**TRI-CITY HEALTHCARE DISTRICT**
**AGENDA FOR A REGULAR MEETING**
**January 30, 2020 – 2:30 o'clock p.m.**
**Assembly Room 1 - Eugene L. Geil Pavilion**
**Open Session – Assembly Rooms 2 & 3**
**4002 Vista Way, Oceanside, CA 92056**

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

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| 1 | Call to Order | 3 min. | Standard |
| 2 | Approval of agenda | | |
| 3 | Public Comments – Announcement<br>Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 19-018, members of the public may have three minutes, individually, to address the Board of Directors. | 3 min. | Standard |
| 4 | Oral Announcement of Items to be Discussed During Closed Session (Authority: Government Code, Section 54957.7) | | |
| 5 | Motion to go into Closed Session | | |
| 6 | Closed Session | 1 hour | |
| | a. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) 2 (1 Matter) | | |
| | b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155) | | |
| | c. Approval of prior Closed Session Minutes | | |
| 7 | Motion to go into Open Session | | |
| 8 | Open Session | | |
| | ***Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.*** | | |
| 9 | Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) | | |
| 10 | Roll Call / Pledge of Allegiance | 3 min. | Standard |

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

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

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| 11 | Public Comments – Announcement<br>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 19-018, members of the public may have three minutes, individually, to address the Board of Directors.<br><br>NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications. | 2 min. | Standard |
| 12 | TCHD Auxiliary, Jeff Marks, President | 10 min. | Standard |
| 13 | December 2019 Financial Statement Results | 10 min. | CFO |
| 14 | New Business<br><br>a) Consideration to approve a Group Physician Recruitment Agreement with Dr. Darrell Wu, M.D., Cardiovascular/Cardiothoracic Surgeon.<br><br>b) Consideration to award Board Scholarship to the Tri-City Hospital Auxiliary in the amount of $10,000 (10 students).<br><br>c) Consideration of nomination to serve on the San Diego Local Agency Formation Commission (LAFCO). | 5 min.<br><br>5 min.<br><br>5 min. | Sr. Dir. Busi. Develop.<br><br>Chair<br><br>Chair |
| 15 | Old Business – None | | |
| 16 | Chief of Staff<br><br>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 27, 2020.<br><br>b) Consideration of revised Cardiology Privilege Card<br><br>c) Consideration of revised Cardiothoracic Surgery Privilege Card | 10 min. | Chief of Staff |
| 17 | Consideration of Consent Calendar<br><br>**Administrative & Board Committees**<br><br>***(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.***<br><br>***(2) All items listed were recommended by the Committee.***<br><br>***(3) Requested items to be pulled require a second.***<br><br>(1) Administrative Committee<br><br>**a) Administrative Policies & Procedures – District Operations**<br>1) Administrator On Call – 281<br><br>**b) Unit Specific – Engineering** | 5 min. | Standard |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| | 1) 5003.2 Lockout Tagout Training (DELETE) | | |
| | **c) Unit Specific – Laboratory**<br>1) Hematology Quality Management (SM) Plan Policy | | |
| | **d) Unit Specific – Outpatient Pharmacy**<br>1) Credit Card Processing Policy<br>2) Drug Supply Chain Security Policy<br>3) Pharmacist Conscientious Objection Policy<br>4) Physical Inventory Policy<br>5) Prevention of Dispensing Potentially Harmful Prescribed Drugs to Patients Policy<br>6) Storage Requirements for Medications Policy | | |
| | **e) Unit Specific – Rehabilitation**<br>1) Disaster Plan – Outpatient 1502 Policy (DELETE)<br>2) Emergency Care – Outpatient Services 1504 (DELETE) | | |
| | **f) Unit Specific – Rehabilitation Center (Acute Rehab Unit)**<br>1) Provision of Durable Medical Equipment (DME) by Tri-City Rehabilitation Center | | |
| | (2) Board Committees | | |
| | **A. Community Healthcare Alliance Committee**<br>Director Chavez, Committee Chair<br>*(Committee minutes included in Board Agenda packet for informational purposes.)* | | CHAC Comm. |
| | **B. Finance, Operations & Planning Committee**<br>Director Nygaard, Committee Chair<br>Open Community Seats – 0<br>*(Committee minutes included in Board Agenda packet for informational purposes.)* | | FO&P Comm. |
| | 1) Approval to add Alexander Foster, M.D. to the ED On Call Coverage Panel for Ophthalmology for 12 months, beginning, February 1, 2020 through January 31, 2021. | | |
| | 2) Approval of an agreement with QuadraMed-Affinity Corporation for software support for a term of 12 months, beginning January 1, 2020 through December 31, 2020, for an annual and total term cost of $360,679.28. | | |
| | 3) Approval of an agreement with Stryker ProCare for a service plan for a term of 24 months for video, beginning January 1, 2020 through December 31, 2021, and also a term of 33 months for power, beginning January 1, 2020 and ending September 30, 2022, for an annual cost of $205,762.68 and a total cost for the term of $478,862.37. | | |
| | **C. Professional Affairs Committee**<br>Director Reno, Committee Chair<br>*(No meeting held in January, 2020)* | | PAC |
| | **D. Audit, Compliance & Ethics Committee**<br>Director Younger, Committee Chair | | Audit, Comp. & Ethics Comm. |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| | Open Community Seats – 1<br>*(No meeting held in January, 2020)*<br><br>(3) Minutes – Approval of:<br><br>a) December 12, 2019 - Regular Meeting<br>b) January 13, 2020 – Special Meeting<br><br>(4) Meetings and Conferences – None<br><br>(5) Dues and Memberships<br><br>a) Modern Healthcare Subscription - $532.00<br><br>(6) Reports<br>(a) Dashboard – None<br>(b) Construction Report – None<br>(c) Lease Report – (December, 2019)<br>(d) Reimbursement Disclosure Report – (December, 2019)<br>(e) Seminar/Conference Reports – None | | Standard |
| 18 | Discussion of Items Pulled from Consent Agenda | 10 min. | Standard |
| 19 | Comments by Members of the Public<br>NOTE: Per Board Policy 19-018, 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 |
| 20 | Comments by Chief Executive Officer | 5 min. | Standard |
| 21 | Board Communications (three minutes per Board member) | 18 min. | Standard |
| 22 | Report from Chairperson | 3 min. | Standard |
| 23 | Total Time Budgeted for Open Session | 1 hour/ 30 min. | |
| 24 | Adjournment | | |

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: January 23, 2020**
**Physician Recruitment Proposal – Cardiovascular 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:** Darrell Wu, M.D.
**Areas of Service:** Cardiovascular / Cardiothoracic Surgery
**Key Terms of Agreement:**

Effective Date: September 1, 2020 or the date Dr. Wu 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 Cardiovascular / Cardiothoracic Surgery

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

| **Terms of the Agreement:** | **Proposal Costs:** |
|---|---|
| Relocation Allowance | $10,000 *(not part of the loan)* |
| Sign - On Bonus | $50,000 |
| Income Guarantee, NTE | $1,950,000<br>*($650,000 annually for a 3-year income guarantee, with a 3-year forgiveness period)* |
| Total Loan Amount, NTE | $2,000,000 |
| **Total Amount of Request:** | **$2,010,000** |

**Unique Features:** Dr. Wu will practice with Dr. Yuan Lin at North County CVT Surgery Associates

**Requirements:**

Business Pro Forma: Must submit a 36 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 / Steve Dietlin, Chief Executive Officer

**Motion:**
Move that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the public health of the communities served by the District to approve the expenditure, not to exceed $2,010,000 in order to facilitate, Darrell Wu, M.D., Cardiovascular / Cardiothoracic Surgeon practicing medicine in the communities served by the District. This will be accomplished through a Group Physician Recruitment Agreement (not to exceed a 36 month income guarantee with a three-year forgiveness period).

# San Diego County
# Local Agency Formation Commission
Regional Service Planning | Subdivision of the State of California

Received
12-9-19

## CALL FOR NOMINATIONS

December 6, 2019

TO: Independent Special Districts in San Diego County

FROM: Tamaron Luckett, Executive Assistant

SUBJECT: **Call for Nominations | Regular Special District Member Election on LAFCO**

This notice serves as a call to nominations pursuant to Government Code Section 56332(1) to solicit one regular special district member to serve on the San Diego Local Agency Formation Commission (LAFCO). The term is four years and commences on May 4, 2020. The incumbent holder – Jo MacKenzie with Vista Irrigation District – is expected to seek nomination and run for a new term. Additional details follow.

- **Eligibility**
  Candidates eligible for election must be members of the legislative body of an independent special district who reside within San Diego County but may not be members of the legislative body of a city or county.

- **Authorized Nominations**
  State Law specifies only the presiding officer or their alternate as designated by the governing board must sign the nomination form. Attached is nomination form for the LAFCO regular special district member **(Attachment A)**.

- **Submittal Process and Deadline**
  Signed nominations and a limited **two-page** resume indicating the candidate's District and LAFCO experience must be returned to San Diego LAFCO **no later** than **Friday, February 7, 2020.** Nominations received after this date will be invalid. Nominations and resumes may be mailed to San Diego LAFCO Office at 9335 Hazard Way, Suite 200, San Diego, CA 92123 or email to tamaron.luckett@sdcounty.ca.gov, if necessary to meet the submission deadline, but the original form must be submitted.

**Administration**
Keene Simonds, Executive Officer
County Operations Center
9335 Hazard Way, Suite 200
San Diego, California 92123
T 858.614.7755 F 858.614.7766
www.sdlafco.org

After nominations and resumes are received it is anticipated a candidate's forum will be held in conjunction with the California Special Districts Association Quarterly Dinner with confirmation being provided under separate/future cover. Election materials will be mailed out **no later** than **Friday, February 14, 2020** unless otherwise communicated by the LAFCO Executive Officer. Should you have any questions, please contact me at 858.614.7755.

Attachment:
1) Nomination form – LAFCO regular special district member

## ATTACHMENT A

## NOMINATION OF THE SPECIAL DISTRICT REPRESENTATIVE FOR THE SAN DIEGO LOCAL AGENCY FORMATION COMMISSION REGULAR MEMBER

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

Candidate for the San Diego Local Agency Formation Commission as a regular special district member with a term expiring 2024.

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

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

_____
(Presiding Officer Signature)

_____
(Print name)

_____
(Print Title)

_____
(Date)

**PLEASE ATTACH RESUME FOR NOMINEE**

- Limit two-pages
- Must be submitted with Nomination Form

Tri-City Medical Center
MEDICAL STAFF

# TRI-CITY MEDICAL CENTER
# MEDICAL STAFF INITIAL CREDENTIALS REPORT
# January 8, 2020

*Attachment A*

## INITIAL APPOINTMENTS (Effective Dates: 1/31/2020 – 12/31/2021)

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 1/31/2020 through 12/31/2021:

- **COHN, Jed MD/Anesthesiology (ASMG)**
- **PADILLA, Patrick MD/Orthopedic Surgery (Orthopedic Specialists of North County)**
- **RUSEV, Stoyan MD/Psychiatry (Vituity)**
- **SHUEN, Jessica MD/Emergency Medicine (TeamHealth)**
- **SNYDER, Bradley MD/Teleradiology (StatRad)**
- **STRAHM, Lisa MD/Endocrinology (Advanced Metabolic Care)**
- **TESFAYE-KEDJELA, Aida MD/Anesthesiology (ASMG)**
- **THALKEN, Gregory MD/Teleradiology (StatRad)**
- **ZENZEN, Charles MD/Ophthalmology (Morris Eye Group)**

Tri-City Medical Center
MEDICAL STAFF

# TRI-CITY MEDICAL CENTER
# MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
# January 08, 2020

*Attachment B*

## BIENNIAL REAPPOINTMENTS: (Effective Dates 02/01/2020 –01/31/2022)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 02/01/2020 through 01/31/2022, 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:

- **BRUNO, Gillian, MD/Internal Medicine/Active**
- **CAMPBELL, Leticia, MD/Obstetrics & Gynecology/Provisional**
- **GUNTA, Sujana, MD/Pediatrics/Active**
- **HAN, James, DPM/Podiatric Surgery/Active Affiliate**
- **JARAMILLO, Mary, MD/Internal Medicine/Refer and Follow**
- **JOSON, Peter, MD/Ophthalmology/Provisional**
- **KANE, Norman, MD/Orthopedic Surgery/Provisional**
- **LAFATA, John, MD/Internal Medicine/Active**
- **LI, Yaohui, MD/Anesthesiology/Active**
- **MOUKARZEL, Elias, MD/Obstetrics & Gynecology/Provisional**
- **MOUSSAVIAN, Mehran, DO/Cardiology/Provisional**
- **MUDD, Brian, DDS/Oral & Maxillofacial Surgery/Active**
- **O'BRIEN, Mark, DO/Internal Medicine/Active**
- **POLLOCK, Max, MD/Diagnostic Radiology/Provisional**
- **ROZENFELD, Michael, DO/Teleradiology/Provisional**
- **SCHMITTER, Stephen, MD/Radiology/Active**
- **TALLMAN, Garrett, MD/Orthopedic Surgery/Refer and Follow**
- **TAYANI, Ramin, MD/Ophthalmology/Provisional**

*Attachment B*

- VERMA, Vishal, MD/Teleradiology/Active Affiliate
- WISNIEWSKI, Morris, MD/Internal Medicine/Active
- YAMANAKA, Mark, MD/Pulmonary Medicine/Active
- ZIZZO, Paolo, DO/Internal Medicine/Refer and Follow

## RESIGNATIONS: (Effective date 01/31/2020 unless otherwise noted)

**Automatic:**

- KIM, James, MD/Cardiology

**Voluntary:**

- BURKE, Michael, MD/Interventional Radiology
- CATTAFI, Paul, DO/Anesthesiology
- GASTELUM, Jennifer, MD/Anesthesiology
- GOLTS, Eugene, MD/Cardiothoracic Surgery
- HAINIK, Christopher, MD/Orthopedic Surgery
- MILLER, Jason, MD/Pain Medicine
- MOHAMEDALI, Burhan, MD/Cardiology
- MURPHY, Kayla, CNM/Allied Health Professional
- NICPON, Gregory MD/Diagnostic Radiology
- PURCOTT, Kari, MD/Obstetrics & Gynecology
- ROSENBERG, Jay, MD/Neurology
- RUELAZ, Robert, MD/Cardiology
- SEUFERT, Kevin, MD/Family Medicine
- WARSHAWSKY, Arthur, MD/Urology

*Attachment B*

- **WHITESIDE, Michael, MD/Teleradiology**
- **YOLER, Katharine, MD/Teleradiology**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
January 8, 2020

## PROCTORING RECOMMENDATIONS

| | |
|---|---|
| • AFRA, Robert MD | Orthopedic Surgery |
| • MCGAHAN, Michele MD | Radiology |
| • SHELLENBERGER, Jeffry MD | Emergency Medicine |
| • SILLDORFF, Morgan MD | Orthopedic Surgery |
| • WONG, Amy DPM | Podiatric Surgery |
| • ZHANG, Clarice DO | Emergency Medicine |

Tri-City Medical Center
MEDICAL STAFF

# TRI-CITY MEDICAL CENTER
# MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
# January 8, 2020

## REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given six 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 **July 31, 2020** would result in these privileges automatically relinquishing.

- KARACHALIOS, Michael, MD — Diagnostic Radiology
- SAMANI, Pargol, MD — Cardiology
- SHIH, Jimmy, MD — Diagnostic Radiology

## REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring, then were given another 6 months extension. These practitioners failed to meet the proposed deadline and are approved for an additional 3 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by **April 30, 2020** would result in these privileges automatically relinquishing.

- JACOBS, Karl, MD — Psychiatry
- KUSHNARYOV, Anton, MD — Otolaryngology
- LOTAN, Roi MD — Teleradiology
- MACEWAN, Jennifer, MD — Otolaryngology
- ONAITIS, Mark, MD — Cardiothoracic Surgery
- PERRIZO, Nathan DO — Pain Medicine
- PIETILA, Michael, MD — Family Medicine
- RIAD, Shareef MD — Teleradiology
- SEIDEN, Grant MD — Orthopedic Surgery

## VOLUNTARY RELINQUISHMENT OF PRIVILEGES

The following providers relinquished the following privileges.

- D'SOUZA, Geehan MD — Plastic Surgery

Tri-City Medical Center
MEDICAL STAFF

# TRI-CITY MEDICAL CENTER
# INTERDISCIPLINARY PRACTICE COMMITTEE REPORT
# January 20, 2020

*Attachment A*

## INITIAL APPOINTMENTS (Effective Dates: 1/31/2020 – 10/31/2021)

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 1/31/2020 through 10/31/2021:

- **GUILLEN, Kathleen PA-C/Allied Health Professional (The Neurology Center)**
- **HEINEN, J. Peter PA-C/Allied Health Professional (The Neurology Center)**
- **WINKEL, Bradley PA-C/Allied Health Professional (TeamHealth)**

Tri-City Medical Center
MEDICAL STAFF

# TRI-CITY MEDICAL CENTER
# INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – 1 of 1
# January 20, 2020

*Attachment B*

## BIENNIAL REAPPRAISALS: (Effective Dates 02/01/2020 – 01/31/2022)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 02/01/2020 through 01/31/2022, 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:

- **RENNE, Brittany, AuD/Allied Health Professional**

## RESIGNATIONS: None

Tri-City Medical Center
MEDICAL STAFF

# TRI-CITY MEDICAL CENTER
# INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 2 of 3
# January 20, 2020

## REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given six months from the last reappointment date to complete their outstanding proctoring, and given an additional six month period after that one. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by ***July 31, 2020*** would result in these privileges automatically relinquishing.

- **TEBON, Renee, PA-C** — **Allied Health Professional**

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring, then were given another 6 months extension. These practitioners failed to meet the proposed deadline and are approved for an additional 3 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by ***April 30, 2020*** would result in these privileges automatically relinquishing.

- **MILLER, Cortney FNP** — **Allied Health Professional**
- **STABLER, Holly, PA** — **Allied Health Professional**
- **VIERRA, Erin NP** — **Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

**TRI-CITY MEDICAL CENTER**
**INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 3 of 3**
**January 20, 2020**

*Attachment C*

## PROCTORING RECOMMENDATIONS

| | |
|---|---|
| • DEMASCO, Michael PA | Allied Health Professional |
| • FREIWALD, Adam PA | Allied Health Professional |
| • LUU, Jackie PA | Allied Health Professional |
| • HAIGLER, Heather PA | Allied Health Professional |
| • VARNER, Alicia OT | Allied Health Professional |

Tri-City Medical Center
MEDICAL STAFF

# Clinical Privilege Request Form

Cardiology (Revised ~~4/19~~1/20)

Provider Name:

| Request | Privilege |
|---|---|
| | |

**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.**

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

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

___ **COGNITIVE PRIVILEGES:**

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

May Include:

Admission of Patient to Inpatient Services

Performance of History and Physical Examination, including via telemedicine

Performance f a Cardiac Consultation, including via telemedicine

**ALLIED HEALTH PRACTITIONER SUPERVISOR PRIVILEGES**

___ Supervision of an approved category of Allied Health Practitioner

**SEDATION/ANALGESIAPRIVILEGES:**

___ ~~Moderate Sedation/Analgesia~~

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

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

**BASIC INVASIVE PROCEDURES:**

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

Provider Name:

| Request | Privilege |
|---|---|

___ Venous cut-down & Percutaneous Central Venous Pressure Catheters

___ Insertion of Temporary Transvenous Cardiac Pacemaker

___ Elective Cardioversion

___ Swan-Ganz Catheter Insertion & Monitoring

___ **CARDIAC CATHETERIZATION PROCEDURES**

**Initial Criteria:** Must meet basic qualifications as outlined above and provide training and show current competency of have performed at least three-hundred (300) cases; if more than 12 months since completion of training, documentation of forty (40) cases within two (2) years prior to application is required. Must successfully complete Moderate Sedation Test.
**Proctoring Requirements:** Five (5) ~~cases~~Left Cardiac Cath Cases meets the requirement for this entire bundle & Swan-Ganz. 5 Right Cardiac Cath cases includes Swan-Ganz.)
**Reappointment Criteria:** In order to maintain this privilege bundle, competency criteria of forty (40)cases within the previous 24 month period is required. Must successfully complete Moderate Sedation Test.

Includes:

RIGHT Cardiac Catheterization

LEFT Cardiac Catheterization

Coronary Arteriography

Operation of Fluoroscopy Equipment -
~~**Prerequisition Criteria: (**~~Requires Current Fluoroscopy certificate.)

**INTERVENTIONAL CARDIOLOGY – PERCUTANEOUS CORONARY INTERVENTIONS (PCI)**

**Initial Criteria:** Must meet basic qualifications as outlined above and requires training & two-hundred fifty (250) cases; if more than 12 months since completion of training, documentation of seventy (75) cases within the two years prior to application. Must successfully complete Moderate Sedation Test.

**Proctoring:** Five (5) Cases (Submittion of 5 Percutaneous Coronary Interventions meets the proctoring requirement for all Cardaic Catheterization Procedure s and Swan-Ganz.)

**Reappointment Criteria:** In order to maintain this privilege bundle, competency criteria of Seventy five (75) cases of which twenty (20) must be done at TCMC within the previous 24 month period Must successfully complete Moderate Sedation Test.

___ Percutaneous Coronary Intervention (includes PTCA)

___ Temporary Percutaneous Left Ventricular Assist Device (Impella) (Requires completion of didactic program followed by on-site proctoring provided by the device manufacturer or a qualified interventional cardiologist to qualify for independent usage of the device. Providers with full interventional privileges will be allowed to complete the pathway

Provider Name:

| Request | Privilege |
|---|---|

to certification on site.~~Requires Certificate~~)

___ Rotational Atherectomy (Requires completion of didactic program followed by on-site proctoring provided by the device manufacturer or a qualified interventional cardiologist to qualify for independent usage of the device. Providers with full interventional privileges will be allowed to complete the pathway to certification on site~~Requires Certificate~~)

___ Orbital Atherectomy (Requires completion of didactic program followed by on-site proctoring provided by the device manufacturer or a qualified interventional cardiologist to qualify for independent usage of the device. Providers with full interventional privileges will be allowed to complete the pathway to certification on site~~Requires Certificate~~)

**SPECIAL PROCEDURES**

**Initial Criteria: Must meet basic qualifications as outlined above and the specific criteria indicated below.** Must successfully complete Moderate Sedation Test.

