TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
June 25, 2015 – 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 (Authority: Government Code Section 54957.7)		
5	Motion to go into Closed Session		
6	Closed Session	**2 Hours**	
	a. Conference with Labor Negotiators (Authority: Government Code Section 54957.6) Agency Negotiator: Tim Moran Employee organization: SEIU		
	b. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: October 31, 2015		
	c. Conference with Legal Counsel – Potential Litigation (Authority Government Code Section 54956.9(d) (1 Matter)		
	d. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	e. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: October 31, 2015		
	f. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: December 31, 2015		

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
	g. Conference with Legal Counsel – Existing Litigation (Authority Government Code Section 54956.9(d)1, (d)4 (1) Lockton Companies vs. TCHD Case No. 37-2015-00013956-CU-BC-NC (2) John E. Patterson vs. TCHD Case No. 37-2015-00017945-CL-MC-NC		
	h. Approval of prior Closed Session Minutes		
	i. Public Employee Evaluation Title: Chief Executive Officer (Authority: Government Code, Section 54957)		
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	Special Presentations (1) Ceremonial Presentation and Awarding of Community Healthcare Grant Awards (2) Recognition of Dr. Scott Worman, for his service as Chief of Staff July 1, 2013-June 30, 2015 (3) Certificates of Appreciation to the following community members for their service on the Audit, Compliance & Ethics Committee, Community Healthcare & Alliance Committee, Finance, Operations & Planning Committee, and Human Resources Committee a) Sydelle Gale – Human Resource Committee b) Henry Halloway – Human Resource Committee c) Robin Iveson – Community Healthcare & Alliance Committee d) Robert Knezek – Finance, Operations & Planning Committee e) Carlo Marcuzzi – Audit, Compliance & Ethics Committee f) William McGaughey – Finance, Operations & Planning Committee	30 min. 5 min. 15 min.	Chair/Director Nygaard Chair Chair
13	Report from Chief Executive Officer	10 min.	Standard
14	Report from Chief Financial Officer	10 min.	Standard

	Agenda Item	Time Allotted	Requestor
15	New Business – a Consideration to approve Resolution No. 773, A Resolution of the Board of Directors of Tri-City Healthcare District Establishing the Appropriations Limit for TCHD for the Fiscal Year Commencing July 1, 2015 and ending June 30, 2016, in Accordance with Article XIIB of the Constitution of the State of California, Code of the State of California	5 min.	CFO
	b Consideration to close both Oceanside and Vista Nifty After Fifty programs effective July 31, 2015	5 min.	Chair
	c. Consideration to appoint Mr. Carlo Marcuzzi to a two year term on the Finance, Operations & Planning Committee	5 min.	FOP Comm.
	d. Consideration to appoint Mr. Tim Keane to a two year term on the Finance, Operations & Planning Committee	5 min.	FOP Comm.
	e. Consideration to appoint Ms. Virginia Carson to a two-year term on the Employee Fiduciary Subcommittee	5 min.	HR Comm.
16	Old Business - None		
17	Chief of Staff a. Consideration of June 2015 Credentialing Actions Involving the Medical Staff – New Appointments Only b. Medical Staff Credentials for June, 2015	5 min.	Standard
18	Consideration of Consent Calendar (1) 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 – 2 (Committee minutes included in Board Agenda packets for informational purposes) **B. Employee Fiduciary Retirement Subcommittee** Director Kellett, Subcommittee Chair Open Community Seats – 1 *No meeting held in June, 2015* **C. Community Healthcare Alliance Committee** Director Nygaard, Committee Chair Open Community Seats - 2 (Committee minutes included in Board Agenda packets for informational purposes)	5 min.	Standard HR Comm. Emp. Fid. Subcomm. CHAC Comm.

	Agenda Item	Time Allotted	Requestor
	D. Finance, Operations & Planning Committee Director Dagostino, Committee Chair Open Community Seats – 2 (Committee minutes included in Board Agenda packets for informational purposes.) 1. Approval of an agreement with UCSD Psychiatrist(s) for a term of 12 months beginning April, 2015 through March, 2016 for non-exclusive, weekend remote and on-call psychiatry services, at an hourly rate of $150 for on site; and $1,000 daily for an annual estimated cost of$91,000. 2. Approval of a Second Amendment to the Lease agreement with Dr. Oscar Matthews for an additional one-year term effective July 1, 2015 through June 30, 2016 at the same current fair market value monthly rate of $2,850.12. 3. Approval of a renewal of a Physician Agreement with Dr. John LaFata for Medical Director of Case Management Department for a term of 12 months, beginning July 1, 2015 through June 30, 2016 for an annual cost of $52,999.92 and a total cost not to exceed $52,999.92 for the term. 4. Approval of a renewal of an agreement with Dr. Scott Worman, Patient Safety Officer and Co-Chair of Patient Safety Committee, for a term of 36 months beginning July 1, 2015 through June 30, 2018, not to exceed an average of six hours per month or 72 hours annually, at an hourly rate of $175 for an annual cost of $12,600 and a total cost for the term of $37,800. 5. Approval of a renewal of an agreement with Dr. Manish Sheth, Medical Director for Inpatient BHU for a term of 12 months beginning July 1, 2015 through June 30, 2016 for an average of 80 hours per month, not to exceed 960 hours annually, at an hourly rate of $125 for an annual cost of $120,000 and total cost for the term. 6. Approval of a renewal of an agreement with Dr. Victor Souza, Medical Director for Forensic Outpatient Clinic for a term of 24 months, beginning July 1, 2015 through June 30, 2017, not to exceed an average of 15 hours per month or 180 hours annually, at an hourly rate of $163 for an annual cost of $29,340 and total cost for the term in the amount of $58,680. 7. Approval of a renewal of an agreement for ED On Call Coverage for the following physician for a term of 12 months, beginning July 1, 2015 through June 30, 2016 on the terms described in agenda write-ups: • **ENT**-Audrey Calzada, M.D. • **Cardiology, General**-Oscar Matthews, M.D.; Mohammad Pashmforoush, M.D.; Paul Sarkaria, M.D. • **Cardiology, General and STEMI**-Kenneth Carr, M.D.; David Spiegel, M.D.		FO&P Comm.

	Agenda Item	Time Allotted	Requestor
	• **Cardiothoracic Surgery**-Theodore Folkerth, M.D.; Frederick Howden, M.D.; Paul Mazur, M.D. • **ENT**-Julie Berry, M.D.; Hernan Goldsztein, M.D.; Robert Jacobs, M.D.; Marc Lebovits, M.D.; Ritvik Mehta, M.D.; Bruce Reisman, M.D.; Ashish Wadhwa, M.D. • **Interventional Radiology**-Michael Burke, M.D.; Brian Goelitz, M.D.; Justin Gooding, M.D. Michael Noud, M.D.; Donald Ponec, M.D.; Richard Saxon, M.D. • **Neurology**-Lesley Aguilar Tabora, M.D.; Andrew Blumenfeld, M.D.; Benjamin Frishberg, M.D.; Michael Lobatz, M.D.; Amy Nielsen, D.O.; Irene Oh, M.D.; Remia Paduga, M.D.; Jay Rosenberg, M.D.; Mark Sadoff, M.D.; Gregory Sahagian, M.D.; Jack Schim, M.D.; Anchi Wang, M.D.; Michael Zupancic, M.D. • **Neurosurgery**-Thomas Nowak, M.D. • **Neurosurgery and Spine**-Tyrone Hardy, M.D.; Thomas Marcisz, M.D.; Mark Stern, M.D.; Frank Kevin Yoo, M.D. • **OB/GYN**-John Bennett, M.D.; Rahele Mazarei, D.O.; Chunkai Clarkson, M.D.; Orna Gil, M.D.; Christos Karanikkis, D.O.; Sandra Lopez, M.D.; Talal Muhtaseb, M.D. • **Oral-Max. Surgery**-Brian Mudd, M.D. • **Orthopedic Surgery**-Christian Bentley, M.D.; Andrew Cooperman, M.D.; David Daugherty, M.D.; Andrew Hartman, M.D.; Harish Hosalkar, M.D.; Serge Kaska, M.D. • **Orthopedic Surgery and Spine**-David Amory, M.D.; Janet Dunlap, M.D.; Payam Moazzaz, M.D. • **Spine**-Neville Alleyne, M.D. • **Spine**-Lokesh Tantuwaya, M.D. • **Urology**-Caroline Colangelo, M.D.; Bradley Frasier, M.D.; Michael Guerena, M.D.; Arthur Warshawsky, M.D. • **Vascular**-Andrew Deemer, M.D.; Mohammad Jamshidi-Nezhad, D.O. 8. Approval of an ED On Call Agreement with the following physicians on the terms described in the agenda packet: • **Ophthalmology**-James Davies, M.D.; Bradley Greider, M.D.; Atul Jain, M.D.; Srinivas Iyengar, M.D.; Peter Krall, M.D.; Sally Mellgren, M.D.; Robert Pendleton; Mark Smith, M.D.; Christopher Spellman, M.D.; Maulik Zaveri, M.D. 9. Approval of an ED On Call Agreement with the Dr. Venugopal Dapala for a term of 13 months beginning June 16, 2015 through June 30, 2016, not to exceed a daily rate of $1,000 for a total cost for the term of $380,000. 10. Approval of a renewal of an agreement with Dr. Karim El-Sherief, Medical Director of Cardiac Rehabilitation for a term of 24 months beginning July 1, 2015 through June 30, 2017, not to exceed an average of 44 hours per month or 528 hours annually, at an hourly rate of $185.50 for an annual cost of $7,944 and a total term cost not to exceed $195,888. 11. Approval of a renewal of an agreement with Dr. Sharon Slowik, alternate Supervising Physician of the Cardiac		

	Agenda Item	Time Allotted	Requestor
	Rehabilitation program for a term of 24 months beginning July 1, 2015 through June 30, 2017, not to exceed an average of 39 hours per month or 468 hours annually, at an hourly rate of $148.30 for an annual cost of $69,404 and a total term cost not to exceed $139,809. 12. Approval of a renewal of an agreement with San Diego Diagnostic Radiology Medical Group, Inc. to provide radiological services supervision and medical directorship coverage for a term of three years beginning July 1, 2015 through June 30, 2018. 13. Approval of an agreement with Dr. Mark Sadoff, Medical Director for the Acute Rehabilitation Unit, for a term of 12 months beginning July 1, 2015 through June 03, 2016, not to exceed an average of 80 hours per month or 960 hours annually, at an hourly rate of $165 for an annual cost of $158,400 and a total cost for the term of $158,400. 14. Approval of a renewal of an agreement with Drs. Frank Corona, Martin Nielsen, Mark Yamanaka and Safouh Malhis for ICU Coverage Panel/ED Pulmonary On-Call Coverage for a term of 24 months, beginning July 1, 2015 through June 30, 2017 at a daily rate of $1,500 for an annual cost of $549,000 for FY2016 and $547,500 for FY 2017 and a total cost for term in the amount of $1,096,500. 15. Approval of a renewal of an agreement with Dr. Chris Guerin, Diabetes Program Medical Director, for a term of 12 months beginning July 1, 2015 through June 30, 2016, not to exceed an average of 16 hours per month or 192 hours annually, at an hourly rate of $150 per hour for an annual cost of $28,800, as the total for the term. 16. Approval of a renewal of an agreement with Dr. James Johnson, Medical Staff Leadership Physician/Quality Assurance/Performance Improvement Committee Chair for a term of 12 months beginning July 1, 2015 through June 30, 2016, for an average of 30 hours per month or 360 hours annually, at an hourly rate of $185 and $5,000 for educational expenses for a total cost of $71,600 for the 12 month term. 17. Approval of a renewal of an agreement with Dr. Chad Bernhardt, Physician Liaison, Disaster Management for a term of 12 months beginning July 1, 2015 through June 30, 2016, not to exceed an average of three hours per month or 36 hours annually, at an hourly rate of $150 per hour for an annual cost of $5,400 for a 12 month term. 18. Approval of a renewal of an agreement with Dr. John LaFata, Medical Director for Home Health for a term of 24 months beginning July 1, 2015 through June 30, 2017, not to exceed an average of 25 hours per month, or 300 hours annually, at an hourly rate of $169 for an annual cost of $50,700 and a total cost for the term of $101,400.		

	Agenda Item	Time Allotted	Requestor
	19. Approval of a renewal of an agreement with Dr. Marcus Contardo, Chair of the Medical Staff Professional Behavior Committee, for a term of 12 months beginning July 1, 2015 through June 30, 2016, for a monthly stipend of $5,000 per month, not to exceed a total of $60,000 per year for the term of the agreement. 20. Approval of an agreement with Dr. Gene Ma, Chief of Staff, for a term concurrent with his appointment as Chief of Staff but no longer than 24 months, beginning July 1, 2015 through June 30, 2017, for a stipend of $4,000 per month, $48,000 annually and $96,000 for 24 months, plus an educational allowance of up to $10,000 for a total not to exceed $106,000 for the term. 21. Approval of a new Hospitalist Services and On-Site Coverage Services agreement with Coastal Hospitalists Medical Associates, Inc., beginning July 1, 2015 through June 30, 2017, at a monthly rate of $148,500 per month , an annual cost of $1,782,000 and total for the term in the amount of $3,564,000. 22. Approval of a renewal of an agreement for Coverage Physician for Pulmonary Services with Dr. Frank Corona for a term of 24 months, beginning July 1, 2015 through June 30, 2017, not to exceed an average of 10 hours per month or 120 hours annually, at an hourly rate of $175 for an annual cost of $21,000 and a total cost for the term of $42,000. 23. Approval of a renewal of an agreement with Dr. Mark Yamanaka, sole Medical Director for the Intensive Care unit, for a term of 12 months beginning July1, 2015 through June 30, 2016, not to exceed an average of 10 hours per month or 120 hours annually, at an hourly rate of $175 for an annual cost of $21,000 and a total cost for the term of $21,000. 24. Approval of a renewal of an agreement with North County Internal Medicine for a cost to TCMC of a maximum of $4,000 for a term of 12 months, beginning July 1, 2015 through June 30, 2016 for an annual cost of $4,000 and a total cost for the term of $4,000. 25. Approval of the placement and financing of the commercial insurance products recommended by BB&T for the policy period commencing July 1, 2015 for an annual premium of $1,273,782. 26. Approval of a renewal of an agreement with Dr. Terry Haas, Dr. John LaFata and Dr. Jeffrey Leach, Physician Consultants to North Coast Medical ACO, Inc. for a term of 12 months, beginning July 1, 2015 through June 30, 2016 for an annual and total cost for the term of $94,500.		

	Agenda Item	Time Allotted	Requestor
	E. Professional Affairs Committee Director Dagostino, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes.) 1) **Patient Care Services Policies and Procedures:** a. HIV Testing: In an Occupational Exposure 385 b. Meals, Patients- Times, Menus, Substitutions and Nourishment Policy c. Nutritional Screening Care & Assessment for Infants, Pediatrics & Adolescents Policy d. Physician's Admission Responsibilities Policy e. Swallow Screening in the Adult Patient Procedure f. Use of Unapproved Abbreviations 367 2) **Emergency Operations Procedures Manual (formerly Disaster Manual)** **Section 1: General Information** 1. Emergency Operations Plan 2. Location of Disaster Work Stations 3. Personnel Expectations 4. Purpose and Authority 5. Scalable Event 6. Scope of Response **Section 2: Resource Management and Preparation** 1. Damage Assessment 2. Disruption of Services **Section 3: Special Circumstances** 1. Drought Conditions 2. Response to Wild Fires **Section 6: Response and Assignment of Personnel** 1. Authorization for Volunteer Caregivers 2. Medical Staff Assignments **Section 7: Patient Management** 1. Victim Tracking **Environment of Care Manual** **Section 1: Safety Management** 1. Safety Plan 1000 **Section 2: Security Management** 1. Security Management- 2000 **Section 3: Life Safety Management** 1. Life Safety Management Plan- 3000 **Section 4: Equipment Management** 1. Medical Equipment Management Plan 5000		PAC Comm.

	Agenda Item	Time Allotted	Requestor
	3) **Formulary** a. Spyrcel Formulary Evaluation **F. Governance & Legislative Committee** Director Schallock, Committee Chair Open Community Seats - 0 (Committee minutes included in Board Agenda packets for informational purposes.) **Rules & Regulations** a. Division of Pediatric **G. Audit & Compliance Committee** Director Finnila, Committee Chair Open Community Seats – 1 (Committee minutes included in Board Agenda packets for informational purposes.) 1) 8610-503 (585) – HIPAA Administrative Requirements 2) 8750-510 – Disposal of Confidential Records (Formerly Disposal of Individually Identifiable Information) 3) 8610-511 - Business Associate Agreement 4) 8610-514 – Privacy: Designated Record Set 5) 8610-518 - Notice of Privacy Practices 6) 8610-520 – Amendment to Protected Health Information 7) 8610-528 – Accounting of Disclosures of Protected Health Information 8) 8610-505 – Confidential Reporting Line (Values Line) 9) 8710-555 – Communicating and Reporting Compliance Concerns: In General 10) 8750-556 – Communicating and Reporting Compliance Concerns: Reporting of Suspected Misconduct/Potential Irregularities (2) Minutes – Approval of a) May 28, 2015 – Regular Board of Directors Meeting b) June 11, 2015 – Special Board of Directors Meeting c) June 12, 2015 – Special Board of Directors Meeting (3) Meetings and Conferences - None (4) Dues and Memberships - a) Payers and Providers Subscription $219.00		Gov. & Leg. Comm. Audit, Comp. & Ethics Comm. Standard Standard Standard
19	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
20	Reports (Discussion by exception only) (a) Dashboard - Included (b) Construction Report – None (c) Lease Report – (May, 2015) (d) Reimbursement Disclosure Report – (May, 2015) (e) Seminar/Conference Reports 1) CHA Report – Chairman Schallock	0-5 min.	Standard
21	Legislative Update	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
22	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
23	Additional Comments by Chief Executive Officer	5 min.	Standard
24	Board Communications (three minutes per Board member)	18 min.	Standard
25	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session **(Includes 10 minutes for recess to accommodate KOCT tape change)**	**3 hours**	
26	Oral Announcement of Items to be Discussed During Closed Session (If Needed)		
27	Motion to Return to Closed Session (If Needed)		
28	Open Session		
29	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
30	Adjournment		

DETAILS OF RECOMMENDATIONS

1. ****Alzheimer's Association of San Diego/Imperial County** **12,000.00**

PROJECT: ALZHEIMERS DISEASE EDUCATION AND FAMILY SERVICES

Funding for this project will create a new early intervention and support program in the TCHD called Take Charge. Through this grant, the chapter proposes to expand its reach into North County, offering targeted education, general public education and community outreach. Their programs are free for diagnosed individuals and their families and emphasize the importance of early detection and diagnosis of the disease; enhance skills and knowledge for family caregivers to increase coping skills and reduce the risk of depression, and offer access to supportive resources, resulting in improved quality of care and quality of life...

It is proposed that the Take Charge classes will take place at the Tri-City Wellness Center...

FUNDING: primarily for staffing for program itself (eliminated sponsorship and walk coordinator)

2. *** American Diabetes Association** **22000.00**

PROJECT: POR TU FAMILIA (For Your Family)

Only grant request for diabetes education which clearly addressed the lifestyle priority of the district. Their program is called Por Tu Familia and will provide diabetes awareness, prevention and management to Latino families, regardless of insurance status, all of which will address the issue to reverse the growing diabetes trends. Basic health education is needed, and many Latinos do not either seek and/or receive services they require. This information will be delivered through a series of educational modules and testing. culminating with Feria de Salud (Health Fair), a one-day diabetes focused community health fair with a festive feel. The goal is to improve participant knowledge, sustainable self-management skills and improve diabetes markers (blood pressure, cholesterol levels)

FUNDING: Primarily recommended for the two main positions as the program is a large undertaking and we wanted to give them enough to support the program but want to see how they are able to actually put it into action.

3. ***BILY San Diego** **2300.00**

PROJECT: EXPANDING AWARENESS OF THE BILY PARENT SUPPORT PROGRAM THROUGHOUT THE TRI-CITY AREA

BILY (BECAUSE I LOVE YOU) is a non-profit volunteer parent support group. BILY works closely with the Carlsbad Police Dept. and local family counselors for referrals. Police officers have BILY brochures in their patrol cars as well as at the station. BILY provides 400-500 brochures annually to the Police Dept. and counselors and would like to expand their program into the mental health networks in Vista and Oceanside. They hold parent support meetings weekly.
FUNDING: For brochures, mailing and costs of labor

4. ****Boys & Girls Clubs Carlsbad** **7500.00**

PROJECT: VILLAGE CLUBHOUSE AND AMORY TEEN CENTER

Seeking support of two of their teen programs, which are offered free of charge to all local teens. Approximately 75% of the teens at the village clubhouse have disabilities. Accommodations are made, according to the needs of the teen, to decrease over stimulation and anxiety. Emphasis is placed on enhancing the abilities they possess. Funding would increase the level of physical activities that are offered at the teen centers. (yoga, basketball, swimming and dance contests)

FUNDING primarily for staff.

5. ****Boys & Girls Clubs Oceanside** **12000.00**

PROJECT: WELLNESS WARRIORS

Year-round program designed to:

- educate youth about nutrition
- teach healthy eating habits and healthy cooking skills
- incorporate daily fitness activities into programming
- utilize technology to research health and nutrition topics
- provide 60 minutes of recommended daily physical fitness

FUNDING: primarily staffing and some supplies

6. ****Boys & Girls Clubs Vista** **7500.00**

PROJECT: FUN, SPORTS AND NUTRITION

To improve knowledge of healthy habits, increase participation in physical activities, and strengthen the ability to interact positively with others – all in association with building a strong commitment to participation in all of the academic programs offered at the club.

FUNDING will primarily cover equipment.

7. ***California State University, San Marcos Foundation** **17000.00**

PROJECT: CSUSM SCHOOL OF NURSING STUDENT HEALTHCARE PROJECT

This project is staffed by volunteer nursing faculty, volunteer providers, graduate and undergraduate nursing students. They currently run four free clinics that provide free medical care to manage acute and chronic diseases, case management, social services, mental health services, health promotion and education. The funding for this project will benefit the Oceanside clinic, in collaboration with St. Anne's Episcopal Church. They do not accept insurance and most patients are uninsured or under insured. They also run wellness program which included a walking group, yoga classes and health education classes. This money will directly affect patients at the Oceanside clinic by funding medications, lab work and radiological services. (eliminated fundraising and office supplies)

FUNDING will cover medical supplies, patient hygiene items, patient medications, laboratory and radiology tests and exams and office needs.

8. ***Emilio Nares Foundation** **5318.00**

PROJECT: RIDE WITH EMILIO

Ensures that low income children with cancer can easily get transportation so they have access to chemotherapy and other crucial medical appointments by providing consistent, reliable and hygienic transportation. Program started in 2005 by a family who lost their five year old son to leukemia in 2003. Estimate 68 rides to life saving treatments at Rady Children's Hospital to low income families in the healthcare district

FUNDING is entirely for fuel.

9. **Fraternity House Inc.** **14000.00**

PROJECT: PROJECT MEND (MEALS, EDUCATION, NUTRITION AND HEALTHY DIRECTION)

This project provides wrap around services to address the critical role that nutrition, exercise and activities play in overall health and well--being for those living with HIV/AIDS. They operate two facilities; one in Vista and one in Escondido. Fraternity house runs the only licensed facility of its kind in San Diego County.

FUNDING requested was mainly for a program manager to oversee both houses. We recommend that half of the amount be awarded and used to operate the home located in Vista.

10. ***Impact Young Adults (C)** **24960.00**

PROJECT: IMPACT MORE, CONNECTED (IM CONNECTED)

This is a peer led support community for young adults (ages 18-35) with serious mental illness. Purpose is to provide peer socialization, peer mentoring and leadership opportunities – to help participants re-integrate into the social world, considered a prerequisite for future success in employment and life.

This specific project will pilot a new leadership program for self-selected participants over a twelve month period. Participants will learn and practice skills needed to create new IYA chapters/groups in the area, increasing IYA participants. This evidence based approach has been researched and demonstrated that leadership training, along with networking and social support have a positive impact for those with severe mental illness.

Partnering with TCMC Outpatient Behavioral Health Services and Schizophrenics in Transition to further the goals of this project

FUNDING: It is a huge and lofty project but needed. We all felt support was indicated but the full amount was perhaps a bit risky, so propose funding the program coordinator position to show support and see what they are able to accomplish this year as it was a relatively unknown organization to all of us.

11. **KOCT Oceanside Community TV Corporation(C)** **45100.00**

PROJECT: COMMUNITY HEALTH MATTERS

This program would provide the production equipment and technical assistance expertise to videotape, edit, air and distribute 18 new thirty minute Community Health Matters program videos, six each to be produced in collaboration with North County Health Services and Vista Community Clinic and by Tri-City Medical Center, for a total of 18 videos. Each of the three partner organizations will select their own program subject matter and topics. All of the programs will address the mission of the healthcare district. FUNDING recommended in full.

12. ****New Haven Youth and Family Services** **10000.00**

PROJECT: MENTAL HEALTH CASE MANAGEMENT

Grant will support staffing for the Center 4 Community Connections. This center provides services to community youth diagnosed with severe mental illness. There will be an individualized service plan for each participating youth. The MHCW will be at the center to support youth in achieving their goals and objectives through personal coaching and direction as needed. And this person will be supervised by an on staff licensed psychologist.
This will benefit approximately 30 at risk youth in the community.

13. ***North County LBGTQ Resource Center** **13500.00**

PROJECT: AFFORDABLE MENTAL HEALTH FOR LGBT YOUTH AND THEIR FAMILIES

The goal is to enhance mental health services in order to address the high risk of suicide and substance abuse that this community sees is disproportionate amounts. This service will be available to youth and their families. The objective is to create a reliable and permanent mental health resource for LGBT families and youth alike where TCHD residents can go and receive a mental health evaluation.

FUNDING: recommend most – not rental space or state certification fee...

14. **North County Lifeline** **19000.00**

PROJECT: MY CHILD'S STORY; STRENGTH BASED PARENTING AFTER A MENTAL HEALTH DIAGNOSIS

This is a project to educate and empower 200 TCHD parents whose children have been diagnosed with mental health disorders. Services range from early intervention to treatment for severe mental health illnesses.

FUNDING would primarily cover staff time (workshop food cost eliminated)

15. ***Operation HOPE, Vista -** **10200.00**

PROJECT: OHV CLIENT TIR THERAPY

This organization provides an emergency cold weather homeless shelter for families with children and single women. Funds are being requested for a new aspect of their program which will uniquely aid their staff in identifying a client's mental health barriers and subsequently offer the client either a more in depth mental health referral or inside certified Trauma Incident Reduction therapy.

FUNDING will cover the intake evaluations of 50 adult clients by a TIR therapist and therapy sessions.

16. ***Parkinson's Association of SD** **55705.00**

PROJECT: MINDS IN MOTION

This association plans to open a North County office in the TC Wellness Center to provide Minds in Motion with a goal of reaching 2000 people. Minds in Motion offers the following services to people with Parkinson's Disease, their families and their caregivers: referral, evidence-based education, transportation, diet, nutrition and food, exercise, support groups and counseling. Currently most services of this kind are centered in the San Diego area

FUNDING would primarily target personnel salaries and contracted services such as counseling.

17. **SD County Medical Society Foundation (C)** **63237.00**

PROJECT: NORTH COUNTY CRC COLLABORATIVE PROJECT

This project is a collaborative with TCMC, the American Cancer Society and Vista Community Clinic. The goal of this project is to reduce the colorectal cancer death rate in the TCHD region by increasing colorectal cancer diagnostic services and treatment if needed among low income, uninsured North County residents.

FUNDING will be used to provide intensive patient care management to VCC patients, support screening efforts, provide colonoscopy prep solution and provide needed patient transportation to diagnostic procedures.

18. ****Solutions for Change** **37500.00**

PROJECT: MENTAL HEALTH SERVICES FOR HOMELESS FAMILIES

Mental health services are a vital part of repairing the deep psychological and emotional damage resulting from the circumstances under which people who are homeless have lived. This includes one on one case management to get to the root of past trauma, abuse and mental health issues, as well as group sessions on parenting, anger management, 12 step programs and co-dependency.

FUNDING will cover the salary of one of seven case managers.

19. **Vista Community Clinic** **61037.00**

PROJECT: DEVELOPMENT OF AN ADVANCED MA TRAINING PROGRAM AT VCC

VCC has been certified as a Level 3 Patient Centered Medical Home (PCMH), mandating integrated, accessible, team-based healthcare. Under this model, patients are assigned to one provider who is supported by a team of RNs, Care Coordinators and Medical Assistants. Current MA training is inadequate to prepare MA's to perform their duties under the PCMH model so support is needed to supplement the MA training so they can acquire advanced clinical and IT skills along with education on chronic health conditions.

FUNDING will essentially cover the cost of a curriculum developer, salaries while others are in core training, and cover other assorted costs to implement this program.

20. **Women's Resource Center** **20143.00**

PROGRAM: MENTAL HEALTH COUNSELING FOR CHILDREN WHO WITNESS DOMESTIC VIOLENCE

This project would help sustain the children's counseling program. Children who are onlookers to domestic violence in their families show more anxiety, low self-esteem, depression, and anger and temperament problems than those who do not witness this type of violence. These children can also exhibit clinical levels of anxiety or PTSD. Without treatment they are at significant risk for delinquency, substance abuse, truancy and relationship difficulties. Because of the uncertainty of government funding, it is necessary to reach out for other funding. This program is centered at the WRC transitional housing.

FUNDING will cover the cost of a children's counselor for 24 weeks.

21. **Wounded Warrior Homes** **15000.00**

PROJECT: TRANSITIONAL HOUSING

This organization serves the medically discharged single veterans diagnosed with TBI (Traumatic Brain Injury) and/or PTS. Because of the lack of resources for sustenance and accessibility to treatment venues, they are potential victims of homelessness. Many require ongoing rehabilitation and retraining to return to civilian independent living as a veteran of foreign wars. Wounded Warrior Homes provides subsidized housing and support to aid in mutually agreeable and obtainable goals.

FUNDING subsidizes a mortgage payment for one year.

*New organization recommended for funding

**Funded last year

RESOLUTION NO. 773

A RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT ESTABLISHING THE APPROPRIATIONS LIMIT FOR TRI-CITY HEALTHCARE DISTRICT FOR THE FISCAL YEAR COMMENCING JULY 1, 2015 AND ENDING JUNE 30, 2016 IN ACCORDANCE WITH ARTICLE XIII B OF THE CONSTITUTION OF THE STATE OF CALIFORNIA; CODE OF THE STATE OF CALIFORNIA

WHEREAS, Section 1 of Article XIII B of the Constitution of the State of California provides that the total annual appropriations of each local government shall not exceed the appropriations limit of such entity of government for the prior year, adjusted for changes in the cost of living and population, subject to certain specified exceptions in said Article; and

WHEREAS, Section 8 of Article XIII B of the Constitution of the State of California defines "Appropriations subject to limitation" of an entity of local government as "any authorization to expand during a fiscal year the proceeds of taxes levied by or for that entity and the proceeds of state subventions to that entity" (other than subventions made pursuant to new programs or services mandates by the State Legislature) "exclusive of refunds to taxes"; and

WHEREAS, Section 7910 of the Government Code of the State of California provides that each year the governing body of each local jurisdiction shall, by resolution, establish its appropriations limit for the following fiscal year pursuant to Article XIII B of the Constitution of the State of California at a regularly scheduled meeting or noticed special meeting; and

WHEREAS, the documentation used in determining the appropriations limit adopted in this resolution has been available to the public for fifteen (15) days prior to the adoption of this resolution.

NOW, THEREFORE, THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT DOES HEREBY RESOLVE AND ORDER AS FOLLOWS:

1. The appropriations limit for TRI-CITY HEALTHCARE DISTRICT, pursuant to Article XIII B of the Constitution of the State of California for the fiscal year commencing July 1, 2015 and ending June 30, 2016 is, not to exceed, $12,507,599.

2. In accordance with Section 2, Article XIII B of the Constitution of the State of California, any revenues received by TRI-CITY HEALTHCARE DISTRICT in excess of that amount, which is appropriated in compliance with Article XIII B of the Constitution of the State of California, during the fiscal year shall be returned by a revision of tax rates or fee schedules within the next two subsequent fiscal years.

ADOPTED, SIGNED AND APPROVED this 25th day of June, 2015.

Larry W. Schallock, Chairperson of
TRI-CITY HEALTHCARE DISTRICT and
of the Board of Directors thereof

ATTEST:

Ramona, Secretary
of the TRI-CITY HEALTHCARE DISTRICT
and of the Board of Directors thereof

STATE OF CALIFORNIA)
)
COUNTY OF SAN DIEGO) **ss.**

I, Ramona Finnila, Secretary of TRI-CITY HEALTHCARE DISTRICT and of the Board of Directors thereof, do hereby certify that the foregoing Resolution was duly adopted by the Board of Directors of said District at a Regular Meeting of said Board held on the 25th day of June, 2054, and that it was adopted by the following vote:

AYES:	DIRECTORS:	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	DIRECTORS:	
ABSTAIN:	DIRECTORS:	
ABSENT:	DIRECTORS:	

Ramona Finnila, Secretary
of the TRI-CITY HEALTHCARE DISTRICT
and of the Board of Directors thereof

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PROPOSAL FOR: Closure of Nifty After Fifty

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

Vendor Name: Nifty After Fifty – Vista and Oceanside locations

Area of Service: Marketing

Term of Agreement: Not Applicable

Maximum Totals Not Applicable

Description of Services/Supplies:

- TCMC assisted Nifty After Fifty in marketing the concept to increase membership. The extensive marketing programs have not been productive in increasing membership due primarily to a lack of physician referrals.
- There are currently less than 200 active members, at both locations.
- TCMC is losing approximately $50,000 per month for both locations combined.

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

Person responsible for oversight of agreement: David Bennett, CMO

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the closure of both Nifty After Fifty locations, effective July 31, 2015.

Carlo Marcuzzi CPA
5159 Via Castilla
Oceanside, California
619-987-8565
carlcpa@ cox.net

A versatile CPA with 20+ years experience providing tax, accounting, financial and audit services to individual, corporate and government clients.

Experience

2011- Present	Carlo Marcuzzi CPA, Oceanside and San Diego California Perform audits of financial statements for corporate clients; tax planning and preparation for individuals, corporations, estates and trusts. Conduct financial statement analysis and provide general financial advice and retirement planning for various clients. Conduct audits of water districts in Southern and Central California.
2007 – 2011	Senior Staff CPA Imbimbo and Associates, CPAs, San Diego California Same as above
2003 – 2007	Senior Staff CPA Griffiths and Associates, CPAs, Vista California Establish corporations, provide tax planning and preparation to various corporate and individual clients.

Prior Experience
Staff CPA, Ernst and Young, New York, New York

Education
Juris Doctor, Western Sierra School of Law

Bachelor of Arts, Accounting
Rutgers University, New Brunswick New Jersey

Community Involvement
2011 – 2015 Community Member, Audit and Compliance Committee, Tri-City Healthcare District

Tim Keane

4812 Baroque Terrace, Oceanside, CA 92057
Telephone: 760-717-3341
Email: tkoside@gmail.com

Professional Profile

Technically sophisticated, performance driven, and an accomplished Senior Vice President of IT Services combining an outstanding academic background with 18 years' invaluable experience within the IT sector in Accounting and System/Network Development with 11 of those years in Executive Leadership. Quick to familiarize with the latest technologies and industry developments while demonstrating a logical and analytical approach to solving complex problems and issues. Passionate about giving 100% and more, possesses a very methodical mind, excellent communication and negotiation skills and the ability to develop and maintain positive internal and external relationships. Enjoys being part of a successful and productive team and thrives in high pressure and challenging working environments. Achieves end-to-end goals, can work on several projects concurrently, and completes each project before set deadlines and within budget constraints.

Key Skills & Experience

Management	Technology	Finance
Team Leadership	Carrier Grade Network & Security	Business Analysis
Contract Negotiation	Software Development & Integration	Reporting and Controls
Policy, Procedures, Compliance	Multi-site Data Centers	Financial Statement Management/GAAP

Career Summary

08/2012-Present **NETCASTBPO SERVICES LLC, HENDERSON, NV**
Senior Vice President, IT Services

- Responsible for the Management of System Development, Data Center Management, Storage, Backup and Recovery, IT Support, Desk Services, Virtualization, Network Architecture, IT Security, and VoIP Infrastructure as well as hands-on system and reporting development using PHP, Python, SQL and Shell
- Developing, establishing and implementing all IT policies and procedures, objectives, PCI Compliance including architecture, security, disaster recovery, standards, purchasing and service provision including leading execution of technology roadmaps and evaluating new technologies and improvements
- Analyzing and planning systems infrastructure, evaluating all hardware and software, forecasting for present and future capacity needs and evaluating and maintaining vendor contracts

12/2003-12/2014 **INTEGRATED COMMUNICATIONS NETWORK LLC, SAN MARCOS, CA**

07/2004-12/2014 **Chief Technology Officer and General Manager**

- Responsible for leading and managing a team of 25 staff both domestic and offshore where I provided the oversight and delegating of projects including ensuring timely completion and within budget
- Successfully oversaw the core operations to include Network Operation, IT/Engineering, Facilities, Accounting and Administration including the creation of the standard operating procedures in an effort to improve and secure efficiencies and response time
- Entrusted with complete financial autonomy on such things as financial statements, payroll, contract approval, light cash flow, accounts payable and the development of timelines for cash expenditures
- Negotiated capital finance lease agreements in the amount of $1 million which are to be used to finance new equipment to support the migration plan of legacy systems by leading the network design, security and architecture to successful decommissioning of legacy data and voice systems
- Oversaw the Oracle and Cisco Call Center application installation utilizing Call Center Anywhere and Cisco Unified Contact Center Express which included systems, training, and ongoing development
- Streamlined the implementation of the Voice Over IP network to the Philippines and Panama ensuring redundancy, quality, and sufficient bandwidth while also responsible for voice and data systems including four separate switching platforms, Alcatel-Lucent, Cisco, Sonus and Avaya
- Researched requirements to facilitate Make vs. Buy software decisions, negotiated with industry partners to ensure best price and maintenance plans, and participated in all sales meetings and application demonstrations

Career Summary Continued

Key Achievement:

- Negotiated with telecommunications carriers for toll free number service which saved 40% on overall cost of sales

12/2003-07/2004 Director Network Operations

- Successfully negotiated with a call accounting vendor on their software and maintenance package as well as developed the automated client reporting system eliminating manual intervention
- Responsible for implementing an Avaya tandem switching platform that included an associated call accounting system
- Performed weekly billing to ensure accuracy and that all detailed reporting requirements were met

Additional Positions Over 10 Years:

Manager, Business Analyst, Medimpact Healthcare Systems, Inc., San Diego, CA (05/2002-12/2003)
I.T. Senior Business Analyst, Medimpact Healthcare Systems, Inc., San Diego, CA (04/1999-05/2002)
Cost Accountant/Consultant, Integrated Medical Organization Systems, Inc. (IMOS), Carlsbad, CA (11/1996-04/1999)

Education and Qualifications

MBA	Accountancy, National University, San Diego, CA (1996)
BS	Health Services Administration, California State University, Fresno, CA (1993)

Key IT Skills

- Oracle 11g Database
- PL-SQL
- HTML
- MS Access
- PowerPoint
- Peachtree Accounting
- UNIX
- TCP/IP
- ATM
- MySQL Database
- UNIX Shell
- JavaScript
- Word
- Project
- QuickBooks
- Linux Operating System
- SIP
- VoIP Connectivity
- SQL and SQL*Plus
- Python and AWK
- Cisco UCCX Scripting
- Excel
- Quicken
- MS Windows
- Mac OS X Operating System
- TDM
- Network Connectivity

Hands on System Development

Toll Free Number Inventory/Provisioning and Billing System:

- ✓ Design and implementation of database using Oracle 11g
- ✓ Analysis and design of front end GUI
- ✓ Shell scripting with SQL, PL/SQL and SQL Loader for system processes and reporting

Cisco Unified Contact Center Express:

- ✓ Design and code scripts for applications such as Interactive Voice Response (IVR), contact center queues, Network monitoring phone alarm system
- ✓ Build external database for reporting using Oracle 10g Express
- ✓ Shell scripting with SQL *Plus for automated reporting and delivery

Oracle Contact Center Anywhere:

- ✓ Client contact center company setup and maintenance
- ✓ Agent visual scripting using HTML and JavaScript
- ✓ Back end reporting using Oracle Database 11g
- ✓ Shell scripting for file transfers, auto loading of dial lists, and reporting

Medical Staff Office
Tri-City Medical Center
ADVANCED HEALTH CARE FOR YOU

TO: Larry Schallock, Chairperson

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

DATE: June 23, 2015

SUBJECT: Medical Executive Committee Credentialing Recommendations – New Appointments

---

The attached Medical Staff New Appointments Credentials report was reviewed and approved at Credentials Committee on June 10, 2015. Their recommendations were reviewed and approved by the Medical Executive Committee on June 22, 2015. 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: ☐

_____ _____
Ramona Finnila, Secretary Date
For and on behalf of the TCHD Board of Directors

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
June 10, 2015

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 06/25/2015 – 05/31/2017)
Medical Staff – Appoint to Provisional Staff and grant privileges as delineated:

Becker, Olga V., MD	Medicine/Psychiatry
Blasko, Barbara J., MD	Emergency Medicine
Lovin, Jeffrey D., MD	Radiology
Martinez, Kelly A., MD	OB/GYN
Morris, Kenneth H., MD	Pediatrics
Nuckols, Matthew C., MD	Anesthesiology
Roher, Alexander A., MD	Anesthesiology
Salimi, Negin, DO	Medicine/Internal Medicine
Yeackle, Wesley O., DO	Emergency Medicine

Allied Health Professionals – Appoint to Allied Health Professional Staff and grant privileges as delineated:

McNally, Paul D., NP, RNFA	Surgery/Neurosurgery – Nurse Practitioner - RNFA
Tuanquin, Tina C., Au.D	Surgery/Orthopedic Surgery – Audiologist
Weary, Yong, CNM	OB/GYN – Certified Nurse Midwife

INITIAL APPLICATION WITHDRAWAL: (Voluntary unless otherwise specified)
Medical Staff:

Armstrong, Theodore N., MD	Emergency Medicine

Allied Health Professionals:
None

TEMPORARY PRIVILEGES:
Medical Staff/Allied Health Professionals:

Depala, Venugopal, MD	Psychiatry
Tuanquin, Tina C., Au.D	Surgery/Orthopedic Surgery – Audiologist

TEMPORARY MEDICAL STAFF MEMBERSHIP:
Medical Staff:
None

Medical Staff Office
Tri-City Medical Center
ADVANCED HEALTH CARE FOR YOU

TO: Larry Schallock, Chairperson

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

DATE: June 23, 2015

SUBJECT: Medical Executive Committee Credentialing Recommendations – Reappointments

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The attached Medical Staff Reappointments Credentials report was reviewed and approved at Credentials Committee on June 10, 2015. Their recommendations were reviewed and approved by the Medical Executive Committee on June 22, 2015. 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: ☐

_____ _____
Ramona Finnila, Secretary Date
For and on behalf of the TCHD Board of Directors

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
June 10, 2015

Attachment B

REAPPOINTMENTS: (Effective Dates 07/01/2015 – 07/31/2017)

Medical Staff:

Afra, Robert, MD **Family Medicine**
Reappoint to Consulting Staff status and grant privileges as requested.

Ajir, Mahyar, DO **Family Medicine**
Reappoint to Affiliate Staff status and grant privileges as requested.

Birhanie, Melaku T., MD **Internal Medicine**
Reappoint from Provisional Staff to Active Staff status and grant privileges as delineated:

Burke, Michael S., MD **Interventional Radiology**
Reappoint to Active Staff status and grant privileges as requested.

Deemer, Andrew S., MD **General Vascular Surgery**
Reappoint to Active Staff status and grant privileges as requested.

Dillman, Ariana N., MD **Emergency Medicine**
Reappoint from Provisional Staff to Active Staff status and grant privileges as delineated:

Etedali, Elaheh, DO **Family Medicine**
Reappoint to Affiliate Staff status and grant privileges as requested.

Frakes, Laurie A., MD **Oncology**
Reappoint to Active Staff status and grant privileges as requested.

Hodsman, Hugh K., MD **Family Medicine**
Reappoint to Affiliate Staff status and grant privileges as requested.

Jamshidi-Nezhad,Mohammed, DO **General and Vascular Surgery**
Reappoint to Active Staff status and grant privileges as requested.

Johnson, William H., MD **Diagnostic Radiology**
Reappoint to Active Staff status and grant privileges as requested.

Ku, Tse-Sun, MD **Anesthesiology**
Reappoint to Active Staff status and grant privileges as requested.

Lozano Jr., Jesus, MD **Anesthesiology**
Reappoint to Courtesy Staff status and grant privileges as requested.

