TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
March 27, 2025 – 3:30 o'clock p.m.
Assembly Rooms 2 & 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

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

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)	2 min.	Board Counsel
3	Roll Call / Pledge of Allegiance	3 min.	Standard
	Approval of Agenda	2 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	February 2025 Financial Statement Results	10 min.	CFO
6	Legislative Update – Dr. Robert Hertzka	15 min.	Chair
7	New Business – None	--	--
8	Old Business – None	--	--
9	Chief of Staff - a) Consideration of March 2025 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on March 24, 2025. b) Consideration of revised Clinical Privilege Form – Pathology	5 min.	COS

Note: This certifies that a copy of this agenda was posted in the entrance to the Tri-City Medical Center at 4002 Vista Way, Oceanside, CA 92056 at least 72 hours in advance of the meeting. Any writings or documents provided to the Board members of Tri-City Healthcare District regarding any item on this Agenda is available for public inspection in the Administration Department located at the Tri-City Medical Center during normal business hours.

Note: If you have a disability, please notify us at 760-940-3348 at least 48 hours prior to the meeting so that we may provide reasonable accommodations.

	Agenda Item	Time Allotted	Requestor
10	Consent Calendar (1) Board Committee **(a) Finance, Operations & Planning Committee** **Director Younger, Committee Chair** 1) Approval of an expenditure, not to exceed $1,215,000, to facilitate the addition of Ahmed Khouqeer, M.D., a Cardiothoracic Physician, to practice medicine in the communities served by the District. This will be accomplished through an independent physician recruitment agreement (not to exceed a two-year income guarantee and a three-year forgiveness period) between Tri-City Healthcare District and Ahmed Khouqeer, M.D. 2) Approval of an agreement with Neville Alleyne, M.D. for the Consulting Services for Spine Surgery for a term of 12 months beginning April 1, 2025 and ending March 31, 2026, for a monthly cost of $6,000 and a total term cost of $72,000. 3) Approval of an agreement with Victor Souza, M.D., as the Medical Staff Physician Behavior Committee Chair for a term of 24 months, beginning May 1, 2025 and ending April 30, 2027, for an annual cost not to exceed $54,000 and a total term cost not to exceed $108,000. 4) Approval of an agreement with Henry Showah, M.D. as the coverage physician for Inpatient Wound Care, for a term of 24 months, beginning May 1, 2025 and ending April 30, 2027, not to exceed an average of 12 hours per month, at an hourly rate of $180 for a total term cost of $51,840. 5) Approval of an agreement with Henry Showah, M.D. as the coverage physician for Outpatient Wound Care, for a term of 24 months, beginning May 1, 2025 and ending April 30, 2027, not to exceed an average of 22.9 hours per month, at an hourly rate of $180 for a total term cost of $99,000. 6) Approval of an agreement with Sharon Slowik, M.D., as the coverage physician for Inpatient Wound Care for a term of 24 months, beginning May 1, 2025 and ending April 30, 2027, not to exceed an average of 12 hours per month, at an hourly rate of $180 for a total term cost of $51,840. 7) Approval of an agreement with Sharon Slowik, M.D. as the coverage physician for Outpatient Wound Care for a term of 24 months, beginning May 1, 2025 and ending April 30, 2027, not to exceed an average of 22.9 hours per month, at an hourly rate of $180 for a total term cost of $99,000. 8) Approval of an agreement with New Ultimate Billing for 1206(b) revenue cycle management services for a term of three years beginning April 1, 2025 and ending March 31, 2028 for a total term cost of $1,890,000. 9) Approval of an agreement with Stryker for placement of nine Neptune Waste Management Systems in the operating room for a term of 36 months, beginning April 1, 2025 and ending March 31, 2028, for an	10 min.	Chair

	Agenda Item	Time Allotted	Requestor
	annual cost of $136,167.50 and a total term cost of $408,502.50. 10) Approval of an agreement with Unifirst Corporation for essential environmental supplies for a term of 60 months, beginning May 16, 2025, and ending May 15, 2030 for a monthly cost of $9,109, and a total term cost of $546,540. 11) Approval of the agreement with 3907 Waring Road MOB, LLC (Suite #4 – Urology San Diego) for an additional 12-month term beginning April 1, 2025 and ending March 31, 2026 for a monthly expense of $7,626 and a total expense for the 12-month term of $91,512. 12) Approval of an agreement with 3907 Waring Road MOB, LLC (Suite #2 – Pulmonary Specialists of North County) for an additional 12-month term beginning May 2, 2025 and ending May 1, 2026, for a monthly expense of $10,112 and a total expense for the 12-month term of $121,344. (2) **Policies and Procedures** **a) Patient Care Services** 1. Patient Safety Plan **b) Mammography Women's Center** 1. Communication of Results Women Center 2. Distribution of Mammography Reports Policy 3. Mammography Medical Outcomes Audit Policy 4. Staff & Personnel Listing Women's Center Policy **c) Pharmacy** 1. Transdermal Fentanyl Patch Prescribing and Use **d) Pulmonary Rehab** 1. Six Minute Walking Test Monitoring 2. Staffing Policy 3. Supplemental Oxygen and Oximetry Monitoring (3) Minutes a) Special Meeting – February 27, 2025 b) Regular Meeting – February 27, 2025 (4) Reports – (Discussion by exception only) a) Building Lease Report – (February, 2025) b) Reimbursement Disclosure Report – (February, 2025)		
11	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
12	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
13	Board Communications	18 min.	Standard
14	Total Time Budgeted for Open Session	1.5 hours	
15	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT
March 12, 2025

Attachment A

Initial Appointments

Any items of concern will be "red" flagged in this report. Verification of education, training, experience, current competence, health status, current licensure, liability coverage, claims history and the National Practitioner Data Bank, the following practitioners are recommended for a 2-year appointment with delineated clinical privileges, to the Provisional Staff with customary monitoring.

Medical Staff:

Practitioner Name	Specialty	Staff Status	Initial Appointment Term	Comments
O'BRIEN, Mark DO	Internal Medicine	Provisional	3/27/2025 – 3/27/2027	
SANCHEZ, Juan MD	Oncology	Refer & Follow	3/27/2025 – 3/27/2027	
SHARIF, Ali MD	Teleradiology	Provisional	3/27/2025 – 3/27/2027	One open claim from 2023, Reviewed by chairman, no concerns found
SINGH, Ajay MD	Teleradiology	Provisional	3/27/2025 – 3/27/2027	
TYE, Karen MD	Oncology	Refer & Follow	3/27/2025 – 3/27/2027	

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
March 12, 2025

Attachment B

Reappointments:

Any items of concern will be "red" flagged in this report. The following practitioners were presented to members of the Credentials Committee for consideration for reappointment to the Medical Staff or Allied Health Professional Staff, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance. Reappointment is for 2-years unless otherwise noted below.

Medical Staff

Department of Medicine:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
BRAR, Karanbir, MD	Internal Medicine	Active	3/27/2025-3/27/2027	
FARHOOMAND, Kaveh S, DO	Internal Medicine	Active	3/27/2025-3/27/2027	
PADUGA, Remia S, MD	Neurology	Active	3/27/2025-3/27/2027	
PARK, Young In, DO	Internal Medicine	Active	3/27/2025-3/27/2027	**Change in staff status from Provisional to Active.**
SHARSAN, Afsaneh, MD	Internal Medicine	Active	3/27/2025-3/27/2027	**Change in staff status from Provisional to Active.**
WANG, Anchi, MD	Neurology	Active	3/27/2025-3/27/2027	

Department of Radiology:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
LORENTS, Evelyn M, MD	Teleradiology	Active Affiliate	03/27/2025-03/27/27	

Department of Surgery:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
DSOUZA, Gehaan F, MD	Plastic Surgery	Active	3/27/2025-3/27/2027	
HARTMAN, Andrew P, MD	Orthopedic Surgery	Active	3/27/2025-3/27/2027	
JACOBS, Robert D, MD	Otolaryngology	Active	3/27/2025-3/27/2027	

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
March 12, 2025

Attachment B

JAIN, Atul, MD	Ophthalmology	Active Affiliate	3/27/2025-3/27/2027	

Resignations *Medical Staff:*

Practitioner Name	Department/Specialty	Reason for Resignation
ALTER, Mark T, MD	Telepsychiatry	Letter received from RTP (CA), PC. dba Array Behavioral Care who provided notice to terminate partnership with Tri-City Medical Center effective 12/03/2024
AQUINO, Suzanne L, MD	Teleradiology	Voluntarily Resignation: Fail to complete Reappointment application effective 3/31/2025.
ATTREYA, Akash, DO	Telemedicine	Voluntarily Resignation: E-mail received by Med Staff effective 2/15/2025
BHATEJA, Anjali, DO	Telemedicine	Voluntarily Resignation: E-mail received by Med Staff effective 2/15/2025
BLAIZE, Marie, MD	Telemedicine	Voluntarily Resignation: E-mail received by Med Staff effective 2/15/2025
BODDU, Navneet K, MD	Pain Medicine	Voluntarily Resignation: Fail to complete Reappointment Application effective 3/31/2025.
CAPINELLO, Matthew, MD	Telepsychiatry	Letter received from RTP (CA), PC. dba Array Behavioral Care who provided notice to terminate partnership with Tri-City Medical Center effective 12/03/2024
DeMASCO, Michael PA	Emergency Medicine	Voluntarily Resignation: E-mail received by Med Staff effective 12/30/2024
DERAKHSHANIAN JONES, Sahar MD	Telepsychiatry	Letter received from RTP (CA), PC. dba Array Behavioral Care who provided notice to terminate partnership with Tri-City Medical Center effective 12/03/2024
FARRELLY, Erin MD	Surgery	Voluntarily Resignation: E-mail received by Med Staff on 01/07/2025
FUSSNER, Steven	Teleneurology	Voluntary Resignation Effective 11/30/2024
GILL, Puneet MD	Telemedicine	Voluntarily Resignat2025ion: E-mail received by Med Staff effective 2/15/2025
GIOIOSO, Valeria MD	Radiology	Voluntarily Resignation: E-mail received by Med Staff on 01/07/2025
KADAKIA, Hemal, MD	Telemedicine	Voluntarily Resignation: E-mail received by Med Staff effective 2/15/2025
LAUW, Marietya I. MD	Pathology	Voluntarily Resignation: E-mail received by Med Staff effective 3/04/2025.
LI, Robin T, MD	Anesthesiology	Voluntary Resignation: E-mail received by MD effective 2/19/2025
RAJA, Wasim, MD	Telemedicine	Voluntarily Resignation: E-mail received by Med Staff effective 2/15/2025
SANBORN, Michelle M, MD	Telemedicine	Voluntarily Resignation: E-mail received by Med Staff effective 2/15/2025

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
March 12, 2025

Attachment B

SHUMATE, Wendy A. MD	Medicine	Voluntarily Resignation: E-mail received by Med Staff effective 3/9/2025
STRIDIRON, Marissa MD	Telepsychiatry	Letter received from RTP (CA), PC. dba Array Behavioral Care who provided notice to terminate partnership with Tri-City Medical Center effective 12/03/2024

MBOC (Medical Board of California): No new information at this time

NPDB (National Practitioner Data Bank): No new information at this time

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 2 of 3
March 12, 2025

Addition/Deletion of Privilege(s)

The following practitioners have requested addition/deletion of privilege(s) as noted below. Effective **March 27, 2025.**

Practitioner Name	Department/Specialty	Change in Privilege/s
MA, Ruhong MD	Internal Medicine	**Additional:** Admit patients and history and physical examination WITH proctoring.

