TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
August 28, 2014 - 1:30 o'clock p.m.
Classroom 6 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 1, 2, 3
4002 Vista Way, Oceanside, CA 92056

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

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors.	3 min.	Standard
4	Oral Announcement of Items to be Discussed During Closed Session (Government Code Section 54957.7)		
5	Motion to go into Closed Session		
6	Closed Session	**2 Hours**	
	a. Conference with Legal Counsel – Potential Litigation Gov. Code Section 54956.9(d) (2 Matters)		
	b. Conference with Legal Counsel – Existing Litigation Gov. Code Section 54956.9(d)1, (d)4 (1) Larry Anderson Employment Claims (2) Medical Acquisitions Company vs. TCHD Case No: 2014-00009108 (3) TCHD vs. Medical Acquisitions Company Case No. 2014-00022523 (4) Hammes Co. Healthcare, LLC and HC Tri-City I, LLC vs. TCHD, et al U.S. District Court, Southern District of California Case No. 3:09-cv-02324-JLS-CAB		
	c. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	d. Approval of prior Closed Session Minutes		

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

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

	Agenda Item	Time Allotted	Requestor
	e. Appointment of Public Employee: Chief Compliance Officer (Authority: Government Code, Section 54957)		
	f. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: January, 2015		
	g. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: January, 2015		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)		
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	Community Activity Update - None	--	
13	Report from TCHD Auxiliary – Sandy Tucker, Auxiliary President	5 min.	Standard
14	Report from Chief Executive Officer	10 min.	Standard
15	Report from Chief Financial Officer	10 min.	Standard
16	New Business		
	a. Introduction of Dr. Karen Hanna – General Surgeon/Bariatric Surgeon	5 min.	W. Knight
	b. Certificate of appreciation to Mr. Irwin Schenker for his two terms on service on the Finance, Operations & Planning Committee	5 min.	Chair/FOP Comm.
	c. Recommendation to remove Dr. Louis Montulli from the community seat on the Governance & Legislative Committee	5 min	Chair
17	Old Business a. Emergency Department On-Call Agreements – (Information Only) 1. **General Surgery**: 1. Andrew Deemer, MD 2. Adam Fierer, MD 3. Dhruvil Gandhi, MD	5 min.	Chair

	Agenda Item	Time Allotted	Requestor
	4. Karen Hanna, MD 5. Mohammad Jamshidi, DO 6. Eric Rypins, MD 7. Katayoun Toosie, MD 2. **Gastro-General**: 1. Andrew Cummins, MD 2. Christopher Devereaux, MD 3. Thomas Krol, MD 4. Javaid Shad, MD 5. Michael Shim, MD 6 Matthew Viernes, MD 3. **Gastro-ERCP:** 1. Christopher Devereaux, MD 2. Thoms Krol, MD 3. Javaid Shad, MD 4. Michael Shim, MD 5. Matthew Viernes, MD		
18	Chief of Staff a. Consideration of August 2014 Credentialing Actions Involving the Medical Staff – New Appointments Only	5 min.	Standard
19	Consideration of Consent Calendar (1) Medical Staff Credentials for August, 2014 (2) Medical Staff Recommendations **A. Department/Divisions Rules & Regulations:** 1. Department of Emergency Medicine: Delegation of Services Agreement Modification 2. Department of Surgery Rules & Regulations Modification (4) Board Committees ***(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.*** ***(2) All items listed were recommended by the Committee.*** ***(3) Requested items to be pulled require a second.*** **A. Human Resources Committee** Director Kellett, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes)	5 min.	Standard Standard HR Comm.
	B. Employee Fiduciary Retirement Subcommittee Director Kellett, Subcommittee Chair Open Community Seats - 0 (Committee minutes included in Board Agenda packets for informational purposes)		Emp. Fid. Subcomm.

	Agenda Item	Time Allotted	Requestor
	C. Community Healthcare Alliance Committee Director Nygaard, Committee Chair Open Community Seats - 2 *(No meeting held in August 2014)*		CHAC Comm.
	D. Finance, Operations & Planning Committee Director Dagostino, Committee Chair Open Community Seats - 1 (Committee minutes included in Board Agenda packets for informational purposes.)		FO&P Comm.
	a) Approval of an agreement with API Healthcare Corp. for ShiftSelect Scheduling System for a term of 36 months beginning September 1, 2014 and ending on August 31, 2017 for an annual amount of $108,000, interface fee of $16,000 and a total expense for the term of $340,000.		
	b) Approval of an agreement with Rady Children's Hospital for a term of 12 months beginning September 1, 2014 through August 31, 2015 at $175.00/hour, not to exceed eight (8) hours per month, for a monthly amount of $1,400 and a total expense for the term of $16,800.		
	c) Approval of the renewal of an agreement with Dr. Manish Sheth as Medical Director for Inpatient Behavioral Health for a term of 12 months beginning July 1, 2014 through June 30, 2015, not to exceed 80 hours per month at an hourly rate of $125 for an annual amount of $120,000.		
	d) Approval of an agreement with MIDWEST TELEVISION for a term of 12 months beginning July 1, 2014 through June 30, 2015, for a monthly amount not to exceed $24,998.50 and a total expense for the term of $299,982.		
	e) Approval of an agreement with NBCOTS for a term of 12 months beginning July 1, 2014 through June 30, 2015 for a monthly amount not to exceed $20,900 and a total expense for the term of $250,800.		
	f) Approval of an agreement with UT-San Diego for a term of 12 months beginning July 1, 2014 through June 30, 2015 for a monthly amount not to exceed $24,300 and a total expense for the term of $291,600.		
	g) Approval of a lease facility agreement with Celtic Financing Corp. for a principal amount not to exceed $5,000,000 with a capital lease term of 60 months, at a maximum interest cost of less than $593,000 over the term of the lease.		
	h) Approval of a lease facility agreement with Bank of the West for a principal amount not to exceed $2,500,000 with a capital lease term of 36 months, at a maximum interest cost of less than $178,000 over the term of the lease.		

	Agenda Item	Time Allotted	Requestor
	i) Approval of a lease of Medical Office Suites located at 2067 West Vista Way (Suite 160) for a term of four months, (Suite 225) for a term of 20 months beginning October 1, 2014 through December 31, 2016, for a total of the term of $298,600. j) Approval of an agreement with Beckman Coulter for a term of 60 months beginning October 1, 2014 through September 30, 2019, for an annual amount of $428,713 and a total expense for the term of $2,143,565. k) Approval of an agreement with Vista Community Clinic for Emergency Room and Unfunded Patients for a term of 12 months beginning August 1, 2014 through July 30, 2015 for an annual amount of $100,000 and a total expense for the term of $100,000. l) Approval of an ED On-Call Agreement with Dr. Sunil Jeswani for Neurosurgery and Spine call coverage at the current approved rate of $800 (Neurosurgery)/24 hour period and $400 (Spine)/24-hour period, for a term of 22 months beginning September 1, 2014 through June 30, 2016, for a total not to exceed $114,000. m) Approval of the renewal of the General Surgery ED On-Call Agreement with Drs. Andrew Deemer, Adam Fierer, Dhruvil Gandhi, Karen Hana, Mohammad Jamshidi, Eric Ripins and Katayoun Toosie for a term of 24 months beginning on the revised effective date of July 1, 2014 through June 30, 2016 at the previously approved rate of $1,400 per 24 hour shift and reimbursement at Medicare rates for unfunded cholecystectomy cases at $725.00 for a revised total amount not to exceed $1,075,591. n) Approval of an agreement with Cerner Corporation for the renewal of Subscription and Hosting Services for a term of 67 months beginning September 1, 2014 through March 31, 2020, not to exceed an annual amount of $4.0 million and a total expense for the term of $22.3 million. **E. Professional Affairs Committee** Director Reno, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes.) 1. Approval of Policies and Procedures: **A. <u>Patient Care Services Policies & Procedures</u>** 1. Central Venous Access Devices – Procedure 2. Dialysis, Acute Treatment of the Inpatient – Policy 3. Family Centered Care – Pediatrics- Adolescent – Policy 4. Patient and Family Education – Policy 5. Patient Rights and Responsibilities – Policy **B. <u>Administrative Policies & Procedures</u>** 1. Equipment Medical Device Reporting- Sequester #201		PAC Comm.

	Agenda Item	Time Allotted	Requestor
	2. Parking Program – Policy #261 3. Use, Security and Accuracy of Data – Policy #242 4. Weapons on Medical Center Campus – Policy #284 **C. <u>Emergency</u>** 1. ED Scope of Practice – Definition – Policy **D. <u>Pulmonary</u>** 1. High Humidity Heated Oxygen Adult – Procedure 2. Respiratory Pre-OP Teaching for Inpatient Cardiothoracic Patients Procedure **E. <u>Infection Control</u>** 1. IC. 11TB Aerosol Transmissible Diseases and Tuberculosis Control Plan 2. IC. 2 Surveillance Program 3. IC. 3 Epidemiologic Investigation of a Suspected Outbreak 4. IC. 6.2 Meningococcal Exposure 5. IC. 9.1 Toy Cleaning 6. IC. 13.3 Mold Abatement 7. IC. & Wound Care Center Department Specific **F. <u>NICU</u>** 1. Admission and Discharge Criteria for the NICU 2. Breastfeeding for the Term and Late Pre-Term Infant in the NICU 3. Formula (Artificial Milk) Use of 4. Formula, Preparation and Storage of 5. Peripheral Arterial Line Insertion, Maintenance and Removal of 6. Peripherally Inserted Central Catheters and Midline Catheters Insertions **<u>Women and Children Services</u>** 1. Emergency/STAT Cesarean Section Notification Process 2. Fetal Heart Rate (FHR) Surveillance/Monitoring 3. Uterine Tamponade Devices 4. Electronic Fetal Monitoring **F. Governance & Legislative Committee** Director Schallock, Committee Chair Open Community Seats - 0 *(No meeting held in August, 2014)* **G. Audit & Compliance Committee** Director Finnila, Committee Chair Open Community Seats – 1 *(No meeting held in August, 2014)*		Gov. & Leg. Comm. Audit, Comp. & Ethics Comm.
	(5) Minutes – Approval of a) July 31, 2014 – Regular Board of Directors Meeting b) August 19, 2014 – Special Board of Directors Meeting		Standard
	(6) Meetings and Conferences - None		Standard

	Agenda Item	Time Allotted	Requestor
	(7) Dues and Memberships - None		Standard
20	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
21	Reports (Discussion by exception only) (a) Dashboard - Included (b) Construction Report – None (c) Lease Report – (July, 2014) (d) Reimbursement Disclosure Report - (July, 2014) (e) Seminar/Conference Reports - None	0-5 min.	Standard
22	Legislative Update	5 min.	Standard
23	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board.	5-10 minutes	Standard
24	Board Communications (three minutes per Board member)	18 min.	Standard
25	Report from Chairperson	3 min.	Standard
26	Additional Comments by Chief Executive Officer	3 min.	Standard
	Total Time Budgeted for Open Session **(Includes 10 minutes for recess to accommodate KOCT tape change)**	**2 hours/ 5 min.**	
27	Oral Announcement of Items to be Discussed During Closed Session (If Needed)		
28	Motion to Return to Closed Session (If Needed)		
29	Open Session		
30	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
31	Adjournment		

CONTACT: Casey Fatch

Agenda Item 17 a. Emergency Department On-Call Agreements (Information Only)

Background: At the July 31, 2014 Board of Directors Meeting, Board members requested that the approved ED On-Call Agreements be brought back to the next meeting to reflect physician names on each agreement. The agreements appear in the agenda packet for information only.

Tri-City Medical Center

GENERAL SURGERY ON CALL COVERAGE AGREEMENT
Effective August 1, 2014-June 30,2016
READ CAREFULLY - THIS CONTRACT HAS LEGAL EFFECT

This On-Call Coverage Agreement ("Agreement") is entered into by and between Tri-City Healthcare District, a local healthcare district that operates Tri-City Medical Center ("Hospital") and the Physician signing below ("Physician").

Recitals

"Emergency Services Coverage" is required by Medical Staff Bylaws (Sections 2.5(k) and 3.2-2), Medical Staff Rules and Regulations and Medical Staff policy. Hospital's Medical Staff Policy 8710-520 outlines the Medical Staff member's responsibilities when participating in "Emergency Services Coverage". The Medical Staff policy addresses compliance with the Emergency Medical Treatment & Active Labor Act ("EMTALA") and implementing regulations.

Purpose and Legal Effect

The purpose of this Agreement is primarily to provide continuity of care for Emergency Department ("ED") on-call services and thereby enhance overall quality and efficiency of patient care. Eligibility/requirements for participation are determined by the Medical Staff. Physician's signature and provision of on-call services shall constitute acceptance of the following terms, which shall be legally binding upon Physician and enforceable by Hospital.

Definition of "On-Call"

"On-Call' means 24 hours per day availability via beeper/pager service. Response time will be within the time periods set forth in Medical Staff Policy 8710-520 with a goal of less than thirty (30) minutes and shall never exceed sixty (60) minutes. An on-call coverage day or shift shall be defined by each department or division as applicable.

Duties of On-Call Physicians

Physician shall perform the following duties in connection with on-call services:

- All duties described in Medical Staff Policy 8710-520.
- Perform preadmission and admission evaluations with the patient and patient's family, including stabilization as requested by an ED or covering physician;
- Write preadmission or admission notes and orders on those patients examined by Physician;
- Conduct medical rounds on those patients under Physicians' care as clinically appropriate.

- Complete, in an accurate and timely manner, medical records in accordance with the standards of The Joint Commission and all other applicable accrediting, licensing, utilization review and payor agencies as well as Medical Staff Bylaws, Rules and Regulations, and policies and procedures;

- Comply with all applicable federal, state and local laws, rules and regulations, including EMTALA, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requirements for participation in the Medicare, Medi-Cal and other federally-funded programs, all criteria of The Joint Commission, Hospital's Medical Staff Bylaws and all other applicable rules and regulations established by Hospital or its Medical Staff, and shall provide an appropriate level and standard of care in the Hospital.

Physician Requirements

Physician shall comply with the following requirements:

- Physician's license to practice in the State of California and/or in any other jurisdiction must be in good standing and not denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or restricted in any way.

- Physician must be and remain in good standing as member of the Medical Staff at Hospital.

- Physician shall obtain and maintain liability insurance in an amount not less than $1,000,000 per occurrence and $3,000,000 annual aggregate covering Physician's services.

- Physician shall be responsible for billing and collection of the charges for professional services and Hospital shall be responsible for billing and collection of charges for hospital services. Physician shall comply with all federal and state laws, regulations and payer contractual requirements prohibiting the balance billing of Hospital's patients.

- Physician shall not to bill, nor cause to be billed, Medicare patients or Medicare (Part B) carriers for administrative or supervisory service or other clinical services that are payable under Part A of the Medicare program.

- Physician must comply with the Hospital's Corporate Compliance Responsibility Program.

- Physician must be and remain eligible to participate in any federal and/or state healthcare program including, without limitation, Medicare or Medi-Cal, and not be suspended, excluded, debarred or otherwise ineligible to participate during the term of this Agreement. Physician must immediately report to Hospital any actual or proposed suspension, debarment or exclusion of Physician from any federal and/or state healthcare program.

Payment Terms

Hospital agrees to reimburse Physician the stipend(s) identified in Attachment A for on-call services. Stipend payments for being available for on-call services are subject to strict compliance with this Agreement, Medical Staff Bylaws, rules and regulations and Hospital and Medical Staff policies. Failure to comply may result in forfeiture or withholding of such payments in the sole reasonable discretion of Hospital, in accordance with Medical Staff Policy 8710-520.

Hospital will reimburse Physician within 45 days of receipt of completed schedules for the month. The on-call roster will be maintained as provided in Medical Staff Policy 8710-520. A final schedule reflecting any changes that have been made during the course of the month will be submitted by the ED Department to the Medical Staff office which will submit request for payment to Finance.

Term and Termination

The term of this Agreement shall be for a period of twenty-three (23) months commencing on August 1, 2014 and ending on June 30, 2016 ("Initial Term").

Hospital may immediately terminate this Agreement upon any of the following events:

- Physician's license to practice medicine is revoked, suspended or curtailed;
- Physician is placed on probation or Physician's Medical Staff privileges are suspended, curtailed or terminated;
- Physician is suspended, debarred or otherwise not eligible to participate in federal and/or state health care programs;
- Physician fails to carry the insurance required by this Agreement.

To the extent permitted by law, the expiration of this Agreement or earlier termination shall not require compliance with any Medical Staff hearing or other procedures.

If this Agreement is terminated prior to the expiration of the initial twelve (12) months of the Initial Term, the parties shall not enter into any new agreement or arrangement for the same or equivalent services during the remainder of such Initial Term.

Other Terms

It is mutually agreed that each party is at all times acting and performing as independent contractors with and not as employees of the other. Each party shall be responsible for its own acts and omissions and shall not be responsible for the acts or omissions of the other. This Agreement shall be interpreted and governed under California law and jurisdiction and venue shall only be proper in San Diego County, California.

If and to the extent required by Section 1395x(v)(1) of Title 42 of the United States Code, until the expiration of four (4) years after the termination of this Agreement, each Physician shall make available, upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the services provided by such Physician under this Agreement.

PHYSICIAN:

_____
Andrew Deemer, MD

Date:_____

HOSPITAL:

_____
Tim Moran,CEO

Date:_____.

Attachment A
On-Call Stipend
Effective August 1, 2014

Andrew Deemer, MD

The stipend for on-call coverage as listed below is for a scheduled 24-hour period of time. It has been determined as the result of an arm's length negotiation, is in accordance with fair market value for the year in effect, is commercially reasonable as far as needed services and is not based on the volume or value of services provided. The additional stipend is for unfunded Cholecystectomy cases at the Medicare rate of $725.

Specialty	Rate
GENERAL SURGERY	$ 1,400
Unfunded Cholecystectomy, as Primary Admitter (Patient Admission Face Sheet with verification as uninsured required)	$ 725

Tri-City Medical Center

GENERAL SURGERY ON CALL COVERAGE AGREEMENT
Effective August 1, 2014-June 30,2016
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Purpose and Legal Effect

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Duties of On-Call Physicians

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- Perform preadmission and admission evaluations with the patient and patient's family, including stabilization as requested by an ED or covering physician;
- Write preadmission or admission notes and orders on those patients examined by Physician;
- Conduct medical rounds on those patients under Physicians' care as clinically appropriate.

- Complete, in an accurate and timely manner, medical records in accordance with the standards of The Joint Commission and all other applicable accrediting, licensing, utilization review and payor agencies as well as Medical Staff Bylaws, Rules and Regulations, and policies and procedures;

- Comply with all applicable federal, state and local laws, rules and regulations, including EMTALA, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requirements for participation in the Medicare, Medi-Cal and other federally-funded programs, all criteria of The Joint Commission, Hospital's Medical Staff Bylaws and all other applicable rules and regulations established by Hospital or its Medical Staff, and shall provide an appropriate level and standard of care in the Hospital.

Physician Requirements

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- Physician must be and remain in good standing as member of the Medical Staff at Hospital.

- Physician shall obtain and maintain liability insurance in an amount not less than $1,000,000 per occurrence and $3,000,000 annual aggregate covering Physician's services.

- Physician shall be responsible for billing and collection of the charges for professional services and Hospital shall be responsible for billing and collection of charges for hospital services. Physician shall comply with all federal and state laws, regulations and payer contractual requirements prohibiting the balance billing of Hospital's patients.

- Physician shall not to bill, nor cause to be billed, Medicare patients or Medicare (Part B) carriers for administrative or supervisory service or other clinical services that are payable under Part A of the Medicare program.

- Physician must comply with the Hospital's Corporate Compliance Responsibility Program.

- Physician must be and remain eligible to participate in any federal and/or state healthcare program including, without limitation, Medicare or Medi-Cal, and not be suspended, excluded, debarred or otherwise ineligible to participate during the term of this Agreement. Physician must immediately report to Hospital any actual or proposed suspension, debarment or exclusion of Physician from any federal and/or state healthcare program.

Payment Terms

Hospital agrees to reimburse Physician the stipend(s) identified in Attachment A for on-call services. Stipend payments for being available for on-call services are subject to strict compliance with this Agreement, Medical Staff Bylaws, rules and regulations and Hospital and Medical Staff policies. Failure to comply may result in forfeiture or withholding of such payments in the sole reasonable discretion of Hospital, in accordance with Medical Staff Policy 8710-520.

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To the extent permitted by law, the expiration of this Agreement or earlier termination shall not require compliance with any Medical Staff hearing or other procedures.

If this Agreement is terminated prior to the expiration of the initial twelve (12) months of the Initial Term, the parties shall not enter into any new agreement or arrangement for the same or equivalent services during the remainder of such Initial Term.

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If and to the extent required by Section 1395x(v)(1) of Title 42 of the United States Code, until the expiration of four (4) years after the termination of this Agreement, each Physician shall make available, upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the services provided by such Physician under this Agreement.

PHYSICIAN:

_____
Adam Fierer, MD

Date:_____

HOSPITAL:

_____
Tim Moran,CEO

Date:_____.

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Effective August 1, 2014

Adam Fierer, MD

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- Complete, in an accurate and timely manner, medical records in accordance with the standards of The Joint Commission and all other applicable accrediting, licensing, utilization review and payor agencies as well as Medical Staff Bylaws, Rules and Regulations, and policies and procedures;

- Comply with all applicable federal, state and local laws, rules and regulations, including EMTALA, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requirements for participation in the Medicare, Medi-Cal and other federally-funded programs, all criteria of The Joint Commission, Hospital's Medical Staff Bylaws and all other applicable rules and regulations established by Hospital or its Medical Staff, and shall provide an appropriate level and standard of care in the Hospital.

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- Physician shall obtain and maintain liability insurance in an amount not less than $1,000,000 per occurrence and $3,000,000 annual aggregate covering Physician's services.

- Physician shall be responsible for billing and collection of the charges for professional services and Hospital shall be responsible for billing and collection of charges for hospital services. Physician shall comply with all federal and state laws, regulations and payer contractual requirements prohibiting the balance billing of Hospital's patients.

- Physician shall not to bill, nor cause to be billed, Medicare patients or Medicare (Part B) carriers for administrative or supervisory service or other clinical services that are payable under Part A of the Medicare program.

- Physician must comply with the Hospital's Corporate Compliance Responsibility Program.

- Physician must be and remain eligible to participate in any federal and/or state healthcare program including, without limitation, Medicare or Medi-Cal, and not be suspended, excluded, debarred or otherwise ineligible to participate during the term of this Agreement. Physician must immediately report to Hospital any actual or proposed suspension, debarment or exclusion of Physician from any federal and/or state healthcare program.

Payment Terms

Hospital agrees to reimburse Physician the stipend(s) identified in Attachment A for on-call services. Stipend payments for being available for on-call services are subject to strict compliance with this Agreement, Medical Staff Bylaws, rules and regulations and Hospital and Medical Staff policies. Failure to comply may result in forfeiture or withholding of such payments in the sole reasonable discretion of Hospital, in accordance with Medical Staff Policy 8710-520.

Hospital will reimburse Physician within 45 days of receipt of completed schedules for the month. The on-call roster will be maintained as provided in Medical Staff Policy 8710-520. A final schedule reflecting any changes that have been made during the course of the month will be submitted by the ED Department to the Medical Staff office which will submit request for payment to Finance.

Term and Termination

The term of this Agreement shall be for a period of twenty-three (23) months commencing on August 1, 2014 and ending on June 30, 2016 ("Initial Term").

Hospital may immediately terminate this Agreement upon any of the following events:

- Physician's license to practice medicine is revoked, suspended or curtailed;
- Physician is placed on probation or Physician's Medical Staff privileges are suspended, curtailed or terminated;
- Physician is suspended, debarred or otherwise not eligible to participate in federal and/or state health care programs;
- Physician fails to carry the insurance required by this Agreement.

To the extent permitted by law, the expiration of this Agreement or earlier termination shall not require compliance with any Medical Staff hearing or other procedures.

If this Agreement is terminated prior to the expiration of the initial twelve (12) months of the Initial Term, the parties shall not enter into any new agreement or arrangement for the same or equivalent services during the remainder of such Initial Term.

Other Terms

It is mutually agreed that each party is at all times acting and performing as independent contractors with and not as employees of the other. Each party shall be responsible for its own acts and omissions and shall not be responsible for the acts or omissions of the other. This Agreement shall be interpreted and governed under California law and jurisdiction and venue shall only be proper in San Diego County, California.

If and to the extent required by Section 1395x(v)(1) of Title 42 of the United States Code, until the expiration of four (4) years after the termination of this Agreement, each Physician shall make available, upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the services provided by such Physician under this Agreement.

PHYSICIAN:

_____
Dhruvil Gandhi MD

Date:_____

HOSPITAL:

_____
Tim Moran,CEO

Date:_____.

Attachment A
On-Call Stipend
Effective August 1, 2014

Dhruvil Gandhi, MD

The stipend for on-call coverage as listed below is for a scheduled 24-hour period of time. It has been determined as the result of an arm's length negotiation, is in accordance with fair market value for the year in effect, is commercially reasonable as far as needed services and is not based on the volume or value of services provided. The additional stipend is for unfunded Cholecystectomy cases at the Medicare rate of $725.

Specialty	Rate
GENERAL SURGERY	$ 1,400
Unfunded Cholecystectomy, as Primary Admitter (Patient Admission Face Sheet with verification as uninsured required)	$ 725

Tri-City Medical Center

GENERAL SURGERY ON CALL COVERAGE AGREEMENT
Effective August 1, 2014-June 30,2016
READ CAREFULLY - THIS CONTRACT HAS LEGAL EFFECT

This On-Call Coverage Agreement ("Agreement") is entered into by and between Tri-City Healthcare District, a local healthcare district that operates Tri-City Medical Center ("Hospital") and the Physician signing below ("Physician").

Recitals

"Emergency Services Coverage" is required by Medical Staff Bylaws (Sections 2.5(k) and 3.2-2), Medical Staff Rules and Regulations and Medical Staff policy. Hospital's Medical Staff Policy 8710-520 outlines the Medical Staff member's responsibilities when participating in "Emergency Services Coverage". The Medical Staff policy addresses compliance with the Emergency Medical Treatment & Active Labor Act ("EMTALA") and implementing regulations.

Purpose and Legal Effect

The purpose of this Agreement is primarily to provide continuity of care for Emergency Department ("ED") on-call services and thereby enhance overall quality and efficiency of patient care. Eligibility/requirements for participation are determined by the Medical Staff. Physician's signature and provision of on-call services shall constitute acceptance of the following terms, which shall be legally binding upon Physician and enforceable by Hospital.

Definition of "On-Call"

"On-Call' means 24 hours per day availability via beeper/pager service. Response time will be within the time periods set forth in Medical Staff Policy 8710-520 with a goal of less than thirty (30) minutes and shall never exceed sixty (60) minutes. An on-call coverage day or shift shall be defined by each department or division as applicable.

Duties of On-Call Physicians

Physician shall perform the following duties in connection with on-call services:

- All duties described in Medical Staff Policy 8710-520.
- Perform preadmission and admission evaluations with the patient and patient's family, including stabilization as requested by an ED or covering physician;
- Write preadmission or admission notes and orders on those patients examined by Physician;
- Conduct medical rounds on those patients under Physicians' care as clinically appropriate.

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- Complete, in an accurate and timely manner, medical records in accordance with the standards of The Joint Commission and all other applicable accrediting, licensing, utilization review and payor agencies as well as Medical Staff Bylaws, Rules and Regulations, and policies and procedures;

- Comply with all applicable federal, state and local laws, rules and regulations, including EMTALA, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requirements for participation in the Medicare, Medi-Cal and other federally-funded programs, all criteria of The Joint Commission, Hospital's Medical Staff Bylaws and all other applicable rules and regulations established by Hospital or its Medical Staff, and shall provide an appropriate level and standard of care in the Hospital.

Physician Requirements

Physician shall comply with the following requirements:

- Physician's license to practice in the State of California and/or in any other jurisdiction must be in good standing and not denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or restricted in any way.

- Physician must be and remain in good standing as member of the Medical Staff at Hospital.

- Physician shall obtain and maintain liability insurance in an amount not less than $1,000,000 per occurrence and $3,000,000 annual aggregate covering Physician's services.

- Physician shall be responsible for billing and collection of the charges for professional services and Hospital shall be responsible for billing and collection of charges for hospital services. Physician shall comply with all federal and state laws, regulations and payer contractual requirements prohibiting the balance billing of Hospital's patients.

- Physician shall not to bill, nor cause to be billed, Medicare patients or Medicare (Part B) carriers for administrative or supervisory service or other clinical services that are payable under Part A of the Medicare program.

- Physician must comply with the Hospital's Corporate Compliance Responsibility Program.

- Physician must be and remain eligible to participate in any federal and/or state healthcare program including, without limitation, Medicare or Medi-Cal, and not be suspended, excluded, debarred or otherwise ineligible to participate during the term of this Agreement. Physician must immediately report to Hospital any actual or proposed suspension, debarment or exclusion of Physician from any federal and/or state healthcare program.

Payment Terms

Hospital agrees to reimburse Physician the stipend(s) identified in Attachment A for on-call services. Stipend payments for being available for on-call services are subject to strict compliance with this Agreement, Medical Staff Bylaws, rules and regulations and Hospital and Medical Staff policies. Failure to comply may result in forfeiture or withholding of such payments in the sole reasonable discretion of Hospital, in accordance with Medical Staff Policy 8710-520.

Hospital will reimburse Physician within 45 days of receipt of completed schedules for the month. The on-call roster will be maintained as provided in Medical Staff Policy 8710-520. A final schedule reflecting any changes that have been made during the course of the month will be submitted by the ED Department to the Medical Staff office which will submit request for payment to Finance.

Term and Termination

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Hospital may immediately terminate this Agreement upon any of the following events:

- Physician's license to practice medicine is revoked, suspended or curtailed;
- Physician is placed on probation or Physician's Medical Staff privileges are suspended, curtailed or terminated;
- Physician is suspended, debarred or otherwise not eligible to participate in federal and/or state health care programs;
- Physician fails to carry the insurance required by this Agreement.

To the extent permitted by law, the expiration of this Agreement or earlier termination shall not require compliance with any Medical Staff hearing or other procedures.

If this Agreement is terminated prior to the expiration of the initial twelve (12) months of the Initial Term, the parties shall not enter into any new agreement or arrangement for the same or equivalent services during the remainder of such Initial Term.

Other Terms

It is mutually agreed that each party is at all times acting and performing as independent contractors with and not as employees of the other. Each party shall be responsible for its own acts and omissions and shall not be responsible for the acts or omissions of the other. This Agreement shall be interpreted and governed under California law and jurisdiction and venue shall only be proper in San Diego County, California.

If and to the extent required by Section 1395x(v)(1) of Title 42 of the United States Code, until the expiration of four (4) years after the termination of this Agreement, each Physician shall make available, upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the services provided by such Physician under this Agreement.

PHYSICIAN:

_____
Karen Hanna, MD

Date:_____

HOSPITAL:

_____
Tim Moran,CEO

Date:_____.

Attachment A
On-Call Stipend
Effective August 1, 2014

Karen Hanna, MD

The stipend for on-call coverage as listed below is for a scheduled 24-hour period of time. It has been determined as the result of an arm's length negotiation, is in accordance with fair market value for the year in effect, is commercially reasonable as far as needed services and is not based on the volume or value of services provided. The additional stipend is for unfunded Cholecystectomy cases at the Medicare rate of $725.

Specialty	Rate
GENERAL SURGERY	$ 1,400
Unfunded Cholecystectomy, as Primary Admitter (Patient Admission Face Sheet with verification as uninsured required)	$ 725

2

Tri-City Medical Center

GENERAL SURGERY ON CALL COVERAGE AGREEMENT
Effective August 1, 2014-June 30,2016
READ CAREFULLY - THIS CONTRACT HAS LEGAL EFFECT

This On-Call Coverage Agreement ("Agreement") is entered into by and between Tri-City Healthcare District, a local healthcare district that operates Tri-City Medical Center ("Hospital") and the Physician signing below ("Physician").

Recitals

"Emergency Services Coverage" is required by Medical Staff Bylaws (Sections 2.5(k) and 3.2-2), Medical Staff Rules and Regulations and Medical Staff policy. Hospital's Medical Staff Policy 8710-520 outlines the Medical Staff member's responsibilities when participating in "Emergency Services Coverage". The Medical Staff policy addresses compliance with the Emergency Medical Treatment & Active Labor Act ("EMTALA") and implementing regulations.

Purpose and Legal Effect

The purpose of this Agreement is primarily to provide continuity of care for Emergency Department ("ED") on-call services and thereby enhance overall quality and efficiency of patient care. Eligibility/requirements for participation are determined by the Medical Staff. Physician's signature and provision of on-call services shall constitute acceptance of the following terms, which shall be legally binding upon Physician and enforceable by Hospital.

Definition of "On-Call"

"On-Call' means 24 hours per day availability via beeper/pager service. Response time will be within the time periods set forth in Medical Staff Policy 8710-520 with a goal of less than thirty (30) minutes and shall never exceed sixty (60) minutes. An on-call coverage day or shift shall be defined by each department or division as applicable.

Duties of On-Call Physicians

Physician shall perform the following duties in connection with on-call services:

- All duties described in Medical Staff Policy 8710-520.
- Perform preadmission and admission evaluations with the patient and patient's family, including stabilization as requested by an ED or covering physician;
- Write preadmission or admission notes and orders on those patients examined by Physician;
- Conduct medical rounds on those patients under Physicians' care as clinically appropriate.

- Complete, in an accurate and timely manner, medical records in accordance with the standards of The Joint Commission and all other applicable accrediting, licensing, utilization review and payor agencies as well as Medical Staff Bylaws, Rules and Regulations, and policies and procedures;

- Comply with all applicable federal, state and local laws, rules and regulations, including EMTALA, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requirements for participation in the Medicare, Medi-Cal and other federally-funded programs, all criteria of The Joint Commission, Hospital's Medical Staff Bylaws and all other applicable rules and regulations established by Hospital or its Medical Staff, and shall provide an appropriate level and standard of care in the Hospital.

Physician Requirements

Physician shall comply with the following requirements:

- Physician's license to practice in the State of California and/or in any other jurisdiction must be in good standing and not denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or restricted in any way.

- Physician must be and remain in good standing as member of the Medical Staff at Hospital.

- Physician shall obtain and maintain liability insurance in an amount not less than $1,000,000 per occurrence and $3,000,000 annual aggregate covering Physician's services.

- Physician shall be responsible for billing and collection of the charges for professional services and Hospital shall be responsible for billing and collection of charges for hospital services. Physician shall comply with all federal and state laws, regulations and payer contractual requirements prohibiting the balance billing of Hospital's patients.

- Physician shall not to bill, nor cause to be billed, Medicare patients or Medicare (Part B) carriers for administrative or supervisory service or other clinical services that are payable under Part A of the Medicare program.

- Physician must comply with the Hospital's Corporate Compliance Responsibility Program.

- Physician must be and remain eligible to participate in any federal and/or state healthcare program including, without limitation, Medicare or Medi-Cal, and not be suspended, excluded, debarred or otherwise ineligible to participate during the term of this Agreement. Physician must immediately report to Hospital any actual or proposed suspension, debarment or exclusion of Physician from any federal and/or state healthcare program.

Payment Terms

Hospital agrees to reimburse Physician the stipend(s) identified in Attachment A for on-call services. Stipend payments for being available for on-call services are subject to strict compliance with this Agreement, Medical Staff Bylaws, rules and regulations and Hospital and Medical Staff policies. Failure to comply may result in forfeiture or withholding of such payments in the sole reasonable discretion of Hospital, in accordance with Medical Staff Policy 8710-520.

Hospital will reimburse Physician within 45 days of receipt of completed schedules for the month. The on-call roster will be maintained as provided in Medical Staff Policy 8710-520. A final schedule reflecting any changes that have been made during the course of the month will be submitted by the ED Department to the Medical Staff office which will submit request for payment to Finance.

Term and Termination

The term of this Agreement shall be for a period of twenty-three (23) months commencing on August 1, 2014 and ending on June 30, 2016 ("Initial Term").

Hospital may immediately terminate this Agreement upon any of the following events:

- Physician's license to practice medicine is revoked, suspended or curtailed;
- Physician is placed on probation or Physician's Medical Staff privileges are suspended, curtailed or terminated;
- Physician is suspended, debarred or otherwise not eligible to participate in federal and/or state health care programs;
- Physician fails to carry the insurance required by this Agreement.

To the extent permitted by law, the expiration of this Agreement or earlier termination shall not require compliance with any Medical Staff hearing or other procedures.

If this Agreement is terminated prior to the expiration of the initial twelve (12) months of the Initial Term, the parties shall not enter into any new agreement or arrangement for the same or equivalent services during the remainder of such Initial Term.

Other Terms

It is mutually agreed that each party is at all times acting and performing as independent contractors with and not as employees of the other. Each party shall be responsible for its own acts and omissions and shall not be responsible for the acts or omissions of the other. This Agreement shall be interpreted and governed under California law and jurisdiction and venue shall only be proper in San Diego County, California.

If and to the extent required by Section 1395x(v)(1) of Title 42 of the United States Code, until the expiration of four (4) years after the termination of this Agreement, each Physician shall make available, upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the services provided by such Physician under this Agreement.

PHYSICIAN:

_____
Mohammad Jamshidi-Nezhad, DO

Date:_____

HOSPITAL:

_____
Tim Moran,CEO

Date:_____.

Attachment A
On-Call Stipend
Effective August 1, 2014

Mohammad Jamshidi-Nezhad, DO

The stipend for on-call coverage as listed below is for a scheduled 24-hour period of time. It has been determined as the result of an arm's length negotiation, is in accordance with fair market value for the year in effect, is commercially reasonable as far as needed services and is not based on the volume or value of services provided. The additional stipend is for unfunded Cholecystectomy cases at the Medicare rate of $725.

Specialty	Rate
GENERAL SURGERY	$ 1,400
Unfunded Cholecystectomy, as Primary Admitter (Patient Admission Face Sheet with verification as uninsured required)	$ 725

Tri-City Medical Center

GENERAL SURGERY ON CALL COVERAGE AGREEMENT
Effective August 1, 2014-June 30,2016
READ CAREFULLY - THIS CONTRACT HAS LEGAL EFFECT

This On-Call Coverage Agreement ("Agreement") is entered into by and between Tri-City Healthcare District, a local healthcare district that operates Tri-City Medical Center ("Hospital") and the Physician signing below ("Physician").

Recitals

"Emergency Services Coverage" is required by Medical Staff Bylaws (Sections 2.5(k) and 3.2-2), Medical Staff Rules and Regulations and Medical Staff policy. Hospital's Medical Staff Policy 8710-520 outlines the Medical Staff member's responsibilities when participating in "Emergency Services Coverage". The Medical Staff policy addresses compliance with the Emergency Medical Treatment & Active Labor Act ("EMTALA") and implementing regulations.

Purpose and Legal Effect

The purpose of this Agreement is primarily to provide continuity of care for Emergency Department ("ED") on-call services and thereby enhance overall quality and efficiency of patient care. Eligibility/requirements for participation are determined by the Medical Staff. Physician's signature and provision of on-call services shall constitute acceptance of the following terms, which shall be legally binding upon Physician and enforceable by Hospital.

Definition of "On-Call"

"On-Call' means 24 hours per day availability via beeper/pager service. Response time will be within the time periods set forth in Medical Staff Policy 8710-520 with a goal of less than thirty (30) minutes and shall never exceed sixty (60) minutes. An on-call coverage day or shift shall be defined by each department or division as applicable.

Duties of On-Call Physicians

Physician shall perform the following duties in connection with on-call services:

- All duties described in Medical Staff Policy 8710-520.
- Perform preadmission and admission evaluations with the patient and patient's family, including stabilization as requested by an ED or covering physician;
- Write preadmission or admission notes and orders on those patients examined by Physician;
- Conduct medical rounds on those patients under Physicians' care as clinically appropriate.

- Complete, in an accurate and timely manner, medical records in accordance with the standards of The Joint Commission and all other applicable accrediting, licensing, utilization review and payor agencies as well as Medical Staff Bylaws, Rules and Regulations, and policies and procedures;

- Comply with all applicable federal, state and local laws, rules and regulations, including EMTALA, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requirements for participation in the Medicare, Medi-Cal and other federally-funded programs, all criteria of The Joint Commission, Hospital's Medical Staff Bylaws and all other applicable rules and regulations established by Hospital or its Medical Staff, and shall provide an appropriate level and standard of care in the Hospital.

Physician Requirements

Physician shall comply with the following requirements:

- Physician's license to practice in the State of California and/or in any other jurisdiction must be in good standing and not denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or restricted in any way.

- Physician must be and remain in good standing as member of the Medical Staff at Hospital.

- Physician shall obtain and maintain liability insurance in an amount not less than $1,000,000 per occurrence and $3,000,000 annual aggregate covering Physician's services.

- Physician shall be responsible for billing and collection of the charges for professional services and Hospital shall be responsible for billing and collection of charges for hospital services. Physician shall comply with all federal and state laws, regulations and payer contractual requirements prohibiting the balance billing of Hospital's patients.

- Physician shall not to bill, nor cause to be billed, Medicare patients or Medicare (Part B) carriers for administrative or supervisory service or other clinical services that are payable under Part A of the Medicare program.

- Physician must comply with the Hospital's Corporate Compliance Responsibility Program.

- Physician must be and remain eligible to participate in any federal and/or state healthcare program including, without limitation, Medicare or Medi-Cal, and not be suspended, excluded, debarred or otherwise ineligible to participate during the term of this Agreement. Physician must immediately report to Hospital any actual or proposed suspension, debarment or exclusion of Physician from any federal and/or state healthcare program.

Payment Terms

Hospital agrees to reimburse Physician the stipend(s) identified in Attachment A for on-call services. Stipend payments for being available for on-call services are subject to strict compliance with this Agreement, Medical Staff Bylaws, rules and regulations and Hospital and Medical Staff policies. Failure to comply may result in forfeiture or withholding of such payments in the sole reasonable discretion of Hospital, in accordance with Medical Staff Policy 8710-520.

Hospital will reimburse Physician within 45 days of receipt of completed schedules for the month. The on-call roster will be maintained as provided in Medical Staff Policy 8710-520. A final schedule reflecting any changes that have been made during the course of the month will be submitted by the ED Department to the Medical Staff office which will submit request for payment to Finance.

Term and Termination

The term of this Agreement shall be for a period of twenty-three (23) months commencing on August 1, 2014 and ending on June 30, 2016 ("Initial Term").

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- Physician's license to practice medicine is revoked, suspended or curtailed;
- Physician is placed on probation or Physician's Medical Staff privileges are suspended, curtailed or terminated;
- Physician is suspended, debarred or otherwise not eligible to participate in federal and/or state health care programs;
- Physician fails to carry the insurance required by this Agreement.

To the extent permitted by law, the expiration of this Agreement or earlier termination shall not require compliance with any Medical Staff hearing or other procedures.

If this Agreement is terminated prior to the expiration of the initial twelve (12) months of the Initial Term, the parties shall not enter into any new agreement or arrangement for the same or equivalent services during the remainder of such Initial Term.

Other Terms

It is mutually agreed that each party is at all times acting and performing as independent contractors with and not as employees of the other. Each party shall be responsible for its own acts and omissions and shall not be responsible for the acts or omissions of the other. This Agreement shall be interpreted and governed under California law and jurisdiction and venue shall only be proper in San Diego County, California.

If and to the extent required by Section 1395x(v)(1) of Title 42 of the United States Code, until the expiration of four (4) years after the termination of this Agreement, each Physician shall make available, upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the services provided by such Physician under this Agreement.

PHYSICIAN:

_____
Eric Rypins, MD

Date:_____

HOSPITAL:

_____
Tim Moran,CEO

Date:_____.

Attachment A
On-Call Stipend
Effective August 1, 2014

Eric Rypins, MD

The stipend for on-call coverage as listed below is for a scheduled 24-hour period of time. It has been determined as the result of an arm's length negotiation, is in accordance with fair market value for the year in effect, is commercially reasonable as far as needed services and is not based on the volume or value of services provided. The additional stipend is for unfunded Cholecystectomy cases at the Medicare rate of $725.

Specialty	Rate
GENERAL SURGERY	$ 1,400
Unfunded Cholecystectomy, as Primary Admitter (Patient Admission Face Sheet with verification as uninsured required)	$ 725

Tri-City Medical Center

GENERAL SURGERY ON CALL COVERAGE AGREEMENT
Effective August 1, 2014-June 30,2016
READ CAREFULLY - THIS CONTRACT HAS LEGAL EFFECT

This On-Call Coverage Agreement ("Agreement") is entered into by and between Tri-City Healthcare District, a local healthcare district that operates Tri-City Medical Center ("Hospital") and the Physician signing below ("Physician").

Recitals

"Emergency Services Coverage" is required by Medical Staff Bylaws (Sections 2.5(k) and 3.2-2), Medical Staff Rules and Regulations and Medical Staff policy. Hospital's Medical Staff Policy 8710-520 outlines the Medical Staff member's responsibilities when participating in "Emergency Services Coverage". The Medical Staff policy addresses compliance with the Emergency Medical Treatment & Active Labor Act ("EMTALA") and implementing regulations.

Purpose and Legal Effect

The purpose of this Agreement is primarily to provide continuity of care for Emergency Department ("ED") on-call services and thereby enhance overall quality and efficiency of patient care. Eligibility/requirements for participation are determined by the Medical Staff. Physician's signature and provision of on-call services shall constitute acceptance of the following terms, which shall be legally binding upon Physician and enforceable by Hospital.

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"On-Call' means 24 hours per day availability via beeper/pager service. Response time will be within the time periods set forth in Medical Staff Policy 8710-520 with a goal of less than thirty (30) minutes and shall never exceed sixty (60) minutes. An on-call coverage day or shift shall be defined by each department or division as applicable.

Duties of On-Call Physicians

Physician shall perform the following duties in connection with on-call services:

- All duties described in Medical Staff Policy 8710-520.
- Perform preadmission and admission evaluations with the patient and patient's family, including stabilization as requested by an ED or covering physician;
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- Physician shall not to bill, nor cause to be billed, Medicare patients or Medicare (Part B) carriers for administrative or supervisory service or other clinical services that are payable under Part A of the Medicare program.

- Physician must comply with the Hospital's Corporate Compliance Responsibility Program.

- Physician must be and remain eligible to participate in any federal and/or state healthcare program including, without limitation, Medicare or Medi-Cal, and not be suspended, excluded, debarred or otherwise ineligible to participate during the term of this Agreement. Physician must immediately report to Hospital any actual or proposed suspension, debarment or exclusion of Physician from any federal and/or state healthcare program.

Payment Terms

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If and to the extent required by Section 1395x(v)(1) of Title 42 of the United States Code, until the expiration of four (4) years after the termination of this Agreement, each Physician shall make available, upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the services provided by such Physician under this Agreement.

PHYSICIAN:

_____
Katayoun Toosie, MD

Date:_____

HOSPITAL:

_____
Tim Moran,CEO

Date:_____.

Attachment A
On-Call Stipend
Effective August 1, 2014

Katayoun Toosie, MD

The stipend for on-call coverage as listed below is for a scheduled 24-hour period of time. It has been determined as the result of an arm's length negotiation, is in accordance with fair market value for the year in effect, is commercially reasonable as far as needed services and is not based on the volume or value of services provided. The additional stipend is for unfunded Cholecystectomy cases at the Medicare rate of $725.

Specialty	Rate
GENERAL SURGERY	$ 1,400
Unfunded Cholecystectomy, as Primary Admitter (Patient Admission Face Sheet with verification as uninsured required)	$ 725

Tri-City Medical Center

(GASTROENTEROLOGY) ON CALL COVERAGE AGREEMENT
Effective August 1, 2014-June 30,2016
READ CAREFULLY - THIS CONTRACT HAS LEGAL EFFECT

This On-Call Coverage Agreement ("Agreement") is entered into by and between Tri-City Healthcare District, a local healthcare district that operates Tri-City Medical Center ("Hospital") and the Physician signing below ("Physician").

Recitals

"Emergency Services Coverage" is required by Medical Staff Bylaws (Sections 2.5(k) and 3.2-2), Medical Staff Rules and Regulations and Medical Staff policy. Hospital's Medical Staff Policy 8710-520 outlines the Medical Staff member's responsibilities when participating in "Emergency Services Coverage". The Medical Staff policy addresses compliance with the Emergency Medical Treatment & Active Labor Act ("EMTALA") and implementing regulations.

Purpose and Legal Effect

The purpose of this Agreement is primarily to provide continuity of care for Emergency Department ("ED") on-call services and thereby enhance overall quality and efficiency of patient care. Eligibility/requirements for participation are determined by the Medical Staff. Physician's signature and provision of on-call services shall constitute acceptance of the following terms, which shall be legally binding upon Physician and enforceable by Hospital.

Definition of "On-Call"

"On-Call' means 24 hours per day availability via beeper/pager service. Response time will be within the time periods set forth in Medical Staff Policy 8710-520 with a goal of less than thirty (30) minutes and shall never exceed sixty (60) minutes. An on-call coverage day or shift shall be defined by each department or division as applicable.

Duties of On-Call Physicians

Physician shall perform the following duties in connection with on-call services:

- All duties described in Medical Staff Policy 8710-520.
- Perform preadmission and admission evaluations with the patient and patient's family, including stabilization as requested by an ED or covering physician;
- Write preadmission or admission notes and orders on those patients examined by Physician;
- Conduct medical rounds on those patients under Physicians' care as clinically appropriate.

- Complete, in an accurate and timely manner, medical records in accordance with the standards of The Joint Commission and all other applicable accrediting, licensing, utilization review and payor agencies as well as Medical Staff Bylaws, Rules and Regulations, and policies and procedures;

- Comply with all applicable federal, state and local laws, rules and regulations, including EMTALA, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requirements for participation in the Medicare, Medi-Cal and other federally-funded programs, all criteria of The Joint Commission, Hospital's Medical Staff Bylaws and all other applicable rules and regulations established by Hospital or its Medical Staff, and shall provide an appropriate level and standard of care in the Hospital.

Physician Requirements

Physician shall comply with the following requirements:

- Physician's license to practice in the State of California and/or in any other jurisdiction must be in good standing and not denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or restricted in any way.

- Physician must be and remain in good standing as member of the Medical Staff at Hospital.

- Physician shall obtain and maintain liability insurance in an amount not less than $1,000,000 per occurrence and $3,000,000 annual aggregate covering Physician's services.

- Physician shall be responsible for billing and collection of the charges for professional services and Hospital shall be responsible for billing and collection of charges for hospital services. Physician shall comply with all federal and state laws, regulations and payer contractual requirements prohibiting the balance billing of Hospital's patients.

- Physician shall not to bill, nor cause to be billed, Medicare patients or Medicare (Part B) carriers for administrative or supervisory service or other clinical services that are payable under Part A of the Medicare program.

- Physician must comply with the Hospital's Corporate Compliance Responsibility Program.

- Physician must be and remain eligible to participate in any federal and/or state healthcare program including, without limitation, Medicare or Medi-Cal, and not be suspended, excluded, debarred or otherwise ineligible to participate during the term of this Agreement. Physician must immediately report to Hospital any actual or proposed suspension, debarment or exclusion of Physician from any federal and/or state healthcare program.

Payment Terms

Hospital agrees to reimburse Physician the stipend(s) identified in Attachment A for on-call services. Stipend payments for being available for on-call services are subject to strict compliance with this Agreement, Medical Staff Bylaws. rules and regulations and Hospital and Medical Staff policies. Failure to comply may result in forfeiture or withholding of such payments in the sole reasonable discretion of Hospital, in accordance with Medical Staff Policy 8710-520.

Hospital will reimburse Physician within 45 days of receipt of completed schedules for the month. The on-call roster will be maintained as provided in Medical Staff Policy 8710-520. A final schedule reflecting any changes that have been made during the course of the month will be submitted by the ED Department to the Medical Staff office which will submit request for payment to Finance.

Term and Termination

The term of this Agreement shall be for a period of twenty-three (23) months commencing on August 1, 2014 and ending on June 30, 2016 ("Initial Term").

Hospital may immediately terminate this Agreement upon any of the following events:

- Physician's license to practice medicine is revoked, suspended or curtailed;
- Physician is placed on probation or Physician's Medical Staff privileges are suspended, curtailed or terminated;
- Physician is suspended, debarred or otherwise not eligible to participate in federal and/or state health care programs;
- Physician fails to carry the insurance required by this Agreement.

To the extent permitted by law, the expiration of this Agreement or earlier termination shall not require compliance with any Medical Staff hearing or other procedures.

If this Agreement is terminated prior to the expiration of the initial twelve (12) months of the Initial Term, the parties shall not enter into any new agreement or arrangement for the same or equivalent services during the remainder of such Initial Term.

Other Terms

It is mutually agreed that each party is at all times acting and performing as independent contractors with and not as employees of the other. Each party shall be responsible for its own acts and omissions and shall not be responsible for the acts or omissions of the other. This Agreement shall be interpreted and governed under California law and jurisdiction and venue shall only be proper in San Diego County, California.

If and to the extent required by Section 1395x(v)(1) of Title 42 of the United States Code, until the expiration of four (4) years after the termination of this Agreement, each Physician shall make available, upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the services provided by such Physician under this Agreement.

PHYSICIAN:

_____
Andrew Cummins, MD

Date:_____

HOSPITAL:

_____
Tim Moran,CEO

Date:_____.

Attachment A
On-Call Stipend
Effective August 1, 2014

Andrew Cummins, MD

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Specialty	Rate
GASTROENTEROLOGY – General	$ 700

Tri-City Medical Center

(GASTROENTEROLOGY) ON CALL COVERAGE AGREEMENT
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- Complete, in an accurate and timely manner, medical records in accordance with the standards of The Joint Commission and all other applicable accrediting, licensing, utilization review and payor agencies as well as Medical Staff Bylaws, Rules and Regulations, and policies and procedures;

- Comply with all applicable federal, state and local laws, rules and regulations, including EMTALA, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requirements for participation in the Medicare, Medi-Cal and other federally-funded programs, all criteria of The Joint Commission, Hospital's Medical Staff Bylaws and all other applicable rules and regulations established by Hospital or its Medical Staff, and shall provide an appropriate level and standard of care in the Hospital.

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- Physician shall be responsible for billing and collection of the charges for professional services and Hospital shall be responsible for billing and collection of charges for hospital services. Physician shall comply with all federal and state laws, regulations and payer contractual requirements prohibiting the balance billing of Hospital's patients.

- Physician shall not to bill, nor cause to be billed, Medicare patients or Medicare (Part B) carriers for administrative or supervisory service or other clinical services that are payable under Part A of the Medicare program.

- Physician must comply with the Hospital's Corporate Compliance Responsibility Program.

- Physician must be and remain eligible to participate in any federal and/or state healthcare program including, without limitation, Medicare or Medi-Cal, and not be suspended, excluded, debarred or otherwise ineligible to participate during the term of this Agreement. Physician must immediately report to Hospital any actual or proposed suspension, debarment or exclusion of Physician from any federal and/or state healthcare program.

Payment Terms

Hospital agrees to reimburse Physician the stipend(s) identified in Attachment A for on-call services. Stipend payments for being available for on-call services are subject to strict compliance with this Agreement, Medical Staff Bylaws, rules and regulations and Hospital and Medical Staff policies. Failure to comply may result in forfeiture or withholding of such payments in the sole reasonable discretion of Hospital, in accordance with Medical Staff Policy 8710-520.

Hospital will reimburse Physician within 45 days of receipt of completed schedules for the month. The on-call roster will be maintained as provided in Medical Staff Policy 8710-520. A final schedule reflecting any changes that have been made during the course of the month will be submitted by the ED Department to the Medical Staff office which will submit request for payment to Finance.

Term and Termination

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- Physician's license to practice medicine is revoked, suspended or curtailed;
- Physician is placed on probation or Physician's Medical Staff privileges are suspended, curtailed or terminated;
- Physician is suspended, debarred or otherwise not eligible to participate in federal and/or state health care programs;
- Physician fails to carry the insurance required by this Agreement.

To the extent permitted by law, the expiration of this Agreement or earlier termination shall not require compliance with any Medical Staff hearing or other procedures.

If this Agreement is terminated prior to the expiration of the initial twelve (12) months of the Initial Term, the parties shall not enter into any new agreement or arrangement for the same or equivalent services during the remainder of such Initial Term.

Other Terms

It is mutually agreed that each party is at all times acting and performing as independent contractors with and not as employees of the other. Each party shall be responsible for its own acts and omissions and shall not be responsible for the acts or omissions of the other. This Agreement shall be interpreted and governed under California law and jurisdiction and venue shall only be proper in San Diego County, California.

If and to the extent required by Section 1395x(v)(1) of Title 42 of the United States Code, until the expiration of four (4) years after the termination of this Agreement, each Physician shall make available, upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the services provided by such Physician under this Agreement.

PHYSICIAN:

_____
Christopher Devereaux, MD

Date:_____

HOSPITAL:

_____
Tim Moran,CEO

Date:_____.

Attachment A
On-Call Stipend
Effective August 1, 2014

Christopher Devereaux, MD

The stipend for on-call coverage as listed below is for a scheduled 24-hour period of time. It has been determined as the result of an arm's length negotiation, is in accordance with fair market value for the year in effect, is commercially reasonable as far as needed services and is not based on the volume or value of services provided.

Specialty	Rate
GASTROENTEROLOGY – General	$ 700
GASTROENTEROLOGY - ERCP	$ 500

Tri-City Medical Center

(GASTROENTEROLOGY) ON CALL COVERAGE AGREEMENT
Effective August 1, 2014-June 30,2016
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This On-Call Coverage Agreement ("Agreement") is entered into by and between Tri-City Healthcare District, a local healthcare district that operates Tri-City Medical Center ("Hospital") and the Physician signing below ("Physician").

Recitals

"Emergency Services Coverage" is required by Medical Staff Bylaws (Sections 2.5(k) and 3.2-2), Medical Staff Rules and Regulations and Medical Staff policy. Hospital's Medical Staff Policy 8710-520 outlines the Medical Staff member's responsibilities when participating in "Emergency Services Coverage". The Medical Staff policy addresses compliance with the Emergency Medical Treatment & Active Labor Act ("EMTALA") and implementing regulations.

Purpose and Legal Effect

The purpose of this Agreement is primarily to provide continuity of care for Emergency Department ("ED") on-call services and thereby enhance overall quality and efficiency of patient care. Eligibility/requirements for participation are determined by the Medical Staff. Physician's signature and provision of on-call services shall constitute acceptance of the following terms, which shall be legally binding upon Physician and enforceable by Hospital.

