TRI-CITY HEALTHCARE DISTRICT AGENDA FOR A Special MEETING August 21, 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.	Chair
3	Roll Call / Pledge of Allegiance		
4	Approval of Agenda	2 min	Standard
5	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
6	 AHA Awards & Recognitions a) STEMI – Aaron Yung, M.D./Kimberly Abrahams, RN/Cardiac Cath Lab b) Stroke – Arthur Omuro, M.D./Ryan Raybold, Stroke Coordinator c) Resuscitation – Cary Mells, M.D./Brian Clowe, RN, ED Manager d) Commitment to Excellence Award – Eva England, VP/Ancillary Services 	10 min.	Chair
7	Executive Management Reports	5 min.	Standard
8	July 2025 Financial Statement Results		CFO
9	New Business – None		
10	Old Business - None		

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.

	Agenda item	Time Allotted	Requestor
11	a) Consideration of August 2025 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals, pending recommendation from the Medical Executive Committee.	5 min.	cos
12	Consent Calendar	10 min.	Chair
	1) Board Committee		
	a. Finance, Operations & Planning Committee Director Younger, Committee Chair		
	 Approval of an agreement with an expenditure not to exceed \$430,000 to facilitate the addition of a Urologist, Joel Rosenberg, M.D. to practice medicine in the communities served by the District through a tri-party physician recruitment agreement (not to exceed a one-year income guarantee with a two-year forgiveness period) between Tri-City Healthcare District, North Coast Urology and Joel Rosenberg, M.D. Approval of the renewal of the agreement with Marius Viseroi, M.D. for the Pulmonary Lung Nodule Program 		
	Medical Directorship for a term of 24 months, beginning September 1, 2025 through August 31, 2027, for a total term cost not to exceed \$272,400. 3) Approval of the renewal of the agreement with Quoc Tran M.D. and Zhong Zhao, M.D. as Co-Medical Directors of the Utilization Review and DRG Oversight program, for a term of 12 months, beginning October 1, 2025 and ending September 30, 2026, for an annual and total term cost not to exceed \$102,000.		
	4) Approval of an agreement with Yuan Hwang Lin, M.D. and Darrell Wu, M.D., as the ED On-Call Coverage Panel for Cardiothoracic Surgery for a term of 24 months, beginning September 1, 2025 and ending August 31, 2027, for an annual panel cost of \$565,750 and a total term shared panel cost of \$1,131,500.		
	5) Approval of an amendment with Yuan Lin, M.D. and Darrell Wu, M.D. for second surgical assist services for registered TCMC hospital patients for cardiovascular bypass procedures for a revised term of 25 months, beginning August 1, 2025 and ending August 31, 2027 for an annual cost of \$73,000 and a shared total term cost of \$152,200.		
	6) Approval of an amendment to add Electrophysiology call to the Emergency Department On-Call agreement for STEMI, General and Non-Invasive Cardiology Panel services with Mohammad Pashmforoush, M.D. for a term of 28 months, beginning September 1, 2025 and ending December 31, 2027, for an annual cost of \$109,500 and a total term cost of \$255,600.		

Agenda Item	Time Allotted	Requestor
7) Approval of the renewal of a Consulting Agreement with Robert E. Hertzka, M.D. for Governmental Affairs for a term of 12 months, beginning September 1, 2025 and ending August 31, 2026, for an annual and total term cost not to exceed \$118,800.		V 000 00 V 00
8) Approval of the renewal of an agreement with San Diego Blood Bank for blood products for a term of 12 months, beginning September 1, 2025, and ending August 31, 2026, for a monthly cost of \$133,333 and a total term cost not to exceed \$1,600,000.		
(2) Administrative Policies & Procedures		
A. Administrative 1. Prior Authorizations for Non-Emergency Services for HMP PPO 213 2. Smoke-Free Environment 205		
B. Infection Control 1. Infection Prevention Risk Assessment 2. Management of Patients with Multi-Drug Resistant Organisms MDPRO) and/or C Difficile Infection		
 C. Medical Staff 1. CME Speaker & Honoraria Reimbursement 8710-604 2. Credentialing Criteria, Chronic Non-Healing Wound Care 8710-523 3. Credentialing Criteria, Hyperbaric Medicine Oxygen Therapy 8710-601 4. Cultural and Linguistic Proficiency and Implicit Bias 8710-601 		
D. Pharmacy 1. Automatic Dose Rounding 2. Restricted Antimicrobials Policy		
(3) Minutes a) Special Meeting – August 6, 2025 b) Special Meeting – June 26, 2025 b) Regular Meeting – June 26, 2025		
 (5) Reports – (Discussion by exception only) a) Building Lease Report – (July, 2025) b) Reimbursement Disclosure Report - (July, 2025) 		
3 Discussion of Items Pulled from Consent Agenda	10 min.	Standard
4 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
5 Comments by Chief Executive Officer	5 min.	Standard
6 Board Communications	5 min,	Standard

Time Allotted	Requestor
1.hour	
	Allotted



TRI-CITY MEDICAL CENTER MEDICAL STAFF CREDENTIALS REPORT August 11, 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 or Allied Health Professional Staff with customary monitoring.

Medical Staff:

Practitioner Name	Specialty	Staff Status	Initial Appointment Term	Comments
AMEN, Sara MD	Emergency Medicine	Provisional	8/21/2025 - 7/21/2027	
ARIBINDI, Vamsi MD	Surgery/Thoracic Surgery	Provisional	8/21/2025 - 7/21/2027	·
JIN, Taegun DO	Medicine/PM & R	Provisional	8/21/2025 - 7/21/2027	
LeCLAIR, Bronson MD	Anesthesiology	Provisional	8/21/2025 - 7/21/2027	
PEYMAN, Elmera MD	Medicine/Internal	Provisional	8/21/2025 - 7/21/2027	



TRI-CITY MEDICAL CENTER MEDICAL STAFF CREDENTIALS REPORT - 1 of 1 AUGUST 11, 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 Surgery

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
TRACY, David J. DDS	Oral & Maxillofacial Surgery	Refer and Follow	7/31/2025 - 7/31/2027	Change in staff status from Active to Refer and Follow.

Resignations Medical Staff:

Practitioner Name	Department/Specialty	Reason for Resignation
HERMANN, Matthew MD	Radiology	Resignation letter received. Resigned effective 7/22/2025
BESSER, Eli DO	Emergency Medicine	Resignation documentation received. Resigned effective 7/16/2025



TRI-CITY MEDICAL CENTER MEDICAL STAFF CREDENTIALS REPORT - Part 2 of 3 August 11, 2025

Addition/Deletion of Privilege(s)

The following practitioners have requested addition/deletion of privilege(s) as noted below. Effective **August 28, 2025**.

Practitioner Name	Department/Specialty	Change in Privilege/s
ANDRY, James, MD	Orthopedic Surgery	Auto relinquish of Ligament reconstructions, Bone Grafting, Arthrodesis of Extremities, Peripheral Nerve Surgery, Osteotomy and Total Joint Arthroplasty Bundle.
BAKER, David, DO	Medicine/Neurology	Auto relinquish of Lumbar Puncture due to not meeting proctoring requirements.



TRI-CITY MEDICAL CENTER CREDENTIALS COMMITTEE REPORT – Part 3 of 3 August 11, 2025

Proctoring Recommendations

The following providers have successfully completed their <u>initial</u> 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)
AUCHTER, Allison, MD	Emergency	General Patient Care, Moderate & Deep Sedation
AVILA, Jailyn, MD	Emergency	General Patient Care
BARVALIA, Mihir, MD	Cardiology	Percutaneous device closure for patient foramen oval (PFO) and atrial septal defect (ASD)
HENRY, Christopher, MD	Emergency	General Patient Care, Moderate & Deep Sedation
LUCCHESI, Archana, MD	Radiology	Teleradiology Bundle
MISKIN, Tyler, MD	Radiology	Genito-Urinary Intervention
NAKHAIMA, Selasi, MD	Radiology	Teleradiology Bundle
OLSEN, Erick MD	Radiology	Teleradiology Bundle
SANTA MARIA, Amanda, MD	Emergency	Moderate and Deep Sedation
TELES, Samuel, MD	Emergency	General Patient Care



TRI-CITY MEDICAL CENTER INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – 1 of 1 August 11, 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.

Allied Health Professional:

Department of Medicine:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
KHOUKAZ, Kthlyn, PHD	Clinical Psychologist, Ph.D.	Allied Health Professional	08/21/2025-8/21/2027	

Tri-City Medical Center Finance, Operations and Planning Committee Minutes August 13, 2025

Members Present Director Tracy Younger, Director Nina Chaya, Director Adela Sanchez, Dr. Mohammad Jamshidi-Nezhad,

Dr. Robert Lee, Dr. Henry Showah

Non-Voting Members

Present: Dr. Gene Ma, CEO, Donald Dawkins, CNE, Roger Cortez, CCO, Mark Albright, CIO,

Anh Nguyen, CFO

Others Present:

Eva England, VP Ancillary Services, Jane Dunmeyer, Miava Sullivan

Members Absent:

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
Call to order	Director Younger called the meeting to order at 3:02 pm.		Chair
2. Approval of Agenda		MOTION It was moved by Director Chaya, Dr. Mohammad Jamshidi-Nezhad seconded, and it was unanimously approved to accept the agenda of August 13, 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 Younger read the paragraph regarding comments from members of the public.	No comments	Chair
4. Ratification of minutes of June 18, 2025	Minutes were ratified.	Minutes were ratified. MOTION It was moved by Director Chaya, Dr. Jamshidi-Nezhad seconded, that the minutes of June 18, 2025, are to be approved without any requested modifications.	Chair

	Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
5. O	old Business	None		
6. N	lew Business	None		200
	consideration of Consent calendar:		MOTION It was moved by Director Chaya to approve the Consent Calendar and seconded by Director Sanchez. Members: AYES: Younger, Chaya, Sanchez, Jamshidi-Nezhad, Lee, Showah NOES: None ABSTAIN: None ABSENT:	Chair
а) Physician RecruitmentAgreement• Dr. Joel Rosenberg - Urologist		Approved via Consent Calendar	Jeremy Raimo
b	 Medical Directorship Agreement Renewal – Pulmonary Lung Nodule Program Dr. Marius Viseroi 		Approved via Consent Calendar	Jeremy Raimo
С	 Co-Medical Director Agreement Renewal – Utilization Review/DRG Program Quoc T. Tran, M.D. & Zhong Zhao, M.D. 		Approved via Consent Calendar	Donald Dawkins Melissa Terah
d	 Physician Agreement Amendment for ED On-Call Coverage – Cardio-Thoracic Surgery		Approved via Consent Calendar	Eva England Jeremy Raimo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
e) Physician Agreement Amendment for ED On-Call Coverage: Cardiovascular Surgery Assist Services • Yuan Lin, M.D. & Darrell Wu, M.D.		Approved via Consent Calendar	Eva England Jeremy Raimo
f) Physician Agreement for ED On-Call Coverage – General/Stemi & Non- Invasive Cardiology Panel • Mohammad Pashmforoush, M.D.		Approved via Consent Calendar	Eva England Dr. Gene Ma
g) Consulting Agreement -GovernmentalRobert Hertzka, M.D.		Approved via Consent Calendar	Dr. Gene Ma
h) Primary Blood SupplyProposalSan Diego Blood Bank		Approved via Consent Calendar	Eva England Tara England
 i) Infusion Pump & Module Replacement Purchase Agreement • BD/Carefusion - Alaris 		PULLED	Donald Dawkins Chuck Sawyers
8. Financials	Anh Nguyen presented the financials ending July 31, 2025 (dollars in thousands) TCHD – Financial Summary Fiscal Year to Date Operating Revenue \$ 27,873 Operating Expense \$ 29,158 EBITDA \$ 1,545 EROE \$ 155 TCMC – Key Indicators Fiscal Year to Date Avg. Daily Census 117 Adjusted Patient Days 6,679 Avg Acute Length of Stay 4.80		Anh Nguyen

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Surgery Cases 448 ED Visits 3,900		
	 Graphs: TCHD-EBITDA and EROE TCMC-Average Daily Census, Total Hospital - Excluding Newborns TCMC-Acute Average Length of Stay TCMC-Paid Full Time Equivalents-13 Month Trend 	38	
a. Dashboard	No discussion	Information Only	Anh Nguyen
7. Comments by Committee Members	None	None	Chair
8. Date of next meeting	September 17, 2025		Chair
10. Adjournment	Meeting adjourned 3:25 pm.		Chair



FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: August 13, 2025 PHYSICIAN RECRUITMENT AGREEMENT

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

Physician Name:

Joel Rosenberg, M.D.

Practice Name:

North Coast Urology

Areas of Service:

Urology

Key Terms of Agreement:

Effective Date:

1-Year - September 1, 2026, or the date Dr. Rosenberg becomes a credentialed

member in good standing of the Tri-City Healthcare District Medical Staff.

Community Need:

TCMC has significant need for urology providers for the north county coastal

community

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:
Monthly Professional Stipend	\$33,333 per month; \$400,0000
Sign-On Advance	\$30,000
Total Amount of Request:	\$430,000

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

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

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize an expenditure, not to exceed \$430,000, to facilitate the addition of a urologist, Joel Rosenberg, M.D. to practice medicine in the communities served by the District. This will be accomplished through a tri-party physician recruitment agreement (not to exceed a one-year income guarantee with a two-year forgiveness period) between Tri-City Healthcare District, North Coast Urology and Joel Rosenberg, M.D.



FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: August 13, 2025 PULMONARY LUNG NODULE PROGRAM - MEDICAL DIRECTORSHIP

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

Physician's Name:

Marius Viseroi, M.D.

Area of Service:

Pulmonary Lung Nodule Program

Term of Agreement:

24 months, Beginning, September 1, 2025 and Ending, August 31, 2027

Maximum Totals:

Within Hourly and/or Annualized Fair Market Value: Yes

Duties	CONTROL SERVICE AND SERVICE SERVICES SERVICES.		Annualized Increase	Term	Total Term Cost (Not to Exceed)	
Medical Director	\$3,750	\$4,150	\$4,800	24 months	\$99,600	
Per Encounter (up to 16 encounters per month)	\$350	\$450	Up to \$19,200	24 months	\$172,800	
		*-		Total Term Cost	\$272,400	

Description of Services/Supplies:

- Medical Direction of new Pulmonary Lung Nodule Program
- Planning, preparation, mapping, referral coordination of each patient encounter undergoing endobronchial ultrasound (EBUS) and/or Ion Procedures for nodule biopsy and excision

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

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

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the renewal of the agreement with Marius Viseroi, M.D. for the Pulmonary Lung Nodule Program Medical Directorship for a term of 24 months, beginning, September 1, 2025 through August 31, 2027, for a total term cost not to exceed \$272,400.



FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: August 13, 2025 CO-MEDICAL DIRECTOR AGREEMENT FOR UTILIZATION REVIEW/DRG PROGRAM

Type of Agreement	Х	Co-Medical Directors	Panel		Other:
Status of Agreement		New Agreement	Renewal – New Rates	Х	Renewal – Same Rates

Physician's Name:

Quoc T. Tran, M.D. & Zhong Zhao, M.D.

Area of Service:

Utilization Review / DRG Program

Term of Agreement:

12 months, Beginning, October 1, 2025 - Ending, September 30, 2026

Maximum Totals:

Within Hourly and/or Annualized Fair Market Value: YES

Rate/Hour	Maximum Hours per Month, per Medical Director	Hours per Year, per Director, Not to Exceed	Total Monthly Cost Not to Exceed	Total Annual / Term Cost Not to Exceed
\$170	25	300	\$8,500	\$102,000

Position Responsibilities:

- CMS "Conditions of Participation" and California Title XXII require the Utilization Review (UR) Committee Ensures DRG program compliance.
- Provide co-medical direction of the UR Committee
- Physician consultation for peer to peer reviews, denial reviews, and utilization review
- Works directly with the Director of Case Management/Social Services in overseeing multidisciplinary rounds, physician education and provider feedback.

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

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

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors approve the renewal of the agreement with Quoc T. Tran, M.D. and Zhong Zhao, M.D. as Co-Medical Directors of the Utilization Review and DRG Oversight program, for a term of 12 months, beginning October 1, 2025 and ending September 30, 2026, for an annual and total term cost not to exceed \$102,000.



FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: August 13, 2025

PHYSICIAN AGREEMENT AMENDMENT for ED ON-CALL COVERAGE: CARDIO-THORACIC SURGERY

Type of Agreement	Medical Directors		Panel		Other: Amendment to previous rate
Status of	New Agreement	Х	Renewal – New		Renewal – Same
Agreement			Rates		Rates

Physician's Names:

Yuan Hwang Lin, M.D. & Darrell Wu, M.D.

Area of Service:

Emergency Department On-Call: Cardio-Thoracic Surgery

Term of Agreement:

24 months, Beginning, September 1, 2025 - Ending, August 31, 2027

Maximum Totals:

Within Hourly and/or Annualized Fair Market Value: YES

Previous Rate Per Day: 9/1/24 - 8/31/25	Panel Annual Cost (12 months)	Panel Total Term Cost
\$1,000	\$365,000	\$730,000
New Rate Per Day: 9/1/25 – 8/31/27	Panel Annual Cost (24 months)	Panel Total Term Cost
\$1,550	\$565,750	\$1,131,500

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Eva England, VP-Ancillary Services / Jeremy Raimo, Chief Operating Officer

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize Yuan Hwang Lin, M.D. and Darrell Wu, M.D., as the ED On-Call Coverage Panel for Cardiothoracic Surgery for a term of 24 months, beginning September 1, 2025 and ending, August 31, 2027, for an annual panel cost of \$565,750 and a total term shared panel cost of \$1,131,500.



FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: August 13, 2025

AMENDMENT TO PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - CARDIOVASCULAR SURGERY ASSIST SERVICES

Type of Agreement	Medical Directors		Panel	Х	Other: Amendment to Current Rate
Status of Agreement	New Agreement	x	Renewal – New Rates	·	Renewal – Same Rates

Physicians Name: Yuan Lin, M.D. and Dr. Darrell Wu, M.D.

Area of Service: Emergency Department On-Call: Cardiovascular Thoracic (CVT) Surgery Assist

Term of Agreement: 25 months, Beginning, August 1, 2025 - Ending, August 31, 2027

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

Previous Rate Per Days: 9/1/24 – 7/31/25	Annual Cost (11 months)	Actual Panel Term Cost
\$750	\$273,750	\$250,500
New Rate Per Days: 8/1/25 - 8/31/27	Annual Cost	Actual Panel Term Cost
\$200	\$73,000	\$152,200

Position Responsibilities:

- Provide 24/7 patient coverage for: Cardiovascular Thoracic Surgery Assist services to the primary CVT surgeon taking call in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete related medical records in accordance with all Medical Staff, accreditation, and regulatory requirements.

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

Person responsible for oversight of agreement: Eva England, VP-Ancillary Services / Jeremy Raimo, Chief Operating Officer

Motion:

I move that the Finance Operations and Planning Committee recommend the TCHD Board of Directors authorize the amendment with Yuan Lin, M.D. and Darrell Wu, M.D. for second surgical assist services for registered TCMC hospital patients for cardiovascular bypass procedures for a revised term of 25 months, beginning August 1, 2025 and ending, August 31, 2027, at an annual cost of \$73,000, and a shared total term cost of \$152,200.



FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: August 13, 2025

AMENDMENT: ED ON-CALL COVERAGE-GENERAL/STEMI & NON-INVASIVE CARDIOLOGY PANEL

Type of Agreement		Medical Directors	х	Panel	Х	Other: Amendment
Status of Agreement	Х	New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Mohammad Pashmforoush, M.D.

Area of Service: Emergency Department On-Call: Addition of Electrophysiology

Term of Agreement: 28 months, Beginning, September 1, 2025 - Ending, December 31, 2027

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

No increase in expense

	Rate/Day (852 days)	Annual Cost	Total Term Cost
Electrophysiology	\$300	\$109,500	\$255,600

Description of Services/Supplies:

 Provide 24/7 patient coverage for all cardiology STEMI specialty services, general cardiology and electrophysiology in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)

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

Person responsible for oversight of agreement: Eva England, VP-Ancillary Services / Dr. Gene Ma, Chief Executive Officer

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors approve the amendment to add Electrophysiology call to the Emergency Department On-Call agreement for STEMI, General and Non-Invasive Cardiology Panel services with Dr. Mohammad Pashmforoush for a term of 28 months, beginning, September 1, 2025 and ending, December 31, 2027, for an annual cost of \$109,500 and total term cost of \$255,600.



FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: August 13, 2025 CONSULTING AGREEMENT – GOVERNMENTAL

Type of Agreement	Medical Director	Panel	Х	Other: Consulting Agreement
Status of Agreement	New Agreement	Renewal – New Rates	х	Renewal – Same Rates

Vendor's Name:

Robert E. Hertzka, M.D.

Area of Service:

Governmental Affairs

Term of Agreement:

12 months, Beginning, September 1, 2025 - Ending, August 31, 2026

Maximum Totals:

Hourly	Hours per Month	Monthly Cost	Total Term Cost
Rate	(Not to Exceed)	(Not to Exceed)	(Not to Exceed)
\$450	22 hours	\$9,900	\$118,800

Description of Services/Supplies:

- Consulting services in the pursuit of legislative, regulatory, or financing objectives that support the interests of Tri-City Healthcare District
- Collaborate in close partnership with administration and Board to develop a strategic roadmap for governmental and legislative priorities
- Provide guidance and recommendations with respect to legislative advocacy on behalf of the District
- Be available as a resource to the Board and Hospital with respect to governmental affairs

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

Person responsible for oversight of agreement: Dr. Gene Ma, Chief Executive Officer

Motion:

I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the consulting agreement with Robert E. Hertzka, M.D. for Governmental Affairs for a term of 12 months, beginning September 1, 2025, and ending August 31, 2026, for an annual and total term cost not to exceed of \$118,800.



FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: August 13, 2025 PRIMARY BLOOD SUPPLY PROPOSAL

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

Vendor's Name:

San Diego Blood Bank

Area of Service:

Laboratory

Term of Agreement:

12 months, Beginning, September 1, 2025 - August 31, 2026

Maximum Totals:

	Monthly Cost (Not to Exceed)	Term Cost (Not to Exceed)
TOTAL	\$133,333	\$1,600,000

Description of Services/Supplies:

- This agreement is to renew our long-standing partnership with San Diego Blood Bank, as our primary blood supplier.
- There is NO increase in pricing for this 1-year extension.
- Exact spend is dependent upon actual blood product usage.
- Benefit highlight #1: San Diego Blood Bank is closest to TCMC, should we require a STAT delivery for a special
 product or a complicated patient work up, they provide prompt service. San Diego Blood Bank is 40 miles away.
 LifeStream is in San Bernardino, 96 miles away. American Red Cross is in Pomona, 80 miles away.
- Benefit highlight #2: San Diego Blood Bank provides the antigen history of the donor for free. LifeStream, a competitor, provides this service for a fee, which saves TCMC money and is excellent service.
- Benefit highlight #3: Sharp Healthcare also utilizes San Diego Blood Bank as their primary supplier. San Diego
 Blood Bank has agreed to renew for 1 year at current pricing, recognizing our potential future partnership. This
 would be greater cost savings per blood product, due to a higher volume of usage.

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

Person responsible for oversight of agreement: Tara Eagle-Assistant Director, Lab Services / Eva England-VP, Ancillary Services

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement with San Diego Blood Bank for blood products for a term of 12 months, beginning September 1, 2025 and ending August 31, 2026, for a monthly cost of \$133,333 and a total term cost not to exceed \$1,600,000.



ADMINISTRATION CONSENT AGENDA August 13, 2025

CONTACT: Donald Dawkins, CNE

Po	licies and Procedures	Reason	Recommendations
Ac	Iministrative		
1.	Prior Authorizations for Non-Emergency Services for HMO PPO 213	3 year review	Forward to BOD for Approval
2.	Smoke-Free Environment 205	3 year review, practice change	Forward to BOD for Approval
In	fection Control		
1.	Infection Prevention Risk Assessment	1 year review, practice change	Forward to BOD for Approval
2.	Management of Patients with Multi-Drug Resistant Organisms (MDRO) and/or C. Difficile Infection	3 year review, practice change	Forward to BOD for Approval
Me	edical Staff		(Apr. 18 / 19 / 12 / 12 / 12 / 12 / 12 / 12 / 12
1.	CME Speaker & Honoraria Reimbursement 8710 - 604	1 year review, practice change	Forward to BOD for Approval
2.	Credentialing Criteria, Chronic Non-Healing Wound Care 8710-523	Practice change	Forward to BOD for Approval
3.	Credentialing Criteria, Hyperbaric Medicine Oxygen Therapy, 8710-523A	Practice change	Forward to BOD for Approval
4.	Cultural and Linguistic Proficiency and Implicit Bias 8710 - 601	3 year review, practice change	Forward to BOD for Approval
Pł	armacy		
1.	Automatic Dose Rounding	3 year review, practice change	Forward to BOD for Approval
2.	Restricted Antimicrobials Policy	3 year review, practice change	Forward to BOD for Approval



ADMINISTRATIVE POLICY DISTRICT OPERATIONS

ISSUE DATE:

07/92

SUBJECT:

Prior Authorizations for Non-

Emergency Services for

HMO/PPO Patients

REVISION DATE(S): 07/94, 06/01, 10/05, 11/08,

POLICY NUMBER: 8610-213

09/10, 01/11, 02/15, 02/18

Administrative Content Expert Approval:

Administrative Policies & Procedures Committee Approval:

08/2106/25 12/21 n/a

Finance & Operations Committee Approval:

02/2208/25

07/2104/25

Administrative Approval: Professional Affairs Committee Approval:

na/

Board of Directors Approval:

02/22

PURPOSE: Α.

To set forth guidelines to ensure Tri-City Healthcare District's (TCHD) control and compliance with the utilization policies of Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) payers and to reduce the number of denied services due to the lack of required authorization.

It is tThe intention of this policy is to ensure prior-authorization is received from all payers for all 2. services performed at TCHD.

В. **PROCEDURE:**

- The Director or designee of each department that schedules non-emergency services which require prior authorization from either the HMO/PPO or physician groups will ensure that said services shall not be scheduled prior to receipt of an authorization number either by telephone, fax, or mail.
 - In the event that a physician, physician's office, patient, patient's family, HMO/PPO staff or any other party or agent requests to be scheduled for a service that requires prior authorization but cannot provide the authorization number, he/she shall be referred to the referral specialist's office or to the patient's primary care physician.
 - If a patient who presents for a scheduled service and TCHD does not have a i. record of the required authorization number, then the patient's service will be postponed until said authorization is obtained.
 - The Access Management Manager, Supervisor or designee will phone ii. physician's office to inform them of the information.
 - iii. The Patient Access Director/Manager or designee can approve the scheduling of a procedure with a pending authorization based on patient's condition and service.

C. **CLARIFICATION:**

For clarification of this policy, contact the TCHD's Main Registration, extension 3151.



ADMINISTRATIVE POLICY DISTRICT OPERATIONS

ISSUE DATE: 11/08 SUBJECT: Smoke-Free Environment

REVISION DATE: 05/12, 03/15, 06/18, 05/22 POLICY NUMBER: 8610-205

Administrative Content Expert Approval: 01/2203/25

Administrative Policies & Procedures Committee Approval: 03/2206/25

Medical Executive Committee Approval 04/2206/25

Administration Approval: 05/2208/25

Professional Affairs Committee Approval: n/a
Board of Directors Approval: 05/22

A. PURPOSE:

 To provide adequate guidelines regarding Tri-City Healthcare District's (TCHD) commitment to providing a safe and healthful work environment for all employees, contracted staff, medical staff, vendors, patients, visitors and other customers

2. Smoke inhaled from direct smoking, as well as, indirectly from other's who are smoking nearby is

a major cause of preventable disease and death.

2.3. The hospital serves as a model for our community in the area of promoting good health of our staff and influencing public attitudes about smoking. It is therefore, TCHD's policy to provide a smoke free environment.

B. **DEFINITIONS**:

1. Tobacco products: -Any product containing tobacco intended to be lit, burned, or heated to produce smoke as well as any device used to smoke the tobacco, including but not limited to a pipe, cigar, or cigarette, (including electronic cigarettes).

2. Electronic cigarette: Any electronic device designed or intended to produce smoke or vapors for

inhalation.

C. POLICY:

 It is the policy of TCHD to provide a safe, healthful and comfortable work environment for all employees, contracted staff, vendors, patients visitors and physicians by prohibiting smoking or all tobacco based products at all facilities owned or operated by TCHD.

2. Employees, contracted staff, patients, vendors, visitors and physicians are prohibited from smoking or utilizing tobacco based products on or in any TCHD facility, adjacent grounds,

including parking lots and TCHD leased or owned vehicles.

2.3. Employees, contracted staff, patients, vendors, visitors and physicians are prohibited from smoking or utilizing tobacco based products in their own or others vehicles when they are parked on TCHD property.

