TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A SPECIAL MEETING
March 26, 2020 – 4:00 o'clock p.m.

In accordance with the current State of Emergency and the Governor's Executive Order N- 25-20, of March 4, 2020, and N-33-20 of March 19, 2020 teleconferencing will be used by the Board members and appropriate staff members during this meeting. Members of the public will be able to participate by telephone, using the following dial in information:

Dial in #: (877-304-9269) To Listen and Address the Board when called upon: Passcode: 784175#

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	Roll Call / Pledge of Allegiance	3 min.	Standard
4	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
5	TCHD Auxiliary Informational Report	5 min.	Chair
6	New Business a) Consideration to approve Resolution No. 798, A Resolution of the Board of Directors of the Tri-City Healthcare District Board of Directors Granting Emergency Authority to the CEO During the Pendency of the Declaration of a State of Emergency	10 min.	Chair
7	Old Business – None		

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

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

	Agenda Item	Time Allotted	Requestor
8	Consideration of Consent Calendar ***(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) Requested items to be pulled require a second.*** a) Consideration to approve a Physician Recruitment Agreement with Dr. Kristen Blaker, Colorectal Surgery physician. b) Approval of the addition of Dr. Jessica Gomez to the ED On Call Coverage Panel for Ophthalmology for 12 months, beginning April 1, 2020 and ending March 31, 2021. c) Approval of the addition of Dr. Bradley Frasier M.D. to the ED On-Call Coverage Panel for Urology for 12 months, beginning April 1, 2020 and ending June 30, 2021. d) Approval of an agreement with the University of Colorado for Dr. Farhouch Berdjis as the coverage physician for a term of 12 months beginning April 1, 2020 through March 31, 2021, not to exceed an average of $250 per day for an annual and term cost of $45,500. e) Approval of the renewal of a physician EKG and echo-cardiology panel agreement with Dr. Hamid Movahhedian for a term of 12 months beginning April 1, 2020 through March 31, 2021, for $250 per day, for a total amount for the term not to exceed $45,750. f) Approval of an agreement with Roche Diagnostics Corporation for instruments and consumables for a term of seven years, beginning April1, 2020 through March 31, 2027 for an annual cost not to exceed $252,000 and a total term not to exceed $1,764,000. g) Approval of an agreement with Direct Difference, Inc. for chart abstraction services for a term of 24 months, beginning March 27, 2020 through March 26, 2022, for an annual cost of $150,000 and a total cost for the term of $300,000. h) Approval of an agreement with Medtronic, USA Service and Support for Mazor #1 and #2 for a term of 24 months, beginning February 29, 2020 through February 28, 2022, for an annual cost of $162,400 and a total cost for the term of $324,800. i) Approval of the addition of Dr. Iris Arrieta to the ED On-Call Coverage Panel for OBGYN for 12 months, beginning April 1, 2020 and ending June 30, 2021. j) Approval of Mr. Jack Cumming to an additional two-year term on the Finance, Operations & Planning Committee **(3) Administrative & Board Committees** (1) Administrative Committee **a) Patient Care Services Policies & Procedures** 1) Telephone Service for Patient Rooms	10 min.	Standard

	Agenda Item	Time Allotted	Requestor
	b) Administrative Policies & Procedures 1) Student Clinical Rotation Education 249 2) Password Security 619		
	c) Unit Specific - Medical Staff 1) Appropriate Use of Commercial Support and Exhibits 8710-603 2) CME Speaker & Honoraria Reimbursement 8710-604 3) Conflict of Interest for Medical Staff 8710-555 4) Conflict of Interest Resolution 8710-605 5) Conflict Resolution Policy 8710-562 6) Credentialing Policy, Mazor Robotic-Assisted Surgery 8710-566 7) Cultural and Linguistic Proficiency 8710-601 8) Disaster Privileges 8710-553 9) Emergency Department Call: Duties of the On-Call Physician 8710-520 10) Joint Providership Co-Providership 8710-602 11) Medical Staff Governance Documents Development and Review and Approval Mechanism 8710-500 12) Name Tags for Health Practitioners 8710-521 13) Physician Orders Family Members 8710-529 14) Physician's Well-Being Committee Policy 8710-511 15) Professional Behavior Policy & Committee 8710-570 16) Regularly Scheduled Series (RSS) 8710-606		
	e) Pay Practice 1) Compensation for Mandatory Education – 474.01		
	f) Unit Specific – Pulmonary Rehab 1) Glucose Monitoring and Exercise Therapy for Diabetic (DELETE)		
	g) Unit Specific – Surgical Services 1) Age Appropriate Care Policy 2) Paracetic Acid: Disposal of Policy (DELETE) 3) Traffic Patterns Policy		
	(4) Board Committees		
	A. Community Healthcare Alliance Committee Director Chavez, Committee Chair *(No meeting held in March, 2020)*		CHAC Comm.
	B. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 0 *(No meeting held in March, 2020)*		FO&P Comm.
	C. Audit, Compliance & Ethics Committee Director Younger, Committee Chair Open Community Seats – 0 *(No meeting held in March, 2020)*		Audit, Comp. & Ethics Comm.
	(5) Minutes – Approval of: a) February 27, 2020 - Regular Meeting		Standard
	(6) Meetings and Conferences – None		

	Agenda Item	Time Allotted	Requestor
	(7) Dues and Memberships - None (8) Reports (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (February, 2020) (d) Reimbursement Disclosure Report – (February, 2020) (e) Seminar/Conference Reports – None		
10	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
11	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
12	Comments by Chief Executive Officer	5 min.	Standard
13	Board Communications (three minutes per Board member)	18 min.	Standard
14	Report from Chairperson	3 min.	Standard
15	Total Time Budgeted for Open Session	1 hour	
16	Adjournment		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2020
Physician Recruitment Proposal

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

Physician Name: Kristen Blaker, M.D.
Areas of Service: Colorectal Surgeon
Key Terms of Agreement:

Effective Date: July 1, 2020 or the date Dr. Blaker 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 Colorectal 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	$20,000
Income Guarantee, NTE	$325,000 annually ($650,000 for two-years with a three-year forgiveness period)
Total Loan Amount, NTE	$670,000
Total Amount of Request:	**$680,000**

Requirements:

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

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

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

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director Business Development / Scott Livingstone, Chief Operating Officer

Motion:

I move that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the communities served by the District to approve the expenditure, not to exceed $680,000 in order to facilitate this Colorectal Surgery physician practicing medicine in the communities served by the District. This will be accomplished through a physician recruitment agreement (not to exceed a two-year income guarantee with a three-year forgiveness period).

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Ophthalmology

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

Physician's Name: Jessica Gomez, M.D.

Area of Service: Emergency Department On-Call: Ophthalmology

Term of Agreement: 12 months, Beginning, April 1, 2020 – Ending, March 31, 2021

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Ophthalmology
Adding physician to existing panel, no increase in expense

Rate/Day	Panel Term Cost
$300	$109,800

Position Responsibilities:

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

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

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

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

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Urology

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

Physician's Name: Bradley Frasier M.D.

Area of Service: Emergency Department On-Call: Urology

Term of Agreement: 15 months, Beginning, April 1, 2020 – Ending, June 30, 2021

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Urology
Adding physician to existing panel, no increase in expense

Rate/Day	Panel Days per Year	Total Term Cost
$650	FY2020: 366	$237,900
$650	FY2021: 365	$237,250
	Total:	**$475,150**

Position Responsibilities:

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

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

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

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors add Bradley Frasier, M.D. to the ED On-Call Coverage Panel for Urology for 15 months, beginning April 1, 2020 and ending June 30, 2021.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2020
Physician Agreement for Pediatric EKG Panel

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

Name: University of Colorado Medicine - Professional Services Agreement on behalf of Dr. Farhouch Berdjis *(Current 3-year pediatric panel contract with Dr. Berdjis to be cancelled on March 31, 2020)*

Area of Service: Pediatric EKG Panel

Term of Agreement: 12 months, Beginning, April, 1, 2020 – Ending, March, 31, 2021

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

Rate/Day	Days per Year	12 month (Term) Cost
$250	182	$45,500

Position Responsibilities:

- Panel Physician shall read and interpret electrocardiograms ("ECGs" or "EKGs"), signal average ECGs and Holter Monitor examinations of pediatric and neonatal intensive care unit ("NICU") patients not assigned to another Pediatric Cardiology Division member (i.e. "unassigned" patients for which the attending physician does not specify an interpreting cardiologist).
- Panel Physician shall perform and interpret echocardiographic studies of "unassigned" patients for which the attending physician does not specify an interpreting pediatric cardiologist.
- Panel Physician shall provide cardiac consultations per the request of a pediatrician or neonatologist. These consults are to be provided within 24 hours of request and the final report documented with 24 hours of performance.
- Panel Physician shall be scheduled for coverage periods from one day to one week periods beginning Mondays at 0700 hours through the following Monday at 0700 hours, during which time such Panel Physician shall be personally responsible for supervising and interpreting all non-invasive cardiology tests on a timely basis, or by assigning another Panel Physician (with that Panel Physician's agreement) to do so. Please note, however, that the compensation set forth in the Agreement will remain constant, regardless of the number of Panel Physician furnishing Services in a given week.

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

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

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with the University of Colorado for Dr. Farhouch Berdjis as the coverage physician for a term of 12 months beginning April, 1, 2020 and ending, March, 31, 2021. Not to exceed an average of $250 per day for an annual and term cost of $45,500.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2020
Pediatric Cardiology Physician Panel Agreement for Coverage

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

Physician's Name: Hamid Movahhedian, M.D. *(Current Pediatric panel 3-year contract with Dr. Movahhedian to be cancelled on March 31, 2020.)*

Area of Service: Cardiology (Pediatric/NICU)

Term of Agreement: 12 months, Beginning, April 1, 2020 – Ending, March 31, 2021

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

Rate/Day	Days per Year	12 month (Term Cost)
$250	183	$45,750

Position Responsibilities:

- Panel Physician shall provide cardiac consultations per the request of a pediatrician or neonatologist. These consults are to be provided within 24 hours of request and the final report documented with 24 hours of performance.
- Panel Physician shall be scheduled for coverage periods from one day to one week periods beginning Mondays at 0700 hours through the following Monday at 0700 hours, during which time such Panel Physician shall be personally responsible for supervising and interpreting
- all non-invasive cardiology tests on a timely basis, or by assigning another Panel Physician (with that Panel Physician's agreement) to do so. Please note, however, that the compensation set forth in the Agreement will remain constant, regardless of the number of Panel Physician
- furnishing Services in a given week.
- ECGs are to be interpreted twice daily on weekdays (Monday-Friday) and at least once per day on weekends (Saturday, Sunday or holidays).

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

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

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors approve the renewal of the physician EKG and echo-cardiology panel agreement with Dr. Hamid Movahhedian for a term of 12 months beginning April 1, 2020 and ending on March 31, 2021, for $250 per day, for a total amount for the term not to exceed $45,750.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2020
Histology Tissue Processing Instruments & Consumables Proposal

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

Vendor's Name: Roche Tissue Diagnostics

Area of Service: Laboratory – Histology & Pathology

Term of Agreement: 7 years, Beginning, April 1, 2020 – Ending, March 31, 2027

Bid Process Requirement:

Yes		**No**	X

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$21,000	$252,000	$1,764,000

Description of Services/Supplies:

- The Roche Ventana Benchmark Ultra is our core instrument of choice for performing automated immunohistochemical (IHC) staining of slides of surgical pathology specimens, and the Benchmark Special Stainer does the same for our automated special staining procedures.
- The laboratory has implemented quality improvement and cost reduction initiatives to reduce the cost of testing by combining the control tissue on the same slide as the patient tissue. This amendment lowers our purchase commitment, and thus, the total annual expenditure by $530,064 compared to the original agreement.
- This proposal includes (4) instruments, 7 years of service on the instruments, 7 years of consumables, and the removal of the proprietary specimen tracking system (Vantage), as we are changing vendors to Cerner for a similar functionality. The consumables are primarily reagents, quality control and calibration material.
- This time-sensitive proposal is predicated on the execution of a new agreement by April 1, 2020.

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

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

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Roche Diagnostics Corporation for instruments and consumables for a term of 7 years, beginning April 1, 2020 and ending March 31, 2027, for an annual cost not to exceed $252,000 and a total cost for the term not to exceed $1,764,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2020
Chart Abstraction Services Proposal

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

Vendor's Name: Direct Difference, Inc.

Area of Service: Quality / Performance Improvement

Term of Agreement: 24 months, Beginning, March 27, 2020 – Ending, March 26, 2022

Bid Process Requirement:

Yes		**No**	X

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$12,500	$150,000	$300,000

Description of Services/Supplies:

- Chart Abstraction for IQR/OQR/IPFQR/TJC/CPQCC/CMQCC/PSH/GWTG - Stroke Measures
- The above listed chart abstracted measures are required by CMS/TJC and or state regulatory agencies.

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

Person responsible for oversight of agreement: Jaclyn Hunter, Clinical Quality Manager - Performance Improvement Department / Barbara Vogelsang, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Direct Difference, Inc. for chart abstraction services for a term of 24 months, beginning March 27, 2020 and ending, March 26, 2022 for at an annual cost of $150,000 and a total cost for the term of $300,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2020
Service & Support Agreement Proposal

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

Vendor's Name: Medtronic, USA

Area of Service: Surgery - Spine Surgical Cases

Term of Agreement: 24 months, Beginning, February 29, 2020 – Ending, February 28, 2022

Bid Process Requirement:

Yes		**No**	X

Maximum Totals:

	Mazor #1	**Mazor #2**	**Annual Cost**
Year #1:	$81,200	$81,200	$162,400
Year #2:	$81,200	$81,200	$162,400
		Total Term Cost	**$324,800**

Description of Services/Supplies:

- Mazor #1 Service & Support Agreement - Serial # 300-17-122011
- Mazor #2 Service & Support Agreement - Serial # 300-28-062012

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

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

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Medtronic, USA Service and Support Agreements for Mazor #1 & #2 for a term of 24 months, beginning February 29, 2020 and ending, February 28, 2022 for an annual cost of $162,400, and a total cost for the term of $324,800.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March , 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – OB/GYN

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

Physician's Names: Iris Arrieta, MD

Area of Service: Emergency Department On-Call: OB/GYN
Term of Agreement: 15 months, Beginning, April 1, 2020 – Ending, June 30, 2021
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Maximum Totals: For entire Current ED On-Call Area of Service Coverage:

OB-GYN - Rate/Day	Panel Days per Year	Panel Annual Cost
Weekday $800 Weekend/holiday $1000	FY20: 254 FY20: 110	$204,000 $100,000
Weekday $800 Weekend/holiday $1000	FY21: 253 FY21: 111	$202,400 $111,000
Total Term Cost:		**$617,400**

Position Responsibilities:

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

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

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

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Iris Arrieta, MD as the OB/GYN ED-Call Coverage Physicians for a term of 15 months, beginning April 1, 2020 and ending June 30, 2021 at daily rate of $800 (weekday) and $1,000 (weekend/holiday), for an annual cost of $204,400 and $100,000 for FY 2020, and an annual cost of $204,400 and $111,000 for FY 2021 for a total cost for the term of $617,400.

Finance, Operations and Planning Committee

Date of Meeting: March 19, 2020

Discussion:

- Mr. Jack Cumming

Second Term Request - Community Member, Finance, Operations & Planning Committee

Projected Second Term Dates: April 2020 – April 2022

ADMINISTRATION CONSENT AGENDA
March 18th, 2020

CONTACT: Barbara Vogelsang, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Telephone Service for Patient Rooms Policy	3 Year Review, Practice Change	Forward To BOD For Approval
Administrative Policies & Procedures		
1. Student Clinical Rotation Education 249	3 Year Review, Practice Change	Forward To BOD For Approval
2. Password Security 619	3 Year Review	Forward To BOD For Approval
Unit Specific		
Medical Staff		
1. Appropriate Use of Commercial Support and Exhibits 8710 – 603	1 Year Review	Forward To BOD For Approval
2. CME Speaker & Honoraria Reimbursement 8710 – 604	1 Year Review	Forward To BOD For Approval
3. Conflict of Interest for Medical Staff 8710 - 555	3 Year Review	Forward To BOD For Approval
4. Conflict of Interest Resolution 8710 – 605	1 Year Review	Forward To BOD For Approval
5. Conflict Resolution Policy Medical Staff 8710-562	3 Year Review	Forward To BOD For Approval
6. Credentialing Policy, Mazor Robotic-Assisted Surgery 8710-566	3 Year Review, Practice Change	Forward To BOD For Approval
7. Cultural and Linguistic Proficiency 8710 – 601	1 Year Review	Forward To BOD For Approval
8. Disaster Privileges 8710-553	3 Year Review	Forward To BOD For Approval
9. Emergency Department Call: Duties of the On-Call Physician 8710-520	3 Year Review	Forward To BOD For Approval
10. Joint Providership Co-Providership 8710 – 602	1 Year Review	Forward To BOD For Approval
11. Medical Staff Governance Documents Development and Review and Approval Mechanism 8710-500	3 Year Review	Forward To BOD For Approval
12. Name Tags for Health Practitioners 8710-521	3 Year Review	Forward To BOD For Approval
13. Physician Orders Family Members 8710-529	3 Year Review	Forward To BOD For Approval
14. Physician's Well-Being Committee Policy 8710-511	3 Year Review	Forward To BOD For Approval
15. Professional Behavior Policy & Committee 8710-570	3 Year Review	Forward To BOD For Approval
16. Regularly Scheduled Series (RSS) 8710 – 606	1 Year Review	Forward To BOD For Approval
Pay Practice		
1. Compensation for Mandatory Education - 474.01	Practice Change	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
March 18th, 2020

CONTACT: Barbara Vogelsang, CNE

Pulmonary Rehab		
1. Glucose Monitoring and Exercise Therapy for Diabetic	DELETE	Forward To BOD For Approval
Surgical Services		
1. Age Appropriate Care Policy	3 Year Review, Practice Change	Forward To BOD For Approval
2. Paracetic Acid: Disposal of Policy	DELETE	Forward To BOD For Approval
3. Traffic Patterns Policy	3 Year Review, Practice Change	Forward To BOD For Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 3/65

SUBJECT: Telephone Service for Patient Rooms

REVISION DATE: 5/88, 9/91, 10/96, 3/00, 11/00, 6/03, 8/05, 7/07, 5/10, 03/17

POLICY NUMBER: II.G

Department Approval:	~~12/16~~11/19
Clinical Policies & Procedures Committee Approval:	~~01/17~~12/19
Nurse Executive Council Approval:	~~02/17~~02/20
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	~~03/17~~03/20
Board of Directors Approval:	03/17

A. **POLICY:**

1. Tri-City Medical Center (TCMC) shall allow telephone access to and from patient rooms while providing adequate amounts of rest for both patients in the room.
   ~~a. Behavioral Health Services – Public phones are available for patients.~~
2. All telephones in patient rooms have the capability for direct dialing. Patients can initiate and receive phone calls on a twenty-four hour basis.
3. Incoming calls to the P.B.X. operator shall not be connected to the patient rooms between the hours of 2200 and 0700 but shall be referred to the Nursing Unit.
4. If telephone communications need to be limited based on nursing assessment or patient behaviors, the process shall be verbally explained to the patient and/or family. Restrictions shall be evaluated by nursing for their effectiveness, so that at the earliest possible time the restriction may be lifted.
5. At the patient's request, phone service may be blocked.
6. Accommodations shall be made for patients requesting a private area for telephone usage. The ~~Assistant Nurse-~~Manager**ment Team/designee** or the Administrative Supervisor may be contacted for assistance.