Noud, Michael J., MD **Interventional Radiology**
Reappoint to Active Staff status and grant privileges as requested.

Patel, Kiran R., MD **Diagnostic Radiology**
Reappoint to Active Staff status and grant privileges as requested.

Patel, Yogesh V., MD **Anesthesiology**
Reappoint to Courtesy Staff status and grant privileges as requested.

Paveglio, Kathleen A., MD **Cardiology**
Reappoint to Active Staff status and grant privileges as requested.

Purcott, Kari L., MD **Obstetrics & Gynecology**
Reappoint to Active status and grant privileges as requested.

Quintela, Eileen R., MD **Anesthesiology**
Reappoint to Active Staff status and grant privileges as requested.

Stark, Erik S., MD **Orthopedic Surgery**
Reappoint to Active Staff status and grant privileges as requested.

Tom, Clifford C., MD **Anesthesiology**
Reappoint to Active Staff status and grant privileges as requested.

Tomaneng, Neil C., MD **Emergency Medicine**
Reappoint to Active status and grant privileges as requested.

Worman, Scott L., MD **Family Medicine**
Reappoint to Active Staff status and grant privileges as requested.

Allied Health Professionals:

Alaoui, Jannah F., CNM **Certified Nurse Midwife**
Reappoint to Allied Health Professionals and grant privileges as requested.

Bayudan Inocelda, Andrew G., PAC **Physician Assistant**
Reappoint to Allied Health Professionals and grant privileges as requested.

Brockman, Joe B., PAC **Emergency Medicine**
Reappoint to Allied Health Professionals and grant privileges as requested.

Crespo, Christopher N., PAC **Physician Assistant**
Reappoint to Allied Health Professionals and grant privileges as requested.

Ventrella, Stephanie H., PAC **Emergency Medicine**
Reappoint to Allied Health Professionals and grant privileges as requested.

RESIGNATIONS: (Effective date 06/30/2015 unless otherwise noted)
Voluntary:

Adler, Mark J., MD	Hematology
Alaynick, Michael., MD	Wound Care
Doshi, Ashmi M., MD	Internal Medicine
Kneass, Zachary T.,	Otolaryngology **(Effective 05.01.2015)**

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
June 10, 2015

McCormick, Suzanne U., DDS	Oral & Maxillofacial Surgery
Meeks, Andrew S, MD	Emergency Medicine
Novikoff, Thays S, MD	Family Medicine **(Effective 05.27.2015)**
Sadler, Charlotte, MD	Emergency **Medicine (Effective 05.18.15)**
Said, Bishoy, MD	Ophthalmology **(Effective 05.22.2015)**
Zalewski Zaragoa, Robert A.,	Psychiatry

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
June 10, 2015

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS (Effective Date: 06/25/2015, unless specified otherwise)

Fierer, Adam, MD **Surgery/GVS**
Add:
- Upper Endoscopy (EGD)

Hanna, Karen, MD **Surgery/GVS**
Add:
- Upper Endoscopy (EGD)

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
June 10, 2015

Attachment B

PROCTORING RECOMMENDATIONS (Effective 06/25/2015, unless otherwise specified)

None

TRI-CITY MEDICAL CENTER
HUMAN RESOURCES COMMITTEE
OF THE BOARD OF DIRECTORS
June 9, 2015

Voting Members Present:	Chair Cyril Kellett, Director Rosemarie Reno, Director Laura Mitchell, Dr. Hamid Movahedian Dr. Martin Nielsen, Virginia Carson, Salvador Pilar
Non-Voting Members Present:	Tim Moran, CEO; Kapua Conley, COO; Sharon Schultz, CNE/CCO; Esther Beverly, VP of HR
Others Present:	Frances Carbajal, Rudy Gastelum
Members Absent:	Sydelle Gale, Dr. Gene Ma, Henry Holloway

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 June 9, 2015 meeting. Director Reno moved and Director Mitchell 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 April 14, 2015 meeting. Director Reno moved and Ginny Carson seconded the motion. The motion was carried unanimously.		Chair Kellett
5. Old Business			

Topic	Discussion	Action Follow-up	Person(s) Responsible
None			
6. New Business			
a. Consideration to appoint Virginia Carson to the Employee Fiduciary Subcommittee	Chair Kellett called for a motion to appoint Virginia Carson to the Employee Fiduciary Subcommittee. Director Reno moved and Director Mitchell seconded the motion. The motion was carried unanimously.		Chair Kellett
b. B.O.D Dashboard- Stakeholder Experience	The Stakeholder Experience pillar- Employee Satisfaction rates were reviewed & discussed.		Chair Kellett
c. Workers Comp Cases Review	Rudy Gastelum, EHS Director presented a review of quarterly work comp. retention rates and current broker info. The committee discussed retention rates & practice, claim counts, incurred cost, third party administrator & broker info, medical provider network, injury management counselor & department reports.		Esther Beverly
d. Review of Legal Developments/New Laws	Esther Beverly, VP of HR presented and explained recent law changes and updates that may affect TCHD process, policies and/or procedures. The committee briefly discussed the most pertinent changes and how to comply properly.		Esther Beverly
7. Work Plan	The work plan was reviewed and updated.		Chair Kellett
8. Committee Communications	None		Chair Kellett
9. Date of next meeting	**August 11, 2015**		Chair Kellett
10. Adjournment	Chair Kellett adjourned the meeting at 2:00 p.m.		Chair Kellett

Employee Fiduciary Subcommittee
(No meeting held in
June, 2015)

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
June 11, 2015 Assembly Room 1

MEMBERS PRESENT: Board of Directors Chairman Larry Schallock, Director James Dagostino, Director Julie Nygaard, Marilyn Anderson, Mary Lou Clift, Marge Coon, Gigi Gleason, Darryl Hebert, Carol Herrera, Marilou de la Rosa Hruby, Robin Iveson, Linda Ledesma, Don Reedy, Roma Ferriter

NON-VOTING MEMBERS: Tim Moran, CEO; Kapua Conley, COO; David Bennett, Sr. VP & CMO

OTHERS PRESENT: Susan McDowell, CHAC Coordinator; Celia Garcia, CHAC Coordinator

MEMBERS ABSENT: Linda Allington, Xiomara Arroyo, Carol Brooks, Rosemary Eshelman, Gina McBride, Jack Nelson, Barbara Perez, Bret Schanzenbach, Laura Vines, Audrey Lopez, Fernando Sanudo

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CALL TO ORDER	The June 11, 2015 Community Healthcare Alliance Committee meeting was called to order at 12:35pm by Director Julie Nygaard.		
APPROVAL OF MEETING AGENDA	Director Jim Dagostino motioned to approve the June 11, 2015 agenda. The motion was seconded by member Don Reedy and unanimously approved.		
PUBLIC COMMENTS & ANNOUNCEMENTS	No public comments were made.		
RATIFICATION OF MINUTES	Director Jim Dagostino motioned to approve the May 14, 2015 meeting minutes. The motion was seconded by Marilou de la Rosa Hruby and unanimously approved.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
June 11, 2015 Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
NEW BUSINESS **CEO UPDATE**	TCMC CEO Tim Moran updated the group as follows: **FINANCE & OPERATIONS:** Tim noted that efforts to improve the financial stability of the hospital have been successful, and it is expected that TCMC will have in excess of 4M dollars at the end of this fiscal year. The Operating and Capital Budgets for the upcoming fiscal year are currently being prepared. Tim Moran will be providing an update to the CHAC Committee members in August. TCMC's focus in the year ahead will include the following areas: • Women's Health • OB/GYN Recruitment • Ortho • Neurosurgery • Acute Rehab Tim also noted that the upcoming year will see the execution of TCMC's growth plans and aggressive pursuit of the hospital's goals. **CAMPUS DEVELOPMENT:** Tim reviewed several areas with regard to the ongoing renovation and campus redevelopment plans noting that renovation to OB/NICU should begin soon.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CEO UPDATE (Con't)	The master renovation plan is being updated to meet the seismic requirements for the campus and focus on the development of a highly functional and improved Emergency Room. **STRATEGIC PLAN:** The Strategic Plan for the upcoming year is heavily focused on Physician recruitment. TCMC is currently looking at a collaborative partnership with other providers to make effective use of resources and help in the management of governmental regulations being implemented in the area of healthcare. Currently all ideas are on the table for review and discussion. Tim noted that there is great concern about behavioral health issues growing in San Diego County. Discussion was held among the group regarding possible causes for the increase among the younger and older populations, noting that the need for senior Dementia care is growing, youth arrests – 5150's - are on the rise, etc. Several ideas proposed were: • Director Dagostino proposed the development of a Visitation Program to help monitor the progress of those recently released from the hospital • Don Reedy suggested the development of a Task Force to focus on behavioral health issues and how TCMC can be in the forefront of finding legal, realistic and workable solutions for our community		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CEO UPDATE (Con't)	Director Schallock noted that he recently visited the Sacramento area and indications are that the same problems are occurring in multiple areas within the state – financial issues, patients using the ER for basic and/or non-emergency health issues, increased behavioral health demands, lack of bed availability, etc. Tim Moran will be providing more detail at his August CHAC presentation.		
PRESENTATION	It's An Emergency! Presented by Marilyn Anderson, R.N., Emergency Service Officer, Vista Fire Department Marilyn Anderson provided information regarding public emergency medical services for our community and how things work in an emergency situation. Among the topic discussed were: • Appropriate use of the 9-1-1 emergency call system • Type of conditions when an ambulance should be called (versus driving yourself or the patient to the hospital by car) • How to assist emergency services to obtain the necessary information they need during the 9-1-1 call • What steps are in place if the caller is unable to answer • Landline versus Cell Phone operations • How units are dispatched from the various locations within the community Marilyn also arranged for a demonstration (with the help of EMT staff who volunteered their time) of the steps taken once the personnel reach the patient.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
June 11, 2015 Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PRESENTATION	The group thanked Marilyn and the EMT volunteers for the wonderful information. Director Nygaard noted that this would be a great presentation to offer to other groups inside and outside the hospital.		
COMMITTEE COMMENTS	Robin Iveson noted that this will be her last CHAC meeting. Director Nygaard and the others thanked Robin for her outstanding service to the committee and the community. Don Reedy reminded the group of Oceanside's 21st annual Independence Day Parade scheduled for Saturday, June 27th. Gigi Gleason reminded the group of the upcoming Heritage Ball in August at the San Luis Rey Mission in Oceanside. Linda Ledesma notified the group that member Rosemary Eshelman's son has been drafted by the Houston Astro's. The group extended their congratulations to the Eshelman family.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
June 11, 2015 Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
DATE & TIME OF NEXT CHAC MEETING	No Community Healthcare Alliance Committee meeting in July. The next scheduled meeting will be August 13, 2015.		
ADJOURNMENT	The meeting was adjourned at 1:53pm.		

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
June 16, 2015

Members Present	Dr. James Dagostino, Director Kellett, Director Julie Nygaard, Dr. John Kroener, Dr. Marcus Contardo, Dr. Frank Corona, Kathleen Mendez, Steve Harrington, Wayne Lingenfelter
Non-Voting Members Present:	Tim Moran, CEO, Steve Dietlin, CFO, Kapua Conley, COO, Wayne Knight, Sr. VP, Medical Services
Others Present:	Director Laura Mitchell, Carol Smyth, Sharon Schultz, Jeremy Raimo, Jody Root, April Lombardo, Charlene Carty, David Bennett, Scott Livingstone, Joy Melhado, Ry Rivas, Jane Dunnmeyer, Carissa Damara, Steve Young, Richard Cornwell, Andrea Benton, Jenelle Lovelady, Thomas Moore, Marcia Cavanaugh, Barbara Hainsworth
Members Absent:	Robert Knezek

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Dagostino called the meeting to order at 12:30 pm.		
2. Approval of Agenda	Director Dagostino stated that item 6.o., Proposal for Medical Office Equipment Lease with Tri-City Primary Care Medical Group would be pulled from the agenda. Director Dagostino requested a motion to include two additional write-ups that were not on the agenda.	**MOTION** **It was moved by Director Nygaard, Director Kellett seconded, and it was unanimously approved to accept the agenda of June 16, 2015 with the following change: Item 6.o. the write–up for Medical Office Equipment Lease for Tri-City Primary Medical Group, is to be pulled from the agenda.** **MOTION** **It was moved by Director Nygaard, Director Kellett seconded, and it was unanimously agreed to add the following items to the agenda:**	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		• **Physician Agreement for Medical Director, Intensive Care Unit (ICU) for Dr. Mark Yamanaka** • **Physician Agreement for Medical Director, Pulmonary Services for Frank Corona, M.D.** **These write-ups would be identified as items w.1. and w.2, respectively.**	
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 Dagostino
4. Ratification of minutes of May 19 2015		Minutes ratified. **MOTION** **It was moved by Director Kellett, Dr. Corona seconded, that the minutes of May 19, 2015, be approved as written, with Mr. Lingenfelter abstaining.**	
5. Old Business	None		
6.a.Interviews-Community Members (2 openings) • Tim Keane • James Ligon • Carlo Marcuzzi • Guy Roney III • Michael Slavinski • Patricia Hacker	All candidates remained outside of the assembly room, and each was brought in separately for their respective interview. Only 3 of the 6 candidates were present for the interview process, Mr. Tim Keane, Mr. Carlo Marcuzzi and Mr. Guy Roney. Voting sheets had been distributed at the outset of the meeting to all voting members in attendance. Director Dagostino asked that the candidates be ranked 1-6, with a score of 6 being the highest. Those	**MOTION** **Director Nygaard moved, and Director Kellett seconded and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors approve Carlo Marcuzzi and Tim Keane as the new Community Members for Finance, Operations and Planning Committee.**	Chair

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	candidates not in attendance at the meeting would be evaluated based on the application documents they had submitted. Barbara Hainsworth would tabulate the results, and Wayne Knight was asked to verify the voting. Each candidate present provided a brief opening statement regarding their resumes, and answered questions asked by the committee members. Candidates were then given the opportunity to give a brief closing statement. Once all the interviews had concluded, all candidates were asked to wait outside the assembly room. The voting sheet scores were tabulated and reviewed for accuracy. The two candidates receiving the most points on the ballots were: • Carlo Marcuzzi • Tim Keane		
b. Physician Agreement for Non-Exclusive, Weekend Remote and On-Call Psychiatry Services - Psychiatry Department of UC San Diego Health System	Director Dagostino conveyed that due to the volume of physician agreements and renewals detailed on this agenda, each write-up would be reviewed individually, with an opportunity for committee members to ask questions and solicit any clarifications required. All contracts would, however, be covered under a single motion.	**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize UCSD psychiatrist(s) as the Coverage Physicians for a term of 12 months beginning April, 2015 and ending March, 2016, for non-exclusive, weekend remote and on-call psychiatry services, at an hourly rate of**	Sharon Schultz

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		$150 for on-site; and $1,000 daily for an annual estimated cost of $91,000.	
c. Proposal for Lease Amendment (Extension) – Oscar Matthews, M.D.		**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors approve the Second Amendment to the Lease Agreement with Dr. Oscar Matthews for an additional 1 year term (July 1, 2015 thru June 30, 2016), at the same current fair market value monthly rental rate of $2,850.12.**	Wayne Knight
d. Physician Agreement, Case Management – John LaFata, M.D.		**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with John LaFata, MD, FACP for Medical Director of Case Management Department for a term of 12 months, beginning July 1, 2015, and ending June 30, 2016, for an annual cost of $52,999.92, and a total cost not to exceed $52,999.92 for the term.**	Scott Livingstone
e. Physician Agreement for Patient Safety Officer and Co-Chair of Patient Safety Committee – Scott Worman, M.D.	On the recommendation from Jody Root, Procopio's legal representative, this agreement would be amended, to reflect "Other" in the Type of Agreement table.	**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Scott Worman as the Patient Safety Officer & Co-Chair of Patient Safety Committee, for**	Kevin McQueen / Sharon Schultz

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		a term of 36 months beginning July 1, 2015 and ending June 30, 2018. Not to exceed an average of 6 hours per month or 72 hours annually, at an hourly rate of $175 for an annual cost of $12,600 and a total cost for the term of $ 37,800. **Write-up to be amended by Barbara Hainsworth.**	
f. Physician Agreement, Medical Director, Inpatient Behavioral Health – Manish Sheth, M.D.	On the recommendation from Jody Root, Procopio's legal representative, this agreement would be amended, to reflect "Medical Director" as the Type of Agreement table, instead of Panel.	**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Manish V. Sheth as Medical Director for Inpatient BHU for a term of 12 months beginning July 1, 2015 and ending June 30, 2016 for an average of 80 hours per month, not to exceed 960 hours annually, at an hourly rate of $125 for an annual cost of $120,000 and total cost for the term.** **Write-up to be amended by Barbara Hainsworth.**	Sharon Schultz / Kapua Conley
g. Physician Agreement, Medical Director, Forensic Outpatient Clinic Victor Souza, M.D.		**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Victor Souza as the Medical Director for Forensic Outpatient Clinic for a term of 24 months, beginning July 1, 2015 and ending June 30, 2017. Not to exceed an average of 15 hours per month or 180 hours annually, at an hourly rate of $163 for an annual cost of $ 29,340 and total cost for the term in the amount of $58,680.**	Sharon Schultz / Kapua Conley

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h. Physician Agreement for ED On-Call Coverage • **ENT**-Audrey Calzada, M.D. • **Cardiology, General**-Oscar Matthews, M.D.; Mohammad Pashmforoush, M.D.; Paul Sarkaria, M.D. • **Cardiology, General and STEMI**-Kenneth Carr, M.D.; David Spiegel, M.D. • **Cardiothoracic Surgery**-Theodore Folkerth, M.D.; Frederick Howden, M.D.; Paul Mazur, M.D. • **ENT**-Julie Berry, M.D.; Hernan Goldsztein, M.D.;	On the recommendation from Jody Root, Procopio's legal representative, this agreement would be amended, to reflect "Renewal-New Rates" in the Type of Agreement table, instead of "New Agreement" for Audrey Calzada, M.D.	**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Audrey Calzada as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $450 and a total cost for the term of $164,700.** **Write-up to be amended by Barbara Hainsworth.** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. Oscar Matthews, Mohammad Pashmforoush, and Paul Sarkaria as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $200 and a total cost for the term of $73,200.** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. Kenneth Carr, and David Spiegel as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016, not to exceed a daily rate of $200/600 and a total cost for the term of $73,200/$219,600.** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. Theodore Folkerth, Frederick Howden, and Paul Mazur as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $750 and a total cost for the term of $274,500.** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. Julie Berry, Hernan Goldsztein,**	Sherry Miller / Kapua Conley

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Robert Jacobs, M.D.; Marc Lebovits, M.D.; Ritvik Mehta, M.D.; Bruce Reisman, M.D.; Ashish Wadhwa, M.D.		**Robert Jacobs, Marc Lebovits, Ritvik Mehta, Bruce Reisman and Ashish Wadhwa as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $450 and a total cost for the term of $164,700.**	
• **Interventional Radiology**-Michael Burke, M.D.; Brian Goelitz, M.D.; Justin Gooding, M.D. Michael Noud, M.D.; Donald Ponec, M.D.; Richard Saxon, M.D.		**Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. Michael Burke, Brian Goelitz, Justin Gooding, Michael Noud, Donald Ponec and Richard Saxon as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $600 and a total cost for the term of $219,600.**	
• **Neurology**-Lesley Aguilar Tabora, M.D.; Andrew Blumenfeld, M.D.; Benjamin Frishberg, M.D.; Michael Lobatz, M.D.; Amy Nielsen, D.O.; Irene Oh, M.D.; Remia Paduga, M.D.; Jay Rosenbery, M.D.; Mark Sadoff, M.D.; Gregory Sahagian, M.D.; Jack Schim, M.D.; Anchi Wang, M.D.; Michael Zupancic, M.D.		**Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize these Neurology physicians as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $500 and a total cost for the term of $183,000.**	

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• **Neurosurgery**-Thomas Nowak, M.D.		**Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Thomas Nowak as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $800 and a total cost for the term of $292,800.**	
• **Neurosurgery and Spine**-Tyrone Hardy, M.D.; Thomas Marcisz, M.D.; Mark Stern, M.D.; Frank Kevin Yoo, M.D.		**Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Tyrone Hardy, Thomas Marcisz, Mark Stern & Frank Kevin Yoo as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $800 (Neurosurgery)/$400 (Spine) and a total cost for the term of $292,800/$146,400.**	
• **OB/GYN**-John Bennett, M.D.; Rahele Mazarei, D.O.; Chunjai Clarkson, M.D.; Orna Gil, M.D.; Christos Karanikkis, D.O.; Sandra Lopez, M.D.; Talal Muhtaseb, M.D.		**Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize these OB/GYN physicians as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $800 weekday; $1000 weekend/holiday; $145/case and a total cost for the term of $317,175.**	
• **Oral-Max. Surgery**-Brian Mudd, M.D.		**Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Brian Mudd as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $350 and a total cost for the term of $128,100.**	
• **Orthopedic Surgery**-Christian Bentley, M.D.;		**Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Christian Bentley, MD; Andrew**	

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Andrew Cooperman, M.D.; David Daugherty, M.D.; Andrew Hartman, M.D.; Harish Hosalkar, M.D.; Serge Kaska, M.D.		**Cooperman, MD; David Daugherty, MD; Andrew Hartman, MD; Harish Hosalkar, MD, Serge Kaska, MD as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $1,400 and a total cost for the term of $512,400.**	
• **Orthopedic Surgery and Spine**-David Amory, M.D.; Janet Dunlap, M.D.; Payam Moazzaz, M.D.		**Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize David Amory, MD; Janet Dunlap, MD; Payam Moazzaz, MD, MD as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $1,400(Orthopedic)/$400(Spine) and a total cost for the term of $512,400/$146,400.**	
• **Spine**-Neville Alleyne, M.D.		**Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Neville Alleyne as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $400 and a total cost for the term of $146,400.**	
• **Spine**-Lokesh Tantuwaya, M.D.		**Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Lokesh Tantuwaya as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $400 and a total cost for the term of $146,400.**	
• **Urology**-Caroline Colangelo, M.D.; Bradley Frasier, M.D.; Michael Guerena, M.D.; Arthur Warshawsky, M.D.		**Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. Caroline Colangelo; Bradley Frasier; Michael Guerena; Arthur Warshawsky as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $350 and a total cost for the term of $128,100.**	

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• **Vascular**-Andrew Deemer, M.D.; Mohammad Jamshidi-Nezhad, D.O.		**Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. Andrew Deemer; Mohammad Nezhad-Jamshidi, DO as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $500 and a total cost for the term of $183,000.**	
i. Physician Agreement for ED On-Call Coverage • **Ophthalmology-** James Davies, M.D.; Bradley Greider, M.D.; Atul Jain, M.D.; Srinivas Iyengar, M.D.; Peter Krall, M.D.; Sally Mellgren, M.D.; Robert Pendleton; Mark Smith, M.D.; Christopher Spellman, M.D.; Maulik Zaveri, M.D.		**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. James Davies; Bradley Greider; Atul Jain; Srinivas Iyengar; Peter Krall; Sally Mellgren; Robert Pendleton; Mark Smith; Christopher Spellman; Maulik Zaveri as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $300 and a total cost for the term of $109,800.**	Sherry Miller / Kapua Conley
j. Physician Agreement for ED On-Call Psychiatry Coverage • **Venugopal Depala, M.D.**	Director Dagostino stated that a replacement version of this write-up had been distributed, to include the last line in the Motion ($380,000), which was inadvertently left off of the copy in the packets that were distributed.	**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Venugopal Dapala, M.D. as ED On-Call Coverage Physician for a term of 13 months beginning 6/16/2015 and ending 6/30/2016. Not to exceed a daily rate of $1,000 and a total cost for the term of $380,000.**	Sherry Miller / Kapua Conley

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k. Physician Agreement for Cardiac Rehabilitation, Medical Director / Physician Supervision • **Karim H. El-Sherief, M.D.**		**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Karim El-Sherief as the Medical Director of Cardiac Rehabilitation for a term of 24 months beginning July 1, 2015 ending June 30, 2017. Not to exceed an average of 44 hours per month or 528 hours annually, at an hourly rate of $185.50 for an annual cost of $97,944 and a total term cost not to exceed $195,888.**	Steve Young
l. Physician Agreement for Cardiac Rehabilitation, Physician Supervision • **Sharon M. Slowik, M.D.**		**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Sharon M. Slowik as the alternate Supervising Physician of the Cardiac Rehabilitation program for a term of 24 months beginning July 1, 2015 ending June 30, 2017. Not to exceed an average of 39 hours per month or 468 hours annually, at an hourly rate of $148.30 for an annual cost of $69,404 and a total term cost not to exceed $139,809.**	Steve Young
m. Radiological Services Supervision & Medical Director Contract • **San Diego Diagnostic Radiology Medical Group, Inc.**	On the recommendation from Jody Root, Procopio's legal representative, this agreement would be amended, to reflect "Panel" as the Type of Agreement table, instead of "Medical Director".	**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the**	Steve Young

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		agreement with San Diego Diagnostic Radiology Medical Group, Inc. to provide radiological services supervision and medical directorship coverage for a term of 3-years beginning July 1, 2015 through June 30, 2018. No fees are associated with the agreement other than facility space and business supply needs for physician operations. **Write-up to be amended by Barbara Hainsworth.**	
n. Physician Agreement for Medical Director of Acute Rehabilitation Unit • **Mark Sadoff, M.D.**		**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Mark Sadoff as the Medical Director for the Acute Rehabilitation Unit, for a term of 12 months beginning July 1, 2015 and ending June 30, 2016, not to exceed an average of 80 hours per month or 960 hours annually, at an hourly rate of $165 for an annual cost of $ 158,400, and a total cost for the term of $158,400.**	Kapua Conley
o. Proposal for Medical Office Equipment Lease • **Tri-City Primary Medical Group**		**PULLED**	Wayne Knight
p. Physician Agreement for Medical Director for Diabetes Program • **Chris Guerin, M.D.**		**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Chris Guerin as the Diabetes Program**	Sharon Schultz / Tim Moran / Kapua Conley

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		Medical Director, for a renewal term of 12 months beginning July 1, 2015 and ending June 30, 2016. Not to exceed an average of 16 hours per month or 192 hours annually, at an hourly rate of $150 per hour for an annual cost of $28,800, as the total for the term.	
q. Medical Staff Leadership Agreement • **James Johnson, M.D.**		**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. James Johnson as the Medical Staff Leadership Physician/Quality Assurance/Performance Improvement Committee Chair for a term of 12 months beginning July 1, 2015 and ending June 30, 2016; an average of 30 hours per month or 360 hours annually, at an hourly rate of $185 and $5,000 for educational expenses for a total cost of $71,600 for the 12 month term.**	Sharon Schultz / Kapua Conley
r. Physician Consulting Agreement-Physician Liaison Disaster Management • **Chad Bernhardt, M.D.**	On the recommendation from Jody Root, Procopio's legal representative, this agreement would be amended, to reflect "Other" in the Type of Agreement table, instead of Renewal. It was also requested to check the box "Renewal-Same Rates".	**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Bernhardt, as the Physician Liaison, Disaster Management for a term of 12 months beginning July 1, 2015 and ending June 30, 2016. Not to exceed an average of 3 hours per month or 36 hours annually, at an hourly rate of $150 per hour for an**	Sharon Schultz

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		annual cost of $5,400, for a 12 month term. **Write-up to be amended by Barbara Hainsworth.**	
s. Medical Director Agreement for Medical Director, Home Health • **John LaFata, M.D.**	This write-up to be amended to replace Medical Director in lieu of Coverage Physician in the Motion.	**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. John LaFata as the Medical Director for Home Health for a term of 24 months beginning July 1, 2015 and ending June 30, 2017. Not to exceed an average of 25 hours per month or 300 hours annually, at an hourly rate of $ 169 for an annual cost of $50,700 and a total cost for the term of $101,400.** **Write-up to be amended by Barbara Hainsworth.**	Sharon Schultz / Kapua Conley
t. Medical Staff Leadership Agreement-Professional Behavior Committee Chair • **Marcus Contardo, M.D.**		**MOTION** **Director Nygaard moved, Dr. Corona seconded, and it was unanimously approved, with Dr. Contardo abstaining, that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the renewal of the Medical Staff Leadership Agreement for Chair of the Medical Staff Professional Behavior Committee, Marcus Contardo, M.D., for a term of 12 months beginning July 1, 2015 and ending on June 30, 2016. A monthly stipend of $5,000 per month; not to exceed a total of $60,000 per year, for the Term.**	Kapua Conley
u. Physician Agreement for Chief of Staff Leadership • **Gene Ma, M.D.**	On the recommendation from Jody Root, Procopio's legal representative, this agreement	**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously**	Kapua Conley

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	would be amended, to reflect "Other" in the Type of Agreement table, instead of "New Agreement".	**approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the Medical Staff Leadership Agreement for Chief of Staff, Gene Ma, M.D., for a term concurrent with his appointment as Chief of Staff but no longer, of 24 months starting July 1, 2015 and ending on June 30, 2017, for a TCHD stipend of $4,000 per month, $48,000 annually and $96,000 for 24 months, plus an educational allowance up to $10,000 for a total not to exceed $106,000 for the Term, paid by TCHD.** **Write-up to be amended by Barbara Hainsworth.**	
v. Physician Agreement for Coastal Hospitalist Medical Associates, Inc.	A revised version of this write-up was received after the packets were distributed. A copy of the revised document was subsequently distributed to Committee members.	**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the new Hospitalist Services and On-Site Coverage Services Agreement beginning July 1, 2015 and ending June 30, 2017 at a monthly rate of $148,500 per month; annual cost of $1,782,000 and total for the Term in the amount of $3,564,000.**	Kapua Conley / Sharon Schultz
w. Physician Agreement for Pulmonary Services, Adult Intensive Care – ICU Coverage and ED On-Call Coverage • **Frank Corona, M.D.** • **Martin Nielsen, M.D.** • **Mark Yamanaka, M.D.** • **Safouh Malhis, M.D.**	This write-up and Exhibit A were unavailable at the time the packets were distributed. Copies of the write-up documents were subsequently distributed to Committee members.	**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved, with Dr. Corona abstaining, that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the ICU Coverage Panel/ED Pulmonary On-Call Coverage Panel Agreement with Drs.**	Kapua Conley

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		Corona, Nielsen, Yamanaka and Malhis for a term of 24 months, beginning July 1, 2015 and ending June 30, 2017. At a daily rate of $1,500 for an annual cost of $549,000 for FY 2016 and $547,500 for FY 2017; and total cost for the Term in the amount of $1,096,500.	
w.1.Physician Agreement for Medical Director, Intensive Care Unit (ICU) • **Mark Yamanaka, M.D.**	This write-up was not on the agenda at the time the packets were distributed. A copy of the write-up document was subsequently distributed to Committee members.	**MOTION** **Director Kellett moved, Dr. Corona seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Mark Yamanaka as the sole Medical Director for the Intensive Care Unit, for a term of 12 months beginning July 1, 2015, and ending June 30, 2016. Not to exceed an average of 10 hours per month or 120 hours annually, at an hourly rate of $175 for an annual cost of $21,000, and a total cost for the term of $21,000.**	Sharon Schultz / Kapua Conley
w.2. Physician Agreement for Medical Director, Pulmonary Services • **Frank Corona, M.D.**	This write-up was not on the agenda at the time the packets were distributed. A copy of the write-up document was subsequently distributed to Committee members.	**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved, with Dr. Corona abstaining, that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Frank Corona, as the Coverage Physician for Pulmonary Services for a term of 24 months beginning July 1, 2015 and ending June 30, 2017. Not to exceed an average of 10 hours per month or 120 hours annually, at an hourly rate of $175 for an annual cost of $21,000 and a total cost for the term of**	Sharon Schultz / Kapua Conley

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		$42,000.	
x. Proposal for Shared Marketing with North County Internal Medicine	David Bennett conveyed that this was a shared marketing agreement, with each entity committing $4,000 per term of 1-year contract, and that all ads will be signed off by each entity and payments to the advertising vendor will be made independently.	**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with North County Internal Medicine for a cost to TCMC of a maximum of $4,000 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016 for an annual cost of $4,000, and a total cost for the term of $4,000.**	David Bennett
y. Proposal for Closure of Nifty After Fifty	David Bennett explained that each location has less than 200 members, as there has been some difficulty with recruitment efforts due to lack of physician referrals, and membership not being covered by health insurance carriers.	**MOTION** **Director Kellett moved, Director Nygaard seconded, with Director Dagostino abstaining, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the closure of both Nifty After Fifty locations, effective July 31, 2015.**	David Bennett
z. Proposal for Commercial Insurance • **BB&T Insurance Services (BB&T)**	Wes Justyn from insurance vendor BB & T was present, and gave an overview of the information found in the write-up for commercial insurance. He also responded to a few questions that were raised by Committee members.	**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the acceptance, placement and financing of the commercial insurance products recommended by BB&T for the policy period commencing July 1, 2015 for an annual premium of $1,273,782.**	Steve Dietlin / Sharon Schultz / Kapua Conley
aa. Physician Agreement for ACO Physician Consulting	Wayne Knight conveyed that this proposal was to extend the	**MOTION** **Director Kellett moved, Director Nygaard**	Wayne Knight

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
• **Terry Haas, M.D.** • **John A. LaFata, M.D.** • **Jeffrey O. Leach, M.D.**	agreement with three primary care physicians to continue their roles as consultants in the ongoing management of TCHD's Accountable Care Organization.	**seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Terry A. Haas, MD; John A. LaFata, MD; and Jeffrey O. Leach, MD; as Physician Consultants to North Coast Medical ACO, Inc., for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016, for an annual and total cost for the term of $94,500.**	
bb. Financials	Steve Dietlin presented the financials ending May 31, 2015 (dollars in thousands) **Fiscal Year to Date** Operating Revenue $308,004 Operating Expense $307,273 EROE $ 4,904 EBITDA $ 19,468 **TCMC –Key Indicators – FYTD** Avg. Daily Census 192 Adjusted Patient Days 103,398 Surgery Cases 6,142 Deliveries 2,383 ED Visits 64,537 **Current Month** Operating Revenue $ 30,033 Operating Expense $ 28,713 EROE $ 1,814 EBITDA $ 3,136 **Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R (in millions) $ 43.2		Steve Dietlin

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Days in Net A/R 49.4 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable • TCMC-Average Daily Census-Total Hospital-Excluding Newborns • TCMC-Adjusted Patient Days • TCMC-Emergency Department Visits • TCHD-EROE and EBITDA		
cc. Work Plan – Information Only	Director Dagostino reported that these agenda items were for review only, but Committee members were welcome to ask questions.		
• Physician Recruitment Tracking (Annual)	Jeremy Raimo gave an abbreviated version of his planned Powerpoint presentation, reflecting on physician recruitment, since September 2011.		Jeremy Raimo
• Aionex Bed Board	Kathy Topp gave a brief Powerpoint presentation from the Hospital-Wide Throughput Committee, which encompasses the Aionex Bed Board.	**It was requested that the reporting of the Aionex Bed Board continue on a monthly basis.**	Kathy Topp
• Dashboard – Financial	Steve Dietlin gave a brief overview of the Dashboard financials.		Steve Dietlin
• Neuroscience Institute (NSI) Directorships, (Quarterly)	Andrea Benton reviewed the handout which had been distributed with the packets. She also answered a number of questions, pertaining to the NSI.	**It was noted that there is a typographical error in the next to the last line in this work plan document, (duplicated: Establishment of Cerebrovascular Team).**	Andrea Benton

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
7. Comments by Committee Members		None	Chair
8. Date of next meeting	July 21, 2015 Director Dagostino conveyed that both he and Director Nygaard would be unable to attend the July meeting, and advised that if there were pressing issues, Dr. Kellett would act as Chairman in his absence at the July 2015 meeting.		Chair
10. Adjournment	Meeting adjourned 3:28 pm.		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for Non-Exclusive, Weekend Remote and On-Call Psychiatry Services

Type of Agreement		Medical Directors		Panel	X	Other: Weekend On-Call Coverage
Status of Agreement	X	New Agreement		Renewal New Rates		Renewal – Same Rates

Physician's Name: Psychiatry Department of UC San Diego Health System

Area of Service: Behavioral Health

Term of Agreement: 12 months, Beginning April, 2015 - Ending March, 2016

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

Rate	Monthly Cost	Annual Cost	12 mo. (Term) Cost
$1,000/daily	9 mo. @ $7,000; 3 mo. @ $9,333	$91,000	$91,000
$150/hourly for On-site	Unknown	Unknown	Unknown

Position Responsibilities:

- UCSD psychiatrist(s) will provide non-exclusive on-call services and remote coverage on weekends, beginning at 12:00 am on Saturdays through 8:00 am on Mondays
- The $150 per hour on-site rate will be offset by UCSD actual collections for on-site professional services.

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize UCSD psychiatrist(s) as the Coverage Physicians for a term of 12 months beginning April, 2015 and ending March, 2016, for non-exclusive, weekend remote and on-call psychiatry services, at an hourly rate of $150 for on-site; and $1,000 daily for an annual estimated cost of $91,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
Proposal for: Lease Amendment (Extension) – Oscar Matthews, MD

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

Physician Name: Oscar Matthews, M.D. (Cardiologist)

Term: 12 months, July 1, 2015 - June 30, 2016
Extends First Amendment to the existing lease agreement for one additional year.

Premises: 2095 Vista Way, Suite 107, Vista, CA 92083 (1,450 sq. ft.)

Rental Rate: Shall remain the same: $2,850.12 per month (gross lease @ 1.9656 per sq. ft.)

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

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

Person responsible for oversight of agreement: Wayne Knight, Senior VP, Medical Services

Motion:
I move that the Finance, Operations and Planning Committee recommend the TCHD Board of Directors approve the Second Amendment to the Lease Agreement with Dr. Oscar Matthews for an additional 1 year term (July 1, 2015 thru June 30, 2016), at the same current fair market value monthly rental rate of $2,850.12.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PROPOSAL FOR: Dr. John LaFata. M.D., FACP

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

Vendor (Physician) Name: Dr. John LaFata, M.D., FACP

Area of Service: Case Management

Term of Agreement: 12 months, Beginning July 1, 2015 - Ending June 30, 2016

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$175/hr (7am – 7pm) & $193/hr (after hours)	25	300	$4,416.66	$52,999.92	$52,999.92

Description of Services/Supplies:

- Physician shall serve as medical director of the Case Management Department (Department);
- Physician shall be responsible for the medical direction of the Department to provide for the proper and adequate medical administrative management and supervision of the Department;
- Provide clinical consultation for the Department as requested by attending physicians including, without limitation, daily review and monitoring of patients receiving services in or through the Department
- Aid in developing, implementing, and evaluating a utilization review program, a quality assurance program, and a risk management program for the Department

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Scott Livingstone, Sr. Dir. Clinical Efficiency & Alternative Care/Kapua Conley, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize this Physician agreement renewal with John LaFata, M.D., FACP for Medical Director of Case Management Department for a term of 12 months (years), beginning July 1, 2015, and ending June 30, 2016, for an annual cost of $52,999.92and a total cost not to exceed $52,999.92 for the term.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for Patient Safety Officer & Co-Chair of Patient Safety Committee

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

Physicians Name: Scott Worman, MD

Area of Service: Patient Safety

Term of Agreement: 36 months, Beginning July 1, 2015 - Ending June 30, 2018

Maximum Totals: Within Hourly and/or Annualized Market Value: Yes

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	36 month (Term) Cost
$ 175/hr.	6	72	$ 1,050	$12,600	$ 37,800

Position Responsibilities:

- Co-Chairs Patient Safety Committee meetings
- Attends monthly QOC, QAPI, Medication Safety and PSC meetings
- Reviews patient safety events
- Makes recommendations to the Medical Staff to improve patient safety
- Organizes efforts to become a high reliability organization (HRO)

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Kevin McQueen, Director, Safety/EOC; Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Scott Worman as the Patient Safety Officer & Co-Chair of Patient Safety Committee, for a term of 36 months beginning July 1, 2015 and ending June 30, 2018. Not to exceed an average of 6 hours per month or 72 hours annually, at an hourly rate of $175 for an annual cost of $12,600 and a total cost for the term of $ 37,800.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for MANISH SHETH, M.D.

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

Physicians Name: Manish Sheth, M.D.
Area of Service: Inpatient BHU
Term of Agreement: 12 months, Beginning, July 1, 2015 – Ending, June 30, 2016
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

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

Position Responsibilities:

- Attend Treatment Team meeting, two days per week. Assistant Nurse Manager will coordinate Treatment Team meeting times
- Attend to psych consults in M/S unit when NP/PL unable to attend to psych consults
- Monitor bed utilization to less than or equal to a 7 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 the Physicians, Psychiatric Liaisons and Nursing Leadership per year
- Ensure that services provided are in compliance with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources
- Documentation – full and timely documentation for all patients. Comply with all legal, regulatory, accreditation, Hospital-Based Inpatient Psychiatric Care (HBIPS) core measures, Medical Staff and billing criteria, including applying Medicare guidelines, including Title IX and/or Interqual criteria to admission and discharge decisions
- Utilization Review, quality, performance improvement and risk programs

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive/Kapua Conley, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Manish V. Sheth as Medical Director for Inpatient BHU for a term of 12 months beginning July 1, 2015 and ending June 30, 2016 for an average of 80 hours per month, not to exceed 960 hours annually, at an hourly rate of $125 for an annual cost of $120,000 and total cost for the term.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for Forensic Outpatient Clinic

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

Physicians Name: Victor Souza M.D.

