacing for vasomotor depressor syndrome.~~
 - c. ~~To determine which patients may benefit from medication therapy for vasomotor depressor syndrome.~~
 - d. ~~To determine which patients may benefit from maneuvers to abort vasopressor syncope when they have premonitory symptoms.~~

B. POLICY

1. ~~Cardiologist will consult with patient or referring physician prior to scheduling test. Any contra-indications will be determined by the Cardiologist.~~
2. ~~Use two (2) patient identifiers to verify correct patient. CVT will explain the test to the patient.~~
3. ~~Consent - CVT will obtain patient's signed consent.~~
4. ~~Perform "Standard Precautions" at all times.~~
5. ~~CVT will verify when patient last ate and obtain current medication list.~~

C. PROCEDURE:

1. ~~Preparation:~~
 - a. ~~CVT to notify nurse and obtain progress notes and tilt table test forms, if medications are planned.~~
 - b. ~~Connect the patient to the ECG module and blood pressure monitor.~~
 - c. ~~If medications are planned, the RN will start an IV with 500 ml of sodium chloride.~~
 - d. ~~The patients will be NPO for 4-8 hours prior to testing. Verify Beta Blockers and anticholinergics (such as Norpace) were discontinued 48 hours to testing. The physician's office is responsible for notifying the patient.~~
2. ~~Performing the Procedure:~~


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- a. Secure the patient to the tilt table bed with the straps.
- b. Obtain a baseline ECG and blood pressure. Make a notation of any symptoms.
- c. Notify the Cardiologist when ready. Patient to remain supine for 15 minutes. Continue to monitor/document vital signs and rhythm every 3 minutes.
- d. Upon the Cardiologist's instruction, tilt the bed upright to 80 degrees. The
 - i. Attending Cardiologist will determine the time period the patient remains upright. Varies between 30–45 minutes, depending on the attending Cardiologist.
- e. Perform continuous ECG monitoring, print an ECG and obtain blood pressure measurements every 3 minutes.
- f. Make a notation of any symptoms the patient may verbalize or display and print ECG.
- g. The test is performed and terminated according to the Cardiologist's instructions.
3. If medications are planned:
 - a. If no syncope or pre-syncope develops, the patient is placed supine for 5 minutes while an infusion of Isoproterenol 1 micrograms per minute is started. (Max 5mcg/minute). Ask cardiologist for target heart rate.
 - b. The RN will mix 1 mg of Isoproterenol in 250ml of D5W or sodium chloride solution.
 - c. Ask Cardiologist for maximum target heart rate or end point of exam.
 - d. Program the IV infusion pump according to the dose ordered. If no specific dose is ordered, Isoproterenol is started at 1 microgram per minute and increased every 15 minutes until a desired effect is observed. Maximum dose of 5 micrograms per minute.
 - e. Attach Isoproterenol to the closest port of the IV insertion site.
 - f. Patient is again tilted upright 80 degrees for 10 minutes or until syncope or a pre-syncope symptom develops.
 - g. If test is positive, the patient is placed supine and an Esmolol (Brevibloc) infusion may be started at 500 mcg/kg/minute for 3 minutes followed by a maintenance infusion of 300 micrograms per KG per minute.
 - h. After 5 minutes of Esmolol infusion while supine, the patient can be rechallenged upright for 10 minutes in a 90-degree tilt alone or with ongoing Isoproterenol infusion of 5 micrograms per minute.
4. If tilt table testing is still positive on Esmolol, it is predictive that Beta Blocker therapy will not be effective. If the test is negative, Beta Blocker therapy may help.
5. If significant bradycardia (heart rate less than 60 bpm) develops during testing with symptoms, it is predictive that a dual chamber pacing may help alleviate further symptoms.
6. Place patient supine upon Cardiologist instructions.
7. Remove straps from patient and continue vital sign and ECG monitoring every 3 minutes.
8. Discontinue monitoring when patient has returned to baseline and or upon the cardiologist instruction.
 - a. The Cardiologist will:
 - i. Release the patient to home. The attending RN in cardiology will discontinue the IV.
 - ii. Admit the patient to SPRA for further observation.
 - iii. Inpatients will return to their room.
9. CVT to record the exam information on the CVT log.
10. Place the patient's file in the Cardiologist in-box for report processing.
11. Process the appropriate billing charges.

D. RESULT DEFINITIONS:

1. A rate x pressure of less than 9,000 mm hg/min x 1,000 results in positive and negative reduction values of greater than 90%.

- ~~2. Neurally mediated hypotension is defined as a 25 mm hg reduction in the systolic blood pressure from the baseline supine values, sustained for at least 1 minute, with no associated increase in heart rate, and accompanied by symptoms of pre-syncope.~~
- ~~3. The presence of premonitory symptoms and signs of imminent syncope such as severe lightheadedness, nausea or diaphoresis defined pre-syncope.~~
- ~~4.1. Postural tachycardia syndrome is defined as the occurrence of orthostatic symptoms in association with either a 30 beats per minute increase in heart rate from the baseline within 10 minutes of being tilted upright.~~

 Tri-City Medical Center	Cardiologyvascular Services
PROCEDURE:	TRANSESOPHAGEAL ECHOCARDIOGRAM (TEE)
Purpose:	Cardiovascular technologists (CVT) shall be knowledgeable in performing a Transesophageal Echocardiogram (TEE) study. A physician's order is required and a cardiologist Cardiologist must be consulted with by the ordering physician before initiation of a TEE procedure. The Cardiologist, assisted by an Echo-echo technician and registered nurse (RN) , performs the procedure.
Supportive Data:	
Equipment:	Transesophageal Echocardiography Probe, Cardiac ultrasound machine, sterile gel packets, disposable bite block, lidocaine spray, crash cart

A. POLICY

1. **Pre-procedure orders and sedation documentation must be completed by the Cardiologist.**
- 1-2. Consent - ~~DDL nurse will obtain patient's written consent for outpatients. Hospital nurse RN will~~ obtain patient's **signed written** consent for inpatients. The Cardiologist will explain the procedure to the patient at time of consultation. Any applicable contra-indications will be decided by the Cardiologist.
- 2-3. Use two (2) patient identifiers to verify correct patient. Sonographer will explain his/her role to patient.
- 3-4. Perform Standard Protocol at all times.
- 4-5. Registered nurse will initiate the "Time Out" Procedure.

B. PROCEDURE:

1. **Catherization Lab ~~DDL~~ or Portable TEE:**
 - a. Equipment:
 - i. TEE probe, individual sterile gel packets, gloves, bite-block, towel/pillow case, lidocaine spray, and copy of views. If a bubble study is anticipated, have the bubble study injection kit available.
 - b. To Perform the Study:
 - i. Connect the probe to the port. Select the proper study type on the ultrasound machine.
 - ii. If portable, ensure equipment needed is available: i.e.; oxygen, suction, cardiac monitor for heart rate and rhythm **and necessary sedation medications**.
 - iii. Assist physician in handling the probe for insertion.
 - iv. Acquire, magnify and alter views in accordance with physician's directions.
 - v. If bubble study injection is necessary the attending nurse will administer upon the Cardiologist instructions and according to procedure.
 - vi. Assist in withdrawal of the probe with gloved hands, towel and pillowcase.
2. **Operating Suite TEE:**
 - a. Disinfect the surface of the machine with appropriate disinfectant.
 - b. Tech needed in OR:
 - i. Prepare ultrasound machine with patient's information and proper study type.
 - ii. Dress in appropriate OR attire, including mask, hat, shoe covers and gloves.
 - iii. Tech is to coordinate with charge or lead person to ensure sterility is maintained in department
 - iv. Acquire, magnify and alter views in accordance with ~~physician's~~ **physician** direction. Use color flow and **Pulse Wave Doppler spectral droppers** when appropriate.
 - c. **Intraoperative TEE**

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- i. Usually probe placement occurs by Anesthesia.
 - ii. In case of a certified cardiac Anesthesiologist, billing and reading of the Intraoperative TEE becomes the Anesthesiologist responsibility.
 - iv.iii. In all other cases, Cardiologist will complete diagnostic TEE read and bill 93314 with 26 modifier.
 - v.iv. At end of procedure disconnect probe, take machine back to echo lab and disinfect.
 - vi.v. Cleaning the Probe: SPD to clean and disinfect the probe.
 - vii.vi. Transfer exam to CPACS digital workstation.
3. ~~Record the exam information on the CVT log.~~

C. **BILLING AND REPORT PROCESSING:**

- 1. ~~DDL exams - DDL will process the appropriate billing charges. Place demographic sheet in Cardiologist's in-box for report processing, if needed.~~
- 2.1. **Catheterization Lab or Portable exams** - Echo tech will process the billing charges. Place demographic sheet in Cardiologist's in-box for report processing, if needed.
 - a. Batch Bill:
 - i. Cardiology Services:-
 - 1) Transesophageal Echo
 - i.a) TEE
 - i) TEE=93312
 - 4)b) Echo color flow (C/F)
 - i) Echo C/F 93325 (add on to 93312)
 - ii) ECHO, Pulsed Wave Doppler=93320 (add on to 93312)
 - a)c) Physician Component=modifier-26
- 3. ~~OR exams - SPD will process the appropriate billing charges.~~
 - i.ii. ~~Upon the completion of an OR TEE, the OR tech/nurse will e-mail to the echo tech the demographic sheet. Echo tech is to confirm that the TEE has been transferred to the CPACS workstation. When exam is in CPACS, place the patient's demographic sheet in the Cardiologist's in-box for report processing.~~

**ENGINEERING
INFECTION CONTROL**

ISSUE DATE: 11/87

SUBJECT: Infection Control

REVISION DATE(S): 09/94, 02/97, 05/11, 05/03, 06/06,
05/09, 06/12

Engineering Department Approval:	07/18
Environmental Health & Safety Committee Approval:	11/18
Infection Control Committee Approval:	01/19
Administration Approval:	01/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. PURPOSE:

1. To provide guidelines for the prevention of cross-contamination arising from operations of the Engineering Department.

B. GENERAL INFORMATION:

1. A.——Basic infection control techniques are included as part of each employee's orientation to the Medical Center.
2. B.——Rodent and pest control is provided by an outside vendor in accordance with a contract made by the Engineering Department.

C. POLICY:

1. 1.——Employees with obvious infectious conditions may be sent home by the Director of Engineering. Refer to the hospital's Employee Relations Manual for other policies regarding employee illness.
2. 2.——Appropriate cover garments will be worn when an employee is required to work in or about contaminated waste, sewage, etc.
3. 3.——Before entering the operating suite, labor and delivery room, nursery or isolation rooms, employees will put on appropriate cover garments as instructed by nursing personnel in those areas. Tools which must be taken into these areas shall be as clean as practicable.
4. 4.——Each employee will be given in service education annually on the basic techniques of infection control and such in service education will be documented in the employees file by the Director of Engineering or designee.

**FOOD AND NUTRITION SERVICES DISASTER-MANUAL
EMERGENCY PREPAREDNESS**

ISSUE DATE: 06/17

SUBJECT: Emergency Preparedness – Meals
For All / Nutricopia

REVISION DATE(S):

Food and Nutrition Services Department Approval:	04/18
Environmental Health & Safety Committee:	11/18
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a 01/19
Administration Approval:	01/19
Professional Affairs Committee:	n/a
Board of Directors:	

A. PURPOSE:

1. Tri-City Medical Center will have the means to provide nutritional assistance to staff and patients for 96 hours in the event of a disaster or emergency situation.

B. DEFINITIONS:

1. An emergency as 'unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in sudden, significantly changed or increased demand for the organization's services.'

C. POLICY:

1. The facility maintains at least a seven days staple and two days perishable foods in inventory. ~~In addition the facility~~ **Within that supply, we** maintains four days (96 hour) emergency meals, bottled water and disposable supplies in the Food and Nutrition secured cage located in the facility basement.
2. A Nutrition Service disaster and emergency plan is prominently posted in food service department and reviewed by all department employees at least annually. This plan will be referred to when the facility experiences a loss of water supply, electricity, natural gas, or experiences an emergency/disaster. It is possible that any one or all of these services may be interrupted.
3. The Nutrition Service Director or Dietitian or Food Service staff member in charge will consult with the House Supervisor or Administrator to determine the nature of the emergency and the anticipated duration.
4. If needed, all or part of this emergency meal plan will be implemented to ensure provision of nutritious meals to patients despite the limitations of the disaster. **The Meals for All Emergency Solution** menu may be used during an emergency/disaster at the discretion of the Food & Nutrition Service department, House Supervisor or Administration. In the event the emergency/disaster is anticipated to last beyond one meal, the Registered Dietitian will be notified.

D. AFFECTED PERSONNEL/AREAS:

1. Governing Board; Medical Staff; all hospital employees; volunteers

E. EQUIPMENT:

1. Food preparation tool box.

F. PROCEDURE:

1. At least once a year, the Food & Nutrition department conducts an in-service session on disaster plans and emergency procedures in regards to the nutritional assistance that will be provided to patients. The Quick Guide to Emergency Feeding guidelines will be posted in food service and the house supervisor office. A copy of the disaster and emergency procedures will be stored with the Meals for All emergency food and supplies ready reference. (See attachment I - Quick Guide to Emergency Feeding Guidelines)

G. HEATING SOURCE FOR WATER:

1. If no heating source is available, Meals for All may be reconstituted using unheated potable water. All food items are fully cooked and safe to serve at room temperature.
2. Do not attempt to cook or boil water over an open flame whenever gas leaks are possible.

H. FOOD TEMPERATURES / FOOD SAFETY:

1. For best palatability, hot foods are best served at 135°F or more, cold foods are best served at 41° or colder.
2. However, all foods on this menu may be safely served at room temperature between 41° - 135° if opened, prepared and served within ~~two~~four hours.

I. HANDWASHING FOR FOOD PREPARERS:

1. Proper hand washing, when water is scarce requires the use of two basins, one with approved sanitizing agent, and one with clear rinsing water. Approved hand sanitizer may also be utilized.

J. FOOD PREPARATION:

1. Follow instructions on the Meals for All containers for proper preparation. See attachment II

K. EMERGENCY FOOD ITEMS STORAGE:

1. The Meals for All emergency meals and other emergency supplies will be secured in the facility storage warehouse and easily accessible during an emergency or disaster situation. All food items are dated by the manufacturer and have a ten year shelf life. During the final year of the expected shelf-life, the Food and Nutrition Services Director will determine if the facility will donate the Meals for All to a charitable organization or may utilize for a facility disaster exercise.

L. EQUIPMENT FOR FOOD PREPARATION:

1. The equipment needed for food preparation is secured and stored in the Food and Nutrition cage located in the facility basement area. The equipment is in its own marked container and located next to the Meals for All pallets. The equipment toolbox includes but not limited to:
2. 4 gray scoops (4oz), 4 green scoops (3oz), 4 spoodles (4oz), 2 serving spoons, 2 slotted serving spoons, 4 ladles (3oz), 2 rubber spatulas, 4 tongs, 2 sets measuring spoons, 2 measuring cups, 4 mixing bowls, 2 containers (12 quart), disposable aluminum pans, 2 spot lights, 6 headlamps; 3 lantern, 10 flashlights, 72 (D) batteries, disposable gloves, 2 can openers, 4 thermometers, 2 boxes storage bags, 2 boxes hairnets, 2 box cutters & extra blades, black markers, 2 scissors, 2 lighters, masking tape 72 (D) batteries, 2 boxes storage bags, 2 cases disinfectant wipes, 2 boxes alcohol wipes, 4 bottles hand sanitizer, black markers, 2 scissors, 2 lighters, masking tape , garbage bags.

M. INVENTORY AND VERIFICATION:

1. The Meals for All Emergency Menu Inventory and Supply list will be maintained in the Food and Nutrition Services Director's Office and a copy will be placed in the Food and Nutrition Services Disaster Manual. The inventory and supply list will be inspected on a semi-annual basis to determine all items are present in the quantities specified. The Emergency Supply Inventory Verification form (attached) will be utilized for documenting the inventory which will include;

- a. Date of inventory check.
 - b. Results of the inventory.
 - c. Corrective action if needed.
 - d. Signature of person performing the supply inventory.
2. The Emergency Supply Inventory Verification form will be kept in the Director of Food and Nutrition Services office and available upon request. (see attachment IV Inventory Verification form)

N. DECENTRALIZED FOOD PREPARATION:

1. The Food and Nutrition Services Director or designee in charge may designate some or all of the emergency food preparation to be conducted at decentralized or on each nursing unit or at a remote locations from the facility. The Meals for All are packaged to be easily transportable in the event of an evacuation and can be set up in any decentralized location.

O. MEAL SERVING HOURS:

1. The meal serving hours for the Meals for All, will be modified or staggered depending on the emergent situation and will be determined by the Incident Commander, Food and Nutrition Services Director or designee. It will be taken into consideration the necessary amount of batch cooking to prepare in order to serve in large quantities to the patients and staff members. The meals may be served tableside to facilitate having a limited staff to efficiently prepare and serve during an emergency situation. If emergency circumstances warrant, the meals may be served directly from the cooking container directly to the patient / staff.

P. USE OF EMERGENCY MENUS:

1. Depending on the time of day and expected duration of the emergency, the Food and Nutrition Services Director or designee may implement the Meals for All emergency menus and may be used for a single meal or for several days. (see attachment III - 4 Day Emergency Menu)

Q. MENUS AND THERAPEUTIC DIETS:

1. The Meals for All menus has been planned to provide basic nutrients and meet the needs of most therapeutic healthcare diets. The Meals for All menu and products have been specially prepared to allow their use for most healthcare therapeutic diets. The therapeutic menu is appropriate for Regular, Mechanical Soft, Cardiac, Sodium Restricted, Diabetic and Renal diets. Specific Therapeutic Diets modifications are as follows:
 - a. Consistent Carbohydrate, Diabetic Gestational Diabetes and Low/No concentrated Sweets Diets may be served all menu items except the puddings are omitted. Offer sugar substitute and diet jelly if available.
 - b. Low Cholesterol/ Low fat Diets may be served on all menu items.
 - c. No Added Salt/Low Salt Diets may be served on all menu items but the salt packets are omitted.
 - d. 2 Gram Sodium Diets may be served on all menu items but the salt packets are omitted.
 - e. Calorie Controlled diets 1500 Calorie or less and Consistent Carbohydrate or Diabetic Diets may be served on all menu items except portions of milk, cracker-biscuits and snacks are reduced and the puddings are omitted. Offer sugar substitute and diet jelly if available.
 - f. Renal and Hepatic Diets may be served on all menu items except the milk, pudding and salt packets are omitted. Limit beverages if fluid restriction is prescribed.
 - g. Resident's allergies will be accommodated by knowledgeable staff by offering suitable foods from the Meals for All Emergency menu. Diets may be deficient in one or more nutrients.
 - h. Powdered milk is included in the Meals for All to meet nutritional needs.
 - i. Puree diets will receive 1 can boost
 - j. Full liquid diets will receive one can boost (boost glucose control for diabetics

h.k. Enteral feedings – Fibersource, Nepro available

h.l. Clear Liquid Diets shall receive broth, gelatin, and clear soda stocked on the nursing units. Nutritional supplements may be ordered to increase calories and nutrient values.

R. BEVERAGES / CONDIMENTS:

1. Beverages will be provided as requested or available during an emergency situation. Patients needing thickened liquids will be served beverages thickened to the appropriate level. Substitute dehydrated milk mixed with water for fluid milk if needed. Condiments such as salt, pepper and sugar are made available when possible and not contraindicated by the prescribed diet order. Consistent Carbohydrate or Diabetics shall receive sugar substitute. Sodium-restricted, Hepatic and Renal diets will not receive salt packets.

S. WATER STORAGE GUIDELINES:

1. The facility will maintain designated emergency water for the Meals for All in a secured storage location. The water will be stored in a cool, dry area away from heat sources and staff will be instructed not to utilize for any other purpose except an emergency situation. One gallon of water per person per day for proper hydration will be stored. This allows two quarts for drinking water and two quarts for food preparation. However, Meals for all dehydrated emergency foods require approximately one quart of water per person per day for reconstitution. Refer to Water Requirements appendix in 4- Day Meal Plan Guide for water requirements table for exact amounts of water per can. Storing one gallon of water per person per day is adequate to meet emergency water needs.

T. MEAL/WATER ALLOCATION:

MEAL/WATER ALLOCATION DAY 1		MEAL/WATER ALLOCATION DAY 2		MEAL/WATER ALLOCATION DAY 3		MEAL/WATER ALLOCATION DAY 4	
Patients	16518 0	Patients	16518 0	Patients	16518 0	Patients	16518 0
Staff / Physicians	400	Staff / Physicians	400	Staff / Physicians	400	Staff / Physicians	400
EMS / Visitors	85	EMS / Visitors	85	EMS / Visitors	85	EMS / Visitors	85
Total gallons	66565 0	Total gallons	65066 5	Total gallons	65066 5	Total gallons	65066 5

**A MINIMUM OF 1 GALLON PER PERSON PER DAY.
(26600 gallons emergency water total)**

U. ATTACHMENT(S):

1. ~~Attachment~~ Appendix I: Quick Guide to Emergency Feeding
2. ~~Attachment~~ Appendix II: Meal Preparation
3. ~~Attachment~~ Appendix III: Four Day Emergency Meal Menu
4. ~~Attachment~~ Appendix IV: Inventory Verification Form

V. REFERENCE(S):

1. Nutricopia – Meals for All Emergency Solutions



Food and Nutrition Services Disaster Manual

| APPENDIX ATTACHMENT- I

QUICK GUIDE TO EMERGENCY FEEDING

1. Notify Food & Nutrition Service Director or Clinical Nutritional Manager using the emergency call back list or appoint alternate to be in charge.
2. Determine nature of emergency or interruption:
 - ELECTRICITY - continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
 - NATURAL GAS - Use alternate heating source if safe. Continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
 - WATER SUPPLY - affects ware washing and cooking, so conserve water and liquids. Continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
 - NO POWER OR WATER - Use alternate heating source if safe. Affects ware washing and cooking, so conserve water and liquids. Substitute *Meals for All* as needed.
3. SELECT MENU PLAN TO FOLLOW:
 - Usual Menu with needed adaptations (uses perishable supplies first)
 - Meals for All emergency solution.
4. DIET MODIFICATIONS refer to usual menu, if using
 - Follow "Emergency Menu Serving Instructions" when using Meals for All.
 - Be aware of those with food allergies
 - Modify texture for chewing/swallow needs (e.g. mince or mash foods, serve thickened liquids.)
5. LOCATE NEEDED ITEMS:
 - Emergency procedures and menus are posted in Nutrition/Food/Dietary Department, Emergency food storage area, and House Supervisor's office.
 - Emergency food supplies are located at SVMC warehouse.
 - Emergency disposable supplies are located at SVMC warehouse.
 - Preparation supplies are located in emergency toolbox at SVMC warehouse.
 - Water supply is located at SVMC warehouse.



Food and Nutrition Services Disaster Manual

| APPENDIX ATTACHMENT II

MEAL PREPARATION

Refer to label on each product for specific instructions.

General Instructions for Hot Foods:

1. Open can and discard oxygen absorber* packet.
2. Boil water amount as directed OR mix with room temperature water if no heating source.
3. Stir dry contents of can or cans into boiling water.
4. Cover and remove from heat.
5. Allow to stand for 15 minutes for boiling water, 1 hour if room temperature water utilized.
6. Stir and serve 1 1/3 cup (2 x No. 6 Scoop) or as directed

Instructions for Ready to Eat Items (Fruit, Vegetables, Crackers):

1. Remove oxygen absorber* packet.
2. Ready to eat from packaging.
3. If desired, rehydrate as above using cold water for fruit

Instructions for Pudding Preparation:

1. Open can and discard oxygen absorber* packet.
2. Stir dry contents of one can into cold water, amount as directed.
3. Whisk thoroughly to mix. Allow to stand for 15 minutes.
4. Stir and serve #8 scoop for 1/2 cup or as directed.

Non-Fat Milk, to prepare:

1. Add water as directed on label, allow to stand 15 minutes, stir and serve 8 ounces or as directed.

Notes:

- ☐ Food Safety Note: food should be consumed within 2 hours of preparation unless maintained at 135° or higher or below 41° for cold foods.
- ☐ No heating methods: Allow 1 hour to rehydrate when using cold or room temperature water.
- ☐ Product shelf life is ten years when properly stored in a cool, dry environment.
- ☐ Contains a non-toxic oxygen



Food and Nutrition Services Disaster Manual

APPENDIX ATTACHMENT III

MEALS for ALL EMERGENCY MENU FOUR DAY				
DAY ONE	DAY TWO	DAY THREE	DAY FOUR	VEGETARIAN
BREAKFAST				
Apple Cereal, Fortified	Apple Cereal, Fortified	Apple Cereal, Fortified	Apple Cereal, Fortified	Apple Cereal, Fortified
Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits
Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)
MID-				
Beef & Mushrooms with Noodles	Turkey & Potatoes with Cranberry	Southwestern Chicken & Rice	Chicken Curry with Rice	Spaghetti with Mushrooms
Green Peas	Corn Niblets	Green Beans	Garden Mixed Vegetables	Green Peas
Apples Diced	Peaches Diced	Applesauce	Peaches Diced	Applesauce
Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits
Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)
DINNER				
Chicken Curry with Rice	Spaghetti with Mushrooms	Beef Stew with Potatoes	Macaroni & Cheese	Macaroni & Cheese
Carrots	Garden Mixed Vegetables	Broccoli	Green Peas	Green Beans
Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits
Chocolate Pudding	Banana Pudding	Vanilla Pudding	Banana Pudding	Vanilla Pudding
Beverage	Beverage	Beverage	Beverage	Beverage
SNACK				
Peanut Butter and Crackers	Peanut Butter and Crackers	Peanut Butter and Crackers	Peanut Butter and Crackers	Peanut Butter and Crackers



Food and Nutrition Services Disaster Manual

APPENDIX ATTACHMENT IV

**25 Person Serving Unit
 Inventory List (Four Day Emergency Menu)**

Case Number	Day	Meal	4-Day Emergency Menu items	Servings Per Can	Number of Cases in Inventory
1-A	1	Breakfast	Apple Cereal, Fortified	25	
	1	Breakfast	Cracker-Biscuits	25	
	1	Mid-meal	Beef & Mushrooms with Noodles	12.5	
	1	Mid-meal	Beef & Mushrooms with Noodles	12.5	
	1	Mid-meal	Green Peas	25	
	1	Mid-meal	Apples Diced	25	
1-B	1	Mid-meal	Cracker-Biscuits	25	
	1	Evening	Curry Chicken and Rice	12.5	
	1	Evening	Curry Chicken and Rice	12.5	
	1	Evening	Carrots	25	
	1	Evening	Cracker-Biscuits	25	
	1	Evening	Chocolate Pudding	25	
2-A	2	Breakfast	Apple Cereal, Fortified	25	
	2	Breakfast	Cracker-Biscuits	25	
	2	Mid-meal	Turkey and Vegetables	12.5	
	2	Mid-meal	Turkey and Vegetables	12.5	
	2	Mid-meal	Corn	25	
	2	Mid-meal	Peaches, Diced	25	
2-B	2	Mid-meal	Cracker-Biscuits	25	
	2	Evening	Spaghetti & Mushrooms	12.5	
	2	Evening	Spaghetti & Mushrooms	12.5	
	2	Evening	Garden Mixed Vegetables	25	
	2	Evening	Cracker-Biscuits	25	
	2	Evening	Banana Pudding	25	
3-A	3	Breakfast	Apple Cereal, Fortified	25	
	3	Breakfast	Cracker-Biscuits	25	
	3	Mid-meal	Southwestern Chicken & Rice	12.5	
	3	Mid-meal	Southwestern Chicken & Rice	12.5	
	3	Mid-meal	Green Beans	25	
	3	Mid-meal	Applesauce	25	

3-B	3	Mid-meal	Cracker-Biscuits	25	
	3	Evening	Beef Stew	12.5	
	3	Evening	Beef Stew	12.5	
	3	Evening	Broccoli	25	
	3	Evening	Cracker-Biscuits	25	
	3	Evening	Vanilla Pudding	25	
4-A	4	Breakfast	Apple Cereal, Fortified	25	
	4	Breakfast	Cracker-Biscuits	25	
	4	Mid-meal	Curry Chicken and Rice	12.5	
	4	Mid-meal	Curry Chicken and Rice	12.5	
	4	Mid-meal	Garden Mixed Vegetables	25	
	4	Mid-meal	Peaches, Diced	25	
4-B	4	Mid-meal	Cracker-Biscuits	25	
	4	Evening	Macaroni & Cheese	12.5	
	4	Evening	Macaroni & Cheese	12.5	
	4	Evening	Green Peas	25	
	4	Evening	Cracker-Biscuits	25	
	4	Evening	Banana Pudding	25	
Milk	1	B'fast & Mid-Meal	Non Fat Dry Milk	50	
	2	B'fast & Mid-Meal	Non Fat Dry Milk	50	
	3	B'fast & Mid-Meal	Non Fat Dry Milk	50	
	4	B'fast & Mid-Meal	Non Fat Dry Milk	50	
Snack	1	Snack	Peanut Butter	25	
	1	Snack	Cracker-Biscuits	25	
	2	Snack	Peanut Butter	25	
	2	Snack	Cracker-Biscuits	25	
	3	Snack	Peanut Butter	25	
	3	Snack	Cracker-Biscuits	25	
Snack	4	Snack	Peanut Butter	25	
	4	Snack	Cracker-Biscuits	25	

FOOD AND NUTRITION SERVICES

ISSUE DATE: 03/88

SUBJECT: Nutrition Assessment and Care for Adult Geriatric Patients

REVISION DATE(S): 06/08, 10/10, 11/11, 02/12

Food and Nutrition Services Department Approval:	44/4707/18
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	04/4811/18
Medical Executive Committee Approval:	02/4801/19
Administration Approval:	01/19
Professional Affairs Committee Approval:	03/48 n/a
Board of Directors Approval:	03/18

A. POLICY:

1. A systematic method for the Registered Dietitian (RD) to collaborate with the physician/Allied Health Professional (AHP) in the assessment of nutrition status of patients, the education of patients regarding nutritional therapies, and the provision of appropriate medical nutrition therapy given the patient's medical diagnosis and assessed nutritional requirements for patient age fourteen (14) years of age and older admitted to Tri-City Healthcare District.
2. Referrals for a nutrition assessment are generated if certain criteria are met via the adult admission assessment in ~~Compass Power Chart~~ **the Electronic Medical Record**.
3. RD will assess nutritional status of triggered patients within 48 hours of referral, considering age of patient, disease states, nutrition history, medical history, medical therapies/treatments and laboratory values.
4. RD may assess nutrition status of any patient and implement an appropriate nutrition care plan, to include evaluation and recommendations for enteral and parenteral nutrition support, addition of supplements, modification of food texture, and education of patients/families regarding appropriate nutrition intervention for a particular disease state.

B. PROCEDURE:

1. Referrals for nutrition assessment are generated if any of the following criteria are met upon completion of the admission data base by nursing:
 - a. **Surgical patient** Greater than (>) 75 years of age ~~with abdominal or thoracic surgery~~
 - b. Currently receiving total parenteral nutrition (TPN) or enteral feedings
 - c. Unplanned weight loss of greater than or equal to (\geq) 5% in the last month or greater than or equal to (\geq) 10% pounds in last 6 months
 - d. ~~Hyperemesis with greater than (>) 10 pounds weight loss~~
 - e. Presence of pressure injury ulcer or skin breakdown
 - f. ~~Braden score of less than (<) 15~~
 - g-f. ~~Eating disorder~~
 - h-g. Impaired nutritional nutrient intake
 - i-h. Nausea/vomiting/diarrhea
 - j-i. Intake less than (<) 50% of normal in the last three (30) days
 - k-j. **Chewing/Swallowing** ~~Aspiration risk~~
 - l-k. ~~Gastrointestinal (GI) problem other than constipation~~
2. RD assesses all medical/surgical patients for nutrition risk upon referral. Upon completion of assessment, appropriate nutrition care plans are implemented.
3. RD will review patient's medical history and current medical status.

4. RD will assess patient's nutrition history, indicating patient's ability to tolerate various modes of feeding, recent intake, previous diet modification, food allergies or aversions, and appropriateness/adequacy of patient's current diet order.
5. RD will document height/weight, ideal body weight (IBW), usual body weight and any other appropriate anthropometric measurements. Usual body weight is more useful than IBW in ill population.

Calculation of IBW

- 1) Males: 106 pounds for first 5 feet; 6 pounds for each inch over 5 feet
- 2) Females: 100 pounds for first 5 feet; 6 pounds for each inch over 5 feet

- a. Body Mass Index (weight [kg]/height [m²]) is determined to assess health and body fat).

Body Mass Index Body Size Classification Table	
Underweight	less than (<) 18.5
Normal Weight	18.5 -24.9
Overweight	25 - 29.9
Obesity	greater than (>) 30
Extreme Obesity	greater than (>) 40

6. Patient will be assessed for malnutrition based on current American Society of Parenteral and Enteral Nutrition (ASPEN) and Academy of Nutrition and Dietetics (AND) guidelines after assessment of weight history, appetite change, and nutrition focused physical assessment is completed.
7. Dietitian will evaluate **nutritional related labs**. ~~pertinent laboratory data to include: serum albumin, transferrin, total iron binding capacity (TIBC), total lymphocyte count, hematocrit, hemoglobin, electrolytes, etc. Other pertinent laboratory data (i.e. BUN/CR, liver function tests, serum glucose levels, lipid levels) will be evaluated as necessary.~~
8. RD will evaluate factors, which may affect nutrition intake, digestion, and absorption, including: medications, previous GI surgeries, on-going treatments, and chronic disease states, i.e. cancer or alcoholism.
9. RD will confer with nursing, pharmacist, and physician/AHP regarding pertinent factors affecting nutrition status (medication, intake and output (I&O) intake, Braden Score, presence of decubitus ulcers, presence of diarrhea, vomiting, reduced oral intake, etc.).
10. RD will determine patients at nutrition risk based upon above assessment and to include, but not limited to, patients with actual or potential malnutrition, patients on altered diets or diet schedule, patients with inadequate nutrition intake, lactating and pregnant women, and geriatric surgical patients.
11. RD will document protein/calorie and fluid requirements for patients as indicated. **See Appendix A (See tables 1, 2, & 3).**

Table 1 Assessment of Energy Requirements

- (a) ~~Harris Benedict~~
Men: ~~$66.5 + 13.75 (w) - 5.0 (h) - 6.76 (a)$~~
Women: ~~$655 + 9.56 (w) - 1.85 (a) - 4.68 (a)$~~
Apply appropriate activity & stress factors
- (b) ~~20 Kcal/Kg to 25-30 Kcal/kg/d (disease specific guidelines follow)~~
- (c) ~~Iroton Jones Energy Equations:~~
 ~~$EEE(V) = 1784 - 11 (A) + 5 (W) + 244 (S) + 239 (T)$~~
 ~~$EEE(S) = 629 - 11 (A) + 25 (W) - 609 (O)$~~
~~EEE = kcal/day~~
~~S = spontaneously breathing~~
~~V = ventilator dependent~~
~~A = age (years)~~
~~W = body weight (kg)~~

S = sex (male = 1, female = 0)
T = trauma
B = burn
O = obesity (if present = 1, absent = 0)

Table 2 – Assessment of Protein Requirements

RDA = 0.8gm/kg IBW or actual weight

~~*modified to reflect requirements for specific diseases and/or metabolic stress (refer to disease specific guidelines to follow and various references available in department)~~

Table 3 – Assessment of Fluid Requirements

30-35ml/kg (18 to 64 yrs. of age) or 1ml/Kcal

12. RD will develop a nutrition care plan indicating type of nutritional support (i.e. oral, oral with supplements, appropriate enteral feeding, or suggestion of parenteral feeding) to be given and its implementation. Determination of care plan will be based on assessment. Care plan will be individualized to meet specific needs of each patient. Goals will be individually determined with delineation of methods of achievement of goals and time frames. **Nutrition care plans are documented within the nutritional assessment.** RD will confer with physician for appropriate ordering and intervention, with register nurse (RN) for delivery of nourishment, with pharmacy and nursing for TPN and Drug Nutrient Interaction.
13. RD will monitor intake, input and output, weight, changes in medical condition and/or treatment and laboratory data and make recommendations as necessary. Intake may be monitored via calorie count. (Refer to Policy and Procedure for Calorie Count.)
14. RD will document patient's reaction and tolerance to dietary regimen.
15. RD will assess adequacy of enteral and parenteral feedings in relation to patient's nutritional requirements (see Food & Nutrition Policies: Enteral Feedings and Nutrition Assessment of TPN Patient).
16. RD may offer appropriate nutritional supplements **with Physician/AHP approval** ~~to patients at any time when a patient is consuming less than 75% of assessed calories/protein requirements (see Table 1 and Table 2).~~ Selection of appropriate supplement will be based upon assessment of patient's diagnosis, laboratory values, tolerance, and personal preference.
17. RD may implement **downgraded** texture changes in foods when indicated based upon patient tolerance and or personal preference (i.e. regular to mechanical soft or pureed).
18. RD will periodically reassess patient's nutritional status throughout hospital stay and document on Nutrition Reassessment form in **Electronic Medical Record** ~~Compass Power Chart~~ every one (1) to seven (7) days depending upon patient's status and individualized needs.
19. Obstetric patients will not be assessed unless RD is requested to do so by Physician/AHP/Nurse. ~~or if patient has nutritional risk factors, i.e. "lying in" or gestational diabetes. (See Food & Nutrition Policy: Nutrition Assessment of High Risk OB Patient)~~
20. ~~Behavioral Health patients will not be routinely assessed by the RD unless requested to do so by Physician/AHP/Nurse or if patient has nutrition risk factors (see Food & Nutrition Policy: Nutrition Assessment BHU).~~
- 21-20. Any significant change in the patient's condition, i.e. surgery, intubation, **or significant change in diagnosis warrants a reassessment. If the RD is not currently following the patient, the Physician/AHP/Nurse should enter a nutritional consult into the Electronic Medical Record.**
- 22-21. ~~A significant change in diagnosis, i.e. cancer, warrants a reassessment.~~

- 23-22. Upon completion of the assessment, the dietitian will complete the initial nutrition assessment form. Additional documentation may be noted in the **progress notes of the paper medical record.** ~~progress notes of the paper medical record~~

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

1. **Appendix A-Tri-City Healthcare District Nutrient**~~Nutritional~~ Requirements for Specific Disease States
- ~~1. Food & Nutrition Policy: Nutrition Assessment BHU~~
2. Food & Nutrition Policy: Nutrition Assessment of High Risk OB Patient
3. Food & Nutrition Policy: Nutrition Assessment of TPN Patient
4. Food & Nutrition Procedure: Calorie Count
5. Food & Nutrition Procedure: Enteral Feedings
- ~~6. Nutrient Requirements for Specific Disease States~~

D. **REFERENCE(S):**

1. Gottlich, MM, ed in chief: *The Science and Practice of Nutrition Support: A Case Based Core Curriculum*. Kendall/Hunt Publishing Company, Dubuque, IA, 2001.
2. *Manual of Clinical Dietetics*, online edition. Academy of Nutrition and Dietetics, Chicago, IL, 2017.
3. *Manual of Clinical Dietetics*, online edition. American Dietetic Association, Chicago, IL, 2000
4. Mueller, Charles, ed in chief: *The A.S.P.E.N Adult Nutrition Support Core Curriculum*. American Society for Parenteral Enteral Nutrition; 2nd ed. edition (2012)
5. Shikora, SA, Martindale, RG, Schwaitzberg, SD, eds: *Nutritional Considerations in the Intensive Care Unit: Science, Rationale, and Practice*. Kendall/Hunt Publ Co, Dubuque, IA, 2002.

Nutrient Requirements for Specific Disease States

Disease State	Calories	Protein	Other considerations
Obesity	22-25 kcal/kg IBW	1.2 to 2.0 gm/kg ideal wt	Consider lower protein requirements in presence of hepatic disease or renal insufficiency
Critically Ill Obesity	BMI >30-50: 11-14 kcal/kg actual wt BMI >50: 22-25 kcal/kg IBW	BMI 30-40: 2.0g/kg IBW BMI >40: up to 2.5g/kg IBW	
Pulmonary/Respiratory	25 to 30 kcal/kg ARDS: 20-30 kcal/kg	1.0 to 1.5 gm/kg	Do not overfeed. If mechanically ventilated, limit CHO to 4-5 mg/kg/min. Consider small frequent feedings.
Renal	ARF: 30-45 kcal/kg CRF: 35-38 kcal/kg *may reduce requirements if wt loss desired or to avoid overfeeding in ventilated pts	Prerenal: 0.6-0.8 gm/kg ARF: 1.0-1.5 gm/kg CRF: 1.0-1.2 gm/kg (with hemodialysis) 1.0-1.5 gm/kg (with peritoneal dialysis) Nephrotic syndrome: 0.8-1.0 gm/kg	Fluid & electrolytes as tolerated
Hepatic	Cirrhosis: 25-35 kcal/kg Hepatitis: 35 kcal/kg	Cirrhosis/hepatitis without encephalopathy: 1.0-1.2 gm/kg Cirrhosis/hepatitis with acute encephalopathy: 0.6-0.8 gm/kg; resume 1.0-1.2 gm/kg asap Cirrhosis with chronic encephalopathy: 0.6-0.8 gm/kg	If persistent encephalopathy, consider BCAA (hepatic formula; i.e. Nutra Hep for enteral; Hepatamine for parenteral.)
Diabetes	Needs as per normal assessment	40-20% total calories	
Cancer	25-35 kcal/kg, dependent upon individual patient	1.5 gm/kg Cancer cachexia: 1.5-2.5	Consider consequences of surgery, chemo, or radiation therapy.
Cardiac	25-30 kcal/kg	1.0-1.5 gm/kg	
Sepsis/critical care	25-30 kcal/kg Use obesity factors as applicable	1.2-1.5 gm/kg	Monitor glu levels; lipid levels if ventilated on propofol
Wound care	25-30 kcal/kg (adjusted levels as appropriate for obesity)	1.2-1.5 gm/kg	30-35 ml/kg Consider supplement with Vitamin C, zinc, Vitamin A if clinically deficient in these nutrients; evidence of clinical deficiency may be difficult to assess; thus, consider supplemental MVI with minerals.