**Permanent Pacemaker Insertion (single/dual/biventricular chamber) and/or intra-cardiac defibrillator (ICD) (single/dual/biventricular chamber)** requires proof of completion of fellowship training or twenty-five (25) cases.
**Pericardiocentesis:** Requires a Fluoroscopy Certificate
**Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation** requires completion of accredited fellowship in Clinical Cardiac Electrophysiology, Board Certification or eligibility & twenty (20) cases within the past 12 months prior to application.
**Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation** requires completion of accredited fellowship in Clinical Cardiac Electrophysiology, Board Certification or eligibility & twenty (20) cases within the past 12 months prior to application.
**Transesophageal echocardiography (including passing the probe)** requires documentation of training or a course.
Transcatheter Aortic Valve Replacement (TAVR) must have PCI Privileges without proctoring and requires completion of didactic program followed by on-site proctoring provided by the device manufacturer or a qualified interventional cardiologist to qualify for independent usage of the device. Providers with full interventional privileges or EP ablation privilege will be allowed to complete the pathway to certification on site
Watchman must have PCI Privileges OR EP Privileges without proctoring and requires completion of didactic program followed by on-site proctoring provided by the device manufacturer or a qualified interventional cardiologist to qualify for independent usage of the device. Providers with full interventional privileges or EP ablation privilege will be allowed to complete the pathway to certification on site

**Proctoring Requirements:**
**Permanent Pacemakers/ICDs:** two (2)
**Pericardiocentesis:** one (1)
**Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation:** two (2)
**Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation:** two (2)
**Transesophageal echocardiography:** two (2)
Transcatheter Aortic Valve Replacement (TAVR): three (3)
Watchman: three (3)

**Reappointment Criteria:** Must successfully complete Moderate Sedation Test.

**Permanent Pacemaker/ICD cases:** ten (10)
**Pericardiocentesis:** one (1)
**Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation:** Twenty (20)

Provider Name:

| Request | Privilege |
|---|---|

**Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation:** Twenty (20)
**Transesophageal echocardiography:** ten(10)
**Transcatheter Aortic Valve Replacement (TAVR): ten (10)**
**Watchman: ten (10)**

___ Permanent Pacemaker/ICD Insertion

___ Pericardiocentesis

___ Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation

___ Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation

___ Transesophageal echocardiography

___ Transcatheter Aortic Valve Replacement (TAVR)

___ Watchman

**NON-INVASIVE PROCEDURES:**

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

**Proctoring Requirements:**

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

**Reappointment Criteria:**

**EKG:** five hundred (500) or active reading panel member as attested by Division of Chief or designee.
**Stress Echo:** five (5) Documentation of Stress Echos performed at other facilities (including the physician's office) will count towards this requirement.
**Thoracic Echos:** two hundred (200) or active reading panel member as attested by Division of Chief or designee.
**Holter Monitor:** ~~forty (40)~~ten (10), of which ~~ten (10)~~two (2) must be performed at TCMC or active reading panel member as attested by Division of Chief or designee.
**Treadmill:** fifty (50) or active reading panel member as attested by Division of Chief or designee.

___ EKG

___ Stress Echo

___ Thoracic Echo

Provider Name:

| Request | Privilege |
|---|---|

___ Holter Monitor

___ Treadmills

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

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

___ Carotid

___ Cerebral

___ Extremity

___ Pulmonary

___ Thoracic

___ Visceral

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

___ Angioplasty

___ Drug infusion

___ Stent graft

___ Stent placement

___ Thrombolysis

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

___ IVC filter

___ Stent

___ Tissue plasminogen activator (tPA)

___ Venous Sampling

___ Venous Thrombolysis

Tri-City Medical Center
MEDICAL STAFF

# Clinical Privilege Request Form

Cardiology (Revised ~~4/19~~1/20)

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
MEDICAL STAFF

# Clinical Privilege Request Form

Cardiothoracic Surgery - (Revised ~~4/17~~1/20)

Provider Name:

| Request | Privilege |
|---|---|
| | |

**CERTIFICATION:** The Division of Cardiothoracic Surgery consists of physicians who are Board Certified or are in the first thirty-six (36) months of Board Eligibility and actively pursuing certification by the American Board of Cardiothoracic Surgery, or able to demonstrate comparable ability, training and experience.

ASSIST IN SURGERY: Cardiothoracic Surgeons are able to assist in Cardiac or Thoracic Surgery withoutproctoring.

**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.

___ Assist in Surgery

___ Admit Patients

___ Consultation, including via telemedicine (F)

___ Perform medical history & physical, including via telemedicine (F)

___ **CARDIAC SURGERY**
Initial: A total of (6) cases from this category must be submitted to initially be granted privileges from this category of procedures.
Proctoring: A total of (6) procedures from this category must be proctored. Assisting in Cardiac Surgery performing specific procedures will be accepted for Cardiathoracic Surgery proctoring. ~~Proctoring for UCSD Cardiac Surgeon: A total of (4) procedures from this category must be proctored.~~
Reappointment: A total of (24) procedures from this category are required for recredentialing of the entire category of procedures.

___ Intra-Cardiac and Valve Surgery

___ Extra-Cardiac Surgery for Traumatic Injury Repair (Thoracic)

___ Thoracic Aneurysmectomy

___ Coronary Artery Bypass Procedure

___ Infarctectomy

**OTHER:**

___ Convergent Procedure for AFIB

Initial: A certificate of training must be submitted to initially be granted privileges for this procedure.

___ **THORACIC SURGERY**

Tri-City Medical Center
MEDICAL STAFF

# Clinical Privilege Request Form

Cardiothoracic Surgery - (Revised ~~4/17~~1/20)

Provider Name:

| Request | Privilege |
|---|---|
| | |

Initial: A total of (5) cases from this category must be submitted to initially be granted privileges from this category of procedures.
Proctoring: A total of (5) procedures from this category must be proctored. Assisting in Cardiac Surgery performing specific procedures will be accepted for Thoracic Surgery proctoring. ~~Proctoring for UCSD Thoracic Surgeon: A total of (2) procedures from this category must be proctored.~~
Reappointment: A total of (6) procedures from this category are required for recredentialing of the entire category of procedures.

___ Trachea and bronchi - All procedures

___ Thorax - Chest Wall Aspiration

___ Thorax - Chest Wall Drainage

___ Thorax - Major Excisional procedure of the Chest Wall

___ Diaphragm - All procedures

___ Esophagus - All procedures

___ Lungs - All procedures

___ Mediastinum - Excision of tumors, cysts, etc.

___ Heart and Pericardium - Repair of Wounds

___ Pericardium - All procedures

___ Placement of Permanent Epicardial and Endocardial Pacing Systems

**OTHER:**

___ Thoracoscopy and Video assisted Thoracic Surgery
Initial: A total of (2) cases must be submitted to initially be granted privileges for this procedure.
Proctoring: (2) cases must be proctored.
Reappointment: (10) cases required per every two year reappointment cycle.

___ Intra-Cardiac Cardio-converter Defibrillator
Initial: A total of (2) cases must be submitted to initially be granted privileges for this procedure.
Proctoring: (2) cases must be proctored.
Reappointment: (2) cases required per every two year reappointment cycle.

___ Laser Surgery (YAG; CO2) to include TMR
Initial: Proof of (2) completed cases required for initial appointment.
Proctoring: (2) cases need to be proctored.

Physicians applying for privileges to use the laser in surgery must submit:
1.) A certificate indicating successful completion of a laser surgery course that should provide at least two hours of hands-on

Provider Name:

| Request | Privilege |
|---|---|
| | |

use of the laser equipment. Separate training must be documented for each wavelength of laser for which the physician is applying for privileges.
2.) Copies of two previous procedures performed with any type of surgical laser, if available.
3.) First two (2) laser cases must be proctored by a physician who holds unrestricted laser privileges.
4.) Proctor reports will be reviewed by Chief of Cardiothoracic Surgery and then reported to the Department of Surgery.
5.) Transmyocardial Laser Revascularization (TMR): Completion of an FDA approved instruction course on the use of CO2 Laser for TMR.

___ Transcatheter Aortic Valve Replacement (TAVR) must have Cardiac Surgery and Thoracic Surgery Privileges without proctoring and requires completion of didactic program followed by on-site proctoring provided by the device manufacturer or a qualified interventional cardiologist to qualify for independent usage of the device. Providers with full interventional privileges will be allowed to complete the pathway to certification on site)

~~CORE ROBOTIC-ASSISTED SURGERY CRITERIA (da Vinci)~~ROBOTIC ASSISTED SURGICAL PROCEDURES **(Refer to Credentialing Policy, Robotic Assisted Surgery #8710-563):**

**Surgeons with prior da Vinci experience:**
Initial:
1. Physicians must have privileges to perform the underlying procedure as an open and thoracoscopic procedure.
2. If residency/fellowship training included robotic surgery training, provide:
a. Letter from program director certifying competency for the requested privilege(s) and in the use of the da Vinci device as primary surgeon; and
b. Documentation of ten (10) da Vinci cases as primary surgeon ~~(may be core or advanced cases, see CTS Rules & Regulations)~~.
c. Proctoring: One (1) case from each of the following procedure bundles must be proctored within a one-hundred-eighty (180) day period ~~must be proctored~~ by a robotic-credentialed surgeon (preferably in the~~ir~~ field) of Robotic Assisted Thoracic Surgery, Robotic Assisted Cardiac Surgery and Robotic Assisted Esophageal/Diaphragmatic Surgery. Additional training will be required prior to scheduling further cases if proctoring has not been completed within the specified time frame.

**Surgeons with prior da Vinci experience at an outside institution, provide:**
a. Documentation of ten (10) cases as primary surgeon beyond proctoring and within the previous 24-month period (see CTS Rules and Regulations)
b. Proctoring: A minimum of one (1) case from each of the following procedure bundles must be proctored must be concurrently proctored by a robotic-credentialed surgeon (preferably in the~~ir~~ field) of Robotic Assisted Thoracic Surgery, Robotic Assisted Cardiac Surgery and Robotic Assisted Esophageal/Diaphragmatic Surgery.

3. The above-listed proctoring requirements are waived for any surgeon on the Intuitive Surgical List of Approved Proctors.

**Surgeons without prior da Vinci experience:**
Initial:
1. Privileges to perform the underlying procedure either as an open or laparoscopic procedure.
2. 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). A minimum of one (1) live case observation.
3. Proctoring: Four (4) cases from each of the following procedure bundles must be proctored within a one hundred eighty (180) day period must be concurrently proctored by a robotic-credentialed surgeon (preferably in the~~ir~~ field) of Robotic Assisted Thoracic Surgery, Robotic Assisted Cardiac Surgery and Robotic Assisted Esophageal/Diaphragmatic Surgery. Additional training will be required prior to scheduling further cases if proctoring has not been completed within the specified time frame.

Tri-City Medical Center
MEDICAL STAFF

# Clinical Privilege Request Form

Cardiothoracic Surgery - (Revised ~~4/17~~1/20)

Provider Name:

| Request | Privilege |
|---|---|
| | |

Reappointment: 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. (If less than 10 cases, refer to Policy 563)

**(Select the procedures below)**

___ ~~**Robotic Surgery (da Vinci) - CORE PRIVILEGES**~~**Robotic Assisted Thoracic Surgery**
Proctoring: First 1 case.

___ ~~**Closed Cardiac Cases**~~

___ ~~Epicardial pacer lead placement~~

___ ~~Left internal mammary artery/right internal mammary artery takedown, off-pump coronary artery bypass graft~~

___ ~~Transmyocardial laser revascularization~~

___ ~~Pericardial window~~

___ ~~**Basic Thoracic Cases**~~

___ Thymectomy

___ Lung biopsy/resection

___ Mediastinal exploration (lymph nodes, mass)

___ ~~Pericardial cysts~~

___ Pulmonary Resection (other than wedge resection)

___ Esophageal resection (other than enucleation)

___ ~~Diaphragm plication~~

___ ~~Esophageal myotomy for achalasia~~

**Robotic Assisted Cardiac Surgery**
Proctoring: First 1 case.

___ Epicardial pacer lead placement

___ Left internal mammary artery/right internal mammary artery takedown, off-pump coronary artery bypass graft

___ Pericardial cysts

___ Transmyocardial laser revascularization

Tri-City Medical Center
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# Clinical Privilege Request Form

Cardiothoracic Surgery - (Revised ~~4/17~~1/20)

Provider Name:

| Request | Privilege |
|---|---|

___ Pericardial window
ASD/Cardiac tumor resection
Initial:
1. Training in Aortic Endo-Balloon (if technique to be used)
2. Endoscopic Suturing Skills Training (simulator or live case)
Proctoring: First 1 case.
Reappointment: Ten (10) Advanced Cardiac/Ten (10) Robotic Cardiaccases per two-year reappointment cycle

___ Mitral valve repair
Initial:
1. Case log of ten (10) successful mitral repairs (non-robotic)
2. Traning in Aortic Endo-Balloon (if technique used)
3. Endoscopic Suturing Skills Training (simulator or live case)
Proctoring: First 2 cases.
Reappointment: Ten (10) Advanced Cardiac/Ten (10) Robotic Cardiac cases per two-year reappointment cycle

**Robotic Assisted Esophageal/Diaphragmatic Surgery**
Proctoring: First 2 cases.

Diaphragm Plication/Hernia Repair

Esophageal myotomy/resection

___ ~~**Robotic Surgery (da Vinci) - ADVANCED PRIVILEGES**~~
~~Initial: See privileges below for specific criteria~~
~~Proctoring: See privileges below for specific criteria~~
~~Reappointment: Ten (10) Advanced Cardiac/Ten (10) Advanced Thoracic cases per two-year reappointment cycle~~

___ ~~ADVANCED CARDIAC~~

___ ~~ASD/Cardiac tumor resection~~
~~Initial:~~
~~1. Unrestricted CORE privileges and~~
~~2. Training in Aortic Endo-Balloon (if technique to be used)~~
~~3. Endoscopic Suturing Skills Training (simulator or live case)~~
~~Proctoring: First 1 case.~~
~~Reappointment: See ADVANCED PRIVILEGE criteria above~~

___ ~~Mitral valve repair~~
~~Initial:~~
~~1. Unrestricted CORE privileges~~
~~2. Case log of ten (10) successful mitral repairs (non-robotic)~~
~~3. Traning in Aortic Endo-Balloon (if technique used)~~
~~4. Endoscopic Suturing Skills Training (simulator or live case)~~
~~Proctoring: First 3 cases.~~
~~Reappointment: See ADVANCED PRIVILEGE criteria above~~

Tri-City Medical Center
MEDICAL STAFF

# Clinical Privilege Request Form

Cardiothoracic Surgery - (Revised ~~4/17~~1/20)

Provider Name:

| Request | Privilege |
|---|---|
| | |

__ ~~ADVANCED THORACIC~~
~~Initial: Unrestricted CORE privileges~~
~~Proctoring: First 1 case~~
~~Reappointment: See ADVANCED PRIVILEGE criteria above~~

__ ~~Pulmonary Resection (other than wedge resection)~~

__ ~~Esophageal resection (other than enucleation)~~

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

__ Moderate Sedation - Refer to Medical Staff policy 8710-517

__ Deep Sedation (Policy #517) - Refer to Medical Staff policy 8710-517

_____
Print Applicant Name

_____
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 20th, 2020

**CONTACT: Barbara Vogelsang, CNE**

| Policies and Procedures | Reason | Recommendations |
|---|---|---|
| **Administrative Policies & Procedures** | | |
| **District Operations** | | |
| 1. Administrator on Call 281 | 3 Year Review | Forward To BOD For Approval |
| | | |
| **Unit Specific** | | |
| **Engineering** | | |
| 1. 5003.2 Lockout Tagout Training | DELETE | Forward To BOD For Approval |
| | | |
| **Laboratory** | | |
| 1. Hematology Quality Management (QM) Plan Policy | 3 Year Review, Practice Change | Forward To BOD For Approval |
| | | |
| **Outpatient Pharmacy** | | |
| 1. Credit Card Processing Policy | NEW | Forward To BOD For Approval |
| 2. Drug Supply Chain Security Policy | NEW | Forward To BOD For Approval |
| 3. Pharmacist Conscientious Objection Policy | NEW | Forward To BOD For Approval |
| 4. Physical Inventory Policy | NEW | Forward To BOD For Approval |
| 5. Prevention of Dispensing Potentially Harmful Prescribed Drugs to Patients Policy | NEW | Forward To BOD For Approval |
| 6. Storage Requirements for Medications Policy | NEW | Forward To BOD For Approval |
| | | |
| **ehabilitation** | | |
| 1. Disaster Plan - Outpatient 1502 Policy | DELETE | Forward To BOD For Approval |
| 2. Emergency Care - Outpatient Services 1504 | DELETE | Forward To BOD For Approval |
| | | |
| **Rehabilitation Center (Acute Rehab Unit)** | | |
| 1. Provision of Durable Medical Equipment (DME) by Tri-City Rehabilitation Center | NEW | Forward To BOD For Approval |
| | | |
| | | |

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

**ISSUE DATE:** 12/01 **SUBJECT: ADMINISTRATOR ON CALL**

**REVISION DATE:** 11/02, 08/03, 03/06, 02/09, 03/11, 11/13, 04/14 **POLICY NUMBER:** 8610-281

| | |
|---|---|
| **Administrative Content Expert~~Department~~ Approval:** | **~~01/17~~11/19** |
| **Administrative Policies & Procedures Committee Approval:** | **~~01/17~~11/19** |
| **Medical Executive Committee Approval:** | **n/a** |
| **Administration Approval:** | **01/20** |
| **Professional Affairs Committee Approval:** | **~~02/17~~ n/a** |
| **Board of Directors Approval:** | **03/17** |

A. **PURPOSE:**

1. To provide a process of administrative oversight and direction to ensure effectiveness of service continues during off hours (after business hours, weekends and holidays).

B. **DEFINITIONS:**

1. Administrator on Call: The Chief Operating Officer (COO), Chief Nurse Executive (CNE) and Chief Financial Officer (CFO) and ~~S~~senior ~~L~~leaders are assigned on a rotational basis to provide administrative oversight and direction.
2. Administrative Supervisor: The Administrative Supervisor on duty is responsible to the Directors and Managers for the management of patient care activities and hospital operations on their assigned shift. They have authority to act in the absence of the Chief Nurse Executive, Directors, and Nurse Managers.

C. **POLICY:**

1. The Administrator on Call (AOC) rotates weekly amongst the Senior Team.
2. The Administrative Supervisor will report any Level IV (Sentinel) occurrence/incident or significant patient care, risk management or operational issues to the Administrator on Call. Types of occurrences/incidents that are reportable to the Administrator on Call are:
   a. Any occurrence requiring reporting to the California Department of Public Health per Administrative Policy: Mandatory Reporting Requirements #236
   b. Significant risk management issues
   c. Significant physician, staff or operational issues
   d. Implementation of Hospital Incident Command System (HICS)
   e. Media contacts or potential media reportable events
   f. Non-availability of inpatient beds
3. All reported occurrences will include the following information in the Administrative Supervisor report:
   a. Brief description of event
   b. Individuals involved
   c. Action Plan (current and proposed)
   d. Impact on Organization or Outcome (current and potential)
   e. Communication Status
   f. Requested Assistance
      i. None Necessary
      ii. Approval
      iii. Plan Modification

D. **RELATED DOCUMENTS:**

1. Administrative Policy: ~~Policy~~ Mandatory Reporting Requirements #236

**DELETE** – Combined with updated Lockout/Tag out Procedure #5003.1

| TRI-CITY MEDICAL CENTER<br><br>Engineering Policy & Procedure | Section: ENGINEERING DEPARTMENT<br><br>Subject: Lockout/Tagout Training<br>Policy Number: 5003.2 Page 1 of 4 |
|---|---|
| Department: Engineering | EFFECTIVE: 8/30/89<br>REVISED: 9/94; 2/97; 5/00; 5/03, 6/06, 6/12 |

## ~~LOCKOUT/TAGOUT TRAINING OUTLINE~~

**~~Definition:~~**

~~Energy runs machines and moves their parts. That energy can be electrical, mechanical, hydraulic or pneumatic. Sometimes the energy is stored, as in springs, steam, or as pressurized air or liquids. Any type of energy, however, can be a serious safety hazard, especially if it comes on or is released unexpectedly while servicing or maintaining equipment. That is why OSHA has developed lockout/tagout procedures to help make sure that anyone working on equipment or a utility system isn't electrocuted, hit, cut, crushed or otherwise is safe injured during machinery a service or repair. If there are any questions regarding the following procedures or safety questions ask your Ssupervisor.~~

**~~Key steps to proper lockout:~~**

~~SHUT OFF and lockout electricity.~~
~~RELEASE and lockout energy.~~
~~DRAIN and lockout material.~~

~~After all the energy has been shut off and drained, lockout is the safest method of keeping you from getting hurt. The law requires you to lockout machine power whenever possible. Only when you can't lockout do you tagout using a warning tag.~~

~~Lockout means putting a lock on the part of the machine that controls the energy: for example, a circuit breaker, switch, block, valve, etc. This locks the energy control device in an "off" position and prevents the machine from starting up or releasing energy accidentally. A lockout lock can have a key or a combination. It cannot be a lock that's used for any other purpose than lockout.~~

**~~Lockout locks must be:~~**
~~Durable enough for the heat, cold, humidity or corrosiveness in the area where it's used – for as long as it is needed.~~

~~Standardized by color, shape or size throughout the facility.~~

~~Strong enough so it cannot be removed without a heavy force or tools like bolt cutters.~~

~~Identified by the name of the employee who installs and removes it.~~

| Effective Date | Department Revision | Environmental Health and Safety Committee | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|
| 08/89 | 9/94; 2/97; 5/00; 5/03, 6/06, 6/12 | 09/19 | n/a | 01/20 | n/a | 06/12 |

**AUTHORIZED PERSONNEL:**

Personnel authorized to perform lockouts will be assigned by the Engineering Managementr. Those assigned this responsibility will be trained in specific lockout procedures and will learn how to recognize the type and

amount of energy used by the machines and equipment and how to control that energy.

If a team is used for lockout/tagout, one member of the group must have primary responsibility. That person makes sure that all group members are safe during lockout. Each authorized group member puts his or her own lock or tag on during the group lockout.

Never remove anyone else's lock or permit anyone else to do so.

Report lost keys to your supervisor immediately and have lock destroyed.

Always use your own lock and key.

**ALL PERSONNEL:**

All personnel who work with equipment must be trained in basic lockout procedures. They need to understand why lockout/tagout is important, how the procedure works, and the importance of not attempting to repair or service machinery without going through proper procedures. Other personnel need to be familiar with lockout/tagout procedures, and know the importance of not trying to restart locked or tagged equipment.

Never remove, ignore or bypass locks or tags you find on machinery.

**LOCKOUT PROCEDURE:**

Locate and identify power sources, potential hazards and all control devices.

Notify all personnel involved.

Turn off all power controls.

Isolate all power sources by blocking, bleeding and venting energy that may be stored in springs, hydraulic systems and pneumatic systems.

Lockout all switches and power controls in the "Off" or "Safe" position.

Test for safety with operating controls in the "On" position. Before testing, always insure that no one is in danger of injury.

Return all operating controls to the off position.

Perform necessary work.

Remove lockout devices once the equipment is fully operational and all affected employees are notified.

Lockout devices must be removed by the person who puts them on.

**TAGOUT:**

**Definition:**
Some equipment cannot be locked out. This does not mean it cannot be dangerous if it starts or is energized accidently. That is where tagout comes in. Tagout means using special tags that warn people of the danger of starting up the machine. A tag has a printed warning about what could happen if the equipment starts up. The tags must be special tags, used only for this purpose. Remember, tags do not provide physical restraints - they are simply warning devices. Do not let tags provide a false sense of security.

These tags must meet the same standards that the locks do, such as they must be durable, strong, standardized and show the identity of the person doing the work. They must also have the same print and format throughout the facility and be tough enough so they cannot be accidentally removed. The law also states that they must be attached with something similar to nylon cable and cannot be reused. They also must be self-locking and cannot be released with less than 50 pounds of strength. A tagout must be attached at the same location as a lockout device would have been attached.

**GETTING BACK ON LINE:**

When maintenance or service is done, only the same authorized person who installed the lock or tag may remove it. Special circumstances may apply during shift changes or unavailability **and in this case Engineering Management is to give direction on removing the lock or tag**. Specific facility procedures must be followed.

**Removal procedure:**

Make sure all personnel are a safe distance from equipment.
Remove tools from machine or equipment.
Reinstall any machine guards.
Remove lockout devices.
Turn on energy.
Notify other personnel that the machines are working again.

**WHO WILL RECEIVE LOCKOUT/TAGOUT TRAINING:**

Lockout/tagout training will be conducted for all new employees. Retraining will be conducted when there is:

- a change in job assignment;
- new hazard due to a change in machine, equipment or process;
- change in procedure; or
- annual evaluation reveals inadequacies in lockout/tagout procedures or employee knowledge.