Modification of Staff Status

The following practitioners have requested privilege status change as noted below.

Practitioner Name	Department/Specialty	Change in Staff Status
MA, Gene, MD	Emergency Medicine	Provider changing from Leave of Absence status to Administrative status, effective 01/01/2025.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
March 12, 2025

Proctoring Recommendations

The following providers have successfully completed their initial FPPE (Focused Professional Practice Evaluation) and are being recommended for release of their proctoring requirements for the privilege(s) as noted below.

Practitioner Name	Department/Specialty	Privilege(s)
ZGLINIEC, Steven W., MD	Medicine/Critical Care	Admit patients, Consultations, including via telemedicine (F) and sleep tests/polysomnography, perform history & physical examination, including via telemedicine (F). General Critical Care Bundle.

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Pathology - (Revised ~~32~~/2519)

Provider Name:

	Privilege

BASIC QUALIFICATIONS: Only physicians who are certified by the American Board of Pathology, or who are actively progressing towards certification during the first five (5) years of eligibility. ~~All pathologists applying for Medical Staff membership or practicing in the Division must have a contractual relationship with the existing pathology group at that time.~~

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

Initial: Training
Proctoring: (15) cases must be proctored
Reappointment: (5) cases required per every two year reappointment cycle

___ Surgical Pathology, Cytopathology

___ Hematopathology

___ Serology

___ Immunopathology

___ Hematology

___ Venipuncture

___ Clinical Chemistry

___ Clinical Microbiology

___ Immunohematology

___ Bone Marrow Interpretation

___ Skin Testing

_____
Print Applicant Name

_____
Applicant Signature

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Pathology - (Revised 3~~2~~/25~~19~~)

Provider Name:

	Privilege

_____

Date

_____

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

_____

Date

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
March 19, 2025

Members Present	Director Adela Sanchez, Dr. Mohammad Jamshidi-Nezhad, Dr. Henry Showah
Non-Voting Members Present:	Janice Gurley, CFO; Jeremy Raimo, COO; Donald Dawkins, CNE; Roger Cortez, CCO; Mark Albright, CIO; Susan Bond, General Counsel
Others Present:	Jane Dunmeyer, Anh Nguyen, Deanine Dolphin, Alona Stein, Miava Sullivan
Members Absent:	Director Tracy Younger, Director Nina Chaya

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Sanchez called the meeting to order at 3:03 pm.		Chair
2. Approval of Agenda		**MOTION** **It was moved by Dr. Showah, Dr. Jamshidi-Nezhad seconded, and it was unanimously approved to accept the agenda of March 19, 2025.**	Chair
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Sanchez read the paragraph regarding comments from members of the public.	No comments	Chair
4. Ratification of minutes of February 19, 2025	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Dr. Jamshidi-Nezhad, Dr. Showah seconded, that the minutes of February 19, 2025, are to be approved without any requested modifications.**	Chair
5. Old Business	None		

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
6. New Business	None		
7. Consideration of Consent Calendar:		**MOTION** **It was moved by Director Sanchez to approve the Consent Calendar and seconded by Dr. Showah.** **Members:** **AYES: Sanchez, Jamshidi-Nezhad, Showah** **NOES: None** **ABSTAIN: None** **ABSENT: Younger, Chaya**	Chair
a) Physician Recruitment Agreement • Dr. Ahmed Khouqeer – Cardiothoracic Medicine		**Approved via Consent Calendar**	Jeremy Raimo
b) Consulting Agreement • Dr. Neville Alleyne – Spine Surgery, OR, Nursing, Supply Chain, ASC Services		**Approved via Consent Calendar**	Jeremy Raimo
c) Physician Agreement for Physician Behavior Committee Chair • Victor Souza, MD – Medical Staff Leadership		**Approved via Consent Calendar**	Dr. Gene Ma
d) Physician Agreement for Covering Physician • Henry Showah, MD – Inpatient Wound Care		**Approved via Consent Calendar**	Donald Dawkins
e) Physician Agreement for Covering Physician • Henry Showah, MD – Outpatient Wound Care		**Approved via Consent Calendar**	Donald Dawkins

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
f) Physician Agreement for Covering Physician • Sharon Slowik, MD – Inpatient Wound Care		**Approved via Consent Calendar**	Donald Dawkins
g) Physician Agreement for Covering Physician • Sharon Slowik, MD – Outpatient Wound Care		**Approved via Consent Calendar**	Donald Dawkins
h) Revenue Cycle Management Agreement • New Ultimate Billing		**Approved via Consent Calendar**	Jeremy Raimo
i) Product Placement Proposal • Stryker – Neptune		**Approved via Consent Calendar**	Donald Dawkins
j) Service Agreement - EVS • Unifirst Corporation		**Approved via Consent Calendar**	Jeremy Raimo
k) Fourth Lease Amendment Proposal • 3907 Waring Rd MOB, LLC – Urology San Diego 1206b Lease Renewal		**Approved via Consent Calendar**	Jeremy Raimo
l) First Lease Amendment Proposal • 3907 Waring Rd MOB, LLC – Pulmonary Specialist of North County 1206b Lease Renewal		**Approved via Consent Calendar**	Jeremy Raimo
8. Financials	Janice Gurley presented the financials ending February 28, 2025 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 219,379 Operating Expense $ 227,741 EBITDA $ 12,360 EROE $ 389		Janice Gurley

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	TCMC – Key Indicators **Fiscal Year to Date** Avg. Daily Census 126 Adjusted Patient Days 54,597 Surgery Cases 3,594 ED Visits 31,620 **TCHD – Financial Summary** **Current Month** Operating Revenue $ 26,688 Operating Expense $ 27,964 EBITDA $ 1,761 EROE $ 370 **TCMC – Key Indicators** **Current Month** Avg. Daily Census 130 Adjusted Patient Days 6,455 Surgery Cases 398 ED Visits 3,638 **Graphs:** • TCHD-EBITDA and EROE • TCHD Financial Summary • TCMC-Average Daily Census, Total Hospital - Excluding Newborns • TCMC-Emergency Department Visits • TCMC-Acute Average Length of Stay • TCMC-Adjusted Patient Days • TCMC-Paid Full Time Equivalents-13 Month Trend		
a. Dashboard	No discussion	Information Only	Janice Gurley
7. Comments by Committee Members	None	None	Chair
8. Date of next meeting	April 16, 2025		Chair

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
10. Adjournment	Meeting adjourned 3:23 pm		Chair

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2025
PHYSICIAN RECRUITMENT AGREEMENT

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

Physician Name: Ahmed F. Khouqeer, M.D.

Areas of Service: Cardiothoracic Medicine

Key Terms of Agreement:

Effective Date: October 1, 2025, or the first of the month following the date Dr. Khouqeer 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 Cardiothoracic Surgery

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

Terms of the Engagement:	Proposal Costs:
Sign-on Advance	$50,000
Monthly Income Guarantee, NTE	$47,917 per month ($575,000/year x 2 yrs.; 3-year forgiveness period)
Relocation Allowance	$15,000 (not part of the loan)
Total Amount of Request:	**$1,215,000**

Requirements:

Business Pro Forma: Must submit a 24-month business pro forma for TCHD approval relating to the addition of this physician to the medical practice.

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: Will be in FY26 Budget	X	Yes		No

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer

Motion:

I move that the Finance, Operations & Planning Committee approve expenditure, not to exceed $1,215,000, to facilitate the addition of Ahmed Khouqeer M.D., a Cardiothoracic Physician to practice medicine in the communities served by the District. This will be accomplished through an independent physician recruitment agreement (not to exceed a two-year income guarantee with a three-year forgiveness period) between Tri-City Healthcare District, and Ahmed Khouqeer, M.D.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2025
CONSULTING AGREEMENT FOR SPINE SERVICES

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

Physician's Name: Neville Alleyne, M.D.

Area of Service: Spine Surgery, OR, Throughput, Supply Chain, ASC services

Term of Agreement: 12 months, Beginning, April 1, 2025 – Ending, March 31, 2026

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	12-month (Term) Cost
$300	20	240	$6,000	$72,000

Position Responsibilities:

- Provide consulting and services for spine surgery
- Recommend to the medical staff that patients receive evidence-based spine and reconstructive care
- Participate in in-service training, utilization review, and service as a liaison for the community and business partners
- Assist with supply chain procurement and identify high-value industry relationships with Tri-City Medical Center

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:		Yes	X	No

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer

Motion:
I move that the Finance Operations & Planning Committee recommend that the TCHD Board of Directors authorize the consulting agreement with Neville Alleyne, M.D. for Spine Services for a term of 12 months beginning April 1, 2025, and ending March 31, 2026, for a monthly cost of $6,000 for a total term cost of $72,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2025
PHYSICIAN AGREEMENT for PHYSICIAN BEHAVIOR COMMITTEE CHAIR

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

Physician's Name: Victor Souza, M.D.

Area of Service: Medical Staff Leadership: Physician Behavior Committee

Term of Agreement: 24 months, Beginning June 1, 2025 – Ending, May 31, 2027

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

Rate/Hour (NTE 30 hours)	Monthly Cost (NTE)	Annual Cost (NTE)	Total Term Cost (NTE)
$150/hr.	$4,500	$54,000	**$108,000**

Position Responsibilities:

- Perform the duties of Chair of the Physician Behavior Committee as set forth in the Tri-City Healthcare District Medical Staff Bylaws
- Be available as a resource to the Medical Staff and Hospital with respect to physician behavior issues
- Liaise with hospital Administration and Medical Staff on issues relating to physician behavior programs

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: Jonathan Gonzalez, Director-Medical Staff Services / Gene Ma, M.D., Chief Executive Officer

Motion:
I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Victor Souza as the Medical Staff Physician Behavior Committee Chair for a term of 24 months, beginning June 1, 2025 and ending May 31, 2027, for an annual cost not to exceed $54,000 and a total term cost not to exceed $108,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2025
PHYSICIAN AGREEMENT FOR COVERING PHYSICIAN – INPATIENT WOUND CARE

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

Vendor's Name: Henry Showah, M.D.