Area of Service: Outpatient Forensics

Term of Agreement: 24 months, Beginning July 1, 2015 and ending June 30, 2017

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	24 month (Term) Cost
$163	15	180	$2,445	$29,340	$58,680

Position Responsibilities:

- Developing, implementing, and evaluating a utilization review program, a quality assurance program, and a risk management program for the clinic
- Establishing and evaluating policies, procedures, and protocols for the Clinic for patient care
- Identifying equipment needs and coordinating standardization of instrumentation, equipment and supplies for the Clinic
- Identifying equipment needs and coordinating standardization of instrumentation, equipment and supplies for the Clinic
- Facilitating effective communications with attending and referring physicians, provide oversight of chart audits and manage delinquencies of dictations
- Assist with introducing new services/programs requested by the California Department of Corrections and Rehabilitation CDCR and the San Diego County Sheriffs

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sharon Schultz; Chief Nursing Executive/Kapua Conley, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Victor Souza as the Medical Director for Forensic Outpatient Clinic for a term of 24 months, beginning July 1, 2015 and ending June 30, 2017. Not to exceed an average of 15 hours per month or 180 hours annually, at an hourly rate of $163 for an annual cost of $ 29,340 and total cost for the term in the amount of $58,680.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2016
PHYSICIAN AGREEMENT for ED ON–CALL COVERAGE

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

Physicians Name: Audrey Calzada, MD

Area of Service: ED On-Call: ENT

Term of Agreement: Twelve (12) months, Beginning 7/1/2015 - Ending 6/30/2016

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$450	FY2016: 366	$164,700	$164,700

Position Responsibilities:

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

Board Approved Physician Contract Template	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Audrey Calzada as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $450 and a total cost for the term of $164,700.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physicians Name: Oscar Matthews, MD; Mohammad Pashmforoush, MD, Paul Sarkaria, MD

Area of Service: ED On-Call: Cardiology –General

Term of Agreement: Twelve (12) months, Beginning 7/1/2015 - Ending 6/30/2016

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$200	FY2016: 366	$73,200	$73, 200

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Oscar Matthews, Mohammad Pashmforoush, and Paul Sarkaria as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $200 and a total cost for the term of $73,200.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physicians Name: Kenneth Carr, MD; David Spiegel, MD

Area of Service: ED On-Call: Cardiology –General and STEMI

Term of Agreement: Twelve (12) months, Beginning 7/1/2015 - Ending 6/30/2016

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
Gen -$200 STEMI- $600	FY2016: 366	$73,200 $219,600	$73, 200 $219,600

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Kenneth Carr, and David Spiegel as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016, not to exceed a daily rate of $200/600 and a total cost for the term of $73,200/$219,600.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: JUNE 16, 2015
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physicians Name: Theodore Folkerth, MD; Frederick Howden, MD; Paul Mazur, MD

Area of Service: ED On-Call: Cardiothoracic Surgery

Term of Agreement: Twelve (12) months, Beginning 7/1/2015 - Ending 6/30/2016

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$750	FY2016: 366	$274,500	$274, 500

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Theodore Folkerth, Frederick Howden, and Paul Mazur as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $750 and a total cost for the term of $274,500.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2016
PHYSICIAN AGREEMENT for ED ON–CALL COVERAGE

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

Physicians Name: Julie Berry, MD; Hernan Goldsztein, MD; Robert Jacobs, MD; Marc Lebovits, MD; Ritvik Mehta, MD; Bruce Reisman, MD; Ashish Wadhwa, MD

Area of Service: ED On-Call: ENT

Term of Agreement: Twelve (12) months, Beginning 7/1/2015 - Ending 6/30/2016

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$450	FY2016: 366	$164,700	$164,700

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Julie Berry, Hernan Goldsztein, Robert Jacobs, Marc Lebovits, Ritvik Mehta, Bruce Reisman and Ashish Wadhwa as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $450 and a total cost for the term of $164,700.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2016
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physicians Name: Michael Burke, MD; Brian Goelitz, MD; Justin Gooding, MD; Michael Noud, MD; Donald Ponec, MD; Richard Saxon, MD

Area of Service: ED On-Call: Interventional Radiology

Term of Agreement: Twelve (12) months, Beginning 7/1/2015 - Ending 6/30/2016

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$600	FY2016: 366	$219,600	$219, 600

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Michael Burke, Brian Goelitz, Justin Gooding, Michael Noud, Donald Ponec and Richard Saxon as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $600 and a total cost for the term of $219,600.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physicians Names: Lesley Aguilar Tabora, MD; Andrew Blumenfeld, MD; Benjamin Frishberg, MD; Michael Lobatz, MD; Amy Nielsen,DO; Irene Oh, MD; Remia Paduga, MD; Jay Rosenberg, MD; Mark Sadoff, MD; Gregory Sahagian, MD; Jack Schim, MD; Anchi Wang, MD; Michael Zupancic, MD

Area of Service: ED On-Call: Neurology

Term of Agreement: Twelve (12) months Beginning 7/1/2015 Ending 6/30/2016

Within Hourly and/or Annualized Fair Market Value: YES
Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$500	FY2016: 366	$183,000	$183,000

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the above Neurology physicians as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $500 and a total cost for the term of $183,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physicians Name: Thomas Nowak, MD

Area of Service: ED On-Call: Neurosurgery

Term of Agreement: Twelve (12) months, Beginning 7/1/2015 - Ending 6/30/2016

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$800	FY2016: 366	$292,800	$292,800

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Thomas Nowak as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $800 and a total cost for the term of $292,800.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physicians Name: Tyrone Hardy, MD; Thomas Marcisz, MD; Mark Stern, MD; Frank Kevin Yoo, MD

Area of Service: ED On-Call: Neurosurgery and Spine

Term of Agreement: Twelve (12) months, Beginning 7/1/2015 - Ending 6/30/2016

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
Neurosurgery $800	FY2016: 366	$292,800	$292,800
Spine $400	FY2016: 366	$146,400	$146,400

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Tyrone Hardy, Thomas Marcisz, Mark Stern & Frank Kevin Yoo as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $800 (Neurosurgery)/$400 (Spine) and a total cost for the term of $292,800/$146,400.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physicians Name: John Bennett, MD; Rahele Mazarei, DO; Chunjai Clarkson, MD; Orna Gil, MD; Christos Karanikkis, DO; Sandra Lopez, MD; Talal Muhtaseb, MD

Area of Service: ED On-Call: OB/GYN

Term of Agreement: Twelve (12) months, Beginning 7/1/2015 - Ending 6/30/2016

Within Hourly and/or Annualized Fair Market Value: YES
Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
Weekday $800	FY2016: 255	$204,000	$204,000
Weekends/Holidays $1000	FY2016: 111	$111,000	$111,000
OB/Assist $145/case	FY2016	$2,175	$2,175

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the above OB/GYN physicians as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $800 weekday; $1000 weekend/holiday; $145/case and a total cost for the term of $317,175.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physicians Name: Brian Mudd, DDS

Area of Service: ED On-Call: Oral/Max Surgery

Term of Agreement: Twelve (12) months, Beginning 7/1/2015 - Ending 6/30/2016

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$350	FY2016: 366	$128,100	$128,100

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Brian Mudd as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $350 and a total cost for the term of $128,100.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physicians Name: Christian Bentley, MD; Andrew Cooperman, MD; David Daugherty, MD; Andrew Hartman, MD; Harish Hosalkar, MD; Serge Kaska, MD;

Area of Service: ED On-Call: Orthopedic Surgery

Term of Agreement: Twelve (12) months, Beginning 7/1/15 - Ending 6/30/16

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$1,400	FY2016: 366	$512,400	$512,400

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Christian Bentley, MD; Andrew Cooperman, MD; David Daugherty, MD; Andrew Hartman, MD; Harish Hosalkar, MD, Serge Kaska, MD as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $1,400 and a total cost for the term of $512,400.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physicians Name: David Amory, MD; Janet Dunlap, MD; Payam Moazzaz, MD

Area of Service: ED On-Call: Orthopedic Surgery and Spine

Term of Agreement: Twelve (12) months, Beginning 7/1/15 - Ending 6/30/16

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
Ortho $1,400	FY2016: 366	$512,400	$512,400
Spine $400	FY2016: 366	$146,400	$146,400

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize David Amory, MD; Janet Dunlap, MD; Payam Moazzaz, MD, MD as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $1,400(Orthopedic)/$400(Spine) and a total cost for the term of $512,400/$146,400.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physicians Name: Neville Alleyne, MD

Area of Service: ED On-Call: Spine

Term of Agreement: Twelve (12) months, Beginning 7/1/15 - Ending 6/30/16

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$400	FY2016: 366	$146,400	$146,400

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Neville Alleyne as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $400 and a total cost for the term of $146,400.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physicians Name: Lokesh Tantuwaya, MD

Area of Service: ED On-Call: Spine

Term of Agreement: Twelve (12) months, Beginning 7/1/15 - Ending 6/30/16

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$400	FY2016: 366	$146,400	$146,400

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Lokesh Tantuwaya as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $400 and a total cost for the term of $146,400.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physicians Name: Caroline Colangelo, MD; Bradley Frasier, MD; Michael Guerena, MD; Arthur Warshawsky, MD

Area of Service: ED On-Call: Urology

Term of Agreement: Twelve (12) months, Beginning 7/1/15 - Ending 6/30/16

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$350	FY2016: 366	$128,100	$128,100

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Caroline Colangelo; Bradley Frasier; Michael Guerena; Arthur Warshawsky as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $350 and a total cost for the term of $128,100.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physicians Name: Andrew Deemer, MD; Mohammad Jamshidi-Nezhad, DO

Area of Service: ED On-Call: Vascular

Term of Agreement: Twelve (12) months, Beginning 7/1/15 - Ending 6/30/16

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$500	FY2016: 366	$183,000	$183,000

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, COO/EVP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Andrew Deemer; Mohammad Nezhad-Jamshidi, DO as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $500 and a total cost for the term of $183,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physicians Names: James Davies, MD; Bradley Greider, MD; Atul Jain, MD; Srinivas Iyengar, MD; Peter Krall, MD; Sally Mellgren, MD; Robert Pendleton, MD; Mark Smith, MD; Christopher Spellman, MD; Maulik Zaveri, MD

Area of Service: ED On-Call: Ophthalmology

Term of Agreement: 12 months, Beginning July 1, 2015 - Ending June 30, 2016

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals: For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$300	FY2016: 366	$109,800	$109,800

Position Responsibilities:

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

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Sherry Miller, MSS Manager/Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. James Davies; Bradley Greider; Atul Jain; Srinivas Iyengar; Peter Krall; Sally Mellgren; Robert Pendleton; Mark Smith; Christopher Spellman; Maulik Zaveri as ED On-Call Coverage Physicians for a term of 12 months beginning 7/1/2015 and ending 6/30/2016. Not to exceed a daily rate of $300 and a total cost for the term of $109,800.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for ED ON-CALL PSYCHIATRY COVERAGE

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

Physicians Name: Venugopal Depala, M.D.

Area of Service: ED On-Call - Psychiatry

Term of Agreement: 13 months, Beginning 6/16/2015 - Ending 6/30/2016

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire ED On-Call Area of Service coverage

Rate/Day	Days per Year	Annual Cost	13 month (Term) Cost
$1,000	FY2016: 366	$366,000	$366,000
$1,000	FY2015: 14	$14,000	$14,000
		TOTAL:	$380,000

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Sherry Miller, MSS Manager / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Venugopal Dapala, M.D. as ED On-Call Coverage Physician for a term of 13 months beginning 6/16/2015 and ending 6/30/2016. Not to exceed a daily rate of $1,000 and a total cost for the term of

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for Cardiac Rehabilitation Medical Director/Physician Supervision

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

Physicians Name: Karim H. El-Sherief, M.D.

Area of Service: **Cardiac Rehabilitation Services,** On-Site and Wellness Center

Term of Agreement: 24 months, Beginning July 1, 2015 - Ending June 30, 2017

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	24 month (Term) Cost
$185.50	44	528	$8,162	$97,944	$195,888

Position Responsibilities:

- Cardiac rehabilitation program Medical Director
- Maintain TCMC's main-campus cardiac rehabilitation program as the physician directed clinic.
- Providing medical supervision of patients receiving services in the Department, and clinical consultation for the Department as requested by attending physicians including, without limitation, daily review and monitoring of patients receiving services in or through the Department.
- Ensuring that all medical and therapy services provided by the Department, Program or Service are consistent with Hospital's mission and vision.
- Supervising the preparation and maintenance of medical records for each patient receiving services in or through the Department.
- Evaluation of all Phase 2 patients enrolled in the Cardiac Rehabilitation Program and ongoing supervision and evaluation of monitored exercise sessions.
- Attend meetings with Hospital administration, Hospital's medical staff as required by Hospital and/or Dept
- Participate in and otherwise cooperate with continuing education and in-service training of Department Personnel and others working in Department.
- Assure that adequate medical coverage is provided for Cardiac Rehabilitation clinical services activities performed within Department during hours of operation.

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Steve Young, Sr. Director Ancillary Services

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Karim El-Sherief as the Medical Director of Cardiac Rehabilitation for a term of 24 months beginning July 1, 2015 ending June 30, 2017. Not to exceed an average of 44 hours per month or 528 hours annually, at an hourly rate of $185.50 for an annual cost of $97,944 and a total term cost not to exceed $195,888.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for Cardiac Rehabilitation Physician Supervision

Type of Agreement		Medical Directors		Panel	X	Supervising Physician
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Physicians Name: Sharon M. Slowik, M.D.

Area of Service: Cardiac Rehabilitation Services, On-Site and Wellness Center

Term of Agreement: 24 months, Beginning July 1, 2015 - Ending June 30, 2017

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	24 month (Term) Cost
$148.30	39	468	$5,784	$69,404	$138,809

Position Responsibilities:

- Cardiac rehabilitation Supervising Physician.
- Maintain cardiac rehabilitation program as a physician directed clinic.
- Providing medical supervision of patients receiving services in the Department, and clinical consultation for the Department as requested by attending physicians including, without limitation, daily review and monitoring of patients receiving services in or through the Department.
- Ensuring that all medical and therapy services provided by the Department, Program or Service are consistent with Hospital's mission and vision.
- Supervising the preparation and maintenance of medical records for each patient receiving services in or through the Department.
- Evaluation of all Phase 2 patients enrolled in the Cardiac Rehabilitation Program and ongoing supervision and evaluation of monitored exercise sessions.
- Attend meetings with Hospital administration, Hospital's medical staff as required by Hospital and/or Dept
- Participate in and otherwise cooperate with continuing education and in-service training of Department Personnel and others working in Department.
- Assure that adequate medical coverage is provided for Cardiac Rehabilitation clinical services activities performed within Department during hours of operation.

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Steve Young, Sr. Director Ancillary Services

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Sharon M. Slowik as the alternate Supervising Physician of the Cardiac Rehabilitation program for a term of 24 months beginning July 1, 2015 ending June 30, 2017. Not to exceed an average of 39 hours per month or 468 hours annually, at an hourly rate of $148.30 for an annual cost of $69,404 and a total term cost not to exceed $139,809.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
Radiological Services Supervision and Medical Director Contract
San Diego Diagnostic Radiology Medical Group, Inc.

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

Vendor Name: San Diego Diagnostic Radiology Medical Group, Inc.
Area of Service: Radiology Services
Term of Agreement: 36 months, Beginning July 1, 2015 – Ending June 30, 2018

Maximum Totals:

Description	Unit Cost (monthly)	One-Time Fee	Total Cost + Tax
Radiology Medical Director	$0.0	$0.0	$0.0
Radiology Services Supervision	$0.0	$0.0	$0.0

Description of Services/Supplies:

- Provide Medical Director Supervision and overall responsibility for radiological services.
- Provide 24/7 physician coverage for diagnostic radiological supervision and radiology procedural support.
- Provide 24/7 consultation services to assure high quality services.
- Provide written diagnostic results for all radiological procedures performed per regulatory requirements.
- Provide strategic planning consultation to ensure the District is current with healthcare technological trends.

Board Approved Physician Contract Template	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

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

Motion:

I move that Finance, Operations and Planning Committee recommend TCHD Board of Directors authorize the agreement with San Diego Medical Group to provide radiological services supervision and medical directorship coverage for a term of 3-years beginning July 1, 2015 through June 30, 2018. No fees are associated with the agreement other than facility space and business supply needs for physician operations.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for Medical Director of Acute Rehabilitation Unit

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

Physicians Name: Mark Sadoff, M.D.

Area of Service: Acute Rehabilitation Unit

Term of Agreement: 12 months, Beginning July 1, 2015 - Ending June 30, 2016

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$165	80	960	$13,200	$158,400	$158,400

Position Responsibilities:

- Provide professional guidance and oversight for 10-bed Rehabilitation Unit on 1 South.
- Oversee all patient admissions.
- Assume Physician oversight and 24/7 coverage.
- Participate in patient/family/team conferences.
- Provide patient and staff education.
- Facilitate liaison activities with peer physicians.
- Oversee regulatory compliance including documentation and coding, Utilization Review/ Quality Assurance of the Center and Outpatient Rehabilitation Services.

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Kapua Conley, Chief Operating Officer

Motion:

I move the Finance, Operations, and Planning Committee recommend the TCHD Board of Directors appoint Dr. Mark Sadoff as the Medical Director for the Acute Rehabilitation Unit, for a term of 12 months beginning July 1, 2015 and ending June 30, 2016, not to exceed an average of 80 hours per month or 960 hours annually, at an hourly rate of $165 for an annual cost of $ 158,400, and a total cost for the term of $158,400.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN PANEL AGREEMENT for ADULT INTENSIVE CARE UNIT

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

Physician's Names: Frank Corona, M.D., Martin M. Nielsen, M.D., Mark Yamanaka, M.D., Safouh Malhis, M.D.

Area of Service: ICU Coverage Panel/ED Pulmonary On-Call Coverage Panel

Term of Agreement: 24 months, Beginning July 1, 2015 - June 30, 2017

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

Rate/Day	Days Per Year	Annual Cost	24 Month (Term) Cost
$1,500	FY 2016: 366 FY 2017: 365	FY 2016: $549,000 FY 2017: $547,500	$1,096,500

Position Responsibilities: See attached Exhibit A - PANEL PHYSICIAN DUTIES AND SERVICES

- At the recommendation of TCHD's Board of Directors this Agreement combines ED Pulmonary On Call Coverage and the ICU Coverage Panel; previous rate at $1,450/day; new rate is: $1,500/day

Board Approved Physician Contract Template:		Yes	X	No
Agreement Reviewed by Legal Counsel:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Kapua Conley, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the ICU Coverage Panel/ED Pulmonary On-Call Coverage Panel Agreement with Drs. Corona, Nielsen, Yamanaka and Malhis for a term of 24 months, beginning July 1, 2015 and ending June 30, 2017. At a daily rate of $1,500 for an annual cost of $549,000 for FY 2016 and $547,500 for FY 2017; and total cost for the Term in the amount of $1,096,500.

EXHIBIT A

PANEL PHYSICIAN DUTIES AND SERVICES

ICU

1. Provide on-call and immediately available medical coverage within 30 minutes of call to the ICU, 24 hours per day, 7 days per week, 365 days per year.
2. Provide medically necessary care and treatment to indigent hospital patients requiring critical care services.
3. Promptly complete medical records, orders and documentation for all patients provided critical care services.
4. Complete monthly on-call calendar.
5. Promptly respond to nursing and administrative staff regarding necessary medical care provided to indigent patients in the ICU.
6. Provide consultations to attending physicians and Emergency Department physicians for patients who require or may require critical care services.

ED

1. Provide on-call and immediately available pulmonary medical coverage with response times set forth in Medical Staff Policy No. 8710-520 with a goal of less than thirty (30) minutes and shall never exceed sixty (60) minutes.
2. Perform preadmission and admission evaluations with the patient and patient's family, including stabilization as requested by ED or Covering Physician.
3. Write preadmission or administrative notes and orders on those patients examined.
4. Conduct medical rounds on those patients under physician's care as clinically appropriate.
5. 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.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for Chris Guerin, M.D.
Medical Director for Diabetes Program

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

Physicians Name: Chris Guerin, M.D.

Area of Service: Diabetes Program

Term of Agreement: 12 months, Beginning July 1, 2015 - Ending June 30, 2016

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

Rate/Hour	Hours per Month-Avg.	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$150/hr.	16	192	$2,400	$28,800	$28,800

Position Responsibilities:

- Provides program development, determination and achievement of financial and quality outcomes determined by the Service Line Team.
- Oversee clinical research and Medical Staff education pertinent to the Diabetic Services.
- Responsible for the strategic and tactical planning for the clinical program for Diabetes, in conjunction with the Administrative Director.
- Ensures that the service line initiatives support Tri-City Medical Center's strategic plan and promotes the continuum of care.
- Develop, implement and monitor the Diabetic quality planning, measurement, and improvement programs to assure continuous quality improvement in compliance with the standards established by the Joint Commission on the Accreditation of Health Care Organizations, and other appropriate accrediting and regulatory agencies. Makes recommendations to the PCCC and Joint Conference committee of the Board and determines appropriate clinical outcome indicators that support a high quality, competitive program.
- Assists with the development of clinical pathways and guidelines to reduce variance of practice and enhance efficiency of care.
- Assure the Diabetic Services program achieves approved financial objectives. Monitors and develops improvement strategies to improve the financial performance of the service line. Actively intervenes in costly variances in practice. Advises on contractual issues as needed.
- Establishes collaborative relationships with medical staff and hospital personnel to facilitate and support high quality and efficient patient care. Ensures that positive relationships are maintained with all members of the medical and clinical staff.

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sharon Schultz, CNE, Tim Moran, CEO, Kapua Conley, COO

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Chris Guerin as the Diabetes Program Medical Director, for a renewal term of 12 months beginning July 1, 2015 and ending June 30, 2016. Not to exceed an average of 16 hours per month or 192 hours annually, at an hourly rate of $150 per hour for an annual cost of $28,800, as the total for the term.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: JUNE 16, 2015
MEDICAL STAFF LEADERSHIP AGREEMENT for James Johnson, M.D.
Quality Assurance/Performance Improvement Committee Chair

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

Physicians Name: James Johnson, M.D.

Area of Service: Medical Staff Leadership – Quality Assurance

Performance Improvement Committee Chair

Term of Agreement: 12 months, Beginning July 1, 2015 - Ending June 30, 2016

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	Continuing Ed Expense (1 year)	12 month Cost
$185	30	360	$5,550	$66,600	$5,000	$71,600

Position Responsibilities:

- Report status of the quality assurance (QA)/Performance Improvement (PI) program, including credentialing, quality, risk management, and programmatic activities
- Accept responsibility and accountability for that portion of the overall QA/PI/ Patient Safety program developed by the Board of Directors and administration which is related to the Medical Staff
- Serve on committees including Medical Executive Committee, QA/PI/Patient Safety Committee, and Professional Affairs Committee of the Board
- Help establish systems to identify opportunities for improvement in patient care and patient safety (medical errors) and set priorities for action
- Analyze results of QA/PI safety activities to show measurable improvement in health outcomes, decreases in medical errors and to ensure sustained improvements
- Review medical errors and adverse patient events which will include reviewing any reportable events as defined by State or Federal regulation
- Act as a resource for physician comportment issues, Medical Staff Peer Review, and Quality of Care Issues

Board Approved Physician Agreement Template	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Chief Nursing Executive/Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. James Johnson as the Medical Staff Leadership Physician/Quality Assurance/Performance Improvement Committee Chair for a term of 12 months beginning July 1, 2015 and ending June 30, 2016; an average of 30 hours per month or 360 hours annually, at an hourly rate of $185 and $5,000 for educational expenses for a total cost of $71,600 for the 12 month term.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN CONSULTING AGREEMENT
Physician Liaison Disaster Management

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

Physicians Name: Chad Bernhardt, M.D.

Area of Service: Disaster Management Emergency Group Liaison

Term of Agreement: 12 months, Beginning July 1, 2015 - Ending June 30, 2016

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$150/hr.	3	36	$450	$5,400	$5,400

Position Responsibilities:

- Participate in the Environmental Health and Safety Group Meetings every other month
- Facilitate training for physicians regarding emergency preparedness
- Oversee and provide advice to the Hospital's Environmental Health and Safety Group
- Liaise with Hospital administrators and staff on issues relating to emergency and disaster plans
- Attend meetings of the County of San Diego Disaster Council as necessary
- Meet with surveyors and assist in regulatory and accreditation matters, as requested

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Bernhardt, as the Physician Liaison, Disaster Management for a term of 12 months beginning July 1, 2015 and ending June 30, 2016. Not to exceed an average of 3 hours per month or 36 hours annually, at an hourly rate of $150 per hour for an annual cost of $5,400, for a 12 month term.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
Medical Director Agreement, Home Health - John LaFata, M.D.

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

Physicians Name: John LaFata, M.D.

Area of Service: Home Health

Term of Agreement: 24 months, Beginning, July 1, 2015 - Ending, June 30, 2017

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	24 month (Term) Cost
$169/hr.	25	300	$4,225	$50,700	$101,400

Position Responsibilities:

- Monitors and assures the delivery of quality, efficient, medically needed, safe home health services.
- Assures accuracy of medical record charts for all (discipline) services.
- Provides professional guidance and oversight for Tri-City Home Health Services. Attends case conference and department meetings.
- Conducts in-service training on (discipline/home health) specific issues and/or topics for physicians and home health staff.
- Provides Primary physician coverage as required.

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive/Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. John LaFata as the Medical Director for Home Health for a term of 24 months beginning July 1, 2015 and ending June 30, 2017. Not to exceed an average of 25 hours per month or 300 hours annually, at an hourly rate of $ 169 for an annual cost of $50,700 and a total cost for the term of $101,400.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: JUNE 16, 2015
MEDICAL STAFF LEADERSHIP AGREEMENT
Professional Behavior Committee Chair

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

Physicians Name: Marcus Contardo, M.D.

Area of Service: Medical Staff – Professional Behavior Committee Chair

Term of Agreement: 12 months, Beginning July 1, 2015 - Ending June 30, 2016

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

Average Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
21.5 hours per month	Approx. 260	$5,000	$60,000	$60,000

Position Responsibilities:

- Perform the duties of Chair of the Professional Behavior Committee as set forth in the Tri-City Healthcare District Medical Staff Bylaws.
- Implement the Medical Staff Professional Behavior Policy #8710-57 (previously numbered 8710-511.1).

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Kapua Conley, Chief Operating Officer

Motion: I move that the Finance, Operations and Planning Committee recommend the TCHD Board of Directors approve the renewal of the Medical Staff Leadership Agreement for Chair of the Medical Staff Professional Behavior Committee, Marcus Contardo, M.D., for a term of 12 months beginning July 1, 2015 and ending on June 30, 2016. A monthly stipend of $5,000 per month; not to exceed a total of $60,000 per year, for the Term.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: JUNE 16, 2015
PHYSICIAN AGREEMENT FOR CHIEF OF STAFF
MEDICAL STAFF LEADERSHIP AGREEMENT, GENE MA, M.D.

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

Physicians Name: Gene Ma, M.D.

Area of Service: Chief of Staff, Medical Staff Leadership

Term of Agreement: Not to Exceed 24 months, July 1, 2015 through June 30, 2017

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

Est. Rate/Hour	Hours per Month	Hours per Year	Monthly Stipend (TCHD)	Annual Stipend (TCHD)	Education Expense (TCHD) for Term	Cost for 24 Month Term (TCHD)	Stipend Paid by Med Staff for Term
$160	40	480	$4,000.00	$48,000	$10,000	$106,000	$48,000

MED STAFF Stipend: $2,000 per month for a total of $24,000 Annually, or $48,000 for the Term may include part of the Education Expenses

Position Responsibilities:

- Perform the duties of Chief of Staff as set for the in the Tri-City Healthcare District Medical Staff Bylaws
- Attend meetings of the Board of Directors and such Board Committees as may be requested from time-to-time, including the Professional Affairs Committee.
- Liaise with Hospital Administration, including reporting on the status of activities of the Medical Staff.
- Attend Education training, including Greeley training regarding Credentialing and Peer Review

Board Approved Physician Contract Template	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Kapua Conley, Chief Operating Officer

Motion: I move that the Finance, Operations and Planning Committee recommend the TCHD Board of Directors approve the Medical Staff Leadership Agreement for Chief of Staff, Gene Ma, M.D., for a term concurrent with his appointment as Chief of Staff but no longer, of 24 months starting July 1, 2015 and ending on June 30, 2017, for a TCHD stipend of $4,000 per month, $48,000 annually and $96,000 for 24 months, plus an educational allowance up to $10,000 for a total not to exceed $106,000 for the Term, paid by TCHD.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: JUNE 16, 2015
PHYSICIAN AGREEMENT for COASTAL HOSPITALIST MEDICAL ASSOCIATES, INC.
HOSPITALIST SERVICES AND COVERAGE AGREEMENT

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

Physicians Name: Coastal Hospitalists Medical Associates, Inc.

Area of Service: On-Site Coverage to Unassigned Patients

New Agreement Term: 24 Months – Beg. July 1, 2015 through June 30, 2017

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

Monthly Cost	Annual Cost Not to Exceed	Total NTE for 24 Month Term
$148,500	$1,782,000	$3,564,000

New Agreement: This request shall create a new Hospitalist Services and On-Site Coverage Services Agreement. The new Agreement brings the Hospitalist program up to the 25% percentile of Fair Market Value. The annual cost includes a Monthly Stipend, Medical Directorship and Performance Incentives/Standards. These metrics include patient throughput and customer service for quality, coverage ratios, documentation and utilization review. The Lease for Coastal Hospitalist group shall be renewed in accordance with the existing Lease terms and conditions.

Position Responsibilities/Scope: Coastal Hospitalists shall provide on-site coverage for all TCMC unassigned patients, as follows:

- Provide care for patients presenting through Emergency Department who require post-ED observation care and/or inpatient admission.
- Coverage by hospitalists will ensure that there are sufficient physicians available as needed for the coverage seven days per week, 24 hours per day, 365 days per year.
- Each physician who provides services shall be licensed and qualified to practice medicine in CA and be a member of TCHD's Medical Staff

Legal Approved Physician Contract	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Kapua Conley, COO/Sharon Schultz, CNE

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors approve the new Hospitalist Services and On-Site Coverage Services Agreement beginning July 1, 2015 and ending June 30, 2017 at a monthly rate of $148,500 per month; annual cost of $1,782,000 and total for the Term in the amount of $3,564,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for Medical Director, Pulmonary Services

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

Physician's Name: Frank Corona, MD
Area of Service: Pulmonary Services
Term of Agreement: 24 months, Beginning July 1, 2015 - Ending June 30, 2017

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	24 month (Term) Cost
$175/hr.	10	120	$1,750	$21,000	$42,000

Position Responsibilities: (As required by: Title 22 Regulation, Article 70619/CMS CoPS, Article 482.57)

- Meets directly with service line leadership at scheduled times to review and approve current or proposed departmental clinical/operational policies, procedures and protocols governing respiratory care practice.
- Meets directly with service line leadership at scheduled times to review and approve the provision and status of the provision of patient education and training.
- Meets directly with service line leadership at scheduled times to monitor the status of service lines established Performance Improvement initiatives.
- Provides in service education and training to service line clinical staff as requested by service line leadership on current or proposed policies, procedures or protocols.
- Serves as an active member at scheduled meetings for the TCMC Pulmonary Division Committee.
- Participates in the recruitment of key departmental clinical and leadership positions as requested by departmental leadership.

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive; Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Frank Corona, as the Coverage Physician for Pulmonary Services for a term of 24 months beginning July 1, 2015 and ending June 30, 2017. Not to exceed an average of 10 hours per month or 120 hours annually, at an hourly rate of $175 for an annual cost of $21,000 and a total cost for the term of $42,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for Medical Director, Intensive Care Unit (ICU)

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

Physician's Name: Mark Yamanaka, M.D.

Area of Service: Intensive Care Unit (ICU)

Term of Agreement: 12 months, Beginning July 1, 2015 – June 30, 2016

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$ 175/hr.	10	120	$ 1,750	$21,000	$21,000

Position Responsibilities:

- Provides clinical documentation
- Utilization review of program
- Evaluates and establishes policies and procedures and protocols for ICU
- Recommending, developing and implementing new services
- Facilitates effective communication
- Assists with interviewing new staff
- Assists in public education
- Attends Hospital meetings as requested

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Mark Yamanaka as the sole Medical Director for the Intensive Care Unit, for a term of 12 months beginning July 1, 2015, and ending June 30, 2016. Not to exceed an average of 10 hours per month or 120 hours annually, at an hourly rate of $175 for an annual cost of $21,000, and a total cost for the term of $21,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PROPOSAL FOR: Shared Marketing Agreement with North County Internal Medicine

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

Vendor Name: North County Internal Medicine

Area of Service: Marketing

Term of Agreement: 12 months, Beginning, July 1, 2015 - Ending, June 30, 2016

Maximum Totals:

Monthly Cost	Annual Cost for TCMC	Total Term Cost for TCMC
N/A	$4,000	$4,000

Description of Services/Supplies:

- Shared Marketing agreement, $8,000/yr. combined maximum(TCMC $4,000 & NCIM $4,000)
- Each entity committing a maximum of $4,000 per term of 1 year contract
- Each entity will be billed and pay any advertising vendor independently
- All ads will be mutually signed off on by each entity

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

Person responsible for oversight of agreement: David Bennett, Sr. VP/CMO

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with North County Internal Medicine for a cost to TCMC of a maximum of $4,000 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016 for an annual cost of $4,000, and a total cost for the term of $4,000.

6.z.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PROPOSAL FOR: Commercial Insurance

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

Vendor Name: BB&T Insurance Services (BB&T)

Area of Service: Commercial Insurance Policies

Term of Agreement: Policy period commencing July 1, 2015

Description of Services/Supplies:

- Policy coverage for TCHD's general and process excess liability program, automobile coverage, property coverage, management liability program and privacy/cyber liability program.

Coverage	Company	AM Best Rating	2014 Expiring Premium	2015 Renewal Premium	% Change
Umbrella (GL/PL $20,000,000 with $1,000,000 SIR)	CAP/Pro Assurance	A+ (Superior) XII	$619,200	*$694,553 Inc. Clms. Handling	▲12%
Auto	Philadelphia	A++ (Superior) XV	$62,805	$62,531	0%
Property	Travelers	A++ (Superior) XV	$163,980	**$216,660	▲32%
Cyber	Markel	A (Excellent) XIV	$43,686	$48,179	▲10%
Directors & Officers / Employment Practices / Fiduciary Liability					
Tri-City Healthcare	AIG	A (Excellent) XV	$182,396	$201,758	▲11%
Cardiovascular Institute	AIG	A (Excellent) XV	$5,252	$5,353	▲ 2%
Orthopedic Institute	AIG	A (Excellent) XV	$5,252	$5,353	▲ 2%
Neuro Institute	AIG	A (Excellent) XV	N/A	$5,376	
Crime – 3 Year Term; Billed Annually	Fidelity & Deposit Companies (Zurich)	A+ (Superior) XV	$13,938	$12,458	▼11%
Pollution – 2 Year Term Billed Annually	Steadfast Insurance	A+ (Superior) XV	$19,393	$19,391	0%
Student Accident	Axis	A+ u (Superior) XV	$3,301	$2,170	▼34%
			$1,119,203	**$1,273,782**	▲ 14%

* Recommendation to change carriers to CAP/Pro Assurance including claims handling costs.

**Recommendation to increase total building values based on an increase in square footage of Loc.#1 to show $450/Sq. Ft.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PROPOSAL FOR: Commercial Insurance

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

Person responsible for oversight of agreement: Steve Dietlin, Chief Financial Officer; Sharon Schultz, Chief Nurse Executive; Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the acceptance, placement and financing of the commercial insurance products recommended by BB&T for the policy period commencing July 1, 2015 for an annual premium of $1,273,782.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 16, 2015
PHYSICIAN AGREEMENT for ACO Physician Consulting Agreements

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

Physicians Name: Terry A. Haas, MD; John A. LaFata, MD; Jeffrey O. Leach, MD
Area of Service: North Coast Medical Accountable Care Organization, Inc.
Term of Agreement: 12 months, Beginning July 1, 2015 – Ending June 30, 2016

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$175/hr.	NTE - 15 per physician	NTE - 180 per physician	NTE $2,625 per physician	NTE $31,500 per physician	Maximum Cost $94,500

This proposal is to extend the agreements with three PCPs (Terry A. Haas, MD; John A. LaFata, MD; and Jeffrey O. Leach, MD) to continue their roles as consultants in the ongoing management of TCHD's ACO. Following are the three areas of unique responsibilities:

Position Responsibilities:

- Development and management of Clinical and Quality Assurance Protocols;
- Development and management of Information Technology and Data Sharing Protocols;
- Development and management of Compensation, Shared Savings Distribution Protocols, and Recruitment Strategies.
- Attendance at ACO Board of Directors meetings; ACO BOD meetings are typically held 4-6 times a year; approximate meeting duration is 2 hours.

Board Approved Physician Contract Template:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Wayne Knight, Sr. VP of Medical Services

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Terry A. Haas, MD; John A. LaFata, MD; and Jeffrey O. Leach, MD; as Physician Consultants to North Coast Medical ACO, Inc., for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016, for an annual and total cost for the term of $94,500.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
June 18, 2015

Members Present: Chairman, Director Jim Dagostino, Director Ramona Finnila, Director Laura Mitchell, Dr. Frank Corona, Dr. James Johnson, Dr. Scott Worman and Dr. Marcus Contardo.

Non-Voting Members Present: Tim Moran, CEO, Kapua Conley, COO/ Exec. VP and Sharon Schultz, CNE/Sr. VP.

Others present: Jody Root, General Counsel, Marcia Cavanaugh, Director of Risk Mgt. and Quality, Jami Piearson, Director of Quality and Regulatory, Patricia Guerra, Sherry Miller, Rick Sanchez, Kathy Topp, Chris Micheowski, Rudy Gastelum, Jeff Surowiec, and Karren Hertz.

Members absent: None.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Dagostino, called the meeting to order at 12:06 p.m. in Assembly Room 1.		Director Dagostino
2. Approval of Agenda	The group reviewed the agenda and there were no additions or modifications.	Motion to approve the agenda was made by Director Finnila and seconded by Director Mitchell.	Director Dagostino
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 Dagostino

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of May 2015.	Director Dagostino called for a motion to approve the minutes of the May 21, 2015. There was a one minor correction on the name of the legal counsel on the 1st page of the minutes.	Minutes ratified. Director Finnila moved and Dr. Worman seconded the motion to approve the minutes from May 2015. Karren Hertz to make the necessary correction.	Karren Hertz
5. New Business a. Quality Outcomes Dashboard	The committee reviewed the dashboard for Core Measures data. It was noted that there is a spike on the rate of falls for the month of January. This is due to the closure of the SAFE units in order to meet productivity targets. This issue will be revisited if the rate does not change after a considerable amount of time. Sharon briefly explained the HAPU scores. The orange sheet which serves as a prompter in the ED was taken away; which is why the scores were up a little bit for April. Managers were informed about this and an improvement process was put into place this week.	Informational.	Sharon Schultz
b. Formulary Evaluation	The medication Sprycel was briefly discussed. Andrea Hanson mentioned that this is considered a preferred therapy for newly-diagnosed Philadelphia chromosome-positive chronic myeloid leukemia.	**ACTION:** Director Mitchell moved and Dr. Corona seconded the motion to approve this formulary.	Andrea Hanson

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. HIV Testing: In an Occupational Exposure 385 2. Meals, Patients- Times, Menus, Substitutions and Nourishment Policy 3. Nutritional Screening Care & Assessment for Infants, Pediatrics & Adolescents Policy 4. Physician's Admission Responsibilities Policy	*Jody Root made a clarification on the definition of LIP as discussed in last month's meeting. LIP (Licensed independent practitioners) belong to the medical staff and they are physicians who have been granted medical privileges. Allied Health Professionals and advanced practice nurses are credentialed but they are not considered independent and distinct from the physicians in the hospital. This policy is stated to be consistent with the compliance rules. Director Finnila made a recommendation to add a clause to the statement that a patient can obtain food in the cafeteria but it should be "appropriate to the patient's diet". There was also a suggestion to add information on early breakfast trays for this policy. Director Mitchell proposed to add the specific birth weight (e.g. how many lbs.) for the description of the low birth weight. There was a minor editorial correction and also, Dr. Johnson made a recommendation to add the MEC date for the revision dates on the cover page of each policy for proper	*The Patient Care Services policies and procedures were approved with the exception of some minor edits. Dr. Worman moved and Dr. Johnson seconded the motion to approve these policies.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	tracking.		
5. Swallow Screening in the Adult Patient Procedure	It was identified that this policy is just a screening and not a swallow evaluation.		
6. Use of Unapproved Abbreviations 367	There was no discussion made on this policy.		
Emergency Operations Procedures Manual (formerly Disaster Manual)			
Section 1: General Information 1. Emergency Operations Plan	Dr. Johnson clarified the function of the House Supervisor/ Admin Supervisor. The emergency credentialing was also narrowed down to be more of a medical staff process and not really nursing staff. Director Finnila made a recommendation that Board Members need to be involved and included in the Disaster plan of the hospital. It was noted that a pre-set and fluid operations process can be expected during a disaster depending on the nature and location of the disaster. Jeff from Facilities also added that MOUs with churches and schools are set up in such cases.	**ACTION:** Section 1 policies were approved and are moving forward for Board approval. Director Finnila moved and Dr. Corona seconded the motion. **ACTION:** Further discussion is needed for this process to be in place. The Board members will be included in the call tree as well as part of the operations plan during a disaster.	Patricia Guerra Administration
2. Location of Disaster Work Stations	Red phones are in place and were just recently checked.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
3. Personnel Expectations	References should be checked and updated for this policy.		
4. Purpose and Authority 5. Scalable Event 6. Scope of Response	The amount of resources are every important during a disaster and also, Director Dagostino emphasized that the Safety Officer is different from the Incident Commander during a disaster.		
Section 2: Resource Management and Preparation	.		
1. Damage Assessment	The services should be alphabetized in the statement regarding disruption of essential services. It was also stressed that the hospital generator is good for 48 hours as we have fuel on site.	*The Section 2 policies were approved and is going forward for Board approval as moved by Dr. Worman and seconded by Director Mitchell.	Patricia Guerra
2. Disruption of Services	Kapua mentioned that the hospital has an agreement with Aramark on lending out equipment if needed from facilities along the Coast in the event of a disaster.		
Section 3: Special Circumstances			
1. Bio-Terrorism Infection Control	Dr. Contardo pulled out this policy for at least a month as there needs to be some work and preparation done for the Anthrax practice sessions. It was mentioned that he needs to change and consolidate with Infection Control and Facilities regarding the processes involved in this policy.	**ACTION**: This policy is being pulled out further review and modifications. *The Section 3 policies were approved with the exception of the bio-terrorism policy and are going forward for Board approval as moved by Dr. Contardo and	Patricia Guerra
2. Drought Conditions	An in-depth discussion was held on the		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	hospital's stand for the water reduction programs implemented by the city. It was agreed that patient care needs come first and the policy will be amended to reflect such.	seconded by Director Mitchell.	
3. Response to Wild Fires	It was clarified that there is a disaster plan in place for wild fires.		
Section 6: Response and Assignment of Personnel			
1. Authorization for Volunteer Caregivers	Sharon mentioned that we have a process in place for this authorization.	*The Section 6 and 7 policies were approved and are moving forward for Board approval as moved by Dr. Worman and seconded by Director Mitchell.	Patricia Guerra
2. Medical Staff Assignments	There was no discussion on this policy.		
Section 7: Patient Management			
1. Victim Tracking	There was a recommendation to add the METTAG as an attachment to this policy.	**ACTION:** The METTAG will be added to this policy.	Patricia Guerra
<u>Environment of Care Manual</u>			
Section 1: Safety Management 1. Safety Plan 1000	As these policies were newly formulated and replaced the old versions, there were no further discussions made.	*The Environment of Care Manual polices were approved approved and is moving forward for Board approval as moved Director Mitchell and seconded by Dr. Corona.	Patricia Guerra
Section 2: Security Management 1. Security Management- 2000			
Section 3: Life Safety Management 1. Life Safety Management Plan- 3000			

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Section 4: Equipment Management 1. Medical Equipment Management Plan 5000			
7. Closed Session	Director Dagostino asked for a motion to go into Closed Session.	Director Finnila moved, Dr. Johnson seconded and it was unanimously approved to go into closed session at 1:00 PM.	Director Dagostino
8. Return to Open Session	The Committee return to Open Session at 2:20 PM.		Director Dagostino
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Dagostino
10. Comments from Members of the Committee	No Comments.		Director Dagostino
11. Adjournment	Meeting adjourned at 2:25 PM		Director Dagostino

PROFESSIONAL AFFAIRS COMMITTEE
June 18th, 2015

CONTACT: Sharon Schultz, CNE

Patient Care Services Policies & Procedures		
1. HIV Testing: In An Occupational Exposure 385	3 year review	Forward to BOD for approval
2. Meals, Patients - Times, Menus, Substitutions, & Nourishments Policy	3 year review	Forward to BOD for approval with revisions
3. Nutritional Screening Care & Assessment for Infants, Pediatrics & Adolescents Policy	3 year review	Forward to BOD for approval with revisions
4. Physician's Admission Responsibilities Policy	3 year review	Forward to BOD for approval with revisions
5. Swallow Screening in the Adult Patient Procedure	3 year review	Forward to BOD for approval
6. Use of Unapproved Abbreviations 367	3 year review, practice change	Forward to BOD for approval
Emergency Operations Procedures Manual (formerly Disaster Manual)		
Section 1 – General Information		
1. Emergency Operations Plan	New – places Disaster 4000 and 4001	Forward to BOD for approval
2. Location of Disaster Work Stations	Disaster 4003 - revised	Forward to BOD for approval
3. Personnel Expectations	New	Forward to BOD for approval
4. Purpose and Authority (HICS)	New	Forward to BOD for approval
5. Scalable Event	New	Forward to BOD for approval
6. Scope of Response	New	Forward to BOD for approval
Section 2 – Resource Management and Preparation		
1. Damage Assessment	New	Forward to BOD for approval with revisions
2. Disruption of Services	New	Forward to BOD for approval
Section 3 – Special Circumstances		
1. Bio-Terrorism Infection Control	New	Pulled for further review
2. Drought Conditions	New	Forward to BOD for approval with revisions
3. Response to Wild Fires	New	Forward to BOD for approval
Section 6 – Response and Assignment of Personnel		
1. Authorization for Volunteer Caregivers	New	Forward to BOD for approval
2. Medical Staff Assignments	New	Forward to BOD for approval
Section 7- Patient Management		
1. Victim Tracking	New	Forward to BOD for approval with revisions

PROFESSIONAL AFFAIRS COMMITTEE
June 18th, 2015

CONTACT: Sharon Schultz, CNE

Environment of Care Manual		
Section 1- Safety Management		
1. Safety Plan - 1000	New – replaces current EOC 1000	Forward to BOD for approval
Section 2 - Security Management		
1. Security Management Plan - 2000	New – replaces current EOC 2000	Forward to BOD for approval
Section 3 – Life Safety Management		
1. Life Safety Management Plan - 3000	New – replaces current EOC 3000	Forward to BOD for approval
Section 5 – Equipment Management		
1. Medical Equipment Management Plan - 5000	New – replaces current EOC 5000	Forward to BOD for approval
Formulary Request		
Dasatinib (Sprycel)		

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES ~~Administrative Policy Manual~~

ISSUE DATE: 04/89

SUBJECT: HIV TESTING: IN AN OCCUPATIONAL EXPOSURE

REVISION DATE: 3/97; 3/00; 5/03; 11/06; 8/10

POLICY NUMBER: 8610-385

Clinical~~Administrative~~ Policies & Procedures Committee Approval:	**~~08/10~~01/15**
Nurse Executive ~~Operations Team~~ Committee Approval:	**~~08/10~~02/15**
Infection Control Committee Approval:	**04/15**
Medical Executive Committee Approval:	**06/15**
Professional Affairs Committee Approval:	**~~09/10~~06/15**
Board of Directors Approval:	**09/10**

A. **PURPOSE:**

1. To provide a mechanism for HIV testing in the event of an occupational exposure.

B. **DEFINITIONS:**

1. Disclosure - includes all releases, transmissions, disseminations or communications whether they are made orally, in writing or by electronic transmission [Health & Safety Code Sections 120980(k)].
2. Exposed individual - any individual health care provider, first responder, or any other person (including any employee, volunteer, or contracted agent of any provider) who is exposed, within the scope of his or her employment, to the blood or other potentially infectious materials of a source patient.
3. First responder - police, firefighters, rescue personnel, and any other person who provides emergency response, first aid care, or other medically related assistance, either in the course of the person's occupational duties or as a volunteer.
4. Health care provider - include the following persons and entities:
   a. Licensed and certified health personnel, including physicians, nurses and other health personnel who work in hospitals, clinics, health dispensaries and facilities. Employees, volunteers or contracted agents of Knox-Keene health care service plans. Professional students of any of the above.
5. HIV test - any clinical test, laboratory or otherwise, used to identify HIV, a component of HIV, or antibodies or antigens to HIV [Health & Safety Code Section 120775].
6. Informed Consent - nature of the procedure; the risk, complications and expected benefits or effects of the procedure; any alternatives to the treatment their risks and benefits.
7. Significant exposure - direct contact with the blood or other potentially infectious materials in a manner that according to the CAL-OSHA guidelines is capable of transmitting HIV.
8. Attending physician of the source patient - any physician who provides health care services to the source patient and includes any of the following:
   a. The private physician of the source patient.
   b. The physician primarily responsible for the patient who is undergoing inpatient treatment in a hospital.
9. Attending physician's designee - a registered nurse or licensed nurse practitioner that has been designated by the attending physician of the source patient.
10. Available blood or patient sample - blood or other tissue or material that was legally obtained in the course of providing health care services and is in the possession of the physician or other health care provider of the source patient prior to the exposure incident.
11. Certifying physician - any physician consulted by the exposed individual for the exposure incident. A certifying physician must have demonstrated competency and understanding of the applicable guidelines or standards of the Division of Occupational Safety and Health (CAL-OSHA). The law does not specify how this competency may be demonstrated.

