## TRI-CITY HEALTHCARE DISTRICT AGENDA FOR AN ADJOURNED REGULAR MEETING

February 4, 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 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.

	Agenda Item	Time Allotted	Requestor
11	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 19-018, members of the public may have three minutes, individually, to address the Board of Directors.  NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	TCHD Auxiliary, Jeff Marks, President	10 min.	Standard
13	December 2019 Financial Statement Results	10 min.	CFO
14	New Business		
	a) Consideration to approve a Group Physician Recruitment Agreement with Dr. Darrell Wu, M.D., Cardiovascular/Cardiothoracic Surgeon.	5 min.	Sr. Dir. Busi. Develop.
	b) Consideration to award Board Scholarship to the Tri-City Hospital Auxiliary in the amount of \$10,000 (10 students).	5 min.	Chair
	c) Consideration of nomination to serve on the San Diego Local Agency Formation Commission (LAFCO).	5 min.	Chair
15	Old Business – None		
16	Chief of Staff	5 min.	Chief of Staff
	a) Membership and Privileges granted for the physicians reflected in the January Credentialing Report – <b>Information Only</b>		
	b) Consideration of revised Cardiology Privilege Card		
	c) Consideration of revised Cardiothoracic Surgery Privilege Card		
17	Consideration of Consent Calendar	5 min.	Standard
	Administrative & Board Committees		
	(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.	·	
	(2) All items listed were recommended by the Committee.		
:	(3) Requested items to be pulled <u>require a second</u> .		
	(1) Administrative Committee		
	<ul> <li>a) Administrative Policies &amp; Procedures – District Operations</li> <li>1) Administrator On Call – 281</li> </ul>		
	b) Unit Specific – Engineering 1) 5003.2 Lockout Tagout Training (DELETE)		

Agenda item	Time Allotted	Requestor
<ul><li>c) Unit Specific – Laboratory</li><li>1) Hematology Quality Management (SM) Plan Policy</li></ul>		
<ul> <li>d) Unit Specific – Outpatient Pharmacy</li> <li>1) Credit Card Processing Policy</li> <li>2) Drug Supply Chain Security Policy</li> <li>3) Pharmacist Conscientious Objection Policy</li> <li>4) Physical Inventory Policy</li> <li>5) Prevention of Dispensing Potentially Harmful Prescribed Dr Patients Policy</li> <li>6) Storage Requirements for Medications Policy</li> </ul>	ugs to	
<ul> <li>e) Unit Specific – Rehabilitation</li> <li>1) Disaster Plan – Outpatient 1502 Policy (DELETE)</li> <li>2) Emergency Care – Outpatient Services 1504 (DELETE)</li> </ul>		
<ul> <li>f) Unit Specific – Rehabilitation Center (Acute Rehab Unit)</li> <li>1) Provision of Durable Medical Equipment (DME) by Tri-City Rehabilitation Center</li> </ul>		
(2) Board Committees		
A. Community Healthcare Alliance Committee Director Chavez, Committee Chair (Committee minutes included in Board Agenda packet for informational purposes.)		HAC Comn
B. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packet for informational purposes.)		O&P Comm
<ol> <li>Approval to add Alexander Foster, M.D. to the ED On Coverage Panel for Ophthalmology for 12 months, beginn February 1, 2020 through January 31, 2021.</li> </ol>		
<ol> <li>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 annual and total term cost of \$360,679.28.</li> </ol>	or an	
3) Approval of an agreement with Stryker ProCare for a splan for a term of 24 months for video, beginning January 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 at total cost for the term of \$478,862.37.	1,	
C. Professional Affairs Committee Director Reno, Committee Chair (No meeting held in January, 2020)		PAC
D. Audit, Compliance & Ethics Committee  Director Younger, Committee Chair  Open Community Seats – 1  (No meeting held in January, 2020)		udit, Comp. thics Comr

	Agenda Item	Time Allotted	Requestor
	(3) Minutes – Approval of:  a) December 12, 2019 - Regular Meeting b) January 13, 2020 – Special Meeting	5 5 5 5	Standard
	(4) Meetings and Conferences – None		
	(5) Dues and Memberships		
	a) Modern Healthcare Subscription - \$532.00		
	<ul> <li>(6) Reports</li> <li>(a) Dashboard – None</li> <li>(b) Construction Report – None</li> <li>(c) Lease Report – (December, 2019)</li> <li>(d) Reimbursement Disclosure Report – (December, 2019)</li> <li>(e) Seminar/Conference Reports – None</li> </ul>		
18	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
19	Comments by Members of the Public 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	х	Other: Recruitment Agreement
Status of Agreement	tus of Agreement X New Agreement Rates		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 (\$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:

<u>Business Pro Forma</u>: 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.

<u>Expenses</u>: 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:	Х	Yes		No
Approved by Chief Compliance Officer:	Х	Yes		No
Is Agreement a Regulatory Requirement:		Yes	Х	No
Budgeted Item:	Х	Yes		No

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director Business Development / Steve Dietlin, Chief Executive Officer

Partion:

we 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

12-9-19

Regional Service Planning | Subdivision of the State of California

### **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.

San Diego LAFCO
Call for Nominations | San Diego Local Agency Formation Commission - Regular Special District Member
December 6, 2019

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

1116	is pleased to n	ominate	as a
(Name of Independent Spe	cial District)	(Name of Candidate)	
Candidate for the San Die with a term expiring 2024	go Local Agency Formatio J.	on Commission as a regular special distric	t member
As presiding officer or h certify that:	is/her delegated alternat	te as provided by the governing board	, I hereby
<ul> <li>The nominee is a resides in San Die</li> </ul>	nember of a legislative go County.	e body of an independent special distr	ict whom
(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 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. Ied 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 Eve Group)



## 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
- IOSON, 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



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

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
- <u>CATTAFI. Paul. DO/Anesthesiology</u>
- 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, Jav. MD/Neurology
- RUELAZ, Robert, MD/Cardiology
- SEUFERT, Kevin, MD/Family Medicine
- WARSHAWSKY, Arthur, MD/Urology

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

Attachment B

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



## 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 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.

IACOBS, Karl, MD Psychiatry

KUSHNARYOV, Anton, MD Otolaryngology

LOTAN. Roi MD
 Teleradiology

MACEWAN, Jennifer, MD
 Otolarvngology

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 RELINOUISHMENT OF PRIVILEGES**

The following providers relinquished the following privileges.