When outside contractors are to be used, Ccontractor and Director of Engineering must make each other aware of their respective lockout/tagout procedures**needs to follow Engineering Department's lockout and tagout procedures.**

Tri-City Medical Center
Oceanside, California

**LABORATORY**
**HEMATOLOGY / QUALITY ASSURANCE**

| Tri-City Medical Center | ~~Laboratory Manual~~ |
|---|---|
| ~~PROCEDURE:~~ | ~~HEMATOLOGY/URINALYSIS DEPARTMENT QUALITY MANAGEMENT PLAN~~ |
| ~~Purpose:~~ | |
| ~~Supportive Data:~~ | |
| ~~Equipment:~~ | |

**SUBJECT: Hematology/Urinalysis Department Quality Management Plan**

**ISSUE DATE: 07/96**
**REVIEW DATE(S): 10/07, 05/19, 05/10, 05/13**
**REVISION DATE(S): 10/98, 03/00, 12/02, 09/03, 110/04, 09/06, 11/07, 01/08, 05/08, 10/08, 11/09, 09/10, 05/11, 08/12, 05/15, 08/16, 11/17, 10/19**

| | |
|---|---|
| **Department Approval ~~Date(s)~~:** | **12/19** |
| **Laboratory Director Approval ~~Date(s)~~:** | **12/19** |
| **Medical Executive Committee Approval ~~Date(s)~~:** | **n/a** |
| **Administration Approval:** | **01/20** |
| **Professional Affairs Committee Approval ~~Date(s)~~:** | **n/a** |
| **Board of Directors Approval ~~Date(s)~~:** | |

A. **PURPOSE:**

1. The purpose of the Hematology Quality Management Plan is to objectively and systematically monitor the quality and appropriateness of laboratory services in the Hematology section in supporting the hospital wide strategic plan and to evaluate and pursue opportunities to resolve problems and improve patient care.
2. The Hematology section actively participates in a Quality ~~Management~~**Assurance** Program for the primary goal of providing the highest possible quality of medical care in a cost efficient manner and with regard for the safety of patients and employees. A focus of the plan is monitoring the Hematology department function and reliability through external agencies **for** ~~including~~ proficiency testing and contracted quality assurance services. In addition patient results are monitored for accuracy, clinical correlation, correct format and timeliness of reporting.
3. The plan provides the system design and evaluation of proper patient identification and preparation; specimen collection; identification; preservation; transportation and processing; accurate result reporting and documentation. The system ensures optimal patient specimen and result integrity throughout the pre-analytical, analytical and post analytical processes. Opportunities for improvement are identified throughout the review process and through individual staff input using the strategic plan. Opportunities are evaluated and improvement proceeds using the FOCUS/PDCA model used throughout the organization.

| ~~EFFECTIVE DATE:~~ | ~~REVIEWED / DATE:~~ | ~~REVISED:~~ | ~~PREPARED BY:~~ |
|---|---|---|---|
| ~~7/24/96~~ | ~~10/31/07 ld; 5/19/09 ld; 5/28/10 ld;~~ | ~~10/19/08; 3/2/00; 12/17/02; 9/2/03; 11/5/04; 9/7/06; 11/16/06; 11/07/07~~ | |
| | ~~5/29/13 ld;~~ | ~~1/30/08; 5/15/08; 10/7/08; 11/9/09;~~ | ~~APPROVED BY:~~ |
| | | ~~9/8/10; 5/26/11; 8/6/12; 5/28/15~~ | |
| | | ~~8/15/16; 11/13/17, 10/26/19~~ | |

4. Hematology Department Quality Assurance is also monitored through review of the Laboratory Director. The Director reviews the Hematology's overall performance through in-house generated ~~Quality Review statement~~**quality incident reports in the RL system**, in lab generated Supervisor's Investigation of QA problems **entered in the RL system**, turnaround time reports, quality assurance reports, **quarterly quality review reports** and feedback at Medical Quality Assurance and medical division meetings.
5. The safety of staff and visitors within the Hematology/Urinalysis Departments is maintained through the Hospital Safety Committee. All state and federal employees' safety requirements are satisfied and training and enforcement is carried out by the **laboratory Operations** ~~supervisor~~**Manager**.
6. The effectiveness of the Hematology/Urinalysis Quality ~~Management~~**Assurance** Plan is evaluated by the Hematology Department ~~Operations Manager~~**Technical Specialist** using key monitors. These indicators are: turn-around time reports for critical tests to critical care areas; review of monthly QC reports and charts; ~~review of monthly QA summary reports;~~ Proficiency Test results; Customer (clients/patients) complaints; numbers of reporting errors; Critical Values Not Called.

~~**LABORATORY MISSION AND VISION:**~~

~~OUR MISSION:~~

~~The Clinical Laboratory Services Department, in partnership with the nurses and physicians of Tri-City Medical Center, will provide accurate, reliable laboratory data in a timely and cost effective manner contributing to the quality care of our patients.~~

~~OUR VISION:~~

~~The Clinical Laboratory's Vision is to be the guide to the future of innovative laboratory technology.~~

~~**LABORATORY OPERATIONAL PLAN:**~~

~~The laboratory plan is developed through a collaboration of the Laboratory Director, Laboratory leadership team (Senior Director Ancillary Services, Operations Managers, Technical Specialists, Lead CLSs) and the laboratory staff. Meetings are held to educate the staff about the Hospital Wide Operations Plan (HWOP) and to invite their input on potential improvement processes that meet the goals and objectives of the HWOP. The improvements objectives are selected, reviewed for appropriateness and alignment to the TCMC HWOP and then approved by the Laboratory Director. See *Laboratory Operations Plan* for the objectives and action steps.~~

~~**CONTINUOUS QUALITY IMPROVEMENT (CQI) "FINE FOCUS":**~~

~~All employees of the Clinical Laboratory have an opportunity to participate in quality improvement to their client group through the Laboratory CQI by using the *Laboratory Quality Improvement* form. This document uses the FOCUS / PDCA model for process improvement. The client group can be another employee, patient care unit, outside doctor's office or any other individual or group for which the individual's services are required.~~

~~To initiate the proposal the individual obtains a form from their supervisor, completes it and returns it to any supervisor. The proposal is submitted as follows:~~

~~1. Laboratory proposals are submitted to the Laboratory Operations Manager and a workgroup may be assigned depending on the extent of the process. A facilitator may be chosen, the work group meets and reports back to the Operations Manager. Alternately, an individual can proceed less formally by working through the CQI form and completing the prompts. Responsibilities of the workgroup or individual are:~~

~~A. Gather all data necessary to develop possible solutions.~~
~~B. Decide which solution is most effective.~~
~~C. Develop and implement the plan.~~
~~D. Decide who will be responsible for monitoring.~~
~~E. Provide status reports on the progress of the workgroup to the Laboratory QA Coordinator.~~

~~2. Once completed the project will be filed in the Lab CQI Manual.~~

~~FINE FOCUS is the laboratories program for staff lead process improvement. A group of lab staff who have been trained in PI/CQI serve as teams for the purpose of addressing opportunities for improvement. The membership of the team is voluntary from lab staff who use it to achieve their performance appraisal goals. The Lab Dashboard serves as the main source of improvement opportunities. The model for PI used in the laboratory is FOCUS/PDCA.~~

B. **QUALITY ~~MANAGEMENT~~ ASSURNACE RESPONSIBILITIES FOR HEMATOLOGY:** (See also Laboratory Organizational Chart)

1. Laboratory Director:

~~a.~~ The Laboratory Director is responsible for ensuring the Quality ~~Management~~ **Assurance** Plan is implemented in the Hematology Department.

**a.**

~~b.~~ The Director or designee; reviews and approves all technical procedures; receives, reviews and approves all reports regarding quality assurance activities; participates in the Laboratory Leadership Meetings; is responsible for ensuring policies and procedures are established for monitoring the competency of personnel (Responsibility for performing competency assessment is delegated to the Technical Specialist and Lead CLS of Hematology).~~; is responsible for Medical Education Activities.~~

~~Additional Laboratory Director Responsibilities:~~

~~• Ensures communication of lab data.~~
~~• Ensures provision of consultations regarding the medical provision of lab data.~~
~~• Interacts with government and other agencies as appropriate.~~
~~• Ensures provision of educational programs; strategic planning (See Laboratory Operations Plan) and research and development appropriate to the needs of the laboratory.~~
~~• Ensures sufficient personnel with adequate documented training and experience and who meet the personnel requirements of CLIA 88 to meet the needs of the lab.~~
~~Ensures implementation of a safe laboratory environment in compliance with good proactive and applicable regulations.~~

**b.**

2. ~~Operations Manager~~**Hematology Technical Specialist**

a. Reviews all Quality Incident Tracking Forms Reviews (RL Solutions) ~~and disseminates reports to appropriate lab staff for their investigation. Coordinates QA activities of Hematology with respect to Patient Care Services. Participates in the Laboratory Leadership Team Meetings, and presides in the absence of the Laboratory Director. Coordinates meetings with Nursing Unit Managers or directors and other ancillary departments. Coordinates lab CQI and assists in facilitating between lab sections. Represents the laboratory at one or more governance council.~~

~~1. Technical Specialist and Lead CLS:~~

b. Responsible for daily and monthly QA activities. Reports to Laboratory Leadership Team Meetings problems and corrective action plans. Responsible for maintaining documentation of QA monitors. Responsible for performing competency assessment along with the Lead CLS and for monitoring the effectiveness of the assessment. Responsible for forming section Quality Management Teams when indicated. Facilitates CQI activities in their section. Responsible for documenting CQI activities and reporting

at Lab Leadership Team meetings. **Reviews all Quality Incident reviews (RL Solutions) pertaining to the Hematology section.**

C. **QUALITY CONTROL PROGRAM:**

1. Quality control management for the Hematology section is the responsibility of the Laboratory Director and is delegated to the Technical Specialist and Lead CLS.
2. Quality Control Management includes review of patient results, quality control values, and instrument performance records. The Hematology section has a defined and organized system of Quality Control, which describes the review process, its timeliness and the person(s) responsible for implementing it. The Quality Control system for each section also defines the tolerance limits, corrective actions, and documentation policies.
3. Monitoring Analyte Performance:
   a. The purpose of the Quality Control Program is to ensure the precision and accuracy, and therefore reliability of analytic test results reported from the laboratory. The Laboratory uses the multi-rule, Westgard, method for determining control status. Control results are selected for each method/control/test combination and are chosen to readily detect random and systematic errors while at the same time maintain a low level of false rejections (rejecting the run when in fact there was no analytical error) and high probability of error detection.
   b. All controls specimens are tested in the same manner as patient samples.
4. Number and Frequency of Controls:
   **a.** For quantitative tests, a minimum of two levels of controls are used on at least a day of use basis. Analytic run is defined as the interval between acceptable quality control results or the time interval within which the accuracy and precision of the measuring system is expected to be stable. The time interval between runs is determined by the control frequency.
5. Establishing Tolerance Limits:
   a. Whenever new controls, new control lot numbers, or new tests are introduced the protocol for establishing tolerance limits is to perform a minimum of 10 replicates over a period of at least one week and run in parallel with the controls currently in use. The Lab tolerance limits must be within the manufacturer's stated limits. All results are entered in Cerner using DB QC Maintenance where a mean and 1 SD are calculated and the ± 2SD limits are determined. After the mean is established the Lead CLS or Technical specialist monitors the means on a weekly basis for the next several weeks and adjusts the ranges as necessary so there is a minimum of 20 quality control runs.
   b. NOTE: For the Hematology analyzers since new control lots are used monthly, the lab mean is established using a minimum of 10 replicates over a period of one week and historical tolerance limits are used which have been calculated from a minimum of 10 IQAP reports. These are monitored monthly from the IQAP reports and LJ charts. The Lab limits are verified to be within the BCI assay ranges. Since the reticulocyte controls are also changed on a monthly basis and not run ~~on a daily basis~~**as frequently as the 6C controls**, the BCI assay ranges are used and the IQAP reports reviewed monthly.
   c. The body fluid controls are only run when a patient specimen is received and the same lot **is** run over several months so the BCI assay ranges are used and IQAP reports **are reviewed at the completion of the lot number.**~~when they are available.~~
6. Quality Control Records:
   a. All QC records are maintained for a minimum of **six**~~three~~ years. This includes QC Summary printouts, instrument printouts and tapes, calibration records, reagent records, proficiency test results and evaluations, method comparisons, calibration verification and linearity records, and new procedure staff review signoff forms. See the Table: Laboratory Record Retention. QC charts and records which are in Cerner are available for an indefinite time.
7. Patient Result Corrective Action Based on Quality Control Data:

a. The quality assurance procedure used in the Hematology Department to review, retest and correct patient values which may have been resulted from the last time acceptable QC was documented up to the time of the QC failure (this time period is sometimes referred to as the "Analytic Run") is called "PATIENT RESULT CORRECTIVE ACTION".

b. When a test/method has been determined to be out of control (OOC) corrective action must be taken such as replacing the reagent, recalibrating, changes or alignments, other maintenance or retesting the control. In most circumstances it is not certain at what time the system was no longer producing reliable results. At this point the test/method is marked OOC and no further patient results are reported from this test/method until corrective action is taken and the test/method is documented to be in control. All patient results reported from the effected test/method back to the last time the test was documented to be in control are reviewed and possibly retested and corrected based on certain review criteria. The steps involved are:

   i. Determine the last QC run.

   ii. The last QC run can be determined from the Table of Control Frequencies, from the Cerner application QC Inquiry or from the test worksheet or instrument printout.

   iii. Obtain a list of patients reported since the last QC run.

~~HOW TO OBTAIN A LIST OF PATIENT RESULTS:~~

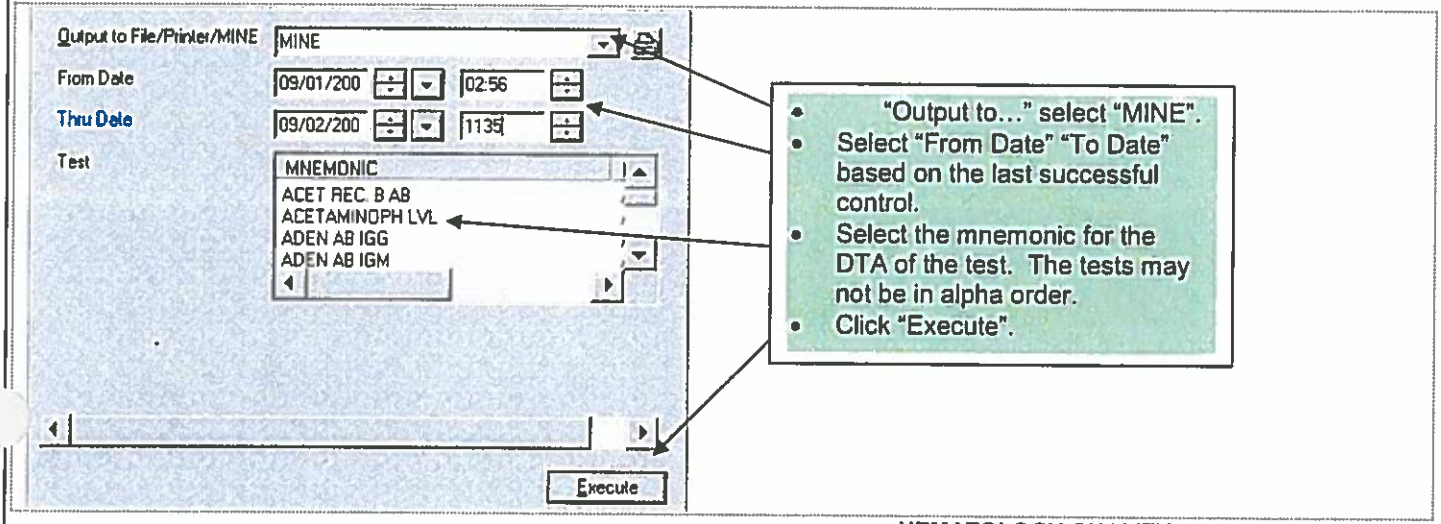
~~Log on to Compass.~~

~~Click on the Explorer Menu Icon~~  ~~and logon.~~


~~Select "Results by DTA" from the menu~~

~~In the "Output to File/Printer/MINE field enter "MINE"~~ 

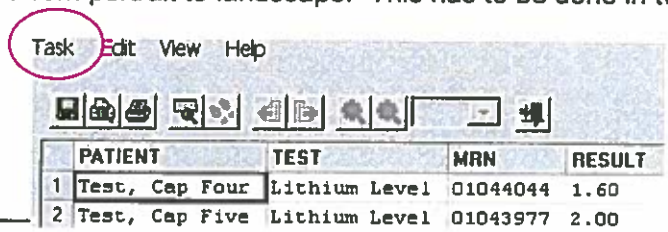

~~Enter the dates for which results are to be recalled.~~



~~6. Scroll through the TEST menu and select the mnemonic of the desired test.~~

~~7. Click "Execute". A list of the patients, test, MRN, results, date/ time performed, acc#, the name of person who performed the test and service resource will be displayed in a spreadsheet mode.~~

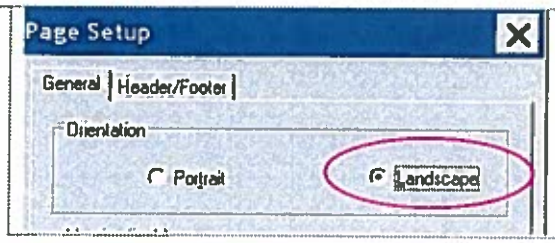
~~8. To obtain a printout of the spreadsheet click on "Task" on the task bar. You will change the paper layout from portrait to landscape. This has to be done in two locations.~~



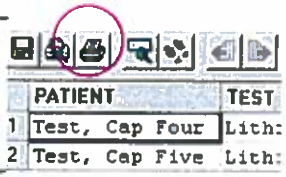

Click on "Task" on the task bar

~~9. Click on "Query Page Set up"~~


~~10. Click on the "General" tab and select "Landscape". Click on "OK".~~

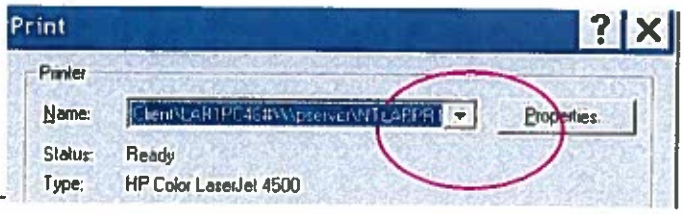



~~D.~~ 11. ~~Click on the printer icon on the menu bar.~~

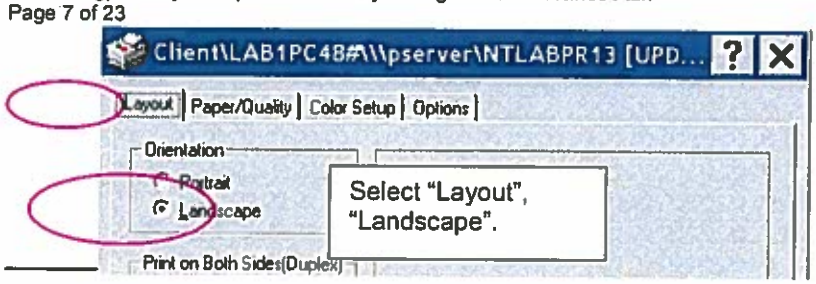



Click on the printer icon on the menu bar

~~E.~~ 12. ~~Click on "Properties"~~




~~13. Click on the "Layout" tab. Select "Landscape".~~




~~B. 14. Click on "OK" to print the spreadsheet.~~

~~i.~~iv. Select the patient samples to be tested. Repeat the test on an instrument or method that is documented to in control and determine if a corrected report is to be made.

~~ii.~~v. The retest value is checked against the original value and a corrected report is made if the difference in values is more than +/- 3.5 times the 1SD value for the control used in the effected test / method combination for the nearest level of control to the effected test. The 1SD values for test / control combination are obtained from the QC Inquiry **or the Hematology instrument.**

~~iii.~~vi. Communicate by phone the corrected results and document the phone call.

~~iv.~~ Refer to the **Laboratory Gen Lab QA procedure:** Procedure for Detecting and Correcting Erroneous Laboratory Results ~~which is located in the General Lab QA Manual.~~

vii.

## ~~F.~~D. QUALITY ~~MANAGEMENT~~ ASSURANCE ACTIVITIES IN THE HEMATOLOGY DEPARTMENT:

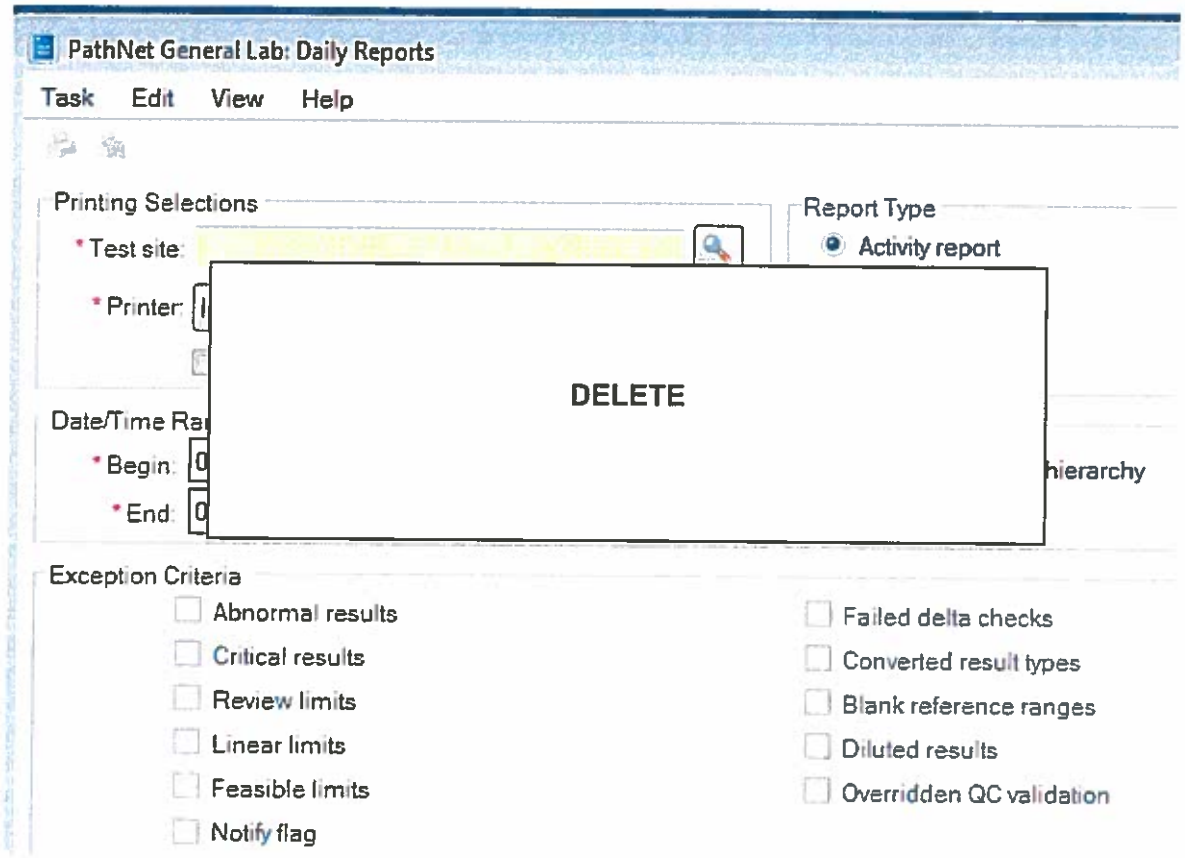
1. The Quality ~~Management~~ **Assurance** Program for the Hematology section may be broken down to active process performed on an individual test, shift, daily, monthly, quarterly, semi-annually and annual basis. In addition other activities may be included as needs arise or performance dictates. All activities are directed toward providing the physician a reliable (accurate, precise, clinically meaningful) result.
2. Quality Control Inquiry/**Quality Control Review**
   - a. Daily the activity report is printed for both the Stago A and Stago B. All the QC results are reviewed from the previous day. Control results, method and test combination, which have failed one or more of the Westgard rules defined for the test/method are reviewed by the ~~Manager~~ **Technical Specialist** or the Lead Clinical Lab Scientist **(CLS)**. This review consists of entering QA Inquiry for the method, test and control combination listed on the QC report and reviewing corrective action that was taken for the out of control result. All subsequent control runs will be reviewed to ensure the appropriate corrective action was taken for the control to be within acceptable limits. Each control that is reviewed is marked as "Reviewed" in the LIS. If necessary, the Levy-Jennings charts are reviewed for further corrective action.
   - b. **The rest of the quality control that is entered into Cerner such as the urine and sedimat 15 quality control is also checked to ensure that the daily qc was run and any corrective action was documented. If corrective action was taken it will be marked "Reviewed" by the Technical Specialist or Lead CLS.**
   - ~~a.~~c. **The manual worksheets are also reviewed and checked to ensure the controls were entered into Cerner and the patient results were also entered correctly.**
   - ~~b.~~d. Exceptions to the above QC Inquiry in the LIS are the Beckman Coulter DXH 1600 and IRIS iQ200. The quality control will not be entered into the LIS. All corrective action will be documented onboard the DXH 1600 and on the QC printouts for the IRIS iQ200, The QC will be reviewed daily Monday through Friday by either the Operations Manager or Lead CLS to ensure all corrective action is performed and documented by the Clinical

Lab Scientists. On a weekly basis the Lead CLS prints the QC report off the iQ **velocity**~~200~~ and reviews the results to ensure compliance.
~~The manual worksheets are also reviewed and checked to ensure the controls were entered into Cerner and the patient results were also entered correctly.~~

3. Quality Review Report (QRR) from RL Solutions)
   a. TCMC uses the RL Solutions QRR system for tracking quality problems and near misses throughout the facility. The Laboratory Operation Managers receive risk alert notifications via email when there is a problem or incident involving the Laboratory that needs investigation. **Any RLs involving the Hematology Department will be tasked to the Technical Specialist for follow up.** The outcome of the investigation determines what action is taken in the lab to correct the problem and is documented in RL Solutions. ~~The QRR reviews are summarized on the QRR Summary spreadsheet for tracking and trending.~~ The incident is reviewed at the Lab Leadership Meeting and other staff meetings as needed for educational opportunities **and possible performance improvement opportunities**. No copies **of the RLs** are maintained in the lab.