Tri-City Healthcare District
Nutritional Requirement for Specific Disease States

DISEASE STATES	INJURY FACTOR	KCAL/KG	PROTEIN/KG	
ALS	sedentary activity factor only (1.1)	25	≥ 1	
ARDS/AUI		25-30	1.5 - 2.0	
Bariatric Surgery (initial post -op)		20-25 of IBW	1.5 - 2 of IBW (min 70gm)	
Cancer	1.1-1.45	25-35 high end for wt gain	1 - 1.5, > 1.5 hypermetabolism	
Closed head injury (GCS: Glasgow Coma Scale)	>1.3 If paralyzed decrease BEE by 20-50%	GCS<5:40-50**, GCS 8-12: 30-35	1.5-2	
CHF	1.1-1.2, severe 1.3-1.5		10-15% of total kcal	
COPD	1.2-1.4	30-35, 25-30 (>80 yr old)	1.2 - 1.5	
Ventilated Critical Care (increased with stress/hypercatabolic state)	Penn State (0.9-1.1)	20-25	1.2 - 1.5 (higher in burn & multi-trauma)	
Ventilated Critical Care Obese (BMI≥30)	Penn State (0.6-0.7)	22-25 IBW or 11-14 actual wt	2 - 2.5 IBW	
Cystic Fibrosis	RDA x 1.2-1.5 (2 if unable to maintain wt)		RDA X 2	
Diabetes Mellitus	1.2	20-30	1 - 1.5	
Fever	7% or each degree F above 98.6, 13% for each °C above 37			
Geriatric (>=65)	1 - 1.55 (1.76 high stress)	RDA = 30	≥ 1 up to 1.5 with significant stress	
HIV/AIDS	1.1-1.5	30-40	1.2 - 2.0	
IBD	1.2 - 1.5 (minor complications/ GI surgery) 1.5-1.7 (significant stress, sepsis, fistula)	25-30 30-35 or higher if wt loss or malabsorption present 35-45 w/ sepsis/fistula	1 - 1.2 1.2 - 2 with significant stress, surgery, sepsis, fistula	
Lactation	X activity + 500	(25-30) + 500	1 + 15	
Liver Disease (acute/chronic)	1.2 - 1.3	25-35	1.2 - 1.5	
Hepatitis	1.2 - 1.5**	30-40** Fulminant 30-35 ETOH 35	1 - 1.5	
Cirrhosis Compensated/No complications	1.2 - 1.5	30-35	1 - 1.2	
Cirrhosis Decompensated	1.2 - 1.5**	30-40**	1 - 1.5	
Malnutrition	1.5 - 1.75	40-50**		
Cholestasis	1.2 - 1.5**	30-40**		
Ascites	1.2 - 1.5**	30-40**		
Encephalopathy	1.2 - 1.5**	25-40**		
Coma	1 - 1.3	25-35		
Multiple/Long Bone Fractures	1.1 - 1.3	30-35	1.2 - 1.5	
Pancreatitis	Acute	1.3-1.5	22-47	1.4 - 2.0
	Chronic	30-35	1 - 1.5	
Peritonitis	1.2-1.5**	35-40**	1.2 - 1.5	
Post op	1.2-1.5	Minor 28 Major >30	1-1.5	

Pregnancy (calculations always based on pregravid wt and additional kcal per fetus)		1.2 + (340 for 2nd or 452 for 3rd) + 300Kcal/day for entire preg WHO + 300 kcal/day for last two trimesters (NRC)	Based on pregravid wt <90% IBW:36-40 90-120% IBW:30 >120 % IBW:24	1.1 - 0.8 + 10
Refeeding syndrome		20 kcal/kg or 1000kcal first week (whichever is lowest) advance per metabolic tolerance		
Renal Disease				
Chronic renal failure (pre-dialysis)		1.1 - 1.2	< 60 yr: 35-40** ≥ 60:30-35	0.6-0.75 for GFR <25ml/min
SLED		Based on underlying disease state (1.3XREE maximum)	25-35	Based on underlying disease state (Minimum 1.5)
Intermittent Hemodialysis (HD)		1.1 - 1.2	<60 yr:35-40** ≥60:30-35	1.2 - 1.3 Maximum 1.8
Nephrotic Syndrome		1.2 - 1.3	35 (dry wt if edema)	0.7-1 dry wt
Peritoneal dialysis		1.1-1.2 Include kcal from dialysate	< 60 yr:35-40** ≥ 60:30-35	1.2 - 1.3 Maximum 1.8
Sepsis (SIRS/Multiple organ failure/Severe sepsis)		1.5	20-35 (55-65% of goal kcal first week)	1.5 - 2.0
Spinal Cord Injury		Para X activity factor QUAD BEE only	Paraplegia 28, QUAD 23	1.5 - 2 acute phase 0.8 - 1 rehab phase
Transplant (post solid organ transplant/initial hospitalization)		1.3-1.5	30-35 acute phase	1.5 - 2 acute phase 1.0 chronic phase
Trauma		1.2-1.8	25-30	1.5 - 1.75
Pressure Injury				
Stage I			>25	1 - 1.2
Stage II			28-30	1.25 - 1.5
Stage III/IV (small, non draining)			30	1.25 - 1.5
Stage III/IV (Large, multiple and/or draining)			35-40**	1.5 - 2
Maximum			40**	2.2 (unless wound losses)
** Caloric needs estimated to be > 35 kcal/kg should be discussed with MD				

Hamwi Method for IBW F = 100lb for 1st 5ft + 5lb for each inch over 5ft M = 106lb for 1st 5ft + 6lb for each inch over 5ft	Penn State (venilated ICU) Mifflin(0.96) + Tmax(167) + Ve(31) - 6212 Modified Penn State (when Age >60 yrs & BMI>30)
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(+/-) 10% for frame size <5ft subtract 2.5lb w/inch <5ft		Mifflin(0.71) + Tmax (85) + Ve(64) - 3085
Mifflin-St. Jeor (floor or non-vent ICU) F = (10 X kg) + (6.25 X cm) - (5 x age) - 161 M = (10 x kg) + (6.25 x cm) + (5 x age) + 5		Knee Height Equation (height in cm) F: 84.8 - (0.24 x Age) + (1.83 x knee ht in cm) M: 61.19 - (0.04 x Age) + (2.02 x knee ht in cm)
Amputations (IBW - % specified)		
Hand 0.7%		
Forearm w/ hand 2.3%		
Entire Arm 5%		
Foot 1.5%		
Below the knee 5.9%		Determining Fluid Needs
Entire leg 16%		RDA 1ml/kcal (use ADJ wt if >120% of IBW)
Spinal Cord Injury		AGE 18-34 yrs = 30-35ml/kg, >65yrs = 25ml/kg
Paraplegia IBW minus 5-10%		Dehydration/Fever 35ml/kg
Quadriplegia IBW minus 10-15%		CHF 25ml/kg
BMI		Pressure Injury 30-35ml/kg, minimum 1500ml
Severely Underweight <16		UTI Add 14% to basic needs
Moderately Underweight 16 - 16.9		Renal 500 - 1000ml + urine output
Mildly Underweight 17 - 18.5		
Normal 18.5 - 24.9		Initial Micronutrient Needs
Overweight 25 - 29.9		AIDS/HIV Multivitamin/Mineral, B-Complex
Obesity Class I 30 - 34.9		Wounds
Obesity Class II 35 - 39.9		Stage I and II Possible MVI with minerals
Severe/Morbid Obesity Class III >40		Stage III and IV MVI w/Mineral, SnSulfate 220mg X 10 days, Vit C 500mg BID
Evaluating Wt Status		GI Losses
Normal 90-100% IBW		Diarrhea Zinc (12mg per liter loss) Na/K, Mg
Mildly Underweight 80-89% IBW		Emesis, NG Loss Na, K
Moderately Underweight 70-79% IBW		Renal HD Nephrovite, Folic Acid, L Carnitine
Severely Underweight <69% IBW		SLED Nephrovite, Folic Acid, Glutamine, Vit C <200
Mild Malnutrition 85-90% UBW		Liver - Wilson's Dz ZnSulfate 220mg 1-3X/day
Moderate Malnutrition 75-84% UBW		Encephalopathy ZnSulfate 220mg
Severe malnutrition ≤74%UBW		Refeeding Syndrome Avoid NA initially preload with Thiamin (100mg/day) X 5 days replete K, Mg, Phos daily
Evaluating Weight Change		SBS Mineral Na, Mg, Vitamins ADEK, B12 (especially w/ loss of ileum)
Timeframe	Significant	Alcoholism MVI 10ml, Folic Acid 1 mg, Thiamine 100mg
Severe		
1wk	1-2%	Trauma Glutamine 0.5g/kg, Omega 3
>2%		5-10g/day

1mo >5%	5%	Sepsis 5-10g/day	Glutamine 0.5g/kg, Omega 3
3mos >7.5	7.5%	ARDS/AUI	Omega 3 5-10 g/day
6mos >10%	10%		

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SUBJECT: Nutrition Assessment: BHU **POLICY NUMBER:** (Optional)

ISSUE DATE: 8/93

REVISION DATE(S): 3/03, 11/03, 11/05, 2/12

Department Approval Date(s):	02/1704/18
Medical Staff Department/Division Approval Date(s):	n/a
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	01/19
Administration Approval:	01/19
Professional Affairs Committee Approval Date(s):	n/a
Board of Directors Approval Date(s):	02/12

A. POLICY:

1. ~~Patients in BHU are screened for nutrition risk via the admission assessment and patient history. Referrals are generated by nursing if certain criteria are met.~~
 - a. ~~Nursing will generate a referral for nutrition assessment if any of the following criteria are met upon completion of the patient history and admission assessment:~~
 - i. ~~Unplanned weight loss of >10# in the last month~~
 - ~~Difficulty chewing/swallowing with change in intake~~ **Unintentional weight change of >10# in last 6 months**
 - ~~Intake <50% of normal intake in the last 30 days~~
 - ~~Enteral Feedings/TPN~~
 - ~~Nausea/vomiting/diarrhea~~
 - ~~Surgical patient > 75 years of age~~
 - ~~Skin breakdown/decubitus ulcer~~
 - ii. ~~Chewing/swallowing~~
- b. ~~Clinical dietitian will assess patient's nutrition status following guidelines of "Nutritional Screening, Assessment, and Care of Adults/Geriatrics" protocol.~~
- c. ~~Follow ups for referred patients will be at the RD's discretion depending on the complexity of the assessment.~~
- d. ~~Consults will be documented within 48 hours of referral~~

MEDICAL STAFF POLICY

ISSUE DATE: 07/11

SUBJECT: Credentialing Policy, da Vinci
Robotic Surgery

REVISION DATE: 07/12, 01/14

POLICY NUMBER: 8710 – 563

Department Approval:	03/17
Division of GVS Approval:	08/1306/17
Urology Division Approval:	10/13
CTS Division Approval:	10/13
Surgery Chiefs and Chair Approval:	11/13
Ob/Gyn Department Approval:	10/13
Credentials Committee Approval:	04/1311/17
Medical Executive Committee Approval:	04/1411/17
Administration:	01/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	07/12; 01/14

A. PURPOSE

1. To provide criteria for use in credentialing physicians who request privileges in da Vinci robotic surgery. For purposes of this policy, terms da Vinci and robotic are interchangeable.

B. INITIAL CREDENTIALING FOR MULTIPLE PORT PROCEDURES:

1. For surgeons with prior da Vinci experience:
 - a. Physicians must have privileges to perform the underlying procedure either as an open or laparoscopic procedure.
 - b. If residency/fellowship training included robotic surgery training, provide:
 - i. letter from program director certifying competency for the requested privilege(s) and in the use of the da Vinci device; and
 - ii. The surgical log of a minimum of ten (10) da Vinci cases;
 - iii. Proctoring: A minimum of two (2) cases within a one-hundred-eighty (180) day period must be proctored by a da Vinci robotic-credentialed surgeon (preferably in their field).
 - iii.1) [±]Additional training will be required prior to scheduling further cases if proctoring has not been completed within the specified time frame.
 - c. For surgeons with prior da Vinci experience at an outside institution, provide:
 - i. Ten (10) cases beyond proctoring and within the previous 24-month period must be submitted for review.
 - ii. Proctoring: A minimum of one (1) case must be concurrently proctored by a da Vinci robotic-credentialed surgeon (preferably in their field).[±]
 - d. The above-listed proctoring requirements may be waived for any surgeon on the Intuitive Surgical, Inc. List of Approved Proctors. However, privilege-specific proctoring requirements must be followed.
2. For surgeons without prior da Vinci experience:
 - a. Privileges to perform the underlying procedure either as an open or laparoscopic procedure.
 - b. Completion of an Intuitive Training Program or comparable program, which includes didactic and hands-on training including cadaver, animal lab, or simulator (See Phase II-Preparation and System Training of Surgeon Clinical Pathway-Intuitive Surgery).

- c. A minimum of one (1) live case observation.
- d. Proctoring: A minimum of three (3) cases within a one hundred eighty (180) day period must be concurrently proctored by a da Vinci robotic-credentialed surgeon (preferably in their field).
 - i. *Additional training will be required prior to scheduling further cases if proctoring has not been completed within the specified time frame.
- 3. *Proctoring requirements include a completed proctoring form from the elected proctor that includes satisfactory outcomes of the procedure, assessment of intraoperative and postoperative complications, and review of pathology reports if indicated. Proctor may recommend to the Chair of the Department or Chief of the Division that additional training and/or proctoring be completed.
- 3.4. For all physicians granted robotic surgery privileges, the first ten (10) cases will be reviewed for evaluation of case selection, OR time, blood loss, conversion to open procedure, complications, length of hospital stay, etc.
- 4.5. For privileges to assist in robotic surgery (for MD/DO, PA, RNFA):
 - a. Unrestricted surgical assisting privileges
 - b. Documented experience in robotic assisting or completion of Intuitive Training Program for assistants (including on-line module and on-site training by Intuitive or a robotics-trained assistant)
 - c. Proctoring: A minimum of six (6) cases must be proctored by the primary surgeon. Surgeons granted privileges for both robotic surgery and to assist in robotic surgery may be deemed to have satisfied proctoring requirements as an assistant in robotic surgery once proctoring requirements as the robotic surgeon have been fulfilled.

C. INITIAL CREDENTIALING FOR SINGLE PORT PROCEDURES:

- 1. Unsupervised multiple port robotic surgery privileges;
- 2. Completion of either:
 - a. Single port Intuitive (or comparable) training program OR
 - b. Training modules
 - i. Proctoring: Two (2) cases with a qualified single port surgeon.

D. REAPPOINTMENT CRITERIA

- 1. A minimum of ten (10) cases performed successfully (may be reviewed by the appropriate Division or Department or Committee) during the previous 24-month period without a proctor present.
- 2. If less than ten (10) but greater than or equal to five (5) cases have been performed successfully during the previous 24-month period, the next two (2) cases must be successfully performed with the assistance of either a da Vinci robotic-certified surgeon on staff from within the same field or an outside proctor/preceptor.
- 3. If fewer than five (5) cases have been performed successfully within the previous 24-month period, additional certified hands-on training must be obtained either by simulator, cadaver or animal lab AND the next two (2) cases must be successfully performed with the assistance of either a da Vinci robotic-certified surgeon on staff from within the same field or an outside proctor/preceptor.
- 4. For single port procedures, a minimum of two (2) procedures during the previous 24-month period. If fewer than two (2) cases, training modules must be redone or the next one (1) case must be concurrently proctored by a qualified single port surgeon.

E. ONGOING PROFESSIONAL PRACTICE EVALUATION

- 1. Robotic-performed cases may be reviewed on an ongoing basis by the appropriate Division/Department/Committee with the goal of patient safety and successful performance of the procedure(s). This may include OR time, blood loss, conversion to open procedure, complications, length of hospital stay.

MEDICAL STAFF

ISSUE DATE: 07/01 **SUBJECT:** Medical Record Documentation Requirements

REVISION DATE(S): 07/07, 03/08, 09/08, 06/09, 09/09, 11/09, 07/11, 05/12, 08/12, 02/15, 12/15, 02/18 **POLICY NUMBER:** 8710-518

Medical Staff Department Approval:	07/1812/18
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	07/1801/19
Administration Approval:	08/1801/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/18

A. PURPOSE:

1. To establish the policy, procedure, and responsibilities for the completion of medical records.

B. POLICY:

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

C. RESPONSIBILITIES:

1. General responsibilities are delegated as indicated in the following subsections:
 - a. Hospital administration in conjunction with the medical staff, will determine the criteria for timely, authenticated, legible, and complete medical records.
 - b. The Medical Records/Health Information Department will monitor to ensure that medical records meet the requirements for completeness as set in this policy.

D. PROCEDURE:

1. Electronic signature:
 - a. It is expected that all members of the medical staff will authenticate documents maintained in Cerner electronically through use of a physician identifier.
 - b. All members of the medical staff will be required to complete an Electronic Signature Certification Statement to document their acknowledgement of the proper use of their identifier in the authentication of documents.
 - c. Dictated reports will be transcribed into the Medical Records transcription system. Upon transcription the report will be saved and sent electronically to the Cerner electronic medical record (EMR).
 - d. Paper-based documents will be scanned to the EMR and will be assigned by HIM for signature when required.
 - e. Physicians will utilize the Cerner Message Center to authenticate transcribed and in progress documents in a timely manner.
 - f. Electronic signature of transcribed and scanned reports by the practitioner will update the medical records/health information profile system to eliminate the signature deficiency assigned by the department.
 - g. The Message Center feature supports the following actions to be taken by the physician:

i. Sign/Review

- 1) Physician reviews the document and selects the OK button that updates the status of the report to "Authenticated"
- 2) Only the responsible physician is eligible to sign a transcribed report.
 - a) Physician Assistants will sign their reports in addition to the report being signed by the supervising physician.
 - b) Resident reports will be signed by the supervising physician.
 - c) All mid-level practitioners (e.g., Nurse Practitioners, Midwives) sign their reports in addition to the report being signed by the supervising physician within 48 hours but prior to patient discharge in the acute care setting

ii. Modify/Sign

- 1) Physician may modify the document PRIOR to signature to correct/clarify any elements of the report.
- 2) Addendums are to follow the structure of new information being bolded and deleted information noted as a strike-through
- 3) Once modified and signed any new revisions to the document are noted as an Addendum

iii. Refuse

- 1) Physician may refuse and redirect a document to Medical Records/Health Information (Med Rec Inbox) for review and reassignment of the deficiency to the correct physician via Cerner message center.

2. Written Signatures

- a. It is expected that members of the medical staff and allied health will utilize acceptable written signatures, including credentials for all paper-based documents being authenticated.
 - i. This expectation relates to orders submitted for outpatient ancillary services as well as emergency, same-day surgery, observation, and inpatient documentation.
- b. Acceptable written signatures are as follows:
 - i. Legible full signature
 - ii. Legible first initial and last name
 - iii. Illegible signature over a typed or printed name
 - iv. Illegible signature where the letterhead or other information on the page indicates the identity of the signer
 - 1) Example: an illegible signature appears on a prescription. The letterhead lists multiple physicians' names. One of the names is circled.
 - v. Initials over a typed or printed name
 - vi. Unsigned handwritten orders where other entries on the same page in the same handwriting are signed
- c. Unacceptable written signatures are as follows:
 - i. Signature stamps alone are not acceptable.
 - ii. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement.
 - iii. Unsigned typed note with provider's typed name
 - iv. Unsigned typed note without provider's typed/printed name
 - v. Unsigned handwritten note, the only entry on the page

3. The following criteria must be met before a chart is considered complete:

- a. A medical record must be legible for each patient; its content shall be pertinent and current. This record shall include:
 - i. Identification data
 - ii. Legal status if mental health patient;

- iii. Emergency care given prior to arrival if any;
 - iv. Findings of assessment;
 - v. Conclusions or impressions from history and physical;
 - vi. Diagnosis or diagnostic impression;
 - vii. Reasons for admission or treatment;
 - viii. Goals of treatment and treatment plan;
 - ix. Known advance directives;
 - x. Informed consent for procedures and treatment;
 - xi. Diagnostic and therapeutic procedures and tests and their results;
 - xii. Operative and other invasive procedures performed;
 - xiii. Progress notes;
 - xiv. Reassessments if needed;
 - xv. Clinical observations;
 - xvi. Response to care;
 - xvii. Consultation reports;
 - xviii. Every medication ordered; every dose administered and any adverse reaction;
 - xix. Every medication dispensed to inpatient at discharge or to ambulatory patient;
 - xx. All relevant diagnoses established during care;
 - xxi. Any referrals/communications to other providers.
4. All patient medical record entries must be legible, completed, dated, timed, and authenticated in written or electronic form by the practitioner responsible for providing or evaluating the service provided.
- a. All documentation is to be without the use of Do Not Use Abbreviations.
 - i. A reference of Do Not Use Abbreviations is referenced on the TCMC intranet.
5. History and Physical
- a. A complete history and physical examination shall be present in the medical record no more than 30 days before or within twenty-four (24) hours of admission.
 - i. Handwritten history and physicals are not acceptable and an electronic or printed H&P must be provided.
 - ii. All history and physical examinations will be validated and authenticated by the attending physician with appropriate privileges.
 - iii. The medical history and physical must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.
 - iv. For patients with H&P's not more than 30 days old (in lieu of a new H&P), an examination of the patient, including any changes in the patient's condition, must be present in the medical record within 24 hours of admission.
 - v. A history and physical completed more than 30 days prior to admission is not valid and must be completed.
 - vi. A history and physical document completed outside Tri-City Medical Center is required to reflect date and time of the examination.
 - b. The history and physical shall include the following elements:
 - i. Chief complaint;
 - ii. Personal, past medical and surgical history;
 - iii. Allergy history;
 - iv. Current medications;
 - v. Family history;
 - vi. History of present illness;
 - vii. All-important findings resulting from a review of systems;
 - viii. Physical examination;
 - ix. Diagnosis or diagnostic impression;
 - x. Plan of treatment.
 - c. Surgeries or procedures requiring anesthesia services must have a history and physical present in the medical record, no older than 30 days.

- i. Physician Pre-Procedure Documentation including an update to the H&P must be recorded on the patient's medical record on the same day, prior to patient admission to the Operating Room or Procedural areas regardless of the date and time the history and physical was completed.
 - ii. If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record the:
 - 1) H&P was completed
 - 2) H&P was reviewed
 - 3) The patient was examined and "No Change" has occurred in the patient's condition since the H&P was completed.
 - iii. When the required history and physical examination is not present before the time stated for the operation, the operation shall be postponed until the history and physical is present in the medical record or the physician has documented that such a delay would constitute a hazard to the patient.
 - d. History and physical for hospital outpatient procedures:
 - i. Ambulatory surgery patients undergoing invasive procedures with anesthesia, procedural sedation, or procedures that could compromise the circulatory or respiratory status as determined by the practitioner, shall have a complete H&P as defined above prior to surgery.
 - ii. Hospital outpatients undergoing invasive procedures without a significant level of risk shall have at least a limited history and physical.
 - iii. A limited history and physical shall contain the same elements as an H&P, except the review of systems and physical examination elements may be abbreviated to include only that which is relevant, appropriate or pertinent to the procedure or intervention to be performed.
- 6. Dentists who are members of the Medical Staff may only admit patients if a physician member of the Medical Staff conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry) and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside the limited license practitioner's lawful scope of practice.
 - a. A history and physical completed by the medical physician in addition to the history and physical completed by the dentist are necessary to be documented on the chart prior to any surgical procedure.
 - b. A qualified oral surgeon or podiatrist with specifically delineated clinical privileges may admit patients without significant underlying or potentially complicating medical problems, may perform the history and physical examination of those patients, and may assess the medical risks of proposed surgical procedures for such patients.
 - i. Completion of a history and physical examination by an oral surgeon or podiatrist who has the special privileges will NOT require completion of a history and physical by another qualified physician.
- 7. Medication reconciliation:
 - a. Admission
 - i. The admitting physician is required to review, complete and reconcile admission medication reconciliation information in Cerner collected upon admission of the patient within 24 hours.
 - ii. If new information is later obtained, the clinician may update the medication by history list in Cerner.
 - b. Transfer
 - i. All medications will be reviewed and revised as appropriate when patient is being transferred to another level of care.
 - 1) Electronic Orders
 - a) The physician will access the transfer medication reconciliation function and will reconcile each medication on the active

- medication list to either be continued or not continued for the next level of care.
- c. Discharge
 - i. All medications will be reviewed against HOME medications in Cerner.
 - 1) Electronic Orders
 - a) The physician will reconcile each medication on the active medication list and home list to either be continued or not continued upon discharge. New medications will be added as required.
 - b) Prescriptions to be completed
 - i) ePrescribe – electronic prescription transmitted to the patient's pharmacy
 - ii) Printed on the unit and handed to the patient
 - iii) Handwritten on personal (physician's) prescription pad
 - 2) Written Orders
 - a) Physician handwrites prescriptions on personal (physician's) prescription pad.
 - b) Physician updates physician medication changes on the electronic medication list through the medication reconciliation tool.
8. Daily progress notes must be documented and reflect medical care and visitation of the patient by the attending member on all patients in the hospital.
- a. All practitioners will document progress notes in any of the following methods:
 - i. Hand-written progress notes are not acceptable;
 - ii. An electronic note may be a progress note typed by the physician or a progress note generated using a voice recognition software application (e.g. Dragon).
 - b. Progress notes recorded by mid-level providers are required to be co-signed by the supervising physician member within 48 hours but prior to patient discharge.
- c.b.**
9. All surgical operations, invasive and diagnostic procedures (including blood transfusions) shall be performed with documented informed consent except in an emergency. The informed consent for hysterectomies and sterilization procedures must meet specific requirements as set forth in Title XXII.
- a. The informed consent documented will include the following:
 - i. Discussion about potential benefits, risks, and side effects of the patient's proposed care, treatment, and services.
 - ii. The likelihood of the patient achieving his or her goals.
 - iii. Any potential problems that might occur during recuperation.
 - iv. Reasonable alternatives including side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.
 - v. Name of the practitioner who will perform the proposed care, treatment, and services.
10. Physicians shall discuss a patient's Do Not Resuscitate (DNR) status with the patient and/or decision-maker prior to a surgery or procedure that requires anesthesia. The discussion shall include possible temporary suspension of the DNR status during the surgery or procedure. The DNR status shall be reevaluated immediately after the procedure. This discussion shall be documented in the medical record and an appropriate order entered/written.
11. A pre-sedation or pre-anesthesia assessment is performed for each patient before beginning moderate or deep sedation and before anesthesia induction within forty-eight (48) hours prior to surgery.
12. A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours after surgery for an inpatient and shall include:
- a. Respiratory function including rate, airway patency and oxygenation saturation;
 - b. Cardiovascular function, including pulse rate and blood pressure;

- c. Mental status;
 - d. Temperature;
 - e. Pain;
 - f. Nausea and vomiting;
 - g. Anesthesia complications;
 - h. Post-operative hydration; and
 - i. Additional types of monitoring and assessment as may be necessary.
13. Operative or other high risk procedure reports shall be completed electronically or dictated immediately after surgery and shall include:
- a. Pre-operative diagnosis;
 - b. Post-operative diagnosis;
 - c. Date of procedure
 - i. If the procedure is canceled, the operative report should include the reason and time of the cancellation.
 - ii. Name of procedure;
 - d. Anesthesia type;
 - e. A detailed account of the procedure including approach and technique used;
 - f. Estimated blood loss if any;
 - g. Specimen removed if any;
 - h. Name of the primary surgeon and any assistants;
 - i. Complications;
 - j. Patient status;
14. A post-operative/procedure note shall be completed immediately following surgery or other high-risk procedures when the operative/procedure report is dictated pending transcription. An operative note is not required if the operative/procedure report is completed electronically and immediately available in the medical record. Use of the electronic post-operative procedure note is necessary to document all required elements.
- a. Name of Procedure;
 - b. Pre-Operative diagnosis
 - c. Post-Operative diagnosis
 - d. Patient status
 - e. Name of primary surgeon and any assistants
 - f. Anesthesia type
 - g. Complications
 - h. Findings
15. When the operative note is dictated, the electronic post-operative note must be completed by the surgeon prior to the patient being discharged or transferred from recovery.
16. An intraoperative anesthesia record containing the following elements shall be completed by an anesthesiologist:
- a. Name and hospital ID number of the patient
 - b. Name of anesthesiologist who administered the anesthesia
 - c. Vital signs reflecting patient status just prior to induction
 - d. Name, dosage, route, and time of administration of drugs and anesthesia agents
 - e. Techniques used and patient position(s), including the insertion/use of any intravascular or airway devices
 - f. Names and amounts of IV fluids, including blood or blood products
 - g. Time-based documentation of vital signs as well as oxygenation and ventilation parameters, and
 - h. Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.
17. All orders, including verbal orders, must be dated, timed, and authenticated.
- a. All orders shall be completed, legible, dated and signed within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.

- a-b. **Physician co-signature is required within 48 hours, and/or prior to patient discharge, of and Allied Health Professional's order excluding those covered under an already approved standardized procedure.**
18. Medical Records/HIM will assign a deficiency to unsigned orders via the Inbox/Message Center.
19. It is acceptable for physicians involved in the care of the patient to sign orders given by other physicians unless they object to the order. A physician may proxy Message Center to another physician for coverage purposes.
- a. Verbal orders are to be used infrequently, only to meet the immediate care needs of the patient when it is impossible or impractical for the ordering practitioner to write/enter the order without delaying treatment. Every effort is to be made by the ordering physician to enter orders electronically into Cerner.
- b. All orders for treatment shall be entered electronically to the medical record. An order for treatment is considered entered if dictated by a member or his designee to a registered nurse and signed by the attending member through the Message Center. When orders are dictated over the telephone, they shall be signed by the responsible physician within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.
- c. Physician orders for neonatal and pediatric populations will contain weight based dosing (e.g., mg/kg) along with the calculated dose and the patient's current weight with the exception of the following defined medication classes:
- i. Medications that are not determined by the patient's weight (e.g., iron sulfate).
- ii. Vaccines
- iii. Intravenous fluids
- iv. Medication doses that if weight based would equal or exceed normal adult doses.
20. When a patient is transferred from one level of care to another the physician is required to complete one of the following options:
- a. Electronic Orders
- i. Utilize the Merge View in Cerner to review and update all orders for the next level of care.
- ii. Complete the Transfer Medication Reconciliation function
- iii. The physician is not required to re-enter orders when a patient is undergoing one of the following minor procedures and returns to the same level of care:
- 1) Heart Catheterization
- 2) Interventional procedures including PICC line placement
- 3) Endoscopy including bronchoscopies
- 4) Inpatient dialysis
- 5) Pain management
21. Consultations and recommendations shall include examination of the patient and a review of the patient's record by the consultant. The consultation shall be made a part of the patient's record. When operative procedures are involved, a consultation, except in an emergency, shall be recorded prior to the operation.
22. Discharge/Depart Process
- a. Electronic orders for discharge and follow-up care (including: activity, diet, equipment, follow-up, and medications) will be entered into the Depart Process application.
- b. Written orders for discharge and follow-up care (including: activity, diet, equipment, and follow-up) will be recorded on the Physician Order sheet.
- i. Nursing will enter into the Depart Process application
- ii. Medication orders must be entered by the physician for Discharge Medication Reconciliation process (see section D.11.c.2)
23. A Discharge Summary shall be completed for all deaths regardless of length-of-stay, and in addition on all patients hospitalized over forty-eight (48) hours, except for normal obstetrical deliveries, and normal newborn infants. A discharge summary must contain:
- a. Discharge Diagnosis
- b. Reason for hospitalization

- c. Significant findings
 - d. Procedures performed and treatment given
 - e. Condition on discharge
 - f. Instructions given to the patient or patient representative
 - i. Follow-up instructions
 - ii. Diet instructions
 - iii. Discharge medications
 - g. A discharge note is acceptable for all patients with a length-of-stay less than forty-eight (48) hours, to include normal obstetrical deliveries, and normal newborn infants.
 - i. Requirements of the note include:
 - 1) Discharge diagnosis
 - 2) Instructions given to the patient or patient representative:
 - i. Follow-up instructions
 - ii. Diet instructions
 - iii. Discharge medications
 - 3) Physicians who have not completed a discharge summary at the time of discharge will be notified by Medical Records/HIM via the Message Center in Cerner and call to their office.
24. Physicians will be notified of all pending dictations and/or signatures via their Cerner Message Center and call to their office.
- a. Physicians will be suspended if the chart is not completed within 14 days of discharge per Medical Staff Policy #8710-519 for Delinquent Medical Records and Medical Staff Bylaws Section 6.4-4(a).
25. Late entries, addendums or corrections to the medical record
- a. Documentation shall be recorded timely within the patient's medical record. When this is not possible a late entry, addendum, or correction will be made with the following required elements documented:
 - i. A late entry, addendum or correction to the medical record, bears the current date of the entry and is signed by the person making the change or addition to the medical record.
 - ii. A late entry supplies additional information that was omitted from the original entry. A late entry bears the current date and is added as soon as possible after the original entry was entered.
 - iii. An addendum is used to provide information that was not made at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum.
 - iv. When making a correction to the medical record, the original entry must remain viewable. Documentation of the correct information should contain the current date and time and reference back to the original entry.
 - b. It is not permitted to have entries "backdated" or "predated".
 - c. The chart shall be completed within fourteen (14) days of discharge; it is expected no late entries will appear after this time period.

E. **FORM(S):**

- 1. Electronic Signature Certification Statement - Sample

SAMPLE



Tri-City Medical Center

ELECTRONIC SIGNATURE CERTIFICATION STATEMENT

The purpose of this form is to certify that each physician identifier is kept confidential. This form also certifies that Tri-City Medical Center is committed to maintaining the confidentiality of the physician identifiers. If it is determined that an assigned identifier has been misused, the authorized hospital official will terminate a physician's use of his or her identifier.

The term 'misused' is defined to mean that the physician has allowed another person or persons to use his or her personally assigned identifier. Any proof of misuse must be documented by the authorized hospital official and actions to terminate the use of the physician identifier must be initiated immediately, including written notice to the physician involved.

PHYSICIAN CERTIFICATION:

I certify I will not disclose the identifier assigned to me to any other person or permit another person to use it.

Physician Signature

Date

Physician Name (Printed)

TRI-CITY MEDICAL CENTER CERTIFICATION

I certify that the identifiers assigned to physicians for purposes of the Compass Physician Inbox electronic signature process will be kept confidential and that I will terminate the use of a physician's identifier in the event that he or she misuses it.

TCMC Authorized Representative

Date

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 08/03

SUBJECT: Standards for Seed Implants in the
OR

REVISION DATE(S): 03/08

POLICY NUMBER: 8710 – 524

Department Approval:	07/17
Department of Medicine Approval:	10/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	03/0811/17
Administration Approval:	01/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/08

A. STANDARDS:

1. All cases involving Seed Implantation must meet the following minimum criteria for adequate facilities and physician skills:
 - a. The minimum criterion for the facility is:
 - i. Sonographic Equipment
 - ii. A large Field of View image intensifier (15 or 16 inches) * with a 1024 matrix.
 - iii. Appropriate supply of seed implants as determined by the radiation oncologist.
 - iv. Appropriate level of sterility.
 - v. Adequate space and facilities for anesthesia.
 - vi. Circulating **Registered Nurse (RN)**.
 - vii. Scrub Technician or Scrub RN.
 - viii. Radiologic technologist.
 - b. The criterion for physician skills is:
 - i. Interventional Radiologist must have current independent (has been released from proctoring) **Tri-City Healthcare District (TCHDMC)** privileges for placement of seed implants.
 - ii. Interventional Radiologist must have met the minimum criteria for device-specific training/certification as defined by the manufactures of the device.
 - iii. During all cases at least one physician credentialed in Interventional Radiology and one physician credentialed in Radiation Oncology must be present.

Approvals:

Medical Division Approval: _____

Medical Executive Committee Approval: _____ **03/08**

Board of Directors Approval: _____ **03/08**

ISSUE DATE: 11/2010

SUBJECT: Discharge Planning

REVISION DATE(S): 11/10, 12/10, 06/12, 11/12, 4/14,
03/16

Patient Care Management Department Approval:	11/15/11/18
Utilization Review Committee Approval:	11/15/12/18
Medical Staff department/Division Approval:	n/a
Pharmacy & Therapeutics Approval:	n/a
Medical Executive Committee Approval:	02/16/01/19
Administration Approval:	01/19
Professional Affairs Committee Approval:	03/16 n/a
Board of Directors Approval:	03/16

A. PURPOSE:

- ~~1. To collaborate with patient and/or family and/or their representative to assess, facilitate, plan and advocate for the patients' ongoing needs on an individual basis. Through collaboration with the multidisciplinary team members as needed, the Case Manager shall initiate and implement an individualized transition plan (discharge plan) as necessary, through monitoring and re-evaluation to accommodate changes in treatment or progress.~~
- ~~2. The discharge planning process applies to all Inpatients; discharge planning is not required for outpatients.~~

B. POLICY:

- ~~1. Refer to Patient Care Services Policy: Discharge Planning for additional information.~~

C. RELATED DOCUMENT(S):

- ~~1. PCS Policy: Discharge Planning~~

Ceftazidime/Avibactam (Avycaz™) Drug Use Criteria

Drug class:¹ Cephalosporin and β -lactamase inhibitor combination

FDA Approval: NDA submission: June 25, 2014²
Approved: February 26, 2015³

Indication(s):¹ Complicated urinary tract infections (cUTI), complicated intra-abdominal infections (cIAI), treatment of nosocomial pneumonia, ventilator-associated pneumonia

Manufacturer: Allergan (Avycaz™)

Formulations:¹ Injection (2.5 g powder for reconstitution)

Cost: \$338.08/2.5g vial

Recommendations:

Ceftazidime/avibactam should only be used for infections not responding to other treatment options. It has activity against some ESBLs, but most remain resistant.

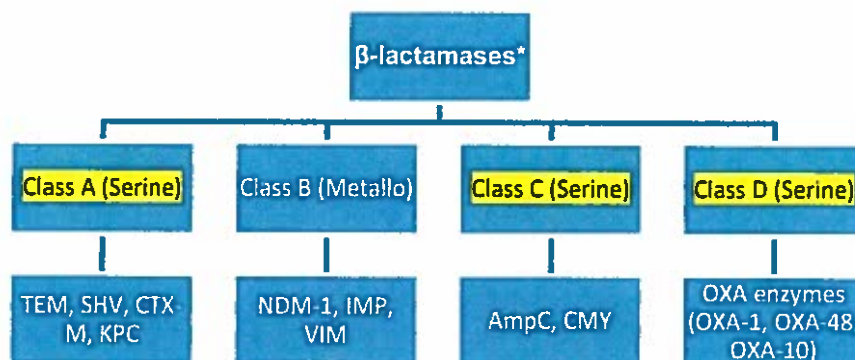
Recommend addition to TCMC formulary however restricted to infectious disease physicians only.

Background:

Gram-negative bacteria are highly adaptive pathogens that can develop resistance through several mechanisms; and can pass along genetic materials that allow other bacteria to become drug-resistant as well. The Centers for Disease Control and Prevention (CDC) has identified antibiotic resistance as a threat in the U.S. and has categorized the level of concern for carbapenem-resistant *Enterobacteriaceae* (CRE) as "urgent" and for both Extended spectrum β -lactamase producing *Enterobacteriaceae* (ESBLs) and Multi Drug Resistant (MDR) *P. aeruginosa* as "serious." Many of these Gram-negative pathogens are particularly worrisome because they are becoming resistant to nearly all drugs, including the carbapenems, often considered the last line of defense in these challenging infections. For this reason, manufacturers have been able to apply for fast-track approval by the Food and Drug Administration (FDA) if their new drug meets the criteria to be considered a Qualified Infectious Disease Product (QIDP). Ceftazidime/Avibactam, marketed as Avycaz™, was approved by the FDA in February 2015.