D. PROCEDURES:

1. Communication of Policy

- a. Signs bearing the message "Smoke-Free Campus" are posted at strategic locations around the property (as applicable), and each building owned or leased in full will display a decal that states "Smoke Free Facility." No ashtrays or smoking shelters are provided on the campus property.
- b. Patients and their families/friends will be informed of this policy upon arrival or as soon thereafter, as is medically appropriate.

c. All employees are authorized to communicate this policy with courtesy and diplomacy to other employees, medical staff, patients and visitors.

2. Tobacco Cessation Programs

- a. TCHD is committed to providing support to all TCHD employees who wish to stop using smoking products. -TCHD is committed to ensuring that TCHD employees have access to smoking cessation assistance.
- b. Supervisors are encouraged to refer employees and other personnel to Employee Health for information on available services.

3. Responsibilities

- a. Adherence to this policy is the responsibility of all individuals working, visiting, or receiving medical care within TCHD as cited above. Compliance with this policy is mandatory and will be strictly enforced. Policy violations by employees will be subjected to the standard TCHD disciplinary actions.
- b. Employees who choose to use smoking products must do so on their own time
- c. Respectful monitoring of this policy will be shared by all TCHD staff and Security.

4. Enforcement - Employees

- a. This policy will be enforced through administrative action by supervisors and managers.
- b. —Once the employee's supervisor has been notified of a violation by an employee under their direction, the supervisor is responsible for discussing the violation with the employee and taking appropriate disciplinary action.
- c. Standard disciplinary procedures will be followed for compliance with staff. Violations of this policy will result in progressive disciplinary actions, up to and including termination.
- d. All personnel are responsible for adherence to and enforcement of the smoke free policy
- 5. Enforcement Patients and Visitors
 - a. Patients, visitors, and any other guests who fail to comply with this policy will be reminded that TCHD is a smoke-free facility and will be advised of resources available to assist with compliance while they are on TCHD property.
 - b. Patients will not be permitted to smoke during hospitalization. Refer to Patient Care Policy, Patient Smoking for management of patients refusing to comply with this policy.

E. RELATED DOCUMENTS:

- Administrative Policy 424: Coaching and Counseling for Work Performance Improvement
- 2. Administrative Policy 234: Security Department Incident Notification

F. REFERENCES:

- Centers for Disease Control and Prevention. Healthy Workforce Initiative: Implementing a Tobacco-Free Campus Initiative – United States 2004. Available at: www.cdc.gov/nccdphp/dnpa/hwi/toolkits/tobacco/index.htm
- 2. The Joint Commission (2011). Keeping your hospital Property Smoke-Free: Successful strategies for effective policy enforcement and maintenance. Retrieved from: http://www.jointcommission.org/assets/1/18/Smoke Free Brochure2.pdf
- 3. The Joint Commission (2015). Caution: E-Cigarettes pose potential hazards: Follow standards and update smoking policies to maintain compliance. *The Joint Commission Perspectives*



INFECTION CONTROL

ISSUE DATE:

03/02

SUBJECT: Infection Prevention Risk

Assessment

REVISION DATE:

07/13, 08/14, 05/16, 03/17, 02/18

03/19, 05/20, 02/23, 01/24, 03/23

Infection Control Department Approval:

04/2201/25

Infection Control Committee Approval:

11/2203/25

Pharmacy & Therapeutics Committee Approval:

n/a

Medical Executive Committee Approval:

02/2306/25 03/2308/25

Administration Approval: Professional Affairs Committee Approval:

n/a

Board of Directors Approval:

03/23

A. **PURPOSE:**

Tri-City Medical Center conducts an annual Infection Prevention (IP) risk assessment to identify the associated risks for the transmission and acquisition of infectious agents throughout the hospital. It pertains to patients, licensed independent practitioners, staff, volunteers, students, visitors and family. The Risk Assessment is based on the geographic location of the hospital, the program/services provided, and the characteristics of the patient population served, community needs, and the results of analysis of the hospital's infection prevention data from CY 20234. The Risk Assessment is formally reviewed at least annually and periodically reassessed whenever significant changes occur in any of these factors.

INFECTION PREVENTION PROGRAM MANAGEMENT AND RESOURCES: B.

- The hospital identifies the individual(s) with clinical authority over the IP program. The Medical Director of the IP program has the clinical authority over the IP program. The Medical Director serves as the Infectious Disease Specialist and chair of the Infection Prevention Committee.
- The hospital assigns responsibility for the daily management of IP activities to the Infection 2. Preventionist. The Infection Preventionist is the individual with the clinical and administrative authority over the implementation of the daily management of the IP program. The Infection Preventionist reviews program issues with the Medical Director of the IP Program. The current FTEs assigned to the IP program is 12.0. -Additional hours have been approved for the Medical Director to provide dedicated services to the IP program.
- 3. The Infection Preventionist has administrative duties that include the following:
 - Developing polices governing control of infections and communicable diseasesa.
 - Implementing policies governing control of infections and communicable diseasesb.
 - Developing a system for identifying, reporting, investigating, and controlling infections C. and communicable diseases.

C. **GEOGRAPHIC REVIEW:**

The geographic location of TCMC is in a suburban area, adjacent to multiple outpatient/office facilities, freeways, and shopping centers in northern San Diego County. San Diego County is the second most populous of California's 58 counties, and the fifth largest county in the United States. San Diego is currently home to 3.32 million residents, as of July 1, 20243. Located within the North County geographic region are 3 college campuses along with a Marine Corp Base (Camp Pendleton).

D. <u>DEMOGRAPHIC REVIEW</u>:

1. San Diego County is becoming increasingly bicultural due to its close proximity to Mexico. In addition, the county is already ethnically diverse, and will be increasingly so. As of 2022, the largest San Diego County racial/ethnic groups are White (43.4 %) followed by Hispanics (35%) & Asian (13.1%). Approximately 22.6% of the county's populations are immigrants, including refugees, who come from other countries, speak many different languages, and have a variety of needs as they assimilate into their new environment. Approximately, 39.4% of people in San Diego County speak a non-English language. The senior and disabled populations are growing disproportionately compared to the rest of the population.

E. LOCATION OF ALL SERVICES WITHIN ACUTE CARE SETTING

	Lower Lev	/el		
Location	Departments	Inpt/OBV	OutPt	Ambulatory
	Assembly Rooms	-		
	Cafeteria			
	Employee Health			
	Medical Records			
	Pharmacy			
	Sterile Processing			
	Quality/Risk/Infection Prevention			
	Level 1		ME II	
Location	Departments	Inpt/OBV	OutPt	Ambulatory
North Wing	Acute Rehab	Х		
South Tower	ICU	Х		
Pavilion	Cardiology Services	Х	Х	X
1st floor	Emergency		Х	
14 st floor	Laboratory			Х
1 st _1 st floorfloor	Pulmonary RehabSurgical Services	Х	ХX	×
1st floor	Radiology	Х	Х	X
THE STREET STREET	Level 2			
Location	Departments	Inpt/OBV	OutPt	Ambulatory
2 nd floor	Pulmonary Rehab		Х	Х
South Tower (2E/2W)	Patient Rooms	X		
Pavilion (2P)	Patient Rooms	X		
	Level 3			
Location	Departments	Inpt/OBV	OutPt	Ambulatory
Center Tower	PCU (Forensics)	X		
Pavilion (3P)	Patient Rooms	Х		
South Tower (3E/3W)	Patient Rooms	X		
	Level 4			- Work of
Location	Departments	Inpt/OBV	OutPt	Ambulatory
Pavilion (4P)	Patient Rooms	X		
South Tower (4E/4W)	Patient Rooms	Х		

1. According to the US Census Bureau 20242 QuickFacts, the demographic information on the three cities most often served by TCHD is listed below:-

4

City	Median income	Total # residents	White	<u>Hispanic</u>	Asian	African American
Oceanside	\$ 93,72484,373	174,068 170,02 0	5 2 8.4 9 %	3 8.5 7.7 %	7. 42 %	4. 23 %
Vista	\$ 80,703 91,854	98,3 448 1	50 7. 43 %	49.72%	5. 2 4%	32.8.3 %
Carlsbad	\$ 133,341 139,3 26	114, 495 746	7 14 . 2 %	16. 68 %	9. 8 7%	1.2%

- 2. Tri City Medical Center Patient Characteristics for Fiscal Year Calendar Year 20234
 - a. Patient Census:

	Average. Daily Census	Average. Length of Stay*	Total Pt. Days
Acute Care (excludes all below)	98.2 106.3	5.334	35,135 39,184
ICU*	11.211.4	5.64 .1	4, 143 088
Rehab Serv.	5. 5 0	9.712.7	18332,017

- *ICU ALOS includes discharges, transfers out, and expirations. All other areas are based only on discharges.
- b. In acute care FY-CY 20243, the three largest age groups are ages -60-69 (19%), 70-79 (20.823%), 60-69 (22%) and 80-89 (1915.5%).
- c. 1576.158 percent (6,57145,983) of Emergency Department patients were admitted to the hospital in CYFY20243.
- 3. TCHD's primary focus is on basic community services. The top **eightten** major diagnostic categories (DRGs) are the following:
 - a. Obstetrics SEPTICEMIA OR SEVERE SEPSIS
 - b. SEPTICEMIA & DISSEMINATED INFECTIONS
 - a.c. PULMONARY EDEMA AND RESPIRATORY FAILURE
 - Newborns & Neonates
 - c. Infectious & Parasitic Diseases
 - d. Circulatory-HEART FAILURE AND SHOCKSystem
 - e. Musculoskeletal & Connective-DEGENERATIVE NERVOUS SYSTEM DISORDERSTissue
 - f. Nervous SystemSIMPLE PNEUMONIA AND PLEURISY
 - g. RESPIRATORY INFECTIONS AND INFLAMMATIONSRespiratory
 - h.g. Digestive System CELLULITIS
 -KIDNEY AND URINARY TRACT INFECTIONSKidney & Urinary Tract
 - j.h. Hepatobiliary System & PERCUTANEOUS AND OTHER INTRACARDIAC PROCEDURESPancreas
- 4.—Top three Inpatient Surgical Procedures (Calendar YearFiscal Year 20234):
 Esophagogastroduodenoscopy (EGD), Ureteroscopy Colonoscopy and Spinal fusion (FUSN),
 Arthroplasty Knee with robotic assist.
- 5.4. Home Care Services provides skilled, intermittent care to individuals in a home setting. The restorative, rehabilitative services are provided by Registered Nurses, Licensed Vocational Nurses, Masters of Social Work, Licensed Clinical Social Workers, Certified Home Health Aides, Physical Therapists, Occupational Therapists, Speech Therapists and/or Dietitians. For FY 2021 in Home Care:

v	r rome oure.			
	Average LOS	Top Payers	Top Primary DX Categories	

5.24 days	Medicare 54.6%	-Factors influencing Status/Sup Class
_	Medi-cal 26.4%	-Injury/Poisoning
	HMO/PPO-14.6%	-Circulatory (not HTN, HF or CVD)
		-Respiratory (COPD)
		-Musculoskeletal/Connective Tissue
		-Respiratory (not COPD)
		Circulatory-CVD
		Genitourinary
		Other health services for specific procedures
		and after care
		2. All Other injuries excluding fractures
		3. Diseases of Cardiovascular System
		4. Diseases of Respiratory System excluding
		complications of care
		5. Complications of surgical and medical care

F. **EMPLOYEE HEALTH:**

- The Employee Health department at TCMC works collaboratively with the Infection Prevention Department to minimize the spread of infectious disease to and from employees.
 - a. The total number of employees who worked at this facility in CY 20243 was approximately 1,585638.
- 2. The Employee Health department contributes to the prevention and control of communicable diseases by established policies and procedures listed in TCMC policies. -Together with Infection Prevention they work collaboratively in:
 - a. Investigating and monitoring exposures to communicable disease and illness-
 - b. Establishing pro-active policies and procedures for management of employee infection risks related to disasters, bioterrorism, and emerging pathogens-
 - Establishing guidelines for work restrictions due to communicable disease.

G. REVIEW AND EVALUATION OF FYCY20243 HOSPITAL SURVEILLANCE:

1. See related document: Infection Prevention Program Plan

H. RISK ANALYSIS FOR CYFY 20243:

See related document: Infection Prevention Risk Assessment Table

I. GOALS, OBJECTIVES, STRATEGIES, EVALUATION:

- 1. The goals, objectives and strategies are described in the annual Infection Prevention Program Plan.
- 2. Using the risk analysis and the summary of healthcare-associated infection surveillance outcomes, prioritized risks are identified based on their nature, scope, and impact on the care, treatment, and services provided.
- 3. Goals and objectives, with specific strategies are developed and implemented to address the prioritized risks. These strategies may take the form of policy and procedure, surveillance and monitoring activities, education and training programs, environment and engineering controls, or combinations thereof. Strategies may differ in approach, form, scope, application and/or duration depending on the specific risk issue, the care setting(s) and environment. See:

J. RELATED DOCUMENT(S):

- 1. Infection Control Policy: Infection Prevention Program Plan
- 2. Infection Control Policy: Epidemiologic Investigation of a Suspected Outbreak
- 3. Infection Control: Infection Prevention Risk Assessment Table

K. REFERENCE(S):

Infection Prevention Infection Prevention Risk Assessment Page 5 of 5

- 1. County of San Diego Public Health & Human Services Agency, Public Health Services. Retrieved from http://www.sandiegocounty.gov/hhsa/programs/phs/ (reviewed 01/2**5**4)
- 2. APIC Text of Infection Control and Epidemiology, 20241.
- 3. https://www.census.gov/quickfacts/fact/table/sandiegocountycalifornia,carlsbadcitycalifornia,vistacitycalifornia,oceansidecitycalifornia/INC110223
 https://www.census.gov/quickfacts/fact/table/missionviejocitycalifornia,orangecountycalifornia/PST045217 (Reviewed 01/24)
- 4. Joint Commission, Hospital Accreditation Standards (reviewed 01/25)
- 5. CMS Conditions of Participation: IC (reviewed 01/25)
- 6. Title 22, Calif. Code of Regulations (reviewed 01/25)
- 7. Health and Safety Code (reviewed 01/25)
- 8. CDC Guidelines as listed (reviewed 01/25)
- 9. CDPH AFL 09-07 (reviewed 01/245)
- 10. FDA 21 CFR Part 1271 (reviewed 01/24)
- 11.10. County of San Diego Tuberculosis Control and Refugee Health Program.) TB Statistics Fact Sheet 2022 (01/24). Retrieved from:
 - http://www.sandiegocounty.gov/hhsa/programs/phs/tuberculosis_control_program/
- 42.11. Healthy Analytics Patient Statistics. Retrieved from https://datausa.io/profile/geo/san-diego-county-ca/
- 13. https://www.sandiegocounty.gov/hhsa/statistics-demographics.html
- 14.12. https://tricitymed.analytics.healtheintent.com/projects/100011908 (reviewed 01/25)