Area of Service: Inpatient Wound Care

Term of Agreement: 24 months, Beginning May 1, 2025 – Ending, April 30, 2027

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	12 Month Term Cost	24 Month Term Cost
$180	12	144	$2,160	$25,920	$51,840

Description of Services/Supplies:

- Provide supervision for the clinical operation of the Inpatient Wound Care Team
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are compliant with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources .
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, Quality Improvement: Actively participate in hospital and Medical Staff utilization review, quality, performance improvement and risk programs

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: Donald Dawkins, RN, BSN, MBA, Chief Nursing Executive

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors approve the agreement with Henry Showah, M.D. as the coverage physician for Inpatient Wound Care for a term of 24 months, beginning May 1, 2025 and ending April 30, 2027, not to exceed an average of 12 hours per month, at an hourly rate of $180 for a total term cost of $51,840.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2025
PHYSICIAN AGREEMENT FOR COVERING PHYSICIAN – OUTPATIENT WOUND CARE

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

Vendor's Name: Henry Showah, M.D.

Area of Service: Outpatient Wound Care

Term of Agreement: 24 months, Beginning May 1, 2025 – Ending, April 30, 2027

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	12 Month Term Cost	24 Month Term Cost
$180	22.9	275	$4,125	$49,500	$99,000

Description of Services/Supplies:

- Provide supervision for the clinical operation of the Outpatient Wound Care Team
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are compliant with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, Quality Improvement: Actively participate in hospital and Medical Staff utilization review, quality, performance improvement and risk programs

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: Donald Dawkins, RN, BSN, MBA, Chief Nurse Executive

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors approve the agreement with Henry Showah, M.D. as the coverage physician for Outpatient Wound Care for a term of 24 months, beginning May 1, 2025 and ending April 30, 2027, not to exceed an average of 22.9 hours per month, at an hourly rate of $180 for a total term cost of $99,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2025
PHYSICIAN AGREEMENT FOR COVERING PHYSICIAN – INPATIENT WOUND CARE

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

Vendor's Name: Sharon Slowik, M.D.

Area of Service: Inpatient Wound Care

Term of Agreement: 24 months, Beginning May 1, 2025 – Ending, April 30, 2027

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	12 Month Term Cost	24 Month Term Cost
$180	12	144	$2,160	$25,920	$51,840

Description of Services/Supplies:

- Provide supervision for the clinical operation of the Inpatient Wound Care Team
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are compliant with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, Quality Improvement: Actively participate in hospital and Medical Staff utilization review, quality, performance improvement and risk programs

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: Donald Dawkins, RN, BSN, MBA, Chief Nursing Executive

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors approve the agreement with Sharon Slowik, M.D. as the coverage physician for Inpatient Wound Care for a term of 24 months, beginning May 1, 2025 and ending April 30, 2027, not to exceed an average of 12 hours per month, at an hourly rate of $180 for a total term cost of $51,840.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNIG COMMITTEE
DATE OF MEETING: March 19, 2025
PHYSICIAN AGREEMENT FOR COVERING PHYSICIAN – OUTPATIENT WOUND CARE

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

Vendor's Name: Sharon Slowik, M.D.

Area of Service: Outpatient Wound Care

Term of Agreement: 24 months, Beginning May 1, 2025 – Ending, April 30, 2027

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	12 Month Term Cost	24 Month Term Cost
$180	22.9	275	$4,125	$49,500	$99,000

Description of Services/Supplies:

- Provide supervision for the clinical operation of the Outpatient Wound Care Team
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are compliant with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, Quality Improvement: Actively participate in hospital and Medical Staff utilization review, quality, performance improvement and risk programs

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: Donald Dawkins, RN, BSN, MBA, Chief Nursing Executive

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors approve the agreement with Sharon Slowik, M.D. as the coverage physician for Outpatient Wound Care for a term of 24 months, beginning May 1, 2025 and ending April 30, 2027, not to exceed an average of 22.9 hours per month, at an hourly rate of $180 for a total term cost of $99,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2025
REVENUE CYCLE MANAGEMENT AGREEMENT

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

Vendor's Name: New Ultimate Billing

Area of Service: Revenue Cycle for OSNC; Credentialing for: TCPC, PSNC, USD, and OSNC

Term of Agreement: 36 months, Beginning, April 1, 2025 – Ending, March 31, 2028

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$52,500	$630,000	$1,890,000

Description of Services/Supplies:

- Revenue Cycle Management Services, coding, authorizations, accounts receivable, appeals management, customer call center for claims, patient statements and provider credentialing

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: Jeremy Raimo, Chief Operating Officer

Motion:
I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement between Tri-City Healthcare District and New Ultimate Billing for a total cost of $1,890,000 for a term of 36 months, beginning April 1, 2025 and ending March 31, 2028

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2025
PRODUCT PLACEMENT PROPOSAL

Type of Agreement		Medical Director		Panel	X	Other: Product Placement
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Stryker - Neptune Product Placement

Area of Service: Surgery- Operating Room

Term of Agreement: 36 months, Beginning, April 1, 2025 – Ending, March 31, 2028

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$11,347.29	$136,167.50	**$408,502.50**

Description of Services/Supplies:

- Placement of 9 Neptune Waste Management Systems in the OR for management of fluids during operation in addition to 3 Smart Docking Stations
- Requires a minimum spend on disposable products each semi-annual period, to cover the cost of product placement.

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

Person responsible for oversight of agreement: Melissa Terah, Clinical Director-Nursing Strategy & Integration / Donald Dawkins, Chief Nursing Executive

Motion:
I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Stryker for placement of nine Neptune Waste Management Systems in the operating room for a term of 36 months, beginning April 1, 2025 and ending March 31, 2028, for an annual cost of $136,167.50 and a total term cost of $408,502.50.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2025
SERVICE AGREEMENT – ENVIRONMENTAL SERVICES SUPPLIES

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

Vendor's Name: Unifirst Corporation

Area of Service: Environmental Service Department Supplies

Term of Agreement: 60 months, Beginning, May 16, 2025 – Ending, May 15, 2030

Maximum Totals:

Services	Monthly Cost	Annual Cost	Total Term Cost
Current Cost	$11,660	$139,920	$699,600
New Cost	$9,109	$109,308	$546,540
Net Change (savings)	($2,551)	($30,612)	($153,060)
		Total:	**$546,540**

Description of Services/Supplies:

- Renewal agreement for mats, scrapers, mop handles, other mops

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

Person responsible for oversight of agreement: Hope Chaney, Manager-Environmental Services / Jeremy Raimo, Chief Operating Officer

Motion:
I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the renewal of the agreement with Unifirst Corporation for essential environmental supplies for a term of 60 months, beginning May 16, 2025, ending May 15, 2030 for a monthly cost of $9,109, and a total term cost of $546,540.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2025
Fourth Lease Amendment Proposal – 3907 Waring Rd. MOB, LLC.

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

Practice Name: Urology San Diego (TCMC 1206b practice)

Premises: 3907 Waring Rd, Ste. #4, Oceanside, CA 92056 (2,460 sq. ft.)

Term of Agreement: 12 months, Beginning, April 1, 2025 – Ending, March 31, 2026

Within Fair Market Value: Yes (FMV was determined by Lease Comparables)

Rental Rate:	**Monthly Expense**
Rental Rate of $2.40 per square foot, per month, (2,460 rentable sq. ft.)	$5,904
Common Area Maintenance (CAM) Fees– $0.70 SF	$1,722
Total 1 Yr. Term Expense Amount:	**$91,512**

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

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the Fourth Amendment Lease Renewal with 3907 Waring Rd. MOB, LLC for an additional 12-month term beginning April 1, 2025 and ending March 31, 2026. This proposal remains within the current fair market value rental rate of $2.40 per square foot, plus monthly CAM fees of $0.70 for a monthly expense of $7,626, for a total expense for the 12-month term of $91,512.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 19, 2025
First Lease Amendment Proposal – 3907 Waring Rd MOB, LLC

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

Practice Name: Pulmonary Specialist of North County (TCMC 1206B Practice)

Premises: 3907 Waring Rd, Ste. #2, Oceanside, CA 92056 (3,262 sq. ft.)

Term of Agreement: 12 Months, Beginning, May 2, 2025 – Ending, May 1, 2026

Within Fair Market Value: Yes (FMV was determined by Lease Comparables)

Rental Rate:	**Monthly Expense**
Rental Rate of $2.40 per square foot, per month, (3,262 rentable sq. ft.)	$7,829
Common Area Maintenance (CAM) Fees – $0.70 SF	$2,283
Total 12 Month Term Expense Amount:	**$121,344**

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

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the First Amendment Lease Renewal with 3907 Waring Rd., Suite #2 MOB, LLC for an additional 12-month term beginning May 2, 2025, ending May 1, 2026. This proposal remains within the current fair market value rental rate of $2.40 per square foot, plus monthly CAM fees of $0.70 per sq. ft. for a monthly expense of $7,829, for a total expense for the 12-month term of $121,344.