β -lactams belong to a family of antibiotics which is characterized by a β -lactam ring. Penicillins, cephalosporins, clavams (or oxapenams), cephamycins and carbapenems are members of this family. The integrity of the β -lactam ring is necessary for the activity which results in the inactivation of a set of enzymes that catalyze the final cross-linking reactions of peptidoglycan synthesis. Resistance to β -lactams in clinical isolates is primarily due to the hydrolysis of the antibiotic by a β -lactamase. Ceftazidime/Avibactam is capable of overcoming some AmpC-mediated resistance in *P. aeruginosa*, and against *Enterobacteriaceae*, it demonstrates activity against Class A, C and some Class D ESBL producing isolates (Figure 1).⁴

Figure 1: Classes of β -lactamases and Inhibition Activity⁴



Pharmacology/Pharmacokinetics:

The following table represents ceftazidime/avibactam's pharmacokinetic parameters. They were similar for single and multiple doses administered.

Table 1: Pharmacokinetic Parameters of Ceftazidime and Avibactam (CAZ-AVI) in Healthy Adult Male Subjects¹

Parameter	Ceftazidime		Avibactam	
	Single CAZ-AVI 2.5 g ^a Dose Administered as a 2-hour infusion (n = 16)	Multiple CAZ-AVI 2.5 g ^a Doses Administered every 8 hours as 2-hour infusions for 11 days (n = 16)	Single CAZ-AVI 2.5 g ^a Dose Administered as a 2-hour infusion (n = 16)	Multiple CAZ-AVI 2.5 g ^a Doses Administered every 8 hours as 2-hour infusions for 11 days (n = 16)
C _{max} (mg/L)	88.1	90.4	15.2	14.6
AUC (mg·h/L) ^b	289 ^c	291	42.1 ^d	38.2
T _{1/2} (h)	3.27 ^c	2.76	2.22 ^d	2.71
CL (L/h)	6.93 ^c	6.86	11.9 ^d	13.1
V _{ss} (L)	18.1 ^c	17.0	23.2 ^d	22.2

a: 2 g ceftazidime + 0.5g avibactam. b: AUC_{0-12h} reported for single dose administration; AUC_{0-24h} reported for multiple dose administration. c: n = 15. d: n = 13.

- **Half Life:** Short for both ceftazidime and avibactam (~ 3 hours)
- **Distribution:** Less than 10% protein bound; steady-state volumes of distribution of ceftazidime and avibactam were 17 L and 22.2 L, respectively, in healthy volunteers
- **Metabolism:** None observed; the presence of hepatic dysfunction had no effect on the pharmacokinetics of ceftazidime in individuals administered 2 grams intravenously every 8 hours for 5 days.
- **Elimination:** Primarily renal and unchanged via glomerular filtration and tubular secretion

Mechanism of Action:¹

Ceftazidime/avibactam is bactericidal and time-dependent.

- Ceftazidime
 - Cell wall synthesis inhibitor
- Avibactam
 - β-lactamase inhibitor

Coverage:¹

- *Escherichia coli*, *Klebsiella pneumoniae*, *Pseudomonas aeruginosa*, *Enterobacter cloacae*
- *Proteus mirabilis*, *Providencia stuartii*, *Klebsiella oxytoca*
- *Citrobacter koseri*, *Enterobacter aerogenes*, *Citrobacter freundii*, *Proteus spp.*

- Ceftazidime/avibactam has *in vitro* coverage of *Morganella morganii* *Serratia marcescens*

Dosing:¹

- Adults: 2.5 g IV every 8 hours
- Renal insufficiency:
 - CrCl 31 to 50 mL/minute: 1.25 grams IV every 8 hours (over 2 hours)
 - CrCl 16 to 30 mL/minute: 0.94 grams IV every 12 hours (over 2 hours)
 - CrCl 6 to 15 mL/minute: 0.94 grams IV every 24 hours (over 2 hours)
 - CrCl less than or equal to 5 mL/minute: 0.94 grams IV every 48 hours (over 2 hours)

Phase II/III Clinical Studies:

Two Phase II trials have been conducted; one evaluated ceftazidime-avibactam versus imipenem-cilastatin in cUTIs (Table 2); the other evaluated ceftazidime-avibactam plus metronidazole versus meropenem in cIAls (Table 3). One Phase III trial led to approval of ceftazidime/avibactam for ventilator-associated pneumonia when compared to meropenem (Table 4).

Table 2⁵: NCT00690378 (n=135)

Objective	<ul style="list-style-type: none"> • Compare efficacy and safety of ceftazidime-avibactam and imipenem-cilastatin in hospitalized patients with serious complicated urinary tract infections due to Gram-negative pathogens. 		
Study Design	<ul style="list-style-type: none"> • Prospective, multicenter, investigator and patient-blinded, randomized comparative study 		
Inclusion Criteria	<ul style="list-style-type: none"> • Between the ages of 18 and 90 years • Diagnoses of acute pyelonephritis or other cUTI • Presence of fever, and/or chills documented within 12 hours of entry into the study and flank pain, pyuria or catheterized urine specimen with ≥ 10 white blood cells and a positive urine culture) • Diagnoses of cUTI due to Gram-negative pathogen • Signs/symptoms consistent with UTI: fever, chills, flank pain, costovertebral angle tenderness, dysuria, urgency, frequency, incontinence, suprapubic pain, nausea, or vomiting and positive urine culture 		
Study arms	<ul style="list-style-type: none"> • IV ceftazidime 500 mg plus avibactam 125 mg every 8 hours, duration: 7 to 14 days • IV imipenem-cilastatin 500 mg every 6 hours, duration: 7 to 14 days 		
Primary Endpoint	<ul style="list-style-type: none"> • A favorable microbiological response at the test-of-cure (TOC) visit, 5-9 days after the last dose of the study therapy, in the microbiologically evaluable (ME) population • Favorable microbiological response defined as eradication of all uropathogens ($\geq 10^5$ CFU/mL to $<10^4$ CFU/mL, with no pathogen present in the blood) • ME patients defined as patients who had no major protocol violations, had a positive urine culture on enrolment that contained $\geq 10^5$ CFU/mL of at least one uropathogen 		
Secondary Endpoints	<ul style="list-style-type: none"> • Microbiological response at the end of IV therapy and at the late follow-up visit (LFU), 4-6 weeks post-therapy in the ME population • Clinical response at the end of IV therapy, at the TOC and LFU visits • Microbiological responses according to the primary diagnosis, baseline uropathogen isolated, and presence of ceftazidime-resistant pathogens • Microbiological response also assessed for the modified intent-to-treat (MITT) population • Safety and tolerability were determined for the safety population by assessment of treatment emergent adverse events, local tolerability, vital signs, physical examination, electrocardiogram and laboratory tests 		
Statistical Analysis	<ul style="list-style-type: none"> • Descriptive statistics for each treatment arm at the end of IV treatment, and at the TOC and LFU visits • Two-sided 95% exact confidence intervals (CIs) were calculated for differences in microbiological response 		
Results: Primary Endpoint (Favorable microbiological response in the ME population at the TOC visit)	Ceftazidime-avibactam (n = 69)	Imipenem-cilastatin (n = 68)	Treatment difference (95% CI)
	19/27 (70.4%)	25/35 (71.4%)	-1.1% (-27.2%, 25%)

Results: Secondary Endpoint (Favorable microbiological response rates at the end of IV therapy and LFU visit)	Ceftazidime-avibactam (n = 69)	Imipenem-cilastatin (n = 68)		Treatment difference (95% CI)
	25/26 (96.2%) –End of IV therapy 15/26 (57.7%)- End of LFU visit	34/34 (100%)– End of IV therapy 18/30 (60.0%)- End of LFU visit		-
Results: Secondary Endpoint (Favorable microbiological response rate at test-of-cure visit according to primary diagnoses and baseline uropathogens)		Ceftazidime-avibactam (n=27)	Imipenem-cilastatin (n=35)	Observed difference (95% CI)
	Primary diagnosis, n (%):			
	Acute pyelonephritis	13/18 (72.2)	14/19 (73.7)	-1.5 (-35.5, 32.6)
	Other cUTI	6/9 (66.7)	11/16 (68.8)	-2.1 (-49, 44.9)
	Baseline uropathogen:			
	<i>E. coli</i>	19/25 (76.0)	23/33 (69.7)	6.3 (-20.1, 32.8)
	<i>P. aeruginosa</i>	0/2 (0.0)	0/0	-
	<i>C. koseri</i>	1/1 (100.0)	0/0	-
	<i>E. cloacae</i>	0/0	1/1 (100.0)	-
	<i>P. mirabilis</i>	0/0	1/1 (100.0)	-
	Ceftazidime-resistant pathogens, n%:			
	<i>E. coli</i>	6/7 (85.7)	8/10 (80.0)	-
<i>E. cloacae</i>	0/0	1/1 (100)	-	
Secondary Endpoint (Favorable microbiological response/eradication in the MITT population)	Ceftazidime-avibactam	Imipenem-cilastatin		Observed difference (95% CI)
	40/46 (87.0%)– End of IV therapy 31/46 (67.4%)– End of TOC visit 23/46 (50.0%)– LFU visit	45/49 (91.8%)—End of IV therapy 31/49 (63.3%)– End of TOC visit 23/49 (46.9%)– LFU visit		-4 (-19.4, 9.6) 4.1 (-17.1, 25.4) 3.1 (-19.1, 25.3)
Safety and Tolerability	<ul style="list-style-type: none">Adverse events observed in 67.6% and 76.1% of patients receiving ceftazidime-avibactam and imipenem-cilastatin, respectivelyThe most common AEs in both treatment arms included constipation, diarrhea, abdominal pain, headache, anxiety, and injection/infusion site reactions			
Conclusion	The efficacy of ceftazidime-avibactam may be non-inferior to that of imipenem-cilastatin in adults with cUTI			

Table 3⁶: NCT00752219 n=204

Study arms	<ul style="list-style-type: none"> IV ceftazidime 2000 mg plus avibactam 500 mg infused over 30 minutes every 8 hours, with the addition of metronidazole 500 mg given over 1 hour every 8 hours, duration: 5 to 14 days IV meropenem 1 g every 8 hours, duration: 5 to 14 days
Primary Endpoint	<ul style="list-style-type: none"> Clinical response at the test-of-cure visit in the microbiologically evaluable (ME) population, a

	subset of the clinically evaluable (CE) population		
Secondary Endpoints	<ul style="list-style-type: none"> Clinical response at the end of IV therapy, at the test of cure (TOC) visit and at the late follow-up (LFU) Micrological response 		
Statistical Analysis	<ul style="list-style-type: none"> 95% Clopper-Pearson CIs 		
Results: Primary Endpoint (Favorable clinical response in the ME population at the TOC visit and end of IV therapy)	Ceftazidime/avibactam + metronidazole (n = 101)	Meropenem (n = 102)	Percentage difference (95% CI)
	62/68 (91.2%)—End of TOC visit 66/68 (97.1%)—End of IV therapy	71/76 (93.4%)—End of TOC visit 74/76 (97.4%)—End of IV therapy	-2.2 (-20.4, 12.2)—End of TOC visit -0.3 (-17.1, 15.4)—End of IV therapy
Results: Secondary Endpoint (Clinical response at the end TOC visit, IV therapy, and LFU visit in CE population)	Ceftazidime/avibactam + metronidazole (n = 101)	Meropenem (n = 102)	Percentage difference (95% CI)
	80/87 (92.0%)—End of TOC visit 84/87 (96.6%)—End of IV therapy 79/86 (91.9%)—LFU visit	85/90 (94.4%)—End of TOC visit 87/89 (97.8%)—End of IV therapy 84/89 (94.4%)—LFU visit	-2.5% (-19.5, 10.1)—End of TOC visit —
Results: Secondary Endpoint (Favorable microbiological response according to pathogen isolates)		ME population	
		Ceftazidime/avibactam plus metronidazole group (n=68)	Meropenem group (n=76)
	Overall	62/68 (91.2)	71/76 (93.4)
	Gram-positive aerobe:		
	<i>Enterococcus faecium</i>	3/4 (75)	4/4 (100)
	<i>Other</i>	13/13 (100)	15/15 (100)
	Gram-negative aerobe:		
	<i>E. coli</i>	47/52 (90.4)	49/53 (92.5)
	<i>Klebsiella pneumoniae</i>	6/6 (100)	11/11 (100)
	<i>Pseudomonas aeruginosa</i>	5/5 (100)	5/5 (100)
	<i>Klebsiella oxytoca</i>	2/2 (100)	2/2 (100)
	<i>Acinetobacter baumannii</i>	1/1 (100)	1/1 (100)
	<i>Enterobacter aerogenes</i>	0/0	0/1 (0.0)
	<i>Enterobacter cloacae</i>	1/1 (100)	4/4 (100)
	<i>Other</i>	2/2 (100)	7/7 (100)
	Anaerobe		
Results: Secondary Endpoint (Favorable microbiological response according to pathogen isolates)		ME population	
		Ceftazidime/avibactam plus metronidazole group (n=68)	Meropenem group (n=76)
	<i>Bacteroides fragilis</i>	3/6 (50.0)	3/3 (100)
	<i>Other</i>	16/16 (100)	11/11 (100)
Conclusion	Ceftazidime/avibactam plus metronidazole had a favorable clinical response rate in the ME population of >90%, and is non-inferior to meropenem		

Table 4.⁷ REPROVE (NCT01808092) n=808

Objective	<ul style="list-style-type: none"> Compare efficacy and safety of ceftazidime-avibactam and meropenem for nosocomial pneumonia 	
Study Design	<ul style="list-style-type: none"> Prospective, multinational, double-blind, non-inferiority 	
Inclusion Criteria	<ul style="list-style-type: none"> Between the ages of 18 and 90 years In the hospital with nosocomial pneumonia <ul style="list-style-type: none"> Onset 48 hours or longer or less than 7 days after discharge 	
Exclusion Criteria	<ul style="list-style-type: none"> Infection due to Gram-positive therapy or a pathogen non expected to be susceptible Infections requiring more than 14 days of therapy 	
Study arms	<ul style="list-style-type: none"> IV ceftazidime 2000 mg plus avibactam 500 mg every 8 hours over 2 hours, duration: 7 to 14 days IV meropenem 1000 mg every 8 hours, duration: 7 to 14 days 	
Primary Endpoint	<ul style="list-style-type: none"> Clinical cure at test of cure visit (resolution of all symptoms of pneumonia such that no antibacterial therapy was needed between the end of therapy and test of cure visit) 	
Secondary Endpoints	<ul style="list-style-type: none"> Clinical response at end of treatment and test of cure All-cause mortality at test of cure and at 28 days Adverse events 	
Statistical Analysis	<ul style="list-style-type: none"> 85% power against a 12.5% non-inferiority margin One-sided alpha of 2.5% calculated with Newcombe-Wilson score method 	
Results: Primary Endpoint (Clinical Cure at Test of Cure Visit Modified Intention to Treat Population)	Ceftazidime-avibactam (n = 409)	Meropenem (n = 408)
	68.8%	73%
(Clinical Cure at Test of Cure Visit Clinically Evaluable Population)	77.4%	78.1%
Results: Secondary Endpoint (All-Cause Mortality) (Adverse Events)	Ceftazidime-avibactam	Meropenem
	9%	7%
	75%	74%

Additional Data Not Reviewed by FDA:

A preliminary analysis of a randomized, blinded phase 3, non-inferiority trial (RECLAIM; Table 5) assessed the non-inferiority of CAZ-AVI (2 g/0.5 g, every 8 hours) plus metronidazole (0.5 g every 8 hours) versus meropenem (1 g every 8 hours) in the treatment of complicated Intra-abdominal Infections c-IAI (N=1,066). The primary endpoint is the clinical cure at TOC; 28-35 days post randomization. Patients with CrCl ≤30 mL/min were excluded. In addition, among subjects with moderate renal impairment, there was also a numerical imbalance of deaths between the treatment groups (8 deaths in the CAZ-AVI subgroup compared to 3 deaths in the meropenem subgroup).⁸

Table 5. Clinical Cure at TOC by Baseline Renal Function Category—Modified Intention to Treat (MITT) Population, RECLAIM Trial

c-IAI	Number of patients with clinical cure/Total number of patients (%)	
Baseline renal function subgroup	CAZ-AVI + MTZ	Meropenem
Normal function / mild impairment (CrCl > 50 mL/min)	322/379 (85%)	321/373 (86%)
Moderate impairment at baseline (CrCl > 30 to ≤ 50 mL/min)	14/31 (45%)	26/35 (74%)
Conclusion	<ul style="list-style-type: none"> Patients with CrCl >30 to ≤50 mL/min had lower clinical cure vs. meropenem. Those with normal renal function, the rates were similar 	

Clinical cure rates from Trial 2002, a phase 2 cIAI trial, by baseline renal function category are shown in Table 6. The clinical cure rates in the mMITT population with mild renal impairment are also lower than those for subjects with normal renal function (77.3% CAZ-AVI, 85.7% meropenem).

Table 6. Clinical Cure Rate at TOC, by Baseline Renal Function Category—mMITT Population, Trial 2002

c-IAI	Number of patients with clinical cure/Total number of patients (%)	
Baseline renal function subgroup	CAZ-AVI + MTZ	Meropenem
Normal function (CrCl > 80 mL/min)	50/60 (83.3)	57/64 (89.1)
Mild impairment at baseline (CrCl > 50 to ≤ 80 mL/min)	17/22 (77.3)	18/21 (85.7)
Moderate impairment at baseline (CrCl > 30 to ≤ 50 mL/min)	0/0	4/4 (100.0)
Normal function (CrCl > 80 mL/min)	50/60 (83.3)	57/64 (89.1)
Conclusion	<ul style="list-style-type: none"> Patients with CrCl >50 to ≤80 mL/min had lower clinical cure vs. meropenem. Those with normal renal function, the rates were similar. 	

Drug Interactions:¹

- Avycaz™ package insert suggests no significant drug-drug interactions; co-administration with probenecid is not recommended.

Adverse Events:⁸

- Adverse reactions reported in post-marketing experience with ceftazidime include anaphylaxis, angioedema, urticaria, hyperbilirubinemia, and jaundice.
- Cephalosporin-class adverse reactions include colitis, toxic nephropathy, hepatic dysfunction (including cholestasis), aplastic anemia, hemorrhage. Toxic epidermal necrolysis, Stevens-Johnson syndrome, and erythema multiforme have also been reported with cephalosporins, including ceftazidime.
- Abnormal laboratory tests include prolonged prothrombin time, false-positive test for urinary glucose, and pancytopenia. Nephrotoxicity has been reported following concomitant administration of cephalosporins with aminoglycosides or potent diuretics such as furosemide.
- Myoclonus and status epilepticus have been described, particularly in patients with renal failure. A specific subtype non-convulsive status epilepticus (NCSE) was reported in 18 of the 20 patients described in 14 publications. NCSE refers to a prolonged seizure diagnosed by electroencephalogram (EEG) that manifests primarily as altered consciousness or encephalopathy, as opposed to the dramatic convulsions seen in generalized tonic-clonic status epilepticus, and may occur even in the presence of dosing adjustments recommended for renally compromised patients.
- In the cumulative CAZ-AVI clinical program, 61 deaths have been reported, including seven in the Phase 2 studies (4 CAZ-AVI, 3 comparator) and 54 in the ongoing Phase 3 studies (3 comparator, 3 CAZ-AVI and 48 remain treatment blinded).

Summary:

- Ceftazidime/avibactam is currently approved for complicated UTIs, complicated intra-abdominal infections (in combination with metronidazole), and nosocomial pneumonia.
- The antibiotic showed similar efficacy when compared to standard therapy.
- Anaerobic coverage is inadequate, so ceftazidime/avibactam must be paired with metronidazole for certain indications.
- Ceftazidime/avibactam is not useful for Gram-positive infections.
- Further and larger studies will be needed to compare efficacy.
- Clinical cure rate was lower and mortality was higher in patients with baseline moderate/severe renal function.

Critical Considerations/Questions:

- What is the benefit of using ceftazidime/avibactam over an equally efficacious antibiotic?
- Is cefepime a better option for the same indications?
- How effective is ceftazidime/avibactam against multi-drug resistant *P. aeruginosa*?
- Will the avibactam component encourage high level resistance in microbes?
- How does this drug compare to piperacillin/tazobactam?
- Is this drug effective with renal dysfunction?

Future Directions and/or Indications:

The manufacturer is currently evaluating the use of ceftazidime/avibactam in:

- The FDA granted ceftazidime-avibactam Qualified Infectious Disease Product (QIDP) status for its indications of complicated intra-abdominal infections and complicated urinary tract infections in February 2015, based on phase 2 studies.
- Phase 3 studies are ongoing in cUTI and cIAI.

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Developed: 3/15

Revised: 3/18

Infliximab-dyyb (Inflectra)

Requestor: Michael Montoya, Pharm.D., BCPS

Drug Class: ¹ Tumor necrosis factor-alpha (TNF-alpha)

FDA Approval: ² Food and Drug Administration (FDA) approved April 5, 2016.

Indication: ³ Crohn's disease, pediatric Crohn's disease, ulcerative colitis, rheumatoid arthritis in combination with methotrexate (MTX), ankylosing spondylitis, psoriatic arthritis, and plaque psoriasis

Manufacturer: ³ Celltrion for Hospira/Pfizer

Dosage Form: 20mL vial containing 100mg of lyophilized infliximab-dyyb for intravenous infusion

Cost:

- Inflectra - \$528.85/100mg vial
- Remicade – \$1100.36/100mg vial

Recommendation: As Inflectra has been granted all FDA approved indications of reference Remicade except for pediatric ulcerative colitis, recommend adding to TCMC formulary. Recommend allowing automatic substitution for Remicade if ordered depending on reimbursement from individual payers. Restrict "switching" product only once as studies⁹ only evaluated single switch modalities.

Background:^{2,4} Infliximab-dyyb (Inflectra[®]) is the second biosimilar product approved by the FDA in the United States. Many patents for current biological agents are reaching expiration; therefore an increase in market availability of biosimilar products is projected. A biosimilar product is a biological product that undergoes an abbreviated pathway for approval but must show high similarity to an already-approved biological product or reference product (such as Remicade[®]). The biosimilar product must also show no clinically meaningful difference and contain only minor differences in inactive components to the reference product. The dyyb suffix signifies that the medication is a biosimilar. All biosimilars are to be named with the biologic core name followed by a suffix. The core name is the same name as the drug substance contained in the relevant previously licensed product. The suffix is determined by the United States Adopted Names Guiding Principles council. It will always contain four letters added by a hyphen to the core name. The FDA found infliximab-dyyb to be similar to infliximab by structural and functional characterization, animal study data, human pharmacokinetic and pharmacodynamics data, clinical immunogenicity data, and other safety and efficacy data by review of evidence.

In order for a biosimilar to be approved, three types of research must be performed: analytical, non-clinical, and clinical. Table 1 describes how infliximab-dyyb meets those requirements.

Table 1: Biosimilar Requirements^{5,6,7}

Biosimilar Requirement	Study Performed	Infliximab-dyyb Requirement Fulfillment
<i>Analytical</i>	Batched chemical analysis to determine various attributes of primary structure	High structural and functional similarity with no clinically meaningful differences
<i>Non-clinical</i>	Animal testing	Similar pharmacologic and toxicological profiles
<i>Clinical</i> <i>(confirming similarity)</i>	Single arm and comparative safety and efficacy studies	Relevant clinical data was collected in 213 healthy volunteers, 250 patients diagnosed with ankylosing spondylitis, and 606 patients diagnosed with rheumatoid arthritis

Pharmacology/Pharmacokinetics:^{1,2}

Infliximab elicits an effect by counteracting the natural activity of cytokine TNF-alpha. Infliximab does this by binding with high affinity to soluble and transmembrane forms of TNF-alpha and inhibition of TNF-alpha binding to its receptors. TNF-alpha is linked to the following biological activities: induction of proinflammatory cytokines, enhancement of leukocyte migration by increasing endothelial layer permeability and expression of adhesion molecules by endothelial cells and leukocytes, activation of neutrophil and eosinophil functional activity, induction of acute phase reactants and other liver proteins, and tissue degradation enzymes. Infliximab is specific for TNF-alpha and does not affect TNF-beta, a related cytokine that utilizes the same receptors.

Limited pharmacokinetic parameters are available for infliximab-dyyb. This is consistent with infliximab (Remicade[®]) as minimal pharmacokinetic parameters were performed for the original version. Available parameters are listed in Table 2.

Table 2. Pharmacokinetic Parameters^{2,3}

Distribution	Independent of dose, distributed primarily within the vascular compartment
Bioavailability	No information available
Half-life	7.7 to 9.5 days
Excretion	In patients diagnosed with Crohn's disease the estimated clearance was inversely related to baseline serum albumin concentrations, directly related to infliximab antibody formation, and directly related to total body weight (kg)

Table 3 details the indications for which infliximab-dyyb is approved and the appropriate dosing.

Table 3. Dosing by Indication:³

Diagnosis	Dosing*
Crohn's Disease	5 mg/kg at weeks 0, 2, and 6 then every 8 weeks
Pediatric Crohn's Disease	5mg/kg at weeks 0, 2, and 6 weeks then every 8 weeks
Ulcerative colitis	5 mg/kg at weeks 0, 2, and 6 then every 8 weeks
Rheumatoid arthritis	In conjunction with MTX, 3 mg/kg at weeks 0, 2, and 6 then every 8 weeks. Dose can be increased up to 10 mg/kg or increase frequency to every 4 weeks
Ankylosing spondylitis [†]	5 mg/kg at weeks 0, 2, and 6 then every 6 weeks
Psoriatic and plaque psoriasis [†]	5 mg/kg at weeks 0, 2, and 6 weeks then every 8 weeks

** Dosing recommendations are the same as infliximab (Remicade®)⁵*

[†] Indications not FDA-approved for pediatric patients

Clinical Safety and Efficacy:

Table 4 summarizes the studies that were used and presented to the FDA advisory committee for the approval of infliximab-dyyb.

Table 4. Studies Presented to FDA Advisory Committee

Citation	Study Design	Methods	End Points	Results	Conclusions
Park W, Lee SL, Yun J, Yoo HD; 2015.	<p>Randomized, double-blind, three-arm, parallel-group, single-dose, phase 1 study</p> <p>The objective was to compare the pharmacokinetic (PK) profiles of three infliximab formulations: CT-P13, Remicade from U.S. (US-RMP) and Europe (EU-RMP).</p> <p>213 participants were randomized (n=71 per treatment group)</p>	<p>Inclusion criteria: healthy male and female volunteers aged 18 to 55 with a body mass index (BMI) of 18-29.9 kg/m²</p> <p>Exclusion criteria: recent surgical intervention, previous exposure to mAb or current use, evidence of drug abuse or excessive alcohol consumption, moderate/heavy smoking, recent live vaccination within 30 days prior to randomization, recent use of over the counter (OTC) medications, and active or latent tuberculosis (TB) or a history of TB</p> <p>All participants received a single dose (5 mg/kg) of CT-P13, US-RMP, or EU-RMP</p>	<p>Primary: evaluate and compare the PK profiles of the three infliximab formulations. PK measurements used were C_{max}, area under the curve (AUC) from time zero to last quantifiable concentration (AUC_{last}) and from time zero to infinity (AUC_{inf})</p> <p>Secondary PK endpoints included volume of distribution during terminal phase, terminal half-life, total body clearance, and mean residence time</p> <p>Secondary: assessment of the safety and tolerability of the three infliximab formulations</p>	<p>90% CI were contained within the predefined equivalence limits of 80-125% for all treatment groups.</p> <p>Ratios of geometric means:</p> <ul style="list-style-type: none"> CT-P13 versus EU-RMP: 105.03% (90% CI 100.64-109.62%), 101.81% (90% CI 96.36-107.56%) and 100.76% (90% CI 94.37-107.59%) for C_{max}, AUC_{last}, AUC_{inf}, respectively CT-P13 versus US-RMP: 106.23% (90% CI 101.86-110.99%), 98.44% (90% CI 93.16-104.03%), and 96.48% (90% CI 90.36-103.02%) for C_{max}, AUC_{last}, AUC_{inf}, respectively EU-RMP versus US-RMP: 101.23% (90% CI 96.99-105.65%), 96.70% (90% CI 	<p>All geometric means for all comparisons fell within the predefined margins meeting the criteria for PK equivalence.</p> <p>Equivalence between products were within normal limits and clinically appropriate.</p> <p>Continued analysis after 54 weeks confirmed the PK profiles of CT-P13 and EU-RMP continued to be highly similar.</p>

Citation	Study Design	Methods	End Points	Results	Conclusions
				<p>91.52-102.16%), and 95.75% (90% CI 89.72-102.19%) for C_{max}, AUC_{last}, AUC_{inf}, respectively</p> <p>All secondary endpoints were similar between treatment groups</p> <p>Adverse events due to treatments were experienced by 28 (39.4%) CT-P13, 17 (23.9%) EU-RMP, and 30 (42.3%) US-RMP</p>	
Park W, Yoo DH, Jaworski J, Brzezicki J, Gnylorybov A, Kadinov V, et al; 2016.	<p>Randomized, double-blind, parallel group study</p> <p>The objective of this study was to compare the 54-week efficacy, immunogenicity, PK and safety of CT-P13 with RMP in patients with ankylosing spondylitis (AS), with a focus on patient-reported outcomes</p> <p>250 patients were randomly assigned to each treatment group (n=125 for CT-P13 and</p>	<p>Inclusion: AS patients aged 18-75 meeting the 1984 modified New York classification criteria for ≥ 3 months prior to screening, with Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score of ≥ 4</p> <p>Patients could receive both oral glucocorticoids and non-steroidal anti-inflammatory drugs (NSAIDs) if at stable dose ≥ 4 weeks prior to screening</p> <p>Exclusion criteria: Not mentioned</p> <p>Patients were randomized to receive CT-P13 or RMP at a dose of 5 mg/kg via 2 hour</p>	<p>Efficacy endpoints: patient-reported outcomes which included BASDAI, the BASFI, and the Short Form Health Survey; the proportion of patients achieving clinical response according to ASAS20 and ASAS40 criteria; the proportion of patients with ASAS partial remission; changes from baseline in ASDAS-C-reactive protein (CRP), BASMI and chest expansion</p> <p>Primary PK endpoints: area under the curve over the dosing interval at steady state between week 22 and</p>	<p>Efficacy was similar between all treatment groups for all efficacy endpoints. The proportion of patients achieving clinical response according to ASAS20 and ASAS40 at weeks 14, 30, and 54 were similar between CT-P13 and RMP groups. ADA-negative patients achieving ASA20 at week 54 was 72.3% for CT-P13 and 73.1% for RMP. ADAS-CRP score at baseline and the mean change from baseline were similar in both CT-P13 and RMP groups at week 54 (-1.7 ± 1.3 and -1.7 ± 1.3). Baseline BASDAI and BASFI scores both decreased</p>	<p>Similar efficacy was observed between CT-P13 and RMP up to week 54.</p> <p>All patient-reported outcomes were comparable across both groups.</p> <p>Long term PK (C_{max} and C_{min}) were similar throughout the 54 week study.</p>

Citation	Study Design	Methods	End Points	Results	Conclusions
	RMP)	intravenous infusion at week 0, 2, and 6 then every 8 weeks up to week 54	<p>week 30 (AUC_T) and the observed maximum serum concentration at study state between week 22 and week 30 ($C_{max,ss}$)</p> <p>Secondary PK endpoints: C_{max} and minimum concentration (C_{min}) immediately before the next infusion up to week 54</p> <p>ADEs: assessed from enrollment and up to 8 weeks after last study treatment</p> <p>Endpoints were assessed at baseline and weeks 14, 30, and 54</p>	<p>from baseline to a similar extent up to week 54</p> <p>SF-36 quality of life questionnaire score were similar between both groups.</p> <p>Mean \pm SD BASMI scores and chest expansion (cm) at baseline were 4.0 ± 2.1 versus 4.1 ± 2.1, and 3.2 ± 1.3 versus 2.9 ± 1.3 for CT-P13 and RMP, respectively.</p> <p>C_{max} and C_{min} were similar between both groups up to week 54.</p>	
Yoo DH, Racewicz A, Brzezicki J, Yatsyshyn R, Arteaga ET, Baranauskaite A, et al; 2016.	<p>Randomized, double-blind, multicenter, parallel-group, prospective phase III study</p> <p>The objective of this study compared CT-P13 to RMP in patients with rheumatoid arthritis (RA) up to 54 weeks including efficacy, radiographic progression, immunogenicity, safety,</p>	<p>Inclusion: Patients 18-75 years old diagnosed with RA according to the revised 1987 ACR classification criteria ≥ 1 year before screening.</p> <p>Exclusion criteria: Not mentioned</p>	<p>Primary: ACR20 response rate at week 30</p> <p>Efficacy parameters: ACR20, ACR50, ACR70, disease activity score in 28 joints (DAS28), simplified disease activity index (SDAI), clinical disease activity index (CDAI), and European league against rheumatism (EULAR) response rate</p>	<p>Efficacy outcomes were similar between both treatment groups. ACR20 was equivalent between the two groups at week 30. At week 54 CT-P13 versus RMP for ACR20, ACR50, and ACR70 were 74.7% (168 of 225) versus 71.3% (154 of 216), 43.6% (98 of 225) versus 43.1% (93 of 216), and 21.3% (48 of 225) versus 19.9% (43 of 216), respectively.</p>	<p>The ARC20 score at week 30 was comparable between both groups.</p> <p>Efficacy of CT-P13 and RMP were similar for multiple measures of disease activity and patient reported outcomes.</p>

Citation	Study Design	Methods	End Points	Results	Conclusions
	<p>PK, and PD.</p> <p>606 patients were randomly assigned to a treatment group (n=302 for CT-P13 and 304 for RMP)</p>		<p>Patient report outcomes: Visual analogue scale (VAS), VAS patient global assessment of disease activity, the Health Assessment Questionnaire estimate of physical ability, the Medical Outcomes Study Short Form Health Survey (SF-36), and joint damage progression</p> <p>PK: mean maximum serum drug concentration, mean minimum serum drug concentration</p> <p>ADEs: assessed at each planned visit</p>	<p>Mean decrease in VAS score from baseline were similar between both groups (65.1 versus 65.3). The mean SF-36 score increased from baseline to week 54 for both groups.</p> <p>ADEs occurred in 213 patients (70.5%) receiving CT-P13 and 211 patients (70.3%) in RMP group</p>	

CT-P13=Inflectra (infliximab-dyyb), RMP=Remicade (infliximab), EU-RMP=European infliximab, Cmax=maximum concentration, AUC=area under the curve, PK=pharmacokinetics, PD=pharmacodynamics, mAb=monoclonal antibody, ADE=adverse drug event, AS=ankylosing spondylitis, RA=rheumatoid arthritis, BASDAI=Bath Ankylosing Spondylitis Disease Activity Index, ASAS=Assessment of Ankylosing Spondylitis, ASDAS= Ankylosing Spondylitis Disease Activity Score, BASFI=Bath Ankylosing Spondylitis Functional Index, BASMI=Bath Ankylosing Spondylitis Metrology Index, CRP=C-reactive protein, ARC=American College of Rheumatology, DAS28=disease activity score, SDAI=simplified disease activity index, CDAI=clinical disease activity index, EULAR=European league against rheumatism, VAS=visual analogue scale, SF-36=Short Form Health Survey

Contraindications:^{3,8}

The contraindications listed below are the same for both infliximab-dyyb and infliximab.

- Dosages greater than 5 mg/kg in moderate to severe heart failure
- Previous hypersensitivity to infliximab-dyyb and/or infliximab, inactive components or murine products

Warnings and Precautions:^{3,8}

Infliximab-dyyb and infliximab share the same warning and precautions listed below:

- Serious infections
- Invasive fungal infections
- Malignancies
- Hepatitis B virus reactivation
- Hepatotoxicity
- Heart failure
- Cytopenias
- Hypersensitivity to infusion
- Demyelinating disease exacerbation or new onset
- Lupus-like Syndrome
- Avoid live vaccines or therapeutic infectious agents

Adverse Reactions:^{3,8}

Infliximab-dyyb and infliximab share the same common adverse reactions. Most common adverse reactions (> 10%) include:

- Infections of the upper respiratory tract, sinusitis, and pharyngitis
- Infusion-related reactions
- Headache
- Abdominal pain

Drug Interactions:^{3,8}

Infliximab-dyyb and infliximab interact or have the possibility to interact with the following:

- TNF-alpha blocking agents (i.e. anakinra or abatacept)
- Tocilizumab
- Other biological agents
- Data is lacking with concomitant medications used for the disease states infliximab-dyyb is indicated for.

Possible drug interactions include:

- 6-mercaptopurine
- Aminosalicylates
- Antibiotics
- Antivirals
- Corticosteroids
- Folic acid
- Methotrexate
- Narcotics
- Nonsteroidal anti-inflammatory agents

- Immunosuppressants
- Medications metabolized by CYP450 enzymes (may cause induction)
- Live vaccines

Monitoring:^{3,8}

Prior to therapy initiation and periodically throughout therapy, patients should be evaluated for active or latent tuberculosis with both infliximab-dyyb and infliximab.

Continued monitoring for signs and symptoms of infection during and after treatment is recommended with infliximab-dyyb.

Special Population Considerations:

Similarly to infliximab, infliximab-dyyb has extra considerations for special populations. Table 5 lists the populations and the corresponding recommendation.

Table 5. Infliximab-dyyb Use in Special Populations³

Population	Recommendation
Pregnancy	<ul style="list-style-type: none"> • Pregnancy category B • No clinical studies performed on pregnant women, animal studies do not apply to humans • Administer to a pregnant woman only if clearly needed
Nursing	<ul style="list-style-type: none"> • Excretion in milk and systemic absorption after ingestion is unknown • Women should not breast-feed infants while receiving therapy
Pediatrics	<ul style="list-style-type: none"> • Safety and efficacy has been established and is approved for use for Crohn's disease in pediatric patients aged 6 to 17 years who have had an inadequate response to conventional therapy • Infliximab-dyyb was only studied in combination with conventional immunosuppressive therapy for less than one year duration
Geriatrics	<ul style="list-style-type: none"> • No overall differences were observed in effectiveness or safety with rheumatoid arthritis and plaque psoriasis in elderly patients; however, the incidence of adverse reactions were higher • There was an insufficient number of elderly patients to determine difference in response for Crohn's disease, ulcerative colitis, ankylosing spondylitis, and psoriatic arthritis • Incidence of serious infection was greater in those aged 65 or older but this may be attributed to the fact there is general a greater incidence of infections in the geriatric population
Renal impairment	<ul style="list-style-type: none"> • No dose adjustments provided by manufacturer
Hepatic impairment	<ul style="list-style-type: none"> • No dose adjustments provided by manufacturer

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**Community Healthcare &
Alliance Committee
(No meeting held in February, 2019)**

Tri-City Medical Center
Finance, Operations and Learning Committee Minutes
February 21, 2019

Members Present	Director Julie Nygaard, Director Leigh Anne Grass, Dr. Mark Yamanaka, Dr. Jeffrey Ferber, Mr. Jack Cumming, Dr. Gene Ma (<i>joined the meeting at 8:32 a.m.</i>)
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, CFO, Scott Livingstone, COO, Carlos Cruz, CCO, Susan Bond, General Counsel
Others:	Joni Penix, Thomas Moore, Jane Dunmeyer, Maria Carapia, Mark Albright, Jeremy Raimo, Barbara Hainsworth
Members Absent:	Director Rocky Chavez

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Nygaard called the meeting to order at 8:30 a.m.		Chair
2. Approval of Agenda		<u>MOTION</u> It was moved by Dr. Ferber, Mr. Cumming seconded, and it was unanimously approved to accept the agenda of February 21, 2019. <u>Members:</u> AYES: Nygaard, Grass, Contardo, Yamanaka, Ferber, Cumming NOES: None ABSTAIN: None ABSENT: Chavez, 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 January 24, 2019		Minutes were ratified. <u>MOTION</u> It was moved by Director Grass, Mr. Cumming seconded, and the minutes of January 24, 2019 were unanimously approved.	