Oceanside, California

TCMC 2025 IP Risk Assessment

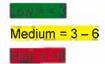
	LIKELIHOOD	SEVERITY	PREPAREDNESS	RISK SCORE
	1(low)-5(high)	1(low)-5(high)	1(low)-5(high)	(Likelihood x Severity)/Preparedness
GEOGRAPHY/COMMUNITY				
Viral Hemorrhagic Fevers (e.g., Ebola virus, Lassa fever)	1	55	3	1.67
Outbreaks with vaccine preventable diseases (e.g., pertussis, measles)	32	4	3	2.74.0
Legionellosis	3	3	3	3.0
SARS-CoV	4	4	5	3.2
Novel influenza virus	4	4	5	3.2
FACILITY				
Infection Types	EME India			
CLABSI	43	4	4	3.04.0
CAUTI	3	3	4	2.3 25
C.difficile	34	3	3	34.0
SSI	3	4	3	4.0
Pneumonia	3	4	3	4.0
CRE	2	4	3	32.07
Influenza	24	3	4	23.0
Norovirus	23	4	4	3.02.0
RSV	3	2	4	1.5
Aspergillus	12	4	3	2.6 1.3
Candida auris	32	5	3	3.35.0
VRE	23	2	4	1.5 1.0
MRSA	3	3	4	2.325
Equipment Related Risks		I Lwen		
Inadequate disinfection/Sterilization of medical devices-(failure)	3	4	3	4.0
Cleaning of common equipment—wet contact time (failure)	3	4	3	4,0
Unsafe injection practices	3	4	4	3.0

Revised: 01.2024, 09/202401.2025 Infection Control Policy: Infection Prevention Risk Assessment



TCMC 2025 IP Risk Assessment

Pathogen Exposure Risks for Patients and Staff				
MDROs (multi drug resistant organisms)	3	3	4	2.25
C. difficile	4	3	4	3.0
Influenza -Seasonal	2	3	4	1.5
Infestations (Scabies, Lice, bed bugs)	3	3	4	2.25
Tuberculosis	3	4	4	3.0
Communicable Diseases(COVID-19)	4	3	5	2.4
Internal Environmental Risks				
Construction or Renovation Projects	3	3	3	3.0
Laundry and linen problems	3	3	4	2.25
Medical Waste mishandling	3	4	4	3.0
Mold	3	4	3	4.0
Water Intrusion/ Disruption	4	4	3	5.3
Environmental cleanliness- terminal cleaning failure	5	4	3	6.7
Clean supplies and equipment are not stored appropriately	3	3	3	3.0
Safe Food Handling: cool down logs, labeling	4	3	4	3.0
Ice Machines – schedule for cleaning Ice containers	3	4	3	4.0
Employee Related Risks	× RELYE			
Hand Hygiene (non-compliance)	5	3	3	5.0
PPE (non-compliance)	4	4	3	5.3
Needlestick: Bloodborne pathogen exposure	3	4	4	3.0
PAPRs (non-compliance,)	3	3	3	3.0
Unidentified TB patients in Emergency department & direct admit	3	4	4	3.0





INFECTION CONTROL

ISSUE DATE:

03/16

SUBJECT: Management of Patients with Multi-

Drug Resistant Organism (MDRO)

and/or C. Difficile Infection

REVISION DATE:

12/18, 03/22

Infection Control Department Approval:

08/2101/25 11/2103/25

Infection Control Committee Approval: Pharmacy & Therapeutics Committee Approval:

n/a

Medical Executive Committee Approval:

02/2206/25

Administration Approval:

03/2208/25

Professional Affairs Committee Approval:

n/a

Board of Directors Approval:

03/22

A. **DEFINITIONS:**

- Multi-drug resistant Organism (MDROs) and Clostridium Difficile are organisms of epidemiological significance in the health care setting. MDROs are defined as microorganisms that are resistant to one or more classes of antimicrobial agents. The clinical manifestations are often similar to infections caused by susceptible pathogens; however the options for treatment are limited. MDROs and C. Difficile infection increase the length of stay, costs and mortality of patients. The MDROs of significance are:
 - Vancomycin Resistant Enterococci (VRE) a.
 - Methicillin Resistant Staphylococcus aureus (MRSA) b.
 - Resistant Acinetobacter baumannii C.
 - Carbapenem- resistant Enterobacteriaceae (CRE) d.
 - Klebsiella pneumonia
 - Escherichia coli ii.
 - Extended Spectrum beta Lactamase Producers (ESBL) e.
 - Klebsiella pneumonia
 - Escherichia coli
 - Other MDROs as identified by Laboratory identification and/or Physician
 - Candida auris f.
 - Other MDROs as identified by Laboratory identification, county and state g. guidance, and/or Physician

- The risk factors for obtaining an MDRO (Infection or colonization) include those with 2. severe disease, ICU stay, compromised host defenses, recent surgery or indwelling medical devices.
- 3. The risk factors for obtaining C.difficile infection are: antimicrobial exposure, acquisition of C.difficile, advanced age, underlying illness, immunosuppression, tube feeds and gastric acid suppression. -The purpose of this policy is to prevent the transmission of MDROs and C.Difficile Infection.
- C.Difficile Infection: This policy applies to patients who have active C.difficile Infection as 4. defined by those with a recent positive test for C.diff during current admission or recent positive test and still has active diarrhea.
- Cohorting is the placement of patients with the same microorganism in the same room. 5. Usually done when private rooms are not available.
- Recommendations for MRSA active surveillance culturing are focused on high-risk 6. populations and the delay inherent in identifying MRSA in clinical cultures makes it

impossible to know the MRSA status of every patient when they are admitted. The use of Standard Precautions and most importantly hand hygiene will reduce the risk of cross transmission from unknown cases. Please note: Routine screening for other types of MDROs is not recommended.

B. **POLICY**

- Transmission:
 - a. Transmission may occur through direct contact with a MDRO carrier and ineffectively disinfected equipment. -The use of Standard and Contact Precautions to break the chain of transmission is recommended in the acute care hospital.
- Strategies To Reduce Risk Of Cross Transmission:
 - a. Because of the difficulty in treating MDRO infections, it is imperative that health care workers prevent the transmission of MDRO from colonized or infected patient to other patients or personnel.
 - b. Compliance with Standard Precautions and Contact Precautions will reduce the risk of transmission between patients.
 - c. Place patients in Contact Precautions in the following cases:
 - Active MRSA, ESBL, VRE, CRE/other MDRO infections. Active infections include positive cultures from blood, urine, respiratory or wound. These will be noted in the patients Problem List in Cerner.
 - ii. Patients with a history of ESBL or CRE. The history can be found in the patients Problem List in Cerner.
 - iii. Patients with active C.difficile infection.
 - iiiiv. Patients suspected/high risk of Candida auris exposure.
 - d. Perform hand hygiene before and after gloving. -Hands of health care workers can become transiently colonized which is the most common mode of transmission of healthcare associated MDROs.
 - i. Wear gloves for contact with membranes, damaged skin, or with any moist body substance (i.e., oral secretions, sputum, blood, urine, feces, and vomitus).
 - ii. Change gloves between patients and on the same patient when an episode of care has multiple components such as care at different anatomical sites involving moist body substances or mucous membranes.
 - 1) Wearing gloves does not take the place of hand washing. Perform hand hygiene after removing gloves.
 - iii. Wear a new pair of gloves with each patient. Failure to change gloves between patient contacts is an infection control hazard.
 - iv. Wear a plastic apron or a gown if it is likely that clothing will be soiled. Change aprons/gowns between patients.
 - e. Remove gloves and gown before leaving the patient's room. Ensure that after glove and gown removal hand hygiene is performed. Ensure that clothing and hands do not come in contact with environmental surfaces (doorknobs and curtains).
 - f. Follow Standard Precautions and wear face protection if it is likely that eyes, nose or mouth will be splashed with moist body substances or secretions (e.g. during wound care or suctioning an intubated patient).
 - g. Environmental cleaning is an important measure to reduce risk of transmission.
 - h. Use of dedicated non-critical patient care equipment is recommended. Reusable equipment must be disinfected before being used on another patient.
 - Patients with C.difficile infection, perform the following in addition to above:
 - i. Wash hands with soap and water after removing gloves.
 - ii. Ensure purple "D" sign is posted along with theenteric contact precautions sign is posted outside patient room
 - iii. Room is cleaned with bleach product by EVS staff, and curtains changed upon patient transfer or discharge.

- iv. Reusable equipment is cleaned after patient use by bleach product (if product tolerates bleach product otherwise utilize hospital approved disinfectant)
- Cohorting:
 - a. Single patient room preferred but if not available then separate patient beds by minimum of 6 feet
 - b. Create a visual barrier to define the isolation space(s). A privacy curtain or a portable wipeable screen may be used. The isolated space must be treated as though they are a separate room.
 - c. Request Environmental Services to do a terminal clean of the isolated area once a patient has been transferred to a single room or discharged.
 - d. Dedicate patient care items and equipment to each isolated patient if possible.
 - e. See Guideline for Cohorting Patients on Additional Precautions for specific MDRO or organism in Related Documents.
- f. When a private room is not available and cohorting is not achievable, consider the epidemiology of the microorganism and the patient population when determining patient placement. First try to select someone with no invasive lines (IV, central line, **indwelling** foley **catheter**, trach, etc.) or open wound. If this is not possible, then select someone with an invasive line that carries a low risk of infection, such as a peripheral IV or NG tube. Consult with infection control staff when there are questions about patient placement. Also consider the conditions of the individual patients and the ability to transmit the infection in giving them priority for single room placement, for example stool incontinence and/or uncontained drainage.
- 4. Discharge, Transfer, And Transport Of Patient:
 - a. Isolation Signs communicate isolation status to visitors and healthcare workers when entering the room. A "D" Sign is placed on the outside of a patient room to communicate to healthcare workers if a patient has C.difficile infection. An "Enteric Precautions" sign is posted in the sign holder to communicate to HCW if a patient has C. difficile infection. The bedboard in Aionex is updated, to communicate to environmental staff that a patient has an infection that requires transmission-based precautions and what specific cleaning procedures must be used for efficient terminal cleaning of that patient zone.
 - i. C.difficile infection is not placed on the problem list since past history does not define isolation in future admissions.
 - b. Hand off communication includes isolation information to receiving unit and transporters.
 - c. Patient Transfer: try to cover or contain potentially infectious body fluids prior to transport. The patient should change into a clean gown and socks, and perform hand hygiene prior to transfer. If a patient requires Airborne or Droplet precautions, a surgical mask is placed on the patient (never an N95).- The transporter should discard contaminated PPE before transport; no PPE should be worn in the transport process, unless it is a surgical mask or fit tested N95.— Perform good hand hygiene. -Don clean PPE at destination to handle the patient.
 - d. When arranging transfer, communicate information to nursing home, home health agency or other hospital receiving patient
 - e. Infection Control communicates final lab results to receiving facilities if they are not available until after discharge in the following situations:
 - i. Positive MDRO culture known after the patient was discharged to another healthcare facility and the patient had no history of the same MDRO
 - ii. Positive C.difficile tests known after the patient was discharged to another healthcare facility.
 - iii. Positive Candida auris colonization after the patient was discharged to another healthcare facility.
- Discontinuation of Contact Precautions:
 - a. Consult Infection Prevention when a decision to discontinue isolation is made
 - b. MRSA

- i. Colonization (positive MRSA PCR nares: -No contact precautions).
- ii. Active infection: remain in Contact Precautions for duration of stay
- iii. History of active infection
 - 1) If greatergreater -than 1 year ago, place patient in contact precautions upon admission and collect 2 MRSA PCR nares at least 5 days apart and patient must be off antibiotic for at least 48 hours. If both tests are negative isolation can be discontinued.
 - 2) If less than 1 year ago contact precautions is required until discharge.
- c. ESBL
 - i. Active infection: remain in Contact Precautions for duration of stay
 - ii. History of active infection
 - If history is greater-greater than 1 year ago place patient in contact precautions upon admission and obtain one urine culture test for ESBL. Patient must be off antibiotics effective against ESBL for at least 48 hours.- If test is negative isolation can be discontinued.
 - 2) If history is less than 1 year ago contact precautions is required until discharge.
- d. VRE
 - i. Active infection: remain in Contact Precautions for duration of stay
 - ii. History of active infection
 - 1) If history is greater-greater than 1 year ago place patient in contact precautions upon admission and obtain three consecutive negative stool, rectal, or peri-rectal cultures at least one week apart. Patient must be off antibiotics effective against VRE for at least 48 hours. If tests are negative isolation can be discontinued.
 - 2) If history is less than 1 year ago contact precautions is required until discharge.
- e. CRE and Other MDRO's
 - i. Contact precautions required at all times. No discontinuation of isolation precautions allowed.
- f. Active C.Difficile infection:- remain in Contact Precautions for duration of stay.
- g. Candida auris
 - f.i. Suspicion/high risk or active infection: Contact precautions required until skin swabs are confirmed negative. If a patient is determined to be colonized without signs and symptoms of an active infection, treatment is not recommended, and they must remain on Contact precautions at all times. No discontinuation of isolation precautions allowed.
- 6. Patient Education:
 - a. Patients discovered to have MRSA, VRE, or ESBL or Candida auris colonization or infection, or C.difficile infection is are given pre-printed educational handouts provided through Micromedex. Micromedex: CareNotes Procedure

C. RELATED DOCUMENT(S)

- 1. Guideline for Cohorting Patients on Additional Precautions
- 2. Guideline for Discontinuing Isolation Precautions
- 3. Infection Control Policy: Standard and Transmission Based Precautions.
- 4. Patient Care Services Standardized Procedure: Methicillin Resistant Staphylococcus Aureas (MRSA) Screening Procedure
- 5. Type and Duration of Precautions Disease Specific (FKA Short Sheet)

D. **REFERENCE(S)**:

 APIC Guide. (2010) Guide to the Elimination of Methicillin Resistant Staphylococcus aureus (MRSA) transmission in Hospital Settings, 2nd edition. (Verified 11/15/2024) Infection Control
Management of Patients with MDRO or C Difficile Infection Policy
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- 2. APIC Text of Infection Control and Epidemiology Fourth edition 20142024.
- 3. Centers for Disease Control and Prevention. Guidance for Control of Carbapenem-resistant Enterobacteriaceae **Updated April 11**, 20**2412**. Available at <u>About Carbapenem-resistant Enterobacterales | CRE | CDChttp://www.cdc.gov/hai/pdfs/cre/CRE-guidance-508.pdf</u>
- 4. Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007 <u>Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007)</u>, <u>Updated September 2024http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf</u>
- 5. Management of Multidrug-Resistant Organisms In Healthcare Settings, Healthcare Infection Control Practices Advisory Committee (HICPAC) 2006 Jane D. Siegel, MD; Emily Rhinehart, RN MPH CIC; Marguerite Jackson, PhD; Linda Chiarello, RN MS; the Healthcare Infection Control Practices Advisory Committee (Verified 11/15/2024)
- 5.6. Centers for Disease Control and Prevention. Guidance for Control of Candida auris April 24,2024. Available at About C. auris | Candida auris (C. auris) | CDC



MEDICAL STAFF **CONTINUING MEDICAL EDUCATION (CME)**

ISSUE DATE:

10/05

SUBJECT: Continuing Medical Education

(CME) Speaker & Honoraria

Reimbursement

REVISION DATE:

05/09, 11/12, 12/15, 06/18, 03/19

03/20, 04/21, 12/22, 03/24

POLICY NUMBER: 8710-604

Medical Staff Department Approval:

CME Committee Approval:

01/2401/25 01/2404/25

Pharmacy & Therapeutics Committee Approval: Medical Executive Committee Approval:

02/2406/25

Administration Approval:

03/2408/25

Professional Affairs Committee Approval:

Board of Directors Approval:

n/a 03/24

n/a

A. PURPOSE:

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

B. POLICY:

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

PROCEDURE:

- The CME Coordinator may contact commercial support in an effort to secure an unrestricted educational grant.
 - a. All commercial support funds shall be made payable to "Tri-City CMedical Center Medical Staff Treasury".
- The CME Coordinator shall inform the speaker of the approved, offered honorarium. 2.6.
 - a. The CME Coordinator shall obtain a completed W-9 form from the speaker.
 - b. Upon completion of the CME activity, the CME Coordinator shall mail the honorarium check, "Thank You Letter", and a copy of the activity "Evaluation Summary" to the speaker.