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
March 7, 2025

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Patient Safety Plan	2 year review, practice change	Forward to BOD for Approval
Mammography Women's Center		
1. Communication of Results Women Center	Practice change	Forward to BOD for Approval
2. Distribution of Mammography Reports Policy	Practice change	Forward to BOD for Approval
3. Mammography Medical Outcomes Audit Policy	Practice change	Forward to BOD for Approval
4. Staff & Personnel Listing Women's Center Policy	Practice change	Forward to BOD for Approval
Pharmacy		
1. Transdermal Fentanyl Patch Prescribing and Use	3 year review, practice change	Forward to BOD for Approval
Pulmonary Rehab		
1. Six Minute Walking Test Monitoring	3 year review	Forward to BOD for Approval
2. Staffing Policy	3 year review	Forward to BOD for Approval
3. Supplemental Oxygen and Oximetry Monitoring	3 year review	Forward to BOD for Approval

Tri-City Medical Center
Oceanside, California

Patient Safety Plan
20235 - 20247

A. **PURPOSE:**

1. Tri-City Hospital District (TCHD) Patient Safety Plan e.g., the Plan supports a culture of safety by adopting Just Culture principles for accountability, communication of learned lessons, transparency, event investigation, early resolutions of potential and actual harmful events to our patients, visitors, and workforce.
2. The Plan incorporates evidence-based and best practices to implement continuous improvement strategies to develop and support an organizational culture of safety.
3. The Patient Safety Plan is also developed to:
   a. Identify system potential and actual patient safety concerns
   b. Reduce system-related errors and potentially unsafe conditions
   c. Implement activities which contribute to the maintenance and improvement of the healthcare equity of the community we serve
   d. Develop a culture that supports a dynamic, proactive, and harm free environment for patients, visitors, and the workforce through continuous learning and improving patient safety policies, procedures, systems and processes
4. TCHD is committed to:
   a. A comprehensive approach to improving patient safety by aligning with our Mission, Vision, and Values identified below:
      i. Mission: to advance the health and wellness of the community we serve
      ii. Vision: be recognized as a healthcare system of choice in our community
      iii. Values: the needs of our patients come first:
         1) Quality
         2) Caring
         3) Innovation
         4) Safety
         5) Integrity
         6) Stewardship
5. The Plan is an overarching conceptual framework that guides the development of a program for patient safety initiatives and activities. It is operationalized through various activities in the realm of both patient safety and patient safety risk.

B. **SCOPE:**

1. The scope of the Plan:
   a. Is organizational and hospital-wide
   b. Requires all workforce members support and participation
   c. Encourages leaders support and implement Just Culture practices that accentuates best practices, learning from harmful events, providing constructive feedback and learning opportunities that are nonpunitive
   d. Is implemented through the coordination of activities in multiple departments

Patient Care Service Content Expert	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/22, 07/23, **02/25**	05/22, 10/23, **02/25**	06/22, 12/23, **03/25**	n/a	06/22, 12/23

C. FOCUS:

1. **The Plan focuses on the process rather than the individual and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes.**
2. **The core principles of the plan include but are not limited to:**
   a. **Identify safety concerns by regularly reviewing incident reports, near misses, and patient complaints to identify patterns and areas of improvement**
   b. **Analyze data on patient safety issues to understand root cases and assist with the development of targeted interventions that are based on data and facts**
   c. **Develop Safety Initiatives by creating and implementing strategies to mitigate identified risks, including new policies, procedures and training programs**
   d. **Monitoring effectiveness by tracking the impact of implemented safety initiatives and adjusting as needed**
   e. **Raising awareness by educating staff about patient safety issues, best practices and reporting mechanisms**

~~1. The Patient Safety Plan is designed to:~~
   ~~a. Reduce system related errors and potentially unsafe conditions by implementing continuous improvement strategies to support an organizational culture of safety by implementing standardized processes throughout the organization.~~
   ~~b. Implement activities which contribute to the maintenance and improvement of patient safety.~~
~~2. The committee's 2023 – 2024 PS activities include but are not limited to the following:~~
   ~~a. Reduce falls with and without injuries by 50% by December 2022~~
   ~~b. Update the National Patient Safety Goals (NSPG) 2022 Net Learning Module and monitor staff compliance to the NSPGs~~
   ~~c. Provide education on Implicit Bias~~
   ~~d. Reinforcing the use of the Teach-Back method to assist with care transition~~
   ~~e. Identify patient safety projects that are potential risk and required Risk Management to conduct one of the following: Root Cause Analysis, Performance Improvement (PI), or Failure Mode and Effects Analysis (FEMA~~
~~3. Conduct a Culture of Safety Employee survey at annually~~
   ~~a. Support the mission, vision, and values of Tri-City Medical Center (TCMC) as it pertains to patient safety, the work force and visitor.~~
      ~~i. Mission: to advance the health and wellness of the community we serve.~~
      ~~ii. Vision: be recognized as a healthcare system of choice in our community.~~
      ~~iii. Values: the needs of our patients come first:~~
         ~~1) Quality~~
         ~~2) Caring~~
         ~~3) Innovation~~
         ~~4) Safety~~
         ~~5) Integrity~~
         ~~6) Stewardship~~

~~B. GUIDING PRINCIPLES~~

~~1. The Patient Safety Plan e.g., the Plan is an overarching conceptual framework that guides the development of a program for patient safety initiatives and activities. It is operationalized through various activities in the realm of both patient safety and patient safety risk.~~
~~2. The plan supports TCMC philosophy that patient safety and risk management are everyone's responsibilities. Teamwork and participation among management, providers, employees, and volunteers is essential for an efficient and effective risk management and patient safety program.~~
~~3. The Plan is implemented through the coordination of activities in multiple departments. TCMC supports the establishment of a just culture that emphasizes evidence-based, best practices, learning from error analysis, and providing constructive feedback, rather than blame and~~

~~punishment. In a just culture, unsafe conditions and hazards are readily and proactively identified and reported.~~

~~a. Medical and/or patient care errors are reported and analyzed, mistakes are openly discussed, and suggestions for systemic improvements are welcomed.~~

~~b. Individuals are still held accountable for compliance with patient safety. As such, if evaluation and investigation of an error or event reveal reckless behavior or willful violation of policies, disciplinary actions may be taken.~~

~~4. The Plan stimulates the development, review, and revision of the organization's practices and protocols in light of identified risk to patient safety, and chosen loss prevention and reduction strategies. These principles provide the foundation for developing and updating key policies and procedures for day-to-day activities, including the following:~~

~~a. Reporting and management of adverse events and near misses~~

~~b. Staff education as it pertains to patient safety matters~~

~~C.~~D. GOVERING BODY LEADERSHIP

1. **TCMC's** ~~The~~ governing Board authorizes the formal program and adoption of this plan through a resolution documented in the Board meeting minutes.
2. The governing Board:
   - ~~2.~~**a.** **Is** ~~is~~ committed to promoting the safety of all patients, visitors, employees, volunteers, and other individuals involved in organization operations.
   - ~~3.~~**b.** ~~The governing body e~~**E**mpowers the organization's leadership and management teams with the responsibility for implementing risk management and patient safety strategies by their leadership, commitment and support.

~~D.~~E. DEFINITIONS

1. Adverse Event or Incident: ~~An~~ **a patient safety event that resulted in harm to a patient. An adverse event may or may not result from an error** ~~undesired outcome or occurrence not expected within the normal course of care or treatment, disease process, condition of the patient, or delivery of services. The outcome may or may not be a patient safety incident.~~
2. ~~1.~~ **Close Call: a patient: a patient safety event that did not cause harm but posed a risk of harm. Also called near miss or good catch**
3. ~~2. Culture of Safety: The collective product of individual and group values, attitudes, competencies, and patterns of behavior in safety performance. It is an environment that regards safety as its primary goal through promotion of teamwork, effective communication, and the implementation of modern safety concepts. A culture of safety is concerned with preventing errors, accidents, and adverse events.~~
4. ~~Healthcare Associated Harm: Harm arising from or associated with plans or actions taken during the provision of health care rather than an underlying disease or injury~~.
5. **Hazardous Condition: A circumstance (other than a patient's own disease process or condition) that increases the probability of an adverse event. Also called unsafe condition**
6. ~~4.~~**5.** Just Culture: **A values-supportive system of shared accountability where organizations are accountable for the systems they have designed and for responsible to the behaviors of their employees in a fair and just manner** ~~An organizational paradigm that emphasizes evidence-based best practices, learning from error analysis, and providing constructive feedback, rather than blame and punishment.~~
7. ~~5. National Patient Safety Goals (NPSGs): Annual list published by The Joint Commission (TJC). The purpose of the NPSGs is to improve patient safety by focusing on problems widely identified in healthcare and ways to mitigate or solve them..~~
8. ~~Patient Safety Evaluation System: The collection, management, and analysis of patient safety information~~.
9. Patient Safety Event: An **event, incident, or condition that could have resulted or did result in harm to a patient.**
   ~~7. event that negatively impacts a patient including patient safety incidents and near misses~~.

~~8. Patient Safety Incident: A patient safety event that reaches a patient and resulted either in no harm (no harm incident) or harm (harm incident).~~

~~9. Preventive Measure: Process designed, or course of action taken, to keep something possible or probable from happening or existing; i.e., to prevent a patient safety event~~

8. **Safety Culture of a Hospital: is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determines the organization's commitment to quality and patient safety.**

~~10.~~9. Sentinel Event: **A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of the duration of harm, or permanent harm (regardless of severity of harm. Sentinel events are subcategory of adverse events** ~~an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse event~~

~~11. Time of Discovery: Date/time when a patient safety concern was discovered.~~

~~12. Time of Occurrence: Date/time when a patient safety event occurred or began if it occurred over a period of time.~~

~~13. Unsafe and/or Hazardous Condition: Any set of circumstances, exclusive of a patient's own disease process, that significantly increases the likelihood of a serious adverse outcome or loss for a patient due to an accident or injury to a visitor, workforce member, volunteer, or other individual. .~~

~~E. SCOPE AND FUNCTIONS~~

~~1. The Patient Safety Plan in collaboration with the Risk Management Program interfaces with many operational and clinical departments and services throughout the organization. These operational and clinical departments include, but are not limited to the following:~~

~~a. Administration and Senior Management~~
~~b. Ancillary Services~~
~~c. Buildings and Grounds~~
~~d. Disaster Preparation and Management~~
~~e. Education Department / Staff Education~~
~~f. Employee Health Services~~
~~g. Event/Incident/Accident Reporting and Investigation~~
~~h. Infection Control~~
~~i. Information Technology~~
~~j. Marketing/Advertising/Public Relations~~
~~k. Medical Records~~
~~l. Nursing Administration~~
~~m. Nursing Services~~
~~n. Pharmaceuticals and Therapeutics~~
~~o. Product/Materials Management~~
~~p. Pulmonary Department~~
~~q. Quality/Performance Improvement~~
~~r. Regulatory Compliance~~
~~s. Safety and Security~~

F. PATIENT SAFETY (PS) PROGRAM

1. Patient Safety (PS) **program**~~lan~~ is administered through by the Patient Safety Officer or alternate ~~as~~ designated by the Chief Nurse Executive (CNE) with the support of the Leadership and the Patient Safety Committee
2. Goals and Objectives
   a. The PS **program** ~~lan~~ goals and objectives **include but are not limited to the following:**~~are as follows:~~
      i. Becoming a learning organization that incorporates the five following principles recommended by The Joint Commission:

1) **Team learning**
2) **Shared visions and goals**
3) **A shared mental model e.g., similar way of thinking**
4) **Individual commitment to lifelong learning**
5) **Systems thinking**

~~i. Encourage organizational learning about medical and health care errors~~
~~ii. Incorporate recognition of patient safety as an integral job responsibility~~
~~iii. Provide education on patient safety in job specific competencies~~
~~iv. Encourage recognition and reporting of medical and health care errors without judgment or blame~~

~~v.~~**ii.** Involve patients **and their caregivers** in decisions about their health care

~~vi.~~**iii.** Report investigative findings internally including actions taken to refine and optimize systems and processes related to patient safety

~~vii.~~ Collaborate with Risk **Department leadership,** ~~Management, Nurse Managers and TCMC~~ clinical and non-clinical staff to promote **patient care** ~~a Just Culture~~

~~viii.~~**iv.** ~~Pursue opportunities to improve the quality of patient care, services, and safety~~

3. Patient Safety **(PS)** Committee

a. The PS Committee is an interdisciplinary group that manages the PS Program through a systematic, coordinated, continuous approach.

b. The committee shall meet at least quarterly to assure the maintenance and improvement of patient safety in establishment of plans, processes and mechanisms identified in the Centers for Medicare and Medicaid (CMS) Conditions of Participation provisions, The Joint Commission (TJC) PS standards and state and federal regulations.