Definition of "On-Call"

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Duties of On-Call Physicians

Physician shall perform the following duties in connection with on-call services:

- All duties described in Medical Staff Policy 8710-520.
- Perform preadmission and admission evaluations with the patient and patient's family, including stabilization as requested by an ED or covering physician;
- Write preadmission or admission notes and orders on those patients examined by Physician;
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- Complete, in an accurate and timely manner, medical records in accordance with the standards of The Joint Commission and all other applicable accrediting, licensing, utilization review and payor agencies as well as Medical Staff Bylaws, Rules and Regulations, and policies and procedures;

- Comply with all applicable federal, state and local laws, rules and regulations, including EMTALA, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requirements for participation in the Medicare, Medi-Cal and other federally-funded programs, all criteria of The Joint Commission, Hospital's Medical Staff Bylaws and all other applicable rules and regulations established by Hospital or its Medical Staff, and shall provide an appropriate level and standard of care in the Hospital.

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- Physician shall not to bill, nor cause to be billed, Medicare patients or Medicare (Part B) carriers for administrative or supervisory service or other clinical services that are payable under Part A of the Medicare program.

- Physician must comply with the Hospital's Corporate Compliance Responsibility Program.

- Physician must be and remain eligible to participate in any federal and/or state healthcare program including, without limitation, Medicare or Medi-Cal, and not be suspended, excluded, debarred or otherwise ineligible to participate during the term of this Agreement. Physician must immediately report to Hospital any actual or proposed suspension, debarment or exclusion of Physician from any federal and/or state healthcare program.

Payment Terms

Hospital agrees to reimburse Physician the stipend(s) identified in Attachment A for on-call services. Stipend payments for being available for on-call services are subject to strict compliance with this Agreement, Medical Staff Bylaws, rules and regulations and Hospital and Medical Staff policies. Failure to comply may result in forfeiture or withholding of such payments in the sole reasonable discretion of Hospital, in accordance with Medical Staff Policy 8710-520.

Hospital will reimburse Physician within 45 days of receipt of completed schedules for the month. The on-call roster will be maintained as provided in Medical Staff Policy 8710-520. A final schedule reflecting any changes that have been made during the course of the month will be submitted by the ED Department to the Medical Staff office which will submit request for payment to Finance.

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If and to the extent required by Section 1395x(v)(1) of Title 42 of the United States Code, until the expiration of four (4) years after the termination of this Agreement, each Physician shall make available, upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the services provided by such Physician under this Agreement.

PHYSICIAN:

_____
Thomas Krol, MD

Date:_____

HOSPITAL:

_____
Tim Moran,CEO

Date:_____.

Attachment A
On-Call Stipend
Effective August 1, 2014

Thomas Krol, MD

The stipend for on-call coverage as listed below is for a scheduled 24-hour period of time. It has been determined as the result of an arm's length negotiation, is in accordance with fair market value for the year in effect, is commercially reasonable as far as needed services and is not based on the volume or value of services provided.

Specialty	Rate
GASTROENTEROLOGY – General	$ 700
GASTROENTEROLOGY - ERCP	$ 500

Tri-City Medical Center

(GASTROENTEROLOGY) ON CALL COVERAGE AGREEMENT
Effective August 1, 2014-June 30,2016
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Recitals

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- Physician shall not to bill, nor cause to be billed, Medicare patients or Medicare (Part B) carriers for administrative or supervisory service or other clinical services that are payable under Part A of the Medicare program.

- Physician must comply with the Hospital's Corporate Compliance Responsibility Program.

- Physician must be and remain eligible to participate in any federal and/or state healthcare program including, without limitation, Medicare or Medi-Cal, and not be suspended, excluded, debarred or otherwise ineligible to participate during the term of this Agreement. Physician must immediately report to Hospital any actual or proposed suspension, debarment or exclusion of Physician from any federal and/or state healthcare program.

Payment Terms

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PHYSICIAN:

_____
Javaid Shad, MD

Date:_____

HOSPITAL:

_____
Tim Moran,CEO

Date:_____.

Attachment A
On-Call Stipend
Effective August 1, 2014

Javaid Shad, MD

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- Physician shall not to bill, nor cause to be billed, Medicare patients or Medicare (Part B) carriers for administrative or supervisory service or other clinical services that are payable under Part A of the Medicare program.

- Physician must comply with the Hospital's Corporate Compliance Responsibility Program.

- Physician must be and remain eligible to participate in any federal and/or state healthcare program including, without limitation, Medicare or Medi-Cal, and not be suspended, excluded, debarred or otherwise ineligible to participate during the term of this Agreement. Physician must immediately report to Hospital any actual or proposed suspension, debarment or exclusion of Physician from any federal and/or state healthcare program.

Payment Terms

Hospital agrees to reimburse Physician the stipend(s) identified in Attachment A for on-call services. Stipend payments for being available for on-call services are subject to strict compliance with this Agreement, Medical Staff Bylaws, rules and regulations and Hospital and Medical Staff policies. Failure to comply may result in forfeiture or withholding of such payments in the sole reasonable discretion of Hospital, in accordance with Medical Staff Policy 8710-520.

Hospital will reimburse Physician within 45 days of receipt of completed schedules for the month. The on-call roster will be maintained as provided in Medical Staff Policy 8710-520. A final schedule reflecting any changes that have been made during the course of the month will be submitted by the ED Department to the Medical Staff office which will submit request for payment to Finance.

Term and Termination

The term of this Agreement shall be for a period of twenty-three (23) months commencing on August 1, 2014 and ending on June 30, 2016 ("Initial Term").

Hospital may immediately terminate this Agreement upon any of the following events:

- Physician's license to practice medicine is revoked, suspended or curtailed;
- Physician is placed on probation or Physician's Medical Staff privileges are suspended, curtailed or terminated;
- Physician is suspended, debarred or otherwise not eligible to participate in federal and/or state health care programs;
- Physician fails to carry the insurance required by this Agreement.

To the extent permitted by law, the expiration of this Agreement or earlier termination shall not require compliance with any Medical Staff hearing or other procedures.

If this Agreement is terminated prior to the expiration of the initial twelve (12) months of the Initial Term, the parties shall not enter into any new agreement or arrangement for the same or equivalent services during the remainder of such Initial Term.

Other Terms

It is mutually agreed that each party is at all times acting and performing as independent contractors with and not as employees of the other. Each party shall be responsible for its own acts and omissions and shall not be responsible for the acts or omissions of the other. This Agreement shall be interpreted and governed under California law and jurisdiction and venue shall only be proper in San Diego County, California.

If and to the extent required by Section 1395x(v)(1) of Title 42 of the United States Code, until the expiration of four (4) years after the termination of this Agreement, each Physician shall make available, upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the services provided by such Physician under this Agreement.

PHYSICIAN:

_____
Michael Shim, MD

Date:_____

HOSPITAL:

_____
Tim Moran,CEO

Date:_____.

Attachment A
On-Call Stipend
Effective August 1, 2014

Michael Shim, MD

The stipend for on-call coverage as listed below is for a scheduled 24-hour period of time. It has been determined as the result of an arm's length negotiation, is in accordance with fair market value for the year in effect, is commercially reasonable as far as needed services and is not based on the volume or value of services provided.

Specialty	Rate
GASTROENTEROLOGY – General	$ 700
GASTROENTEROLOGY - ERCP	$ 500

Tri-City Medical Center

(GASTROENTEROLOGY) ON CALL COVERAGE AGREEMENT
Effective August 1, 2014-June 30,2016
READ CAREFULLY - THIS CONTRACT HAS LEGAL EFFECT

This On-Call Coverage Agreement ("Agreement") is entered into by and between Tri-City Healthcare District, a local healthcare district that operates Tri-City Medical Center ("Hospital") and the Physician signing below ("Physician").

Recitals

"Emergency Services Coverage" is required by Medical Staff Bylaws (Sections 2.5(k) and 3.2-2), Medical Staff Rules and Regulations and Medical Staff policy. Hospital's Medical Staff Policy 8710-520 outlines the Medical Staff member's responsibilities when participating in "Emergency Services Coverage". The Medical Staff policy addresses compliance with the Emergency Medical Treatment & Active Labor Act ("EMTALA") and implementing regulations.

Purpose and Legal Effect

The purpose of this Agreement is primarily to provide continuity of care for Emergency Department ("ED") on-call services and thereby enhance overall quality and efficiency of patient care. Eligibility/requirements for participation are determined by the Medical Staff. Physician's signature and provision of on-call services shall constitute acceptance of the following terms, which shall be legally binding upon Physician and enforceable by Hospital.

Definition of "On-Call"

"On-Call' means 24 hours per day availability via beeper/pager service. Response time will be within the time periods set forth in Medical Staff Policy 8710-520 with a goal of less than thirty (30) minutes and shall never exceed sixty (60) minutes. An on-call coverage day or shift shall be defined by each department or division as applicable.

Duties of On-Call Physicians

Physician shall perform the following duties in connection with on-call services:

- All duties described in Medical Staff Policy 8710-520.
- Perform preadmission and admission evaluations with the patient and patient's family, including stabilization as requested by an ED or covering physician;
- Write preadmission or admission notes and orders on those patients examined by Physician;
- Conduct medical rounds on those patients under Physicians' care as clinically appropriate.

- Complete, in an accurate and timely manner, medical records in accordance with the standards of The Joint Commission and all other applicable accrediting, licensing, utilization review and payor agencies as well as Medical Staff Bylaws, Rules and Regulations, and policies and procedures;

- Comply with all applicable federal, state and local laws, rules and regulations, including EMTALA, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requirements for participation in the Medicare, Medi-Cal and other federally-funded programs, all criteria of The Joint Commission, Hospital's Medical Staff Bylaws and all other applicable rules and regulations established by Hospital or its Medical Staff, and shall provide an appropriate level and standard of care in the Hospital.

Physician Requirements

Physician shall comply with the following requirements:

- Physician's license to practice in the State of California and/or in any other jurisdiction must be in good standing and not denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or restricted in any way.

- Physician must be and remain in good standing as member of the Medical Staff at Hospital.

- Physician shall obtain and maintain liability insurance in an amount not less than $1,000,000 per occurrence and $3,000,000 annual aggregate covering Physician's services.

- Physician shall be responsible for billing and collection of the charges for professional services and Hospital shall be responsible for billing and collection of charges for hospital services. Physician shall comply with all federal and state laws, regulations and payer contractual requirements prohibiting the balance billing of Hospital's patients.

- Physician shall not to bill, nor cause to be billed, Medicare patients or Medicare (Part B) carriers for administrative or supervisory service or other clinical services that are payable under Part A of the Medicare program.

- Physician must comply with the Hospital's Corporate Compliance Responsibility Program.

- Physician must be and remain eligible to participate in any federal and/or state healthcare program including, without limitation, Medicare or Medi-Cal, and not be suspended, excluded, debarred or otherwise ineligible to participate during the term of this Agreement. Physician must immediately report to Hospital any actual or proposed suspension, debarment or exclusion of Physician from any federal and/or state healthcare program.

Payment Terms

Hospital agrees to reimburse Physician the stipend(s) identified in Attachment A for on-call services. Stipend payments for being available for on-call services are subject to strict compliance with this Agreement, Medical Staff Bylaws, rules and regulations and Hospital and Medical Staff policies. Failure to comply may result in forfeiture or withholding of such payments in the sole reasonable discretion of Hospital, in accordance with Medical Staff Policy 8710-520.

Hospital will reimburse Physician within 45 days of receipt of completed schedules for the month. The on-call roster will be maintained as provided in Medical Staff Policy 8710-520. A final schedule reflecting any changes that have been made during the course of the month will be submitted by the ED Department to the Medical Staff office which will submit request for payment to Finance.

Term and Termination

The term of this Agreement shall be for a period of twenty-three (23) months commencing on August 1, 2014 and ending on June 30, 2016 ("Initial Term").

Hospital may immediately terminate this Agreement upon any of the following events:

- Physician's license to practice medicine is revoked, suspended or curtailed;
- Physician is placed on probation or Physician's Medical Staff privileges are suspended, curtailed or terminated;
- Physician is suspended, debarred or otherwise not eligible to participate in federal and/or state health care programs;
- Physician fails to carry the insurance required by this Agreement.

To the extent permitted by law, the expiration of this Agreement or earlier termination shall not require compliance with any Medical Staff hearing or other procedures.

If this Agreement is terminated prior to the expiration of the initial twelve (12) months of the Initial Term, the parties shall not enter into any new agreement or arrangement for the same or equivalent services during the remainder of such Initial Term.

Other Terms

It is mutually agreed that each party is at all times acting and performing as independent contractors with and not as employees of the other. Each party shall be responsible for its own acts and omissions and shall not be responsible for the acts or omissions of the other. This Agreement shall be interpreted and governed under California law and jurisdiction and venue shall only be proper in San Diego County, California.

If and to the extent required by Section 1395x(v)(1) of Title 42 of the United States Code, until the expiration of four (4) years after the termination of this Agreement, each Physician shall make available, upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the services provided by such Physician under this Agreement.

PHYSICIAN:

_____
Matthew Viernes, MD

Date:_____

HOSPITAL:

_____
Tim Moran,CEO

Date:_____.

Attachment A
On-Call Stipend
Effective August 1, 2014

Matthew Viernes, MD

The stipend for on-call coverage as listed below is for a scheduled 24-hour period of time. It has been determined as the result of an arm's length negotiation, is in accordance with fair market value for the year in effect, is commercially reasonable as far as needed services and is not based on the volume or value of services provided.

Specialty	Rate
GASTROENTEROLOGY – General	$ 700
GASTROENTEROLOGY - ERCP	$ 500

Medical Staff Office
Tri-City Medical Center
4002 Vista Way, Oceanside, CA 92056-4506 • (760) 940-3001

TO: Larry Schallock, Chairperson

FROM: Scott Worman, M.D., Chief of Staff

DATE: August 28, 2014

SUBJECT: Medical Executive Committee Credentialing Recommendations – New Appointments

---

The attached Medical Staff New Appointments Credentials report was reviewed and approved at Credentials Committee on August 13, 2014. Their recommendations were reviewed and approved by the Medical Executive Committee on August 25, 2014. This report is forwarded to the Board of Directors with recommendations for approval:

SUBMITTED BY:

_____ _____
Scott Worman, M.D., Chief of Staff Date

GOVERNING BOARD DISPOSITION:

Approved: ☐

Denied: ☐

_____ _____
Julie Nygaard, Secretary Date
For and on behalf of the TCHD Board of Directors

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
August 13, 2014

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 08/28/2014 – 07/31/2016)
Medical Staff – Appoint to Provisional Staff and grant privileges as delineated:
Barrus, Adam B., MD – Anesthesiology
Choudry, Bilal A., MD – Medicine/Neurology
Idemundia, Ann O., MD – Pediatrics
Krishna, Sheila M., MD – Medicine/ Dermatology-Allergy
Mau, Nicole M., MD – Medicine/ Dermatology-Allergy
Parikh, Parag P., MD – Surgery/ Otolaryngology
Phillips, Jason M., MD – Surgery/Urology
Pletcher, Jacob R., MD – Anesthesiology
Quick, Alexander K., MD – Anesthesiology
Rayan, Sunil S., MD – Surgery/General Vascular Surgery
Wang, Chunyang T., MD – Medicine/Neurology

Allied Health Professionals – Appoint to Allied Health Professional Staff and grant privileges as delineated:
Heldt, Emily W., AuD – Neurophysiology Intraoperative Monitor/Orthopedics

INITIAL APPLICATION WITHDRAWAL: (Voluntary unless otherwise specified)
Medical Staff:
None

Allied Health Professionals:
Montoya, Julie, MFT Intern (effective 08/10/14)

TEMPORARY PRIVILEGES:
Medical Staff/Allied Health Professionals:
Choudry, Bilal A., MD – Medicine/Neurology
Idemundia, Ann O., MD – Pediatrics
Parikh, Parag P., MD – Surgery/ Otolaryngology
Quick, Alexander K., MD – Anesthesiology
Wang, Chunyang T., MD – Medicine/Neurology

TEMPORARY MEDICAL STAFF MEMBERSHIP:
Medical Staff:
None

Medical Staff Office
Tri-City Medical Center
4002 Vista Way, Oceanside, CA 92056-4506 • (760) 940-3001

TO: Larry Schallock, Chairperson

FROM: Scott Worman, M.D., Chief of Staff

DATE: August 28, 2014

SUBJECT: Medical Executive Committee Credentialing Recommendations – Reappointments

---

The attached Medical Staff Reappointments Credentials report was reviewed and approved at Credentials Committee on August 13, 2014. Their recommendations were reviewed and approved by the Medical Executive Committee on August 25, 2014. This report is forwarded to the Board of Directors with recommendations for approval:

SUBMITTED BY:

_____ _____
Scott Worman, M.D., Chief of Staff Date

GOVERNING BOARD DISPOSITION:

Approved: ☐

Denied: ☐

_____ _____
Julie Nygaard, Secretary Date
For and on behalf of the TCHD Board of Directors

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
August 13, 2014

Attachment B

REAPPOINTMENTS (Effective Dates: 09/01/2014 to 08/31/2016)

MEDICAL STAFF

Aizarani-Hallak, Antoine, MD, Surgery/Plastic Surgery
Reappoint to Courtesy Staff and grant privileges as delineated.
Relinquish:
- Intermediate Plastic and Reconstructive Surgery of Head and Neck (Crossover)
  - Otoplasty
  - Blepharoplasty
  - Mentoplasty
  - Facial Liposuction
  - Grafting – Cartilage Bone, Alloplasts

Batra, Munish K., MD, Surgery/Plastic Surgery
Reappoint to Courtesy Staff and grant privileges as requested.

Brooker, Jr., George A., DO, Anesthesiology
Reappoint from Active to Courtesy Staff and grant privileges as delineated.
Add:
- Evaluate and treat patients with anesthesia related problems

Relinquish:
- Pain Management Core Privileges
  - Epidural procedures

Clark, Ma. Belen S., MD, Family Medicine
Reappoint to Active Staff and grant privileges as requested.

Coffler, Mickey S., MD, OB/GYN
Reappoint to Active Staff and grant privileges as requested.

Esch, James C., MD, Surgery/Orthopedic Surgery
Reappoint to Active Staff and grant privileges as delineated.
Add:
- Forensic Site Specific Privileges
  - Implant removal, small (i.e. K-wires) (F)
  - Injections into joints or tendon sheaths (F)
  - Aspiration of joints (F)
  - Minor I&D abscess or hematoma (F)
  - Closed reduction of fractures using local anesthesia (F)
  - Casting and splinting (F)

Relinquish:
- Hand Surgery
  - Nerve Repair of hand
  - Tendon Repair

Fenton, Douglas K., MD, OB/GYN
Reappoint to Consulting Staff and grant privileges as delineated.
Add:
- Gynecology Privileges (Abdominal Surgery)
  - Exploratory laparotomy
- Gynecology Privileges (Endoscopy-Laparoscopy Surgery)
  - Endometrial ablation

Relinquish:
- Obstetrical Privileges
  - Cesarean section
  - Vaginal deliveries
- Intra-Abdominal Laser Surgery
  - Nd Yag Laser

Gabriel, Steven MD, Emergency Medicine
Reappoint to Active Staff and grant privileges as delineated.
Unsupervised to Proctor Status – (due to low activity)
- Moderate Sedation

Ghosh, Kris, MD, OB/GYN
Reappoint to Active Staff and grant privileges as delineated.
Add:
- Gynecology Privileges (Abdominal surgery)
  - Exploratory laparotomy

Relinquish:
- Intra-Abdominal Laser Surgery
  - Nd Yag Laser

Gil, Orna, MD, OB/GYN
Reappoint to Active Staff and grant privileges as delineated.
Add:
- Forensic Outpatient Site-Specific Privileges
  - Biopsy: Endometrial (F)
  - Biopsy: cervical, vulvar, vaginal (F)
  - Perform history and physical examination (includes pelvic exam and cultures) (F)

Relinquish:
- Gynecology Privileges (Abdominal surgery)
  - Pelvic lymph-node sampling
- Maternal-Fetal Medicine (Perinatology)
  - Chorionic villus sampling

Gupta, Abhay, MD, Surgery/Plastic Surgery
Reappoint to Active Staff and grant privileges as delineated.
Relinquish:
- Intermediate Hand Surgery
- Basic Burn Treatment
- Intermediate Burn Treatment

Haas, Terry A., MD, Medicine/Internal Medicine
Reappoint to Affiliate Staff, Refer and Follow only.

Hergesheimer, Charles E., MD, Medicine/Internal Medicine
Reappoint to Affiliate Staff, Refer and Follow only.

Italiano, James E., MD, Family Medicine
Reappoint to Affiliate Staff, Refer and Follow only.

Karanikkis, Christos A., DO, OB/GYN
Reappoint from Provisional to Active Staff and grant privileges as requested.

Koka, Anuradha, MD, Medicine/Radiation Oncology
Reappoint to Active Staff and grant privileges as requested.

Motadel, Kelly D., MD, Pediatrics
Reappoint to Active Staff and grant privileges as delineated.
Relinquish:

- Lumbar puncture
- Circumcision
- Intubation, Pediatric

Movahhedian, Hamid R., MD, Pediatrics/Neonatology
Reappoint to Active Staff and grant privileges as delineated.
Relinquish:

- Pneumogram interpretation

Murillo, Maria P., MD, OB/GYN
Reappoint to Active Staff and grant privileges as requested.

Nguyen, Vu H., MD, Medicine/Dermatology
Reappoint from Provisional to Active Staff and grant privileges as delineated.
Add:

- Destruction, pre-malignant and benign < 10 cm (F)

Paz, Alejandro, MD, Family Medicine/Family Medicine
Reappoint to Active Staff and grant privileges as requested.

Peel, Avanee S., MD, Radiology/Teleradiography
Reappoint to Associate Staff and grant privileges as requested.

Rogers, Christopher J., MD, Medicine/Internal Medicine
Reappoint to Consulting Staff and grant privileges as requested.

Schoellerman, Manal M., MD, Radiology/Teleradiography
Reappoint to Associate Staff and grant privileges as requested.

Shimomaye, Susan Y., MD, Medicine/Dermatology
Reappoint to Consulting Staff and grant privileges as requested.

Siddique, Nayyar, MD, Medicine/Oncology
Reappoint to Active Staff and grant privileges as requested.

Snyder, Ole W., MD, Family Medicine
Reappoint to Affiliate Staff, Refer and Follow only.

Souza, Victor L., MD, Medicine/Internal Medicine
Reappoint to Active Staff and grant privileges as delineated.
Relinquish:

- Paracenthesis
- Thoracentesis

Thuen, Eric, DPM, Surgery/Podiatric Surgery
Reappoint to Active Staff and grant privileges as requested.

Toosie, Katayoun, MD, Surgery/General Surgery
Reappoint to Active Staff and grant privileges as delineated.
Relinquish:

- Ligation of perforating veins (open or minimally invasive using laser or ablation using radiofrequency)

Viernes, Matthew E., MD, Medicine/Gastroenterology
Reappoint to Active Staff and grant privileges as requested.

Vridhachalam, Sanjeevi, MD, Radiology/Teleradiography
Reappoint to Associate Staff and grant privileges as requested.

Wadhwa, Ashish K., MD, Surgery/Otolaryngology
Reappoint to Courtesy Staff and grant privileges as delineated.
Unsupervised to Proctor Status – (due to low activity)

- Intermediate Otology
- Advanced Otology
- Intermediate Rhinologic
- Advanced Rhinologic
- Intermediate Aerodigestive Tract
- Advanced Aerodigestive Tract
- Intermediate Neck
- Advanced Neck
- Intermediate Plastic and Reconstructive Surgery of Head and Neck (Crossover)
- Advanced Plastic and Reconstructive Surgery of Head and Neck (Crossover)

Wakeman, Gregory L., DO, Family Medicine
Reappoint to Affiliate Staff, Refer and Follow only.

Wosk, Bernard, MD, Pediatrics
Reappoint to Active Staff and grant privileges as delineated.
Relinquish:

- Moderate sedation

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
August 13, 2014

Attachment B

REAPPOINTMENTS (Effective Dates: 09/01/2014 to 2/28/2015)

Luschwitz, Brian S., MD, Pediatrics
Reappoint to Active Staff and grant privileges as requested.

ALLIED HEALTH PROFESSIONALS (Effective Dates: 09/01/2014 to 08/31/2016)

Anderson, Rachel A., NP, Surgery/ Allied Health Professional
Reappoint to Allied Health Professionals and grant privileges as requested.

Cowan, John W., PAC, Surgery/ Allied Health Professional
Reappoint to Allied Health Professionals and grant privileges as requested.

Kolt, Thomas L., PA, Surgery/ Allied Health Professional
Reappoint to Allied Health Professionals and grant privileges as requested.

Lam, Christina, NP, Medicine/ Allied Health Professional
Reappoint to Allied Health Professionals and grant privileges as requested.

ALLIED HEALTH PROFESSIONALS (Effective Dates: 09/01/2014 to 2/28/2015)

Hammonds, Tommy D., PAC, Surgery/Allied Health Professional
Reappoint to Allied Health Professionals and grant privileges as requested.

RESIGNATIONS (Effective August 31, 2014, unless otherwise specified)
Voluntary:

Allen, Jennifer, PAC, Surgery/Allied Health Professional (effective 8/8/2014)
Deza, Juan C., MD, Medicine/Critical Care Medicine
Gelland, Yuri, MD, Anesthesiology/Anesthesiology
Katsiyiannis, Peter T., MD, Medicine/Cardiology
Machhor, Nedal, MD, Pediatrics/Neonatology
Mohammadi, Kourosh, MD, Surgery/Ophthalmology (effective 8/19/2014)
Ransom, Nicholas A., MD, Surgery/Orthopedic Surgery
Robertson, Edward J., MD, Surgery/General Vascular Surgery (effective 9/1/2014)
Wilson, Stephen C., MD, Surgery/General Vascular Surgery (effective 7/25/2014)

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
August 13, 2014

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS (Effective Date: 8/28/2014)

Ebersohl, Tiffany, PAC, Allied Health Professional
Add: Assist in Mazor robotic surgery

Fierer, Adam, MD, Surgery/General & Vascular Surgery
Add: Privileges as listed on new GVS privilege form; privileges have been re-categorized

Hannah, Karen, MD, Surgery/ General and Vascular Surgery
Add: Privileges as listed on new GVS privilege form; privileges have been re-categorized
Colonoscopy

Hwang, Sarah, PAC, Allied Health Professional
Relinquish: A physician assistant may also act as first or second assistant in surgery under the supervision of an approved supervising physician (effective 8/15/14)

Jamshidi-Nezhad, Mohammad, MD, Surgery/General & Vascular Surgery
Add: Privileges as listed on new GVS privilege form; privileges have been re-categorized

Rypins, Eric, MD, Surgery/General & Vascular Surgery
Add: Privileges as listed on new GVS privilege form; privileges have been re-categorized

Sorkhi, Ramin, MD, Surgery/General & Vascular Surgery
Add: Privileges as listed on new GVS privilege form; privileges have been re-categorized

Terramani, Thomas, MD, Surgery/General & Vascular Surgery
Add: Retroperitoneal approach for Anterior Lumbar Interbody Fusion (ALIF)

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
August 13, 2014

Attachment B

PROCTORING RECOMMENDATIONS (Effective 8/28/14, unless otherwise specified)

Amin, Arti, MD, Anesthesiology
Release from specific proctoring: General anesthesia

Carlton, Vivian, PAC, Allied Health Professional/Emergency Medicine
Release from specific proctoring: Thoracentesis & paracentesis

Gray, Jonathan, MD, Anesthesiology
Release from specific proctoring: General anesthesia
Regional anesthesia

Gunta, Sujana, MD, Pediatrics
Release from specific proctoring: Newborn care level 1 and level 2

Hudson, Henry, MD, Surgery/Ophthalmology
Release from all proctoring: 100% Complete

Kneass, Zachary, MD, Otolaryngology/Surgery
Release from specific proctoring: History and physical examination
Intermediate neck category
CO_2 laser

Liou, Melinda, PAC, Allied Health Professional/Emergency Medicine
Release from specific proctoring: Thoracentesis and paracentesis

Olson, Lindsey, PAC, Allied Health Professional/Emergency Medicine
Release from specific proctoring: Central IV access
Repair of complex lacerations

Paz, Pedro, MD, Pediatrics/Neonatology
Release from specific proctoring: Admit patients
Non-Invasive Procedures category
Invasive Procedures category
Moderate sedation

Pregerson, Heather, PAC, Imaging
Release from specific proctoring: Moderate sedation

Theisen, April, PAC, Allied Health Professional/Emergency Medicine
Release from specific proctoring: Lumbar puncture
Repair of complex lacerations

Uher, Romana, MD, Pediatrics/Neonatology
Release from specific proctoring: Admit patients

Medical Staff Office
Tri-City Medical Center
4002 Vista Way, Oceanside, CA 92056-4506 • (760) 940-3001

TO: Larry Schallock, Chairperson

FROM: Scott Worman, M.D., Chief of Staff

DATE: August 28, 2014

SUBJECT: Medical Executive Committee Recommendations

The following documents were reviewed and approved by the Medical Executive Committee on August 25, 2014. These documents are forwarded to the Board of Directors with recommendations for approval.

Department/Divisions Rules & Regulations:

1. Department of Emergency Medicine: Delegation of Services Agreement Modification pg. 1
2. Department of Surgery Rules & Regulations Modification pg. 2

The above recommendations are presented to the Board of Directors for final review and disposition.

SUBMITTED BY:

_____ _____
Scott Worman, M.D., Chief of Staff Date

GOVERNING BOARD DISPOSITION:

Approved: ☐
Denied: ☐

_____ _____
Julie Nygaard, Secretary Date
For and on behalf of the TCHD Board of Directors

Tri-City Medical Center

MEMO

TO: **Credentials Committee**

FROM: **Department of Emergency Medicine**

DATE: August 12, 2014

SUBJECT: **Delegation of Services Agreement Modification – Midline Catheters**

Central IV Access, includes Midline Catheters
Physician Assistants: Must have ultrasound privileges in accordance with TCMC Medical Staff policy #8710-522 to be eligible for these privileges in a non-assist only role. All new physician assistants applying for this privilege due to their training will have their first three (3) central IV/midline catheter cases proctored by the Supervising Physician. Thereafter, the Supervisory Physician must be physically present in the Emergency Department before midline catheter placement and Central IV Access could be carried out.

Approved:
Department of Emergency Medicine: 7/30/14
Interdisciplinary Practice Committee: 8/18/14
Credentials Committee: 8/13/14
Medical Executive Committee:
Board of Directors:

4002 VISTA WAY, OCEANSIDE, CA 92056
Phone: 760-940-3001 Fax: 760-940-3299

Tri-City Medical Center

Medical Staff

MEMO

TO: **Medical Executive Committee**

FROM: Department of Surgery

DATE: **August 25, 2014**

SUBJECT: **Surgery Department Rules and Regulations Modification**

The Department of Surgery, on the recommendation of the Division of Cardiothoracic Surgery, recommends approval of the modifications to the Surgery Department Rules and Regulations as follows:

Physician Assistant

- A physician assistant may also act as first or second assistant in surgery, under the supervision of an approved supervising physician, **including acting as a second assist during cardiac procedures using cardiopulmonary bypass**.

- **Perform open harvesting of saphenous vein for use as bypass conduit for cardiac and vascular surgery under the direct supervision of surgeon (no separate proctoring required).**

ADDITIONAL PRIVILEGES

Requests for additional privileges must be accompanied by documentation of training and/or experience. Proctoring is required for all additional privileges and will be determined by the Department/Division Chair/Chief.

- Harvesting of saphenous vein for use as bypass conduit for cardiac and vascular surgery using ~~**both open and**~~ endoscopic techniques. This privilege requires approval of Cardiothoracic Surgery Division.

- ~~**Second assisting during cardiac procedures using cardiopulmonary bypass.**~~

Approved:
Division of Cardiothoracic Surgery: 8/14/14
IDPC:
Department of Surgery:
Medical Executive Committee:
Board of Directors:

4002 VISTA WAY, OCEANSIDE, CA 92056
Phone: 760-940-3001 Fax: 760-940-3299

TRI-CITY MEDICAL CENTER
HUMAN RESOURCES COMMITTEE
OF THE BOARD OF DIRECTORS
August 12, 2014

Voting Members Present:	Chair Cyril Kellett, Director Rosemarie Reno, Director James Dagostino , Salvador Pilar, Virginia Carson, Dr. Hamid Movahedian, Dr. Martin Nielsen
Non-Voting Members Present:	Tim Moran, CEO; Sharon Schultz, CNE/CCO; Esther Beverly, VP of HR; Daniel Kanter, Esq.
Others Present:	Frances Carbajal
Members Absent:	Dr. Gene Ma, Henry Holloway, Sydelle Gale

Topic	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	Chair Kellett called the meeting to order at 12:35 p.m.		Chair Kellett
2. Approval of the agenda	Chair Kellett called for a motion to approve the agenda of August 12, 2014 meeting. Director Reno moved and Director Dagostino seconded the motion. The motion was carried unanimously.		Chair Kellett
3. Comments from members of the public	Chair Kellett read the paragraph regarding comments from members of the public.		Chair Kellett
4. Ratification of Minutes	Chair Kellett called for a motion to approve the minutes of the July 8, 2014 meeting. Director Dagostino moved and Director Reno seconded the motion. The motion was carried unanimously.		Chair Kellett

Topic	Discussion	Action Follow-up	Person(s) Responsible
5. Old Business			
NONE	Dr. Kellett briefed the committee on the quarterly results and highlights from the Employee Fiduciary Retirement Plan Subcommittee.		Chair Kellett
6. New Business			
a. B.O.D Dashboard- Stakeholder Experience	The Stakeholder Experience pillar- Employee Satisfaction rates were reviewed & discussed.	Nationally California accredited numbers and benchmarks to be made more visible, specific hospitals in North County to be compared and to be listed next to our results vs. on top.	Chair Kellett
b. Policy Discussion/Action Policy 8610-432 Employee Transfers Policy 8610-448 Reduction in Force	The Committee reviewed Policy 8610-432 and agreed to the proposed revisions. Chair Kellett called for a motion to send Policy 8610-479 with suggested amendments to the Board of Directors for approval. Director Reno moved and Director Dagostino seconded the motion. The motion was carried unanimously. The Committee reviewed Policy 8610-448 and agreed to the proposed revisions. Chair Kellett called for a motion to send Policy 8610-479 with suggested amendments to the Board of Directors for approval. Director Dagostino moved and Ginny Carson seconded the motion. The motion was carried unanimously.	Policy 8610-432 to be reviewed and approved by the 2 unions then sent to Board of Directors for approval. Policy 8610-448 to be reviewed and approved by the 2 unions then sent to Board of Directors for approval.	Esther Beverly
7. Work Plan	The work plan was reviewed.		Chair Kellett
8. Committee Communications	None		Chair Kellett
9. Date of next meeting	**September 9, 2014**		Chair Kellett
10. Adjournment	Chair Kellett adjourned the meeting at 2:00 p.m.		Chair Kellett

TRI-CITY MEDICAL CENTER
EMPLOYEE FIDUCIARY RETIREMENT PLAN SUB COMMITTEE
OF THE BOARD OF DIRECTORS
August 12, 2014

Voting Members Present:	Chair Dr. Cyril Kellett, Director Dr. James Dagostino
Non-Voting Members Present:	Tim Moran, CEO; Esther Beverly, VP of HR; Daniel Kanter, Esq.
Others Present:	Marilyn Hatch, Maureen Peer, Dene Baker, Scott Simon, Gary Allen, Frances Carbajal
Members Absent:	Sydelle Gale, Henry Holloway

Topic	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	Chair Kellett called the meeting to order at 11:00 a.m.		Chair Kellett
2. Approval of Agenda	Chair Kellett called for a motion to approve the meeting agenda. Due to insufficient quorum the motion was not approved.	August 12th agenda to be approved at the December 9th meeting.	Chair Kellett
3. Comments by members of the public on any item of interest to the public before Committee's consideration of the item	Chair Kellett read the paragraph regarding comments from members of the public.	No public comments	Chair Kellett
4. Ratification of Minutes	Chair Kellett called for a motion to approve the minutes of the April 8 meeting. Due to insufficient quorum the motion was not approved.	April 8th minutes to go be approved at the December 9th meeting.	Chair Kellet

Topic	Discussion	Action Follow-up	rson(s) Responsible
5. **Old Business**			
None			
6. **New Business**			
a. Lincoln Quarterly Update	Maureen Peer, Lincoln Relationship Manager updated the committee on the current Lincoln team serving TCHD. Maureen summarized second quarter results: plan assets, contributions, earnings, participation rates, average deferral rates and account balances. Maureen also presented Lincolns available communication and education for plan participants.		Esther Beverly
b. Prudent Quarterly Update	Gary Allen, Prudent Investment Advisor presented the second quarter plan growth results. Gary explained the benefits in the highly diversified model portfolios to minimize the potential negative short term impact that anyone may have on a participant portfolio due to the always unknown stock market results. Dene Baker from Prudent summarized the employee level participation. Dene described highlights and the growing enrollment, participation rate and great communication and relationship between TCHD employees and investment advisors. Dene would like to see more of the younger employees participate.	Model Names on the statements is a goal for Prudent.	Esther Beverly
7. Comments made from the Committee	None		Chair Kellett

Topic	Discussion	Action Follow-up	son(s) Responsible
8. Date of next meeting	**December 9, 2014**		Chair Kellett
9. Adjournment	Chair Kellett adjourned the meeting at 12:30 p.m.		Chair Kellett

19 (4) C.

Community Healthcare & Alliance Committee
(No meeting held in August, 2014)

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
August 19, 2014

Members Present	Dr. James Dagostino, Director Kellett, M.D., Director Paul Campo Robert Knezek, Irwin Schenker, Kathleen Mendez, Dr. Frank Corona, William McGaughey, Steve Harrington, Dr. Kroener
Non-Voting Members:	Tim Moran, CEO, Casey Fatch, COO, Steve Dietlin, CFO, Matt Mushet, Legal Affairs, Wayne Knight, Sr. VP, Medical Services
Others Present:	Director RoseMarie Reno, Linda Cline, Carol Smyth, Sharon Schultz, Charlene Carty. Jane Dunmeyer David Bennett, Mr. Gould, Ray Rivas, Glen Newhart, Francisco Valle Steve Young, Kathy Topp, Mary Diamond, Kimberly Cook, Daniel Martinez, Jeremy Raimo Chris Miechowski
Absent:	Dr. Contardo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Dagostino called the meeting to order 12:35 pm.		
2. Approval of Agenda	Director Dagostino announced that Item P (OB/GYN) was being pulled.	**MOTION** **It was moved by William McGaughey, Director Kellett, seconded and was unanimously approved, that the agenda of August 19, 2014 be approved as changed.**	
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Dagostino read the paragraph regarding comments from members of the public.		Director Dagostir

19 (4) D.

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
4. Ratification of minutes of July 22, 2014		Minutes ratified **MOTION** **It was moved by Director Campo, Bill McGaughey seconded and was approved with Director Dagostino abstaining that the minutes of July 22, 2014 be approved as written.**	
5. Old Business	None		
6. For Information only	None		
7 a. Neuroscience Institute Committee Physician Agreements	Discussion ensued and there were some legal clarifications that were needed. This item was pulled	**MOTION-1** **Director Campo moved, Bill McGaughey seconded and it was unanimously approved that the Finance, Operations and Planning committee recommend to the TCHD Board of Directors find it in the best interest of the public health of the communities served by the District to approve an expenditure for the Neuroscience Institute Committee Agreements for a 12-month term, beginning 8/1/14 and ending 7/31/15, at the amount not to exceed $30,240, with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval.** **MOTION -2** **Director Campo moved, Bill McGaughey seconded and it was unanimously approved to reconsider the original motion and pull the item from the agenda for further legal review.**	Wayne Knight

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
b. Orthopedic & Spine and Institute Committee Physician Agreements	Discussion ensued and there were some legal clarifications that were needed. This item was pulled. One of the Community members stressed the fact that he was very upset that the items come to Committee and are discussed and voted on, but then they are not considered.	**MOTION-1** **Director Campo moved, Director Kellett seconded and it was unanimously approved that the Finance, Operations and Planning Committee recommend to the TCHD Board of Directors.** **find it in the best interest of the public health of the communities served by the District to approve an expenditure for the Orthopedic & Spine Institute Committee Agreements for a 12-month term, beginning 8/1/14 and ending 7/31/15, at the amount not to exceed $22,560, with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval.** **MOTION-2** **Director Campo moved, Bill McGaughey seconded and it was unanimously approved to reconsider the original motion and pull the item from the agenda for further legal review.**	Wayne Knight

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
c. API Healthcare Corporation-ShiftSelect Proposal	Kathy Topp explained this is a staffing and scheduling system which is very user friendly. It will enable us to reduce TCMC overtime usage/premium labor costs. Medical Staff/Physicians can use this for scheduling. There is 24/7/365 support and ShiftSelect support office is 30 minutes from TCMC,	**MOTION** **Director Campo moved, Irwin Schenker seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize the Agreement with API Healthcare Corp for ShiftSelect Scheduling System for a term of 36 months starting 9/1/14 and ending on 8/31/17, for an annual (12 month) amount of $108,000, interface fee of $16,000 and a total expense for the term of $340,000.**	Kathy Topp
d. Rady's Children Hospital Newborn Hearing Screening-Renewal	Mary Diamond stated this is an annual renewal. Rady's will provide: • Up to date state guidelines for Newborn Screening and Program Certification. • Training for staff. • Policy and Procedure review. • Email/telephone/onsite support as requested. This is not to exceed 8 hours per month	**MOTION** **Director Kellett moved, Director Campo seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize the Agreement with Rady Children's Hospital for a term of 12 months starting September 1, 2014 and ending on August 31, 2015 at $175 per hour, not to exceed 8 hours per month, for a monthly amount of $1,400 and a total expense for the Term of $16,800.**	Mary Diamond
e. Manish Sheth, MD Medical Director Agreement for Inpatient BHU Services	Joy Melhado stated that this is a renewal with no change to rate. This agreement was previously shared with Dr. Melden. Dr. Sheth will now be the sole Director of Inpatient BHU.	**MOTION** **Director Campo moved, Dr. Corona seconded and it was unanimously approved that Finance Operations and Planning Committee recommend that**	Joy Melhado

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		TCHD Board of Directors authorize Dr. Manish Sheth as Medical Director for a term of 12 months starting July 1, 2014, ending June 30, 2015, not to exceed 80 hours per month at an hourly rate of $125 for an annual amount of $120,000.	
f. 3 Media Contracts - Midwest Television (CBS - NBC -UT-San Diego	Discussion ensued whether we would discuss these three agreements at the same time or one at a time. The Committee made the decision to have them presented and explained at once and we would have three separate motions to identify each. David Bennett presented the three agreements with CBS, NBC and UT-San Diego. David Bennett explained this is the first time the Committee has ever seen these agreements, as in previous years they were within the signature approval of the CEO • These are shown County wide. • NBC and CBS are television advertisements • UT-San Diego is the newspaper.	**MOTION-Miidwest (CBS)** **Director Campo moved, Bill McGaughey seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize the Agreement with MIDWEST TELEVISION for a term of 12 months starting 07/01/2014 and ending on 06/30/2015, for a monthly amount not to exceed $24,998.50 and a total expense for the term of $299,982.** **MOTION-NBCOT's** **Director Campo moved, Bill McGaughey seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize the Agreement with NBCOTS for a term of 12 months starting 07/01/2014 and ending on 06/30/2015, for a monthly amount not to exceed $20,900 and a total expense for the term of $250,800.** **MOTION-UT-San Diego** **Director Campo moved, Bill McGaughey seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize the Agreement with UT-SAN**	David Bennett

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		DIEGO for a term of 12 months starting 07/01/2014 and ending on 06/30/2015, for a monthly amount not to exceed $24,300 and a total expense for the term of $291,600.	
g. Nielsen Construction California, Inc. (Primary Care Physicians Clinic)	Discussion ensued by Committee and several questions were asked by Director Campo and Bill McGaughey regarding the price increase/the bidding process and the use of the contractors. After a long discussion it was decided there were a number of questions that still needed to be answered so the decision was made by the committee to pull this item. Additional discussion ensued regarding a more equitable allocation of funds used for construction costs between Tri-City Medical Center and Physicians. Casey Fatch will discuss this with the physicians to make this and future projects more financially equal.	**MOTION-1** **Director Campo moved, Director Kellett seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize the Agreement with Nielsen Construction California, Inc. for a term of 6 months starting September 1, 2014 and ending on February 28, 2015 for an amount not to exceed $967,253, in addition to procurement of goods and services to complete the project in an amount not to exceed $125,400 for a total project amount not to exceed $1,092,653 of which TCHD portion of the costs shall not exceed $844,653.** **MOTION-2** **Irwin Schneker moved, Director Campo seconded and it was unanimously approved that this item be pulled from the agenda or further legal review.**	Jeremy Raimo/Wayne Knight
h. Celtic Leasing Corp. Capital Lease Financing	Charlene Carty explained we are requesting to enter into a $5,000,000 Capital Equipment Financing Agreement with Celtic Leasing Corp to fund capital equipment purchases for Tri-City Medical Center.	**MOTION** **Director Campo moved, Dr. Corona seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize entering into a lease**	Charlene Carty

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Acquisition of capital equipment is subject to authorization in accordance with TCHD policies and procedures. The FY 2015 Budget includes $14.6 million of capital purchases, of which $6.5 million was budgeted to be purchase through financing agreements	**facility with Celtic Financing Corp for a principal amount not to exceed $5,000,000 with a capital lease term of 60 months, at a maximum interest cost of less than $593,000 over the term of the lease.**	
I Bank of the West-Lease Financing	Steve Dietlin explained we are requesting to enter into a $2,500,000 Capital Equipment Financing agreement with Bank of the West to fund capital equipment purchases for Tri-City Medical Center. Acquisition of capital equipment is subject to authorization in accordance with TCHD policies and procedures. The FY2015 Budget includes $14.6 million of capital purchases, of which $6.5 million was budgeted to be purchased through financing agreements.	**MOTION** **Director Kellett moved, Director Campo seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize entering into a lease facility with Bank of the West for a principal amount not to exceed $2,500,000 with a capital lease term of 36 months, at a maximum interest cost of less than $178,000 over the term of the lease.**	Steve Dietlin
j. Lease Medical Office Space 2067 W. Vista Way-AmeriCare Medical Properties-OB/GYN Practice	Jeremy Raimo explained this property is about two blocks away. TCHD will be placing the OBGYN doctor in the smaller location until the renovations are completed on the larger unit at which time that physician will move to the larger	**MOTION** **Dr. Corona moved, Dr. Kroener seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize the lease of Medical Office**	Jeremy Raimo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	unit and will share with another physician.	**Suites located at 2067 W. Vista Way (Suite 160 for a term of 4 months) (Suite 225 for a term of 20 months) starting October 1, 2014 and ending on December 31, 2016, for a total of the Term of $298,600.**	
k. Beckman Coulter Agreement	Steve Young explained this is a new agreement to replace a 7 year old instrumentation in the chemistry section. This is a 60-month cost per test agreement. The net result of this agreement is to replace two DXC 800 General Chemistry Analyzers, one DXI Immunochemistry Analyzer and one Access Immunochemistry analyzer with the DXC 660i and DXI 600 at the current annual spend. • This price is based on VHA pricing • It is an integrated platform meaning it can test all chemistries (general and immune) on a single sample. • It can perform Autoverification • Can be upgraded to full automation • Critical and positive results prioritization	**MOTION** **Director Campo moved, Director Kellett seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize the Agreement with Beckman Coulter for a term of 60 months starting October 1, 2014 and ending on September 30, 2019. For an annual (12 month) amount of $ 428,713 and a total expense for the Term of $2,143,565.**	Steve Young
l. Vista Community Clinic	Wayne Knight presented the Vista Community Clinic. This used to be done as a donation, but this	**MOTION** **Dr. Corona moved, Director Campo seconded and it was approved that**	Wayne Knight

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	year was transferred over to an operational expense, which will also provide a performance matrix. This helps with unfunded patients. When an unfunded patient comes to Tri-City Medical Center and we release them and transfer them into the care of Vista Community Clinic, it enables these patients to get care on an ongoing basis and stops the constant flow back to the Emergency Rm. Our plan is to have all of the Program Objectives completed by June 30, 2015. This $100,000 expense will be funded monthly. The program will be closely monitored to be sure that the patients are getting continued care.	**Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize Directors authorize the Agreement with Vista Community Clinic for a term of 12 months starting August 1, 2014 and ending on July 30, 2015, for an annual (12 month) amount of $100,000 and a total expense for the term of $100,000.**	
m. Physician Agreement for ED Coverage Addition to Panel Agreement-Sunil Jeswani, M.D.	Donna Dempster stated this is to place an additional physician on the ED Coverage Panel. There is no extra expense or change. The question was posed as to whether each time we add a new physician to the panel it had to come back through FOB Committee. The answer from Director Campo was yes the Committee and Board needs to be made aware of new doctors on the Panels.	**MOTION** **Director Campo moved, Director Kellett seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize approve the addition of Sunil Jeswani, MD to the current Neurosurgery and Spine ED On-Call Coverage Agreements at the current approved rates of $800 (Neurosurgery)/24-hour period and $400 (Spine)/24-hour period, for a term of 22 months starting September 1, 2014, ending on June 30, 2016, for a total not to exceed $114,000.**	Donna Dempster

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
n. ED Call-General Surgeons	Donna Dempster explained this was previously approved at the July Board meeting for a start date of August, 2014. However, the doctors have been doing the ED on-Call since July 2014, therefore, the contract needed to be corrected.	**MOTION** **Director Campo moved, Dr. Corona seconded, and it was approved with Dr. Kroener abstaining that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize approve the renewal of the General Surgery ED On-Call Agreement for a term of 24 months starting on the revised effective date of July 1, 2014, ending on June 30, 2016 at the previously approved rate of $1,400 per 24-hour shift and reimbursement at Medicare rates for unfunded cholecystectomy cases at $725.00, for a revised total amount not to exceed $1,075,591.**	Donna Dempster
o. Cerner RHO Agreement	Dan Martinez and Kim Cook presented this stating the existing Cerner RHO contract expires on March 31, 2016. Cerner Millennium is our core hospital system which was installed in 2004. The system is monitored 24/7/365, which supports our 99.9% system uptime and availability. The benefit of negotiating a 4 year extension of our existing contract will result in a cost savings of our current term (19 months remaining) of approximately $2.9 million dollars.	**MOTION** **Director Kellett moved, Dr. Corona seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize the Agreement with Cerner Corporation for the renewal of Subscription and Hosting Services for a term of 67 months starting September 1, 2014 and ending on March 31, 2020, not to exceed an annual amount of $ 4.0 million and a total expense for the term of $22.3 million.**	Dan Martinez/Kim Cook

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Some additional benefits would be: • Co-terminus extensions of current subscriptions at reduced costs • CPI Index savings • New applications If TCMC decided to go to a different company, it would not be cost or time effective, as we are so well established with Cerner and it would slow down our process substantially.		
p. OB/GYN	Director Campo left at 2:20	**This item was pulled**	Casey Fatch
q. Financials-July 2014	Steve Dietlin gave the presentation on the financials ending July 30, 2014..(dollars in thousands) **Month to Date** Gross Revenue $ 118,027 Operating Revenue $ 27,600 Operating Expense $ 27,537 EROE $ 368 EBITDA $ 1,761 Other areas covered were: • Key Indictors-YTD • AR Receivable/Net A/R Days • Surgery IP Cases • Surgery OP Cases • Deliveries • ED Visits • TCMC Patients Receivable & Net A/R Days by FY		Steve Dietlin

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Graphs: • Net Days in Accounts Receivable • Average Daily Census • Adjusted Patient Days • Paid Full time Equivalents • Emergency Department Visits • EROE and EBITDA		
r. Work plan -Studer (quarterly) -Dashboard for 10 main Management indicators-Update Accountable Care Organization (ACO-Semi-Annual-Update)	A review of the items was completed and questions were answered.		
8. Comments by Committee Members.			Chair
9. Date of next meeting.	September 16, 2014		Chair
10. Community Openings.	Director Dagostino thanked Mr. Schenker for his dedication and hard work.	**It was announced by Director Dagostino that September would be the last meeting for Irwin Schneker. Linda Cline to ask Teri Donnellan to put an advertisement in the paper.**	Chair
11. Oral Announcement of items to be discussed during closes session (Government Code Section 54957.7)			
12. Motion to go into Closed Session a. Report Involving Trade Secrets, (Authority: Health and Safety Code Section		**Director Kellett moved, Dr. Corona seconded and it was unanimously approved to go into closed session at 2:40.**	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
32106) Discussion will concern proposed new service or program (One Item)			
13. Motion to go into Open Session		**Director Kellett moved, Bill McGaughey seconded and it was unanimously approved to go into closed session at 3:14**	
14. Open Session			
15. Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)			
11. Adjournment.	Meeting adjourned 3:15 pm.		

19 (4) D.a)

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 19, 2014
Proposal for: Agreement with API Healthcare Corporation for ShiftSelect Scheduling Solution Web Based

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

Vendor Name: API Healthcare Corporation – ShiftSelect

Area of Service/Dept: Bed Control Staffing/8722

Term of Agreement: 36 months Beg.: 9/1/2014 end: 8/31/2017

Maximum Annual Total: $108,000, with one time interface fee of $16,000 Total for Term: $340,000

Annual Amount	36 month (Term)Cost	Interface Fee	Total Term Cost
$108,000	$324,000	$16,000	$340,000

Description of Services/Supplies:

- User-friendly solution that can be implemented in 16 weeks.
- Need to reduce OT usage/premium labor costs. Provides OT data for managers so they can see projected OT a staff member may have at end of week so they can make the best decision on who to schedule and avoid OT all together.
- True bi-directional integration with Kronos so schedules from ShiftSelect are compared to actual time worked for each employee and incremental OT is made visible to managers.
- Medical Staff/Physicians can use for scheduling. Reports available for Medical Staff/ED Call Schedule so they can generate invoice and know what to reimburse physicians.
- Notifications can be sent to staff for last minute needs via emails, text & phone. Reduce Manager time filling open shifts and making manual calls.
- Can track travelers and registry staff and generate reports for billing purposes.
- No software to download or additional hardware to purchase. On-going maintenance and upgrades to ShiftSelect provided at no additional charge.
- 24/7/365 support and ShiftSelect support office is 30 minutes from TCMC.

Concept Submitted to Legal:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Sharon Schultz ,Chief Nurse Executive/Kathy Topp, Director Education & Clinical Informatics

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Agreement with API Healthcare Corp for ShiftSelect Scheduling System for a term of 36 months starting 9/1/14 and ending on 8/31/17, for an annual (12 month) amount of $108,000, interface fee of $16,000 and a total expense for the term of $340,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 19, 2014
Proposal for: Agreement with Rady Children's Hospital

Type of Agreement		Medical Directors		Panel	X	Other: Consulting
Status of Agreement		New Agreement	X	Renewal		

Vendor Name: Rady Children's Hospital San Diego

Area of Service/Dept: Women's and Newborn Services

Term of Agreement: 12 months (Beg: September 1, 2014 End: August 31, 2015)

Maximum Monthly Total $1,400 Total for Term (One Year) : $16,800

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$175	8 hrs.	96	$1,400	$16,800	$16,800

Description of Services/Supplies:

- Provide information regarding state guidelines for Newborn Screening testing and Program Certification
- Training for staff as requested
- Newborn Hearing Screening Policy/Procedure Review
- Information/Education as needed for referrals for additional testing, including Brainstem Evoked Response, Otoacoustic Emission, Tympanometry
- Email/telephone/onsite support as requested
- Not to exceed 8 hours per month

Concept Submitted to Legal:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive/Mary Diamond, Sr. Director Nursing

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Agreement with Rady Children's Hospital for a term of 12 months starting September 1, 2014 and ending on August 31, 2015 at $175 per hour, not to exceed 8 hours per month, for a monthly amount of $1,400 and a total expense for the Term of $16,800.

ADVANCED HEALTH CARE FOR YOU

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 19, 2014
PHYSICIAN AGREEMENT for Dr. Manish Sheth

Type of Agreement	X	Medical Directors		Panel
Status of Agreement		New Agreement	X	Renewal

Physician Name: Manish Sheth, MD

Area of Service: Inpatient Behavioral Health Unit

Term of Agreement: 12 months (begin: July 1, 2014, end: June 30, 2015)

Total Expense:

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$125	80	960	$10,000	$120,000	$120,000

The Medical Directorship role was previously shared between Drs. Sheth and Melden.
Dr. Sheth is now the sole Medical Director for IP Behavioral Health with no change in total cost.

Position Responsibilities:

- Provide professional guidance and oversight for the Inpatient Behavioral Health Services Department including Medical floor and Emergency Department Psychiatric consultation services
- Provide supervision for the clinical operation of the Department and programs;
- Attend treatment team meetings, two days per week. Assistant Nurse Manager will coordinate treatment team meeting times;
- Perform ED rounds on 6 out of 7 days;
- Attend to psychiatric consults in M/S unit when NP/PL unable to attend to psych consults;
- Monitor bed utilization to less than or equal to a 5-6 day length of stay;
- Provide staff education to improve outcome of care;
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Initiate at least four (4) Department meetings with Physicians, Psychiatric Liaisons, and Nursing Leadership per year;
- Ensure that services provided are in compliance with regulatory standards;
- Timely communication with primary care physicians and/or other community health resources;
- Documentation-full and timely documentation for all patients. Comply with all legal, regulatory, accreditation, Hospital-Based Inpatient Psychiatric Care (HBOPS) core measures, Medical Staff and billing criteria, including applying Medicare guidelines Including Title IX/or Interqual criteria to admission and discharge decisions.
- Utilization Review, Quality Improvement- actively participate in Hospital's and Medical Staff's utilization review, quality, performance improvement and risk programs
- Respond to insurance authorization calls, doc-to-doc reviews, and appeals with guidance of BHU UR staff;
- Physician shall maintain time sheets of hours worked, and submit signed sheets at end of each month to Department Manager for review

Concept Submitted to Legal:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive/Joy Melhado, Clinical Nurse Educator-BHU

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Manish Sheth as Medic Director for a term of 12 months starting July 1, 2014, ending June 30, 2015, not to exceed 80 hours per month at an hourly rate of $125 for an annual amount of $120,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 19, 2014
Proposal for: Agreement with Midwest Television, Inc.

Type of Agreement		Medical Directors		Panel	X	Other: TV Advertising
Status of Agreement	X	New Agreement		Renewal		

Vendor Name: MIDWEST TELEVISION

Area of Service/Dept: Marketing/Marketing, Communications, and Public Affairs

Term of Agreement: 12 months (Beg.: 07/01/2014 end: 06/30/2015)

Maximum Monthly Total: $24,998.50 **Total for Term:** $ 299,982

Description of Services/Supplies:

- MIDWEST TELEVISION shall provide Tri-City Medical Center (TCMC) the use of advertising spots to be telecast on CBS8 and to be aired on KFMB Radio Station from July 1, 2014 to June 30, 2015 on specific dates, time of the day, and programs as ordered by TCMC.
- MIDWEST TELEVISION shall charge TCMC a net amount for each spot calculated at a 15% discount of CBS8 and KFBM Radio Station's rate cards.
- MIDWEST TELEVISION through its CBS8 and KFBM Radio Station and TCMC will agree on the dates, times and programs to air TCMC's TV commercials and the number of times to run the commercials at a monthly cost not to exceed $24,998.50 net per month.
- MIDWEST TELEVISION CBS8 will provide to TCMC a Sports Sponsorship title on its Monday to Sunday 6:30 to 7:00 PM news.
- MIDWEST TELEVISION through CBS8 its local TV station and KFMB its local radio station will produce for TCMC up to two premium billboards and TV & radio commercials.
- MIDWEST TELEVISION through CBS8 its local TV station and KFMB its local radio station will provide to TCMC additional bonus advertising either broadcast, radio or online at no extra cost to TCMC.