C. **POLICY:**

1. California law [Health and Safety Code Sections 120260-120263] provides a narrow exposure notification and information mechanism to permit health care personnel and other first responders who have experienced a significant exposure to a patient's blood or other potentially infectious materials, to learn of the patient's HIV status. The exposed individual may have a source patient's blood~~;~~, tissue or other material tested for HIV even though the patient refuses to be tested. **The testing may be done** provided the blood, tissue or other material was obtained prior to the exposure. [See Administrative Policy #530 regarding Emergency Response Employees.]
2. A person who has experienced an exposure to potentially infectious materials while rendering occupational or health care related services must request, in writing, evaluation by a physician within 72 hours of the exposure to determine if the exposure was significant.
3. The physician must evaluate and certify the significant exposure, including the nature and extent, in writing within 72 hours of the request. Exposed individuals, including physicians may not certify their own exposures as significant
4. Regardless of the HIV status of the source person, the exposed individual will be given counseling regarding the transmission of HIV, the limitations of HIV testing, need for follow-up testing, and precautionary procedures to be followed. Tri-City Medical Center Employee Health Department will be responsible for the counseling of the exposed individual.
5. To establish baseline information, the exposed individual must be tested for HIV and the results of that test must be confirmed as negative before testing the source patient for HIV without the source patient's consent.
6. The certifying physician must provide certification that an exposure is significant to the source patient's attending physician. The certification must be in writing within 72 hours of certifying the exposure. The certifying physician must also request information on the HIV status of the source patient and the availability of blood or other patient sample.
7. **T**he source patient's attending physician must respond to the certifying physician's request for the information within three working days.
8. If the source patient is known to be HIV positive, the attending physician must attempt to obtain the source patient's consent to release this information to the exposed individuals.
   a. If the source patient refuses or cannot be contacted, an attending physician of the source patient may advise the exposed individual of the source patients HIV status as soon as possible after certification.
   b. Consent for release of information is not required where the exposed individual is a treating health care provider.
   c. The hospital will attempt to obtain consent from a legal representative of an incompetent or deceased patient, however if the legal representative refuses or cannot be contacted or if there is no legal representative, this law may authorize the hospital to disclose the HIV status if known. Where authorization to disclose HIV status is unclear, hospital legal counsel should be consulted.
9. If the source patient's HIV status is not known, and blood or other patient samples are available, and if the exposed individual has tested negative on a baseline HIV test, the source patient is given the opportunity to consent to HIV test. Within 72 hours after receiving written certification of a significant exposure, the attending physician of the source patient must do all of the following:
   a. **T**he attending physician must make a good faith effort to notify the source patient, or the patient's authorized legal representative, of the significant exposure. This effort includes, but is not limited to, an effort to locate the patient by telephone or certified first class mail. The efforts to contact the source patient must be documented in the source patient's medical record.
   b. If the source patient or legal representative is contacted, the attending physician must attempt to get the voluntary written informed consent to the HIV test.
   c. The exposed individual is prohibited from directly seeking consent to HIV testing from the source patient.
   d. If the source patient or the legal representative cannot be contacted after a good faith effort, it may be treated as if the source patient has refused to be tested.

10. If the source patient or authorized legal representative refuses consent for an HIV test, available blood may be tested and the exposed individual informed of the test results.

~~e.~~**a.** An inability of the source patient to provide informed consent constitutes a refusal of consent provided all of the following conditions are met:

i. The source patient has no legal representative authorized to consent on his behalf.

ii. The source patient is incapable of giving consent.

iii. In the opinion of the attending physician, it is likely that the source patient will be unable to grant informed consent within the 72-hour period during which the physician is required to act pursuant to Section 3.8 herein.

~~10.~~**11.** If the source patient is deceased, consent for HIV testing is deemed granted.

~~11.~~**12.** The exposed individual's employer will pay for the cost of HIV testing and counseling. Exposed individuals who are not employees of the health facility or health care providers are financially responsible for the cost of their own post-exposure evaluation, follow-up counseling and the cost of testing and counseling of the source patient. (Health & Safety Code Section 121135(f)).

~~12.~~**13.** The source patient or authorized legal representative must be given the option as to whether or not he or she is advised of the HIV results.

a. If the source patient refuses to consent to HIV test and refused to learn of the results of the test, the patient must sign a form documenting the refusal.

b. HIV test results may be placed in the source patient's medical record only if the patient has given written consent to be informed of the test results.

c. If the source patient or legal representative refuses to be informed of the test results, the HIV test results may be provided to the exposed individual only in accordance with the then applicable CAL-OSHA regulations.

d. The source patient's identity must be "encoded" in the HIV test result record.

~~13.~~**14.** If the exposed individual is informed of the source patient's HIV test results pursuant to the law, the exposed individual must be counseled regarding confidentiality laws protecting HIV test results, protecting the identity of the source patient and the penalties for violating the law.

D. RELATED DOCUMENTS

1. Administrative Policy # 530 Emergency Response Employees, Notification

~~D.~~E. REFERENCE:

~~1. Administrative Policy # 530 Emergency Response Employees, Notification of~~

~~2.~~**1.** Current California Hospital Association Consent Manual

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 5/78

SUBJECT: Meals, Patients – Times, Menus, Substitutions, and Nourishments

REVISION DATE: 4/00, 6/03, 8/05; 5/08; 02/11

POLICY NUMBER: IV.AA

Clinical Policies & Procedures Committee Approval: ~~01/11~~05/15
Nursing Executive Council Approval: ~~01/11~~05/15
Professional Affairs Committee Approval: ~~02/11~~06/15
Board of Directors Approval: 02/11

A. **POLICY:**

~~B.~~**1.** The Food and Nutrition Services Department provides three (3) patient meals daily and offers between-meal nourishments three (3) times daily. No more than 14 hours shall elapse between the serving of the dinner meal and the breakfast meal of the following day.

~~1.~~**a.** Patient tray line shall operate according to the following schedule:

i. Breakfast: 7:00 AM – 8:15 AM
ii. Lunch: 11:00 AM – 12:15 PM
iii. Dinner: 4:45 PM – 6:15 PM
iv. (All finish times are approximate)

~~2.~~**b.** Patient trays shall be loaded on food carts and delivered to the nursing units in a predetermined sequence.

~~C.~~**2.** Meal service shall be provided for patients who are not served meals during normal meal service time.

~~1.~~**a.** Delayed trays are ordered via the computer system.

~~a.~~**i.** All delayed tray requests shall be filled with a minimum of delay.
~~b.~~**ii.** Food & Nutrition personnel trained on special diets shall prepare the tray as listed on the diet slip. Supervisory personnel shall monitor performance.
~~c.~~**iii.** All food items shall be covered.
iv. Normal tray line delivery systems shall be used to ensure maximum temperature retention.

~~d.~~**b.** **Early breakfast trays are available upon request.**

~~2.~~**c.** Standard late breakfast trays are served from 8:30 AM until 10:00 AM. Late trays shall be delivered on the half-hour.

~~3.~~**d.** From 10 AM to 10:30 AM, Continental-type breakfast may be served.

~~4.~~**e.** Standard late lunch trays are served from 12:30 PM until 2:30 PM.

~~a.~~**i.** From 2:30 PM until 4:00 PM, soup, sandwich, dessert, and beverage lunch shall be served.

~~5.~~**f.** Standard late dinner trays are served from 6:00 PM until 7:00 PM.

~~a.~~**i.** From 7:00 PM until 1:30 AM, grilled items and cold sandwiches**, appropriate to the patient's diet,** can be obtained in the cafeteria.

~~6.~~**g.** Late trays served shall comply with the patient's diet order.

~~7.~~**h.** Floor stocks are used for after-hours ~~feeding~~.

~~D.~~**3.** Most patients receive selective menus from which to make their meal choices. Exceptions are: New admissions, patients who are NPO, patients on liquid diets, severely restricted diets, and those electing not to select.

~~1.~~**a.** ~~The next day's menu is sent with the breakfast tray for patients selecting their meals.~~**The next day's menu is distributed by a representative from Food & Nutrition. The menu**

is reviewed with the patient and appropriate selections are made. New admits receive a selective menu by their second meal.

~~2.~~**b.** ~~The next day's menu is attached to the breakfast menu; both menus are placed on the tray together.~~

~~3.~~**c.** Patients willing but unable to fill out the menu by themselves shall receive assistance from family members, Nursing or Food & Nutrition personnel.

~~4.~~**d.** Upon receipt of a new diet order, the patient shall be visited by a dietitian, diet technician, or menu clerk, within two (2) meals of receipt of the diet order.

~~a.~~**i.** The patient shall receive the house menu prior to visitation.

~~b.~~**ii.** Patients with new diet orders received by 8:00 AM shall be allowed to choose a lunch and dinner for that day in addition to the next day's menu.

~~c.~~**iii.** Patients with new diet orders received between 8:00 AM and 12:30 PM shall be allowed to choose dinner for that day as well as the next day's menu.

~~d.~~**iv.** Patients with new diet orders received between 12:30 PM and 8:00 AM the next day receive a house diet for dinner and breakfast and then are allowed to choose subsequent meals.

~~E.~~**4.** Menu substitutions are offered to patients who cannot make adequate choices from the printed menu.

~~1.~~**a.** Substitutions are offered from the substitution list when the patient asks for other foods due to reasons as stated above.

~~2.~~**b.** Suggestions are made based on the reason for patient's request from substitution list.

~~3.~~**c.** A two-hour notice is required for staff to request a substitution item.

~~4.~~**d.** Production area is alerted by diet clerk if "write-ins" are done on the day food substitutions are to be served.

~~5.~~**e.** Patients are familiarized with available menu substitutions.

~~6.~~**f.** The hospital cafeteria menu**, appropriate to the patient's diet,** is made available to patients who request additional selections.

~~7.~~**g.** Every effort within reason shall be made to accommodate the patient's nutritional needs.

~~F.~~**5.** Nourishments or "between meal feedings" shall be recommended and provided to meet the patients' nutritional requirements.

~~1.~~**a.** Criteria for recommending/providing supplements or nourishments:

~~a.~~**i.** Multiple feeding plan, i.e. IDDM, dumping syndrome, hypoglycemia.

~~b.~~**ii.** Patients' inability to consume daily caloric requirements within a three (3)-meal per day plan.

~~c.~~**iii.** Calorie or protein needs are greater than the prescribed diet.

~~2.~~**b.** All nourishment orders shall be received and planned by the clerk, technician, or dietitian. The diet technician, menu clerk, or the dietitian shall initiate specific nourishment orders.

~~3.~~**c.** The dietitian, diet technician, or menu clerk shall review patient acceptance and tolerance and revise the nourishment/meal plan as appropriate.

~~G. Wine/beer service shall be offered to patients only with a physician's written order.~~

~~1. The written order is communicated to Food & Nutrition Services via the computer system.~~

~~2. The patient must be 21 years of age or older.~~

~~3. The patient may select between Chablis, Cabernet Sauvignon, Chardonnay, regular beer, or light beer.~~

~~a.~~**i.** ~~The portion is limited to 2 to 3 oz. portion of wine per day unless otherwise ordered by the physician. Beer is limited to one can per day unless otherwise ordered by the physician.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 3/88

SUBJECT: **Nutritional Screening, Care, and Assessment for Infants, Pediatrics & Adolescents**

REVISION DATE: 10/04; 01/07; 10/07, 01/08; 10/10

POLICY NUMBER: VI.L

Clinical Policies & Procedures Committee Approval: ~~10/10~~03/15
~~Operations~~ Nurse Executive Committee Approval: ~~11/10~~03/15
Medical Executive Committee Approval: 05/15
Professional Affairs Committee Approval: ~~01/11~~06/15
Board of Directors Approval: 01/11

A. **DEFINITIONS:**
1. Malnourished or Nutritionally at Risk:
   a. Five (5) percent or greater weight loss over one month
   b. Body Mass Index (BMI) Percentile less than 5th percentile and greater than or equal to the 95th percentile
      i. Indication of underweight and overweight/obesity
   c. Weight below 5th percentile on growth chart
   d. Decreased percentage scores of height and/or weight
   e. Increased metabolic requirements
   f. Low birth weight **(less than 2500 grams)** or prematurity **(less than 37 weeks)**
   g. Inadequate provision or tolerance of nutrients/feedings (rate or volume)

B. **POLICY:**
1. The Registered Dietitian shall provide nutrition assessment, consultation, and/or medical nutrition therapy for patients, families, and for medical professionals providing care ~~in the pediatric department.~~ **for infant, pediatric or adolescent patients.**
2. Referrals for a nutrition assessment are generated if certain criteria are met via the admission database and/or as requested by the physician. Clinical Dietitians shall assess nutritional status of triggered patients within 48 hours of referral, considering age of patient, disease states, diet history, medical history, and laboratory values.
3. Referrals for nutrition assessment are generated if the following criteria are met upon completion of the admission data base:
   a. Currently receiving TPN/enteral feedings
   b. Unplanned weight loss
   c. Presence of pressure ulcer or skin breakdown
   d. Eating disorder
   e. Impaired nutrient intake, nausea, vomiting, diarrhea
   f. Intake of less than 50% normal in 3 days
   g. Aspiration risk
   h. BMI Percentile less than 5th percentile and greater than or equal to the 95th percentile
4. Additional criteria for infants and pediatric patients include:
   a. Weight/length less than 5th percentile or greater than or equal to 95th percentile on growth charts for children under two (2) years of age.
   b. Difficulty with suck/swallow
   c. Poor weight gain
   d. Failure to thrive

e. Presence of enteral tube/button

5. The dietitian shall complete the assessment with consideration of:
   a. Diet order
   b. Diagnosis
   c. Chronological age and/or gestational age
   d. Weight
   e. Height or length
   f. Head circumference as appropriate
   g. Food allergies
   h. Diet prior to admission
   i. Birth weight - if available
   j. History of weight changes
   k. Potential drug nutrient interactions
   l. Labs and biochemical values: to include, among others, serum albumin, Hgb, Hct, MCV
   m. Feeding problems such as chewing, swallowing, and appetite changes
   n. Nutrition/diet history
   o. Psychosocial, physiological, social and/or environmental issues
   p. Clinical assessment changes
   q. Any other general nutrition concerns
   r. BMI percentile
6. Clinical dietitian shall document nutrition assessment in the electronic medical record. Assessments shall be based on the following information provided by admission assessment, review of history and physical, physician notes, other disciplines' notes, and interview with patients, parents, or nursing:
   a. Diet order
   b. Diagnosis
   c. Age
   d. Weight, height
   e. Food allergies
   f. Labs and biochemical values: pertinent to assessment
   g. History of weight changes
   h. Feeding problems such as chewing, swallowing, appetite
   i. Psychosocial, physiological, social and/or environmental issues
   j. Nutrition/diet history
   k. Pregnancy/Lactating
   l. BMI percentile
7. The Dietitian shall also calculate the following:
   a. Weight for height percentile or weight for age/weight for height percentile
   b. Weight change percentile
   c. BMI percentile
   d. Estimation of calories and is based on the child's age, gender, weight, disease state, and nutrition status
   e. Grams of protein per day
   f. Fluid requirements
8. A nutrition care plan shall be developed and individualized based on assessment and shall meet specific needs of the patient. Goals shall be individually determined with delineation of methods of achievement of goals and time frames.
9. Normally nourished and malnourished children who have adequate intake to satisfy nutrient requirements shall be monitored on at least a 3-day follow-up basis or as indicated by nursing/physician referral.
10. Normally nourished and malnourished children who have inadequate intake may require nutrition support (i.e. parenteral or enteral nutrition) after 5 days of inadequate nutrition intake. These patients shall be monitored on a 1-3 day follow-up basis or as indicated by nursing/physician referral.

Estimated Energy and Protein Requirements/Dietary Reference Intakes			
Age (yr)	Protein g/kg/d	Kcal/Kg/d	Kcal/d
0.0-0.5	2.2	108	Kg x 108
0.5-1.0	1.5	98	Kg x 98
1-3	1.3	102	1300
4-6	1.2	90	1800
7-10	1.0	70	2000
Males: 11-14 15-18	 1.0 0.9	 55 45	 2500 3000
Females: 11-14 15-18	 1.0 0.8	 47 40	 2200 2200

11. Clinical Dietitian shall confer with Physician, R**egistered Nurse**, and/or Pharmacist regarding pertinent factors affecting nutrition status (i.e., medication, intake and output (I&O), intake, Braden Score).
12. Clinical Dietitian shall provide and document follow-up visits for patients assessed at risk as necessary or at least every three (3) days depending on medical status and revise therapy as indicated. Patients with adequate intake shall be followed throughout their stay with documentation in the medical record within at least seven (7) days. Follow-up assessment is documented on the Nutrition Reassessment powerform, to include nutrient intake, tolerance to diet, weight changes, laboratory parameters, and I&O. Follow-up assessments may be triggered sooner as warranted by change in status.
13. Clinical Dietitian shall provide nutrition counseling and education explaining rationale to patient/parent/significant other as ordered by physician, as requested by nursing, or family, or as deemed appropriate by RD.
    a. Documentation of education is completed on the Patient/Family Education All Topics PowerForm.
    b. Relevant nutrition and education and referral information are documented in the discharge plan.
14. Standard adult and pediatric menus and snacks are utilized. If enteral formulas are required, adult formulas are utilized for children ages 7-12 and adolescents; pediatric formulas are used for children ages 1-6. Infant formulas are available as 20 kcal/oz and can be concentrated to 24 kcal/oz, 27 kcal/oz, or 30 kcal/oz as needed.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**12/01**	**SUBJECT:**	**Physician's Admission Responsibilities**
REVISION DATE:	**6/03, 11/05, 12/08, 08/11**	**POLICY NUMBER:**	**I.N**

Clinical Policies & Procedures Committee Approval:	**~~06/11~~04/15**
Nursing Executive Committee Approval:	**~~06/11~~04/15**
Medical Executive Committee Approval:	**~~07/11~~05/15**
Professional Affairs Committee Approval:	**~~08/11~~06/15**
Board of Directors Approval:	**08/11**

A. **POLICY:**

1. Admitting Orders
   a. Physicians' orders must be obtained within one hour for routine elective admissions, direct admissions, and admissions from the Emergency Department (ED) to Acute Care Services, Forensic Unit, ~~Pediatrics~~ or Women~~'s~~ and ~~Children's~~ **Newborn** Services **(WNS)**. ED admissions to Intensive Care Unit (ICU) and Telemetry shall arrive on the unit with orders from the physician.
   b. Minimum content for orders includes:
      i. Admit
      ii. Admitting diagnosis
      iii. Diet
      iv. Activity
      v. Lab work
      vi. Medication Orders
      vii. Admission status (observation, inpatient)
      viii. Level of care (ICU, Telemetry, Medical/Surgical)
   c. When ~~a member of the medical staff does not complete their~~ initial admitting orders **have not been received from a physician** within one hour, the **following** chain of command is activated.
      i. **Assistant Nurse Manager (ANM)/Relief Charge Nurse or Designee.**
      ii. **Administrative Supervisor**
      iii. Chief of Division, Department Chair, or in his/her absence, the Chief of Staff shall be notified to ensure that patient care will be provided promptly.
      iv. When no orders have been received for one hour the patient shall be admitted to the service of a physician appointed by the Chief of Division, Department Chair or in his/her absence, the Chief of Staff. In such cases, the department director/designee is to be notified as soon as possible.
2. The attending physician maintains responsibility for the direction of patient care by providing the following:
   a. Clear and legible orders.
   b. Clinical direction to healthcare professionals regarding medical plan of care.
   c. Collaboration with healthcare professionals on a regular basis pertaining to the plan of care, prognosis, and discharge planning.
   d. Collaboration with patient and family members.
   e. Complete and adequate documentation per the ~~medical~~ **Medical** ~~staff~~ **Staff** ~~by~~**By**-laws.
   f. Availability to healthcare professionals when questions arise regarding specific symptoms and/or physician orders.

g. Coverage when not available.
   i. Ensure the healthcare professionals are informed when not available.
h. Participation in ~~educational activities of healthcare professionals,~~ patient care, conferences~~, and standards review~~.
i. Assistance in preventing/clarifying conflict with consultants.
j. Communication regarding patient's condition.

3. The consulting physicians ~~are responsible to~~ collaborate with the attending physician to prevent conflicts in patient care orders or clinical direction.
4. Medical ~~directors~~**Directors**, Medical Staff Officers, Department/Division Chairs/Chiefs, and Medical Staff ~~committees~~ **Committees** interact with the Patient Care Services Departments as follows:
   a. Work in cooperation with the Patient Care Services Departments by:
      i. Being readily available to the Management Team
      ii. Participating as active team members in standards review
      iii. Identifying, solving and assisting with conflict resolution as needed
   b. The Chief Nurse Executive (CNE) will serve as the formal liaison between the ~~medical~~ **Medical** ~~staff~~ **Staff** and ~~clinical practice~~**Patient Care Services** departments either by direct participation and committee work or by designating a qualified healthcare professional.
   c. Healthcare professionals are responsible to maintain communication with physicians regarding patient's conditions.
   d. Medical Directors shall meet regularly with the clinical/operations manager of the respective departments to review quality improvement data, and refer problems for resolutions to appropriate ~~medical~~ **Medical** ~~staff~~ **Staff** ~~committees~~**Committees**/~~departments~~**Departments**/~~divisions~~**Divisions**, if indicated.
5. The list of current Medical Staff leaders and committees is maintained in the Medical Staff Office ~~and on the TCMC Intranet~~.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**SWALLOW SCREENING IN THE ADULT PATIENT**
Purpose:	To screen for appropriateness of oral intake.
Supportive Data:	The swallow screen is performed on any patient who is at risk for aspiration secondary to the inability to swallow safely. This includes the nursing assessment of patient alertness, respiratory status, secretion management, voice quality and an effective cough. Oral intake is contraindicated if any of the above are compromised. This would constitute failure of the swallow screen.

A. **PROCEDURE:**

LOOK Observe patient. If patient is not alert then make patient NPO until alert and then screen patient. If patient is alert, face is symmetrical, and tolerating their own secretions, proceed to **LISTEN**. If patient fails **STOP** assessment and proceed to At Risk Section of the Swallowing Screening Results Table.

LISTEN Have the patient say "ahhh" and hold the sound for a count of three. If patient's voice sounds clear, proceed to **FEEL.** If patient coughs, sounds wet or gurgly **STOP** assessment and proceed to At Risk Section of the Swallowing Screening Results Table.

FEEL Feel for movement of the larynx by placing the tips of the fingers vertically on the front of the throat. If you feel a strong and timely vertical movement of the larynx, then proceed to Safe Section of the Swallowing Screening Results Table. If patient fails, **STOP** assessment and proceed to Swallowing Screening Results Table.

SWALLOWING SCREENING RESULTS TABLE	
AT RISK – Screening Failed	**SAFE – Screening Passed**
If the patient is unable to pass any of the above steps:	If the patient is able to perform **all** of the above steps:
• **DO NOT** give any oral intake, including oral medication. Make patient NPO for 24 hours or until Swallow Evaluation is ordered and performed by Speech Pathologist. • Document **FAIL** in Cerner under Swallow Screen.	• Give patient sips of water without a straw. • Look, Listen and Feel as above. • If patient coughs, sounds gurgly or wet in response to water then document as **FAIL** in Cerner under Swallow Screen. • If patient passes, document **PASS** in Cerner under Swallow Screen, then resume diet per physician's orders. • Proceed with oral medications. • Supervise the patient's initial attempts of eating and drinking.

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/06, 7/09	09/11, **4/15**	10/11; 4/15	11/11; 05/15	1/12; 06/15	1/12

Tri-City Health Care District
Oceanside, California

~~Administrative Policy Manual~~PATIENT CARE SERVICES

ISSUE DATE: 03/97 **SUBJECT: Use of ~~Unapproved~~ Abbreviations**

REVISION DATE: 5/02, 12/02, 5/03, 12/03, 3/04, 4/06, 08/06, 06/09 **~~POLICY NUMBER: 8610-367~~**

Clinical~~Administrative~~ Policies & Procedures Committee Approval:	**~~06/09~~4/15**
Nurse Executive~~Operations Team~~ Committee Approval:	**~~06/09~~4/15**
Pharmacy and Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**05/15**
Professional Affairs Committee Approval:	**~~07/09~~06/15**
Board of Directors Approval:	**07/09**

A. **PURPOSE:**

1. To provide **optimal safety for patients and clear understanding of written medical communication by eliminating the use of potentially dangerous abbreviations and dose designations.** ~~a list of unapproved abbreviations that are not to be used when documenting in the patient's record.~~

B. **POLICY:**

1. **Tri-City Medical Center (TCMC) has adopted the Neil-Davis Med Abbreviations (Neil-Davis Med Abbreviations for abbreviations**
   a. **In addition, Pharmacy has adopted the Institute for Safe Medication Practices ISMP's Error-Prone Abbreviations, Symbols, and Dose Designations for medication orders**
2. **Abbreviations identified as "Do Not Use Abbreviations" by the Joint Commission are prohibited for use in all orders and medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed orders.**
   ~~Tri-City Medical Center (TCMC) will maintain a list of unapproved abbreviations in compliance with The Joint Commission requirements.~~
3. **Medication orders**
   a. **If an unapproved abbreviation is used on a medication order or other written communication for patient care, the ordering physician shall be contacted by the nurse or pharmacist for clarification. The clarified order shall be documented in the medical record.~~rewritten (or redone via telephone order if re-writing is not practical.)~~**
   ~~1.~~b. **Medication orders containing unapproved abbreviations shall not be dispensed by pharmacy or administered by the nurse until clarified and the medication order re-entered.**
4. **Changes to** ~~Proposed **new "do not use"**~~ abbreviation **references** ~~revisions~~ will be approved by **the Pharmacy and Therapuetics Committee (P&T),** the Medical ~~Records~~ **Executive** Committee **and the Board of Directors**.

~~2.5. **Any changes to the "do not use" abbreviations will require revisions on the paper physician order form and on the physician progress notes to reflect these changes.**~~

~~3.6. Upon final approval of the "unapproved abbreviation list", the final list will be distributed to all departments including medical staff.~~

~~4.7. When a non-approved abbreviation is used and there is a question regarding the intent of the order, the order will be verified with the physician.~~

~~5.8. An abbreviation reference is available on the TCMC Intranet.~~

C. **RELATED DOCUMENTS:**

1. **ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations (2013)**

2. Joint Commission "Do Not Use" List (2014)

D. EXTERNAL LINK(S):

~~6.~~1. Neil-Davis Medical Abbreviation - MedAbbrev.com

E. REFERENCES:

1. The Joint Commission (June 2014). *Facts about the Official "Do Not Use" List.* Retrieved from www.jointcommission.org on April 6, 2015. http://www.jointcommission.org/assets/1/18/Do_Not_Use_List.pdf

~~C.~~F. ~~UNAPPROVED ABBREVIATIONS:~~

~~*Item*~~	~~*Abbreviation*~~	~~*Potential Problem*~~	~~*Preferred Term*~~
~~1.~~	~~U (for unit)~~	~~Mistaken as zero, four or cc~~	~~Write "unit"~~
~~2.~~	~~IU (for international unit)~~	~~Mistaken as IV (intravenous) or 10 (ten)~~	~~Write "international unit"~~
~~3.~~ ~~4.~~	~~Q.D.~~ ~~Q.O.D.~~ ~~(Latin abbreviation for once daily and every other day)~~	~~Mistaken for each other. The period after the Q can be mistaken for an "I" and the "O" can be mistaken for "I".~~	~~Write "daily" and "every other day"~~
~~5.~~ ~~6.~~	~~Trailing zero (X.0 mg),~~ ~~Lack of leading zero (.X mg)~~	~~Decimal point is missed~~	~~Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)~~
~~7.~~ ~~8.~~ ~~9.~~	~~MS~~ ~~MSO_4~~ ~~$MgSO_4$~~	~~Confused for one another. Can mean morphine sulfate or magnesium sulfate~~	~~Write "morphine sulfate" or "magnesium sulfate"~~
~~10.~~	~~CC (for cubic centimeter~~	~~Mistaken for U (units) when written poorly~~	~~Write "mL" or "ml" for milliliters~~
~~11.~~	~~S.C. or S.Q. (for subcutaneous)~~	~~Mistaken as SL for sublingual, or "5 every."~~	~~Write "Sub-Q," "subQ," or "subcutaneously"~~
~~12.~~	~~µg (for microgram)~~	~~Mistaken for mg (milligrams) resulting in one thousand-fold dosing overdose~~	~~Write "mcg"~~

ISMP's List of *Error-Prone Abbreviations, Symbols,* and *Dose Designations*

The abbreviations, symbols, and dose designations found in this table have been reported to ISMP through the ISMP National Medication Errors Reporting Program (ISMP MERP) as being frequently misinterpreted and involved in harmful medication errors. They should **NEVER** be used when communicating medical information. This includes internal communications, telephone/verbal prescriptions, computer-generated labels, labels for drug storage bins, medication administration records, as well as pharmacy and prescriber computer order entry screens.

Abbreviations	Intended Meaning	Misinterpretation	Correction
µg	Microgram	Mistaken as "mg"	Use "mcg"
AD, AS, AU	Right ear, left ear, each ear	Mistaken as OD, OS, OU (right eye, left eye, each eye)	Use "right ear," "left ear," or "each ear"
OD, OS, OU	Right eye, left eye, each eye	Mistaken as AD, AS, AU (right ear, left ear, each ear)	Use "right eye," "left eye," or "each eye"
BT	Bedtime	Mistaken as "BID" (twice daily)	Use "bedtime"
cc	Cubic centimeters	Mistaken as "u" (units)	Use "mL"
D/C	Discharge or discontinue	Premature discontinuation of medications if D/C (intended to mean "discharge") has been misinterpreted as "discontinued" when followed by a list of discharge medications	Use "discharge" and "discontinue"
IJ	Injection	Mistaken as "IV" or "intrajugular"	Use "injection"
IN	Intranasal	Mistaken as "IM" or "IV"	Use "intranasal" or "NAS"
HS **hs**	Half-strength At bedtime, hours of sleep	Mistaken as bedtime Mistaken as half-strength	Use "half-strength" or "bedtime"
IU**	International unit	Mistaken as IV (intravenous) or 10 (ten)	Use "units"
o.d. or OD	Once daily	Mistaken as "right eye" (OO-oculus dexter), leading to oral liquid medications administered in the eye	Use "daily"
OJ	Orange juice	Mistaken as OD or OS (right or left eye); drugs meant to be diluted in orange juice may be given in the eye	Use "orange juice"
Per os	By mouth, orally	The "os" can be mistaken as "left eye" (OS-oculus sinister)	Use "PO," "by mouth," or "orally"
q.d. or QD**	Every day	Mistaken as q.i.d., especially if the period after the "q" or the tail of the "q" is misunderstood as an "i"	Use "daily"
qhs	Nightly at bedtime	Mistaken as "qhr" or every hour	Use "nightly"
qn	Nightly or at bedtime	Mistaken as "qh" (every hour)	Use "nightly" or "at bedtime"
q.o.d. or QOD**	Every other day	Mistaken as "q.d." (daily) or "q.i.d. (four times daily) if the "o" is poorly written	Use "every other day"
q1d	Daily	Mistaken as q.i.d. (four times daily)	Use "daily"
q6PM, etc.	Every evening at 6 PM	Mistaken as every 6 hours	Use "daily at 6 PM" or "6 PM daily"
SC, SQ, sub q	Subcutaneous	SC mistaken as SL (sublingual); SQ mistaken as "5 every;" the "q" in "sub q" has been mistaken as "every" (e.g., a heparin dose ordered "sub q 2 hours before surgery" misunderstood as every 2 hours before surgery)	Use "subcut" or "subcutaneously"
ss	Sliding scale (insulin) or ½ (apothecary)	Mistaken as "55"	Spell out "sliding scale;" use "one-half" or "½"
SSRI **SSI**	Sliding scale regular insulin Sliding scale insulin	Mistaken as selective-serotonin reuptake inhibitor Mistaken as Strong Solution of Iodine (Lugol's)	Spell out "sliding scale (insulin)"
i/d	One daily	Mistaken as "tid"	Use "1 daily"
TIW or tiw	3 times a week	Mistaken as "3 times a day" or "twice in a week"	Use "3 times weekly"
U or u**	Unit	Mistaken as the number 0 or 4, causing a 10-fold overdose or greater (e.g., 4U seen as "40" or 4u seen as "44"); mistaken as "cc" so dose given in volume instead of units (e.g., 4u seen as 4cc)	Use "unit"
UD	As directed ("ut dictum")	Mistaken as unit dose (e.g., diltiazem 125 mg IV infusion "UD" misinterpreted as meaning to give the entire infusion as a unit [bolus] dose)	Use "as directed"
Dose Designations and Other Information	**Intended Meaning**	**Misinterpretation**	**Correction**
Trailing zero after decimal point (e.g., 1.0 mg)**	1 mg	Mistaken as 10 mg if the decimal point is not seen	Do not use trailing zeros for doses expressed in whole numbers
"Naked" decimal point (e.g., .5 mg)**	0.5 mg	Mistaken as 5 mg if the decimal point is not seen	Use zero before a decimal point when the dose is less than a whole unit
Abbreviations such as mg. or mL. with a period following the abbreviation	mg mL	The period is unnecessary and could be mistaken as the number 1 if written poorly	Use mg, mL, etc. without a terminal period

ISMP's List of *Error-Prone Abbreviations, Symbols,* and *Dose Designations* (continued)

Dose Designations and Other Information	Intended Meaning	Misinterpretation	Correction
Drug name and dose run together (especially problematic for drug names that end in "l" such as Inderal40 mg; Tegretol300 mg)	Inderal 40 mg Tegretol 300 mg	Mistaken as Inderal 140 mg Mistaken as Tegretol 1300 mg	Place adequate space between the drug name, dose, and unit of measure
Numerical dose and unit of measure run together (e.g., 10mg, 100mL)	10 mg 100 mL	The "m" is sometimes mistaken as a zero or two zeros, risking a 10- to 100-fold overdose	Place adequate space between the dose and unit of measure
Large doses without properly placed commas (e.g., 100000 units; 1000000 units)	100,000 units 1,000,000 units	100000 has been mistaken as 10,000 or 1,000,000; 1000000 has been mistaken as 100,000	Use commas for dosing units at or above 1,000, or use words such as 100 "thousand" or 1 "million" to improve readability
Drug Name Abbreviations	**Intended Meaning**	**Misinterpretation**	**Correction**
To avoid confusion, do not abbreviate drug names when communicating medical information. Examples of drug name abbreviations involved in medication errors include:			
APAP	acetaminophen	Not recognized as acetaminophen	Use complete drug name
ARA A	vidarabine	Mistaken as cytarabine (ARA C)	Use complete drug name
AZT	zidovudine (Retrovir)	Mistaken as azathioprine or aztreonam	Use complete drug name
CPZ	Compazine (prochlorperazine)	Mistaken as chlorpromazine	Use complete drug name
DPT	Demerol-Phenergan-Thorazine	Mistaken as diphtheria-pertussis-tetanus (vaccine)	Use complete drug name
DTO	Diluted tincture of opium, or deodorized tincture of opium (Paregoric)	Mistaken as tincture of opium	Use complete drug name
HCl	hydrochloric acid or hydrochloride	Mistaken as potassium chloride (The "H" is misinterpreted as "K")	Use complete drug name unless expressed as a salt of a drug
HCT	hydrocortisone	Mistaken as hydrochlorothiazide	Use complete drug name
HCTZ	hydrochlorothiazide	Mistaken as hydrocortisone (seen as HCT250 mg)	Use complete drug name
MgSO4**	magnesium sulfate	Mistaken as morphine sulfate	Use complete drug name
MS, MSO4**	morphine sulfate	Mistaken as magnesium sulfate	Use complete drug name
MTX	methotrexate	Mistaken as mitoxantrone	Use complete drug name
PCA	procainamide	Mistaken as patient controlled analgesia	Use complete drug name
PTU	propylthiouracil	Mistaken as mercaptopurine	Use complete drug name
T3	Tylenol with codeine No. 3	Mistaken as liothyronine	Use complete drug name
TAC	triamcinolone	Mistaken as tetracaine, Adrenalin, cocaine	Use complete drug name
TNK	TNKase	Mistaken as "TPA"	Use complete drug name
ZnSO4	zinc sulfate	Mistaken as morphine sulfate	Use complete drug name
Stemmed Drug Names	**Intended Meaning**	**Misinterpretation**	**Correction**
"Nitro" drip	nitroglycerin infusion	Mistaken as sodium nitroprusside infusion	Use complete drug name
"Norflox"	norfloxacin	Mistaken as Norflex	Use complete drug name
"IV Vanc"	intravenous vancomycin	Mistaken as Invanz	Use complete drug name
Symbols	**Intended Meaning**	**Misinterpretation**	**Correction**
ʒ ♏	Dram Minim	Symbol for dram mistaken as "3" Symbol for minim mistaken as "mL"	Use the metric system
x3d	For three days	Mistaken as "3 doses"	Use "for three days"
> and <	Greater than and less than	Mistaken as opposite of intended; mistakenly use incorrect symbol; "< 10" mistaken as "40"	Use "greater than" or "less than"
/ (slash mark)	Separates two doses or indicates "per"	Mistaken as the number 1 (e.g., "25 units/10 units" misread as "25 units and 110" units)	Use "per" rather than a slash mark to separate doses
@	At	Mistaken as "2"	Use "at"
&	And	Mistaken as "2"	Use "and"
+	Plus or and	Mistaken as "4"	Use "and"
°	Hour	Mistaken as a zero (e.g., q2° seen as q 20)	Use "hr," "h," or "hour"
Φ or ø	zero, null sign	Mistaken as numerals 4, 6, 8, and 9	Use 0 or zero, or describe intent using whole words

**These abbreviations are included on The Joint Commission's "minimum list" of dangerous abbreviations, acronyms, and symbols that must be included on an organization's "Do Not Use" list, effective January 1, 2004. Visit www.jointcommission.org for more information about this Joint Commission requirement.

The Joint Commission

Facts about the Official "Do Not Use" List

In 2001, The Joint Commission issued a *Sentinel Event Alert* on the subject of medical abbreviations, and just one year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its "do not use" list of abbreviations (see below) as part of the requirements for meeting that goal. In 2010, NPSG.02.02.01 was integrated into the Information Management standards as elements of performance 2 and 3 under IM.02.02.01.

Currently, this requirement does not apply to preprogrammed health information technology systems (for example, electronic medical records or CPOE systems), but this application remains under consideration for the future. Organizations contemplating introduction or upgrade of such systems should strive to eliminate the use of dangerous abbreviations, acronyms, symbols, and dose designations from the software.

Official "Do Not Use" List[1]

Do Not Use	*Potential Problem*	**Use Instead**
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d, qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I	Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" Write "magnesium sulfate"
MSO_4 and $MgSO_4$	Confused for one another	

[1] Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

***Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

The National Summit on Medical Abbreviations

Participants at the November 2004 National Summit on Medical Abbreviations supported the "do not use" list. Summit conclusions were posted on the Joint Commission website for public comment. During the four-week comment period, the Joint Commission received 5,227 responses, including 15,485 comments. More than 80 percent of the respondents supported the creation and adoption of a "do not use" list. This special one-day Summit brought together representatives of more than 70 professional societies and associations and special interest groups to discuss medical errors related to the misuse and misinterpretation of abbreviations, acronyms, and symbols. The objective of the Summit was to reach consensus on the scope and implications of this serious and complex problem and to find reasonable solutions using all of the evidence at hand and in the most dispassionate way possible.

The National Summit on Medical Abbreviations was hosted by The Joint Commission with its co-conveners American College of Physicians, American College of Surgeons, American Dental Association,

American Hospital Association, American Medical Association, American Society of Health-System Pharmacists, Institute for Safe Medication Practices, and United States Pharmacopeia. Approximately 50 professional societies and associations and selected interest groups participated in the Summit representing every perspective.

For more information
Contact the Standards Interpretation Group at (630) 792-5900, or complete the Standards Online Question Submission Form at http://www.jointcommission.org/Standards/OnlineQuestionForm/.

Tri-City Medical Center
Oceanside, California

Emergency Operations Procedure Manual
General Information

SUBJECT: Emergency Operations Plan

ISSUE DATE: 06/08 ~~**POLICY NUMBER: 4001**~~
REVIEW DATE(S): 06/11
REVISION DATE(S): 05/15

Department Approval Date(s):	**05/15**
Environmental Health and Safety Committee Approval Dates(s):	**06/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**06/15**
Board of Directors Approval Date(s):	

A. SCOPE OF SERVICES:

1. The scope of ~~Tri City Medical Center~~**Tri-City Healthcare District (TCHD)**'s Emergency Operations Plan (EOP) is to provide a program that ensures effective mitigation, preparation, response and recovery to disasters or emergencies affecting the environment of care. The medical center has developed an "all hazards" approach that supports a level of preparedness sufficient to address a wide range of emergencies regardless of cause. The Emergency Operations Plan and associated Emergency Management Program extends to all inpatient and outpatient line programs, ancillary services, support services and facilities including patient care, business occupancies and temporary alternate care sites of ~~Tri City Medical Center~~**TCHD**. The plan also affects all staff, volunteers, contract staff, medical staff and associates including contracted services of ~~Tri City Medical Center~~**TCHD**.

B. OBJECTIVE:

1. The objective of the Emergency Operations Plan is to effectively prepare for, manage an emergency situation and restore the facility to the same operational capabilities as pre-emergency levels.
2. Six (6) critical areas of emergency response shall be managed in order to assess the medical center's needs and prepare personnel to respond to incidents. The six critical areas are:
   a. Communication
   b. Resources and Assets
   c. Safety and Security
   d. Personnel Responsibilities
   e. Utilities Management
   f. Patient Clinical and Support Activities

C. OBJECTIVES:

1. The objectives of the Emergency Operations Plan will include the following:
   a. Identifying procedures to prepare and respond to potential disasters or emergencies.
   b. Provide education to personnel on the elements of the Emergency Operations Plan.
   c. Establish and implement procedures in response to an assortment of disaster and emergency situations.
   d. Identify alternate sources for supplies and services in the event of a disaster or emergency through establishing mutual-aid agreements with neighboring hospitals and/or healthcare systems; public health departments; hazardous materials response

teams; local fire department; local police department; area pharmacies; medical supply vendors.

e. Identify recovery strategies and actions to be activated in the event of a disaster or emergency situation.

D. RESPONSIBILITY:

1. The ~~Safety/Security Officer~~**Safety (Safety Officer)**, in conjunction with the Environmental Health and Safety Committee is responsible for developing, implementing and monitoring all aspects of the Emergency Operations Plan, including the hazard vulnerability analysis, mitigation, preparedness, response and recovery.
   a. The ~~Safety/Security Officer~~**Safety (Safety Officer)** shall also track National Incident Management System (NIMS) implementation.
   b. The ~~Safety/Security Officer~~**Safety (Safety Officer)** will have a working knowledge of emergency management, the medical centers operations (daily/emergency) and the Hospital Incident Command Center operations.
   c. It will be the responsibility of the medical centers leaders, as well as, medical personnel to actively participate in the organizations Emergency Operations Plan.
   d. The Emergency Operations Plan shall be developed in coordination with local community agencies. The medical center shall communicate its needs and vulnerabilities to community emergency response agencies and identify the capabilities of the community in meeting the needs of the medical center.