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE POLICY MANUAL
DISTRICT OPERATIONS

ISSUE DATE: 5/95 **SUBJECT:** Student ~~Clinical~~ Rotation/Education

REVISION DATE: 4/98; 4/02; 12/02; 9/05; 11/08; 12/10, 09/16 **POLICY NUMBER:** 8610-249

Administrative Content Expert Approval:	**02/20**
Administrative Policies & Procedures Committee Approval:	**~~08/16~~02/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a/**
Administration Approval:	**03/20**
Professional Affairs Committee Approval:	**~~09/16~~ n/a**
Board of Directors Approval:	**09/16**

A. **PURPOSE:**

1. To ensure a consistent policy for establishing student clinical affiliations.

B. **POLICY:**

1. A written ~~clinical~~ affiliation agreement must be approved before students are allowed to participate in ~~clinical~~ education. The ~~clinical~~ affiliation agreements are to be coordinated by the Education Department.
2. Tri-City Healthcare District (TCHD) utilizes an education affiliation agreement for organizations requesting educational experiences (internships, shadowing, etc) for their students:
   a. Tri-City Medical Center (TCMC) ~~Clinical~~ Education Affiliation Agreement will be completed for all ~~clinical~~ placements
   b. All schools must sign a copy of the Business Associate Agreement provided by the Compliance Department.
3. Education staff will review any requested changes to the standard ~~Clinical~~ Education Affiliation Agreement with the **Legal**~~Compliance~~ Department for appropriateness and legal concerns.
4. Any necessary changes will be communicated directly to the school for discussion and approval.
5. The ~~Clinical~~ Affiliation Agreement is then sent to Administration for final review and signature approval.
6. Copies of the approved agreement are retained in the Education Department, the online contract database and sent to the school.
7. Scheduling of clinical education for nursing students will be coordinated by the Education Department. ~~Clinical e~~Education of all other students will be coordinated by the appropriate service or department.
   a. All students must complete TCMC **non-employee** orientation requirements prior to starting their internship/shadow experience. The Education Department provides a self-paced student orientation and maintains orientation paperwork.
8. The schools of Nursing are apprised on a continuing basis regarding census fluctuation and the availability of clinical opportunities for students.
   a. All schools of Nursing are invited to participate in a Nursing Faculty meeting at the Medical Center to discuss clinical schedules and current issues as needed.
9. Cancellation of ~~Clinical~~ Affiliation Agreements when requested by departments will be coordinated by the Education Department and approved by Administration.

C. **FORMS:**

1. ~~Clinical~~ Education Affiliation Agreement

2. Business Associate Agreement Form

D. **RELATED DOCUMENTS:**

1. Patient Care Services (PCS) Policy: Nursing Students in Patient Care Areas
2. PCS Policy: Allied Health Students in Patient Care Areas
3. PCS Policy: Nursing Students in Advanced Practice

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
INFORMATION TECHNOLOGY

ISSUE DATE: 3/04 **SUBJECT: Password Security**

REVISION DATE: 2/05; 11/08; 067/12 **POLICY NUMBER:** 8610-619

Administrative Content Expert:	**02/20**
Administrative Policies & Procedures Committee Approval:	**~~06/12~~02/20**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**03/20**
Professional Affairs Committee Approval:	**~~07/12~~ n/a**
Board of Directors Approval:	**07/12**

A. **SCOPE**

1. This policy applies to all Tri-City Healthcare District (TCHD) computers, including desktop computers, laptops, servers, and any other computers, and all Authorized Users of Tri-City Healthcare District (TCHD) Network, Email, Internet, or Remote Access Services, including employees, internal and external case managers, authorized physicians, vendors and other persons engaged in legitimate business at TCHD.

B. **PURPOSE**

1. A Password is an important aspect of computer security. It is the front line of protection for each user. A poorly chosen password may result in unauthorized access to critical patient or financial information. Each TCHD Authorized User is responsible for taking the appropriate steps to select a secure password. The purpose of this policy is to establish a standard for strong passwords, the protection of those passwords, and the frequency of change.

C. **POLICY**

1. Each password must be changed at least every six months, and must conform to the guidelines described below.

D. **PROCEDURE**

1. General Password Construction
   a. A strong password has the following characteristics:
      i. Contains both upper and lower case characters (e.g., a-z, A-Z)
      ii. Contains digits and punctuation characters, as well as letters
      iii. Is at least seven alphanumeric characters long.
      iv. Is not a word in any language, slang, dialect, jargon
      v. Is not based on personal information (e.g. family, pets, friends, birthdays, addresses, phone numbers, co-worker names)
      vi. Does not contain the words "Tri-City," "Oceanside," "Carlsbad," "Vista" or any derivation.
      vii. Does not contain common words.
      viii. Is -easily remembered by you, but hard to guess. For example, a password could be based on a song title, affirmation, or other phrase, such as "This May Be One Way To Remember" and the password could be: "TMB1w2r!" or "TmB1wTrr" or some other variation.
      NOTE: Do not use either of these examples as passwords
2. Password Protection
   a. Each password is to be treated as Confidential District information.

b. Mobile communication devices such as smartphones must be secured with a password to protect any data that might reside on the device.
c. Do not write passwords down and store them anywhere in your office.
d. Use encryption if you store passwords in a file on a computer system (PDA, laptop or similar devices).
e. Do not share your TCHD password with anyone, including administrative assistants or secretaries.
f. Do not reveal a password over the phone to anyone.
g. Do not reveal a password in an email message
h. Do not reveal a password to your boss or co-workers
i. Do not talk about a password in front of others
j. Do not hint at the format of a password (e.g., "my family name")
k. Do not reveal a password on questionnaires or security forms
l. Do not share a password with family members
m. If someone demands a password, have the person call the Information Technology Department Help Desk.
n. If you believe that someone has learned your password, immediately change the password and report the incident to the Information Technology Help Desk.

3. Violations
   a. Adherence to this Policy is neither voluntary nor optional. Violation of this policy may constitute grounds for formal counseling, up to and including termination, as described in Administrative **Human Resources** Policy:~~424,~~ Coaching and Counseling for Work Performance **424**. If necessary, TCHD also reserves the right to advise appropriate legal officials of any illegal violations.
4. Legal Notice
   a. California Penal Code 502 states that unauthorized use of a computer in the state of California is a felony.
5. Notification of Improper Use
   a. Each employee is expected to report unauthorized use or violation of this policy to the employee's manager or to the Information Technology Department.

E. RELATED DOCUMENT(S):

~~a.~~**1. Administrative Human Resources Policy:Coaching and Counseling for Work Performance 424**

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 03/06	**SUBJECT:** Appropriate Use of Commercial Support and Exhibits
REVISION DATE(S): 05/08, 11/12, 12/15, 06/18, 03/19	**POLICY NUMBER:** 8710-603
Medical Staff Department Approval:	03/17, 01/19, 02/20
CME Committee Approval:	04/08, 10/12, 10/15, 01/18, 01/19, 02/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	05/08, 11/12, 11/15, 05/18, 02/19, 02/20
Administration Approval:	03/19, 03/20
Professional Affairs Committee Approval:	06/18, n/a
Board of Directors Approval:	05/08, 11/12, 12/15, 06/18, 03/19

A. PURPOSE:

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

B. DEFINITION(S):

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

C. POLICY:

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

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

c. TCHD is not required to accept advice or services from the commercial interest regarding presenters or content as conditions of contributing funds or services. Content development must remain beyond the control of the commercial supporter. Content validation by the provider should be established.

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

i. Written Agreement documenting terms of support

1) TCHD and the commercial supporter will have a written agreement indicating the terms, conditions, and purposes of the commercial support for all directly and jointly sponsored activities.

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

3) The Letter of Agreement must be signed by TCHD (accredited provider) and commercial supporter.

ii. Expenditures for an individual providing CME

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

2) TCHD CME Committee/designee is responsible for payment of honoraria and expense reimbursement in compliance with policy governing such.

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

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

iii. Expenditures for learners

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

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

iv. Accountability

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

5. Standard 4: Appropriate Management of Associated Commercial Promotion

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

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

c. Educational materials such as slides, abstracts and handouts cannot contain any advertising, trade name or product message.

d. The program book which contains non-CME elements that are not directly related to the transfer of education may include product promotion material or product specific advertisement.

e. Commercial interests cannot provide a CME activity to learners either by distribution of self-study activities or arranging for electronic access to CME activities. The commercial supporter may distribute promotional materials developed by the provider.
f. CME Exhibits are not considered "Commercial Support;" however, the ACCME Standards of Commercial Support apply with regard to the location of the exhibits.
   i. Exhibitors may not display exhibits in the same room as the CME activity or in the direct path of the activity.
   ii. Exhibitors may not promote products or services directly prior to, during, or immediately following the CME activity in the same lecture hall.
   iii. Exhibitors/vendors are required to complete a "CME Exhibit Request Form." Prior approval from the CME Committee/designee is required for vendors to exhibit during a TCHD sponsored CME activity.
   iv. Reasonable exhibit fees shall be assessed to exhibitors in an amount to be determined by the CME Committee, but shall not be less than $500, and are due and payable to "TCHD Medical Staff Treasury" prior to the activity.

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

D. RELATED DOCUMENT(S):

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

E. REFERENCE(S):

1. Accreditation Council for Continuing Medical Education (ACCME) Standards for Commercial Support
2. *Institute for Medical Quality (IMQ)/California Medical Association (CMA) 2017 CME Accreditation Standards Manual/ Essential areas and their Elements/ Accreditation Criteria*
   a. Element 3.3: The provider must present CME activities in compliance with the ACCME's policies for disclosure and commercial support

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 10/05	**SUBJECT:** CME Speaker & Honoraria Reimbursement
REVISION DATE(S): 05/09, 11/12, 12/15, 06/18, 03/19	**POLICY NUMBER:** 8710-604
Medical Staff Department Approval:	03/17, 01/19, 01/20
CME Committee Approval:	04/09, 10/12, 10/15, 01/18, 01/19, 01/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	05/09, 11/12, 11/15, 05/18, 02/19, 02/20
Administration Approval:	03/19, 03/20
Professional Affairs Committee Approval:	06/18, n/a
Board of Directors Approval:	05/09, 11/12, 12/15, 06/18, 03/19

A. **PURPOSE:**

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

B. **POLICY:**

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

C. **PROCEDURE:**

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

D. **REFERENCE:**

1. ACCME Standards of Commercial Support – Standard 3.7

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE:	**09/09**	**SUBJECT:**	**Conflict of Interest Policy for Medical Staff**
REVISION DATE(S): 09/09, 04/17		**POLICY NUMBER:**	**8710-555**

~~Department Approval Dates(s):~~	**~~03/17~~**
Medical Staff Department Approval ~~Date(s)~~:	**09/09, 03/17, 02/20**
Medical Staff Committee Approval:	**n/a**
Pharmacy and Therapeutics Approval ~~Date(s)~~:	**n/a**
Medical Executive Committee Approval ~~Date(s)~~:	**03/17, 02/20**
Professional Affairs Committee Approval ~~Date(s)~~:	**04/17, 03/20**
Board of Directors Approval ~~Date(s)~~:	**04/17**

A. **PURPOSE:**
1. To safeguard the integrity and reputation of Tri-City Healthcare District (TCHD) and their medical staffs by fostering the proper and unbiased conduct of all medical staff activities.
2. To encourage unbiased, responsible management and decision-making.

B. **DEFINITIONS**
1. Conflict of Interest: a divergence between an individual's private interests and his/her professional obligations to the medical staff, hospital, patients, and employees, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by considerations of personal gain, financial or otherwise.
2. Immediate family: Spouse, children, parents, siblings, or equivalents by marriage, or others residing in the physician's household.
3. This policy serves to:
   a. Describe situations that are prohibited.
   b. Educate medical staff members about situations that generate conflicts of interest.
   c. Provide means for the medical staff and the Hospital to disclose and manage conflicts of interest.
   d. Promote the best interests of patients, their families, employees, and other practitioners.

C. **POLICY:**
1. Medical Staff members shall conduct their affairs so as to avoid or minimize conflicts of interest, and must respond appropriately when conflicts of interest arise. The following are representative, but not inclusive, of conflict of interest situations:
   a. Influence on purchases of equipment, instruments, materials, or services for TCHD from the private firms in which the medical staff member, or an immediate family member, has a financial interest.
   b. Unauthorized disclosures of patient or Hospital's information for personal gain.
   c. Provide, offer, or promise anything of value, as a representative of TCHD to any government official to enhance relations with that official or the government.
   d. Transmit to a private firm or other use for personal gain of TCHD supported work, products, results, materials, record, or information that are not generally made available.
   e. Influence upon the negotiation of contracts between TCHD and private organizations with which the medical staff member, or immediate family member, has consulting or other significant relationships, or will receive favorable treatment as a result of such influence.
   f. Improper use of institutional resources for personal financial gain.

g. Accept compensation or free services from a vendor, service provider, or contractor of TCHD, when the medical staff is in a position to determine or influence TCHD's purchases from those persons.

2. All members of the Medical Staff shall complete a general disclosure statement upon appointment and reappointment.
3. Candidates for Medical Staff elected offices must submit a Conflict of Interest statement.
4. Whenever a medical staff member is in a situation where he/she may have a potential conflict of interest, he/she shall make a full disclosure in writing to the Chief of Staff with details of the situation to request an exception.
   a. For any conflict of interest disclosed, the Chief of Staff shall evaluate and determine how the conflict of interest may be managed or avoided.
   b. Confirmed conflict of interest may be disclosed to the Medical Executive Committee by the Chief of Staff.
5. Suspected violations of this policy shall be reported to and evaluated by the Chief of Staff. Reports are confidential and shall remain anonymous.
6. Disciplinary action, if indicated, shall be taken in accordance with the Medical Staff Bylaws.
7. A confirmed conflict of interest shall result in one or more of the following:
   a. Disclosure of the conflict of interest to the Medical Executive Committee;
   b. Abstention from voting on the matter to which the conflict relates;
   c. Recusal from the decision-making process and participation in, including the receipt of information related to the matter to which the conflict relates.

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

1. Conflict of Interest Form - Sample

E. **REFERENCES:**

1. Joint Commission Standards 2017
2. Conflict of Interest Guidelines for Organized Medical Staffs. American Medical Association.

Tri-City Medical Center

Conflict of Interest Form - Sample

Practitioner Name:_____ **Date:**_____
Print

Do you have any relationships that may be considered as potential conflict of interest which may include, but may not be limited to, other care providers, educational institutions, manufacturers, and payers? (See Medical Staff Policy, *Conflict of Interest Policy for Medical Staff, 8710-555*)

Yes _____ **No**_____

If you answered "YES," please disclose them in the space provided below.

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Practitioner Signature

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 05/08	**SUBJECT: Conflict of Interest Resolution**
REVISION DATE(S): 05/08, 11/12, 08/14, 06/18, 03/19	**POLICY NUMBER: 8710-605**
Medical Staff Department Approval:	**03/17, 01/19, 01/20**
CME Committee Approval:	**04/08, 10/12, 08/14, 01/18, 01/19, 02/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**05/08, 11/12, 08/14, 05/18, 02/19, 02/20**
Administration Approval:	**03/19, 03/20**
Professional Affairs Committee Approval:	**06/18, n/a**
Board of Directors Approval:	**05/08, 11/12, 08/14, 06/18, 03/19**

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

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

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

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

2. Ask participants if commercial bias was observed in the speaker/author's presentation.
3. If commercial bias is determined, appropriate action shall be taken by the CME Committee/designee to rectify future CME activities and reduce the potential for commercial bias in these activities.

E. **FORM(S)**:
1. Faculty Disclosure Form & Resolution Declaration
2. Content Validation Form

F. **REFERENCE(S):**
1. ACCME Standards of Commercial Support

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 11/10	**SUBJECT:** Conflict Resolution Medical Staff
REVISION DATE(S): 11/10	**POLICY NUMBER:** 8710 – 562

Medical Staff Department Approval ~~Dates(s)~~:	03/17, 02/20
Medical Staff Committee Approval ~~Date(s)~~:	n/a
Pharmacy and Therapeutics Approval ~~Date(s)~~:	n/a
Medical Executive Committee Approval ~~Date(s)~~:	03/17, 02/20
Administration Approval:	03/20
Professional Affairs Committee Approval ~~Date(s)~~:	04/17, n/a
Board of Directors Approval ~~Date(s)~~:	04/17

A. **PURPOSE:**

1. The Medical Staff, Healthcare District (TCHD) hospital management, and the District Board, will each use their best efforts to address and resolve all conflicts between the Board, Medical Center, and the Medical Staff in the best interests of patients, the Medical Staff, TCHD, and the District Board.

B. **POLICY:**

1. Prior to the District Board taking any action contrary to a recommendation made by the Medical Executive Committee ("MEC") relating to patient safety or quality, the Chair of District Board, or a designee and management shall meet with representatives of the MEC, including the Chief of the Medical Staff, and seek to resolve the conflict through informal discussions.
2. If these informal discussions fail to resolve the conflict, the Chief of Staff or the Chairperson of the District Board may request the issue be addressed by the Joint Conference Committee. If a resolution is agreed upon in the Joint Conference Committee, the resolution will be forwarded to the MEC for approval.
3. If after consideration at the Joint Conference Committee the conflict is still unresolvable, then the Chief of Staff and the Chairman of the District Board or the Chief Executive Officer may request a formal conflict resolution process.