Concept Submitted to Legal:	x	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Chief Marketing Officer David Bennett

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Agreement with MIDWEST TELEVISION for a term of 12 months starting 07/01/2014 and ending on 06/30/2015, for a monthly amount not to exceed $24,998.50 and a total expense for the term of $299,982.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 19, 2014
Proposal for: Agreement with NBC Owned Television Stations ("NBCOTS").

Type of Agreement		Medical Directors		Panel	X	Other: TV Advertising
Status of Agreement	X	New Agreement		Renewal		

Vendor Name: NBC Owned Television Stations ("NBCOTS")

Area of Service/Dept: Marketing/Marketing, Communications, and Public Affairs

Term of Agreement: 12 months (Beg.: 07/01/2014 end: 06/30/2015)

Maximum Monthly Total: $ 20,900 **Total for Term:** $ 250,800

Description of Services/Supplies:

- NBCOTS shall provide Tri-City Medical Center (TCMC) the use of advertising spots to be telecast on NBC7 from July 1, 2014 to June 30, 2015 on specific dates, time of the day, and programs as ordered by TCMC.
- NBCOTS shall charge TCMC a net amount for each spot calculated at a 15% discount of NBCOTS' rate card for NBC7.
- NBCOTS and TCMC will agree on the dates, times and programs to air TCMC's TV commercials and the number of times to run the commercials at a monthly cost not to exceed $20,900 net per month.
- NCBCOTS will provide to TCMC a monthly online delivery of at least 120,000 online impressions on NBC7.com. The cost for this service is included in the monthly cost.
- NBCOTS through NBC7 its local TV station will produce for TCMC up to two premium commercials at no charge.
- NBCOTS through NBC7 will provide to TCMC additional bonus advertising either broadcast or online at no extra cost to TCMC.

Concept Submitted to Legal:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Chief Marketing Officer David Bennett

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Agreement with NBCOTS for a term of 12 months starting 07/01/2014 and ending on 06/30/2015, for a monthly amount not to exceed $20,900 and a total expense for the term of $250,800.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 19, 2014
Proposal for: Agreement with UT-San Diego

Type of Agreement		Medical Directors		Panel	X	Other: Newspaper Advertising
Status of Agreement	X	New Agreement		Renewal		

Vendor Name: UT-San Diego ("UT-SAN DIEGO")

Area of Service/Dept: Marketing/Marketing, Communications, and Public Affairs

Term of Agreement: 12 months (Beg.: 07/01/2014 end: 06/30/2015)

Maximum Monthly Total: $ 24,300 **Total for Term**: (one year): $291,600

Description of Services/Supplies:

- UT-SAN DIEGO shall provide Tri-City Medical Center (TCMC) the use of advertising space on UT-SANDIEGO's newspapers from July 1, 2014 to June 30, 2015 on specific dates, time of the day, and programs as ordered by TCMC.
- UT-SAN DIEGO shall charge TCMC a net monthly amount of $24,300.
- UT-SAN DIEGO and TCMC will agree on the dates to publish TCMC's newspaper ads and the sizes and number of times to run the commercials at a monthly cost not to exceed $24,300 net per month (5 Full pages on Sunday's Main News Section and 2 Half Pages on the Health Section).
- UT-SAN DIEGO will provide to TCMC a monthly digital campaign including UTSANDIEGO.com and a monthly e-blast campaign to at least 50,000 e-mail addresses. The cost for this service is included in the monthly cost.
- UT-SAN DIEGO will produce for TCMC the ads for the digital campaigns at no charge.
- UT-SAN DIEGO will provide to TCMC additional bonus advertising either print or online at no extra cost to TCMC.

Concept Submitted to Legal:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Chief Marketing Officer David Bennett

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Agreement with UT-SAN DIEGO for a term of 12 months starting 07/01/2014 and ending on 06/30/2015, for a monthly amount not to exceed $24,300 and a total expense for the term of $291,600.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 19, 2014
Proposal for: Agreement with Celtic Leasing Corp.

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

Vendor Name: Celtic Leasing Corp.
Area of Service: Finance
Term of Agreement: 5 year financing term
Maximum Totals:

Current Interest Rate Range *	60 month (Term) Interest cost if fully drawn
3.74% - 4.50%	$490,000 - $593,000

Description of Services:

Request to enter into a $5,000,000 Capital Equipment Financing agreement with Celtic Leasing Corp to fund capital equipment purchases for Tri-City Medical Center.

Acquisition of capital equipment is subject to authorization in accordance with TCHD policies and procedures.

The FY 2015 Budget includes $14.6 million of capital purchases, of which $6.5 million was budgeted to be purchased through financing agreements.

*Interest rate is subject to a one-time adjustment for each schedule of equipment, as the funding for each schedule is completed. The current quoted rate is 3.74%.

Concept Submitted to Legal:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Steve Dietlin, Chief Financial Officer/Charlene Carty, Director of Finance

Motion:

I move the Finance Operations and Planning Committee recommend TCHD Board of Directors authorize entering into a lease facility with Celtic Financing Corp for a principal amount not to exceed $5,000,000 with a capital lease term of 60 months, at a maximum interest cost of less than $593,000 over the term of the lease.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 19, 2014
Proposal for: Agreement with Bank of the West

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

Vendor Name: Bank of the West
Area of Service: Finance
Term of Agreement: 3 year financing term
Maximum Totals:

Current Interest Rate Range *	36 month (Term) Interest cost if fully drawn
2.90% - 4.50%	$114,000 - $178,000

Description of Services:

Request to enter into a $2,500,000 Capital Equipment Financing agreement with Bank of the West to fund capital equipment purchases for Tri-City Medical Center.

Acquisition of capital equipment is subject to authorization in accordance with TCHD policies and procedures.

The FY 2015 Budget includes $14.6 million of capital purchases, of which $6.5 million was budgeted to be purchased through financing agreements.

*Interest rate is subject to a one-time adjustment for each schedule of equipment, as the funding for each schedule is completed. The current quoted rate is 2.90%.

Concept Submitted to Legal:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Steve Dietlin, Chief Financial Officer/Charlene Carty, Director of Finance

Motion:

I move the Finance Operations and Planning Committee recommend TCHD Board of Directors authorize entering into a lease facility with Bank of the West for a principal amount not to exceed $2,500,000 with a capital lease term of 36 months, at a maximum interest cost of less than $178,000 over the term of the lease.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 19, 2014
Proposal to Lease Medical Office Space at 2067 W. Vista Way

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

Vendor Name: AmeriCare Medical Properties, Inc.

Area of Service/Dept: Ambulatory Medical Services for OB/GYN practice

Term of Agreement: Suite 160 X 4 Months (Beg.: 10/1/14)
Suite 225 X 20 months (Beg.: 1/1/15 - 12/31/16)

60 months for the entire lease, 24 months to TCMC followed by 36 months to OB/GYN practice. The OB physicians in the space will lease from TCMC for the initial 24 months, at 100% of the lease cost.

Maximum Annual Total: **Suite 160** - $5,050 / X 4 months **Total for Term**: $20,200

- 1545 SF @ 2.25/SF
- NNN @ .77/SF
- Utilities @ .25/SF (estimate)

Maximum Annual Total: **Suite 225** - $13,920 / X 20 months **Total for Term**: $278,400

- 4000 SF @ 2.25/SF
- NNN @ .77/SF
- Additional TI cost @ .21/SF
- Utilities @ .25/SF (estimate)

Description of Services/Supplies:

- Lease Premises for new OB/GYN Practice
- Use: 5 days per week, with weekends as needed
- Lease Type: NNN

Concept Submitted to Legal:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Wayne Knight, Sr. Vice President of Medical Services /Jeremy Raimo, Sr. Director, Business Development and Physical Medicine

Motion:

I move that Finance Operations and Planning Committee Recommend that TCHD Board of Directors authorize the lease of Medical Office Suites located at 2067 W. Vista Way (Suite 160 for a term of 4 months) (Suite 225 for a term of 20 months) starting October 1, 2014 and ending on December 31, 2016, for a total of the Term of $298,600.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 19, 2014
Proposal for: Agreement with Beckman Coulter

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

Vendor Name: Beckman Coulter

Area of Service/Dept: Laboratory/Chemistry, Hematology, Coagulation, Urinalysis.

Term of Agreement: 60 months (Beg: October 1, 2014 end: September 30, 2019)

Maximum Annual Total: $ 428,713 **Total for Term:** $ 2,143,565

Description of Services/Supplies:
Requesting approval to replace the 7 year old current instrumentation in the chemistry section as per Beckman Coulter Amendment to Agreement # 17886. This is a 60 month cost per test agreement. The net result of this agreement is to replace two DXC 800 General Chemistry Analyzer, one DXi Immunochemistry analyzer and one Access Immunochemistry analyzer with the DXC 660i and DXI 600 at the current annual spend. The reasons for the request are:

- Equipment being replaced is 7 years old, all consumables and equipment are based on VHA pricing.
- The new DXC 660i is an integrated platform meaning it can test all chemistries (general and immune) on a single sample reducing blood requirement and turnaround time.
- The new instrument's data manager can perform Autoverification meaning normal test results are verified through the instrument's computer leaving the Clinical Lab Scientist free to work on the exceptions (abnormal results including critical values). The autoverification process may include roughly 75% of daily test results including Chemistry, Hematology, Coagulation and Urinalysis.
- The new instrument can be upgraded to full automation should the lab upgrade to robotic workflow in the future.
- Software enables critical and positive results prioritization. Total test volume performed on these instruments is 1.7 million annually, or 8.5 million for 5 yrs.
- Operational agreement reflecting current annual expense. Beckman retains title to all instruments. No construction expense

Concept Submitted to Legal:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Casey Fatch, Chief Operating Officer/Steve Young, Sr. Director Ancillary Services

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Agreement with Beckman Coulter for a term of 60 months starting October 1, 2014 and ending on September 30, 2019. For an annual (12 month) amount of $ 428,713 and a total expense for the Term of $2,143,565.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 19, 2014
Proposal for: Agreement with Vista Community Clinic

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

Vendor Name: Vista Community Clinic

Area of Service/Dept.: Emergency Room & Unfunded Patients

Term of Agreement: 12 months (8/01/14 through 7/30/15)

Maximum Annual Total: $100,000 **Total for Term:** $100,000

Description of Services/Supplies:
Program Objectives:

(1) By June 30, 2015, complete training of new staff as needed on the electronic referral system between TCMC-ED, VCC.
(2) By June 30, 2015, document the scheduling of appointments for 6,000 TCMC-referred patients at either VCC or NCHS (approximately 500 appointments per month).
(3) By June 30, 2015, document that at least 85% of patients contacted keep their scheduled appointments.
(4) By June 30, 2015, document referral of approximately 2,000 patients, without health insurance, that keep appointments with a certified enrollment counselor to determine if they qualify for public/subsidized insurance programs, in support of establishing medical homes.
(5) By June 30, 2015, provide and document utilization information and health education to all referred patients during visits to VCC.

Concept Submitted to Legal:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Casey Fatch, Chief Operating Officer/ Wayne Knight, Sr. Vice President, Medical Services

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Agreement with Vista Community Clinic for a term of 12 months starting August 1, 2014 and ending on July 30, 2015, for an annual (12 month) amount of $100,000 and a total expense for the term of $100,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING AUGUST 19, 2014
PHYSICIAN AGREEMENT for ED COVERAGE (Addition to Panel)

Type of Agreement		Medical Directors		Panel	X	Other: ED On-Call Coverage
Status of Agreement		New Agreement		Renewal	X	Addition to Panel

Physician Name: Sunil Jeswani, MD

Area of Service: ED On-Call Agreement– Neurosurgery & Spine

Term of Agreement: 22 months (September 1, 2014 through June 30, 2016)

Maximum Annual Total:

Discipline	FY15/9 on panel	$$/day	Annual Cost
Spine	303/9 = 34	$ 400	$ 13,600
Neurosurgery	303/9 = 34	$ 800	$ 27,200
Total			$ 40,800
Discipline	**FY16/6 on panel**	**$$/day**	**Annual Cost**
Spine	366/6 = 61	$ 400	$ 24,400
Neurosurgery	366/6 = 61	$ 800	$ 48,800
Total			$ 73,200
	Contract Total		$ 114,000

Position Responsibilities:

- Provide 24/7 patient coverage for all General Surgery services in accordance with Medical Staff Policy #8710-520.
- Complete related medical records in accordance with all Medical Staff, accreditation and regulatory requirements.

Agreement Reviewed by Legal: (Template approved by Board 5-29-14)	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Casey Fatch, Chief Operating Officer/Donna Dempster, Director Medical Staff

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors approve the addition of Sunil Jeswani, MD to the current Neurosurgery and Spine ED On-Call Coverage Agreements at the current approved rates of $800 (Neurosurgery)/24-hour period and $400 (Spine)/24-hour period, for a term of 22 months starting September 1, 2014, ending on June 30, 2016, for a total not to exceed $114,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
PHYSICIAN AGREEMENT for E.D. COVERAGE

Type of Agreement		Medical Directors		Panel	X	Other: E.D. Coverage
Status of Agreement		New Agreement	X	Renewal – New Date		

Physician Name(s): Andrew Deemer, MD; Adam Fierer, MD; Dhruvil Gandhi, MD; Karen Hanna, MD; Mohammad Jamshidi, DO; Eric Rypins, MD; Katayoun Toosie, MD

Area of Service: General Surgery

Term of Agreement: Twenty Four (24) months (July 1, 2014 end: June 30, 2016)

Maximum Annual Total:

Discipline	FY 15	$'s/day	Annual Cost	July 2014 Addition	July 2014 Addition	Revised Annual
Gen Surg	334	$ 1,400	$ 467,600	31	$ 43,400	$ 511,000
GB Surgeries UF.	33	$ 725	$ 23,921	3	$ 2,175	$ 26,096
Total			$ 491,521		$ 45,575	$ 537,096
Discipline	FY 16	$'s/day	Annual Cost			
Gen Surg	366	$ 1,400	$ 512,400		-0-	$512,400
GB Surgeries UF	36	$ 725	$ 26,095		-0-	$ 26,095
Total			$ 538,495		-0-	$538,495
	Contract Total		$ 1,030,016		$ 45,575	$ 1,075,591

Position Responsibilities:

- Provide24/7patient coverage for all General Surgery services in accordance with Medical Staff Policy #8710-520.
- Complete related medical records in accordance with all Medical Staff, accreditation and regulatory requirements.
- Primary admitter for gallbladder related cases.

Agreement Reviewed by Legal: (Template approved by Board 5/29/14)	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Casey Fatch, Chief Operating Officer/Donna Dempster, Director Medical Staff

Motion:

I move that Finance Operations and Planning Committee Recommend that TCHD Board of Directors approve the renewal of the General Surgery ED On-Call Agreement for a term of 24 months starting on the revised effective date of July 1, 2014, ending on June 30, 2016 at the previously approved rate of $1,400 per 24-hour shift and reimbursement at Medicare rates for unfunded cholecystectomy cases at $725.00, for a revised total amount not to exceed $1,075,591.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 19, 2014
Proposal for: Agreement with Cerner Corporation

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

Vendor Name: Cerner Corporation

Area of Service/Dept.: Hospital Electronic Medical Record – Information Technology

Term of Agreement: 67 months (Beg.: 9/1/2014 end: 3/31/2020)

Maximum Annual Total: $ 4.0 Million **Total for Term:** $ 22.3 Million

Description of Services/Supplies:

The existing Cerner RHO contract expires on 3/31/2016.

The benefits of negotiating a 4 year extension (48 months) of our existing contract at this time will result in a cost savings for the remainder of our current term (19 months remaining) of approximately $2.9 million dollars.

Additional benefits include:

- Co-terminus extensions of current subscriptions at reduced costs each year.
- CPI Index savings by eliminating the CPI increase thru 2017 with an estimated rate of 2% thereafter.
- New Applications to include:
  - Readmission Reduction & Prevention Algorithms and Dashboards.
  - Hand Held Specimen Collection for Laboratory – improving patient safety.
  - PowerChart Touch Licenses for device mobility.

Cerner Millennium is our core hospital system which was installed in 2004. Tri City Medical Center is hosted by Cerner's Remote Hosting Option (RHO) in Kansas City, MO.

The system is monitored 24/7/365, which supports our 99.9% system uptime and availability. The agreement provides service level agreements for uptime, support for hardware, software and application upgrades. The infrastructure supports 28+ applications.

Agreement Reviewed by Legal:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Kim Cook, Daniel Martinez & Steve Dietlin

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Agreement with Cerner Corporation for the renewal of Subscription and Hosting Services for a term of 67 months starting September 1, 2014 and ending on March 31, 2020, not to exceed an annual amount of $ 4.0 million and a total expense for the term of $22.3 million.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
August 21, 2014

Members Present: Director Jim Dagostino, Director Ramona Finnila, Dr. Frank Corona, Dr. Marcus Contardo and Dr. Jamie Johnson.

Non-Voting Members Present: Tim Moran, CEO, Casey Fatch, Exe. VP & COO, Sharon Schultz, CNE/Sr. VP, Marcia Cavanaugh, Sr. Director of Quality & Risk Management, Jami Piearson, Director for Quality and Regulatory.

Others present: Jody Root, General Counsel, Donna Dempster, Director of Medical Staff, Colleen Thompson, Sharon Davies, Sue Kirk, Steve Sims, Kerry Moriarty-Homsy, Lisa Mattia, Dr. Mazarei, Mimi Mateo, Megan McGraw, Margaret Strimple, Flora Tomoyasu , Patricia Guerra, Monica Marshall and Karren Hertz.

Members absent: Chairman, Director Reno.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	On behalf of Director RoseMarie Reno, Director Dagostino called the meeting to order at 12:07 p.m. in Assembly Room 1.		
2. Approval of Agenda	The group reviewed the agenda. There were no additions or modifications made.	Motion to approve the agenda was made by Director Finnila and seconded by Dr. Corona.	Director Dagostino
3. Comments by members of the public on any item of interest to the public before committee's consideration of	Director Dagostino read the paragraph regarding comments from members of the public.	Announcement by Director Dagostino.	Director Dagostino

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Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
the item.			
4. Ratification of minutes of July 17, 2014.	Director Dagostino called for a motion to approve the minutes of the June 19, 2014 meeting.	Minutes ratified. Director Finnila moved and Dr. Corona seconded the motion to approve the minutes for the July meeting of PAC.	
5. Old Business	None.		
6. New Business Quality Outcomes Dashboard **Consideration and Possible Approval of Policies and Procedures** **Patient Care Policies and Procedures:** 1. Central Venous Access Devices, Adults – Procedure 2. Dialysis, Acute Treatment of the Inpatient - Policy 3. Family Centered Care – Pediatrics / Adolescent –	The group briefly reviewed the dashboard of the Core Measures indicators. These risk indicators are publicly reported and is beneficial for the committee to know on a regular basis as an informational item. Director Finnila made a comment on the term "family centered care" in this policy.	Informational. *The Patient Care Services policies and procedures were all approved and are moving forward for Board approval. Director Finnila moved and Dr. Corona seconded the motion.	Casey Fatch Monica Marshall

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Policy	Sharon mentioned the hospital used this term since it was the term being utilized in the CCS guidelines. It was identified in this policy that the parents are part of the decision making process thus making them members of the health care team as mentioned in the section family involvement/ family attachment. The surveys are sometimes being filled out by the patient's families so it just makes sense to involve them since they affect patient satisfaction as well.		
4. Patient and Family Education – Policy	Patient classes are being held once they get discharged or on most occasions, they are for outpatient patients only.		
5. Patient Rights and Responsibilities - Policy			
Administrative Policies and Procedures: 1. Equipment/ Medical Device Reporting - Sequester - #201 2. Parking Program - Policy #261 3. Use, Security and Accuracy of Data Policy – Policy #242 4. Weapons on Medical Center Campus – Policy #284	The map in this policy needs to be updated. Pedestrian walkways should be identified and Director Finnila also made a suggestion to put the TCMC map n the valet area so that people would know where to go as they enter the hospital.	*The Administrative policies and procedures were all approved with the amended changes. Director Finnila moved the motion and Dr. Corona seconded.	Monica Marshall

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Unit Specific Policies and Procedures: **Emergency** 1. ED Scope of Practice / Definition of Emergency Department— Policy	There were no changes made to the ED policy.	*The ED policy was approved and is moving forward for Board approval as moved by Director Finnila and seconded by Dr. Corona.	Monica Marshall
Pulmonary 1. High Humidity Heated Oxygen Adult - Procedure 2. Respiratory Pre-Op Teaching for Inpatient Cardiothoracic Patients – Procedure 3. Inpatient Cardiothoracic Patients – Procedure	Director Finnila asked for a short explanation and clarification on the purpose section of the policy for respiratory teaching for inpatient cardiothoracic patients.	*The Pulmonary policies were approved as Dr. Corona moved the motion and Director Finnila seconded.	Monica Marshall
Infection Control 1. IC. 8 Hand Hygiene	The hand hygiene policy needs some revisions; there are 3 or 4 distinct categories that need to be marked and formatting should be checked as well. The section with artificial fingernails need to be corrected too as the policy on this has recently changed.	This policy was pulled out for further revisions and will be brought back next month for approval.	Monica Marshall
2. IC. 11 Aerosol Transmissible Diseases and Tuberculosis Control Plan 3. IC. 2 Infection Prevention and Control Risk Assessment and Surveillance Plan		*The rest of the Infection Control polices with the exception of the Hand Hygiene were approved and moving forward for Board approval. Dr. Johnson made the motion and was seconded by Dr. Corona.	Monica Marshall

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. IC. 3 Epidemiologic Investigation of a Suspected Outbreak 5. IC. 6.2 Meningococcal Exposure 6. IC. 9.1 Toy Cleaning 7. IC.13.3 Mold Abatement 8. IC.7 Wound Care Center Department Specific	There were some formatting changes made to the epidemiologic investigation policy.		
<u>NICU</u> 1. Admission and Discharge Criteria for the NICU 2. Breastfeeding for the Term and Late Pre-Term Infant in the NICU 3. Formula (Artificial Milk) Use of 4. Formula, Preparation and Storage of 5. Peripheral Arterial Line Insertion, Maintenance and Removal of Peripherally Inserted Central Catheters and Midline Catheters Insertions of	There were no changes and/or corrections to the policies for the NICU Department.	*This NICU policies were approved and are moving forward for Board approval as moved by Director Finnila and seconded by Dr. Corona.	Monica Marshall
<u>Women and Children's Services</u> 1. Emergency/STAT Cesarean Section Notification Process		*The Women's and Children's policies and procedures were all approved with the amended	Monica Marshall

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
2. Fetal Heart Rate (FHR) Surveillance/Monitoring 3. Uterine Tamponade Devices 4. Electronic Fetal Monitoring	Formatting revisions will also be made to the fetal heart rate surveillance policy. The electronic fetal heart monitoring policy was deleted and was made into a new policy to reflect the current practices.	changes. Director Finnila moved the motion and Dr. Corona seconded.	
8. Closed Session	Director Dagostino made a motion to go into Closed Session.	Director Finnila moved, Dr. Corona seconded and it was unanimously approved to go into closed session at 12:30 PM.	Director Dagostino
10. Return to Open Session	The Committee return to Open Session at 1:55 PM.		Director Dagostino
11. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Dagostino
12. Comments from Members of the Committee	No Comments.		Director Dagostino
13. Adjournment	Meeting adjourned at 3:20PM.		Director Dagostino

PROFESSIONAL AFFAIRS COMMITTEE
August 21st, 2014

CONTACT: Sharon Schultz, CNE

Patient Care Services Policies & Procedures		
1. Central Venous Access Devices – Procedure	Practice Change	Forward to BOD for approval
2. Dialysis, Acute Treatment of the Inpatient - Policy	3 Year Review	Forward to BOD for approval
3. Family Centered Care-Pediatrics-Adolescent - Policy	3 Year Review	Forward to BOD for approval
4. Patient and Family Education Policy	3 Year Review	Forward to BOD for approval
5. Patient Rights and Responsibilities – Policy	3 Year Review	Forward to BOD for approval
Administrative Policies & Procedures		
1. Equipment Medical Device Reporting – Sequester #201	3 Year Review	Forward to BOD for approval
2. Parking Program - Policy #261	3 Year Review	Forward to BOD for approval
3. Use, Security and Accuracy of Data – Policy #242	3 Year Review	Forward to BOD for approval
4. Weapons on Medical Center Campus – Policy #284	3 Year Review	Forward to BOD for approval
Emergency		
1. ED Scope of Practice – Definition – Policy	3 Year Review	Forward to BOD for approval
Pulmonary		
1. High Humidity Heated Oxygen Adult – Procedure 2. Respiratory Pre-OP Teaching for Inpatient Cardiothoracic Patients - Procedure	Practice Change NEW	Forward to BOD for approval

PROFESSIONAL AFFAIRS COMMITTEE
August 21st, 2014

CONTACT: Sharon Schultz, CNE

Unit Specific		
Infection Control 1. IC. 8 Hand Hygiene 2. IC. 11TB Aerosol Transmissible Diseases and Tuberculosis Control Plan 3. IC. 2 Surveillance Program 4. IC. 3 Epidemiologic Investigation of a Suspected Outbreak 5. IC. 6.2 Meningococcal Exposure 6. IC. 9.1 Toy Cleaning 7. IC.13.3 Mold Abatement 8. IC.7 Wound Care Center Department Specific	3 Year Review for All	Hand Hygiene pulled for more review. Infection Control #2-8 Forward to BOD for approval
NICU 1. Admission and Discharge Criteria for the NICU 2. Breastfeeding for the Term and Late Pre-Term Infant in the NICU 3. Formula (Artificial Milk) Use of 4. Formula, Preparation and Storage of 5. Peripheral Arterial Line Insertion, Maintenance and Removal of 6. Peripherally Inserted Central Catheters and Midline Catheters Insertions	Practice Change NEW DELETE –Incorporated into Formula Preparation and Storage Practice Change Practice Change Practice Change	Forward All to BOD for approval
Women and Children's Services 1. Emergency/STAT Cesarean Section Notification Process 2. Fetal Heart Rate (FHR) Surveillance/Monitoring 3. Uterine Tamponade Devices 4. Electronic Fetal Monitoring	NEW NEW New DELETE –Incorporated into Fetal Heart (FHR) Surveillance Program	Forward All to BOD for approval

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CENTRAL VENOUS ACCESS DEVICES, ADULTS**
Purpose:	To outline the nursing responsibility in: A. Insertion B. Assessment C. Maintenance D. Documentation E. Flushing F. Blood draws G. Dressing changes H. Accessing or de-accessing implantable venous access ports I. Removal of non-tunneled central lines (Peripherally Inserted Central Venous Catheter (PICCs), short-term multi lumen catheters, vas catheters)
Supportive Data:	See Infection Control Manual Bloodborne Pathogen Exposure Control Plan (I.C.10).
Equipment:	Refer to Appendix A for details.

~~1.~~**A. POLICY**

~~A.~~**1.** Only Registered Nurses (RNs) may access central lines.

~~A.~~**2.** Insertion

~~B.~~**a.** Assemble supplies (See Attachment **A**~~B~~ for procedure lists)

~~C.~~**b.** Assist physician with selection of optimal catheter site.

~~D.~~**c.** Ensure the physician**/designated healthcare procedure (HCP)** has performed chlorhexidine skin antisepsis

~~E.~~**d.** Provide maximal barrier precautions for inserting **the** physician and assisting personnel (i.e., cap, mask, sterile gown, sterile gloves and full body sterile drape)

~~F.~~**e.** Ensure "time out" is performed per Patient Care Services (PCS) Universal Protocol procedure

~~a.~~**f.** **Ensure** ~~The Registered Nurse (RN)~~ **the physician**/healthcare provider (HCP) ~~shall ensure~~ **maintains** sterility of the field ~~is maintained~~ throughout the procedure.

~~b.~~**g.** Verify an X-ray is ordered and completed after placement on newly inserted central venous catheters.

~~c.~~**h.** Ensure Central Line Insertion Procedural Checklist is completed ~~(see Attachment A)~~ **in Cerner**

~~2.~~**3.** Assessment

~~G.~~**a.** Monitor intravenous sites every 2 hours and PRN. Document each shift on the Assessment Ongoing PowerForm Central IV section.

~~H.~~**b.** **Assess** Central venous catheters are assessed daily to determine continued need and are removed when no longer needed.

~~a. The primary RN is responsible for ensuring the unit secretary places a "Physician Daily Assessment of Central Line Necessity "sticker on a Physician Order sheet daily.~~

~~b. When a unit secretary is not available, the Shift Supervisor shall ensure the "Physician Daily Assessment of Central Line Necessity" sticker is placed on a Physician Order sheet.~~

~~c.~~**i.** Does not apply to long term catheters (i.e. groshong, tunneled catheter, medi-port, and vas cath)

B. **MAINTENANCE**

1. Use all new tubing after new PICC/central line placement.

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
12/94; 12/09, 7/10;3/13;**4/14**	7/10;3/13;**4/14**	8/10; 3/13; **4/14**	**4/14**	8/10;5/13; **7/14**	06/13	06/13

~~A.~~2. ~~**Interventional Radiology (IR) will place a "change tubing" sticker on all IV tubing connected to the peripheral when a central line is placed in IR to remind nurse to change IV tubing.**~~

~~B.~~3. Label IV tubing ~~and/or neutral displacement connector (Microclave)~~ with change date sticker indicating date tubing is to be changed using numerical day and month.

~~C.~~4. Change tubing and any attached devices (e.g. extension tubing, neutral displacement connector) every 4 days.

~~D.~~5. Use an infusion pump for all infusions.
   a. DO NOT ALLOW INFUSIONS TO RUN DRY.

~~E.~~6. Clamp tubing distally if air enters infusion tubing; aspirate fluid and air with a syringe from Y port. Never purge infusion line into patient.

~~F.~~7. Maintain keep open rates at 20 mL per hour.

~~G.~~8. **May connect ~~C~~c**ontinuous infusions ~~may be connected~~ hub to hub. ~~-~~Microclave device is only required for intermittent access.

~~H.~~9. SwabCap – Unused central line ports will have a SwabCap placed on the end of the neutral displacement connector (Microclave).
   a. Apply the SwabCap to the end of the neutral displacement connector (Microclave) by opening the packaging of the SwabCap and twist into the end of the neutral displacement connector (Microclave).
   b. To access a central line that has a SwabCap, remove the SwabCap from the neutral displacement connector (Microclave) and access central line port. No initial cleaning of the neutral displacement connector (Microclave) is needed after SwabCap is removed. ~~**Swabcap is not to be used to disinfect the displacement connector.**~~
   c. Do not reuse the SwabCap, a new one should be used each time it is removed, every 8 hours with routine IV flushing**, when tubing is changed** and PRN.
   d. SwabCap shall be placed only on the lowest IV port of the mainline (maintenance) infusion tubing.
      i. Swab Caps are not required on ports above the lowest port on a mainline.
   ~~c.~~**e. If additional cleaning required between flushes, cleanse port thoroughly using 3 alcohol wipes. ~~SwabCap~~**

~~I. Outpatient Infusion Center may replace Chlorhexadine with Alchohol/Betadine skin prep for dressing changes and Implanted Port access.~~

~~B.~~C. DOCUMENTATION / EDUCATION

1. Document and complete all **appropriate fields in the "Lines and Devices"** sections **in IView** ~~of the Assessment Ongoing PowerForm in the Central IV section~~.

~~J.~~2. Document flushing on the Medication Administration Record (MAR)

~~K.~~3. Record teaching on the Patient Education PowerForm.

~~C.~~D. FLUSHING

~~A.~~1. Obtain a physician's order prior to accessing any central venous catheter if the patient is admitted with a pre-existing line and a diagnosis of sepsis or suspicion of line sepsis.

~~B.~~2. ~~Always~~ ~~f~~**F**lush and check patency **always** with a 10 mL size syringe due to the greater amount of pressure per square inch exerted with smaller syringes. Once patency **(blood return flash when you aspirate from the central line with a 10 mL syringe)** has been established with a 10 mL normal saline flush, the use of a smaller syringe to administer medications is acceptable.

~~C.~~3. Flush with minimum of 10 mL normal saline:
   a. Before and after medication administration,
   b. After IV fluids or TPN discontinued
   c. For maintenance
   ~~a.~~**d.** Before and after blood draws
   ~~b.~~**e.** After blood backs up in the tubing

~~D.~~4. Flush unused ports with each use and as indicated in Catheter Specific Flushes table (see Attachment ~~C~~**B**)

~~E.~~**5.** **Obtain physicians order for** Heparin flushes ~~require a physicians order.~~**(See ~~Refer to~~ the CPOE** Central Venous Access ~~Device Flushes Pre-Printed oOrder~~ **set Powerplan)**.

~~F.~~**6.** Flush ports with heparin for patients discharged with a central line to ensure patency for home care or other facility use (see Attachment **B~~C~~**).

~~G.~~**7.** Procedure:

a. Identify type of catheter

b. Check for ~~Chloraprep (2%~~ chlorhexidine gluconate~~/70% isopropyl alcohol)~~, ~~H~~**h**eparin, **povidone-iodine**~~Betadine~~, and alcohol allergies.

c. Assemble supplies (See Attachment **A~~B~~** for procedure lists)

d. Explain procedure to patient.

e. Perform hand hygiene and don clean non-sterile gloves.

f. Remove SwabCap from the neutral displacement connector (Microclave) if used.

i. If a SwabCap is not present on injection port, cleanse neutral displacement connector thoroughly using 3 alcohol wipes or chlorhexidine swab.

g. Briskly flush catheter ~~with~~ **with10 mL** normal saline **after patency has been established.**

~~g. Heparinize catheter lumen(s) if applicable. and follow with catheter specific flush (See Attachment BC).~~

h. Always wipe the neutral displacement connector with an alcohol wipe immediately before and after each syringe insertion to remove bacteria and prevent blood from accumulating.

~~e.~~**i.** **Heparinize catheter lumen(s) if applicable. (See Attachment B).**

~~i.~~**j.** Repeat flush procedure for each catheter lumen.

~~D.~~E. BLOOD SPECIMEN COLLECTION FROM VENOUS ACCESS DEVICES

~~A.~~**1.** Peripheral blood is preferable for coagulation studies. A physician's order is required if a line will be used to obtain blood for coagulation studies when the line has heparin infusing or if heparin was used as a routine flush.

~~B.~~**2.** Maintain a closed system by drawing blood directly from the neutral displacement connector when possible; except when drawing blood cultures.

a. If the neutral displacement connector is removed for a blood draw, aseptic technique (with sterile gloves, mask and sterile field) must be used.

~~C.~~**3.** On Acute Care Services (ACS) and Telemetry, a phlebotomist shall place plastic bags labeled with the patient's identifiers in the "Pending Labs" box on each unit prior to the morning blood draws.

~~D.~~**4.** Nursing shall review their orders for morning draws and complete the blood draws.

~~E.~~**5.** Once the blood draws are completed, nursing shall return the labeled specimen collection tubes to the patient's plastic specimen bag and place the specimen bag in the "Lab Test Pick-Up" box for phlebotomy to pick up.

~~F.~~**6.** Phlebotomy shall contact nursing on ACS and Telemetry if additional blood draws are required after the morning draw.

a. Nursing may complete the blood draws without a phlebotomist being present.

b. A phlebotomist must be present for blood cultures and blood bank draws **in all clinical areas**.

~~G.~~**7.** Procedure:

a. Remove patient identified plastic bag with specimen collection supplies from the Pending Lab box on Acute Care Services and Telemetry.

i. Do not take plastic specimen bag into isolation rooms.

b. Verify patient by ensuring two patient identifiers match the specimen collection labels

c. Perform hand hygiene

d. Assemble supplies (See Attachment **A~~B~~** for procedure lists).

e. Explain procedure to patient.

f. Position patient, supine is the preferred position.

g. Turn off any continuous infusions and disconnect as needed.

h. Ensure all clamps are open.
i. Perform hand hygiene and don clean non-sterile gloves.
j. Remove SwabCap from the neutral displacement connector (Microclave) if used.
    i. If a SwabCap is not present on injection port, use alcohol pad to vigorously cleanse the neutral displacement connector or injection port and the area where valve connects to end of catheter. Repeat three times using a new alcohol pad each time. Allow injection port to dry, do not fan or blow on port to speed drying.
~~k. Use alcohol pad to vigorously cleanse the neutral displacement connector or injection port and the area where valve connects to end of catheter. Repeat three times using a new alcohol pad each time. Allow injection port to dry, do not fan or blow on port to speed drying.~~
~~l.~~**k.** Flush with 10 mL normal saline **after patency has been established**; wait 2 minutes.
~~m.~~**l.** Draw off and discard 5 mL of blood. If drawing specimens for blood cultures or coagulation studies are to be obtained or the line has TPN infusing draw off and discard 10 mL of blood.
    i. Prior to drawing blood cultures, disconnect tubing or neutral displacement connector, attach 10 mL syringe to hub, and collect **the blood to be discarded.** ~~discard blood~~.
    ii. To draw blood culture, follow aseptic technique, use a new 10 mL syringe, and collect blood directly at the hub. **Flush with 10 mL of Normal Saline and clamp tubing before disconnecting syringe.** Reconnect tubing or replace with a new neutral displacement connector **being careful not to contaminate the end of the hub**.
~~n.~~**m.** Clean the neutral displacement connector with an alcohol wipe immediately before and after each access to remove bacteria and prevent blood from accumulating.
    i. Allow to dry, do not fan or blow on site to speed drying.
~~o.~~**n.** **For Direct Transfer Method**
    i. Insert safety vacutainer blood collection device into the neutral displacement connector using a slight clockwise turning motion.
    ii. Insert blood specimen collection tube and activate vacuum by fully engaging the blood tube.
        1) ~~On ACS and Telemetry, i~~insert blood specimen collection tube in the appropriate numbered draw order i.e. 1, 2, etc).
    iii. Remove and insert new vacuum tubes as needed.
~~p.~~**o.** **For Indirect Transfer Method**
    i. Attach new 10 mL luer lock syringe(s) to collect blood as needed.
        1) A safety transfer device must be used to fill the vacuum tube from a syringe.
~~q.~~**p.** Remove device or syringe and wipe away blood residual.
~~r.~~**q.** Flush as indicated in Catheter Specific Flushes table (see Attachment C) and reconnect to infusions.
~~s.~~**r.** Re-clamp lines as appropriate.
~~t.~~**s.** Remove gloves and perform hand hygiene
~~u.~~**t.** Don clean gloves
~~v.~~**u.** Document your Cerner logon, date and time of lab draw on the specimen label(s)
~~w.~~**v.** Place label(s) on specimen collection tube(s) at patient's bedside.
    i. On ACS and telemetry, ensure the color written on the patient label(s) matches the color of the specimen collection tube(s).
~~x.~~**w.** Place labeled specimen collection tube(s) in the patient's specimen collection bag on ACS and Telemetry units.
~~y.~~**x.** Place specimen collection bag in the "Lab Test Pick Up" box.
    i. A phlebotomist will transport the specimen(s) to the lab.

~~E.~~F. DRESSING CHANGES

1. **All central lines shall** ~~with~~**have a** Biopatch disk **at the insertion site and be covered with a** ~~T~~**t**ransparent dressing~~s~~
   - ~~A.~~**a. Gauze dressing will only be used for bleeding or leaking at insertion site (edematous patient)**
2. **All central line d**ressing**s** shall be changed every 7~~th~~ days **from insertion or last dressing change**.
   - **a. Gauze dressing**
     - ~~B.~~**i. For newly inserted PICCs with a gauze dressing, the original dressing must be changed one day after insertion.**
     - **ii.** Gauze dressings (including transparent dressings with gauze underneath) shall be changed every **second**~~two~~ days **from last dressing change**.
   - **b. Implanted Ports**
     - **i. Dressing and** ~~A~~**a**ccess needles for implanted ports shall be changed every 7~~th~~ days **from last dressing change or as needed**~~needle change~~.

~~C.~~**3. All** ~~D~~**d**ressings shall be changed as needed if they become loose, soiled, or moist..

~~D. Central neutral displacement connector (Microclave) shall be changed every 4 days.~~

~~For newly inserted PICCs with a gauze dressing, the original dressing must be changed one day after insertion.~~

~~E.~~**4. Patients admitted with a pre-existing central line will have the dressing changed within 24 hours after admission unless dressing is not dry and intact then the dressing will be changed ASAP.**

~~F.~~**5.** Procedure**:**

a. Obtain central line dressing change kit **and sterile gloves** from supply Pyxis.
b. Explain procedure to patient.
c. Use Standard Precautions during dressing change (Refer to Infection Control Policy IC.5 *Standard and Transmission Based Precautions).*
~~d. Avoid talking over site and have the patient turn away from the site to prevent contamination.~~**Where a mask and surgical hat during dressing change.**
~~e.~~**d.** Perform hand hygiene, **apply surgical hat and mask to self and apply mask to patient. Complete hand hygiene once again, apply** ~~don~~ clean non-sterile gloves~~, and~~ remove the dressing and discard.
~~f.~~**e.** ~~Inspect~~ **Inspect and palpate** the site for:
   i. Signs of infection i.e. redness, or purulent drainage.
   ii. Ensure the securement device and/or sutures are intact
   iii. Ensure the catheter is not kinked, leaking, or otherwise compromised.
~~g.~~**f.** Remove non-sterile gloves and perform hand hygiene.
~~h. Open sterile supplies and don sterile~~ **gloves.** ~~gloves and sterile mask.~~
~~i.~~**g.** ~~Perform hand hygiene and don sterile gloves~~
~~j.~~**h.** Apply Chloraprep using a gentle back-and-forth motion for 30 seconds to cleanse exit site.~~and allow site to air-dry for at least 30 seconds~~.
~~k.~~**i.** Cleanse catheter tubing from exit site to ~~distal~~ end **of catheter tubing**.
~~l.~~**j.** Allow antiseptic **on skin and tubing** to air dry (do not blow on or fan site) before redressing.
~~m.~~**k.** Replace securement device if needed per manufacturer's guidelines.
~~n. Position tubing in a loop away from the insertion site.~~
~~o.~~**l. Transparent Dressing with Biopatch**
   i. Place Biopatch disk around catheter **(not on top)** with blue side up and white foam side next to skin at exit site.
   ii. ~~To~~ **Ee**nsure easy removal, **by** placing **e** Biopatch disk with the catheter resting on or near the radial slit. The edges of the slit must touch the skin to ensure efficacy.

iii. **Place** Center transparent dressing over exit site and the Biopatch disk.
iv. Write date of dressing change and your initials legibly with a permanent black marker directly on the transparent dressing, allowing time for the ink to dry.

~~p.~~**m. Special Consideration -Implanted Venous Access Devices/Vita Ports/Medi-Ports**

i. Place folded 2x2 gauze under ~~wings~~ **huber needle** only if **the huber needle** ~~wings~~ **is** ~~are~~ not flush with skin **after insertion**.
ii. **Place** Gauze should be placed under ~~wings~~ **the huber needle** in such a way as to allow visibility of insertion point.
iii. Secure **the huber needle tubing** ~~wings~~ with sterile steri-strips **if needed**.
~~iv. Continue with dressing application as outlined above. Use transparent dressing to cover site.~~
~~v. Write date of dressing change and your initials legibly with a permanent black marker directly on the dressing, allowing time for the ink to dry.~~

~~F.~~G. ACCESSING OR DE-ACCESSING IMPLANTED VENOUS PORTS

~~A.~~**1.** Accessing procedure**:**

a. Obtain physician's order to use implanted device.
b. Assemble supplies (See Attachment **A**~~B~~ for procedure lists) and use safety needles.
c. Explain procedure to patient.
d. Check for Chloraprep, Heparin, Betadine, and alcohol allergies.
e. Use Standard Precautions while accessing implanted venous ports (Refer to Infection Control Policy IC.5 Standard and Transmission Based Precautions)
f. **Wear** ~~Where~~ **a mask and surgical hat during procedure** ~~Avoid talking over site and have the patient turn away from the site to prevent contamination.~~
g. Assemble equipment on sterile field.
h. Perform hand hygiene and don sterile gloves and using aseptic technique waste 5mL normal saline from 10mL pre-filled syringe then prime the ~~non-coring~~ **huber** needle and extension tubing (with neutral displacement connector attached). Leave the syringe attached.
i. Use ~~ing~~ Chloraprep~~,~~ **to** cleanse area over implanted port thoroughly with a gentle back-and-forth motion for 30 seconds. Allow to air-dry for 30 seconds. Do not fan or blow on site to speed drying. Use Betadine if patient is allergic to Chloraprep or alcohol.
    i. Locate port septum by palpation and triangulate port between the thumb and first two fingers of non-dominant hand.
    ii. Aim for the center of the port and insert the needle, perpendicular to port septum. Advance needle through skin and septum until it reaches the bottom of the reservoir.
j. Do not begin injection or infusion until proper needle placement is confirmed by aspirating blood. Confirm placement by:
    i. Aspirating 5 mL of blood using the 10 mL syringe attached to the extension tubing.
    ii. Waste 5mL aspirant.
    iii. Flush with 10mL normal saline.
    iv. Apply dressing per "Dressing Change" (section **G**~~F~~) procedure.
        1) Date and initial dressing.
k. ~~After procedure,~~ **F**flush with 10 mL normal saline **after procedure** and follow with catheter specific flush (see Attachment **B**~~C~~) or connect to IV infusion as ordered.
    i. If implanted port must be accessed multiple times for PRN or intermittent medication regime, obtain a physician's order for KVO solution.
    ii. If KVO order is unobtainable and port must be accessed multiple times perform the following:
        1) Withdraw 5 mL from accessed implanted port and discard (removes heparin)
        2) Flush port with 10 mL of normal saline after heparin has been removed

3) Administer medication or IV via port
a) When port is no longer needed, flush with 10 mL of normal saline and heparinize port per flush table. (Attachment **B~~C~~**)

l. Access needle for implanted ports shall be changed every 7 days.

~~B.~~**2.** De-accessing procedure:

a. **If port is heparinized no flush is needed (skip to e of this section).**

~~a.~~**b.** Check for blood return prior to flushing port with a 10 mL pre-filled normal saline syringe.

~~b.~~**c.** Flush port with 10 mL normal saline

~~c.~~**d.** ALWAYS flush port with specific flush prior to de-accessing (See Attachment **B~~C~~**).

~~d.~~**e.** Perform hand hygiene**, apply mask** and don clean non-sterile gloves to remove transparent dressing. Lift from the edge and stretch film laterally for easier removal. Remove securement device if applicable.

~~e.~~**f.** Inspect the site for signs of infection (redness, pain, swelling and/or purulent drainage.

~~f.~~**g.** Cleanse exit site using Chloraprep, the preferred antiseptic, or Betadine if patient is allergic to Chloraprep or alcohol. **Let dry for 30 seconds.**

h. To remove the safety needle device, place fingers on the base to stabilize. With other hand, place finger on the tip of the safety arm. Lift the safety arm straight back as needle is safely removed. A click will be heard indicating the tip of the needle is fully encased.

~~g.~~**i.** **If removing a huber needle that does not have a safety feature to prevent a needle stick, use two tongue depressors to stabilize in between the patients skin and underneath the huber needle to prevent a rebound of the needle.**

~~h.~~**j.** Discard needle in a sharps container.

~~i.~~**k.** Apply small band-aid.

~~G.~~H. REMOVAL OF NON-TUNNELED CENTRAL LINES (PICCs, Multi-Lumen, Vas Cath)

~~A.~~**1.** Procedure:

a. Verify physician order to discontinue line.

b. Assemble supplies (See Attachment **A~~B~~** for procedure lists)

c. Explain procedure to patient.

d. Place absorbent pad under catheter site.

e. Have patient lay flat or have head of bed no more than 30 degrees if possible.

f. Use Standard Precautions for removal of non-tunneled central lines (Refer to Infection Control Policy IC.5 Standard and Transmission Based Precautions)

g. Open the suture removal kit.

h. Perform hand hygiene**, apply mask** and don clean non-sterile gloves to remove the dressing and discard.

i. Check site for signs of infection.
i. If there are signs of infection, send the catheter tip to the laboratory for culture and sensitivity testing, per physician's order.

j. Remove securement device if applicable.

k. Cleanse exit site with Chloraprep with a back and forth motion for 30 seconds. Use Betadine if patient is allergic to Chloraprep or alcohol.

l. Carefully remove sutures by grasping one-at-a-time with forceps held by the non-dominant hand. Use the dominant hand to clip suture at a spot close the skin. Take care so as not to cut catheter or patient's skin.

m. Instruct patient to perform Valsalva maneuver during removal. If patient is unable to hold his/her breath and bear down, place the bed as flat as possible.
i. For PICCs, have patient keep her/his arm straight.

n. With 4x4 pad in non-dominant hand, grasp catheter with dominant hand and gently pull the catheter to remove. As catheter is coming out, place 4x4 over insertion site.

o. Once removed, apply pressure with sterile 4x4 gauze to the insertion site for 5-10 minutes or until bleeding has ceased.

p. Apply new sterile folded 4x4, secure with large transparent dressing, and instruct patient to leave dressing on for 24 hours. **Place date and initials with a permanent black marker on dressing.**

q. Instruct patient to report shortness of breath, hematoma, or bleeding.

~~H.~~**I. ACCESSING THE DOUBLE LUMEN SUBCLAVIAN/INTERNAL JUGULAR VASCATH/PERMCATH**

~~A.~~**1.** These Catheters Contain Large Doses of Heparin. HEPARIN MUST BE ASPIRATED BEFORE USE.

~~B.~~**2.** Accessing procedure:

a. Obtain a physician's order to access ONLY the venous port (blue port) ~~F~~.

b. Explain procedure to patient.

c. Assemble supplies (See Attachment B for procedure lists)

d. Use Standard Precautions while accessing the double lumen subclavian/internal jugular vascath/permcath (Refer to Infection Control Policy IC.5 *Standard and Transmission Based Precautions)*

e. Expose ~~limb with the~~ **the** vas cath/permacath **in a way** to prevent the patient from contaminating the ports with linens or gown.

f. Place **a sterile chux or drape** ~~absorbent pad under the limb~~ **under the access area** to protect clothing and linen. ~~Place sterile drape over Chux and have patient center limb on the drape.~~

g. Perform hand hygiene**,apply mask** and don sterile gloves.

h. Ensure venous line is clamped before accessing.

i. Saturate venous port thoroughly with Betadine and let stand for 5 minutes.

~~i.~~**j. Remove access cap and place sterile displacement connector (Microclave) on the end of port.**

~~j.~~**k.** Attach 10 mL syringe using aseptic technique

~~k.~~**l.** Unclamp and aspirate 5 mL (7 mL if drawing a PT or PTT).

~~l.~~**m.** Clamp line and discard syringe.

~~m.~~**n.** Attach 10 mL syringe containing 10 mL of normal saline.

~~n.~~**o.** Unclamp venous port and instill 10 mL of normal saline.

~~o.~~**p.** Clamp venous port and remove syringe.

i. Venous line may now be accessed for IV fluids/IV medication administration.

1) If a blood draw is needed, follow item E of this procedure "Blood Specimen Collection from Venous Access Devices."

~~C.~~**3.** De-accessing:

a. Flush venous port with 10 mL of normal saline after medication administration, after discontinuing IV fluids or after completion of blood draw.

b. Heparinize Port (see Attachment C for dosage) and label with a "**Caution – High Dose Heparin"** sticker.

~~I.~~**J. ~~FORMS~~Attachments**

~~A. Central Line Insertion Procedural Checklist~~

~~B.~~**1.** Central Line Supply List

~~C.~~**2.** Central Line Catheter Specific Flushes

~~J.~~**K. REFERENCES:**

~~A.~~**1.** San Diego Dialysis Center. (20~~2~~04). Fmc hemodialysis procedure manual.

~~B.~~**2.** Infusion Nursing Standards of Practice. (2011~~06~~)

~~C.~~**3.** Bard. (n.d.) Long term polyurethane hemodialysis/apheresis catheters Bard nursing procedure manual

L. Attachment A

Central Line Insertion Procedural Checklist

Rationale: Evaluation of procedural practice during Central Venous Catheter insertion. Achieve compliance with CDPH mandates for public reporting under SB739.

Date: _____

Patient Name: _____ **MRN:** _____ **Room Number:** _____

Procedure performed in: ☐ Interventional Radiology ☐ Other - Specify _____ (i.e. NICU ICU, ED, OR)

Occupation of inserter: ☐ Interventional Physician ☐ Interventional PA ☐ Other Medical Staff
☐ Other specify _____

Checklist completed by: ☐ Inserter ☐ Observer

Indication for Central Line:
☐ New access ☐ Replace malfunctioning line ☐ Suspect central line infection

Line changed over guide wire? ☐ Yes ☐ No

Hand hygiene performed prior to central line insertion: ☐ Yes ☐ No
(Appropriate hand hygiene includes the use of alcohol-based hand rub or 15-2 econd s er hand wash.)

Maximal Sterile Barriers used:
Mask/Eye Shield: ☐ Yes ☐ No
Sterile Gown: ☐ Yes ☐ No
Large sterile drape (full bo ☐ Yes ☐ No
Sterile Gloves: ☐ Yes ☐ No
Cap: ☐ Yes ☐ No
Did assisting nurse follow the same precautions? ☐ Yes ☐ No

Skin Preparation:
Chlorhexidine gluconate (Chloraprep) ☐ Yes ☐ No
Betadine ☐ Yes ☐ No
Alcohol ☐ Yes ☐ No

Was skin agent completely dry at the time of first puncture? ☐ Yes ☐ No
*30 seconds for dry site
**2 minutes for moist site (especially femoral)

Insertion Site: ☐ PICC Upper extremity ☐ PICC Lower extremity ☐ Jugular
☐ Subclavian ☐ Femoral ☐ Other: _____

Type of catheter: ☐ PICC ☐ Non-tunneled catheter (other than dialysis)
☐ Tunneled Catheter ☐ Dialysis Catheter tunneled
☐ Dialysis Catheter non-tunneled ☐ Vascular Catheter tunneled
☐ Other: _____

Number of lumens _____

Was antiseptic ointment applied to the site? ☐ Yes ☐ No ☐ N/A
Was biopatch placed on insertion site, dressing labeled with date and time? ☐ Yes ☐ No ☐ N/A

ease return completed form to the Manager and forward to Infection Prevention and Control. **Thank you**

Central Line Supply lists	Attachment ~~B~~A
	1. Central Line insertion kit 2. Caps for assistant and physician 3. Full face shield for assistant 4. Mask with face shield for physician 5. Sterile gloves for assistant and physician 6. Sterile gown for physician 7. Full body sterile drape 8. Alcohol gel hand hygiene solution
Flushes	1. Non-sterile gloves. Mask if flushing a vas cath/permacath. 2. Alcohol wipes 3. Sterile field (may use 4x4 sterile gauze) 4. Sterile flush solution (see Catheter Specific Flushes - Attachment B~~C~~) 5. 10mL Sterile normal saline filled syringe 6. 1 neutral displacement connector for each lumen.
Blood Specimen Collection	1. Non-sterile gloves (sterile gloves and sterile field for blood cultures) 2. Mask and goggles or full face shield 3. Alcohol wipes (3) or chlorhexidine swab 4. One 10 mL luer lock syringe for blood waste 5. Luer lock syringe(s) for blood specimen collection as provided by phlebotomist or safety vacutainer blood collection device 6. Patient lab identification labels 7. Vacuum blood specimen tubes as provided by phlebotomist 8. Plastic bag with patient labels for ACS and Telemetry morning blood draws 9. 10mL luer lock syringe with 10mL sterile normal saline 10. Sterile flush solution as appropriate (see Catheter Specific Flushes - Attachment B~~C~~) 11. Neutral displacement connector
Dressing Changes	Obtain central line dressing change kit **and sterile gloves** from supply Pyxis.
Accessing or De-accessing Implantable Venous Ports	**1. Central Line Dressing Kit** ~~1.~~**2.** Non-sterile gloves ~~2.~~**3.** Mask and goggles or full face shield ~~3.~~**4.** Alcohol wipes ~~4.~~**5.** Sterile drape ~~5.~~**6.** Sterile gloves ~~6.~~**7.** Use only safety, non-coring needles to access implanted port, ~~7.~~**8.** Extension tubing per patient needs for length and gauge. ~~8.~~**9.** Neutral displacement connector attached to extension tubing ~~9.~~**10.** 10mL syringe filled with sterile normal saline a. Chloraprep or Betadine if patient is allergic to Chloraprep or alcohol. ~~10.~~**11.** Transparent dressing or 2x2 split sterile gauze and 4x4 or 2x2 sterile gauze. ~~11.~~**12.** Steri-strips (optional) ~~12.~~**13.** Tape ~~13.~~**14.** Flush solution as appropriate (See Catheter Specific Flushes — Attachment B~~C~~)
Removal Of Non-Tunneled Central Lines (PICCs, Multi-Lumen, Vas Cath)	1. Non-sterile gloves/ Mask and goggles or full face shield 2. Suture Removal Kit 3. Barrier-proof absorbent pad 4. Regular plastic bag for packaging and dressing disposal 5. 2x2 gauze, two 4x4 gauze 6. Large transparent dressing 7. Chloraprep or Betadine if patient is allergic to Chloraprep or alcohol

CENTRAL LINE CATHETER SPECIFIC FLUSHES — Attachment CB

TYPE	FLUSH SOLUTION	FREQUENCY	COMMENTS
Central Lines	Normal saline10mL	Q 8 hrs	1. Use proximal port as 1st choice for drawing blood, routine IV administration, and medication. 2. Use Medial port for TPN and may use for medications only if TPN not being given and not anticipated. 3. Distal port as alternative site for blood draw, administration of viscous fluids (i.e. blood products, colloids, albumin), CVP monitoring, and continuous fluid administration.
PICC/**Midline**	Normal saline 10mL	Q 8 hrs	
Patients going home with Central line or PICC	Heparin 200 units per lumen • 2mL of Heparin (100units /mL)	Q 12 hrs	Home Care: Q 24 hrs
Groshong	Normal saline 10mL	Once a week	
Implanted Port (VAD)			
Groshong	Normal saline 10mL	Once a month	
Vita-Port	Heparin 300 units • 300 units Heparin in pre-filled syringe (100 units/ml) • If Heparin pre-filled syringes are unavailable, pharmacy will provide patient-specific syringes.	Once a month	1. Get a physician order for KVO solution if port must be accessed multiple times. 2. Withdraw 5mL from port to remove heparin if port must be accessed multiple times before flushing with 10mL of normal saline.
Medi-Port	Heparin 500 units • 500 units Heparin in pre-filled syringe (100 units/ml) • If Heparin pre-filled syringes are unavailable, pharmacy will provide patient-specific syringes.	Once a month	1. Get a physician order for KVO solution if port must be accessed multiple times. 2. Withdraw 5mL from port to remove heparin if port must be accessed multiple times before flushing with 10mL of normal saline.
Vas Cath	Heparin Concentration 1000 units/mL • Check number on venous port • Instill that exact number in mL of heparin using the 1000 units/mL concentration (i.e. 1.6=1.6mL, 1.7=1.7mL, 1.8=1.8mL).	Once a week If not being accessed for dialysis	1. Only the Venous (blue port) port may be accessed and a Physician's order is required before use. 2. Venous port must be clamped before syringes are connected or withdrawn. 3. Accessing -- MUST ASPIRATE HEPARIN BEFORE USE. Using a 10mL syringe, remove 5mL of blood from the venous port and discard (7mL if drawing PT and/or PTT). Then port can be accessed. 4. De-accessing – Each Vas Cath/Permacath have a number located on the venous port that is the number of mL of heparin to be instilled when heparinizing the port (i.e. 1.6,1.7, 1.8)

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 3/02

SUBJECT: Dialysis, Acute Treatment of the Inpatient

REVISION DATE: 10/02, 6/03, 4/06, 7/08, 5/11; 6/14

POLICY NUMBER: IV.FF

Clinical Policies & Procedures Committee Approval: ~~03/11~~ 06/14
Nursing Executive Committee Approval: ~~03/11~~ 06/14
Medical Executive Committee Approval: ~~04/11~~ 07/14
Professional Affairs Committee Approval: 05/11
Board of Directors Approval: 05/11

A. **POLICY:**

1. Tri-City Medical Center (TCMC) has a contractual agreement with San Diego Dialysis (~~DBA~~ Fresenius) to perform acute hemodialysis and peritoneal dialysis for inpatients.
2. TCMC's direct care responsibilities for patients undergoing dialysis treatments are as follows:
   a. Nursing care normally provided to patients while not receiving dialysis, unless otherwise contraindicated during dialysis. This includes treating pain and providing immediate emergency response in the event a patient on dialysis treatment suffers a sudden change in condition.
   b. Providing the dialysis staff with equipment and supplies outlined in **Dialysis Supplies and Equipment Provided by TCMC.** ~~Attachment A~~.
   c. Providing written physician orders for the necessary dialysis services and making these orders available to the dialysis staff at the time services are to be rendered.
   d. Obtaining a signed consent for hemodialysis from the patient or appropriate designee prior to the first treatment.
   e. Providing access for treatment. The physician who inserts a dialysis catheter is responsible for proper placement via chest x-ray that is confirmed by a radiologist.
   f. Patients shall be dialyzed on the nursing units at bedside.
   g. Review the MAR for PRN post dialysis medications.
      ~~f.~~i. If no IV access request Fresenius to give IV medications post dialysis.
3. Fresenius Medical direct care responsibilities for patients undergoing dialysis are as follows:
   a. Providing specially trained and competent nursing staff that will perform all patient care functions directly related to the dialysis services ordered.
   b. Providing those items in ~~Attachment B~~ **Dialysis Supplies and Equipment Provided by Fresenius**.
   c. Maintaining equipment required for dialysis treatments, including set-up, take down, and cleaning.
   d. Obtaining and reviewing physician orders directly related to the dialysis services for appropriateness, and directly contacting ordering physicians for any order clarification required.
      i. Review for post dialysis medications and request all of the medications from pharmacy.
   e. Documenting nursing services provided during treatment **per Fresenius policy**.
      ~~d.~~i. Document post dialysis vital signs in the electronic health record.
   ~~e.~~f. Assuring patient is medically stable before leaving at completion of treatment.
   ~~f.~~g. Will receive a handoff report from the patient's primary nurse pre-dialysis treatment.
   ~~g.~~h. Will give a post dialysis handoff report to the patient's primary nurse that will include but not limited to:
      i. How patient tolerated treatment

ii. Dialysis output
iii. Current vital signs
iv. Medications given and/or blood products
v. Dialysis catheter assessment
vi. Any medications not given on dialysis that need to be administered by the primary care nurse (i.e. IV antibiotics).

i. Adhering to TCMC policies and procedures, and all regulatory requirements

B. RELATED DOCUMENT (LOCATED IN THE PATIENT CARE SERVICES MANUAL; FORMS/RELATED DOCUMENTS FOLDER):

1. Dialysis Supplies and Equipment Provided by TCMC
~~h.~~2. Dialysis Supplies and Equipment Provided by Fresenius

ATTACHMENT A

The following exhibit set forth such equipment and supplies to be provided by HOSPITAL (Tri-City Medical Center) pursuant to the contract:

1. Electrodes and monitoring equipment
2. Non-invasive blood pressure monitoring machine
3. IV infusion pumps and tubing
4. IV administration sets
5. Normal Saline
6. Anticoagulant Citrate Dextrose – Formula A Solutions
7. Priming and Replacement fluids
8. Hemoperfusion Cartridge
9. Syringes as needed
10. Hypodermic Needles as needed
11. Iodine swab sticks and Alcohol swabs
12. Tape as needed
13. 2X2 and 4X4 gauze pads (sterile & non) as needed
14. **Non sterile gloves, various sizes** ~~Gloves-vinyl, small, medium & large~~ and latex non-powder same sizes
15. ~~14.~~**15. Sterile gloves, various sizes**
16. ~~15.~~**16.** Surgical masks or N 95 masks as needed
17. ~~16.~~**17.** Blood administration sets and appropriate blood filters
18. ~~17.~~**18.** Pressure wrap bandage
19. ~~18.~~**19.** Bed pans and urinals
20. ~~19.~~**20.** Drinking cups and straws
21. ~~20.~~**21.** Any other supplies not provided by provider, which are necessary to perform the service.