• <u>D'SOUZA, Geehan MD</u> <u>Plastic Surgery</u>



## 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 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 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 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



Cardiology (Revised 4/191/20)

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. <u>Must successfully complete Moderate Sedation Test.</u>

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.

Page 1

Printed on Tuesday, January 21, 2020



Cardiology (Revised 4/191/20)

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-Griteria: (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 <a href="Must successfully complete Moderate Sedation">Must successfully complete Moderate Sedation</a> <a href="Test">Test</a> .
<del></del>	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



Cardiology (Revised 4/191/20)

equest	Privilege
I	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. Provide with full interventional privileges will be allowed to complete the pathway to certification on siteRequires 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 siteRequires 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 o 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 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)

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Cardiology (Revised 4/191/20)

active reading panel participant and has sufficient case volumes to fulfill reappointment volume requirements as outlin 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 co towards this requirement. Thoracic Echos: two hundred (200) or active reading panel member as attested by Division of Chief or designee.	Request	Privilege
Transcatheter Arrite 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  Transcaphageal 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 outline below for each procedure requested.  Proctoring Requirements:  EKG: twenty five (25) Stress ECHO: two (2) Thoracic ECHO: two (2) Thoracic ECHO: two (2) Thoracic ECHO: two (2) Treadmill: 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 co towards this requirement. Thoracic ECHO: two (2) Thoracic ECHO: two (3) Thoracic ECHO: two (4) Thoracic ECHO: two (5) Documentation of Stress Echos performed at other facilities (including the physician's office) will co 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)(en (10)) of which ten (40)(wo (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.  Treadmill: fifty (50) or active reading panel member as attested by Division of Chief or designee.		
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Stress Echo		Treadmill: fifty (50) or active reading panel member as attested by Division of Chief or designee.
		EKG
Thoracic Echo	_	Stress Echo
	_	Thoracic Echo
	_	



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## **Clinical Privilege Request Form**

Cardiology (Revised 4/191/20)

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

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Cardiology (Revised 4/191/20)

it	Privilege	
	3-	
		<del></del>
Print Applicant Name		
Applicant Signature		
Date		
Division/Department Signature (By Signin	ng this form I agree with the granting of these privileges indicated	above.)
		•





Cardiothoracic Surgery - (Revised 4/171/20)

Request	er Name: Privilege
	· Financke
<u> </u>	
	<b>CERTIFICATION:</b> The Division of Cardiothoracic Surgery consists of physicians who are Board Certified or are in the first thirty-s (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 without proctoring.
	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)
	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

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Cardiothoracic Surgery - (Revised 4/171/20)

Reques	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



Cardiothoracic Surgery - (Revised 4/171/20)

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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 their-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 <u>from each of the following procedure bundles must be proctored</u> must be concurrently proctored by a robotic-credentialed surgeon (preferably in their field) <u>of Robotic Assisted Thoracic Surgery.</u>

  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 their-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.



Cardiothoracic Surgery - (Revised 4/171/20)

	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)			
1	_	Robotic Surgery (da Vinci) - CORE PRIVILEGES Robotic Assisted Thoracic Surgery Proctoring: First 1 case.			
1	=	-Closed Cardiac Cases			
l	=	-Epicardial pacer-lead placement			
]	=	Left internal mammary artery/right internal mammary artery takedown, off pump coronary artery bypass graft			
	=	<del>Transmyocardial laser revascularization</del>			
	=	-Pericardial window			
1	=	-Basis Thoracis Cases			
	_	Thymectomy			
		Lung biopsy/resection			
	_	Mediastinal exploration (lymph nodes, mass)			
1	=	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			
	_	<u>Transmyocardial laser revascularization</u>			

Page 4



Cardiothoracic Surgery - (Revised 4/171/20)

Provider	Provider Name:					
Request	Privilege					
	Pericardial window ASD/Cardiac tumor resection					

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)

1. Training in Aortic Endo-Balloon (if technique to be used)

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



Cardiothoracic Surgery - (Revised 4/171/20)

Request	Privilege
	Filvinege
_	-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 X
	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

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## ADMINISTRATION REVIEW CONSENT AGENDA January 20<sup>th</sup>, 2020

CONTACT: Barbara Vogelsang, CNE

	Policies and Procedures	Reason	Recommendations
A	Iministrative Policies & Procedures		
	strict Operations		
	Administrator on Call 281	3 Year Review	Forward To BOD For Approval
Ur	nit Specific		
Er	ngineering		
1.	5003.2 Lockout Tagout Training	DELETE	Forward To BOD For Approval
	boratory	<u> </u>	
1.	Hematology Quality Management (QM) Plan Policy	3 Year Review, Practice Change	Forward To BOD For Approval
Οι	Itpatient 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.		NEW	Forward To BOD For Approval
ā	habilitation		
1.	Disaster Plan - Outpatient 1502 Policy	DELETE	Forward To BOD For Approval
2.		DELETE	Forward To BOD For Approval
Re	habilitation Center (Acute Rehab Unit)		
1.	Provision of Durable Medical Equipment (DME) by Tri-City Rehabilitation Center	NEW	Forward To BOD For Approval



## **Administrative Policy Manual**

**ISSUE DATE:** 

12/01

SUBJECT: ADMINISTRATOR ON CALL

**REVISION DATE:** 

11/02, 08/03, 03/06, 02/09, 03/11,

POLICY NUMBER: 8610-281

11/13, 04/14

Administrative Content ExpertDepartment Approval:

01/1711/19

**Administrative Policies & Procedures Committee Approval:** 

01/1711/19

**Medical Executive Committee Approval:** 

n/a

Administration Approval:
Professional Affairs Committee Approval:

01/20 <del>02/17</del> n/a

Board of Directors Approval:

03/17

### A. PURPOSE:

 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:**

- Administrator on Call: The Chief Operating Officer (COO), Chief Nurse Executive (CNE) and Chief Financial Officer (CFO) and Senior Lleaders are assigned on a rotational basis to provide administrative oversight and direction.
- 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:

- 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:
  - 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)
  - Media contacts or potential media reportable events
  - f. Non-availability of inpatient beds
- 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:

Administrative Policy: Policy-Mandatory Reporting Requirements #236

	DELETE – Combined with updated Lockout/Tag out Procedure #5003.1
TRI-CITY MEDICAL CENTER	Section: ENGINEERING DEPARTMENT
Engineering Policy & Procedure	Subject: Lockout/Tagout Training Policy Number: 5003.2 Page 1 of 4
Department: Engineering	<b>EFFECTIVE:</b> 8/30/89 <b>REVISED:</b> 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
Ĺ	08/89	9/94; 2/97; 5/00; 5/03, 6/06, 6/12	09/19	n/a	01/20	n/a	06/12

Engineering Manual Lockout Tagout Training 5003.2 Page 2 of 3

#### 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.

Engineering Manual Lockout Tagout Training 5003.2 Page 3 of 3

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-proceduresneeds to follow Engineering Department's lockout and tagout procedures.



## LABORATORY **HEMATOLOGY / QUALITY ASSURANCE**

Tri-City Medical Center	Laboratory Manual
PROCEDURE: HEMATOLOGY/URINALYSIS DEPA	RTMENT 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 n/a

Professional Affairs Committee Approval-Date(s):

Board of Directors Approval Date(s):

#### A. **PURPOSE:**

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 ManagementAssurance 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.

The plan provides the system design and evaluation of proper patient identification and 3. 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;	<del>10/19/98; 3/2/00; 12/17/02; 9/2/03;</del> <del>11/5/04; 9/7/06; 11/16/06; 11/07/07</del>	
	5/29/13 ld;	<del>1/30/08; 5/15/08; 10/7/08; 11/9/09;</del>	APPROVED BY:
		<del>9/8/10; 5/26/11; 8/6/12; 5/28/15</del>	
Ц		8/15/16; 11/13/17 <b>, 10/26/19</b>	

- 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 statementquality 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, 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** supervisorManager.
- 6. The effectiveness of the Hematology/Urinalysis Quality ManagementAssurance Plan is evaluated by the Hematology Department Operations ManagerTechnical 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-loadership team-(Senier-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:

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:

Lab Hematology/Quality Assurance Hematology/Urinalysis Department Quality Management-Assurance Plan Page 3 of 23

- 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.
- 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. <u>Laboratory Director:</u>
    - 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 preactive and applicable regulations.

b.

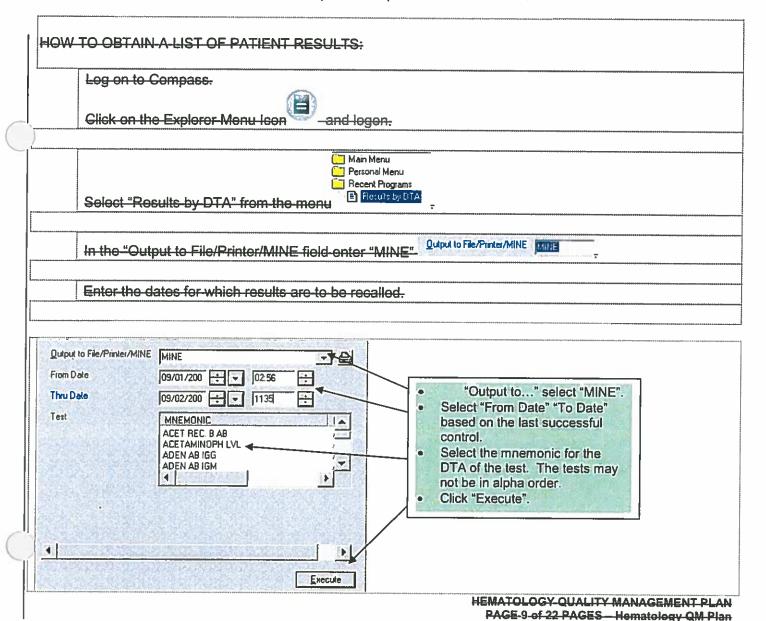
- 2. Operations ManagerHematology Technical Specialist
  - a. Reviews all Quality Incident Tracking Forms Reviews (RL Solutions) and disseminates reports to appropriate lab staff for their investigation. Coordinates QA activities of Hematology with respect to Patient Care Services. Participates in the 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.
  - 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

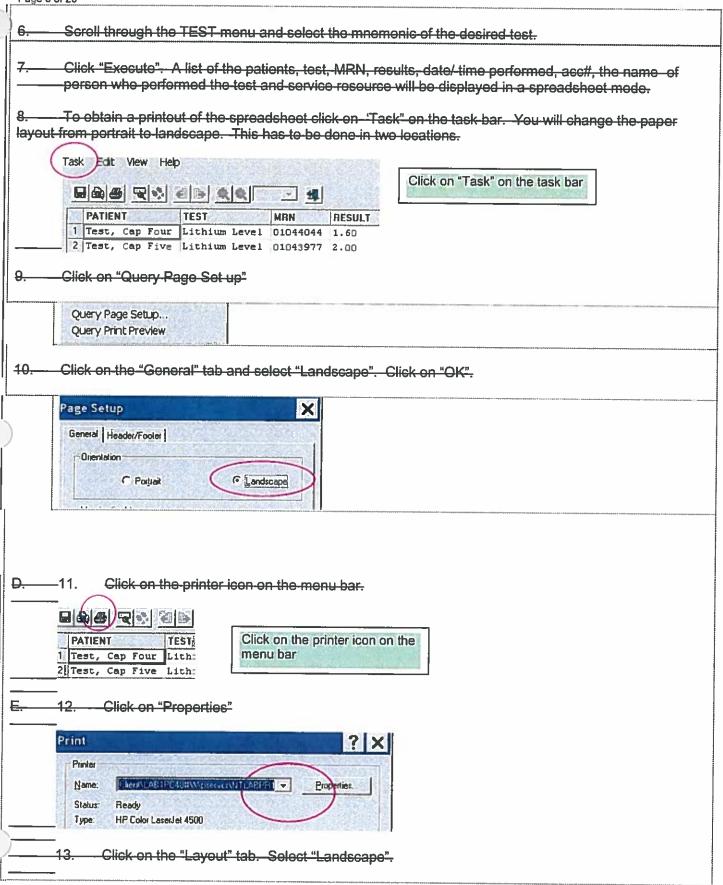
at Lab Leadership Team meetings. Reviews all Quality Incident reviews (RL Solutions) pertaining to the Hematology section.