C. **PROCEDURE:**

1. The formal conflict resolution process will begin with a meeting of an Ad Hoc Committee within 30 days of the initiation of the formal conflict resolution process. The Ad Hoc Committee will be composed of:
   a. The Chief of Staff, past Chief of Staff, and at the discretion of the Chief of Staff either the Medical Staff Professional Behavioral Chair or the Chair for Quality Assurance/Performance improvement/Patient Safety
   b. The Chair, Secretary, and Vice Chair of the District Board
   c. The Chief Executive Officer or his/her designee
2. If the Committee cannot produce a resolution to the conflict that is acceptable to the MEC and the Board within 30 days of the initial meeting, the MEC and the District Board shall enter into Mediation as that term is defined by California Evidence Code Section 1115. The MEC and the District Board shall together select the third-party mediator. The MEC and the District Board shall use their best efforts to collaborate with the third-party mediator to resolve the conflict. The District Board Chair and the MEC shall each designate at least three people to participate in the mediation. Any resolution arrived at during such a meeting shall be subject to the approval of the MEC and the District Board. The Mediation proceedings shall be confidential pursuant to Evidence Code Section 1119.

a. If, after 90 days from the date of the initial request for Mediation the MEC and the District Board cannot resolve the conflict in a manner agreeable to all parties, the District board shall have the authority to act on the issue that gave rise to the conflict in a manner consistent with the Medical Staff Bylaws and California law.

b. With respect to membership, privileges and peer review matters governed by Articles IV, V, VI and VII of the Medical Staff By-laws, this Conflict Resolution Policy shall not be utilized until the procedures set out in the By-laws have been exhausted. This Policy shall also be used for the meet and confer requirements of California Business & Professions Code Section 2282.5.

c. If the Board determines, in its reasonable discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of TCHD, the District Board may take action subject to subsequent review, and any necessary revision, through the conflict resolution process described above.

D. **REFERENCES:**

1. Joint Commission Standards 2017

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 042/12	**SUBJECT:** Credentialing Policy, Mazor Robotic Surgery
REVISION DATE(S): 03/13	**POLICY NUMBER:** 8710 – 566

Medical Staff Department ~~Review~~Approval:	**07/17**
Division of Neurosurgery Approval:	**03/13,~~07/1809/1803/1906/19~~11/19**
Division of Orthopedics ~~Surgery~~ Approval:	**~~03/1303/1906/19~~11/19**
~~**Department of Surgery Chiefs Approval:**~~	~~**03/13**~~
~~**Operating Room Committee Approval:**~~	~~**03/13**~~
Credentials Committee Approval:	**03/13, 11/19, 02/20**
Pharmacy & Therapeutics Approval Committee:	**n/a**
Medical Executive Committee Approval:	**03/13, 02/20**
Administration Approval:	**03/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/12; 03/13**

A. **PURPOSE:**

1. To provide criteria for use in credentialing physicians who request privileges in Mazor robotic surgery.

B. **INITIAL CREDENTIALING:**

1. All physicians requesting Mazor robotic surgery privileges must be Board Certified in Orthopedic Surgery or Neurosurgery, or be actively pursuing the applicable certification, or be able to demonstrate comparable ability, training and experience
2. For surgeons with residency or fellowship training which included training in the Mazor Robotics Renaissance Guidance System:
   a. Physicians must have privileges to perform underlying procedure; and
   b. Provide:
      i. letter from training program director certifying adequate training and current competency for the requested privilege(s) using the Mazor device; and
      ii. The surgical log of a minimum of ten (10) Mazor cases;
      iii. Proctoring: A minimum of one (1) case ~~within a one-hundred-eighty (180) day period~~ must be concurrently proctored by a Mazor robotic-credentialed surgeon.~~*~~ ~~Additional training will be required prior to scheduling further cases if proctoring has not been completed within the specified time frame.~~
3. For surgeons with prior Mazor experience at an outside institution:
   a. Ten (10) cases beyond proctoring and within the previous 24-month period must be submitted for review.
   b. Proctoring: A minimum of one (1) case must be concurrently proctored by a Mazor robotic-credentialed surgeon.*

~~4. The above-listed proctoring requirements are deemed fulfilled for any surgeon on the Mazor List of Approved Proctors.~~

~~5.~~4. For surgeons without residency/fellowship training or prior Mazor experience:
   a. Privileges to perform the underlying procedure; and
   b. Certification of completion of a Mazor Training Program or comparable program, which includes cadaveric training module and completion and passing of test modules.

c. Proctoring: A minimum of one (1) case ~~within a one hundred eighty (180) day period~~ must be concurrently proctored by a Mazor robotic-credentialed surgeon (preferably in their field).* ~~Additional training will be required prior to scheduling further cases if proctoring has not been completed within the specified time frame.~~

d. *Proctoring requirements include a completed proctoring form from the elected proctor that includes satisfactory outcomes of the procedure, assessment of intraoperative and postoperative complications, and review of pathology reports if indicated. Proctor may recommend to the Chair of the Department or Chief of the Division that additional training and/or proctoring be completed..

~~6.~~**5.** Surgeons who have been granted Mazor robotic surgical privileges may assist in Mazor procedures without separate Mazor assist privileges.

~~7.~~**6.** For privileges to assist in Mazor robotic surgery (for MD/DO, PA, RNFA/RNFA trained):

a. Unrestricted surgical assisting privileges

b. Documented experience in Mazor robotic assisting (three [3] cases beyond proctoring) or completion of Mazor Training Program.

c. Proctoring: A minimum of three (3) cases must be proctored by the primary surgeon. Surgeons who have been granted unsupervised privileges to perform Mazor robotic surgery are not required to undergo additional proctoring in the assistant role.

C. **REAPPOINTMENT CRITERIA (MAZOR ROBOTIC SURGEONS):**

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

D. **ONGOING PROFESSIONAL PRACTICE EVALUATION:**

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

~~**Approvals:**~~
~~**Division of Orthopedic Surgery Approval: 03/20/13**~~
~~**Division of Neurosurgery Approval: 03/20/13**~~
~~**Department of Surgery Chiefs Approval: 03/14/13**~~
~~**Surgery Department Approval: 03/13**~~
~~**Credentials Committee Approval: 03/13**~~
~~**Medical Executive Committee Approval: 03/13**~~
~~**Board of Directors Approval: 04/12; 03/13**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 03/06	**SUBJECT: Cultural and Linguistic Proficiency**
REVISION DATE(S): 05/08; 08/12; 09/14	**POLICY NUMBER: 8710-601**
Medical Staff Department Approval:	**07/18, 01/20**
Continuing Medical Education Committee Approval:	**04/08; 07/12; 08/14: 07/18, 01/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**05/08; 08/12; 09/14; 08/18, 02/20**
Administration Approval:	**08/18, 03/20**
Professional Affairs Committee:	**n/a**
Board of Directors Approval:	**05/08; 08/12; 09/14; 08/18**

A. **PURPOSE:**
To ensure subjects of cultural and linguistic competency in the practice of medicine are included in Continuing Medical Education (CME) activities in accordance with California Bill AB 1195. The IMQ/CMA policy applies to non-exempt CME activities and addresses the essential elements for compliance with Assembly Bill 1195 and was updated by the Boards of CMA and IMQ in July and August 2013.

B. **DEFINITIONS:**
1. **Cultural Competency:** A set of integrated attitudes, knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities.
2. **Linguistic Competency:** The ability of a physician and surgeon to provide patients who do not speak English, or who have limited ability to speak English, with direct communication in the patient's primary language.

C. **POLICY:**
1. **Identification of CLC Disparity:** Planners are responsible for proactively identifying one (or more) CLC disparities when planning an educational activity with **clinical content**. The CLC disparity must be relevant to the identified gaps or learning needs of the target audience or our patient population.
   a. Faculty is not responsible for identifying CLC disparities.
   b. The planner will document on the planning form if there is no clinical care component or no CLC disparity identified.
2. **Objectives:** Tri-City Medical Center shall include cultural and linguistic objectives in CME activities that address cultural beliefs, which may include cause, severity, treatment, and acceptability of the patient's own illness, as well as, language barrier implications and the need for providing appropriate interpreters and appropriately interpreted material. Objectives shall include at least one, or a combination of, the following:
   a. Application of linguistic skills to communicate effectively with the target population.
   b. Utilization of cultural information to establish therapeutic relationships.
   c. Elicitation and incorporation of pertinent cultural data in diagnosis and treatment.
   d. Understanding and application of cultural and ethnic data to the process of clinical care.
3. **Cultural Diversity Form:** Each CME speaker shall complete and sign a *Cultural Diversity* form which informs the speaker of the requirement that cultural and linguistic information/resources are required for each CME activity with clinical content.

4. Cultural references shall be made available to attendees at CME activities.

D. FORM(S):

1. Cultural Diversity Form - Sample

E. RELATED DOCUMENT(S):

1. Tri-City Medical Center "A Guideline for General Cultural Awareness" – Sample

F. REFERENCE(S):

*Institute for Medical Quality (IMQ)/California Medical Association (CMA) 2014 CME Accreditation Criteria and Policies for Continuing Medical Education (CME) *with annual report glossary.*

Cultural Diversity Form - Sample

Tri-City Medical Center
CULTURAL DIVERSITY FORM

Date: _____

Topic: _____

Speaker: _____

The California legislature passed AB 1195, which states that as of July 1, 2006 all Category 1 CME activities that relate to patient care must include a cultural diversity/linguistics component.

DEFINITIONS: Cultural competency means a set of integrated attitudes, knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities. Linguistic competency means the ability of a physician and surgeon to provide patients who do not speak English or who have limited ability to speak English, direct communication in the patient's primary language.

We believe there is relevant cultural diversity information relating to one or more of the following: age, gender, race, socio-economics, sexual orientation, religion, language, ethnicity, etcetera that impacts the care of patients and you are required to include it in your presentation. If no relevant cultural or linguistic health or health care disparities are identified, this should be documented.

Therefore, the following objective will be added to the activity publicity to potential attendees and also to the attendee evaluation form:

Discuss the various culturally relevant diversities (gender, age, race, religion, ethnicity, language, sexual orientation, socio-economics, etc.) that relate to demographics, diagnosis, and treatment.

I have read this form and will comply with AB 1195 as outlined above.

Signature:_____ **Date:**_____

Cultural Awareness Guide - Sample
Tri-City Medical Center
A Guideline for General Cultural Awareness

Culture Group and Language	Belief Practices	Nutritional Preferences	Communication Awareness	Patient Care/Handling of Death
American English	Christian and Jewish beliefs are prominent. Many others exist in smaller numbers. Family-oriented.	Beef, chicken, potatoes, vegetables; fast foods; ethnic foods.	Talkative, shake hands, not much touching during conversation. Prefer to gather information for decision-making. Some hugging and kissing, mainly between women.	Family members and friends visit in small groups. Expect high-quality care.
Argentinean Spanish	90% Catholic, some Protestant and Jewish. Strong belief in saints, purgatory, and heaven. People from rural areas may be more superstitious.	Emphasis on meat, especially beef with homemade pastas, pastries, and local wines. Maté, national beverage that is stimulating and "addictive" like coffee.	Talkative, very expressive, direct and to the point. Extroverted. Good eye contact. Like personal and physical contact such as holding hands, hugging, and kissing.	Educated, yet reluctant to get medical attention or accept new medical advancements. Independent, often deny disability. Believe in natural and holistic remedies, herbal teas, pure aloe, natural oils, and poultices. Family gets involved with caring for the ill family member.
Brazilian Portuguese. Diverse cultural backgrounds including: European, African, Indian.	Mostly Catholic. Growing Evangelical representation. Candomble, similar to Santeria. Macumba (blend of African, Brazilian, Indian).	Beans and rice are staple. Feijoada-black beans, beef, and pork; churrasco (charcoal-broiled meats); manioc (vegetable); tropical fruits.	Very sociable. Will stand close to each other. Social kissing, hugging, touching, good eye contact.	Emphasis on family unity – will want to be actively involved. Tend to trust medical personnel; place great faith in doctors and nurses. Some believe in herb treatment, teas, and balsams.
Canadian English, French and Innuit (Eskimo)	Protestant, Catholic, and Jewish. 80% of the population lives within 1,00 miles of the United States boarder.	Comparable to American diet. French influence in Montreal and Quebec.	Prefer no touching or kissing. Take things at face value.	Follow nurses' instructions. Accustomed to socialized medicine, less litigation. Take physicians at their word. Willing to wait for treatment.
Cayman English, with some changes in accents and verbs.	People are very religious. Majority of the island is Baptist or "Church of God." Voodoo and psychics are outlawed.	Fish, turtle, beef, goat, and conch; rice, beans, and plantains; fried food very rich in fat; cooked or fried in coconut oil or milk.	Like to be acknowledged. Good eye contact. Prefer no touching or kissing. Very talkative and known for their friendliness. Everyone on the island knows each other.	Like to be told what is going on by doctor. Would rather talk to doctors than nurses. Prefer one-on-one care.
Chinese Many dialects spoken; one written language.	Religions: Taoism, Buddhism, Islam, and Christianity. Harmonious relationship with nature and others; loyalty to family, friends, and government. Public debate of conflicting views is unacceptable. Accommodating, not confrontational. Modesty, self-control, self-reliance, and self-restraint. Hierarchical structure for interpersonal and family interactions.	Belief in theory of "yin" (cold) and "yang" (hot) when they are sick. No food with "yin" after surgery (e.g., cold desserts, salad). Often lactose intolerant. Soy sauce, MSG, and preserved foods. Diet consisting of vegetables and rice. Tofu (bean curd) can be prepared in various ways.	Quiet, polite, and unassertive. Suppress feelings of anxiety, fear, depression, and pain. Eye contact and touching sometimes seen as offensive or impolite. Emphasize loyalty and tradition. Self-expression and individualism are discouraged.	Women uncomfortable with exams by male physicians. May not adhere to fixed schedule. May fear medical institutions. Use a combination of herbal and Western medicine at the same time. Traditional: acupuncture, herbal medicine, massage, skin scraping, and cupping. Alcohol may cause flushing.
Cuban Spanish	Catholic with Protestant minority. Santeria, which can include animal sacrifice.	Cuban bread, café con leche. Cuban coffee; roast pork, black beans, and rice; plantains, yucca, chicken and rice.	Some may have a tendency to be loud when having a discussion. Use their hands for emphasis and credibility, and prefer strong eye contact.	Culture requires visiting the sick; the extended family supports the immediate family. It is an insult to the patient if there is not a large family/friend presence.
Ecuadorian Spanish, Quechua-Indian	Primarily Catholic. Increase in Protestant, Baptist, and Jehovah Witness. Very respectful toward religious leaders. Small percentage of population is wealthy with much political control. Family size is usually large.	Diet high in fruits and proteins; starches: rice, potatoes, and corn. Food is prepared fresh daily, usually with salsa. Coastal diet: rice and fish (ceviche). Drink beer and soda.	Extremely polite. Reserved. Respectful. Especially helpful.	Prefer pampering ill family members; stay overnight with patient. Not stoic when it comes to pain. Very private and modest. Embarrassed if they do not look their best. Extremely protective of family; often parents live with grown children.
Filipino English, Spanish, and Tagalog (80 Dialects)	Catholic. Seek both faith healer and Western physician when ill. Belief that many diseases are the will of God.	Theory of hot and cold food. Certain foods in the Philippines are traditionally eaten hot or cold, e.g., milk is only taken HOT. Fish, rice, vegetables, and fruit. Meals have to be HOT.	Value and respect elders. Loving and family-oriented. Set aside time just for family.	Family decision important. Ignore health-related issues; often noncompliant. In spite of Western medicine, they often leave things in the hands of God, with occasional folk medicine. Home remedies: herbal tea, massage, and sleep. May subscribe to supernatural cause of disease.