In instances where any of the foregoing are unavailable, the Hospital shall provide reasonable substitute products.

ATTACHMENT B

The following exhibit sets forth such equipment and supplies to be provided by Provider (Fresenius) pursuant to the contract:

Dialysis Supplies

1. Artificial Kidneys
2. Arterial and Venous Blood Lines
3. Transducers
4. Dialyzing Fluids
5. Fistula Needles
6. Universal Connectors
7. Extension Clamps
8. Adapter Seal Clamps
9. Convertible Adapters
10. Drain Set
11. Del Clamps
12. Treatment Record

Apheresis Supplies (general)

1. Blood Cell Separator
2. Blood Cell Separator Tubing set
3. Machine Maintenance
4. Blood Warmer and Blood Warmer Tubing
5. AV Fistula needles
6. Treatment Record

Immunoadsorption Therapy Supplies (in addition to the above apheresis supplies):

1. Plasma transfer sets with spike and needle adapter (Fenwal or equivalent)
2. Transfer pack container 2000 mL with coupler (Fenwal or equivalent)
3. Transfer pack unit 600 mL with needle adapter (Fenwal or equivalent)
4. Y-type blood component recipient set (Fenwal or equivalent)
5. Spike to Syringe Adapter
6. PXL8 Leukocyte filters (Pall or equivalent)
7. Extension Set 3.0 mL 51 cm
8. Needle Lock Device (Baxter or equivalent)
9. Male to male adapter
10. 3-way stopcock

Provider and Hospital agree as new state-of-the-art supplies or equivalent equipment may be substituted as may be worked between both parties.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE:	**8/07**	**SUBJECT:**	**Family Centered Care – Pediatrics/Adolescents**
REVISION DATE:	**1/08; 4/09; 06/11; 07/14**	**POLICY NUMBER:**	**IV.MM**

Clinical Policies & Procedures Committee Approval:	**~~07/11~~ 07/14**
Nursing Executive Council Approval:	**~~07/11~~ 07/14**
~~Medical Executive Committee Approval:~~	**~~08/11~~ 07/14**
Professional Affairs Committee Approval:	**09/11**
Board of Directors Approval:	**09/11**

A. **PURPOSE:**

1. Create a healing relationship with families at all levels of care that focuses on the developmental, physical, and social needs of the patient and family.

B. **POLICY:**

~~1. Promotion of Family Centered Care~~

~~a.~~**1.** All members of the health care team are responsible for **the promotion of** family centered care.

2. To achieve family-centered care:
   a. We respect families and their pivotal role in promoting the well-being of their children.
   b. We recognize families as the constant factor in the life of the child and the family as an intrinsic part of the health care team.
   c. We recognize that service systems and personnel are episodic.
   d. Families may collaborate with staff to guide decisions regarding care patterns and day-to-day activities.
3. Relationships between families and healthcare providers are fostered by encouraging family members to participate in the direct care of the child and participate in decision-making regarding the child's care.
4. Healthcare team members make families feel comfortable both physically and emotionally throughout their Pediatric/Adolescent experience, and nurture their role as principal caregivers.
5. Hospital staff/personnel are educated on the benefits of enhanced family interaction to ensure optimal physical care and emotional outcomes for our hospitalized children and their families.

C. **DEFINITIONS:**

1. Family Centered Hospital**:** Families are involved in and empowered to care for their children's well-being. Family-centered care designates the family as the key decision-maker. To aid parents in making appropriate decisions, healthcare professionals collaborate and share information with families on an ongoing basis.
2. Adolescent population is defined as age 14 through age 20.

D. **FAMILY INVOLVEMENT:**

1. Collaboration and sharing information with families is ongoing. Families will be provided with accessible support services that may include educational, ethical, financial, and community resources.

E. **PROCEDURE:**

1. Physical Accommodations and Family Resources

a. Provide maps with directions to hospital and information about alternative transportation options, parking provisions, and hospital entry access to facilitate visitation to.

2. Provide hospital/unit orientation **as appropriate** to include:
   a. Printed information regarding family participation in care
   b. Visiting policy
   c. Telephone calls by parents if unable to be at the bedside
   d. Support services
   e. Food service
   f. **Automated Teller** M~~-m~~achine
   g. Family library/resource center with a variety of textbooks, articles, videotapes and internet access.
3. A private space **shall be provided** for families to meet with caregivers for consultation or family discussions.
4. Healthcare personnel are welcoming and reassuring to each family member that visits. Opportunities that reinforce the importance of the family's role in the care of their child/adolescent are encouraged and provided. Opportunities are provided for families to ask questions about their pediatric/adolescent experience and share concerns that may arise.

F. FAMILY INVOLVEMENT/ATTACHMENT

1. Encourage parents to participate in all aspects of the **patient's** ~~infant's~~ care. Elicit their perception of goals and needs.
2. Parents are treated as full members of the health care team.
3. Parents have accessibility to the child/adolescent 24 hours a day including during procedures, rounds, and end-of shift-reports.
4. Continual, open and honest communication about medical, psychosocial and ethical issues relevant to the child and family are fostered.
5. Family members may stay with patients as appropriate.
6. Provide information on what parents may expect during procedures and encourage participation when possible.
7. Inform families of patient's/parent's rights and responsibilities.
8. Provide explanations and access to educational materials concerning the child's medical and nursing care.
9. The roles and activities of participating disciplines and the parents are incorporated into the plan of care.
10. Staff shall encourage families to read and educate themselves regarding their child's medical condition.
11. Families are encouraged to become actively involved in the preparation for discharge.
    a. Parents are encouraged and informed of the process available to provide feedback through **hospital** ~~Press-Ganey~~ survey as well as the follow-up telephone survey.

G. REFERENCES:

1. Advances in Family-Centered Care. (2003). *Collaborating with Patients and Families to Improve Quality and Patient Safety*. Vol. 9 No.1
2. The Advisory Board. (2003). *The Family As Patient Care Partner*.
3. Lewandowski, L., Tesler, Mary D. (2003). *Family-Centered Care: Putting It Into Action. The SPN/ANA Guide to Family -Centered Care.*

H. FORMS WHICH CAN BE FOUND ON IN THE INTRANET:

1. Bill of Rights for Children and Teens
2. Bill of Rights for Parents
3. Family Responsibilities

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 12/01	**SUBJECT:** Patient and Family Education
REVISION DATE: 6/03, 4/06, 10/07, 02/09, 06/11	**POLICY NUMBER:** V.A
Clinical Policies & Procedures Committee Approval:	~~04/11~~ 07/14
Nursing Executive Council Approval:	~~04/11~~ 07/14
Professional Affairs Committee Approval:	06/11
Board of Directors Approval:	06/11

A. **PURPOSE:**

1. To ensure every patient is provided with the necessary information to address individual health needs and challenges.

B. **DEFINITIONS:**

1. **Patient** – refers to patient, family, caregiver, and significant other(s) who may benefit from patient education.

C. **POLICY:**

1. Healthcare providers shall ensure the patient receives education and training specific to the patient's needs and abilities and as appropriate to the care, treatment, and services provided.
2. All patient and family education shall be documented **in the Electronic Health Record (EHR)**~~.~~
3. Healthcare providers shall support the provision and coordination of patient education activities~~;~~ and identify and provide the resources necessary for achieving educational objectives.
4. Tri-City Medical Center (TCMC) shall provide all patients with basic safety related information at the time of admission to TCMC.
5. All patient care providers participate in patient education in the course of daily patient care.
6. Patient education is a collaborative process that promotes independence and self care.
   a. All patients are entitled to information that helps them better understand and cope with their medical condition and treatment plan.
   b. Education enables the patient to resolve health problems, make informed decisions, and institute healthy behaviors.
7. Education provided is based on the patient's assessed needs.
8. The assessment of learning needs addresses age, cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, barriers to communication, literacy, living environment, previous experience and resource availability as appropriate.
9. As appropriate to the patient's condition and assessed needs and the hospital's scope of services, the patient is educated about the following:
   a. Plan for care, treatment, and services
   b. Basic health practices and safety
   c. Safe and effective use of medications
   d. Food-drug interactions
   e. Nutrition interventions, modified diets, or oral health
   f. Safe and effective use of medical equipment or supplies when provided by the hospital
   g. Understanding pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management
   h. Rehabilitation techniques to help them reach the maximum independence possible
   i. Infection prevention measures

j. Measures taken to prevent adverse events in surgery
k. Community resources and when necessary, how to obtain further care, services, or treatment to meet identified needs
l. Appropriate information about patient responsibilities and self-care activities
m. Discharge instructions to the patient and those responsible for providing continuing care
n. Information on oral health
o. Fall reduction strategies

~~9.~~**10.** Patients receive education and training specific to the patient's abilities as appropriate to the care, treatment, and services provided.
a. Education is coordinated among the disciplines providing care, treatment, and services.
b. The content is presented in an understandable manner.
~~b.~~**c.** Teaching methods include verbal discussion, written materials, **electronic** ~~Micromedex~~ ~~C~~**c**arenotes, demonstration~~,~~ and videos.
~~c.~~**d.** Teaching methods accommodate various learning styles and readiness to learn
~~d.~~**e.** Patient education is documented in the **EHR**~~medical record~~
i. Assessment of learning needs
ii. Interventions to meet those needs
iii. Patient response to education
iv. Educational materials provided
~~e.~~**f.** Comprehension is evaluated and documented

~~10.~~**11.** Patients receive education on how to communicate concerns about patient safety issues that occur before, during, and after care is received.

Tri-City Health Care District
Oceanside, California

~~Administrative~~ Patient Care Services Clinical Policy Manual

ISSUE DATE: 7/97

SUBJECT: Patient Rights & Responsibilities

REVISION DATE: 4/00; 5/02; 12/02; 12/03; 1/06; 5/07; 7/08; 02/09; 02/11; 6/14

POLICY NUMBER: 8610-302

Clinical Policies & Procedures ~~Administrative Policies & Procedures~~ Committee Approval:	**~~12/10~~ 06/14**
Nurse Executive Council ~~Executive Council~~ Approval:	**~~01/11~~ 06/14**
Medical Executive Committee Approval:	**07/14**
Professional Affairs Committee Approval:	**02/11**
Board of Directors Approval:	**02/11**

A. **PURPOSE:**

1. To describe Tri-City Healthcare District's (TCHD) process of informing patients of their rights and responsibilities while receiving care, treatment, or services.
   a. To ensure TCHD staff are aware of and their conduct supports patient's rights.
   b. To set forth behavioral guidelines for patients and families to ensure safe delivery of care, treatment, and services.

B. **DEFINITIONS:**

1. Patient Rights: A standard belief that patients deserve care, treatment, and services that safeguard their personal dignity and respect their cultural, psychosocial, and spiritual values. These values often influence the patient's perceptions and needs. By understanding and respecting these values, providers can meet care, treatment, and service preferences.

C. **POLICY:**

~~1. TCHD respects the rights of each patient.~~

~~2.~~1. TCHD facilitates the fulfillment of patient's responsibilities by ensuring that each patient, as appropriate to his/her condition, is a partner in the healthcare process.

~~3.~~2. Care is provided in a manner that respects and fosters dignity, autonomy, positive self-image, cultural values, and involvement in care decisions.

~~4.~~3. Care is individualized to incorporate cultural, psychosocial, and spiritual values.

~~5.~~4. Upon admission, each patient is given a copy of the *Patient's Bill of Rights* and *Patient Responsibilities* located in the Patient **Guide**~~Handbook~~.
   a. The *Patient's Bill of Rights* is also printed on the TCHD Conditions of Admissions Form and is acknowledged by the patient's signature.

~~6.~~5. The "Patient's Bill of Rights" is posted (in both English and Spanish) in each patient care area **and Registration**.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 01/87

SUBJECT: EQUIPMENT/MEDICAL DEVICE REPORTING/SEQUESTERING

REVISION DATE: 12/91; 8/94; 5/96; 1/99; 5/02; 2/03; 04/06; 02/11; 4/14

POLICY NUMBER: 8610-201

Administrative Policies & Procedures Committee Approval:	~~12/10~~ 06/14
~~**Executive Council Approval:**~~	~~01/11~~
Professional Affairs Committee Approval:	02/11
Board of Directors Approval:	02/11

A. **PURPOSE:**

To assure that safe medical device reporting/sequestering is implemented. To assure that medical devices on the market are safe and effective through user facility reporting, identification, tracking and corrective actions. ***For purposes of this policy, the Risk Manager is designated as the hospitals official contact for the Food and Drug Administration (FDA)***

B. **DEFINITIONS:**

1. Patient – A "patient" of a facility is (1) an individual being diagnosed, or treated, or receiving medical care under the auspices of the facility, from medical personnel working in, for or who are otherwise affiliated with a device user facility; or (2) an employee of the facility who suffers death, serious illness, or serious injury from a device used at or by the facility, and, as a consequence, becomes a patient.
2. Affiliated – Affiliated is defined to include medical personnel who are associated with a device user facility and is interpreted to include physicians with admitting privileges.
3. Medical Device – An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part or accessory which is:
   a. Recognized in the official national formulary, or the USP, or any supplement to them.
   b. Intended for use in the diagnosis of disease or *other conditions, or in the cure, mitigation, treatment or prevention of disease, in man or other animals, or;
   c. Intended to affect the structure of any function of the body, or other animals, and which does not achieve its primary intended purposes through chemical action within, or on, the body of man or other animals; and which is not dependent upon being metabolized for the achievement of its primary intended purposes.
      i. (Per Safe Medical Devices Act (SMDA) 1990 and Medical Device Amendments, 1992)
4. Examples of Devices – Anesthesia machines, defibrillators, pacemakers, hemodialysis machines, heart valves, catheters, thermometers, patient restraints, contact lenses, hearing aids, blood glucose monitors, x-ray machines, tampons, ventilators, wheelchairs, bedside commodes, infusion pumps, laser, electrosurgery, etc.
5. Serious Illness and Serious Injury – An illness or injury that a) is life threatening, b) results in permanent impairment of a body function or permanent damage to a body structure, c) necessitates immediate medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure.

C. **POLICY:**

In compliance with Safe Medical Devices Act, all incidents that reasonably suggest that there is a probability that a medical device or user error caused or contributed to a death, serious illness or serious injury of a patient or employee of the facility, will be reported to the appropriate persons and/or organization.

D. **STAFF RESPONSIBILITY:**

1. In the event of a patient death, serious injury or illness, whether it is due to equipment/product failure or user error the staff member responsible for the patient shall follow these procedures.
   a. Immediately notify the Department Director or Supervisor of the occurrence who will then notify Administration and Risk Management.
   b. Immediately sequester the equipment/product.
   c. Preserve evidence.
   d. Maintain control settings as existed at the time of injury (if applicable), i.e., power settings, gas flow (see D.b).
      i. Device is not to be cleaned or processed,
      ii. **U**~~u~~niversal precautions to be used in handling all accessory components, or related equipment,
      ~~e.~~**iii.** ~~is identified incident~~ **Device** will be kept intact for impoundment.
2. Sequestering the Equipment/Device (to preserve evidence):
   a. Notify Biomedical Engineering of equipment failure. Notify Risk Management of all sequestering, whether a product or equipment.
   b. Maintain the equipment/device in a secure place under the care of an individual who will be able to testify that the device has been preserved in its original condition until arrangements are made with Risk Management for further safekeeping through off-site or on-site storage as needed.
   c. When the decision to sequester is made, the equipment/supplies shall be disconnected from the patient and power supply without changing any control settings or turning the equipment off (if possible). No cleaning or processing of the equipment/supplies shall occur until the Risk Manager has identified if these processes will hinder subsequent investigation. All equipment and associated supplies shall be preserved as found. The equipment/supplies will be sequestered by the user department, biomedical engineer, or Risk Manager as appropriate.
   d. Whenever any piece of equipment is to remain sequestered, the department director will provide for replacement of the equipment and notify physicians who use this equipment.
      i. Preserve original packaging of the device if possible.
   e. Complete Quality Review Report, which includes:
      i. Name of patient
      ii. Date and time of patient injury
      iii. Description of event in detail and patient outcome
      iv. Description of malfunction and condition of device upon removal
      v. Biomed Data Control number if possible and manufacturer, model name, serial or lot number
      vi. Verification of notification to supervisor
      vii. Notations of settings as existed at the time of injury (see D.C.)
   f. Risk Management and Biomedical Engineering (if equipment) will determine if the product/equipment is to be returned to the manufacturer (if patient injury).
   g. Equipment, instruments or supplies potentially involved in a patient's adverse occurrence are <u>not</u> to be returned to the manufacturer, or discarded until authorization is given by the Risk Manager.

E. **RISK MANAGEMENT DEPARTMENT REPORTING RESPONSIBILITY:**

1. Risk Management will report patient deaths, serious illness and injury or user error resulting from a medical device to the Food and Drug Administration (FDA), California Department of Public Health (CDPH) and to the manufacturer, if known.
2. The Risk Management Director will also notify the professional liability carrier and Administration.

. . **REPORTING SCHEDULE:**

1. A facility will be treated as first becoming aware of information when medical personnel, who are employed by or otherwise formally affiliated with the facility, become aware of information with respect to a device in the course of their duties.

2. The Risk Manager shall determine if the event is reportable under the SMDA. Reports will be sent to:
   a. The manufacturer of the device for incidents involving serious illness, serious injury, or death.
   b. The FDA if the event resulted in death or for any serious outcome where the manufacturer is unknown.
3. If determined to be reportable, the Medwatch Form 3500A will be completed by the Risk Manager according to SMDA regulations, starting from when the hospital first became aware that the device may have caused or contributed to the event.
4. Each device user facility is required to submit to FDA, on a semiannual basis (January 1 and July 1), a summary of the reports that it has submitted to the FDA and to manufacturers. If no reports have been submitted, no summary need be sent.
5. Reporting Format: The Risk Management Director will, at a minimum, include information such as the identity of the reporting facility, product name, model, serial number, name of manufacturer, if known, and a description of the event.
6. The Risk Manager shall be responsible for maintaining a separate "File of Device Reportable Incidents." **See Attachment A**

G. **FDA CONTACT WITH THE HOSPITAL:**

1. If an FDA inspector visits the hospital for any purpose related to medical devices, he/she will be directed to the Risk Manager. The Risk Manager will ask for, review, and record the inspector's credentials prior to providing requested information.
2. Written or telephone inquiries from FDA representatives will be directed to the Risk Manager for response.

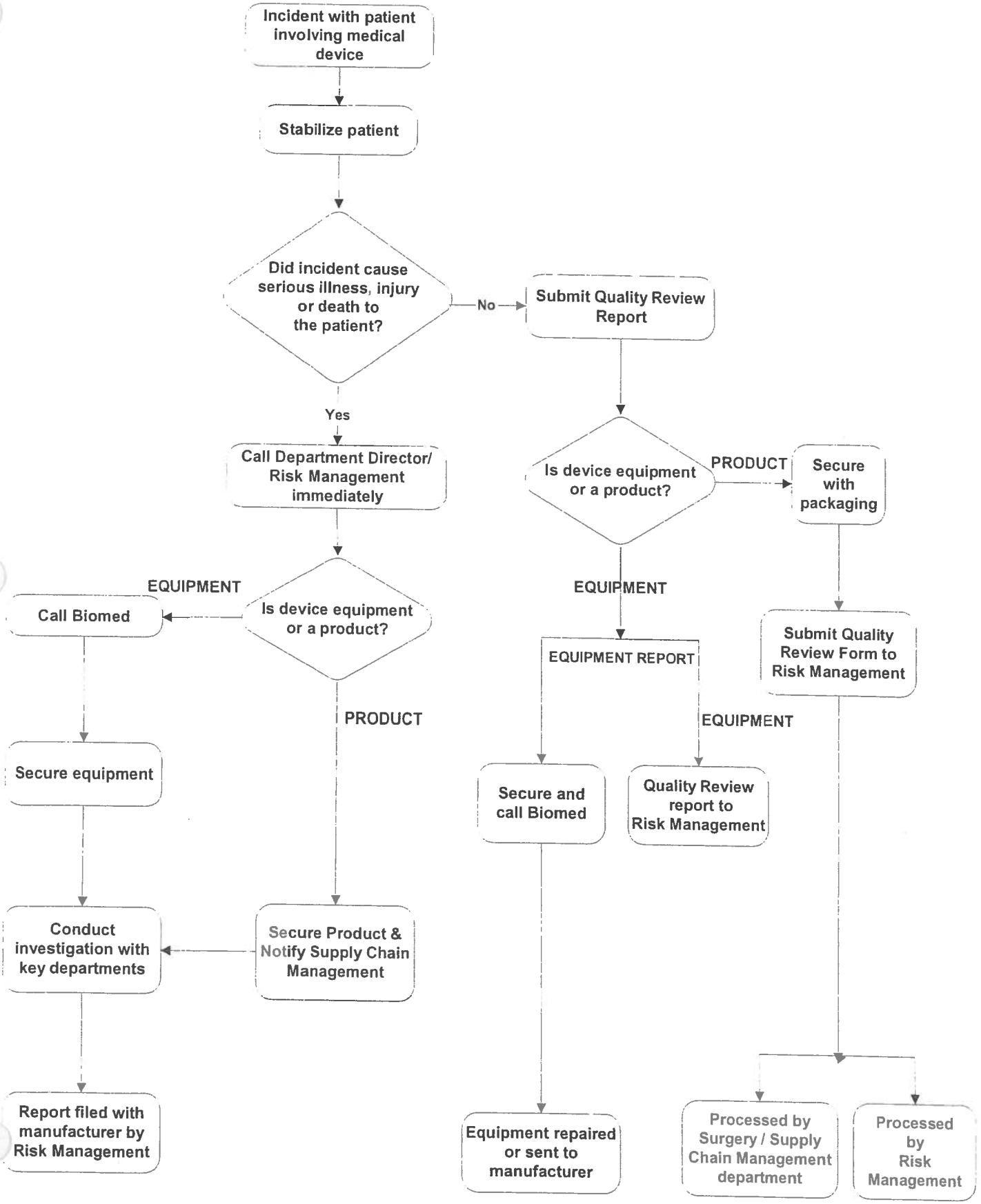
H. **ATTACHMENTS:**

~~2.~~**1. Tri City Medical Device Incident Flow Chart**

~~H.~~**I. REFERENCE:**

1. Administrative Policy #501, Adverse Events, Mandatory Reporting of
~~1.~~**2. Patient Care Services Patient Owned/Supplied Equipment Brought into the Facility**

TRI-CITY MEDICAL CENTER
MEDICAL DEVICE INCIDENT FLOW CHART



Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Environment of Care

ISSUE DATE: 6/94

SUBJECT: PARKING PROGRAM

REVISION DATE: 9/02; 3/03, 7/04; 12/05; 4/08 9/10; 1/14

POLICY NUMBER: 8610-261

Administrative Policies & Procedures Committee Approval:	~~10/10~~07/14
~~Operations Team Committee Approval:~~	~~11/10~~
Professional Affairs Committee Approval:	01/11
Board of Directors Approval:	01/11

A. **PURPOSE:**

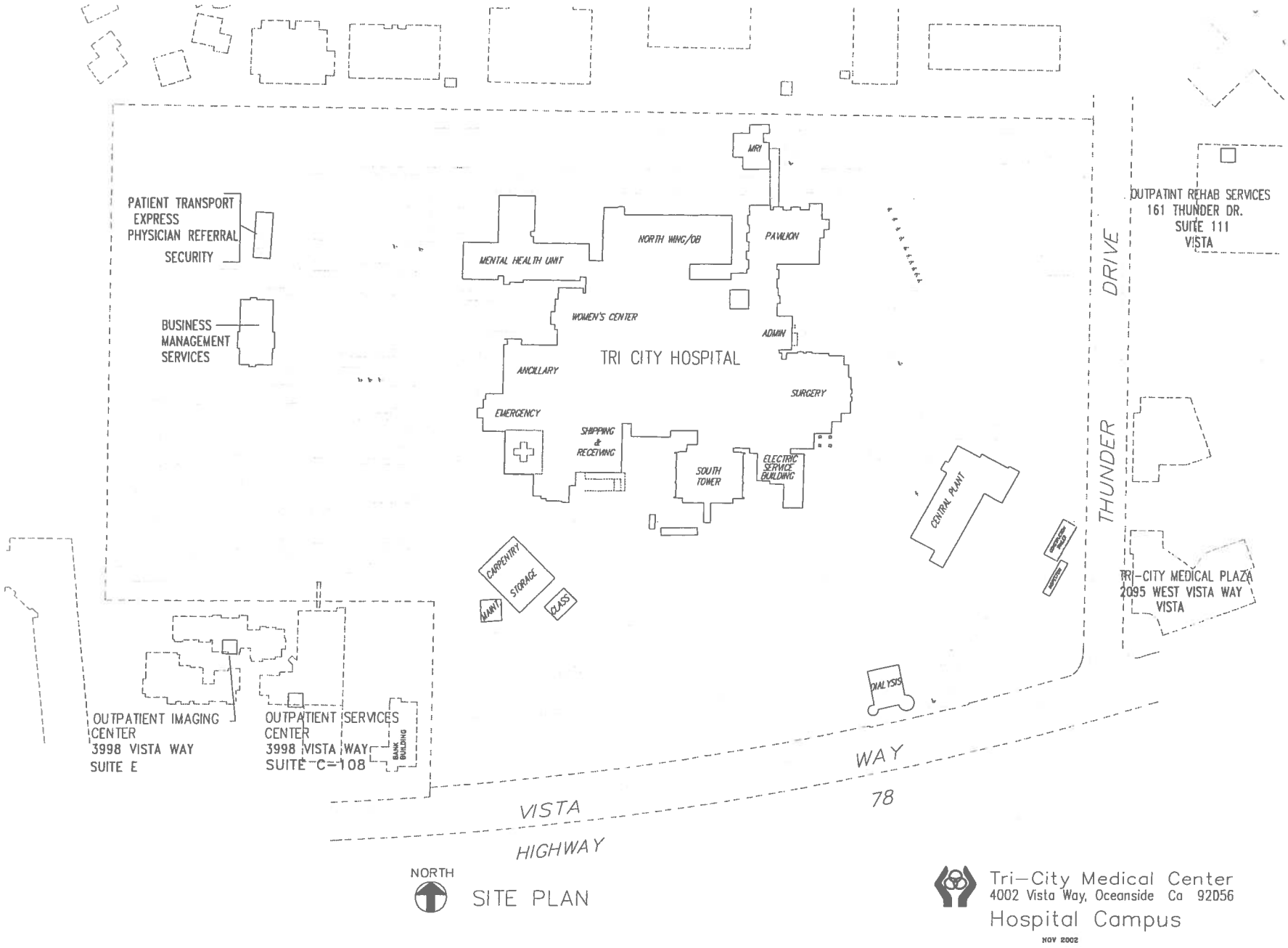
1. To provide adequate parking for patients and visitors by defining Tri-City Healthcare District's (TCHD) parking program.

B. **POLICY:**

1. All employees and physicians are required to complete a parking application form.
   a. The parking application form details their mode of transportation and identifying characteristics.
      i. Employees shall submit a completed and/or revised form to Human Resources.
      ii. Physicians shall submit a completed and revised form to the Medical Staff Office.
   b. All employees and physicians are required to display the TCHD parking placard while parked on TCHD campus.
2. All TCHD Board Members, Medical staff, **Executives,** ~~Vice Presidents~~, ~~and~~ Directors **and authorized administrative staff** may park in the Medical Staff parking area.
3. Employees shall park in designated employee parking areas (Refer to Attachment 1: "Tri-City Healthcare District Parking Map").
   a. Employees or others who use a bike as their mode of transportation shall park and secure bikes in the designated bike parking areas.
   b. Volunteers may park either in reserved volunteer parking areas or in employee parking areas.
4. Construction personnel shall receive parking instructions from the Engineering Department during their orientation.
5. Non-compliance with parking standards results in the issuance of a Security Department Parking Violation.
   a. The department manager shall be notified if an employee receives a second parking violation. Corrective action follows Administrative Policy, Coaching and Counseling for Performance Improvement.
6. Valet services are provided to all District residents with a District benefit card. Valet services **are provided Monday – Friday from 8:00 am to 4:30 pm and** may be used for special events **with notification one week prior to event**.
7. The designated speed limit on campus is 15 MPH unless posted otherwise.

C. **ATTACHMENTS:**

~~7.~~**1. Tri City Map**


PATIENT TRANSPORT
EXPRESS
PHYSICIAN REFERRAL
SECURITY
BUSINESS
MANAGEMENT
SERVICES
MRI
MENTAL HEALTH UNIT
NORTH WING/OB
PAVILION
WOMEN'S CENTER
ADMIN
TRI CITY HOSPITAL
ANCILLARY
SURGERY
EMERGENCY
SHIPPING
&
RECEIVING
SOUTH
TOWER
ELECTRIC
SERVICE
BUILDING
CENTRAL PLANT
CARPENTRY
STORAGE
PAINT
GLASS
THUNDER
DRIVE
OUTPATINT REHAB SERVICES
161 THUNDER DR.
SUITE 111
VISTA
TRI-CITY MEDICAL PLAZA
2095 WEST VISTA WAY
VISTA
DIALYSIS
OUTPATIENT IMAGING
CENTER
3998 VISTA WAY
SUITE E
OUTPATIENT SERVICES
CENTER
3998 VISTA WAY
SUITE C-108
BANK
BUILDING
VISTA
HIGHWAY
78
WAY
NORTH
SITE PLAN
Tri-City Medical Center
4002 Vista Way, Oceanside Ca 92056
Hospital Campus
NOV 2002

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 8/93

SUBJECT: USE, SECURITY, AND ACCURACY OF DATA

REVISION DATE: 4/94; 6/98; 8/99; 4/03; 12/05; 01/09, 02/11;6/14

POLICY NUMBER: 8610-242

Administrative Policies & Procedures Committee Approval: ~~03/11~~ 07/14
~~**Executive Council Approval:**~~ ~~04/11~~
Professional Affairs Committee Approval: 04/11
Board of Directors Approval: 04/11

A. **PURPOSE:**

1. To define the philosophy and policy of Tri-City Medical Center (TCMC) related to the use, accuracy and protection of all data generated and maintained in the hospital information systems. Increased public and other third-party access to hospital and provider-specific data requires collaboration and a proactive approach to analyzing information.

B. **POLICY:**

1. TCMC is committed to basing essential clinical and financial decisions on accurate and current information. All data used for these functions will be collected, interpreted, and utilized appropriately. Provider-specific data will not be released to outside entities except as mandated by state or federal statutes.
2. Physician specific data requests may initiate from the Department/Division chairperson, or from the Service Line team.
   a. All physician specific data will be coded to maintain confidentiality.
   b. Studies initiated from a Department/Division must be in the Department/Division meeting minutes with approval documented.
   c. Physicians not present at the meeting must be contacted in writing to inform them of study request.
   d. Studies will not be initiated until authorized by the Quality Assurance/Performance Improvement/Patient Safety Committee.
   e. The results may only be reported at a Medical Staff Department/Division meeting or a Medical Staff Committee meeting.
3. Clinical data will be used to:
   a. Develop or refine systems to improve patient care and to use hospital resources cost-effectively.
   b. Illustrate patterns of care and variation in treatment through aggregate data by diagnosis, procedure, DRG, practitioner, or other defined categories.
   c. Support and facilitate coordination with other provider groups (i.e., PPOs, PHOs, HMOs)
4. Data Security
   a. Handling of and access to data will be directed by the Administrative Policy for Confidentiality (Policy # 455)
   b. Employees and/or the Medical Staff are notified of data elements required by government and regulatory agencies. Specific internal data sources will be established by appropriate hospital or medical staff group.
   c. Individuals assigned the task of collecting registration data from patients will be oriented to the hospital policies and procedures and to federal and state regulatory statutes to ensure accuracy, confidentiality, and compliance.
   d. Providers will have access to their own profile data through an established procedure designated by the Medical Executive Committee.
   e. Printed reports containing individual physician data will be protected by the use of a confidential numerical code system.

f. Provider-specific data will not be released to outside entities except as mandated by state or federal statutes;
g. All information protected under Evidence Code section 1157 will be protected to the fullest extent and will not be released without authorization from the Medical Staff and legal counsel.

5. Accuracy
   a. Coding of clinical information for all inpatients, outpatient surgery, and emergency patients will be the responsibility of the Medical Records/Health Information Department.
   b. Routine validation of accuracy of data reports will be the responsibility of the individual department distributing or presenting the data.
   c. Identified inaccuracies will be referred to the appropriate department and Compliance Officer if applicable. Corrections will be completed.

C. **REFERENCES:**

1. Administrative Policy and Procedures:
   a. Disclosure of Protected Health Information # 513
   b. HIV Testing Consent and Disclosure of HIV Test Results #384
   c. Confidentiality of Psychiatric, Alcohol or Drug Abuse Information #311
   d. Hospital Records Retention #237
   e. Security Department Incident Notification #234
   f. Confidentiality #455
2. The Employee Handbook "General Rules of Conduct for Confidentiality"
3. Management Information Systems "Disaster Recovery Plan"
4. Medical Records "Disaster Recovery Plan"
5. Title 22 CCR Section 70751 (b)
6. Medical Staff Bylaws Section 12.2

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 4/91

SUBJECT: WEAPONS ON MEDICAL CENTER CAMPUS

REVISION DATE: 6/99; 9/05; 11/08; 03/11; 07/14

POLICY NUMBER: 8610-284

Administrative Policies & Procedures Committee Approval:	~~01/11~~ 7/14
~~Executive Council Approval:~~	~~02/11~~
Professional Affairs Committee Approval:	03/11
Board of Directors Approval:	03/11

A. **PURPOSE:**

1. To provide guidelines for all Security Department personnel, for insuring that patients and visitors are not permitted to bring weapons upon the Medical Center campus.

B. **DEFINITIONS:**

1. Weapons include firearms, knives, night sticks, brass knuckles, and other items defined as weapons by California and federal law.

C. **POLICY:**

1. It is the primary objective of the Security Department to provide a safe and secure environment for all Patients, Visitors, and Staff Members and free of any weapons, which could cause bodily harm or injury.

D. **PROCESS:**

1. Whenever a Security Officer discovers or is notified by staff of the presence of a weapon in the possession of a patient, visitor, or staff member, the Security Officer will immediately respond to the location of occurrence.
2. After evaluating the circumstances of the situation, the responding Security Officer, utilizing the following options, will determine the most practical and safe way to secure the weapon.
3. If upon admission a patient brings a weapon into the Medical Center, the weapon will be confiscated and released to a responsible family member.
4. If a family member is not present, the weapon will be confiscated, made safe, placed in a proper container and locked in the Emergency Department Security Office (EDSO) for safekeeping. A "Property Custody" form will be completed with the receipt given to the patient and the department copy attached to the item. If the patient informs the Behavioral Health Liaison (BHL) that they have weapons in their possession or in their vehicle, or anywhere on TCMC property the BHL is to notify security, the patient's ED physician, the charge nurse, and the patient's nurse immediately. Security will ensure that the weapons are secured per security's policy. If the patient is refusing treatment is a danger to self or others, a 5150 must be initiated. If the patient agrees to voluntary treatment, she/he must be allowed to do so, but must be placed on a 5150 if they attempt to leave Against Medical Advice (AMA).
5. If the patient is already in a patient care area, the Security Officer will confiscate the weapon and follow the procedure as stated above in a timely manner.
6. If it is determined that a Visitor had entered the Medical Center in possession of a weapon, the Security Officer will make contact and inform the visitor of this policy. The visitor will then be directed to immediately remove the weapon from the Medical Center campus or turn the weapon over to the Security Department for safekeeping. If the weapon is given to the Security Department for safekeeping,"Property Custody" form will be completed.
7. If a Patient or Visitor is unwilling to secure the weapon, the Security Supervisor/Shift Lead will be informed of the situation and attempt to gain cooperation with the individual.

8. If a Patient or Visitor is displaying the weapon in a reckless manner, causing a disturbance, or problem, threatening to cause a problem or disturbance, or is placing unusual/unreasonable demands on the staff, the responding Security Officer will only attempt contact if the safety and security of all involved parties will not be placed in jeopardy.
9. If the situation has escalated to the point where there is a high probability of harm or injury occurring, the responding Security Officer will immediately ensure that the Oceanside Police Department is contacted for assistance. The Security Officer will also ensure that an attempt is made to remove all persons from the immediate location safely.
10. Police Officers or Correctional Officers, who are guarding a "Police Hold"/in-custody patient, are permitted to carry weapons while discharging their duties. All cases requiring law enforcement personnel to carry weapons will be reported to the Security Department.
11. Police Officers or Detectives questioning or interviewing a patient, employee or physician are permitted to carry weapons. All cases requiring law enforcement personnel to carry weapons will be reported to the Security Department.

Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT

SUBJECT: ED Scope of Practice/Definition of Emergency Department **POLICY NUMBER: 7010-001**

ISSUE DATE:
REVISION DATE(S): 07/05; 02/11; 10/11; 06/14

Emergency Department Approval Date(s): 07/14
Emergency Department Medical Director Approval: 07/14
Professional Affairs Committee Approval:
Board of Directors Approval:

A. **DEFINITIONS:**

1. To delineate the scope of services provided throughout the various areas of the Emergency Department.

B. **SCOPE OF SERVICES:**

1. This is a basic Emergency Department (ED)/Paramedic Base Station. It is a non-bedded (episodic) department with a total of 47 treatment areas and two (2) Triage stations. It is located on the first floor of the southwest side of the medical center. The ED includes five (5) areas for care and treatment with a Triage station for patient sorting. A Clinical Operations Manager, Assistant Nurse Managers (ANM) and a Hospital Base Station Coordinator lead and manage the services and staff 24 hours/7 days per week. Tri-City Emergency Medical Group (TCEMG) provides medical management and leadership.
   a. Treatment Area Scope:
      i. Triage is staffed 24 hours/7 days per week with an RN. During peak hours there is an additional RN and EMT. The area is not equipped with monitors, but can accommodate portable monitoring equipment.
      ii. Stations A, B, C and D have a total of 41 treatment bays and are the primary acute areas. They are equipped to accommodate all ages and types of illnesses and injuries for this level of emergency services, 24/7. It is staffed at all times with at least one physician who is board-certified or board-eligible in emergency medicine, along with an RN at a ratio of at least 1:4 and a supporting staff comprised of EMTs and ACTs.
      iii. Fast Track has six (6) minor treatment bays. It is non-monitored, designed to accommodate lower acuity illnesses and injuries than those seen in stations A-D. The hours of service are variable and are subject to change in volume. It is staffed with an RN, EMT and a Physician who is board-certified or board-eligible in emergency medicine. TCEMG may alternatively designate a Physician Assistant (PA) experienced in emergency medicine in lieu of a Physician.
   b. Community Relationships:
      i. Guidelines for the relationship between pre-hospital providers and Tri-City Medical Center (TCMC) may be found in the Base Station Administrative Committee Bylaws.
      ii. Participating agreements for disaster drills and planning are referenced in the TCMC Disaster Manual Guidelines.
      iii. Trauma transfer facilities are the following:
         1. Sharp Memorial Hospital.
         2. Scripps Memorial Hospital, La Jolla.
         3. Scripps Mercy Hospital and Medical Center.
         4. Palomar Medical Center.

5. Rady Children's Hospital, San Diego.
6. UCSD Medical Center, Hillcrest.

c. Staffing:
   i. The ED is staffed with variable FTEs based on patient volume which includes a Clinical Nurse Educator/CNS, Case Manager, Assistant Nurse Manager (ANM) or Charge RN, Registered Nurses (RN), EMTs, ACTs and Unit Secretaries (US).

2. Staffing Considerations will take into account the following variables:
   a. *Patients:* Patient characteristics and the number of patients for whom care is being provided.
   b. *Complexity of Care:* Individual patient complexity, across the department complexity, variability of care and volume.
   c. *Context:* Architecture and physical limitations of the facility; technology and variability of equipment; clustering of patients within geographic locations.
   d. *Expertise:* Learning curve for individuals and groups of nurses; staff consistency; continuity and cohesion; cross training;; control of practice; involvement in quality improvement activities; professional expectations, preparation and experience.
   e. *ANMs and Charge RNs:* The ANM and/or Charge RN for the day is responsible for making assignments. The ANM and/or Charge RN is accountable for maintaining the appropriate skill mix required for comprehensive, holistic care. The ANM and/or Charge RN has the authority to increase staff levels when census and patient stability deem it necessary. They may make adjustments to the staffing plan as needed in order to provide the best staffing options for optimum patient outcomes while considering regulatory and budgetary issues. The authority to decrease staff will rest with the ANM and/or Charge RN.
3. Environment of Care:
   a. One (1) airborne precaution room (#C26) provides negative pressure ventilation for patients requiring airborne precautions.
4. Methods Used to Assess Patient's Needs:
   a. Initial assessments are performed by the Registered Nurse upon arrival of the patient in the ED. Reassessments are performed as needed when a change in status occurs, when there is a change in the caregiver and at a minimum once every shift. RNs utilize a variety of sources to gather pertinent information like physical assessment, data from the patient's chart, observation of team members, patient, families or significant others and other disciplines.

C. **QUALIFICATIONS OF STAFF:**

1. Registered Nurses in the ED are required to be certified in basic life support (BLS) and advanced care life support ACLS upon hiring, within six (6) months Pediatric Advanced Life Support (PALS) and/or Emergency Nursing Pediatric Course (ENPC) and within three (3) months ~~Safety Always for Employees (SAFE)~~ **Non-Violence Crisis Intervention (NVCI)** certified. Triage education is required and offered to staff after eighteen (18) months of ED experience. RNs are required to attend at least one (1) clinical education event per year, complete orientation materials, initial and annual competencies and complete all educational tools and activities given to them by the Clinical Nurse Educator/CNS.
   a. A minimum of eighteen (18) months of ED experience is required to be an MICN or Triage RN. Additionally, in order to become an MICN or Triage RN, nurses must complete training and pass an examination specific to those roles.
   b. In order to respond to Code Pinks, an ED RN must have a certificate in Pediatric Advanced Life Support (PALS) or Emergency Nursing Pediatric Course (ENPC).
2. EMTs are unlicensed personnel in the ED. They are required to be certified in basis life support (BLS) and perform patient care activities delegated to them by an RN, PA or Physician. All EMTs and ACTs are required to complete orientation materials, initial and annual competencies, educational tools and activities given to them by the Clinical Nurse Educator/CNS. Per the Board of Registered Nursing, EMTs in the ED are **NOT ALLOWED** to perform those functions

that require a substantial amount of scientific knowledge and technical skills, including but not limited to the following:

a. Venipuncture or IV therapy.
b. Parental or tube feedings.
c. NG tube, catheter insertions and/or removal and tracheal suctioning.
d. Assessment of patient condition.
e. Patient and family education for care or post discharge care.
f. Moderate complex lab testing.

3. Individuals and multidisciplinary groups provide in-services. The Clinical Nurse Educator/CNS and Leadership arrange for vendor in-services, self-study modules, case study presentations, department-based competencies as well as peer mentoring with experienced ED team members. The education needs are identified through chart reviews, patient complaints, and direct communication relating to the educational needs of the ED, surveys, audits and peer review activities.
4. The nursing service abides by regulations by California Title XXII, JCAHO, HCFA and BRN.

D. **COMMUNICATION, COLLABORATION AND FUNCTIONAL RELATIONSHIP:**

1. Communication is shared through monthly department meetings, staff mailboxes, e-mails, mailing to staff members homes, communication books and communication/educational boards located throughout the ED. Practicing the TCMC Mission and Values is an expectation, as is teamwork, professionalism and a positive attitude.

E. **DEPARTMENTS LEVEL OF CARE/SERVICE:**

1. The level of care provided by the Emergency Department meets the needs of outpatients through availability of staff who are competent to provide service for the current patient population and the coordination of nursing services with services of other disciplines.

F. **PERFORMANCE IMPROVEMENT:**

1. In order to improve patient care, several indicators are monitored to measure care given and effect change. Data is reported quarterly to the Quality Council.

G. **MISSION OF THE EMERGENCY DEPARTMENT:**

1. The Mission of the Emergency Department is to deliver exceptional care and service to all patients and their families by providing timely service, individualized care and excellent customer service.

Tri-City Medical Center	Distribution: **PULMONARY**
PROCEDURE:	**HIGH HUMIDITY HEATED OXYGEN ADULT**
Purpose:	Nasal high flow has been demonstrated to meet or exceed normal inspiratory demand, creating minimal air dilution and more accurately delivering prescribed oxygen concentrations. High flow delivery with nasal cannula produces a flushing effect in the pharynx, eliminating deadspace and creating a reservoir of fresh gas with each breath while minimizing re-breathing of carbon dioxide. Mean airway pressure has been shown to be elevated with the delivery of nasal high flow without adverse effect.
Supportive Data:	Fisher and Paykel Healthcare. Turnbull, B. (2008), British Journal of Nursing, 17/19, 1226-1230. Dysart, K., Miller, T., Wolfson, M., Shaffer, T. (2009) Respiratory Medicine, 103, 1400-1405. Respiratory Care March 2011, High Flow Nasal Cannula Oxygen in Critically ill Adults
Equipment:	Fisher and Paykel Blender/High Flow generator system with heated humidifier; Breathing circuit with chamber; Adult Optiflow Nasal Cannula or Trach Adaptor; Bacterial filter (if applicable); Sterile H2O bag for humidifier; continuous pulse oximeter.
Issue Date:	1/2013
Revision Date:	10/13, 2/14
Board of Director Approval Date (s):	

A. **AUTHORIZED TO PERFORM:**
1. ALL LICENSED TCMC RESPIRATORY CARE PRACTITONERS (RCPs).

B. **INFECTION CONTROL STATEMENT**
1. Unless hands are soiled, **use a waterless hand hygiene** product. If hands are soiled, wash with soap and water.
2. Hand hygiene is performed **prior to and immediately after touching a patient**, whether or not gloves are worn.
3. Gloves are worn to protect HCW from blood or body fluids.
4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch any surface (i.e. patient, I.V. pole, countertop, doorknob or phone) they are no longer 'clean'.
5. Change gloves when moving from one body site to another, for example, moving from oral to foley care.
6. Perform hand hygiene each time gloves are removed or changed.
7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. Add a gown to protect your clothes.

C. **GOALS:**
1. Decrease work of breathing in patients with mild to moderate respiratory distress
2. Reverse mild to moderate hypoxemia
3. Increase patient comfort and compliance with oxygen delivery device
4. Reduce intubation rate.

D. **INDICATIONS:**
1. Determine if the patient is **appropriate** for the high flow therapy. Patient populations that will potentially benefit from this therapy include:
   a. Patients requiring high flows who are currently on devices that utilize high flows.
   b. Patients where traditional nasal cannula does not meet patient flow demand and/or FiO2 requirement.
   c. Tracheostomy patients, who may require higher flows and/or heated, humidified gas
   d. COPD and asthma patients

e. Post-extubation and/or post-surgical patients who require higher flows, higher FiO2, and/or heated, humidified gas.

E. **CONTRAINDICATIONS:**

1. Determine if patient is **inappropriate** for the high flow therapy. Patient populations that may be inappropriate include:
   a. Patients who are obtunded
   b. Patients who may be unable to maintain their airway.
   c. Patients with severe respiratory acidosis
   d. Patients with suspected facial fractures or skull fractures
   e. **Note: Adult High Flow Cannula is not meant to be a substitute for CPAP or BIPAP if clinically indicated!**

F. **PROCEDURE:**

1. Verify physician orders.
2. Follow universal precautions
3. Identify yourself to patient.
4. Verify correct patient using 2 identifiers prior to initiating therapy.
5. Explain procedure and educate patient and family if present about high flow therapy.
6. Assemble equipment for use.
   i. -Attach new patient circuit to the device.
   ii. -Fill the heater water reservoir via sterile water bag and tubing
   ~~iii.~~ —Connect **oxygen from flowmeter.**
   ~~iv.~~**iii.** **--Turn on the Airvo device, allowing for audible indicator for patient connection.**
   ~~v.~~**iv.** -Place patient on continuous pulse oximeter.
   ~~vi.~~**v.** -Connect patient to high flow therapy system using appropriate size nasal cannula (no
   ~~vii.~~**vi.** largerthan half the diameter of the patient's nare) or trach adaptor.
   ~~viii.~~**vii.** **--Set FiO2 by adjusting flowmeter to meet ordered SpO2.**
   viii. -Start flow at 20-30 lpm for initial application and wean as appropriate to meet patient demand.
   ix. **-Range on the flow is 15-50 lpm.**
   x. **--If SpO2 drops, increase flow and increase FiO2 until SpO2 at desired level.**
   xi. -Monitor patient and Document therapy in **Hospital electronic record.**

F. **MANAGEMENT:**

1. Adjust initial liter flow to meet patient demand and decrease work of breathing.
2. With stabilization of work of breathing and oxygenation, FiO2 is weaned first. Wean FiO2 to less than or equal to 40% before decreasing flow.
3. Once FiO2 is less than or equal to 40%, wean flow **slowly** until down to **15** lpm--, keeping SpO2 in the range that it is ordered and based on patient tolerance.
4. When patient is stable on FiO2 of less than or equal to 40% and flow of **15** lpm, patient may be transitioned to regular nasal cannula.
5. Maintain H20 level in heater chamber to ensure adequate humidity (do not allow chamber to run dry.)
6. Nebulizer treatments are not to be given inline **using this device**.
7. A patient cannot be transported on the High Flow machine. The patient must be switched over to **another oxygen device that ensures the ordered SpO2 %** for transport.
8. **Cleaning: follow the manufacturer's recommendations for cleaning.**

Tri-City Medical Center	PULMONARY
PROCEDURE:	**RESPIRATORY PRE-OP TEACHING FOR INPATIENT CARDIOTHORACIC PATIENTS.**
Purpose:	To establish a process for the RCP to educate the inpatient cardiothoracic patients.
Issue Date:	1/14
Revision Date(s):	
Board of Director Approval Date(s):	

A. **PURPOSE: Under the following problematic conditions** ~~Note: T~~ this procedure is applicable to inpatient cardiothoracic patients only. (All pre-op teaching on the Outpatients is done by the Cardiovascular Institute.)

1. Potential patient complications and/or limitations:
2. Inconsistency in the information presented or failure to validate the learning process.
3. Lack of cultural competence, lack of materials in plain language, to the needs of the patient or caregiver, including languages other than English.
4. Impairment (eg., hearing, or vision, poor dexterity, decreased energy, strength, learning defects or stamina, age specific, pain, or medication adverse effects.)
5. Inability to comprehend or lack of awareness due to factors such as anxiety, depression, hypoxemia, substance abuse. This may include denial.
6. Lack of health literacy, despite level of education completed. This may include functional literacy in dealing with the healthcare process.

B. **PROCEDURE:**

1. A physician's order is required for the RCP to perform Pre Op Teaching.
2. The RCP will collect the following prior to entering the patient's room to support patient education, teaching and device demonstration:
   a. CVHI's most recent edition of "Preparing for Heart Surgery" booklet.
   b. An unopened Incentive Spirometer device
   c. A pillow to demonstrate proper splinting/coughing technique.
   d. Upon entering the patient's room, the RCP will:
      i. Introduce him/herself
      ii. Explain to the patient and family the purpose of their visit as designed as an educational opportunity to inform the patient of the RCP's role in their postoperative surgical care and to answer any additional questions the patient or family may have.
3. Pages 20-23 in CVHI's, "Preparing for Heart Surgery" booklet will be reviewed with the patient and/or family members.
4. Specifically, the areas in the booklet to be reviewed will be:
   a. The RCP's role in postoperative ventilator management.
   b. The RCP's role in airway management.
   c. The RCP's role in volume expansion therapies, such as Incentive Spirometry.
   d. The RCP's role in splinting/ cough support.
5. A sealed, unopened Incentive Spirometer will be shown to the patient, with an explanation of the importance of controlled volume and paused expansion during therapy. The patient should be provided the opportunity to see and touch the Incentive Spirometer device.
6. A pillow will be used to show the patient how to perform a controlled, splinted cough technique. Patient should return demonstrate the proper technique.
7. The RCP will thank both the patient and family for the opportunity to meet with them and ask if they have any additional questions.

C. **DOCUMENTATION PROCESS:**

1. The education will be charted in the Electronic Medical Record.
2. D.REFERENCE LIST:
   a. AARC Clinical Practice Guideline, "Providing Patient and Caregiver Training: 2010.

ISSUE DATE: 9/95

SUBJECT: Aerosol Transmissible Diseases and Tuberculosis Control Plan

REVISION DATE: 9/01; 9/02; 10/03; 10/06; 10/08, 7/09; 10/09; 7/11;~~7~~7/2014 **POLICY NUMBER:** IC.11

Infection Control Committee Approval: 07/2014
Medical Executive Committee Approval: 07/2014
Board of Directors Approval:

A. **TUBERCULOSIS AND AEROSOL TRANSMISSIBLE EXPOSURE CONTROL PLAN**
INTRODUCTION:

1. Legal mandates and regulatory agencies such as California Code of Regulation Title 8, Occupational Safety and Health Administration and the Centers for Disease Control and Prevention have set the standards for the implementation of an Aerosol Transmissible Diseases (ATD) including Tuberculosis Exposure Control Plan.