REFERENCE(S): D.

ACCME Standards of Commercial Support - Standard 3.7. Accreditation Council for Continuing Medical Education (ACCME), (2004, May) Standard 4: Managing Commerical Support Appropriately.



MEDICAL STAFF

ISSUE DATE:

02/07

SUBJECT: Credentialing Criteria, Chronic Non

Healing Wound Care

REVISION DATE:

03/07, 03/10, 07/11, 07/12

POLICY NUMBER: 8710 - 523

04/17, 04/20, 08/23

06/2306/25

Medical Staff Department Approval: Credentials Committee/IDPC Approval:

06/2306/25

Pharmacy and Therapeutics Approval:

Medical Executive Committee Approval:

06/2306/25

Administration Approval:

08/2308/25 n/a

Professional Affairs Committee Approval:

Board of Directors Approval:

08/23

PURPOSE: A.

- The following sites have been designated as locations with adequate resources to allow the performance of the designated privileges:
 - 6260 El Camino Real, Carlsbad California
 - 4002 Vista Way, Oceanside, California b.

B. POLICY:

- Physicians/Physician Assistants/Podiatrists who request wound care privileges must work within their scope of practice (*Podiatrists scope of practice means foot and ankle only) and shall demonstrate the ability to care for chronic non-healing wounds, including but not limited to: pressure, diabetic, venous, arterial, collagen vascular, autoimmune, and oncologic, and provide assessment and evaluations for patients with chronic non-healing wounds inclusive of:
 - Routine review of patient record and recent labs a.
 - Physical examination of all patient's bony prominences for evidence of excessive b. pressure or skin breakdown
 - Determination of the number of observed chronic non-healing wounds and definition of C. their acuity
 - d. Evaluation and management of any medical problems that would prevent wound healing
 - Development of a treatment plan that facilitates wound healing
- 2. Physicians/Physician Assistants/Podiatrists shall be knowledgeable and capable of managing:
 - Wound colonization and infection a.
 - Appropriate antibiotics usage b.
 - C. Prescription of needed support surfaces
 - d. Advisement on off-loading techniques
 - Enzymatic, mechanical and sharp debridement e.
 - Wound biopsy techniques f.
 - Pain management g.
 - Indications for the use of adjunctive chronic wound care therapy such as, but not limited h. to: Vacuum Assisted Closure Devices, Collagen Matrix Implants, Platelet Derived Growth Factor, Oxidized Regenerated Cellulose, Living Dressings, Selective Impedance Electrical Stimulation and other adjunctive therapy which may, from time to time, become available.
 - Referrals demonstrate proficiency in knowing when and to whom to refer a patient i.

requiring specialized care outside of his/her area of expertise.

C. CREDENTIALING CRITERIA:

- 1. Initial Criteria:
 - a. Surgeon: The applicant must have completed an ACGME accredited residency program in one of the following: Orthopedic Surgery, General Surgery, Vascular Surgery, Plastic Surgery or possess Board Certification in Podiatric Medicine.
 - b. Non-Surgeon: The applicant must have completed an ACGME accredited residency program in one of the following areas: Family Practice, Internal Medicine, Infectious Disease, Emergency Medicine, Physical Medicine and Rehabilitation, Interventional Cardiology, Interventional Radiology, a fellowship in a field that includes the care of wounds, or completion of applicable course work within specified time frame.
 - c. **Physician Assistants**Allied-Health Professionals: The applicant must have the following:
 - i. Completed a PA program accredited by ARC-PA;
 - i. Certified through the National Commission on Certification of Physician Assistants (NCCPA);
 - ii. Currently licensed by the Physician Assistant Board of California; and have
 - d.iii. eCompleted hands-on training within the past 2-years that includes the care of wounds or completion of applicable course work within the past 2-years.
- 2. Proctoring Criteria:
 - a. Non-Surgeon: The proctoring of five (5) cases of debridement must be done by a physician or surgeon who routinely performs unsupervised debridement at Tri-City Healthcare District (TCHD) or at another Joint Commission-approved facility.
 - b. **Physician Assistants**Allied Health Professionals: The proctoring of five (5) cases of debridement must be done by a physician or surgeon who routinely performs unsupervised debridement at TCHD or at another Joint Commission-approved facility.
 - Surgeon: Does not require proctoring.
- Reappointment Criteria:
 - a. Twenty (20) documented procedures of chronic wound care per two-year reappointment cycle.
 - a.b. Practitioner specific quality outcome data will be evaluated on an on-going basis as defined in Medical Staff Policy #8710-509.



MEDICAL STAFF

ISSUE DATE:

02/07

SUBJECT:

Credentialing Criteria, Hyperbaric

Medicine Oxygen Therapy

REVISION DATE:

03/07, 03/11, 01/12, 07/12, 12/13

POLICY NUMBER: 8710 - 523A

04/17, 04/20, 08/23

06/2306/25

Credentials Committee/IDPC Approval:

Medical Staff Department Approval:

06/2306/25

Pharmacy and Therapeutics Approval:

n/a

Medical Executive Committee Approval:

06/2306/25

Administration Approval:

08/2308/25 n/a

Professional Affairs Committee Approval: Board of Directors Approval:

08/23

A. **PURPOSE:**

The following sites have been designated as outpatient chronic non-healing wound care centers ("WCCs") with adequate resources to allow the performance of the designated privileges:

6260 El Camino Real, Carlsbad, California

The following criteria shall be used in credentialing physicians who request privileges for 2. Hyperbaric Medicine Oxygen Therapy in the WCCs.

CREDENTIALING CRITERIA: B.

- Initial Criteria:
 - M.D., or D.O., or DPM a.
 - The applicant must have completed an ACGME accredited residency program in one of b. the following areas: Family Practice, Internal Medicine, Infectious Disease, Emergency Medicine, Physical Medicine and Rehabilitation, Orthopedic Surgery, Interventional Cardiology, Interventional Radiology, General Surgery, Vascular Surgery, or Plastic Surgery, or hold a license to practice Podiatric Medicine.
 - The applicant must have malpractice insurance that includes coverage for hyperbaric C. medicine.
 - d. In addition to the above, the applicant must have one of the following:
 - i. Completion of a Residency or Fellowship Training in hyperbaric medicine.
 - Completion of a hyperbaric medicine Training course approved by the American ii. College of Hyperbaric Medicine (ACHM) or the Undersea and Hyperbaric Medical Society (UHMS)
 - iii. Certified by the American Board of Preventive Medicine or the American Board of Emergency Medicine, in the subspecialty of Undersea and Hyperbaric Medicine.
 - If more than two years has elapsed since completion of training, documentation of a e. minimum of sixteen (16) hours of CME related to hyperbaric medicine must be submitted.
- 2. Proctoring Criteria:
 - A TCMC physician with unsupervised privileges in hyperbaric medicine, or a physician who holds hyperbaric medicine privileges at another Joint Commission-approved facility will proctor the first five (5) hyperbaric medicine therapy consults for practitioners with newly approved hyperbaric medicine privileges.
- Reappointment Requirements: 3.
 - A minimum of sixteen (16) hours of CME related to hyperbaric medicine must be a.

Medical Staff Credentialing Criteria, Hyperbaric Medicine Oxygen Therapy $-\,8710\text{-}523A$ Page 2 of 2

- documented per two-year reappointment cycle. Half of this requirement can be met by reading hyperbaric literature, with the rest being fulfilled through attending meetings and making presentations on hyperbarics.
- b. Hyperbaric Medicine Oxygen Therapy: twelve (12) documented cases per two-year reappointment cycle.
- c. Physician specific quality outcome data will be evaluated on an on-going basis as defined in Medical Staff Policy #8710-509.



MEDICAL STAFF CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE:

03/06

SUBJECT:

Cultural and Linguistic

Proficiency Competency (CLC) and Implicit Bias (IB)

REVISION DATE: 05/08, 08/12, 09/14, 08/18, 03/20,

POLICY NUMBER:

8710-601

08/21, 04/22

Medical Staff Department Approval:

10/2101/25

Continuing Medical Education Committee Approval:

01/2104/25

Pharmacy & Therapeutics Committee Approval:

n/a 03/2206/25

Medical Executive Committee Approval: Administration Approval:

04/2208/25

Professional Affairs Committee:

n/a

Board of Directors Approval:

04/22

Α. **PURPOSE POLICY:**

The California legislature intended Assembly Bill (AB) 1195 and AB 241 to "encourage physicians and surgeons to meet the cultural and linguistic concerns" of California diverse patient populations.-

2. Planners, faculty and speakers are central to adhering to state law as noted in Business and Professions (B&P) Code 2190.2, which codifies the aforementioned legislation. B&P Code 2190.1 defines CLC and IB and these definitions were further refined by the CMA CME team under the guidance of an Advisory Committee composed of physicians and health equity experts.-

3. The CLC and IB definitions reiterate how patient's social determinants of health impact

their access to care.-

Presenting the CLC and IB definitions reminds planners, faculty and speakers to consider 1.4. legislative intent when planning, developing, executing and evaluating CME activities

B. **DEFINITION(S):**

Cultural Competency and Linguistic Competency (CLC): The ability and readiness of health care providers and organizations to humbly and respectfully demonstrate, effectively communicate, and tailor delivery of care to patients with diverse values, beliefs, identities and behaviors, in order to meet social, cultural and linguistic needs as they relate to patient health

Implicit Bias (IB): The attitudes, stereotypes and feelings, either positive or negative that 2. affect our understanding, actions and decisions without conscious knowledge or control.

Implicit bias is a universal phenomenon.

- When negative, implicit bias offer contributes to unequal treatment and disparities in a. diagnosis, treatment decisions, levels of care and health care outcomes people base on race, ethnicity, gender identity, sexual orientation, age, disability and other characteristics
- 3. Demographic diversity can mean a group composed of people of different genders, races/ethnicities, cultures, religions, physical abilities, sexual orientations or preferences,
- 4. Diversity: Having many different forms, types or ideas; showing variety.

C. POLICY:

Identification of CLC Disparity: The goal of this standard is for medical education to

address how IB affects-perceptions and treatment decisions, which lead to disparities in health outcomes. Unintended biases in decision-making may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, age, socioeconomic status or other characteristics

- 2. Tri-City Hospital District (TCHD) Staff is not responsible for identifying CLC disparities. It is the responsibility of the speaker and/or planners.
- The planner will document on the planning form if there is no clinical care component or no CLC disparity identified.
- 4. Tri-City Medical Center shall include cultural and linguistic objectives in CME activities that address cultural beliefs, which may include cause, severity, treatment, and acceptability of the patient's own illness, as well as, language barrier implications, and the need for providing appropriate interpreters and appropriately interpreted material. Objectives shall include at least one or a combination of the following:
 - a. Application of linguistic skills to communicate effectively with the target population
 - b. Utilization of cultural information to establish therapeutic relationships
 - c. Elicitation and incorporation of pertinent cultural data in diagnosis and treatment
 - d. Understanding and application of cultural and ethnic data to the process of clinical care
- 5. Each CME speaker shall complete and sign a *Cultural Diversity* form. The form informs speaker(s) of the requirement that cultural and linguistic information/resources are required for each CME activity with clinical content. See attached
- 6. Cultural references shall be made available to attendees at CME activities.

D. FORM(S):

- 1. Cultural and Linguistic Competency and Implicit Bias Standards Planning Worksheet Sample.
- 2. Cultural Awareness Guide Sample
- 4.3. Cultural Linguistic Competency (CLC) and Implicit Bias (IB) in Accredited CME Fact Sheet Sample

E. RELATED DOCUMENT(S):

- Tri-City Medical Center "A Guideline for General Cultural Awareness" Sample.
- F. REFERENCE(S): Assembly Bill (AB)1195-Cultrual and Linguistic Competency
 - 1. AB1195 and AB241Implicit Bias: Continuing Medical Education
 - 2. Accreditation Council for continuing Medical Education. California Medial Association Diversity, Equity, and Inclusion Resources (ACCME) 2022-2026: Strategic Plan
 - 3. California Legislative Information. (2019-2020). Assembly Bill (AB) 241 Implicit Bias: Continuing education requirements. Retrieved from (https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=200520060AB1195)

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1 As defined by EMA at cmadocs.org/CME-standards

Cultural Diversity Form - Sample



CULTURAL AND LINGUISTIC COMPETENCY (CLC) and IMPLICIT BIAS (IB) Standards

Planning Worksheet

This worksheet is designed to assist continuing medical education (CMED) planners in ensuring a given CME activity follow the cultural and linguistic competency (CLC) and implicit bias (IB) standards required by law and developed by the California Medical Association (CMA) Name of CME Activity: Date of CME Activity: _____ Select the statement which is most applicable: This activity will contain curriculum that includes the understanding of CLC and IB This activity will not contain curriculum that includes the understanding of CLC and IB. I certify that the topic of this activity is research focused and/or does not contain a direct patient care component. Standard 1: Website he text of (or direct links to) AB1195 and AB241 were posted to the provider's organization website. Yes NO It was not feasible to include this information on the website. Information was provided using an alternative method. Please specify: Standard 2: Definition All individuals in control of content were provided with the definition of CLC and IB1 Yes l No Standard 3: Resources All individuals in control of content were directed to or provided with CCLC and IB educational resourced. Yes No No Please specify:

Page 5 of 6 Standards 4 and 5: Patient Populations and Disparities What are the commonalities of your organization's patient population? What CLC factors were communicated to planners, faculty and speakers relevant to this population? What are some disparities that may influence the health outcomes of these patients if not properly mitigated? Standard 6: Diversity Individuals in control of content represent a diverse² Perspective on the proposed topic. Yes No Comments: 2 The following definition has been adapted from the National Institute of Health-Diversity: Having many different forms, types or ideas; showing variety. Demographic diversity can mean a group comprised of people of different genders, races/ethnicities, cultures, religions, Standard 7: Incorporated what are some of the CLC and IB educational resources included, referenced or introduced during this activity?