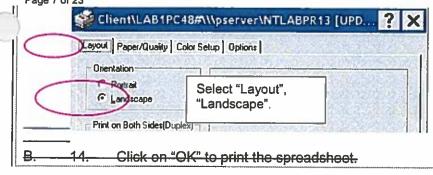
### C. QUALITY CONTROL PROGRAM:

- 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.
- 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:
  - 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 en a daily basisas 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.
- Quality Control Records:
  - All QC records are maintained for a minimum of sixthree 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:
  - 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.







- 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:

- 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 velocity200 and reviews the results to ensure compliance.

The manual worksheets are also reviewed and checked to ensure the controls were

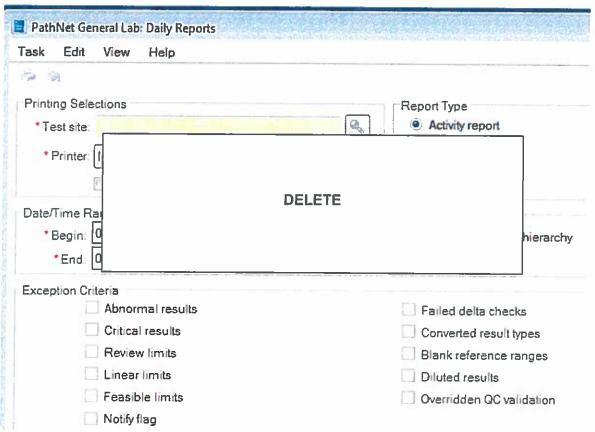
+ne manual worksheets are also reviewed and shecked to ensure the controls were entered into Cerner and the patient results were also entered correctly.

- 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 Man

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 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. <u>Daily QA Review (Daily Reports)</u>
  - a. The Daily Exception Reports are generated each day from the Daily Reports in Cerner iscern-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. <u>Monitoring Timeliness And Completeness Of Critical Value Communication:</u>

- 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.
  - 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

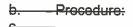
- c. All completed Daily Reports should be initialed by the reviewing tech and placed in the Daily Report box.
- d. Critical values will also be reviewed by the Operations ManagerTechnical Specialist or Lead CLS by reviewing the Daily Exception Report printed at 0600 each day. Each critical value will 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:

Access the Daily Reports Icon on the AppBar:
 At Test Site: onter Hematology and at Printer: onter labpr07.

PathNet General Lab:	Daily Reports	×
Task Edit View Help		
Test <u>S</u> ite: Hematology	Report type  Activity Report	
	DELETE	
Soil by	DELETE	
Soil by  Service Resource Hierarchy  Person Name	DELETE	
Service Resource Hierarchy	DELETE	
© Service <u>Resource Hierarchy</u> C Person <u>Name</u>	DELETE    Failed Delta Checks	
© Service Resource Hierarchy © Person Name Exception criteria		

- 2) Click on Exception Report and then Critical Results and Review Limits and click on the printer Icon.
  - 9. Pending Inquiry
    - 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.



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

Select Per	nding Procedures		×
Lest Site:	Hematology		<u>0</u> K
Procedure:	Antomongosta	an received the	Cancel
☐ <u>R</u> eceived Only			

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

### 10. <u>Instrument Function Checks and Maintenance</u>

- 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 ManagerTechnical 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.

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

- 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:
  - Shifts, trends and corrective action by technologists.
  - 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.
- 4.2. Calibration of the DxH 1600 is performed at least every six months.

#### HG. ANNUALLY

- 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.

- 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.

#### ♣H. BIENNIAL REVIEW:

Procedure manual review and review of the QA Plan done by the Operations
 ManagerHematology Technical Specialist and Lead CLS.

## K.I. SUMMARY OF OTHER QUALITY ASSURANCE PROCEDURES:

- 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. <u>Detecting and Correcting Erroneous</u> Lab Results
  - 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 thefive 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
  - 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. <u>Clinical Laboratory Scientist Orientation-Training Checklist</u>
  - All new employees of the Hematology Department are trained en the AM shift by the department Operations ManagerTechnical Specialist, Lead CLS or qualified staff

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CLSs. The -orientationtraining checklist is used to verify successful orientation to the department as well as a guide for topics to be reviewed during the -orientationtraining. 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. <u>Method Validation (Method Performance Specification</u>

- a. The step-by-step process for the integration of new test in to the lab is as follows:
  - 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. <u>Method Validation: Summary Statement Of Acceptable Performance:</u>

- 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\_\_\_\_

## J. HEMATOLOGY QUALITY CONTROL SUMMARY

- 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)
- I. 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

- 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. <u>Comparability Studies of Instrumentation:</u>
  - 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

1 1000 I OEEIOMIOE	-EINIT-O
Paramet	Absolute
0	U U
F	ni ni
	ts
<del>WBC</del>	±0.5
RBC	±0.2
HGB	±0.3
MCV	<u>+2.0</u>
RDW	<u>+0.5</u>
PLT	<del>±20</del>
MPV	<del>±0.5</del>
%NE	+2.0
%LY	<del>±2.0</del>
%MO	<del>±2.0</del>
%EO	<u>+1.0</u>
%BA	<del>±0.5</del>
% 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
     4) (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
  - 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
  - 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
  - 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

#### 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 lvy 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. <u>Laboratory Reference Intervals:</u>

- 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 <u>How To Define And Determine Reference Intervals In The Clinical Laboratory; Approved Guideline</u>

<u>C28-A2</u> 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.
  - Run the samples and check to be sure none are outliers.
  - 3) Any apparent outliers should be discarded and a new patient substituted.
  - 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

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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