B. **PURPOSE AND POLICY:**

1. It is the policy of Tri-City Medical Center to provide care to patients with ATD's with a minimum risk of transmission to others. The Infection Control Committee will provide assistance in ensuring compliance with the policy. The plan includes:
   a. Protection of patients, employees and visitors from exposure to ATD's. These include:
      i. **Pathogens requiring Airborne Precautions;**
      ii. Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g. Anthrax/Bacillus anthracis
      iii. Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
      iv. Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out
      v. Measles (rubeola)/Measles virus
      vi. Monkeypox/Monkeypox virus
      vii. Novel or unknown pathogens
      viii. Severe acute respiratory syndrome (SARS)/SARS-associated coronavirus (SARS-CoV)
      ix. Smallpox (variola)/Varioloa virus (see vaccinia for management of vaccinated persons)
      x. Tuberculosis (TB)/Mycobacterium tuberculosis -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected
         1) Any other disease for which the CDC or CDHS recommends airborne infection isolation
         2) Diseases requiring Droplet Precautions;
      xi. Diphtheria/Corynebacterium diphtheriae – pharyngeal
      xii. Epiglottitis, due to Haemophilus influenzae type b
      xiii. Group A Streptococcal (GAS) disease (strep throat, necrotizing fasciitis, impetigo)/Group A streptococcus
      xiv. Haemophilus influenzae Serotype b (Hib) disease/Haemophilus influenzae serotype b -- infants and children

xv. Influenza, human (typical seasonal variations)/influenza viruses
xvi. Meningitis caused by the following organisms:
1) Haemophilus influenzae, type b known or suspected
2) Neisseria meningitidis (meningococcal) known or suspected
xvii. Meningococcal disease/Neisseria meningitidis: sepsis, pneumonia (see also meningitis)
xviii. Mumps (infectious parotitis)/Mumps virus
xix. Mycoplasmal pneumonia/Mycoplasma pneumoniae
xx. Parvovirus B19 infection (erythema infectiosum, fifth disease)/Parvovirus B19
xxi. Pertussis (whooping cough)/Bordetella pertussis
xxii. Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus,
xxiii. Pneumonia caused by the following organisms:
1) Adenovirus
2) Chlamydia pneumoniae
3) Mycoplasma pneumoniae
a) Neisseria meningitidis
4) Streptococcus pneumoniae (use droplet precautions if evidence of transmission within a patient care unit or facility)
xxiv. Pneumonic plague/Yersinia pestis
xxv. Rubella virus infection (German measles) (also see congenital rubella)/Rubella virus
xxvi. Scarlet fever in infants and young children/Group A streptococcus,
xxvii. Serious invasive disease
xxviii. Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses, and Hantaviruses

~~a.~~**b.** Source Control Procedures including cough etiquette / respiratory hygiene.
~~b.~~**c.** Implementation of an effective triage system and early identification of suspects and active cases
~~c.~~**d.** Engineering control measures
~~d.~~**e.** Respiratory protection programs
~~e.~~**f.** Education and training of employees
~~f.~~**g.** Evaluation and treatment of employees exposed to ATD's

C. **SCOPE:**

1. The Tuberculosis Control and Aerosol Transmissible Diseases Plan applies to all inpatient and outpatient services

D. **RESPONSIBILITY:**

1. The Tuberculosis Control and Aerosol Transmissible Disease Program will require the participation of the following personnel:
   a. The Infection Control Officer and the Infection Preventionist are responsible for overseeing the plan. This includes, but is not limited to implementation of the plan for the facility; development of policies and procedures to support the implementation of the plan; reporting of suspected and diagnosed cases of A**TD**~~DT~~'s and Tuberculosis as defined in under CA title 22 to the Infection Control Committee and county department of health. It is also the responsibility of the Infection Preventionist to evaluate the risk assessment at least annually.
   b. The Environment of Care Officer is responsible for implementation and maintenance of current standards to meet the requirements of the California Code of Regulation Title 8, Title 24 and the guidelines from the Centers for Disease Control and Prevention.
   c. Employee Health Services is responsible for employee TB skin testing and interpretations; conducting investigation regarding employee exposure to ATD's and TB; maintaining employee TB skin test conversion data; reporting employee conversion and

diagnosed cases to the Infection Control and Safety committees annually; and managing and counseling health care workers who have active ATD's. Employee Health is responsible for developing and implementing policies and procedures related to the respiratory protection program. Employee Health is also responsible for screening, testing, and provision of immunizations as indicated and seasonal influenza vaccination administration and declination statement documentation.

d. Department Directors are responsible for implementation of the TB and ATD Control Plan in their respective areas, providing educational training to all employees before exposure to a source case; maintaining documentation of personnel training; notification of the Infection Preventionist and Facilities Management when active TB patients or patients with other ATD's are admitted to their area.

e. Administrative Supervisor is responsible for implementation of the TB control plan in the hospital during the hours of 1600-0800 and on weekends and holidays; and overseeing the reporting and discharge of suspected or confirmed cases of ATD or Tuberculosis on weekends and holidays.

f. The Director of Education is responsible for including TB and ATD control plan in orientation of new employees and annual OSHA required training related to ATD's.

g. The Director of Environmental Services is responsible for developing, implementing and monitoring procedures for cleaning rooms occupied by a patient with ATD's.

h. The Facilities Director is responsible for monitoring and verifying air changes and air pressures daily on Airborne Infection isolation rooms, when in use, and reporting of air changes and air pressures to the Infection control and Safety committees annually.

i. The Director of Pulmonary Services is responsible for developing, implementing and monitoring procedures for high-hazard procedures.

j. The Director of Engineering is responsible for maintaining and cleaning of portable HEPA recirculators and providing portable HEPA recirculators to units as needed.

k. Microbiology Supervisor is responsible for the notification of the local health authority according to California and Federal regulations of ATD's and TB. The Employees are responsible for early identification of suspects and active cases of ATD's and TB; early implementation of Airborne Precautions; knowledge of Tuberculosis and ATD control plan; reporting of cases to the Infection Preventionist and/or the Public Health Nurse; compliance with all protective practices; attendance of New Employee Orientation Program and annual OSHA required education; and reporting noncompliance and unusual occurrences using a quality review (QR) report.

l. The Physicians play an important part in TB and ATD Control by maintaining a high index of clinical suspicion.

   i. Physicians should place all HIV positive patients with infiltrates in Airborne Precautions until three sputum concentrated smears are negative for AFB or until a diagnosis other than tuberculosis is clearly established.

   ii. Place all new admits with a history of fever, weight loss and cough or pneumonia greater than 2-3 weeks in Airborne Precautions if no clear etiologic agent is identified.

   iii. Treat all highly suspected tuberculosis cases with antituberculosis medications pending sputum results.

   iv. Consider ATD in patients with temperature greater than 100 degrees F and cough. ATD may also be considered in the presence of rash with fever.

   v. Implement control measures when ATD is suspected.

E. **AVAILABILITY OF THE PLAN:**

1. The Tuberculosis and ATD Control Plan will be available via the Intranet in the Infection Control Manual in every department. OSHA required education will be conducted at the new employee orientation program and all other employees are required to complete an annual review. The written plan will be reviewed and updated annually and as indicated by regulations.

~~A.~~F. FUNDAMENTALS OF TUBERCULOSIS INFECTION CONTROL:

1. Some segments of the U.S. population have a higher risk for TB because they are more likely to have been exposed or because their infection is more likely to progress to active TB after infection. TB is carried in the air after being generated when persons with pulmonary or laryngeal TB sneeze, cough, speak or sing. These particles are carried on air currents and stay afloat for a long time. Infection occurs when a person inhales the germs into their lungs. Usually within 2-10 weeks after infection, the immune response limits further multiplication and spread but some bacteria can remain dormant for years (latent infection). People with normal immune systems have a 5-10% lifetime risk of the latent infection progressing to active disease. Factors that influence infection include the concentration (number) of the bacteria in the air and duration of exposure. Exposure in a relatively small space with inadequate ventilation can increase the risk of infection. Persons who are immunocompromised are more likely to become infected and to also develop active disease. The transmission, epidemiology and pathogenesis of TB were all considered in our plan. An effective program requires early identification, isolation and effective treatment of persons who have active disease.
   a. The most effective control measure is to ensure rapid identification, isolation, diagnostic evaluation and treatment of persons likely to have TB.
   b. The next level of effective control is the use of engineering controls (i.e. airflow, dilution, filtration and exhaust of air)
   c. The final and least effective control is the use of respiratory protection.

~~B.~~G. TUBERCULOSIS RISK ASSESSMENT:

1. Risks assessment will be performed annually by the Infection Preventionist and reviewed by the Infection Control and Environment of Care Committees. The purpose of this assessment is to evaluate the risk of transmission of Tuberculosis so that appropriate interventions can be developed. The assessment will include:
   a. Community TB profile from public health department data
   b. Number of infectious TB patients treated in outpatient and inpatient areas.
   c. Drug susceptibility patterns of TB patients
   d. Analysis of healthcare workers PPD test results by area
   e. Review medical records for appropriate precautions, timing of specimens, duration of precautions and timely communication with public health.
   f. Observation of practice and review of engineering controls.
2. Considerations for determining the hospital's risk classification will be based on the following:

H.	VERY LOW RISK	**I.**	There are no TB patients admitted to the facility during the preceding year
J.	LOW RISK	**K.**	The employee PPD conversion rate in an area is not higher than in areas with increased occupation exposure to Tuberculosis
		L.	Fewer than 6 patients were admitted to area during the preceding year
		M.	There is no evidence of person-to-person transmission
		N.	No clusters of HCW PPD conversion
O.	INTERMEDIATE RISK	**P.**	Same as Low Risk with the addition of six or more TB patients admitted to the area during the preceding year.
Q.	HIGH RISK	**R.**	PPD conversion rate is higher in areas without occupational exposure to Tuberculosis.
		S.	Clusters of HCW PPD conversion.
		T.	Evidence of person-to-person transmission.
		U.	More than 6 patients admitted to an area.

3. Early identification of suspected and active TB patients can initiate prompt treatment and prevent transmission of the disease. This is the most effective method for controlling the spread of tuberculosis, an Administrative Control. A suspected case of TB is defined as:

a. A patient with unexplained cough, cough with bloody sputum, and/or a cough lasting longer than 3 weeks
b. A patient with unexplained fever, night sweats, weight loss and anorexia
c. Readmission of patients recently diagnosed with Tuberculosis

4. A high index of suspicion for Tuberculosis should be maintained for the following
   a. Patients requiring high-risk procedures such as aerosolized pentamidine and sputum induction for Acid Fast Bacilli (AFB)
   b. Patients who belong to a group with a higher prevalence of TB infection: medically under-served, foreign born from a developing country, homeless, current or past prison inmate, alcoholic, injecting drug-user, elderly, or extended contact with an active TB case.
   c. Patients who belong to a group with a higher risk to progress from latent TB to active disease: immunocompromised (HIV, organ transplant, or on high dose steroids), silicosis, status post gastrectomy or jejunoileal bypass surgery, >10% below body wt, chronic renal failure, diabetes mellitus, infected within past two years, or child >5 years old.
5. In outpatient areas where patients with undiagnosed Tuberculosis may be present, precautions must be taken to minimize the risk of transmission.
   a. Instruct patients to cover their mouths with a handkerchief or tissue, and give them a surgical mask to wear. Tissues and masks must be readily available in the waiting areas.
   b. Questionnaires will be utilized in all outpatient areas and Emergency Department to assist in the early identification of suspected cases. See Appendices A and B for a flow cart and sample questionnaire.
   c. Patients with symptoms suggestive of Tuberculosis will be removed from the common area and placed in a designated waiting area.
   d. Patients unable to wear a mask can be placed outside with appropriate supervision until an appropriate room is available.
6. For departments in main hospital building without a built in negative pressure room, staff shall obtain HEPA recirculator from the ~~Pulmonary Services~~**Engineering department** to enhance circulation in the exam or treatment room to be used by the patient. Contact Engineering for placement assistance.
   a. HCW wear N95 particulate respirators and visitors wear surgical masks when entering this area.
   b. If the patient is suspected or known to have infectious TB, the room must remain vacant for **one hour** after the patient leaves. The door is to remain closed and the filter running.
   c. Personnel may enter the area but must continue to wear respiratory protection until the time has lapsed.
7. For off-site areas, the patient will be asked to wear a mask while inside the building.
8. Any possibility of TB as a diagnosis should be communicated by telephone to other departments, prior transporting the patient to those areas.
9. Patients seen in the ED with confirmed or suspected Pulmonary or Laryngeal TB might require hospitalization to control the spread of infection. See Page 10 for algorithm.
   a. Emergency Department rooms should remain closed for 30 minutes after the patient leaves to ensure 99.9% removal of contaminants. Personnel may enter the room before this time has lapsed but must wear an appropriate respirator.

~~C.~~V. MANAGEMENT OF HOSPITALIZED PATIENTS WHO MAY HAVE ACTIVE TB:

1. Health Care Workers who are the first points of contact should ask questions that will facilitate identification of patients with signs and symptoms suggestive of TB. See the Admission Database screening questions.
~~1.~~**2.** Upon identification of a patient with active or suspected Tuberculosis, the nurse must place the patient in an Airborne Illness Isolation Room (AIIR) (i.e. negative pressure room: C-26, 143, 243, 443, 287, 387, 487, ~~and~~ 200 **and Forensic Rooms 312 and 326**). The door must be closed and the HEPA filter running. Post the Airborne Precautions sign, outside the room.

a. If a designated room is not available, notify the charge nurse and the bed coordinator of the need for an Airborne Precautions room. Remove any roommates and call ~~Pulmonary Services~~**Engineering** for the HEPA filter. Keep the door closed and post the Airborne Precautions sign. **HCW wear N95 particulate respirators and visitors wear surgical masks when entering this room.**

~~a.~~**b.** Patients with TB must not be placed together in the same room unless they have culture- confirmed TB, have drug susceptibility test available on current specimens obtained during the present hospitalization, have identical drug susceptibility patterns on these specimens and are on effective therapy.

~~2.~~**3.** Reporting:

a. The Unit Secretary notifies Engineering **(by placing a worker order)** and the Infection Control office that an Airborne Precautions room is in use for tuberculosis.

b. The charge or patient's nurse must notify the Infection Preventionist of the patient's name, medical record and room number. Phone call ~~or Affinity report~~ is used.

c. On weekends and holidays, the charge nurse or the primary nurse will notify the Public Health Nurse by calling cell phone number (619) 540-0194. Go to http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport.pdf for a copy of the report.

d. Laboratory Results: Hospitals and health care providers are required by law to report TB to protect the public. This must be done within one day of identification of the case or suspected case.

e. The Microbiology department will notify the nursing unit and the Infection Preventionist of a positive AFB smear or culture results. A fax report of all positive AFB smears and cultures is sent to the Public Health.

f. The Infection Preventionist or designee is responsible for reporting to public health. Tuberculosis (TB) Program Nurses are available 8:00 a.m. to 5:00 p.m., 7 days a week and all holidays on cell phone number (619) 540-0194 TB control does not have personnel available between the hours of 5:00 p.m. and 8:00 a.m. Persons with routine questions or questions about TB exposure should call phone number (619) 692-8610 after 8:00 a.m. on the following day.

g. Person wanting to report a case of TB after 5 P.M. should do one of the following:
   i. Call pager (619) 540-0194 after 8:00 a.m. the following day to report directly to TB RN if they feel there is urgency about reporting; or
   ii. Leave a message on the Tuberculosis RN voice mail (619) 692-8610 and their call will be returned on the next working week day. Message should include patient's name, date of birth, facility name, reporter's name and phone number, and contact person at facility who will be available for more patient information.

h. Person requesting Discharge Approval should:
   i. Contact TB RN between 8:00 a.m. and 5:00 p.m.

i. Physicians from emergency rooms requesting recommendations regarding patients they suspect may be infectious after 5 P.M., should do the following:
   i. If patient is homeless or from congregate setting (SNF, school dormitory, etc.) and has clinical picture consistent with TB, we recommend to admit and rule out infectiousness.
   ii. If patient has a home and is otherwise medically stable (not in need of admission) patient can be sent home, obtain one sputum for AFB smear and culture prior to release, start on medication if indicated. Direct caller to contact TB RN on phone number (619) 692-8610 after 8:00 a.m. on the following day.

j. Persons calling about patients who are leaving against medical advice (AMA):
   i. Have facility get as much locating information as possible on patient (including address/phone of relatives or friends)
   ii. Call intake RN between 8 am and 5 pm; after hours call 8:00 a.m .the next day
      1) Go to http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport.pdf for the report form.

~~3.~~**4.** Health-care workers (fit-tested and approved for use) will wear an N-95 respirator when entering the patient's room. See the Respiratory Protection Program under the Employee Health section ~~7.1. Disposable respirators reuse by the same health care worker is permitted as long as the respirator maintains its structural and functional integrity and the filter material is not physically damaged or soiled~~.

~~4.~~**5.** The nurse will initiate the Tuberculosis Management protocol and the Communicable Disease teaching protocol.

~~5.~~**6.** Pediatric patients with suspected or confirmed TB must be evaluated for potential TB according to the same criteria, as are adults. Parents and other visitors of pediatric patients must be evaluated for TB as soon as possible. Until they are evaluated, they must wear surgical masks when in areas of the facility outside of the child's room.

~~6.~~**7.** Diagnostic and treatment procedures must be performed in the Airborne Precautions rooms to prevent transporting to other areas of the facility. If the procedure cannot be done in the isolation room, the patient must wear a surgical mask during transport. Procedures should be scheduled at times when they can be performed rapidly and the areas are less crowded.

~~7.~~**8.** Limit the number of persons entering an isolation room to a minimum. All visitors (except HCW who have been fit-tested for an N95 respiratory) wear a surgical mask when entering an Airborne Precautions room.

~~2.~~**9.** Facilities will verify airflow rates and negative pressures at the time the negative pressure room is established. Negative pressures will be verified daily and a log maintained by Facilities department.

~~8.~~**10.** Cough-inducing procedures will not be performed on patients who have or may have active Tuberculosis unless the procedures are absolutely necessary and can be performed with appropriate precautions.

a. The patient is in an Airborne Precautions room.
b. The portable air filtration system has been set-up in a regular room.
c. The Pulmonary Services Isolation Booth is used for sputum induction.

~~9.~~**11.** Health care workers must wear respiratory protection (N95 respirator) when present in rooms or enclosures in which cough-inducing procedures are being performed on patients who may have infectious Tuberculosis.

~~10.~~**12.** After completion of the cough-inducing procedures, patients who may have infectious Tuberculosis will remain in the Airborne Precautions room until the coughing subsides. (If transport is necessary, patient will be provided with a surgical mask to wear.) Outpatients will wear surgical masks until outside the hospital.

~~11.~~**13.** Before the Pulmonary Function Testing room is used again, after the booth has been in use, the HEPA filter is kept on and the door to the room closed for 1.5 hours. Healthcare workers entering the room before the 1.5 hours are over will wear an N95 respirator.

~~12.~~**14.** Bronchoscopy considerations

a. The bronchoscopy room for all inpatient and outpatient procedures will be a negative pressure room. The air filtration system will remain in use whenever a suspect case is performed. Respiratory protection will be worn. The patient waiting for bronchoscopy will be provided a surgical mask and escorted to a non-communal waiting room.

~~13.~~**15.** Administration of aerosolized Pentamidine (see Pulmonary Policy 6.8)

a. Patients with suspected Tuberculosis will be provided surgical masks and asked to wait in a non-communal waiting area.
b. Health care workers will wear N95 particulate respirator and use isolation booth for treatment.
c. Patients will be instructed to wear surgical masks until out of the hospital.
d. Room will remain closed with the filter running for 1.5 hours prior to reuse.

~~J.~~W. ADDITIONAL CONSIDERATIONS FOR SELECTED AREAS:

1. Operating Rooms
   a. Elective procedures on patients with tuberculosis should be delayed until the patient is no longer infectious.

b. If procedures must be performed, they should be done in OR rooms with anterooms with door closed and traffic at a minimum.
c. Personnel present when operative procedures are performed on patients who have infectious tuberculosis should wear respiratory protection rather than standard surgical masks alone. Valved or positive-pressure respirators are not appropriate for use during procedures requiring surgical masks.
d. Procedures should be done when other patients are not present in the operating suite e.g., end of day) and when minimum number of personnel are present. This applies to pulmonary and non-pulmonary sites.
e. A bacterial filter placed on the patient endotracheal tube or at the expiratory side of the breathing circuit of the anesthesia machine may be useful in reducing the risk of contamination of anesthesia equipment or discharge of tubercle bacilli into the ambient air when anesthesia is being administered to a patient with possible tuberculosis.
f. The pulmonary TB patient should be monitored during recovery in an individual room meeting Airborne Isolation room ventilation requirements.
g. Surgery Suites should be **closed for one hour** after the patient leaves to ensure 99.9% removal of contaminants. Personnel may enter the room before this time has lapsed but must wear an appropriate respirator.

2. Autopsy Rooms
   a. Due to the probability of the presence of infectious aerosols, autopsy rooms should be at negative pressure with respect to adjacent areas, with room air exhausted directly to the outside of the building. ASHRAE recommends that autopsy rooms have ventilation that provides 12 total ACH.
   b. Personnel performing autopsies on patients who may have had tuberculosis should wear respiratory protection.
   c. In-duct HEPA filtered air re-circulation or UVGI may be used as a supplement to the recommended ventilation.
   d. The autopsy room should remain closed for **one hour** after the patient leaves to ensure 99.9% removal of contaminants. Personnel may enter the room before this time has lapsed but must wear an appropriate respirator.
   e. Deaths caused by a known or suspected contagious disease constituting a public health hazard are reportable to the Medical Examiner's Office. Autopsy performed on these cases will be performed by the medical examiner.
3. Home Health Services
   a. HCWs entering the home of a patient with confirmed or suspected TB or ATD should wear respiratory protection.
   b. The patient should be taught to cover mouth and nose with a tissue when coughing or sneezing.
   c. Educate patient regarding importance of taking medication (and administering directly observed therapy).
   d. Immunocompromised persons or young children living in home with TB patient should be temporarily relocated until patient is no longer infectious.
4. Cough-inducing procedures should be performed on patients with infectious tuberculosis only if absolutely necessary. If their performance is required a well-ventilated area away from other household members should be used (for example, go outside or open a window). HCWs will wear respiratory protection during the procedure
5. Specific processes and procedures pertaining to ATD's in the home are found in the Home Health Care policy manual.

IX. DIAGNOSTIC EVALUATION:

1. Diagnostic evaluation should include the following:
   a. Medical history and evaluation - The probability of TB is greater among patients who have positive PPD test results or a history of positive PPD results, who have previously had TB or who have been exposed to someone with TB, or who belong to a group at

high risk for TB.

b. Mantoux skin test (PPD skin test) – is placed by the specially trained staff and read at 48- 72 hours after injection. Results are to be documented in the Medical Record.

c. QuantiFERON-TB Gold (QFT-G) test can be used in any situation a Mantoux PPD skin test is indicated. A positive result has the same significance as a positive PPD skin test, and neither a positive PPD nor a positive QFT-G by itself warrants Airborne Precautions.

d. Chest radiograph - radiographic abnormalities that strongly suggest active TB include upper lobe infiltrates, particularly if the cavitations are seen, and patchy or nodular infiltrates in the apical or sub apical posterior upper lobes or the superior segment of the lower lobe. The MD may include the words "cavitary lesion", "granuloma disease" or "suspected tuberculosis" in the results.

e. Microscopic examination and culture of sputum or other appropriate specimen. Three sputum specimens should be collected 8–24 hours apart, and at least one should be an early morning specimen, induced, or bronchoalveolar lavage (BAL). (See Table 1).This will assist in determining if the patient is infectious. Although direct AFB smears are available in house, concentrated smears performed by our reference laboratory are preferred and are included with orders for a TB culture. Since neither a direct nor a concentrated smear has sufficient sensitivity to exclude a diagnosis of tuberculosis, cultures must also be ordered.

f. Initiating Treatment: Patients who have confirmed active TB or who are considered highly likely to have active TB should be started promptly on appropriate treatment in accordance with the current guidelines.

g. Drug susceptibility should be performed on all initial isolates from patients with TB.

h. Contact Infection Control at Ext. ~~3007~~ **5696** or 7410 for the latest recommendations.

~~F.~~Y. AIRBORNE PRECAUTIONS:

1. Airborne Precautions can be discontinued as soon as the diagnosis of TB has been ruled out, when another diagnosis is confirmed, or when the patient is no longer infectious.
   a. Airborne Precautions can be discontinued:
      i. In a patient with active tuberculosis when the patient is on effective therapy, improving clinically, and has had three consecutive negative concentrate sputum AFB smears
      ii. In a patient with suspect tuberculosis as soon as the diagnosis of TB has been excluded by three negative AFB sputum smears taken 8-24 hours apart with at least one from an early morning specimen, induced specimen, or BAL OR when another diagnosis is confirmed
2. Continued isolation throughout the hospitalization should be considered for patients who have multi-drug resistant tuberculosis (MDR-TB) because of the tendency for treatment failure or relapse.

~~G.~~Z. DISCHARGE:

~~3.~~**1. Before leaving the hospital, TB patients must be approved for discharge by the Public Health Department.** A discharge plan must include all of the following prior to approval from the TB Control Officer (This form can be accessed at **http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB-273TuberculosisDischargeCarePlan.pdf**)

   a. Three consecutive negative sputum smears from concentrate or approved living arrangements so that TB isolation can be maintained. For example, the accepting facility has an airborne precautions room available or the house and household contacts have been evaluated and cleared by the **TB County** public health nurse.

   b. A confirmed outpatient appointment (date/time/place) with a provider (name and phone number) who will manage the patient's care until cured.

   c. Sufficient medication to take until the outpatient appointment. Contact Pharmacy for assistance with take-home medications.

d. Placement into case management (e.g. DOT) or outreach programs of the public health department.

~~a.~~**e.** The charge nurse or shift supervisor will notify the Public Health Department at (619) 692-8610 prior to the anticipated discharge and obtain approval.

i. **Public Health requires at least two days prior to discharge to review the case.** On weekends and holidays, obtain approval from the on-call **TB County** public health nurse at cell phone number (619) 540-0194

2. Cleaning of the room after a known or suspected TB patient is moved or discharged:

a. The patient is infectious or might be infectious and **was not** in a negative pressure and HEPA filtered room: Post the Airborne Precautions sign and keep the door closed. Call Pulmonary Services for a HEPA filter. Plug in the filter, turn it on and close the door. Post a sign that specifies the appropriate time period from the table below. TCMC staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed. After the time period has ended, discontinue Airborne Precautions and return the HEPA filter to Pulmonary Services.

Area	Length of Time Room is Closed
Orthopedics/Rehab (1N/S)	Two hours
Maternal/Child	Two Hours
South	Two hours
3 N/S	Two hours
Pavilion	One hour
E/W Tower	One hour
Surgery	One hour
Radiology	One hour
Emergency Department and Bronchoscopy area	30 minutes

3. The patient is still infectious and was in a negative pressure room: keep the Airborne Precautions sign posted, leave the HEPA filter running and close the door for one more hour. Post a sign that specifies this time period. TCMC staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed. After the one-hour period has ended, discontinue Airborne Precautions.

4. The patient is no longer infectious or TB has been ruled out: no special precautions needed. The door may be immediately opened and the room cleaned as usual.

~~H.~~AA. ANNUAL TUBERCULOSIS SCREENING:

1. Auxiliary and Employees: See the Employee Health section 7.1, TB Surveillance and Respiratory Protection policies.
2. Physicians: the Medical Staff Office sends an annual screening survey to each physician on staff. PPD testing for physicians is required and available in Work Partners.

~~A.~~BB. AEROSOL TRANSMISSIBLE DISEASE CONTRO EXPOSURE DETERMINATION

1. A list of tall job classifications in which employees have occupational exposure is available in the Infection Control Manual IC.14 Employee Health Respiratory Protection Program.

~~B.~~CC. ISOLATION PRECAUTIONS

1. Standard Precautions and Transmission based precautions including cough etiquette, Airborne Precautions, Droplet Precautions and Contact Precautions are outlined in IC.5 IC.5.1; IC.5.2

~~C.~~DD. HIGH HAZARD PROCEDURES:

LOCATION	COMMON HIGH HAZARD PROCEDURES REQUIRING THE USE OF AN N-95 RESPIRATOR (POSITIVE AIR PURIFYING RESPIRATOR (PAPR) AS REQUIRED 9/1/10) FOR PATIENTS WITH KNOWN OR SUSPECTED ATD.
ACCU, PACU, ED and Bronchoscopy Suite	Intubation and Extubation Sputum Induction Endotracheal & Tracheostomy Tube Care Bronchoscopy
Medical / Surgical Units	Sputum Induction Endotracheal Intubation
Pulmonary Services	Sputum Induction Pulmonary Function Tests Bronchoscopy Aerosolized administration of pentamidine or other medication
Operating Rooms	Intubation and Extubation Bronchoscopy Tracheotomy Thoracotomy Lung Biopsy Endotracheal & Tracheostomy Tube Care
Recovery	Endotracheal & Tracheostomy Tube Care Intubation or Extubation

~~D.~~EE. SOURCE CONTROLS AND ENGINEERING CONTROLS IN SPECIFIC HOSPITAL AREAS

1. Throughout the facility cough etiquette is used in waiting areas. Signs with instructions are posted in these areas in Spanish and English. Patients are provided tissues and are asked to wear surgical masks to prevent droplets from disseminating into the environment. Alcohol hand hygiene solutions are made available for patient use. Bilingual signs are posted in waiting areas instructing patients to "Cover your cough."

~~1.~~**2.** Emergency Department

   a. Engineering Controls during a surge of patients with ATD is addressed in the TCMC Infection Control Policy IC15.0 Influx of Infectious Patients: *Epidemic Influenza or other respiratory transmitted disease*.
   b. At the point of triage, ED staff shall screen and identify patients with symptoms of ADT and implement source control by placing a surgical mask on the patient and asking the patient to keep the mask on during their visit. If the patient cannot tolerate a surgical mask, tissues shall be provided and patients shall be instructed to cover their cough.
   c. Staff wears N-95 respirators (PAPR's as required after 9/1/10) during high hazard procedures (listed above).
   d. N-95 respirators or PAPR's are used during patient contact for diseases spread by airborne route.
   e. Surgical masks are used during patient contact for diseases spread by the droplet route.
   f. Patients with diseases known to be transmitted by the airborne route, including novel viral infections, will be prioritized for Airborne Infection Isolation Room (AIIR) C-26.
   g. When room C-26 is not available a private room is used.
   h. When there are no private rooms available, patients are asked to keep their mask in place and use tissues to prevent droplet aerosolization.
   i. Patients may be cohorted in designated rooms or bays when indicated.
   j. Patients suspected of having ATD's are provided with disposable nebulizer units with expiratory filters or multi-dose inhalers as clinically indicated.
   k. There are no special environmental cleaning recommendations for TB or r/o TB patients.

l. Rooms shall be cleaned between patient using the hospital approved disinfectant.

~~a.~~**m.** When used for an patient with ATD, room C-26 shall remain empty with Airborne Precautions sign posted and door closed for 30 minutes prior to being used by another patient.

~~2.~~**3.** Nursing Units

a. Patients who are admitted with airborne transmissible diseases are admitted to AIIR's on nursing units.

b. Airborne Precautions are initiated and followed in accordance with CDC recommendations for Transmission Based Precautions. A TB quicklook is posted outside each AIIR for step by step instructions on initiating and maintaining proper airflow.

c. Doors are kept closed.

d. Patients in Droplet precautions do not need AIIR's for routine care. However, high hazard and cough inducing procedures performed as part of the clinical care of patients in both Airborne and Droplet Precautions will be done in AIIR using N-95 respirators (PAPR's as required after 9/1/10).

e. Portable HEPA filtration units can be used to facilitate AIIR. Engineering installs and maintains these devices. Place a work order for installation and monitoring.

~~b.~~**f.** Airborne Infection Isolation rooms shall remain empty with Airborne Precautions sign posted and door closed for designated time (see G.2.a) when a patient with Airborne transmissible disease has occupied the room.

~~3.~~**4.** Pulmonary Medicine

a. Bronchoscopy for patients in Airborne or Droplet Precautions will be performed in an AIIR.

b. N-95 respirators or PAPR's are used during Bronchoscopy.

c. In areas where AIIR is not available, aerosolized medications are administered using disposable nebulizer units with expiratory filters or multi-dose inhalers as clinically indicated.

d. Aerosolized medications may be administered using traditional routes while the patient is in an AIIR. The HCW should wear an N-95 during this treatment.

e. Bronchoscopy suite will remain closed for the designated time (see G.2.a) when procedure is performed on a patient with and ATD.

~~c.~~**f.** Expiratory filters are used for intubated patients with known or suspected ATD during transport.

~~4.~~**5.** Surgical Services

a. The Surgical Suite is a positive pressure environment.

b. Patients in Airborne and Droplet Precautions should have elective procedures delayed for the duration of illness. When this cannot be accomplished, surgery should be scheduled as the last case of the day.

c. Provide surgical mask for patients during transport.

d. Expiratory filters can be used for intubated patients during transport.

e. A portable HEPA unit should be utilized in the OR suite during intubation and extubation and HCW's shall wear N-95 respirator or PAPR.

f. Airborne precautions are maintained in the Post Anesthesia Care Unit. Post operative patients are placed in a private recovery room with a portable HEPA unit.

~~d.~~**g.** Surgical suite shall remain empty for designated time (see G.2.a) with door closed when a procedure has been performed on a patient with known or suspected ATD.

~~5.~~**6.** Maternal Child Health Services (MCH)

a. Neonatal Intensive Care Unit (NICU)

i. The NICU has a dedicated AIIR.

ii. Neonates born to mothers with diseases known to be spread by Airborne Route are placed in the AIIR until the neonate is found to be non-infectious.

iii. Prior to entering the unit, visitors are screened for signs of ADT and immunization history. Visitors are asked not to visit for duration of illness.

b. Labor and Delivery and Post Partum
   i. Labor rooms may have portable HEPA units installed for mothers who have suspected ADT.
   ii. Healthcare workers follow Standard and Transmission based Precautions as indicated using the appropriate N-95 respirators or PAPR's for Airborne Precautions.
   ~~i.~~**iii.** Rooms 200 and 201 are an AIIR and are used for MCH patients who require Airborne Precautions or need high hazard procedures.

~~6.~~**7.** Behavioral Health
   i. Patients who develop symptoms of ATD will be assessed by the physician to determine the need for medical intervention.
   ii. Source control will be implemented including masking the patient, use of tissues and hand hygiene.
   iii. If ATD illness is suspected (see list above) the patient will be asked to remain in their room and wear a surgical mask while awaiting admission to the hospital for further treatment.
   iv. If the patient is unable to wear a mask and non compliant with containing respiratory secretions with tissues. Healthcare workers will wear appropriate PPE based on the transmission of the suspected illness (Droplet or Airborne transmission).
   v. If droplet precautions are indicated (see list above) and the patient is medically stable, the patient may remain on the BHU and Droplet precautions will be instituted and maintained for the duration of illness.
   vi. Airborne precautions cannot be implemented in the BHU. The need for admission to the hospital will be assessed on a case by case basis.
   ~~ii.~~**vii.** Patients who are identified as needing and AIIR will be transferred within five hours of identification.

~~7.~~**8.** Laboratory Medicine
   a. Methods of implementation for ATD exposure control in are found in the Laboratory Medicine Biosafety Plan.
   b. For respiratory protection in Laboratory Medicine See IC.14 Employee Health: Respiratory Protection Policy

~~8.~~**9.** Facilities Management Staff
   a. Facilities Management staff will wear N-95 respirators when entering an AIIR housing patient(s) with known or suspected ATD.
   ~~c.~~**b.** N-95 respirators are required when repairing, replacing, or maintaining air systems or equipment that may contain or generate aerosolized pathogens.

~~9.~~**10.** Personal Protective Equipment
   a. The respiratory protection policy IC.14.0 describes requirements of PPE used for ATD protection in accordance with 29CFR1910.134 and CCR Title 8, section 5144.
   b. Respiratory Protection including N-95 respirators or PAPR's is required in any hospital location in the following circumstances:
      i. Entering an Airborne Isolation Room occupied by a patient with an airborne transmitted ATD
      ii. Entering an Airborne Precautions room that is occupied or has been occupied within the past hour by a patient with active untreated airborne illness including pulmonary or laryngeal TB.
      iii. Entering a regular room where a patient with active or untreated pulmonary or laryngeal TB is undergoing or has undergone within the past 8 hours any high-hazard medical procedure.
      iv. Providing services that involve the need to be in close prolonged contact with a patient with active untreated airborne transmissible illness including pulmonary or laryngeal TB.
      v. Attending high hazard procedures.

c. Respirator Shortages

i. In the event of reported shortages of N-95 respirators the following is recommended (notification received from supplier but still able to meet historic usage):

1) TCMC will maintain a cache of N-95 respirators in accordance with the disaster plan.
2) Materials Distribution staff will perform in-house inventory to determine available stock and develop a timeline for inventory depletion.
3) According to available stock, N-95 respirators will be prioritized for distribution to Pulmonary Services ICU, and Emergency Department for use in high hazard procedures.
4) Re-use of N-95 respirators for known or suspected Tuberculosis patients over a 12 hour shift unless the respirator is contaminated (e.g. visibly soiled) or the integrity of the respirator is disrupted (e.g. torn, cracked nose piece).
5) Reuse of N-95 respirators is acceptable during the care of patients with other ADT's under the following circumstances:
   a) A protective face shield (no surgical mask) is donned over the respirator to protect the respirator from contamination of ATD (see 8.b.ii for tuberculosis).
   b) The respirator integrity remains intact
   c) During the care of ventilated patients using the Puritan Bennett 840 with DX/800 filter and closed circuit suction systems.

ii. In severe respirator shortages (less than 30 days of stock available in house, when supplier cannot meet the demand or can only supply an alternative N-95) the following steps may be considered:

1) Prioritize available N-95 for high hazard procedures.
2) Provide surgical grade masks for employees who are not provided a respirator due to the implementation of prioritized respirator use.
3) Contact Local Public Health Officer for possible acquisition of N-95 respirators from local or state stockpiles.
4) Alternate manufacturer's respirators may be used in cases of tuberculosis and other airborne illnesses. Fit testing will be waived in a declared state of emergency.
5) Except during high hazard procedures, surgical masks may be used for H1N1 influenza.
6) PAPR's may be used.
7) The Infection Control Officer, Infection Preventionist, and the Safety Officer will determine if Internal Disaster Code Orange is warranted based on patient surge, physical and staffing resources.
8) When there is no option for providing N-95 respirators, surgical masks will be provide to the employee

iii. Positive Air Purifying Respirators (PAPR's)

1) PAPR's used for bronchoscopy are maintained in Respiratory Care Department
2) SPD stores and maintains all other PAPR's
3) Units are cleaned, disinfected using a hospital approved disinfectant and tested after each use.
~~1)~~**4)** Disposable hoods are used

~~10.~~**11.** Admissions and transfers of patients with known or suspected Airborne transmissible ATD.

~~f.~~**a.** Airborne transmissible ATD suspect cases shall be identified, and the individuals shall be given disposable tissues, hand hygiene materials and the patient will be masked until an AIIR is available. Transfer to an AIIR shall be facilitated within five (5) hours of

identification.

~~g.~~**b.** If an AIIR is not available, patients shall be transferred to a facility with AIIR availability.

~~h.~~**c.** If the physician determines that transfer to another facility AIIR would be detrimental to the patient's condition the patient need not be transferred. In this case, employees will use N-95 ~~respriators~~**respirators** when entering the room or area housing the individual. The patient's condition will be reassessed every 24 hours to determine if transfer is safe and the determination shall be documented.

~~11.~~**12.** Influenza Season

a. From November 15 to March 31, all employees, volunteers, contract workers or others covered under the ATD standard must wear a standard surgical mask while on duty in the hospital. This requirement does not apply to anyone who has received the current influenza vaccine as recommended by the Centers for Disease Control and Prevention.

b. The enforcement dates are subject to change based on the recommendations of the hospital's Infection Control Committee.

c. Non-compliance with this requirement is subject discipline as outlined in the hospital's Human Resources policy.

~~E.~~FF. MEDICAL SERVICES

1. Vaccinations are offered to employees free of charge ((IC 14.0 Employee Health Immunization Policy).
2. Medical Services shall be provided to employees who have occupational exposure to ATD's.
3. Medical Services may include vaccinations, tests, examinations, evaluations, determinations, procedures and medical management and follow-up.
4. Medical Services shall be conducted in accordance with EHS policies

~~F.~~GG. TRAINING

1. Training is provided during the New Employee Orientation Process and annually through computer based education modules.
2. Opportunity is provided for questions to be answered by an infection control professional.
3. Respirator Fit testing
   a. Medical screening and training is performed in accordance with IC.14 Employee Health: Respiratory Protection Program.

~~G.~~HH. REVIEW SCHEDULE

1. The ATD plan will be reviewed annually by the Infection Control Committee.
2. Employees will assess the effectiveness of the program in their respective areas annually during the Annual Work Survey and deficiencies will be corrected.

~~H.~~II. REFERENCES:

1. Centers for Disease Control & Prevention, Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis In Health Care Facilities, 1994.
2. Centers for Disease Control & Prevention H1N1 guidance, Seasonal Influenza and vaccine Guidance www.cdc.gov
3. Respiratory Hygiene/Cough Etiquette in Healthcare Settings www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm
4. OSHA Directives CPL 2.106- Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis US Department of Health and Human Services. http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=DIRECTIVES&p_id=1586&p_text_version=FALSE
5. Cal-OSHA Aerosol Transmissible Diseases Standard, August 5, 2009
6. New Guidelines for Purified Protein Derivative (PPD) Skin Test Interpretation and Treatment Modalities for Tuberculosis Infection. Pulmonary Perspectives, April 2001 Volume 18, Issue 1.
7. APIC position paper: Responsibility for interpretation of the PPD tuberculin skin test. February 1999, Vol. 27, No.1.

8. TB Respiratory Protection Program In Health Care Facilities Administrator's Guide U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Public Health Service Centers for Disease Control and Prevention National Institute for Occupational Safety and Health September 1999
9. Surveillance QI Plan IC .2
10. Epidemiologic Investigation of a Suspected Outbreak IC .3
11. Facility Acquired (Nosocomial) Infections, Defined IC .4
12. Reducing Facility Acquired Infections IC. 13
13. Participation of Staff in the Infection Control Program IC. 7

TABLE 1

Criteria for Infectiousness and placement in high risk setting (Forensic Unit only)

CATEGORY	SETTING	CRITERIA
TB suspect - Not on treatment for suspect active TB	Forensic Unit	3 consecutive respiratory specimens, including one early AM or induced sputum, or BAL, collected at least 8 hours apart, are AFB smear negative
TB case or suspect on treatment for active TB -AFB smear positive -No risk factor for MDR-TB	Forensic Unit	1. 3 consecutive respiratory specimens, including one early AM or induced sputum, or BAL, collected at least 8 hours apart, are AFB smear negative 2. At least 14 daily doses of treatment for TB, preferably by directly observed therapy (DOT), taken and tolerated; and 3. Clinical improvement
TB case or suspect on treatment for TB -AFB smear negative X3 -No risk factor for MDR-TB	Forensic Unit	At least 5 daily doses of treatment for TB taken and tolerated
TB case or suspect on treatment for TB -At increased risk for MDR-TB	Forensic Unit	1. Obtain direct genetic test, if available, for Rifampin resistance 2. If direct genetic test not available, while phenotypic DST for Rifampin is pending, other criteria for patients with known MDR-TB, or criteria for patients not at increased risk of MDR-TB, or criteria for patients not at increased risk of MRD-TB may be applied, at the discretion of the local TB controller
Known MDR-TB case	Forensic Unit	1. 3 consecutive respiratory specimens, including one early AM or induced sputum, or BAL, collected at least 8 hours apart, are AFB smear negative 2. At least 14 daily doses of treatment for TB, preferably by directly observed therapy (DOT), taken and tolerated; and 3. Clinical improvement 4. At least 2 consecutive negative sputum cultures without a subsequent positive culture

Reference

CDPH/CTCA (2005). Guidelines for the assessment of tuberculosis patient infectiousness and placement in high and low risk settings. California Department of Public Health and California Tuberculosis Controllers Association.

EMERGENCY DEPARTMENT TUBERCULOSIS DECISION TREE
APPENDIX A

Patient has signs and symptoms or chest x-ray compatible with TB

AND

Unstable housing or resident in a group setting
OR
Acutely ill or needing invasive diagnostic or therapeutic procedure
OR
Strong likelihood that patient will **not** follow-up with outpatient work-up

↓

Admit to Medicine and place on Airborne Precautions
For assistance
contact the TB Control Program or Infection Control at the numbers below.

AND

Stable, non-group housing
AND
Not acutely ill or needing invasive diagnostic or therapeutic procedure
AND
Strong likelihood that patient will follow-up with outpatient work-up

↓

Discharge the patient with a written plan for outpatient care & surgical masks to wear
AND
Instruct the patient to remain on home isolation[1] until infectiousness is ruled out
AND
Alert the TB Control Program ASAP, but no longer than 24 hours.

[1]Home isolation: Stay alone in a separate room with the door closed, as much as possible. Keep a window slightly open at all times. When alone in this room, you do not need to wear a mask. Please be sure to sleep and eat while alone in this room. Persons entering this room need to wear a mask. If you leave the room, you need to wear a mask. For example, when you use a shared bathroom or go to the doctor's office wear a mask.

TB Control in San Diego County is available 7 days a week from 0800 to 1700 only. Weekdays call TB Control at (619) 692-8610 and on Weekends and holidays call cell phone number (619) 540-0194 OR Leave a message on the Tuberculosis RN voice mail (619) 692-8610 and your call will be returned on the next working week day. Messages should include patient's name, date of birth, facility name, reporter's name and phone number, and contact person at facility who will be available for more patient information. Also leave a message at TCMC Infection Control: call **ext.** 7410 **or 5696**

APPENDIX B

Tri-City Medical Center

Welcome to Tri-City Medical Center. Our commitment to you, our patient, is to give you the highest quality care. In order to do that, we need your help. Please answer the questions below, so that we can take better care of you. If there are any questions you do not understand, please ask for help from one of our employees.

If you are filling this out for someone else, please answer the questions as if you were that person.

Medical Record Number _____

Name_____ Date_____
(Please Print Clearly)

1. Have you had any of these problems?

	Please circle your answer	
Cough longer than 10 days?	Yes	No
Do you cough up blood?	Yes	No
Do you have night sweats?	Yes	No
Have you lost weight?	Yes	No
If you have lost weight- how much?		
Have you lost your appetite?	Yes	No
Do you have a fever	Yes	No

2. Have you ever had?

	Please circle your answer	
A positive skin test for TB?	Yes	No
Active Tuberculosis?	Yes	No
Lived or worked with someone who had TB?	Yes	No
Have you lived outside the United States for longer than one month?	Yes	No

3. What country were you born in? _____

4. Have you had?

	Please circle your answer	
Severe coughing spasms, that interfere with eating, drinking and breathing?	Yes	No
Fever with painful swollen salivary glands on one side or both sides of your face under your jaw?	Yes	No
Fever with chills, cough, runny nose watery eyes and unexplained diffuse rash or blister type skin rash?	Yes	No
Fever with headache, stiff neck, or changes in your mental status.	Yes	No

THANK YOU

Tri-City Medical Center

Bienvenido/a a Tri-City Medical Center. Nuestro compromiso con usted, como paciente nuestro/a, es ofrecerle una atención médica de la más alta calidad. Para lograr esto, necesitamos su ayuda. Tenga la bondad de contestar las preguntas a continuación, y así le podremos atender mejor. Si hay preguntas que no entiende, pida ayuda a un miembro de nuestro personal.

Si está ayudando a otra persona a llenar este formulario, por favor, conteste las preguntas como si usted fuera la persona a quien ayuda.

Número de historial medico _____

Nombre_____ Fecha_____
(Escriba claramente en letra de molde)

1. ¿Ha tenido usted alguna de las condiciones siguientes?

	Marque sus respuestas con un círculo	
¿Tos durante más de 10 días?	Sí	No
¿Ha expectorado sangre al toser?	Sí	No
¿Ha experimentado usted sudores nocturnos?	Sí	No
¿Ha experimentado pérdida de peso?	Sí	No
Si ha perdido peso, ¿cuánto ha perdido?		
¿Ha experimentado pérdida de su apetito?	Sí	No
¿Tiene usted fiebre?	Sí	No

2. ¿Ha tenido usted alguna vez una de las siguientes condiciones?

	Marque sus respuestas con un círculo	
¿Una reacción positiva en la piel por una prueba de tuberculosis?	Sí	No
¿Ha padecido activamente de tuberculosis?	Sí	No
¿Ha vivido o trabajado con alguien que sufría de tuberculosis?	Sí	No
¿A vivido afvera de los Estodos Unidos por mas de un mes?	Sí	No

3. ¿En qué país nació? _____

4. ¿Ha tenido...

	Marque sus respuestas con un círculo	
¿espasmos de tos graves que le impidan comer, beber o respirar?	Sí	No
¿fiebre con inflamación y dolor en glándulas salivales de uno o ambos lados de su rostro debajo de la mandíbula?	Sí	No
¿fiebre con escalofríos, tos, secreciones nasales, ojos llorosos y erupciones difusas o erupciones con ampollas sin explicación?	Sí	No
¿fiebre con dolor de cabeza, rigidez en el cuello o cambios del estado mental?	Sí	No

Tri-City Health Care District
Oceanside, California

Infection Control Policy Manual

ISSUE DATE: 3/2002

SUBJECT: Infection Prevention and Control Risk Assessment and Surveillance Plan

REVISION DATE: 7/2013, **7/2014**

POLICY NUMBER: IC. 2

Infection Control Committee Approval: 07/2014
Medical Executive Committee Approval: 07/2014
Board of Directors Approval:

A. **Purpose of Risk Assessment**

1. Sound epidemiological principles must be considered in the formation of the surveillance program designed to provide maximum information and identify opportunities to reduce disease. Measures directed toward cost effective care must include best practice and technology to prevent infection. The economic impact of an efficient and flexible infection control plan is especially relevant in times of changing reimbursement and payment patterns. Tri-City Medical Center's plan outlines how this may be accomplished within the confines of resources, external regulatory guidelines, and medical staff requirements.

B. **Purpose of Surveillance**

1. The foundation of and most important purpose of this program is to decrease the risk of infectious complications for all patients, healthcare workers, visitors and staff. Ongoing epidemiological information assists with identifying at risk populations and opportunities to interrupt, prevent or reduce the occurrence of healthcare associated infections. Surveillance will be compared to nationally recognized benchmarks such as the National Healthcare Safety Network (NHSN) rates whenever possible.

C. **Responsibility**

1. Successful creation of an organization-wide infection control program requires collaboration with all relevant components/functions. Individuals within the hospital who have the power to implement plans and make decisions related to prevention and control of risks related to infections are included in the design and coordination of processes. In consultation with the Medical Staff, ~~,~~ Directors, **Medical Director of Infection Control,** the Patient Care Coordinating Council and the Infection Control Committee, the Infection Preventionist (IP) shall implement a systematic process for monitoring and evaluating the quality and effectiveness of the infection control program. Significant deviations are discussed in Infection Control, Quality Improvement Medical Staff Committees, and the Patient Care Coordinating Council and referred to appropriate councils and committees for action.
2. Infection Prevention and Control Services are staffed with 2.8 FTE (includes one FTE with certification in Infection Control). There are computer resources with Internet connection, Microsoft Office software, NHSN National internet based database and access to the hospital's electronic medical records (Compass and Affinity). Telephone with voice mail, fax and pager access is provided. The office is located within the ~~Medical Staff Office~~**Surgical Scheduling office**.
3. Infection Control Services works in conjunction with others, as a consultant and resource for best practices. We support system changes and an interdisciplinary focus to improving care. We believe that all our employees, medical staff, and volunteers play an important role in

preventing and controlling infections. Ultimately, the leadership team within the district is responsible for adopting and ensuring compliance with appropriate policies and practices

D. **Links with Internal Sources**

1. On at least an annual basis, the ICP will meet with the staff to assess whether the goals and priorities have been achieved and what steps are required to implement any indicated changes. **The goals are shared with and reviewed by the Infection Control Committee.** Education on infection control goals and priorities will be included with quarterly reports and during individual meetings with the hospital leadership. The IP reports to Infection Control Committee quarterly and attends other medical staff and hospital committees as requested, regulatory requirements and department specific Quality Reports are reviewed.

E. **Links with External Sources**

1. The San Diego County Public Health Department, state health authorities, the Division of Occupational Safety and Health, and other recognized infection control specialists, for example, the Centers for Disease Control and Prevention (CDC), Association for Professionals in Infection Control and Epidemiology (APIC), Society for Healthcare Epidemiology of America (SHEA), and the California Healthcare Association (CHA) are important links between the district and outside resources. Infection Control Services subscribes to automatic notifications available via email from the CDC, San Diego County public health (CAHAN) and California Department of Health and Human Services. Infection surveillance covers a broad range of processes and activities with potential for intervention and these organizations assist with the where, when, and how of targeting.
2. Healthcare associated infections (HAI) are reported by the IP to the referring organization when the infection was not known at the time of transfer. TCMC receives reports from outside organizations/ physicians when a patient develops an infection that might meet criteria for a healthcare associated infection. We also request information; for example, surgeons are sent a letter requesting reporting of surgical site infections. Home Health/Hospice quality review staff report directly to Infection **Control Committee**~~Prevention and Control~~.
3. The following conditions will be reported to external healthcare organizations with the intent to satisfy JCAHO IC 1.10(5) **(and recorded in the patient's chart** using PowerForm**)**. The Infection Surveillance Report will document notification to the referring healthcare organization within 7 days of discovery by the TCMC Infection Prevention and Control Staff:
   a. Positive culture from a surgical site and surgery performed at another facility
   ~~1.1.1.~~**i.** Influenza rapid test is positive and patient was discharged to another healthcare facility **prior to results being known**
   b. Positive C difficile toxin test known after the patient was discharged to another healthcare facility
   c. Positive MRDO culture known after the patient was discharged to another healthcare facility and the patient had no history of the same MDRO.
   d. Unusual occurrences based on the opinion of the Infection Preventionist in consultation with the Infection Control Medical Director

F. **Pertinent risk factors**

1. Each facility is unique and we considered the following factors in our planning.
   a. National and international published scientific studies, community standard of care, professional recommendations and regulatory requirements.
   b. A review of hospital specific surveillance data from years past.
   c. Medically fragile and at-risk populations such as newborns and those with invasive devices.
   d. The increasing antibiotic resistance in our facility and across the United States (as reported by the CDC in by NHSN).

G. **Epidemiological factors**

1. The District is impacted by factors such as location, population served, community health, financial status, population age, clinical focus, and healthcare worker demographics and these were included in our planning.
2. The hospital's geographic location is north San Diego County. Our county is the third most populous of California's 58 counties, and the sixth largest county in the United States. San Diego is currently home to 2.8 million residents, and is anticipated to grow to four million by 2020.
3. The County is already ethnically diverse, and will be increasingly so. Of residents under 18, 37% are Hispanic, and the Hispanic population is expected to continue to grow at a rapid rate. Approximately 21.5% of the county's population is immigrants, including refugees, who come from other countries, speak 68 different languages, and have a variety of needs as they assimilate into their new environment. The senior and disabled populations are growing disproportionately compared to the rest of the population.
4. Demographic information on the three cities most often served by Tri-City Medical Center is listed below.

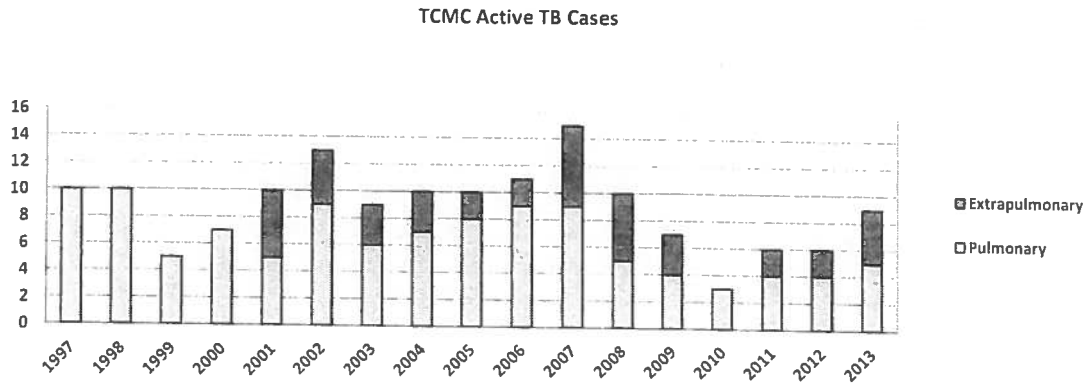
City	Median income	Total # residents	Percent increase in 11 years	White	Hispanic	Asian & Pacific Islander
Oceanside	$ 59,395	161,029 (2000) 167,630 (2011)	+4.1%	48.4%	35.9%	7.6%
Vista	$ 50,513	89,857 (2000) 94,136 (2011)	+4.8%	40.8%	48.4%	4.8%
Carlsbad	$ 81,468	78,247 (2000) 105,671 (2011)	+35.0%	74.9%	13.3%	7.2%

http://www.city-data.com/city/Oceanside-California.html
http://www.city-data.com/city/Vista-California.html
http://www.city-data.com/city/Carlsbad-California.html

5. Enteric illness represents a significant burden of disease in the US and because of this the **San Diego** County Health and Human Services Agency conducts outbreak investigation and education to reduce the medical and cost-related impact of these diseases in the community. ~~Foodborne~~**Food borne** illnesses largely result from the ingestion of **food or water** ~~fecally~~ contaminated **by fecal matter** ~~food or water~~ or ingestion of infected animal products. Hospitals play an important role in early intervention by the identification and reporting of significant bacteria. The most common **mandated reported** enteric illnesses in SD County are **C**~~c~~ampylobacter, **G**~~g~~iardia, **H**~~h~~epatitis A, Salmonella and Shigella.
6. Sexually transmitted diseases have declined in incidence during the last decade except for Chlamydia and HIV infections. AIDS disproportionately impacts males of color in SD County. The increase in AIDS from 1995-2005 is nearly three times higher among Blacks and nearly two times higher among Hispanics when compared with Whites.
7. In 201**3, San Diego had 206 reported cases of active tuberculosis. In 2012,** ~~1,~~ San Diego County had 26**3**~~4~~ reported cases of **active** tuberculosis. This is a higher rate (**case rate of 7.5**~~8.4~~/100,000 persons) compared to state (**5.8**~~7.4~~/100,000 persons in 201**2**~~06~~) and national averages (**3.2**~~4.6~~/100,000 persons in 201**2**~~06~~). The number of pulmonary site tuberculosis cases reported to San Diego County has fluctuated only slightly from 200**6**~~4~~ to 201**3**~~1~~,

ranging between 7~~3~~8% (23~~1~~49 cases in 2006~~3~~4) to 8~~5~~1% (176~~2~~11 cases in 2013~~1~~). Asians had the highest rates of TB (94/100,000 persons in 2011) but rates have decreased over the years. The next highest group was Hispanic, with rates of 12.8/100,000. In 2013~~1~~, **69%**~~over 70~~% of TB cases are foreign-born persons **(Source: County of San Diego Health and Human Services Agency, Tuberculosis and refugee Health Branch, March 13, 2014)**.