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

Cutture Group and Language	Belief Practices	Nutritional Preferences	Communication Awareness	Patient Care/Handling of Death
American Engilsh	Onistian and Jewish beliefs are prominent. Many others exist in smaller numbers. Family-oriented.	Beef, chicken, potatoes, vegetables; fast foods; ethnic foods.	Talkative, shake hands, not much touching during conversation. Prefer to gather information for decisionmalking. Some hugging and kissing, mainly between women.	Family members and friends visit in small groups. Expect high- quality care.
Argentinean Spenish	90% Catholic, some Protestant and Jewish. Strong belief in saints, purgatory, and heaven. People from rural areas may be more superstitious.	Emphasis on meat, especially beef with homemade pastas, pastnes, and local wines. Mate, mational beverage that is stimulating and "addictive" like coffee.	Talkative, very expressive, direct and to the point. Extroverted. Good eye contact. Like personal and physical contact such as holding hands, hugging, and kissing.	Educated, yet reludant to get medical attention or accept new medical advancements. Independent, often deny disability. Betieve in natural and holistic remedies, herbal teas, pure alce, natural oils, and poulitices. Family gets involved with caring for the ill family member.
Brazillan Portuguese, Oiverse cultural backgrounds including: European, African, Indian.	Mostly Catholic. Growing Evangelical representation Candomble, similar to Santeria, Macumba (blend of African, Brazilian, Indian).	Beans and rice are staple. Felgeda-black beans, beef, and port; churrasco (charcoal-broiled meats); manice (vegetable); tropical ffults.	Very sociable. Will stand close to each other. Social kissing, hugging, touching, good eye contact.	Emphasis on family unity – will want to be actively involved. Tend to trust medical personnel; place great faith in doctors and nurses. Some believe in herb treatment, teas, and balsams.
Canadian English, French and Innuit (Eskimo)	Protestant, Catholic, and Jewish. 80% of the population lives within 1.00 miles of the United States boarder.	Comparable to American diet. French influence in Montreal and Quebec.	Prefer notouching or kissing. Take things at face value.	Follow nurses' instructions. Accustomed to socialized medicine, less litigation. Take physicians at their word. Willing to wait for treatment.
Cayman English, with some changes in accents and verbs.	People are very religious. Majority of the Island is Baptist or "Church of God." Voodoo and psychics are outlawed.	Fish, turtle, beef, goat, and conch, rice, beans, and plantains: fried food very rich in fat; cooked or fried in coconut oil or milk.	Like to be acknowledged. Good eye contact, Prefer no touching or kissing. Very talk ative and known for their friendliness. Everyone on the island knows each offler.	Like to be told what is going on by doctor. Would rather talk to doctors than nurses. Prefer one-on-one care.
Chinese Many dialects spoken one written language.	Religions: Taoism. Buddhism, Islam, and Christanhy. Harmondous relationship with nature and others; loyalty to family, rifends, and government. Public debate of conflicting views is unacceptable. Accommodating, not confrontational. Modesty, self-control, self-reliance, and self-restault. Hierarchical structure for interpersonal and family interactions.	Belief in theory of "yin" (cold) and yang (no) when they are side. Yang (no) when they are side. No food with "yin" after surgery (e.g., cold desserts, salad). Often lactoce intolerant. Soy sauce. MSG, and preserved foods. Diet consisting of vegetables and rice. Totu (bean curd) can be prepared in various ways.	Quiet, polite, and unassertive. Suppress Feelings of anxiety, feer, depression, and pain. Eye contact and touching sometimes seen as offensive or impolite. Emphasize loyalty and tradition. Self-expression and individualism are discouraged.	Women uncomfortable with exams by male physicians. May not adher to fixed schedule. May tear medical institutions. Use a combination of herbal and Westen medicine at the same time. Traditional: acupuncture, herbal medicine, massage, skin scraping, and cupping. Alcohol may cause flushing.
Cuban Spanish	Catholic with Protestant minority. Santeria, which can include animal sacrifice.	Outen bread, cafe con leiche. Cuban coffee, roast ports, black beans, and rice; plantains, yucca, chicken and rice.	Some may have a tendency to be loud when having a discussion. Use their hands for emphasis and credibility, and prefer strong eye contact.	Culture requires visiting the sick; the extended family supports the immediate family. It is an insult to the patient if there is not a large family/friend presence.
Ecuadorian Spanish, Quechua- indian	Primarily Catholic. Increase in Protestaril. Bagistis, and Jehrovah Witness. Very respectful toward religious leaders. Small percentage of population is wealthy with much political control. Family size is usually large.	Diet high in fruits and proteins. Starches froe potatoes, and com. Food is prepared fresh daily, usually with salsa. Coastal diet. Ifee and fish (certiche). Drink beer and soda.	Extremely polite Reserved Respectful. Especially helpful.	Prefer pampering ill family members: stay overnight with patient. Not störe when it connes to patien. Very private and modest. Embarnassed if they do not look their best. Extremely protective of family; often parents live with grown children.
Filipino English, Spanish, and Tagalog (80 Dielects)	Catholic. Seek both faith healer and Western physician when III. Belief that many diseases are the will of God.	Theory of hat and cold food. Certain foods in the Philippines are traditionally eaten hat or cold. e.g., milk is only taken HOT. Fish, rice, vegetables, and fruit. Meals have to be HOT.	Vatue and respect elders. Loving and family-oriented. Set aside time just for family.	Family decision important. Ignore health-related issues; often noncompliant, in spite of Western medicine, they often leave things in the hands of God, with occasional folk medicine, Home remedies; herbal tea, massage, and sleep. May subscribe to supernatural cause of disease.

s:tmedstaffomet@euttural awareness guide.docx

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Patient Care/Handling of Death	Modest, private, and stoic. Believe inatternative methods of healing.	Obedient to doctor and nurse, but hesitant to ask questions. View use of oxygen as indication of severe ilness. Occasionally share prescriptions and home remedies.	Do not try to force food when religiously forbidden. Death: The priest may tie a thread around the neck or wrist to signify a blessing. This thread should not be removed. The priest will pour water into the mouth of the body. Family will request to wash the body. Eldest son is responsible for the funeral.	Will try some home remedies before seeking medical help Like To becompletely rarrabefore procedures. Respectful of doctor's opinion. Can be reluctant to admit that they are in pain. May not adhere to a fixed schedule.	Family role for support is important. Insulted when addressed by first name. Confidentially is very important for honor. Information about liness kept in immediate family. Prone to keloid formation. Cleft is or palate not uncommon. Aboholmay cause flushing. Tendency to control anger.	Stoic and authoritative ive. Appreciate family accommodate bn., Jewish law demands that they seek complete medical are. Donor transplants are not acceptable to Orthodox Jews, but are too Conservative and Romm. Death: Cremation is discouraged. Autopsy is permitted in less strict groups. Orthodox believes that entire body, tissues, organs, amputated limbs, and blood sponges need to be available to family for burial. Do not cross hands in postmortem care.	Family needs to be included in plan of care. Prefer non-contact. Respond to sincerity.	May believe that outcome of circumstances is controlled by external force; this can influence patient's compliance with health care. Women do not expose their bodies to men or other women.	Do no force foods when it is religiously forbidden Abortion before 130 days, is treated as discarded issue, after 130 days, as a human being. Before death, confession of sins with family present. After death, only relatives or priest may touch the body. Koran, the holy book, is recited near the dying person. The body is bathed and dothed in white linen and buried within 24 hours.
					ngs to e. e. cept	V-9.			ale
Communication Awareness	Quiet, reserved, and respectful. Will not question for fear of insulting professional.	Quite and polite.Value touch and eye contact.	Limited eye contact. Do not touch while talking.	Respect for elders is encouraged. Reserved. Avoid hugging and showing affection in public. Curious and tend to ask a lost of questions.	Use attitude, actions, and feelings to communicate. Talkative people are considered showoffs or instruction. Openness considered sign of immaturity, lack of self-control. Implicit nonverbal messages are of central importance. Use concept of hierarchy and status. Avoid eye contact and touch.	Orthodox men do not touch women, except for their wives. Touch only for hands-on care. Very talkafive and known for their friendliness,	Reserved with strangers. Will use eye contact with familiar individuals. Edquette is important. First names used only for family members. Proud and independent. Children should not be used as translators due to reversal of parent/child relationship.	Tend to describe emotions by using dramatic body language. Very dramatic with grief, but otherwise diplomatic and tacful. Direct confrortation is rude.	Limit eye contact. Do not touch while talking. Women may cover entire body except face and hands.
Nutritional Preferences	Diet high in frurts, vegetables ince beans, and tortillas (com flour bread).	Large breakfast and lunch. Light Dinner. Rice, fried pork, grillot, and red beans. Herbs and cloves.	Cow is sacred. No beef. Some strictly vegetarian.	Beef, goat, rice and peas, chicken, vegetables, fish and lots of spices. Some avoid eating pork and pork products because of religious beliefs.	Food presentation is important. Fish and soybean are main sources of protein, as well as meats and vegetables (some pickled). Rice and noodles; tea; soy sauce. Often lactose-intolerant.	Orthodox and some Conservatives maintain a Kosher diet. Kosher food is prepared according to Jewish law under Rabbinical supervision. Eating of unclean animals is forbidden. Blood and animal fats are taboo (blood is synonymous with [E). Do not mix meat with dairy products.	High fiber, spicy seasoning, rice, Kim Chee (fermented cabbage). Speak little during meal. Often lactose- and alcohol-intolerant.	Corn, beans, avocado, chilies, and yellow rice. Heavy use of spices.	No pork or alcohol. Eat only Halal meat (type of Kosher).
Belief Practices	Primarily Catholic, Increase in Protestants, Very respectful toward eders. European heritage; strong family ties.		The belief in cyclic birth and reincamation lies at the center of Hinduism. The status, condition, and caste of each life is determined by behavior in the last life	Christian beliefs dominate (Catholic, Baptist, and Anglican), Some Rastafari influence.	Sek-praise or the acceptance of praise is considered poor manners. Family is extremely important. Behavior and communication are defined by role and status.	Brael is the holy land. Sabbath is from Sundown Friday to sundown on Safurday. It is customary to invite other families infor Friday evening Sabbath dinner.	Family-oriented. Befeve in reincarnation. Religions include Shamanism, Taoism, Buddhism, Confucianism, and Christianity. Belief in balance of two forces: hot and cold.	Predominantly Roman Catholic. Pray, say rosary, have priest intime of crisis. Limited belef in "brujeria" as a magical, supernatural, oremotional illness precipitated by evil forces.	Belief on one God,"Allah, and Mohammed, Insprophet, Five daily prayers, Zakat, a compulsory giving of alms to the poor, Fasting during the month of Ramadan, Pligimage to Mecca is the goal of the faithful.
Culture Group and Language	Guatemalan Spanish; Mayan heritage; European	Haitian Creole; French is taught in schools	Hindu Hindi	Jamaican English, Patois (broken English)	Japanese	Jewish Manyfrom Eastem European countries. English, Hebrew, and Ylddish, Three basic groups; Orthodox (most strict), Conservative, and Reform (least strict).	Korean Hangul	Mexican Spanish, People of Indian heritage may speak one of more than 50 dialects.	Muslim Language of the country and some English

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

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



NOTE FOR CONTINUING EDUCATION STAFF

By preparing this fact sheet for your organization and sending out to your faculty, planners and speakers, you will have met the California CLC & IB Standards 1-5.

Tri-City Medical Center



Cultural Linguistic Competency (CLC) and Implicit Bias (IB) in Accredited CME Fact Sheet

Dear Prospective Faculty/Planner/Speaker,

It is California State Law that <u>Cultural Linguistic Bias</u> (AB 1195) and <u>Implicit Bias</u> be included in all accredited CME educations that take place after January 1, 2022.

The California Medical Association (CMA) has defined cultural and linguistic competency (CLC) to be:

The ability and readiness of health care providers and organizations to humbly and respectfully demonstrate, effectively communicate, and tailor delivery of care to patients with diverse values, beliefs, identities and behaviors, in order to meet social, cultural and linguistic needs as they relate to patient health.

CMA has defined implicit bias (IB) to be:

The attitudes, stereotypes and feelings, either positive or negative, that affect our understanding, actions and decisions without conscious knowledge or control. Implicit bias is a universal phenomenon. When negative, implicit bias often contributes to unequal treatment and disparities in diagnosis, treatment decisions, levels of care and health care outcomes of people based on race, ethnicity, gender identity, sexual orientation, age, disability and other characteristics.

Tri-City Medical Center works with the following patient populations:

<< Organization statistics>>

Tri-City Medical Center is aware that implicit bias is unconscious, and therefore, needs to be brought to the learners' attention, so that they can self-evaluate how they will mitigate the potential. As planners, we have identified the following areas where disparities in care affecting the patient population above and the role that IB might play in this topic:

<<committee identified disparities>>

This list is not exhaustive, and you should address any other potential areas for bias that you have identified, in addition to above.

As someone affiliated with our CME program, it is important that you are aware of and consider the CLC and IB when implementing any educational intervention.

Please attest that you have read the above information and will incorporate CLC and IB into educational interventions you are involved with.