~~3. Supervisor's Investigation of QA Problem (SIR)~~
~~The SIR is documentation generated by a section Operations Manager or Lead in response to a Laboratory identified problem. The problem is reviewed with all concerned staff and corrective action is documented. SIR's may be reviewed at the Lab Leadership meeting.~~

4. PI/CQI Workgroups (FINE FOCUS):
   a. A group of lab staff who have been trained in PI/CQI serve as teams for the purpose of addressing opportunities for improvement. The membership of the team is voluntary from lab staff who use it to achieve their performance appraisal goals. The Lab Dashboard serves as the main source of improvement opportunities. The model for PI used in the laboratory is FOCUS/PDCA.
5. Turn Around Time Reports (TAT)
   a. The TAT is used to assess actual turn-around times against stated goals and benchmark standards. Selected critical tests for critical care area are reviewed each month and added to the Laboratory Dashboard. For the Hematology/Urinalysis Department these tests are PT/PTT TAT for Stroke Codes and urine pregnancy tests TAT from the Emergency Department. Target TATs are identified and results are monitored for outliers. Outliers may become an opportunity for improvement for the FINE FOCUS teams (see above).
6. Daily QA Review (Daily Reports)
   a. The Daily Exception Reports are generated each day from the **Daily Reports in Cerner** ~~iscorn Explorer (see below)~~ and are reviewed by the Technical Specialist or Lead Clinical Laboratory Scientist. The report lists all patient results that have failed predefined limits for acceptability. These limits are Correction Report, Critical Results, Failed Delta Checks (the difference between the current and previous results), and Converted Result Types.
   b. Press the **Daily Reports** Icon and the following menu will be displayed:




c. At the Test site box enter **Hematology**.
d. At the Date/Time Range box, enter the appropriate date range.
e. Then at **Report Type** select **Exception report** and which **Exception Criteria** (Critical results,
f. Failed delta checks or Converted result types) report you want to print.

7. Corrected Test Report
   a. Daily the Technical Specialist or Lead CLS will print and review the Correction Report from the previous day. Use the Daily Reports icon from 6.a. except at **Report Type** select **Correction report**. Hematology utilizes the procedure for handling corrected reports in the General Lab QA Manual. During this review the Technical Specialist or Lead CLS reviews the correction report to ensure compliances. Critical review of each correction is also performed to determine if there is a systematic trend or if disciplinary action needs to be taken. It is also documented on the QA review log and error log.
   b. Any corrections of critical values to non-critical value or non-critical value to critical value or corrections of critical test results must be fully investigated and reported to the Laboratory Director. This includes all tests listed in the procedure **Laboratory/General Laboratory Manual Procedure:** Critical Values and Critical Tests.
8. Monitoring Timeliness And Completeness Of Critical Value Communication:
   a. To check to be sure critical values have been timely reported and correctly documented, the bench technologists assigned to Hematology must print a Daily Report for critical value exceptions. Check Order Result Viewer in Cerner for the communication documentation for those tests that appear on the
   b. *Critical Value Table* according to the schedule below: Note: At the same time the Review Results report will also be called for Urinalysis to verify that urine cultures have not been missed.
      i. **Daily Report recommended review schedule:**

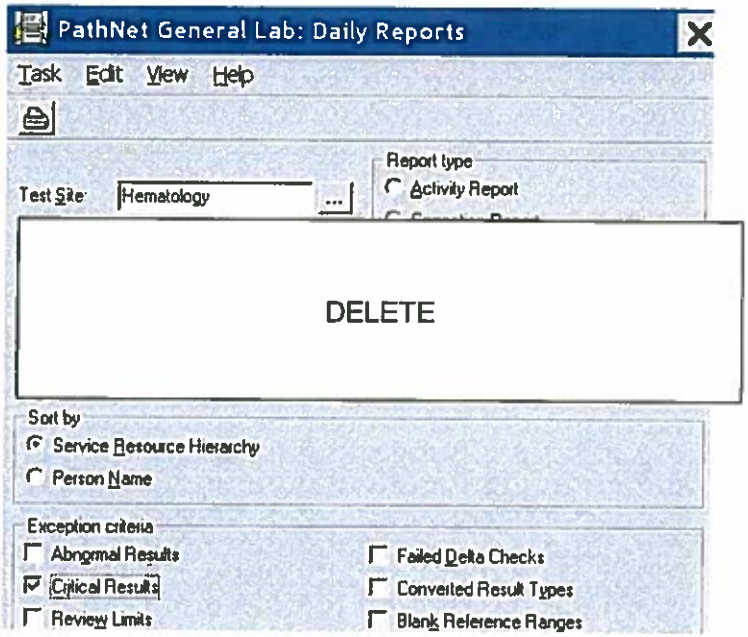
| Time (Approximate) | Responsible | Review |
|---|---|---|
| 0800-0900 (prior to morning break) | AM Tech | Hematology/Urinalysis |
| 1400-1500 | AM Tech | Hematology/Urinalysis |
| 2200-2300 | PM Tech | Hematology/Urinalysis |
| 0600-0630 | NT Tech | Hematology/Urinalysis |

c. All completed Daily Reports should be initialed by the reviewing tech and placed in the Daily Report box.

d. Critical values will also be reviewed by the ~~Operations Manager~~**Technical Specialist** or Lead CLS by reviewing the *Daily Exception Report* printed at 0600 each day. Each critical value will be reviewed for proper documentation including name of person to whom the call was made, their credential (RN, LVN, RCP, physician), the name of the test, the date and time of call and the Cerner ID of the person calling the critical result

~~Procedure:~~

~~a) Access the Daily Reports Icon on the AppBar:~~
~~At **Test Site:** enter Hematology and at **Printer:** enter labpr07.~~



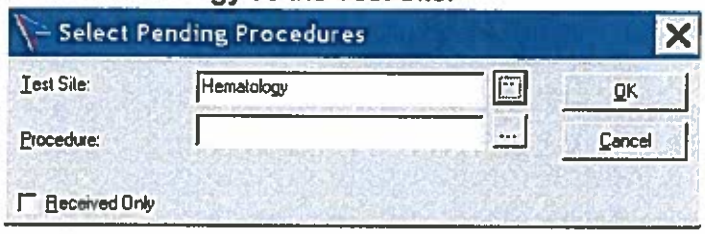

~~2) Click on **Exception Report** and then **Critical Results** and **Review Limits** and click on the printer Icon.~~

9. Pending Inquiry

a. Pending Inquiry logs list tests that have not been resulted or dispatched and not received in the Lab. Along with the pending tests, the log includes the accession number, patient location and medical record number and the priority if any. The logs are reviewed at frequent intervals throughout the day by the Hematology staff and reviewed by the staff CLSs or the phlebotomy team for unreceived specimens. Logs are reviewed between outgoing and incoming shifts for testing status, turn around time and specimen location and should be printed. This coordinated effort is done to prevent unnecessary delays in reporting or improper specimen handling.

~~b. Procedure:~~
~~c.~~

~~1) At the AppBar access **Pending Inquiry:**~~
~~2) Enter **Hematology** as the Test Site:~~




~~3) Click **OK** and then press the **Printer Icon** and then click **OK** to print the report.~~

10. Instrument Function Checks and Maintenance
    a. To maintain optimal performance of instrumentation and to reduce down time, a rigid schedule of instrument maintenance and function checks are performed by and are the responsibility of the staff CLSs using the instruments. ~~.~~Function checks and maintenance are performed according to the individual instrument manufacturer's requirements. All maintenance and checks are recorded in an instrument specific log located at the instrument. Refer to the Hematology QC Flow Chart for the daily maintenance and QC performed on the hematology analyzers. The logs and/or Hematology/Urinalysis Function Checks log sheets are monitored weekly and reviewed monthly by the ~~Operations Manager~~**Technical Specialist** and/**or** Lead CLS.
    b. If any instrument function checks results are out of tolerance limits or if any problems are encountered the CLS may begin troubleshooting based on their ability to diagnose and correct problems on the particular instrument. Major repair and troubleshooting documentation is included with most manufacturer instrument manuals. Telephone hotline assistance is also available and is expected to be used by the **CLS** ~~technologist.~~. Instruments that cannot be brought into acceptable tolerance may not be used for patient testing and the ~~Operations Manager~~ **Technical Specialist** and/or Lead CLS must be notified. Documentation of all actions are recorded in the Problem / Corrective Action sections of the individual instrument maintenance logs.
11. Test Specific Quality Control
    a. Quality control materials of two or three levels are tested for each analyte performed in the Hematology Department according to a schedule of frequency determined by the instrument manufacturer, instrument performance and in no case greater than 24 hours or the day of use. Whenever possible quality control material is handled and tested in the same manner as patient samples. Quality control procedures are performed by the staff Clinical Lab Scientists who evaluate and interpret the results and take action according to the **Laboratory/Hematology/Quality Assurance Procedure:** Hematology Quality Control Outline and patient results are not released until the quality control is acceptable and documented in the LIS or the instrument. LJ Charts and outlier interpretation and corrective action documentation are kept in the LIS except for the Beckman Coulter DXH 1600 and the Iris iQ which is kept on the instrument. Monday through Friday the QC is reviewed by the Technical Specialist or Lead CLS using QC Inquiry for the Stagos and on board for the DXH 1600 and Iris iQ. If an analyte fails one of the Westgard rules used for that assay, the LJ charts will be reviewed and appropriate corrective action verified. Monthly the Levey-Jennings Charts generated by the Beckman Coulter DXH 1600 are printed and reviewed by the Technical Specialist. The LJ charts generated by the STAGO instruments are -reviewed monthly by the Lead ~~Coagulation~~ CLS. The means and CVs of both instruments are then compared. The QC on the Iris iQ is indicated as "Pass or Fail" and is reviewed daily for appropriate action if any control Fails the instrument parameters and printed weekly. Refer to the **Laboratory/Hematology/Quality Assurance Procedure:** Hematology and Urinalysis Quality Control Outline.

12. Review of Hematology Department Worksheets
    a. Worksheets are generated throughout the day for methods that are not interfaced to the LIS. Recorded on the worksheets is the patient as well as QC values. The worksheets are reviewed for appropriate control runs and reagent checks. Problems revealed through review are brought to the attention of the CLS involved. The previous day's Coagulation Activity Report is also reviewed for appropriate action on abnormal results, and appropriate comments. The Stago Compact printouts are reviewed for appropriate action taken by the staff CLSs when instrument flags are given and verifies appropriate repeats and dilutions. Problems revealed through the review are brought to the attention of the CLS involved and disciplinary action taken when necessary and documented on the Quality Assurance Log. Worksheets are filed each month and maintained for **at least** three years. ~~and three months.~~

~~G.~~E. **MONTHLY**

1. Review of Temperature Charts, Instrument Maintenance and Function Check logs by the ~~Operations~~ **Technical Specialist** ~~Manager~~ and Lead CLS
2. Review of the Levy-Jennings Charts for all control lots on the Beckman Coulter DXH 1600 by the Technical Specialist. The LJ charts generated by the STAGO instruments are reviewed monthly by the Lead Coagulation CLS. The QC on the Iris iQ is indicated as "Pass or Fail" and is printed and reviewed monthly for appropriate action if any control Fails the instrument parameters. The control charts are reviewed for:
    a. Shifts, trends and corrective action by technologists.
    b. Comments and corrective action are documented on the charts.
3. Quality Assurance Program (QAP)
    a. Accuracy and Precision Check: Review of control material Quality Assurance Data reports from Beckman Coulter (IQAP) by the Operations Manager. Data is collected for a period of a month and submitted to Beckman Coulter. The returned reports contain analytic method specific control statistics for our laboratory's lot to date performance as well as comparative statistics for all participating laboratory's analytic method specific control results.
        i. **ACCURACY:** Method / test accuracy is evaluated for the DXH 1600 by reviewing the IQAP report each month for monthly TCMC mean SDI (standard deviation interval) vs all laboratories analytic system SDI. Corrective action may be taken for analytes that fall outside +/- 2 SDI for either the month or lot to date data.
        ii. **PRECISION:** Method / test precision is evaluated for the DXH 1600 using the Beckman Coulter IQAP report. The QAP reports are used to compare the TCMC coefficient of variation (CV) for the last month's data vs the CV of the previous month and the Pool CV. For the Diagnostica Stago Compacts, monthly the QC data is reviewed for any significant changes in the SD and CVs. Action is taken if the CVs differ by more than a factor of two and documented on the report form.

~~H.~~F. **SEMI-ANNUALLY**

~~1. Microscope maintenance is performed annually by an outside microscope vendor.~~
1. Method comparison studies for the Hematology, Coagulation and Urinalysis analyzers.
~~1.~~2. **Calibration of the DxH 1600 is performed at least every six months.**

~~I.~~G. **ANNUALLY**

1. Thermometer verification is performed by the staff technologists and reviewed by the Operations Manager. Refer to the PIPET / THERMOMETER Manual.
2. Hematology hazardous chemical inventory reviewed by the Hematology Technical Specialist.
3. Review of the Hematology Chemical Hygiene and Bloodborne Pathogen Task Assessment by the Hematology Technical Specialist.

4. Micropipettor calibration and accuracy / precision checks are performed by the staff CLSs and reviewed by the Technical Specialist. ~~Refer to the *Quality Assurance of Micropipettor procedure* in the PIPETTE / THERMOMETER Manual.~~
5. Centrifuge tachometer and timer checks and electronic timers are checked annually by the Biomedical Engineering Department. NOTE: Certified Calibrated three channel timers are used until their expiration date and then new timers are purchased. These timers do not have to be checked annually.
6. The Microfuge tachometer and timer check is performed by a staff CLS.
~~6.~~**7. Microscope maintenance is performed annually by an outside microscope vendor.**

~~J.~~**H. BIENNIAL REVIEW:**

1. Procedure manual review and review of the QA Plan done by the ~~Operations Manager~~**Hematology Technical Specialist** and Lead CLS.

~~K.~~**I. SUMMARY OF OTHER QUALITY ASSURANCE PROCEDURES:**

1. Technical Procedures
   a. Technical procedures written for the department or those used from manufactures must conform to the standard format established for this institution in compliance with NCCLS GP2-A4 Clinical Laboratory Technical Procedure Manuals. The Hematology/Urinalysis Department guidelines are stated in the ~~*Procedure Manual & Technical Procedures* document located~~ in the **Laboratory/**General Laboratory ~~Quality Assurance~~ Manual: **Procedure Manuals and Technical Policies, Procedures, and Document Control.** These will be reviewed on a bi-annual basis.
2. Detecting and Correcting Erroneous Lab Results
   **a.** Staff technologists review all quality assurance failure flags (delta, normal and technical limit failures) before a result is reported. The specimen container is also inspected for multiple labels name match to be sure there has not been a labeling error. The specimen is examined for clots, fibrin, particulate matter and other conditions that would cause rejection. Refer to **the**~~five~~ procedures ~~All are~~ located in the **Laboratory/**General Laboratory ~~Quality Assurance~~ Manual.:
      **i.** Procedure for Detecting and Correcting Erroneous Lab Results~~;~~
      **ii.** Verification of Specimen ID and Review of Results~~;~~
      **iii.** Procedure for Assuring Correct Specimen Identification and Labeling;
      **iv.** Specimen and Aliquot Labeling~~;~~
      **v.** Specimen Handling, Transportation, Special Collection, Processing, Aliquoting and Criteria for Rejection~~.~~
      ~~a.~~**vi.** Also refer to the **Laboratory/Hematology/Quality Assurance Procedure:** Rejection ~~and Handling~~ of Specimens~~: Criteria For located in the Hematology Quality Assurance Manual~~.
3. Manual Backup System for LIS Downtime
   **a.** At times when the LIS is down for scheduled or unscheduled maintenance the Hematology Department utilizes a manual backup system. The system's purpose is to provide timely results to the caregiver while maintaining quality control. The system also provides for rapid recovery once the LIS is back on line. Refer to the procedures~~-~~:
      **i.** **Laboratory/**Hematology ~~Department~~ /Quality Assurance ~~Manual~~**Procedure:**~~,~~ **Laboratory Information System** (LIS) **Downtime Procedures for Hematology**
      **ii.** **Laboratory/Hematology/Urinalysis Procedure:** Downtime Procedures For Urinalysis ~~in the Urinalysis Procedure Manual Manual Backup for the LIS located in the and~~
      ~~b.~~**iii.** **Laboratory/Hematology/Coagulation Procedure:** Downtime ~~for~~ Coagulation Procedures ~~in the Coagulation Procedure Manual~~.
4. Clinical Laboratory Scientist ~~Orientation~~ **Training** Checklist
   a. All new employees of the Hematology Department are trained ~~on the AM shift by~~ the department ~~Operations Manager~~**Technical Specialist**, Lead CLS or qualified staff

CLSs. The ~~orientation~~**training** checklist is used to verify successful orientation to the department as well as a guide for topics to be reviewed during the ~~orientation~~**training**. Upon completion of the orientation and evaluation, both the employee and ~~Operations Manager~~ **Technical Specialist** will verify competency in all sections reviewed. ~~Refer to the *Hematology Competency Checklist* in the Hematology Department Quality Assurance Manual~~

5. Method Validation (Method Performance Specification
   a. The step-by-step process for the integration of new test in to the lab is as follows:
      i. Order the product.
      ii. Add the test to the CAP Activity menu for the lab. Obtain the test product insert.
      iii. Check for and enroll in proficiency testing.
      iv. Obtain control material.
      v. Create orderables in Cerner. Consult with Information Technology (IT)
      vi. Obtain CPT codes.
      vii. Submit for Charge Master Code.
      viii. Obtain linearity material.
      ix. Method Validation – Precision, Linearity, Correlation, Reference Range Validation.
      x. Submit Validation Statement to Lab Director.
   b. Method Validation: **Summary Statement Of Acceptable Performance:**
      i. The Laboratory Director must review the validation study and approve each test for clinical use (for tests implemented after 6/15/09). The review must be documented on the validation study using the statement.
      ii. This validation study has been reviewed and the performance of the method is considered acceptable for patient testing.
      iii. *By :_____Date:_____Laboratory Director_____*

## ~~L.~~J. HEMATOLOGY QUALITY CONTROL SUMMARY

1. Internal Quality Control
   a. The Hematology Department uses assayed control material for the evaluation of method performance. The **Laboratory/Hematology/Quality Assurance Procedure: Hematology and Urinalysis Quality Control Outline** ~~"Quality Control Outline" located in the Hematology Quality Assurance Manual,~~ describes the procedure to follow for one, two and three level control systems. The procedure describes the method for documentation of QC outliers and the corrective action taken.
2. QC Material:
   a. Beckman Coulter 6C tri-level control
   b. Beckman Coulter Retic-X tri-level control
   c. Beckman Coulter Latron CP-X Control
   d. Polymedco Sed-Check 2 bi-level controls (Sedimat 15 and Manual Sediplast)
   e. Seradyn Access Mono Test Positive and Negative Controls
   f. Diagnostica Stago Coag Normal and Abnormal Controls
   g. Diagnostica Stago Lia Normal and Abnormal Controls
   h. Diagnostica Stago FDP Positive and Negative Controls
   i. Medical Analysis Systems Moni-Trol Urinalysis Abnormal and Normal Controls
   j. Distilled H20
   k. 5% **Sodium Chloride** (Nacl)
   l. Streck Retic Chex bi-level control
   m. IriSpec CA and CB Controls
   n. Iris iQ Positive/Negative Controls and Focus
   o. Pacific Hemostasis Sickling Hemoglobin Positive and Negative Controls
3. External QC (IQAP): Precision and Accuracy Check

a. The Hematology Department is enrolled in the following Quality Assurance Peer Group Comparative Pool: Beckman Coulter Corporation IQAP and Sedimat 15 Peer Review Report.

4. Comparability Studies of Instrumentation:

a. The Hematology Department verifies the comparability of results for those tests run on different instrumentation as follows.

i. **INTER:**

1) **Hematology Analyzers: Beckman Coulter DXH 1600:**

2) Semi-annually 20 patients are run on the DxH1 in the repeatability automated mode- and then run on the DXH2 in the repeatability automated mode. NOTE: As wide a range of results for each analyte will be chosen.

3) Results are compared to ensure acceptability of the results between the two analyzers **using an unpaired *t* test.** ~~See Tolerance limits below:~~

~~DXH 1600 TOLERANCE LIMITS~~

| ~~Parameter~~ | ~~Absolute Units~~ |
|---|---|
| ~~WBC~~ | ~~±0.5~~ |
| ~~RBC~~ | ~~±0.2~~ |
| ~~HGB~~ | ~~±0.3~~ |
| ~~MCV~~ | ~~±2.0~~ |
| ~~RDW~~ | ~~±0.5~~ |
| ~~PLT~~ | ~~±20~~ |
| ~~MPV~~ | ~~±0.5~~ |
| ~~%NE~~ | ~~±2.0~~ |
| ~~%LY~~ | ~~±2.0~~ |
| ~~%MO~~ | ~~±2.0~~ |
| ~~%EO~~ | ~~±1.0~~ |
| ~~%BA~~ | ~~±0.5~~ |
| ~~% RET~~ | ~~±0.5~~ |

~~c. In addition, an upaired *t* test will be performed to ensure that the test results are considered to be not statistically significant.~~

4) See **Laboratory/Hematology/Quality Assurance Procedure:** "Comparison Studies for Hematology/Urinalysis Instruments/Methods" for further details.

b. **Manual Differential vs Automated Differential from the DXH 1600**

i. Semi-annually the method comparison is performed using fresh human samples

~~1)~~ (EDTA whole blood) rather than stabilized commercial control material. Before

~~2)~~**1)** beginning the comparison be sure both instruments meet quality control specifications. Ensure that variations in slide preparation are minimized by making quality smears, staining quality standards are met and a qualified technologist performs the differential count. A total of 20 patients will be run on the DxH 1600 and a manual differential will be performed.