8. At TCMC, most AFB positive smears and cultures grow organisms that are not communicable person to person. ~~In 2012 there were four patients with pulmonary *Mycobacterium tuberculosis* compared to the same number as in 2011.~~ **In 2013, there were five patients with pulmonary TB and 4 patients with Extrapulmonary compared to four patients with pulmonary TB in 2012 and 2011.** The number of active TB patients ~~seen annually~~**seen annually** at Tri-City Medical Center varies from 5 –12.



I. At TCMC, in fiscal year ~~2011-2012~~**2013**:

- The top ~~five~~ **six** insurance coverage for our acute cases (Not OB/Newborn, BHU and Rehab) follows:

MEDICARE	~~32.0~~**36.37** ~~%~~%
MEDICARE SR HMO~~MEDICAL~~	**12.04**~~18.7~~%
HMO	~~9.1~~**9.36**%
~~PPO~~**HMO CAPITATED SENIOR**	~~4.9~~**8.32**%
~~SELF PAY~~**MEDI-CAL HMO**	~~6.8~~**5.87**%
SELF PAY/CASH	**5.66%**

- The majority of insurance coverage for our newborns (nursery and NICU) is funded by Medi-Cal or Medi-Cal HMO (~~55.8%~~)**71.5%** compared to an HMO and PPO insurance (~~38.9~~**18.4%**) **and other (10.1%)**.

ii. Patient census:

	Average. Daily Census	Average. **Length of** ~~O~~**Stay***	Total Pt. Days
Acute Care **(excludes all below)**	~~208.5~~**135.2**	~~4.01~~**3.53**	~~66,893~~**49,339**
ICU	15.9	2.6	~~5822~~**5,791**
BHU	~~20.8~~**16.7**	~~10.36~~**5.58**	~~7601~~**6,088**
NICU	13.~~0~~**9**	10.~~5~~**65**	~~4774~~**5,091**
Rehab Serv.	~~5.0~~**6.5**	11.~~2~~**169**	~~1827~~**2,374**

ICU ALOS includes discharges, transfers out, and expirations. All other areas are based only on discharges.

iii. In acute care, the t**hree**~~wo~~ largest age groups are 66-75 year olds (~~2,021, 16.2~~**16.8**%), **55-65 year olds (17.9%)** and 76-85 year olds (**19.1%**~~2,992, 24.5~~%).

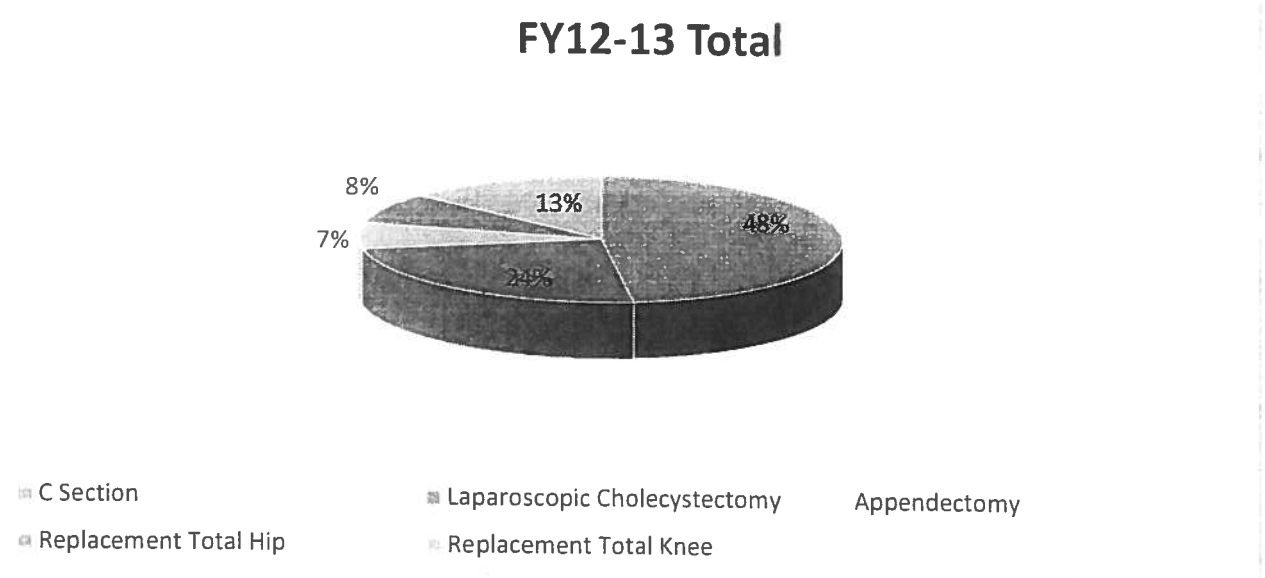
~~1.~~**a.** ~~Sixteen~~ **Fifteen** percent **(10,113/66,019)** of Emergency Department patients are admitted to the hospital.

iv. The total number of employees working at Tri-City Medical Center is approximately ~~2221~~ **2117** with about ~~1332~~ **1,251** staff providing direct patient care.

v. Tri-City Medical Center's primary focus is on basic community services. **In fiscal year 2013,** ~~; see~~ the top ~~five~~ **ten major Diagnostic categories** (DRGs)~~ below~~ **are the following:**

~~2.~~**a. Newborns & Neonates (normal newborn)**
~~3.~~**b. Obstetrics (Vaginal delivery)**
~~4.~~**c. Mental diseases (psychoses)**
~~5.~~**d. Obstetrics (cesarean section)**
~~a.~~**e. Infectious & parasitic Diseases (septicemia)**
~~6.~~**f. Newborns (with significant problems)**
~~7.~~**g. Musculoskeletal & Conn. Tissue (Major joint replacement or reattachment of lower extremity)**
~~8.~~**h. Respiratory (Chronic obstructive pulmonary disease**
~~b.~~**i. Circulatory system (Heart failure and shock)Respiratory (Simple pneumonia and pleurisy)**

9. Top five Inpatient Surgical Procedures:



10. 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 and or Dietitians. For 2007 in Home Care:

Average LOS	I. Top Payers	II. Top 4 Primary DX
35 days	III. Medicare- 66% HMO 20%	IV. Circulatory Endocrine disorder Gastrointestinal

		Injury

11. General Process
    a. Infection Control Department will regularly review all Quality Reports, information from internal sources (case manager, utilization review) or external sources (other IC practitioners, home health/hospice, or nursing homes) and the positive microbiology reports (furnished by the clinical laboratory). The following are some of the patterns or issues that are evaluated.
    b. Clusters of infections by the same organism, in the same ward or service or infections after undergoing the same procedure.
    c. Infections due to unusual or highly resistant organisms such as MRSA or VRE.
    d. All cases of infectious or parasitic conditions ~~that are~~**that is** reportable. These shall be reported in accordance with the ordinances of the County of San Diego Department of Health.
    e. Unusual or problem situations shall be brought to the Infection Control Committee for review and discussion. See Epidemiologic Investigation of a Suspected Outbreak IC. 03
    f. In the absence of the Infection Prevention and Control Practitioner, hospital staff can direct questions to Employee Health Services, the **Director of Regulatory Compliance, the Medical Director of Infection Control** ~~Hospital Epidemiologist~~ and/or Chair of the Infection Control Committee.
12. **Targeted And Focused Surveillance for FY 2014**
    a. Institution surveillance for infection control activities is systematic, active, concurrent, and ongoing observation. We have chosen efforts directed toward high risk, high volume and/or device related such as urinary tract infection, selected surgical site infection, ventilator-associated ~~pneumonia~~ **events** (ICU only), and central line bacteremia. Goals will include limiting unprotected exposure to pathogens throughout the organization (Goals 13.7 and 13.8), Enhancing hand hygiene (Goal 13. 7) and limiting the risk of transmission of infections associated with procedures (Goal 13.1), medical equipment and supplies (Goal 13.8) and medical devices (Goals 13.3, 13.4, 13.5, and 13.11).
    b. Surgical Site Infections
        i. GOAL**#1**:The **combined** surgical site infection rate will not be statistical**ly significantly higher** ~~different~~ th**a**en the most recent published NHSN rates, using the standardized infection ratio (SIR).
        ii. **GOAL#2: Each individual surgical site infection rate (that is able to be calculated) will not be statistically significantly higher than the most recent published NHSN rates, using the standardized infection ratio (SIR).**
        iii. Due to ever-decreasing lengths of stay, the majority of postoperative infections are not seen while the patient is in the hospital. Further, the increasing trend toward more outpatient surgery and shorter postoperative hospital stays limits the ability of infection control practitioners to detect infections.
        iv. Surgical Site Infections that occur within 30 ~~days post-operatively (non-implant surgery) and one year (surgical implants)~~ **to 90 days (based upon the individual NHSN definitions** are counted in **the** statistics. Surgical patients are risk stratified using the methods described in the CDC's NHSN surgical site component. ~~(Risk Factors M, 0, 1, 2, 3).~~
        v. Case finding methods include a mail survey to the surgeon >30 days after surgery-, review of all microbiology cultures, and ICD coding for post operative infection. Potential cases have a chart review performed by Infection Prevention and Control personnel using the most recent definitions of infection published by the Centers for Disease Control and Prevention.

vi. Infection rates as described in NHSN are compared NHSN rates and reported to the California Department of Public Health through NHSN.

AAA	Abdominal aortic aneurysm repair	Resection of abdominal aorta with anastomosis or replacement	38.34, 38.44, 38.64
APPY	Appendix surgery	Operation of appendix (not incidental to another procedure)	47.01, 47.09, 47.2, 47.91, 47.92, 47.99
BILI	Bile duct, liver or pancreatic surgery	Excision of bile ducts or operative procedures on the biliary tract, liver or pancreas (does not include operations only on gallbladder)	50.0, 50.12, 50.14, 50.21-50.23, 50.25, 50.26, 50.29, 50.3, 50.4, 50.61, 50.69, 51.31-51.37, 51.39, 51.41-51.43, 51.49, 51.51, 51.59, 51.61-51.63, 51.69, 51.71, 51.72, 51.79, 51.81-51.83, 51.89, 51.91-51.95, 51.99, 52.09, 52.12, 52.22, 52.3, 52.4, 52.51-52.53, 52.59-52.6, 52.7, 52.92, 52.95, 52.96, 52.99
CARD	Cardiac surgery	Open chest procedures on the valves or septum of heart; does not include coronary artery bypass graft, surgery on vessels, heart transplantation, or pacemaker implantation	35.00-35.04, 35.10-35.14, 35.20-35.28, 35.31-35.35, 35.39, 35.42, 35.50, 35.51, 35.53, 35.54, 35.60-35.63, 35.70-35.73, 35.81-35.84, 35.91-35.95, 35.98-35.99, 37.10, 37.11, 37.24, 37.31-37.33, 37.35, 37.36, 37.41, 37.49, 37.60*
CBGB	Coronary artery bypass graft with both chest and donor site incisions	Chest procedure to perform direct revascularization of the heart; includes obtaining suitable vein from donor site for grafting.	36.10-36.14, 36.19
CBGC	Coronary artery bypass graft with chest incision only	Chest procedure to perform direct vascularization of the heart using, for example, the internal mammary (thoracic) artery	36.15-36.17, 36.2
CHOL	Gallbladder surgery	Cholecystectomy and cholecystotomy	51.03, 51.04, 51.13, 51.21-51.24
COLO	Colon surgery	Incision, resection, or anastomosis of the large intestine; includes large-to-small and small-to-large bowel anastomosis; does not include rectal operations	17.31-17.36, 17.39, 45.03, 45.26, 45.41, 45.49, 45.52, 45.71-45.76, 45.79, 45.81-45.83, 45.92-45.95, 46.03, 46.04, 46.10, 46.11, 46.13, 46.14, 46.43, 46.52, 46.75, 46.76, 46.94
CSEC	Cesarean section	Obstetrical delivery by Cesarean section	74.0, 74.1, 74.2, 74.4, 74.91, 74.99

FUSN	Spinal fusion	Immobilization of spinal column	81.00-81.08
FX	Open reduction of fracture	Open reduction of fracture or dislocation of long bones that requires internal or external fixation; does not include placement of joint prosthesis	79.21, 79.22, 79.25, 79.26, 79.31, 79.32, 79.35, 79.36, 79.51, 79.52, 79.55, 79.56
GAST	Gastric surgery	Incision or excision of stomach; includes subtotal or total gastrectomy; does not include vagotomy and fundoplication	43.0, 43.42, 43.49, 43.5, 43.6, 43.7, 43.81, 43.89, 43.91, 43.99, 44.15, 44.21, 44.29, 44.31, 44.38-44.42, 44.49, 44.5, 44.61-44.65, 44.68-44.69, 44.95-44.98
HPRO	Hip prosthesis	Arthroplasty of hip	00.70-00.73, 00.85-00.87, 81.51-81.53
HTP	Heart transplant	Transplantation of heart	37.51-37.55
HYST	Abdominal hysterectomy	Removal of uterus through an abdominal incision	68.31, 68.39, 68.41, 68.49, 68.61, 68.69
KPRO	Knee prosthesis	Arthroplasty of knee	00.80-00.84, 81.54, 81.55
KTP	Kidney transplant	Transplantation of kidney	55.61, 55.69
LAM	Laminectomy	Exploration or decompression of spinal cord through excision or incision into vertebral structures	03.01, 03.02, 03.09, 80.50, 80.51, 80.53, 80.54+, 80.59, 84.60-84.69, 84.80-84.85
LTP	Liver transplant	Transplantation of liver	50.51, 50.59
NEPH	Kidney surgery	Resection or manipulation of the kidney with or without removal of related structures	55.01-55.02, 55.11, 55.12, 55.24, 55.31, 55.32, 55.34, 55.35, 55.39, 55.4, 55.51, 55.52, 55.54, 55.91
OVRY	Ovarian surgery	Operations on ovary and related structures	65.01, 65.09, 65.12, 65.13, 65.21-65.25, 65.29, 65.31, 65.39, 65.41, 65.49, 65.51-65.54, 65.61-65.64, 65.71-65.76, 65.79, 65.81, 65.89, 65.92-65.95, 65.99
PACE	Pacemaker surgery	Insertion, manipulation or replacement of pacemaker	00.50-00.54, 17.51, 17.52, 37.70-37.77, 37.79-37.83, 37.85-37.87, 37.89, 37.94-37.99

REC	Rectal surgery	Operations on rectum	48.25, 48.35, 48.40, 48.42, 48.43, 48.49-48.52, 48.59, 48.61-48.65, 48.69, 48.74
RFUSN	Refusion of spine	Refusion of spine	81.30-81.39
SB	Small bowel surgery	Incision or resection of the small intestine; does not include small-to-large bowel anastomosis	45.01, 45.02, 45.15, 45.31-45.34, 45.51, 45.61-45.63, 45.91, 46.01, 46.02, 46.20-46.24, 46.31, 46.39, 46.41, 46.51, 46.71-46.74, 46.93
SPLE	Spleen surgery	Resection or manipulation of spleen	41.2, 41.33, 41.41-41.43, 41.5, 41.93, 41.95, 41.99
THOR	Thoracic surgery	Noncardiac, nonvascular thoracic surgery; includes pneumonectomy and hiatal hernia repair or diaphragmatic hernia repair (except through abdominal approach.)	32.09, 32.1, 32.20, 32.21-32.23, 32.25, 32.26, 32.29, 32.30, 32.39, 32.41, 32.49, 32.50, 32.59, 32.6, 32.9, 33.0, 33.1, 33.20, 33.25, 33.28, 33.31-33.34, 33.39, 33.41-33.43, 33.48, 33.49, 33.98, 33.99, 34.01-34.03, 34.06, 34.1, 34.20, 34.26, 34.3, 34.4, 34.51, 34.52, 34.59, 34.6, 34.81-34.84, 34.89, 34.93, 34.99, 53.80-53.84
VHYS	Vaginal hysterectomy	Removal of the uterus through vaginal or perineal incision	68.51, 68.59, 68.71, 68.79
XLAP	Abdominal surgery	Abdominal operations not involving the gastrointestinal tract or biliary system. Includes diaphragmatic hernia repair through abdominal approach.	53.71, 53.72, 53.75, 54.0, 54.11, 54.12, 54.19, 54.3, 54.4, 54.51, 54.59, 54.61, 54.63, 54.64, 54.71-54.75, 54.92, 54.93

13. Antibiotic Resistant Bacteria
    a. GOAL#1: The number of healthcare associated MRSA infections and colonization will remain below the Institute for Healthcare Improvement's (IHI) published rate of 3.95 nosocomial acquisitions per 1000 hospital discharges for the calendar year.
    b. GOAL#2: ~~The number of healthcare associated VRE infections and colonization will remain below the Institute for Healthcare Improvement's (IHI) previous annual mean rates.~~ The MRSA and VRE Lab ID events (Blood culture specimen) rate will not be statistically higher than the most recent NHSN published rates (using the SIR).
    c. GOAL #3: Positive blood cultures for MRSA and VRE are entered into NHSN 100% of the time.
        i. # Patients with + MRSA and/or VRE cultures
        ii. # Hospital Discharges
        iii. Antibiotic resistance is an ongoing concern. Multiple studies have documented increased costs and mortality due to infections caused by multidrug resistant organisms. Data will be collected using positive cultures on patients with community acquired and hospital acquired methicillin resistant Staphylococcus aureus (MRSA) vancomycin resistant enterococci (VRE), ESBL Klebseilla, and ESBL *E. coli, and Carbapenem-resistant Enterobacteriaceae (CRE) CRE*. A healthcare associated case is defined as a positive culture from any ~~body site~~body site ~~> 48 hours~~ on or after the third hospital day~~on after admission~~, with no prior history of the organism. A MRSA risk assessment is performed annually to determine need for additional interventions, resources, and surveillance. Positive blood cultures with MRSA or VRE are now publically reported to CDPH through NHSN Multi-Resistant Organism & Clostridium difficile Infection Module (LabID Event Reporting).
    d. Ventilator Associated Event – Adult Critical Care Unit
        i. GOAL: There will be ~~six~~ seven consecutive months without ventilator associated pneumonia (VAP)
        ii. # Cases ventilator associated pneumonia in ICU x 1000
        iii. Total # ventilator days for the month
            1) Ventilator Associated Pneumonia (VAP) is defined as pneumonia in persons who had a device to assist or control respiration continuously through a tracheostomy or by endotrachael tube within the 48 hour period before the onset of infection (inclusive of the weaning period). ~~NOTES: Beginning January 2013, the definitions for ventilator associated events were expanded and revised. This will change how VAP is reported. The~~As of January 2013 the new CDC/NHSN Ventilator Associated Events definition has been used.~~s~~ This definition has ~~have~~ three tiers: ventilator associated condition (VAC), infection related ventilator associated condition (IVAC), and ventilator associated pneumonia (VAP). All three will be reported and each VAP case will be reviewed.
        iv. Central Line Associated Bloodstream Infection (CLABSI)– Intensive Care Units
            1) GOAL #1: Using NHSN definitions for CLABSI, the CLABSI rate for ICU patients will not be statistically higher than the ~~The rate will be not be statistically higher then the~~ NHSN standardized infection ratio (SIR)

2) GOAL #2: Using NHSN definitions for CLABSI, the CLABSI rate for non-ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR)

3) GOAL #3: All central line associated bloodstream infections (CLABSI) are entered into NHSN 100% of the time ~~GOAL: All central line insertion practice observations for ICU and NICU are entered into NHSN 100% of the time~~

4) Patients with a central line (defined by NHSN as a vascular access device that terminates at or close to the heart or one of the great vessels) and a primary bloodstream shall be counted. If a bloodstream infection occurs while a central line is in place or if a central line was inserted ~~within 48 hours~~> than two calendar days before the onset of infection a chart review will be performed. Current CDC/NHSN definitions are used to determine CLA-BSI ~~Data is~~data is collected by reviewing cultures. Actual line day information is available on-demand through the Compass Explorer program created by IT in 2005. NICU line days data is collected ~~by~~by Nursing Services daily and reported to the Infection Prevention and Control Department at the end of each month. NICU rates are stratified by birth weight as per NHSN data comparison.

5) Catheter Associated Urinary Tract Infection (CAUTI) ~~GOAL: Appropriate use of urine catheters will be > 75% throughout the hospital~~

6) GOAL #1: Using NHSN definitions for catheter associated urinary tract infection (CA-UTI), the CAUTI rate for ICU patients will ~~be less than the NHSN 25th percentile~~not be statistically higher than the NHSN standardized infection ratio (SIR)

7) GOAL #2: Using the NHSN definitions for CAUTI, the CAUTI rate for non ICU patients will not be more than expected based upon the NHSN standardized infection ratio (SIR).

8) Symptomatic urinary tract infection – ICU patients with an indwelling urinary catheter at the time of or within 7 days before the onset of a positive urine culture will have a chart review using current CDC/ NHSN definitions and methodology.
   a) # Cases CAUTI in ICU x 1000
   b) Estimation of urinary catheter days ICU

14. Hand Hygiene
   a. GOAL: 100 % Compliance with Hand Hygiene is expected when hand hygiene is indicated.
   b. GOAL #2: Hand Hygiene compliance will be electronically monitored on two units (Tele and Labor & Delivery) and show an increase in compliance from baseline.
      i. ~~Monthly observation of staff~~ Hand hygiene compliance rates~~, organized by job classification or department~~ are collected by manual observation performed by unit staff on a monthly basis. The Hand Hygiene compliance rates are r~~R~~eported to Patient Safety Committee, Infection Control Committee and Managers Council. Number of opportunities (rated as level 1A or 1B by the CDC) to perform hand hygiene compared to hand hygiene completed (% compliance) during care of patients.
      ii. In addition, the Telemetry Unit has a electronic hand monitoring system that measures the times that a person enters and exits the room

(opportunities- denominator) compared to the times that the hand hygiene product is dispensed (numerator). The Labor and Delivery Unit will be utilizing a new system that monitors individual staff hand hygiene compliance and duration of hand hygiene activity. These two projects are on a trial basis and interventions are determined by unit leadership and Infection Control staff as needed

15. Environmental Rounds
    a. GOAL: Infection Control assessments will be represented 90% of the time during scheduled environmental rounds and tracers.
    b. GOAL #2: Infection Control will attend 90%the biweekly construction meeting to review current and upcoming construction projects.
    c. GOAL #3: Engineering staff in collaboration with Infection Control will complete an Infection Control Construction Permit 100% of the time for projects that require a Class III or higher containment.
    d. Environment of Care rounds are pPerformed biannually in patient care areas and once a year in non-patient care areas in conjunction with Environment of Care Committee. These rounds will identify risks associated with, but not limited to, medical equipment and supplies. In addition, tracers are performed monthly on a schedule throughout the patient care areas.~~Weekly rounds are made in areas were construction is taking place.~~
16. Reportable Diseases
    a. GOAL: Required reportable disease will be sent to the local health department within the required time frame 100% of the time.
    b. Assisted by the Microbiology Laboratory and Emergency Department, required reporting to Public Health is performed by phone and/or fax or electronic submission, using the California Confidential Morbidity Report or other special form as directed by the County of San Diego Department of Health. Case finding is done through review of microbiology report and calls from hospital staff (including physicians).
    c. Employee Health, collects and reports the following:
        i. GOALS: There will be 10% less needle stick injuries from the previous calendar year
            1) 100% of employees will complete the annual tuberculosis screen
            2) 100% of employees and volunteers will receive influenza vaccine or sign a declination statement
            3) Greater than 90% of staff will receive influenza vaccine
            4) Number of needlestick injuries and details of department involved, device, and cause
            5) # Staff completing annual TB screening (PPD, blood test or survey)
            6) # Employees in whom compliance is required
            7) # Employees and volunteers who received influenza vaccine
            8) # Employees with patient contact
            9) # Medical staff (LIPs) who received vaccine
            10) # Medical Staff (LIPs)
    d. Home Care, collects and reports the following:
        i. GOAL #1::CAUTI and CLABSI rates will be monitored and reported to the Infection Control Committee quarterly.
        ii. GOAL #2: There will be less than two CAUTI infections in the calendar year.
        iii. # Cases UTIs with foley catheter
        iv. Total # device days

v. GOAL #3: There will be no infections related to central lines in the calendar year.~~Urinary Tract Infections related to urinary catheter will remain below the upper control limit (2 standard deviations above the mean) once 20 data points are collected (FY2010).~~

vi. # Cases ~~UTIs with foley catheter~~BSI with Central Line

vii. Total # device days

e. *Clostridium difficile* (*C. difficile*) surveillance is performed utilizing ~~a definition that was developed in cooperation with other San Diego County healthcare facilities~~the Multi-Resistant Organism & *Clostridium difficile* Infection Module (LabID Event Reporting).

i. GOAL #1: All *C. difficile* positive lab results are entered into NHSN 100% of the time.

ii. GOAL #2: The C. *difficile* hospital onset (HO) rate will not be higher than expected based upon the recent published NHSN rates (SIR).~~*C. difficile* enterocolitis is classified as Healthcare associated, in determinant Healthcare associated, and Community Acquired infection.~~ All positive *C. difficuile* results are entered into NHSN; reports are produced through NHSN. Incraeases in hospital onset (HO) cases will be reviewed ~~monthly~~ and action taken if they are epidemiologically associated.

H. REFERENCES:

1. Centers for Disease Control and Prevention, Healthy People 2000 Progress: Immunizations and Infectious Diseases December 1, 1999 Lecture by Sondik, EJ.
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3. www.cdc.gov/nchs/about/otheract/hp2000/immunization/immunizationcharts.htm
4. County of San Diego Tuberculosis Control and Refugee Health Program. (2014, June) TB Statistics. Retrieved from (26 June, 2014) http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/ComparativeData2013_final 3-13-14Rev1031914.pdf
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6. Chapter 1, Infection Control Program In: APIC Text of Infection Control and Epidemiology. Washington DC; 2000:15.1-8.
7. CMS SCIP Tools: http://www.medqic.org/dcs/ContentServer?cid=1089815967030&pagename=Medqic%2FMeasure%2FMeasuresHome&parentName=Topic&level3=Measures&c=MQParents

I. CROSS REFERENCE:

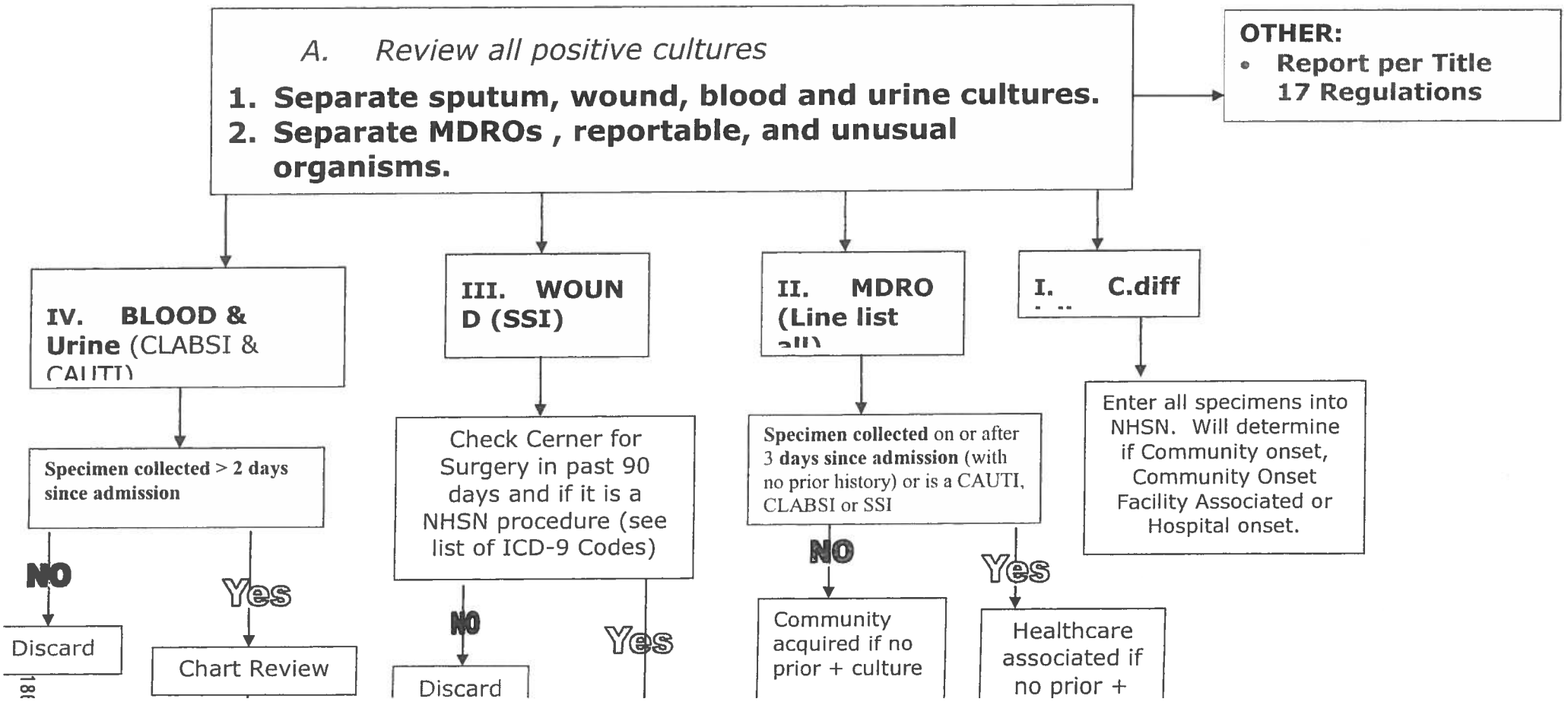
1. Philosophy IC. 1
2. Epidemiologic Investigation of a Suspected Outbreak IC. 3
3. Facility Acquired Infections, Defined IC. 4
4. Participation of Staff in the Infection Control Plan IC. 7
5. Reducing Facility Acquired Infections IC. 13

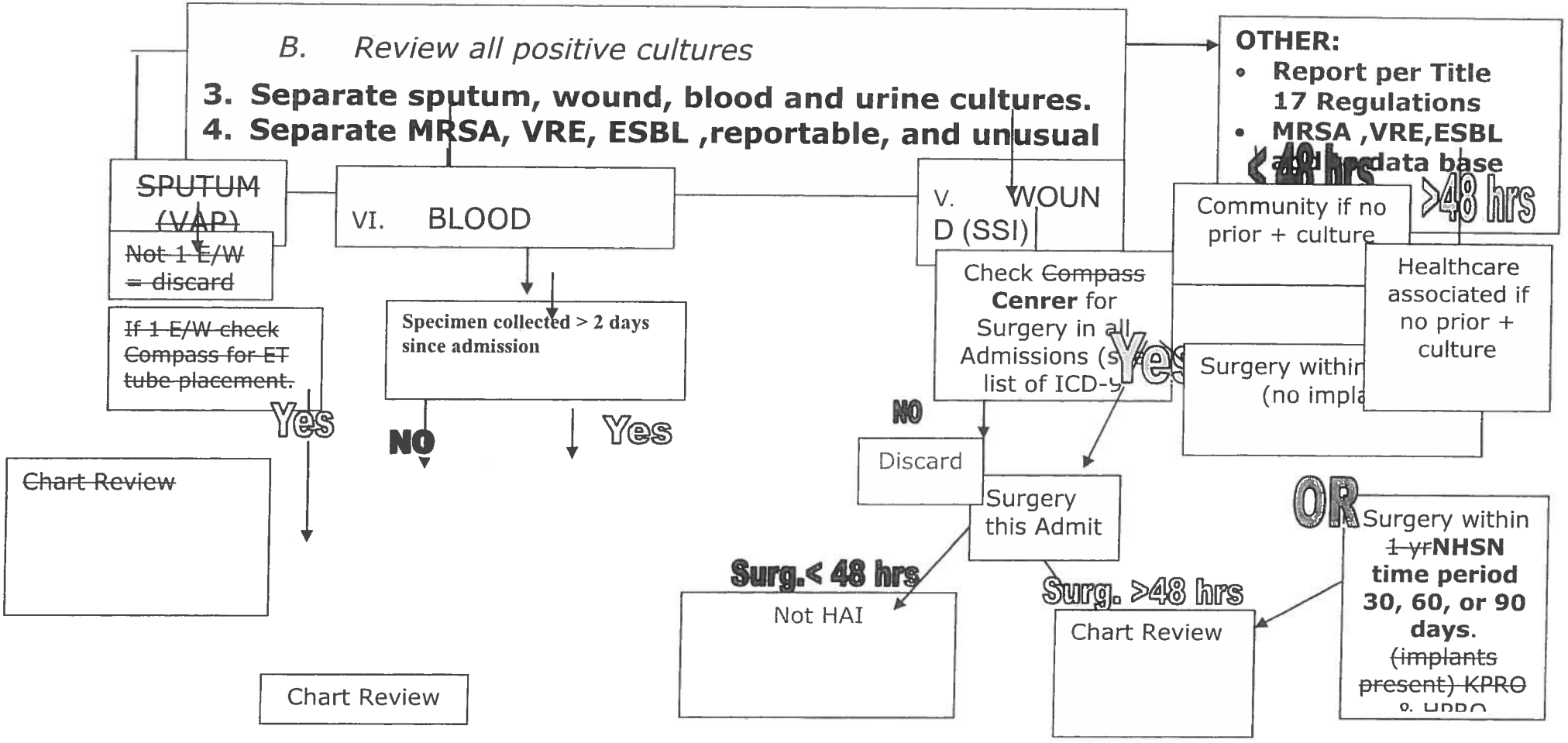
INFECTION CONTROL PROGRAM TIMELINE FY 2014

Infection Control Committee	Meet			Meet			Meet			Meet		
Targeted Surveillance	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
SSI (CARD, CBGB, CBGC, COLO, FUSN, HPRO, & KPRO)	*			*			*			*		
Multi-antibiotic Resistant Organisms • VRE • MRSA • ESBL • **CRE**	*			*			*			*		
CLABSI	*			*			*			*		
CAUTI	*			*			*			*		
VAE~~P~~ in ACCU	*			*			*			*		
A. PI SCIP measures	*			*			*			*		
*B. ~~M. tuberculosis~~ **Home Health report of CAUTI and CLABSI rates***	*			*			*			*		
C. Outbreak Investigation and Disease Reporting												
D. OSHA Compliance												
• Tuberculosis Exposure Control Plan Review				*						*		
• Bloodborne Pathogen Exposure Control Plan Review				*						*		
Employee Health												
• TB Screening (PPD or questions)	*											
• N95 Fit-testing	*											
• Sharps & BBP Exposures	*			*			*			*		
• Infectious Diseases Exposures	*			*			*			*		
• Influenza Campaign				Begin			*			*		
Environment of Care												
• **Infection control staff review of current contruction projects**	*	*	*	*	*	*	*	*	*	*	*	*
• **Sterile Processing Department Report**	*			*			*			*		
• **Pharmacy Report on Biologicals and findings**	*						*					
• **Environment of Care Officer, Pantient Safety Officer and/or Engineering report**	*			*			*			*		
Surveillance Plan												

• Managers or Directors Meetings (Education & Planning)		*	*				*					
• Input (**E**ducation & Planning)												
• Present Risk Assessment and Surveillance Plan to ICC	*									*		
• ICC Approval of Plan	*									*		
• ~~Statistics from IT~~												
Performance Improvement Projects												
• ~~FY 2014 Tuberculosis Plan~~				*								
• ~~FY 2014 BBP Exposure Plan~~				*								
• Reducing Surgical Site Infections										*		
• ~~Interdisciplinary Plans/Protocols~~ **Reducing CAUTIs**												
• Hand Hygiene Compliance **(Electronic monitoring)**	*	*	*	*	*	*	*	*	*	*	*	*
• ~~EOC Rounds and Construction Containment~~												
• **Reducing CLABSIs**												
1. Education												
• New Employees	*	*	*	*	*	*	*	*	*	*	*	*
• Unit Based or Topic Specific **(As requested)- Performed through Quest, during rounds, presentations, power minute.**	*		Net Learning	*	*	*	*	*	*		*	*

*Presented to IC


A. Review all positive cultures
1. Separate sputum, wound, blood and urine cultures.
2. Separate MDROs , reportable, and unusual organisms.
OTHER:
• Report per Title 17 Regulations
IV. BLOOD & Urine (CLABSI & CAUTI)
III. WOUND (SSI)
II. MDRO (Line list all)
I. C.diff
Specimen collected > 2 days since admission
Check Cerner for Surgery in past 90 days and if it is a NHSN procedure (see list of ICD-9 Codes)
Specimen collected on or after 3 days since admission (with no prior history) or is a CAUTI, CLABSI or SSI
Enter all specimens into NHSN. Will determine if Community onset, Community Onset Facility Associated or Hospital onset.
NO
Yes
NO
Yes
NO
Yes
Discard
Chart Review
Discard
Community acquired if no prior + culture
Healthcare associated if no prior +


B. Review all positive cultures
3. Separate sputum, wound, blood and urine cultures.
4. Separate MRSA, VRE, ESBL ,reportable, and unusual
OTHER:
• Report per Title 17 Regulations
• MRSA ,VRE,ESBL
SPUTUM (VAP)
Not 1 E/W = discard
If 1 E/W check Compass for ET tube placement.
Yes
Chart Review
VI. BLOOD
Specimen collected > 2 days since admission
NO
Yes
Chart Review
V. WOUND (SSI)
Check Compass Cenrer for Surgery in all Admissions (s
list of ICD-9
Yes
NO
Discard
Surgery this Admit
Surg.< 48 hrs
Not HAI
Surg. >48 hrs
Chart Review
<48 hrs
Community if no prior + culture
>48 hrs
Healthcare associated if no prior + culture
Surgery within
(no impla
OR
Surgery within 1 yrNHSN time period 30, 60, or 90 days. (implants present) KPRO

Tri-City Health Care District
Oceanside, California

Infection Control Policy Manual

Issue Date: 9/2000 Subject: Epidemiologic Investigation of a Suspected Outbreak

Next review date: ~~4/2014~~**7/2017** Standard Number: IC. 3
Revised: 3/2002, 3/2005, **7/2014**
Infection Control Committee Approval: **7/14**
Medical Executive Committee Approval: **7/14**
Professional Affairs Committee Approval: **8/14**
Board of Directors Approval:

A. **PURPOSE:**

1. To provide guidelines for uniform and complete investigation of suspected outbreaks of ~~health~~ **healthcare** associated **infections** (HAI) or community acquired infections seen in the hospital.

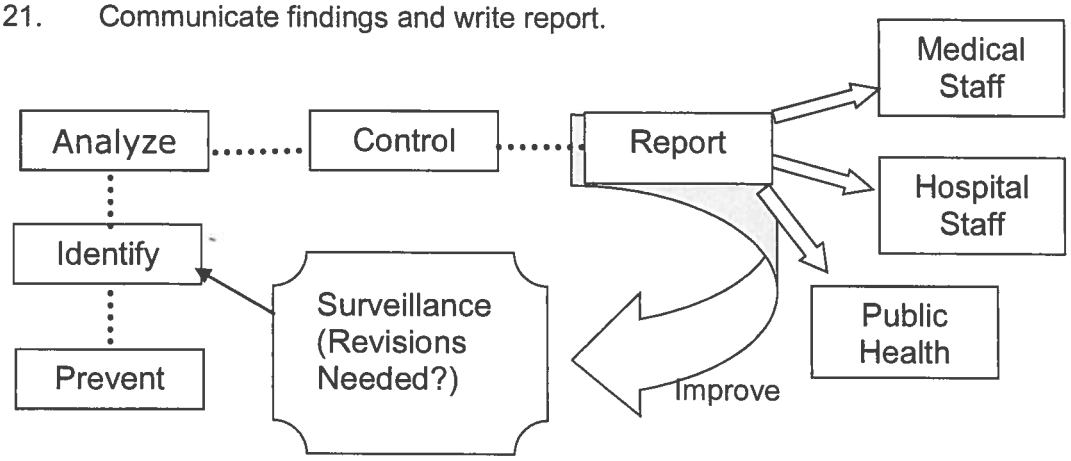
B. **Policy:**

1. The Infection Control Committee shall have ultimate responsibility for investigating outbreaks and developing policies aimed at prevention and control of healthcare associated infections (HAI). If an outbreak is suspected, the hospital epidemiologist or his designee will direct the investigation. The aim of the process is to identify the source of the organism and the mode of spread so that infection control measures can be instituted to halt an outbreak.

C. **Procedure:**

1. The hospital epidemiologist (or designee) will determine whether a situation is a probable outbreak that poses a threat to the health of patients, employees or visitors and warrant further investigation. He may elect to call an emergency meeting of the Infection Control Committee. The meeting would be called to accomplish the following:
2. Clarify the nature and extent of the potential outbreak.
3. Discuss proposed investigational steps.
4. Determine exact criteria for selection of subjects for possible epidemiologic studies.
5. Determine and assign responsibility of each department; determine who will collect and record data.
6. Anticipate questions that may arise and develop consistent answers. Assign resource people to respond to queries and keep personnel informed.
7. **Appraise t**~~T~~he State and local health departments ~~will be appraised~~ of outbreaks and reportable conditions.
8. **Identify c**~~C~~omponents of an Investigation
9. Confirm that an outbreak exists.
10. Establish or verify diagnosis of reported cases; identify agent and develop a case definition.
11. Search for additional cases; collect critical data and specimens. See Data Collection Tool in Appendix A
12. Characterize the cases by person, place and time; plot the epidemic curve and geographic **areas that** are involved.
13. Analyze the data; show that the current rates are higher than pre-outbreak rates.
14. Perform a literature review.

15. Communicate with department heads, microbiology director, administrators, and employee health as appropriate.
16. Formulate tentative hypothesis; keep a diary with detailed notes about the investigation.
17. Test hypothesis.
18. Consider control measures and alternatives; institute most appropriate measures.
19. Evaluate and document efficacy of control measures.
20. Change policies and procedures if necessary.
21. Communicate findings and write report.



D. **REFERENCES:**

1. Centers for Disease Control and Prevention, Principles of Epidemiology: An Introduction to Applied Epidemiology. 2nd ed. Atlanta: United States Department of Health and Human Services, Public Health Service, CDC; 1992.
2. Jarvis, W. R. (2004). Investigation of outbreaks. In C. G. Mayhall (Ed.), Hospital Epidemiology and Infection Control (3rd Ed.), (pp. 107-122). Philadelphia, PA: Lippincott Williams & Williams.
3. Dixon RE. Investigation of endemic and epidemic nosocomial infections. In: Bennett JV, Brachman PS, eds. Hospital Infections. 3rd ed. Boston: Little, Brown; 1992:109-134.
4. Srinivasan,A. (2009). Outbreak Investigation. In: APIC Text of Infection Control and Epidemiology. Washington DC: APIC.

MR #	Patient's Name	Admit Date	Date of Onset of S & S	Culture Date	Culture Results	Invasive Device or Procedure	Device / Procedure Date	Unit	Comments

Tri-City Health Care District
Oceanside, California

Infection Control Policy Manual

ISSUE DATE: 1/1985
REVIEW DATE: 9/2007
REVISED: 9/2003, 10/2004, **07/2014**

SUBJECT: Meningococcal Exposure
STANDARD NUMBER: IC. 6.2

Infection Control Committee Approval: **7/14**
Medical Executive Committee Approval: **7/14**
Board of Directors Approval:

A. Purpose: To help prevent the transmission of disease to and colonization of healthcare workers **(HCWs)**.

1. Health care workers may require prophylactic antibiotics after a significant exposure to a patient with an infection (meningitis, bacteremia, or pneumonia) due to *Neisseria meningitidis* ~~Note that the incidence of the latter has decreased greatly in the United States following the introduction of a conjugate vaccine. The vast majority of meningitis cases at TCMC are not due to *Neisseria meningitidis*, and indeed there was only one positive culture for *N. meningitidis* in our laboratory 2009-2010. There for the number of times health care workers might actually require prophylaxis should be quite small.~~ **Bacterial meningitis infection presents as a sudden onset of fever, headache, and stiff neck. The symptoms of bacterial meningitis can appear quickly or over several days. ~~Thypically~~Typically they develop within 3 – 7 days after exposure.**
2. ~~For health-care workers (HCW) the estimated attack rate is 0.8 per 100,000.[3]~~
3. Prophylaxis most effective within the first 4 days post-exposure.
4. Patient is placed in Droplet Precautions if disease is known or suspected before lab confirmation.
5. Chemoprophylaxis is offered to HCWs if:
   a. the patient's CSF gram stain is positive *for* gram negative diplococci, **or** blood, sputum, or CSF is culture positive for *Neisseria meningitis* **and**
   b. (2) HCW had an "intimate exposure" as defined on the **Meningococcal Meningitis** worksheet **(Appendix A)**, was not wearing appropriate PPE, and the patient was not receiving appropriate antibiotics for at least 24 hours.
   c. Staff Roles **(See hyperlink for flow chart)**:
   d. Microbiology: report signi*ficant stains* and cultures to patient's attending physician, public health and Infection Preventionist (M – F 8 am to 5pm) or the Administrative Supervisor after hours and weekends.
   e. Infection Preventionist or Administrative Supervisor: assist in identification of departments or units involved and report to San Diego County Health and Human Services. Reference Infection Control Manual, IC 12 Required Reporting for forms and fax/phone numbers.
   f. Charge Nurse: review the patient's chart to identify staff, complete and send attached Meningococcal Meningitis Worksheet **(Appendix A)** to Employee Health.
   g. ED MICN: reference Patient Care Services manual, Policy X.B. Exposure to Communicable Diseases for questions related to pre-hospital personnel.
   ~~h.~~ Exposed employee: complete an Injury/Illness Investigation Report and sign in to be seen in ~~WorkPartners or~~ **Emergency Department**. ~~Treatment Recommendations: The California State Department of Health presently recognizes Rifampin as the drug of choice in chemoprophylaxis. The recommended schedule for adults is 600 mg every 12 hours X four doses P.O. Alternatively, Ciprofloxacin 500 mg X one dose P.O. Pregnant healthcare workers can be offered Ceftriaxone 250 mg IM X one dose.~~

B. **REFERENCES:**

1. APIC, Ready Reference to Microbes, Washington DC: Ed. Brooks, K, 2007
2. APIC, APIC Text of Infection Control and Epidemiology, Washington, DC: Association for Professionals in Infection Control and Epidemiology, 2009.
3. Gilmore A, Stuart J, Andrews N, Risk of secondary meningoccoccal disease in health-care workers. Lancet 2000, 11;356(9242): 1654-1655.
4. **4. http://www.cdc.gov/meningitis/bacterial.html**

Meningococcal Meningitis Worksheet

Charge Person/Department Manager: _____

Date:_____ Time:_____ Patient's MR#_____

Staff Involved:	Exposed	
1.	Y	N
2.	Y	N
3.	Y	N
4.	Y	N
5.	Y	N
6.	Y	N
7.	Y	N
8.	Y	N
9.	Y	N
10.	Y	N
11.	Y	N
12.	Y	N
13.	Y	N
14.	Y	N
15.	Y	N

Exposure is defined as intimate and unprotected (no mask or face shield) contact with a patient with meningococcal disease (*Neisseria meningitis*) prior to antibiotic administration for at least 24 hours. There is a negligible risk of disease following casual contact. The following are examples of an "exposure"

Mouth to mouth resuscitation
Suctioning without using personal protective equipment (mask and goggles or face shield)
Participation in intubation without using personal protective equipment (mask and goggles or face shield)
Oral or endoscopic examination without using personal protective equipment (mask and goggles or face shield)
Assisting with vomiting patient without using personal protective equipment (mask and goggles or face shield)
Other mucus-membrane contact with respiratory secretions.

All staff identified as "exposed" are directed to ~~Occupational Health or~~ **the** Emergency ~~Room (when OHS closed)~~ **Department** for further evaluation and possible prophylactic treatment.

Please ~~send this~~ fax the completed form to Employee Health Services at (760) 940-4005~~when completed~~.

Tri-City Health Care District
Oceanside, California

Infection Control Manual

ISSUE DATE: 7/2008	**SUBJEC: Toy Cleaning**
REVISION DATE: 7/2014	**STANDARD NUMBER: IC. 9.1**

Infection Control Committee Approval:	**07/14**
Medical Executive Committee Approval:	
Professional Affairs Committee Approval:	**04/11**
Board of Directors Approval:	**04/11**

A. **PROCEDURE:**

1. Children can be in close proximity to one another and spend time in common areas, such as playrooms, where sharing of contaminated toys, equipment, and secretions can occur. Toys may be colonized with infectious pathogens.
2. An outbreak of multiresistant *P. aeruginosa* on an oncology ward related to bath toys has been described, as has a rotavirus outbreak in a similar population. There are no published guidelines on toy cleaning in the hospital setting, but we extrapolate from experience with community and home care of children.
3. Avoid high-risk toys, such as water-retaining toys, soft/stuffed toys, and others that are difficult to clean and dry. Stuffed and cloth toys quickly become colonized when used by hospitalized patients and have the potential to serve as fomites for infection and are discouraged.
4. Appropriate toy cleaning involves scrubbing with soap and water to remove surface dirt, followed by disinfection with the hospital approved disinfectant. Toys are then thoroughly rinsed and air-dried completely between patients.
- ~~4.~~**5. Toy cleaning is performed by the Rehab Aide. Therapists perform cleaning on an as needed basis during therapy sessions.**
- ~~5.~~**6.** Phenolics are not used.
- ~~6.~~**7.** Toys that have become contaminated ~~with secretions~~ **(such as dropped on the floor or soiled with secretions)** during use are segregated and immediately washed with detergent followed by disinfection with a **low level, non toxic** hospital-approved disinfectant. **Toys should be air dried completely.**
- ~~7.~~**8.** Solid plastic toys can be washed in a dishwasher or on a hot cycle in a washing machine, but this method cannot be used for hollow toys that might fill with water—an outbreak of resistant *Pseudomonas aeruginosa* infection related to retained water in bath toys has been documented.
- ~~8.~~**9.** Toys and playroom surfaces are cleaned and disinfected daily by Environmental Services Department
- ~~9.~~**10.** Clean toys are clearly separated from dirty ones.
- ~~10.~~**11.** Sharing of toys between children is avoided to prevent cross-transmission.

B. **REFERENCES:**

1. **West, K. L., Nyquist, A., Bair, T., Berg, W. & Spencer, S. (2014). -Pediatrics. In P. Grota (Ed.), *APIC Text of Infection Control and Epidemiology* (4th ed. Vol. 2, 42- to 42-19) Washington, DC: APIC.**

ISSUE DATE: 10/2007

SUBJECT: Mold Abatement

NEXT REVIEW DATE: 7/2014

STANDARD NUMBER: IC. 13.3

REVISED: 7/2014

Infection Control Committee Approval: **07/2014**
Medical Executive Committee Approval: **07/2014**
Board of Directors Approval:

A. **INTRODUCTION:**

1. Molds and fungi can be found anywhere inside or outside throughout the year. About 1000 species of mold can be found in the United States with more than 100,000 known species worldwide. Outdoors, molds play an important role in nature by breaking down organic matter such as toppled trees, fallen leaves, and dead animals. We would not have food and medicines, like cheese and penicillin, without mold. When excessive moisture or water accumulates indoors, mold growth often will occur, particularly if the moisture problem remains uncorrected. While it is impossible to eliminate all molds and mold spores, controlling moisture can control indoor mold growth. Delayed or insufficient maintenance may contribute to moisture problems in buildings. Molds may cause localized skin or mucosal infections but, in general, do not cause systemic infections in humans, except for persons with impaired immunity, AIDS, uncontrolled diabetes, or those taking immune suppressive drugs.

B. **PURPOSE:**

1. The purpose of mold remediation is to correct the moisture problem and to remove moldy and contaminated materials to prevent human exposure and further damage to building materials and furnishings. Porous materials that are wet and have mold growing on them may have to be discarded because molds can infiltrate porous substances and grow on or fill in empty spaces or crevices.

C. **PROCEDURE:**

1. Responsibility
2. Infection Preventionist and Environment of Care Officer will:
   a. Provide consultation during water damage remediation and mold abatement.
   b. Inspect abatement areas for compliance with recommended practices.
   c. Review indication for environmental cultures or volumetric air sampling.
3. Engineering staff will:
   a. Participate in training process for mold remediation activities and construction barrier containment.
   b. Follow remediation precautions as outlined in this plan.
   c. Notify Infection Preventionist and Safety Officer about water intrusion and remediation.
   d. Follow procedure for containment found in IC 13.2 Construction Policy Matrix.
   e. Coordinate the remediation of the mold by trained staff,
   ~~e.~~**f.** Wear the appropriate PPE during remediation.
   ~~f.~~**g.** Assess the extent of mold contamination for appropriate remediation activity level.

4. **Mold Remediation/Cleanup Methods**
   a. For mold remediation Level IV barrier precautions are required. See Construction Policy 13.2 Matrix and permit to determine appropriate job class and precautions. Water damaged areas should be dried within 48-72 hours of water exposure. It is recommended that dehumidifiers be used for this purpose because fans can cause aerosolization of mold spores.
   b. *Wet Vacuum* - can be used to remove water from floors, carpets, and hard surfaces where water has accumulated. They should not be used to vacuum porous materials, such as gypsum board. Wet vacuums should be used only on wet materials, as spores may be exhausted into the indoor environment if insufficient liquid is present. The tanks, hoses, and attachments of these vacuums should be thoroughly cleaned and dried after use since mold and mold spores may adhere to equipment surfaces.
   c. *Damp Wipe* - Mold can be removed from nonporous surfaces by wiping or scrubbing with a hospital approved disinfectant. It is important to dry these surfaces quickly and thoroughly to discourage further mold growth.
   d. *HEPA Vacuum* - HEPA (High-Efficiency Particulate Air) vacuums are used for final cleanup of remediation areas after materials have been thoroughly dried and contaminated materials removed. HEPA vacuums also are used for cleanup of dust that may have settled on surfaces outside the remediation area. Care is taken to assure that the filter is properly seated in the vacuum so that all the air passes through the filter. When changing the vacuum filter, wear N-95 respirators, appropriate personal protective clothing, gloves, and eye protection to prevent exposure to any captured mold and other contaminants. The filter and contents of the HEPA vacuum must be disposed of in impermeable bags or containers in such a way as to prevent release of the debris.
   e. *Disposal of Damaged Materials* - Building materials and furnishings contaminated with mold growth that are not salvageable should be placed in sealed impermeable bags or closed containers while in the remediation area. These materials can usually be discarded as ordinary construction waste. Large items with heavy mold growth are covered with polyethylene sheeting and sealed with duct tape before being removed from the remediation area.
   f. *Use of Biocides* - The use of a biocide, such as chlorine bleach, is indicated when immuno-compromised individuals are present. A dilution of 500 ppm is recommended for this purpose (dilution to attain this concentration is 1 part bleach to 100 parts water). Containers shall be labeled appropriately and discarded after use.
   g. **Never mix chlorine bleach solution with other cleaning solutions or detergents that contain ammonia because this may produce highly toxic vapors and create a hazard to workers.**

5. **Mold Remediation Procedure**
   a. **Level I: Small Isolated Areas** (10 sq. ft or less) - e.g., ceiling tiles, small areas on walls.
   b. Install Infection Control Containment. Containment level to be determined by the infection control officer and engineering supervisor.
   c. Trained ~~Engineering Department staff~~ **workers** conducts remediation**, coordinated and supervised by the Engineering department**. The staff is trained on proper clean-up methods, personal protection, and potential health hazards.
   d. N-95 disposable respirators are used. Gloves and eye protection are worn.
   e. Contaminated materials that cannot be cleaned are removed from the building in a sealed impermeable plastic bag. These materials are disposed of as ordinary waste.
   f. The work area and egress area are cleaned with a damp cloth or mop and a hospital approved disinfectant.
   g. All areas are left dry and visibly free from contamination and debris.
   h. **Level II: Mid-Sized Isolated Areas** (10-30 sq. ft.) – e.g., individual wallboard panels.
   i. Install Infection Control Containment. Containment level to be determined by the infection control officer and engineering supervisor.
   j. Trained ~~Engineering Department staff~~**workers** conducts remediation**, coordinated and supervised by the Engineering department**. The staff is trained on proper clean-up

methods, personal protection, and potential health hazards.

k. N-95 disposable respirators are used. Gloves and eye protection are worn.

l. Surfaces in the work area that could become contaminated are covered with a secured plastic sheet(s) before remediation to contain dust/debris and prevent further contamination.

m. Dust suppression methods, such as misting (not soaking) surfaces prior to remediation, are used.

n. Contaminated materials that cannot be cleaned are removed from the building in a sealed impermeable plastic bag. These materials are disposed of as ordinary waste.

o. The work area and egress areas are HEPA vacuumed and cleaned with a damp cloth or mop and a detergent solution.

p. All areas are left dry and visibly free from contamination and debris.

6. **Level III: Large Isolated Areas** (30 –100 square feet) – e.g., several wallboard panels.

a. The following procedures may be implemented depending upon the severity of the contamination:

i. Install Infection Control Containment. Containment level to be determined by the infection control officer and engineering supervisor.

ii. Trained ~~Engineering Department staff~~**workers** conducts remediation, **coordinated and supervised by the Engineering department**. The staff is trained on proper clean-up methods, personal protection, and potential health hazards.

iii. N-95 disposable respirators are used. Gloves and eye protection are worn.

iv. Surfaces in the work area and areas directly adjacent that could become contaminated should be covered with a secured plastic sheet(s) before remediation to contain dust/ debris and prevent further contamination.

v. Seal ventilation ducts/grills in the work area and areas directly adjacent with plastic sheeting.

vi. Dust suppression methods, such as misting (**not soaking**) surfaces prior to mediation, are used.

vii. Contaminated materials that cannot be cleaned are removed from the building in sealed impermeable plastic bags. These materials may be disposed of as ordinary waste.

viii. The work area and surrounding areas should be HEPA vacuumed and cleaned with a damp cloth or mop and a detergent solution.

ix. All areas should be left dry and visibly free from contamination and debris.

x. Note: If abatement procedures are expected to generate a lot of dust (e.g., abrasive cleaning of contaminated surfaces, demolition of plaster walls) or the visible concentration of the mold is heavy (blanket coverage as opposed to patchy), it is recommended that the remediation procedures for Level IV be followed.

7. **Level IV: Extensive Contamination** (greater than 100 contiguous square feet in an area).

a. Industrial hygienists or other environmental health and safety professionals with experience performing microbial investigations and/or mold remediation should be consulted prior to remediation activities to provide oversight for the project.

8. **Personal Protective Equipment (PPE)**

a. Gloves are used to protect the skin from contact with mold and disinfecting agents.

b. Eye Protection:
To protect your eyes, use properly fitted goggles or a full face piece respirator. Goggles must be designed to prevent the entry of dust and small particles. Safety glasses or goggles with open vent holes are not appropriate in mold remediation.

c. Respiratory Protection - N-95 disposable respirators are available for use during Level I through Level III remediation procedures. It is recommended that during Level IV remediation procedures utilize PAPR units.

d. Protective Clothing

e. Disposable PPE should be discarded after it is used. They should be placed into

impermeable bags, and usually can be discarded as ordinary construction waste.