Topic	Discussions, Conclusions/Recommendations	Action Recommendations/Conclusions	Person(s) Responsible
5. Old Business	None		
6. New Business			
7. Consideration of Consent Calendar:	<p>It was requested that the following items be pulled for discussion:</p> <p><u>Dr. Yamanaka:</u> 7.a. Collections & Report Management Tool Proposal</p> <ul style="list-style-type: none"> nThrive Revenue Systems, LLC <i>(Formerly MedAssets)</i> 	<p><u>MOTION</u> It was moved by Director Grass, Dr. Ma seconded, and it was unanimously approved to accept the agenda of February 21, 2019.</p> <p><u>Members:</u> AYES: Nygaard, Grass, Contardo, Ma, Yamanaka, Ferber, Cumming NOES: None ABSTAIN: None ABSENT: Chavez</p>	Chair
a. Collections & Report Management Tool Proposal <ul style="list-style-type: none"> nThrive Revenue Systems, LLC <i>(Formerly MedAssets)</i> 	<p>Joni Penix stated that this system is a replacement for the QMS product which has been used by TCMC for the past 13 years. MedAssets, now rebranded as nThrive, will be sun-setting the QMS system as of August 2019. She further explained that the existing program is used daily by the Patient Financial Services staff for collection worklists, payment sheets, refunds and denials. Ray Rivas interjected that this product is also utilized for reports including delinquent data, month-end reconciliations, month-end reports for Finance and queries on accounts receivables. Joni further conveyed that the use of this updated product will provide consistency, no disruption in cash collections, productivity, reports and continue to minimize bad debt. Significant discussion ensued.</p>	<p><u>MOTION</u> It was moved by Director Grass, seconded by Dr. Ma to authorize the agreement with nThrive for a term of 36 months, beginning March 1, 2019 and ending February 28, 2022 for an annual cost of \$120,000 and a total cost for the term of \$360,000.</p> <p><u>Members:</u> AYES: Nygaard, Grass, Contardo, Ma, Yamanaka, Ferber, Cumming NOES: None ABSTAIN: None ABSENT: Chavez</p>	Joni Penix

Topic	Discussions, Conclusions/Recommendations	Action Recommendations/Conclusions	Person(s) Responsible																																				
b. Physician Agreement for ED On-Call Coverage – General Surgery <ul style="list-style-type: none">Hussna Wakily, M.D.		Approved via Consent Calendar	Sherry Miller																																				
c. Physician Recruitment Proposal – Orthopedic Surgeon <ul style="list-style-type: none">Morgan Silldorff, M.D.		Approved via Consent Calendar	Jeremy Raimo																																				
8. Financials:	<p>Ray Rivas presented the financials ending January 31, 2018 (dollars in thousands)</p> <p><u>TCHD – Financial Summary</u></p> <p><u>Fiscal Year to Date</u></p> <table><tr><td>Operating Revenue</td><td>\$ 206,514</td></tr><tr><td>Operating Expense</td><td>\$ 210,867</td></tr><tr><td>EBITDA</td><td>\$ 8,930</td></tr><tr><td>EROE</td><td>\$ (175)</td></tr></table> <p><u>TCMC – Key Indicators</u></p> <p><u>Fiscal Year to Date</u></p> <table><tr><td>Avg. Daily Census</td><td>153</td></tr><tr><td>Adjusted Patient Days</td><td>58,924</td></tr><tr><td>Surgery Cases</td><td>3,806</td></tr><tr><td>Ortho Clinic Visits</td><td>48,802</td></tr><tr><td>ED Visits</td><td>32,991</td></tr></table> <p><u>TCHD – Financial Summary</u></p> <p><u>Current Month</u></p> <table><tr><td>Operating Revenue</td><td>\$ 28,899</td></tr><tr><td>Operating Expense</td><td>\$ 31,201</td></tr><tr><td>EBITDA</td><td>\$ 826</td></tr><tr><td>EROE</td><td>\$ (527)</td></tr></table> <p><u>TCMC – Key Indicators</u></p> <p><u>Current Month</u></p> <table><tr><td>Avg. Daily Census</td><td>165</td></tr><tr><td>Adjusted Patient Days</td><td>8,813</td></tr><tr><td>Surgery Cases</td><td>524</td></tr><tr><td>Ortho Clinic Visits</td><td>7,036</td></tr><tr><td>ED Visits</td><td>4,812</td></tr></table>	Operating Revenue	\$ 206,514	Operating Expense	\$ 210,867	EBITDA	\$ 8,930	EROE	\$ (175)	Avg. Daily Census	153	Adjusted Patient Days	58,924	Surgery Cases	3,806	Ortho Clinic Visits	48,802	ED Visits	32,991	Operating Revenue	\$ 28,899	Operating Expense	\$ 31,201	EBITDA	\$ 826	EROE	\$ (527)	Avg. Daily Census	165	Adjusted Patient Days	8,813	Surgery Cases	524	Ortho Clinic Visits	7,036	ED Visits	4,812		Ray Rivas
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Topic	Discussions, Conclusions/Recommendations	Action Recommendations/Conclusions	Person(s) Responsible
	<p><u>TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year</u></p> <p>Net Patient A/R Avg. (in millions) \$ 43.9</p> <p>Days in Net A/R Avg. 52.4</p> <p><u>Graphs:</u></p> <ul style="list-style-type: none"> • 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. Dashboard	No discussion.		Ray Rivas
10. Comments by committee members			
11. Date of next meeting	Tuesday, March 21, 2019		Chair
12. Community Openings (1)			
13. Adjournment	Meeting adjourned 9:52 a.m.		



FINANCE, OPERATIONS & PLANNING COMMITTEE

DATE OF MEETING: February 21, 2019

Collection & Report Management Tool Proposal

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

Vendor's Name: nThrive Revenue Systems, LLC (formally MedAssets)

Area of Service: Patient Accounting

Term of Agreement: 36 months, Beginning, March 1, 2019 – Ending, February 28, 2022

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
\$10,000	\$120,000	\$360,000

Description of Services/Supplies:

- Med Assets has rebranded as nThrive, and with that branding they are sunsetting the QMS Product we have used for the past 13 years
- Used daily by the entire staff for collection worklists, payment sheets, refunds, denials
- Utilized for reports to include delinquent data, month-end reconciliation, monthend reports for finance, and queries on active accounts receivable
- Entire Aged Trial Balance resides in the tool and is updated daily via interface automation
- Benefits – Consistency, no disruption in cash collections, productivity, reporting and continue to minimize bad debt.

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: Joni Penix, Director, Patient Accounting / Ray Rivas, Chief Financial Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with nThrive for a term of 36 months, beginning March 1, 2019 and ending February 28, 2022 for an annual cost of \$120,000 and a total cost for the term of \$360,000.

**FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: February 21, 2019
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – General Surgery**

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

Physician's Name: Hussna Wakily, M.D.

Area of Service: Emergency Department On-Call: General Surgery

Term of Agreement: 17 months, Beginning, February 1, 2019 – Ending, June 30, 2020

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Adding physician to existing panel; no increase in expense

Rate/Day	Panel Days per Year	Panel Annual Cost
Mon-Sunday \$1,400	FY19: 365 days	\$511,000
Total Term Cost:		\$511,000

Unfunded Cholecystectomy Cost	Estimated Cases per Year	Estimated Annual Cost
\$725, per case	FY19: 36	\$26,100
Unfunded Laparoscopic Cholecystectomy with Common Bile Duct Exploration	Estimated Cases per Year	Estimated Annual Cost
Procedure Code 47564: \$1,144.51, per case	FY19: 5	\$5,722.55
Procedure Code 47550: \$168.05, per case	FY19: 5	\$840.25
Total Term Cost:		\$32,662.80

Position Responsibilities:

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

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

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 approve the agreement to add Dr. Hussna Wakily to the currently existing Panel Agreement for ED On-Call Coverage-General Surgery for a term of 17 months, beginning February 1, 2019 – Ending, June 30, 2020.

**Professional Affairs Committee
(No meeting held in
February, 2019)**

Tri-City Medical Center
 Audit, Compliance & Ethics Committee
 February 19, 2019
 Assembly Room 1
 8:30 a.m.-10:00 a. m.

Members Present:	Director Larry W. Schallock(Chair); Director George Coulter; Director Tracy Younger; Faith Devine, Community Member; L; Kathryn Fitzwilliam, Community Member (Subject Matter Expert); Dr. Cary Mells, Physician Member
Non-Voting Members:	Steve Dietlin (CEO); Ray Rivas, CFO; Scott Livingstone, COO; Carlos Cruz, CCO; Susan Bond, General Counsel
Others Present:,	Maria Carapia, Compliance Manager; Teri Donnellan, Executive Assistant
Absent:	Steve Dietlin (CEO); Leslie Schwartz, Community Member

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order/Welcome Introduction of New Board Members	The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairman Schallock. Chairman Schallock introduced new Board members, Director George Coulter and Director Tracy Younger.		
2. Approval of Agenda	It was moved by Mrs. Faith Devine and seconded by Dr. Cary Mells to approve the agenda as presented. The motion passed unanimously.	Agenda approved.	
3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item	There were no public comments.		
4. Ratification of minutes -- October 18, 2018	It was moved by Mrs. Faith Devine and seconded by Chairman Schallock to approve the minutes of October 18, 2018 as presented. The motion passed with Directors Coulter and Younger abstaining from the vote.	Minutes ratified.	
5. Old Business	None		
6. New Business			

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
a) Update on FY2019 Financial Statement Audit	Mr. Ray Rivas, CFO stated that over the years the committee has had discussion regarding changing auditors from time to time. The options were to engage a new firm or remain with the same firm but do a switch in audit partners which is more cost effective while still getting a "fresh set of eyes" on the books. Moss Adams has also acknowledged it is a good practice to rotate auditors every few years which has been our practice. Mr. Rivas stated he has requested a proposal from Moss Adams to perform the FY 2019 Financial Statement Audit and will bring that forward to the committee for their consideration. Mr. Rivas anticipates the price will be in line with previous year's audits.	Information Only; Moss Adams proposal to be brought forward to next meeting.	Mr. Ray Rivas
b) Administrative Policies & Procedures: 1) Compliance Officer – 535	<p>Mr. Carlos Cruz reported the policies brought forward today do not involve any significant changes and are mainly "housekeeping" changes that are being made as part of the three year review process.</p> <p>With regard to Policy 535 – Compliance Officer, Mr. Cruz noted previously the Board was responsible for the hiring of the Chief Compliance Officer however the Board has delegated that duty to the Chief Executive Officer. Director Younger questioned why the change was made. Chairman Schallock explained the Board determined there should be more day-to-day oversight of the Compliance Officer and believed it was more appropriate for the Chief Compliance Officer to be hired by and report to the CEO. Ms. Fitzwilliam stated the current reporting relationship for the CCO is consistent with best practice.</p> <p>Chairman Schallock requested clarification on Section E. Authority of Compliance Officer: Review of Findings, related to the CCO's "authority to engage qualified outside legal counsel and consultants to assist him achieve the objectives of the Compliance Program". Mr. Cruz stated typically if there is an issue that requires legal counsel he would work with our General Counsel Ms. Bond. However if the situation required outside legal counsel the policy provides the CCO with authority to engage outside counsel.</p>		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
2) Compliance Program Overview – 532	Mr. Cruz stated the Compliance Program Overview Policy 532 follows OIG requirements. Dr. Mells questioned if the Medical Staff is included as a "Workforce Member". Mr. Cruz stated the Medical Staff is considered a Workforce Member. After further discussion it was suggested that the definition be further defined to include Medical Staff and Allied Health Professionals as it is a definition that is used in several subsequent policies. Ms. Guerra stated she would revise the definition in subsequent policies to reflect this change.		
3) Disclosure of Protected Health Information – 513	Mr. Cruz stated minor "housekeeping" changes are reflected in Policy 513 – Disclosure of Protected Health Information. The committee had no comments or questions.		
4) HIPAA Mitigation - 591	Mr. Cruz explained that his responsibilities now include that of the Privacy Officer however his title remains Chief Compliance Officer. He suggested that Privacy Officer be removed throughout the HIPAA Mitigation Policy since his title does not include that of the Privacy Officer. There was discussion as to whether removal of the Privacy Officer could cause confusion and if the language in the policy is sufficient to make it clear that the Chief Compliance Officer's responsibilities include that of the Privacy Officer. There was also a question as to the Security Officer title. Mr. Cruz explained in this instance Security Officer is referring to the Vice President of IT, Mark Albright. After further discussion it was suggested the committee recommend approval of the policy as written with the exception of the addition to the Work Force Member definition and directed Mr. Cruz to revisit the policy with Mr. Dietlin.		
5) Duty to Report Suspected Misconduct; Potential Compliance Irregularity - 544	Mr. Cruz reported the Duty to Report Suspected Misconduct policy 544 was revised to reduce the complexity of the policy. He noted the duty to report is also reflected in our Code of Conduct.		
6) Monitoring Compliance – Auditing & Reporting; Introduction; General Policies	Mr. Cruz reported the Policy 551 Monitoring Compliance – Auditing & Reporting: Introduction; General Policies was deleted and incorporated into policy 553 which will be		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
– 551 (DELETE)	presented at the committee's next meeting.		
7) Notice of Privacy Practice – 518	<p>Mr. Cruz stated per discussion at the October, 2018 meeting, the Notice of Privacy Practice Policy 518 was modified to define patient vs. patient relationship. Mr. Livingstone provided clarification on the policy and Notice of Privacy Practices as well. It was noted the effective date on the Notice of Privacy Practices should be March 1, 2019, following Board approval of the policy.</p> <p>Ms. Bond questioned if the Notice is also available in Braille. Ms. Guerra stated the Notice is available in Spanish and we have an interpretation service that is used for other languages as needed. Mr. Cruz indicated he would follow up on whether we are required to have the Notice in Braille.</p> <p>Ms. Guerra noted the definition of Work Force member will also be revised to reflect the Medical Staff and Allied Health Professionals.</p>		
8) Use and Disclosure of Protected Information for Fundraising – 525	<p>Mr. Cruz stated there were minor housekeeping changes to Policy 525 – Use and Disclosure of Protected Information for Fundraising. Again, the definition of Work Force member will be amended.</p>		
9) Verification of Identity and Authority of Persons Requesting Protected Health Information (PHI), including Personal Representatives - 593	<p>Mr. Cruz stated there were no significant changes to the Verification of Identity and Authority of Persons Requesting Protected Health Information (PHI), including Personal Representatives Policy 593.</p> <p>It was moved by Director Coulter to recommend approval of policies as presented and amended as follows:</p> <ol style="list-style-type: none"> 1) Compliance Officer – 535 2) Compliance Program Overview – 532 3) Disclosure of Protected Health Information – 513 4) HIPAA Mitigation - 591 5) Duty to Report Suspected Misconduct; Potential Compliance Irregularity - 544 6) Monitoring Compliance – Auditing & Reporting; 	<p>Recommendation to be sent to the Board of Directors to approve the aforementioned Policies as amended; policies to be placed on Board agenda and included in agenda packet.</p>	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	<p>Introduction; General Policies – 551 (DELETE) 7) Notice of Privacy Practice – 518 8) Use and Disclosure of Protected Information for Fundraising – 525 9) Verification of Identity and Authority of Persons Requesting Protected Health Information (PHI), including Personal Representatives - 593</p> <p>Mrs. Faith Devine seconded the motion. The motion passed unanimously.</p> <p><i>Ms. Tricia Guerra left the meeting at 9:10 a.m.</i></p>		
c) 2019 Enforcement Trends	<p>Mr. Cruz presented an overview of 2019 Health Care Enforcement Trends that included the following:</p> <ul style="list-style-type: none"> ➤ Opioids ➤ Telemedicine ➤ Home Health ➤ Stark Law/Anti-Kickback Statute ➤ False Claims Act ➤ Hospital Billing of Inpatient Services ➤ Cybersecurity/Privacy <p>Mr. Cruz stated the Office of Civil Rights (OCR) has concluded an all-time record year in HIPAA enforcement activity of 10 cases and one judgment, totaling \$28.7 million with surpassed the previous record of \$23.5 million in 2016.</p>	Information Only.	
d) TCHD Compliance Program Update	<p>Mr. Cruz presented the calendar year 2018 TCHD Compliance Program Year in Review which included information on the following:</p> <ul style="list-style-type: none"> ➤ Compliance and Privacy Policies ➤ Compliance Program Marketing ➤ Privacy/Security ➤ Hotline ➤ Culture of Compliance ➤ Compliance Training 	Information only.	

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1) Work Plan Development	<p>Mr. Cruz stated Compliance works with various stakeholders to identify areas of concern, gaps, and opportunities to improve. He presented information on the Work Plan as follows:</p> <ul style="list-style-type: none"> ➤ Stakeholder Meetings ➤ Review of Enforcement Trends ➤ Compliance Program Maturation ➤ Marketing of Program ➤ Training and Education of Staff ➤ Training and Education of Leadership ➤ Evaluate Program Regularly 	Information only.	
7. Comments from Committee Members	There were no comments from Committee Members.		
8. Committee Openings	Chairman Schallock reported there is one opening on the Committee which has been posted.	Information only.	Ms. Donnellan
9. Date of Next Meeting	Chairman Schallock stated the committee's next meeting will be held on April 16, 2019.	The committee's next meeting is scheduled for April 16, 2019.	
11. Adjournment	Chairman Schallock adjourned the meeting at 9:49 a.m.		



TCHD Audit, Compliance & Ethics Committee: February 19, 2019

Carlos A. Cruz, JD, MHA

Chief Compliance and Privacy Officer

CruzC@temc.com

(760) 940-5381



2019 HEALTH CARE ENFORCEMENT TRENDS

2019 Health Care Enforcement Trends

- Opioids
 - Department of Justice (“DOJ”) prosecution of individuals (e.g. physicians, nurses, sales reps and pharmacists) under drug trafficking statutes
 - Charges brought against 601 defendants in 2018
 - 165 health care professionals
- Related Issue
 - Drug Diversion

2019 Health Care Enforcement Trends

- Telemedicine
 - Rapidly growing industry within health care
 - Specific technology requirements
 - Documentation requirements

2019 Health Care Enforcement Trends

- Home Health
 - Area of scrutiny by DOJ and Office of Inspector General (“OIG”)
 - Specific requirements
 - Face-to-Face (“FTF”) Encounter
 - Home Health Documentation in Physician Medical Record
 - Homebound
 - Medically Necessary and Reasonable

2019 Health Care Enforcement Trends

- Stark Law/Anti-Kickback Statute
 - Physician Agreements
 - Recruitment Agreements
 - Office Space Leases
- False Claims Act (“FCA”)

2019 Health Care Enforcement Trends

- Hospital Billing of Inpatient Services
 - OIG Audits
 - Recovery Audit Contractor (“RAC”) Audits

2019 Health Care Enforcement Trends

Community Hospital in Munster, Ind., a 458-bed nonprofit hospital, failed to comply with Medicare billing requirements for 86 inpatient claims of 170 inpatient and outpatient claims reviewed by HHS' Office of Inspector General, according to an OIG report.

The **86 claims** that did not comply with Medicare billing requirements resulted in the hospital receiving **\$1.3 million** in combined **overpayments** during the audit period of Jan. 1, 2015, through Dec. 31, 2016, according to the OIG.

2019 Health Care Enforcement Trends

- Cybersecurity/Privacy
 - Security Risk Assessments
 - Office of Civil Rights (“OCR”) Audits of Privacy Programs
 - Breach Notifications

2019 Health Care Enforcement Trends

OCR Concludes 2018 with All-Time Record Year for HIPAA Enforcement

February 7, 2019- OCR has concluded an all-time record year in HIPAA enforcement activity. In 2018, OCR settled **10 cases** and secured one judgment, together totaling **\$28.7 million**. This total surpassed the previous record of \$23.5 million from 2016 by 22 percent. In addition, OCR also achieved the single largest individual HIPAA settlement in history of \$16 million with Anthem, Inc., representing a nearly three-fold increase over the previous record settlement of \$5.5 million in 2016.



TCHD COMPLIANCE PROGRAM UPDATE

CY 2018 TCHD Compliance Program Year in Review

- Compliance and Privacy Policies
 - Gap analysis
 - Revisions
- Compliance Program Marketing
 - Staff Rounding
 - Posters/Business Cards
 - Intranet Update

CY 2018 TCHD Compliance Program Year in Review

- Privacy/Security
 - Proactive electronic medical record monitoring
- Hotline (TCHD Values Line)
 - Updated
 - Re-Education of Workforce Members on purpose of Values Line

CY 2018 TCHD Compliance Program Year in Review

- Culture of Compliance
 - “Speak up” Culture Training
 - Focus on Non-Retaliation Policy
- Compliance Training
 - CMS General Compliance Training (required)
 - 5Ws of Compliance



2019 WORK PLAN

WORK PLAN DEVELOPMENT

- Stakeholder Meetings
 - Leadership in Operational Units
 - Feedback (Survey) on areas to focus
- Review of Enforcement Trends
- Compliance Program Maturation
 - Identify opportunities that create efficiencies and improve communication



Marketing of Program

- Take time to promote avenues of reporting
 - Internal sites (e.g. compliance webpage)
 - Newsletters
 - Formal Town Halls
 - Informal Meetings (e.g. “lunch and learn”)
 - Posters



Training and Education of Staff

- Element of an Effective Compliance Program
 - Employees should be aware of how to report a concern
 - Code of Conduct
 - Posters
 - Policies
- Avenues for Reporting
 - Hotline
 - Email



Training and Education of Leadership

- Train management on mitigating the potential for whistleblowers and reinforce the importance of non-retaliation
 - Importance of middle management
 - Employees regularly interface with and take their cues from these leaders



Evaluate Program Regularly

- Track issues reported to compliance and HR
 - Increase in calls to hotline?
 - Increase in questions/issues from Workforce Members?
- Conduct Surveys
 - Do employees feel comfortable/safe reporting issues?



Questions?





AUDIT COMPLIANCE AND ETHICS COMMITTEE CONSENT AGENDA
February 19, 2019

Administrative Policies & Procedures	Policy #	Reason	Recommendations
1. Compliance Officer	535	3 Year Review, Practice Change	Forward To BOD For Approval
2. Compliance Program Overview	532	3 Year Review, Practice Change	Forward To BOD For Approval with Revisions
3. Disclosure of Protected Health Information	513	3 Year Review, Practice Change	Forward To BOD For Approval
4. HIPAA Mitigation	591	3 Year Review, Practice Change	Forward To BOD For Approval with Revisions
5. Hiring and Employment; Duty to Report Suspected Misconduct Potential Compliance Irregularity	544	3 Year Review, Practice Change	Forward To BOD For Approval with Revisions
6. Monitoring Compliance - Auditing & Reporting; Introduction; General Policies	551	DELETE	Forward To BOD For Approval
7. Notice of Privacy Practice	518	3 Year Review, Practice Change	Forward To BOD For Approval with Revisions
8. Use and Disclosure of Protected Information for Fundraising	525	Practice Change	Forward To BOD For Approval with Revisions
9. Verification of Identity and Authority of Persons Requesting Protected Health Information (PHI), including Personal Representatives	593	3 Year Review, Practice Change	Forward To BOD For Approval

**ADMINISTRATIVE POLICY MANUAL
COMPLIANCE**

ISSUE DATE: 05/12 **SUBJECT:** Chief Compliance Officer

REVISION DATE(S): 12/12 **POLICY NUMBER:** 8750-535

~~Department Administrative Compliance Content Expert Approval-Date(s):~~ 03/1501/19
~~Administrative Policies and Procedures Committee Approval-Date(s):~~ 03/1501/19
~~Organizational Compliance Committee Approval:~~ n/a
~~Medical Executive Committee Approval:~~ n/a
~~Audit, and Compliance & Ethics Committee Approval-Date(s):~~ 04/1502/19
~~Board of Directors Approval:~~ 04/15

A. PURPOSE:

1. This policy provides for the appointment of, and sets forth the general duties and responsibilities of, Tri-City Healthcare District's ("TCHD's") Chief Compliance Officer.

B. GENERAL POLICY:

1. The Chief Compliance Officer ("CCO") shall advise the Board of Directors ("Board") and Chief Executive Officer ("CEO") regarding the design and implementation of the agency's ethics and compliance programs. The CCO Compliance Officer shall report directly to the Board regarding material legal and compliance risks and mitigation efforts. In the event that the CCO ceases to be a TCHD employee or is removed or resigns from the position of CCO, the Board shall promptly appoint an interim CCO until such time as an appropriate permanent CCO may be identified and engaged.

C. HIRE OF CHIEF COMPLIANCE OFFICER:

1. The CCO shall be hired by the CEO with approval from the TCHD's Board of Directors and Chief Executive Officer CEO.
2. The Chief Executive Officer CEO shall cause the hiring of the CCO to be recorded in writing and properly and effectively announced to the TCHD's employees, members of the Medical Staff and other affected individuals, including, but not limited to, contractors who furnish patient care or related services to TCHD and/or its patients.
3. The Compliance Officer CCO shall have the duties and responsibilities set forth below.
4. The Compliance Officer CCO shall have direct access and report directly to TCHD's Board of Directors, Audit, and Compliance & Ethics ("ACE") Committee, and Chief Executive Officer CEO regarding the status of the Compliance Program and any material developments affecting the Compliance Program. Such reports shall occur as frequently as needed in the best interests of TCHD, but in any event no less than on a quarterly basis.
5. For administrative purposes, the CCO shall report directly to the CEO. Chief Executive Officer.

D. QUALIFICATIONS OF COMPLIANCE OFFICER

1. The Compliance Officer CCO shall have credentials and experience appropriate for understanding the TCHD's mission and operations, and for executing the duties and responsibilities -set forth in this Policy.
2. The Compliance Officer CCO shall demonstrate high integrity, good judgment, assertiveness, and an approachable demeanor, when working with TCHD's Board, senior management, employees, Medical Staff, and relevant contractors and agents.

3. The ~~Compliance Officer~~CCO must have sufficient time to dedicate to the ~~Compliance Officer~~CCO position and its attendant duties and responsibilities. The CCO also shall have sufficient resources to perform his/her duties and responsibilities.

E. AUTHORITY OF COMPLIANCE OFFICER; REVIEW OF FINDINGS

1. The CCO shall have the authority to access and review all TCHD records and other documents (whether in paper or electronic form) and interview all TCHD employees, as necessary to discharge his/~~or~~-her duties and responsibilities.
2. The CCO shall have sufficient management authority, responsibility, and resources to permit the performance of his/her duties.
3. The CCO shall have the authority to report to the ~~TCHD Chief Executive Officer~~CEO, Board of ~~Directors~~, and ~~Audit & Compliance & Ethics~~ACE Committee regarding compliance matters at any time.
4. The CCO shall have direct access to all senior management.
5. With approval of the Board of ~~Directors~~ or ~~Chief Executive Officer~~CEO, the CCO shall have authority to engage qualified outside legal counsel and consultants to assist him/her achieve the objectives of the Compliance Program.
6. TCHD may commission an independent review to verify any findings of the CCO.

F. SPECIFIC DUTIES AND RESPONSIBILITIES OF COMPLIANCE OFFICER

1. The CCO will be responsible for, among other things:
 - a. Advise the Board of ~~Directors~~ and the ~~Chief Executive Officer~~CEO regarding the design and implementation of TCHD's Compliance Program.
 - b. Oversee and monitor the implementation and operation of TCHD's Compliance Program, including staff supervision as necessary.
 - c. Monitor changes and/or updates in relevant state and federal health care program laws and regulations.
 - d. Report on a regular basis (at least quarterly) to the ~~Chief Executive Officer~~CEO, ~~Audit & Compliance & Ethics~~ACE Committee, and Board of ~~Directors~~ regarding compliance issues and the status of TCHD's Compliance Program.
 - e. Monitor various guidance, alerts and other communications issued by federal or state government agencies, including the U.S. Department of Health and Human Services, the Federal Trade Commission, and the U.S. Department of Justice.
 - f. Develop written policies to implement the Compliance Program and address existing and new compliance risk areas.
 - g. Amend the Compliance Program (including the Code of Conduct and Policies), as necessary.
 - h. Oversee the meetings, work plans, and operations of the ~~Internal~~ cCompliance cCommittee.
 - i. Develop, coordinate, and document TCHD's compliance-related educational and training programs.
 - j. Promote awareness of, and compliance with, applicable laws and policies on the part of Directors, employees, members of the Medical Staff, contractors, and agents.
 - k. Ensure new employees and contractors are screened against appropriate state and federal debarment/sanction lists.
 - l. Ensure new employees receive the Code of Conduct and related training.
 - m. Coordinate internal and external compliance reviews or audits of TCHD's business operations and practices.
 - n. Review TCHD business arrangements to ensure compliance with applicable laws, regulations, and policies. This may be accomplished by conferring with legal counsel, as appropriate.
 - o. Respond to compliance inquiries.

- p. Ensure TCHD's Confidential Reporting Line (Values Line) and other lines of communication are operating effectively and that compliance concerns are documented and addressed promptly and appropriately.
- q. Ensure exit interviews of departing employees are conducted to elicit information concerning potential violations of laws, regulations or TCHD's policies.
- r. Investigate suspected violations of applicable laws, regulations and policies and make recommendations regarding corrective actions, as appropriate.
- s. Consult with Board and legal counsel, as appropriate to the foregoing.

G. REFERENCE(S):

1. Compliance Program Guidance for Hospitals, published by the U.S. Department of Health and Human Services, Office of Inspector General, February 1998.
2. Office of Inspector General Supplemental Compliance Program Guidance for Hospitals, January 2005.

**ADMINISTRATIVE POLICY
COMPLIANCE**

ISSUE DATE: 05/12 **SUBJECT:** Compliance Program Overview

REVISION DATE(S): 12/12 **POLICY NUMBER:** 8750-532

Administrative Compliance Content Expert Approval: 10/1512/18
Administrative Policies and Procedures Committee Approval: 10/1512/18
Organizational Compliance Committee Approval: n/a
Medical Executive Committee Approval: n/a
Audit, Compliance and Ethics Committee Approval: 11/1502/19
Board of Directors Approval: 12/15

A. PURPOSE:

1. To provide an overview of Tri-City Healthcare District's (TCHD) Healthcare Compliance Program (Compliance Program) and the scope and objectives of the Compliance Program. As set forth below, the Compliance Program is comprised of TCHD's Code of Conduct, General Compliance Policies ("General Policies"), and Specific Compliance Policies (Specific Policies). The General and Specific Policies are referred to collectively as the "Policies").

B. DEFINITION(S):

1. **Workforce Member:** Employees, Medical Staff and Allied Health Professionals, volunteers, trainees, and other persons whose conduct, in the performance of work for TCHD, is under the direct control of TCHD whether or not they are paid by TCHD.

~~B. INTRODUCTION:~~

- ~~1. TCHD owns and operates Tri-City Medical Center, a licensed 397-bed, general acute care hospital organized under the California Health & Safety Code § 32000, et. seq., which is governed by a publicly-elected Board of Directors (the "Board"), that represents the residents of Carlsbad, Oceanside and Vista. As set forth in the Code of Conduct, TCHD's mission is to advance the health and wellness of those TCHD serves. An integral component of this mission is TCHD's unequivocal commitment to operating in compliance with applicable federal and state laws and regulations and to demonstrate good corporate citizenship. Both to reflect and achieve this commitment, TCHD has developed and implemented a formal Compliance Program, as described in this Policy.~~

C. INTRODUCTION POLICIES:

- ~~C-1.~~ As set forth in the Code of Conduct, TCHD's mission is to advance the health and wellness of those TCHD serves. An integral component of this mission is TCHD's unequivocal commitment to operating in compliance with applicable federal and state laws and regulations and to demonstrate good corporate citizenship. Both to reflect and achieve this commitment, TCHD has developed and implemented a formal Compliance Program, as described in this Policy.
- 1-2. TCHD's Compliance Program supplements laws, regulations and other governmental rules. As a general matter, laws, regulations, and other governmental rules control the standards set forth in the Compliance Program unless the Compliance Program imposes stricter requirements than these authorities.
- 2-3. TCHD's Code of Conduct provides ethical and compliance guidance on a broad range of conduct. TCHD's Compliance Policies provide more detailed guidance regarding ethical and

appropriate conduct, and are intended to be consistent with the general principles established in the Code of Conduct.

D. SCOPE:

1. Unless otherwise limited, the Compliance Program applies to: **all workforce members.**
 - a. ~~All members of the TCHD's Board of Directors and members of TCHD's committees;~~
 - b. ~~All employees, including officers and managers;~~
 - c. ~~All members of TCHD's Medical Staff and TCHD's allied health professionals, and their respective agents, including independent contractors who or which provide health care or related services in any of TCHD's facilities, including facilities that are owned and/or operated through joint ventures or under arrangements, for such time periods in which they furnish patient care or other related services at TCHD and/or with respect to the delivery of patient care or related services to TCHD or any of its patients;~~
 - d. ~~All vendors;~~
 - e. ~~All volunteers~~

E. OBJECTIVES:

1. The primary objective of TCHD's Compliance Program is to promote ethical and lawful conduct and to ensure compliance with both the letter and the spirit of applicable healthcare laws and regulations. TCHD's Compliance Program is modeled after the voluntary "Compliance Program Guidance for Hospitals," initially published by the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) in February 1998, and supplemented in the "OIG Supplemental Compliance Program Guidance for Hospitals" published in January 2005.
2. TCHD's Compliance Program includes the **following** seven elements identified by the OIG as fundamental to an effective compliance program:
 - a. Implement written policies and standards of conduct;
 - b. Designate a Compliance Officer and establish an Internal Compliance Committee;
 - c. Conduct effective training and education regarding policies, procedures and practices;
 - d. Develop effective lines of communication regarding compliance concerns;
 - e. Enforce policies and standards through well-publicized disciplinary guidelines;
 - f. Conduct internal monitoring and audits; and
 - g. Respond promptly to detected compliance irregularities and implementing appropriate corrective action.
3. A second, but equally important, objective is to ensure maintenance and enforcement of high standards of individual and organizational ethical and legal business practices throughout TCHD. ~~This~~ **The Compliance Program** facilitates TCHD's ability to carry out its health care mission in a manner consistent with its values, principles and mission.

F. COMPLIANCE PROGRAM COMPONENTS:

1. ~~Code of~~ **Code of Conduct:** TCHD has adopted a written Code of Conduct to govern **all of** TCHD's interactions including **interactions with** patients, their families, and providers of care, vendors, federal, state and local regulators, payors and the public in general. The Code of Conduct is a critical part of and is incorporated by reference into the Compliance Program.
2. **Policies:**
 - a. TCHD has General and Specific Compliance Program policies. General policies address the fundamental requirements of an effective Compliance Program. Specific policies provide more detailed guidance on compliance with applicable federal and state laws and regulations.
 - b. General policies include the following:
 - i. **Administrative Compliance Policy:** Compliance Program Overview 8750-532;
 - ii. **Administrative Compliance Policy:** Compliance Officer 8750-535;
 - iii. **Administrative Human Resources Policy:** Hiring and Employment 8750-544;

- iv. **Administrative Human Resources Policy: Compliance Training Program**~~Education and Training~~ 8750-547;
- ~~iv.v.~~ **Administrative Human Resources Policy: Education and Training; Specific Training Programs** 8750-548
- ~~v.vi.~~ **Administrative Compliance Policy: Monitoring Compliance/Auditing and Reporting; Introduction; General Policies** 8750-551;
- ~~vi.vii.~~ **Administrative Compliance Policy: Communicating and Reporting Compliance Concerns** 8750-557;
- ~~i.viii.~~ **Administrative Compliance Policy: Responding to Compliance Issues; Introduction; Suspected Misconduct; Confidentiality** 8750-559; and
- ~~ii.i.~~ **Administrative Compliance Policy: Development, and Revision and Approval of Standards**~~Code of Conduct and Policies~~ 8750-564.
- c. Specific policies include, but are not limited to the following:
 - i. **Administrative Compliance Policy: Physician Recruiting Arrangements** 8750-579;
 - ii. **Administrative Human Resources Policy: Conflicts of Interest and Acceptance of gifts** 8610-483;
 - iii. **Administrative District Operations Policy: Document**~~Hospital Records~~ Retention 8610-237; and
 - ~~iv. Gifts and Other Non-Monetary Compensation.~~
- 3. ~~Resolution Of~~ **Conflicts:**
 - a. Some of the policies that make up TCHD's Compliance Program summarize various government laws, regulations and guidelines. Such policies should not be read or used as substitutes for the actual laws or regulations to which they relate. In other words, TCHD's policies may supplement, and clarify, applicable laws and regulations.
 - b. In the event of an inconsistency between any policy in the Compliance Program and applicable laws or regulations, ~~you are to:~~
 - i. ~~(1) follow~~ Follow the applicable law or regulation unless TCHD's policy imposes stricter requirements and
 - ~~b.ii. (2) report~~ Report the inconsistency to the Compliance Officer.
 - c. If ~~you~~ workforce members are unsure as to the appropriate standard, ~~do they should~~ not guess. Ask a supervisor or the Chief Compliance Officer.

G. RELATED DOCUMENT(S):

- 1. **Code of Conduct**
- 2. **Administrative Compliance Policy: Compliance Program Overview** 8750-532
- 3. **Administrative Compliance Policy: Compliance Officer** 8750-535
- 4. **Administrative Compliance Policy: Hiring and Employment, Duty to Report Suspected Misconduct/Potential Compliance Irregularity** 8750-544
- 5. **Administrative Compliance Policy: Education and Training; General Annual Compliance Training Program** 8750-547
- 6. **Administrative Compliance Policy: Education and Training; Specific Training Programs** 8750-548
- 7. **Administrative Compliance Policy: Monitoring Compliance/Auditing and Reporting; Introduction; General Policies** 8750-551
- 8. **Administrative Compliance Policy: Communicating and Reporting Compliance Concerns (Values Line)** 8750-557
- 9. **Administrative Compliance Policy: Responding to Compliance Issues; Introduction; Suspected Misconduct; Confidentiality** 8750-559
- 10. **Administrative Compliance Policy: Physician Recruiting Agreements** 8750-579
- 11. **Administrative Human Resources Policy: Conflicts of Interest and Acceptance of Gifts** 8610-483

- 12. **Administrative District Operations Policy: Hospital Records Retention 8610-237**
- ~~4.13.~~ **Administrative Compliance Policy: Development and Revision of Code of Conduct and Policies 8750-564**

H. **REFERENCES:**

- 1. Compliance Program Guidance for Hospitals, published by U.S. Department of Health and Human Services, Office of Inspector General, February 1998.
- 2. Office of Inspector General Supplemental Compliance Program Guidance for Hospitals, January 2005.

Tri-City Healthcare District

Code of Conduct

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About Our Code and Your Responsibilities

OUR COMMITMENT TO QUALITY CARE - OUR VALUES

Quality
Caring
Safety
Integrity
Innovation
Stewardship

Tri-City Healthcare District exists to serve the healthcare needs of its community. We are committed to furnishing each and every patient with high quality, compassionate care. To achieve this, we must all adopt a strong and deep commitment to embracing and living our values: quality, caring, safety, integrity, innovation, and stewardship.

Our values must be more than words on paper. Each of us has a responsibility to think about and be guided by the Tri-City values in everything we do, especially when faced with difficult decisions. Our values, as embodied in this Code of Conduct, applicable Policies and Procedures, and the support we provide to one another, will help guide us and ensure that we meet our ethics and compliance responsibilities and aspirations.

TO WHOM THIS CODE APPLIES

The Code of Conduct provides the ethical guidelines and expectations for conducting business for, or on behalf of Tri-City Healthcare District. It applies to all District officers and employees, at every level, and to our Board of Directors. It also applies to the District's medical staff, as well as vendors, consultants, contractors, and temporary employees, who often serve as an extension of the District.

COMPLIANCE WITH THE LAW AND REGULATIONS

This Code of Conduct reflects our commitment to conduct business consistent with fundamental ethical standards and to comply with applicable laws and regulations, including all applicable federal health care program laws, regulations, and program requirements.

Each of us is responsible for knowing and upholding the rules that apply to our jobs, including, as applicable, the requirements of Medicare, Medicaid, the Emergency Medical Treatment and Active Labor Act (EMTALA), the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), the False Claims Act, California's Confidentiality of Medical Information Act (CMIA), and all other applicable state and federal healthcare laws and regulations.

We are also required to seek advice from a manager, the Chief Compliance Officer, or the Legal Department if we are in doubt about the appropriateness and/or legality of an action. To help us understand and meet these obligations, this Code defines expectations, provides guidance, and identifies resources to help us address concerns.

RESPONSIBILITIES

Everyone is responsible for maintaining our reputation as a quality healthcare provider that practices legally and ethically. Meeting these responsibilities is critical to the District's success today and in the future. We need to act with integrity.

Without integrity, we fail our patients, our community, our coworkers, and ourselves. We must strive to maintain the highest ethical standards:

- **Be honest** in all you do.
- **Always obey** the law and all District policies and procedures, and act in a professional, honest, and ethical manner when acting on behalf of the District. Seek advice if in doubt about the appropriateness and/or legality of an action.
- **Know** the information contained in this Code and the related District policies and procedures, paying particular attention to the policies and procedures that pertain to your job responsibilities.
- **Complete** all required training in a timely manner.
- **Promptly report** concerns about possible violations of laws, regulations, this Code, or any District policies or procedures in accordance with the District's policies.
- **Cooperate** and tell the whole truth when responding to a compliance review or investigation. Never alter or destroy any records.
- **No excuses!** No reason, including the need to meet job responsibilities or organizational goals, is an excuse for violating laws, regulations, this Code, or District policies and procedures.

ADDITIONAL RESPONSIBILITIES OF DISTRICT LEADERSHIP

Individuals who manage others or are otherwise in a position of authority have these additional responsibilities:

- **Lead by example.** Managers are expected to exemplify the highest standards of ethical conduct.
- **Create a positive working environment** where everyone feels comfortable asking questions and reporting potential violations of this Code and its underlying policies and procedures. Never retaliate or seek retribution against those who raise issues or concerns.
- **Never ask or pressure anyone** to do something that you would be prohibited from doing yourself.
- Be aware of the **limits of your authority** and do not take any action that exceeds those limits. Never delegate authority to any individual whom you believe may engage in unlawful or unethical conduct.
- If you **supervise contractors** working on our behalf, ensure that they understand our expectations that they comply with applicable law, regulations and our Code.

As a manager, you need to monitor what is happening with those whom you supervise. If you become aware of conduct that may violate applicable law, regulations, our Code, or our policies and procedures, you **MUST** report it immediately. Not reporting a violation when you know or should have known about it may result in discipline up to and including termination of your employment.

Managers should not consider ethics concerns as threats or challenges to their authority. We want open, honest, and truthful dialogue to become a natural part of our daily work.

Q: I'm a manager, and I'm not clear what my obligations are if someone comes to me with an allegation – and what if it involves a senior leader?

A: No matter who the allegation involves, you must report it. See the next section of this Code for more detail on how to report it.