~~3~~)2) See **Laboratory/Hematology/Quality Assurance Procedure:** "Comparison Studies for Hematology/Urinalysis Instruments/Methods" for further details.

c. **Coagulation Analyzers: Diagnostica Stago Compacts**
   i. Semi-annually 20 patients that have been run on Stago A Compact will be analyzed on the Stago B Compact for PT, PTT, d-Dimer and Fibrinogen.
   ii. See **Laboratory/Hematology/Quality Assurance Procedure:** "Comparison Studies for Hematology/Urinalysis Instruments/Methods" for further details.

d. **Urinalysis Analyzers: iChem Velocity and the iChem 100**
   i. Semi-annually 20 patients that have been run on the iChem Velocity will be run on the iChem 100 which is the backup dipstick analyzer.
   ii. See **Laboratory/Hematology/Quality Assurance Procedure:** "Comparison Studies for Hematology/Urinalysis Instruments/Methods" for further details.

e. **Refractometer: iChem Velocity and the Refractometer**
   i. Semi-annually 20 patients that have been run on the iChem Velocity will be run on the Refractometer.
   ii. Results are recorded on the iChem Velocity vs Refractometer Correlation worksheet.
   iii. See **Laboratory/Hematology/Quality Assurance Procedure:** "Comparison Studies for Hematology/Urinalysis Instruments/Methods" for further details.

5. Proficiency Tests:

a. ~~A.~~ ——The Hematology Department is enrolled in the College of American Pathologists Proficiency Survey Program for all regulated analytes as well as those analytes for which survey material is available. The surveys are handled as though patient samples according to the **Laboratory/General Laboratory Manual Procedure:** ~~"Procedure for Handling~~ Proficiency Testing **Procedure** ~~Samples" located in the Hematology Quality Assurance Manual~~. The Hematology Department is enrolled in the following surveys:
   i. Comprehensive Hematology with Flow-Through Differential (FH13) – Beckman Coulter DXH 1600 and photomicrographs
   ii. Reticulocyte (RT1) and (RT) – Beckman Coulter DxH 1600 and Manual
   iii. Erythrocyte Sedimentation Rate (ESR and ESR1) – Sedimat 15 and Manual
   iv. Hemacytometer Fluid Count (HFC)
   v. Clinical Microscopy (CM/DSC) - iChem Velocity, Ictotest, Urine Protein and photomicrographs.
   vi. Coagulation Limited (CGL) – Stago Compacts (PT/INR, PTT, Fibrinogen, d-Dimer, FDP)
   vii. Coagulation Extended (CGE) – Stago Compacts (Thrombin Time, PT/PTT Mixing Studies)
   viii. Serology Fulfillment (S) – Mono Test
   ix. Calibration Verification/Linearity Survey LN9 (WBC, RBC, HGB, PLT) and LN19 (Retic) – Beckman Coulter DxH 1600; LN42 D-Dimer and LN44 Fibrinogen – Stago Compacts
   x. Sickling Hemoglobin Screen (SCS) – Sicklescreen
   xi. Automated Body Fluid (ABF2) – Beckman Coulter DxH 800
   xii. Hemacytometer Fluid Count (HFC) – Manual counts
   xiii. Automated Urinalysis (UAA) – IRIS iQ
   xiv. Special Clinical Microscopy (SCM2) – Urine Eosinophils
   xv. Body Fluid/Urine Crystals (CRS - BFC)
   xvi. Urine Crystals (CRS - URC)
   xvii. Instrumentation (I) – Refractometer
   **xviii.** Platelet Induced Aggregation (PIA) — VerifyNow
   ~~xviii.~~**xix. CMQ – Clinical Microscopy Quality Cross Check – iChem Velocity and Siemens Clinitek Status**

~~A. Alternate Proficiency Testing~~

~~1) Ivy Bleeding Time by Chart Review: No commercial proficiency testing material is available or appropriate for this laboratory test. The following chart review procedure will be followed for proficiency testing:~~

~~a) Interval: Every six months if any patient bleeding times have been performed, three Ivy Bleeding Time results will be reviewed. If possible at least one abnormal will be reviewed.~~

~~b) Chart Review Criteria: The following parameters will be reviewed:~~

~~1) Age~~
~~2) Diagnosis~~
~~3) Platelet Count~~
~~4) Pertinent Comments~~
~~5) Drug History~~
~~6) Previous Results~~

~~c) Hematocrit, kidney function tests and Liver function tests~~

~~d) Proficiency Test Worksheets will be reviewed by the Technical Specialist or Lead Coagulation CLS as well as the Medical Director.~~
~~Reviewed Worksheets will be filed in the current year CAP binder.~~

~~NOTE: This is a low volume test so three patient's results in a six month time period may not be available for review~~

6. Laboratory Reference Intervals:

a. The laboratory reference range must be established or verified for each analyte and specimen source (e.g., blood, urine, cerebrospinal fluid), when appropriate. For many analytes (e.g., CSF ranges), literature references or a manufacturer's package insert information may be appropriate.

b. The laboratory evaluates the appropriateness of the reference intervals and takes corrective action if necessary.

c. The criteria for evaluation of reference intervals include:
   i. Introduction of a new analyte to the test repertoire
   ii. Change of analytic methodology
   iii. Change in patient population

d. If it is determined that the range is no longer appropriate for the patient population take corrective action-.

e. Evaluation of the reference range may be done using the NCCLS How To Define And Determine Reference Intervals In The Clinical Laboratory; Approved Guideline C28-A2 by validation of the transfer of the manufacturer's reference range. This guideline is how the Hematology and Urinalysis reference ranges were verified
   i. Procedure:
      1) Using the labs subject population by selecting 20 healthy subjects stratified into age and sex categories that cover the usual patient population serviced by the lab.
      2) Run the samples and check to be sure none are outliers.
      3) Any apparent outliers should be discarded and a new patient substituted.
      4) The manufacturer's donor range may be considered valid for application in the receiving lab if no more than 2 of the 20 test subject values or 10% of the test results fall outside of the original reporting limits.
      5) If three or more test results do fall outside the limits, another 20 reference specimens must be obtained and re-tested. Validity is confirmed using the same criteria as the preceding sample.

f. The exception to the above is for the pediatric population. TCMC does not have a pediatric unit so this patient population is not readily available. Rady's Children's Hospital is in the same basic geographical area and their hematology analyzer is the

DxH 1600 so TCMC adopted their reference range for the pediatric population less than 17 years of age.

## ~~M.~~K. COMPETENCY ASSESSMENT, ORIENTATION AND PERFORMANCE EVALUATION

1. Competency assessment is done to provide a system to document all staff are knowledgeable about policies and the contents of procedure manuals relevant to the scope of their activities and that Clinical Laboratory Scientists meet the competency requirements to perform moderate and/or high complexity testing as appropriate.
2. Responsibilities:
   a. The Laboratory Director is responsible for ensuring that policies and procedures are established for monitoring the competency of personnel. Responsibility for performing competency assessment is delegated to the Technical Specialist and Lead CLS.
   b. All laboratory employees are responsible for being knowledgeable of procedure manuals within their area of assignments and for demonstrating competency in those procedures. Employees must review new or revised policies or procedures applicable to their job duties that are distributed by Lab Leadership throughout the year.
3. Department Orientation:
   a. Each new employee or employees transferring into the laboratory will have an orientation to the laboratory. The orientation includes a review of their job description, hospital and laboratory organizational charts, a tour of the lab and hospital, an introduction to the staff and review of their customers, annual physical requirements, various laboratory policies and scheduling of Lab Safety Training. The Operations Manager or Technical Specialist completes the department orientation. The record of the review is maintained on the "Department Orientation Checklist" and should be completed within 1 month of the start date. The form is filed in the employee's main file.
4. Orientation and Initial Competency Evaluation:
   a. All lab staff undergoes an orientation process in each section of the laboratory where they will be assigned. During the orientation an evaluation of their competency is conducted. Upon completion of the orientation and competency both the employee and the technical specialist will verify competency in all sections reviewed. The following section, **including but not limited to,** will be completed on all competency checklists to verify training and competency:

**TRAINING APPROVAL AND AUTHORIZATION TO PERFORM JOB DUTIES:**

**I_____ confirm that I have completed training on the above**
**Name of (Position Title)**

**checklist items and that I am competent to perform these waived, moderate complexity to high complexity tests. I acknowledge that I am authorized by the Medical Director or designee to independently perform these tests without direct supervision.**

**Signature:_____ Date:_____**
**Signature of (Position Title)**

**The CLS has completed training on the above checklist items. He/she is competent to perform specimen processing, test performance and result reporting for these CLIA categories of testing independently without direct supervision.**

**Signature:_____Date:_____**
**(Medical Director or designee)**

| **Annual ID Verification** | Please complete the information below, using your normal handwriting, as you would while performing your routine laboratory duties. | | |
|---|---|---|---|
| Signature | Print Cerner Code | Initials | **My name has changed in the last 12 months: YES NO** (CIRCLE ONE) |
| | | | Previous Name: |

5. Six-Month and One Year Competency Assessment:
   a. The Operations Manager in consultation with the Lead CLS will complete a Six Month Competency Assessment within the initial six-month period and then a One Year Competency Assessment. These will be filed in the employee's main file.
6. Annual Competency and Performance Review:
   a. Annual review of the performance of employees is conducted according to the schedule determined by the Human Resources Department.
   b. Prior to the employee's annual performance appraisal a Competency Assessment, along with all other required departmental specific competencies must be completed. The Competency Assessment is reviewed with the employee during the Annual Performance Appraisal conference and areas requiring additional review are identified. The areas for improvement may then be made into performance goals to be evaluated on the following year's performance appraisal.
7. Methods of Competency Assessment:
   a. Direct observation of routine test performance, including as applicable, patient identification and preparation; specimen collection, handling, processing and testing, instrument maintenance and function checks.
   b. Monitoring the recording and reporting of test results including as applicable, reporting critical results.
   c. Review of intermediate test results or worksheets, test results, worksheet, quality control records, proficiency test results, turn around time logs, daily patient result exception reports and preventive maintenance records
   d. Direct observation of performance of instrument maintenance and function checks.
   e. Assessing test performance by testing previously analyzed specimens, internal blind samples, or external proficiency testing samples.
   f. Assessing problem solving skills using case studies.
   g. Paper and pencil tests.
   h. CAP Photomicrograph Slide Tests.
8. Frequency of Competency Assessment:
   a. Competency assessment will be performed throughout the year but during the first year of the employee's duties, competency must be assessed at least every six months. Retraining and reassessment of employee competency must occur when problems are identified with employee performance.

b. CAP slide tests will be given at least semi-annually to ensure consistency of morphologic observations of all technologists who perform blood cell microscopy and annually editing of urine samples on the Iris iQ200 to ensure consistency of morphologic observations among all personnel performing urine sediment microscopy. As the Technical Specialist perform annual review of technical procedure manuals, written competency tests will be given to the CLSs to ensure that testing personnel are knowledgeable about the contents of the procedure manuals relevant to the scope of their testing. When policies and procedures are revised, any changes are highlighted and put out for all employees to read and sign off on. In addition, when there is a change in methodology or instrumentation, extensive training and competency assessments will be conducted.

9. Documentation Competency Assessment:
   a. Many of the elements of competency assessment are performed by the Technical Specialist or Lead CLS during the daily review process. The review process uses any or all of the following; direct observation of test performance, daily review of failures to call critical values, reporting errors due to failure to follow procedure, reporting errors due to failure to follow-up on QA flags (delta check, technical limit failures and verify failures), review of QA Logs, failures to run Quality Control and document corrective action of outlier, review of Outlier reports, failures to log in new lot number and calibration dates in Calibration Logs, incomplete entries in Instrument Function Check and Maintenance Logs, completed result worksheets, unacceptable test performance as detected by direct observation, unacceptable proficiency survey results and with investigation, and other quality assurance activities previously listed.
10. Remediation (Competency Re-assessment):
   a. After completion of annual procedure review with time allowed for additional training and question review, if personnel fail the competency test the following remedial action will occur: Also refer to
   b. Verbal warning and immediate retraining with possible work restriction as directed by the Manager until employee can demonstrate competency by direct observation documented on the "Competency Re-assessment Tool.
   c. Reassess competency in three months. A failure may result in further disciplinary action up to and including termination.
11. Annual Competency Assessment Record Keeping:
   a. Each evaluation period, every employee will have an annual competency file. Within the file is the "Annual Department Specific Employee Competency Verification Record". Competency assessments are recorded on this document by each of the staff. Whenever a competency assessment is initiated by Lab Management, the assessment tool will contain a template that guides the staff member in completing the competency verification record. As indicated above, this file is reviewed at each employee's performance evaluation.
   b. Competency Log File Template:

| Competency/Training | Procedures | Technical | Technology | Equipment | Skills | Methods of Validation T = Test D = Demonstration V = Verbalized | Date Of Completion | Evaluator's Initials | Criteria (Bold all that apply) |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | **High Risk Problem Prone Essential** |

| Competency/Training | Procedures | Technical | Technology | Equipment | Skills | Methods of Validation T = Test D = Demonstration V = Verbalized | Date Of Completion | Evaluator's Initials | Criteria (Bold all that apply) |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | New/Improved |

~~N.~~L. **HEMATOLOGY/URINALYSIS SECTION RECORD MAINTENANCE**

1. Laboratory records must be retained for certain periods of time as defined by the State of California, and College of American Pathologists. Records will accumulate in the lab until a time when the working records are no longer required then they will be moved to off site locations designated by the Medical Center.
2. Record Retention
   a. Laboratory records must be retained for certain periods of time as required by regulatory and accreditation requirements. The period of time meets or exceeds these requirements and is appropriate for educational or quality improvement needs. The Lab records are retained as follows:

| ***Clinical Laboratory*** | | |
|---|---|---|
| Instrument Printouts | ~~3 years~~**6 years** | Lab current month, then warehouse |
| Patient Reports | Indefinite | HIS. Indefinite (remote hosted) |
| Requisitions | ~~3 years~~**6 years** | Lab current month, then warehouse |
| Quality Control Records | ~~3 years~~**6 years** | Lab |
| Proficiency Test Records | ~~3 years~~**6 years** | Lab |
| Quality Improvement Records | ~~3 years~~**6 years** | Lab |
| Worksheets | ~~3 years~~**6 years** | Lab |
| Archived Procedures | ~~3 years~~**6 years** | Lab |
| ~~Lab FAXed reports and Disclosure forms~~ | ~~10 years +2 months~~ | |
| Instrument Maintenance Logs | Life of instrument. | Lab |
| Method Performance Records | Life of Method + 2 years | Lab |
| ***Specimens*** | | |
| Blood (EDTA, Serum, Plasma) | 3 days (BB 14 days) | Refrigerator |
| Urine for UA | 2 days | Refrigerator |
| Peripheral smears, body fluid slides | 7 days | Lab |
| Body Fluids | 3 days | Refrigerator |

~~O.~~M. **DELEGATION OF RESPONSIBILITY:**

1. The Laboratory Director has delegated certain responsibilities to key Laboratory Management team members. The name and title of the individuals and the specific activities are listed in Table 1 below:

**Table 1: Laboratory Director Delegated Responsibilities**

| Table 1: Laboratory Director Delegated Responsibilities | |
|---|---|
| **Activity:** | **Delegated To:** |
| Hematology - Review of QC data, QA review, procedure manual review, proficiency testing performance, instrument maintenance records, competency review, selection of equipment and supplies. | Hematology Technical Specialist ~~Coagulation~~ Lead **Clinical Laboratory Scientist or qualified designee** ~~Technologist~~ |
| Proficiency testing – Director's attestation statement signature. Review of Summary Reports. | Technical Specialist |

~~P.~~N. **SELECTION OF LABORATORY EQUIPMENT AND SUPPLIES:**

1. The selection of laboratory instruments, equipment and supplies are under the control of the Laboratory Director. While the director has delegated the selection process to specific Laboratory management team members the technical, clinical and operational criteria of the Director must be met. The individuals designated for instrument, equipment and supply selection are listed in Table 1 above.

~~Q.~~O. **RELATED DOCUMENT(S)~~ATTACHMENTS~~:**

~~5. Ivy Bleeding Time Proficiency Test Worksheet~~
1. Annual Department Specific Employee Verification Record
~~1.~~2. Hematology Daily Quality Assurance Review
~~2.~~3. Hematology QC Flow Chart
~~3.~~4. **HematologyChemical Hygiene and Bloodborne Pathogen Task Assessment**
~~4.~~5. Instrument Problem/Repair Log
6. **Laboratory/General Laboratory Manual Procedure: Critical Values and Critical Tests**
7. **Laboratory/General Laboratory Manual Procedure: Procedure for Assuring Correct Specimen Identification and Labeling;**
8. **Laboratory/General Laboratory Manual Procedure: Procedure for Detecting and Correcting Erroneous Lab Results**
9. **Laboratory/General Laboratory Manual Procedure: Specimen and Aliquot Labeling**
~~5.~~10. **Laboratory/General Laboratory Manual Procedure: Specimen Handling, Transportation, Special Collection, Processing, Aliquoting and Criteria for Rejection**
11. **Laboratory/General Laboratory Manual Procedure: Verification of Specimen ID and Review of Results**
12. **Laboratory/Hematology/Coagulation Procedure: Downtime ~~for~~ Coagulation Procedure**
13. **Laboratory/Hematology/Quality Assurance Procedure: Comparison Studies for Hematology/Urinalysis Instruments/Methods**
14. **Laboratory/Hematology/Quality Assurance Procedure: Hematology and Urinalysis Quality Control Outline**
15. **Laboratory/Hematology/Quality Assurance Procedure:~~,~~ Laboratory Information System (LIS) Downtime Procedures for Hematology**
16. **Laboratory/Hematology/Quality Assurance Procedure: Rejection of Specimens**
17. **Laboratory/Hematology/Urinalysis Procedure: Downtime Procedures For Urinalysis**
18. Stago A vs Stago B QC Mean/CV Correlation

~~R.~~P. **REFERENCES:**

1. California Association of Hospital and Health Systems. *Guide to Record Retention.* 2000.
2. College of American Pathologists. Inspection and Accreditation Checklist, Section 1 General Laboratory. September 2007.

3. NCCLS. How to define and determine reference intervals in the clinical laboratory; approved guideline C28-A2. Wayne, PA: NCCLS, 2000.

Tri-City Medical Center
Oceanside, California

**OUTPATIENT PHARMACY**

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**ISSUE DATE:** NEW

**SUBJECT:** Credit Card Processing

**REVISION DATE(S):**

| | |
|---|---|
| **Outpatient Pharmacy Approval:** | 11/19 |
| **Medical Staff Department/Division Approval:** | n/a |
| **Pharmacy & Therapeutics Committee Approval:** | 11/19 |
| **Medical Executive Committee Approval:** | n/a |
| **Administration Approval:** | 01/20 |
| **Professional Affairs Committee Approval:** | n/a |
| **Board of Directors Approval:** | |

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A. **POLICY**

1. The Manager of the Tri-City Medical Center Outpatient Pharmacy has been designated as the Merchant Department Responsible Person (MDRP) who shall have the primary authority and responsibility for credit card transaction processing. Job responsibilities are to ensure that all credit card data collected in the course of pharmacy services business, regardless of how payment card data is stored, is secure.
2. Credit Card data is considered secure following guidelines below
   a. Only those with a need to know shall be granted access to credit card data.
   b. Email shall not be used to transmit or store credit card personal payment information.
   c. Credit card information shall never be stored or downloaded onto any portable devices and computers unless these devices meet all PCI-DSS compliance requirements.
   d. Three digit codes shall never be stored in any form, written or electronic.
   e. All credit card numbers with the exception of the last four digits of any credit card shall be masked.
   f. In the event of maintaining written records of credit card data, these documents shall be securely stored in a locked area.
   g. All physical data that is no longer deemed necessary shall be destroyed or rendered unreadable.
3. Pharmacy must comply with Payment Card Industry Data Security Standards (PCI-DSS). The standards may be found at https://www.pcisecuritystandards.org/.
4. Pharmacy must comply with rules and regulations of each card association.
   a. http://www.mastercard.us/merchants/security/requirements.html
   b. http://usa.visa.com/download/merchants/card-acceptance-guidelines-for-visa-merchants.pdf

Tri-City Medical Center
Oceanside, California

**OUTPATIENT PHARMACY**

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**ISSUE DATE:** NEW **SUBJECT:** Drug Supply Chain Security

**REVISION DATE(S):**

| | |
|---|---|
| **Outpatient Pharmacy Approval:** | **11/19** |
| **Medical Staff Department/Division Approval:** | **n/a** |
| **Pharmacy & Therapeutics Committee Approval:** | **11/19** |
| **Medical Executive Committee Approval:** | **n/a** |
| **Administration Approval:** | **01/20** |
| **Professional Affairs Committee Approval:** | **n/a** |
| **Board of Directors Approval:** | |

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A. **DEFINITION(S):**

1. **Trading partner**: A manufacturer, re-packager, wholesale distributor, dispenser or third-party logistics provider.
2. **Dispenser**: A retail pharmacy, hospital pharmacy, a group of chain pharmacies under common ownership and control that do not act as a wholesale distributor.
3. **Third-party logistics provider**: An entity that provides or coordinates warehousing or other logistics services of a product in interstate commerce on behalf of a manufacturer, wholesale distributor, or dispenser of a product, but does not take ownership of the product, nor have responsibility to direct the sale or disposition of the product.
4. **Product:** A prescription drug in a finished dosage form for administration to a patient without substantial further manufacturing (such as capsules, tablets, and lyophilized products before reconstitution); does not include blood or blood components intended for transfusion, radioactive drugs or radioactive biological products, imaging drugs, intravenous products, medical gas, homeopathic drugs, or a drugs compounded in compliance with section 503A or 503B.
5. **Transaction:** The transfer of product between persons in which a change of ownership occurs. *Exemptions*: The term transaction does not include the distribution of; sample medications, blood and blood component products, IV fluids, dialysis solutions, medical gases, etc. See Attachment A: **Exceptions to the DSCSA Tracing Requirements**
6. **Transaction History (TH)**: A statement in paper or electronic form, including the transaction information for each prior transaction going back to the manufacturer of the product.
7. **Transaction Information (TI)**: TI includes the:
   a. Proprietary or established name or names of the product
   b. Strength and dosage form
   c. National Drug Code number
   d. Container size and the number of containers
   e. Lot number
   f. Date of the transaction
   g. Date of the shipment, if more than 24 hours after the date of the transaction
   h. Business name and address of the person from whom ownership is being transferred
   i. Business name and address of the person to whom ownership is being transferred.
8. **Transaction Statement(TS):** A statement or attestation, in paper or electronic form, that the entity transferring ownership:
   a. Is authorized as required under the Drug Supply Chain Security Act;
   b. Received the product from a person that is authorized;

c. Received transaction information and a transaction statement from the prior owner of the product;
d. Did not knowingly ship a suspect or illegitimate product

9. **Suspect product:** A product for which there is reason to believe that such product is:
   a. Potentially counterfeit, diverted, or stolen;
   b. Potentially intentionally adulterated
   c. Potentially the subject of a fraudulent transaction; or
   d. Appears otherwise unfit for distribution such that the product would result in serious adverse health consequences or death to humans.