Culture Group and Language	Belief Practices	Nutritional Preferences	Communication Awareness	Patient Care/Handling of Death
Guatemalan Spanish; Mayan heritage; European influence	Primarily Catholic. Increase in Protestants. Very respectful toward elders. European heritage; strong family ties.	Diet high in fruits, vegetables, rice, beans, and tortillas (corn flour bread)	Quiet, reserved, and respectful. Will not question for fear of insulting professional.	Modest, private, and stoic. Believe in alternative methods of healing.
Haitian Creole; French is taught in schools	Catholic and Protestant. Voodoo is practiced. Large social gap exists between wealthy and poor citizens.	Large breakfast and lunch. Light dinner. Rice, fried pork, grillot, and red beans. Herbs and cloves.	Quite and polite. Value touch and eye contact.	Obedient to doctor and nurse, but hesitant to ask questions. View use of oxygen as indication of severe illness. Occasionally share prescriptions and home remedies.
Hindu Hindi	The belief in cyclic birth and reincarnation lies at the center of Hinduism. The status, condition, and caste of each life is determined by behavior in the last life.	Cow is secred. No beef. Some strictly vegetarian.	Limited eye contact. Do not touch while talking.	Do not try to force food when religiously forbidden. Death: The priest may tie a thread around the neck or wrist to signify a blessing. This thread should not be removed. The priest will pour water into the mouth of the body. Family will request to wash the body. Eldest son is responsible for the funeral rites.
Jamaican English, Patois (broken English)	Christian beliefs dominate (Catholic, Baptist, and Anglican). Some Rastafari influence.	Beef, goat, rice and peas, chicken, vegetables, fish and lots of spices. Some avoid eating pork and pork products because of religious beliefs.	Respect for elders is encouraged. Reserved. Avoid hugging and showing affection in public. Curious and tend to ask a lost of questions.	Will try some home remedies before seeking medical help. Like to be completely informed before procedures. Respectful of doctor's opinion. Can be reluctant to admit that they are in pain. May not adhere to a fixed schedule.
Japanese Japanese	Self-praise or the acceptance of praise is considered poor manners. Family is extremely important. Behavior and communication are defined by role and status.	Food presentation is important. Fish and soybean are main sources of protein, as well a meats and vegetables (some pickled). Rice and noodles; tea; soy sauce. Often lactose-intolerant.	Use attitude, actions, and feelings to communicate. Talkative people are considered showoffs or insincere. Openness considered a sign of immaturity, lack of self-control. Implicit nonverbal messages are of central importance. Use concept of hierarchy and status. Avoid eye contact and touch.	Family role for support is important. Insulted when addressed by first name. Confidentiality is very important for honor. Information about illness kept in immediate family. Prone to keloid formation. Cleft lip or palate not uncommon. Alcohol may cause flushing. Tendency to control anger.
Jewish Many from Eastern European countries. English, Hebrew, and Yiddish. Three basic groups: Orthodox (most strict), Conservative, and Reform (least strict).	Israel is the holy land. Sabbath is from sundown Friday to sundown on Saturday. It is customary to invite other families in for Friday evening Sabbath dinner.	Orthodox and some Conservatives maintain a Kosher diet. Kosher food is prepared according to Jewish law under Rabbinical supervision. Eating of unclean animals is forbidden. Blood and animal fats are taboo (blood is synonymous with life). Do not mix meat with dairy products.	Orthodox men do not touch women, except for their wives. Touch only for hands-on care. Very talkative and known for their friendliness.	Stoic and authoritative. Appreciate family accommodation. Jewish law demands that they seek complete medical are. Donor transplants are not acceptable to Orthodox Jews, but are to Conservative and Reform. Death: Cremation is discouraged. Autopsy is permitted in less strict groups. Orthodox believes that entire body, tissues, organs, amputated limbs, and blood sponges need to be available to family for burial. Do not cross hands in postmortem care.
Korean Hangul	Family-oriented. Believe in reincarnation. Religions include Shamanism, Taoism, Buddhism, Confucianism, and Christianity. Belief in balance of two forces: hot and cold.	High fiber, spicy seasoning, rice, Kim Chee (fermented cabbage). Speak little during meal. Often lactose- and alcohol-intolerant.	Reserved with strangers. Will use eye contact with familiar individuals. Etiquette is important. First names used only for family members. Proud and independent. Children should not be used as translators due to reversal of parent/child relationship.	Family needs to be included in plan of care. Prefer non-contact. Respond to sincerity.
Mexican Spanish. People of Indian heritage may speak one of more than 50 dialects.	Predominantly Roman Catholic. Pray, say rosary, have priest in time of crisis. Limited belief in "brujeria" as a magical, supernatural, or emotional illness precipitated by evil forces.	Corn, beans, avocado, chilies, and yellow rice. Heavy use of spices.	Tend to describe emotions by using dramatic body language. Very dramatic with grief, but otherwise diplomatic and tactful. Direct confrontation is rude.	May believe that outcome of circumstances is controlled by external force; this can influence patient's compliance with health care. Women do not expose their bodies to men or other women.
Muslim Language of the country and some English	Belief on one God, "Allah," and Mohammed, his prophet. Five daily prayers. Zakat, a compulsory giving of alms to the poor. Fasting during the month of Ramadan. Pilgrimage to Mecca is the goal of the faithful.	No pork or alcohol. Eat only Halal meat (type of Kosher).	Limit eye contact. Do not touch while talking. Women may cover entire body except face and hands.	Do no force foods when it is religiously forbidden. Abortion before 130 days is treated as discarded tissue; after 130 days, as a human being. Before death, confession of sins with family present. After death, only relatives or priest may touch the body. Koran, the holy book, is recited near the dying person. The body is bathed and clothed in white and buried within 24 hours.

Culture Group and Language	Belief Practices	Nutritional Preferences	Communication Awareness	Patient Care/Handling of Death
Northern European Language of the country and some English	Similar to American customs. Protestant with large Catholic population and some Jewish. Multi-ethnic groups.	Comparable to American diet – meat, vegetables, and starches. Coffee, hot tea, and beer.	Courtesy is of utmost importance. Address by surname and maintain personal space and good eye contact.	Maintain modesty at all times. Stoic regarding pain tolerance. Death is taken quietly with little emotional expression. Patients/family tend not to question medical authority.
Southern European Language of the country and some English	Roman Catholic, Protestant, Greek Orthodox, and some Jewish	Main meal at midday: pasta, meat, and fish with cheeses and wine. Fresh fruit. Espresso coffee.	Talkative and very expressive Direct and to the point. Extroverted. Good eye contact. Like personal and physical contact: holding hands, patting on back, and kissing.	Educated, yet reluctant to get medical attention. Very independent. Birth control and abortion are accepted in some countries and not in others. The whole family is involved in care of ill family member.
Samoan Samoan, English	Christian 99.7%. Religion plays important role. Believe that outcome of medical treatment, both western and traditional medicine, is a manifestation of the healing power of God through intervention of human prayers. Children seen as gifts of God. Big families are valued.	Traditional food derives mainly from tropical crops, root vegetables, coconut products, fresh fruit, pork, chicken, and seafood. Adoption of westernized eating habits has caused increase in obesity and diabetes.	Shy and tend not to ask questions or question a health professional's authority. Tend to say they understand even if they do not and will often give you the answer you want to hear rather than the truth. Samoans are very tradition-oriented; culture is steeped in complex set of social hierarchies, courtesies and customs. Respect, modesty, politeness, and humility are valued.	Facilities should assign health providers of the same gender. If western medicine is perceived as ineffective, Samoans may use traditional healers. Prayer is important part of the healing process and often seen as final solution to a health problem. Relatives are use to being allowed to be with patient at all times. When a patient is dying, it is important to let relatives have as much time with them as possible. Many Samoans believe that illness is caused by demons, a curse, or past wrongdoing. Mental health issues are not easily talked about due to stigma and shame.
Vietnamese Vietnamese language has several dialects. Also French, English, and Chinese	Family loyalty is very important Religions include Buddhism, Confucianism, Taoism, Cao Di, Hoa Hoa, Catholicism, and occasional ancestral worship. General respect and harmony. Supernatural is sometimes used as an explanation for disease.	Rice often with green leafy vegetables, fish sauce added for flavor. Meat used sparingly and cut into small pieces. Tea is main beverage. Often lactose- and alcohol-intolerant	Communication – formal, polite manner; limit use of touch. Respect conveyed by nonverbal communication. Use both hands to give something to an adult. To beckon someone, place palm downward and wave. Don't snap your fingers to gain attention. Person's name used with title, i.e., "Mr. Bill," "Director James." "Ya" indicates respect, no agreement.	Negative emotions conveyed by silence and reluctant smile; will smile even if angry. Head is sacred – avoid touching. Back rub – uneasy experience. Common folk practices – skin rubbing, pinching, herbs in hot water, balms, string tying. Misunderstanding about illness – drawing blood seen as loss of body tissue; organ donation causes suffering in next life. Hospitalization is last resort. Flowers only for the dead.

(Note: This chart was developed by the culture connection, a continuous quality improvement team at South Miami Hospital that eventually evolved into the culture committee. This chart is hung in the various departments around the hospital as a quick reference tool for health care personnel in their dealings with patients from different cultures. The culture tool is the result of a cooperative effort by hospital employees who represent the various cultures mentioned. The hospital welcomes input from other health care organizations so it can add information about additional cultures and languages. Reprinted with permission of Carol Biggs, South Miami Hospital.)

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 04/09	**SUBJECT: Disaster Privileges**
REVISION DATE: 09/09	**POLICY NUMBER: 8710-553**
Medical Staff Department Approval:	**08/16, 10/19**
Credentials Committee Approval:	**08/16, 11/19**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**11/16, 02/20**
Administration Approval:	**03/20**
Professional Affairs Committee Approval:	**01/17, n/a**
Board of Directors Approval:	**01/17**

A. **PURPOSE:**

1. To provide a process to credential and grant Disaster Clinical Privileges or Practice Prerogatives to Volunteer Practitioners and/or Allied Health Professionals (AHP's), as appropriate, in the event of a disaster when the HICS plan has been activated and the hospital is unable to meet immediate patient care needs.
2. SCOPE and RESPONSIBIITY includes the Medical Staff Services Department of Tri-City Medical Center or Designee and the designated Disaster Coordinator.

B. **DEFINITIONS AND TERMS:**

1. The following definitions shall apply for purposes of this policy and procedure only.
   a. Practitioner: A physician (M.D., D.O.), podiatrist (D.P.M.), dentist or oral maxillofacial surgeon (D.D.S., D.M.D.)
   b. Allied Health Professional or AHP: All health care professionals other than Practitioners, as defined above, who are classified as Dependent practitioners to work as a physician extender under the direction of a supervising physician and required by law and regulation to have a license, certificate or registration to practice their profession and.
   c. Surgical Tech, Orthopedic Tech shall be credentialed as follows:
      i. If a "tech" is employed by another hospital, they will be sent to Human Resources for appropriate credentialing.
      ii. Any "tech" who is not employed by another hospital will be credentialed per this policy.
   d. Volunteer Practitioner or AHP: A Volunteer Practitioner who is not currently a member of the medical staff of Tri-City Medical Center, or an AHP who has not been credentialed as an AHP by the facility.
   e. Disaster Clinical Privileges: Clinical Privileges granted to a Volunteer Practitioner, as defined above, pursuant to this policy and procedure.
   f. Disaster Practice Prerogatives: Practice prerogatives granted to an AHP, as defined above, pursuant to this policy and procedure.

C. **PROCEDURE:**

1. Upon presentation to the hospital, Volunteer Practitioners and/or AHPs shall be directed to the Hospital Representative responsible for disaster credentialing under the HICS plan.
   a. Volunteer Practitioners and/or AHPs must sign in and present required identification as follows:
      i. A valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport), and at least one of the following:

1) A current hospital photo ID badge that clearly identifies professional designation;
2) A current license, certificate or registration to practice, as appropriate;
3) Identification indicating the individual is a member of a Disaster Medical Assistance Team (*DMAT*), or Medical Reserve Corps (*MRC*), Emergency System for Advanced Registration of Volunteer Health Professionals (*ESAR-VHP*), or other recognized state or federal organizations or groups;
4) Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a deferral state, or municipal entity); or
5) Identification of Volunteer Practitioners by current hospital or medical staff members(s) who possess personal knowledge regarding the Volunteer Practitioner's ability to act as a licensed independent practitioner during a disaster and of Volunteer AHPs by current hospital member(s) who possess personal knowledge regarding the AHP's qualifications.

b. Required Documentation on the Disaster Privileges/Prerogative Approval Form:
   i. Name of Volunteer Practitioner or AHP (printed and signed)
   ii. Specialty or AHP Category
   iii. Office Address and Phone Number
   iv. Professional License/Certificate/Registration Number and Expiration Date
   v. Driver's License or Passport Number and Expiration Date
   vi. Date of Birth
   vii. Name of Professional Liability Insurance Carrier and Limits of Liability
   viii. Name of Professional School and Year of Graduation
   ix. Hospital Affiliation(s) and Staff Status

c. Verification Process:
   i. The hospital Representative shall verify professional licenses/certificates/ registrations as follows:
      1) Primary Source Verification:
         a) Query the appropriate licensing/certification/registration board on-line, e.g.= Medical Board of California website = *www.medbd.ca.gov* – use for M.D.s, D.P.Ms and PAs; California Osteopathic Medical Board = *www.ombc.ca.gov* – use for D.O.s, California Board of Registered Nursing = www.rn.ca.gov – use for R.N.F.A.s, N.P.s, C.N.M.s and other R.N.s; Board of Behavioral Sciences = www.bbs.ca.gov --- use for M.F.C.C.s and L.C.S.W.s; California Psychology Board = www.psychboard.ca.gov –use for clinical psychologists, and print verification if possible.
      2) If computer access is not available, a copy (if possible) of the Volunteer Practitioner's or AHP's professional license/certificate/registration and driver's license or other identification shall be made and attached to the Disaster Privilege/Prerogative Approval Form. If a copier is not available, the Hospital Representative shall perform a visual verification of the above documents, and document such verification.
      3) If primary source verification of professional licensure/certification/ registration cannot be accomplished at the time of initial credentialing, it must be performed as soon as the immediate situation is under control and completed no later than seventy-two (72) hours from the time the Volunteer Practitioner or AHP presented to the campus. In extraordinary circumstances when primary source verification cannot be completed within seventy-two (72) hours (e.g., no means of communication or lack of

resources) it shall be accomplished as soon as possible. In this extraordinary circumstance, the following must be documented:

a) Why primary source verification could not be performed in the required timeframe;
b) Evidence of the Volunteer Practitioner's or AHP's demonstrated ability to continue to provide adequate care, treatment, and services;
c) Attempt(s) to rectify the situation as soon as possible.

4) The Medical Staff Services Representative or designee shall query the National Practitioner Data Bank (NPDB) and other sources as needed as soon as the emergency situation has been contained.
5) Primary source verification shall not be required if the Volunteer Practitioner or AHP has not provided care, treatment and services under the Disaster Clinical Privileges or Practice Prerogatives, as appropriate.

d. Who May Grant Disaster Clinical Privileges/Practice Prerogatives:
   i. As described in the Medical Staff Bylaws, the Chief Executive Officer (CEO) or Chief of Staff or their designees may grant Disaster Clinical Privileges or Practice Prerogatives. The option to grant Disaster Clinical Privileges or Practice Prerogatives to Volunteer Practitioners and/or AHPs shall be made on a case-by-case basis in accordance with the immediate needs of the hospital's patients, based on the qualifications of the Volunteer Practitioners and/or AHPs.
e. Temporary Badges:
   i. So that they may be readily identified, Volunteer Practitioners and/or AHPs shall be issued badges containing the following information:
      1) Name
      2) Specialty or AHP category
      3) Practicing with Disaster Clinical Privileges or Practice Prerogatives, as appropriate.
f. Oversight:
   i. The Medical Staff shall oversee the care, treatment, and services provided by a Volunteer Practitioner or AHP who has been granted Disaster Clinical Privileges or Practice Prerogatives. Oversight shall be accomplished whenever possible by partnering the Volunteer Practitioner or AHP with a current credentialed medical staff member or AHP, as appropriate, to observe or mentor the Volunteer Practitioner or AHP. If partnering is not possible, oversight shall be by clinical record review. A Volunteer Practitioner or AHP may be assigned additional responsibilities by the Medical Staff Officer designated under the *HICS* plan.
g. Termination of Disaster Clinical Privileges/Practice Prerogatives:
   i. A Volunteer Practitioner's or AHP's Disaster Clinical Privileges or Practice Prerogatives shall be terminated immediately in the event that any information received through the verification process or otherwise indicates adverse information or suggests the Volunteer Practitioner or AHP is not capable of exercising Disaster Clinical Privileges or Practice Prerogatives. Disaster Clinical Privileges and Practice Prerogatives are time-limited and shall expire automatically at the time the CEO or designee declares the disaster to be over, or that the services of Volunteer practitioners or AHPs are no longer required.

D. **REFERENCES**:
1. The Joint Commission Standards

APPLICATION FOR DISASTER PRIVILEGES

To be completed by the Volunteer Licensed Independent Practitioner/Volunteer Practitioner

Full Name:_____
Cell Phone Number:_____
Social Security Number:_____
Date of Birth:_____
Office Address, City, State, Zip Code:_____
_____
Office Telephone:_____
Photo Identification Type (i.e., driver's license, government I.D.)
_____
Identifying Number:_____
Issuing State/Agency:_____
(If copy not obtained, list other information):_____
_____
License (certification or registration) Number:_____
Issuing State:_____
Expiration Date:_____
(If copy not obtained, list issuing agency name/address/phone/other information)
_____
Malpractice Insurance Carrier Name:_____
Telephone Number (if available):_____

Current Hospital Affiliation(s) – Facility(s) Name(s)
Address(s), City(s), State(s), Zip Code(s)
Telephone Number(s)
_____
_____
_____

LIP/Volunteer Practitioner's Signature:_____

VERIFICATIONS/APPROVAL

Review all documents and attach copies if possible. Conduct verification of information as possible

License/Certification/Registration:_____

Affiliation(s):_____

Insurance:_____ NPDB:____OIG:_____Other:_____

On Site Medical Staff Member's Name:_____

Responsibilities (following interview with volunteer Health Care Practitioner):_____

_____

_____

Assigned Partner:_____

Approved by: (print name, signature, title):_____

CONSENT, ACKNOWLEDGEMENT & RELEASE OF INFORMATION FOR DISASTER PRIVILEGES

I, the undersigned, hereby apply for disaster privileges as requested on this application. I acknowledge and agree to abide by the Medical Staff Bylaws, Rules and Regulations and applicable hospital policies. By applying for disaster privileges, I accept the following conditions during the processing and consideration of my application and for the duration of my privileges, regardless of whether or not I am granted the privilege requested:

1. I agree the information provided in conjunction with this application is accurate and represents the current level of my training, experience, capability, health status and competence to practice the disaster privileges requested.

2. I fully understand and agree that any significant misrepresentation, misstatement or omission from this application, whether intentional or not, shall constitute cause for denial of requested disaster privileges. In the event that disaster privileges have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in summary termination of disaster privileges.

3. I hereby authorize my professional liability insurance carrier to notify the Chief of Staff or his agent, in the event that my insurance coverage is terminated, canceled, modified or otherwise acted upon.

4. I understand and agree that as an applicant for disaster privileges that I have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics, health status, and other qualifications and for resolving any doubts about such qualifications. I agree to make myself available for interviews with regard to my application and any peer review related matters during the time that I hold disaster privileges.

5. I agree to provide continuous care for my patients either personally or through an identified qualified member of the medical staff.

6. Immunity is extended to the fullest extent permitted by law and I release from liability all persons, organizations, committees and their agents from participating in good faith in requesting or supplying information relative, but not limited to: (a) applications for appointment and/or clinical privileges; (b) periodic reappraisals undertaken as part of the peer review process; (c) investigations, reprimands, corrective action, suspension or reduction of clinical privileges, or other disciplinary action; (d) hearings and appellate reviews: (e) reviews before the governing board; (f) case evaluations; (g) utilization reviews: (h) other hospital, medical staff or departmental, service or committees activities relating to the quality of patient care or my professional conduct; (i) inquiries concerning my professional qualifications, character, ethics, physical or mental health status, or behavior; and (j) any other matter that may affect patient care, or the orderly operation of this or any other hospital, and I hereby authorize and consent to the release of such information.

7. I understand and agree that after I submit this application it is my sole obligation to promptly report to the Chief of Staff or his designee of any: (1) change in the contents of this application; (2) change in my physical or mental health that could impair my ability to practice; (3) change in my staff membership or privileges at any other health care facility; (4) investigation or accusation with regard to my license or DEA; or (5) conviction of, or plea of guilty or no contest, or its equivalent, to a felony in any jurisdiction; (6) sanction and/or exclusion from participation in any Federal health care program; or (7) change in the status of my professional liability insurance coverage.