Name	Role	Date



Below is a sample chart of what could be created to show your organizations patient populations statistics:

Race/Ethnicity

	XX	Provider	XX Prov	ider County	Cali	California		
	Number	Percent	Number	Percent	Number	Percent		
Hispanic or Latino	588,937	60.5%	1,089,104	51.7%	14,903,982	38.6%		
White	232,768	23.9%	642,786	30.5%	14,837,242	38.4%		
Black or African American	83,567	8.6%	170,376	8.1%	2,158,363	5.6%		
Asian	42,448	4.3%	138,751	6.6%	5,280,818	13.7%		
Other or multiple	19,902	2.0%	52,529	2.5%	1,198,263	3.1%		
Native HI/Pacific Islander	3,543	0.4%	6,368	0.3%	139,956	0.4%		
American Indian/AK Native	2,864	0.3%	6,840	0.3%	136,582	0.4%		

Source: U.S. Census Bureau, American Community Survey, 2012-2016, DP05. factfinder.census.gov



NOTE FOR CONTINUING EDUCATION STAFF

Additional tables could be created for topics such as, but not limited to:

- Foreign Born Residents and Citizenship
- Language Spoken at Home
- English Learners
- Income to Poverty Level
- Median Household Income
- Household Supportive System
- Educational Attainment
- Insurance Coverage by Type
- Insurance Coverage by age
- Source of Care
- Health Status Before & During Pregnancy
- Age of Pregnancy

- Infant Mortality Rate
- Mortality Rates
- Cancer incidence rates
- Asthma
- Adult Diabetes
- Adult Heart Disease
- High Blood Pressure
- Weight adults and/or children
- Smoker/Non-Smoker
- Sexual Orientation
- Political Belief
- Handicaps

Sources for Statistical Data:

U.S. Census Bureau Data Center. data.census.gov

California Department of Education DataQuest, 2017-2018 Language Group Data. dg.cde.ca.gov/dataquest

Source: California Health Interview Survey, 2016. ask.chis.ucla.edu

California Department of Public Health, Maternal Infant Health Assessment, 2013-2015. cdph.ca.gov/Programs/CFH/DMCAH/MIHA/Pages/Data-and-Reports.aspx?Name=SnapshotBy

California Department of Public Health, Maternal and Infant Health Assessment 2013-2015. cdph.ca.gov/Programs/CFH/DMCAH/MIHA/Pages/Data-and-Reports.aspx

California Cancer Registry, Cancer Surveillance Section, California Department of Public Health, 2011-2015. cancer-rates.info/ca

California Department of Public Health, County Health Profiles, 2018 programs/CHSI/CDPH%20Document%20Library/CHSP-County%20Profiles%202018.pdf

California Department of Public Health, 2017. *Early Syphilis includes primary, secondary, and early latent syphilis. cdph.ca.gov/Programs/CID/DCDC/Pages/STD-Data.aspx

California Department of Education, Fitnessgram Physical Fitness Testing Results, 2016-2017. data1.cde.ca.gov/dataquest



PHARMACY

ISSUE DATE:

08/12

SUBJECT: Automatic Dose Rounding

REVISION DATE:

09/15, 01/18, 06/22

Department Approval:

12/2104/25 03/2204/25

Pharmacy and Therapeutics Approval: **Medical Executive Committee Approval:**

05/2206/25

Administration Approval:

06/2208/25

Professional Affairs Committee Approval:

n/a

Board of Directors Approval:

06/22

A. **PURPOSE:**

To provide a procedure for rounding medication dosages to deliver high-quality, cost-effective pharmaceutical care while minimizing charge errors and medication waste.

PROCEDURE: B.

- It is preferred that the prescriber round the dose of a medication to the nearest available package size or closest measurable dose.
- If the prescriber does not round to the nearest available package size or closest measurable 2. dose, the pharmacist will round a dose to the nearest available package size or closest measurable dose providing the following criteria are met:
 - Doses may be adjusted by the pharmacist for approved medications listed below or pursuant to an approved protocol (for example enoxaparin and heparin per the Pharmacy Procedure: Anticoagulation Dosing and Monitoring).
 - Approved Medications:
 - Chemotherapy 1)
 - Immune globulin 2)
 - 3) G-CSF: granulocyte colony-stimulating factors (i.e., filgrastim)
 - Erythropoetin stimulating factors (i.e. Epogen) 4)
 - Coagulation factors (VII, VIII, IX, Prothrombin Complex Concentrate) 5)
 - Alpha-proteinase inhibitors (i.e. Zemaira, Aralast) 6)
 - 7) Antimicrobials, antifungals, and antivirals
 - 8) Tranexamic acid
 - **Monoclonal Antibodies** 9)
 - Doses of non-chemotherapeutic agents-will be adjusted within 10% (plus or minus) of b. the calculated prescribed dose.
 - Chemotherapeutic agents may be adjusted pursuant to Pharmacy Policy: Chemotherapy, Prescribing, Processing, and Preparation.
 - The dose for the ordered medication is within the normal dosing range based upon the d.c. indication, age, weight, and clinical status.
- The pharmacist shall contact the prescriber prior to rounding the dose of an unapproved 3. medication.
- Dose-rounding for patients on an investigational protocol will occur based on protocol 4. specifications only.
- The prescriber shall be notified of potential rounding of doses greater than 10% for non-5. chemotherapeutic agents and shall approve the new dose prior to any changes made by the pharmacist. For Chemotherapeutic agents, the prescriber will be notified pursuant to Pharmacy Policy: Chemotherapy, Prescribing, Processing, and Preparation.

Pharmacy Automatic Dose Rounding Page 2 of 2

6. The pharmacist shall round the dose and complete the order "per protocol" in the patient medical record.

C. RELATED DOCUMENT(S):

- 1. Pharmacy Policy: Chemotherapy, Prescribing, Processing, and Preparation
- 2. Pharmacy Procedure: Anticoagulation Dosing and Monitoring
- 2.3.



PHARMACY

ISSUE DATE:

10/10

SUBJECT: Restricted Antimicrobials

REVISION DATE:

07/15, 01/19, 05/22

Pharmacy Department Approval:

03/2204/25

Pharmacy & Therapeutics Committee Approval:

03/2204/25

Medical Executive Committee Approval:

04/2206/25

Administration Approval:

05/2208/25

Professional Affairs Committee Approval:

n/a

Board of Directors Approval:

05/22

A. **PURPOSE:**

- To provide a list of restricted antimicrobials where prescribing of such medications is limited to specific indications or medical specialty in order to improve clinical outcomes, reduce rates of emerging resistance, and reduce the incidence of adverse events.
- 2. To provide restriction criteria and outline requirements for prescribing and dispensing of restricted antimicrobials
- To provide a process that streamlines the approval of restricted antimicrobials 3.

B. **POLICY:**

- Restriction criteria shall be reviewed and revised at least annually by Pharmacy and the Infectious Disease (ID) Physician based on usage patterns, microbiology data, and costeffective analyses.
- Restriction Criteria shall be approved by the Pharmacy & Therapeutics (P&T) committee. 2.
 - Use of antimicrobials that do not meet criteria shall require ID approval. a.
 - The Infectious DiseaseID Physician shall collaborate with those who fail to comply with b. the restriction guidelines set forth by P&T.
- 3. All restrictions apply to inpatient and emergency room patients with the exception of patients enrolled in investigational antibiotic drug studies.

C. PROCEDURE:

- The clinical pharmacist and/or Pharmacy Clinical Manager shall review all requests for restricted antimicrobials.
- 2. If the patient meets criteria for use of the agent (see Antimicrobial Agents Requiring Approval: Criteria For Use), the clinical pharmacist will approve the request.
- 3. If the patient fails to meet criteria, the prescriber will be notified that continued use of restricted antimicrobials requires approval by the Infectious Disease Physician, and/or-Intensivist, or Oncologist as indicated by criteria use guidelines.
- 4. If the prescriber insists on using a restricted antimicrobial, the patient will be provided with enough doses (i.e. up to 24 hours, or through the weekend) to allow enough time for the prescribing physician to contact the Infectious Disease Physician and obtain approval. The prescriber will be notified of how many doses will be dispensed pending approval.
 - The clinical pharmacist will document a clinical intervention about their 4.a. discussion with the prescriber and relevant information regarding the restricted antimicrobial order.
- 5. The Infectious DiseaseID Physician will determine if the antimicrobial is indicated and provide approval if continued use of restricted antimicrobial is deemed appropriate.

Pharmacy Restricted Antimicrobials Policy Page 2 of 2

- 6. It is the ordering physician's responsibility to follow-up with a maintenance order for the antimicrobial after approval from the Infectious DiseaseID Physician has been obtained
- 7. In addition to Infectious DiseaseID Physician approval, all non-formulary agents require approval from the Clinical Pharmacy Manager or ID Pharmacist

D. RELATED DOCUMENT(S):

1. Antimicrobial Agents Requiring Approval: Criteria For Use



ANTIMICROBIAL AGENTS REQUIRING APPROVAL: CRITERIA FOR USE

Patients transferred from another facility **on or already taking outpatient**en a restricted antimicrobial may be continued on the agent or switched to a TCMC formulary equivalent until culture and sensitivity results become available.

ANTIBIOTICS:

- 1. Amikacin (Amikin)
 - a. All use Formulary agent restricted to Infectious Diseases Physicians
- 2. Aztreonam (Azactam)
 - a. Formulary agent
 - b. Empiric therapy is restricted to Intensivists or Infectious Diseases Physicians
 - c. Restricted to pharmacist approval for
 - i. Treatment of documented aerobic gram-negative bacilli infections in which beta-lactams are contraindicated due to a true anaphylactic penicillin ander cephalosporin allergy
 - Monotherapy should be used only when cultures and sensitivities have been reported
- 3. Ceftaroline (Teflaro)
 - a. Formulary agent restricted to Infectious Diseases Physicians
- 4. Ceftolozane-tazobactam (Zerbaxa)
 - a. Formulary agent restricted to Infectious Diseases Physicians
- 5. Ceftazidime (Fortaz)
 - a. Formulary agent restricted to Intensivists or Infectious Diseases Physicians
- 6. Ceftazidime-avibactam (Avycaz)
 - a. Formulary agent restricted to Infectious Diseases Physicians
- 7. Colistin/colistimethate
 - a. Non-formulary agent restricted to Infectious Diseases Physicians
- 8. Dalbavancin (Dalvance) & oritavancin (Orbactiv)
 - a. Non-formulary agent restricted to Infectious Diseases Physicians
 - b. Should not be dispensed unless ordered by Infectious Diseases Physician and approved by Pharmacy Clinical Manager
- 9. Daptomycin (Cubicin)
 - a. Formulary agent
 - b. Empiric therapy or UTI-is restricted to Intensivists or Infectious Diseases Physicians
 - b.c.Restricted to pharmacist approval for treatment of serious infections (except involving the urinary tract or lungs)
 - i. with confirmed MRSA bacteremia from a non-pulmonary source
 - i.ii. with confirmed vancomycin resistant Enterococcus (VRE) species
 - **ii.iii.** with confirmed MRSA infection when patient allergic to or failed vancomycin IV therapy
 - iii-iv.with confirmed MRSA infection where patient has developed or is at high risk of acute kidney injury from vancomycin IV
- 10. Eravacycline (Xerava)
 - a. All use-Formulary agent restricted to Infectious Diseases Physicians
- 11. Ertapenem (Invanz)
 - a. Non-fFormulary agent restricted to Infectious Diseases Physicians or Intensivists
 - b. Restricted to pharmacist approval for treatment of
 - i. Documented bacterial infection resistant to other beta-lactams, fluoroquinolones, or aminoglycosides (i.e. ESBLs when susceptible)
 - ii. Patient with a history of ESBL *Enterobacterales* may be empirically prescribed a carbapenem prior to culture result



ANTIMICROBIAL AGENTS REQUIRING APPROVAL: CRITERIA FOR USE

- a.iii. Note: ertapenem does not treat Pseudomonas spp.
- 12. Fidaxomicin (Dificid)
 - a. Formulary agent restricted to Infectious Diseases Physicians
- 13. Linezolid (Zyvox)
 - Formulary agent empiric therapy or UTL is restricted to Intensivists, or Infectious Diseases Physicians
 - b. Restricted to pharmacist approval for treatment of
 - i. Respiratory tract infection excluding empyema or loculated parapneumonic pleural effusions
 - ii. Skin/soft tissue infection with no signs of bone/joint involvement
 - iii. serious infections (except-involving the urinary tract) with C-confirmed vancomycinresistant Enterococcus species VRE
 - iv. Exclusions: any of the following
 - b.• Gram positive bacteremia, empyema, endocarditis, bone/joint infection (osteomyelitis), concurrent use of MAOOA inhibitors
- 14. Fosfomycin (Monurol)
 - a. FNon-formulary agent restricted to Infectious Diseases Physicians
 - b. Restricted to pharmacist approval for treatment of
 - a-i. Empiric oral treatment of cystitis caused by ESBL E. coli or VRE
- 15. Meropenem (Merrem)
 - a. Formulary agent restricted to Intensivists or Infectious Diseases Physicians
 - b. Restricted to pharmacist approval for treatment of
 - Documented bacterial infection resistant to other beta-lactams, fluoroquinolones, or aminoglycosides (i.e. ESBLs or MDRO *Pseudomonas* when susceptible)
 - ii. Patient with a history of ESBL *Enterobacterales* or MDRO *Pseudomonas* may be empirically prescribed a carbapenem prior to culture result
- 16. Meropenem/vaborbactam
 - a. Non-formulary agent restricted to Infectious Diseases Physicians
- 17. Quinupristin/dalfopristin (Synercid)
 - a. Non-formulary-agent restricted to Infectious Diseases Physicians
- 18.17. Tigecycline (Tygacil)
 - a. Non-formulary agent restricted to Infectious Diseases Physicians



ANTIMICROBIAL AGENTS REQUIRING APPROVAL: CRITERIA FOR USE

ANTIFUNGALS:

- 1. Amphotericin B liposomal (Ambisome)
 - a. All use restricted to Oncologists, Intensivists, or Infectious Diseases Physicians
- 2. Flucytosine (Ancobon)
 - a. All use restricted to Infectious Diseases
- 3. Micafungin (Mycamine)
 - a. Empiric therapy is restricted to Oncologists, Intensivists, or Infectious Diseases Physicians
 - b. Restricted to pharmacist approval for treatment of documented invasive candidiasis (not urinary, respiratory, ocular, or intra-cranial), pending species identification
- 3. Posaconazole (Noxafil)
 - a. IV formulation: All use restricted to Infectious Diseases Physicians
 - b. PO formulation: All use restricted to Oncologists or Infectious Diseases Physicians
- 4. Isavuconazonium (Cresemba)
 - a. Formulary agent restricted to Infectious Diseases Physicians
- Voriconazole (Vfend)
 - a. Empiric therapy or other fungal infections restricted to Oncologists, Intensivists, or Infectious Diseases Physicians
 - b. Restricted to pharmacist approval for treatment of documented invasive Aspergillus infections

ANTIVIRALS:

- 1. Ganciclovir
 - a. Formulary agent restricted to Infectious Diseases Physicians
- 2. Valganciclovir
 - a. Formulary agent restricted to Infectious Diseases Physicians
- 3. Remdesivir
 - Formulary agent restricted to Infectious Diseases Physicians or pharmacist approval for treatment of COVID-19

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

August 6, 2025 – 3:30 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:30 p.m. on August 6, 2025.