9. **Sampling for Mold -** Air sampling is not a necessary part of a routine assessment because decisions about appropriate remediation strategies often can be made on the basis of a visual inspection. The Medical Director of Infection Prevention and Control will be consulted when air sampling is considered.
10. **Moisture Meters -** Moisture meters measure/monitor moisture levels in building materials, and may be helpful for measuring the moisture content in a variety of building materials following water damage. Moisture content ≤ 20% as determined by moisture meter readings is considered to be acceptable.

D. **REFERENCES**:

1. Centers for Disease Control and Prevention, Healthcare Infection Control Practices Advisory Committee (HICPAP) Guideline for Environmental Infection Control in Healthcare Facilities, 2003.
2. U.S. Department of Labor Occupational Safety and Health Administration, A brief Guide to Mold in the Workplace SHIB 03-10-10

Tri-City Health Care District
Oceanside, California

Infection Control Policy Manual

ISSUE DATE: 10/07

SUBJECT: Department Specific: Wound Care Center

NEXT REVISION DATE: 7/ 2011, ~~7~~4/2014

POLICY NUMBER: IC.7.1

Infection Control Committee Approval:	~~7/2011~~ 07/2014
Medical Executive Committee Approval:	~~8/2011~~ 07/2014
Board of Directors Approval:	~~8/2011~~

A. **PURPOSE:**

1. Comprehension of and compliance with infection control principles is an essential component of the quality of care provided in the Center. The purpose of this document is to:
   a. Delineate the role in and scope of infection prevention and control activities.
   b. Define the infection control and prevention measures to be followed to prevent cross-infection among patients.
   c. Provide procedures to be adhered to by the staff of the clinic for protection from illnesses/conditions related to working with and caring for patients admitted to the program.

B. **POLICY:**

1. A qualified patient will not be denied access to the services offered by the program *unless* the patient has an active infectious communicable airborne disease such as tuberculosis or has any other active communicable disease that cannot be safely managed by the clinic. This type of patient may be admitted to the program once he/she is medically cleared by a qualified physician.
2. All healthcare workers shall comply with the hospital's infection control policies and procedures.
3. The clinic shall follow infection control department policies and procedures related to compliance with State regulations for reporting of specified conditions.

C. **ACCOUNTABILITY:**

1. The clinical manager is responsible for implementing and monitoring compliance with all infection control policies and procedures.
2. The clinical manager is responsible for ensuring the appropriate infection control education/training is provided to all personnel.
3. The infection control policy is submitted to the Infection Control Committee as often as the hospital requires.

D. **PROCEDURE:**

1. Patient Considerations
   a. Patients with a known or suspected infectious communicable airborne disease/condition (or any other condition that cannot be safely managed in the clinic) shall *not* be admitted to the program until medically cleared by a qualified physician.
   b. Patients with known or suspected infection/condition that can be safely managed in the clinic shall be admitted to the program, and appropriate precautions shall be taken to prevent cross-infection. These include, but are not limited to, MRSA, VRE, and HIV.
   c. Cultures are obtained from patients with open wounds/soft tissue infections or suspected bone infections for treatment purposes and to identify potential communicability.
   d. **At each clinic visit all patients will have affected extremity and hands cleansed with chlorhexidine gluconate cloth wipe prior to treatment unless allergy to product is noted.**

2. Occupational/Employee Health
   a. All personnel shall comply with hospital policies related to the occupational health, safety, and well-being of healthcare workers as delineated in such policies as those found in the:
      i. Infection Control Manual **and the Employee Health & Wellness Manual** and include those related to:
         1. Employee health
         2. Hepatitis B vaccine program
         3. Post-blood exposure management
      ~~ii. Environment of Care (EOC) Manual:~~
         ~~1.~~**4.** Blood-borne pathogens exposure control plan
         ~~2.~~**5.** **Aerosol Transmissible Diseases and** Tuberculosis management
3. Infection Transmission Reduction Methods: All staff members are expected to fully support the hospital's infection control efforts and to clearly understand the role they play in the infection control program. All clinic personnel shall comply with:
   a. Hospital transmission-based precautions such as Standard ~~(with Universal)~~ and Contact Precautions.
   b. The Blood-borne Pathogens Exposure Control Plan
   c. The hospital's hand hygiene policy
   d. The proper handling of biohazardous waste as defined in the Infection Control Manual.
   e. Aseptic sterile and clean technique
   f. Visitor and traffic control policies
4. Listed below are the minimum requirements recommended during controlled situations to protect the healthcare worker from potentially infectious agents. This list is not all-inclusive. If the situation indicates, increased infection control measures may be indicated, e.g., additional barrier protection in less-controlled situations.

Category	Hand-washing	Gloves	Gown	Mask	Eye Protection
Vital signs - TPR & BP	R				
Phlebotomy	R	R			
Handling specimens	R	R			
Routine dressing changes	R	R	S		
Dressing changes large amount draining	R	R	R	**	**
Handling medical waste	R	R	S		
Decontamination instruments	R	R	S	**	**
Cleaning equipment	R	R	S		
Applying pressure to control bleeding	R	R	S		
Assisting with procedures such as wound debridement	R	R	S	**	**
Wound irrigation	R	R	S	**	**
Suture/staple removal clean, dry wound	R	R			
Capillary blood glucose testing	R	R			
Cleaning work surfaces	R	R			
Cleaning up small blood spills	R	R			
Cleaning large blood spills	R	R	R	**	**

Category	Hand-washing	Gloves	Gown	Mask	Eye Protection
Legend **R = routinely** **S = If soiling likely** **** = If splattering likely**					

5. Decontamination and Sterilization
   a. Utilizing appropriate personal protective equipment (PPE), only trained personnel shall clean and decontaminate the clinic's surgical instruments and equipment.
   b. Decontaminated instruments shall be transported safely to Central Supply/Processing in a covered container.
   c. Central Supply shall decontaminate and sterilize all instruments used in the clinic.
   d. The hospital's "Event-Related Sterility" policy will be followed.
6. Housekeeping
   a. Routine environmental cleaning is performed by the designated housekeeping staff using hospital-approved germicidal products.
   b. Germicidal agents with "Hepatitis B" claim shall be used for cleaning blood or OPIM spills.
   c. Exam chairs are disinfected between patients by the clinical staff using approved germicidal wipes/solution. Linen may be placed on the chair for protection from large draining wounds.
   d. The clinical staff shall disinfect reusable items such as BP cuffs, stethoscopes, and electronic thermometers ~~daily, or more frequently as needed~~**between each patient use**.
   e. Work surfaces are cleaned/disinfected ~~daily~~ **between each patient use** and as needed by the clinic staff using the hospital-approved germicide.
   f. The cleaning/decontamination of medical equipment is the responsibility of the clinic staff.
   g. Biohazardous waste is handled according to policy in the Infection Control Manual.
7. Surveillance Activities
   a. The clinic shall participate in the surveillance activity of the Infection Control Department, as requested by the Infection Control Committee.
   b. Any unusual microbial patterns or isolated findings shall be reported to the Infection Control Department/practitioner.
8. Infection Control Education/Training
   a. All personnel shall attend the infection control orientation program upon hire.
   b. All personnel shall complete the annual infection control module.
   c. Additional infection control inservice presentations and consultation shall be provided as needed.

E. **REFERENCES:**

1. Centers for Disease Control and Prevention (CDC), Guideline for Isolation Precautions in Hospitals, 2007
2. Centers for Disease Control and Prevention (CDC), Guideline for Infection Control in Health Care Personnel, 1998
3. OSHA Bloodborne Pathogens Standard, 1997
4. Title 17 California Code of Regulations, 2001
5. Philosophy IC. 2
6. Standard and Transmission Based Precautions IC. 5
7. Participation of Staff in the Infection Control Program IC.7
8. Hand Hygiene IC. 8
9. Cleaning and Disinfection IC. 9
10. Employee Health Services Policies
11. Administrative Policy #401 Injury Prevention Program

Tri-City Medical Center
Oceanside, California

WOMEN'S & CHILDREN'S SERVICES POLICY MANUAL-NICU

SUBJECT: ADMISSION AND DISCHARGE CRITERIA FOR THE NICU

ISSUE DATE: 06/07
REVISION DATE(S): 04/09, 06/11

Board of Directors Approval Date(s): 06/11, 08/12

A. **PURPOSE:**
1. To define the criteria for admission and discharge to the Neonatal Intensive Care Unit **(NICU).**

B. **GENERAL INFORMATION:**
1. Patients shall be admitted under the care of a **California Children's Services** (CCS) paneled attending neonatologist.
2. All admissions to the NICU are arranged with the NICU Assistant Nurse Manager and/or relief charge **Registered Nurse** (RN).
3. ~~Patients under 14 days of age may be admitted to the NICU at the discretion of the Neonatologist on call and depending on staff and bed availability.~~ **Patients up to adjusted 44 week post conceptual presenting with a diagnosis of a non-communicable nature may be admitted to the NICU at the discretion of the Neonatologist on call and depending on staff and bed availability.**
4. **The patient being admitted from the community must be screened for Respiratory Syncytial Virus (RSV) and influenza.**
5. **The back transport from another facility must have a completed negative Methicillin-resistant Staphylococcus Aureus (MRSA) screen prior to acceptance of admission.**
~~4.~~**6.** The attending physician shall be notified of patient arrive in the unit.
~~5.~~**7.** All Patients admitted to the NICU shall have a patient history completed and documented in the patient's medical record. An initial assessment shall be completed within 30 minutes of admission and documented within 4 hours of admission.
   a. This admission assessment is done and documented on patients admitted from any area of the hospital as well as transfers from other facilities.
~~6.~~**8.** Ongoing assessments are completed based on the patient's acuity and documented in the patient's medical record.

C. **ADMISSION CRITERIA:**
1. **Respiratory system:**
   Admission criteria may include but not limited to the following:
   a. Apnea requiring monitoring and observation
   b. Respiratory instability (tachypnea, grunting, cyanosis, etc.)
2. **Cardiac system:** Patients with severe, life threatening or unstable cardiovascular disease. Conditions include but are not limited to:
   a. Newly diagnosed or suspected arrhythmias.
   b. Hemodynamic instability.
   c. Suspected complex congenital heart defects.
3. **Endocrine/Metabolic:** Patients with life threatening or unstable endocrine or metabolic disease or active life threatening bleeding. Conditions include but are not limited to:
   a. Inborn errors of metabolism with acute deterioration requiring respiratory support, management of intracranial hypertension or ionotropic support.

b. Other severe electrolyte abnormalities such as hyperkalemia, severe hypo - or hypernatremia, hypo - or hyperglycemia requiring intensive monitoring.
c. Severe metabolic acidosis requiring bicarbonate infusion, intensive monitoring or complex intervention to maintain fluid balance.
d. Acute **Intraventricular Hemorrhage** (IVH).
e. Post-hemorrhahagic hydrocephalus
f. Twin-to-twin transfusion
g. Anemia of the newborn
h. Hyperbilirubinemia
i. Thrombocytopenia

4. **Other:**
a. Patients requiring a medical subspecialist.
b. Patients requiring advanced imaging with interpretation on an urgent basis including computer tomography, magnetic resonance imaging, and echocardiography.
c. Patients less than 2000 grams.
d. Patients with gestational age less than ~~36~~ **35 completed** weeks **(35 6/7)**.
e. Patients with suspected or confirmed sepsis.
f. Any patient requested by a referring physician.
g. Patients with suspected or confirmed genetic malformations requiring stabilization, surgical intervention and/or consultation with subspecialist.
h. Patients with suspected or confirmed necrotizing enterocolitis.

D. **DISCHARGE CRITERIA:**

1. **Transfer to other in-patient facility:**
a. Based on level of care required and bed availability; and/or where the infant's family lives, an infant may be transferred to a tertiary NICU for completion of care.
b. The infant shall be referred to an attending Neonatologist.
c. These babies may include but are not limited to the following:
i. Cardiac disease requiring surgical intervention and subspecialist follow up.
ii. Patients requiring surgical intervention.
iii. Neurologic disease needing subspecialist intervention and follow up.

2. **To Home:**
a. Completion of discharge teaching.
b. Stable cardio respiratory status. No apnea or bradycardia episodes requiring intervention within 5 to 7 days of discharge.
-The following infants will require home cardio respiratory monitoring:
~~i. Apnea > 20 seconds on the first Oxycardiogram (OCG), or~~
~~ii. > 10% symptomatic periodic breathing on caffeine citrate with second OCG~~
~~iii.~~**i.** SIDS sibling history.
c. Stable nutritional status
d. Ability to maintain temperature without artificial heart source
e. Stable medication regimen.
f. Completed assessment of outpatient neurodevelopmental needs.
g. Hearing screening.
h. Confirmed outpatient physician follow-up.

~~E. EXTERNAL LINK(S):~~

~~F.~~**E. REFERENCES:**

~~1. American Academy of Pediatrics. (2004). Committee on Fetus and Newborn Levels of Neonatal Care. *Pediatrics;* 114(5), 1341-1347. (doi:10.1542/peds.2004-1697)~~
~~2. American Academy of Pediatrics. (1998). Hospital Discharge of the High Risk Neonate-Proposed Guidelines. *Pediatrics;* 102(2), 411-417.~~
1. American Academy of Pediatrics. (2008). Hospital Discharge of the High-Risk Neonate: Committee on Fetus and Newborn. *Pediatrics;* 122 (5) 1119-1127.

2. **American Academy of Pediatrics and the American Congress of Obstetrician and Gynecologists. (2012). Guidelines for Perinatal Care (7th ed.), 321-382.**

~~G.~~**F. APPROVAL PROCESS:**

~~1. Clinical Policies and Procedures Committee~~
~~2. Nurse Executive Council~~
1. **NICU Director – 06/14**
2. **Perinatal Collaborative Practice – 06/14**
3. **NICU Medical Director – 06/14**
4. **Division of Neonatology – 06/14**
~~3.~~**5.** Medical Executive Committee**-07/14**
~~4.~~**6.** Professional Affairs Committee
~~5.~~**7.** Board of Directors

Tri-City Medical Center	NICU
PROCEDURE:	**BREASTFEEDING FOR THE TERM AND LATE PRE-TERM INFANT IN THE NICU**
Purpose:	To promote and support human milk as the preferred method of providing nutrition to infants in the NICU, and to provide assistance to the mother in establishing and maintaining breastfeeding for optimal growth and developmen
Supportive Data:	
Equipment:	
Issue Date:	NEW
Revision Date(s):	
Board of Directors Approval Date(s):	

A. **DEFINITIONS:**

1. LATCH (Latch, audible swallowing, type of nipple, comfort and hold) Scoring system for evaluating quality of a feeding at breast.
2. SSC – skin to skin care, also called kangaroo care

B. **POLICY:**

1. To promote a philosophy of infant care that advocates breastfeeding and the feeding of breastmilk as the preferred method of infant nutrition. To assist those families choosing to breastfeed with initiating and developing a successful and satisfying experience. To facilitate the procedure of collecting breastmilk and/or breastfeeding to benefit the mother/infant dyad.
   a. Skin to skin care (SSC)
   b. Informed Decision
   c. Attachment/LATCH-Breastfeeding Outcome
   d. Pumping and collection of mother's milk for infant nutrition

C. **PROCEDURE:**

1. SSC will be encouraged throughout the infant's hospitalization. (Refer to the WCS/ NICU, *Skin to Skin Care Procedure).*
2. First oral feeding shall be at breast whenever possible.
3. Minimize use of pacifiers except for during tube-feeding, for pain relief, and for calming infants.
4. Nipple shields may be used for facilitating establishment of breastfeeding, but only after evaluation by qualified staff.
5. Whenever mother is present, assist her in breastfeeding first, before a bottle is offered. Make every effort to communicate with mother to avoid feeding her baby before she arrives.
6. Infant driven feedings will vary in duration. However, an infant actively feeding at breast for longer than 30 minutes shall be evaluated and a lactation consult ordered.
7. Infants may be offered both breasts at each feeding but may only be interested in feeding on one side in the early days.
8. Experienced hospital staff should observe mother breastfeeding to assess for position, latch, and milk transfer. A LATCH score should be documented in the EMR (electronic medical record) at least once a shift.
9. Hospital staff should make sure that mother knows what a swallow of milk sounds like.

Evidence of Successful Feeding

10. Signs of adequate infant hydration.
    a. Voiding/Stooling- DOL 1-minimum 1 void/1 stool
       DOL 2- 2 void/2 stool
       DOL 3- 3 void/3 stool
       DOL4 – 6-8x/day
    b. <3%/day weight loss
    c. <8% total weight loss

Supplementation:

11. Babies whose parents have designated breastmilk as their feeding of choice will not be offered formula as an option in the first 48 hours of life.
12. Informed decision: Prior to formula supplementation, the parents will be informed of the risks of formula feeding.
13. Unless medically indicated for physiologic stability, such as newborns that are at risk of hypoglycemia by virtue of impaired metabolic adaptation or increased glucose demand, provide feedings of breastmilk only.
14. If breastfeeding intake is not adequate, supplemental feeds can be given using expressed breastmilk (first choice) or an artificial milk substitute containing partially broken-down protein. Supplemental feedings shall be offered after the baby goes to breast (provided mother of baby is available).
15. Neonatologist to determine need for supplementation daily, taking into account the small volume of colostrum intake expected during normal lactogenensis as well as infant's hydration needs (voiding patterns, electrolytes, course of illness). Supplementation frequency and duration to be given as ordered. **Supplemental feedings are not necessary if the infant shows signs of adequate intake (voiding, stools) and electrolytes are normal.**

Table for Supplementation Volumes

Time (hours)	Volume (mL/feed)
1st 24	2-10
24-48	5-15
48-72	15-30
72-96	30-60

Academy of Breastfeeding Clinical Protocol # 3: Hospital Guidelines for the Use of Supplemental Feedings in the Healthy Term Breastfed Neonate. Revised 2009.

16. An adequately nourished infant feeds 8 or more times per 24 hours.
17. A term infant shall be allowed to feed more frequently than every 3 hours.
18. Infants are expected to lose weight during the first few days of life, but should regain birth weight by two weeks of age. Excessive weight loss (>10% or >3%/day) should prompt a medical and nutritional evaluation of feeding techniques and mother's milk supply. In addition to medical evaluation of the infant, mother should be referred to a lactation evaluation and support.
19. Infants who are discharged prior to regaining birth weight should have a follow-up evaluation by the infant's primary health care provider or home health nurse within 24-48 hours of discharge to monitor weight, hydration, number of wet diapers and stools and assess for jaundice and signs of sepsis.

D. REFERENCE LIST

1. American Academy of Pediatrics, The American College of Obstetricians & Gynecologists. Guidelines for Perinatal Care 7th ed. Washington, DC: AAP & ACOG;
2. 2012.
3. Nyqvist, KH, Hansen, MN, Frandsen, AL, Ezeonodo, A, Hannula, L. Expansion of the Baby-Friendly Hospital Initiative Ten Steps to Successful Breastfeeding into Neonatal Intensive Care: Expert Group Recommendations. Journal of Human Lactation. 2013; 29(3) 300-309.
4. The Academy of Breastfeeding Medicine Protocol Committee. ABM Clinical Protocol #3: Hospital Guidelines for the Use of Supplementary Feedings in Healthy Term Breastfed Neonate, Revised 2009. Breastfeeding Medicine. 2009; Vol 4 (3).
5. Lawrence, RA, Lawrence, RM. Breastfeeding A Guide to the Medical Professional. 7th Ed. Philadelphia, PA: Saunders; 2010.
6. U. S. Department of Health and Human Services. The Surgeon General's Call to Action to Support Breastfeeding. 2011; Office of the Surgeon General, Washington D. C.

7. World Health Organization. Acceptable medical reasons for use of breast- milk substitutes. World Health Organization Website. http//whqlibdoc.who.int/hq/2009/WHO_FCH_09.01_eng.pdf/. Published 2009. Accessed April 10, 2013.
8. Stroustrup, A, Trasande, L., & Holzman, IR. Randomized Controlled Trial of Restrictive Fluid Management in Transient Tachypnea of the Newborn. The Journal of Pediatrics 2012;160 (1):38-43.

E. APPROVAL PROCESS

1. NICU Director – 06/14
2. Perinatal Collaborative Practice – 06/14
3. NICU Medical Director – 06/14
4. Division of Neonatology – 06/14
5. Medical Executive Committee-07/14
6. Professional Affairs Committee
7. Board of Directors.

~~SUBJECT: FORMULA (ARTIFICIAL MILK), USE OF~~

~~ISSUE DATE: 8/12 REVISION DATE:~~

This policy was combined into the Formula: Preparation and Storage of policy

~~A. PURPOSE:~~

~~1. Formula (artificial milk) will be available for supplementary use for infant feedings. Breast milk is recognized as the feeding of choice for most infants, however, when breastmilk is not available for use, or its use is contraindicated due to infant and/or maternal condition, or mother chooses to use formula, formula (artificial milk) will be available per physician order.~~

~~B. PROCEDURE:~~

~~1. New bottles of formula will be used for each feeding. Needed amount of formula is to be poured into secondary feeding bottle. Any opened, unused formula needs to be discarded.~~

~~2. Formulas that require mixing will be mixed under clean conditions according to the policy "PREPARATION OF SPECIALITY FORMULA, FORMULA FORTIFICATION AND BREASTMILK FORTIFICATION."~~

~~3. Formula may be heated by placing sealed bottle in a container of warm water or capping syringe and placing in a glove before placing in warm water. Do not let the level of water in the cup from the tap touch the mouth or top lid of the container.~~

~~4. Microwave ovens or excessive heat should not be used to heat formula.~~

~~C. EXTERNAL LINKS:~~

~~D. REFERENCES:~~

~~1. California Code of Regulation, Title 22: Social Security, Volume 28, Revised, November 29, 1996. Barclays Law Publishers, South San Francisco, CA.~~

~~2. Young, D. (2002). *Guidelines for Perinatal Care.*~~

~~E.~~A. APPROVAL PROCESS

~~1. Clinical Policies & Procedures Committee~~

~~2. Nurse Executive Council~~

1. **NICU Director – 06/14**
2. **Perinatal Collaborative Practice – 06/14**
3. **NICU Medical Director – 06/14**
4. **Division of Neonatology – 06/14**

~~3.~~5. Medical Executive Committee – **07/14**

~~4.~~6. Professional Affairs Committee

~~5.~~7. Board of Directors

Tri-City Medical Center	Women's & Children's Services Manual - NICU
PROCEDURE:	~~**PREPARATION OF SPECIALITY FORMULA, FORMULA FORTIFICATION AND BREASTMILK FORTIFICATION** **FORMULA, PREPARATION AND STORAGE OF**
Purpose:	Powered specialty formula, fortification of formula and breast milk will be prepared in the NICU in an aseptic manner to assure sterility.
Supportive Data:	
Equipment:	Sterile container Disinfecting wipes for cleaning Gloves Patient identification label Powdered specialty formula/~~Human milk fortifier~~ ~~Sterile Water~~
Issue date:	8/12
Revision Date(s):	**3/14**
Board of Directors Approval Date(s):	**8/12**

A. **POLICY:**

1. **Formula (artificial milk) will be available for supplementary use for infant feedings. Breast milk is recognized as the feeding of choice for most infants, however, when breastmilk is not available for use, or its use is contraindicated due to infant and/or maternal condition, or mother chooses to use formula, formula (artificial milk) will be available per physician order.**

~~1.~~**2.** Formula preparation and ~~the~~ fortification ~~of formula and breast milk~~ are the responsibility of the Registered Nurse in the NICU. Caloric density and type of formula must be verified with the physician order prior to preparation.

~~2.~~**3.** The preparation of formula ~~or the addition of human milk fortifier to breast milk~~ will be carried out in a designated area to decrease the risk of contamination.

B. **PROCEDURE:**

1. **Gather necessary equipment and supplies in designated formula preparation area.**
2. **Sanitize work surface, perform hand hygiene, and put on gloves.**

~~1. Prepare area by cleaning with antiseptic wipes.~~
~~2. Wash hands.~~
~~3. Assemble supplies.~~
~~4. If fortifying breastmilk double-check the labeled breast milk container with second licensed personnel.~~
~~a. Refer to WCS procedure "BREAST MILK, PUMPING, HANDLING, AND STORAGE OF".~~
~~5. Put on gloves.~~

~~6.~~**3.** Measure ~~sterile water, breast milk or~~ formula into sterile container to desired volume.

~~7.~~**4.** Add powdered/**liquid** specialty formula into container with ~~sterile water or~~ formula as per physician's orders:

a. Use ~~scoop provided with powder or~~ single-use scoop.
b. Transfer appropriate number scoops required for caloric density to sterile container
c. Cap and shake vigorously to mix.

~~8.~~**5.** ~~Add liquid HMF to breast milk and gently swirl the contents to mix.~~

~~9.~~**6.** ~~Label with patient identification, contents, date, and time. Initial label.~~

7. **Fortified/mixed** ~~F~~formula/~~breast milk~~ should be prepared **fresh for each feed.**

~~10.~~**8.** **Refer to manufacturer guidelines for storage of unused formula.** ~~to accommodate the next 12 hours. Once prepared, formula/breast milk should be refrigerated.~~
~~a. Discard any unused mixed/fortified formula/breast milk after 24 hours.~~

~~11.~~**9.** Clean area after completion, wiping surface down with antiseptic wipes.

~~C. **EXTERNAL LINKS:**~~

~~D.~~**C.** **REFERENCES:**

1. American Academy of Pediatrics (AAP) and American College of OB and GYN (ACOG). (2002). *Guidelines for Perinatal Care, 5th ed.*
2. California Code of Regulation, Title 22: Social Security, Volume 28, Revised, November 29, 1996. Barclays Law Publishers, South San Francisco, CA.

~~E.~~D. APPROVAL PROCESS:

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3.~~**1.** NICU Director – 06/14
~~4.~~**2.** Perinatal Collaborative Practice – 06/14
~~5.~~**3.** NICU Medical Director – 06/14
~~6.~~**4.** Division of Neonatology – 06/14
~~7.~~**5.** Medical Executive Committee
~~8.~~**6.** Professional Affairs Committee
~~9.~~**7.** Board of Directors

Tri-City Medical Center	Women's & Children's Services Manual - NICU
PROCEDURE:	**PERIPHERAL ARTERIAL LINE (PAL): INSERTION, MAINTENANCE, AND REMOVAL OF**
Purpose:	To facilitate the efficient aseptic and complication free insertion of a peripheral arterial line for monitoring blood pressure and obtaining arterial blood samples.
Supportive Data:	
Equipment:	1. Non-sterile Gloves 2. Cholrhexidine swabs 3. Infusion solution 4. IV tubing 5. transducer 6. 3 ml syringe 7. Leur-lock **(preferred) or Slip-tip** t-connector ~~8. 3-way stopcock~~ ~~9.~~**8.** 22 or 24 gauge angiocath ~~10.~~**9.** Tape ~~11.~~**10.** Transparent dressing ~~12.~~**11.** IV infusion pump ~~13.~~**12.** Light source transilluminator ~~14.~~**13.** IV board ~~15.~~**14.** Cotton balls
Issue date:	9/07
Revision Date(s):	5/08, 4/09, 6/11, 8/12
Board of Directors Approval Date(s)	5/08, 4/09, 6/11, 8/12

A. **POLICY:**

1. Placement of a peripheral arterial line is done by a physician.
2. Transparent dressing will be placed over the site for stabilization and to allow continuous visualization of skin around catheter insertion site.
3. Excessive extension of extremity is to be avoided to prevent occlusion of artery.
4. Fingertips or toes are to be exposed so that circulatory status can be monitored.
5. Usual infusion is ½ NS or NS with 1 to 2 units heparin/ml at a rate of **0.5 to** 1 ml/hour. Infusions into PALs should not exceed 1 ml/hour.
6. Infusion is to run continuously on an infusion pump with a transducer to monitor blood pressure.
7. No medications, glucose, blood products or any rapid bolus will be administered through a PAL.
8. The physician will be notified if there is blanching, cyanosis, circulatory compromise, bleeding, dampened waveform or difficulty drawing blood from the PAL.

B. **PROCEDURE (PAL INSERTION):**

1. Perform hand hygiene.
2. Confirm patient identity using two-identifier system. Refer to Patient Care Services "Identification, Patient" (IV.A) policy
3. Immobilize patient with developmentally supportive methods, such as swaddling.
4. Attach syringe containing ~~heparinized~~ flush **solution** to leur-lock T-connector **(preferred) or slip-tip T-connector**.
5. Flush ~~luer-lock~~ T-connector.
6. Dim lights if transilluminator is being used to visualize artery.
7. Provide pain management as indicated.
8. Don nonsterile gloves.
9. Assist with immobilizing the extremity during catheter insertion.
10. Assist physician as necessary with securing the line.
11. Assist with taping or placement of an occlusive dressing.
12. Apply an arm or foot board. Dressing is applied in a manner as to display all digits as much as possible.

13. Once artery is cannulated, **attach** t-connector ~~is attached~~ firmly to cannula, gently flush and clamp. **If slip-tip T-connector is used, make sure it is taped securely to prevent accidental disconnection and blood loss.**
14. **Attach** T-connector ~~is attached~~ to transducer and IV tubing. ~~T-connector is then~~ **U**~~u~~nclamped **the T-connector** and **begin** fluid administration. ~~is started.~~
15. Discard used supplies in appropriate receptacles, remove gloves, and perform hand hygiene.
16. Documentation of insertion in patient's medical record:
    a. Cannula size and type
    b. Location of arterial site
    c. Date and time of procedure
    d. How procedure was tolerated
    e. Estimated blood loss
    f. Characteristics of waveform on monitor
    g. Perfusion of extremity

C. **MAINTENANCE:**

1. Assess the neurovascular and peripheral vascular status of the cannulated extremity immediately after catheter insertion and hourly or more often if warranted.
2. The transducer is calibrated once a shift and PRN:
    a. Open the transducer stopcock to air by turning it off to the patient~~, remove~~**and loosening the non-vented** cap **while maintaining sterility.**.
    b. Maintain transducer at the level of the infant's right atrium.
    c. Press "zero" on the monitor.
    d. Replace cap and **c**lose stopcock to air by opening stopcock to infant.
    e. If waveform dampens:
        i. Check connections.
        ii. Flush transducer if bubbles are present.
        iii. Check selected pressure scale on monitor.
        iv. Recalibrate transducer.
        v. Compare cuff blood pressure (BP) to arterial reading.
        vi. Change stopcock and transducer.
        vii. Notify physician if interventions do not correct waveform.
3. Daily Documentation:
    a. BP and vitals **per Standards of Care.**
    b. Correlating cuff BP once per shift
    c. Location
    d. Hourly site checks including: site status, extremity color, waveform assessment
    e. ~~Lab draws~~

D. **BLOOD SAMPLING:**

1. Equipment:
    a. Non-sterile Gloves
    b. Cholrhexidine swabs
    c. ~~Capillary tube~~**ABG syringe sampling kit**/lab tubes
    d. 22**-25** gauge needle
    e. 2x2 gauze
2. Procedure:
    a. Perform hand hygiene.
    b. Confirm patient identity using two-identifier system. ~~Refer to Patient Care Services "Identification, Patient" (IV.A) policy~~
    c. Don non-sterile gloves.
    d. Place 2x2 gauze under t-connector port.
    e. Clean diaphragm with Cholrhexidine swab for 30 seconds. Allow to dry for 30 seconds.

f. Clamp ~~proximal end of~~ t-connector **close to the hub** with attached clamp. Keep infusion pump running.
g. Insert needle into t-connector port.
h. Allow three drops of blood to flow onto 2x2.
i. Fill ~~capillary tube/~~lab tubes directly from the needle hub **by allowing the blood to drip directly into the lab tube.**
~~i.~~**j.** **For ABG sample, adjust plunger on the ABG syringe to the 0.2ml mark then insert the syringe into the needle hub and allow the syringe to fill.**
~~j.~~**k.** Withdraw the needle carefully **and activate the safety mechanism.**
l. Release clamp on the t-connector, allowing backpressure from pump to flush line.
~~k.~~**m.** **Dispose of needle in the sharps container.**
n. Remove gloves and perform hand hygiene.
~~l.~~**o.** **Label labs with the appropriate patient information.**
~~m.~~**p.** ~~Document the procedure in the patient's medical record.~~

E. **CATHETER REMOVAL:**

1. Perform hand hygiene.
2. Confirm patient identity using two-identifier system. Refer to Patient Care Services "Identification, Patient" (IV.A) policy
3. Don nonsterile gloves.
4. Turn infusion pump off.
5. Remove dressing and tape.
6. Pull catheter out and assess intactness of catheter.
7. Apply pressure over insertion site with sterile 2x2 gauze,for a minimum of five minutes and re-evaluate every five minutes until bleeding stops.
8. Discard used supplies in appropriate receptacles.
9. Remove gloves and perform hand hygiene.
10. Document the procedure in the patient's medical record.

F. **REFERENCES**

1. Ikuta, L.M. & Beauman, S.S. (Eds.). (2011). Policies, Procedures, and Competencies for Neonatal Nursing Care. National Association of Neonatal Nurses.
~~1.~~**2.** MacDonald, M. G.,~~ &~~ Ramasethu, J. **& Rais-Bahrami, K.** (Eds.). (201207). *Atlas of procedures in Neonatology, 5th ed.* Lippincott Williams & Wilkins.
~~2.~~**3.** O'Shea, J. (2009). A comparison of blood pressure measurements in newborns. American *Journal of Perinatology, 26*(2), 113-116.
~~3.~~**4.** Ramasethu, J. (2008). Complications of vascular catheters in the neonatal intensive care unit. *Clinical Perinatology, 35*(1), 199-222
~~4.~~**5.** Verklan, M. T. & Walden, M. (2010). Core Curriculum for Neonatal Intensive Care Nursing, 4th ed. St. Louis: Elsevier Saunders.

G. **APPROVAL PROCESS:**

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
1. NICU Director – 06/14
2. Perinatal Collaborative Practice – 06/14
3. NICU Medical Director – 06/14
4. Division of Neonatology – 06/14
~~3.~~**5.** Medical Executive Committee – 07/14
~~4.~~**6.** Professional Affairs Committee
~~5.~~**7.** Board of Directors

Tri-City Medical Center	Women's and Children's Services Manual - NICU
PROCEDURE:	**PERIPHERALLY INSERTED CENTRAL CATHETERS AND MIDLINE CATHETERS, INSERTION OF**
Purpose:	To outline the procedure for the placement of peripherally inserted central catheters (PICC) in the neonate by a qualified PICC Registered Nurse.
Equipment:	**1.** PICC kit ~~1.~~**2.** **Appropriately sized catheter** ~~2.~~**3.** 26-gauge autoguard introducer ~~3.~~**4.** Mask, cap, sterile gown, and sterile gloves ~~4.~~**5.** 1:1 heparinized normal saline ~~5.~~**6.** Transfer set ~~6. 2% chlorhexidine gluconate swabs, two packs~~ ~~7. Transparent dressing~~ ~~8. Adhesive skin closure strips~~ ~~9. 10 mL syringe~~
Issue date:	**9/07**
Revision date(s):	**6/09, 11/09, 6/11, 8/12, 4/14**
Board of Directors Approval Date(s):	

A. **POLICY:**

1. RN Requirements/Experience
   a. Must have a minimum of 2 years experience as a NICU RN at Tri City Medical Center.
   b. Must be a benefitted TCMC employee**, preferably full time FTE**.
   c. Must demonstrate proficiency in peripheral IV skills.
   d. Must successfully complete a PICC Insertion didactic and laboratory practical course **every 2 years**.
   e. RNC-NIC preferred.
2. Initial and Ongoing Competency Evaluation
   a. Initial Competency Evaluation includes completion of three successful PICC placements under the direct supervision of PICC team coordinator or designee**, within 6 months of didactic training completion.**
   ~~a.~~**b.** Annual Competency Evaluation includes the completion of 4 successful PICC insertions per year (1 per quarter), one of which will be proctored. If the PICC RN is unable to achieve 4 successful PICC insertions per year (1 per quarter), then demonstration of a PICC insertion will either be performed in a lab setting or through the completion of one successful PICC placement under the direct supervision of the PICC team coordinator or designee.
3. The medical team in collaboration with the PICC qualified RN and Assistant Nurse Manager (ANM) or designee will determine the need for a PICC and discuss any special considerations/ contraindications including septicemia, thrombocytopenia or coagulopathy, or the presence of fractures prior to insertion.
   i. Indications for PICC placement include:
      1) Infants requiring venous access for long term (≥7 days) intravenous fluid/hyperalimentation or medications.
      2) Infants with poor vascular access.
      3) Caustic drug therapy,
      4) Very low birth weight
4. The PICC qualified RN will notify the physician if complications occur during insertion including excessive bleeding from the site, bradycardia or cardiac arrhythmia, catheter embolism, or a failed PICC attempt.
5. Maximal Barrier Precautions and sterile technique will be used at all times. Staff within 3 feet of the sterile field will wear a hat and mask.

6. The physician will verify placement of the catheter by chest and/or ~~abdomenal~~**abdominal** x-ray immediately after the procedure. The PICC RN will make any necessary adjustments in catheter placement. Line placement will be verified on all subsequent x-rays.

~~6.~~**7.** **PICC placement with be verified a minimum of every 2 weeks by X-ray.**

~~7.~~**8.** An informational handout will be provided to the parent or legal guardian. Questions will be answered or forwarded to the infant's physician.

B. **PICC PLACEMENT:**

1. Procedure:
   - a. Verify ~~written~~ order from physician to place PICC and that informed consent has been obtained from parent or legal guardian.
   - b. Ensure that comfort is provided for the infant during the procedure. Refer to NICU "Pain Management" policy.
   - c. Perform hand hygiene.
   - **d.** Perform "time out" to verify patient and procedure **per patient care services Universal Protocol policy**.
     - **i. NICU PICC RN calls for time out immediately before starting the procedure.**
     - **ii.** Confirm patient identity using two-identifier system. Refer to Patient Care Services "Identification, Patient" -policy.
     - ~~d.~~**iii. The NICU PICC RN states the procedure, verifies correct sites with RN that is assisting**
   - e. Select vein to be used for procedure.
   - f. Measure the desired length of the catheter.
     - i. For arm placement, measure from the insertion site up to the shoulder, across the chest to the top of the sternum and then down to the midpoint of the sternum (the third intercostal space).
     - ii. For leg placement, measure from insertion site following vein track up to the xyphoid process.
   - g. Position patient using developmentally supportive methods and immobilize the infant securely.
     - i. Position patient with desired insertion site accessible.
     - ii. For arm insertion, position the patient's head facing toward the insertion side with chin down, to prevent catheter insertion into the jugular vein.
   - h. Restrict traffic near the sterile field.
   - i. Don a mask, cap, and sterile gown. If assistant will enter the sterile field or reach over it, they will perform hand hygiene and also wear maximal barrier precautions (sterile gown, mask, hair covering, and sterile gloves).
   - j. Open the PICC kit. Put on sterile gloves, set up, and drape a sterile work area. Cover the infant with a full-body sterile drape with only the involved skin area exposed.
   - k. Prepare the involved skin area with three 2% chlorhexidine gluconate swabs per manufacturer's guidelines.
   - l. Do not touch the part of the catheter to be inserted; use forceps to manipulate it. Check the catheter and insertion needle for defects.
   - m. Fill two 10 mL syringes with 1:1 heparinized flush solution.
   - n. Attach syringe and flush catheter with heparinized saline solution.
   - o. Insert the introducer bevel up at a 15 ° -30 ° angle into the skin a few millimeters before anticipated entry into the vein. Observe for blood return.
   - p. Advance the catheter through the introducer with small forceps to thread it into the vessel to the pre-measured length. Apply pressure well above the tip of the introducer to stabilize the catheter during the removal of the introducer. Remove the introducer and pull the wings apart to break and remove them.
   - q. Aspirate to verify blood return and flush with heparinized normal saline.
   - r. Secure catheter at insertion site with sterile adhesive skin closure strip.

s. Obtain an order for x-rays. Catheter placement is to be confirmed by x-ray and read by a physician prior to infusing fluids. It is optimal to have the infant's arms in a neutral position for the x-ray, (not raised above shoulder level).
t. If catheter tip is not in the desired location, adjust catheter placement to desired location.
u. Apply dressing by removing the skin prep with sterile water or normal saline and allowing to dry.
    i. Secure catheter at insertion site with sterile adhesive skin closure strip (if not already done).
    ii. Coil the external catheter in small concentric circles (avoid kinks) and secure with a second steri-strip.
    iii. ~~Cut sterile gauze, duoderm, or~~ **Use** foam tape to fit and place under hub to avoid skin irritation/breakdown. Secure hub with sterile adhesive skin closure strip.
    iv. Place transparent dressing over the insertion site, length of catheter and hub
v. Secure the exit site:
    i. Apply sterile adhesive skin closure strip using chevron technique (v-shaped pattern) and secure to skin above transparent dressing.
w. Begin infusion of IV fluids after proper placement is confirmed.
x. Cleanse extremity of residual chlorhexidine gluconate with sterile water or normal saline.
y. Document the procedure in the patient's medical record, including the Central Line Insertion Procedure (CLIP) form.

C. REFERENCES:

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D. APPROVAL PROCESS

1. **NICU Director – 06/14**
2. **Perinatal Collaborative Practice – 06/14**
3. **NICU Medical Director – 06/14**
4. **Division of Neonatology – 06/14**
5. **Medical Executive Committee – 07/14**
6. **Professional Affairs Committee**
7. **Board of Directors**

Tri-City Medical Center
Oceanside, California

WOMEN AND CHILDREN'S UNIT SPECIFIC POLICY MANUAL

ISSUE DATE: NEW

SUBJECT: EMERGENCY/STAT CESAREAN SECTION NOTIFICATION PROCESS

REVISION DATE:

Women and Children's Services Director –	**05/14**
Department of OB/GYN –	**04/14**
Medical Executive Committee	**07/14**
Professional Affairs Committee	
Board of Directors Approval:	

A. **PURPOSE:**

1. To delineate the notification process for an Emergency Cesarean Section (C-Section) for maternal or fetal indications and responder roles. Clinical indications that may require an emergency, urgent or crash C-Section can include but are not limited to:
   a. Prolapsed Umbilical Cord
   b. Uterine Rupture
   c. Placental Abruption
   d. Uncontrolled Placenta Previa
   e. Category III Fetal Heart Rate Tracings
   f. Fetal Bradycardia
   g. Failed assisted vaginal delivery attempt (Forceps/Vacuum)
   h. Eclampsia

B. **DEFINITIONS:**

1. An Emergency C-Section paging tree can be activated when a patient on the Labor and Delivery (L&D) unit experiences an obstetrical emergency indicating emergent delivery by C-Section.
2. The Emergency C-Section response team consists of:

Primary Obstetrician(OB) and/or any OB Provider IN HOUSE	**OB-1 Anesthesiologist**	**Anesthesia Technician (if in house)**
L&D Charge RN	**OB Surgical Tech**	**L&D RN/RNs**
Respiratory Therapist (RT)	**Neonatologist**	**Nursery RN**
L&D Unit Secretary		

3. Ad hoc members may be called at the discretion of the charge RN and can include: Perioperative Aide, Other L&D RN's, Mother-Baby Unit Charge RN, Mother/Baby Unit Assistant Care Technician (ACT), Chaplain and Social Services.

C. **POLICY:**

1. An Emergency C-section Page shall be called for any of the clinical indications identified in A.1.
2. The Emergency Page may be requested and/or activated by the following personnel:
   a. Provider
   b. L&D Charge Nurse/Assistant Nurse Manager (ANM)
   c. Nurses
   d. Unit Secretary when directed from any of the above members
3. The paging tree is initiated by dialing the operator at extension "66" on the telephone and informing the operator to initiate the "EMERGENCY C-SECTION" page tree. Staff should tell the

operator the location of the expected C-Section (Emergency C-Section: L&D Operating Room (OR) #1 or OR #2)

a. The operator will page out this TEXT message to the listed members (STAT C-Section, OR #1). Please note there is NO OVERHEAD page.

D. **RESPONSE PLAN:**

1. When an Emergency C-Section text page is received, the members of the health care team responsible for responding are to report to the location identified and provide assistance as indicated by their role.
2. **The Primary L&D RN:** shall notify the charge RN of the emergency, acts as the team leader until relieved by the obstetrical provider or anesthesiologist, and ensures patient is safely transported back to the OR for an emergency C-Section. Other responsibilities shall include:
   a. Establishment of a patent IV site if not already in place
   b. Patient should be positioned to maximize uterine and fetal perfusion on transfer
   c. Oxygen via face mask a consideration
   d. When in the OR: Obtain fetal heart tones if indicated, Foley placement if not already done, Betadine splash prep
3. **The Charge Nurse** obtains a history of the situation and may initiate or designate someone to initiate the Emergency C-Section notification tree by dialing 66, if not already done.
   a. Directs personnel, make reassignments as necessary and assists the patient transport to the OR
   b. Assigns another RN/s to assist the primary RN with patient transfer, OR prep and/or anesthesia support for Rapid Sequence Intubation (RSI) need
4. **The Obstetrical Provider** evaluates the patient's condition and directs the surgery initiation if required.
5. **The Anesthesiologist** acts/assists the obstetrician, provides airway management, RSI if indicated, and surgical anesthesia support.
6. **The second/third L&D RN** supports the primary RN to assist with OR preparations and/or assists anesthesia with RSI, if the anesthesia technician is not available. Items can include
   a. Starting IV line/s, inserting a Foley, administering medications as needed
   b. Being available to the anesthesiologist to assist with RSI:
      i. Place ECG leads, BP cuff and pulse ox on the patient
      ii. Give supplementation oxygen to the patient, as directed
      iii. Assist with cricoid pressure as directed. Do not release until told by anesthesiologist
   c. Performing surgical preparations, recording the events
7. **The Anesthesia Technician** receives direction from the anesthesiologist, which can include
   a. Giving supplementation oxygen to the patient, as directed
   b. Assisting the anesthesiologist with RSI preparations
8. **The OB Surgical Technician** Prepares the OB OR as directed for potential operative procedure.
9. **The Nursery RN** is responsible for calling the NICU team if a NICU Nurse is requested and shall call the RT and Neonatologist from the OR if they have not yet arrived to the OR. Other considerations can include:
   a. Bringing the Neonatal Crash Cart to the OR
10. **RT- Neonatal Intensive Care Unit** is responsible for supporting the neonatal respiratory resuscitation needs and readying the equipment in the OR as indicated.
11. **Neonatologist** directs and leads the neonatal resuscitation.
12. **The Unit Secretary** for L&D receives direction from the charge RN.
    a. Initiates the Emergency C-section Paging Tree by calling #66
    b. Pages/Calls the primary OB provider to the OR STAT
    c. Helps direct response team members to the correct room/location
    d. Takes care of charting paperwork preparation of surgery paperwork if indicated

E. **CROSS-REFERENCE:**

1. Patient Care Standard (PCS) Standardized Procedure – Code Blue PCS Standardized Procedure.
2. Patient Care Standards Rapid Response Team (RRT).
3. Patient Care Standards, OB CODE STAT Policy

F. **REFERENCES:**

1. American Academy of Pediatrics (AAP) and American Congress of Obstetrics and Gynecology (ACOG) 2012. Guidelines for Perinatal Care, 7th Ed. Washington, DC.
2. Simpson, K. & Creehan, P. (2008) Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) Perinatal Nursing. Philadelphia, PA.
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Tri-City Medical Center	Women and Children's Services Procedure Manual
PROCEDURE:	**FETAL HEART RATE(FHR) SURVEILLANCE/ MONITORING**
Purpose:	To provide current terminology and nomenclature for the description of FHR tracings and uterine contractions for use in clinical practice. Terminology and nomenclature are based on the 2008 National Institute of Child Health and Human Development (NICHD) workshop report on electronic fetal monitoring.
Issue Date:	NEW
Revision Date(s):	
Board of Director Approval Date(s):	

A. **POLICY:**

1. The Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) supports the assessment of the laboring woman and her fetus during labor through the use of auscultation, palpation and/or electronic fetal monitoring (EFM) techniques.
2. The availability of registered nurses and other health care professionals who are skilled in maternal-fetal assessment, to include fetal heart monitoring (FHM) techniques is important for optimal care of the mother and fetus.
3. FHM policies/procedures shall specify the standardized FHM language to be used and staff shall use these standardized descriptive terms to communicate and document FHR characteristics, interpretation and any associated interventions.
4. Consensus regarding interpretation and management of EFM across disciplines is essential in providing safe patient outcomes.

B. **DEFINITIONS:**

1. FETAL HEART RATE (FHR):
   a. BASELINE FHR is determined by approximating the mean FHR rounded to increments of 5 beats per minute(bpm) during a 10 minutes window, excluding accelerations, decelerations and periods of marked FHR variability (>25bpm).
   b. There must be at least 2 minutes of identifiable baseline segments (not necessarily continuous) in any 10 minute window or the baseline for that period is INDETERMINATE. In the case of indeterminate baseline, refer the the prior 10 minute window for baseline determination.
   c. NORMAL baseline rate: 110- 160 bpm
   d. TACHYCARDIA: Baseline rate: > Greater than 160 bpm
   e. BRADYCARDIA: Baseline rate: < Less than 110 bpm
2. FHR VARIABILITY: Determined in a 10 minute window, excluding accelerations and decelerations. Defined as fluctuations in the baseline FHR that are irregular in amplitude and frequency. The fluctuations are visually quantitated as the amplitude of the peak to trough in bpm.
   a. Absent= amplitude range is undetectable
   b. Minimal= amplitude range of 5 bpm or fewer
   c. Moderate= amplitude range of 6-25 bpm
   d. Marked= amplitude ranger of greater than 25 bpm
3. ACCELERATION: visually apparent abrupt increase in FHR. Increase from the onset of the acceleration to the peak is usually less than < 30 seconds.
   a. For gestations > 32 weeks: The peak must be > or equal to 15 bpm above the baseline FHR and must last > or equal to 15 seconds from the FHR acceleration onset to baseline return.
   b. For gestations < 32 weeks: an acceleration is defined as having a peak of >greater than 10 bpm above baseline with a duration of at least 10 seconds.
   c. Prolonged accelerations= an acceleration lasting longer than 2 minutes duration, but < 10 minutes duration.
   d. An acceleration lasting longer than 10 minutes in duration is defined as a FHR baseline change.
4. PERIODIC/EPISODIC/RECURRENT and/or INTERMITTENT PATTERNS:
   a. Periodic FHR patterns are changes that occur with the uterine contraction

b. Episodic patterns are those that are not associated with uterine contractions. (can occur at any time)
c. FHR changes are also defined as recurrent if they occur with > greater than or equal to 50% of the contractions in a 20 minute window.
d. FHR changes are defined intermittent if they occur with < less than 50% of the contractions in any 20 minute window

5. DECELERATIONS (DECEL): Visual or subtle decreases in the FHR bpm from the baseline which usually returns to baseline. Characteristics of the deceleration are indicative of the pathophysiology associated with the FHR decrease.
   a. LATE DECEL: visually apparent, but can be subtle decelerations that are, usually symmetrical with a gradual decrease and return of the FHR, associated with a contraction. They are PERIODIC. A gradual FHR decrease is defined as the deceleration taking longer than 30 seconds to get to the lowest point/ or nadir before returning to the baseline rate AND the nadir of the deceleration occurs after the peak of the contraction.
      i. CAUSE: Utero-placental Insufficiency (UPI)
   b. EARLY DECEL: visually apparent, but can also be subtle decelerations that are usually symmetrical with a gradual decrease and return of the FHR, associated with a contraction. They are PERIODIC. The nadir of the deceleration usually occurs at the same time as the peak of the contraction, almost mirroring the contraction from start to finish. In most cases the onset, nadir and recovery of the deceleration are coincident with the beginning, peak and ending of the contraction.
      i. CAUSE: Fetal Head Compression
   c. VARIABLE DECEL: visually apparent, ABRUPT deceleration in the FHR. An abrupt decrease is defined as the FHR decel getting to the nadir or lowest point in less than 30 seconds. The decrease in FHR is >greater than 15 bpm, lasting greater than 15 seconds but less than 2 minutes duration. THEY are EPISODIC in pattern, so can occur at any time. When a variable decel is associated with a contraction, the onset, depth and duration commonly vary with successive uterine contractions.
      i. CAUSE: Umbilical Cord Compression
   d. PROLONGED DECEL: visually apparent decrease in FHR from the baseline that is >greater than 15 bpm, lasting longer than 2 minutes until its return to the baseline FHR BUT less <than 10 minutes. (A change in FHR longer than 10 minutes is a baseline change)
6. SINUSOIDAL FHR PATTERN: specific FHR pattern that is defined as having visually apparent, smooth, sine wave-like undulating pattern in FHR baseline with a cycle frequency of 3-5 minutes that persists for >greater than or equal to 20 minutes.
7. FHR PATTERN CATEGORIZATION: FHR tracings and patterns provide information on the current acid-base status/ oxygenation status of the fetus. Categorization of the FHR tracing provides and evaluation based on the FHR at that point in time and these are based on a (3) tier system. FHR tracings and patterns can and will change. A FHR tracing may move back and forth between categories depending on the clinical situation, management and intervention strategies employed.
   a. CATEGORY I- FHR tracings are normal and strongly predictive of normal fetal acid-base status at the time of observation and may be managed in a routine manner with either continuous or intermittent monitoring. Catergory I FHR tracings include al of the following:
      i. Basline FHR : 110-160
      ii. FHR Varability: Moderate
      iii. Early decels may be present or absent
      iv. Accelerations in FHR may be present or absent
      v. Late or Variable decels are NOT present
   b. CATEGORY II- FHR tracings are indeterminate; not predictive of abnormal fetal acid-base staus. Category II FHR tracings require evaluation, continued surveliance, initiation of appropriate corrective measures when indicated and re-evaluation. Once identified, these tracings may require more frequent evaluation and continued surveillance, unless they revert to a Category I. Category II FHR tracings include all FHR characteristics NOT

categorized as a Category I or Category III. Examples of Category II FHR tracings include any of the following:

i. Bradycardia not accompanied by absent FHR variability
ii. Tachycardia
iii. Minimal FHR variability
iv. Absent FHR variability without recurrent decelerations
v. Marked FHR variability
vi. Absence of induced FHR accelerations after fetal stimulation
vii. Recurrent variable decels accompanied by minimal or moderate FHR variability
viii. Prolonged decelerations
ix. Recurrent late decels with moderate FHR variability
x. Variable decels with other characteristics such as slow return to baseline FHR, FHR overshoots or "shoulders" which are indicative of reduced fetal oxygenation.

c. CATEGORY III- FHR tracings are abnormal. Category III tracings are predictive of abnormal fetal acid-base status at the time of observation. The implementation of uterine resuscitation interventions are required. If unresolved, Category III FHR tracings most often necessitate prompt delivery. Category III tracings include either:

i. Absent FHR variability AND any of the following:
   1) Recurrent late decels
   2) Recurrent variable decels
   3) Bradycardia
   4) Sinusoidal pattern

ii. FHR patterns shall be described in terms of these established Categories rather than indicating if they are reassuring or non-reassuring patterns.

8. SBAR (Situation, Background, Assessment, Recommendations): A full descriptions of a FHR tracing to providers requires a qualitative and quantitative description of:
   a. Baseline FHR
   b. FHR variability
   c. Presence of FHR accelerations
   d. Uterine contraction pattern
   e. Any periodic or episodic decelerations
   f. Any changes or trends of FHR pattern over time
   g. Category Interpretation of the FHR tracking (Category I, II, or III)
9. INTERMITTENT or FHR by ASCULATATION: Please see Mosby's Nursing Procedure for Intermittent Fetal Monitoring/ Ascultation.

C. **EQUIPMENT NEEDED:**

1. Electronic Fetal Monitor
2. External Transducer (Dopplar)
3. External Tocodynamometer
4. Fetal Monitoring Belts/ Straps
5. Internal Leg Plate Transducer for Fetal Spiral Electrode(FSE) monitoring
6. Internal Leg Plate for Intrauterine Pressure Catheter (IUCP) monitoring
7. FSE
8. IUPC
9. Transducer Gel
10. Fetal Monitor Paper

D. **STANDARDS OF PRACTICE:**

1. FHR surveillance shall be performed by an RN who has attended at least a Basic Fetal Monitoring Course and/or has continuing educational units in intermediate or advanced fetal monitoring courses every two years.
2. Using a fetal monitor to observe the FHR and FHR pattern is one method of assessing fetal well-being in utero and be done by continuous external or internal electronic fetal monitoring OR by intermittent monitoring via auscultation.