E. SPECIFIC PROCEDURES IN RESPONSE TO A VARIETY OF EMERGENCIES BASED ON A HAZARD VULNERABILITY ANALYSIS PERFORMED BY THE MEDICAL CENTER.

1. The medical center has developed specific procedures in response to potential disasters and emergencies that may occur. Additionally, the medical center will create a Hazard Vulnerability Analysis (HVA) to identify areas of vulnerability and to undertake provisions to lessen the severity and/or impact of a disaster or emergency that could affect the services provided by the medical center.
2. The HVA is evaluated on an annual basis and input from the local fire department and community agencies and will be obtained to assure the medical center is aware of hazards in the community to which an emergency response may be required.
3. The medical center has developed a Utilities Disruption Matrix designed to provide available operational hours prior to departmental shut down or commencing of evacuation procedures. The Utilities Disruption Matrix is based on the medical center having the capabilities of operating self-sufficiently for up to *96 hours* without the assistance of external agencies or resources.
4. For each emergency identified in the medical center's HVA as a high risk, the following shall be defined:
   a. Mitigation activities that are designed to reduce the risk of potential damage due to an emergency situation.
   b. Preparedness activities that organize and mobilize essential resources.
   c. Response strategies and actions to be activated during an emergency situation.
   d. Recovery strategies/actions that will help restore the systems that are critical to resuming normal operations of the medical center.
5. Will maintain a documented inventory of on-site assets and resources that will be needed during an emergency. At a minimum, this inventory should include:
   a. Personal Protection Equipment (PPE)
   b. Water
   c. Fuel
   d. Staffing
   e. Linen
   f. Cleaning Supplies

g. Food
h. Medical/Surgical Resources
i. Pharmaceutical Resources

6. The inventory of assets and resources shall be evaluated on an annual basis or as needed.
7. Methods shall be in place for the monitoring of the inventory of assets and resources during an emergency situation.

F. DEFINE AND INTEGRATE THE MEDICAL CENTERS ROLE WITH THE COMMUNITYWIDE EMERGENCY OPERATIONS EFFORTS TO PROMOTE INTER-OPERABILITY BETWEEN THE FACILITY AND THE COMMUNITY:

1. The Emergency Operations Plan shall be tested and exercises shall be developed based on the medical center's top scoring emergency situations within the Hazard Vulnerability Analysis. The exercise shall validate the effectiveness of the Emergency Operations Plan and will identify opportunities to improve.
2. The Emergency Operations Plan shall be tested and exercised a minimum of two (2) times per year, either in response to an actual emergency or in a planned exercise.
3. Only one (1) exercise per year shall include an influx of volunteer or simulated patients.
4. At least one (1) exercise per year shall be evaluated to see how effectively the hospital performs when the medical center cannot be supported by the local community for up to 96 hours. (Tabletop sessions are acceptable to meet the community portion of this exercise).
5. If applicable, the medical center will participate in at least one (1) communitywide exercise annually that is relevant to the priority of emergencies defined in the hazard vulnerability analysis. (Tabletop sessions are acceptable to meet the community portion of this exercise).
6. The Director of the Environment of Care is identified as the designee whose sole responsibility during emergency response exercises is to monitor performance and document opportunities for improvement.
7. The medical center cooperates with all local, county and state emergency management exercises. The ~~Safety/Security Officer~~**Safety (Safety Officer)** is a member of the countywide emergency management system and coordinates with other agencies on any large scale exercises. San Diego Department of Public Health and Human Services Agency/EMS and Statewide Disaster planning efforts, coordinate with local police, fire and ambulance services in conjunction with acute care facilities.

G. COMMAND STRUCTURE:

1. The command structure utilized by the medical center in coordination with the communitywide structure will be the Hospital Incident Command System (HICS).

H. INITIATING THE PLAN, INCLUDING DESCRIPTION OF PLAN ACTIVATION:

1. The Emergency Operations Plan will be activated when it has been determined that a disaster or emergency situation has occurred or has the potential of occurring.
2. The Joint Commission's definition of an emergency:
   a. *"a natural or man-made event that significantly disrupts the environment of care; that significantly disrupts care and treatment; or that results in sudden, significantly changed or increased demands for the organizations services. Some emergencies are called 'disasters' or 'potential injury creating events'."*
3. When the facility is notified of an emergency situation, the person receiving notification will immediately notify the Chief Executive Officer or his/her designee of the situation whether it be an external or internal emergency. The ~~Nursing House~~**Administrative** Supervisor will respond to the site of an internal emergency and report back to the Chief Executive Officer or his/her designee, the status of the situation.
4. The Chief Executive Officer or his/her designee will evaluate the emergency situation to determine whether the Emergency Operations Plan will be activated. If the Emergency Operations Plan is to be activated, the Chief Executive Officer or his/her designee will notify the Switchboard Operator to announce Code Orange External/Internal overhead.

5. The Chief Executive Officer or appointed designee will assume responsibility of the Hospital Incident Command center and activate the appropriate positions noted on the Incident Management Team Chart as deemed necessary for the occurrence:
   a. Until the Incident Command System is in place, the Chief Executive Officer or his/her designee will determine if the Labor Pool will be opened depending on the size of the emergency situation. If the Labor Pool is not opened, the Nursing House Supervisor may assign additional assistance to the Emergency Area as needed. Additional personnel will be called in as needed via the staff call back system.
   b. The Nursing House Supervisor will notify additional outside agencies that may need to assist the medical center in the event of an internal emergency (*i.e. fire department, police department or other agencies).*
6. The recovery phase will be initiated after the emergency situation is over and the medical center has been evaluated. The recovery phase of the plan is to be initiated by the Chief Executive Officer or his/her designee.

I. COMMUNICATION:

1. Notification of External Authorities:
   a. The medical center shall have a communications system in place, including two-way radio equipment and operators who are familiar with the equipment's operation.
   b. The medical center will provide for alternate communication methods in the event of a failure. Two-way radio equipment and cell phones shall be available in the event of an emergency. In the event that cell phones are not working, microwave communications, satellite phones, ham radios or portable 800 MHZ radios may be used.
2. The ~~Safety/Security Officer~~**Safety (Safety Officer)** will approve media access to the facility, with only the Public Information Officer (PIO) interacting with the media.
3. A medical record system will be used to meet the minimum requirements of emergency management operations.

J. PERSONNEL RESPONSIBILITIES:

1. Notification of Personnel When Emergency Operations Plan is initiated:
   a. In an emergency situation which is so wide spread to be considered an emergency and/or involving mass casualties, all medical center personnel, regardless of position, are expected to report to the medical center as soon as it is feasible to travel. Each department director maintains a current callback list of all personnel assigned to their department. Once the Emergency Operations Plan has been activated, the department director in cooperation with Human Resources will assign a staff member to initiate the call back list.
   b. In the event there are excess personnel, the Hospital Command Center will communicate with department directors regarding rescheduling of personnel future needs. The medical staff will report to the Chief of Medical Staff or Medical Specialist Officer for their assignments.
2. Alternate Roles and Responsibilities of Personnel during Emergencies:
   a. Personnel may not be assigned to their regular duties. Personnel will be asked to perform various jobs which will be considered vital to the effective operation of the hospital during the emergency situation. Personnel will be assigned duties based on the needs of the medical center. If personnel are not needed in their perspective units/departments, they will be sent to the Labor Pool for assignment.
3. Identification of Personnel in Emergencies:
   a. Personnel on duty during activation of the Emergency Operations Plan will be identified by their picture identification nametag, which is mandated to be worn at all times while on duty.
   b. Only persons wearing proper identification or possess valid credentials shall be allowed entrance into the medical center during an emergency situation.
4. Personnel Activities and Support:

a. The medical center has made provisions for staff support that can be implemented in the event of a communitywide emergency. Such provisions may include but not limited to:
   i. Temporary housing/lodging needs.
   ii. Transportation needs.
   iii. Family support needs, as necessary (including short term child care)
   iv. Incident stress debriefing and counseling.

5. Orientation and Training:
   a. Personnel will attend orientation upon hire and annually thereafter, reviewing their specific roles and responsibilities during an emergency/disaster situation.
   b. In-service education will be given to the specific staff on the backup communication system and obtaining supplies/equipment in the event of an emergency/disaster situation.
   c. The ~~Safety/Security Officer~~**Safety (Safety Officer)** or designee is responsible for in-servicing personnel to the Emergency Operations Plan.
   d. The department directors are responsible for in-servicing their department personnel on the department specific responsibilities during an emergency/disaster situation.

K. EMERGENCY CREDENTIALING OF CAREGIVERS:

1. To provide a mechanism for emergency credentialing and granting privileges to volunteer/non-staff licensed independent practitioners in the event of a disaster.
2. The Chief Executive Officer or Chief of Staff or their designee(s), may grant emergency privileges upon presentation of a valid picture ID (issued by a state, federal or regulatory agency) e.g., driver's license or passport and at least one of the following:
   a. A current license to practice or primary source of verification of the license.
   b. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT)
   c. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity.
   d. Presentation by current facility or medical staff member with personal knowledge regarding practitioner's identity.
3. Verification of Information:
   a. Verification of the required information shall be done by the Medical Staff Office or designee as soon as feasible. A record of this information will be retained in the Medical Staff Office.
4. Conditions of Emergency Privileges:
   a. The emergency designee must practice under the direction and supervision of an existing member of the ~~Tri City Medical Center~~**TCHD**.

L. RESOURCES AND ASSETS:

1. The medical center keeps a documented inventory of assets it has on site that would be needed in the event of an emergency or disaster situation. At a minimum, the inventory should include:
   a. Linen
   b. Cleaning Supplies
   c. Personal Protective Equipment (PPE)
   d. Water
   e. Food
   f. Fuel
   g. Staffing
   h. Medical Resources and Assets
   i. Surgical Resources and Assets
   j. Pharmaceutical Resources and Assets

2. Methods are established to monitor quantities of assets and resources during an emergency or disaster situation.
3. Arrange for emergency/disaster supporting services to be performed by local businesses, utility companies, government agencies and individuals. Emergency/ disaster supporting services may include:
   a. Transportation
   b. Communications
   c. Traffic Control
   d. Food Supplies
   e. Utility Maintenance
   f. Medical Supplies
4. These arrangements must be coordinated with the assistance of the ~~Safety/Security Officer~~**Safety (Safety Officer)**, San Diego Department of Public Health or the local Office of Emergency Services (OES) whenever possible.
5. The medical center shall estimate its emergency needs for each kind of support and when feasible arrange to have supporting supplies, equipment and manpower pre-designated for medical center use.
6. Essential supplies, pharmaceuticals, medical supplies, equipment, food, water, linen, cleaning supplies and utilities shall be provided to meet shelter requirements for up to *96 hours* when the medical center cannot be supported by the community. Procedures are in place for the procurement of additional supplies in an emergency.
7. In the event that the medical center cannot be supported by the local community for at least *96 hours,* the Chief Executive Officer/Incident Commander, Incident Command Staff and in consultation with community leaders, will evaluate the following options and implement those options that best serve the medical center and community:
   a. Conservation of Resources
   b. Curtailment of Services
   c. Supplementing of resources from outside of the local community
   d. Staged Evacuation
   e. Total Evacuation

M. SAFETY AND SECURITY:

1. Efficient traffic flow must be established:
   a. Prepare floor plans which designate areas for specific patient care functions and ensure that personnel are familiar with these plans.
   b. Prepare and have available traffic control tools to show external and internal routing of casualties and other traffic.
   c. Assign and train volunteers to perform traffic control and security functions.
2. At the time the Emergency Operations Plan is activated, the Security Department personnel will be responsible for locking all exits and entrances with the exception of the ambulance entrance which will be manned. The Security Staff shall maintain control of entry and egress from the facility. Personnel of the medical center are required to wear badges identifying them as personnel. Only persons with proper identification shall be admitted to the medical center during an emergency situation.
3. Radioactive or Chemical Isolation and Decontamination:
   a. There is a designated decontamination room with separate ventilation system or ventilation shut off available for radioactive or chemical isolation and decontamination. Staff is trained in the response to radiological, biological, chemical or hazardous material contamination.
   b. Arrange with a local or State Emergency Management Agency Director (if applicable) for the training of staff who would perform the radiological monitoring of casualties and hospital areas and the acquisition of necessary radiological monitoring equipment. This equipment shall be stored in the medical center as part of its essential emergency supply equipment.

N. UTILITIES MANAGEMENT:

1. The medical center will provide for alternative sources of essential utilities, including:
   a. An emergency source of electrical power capable of operating all essential electrical equipment and plan for failure of back-up generators
   b. An alternate source for medical gas and vacuum delivery
   c. An alternate means of waste disposal in the vent of sewage system failure
   d. Sufficient fuel to last for at least *96 hours* of expanded operation

O. PATIENT CLINICAL AND SUPPORT ACTIVITIES:

1. Management of Patients during Emergencies (i.e. Scheduling, Modification or Discontinuation of Services, Control of Patient Information and Patient Transportation)
   a. Upon activation of the Emergency Operations Plan, normal admission requirements will be modified. Initially, admissions to the medical center will be limited to those whose survival depends upon services obtainable only through medical care.
   b. Outpatient care will be restricted to those whose lives may be ultimately depending upon the present expenditure of medical supplies and health manpower time.
2. All elective admissions and procedures will be canceled, including elective surgery, no emergent outpatient and transferring patients who are stable to be discharged.
   a. Patients may be transferred to other facilities so those emergency victims may be accommodated.
   b. Individuals may be redirected or relocated for a Medical Screening Exam in the event that the Emergency Operations Plan has been activated. (Section 1135(b) of the Social Security Act §489.24(a)(2)).
   c. In the event the Emergency Operations Plan is activated, persons may be transferred prior to being stabilized, if, based upon the circumstances of the emergency the medical center is unable to provide proper care or treatment of services. (Section 1135(b) of the Social Security Act §489.24(a)(2)).

P. EVACUATION OF THE FACILITY:

1. When an emergency situation arises requiring evacuation of patients from threatened or affected areas, the safety of lives at ~~Tri City Medical Center~~**TCHD** is the primary concern. Authority to order an evacuation is vested only with the Chief Executive Officer **(CEO)** or **in the event the CEO is unreachable then** his/her designee**(s) in the following order: Chief Operating Officer, Chief Nurse Executive**, or the ~~Safety/Security Officer~~**Safety (Safety Officer)**. Patients shall be evacuated to an area of safety by whatever means are available. Formal agreements are in place with ambulance services and alternate care sites to transfer patients as necessary.
2. All personnel have been trained in evacuation procedures. Evacuation routes are posted throughout the medical center.
3. Relocation to alternate health facility or place of safety (i.e., churches, schools)
   a. Prepare maps of routes to relocation site
   b. Confirm periodically the availability of the relocation site
   c. Establish lists of supplies and equipment, by priority, to be relocated
   d. Arrange adequate transportation for evacuation and relocation
4. Establishing an Alternate Care Site When the Environment Cannot Support Adequate Patient Care
5. Formal agreements should be in place so that patients may be transferred to a facility that can provide adequate patient care. The Liaison Officer will be responsible for the inter-facility communication between the medical center and the designated alternative care site, and for retaining records of which patients were transferred to and/or from an alternative care site. The patient care unit transferring the patient is responsible for obtaining copies of the patient's medical records, gathering personal belongings and ensuring the patient's medications are continued throughout the transfer. If an medical equipment is transferred with the patient, the

patient care unit is responsible for documenting what equipment was transferred with the patient so that equipment may be retrieved during the recovery phase post emergency. The following agreements are in place:

a. Ambulance contract agreements for transfer of patients between facilities
b. Transfer agreements will be made between neighboring facilities
c. Emergency acquisitions of medical supplies, pharmaceuticals, food, equipment, water, linen, emergency repair services, etc

Q. CONTINUING AND/OR RE-ESTABLISHING OPERATIONS FOLLOWING AN EMERGENCY:

1. The medical center has mechanisms in place to restore the operational capabilities of the facility to pre-emergency levels. Once the emergency is over, the Engineering Department, including the Director of Facilities, ~~Safety/Security Officer~~**Safety (Safety Officer)**, Risk Manager and other administration representatives, will begin assessing the damage to the facility and the environmental concerns to determine whether the medical center can safely provide medical care to the community and proved a safe environment for patients, personnel and visitors.
   a. Picture and/or videos will be taken of all damages to the facility's buildings, grounds, equipment, etc., including all off campus facilities.
   b. Architects, building inspectors and structural engineers may be called in to determine if the buildings are safe for occupancy.
   c. All potential environmental concerns will be evaluated for proper function, i.e., hazardous waste, fuel tanks, to ensure there is no leakage into the local sewer or water system or any other impact on other environmental concerns.
   d. Ensure personnel support programs have been instituted, i.e., crisis counseling, flexible work hours, cash advances, day care, particularly if your personnel and the medical center have been directly impacted by the emergency.
   e. Clear debris and secure unsafe buildings as necessary.
   f. Restore internal and external communication devices
   g. Inventory equipment and supplies for damage and determine if additional supplies need to be obtained from suppliers. Picture/videos will be taken of all damaged supplies and equipment for insurance purposes. Damaged supplies and equipment will be retained until approval is received from insurance providers for disposal.
2. Notify the community through local media services regarding the services the medical center will be providing and the location they will be provided in the event that services are moved off-campus.
   a. Notify the medical center's insurance provider and contact third-party expert to prepare the claim.
   b. Ensure records and data have been protected and restore information as necessary from backup tapes.
   c. Keep detailed records.
3. A proactive process shall be developed and implemented to seek other federal funding to support preparedness that takes advantage of developing interoperability training with local and regional multi-disciplinary partners.

R. PERFORMANCE STANDARDS:

1. There is a planned, systematic, interdisciplinary approach to process design and performance measurement analysis and improvement related to organization wide safety. The Environmental Health and Safety Committee will develop and establish performance measures and related outcomes in a collaborative fashion, based on those priority issues known to be associated with the healthcare environment. Performance measures and outcomes will be prioritized based upon high risk; high volume, problem prone situations and potential or actual sentinel event related occurrences. Criteria for performance improvement measurement and outcome indicator selection will be based on the following:
   a. The measure can identify the events it was intended to identify

b. The measurement has a documented numerator and denominator statement or description of the population to which the measure is applicable.
c. The measure has defined data elements and allowable values
d. The measure can detect changes in performance over time
e. The measure allows for comparison over time within the organization or between the organization and other entities.
f. The data intended for collection is available.
g. Results can be reported in a way that is useful to the organization and other interested stakeholders.

S. NIMS PREPAREDNESS FUNDING:

1. ~~Tri City Medical Center~~**TCHD** shall establish a working relationship with State and San Diego County Department of Health and Human Services Agency/EMS and state associations to identify activities to obtain and appropriately allocate preparedness funding.
2. The Environmental Health and Safety Committee on an on-going basis monitors performance regarding actual or potential risk related to one or more of the following:
   a. Personnel knowledge and skills
   b. Level of personnel participation
   c. Monitoring and inspection activities
   d. Emergency and incident reporting
   e. Inspection, preventative maintenance and testing of safety equipment
   f. Other performance measures and outcomes will be established by the Environmental Health and Safety Committee based on the criterion listed above. Data sources, frequency of data collection, individual(s) responsible for data collection, aggregation and reporting will be determined by the Environmental Health and Safety Committee.
3. To identify opportunities for improvement/corrective action, the Environmental Health and Safety Committee will follow the organization's improvement methodology. The basic steps to this model will consistently be followed and include planning, designing, measuring, analyzing/assessing, improving and evaluating effectiveness. Should the Environmental Health and Safety Committee feel a team approach is necessary for performance and process improvement to occur, the Environmental Health and Safety Committee will follow the organization's performance improvement guidelines for improvement team member selection.
4. Determination of team necessity will be based on those priority issues listed (high-risk, volume and problem prone situations and sentinel event occurrence). The Environmental Health and Safety Committee will review the necessity of team development, requesting primarily, team participation only in those instances where it is felt the Environmental Health and Safety Committee's contributions toward improvement would be limited (due to specialty, limited scope and/or knowledge of the subject matter). Should team development be deemed necessary, team members will be selected on the basis of their knowledge of the subject identified for improvement and those individuals who are "closest" to the subject identified. The team will be interdisciplinary, as appropriate to the subject to be improved.
5. Performance Improvement monitoring and outcome activities will be presented to the Environmental Health and Safety Committee by the ~~Safety/Security Officer~~**Safety (Safety Officer)** at least on a quarterly basis, with a report of performance outcome to the Organizational Performance Improvement Committee.

T. ANNUAL EVALUATION OF THE EMERGENCY OPERATIONS PLAN OBJECTIVES, SCOPE, PERFORMANCE AND EFFECTIVENESS:

1. The annual evaluation of the Emergency Operations Plan will include a review of the scope according to Joint Commission standards and NIMS requirements to evaluate the degree in which the program meets accreditation standards, NIMS requirements and the current risk assessment of the medical center.
   a. A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met.

b. The overall performance of the program will be reviewed by evaluating the results of performance improvement outcomes. The overall effectiveness of the program will be evaluated by determining the degree that expectations were met.

c. The Emergency Operations Plan shall be revised and updated based on the annual evaluation of the Emergency Operations Program, including the Hazard Vulnerability Analysis.

2. The performance and effectiveness of the Emergency Operations Plan shall be reviewed by the Environmental Health and Safety Committee, the **Quality Assurance** Performance Improve**ment** Committee, Administration and reported to the Board of Directors as well.

TRI-CITY HEALTHCARE DISTRICT Safety Policies & Procedures	**Section:** Emergency Preparedness Management **Subject:** Emergency Preparedness Management Disaster Plan **Policy Number:** 4000 Page 1 of 3
Department: Hospital Wide	**EFFECTIVE:** 7/87 **REVIEWED:** 7/90, 7/93, 7/96, 6/12 **REVISED:** 3/97; 5/00, 4/03,10/05, 6/08

1.0 ~~Purpose:~~

~~To insure efficient Emergency Preparedness Management services, and to maintain adequate availability of personnel in the event of disaster.~~

~~2.0 Introduction:~~

~~Due to the varying types and magnitudes of emergency events, Tri-City Medical Center has adopted the command structure of Hospital Emergency Incident Command Systems (HEICS). Once the decision has been made to activate the disaster plan, the HICS becomes the standard operating procedure. The complete plan is located in the TCMC Disaster Plan Manual located in each department.~~

~~French Rooms 1 and 2 are designated as the Incident Command Center (ICC).~~

~~3.0 Notification:~~

~~In the event of a disaster of a Code Orange or Code Yellow, departments will be notified via the overhead paging system. Management staff is to be notified by their respective area lead staff via pager/phone 24/7.~~

~~3.1 Director/ Designee Responsibilities~~

~~a. All hospital Directors are responsible for the following disaster preparations:~~

~~1) Orientation of department personnel to the overall disaster plan and training and specific departmental responsibilities.~~
~~2) Orientation of staff to evacuation routes.~~
~~3) Regular review of the disaster plan with all personnel~~
~~4) Maintain up to date telephone lists of all employees both in the department and at home. Lists to be reviewed quarterly and revised, as necessary.~~
~~5) Determine a plan for calling in staff form home, depending on the disaster situation and the needs of the individual department as necessary.~~

~~**3.2 Manager / Supervisor Responsibilities**~~

~~a. Following the activation of the plan for a disaster or a drill, each Manager/ Supervisor will:~~

~~1) Report to the IC Center and assign leadership to responsible person.~~
~~2) If designated in their Unit/Department Policy, send appropriate staff to the ICC.~~
~~3) Evaluate staffing levels and send one person to the labor pool if possible.~~
~~4) If a patient care area, prepare log for bed availability, including patients who can be discharged, transferred or relocated to another area of responsibility.~~
~~5) Revaluate staffing schedules, as needed.~~
~~6) Participate in a critique immediately following an actual disaster or drill if appropriate.~~
~~7) Prepare a written summary of activities occurring within each respective department utilizing the Disaster Drill Report form if appropriate.~~
~~8) Attach suggestions for a resolution of any problems that may have occurred.~~
~~9) Submit reports to the Disaster Committee Chairperson, Environment of Care/ Safety Officer within 48 hours, following a disaster or disaster exercise.~~

~~**3.2 Employee's Responsibilities:**~~

~~a. Be familiar with the Disaster Plan and review it regularly.~~
~~b. Know and be prepared to perform specific responsibilities. Participate in regular training sessions and exercises.~~
~~c. Know how to use the telephone notification chain and keep the telephone list at home.~~
~~d. The management team will plan for long-range staffing, changing the time schedule as necessary.~~
~~e. Extended work shifts may be initiated at the discretion of the Incident Commander to address the needs of the incident.~~
~~f. Status reports from each department and nursing floor should be sent to the Command Center (French Rooms 1 & 2), immediately after the start of the activation of this plan. As the department situation CHANGES throughout the disaster, hourly reports should be faxed to the ICC.~~
~~g. Identification vests identifying employee roles in the disaster will be distributed by the Incident Commander and worn by personnel assigned to critical roles. These vests are distributed at the Command Center in French Rooms 1 & 2.~~
~~h. Hospital photo ID badges are to be worn always and are required for entry into the hospital during a disaster.~~

~~**4.0 ANNUAL SUMMARY**~~

~~a. All Emergency Preparedness Plans and Action Sheets will be evaluated annually for their effectiveness.~~

TRI-CITY HEALTHCARE DISTRICT Safety Policies & Procedures	Section: Emergency Preparedness Management Subject: Emergency Operations Plan Policy Number: 4001 Page 1 of 23
Department: Hospital Wide	EFFECTIVE: 6/08 REVIEWED: 6/11 REVISED:

I. PURPOSE

The Emergency Operations Plan describes the method in which the hospital will respond to an event by activating various support functions within the hospital using the Hospital Incident Command System (HICS) as a model for incident command. This plan outlines the activation and response of the various Sections under HICS, the reporting sites, evacuation plans, Job Action Sheets, and various forms used during a response.

II. POLICY

A. It is the policy of Tri-City Medical Center (TCMC) to provide a system for maintaining the integrity of physical facilities to the best level; continuing the organization's primary mission, saving human life and preventing immediate human suffering; and coordinating emergency/disaster recovery operation efforts.

B. Tri-City Medical Center (TCMC) has adopted the National Incident Management System (NIMS) to manage emergency incidents, exercises and preplanned events. TCMC will utilize the Incident Command System (ICS) as represented by the Hospital Incident Command System to respond to and manage emergencies/incidents.

III. HOSPITAL INCIDENT COMMAND SYSTEM

A. GENERAL

The Hospital Incident Command System (HICS) is an enhanced version of the Hospital Emergency Incident Command System or (HEICS) developed in the early 1990's by Orange County Health Care Agency and revised in 1998 (Third Edition) by the San Mateo County Health Services Agency, Emergency Medical Services. While based on the Hospital Emergency Incident Command System, it incorporates and clarifies the components National Incident Command System as they relate to the hospital.

It is important to note that the Hospital Incident Command System is a management system not an organizational chart. It is built on a the principal that every incident or event requires that certain actions be performed. These include:

1. The problem encountered is recognized and evaluated.
2. A plan to remedy the problem is identified and implemented.
3. Only the necessary resources are assigned.
4. When the plan objectives are completed recovery commences.
5. The response is reviewed and evaluated for organizational learning,

B. INCIDENT MANAGEMENT FUNCTIONS

The HICS organization does not often correlate to the daily administrative structure of the hospital. This practice is purposeful and done to reduce role and title confusion. In ICS the management functions to be performed include:

1. **Command** – The Incident Commander (IC) is the only role that is always activated in an incident regardless of its nature. The function of Command is to access the objectives, devises strategies and priorities, interact with internal and external stakeholders and maintain overall responsibility for managing the incident. The IC may appoint other Command Staff personnel to assist:

   The Executive Staff

   a. The ***Public Information Officer*** (PIO) will be responsible for coordinating information sharing inside and outside the facility.

   b. The ***Safety Officer*** will monitor hospital response operations to identify and correct unsafe practices.

   c. The ***Liaison Officer*** will be the hospital link to outside agencies such as a fire or police incident command post or the local Emergency Operations Center.

   d. ***Medical/Technical Specialists*** are persons with specialized expertise in areas such as infectious disease, legal affairs, risk management, and medical ethics who may be asked to provide the Incident Command staff with needed advise and coordination assistance.

The General Staff

2. **Operations**, represented by the Operations Section Chief, conducts the tactical operations (e.g., patient care, clean up, etc) to carry out the plan using defined objectives and directing all needed resources.

3. **Planning**, represented by the Planning Section Chief, collects and evaluates information for decision support, maintains resource status information, prepares documents such as the Incident Action Plan and maintains documentation for incident reports.

4. **Logistics**, represented by the Logistics Section Chief, provides support, resources and other essential services to meet the operational objectives set by Incident Command.

5. **Finance/Administration**, represented by the Finance Section Chief, monitors costs related to the incident while providing accounting, procurement, time recording, and cost analyses.

The Incident Commander may be able to accomplish all five management functions alone on small scale incidents, but on larger incidents effective management may require that the Incident Commander establish one or more of the four other functions and appoint the Section Chiefs.

C. SYSTEM ATTRIBUTES

1. Responsibility oriented chain of command

This is an incident management structure, which provides for the addressing of many facets of an emergency. It provides a manageable scope of supervision for all functions/positions.

2. Wide acceptance through commonality of mission and language

Through the use of ICS management structure, HICS, fits neatly into the command system used by all public safety agencies, emergency services and most privates agencies in San Diego county. The use of common language rather then agency specific "jargon" increases understanding across a wide range of responders.

3. Prioritization of duties with the use of Job Action Sheets

The Job Action Sheets are position job descriptions, which have a prioritized list of emergency response tasks. The Job Action Sheets also serve as reminders of the lines of reporting and promote the documentation of the incident.

4. Applicability to varying types and magnitudes of emergency events

HICS is a flexible program which can be scaled to meet the particular needs of a specific incident or event.

5. Thorough documentation of actions taken in response to the emergency

The Job Action Sheets and the associated forms promote vigorous documentation of both personal and overall facility response to the incident. This comprehensive documentation may improve recovery of financial expenditures, while it decreases liabilities.

6. Expeditious transfer of resources (mutual aid) within a particular system or from one facility to another

The idea of sharing material and human resources in time of need is not new to hospitals. Mutual aid among medical institutions will be facilitated with a common system of management and terms.

7. Flexibility in implementation of individual sections or branches of HICS

Activation of HICS can be customized to meet the needs of a particular incident or event.

8. Minimal disruption to existing hospital departments by virtue of parallel job qualifications/duties

The HICS Incident Management Team Chart and Job Action Sheets are designed to mitigate an incident affecting the hospital. However, it is readily apparent that there are many individuals within the day to day management structure whose jobs closely match those of the HICS.

D. CHAIN OF COMMAND

1. Figure 1 shows a chain of command that incorporates four sections under the overall leadership of an Incident Commander (IC). The four sections: Logistics, Planning, Finance and Operations, have a Section Chief appointed by the Incident Commander. This structure limits the span of control of each section chief to a reasonable level.

2. Each defined position under HICS has a prioritized Job Action Sheet (JAS) written to describe the duties of each particular role. The job title and the mission will not be

altered, however, the duties found in the sections of the JAS may be modified as a result of organizational learning due to actual events or exercises to meet the needs of the facility.

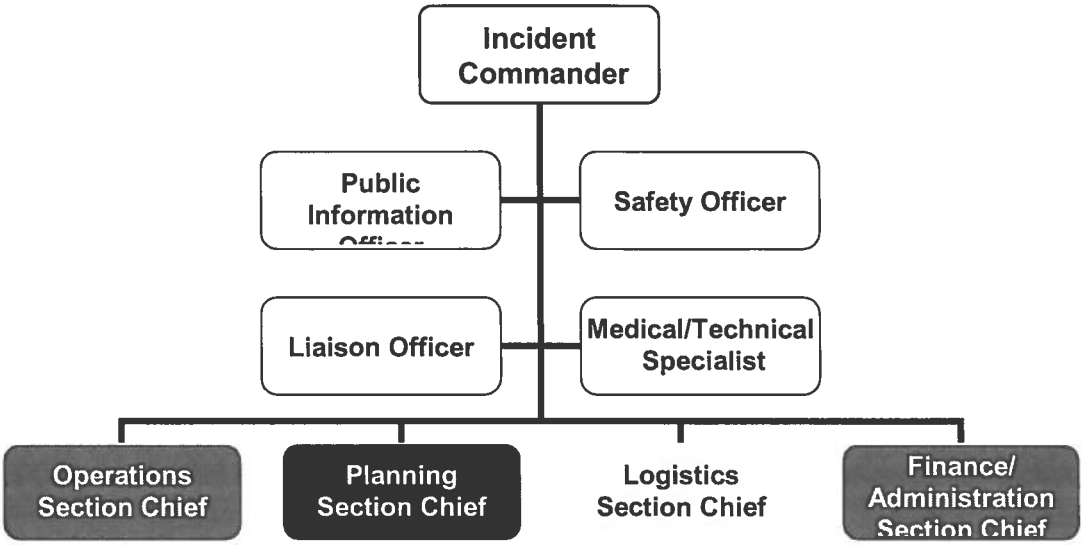


Figure 1.

E. HICS SECTION COLOR DESIGNATION AND IDENTIFICATION

1. Position Identification

All officers will wear a vest or other designation that provides easy identification of their role in the incident response. The color of the vests is dependent on the role/position in the ICS structure or team. The job title is to be placed on the back of the vest and, if possible, on the front.

2. HICS Section Color Designation

Section	Color Designation
Command	White
Operations	Red
Finance	Green
Planning	Blue
Logistics	Yellow

F. PATIENT TRACKING

Patient Tracking is critical following a mass casualty event. Coupled with this is the need to have a patient care record that is concise, yet comprehensive. The patient tracking system and forms are outlined in the HICS Forms policy found in the Emergency Management Manual.

G. DEPARTMENT RESPONSES

Department response to an emergency/disaster incident are required by the Hospital Command Center based on the nature of the incident. Generalized department responses are found in the Key Locations and Department Response Section of the Emergency Management Manual and the checklist in the Emergency Management quick reference. If the response is to be modified for a specific situation, the modifications will be noted in the Section of the manual pertaining to that situation.

H. POSITION DESIGNATIONS

While it must be accepted that the flexibility to assign individuals to assume an officer role is critical, senior positions on the Incident Management Team chart will have an individual identified by normal job title to be the primary for filling the positions. Also, it may be necessary for more than one job action sheet to be delegated to an individual. Currently these roles can be found in the HICS Position Designations Section of the Emergency Management Manual.

I. HICS FORMS

The forms associated with HICS are very simple and self explanatory. While paper work is often portrayed as burdensome, it should also be pointed out that it is only through accurate documentation an event can be reconstructed so that lessons may be learned. Sound documentation is also the beginning step in the road to financial recovery. Samples of the HICS Forms are found in that Section of the Emergency Management Manual.

IV. PROGRAM COMPONENTS/SYSTEMS

A. EMERGENCY MANAGEMENT MANUAL SECTIONS

The HICS publication recognized the need to supplement the management team concept with material dealing with specific emergencies such as earthquakes, utility outage, special threats, etc., which are only addressed generically in the HICS publication. The responses to each of these situations are located in the Emergency Management Manual and various other policies and procedures.

B. ACTIVATION AND INITIAL RESPONSE

Emergency Command Staff

1. The Emergency Command Staff has authority for the purpose and direction of the Emergency Operations Plan. The members include the Chief Operating Officer, Medical Director, Administrator on Call (AOC), Operations Supervisor, Security Supervisor, EOC/Safety Officer, VP Support Services, Chief Nursing Executive.

External Disaster

2. In the event of an incident occurring outside of the Hospital, the need for mass casualty support will be identified by the county Office of Emergency Services and a **"Annex D"** notification will be transmitted by County Communications System to the Emergency Department (ED). An "Annex D" indicates an event has occurred somewhere in the county and that casualties may be sent to the hospital. The ED will notify the Administrator on Call or Operations Supervisor of the Annex D notification, who will in turn advise the other members of the Emergency Command Staff.

3. Upon receipt of a **"Annex D"** notification, the ED will advise the AOC or Operations Supervisor that the hospital may get victims. The AOC or Operations Supervisor will declare a **Code Orange** and authorize telecommunications to initiate the Code Orange activation via overhead page and pagers. The AOC or House Supervisor will report to the Hospital Command Center (HCC) and initiate the HICS response teams.

Internal Disaster

4. An internal disaster is declared when an internal emergency progresses beyond the ability of an initial localized response to contain or suppress the event. Internal emergencies can

include utility system disruptions, clinical equipment problems, communications system failures, fire, bomb threats or other similar situations.

5. Any staff member responding to an urgent situation in accordance with the hospital red emergency procedures flip chart can initiate a call to any member of the Emergency Command Staff, the AOC or Operation Supervisor for assessment of the situation and authorization to initiate the Code Orange. Notification of the Command Staff will be made via pagers, phone or email. The Incident Commander in conference with Command Staff will determine and authorize the appropriate level of response.

6. As a general guide, **it is better to be premature in declaring an emergency than to delay the activation!** The HICS organization allows the response to grow or scale down according to the situation. When the decision to declare a **Code Orange** is authorized, the PBX operator will initiate the Code Orange activation via overhead page and pagers. (See below.) The AOC or Operations Supervisor will report to the Hospital Command Center (HCC) and initiate the appropriate HICS response teams.

7. Specific Code Activation Authorization

CODES will be activated by the individuals as designated below. If the individuals identified are not available, the Operations Supervisor or designee may activate the Emergency Operations Plan.

CODE ACTIVATION	**AUTHORIZATION AUTHORITY**
Full activation of the HICS structure.	Administrator, Administrative Directors, Administrator On Call, Safety Officer or designee. Administrative Coordinator
CODE BLUE (Medical Emergency, Adult)	Any hospital staff member.
CODE PINK (Medical Emergency, Infant)	Any hospital staff member.
CODE RED (Fire)	Any staff member. Pulling fire alarm initiates CODE RED
CODE YELLOW (Radiation Exposure)	All individuals authorized to initiate HICS and Radiation Safety Officer or designee.
CODE ORANGE (General Disaster)	All individuals authorized to initiate HICS and Laboratory Safety Officer or Pharmacy Director.
CODE ORANGE (Mass Casualty)	All individuals authorized to initiate HICS and Emergency Dept. Charge Nurse/or OnDuty Physician
CODE ORANGE (Disruption of Services)	All individuals authorized to initiate HICS and Facility Support Services Director/Supervisor.
CODE ORANGE (Community Disaster)	All individuals authorized to initiate HICS
Dr. Strong (Violent Person, Not Known to be Armed)	Any hospital staff member
CODE GRAY (Person, Armed or Hostage)	Any hospital staff member.
CODE GREEN (Oxygen Failure)	Any hospital clinical staff

CODE ACTIVATION	AUTHORIZATION AUTHORITY
CODE ADAM (Missing/Kidnapped Person)	Any hospital staff member

8. The Incident Commander determines the degree of recovery activity required. The Incident Commander is responsible for assigning clinical and management staff to oversee recovery activities. The Emergency Operations Plan is continued in force until the recovery can be affected or long-term recovery responsibilities are assigned. Long-term recovery operations are developed and directed by the Hospital Executive Management Team.

9. Activation Duties

Notification of Emergency Operations Plan activation by the PBX operator or appropriate personnel through the overhead paging system will be by repeating the following statement every 5 minutes during first 30 minutes, or as often as the Incident Commander directs.

"YOUR ATTENTION PLEASE"

"CODE DESIGNATION AND LOCATION"

"Hospital Command Center LOCATION"

(If activated)

10. Response Upon Activation

a. During normal working hours: Upon hearing the activation code or receiving a recall, personnel will report to the location required by the nature of the incident and their individual responsibility for incident response. In the absence of any specific responsibility, the individuals will report to their normal duty section for further assignment as required for response to the incident.

b. After normal working hours: The Hospital Command Center will be established and manned with individuals designated by the Operations Supervisor. All department personnel will initially report and sign in to to the Labor Pool. Engineering staff will report directly to the site of an internal incident or the Engineering Offices. Off duty managers will report to the Hospital Command Center.

11. Termination of Code

The decision to terminate the incident response will be made by the Incident Commander. Notification of termination of the Emergency Operations Plan activation will be made over the overhead paging system by repeating three times, "CODE DESIGNATION and ALL CLEAR.

C. ALERT SYSTEM

When possible a tiered disaster notification system will be used in the event of an external disaster. The system consists of an Alert Phase and an Activate Phase. The Alert Phase will be initiated when the hospital receives notification of a multicasualty event. The Activation Phase

will be implemented when patients are transported from the scene of the disaster. NOTE: The Alert Phase could go immediately into the Activation Phase.

D. TYPES OF EMERGENCIES/DISASTERS

1. CODE RED: FIRE

The initial CODE RED designation will not activate the Emergency Operations Plan unless the fire is deemed out of control. **RACE: R**escue, **A**larm, **C**onfine, **E**xtinguish will be followed. When a fire is determined to be out of control, the PBX will be notified to announce the activation of the plan/Incident Command Center.

2. CODE YELLOW: RADIOLOGICAL CONTAMINATION

This CODE represents a situation involving either a radiological spill or a radiologically contaminated individual from San Onofre Nuclear Generating Station (S.O.N.G.S.). The magnitude of the problem will dictate the level of response.

3. CODE ORANGE: **HAZARDOUS SPILL OR CONTAMINATION**

This CODE represents a situation involving a chemical or biological spill. The magnitude of the problem will dictate the level of response.

4. CODE ORANGE (Mass Casualty): **INTERNAL/EXTERNAL DISASTERS INVOLVING CASUALTIES**

CODE ORANGE/ Mass Casualty will be initiated when the number of casualties to be received from either an internal or external disaster exceed the number the Emergency Department can manage with normal operating procedures or when the hospital is notified of an activation of the county disaster plan, Annex D. If a facility is damaged to a significant extent and/or there are more casualties than can be handled, the County Emergency Operations Center will be contacted in accordance with Annex D of the San Diego County Emergency Plan, and the patients evacuated as directed.

5. *CODE ORANGE*: **DISRUPTION OF SERVICES**

Disruption of essential services caused by natural disaster, utility failure, employee walkout or any other service emergent or planned failure within a facility that warrants the initiation of the HICS for incident management.

6. CODE ORANGE: **Lockdown**

The need to lockdown a facility varies but generally falls into the categories of access control. A single point of entry/egress will be established and controlled as the situation dictates. Civil disturbances will be managed by local law enforcement with the hospital's responsibility being to prevent any element of the disturbance from entering the facility.

7. CODE GRAY: **SPECIAL THREAT SITUATION, VIOLENT PERSON (ARMED)**

In Special threat situations the major objectives are to isolate the situation, confine any further involvement, and allow law enforcement to deal with the situation. The emergency response will initially be to a designated area other than the location of the situation. Law Enforcement will be contacted immediately and manage the individual(s) with weapons or who have taken hostages.

The Incident Commander will form a Unified Command with Law Enforcement representatives to ensure the safety of our patients, visitors and staff.

8. CODE ORANGE : **BOMB THREAT RESPONSE**

A CODE ORANGE will be used to activate the Bomb Response Plan in support of any bomb threat or the location of any suspected explosive device.

9. CODE ADAM: MISSING PERSON/KIDNAPPING

A CODE ADAM will be passed for a kidnapped or missing person. All entrances will be closed and guarded. All staff will look for individuals who do not look like they belong.

E. STAFF SUPPORT AND ASSISTANCE AREA

The Staff Support and Assistance Area is provided for the use of all staff members during a disaster. The Employee Health and Well Being Unit Leader ensures the the availability of behavioral and psychological support for the hospital staff.

1. Employee Rest Area: In a prolonged response, it may become necessary to create a location for staff members to sleep, obtain food, and to relax. An area will be assigned for this purpose.

2. Employee Assistance Area: In conjunction with the Rest Area, an Assistance Center for the use of all staff members will be established.

3. The purpose of this Center will be to provide a large scope of assistance from helping resolve administrative problems to helping prevent secondary injury caused by emotional trauma.

4. A key element of the Employee Assistance is that it will provide a place where staff members may come to contact their families, either in person or via telephone, at any time and, if necessary, obtain help in dealing with any problems that might arise from their being absent from the family

F. KEY LOCATIONS

The following Key Locations will be planned for and established during an emergency/disaster as required by the scope of the situation. The primary locations are:

1. Incident Command Center (French Rooms 1 &2)

2.

6. Medical Care Director's Office

7. Triage Area

8. Immediate Treatment Area

9. Delayed Area

10. Minor Injury Treatment Area

11. Morgue

12. Patient Information Center

13. Press Briefing Area

14. Staff Support and Assistance Area

15. Labor Pool

16. Dependent Care

17. Shelter in Place Area – North West area adjacent to BAMS building

The above areas will be established during the event.