B. **POLICY:**

1. It is the policy of Tri-City Medical Center to maintain awareness about suspicious activity or potential threats to the drug supply chain, and to devote attention and effort to detect suspect product.
2. Obtain pharmaceuticals only from authorized trading partners as defined by the Food Drug and Cosmetic Act
3. Trace, quarantine, investigate, retain samples, clear, notify others and dispose of suspect or illegitimate products
4. Accept ownership of product only if the prior owner provides the transaction history (TH), transaction information (TI), and transaction statement (TS)
5. Provide subsequent owners with the TH/TI/TS unless the transaction is exempt or the sale is from dispenser to dispenser to fill a specific patient need
6. Retain records of TH/TI/TS for no less than 3 years (Tri-City recommends 6 years) after the transaction
7. Respond to request for TH/TI/TS due to a recall or investigation of suspect or illegitimate product from the Secretary of Health and Human Services or other appropriate Federal or State official within 2 business days
8. Return a product to the trading partner where the product was obtained without providing tracing information
9. Have a written agreement with a third-party provider (i.e. authorized wholesaler, distributor or other third-party service provider) to maintain the required TH/TI/TS on behalf of the facility.
10. Transaction records (TH/TI/TS), suspect product investigations and notifications must be retained for 6 years.

C. **PROCEDURE:**

1. Confirm Authorized Trading Partners
   a. Pharmaceuticals are only obtained from authorized trading partners.
   b. Trading partners (manufacturers, re-packagers, wholesale distributors, dispensers, and third-party logistics providers) are confirmed to be authorized as defined by the Food Drug and Cosmetic Act.
   c. Manufacturer's and re-packagers are confirmed as authorized trading partners using the FDA's drug establishment registration database
   d. Wholesale distributors, third-party logistic providers and dispensers, are validated with the state authority to confirm licensure.
2. Identification or Suspect Product
   a. Characteristics that might increase the likelihood that a product is a suspect or illegitimate product are listed but are not limited to:
      i. Avoid unsolicited offers and offers for product for sale at a very low price or one that is "too good to be true."
      ii. Examine the package and the transport container (case or tote) for signs that it has been compromised (e.g., opened, broken seal, damaged, repaired, or altered).
      iii. Identify any unexplained changes since it was last received.
      iv. Identify if product inserts are missing or do not correspond to the product.

v. Verify shipping addresses, postmarks, or other materials to validate that the product did not come from an unexpected foreign entity or source.
vi. Examine the label on the package, or the label on the individual retail unit, for;
vii. Missing information, such as the lot number or other lot identification, NDC, or strength of the drug
viii. Altered product information, such as smudged print or print that is very difficult to read
ix. Misspelled words
x. Bubbling in the surface of a label
xi. Lack of an Rx symbol
xii. Foreign language with little or no English provided
xiii. Foreign language that is used to describe the lot number
xiv. A product name that differs from the name of the FDA-approved drug
xv. A product name that is the product name for a foreign version of the drug
xvi. Lot numbers and expiration dates on product that do not match the lot numbers and expiration dates of its outer container.

3. Quarantine
   a. Identified suspect products are quarantined to prevent distribution or transfer until they are cleared for distribution or dispensing; or are determined to be illegitimate.
   b. Suspect products are quarantined in a physically separate area that is clearly identified.
4. Notifications
   a. Upon determination that a product is suspect or illegitimate, immediate trading partners and the FDA are notified within 24 hours of the determination.
   b. FDA Notification
      i. FDA Form 3911 accessed at the FDA website http://www.accessdata.fda.gov/scripts/cder/email/drugnotification.cfm
   c. Termination of Notification in Consultation with the FDA
      i. To terminate notification in consultation with the FDA when the notification is believed to be no longer necessary access the FDA website http://www.accessdata.fda.gov/scripts/cder/email/drugnotification.cfm
5. Investigation
   a. Upon identification of a suspect product, an investigation is promptly conducted in coordination with trading partners (wholesale distributor, manufacturer) to determine if the product is illegitimate.
      i. Validate transaction history and transaction information and otherwise investigate to determine if the product is illegitimate.
      ii. If investigation determines that the product is not illegitimate and the product is cleared, the FDA is notified and the product may be distributed or dispensed.
      iii. If investigation determines that the product is an illegitimate product
         1) The product is removed from the pharmaceutical distribution supply chain, which may include disposal or return of the product for disposal.
         2) A sample of the product is retained for further physical examination or laboratory analysis of the product by the manufacturer or other appropriate Federal or State official upon request.
      iv. Records of the investigation are retained for at least 3 years (Tri-City recommends 6 years) after the conclusion of the investigation.
6. Obtaining, Retaining and retrieving Transaction records TH/TI/TS
   a. Transaction records (TH/TI/TS) are obtained from authorized trading partners for all applicable products. The records are maintained and retained in a readily retrievable manner for at least 3 years (Tri-City recommends 6 years) from date of the transaction.
7. Wholesaler/ Distributor
   a. See Cardinal's Policy and Procedures

8. Data Storage and Retrieval Requirements- Pharmacy software
    a. See Backup methodologies for Rx30 and applicability within Business Continuity and Disaster Recovery Version 2.0.
    b. RX30 Software Updates
        i. Rx30 software/build updates are not released on a set frequency. When they are released, you will be prompted to run the update when you first log into Rx30.
            1) If that is bypassed, then in the top right corner of the Rx30 program is an alternating display message that will include the message "New Build Available." You can also run the build update under F1 menu, System, Utilities, Rx30 Build Update if bypassed at the initial login.
9. 340B Ship to Bill To:
    a. Tri-City has identified locations where Tri-City dispenses or prescribes 340B drugs:
    b. Within the four walls of the parent entity, within off-site outpatient locations that are fully integrated into the DSH, reimbursable on the most recently filed Medicare cost report and registered on HRSA's 340B Database. Also within entity-owned and operated outpatient pharmacies and contract pharmacies where applicable.

D. **ATTACHMENT(S):**
1. A- Exceptions to the DSCSA Tracing Requirements

E. **RELATED DOCUMENT(S):**
1. Exceptions to the DSCSA Tracing Requirements
2. Characteristics of Suspect Products

## Attachment A:
## Exceptions to the DSCSA Tracing Requirements

1. Intracompany distribution of any product between members of an affiliate or within a manufacturer
2. Distribution of product between hospitals or healthcare entities under common control
3. Distribution of product for emergency medical reasons, which includes a public health emergency, and excludes a drug shortage unless caused by such a public health emergency
4. Distribution of product samples by a manufacturer or a licensed wholesale distributor
5. Distribution of blood or blood components intended for infusion
6. Distribution of minimal quantities of product by a licensed retail pharmacy to a licensed practitioner for office use
7. Products transferred to or from a facility that is licensed by the Nuclear Regulatory Commission or by a State pursuant to an agreement with the Commission
8. Product comprised of a device and on or more other regulated components (such as a drug/device, biologic/device, or drug/device/biologic) that are physically, chemically, or otherwise combined or mixed and produced as a single entity
9. Distribution of intravenous product intended for fluid and electrolyte replenishment (e.g., sodium, chloride, potassium) or calories (e.g., dextrose and amino acids)
10. Distribution of intravenous product used to maintain equilibrium of water and minerals in body (e.g., dialysis solution)
11. Product intended for irrigation or sterile water
12. Distribution of medical gas
13. Drugs compounded in compliance with section 503A or 503B.

**Note:** Additional exemptions and more detail can be found in Title II of the Drug Quality and Security Act-Drug Supply Chain Security (DSCSA) (http://www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/DrugSupplyChainSecurityAct/ucm376829.htm Accessed April 2015

Tri-City Medical Center
Oceanside, California

**OUTPATIENT PHARMACY**

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**ISSUE DATE:** **NEW**

**SUBJECT:** **Pharmacist Conscientious Objection**

**REVISION DATE(S):**

| | |
|---|---|
| **Outpatient Pharmacy Approval:** | **11/19** |
| **Medical Staff Department/Division Approval:** | **n/a** |
| **Pharmacy & Therapeutics Committee Approval:** | **11/19** |
| **Medical Executive Committee Approval:** | **n/a** |
| **Administration Approval:** | **01/20** |
| **Professional Affairs Committee Approval:** | **n/a** |
| **Board of Directors Approval:** | |

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A. **PURPOSE:**

1. Establish a Policy for how a patient will receive a medication when a pharmacist has a conscientious objection

B. **POLICY:**

1. A pharmacist shall not obstruct a patient in obtaining a prescription drug or device that has been legally prescribed or ordered for that patient. A violation of this section constitutes unprofessional conduct by the licentiate and shall subject the licentiate to disciplinary or administrative action by his or her licensing agency.
2. If a pharmacist refuses on ethical, moral, or religious grounds to dispense a drug or device pursuant to an order or prescription, he or she may decline to dispense a prescription drug or device on this basis only if they have previously notified their employer, in writing, of the drug or class of drugs to which he or she objects, and the pharmacist's employer can, without creating undue hardship, provide a reasonable accommodation of the objection.

Tri-City Medical Center
Oceanside, California

**OUTPATIENT PHARMACY**

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**ISSUE DATE:** NEW **SUBJECT:** Physical Inventory Policy

**REVISION DATE(S):**

| | |
|---|---|
| **Outpatient Pharmacy Approval:** | 11/19 |
| **Medical Staff Department/Division Approval:** | n/a |
| **Pharmacy & Therapeutics Committee Approval:** | 11/19 |
| **Medical Executive Committee Approval:** | n/a |
| **Administration Approval:** | 01/20 |
| **Professional Affairs Committee Approval:** | n/a |
| **Board of Directors Approval:** | |

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A. **POLICY:**

1. Pharmacists and technicians dispense 340B drugs only to patients meeting all the criteria in Tri-City Medical Center (TCMC) 340B Outpatient Drug Pricing Program Policy Number 8610-295 with a clinical need driven, occasional exception.
2. To accommodate the infrequent, but potential need to provide prescriptions for non 340B-eligible patients, TCMC Outpatient Pharmacy physically separates 340B and non-340B purchased inventory.
3. Staff fills non-340B-eligible patient drugs with WAC purchased inventory. TCMC OP staff acknowledges there can be no borrow/loan between the separate inventories, and that staff is suitably trained in this and other 340B regulations, rules and statues

B. **PROCEDURE:**

1. TCMC OP staff identifies all 340B and non-340B accounts used for purchasing drugs
2. TCMC OP staff performs daily inventory reviews and shelf inspections of periodic automatic replenishment (PAR) levels to determine daily purchase order. This is done via RX30 software (reorder quantity on hands) and submits an order into Cardinal Order Express for staff analysis and submission.
3. TCMC OP staff places 340B and non-340B drug orders separately in specified locations in outpatient pharmacy.
4. TCMC OP staff receives shipment and keeps WAC inventory separated from 340b inventory as to avoid accidental mixing.
5. TCMC OP staff verifies quantity received with quantity ordered by physically checking the drug items and cross checking each line item on the Cardinal invoices with signature and date.
   a. Identifies any inaccuracies.
   b. Resolves inaccuracies.
   c. Documents resolution of inaccuracies.
6. TCMC OP maintains records of 340B-related transactions for 3 years (Tri-City recommends 6 years) in a readily retrievable and auditable format located in Cardinal Invoice Binder or through Cardinal Order Express Website.
   a. These reports are reviewed as part of its 340B oversight and compliance program

Tri-City Medical Center
Oceanside, California

**OUTPATIENT PHARMACY**

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**ISSUE DATE:** **NEW**

**SUBJECT:** **Prevention of Dispensing Potentially Harmful Prescribed Drugs to Patients**

**REVISION DATE(S):**

| | |
|---|---|
| **Outpatient Pharmacy Approval:** | **11/19** |
| **Medical Staff Department/Division Approval:** | **n/a** |
| **Pharmacy & Therapeutics Committee Approval:** | **11/19** |
| **Medical Executive Committee Approval:** | **n/a** |
| **Administration Approval:** | **01/20** |
| **Professional Affairs Committee Approval:** | **n/a** |
| **Board of Directors Approval:** | |

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A. **PURPOSE:**

1. Establish a Policy and Procedure for preventing the dispensing of a prescription to a patient when the pharmacist determines that the prescribed drug or device would cause a harmful drug interaction or would otherwise adversely affect the patient's medical condition.

B. **POLICY:**

1. A pharmacist shall not obstruct a patient in obtaining a prescription drug or device that has been legally prescribed or ordered for that patient. A violation of this section constitutes unprofessional conduct by the licentiate and shall subject the licentiate to disciplinary or administrative action by his or her licensing agency.

C. **PROCEDURE:**

1. A pharmacist shall dispense drugs and devices, as described in subdivision (a) of Section 4024, pursuant to a lawful order or prescription unless the following circumstance exists:
   a. The pharmacist, based solely on his or her professional training and judgment finds that dispensing the order or the prescription is contrary to law, or if he or she determines that the prescribed drug or device would cause a harmful drug interaction or would otherwise adversely affect the patient's medical condition.

Tri-City Medical Center
Oceanside, California

OUTPATIENT PHARMACY

**ISSUE DATE:** NEW

**SUBJECT:** Storage Requirements for Medications

**REVISION DATE(S):**

| | |
|---|---|
| **Outpatient Pharmacy Approval:** | 11/19 |
| **Medical Staff Department/Division Approval:** | n/a |
| **Pharmacy & Therapeutics Committee Approval:** | 11/19 |
| **Medical Executive Committee Approval:** | n/a |
| **Administration Approval:** | 01/20 |
| **Professional Affairs Committee Approval:** | n/a |
| **Board of Directors Approval:** | |

A. **POLICY:**

1. Provisions for medication storage and security comply with all applicable federal, state and professional rules and regulations and accepted pharmaceutical standards of practice.
2. Storing medications outside the licensed Pharmacy is prohibited.
3. Only authorized persons may access the Pharmacy and medications.
4. Controlled substances are secured to prevent diversion and in accordance with law and regulations.
5. Proper environmental controls are maintained to ensure product integrity and stability, to include:
   a. Sanitation
   b. Temperature
   c. Humidity
   d. Light
   e. Ventilation
   f. Segregation
   g. Security
6. Medications are stored according to the manufacturer's recommendations for product storage or, in the absence of such recommendations according to a pharmacist's instruction.
7. Pharmacy staff will identify pharmaceutical products that require specific storage conditions. These storage and/or handling requirements will be clearly indicated on the product label.
8. Cytotoxic and hazardous chemicals/medications are stored in accordance with NIOSH, RCRA, and USP <797> requirements and are segregated from other medications to minimize the risk of a storage-associated event and to promote environmental safety.

B. **PROCEDURE:**

1. **General Medication Storage Requirements**
   a. Medications are stored in an orderly and clean environment. Containers are stored on shelves or pallets and not directly on the floor. Maximum height from the ceiling (18") is maintained to prevent blockage of any fire suppression systems.
   b. Medication dosage forms are segregated and stored separately in dispensing areas. Oral medications, injectable medications, topical/external use only medications; eye and ear preparations are all stored in separate designated areas.
   c. Bulk chemicals are stored separately from other medications.

d. Cytotoxic agents are stored separate and apart from all other drugs, including cytotoxic agents that require refrigerated storage.
e. Medications are stored at the appropriate temperature, humidity and are protected from light as specified by the manufacturer. For additional information see Outpatient Pharmacy Procedure: Temperature Storage Standards for Medications.
f. Storage equipment (i.e. refrigerators, freezers,) is maintained in accordance with the standards of practice and/or manufacturer's recommendations to ensure proper functioning. For additional information see Outpatient Pharmacy Procedure: Temperature Log -Medication Storage.
g. All stored medications and the components used in their preparation are labeled with the contents, expiration date and any applicable warnings.
h. Expired, recalled, damaged, contaminated or otherwise unusable medications are stored in a specially designated area away from the active inventory where they will remain segregated until they are removed from the Pharmacy. For additional information see Outpatient Pharmacy Procedure: Expired and Unusable Policy.
i. Sound A-Like and Look A-Like drugs are identified and storage safeguards are implemented to reduce the risk of misidentification and the potential for medication errors.
j. The Pharmacy Department periodically inspects all medication storage areas to ensure the proper storage, integrity, control, and security of medications throughout the Pharmacy.

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

1. Outpatient Pharmacy Procedure: Temperature Storage Standards for Medications
2. Outpatient Pharmacy Procedure: Temperature Log -Medication Storage
3. Outpatient Pharmacy Procedure: Expired and Unusable Policy

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

DELETE - no longer required due to Location closure. All Outpatient services from 2124 ElCamino real have been consolidated to Wellness Center and Main hospital.

SUBJECT: Outpatient Disaster Plan - 2124 El Camino Real
POLICY NUMBER: 1502

ISSUE DATE: 7/91
REVISION DATE(S): 10/93, 9/97, 12/99, 11/02, 2/03, 1/06, 1/09, 5/12

| | |
|---|---|
| Department Approval: | ~~03/18~~12/19 |
| Department of Medicine Approval: | n/a |
| Pharmacy and Therapeutics Approval: | n/a |
| Medical Executive Committee Approval: | n/a |
| Administration Approval: | 01/20 |
| Professional Affairs Committee Approval: | ~~05/18~~ n/a |
| Board of Directors Approval: | 05/18 |

~~A. PURPOSE:~~

~~1. To ensure the appropriate response and safety of the Outpatient Rehabilitation Services personnel in the event of a major disaster.~~

~~B. PERSONNEL:~~

~~1. The Rehab Leadership Staff~~
~~2. Department Staff~~

~~C. PROCEDURE:~~

~~1. In the event of a Disaster Alert Phase:~~
~~a. The Rehab Services Leadership In Charge or their designee will be notified by Administration and advised of the circumstances.~~
~~2. The Rehab Leadership/Designees will then:~~
~~a. Notify the Outpatient clinic by phone if possible, two-way radio, or by messenger in the event the phone/radio is not working.~~
~~b. Review the Department's Disaster Plan and call back protocol.~~
~~c. Inventory equipment and supplies.~~
~~d. Emergency evacuation/area of refuge will be located at the South East corner of the parking lot.~~
~~3. In the event of a Disaster Activation Phase:~~
~~a. Employees in the outpatient clinic, located at 2124 El Camino Real, will immediately cancel all therapies, lock/secure the building, and return to the main hospital Rehabilitation Services Department or other assigned area.~~
~~b. Activate the call back protocol.~~
~~c. In the event that the disaster is in the clinic, dial 911 and report the disaster to the Rehab Services Leadership In Charge and the main hospital's Emergency Department by phone, two way radio, or by messenger if phone/radio contact is impossible. Outpatient employees shall remove any patients from danger. They should then wait for assistance from EMS or the Medical Center in a safe area, such as outside in the back parking lot.~~
~~d. The Rehab Services Leadership In Charge will notify the Disaster Incident command (ICC) and Emergency Department of the Department's readiness.~~
~~e. The Rehab Services Leadership In Charge will submit periodic reports to the ICC.~~
~~f. The Department will be expected to assist in the management of disaster victims. Personnel will be requested to respond to triage areas.~~

~~4. Ongoing Review:~~

~~a. This Policy/Procedure will be reviewed and updated as needed.~~

~~b. It is the responsibility of the Department Leadership to orient and educate the staff to the plan, including periodic drills, to maintain an updated version of the plan and update the call-back roster.~~

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

DELETE this policy due to location closure of 2124 El Camino Real. Wellness has its own independent policy

**SUBJECT:** Emergency Care – Outpatient Services

**ISSUE DATE:** 07/91
**REVISION DATE(S):** 02/94, 09/97, 10/00, 01/15

| | |
|---|---|
| Department Approval: | ~~08/16~~12/19 |
| Department of Medicine Approval: | n/a |
| Pharmacy and Therapeutics Approval: | n/a |
| Medical Executive Committee Approval: | n/a |
| Administration Approval: | 01/20 |
| Professional Affairs Committee Approval: | ~~09/17~~ n/a |
| Board of Directors Approval: | 09/17 |

~~A. POLICY:~~

~~1. All emergency medical, fire and law enforcement situations occurring at the Rehabilitation Services Outpatient Department and the Wellness Center will be provided by city emergency response systems.~~

~~B. PROCEDURE:~~

~~1. In case of any medical, fire or law enforcement emergency, staff members will initiate appropriate interventions such as assessing vital signs, initiating CPR, RACE, etc., as indicated per Departmental Policy, and dial 911 for assistance, specifying outpatient location.~~
~~a. Notify main hospital for fire or other emergencies.~~

~~2. Appropriate documentation of each incident will be completed by Rehabilitation Staff members, including notifying the patient's physician when the incident involves a patient.~~

~~3. Follow up on patient status/outcome is documented in the medical record.~~

Tri-City Medical Center
Oceanside, California

REHABILITATION CENTER

**SUBJECT: Provision of Durable Medical Equipment (DME) by Tri-City Rehabilitation Center**

**ISSUE DATE:** NEW
**REVISION DATE(S):**

| | |
|---|---|
| **Rehabilitation Department Approval:** | 11/18 |
| **Department of Medicine Approval:** | n/a |
| **Pharmacy and Therapeutics Approval:** | n/a |
| **Medical Executive Committee Approval:** | |
| **Administration Approval:** | 01/20 |
| **Professional Affairs Committee Approval:** | n/a |
| **Board of Directors Approval:** | |

A. **POLICY:**

1. DME provision is based on preparation for promoting patient safety at discharge destination. In doing so, DME requests will be based off of Physical Therapy (PT)/Occupational Therapy (OT) recommendations for the same and submitted by the Social Worker (SW) to the appropriate Insurance.
2. SW will keep Acute Rehabilitation Team Members duly informed via EMR as to the status of Insurance authorization request and approvals received if any.
3. It is recommended that Insurance authorization should be requested for DME at least three days prior to plan discharge date.
4. In the event that Insurance authorization is not received 24 hours prior to plan discharge, then Tri-City Rehabilitation Center may dispense through their supply closet, DME items that are deemed necessary to promote safe and timely discharge.
5. DME dispensing maybe restricted to the primary 1-2 items only so that it is not cost prohibitive to the organization.
6. Patients or Insurance will not be charged for such equipment and it will be dispensed free of cost.
7. Such DME will be dispensed responsibly following patient/ caregiver training in its use.