8. I present this application and arrange for the submission of other information with the understanding: (1) that such information is requested by the peer review committee(s) of this hospital as part of the credentialing process; (2) that the confidentiality and privacy of this information will be preserved; and (3) that this information and materials will only be released or disclosed as part of current or future credentialing, peer review or quality improvement processes as described above and in the medical staff bylaws, rules and regulations.

9. I understand that the completion of this application is my sole responsibility. I declare that the information on this application is true and without omission to the best of my knowledge. I hereby apply for disaster privileges.

SIGNATURE: _____ DATE: _____

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 05/02	**SUBJECT:** Emergency Department Call: Duties of the On-Call Physician
REVISION DATE(S): 07/10; 11/10; 05/14	**POLICY NUMBER:** 8710 – 520

Medical Staff Department Approval ~~Dates(s)~~:	03/17, 02/20
Medical Staff Committee Approval ~~Date(s)~~:	n/a
Pharmacy and Therapeutics Approval ~~Date(s)~~:	n/a
Medical Executive Committee Approval ~~Date(s)~~:	03/17, 02/20
Administration Approval:	03/20
Professional Affairs Committee Approval ~~Date(s)~~:	04/17, n/a
Board of Directors Approval ~~Date(s)~~:	04/17

A. **PURPOSE:**

1. To define timely attention to patients in the Emergency Department (ED), including the timely response and duties of the on-call physician.

B. **DEFINITION(S):**

1. Emergency Department:
   a. The Emergency Department is a specially equipped and staffed department, designed to provide monitoring, close observation, skilled emergency medical/nursing care, and/or respiratory therapy to the acutely injured or critically ill surgical, medical, or cardiac patient.
2. On-call Physician:
   a. The on-call physician is the individual physician available for his/her specialty who responds to the Emergency Department when his/her specialty is needed. The on-call physician is a resource to the hospital to assist in the screening evaluation and stabilization of a patient with emergency medical conditions. The on-call physician's duties mirror the hospital's three main duties under the law: medical screening, stabilization, and acceptance of appropriate transfers.
3. Emergency Medical Condition (EMC):
   a. A medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to severe pain, psychiatric disturbances, and/or symptoms of substance abuse), such that the absence of immediate medical attention could reasonably be expected to result in:
      i. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or the unborn child) in serious jeopardy;
      ii. Serious impairment to any bodily function;
      iii. Serious dysfunction of any bodily organ or part or;
      iv. With respect to a pregnant woman who is having contractions, inadequate time to affect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.
4. Medical Screening Examination (MSE):
   a. The screening, examination, and evaluation by an emergency physician or other practitioner qualified to determine whether the patient is in active labor or has an emergency medical condition. It also includes the care, treatment, and surgery by a

physician necessary to stabilize that emergency medical condition, within the capability of this facility (TCMC). A triage nurse exam is not a medical screening exam.

b. An MSE is required on all patients who present to the ED/hospital campus with a medical complaint.

c. A request for an MSE will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, the individual needs an examination or treatment for a medical condition.

d. The MSE is an ongoing process, not an isolated event.

5. Capacity:
   a. The ability of the hospital to accommodate the individual requesting examination or treatment. In certain circumstances (e.g., redirecting an individual to an alternate location for a MSE pursuant to an emergency preparedness plan or a transfer as necessitated in the instance of a declared emergency), the hospital may be eligible to request a waiver.
   b. Includes the hospital's past practices of accommodating patients in excess of occupancy limits.
6. Stable:
   a. Stable for Transfer:
      i. With respect to an emergency medical condition, to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during the transfer of the individual from a facility, or that the woman has delivered the child or placenta. A patient will be deemed stabilized if the treating physician attending the patient in the emergency department/hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.
   b. For transfer between facilities:
      i. a patient is stable for transfer if the patient is transferred from one facility and the treating physician attending to the patient has determined, within reasonable clinical confidence, that the patient is expected to leave the hospital and be received at the second facility, with no material deterioration in his/her medical condition; and the treating physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition.
      i. If the patient is determined by the treating physician to require a higher level of care than can be provided at TCMC, the transfer can be accomplished by mutual agreement between the sending and receiving physicians. This may be accomplished even if the patient is "unstable," if the physicians determine that the benefits of the transfer outweigh the risks.
      ii. Transfers should only be made in the following circumstances:
         1) For care that exceeds the capabilities of the transferring hospital
         2) Upon patient request
   c. Stable for Discharge:
      i. Means the treating physician has determined within reasonable clinical confidence that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, may be reasonably performed on an outpatient basis or a later inpatient basis and the patient has been given a plan for appropriate follow-up care with the discharge instructions.
      ii. The emergency medical condition that caused the individual to seek care in the Emergency Department must be resolved (although the underlying medical condition may persist).
   d. Psychiatric Patients Stable for Transfer:
      i. A psychiatric patient is considered stable when he/she is protected and prevented from injuring himself/herself or others. For purposes of discharging a

patient (other than for the purpose of transfer from one facility to a second facility), for psychiatric conditions, the patient is considered stable when he/she is no longer considered an imminent threat to himself/herself or to others.

ii. Psychiatric patients who are being transferred on a psychiatric hold will be placed in restraints, solely for the duration of the transfer, in order to minimize the risk of elopement.

e. Stable for transfer or Stable for Discharge: does not require the final resolution of the emergency medical condition.

7. Inpatient:
   a. A person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.
8. Outpatient:
   a. A person who has come to a hospital outpatient department for the purposes of keeping a previously scheduled appointment. This shall include any patient presenting to the ED with a medical complaint.

C. **GUIDELINES:**

1. The goal is every ED patient will be seen by a physician or physician assistant within 30 minutes after the patient is placed in a bed and assessed by a nurse; this should occur in the majority of cases.
2. The appropriate on-call physician will be called when the Emergency Medicine physician:
   a. Does not have the expertise or capability to treat the EMC; or,
   b. Needs the on-call physician to stabilize the patient in the ED; or,
   c. Needs the on-call physician to admit the patient for further stabilizing treatment; or,
   d. Needs the on-call physician to help stabilize the patient in the ED prior to transfer to a tertiary facility or another acute care facility.
   e. Requires assistance of the on-call physician to determine if an EMC exists.
3. The on-call physician is expected to respond telephonically to the Emergency Department within 30 minutes for STAT calls, and within 60 minutes for routine calls. The on call physician will come to the Emergency Department to see the patient if the Emergency Medicine physician determines it is necessary, and within the timeframe reasonably determined by the Emergency Department physician. In any event, the on-call physician must be able to respond in person to the Emergency Department within 30 minutes of the request to respond in person.
4. If the personal physician is treating his/her patient in the ED, that physician is expected to see the patient in the ED or consult by telephone with the Emergency Medicine physician within 30 minutes of being notified the patient is in the ED, and see the patient in the ED less than 60 minutes after notification the patient is in the ED.
   a. If the on-call physician or a personal physician meets the patient in the ED, that physician's evaluation of the patient constitutes the MSE. The examination, the treatment, and the documentation of the encounter must comply with EMTALA exactly as if the Emergency Medicine physician were caring for the patient. The on-call or personal physician shall inform the Emergency Medicine Physician of the MSE.
   b. If a personal physician wishes to see their patient in the ED, but is unable to respond within 60 minutes, or if the Emergency physician or ED nurse feels the patient is potentially unstable, the MSE will be performed by the Emergency Medicine physician.
5. A patient will not be sent to the on-call (or personal) physician's office for an examination or treatment, unless deemed stable and appropriate by the Emergency Medicine physician. Notwithstanding the above, if specialized equipment exists in the practitioner's office, which would be necessary for care, the on-call physician may confer with the Emergency Medicine physician to determine if further treatment in the office would be safe for the patient and beneficial for care.
6. With regard to ED patients and inpatients, the physician on the ED call panel at the time consultant/specialist/surgical services are needed is the physician responsible for ensuring the related needs of the patient are met during that service encounter/admission.

a. If a patient presents to the ED with an Emergency Medical Condition and the on-call specialist is unavailable, the Emergency Medicine Physician will proceed as defined in section C.12 below.

7. Duties Of The On-Call Physician:
   a. Respond to the ED to medically screen and/or stabilize emergency patients.
   b. Respond to inpatient unit of the hospital to stabilize patients as requested. The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. See required timeframes under "duties of the on-call physician to inpatients" below.
   c. Accept transferred patients, from other hospitals, with an emergency medical condition on behalf of the hospital .If the hospital can provide the requested care for an emergency medical condition, and the transferring facility cannot provide this care, the hospital/on-call physician is obliged to accept the transfer.
   d. Report suspected EMTALA violations by other hospitals to the hospital's legal counsel and provide the necessary documentation.
8. Duties of the On-Call Physician to Inpatients
   a. Any member of the Medical Staff may request the services of the on-call physician to help stabilize and manage an inpatient in accordance with acceptable standards. All such requests shall indicate it is an urgent/emergent request (requiring a 30 minute telephone response) or non-emergent/urgent (requiring a 2-hour telephone response). The in-person consultation must be completed by the on-call physician or designated alternate within a clinically appropriate time frame and not to exceed 48 hours of request. Insurance Status:
   b. The hospital's normal registration process may be followed so long as a screening or stabilizing treatment is not delayed. The process may include discussion of insurance or payment obligations.
   c. The hospital will not require authorization from an individual's insurance company before providing a screening or initiating any necessary stabilizing treatment.
9. Mechanisms for maintaining the call roster:
   a. The rules and regulations of each applicable Department/Division will address credentials and qualifications regarding on-call services.
   b. The Emergency Department Roster for each specialty will:
      i. Be submitted to the Medical Staff Office at least two weeks in advance of the first day of the month.
      ii. Include the full month of coverage
      iii. List a specific physician's name for each day on call
         1. Every physician listed must be a member of the Medical Staff at TCMC and a member of the Department/Division responsible for the specialty's emergency coverage.
   c. Each on-call physician is solely responsible for arranging trades or temporary coverage of on-call duties. The on-call physician must notify the ED and the Medical Staff Office of any changes in advance.
   d. The Medical Staff Office will provide the ED on-call schedule to each physician who is taking call during the month.
   e. The Medical Staff Office will provide the ED on-call schedule to the ED and the TCMC Operators prior to the schedule starting.
10. Dispute Resolution:
   a. If an on-call physician disagrees with the Emergency Medicine physician about the need to come to the ED, he/she must still come to the ED to examine and treat the patient.
   b. The appropriateness of the Emergency Medicine physician's request for assistance can be reviewed through the regular Medical Staff processes after the patient has been treated (see Sections C.13 and 14).
11. Lack of Timely Response or refusal of the on-call to respond or unexpected lapses in on-call coverage:

a. If the Emergency Medicine physician or any member of the Medical Staff pursuant to item #8 above determines the patient requires the services of a physician listed by the hospital on its roster of on-call physicians, and if after being notified, the on-call physician fails or refuses to respond as described above, the Division Chief or Department Chair for the requested specialty shall be contacted to enforce the on-call obligation, or designate an alternative. A Quality Review Report (QRR) shall be completed regarding the failure/lack of timely response by the on-call physician, and submitted to Risk, Legal and Regulatory Services and the Medical Staff Office for follow-up.

b. If the failure/lack of timely response results in the Emergency Medicine physician ordering the transfer of the individual because without the services of the on-call physician the benefits of the transfer outweigh the risks of transfer; the Emergency Medicine physician responsible for transfer shall provide the name and address of the on-call physician to the receiving medical facility at the time of transfer. A QRR shall be completed for this event as well and submitted to Risk, Legal and Regulatory Services and the Medical Staff Office for follow-up.

c. In the event the on-call physician is unavailable as he/she is otherwise detained providing medical care, the on-call physician or his/her designee should inform the Emergency Medicine physician of the status of his/her availability. The Division Chief or Department Chair (for the requested specialty) shall be contacted to designate an alternative specialist to respond. If an alternative specialist is not available, the hospital's transfer policy will be invoked.

12. Disciplinary proceedings for failure to comply:
    a. Any QRR received due to failure to comply, will be referred to the respective Department Chair/Division Chief or designee for review and consideration. Investigation and subsequent actions may be instituted as described in the Medical Staff Bylaws, Article VI. At a minimum, a letter of inquiry should be sent to the non-compliant on-call physician requesting an explanation of his/her failure/lack of timely response to the request of the Emergency Medicine physician.
13. Quality Assurance Monitoring:
    a. Physician delay(s) as defined in this policy will be reviewed.
    b. Patient transfer(s) due to lack of response of on-call physician(s) or refusal to respond to Emergency Medicine physician when notified
14. CME:
    a. Provide a copy of current policy to each physician executing an agreement to provide on-call services.

D. **REFERENCES:**

1. 42 Code of Federal Regulations 489.24,Special Responsibilities of Medicare Hospitals in emergency cases. Medicare State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospital in Emergency Cases, Rev. 60, 07-16-10.
2. California Hospital Association, EMTALA – A Guide to Patient Anti-Dumping Laws, 2012.
3. EMTALA Field Guide, Third Edition, Stephen A. Frew, JD and Kris Giese, MHA, CHC, MT(ASCP).

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 10/05	**SUBJECT: Joint Providership/Co-Providership**
REVISION DATE(S): 05/09, 08/12, 09/14, 08/18	**POLICY NUMBER: 8710-602**
Medical Staff Department Approval:	**07/18, 01/19, 01/20**
CME Committee Approval:	**04/09, 07/12, 08/14, 07/18, 01/19, 01/20**
Pharmacy & Therapeutics Committee:	**n/a**
Medical Executive Committee Approval:	**05/09, 08/12, 09/14, 08/18, 02/19, 02/20**
Administration Approval:	**08/18, 03/19, 03/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/09, 08/12, 09/14, 08/18, 03/19**

A. **PURPOSE:**
1. To outline criteria utilized for Joint Providership or Co-Providership of a CME activity.

B. **DEFINITION(S)**:
1. Joint Providership– A relationship between an accredited CME provider and a non-accredited provider in which the accredited provider works in partnership with the non-accredited provider to plan and present CME activities in accordance with the mission of the accredited provider.
2. Co-Providership– A relationship between two accredited CME providers to plan and present CME activities.

C. **POLICY**:
1. The non-accredited organization should have as its primary interest the dissemination of health care information or the findings of medical research.
2. The non-accredited organization agrees to follow all procedures outlined by Tri-City Medical Staff and contained in the CME Policy Manual.
3. The Course Director should be a physician with an affiliation in the non-accredited organization.
4. The program planning request should be received at least six (6) months before the scheduled date of the activity. Timing for the activity should not conflict with other CME activities sponsored by Tri-City Medical Center.
5. Tri-City Medical Center CME planning forms are to be completed and submitted as part of the course file.
6. All promotional material shall follow Tri-City Medical Center's CME policies and be submitted for approval to the CME Coordinator before being distributed. Appropriate accreditation statements will be used and all materials must indicate joint sponsorship with Tri-City Medical Center CME as the accredited sponsor.
7. A course coordinator should be designated by the non-accredited organization to manage the administrative details.
8. All potential joint/co-providership relationships will be examined on their individual merits. Although all CME activities joint/co-providership with Tri-City Medical Center CME must comply with this policy, Tri-City Medical Center CME reserves the right to refuse to enter into a joint/co-providership agreement for any reason whatsoever, regardless of that organization's willingness to comply with this policy.
9. The responsibilities and role of the joint/co-provider will be clearly delineated in a letter of agreement between the joint/co-provider and Tri-city Medical Center CME. Tri-City Medical Center CME has the right to withdraw from any activity if the joint/co-provider fails to meet its

obligations as described in the letter of agreement or fails to comply with Tri-City Medical Center CME policies and procedures.

10. Tri-City Medical Center CME will charge fees for its services. These fees and the terms for its payment will be mutually agreed upon and delineated in the aforementioned letter of agreement between Tri-City Medical Center CME and the joint/co-provider.
11. All commercial support for Joint/co-provider activities shall be obtained as unrestricted grants, and all aspects of commercial support should be disclosed prior to approval of the activity. The CME Coordinator acting in behalf of the CME Committee will administer commercial support.
12. Joint provider activities shall be consistent with Tri-City Medical Center's CME Mission Statement.
13. Tri-City Medical Center, through its CME Committee, shall participate in the planning and implementation of these activities. A representative from the non-accredited entity should attend the CME Committee meeting to discuss progress.
14. All activity expenses are the responsibility of the organization seeking joint providership. Evidence of a proposed neutral budget is to be completed before expenses are incurred. Tri-City Medical Center will withdraw from an activity if resources are inadequate for the development of a high quality educational product or activity.
15. Attendance information should be submitted to the CME Coordinator within two (2) weeks of the activity in order to provide timely distribution of CME certificates.
16. The proposed CME activity cannot be advertised prior to CME Committee approval and the designation of CME credit.

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

1. Written Agreement for Joint Providership

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 06/04	**SUBJECT:** Medical Staff Governance Documents Development and Review and Approval Mechanism
REVISION DATE(S): 09/11	**POLICY NUMBER:** 8710 – 500

Medical Staff Department Approval ~~Date~~:	**03/17, 02/20**
Medical Staff Committee Approval ~~Date~~:	**n/a**
Pharmacy and Therapeutics Approval ~~Date~~:	**n/a**
Medical Executive Committee Approval ~~Date~~:	**03/17, 02/20**
Administration Approval:	**03/20**
Professional Affairs Committee Approval ~~Date~~:	**04/17, n/a**
Board of Directors Approval ~~Date~~:	**04/17**

A. **PURPOSE:**
1. To provide guidelines for development, review, revision and approval of Medical Staff self-governance documents.

B. **DEFINITION(S):**
1. For purposes of this policy, Medical Staff governance documents are the Medical Staff Bylaws and documents that supplement them, including but not limited to, rules and regulations, policies, protocols, and standardized procedures.
2. Standardized Procedures are as defined by Title 22 and Title 16 for the performance of medical procedures outside the normal scope of practice for a Registered Nurse.
3. Protocols are developed when the supervising physician adopts standards to govern the performance of a physician assistant for some or all tasks.
4. Process is a series of steps taken to accomplish a goal.
5. Policy describes a deliberate plan of action to guide decisions and achieve rational outcome(s).
6. Procedure describes how each step in the process is to be carried out.
7. Rules and Regulations refer to the rules and regulations that describe the privileges, competency, and other requirements of each Medical Staff Department and/or Division. The General Medical Staff Rules and Regulations apply to all Medical Staff Members regardless of Medical Staff status.
8. Medical Staff Bylaws define the Medical Staff as a self-governing body.
   a. Issues that must be addressed in the Medical Staff Bylaws are as required by:
      i. The Medicare Conditions of Participation
      ii. The Joint Commission Standards pertaining to the Medical Staff.
      iii. California Code of Regulations, Title 22 pertaining to the Medical Staff
   b. The Criteria used to identify the issues that must be addressed in the Medical Staff Bylaws are as required by the:
      i. Medicare Conditions of Participation
      ii. Joint Commission Standards pertaining to the Medical Staff
      iii. California Code of Regulations, Title 22, pertaining to the Medical Staff
      iv. Specific issues reviewed and determined to be appropriate by the Medical Staff Bylaws Committee
      v. Specific issues as presented by Medical Staff members.