ASKING QUESTIONS AND REPORTING SUSPECTED VIOLATIONS

In today's complex healthcare environment, legal and ethical concerns routinely occur. When they do, employees must report the issues so that they can be addressed quickly and appropriately, minimizing the damage to the District and any involved parties. The sooner we know about possible problems, the sooner we can address them and find solutions. And of course, employees **MUST** report misconduct which they commit, witness, or hear about.

For reporting, employees have several options:

- Bring matters involving employee relations and discipline, work safety, job duties, harassment, and employee health to the attention of your manager or the Human Resources Department.
- Ask your manager or the Legal Department questions regarding handling legal documents, responding to regulatory inquiries, and how to determine and interpret the laws that apply to your job.
- Concerns regarding noncompliance with applicable laws and regulatory requirements must be reported to your manager, the Chief Compliance Officer, or by calling the **Values Line (800) 273-8452**.

The Values Line is available 24 hours per day, 365 days per year. Translators are available to speak in your native language, all calls are kept confidential, **and you can make your report anonymously, if you so choose**. If you make a report through the Values Line, you will receive an identification number so you can follow up on the concern. This is especially important if you have submitted a report anonymously, because it will enable you to provide additional information, and track the resolution of the matter.

Tri-City Healthcare District has an opportunity to improve every time an employee asks a question or raises a concern. When employees take action, speak up, and report questionable conduct, they are protecting their colleagues and our reputation. Remember, an issue cannot be addressed unless it is brought to someone's attention.

PROTECTION FROM RETALIATION

To build trust, we must listen openly to concerns about misconduct, respond appropriately, and never retaliate or seek retribution against those who raise issues or participate in investigations.

We take claims of retaliation and retribution seriously. All such claims will be thoroughly investigated. If they are substantiated, retaliators will be disciplined, up to and including dismissal from the District. If an employee believes he or she has experienced retaliation, the individual should report it using any of the methods described in the above section on *Asking Questions and Reporting Suspected Violations*.

ACCOUNTABILITY AND DISCIPLINE

All employees of Tri-City Healthcare District are required to obey all federal, state, and local laws and to abide by the rules set forth in this Code of Conduct and all District policies and procedures. Any individual who fails to do so is subject to penalties up to and including dismissal from the District along with criminal and/or civil prosecution.

AMENDMENTS AND WAIVERS

On rare occasions, Tri-City Healthcare District may amend or waive certain provisions of this Code. Anyone who believes that a waiver may be appropriate should discuss the matter with the Chief Compliance Officer or the CEO.

Any proposed waiver or exception must be approved by the Chief Compliance Officer and CEO in writing, per policy 8750-566.

OUR ETHICS AND COMPLIANCE RESOURCES

This Code and District policies serve as resources for employees to help guide their actions.

Employees also should be alert to changes in the law or new requirements that may affect their work as well as new District services that may be subject to special legal requirements.

In addition to the Code, it is important to remember that District leaders are a good resource when it comes to ethical business conduct, as are the Chief Compliance Officer, the Legal Department, the Human Resources Department, and the Values Line (800) 273-8452. Employees should feel free to take advantage of any of the resources provided.

MAKING THE RIGHT DECISION

Pressure often clouds our judgment, and occasionally, the right choice is not clear. Remember, support is available for employees facing a tough call. Our colleagues and managers can help us think through our options. Employees also may rely on this Code for help, or contact the Values Line (800) 273-8452.

When making a difficult decision, employees should ask three simple questions:

- **Is it legal?** If it isn't, don't do it.
- **Is it right?** How do you feel about the choice? Does your conscience give you pause? Would a close, trusted friend be okay with it?
- **How would I feel if the conduct appeared on YouTube or in the newspaper?** If someone posted a video of (or a blog entry about) what you had done and individuals around the world saw it, would it hurt your reputation or the reputation of Tri-City Healthcare District? If so, it is the wrong choice – don't do it!

Our Commitment to Our Patients

PROVIDING QUALITY MEDICAL CARE

The only acceptable standard of care at Tri-City Healthcare District is that of the highest quality. We provide care that is compassionate and that advances the health and wellness of all the people we serve. Our commitment in this regard is more fully set forth in the District's *Patient Handbook*, Policy 8610-302, and the Joint Commission's National Patient Safety Goals.

CARING FOR OUR PATIENTS AND THEIR RIGHTS

The District adheres to the highest standards in the realm of patients' rights and respecting patients' privacy, safety, and sovereignty over their own bodies. We communicate clearly with our patients about their rights and their options, and we make sure that they are empowered while availing themselves of our services and care.

District employees must be mindful that each of our patients has specific rights including:

- Considerate and respectful care, personal dignity, and comfort.
- To receive information about his or her health status, diagnosis, prognosis, and treatment.
- Free interpreter services available.
- To make decisions regarding medical care and to receive needed information.
- To request or refuse treatment, to the extent permitted by law.
- To have personal privacy respected.
- To receive care in a safe setting, free from abuse, neglect, or exploitation.

Patient Safety

No patient care goal is more important than that of ensuring patient safety. Employees of the District work diligently to correctly identify our patients, promptly communicate key care information to correct staff, properly use medications, and identify and manage other patient safety risks.

The Joint Commission provides certain patient safety goals, generally including:

- Identifying patients correctly.
- Maintaining and communicating accurate patient medication information.
- Preventing infection of all types, making use of all appropriate guidelines.
- Identify patient safety risks, including suicide risk.
- Complying with current CDC and WHO hand hygiene guidelines.

Safeguarding Patient Privacy and Confidentiality

Our commitment to upholding the law includes patient information privacy and security. Employees should disclose confidential patient information only as permitted by law to those with a need to know. We will hold our contractors and care partners to the same standards.

Our Commitment to One Another

RESPECT IN THE WORKPLACE

We are committed to fair and respectful treatment and equal opportunity in our employment interactions and decisions. Our colleagues and job applicants are entitled to respect and should be judged only on the basis of their qualifications, demonstrated skills, and achievements.

Remember:

- Treat others as you wish to be treated.
- Review your own decisions to ensure that only objective merit and healthcare considerations drive your actions.
- If you supervise others, judge them on performance. Avoid introducing unrelated considerations into your decisions.

Equal Employment Opportunity

We believe every employee deserves to work and grow in an environment free of unlawful discrimination, harassment, intimidation, and abuse. We understand that the District is best served when all perspectives are considered fairly and without prejudice. We prohibit any form of discrimination on the basis of a characteristic protected by state and federal law, and our policies. For more detailed information, please consult Policy 8610-418, or ask Human Resources.

Harassment

The District is committed to providing a harassment-free environment. The District's anti-harassment policy applies to all persons involved in the operation of the District and prohibits unlawful harassment by any employee of the District, including supervisors and managers, as well as vendors and customers. For more specific information regarding harassment, please consult Policy 8610-403, or ask Human Resources.

Remember:

- Treat coworkers with respect. Do not discriminate or harass anyone. Be open to different points of view, backgrounds, and experiences and recognize the value that diversity brings to our work.
- Let people know if you find their behavior to be demeaning or disrespectful of you or others. Don't tolerate discrimination or harassment in any form.
- Be professional. Do not visit inappropriate internet sites or display sexually explicit or offensive pictures. This prohibition does not include internet sites or pictures legitimately used in connection with your work for the District.
- Report all incidents of harassment and discrimination that may compromise our ability to work together in an appropriate environment.

Q: *One of my co-workers sends e-mails and text messages containing jokes and comments that make fun of certain nationalities. They make me uncomfortable, but no one else has spoken up about them. What should I do?*

A: *You should notify your manager or the Human Resources Department. Jokes that demean or stereotype people's national origin, or any other protected characteristic, are inappropriate. Raise the issue now, so that it does not continue or even escalate.*

Q: *While attending an educational program with some coworkers at a local hotel, a colleague repeatedly asked me out for drinks and made comments about my appearance that made me uncomfortable. I asked him to stop, but he wouldn't. We weren't in the office and it was "after hours" so I wasn't sure what I should do. Does this violate our Code?*

A: *Yes. This type of conduct will not be tolerated, not only during working hours but in all work-related situations. Tell your colleague such actions are inappropriate. If they do not stop immediately, or if you don't feel comfortable confronting your colleague, report the issue.*

HEALTH AND SAFETY

Safe Working Environment

The District is committed to providing a safe and healthy workplace for our employees, as well as for patients and visitors to our facilities. We need to protect ourselves and others in our everyday actions. Situations that may pose a health, safety, or environmental hazard must be immediately fixed or reported to management. We can only achieve our goal of a safe and healthy workplace through the active participation and support of everyone. **The more we communicate, the better we can respond to any unsafe or unhealthy working conditions.**

Remember:

- Comply with all applicable health and safety laws, policies, and procedures. If you don't know what the safe thing to do is, ask someone who knows.
- Understand your job fully and follow instructions. Wear personal protective equipment in accordance with the job you are performing. Use, adjust, and repair equipment only if you are trained and qualified.
- If an unsafe condition cannot be immediately fixed, notify your manager or Human Resources immediately.

Q: I've noticed some practices in my area that don't seem safe. Who can I speak to? I'm new here, and don't want to be considered a troublemaker.

A: Discuss your concerns with your manager. There may be very good reasons for the practices. On the other hand, sometimes new eyes see things that more experienced eyes have missed. Raising a concern about safety is not making trouble; it is being responsible.

Abuse of Drugs and Alcohol

Part of maintaining a safe working environment is being certain that every employee is fully awake, aware, and able to do his or her job carefully and safely. We must be mindful of how others might be affected by our actions. We also should be mindful of our intake of alcohol at work-related events.

Remember:

- While at work or on District business, you should be alert, never impaired, and always ready to carry out your work duties.
- The use of alcoholic beverages or illegal substances during working hours will not be tolerated. The possession of alcoholic beverages or illegal substances on District property is forbidden.
- If you have a medical condition that requires you to use medication while working, and that medication could impair your mental or physical capabilities, you must notify Employee Health.

Workplace Violence

The District has a zero tolerance for acts and threats of violence. All such acts and threats, even those made in apparent jest, will be taken seriously, and will lead to discipline up to and including termination.

It is every employee's responsibility to assist in establishing and maintaining a violence-free work environment. Therefore, each employee is expected and encouraged to report any incident which may be threatening to you or your co-workers or any event which you reasonably believe is threatening or violent.

Threats include any indication of intent to harm a person or damage District property. Threats may be direct or indirect, and they may be communicated verbally or nonverbally.

Q: Are visiting physicians, medical personnel, and contractors expected to follow the same health, safety, and security policies and procedures as employees?

A: Absolutely. Managers and supervisors are responsible for ensuring that anyone working on District premises understands and complies with all applicable laws, regulations and policies.

PROTECTING DISTRICT ASSETS

It is our responsibility to care for, properly use, and protect our assets and resources. We must each use our best judgment to make sure District assets are not lost, stolen, or wasted, and are used only for legitimate business purposes. We must never use District assets for personal gain.

Our assets include:

- Our physical facilities;
- Computers, files, documents, and passwords;
- Confidential information;
- Employee time; and
- Machines, equipment, materials, and supplies.

Remember:

- Ask your manager before you take hospital property, such as files or personal computers, off District premises.
- Be aware that Tri-City Healthcare District reserves the right to search all our property, as well as anything brought onto or taken from District premises (including employee personal possessions).
- Do not use our equipment or systems, including email and the internet, to download, create, store, or send content that others might find offensive or that is illegal.
- Do not share passwords or allow others to use District assets.

CONFIDENTIAL INFORMATION

One of the District's most valuable assets is its confidential information. Confidential information includes information not publicly released such as patient information, personnel information, staffing changes, trade secrets, business plans, and employee medical information. The obligation to preserve and protect District confidential information is ongoing, even after employment ends.

Remember:

- Use confidential information only for legitimate operational purposes.
- Share confidential information only with people who need to know it.
- Forward all requests for information regarding a current or former employee's position/compensation with the District to the Human Resources Department.
- Avoid discussing confidential information when others might be able to overhear what is being said.
- Never use confidential information for personal financial gain or to compete with Tri-City Healthcare District.

Employee Privacy

Tri-City Healthcare District is committed to respecting the confidentiality of employees' personal information, such as personal records, photos, social security numbers, medical information, and home addresses. Only such personal data as is necessary will be acquired and retained by the District.

Employees authorized to have access to personal employee data are expected to ensure the security of the information and share it only with authorized persons on a "need-to-know" basis. We must make sure such information is stored securely and we should refrain from holding the information longer than is necessary to meet the legal or business reason for which it was acquired.

Q: Are the emails I send from my computer protected by the District's privacy policy?

A: Tri-City Healthcare District respects the confidentiality of the personal information of employees; however, it is important to remember that employees have no expectation of privacy with regard to workplace communication, including emails, texts, and voicemails. Even communications with your personal attorney will not be privileged if the District email system or computers are used.

Confidential Information – Business partners

Everyone with necessary access to District confidential information who is not employed by the District, including visiting physicians and medical personnel, contractors, and consultants, is expected to adhere to the District's specific policies and procedures with regard to information protection. Managers are responsible for ensuring that our business partners are duly authorized to handle our confidential information and are appropriately cautious with it.

ACCURATE CODING, BILLING, AND RECORDS

Trustees, patients, insurance companies, government officials, and others need to be able to rely on the accuracy and completeness of our business records and invoices. We must be honest in what we say, what we write and what we do. Accurate information is also essential within the District so that we can make good business decisions. This is why our coding, billing, and records must be accurate, timely, complete, and understandable.

Each of us is responsible for helping to ensure that invoices we submit are legitimate and appropriate, and that the codes and information we record are accurate, complete, and maintained in a manner consistent with our system of internal controls.

Remember:

- Always code and bill accurately, only for services rendered and documented properly. Ensure that any bills submitted are consistent with federal billing standards and federal medical program requirements.
- Make sure that financial entries are clear and complete and do not hide or disguise the true nature of any transaction.
- Do not record, understate, or overstate known liabilities and assets, or defer the recording of items which should be expensed.
- Do not maintain undisclosed or unrecorded funds, assets, or liabilities.
- Do not back date documents.
- Never make false claims on an expense report, time sheet, or in billing a health care program.
- If you are uncertain about the validity of an entry or process consult with your manager, or contact Human Resources.
- Only sign documents that you are authorized to sign and that you are certain are accurate and truthful. This includes approving invoices and journal entries as well as 'signing off' on financial statements.
- Bring any evidence of fraud in accounting, financial reporting, or internal controls to the attention of your manager, the Chief Compliance Officer, or the Values Line (800) 273-8452.

PROPER USE OF ELECTRONIC MEDIA

Electronic media includes everything from the content of CDs to email and text messages to websites, television, and radio broadcasts. We should all exercise discretion when using electronic media. These tools should never be used in a way that interferes with the conduct of District business. We also should avoid any usage that might lead to loss or damage, such as the introduction of viruses or a breach of our firewalls. We also must be aware of software licensing rules and never use unauthorized copies of software on District computers, or use District software on our personal computers in a way not intended by the license.

Remember, do not use District equipment:

- To download, save, send, or access any defamatory, discriminatory, obscene or illegal material.
- To gain or attempt to gain unauthorized or unlawful access to computers, equipment, networks, or systems of Tri-City Healthcare District or any other person or entity.
- In connection with any infringement of intellectual property rights, including but not limited to copyrights.
- In connection with the violation or attempted violation of any law.

Use of Social Media

District employees who choose to use social media should do so on their own time, be careful to comply with Policy 8610-479, and avoid discussing any District confidential or work information. Employees also should be careful when posting online to avoid giving the impression that they are speaking on behalf of the District unless authorized to do so.

Think carefully before hitting the 'send' button. These types of communications live forever. Remember, if you are not authorized to speak publically on behalf of the District, you should not do so.

RETENTION AND DISPOSAL OF DOCUMENTS AND RECORDS

Medical and business documents and records must be maintained in accordance with procedures and time frames established by applicable laws, accreditation standards, and the District's document retention policies. Medical and business documents include paper documents, such as letters and memoranda; computer-based information, such as e-mail or computer files on disk or tape; and any other medium that contains information about the District or its business activities.

We will not tamper with records, nor remove or destroy them before the time period specified in the District's document retention policies, and we will not destroy any records we know relate to pending litigation or government investigation.

Meeting the Letter and the Spirit of Laws and Regulatory Requirements

COMPLIANCE AND TRANSPARENCY

We are obligated to follow all relevant local, state, and federal laws and regulations. Each of us is responsible for knowing which of these apply to our respective jobs. An employee who is unclear about a law is responsible for asking questions of his or her manager, the Legal Department, or Human Resources. Failure to comply with the laws and regulations which govern our services undermines our mission and will ultimately lead to serious consequences for the District and its employees.

Transparency is key to maintaining a culture of compliance with healthcare laws and regulations. When we are open and clear about our actions we can more readily demonstrate our compliance, and we can more easily spot and remedy any errors or confusion about a law or regulation.

CONFLICTS OF INTEREST

A conflict of interest occurs whenever an employee has a competing interest that may interfere with his or her ability to make a sound, objective decision for the District. We must never use our positions with Tri-City Healthcare District, or with any of its patients or vendors, for private gain, to advance personal interests, or to obtain favors or benefits for ourselves, members of our families, or any other individuals or entities. Each of us is expected to use good judgment and avoid situations that can lead to even the appearance of a conflict.

It is impossible to describe every potential conflict. Therefore, the District relies on each of us to uphold the highest standards of integrity and to seek advice when needed. Please consult Policy 8610-462 or Human Resources for more specific information.

Remember:

- If you believe a conflict or potential conflict exists, you must disclose it to your manager, or Human Resources.
- Any situation that creates, or even appears to create, a conflict of interest between your personal interests and the interests of the District and our patients should be avoided.

Personal Relationships

We must not let personal relationships with friends or family members influence our work-related decisions in a way that causes us to act against the best interests of Tri-City Healthcare District. This includes decisions made about hiring employees, selecting vendors, and billing. Employees should obtain management approval before becoming involved in such decisions.

Financial Incentives to Provide Care

We should be especially careful to avoid even the appearance of any conflicts of interest in our dealings with physicians and other healthcare providers. We must never offer or provide anything of value to encourage or reward referrals from other healthcare professionals, and we also must not accept them. These types of gifts are typically viewed as bribes or kickbacks, which are illegal.

Remember:

- Do not offer, pay, or accept bribes or kickbacks.
- Do not tie compensation to volume or value of referrals.
- If you are aware of a District employee who is offering, paying, or receiving kickbacks or bribes, or if you suspect such behavior is occurring, report your concern to your manager, the Chief Compliance Officer, or the Values Line (800) 273-8452.

Outside Business or Employment

Tri-City Healthcare District employees occasionally take on additional, outside employment. This could constitute a conflict of interest if that outside work interferes with the employee's ability to fulfill his or her responsibilities to the District, or if there is a risk that the outside employment may cause the employee to disclose District confidential information.

An employee who plans to take on outside employment or who already has an outside job or consulting arrangement that is related in any way to the healthcare industry must disclose it to Human Resources. Please see Policy 8610-462 for more detailed information.

Personal Investments or Transactions

Ownership by a District employee of an investment in a vendor, competitor or business partner could influence decisions made by that employee. For those employees who are not already required to annually disclose such interests under the District Conflict of Interest Code, such ownership interests in companies not publicly traded on a national stock exchange must be reported to Human Resources.

Additionally, any District employee who holds an ownership stake in any other healthcare entities (e.g., labs, outpatient imaging centers, rehabilitation facilities, etc.) must be careful about how this ownership affects any decisions made on behalf of the District. Referring Tri-City patients to such entities is called self-referral and may implicate and violate various anti-self-referral and anti-inducement laws and regulations. In addition, such interests are reportable by employees designated in the District Conflict of Interest Code, and may result in disqualification from some decision-making.

Boards, Panels, Foundations, Consulting Arrangements

Memberships or participation in outside organizations, especially those which oversee, approve actions by, receive grants from, or have contracts with the District, should be disclosed in advance to Human Resources. Examples of such arrangements are municipal Board memberships; focus groups, discussion panels and advisory boards for makers of healthcare products; community health clinic boards; and participation in a Foundation that distributes financial support to research or healthcare entities. You may be directed to manage such conflicts by removing yourself from any decision making that will impact Tri-City Healthcare District. In some instances in which a conflict of interest precludes you from carrying out your responsibilities to the District, resignation may be necessary.

ACCEPTING GIFTS AND ENTERTAINMENT

District employees are not allowed to accept gifts or gratuities that are inconsistent with Policy 8610-425, 8610-462, this Code, or that could influence decisions regarding patient care or business. We have one excellent standard of care for all patients, and that standard should not be affected in any way by gifts.

PROVIDING GIFTS, MEALS AND ENTERTAINMENT

Gifts, meals or entertainment may only be given to others if they are reasonable complements to business relationships, are of modest value, and are not against the law or the policy of the District or the recipient's organization. While it is a legitimate business activity to entertain our business partners and prospects ancillary to our business with them, no such activity should involve behavior that would otherwise violate policies or reflect poorly on our reputation. In addition, these activities may implicate the federal health care program anti-kickback law (the "Anti-Kickback Law"), 42 U.S.C. § 1320a-7b(b), and the federal physician self-referral law (the "Stark Law"), 42 U.S.C. § 1395nn.

Remember:

- Before you provide gifts or entertainment, be sure it is consistent with both District policy and the policies of the recipient's employer.
- Never provide gifts to government officials without prior Legal Department approval.

COMPLIANCE WITH GOVERNMENT HEALTHCARE REGULATIONS

Tri-City Healthcare District complies with all federal, state, and local laws that govern our healthcare practices. We operate in full cooperation with the Federal False Claims Act and the Deficit Reduction Act, which are intended to protect government programs including Medicare, Medicaid, and TRICARE from fraud, waste and abuse. Our policies promote accuracy and transparency in our coding and billing practices for both government and private payers, and we offer protection for whistleblowers.

We comply fully with EMTALA, which protects patients seeking emergency care, and are committed to providing all necessary care to any patients who come to us requiring emergency medical treatment. We adhere to all laws governing improper payments, such as the Federal Anti-Kickback Law, which prohibits offering, giving, or accepting anything of value to motivate or reward referrals.

WORKING WITH REGULATORY AUTHORITIES

Tri-City Healthcare District and its employees are committed to cooperate with all regulatory authorities. We will provide any information required by state and federal audits and investigations promptly, fully, and honestly. We will not alter, withhold, or destroy any records related to an investigation.

Employees should notify the Legal Department before responding to a subpoena, search warrant, request for an interview or other non-routine request for access to information related to District matters.

Our Commitment to the Community

TRI-CITY HEALTHCARE DISTRICT – IN THE COMMUNITY

We have a responsibility, as a healthcare provider, to be a good corporate citizen. We encourage participation in, and strive for the improvement of, the communities in which we live and work. We support giving and volunteering in our communities, and we understand the value of our good reputation to our communities.

While employees are encouraged to be involved in community organizations and projects of their choice, we should never present our personal views or actions as if they represent Tri-City Healthcare District's position. Any charitable contributions or donations on behalf of the District must be approved by the Board of Directors.

Outside activities must not interfere with job performance. Employees should not exert improper influence in business decisions regarding a charity or other organization where they volunteer.

Q: *My manager often asks me to buy candy bars as part of fund raising activities for his children's schools. He also encourages us to support his favorite charities and sponsor him in fundraising walks and races. Sometimes I feel I don't have a choice. What can I do?*

A: *Selling, soliciting, or collecting contributions for any purpose on the District's premises is prohibited. The only exception is for District-approved fundraisers such as March of Dimes. In addition, pressuring others to contribute to or join charities, groups, or political activities is not allowed. Your manager may not view his actions as 'pressure' and may not be aware of our policy. If you are comfortable doing so, talk to him about the problem. As an alternative, you can contact Human Resources.*

ENVIRONMENTAL COMPLIANCE

The District actively seeks opportunities to improve the quality of life in our communities and to improve the environment that sustains us all. We recognize the need to provide our services in a way that protects and improves the state of the environment for future generations.

We are committed to meeting or exceeding applicable environmental laws and regulations and to continuously improving our environmental performance through resource conservation, waste minimization, and water and energy efficiency.

Remember, we must:

- Comply with all applicable environmental laws, regulations, and District policies.
- Be proactive and help identify opportunities for improving our environmental performance, including, for example, additional ways that we can conserve and recycle.
- Support waste reduction and recycling efforts at the District and in our communities.
- Comply with medical waste disposal protocols.

COMMUNICATING WITH THE PUBLIC

Tri-City Healthcare District needs a clear, consistent voice when providing information to the public and the media. For this reason, it is important that only authorized persons speak on behalf of the District. Employees should never give the impression that they are speaking on behalf of the District in any communication that may become public if they are not authorized to do so.

Remember:

- If you receive an inquiry regarding District activities, results, or plans, or its position on public issues, and are not specifically authorized by District leadership to respond, refer the request to your manager.
- Obtain approval from the Legal Department, Chief Executive Officer, or Director of Public Relations before making public speeches, writing articles for professional journals, or engaging in other public communications on behalf of the District.

POLITICAL CONTRIBUTIONS AND POLITICAL ACTIVITY

As a responsible healthcare provider and member of our community, we respect the rights of employees to voluntarily participate in the political process outside of work hours and beyond District premises.

We also are committed to following the rules and requirements set forth by the Political Reform Act of 1974 in its most current form.

Employees must always make it clear that their views and actions are their own and not those of Tri-City Healthcare District. Employees must not use the District's resources to support their personal choice of political parties, causes, or candidates.

Remember:

- Lobbying activities or government contacts on behalf of the District must be coordinated with management, and be consistent with Board-adopted policies, as well as local and state registration laws.
- The District may not engage in any political spending, including donating products, services, transportation, or facilities to politicians or political organizations.
- Holding or campaigning for political office must not create, or appear to create, a conflict of interest or incompatibility with your duties at the District.

Q: *What types of expenditures are covered by the prohibition on political contributions by the District?*

A: *Political contributions include monetary spending, as well as indirect contributions such as the purchase of tickets to a political fundraiser. The prohibition also applies to "in-kind" contributions such as the use of District personnel or facilities, telephones, email systems, or payment for services.*

**ADMINISTRATIVE POLICY Manual
COMPLIANCE**

ISSUE DATE: 12/02

SUBJECT: Disclosure of Protected Health
Information (PHI)

REVISION DATE(S): 02/03, 09/05, ~~09/10~~

POLICY NUMBER: 8610-513

Administrative Compliance Content Expert Approval:	10/18
Administrative Policies & Procedures Committee Approval:	09/10 12/18
Operations Team Committee Approval:	10/10
Organizational Compliance Committee Approval:	12/18
Medical Executive Committee Approval:	01/19
Audit, Compliance & Ethics Committee:	02/19
Administration Approval:	
Professional Affairs Committee Approval:	11/10
Board of Directors Approval:	12/10

A. **PURPOSE:**

1. To establish a policy/guidelines at Tri-City Healthcare District (~~"District"~~ TCHD) for the release of protected health information ("PHI") for uses and disclosures that require a patient have an opportunity to agree or to object. This policy addresses the following categories of ~~circumstances for the release of protected health information~~ **uses and disclosures of PHI:**
2. ~~Use and Disclosure of Health Information:~~
 - a. Facility Directory
 - b. Emergency Circumstances
 - c. Disclosure to Family/Others Involved in Care
 - i. With patient present
 - ii. When patient is not present

B. **POLICY:**

1. Disclosures of ~~health information~~ **PHI** should be limited to the minimum necessary as indicated by the patient authorizing release to achieve the purpose of the disclosure. ~~TCMC-TCHD~~ personnel may exercise professional judgment in determining minimum necessary information to achieve purpose of disclosure when a disclosure may avert a serious threat to health or safety.
2. Categories for the release of ~~health information~~ **PHI** are as follows:
 - a. Use and disclosure for Facility Directory. Permitted uses and disclosure. Except for **patients with Behavioral health Issues** ~~Patients whose information is never listed in the directory and when an objection is expressed, TCMC-TCHD may use the following PHI to maintain a directory of patients in its facility:~~
 - i. Patient's name
 - ii. Patient's location in the facility ~~TCMC-TCHD~~
 - iii. Patient's condition (described in general terms that does not communicate specific medical information about the patient)
 - 1) Undetermined. Patient is awaiting physician assessment.
 - 2) Good. Vital signs stable, within normal limits. Patient is conscious, comfortable. Indicators are excellent.
 - 3) Fair. Vital signs stable, within limits. Patient is conscious, may be uncomfortable. Indicators are favorable.
 - 4) Serious. Vital signs may be unstable, not within normal limits. Patient acutely ill. Indicators questionable.
 - 5) Critical. Vital signs unstable, not within normal limits. Patient may be

- unconscious. Indicators are unfavorable.
- 6) Deceased. No other information may be released by hospital ~~TCMCTCHD~~.
- iv. Patient's religious affiliation
- b. Directory information can be disclosed to:
- i. Members of the clergy
- ii. Other persons who ask for the patient by name (the patient's religious affiliation shall not be disclosed to such persons).
- c. Patient's opportunity to object: ~~TCMG-TCHD~~ must inform a patient of the PHI that it may include in a directory and the persons to whom it may disclose such information (including disclosures to clergy of information regarding religious affiliation) and provide the patient with the opportunity to restrict or prohibit some or all of the uses or disclosures.
- d. Circumstances not requiring patient consent: If the patient's opportunity to object to uses or disclosures cannot practicably be provided because of the patient's incapacity or an emergency treatment circumstance, ~~TCMG-TCHD~~ may use or disclose some or all of the PHI permitted under this section for ~~TCMG's-TCHD's~~ directory, if such disclosure is:
- i. Consistent with a prior expressed preference of the patient, if any is known to the covered health care provider
- ii. In the patient's best interest as determined by ~~TCMG~~ the treating healthcare professional, in the exercise of their professional judgment.
- iii. ~~TCMG-TCHD~~ must inform the patient and provide an opportunity for the patient to object to uses or disclosures for directory purposes when it becomes practicable to do so.
- e. Use and Disclosure to Family/Others involved in Patient's care: ~~TCMG-TCHD~~ may disclose to a family member, other relative, or a close personal friend of the patient, or any other person identified by the patient, the PHI directly relevant to such person's involvement with the patient's care.
- i. ~~TCMG-TCHD~~ may use or disclose PHI to notify, or assist in the notification of (including identifying or locating) a family member, a personal representative of the patient, or another person responsible for the care of the patient. Information may include:
- 1) Patient's location at ~~TCMCTCHD~~
- 2) General condition
- 3) Death
- 3)ii. **See Patient Care Services Policy: Privacy Code for additional information.**
- f. Use and Disclosure with the Patient present: If the patient is present for, or otherwise available prior to, use or disclosure and has the capacity to make health care decisions, ~~TCMG-TCHD~~ may use or disclose the PHI if it:
- i. Obtains the Patient's agreement; (~~i.e. privacy code per Patient Care Services Policy: Privacy Code~~)
- ii. Provides the patient with the opportunity to object to the disclosure, and the patient does not express an objection; or
- iii. Is in the patient's best interest as determined by ~~TCMG~~ the treating healthcare professional, in the exercise of their professional judgment.
- g. Use and Disclosure when the Patient is not present: If the patient is not present for, or the opportunity to agree or object to the use and disclosure cannot practicably be provided because of the patient's incapacity or an emergency circumstance, ~~TCMG~~ the treating healthcare professional may, in the exercise of their professional judgment, determine whether the disclosure is in the best interests of the patient and, if so, disclose only the PHI that is directly relevant to the person's involvement with the patient's health care. ~~TCMG-TCHD~~ may use professional judgment and its experience with common practice to make reasonable inferences of the Patient's best interest in allowing a person to act on behalf of the patient to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of PHI.

- h. Use and Disclosure for Disaster Relief Purposes: See ~~TCMC~~-TCHD Disaster Manual for information regarding disclosure of PHI for disaster relief purposes.

C. **RESPONSIBILITIES:**

1. All personnel providing services ~~within~~ on behalf of ~~TCMC~~-TCHD to include but not limited to, employees, volunteers, physicians, Allied Health Professionals, students and affiliated business associates are responsible for awareness of this policy and for protecting patient health information from unauthorized release. The protection of health information and appropriate release of information is a shared responsibility of all personnel to safeguard the information against loss, tampering, access, or use by unauthorized persons.

D. **INFORMATION/DISCLOSURE:**

1. ~~TCMC~~-TCHD may orally inform the patient of and obtain the patient's oral agreement or objection to a use or disclosure.
2. ~~TCMC~~-TCHD must obtain permission from the parent or guardian for patients who are minors (under 18 years of age) except in the following circumstances:
 - a. Emancipated minors (in addition to other specified categories of minors), as specified by law, may inspect or request copies of part or all of their health record.
 - b. Pregnancy
 - c. Drug abuse
 - d. Mental health
 - e. Reportable disease
 - f. Rape
 - g. Sexual assault
3. Patient's agreement or objection will be noted in ~~TCMC's~~ the registration system. In the event patient objects to the use and disclosure of PHI the information will not be used or disclosed.

E. **CROSS-REFERENCED RELATED DOCUMENT(S):**

1. Administrative Human Resources Policy: ~~455~~-Confidentiality 8610-455
2. Administrative Human Resources Policy: ~~424~~-Coaching and Counseling for Work Performance Improvement 8610-424
3. Administrative Human Resources Policy: ~~479~~-Social Media 8610-479
4. Administrative Compliance Policy: ~~594~~-Minimum Necessary Requirements for Use and Disclosure of PHI 8610-594
- 3-5. Patient Care Services Policy: Privacy Code

F. **REFERENCE(S):**

1. Guidance and complete information beyond the scope of this policy for release of information will be obtained from the California Hospital Association Consent Manual, ~~and~~ Federal Register-~~164~~. (79 FR 784) and Code of Federal Regulations (45 CFR 164)
2. ~~Federal Register-164.~~



Tri-City Medical Center
Oceanside, California

**ADMINISTRATIVE POLICY MANUAL
COMPLIANCE**

ISSUE DATE: New

SUBJECT: HIPAA Mitigation

REVISION DATE(S): 08/15

POLICY NUMBER: 8610-591

Administrative Compliance Content Expert Approval:	11/18
Administrative Policies and Procedures Approval Date(s):	06/15 12/18
Organizational Compliance Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Audit, Compliance and Ethics Committee Approval Date(s):	08/15 02/19
Board of Directors Approval Date(s):	08/15

A. PURPOSE:

1. The purpose of this Policy is to establish guidelines for mitigating ~~to the extent practicable of~~ any harmful effects ~~that are known to~~ Tri-City Healthcare District ("TCHD") arising from the Use or Disclosure of Protected Health Information in violation of TCHD's policies and procedures or applicable state and federal privacy laws.

B. DEFINITION(S):

1. Business Associate: ~~a~~A person or organization who, on behalf of the District, ~~performs certain functions or activities involving the use or Disclosure or activities involving the Use or Disclosure of Protected Health Information (PHI) or services that require the Business Associate to create, receives, maintains or transmits PHI on behalf of the District or where the District needs to Discloses PHI to Business Associates. for the services.~~
2. Disclosure: ~~The release, transfer, provision of, or access to or divulging of PHI outside TCHD.~~
3. Electronic Protected Health Information or ("EPHI"): PHI that is transmitted by Electronic Media or Maintained in Electronic Media.
4. Protected Health Information ("PHI"): ~~is h~~Health data created, received, stored, or transmitted by HIPAA-covered entities and their business associates in relation to the provision of healthcare, healthcare operations and payment for healthcare services. individually identifiable health information transmitted or maintained in paper or electronic form that is created or received by TCHD AND
 - a. Relates to the past, present or future physical or mental health or condition of an individual; OR
 - b. Relates to the provision of health care to an individual; OR
 - c. Relates to the past, present or future payment, AND
 - d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
5. Use: the sharing, application, utilization, examination or analysis of PHI within TCHD.
6. Workforce member: ~~employees~~Employees, Medical Staff and Allied Health Professionals, volunteers, trainees, and other persons whose conduct, in the performance of work for TCHD is under the direct control of TCHD whether or not they are paid by TCHD.

C. POLICY:

1. TCHD shall mitigate, to the extent practicable, any harmful effects that are known to TCHD arising from a Use or Disclosure of a patient's PHI, ~~including EPHI~~, in violation of TCHD's policies and procedures or applicable state and federal laws.

D. **PROCEDURE:**

1. Investigation and Evaluation

- a. The Chief **Compliance and Privacy** Officer or designee will investigate reports of a potential or suspected violation of privacy rights, whether by a Workforce ~~Member~~, Medical Staff, or a Business Associate. If the report is substantiated, the Chief **Compliance and Privacy** Officer will consult with the **appropriate TCDH leaders** ~~Senior VP Information Technology/Security Officer, the Chief Compliance Officer, Chief Nurse Executive/Senior VP, Senior Director Clinical Risk Management, Quality and PI, Director of Regulatory Compliance and Quality~~ and/or legal counsel to determine the extent of any harmful effects resulting from the incident.
- b. An evaluation will be conducted to determine the nature and extent of any harmful effects. The evaluation will consider the following factors:
 - i. Whether any damage occurred;
 - ii. The type of damage;
 - iii. The nature and extent of PHI (including types of identifiers) that was Use or Disclosed;
 - iv. The reason for the Use and Disclosure;
 - v. The extent of distribution of the improperly Disclosed PHI, including the identity of recipients;
 - vi. The cause of the violation including any TCHD policies and procedures and/or privacy laws that were violated by the Use or Disclosure; and
 - vii. Any other information that is relevant to the evaluation.

2. Mitigation Steps

- a. Based on the evaluation, the Chief **Compliance and Privacy** Officer and/or the Security Officer shall determine appropriate actions to mitigate harm caused by the violation and **will consult with appropriate TCHD leadership as needed.** ~~after consultation with the Chief Compliance Officer, Chief Nurse Executive/Senior VP, Senior Director Clinical Risk Management, Quality and Performance Improvement (PI) Director of Regulatory Compliance and Quality and/or legal counsel.~~
- b. Mitigation steps may include any of the following actions or a combination of them:
 - i. Amend applicable policies and procedures to assure that the violation does not recur;
 - ii. Provide focused training and education to person(s) responsible for the violation and/or to a category of ~~Workforce~~ **workforce** members depending on the scope of the violation and policy changes;
 - iii. Impose sanctions and/or disciplinary actions up to and including termination against person(s) responsible for the violation in accordance with TCHD's policies;
 - iv. Attempt to recover the improperly Used or Disclosed PHI ~~including EPHI~~ (or obtain confirmation of its destruction) (e.g. misdirected fax, delivery of PHI to wrong patient);
 - v. Deactivate/disable access to EPHI (e.g. remotely wipe/lock mobile devices where lost or stolen);
 - vi. Identify and correct Information Technology ("IT") system or physical space vulnerabilities, if any that contributed to the violation;
 - vii. Notify affected Individuals of the violation in accordance with TCHD's security incident/breach response policies and of self-protective actions that may be taken to ameliorate or avoid potential harm (e.g. identity theft); and/or
 - viii. Other actions as determined by the Chief **Compliance and Privacy** Officer and/or Security Officer in consultation with Executive Management and/or legal counsel, if applicable.

3. Business Associate Violations

- a. In the event that TCHD learns of a potential or actual violation of a Use or Disclosure of PHI by one of its Business Associates, TCHD must, if practicable, mitigate the harmful

effects of such violation. The **Chief Compliance and Privacy Officer** and/or **Security Officer**, in consultation with legal counsel, **if applicable**, will contact the **Business Associate** to develop a mitigation plan.

- b. TCHD will also review whether further action is required under the terms of the **Business Associate Agreement** and TCHD's policies and procedures based on the nature and extent of the violation (e.g. termination).

E. RELATED DOCUMENT(S):

1. **Administrative Compliance Policy: HIPAA Administrative Requirements 8610-585**
2. **Administrative Compliance Policy: Protected Health Information (PHI) Breach Response 8610-586**
3. **Administrative Compliance Policy: Sanctions for Non-Compliance with Privacy and Security Policies & Procedures 8610-531**
4. **Administrative Compliance Policy: Business Associate Agreement 8610-511**
5. **HIPAA Business Associate Agreement**

E.F. REFERENCE(S) LIST:

1. 45 Code of Federal Register (CFR) Section 160.103
2. 45 CFR Section 164.530(f)
- 2.3. **California HIPAA Codes and Regulations**
3. ~~TCHD HIPAA Administrative Requirements Policy No. 8610-503~~
4. ~~TCHD Sanctions Policy No. 8610-531~~
5. ~~TCHD HIPAA Breach Response Policy No. 8610-546~~



BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the "Agreement") is entered into by and between Tri-City Healthcare District, a health care district organized under the Local Health Care District Law of the State of California ("HOSPITAL"), and _____ ("CONTRACTOR") (the HOSPITAL and CONTRACTOR may be referred to individually as a "Party" and collectively as the "Parties"), and is effective, as detailed within, when signed by authorized representatives of both Parties.