# Tri-City Healthcare District
# Community Healthcare Alliance Committee (CHAC)
## MEETING MINUTES
### January 16, 2020



| | |
|---|---|
| MEMBERS PRESENT: | Chair Rocky Chavez, Director Julie Nygaard, Director RoseMarie Reno, Scott Ashton, Mike Lopez, Jeff Schroeder, Lynne Seabloom, Gwen Sanders, Jacqueline Simon, Mary Lou Clift |
| MEMBERS ABSENT: | Rachel Beld, Dr. Henry Showah, Bret Schanzenbach |
| NON-VOTING MEMBERS PRESENT: | Steve Dietlin, CEO; Aaron Byzak, Chief External Affairs Officer; Susan Bond, Legal Counsel |
| NON-VOTING MEMBERS ABSENT: | Scott Livingstone, COO |
| OTHERS PRESENT: | Jane Dunmeyer, Kandice Ward, Jessica Shrader, Christina Gawrych |

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| Call To Order | The January 1, 2020 Community Healthcare Alliance Committee meeting was called to order at 12:32pm by Chair Rocky Chavez. | | |

Tri-City Healthcare District

# Community Healthcare Alliance Committee (CHAC)

## MEETING MINUTES

**January 16, 2020**

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| Approval Of Meeting Agenda | Gwen Sanders motioned to approve the January 16, 2020 meeting agenda. The motion was seconded by Director Reno and approved by the committee with no objections. | | |
| Public Comments & Announcements | No public comments or announcements. | | |
| Ratification Of Minutes | Director Nygaard motioned to approve the October 17, 2019 meeting minutes. The motion was seconded by Director Reno and approved by the committee with no objections. | | |
| Presentation: Coastal Commitment Aaron Byzak, CEAO | Aaron Byzak presented the 2019-2020 TCMC Coastal Commitment noting the following:<br>1. TCMC's Coastal Commitment supports community outreach through active leadership, engagement, financial support, and in-kind support. The money invested by TCMC is tied to program outcomes.<br>2. The 2019 Community Health Needs Assessment is the road map for TCMC's community outreach and engagement.<br>3. Areas of TCMC support include:<br>▪ Access to Healthcare<br>▪ Community & Social Support<br>▪ Economic Security & Education<br>▪ Homelessness & Housing Instability | | |

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| Presentation: Coastal Commitment Aaron Byzak, CEAO (cont.) | 4. The Coastal Commitment supports student opportunities through:<br>▪ Guest speakers highlighting healthcare careers<br>▪ Tours<br>▪ Training assistance<br>▪ Lectures<br>▪ One-on-one shadowing experiences<br>▪ Internships<br>▪ Coaching and mentorship<br><br>5. TCMC aligns with key community organizations such as Operation HOPE (and others) who are working to achieve similar goals for the residents of the District.<br><br>6. TCMC's involvement in Government Affairs includes:<br>▪ Advocacy on issues of importance<br>▪ Health policy and legislative analysis<br>▪ Interactions with elected officials and key community leaders and stakeholders<br><br>7. Aaron introduced the Community Engagement Dashboard which provides detailed analysis of program outcomes so that necessary adjustments can be made to ensure the best outcomes on investment. The current dashboard shows opportunities for improvement in the areas of aging, cancer, economic security, homelessness and unintentional injury and violence. | | |

Tri-City Healthcare District

# Community Healthcare Alliance Committee (CHAC)

## MEETING MINUTES

January 16, 2020

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| Presentation: Coastal Commitment Aaron Byzak, CEAO (cont.) | Director Nygaard suggested that program recipients be invited to future CHAC meetings to present about their progress and goals. Director Nygaard also requested quarterly dashboard reports for the Committee's review. | | |
| Chief of Staff Mark Yamanaka, MD | Director Chavez introduced TCMC's Chief of Staff, Mark Yamanaka MD. Dr. Yamanaka spoke for a few moments about his history with TCMC and his appreciation for the work TCMC does for the community. | | |
| CEO Update Steve Dietlin | CEO Steve Dietlin addressed the committee as follows:<br>1. Steve thanked Dr. Yamanaka for attending and applauded the work of the TCMC Physician Staff.<br>2. Steve noted that the CHAC Committee is a conduit to our district residents. A primary focus of the hospital is to serve the community. Our service is to be data driven so it is as effective as possible, and the Coastal Commitment is a great way to ensure priority health needs are being addressed in an effective manner.<br>3. Steve reviewed the positive results the In-Quicker program is making on wait times in the ED. TCMC has received great feedback from members of the community. It was suggested that members of the committee share this important information with community members in their areas of influence. | | |

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| CEO Update<br>Steve Dietlin (cont.) | 4. Steve discussed the recent happenings regarding mental health services at TCMC, noting that 1.5 years ago, even though necessary actions were taken to suspend the BHU, TCMC still remained committed to finding a solution for mental health services in North County. In response to that need, the TCMC Board of Directors and Board of Supervisors recently came to an agreement for the development and operation of a 16 bed, licensed facility, on the campus of TCMC. The agreement is impactful and sustainable with the County and TCMC assuming 50/50 responsibility. The agreement provides a lease term of 30 years and a no-interest loan.<br><br>Future goals include:<br>• Crisis intervention<br>• Solutions for long-term patient needs<br>• Potential medical partnership with the County<br><br>Director Chavez expressed his appreciation for Steve's leadership that has allowed a better and more sustainable solution for the health of the TCMC community.<br><br>5. Steve noted that it will take anywhere from 18 months to 2 years for the new mental health services to be up and running (depending on permitting, etc.), but in the interim, TCMC does have a successful and fully operational outpatient program which treats up to 50 patients daily. | | |

Tri-City Healthcare District

# Community Healthcare Alliance Committee (CHAC)

## MEETING MINUTES

**January 16, 2020**

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| COO Update<br>Scott Livingstone | Scott Livingstone was not present. | | |
| Committee Communications | Committee comments were as follows:<br>▪ Scott Aston addressed the desire for more community partnerships, noting that the Oceanside Chamber of Commerce is interested in the sharing of expertise and experience to align and develop various beneficial programs.<br>▪ Gwen Sanders announced the MLK Prayer Breakfast on January 20th of which TCMC is a sponsor. Gwen noted that the NAACP has been in collaboration with the City of Oceanside for 20 plus years.<br>▪ Mike Lopez announced that he will be leaving his current position, and the CHAC committee, as he has accepted the position of Deputy Fire Chief for the City of Murrieta. Mike expressed his appreciation for TCMC on behalf of the community he has worked for and lived in for over 26 years. The Committee thanked Mike for his service, both to the District and TCMC. | | |
| Public Comments | No public comments. | | |

Tri-City Healthcare District

# Community Healthcare Alliance Committee (CHAC)

## MEETING MINUTES

**January 16, 2020**

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| Next Meeting | The next CHAC meeting is scheduled for Thursday, April 16, 2020, at 12:30 pm. | | |
| Adjournment | The January 16, 2020 CHAC meeting was adjourned at 1:45pm. | | |

**Tri-City Medical Center**
**Finance, Operations and Planning Committee Minutes**
**January 23, 2020**

| | |
|---|---|
| **Members Present** | Director Julie Nygaard, Director Leigh Anne Grass, Director Tracy Younger, Dr. Marcus Contardo, Dr. Jeffrey Ferber, Dr. Cary Mells, Mr. Jack Cumming, Ms. Kathryn Fitzwilliam |
| **Non-Voting Members Present:** | Steve Dietlin, CEO, Ray Rivas, CFO, Scott Livingstone, COO, Dr. Gene Ma, CMO, Roger Cortez, CCO, Susan Bond, General Counsel |
| **Others:** | Kristy Larkin, Jeremy Raimo, Maria Carapia, Mark Albright, Candice Parras, Debra Feller, Barbara Hainsworth |
| **Members Absent:** | Dr. Javaid Shad, Barbara Vogelsang, CNE |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| 1. Call to Order | Director Nygaard called the meeting to order at 8:33 a.m. | | Chair |
| 2. Approval of Agenda | | **MOTION**<br>**It was moved by Director Grass, Dr. Mells seconded, and it was unanimously approved to accept the agenda of January 23, 2020.**<br>**Members:**<br>**AYES: Nygaard, Grass, Younger, Contardo, Ferber, Mells, Cumming, Fitzwilliam**<br>**NOES: None**<br>**ABSTAIN: None**<br>**ABSENT: Shad** | Chair |
| 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. | No comments | Chair |
| 4. Ratification of minutes of October 24, 2019 | | Minutes were ratified.<br>**MOTION**<br>**It was moved by Director Grass, Dr. Contardo seconded, and the minutes of October 24, 2019 were unanimously approved, with** | Chair |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | | **Director Younger and Mr. Cumming abstaining from the vote.** | |
| 5. Old Business | None | | |
| 6. New Business | | | |
| a. 2020 – Meeting Schedule<br>• Finance, Operations & Planning Committee | Chair Nygaard encouraged the committee members retain the 2020 meeting schedule for future reference.<br><br>In addition, she welcomed Director Tracy Younger to the Finance, Operations & Planning Committee. Director Younger has assumed the committee seat previously held by Director Chavez. | | Chair |
| 7. Consideration of Consent Calendar: | It has been requested that the following items be pulled for discussion:<br><br><u>Director Nygaard requested:</u><br>7.a. Physician Recruitment Proposal – Cardiovascular Surgeon<br>• Darrell Wu, M.D.<br><br>7.c. Patient Accounting System & Interfaces<br>• QuadraMed-Affinity | **<u>MOTION</u>**<br>**It was moved by Director Grass, Dr. Contardo seconded, and it was unanimously approved to accept the Consent Calendar for January 23, 2020.**<br>**<u>Members:</u>**<br>**AYES: Nygaard, Grass, Younger, Contardo, Ferber, Mells, Cumming, Fitzwilliam**<br>**NOES: None**<br>**ABSTAIN: None**<br>**ABSENT: Shad** | Chair |
| a. Physician Recruitment Proposal – Cardiovascular Surgeon<br>• Darrell Wu, M.D. | Jeremy Raimo gave a brief overview for this write-up, citing the service enhancements in the recruitment of Dr. Darrell Wu as a new cardiovascular surgeon at Tri-City Medical Center. Brief discussion ensued. | **<u>MOTION</u>**<br>**It was moved by Director Grass, Dr. Contardo seconded, to authorize the agreement with Darrell Wu, M.D., Cardiovascular / Cardiothoracic Surgeon for the expenditure, not to exceed $2,010,000 in order to facilitate, practicing medicine in the communities served by the District.** | Jeremy Raimo |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | | **This will be accomplished through a Group Physician Recruitment Agreement (not to exceed a 36 month income guarantee with a three-year forgiveness period).**<br>**Members:**<br>**AYES: Nygaard, Grass, Younger, Contardo, Ferber, Mells, Cumming, Fitzwilliam**<br>**NOES: None**<br>**ABSTAIN: None**<br>**ABSENT: Shad** | |
| b. Physician Agreement for ED On-Call Coverage - Ophthalmology<br>• Alexander Foster, M.D. | | **Approved via Consent Calendar** | Sherry Miller / Scott Livingstone |
| c. Patient Accounting System & Interfaces<br>• QuadraMed-Affinity Corp. | Mark Albright conveyed that this write-up was for renewal of QuadraMed software support. This agreement provides software support 7-days a week, 24-hours a day and covers break / fix issues, software enhancements and software upgrades. He further conveyed that the need for this software support will cease, once the Cerner Community Works upgrade has been fully integrated. Brief discussion ensued. | **MOTION**<br>**It was moved by Director Grass, Dr. Contardo seconded, to approve the agreement with QuadraMed-Affinity Corporation for software support for a term of 12 months, beginning January 1, 2020 and ending December 31, 2020 for an annual and total term cost of $360,679.28.**<br>**Members:**<br>**AYES: Nygaard, Grass, Younger, Contardo, Ferber, Mells, Cumming, Fitzwilliam**<br>**NOES: None**<br>**ABSTAIN: None**<br>**ABSENT: Shad** | Mark Albright |
| d. Service Contract Agreement – Video / Power<br>• Stryker ProCare | | **Approved via Consent Calendar** | Debra Feller |
| 8. Financials: | Ray Rivas presented the financials ending December 31, 2019 (dollars in thousands) | | Ray Rivas |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | **TCHD – Financial Summary**<br>**Fiscal Year to Date**<br>Operating Revenue $ 169,607<br>Operating Expense $ 178,846<br>EBITDA $ 2,653<br>EROE $ (4,115)<br>**TCMC – Key Indicators**<br>**Fiscal Year to Date**<br>Avg. Daily Census 147<br>Adjusted Patient Days 50,514<br>Surgery Cases 3,160<br>ED Visits 28,231<br>**TCHD – Financial Summary**<br>**Current Month**<br>Operating Revenue $ 27,742<br>Operating Expense $ 29,375<br>EBITDA $ 128<br>EROE $ (1,040)<br>**TCMC – Key Indicators**<br>**Current Month**<br>Avg. Daily Census 160<br>Adjusted Patient Days 8,906<br>Surgery Cases 494<br>ED Visits 4,695<br>**TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year**<br>Net Patient A/R Avg. (in millions) $ 46.8<br>Days in Net A/R Avg. 59.0<br>**Graphs:**<br>• TCMC-Net Days in Patient Accounts Receivable<br>• TCMC – Adjusted Patient Days<br>• TCMC-Acute Average Length of Stay | | |
| 9. Work Plan: | | | Chair |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| a. Wellness Center *(quarterly)* | Scott Livingstone gave a brief PowerPoint presentation detailing the financial performance for FY 2019 for both the Fitness Center alone and Fitness Center & Rehab collectively. | | Scott Livingstone |
| b. Construction Report *(quarterly)* | No Report | | Chris Miechowski / Scott Livingstone |
| c. ED Throughput *(quarterly)* | Candice Parras gave a single PowerPoint slide presentation for the ED Throughput update. She emphasized the "In Quicker" online appointment scheduling continues to be successful, with 86% of those using the program conveying they would recommend it to others. The "left without being seen" (LWBS) patient population was 2.6% for 2019. | | Candice Parras |
| d. I.T. Physician Liaison *(semi-annual)* | Scott Livingstone conveyed that this Work Plan item is no longer necessary, as the physician education piece will be included as part of the Cerner Community Works system upgrade. | **Barbara Hainsworth will remove this item from future Work Plan updates.** | Scott Livingstone |
| e. PRIME Update *(annual)* | Scott Livingstone conveyed that the current PRIME program will be replaced by a revised program known as QIP, (Quality Incentive Program), following the final PRIME reporting period in March 2020. | | Scott Livingstone |
| f. Dashboard | No discussion | | Ray Rivas |
| 10. Comments by committee members | None | | Chair |
| 11. Date of next meeting | Thursday, February 20, 2020 | | Chair |
| 12. Community Openings (0) | | | |
| 13. Adjournment | Meeting adjourned 9:22 a.m. | | Chair |

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: January 23, 2020**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Ophthalmology**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Type of Agreement** | | Medical Directors | X | Panel | X | Other: Add Physician to Panel |
| **Status of Agreement** | X | New Agreement | | Renewal – New Rates | | Renewal – Same Rates |

**Physician's Name:** Alexander Foster, M.D.

**Area of Service:** Emergency Department On-Call: Ophthalmology

**Term of Agreement:** 12 months, Beginning, February 1, 2020 – Ending, January 31, 2021

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

| Rate/Day | Panel Days per Year | Panel Annual Cost |
|---|---|---|
| $300 | 366 | $109,800 |
| | **Total Term Cost:** | **$109,800** |

**Position Responsibilities:**

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

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

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

**Motion:** I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors add Alexander Foster, M.D. to the ED On-Call Coverage Panel for Ophthalmology for 12 months, beginning February 1, 2020 and ending January 31, 2021.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: January 23, 2020**
**Software Support Proposal**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Type of Agreement** | | Medical Directors | | Panel | X | Other: Software Support |
| **Status of Agreement** | | New Agreement | X | Renewal – New Rates | | Renewal – Same Rates |

**Vendor's Name:** QuadraMed - Affinity Corporation

**Area of Service:** Patient Accounting

**Term of Agreement:** 12 months, Beginning, January 1, 2020 – Ending, December 31, 2020

**Maximum Totals:**

| Quarterly Cost | Annual Cost | Total Term Cost |
|---|---|---|
| $90,169.82 | $360,679.28 | $360,679.28 |

**Description of Services/Supplies:**

- Affinity is the patient accounting information system used primarily for generating patient bills and sending them to the appropriate insurance companies for reimbursement. Additionally, it stores the charge master which assigns a charge to a service provided or a supply item used or medication given in the provision of a service. This software is a critical component of our entire revenue cycle management.
- This agreement/renewal provides software support 7 days per week, 24 hours per day and covers break/fix issues, software enhancements, and software upgrades. The support fees are invoiced quarterly in advance. This support is critical to ensure system reliability and uptime and prevent potential disruptions to cash flow.

| | | | | |
|---|---|---|---|---|
| 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:** Mark Albright, VP-IT/Information Systems / Scott Livingstone, Chief Operating Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with QuadraMed-Affinity Corporation for software support for a term of 12 months, beginning January 1, 2020 and ending December 31, 2020 for an annual and total term cost of $360,679.28.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: January 23, 2020**
**Stryker ProCare Service Contract Video/Power**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Type of Agreement** | | Medical Directors | | Panel | X | Other: Service Plan |
| **Status of Agreement** | | New Agreement | X | Renewal – New Rates | | Renewal – Same Rates |

**Vendor's Name:** Stryker ProCare

**Area of Service:** Surgery

**Term of Agreement:** Video: 24 Months, Beginning, January 1, 2020 – Ending, December 31, 2021
Power: 33 Months, Beginning, January 1, 2020 – Ending, September 30, 2022

**Maximum Totals:**

| Service Contract: | Monthly Cost | Annual Cost | Total Term Cost |
|---|---|---|---|
| Video (24 mos.) | $9,665.00 | $115,980.00 | $231,960.00 |
| Power Tools (33 mos.) | $7,481.89 | $89,782.68 | $246,902.37 |
| **Totals:** | **$17,146.89** | **$205,762.68** | **$478,862.37** |

**Description of Services/Supplies:**

Equipment to be covered -

1. All power tools for the following specialties:
   a. Ortho, Neuro, Spine & ENT
2. Complete Coverage of Video Equipment:
   a. 1688 Cameras (quantity: 17)
   b. Urology Cameras (quantity: 3)
   c. 5mm Laparoscopes (quantity: 22)
   d. 10mm Laparoscopes (quantity: 22)
   e. 5mm Bariatric Laparoscopes (quantity: 4
   f. 10 mm Bariatric Laparoscopes (quantity: 4)
   g. 1688 Camera Boxes (quantity: 5)
   h. L11 Light Sources (quantity: 5)
   i. PneumoClear Insufflators (quantity: 5)
   j. ConnectedOR Hub (quantity: 5)
   k. Synk Transmitter (quantity: 4
   l. SPY PHI Handheld (quantity: 1)

| | | | | |
|---|---|---|---|---|
| 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:** Debra Feller, Clinical Director, Surgery / Barbara Vogelsang, Chief Nurse Executive

**Motion:**

Move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Stryker ProCare for a service plan for a term of 24 months for video, beginning January 1, 2020 and ending December 31, 2021, and also a term of 33 months for power, beginning January 1, 2020 and ending September 30, 2022, for an annual cost of $205,762.68, and a total cost for the term of $478,862.37.

# Professional Affairs Committee
# (No meeting held in January, 2020)

# Audit, Compliance & Ethics Committee
# (No meeting held in January, 2020)

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

## December 12, 2019 – 2:30 o'clock p.m.
## Assembly Room 1 – Eugene L. Geil Pavilion
## 4002 Vista Way, Oceanside, CA 92056

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 2:30 p.m. on December 12, 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
Barbara Vogelsang, Chief Nurse Executive
Dr. Mark Yamanaka, Chief of Staff
Susan Bond, General Counsel
Jeffrey Scott, Board Counsel
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 Assembly Room 1 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

   Chairperson Grass reported she received a request from the City Treasurer asking for the Board's support on Measure "K". She explained that the request would require an addition to the agenda. Board Counsel Jeff Scott explained in order for an item to be added to the agenda it must have arisen after the agenda was posted and be of an urgent nature. Due to the fact that the election is in March the item does not meet the definition of "urgent" and at the recommendation of Board Counsel was not brought forward for consideration.

   **It was moved by Director Reno to approve the agenda as presented. 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 December 12, 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 December 12, 2019 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included two matters of Existing Litigation, one matter of Potential Litigation, one Report involving Trade Secrets, 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 Nygaard and seconded by Director Schallock 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 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:

Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Barbara Vogelsang, Chief Nurse Executive
Ray Rivas, Chief Financial Officer
Roger Cortez, Chief Compliance Officer
Aaron Byzak, Chief External Affairs Officer
Dr. Gene Ma, Chief Medical Officer
Dr. Mark Yamanaka, Chief of Staff
Jeffrey Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairperson Grass reported the Board in Closed Session heard a report concerning one potential litigation matter and took no action.

The Board in Closed Session heard a report concerning an Existing Litigation matter and took no action.

The Board in Closed Session also heard reports of the Hospital Medical Audit or Quality Assurance Committees as well as a report on a Trade Secret matter and no action was taken on either matter.

Lastly, the Board in Closed Session approved Closed Session minutes.

Chairperson Grass reported when today's agenda was adopted there was Board consideration of adding an item from the City of Oceanside regarding Measure "K" however after discussing the matter and on advice of legal counsel the item was not added.

10. Director Reno 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 19.

12. TCHD Foundation – Jennifer Paroly, Foundation President

Ms. Jennifer Paroly, Foundation President provided a recap of the Diamond Ball. She stated the goal is to raise money but also raise awareness and development, all of which was accomplished at this year's event. Ms. Paroly stated feedback on the event has been very positive. She expressed her appreciation to everyone who participated in a myriad of ways from volunteering, donations, to our high-end scotch tasting. She recognized Mr. Aaron Byzak in particular for all his support throughout the evening.

Ms. Paroly reported she was asked to meet with Fresh Creative Foods who presented a check for $450 in support of the MRI. They indicated they are developing their budget for 2020 and Tri-City Hospital will once again be included.

In looking forward to 2020, the Foundation will launch their Corporate Council in January. Plans are already underway for the annual Golf Tournament and the Diamond Ball has been tentatively scheduled for November 7, 2020.

No action taken.

13. October 2019 Financial Statement Results – Mr. Ray Rivas, Chief Financial Officer

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

- Net Operating Revenue – $113,349
- Operating Expense – $120,310
- EBITDA – $2,462
- EROE – ($2,039)

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

- Average Daily Census – 145
- Adjusted Patient Days – 33,555
- Surgery Cases – 2,166

- ED Visits – 19,065

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

- Net Operating Revenue - $28,892
- Operating Expense - $30,545
- EBITDA - $683
- EROE – ($311)

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

- Average Daily Census - 143
- Adjusted Patient Days – 8,271
- Surgery Cases – 572
- ED Visits – 4,704

Mr. Rivas reported on the following indicators for FY20 Average:

- Net Patient Accounts Receivable - $45.7
- Days in Net Accounts Receivable - 57.4

Mr. Rivas stated the goal is to get Accounts Receivable down to a more acceptable level.

No action taken.

14. New Business –

a) Consideration and possible action to elect Board of Director Officers for calendar year 2020.

**It was moved by Director Nygaard to leave the existing Board Officers in place for 2020. Director Younger seconded the motion.**

**Director Chavez amended the motion to leave the existing Board Officers in place for 2020 with the exception of Director Younger moving to the office of Assistant Secretary and Director Chavez moving to the office of Board Member. Director Nygaard accepted the amendment to the motion.**

**The vote on the amended 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 proposed 2020 Board Meeting Schedule

**It was moved by Director Schallock to approve the proposed 2020 Board Meeting Schedule as presented. 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 to authorize the Chairperson to cast the ballot to fill eight open seats on the 16-member LAFCO Special Districts Advisory Committee.

**It was moved by Director Nygaard to authorize Chairperson Grass to cast the ballot to fill eight open seats on the 16-member LAFCO Special Districts Advisory Committee. Director Schallock seconded the motion.**

Chairperson Grass requested Board members provide feedback on the candidates prior to her casting the ballot.

**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** |

15. Old Business – none

16. Chief of Staff

Consideration of November 2019 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on November 25, 2019.

**It was moved by Director Reno to approve the November 2019 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on November 25, 2019. 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** |

17. Consideration of Consent Calendar

**It was moved by Director Schallock to approve the Consent Agenda. 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** |

18. Discussion of items pulled from Consent Calendar

There were no items pulled from the Consent Calendar however Director Reno requested clarification on the omission of the Board Approval date on the Administrative Policies & Procedures. Director Schallock explained that after the Board approves the policies today, staff will fill in today's date on the policy(s).

19. Comments by Members of the Public

There were no comments by members of the public.

20. Comments by Chief Executive Officer

Mr. Steve Dietlin wished everyone happy holidays.

21. Board Communications

Director Younger expressed her appreciation to Director Chavez for providing her with the opportunity to serve as Assistant Board Secretary.

Director Younger wished everyone happy holidays.

Director Coulter expressed his appreciation to everyone involved in making the Diamond Ball a success, and in particular Ms. Jennifer Paroly for all her hard work.

Director Chavez commented on a personal experience in the Emergency Department recently and recognized the staff for their excellent service. He also commented on his positive experience with the new on line Emergency Department appointment scheduler.

Director Reno read a note that she had written entitled *"What is a Volunteer"* and recognized the Tri-City Auxilians and Foundation for their loyal and faithful service and contributions. She also recognized all the employees for their service to the hospital.