- 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. <u>Orientation and Initial Competency Evaluation:</u>
  - 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:

	confirm that I have a serviced desiration
on the above	confirm that I have completed training
	of (Position Title)
to high complexity tests. I	m competent to perform these waived, moderate complexity acknowledge that I am authorized by the Medical Director or perform these tests without direct supervision.
	paratin tribus tools intribut uncot super 4/3/0/1.
Signature:	Date:
Signature:	
Signature: Signature of The CLS has completed tra perform specimen process	Date:
Signature: Signature of Signature of Signature of Signature of the CLS has completed traperform specimen process categories of testing indepositions.	Date:Date:Date:Date:Date:

- 5. <u>Six-Month and One Year Competency Assessment:</u>
  - 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. <u>Annual Competency and Performance Review:</u>
  - 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. <u>Methods of Competency Assessment:</u>
  - 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.
  - 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. <u>Documentation Competency Assessment:</u>

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):

- 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
- 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

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	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)
L						<b>'</b> .	10 10 10 10			New/Improved

### N.L. HEMATOLOGY/URINALYSIS SECTION RECORD MAINTENANCE

- 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 years6 years	Lab current month, then warehouse
Patient Reports	Indefinite	HIS. Indefinite (remote hosted)
Requisitions	3 years6 years	Lab current month, then warehouse
Quality Control Records	3 years6 years	Lab
Proficiency Test Records	3 years6 years	Lab
Quality Improvement Records	3 years6 years	Lab
Worksheets	3 years6 years	Lab
Archived Procedures	3 years6 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:

 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 designeeTechnologist							
Proficiency testing – Director's attestation statement signature. Review of Summary Reports.	Technical Specialist							

## P.N. SELECTION OF LABORATORY EQUIPMENT AND SUPPLIES:

 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:

- Ivy-Bleeding Time-Proficiency Test Worksheet
- 1. Annual Department Specific Employee Verification Record
- 4.2. 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.

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| Hematology/Urinalysis Department Quality Management Assurance Plan
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3. NCCLS. How to define and determine reference intervals in the clinical laboratory; approved guideline C28-A2. Wayne, PA: NCCLS, 2000.



ISSUE DATE: NEW SUBJECT: Credit Card Processing

**REVISION DATE(S):** 

Outpatient Pharmacy Approval:

Medical Staff Department/Division Approval:

Pharmacy & Therapeutics Committee Approval:

Medical Executive Committee Approval:

Administration Approval:

Professional Affairs Committee Approval:

Board of Directors Approval:

#### A. POLICY

- 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.
- 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.
  - 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 <a href="https://www.pcisecuritystandards.org/">https://www.pcisecuritystandards.org/</a>.
- 4. Pharmacy must comply with rules and regulations of each card association.
  - a. <a href="http://www.mastercard.us/merchants/security/requirements.html">http://www.mastercard.us/merchants/security/requirements.html</a>
  - b. <a href="http://usa.visa.com/download/merchants/card-acceptance-guidelines-for-visa-merchants.pdf">http://usa.visa.com/download/merchants/card-acceptance-guidelines-for-visa-merchants.pdf</a>



**ISSUE DATE:** 

**NEW** 

SUBJECT: Drug Supply Chain Security

**REVISION DATE(S):** 

Outpatient Pharmacy Approval:

11/19

Medical Staff Department/Division Approval:

Pharmacy & Therapeutics Committee Approval:

n/a

**Medical Executive Committee Approval:** 

11/19 n/a

Administration Approval:

01/20

**Professional Affairs Committee Approval:** 

n/a

**Board of Directors Approval:** 

#### A. **DEFINITION(S):**

- 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
  - National Drug Code number C.
  - d. Container size and the number of containers
  - e. Lot number
  - f. Date of the transaction
  - Date of the shipment, if more than 24 hours after the date of the transaction g.
  - h. Business name and address of the person from whom ownership is being transferred
  - 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:
  - Is authorized as required under the Drug Supply Chain Security Act; a.
  - Received the product from a person that is authorized; b.

- 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:
  - Potentially counterfeit, diverted, or stolen;
  - b. Potentially intentionally adulterated
  - 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:**

- 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:

- 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.
- 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.
- 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 <a href="http://www.accessdata.fda.gov/scripts/cder/email/drugnotification.cfm">http://www.accessdata.fda.gov/scripts/cder/email/drugnotification.cfm</a>
  - Termination of Notification in Consultation with the FDA
    - To terminate notification in consultation with the FDA when the notification is believed to be no longer necessary access the FDA website <a href="http://www.accessdata.fda.gov/scripts/cder/email/drugnotification.cfm">http://www.accessdata.fda.gov/scripts/cder/email/drugnotification.cfm</a>
- Investigation
  - 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
      - The product is removed from the pharmaceutical distribution supply chain, which may include disposal or return of the product for disposal.
      - 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 <u>investigation</u>.
- 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

Outpatient Pharmacy Drug Supply Chain Security Page 4 of 5

- 8. Data Storage and Retrieval Requirements- Pharmacy software
  - See Backup methodologies for Rx30 and applicability within Business Continuity and Disaster Recovery Version 2.0.
  - b. RX30 Software Updates
    - 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.
      - 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):

A- Exceptions to the DSCSA Tracing Requirements

### E. RELATED DOCUMENT(S):

- Exceptions to the DSCSA Tracing Requirements
- 2. Characteristics of Suspect Products

# Attachment A: Exceptions to the DSCSA Tracing Requirements

- 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
- 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
- Distribution of product samples by a manufacturer or a licensed wholesale distributor
- 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/DrugSupplyChainSecurity Act/ucm376829.htm Accessed April 2015

e



Objection

ISSUE DATE: NEW SUBJECT: Pharmacist Conscientious

REVISION DATE(S):

Outpatient Pharmacy Approval:

Medical Staff Department/Division Approval:

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. PURPOSE:

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

### B. POLICY:

 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.



**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:

n/a

**Professional Affairs Committee Approval:** 

01/20

**Board of Directors Approval:** 

n/a

#### 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.
- 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.
  - 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



**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: Board of Directors Approval:** 

#### A. **PURPOSE:**

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.

n/a

#### POLICY: В.

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:

- 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:
  - 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.