~~a.~~**c.** The PS committee will be chaired by the Patient Safety Officer or designee

d. The Patient Safety Officer (PSO) will be the Manager of Regulatory Compliance and Accreditation or designee identified by CNE. The PSO:

i. ~~r~~Reports to the CNE or designee.

1) **Chairs the Patient Safety Committee**
2) **Leads the committee to oversee patient safety activities, compliance with patient safety standards and initiatives, and evaluation of work performance as it relates to patient safety**
3) **Reinforcement of PS plan expectations**
~~b.~~**4) Reports patient safety measures and activities to the Quality Assessment and Performance Improvement (QAPI) Committee**

~~c. The responsibilities of the PSO include but are not limited to compliance with patient safety standards and initiatives, evaluation of work performance as it relates to patient safety, reinforcement of the expectations of the PS plan and reporting patient safety measures and activities to the Quality Assessment and Performance Improvement (QAPI) Committee~~

~~i. The PS Committee is an interdisciplinary group that manages the Patient Safety Program through a systematic, coordinated, continuous approach~~

~~ii. The PS Committee membership includes a medical staff representative and services involved in patient care i.e., Pharmacy, Laboratory, Surgical Services, Risk Management, Infection Control, Radiology, Rehabilitation Services, and Nursing and non-clinical services and departments~~

~~iii. The team shall meet at least quarterly to assure the maintenance and improvement of patient safety in establishment of plans, processes and mechanisms identified in the Centers for Medicare and Medicaid (CMS) Conditions of Participation provisions and The Joint Commission (TJC) PS standards~~

e. The PS Committee membership includes:

i. Medical Staff representative or designee
ii. Services involved in patient care:
1) **Pharmacy**
2) **Laboratory**

3) **Surgical Services**
4) **Risk**
5) **Infection Control and Prevention**
6) **Radiology**
7) **Rehabilitation Services**
8) **Nursing**
9) **Non-clinical providing indirect patient care services**

4. Scope and Functions

~~d.~~**a.** The scope of the PS committee includes the sharing of knowledge and practices across multiple disciplines to optimize the use of findings from internal reports e.g., incident reporting, quality measures, risk management, and committee discussions

~~e.~~**b.** The committee will review and analyze external resources e.g., Sentinel Events, California Department of Public Health All Facilities Letters (AFLs), and nationally recognized patient safety organizations

~~f.~~**c.** The committee will make recommendations to reduce the overall prospect of adverse events based on evidence-based and best practices to improve patient safety

i. As an integral part of a patient safety and quality improvement the PS committee will **monitor data from the following as outlined in the PS Reporting Calendar:**

~~i.~~**1)** Medication Safety, Adverse Drug Events/Reactions, Medication Errors, Use of Opioids
~~ii.~~**2)** **Nursing** Documentation in the medical record
~~iii.~~**3)** Blood Transfusion Administration and Reactions
~~Patient Flow (throughput)~~
4) Pain Management and Assessment Documentation when Opioids are used
~~iv.~~**5)** Nursing Quality Indicators:
~~1)~~**a)** Pressure Injuries
~~2)~~**b)** Falls
~~a)~~**c)** Restraint monitoring and documentation ~~of discontinue use~~
~~v.~~**6)** Moderate Sedation Outcome monitoring
7) Critical Results of Test Timeliness **e.g., laboratory and diagnostic**
8) **Suicide screening and monitoring**
9) **Patient elopements in the Emergency Department**
10) **Patient Safety Survey results**
11) **Risk reported events related to patient, visitor, and staff safety**
~~1) Staff and patient communication~~
~~2) Conduct a Patient Safety Survey~~

~~vi. As an integral part of a patient safety and quality improvement the PS measures will focus of the following activities:~~
~~1) Medication Safety, Adverse Drug Events/Reactions, Medication Errors, Use of Opioids~~
~~2) Documentation in the medical record~~
~~3) Blood Transfusion administration and reactions~~
~~4) Patient Flow (throughput)~~
~~5) Pain Management & Assessment Documentation when Opioids are used~~
~~6) Nursing Quality Indicators~~
~~a) Pressure Injuries~~
~~b) Falls~~
~~c) Restraint use and documentation of discontinue use~~
~~7) Moderate Sedation Outcome monitoring~~
~~8) Critical Results of Test Timeliness e.g., laboratory and diagnostic~~
~~Patient elopements in the Emergency Department~~
~~Patient Safety Survey results~~
~~Risk reported events related to patient, visitor, and staff safety~~
~~9) Staff and patient communication~~

~~10) Conduct a Patient Safety Survey~~

5. **The committee's FY 2025 PS activities include, but are not limited, to the following:**
   a. **Optimize clinical alarm settings for the Telemetry new cardiac monitoring system**
   b. **Improve staff education and training on patient safety practices related to the following:**
      i. **Using and disposing of sharps**
      ii. **Pressure injury preventative care**
      iii. **Screening and management patients at risk for self-harm or harm to others in the Emergency Department (ED)**
      iv. **Monitoring patients at risk for elopement from the ED**
      v. **Improve healthcare equity by addressing disparities in a selected patient population that we serve**
      vi. **Restraints, initial assessment, reassessment, and monitoring of patient care needs**
      vii. **Nursing Quality Indicators; reduce slips and falls with injuries**
   c. **Adopt two Just Culture principles of accountability across the organization**
   d. **Conduct a Culture of Safety Employee survey with at least 60% response rate.**
   e. **Facilitate unit-level debriefs of the results of culture of safety survey**
   f. **The time frame for initiating and completing PS activities will be determined by the PS committee.**

~~vii. The committee's FY 20244 PS activities include but are not limited to the following:~~

~~1) Reduce falls with and without injuries by 50% based on the previous year reported data~~

~~2) Update the National Patient Safety Goals (NSPG) annual Net Learning Module and monitor staff compliance to the NSPGs~~

~~3) Reinforcing the use of the Teach-Back method to assist with care transition~~

~~4) Reintroduction of AIDET communication process {AIDET = Acknowledge, Introduce, Duration, Explanation and Thank your}~~

~~5) Identify patient safety projects that are potential risk and required for Risk Management to conduct one of the following: Root Cause Analysis, Performance Improvement (PI), or Failure Mode and Effects Analysis (FEMA)~~

~~6) Conduct a Culture of Safety Employee survey at annually~~

~~The time frame for completion of PS activities will be determined by the PS committee. Data for improvement will be reported to the PS Committee as scheduled by the PS reporting schedule.~~

G. REFERENCE(S):

1. **Agency for Healthcare Research and Quality. (2025, February). AHRQ Quality & Patient Safety Programs by Setting: Hospital. Retrieved from AHRQ's Quality & Patient Safety Programs by Setting: Hospital | Agency for Healthcare Research and Quality**
2. **Code of Federal Regulations Title 42 §482.13(C) Condition of participation: Patient's Rights: Privacy and Safety**
3. **Schreiber, M., Van, C., & Mossburg, S. (2022, December). Measuring Patient Safety. Agency for Healthcare Research and Quality: Patient Safety Network,**
4. **Agency for Healthcare Research and Quality. (2025). Patient Safety indicators: Complications and Adverse Events**
5. **The Joint Commission (TJC). (2025, January). TJC Manual: Patient Safety System.**
6. **The Joint Commission (TJC). (2025, January). THC Manual: Sentinel Event Policy**
7. **The Joint Commission (TJC). (2025, January). Standards and Evidence of Performance Manual: National Patient Safety Goals for Hospital Program.**

~~viii.~~

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE: 11/99 **SUBJECT:** Communication of Results – Women's Center

REVISION DATE: 08/11, 02/19, 02/23

Mammography Department Approval:	~~09/21~~11/24
Department of Radiology Approval:	~~12/22~~02/25
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~01/23~~02/25
Administration Approval:	~~02/23~~03/25
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/23

A. **AUTHORIZED TO PERFORM:**
1. Radiologists and Records Techs

B. **PURPOSE:**
1. To meet Mammography Quality Standard Act (MQSA) standards to ensure that reports/results are sent to patients and referring physicians in a timely way.

C. **POLICY:**
1. The Mammography Center will provide patients with written results within thirty (30) days. Self-referring patients will receive the written report as well as the summary.
2. Results that are "suspicious" or "highly suggestive of malignancy" will be communicated directly by the interpreting Radiologist or designee ASAP to the referring MD; **the mammography report is provided to the healthcare provider and the patient lay summary is provided to the patient within 7 calendar days of the date the mammogram was interpreted.**
3. -or, if self-referred, to the patient. Self referred patients will be given the Breast Help Line phone number, 940-5100, for a list of physicians for follow-up.
4. Patients that are called back to the facility for additional views will be scheduled within ten (10) working days. The department's scheduler will make several attempts to contact the patient. If the patient cannot be reached, a letter will be sent to the referring physician reporting our request for follow-up. If the mammography department receives no response within **seven**~~five~~ (~~5~~7) working days, a certified letter will be sent to the patient's residence signifying the importance of breast imaging follow-up. A copy of receipt of letter will be filed with the patient's records.
5. **When the exam has an assessment of" incomplete: Need prior mammograms for comparison", the facility issued a follow-up report with a final overall assessment within 30 calendar days of the initial report, regardless of whether comparison views are obtained.**

D. **EXTERNAL LINK(S):**
1. Mammography Quality Standards Act (MQSA) of 1998 https://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/UCM110849.pdf
2. Mammography Clinical Experience Requirements (2017) https://www.arrt.org/docs/default-source/discipline-documents/mammography/mammography-clinical-experience-

requirements-2017.pdf?sfvrsn=4

E. **REFERENCE(S):**

1. Mammography Quality Standards Reauthorization Act, Pub. L., Title XLII § 263b. (1998).
2. U.S. Food & Drug Administration (2017, November 16) Mammography Quality Standards Act and Program. Retrieved from https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm
3. **https://www.fda.gov/radiation-emitting-products/mammography-quallity-standards-act-and-program.**

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE:	**05/12**	**SUBJECT:**	**Distribution of Mammography Report**
REVISION DATE:	**01/19, 02/23**		

Mammography Department Approval:	**~~09/24~~11/24**
Department of Radiology Approval:	**~~10/24~~02/25**
Pharmacy &Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/23~~02/25**
Administration Approval:	**~~02/23~~03/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/23**

A. **AUTHORIZED TO PERFORM:**
   1. Radiologists and Radiology records techs

B. **PURPOSE:**
   1. To expedite the finalization and timely distribution of the of the mammography reports to the Requesting physicians.