V. REPORTING

A. Internal reporting will consist of status reports. These reports will normally include personnel and department readiness and disruption of services information (damage reports). All departments/Nursing Units will submit status reports as directed by the Incident Commander and type of incident. Form HICS 302, "Department Disaster Status Report" should be used for these reports.

B. President and CEO Office (760-940-3352) will be contacted and made aware of disaster responses.

C. A report of disaster involving the discontinuance or disruption of services or upon the threat of a walkout or a substantial number of employees, or earthquake, fire, power outage or other calamity that causes damage to the facility or threatens the safety or welfare of patients or clients is to be rendered to the State Department of Health as required in Title 22 Section 70746.

D. For HAZMAT emergencies/disasters, which can not be internally managed, the appropriate San Diego County HAZMAT office can be contacted by dialing 911 and stating that a chemical, biological, or radiological emergency exists.

E. All emergencies which disrupt normal operations to the point of interfering with patient care will be reported to the County Medical Operation Center and other state/county agencies as required by regulations.

VI. COMMUNICATIONS

A. Communications plans will have site specific details.

B. **Emergency Medical Services Communications:**

1. In the event of an external disaster, receiving hospitals will be notified of incoming patients through the County Base Hospital system. Notification of incoming patients will be accomplished via the County 800 MHz Regional Communication System (RCS) radio system, San Diego County QCS system, telephone, or microwave radio system.

2. External events will be coordinated through the Officer of Emergency Services (OES) via the Medical Operations Center (MOC). Additional resources (personnel and materials) not available to Tri-City Medical Center the MOC will coordinate all requests. The county will be updated on emergency status via WebEOC or other systems as required.

3. In the event of failure of the County Communications System and/or telephones, arrangements have been established through the County Mass Casualty Plan: Annex D, for ARES, the amateur ham radio station system, to be activated and report to area hospitals. An antennae and radio hook-ups are preestablished for the ARES radio operators at each facility.

C. As part of the Tri-City Medical Center Communication Plan an alternate means of communications system has been developed when telephone service or cellular phones are not available. This Emergency Communications program is a radio system comprised of a base station, Satellite phone and hand-held units assigned to key decision makers to facilitate intra system communications. The system will provide stable, reliable communications between staff, Hospital Administrators, Facility Administrative Directors, Security Operations Management and the Hospital Command Center.

VII. ADDITIONAL REQUIREMENTS

A. DIALYSIS SERVICES

Included in information regarding CODEs RED, ORANGE, and EVACUATION AND DISCHARGE accompanying the management plan are dialysis procedures for use during evacuation.

B. EMPLOYEE'S IDENTIFICATION

Photo identification badges will function as staff identification during activation of the Emergency Operations Plan. Volunteers will receive a temporary badge after credentialing.

C. DEPARTURE OF ON-DUTY STAFF PERSONNEL

Staff personnel on duty, upon initiation of this plan, will not be authorized to depart the facility without approval from their department head. The department head shall first receive approval to release individuals from the Incident Commander.

D. OFF-DUTY STAFF PERSONNEL

During emergencies/disasters, individuals will normally be contacted and will be expected either to come to their facility or to be placed on standby. During an earthquake only, staff personnel will report to the Labor Pool as soon as possible without a recall. DO NOT CALL THE HOSPITAL! ALLOW THE RECALL SYSTEM TO CONTACT YOU AT YOUR HOME.

E. CLERGY

Clergy will be allowed into restricted areas to minister to the spiritual needs of the casualties at the discretion of the appropriate Unit Leader. Clergy will also be used to assist in family notification when possible. A list of clergy will be maintained, and they will be contacted and assistance requested, if required.

DEPARTMENTAL RESPONSIBILITES IN EMERGENCY RESPONSE

In an emergency, the Chief Executive Officer, Chief Operating Officer, Vice President Support Services, Chief Nursing Executive, or the on-duty Administrator will assume the role of Incident Commander.

INCIDENT COMMANDER: The Incident Commander's focus is on the management of the hospital. In order to make informed decisions, a briefing with all Section Chiefs should take place as soon as possible. Information is needed from each section so the IC can issue the general directives concerning the hospital.

1. Initiate the Hospital Incident Command System (HICS) by assuming role of Incident

Commander. Refer to the Incident Commander's Job Action Sheet.

2. Assign a Deputy Incident Commander, Command Staff (PIO, Safety Officer, Liaison Officer, and Medical/Technical Specialist), and General Staff (Operations, Planning, Logistics, and Finance/Administration), as needed.
3. Activate the Hospital Command Center (HCC) French Rooms 1&2, and coordinate the hospital's emergency response. The IC has command of all hospital personnel and resources during an emergency.
4. Check with local authorities to verify magnitude and scope of the disaster and other additional information.
5. Assign Liaison Officer to Local Emergency Operations Center (EOC), if activated.
6. Authorize announcement of disaster to hospital personnel utilizing the Concept of Operations outlined in the EOP.
7. Request assistance from local law enforcement, fire, and volunteer organizations as necessary.

SECTION CHIEFS (Planning, Logistics, Operations, and Finance/Administration)

1. Section Chiefs are appointed by the Incident Commander.
2. Obtain the Job Action Sheets for the assigned Section Chief positions.
3. Coordinate actions of assigned sections from the HCC.
4. Brief the IC and other Section Chiefs concerning the status/actions of their section.
5. Ensure directors and unit leaders are designated for sub-functions within their sections as needed and staff members have Job Action Sheets for their assigned positions.
6. Ensure you have all the proper HICS forms to be completed by your assigned Section.

CHIEF NURSING EXECUTIVE

1. Assume duties as Operations Section Chief. Obtain the position's Job Action Sheet and all forms required to be completed by the Operations Section.
2. Report to the HCC and receive an initial briefing from the Incident Commander.
3. The Operations Section Chief will brief the Operations Section's Branch Directors.
4. Notify all department heads or alternates and the hospital's Communications Center/Switchboard of the emergency.
5. Ensure families of victims are notified as soon as possible. Notification calls may be made by the physician who treats the patient, the Director of Social Services, or the Director of Nursing or his/her designee.

ON-DUTY NURSING SUPERVISOR

1. Determine the extent of the emergency, whether it is a "major" or a "minor" emergency; act as the Administrator and Director of Nursing, if they are absent. The Director of Nursing will notify all department heads or alternates.
2. Assume duties as Medical Care Branch Director. Obtain the Medical Care Branch Director Job Action Sheet and all forms to be completed by the Medical Care Branch.
3. Receive initial briefing from the Operations Section Chief at the
4. The Medical Care Branch Director will provide briefing to the Unit Leaders within the

Medical Care Branch at

5. Set up the Hospital Command Center (HCC). All department heads will report in to the HCC.
6. Attempt to find adequate numbers of nursing personnel; keep a list of those notified. This task may be assigned to the Resources Unit Leader or another nurse by the Planning Section Chief, but the Director of Nursing must be aware of the number of nurses coming in.

CHIEF OPERATING OFFICER

1. The Director of Administration will assume duties as Planning Section Chief. Obtain the position's Job Action Sheet and all forms required to be completed by the Planning Section.
2. Call in department personnel as needed after reporting to HCC to receive initial briefing from the Incident Commander.
3. The Planning Section Chief will hold briefings for the Planning Section's Unit Leaders at the

DIRECTOR OF SUPPLY CHAIN MANAGEMENT

1. The Director of the Supply Chain Management Dept. will assume duties as Logistics Section Chief. Obtain the position's Job Action Sheet and all forms required to be completed by the Logistics Section.
2. Call in department personnel as needed after reporting to HCC to receive initial briefing from the Incident Commander.
3. The Logistics Section Chief will hold briefings for the Logistics Section's Branch Directors.

ADMITTING/REGISTRATION OFFICES

1. Department Head/Designee will assume duties of the Patient Registration Unit Leader. Obtain the position's Job Action Sheet and all forms required to be completed by the Patient Registration Unit.
2. Call in administrative personnel as needed after reporting to the Medical Care Branch Director (Operations Section) to receive a briefing.
3. The Admitting Office is responsible for announcements via Public Address, as directed by the Medical Care Branch Director.
4. Do not accept routine non-emergency admissions, except OBs.
5. Refer all public information calls to Public Information Officer (PIO).
6. Assign an admissions person to aid with discharging hospital patients if requested by Triage/Surge. This function could be tasked as the Outpatient Unit Leader by the Medical Care Branch Director.

MEDICAL RECORDS

1. Department Head/Designee will assume duties of Documentation Unit Leader. Obtain the position's Job Action Sheet and all forms to be completed by hospital staff during the incident.

2. Call in department personnel as needed, after reporting to the Planning Section Chief at the

3. Assign person to maintain casualty lists and assist with paperwork as needed at the HCC. This duty could be tasked as the Documentation Unit Leader by the Medical Care Branch Director.

PUBLIC INFORMATION OFFICER (PIO)

1. Obtain the Public Information Officer Job Action Sheet and all forms required to be completed by the PIO.

2. Coordinate information sharing with internal and external stakeholders, including the news media.

3. Call in personnel as needed after reporting to HCC to receive initial briefing from Incident Commander. Additional media relations personnel will serve as Assistants and report to the PIO.

4. The PIO will be attached to the County Joint Information Center (JIC) if an emergency is activated by the County. If a County JIC is not established, the PIO will operate from the HCC. A minimum of 10 phone lines and 10 walkie-talkies should be reserved for use by the PIO and his/her Assistants. Public and media inquires should be directed to those 10 phone lines; hospital staff should not give out the PIO and Assistants' cell phone numbers.

5. The PIO will establish "ground rules" in working with the media as determined necessary by the IC and given the seriousness of the emergency. Only information authorized by the IC may be released by the PIO or his/her Assistants.

6. Establish a Media Staging Area to control movement of news media at the facility and enforce the restrictions of the Media Staging Area. The Media Staging Area should provide the media with a suitable work area, but shall not interfere with emergency operations. Coordinate the location of the Media Staging Area with the incident Staging Manager.

7. Maintain written log of information received and authorized by the IC for release.

8. All news releases will be standardized to ensure consistency and accuracy of information. All written news releases will be initialed and authorized by the IC for release. Legal staff also will review all media releases prior to releasing the information.

9. Each staff member is responsible for directing media personnel to the PIO. The PIO will receive all incoming telephone inquiries from the news media, the public, and patients' families.

10. Coordinate and supervise any media interviews with hospital staff (as authorized by the IC) to ensure the established "ground rules" are followed.

11. If the emergency is extended in duration, coordinate and schedule regular news conferences for frequent release of information.

12. Monitor and minimize any negative publicity about and correct inaccurate news reports, and provide rumor control.

13. After the incident has concluded or entered the recovery phase, prepare a written news release announcing conclusion/recovery phase upon approval of the IC.

14. After the event, monitor departure of all news media representatives from the facility's grounds per IC's instruction.

SUPPLIES & EQUIPMENT

1. Department Head/Designee will assume duties as Resources Unit Leader. Obtain the position's Job Action Sheet and all forms required to be completed by the Resources

Unit.

2. Call in department personnel as needed after reporting to the Planning Section Chief and receive a briefing.
3. Assesses needs, and process and distribute supplies and equipment.
4. Maintain a list of all resources for incident operations.
5. Work with the Finance/Administration Section to procure additional supplies and equipment as needed.

COMMUNICATIONS/SWITCHBOARD

1. Department Head/Designee will assume duties as Communications Unit Leader. Obtain the position's Job Action Sheet and all forms required to be completed by the Communications Unit.
2. Call department personnel as needed after reporting to the Service Branch Director for a briefing.
3. Assist with call back of employees as directed. An updated call back list will be kept with the on duty switchboard supervisor.
4. Calls from concerned family members and all media representatives will be referred to the Public Information Officer (PIO).
5. Communications/switchboard will keep a copy of the Resource Directory, listing phone numbers of emergency management agencies, supply and equipment vendors, etc. (See Annex F for Resource Directory).

DIETARY

1. Department Head/Designee will assume duties as Service Branch Director. Obtain the position's Job Action Sheet and all forms required to be completed by the Service Branch.
2. Call in department personnel as needed after reporting to the Logistics Section Chief.
3. Prepare to serve nourishments to ambulatory patients, house patients, and personnel as the need arises.
4. Clear the hallways of all tray carts.
5. Utilize the hospital dining room and Physician Dinning Room for additional eating space.
6. Ensure items most needed in an emergency are kept on hand.
7. Set up emergency menus and maintain adequate supplies for the emergency menus.
8. Contact vendors as necessary to ensure supplies on hand are replenished as soon as used.
9. Document events into a Food Service Department Log.
10. In the case of loss of water, all food will be served on disposable service ware.
11. In the case of loss of electricity, Food Service will evaluate the possibility of using an alternate method of cooking. If alternate power is available, the standard menus will be followed.
12. The Food Service Department will maintain the standard house menus with appropriate substitutions unless delivery failure is of such a significant amount that emergency menus are required.
13. All Food Service employees are subject to call back in the case of an emergency.

~~ENGINEERING~~

1. ~~Department Head and Designee will assume duties as Infrastructure Branch Director and Staging Manager. Obtain the positions' Job Action Sheets and all forms required to be completed by the Infrastructure Branch and Staging Branch.~~
2. ~~Call in department personnel as needed after reporting to the Operations Section Chief.~~
3. ~~Maintain full operation of all facilities.~~
4. ~~All doors should be locked immediately except employee entrance, Emergency Department door, and front lobby.~~
5. ~~Set up any needed extra beds, transport store room supplies, and bring in extra supplies from other areas.~~

~~ENVIRONMENTAL SERVICES/HOUSEKEEPING~~

1. ~~Department Head/Designee will call in personnel as needed after reporting to the Labor Pool (Logistics Section).~~
2. ~~Assign all personnel to Labor Pool for assignment.~~

~~INTENSIVE CARE UNIT~~

1. ~~The ICU nurse will assume duties as Inpatient Unit Leader and report to the Medical Care Branch Director for a briefing. Obtain the position's Job Action Sheet and all forms required to be completed by the Inpatient Unit.~~
2. ~~Evaluate patients in the Intensive Care Unit for possible transfer using established discharge criteria as a guide, and transfer patients out if indicated.~~
3. ~~Prepare to admit more critically ill patients.~~
4. ~~Call in personnel or request additional personnel from the Labor Pool as needed.~~

~~MEDICAL/DIAGNOSTIC IMAGING~~

1. ~~Department Head will:~~
   - ~~Assume duties as Clinical Support Services Unit Leader and report to the Medical Care Branch Director for a briefing. Obtain the position's Job Action Sheet and all forms required to be completed by the Clinical Support Services Unit.~~
   - ~~Determine the number of patients.~~
   - ~~Call in personnel or request additional personnel from the Labor Pool as needed.~~
   - ~~Work with Support Branch Director and Finance/Administration Section for extra supplies to be brought in, if needed.~~
   - ~~Coordinate flow of work and delegation of work areas.~~
2. ~~Day Shift~~
   - ~~The Department Head/Designee will determine the number of patients involved and any other pertinent information from the HCC.~~
   - ~~The Department Head/Designee will call in personnel needed to sufficiently handle the patient load.~~

3. Evening Shift

- The technician on duty or on call will report to the Medical Care Branch Director further information/direction.
- Additional personnel may be called in and should report directly to Radiology to check in with the on-duty Department Head/Designee.

LABORATORY

1. Staff will remain in the Laboratory and will not report to the Labor Pool.
2. Department Head/Designee will call in department personnel as needed after reporting to HCC to receive briefing from the Incident Commander.
3. Call personnel from nearby hospitals and clinics as necessary.
4. Work with the Logistics Section and Finance/Administration to obtain additional blood, equipment, and supplies from area agencies.

PHARMACY

Department Head/Designee will report to HCC to receive a briefing from the Incident Commander. Staff will remain in the Pharmacy Department and will not report to the Labor Pool.

1. Maintain a list of drug suppliers that can provide emergency supplies quickly (Refer to Annex F: Resource Directory).
2. Keep minimum supply of emergency drugs on hand at all times.
3. Pharmacy should remain open and have a runner to deliver meds.
4. Work with the Finance/Administration Section to coordinate needed purchases.

PHYSICAL THERAPY

1. Department Head/Designee will assume duties as Labor Pool & Credentialing Unit Leader. Obtain the position's Job Action Sheet and all forms required to be completed by the Labor Pool & Credentialing Unit.
2. Call in personnel as needed after reporting to the Logistics Section Chief at the
3. Coordinate assignments of all staff reporting to the Labor Pool, and maintain a log of those assignments.
4. Work with the Finance/Administration Section on time, compensation/claims, and other personnel related expenses.

RESPIRATORY THERAPY

1. Department Head/Designee will call in extra personnel as needed after reporting to the HCC to receive a briefing from the Support Branch Director (Logistics Section). Staff will report to the Labor Pool & Credentialing Unit Leader as situation allows.
5. Keep supply of bubblers, cannulas, masks, and flow meters available in Respiratory Therapy Department.

6. Be prepared to request additional respirators and equipment as needed. Work with the Logistics Section to obtain needed equipment.

HUMAN RESOURCES

1. Department Head/Designee will assume duties as Situation Unit Leader. Obtain the position's Job Action Sheet and all forms required to be completed by the Situation Unit.
7. Call in department personnel as needed after reporting to HCC and receiving briefing from the Planning Section Chief.
8. Assign personnel to Labor Pool as they arrive.

SOCIAL SERVICES

Department Head/Designee will assume duties the Support Branch Director. Obtain the position's Job Action Sheet and all forms required to be completed by the Support Branch.

1. Report to and receive initial briefing from the Logistics Section Chief..
2. Be prepared to counsel victims and/or their families, staff, and other responders.
3. Observe and assist staff members who exhibit signs of stress, fatigue, and inappropriate behavior.
4. Provide HCC staff with a list of the family members who arrive at hospital.
5. Pastoral care will consult with the Medical Care Branch Director and/or Logistics Chief to determine areas of need.

LIFT TEAM/MORGUE

1. The Department Head/Designee will assume duties as the Morgue Unit Leader and report to HCC the Medical Branch Director to receive a briefing. Obtain the position's Job Action Sheet and all forms required to be completed by the Morgue Unit.
2. During a Mass Fatality Incident (MFI), the Morgue Leader or his/her designee will assume the position of Morgue Unit Leader. Morgue personnel will not report to the Labor Pool during an MFI.
3. Collect and protect deceased patients.
4. Coordinate with the Medical Care Branch Director and Staging Manager to establish a morgue area and Family Assistance Center, as needed.
5. Ensure all transporting devices are removed from under deceased patients and returned to the transportation area.
6. Maintain master list of deceased patients.
7. Ensure all deceased patients in morgue areas are covered, tagged, and identified where possible.
8. Keep PIO and IC informed of the number of deceased.
9. Department head will arrange for frequent rest and recovery periods away from the morgue, as well as staff relief.
10. Observe and assist staff members who exhibit signs of stress, fatigue, and inappropriate behavior.
11. Review and approve the area documenter's recording of action/decisions in the morgue area.

HOSPITAL SECURITY

1. The Department Head/Designee will assume the position of Security Branch Director. Obtain the position's Job Action Sheet and all forms required to be completed by the Security Branch.
2. Report to the HCC and receive initial briefing from the Operations Section Chief.
3. Coordinate all activities relating to the safety of personnel, the facility, patients, and visitors including access control and traffic control.
4. Establish, maintain, and enforce any needed checkpoints or restricted access areas of the hospital.
5. Work with local law enforcement on issues of security outside the facility.
6. See Annex B of this EOP for actions related to specific security issues.

FINANCIAL SERVICES

1. The Chief Financial Officer/Designee will assume the position of Finance/Administration Section Chief. Obtain the position's Job Action Sheet and all forms required by the Finance/Administration Section.
2. Report to the HCC and receive initial briefing from the Incident Commander.
3. Provide briefings to Unit Leaders within the Finance/Administration Section.
4. Maintain accurate records of all emergency/disaster related expenditures.
5. If required, arrange to advance funds to those in need and coordinate recovery of the funds.
6. Prepare claims for potential state and/or federal funding.
7. Analyze the impact of the emergency/disaster on the hospital's budget.
8. Prepare insurance claims on behalf of the hospital.
9. Assist, if required, with insurance claims on behalf of affected residents.

INFORMATION TECHNOLOGY

1. The Department Head /Designee will assume the position of IT/IS Unit Leader. Obtain the position's Job Action Sheet and all forms required to be completed by the IT/IS Unit.

10. Report to the HCC and receive initial briefing from the Logistics Section Chief.
11. Attempt to keep the facility's computerized system operational for information sharing among various areas of the hospital.
12. Assist setting up information technology needs in the HCC.
13. Provide computer hardware, software, and infrastructure to support staff.

OTHER DEPARTMENTS

1. After reporting to your supervisor, check in with the Labor Pool to receive an assignment.

Table 1: This table depicts which HICS duties will be assumed by the hospital staff. This table only depicts the essential positions and a limited number of the sub-functions.

EMERGENCY ASSIGNMENTS	
Essential Positions	
Regular Hospital Duty	**HICS Assigned Position**

On-Duty Administrator	Incident Commander (IC)
Public Information Officer	Public Information Officer
Appointed by IC	Safety Officer
Appointed by IC	Liaison Officer
Appointed by IC	Medical/Technical Specialist(s)
Chief Nursing Executive	Operations Section Chief
Chief Operating Officer	Planning Section Chief
Director Supply Chain Management	Logistics Section Chief
Chief Financial Officer	Finance/Administration Section Chief
Engineering	Staging Manager
On-Duty Nursing Supervisor	Medical Care Branch Director
Maintenance	Infrastructure Branch Director
Director of Security	Security Branch Director
Dietary	Service Branch Director
Social Services/Pastoral Care	Support Branch Director
Supplies & Equipment	Resources Unit Leader
Human Resources	Situation Unit Leader
Medical Branch Specialist	Infection Control Preventionist
Non-Essential Positions	
Medical Records	Documentation Unit Leader
Admitting Office	Patient Registration Unit Leader
ER Admitting Office	Outpatient Unit Leader
Diagnostics/Imaging	Clinical Support Services Unit Leader
Communications/Switchboard	Communications Unit Leader
ICU Nurse	Inpatient Unit Leader
Physical Therapy	Labor Pool & Credentialing Unit Leader
(Others)	

VIII. ATTACHMENTS

1. HICS Organization Chart

IX. REFERENCES

A. Joint Commission for Healthcare Facilities Accreditation

B. San Diego County Operational Area Emergency Plan, Annex D, Medical Multi-Casualty Plan, March 2000

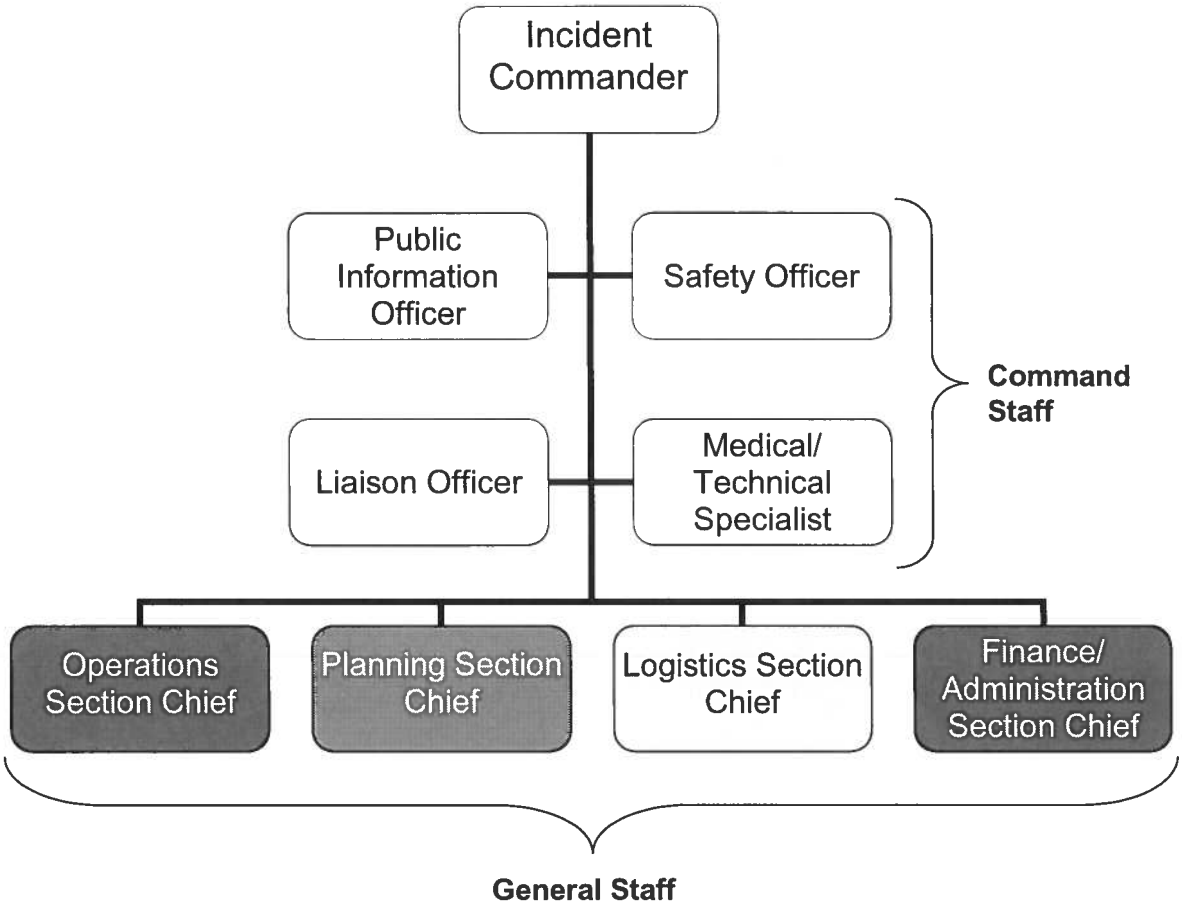
C. San Diego County Operational Area Emergency Plan, Annex P, Terrorism, June 2001

D. HICS, THE HOSPITAL INCIDENT COMMAND SYSTEM, Emergency Medical Services Authority California, August 2006

ATTACHMENT 1 To Emergency Operations Plan, Introduction,

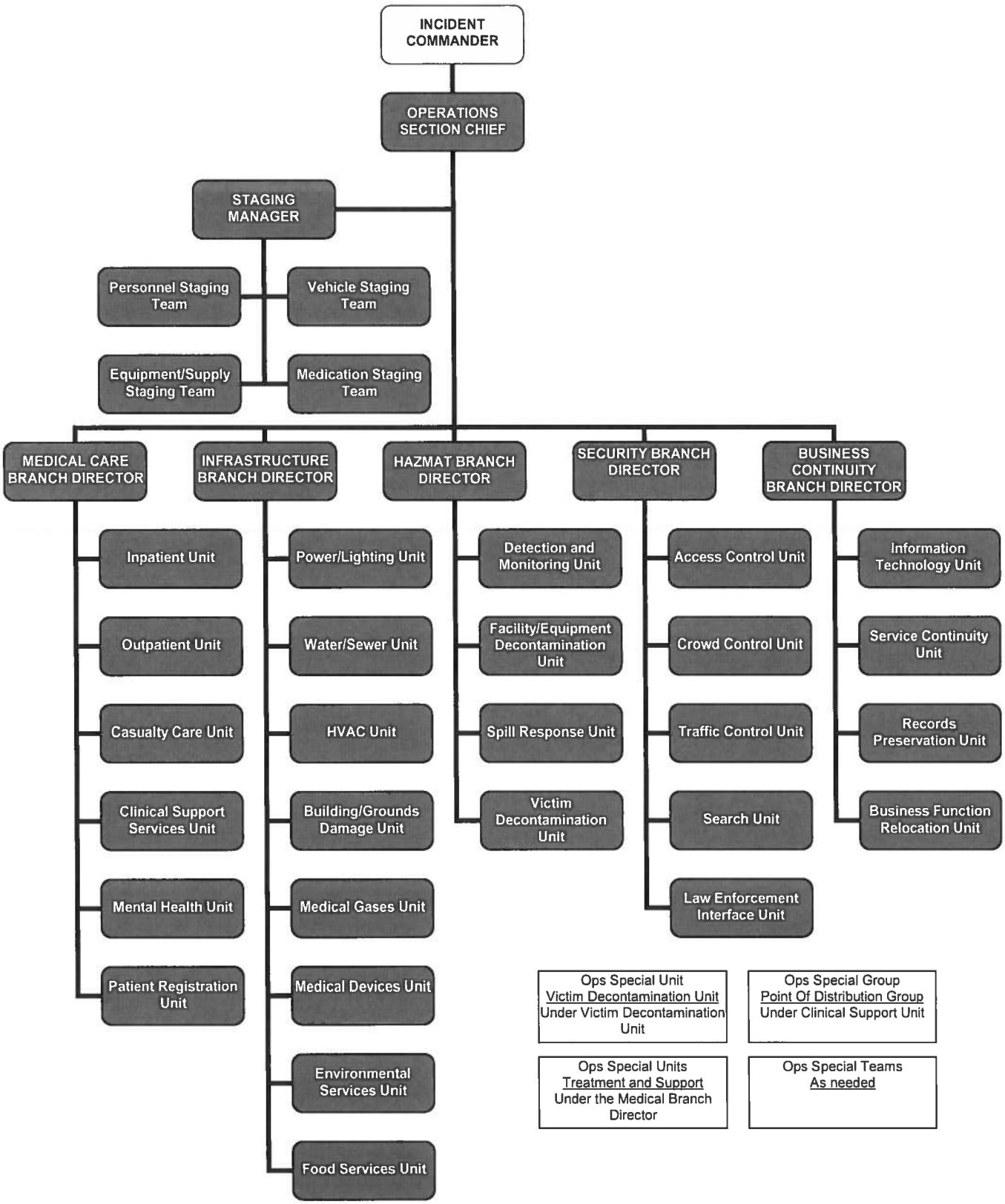
~~**HOSPITAL INCIDENT COMMAND SYSTEM (HICS)**~~
~~**Incident Management Team Chart**~~

~~**COMMAND GROUP**~~



ATTACHMENT 1 To Emergency Operations Plan, Introduction,

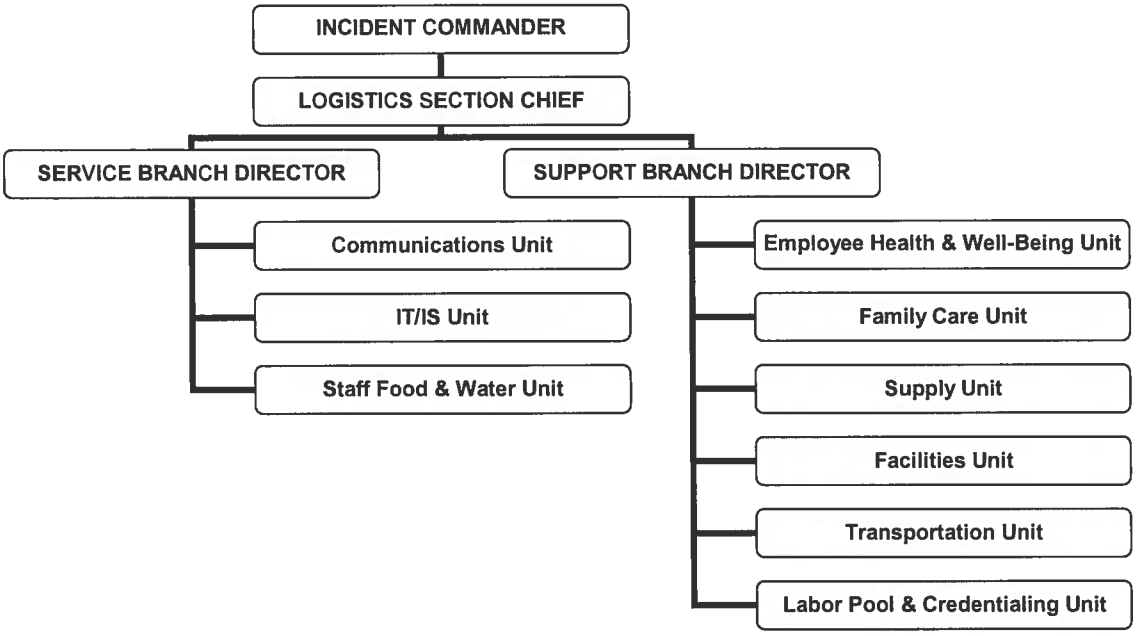
~~HOSPITAL INCIDENT COMMAND SYSTEM (HICS)~~
~~Incident Management Team Chart~~
~~OPERATIONS SECTION~~



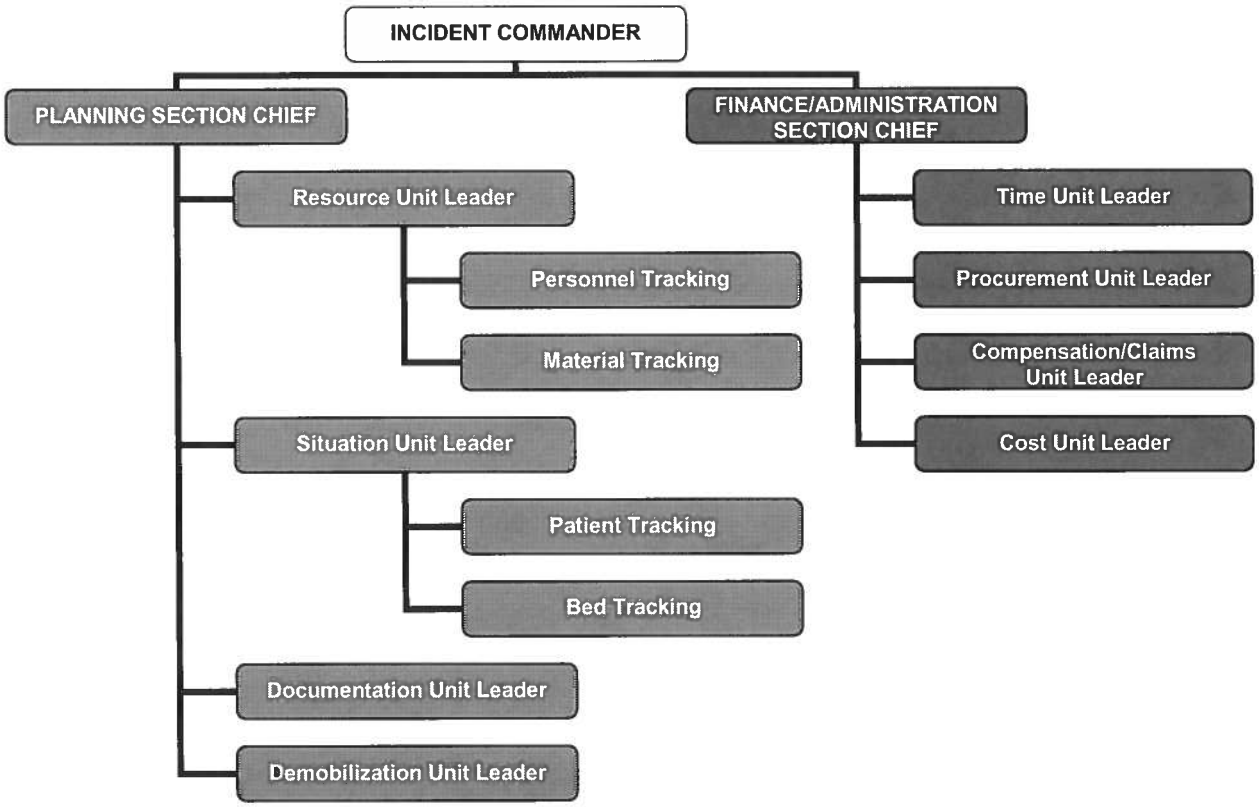
ATTACHMENT 1 To Emergency Operations Plan, Introduction,

~~HOSPITAL INCIDENT COMMAND SYSTEM (HICS)~~
~~Incident Management Team Chart~~

~~LOGISTICS SECTION~~



~~PLANNING and FINANCE SECTIONS~~



Tri-City Medical Center
Oceanside, California
Emergency Preparedness Management
General Information

SUBJECT: Location of Disaster Work Stations~~& Emergency Telephone Locations:Hospital Wide~~

EFFECTIVE DATE: 11/88 **~~POLICY NUMBER: 4003 Page 1 of 2~~**
REVIEW DATE(S): 11/91
REVISION DATE(S): 1/94, 3/97, 5/00, 4/03, 11/05
~~CROSS REFERENCE:~~

Department Approval Date(s):	**05/15**
Environmental Health and Safety Committee Approval Dates(s):	**06/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**06/15**
Board of Directors Approval Date(s):	

A. DISASTER STATION LOCATIONS:

1. Administrative Coordinator - Nursing Administration – Staffing Office
2. Business Office - Pavilion first floor and Emergency Department.
3. Cardiology - Center Tower first floor.
4. Child Care Center - Cardiac Wellness Center
5. Decontamination Area - Immediately external to the Emergency Department/adjacent to Security Trailer
6. Incident Command Center (ICC) - French Room 1 & 2. Alternate area designated as Security Trailer. In the event that neither are available due to the nature of the disaster, the Incident Commander will designate an alternate location.
7. Emergency Department Base Station - Emergency Department.
8. Emergency Department - First floor, west side of hospital.
9. Minor Care - North wing first floor PT Gym located in Acute Rehab area.
10. Morgue ~~—~~ **West of the Magnetic Resonance Imaging (MRI) builiding**~~Classroom Annex~~.
11. **Private Branch Exchange** (PBX) - Center tower, lower level.
12. Physician Labor Pool - Physician Dining area.
13. Alternate Operating Room~~/InfectiousPatient Surge~~ ~~—~~ **Women and Newborn Services**~~Maternal Child Health Unit~~ - Labor & Delivery O**perating** R**oom** Suite
14. Mass Casualty Tent – **Parking lot**
15. Triage Area
    a. Ambulance entrance area.
        i. In the event any of the above areas are involved as a disaster site, the Incident Commander will designate alternative site.
        ii. Security will be notified and be responsible for signage and detouring traffic.

EMERGENCY (RED) PHONE: (all phones need outside line access via dialing **809** first)	
LOCATIONS	NUMBER
E/R Radio Room	**1-760-**724-0896
Nursing Administration/Admin Coordinators	**1-760-**724-1067
Administration	**1-760-**724-1518
PBX #1	**1-760-**724-1690
PBX #1	**1-760-**724-1832
1 Tower 1East Nurse Station	**1-760-**724-8412
2 Tower 2East Nurse Station	**1-760-**724-8413
3 Tower 3East Nurse Station	**1-760-**724-8414
4 Tower 4East Nurse Station	**1-760-**724-8415
2 PAV Nurse Station	**1-760-**724-8416
3 PAV Nurse Station	**1-760-**724-8417
4 PAV Nurse Station	**1-760-**724-8418
Women Center	**1-760-**724-8419
1 North Nurse Station	**1-760-**724-8420
2 South Nurse Station	**1-760-**724-8421
BHU Nurse Station	**1-760-**724-8422
Surgery Nurse Station	**1-760-**724-8423
Lab	**1-760-**724-8880
Radiology	**1-760-**724-8881
SPD	**1-760-**724-8882
Material Distribution	**1-760-**724-8883
French Room 1 (5536)	**1-760-**724-8884
French Room 1 (5537)	**1-760-**724-8885
French Room 1 (5538)	**1-760-**724-8886
French Room 1 (5539)	**1-760-**724-8887
Facilities	**1-760-**724-8972
Lift Team Room	**1-760-**724-8973
BAMS Building	**1-760-**724-8974

Tri-City Medical Center
Oceanside, California

Emergency Operations Procedure Manual
General Information

SUBJECT: **Personnel Expectations**

ISSUE DATE: **New**
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**05/15**
Environmental Health and Safety Committee Approval Dates(s):	**06/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**06/15**
Board of Directors Approval Date(s):	

A. POLICY:

1. **Tri-City Healthcare District**~~Medical Center~~ staff shall be trained to respond to the incident in accordance with guidance provided in the plan. Medical Center staff, regardless of position, is expected to report to the hospital for duty as soon as it is feasible to travel.

B. RULES OF CONDUCT:

1. All personnel shall wear a hospital badge for identification, which shall be displayed to officials and will ensure passage to the hospital through mass casualty lines.
2. Keep to the right in corridor traffic.
3. Do not become an observer.
4. Do not crowd around treatment areas.
5. Maintain a quiet and orderly atmosphere. Remain calm and cooperate in performance of duties assigned to you.
6. Be willing to perform all tasks asked, regardless of usual roles.
7. When called in, ~~park in front of the hospital and~~ proceed through to the appropriate area for briefing and assignment.
8. Remain in working areas unless otherwise instructed.

C. PROCEDURE:

1. Personnel may be assigned to perform duties outside their usual roles. They may be asked to perform jobs, which are vital to an effective disaster response utilizing their individual abilities.

D. REFERENCE LIST:

1. Title 22: Section 70741, 70743, 70745, 70746
2. The Joint Commission EM.02.02.07

Tri-City Medical Center
Oceanside, California

Emergency Operations Procedure Manual
General Information

SUBJECT: **Purpose and Authority**

ISSUE DATE: **New**
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**05/15**
Environmental Health and Safety Committee Approval Dates(s):	**06/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**06/15**
Board of Directors Approval Date(s):	

A. PURPOSE:

1. Disasters can and do occur anytime and anywhere. They may vary in severity, number of victims involved and impact on the physical plant of the hospital facility. The community expects its hospital will always be ready and able to respond efficiently and effectively to any and all situations.
2. The objective of the Emergency Operations Plan is to provide a structured method for hospital personnel to follow in mobilizing for response to a disaster situation. The plan is designed to provide for maintaining a high standard of care when normal demands for service are exceeded and to provide for a safe working environment for staff. The plan establishes procedures for the maximum utilization of our facilities and personnel, as well as integration with local community, county, and regional resources.

B. POLICY:

1. Tri-City Healthcare District (TCHD) shall establish and maintain an emergency action plan, referred to as the Emergency Operations Plan, to permit appropriate response to internal and external disasters. The staff shall be trained to respond to the incident in accordance with guidance provided in the plan. A Disaster Exercise will be conducted at least twice a year to test and evaluate the plan

C. PROCEDURE:

1. Organization:
   a. In times of crisis, the facility will operate under the Hospital Incident Command System (HICS) as developed by the State of California Emergency Medical Services Authority.
   b. The HICS Plan consists of a chain of command, which incorporates four sections under the overall leadership of an Emergency Incident Commander. Each of the four sections: Logistics, Planning, Finance, and Operations, has a chief appointed by the Incident Commander and responsible for their sections. The Chiefs' in turn designate directors and unit leaders to subfunctions. This structure limits the span of control of each manager in the attempt to distribute the work.
   c. Each position on the organizational chart has a prioritized Job Action sheet written to describe the important duties of each particular role. The duties on the Job Action sheets are put into categories of "Immediate", "Intermediate", and "Extended".

2. Authority:
   a. The overall authority and direction of the Emergency Preparedness Plan rests with the Chief Executive Officer or Administrator On-Call. In the absence of the CEO, the Administrator On-Call or the **Administrative Supervisor**~~Nursing House Manager~~ on duty will be in charge. This person is responsible for declaring the phase of the disaster and will direct and coordinate all hospital activities until relieved by Administrative Authority.

D. REFERENCES:

1. **T**itle 22: Section 70741, 70743, 70745, 70746
2. **T**he Joint Commission EM.02.01.01

Tri-City Medical Center
Oceanside, California

Emergency Operations Procedure Manual
General Information

SUBJECT: **Scalable Event**

ISSUE DATE: **New**
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**05/15**
Environmental Health and Safety Committee Approval Dates(s):	**06/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**06/15**
Board of Directors Approval Date(s):	

A. PURPOSE:

1. To monitor, track, and report internal and external emergency code activations, to prepare **T**ri City Medical Center for scalable events.

B. POLICY:

1. **T**he National Incident Management Systems (NIMS) and the Hospital Incident Command System (HICS) established the need for organizations to use the Incident Command System to manage all incidents, emergencies and disasters.
2. **T**he Director of ~~the Environment of Care~~**Safety (Safety Officer)** will track the activation of the **Tri-City Healthcare District**~~Sierra View District Hospital~~'s emergency codes to determine if a code scales to an incident, emergency, or disaster. In addition, external events will be tracked, monitored, and reported.