Director Nygaard commented on an ad in the *Coast News* regarding our new Emergency Department online appointment scheduler. She believes Tri-City is the only hospital in San Diego County offering this service.

Lastly, Director Nygaard wished everyone a peaceful, restful holiday season.

Director Schallock commented on a segment that Channel 8 ran recently on the Honor Walk and organ donation program here at Tri-City. He commented on how respectful the employees of this facility are in trying to honor that family in what is an

extremely sad and stressful time for them. Director Schallock complimented Mr. Aaron Byzak on the impressive filming.

Director Schallock also commented on Tri-City Medical Center's pledge to join the San Diego Senior Emergency Care Initiative in collaboration with the County of San Diego and West Health. As part of its pledge, Tri-City will seek to earn Geriatric Emergency Department Accreditation to help address aging concerns and optimizing its emergency department experience for our senior population.

Lastly, Director Schallock wished everyone a happy and safe holiday and he looks forward to seeing everyone at the holiday party on Saturday, December 14th.

Director Reno reported Mary Stout, one of Tri-City Medical Center's first administrative staff passed away December 11, 2019 and her services will be held on December 1, 2019 at Eternal Hills at 1:00 p.m.

26. Report from Chairperson

Chairperson Grass read a humorous themed hospital version of Clement Clark Moore's poem, *"A visit from Saint Nicholas"* which we all know as *"Twas the Night before Christmas".* She also extended her best wishes for a happy holiday season.

27. There being no further business Chairperson Grass adjourned the meeting at 4:05 p.m.

_____
Leigh Anne Grass, Chairperson

ATTEST:

_____
Julie Nygaard, Secretary

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

**January 13, 2020 – 3:00 o'clock p.m.**
**Assembly Rooms 2&3 – Eugene L. Geil Pavilion**
**4002 Vista Way, Oceanside, CA 92056**

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 3:00 p.m. on January 13, 2020.

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

Director Rocky J. Chavez
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy M. Younger

Absent was Director George W. Coulter

Also present were:

Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Barbara Vogelsang, Chief Nurse Executive
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief Government Affairs Officer
Dr. Gene Ma, Chief Medical Officer
Susan Bond, General Counsel
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairperson, Director Grass, called the meeting to order at 3:00 p.m. in Assembly Room 1 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Younger led the Pledge of Allegiance.

2. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the Board Agenda. There were no public comments.

3. Approval of agenda.

   **It was moved by Director Nygaard to approve the agenda as presented. Director Schallock seconded the motion. The motion passed (6-0-0-1) with Director Coulter absent.**

   Oral Announcement of Items to be discussed during Closed Session

   Chairperson Grass made an oral announcement of the item listed on the January 13, 2020 Special Board of Directors Meeting Agenda to be discussed during Closed Session

which included one Report Involving Trade Secrets with a disclosure date of January 13, 2020.

5. Motion to go into Closed Session

**It was moved by Director Reno and seconded by Director Schallock to go into Closed Session at 3:05 p.m. The motion passed (6-0-0-1) with Director Coulter absent.**

8. At 3:30 p.m. the Board returned to Open Session with attendance as previously noted.

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

Chairperson Grass reported the Board in Closed Session heard a report on a Trade Secret and took no action.

10. Consideration for approval of definitive agreements for the development and operation of a 16-bed Inpatient Psychiatric Health Facility.

Mr. Steve Dietlin, CEO reported we have come to definitive agreements with the county for a new 16-bed inpatient bed Psychiatric Health Facility on the Tri-City campus and community based Crisis Stabilization units in the neighboring cities, one of which will be in the city of Oceanside. Those agreements include a Ground Lease, Sublease and Operating Agreement and are presented to the Board for consideration.

**It was moved by Director Chavez that the Tri-City Healthcare District Board of Directors approve the Ground Lease Agreement, the Sublease Agreement, and the Operating Agreement between Tri-City Healthcare District and the County of San Diego for the provision of Mental Health Services in substantially the form presented, subject to any required legal, regulatory, lender/guarantor approvals/revisions and amendments as necessary to carry out the intent of the Agreements. Director Nygaard seconded the motion.**

**The vote on the motion was as follows:**

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Chavez, Grass, Nygaard, Reno, Schallock and Younger** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **None** |
| **ABSENT:** | **Directors:** | **Coulter** |

11. Comments by members of the public.

There were no comments by members of the public.

12. Comments by Board Members

Director Chavez recognized Chairperson Grass and Mr. Dietlin for their leadership and diligence in consummating the agreements with the County of San Diego.

Director Younger reiterated Director Chavez's comments.

**Modern Healthcare**
P.O. BOX 433290
Palm Coast, FL 32143-3290

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TCMC ADMINISTRATION
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OCEANSIDE, CA 92056-4506

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| YES | NO | 503270000074111940 R05109GG4<br>LARRY SCHALLOCK<br>PO BOX 428, SAN LUIS REY, CA 92068<br>000007411194 EXPIRES MAY 20 00001 COPIES 051 ISSUES $76.00 |
| YES | NO | 503270000403108336 R05109GG4<br>LEIGH ANNE GRASS<br>2882 WOODRIDGE CIR, CARLSBAD, CA 92008<br>000040310833 EXPIRES MAY 20 00001 COPIES 051 ISSUES $76.00 |
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| YES | NO | 503270000413331467 R05109GG4<br>GEORGE COULTER, TCMC<br>1501 ANZA AVE SPC 46, VISTA, CA 92084<br>000041333146 EXPIRES MAY 20 00001 COPIES 051 ISSUES $76.00 |
| YES | NO | 503270000413331490 R05109GG4<br>TRACY YOUNGER, TCMC<br>3436 RICH FIELD DR, CARLSBAD, CA 92010<br>000041333149 EXPIRES MAY 20 00001 COPIES 051 ISSUES $76.00 |
| YES | NO | 503270000901044116 R05109GG4<br>ROSEMARIE V RENO, TRICITY MEDICAL CENTER<br>4916 BELLA COLLINA ST, OCEANSIDE, CA 92056<br>000090104411 EXPIRES MAY 20 00001 COPIES 051 ISSUES $76.00 |

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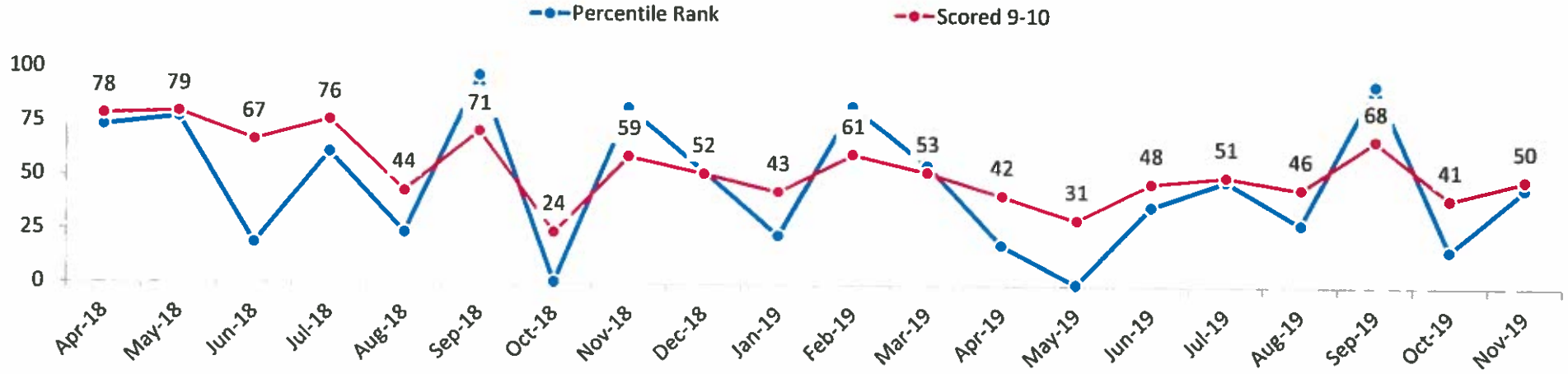
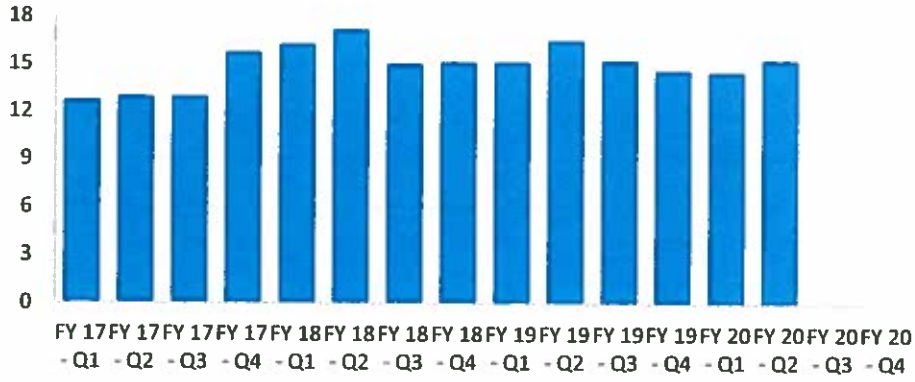
# Stakeholder Experiences

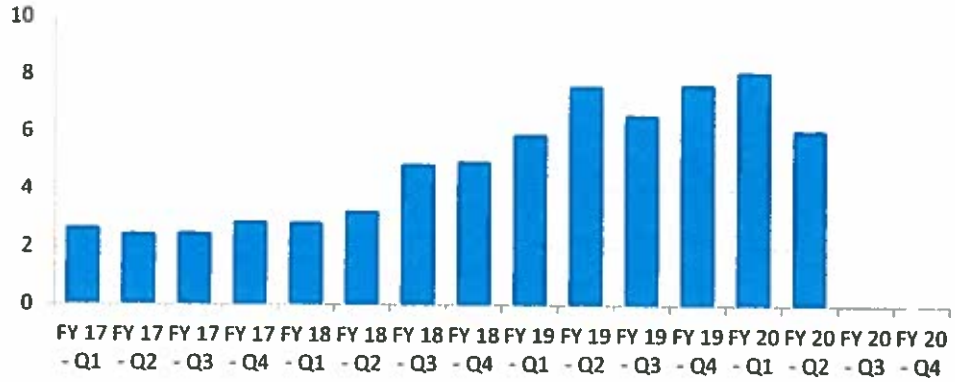
## Overall Rating of Hospital (0-10)




## 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 16 | 19 | 18 | 31 | 30 | 15 | | | | | | | 129 |
| FY19 | 18 | 29 | 19 | 27 | 18 | 24 | 22 | 16 | 23 | 30 | 25 | 24 | 135 |

## Mazor Robotic Spine Surgery Cases

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 9 | 8 | 9 | 12 | 7 | 5 | | | | | | | 50 |
| FY19 | 10 | 12 | 3 | 7 | 7 | 9 | 10 | 4 | 16 | 15 | 11 | 12 | 48 |

## Inpatient DaVinci Robotic Surgery Cases

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 9 | 16 | 11 | 11 | 12 | 13 | | | | | | | 72 |
| FY19 | 19 | 16 | 12 | 16 | 12 | 16 | 17 | 13 | 18 | 16 | 10 | 15 | 91 |

## Outpatient DaVinci Robotic Surgery Cases

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 19 | 23 | 27 | 33 | 31 | 24 | | | | | | | 157 |
| FY19 | 20 | 23 | 18 | 22 | 17 | 21 | 19 | 16 | 18 | 12 | 20 | 24 | 121 |

## Major Joint Replacement Surgery Cases (Lower Extremities)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 33 | 33 | 23 | 31 | 35 | 31 | | | | | | | 186 |
| FY19 | 31 | 31 | 27 | 35 | 38 | 31 | 23 | 40 | 36 | 24 | 29 | 36 | 193 |

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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | - | - | - | - | - | - | - | - | - | - | - | - | - |
| FY19 | 10.8 | 11.3 | 9.7 | - | - | - | - | - | - | - | - | - | 5.3 |

Acute Rehab Unit - Average Daily Census (ADC)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 6.2 | 4.5 | 7.7 | 7.0 | 5.0 | 3.0 | | | | | | | 5.6 |
| FY19 | 7.4 | 9.1 | 6.5 | 4.7 | 5.7 | 5.3 | 6.8 | 8.4 | 7.2 | 5.8 | 4.4 | 6.5 | 6.4 |

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

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 9.4 | 10.3 | 10.4 | 9.7 | 9.5 | 9.4 | | | | | | | 10.3 |
| FY19 | 11.4 | 9.8 | 10.0 | 11.0 | 11.6 | 8.7 | 10.1 | 8.9 | 11.3 | 10.0 | 9.5 | 10.4 | 10.4 |

Hospital - Average Daily Census (ADC)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 143.4 | 143.6 | 150.6 | 143.2 | 144.0 | 160.2 | | | | | | | 147.5 |
| FY19 | 160.3 | 155.9 | 146.4 | 149.6 | 143.7 | 153.2 | 164.8 | 166.3 | 157.7 | 142.4 | 143.3 | 146.5 | 151.6 |

Deliveries

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 168 | 171 | 156 | 159 | 146 | 159 | | | | | | | 959 |
| FY19 | 186 | 202 | 170 | 187 | 185 | 166 | 170 | 150 | 177 | 131 | 146 | 156 | 1,096 |

Inpatient Cardiac Interventions

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 7 | 8 | 7 | 17 | 14 | 10 | | | | | | | 63 |
| FY19 | 8 | 10 | 6 | 8 | 3 | 15 | 6 | 9 | 11 | 10 | 20 | 13 | 50 |

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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 7 | 5 | 12 | 6 | 11 | 9 | | | | | | | 50 |
| FY19 | 3 | 4 | 3 | 13 | 13 | 6 | 11 | 17 | 6 | 10 | 7 | 9 | 42 |

Open Heart Surgery Cases

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 9 | 5 | 2 | 8 | 5 | 5 | | | | | | | 34 |
| FY19 | 8 | 8 | 6 | 8 | 4 | 14 | 8 | 10 | 16 | 6 | 7 | 5 | 48 |

TCMC Adjusted Factor (Total Revenue/IP Revenue)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 1.85 | 1.89 | 1.91 | 1.86 | 1.86 | 1.79 | | | | | | | 1.86 |
| FY19 | 1.79 | 1.83 | 1.90 | 1.78 | 1.78 | 1.70 | 1.72 | 1.73 | 1.75 | 1.82 | 1.80 | 1.79 | 1.79 |


Tri-City Medical Center

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# 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 52.8 | 56.4 | 59.2 | 61.2 | 61.9 | 62.6 | | | | | | | 59.0 | 48-52 |
| FY19 | 51.0 | 48.5 | 50.3 | 49.5 | 52.3 | 56.5 | 58.9 | 56.7 | 57.0 | 50.5 | 48.9 | 53.2 | 51.3 | |

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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 93.0 | 89.9 | 90.8 | 98.4 | 92.8 | 85.5 | | | | | | | 91.7 | 75-100 |
| FY19 | 84.9 | 86.5 | 90.2 | 91.4 | 92.5 | 87.8 | 93.1 | 92.2 | 83.6 | 84.1 | 91.4 | 87.6 | 88.9 | |

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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | ($476) | ($494) | ($759) | ($311) | ($1,036) | ($1,040) | | | | | | | ($4,115) | ($4,296) |
| FY19 | ($478) | ($121) | $119 | $254 | $342 | $236 | ($527) | $99 | $206 | $885 | $904 | ($6,138) | $352 | |

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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | -1.65% | -1.66% | -2.71% | -1.08% | -3.91% | -3.75% | | | | | | | -2.43% | -2.52% |
| FY19 | -1.64% | -0.39% | 0.41% | 0.86% | 1.19% | 0.79% | -1.76% | 0.34% | 0.67% | 2.89% | 2.88% | -21.60% | 0.20% | |


Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

# Financial Information

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD | C/M YTD Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | $686 | $681 | $412 | $683 | $62 | $128 | | | | | | | $2,653 | $ 2,649 |
| FY19 | $796 | $1,168 | $1,417 | $1,561 | $1,618 | $1,544 | $826 | $1,468 | $1,548 | $2,219 | $2,221 | ($4,712) | $8,104 | |

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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 2.38% | 2.30% | 1.47% | 2.36% | 0.24% | 0.46% | | | | | | | 1.56% | 1.55% |
| FY19 | 2.73% | 3.81% | 4.90% | 5.28% | 5.65% | 5.20% | 2.76% | 5.07% | 5.00% | 7.25% | 7.07% | -16.58% | 4.59% | |

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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | 7.04 | 6.80 | 6.21 | 6.90 | 6.58 | 6.44 | | | | | | | 6.65 | 6.92 |
| FY19 | 6.73 | 6.70 | 6.75 | 6.98 | 7.82 | 6.50 | 6.68 | 6.52 | 6.71 | 7.27 | 7.29 | 6.79 | 6.91 | |

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

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY20 | $52.4 | $44.8 | $43.7 | $45.6 | $38.2 | $31.9 | | | | | | | |
| FY19 | $50.0 | $49.5 | $49.3 | $48.1 | $37.5 | $29.5 | $36.3 | $32.9 | $20.6 | $40.7 | $57.1 | $54.5 | |

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending December 31, 2019

| Lessor | Sq. Ft. | Base Rate per Sq. Ft. | | Total Rent per current month | Lease Term Beginning | Lease Term Ending | Services & Location | Cost Center |
|---|---|---|---|---|---|---|---|---|
| **6121 Paseo Del Norte, LLC**<br>6128 Paseo Del Norte, Suite 180<br>Carlsbad, CA 92011<br>V#83024 | Approx 9,552 | $3.59 | (a) | 46,367.60 | 07/01/17 | 06/30/27 | **OSNC - Carlsbad**<br>6121 Paseo Del Norte, Suite 200<br>Carlsbad, CA 92011 | 7095 |
| **American Health & Retirement**<br>DBA: Vista Medical Plaza<br>140 Lomas Santa Fe Dr., Ste 103<br>Solona Beach, CA 92075<br>V#82904 | Approx 1,558 | $2.47 | (a) | 5,268.79 | 01/27/17 | 05/31/20 | **PCP Clinic - Venus**<br>2067 W. Vista Way, Ste 160<br>Vista, CA 92083 | 7093 |
| **Cardiff Investments LLC**<br>2729 Ocean St<br>Carlsbad, CA 92008<br>**V#83204** | 10,218 | $2.58 | (a) | 27,500.69 | 07/01/17 | 06/30/22 | **OSNC - Oceanside**<br>3905 Waring Road<br>Oceanside, CA 92056 | 7095 |
| **Creek View Medical Assoc**<br>1926 Via Centre Dr. Suite A<br>Vista, CA 92081<br>V#81981 | Approx 6,200 | $2.70 | (a) | 21,112.00 | 02/01/15 | 01/31/20 | **PCP Clinic Vista**<br>1926 Via Centre Drive, Ste A<br>Vista, CA 92081 | 7090 |
| **CreekView Orhopaedic Bldg, LLC**<br>1958 Via Centre Drive<br>Vista, Ca 92081<br>**V#83025** | Approx 4,995 | $2.58 | (a) | 16,109.57 | 07/01/17 | 06/30/22 | **OSNC - Vista**<br>1958 Via Centre Drive<br>Vista, Ca 92081 | 7095 |
| **Elfin Investments, LLC**<br>Clancy Medical Group<br>20136 Elfin Creek Trail<br>Escondido, CA 92029<br>V#82575 | 3,140 | $2.62 | (a) | 10,101.37 | 12/01/15 | 12/31/20 | **PCP Clinic - Clancy**<br>2375 Melrose Dr. Vista<br>Vista, CA 92081 | 7091 |
| **Melrose Plaza Complex, LP**<br>c/o Five K Management, Inc.<br>P O Box 2522<br>La Jolla, CA 92038<br>V#43849 | 7,347 | $1.35 | (a) | 10,399.54 | 07/01/16 | 06/30/21 | **Outpatient Behavioral Health**<br>510 West Vista Way<br>Vista, Ca 92083 | 7320 |
| **OPS Enterprises, LLC**<br>3617 Vista Way, Bldg. 5<br>Oceanside, Ca 92056<br>#V81250 | 4,760 | $4.12 | (a) | 27,850.00 | 10/01/12 | 10/01/22 | **Chemotherapy/Infusion Oncology Center**<br>3617 Vista Way, Bldg.5<br>Oceanside, Ca 92056 | 7086 |
| **SCRIPPSVIEW MEDICAL ASSOCIATES**<br>P O Box 234296<br>Encinitas, CA 234296<br>V#83589 | 3,864 | $3.45 | (a) | 13,316.37 | 08/08/19 | 05/31/21 | **Encinitas Medical Center**<br>351 Santa Fe Drive, Suite 351<br>Encinitas, CA 92023 | 7095 |
| Total | | | | $ 178,025.93 | | | | |

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

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

**Education & Travel Expense**
**Month Ending December 2019**

| Cost Centers | Description | Invoice # | Amount | Vendor # | Attendees |
|---|---|---|---|---|---|
| 7400 | 7th EDITION NRP PROVIDER COURSE | 112619 EDU | 149.00 | 83648 | SARAH BRESSLER |
| 7420 | CNOR RECERTIFICATION | 111219 EDU | 375.00 | 79190 | JENNIFER STEPHENSON |
| 7500 | MANAGEMENT BASICS, CSSM | RA022005 | 1,194.00 | 15822 | ELAINE BURKE |
| 7500 | MANAGEMENT BASICS, CSSM | RA022005 | 1,194.00 | 15822 | CARRIE DOLAN |
| 8480 | CERNER TRAINING | 120619 EDU | 5,615.66 | 83567 | 10 OF PATIENT ACCOUNTING DEPARTMENT |
| 8510 | LORMAN EDUCATION SERVICE | 120619 EDU | 488.12 | 82623 | WINITA PHOGNSAMRAN |
| 8532 | CERNER TRAINING | 122319 EDU | 885.36 | 80216 | JONI PENIX |
| 8650 | MANAGEMENT BASICS, CSSM | RA022005 | 1,176.00 | 15822 | NINA LUNA |
| 8710 | NATIONAL ASSOCIATION OF MEDICAL STAFF SERVICES | 121819 EDU | 2,032.08 | 82538 | SHERRY MILLER |
| 8740 | ONS/ONCC CHEMOTHERAPY RENEWAL COURSE | 120619 EDU | 103.00 | 80734 | RENATA MACIK |
| 8740 | ONS/ONCC CHEMOTHERAPY RENEWAL COURSE | 112219 EDU | 103.00 | 83644 | EUNICE W GACHOMO |
| 8740 | AHA/AAP NRP SKILLS | 122019 EDU | 110.00 | 44920 | LYNN MISNER |
| 8740 | ASRT YEORLY MEGOZINE COURSE | 120619 EDU | 125.00 | 82343 | MIKE TRACEY |
| 8740 | INTRODUCTION TO BREAST TOMOSYNTHESID AND CANCER RISK | 122019 EDU | 128.00 | 29219 | CONNIE J. GEORGE |
| 8740 | SCRIPPS CARDIOGENIC STROCK | 122019 EDU | 130.00 | 83227 | GEMMA-ELIZABETH MARIE JOHNSON |
| 8740 | PALS RENEWAL | 112619 EDU | 132.00 | 83642 | LAUREN GRIFFITH |
| 8740 | AHA ACLS UPDATE | 121919 AHA | 150.00 | 79784 | DEANNA DALY |
| 8740 | PALS RENEWAL | 121219 EDU | 160.00 | 83465 | ALLAN MEDINA |
| 8740 | BODY CT: THE ESSENTIALS | 120619 EDU | 172.63 | 83402 | STEVEN SAHA |
| 8740 | CCRN AND ADVANCED CRITICAL CARE COURSE | 120619 EDU | 200.00 | 78123 | CAMILLE BRYAN |

**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.