RECITALS

- A. HOSPITAL and CONTRACTOR wish to form or have already formed a business relationship, under which CONTRACTOR may perform certain functions for or on behalf of HOSPITAL involving either or both of the Disclosure of Protected Health Information (hereafter "PHI") by HOSPITAL to CONTRACTOR and/or the creation or Use of PHI by CONTRACTOR on behalf of HOSPITAL.
- B. HOSPITAL and CONTRACTOR intend to protect the privacy and provide for the security of PHI Disclosed to or Used by CONTRACTOR pursuant to this Agreement, in compliance with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104.191; commonly referred to as "HIPAA"), the regulations promulgated thereunder, and other applicable laws, including without limitation the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (Public Law 111-005; commonly referred to as the "HITECH Act"), the HIPAA Final Omnibus Rule of January 2013, the California Medical Information Act ("CMIA") (CA Civil Code §§ 56-56.37), the California Information Practices Act (CA Civil Code §§ 198-1798.78), California Health & Safety Code § 1280.15, California Health & Safety Code §§ 123100-123149.5, and any statutes and regulations adopted or to be adopted in conjunction with or pursuant thereto (hereinafter, collectively referred to as the "HIPAA Rules").
- C. HOSPITAL may engage in one or more enterprises governed by HIPAA regulation 45 C.F.R. § 160.103, and may require services from CONTRACTOR, the nature of which may require that PHI be Used or generated by CONTRACTOR on behalf of HOSPITAL.
- D. This Agreement sets forth the terms and conditions pursuant to which PHI that is created, received, maintained, or transmitted by CONTRACTOR, from or on behalf of HOSPITAL, shall be managed. This Agreement supplements and/or amends each of the Contractual Agreements with respect to CONTRACTOR's creation, receipt, Use, and transmission of PHI thereunder, so as to allow HOSPITAL and CONTRACTOR to comply with the HIPAA Rules.

In consideration of the mutual promises below, in contemplation of the exchange of information under this or other contractual arrangements and in order to comply with legal requirements for the protection of this information, the parties agree as follows:

1. DEFINITION OF TERMS

- 1.1 **Catch-all definition.** The following terms (and any other capitalized terms not specified here), if used in this Agreement, shall have the same meaning as those terms in the HIPAA Rules: Accounting of Disclosures, Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.
- 1.2 **Agreement** means this Business Associate Agreement.
- 1.3 **Contractual Arrangements** shall refer to all other contracts, memoranda of understanding or agreement, or any similar instruments or oral arrangements establishing the exchange of goods or services between HOSPITAL and CONTRACTOR.
- 1.4 **De-identified** shall have the meaning set forth in 45 C.F.R. § 164.514(b). This definition, and the related section of the HIPAA Rules, specifies that all 18 of the PHI identifiers shall be removed. De-identified information does not constitute Protected Health Information and is not subject to the terms of this Agreement so long as the information remains separated from any information by which the Record Subject may be identified.
- 1.5 **HOSPITAL** shall mean the Party so named above, and shall include any members of its workforce, officers, agents, representatives and contractors.
- 1.6 **CONTRACTOR** shall mean the Party so named above, and any members of its workforce, officers, agents, subcontractors, representatives and affiliated contractors.
- 1.7 **Record Subject** shall mean the Individual who may be identified by, and who is the subject of, any record or records containing PHI.

2. RIGHTS OF CONTRACTOR

- 2.1 **Data Ownership:** CONTRACTOR acknowledges that he or she has no ownership interest in PHI received from HOSPITAL or created on HOSPITAL's



behalf. CONTRACTOR will take no actions and make no representations that contradict this acknowledgment.

- 2.2 **Services:** Except as otherwise specified in this Agreement or by law, CONTRACTOR may make any and all Uses or Disclosures of PHI necessary to perform its obligations to HOSPITAL under existing or future Contractual Arrangements. All other Uses or Disclosures are prohibited. CONTRACTOR may Use or Disclose PHI for the purposes made necessary under its Contractual Arrangements with HOSPITAL only (i) to members of its workforce, contractors, and agents, in accordance with this Agreement; or (ii) as directed by the HOSPITAL.

3. OBLIGATIONS AND ACTIVITIES OF CONTRACTOR

With regard to his or her Use and/or Disclosure of PHI, CONTRACTOR agrees to:

- 3.1 Use or Disclose the Minimum Necessary PHI that it receives from or creates for HOSPITAL only as permitted or required by this Agreement or as otherwise Required by Law. [164.502(a)(4)(i) and (ii); 164.504(e)(2)(i); 164.504(e)(2)(ii)(A)] This includes, but is not limited to, CONTRACTOR being able to:
- a. Disclose PHI when required by the Secretary to investigate or determine the CONTRACTOR's compliance with the HIPAA Rules.
 - b. Disclose PHI to the HOSPITAL, Individual, or Individual's designee, as necessary to satisfy a HOSPITAL's obligations under § 164.524(c)(2)(ii) and (3)(ii) with respect to an Individual's request for an electronic copy of PHI.
 - c. Use the PHI in its possession for its own normal management and administration, and to fulfill any present or future legal responsibilities of CONTRACTOR, provided that such Uses are permitted under California and federal confidentiality laws.
 - d. Disclose the PHI in its possession to third parties for the purpose of its own normal management and administration, or to fulfill any present or future legal responsibilities of CONTRACTOR, provided that:
 - i. the Disclosures are Required by Law; or
 - ii. CONTRACTOR has received from the third party reasonable assurances that that entity will treat PHI as CONTRACTOR would under this Agreement including, where applicable, via written contract as required in 45 C.F.R. § 164.504(e)(5).
 - e. provide Data Aggregation services relating to the Health Care Operations of HOSPITAL. Under no circumstances may

CONTRACTOR Disclose PHI of HOSPITAL to another Covered Entity absent the explicit authorization of HOSPITAL.

- f. request PHI in the form of a Limited Data Set, to be used for limited research, public health or health care operations purposes.
 - g. De-identify PHI obtained by CONTRACTOR under this Agreement and use such De-identified data, provided that such use is in accordance with the De-identification requirements of the HIPAA Rules.
- 3.2 report to HOSPITAL's designated Privacy Officer any Use or Disclosure of PHI that is not permitted or required by this Agreement, and in addition, report to HOSPITAL's designated Privacy Officer any Security Incident, or any Breach (as defined in the HITECH Act or applicable state law, including without limitation section 1280.15 of the California Health & Safety Code), **within 1 day** of CONTRACTOR's discovery of such Breach, Security Incident, and/or unauthorized Use or Disclosure, with pertinent detail as this information is collected and to include the Risk Assessment performed by CONTRACTOR (and any necessary supporting information) in accordance with the HIPAA Rules included or following as soon thereafter as may be possible and mutually agreed by the Parties. [164.314(a)(2)(i)(C); 164.504(e)(2)(ii)(C); 164.410(b); 164.410(c)]
- 3.3 establish and act upon policies and procedures for protecting the privacy and security of PHI, including, but not limited to, contingency planning/backup and periodic security training, as required by the HIPAA Rules, and to the extent the CONTRACTOR is to carry out HOSPITAL's obligations the CONTRACTOR will comply with the requirements of 45 C.F.R., Part 164, Subpart C and Subpart E. [164.314(a)(2)(i)(A); 164.504(e)(2)(ii)(B); 164.504(e)(2)(ii)(H)]
- 3.4 implement administrative, physical, and technical safeguards that meet or exceed industry-standards and appropriately protect the confidentiality, integrity, and availability of the PHI that it creates, receives, maintains, or transmits on behalf of HOSPITAL, as required by the HIPAA Rules, covering at a minimum those elements of the HIPAA Rules made directly applicable to CONTRACTOR or any of CONTRACTOR's contractors. [164.504(e)(2)(ii)(B)]
- 3.5 ensure, through written contract or similar vehicle, that any subcontractor that creates, receives, maintains or transmits PHI on behalf of CONTRACTOR or HOSPITAL, agrees to the same restrictions and conditions that apply through this Agreement to CONTRACTOR with respect to such information. [164.314(a)(2)(i)(B); 164.504(e)(2)(ii)(D)]
- 3.6 make available its internal practices, books and records relating to any Use or Disclosure of PHI to the Department of Health and Human Services for purposes of determining HOSPITAL's and/or CONTRACTOR's compliance with the HIPAA Rules. [164.504(e)(2)(ii)(I)]



- 3.7 provide HOSPITAL any information requested by HOSPITAL, in writing, that is needed to permit HOSPITAL to respond under the HIPAA Rules to a request by a Record Subject for an Accounting of the Disclosures of PHI of the individual, **within 10 business days** of the request; the response shall be in electronic format if so required by the HITECH Act and requested by HOSPITAL, and shall cover the lesser of the timeframe specifically requested or the maximum timeframe that over which such information must be retained by HOSPITAL and/or CONTRACTOR under the applicable portion of the HIPAA Rules, in accordance with 45 C.F.R. § 164.528. [164.504(e)(2)(ii)(G)]
- 3.8 return to HOSPITAL or destroy, **within 20 business days** of the termination of this Agreement, all PHI in CONTRACTOR's possession and retain no copies, transcripts or backups thereof. In the event that it is infeasible to return or destroy some PHI, CONTRACTOR agrees to inform HOSPITAL in writing **within 10 business days**, and to limit further Use or Disclosure of the PHI to those purposes that make return or destruction infeasible, and to maintain the protections specified in this Agreement for any retained information, for as long as the information is retained by CONTRACTOR. [164.504(e)(2)(ii)(J)]
- 3.9 Use internally and/or Disclose to CONTRACTOR's contractors, agents or other third parties, and request from HOSPITAL, only the Minimum Necessary PHI to perform or fulfill a specific function permitted or Required by Law or CONTRACTOR's Contractual Arrangements with HOSPITAL, utilizing Limited Data Sets wherever feasible and practicable, as further specified in Section 3.13 of this Agreement and as required by the HIPAA Rules. [164.502(b); 164.514(d)]
- 3.10 defer to HOSPITAL with respect to any notifications that may be necessary, as specified in Sections 4.3 and 4.4 of this Agreement, in the event of a Breach.
- 3.11 allow HOSPITAL, within ten (10) business days of a written request to CONTRACTOR by HOSPITAL, to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies, and procedures of CONTRACTOR relating to the Use or Disclosure of PHI pursuant to this Agreement and the HIPAA Rule.
- 3.12 **With Respect to the Handling of Designated Record Sets**, CONTRACTOR further agrees to:
- a. provide access to the PHI for HOSPITAL or the Record Subject to whom such PHI relates (or his or her authorized representative), at the request of, and within the timeframe designated by the HIPAA Rules and HOSPITAL, in order to meet a request by such Individual under the HIPAA Rules, in accordance with 45 C.F.R. § 164.524. [164.504(e)(2)(ii)(E)]



- b. make any amendment(s) to the PHI required by the HIPAA Rules that HOSPITAL directs, at the request of and within the timeframe designated by the HIPAA Rules and HOSPITAL, in accordance with 45 C.F.R. § 164.526. [164.504(e)(2)(ii)(F)]

3.13 With Respect to the Use or Disclosure of Limited Data Sets, CONTRACTOR further agrees to:

- a. limit the use of the Limited Data Set to the specific research, public health, or health care operations purposes for which the data was requested;
- b. make no attempt to reconstruct the identity of the Record Subject from the Limited Data Set;
- c. establish in advance what entities other than CONTRACTOR may be asked by CONTRACTOR to Use or Disclose the Limited Data Set, obtain agreements from such entities to abide by the specific restrictions applicable to CONTRACTOR with respect to Limited Data Sets (as set forth in this section 3.13), and certify compliance with this section to HOSPITAL in writing.

4. OBLIGATIONS OF HOSPITAL

- 4.1 HOSPITAL shall not request CONTRACTOR to Use or Disclose PHI in any manner that would violate this Agreement or the HIPAA Rules.
- 4.2 With regard to the Use or Disclosure of PHI by CONTRACTOR, HOSPITAL agrees to notify CONTRACTOR, in writing and in a timely manner, of any arrangements or limitations permitted or required of the HOSPITAL under the HIPAA Rules that will significantly impact the Use or Disclosure of PHI by CONTRACTOR under their Contractual Arrangements, including, but not limited to, restrictions on Use or Disclosure of PHI agreed to by the HOSPITAL pursuant to a Record Subject's approved request for additional privacy restrictions.
- 4.3 Notification to Individual. It is the sole responsibility of the HOSPITAL to notify Individuals of any Breach of PHI. At no time, is CONTRACTOR to contact or speak directly with any of HOSPITAL's Individuals who are the subject of any Breach of PHI. Any such inquiries should be directed to the HOSPITAL's Privacy Officer. CONTRACTOR shall cooperate with HOSPITAL as necessary to provide such notification and any details pertaining to any Breach of PHI.
- 4.4 Notification to Media. For a Breach of PHI involving more than 500 Individuals, it is solely the responsibility of HOSPITAL to notify the media and appropriate law enforcement and federal and state agencies as required by the HITECH Act, 45 C.F.R. § 164.406, and applicable state law. At no time is CONTRACTOR to contact or speak directly with the media without the prior



authorization of HOSPITAL. CONTRACTOR shall cooperate with HOSPITAL as necessary to gather information or provide such notification to the media.

5. WARRANTIES AND REPRESENTATIONS

Each Party represents and warrants to the other Party that all of its workforce members, officers, agents, representatives and contractors whose services may be used to fulfill obligations under this Agreement or other Contractual Arrangements are or shall be appropriately informed of their responsibilities and duties with respect to PHI and the HIPAA Rules, are qualified to render those services competently and in compliance with the HIPAA Rules, and are under legal obligation to each Party, respectively, to observe and comply with all applicable medical privacy and confidentiality requirements, by contract or otherwise, sufficient to enable each Party to fully comply with all provisions of this Agreement and all other standards set by applicable federal and California law.

6. TERM AND TERMINATION

6.1 **Term.** This Agreement shall become effective when signed by authorized representatives of both Parties and shall continue in effect, unless specifically terminated as provided in this Section. In addition, certain provisions and requirements of this Agreement may survive its expiration or other termination.

6.2 **Termination by HOSPITAL.** If HOSPITAL determines that CONTRACTOR has breached a material term of this Agreement, HOSPITAL shall provide CONTRACTOR with written notice of the existence of a breach and afford CONTRACTOR an opportunity to cure said breach upon mutually agreeable terms. CONTRACTOR must provide an acceptable and effective plan to cure said breach to the satisfaction of HOSPITAL **within 10 days** of receiving notice. Failure to cure will be grounds for the immediate termination of this Addendum. [164.504(e)(2)(iii)]

6.3 **Termination by CONTRACTOR.** If CONTRACTOR determines that HOSPITAL has breached a material term of this Agreement, or that a material condition of performance under this Agreement has so changed that CONTRACTOR finds it impossible to comply with the new condition, CONTRACTOR may provide **60 days'** notice of its intention to terminate this Agreement and any related Contractual Arrangements.

6.4 **Effect of Termination.** In the event of termination pursuant to this Section, CONTRACTOR agrees to return or destroy all PHI received from or created, transmitted, or maintained for HOSPITAL as specified in Section 3.8. Further, the obligation to indemnify the other party set forth in Section 7.1 shall survive the termination of this Agreement for any reason.

In the event that CONTRACTOR determines that returning or destroying a subset of the PHI is infeasible, CONTRACTOR shall provide to HOSPITAL notification of the conditions that make return or destruction infeasible. CONTRACTOR



shall extend the protections of this Agreement to such PHI and limit further Uses and Disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as CONTRACTOR maintains such PHI.

7. INDEMNIFICATION AND INSURANCE

7.1 **Indemnification.** The Parties agree to indemnify and hold harmless each other and each other's respective employees, agents and affiliated entities against any claim, damage or liability, including reasonable defense costs, that may result from any third party claim if and to the extent proximately caused by any breach of this Agreement by the other, as determined by a court, administrative body of competent jurisdiction, formal alternative dispute resolution process or good faith negotiated settlement, and provided that the party seeking indemnification furnishes to the other prompt written notice and requisite authority, information and assistance to defend, save that the Indemnifying Party may not make any admission of fault or liability on behalf of the other without the other Party's prior written permission.

7.2 **Insurance.** CONTRACTOR, at its sole cost and expense, shall insure its activities in connection with this Agreement. Specifically, CONTRACTOR shall obtain, keep in force, and maintain insurance or equivalent programs of self-insurance with appropriate limits that shall cover losses that may arise from breach of this Agreement, breach of CONTRACTOR's security, or other unauthorized Use or Disclosure of PHI by CONTRACTOR. At HOSPITAL's request, CONTRACTOR shall provide copies of Certificates of Insurance, or other similar documentation satisfactory to HOSPITAL, prior to the effective date of this Agreement, and in such cases shall continue to update HOSPITAL with regard to changes in CONTRACTOR's chosen insurance carriers or coverage limits. It should be expressly understood, however, that the limits and coverage expressed therein shall in no way limit the liability of CONTRACTOR.

8. MISCELLANEOUS

8.1 **Amendments.** The Parties acknowledge that technology, best industry practices, and state and federal law regarding the privacy of PHI are rapidly evolving, and that amendment of this Agreement may be required to reflect such developments. Upon HOSPITAL's request, CONTRACTOR agrees to promptly enter into the negotiations with HOSPITAL concerning the terms of any necessary changes to this Agreement consistent with these developments, in order to maintain optimal privacy and confidentiality for the PHI that CONTRACTOR receives from or creates for HOSPITAL. This Agreement may not be modified, nor any provision hereof waived or amended, except in a writing duly signed by authorized representatives of the Parties.



- 8.2 **Assignments/Subcontracting.** This Agreement shall inure to the benefit of and be binding upon the Parties hereto and their respective legal representatives, affiliated entities, successors and assigns. CONTRACTOR may not assign the rights or obligations under this Agreement without the express written consent of HOSPITAL.
- 8.3 **Assistance in Litigation/Administrative Proceedings.** Upon written request of either Party, and upon making arrangement to pay reasonable expenses incurred, the Parties agree to provide good-faith assistance, in the form of records, witness testimony, and other evidence as the requesting Party may reasonably deem necessary in order to defend against a third party judicial or administrative action or investigation, provided that such assistance would not unfairly prejudice the ability of that Party to defend itself in any pending or expected legal or administrative proceeding or investigation. This clause shall not have effect in cases of adversarial proceedings between the Parties, and under such circumstances the normal rules of discovery shall instead apply.
- 8.4 **Attorneys' Fees.** If any legal action, suit or proceeding, including mediation, arbitration or other non-judicial proceeding, is commenced between CONTRACTOR and HOSPITAL regarding their respective rights and obligations under this Agreement, the prevailing Party shall be entitled to recover, in addition to damages or other relief, all costs and expenses, attorneys' fees and court costs (including, without limitation, expert witness fees). As used herein, the term "prevailing Party" shall mean the Party that obtains the principal relief that it has sought by judgment. If the Party that commenced or instituted the action, suit or proceeding shall dismiss or discontinue it without the concurrence of the other Party, such other party shall be deemed the prevailing Party.
- 8.5 **Dispute Resolution.** The Parties agree to attempt, in good faith, to resolve any breach or alleged breach that does not result in summary termination under Section 6.2 of this Agreement. Should such attempts fail to produce a mutually agreeable result within a reasonable period of time, the Parties agree to seek mediation before a mediator approved by, and in a process conducted under the applicable rules of, the American Arbitration Association before filing a lawsuit over the unresolved matters. Notwithstanding the foregoing, the Parties waive all rights to, and agree not to assert any right to, any trial by jury on any issues or disputes arising under or related to this Agreement.
- 8.6 **General Interpretation.** The Parties have negotiated the terms of this Agreement and the language used in this Agreement shall be deemed to be the language chosen by the Parties to express their mutual intent. This Agreement shall be construed without regard to any presumption or rule requiring construction against the Party causing such instrument or any portion thereof to be drafted, or in favor of the Party receiving a particular benefit under the



Agreement. In addition, any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

- 8.7 **Governing Law.** This Agreement shall be governed by the laws of the State of California. All disputes arising hereunder shall be adjudicated before the courts of the County of San Diego, California. The Parties hereby waive all objections to the exercise of personal jurisdiction or venue of said courts.
- 8.8 **Merger.** This Agreement and the respective Contractual Arrangements comprise the entire agreement between the Parties, with respect to the privacy of PHI and the ordering and termination of relationships that impact such concerns, and supersedes all prior discussions, negotiations, and arrangements.
- 8.9 **Notice.** Any notice to be given under this Agreement shall be in writing and delivered personally or sent by certified or registered mail or overnight delivery

(for HOSPITAL): Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056
Attn: Chief Executive Officer

(for CONTRACTOR): _____

- 8.10 **Remedies.** The right to any redress, cure, indemnification, termination, or any other right conferred under this Agreement is not intended to be exclusive and exists in addition to any other rights or remedies available to either Party at law or in equity.
- 8.11 **Severance.** The invalidity or unenforceability of any part of this Agreement shall not affect the remaining provisions, and the Agreement shall be construed as if the invalid provisions were omitted.
- 8.12 **Survival.** The respective rights and obligations of the Parties under the provisions of this Agreement, solely with respect to PHI that CONTRACTOR retains in accordance with Sections 3.10, shall survive termination of this Agreement indefinitely. All of Section 3 shall survive termination of this Agreement with respect to retained PHI that comprises some or all of a Designated Record Set.
- 8.13 **Third Party Beneficiaries.** Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the Parties and their respective affiliated entities, successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.
- 8.14 **Waiver.** All rights and obligations created under this Agreement shall survive any attempt, other than through a valid Amendment as per Section 8.1, to remove or modify them. No action or failure to act by either Party, other than the execution of a valid written Amendment, may waive any right or obligation to subsequently act,

refrain from acting, or command the action or inaction of the other Party, as applicable, as provided within this Agreement.

IN WITNESS WHEREOF, the Parties have executed this Agreement to be effective when signed by authorized representatives of both Parties.

For HOSPITAL

By: _____

Name: Steve Dietlin

Title: Chief Executive Officer

Date: _____

For CONTRACTOR

By: _____

Name: _____

Title: _____

Date: _____



Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY MANUAL
COMPLIANCE

ISSUE DATE: 05/12

SUBJECT: ~~Hiring and Employment;~~ Duty to
Report Suspected
Misconduct/Potential Compliance
Irregularity

REVISION DATE(S): 12/12

POLICY NUMBER: 8750-544

Administrative Compliance Content Expert Department Approval Date(s):	40/4511/18
Administrative Policies and Procedures Approval Date(s):	40/4512/18
Organizational Compliance Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Audit, Compliance and Ethics Committee Approval Date(s):	41/4502/19
Board of Directors Approval Date(s):	12/15

A. **PURPOSE:**

1. To provide a statement of the Tri-City Healthcare District's (TCHD) policy regarding the duty to report suspected misconduct or potential compliance irregularities.

B. **DEFINITIONS:**

1. **Workforce Members:** Employees, Medical Staff and Allied Health Professionals, volunteers, trainees, and other persons whose conduct, in the performance of work for TCHD, is under the direct control of TCHD whether or not they are paid by TCHD.

C. **POLICY:**

B. DUTY TO REPORT:

1. ~~Each District employee is a~~ Workforce members are required, as a condition of employment, to report suspected misconduct, including, but not limited to, any practice that the employee-workforce member believes violates or may violate the District's TCHD Compliance Program or applicable laws, regulations, or other governmental rules. For workforce members who are employees, reporting of suspected misconduct is a condition of employment.
2. ~~The procedures for reporting suspected misconduct or potential compliance irregularities are set forth in Administrative Policy 8750-556, Communicating and Reporting Compliance Concerns; Reporting of Suspected Misconduct/Potential Irregularities and Administrative Policy 8750-557, Communicating and Reporting Compliance Concerns; Confidential Reporting Line (Values Line). Note that suspected misconduct may be reported (free of charge) any day, any time, through the District's Confidential Reporting Line (Values Line) at 1-800-273-8452, or online at www.tricitymed.alertline.com. Note further that the District is committed to ensuring that there will be no retaliation or retribution against any employee for performing his or her duty to report pursuant to 8750-544 in good faith.~~
3. ~~The procedures for responding to such reports are set forth in 8750-558 through 8750-561.~~
4. ~~The procedures for determining the appropriate corrective action and/or discipline for employees who violate applicable laws, regulations, other governmental rules, or the District's Compliance Program or supervisors who fail to detect or report such violations, are set forth in 8750-562.~~

G.D. **DOCUMENTATION PROCEDURES:**

1. The procedures for reporting suspected misconduct or potential compliance irregularities are set forth in the following policies:

- a. **Administrative Compliance Policy: Communicating and Reporting Compliance Concerns; Reporting of Suspected Misconduct/Potential Irregularities 8750-556, and**
- b. **Administrative Compliance Policy: Communicating and Reporting Compliance Concerns; Confidential Reporting Line (Values Line) 8750-557, and**
2. The procedures for responding to such reports are set forth in the following policies:
 - a. **Administrative Compliance Policy: Responding to Compliance Issues - Introduction; Suspected Misconduct; Confidentiality 8750-559 through**
 - b. **Administrative Compliance Policy: Non-Retaliation for Reporting Compliance Issues or Suspected Misconduct 8750-560**
 - c. **Administrative Compliance Policy: Responding to Reports of Suspected Non-Compliance and Misconduct 8750-561.**
3. The procedures for determining the appropriate corrective action and/or discipline for employees who violate applicable laws, regulations, other governmental rules, or the District's TCHD Compliance Program or supervisors who fail to detect or report such violations, are set forth in the following policy:
 - a. **Administrative Compliance Policy: Responding to Compliance Issues; Remedial Action 8750-562**
4. The documentation requirements for misconduct reports are set forth in the following policy:
 - 4.a. **Administrative Compliance Policy: Communicating and Reporting Compliance Concerns; Reporting of Suspected Misconduct/Potential Irregularities 8750-556.**
5. Note that suspected misconduct may be reported ~~(free of charge)~~ any day, any time, through the District's TCHD Confidential Reporting Line (Values Line)—at 1-844-521-7862, or online at <https://TCHD.ethicspoint.com>. Note further that the District TCHD is committed to ensuring that there will be no retaliation or retribution against any employee for performing his or her duty to report pursuant to 8750-544 in good faith.

B. REFERENCES RELATED DOCUMENT(S):

1. **Administrative Compliance Policy: Communicating and Reporting Compliance Concerns; Reporting of Suspected Misconduct/Potential Irregularities 8750-556,**
2. **Administrative Compliance Policy: Communicating and Reporting Compliance Concerns; Confidential Reporting Line (Values Line) 8750-557**
3. ~~Administrative Policy 8750-558, Responding to Compliance Issues; Introduction; General Policies~~
- 4.3. **Administrative Compliance Policy: Responding to Compliance Issues; Introduction; Reports of Suspected Misconduct; Confidentiality 8750-559**
- 5.4. **Administrative Compliance Policy: Responding to Compliance Issues; Reports of Suspected Misconduct; Non-Retaliation Non-Retaliation for Reporting Compliance Issues or Suspected Misconduct 8750-560,**
- 6.5. **Administrative Compliance Policy: Responding to Compliance Issues; Reports of Suspected Non-Compliance and Misconduct; Investigation 8750-561**
- 7.6. **Administrative Compliance Policy: Responding to Compliance Issues; Remedial Action 8750-562,**

**ADMINISTRATIVE POLICY
COMPLIANCE**

DELETE: Information is included in
Administrative Compliance Policy:
Monitoring Compliance - Auditing &
Reporting – Annual Compliance
Workplan 8750-552

ISSUE DATE: 05/12

SUBJECT: Monitoring Compliance/Auditing
and Reporting; Introduction;
General Policies

REVISION DATE(S):

POLICY NUMBER: 8750-551

Administrative Compliance Content Expert Approval:	44/4511/18
Administrative Policies & Procedures Committee Approval:	44/4501/19
Organizational Compliance Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Audit, Compliance & Ethics Committee Approval:	04/4602/19
Board of Directors Approval:	01/16

A. PURPOSE:

1. ~~To establish Tri-City Healthcare District's (TCHD's) commitment to actively monitor and audit its practices to ensure compliance with applicable laws and regulations, TCHD's Code of Conduct and its Policies and Procedures.~~

POLICY:

B. INTRODUCTION:

1. ~~TCHD recognizes that ongoing monitoring and auditing are critical components of a successful Compliance Program, enabling the organization to ensure that its practices are consistent with its stated Policies and Procedures. As such, TCHD has developed a multi-faceted approach to ensuring ongoing compliance, which includes day-to-day monitoring, and conducting regular compliance reviews, periodic audits (prospective and retrospective), and exit interviews of departing employees and contractors. TCHD's Policies regarding monitoring and auditing are set forth in Administrative Policy 8750-552—Monitoring Compliance Auditing & Reporting—Annual Compliance Workplan; Administrative Policy 8750-553—Monitoring Compliance Auditing and Reporting—Compliance Reviews and Audits and Administrative Policy 8750-554—Monitoring Compliance Auditing and Reporting—Exit Interviews.~~

PROCESS/PROCEDURE:

C. QUESTIONS RELATING TO MONITORING COMPLIANCE:

1. ~~Any questions about Administrative Policies 8750-552 and through 8750-554 shall be directed to the Chief Compliance Officer.~~

D. AUDIT AND DOCUMENTATION:

1. ~~TCHD shall audit and document compliance with Administrative Policies 8750-552 through and 8750-554. Relevant documentation shall be maintained in TCHD's compliance files, consistent with TCHD's document retention policies.~~

E. REFERENCES:

- ~~Compliance Program Guidance for Hospitals, published by U.S. Department of Health and Human Services, Office of Inspector General, February 1998.~~
1. ~~Office of Inspector General Supplemental Compliance Program Guidance for Hospitals, January 2005.~~

RELATED DOCUMENTS:

2. ~~Administrative Policy 8750-552—Monitoring Compliance Auditing & Reporting—Annual~~

~~Compliance Workplan~~

- ~~3. Administrative Policy 8750-553—Monitoring Compliance Auditing & Reporting—Compliance Reviews and Audits~~
- ~~4. Administrative Policy 8750-554—Monitoring Compliance Auditing & Reporting—Exit Interviews~~

**ADMINISTRATIVE POLICY
COMPLIANCE**

ISSUE DATE: 12/02 **SUBJECT:** Notice of Privacy Practices

REVISION DATE(S): 09/05, 01/09 **POLICY NUMBER:** 8610-518

Administrative Compliance Content Expert Approval:	08/18
Administrative Policies & Procedures Committee Approval:	05/1508/4812/18
Organizational Compliance Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Audit, and Compliance & Ethics Committee Approval:	06/1502/19
Board of Directors Approval:	06/15

A. PURPOSE:

1. To establish policy for documenting the acknowledgment of the patient's receipt of the Notice of Privacy Practices in accordance with the Health Information Portability and Accountability Act of 1996 (HIPAA) which gives patients the right to know the Uses and Disclosure of their protected health information.

B. DEFINITIONS:

1. Disclosure: the release, transfer, provision of, access to or divulging of PHI outside Tri-City Healthcare District (TCHD).
2. Notice of Privacy Practices ~~or~~ (NPP): TCHD's written notice to individuals of Uses and Disclosures of PHI as required by 45 Code of Federal Regulations (CFR) Section 164.520.
3. Protected Health Information (PHI): individually identifiable health information transmitted or maintained in paper or electronic form that is created or received by TCHD AND
 - a. Relates to the past, present, or future physical or mental health or condition of an individual; OR
 - b. Relates to the provision of health care to an individual; OR
 - c. Relates to the past, present, or future payment, AND
 - d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
4. Use: the sharing, application, utilization, examination or analysis of PHI within TCHD
- 4-5. Workforce Member: means employees, Medical Staff and Allied Health Professionals, volunteers, trainees and other persons whose conduct in the performance of work for TCHD is under the control of TCHD whether or not they are paid by TCHD.

C. POLICY:

1. In accordance with HIPAA, all patients have a right to adequate notice of the Uses and Disclosures of PHI that may be made by TCHD.
2. TCHD communicates Uses and Disclosures of PHI that may be made by TCHD in its Notice of Privacy Practices.
3. TCHD must make the Notice of Privacy Practices available to patients as described in this Policy.
4. As provided under HIPAA, TCHD is required to abide by the terms of the Notice that is currently in effect.

D. PROCEDURE:

1. TCHD must make the NPP available as follows:

- a. TCHD must make the NPP available on request to any patient.
 - b. Where TCHD has a direct treatment relationship with an individual, it must also provide the NPP no later than the date of the first service delivery except for emergency treatment situations where the NPP can be provided as soon as practicable after the emergency treatment situation.
2. The NPP will also be posted on the TCHD Website and will be made available at all registration sites, ~~and the Medical Records/HIM Health Information Management office in Administration, and with the Patient Representative.~~ Registration or other points of entry to ~~the Medical Center~~ TCHD including but not limited to those listed below will be the primary sites where this process takes place. Since a patient's condition or location may preclude documenting the acknowledgement at the time of registration or entry into ~~the Medical Center~~ TCHD, all ~~Medical Center~~ TCHD staff share the responsibility of ensuring acknowledgement of the Notice.
 - a. Homecare
 - b. Outpatient Rehabilitation
 - c. Outpatient Behavioral Health
 - d. Obstetrics
3. NPP Exception: Lab specimens are an exception to this Policy. No Notice of Privacy Practices will be offered because specimens are covered under the Indirect Treatment Relationship provision.
- a.4. Amendment of NPP: If the NPP is revised, TCHD shall make the revised NPP available on request on or after the effective date of the revision ~~in accordance with D.1 through D.3 above.~~
- 4.5. TCHD must document the patient's acknowledgment of receipt or good faith efforts to obtain the acknowledgement.
 - a. The Condition of Admissions document includes a section reflecting patient's acknowledgement that a NPP has been offered and online access is available via TCHD website is communicated. Patients will be asked to initial the Conditions of Admission acknowledgement referencing the most current version of the NPP, even if they have signed an acknowledgement of a previous version.
 - b. If the patient receives the NPP and the acknowledgement section of the Conditions of Admissions is not initialed, TCHD personnel must document good faith efforts to obtain it and the reason for lack of signature.
 - c. The Notice of Privacy Practice acknowledgment need only be documented once, unless there is a significant content change in the Notice. Each new version of the Notice requires the patient to initial a new acknowledgement.
- 5.6. TCHD has the right to change the NPP at any time including for the purpose of amending it to conform to changes in the law. The effective date of the NPP is located on the first page of the NPP.
- 6.7. Retention of NPP:
 - a. The completed Conditions of Admission acknowledgement will be kept in the patient's medical record for the encounter for which it was signed.
 - b. TCHD will retain the required documentation related to the NPP for at least 6 years from the date of creation or the date when it was last in effect whichever is later.
- 7.8. Training on NPP: All employees of ~~the Medical Center~~ TCHD will be trained on and knowledgeable of the contents of the Notice because it documents how TCHD will handle Uses and Disclosures of its patients' protected health information.

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

1. Notice of Privacy Practices

F. **REFERENCE(S):**

1. 45 Code of Federal regulations (CFR) section 164.520

NOTICE OF PRIVACY PRACTICES

Tri-City Healthcare District

4002 Vista Way

Oceanside, CA 92056

[Effective Date 03/01/20182019]

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

If you have any questions about this ~~notice~~ Notice, please contact our Privacy Officer at (760) 940-5381

OUR PLEDGE TO PROTECT YOUR PRIVACY

Tri-City Healthcare District is committed to protecting the privacy of health information we create or receive about you. Health information that identifies you ("protected health information", or "health information") includes your medical record and other information relating to your care or payment for care.

Tri-City Healthcare District (the "District" for purposes of this ~~Notice~~ Notice) includes the following entities: Tri-City Medical Center and outpatient clinics, Tri-City Wellness Center outpatient clinics, Tri-City Primary Care, Orthopedic Specialists of North County, and the Clancy Medical Group. ~~Clinic, the Radianee Clinic, and the Venus Clinic. (I don't have a list of all affiliated physician clinics),~~

WHO WILL FOLLOW THIS NOTICE

This ~~notice~~ Notice describes ~~our hospital's~~ the District's practices and that of:

Any health care professional authorized to **update or create health information about you.** ~~enter information into your hospital chart.~~

All departments and units of the ~~hospital~~ District, including affiliated physician clinics.

Any member of a volunteer group we allow to help you while you are in ~~the hospital~~ one of the District's facilities.

All employees, staff and other ~~hospital~~ District personnel.

All affiliated entities, sites, and locations.

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

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

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

We are required by law to:

- Make sure that medical information that identifies you is kept private (with certain exceptions);

- Give you this ~~notice~~**Notice** of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the ~~notice~~**Notice** that is currently in effect

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

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

DISCLOSURE AT YOUR REQUEST

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

FOR TREATMENT

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other ~~hospital~~**District** personnel who are involved in taking care of you ~~at the hospital~~.

For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may tell the dietician if you have diabetes so that we can arrange for appropriate meals.

Different departments ~~of the hospital~~**within the District's facilities** also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and X-rays. We also may disclose medical information about you to people outside the ~~hospital~~**District** who may be involved in your medical care after you leave the ~~hospital~~**District's facilities**, such as skilled nursing facilities, home health agencies, and physicians or other practitioners.

For example, we may give your physician access to your health information to assist your physician in treating you.

FOR PAYMENT

We may use and disclose medical information about you so that the treatment and services you receive at the ~~hospital~~**District** may be billed to and payment may be collected from you, an insurance company or a third party.

For example, we may need to give information about surgery you receive at the ~~hospital~~**Tri-City Medical Center District** to your health plan so it will pay us or reimburse you for the surgery.

We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also provide basic information about you and your health plan, insurance company or other source of payment to practitioners outside the ~~hospital~~**District** who are involved in your care, to assist them in obtaining payment for services they provide to you. However, we cannot disclose information to your health plan for payment purposes if you ask us not to, and you pay for the services yourself.

FOR HEALTHCARE OPERATIONS

We may use and disclose medical information about you for health care operations. These use and disclosures are necessary to run the ~~hospital~~**District** and make sure that all our patients receive quality care.

For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.

We may also combine medical information about many hospital patients to decide what additional services the ~~hospital~~**District** should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other ~~District~~**hospital** personnel for review and learning purposes. We may also combine the medical information we have with medical information from other hospitals to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

FUNDRAISING ACTIVITIES

We may use information about you or disclose such information to a foundation related to the ~~hospital~~**District**, to contact you in an effort to raise money for the hospital and its operations. You have the right to opt out of receiving fundraising communications. If you receive a fundraising communication, it will tell you how to opt out.

HEALTH INFORMATION EXCHANGE

We participate in both the ~~Commonwealth~~**Commonwell** and San Diego Health Connect information exchanges with other healthcare providers. This ~~Notice~~**Notice** is to inform our patients that our clinical team exchanges information for patient care and you can OPT OUT of the sharing of your information by communicating your choice during the Registration process or by sending a message to our Privacy Officer via our website (tricitymed.org) or submitting a written request to our Privacy Officer (4002 Vista Way, Oceanside, CA 92056).

HOSPITAL DIRECTORY

We may include certain limited information about you in the ~~hospital~~**Tri-City Medical Center** directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (e.g. good, fair, etc.) and your religious affiliation. Unless there is a specific written request from you to the contrary, this directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This information is released so your family, friends and clergy can visit you in the hospital and generally know how you are doing.

MARKETING AND SALE

Most uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of medical information, require your authorization.

TO INDIVIDUALS INVOLVED IN YOUR CASE OR PAYMENT FOR YOUR CASE

We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. Unless there is a specific written request from you to the contrary, we may also tell your family or friends your condition and that you are in the hospital.

In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you arrive at the emergency department either unconscious or otherwise unable to communicate, we are required to attempt to contact someone we believe can make healthcare decisions for you (e.g. a family member or agent under a health care power of attorney).

FOR RESEARCH

Under certain circumstances, we may use and disclose medical information about you for research purposes.

For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information.

Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, as long as the medical information they review does not leave the ~~hospital~~ District.

AS REQUIRED BY LAW

We will disclose medical information about you when required to do so by federal, state or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

ORGAN AND TISSUE DONATION

We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

MILITARY AND VETERANS

If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

~~(A hospital that is component of the Department of Defense or Transportation should also include the following: "If you are a member of the Armed Forces, we may disclose medical information about you to the Department of Veterans Affairs upon your separation or discharge from military services. This disclosure is necessary for the Department of Veterans Affairs to determine if you are eligible for certain benefits.")~~

WORKERS' COMPENSATION

We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

PUBLIC HEALTH ACTIVITIES

We may use and disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report regarding the abuse or neglect of children, elders and dependent adults;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- To notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

HEALTH OVERSIGHT ACTIVITIES

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil right laws.

LAWSUIT AND DISPUTES

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written ~~notice~~ Notice to you) or to obtain an order protecting the information requested.

LAW ENFORCEMENT

We may release medical information if asked to do so by law enforcement official:

- In response to court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS

We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

~~(A Hospital that is component to the U.S. Department of State should also include the following:~~

SECURITY CLEARANCES

"We may use medical information about you to make decisions regarding your medical suitability for a security clearance or service abroad. We may also release your medical suitability determination to the officials in the U.S. Department of State who need access to that information for these purposes.")

INMATES

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose medical information about you to the correctional institution or law enforcement official. This disclosure would be necessary

- for the institution to provide you with health care;
- to protect your health and safety or the health and safety of others; or
- for the safety and security of the correctional institution.

MULTIDISCIPLINARY PERSONNEL TEAMS

We may disclose health information to a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

SPECIAL CATEGORIES OF INFORMATION

In some circumstances, your health information may be subject to restriction that may limit or preclude some uses or disclosures described in this ~~notice~~Notice.