C. **POLICY FOR MAMMOGRAPHY EXAMS**
   1. Requiring no prior films from outside facilities
      a. Scheduled returning patients will have their images loaded from the PAC's system and available at their appointment time.
      b. Radiologist will interpret mammogram and compare with previous images.
      c. Report will be transcribed and Radiologist will finalize the report.
      d. Reports will be automatically faxed to the referring physician within 24 hours of Transcription.
      e. Normal result letters will be mailed to patients within 30 days.
      f. Self-referred patients, if a health provider (or a responsible designee) is not named or is unavailable, then the report must be provided to the patient.
      g. Communications to the patient, if there is no health care provider, must include: 1) the complete report of findings referenced above and 2) the summary written in lay terms that is required for all patients.
   2. Needing comparison films from outside facilities
      a. **When the exam has an assessment of "incomplete: Need prior mammograms for comparison:**
      b. The patient's current mammogram study will be flagged in the "hold-pending prior films" box for no longer than 10 working days.
      c. If outside images have not arrived within a 10-day period, images will be dictated and results faxed to referring physician within 24 hours;
      d. When and if images arrive from outside facilities, the mammography study will be flagged for the radiologist and an addendum comparison report will be dictated, transcribed and finalized by the radiologist. The final result will be faxed to the referring physician through the automated fax server application.
      e. **The facility will issue a follow-up report with a final overall assessment within 30 calendar days of the initial report, regardless of whether comparison views are obtained.**
   3. Mammograms with "suspicious or highly suggestive malignancy" assessment
      a. The interpreting Radiologist will dictate and finalize the report and fax to the referring

physician with their findings within 24 hours of mammography study.

i. A letter will be mailed to the patient indicating the need to follow-up with their physician any abnormality seen on their mammogram within **7 calendar** ~~5 working~~ **days of the date the mammogram was interpreted**.

ii. If a biopsy or surgical intervention is attained, then the pathology report is collected from the lab and these findings are entered into the mammography tracking program for statistical computation.

iii. The interpreting Radiologist will add an addendum to the report documenting the pathology findings. The addended report is refaxed to the referring physician with the addended results.

4. Patient Lay Summaries (letters):

a. Patient lay summary include one of the following notification statements:

i. "Breast tissue can be either dense or not dense. Dense tissue makes it harder to find breast cancer on mammogram and also raises the risk of developing breast cancer. Your breast tissue is not dense. Talk to your healthcare provider about breast density, risks for cancer, and your individual situation."

ii. "Breast tissue can be either dense or not dense. Dense tissue makes it harder to find breast cancer on mammogram and also raises the risk of developing breast cancer. Your breast tissue is dense. In some people with dense tissue. Other imaging tests in addition to a mammogram may help find cancers. Talk to your healthcare provider about breast density, risks for breast cancer, and your individual situation."

D. **PROCEDURE**:

1. Twice daily Remote Installation Service (RIS) will automatically transmit a facsimile to the requesting physician after the Radiologist approves the diagnostic report.
2. **https://www.fda.gov/radiation-emitting-products/mammography-quality-standards-act-and-program.**

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE:	**05/11**	**SUBJECT:**	**Mammography Medical Outcomes Audit**
REVISION DATE:	**03/13, 01/19, 04/23**		

Mammography Department Approval:	**~~01/23~~11/24**
Department of Radiology Approval:	**~~02/23~~02/25**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~03/23~~02/25**
Administration Approval:	**~~04/23~~03/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/23**

A. **AUTHORIZED TO PERFORM:**
1. Computer data input and output coordinated by Mammography supervisor. Pathology reports and mammography exams are correlated and presented to the lead interpreting Radiologist for review and presentation at the Radiology Division meeting.

B. **PURPOSE**:
1. To statistically aggregate patient mammography data outcomes for physician analysis and to comply with Mammography Quality Standard Act (MQSA) standards.

C. **POLICY**:
1. Medical Audit analysis will be prepared, reviewed and presented semi-annually at the Radiology Division meeting. Audit analysis must be retained for 36 months.

D. **PROCEDURE**:
1. Tri-City Medical Center's system for tracking positive mammograms is as follows:
   a. Mammograms with "suspicious" or "highly suggestive of malignancy" assessment:
      i. The interpreting radiologist will explain the results to the patient.
      ii. The radiologist will dictate and finalize the report.
      iii. The report will automatically be sent to the referring physician.
      iv. Mammography department's patient coordinator will request the order from ordering physician's office by a phone call or a fax request to follow up radiologist's recommendations for new findings.
      The letter will be mailed to the patient, within **7 calendar** ~~5 working~~ days, indicating the need to follow-up with their physician on any abnormal finding.
      v. Mammography supervisor tracks pathology results for all breast biopsies. The pathology report is verbally called and faxed to the ordering physician by pathologist's office/ Lab within 24-48 hours of result.
      vi. Once pathology report has been called into ordering physician the report is then scanned into PAC system for radiology-pathology correlation by lead interpreting radiologist. The pathology reports are given to the Mammography Supervisor who will document this information into patient's mammogram's chart through computerized mammography medical audit.
      vii. Women's Diagnostic tracking system for "positive mammography findings" as "suspicious or highly suggestive Malignancy":
      viii. Determines whether biopsies are done on the patient by tracking the list of Birads 4&5 through Discern Analysis on Cerner

ix. Determines whether the biopsy specimen was benign or malignant by tracking pathology on patient's power chart and directing the report to lead interpreting physician for correlation.

x. Facility provides list of any non-compliant patients who were recommended biopsy but not result were obtained. Facility documents all attempts to provide this information.

E. **TO RETRIEVE CLINICAL OUTCOMES DATA:**

1. Log on to Cerner application mammography
2. Select Medical Audit icon
3. Select date range and run reports
4. Print rep011and submit to lead interpreting radiologist for review and presentation
5. Place report in Medical Audit Binder for documentation.

F. **REFERENCE(S):**

1. U.S. Food & Drug Administration (2017, November 16) Mammography Quality Standards Act and Program. Retrieved from https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE:	**11/99**	**SUBJECT:**	**Staff & Personnel Listing Women's Center**
REVISION DATE:	**08/11, 02/19, 02/23**		

Mammography Department Approval:	**~~09/21~~11/24**
Department of Radiology Approval:	**~~12/22~~02/25**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/23~~02/25**
Administration Approval:	**~~02/23~~03/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/23**

A. **PURPOSE:**

1. In addition to Quality Control (QC) test records, a Quality Assurance (QA) program includes clearly assigned personnel responsibilities. The QA program should identify the person responsible for overall quality assurance and compliance with the quality standards at the facility. It should also identify the QC technologist and the medical/ physicist and describe their responsibilities within the QA/QC program

B. **PERSONNEL:**

1. The Edgar and JoAnne Women's Center has an actively involved lead interpreting radiologist to oversee the program. The program also includes a physicist and a Mammography Diagnostic Specialist who serves as the facility's Quality Control technologist. Other technologists and personnel help with testing. The Diagnostic Specialist ensures that the program is run according to MQSA standards. All personnel associated with mammography services must meet the MQSA qualifications, training and continuing education requirements.
2. See the Mammography Staff and Responsibilities List

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

1. Mammography Staff and Responsibilities List

D. **EXTERNAL LINK(S):**

1. Mammography Quality Standards Act (MQSA) of 1998 https://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/UCM110849.pdf
2. The Mammography Quality Standards Act Final Regulations: Preparing for MQSA Inspections; Final Guidance for Industry and FDA (2001) https://www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm094441.pdf

E. **REFERENCE(S):**

1. Mammography Quality Standards Reauthorization Act, Pub. L., Title XLII § 263b. (1998).
2. U.S. Food & Drug Administration (2017, November 16) Mammography Quality Standards Act and Program. Retrieved from https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm

Mammography Staff and Responsibilities List

	Name	Pgr/Ext/Telephone	Primary Responsibilities
Responsible Radiologist	Dr. Jennifer Mayberry	Ext: 5574 Cell: 503-330-5719	Lead Interpreting Physician Clinical/Medical Oversight of Mammography Program Auditing Interpreting Physician
Responsible Technologist	Nazita Sanders	Ext: 5573 Hm: 858-676-3996 Work mobile phone: 760-696-7964	QC/QA program, ensure MQSA standards
QC Technologists	Karen Niggli Connie George	Ext: 5572	Daily Calibrations, Mammography
Physicist	Hamid Khosravi	Cell: 601-988-5006 Fax: 614-652-4848	Radiation Safety QC, Program Validation, Equipment
Imaging Director	Ann Palmisano	Ext: 3706 Work mobile phone: 760-300-7219	Administrative Oversight, Budget, QA/QC/PI Programs for departments

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 09/11

SUBJECT: Transdermal Fentanyl Patch Prescribing and Use

REVISION DATE: 08/15, 09/17, 02/22

POLICY NUMBER: 8390-6020

Departmental Approval:	~~11/21~~09/24
Pharmacy & Therapeutics Committee Approval:	~~11/21~~10/24
Medical Executive Committee Approval:	~~01/22~~02/25
Administration Approval:	~~02/22~~03/25
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/22

A. **PURPOSE**:
1. To provide a guideline summarizing safe use practices to reduce the preventable harm to patients in the hospital setting.