C. **GUIDELINES:**

1. Medical Staff governance documents are developed as needs are identified. They may relate to regular operations or functions of the Medical Staff and are used to assure consistency for Medical Staff processes. Medical Staff governance documents are approved by the Medical Executive Committee and the Board of Directors. Medical Staff governance documents that are related to specific departments, divisions or committees will also be reviewed and approved by that respective group.
2. Standardized Procedures are developed when the physician is authorizing nurses to assist in certain patient care activities under the general supervision of physicians. Standardized Procedures are approved by the Division and/or Department level, the Pharmacy and Therapeutics Committee (if necessary), the Interdisciplinary Practice Committee, the Credentials Committee, the Medical Executive Committee and the Board of Directors of the hospital. Standardized Procedures are reviewed as provided in the standardized procedure, and updated as necessary.
3. Department and Division Rules and Regulations are subject to the approval process outlined in the Medical Staff Bylaws (Section 9.4(l) and 9.5).
4. The General Medical Staff Rules and Regulations are subject to the approval process outlined in Section 13.1 of the Medical Staff Bylaws.
5. Medical Staff Bylaws are reviewed and approved per Medical Staff Bylaws (Article 14).
6. The minimum content of protocols shall be as provided in California Business & Professions Code Section 3502. Protocols must be authenticated and dated by the supervising physician and the physician assistant, with a copy provided to the Medical Staff. The supervising physician shall review, counter-authenticate, and date a minimum of 10% sample of medical records of patients treated pursuant to protocols within thirty (30) days of the date of treatment. Protocols are approved by the Division and/or Department level, the Pharmacy and Therapeutics Committee (if necessary), the Interdisciplinary Practice Committee, the Credentials Committee, the Medical Executive Committee and the Board of Directors of the hospital. Protocols are reviewed and updated as necessary.

D. **REFERENCES:**

1. The Joint Commission 2017 Medical Staff Standards

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 10/01	**SUBJECT:** Name Tags for Health Care Practitioners
REVISION DATE(S): 09/11, 11/14	**POLICY NUMBER:** 8710 – 521
Medical Staff Department Approval ~~Date~~:	03/17, 02/20
Medical Staff Committee Approval ~~Date~~:	n/a
Pharmacy and Therapeutics Approval ~~Date~~:	n/a
Medical Executive Committee Approval ~~Date~~:	03/17, 02/20
Administration Approval:	03/20
Professional Affairs Committee Approval ~~Date~~:	04/17, n/a
Board of Directors Approval ~~Date~~:	04/17

A. **PURPOSE:**

1. To outline the requirements for name badges for Medical Staff members and Allied Health Professionals (AHP) in accordance with the provisions of California Business & Professions Code Section 680.

B. **REQUIREMENTS:**

1. All health care practitioners who have been granted membership and/or clinical privileges must wear name badges.
2. The name badge must disclose his/her name per license/credential, licensure status as granted by the State, and photo.
3. This name badge must be in at least 18-point type font.
4. The name badge must be worn and visible while providing care in the hospital.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 11/03	**SUBJECT: Physician Orders/Family Members**
REVISION DATE(S): 09/11. 12/14	**POLICY NUMBER: 8710 – 529**

Medical Staff Department Approval ~~Date~~:	**03/17, 02/20**
Medical Staff Committee Approval ~~Date~~:	**n/a**
Pharmacy and Therapeutics Approval ~~Date~~:	**n/a**
Medical Executive Committee Approval ~~Date~~:	**03/17, 02/20**
Administration Approval:	**03/20**
Professional Affairs Committee Approval ~~Date~~:	**04/17, n/a**
Board of Directors Approval ~~Date~~:	**04/17**

A. **PURPOSE:**

1. To outline the ethical and compliance issues for a physician who wants to order tests or therapies on themselves or their family members.

B. **POLICY:**

1. It is the policy of the Medical Staff of Tri-City Healthcare District (TCHD) that it is inappropriate for physicians to evaluate and treat themselves or immediate family members except in emergency settings, isolated settings where there is no other qualified physician available, or in situations in which routine care is acceptable for short-term, minor problems.
2. The AMA issued a statement, E-8.19 regarding physicians treating themselves or members of their immediate families and the Medical Staff supports that statement. (See attached AMA Statement)
3. The Code of Federal Regulations states that Medicare will not cover charges for services provided to a patient who is an immediate family member of the physician or a member of the physician's household.
4. TCHD follows Medicare rules with regard to compliance issues.

C. **DEFINITIONS OF TERMS:**

1. Immediate family members are defined as follows:
   a. Husband or wife
   b. Natural or adoptive parent, child or sibling
   c. Stepparent, stepchild, stepbrother, stepsister,
   d. Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law.
   e. Grandparent or grandchild
   f. Spouse of grandparent or grandchild.
2. Member of the household means:
   a. Any person sharing a common abode as part of a single-family unit.
   b. Domestic employees and others who live together as part of a family unit, not a roomer or boarder.
3. Physician:
   a. Immediate family member
   b. Member of household
   c. MD, DO, DDS with membership to TCHD Medical Staff
4. Patient means whoever of the following is receiving the tests or therapies:
   a. Physician
   b. Immediate family member
   c. Member of household

D. **PROCESS:**

1. Medical Staff members can only order tests and prescribe treatment for themselves, their immediate family members, and members of their household in an emergency, if there is no other qualified physician available, or in situations in which routine care is acceptable for short-term, minor problems.
2. Per Code of Federal Regulations and other TCHD contractual agreements, the patient may be responsible for charges incurred.

E. **GUIDELINES:**

1. AMA Ethical Opinion E-8.19.
2. 42 C.F.R. § 411.12

AMA STATEMENT

E-8.19 Self-Treatment or Treatment of Immediate Family Members.

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems.

Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members. (I, II, IV) Issued June 1993.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 06/04	**SUBJECT:** Physicians' Well-Being Committee Policy
REVISION DATE(S): 09/07, 03/12	**POLICY NUMBER:** 8710 – 511

Medical Staff Department Approval ~~Date~~:	03/17, 02/20
Medical Staff Committee Approval ~~Date~~:	n/a
Pharmacy and Therapeutics Approval ~~Date~~:	n/a
Medical Executive Committee Approval ~~Date~~:	03/17, 02/20
Administration Approval:	03/20
Professional Affairs Committee Approval ~~Date~~:	04/17, n/a
Board of Directors Approval ~~Date~~:	04/17

A. **POLICY:**

1. It is the policy of Tri-City Healthcare District (TCHD) Medical Staff to offer assistance to those physicians who are physically or emotionally impaired or under the influence of alcohol or drugs and who may benefit from rehabilitation or hospitalization. Furthermore, TCHD's policy is to enhance the safety and security of patients, physicians, and employees and to prevent impaired physicians who may harm patients from practicing medicine.
2. In this regard, this process provides education about physician health; addresses prevention of physical, psychiatric, or emotional illness; and facilitates confidential diagnosis, treatment, and rehabilitation of physicians who suffer from a potentially impairing condition.

B. **PURPOSE:**

1. The Physicians' Well-Being Committee is established to provide a process for assistance and rehabilitation, rather than discipline, to aid a physician in retaining or regaining optimal professional functioning, consistent with protection of patients, staff and physicians. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a physician is unable to safely perform the privileges he or she has been granted, the matter is forwarded for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

C. **PROCESS:**

1. The process design includes but is not limited to the mechanisms for the following:
   a. Evaluate the credibility of a complaint, allegation, or concern; communicate with the referred physician.
   b. Provide annual education to the medical staff and other TCHD staff about illnesses and impairment recognition issues specific to physicians, (at-risk criteria), and to take steps to promote wellness.
   c. Establish a self-referral process by a physician or other TCHD staff.
      i. Self-referrals shall be made directly to the Chairman of the Physicians' Well-Being Committee when possible.
      ii. Issues identified through the hospital's Quality Review Reporting process should be routed directly to the Medical Staff Office and forwarded to the Chairman of the Physicians' Well-Being Committee.
   d. Referral of the affected physician to the appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.

e. Assure and maintain the confidentiality of the physician who is seeking referral or being referred for assistance, and/or the informant if applicable, except as limited by applicable law, ethical obligation, or when the health and safety of a patient, staff, or other physician is threatened.
   i. Any retaliation against the informant will not be tolerated and will be referred to the Professional Behavior Committee for appropriate action.

f. Monitor the affected physician and the safety of patients until rehabilitation is complete and if applicable periodically thereafter.

g. Report to the Medical Staff leadership instances in which a physician is providing unsafe treatment or engaging in behavior that undermines the culture of safety.

D. **SPECIAL CONSIDERATION:**

1. It is the physician's responsibility to comply with the Physicians' Well-Being Committee's assistance and recommendations.
2. Noncompliance with completion of the required rehabilitation program will be reported to the Medical Executive Committee for appropriate action.
3. Unsafe treatment provided by an impaired physician will be reported to the Medical Executive Committee for appropriate action or referral.

E. **REPORTING:**

1. A report will be provided to the Medical Executive Committee and to the Board on a quarterly basis.

F. **DOCUMENTATION:**

1. While the Physicians' Well-Being Committee records are ultimately the property of TCHD Medical Staff, active records will be retained by the Chair of the Physician Well Being Committee.
2. Information, as applicable, will be maintained in a locked file in the Medical Staff Office with access only to the Chief of Staff and the Chair of the Physicians' Well-Being Committee.

G. **REFERENCES:**

1. The Joint Commission Medical Staff Standards 2017
2. Medical Staff Bylaws

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 02/01	**SUBJECT:** Professional Behavior Policy & Committee
REVISION DATE(S): 08/17, 01/13	**POLICY NUMBER:** 8710 – 570

Medical Staff Department Approval ~~Date~~:	03/17, 02/20
Medical Staff Committee Approval ~~Date~~:	n/a
Pharmacy and Therapeutics Approval ~~Date~~:	n/a
Medical Executive Committee Approval ~~Date~~:	03/17, 02/20
Administration Approval:	03/20
Professional Affairs Committee Approval ~~Date~~:	04/17, n/a
Board of Directors Approval ~~Date~~:	04/17

A. **POLICY:**

1. It is the policy of Tri-City Healthcare District (TCHD) Medical Staff to support and encourage appropriate professional behavior and a safe working environment at all times, and to evaluate allegations of behavior that undermines the culture of safety by physicians and to intervene when appropriate. The Medical Staff of TCHD recognizes the right of all individuals within the TCHD organization to be treated with dignity, courtesy and respect. Behavior that undermines the culture of safety compromises the ability of the healthcare team to perform effectively and may create a hostile work environment inhibiting optimal communication and performance.

B. **PURPOSE:**

1. To promote a professional atmosphere and a safe work environment where all Medical Staff members and Allied Health Professionals (AHP) shall conduct themselves in a professional manner when interacting with colleagues, hospital staff, patients, and guests. The Medical Staff, via the Medical Executive Committee (MEC) and in accordance with the Medical Staff Bylaws, shall be responsible for implementing and maintaining standards of behavior to promote and maintain a professional atmosphere.

C. **DEFINITION(S):**

1. Complainant: Any individual who witnesses a behavior and perceives it to be significant and worthy of intervention based on the Guidelines below.
2. Attributed Individual: Any Medical Staff member or AHP about whom a behavior concern has been reported.
3. Direct Supervisor: Hospital staff member (Director or Service Line Leader) who is responsible for initially investigating the alleged unprofessional behavior and initiating the process as defined below.

D. **POLICY:**

1. Acceptable behavior may include, but is not limited to the following attributes and behavior patterns:
   a. Consistent adherence to hospital and/or Medical Staff policies and procedures.
   b. Treatment of all persons with courtesy, respect, and dignity
   c. Appropriate response to inquiries
   d. Timely response to pages and staff requests
   e. Civil communication – i.e. well-mannered responses, appropriate language and tone, and a team-centered approach
   f. Utilization of chain of command to express concerns or to report issues

2. Unacceptable behavior may include, but is not limited to, the following attributes and behavior patterns:
   a. Disregard of hospital and/or Medical Staff policies and procedures
   b. Verbal or physical threats against anyone
   c. The use of demeaning or insulting remarks
   d. Aggressive or violent actions
   e. The use of profanity or excessive sarcasm
   f. Sexual or ethnic innuendos or harassment
   g. Inappropriate critiquing of hospital and/or Medical Staff members in public
   h. Inappropriate delay in responding to concerns and issues from hospital staff members
   i. Retaliation
3. The Professional Behavior Form provides a suggested sequence of procedural steps that creates a framework to document and resolve issues.

E. SPECIAL CONSIDERATIONS:

1. Communication:
   a. All parties involved, except when mandatory reporting is required by State or Federal regulations, will maintain confidentiality.
   b. Involved parties will limit discussion of the alleged issue to appropriate and/or formal venues.
   c. When there is suspicion the behavior is related to chemical dependency, or physical, psychological, or emotional impairment refer to Physician Well-Being policy, 8710-511.
   d. Education of Medical Staff and TCHD organization members will be provided to promote awareness of the policy.
   e. All new Medical Staff applicants will be informed about the policy
2. Flexibility:
   a. The Medical Staff leadership retains the prerogative to respond in an alternative manner other than by the Procedural Guidelines set forth below. In its discretion, leadership may direct a more immediate approach to an instance or a pattern of unacceptable behavior. Such a response may not utilize some or all of the elements of the Procedural Guidelines, or may use them in a different order. A situation may also necessitate a non-programmed response. Within the framework of the Medical Staff Bylaws and the operation of law, this policy is not intended to limit the responses of the Medical Staff to any prescribed formula or sequence of action.

F. PROCEDURE GUIDELINES:

1. This guideline is a suggested course of action, subject to deviation, based upon unique circumstances.
   a. Alleged unacceptable behavior occurs and is identified by the Complainant. (Box 1 of Professional Behavior Form)
   b. Complainant and Attributed Individual will attempt to resolve the issue in an amicable and timely manner. Direct communication between the Attributed Individual and the Complainant may be encouraged. If the issue is resolved then no further action will be needed.
   c. If Complainant is unable or unwilling to resolve the incident directly with the Attributed Individual, then the Direct Supervisor will become involved.
   d. The Direct Supervisor will investigate the perceived unacceptable behavior and document the findings on the Professional Behavior (PB) Form and assesses whether further intervention is required. (Box 2 of Professional Behavior Form)
   e. If the Direct Supervisor determines further intervention is not required, the completed Professional Behavior form will be forwarded to the Medical Staff Office for review by the Chief of Staff and for filing. Professional Behavior form will be labeled "No Intervention Required" and process will end.
   f. If the Direct Supervisor determines that further intervention is warranted, the Direct Supervisor and the Attributed Individual will meet to discuss the incident (Complainant

may be present).

g. If the issue is resolved, then an action plan, with identified goals for all involved parties, will be documented on the Professional Behavior Form and forwarded to the Medical Staff Office for review by the Chief of Staff and placement in the Professional Behavior Chair file.

h. If the issue is not resolved, the Director of the Direct Supervisor will contact the Director of the Medical Staff Office and relevant Hospital Administration (CEO, COO/CNE, and VP of Human Resources) if appropriate. The Chief of Staff will be notified.

i. The Chief of Staff will notify and confer with the Chair of the Professional Behavior Committee. An action plan will be developed that is tailored to the circumstances of the situation. The Authority of the Professional Behavior Committee Chair will be the following:
   i. Attempt further mediation and resolution by counseling the Attributed Individual.
   ii. Arrange meetings of relevant parties, at which he may attend or preside.
   iii. If voluntary measures fail to resolve the situation satisfactorily, the Chair, after consulting with the Professional Behavior Committee, may make any recommendations to the MEC, including:
      1) Mandatory psychological/medical evaluation and treatment,
      2) Restriction of privileges by the MEC and the Board of Directors,
      3) Suspension and/or termination of membership by the MEC and the Board of Directors.

j. All Professional Behavior Forms will be maintained in the Attributed Individual's Professional Behavior Committee file for confidential review by the Chief of Staff, Professional Behavior Committee Chair, and the Director of Medical Staff Services. The information contained therein will be considered at the time of reappointment of Attributed Individual, and may be shared on a strict-need-know basis with the Credentials Committee, the MEC, or ad-hoc committees, all meeting in executive session. The pertinent Department Chair or Division Chief may be invited to those sessions.

k. Non-confidential feedback may be provided to the Complainant regarding resolution of the issue, but only from the Chief of Staff, the Professional Behavior Committee Chair, or their designees.

l. This statement is included in #10

G. DOCUMENTATION:

1. Documentation will be prepared as objectively as possible, utilizing factual information.
2. Completion of the Professional Behavior Form (PB form).

H. ATTACHMENT(S):

1. Professional Behavior (PB) Form - Sample

I. REFERENCES:

1. The Joint Commission Standards, 2017

Tri-City Medical Center

Professional Behavioral Form - Sample
(PB Form)
Confidential Report

Abbreviations Used:

PBC:	Professional Behavior Committee
MSO:	Medical Staff Office
COS:	Chief of Staff
AI:	Attributed Individual
MEC:	Medical Executive Committee

Box 1 (refers to step 1 of Procedural Guidelines)

I. Complainant will describe issues of concern:

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

Complainant Printed Name: _____

Box 2 (refers to step 4 of Procedural Guidelines)

II. Direct Supervisor Investigation and Documentation:

_____

_____

_____

_____

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_____

_____

_____

A. Is intervention with the AI necessary? ☐ Yes ☐ No

If **NO**, forward this completed form to the MSO for review by the COS and the PBC Chair, and filing.

If **YES**, proceed with meeting the AI.

B. Did the meeting with the AI resolve the issue(s)? ☐ Yes ☐ No

If **Yes**, forward this completed form with an action plan and goals for all involved parties to the MSO for review and filing.

If **No**, COS and PBC Chair shall be informed immediately. Refer to step 8 of the Procedural Guidelines.

Documentation and narrative of meeting between AI and Direct Supervisor. Include Action Plan/Goals/and Resolution if they were achieved.