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:** 

#### **POLICY:** A.

- Provisions for medication storage and security comply with all applicable federal, state and professional rules and regulations and accepted pharmaceutical standards of practice.
- Storing medications outside the licensed Pharmacy is prohibited. 2.
- Only authorized persons may access the Pharmacy and medications. 3.
- 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
  - Humidity C.
  - d. Light
  - Ventilation e.
  - Segregation f.
  - Security g.
- 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:

- **General Medication Storage Requirements** 
  - Medications are stored in an orderly and clean environment. Containers are stored on a. 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.
  - Medication dosage forms are segregated and stored separately in dispensing areas. b. 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.
- 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. <u>RELATED DOCUMENT(S):</u>

- 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

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:

03/4812/19

**DELETE** - no longer required

due to Location closure. All

**Outpatient services from** 2124 ElCamino real have

been consolidated to Wellness Center and Main

hospital.

Department of Medicine Approval: Pharmacy and Therapeutics Approval:

n/a n/a

Medical Executive Committee Approval: **Administration Approval:** 

n/a 01/20

**Professional Affairs Committee Approval:** 

05/18 n/a

**Board of Directors Approval:** 

05/18

### PURPOSE:

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

#### PERSONNEL:

- The Rehab Leadership Staff
- Department Staff

#### PROCEDURE:

- In the event of a Disaster Alert-Phase:
  - The Rehab Services Leadership In Charge or their designee will be notified by Administration and advised of the circumstances.
- The Rehab-Leadership/Designees will then:
  - Notify the Outpatient clinic by phone if possible, two-way radio, or by-messenger in the event the phone/radio-is not working.
  - Review the Department's Disaster-Plan and call-back protocol.
  - Inventory equipment and supplies.
  - Emergency-evacuation/area of-refuge will-be located at the South-East corner of the parking lot.
- In the event of a Disaster Activation Phase:
  - 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.
  - Activate-the call-back protocol.
  - 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 hespital'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.
  - The Rehab Services Leadership In Charge will notify the Disaster Incident command (ICC) and Emergency Department of the Department's readiness.
  - The Rehab Services Leadership-In-Charge will submit periodic reports to the ICC.
  - The Department will be expected to assist in the management of disaster victims. Personnel will be requested to respond to triage areas.

Rehabilitation Services Manual
Outpatient Disaster Plan -2124 El Camino RealPage 2 of 2

- 4. Ongoing Review:
  - a. This Policy/Procedure will be reviewed and updated as needed.
  - b. It is the responsibility of the Department Leadership to crient and educate the staff to the plan, including periodic drills, to maintain an updated version of the plan and update the call back roster.



### **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:** 

08/1612/19

Department of Medicine Approval: Pharmacy and Therapeutics Approval:

n/a

Medical Executive Committee Approval:

n/a

Administration Approval:

n/a 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:

- In case of any medical, fire-or law enforcement-emergency, staff-members will-initiate
  apprepriate-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.
- 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.

### 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:** 

#### POLICY: A.

- 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.
- Patients or Insurance will not be charged for such equipment and it will be dispensed free of cost. 6.
- Such DME will be dispensed responsibly following patient/ caregiver training in its use. 7.

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.		

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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:  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.  2. The 2019 Community Health Needs Assessment is the road map for TCMC's community outreach and engagement.  3. Areas of TCMC support include:  Access to Healthcare  Community & Social Support  Economic Security & Education  Homelessness & Housing Instability		

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TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Presentation: Coastal Commitment Aaron Byzak, CEAO (cont.)	<ul> <li>4. The Coastal Commitment supports student opportunities through: <ul> <li>Guest speakers highlighting healthcare careers</li> <li>Tours</li> <li>Training assistance</li> <li>Lectures</li> <li>One-on-one shadowing experiences</li> <li>Internships</li> <li>Coaching and mentorship</li> </ul> </li> <li>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: <ul> <li>TCMC's involvement in Government Affairs includes: <ul> <li>Advocacy on issues of importance</li> <li>Health policy and legislative analysis</li> <li>Interactions with elected officials and key community leaders and stakeholders</li> </ul> </li> <li>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.</li> </ul> </li> </ul>		

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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	<ol> <li>Steve thanked Dr. Yamanaka for attending and applauded the work of the TCMC Physician Staff.</li> <li>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.</li> <li>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.</li> </ol>		

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TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CEO Update Steve Dietlin (cont.)	<ul> <li>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.</li> <li>Future goals include: <ul> <li>Crisis intervention</li> <li>Solutions for long-term patient needs</li> <li>Potential medical partnership with the County</li> </ul> </li> <li>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.</li> <li>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.</li> </ul>		

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TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
COO Update Scott Livingstone	Scott Livingstone was not present.		
Committee Communications	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.  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.  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.		

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TOPIC	DISCUSSION ACTION FOLLOW UP			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 C	HAC meeting was a	djourned at 1:45pm.			

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Tri-City M Vical Center
Finance, Operations and F Ining 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
Call to Order	Director Nygaard called the meeting to order at 8:33 a.m.		Chair
2. Approval of Agenda		MOTION It was moved by Director Grass, Dr. Mells seconded, and it was unanimously approved to accept the agenda of January 23, 2020. Members: AYES: Nygaard, Grass, Younger, Contardo, Ferber, Mells, Cumming, Fitzwilliam NOES: None ABSTAIN: None ABSENT: Shad	Chair
<ol> <li>Comments by members of the public on any item of interest to the public before committee's consideration of the item.</li> </ol>	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.  MOTION It was moved by Director Grass, Dr. Contardo seconded, and the minutes of October 24, 2019 were unanimously approved, with	Chair