B. **POLICY**:
1. Due to the Food and Drug Administration (FDA) black box warning, this policy and procedure restricts prescribing to opioid-tolerant patients for the management of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time AND cannot be managed by other means such as nonsteroidal anti-inflammatory drugs, opioid combination products, or immediate-release opioids. Fentanyl patch use in non-opioid tolerant patients has resulted in fatal respiratory depression.
2. Fentanyl patches are not to be used to treat sudden, occasional or mild pain, or pain after surgery.
3. Fentanyl patches should not be prescribed for opioid-naïve patients receiving comfort care measures or end of life management. Patients must meet the Tri-City **Medical Center (TCMC)** ~~Healthcare District (TCHD)~~**Criteria** for use of Fentanyl Transdermal System ~~(see appendix II)~~ and follow dosing guidelines in order to receive fentanyl patches.

C. **PROCEDURE**:
1. Prescribing:
   a. Upon receiving an order for fentanyl patches the pharmacist shall evaluate the following:
      i. Determine if patient is continuing therapy for chronic pain.
      ii. Determine if the patient is opioid-tolerant, defined as:
         1) Taking oral morphine 60 mg/day or oral hydromorphone 8 mg/day or oral oxycodone 30 mg/day OR **an equianalgesic dose of** another opioid at a dose ~~comparable~~**equivalent** to **at least** a fentanyl **25 mcg/hr** patch per the Fentalnyl (Duragesic) Dose Conversion Guidelines for 7 days or longer.
      iii. Determine if the patient has any absolute contraindications for use:
         1) Patients who are not opioid-tolerant as defined above.
         2) Management of postoperative pain.
         3) Management of mild pain or intermittent pain.
         4) Management of acute pain or if opioid analgesia is only needed for a short period of time (less than 7 days).
      iv. Determine if the patient has any relative contraindications for use:

1) Concomitant use with ketoconazole, erythromycin, nefazodone, diltiazem or grapefruit juice requires careful monitoring and may require adjustment in fentanyl dosage.
2) Transdermal fentanyl may not be appropriate for patients with fever, diaphoresis, cachexia, morbid obesity, and ascites, all of which may have a significant impact on the absorption, blood levels, and clinical effects of the drug.

b. Pharmacist will then verify the following and, if necessary, change dose of fentanyl patch based on Fentanyl Dose Conversion Guideline:
   i. Fentanyl patch is prescribed at the lowest dose needed for pain relief.
   ii. First-time doses (new starts) should not exceed 25mcg/hr unless recommended by pain specialist or approved by Clinical Manager. Fentanyl patch 12 mcg/hr should be considered for elderly or frail patients.
   iii. Consider concomitant opiates and other medications known to have additive CNS or respiratory depression effects in evaluating the appropriateness of the dose.
      1) Discontinue or taper all other around-the-clock or extended release opioids when initiating therapy with fentanyl transdermal patch.
   iv. In selecting an initial dose, attention should be given to the following:
      1) Daily dose, potency, and characteristics of the opiate the patient has been taking previously.
      2) Reliability of dose conversion guidelines to predict the potency of the fentanyl dose needed.
      3) Patient's medical status.
      4) To account for incomplete cross-tolerance, a 25% dose reduction is needed when switching ~~among~~ opiates in patients whose pain is well-controlled. No reduction is necessary in patients with poorly–controlled chronic pain. For patients who have acute pain but whose chronic pain is otherwise controlled, a 25% dose reduction is still needed.
   v. Frequencies of q48h are generally not recommended.
      1) Frequencies of ~~Q~~q48h may be appropriate for a small number of adult patients and may be evaluated on a case-by-case basis. Such frequencies will not be allowed for new starts unless approved by the Clinical Manager.
   vi. During dose titration, increasing dosages shall not be made prior to 72 hours after initiation of therapy, and not prior to 6 days after dose changes.
      1) Titrate dose based on the daily dose of supplemental opioids required by the patient on the second or third day of the initial application.
      2) Dose should be increased in 25 mcg increments. Larger increments may be considered for some patients on high doses if prescribed and followed by pain specialist.
      3) Dose increases are not appropriate for patients who have acute pain but whose chronic pain is otherwise controlled. Such pain should be managed by appropriate use of breakthrough analgesia.
   vii. When discontinuing transdermal fentanyl and not converting to another opioid, use a gradual downward titration, such as decreasing the dose by 50% every 6 days to reduce risk of withdrawal symptoms.
      1) For disposal of fentanyl patches see Patient Care Services Controlled Substances Management Policy.

c. The pharmacist reviewing the order will document the following:
   i. Verification of inclusion criteria.
   ii. Initial dose and date/time of initiation.
   iii. Validation of inpatient and outpatient drug dosing history (including last refill information).

iv. Any potential drug interactions.
v. Discussions with prescriber, if any.

2. Dispensing and Labeling:
   a. Fentanyl patches will ~~be~~**en** sent up **and loaded into the Pyxis** as a patient–specific medication.
   b. "Do not cut patch" warning will be placed in MAR notes.
   c. Tall–man lettering will be used **for** fentanyl.
3. Monitoring:
   a. Patient monitoring for opioid–related side effects will be performed by nursing staff as per the Pain Management Patient Care Services Policy.

D. **RELATED DOCUMENT(S):**
1. Fentanyl (Duragesic) Dose Conversion Guidelines
2. Tri-City Medical Center Criteria for Use of Fentanyl Transdermal System
3. Patient Care Services: Controlled Substances Management Policy

E. **REFERENCE(S)**:
1. ISMP Medication Safety Alert! Community/Ambulatory Care Edition. Volume 13, Issue 3. March 2014
2. Acute Care ISMP Medication Safety Alert! Ongoing, Preventable Fatal Events with Fentanyl Transdermal Patches are Alarming! June 28, 2007.
3. CHA Medication Safety Committee High Alert Medication Guideline- Fentanyl Transdermal Patch. April 2011.
4. Grissinger, Matthew. Inappropriate Prescribing of Fentanyl Patches is Still Causing
5. Alarming Safety Problems. Pharmacy and Therapeutics. 2010; 35(12): 653-654.
6. Lexicomp, Inc. (Lexi-DrugsTM). Lexicomp. July 5, 2017.

Tri-City Medical Center
Oceanside, California

PULMONARY REHABILITATION SERVICES

SUBJECT: **Six Minute Walking Test Monitoring Policy**

ISSUE DATE: **08/08**
REVISION DATE: **11/11, 12/12, 10/13, 10/21**

Department Approval:	**~~02/20~~01/25**
Division of Pulmonary Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~09/21~~02/25**
Administration Approval:	**~~10/21~~03/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**10/21**

A. **DEFINITIONS:**
1. To establish guidelines to perform a 6-minute walking test for pulmonary rehabilitation program patients.
2. Establish a standard of care for performing and assessing distance and oximetry levels of pulmonary rehabilitation patients.

B. **PROCEUDRE:**
1. Explain test to patient; they are going to walk as far as possible for 6 minutes. Instruct they are permitted to slow down, to stop and to rest as necessary.
2. Take patients resting blood pressure, SpO2 level, note FiO2 and heart rate. Enter on 6-minute walking test form.
3. If patient requires a walker, or wheel chair to push, provide one. If they brought their own, allow them to use theirs.
4. Position the patient at the starting mark.
5. When they begin walking, start timer.
6. Walk behind patient so you don't pace their walk, holding the SpO2 monitor. If the patient appears unstable, walk next to them.
7. Walk to either the 200 ft. mark or the 400 ft. mark, depending on patients walking ability.
8. On the form note the following:
   a. Distance the patient walked.
   b. SpO2 levels, note FiO2.
   c. Heart rate.
   d. Number of stops.
   e. With each stop how long did they rest.
9. If the patient SpO2 level drops below 88%, place them on oxygen or increase their oxygen liter flow.
10. At the completion of the six minutes. Have the patient stop, note final SpO2 level and heart rate.
11. Have patient rate shortness of breath and fatigue, using the borg scale.
12. Note if patient is using accessory muscles, diaphragm breathing, pursed lip breathing.
13. Have patient sit down.
14. Re-take blood pressure.

C. **REFERENCE LIST**
1. AACVPR Guidelines for Pulmonary Rehabilitation Programs 4th Edition

Tri-City Medical Center
Oceanside, California

PULMONARY REHABILITATION SERVICES

SUBJECT: Staffing

ISSUE DATE: 09/08
REVISION DATE: 12/12, 08/21

Department Approval:	~~05/18~~05/24
Division of Pulmonary Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~08/21~~03/25
Professional Affairs Committee Approval):	n/a
Board of Directors Approval:	08/21

A. **PURPOSE**
1. To define staffing needs and to provide safe care to participants during exercise sessions.

B. **POLICY**
1. The Pulmonary Rehabilitation Center shall meet or exceed AACVPR Staffing Guidelines
2. During the Pulmonary Rehabilitation Program (Tuesday and Thursday), sessions are staffed at a ratio of 4 participants to one staff member.
3. During the Pulmonary Rehabilitation Maintenance (Monday, Wednesday and Friday), sessions are staffed with one staff member.
4. Two staff members shall be present in the department at all times while participants are exercising.

Tri-City Medical Center
Oceanside, California

PULMONARY REHABILIATION SERVICES

SUBJECT: **Supplemental Oxygen and Oximetry Monitoring**

ISSUE DATE: **08/08**
REVISION DATE: **11/11, 12/12, 10/13, 10/21**

Department Approval:	**~~02/20~~01/25**
Division of Pulmonary Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~09/21~~02/25**
Administration Approval:	**~~10/21~~03/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**10/21**

A. **PURPOSE:**
1. To establish guidelines for the use of supplemental oxygen during the pulmonary rehabilitation program.
2. To establish guidelines for the use of supplemental oxygen during the pulmonary rehabilitation maintenance program.

B. **POLICY:**
1. The need for and quantity of supplemental oxygen during exercise is either pre-determined by the physician, during the evaluation process, or during the program.
2. A program oxygen source will be provided for those who use oxygen during the exercise class.
3. All participants involved in the early outpatient pulmonary rehabilitation program will have oxygen saturation monitored pre exercise. It will also be monitored during exercise to ensure adequate oxygenation and to prevent complications.
4. Participants in the maintenance program will have oxygen saturation monitored pre exercise and during one exercise station per session.
5. Oxygen saturation shall remain $\geq$ 90% pre and during exercise.
6. The participant will remain at the facility for supervision until the SaO2 returns to normal limits.