_____

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Signatures

Direct Supervisor:_____ Date:_____

Direct Supervisor Printed Name:_____

AI:_____ Date:_____

AI Printed Name:_____

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 04/09	**SUBJECT: Regularly Scheduled Series (RSS)**
REVISION DATE(S): 12/09, 11/12, 09/14, 08/18	**POLICY NUMBER: 8710-606**
Medical Staff Department Approval:	**07/18, 01/19, 01/20**
CME Committee Approval:	**10/09, 10/12, 08/14, 07/18, 01/19, 01/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**11/09, 11/12, 09/14, 08/18, 02/19, 02/20**
Administration Approval:	**08/18, 03/19, 03/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/09, 11/12, 09/14, 08/18, 03/19**

A. **PURPOSE:**
1. To outline criteria and process for approving and evaluating outcomes for Regularly Scheduled Series (RSS).

B. **DEFINITION(S)**: A regularly scheduled Series (RSS) is planned to have:
1. A series with multiple sessions
2. The series occurs on an ongoing basis (offered weekly, monthly, or quarterly)
3. The series is planned by and presented to the accredited organization's professional staff
4. The series are only offered as directly-sponsored activities to the accredited organization's professional staff

C. **POLICY:**
1. RSS conferences such as cancer conferences and cardiovascular conferences are approved on the basis of common needs and goals for each session for a one-year period.
2. Initial RSS Request: Required documentation to be provided to the CME Committee at least 60 days before the first session is scheduled:
   a. Request for AMA PRA Category 1 Credit(s)™
   b. Planner and Faculty disclosure forms
3. Continuing RSS: For regularly scheduled series conferences currently taking place with Category 1 credit, the planner shall submit on an annual basis to the CME Coordinator the Annual Evaluation and Outcomes form and a new Request for AMA PRA Category 1 Credit(s)™ and Faculty Disclosure form(s). A 60-day time frame for CME Committee review is encouraged.
4. Conference Planner: The conference planner is responsible for providing the following documentation to the CME Coordinator within 30 days of the session date:
   a. Session Case Selection & Outcomes form
   b. Completed evaluation forms
   c. Evaluation summary
   d. CME Reporting Form
   e. Attendance roster
   f. Case summaries (if applicable)
   g. Copy of promotion materials (flyer)
5. Regularly scheduled series conferences must be at least 50 minutes in length for one (1) category 1 credit.

D. **EVALUATION – IMPROVEMENT:**
1. Learners will complete an annual RSS *Learner Evaluation* form. Results will be summarized

and provided to the CME Committee.

E. REFERENCE(S):

1. Institute for Medical Quality (IMQ)/California Medical Association (CMA) 2014 CME Accreditation Criteria and Policies for Continuing Medical Education (CME) * with annual report.

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
HUMAN RESOURCES – PAY PRACTICE

ISSUE DATE: 10/04

SUBJECT: Compensation for Mandatory Education

REVISION DATE(S): 12/14, 06/19

POLICY NUMBER: 8610-474.01

Human Resources Department Approval:	~~05/19~~02/20
Administrative Policies & Procedures Committee Approval:	~~05/19~~02/20
Medical Executive Committee Approval:	n/a
Administration Approval:	~~06/19~~03/20
Professional Affairs Committee:	n/a
Board of Directors:	06/19

A. **PURPOSE:**

1. To establish compensation practices for mandatory training and education.

B. **POLICY:**

~~1. To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.~~

~~2.~~1. All fulltime, part time and per diem employees ~~of Tri-City Healthcare District (TCHD)~~ will be compensated for ~~their~~ attendance at approved mandatory meetings, training programs, ~~lectures~~ and/or similar activities **(e.g., renewal of required certifications)**.

2. Employees will not be reimbursed for expenses related to the re-certification or renewal of expired certificates or professional licenses.

~~3 Employees will not be reimbursed for expenses related to the re-certification or renewal of expired certificates or professional licenses.~~

3. **Registered Nurses under the CNA contract must code mandatory training using the appropriate Kronos workrule – MandClass.**

~~4. Eligible employees will be compensated for actual time spent at approved mandatory meetings, training programs, lectures and/or similar activities and TCHD will consider the time as hours worked.~~

~~5. Employees must schedule their approved mandatory meetings, training programs, lectures and/or similar activities without incurring overtime.~~
~~Approved training and seminars are listed on the following table and are not to exceed the maximum hours.~~

C. **FORMS/TABLES/SCHEDULES:**

~~C.~~1. **Approved hours for Required Education/Certification**

Class/Course Certification ~~Training and Seminars~~	~~Compensation~~	Payment Schedule ~~Maximum Hours~~
Advanced Cardiac Life Support (ACLS)	~~Actual Time in Attendance~~	Initial Certification: 16 Hours Renewal ~~Certification~~: 8 Hours

Class/Course Certification ~~**Training and Seminars**~~	~~**Compensation**~~	**Payment Schedule** ~~**Maximum Hours**~~
Basic Life Support (BLS)	~~Actual Time in Attendance~~	Initial Certification: **Up to** 4 Hours ~~In-Class~~ Renewal ~~Certification~~: **Up to** 3 Hours Online Renewal~~/Skills Certification~~: **Up to** ~~23~~ Hours total
Fetal Monitoring	~~Actual Time in Attendance.~~	Initial ~~Certification~~: **Up to** 16 Hours Renewal ~~Certification~~: **Up to** 8 Hours
Neonatal Resuscitation Program (NRP)	~~Actual Time in Attendance~~	**Certification:** 4 Hours
Nonviolent Crisis Intervention (NVCI)	~~Actual Time in Attendance~~	Initial Certification: **Up to** 8 Hours Renewal ~~Certification~~: **Up to** 4 Hours Flex Certification: 3 Hours total
Pediatric Advanced Life Support (PALS)	~~Actual Time in Attendance~~	Initial Certification: 16 Hours Renewal ~~Certification~~: 8 Hours
Safety, Joint Commission, and/or Annual NetLearning Education	~~Actual Time in Attendance~~	**Paid for actual time required**~~No Maximum~~
~~**Skills Lab**~~		~~**Up to 4 hours annually**~~
~~**ENPC**~~		~~**Certification 16 hours**~~
Other	**VP**~~Human Resources~~ Approval Required	

Tri-City Medical Center
Oceanside, California

PULMONARY REHABILITATION

DELETE follow Patient Care Service Policy: Glucose Monitoring During Exercise Therapy for Diabetic Patients

ISSUE DATE: 09/08

SUBJECT: Glucose Monitoring and Exercise Therapy for Diabetic Patients

REVISION DATE:

Pulmonary Rehab Department Approval Date(s):	02/20
Division of Pulmonary Approval Date(s):	n/a
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	02/20
Administration Approval:	03/20
Professional Affairs Committee Approval Date(s):	n/a
Board of Directors Approval Date(s):	12/12

~~A. **PERSONNEL:**~~

~~1. All staff members of Pulmonary Rehabilitation with specific training for use of the glucose monitoring system.~~

~~B. **PURPOSE:**~~

~~1. To provide safe, therapeutic care for diabetic patients while exercising.~~

~~C. **POLICY:**~~

~~1. All insulin dependent diabetic patients will check their own blood glucose levels at home within 1 hour prior to exercise and a Pulmonary Rehabilitation staff member will check the patient following each exercise session during the course of Pulmonary Rehabilitation. All non- insulin dependent diabetic patients will follow this course if unstable.~~

~~D. **PROCEDURE:**~~

~~1. Each patient shall check their own glucose at home and report findings to rehab staff before initiation of exercise therapy. Blood glucose levels shall be checked before exercise and after exercise. Follow immediately with action based on results.~~

~~2. If blood glucose is less than 100 mg/dL, the patient shall eat a pre-exercise snack of 15 gm carbohydrate which they are instructed to bring to every session. Graham crackers, peanut butter and juice are kept in the department in case the patient did not bring his/her own snack.~~

~~3. For patients with a pre exercise blood sugar less than 100 who have eaten a 15 gm carbohydrate snack, monitor blood glucose level half way through exercise. If blood glucose level remains low despite snacks, stop exercise and notify physician. If blood glucose level is 100-300 mg/dL, exercise may be continued.~~

~~4. If blood glucose is greater than 300 mg/dL, patient may not exercise unless approved by his/her physician. Notify physician if patient is unable to exercise due to elevated blood glucose level.~~

~~5. For blood sugars less than 70 with complaints of nausea, anxiety, dizziness, shakiness and/or diaphoresis. Provide fast acting carbohydrates such as:~~

~~a. Four ounces of juice.~~

~~b. 15 grams of carbohydrate.~~

~~Following intervention, continue to observe the patient for recurrent hypoglycemia and recheck blood sugar in 15 minutes. If repeat blood sugar is less than 70, repeat treatment and retest in 15 minutes. Notify the physician for repeated low blood sugar levels.~~

~~6. If the patient is driving him/herself, the post exercise blood sugar should be 100 or greater. If the post exercise blood sugar is less than 100 they should have a snack of 15 grams of carbohydrate and retest in 15 minutes and repeat until 100 or greater~~ before discharged home.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 06/09 **SUBJECT:** Age Appropropriate Care

REVISION DATE(S): 11/12

Surgical Services Department Approval:	02/20
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	03/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/13

A. **PURPOSE:**
1. All employees shall demonstrate the skills and knowledge required to provide age specific care for patients and their caregiver/family in the perioperative setting.

B. **POLICY:**
1. Educational content including the principles of growth and development over the life span **served by Tri-City Medical Center department of Surgery** shall be provided during orientation.
2. Reviews of the knowledge and skills necessary for required age specific care shall be provided annually via a Net Learning module and exam.
3. Knowledge, skill base and ability to provide care appropriate to the patients served on the unit shall be evaluated during orientation and at each annual performance review.
4. Employees shall include family/caregiver as appropriate in meeting age specific needs of the patient.
5. Plans of care shall be modified to meet age specific physiological, psychological, and the social needs of the patient.
6. The guidelines for age specific care shall be followed for planning, implementation and evaluation of patient care.
7. Age appropriate medication dosages, therapeutic ranges and age specific laboratory values can be obtained from the pharmacy and laboratory departments as needed.
8. Additional guidelines for care of patients with age-associated illness, physical limitations and needs are obtainable from the education department.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

DELETE
Follow SDS and Manufacturer's IFU

ISSUE DATE: 09/09

SUBJECT: PERACETIC ACID: DISPOSAL OF

REVISION DATE(S): 10/12

Department Approval:	**02/20**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**03/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/13**

A. **PURPOSE:**
1. To provide guidelines for the proper disposal of Steris S40 Sterilant Concentrate (Peroxyacetic Acid), that may be spilled or from a leaking container or from an aborted sterilization cycle.

B. **DEFINITIONS:**
1. STERIS S40 Sterilant Concentrate: Consists of liquid 35% Peracetic acid (PAA) and powered inactive salts/buffers. 35% PAA is a corrosive liquid due to its low pH. Contact with the powdered ingredients in the outer cup of S40 sterilant may cause an allergic reaction. PAA poses the greatest hazard of these three constituents and is therefore the focus of this policy and procedure. Contact with the PAA portion of the S40 sterilant may cause irreversible eye damage, blindness, irritation to the nose, throat and lungs, and skin.
2. MSDS: Material Safety Data Sheet
3. 3E Company Emergency Hotline: 1-800-451-8346
4. Appropriately Trained Personnel: Those individuals having documented in-service training on Peracetic acid and this policy and procedure.

C. **POLICY:**
1. Leaking Containers:
   a. Notify Immediate Supervisor.
   b. Increase ventilation to the area.
   c. Determine if Safety Officer needs notification, and/or additional resources are necessary.
   d. Shut off any ignition sources.
   e. Put on protective goggles, gloves, apron, and any other impervious clothing.
   f. Remove an individual box and cup submerge ina sink filled with at least 12 inches of water.
   g. **WHILE SUBMERGED**, remove cup from the box. Rinse box in water and drain. Discard box following procedures for clean paper waste. Open the submerged container cup manually with scissors, to dilute the remaining acid. **AVOID SPLASHING OR SPRAYING.** Dilute both liquid (PAA) and powder (both outer & inner container) in a minimum of 20 volumes of water.
   h. Drain sink and wash residual powders away.
   i. Rinse inner and outer cups with copious amounts of running water (at least one gallon per cup.
   j. Thoroughly drain the cup and discard following the procedures for clean plastic/paper waste.

2. Small Spills (Up to One Cup):
   a. Notify Immediate Supervisor or Administrative Liaison
   b. Notify Safety Officer by the next business day.
   c. Increase ventilation to the area, and/or use portable fans where applicable.
   d. Shut off any ignition sources.
   e. Put on protective goggles, gloves, apron, and any other impervious clothing.
   f. Approach the release enduring fans are moving contaminated air away from you. Flush the spilled materials with large quantities of water or until all materials are dissolved/diluted by at least 20 volumes.
   g. Wipe up small liquid spills with absorbent towels, sponges or mops. Thoroughly rinse the area and dry.
      NOTE: Towels, sponges or mops, whether reusable or disposable used to clean up spillage, must be thoroughly rinsed with a minimum of 20 volumes of water before disposal into appropriate receptacles (i.e. trash or soiled linen).
   h. After Initial Spill cleanup, notify EVS to decontaminate area using a general purpose cleaner and water.
3. Special note about fire:
   Stabilized Peracetic acid decomposes under fire conditions to release oxygen that may intensify the fire. Therefore, containers that are exposed to fire conditions will be controlled only by those with appropriate fire fighting training.

D. **REFERENCES**
1. Steris System 1 E Operation Manual
2. MSDS No.612038 REV. (01/21/2009)

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94 **SUBJECT:** Traffic Patterns

REVISION DATE(S): 02/05; 06/09; 10/12

Surgical Services Department Approval:	02/20
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	03/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/13

A. **PURPOSE:**

1. To define the traffic patterns and designated ~~control zones in~~**zones in** Surgical Services ~~to reduce the level of microorganisms within the environment and control cross contamination of personnel and supplies~~**based on the activities performed in each area, the access pathway, and required attire, in order to provide the cleanest environment in the restricted area.**

B. **DEFINITION(S):**

1. **Restricted areas: Areas which are accessible only from semi-restricted areas. Wearing of surgical attire is required and masks are required in the presence of open sterile supplies or scrubbed personnel. Restricted areas include the Operating Rooms (OR's) and sub-sterile rooms. The restricted area is separated from the semi-restricted area by a door.** ~~Restricted Zone of the surgical area is beyond the red lines in the main hallway by OR 5 and OR 1, at the entrances to OR 11, in the Case Cart Storage room by the front desk, the dirty utility room, and the clean elevator to Sterile Processing Department (SPD) by the front desk.~~
2. **Semi-restricted areas: Areas which are accessible from unrestricted, other semi-restricted, or restricted areas. Wearing of surgical attire is required. Semi-restricted areas include corridors leading to the Operating Rooms, sterile storage rooms, Anesthesia workroom, peripheral support areas and processing areas.**
3. **Unrestricted areas: Areas which are accessible from the exterior of the building, other unrestricted areas or semi-restricted areas. Wearing of surgical attire is not required. Unrestricted areas include Pre-Op Hold, PACU, OR desk, offices, and hallways leading to these areas.** ~~Unrestricted Zone of the surgical area includes the main hallway to the OR suites and the side hallway by OR's 11 and 12.~~

C. **POLICY:**

1. **Semi-restricted areas in Surgical Services and Sterile Processing Department (SPD) are identified by a red line on the floor.**
2. ~~Restricted Zone: Full s~~Surgical attire is required in ~~the~~ **semi-**restricted **and restricted** ~~zone~~**areas, per Patient Care Services (PCS) Policy: Surgical Attire.** ~~including scrub garments, surgical head covers, and optional shoe covers.~~ A mask is required in these areas ~~when sterile procedures are being performed, sterile supplies are open or being transported, or personnel are performing a surgical hand scrub~~**in the presence of an open sterile field or scrubbed personnel.**
3. ~~Unrestricted Zone:~~ **Surgical Attire is not required in unrestricted areas; wearing of street clothes is permitted.** ~~Street clothes are permitted in the unrestricted zone and traffic is not~~

~~limited. Personnel in PACU wear personal (non-hospital) scrub garments. Personnel in PreOp Hold wear hospital scrub garments, for the need may arise to enter the restricted zone.~~

~~3.~~4. All external packing **and shipping** boxes/**containers** must be removed before they are transported into the **semi-**restricted **or restricted** zones of ~~the surgical suite or SPD~~**Surgical Services**.

~~4.~~5. ~~Soiled c~~**C**ontaminated instruments ~~must never be~~**are** transported **to SPD** ~~from one restricted area to another restricted area~~**in enclosed case carts marked Biohazard**. All contaminated trash, soiled linen and ~~dirty~~ **contaminated** instruments **and equipment** ~~will are go down~~ **transported** to the decontamination area of SPD via the dirty elevator.

~~5.~~6. ~~All c~~**C**lean case carts with sterile instruments and supplies ~~will arrive~~**are transported to Surgery** via ~~the~~ **a** clean elevator. ~~from SPD's clean area.~~

7. Equipment -brought into the **semi-**restricted **or restricted** areas (i.e. x-ray machines, gas tanks) must be covered or ~~wiped down~~ **cleaned** with hospital approved disinfectant ~~to remove dust and external debris~~ before ~~it is used~~**being transported into these areas**. ~~Equipment is to be wiped down outside the restricted area.~~

~~6.~~8. **Heating, Ventilating, and Air Conditioning (HVAC) design parameters for all zones in Surgical Services are monitored by Building Engineering department.**

~~7. Restricted areas of SPD include the prep and pack room, and the sterile instrument supply area. There is a red line in both of these areas to denote the restriction.~~

D. <u>REFERENCES</u>:

1. **AORN, Inc. (2020).** ***Guidelines for Perioperative Practice.*** **Denver.**

~~1.~~2. **Rothrock, J. C. & McEwen, D. R. (2019).** ***Alexander's Care of the Patient in Surgery, 16th Edition.*** **St. Louis, MO: Elsevier.**

Community Healthcare & Alliance Committee (No meeting held in March, 2020)

Finance, Operations & Planning Committee (No meeting held in March, 2020)

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

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

February 27, 2020 – 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 February 27, 2020.