Topic	Discussions, Conclus is Recommendations	Action Recommendations/ Conclusions	ر (son(s) Responsible
		Director Younger and Mr. Cumming abstaining from the vote.	
5. Old Business	None		
. New Business			
<ul> <li>a. 2020 – Meeting Schedule</li> <li>Finance, Operations &amp; Planning Committee</li> </ul>	Chair Nygaard encouraged the committee members retain the 2020 meeting schedule for future reference.  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:  Director Nygaard requested: 7.a. Physician Recruitment Proposal – Cardiovascular Surgeon  Darrell Wu, M.D.  7.c. Patient Accounting System & Interfaces  QuadraMed-Affinity	MOTION It was moved by Director Grass, Dr. Contardo seconded, and it was unanimously approved to accept the Consent Calendar for January 23, 2020. Members: AYES: Nygaard, Grass, Younger, Contardo, Ferber, Mells, Cumming, Fitzwilliam NOES: None ABSTAIN: None ABSENT: Shad	Chair
<ul> <li>a. Physician Recruitment Proposal – Cardiovascular Surgeon</li> <li>Darrell Wu, M.D.</li> </ul>	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.	MOTION 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	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).  Members: AYES: Nygaard, Grass, Younger, Contardo, Ferber, Mells, Cumming, Fitzwilliam NOES: None ABSTAIN: None ABSENT: Shad	
<ul> <li>b. Physician Agreement for ED</li> <li>On-Call Coverage -</li> <li>Ophthalmology</li> <li>Alexander Foster, M.D.</li> </ul>		Approved via Consent Calendar	Sherry Miller / Scott Livingstone
<ul> <li>c. Patient Accounting System &amp; Interfaces</li> <li>QuadraMed-Affinity Corp.</li> </ul>	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 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.  Members: AYES: Nygaard, Grass, Younger, Contardo, Ferber, Mells, Cumming, Fitzwilliam NOES: None ABSTAIN: None ABSTAIN: None	Mark Albright
<ul><li>d. Service Contract Agreement –</li><li>Video / Power</li><li>Stryker ProCare</li></ul>		Approved via Consent Calendar	Debra Feller
8. Financials:	Ray Rivas presented the financials ending December 31, 2019 (dollars in thousands)		Ray Rivas

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

Topic	Discussions, Conclucins Recommendations	Action Recommendations/ Conclusions	/son(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 <i>(semi-annual)</i>	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
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	х	Panel	1 Y	Other: Add Physician to Panel
Status of Agreement	х	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:	х	Yes	No
Approved by Chief Compliance Officer:	Х	Yes	No
Is Agreement a Regulatory Requirement:	х	Yes	No
Budgeted Item:	Х	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	х	Other: Software Support
Status of Agreement	New Agreement	х	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:	х	Yes		No
Approved by Chief Compliance Officer:		Yes	N/A	No
Is Agreement a Regulatory Requirement:		Yes	Х	No
Budgeted Item:	Х	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	х	Other: Service Plan
Status of Agreement	New Agreement	Х	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
  - I. SPY PHI Handheld (quantity: 1)

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

Person responsible for oversight of agreement: Debra Feller, Clinical Director, Surgery / Barbara Vogelsang, Chief Nurse Executive

#### ntion:

miove 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: ABSENT:

Directors:

None 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: ABSTAIN: Directors:

None 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: ABSTAIN: Directors:

None

ABSENT: Directors:

None None

- 15. Old Business none
- 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: ABSTAIN:

Directors:

None

ABSTAIN: Directors: ABSENT: Directors:

None 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 None

ABSTAIN: 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 14<sup>th</sup>.

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.
- Public Comments Announcement

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

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.

- 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.

 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.

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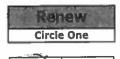
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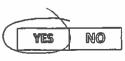
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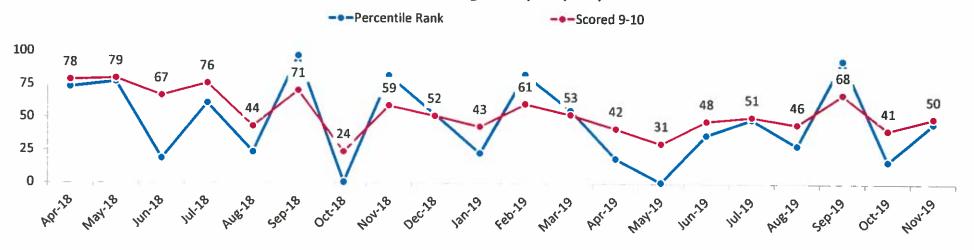
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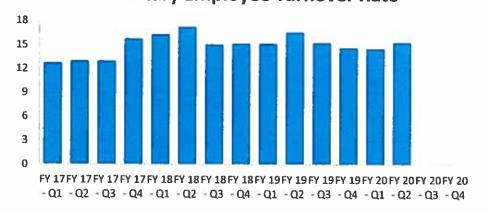
### ADVANCED HEALTH CARE