C. **PROCEDURE:**
1. The pulmonary rehabilitation employee will be responsible for making sure saturation is obtained and recorded prior to warm-up.
   a. Oxygen saturation must be > 90% prior to warm-up unless otherwise noted by the referring physician or medical director.
   b. If the oxygen saturation is below normal limits prior to exercise, the etiology must be identified, i.e., oxygen flow rate too low, respiratory complications, and corrected.
2. The pulmonary rehab team is responsible for titrating the flow rate of his/her oxygen up during the exercise session per guidelines set during the exercise test.
3. Oxygen flow may be further titrated by the pulmonary rehabilitation team.
4. During exercise, oxygen saturation will be monitored during one activity station. Frequency of monitoring may be increased if a participant is demonstrating difficulty maintaining saturations $\geq$ 90%.
5. For saturations between 85% - 90%:
   a. Visually confirm that the oxygen source is set on the appropriate flow rate for activity.
   b. Reinforce and remind the participant of the importance of proper breathing techniques, i.e., pursed lip breathing and diaphragmatic breathing.

c. Decrease exercise intensity by decreasing resistance, speed and/or grade on treadmill.
d. Have the participant note his/her obvious and subtle signs of a low saturation. This assists the participant to be better able to recognize decreasing oxygen saturation at home.

D. **REFERENCE(S):**

1. Guidelines for Pulmonary Rehabilitation Programs 4th Edition
2. Pulmonary Health, Rehabilitation and Exercise Testing Policy and Procedure Guideline Manual 2nd Edition

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

February 27, 2025 – 1:30 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 1:30 p.m. on February 27, 2025.

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

Director Sheila D. Brown
Director Rocky J. Chavez
Director Nina Chaya
Director Gigi S. Gleason
Director Adela Sanchez
Director Tracy M. Younger

Absent was Director Coulter

Also present were:

Dr. Gene Ma, Chief Executive Officer
Henry Showah, M.D., Chief of Staff
Jennifer Paroly, Foundation President
Jeff Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. The Chairperson, Director Tracy M. Younger. called the meeting to order at 1:30 p.m. with attendance as listed above.

2. Approval of Agenda

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

3. Oral Announcement of Items to be discussed during Closed Session

   Chairperson Younger made an oral announcement of the items listed on the February 27, 2025 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Reports Regarding Trade Secrets, Reports of the Hospital Medical Audit or Quality Assurance Committees and Conference with Real Property Negotiators regarding APN: 166-051-339-16.

4. Motion to go into Closed Session

   It was moved by Director Gleason and seconded by Director Brown to go into Closed Session at 1:35 p.m. The motion passed (6-0-0-1) with Director Coulter absent.

5. At 3:25 p.m. the Board returned to Open Session with attendance as previously noted.

6. Report from Board Counsel on any action taken in Closed Session.

Board Counsel Scott stated he would give a Report from Closed Session at the beginning of today's Regular meeting.

7. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 3:25 p.m.

Tracy M. Younger
Chairperson

ATTEST:

Adela I. Sanchez
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
February 27, 2025 – 3:30 o'clock p.m.

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:30 p.m. on February 27 2025.

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

Director Sheila D. Brown
Director Rocky Chavez
Director Nina Chaya, M.D.
Director Gigi Gleason
Director Adela Sanchez
Director Tracy M. Younger

Absent was Director George Coulter

Also present were:

Dr. Gene Ma, Chief Executive Officer
Donald Dawkins, Chief Nurse Executive
Jeremy Raimo, Chief Operating Officer
Janice Gurley, Chief Financial Officer
Mark Albright, Chief Information Officer
Roger Cortez, Chief Compliance Officer
Dr. Henry Showah, Chief of Staff
Susan Bond, General Counsel
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. Chairperson Younger called the meeting to order at 3:30 p.m. with attendance as listed above.

2. Report from Closed Session

   Board Counsel Jeff Scott reported the Board in Closed Session discussed reports regarding Trade Secrets and took no action.

   The Board also conferred with its Real Property Negotiator pursuant to Government Code section 54956.8 and took no action.

   Finally, the Board heard a report involving Quality Assurance pursuant to Health & Safety Code section 32155 and took no action.

3. Pledge of Allegiance

   Director Chavez led the Pledge of Allegiance.

4. Approval of Agenda

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

5. Public Comments – Announcement

Chairperson Younger read the Public Comments section listed on the February 27, 2025 Regular Board of Directors Meeting Agenda.

6. January 2025 Financial Statements – Janice Gurley, Chief Financial Officer

Janice Gurley, CFO reported on the current and fiscal year to date financials as follows (Dollars in Thousands):

- Net Operating Revenue – $192,691
- Operating Expense – $199,777
- EBITDA – $10,599
- EROE – $19

Janice reported on the fiscal year to date Key Indicators as follows:

- Average Daily Census – 126
- Adjusted Patient Days – 48,142
- Surgery Cases – 3,196
- ED Visits – 27, 982

Janice reported on the current month financials as follows (Dollars in Thousands):

- Net Operating Revenue – $29,939
- Operating Expense – $30,596
- EBITDA – $2,222
- EROE – $734

Janice reported on the current month Key Indicators as follows:

- Average Daily Census – 142
- Adjusted Patient Days – 7,375
- Surgery Cases – 473
- ED Visits – 4,256

Janice also presented graphs including Average Length of Stay, Paid Full Time Equivalents per Adjusted Occupied Bed and Emergency Department Visits, all of which are trending in the right direction.

7. New Business

a) Consideration to approve the 2024-2025 Risk Management Plan

Susan Bond, General Counsel introduced Judith Lubega, Risk Specialist. Susan discussed the role of the Risk Specialist in the day-to-day operations of the

hospital. Susan also reviewed the Risk Management Plan for 2024/2025 included in today's agenda packet for consideration.

Hearing no questions or comments,

It was moved by Director Chaya to approve the 2024-2025 Risk Management Plan. Director Gleason seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Brown, Chavez, Chaya, Gleason, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Coulter**

b) Consideration to approve the agreement with Hologic for two (2) Fluent Pro Systems & SureCare Services Agreement for a term of 36 months, beginning March 1, 2025 and ending February 29, 2028, for a total annual combined cost of $137,200 and a total combined cost for the term of $411,600.

Donald Dawkins, CNE explained the Hologic agreement is for cystoscopy pumps. The old pumps have outlived their life expectancy and need to be replaced. Hologic is providing new pumps at no upfront cost, however require the use of a certain amount of disposable equipment as well as a service agreement to support the pumps over a three-year period

Hearing no questions or comments,

It was moved by Director Chavez to approve the agreement with Hologic for two (2) fluent Pro Systems & SureCare Service Agreement for a term of 36 months, beginning March 1, 2025 and ending February 29, 2028, for a total annual combined cost of $137,200 and a total combined cost for the term of $411,600. Director Chaya seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Brown, Chavez, Chaya, Gleason, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Coulter**

8. Old Business - None

9. Chief of Staff

a. Consideration to approve the February 2025 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on February 24, 2025.

It was moved by Director Sanchez to approve the February 2025 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on February 24, 2025. Director Chavez seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Brown, Chavez, Chaya, Gleason, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Coulter**

10. Consideration of Consent Calendar

It was moved by Director Gleason to approve the Consent Agenda as presented. Director Chaya seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Brown, Chavez, Chaya, Gleason, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Coulter**

11. Discussion of items pulled from Consent Calendar

There were no items pulled from the Consent Calendar.

12. Comments by Members of the Public

There were no comments by members of the public.

13. Comments by Chief Executive Officer

Dr. Gene Ma, CEO highlighted the organization's growth and success while emphasizing the hard work and dedication of the staff, particularly nurses and techs, who have faced significant challenges. He expressed pride in their commitment and acknowledged the need for better support to ensure sustainability. He also reinforced that, despite financial considerations, the organization's primary focus remains on delivering quality healthcare. Additionally, he recognized that success is a collective effort, requiring contributions from the entire team.

14. Board Communications

Chairperson Younger reported Doctor's Day is March 31, 2025.

15. Adjournment

There being no further business Chairperson Younger adjourned the meeting at 3:55 p.m.

Tracy M. Younger
Chairperson

ATTEST:

Adela I. Sanchez
Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending February 28, 2025

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	56,415.02	07/01/17	06/30/27	**OSNC - Carlsbad** 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011	7095
Cardiff Investments LLC 2729 Ocean St Carlsbad, CA 92008 V#83204	Approx 10,218	$2.58	(a)	40,067.98	07/01/17	02/28/25	**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)	20,594.69	07/01/20	06/30/25	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA 92081	7090
SoCAL Heart Property LLC 1958 Via Centre Drive Vista, Ca 92081 **V#84195**	Approx 4,995	$2.50	(a)	22,565.63	10/01/22	06/30/27	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081	7095
BELLA TIERRA INVESTMENTS, LLC 841 Prudential Dr, Suite 200 Jacksonville, FL 32207 V#84264	Approx 2,460	$2.21	(a)	8,208.01	04/01/23	03/31/25	**La Costa Urology** 3907 Waring Road, Suite 4 Oceanside, CA 92056	7082
Mission Camino LLC 4350 La Jolla Village Drive San Diego, CA 92122 V#83757	Appox 4,508	$1.75	(a)	16,350.14	05/14/21	10/31/31	**Seaside Medical Group** 115 N EL Camino Real, Suite A Oceanside, CA 92058	7094
Nextmed III Owner LLC 6125 Paseo Del Norte, Suite 210 Carlsbad, CA 92011 V#83774	Approx 4,553	$4.00	(a)	39,997.96	09/01/21	08/31/33	**PCP Clinic Cairsbad** 6185 Paseo Del Norte, Suite 100 Carlsbad, CA 92011	7090
500 W Vista Way, LLC & HFT Melrose P O Box 2522 La Jolla, CA 92038 V#81028	Approx 7,374	$1.67	(a)	13,794.33	07/01/21	06/30/26	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083	7320
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	Approx 7,000	$4.12	(a)	34,015.00	10/01/22	09/30/25	**North County Oncology Medical Clinic** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
SCRIPPSVIEW MEDICAL ASSOCIATES P O Box 234296 Encinitas, CA 234296 V#83589	Approx 3,864	$3.45	(a)	14,880.52	06/01/21	05/31/26	**OSNC Encinitas Medical Center** 351 Santa Fe Drive, Suite 351 Encinitas, CA 92023	7095
BELLA TIERRA INVESTMENTS, LLC 841 Prudential Dr, Suite 200 Jacksonville, FL 32207 V#84264	Approx 3,262	$2.21	(a)	11,165.33	05/01/23	06/30/25	**Pulmonary Specialists of NC** 3907 Waring Road, Suite 2 Oceanside, CA 92056	7088
Total				**278,054.61**				

(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 2025

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
7320	GROUP THERAPY	10825 EDU	229.99	84558	GARCIA LOURDES

**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.