For example, there are special restrictions on the use or disclosure of certain categories of information — e.g. tests for HIV or treatment for mental health conditions or alcohol and drug abuse. Government health benefit programs, such as Medi-Cal, may also limit the disclosure of beneficiary information for purposes unrelated to the program.

SITUATIONS THAT REQUIRE US TO OBTAIN YOUR AUTHORIZATION

For uses and disclosure not described above, we must first obtain your authorization. For example, the following uses and disclosures will only be made with your authorization:

- Uses and disclosures for marketing purposes;
- Uses and disclosures that constitute the sale of Protected Health Information;
- Most uses and disclosures of psychotherapy notes; and
-
- Other uses and disclosures not described in this ~~notice~~Notice.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

You have the following rights regarding medical information we maintain about you:

RIGHT TO INSPECT AND COPY

You have the right to inspect and obtain a copy of medical information that may be used to make decisions about your care. Usually this includes medical and billing records, but may not include some mental health information.

To inspect and obtain a copy of medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer. If you request a copy of the information, we may charge a **reasonable** fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and obtain a copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

RIGHT TO AMEND

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the hospital.

To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the hospital;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

RIGHT TO AN ACCOUNTING OF DISCLOSURES

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations (as those functions are described above), and with other exceptions pursuant to the law.

To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

In addition, we will notify you as required by law following a breach of your unsecured protected health information.

RIGHT TO REQUEST RESTRICTIONS

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request, except to the extent that you request us to restrict disclosure to a health plan or insurer for payment or health care operations purposes if you, or someone else on your behalf (other than the health plan or insurer), has paid for the item or service out of pocket in full. Even if you request this special restriction, we can disclose the information to a health plan or insurer for purposes of treating you.

If we agree to another special restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to our Privacy Officer. In your request, you must tell us:

- What information you want to limit
- Whether you want to limit our use, disclosure or both; and
- To whom you want the limits to apply, for example, disclosures from your spouse

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

RIGHT TO A PAPER COPY OF THIS NOTICE

You have a right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

You may obtain a copy of this Notice at our website: tricitymed.org

To obtain a paper copy of this Notice: contact our Registration department.

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the hospital. The Notice will contain the effective date on the first page, in the top right-hand corner. In addition, each time you register at or are admitted to the hospital for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current Notice in effect.

COMMENTS OR COMPLAINTS

We welcome your comments about our Notice and our privacy practices. If you believe your privacy rights have been violated, you may file a complaint with:

TRI-CITY HEALTHCARE DISTRICT
CHIEF COMPLIANCE OFFICER/PRIVACY OFFICER
4002 VISTA WAY
OCEANSIDE, CA 92056
(760) 940-5381

Or with the: Secretary of the Department of Health and Human Services
200 Independence Avenue, S.W.

Washington, D.C. 20201

1-877-696-6775

www.hhs.gov/ocr/privacy/hipaa/complaints/

Please be assured that no one will retaliate or take action against you for filing a complaint.

Other uses and disclosures of medical information not covered by this ~~notice~~Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, this will stop ~~by~~ any further use or disclosure of your medical information for the purposes covered by your written authorization, except if we have already acted in reliance on your permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of care that we provided to you.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and update this ~~Notice~~Notice accordingly. We reserve the right to make the revised or changed ~~Notice~~Notice effective for medical information we already have about you as well as any information we receive in the future. We post copies of the current ~~Notice~~Notice in the registration areas and on our internet sites. If the ~~Notice~~Notice is changed, we will post the new ~~Notice~~Notice in our registration areas and provide it to you upon request. The ~~Notice~~Notice contains the effective date on the first page, in the top right-hand corner.

**ADMINISTRATIVE POLICY MANUAL
COMPLIANCE**

ISSUE DATE: 03/03

SUBJECT: Use and Disclosure of Protected
Health Information (PHI) for
Fundraising

REVISION DATE(S): 02/06; 01/09;

POLICY NUMBER: 8610-525

Administrative Compliance Content Expert Approval:	06/15/12/18
Administrative Policies & Procedures Committee Approval:	06/15/12/18
Organizational Compliance Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Audit, Compliance and Ethics Committee Approval:	04/16/02/19
Board of Directors Approval:	01/16

A. PURPOSE:

1. To establish policies and procedures for the Use and Disclosure of specified Tri-City Healthcare District (TCHD) patient information for fundraising activities ~~including Disclosures to the Tri-City Hospital Foundation and/or Business Associates for the purpose of TCHD fundraising in~~ accordance with the Health Information Portability and Accountability Act of 1996 (HIPAA).

B. DEFINITIONS:

1. Authorization: The written form that complies with HIPAA and state law that is obtained from the Individual or his or her ~~Personal~~ **personal Representative** in order for TCHD to Use and Disclose PHI.
2. Business Associate: A person or organization who, on behalf of the District, performs certain functions or activities involving the Use or Disclosure of PHI or services that require the Business Associate to create, receive, maintain or transmit PHI on behalf of the District or where the District needs to ~~Disclose~~ **disclose** PHI to Business Associates for the services.
3. Direct Solicitation Fundraising Literature: Any written communications which primary purpose is the direct solicitation of the financial resources necessary to support the mission and purposes of TCHD.
4. Disclosure: The release, transfer, provision of, access to or divulging of PHI outside TCHD.
5. Fundraising: The process of securing the financial resources necessary to support the mission and purposes of the TCHD.
6. Minimum Necessary Standard: The amount of information reasonably necessary to accomplish the purpose of the Use, Disclosure or ~~Request~~ **request**.
7. Payment: ~~Reimbursement for health care services provided.~~ **includes** ~~Includes~~ activities undertaken by a health care provider to obtain or provide reimbursement for the provision of care including, but not limited to, determinations of eligibility, billing, claims management, collection activities, obtain payment under a contract of reinsurance or stop loss, related health care data processing, review of coverage under health plans, medical necessity reviews, and utilization management.
8. Permissible Patient Information: The limited categories of PHI that TCHD may Use or Disclose to a Business Associate or to the Tri-City Hospital Foundation without a patient Authorization, for the purpose of raising funds for TCHD's own benefit and expressly limited to the following:
 - a. Demographic information relating to the Individual including name, address, other contact information, age, gender, and date of birth
 - b. Dates of health care provided to an Individual
 - c. Department of service (general department ~~of transferred~~) information
 - d. Treating physician

- e. Outcome information (to screen out only)
- f. Health insurance financial class
- 9. **Protected Health Information (PHI):** individually identifiable health information transmitted, ~~or maintained, in paper or electronic or other form that is created or received by TCHD AND and~~
 - a. Relates to the past, present, or future physical or mental health or condition of an individual; OR
 - b. Relates to the provision of health care to an individual; OR
 - c. Relates to the past, present, or future payment, AND
 - d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- 10. **Treatment:** ~~The provision, of coordination, or management, consultation or referral of a patient's health care by a provider(s) of health care and related services by one or more providers, including coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient from health care from one health care provider to another.~~
- 11. **Use:** the sharing, application, utilization, examination or analysis of PHI within TCHD.
- 12. **Workforce Member:** ~~employees~~ **Employees, Medical Staff and Allied Health Professionals,** volunteers, trainees, and other persons whose conduct, in the performance of work for TCHD is under the direct control of TCHD whether or not they are paid for by TCHD.

C. **POLICY:**

- 1. In order to protect the privacy of a patient's information, Tri-City Hospital Foundation shall act in accordance and compliance with HIPAA and the Privacy Practices of TCHD when conducting fundraising activities for TCHD.
- 2. TCHD may Use or Disclose ~~Permissible-permissible Patient-patient information information~~ to its Business Associates or to the Tri-City Hospital Foundation for the benefit of TCHD fundraising.
- ~~2.3.~~ Such Uses and Disclosures are subject to the minimum necessary requirements.
- ~~3.4.~~ TCHD may not condition ~~Treatment-treatment~~ or ~~Payment-payment~~ on a patient's choice with respect to fundraising communications.

D. **PROCESS:**

- 1. Notice of Privacy Practices
 - a. TCHD's Notice of Privacy Practices shall indicate that TCHD may Use or Disclose a patient's PHI to its Foundation or Business Associates for fundraising purposes and that the patient has the right to opt out of receiving such communications.
 - b. TCHD may not Use or Disclose PHI for fundraising purposes unless the statement required by Section 1.a is included in the Notice of Privacy Practices.
- 2. Use of ~~Permissible-permissible Patient-patient~~ **Permissible Patient** Information
 - a. After a patient has been made aware of the ~~TCMC's~~ TCHD's Notice of Privacy Practices, TCHD may Use or Disclose ~~Permissible-permissible Patient-patient~~ **Permissible Patient** information for ~~Fundraising-fundraising~~ purposes.
 - b. Except as provided in this Policy, TCHD *may disclose permissible patient* information to the Tri-City Hospital Foundation or Business Associates for fundraising purposes without first obtaining a patient's ~~authorization for such purpose~~.
 - c. TCHD and/or the Foundation may use permissible patient information to identify patients for patient testimonials that will be Used and/or Disclosed for ~~Fundraising-fundraising~~ purposes; ~~however, when doing so, TCHD and/or the Foundation must follow the process for obtaining Authorizations and consents set forth in Section 3.~~
 - d. Before contacting a patients ~~(current or former)~~ for ~~Fundraising-fundraising~~ purposes, TCHD and the Foundation shall verify that the individuals they wish to contact have not opted out of ~~Fundraising-fundraising~~ communications.
 - e. TCHD and the Foundation shall implement the ~~Minimum-minimum Necessary-necessary Standard-standard~~ **Minimum-minimum Necessary-necessary Standard-standard** on ~~Fundraising-fundraising~~ Uses and Disclosures. TCHD and the Foundation must adhere to more restrictive federal and state privacy laws for certain highly sensitive health information (including **but not limited to** mental health, substance

abuse, HIV/AIDS, psychotherapy notes and ~~abuse and other categories~~). Due to the sensitive nature of these treatments, additional authorization is needed prior to using for fundraising communication. The Chief Compliance and/ Privacy Officer should be consulted prior to obtaining the patient's authorization. ~~This means that it may not be possible to Use and Disclose highly sensitive PHI for Fundraising purposes without a patient Authorization or even at all. TCHD Workforce members and the Foundation shall consult the Privacy Officer or Compliance Officer before Using or Disclosing any PHI, including Permissible Patient Information, involving highly sensitive PHI.~~

- f. TCHD and the Foundation may not Use or Disclose ~~Permissible-permissible Patient patient information information~~ (or any patient PHI) with a non-affiliated entity for purposes of that entity's ~~Fundraising-fundraising~~ (for example where a Medical Staff member specializes in the treatment of a specific disease and a non-profit association fundraises for research related to that specialty).
3. Patient Testimonials Used for Fundraising Purposes.
 - a. When Using and/or Disclosing a patient's testimonial, including the patient's PHI ~~(e.g. hospital experience, medical treatment)~~, for ~~Fundraising-fundraising~~ purposes, TCHD and/or the Foundation acting as TCHD's Business Associate must obtain from the patient prior to such Use and/or Disclosure:
 - i. ~~an An Authorization~~authorization; and
 - ii. Consents to videotape, photograph and/or publish the patient's testimonial, as appropriate.
 - b. The ~~Authorization~~authorization and cConsent form shall be obtained regardless of the manner in which TCHD/Foundation learned about the patient's testimonial or whether the patient has consented either verbally or in writing (e.g. e-mail) to such Use/Disclosure.
 - c. The ~~Authorization~~authorization must be completed in a manner that adequately describes the categories of PHI being Used/Disclosed and the ~~Purpose-purpose~~ of the Use/Disclosure.
 - d. TCHD and the Foundation shall only Use or Disclose the patient's testimonial (and PHI) with a valid patient ~~Authorization~~authorization.
4. Fundraising Notifications
 - a. Each fundraising notification shall provide the patient with a clear and conspicuous opportunity to elect not to receive any further fundraising communications.
 - b. The method provided to opt out of receiving further fundraising communications shall not result in a patient incurring an undue burden or more than a nominal cost. Tri-City Hospital Foundation permits patients to opt out of future fundraising communications by telephone at (760) 940-3370 or by e-mail at TCHFoundation@tcmc.com.
 - c. Any TCHD workforce member or business associate who is advised by a patient of his/her request to opt out of receiving future ~~Fundraising-fundraising~~ communications, must contact the Foundation to document the request.
5. Patients Who Opt Out
 - a. Fundraising communications will not be made to patients who have opted out of such communications.
 - b. Tri-City Hospital Foundation will track opt out notifications to ensure that further fundraising communications are not made to patients who have elected to opt out.
6. Opting Back In.
 - a. Patients who desire to opt back in to receive fundraising communications can do so by sending an e-mail with such request to TCHFoundation@tcmc.com or by opting in at an event or through the Foundation's website.
7. Direct Solicitation Fundraising Literature
 - a. Direct solicitations ~~fundraising literature~~ does not include general-marketing ~~communications to donors or prospective donors. (e.g. such as nnewsletters) or other similar general communication media where TCHD does not Disclose patient PHI is not used. to Tri-City Hospital Foundation for such purposes.~~

8. Business Associates

- a. Before the Tri-City Hospital Foundation shares any ~~Permissible-permissible~~ Patient patient information with a Business Associate, the Tri-City Hospital Foundation shall have the Business Associate sign the TCHD Business Associate Addendum.
- b. If the Tri-City Hospital Foundation becomes aware of a breach of the Privacy Practices of TCHD by a Business Associate, the Tri-City Hospital Foundation shall immediately notify the Chief Compliance ~~Officer and~~ Privacy Officer.

E. FORMS):

- ~~b.1.~~ Authorization for Use or Disclosure 8700-1002 - Sample

F. RELATED DOCUMENT(S):

~~Administrative Policy 8750-508~~

1. Administrative Compliance Policy: Notice of Privacy Practices 87508610-518
2. Administrative Compliance Policy: Business Associate Agreement 8610-511
3. HIPAA Business Associate Addendum

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

1. 45 Code of Federal Regulations (CFR) Section 164.502
2. 45 CFR Section 164.514(f)
3. 45 CFR Section 164.508
- 2.4. Health Information Portability and Accountability Act of 1996 (HIPAA)
- 3.5. ~~TCHD Notice of Privacy Practices Policy # 518~~

SAMPLE

Completion of this document authorizes the use or disclosure of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.
Failure to provide all information requested may invalidate this Authorization.

USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth _____

(Please print)

I hereby authorize the use or disclosure of my health information as follows:

Person/Organization authorized to *release* (use or disclose) the information:¹ _____

Tri-City Medical Center

(TCMC or other Entity)

Person/Organization authorized to *receive* the information (name and address of entity):

Phone Number (with area code)

This Authorization applies to the following specific information to be disclosed (select from the following).²:

- ☐ All health information pertaining to any medical history, mental or physical condition and treatment received.

Dates include: _____

[Optional] Except for these specific limitations:

- ☐ Only the following records or specific types of health information. Dates include: _____

☐ Discharge Summary

☐ History/Physical Report

☐ Consultation Reports

☐ Operative/Procedure Report

☐ Emergency Dept Report

☐ EKG

☐ Laboratory Tests

☐ X-Ray Reports

- ☐ Other

(please specify) _____

I understand that this will include information relating to (check if applicable):

- ☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection

- ☐ Psychiatric Care (patient to initial here _____)

- ☐ Treatment for alcohol and/or drug abuse.

EXPIRATION

This Authorization expires [on the following specific date]: 30 days

RESTRICTIONS

I understand that California law prohibits the recipient of my health information pursuant to this authorization from making further disclosure of my health information unless the Recipient obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS

I understand that I may refuse to sign this Authorization.

I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: 4002 Vista Way Oceanside, CA 92056. Attn: Medical Records/Health Information.

I understand that my revocation will be effective upon receipt, but will not affect any use or disclosures completed prior to receipt of the revocation.

AUTHORIZATION FOR USE OR DISCLOSURE

8700-1002
(Rev 5/15)



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

White-Med Records Yellow-Patient

SAMPLE

ADDITIONAL RIGHTS AND REQUIREMENTS IF REQUESTOR SEEKS THIS AUTHORIZATION¹

I understand that if Requestor seeks this authorization:

1. My health information will be used for the following purpose(s): ☐ Continuing Medical Care
☐ Insurance ☐ Legal ☐ Other (Please specify) _____
2. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
3. I must receive a copy of this Authorization⁴.
4. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. However, this does not apply if the Requestor is seeking to use the information as follows: (i) to conduct research-related treatment; (ii) to obtain information in connection with my eligibility or enrollment in a health plan of which I am not already a member; (iii) to enable the Requestor to determine its obligation to pay a claim; or (iv) to create health information to provide to a third party. Under no circumstances, however am I required to authorize the disclosure of psychotherapy notes.
5. If this box ☐ is checked, I understand the Requestor may receive compensation or other remuneration directly or indirectly for the use or disclosure of my information.

SIGNATURE

Signature _____ Date/Time _____ AM/PM
[Patient/representative/spouse/financially responsible party]

If signed by someone other than the patient, state your legal relationship to the patient⁵:

Witness: _____

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.)

Authorization for Use or Disclosure of Health Information – Footnote references

¹ If the Authorization is being requested by the entity holding the health information, then such entity shall be referred to as the Requestor throughout this form.

² This form may not be used to release both psychotherapy notes and other types of health information [(see 45 CFS § 164.508(b)(3)(ii)]. If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.

³ The Requestor is to complete this section of the form.

⁴ Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures [(see 45 CFR § 164.508(d) (1), (e) (2)].

⁵ A spouse or financially responsible party may only authorize release of medical information for use in the following:

- a. to process an application for the patient
- b. as a spouse or dependent for the following:
 - a. a health insurance plan or policy
 - b. a nonprofit hospital plan
 - c. a health care service plan or
 - d. an employee benefit plan

For TCMC Medical Records/Health Information use Only

MRUN: _____ Date Received: _____

Date of Birth: _____ Visits to be Included: _____

SS#: _____

Telephone #: _____

Distribution: ☐ Mail ☐ Pick-up ☐ CD ☐ Other _____ Completed by: _____
Signature Date

HIPAA BUSINESS ASSOCIATE ADDENDUM

This HIPAA BUSINESS ASSOCIATE ADDENDUM ("Addendum") is entered into as of _____, 20__ (the "Execution Date"), by and between Tri-City Healthcare District, a health care district organized under the Local Health Care District Law of the State of California ("Hospital") and _____ ("Contractor").

A. Hospital owns and operates a general acute care hospital that is located at 4002 Vista Way, Oceanside, California.

B. Hospital is a "covered entity" under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and, as such, must enter into so-called "business associate" contracts with its contractors that may have access to patient medical information in either paper or electronic form.

C. Pursuant to that certain _____ Agreement by and between Hospital and Contractor, dated as of _____, 20__ (the "Agreement"), Contractor may have access to patient medical information from Hospital.

D. Hospital and Contractor are committed to complying with HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act, Public Law 111-05 ("HITECH Act") and their implementing regulations ("the HIPAA Regulations") as they become effective or as otherwise amended from time to time (collectively these changes, HIPAA and the HIPAA Regulations shall hereinafter be referred to as the "HIPAA Laws"), the California Medical Information Act ("CMIA"), contained in the California Civil Code Section 56 *et seq.*, the Patient Access To Medical Records Act ("PAMRA") contained in the California Health and Safety Code, Section 123100 *et seq.*, California Health and Safety Code Section 1280.15 ("Section 1280.15") and other California patient privacy laws.

NOW, THEREFORE, in consideration of the recitals, conditions and promises herein contained, the parties do hereby agree as follows:

1. Defined Terms.

(a) Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the HIPAA Laws. A reference in this Addendum to a section in the HIPAA Regulations, means the section of the Code of Federal Regulations (CFR) as in effect or as amended, and for which compliance is required.

(b) Unauthorized or Unlawful Access shall mean the inappropriate review or viewing of patient medical information without a direct need for diagnosis, treatment or other lawful Use as permitted by HIPAA, CMIA or by other statutes or regulations governing the lawful access, Use or Disclosure of medical information.

(c) Designated Data Set is a group of records, from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the Individual, and which is used to make decisions about the Individual.

(d) Data Use Application describes the purpose, controls and safeguards agreed to by the Contractor and Hospital.

2. Billing and Collecting. If Contractor provides billing and collecting services to Hospital or otherwise conducts any Standard Transactions on behalf of Hospital, Contractor shall comply with this Section. Contractor shall comply with 45 CFR Parts 160 and 162 (the "Transaction Rule"), including: (a) Contractor shall not change the definition, data condition, or use of a data element or segment in a standard of the

Transactions Rule (a “Standard”); (b) Contractor shall not add any data elements or segments to the maximum defined data set; (c) Contractor shall not use any code or data elements that are either marked “not used” in the Standard’s implementation specification or are not in the Standard’s implementation specification(s); and (d) Contractor shall not change the meaning or intent of the Standard’s implementation specification(s).

3. Contractor’s Obligations

(a) Contractor acknowledges and agrees that all Protected Health Information that is created or received by Hospital and Disclosed or made available in any form, including paper record, audio recording, and electronic display by Hospital or its operating units to Contractor, or is created, received, maintained or transmitted by Contractor on Hospital’s behalf, shall be subject to the Agreement and this Addendum.

(b) Contractor shall not Use or Disclose Protected Health Information in any form, including electronic form (“PHI”), other than as permitted or required by this Addendum or required by law.

(c) Contractor shall not permit Unauthorized or Unlawful Access to PHI.

(d) Except as otherwise limited in this Addendum, Contractor may Use or Disclose PHI to perform functions, activities, or services for, or on behalf of, Hospital as specified in the Agreement or for Contractor’s internal operational purposes, provided that such Use or Disclosure would not violate the HIPAA Regulations or California law if done by Hospital.

(e) The Contractor shall not further Disclose any PHI (including to subcontractors) received from the Hospital or maintained by the Contractor, unless permitted by this Addendum and, in such cases, only if such Disclosure is required or permitted under California law.

(f) The Contractor shall not Disclose PHI to a health plan for payment or health care operations purposes if the Individual has requested this special restriction and has paid out-of-pocket in full for the health care item or service to which the PHI solely relates.

(g) Except as otherwise provided for in this Addendum, Business Associate may use Protected Health Information for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate. (See 45 C.F.R. §164.504(e)(4)(i)).

(h) Except as otherwise provided for in this Agreement, Business Associate may Disclose Protected Health Information for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that Disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is Disclosed that it will remain confidential and Used or further Disclosed only as Required By Law or for the purpose for which it was Disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been Breached. (See 45 C.F.R. §164.504(e)(4)(ii)).

(i) To the extent that Contractor is to carry out one or more of Hospital’s obligations under Subpart E of 45 CFR Part 164, Contractor shall comply with the requirements of Subpart E that apply to Hospital in the performance of the obligations.

4. Disclosure Accounting. In the event that Contractor makes any Disclosures of PHI that are subject to the accounting requirements of 45 CFR Section 164.528, Contractor promptly shall report such Disclosures to Hospital in writing. Such notice shall include the name of the individual and company affiliation to whom the PHI was Disclosed and the date of the Disclosure. Contractor shall maintain a record of each such Disclosure, including the date of the Disclosure, the name and, if available, the address of the recipient of the PHI, a brief description of the PHI Disclosed and a brief description of the purpose of the Disclosure.

Contractor shall maintain this record for a period of six (6) years and make such records available to Hospital upon request in an electronic format so that Hospital may meet its Disclosure accounting obligations under 45 CFR Section 164.528.

5. Access to PHI by Individuals. Contractor shall cooperate with Hospital to fulfill all requests by Individuals for access to the Individual's PHI that are approved by Hospital. Contractor shall cooperate with Hospital in all respects necessary for it to comply with 45 CFR Section 164.524. If Contractor receives a request from an Individual for access to PHI, Contractor immediately shall forward such request to Hospital, who shall be solely responsible for determining the scope of PHI and Designated Record Set with respect to each request by an individual for access to PHI. If Contractor maintains PHI in a Designated Record Set on behalf of Hospital, Contractor shall permit any Individual, upon notice by Hospital, to access and obtain copies of the individual's PHI in accordance with 45 CFR Section 164.524. Contractor shall make the PHI available in the format requested by the Individual and approved by Hospital. If Business Associate maintains the PHI in a Designated Record Set in electronic form and an Individual requests a copy of such information in electronic format, Business Associate shall provide such information in electronic format to Hospital in order for it to comply with its obligation. Contractor shall not charge Hospital or the Individual any fees for such access to PHI. If Contractor does not hold any information as part of a Designated Record Set, this Section shall not apply to Contractor.

6. Amendment of PHI. Contractor shall incorporate all amendments to PHI received from Hospital within five (5) business days of receipt. Contractor shall provide written notice to Hospital within five (5) business days of completing such amendment(s). Such notice shall confirm that Contractor has made the amendment(s) to PHI as directed by Hospital and shall contain any additional information necessary for Hospital to provide adequate notice to the Individual in accordance with 45 CFR Section 164.526. If Contractor does not hold any information as part of a Designated Record Set, this Section shall not apply to Contractor.

7. Access to Contractor's Books and Records. Contractor shall make its internal practices, books and records relating to the Use and Disclosure of PHI received from, or created or received by Contractor on behalf of Hospital, available to the Secretary of the Department of Health and Human Services ("Secretary") for purposes of determining Hospital's compliance with the HIPAA Laws. Contractor shall provide to Hospital a copy of any PHI that Contractor provides to the Secretary concurrently with providing such PHI to the Secretary. Contractor also shall make its internal practices, books and records available within five (5) business days of a request by Hospital for inspection for purposes of determining compliance with this Agreement.

8. Security Safeguards. Contractor shall implement a documented information security program that includes administrative, technical and physical safeguards designed to prevent the accidental or otherwise unauthorized Use or Disclosure of PHI. Contractor shall require any agents, affiliates, subsidiaries or subcontractors, with access to electronic PHI related to Hospital in any way, to agree in writing to the same requirements under this Section. Moreover, Contractor shall implement administrative, physical, and technical safeguards and policy, procedure, and documentation requirements consistent with the requirements of 45 CFR Sections 164.308, 164.310, 164.312, and 164.316.

9. Reporting and Mitigating. Contractor shall immediately report, but in no event later than 24 hours, any Security Incident including any Unauthorized or Unlawful Access, Use or Disclosure of PHI or Breach of Unsecured PHI not provided for or permitted by this Addendum of which the Contractor becomes aware. Moreover, in the event that Contractor becomes aware that PHI has been or reasonably believes has been accessed, acquired or Disclosed as a result of a "Breach," or Unauthorized or Unlawful Access as those terms are defined by the HIPAA Laws or Section 1280.15, Contractor will notify Hospital of the Breach and/or Unauthorized or Unlawful Access, Use or Disclosure, including the identification of each Individual who has been or is reasonably believed to have been affected thereby. Contractor's notification to Hospital shall be provided in accordance with HIPAA Laws and Section 1280.15 and guidance as it may be provided by the

Secretary and the California Office of Health Information Integrity. Contractor shall use its best efforts to mitigate the deleterious effects of any Unlawful Access, Use or Disclosure of PHI not authorized by this Addendum or any Security Incident.

10. Term and Termination.

(a) The Term of this Addendum shall be effective as of the Execution Date and shall terminate when all of the PHI provided by Hospital to Contractor, or created or received by Contractor on behalf of Hospital, is destroyed or returned to Hospital, or, if it is infeasible to return or destroy the PHI, protections are extended to such information, in accordance with Section 11 below.

(b) If Hospital becomes aware of any material breach of this Addendum by Contractor, Hospital shall provide Contractor with written notice of such breach and such breach shall be cured by Contractor within thirty (30) business days of such notice. If such breach is not cured with such time period, Hospital shall immediately terminate this Addendum.

(c) If Contractor becomes aware of any material breach of this Addendum by Hospital, Contractor shall provide Hospital with written notice of such breach and such breach shall be cured by Hospital within thirty (30) business days of such notice. If such breach is not cured with such time period, Contractor shall immediately terminate this Addendum.

(d) Contractor acknowledges and agrees that Hospital may be required by HIPAA Laws to report a Breach to the Secretary of the U.S. Department of Health and Human Services and Unauthorized or Unlawful Access, Use or Disclosure of PHI to the State.

(e) The Agreement shall automatically terminate upon termination of this Addendum for any reason whatsoever.

11. Effect of Termination.

(a) Upon termination or expiration of this Addendum, Hospital shall direct Contractor to either return or destroy all PHI that Contractor obtained, created or maintained pursuant to the Agreement on behalf of Hospital. If Hospital determines at that time that the return or destruction of PHI is not feasible, Contractor shall extend the protections provided under this Addendum to such PHI, and limit further Use or Disclosure of the PHI to those purposes that make the return or destruction of the PHI infeasible.

(b) Upon termination or expiration of this Addendum, Contractor shall recover all PHI that is in the possession of Contractor's agents, affiliates, subsidiaries or subcontractors. If Contractor believes at that time that it is infeasible for the Contractor to recover all PHI in the possession of Contractor's agents, affiliates, subsidiaries or subcontractors, Contractor shall provide written notice to Hospital regarding the nature of the unfeasibility. Upon a determination by Hospital that such recovery is infeasible, Contractor shall require that its agents, affiliates, subsidiaries and subcontractors agree to the extension of all protections, limitations and restrictions required of Contractor hereunder. If Hospital determines that it is feasible to make such recovery, Contractor shall recover all PHI in the possession of Contractor's agents, affiliates, subsidiaries or subcontractors.

(c) If Contractor or Contractor's agents, affiliates, subsidiaries or subcontractors retain any PHI pursuant to this Section 11, the terms of this Addendum shall continue to apply to the PHI retained by Contractor or any of Contractor's agents, affiliates, subsidiaries or subcontractors, even after termination of the Agreement.

12. Prohibition of Sale of PHI. Contractor may not directly or indirectly receive remuneration in exchange for any PHI without a valid Authorization specifically indicating that the PHI may be sold to the entity receiving the PHI unless the sale is otherwise authorized by the HIPAA Laws.

13. Indemnification. Each party, to the extent allowable under the California Tort Claims Act, shall indemnify, defend and hold harmless the other party and its agents, employees, contractors, officers and directors against: (i) any and all liability arising out of such party's failure to comply with the terms of this Addendum, and any injury, loss, fines, claims, or damages arising from the negligent operations, acts, or omissions of such party or its employees relating to or arising out of this Addendum; and (ii) any and all costs and expenses, including reasonable legal expenses, incurred by or on behalf of the other party in connection with the defense of such claims.

14. Contractor's Compliance with HIPAA. Hospital makes no warranty or representation that compliance by Contractor with this Addendum, the HIPAA Laws or California law will be adequate or satisfactory for Contractor's own purposes or that any information in Contractor's possession or control, or transmitted or received by Contractor, is or will be secure from unauthorized Use or Disclosure. Contractor is solely responsible for all decisions made by Contractor regarding the safeguarding of PHI.

15. Continuing Agreement. Except as expressly modified by this Addendum, the Agreement shall continue in full force and effect. In the event of any conflict between any provision of this Addendum and any provision of the Agreement, the provision of this Addendum shall control.

16. Assignment; Binding Effect. This Addendum shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns. Unless otherwise provided in the Agreement, Contractor may not assign the rights or obligations under the Agreement without the express written consent of Hospital; however, Hospital may assign its rights and obligations under this Agreement to any successor or affiliated entity without the consent of Contractor.

17. Affiliates, Agents, Subsidiaries and Subcontractors. Contractor shall require any agents and subcontractors which creates, receives, maintains or transmits PHI related to Hospital on its behalf, to agree in writing to the same Use and Disclosure restrictions and conditions imposed on Contractor by this Addendum including the requirement that such agents and subcontractors implement reasonable and appropriate administrative, physical and technical safeguards to protect such PHI. Business Associate shall incorporate, when applicable, the relevant provisions of this Addendum into each subcontract to such agents and subcontractors including the requirement to report Security Incidents, Breaches and Unauthorized or Unlawful Access, Use and Disclosures to Business Associate. Unless the Agreement permits Contractor to subcontract its services, Contractor shall not subcontract any of its services under the Agreement without first obtaining Hospital's prior written consent.

18. Compliance with Laws. The parties shall comply with all applicable laws, ordinances, codes and regulations of federal, state and local governments, applicable to the performance of the Agreement and this Addendum.

19. Governing Law. Unless provided otherwise in the Agreement, this Addendum shall be construed in accordance with and governed by the laws of the State of California, except the conflicts of laws provisions which would require the application of the laws of any other jurisdiction.

20. Headings. The headings in this Addendum are intended solely for convenience of reference and shall be given no effect in the construction or interpretation of this Agreement.

21. No Third-party Beneficiary Rights. Unless provided otherwise in the Agreement, the parties do not intend to confer and this Addendum shall not be construed to confer any rights or benefits to any person, firm, physician, corporation or entity other than the parties.

22. Data Ownership. Contractor acknowledges and agrees that all PHI that Contractor obtains, creates or maintains pursuant to the Agreement, on behalf of Hospital or for Contractor's internal use, is the property of Hospital and Contractor has no ownership rights with respect thereto.

23. Severability. If any provision of this Addendum is determined to be illegal or unenforceable, that provision shall be severed from this Addendum and/or the Agreement, as applicable, and such severance shall have no effect upon the enforceability of the remainder of the Agreement.

24. Counterparts. This Addendum may be executed in one or more counterparts, each of which shall be deemed to be an original, and all of which together shall constitute one and the same instrument.

25. Data Use Application. If Contractor requests a "Designated Data Set" from Hospital, Contractor must complete a Data Use Application (Instructions and Application attached to this Addendum) and submit a completed Data Use Application with this signed Addendum. The Data Use Application may be modified or amended by mutual agreement of the parties at any time without amending the Agreement or this Addendum.

IN WITNESS WHEREOF, the parties have executed this Addendum as of the Execution Date.

HOSPITAL

Tri-City Healthcare District, a health care district organized under the Local Health Care district Law of the State of California

By: _____
Chief Executive Officer

CONTRACTOR

Signature: _____

Print Name: _____

Title: _____

**ADMINISTRATIVE
POLICY MANUAL
COMPLIANCE**

ISSUE DATE: 08/15

SUBJECT: Verification of Identity and
Authority of Persons Requesting
Protected Health Information
(PHI), including Personal
Representatives

REVISION DATE(S):

POLICY NUMBER: 8610-593

Administrative Compliance Content Expert:	09/18
Administrative Policies and Procedures Committee Approval-Date(s):	07/1512/18
Organizational Compliance Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Audit, Compliance and Ethics Committee Approval-Date(s):	08/1502/19
Board of Directors Approval-Date(s):	08/15

A. PURPOSE:

1. The purpose of this Policy is to define the steps for verifying the identity and legal authority of a person requesting a patient's PHI, including Personal Representatives, prior to Disclosure.

B. DEFINITION(S):

1. Authorization: the written form that complies with Health Insurance Portability and Accountability Act (HIPAA) of 1996 and state law that is obtained from the Individual or his or her Personal Representative in order for TCHD to Use and Disclose PHI.
2. Disclosure: the release, transfer, provision of, access to, or divulging of PHI outside of Tri-City Healthcare District (TCHD).
3. Individual: the person who is the subject of protected health information.
4. Personal Representative: the person who has the authority to act for the Individual in making decisions related to health care under state law (except where an unemancipated minor has the authority to act as an Individual for certain services or circumstances) or, with respect to deceased persons, the person who has the authority to act on behalf of the deceased Individual or the Individual's estate as relevant to such personal representation.
5. Protected Health Information (PHI): individually identifiable health information transmitted or maintained in paper or electronic form that is created or received by TCHD AND
 - a. Relates to the past, present or future physical or mental health or condition of an individual; OR
 - b. Relates to the provision of health care to an individual; OR
 - c. Relates to the past, present, or future payment, AND
 - d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
6. Use: the sharing, application, utilization, examination or analysis of PHI within TCHD.

C. POLICY:

1. TCHD shall take reasonable steps to verify the identity of a person requesting Disclosure

- of a patient's PHI and the authority of such person to have access to the PHI where the authority is not known to TCHD.
2. TCHD shall take reasonable steps to verify the legal authority of a patient's Personal Representative where TCHD is required to treat such person as the patient.
3. If, under applicable laws, a Disclosure is conditioned on particular documentation, statements or representations from the person requesting the PHI, TCHD may rely, if such reliance is reasonable under the circumstances, on documentation, statements or representations that, on their face, meet the applicable requirements.
4. TCHD shall obtain any documentation, statements or representations, whether oral or written, from the person requesting PHI when they are a condition of a Disclosure.

D. **PROCEDURE:**

1. Verification of Identity of a Patient
 - a. Telephone: A person representing himself or herself as a patient can be verified using the following information:
 - i. Demographic information that can be confirmed in TCHD's [system], electronic health record or Patient Accounting system.
 - ii. The patient is known to TCHD from prior contact.
 - b. In Person: A person representing himself or herself as a patient can be verified by using the following information:
 - i. Presentation of identification such as a driver's license or other official photo identification record that would permit TCHD to confirm the identity is that of the patient.
 - ii. Verbal statements of demographic information that can be confirmed in TCHD's [system] electronic health record.
 - iii. The patient is known to TCHD from prior contact.
 - c. Emancipated minor patients: an emancipated minor is deemed equivalent to an adult for purposes of determining who may be given access to his or her PHI. TCHD shall obtain a copy of the minor's Department of Motor Vehicles identification card showing emancipation or a signed Declaration of Emancipation.
 - d. Deceased patients: The PHI of a deceased patient is subject to HIPAA privacy protections for as long as TCHD maintains the PHI.
 - i. TCHD should obtain a copy of the death certificate if the patient's death is not otherwise directly known to TCHD.
 - ii. TCHD shall follow the procedures for verifying the identity of the patient's Personal Representative when responding to requests for Disclosures of PHI of deceased patients.
2. Verification of Identity and Authority of Third Parties
 - a. Personal Representative: ~~an individual who Personal Representative may represent stand in the shoes of~~ the patient and authorize TCHD's Use and Disclosure of PHI to the extent of the Personal Representative's legal authority.
 - i. TCHD shall verify the identity of the patient's Personal Representative in the same manner it would a patient as set forth in Sections 1.a and 1.b above.
 - ii. The Personal Representative's authority to act for the patient arises from his or her authority under state law to make health care decisions for the patient (or in the case of deceased Individuals it may also be to carry out responsibilities related to the estate). TCHD shall verify the legal authority of the patient's Personal Representative by obtaining and reviewing written documents that support the nature and scope of the Personal Representative's legal authority under state law.
 - iii. The Personal Representative shall provide information and/or documents to support his or her authority as follows:
 - 1) Unless an exception applies, a parent or guardian appointed by the

Court or other person acting *in loco parentis* with legal authority to make health care decisions on behalf of the unemancipated minor: Court issued Letters of Guardianship or other legal documents evidencing parental rights to make health care decisions.