### **Stakeholder Experiences**

### **Overall Rating of Hospital (0-10)**

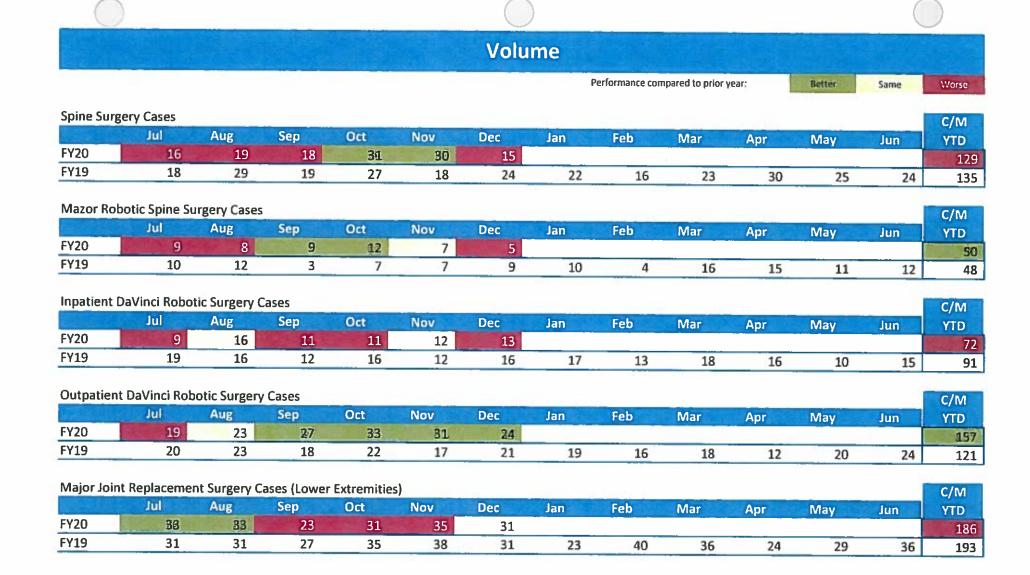


### **Voluntary Employee Turnover Rate**



### **Involuntary Employee Turnover Rate**





							Р	erformance con	apared to prior y	rear:	Better	Same	Worse
npatient B	lehavioral He		ge Daily Ce	nsus (ADC)									C/M
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
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Y19	10.8	11.3	9.7		-	-	-	-	-		-	2	5.
cute Reha	ab Unit - Ave	rage Daily C	ensus (ADC)	)									C/M
N 9 1	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
Y20	6.2	4.5	7.7	7.0	5.0	3.0					may	Juli	5.
Y19	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.
	- 3103	18/08										22.	
leonatal Ir	ntensive Care	Unit (NICU	) - Average	Daily Censu	is (ADC)								C/M
			Com	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
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Y19 lospital - / Y20 Y19	9.4 11.4 Average Dail Jul 143.4 160.3	10.3 9.8 y Census (Al Aug 143.6 155.9	13.4 10.0 DC) Sep 150.6 146.4	9.7 11.0 Oct 143.2 149.6	9.5 11.6 Nov 144.0 143.7	9.4 8.7 Dec 160.2 153.2	10.1 Jan 164.8	8.9 Feb 166.3	11.3 Mar 157.7	10.0 Apr 142.4	9.5 May 143.3	Jun 146.5	10. 10. C/M YTD 147. 151.
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Y19 Hospital - A Y20 Y19 Deliveries Y20 Y19	9,4 11.4  Average Dail Jul 143.4 160.3  Jul 168 186	10.3 9.8 y Census (Al Aug 143.6 155.9 Aug 171 202	13.4 10.0 DC) Sep 150.6 146.4 Sep 156	9.7 11.0 Oct 143.2 149.6 Oct 159 187	9.5 11.6 Nov 144.0 143.7 Nov 146 185	9.4 8.7 Dec 160.2 153.2 Dec 159	10.1 Jan 164.8 Jan 170	8.9 Feb 166.3	11.3 Mar 157.7 Mar	10.0 Apr 142.4 Apr	9.5 May 143.3	Jun 146.5	10. 10. C/M YTD 147. 151. C/M YTD 95 1,09



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### **Outpatient Cardiac Interventions**

A CONTRACTOR	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Dura	C/ IVI
FY20	7	5	12	6	11	9	3411	100	14101	whi	iviay	Jun	YTD 50
FY19	3	4	3	13	13	6	11	17	6	10	7	9	42

### **Open Heart Surgery Cases**

		0000			-								C/M
<b>C</b> ALL IN	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	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)

	asted ractor	(Total Neve		chacj		-		01019			1000		C/M
EMILES :	lut	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	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
A TOTAL CONTRACT						2.7.0	2172	4.75	1.73	1.02	1.00	1./5	

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Building Operating Leases Month Ending December 31, 201

Month Ending December 31, 2019	To Statement	i sa Base sa	-	or our personnel or are	- AA management of the	A STATE OF THE PARTY OF	and distance for the particular deposits of contract of the contract of	
		Rate per	133	Total Rent per	Lease	Torm		Pagina da Pa
Lessor	Sq. Ft.	Sq. Ft.	183	current month	Beginning	Endina	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carisbad, CA 92011 V#83024	Approx 9,552	\$3.59	(=)	46.367.60	07/01/17		OSNC - Carlsbad 6121 Paseo Del Norte, Suite 200	
American Health & Retirement DBA: Vista Medical Plaza 140 Lomas Santa Fe Dr., Ste 103 Solona Beach, CA 92075 V#82904	Approx 1,558	\$2.47		5,268.79	01/27/17		Carlsbad, CA 92011 PCP Clinic - Venus 2067 W. Vista Way, Ste 160 Vista, CA 92083	7095
Cardiff investments LLC 2729 Ocean St Carlsbad, CA 92008 V#83204	10,218	\$2.58	(a)	27,500.69	07/01/17	54	OSNC - Oceanside 3905 Waring Road Oceanside, CA 92056	7095
Creek View Medical Assoc 1926 Vla Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	\$2.70	(a)	21,112.00	02/01/15	01/31/20	PCP Clinic Vista 1926 Via Centre Drive, Ste A Vista, CA 92081	7090
CreekView Orhopaedic Bldg, LLC 1958 Via Centre Drive Vista, Ca 92081 V#83025	Approx 4,995	\$2.58	(a)	16,109.57	07/01/17	06/30/22	OSNC - Vista 1958 Via Centre Drive Vista, Ca 92081	7095
Eflin Investments, LLC Clancy Medical Group 20136 Elfin Creek Trail Escondido, CA 92029 V#82575	3,140	\$2.62	(a)	10,101.37	12/01/15		PCP Clinic - Clancy 2375 Melrose Dr. Vista Vista, CA 92081	7091
Meirose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	7,347	\$1.35	(a)	10,399.54	07/01/16		Outpatient Behavioral Health 510 West Vista Way Vista, Ca 92083	7320
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	4,760	\$4.12	(a)	27,850.00	10/01/12	10/01/22	Chemotherapy/Infusion Oncology Center 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
SCRIPPSVIEW MEDICAL ASSOCIATES P O Box 234296 Encinitas, CA 234296 V#83589	3,864	\$3.45	(a)	13,316.37	08/08/19		Encinitas Medical Center 351 Santa Fe Drive, Suite 351 Encinitas, CA 92023	7095
Tota	1			\$ 178,025.93				1

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





Education & Travel Expense
Month Ending December 2019

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	B0734	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
	AHA ACLS UPDATE	121919 AHA	150.00	79784	DEANNA DALY
	PALS RENEWAL	121219 EDU	160.00	83465	ALLAN MEDINA
	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

<sup>\*\*</sup>This report shows reimbursements to employees and Board members in the Education

<sup>&</sup>amp; Travel expense category in excess of \$100.00.

<sup>\*\*</sup>Detailed backup is available from the Finance department upon request.