C. DEFINITIONS:

1. Level 1 – An incident is localized and can be handled at the scene.
2. Level 2 – An emergency may affect a larger area and require off-site emergency responders.
3. Level 3 – A disaster affects the entire site or region and requires a full-scale response.
4. Communications:
   a. The Operators will receive calls from the Director of ~~Environment of Care Manager~~**Safety (Safety Officer)** regarding any emergency code activation. Announcements will be made overhead three (3) times by the **Private Branch Exchange** (PBX) Operator, "Code Orange~~ I" or Code Orange II~~".
   b. Codes that are not cleared in 20 minutes are viewed as incidents that may have the potential to scale and require a larger response effort.
5. Reports:
   a. The Director of the ~~Environment of Care~~**Safety (Safety Officer)** will generate a **quarterly**~~monthly~~ report identifying all approved code activations. All reports will be forwarded to the Emergency Management ~~Sub~~-Committee, Environmental Health and Safety Committee and through all review and approval processes.

D. REFERENCES:

1. The Joint Commission EM.02.01.01EP6

Tri-City Medical Center
Oceanside, California

Emergency Operations Procedure Manual
General Information

SUBJECT: **Scope of Response**

ISSUE DATE: **New**
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**05/15**
Environmental Health and Safety Committee Approval Dates(s):	**06/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**06/15**
Board of Directors Approval Date(s):	

A. POLICY:

1. The scope of response initiated will be dependent on the type and size of the disaster incident and upon its impact to the physical plant.

B. DEFINITIONS:

1. External Disaster:
   a. Multiple Patient Incident: (Minor) Any incident that involves 10 or less victims with at least one or more "Immediate" category patient.
   b. Multiple Casualty Incident: (Moderate) Any incident that involves over 10 victims and up to 100 victims.
   c. Mass Casualty Incident: (Large) Any incident that involves over 100 victims and involves significant infrastructure damage.
2. Mutual Aid Response:
   a. Any incident involving Multiple Casualty or Mass Casualty numbers of victims resulting in the expansion of treatment areas to receive casualties transferred from the stricken community or the sending of personnel and supplies, upon request to provide medical support in the affected community.
3. Internal Disaster:
   a. Any incident that impacts the physical plant or internal functioning of the facility: fire, earthquake, flood, security breach, etc.

C. FLEXIBILITY OF RESPONSE:

1. One of the attributes of the HICS plan is its flexibility in the implementation of individual sections or branches which can be customized to meet the needs of a particular crisis. The activation of positions for a mass casualty accident may differ from those activated for an internal disaster affecting the physical plant. There may be minimal activation of positions in the initial stages of an incident to begin management and other positions added as more personnel arrive. A person might be required to perform more than one job and as more staff becomes available they can be relieved of multiple assignments.

D. REFERENCES:

1. Title 22: Section 70741, 70743, 70745, 70746
2. The Joint Commission EM.02.01.01 EP 2

Tri-City Medical Center
Oceanside, California

Emergency Operations Procedure Manual
Resource Management and Preparation

SUBJECT: **Damage Assessment**

ISSUE DATE: **New**
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**05/15**
Environmental Health and Safety Committee Approval Dates(s):	**06/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**06/15**
Board of Directors Approval Date(s):	

A. POLICY:

1. In the event of an internal disaster or emergency situation such as fire, earthquake, flooding, etc., damage to the facility must be assessed as soon as possible to protect the lives of patients and staff.

B. PROCEDURE:

1. Upon recognition of an internal disaster situation, the Engineering staff will conduct an assessment of:
   a. Immediate threat to patients and staff.
   b. Potential threat to patients and staff from structural damage.
   c. Implement Search and Rescue of injured persons in the event of major structural impact.
   d. Evaluation of disruption of essential services;
      i. Air Conditioning
      ii. Electricity
      iii. Elevators
      iv. Essential Medical equipment
      ~~v. ETO~~
      ~~vi.~~**v.** Food Preparation
      ~~vii.~~**vi.** Natural Gas
      ~~viii.~~**vii.** Other Medical Gases
      ~~ix.~~**viii.** Oxygen
      ~~x.~~**ix.** Steam Boilers
      ~~xi.~~**x.** Telephones
      ~~xii.~~**xi.** Vacuum
      ~~xiii.~~**xii.** Water
   e. Institute salvage of essential supplies
   f. Document damage assessment and situation status on "HICS Facility System Status Report" and forward to Administration or Command Center if activated as soon as possible.
   g. Institute Evacuation procedures as indicated.
      i. Immediate evacuation of affected areas in the event of fire.
      ii. Planned evacuation of patients and staff from areas with major structural damage
      iii. Planned evacuation of areas unable to continue to function due to actual or potential damage.

h. Implement plans to mitigate disruption of essential services.
i. Refer to procedures for **Disaster Policy Code Red** ~~"Fire Emergencies",~~ **and Disaster Policy – Disaster Procedure for** Earthquake ~~Emergencies~~".

C. RELATED DOCUMENTS:

1. **Disaster Policy Code Red**
2. **Disaster Policy – Disaster Procedure for Earthquake**

~~C.~~D. REFERENCES:

1. Title 22: Section 70741, 70743, 70745, 70746
2. The Joint Commission EM.02.02.01, EM.03.01.03, EP5

Tri-City Medical Center
Oceanside, California

Emergency Operations Procedure Manual
Resource Management and Preparation

SUBJECT: **Disruption of Services**

ISSUE DATE: **New**
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**05/15**
Environmental Health and Safety Committee Approval Dates(s):	**06/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**06/15**
Board of Directors Approval Date(s):	

A. POLICY:

1. In the event disruption of services should occur, as a result of an internal or external situation, Tri City Medical Center shall exercise a plan to provide for the safety and welfare of patients, visitors, and staff.
2. Alternative sources for provision of essential utilities shall be identified and planned for in order to maintain the hospital's ability to provide for patient care when essential utilities are disrupted.

B. PROCEDURE:

1. Authority:
   a. The Chief Executive Officer or Administrator On-call will be notified immediately of any actual or anticipated disruption of services that impairs the facility's ability to deliver safe care. They will report to the hospital immediately to assume responsibility for evaluating the situation and determining an appropriate course of action including possible evacuation, transfer, or relocation of patients.
   b. Department **Leaders**~~Heads~~ may be recalled the hospital to participate in the response to the incident.
2. Reporting:
   a. The Chief Executive Officer **or designee** shall be responsible for informing the **California** Department of **Public** Health **(CDPH)** ~~Services~~, by telephone, immediately upon being notified of the disruption of services or the need to discontinue services due to earthquake, fire, power outage, or other calamity that causes damage to the facility or threatens the safety or welfare of patients.
3. Bed Limitation:
   a. Transfers of patients from this facility to another because of lack of beds or staff will not occur until all measures to accommodate the patient have been exhausted and documented.
   b. Decisions to limit admissions will be made by the CEO, in consultation with the Chief of Staff, after evaluation of all efforts to accommodate the patients.
4. Physician Notification:
   a. Physicians shall be notified if a decision is made to restrict admissions and when the closure of the facility or portions of the service are imminent. Staff will determine from the physician whether in-patients currently in the facility may be discharged or may require transfer to another facility.
5. Essential Services and Utilities~~S~~:
   a. Contingency plans are in place to address management of loss of essential utilities and

services including power, water, ~~M~~medical gases, and sewer.

i. If the interrupted service has been due to loss of electricity, the on-duty Engineering Department personnel shall, proceed immediately to the emergency generator to ensure that on hand associated systems are operating satisfactorily. When proper operation has been verified, he/she shall then inform the ~~Administrative~~ Director of **Engineering**~~General Services~~ or designee and notify the CEO or designee.

ii. Appropriate utility companies shall be notified without delay when their services are required to repair or assist with returning services to proper functioning levels. ~~See *"Essential Services Phone Reference List".*~~

C. RELATED DOCUMENTS:

1. **Engineering Policy – Code Green**
2. **Engineering Policy – Disruption of Services Natural Gas**
3. **Engineering Policy – Elevator Failure and Passenger Evacuation**
4. **Engineering Policy – Failure of Heating, Ventilation, Air Conditioning (HVAC) System**
5. **Engineering Policy – Failure of Internal Plumbing Lines**
6. **Engineering Policy – Failure of Medical Air System**
7. **Engineering Policy – Failure of Nurse Call System**
8. **Engineering Policy – Failure of Vacuum System**
9. **Engineering Policy – Failure of Water Distribution**
10. **Engineering Policy – Medical Gas System Failure Oxygen**

~~C.~~D. REFERENCES:

1. Title 22: Section 70741, 70743, 70745, 70746
2. The Joint Commission EM.02.02.09
3. ~~PCS Structure Standard: "Management of Hospital Capacity to Render Care" Emergency Preparedness Manual: "Disruption of Services – Electrical", "Disruption of Services – Water", "Disruption of Services - Medical Gas", "Disruption of Services – Natural Gas", "Disruption of Services – Sewage"~~

Tri-City Medical Center
Oceanside, California

Emergency Operations Procedure Manual
Special Circumstances

SUBJECT: Drought Conditions

ISSUE DATE: **NEW**
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**05/15**
Environmental Health and Safety Committee Approval Dates(s):	**06/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**06/15**
Board of Directors Approval Date(s):	

A. PURPOSE:

1. To provide operational guidance during declared drought condition periods.

B. POLICY:

1. The State of California is subject to low rain years and periodic drought conditions. Facility water sources are provided by the City of Oceanside domestic water system ~~from deep water wells~~. Tri-~~-~~City **Healthcare District**~~Medical Center~~ **may**~~will~~ comply with all City of Oceanside water consumption reduction programs. Examples include limited landscape watering and facility designs that limit the consumption of domestic water.

C. AFFECTED PERSONNEL/AREAS:

1. Engineering Staff

D. PROCEDURE:

1. During periods of water conservation declared by the City of Oceanside, program modifications will be implemented to comply with the City's requirements.
2. Facilities and Grounds will be designed with water conservation technology whenever possible. Drought tolerant plants, trees and shrubs shall be considered. Physical Plant systems and fixtures shall comply with the City's standards for low flow and conservation guidelines.

Tri-City Medical Center
Oceanside, California

Emergency Operations Procedure Manual
Special Circumstances

SUBJECT: Response to Wild Fires

ISSUE DATE: New
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**05/15**
Environmental Health and Safety Committee Approval Dates(s):	**06/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**06/15**
Board of Directors Approval Date(s):	

A. PURPOSE:

1. To be aware of the hazards associated with a variety of large scale exterior fire situations. ~~Forest~~ **Wild** fires and large residential fire storms have the ability to affect and alter how the organization functions and provides treatment to affected patients. This policy follows Tri-~~-~~City **Healthcare District**~~Medical Center~~ **(TCHD)**all hazards approach to a variety of emergency situations contained within the Emergency Management Program and Emergency Operations Plan manual.
2. Wild fires have the potential to impact the facility with an influx of patients. Residential fire storms can occur when extreme low humidity levels coupled with strong wind conditions and careless acts occur.

B. POLICY:

1. For unusual influx of patients due to wild fires, refer to the Emergency Operations Plan and High Census Action Plan policies for direction on managing the event.
2. When extreme low humidity conditions coupled with high winds (Santa Ana affect) occur~~, a cessation of smoking on the campus shall be considered.~~, ~~P~~processes that create an open flame condition will also be reviewed for suspension. Examples may include welding, cutting and other construction practices.
3. **TCHD**~~Tri City medical center~~ will rely on the City of Oceanside Fire Department for direction for sheltering in place, suspension of specific practices and possible evacuation orders during residential fire events near the hospital complex.

C. PROCEDURE:

1. For situations involving wild fires or residential fire storms, refer to the Emergency Management Program policy and procedure manual for specific direction and actions to be implemented in an emergency situation.

~~1.~~

D. RELATED DOCUMENTS:

1. Emergency Operations Procedure Manual General Information - Emergency Operations Plan
~~1.~~2. Emergency Operations Procedure Manual Patient Management – High Census Action Plan

~~**E. REFERENCE:**~~

~~1. EOP, Emergency Management Program policy & procedure manual~~

~~2. Environment of Care policy & procedure manual~~
~~3. High Census Action Plan policy & procedure~~

Tri-City Medical Center
Oceanside, California

Emergency Operations Procedure Manual
Response and Assignment of Personnel

SUBJECT: **Authorization for Volunteer Caregivers During Disasters**

ISSUE DATE: **NEW**
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**05/15**
Environmental Health and Safety Committee Approval Dates(s):	**06/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**06/15**
Board of Directors Approval Date(s):	

A. PURPOSE:

1. To establish guidelines for authorization of volunteer caregivers during disasters.

B. POLICY:

1. Upon activation of the Disaster Plan, the Incident Commander is empowered to authorize the use of volunteer caregivers to assist hospital staff in the event that the organization is unable to fully meet immediate patient needs without such volunteers. Such authorization may be given on a case-by-case basis.
2. Occupations considered volunteer caregivers are listed below. Occupations that fall under ~~Licensed Independent~~ Practitioner ~~(LIP)~~ and Allied Health Professional (AHP) are covered under the Medical Staff Bylaws ~~Article 5.8~~ covering disaster privileges.
   a. Volunteer Caregivers
      i. Registered Nurse
      ii. Licensed Vocational Nurse
      iii. Certified Nursing Assistant
      iv. Clinical staff in these specialties:
         1) Lab Sciences
         2) Pharmacy
         3) Imaging and diagnostics
         4) Rehabilitation Services
         5) Behavioral Health Services
   b. ~~LIP~~**Practictioners**
      i. Physician (Medical Doctor or Doctor of Osteopathy)
      ii. Dentist
      iii. Psychologist
      iv. Podiatrist
   c. AHP**s**
      i. Nurse Practitioner/Physician Asst.
      ii. Certified RN Anesthetist
      iii. Certified Nurse Midwife
      iv. Perfusionist / RNFA

C. PROCEDURE:

1. Once the volunteer caregiver has been authorized to assist, he/she will be under the direct supervision of the department manager or his/her designee to whom the volunteer caregiver has been assigned. The department manager or his/her designee must oversee the "just in time

orientation" and professional performance of the volunteer care-giver who has been assigned disaster responsibilities through direct observation, mentoring, and/or clinical record review. Based on situation and need, consider assigning volunteer physicians in a "buddy" situation until competency is clearly evaluated. When possible utilize volunteers in a secondary triage, managing worried well, and handling family of injured patients, phone advice and other useful but low risk assignments.

2. At a minimum, volunteer caregivers must present a valid government-issued photo identification issued by the state or federal agency (example, a driver's license or passport) and at least one of the following:
   a. A current hospital picture identification card that clearly identifies professional designation.
   b. A current license, certification, or registration.
   c. Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession).
   d. Identification indicating that the individual is a member of a Disaster Medical Assistance **T**eam (DMA**T**), or Medical Reserve Corps (MRC), **T**he Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal emergency response organizations or groups.
   e. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
   f. Identification by current organization member(s) who possesses personal knowledge regarding the volunteer practitioner's qualifications.
3. The Human Resources department will begin the verification process within 72 hours from the time the volunteer caregiver presents him/herself to the organization and has been authorized to provide care by the incident commander or designee. In the extraordinary circumstances that primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) cannot be completed within 72 hours (e.g. no means of communication or lack of resources), it is expected to be completed as soon as possible.
4. The following must be documented:
   a. Why primary source verification could not be performed in the required time frame.
   b. Evidence of a demonstrated ability to continue to provide adequate care, treatment, and services.
   c. An attempt to rectify the situation as soon as possible.
5. The hospital makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours from the start of the assignment of the volunteer caregiver if the services of the volunteer caregiver are still needed.
6. Authorized volunteer caregivers will be provided with an identification badge indicating their name, professional degree, and specialty. The volunteer caregiver's assignment and authorization to provide patient care will be automatically terminated when the incident commander determines the hospital's emergency plan is no longer in effect or when the immediate needs of the patients can be met by the hospital without the volunteer caregiver's assistance.

D. FORMS:

1. Temporary Disaster Privileges Application

~~1.~~

E. REFERENCES:

1. The Joint Commission EM.02.02.13

Temporary Disaster Privileges Application

Tri City Medical Center Temporary Disaster Privileges Application			
Name of Non-physician Practitioner:			
Name of Agency Represented ☐DMAT ☐MRC ☐ESAR-VHP ☐Other			
Credential	**Photocopy Obtained**	**Verified Date/Time Verified By**	**Comment**
License			
Hospital Photo ID identifying professional designation			
Identification indication authorization to render patient care, treatment, and services in disaster circumstances.			
Identification by current organization member(s) who possesses personal knowledge regarding volunteer's qualifications.			
Name of hospital where practitioner actively practices:			
Other Information		**Completed**	**Comment**
Current CPR certification			
Verification/Approval Signatures and Dates			
Human Resource Representative: Date:	Incident Commander/ Designee: Date:	Comments:	
Assignment:			
Acting Supervisor/Manager:			
Security Badge issued:			

~~DMAT: Disaster Medical Assistance Team~~
~~MRC: Medical Reserve Corps~~
~~ESAR-VHP: Emergency System for Advance Registration of Volunteer Health Professionals~~

Tri-City Medical Center
Oceanside, California

Emergency Operations Procedure Manual
Response and Assignment of Personnel

SUBJECT: Medical Staff Assignments

ISSUE DATE: NEW
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**05/15**
Environmental Health and Safety Committee Approval Dates(s):	**06/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**06/15**
Board of Directors Approval Date(s):	

A. **POLICY:**

1. Several teams of physicians will be needed to assist in the provision of definitive treatment and sorting. Assignments will be made after consideration of the physician's area of expertise.

B. **PROCEDURE:**

1. Initial responsibility for Triage and Treatment will be the responsibility of the Emergency Department **(ED)** Physician. As the disaster response expands, Medical Control responsibilities will be assumed by the Chief of Staff or his/her designee.
2. Upon initiation and notification of the disaster response, all available physicians in the facility will report to the Emergency Department.
3. The designated Medical Staff Unit Leader and the Chief of Staff or designee will implement a physician call-in from the Medical Staff Office after receiving a briefing on the status of the disaster situation and determining actual or potential medical care needs.
4. The designated Medical Staff Director will organize, prioritize, and assign physicians to areas where medical care is being delivered. S~~ee *Disaster Physician Assignments* and *Available Physician Log.*~~
5. Team assignments which will be needed include:
   a. Physician coverage for Immediate, Delayed, and Minimal Treatment areas. Orthopedic Surgeons should report to the ED.- ED Physician will designate assignments as necessary to cover all areas where care is delivered.
   b. Operating Room – Anesthesiologist, Surgeons.- evaluate and prioritize surgical candidates and perform surgical procedures as required.
   c. Radiology – for interpretation of X-rays and other diagnostics.
   d. Intensive Care and Med/Surg units- (provide medical care to patients on units if the attending physician isn't available. Assist with and provide care for disaster patients admitted to the units.
   e. Utilization Review – make rounds with the Nursing Unit Leader and review for discharge or potential transfer.
   f. Pathology – to assist with laboratory diagnostics, forensic issues, and pathological tissue diagnosis.

C. **REFERENCES:**

1. Title 22: Section 70741, 70743, 70745, 70746
2. The Joint Commission EM.02.02.07, EM.02.02.07, EP 8

Tri-City Medical Center
Oceanside, California

Emergency Operations Procedure Manual
Patient Management

SUBJECT: Victim Tracking

ISSUE DATE: NEW
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**05/15**
Environmental Health and Safety Committee Approval Dates(s):	**06/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**06/15**
Board of Directors Approval Date(s):	

A. **POLICY:**

1. The disaster plan will provide a mechanism for identifying and tracking disaster patients during the treatment process. This process is used for regular Hospital facilities and alternate care sites alike.

B. **PROCEDURE:**

1. All patients arriving during a disaster will be identified at the Triage Area using a **Medical Emergency Triage Tag (**METTAG**)** Disaster Tag. ~~(see Disaster Medical Record)~~
2. The METTAG number will serve as the patient identifier throughout the Triage and Treatment process.
3. At Triage, an assistant will be assigned to log all patients onto the "Victim List". Information logged will include triage category, name (if known), and treatment destination.
4. At each ~~Treatment~~ **treatment** location clerical personnel shall be assigned to maintain a Victim List and a Disaster Control Board for their own treatment area. It is important to maintain a log for identification of all persons treated as part of the disaster response.
5. The Victim Lists should be updated as patient conditions change and dispositions are made.
6. Periodically, copies of the updated Victim Lists should be routed to the Planning Section of the Emergency Operations Center. Origin of the list and time of the update should be clearly noted. At the termination of the response the list in its final form should be forwarded to the Planning Section of the Emergency Operations Center.
7. The Patient Tracking Officer in the Planning Section will maintain the "HICS Patient Tracking Sheet". Information will be shared with the Public Information Officer.
8. At the completion of the disaster, all victims treated must be logged into the Emergency Department Log, and all transfers must be logged into appropriate transfer logs.

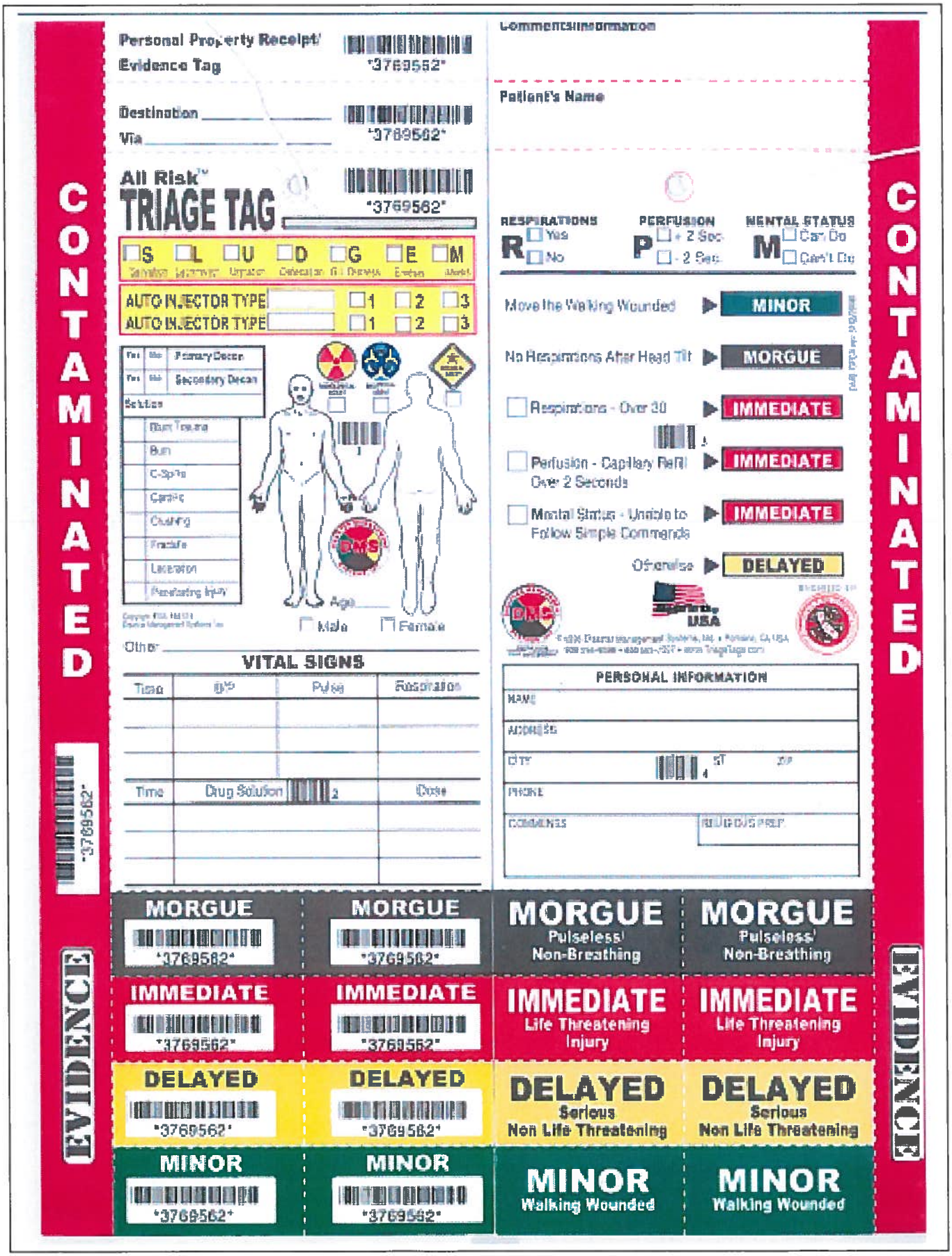
C. **ATTACHMENTS:**

1. **Sample of METTAG**

D. **REFERENCES:**

1. Title 22: Section 70741, 70743, 70745, 70746
2. The Joint Commission EM.02.02.11, EP 8

Sample METTAG



Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Safety Management

SUBJECT: Safety Plan

ISSUE DATE: 11/87 ~~**POLICY NUMBER: 1000**~~
REVIEW DATE(S): 06/08, 06/12
REVISION DATE(S): 05/96, 06/97, 7/00, 03/11

Department Approval Date(s): 05/15
Environmental Health and Safety Committee Approval Dates(s): 06/15
Professional Affairs Committee Approval Date(s): 06/15
Board of Directors Approval Date(s):

A. EXECUTIVE SUMMARY:

1. Each environment of care poses unique risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Environment of Care Safety (EC) Program is designed to identify and manage the risks of the environments of care operated and owned by Tri-City Healthcare District. The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. An environmental safety program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Tri-City Healthcare District.
2. The Management Plan for Environmental Safety describes the risk, safety, and daily management activities that Tri-City Healthcare District has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other individuals, coming to the organization's facilities. The management plan and the environmental management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
3. The program is applied to the Medical Center and all offsite clinics and care sites owned and operated by Tri-City Healthcare District. The Management Plan for Environmental Safety and associated polices extends to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of Tri-City Healthcare District. The plan also affects all staff, volunteers, medical staff and associates including contracted services of Tri-City Healthcare District.

B. PRINCIPLES:

1. The identification of specific risks faced by patients and employees, and others is essential for designing safe work areas and work practices.
2. The identified risks and proven risk management practices are used to design procedures and controls to reduce the threats of adverse outcomes. In addition, the identified risks and the procedures and controls are used to educate staff to effectively use work environments and safe work practices to minimize the potential for adverse impact on them, patients, and other individuals coming into the environment.
3. Ongoing monitoring and evaluation of performance, assessment of accidents and incidents, and regular environmental rounds are essential management tools for improving the safety of the environment. The knowledge developed using these management tools is used to make changes in the physical environment, work practices, and increase staff knowledge.

C. OBJECTIVES

1. Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities, and the care and work environment for patients and employees to evaluate the potential adverse impact on all persons coming to the facilities of Tri-City Healthcare District.
2. Perform additional risk assessments when changes involving these issues occur.
3. Analyze accidents, incidents, and occurrences to identify root cause elements of those incidents.
4. Make changes in the procedures and controls to address identified root causes of incidents.
5. Conduct environmental "EOC" rounds in all areas of the hospital and affiliated medical practices. Staff making rounds evaluates the physical environment, equipment, and work practices. Rounds are conducted in all support areas at least annually and all patient care areas at least semi-annually.
6. Present quarterly reports of EC management activities to the environmental Health & Safety Committee. The reports from each EC area manager will identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified EC issues. The Safety Officer coordinates the documentation and presentation of this information.
7. Assure that all departments have current organization-wide and department specific procedures and controls designed to manage identified risks.
8. Review the risks and related procedures and controls at least once every three years to assure that the EC programs are current.
9. Assign qualified individuals to manage the EC programs and to respond to immediate threats to life and health.
10. Perform an annual evaluation of the management plan and the scope, objectives performance and effectiveness of the environmental safety program.
11. Design and present environmental safety education and training to all new and current employees, volunteers, members of the medical staff and others as appropriate.

D. PROGRAM MANAGEMENT STRUCTURE:

1. The Director of Safety (Safety Officer), Director of Risk Management/Quality Improvement, Director of Regulatory Compliance and Infection Control, and the Director of Engineering work as the Environmental Safety Leadership Team (ESLT) to develop the environmental safety program. They collaborate with leaders throughout the organization to conduct appropriate risk assessments, develop risk related procedures and controls, develop staff education and training materials, and manage day-to-day activities of the environmental safety program. They also collaborate with the Patient Safety Committee to integrate environment of care safety concerns into the Patient Safety program.
2. The Environmental Safety Leadership Team coordinates the development of reports to the Environmental Health & Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other environmental safety issues.
3. The Environmental Health & Safety Committee monitors and evaluates the processes used to manage the environment of care. Members of the Environmental Health & Safety Committee are appointed by the Committee Chair. The Environmental Health & Safety Committee meets a minimum of four (4) times per year. During each meeting one or more EC performance management and improvement reports is presented. In addition, reports of the findings of environmental rounds, incident analysis, regulatory changes and other issues are presented as appropriate. The Committee acts on recommendations for improvement, changes in procedures and controls, orientation and education, and program changes related to changes in regulations.
4. The Committee assigns individuals or groups responsibility for developing solutions to identified issues. Finally, the Committee maintains a tracking log to assure identified issues are acted on and that analysis of activities after implementation of changes demonstrates that the changes

are effective.

5. Membership of the Committee includes representation from Nursing Administration, Facilities Management, Risk Management, Quality Improvement, Human Resources, Senior Administration, Bio-Medical Services, Education, Medical Staff, Physician representation, Infection Control and others as deemed appropriate.
6. The Board of Directors of Tri-City Healthcare District receives regular reports of the activities of the environmental safety program from the Environmental Health & Safety Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer. The Board collaborates with the CEO and other senior leadership to assure budget and staffing resources are available to support the environmental safety program.
7. The CEO or designee of Tri-City Healthcare District receives regular reports of the activities of the Environmental Safety Program. The CEO or designee collaborates with the ESLT and other appropriate staff to address environmental safety issues and concerns.
8. The Emergency Management Program contains provisions for management staff on duty to take immediate, appropriate action in the event of a situation that poses an immediate threat to life, health, or property.
9. The Human Resources Department with the assistance from the Education Department and other leadership staff are responsible for the development and presentation of appropriate materials for orienting new staff members to the organization, the department to which they are assigned, and task specific safety and infection control procedures. The orientation and ongoing education and training emphasize patient safety.
10. Department leaders are responsible for assuring that all staff actively participates in the environmental safety program by observing established procedures and conducting work related activities in a manner consistent with their training. Department leaders also participate in the reporting and investigation of incidents occurring in their departments and in the monitoring, evaluation, and improvement of the effectiveness of the environmental safety program in their areas of responsibility.
11. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

E. ELEMENTS OF THE ENVIRONMENTAL SAFETY MANAGEMENT PROGRAM:

1. Appointment of Environmental Safety Leadership (EC.01.01.01 EP1)
   a. The CEO appoints a team of qualified individuals to assume responsibility for the development, implementation and monitoring of the environmental safety management program. The Environmental Safety Leadership Team (ESLT) includes the Director of Safety (Safety Officer), Director of Risk Management/Quality Improvement, Director of Regulatory Compliance and Infection Control, and the Director of Engineering.
   b. The ESLT coordinates the development and implementation of the environmental safety program and assures it is integrated with the patient safety, infection control, risk management, and other programs as appropriate.
   c. The ESLT maintains a current knowledge of environmental safety laws, regulations, and standards of safety, assesses the need to make changes to procedures, controls, training, and other activities to assure that the environmental safety management program reflects the current risks present in the environment of Tri-City Healthcare District.
2. Designation of Persons to Intervene When Immediate Threats to Life, Health, or Property are identified (EC.01.01.01 EP2)
   a. The Emergency Management program includes specific response plans for Tri-City Healthcare District that address implementation of an appropriate intervention whenever

conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the Hospital Incident Command System (HICS) all hazards response protocol. An appropriate event incident commander is appointed at the time any emergency response is implemented.

b. The Immediate Threat Procedure is included in the Emergency Operations Plan. The procedure lists the communications and specific actions to be initiated when situations posing an immediate threat to patients, staff, physicians, or visitors or the threat of major damage to buildings or property. The objective of the plan is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.

c. The CEO has appointed the Safety Officer, the Nursing Administrative Supervisor on duty, and the Administrator on Call to exercise this responsibility. These individuals are to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.

3. Environmental Safety Management Plan (EC.01.01.01 EP3)
   a. The Environmental Safety Management Program is described in this management plan. The Environmental Safety Management Plan describes the procedures and controls in place to minimize the potential adverse impact of the environment on patients, staff, and other people coming to the facilities of Tri-City Healthcare District.
4. The hospital identifies safety risks associated with the environment of care (EC.01.02.01 EP1)
   a. The ESLT of Tri-City Healthcare District performs proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others. The risk assessments use information from sources such as environmental "EOC" rounds, the results of root cause analysis (RCA), incident reports, and external reports such as The Joint Commission Sentinel Event Alerts and FDA product recall notices.
   b. The ESLT coordinates the risk assessment process with the Director of Engineering, department Directors and others as appropriate.
5. The hospital takes action to minimize or eliminate identified safety risks in the physical environment (EC.02.01.01 EP3)
   a. The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of environmental safety in a planned and systematic manner.
6. Development and Management of Policies and Procedures (LD.04.01.07 EP1 & EP2)
   a. The Safety Officer follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize the identified risks. The Safety Officer assists department leaders with the development of department or job specific environmental safety procedures and controls.
   b. The organization-wide policies and procedures and controls are available to all departments and services on the organizational intranet. Departmental procedures and controls are maintained by department directors. The department directors are accountable for ensuring that all staff are familiar with organizational, departmental, and appropriate job related procedures and controls. Department directors are also accountable for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is accountable for implementing the policies, procedures and controls related to her/his work processes.
   c. The policies, procedures and controls are reviewed when significant changes in services

occur, when new technology or space is acquired, and at least every three years.

d. The Safety Officer assists with the reviews of policies and procedures with department heads and other appropriate staff.

7. The hospital maintains all grounds and equipment (EC.02.01.01 EP5)
   a. The Director of Engineering (Facilities Management) is responsible for managing the appearance and safety of the hospital grounds. In addition, the Director of Engineering is responsible for assuring that the equipment used to maintain the grounds is in proper operating condition and that grounds staff is trained to operate and maintain the equipment.
   b. The Director of Engineering (Facilities Management) is responsible for scheduling the work required to maintain the appearance and safety of hospital grounds. The Engineering staff and Security Officers make regular rounds of the grounds to identify unsafe conditions. The Security Manager and Engineering staff reports all deficiencies to the Director of Engineering (Facilities Management) for appropriate action.
8. The hospital responds to product notices and recalls (EC.02.01.01 EP11)
   a. The Director of Safety and the Director of Materials Management coordinate a product safety recall system. Tri-City Healthcare District utilizes the NRAC E-Class system that is designed to quickly assess safety recall notices; to respond to those that affect Tri-City Healthcare District; and to assure all active safety recalls are completed in a timely manner.
   b. A quarterly report of safety recall notices that required action to eliminate defective equipment or supplies from Tri-City Healthcare District is presented to the Environmental Health & Safety Committee by the Director of Safety.
9. The hospital prohibits smoking (EC.02.01.03 EP1 & EP2)
   a. Tri-City Healthcare District has developed a Smoke Free Environment policy. The policy prohibits smoking of any kind (*ie: cigarettes, cigars, pipe, chewing tobacco, e-cigarettes and vapor producing devices)* in any hospital building or grounds by all, including staff, visitors and patients.
   b. Tri-City Healthcare District has identified alternatives to tobacco products that are offered to all. Tri-City Healthcare District has developed tobacco replacement product resources to assist staff and patients with smoking cessation as desired. Staff may purchase tobacco replacement products via Employee Health at a discounted cost.
10. The hospital takes action to maintain compliance with its smoking policy (EC.02.01.03 EP6)
    a. The procedures for managing the use of smoking materials are followed and enforced by all leadership and staff.
11. The hospital monitors conditions in the environment (EC.04.01.01 EP1 - EP11)
    a. The Director of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Director of Safety (Safety Officer) works with Risk Management to design appropriate processes to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.
    b. Incident reports are completed by a staff member or witness to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.
    c. In addition, the Director of Risk Management and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment or staff behaviors that require action. The findings of such analysis are reported to the Environmental Health & Safety Committee and the Patient Safety Committee, as appropriate. The Safety Officer provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.

d. The Safety Officer coordinates the collection of information about environmental safety, patient safety deficiencies including identification of opportunities for improvement from all areas of Tri-City Healthcare District.
e. The Environmental Health & Safety Committee and the Patient Safety Committee are responsible for identifying opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.
f. The Chairperson of the Environmental Health & Safety Committee prepares quarterly reports to the leadership of Tri-City Healthcare District. The quarterly reports summarize key issues reported to the Committees with their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure Hospital leaders that management responsibilities have been carried out.

12. Environmental tours are conducted every six months in patient care areas (EC.04.01.01 EP12)
    a. Environmental "EOC" rounds at Tri-City Healthcare District are conducted throughout the year on a schedule prepared by the ESLT. Each patient care area is scheduled for an environmental tour every six months. The Safety Officer with the ESLT coordinates correction of identified deficiencies with the appropriate department director(s).
    b. Additional environmental "EOC" tours are performed when construction or other activities create unusual risks that may require design and implementation of a plan to manage Interim Life Safety Measures, Infection Control Risk Measures, Proactive Construction Risk Management Measures, or other temporary issues.
    c. The ESLT analyzes the results of the environmental tours to determine if deficiencies are corrected in a timely manner and to determine if there are patterns or trends that require action to improve practices or environmental conditions.
13. Environmental tours are conducted annually in non-patient care areas (EC.04.01.01 EP13)
    a. Environmental "EOC "rounds at Tri-City Healthcare District are conducted throughout the year on a schedule prepared by the ESLT. Each non-patient care area is scheduled for an environmental tour annually. The Safety Officer with the ESLT coordinates correction of identified deficiencies with the appropriate department director(s).
    b. Additional environmental "EOC" tours are performed when construction or other activities create unusual risks that may require design and implementation of a plan to manage Interim Life Safety Measures, Infection Control Risk Measures, Proactive Construction Risk Management Measures, or other temporary issues.
14. The hospital uses its tours to identify deficiencies, hazards, and unsafe practices (EC.04.01.01 EP14)
    a. The ESLT manages a process of environmental "EOC" rounds designed to evaluate staff knowledge and skills, observe current environmental and patient safety practices, and to evaluate environmental conditions. Findings of the environmental rounds are used as a resource for improving environmental and patient safety procedures and controls, updating orientation education and education programs, and improving staff performance.
    b. The ESLT analyzes the results of the environmental tours to determine if deficiencies are corrected in a timely manner and to determine if there are patterns or trends that require action to improve practices or environmental conditions.
15. Every twelve months the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan. (EC.04.01.01 EP15)
    a. The Director of Safety (Safety Officer) coordinates the annual evaluation of the management plans associated with the Environment of Care functions.
    b. The annual evaluation examines the management plans to determine if they accurately

represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Environmental Health & Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

c. In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review (PPR). Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement.
d. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.
e. The results of the annual evaluation are presented to the Environmental Health & Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes.
f. The annual evaluation is distributed to the Chief Executive Officer, Board of Directors, organizational leaders, the Patient Safety Committee, the Quality Assurance Performance Improvement Committee and others as appropriate. The manager of each Environment of Care program is responsible for implementing the recommendations in the report as part of the performance improvement process.

16. Analysis and actions regarding identified environmental issues (EC.04.01.03 EP1 – EP3)
    a. The Environmental Health & Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement.
    b. Each time a need for improvement is identified the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the quality improvement program, and the patient safety program.
17. Improving the Environment (EC.04.01.05 EP1 – EP 3)
    a. When the leadership of the hospital, regulatory compliance, quality improvement, or patient safety concurs with the Environmental Health & Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Environmental Health & Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
    b. The Environmental Health & Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, performance improvement, and patient safety leadership.
18. Orientation and Ongoing Education and Training (LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1 & EC.03.01.01 EP1 – EP3)
    a. Orientation and training addressing the environment of care is provided to each employee, contract staff and volunteer. All Licensed Independent Practitioners (LIP) receive orientation to the Environment of Care in accordance with the Medical Staff policies and bylaws.
    b. In addition, annual EOC training is provided and documented via NetLearning.
    c. The Human Resources Department with participation from the Education Department

coordinates the general New Employee Orientation (NEO) program. New staff members are required to attend the NEO program within 30 days of their date of employment. The Human Resources Department with participation from the Education Department maintains attendance records for each new staff member completing the general orientation program.

d. New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.

e. The Safety Officer collaborates with the EC managers, department leaders, the Director of Risk Management/Quality, Director of Regulatory Compliance and Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs.

f. The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work. In addition the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

g. Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Environmental Health & Safety Committee. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

F. RELATED DOCUMENTS:

1. Smoke Free Environment policy

G. REFERENCES:

1. The Joint Commission/NFPA Life Safety Book for Health Care Organizations (2013)

TRI-CITY MEDICAL CENTER Safety Policies & Procedures	**Section:** SAFETY MANAGEMENT **Subject:** Safety Management Plan **Policy Number:** 1000 Page 1 of 2
Department: Hospital Wide	**EFFECTIVE:** 11/87 **REVISED:** 5/96, 6/97; 7/00, 3/11 **REVIEWED**: 6/08, 6/12

1.0 PURPOSE:

1.1 The mission of Tri-City Medical Center is to improve the health of the people of North San Diego County by providing cost-effective, quality health and hospital services. Consistent with this mission the Board of Governors, medical staff and administration have established and provide ongoing support for the Joint Commission on Accreditations of Healthcare Organizations Environment of Care Standards (EOC).

1.2 The purpose of the Safety Management Plan is to reduce the risk of injury to our patients, and visitors.

1.3 The Environmental Health & Safety Committee is to provide oversight for the Tri-City Healthcare District's Environment of Care management plans.

2.0 POLICY

Tri-City Medical Center is committed to providing a safe and healthy environment for all employees, medical staff, patients and visitors by establishing ongoing mechanisms for controlling and monitoring potential risk to the environment of care.

2.1 RESPONSIBILITIES:

2.1 Administration:

2.1.2 To fulfill the compliance requirements outline in the Joint Commission on Accreditations of Healthcare Organizations the President/Chief Executive Officer (CEO) will:

2.1.3 Appoint a Safety Officer to coordinate the implementation and monitoring of the 7 Environment of Care Management Plans.

2.1.4 Assure the formation and development of the Environmental Health & Safety Committee that will provide oversight to the Environment of Care Program.

2.1.5 Ensure Administration is represented as an ad-hoc member to the Environment of Care Committee.

2.2 The Environment of Care/Safety Officer:

2.2.1 The Safety Officer has the authority and responsibility to act when hazardous conditions exist which could result in personal injury to individuals or damage to equipment or buildings.

2.2.2 Serves as the Chairperson of the Environment of Care Committee.

2.2.3 Convenes the Environmental Health and Safety Committee, formulates an agenda, assure room availability for meetings, and assure the maintenance of appropriate records.

2.2.4 Oversee all responsibilities of the Environmental Health & Safety Committee are carried out.

2.2.5 Assure timely follow-up of actions and business of the Environmental Health and Safety Committee.

2.2.6 Supervise ongoing inspections and survey activity.

~~2.2.7 Report recommendations and actions to Administration.~~
~~2.2.8 Act as liaison with pertinent agencies as needed on matters relative to the environment.~~
~~2.2.9 Develop, implement, and monitor the 7 EOC Management Plans.~~
~~2.2.10 Provide a Annual Summary on the Objective, Scope, Performance and Effectiveness of the Environment of Care Management Programs.~~
~~2.2.11 Collaborates with Employee Health Nurse in evaluating injuries to identify cause and recommend corrective actions to reduce or eliminate reoccurrences.~~
~~2.2.12 Serves as liaison in environment of care issues to all internal and external stake holders.~~
~~2.2.13 Collaborates with education department to evaluate ongoing staff education programs with regard to environment of care programs.~~
~~2.2.14 Conduct annual evaluation for effectiveness.~~

~~2.3 Department Directors:~~

~~2.3.1. Develop, implement, and annually review departmental safety policies and procedures .~~
~~2.3.2 Assure department specific safety orientation and continuing education of employees regarding hospital and departmental safety practices.~~
~~2.3.3 Ensure safety related topics are discussed at monthly staff meetings.~~
~~2.3.4 Monitor safety practices of employees.~~
~~2.3.5 Investigate and report employees injuries to the Employee Health Services within a timely manner.~~
~~2.3.6 Conduct quarterly inspections of the work environment to proactively assess potential safety issues.~~

~~2.4 Managers/Supervisors:~~

~~2.4.1 Ensure department compliance with all Environment of Care Programs.~~
~~2.4.2 Monitor employee safe work practices.~~
~~2.4.3 Provide departmental safety orientation to employees, and ensure all employees complete the EOC Computer Based Learning Modules annually.~~
~~2.4.4 Immediately report unsafe conditions or work practice to the Department Director/and or Environment of Care/Safety Officer.~~

~~2.5 Employees:~~

~~2.5.1 Follow safe work practices at all times.~~
~~2.5.2 Participate in ongoing education.~~
~~2.5.3 Communicate to any member of management any concerns you may have regarding yours or anyone else's safety.~~

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Security Management

SUBJECT: **Security Management Plan**

ISSUE DATE: 01/97 ~~**POLICY NUMBER: 2000**~~
REVIEW DATE(S): 01/99
REVISION DATE(S): 07/00, 04/03, 12/05, 12/11

Department Approval Date(s): 05/15
Environmental Health and Safety Committee Approval Dates(s): 06/15
Professional Affairs Committee Approval Date(s): 06/15
Board of Directors Approval Date(s):

A. EXECUTIVE SUMMARY

1. Each environment of care poses unique security risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The security management program is designed to identify and manage the security risks of the environments of care operated and owned by Tri-City Healthcare District. The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. A security management program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified.
2. The Management Plan for a Secure Environment describes the security risk and daily management activities that Tri-City Healthcare District has put in place to achieve the lowest potential for adverse impact on the security of patients, staff, and other individuals, coming to the organization's facilities. The management plan and the Security Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
3. The scope of the program is applied to the medical center and all offsite care centers owned and operated by Tri-City Healthcare District. The Security Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of Tri-City Healthcare District. The plan also affects all employees, volunteers, medical staff and associates including contracted services of Tri-City Healthcare District.