3. During labor induction or cervical ripening with Pitocin, Misoprostol (Cytotec) or Cervidil (prostaglandin E2) continuous fetal monitoring shall be utilized, unless otherwise indicated in the provider orders.
4. The frequency of assessment and documentation is determined by AWHONN practice guidelines
5. The objective assessment of actual contraction strength requires the use of an IUPC.
6. If the patient refuses fetal monitoring, the provider will be notified, refusal documented in the patient's medical record and refusal of treatment form signed by the patient.
7. Paper speed for EFM is maintained at 3 centimeters/ minute.
8. FHR Interpretation will include the assessment of the FHR baseline rate rounded to the nearest 5 bpm, variability, the presence or absence of accelerations, decelerations, changes or trends in the FHR patterns over time. Documentation of the FHR interpretation is completed hourly at a minimum.
    a. In the absence of risk factors assess and document:
        i. Every 30 minutes during the latent phase of labor
        ii. Every 15 minutes during the active phase and 2nd stage of labor
    b. In the presence of RISK FACTORS assess and document:
        i. Every 15-30 minutes during the latent phase of labor
        ii. Every 15 minutes during active phase of labor
        iii. Every 5 minutes during the 2nd stage
    c. Antepartum considerations:
        i. May have continuous monitoring in the presence of risk factors, based on medical history ad per provider order.
        ii. Consider obtaining fetal heart tones, at least once daily.
9. Uterine Contractions are quantified as the number of contractions present in a 10 minute window, averaged over 30 minutes. Contraction frequency alone is a partial assessment of uterine activity. Other factors such as duration, intensity, and resting tone/ uterine muscle relaxation time between contractions are equally important to assess. The following represents the terminology to describe uterine activity:
    a. Normal contraction pattern: Less than < 5 contractions in 10 minutes averaged over a 30 minute period.
    b. Tachysystole: Greater > 5 contractions in a 10 minutes averaged over a 30 minute period.
        i. Tachysystole should always be qualified as it related to the presence or absence of FHR decelerations.
        ii. Tachysystole applies to both spontaneous or stimulated contractions
    c. External Assessment (Tocodynamometer) assess and document:
        i. Frequency (Time averaged from the beginning of one contraction to the beginning of another): Usually in minutes
        ii. Duration (Time measured from the start to the end of the contraction): Usually in seconds
        iii. Intensity(By palpation): Mild, Moderate or Strong
        iv. Resting Tone (By palpation): After contraction is uterine muscle soft or firm?
    d. Internal Assessment (IUPC) assess and document:
        i. Frequency in minutes
        ii. Duration in seconds
        iii. Intensity in mmHg
        iv. Resting tone in mmHg
    e. Abnormal contraction assessment can include:
        i. Uterine resting tone greater than 20 mmHg for IUPC use OR muscle stays firm on palpation (no rest/ not soft)
        ii. Tachysystole or contractions lasting longer than 2 minutes duration.
10. Interventions/ Management of FHR Findings: For Category II progressing to Category III or Category III FHR patterns, initiate interventions based on suspected mechanism of insult (listed below), notify provider of the patient/ FHR status and response to the interventions:
    a. LATE DECELERATIONS: (UPI)
        i. Reposition the patient to maximize blood flow to the uterus

ii. Discontinue oxytocin infusion
iii. Increase Intravenous (IV) fluids
iv. Administer O2 at 10 Liters via non-rebreather face mask

b. VARIABLE DECELERATIONS: (Umbilical Cord Compression):
i. Reposition the patient to alleviate suspected compression
ii. Increase IV Fluids
iii. Administer O2 at 10 Liters via non-rebreather face mask
iv. Perform a vaginal exam to assess for prolapsed cord possibility. If prolapsed cord is felt, relieve cord compression by lifting the presenting part off the cord and immediately call for help.
v. Discontinue oxytocin infusion, as indicated
vi. Consider amnioinfusion per provider order

c. PROLONGED DECELERATION:
i. Reposition the patient to maximize blood flow to the uterus
ii. Discontinue oxytocin infusion
iii. Increase IV fluids
iv. Administer O2 at 10 Liters per minute via non-rebreather face mask
v. Anticipate the possible administration of terbutaline if deceleration is related to tachysystole or tetanic uterine contraction per provider order

d. TACHYSYSTOLE:
i. Reposition the patient to maximize blood flow to the uterus
ii. Discontinue oxytocin infusion if FHR is demonstrating Category II or Category III tracings (See Oxytocin administration procedure)
iii. Increase IV Fluids
iv. Administer O2 at 10 Liters per minute via non-rebreather face mask
v. Anticipate the administration of terbutaline per provider order as needed

E. **STEPS OF THE PROCEDURE:**

1. Review EFM equipment and explain reasons for use
2. Position the patient so the uterus is displaced off o her spine to increase uterine perfusion and fetal oxygenation.
3. Apply belts or other securing device to the patient to hold the fetal monitoring cables in place.
4. Determine the fetal lie using leopald's maneuvers for best placement of the dopplar.
5. Apply transducer gel to the Doppler to gain maximum signal of the FHR.
6. Secure the Doppler in place using the belts, assuring patient comfort.
7. If the patient is having contractions, palpate the uterus during a contraction to determine the hardest point of the contraction and place the tocodynamometer (toco) over this point.
   a. Calibrate the uterine resting tone by "zeroing" the monitor when the uterus is at rest or become soft.
8. Secure the toco with the belt, assuring patient comfort
9. For internal monitoring application, please see the FSE and IUPC procedures in Mosby's

F. **DOCUMENTATION GUIDELINES:**

1. Intrapartum and Antepartum Monitoring: A complete analysis of the FHR and uterine activity will be documented hourly at a minimum and per AWHONN guidelines in the patient's Electronic Medical Record (EMR).
   a. Documentation may be accomplished via written charting on established forms, as directed, per hospital contingency plan for unexpected computer downtime.
   b. When electronic fetal monitoring is used to record FHR data permanently, periodic documentation can be used to summarize evaluation of fetal status.
      i. For example, during active pushing phase, summary documentation of fetal status approximately every 30 minutes indicating there was continuous nursing bedside attendance and evaluation is reasonable.
2. Annotations- Complete annotations for any clinical, medical, and/or nursing interventions performed in response to labor progress and/or FHR assessment on the electronic strip or in the

fetal monitoring evaluation section in the EMR. Items for consideration can include but not limited to:

a. Ambulation of the patient; position changes
b. Initiating inductions or insertion of cervical ripening agent both mechanical or pharmacological.
c. Increasing or decreasing Pitocin
d. Medication administration
e. Oxygen administration
f. Anesthesia introduction
g. Artificial or Spontaneous rupture of membranes
h. Vaginal examinations
i. Interventions completed for Category II or Category III strips
j. Vacuum assisted delivery application times, pull attempts
k. Others

G. REFERENCE LIST:

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8. Simpson, K.R. & Creehan, P.A. (2008). AWHONN's Perinatal Nursing. Philadelphia, PA: Wolters Kluwer/ Lippincott, Williams and Wilkins.

H. APPROVAL PROCESS

1. Women and Children's Services Director – 05/14
2. Department of OB/GYN – 04/14
3. Medical Executive
4. Professional Affairs Committee
5. Board of Directors

Tri-City Medical Center	Women and Children's Services
PROCEDURE:	**UTERINE TAMPONADE DEVICES**
Purpose:	To provide guidelines for the use of uterine tamponade balloons for postpartum hemorrhage management.
Supportive Data:	Estimates of the incidences of Postpartum Hemorrhage range from 1:100 to as frequent as 1:20. The indication for use of the EBB or Bakri tamponade balloon is for the temporary management of lower uterine segment bleeding. The placement is intended to reduce uterine bleeding when conservative management is warranted. Close monitoring for signs or arterial bleedings, continued uterine bleeding associated with atony and/or disseminated intravascular coagulation (DIC) is required.
Equipment:	1. OB Hemorrhage Cart 2. One sterile EBB or BAKRI Tamponade Balloon Device 3. One (1000 ml) 0.9% Normal Saline bag for the EBB 4. One (500 ml) 0.9 % Normal Saline bag for the EBB and BAKRI 5. Foley Catheter bag to be attached to tamponade device, post placement for drainage collection for both devices 6. Foley Catheter for urine collection 7. One 60 ml leur-lock syringe to remove residual air in the EBB uterine and vaginal balloons prior to insertion
Issue Date:	NEW
Revision Date(s):	
Board of Director Approval Date(s):	

A. POLICY:

1. The EBB/Bakri tamponade balloon is not a substitute for surgical management and fluid resuscitation for life threatening postpartum hemorrhage.
2. Maximum recommended time for the balloon placement is **24 hours**.
3. Contraindications or exclusion criteria include but are not limited to:
   a. Arterial bleeding requiring surgical intervention or angiographic embolization
   b. Complete uterine atony, although it may be effective in partial uterine atony
   c. Post-partum bleeding cases indicating hysterectomy
   d. Untreated uterine anomaly
   e. Cervical cancer
   f. Purulent infections of the vagina, cervix or uterus
   g. Surgical site that would prohibit the device from effectively controlling bleeding
   h. DIC

B. **PROCEDURE:**

1. The Registered Nurse (RN) assisting the physician with placement shall:
   a. Perform hand hygiene and don sterile gloves.
   b. Ensure the physician has determined uterus is clear of any retained placental fragments, arterial bleeding or lacerations.
   c. Insert a Foley catheter prior to the procedure, if not already in place.
   d. Get equipment ready to assist physician with placement of the balloon. The deflated balloon should be placed in the uterus, inserted past the cervical canal and internal ostium.
   e. FOR EBB:
      i. Remove residual air from both balloons with sterile 60 ml syringe.
      ii. Under the direction of the provider, use the uterine and vaginal spikes to fill both balloons.
      iii. Filling process is to be incremental (50-100ml) with provider assessment.
      iv. Use a 1000 ml bag of fluid to fill the UTERINE balloon, the 500 ml bag of fluid to fill the VAGINAL balloon
      v. Maximum fill amount for EBB uterine balloon is: 750 mL/ Vaginal balloon: 300 mL

f. FOR BAKRI:
   i. Attach 500 ml bag of normal saline to the Bakri administration set, using the three way stop cock and syringe to draw up no more than 500 ml to inflate the balloon. DO NOT overinflate the balloon.
   ii. Apply gentle traction to the balloon shaft to ensure proper contact between the balloon and tissue surface by securing it to the patient's leg. (If provider desires to maximize the tamponade effect and maintain the balloon's position s/he may pack the vagina with iodine or antibiotic soaked gauze pads).
   iii. Maximum fill amount for BAKRI: 500 mL.

g. Once balloon is inflated, document the amount of fluid used to create the tamponade and if any vaginal packing is used, this must be counted and documented. (See Vaginal Sponge Count Procedure)

h. Connect the EBB/ BAKRI drainage port to a Foley collection bag and monitor the drainage amount hourly.
   i. Notify the physician if blood volume output is greater than or equal to 200mL in one hour or collection exceeds 100 mL/ hr. consistently.
   ii. The balloon drainage port and tubing may need to be flushed clear of clots with 20 mL sterile isotonic saline, as needed.

i. Assess the patient's pain level/ uterine cramping, intake and output, hourly at a minimum.

j. Vital signs shall be monitored every 5-1 5 minutes throughout the insertion process per physician direction and then monitored:
   1) Every 15 minutes x 1 hour post procedure, then every hour x 3, then every 4 hours x 24 hours post procedure.
   2) Temperature shall be taken every hour x 4, then every 4 hours.

k. There is no need to complete fundal massage when the balloon is in place, but the position/location of the fundus/ fundal height should be documented at least once a shift. (Note any changes in position or height)

l. The patient shall remain on strict bed rest until the balloon is removed. Consider application of sequential devices.

m. Administer prophylactic antibiotics as ordered.

n. Notify the physician for any signs of worsening patient condition.

o. BALLOON REMOVAL:
   i. The balloon **must be removed by the physician within 24 hours of placement** or sooner as indicated
   ii. Verify that the fluid amount instilled into the balloon, matches the amount the physician removes from the balloon.
   iii. Verify that initial vaginal packing count, matches removal count, if used. (An x-ray should be considered when a count is unknown or incorrect)
   iv. After the balloon is removed, monitor the patient's vital signs and vaginal/ uterine bleeding initially, every 30 minutes x 4, and then hourly or per physician order.

p. Document all assessments, interventions and communications in the electronic medical record.

C. REFERENCES:

1. Dabelea, V., Schultze, P.M>, & McDuffie, R.S. (2007). Intrauterine Balloon Tamponade in the Management of Postpartum Hemorrhage, American Journal of Perinatology, Vol 24, No 6, 359-364.
2. Tindell, K., Garfinkel, R., Abu-Haydar, E.,, Ahn, R., Burke, TF, Conn, K., Eckardt, M. (2012) Uterine balloon tamponade for the treatment of postpartum haemorrhage in resource-poor settings: a systematic review
3. Simpson, K.R., & Creehan, P.A. (2008). Association of Women's Health, Obstetric and Neonatal Nurses: Perinatal Nursing (3rd ed.). Philadelphia, PA.

D. APPROVAL PROCESS

1. Women and Children's Services Director – **05/14**
2. Department of OB/GYN – **04/14**
3. Medical Executive
4. Professional Affairs Committee
5. Board of Directors

Tri-City Medical Cent
Oceanside, California

New Policy created to reflect current practices – Fetal Heart Rate (FHR) Surveillance/Monitoring

WOMEN AND NEWBORN SERVICES POLICY MANUAL

ISSUE DATE: 10/94 **SUBJECT:** Electronic Fetal Monitoring

REVISION DATE: 1/00, 6/03, 7/03, 5/09

Clinical Policies & Procedures Committee Approval:
Patient Care Quality Committee Approval:
Medical Department Approval: 6/09
Medical Executive Committee Approval:
Professional Affairs Committee Approval:
Board of Directors Approval: 7/03

A. **PURPOSE:**
1. Fetal heart rate monitoring is an important tool for assessment of the fetus during the Antepartum and intrapartum periods.
2. This is accomplished via the use of either:
   a. Intermittent auscultation:
      i. Hand-held Doppler
      ii. Electronic fetal monitoring ultrasound unit
      iii. Fetoscope
   b. Continuous electronic monitoring
      i. External
      ii. Internal
3. Patient risk factors, stage of labor, presence of a qualified nurse, and availability of equipment need to be considered when selecting the method of assessing fetal heart rate.

B. **INTERMITTENT AUSCULTATION:**
1. Auscultation of fetal heart rate will be conducted:
   a. On admission to the Obstetric service.
   b. Before and after patient ambulation.
   c. Following artificial or spontaneous rupture of membranes.
   d. After vaginal examination or fetal stimulation.
   e. Abnormal uterine activity.
   f. Any invasive procedure and/or medication.
   g. Prior to discharge or transfer.
   h. Until abnormal FHT's resolve, and/or as ordered by physician
2. The antepartum patient:
   a. Auscultate fetal heart tones as ordered by physician.
3. The intrapartum patient:
   a. The low risk patient
      1) Auscultate heart tones every 30 minutes during the active phase of labor.
      2) Auscultate heart tone every 15 minutes during the second stage of labor.
   b. The high risk patient
      1) Auscultate heart tone every 15 minutes during the active phase of labor.
      2) Auscultate heart tone every 5 minutes during the second stage of labor
4. Documentation
   a. Document pre-, intra-, and post-contraction fetal heart rate in the Patient Care Record.

C. **CONTINUOUS ELECTRONIC FETAL MONITORING:**
1. Continuous Fetal Monitoring Alarm System
   a. Alarms will remain on and audible at the nurse's stations:
      1) M-1: LDRP 1 to 8

2) M-2: LDRP 9 to 12
3) M-3: LDRP 13 to 16, LDR 17, 18 when laboring patients are present.

b. If alarms are activated, it is the Registered Nurse's responsibility to acknowledge and respond to the alarm situation.

c. Monitoring parameters (e.g. baseline fetal heart rate) may be adjusted by the Registered Nurse as the clinical situation warrants.

2. Electronic fetal monitoring will be initiated/maintained:

a. On admission to the Obstetric service

b. Before and after patient ambulation

c. Following artificial or spontaneous rupture of membranes

d. After vaginal examination or fetal stimulation

e. Abnormal uterine activity

f. Any invasive procedure and/or medication

g. Prior to discharge or transfer

h. Until abnormal FHR tracing is resolved, and/or as ordered by physician

3. The antepartum patient will be monitored using electronic fetal monitoring as ordered by the physician.

a. Interpretation of the fetal heart rate tracing will be conducted every four hours and as needed or as ordered by the physician. This will be documented in the Patient Care Record.

4. The intrapartum patient

a. The low risk patient

1) The fetal heart rate tracing will be interpreted every 30 minutes during the active phase of labor.

2) The fetal heart rate tracing will be interpreted every 15 minutes during the second stage of labor.

b. The high risk patient

1) The fetal heart rate tracing will be interpreted every 15 minutes during the active phase of labor.

2) The fetal heart rate tracing will be interpreted every 5 minutes during the second stage of labor.

5. Documentation:

a. Interpretation and documentation of the fetal heart rate obtained through electronic fetal monitoring will include:

i. **FHR baseline**:

1) Determined by approximating the mean FHR rounded to increments of 5 beats per minute (bpm) during a 10-minute window, excluding accelerations, decelerations, and periods of marked variability (> 25 bpm); FHR ranges can be used for the rounding up or down principle, ie, 120-130 = 125 FHR baseline, etc. Documentation of ranges is no longer acceptable.

2) Must be at least 2 minutes of identifiable baseline segments (not necessarily contiguous) in any 10-minute window, or the baseline for that period is indeterminate. If indeterminate, may be necessary to refer to the previous 10-minute window to determine baseline.

ii. **Baseline FHR variability**:

1) Determined in a 10-minute window, excluding accelerations or decelerations

2) Defined as fluctuations in baseline FHR that are irregular in amplitude and frequency

3) Fluctuations are visually quantified as the amplitude of the peak-to-trough in bpm

iii. **Classifications**:

1) *Absent* variability: amplitude range undetectable

2) *Minimal* variability: amplitude range > undetectable and ≤ 5 bpm

3) *Moderate* variability: amplitude range 6 bpm to 25 bpm

4) *Marked* variability: amplitude range > 25 bpm

iv. **Accelerations**:

1) Visually apparent *abrupt* increase in FHR baseline
2) Defined as an increase from the onset of acceleration-to-peak in < 30 seconds
3) Peak must be ≥ 15 bpm, and must last ≥ 15 seconds from onset to return for gestational ages ≥ 32 weeks
4) Peak must be ≥ 10 bpm, and a duration of ≥ 10 seconds from onset to return for gestational ages < 32 weeks
5) Prolonged acceleration: ≥ 2 minutes but < 10 minutes in duration
6) *Baseline change*: acceleration lasting ≥ 10 minutes

v. **Decelerations**:

1) Classified as late, early or variable based on specific characteristics
2) Characteristics of *Late* Decelerations:
   a) Visually apparent usually symmetrical *gradual* decrease and return of FHR to baseline, associated with a uterine contraction
   b) *Gradual* FHR decrease -- defined as one from the onset-to-FHR nadir of ≥ 30 seconds
   c) The decrease in FHR is calculated from the onset-to-nadir of the deceleration
   d) The deceleration is delayed in timing, with the nadir of deceleration occurring after the peak of the contraction
   e) In most cases, the onset, nadir, and recovery of the deceleration occur after the beginning, peak and ending of contraction
3) Characteristics of *Early* Decelerations:
   a) Visually apparent, usually symmetrical, *gradual* decrease and return of FHR associate with uterine contraction
   b) *Gradual* decrease in FHR defined as one from onset-to-nadir of ≥ 30 seconds
   c) The decrease in FHR is calculated from the onset-to-nadir of the deceleration
   d) The nadir of the deceleration occurs at the same time as the peak of the contraction
   e) In most cases the onset, nadir, and recovery of the deceleration are coincident with the beginning, peak and ending of contraction (the deceleration appears to mirror the contraction)
4) Characteristics of *Variable* Decelerations:
   a) Visually apparent *abrupt* decrease in FHR
   b) *Abrupt* decrease in FHR is defined as from onset of deceleration to beginning of the FHR nadir of < 30 seconds. The decrease in FHR is calculated from the onset-to-nadir of deceleration.
   c) The decrease in FHR is ≥ 15 second, and < 2 minutes in duration
   d) When associated with uterine contractions, their onset, depth, and duration commonly vary with successive contractions
   e) Note: Variable decelerations *accompanied by other* characteristics, such as "slow return to baseline", biphasic decelerations, tachycardia after variable deceleration(s), accelerations preceding and/or following, sometimes called "shoulders" or "overshoots", and fluctuations in the FHR in the trough of the deceleration, *require* further research investigation for clinical significance.
5) Characteristics of *prolonged* deceleration:
   a) Visually apparent decrease in FHR from the baseline that is ≥ 15 bpm, lasting ≥ 2 minutes but < 10 minutes
   b) Deceleration that lasts ≥ 10 minutes is a *baseline change*
6) Characteristics of decelerations to be *documented* are defined as those commonly used in clinical practice and research communications. The characteristics described in C.5.a.v.4.e, have *not* been defined as *clinically*

significant at this time and therefore, should **not** be documented in the patient's medical record.

7) Quantitation of decelerations:
   a) ***Recurrent*:** defined as decelerations occurring with ≥ 50% of uterine contractions in any 20-minute window.
   b) ***Intermittent*:** defined as decelerations occurring with < 50% of uterine contractions in any 20-minute segment.

vi. Features of FHR patterns are categorized as:
   1) Baseline – acceleration and decelerations determined in reference to adjacent baseline FHR
   2) Periodic – associated with contractions; either "abrupt" or "gradual" onset
   3) Episodic – not associated with contractions

vii. **Uterine Contractions**: qualified as the number of contractions present in a 10-minute window, averaged over 30 minutes. Contraction frequency alone is a partial assessment of uterine activity. Other clinical factors to be assessed include: duration, intensity and relaxation time between contractions.
   1) **Terminology** to describe uterine activity:
      a) **Normal**: ≤ 5 contractions in 10 minutes, averaged over a 30-minute window
      b) **Tachysystole**: > 5 contractions in 10 minutes, averaged over a 30-minute window, documented as with or without non-reasurring FHR pattern
   2) **Characteristics of uterine contractions:**
      a) Qualified as to presence or absence of associated FHR decelerations
      b) Term tachysystole applies to spontaneous or stimulated labor. The clinical response may differ based on whether the tachysystole is spontaneous of stimulated.
      c) The terms "hyperstimulation" and hypercontractility are ***not defined*** and ***should be abandoned***.

D. **REFERENCES:**

1. ACOG Committee Opinion. (2006). Induction of Labor for Vaginal Birth after Cesarean Delivery, Number 342 Vol. 108, No.2, August 2006
2. ACOG Committee on Practice Bulletin. (2005). Intrapartum Fetal Heart Rate Monitoring. Clinical Management Guidelines for Obstetrician-Gynecologists. Number 70, December 2005 replaces Practice Bulletin Number 62, May 2005.
3. Besuner, P. AWHONN Templates for Protocols and Procedures for Maternity Services, 2nd Edition (2007)
4. Chauhan, S.P. et al. (2005). Suspicion and treatment of the macrosomic fetus: A review. American Journal of Obstetrics and Gynecology, 193, 332-346.
5. Creasy, R.K., & Resnik, R. (2004). Maternal-fetal medicine (5th Ed.). Philadelphia: Saunders.
6. Dodd, J et al (2004). Planned elective repeat cesarean section versus planned vaginal birth for women with a previous cesarean birth, *Cochrane Database Syst Rev* Issue 4, 2004
7. Gilbert, E.S. and Harmon, J.S. (2008), Manual of High Risk Pregnancy and Delivery (4th Ed.), Mosby
8. Institute for Clinical Systems Improvement: *Health care guideline: Management of Labor,* (2005) ICSI. Retrieved from http://www.icsi.org on February 17, 2009
9. Kennedy, B.B, Ruth, D.J., Martin, E.J. (2009) Intrapartum Management Modules (3rd Ed.) Lippincott Williams and Wilkins.
10. Mandeville, L.K. & Troiano, N.H. (1999) *High Risk and Critical Care Intrapartum Nursing (2nd Ed.)* Philadelphia: Lippincott.
11. Mattson, S., & Smith, J.E. (Eds.) (2004) *Core Curriculum for Maternal-Newborn Nursing (4th Ed.)* Philadelphia: Saunders.
12. Macones, G.A., Hankins, G.D.V., Spong, C.Y., Hauth, J., Moore, T. (2008). The 2008 National Institute of Child Health and Human Development Workshop Report on Electronic Fetal Monitoring: Update on Definitions, Interpretation, and Research Guidelines. JOGNN, Principles & Practice, 37, 510-515. Retrieved from http://jognn.awhonn.org

13. Simpson, K. R. (2008). *Cervical Ripening & Induction & Augmentation of Labor*, 3rd Edition
14. Simpson, K. R., & Creehan, P. A. (2008). AWHONN's Perinatal nursing. Philadelphia, PA: Wolters Kluwer / Lippincott Williams & Wilkins.
15. Tucker, S.M. (2004) Fetal Monitoring and Assessment (5th Ed.), Mosby.

Governance & Legislative Committee (No meeting held in August, 2014)

Audit, Compliance & Ethics Committee
(No meeting held in August, 2014)

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

July 31, 2014 – 1:30 o'clock p.m.
Classroom 6 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 1:30 p.m. on July 31, 2014.

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

Director Paul V. L. Campo
Director James Dagostino, DPT, PT
Director Ramona Finnila
Director Julie Nygaard
Director RoseMarie Reno
Director Larry Schallock

Absent was Director Kellett

Also present were:

Greta Proctor, General Legal Counsel
Tim Moran, Chief Executive Officer
Casey Fatch, Chief Operating Officer
Steven L. Dietlin, Chief Financial Officer
Sharon Schultz, Chief Nursing Executive
Dr. Scott Worman, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 1:30 p.m. in Classroom 6 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Campo to approve the agenda as presented. Director Dagostino seconded the motion.

   Director Reno questioned the placement of the Approval of Agenda item. Chairman Schallock responded the approval refers to the agenda as a whole including both closed and open session agenda items.

   The motion passed (5-1-1) with Director Reno opposed and Director Kellett absent.

3. Public Comments – Announcement

Chairman Schallock read the Public Comments section listed on the July 31, 2014 Regular Board of Directors Meeting Agenda.

There were no public comments.

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

Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Ms. Proctor, made an oral announcement of items listed on the July 31, 2014 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter of potential litigation, two matters of existing litigation, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees, approval of closed session minutes, one report involving Trade Secret, and Consideration of Appointment of Public Employee: Chief Compliance Officer.

5. Motion to go into Closed Session

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

6. The Board adjourned to Closed Session at 1:33 p.m.

8. At 3:43 p.m. in Assembly Rooms 1, 2 and 3, Chairman Schallock announced that the Board was back in Open Session.

The following Board members were present:

Director Paul V. L. Campo
Director James Dagostino, DPT, PT
Director Ramona Finnila
Director Julie Nygaard
Director RoseMarie Reno
Director Larry Schallock

Also present were:

Greta Proctor, General Legal Counsel
Tim Moran, Chief Executive Officer
Casey Fatch, Chief Operating Officer
Steven Dietlin, Chief Financial Officer
Sharon Schultz, RN, Chief Nurse Executive
Esther Beverly, VP, Human Resources
Dr. Scott Worman, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairman Schallock reported the Board rejected a claim by Mr. Larry Anderson for indemnification on other matters. Chairman Schallock also stated the Board will be returning to closed session following the conclusion of open session.

(The numbering sequence below follows that of the Board Agenda)

10. Chairman Schallock noted all Board members were present with the exception of Director Kellett. Director Finnila led the Pledge of Allegiance.

11. Chairman Schallock read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 21.

12. Special Presentation

Clinical Research – Ingrid Stuiver, Director Clinical Research

Ms. Ingrid Stuiver, Director of Clinical Research provided a presentation on Clinical Research which has been ongoing since the 1990s and established at Tri-City in April of 2011. Ms. Stuiver explained Tri-City Medical Center interacts with various clinical trial sites and those sites have physician investigators who have privileges here at Tri-City. She explained the types of active Clinical Trials at Tri-City include drug, device, biological, radiation, nutritional supplement and humanitarian device exemption. Ms. Stuiver stated currently TCMC has 29 active studies in the areas of flu, abscess/skin infections, C-diff, stroke, vascular occlusions, several types of cancers including lung, prostate, breast and leukemia, Diabetes, Hepatitis C and Robotic Spine Surgery. With regard to safety statistics, Ms. Stuiver stated Tri-City has had no reportable adverse or serious adverse events in the last two years. Ms. Stuiver explained as Clinical Research Director, she is responsible for managing research exempted studies that are exempted from federal oversight, assists staff in research study design and statistical significance, tracks all study abstracts and manuscripts being released from TCMC, composes manuscripts for publication as well as grant proposals and is the co-facilitator of the Comprehensive Unit-Based Safety Program.

Director Reno suggested Ms. Stuiver approach the *Modern Healthcare* magazine regarding publishing her manuscripts.

Directors asked questions that were answered by Ms. Stuiver, Ms. Schultz and Mr. Fatch.

Ms. Stuiver confirmed that any patient participating in a clinical study is required to sign a confidentiality agreement and acknowledge participation in the study. She noted the drug for the study is paid for by the sponsor and in certain instances patients may get reimbursed for travel and/or receives an honorarium.

13. Report from Chief Executive Officer

Mr. Tim Moran, CEO provided a brief report capturing his first 30 days with Tri-City Medical Center. Mr. Moran stated during the past month he has meet with approximately 50 physicians on a one to one basis, as well as groups of specialists and the team that operates the Emergency Department. In addition, he has outreached with civic and community leaders in Vista, Oceanside and Carlsbad and was appointed to the Board of the Hospital Association of San Diego & Imperial Counties to represent the District on legislative matters and matters of interest to our region.

Mr. Moran stated he is particularly encouraged with the work being done in the Institutes of Clinical Effectiveness that is intended to organize, assess, collect and

use data so we can make better decisions and be proactive about decisions we make on behalf of our patients.

No action taken.

14. Report from Chief Financial Officer

Mr. Steve Dietlin, Chief Financial Officer reported June 30th is the fiscal year end at which time the books are held open a bit longer to capture all adjustments that are necessary. Mr. Dietlin stated we are preparing for our yearly independent financial statement audit and therefore his report will be briefer this month and will cover some statistics for year-end as well as comparative figures to the prior year. He noted he will also present a few preliminary pre-audit summary results. He explained the auditors will be on site for approximately 3-4 weeks and a final audit report in expected in September.

Mr. Dietlin reported the following key indicators for the current year:

Average Daily Census: 193
Adjusted Patient Days: 111,838
Surgery IP Cases: 3,756
Surgery OP Cases: 2,756
ED Visits: 69,357

Mr. Dietlin reported the planned delay by the State in MediCal payments for the last two weeks of the year resulted in an impact of $1.2 million. With regard to Accounts Receivables, there was an increase in Net Patient Accounts Receivable, however a decrease in days in Net Accounts Receivable. Mr. Dietlin stated we are in a pretty good place at year end for days in Net A/R at 48.3.

Mr. Dietlin reported TCHD Pre-Audit Fiscal '14 vs. Fiscal '13 reflects an EROE Improvement >$15M and Liquidity Improvement > $30M. Mr. Dietlin explained an improvement in the bottom line will drive liquidity.

No action taken.

15. New Business

a. Introduction of Dr. Erman Wei, Internal Medicine Physician into North County Internal Medicine Group.

Mr. Wayne Knight, SVP for Medical Services stated he works with an incredible team in Business Development and physician recruitment and the Board has been very instrumental in approving the new recruits. Mr. Knight stated he is here today to introduce two physicians that the Board previously approved recruitment agreements with including Dr. Erman Wei, Internal Medicine Physician and Dr. Karim El-Sherief., Invasive Cardiologist.

Mr. Knight introduced Dr. Erman Wei who will be working closely with Dr. Todd Wine at North County Internal Medicine.

Dr. Wine spoke briefly and expressed his appreciation for the opportunity to bring Dr. Wei into their practice.

Dr. Wei stated she comes to Tri-City from Connecticut and is very excited to begin her new career at Tri-City Medical Center and appreciates the opportunity.

No action was taken.

b. Introduction of Karim El Sherief, M.D., Invasive Cardiologist

Mr. Knight introduced Dr. El-Sherief, an Invasive Cardiologist who will be practicing with Drs. Sarkaria and Paveglio. Mr. Knight provided background information on Dr. El-Sherief noting he did his undergraduate and medical school training at UCLA and Internal Medicine Residency training at USC.

Dr. El-Sherief expressed his appreciation to Mr. Jeremy Raimo, Senior Director of Business Development and Rehab and Ms. Miava Sullivan, Business Development Coordinator for their assistance in the recruitment process. Dr. El-Sherief also expressed his appreciation to Drs. Paveglio and Sarkaria for bringing him into their practice. He stated it is an honor to be able to continue their legacy and hopes to do that justice. Dr. El Sherief stated it is truly a blessing to call Tri-City his home and thanked the Board for the introduction.

No action was taken.

Chairman Schallock thanked Mr. Wayne Knight and his staff for recruiting these fine physicians and helping meet the community needs.

c. Approval of use of legal counsel for the Institutes and ACO – Jones Day/Scott Edelstein

It was moved by Director Finnila that the TCHD Board of Directors approve the representation agreement with Jones Day at a rate of $655/hour for Scott Edelstein and $350-$450/hr for associates. Director Nygaard seconded the motion.

Mr. Matt Mushet, in house legal counsel explained that Mr. Scott Edelstein who has worked with the District in the past with regard to the Institutes and the ACO has joined the firm of Jones Day. Mr. Mushet stated the District would like to continue to utilize the services of Mr. Edelstein with the new firm due to his expertise in this area, however Board approval is required to do so. Mr. Mushet confirmed Mr. Edelstein's fee of $655/hour is not an increase from his fee previously charged.

Mr. Casey Fatch reminded the Board that the costs associated with the start up of the ACO will come back to the hospital in the form of shared savings. Mr. Fatch confirmed the ACO is a new area of law that requires specialized services and he is in support of maintaining Mr. Edelstein's services.

The vote on the motion was as follows:

AYES: Directors: Campo, Dagostino, Finnila, Nygaard, Reno and Schallock

NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

d. Approval of Fee Agreement with Saucedo Chavez, P.C. for matters associated with providing federal, state and regulatory healthcare advice and drafting and reviewing documents.

It was moved by Director Campo that the TCHD Board of Directors approve the representation agreement with Saucedo Chavez at a rate of $300/hr for partners and $200/hr for associates. Director Nygaard seconded the motion.

Mr. Mushet stated Mr. Ryan Harrigan also worked with the District in the past and provided specialized advice with regard to CMS, Medicare and administrative healthcare law. Mr. Harrigan has joined the firm of Saucedo Chavez and the District would like to continue to utilize Mr. Harrigan's services. Mr. Mushet noted Mr. Harrigan's fee of $300/hour is a decrease in his rate previously charged.

Director Reno expressed concern with the amount of money spent on legal fees. Chairman Schallock clarified the two attorneys described today were previously with firms the District has used in the past and Mr. Mushet is simply requesting approval to continue their service under a different firm name.

The vote on the motion was as follows:

AYES:	**Directors:**	**Campo, Dagostino, Finnila, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

16. Old Business - None

17. Chief of Staff

a. Consideration of July 2014 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on July 28, 2014.

It was moved by Director Reno to approve the July 2014 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on July 28, 2014. Director Dagostino seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Campo, Dagostino, Finnila, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

18. Consent Calendar

It was moved by Director Dagostino to approve the Consent Calendar. Director Nygaard seconded the motion.

It was moved by Director Nygaard to pull items 18 (4) C. Community Healthcare & Alliance Committee minutes for discussion only and 18 (7) a) Healthcare Compliance Association Subscription.

It was moved by Director Reno to pull items 18 (4) D. a. Approval of the renewal of the Gastroenterology ED On Call Agreement for a term of 23 months commencing August 1, 2014 through June 30, 2016 with an increase to Gastro-General from $500 to $700 per 24-hour shift and the addition of separate Gastro-ERCP call at the rate of $500 per 24 hour shift, together not to exceed $400,800 for the eleven (11) months of 8/1/14 through 6/30/15 and not to exceed $438,000 and 18 (4) D. b. Approval of the renewal of the General Surgery Ed On Call Agreement for a term of 23 months beginning August 1, 2014 through June 30, 2016 at the increased rate from $1,000 to $1,400 per 24 hour shift and reimbursement at Medicare rates for unfunded cholecystectomy cases at $725.00, for a total not to exceed an amount of $1,030,016.

Director Campo stated for the record he would be abstaining from the Minutes of June 26, 2014.

Chairman Schallock requested agenda item 18 (4) E. B. 5. Hospital Records Retention - #237 be pulled from the agenda for review and consistently with the Board policy related to Records Retention.

Director Campo seconded the motions to pull the above mentioned items.

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

AYES:	**Directors:**	**Campo, Dagostino, Finnila, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

19. Discussion of items pulled from Consent Agenda.

Director Nygaard, who pulled item 18(4) C. Community Healthcare & Alliance Committee (CHAC) minutes stated there was discussion at the meeting regarding moving forward with a subcommittee to look at the mental health issues of our youth. Director Nygaard invited Ms. Gigi Gleason, CHAC committee member to the podium to provide an overview of the committee's mission.

Ms. Gigi Gleason stated one of the components of the CHAC charter is to address concerns of the healthcare needs of the community. She stated a priority of both the Board and CHAC is the mental health of our youth. She explained the subcommittee will begin by pulling together information from other organizations and agencies that deal with our youth on a regular basis. They will do a swat analysis to look at

strengths, weaknesses, opportunities and threats in the community. Ms. Gleason stated the subcommittee has requested a room to hold these meetings along with light refreshments. Chairman Schallock stated those arrangements have been made for the subcommittee.

Director Reno who pulled item 18 (4) D. a. Approval of the renewal of the Gastroenterology ED On Call Agreement for a term of 23 months commencing August 1, 2014 through June 30, 2016 with an increase to Gastro-General from $500 to $700 per 24-hour shift and the addition of separate Gastro-ERCP call at the rate of $500 per 24 hour shift, together not to exceed $400,800 for the eleven (11) months of 8/1/14 through 6/30/15 and not to exceed $438,000 stated she cannot accept a contract with the word "various" and requested the contracts include the names of physicians. Director Campo explained a list of physician names was provided at the dais and he suggested staff be directed to prepare separate contracts reflecting the name of the physician for each contract. Director Reno stated she is in support of the increase and does not want to delay approval but requests that the contracts be brought back to the August meeting reflecting that the physician names have been incorporated into the contracts.

It was moved by Director Finnila to approve item 18 (4) D. a. Approval of the renewal of the Gastroenterology ED On Call Agreement for a term of 23 months commencing August 1, 2014 through June 30, 2016 with an increase to Gastro-General from $500 to $700 per 24-hour shift and the addition of separate Gastro-ERCP call at the rate of $500 per 24 hour shift, together not to exceed $400,800 for the eleven (11) months of 8/1/14 through 6/30/15 and not to exceed $438,000 Director Dagostino seconded the motion.

Chairman Schallock recognized Mr. Frank Gould, Vista Resident. Mr. Gould stated he agreed there is a necessity to incorporate the appropriate physician name into the contract. Mr. Gould noted the contract reflects a 40% increase.

The vote on the motion was as follows:

AYES:	**Directors:**	**Campo, Dagostino, Finnila, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

It was moved by Director Campo to approve item 18 (4) D. b. Approval of the renewal of the General Surgery Ed On Call Agreement for a term of 23 months beginning August 1, 2014 through June 30, 2016 at the increased rate from $1,000 to $1,400 per 24 hour shift and reimbursement at Medicare rates for unfunded cholecystectomy cases at $725.00, for a total not to exceed an amount of $1,030,016. Director Dagostino seconded the motion.

Director Reno who pulled agenda item 18(4) D. b. echoed the same comments and concerns as agenda item 18(4) D. a.

The vote on the motion was as follows:

AYES:	**Directors:**	**Campo, Dagostino, Finnila, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

Director Reno requested clarification with regard to the rate difference for unfunded cholecystectomy patients. Mr. Fatch explained we agreed to compensate the physicians for unfunded patients that require gallbladder surgery at the Medicare rate. Mr. Fatch further stated General Surgery did a pilot study with us that reflected when the surgeons took over the admission of these patients it greatly reduced the length of stay across the board which demonstrates a better outcome for the patient and a savings to the hospital.

Director Reno suggested the Board Dashboard be included on the Board's Work Plan. Mr. Fatch stated the Dashboard would be included in all future Regular Board agenda packets.

Chairman Schallock noted agenda item 18(4) E. 1. B. 5. Hospital Records Retention - #237 was pulled from the agenda for further review.

Director Nygaard who pulled item 18(7) a) Healthcare Compliance Association Subscription stated she does not wish to have the subscription renewed.

20. Reports (Discussion by exception only)

21. Legislative Update

There was no legislative update.

22. Comments by members of the Public

Chairman Shallock recognized Mr. Frank Gould, Vista resident who expressed concern with legal fee expenditures. Mr. Gould also spoke regarding former CEO Larry Anderson's unemployment hearing.

Chairman Schallock recognized Ms. Jane Mitchell. Ms. Mitchell spoke regarding hospital contracts, legal expenses and the demolition of the bank building.

Chairman Schallock recognized Mr. Lou Montulli. Mr. Montulli spoke regarding the background and qualifications of current Board members and individuals who plan to run in the November election.

Chairman Schallock recognized Mr. Michael Slavinski, Vista Resident. Mr. Slavinski read a letter addressed to Ms. Sharon Schultz expressing his appreciation for her efforts in the Patient Partnership Counsel. Mr. Slavinski also expressed his appreciation to Ms. Ingrid Stuiver, Director of Clinical Research for her work and enthusiasm with Clinical Research. Lastly, Mr. Slavinski thanked the entire staff for working towards goals that will benefit our community as a whole.

23. Board Communications

Director Campo commented on the wonderful event at the Oceanside Art Museum fundraiser Saturday evening. He extended a special thank you to Mr. David Bennett for rescuing an item of clothing that was put on the auction block. He noted a little extra money was made for a very worthy cause.

Director Dagostino stated he looks forward to the reception on August 7th with community leaders to welcome our new CEO.

Director Finnila reported there is an opening on the Audit, Compliance & Ethics Committee. Interested applicants should submit their papers to Ms. Donnellan, Clerk of the Board.

Director Finnila also commented on the increase in Melanoma and encouraged everyone to be diligent in applying sunscreen.

Director Reno stated tomorrow the hospital will recognize Mr. Michael Henchman, a long term employee. She noted Mr. Henchman has been a true example of service excellence and will be missed. Director Reno wished Mr. Henchman well in his future endeavors.

Director Reno also commented on a recent study in the *American Economics Journal* which revealed when it comes to the cost and quality of hospital care, nurse tenure and teamwork matters. This study, the largest of its kind linked nurse staffing to patient outcomes. Director Reno encouraged management to think about this when making staffing changes and decisions.

Director Nygaard did not have any comments.

24. Chairman Schallock

Chairman Schallock echoed Director Reno's comments regarding Mr. Mike Henchman who was an outstanding employee for 33 years.

Chairman Schallock commented on the fact that Mr. Jeremy McGhee was unable to participate in the Molokai2Oahu Paddleboard Lager due to an infection that caused him to be hospitalized for a week. Chairman Schallock stated Jeremy hopes to come back and do the paddle at a future time.

25. Additional Comments by Chief Executive Officer

Mr. Moran had no additional comments.

26. Oral Announcement of Items to be Discussion in Closed Session

Chairman Schallock reported the Board would be returning to Closed Session to complete unfinished closed session business.

27. Motion to return to Closed Session.

It was moved by Director Finnila and seconded by Director Nygaard to return to closed session. The motion passed (6-0-1) with Director Kellett absent.

Chairman Schallock adjourned the meeting to closed session at 5:12 p.m.

28. Open Session

At 6:08 p.m. Chairman Schallock reported the Board was back in open session. All Board members were present with the exception of Director Kellett.

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

Chairperson Schallock reported no action had been taken in closed session.

30. There being no further business Chairman Shallock adjourned the meeting at 6:08 p.m.

_____
Larry Schallock, Chairman

ATTEST:

_____
Ramona Finnila
Assistant Secretary

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

August 19, 2014 – 11:00 o'clock a.m.
Assembly Room 1 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way, Oceanside, CA on August 19, 2014.

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

Director Paul Campo
Director Jim Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director RoseMarie Reno
Director Larry Schallock

Absent was Director Nygaard

Also present were:

Greg Moser, General Legal Counsel
Tim Moran, President and CEO
Casey Fatch, Chief Operating Officer
Steven Dietlin, Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Esther Beverly, Vice President of Human Resources
David Bennett, Chief Marketing Officer
Wayne Knight, SVP, Medical Services
Jami Piearson, Director of Regulatory & Compliance Services
Colleen Thompson, Director of Medical Records
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 11:00 a.m. in Assembly Room 1 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Schallock led the Pledge of Allegiance.

2. Approval of Agenda

   It was moved by Director Campo and seconded by Director Kellett to approve the agenda. The motion passed (6-0-1) with Director Nygaard absent

3. Public Comments – Announcement

   Chairman Schallock read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Oral Announcement

Chairman Schallock deferred this item to Legal Counsel. Legal Counsel made an oral announcement of the item listed on today's Agenda to be discussed during Closed Session which included one matter of Potential Litigation.

5. Motion to go into Closed Session.

It was moved by Director Kellett and seconded by Director Dagostino to go into closed session. The motion passed (6-0-1) with Director Nygaard absent.

The Board adjourned to closed session at 11:05 a.m.

7. The Board returned to open session at 12:17 p.m.

8. Report from Chairperson on any action taken in closed session.

Chairman Schallock reported no action had been taken in closed session.

9. Open Session

(a) Discussion and action related to Board Policy 14-022, Maintenance of Confidentiality by Directors and Committee Members.

Chairman Schallock announced per the District's Bylaws, as Board Chair he plans to seek Board approval to remove Dr. Montulli from the Governance Committee.

10. There being no further business, Chairman Schallock adjourned the meeting at 12:19 p.m.

_____
Larry W. Schallock
Chairman

ATTEST:

_____
Ramona Finnila
Assistant Secretary

Tri-City Medical Center
ADVANCE

Core Measures

Center for Medicare & Medicaid Services (CMS)

AMI-8a: Primary PCI Received Within 90 Minutes of Hospital Arrival — California (Oct. 2012 - Sep 2013): 95%

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY14	88%	100%	100%	100%	100%	88%	86%	100%	100%	100%	100%		95%
FY13	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

HF-1: Discharge Instructions — California (Oct. 2012 - Sep 2013): 94%

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY14	100%	100%	100%	100%	100%	100%	N/A						100%
FY13	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

PN-3b: Blood Culture Performed in the ED Prior to Initial Antibiotic Received in Hospital — California (Oct. 2012 - Sep 2013): 98%

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY14	89%	100%	94%	94%	85%	87%	N/A						91%
FY13	100%	100%	100%	100%	73%	85%	100%	92%	100%	100%	100%	100%	96%

SCIP-Inf-1: Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision — California (Oct. 2012 - Sep 2013): 99%

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY14	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%
FY13	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Performance compared to prior year: Better | Same | Worse

21(a)

SCIP-Inf-2: Prophylactic Antibiotic Selection for Surgical Patients — California (Oct. 2012 - Sep 2013): 99%

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY14	96%	100%	100%	100%	96%	100%	100%	100%	100%	100%	97%		99%
FY13	100%	100%	100%	96%	98%	100%	100%	100%	100%	100%	100%	100%	99%

SCIP-Inf-3: Prophylactic Antibiotics Discontinued Within 24 Hrs After Surgery End Time — California (Oct. 2012 - Sep 2013): 98%

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY14	95%	100%	100%	100%	100%	96%	100%	94%	100%	100%	96%		98%
FY13	97%	95%	100%	95%	100%	100%	100%	100%	100%	100%	100%	96%	99%

SCIP-Inf-4: Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Blood Glucose — California (Oct. 2012 - Sep 2013): 96%

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY14	100%	100%	100%	92%	88%	86%	75%	100%	83%	100%	88%		92%
FY13	90%	33%	80%	100%	92%	92%	83%	100%	100%	100%	100%	88%	91%

SCIP-Inf-9: Urinary Catheter Removed on POD 1 (Post-Op Day) or POD 2 — California (Oct. 2012 - Sep 2013): 97%

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY14	100%	100%	95%	95%	95%	92%	88%	93%	100%	96%	92%		95%
FY13	92%	100%	94%	94%	100%	96%	94%	100%	95%	96%	100%	100%	97%

SCIP-Card-2: Surgery Patients on Beta Blocker Therapy Prior to Arrival — California (Oct. 2012 - Sep 2013): 97%

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY14	100%	100%	100%	100%	89%	100%	100%	82%	100%	100%	100%		97%
FY13	100%	100%	100%	100%	100%	100%	100%	92%	100%	96%	100%	100%	99%

SCIP-VTE-2: Surgery Patients Who Received Appropriate VTE Prophylaxis after Surgery — California (Oct. 2012 - Sep 2013): 98%

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY14	100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%		100%
FY13	96%	100%	92%	96%	97%	96%	92%	96%	93%	86%	96%	100%	95%

Performance compared to prior year: Better Same Worse

Emergency Department (ED)

Left without Treatment (LWOT)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY14	2.6%	3.3%	3.3%	3.0%	2.7%	3.6%	4.8%	2.4%	4.0%	3.8%	5.8%	3.5%	3.6%
FY13	4.5%	5.7%	5.6%	3.2%	4.5%	3.2%	5.1%	4.6%	3.7%	2.0%	3.3%	3.0%	4.1%

Transfers out of the ED

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY14	2.68%	2.75%	2.58%	2.09%	2.44%	2.93%	2.61%	2.53%	2.15%	2.57%	2.16%	2.48%	2.49%
FY13	2.65%	2.62%	2.19%	2.64%	2.96%	2.61%	2.72%	2.89%	2.50%	2.99%	2.32%	2.53%	2.63%

Door to Bed Assignment - Median Time in min.

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY14	16	17	21	18	18	20	31	24	26	26	36	22	22
FY13	42	48	50	31	33	33	38	26	19	18	19	19	30

Performance compared to prior year: Better Same Worse

Tri-City Medical Center
ADVANCE

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	46.3												
FY14	49.0	48.7	48.0	49.9	51.3	52.5	53.2	50.3	48.2	48.1	49.1	pending audit	49.9

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg
FY15	78.1												
FY14	78.0	87.4	90.8	90.5	91.5	89.8	82.8	73.4	87.4	83.1	81.1	pending audit	85.1

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	$ 368												
FY14	$ (569)	$ (571)	$ 714	$ 97	$ 3,921	$ 107	$ (269)	$ (380)	$ (554)	$ 614	$ (451)	pending audit	$ 2,659

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	1.33%												
FY14	-2.16%	-2.17%	2.73%	0.36%	15.31%	0.40%	-0.96%	-1.42%	-2.16%	2.20%	-1.64%	pending audit	0.90%

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	$ 1,761												
FY14	$ 1,059	$ 916	$ 2,148	$ 1,635	$ 5,403	$ 1,610	$ 1,431	$ 1,087	$ 969	$ 2,132	$ 937	pending audit	$ 19,327

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	6.38%												
FY14	4.02%	3.49%	8.21%	6.01%	21.10%	6.09%	5.10%	4.07%	3.78%	7.63%	3.42%	pending audit	6.58%

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg
FY15	5.93												
FY14	6.03	6.00	6.05	6.06	6.22	5.93	5.75	5.86	6.09	6.04	5.95	pending audit	6.00

TCHD Fixed Charge Coverage Covenant Calculation

	YTD Jul	YTD Aug	YTD Sep	YTD Oct	YTD Nov	YTD Dec	YTD Jan	YTD Feb	YTD Mar	YTD Apr	YTD May	YTD Jun	
FY15	1.55												
FY14	-	-	1.45	1.69	2.50	2.37	2.08	1.94	1.78	1.78	1.50	pending audit	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line, in Excess of Covenant Requirement)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY15	$ 27.7												
FY14	$ 17.7	$ 21.6	$ 20.2	$ 19.3	$ 27.1	$ 27.3	$ 22.0	$ 21.9	$ 23.6	$ 24.5	$ 30.7	pending audit	

Tri-City Medical Center
ADVANCE

Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	34												34
FY14	28	27	28	32	38	25	25	40	31	34	34	41	383

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	14												14
FY14	14	7	13	17	16	16	12	18	19	19	16	14	181

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	6												6
FY14	5	8	8	9	9	13	9	7	9	8	7	11	103

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	10												10
FY14	14	10	15	4	16	16	10	10	12	7	14	9	137

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	45												45
FY14	20	41	27	35	44	32	50	33	29	38	35	35	419

Performance compared to prior year: Better Same Worse

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	23.3												23.3
FY14	19.3	21.7	22.0	17.6	19.8	19.9	18.1	22.4	24.3	21.3	21.9	24.9	21.1

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	5.2												5.2
FY14	4.7	4.8	4.0	3.5	4.6	3.8	3.7	6.1	5.7	4.0	4.2	5.0	4.5

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	13.2												13.2
FY14	12.4	13.5	16.7	19.3	16.0	16.8	17.2	18.6	10.1	11.0	12.1	14.0	14.8

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	190.8												190.8
FY14	181.9	179.2	184.2	197.9	188.6	196.4	202.2	210.9	187.7	193.1	198.1	199.0	193.1

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	246												246
FY14	226	223	237	229	224	220	229	188	177	208	218	197	2576

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	16												16
FY14	22	15	18	18	15	18	27	11	20	14	12	16	206

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	4												4
FY14	7	10	8	12	13	5	12	7	13	8	9	2	106

Performance compared to prior year: Better | Same | Worse

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	10												10
FY14	6	9	12	11	9	6	10	15	10	7	12	16	123

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	1.64												1.64
FY14	1.65	1.69	1.63	1.53	1.57	1.56	1.58	1.49	1.60	1.58	1.59	1.58	1.59

Performance compared to prior year: Better Same Worse

Foundation

Funds Raised

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	$ 7,507												$ 7,507
FY14	$ 18,153	$ 8,490	$ 20,751	$ 243,582	$ 199,040	$ 141,909	$ 20,016	$ 12,697	$ 50,627	$ 45,735	$ 120,625	$ 52,731	$ 934,357

Endowment Portfolio Value*

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	$ 775,459												$ 775,459
FY14	$ 717,484	$ 704,609	$ 733,341	$ 751,741	$ 764,377	$ 776,902	$ 758,698	$ 788,703	$ 786,194	$ 763,512	$ 777,913	$ 791,841	$ 791,841

*fully restricted and subject to market fluctuations

Performance compared to prior year: Better | Same | Worse

Covered California / Healthcare Reform

Number of Covered California Patients Treated

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	173												173
FY14				N/A			60	66	54	78	114	171	543

Covered California Patient Charges

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	$ 2,232,644												$ 2,232,644
FY14				N/A			$ 421,882	$ 1,278,266	$ 852,155	$ 1,442,508	$ 1,397,561	$ 2,295,174	$ 7,687,546

Covered California Expected Net Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	$ 647,467												$ 647,467
FY14				N/A			$ 77,204	$ 233,923	$ 155,944	$ 263,979	$ 313,054	$ 514,174	$ 1,558,278

Performance compared to prior year: Better | Same | Worse

Tri-City Medical Center

21(c)

Building Operating Leases
Month Ending July 31, 2014

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month (a)	Lease Term Beginning	Lease Term Ending	Services & Location	Cost Center
Gary A. Colner & Kathryn Ainsworth-Colner Family Trust 4913 Colusa Dr. Oceanside, Ca 92056 V#79235	1,650	$1.85	(a)	$ 4,052.95	8/1/12	7/31/15	**Dr Dhruvil Gandhi** 2095 West Vista Way,Ste.106 Vista, Ca 92083	8460
Tri-City Wellness, LLC 6250 El Camino Real Carlsbad, CA 92009 V#80388	Approx 87000	$4.08	(a)	$225,517.00	7/1/13	6/30/28	**Wellness Center** 6250 El Camino Real Carlsbad, CA 92009	7760
GCO 3621 Vista Way Oceanside, CA 92056 #V81473	1,583	$1.50	(a)	$ 3,398.15	1/1/13	12/31/14	**Performance Improvement** 3927 Waring Road, Ste.D Oceanside, Ca 92056	8756
Golden Eagle Mgmt 2775 Via De La Valle, Ste 200 Del Mar, CA 92014 V#81553	4,307	$0.95		$ 5,566.11	5/1/13	4/30/18	**Nifty After Fifty** 3861 Mission Ave, Ste B25 Oceanside, CA 92054	9550
Investors Property Mgmt. Group c/o Levitt Family Trust 2181 El Camino Real, Ste. 206 Oceanside, Ca 92054 V#81028	5,214	$1.65	(a)	$ 8,861.09	9/1/12	8/31/17	**OP Physical Therapy, OP OT & OP Speech Therapy** 2124 E. El Camino Real, Ste.100 Oceanside, Ca 92054	7772 - 76% 7792 - 12% 7782 - 12%
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	7,247	$1.22	(a)	$ 9,379.78	7/1/11	7/1/16	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083	7320
Medical Acquisition Co., Inc. 2772 Gateway Rd. C[illegible]ad, Ca 92009 V[illegible]90	3,527	$2.00	(a)	$ 7,054.00	4/1/11	3/30/15	**Human Resources Office** 1211 West Vista Way Vista, Ca 92083	8650
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 V#81250	4,760	$3.55	(a)	$ 22,377.00	10/1/12	10/1/22	**Chemotherapy/Infusion Oncology Office** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
Ridgeway/Bradford CA LP DBA: Vista Town Center PO Box 19068 irvine, CA 92663 V#81503	3,307	$1.10	(c)	$ 5,151.83	10/28/13	3/3/18	**Nifty after Fifty** 510 Hacienda Drive Suite 108-A Vista, CA 92081	9550
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	6,123	$1.37	(b)	$ 8,254.74	12/19/11	12/18/16	**Vacant Medical Office Building** 4120 Waring Rd Oceanside, Ca 92056	8462 Until operational
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	4,295	$3.13	(b)	$ 13,242.19	1/1/12	12/31/16	**Vacant Bank Building** 4000 Vista Way Oceanside, Ca 92056	8462 Until operational
Total				**$ 312,854.84**				

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

(b) Rate per Square Foot is computed based on the initial base rent at inception of lease. The current rent payment is based on the related outstanding debt, therefore the rent payment declines over time.

(c) The term of this Lease, and Tenant's obligation to pay rent, shall commence October 1, 2013, which is one hundred twenty days (120) after delivery of the of the premises to Tenant and approval by the city of Tenant's intended use.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending July 31, 2014

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6185	TUITION REIM	61614	139.00	75743	CYNTHIA ZAJAC
6185	TUITION REIM	61614	139.00	77154	DEBBIE KEVINS
7010	CHA DISASTER PLAN	62714	510.00	14365	SUE KIRK
7010	CMS RESTRAINT WEBINAR	71714	199.00	77653	SUE KIRK
7290	HOMECARE USERS CONFERENCE	63014	1,183.92	29234	MARCUS GERRITS
7290	HOMECARE USERS CONFERENCE	63014	676.39	16560	MARIA CHONES
7290	HOMECARE USERS CONFERENCE	630142	674.80	42091	GERRI MCDONALD
7400	MATERNAL DATA QUALITY CONFERENCE	62714	1,033.96	80257	KIMBERLY MARQUARDT
7420	AORN PERIOP 101	53014	3,540.00	9999	MARY DIAMOND
7660	SAFETY TRAINING	62614	396.78	17700	THOMAS W. COBB
8340	ADVISORY COMMITTEE CONFERENCE	61814	115.76	5215	MARTHA ACEVEDO
8390	ASHP CONFERENCE	32814 EXP	258.93	10894	LAURA BALL
8615	SOCIAL MEDIA MARKTING CONFERENCE	62514	463.86	80986	JAMIE JOHNSON
8631	AHP CONFERENCE/ TRANING/ INTEGRATION SPECIAL EVENT REGISTRATION	71014	628.50	27266	GLEN NEWHART, NANI CHANG, DANIELLE PORTER
8650	EMPLOYERS GROUP WEBINAR	10056806	890.00	26254	MARILYN HATCH, CARMELA FORD
8661	HASC WELLNESS CONFERENCE	21214	874.90	14289	JILL R. BYRD
8740	TUITION REIM	63014	2,500.00	77715	JESSICA MARTIN
8740	TUITION REIM	62614	924.67	81615	BEKEZALA PILCH
8740	TUITION REIM	62414	200.00	78832	HEATHER GALLO
8740	TUITION REIM	62414	200.00	81008	LONNA CRUMP
8740	TUITION REIM	62414	140.00	77983	JULIE MATTISON
8740	CEU CERTIFICATION	60914	114.00	82111	JENNIFER YONKER
8750	CORPORATE LABOR SEMINAR	70214	1,613.98	81334	DANIEL KANTER
8750	HCCA CONFERENCE	32114	304.05	79749	RUTH GOSSARD
8750	SOLVING YOUR NURSING WEBINAR	70114	199.00	81004	MATTHEW MUSHET
8750	DEALING WITH DIFFICULT PEOPLE SEMINAR	63014	172.11	80645	CAROL A. SMYTH

**This report shows reimbursements to employees and Board members in the Education & Travel expense category in excess of $100.00.

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