- 2) Surrogate who is 18 years or older and appointed by the patient to make health care decisions for the patient: The patient must personally inform the supervising provider, orally or in writing, of the appointment and it must be promptly recorded in the record. The surrogate appointment is effective only during the course of treatment or illness or stay or for 60 days whichever is shorter.
 - 3) Agent named under a Power of Attorney for Health Care or Advance Health Care Directive: valid, executed Power of Attorney for Health Care Directive form naming the person requesting PHI as the agent for health care decisions.
 - a) The Power of Attorney for Health Care document may specify limitations on an agent's ability to make health care decisions on behalf of the patient. For example, it may only apply for a specific treatment. In such cases, TCHD should not treat the person as the Individual for all purposes such as signing an Authorization for the Disclosure.
 - b) The Power of Attorney for Health Care document may contain conditions precedent to the agent's powers such as only applying when the patient is incapacitated. In such cases, TCHD should not treat the agent as the patient's Personal Representative when the patient is not incapacitated.
 - c) The Power of Attorney document may only be a General Power of Attorney to manage finances and other business. In such cases, TCHD should not rely on the Power of Attorney as it does not permit the person to make health care decisions for the patient unless it specifically mentions the right to make health care decisions.
 - 4) Guardian or Conservator: Obtain court-issued Letters of Guardianship or conservatorship.
 - 5) Executor or Administrator: Obtain court-issued Letters Testamentary of Letters of Administration.
 - 6) Beneficiary of a deceased patient as defined in Probate Code Section 24: Obtain excerpts of the will identifying the beneficiary.
 - 7) To release PHI to site and sponsor representatives on study subject, TCMC must have fully executed study-related patient consent on file.
- b. Family, relatives, domestic partners, close friends and other persons designated by the patient who are involved in patient's care or payment of the patient's care and for notification purposes: TCHD may ~~Disclose~~-disclose limited PHI upon verifying the following circumstances:
- i. If the patient is available for, or otherwise available prior to a Use or Disclosure and has the capacity to make health care decisions, TCHD may Use or Disclose PHI if it has the patient's agreement; or it provides the patient with the opportunity to object and the patient does not express an objection; or it can reasonable infer from the circumstance, based on professional judgment, that the patient does not object to the Disclosure. For example, an emergency room nurse may discuss a patient's treatment in front of the patient's friend when the patient asks the friend to come into the treatment room or a patient account representative may discuss the patient's bill with their son who is at

- TCHD with the patient.
 - ii. If the patient is not available, or the opportunity to agree or object is not practicable because of incapacity or emergency circumstances, TCHD may use its professional judgment to determine if the Disclosure is in the best interest of the patient and, if so, only ~~Disclose~~ disclose the PHI that is directly relevant to the person's involvement with the patient's care or payment related to the patient's health care or needed for notification purposes. For example, TCHD may use professional judgment and experience with common practice to make reasonable inferences of the patient's best interest in allowing a person to pick up filled prescriptions, x-rays or similar forms of PHI or may provide information on a patient's condition to their spouse when the patient is unconscious.
 - iii. TCHD will not discuss a patient's PHI with family, relatives, domestic partners, and close friends if the patient expressly indicates it may not do so.
 - iv. When TCHD is permitted to share limited PHI with family, relatives, domestic partner, and close friends as provided above, it should not discuss past medical information that is unrelated to the patient's current condition..
 - c. Public Officials seeking PHI:
 - i. Verification of Identity: TCHD may rely, if such reliance is reasonable under the circumstances on the following to verify the identity of a person when the Disclosure of PHI is to a public official or a person acting on behalf of a public official:
 - 1) For in person requests, presentation of an agency identification badge, other official credentials, or other proof of government status;
 - 2) For requests made in writing, the request is on the appropriate government letterhead; and
 - 3) If the Disclosure is to a person acting on behalf of a public official, a written statement on appropriate government letterhead that the person is acting under the government's authority or other evidence or documentation of agency such as a contract for services, memorandum of understanding, or purchase order, that establishes that the person is acting on behalf of the public official.
 - ii. Verification of Authority: TCHD may rely, if such reliance is reasonable under the circumstances on the following to verify authority when the Disclosure of PHI is to a public official or a person acting on behalf of a public official.
 - 1) A written statement of the legal authority under which the information is requested, or, if a written statement would be impracticable, an oral statement of such legal authority; and
 - 2) If a request is made pursuant to legal process, warrant, subpoena, order, or other legal process issued by a grand jury or a judicial or administrative tribunal is presumed to constitute legal authority for purposes of verification of identity and authority.
 - d. Exceptions to Recognizing Persons as Personal Representatives
 - i. TCHD may elect not to treat a person as the Personal Representative of a patient (adult or minor) if the following requirements are satisfied and the election is documented in the patient's record:
 - 1) TCHD has a reasonable belief that:
 - a) ~~the~~The patient has been or may be subject to domestic violence, abuse or neglect by such person;
 - b) ~~treating~~Treating such person as the Personal Representative could endanger the patient; ~~AND~~and
 - 2) TCHD, in the exercise of the professional judgment of the health

- care provider, decides it is not in the best interest of the patient to treat the person as the patient's Personal Representative.
 - 3) TCHD shall consult with Legal Counsel as necessary and appropriate regarding the election decision.
 - ii. TCHD shall not treat a parent as the Personal Representative of a minor in the following circumstances:
 - 1) If the minor has the authority to consent to medical treatment under state law, he or she is generally the person authorized to have access to medical records regarding the treatment and to decide whether records get released to other persons. If a minor has the right to inspection, then TCHD shall not grant a Personal Representative access to the minor patient's PHI.
 - 2) A court determines or other law authorizes someone other than the parent to make treatment decisions for a minor.
 - 3) A provider makes a good faith determination that a parent or other legal representative who has authority to consent to treatment would have a detrimental effect on the provider's professional relationship with the minor.
 - 4) If the minor has been removed from the physical custody of a parent or guardian in a dependency proceeding, the parent or guardian may not access the minor's mental health information without a court order.
 - e. Legal Review
 - i. TCHD Compliance Department shall consult with Legal Counsel as necessary and appropriate regarding the authority of a Personal Representative, issues involving unemancipated minor rights to access medical records or any other information relevant to this policy.
 - f. Documentation
 - i. TCHD shall retain copies of all documentation obtained for purposes of these verification procedures.

E. FORM(S):

- 1. Authorization for Use or Disclosure 8700-1002 - Sample

E.F. REFERENCE(S) LIST:

- 1. 45 Code of Federal Regulations (CFR Section 160.103)
- 2. 45 CFR Section 164.502(g)
- 3. 45 CFR Section 164.510
- 4. 45 CFR Section 164.514(h)
- 5. Cal. Health & Safety Code Section 123110(g)
- 5-6. Probate Code Section 24

SAMPLE

Completion of this document authorizes the use or disclosure of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.
Failure to provide all information requested may invalidate this Authorization.

USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth _____
(Please print)

I hereby authorize the use or disclosure of my health information as follows:

Person/Organization authorized to *release* (use or disclose) the
information:¹ Tri-City Medical Center
(TCMC or other Entity)

Person/Organization authorized to *receive* the information (name and address of entity):

Phone Number (with area code)

This Authorization applies to the following specific information to be disclosed (select from the following):²

- ☐ All health information pertaining to any medical history, mental or physical condition and treatment received.
Dates include: _____
[Optional] Except for these specific limitations:

- ☐ Only the following records or specific types of health information. Dates include: _____
- | | |
|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History/Physical Report |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Operative/Procedure Report |
| <input type="checkbox"/> Emergency Dept Report | <input type="checkbox"/> EKG |
| <input type="checkbox"/> Laboratory Tests | <input type="checkbox"/> X-Ray Reports |
- ☐ Other
(please specify) _____

I understand that this will include information relating to (check if applicable):

- ☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection
☐ Psychiatric Care (patient to initial here _____)
☐ Treatment for alcohol and/or drug abuse.

EXPIRATION

This Authorization expires [on the following specific date]: 30 days

RESTRICTIONS

I understand that California law prohibits the recipient of my health information pursuant to this authorization from making further disclosure of my health information unless the Recipient obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS

I understand that I may refuse to sign this Authorization.

I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: 4002 Vista Way Oceanside, CA 92056. Attn: Medical Records/Health Information.

I understand that my revocation will be effective upon receipt, but will not affect any use or disclosures completed prior to receipt of the revocation.

AUTHORIZATION FOR USE OR DISCLOSURE

8700-1002
(Rev 5/15)



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

White-Med Records Yellow-Patient

SAMPLE

ADDITIONAL RIGHTS AND REQUIREMENTS IF REQUESTOR SEEKS THIS AUTHORIZATION³

I understand that if Requestor seeks this authorization:

1. My health information will be used for the following purpose(s): ☐ Continuing Medical Care
☐ Insurance ☐ Legal ☐ Other (Please specify) _____
2. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
3. I must receive a copy of this Authorization⁴.
4. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. However, this does not apply if the Requestor is seeking to use the information as follows: (i) to conduct research-related treatment; (ii) to obtain information in connection with my eligibility or enrollment in a health plan of which I am not already a member; (iii) to enable the Requestor to determine its obligation to pay a claim; or (iv) to create health information to provide to a third party. Under no circumstances, however am I required to authorize the disclosure of psychotherapy notes.
5. If this box ☐ is checked, I understand the Requestor may receive compensation or other remuneration directly or indirectly for the use or disclosure of my information.

SIGNATURESignature _____ Date/Time _____ AM/PM
[Patient/representative/spouse/financially responsible party]If signed by someone other than the patient, state your legal relationship to the patient⁵:

Witness: _____

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.)

Authorization for Use or Disclosure of Health Information – Footnote references

¹ If the Authorization is being requested by the entity holding the health information, then such entity shall be referred to as the Requestor throughout this form.

² This form may not be used to release both psychotherapy notes and other types of health information [(see 45 CFS § 164.508(b)(3)(ii)]. If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.

³ The Requestor is to complete this section of the form.

⁴ Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures [(see 45 CFR § 164.508(d) (1), (e) (2)].

⁵ A spouse or financially responsible party may only authorize release of medical information for use in the following:

- a. to process an application for the patient
- b. as a spouse or dependent for the following:
 - a. a health insurance plan or policy
 - b. a nonprofit hospital plan
 - c. a health care service plan or
 - d. an employee benefit plan

For TCMC Medical Records/Health Information use Only

MRUN: _____ Date Received: _____

Date of Birth: _____ Visits to be Included: _____

SS#: _____

Telephone #: _____

Distribution: ☐ Mail ☐ Pick-up ☐ CD ☐ Other _____ Completed by: _____
Signature Date

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

**January 31, 2019 – 2:30 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 2:30 p.m. on January 31, 2019.

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

Director Rocky J. Chavez
Director George W. Coulter
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy M. Younger

Also present were:

Steven Dietlin, Chief Executive Officer
Susan Bond, General Counsel
Sharon Schultz, Chief Nurse Executive
Scott Livingstone, Chief Operations Officer
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairperson, Leigh Anne Grass, called the meeting to order at 2:30 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

It was moved by Director Nygaard to approve the agenda. Director Schallock seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

Chairperson Grass read the Public Comments section listed on the January 31, 2019 Regular Board of Directors Meeting Agenda.

There were no public comments.

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

Chairperson Grass made an oral announcement of the items listed on the January 31, 2019 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 and approval of Closed Session Minutes.

5. Motion to go into Closed Session

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

6. The Board adjourned to Closed Session at 2:35 p.m.
8. At 3:30 p.m. in Assembly Rooms 1, 2 and 3, Chairperson Grass announced that the Board was back in Open Session.

The following Board members were present:

Director Rocky J. Chavez
Director George W. Coulter
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy M. Younger

Also present were:

Noel Caughman, Board Counsel (via teleconference)
Steve Dietlin, Chief Executive Officer
Sharon Schultz, Chief Nurse Executive
Scott Livingstone, Chief Operations Officer
Ray Rivas, Chief Financial Officer
Carlos Cruz, Chief Compliance Officer
Aaron Byzak, Chief External Affairs Officer
Susan Bond, General Counsel
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairperson Grass reported no action was taken in closed session.
10. Director Nygaard led the Pledge of Allegiance.
11. Chairperson Grass read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 24. Chairperson Grass requested that speakers adhere to the three minute time allotment.
12. Special Recognition
 - a) In recognition of Sharon Schultz, MSN, RN, MPH for her 13 years of service and dedication to Tri-City Medical Center both as the Director of Emergency Services and Chief Nurse Executive.

Chairperson Grass invited Mrs. Schultz, CNE to the podium to accept a token of appreciation from the Board of Directors. On behalf of the Board, Chairperson Grass expressed her appreciation to Ms. Schultz for the many years of dedication, loyalty and selfless servitude tirelessly given by Ms. Schultz during her 13 years of service to Tri-City Medical Center both as the Director of Emergency Services and Chief Nurse Executive. Chairperson Grass stated Ms. Schultz will be greatly missed but the Board extends their wishes for many healthy and happy years in retirement.

13. Report from TCHD Auxiliary – Mary Gleisberg, President

Mrs. Mary Gleisberg, Auxiliary President echoed Chairperson Grass's comments related to Ms. Sharon Schultz. She stated that every Auxiliary President that has had the privilege of working with Sharon has raved about how supportive she has been to the Auxiliary.

Ms. Gleisberg reported each year the Auxiliary donates a minimum of \$55,000 for the purchase of critical needs. This year the Auxiliary worked with Ms. Schultz to identify those needs and will be purchasing items for the ER, ICU and OR. Ms. Gleisberg stated if additional funds become available they plan to purchase more wheelchairs as this has been a request of the Auxilians the past couple of years.

Ms. Gleisberg expressed her appreciation to Director Grass and the Administration for taking their time to join the Auxiliary for the Past President's Luncheon.

Ms. Gleisberg reported on the following upcoming events for the Auxiliary:

- Scholarship Awards Night – April 24th
- Volunteer Appreciation Luncheon – April 29th
- Installation of Officers Luncheon – June 29th

Ms. Gleisberg stated she has spotlighted several of the departments throughout the last year and today would like to highlight the Department of Women & Newborn Services which is one of the most popular departments for the volunteers. Ms. Gleisberg invited the Department Chair Sandy Tucker who is also a Past President and Manager of the *Pulse* to present a brief report on her department.

Ms. Tucker stated the main task in the NICU is to hold fussy babies or babies whose parents are unable to come and spend much time with them. In addition they stock the cribs and feeding supplies. The volunteers also clean equipment, answer the phone, keep the waiting room clean and stocked with magazines as well as stock the warmer and sort baby clothes. In Postpartum the volunteers serve the meals, pick up trays and pass out snacks and fresh water. In addition, the volunteers help make beds, help moms to the showers and watch the babies if no one is visiting mom. Another duty of the postpartum volunteers is to assist in discharging patients or taking moms to the NICU.

Ms. Tucker stated the Auxiliary's Workshop Department makes lovey dolls for the NICU and the Christmas stockings for December and the New Year's babies. Baby caps are donated every year by individual volunteers and La Costa Glen and Fair Winds Residential Homes.

Ms. Tucker stated our Gift Shop sells baby items and has its own show case in the waiting room for Maternity.

Chairperson Grass commented on the many hours of service that the Auxilians provide and we are blessed to have them here at our hospital.

No action taken.

14. Report from Chief Financial Officer

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

- Net Operating Revenue – \$176.615
- Operating Expense – \$179,666
- EBITDA - \$8,104
- EROE – \$352

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

- Average Daily Census – 152
- Adjusted Patient Days – 50,111
- Surgery Cases – 3,282
- Deliveries – 1,096
- ED visits – 28,179

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

- Operating Revenue - \$29,704
- Operating Expense - \$29,962
- EBITDA - \$1,544
- EROE –\$236

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

- Average Daily Census – 153
- Adjusted Patient Days – 8,069
- Surgery Cases – 519
- Deliveries – 166
- ED Visits – 4,629

Mr. Rivas reported on the following indicators for FY19 Average:

- Net Patient Accounts Receivable - \$43.2
- Days in Net Accounts Receivable - 51.3

Mr. Rivas noted Days in AR should come down in the next couple of months.

Mr. Rivas stated this month there was an increase in high acuity patients in our ICU and longer length of stay is a fixed reimbursement rate which made it more difficult to meet budget.

Director Grass commented on the current month indicators. She questioned the decline in ED visits. Mr. Rivas stated with the 2014 Affordable Care Act the cost for care has shifted from the insurance companies to the payor and cited a

recent article that stated the patient portion of care has gone up almost 30% since 2015. Mr. Rivas stated ED visits are going down nationwide.

Director Schallock commented that literature is showing that insurance companies are stressing that they don't want the patient to go to the ED because costs are much higher and the patient risks not being reimbursed. Consequently the patient may go to alternative sources such as urgent care centers. Chairperson Grass stated insurance companies are also utilizing Telehealth to keep patients out of the ED.

Director Reno questioned whether most of our admissions to the hospital come from the ED. Mr. Rivas responded that 80% of our admissions do come through the ER. Consequently if visits to the ED are down our revenue goes down. Mr. Rivas commented on the importance of staffing accordingly and keeping our expenses down which has resulted in us being able to show a profit for the first six months of the fiscal year.

No action was taken.

15. New Business

- a) Consideration to nominate Director Chavez to be considered on the CHA Governance Forum

It was moved by Director Reno that the Tri-City Healthcare District Board of Directors recommend consideration of Director Rocky Chavez to serve on the CHA Governance Forum. Director Coulter seconded the motion.

The vote on the motion was as follows:

AYES:	Directors:	Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

- b) Discussion and recommendations regarding Board's Self-Evaluation Retreat/Facilitators to be held in the fall of 2019.

Director Schallock stated it is the Board's practice to perform a Self-Assessment in non-election years in the fall. He suggested Board members think about who they would like to see facilitate the Self-Assessment Retreat and send their recommendations to the Board Chair.

No action taken.

- c) Consideration to accept recommendations from CHAC Ad Hoc Committee related to its committee structure and function including amendments to the CHAC Charter.

It was moved by Director Chavez to accept the recommendations from the CHAC Ad Hoc Committee related to its committee structure and function including amendments to the CHAC Charter as presented. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	Directors:	Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

16. Old Business

Consideration to award Board Scholarship to the Tri-City Hospital Auxiliary in the amount of \$10,000.

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors award \$10,000 in Auxiliary Student Scholarships. Director Nygaard seconded the motion.

Chairperson Grass invited Ms. Connie Jones, Chairperson of the Scholarship Committee to the podium. Ms. Jones provided a brief history of the Scholarship program which was first initiated in 1973 with the first scholarship being given to a vocational licensed student in the amount of \$100. Ms. Jones explained that today the Auxiliary awards scholarships to our Junior Volunteers who are high school students that are graduating and going on to a university or college. She stated last year the Auxiliary began awarding scholarships to our college student volunteers who are taking the prerequisite course study that will lead them to a career in the healthcare field and we continue to give scholarships to our Nursing students at Palomar College, Mira Costa Collage and Cal State University San Marcos.

Mr. Jones stated seven years ago the Auxiliary saw their inability to continue to financially award the increasing number of applications with the available funds and began a private donor campaign which has been very successful. Last year there were 127 acceptable applications and 90 scholarships were awarded to our local students and this was possible because of their donor program. Ms. Jones explained that one of the reasons the Auxiliary was able to do is they secured a major donor from Orange County who contributed \$50,000 a year for the last five years. However this year the Auxiliary was informed that the donor was not going to be able to continue their support as they were redirecting their funds to others in Orange County. She noted last year the program was \$37,000 short of meeting the needs of the community and this is why the donor program is so important.

Chairperson Grass stated she attended the Medical Executive Committee meeting this past week and reminded physicians of the program and encouraged their support.

Chairperson Grass questioned how someone in the audience or Board would go about sponsoring a student. Ms. Jones stated anyone interested should contact her in the Auxiliary office. Director Reno questioned if a donor could designate a specific student to receive a scholarship. Ms. Jones stated if the student qualifies as a

recipient that donor could indeed designate a specific student. To qualify the student must be currently enrolled in a nursing program or taking the prerequisite course study that will lead them into a career in the healthcare field and attending one of the three local colleges, Palomar, Mira Costa or Cal State University San Marcos. Ms. Jones stated the donors are invited to the Scholarship Awards night, sit with their recipient and then present the award. Director Reno requested that Ms. Jones contact her regarding setting up a scholarship.

Director Grass stated our donations will come back ten-fold to the community and it is truly an investment in our own future.

The vote on the motion was as follows:

AYES:	Directors:	Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

17. Chief of Staff

- a. Consideration of January 2019 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on January 28, 2019.

It was moved by Director Reno that the Tri-City Healthcare District Board of Directors approve the January 2019 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on January 28, 2019. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	Directors:	Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

- b) Consideration of amended Medical Staff Bylaws

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors approve the amended Bylaws as recommended by the Medical Executive Committee on January 28, 2019. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	Directors:	Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

c) Consideration of revision to Cardiology Privilege Card

It was moved by Director Nygaard that the Tri-City Healthcare Board of Directors approve the revised Cardiology Privilege Card as recommended by the Medical Executive as recommended by the Medical Executive Committee on January 28, 2019. Director Schallock seconded the motion.

Director Reno questioned if the revision to the Privilege Card was included in the agenda packet. Dr. Souza confirmed that the revised Privilege Card was included in the agenda packet and referred Director Reno to page 124 of the agenda packet.

The vote on the motion was as follows:

AYES:	Directors:	Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

18. Consideration of Consent Calendar

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

It was moved by Director Reno to pull items 18 (2) B. 3) Approval of a Lease Agreement for Suite 101 in the Carlsbad Wellness Center MOB located at 6260 El Camino Real, Carlsbad, CA 92009, with Ohana Medical Services Organization, Inc. for a ten-year, five month term (125 months), at a rate of \$7,971 per month, increasing base rent 3% yearly and with a total credit from the landlord not to exceed \$239,609 and 18 (2) B. 6) Approval of a Sublease Agreement for Suite 160 at 2067 West Vista Way, Vista, CA 92083 with Dr. Kenneth Carr for a month-to-month term to commence February 1, 2019 at the rate of \$2,169.76 per month. Director Chavez seconded the motion.

The vote on the motion to approve the Consent Calendar minus the items pulled was as follows:

AYES:	Directors:	Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

20. Discussion of items pulled from Consent Calendar

Director Reno who pulled the Lease Agreement for the Carlsbad Wellness Center stated she is uncomfortable with a 10-year lease and the Board has never approved ten-year leases in the past. Mr. Jeremy Raimo, Senior Director of Business Development explained that a ten-year lease is reasonable, there is precedent (citing the 15-year lease entered last year with the Ortho group) and stated the lease provides an opportunity to meet the needs of the community without the actual

running of an Urgent Care Center. Mr. Raimo further explained that Colliers handles negotiation of all of these leases and protects the interests of the District. He stated the lease includes automatic escalators which are common in a long-term lease and the District is comfortable with the terms that Collier was able to negotiate.

It was moved by Director Nygaard to approve a Lease Agreement for Suite 101 in the Carlsbad Wellness Center MOB located at 6260 El Camino Real, Carlsbad, CA 92009, with Ohana Medical Services Organization, Inc. for a ten-year, five month term (125 months), at a rate of \$7,971 per month, increasing base rent 3% yearly and with a total credit from the landlord not to exceed \$239,609. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	Directors:	Chavez, Coulter, Grass, Nygaard, Schallock and Younger
NOES:	Directors:	Reno
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

Director Reno who pulled the Sublease Agreement with Dr. Carr stated she was not aware that we were subleasing space. Mr. Raimo stated the approximate 1500 square foot space was previously occupied by Venus Women's Health. This was vacant space that Dr. Carr wants to lease with us. He is not taking on the full lease but a portion of it. The month to month lease works out in the best interest of the District. Director Nygaard commented that this is revenue for the District.

It was moved by Director Nygaard to approve the Sublease Agreement for Suite 160 at 2067 West Vista Way, Vista, CA 92083 with Dr. Kenneth Carr for a month-to-month term to commence February 1, 2019 at the rate of \$2,169.76 per month. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	Directors:	Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

21. Reports (Discussion by exception only)

Director Reno pulled the construction report and requested information on the parking garage. Chairperson Grass stated there was no construction report on today's agenda however Director Reno could request the report for a future meeting. Director Reno requested that the construction report be added to next month's agenda.

22. Comments by Members of the Public

Chairperson Grass recognized Mr. Stan Prowse, Foundation Board Member who commented on his "favorite office building" which he perceives as a black eye for the district and the hospital. He stated he does not have access to enough information to make a comment as to what should be done or not be done however the "black eye"

sitting over the 78 for all to see is not a good thing and removing it is probably worth some money along the way. Mr. Prowse asked that the Board keep that in mind and get the building filled and give us a building we can be proud of.

23. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO stated he had the opportunity to attend the Past President's Auxiliary Luncheon. Mr. Dietlin expressed his appreciation to the hundreds of Auxilians who are here every single day providing services. They really do make this hospital different.

Mr. Dietlin congratulated the Board of Directors for their decision to participate in the Auxiliary Scholarship program. He commented that to see the gratitude of the recipients is really rewarding.

Mr. Dietlin Congratulated Ms. Jennifer Paroly on her position as Executive Director of the Tri-City Hospital Foundation.

Mr. Dietlin reported we have received notification from The Joint Commission that we have received full accreditation. He congratulated everyone on this great accomplishment and thanked everyone who participated in reaching our goals.

Mr. Dietlin reported HCAPS are above the 70th percentile. Left Without Treatment (LWOT) dropped below 2 % and wall time is the lowest in San Diego County.

Mr. Dietlin acknowledged the positive bottom line financial results and stated it takes everyone working together to accomplish these goals.

Lastly, Mr. Dietlin congratulated Ms. Sharon Schultz on her retirement and expressed his appreciation for her 13 years of dedication to Tri-City Medical Center.

24. Board Communications

Director Younger did not have any comments.

Director Coulter did not have any comments.

Director Chavez did not have any comments.

Director Nygaard expressed her appreciation to Ms. Sharon Schultz for her support and dedication.

Director Schallock also expressed his appreciation to Ms. Sharon Schultz for her loyalty, dedication and leading this organization and wished her good luck in her retirement.

29. Report from Chairperson

Chairperson Grass congratulated Ms. Jennifer Paroly on her appointment to the office of Executive Director of the Foundation.

Chairperson Grass congratulated staff on the upcoming opening of the Pharmacy which is predicted to open in May.

Chairperson Grass reported the Board held their Orientation this past month and it went well. She stated she is looking forward to moving forward with the administrative team in the right trajectory and serving the community.

34. There being no further business Chairperson Grass adjourned the meeting at 4:23 p.m.

Leigh Anne Grass
Chairperson

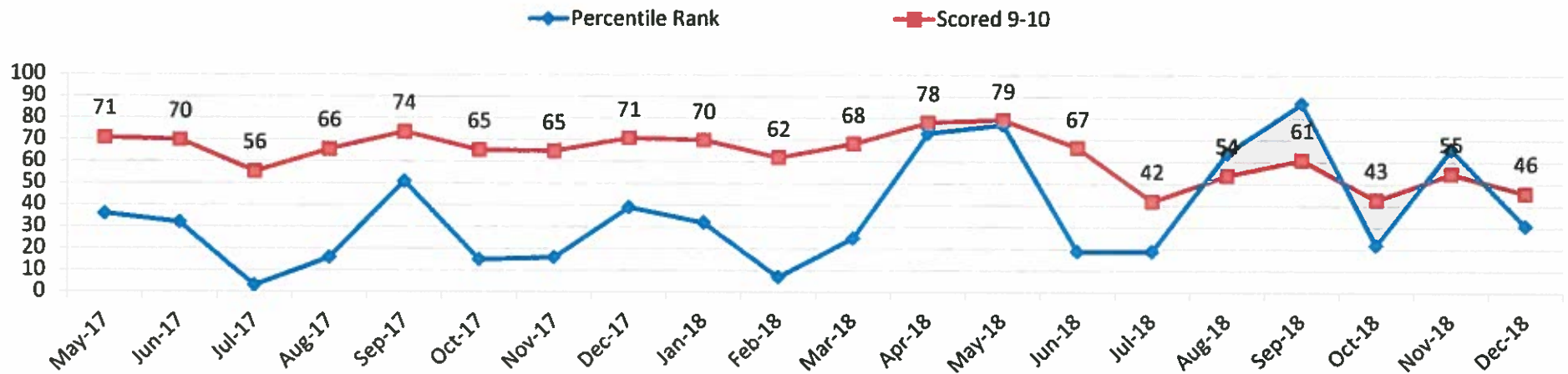
ATTEST:

Secretary

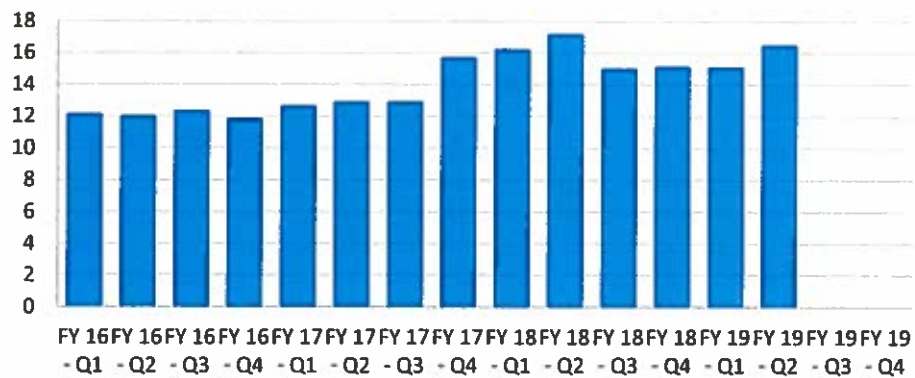


Stakeholder Experiences

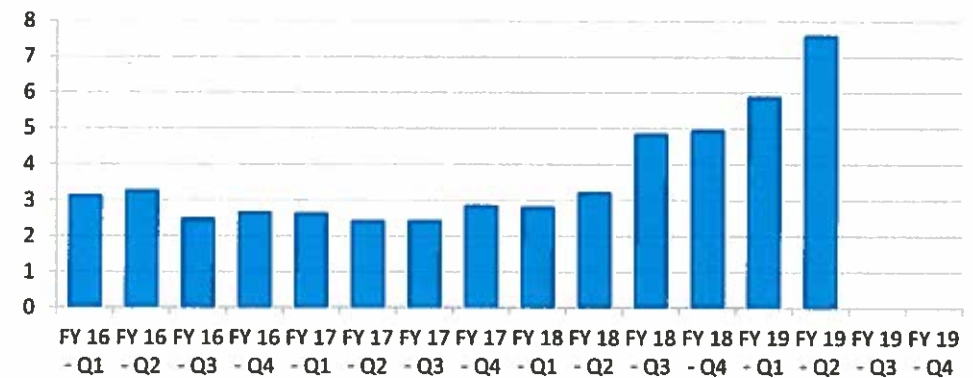
Overall Rating of Hospital (0-10)



Voluntary Employee Turnover Rate



Involuntary Employee Turnover Rate



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	18	24	22						157
FY18	26	23	23	20	27	27	22	23	24	20	20	28	168

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	10	14	3	7	7	9	10						60
FY17	14	6	7	13	7	15	14	8	12	7	10	6	76

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	12	16	17						108
FY18	11	12	12	14	16	18	23	12	15	15	16	20	106

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	17	21	19						140
FY18	15	20	20	16	23	15	15	19	23	11	20	17	124

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	38	31	23						216
FY18	48	37	33	32	26	38	29	24	30	38	33	38	243

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	-	-	-	-						4.6
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	14.8

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	5.7	5.3	6.8						6.5
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	7.8

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	11.6	8.7	10.1						10.4
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	12.9

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	143.7	153.2	164.8						153.5
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	176.2

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	186	202	170	187	185	166	170						1,266
FY18	210	222	194	206	184	166	209	169	186	156	163	188	1,391

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	8	10	6	8	3	15	6						56
FY18	12	11	11	11	11	18	16	5	7	16	15	20	90

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	13	6	11						53
FY18	4	7	7	3	4	3	2	4	8	2	7	8	30

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	8	8	6	8	4	14	8						56
FY18	8	7	7	11	3	14	11	10	4	10	8	5	61

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	1.78	1.7	1.72						1.78
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	1.76



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	52.3	56.5	58.9						52.4	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	49.2	

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	92.5	87.8	93.1						89.5	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	82.2	

TCHD EROE \$ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY19	(\$478)	(\$121)	\$119	\$254	\$342	\$236	(\$527)						(\$175)	\$895
FY18	(\$394)	(\$429)	(\$224)	(\$171)	(\$2,571)	(\$383)	(\$1,242)	(\$542)	(\$337)	(\$679)	(\$408)	\$3,118	(\$5,415)	

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%	1.19%	0.79%	-1.76%						-0.08%	0.44%
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%	-2.57%	



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	\$1,618	\$1,544	\$826						\$8,930	\$10,313
FY18	\$898	\$864	\$1,091	\$1,146	(\$1,288)	\$908	\$81	\$751	\$963	\$571	\$900	\$4,407	\$3,700	

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%	5.65%	5.20%	2.76%						4.32%	5.07%
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%	1.76%	

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	7.82	6.50	6.68						6.88	6.64
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	6.33	

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	\$37.5	\$29.5	\$36.3							
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		

Measure	Source	Description	CY18 Q1	CY18 Q2	CY18 Q3	CY18 Q4			Rolling 12months
						Oct-18	Nov-18	Dec-18	
Sepsis									
Sepsis Compliance	Quantros	Compliance with the 3hr & 6hr bundle treatment (Benchmark 2Q18 State: 60%, National 56%)	48.3%	56%	49%	36%	15%		46%
Post Op Sepsis	HSAG	# Sepsis per 1,000 discharges (PSI13) (Medicare FFS)	16.67	4.88					11.88
Overall Sepsis Rate	HSAG	# Sepsis diagnosis per 1,000 admits (Medicare FFS)	8.96	9.19					9.07
Sepsis Readmission	PowerInsight	Medicare FFS Pts with a prim Dx of Sepsis, readmitted within 30days	8.6%	10.8%	7.1%	2.1%	6.0%	6.3%	7.8%
Sepsis Mortality	PowerInsight	Medicare FFS Pts with a prim Dx of Sepsis, expired within 30days (Benchmark 25%)	16.3%	9.4%	9.4%	14.9%	18.0%	22.9%	13.4%
Hospital Acquired Infections - Standardized Infection Ratio (green = better, yellow = no different, red = worse than expected)									
CLABSI	NHSN	CMS 2Q18 St 0.824, Ntl 0.744; CDPH '19 0.60		1.4	9			8	66
CAUTI	NHSN	CMS 2Q18 St 0.919, Ntl 0.779	2.1	.7				7	94
COLO	NHSN	CMS 2Q18 St 1.094, Ntl 0.937; CDPH '19 0.76	1.1	3.3	2			2.4	2.16
HYST	NHSN	CMS 2Q18 St 0.932, Ntl 0.904; CDPH '19 0.78							
MRSA	NHSN	CMS 2Q18 St 0.774, Ntl 0.839; CDPH '19 0.60	.8		1.2			1.3	85
CDI	NHSN	CMS 2Q18 St 0.666, Ntl 0.710; CDPH '19 0.78	1.3	.8	9			1.3	1.07
Hospital Acquired Conditions									
HAC01/PSI5	PowerInsight	Foreign Object Retained After Surgery							
HAC02/PSI12	PowerInsight	Air Embolism							
HAC03	PowerInsight	Blood Incompatibility							
HAC04	PowerInsight	Stage III And IV Pressure Ulcers	2						2
HAC05	PowerInsight	Falls And Trauma			1				1
HAC06	PowerInsight	Catheter-Associated Urinary Tract Infection (UTI)	2	2	1	1			6
HAC07/PSI7	PowerInsight	Vascular Catheter-Associated Infection						1	1
HAC08	PowerInsight	Surgical Site Infection-Mediastinitis After Coronary Bypass Graft (CABG)							
HAC09	PowerInsight	Manifestations Of Poor Glycemic Control							
HAC10	PowerInsight	Deep Vein Thrombosis (DTV)/Pulmonary Embolism (PE) w Total Knee/Hip Replacement	2	1		1		1	5
HAC11	PowerInsight	Surgical Site Infection - Bariatric Surgery							
HAC12	PowerInsight	Surgical Site Infection - Certain Orthopedic			1				1
HAC13	PowerInsight	Surgical Site Infection (SSI) Following Cardiac							
HAC14/PSI6	PowerInsight	Iatrogenic Pneumothorax W/ Venous Catheterization	1					1	2
Adverse Drug Events									
Anticoagulation (INR > 5)	PowerInsight	Number of pt days with at least 1 INR>5 for adult pts on Warfarin X1000	82.1	35.7	23.8	80.3	60.1	41.3	54.5
Antidiabetics (BG<50)	PowerInsight	Number of pt days with at least 1 BG < 50mg/dl for adult pts on insulin X1000	14.83	14.97	17.41	11.53	7.39	7.12	13.92
Opioids (Naloxone Use)	PowerInsight	Number of pt days Naloxone administration was required for pts on an opioid X1000	57.0	53.0	8.0	18.0	17.9	4.5	16.6
BCMA	Explorer	Bar code med administration where both patient & medication scanned							
CPOE	Explorer	Computer Physician Order Entry usage							
Opioid IP Rx	PowerInsight	% opioid prescribe at discharge for inpatients	10.6%	11.3%	12.3%	12.7%	14.0%	12.3%	11.7%
Opioid ED Rx	PowerInsight	% opioid prescribe at discharge for ED patients	7.6%	8.4%	8.8%	9.7%	8.8%	8.5%	8.5%
Patient Satisfaction - Top Box Scores (green = VBP 5pts, yellow = VBP 4pts, red = VBP 3pts)									
Healthstream/NRC		Communication with Nurses	81.8	84.7	80.2	70.4	83.3	80.5	80.0
Healthstream/NRC		Communication with Doctors	84.5	77.3	84.4	80.7	85.9	78.8	82.1
Healthstream/NRC		Responsiveness of Hospital Staff	67.2	78.0	66.0	68.5	71.0	79.4	71.4
Healthstream/NRC		Communication about Pain	55.1	55.7	70.6	70.9	77.5	72.6	67.8
Healthstream/NRC		Communication About Meds	61.6	64.9	68.7	60.0	72.2	62.9	65.3
Healthstream/NRC		Discharge Information	91.0	89.3	93.4	83.3	94.8	95.8	91.4
Healthstream/NRC		Cleanliness / Quietness	64.3	68.6	64.3	62.1	69.8	67.0	65.9
Healthstream/NRC		Overall Rating of Hospital	66.8	74.8	52.4	42.9	54.9	48.0	55.4
Healthstream/NRC		Would Recommend Hospital	67.7	75.3	73.8	64.3	76.5	81.2	69.9
Healthstream/NRC		Care Transitions	46.8	46.0	47.9	38.6	45.0	36.5	43.5
Emergency Patient Satisfaction - Top Box Scores (green = 10% improvement, yellow = improvement, red = no improvement; Baseline = CY18Q3)									
NRC		How likely would you be to recommend this facility to your family and friends?			40.4	42.7	46.0	50.4	43.0
NRC		Did you trust the care providers with your care?			39.1	46.1	45.5	43.8	41.9
NRC		Did you receive consistent information from all care providers during this visit?			35.5	41.4	42.2	41.0	38.3
NRC		Was a family member/friend allowed to be involved as much as you wanted?			42.1	49.0	47.6	44.7	44.4
NRC		Did the care providers explain things in a way you could understand?			36.8	42.9	42.4	44.4	39.7
NRC		Did the care providers spend enough time with you?			32.7	37.6	39.3	38.2	35.3
NRC		Did the care providers do everything they could to ease your discomfort?			36.8	42.7	45.0	41.0	39.6
NRC		Did the care providers explain what to do if you did not get better after leaving?			42.2	46.3	47.1	46.7	44.3
NRC		Were you seen by a care provider in a timely manner?			27.5	31.8	31.5	31.4	29.4


Tri-City Medical Center
**ADVANCED HEALTH CARE
FOR YOU**

**Construction Report
As of January 2019**

Project	FOP/Board Approval Date	% of Design Complete	Construction Start or Estimated Construction Start Date	Estimated Construction Completion Date*	% of Construction Complete	Total Budget	Actual Expenditures	Remaining Budget	Status / Comments
OR #4 Surgical Lights Replacement	September-17	100%	October-18	February-19	95%	\$ 510,761.00	\$ 238,531.28	\$ 272,229.72	Construction in progress
Surface Parking Lot	December-17	100%	February-18	October-18	100%	\$ 2,589,975.00	\$ 2,351,076.68	\$ 238,898.32	Construction complete. Actual expenditures are being finalized but the project completed under budget.
Pharmacy USP 800 Upgrades	October-18	100%	January-19	June-19	0%	\$ 1,099,949.00	\$ 98,587.94	\$ 1,001,361.06	Construction in progress
Total Construction Projects						\$ 3,100,736.00	\$ 2,589,607.96	\$ 511,128.04	

*Estimated completion is based on actual physical project progress and not on amounts invoiced to the District

Building Operating Leases
Month Ending January 31, 2019

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term Ending	Services & Location
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	\$3.59	(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 Solana 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)	10,720.64	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)	26,711.35	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	\$2.76	(a)	21,045.00	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)	11,701.64	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 V#81250	4,760	\$4.24	(a)	26,713.00	10/01/12	10/01/22	Chemotherapy/Infusion Oncology Center 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056
Total				\$183,167.88			

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

Education & Travel Expense
Month Ending January 2019

Cost Center	Description	Invoice #	Amount	Vendor #	Attendees
6185	ONS/ONCC CHEMOTHERAPY BIOTHERAPY	110918EDU	103.00	81437 KAROLINA WASILEWICZ	
6185	CANCER BASICS ONLINE COURSE	122718EDU	220.00	77105 LISA LIPPUS	
6185	CANCER BASICS ONLINE COURSE	011219EDU	220.00	83405 JENNY SOHN	
6185	ONS/ONCC CHEMOTHERAPY BIOTHERAPY	011419EDU	279.00	77105 LISA LIPPUS	
6185	ONS/ONCC CHEMOTHERAPY BIOTHERAPY	011819EDU	279.00	83405 JENNY SOHN	
7320	CAMS REGISTRATION	011719EDU	135.00	71410 TONY VITRANO	
7320	CAMS REGISTRATION	122018EDU	135.00	78031 SARAH JAYYOUSI	
7400	INPATIENT OBSTETRIC NURSE CERTIFICATION	012119EDU	325.00	83375 LESLIE LUCERO	
8650	ESSENTIALS OF HR LAW	1-8387841	149.00	37911 CARMELA FORD	
8740	ONCOLOGY PREP COURSE 2018	011119EDU	110.00	82580 ASHLEY DROLSHAGEN	
8740	PALS COURSE	121918EDU	132.00	83401 YANINA GRITSEVSKAYA	
8740	SCANN CONFERENCE	011119EDU	145.00	83399 MINDY DIAZ	
8740	ACLS COURSE	010419EDU	150.00	83400 VANESSA ESPINELI	
8740	METHOD OF ESTIMATION OF FETAL WELLBEING	010419EDU	157.00	77564 GAIL HART	
8740	RNC RECERTIFICATION	010419EDU	166.00	77603 MARY SUSAN MCCAY	
8740	AHA PALS COURSE	121918EDU	170.00	19232 JOHN BAILEY	
8740	ACLS COURSE	011119EDU	200.00	78610 DORIS A TORCUATO	
8740	CNDR RECERTIFICATION	010419EDU	200.00	79052 MARYBETH VISITACION	
8740	NCC COURSE - FETAL MONITORING & PHARMACOLOGY	011819EDU	200.00	81826 MELINDA RUIZ	
8740	ACLS COURSE	010419EDU	200.00	82028 DAVINA LAM	

**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.