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

Absent was Director Tracy M. Younger

Also present were:

Steven Dietlin, Chief Executive Officer
Ray Rivas, Chief Financial
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 indicated that a settlement of an existing litigation matter (Case No. 37-2018-00038033CU-BC-CTL) has arisen subsequent to the posting of the agenda. In addition, Foundation President Jennifer Paroly is not available today so the Foundation Report (item 13) will be deferred.

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

3. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the February 27, 2020 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 February 27, 2020 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included three (3) matters of Potential Litigation, one matter of Existing Litigation, and Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committee and Approval of Closed Session Minutes.

5. Motion to go into Closed Session

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

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

Absent was 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 reports of the Hospital Medical Audit or Quality Assurance Committees and took no action.

The Board in Closed Session unanimously authorized settlement in Case No. 37-2018-00038033CU-BC-CTL).

The Board in Closed Session also heard reports on three matters of Potential Litigation and took no action.

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

10. Director Chavez 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. Special Presentation –

Environment of Care Report – Jeff Surowiec, Manager/Safety Officer

Mr. Jeff Surowiec, Manager/Safety Officer provided an overview of the following plans:

- Environment of Care which included an annual review/revision of the seven (7) EOC chapters to maintain regulatory compliance, identify opportunities for improvement and objectives reached;
- Safety Management which reflected Environmental Tours Rounding and is controlled by the Joint Commission;
- Security Management which ensures a secure environment as well as a Weapons Scanner; and
- Emergency Management which included CMS Requirement Changes Effective 2019.

13. TCHD Foundation – Jennifer Paroly, President

The Foundation report was deferred to a future meeting.

14. January 2020 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 – $199,768
- Operating Expense – $210,352
- EBITDA – $3,020
- EROE – ($4,976)

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

- Average Daily Census –148
- Adjusted Patient Days – 59,124
- Surgery Cases – 3,677
- ED Visits – 33,063

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

- Net Operating Revenue - $30,162
- Operating Expense - $31,506
- EBITDA - $367

- EROE – ($860)

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

- Average Daily Census - 154
- Adjusted Patient Days – 8,610
- Surgery Cases – 517
- ED Visits – 4,832

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

- Net Patient Accounts Receivable - $47.1
- Days in Net Accounts Receivable – 59.4

No action taken.

15. New Business –

a) Consideration to dissolve Professional Affairs Committee

It was moved by Director Reno to dissolve the Professional Affairs Committee. Director Schallock seconded the motion.

Director Reno stated the committee has not met in over a year. She commented on topics she would like to see discussed on the Governance & Legislative Committee which was recently resurrected. Chairperson Grass stated the Governance & Legislative Ad Hoc Committee will bring forward a proposed Charter and committee structure for the Board's consideration.

The vote on the motion was as follows:

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

16. Old Business – none

17. Chief of Staff

a) Consideration of February 2020 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on February 24, 2020.

Dr. Yamanaka reported one exception to the proposed Initial Credentials Report. He stated Dr. Alexander Zabaneh has withdrawn his application.

It was moved by Director Nygaard to approve the 2020 Credentialing Actions and Reappointments Involving the Medical Staff as amended and recommended by the Medical Executive Committee on February 24, 2020.

The vote on the motion was as follows:

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

b) Rules & Regulations

1) Department of Surgery

It was moved by Director Schallock to approve the Department of Surgery Rules & Regulations as recommended by the Medical Executive Committee on February 24, 2020. Director Reno seconded the motion.

The vote on the motion was as follows:

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

c) Continuing Medical Education Mission Statement

It was moved by Director Nygaard to approve the Continuing Medical Education Mission Statement as recommended by the Medical Executive Committee on February 24, 2020. Director Reno seconded the motion.

The vote on the motion was as follows:

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

d) Categories of AHP's Eligible to Apply for Clinical Privileges

It was moved by Director Schallock to approve the Categories of AHP's Eligible to Apply for Clinical Privileges as recommended by the Medical Executive Committee on February 24, 2020. Director Nygaard seconded the motion.

The vote on the motion was as follows:

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

18. Consideration of Consent Calendar

It was moved by Director Nygaard to approve the Consent Agenda. Director Reno seconded the motion.

It was moved by Director Schallock to pull item 18 (1) d) 2) Rehabilitation Leadership Structure. Director Reno seconded the motion.

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

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

19. Discussion of items pulled from Consent Calendar

Director Schallock requested clarification on the Leadership Structure policy. Mr. Scott Livingstone, COO explained that general requirements for an acute care hospital require that the structure be identified in a document which necessitated the creation of the Rehabilitation Leadership Structure policy.

It was moved by Director Schallock to approve the Rehabilitation Leadership Structure as presented. Director Nygaard seconded the motion.

The vote on the motion was as follows:

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

20. Comments by Members of the Public

There were no comments by members of the public.

21. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO reported on the following events:

- Heroes of Vista Gala will be held on Saturday, February 29th with Lifetime Achievement award going to Rita Geldert, Foundation President.
- American Heart Association Annual Heart Walk will be held on Saturday, March 7th at the Carlsbad Flower Fields

In closing, Mr. Dietlin read a letter from a patient to the Board of Directors in deep appreciation for the care provided.

22. Board Communications

Director Chavez reported he will be unable to attend the Heart Walk but will be there in spirit.

Director Coulter urged everyone to remain calm in the wake of COVID-19, practice good hand hygiene and social distancing.

Director Reno recognized Dr. Robert Andrews, a former Tri-City Neurosurgeon from 1967 – 2000 who recently passed away. Director Reno stated she plans to make a donation to the Auxiliary Scholarship fund for $1,000 in Dr. Andrews' honor.

Director Nygaard commented on how fortunate we are to have such excellent heart care in our community. She stated her family has personally benefited from Tri-City's excellent heart care.

Director Schallock reiterated Director Coulter's comments related to the Corona Virus. He also commented on the importance of hospital readiness in terms of necessary staff and supplies.

23. Report from Chairperson

Chairperson Grass reported on the following events:

- March is National Social Worker month.
- March 30th is National Doctors' Day.

She encouraged everyone to recognize our hand-working Social Workers and outstanding physicians.

24. There being no further business Chairperson Grass adjourned the meeting at 4:08 p.m.

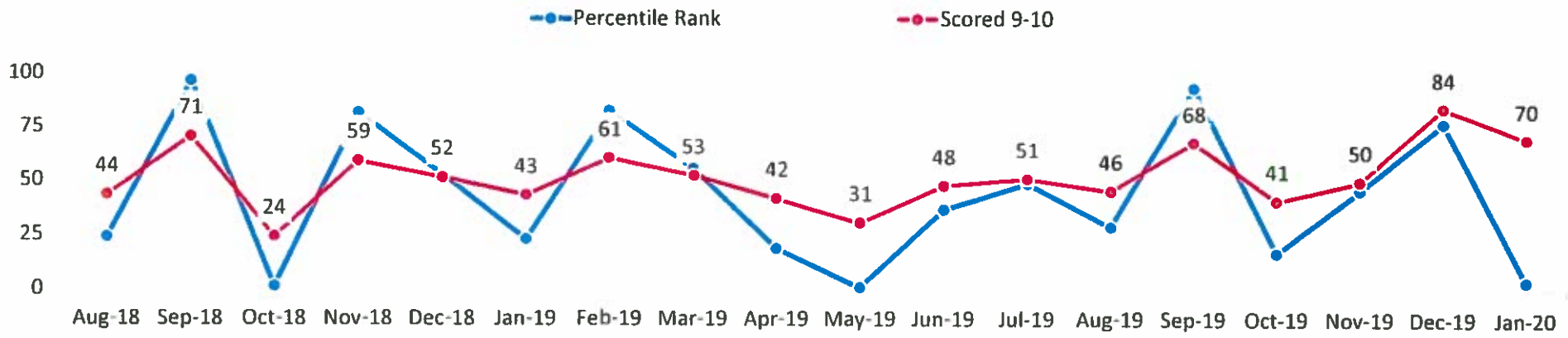
_____
Leigh Anne Grass, Chairperson

ATTEST:

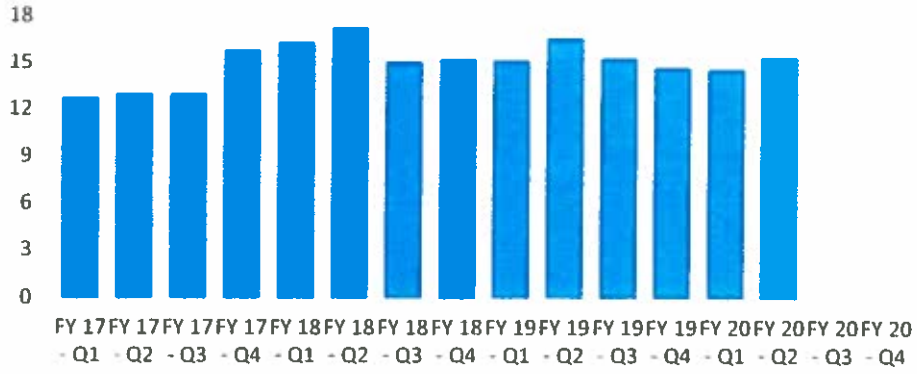
_____
Julie Nygaard, Secretary

Stakeholder Experiences

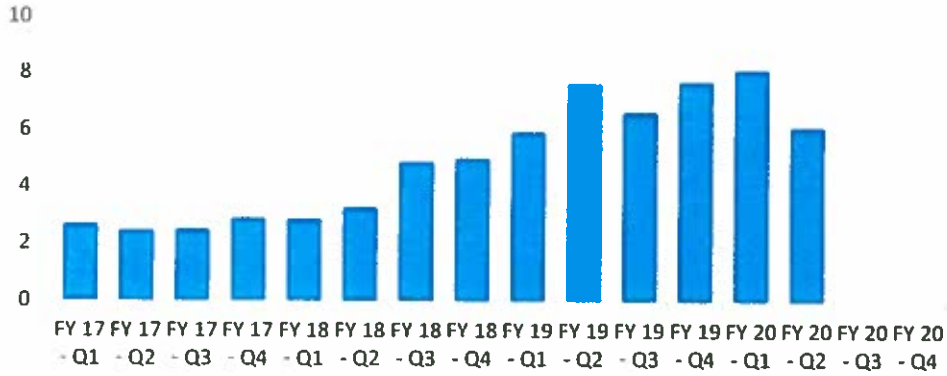
Overall Rating of Hospital (0-10)



Voluntary Employee Turnover Rate



Involuntary Employee Turnover Rate



Volume

Performance compared to prior year: Better | Same | Worse

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	16	19	18	31	30	15	20	19					168
FY19	18	29	19	27	18	24	22	16	23	30	25	24	173

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	9	8	9	12	7	5	11	9					70
FY19	10	12	3	7	7	9	10	4	16	15	11	12	62

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	9	16	11	11	12	13	10	8					90
FY19	19	16	12	16	12	16	17	13	18	16	10	15	121

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	19	23	27	33	31	24	27	29					213
FY19	20	23	18	22	17	21	19	16	18	12	20	24	156

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	33	33	23	31	35	31	26	29					241
FY19	31	31	27	35	38	31	23	40	36	24	29	36	256

Performance compared to prior year: Better | Same | Worse

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	-	-	-	-	-	-	-	-	-	-	-	-	-
FY19	10.8	11.3	9.7	-	-	-	-	-	-	-	-	-	4.0

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	6.2	4.5	7.7	7.0	5.0	3.0	7.1	7.7					6.0
FY19	7.4	9.1	6.5	4.7	5.7	5.3	6.8	8.4	7.2	5.8	4.4	6.5	6.7

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	9.4	10.3	13.4	9.7	9.5	9.4	7.8	10.7					10.0
FY19	11.4	9.8	10.0	11.0	11.6	8.7	10.1	8.9	11.3	10.0	9.5	10.4	10.2

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	143.4	143.6	150.6	143.2	144.0	160.2	153.9	149.3					148.5
FY19	160.3	155.9	146.4	149.6	143.7	153.2	164.8	166.3	157.7	142.4	143.3	146.5	155.0

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	168	171	156	159	146	159	153	136					1,248
FY19	186	202	170	187	185	166	170	150	177	131	146	156	1,416

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	7	8	7	17	14	10	13	10					86
FY19	8	10	6	8	3	15	6	9	11	10	20	13	65

Performance compared to prior year: Better | Same | Worse

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	7	9	12	6	11	9	14	8					72
FY19	3	4	3	13	13	6	11	17	6	10	7	9	70

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	9	5	2	8	5	5	4	8					46
FY19	8	8	6	8	4	14	8	10	16	6	7	5	66

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	1.85	1.89	1.91	1.86	1.86	1.79	1.80	1.80					1.85
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	1.78

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY20	52.8	56.4	59.2	61.2	61.9	62.6	61.5	58.7					59.3	48-52
FY19	51.0	48.5	50.3	49.5	52.3	56.5	58.9	56.7	57.0	50.5	48.9	53.2	53.0	

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY20	93.0	89.9	90.8	98.4	92.8	85.5	88.5	94.3					91.6	75-100
FY19	84.9	86.5	90.2	91.4	92.5	87.8	93.1	92.2	83.6	84.1	91.4	87.6	89.8	

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY20	($476)	($494)	($759)	($311)	($1,036)	($1,040)	($860)	($735)					($5,711)	($2,052)
FY19	($478)	($121)	$119	$254	$342	$236	($527)	$99	$206	$885	$904	($6,138)	($76)	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY20	-1.65%	-1.66%	-2.71%	-1.08%	-3.91%	-3.75%	-2.85%	-2.69%					-2.51%	-0.88%
FY19	-1.64%	-0.39%	0.41%	0.86%	1.19%	0.79%	-1.76%	0.34%	0.67%	2.89%	2.88%	-21.60%	-0.03%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY20	$686	$681	$412	$683	$62	$128	$367	$551					$3,571	$ 7,284
FY19	$796	$1,168	$1,417	$1,561	$1,618	$1,544	$826	$1,468	$1,548	$2,219	$2,221	($4,712)	$10,398	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY20	2.38%	2.30%	1.47%	2.36%	0.24%	0.46%	1.22%	2.02%					1.57%	3.13%
FY19	2.73%	3.81%	4.90%	5.28%	5.65%	5.20%	2.76%	5.07%	5.00%	7.25%	7.07%	-16.58%	4.42%	

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY20	7.04	6.80	6.21	6.90	6.58	6.44	6.71	6.82					6.69	6.88
FY19	6.73	6.70	6.75	6.98	7.82	6.50	6.68	6.52	6.71	7.27	7.29	6.79	6.83	

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY20	$52.4	$44.8	$43.7	$45.6	$38.2	$31.9	$35.2	$35.8					
FY19	$50.0	$49.5	$49.3	$48.1	$37.5	$29.5	$36.3	$32.9	$20.6	$40.7	$57.1	$54.5	

Tri-City Medical Center ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending February29, 2020

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	47,418.30	07/01/17	06/30/27	**OSNC - Carlsbad** 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011	7095
American Health & Retirement DBA: Vista Medical Plaza 140 Lomas Santa Fe Dr., Ste 103 Solona Beach, CA 92075 V#82904	Approx 1,558	$2.47	(a)	5,268.79	01/27/17	05/31/20	**PCP Clinic - Venus** 2067 W. Vista Way, Ste 160 Vista, CA 92083	7093
Cardiff Investments LLC 2729 Ocean St Carlsbad, CA 92008 **V#83204**	10,218	$2.58	(a)	27,500.69	07/01/17	06/30/22	**OSNC - Oceanside** 3905 Waring Road Oceanside, CA 92056	7095
Creek View Medical Assoc 1926 Via 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
Melrose 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	06/30/21	**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	$3.45	(a)	13,316.37	08/08/19	05/31/21	**Encinitas Medical Center** 351 Santa Fe Drive, Suite 351 Encinitas, CA 92023	7095
Total				**$ 168,975.26**				

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

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending February 2020

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6185	ONS/ONCC CHEMOTHERAPY RENEWAL	021020 EDU	299.00	83189	DINO REYES
6185	ONS/ONCC CHEMOTHERAPY RENEWAL	20220 EDU	103.00	80217	CHANNGHIA LE
7290	BLUEPRINT FOR OASIS ACCURACY WORKSHOP	21820 EXP	510.40	82655	CYNTHIA BOATRIGHT
7420	ASSOCIATION OF SURGICAL TECHNOLOGISTS	22120 EDU	198.00	82729	AUDRA YOUNG
8532	CERNER PATIENT ACCOUNTING TRAINING	021820 EDU	259.96	55850	ELIZABETH RILEY
8723	HOSPITAL ASSOCIATION OF SAN DIEGO ANNUAL MEETING	013020 EDU	245.00	77502	LISA STROUD
8723	CALIFORNIA HOSPITAL ASSOCIATION MEETING	13020 EDU	184.96	77502	LISA STROUD
8740	SMALL BABY CARE SPECIALIST PROGRAM	12420 EDU	200.00	81919	NATALIE MURRAY
8740	INTERMEDIATE FETAL MONITORING COURSE	22120 EDU	200.00	83648	SARAH BRESSLER
8740	ONS/ONCC CHEMOTHERAPY RENEWAL	021320 EDU	200.00	83656	MARY KELLEY CARLENO
8740	ADVANCED CARDIOVASCULAR LIFE SUPPORT	012420 EDU	200.00	83671	MITCHELL LEKOSKI
8740	BODY SYSTEM SURVEY FOR HEALTH PROFESSIONALS	20720 EDU	155.00	82889	FATIMA KUNDINGER
8740	ADVANCED CARDIOVASCULAR LIFE SUPPORT	13120 EDU	150.00	77105	LISA LIPPUS
8740	ADVANCED CARDIOVASCULAR LIFE SUPPORT	021320 EDU	150.00	81810	MYRNA MARTIN REYES
8740	ADVANCED CARDIOVASCULAR LIFE SUPPORT	021320 EDU	150.00	82463	ANNA MENDOZA
8740	ADVANCED CARDIOVASCULAR LIFE SUPPORT	20720 EDU	150.00	82656	ALEX ADAYA
8740	ADVANCED CARDIOVASCULAR LIFE SUPPORT	20720 EDU	150.00	83188	SUSAN AUSTIN
8740	ADVANCED CARDIOVASCULAR LIFE SUPPORT	013120 EDU	150.00	83669	MIRJANA POPOVIC
8758	HOSPITAL DIABETES MEETING	021220 EDU	590.00	83667	DEIRTDRE MILLS

**This report shows reimbursements to employees and Board members in the Education & Travel expense category in excess of $100.00
**Detailed backup is available from the Finance department upon request