Board Counsel Jeff Scott informed the Board that Director Younger, due to illness, would participate remotely under the Brown Act's emergency circumstance provision. Director Chaya chaired the meeting. Upon motion by Director Chavez, unanimously approved by roll call, the Board recognized the emergency circumstances permitting Director Younger's remote participation.

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

Director Sheila Brown
Director Nina Chaya, M.D.
Director George W. Coulter
Director Rocky J. Chavez
Director Gigi S. Gleason
Director Adela I. Sanchez
Director Tracy M. Younger (via teleconference)

Also present were:

Gene Ma, M.D., Chief Executive Officer
Donald Dawkins, Chief Nurse Executive
Anh Nguyen, Chief Financial Officer
Mark Albright, Chief Information Officer
Roger Cortez, Chief Compliance Officer
Jennifer Paroly, Foundation President
Mohamad Jamshidi-Nezhad, D.O., Chief of Staff Elect
Susan Bond, General Counsel
Jeff Scott, Board Counsel
Nandan Prasad, M.D., Medical Director of Quality
Heidi Benson, Clinical Quality Manager
Shirley Krussel, Clinical Quality Coordinator
Kim Quinn, Clinical Informatics Manager
Josh Smiley, Clinical Nurse Manager/Forensics
Teri Donnellan, Executive Assistant

- 1. Vice Chairperson Chaya called the meeting to order at 3:30 p.m. with attendance as listed above.
- Approval of Agenda

It was moved by Director Coulter and seconded by Director Gleason to approve the agenda as presented. The motion passed unanimously (7-0).

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

Vice Chairperson Chaya made an oral announcement of the item listed on the

August 6, 2025 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees.

4. Motion to go into Closed Session

It was moved by Director Chavez and seconded by Director Gleason to go into Closed Session at 3:35 p.m. The motion passed unanimously (7-0).

- 5. At 5:10 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 reported the Board in Closed Session heard a Quality Assurance Report pursuant to Health & Safety Code 32155 and took no action.

7. Adjournment

There being no further business, Chairperson Chaya adjourned the meeting at 5:12 p.m.

	Tracy M. Younger Chairperson
ATTEST:	
2	
Adela I. Sanchez	
Secretary	

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

June 26, 2025 – 2:30 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 2:30 p.m. on June 26, 2025.

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

Director Sheila Brown (via teleconference)
Director Nina Chaya, M.D.
Director George Coulter
Director Rocky Chavez
Director Gigi Gleason
Director Adela Sanchez
Director Tracy Younger

Also present were:

Gene Ma, M.D., Chief Executive Officer
Anh Nguyen, Chief Financial Officer
Henry Showah, M.D., Chief of Staff
Mohamad Jamshidi-Nezhad, D.O., Chief of Staff Elect
Jeff Scott, Board Counsel (via teleconference)
Teri Donnellan, Executive Assistant

Chairperson Younger called the meeting to order at 2:30 p.m. with attendance as listed above.

2. Approval of Agenda

It was moved by Director Chavez and seconded by Director Gleason to approve the agenda as presented. The motion passed unanimously (7-0).

Oral Announcement of Items to be discussed during Closed Session

Chairperson Younger made an oral announcement of the items listed on the June 26, 2025 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Reports Involving Trade Secrets, Public Employee Evaluation: General Counsel and Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees.

4. Motion to go into Closed Session

It was moved by Director Gleason and seconded by Director Sanchez to go into Closed Session at 2:30 p.m. The motion passed unanimously (7-0).

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

ð.	Report from Board Counsel on any action taken in Closed Session.
	Board Counsel Scott stated he would provide a report out of Closed Session at the beginning of today's open session.
7.	Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 3:30 p.m.

ATTEST:	Tracy M. Younger Chairperson
Adela I. Sanchez Secretary	

TRI-CITY HEALTHCARE DISTRICT MINUTES FOR A REGULAR MEETING OF THE BOARD OF DIRECTORS June 26, 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 June 26, 2025.

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

Director Sheila Brown (via teleconference)
Director Rocky J. Chavez
Director Nina Chaya, M.D.
Director George W. Coulter
Director Gigi Gleason
Director Tracy M. Younger

Absent was Director Adela I. Sanchez

Also present were:

Dr. Gene Ma, Chief Executive Officer
Jeremy Raimo, Chief Operating Officer
Anh Nguyen, Chief Financial Officer
Mark Albright, Chief Information Officer
Roger Cortez, Chief Compliance Officer
Jennifer Paroly, Foundation President
Dr. Henry Showah, Chief of Staff
Dr. Mohamad Jamshidi-Nezhad, Incoming Chief of Staff
Susan Bond, General Counsel
Jeff Scott, Board Counsel (via teleconference)
Teri Donnellan, Executive Assistant

- 1. Board 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 involving Trade Secrets and took no action.

The Board also discussed the Public Employee Evaluation of the District General Counsel and took no action.

Finally, the Board heard a report related to a Quality Assurance matter and took no action.

3. Pledge of Allegiance

Director Chavez the Pledge of Allegiance.

4. Approval of Agenda

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

5. Public Comments – Announcement

Chairperson Younger read the Public Comments section listed on the June 26, 2025 Regular Board of Directors Meeting Agenda.

6. Special Recognition – Henry Showah, MD, Chief of Staff

The Board presented Dr. Showah with a plaque recognizing his service as Chief of Staff beginning in October 2022 through June 2025.

7. Introduction – Mohamad Jamshidi-Nezhad, D.O., Incoming Chief of Staff.

Dr. Showah introduced incoming Chief of Staff, Dr. Mohamad Jamshidi-Nezhad.

8. May, 2025 Financial Statements – Anh Nguyen, Chief Financial Officer

Anh Nguyen, Chief Financial Officer reported on the current and fiscal year to date financials as follows (Dollars in Thousands):

Fiscal year to date financials as follows: (Dollars in Thousands):

- ➤ Net Operating Revenue \$307,527
- ➤ Operating Expense \$312,726
- ➤ EBITDA \$25,002
- ➤ EROE \$8,851

Fiscal year to date Key Indicators as follows:

- ➤ Average Daily Census 125
- Average Acute Length of Stay (ALOS)
- Adjusted Patient Days 74,098
- ➤ Surgery Cases 4,966
- ➤ ED Visits 43,438

Current month financials as follows (Dollars in Thousands):

- ➤ Net Operating Revenue \$33,241
- ➤ Operating Expense \$30,155
- ➤ EBITDA \$6,224
- ➤ EROE \$4,994

Anh also presented graphs including EBITDA and EROE, Average Daily Census, Average Length of Stay, Paid Full Time Equivalents per Adjusted Occupied Bed (13 Month Trend) Days in Accounts Payable and Cash on Hand (Days), all trending in the right direction.

a. Review, discussion and action regarding the Operating and Capital Budgets for FY2026.

Anh Nguyen, CFO presented the FY2026 Operating and Capital Budgets for the Board's consideration.

Key indicators driving our budget next year include:

- Average Daily Census (ADC) 126 (increase by 2%)
- Average Length of Stay (ALOS) (flat or decreased by 1-2%).
- Patient Days 46,057 (increase by 2%)
- Discharges 8,981 (increase by 3.2%)

Key Ancillary Departments include:

- ED Visits 48,202 (increase by 2%)
- Total Surgery Cases 5,635 (increase by 3.4%).

Gross revenue is expected to increase to \$54M (3.1%) and net revenue increase by approximately \$10M (3.6%).

Expenses will be increased this year by \$29M primarily from salary and benefits (\$8M) which is due to implementation of our clinical ladder. Supplies and pharmaceuticals are expected to increase by 8% compared to prior year, mainly due to inflation.

Cash is projected to increase by \$3-4M. Projected days cash on hand is 34-35 days.

The Fiscal 2026 proposed Capital Budget totals approximately \$18.6M. Funding for the \$18.9M includes the following components:

- \$5.7M is projected to be funded with operating and existing cash.
- \$5.0M is projected to be acquired through capital leases
- \$8.2M is projected to be funded by the Tri-City Hospital Foundation

Anh reviewed a prioritized list of equipment and renovations; however, priorities are expected to fluctuate throughout the year as operational needs change and/or critical circumstances arise.

Director Chavez commended the financial progress, crediting leadership and staff, noting improved affiliation prospects and strategic salary investments.

Hearing no comments from the public or the board.

It was moved by Director Chavez to approve the Operating and Capital Budgets for FY2026. Director Gleason seconded the motion.

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

AYES: Directors: Brown, Chavez, Chaya, Coulter,

Gleason and Younger

NOES: Directors: None
ABSTAIN: Directors: None
ABSENT: Directors: Sanchez

b) Consideration to approve the addition of Bayan Aghdasi, M.D. as a provider to Tri-City Healthcare District's 1206(b) clinic through Addendum Two to the existing Professional Services Agreement between Tri-City Healthcare District and Tri-City Orthopedic Surgery Medical Group, Inc.

Jeremy Raimo, Chief Operations Officer, announced that Dr. Bayan Aghdasi, a highly trained, board-certified spine surgeon specializing in both minimally invasive and complex spinal deformity procedures, will be joining Tri-City Orthopedic Surgery Medical Group. Dr. Aghdasi's presence will fill the vacancy left by Dr. Alleyne, who served Tri-City for over 30 years, and is expected to become a key supporter of the organization alongside Dr. Moazzaz.

Hearing no comments from the public or the board:

It was moved by Director Chavez to approve the addition of Bayan Aghdasi, M.D. as a provider to Tri-City Healthcare District's 1206(b) clinic through Addendum Two to the existing Professional Services Agreement between Tri-City Healthcare District and Tri-City Orthopedic Surgery Medical Group, Inc. Director Brown seconded the motion.

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

AYES:

Directors:

Brown Chavez, Chaya, Coulter,

Gleason and Younger

NOES:

Directors:

None

ABSTAIN: ABSENT: Directors:

None Sanchez

- 8. Old Business None
- 9. Chief of Staff -

Dr. Henry Showah, Chief of Staff explained the June Credentialing Actions and Reappointments Involving the Medical Staff, as well as the Clinical Privilege Form and Proctoring Form for Wound Care PA are presented for the Board's approval as recommended by the Medical Executive Committee on June 23, 2025.

It was moved by Director Coulter to approve the June 2025 Credentialing Actions and Reappointments Involving the Medical Staff, Clinical Privilege Request Form – PA (Wound Care), and PA - (Wound Care) Proctoring Form as recommended by the Medical Executive Committee on June 23, 2025. Director Chavez seconded the motion.

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

AYES:

Directors:

Brown Chavez, Chaya, Coulter,

Gleason and Younger

NOES:

Directors:

None

ABSTAIN:

Directors:

None

ABSENT: Directors:

Sanchez

Consideration of Consent Calendar

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

		The vote on	the motion via	a roll call vote was as follows:				
		AYES:	Directors:	Brown, Chavez, Chaya, Coulter, Gleason and Younger				
		NOES: ABSTAIN: ABSENT:	Directors: Directors: Directors:	None None Sanchez				
11.	Discussion of	items pulled fr	om Consent Ca	alendar				
	There were no	o items pulled	from the Conse	ent Calendar.				
12.	Comments by	Members of t	he Public					
	Hicks, Chief S		Children's Par	ullen, Chief Financial Officer and Lisa adise who provided information on a new				
	Chairperson Younger also recognized Julie Abraham, Director of Pharmacy who is a former Sharp employee who shared insight about Sharp Healthcare.							
13.	Comments by Chief Executive Officer							
	Dr. Ma expressed deep appreciation to Dr. Showah for his steady leadership over the past three challenging years, uniting the medical staff and guiding the organization with dignity.							
				re a critical component to the organization. 5,000 donation to the hospital.				
14.	Board Communications							
	On behalf of the Board of Directors, Chairperson Younger wished everyone a happy 4 th of July.							
15.	Adjournment							
	There being n p.m.	o further busir	iess, Chairpers	on Younger adjourned the meeting at 4:15				
				Tracy M. Younger Chairperson				
	ATTECT:							

Adela Sanchez Secretary



ADVANCED HEALTH CARE

Building Operating Leases

Month Ending July 21, 2021

Month Ending July 31, 2025	Ties de la	Base		7	English	TENOYS S	netiensonayanokkawi	
Lessor	Sq. Ft.	Rate per Sq. Ft.		Total Rent per current month	Lease1 Beginning	Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	\$3.59	(a)		07/01/17		OSNC - Cartsbad 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	08/31/26	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	06/30/30	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)	23,026.37	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)	9,474.51	04/01/23	03/31/26	La Costa Urotogy 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)	19,523.79	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)	25,733.72	09/01/21	08/31/33	PCP Clinic Calrsbad 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	(2)	14,872.55	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	Approx				07/01/21	00/30/20	North County Oncology Medical Clinic 3617 Vista Way, Bldg 5	1320
#V81250 SCRIPPSVIEW MEDICAL ASSOCIATES P O Box 234296	7,000	\$4.12	(a)	34,015.00	10/01/22	09/30/25	Oceanside, Ca 92056 OSNC Encinitas Medical Center 351 Santa Fe Drive, Suite 351	7086
Encinitas, CA 234296 V#83589 BELLA TIERRA INVESTMENTS, LLC 841 Prudential Dr. Suite 200	Approx 3,864	\$3.45	(a)	14,880.52	06/01/21	05/31/26	Encinitas, CA 92023 Pulmonary Specialists of NC	7095
Jacksonville, FL 32207 V#84264	Approx 3,262	\$2.21	(a)	11,165.33 269,769.48	05/01/23	04/30/26	3907 Waring Road, Suite 2 Oceanside, CA 92056	7088

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



ADVANCED HEALTH CARE

Education & Travel Expense Month Ending July 2025

Cost

Centers	Description	Invoice #	Amount	Vendor#	Attendees
6171 BERYL	LINST MEM	072225	275.00	84098	JOSHUA SMILEY
6185 ONS 8	BASIC CANCER COURSE	071825 EDU	227.00	999050741	ALYXANDRIA PRICE
6185 ONS/	ONCC CHEMO	071825 EDU	325.00	999050741	ALYXANDRIA PRICE
7320 MIND	FULNESS INTERVENTIONS	071825 EDU	154.99	999050740	MICHELLE BURDETT
8740 CCRN	ADULT	071825 EDU	200.00	999050739	BLAKE RISER
8740 PELVI	C FUNCTION	071825 EDU	200.00	999050738	ANDREA MUNCADA
8740 ULTRA	A SOUND	70225 EDU	200.00	80745	SARMIENTO, EVELYN
8740 RN TO	BSN	070225EDU	1,225.00	81355	REXRODE, SHANNON
8740 NAHO)	71025 EDU	200.00	83899	KRAUS DANA

^{**}This report shows reimbursements to employees and Board members in the Education

[&]amp; Travel expense category in excess of \$100.00.

^{**}Detailed backup is available from the Finance department upon request.