B. PRINCIPLES

1. Security is a system made up of human assets and technology.
2. Visible and clandestine components of the system are used to reduce the potential for criminal activity, the threat of workplace violence, and to increase feelings of security among patients, staff, and others coming to Tri-City Healthcare District.
3. Initial and ongoing assessment of security threats is essential for timely identification of changes in the types of security threats facing Tri-City Healthcare District.
4. Collection and analysis of information about adverse security events provides information to help predict and prevent personal violence, crime, and other incidents.
5. Staff awareness of security is an essential part of an effective program. Tri-City Healthcare District orients and trains all staff to basic components of the security program and to techniques for managing security risks related to work areas or daily activities.

C. OBJECTIVES

1. Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities, and the care and work environment for patients and employees to evaluate the potential adverse impact on all persons coming to the facilities of Tri-City Healthcare District.
2. Perform additional risk assessments when changes in the campus design or patterns of security events indicate a change in the security threat level.
3. Analyze security incidents and occurrences to identify root cause elements.
4. Conduct ongoing random security patrols in all areas of the medical center, affiliated business offices and outpatient facilities. Staff making rounds evaluates the physical environment, equipment, and work practices. Rounds are conducted in all support areas and all patient care areas at least once per day.
5. Present reports of Environment of Care management activities to the Environmental Health & Safety Committee quarterly. The reports identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified security issues. The Security Manager coordinates the documentation and presentation of this information.
6. Assure that departments have current organization-wide and as needed department specific procedures and controls designed to manage identified security risks.
7. Review the risks and related procedures and controls at least once every three years to assure that the security program is current.
8. Assign qualified individuals to manage the program and to respond to immediate security threats.
9. Perform an annual evaluation of the management plan and of the scope, objectives performance and effectiveness of the security program.
10. Design and present security education and training to all new and current employees, volunteers, members of the medical staff, contract staff and others as appropriate.
11. Provide timely response to emergencies and requests for assistance.
12. Communicate with law enforcement and other civil authorities as needed.
13. Manage access to the grounds, buildings, and sensitive areas of Tri-City Healthcare District.\

D. PROGRAM MANAGEMENT STRUCTURE

1. The Board of Directors of Tri-City Healthcare District receives regular reports of the activities of the Security program from the Environmental Health & Safety Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer.
2. The Board collaborates with the CEO and other senior leaders to assure budget and staffing resources are available to support the Security Program.
3. The CEO or designee of Tri-City Healthcare District receives regular reports of the activities of the Security program. The CEO or designee collaborates with the Security Manager and other appropriate staff to address security issues and concerns.
4. The Security Manager works under the general direction of the CEO or designee. The Security Manager, in collaboration with the Safety Officer, is responsible for managing the Security Program. The Security Manager reports program findings to the Environmental Health & Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other security issues.
5. Department leaders are responsible for orienting new staff members to the department and to job and task specific security procedures. The orientation and ongoing education and training emphasize patient safety. Department heads are also responsible for participating in the reporting and investigation of incidents occurring in their departments.
6. Individual staff members are responsible for learning and following job and task specific procedures for secure operations.

E. ELEMENTS OF THE SECURITY PLAN

1. Appointment of Security Leadership (SEC.EC.01.01.01 EP1)
   a. The CEO of Tri-City Healthcare District appoints the Safety Officer, and selects a qualified individual capable of overseeing the development, implementation and monitoring of the security program. The Safety Officer's job is defined by a job description. The CEO or a designee evaluates the competence of the Safety Officer annually.
   b. The Security Manager coordinates the development and implementation of the security program and assures it is integrated with the patient safety, information management, and other programs as appropriate. The Security Manager's job is defined by a job description. The CEO or a designee evaluates the competence of the Security Manager annually.
   c. The Security Manager maintains a current knowledge of laws, regulations, and standards of security. The Security Manager also continually assesses the need to make changes to procedures, controls, training, and other activities to assure that the security management program reflects the current risks present in the environment of Tri-City Healthcare District.
2. Designation of Persons to Intervene When Immediate Threats to Life, Health, or Property are identified (EC.01.01.01 EP2)
   a. The Emergency Management program includes specific response plans for Tri-City Healthcare District that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the HICS (Hospital Incident Command System) all hazards response protocol. An appropriate Incident Commander is appointed at the time any emergency response is implemented.
   b. The Immediate Threat Procedure is included in the Emergency Operations Procedure manual. The procedure lists the communications and specific actions to be initiated when situations posing an immediate threat to patients, staff, physicians, or visitors or the threat of major damage to buildings or property. The objective of the procedure is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.
   c. The CEO has appointed the Safety Officer, the Nursing Administrative Supervisor on duty, and the Administrator on Call to exercise this responsibility. These individuals are to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.
3. Management Plan for a Secure Environment (SEC.EC.01.01.01 EP4)
   a. The Security Management Program is described in this management plan. The security management plan describes the policies, procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Tri-City Healthcare District experience an adverse security event.
4. Proactive Risk Assessment (SEC. EC.02.01.01 EP1)
   a. The Security Manager of Tri-City Healthcare District coordinates proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others.
   b. The Security Manager works with department directors, managers, the Patient Safety Officer, Risk Management and others as appropriate.
   c. The Security Department will be responsible for enacting proactive security measures as follows:
      i. Scheduling patrolling of the Medical Center and parking lots to help prevent work place violence/accidents.

ii. Locking/unlocking of exterior doors, departments, and associated rooms; on-going inspections of all sensitive areas throughout the Medical Center.
iii. Ensuing that all employees and physicians properly display their photographic identification badges at all times.
iv. Submitting reports to the Director of Engineering pertaining to security and safety violations, including but not limited to: defective lighting, damaged equipment, unsafe situations or conditions that may present a danger to others.
v. Maintaining unrestricted locations for the timely loading and unloading of persons seeking medical treatment in the Emergency Department and Women's Center. Security will also ensure a location for long-term vehicle parking.
vi. Monitoring the Security Department CCTV.
vii. Providing campus escort services 24 hours per day as needed for employees and visitors.

5. The hospital takes action to minimize or eliminate identified security risks in the physical environment (EC.02.01.01 EP3)
   a. The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of security in a planned and systematic manner.
   b. Tri-City Hospital District has elected to implement the Non-Violent Crisis Intervention Program (NVCI) for the mandated training of staff in compliance with the California Health and Safety Code Section 1247.7 and 1257.8. This training includes:
      i. General safety measures.
      ii. Personal safety measures.
      iii. The assault cycle.
      iv. Aggression and violence predicting factors.
      v. Characteristics of aggressive and violent patients and victims.
      vi. Verbal and physical maneuvers to diffuse and avoid violent behavior.
      vii. Strategies to avoid physical harm.
      viii. Restraining techniques.
      ix. Resources available to employees coping with violence (stress debriefing, employee assistance programs, etc.).
   c. A condensed version of the NVCI program will be offered to ancillary staff routinely assigned to the Emergency Department. Ancillary department managers will be responsible for determining staff appropriate for this training.
6. Development and Management of Policies and Procedures (LD.04.01.07 EP1 & EP2)
   a. The Security Manager follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize the identified risks. The Security Manager assists department leaders with the development of department or job specific environmental safety procedures and controls.
   b. The organization-wide policies, procedures and controls are available to all departments and services on the organizational intranet. Departmental policies, procedures and controls are maintained by department directors. The directors are responsible for ensuring that all staff is familiar with organizational, departmental, and appropriate job related policies, procedures and controls. Department directors are also responsible for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is responsible for implementing the policies, procedures and controls related to her/his work processes.
   c. The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years. The

Security Manager coordinates the reviews of procedures with department leaders and other appropriate staff.

7. Identification of Patients, Staff, and Others Entering the Facility (SEC.EC.02.01.01 EP7)
   a. The identification of staff is an interdisciplinary function. Several Directors share responsibility for designing identification systems and establishing procedures and controls to maintain the effectiveness of the systems.
   b. The current systems in place at Tri-City Healthcare District include photographic ID badges for all staff, volunteers, students, contracted staff and members of the medical staff, password systems to limit access to authorized users of information system applications, physical security systems to limit access to departments and areas of the hospital, and distinctive clothing/badges to facilitate rapid visual recognition of critical groups of staff.
   c. The identification of patients is also an interdisciplinary function. The current system includes personal identification of patients in medical records and by use of various arm band systems.
   d. The identification of others entering Tri-City Healthcare District is managed by the Security and Materials Management Departments. The Security Manager in collaboration with the CEO or designee and other appropriate staff provides a secure environment that requires identification of all contractors/vendors and the badging of visitors to the various areas of the facility. The Director of Materials Management manages the procedures for identification of vendors. The Security Manager takes appropriate action to remove unauthorized persons form areas and to prevent unwanted individuals from gaining access to Tri-City Healthcare District.
8. Identification and Management of Security Sensitive Areas (SEC.EC.02.01.01 EP8)
   a. The following areas have been designated as sensitive areas:
      i. Emergency Department
      ii. Behavioral Health Units
      iii. Maternal Child Health
      iv. Neonatal Intensive Care Unit
      v. Pharmacy Department
      vi. Human Resources Department
      vii. Adult Critical Care Unit
      viii. Information Technology
      ix. Administration
      x. 3rd Floor Center Tower California Department of Corrections Unit
      xi. Medical Records Office and Storage areas
      xii. Nuclear Medicine Hot Lab
   b. Staff in each sensitive area participates in training addressing the unique risks of the area and the procedures and controls in place to manage them. Key personnel and security staff receive specialized training related to processes in high risk security areas.
   c. The Security Plan has a program for the inspection, preventative maintenance and testing of the following security equipment:
      i. Emergency Department:
         1) Electronic access control.
         2) Panic buttons.
         3) Closed Circuit Television (CCTV) cameras.
         4) Security Officer Station – Posted 24 hours per day.
      ii. Behavioral Health Units:
         1) Electronic access control.
         2) CCTV.
      iii. Maternal Child Health Units:
         1) Electronic access control.
         2) Access Control System CCTV.

3) Department policy in place for identifying visitors.
4) Department procedure for uniquely identifying mother-infants.
5) Teaching program to educate parents or guardians to explain the security processes.
6) Unique identification for staff members.

iv. Neonatal Intensive Care Unit:
1) Electronic access control.
2) The Maternal Child Health units are protected with both active video surveillance systems on entrances and exits of the units. Additionally, the unit has electronic access control systems for entrances and exits that alarm if unauthorized entry or exit occurs.

v. Pharmacy Department:
1) Electronic access control.
2) Infrared Security System.

vi. Business Office:
1) Electronic access control.
2) Panic button.
3) Local area surveillance system.

vii. Human Resources department:
1) Panic buttons.
2) Access Control System CCTV.

viii. Adult Critical Care Unit:
1) Electronic access control.

ix. Patient Representative Office:
1) Panic button.

9. Management of Security Incidents Including an Infant or Pediatric Abduction (SEC.EC.02.01.01 EP9)
   a. The Security Manager has developed procedures for rapid response to breaches of security. The on-duty Security Officers and local police have the manpower and technological resources to respond to a wide variety of incidents. The Security Manager or a designee is responsible for assessing breaches of security and determining what resources are required to respond effectively.
   b. The Security Manager, Safety Officer and the Director of Women's and Children's Services are responsible for the design and management of systems to reduce the threat of abduction of infants or children and to respond to any threats of or actual abductions.
   c. A Code Adam is announced over the paging system, as well as selected radios when a potential or actual abduction has occurred.
      i. All available staff respond **per the Patient Care Services Code Adam** ~~to exit doors and specified areas to observe for persons with children, packages, bags or anything that could possible hide an infant or child, and call Security via dialing "66" to notify them of the findings.~~
      ~~ii. Other staff check designated areas, and respond to the unit involved to document information, and provide necessary support to the parents.~~
      ~~iii.~~**ii.** The Code Adam plan is tested at least annually and the responses are documented, evaluated, critiqued and as appropriate corrective activity, additional training, or program improvements are made.
   d. The Security Manager and the Director of Women~~'s~~ and **Newborn**~~Children's~~ Services are required to conduct at least one abduction drill annually. In addition, activations of the abduction alert system and all attempted or actual abductions of infants or children are treated as security incidents and reported and analyzed appropriately.
10. The hospital monitors conditions in the environment (EC.04.01.01 EP1 – EP11)

a. The Director of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Security Manager works with the Director of Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.
b. Incident reports are completed by the staff member or witness to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.
c. In addition, the Director of Risk Management and the Security Manager collaborate to conduct an aggregate analysis of incident reports generated to determine if there are patterns of deficiencies in the environment or staff behaviors that require action. The findings of such analysis are reported to the Environmental Health & Safety Committee and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Committee Chairpersons provide summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.
d. The Security Manager works with the Environmental Health & Safety Committee to collect information about security deficiencies and opportunities for improvement from all areas of Tri-City Healthcare District. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the six environments of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.
e. The Environmental Health & Safety Committee and the Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the Environment of Care Management Programs.
f. The Safety Officer and the Patient Safety Committee prepare a quarterly report to the leadership of Tri-City Healthcare District. The quarterly report summarizes key issues reported to the Committees and the recommendations of them. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders of management responsibilities have been carried out.

11. Every twelve months the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan. (EC.04.01.01 EP15)
    a. The Safety Officer coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.
    b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each EC program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources.
    c. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Environmental Health & Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of the Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

d. In addition, the annual review incorporates appropriate elements of the The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.
e. The results of the annual evaluation are presented to the Environmental Health & Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, the Board of Directors, organizational leaders, the Patient Safety Committee, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

12. Analysis and actions regarding identified environmental issues (EC.04.01.03 EP1 – EP3)
    a. The Environmental Health & Safety Committee receives reports of activities related to the environmental "EOC Rounding" program at least quarterly.
    b. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital and the Patient Safety Committee as indicated.
13. Improving the Environment (EC.04.01.05 EP1 – EP3)
    a. When the leadership of the hospital, quality improvement, or patient safety concurs with the Environmental Health & Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Environmental Health & Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
    b. The Environmental Health & Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, quality improvement, and patient safety leadership.
14. Orientation and Ongoing Education and Training (LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1 and EC.03.01.01 EP1 – EP3)
    a. Orientation and training addressing the environment of care is provided to each employee, contract staff and volunteer. All Licensed Independent Practitioners (LIP) receive orientation to the Environment of Care in accordance with the Medical Staff policies and bylaws.
    b. In addition, annual EOC training is provided and documented via NetLearning.
    c. The Human Resources Department with assistance from the Education Department coordinates the general New Employee Orientation (NEO) program. New employees are required to attend the general NEO orientation program within 30 days of their date of employment. The Human Resources Department and the Education Department maintains attendance records for each new staff member completing the general orientation program.
    d. New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.
    e. The Safety Officer collaborates with the Environment of Care leaders, the Director of Quality Improvement, Infection Control, Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care program and revised as necessary.

f. The Safety Officer gathers data during environmental EOC rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work. The EOC Rounds evaluate the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

g. Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Environmental Health & Safety Committee. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

F. RELATED DOCUMENTS:

1. Patient Care Services Code Adam Policy

G. REFERENCES:

1. The Joint Commission

TRI-CITY MEDICAL CENTER Safety Policies & Procedures	**Section:** SECURITY MANAGEMENT **Subject:** Security Management Plan **Policy Number:** 2000 Page 1 of 8
Department: Security	**Effective:** 1/97 **Reviewed:** 1/99 **Revised:** 7/00; 4/03; 12/05, 12/11

1.0 ~~PURPOSE:~~

~~Tri-City Medical Center is committed to protecting the personnel and property rights of patients, visitors, members of the medical staff, and employees. To maintain a program of high quality health care, it is essential that the property of the Medical Center be protected from damage, defacement and theft. All employees are responsible for making the facilities safe and secure for those who use them. (See AP&P 305, 436 and 463)~~

~~**2.0 PURPOSE:**~~

~~2.1 The Environment of Care/Safety Officer have been given the authority by Administration to take action when a condition exists that could result in personal injury to individuals or damage to equipment or buildings. The Security Supervisor is responsible for the daily management of the Security Department, and is a member of the Tri-City Medical Center Security Management Committee. The Security Supervisor attends monthly meetings and submits monthly reports that identify all related security activities of the previous month, and makes recommendations for improvements. Adverse outcomes are reported through the Security Incident Notification Form and routed to the VP Support Services and the respective Dept. Director, Legal & Risk Management, and the Environmental Health and Safety Committee via monthly security statistics.~~

~~2.2 Organization wide and Security Department specific policies and procedures are in place and have the support of the Environmental Health and Safety Committee and Administration.~~

~~**3.0 PROCEDURE:**~~

~~3.1 All employees have the responsibility to maintain a workplace free from acts and threats of violence.~~

~~3.1.1 All personnel must refrain from engaging in acts or threats of violence and are responsible for maintaining a work environment free from acts or threats of violence.~~
~~3.1.2 The Environmental Health and Safety Committee is responsible for overseeing the implementation and maintenance of Tri-City Medical Center's security management program and the workplace violence prevention plan. The Environmental Health and Safety Committee members include all levels of management and non-supervisory employees who have a primary responsibility for the safety, health, and well-being of patients, visitors, and staff members.~~
~~3.1.3 The Environment of Care/Safety Officer serves as the Chairperson of the Environmental Health and Safety Committee.~~

~~3.2 The Environmental Health and Safety Committee chairperson's responsibilities pertaining to workplace violence are:~~

~~3.2.1 Tracking and Trending past incidents of violence at Tri-City Medical Center.~~

~~3.2.2 Reviewing Tri-City Medical Center's current readiness to respond to issues of workplace violence.~~

~~3.2.3 Supporting training of appropriate personnel regarding issues of workplace violence.~~
~~3.2.4 Overseeing the establishment of a liaison with local police departments and other emergency services.~~
~~3.2.5 Establishing and maintaining policies and procedures for dealing with issues of workplace violence.~~

~~3.3 The Environmental Health and Safety Committee will oversee delegations of these tasks to other individuals within the Medical Center~~

~~3.3.1 The Environmental Health and Safety Committee remains responsible for the implementation and maintenance of the Medical Center's workplace violence prevention plan.~~

~~3.4 Director's Duties Regarding Workplace Violence are:~~

~~3.4.1 Provide new employee orientation to the Medical Center's Security policies, procedures and work practices.~~
~~3.4.2 Annual review of the Security Plan to address department specific aspects of workplace security issues.~~
~~3.4.3 Post or distribute workplace security information.~~
~~3.4.4 Provide a system for employees to inform management about workplace security hazards or threats of violence.~~
~~3.4.5 Provide protection of employees who report threats from retaliation by the person making the threats.~~
~~3.4.6 Ensure timely notification of the Security Department of any condition or situation which could jeopardize the safety, security and welfare of any employee, patient or visitor.~~
~~3.4.7 Request assistance from Security Department with these duties as needed.~~

~~3.5 Employees duties regarding workplace violence are:~~

~~3.5.1 Adhere to all Administrative and/or Department specific policies and procedures, rules, regulations and reporting requirements pertaining to workplace violence.~~
~~3.5.2 Notify supervisor and/or the Security Department immediately of any condition or situation which could jeopardize the safety, security or welfare of any employee patient or visitor.~~
~~3.5.3 An increased security awareness and continual practice of personal safety procedures while on the Medical Center campus or while conducting duties or activities within the community.~~
~~3.5.4 Comply with procedure for all Medical Center emergency codes, policies, procedures, protocols and panic buttons or alarms.~~
~~3.5.5 Utilize the Security Department's escort service or the "buddy system" when leaving the facility and walking to their parked vehicle in the evening or nighttime hours.~~
~~3.5.6 Control access to the workplace and freedom of movement within it, consistent with the Medical Center business practices.~~
~~3.5.7 Adhere to Administrative Policy #436 regarding Employee Identification.~~

~~3.6 Work place violence reporting responsibilities:~~

~~3.6.1 All employees are required to report immediately any acts or threats of violence, occurring on the Medical Center premises to their supervisor. No employee will be disciplined or discharged for reporting any threats or acts of violence. In addition, employees will be responsible to ensure that all departmental or Medical Center reporting policies are completed in the prescribed manner.~~

~~3.6.2 All supervisors are required to immediately report any acts or threats of violence to their director or Security Department. Supervisors are also required to report the occurrences of any warning sign of violence they observe.~~

~~3.6.3 The Human Resources Department will be consulted and assist, as needed, with all employee disciplinary and discharge policies and procedures.~~

~~3.6.4 Risk Management and Legal Services will be immediately notified, through the proper reporting mechanism, of any condition or situation which addresses the quality of service to any Medical Center patient.~~

~~3.6.4.1 It is the responsibility of Risk Management and Legal Services Department to coordinate and supervise all mandated patient reporting policies or procedures.~~

~~3.7 Investigation of incidents of work place violence:~~

~~3.7.1 The Security Department will be responsible for responding to any reported act or threat of work place violence. Additionally, the Security Department will be responsible for the appropriate documentation of all incidents.~~

~~3.7.2 The Security Supervisor will be responsible for conducting any follow up investigation and the preparation of all investigative documentation. This investigation will include, but is not limited to:~~

~~3.7.2.1 Reviewing all submitted reports.~~

~~3.7.2.2 Reviewing all previous incidents.~~

~~3.7.2.3 Visiting the scene of an incident as soon as possible.~~

~~3.7.2.4 Interviewing threatened or injured employees and witnesses.~~

~~3.7.2.5 Examining the workplace for security risk factors associated with the incident, including any previous reports of inappropriate behavior by the perpetrator.~~

~~3.7.2.6 Determining the cause of the incident.~~

~~3.7.2.7 Recommending corrective actions to prevent the incident from recurring.~~

~~3.7.2.8 Recording the findings and corrective actions taken.~~

~~3.7.3 The Security Supervisor will ensure that documentation is disseminated to all appropriate administrative or management personnel and that the mandatory reporting of all incidents is done in the appropriate time frame.~~

~~3.7.4 The Security Supervisor will be responsible for the maintaining of all investigative documentation for a five (5) year period.~~

~~3.7.5 The Security Supervisor will prepare a monthly risk assessment report and present it to the Environmental Health and Safety Committee for review and follow up. This report will detail all reported incidents and issues affecting the safety, security and welfare of employees, patients and visitors.~~

~~3.7.6 The Security Supervisor will ensure that the Human Resources Department is continually updated if the~~

~~investigation involves an employee of the Medical Center. Risk Management, Legal Services will be updated if the investigation involves any patient at the Medical Center.~~

~~3.7.7 The Security Supervisor will assign standby security personnel for employee disciplinary and/or discharge procedures as required (i.e. the employee has been involved in prior violent acts, expressed threats of physical violence, expressed verbal abuse, or displayed signs of stress, strain or pressure in the workplace).~~

~~3.7.8 With the approval of the Interim Director of Engineering or The Environment of Care/Safety Officer, the Security Supervisor will be responsible for notifying and interacting with local, city, county, state and federal law enforcement agencies when their assistance is required. (The exception is when a staff member or visitor is in immediate danger from a individual who presents a weapon, the staff is given authority per AP&P 288 " Calling 911" the notify law enforcement.)~~

~~4.0 SECURITY SENSITIVE AREAS~~

~~4.1 The following areas have been identified as high risk security areas.~~

~~4.1.1 Emergency Department~~
~~4.1.2 Behavioral Health~~
~~4.1.3 Maternal Child Health Units~~
~~4.1.4 Neonatal Intensive Care Unit~~
~~4.1.5 Pharmacy Department~~
~~4.1.6 Human Resources Department~~
~~4.1.7 Adult Critical Care Unit~~
~~4.1.8 Information Technology~~
~~4.1.9 Administration~~
~~4.1.10 3rd Floor Center Tower Calif. Dept. of Corrections Unit~~

~~4.2 These policies will be reviewed by the Department Director, Security Department Supervisor and the Environmental Health and Safety Committee on an annual basis.~~

~~4.3 The Security Department has developed and does provide annual specialized security training to staff of all high risk security areas.~~

~~4.4 The Security Plan has a program for the inspection, preventative maintenance and testing of the following security equipment:~~

~~4.4.1 Emergency Department:~~

~~4.4.1.1 Electronic access control;~~
~~4.4.1.2 Panic buttons;~~
~~4.4.1.3 CCTV camera~~
~~4.4.1.4. Security Officer Station Posted 24 hours per day~~

~~4.4.2 Behavioral Health: Electronic access control~~

~~4.4.3 Maternal Child Health Units:~~

~~4.4.3.1 Electronic access control;~~
~~4.4.3.2 CCTV;~~
~~4.4.3.3 Department policy in place for identifying visitors;~~
~~4.4.3.4 Department procedure for uniquely identifying mother-infant units~~
~~4.4.3.5 Teaching program for parents to explain the security process~~
~~4.4.3.6. Unique Identification for Staff~~

~~4.4.4 Neonatal Intensive Care and Maternal Child Units: Electronic access control~~
~~4.4.4.1 The Maternal Child Health Units are protected with both e-Active Video Surveillance Systems on Entrances and Exits of the Units. Additionally the unit has Electronic Access Control systems for Entrances and Exit that Alarm of unauthorized Entry or Exit of the Units.~~

~~4.4.5.0 Pharmacy Department:~~
~~4.4.5.1 Electronic access control~~
~~4.4.5.2 Infrared Security System~~

~~4.4.6 Business Office:~~

~~4.4.6.1 Electronic access control~~
~~4.4.6.2 Panic button~~
~~4.4.6.3. Local area surveillance system~~

~~4.4.7 Human Resources department: Panic buttons and Access Control System CCTV~~
~~4.4.8 Adult Critical Care Unit: Electronic access control~~
~~4.4.9 Patient Representative Office Panic Button~~

~~5.0 **PROACTIVE SECURITY MEASURE**:~~

~~5.1 The Security Department will be responsible for enacting proactive security measures as follows:~~

~~5.1.1 Scheduling patrolling of the Medical Center and parking lots to help prevent work-place violence/accidents.~~
~~5.1.2 Locking/unlocking of exterior doors, departments, and associated rooms; on-going inspecting of all sensitive areas throughout the Medical Center.~~
~~5.1.3 Ensuring that all employees properly display their photographic identification badges at all times.~~
~~5.1.4 Submitting reports to the Director of Engineering pertaining to security and safety violations, including~~

~~but not limited to: defective lighting, damaged equipment, unsafe situations or conditions that may present a danger to others.~~

~~5.1.5 Providing unrestricted locations for the timely loading and unloading of persons seeking medical treatment in the Emergency Department and the Women's Resource Center. Security will also ensure that there is a lot or location reserved for long-term vehicle parking.~~

~~5.1.6 Monitoring the Security Department Closed Circuit Television System (CCTV).~~

~~5.1.7 Providing campus escort services 24 hours per day for employees and visitors.~~

~~6.0 REACTIVE SECURITY MEASURES~~

~~6.1 These measures are to be implemented by the Security Department:~~

~~6.1.1 Timely completion of departmental reports of theft.~~

~~6.1.2 Assistance of patients, visitors and employees with reporting of crimes to the appropriate law enforcement agency.~~

~~6.1.3 Response to alarm/panic button activations both on-site and off-site.~~

~~6.1.4 In addition, Individual Department Director's or their designee will conduct in-service training of newly hired employees in proper alarm activation, and departmental security procedures.~~

~~7.0 AGGRESSIVE RESPONSE TRAINING:~~

~~7.1 Tri-City Medical Center has elected to implement the Safety Always For Employees (S.A.F.E.) format for the mandated training of staff in compliance with the California Health and Safety Code Section 1247.7 and 1257.8. This training includes:~~

~~7.1.1 General safety measures.~~

~~7.1.2 Personal safety measures.~~

~~7.1.3 The assault cycle.~~

~~7.1.4 Aggression and violence predicting factors.~~

~~7.1.5 Characteristics of aggressive and violent patients and victims.~~

~~7.1.6 Verbal and physical maneuvers to diffuse and avoid violent behavior.~~

~~7.1.7 Strategies to avoid physical harm.~~

~~7.1.8 Restraining techniques.~~

~~7.1.9 Resources available to employees coping with violence (stress debriefing, employee assistance programs, etc.).~~

~~7.2 A condensed version of the S.A.F.E. format will be offered to ancillary staff routinely assigned to the Emergency Department. Ancillary department managers will be responsible for determining staff appropriate for this training.~~

~~7.3 The Security Department, Education Department, and the Environment of Care/Safety Officer will~~

~~develop a self learning packet and competency assessment to comply with the annual update for all appropriate staff. This will ensure quality, continuity, consistency and evaluation.~~

~~7.4 The Security Department will assist, as needed, in developing training and instruction on general and job-specific workplace security practices for all employees.~~

~~7.4.1 Training and instruction will be provided when the Security Plan is first established and appropriately thereafter.~~

~~7.4.2 Training will also be provided to all employees and to other employees for whom training has not previously been provided and to all employees, supervisors and managers given new job assignments for which specific workplace security training is required.~~
~~7.4.3 Additional training and instruction will be provided to all personnel whenever new or previously unrecognized security hazards are identified.~~

~~7.5 Security Department personnel will be responsible for implementing and monitoring all appropriate administrative or department specific policies, procedures and protocols pertaining to the following situations:~~

~~7.5.1 The receiving of a VIP patient;.~~
~~7.5.2 The utilization of non-Security Department personnel to assist in the controlling of all vehicular and pedestrian traffic within the Medical Center campus in the event of a disaster or civil disturbance.~~

~~7.6 The Environment of Care/Safety Officer will be responsible for submitting to the Environmental Health and Safety Committee an annual evaluation of the Security Management Plan focusing on:~~

~~7.6.1 Objectives~~
~~7.6.2 Scope~~
~~7.6.3 Performance~~
~~7.6.4 Effectiveness~~

~~7.7 The Security Department will conduct an annual training program for Security staff in the proper process of reporting patient related incidents.~~

~~8.0 SECURITY STAFFING~~

~~8.1 The Security Department will provide service 24 hours a day, 7 days per week coverage of the Medical Center.~~

~~8.2 Staffing will consist of one (1) Security Supervisor, one (1) Security Officer assigned to the east side of the campus and one (1) Security Officer assigned to the interior of the hospital, (1) Officer assigned to the ED Front Lobby area, (1) Officer assigned to the Hospital Lobby, and (1) Officer assigned to External Patrol of the~~

~~medical center campus.~~

~~8.3 Within the Security Department, a pool of trained Security Officers will be utilized to cover staffing vacancies.~~

~~8.4 In the event of a critical workplace violent incident or situation, the Security Department will supplement the current staffing levels with contractual security personnel.~~

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Life Safety Management

SUBJECT: **Life Safety Management Plan**

ISSUE DATE: **11/87** ~~**POLICY NUMBER: 3000**~~
REVIEW DATE(S): **03/00, 04/06, 04/09**
REVISION DATE(S): **04/03, 05/12**

Department Approval Date(s): **05/15**
Environmental Health and Safety Committee Approval Dates(s): **06/15**
Professional Affairs Committee Approval Date(s): **06/15**
Board of Directors Approval Date(s):

A. **EXECUTIVE SUMMARY:**

1. Each environment of care and the physical condition of occupants poses unique fire safety risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Life Safety Management Program is designed to identify and manage the risks of the environments of care operated and owned by Tri-City Healthcare District. The specific fire safety risks of each environment are identified by conducting and maintaining a proactive risk assessment. A fire safety program based on applicable laws, regulations, codes, standards, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Tri-City Healthcare District.
2. The Management Plan for Life Safety describes the risk and daily management activities that Tri-City Healthcare District has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people, coming to the organization's facilities. The management plan and the Life Safety Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
3. The program is applied to the Medical Center and all offsite clinics and care facilities of Tri-City Healthcare District. The Life Safety Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of Tri-City Healthcare District.

B. **PRINCIPLES:**

1. All buildings of Tri-City Healthcare District housing patient care services must be designed, operated, and maintained to comply with the 2000 edition of the National Fire Protection Association (NFPA) *Life Safety Code*.
2. All fire alarm, detection, and extinguishing systems and equipment must be maintained to comply with applicable codes and standards.
3. All staff must be educated and trained to respond effectively to fire, smoke, or other products of combustion to minimize the potential of loss of life or property in the event of a fire.
4. Appropriate temporary administrative and engineering controls must be designed, implemented, and maintained whenever existing deficiencies or conditions created by construction activities significantly reduce the level of life safety in any area where patients are cared for or treated.

C. **OBJECTIVES:**

1. Design and construct all spaces intended for housing patient care and treatment services to meet national, state, and local building and fire codes.

2. Conduct required fire drills in all buildings of Tri-City Healthcare District housing patient care services.
3. Calibrate, inspect, maintain, and test fire alarm, detection, and suppression systems in accordance with codes and regulations.
4. Inspect and maintain all buildings housing patient care services to assure compliance with the applicable requirements of the 2000 edition of the NFPA *Life Safety Code.*
5. Train all staff, volunteers, and members of the medical staff to respond effectively to fires.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. The Director of Engineering (Facilities Manager) assures that an appropriate maintenance program is implemented. The Director of Engineering (Facilities Manager) also collaborates with the Safety Officer to develop reports of Life Safety Management performance for presentation to the Environmental Health & Safety Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other fire safety issues.
2. The facilities management technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe reliable performance of fire safety equipment in a timely manner. In addition, the technicians and service company staff perform necessary repairs.
3. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.
4. The Board of Directors of Tri-City Healthcare District receives regular reports of the activities of the Life Safety Management program from the Environmental Health & Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Director of Engineering (Facilities Manager) and appropriate clinical staff. The Board collaborates with the CEO and other senior managers to assure budget and staffing resources are available to support the Life Safety Management program.
5. The CEO or designee of Tri-City Healthcare District receives regular reports of the activities of the Life Safety Management program. The CEO or designee collaborates with the Director of Engineering (Facilities Manager) and other appropriate staff to address fire safety issues and concerns.

E. **ELEMENTS OF THE LIFE SAFETY MANAGEMENT PLAN:**

1. Life Safety Management Plan (FS.EC.01.01.01 EP6)
   a. The Life Safety Management Program is described in this management plan. The Life Safety Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Tri-City Healthcare District experience an adverse outcome in the event of a fire.
2. Processes for Protecting Building Occupants and Property (FS.EC.02.02.01 EP1)
   a. The Director of Engineering (Facilities Manager) and Safety Officer are responsible for coordinating the development of design, operations, maintenance, and training processes to minimize the potential for fires and of adverse consequences related to the presence of fire, smoke, or other products of combustion.
   b. Design
      i. The Director of Engineer (Facilities Manager) and other project managers collaborate with qualified design professionals, code enforcement, and facility licensing agencies to assure that buildings and spaces are designed to comply with local, state, and national building and fire codes. American Institute of Architects (AIA) guidelines are also considered in the design process for compliance with the International Building Codes with California amendments. The Director of Engineer (Facilities Manager) assures that all required permits

and inspections are obtained or completed prior to occupancy. The Director of Engineer (Facilities Manager) permanently maintains all plans, inspection reports, and other documents related to the design and construction of any building or space housing patient care or treatment services of Tri-City Healthcare District.

c. Management
   i. The Facilities Manager oversees the design, implementation, and documentation of processes designed to assure optimal performance and continual compliance with code requirements of fire alarm, detection, and suppression systems. Similar programs are in place for maintenance of building elements operating conditions that play a role in the fire safety level of the environment.
   ii. The Director of Engineer (Facilities Manager) is responsible for assuring that all renovation and new construction within existing buildings is done in a manner that preserves compliance with codes and standards.

d. Fire Response Process
   i. The Safety Officer is responsible for the design and management of a fire response plan that meets the unique needs of the occupants of each department or service of Tri-City Healthcare District. The current fire response plan is based on the remove from immediate danger, activate alarms, confine fire, extinguish or evacuate area "RACE" principle. Area specific response and evacuation plans that include training and equipment required to manage unique risks identified in areas are in place. The plans are evaluated annually as part of the overall program review.
   ii. The emergency number "66" is to be dialed to report a fire.
   iii. The unattached buildings located on the Medical Center campus will dial "66" to report a fire.
   iv. All buildings off the main Medical Center campus will dial "911" for assistance in case of a fire.

3. The hospital prohibits smoking on all facility grounds (FS.EC.02.03.01 EP2 & EC.02.01.03 EP1)
   a. Tri-City Healthcare District has implemented a Smoke- Free Environment policy. The policy prohibits smoking of all kinds (*ie: cigarettes, cigars, pipe, chewing tobacco, e-cigarettes, and all vapor producing devices)* in any hospital building or campus grounds by all, including staff, visitors and patients.
   b. Tri-City Healthcare District has identified alternatives to tobacco products that are offered to all. Tri-City Healthcare District has developed tobacco replacement resources to assist staff and patients with smoking cessation as desired.
   c. The procedures for managing the use of tobacco replacement materials are followed and enforced by all managers and staff.
4. The hospital maintains free and unobstructed access to all exits (FS.EC.02.03.01 EP4)
   a. Leaders in all areas of the hospital are responsible for assuring that equipment, furniture, and supplies are not stored in corridors. The condition of corridors is evaluated during each environmental rounds activity. All violations are reported to the Director and/or Manager of the area where the deficiency was identified, the Safety Officer, and the Environmental Health & Safety Committee.
5. The hospital has a written fire response plan (FS.EC.02.03.01 EP9-10)
   a. The Safety Officer is responsible for coordinating the implementation of the fire response plan. All staff is oriented to the RACE response model and effective use of portable fire extinguishers. In addition, all staff are oriented to the department or service specific plans that account for the unique challenges posed by the condition of occupants and the design of space in which they work.
   b. The department and area specific fire response plans include information about:
      i. The roles of all employees, medical staff, volunteers, contract staff and students near the point of fire origin.

ii. The roles of all employees, medical staff, volunteers, contract staff and students away from the point of fire origin.
   1) Note: Tri-City Healthcare District believes strongly in the principle of life safety. The organization recognizes as a practical matter that members of the medical staff and many volunteers and students are not present much of the time and are not likely to be a reliable resource during a fire response. Therefore, the medical staff, volunteers, and students do not have a specific defined role in the fire response plan. They are instructed to remain in the area they are located at the time an alarm sounds and to render assistance under the direction of the manager or employees of the area as needs arise.

iii. Operation of the fire alarm system

iv. Exit routes and use of equipment used to relocate or evacuate patients, visitors, and staff

6. Fire Drills (FS.EC.02.03.03 EP1 – 5)
   a. Regular fire drills are conducted to reinforce training and education. At least 50% of the drills are unannounced. The frequency of drills is based on regulations and accreditation requirements. All healthcare, ambulatory healthcare and overnight sleeping areas are drilled at least once per shift per quarter.
   b. If conditions evaluated as part of the Interim Life Safety Measures (ILSM) indicate a need for additional drills to enhance staff awareness of degraded life safety protection in various areas, there is documentation that the additional drills are performed. All freestanding business occupancies are drilled at least once per shift per year.
   c. All fire drills are evaluated to determine if individual areas respond appropriately. An aggregate evaluation of fire drills is done at least twice a year. The aggregate analysis looks for patterns or trends of deficiencies. When deficiencies are identified, there is documentation that the deficiencies are corrected.
7. Inspection, Testing, and Maintenance of Fire Safety Systems (FS.EC.02.03.05 EP1 – 20)
   a. The Director of Engineering (Facilities Manager) works with qualified contractors and staff to design a program of calibration, inspection, maintenance, and testing to assure the reliability of all fire safety systems and equipment. The program includes systems and equipment such as fire sprinklers, smoke detection, fire pumps, fire dampers, doors, and shutters, and smoke control elements of the environment. Each system or piece of equipment is maintained to comply with requirements of the National Fire Protection Association or other applicable codes and standards. The hospital conducts annual tests of battery powered exit lights for 90 minutes. The hospital conducts monthly evaluations of nuclear powered exit signs and verified for expiration dates and replaced accordingly.
   b. When deficiencies are identified, they are corrected within 48 hours. If a deficiency cannot be corrected within 48 hours, the Facilities Manager evaluates the impact of the deficiency using the ILSM criteria to determine if an ILSM plan needs to be put in place until the deficiency can be corrected. All ILSM plans are monitored for effect and documentation demonstrating compliance with the plan is maintained by the Safety/Security Officer.
8. Life Safety Management (LS.EC.01.01.01 EP1 – 3)
   a. The Director of Engineering (Facilities Manager) is responsible for maintaining the Statement of Conditions. The Director of Engineering (Facilities Manager) prepares a quarterly report of the rate of completion of any Plan for Improvement for the Environmental Safety Committee. If any items will not be completed within the established timeframe plus The Joint Commission allowed six month grace period, the Director of Engineering (Facilities Manager) is responsible for preparing a letter to the appropriate Joint Commission staff requesting an extension of the timeframe or a change of the method of correction.

9. Management of Fire Safety Risks (LS.01.02.01 EP1 – 14)
   a. A program of Interim Life Safety Management based on Interim Life Safety Measures (ILSM) is used to manage degradation of the level of life safety required by NFPA 101 – 2000 Life Safety Code. The ILSM program consists of a screening tool used to assess the severity of the potential impact of a degraded level of life safety. When risk factors indicate a need to implement one or more of the ILSM, a project specific Interim Life Safety Management Plan (ILSMP) is designed.
   b. The Director of Engineering (Facilities Manager) and Safety Officer are responsible for implementation of the ILSMP. The implementation may include training, installation of engineering controls, posting of temporary advisory signs, and other actions deemed necessary. Affected staff are oriented and drilled, as appropriate, to familiarize them with the Interim Life Safety Management Plan.
   c. The Director of Engineering (Facilities Manager) and Safety Officer are responsible for monitoring the effectiveness of the implementation of the ILSMP. When deficiencies are identified, the Safety Officer and/or the Director of Engineering (Facilities Manager) take appropriate action to resolve the deficiencies.
   d. All monitoring and actions to resolve deficiencies related to an ILSMP are documented. The documentation is presented to the Environmental Health & Safety Committee as part of the quarterly Life Safety Management report to the Committee. All ILSM evaluations, plans, and monitoring documentation are maintained for at least three years.
10. The hospital monitors conditions in the environment (EC.04.01.01 EP1 – EC.04.01.01 EP11)
   a. The Director of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Director of Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.
   b. Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to the Director of Risk Management who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.
   c. In addition, the Director of Risk Management and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated form environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Environmental Health & Safety Committee and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.
   d. The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of Tri-City Healthcare District.
   e. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven management of the environment of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.
   f. The Environmental Health & Safety Committee and the Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

g. The Safety Officer prepares a quarterly report to the leadership of Tri-City Healthcare District. The quarterly report summarizes key issues reported to the Committees and the recommendations of them.
h. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders of management responsibilities have been carried out.

11. Every twelve months the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan. (EC.04.01.01 EP15)
    a. The Safety Officer coordinates the annual evaluation of the management plan associated with the Life Safety Management Program functions.
    b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care Program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Environmental Health & Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care Program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.
    c. In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety/Security Officer.
    d. The Environmental Health & Safety Committee reviews and approves the annual reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, organizational leaders, The Board of Directors, the Patient Safety Committee, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

12. Analysis and actions regarding identified environmental issues (EC.04.01.03 EP1 – 3)
    a. The Environmental Health & Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

13. Improving the Environment (EC.04.01.05 EP1 – 3)
    a. When the leadership of the hospital, quality improvement, or patient safety concurs with Environmental Health & Safety Committee recommendations for improvements to the Environment of Care Management Programs, a team of appropriate staff is appointed to manage the improvement project. The Environmental Health & Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
    b. The Environmental Health & Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of

the annual review of the program and presented to hospital leadership, performance improvement, and patient safety leadership.

14. Orientation and Ongoing Education and Training (LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1 and EC.03.01.01 EP1 – 3)
    a. Orientation and training addressing subjects of the environment of care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.
    b. In addition, all current employees complete an annual review of life safety via a CBL module and documented in the Netlearning system.
    c. The Human Resources Department assisted by the Education Department coordinates the general New Employee Orientation (NEO) program. New staff members are required to attend the general NEO program within 30 days of their date of employment. The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.
    d. New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.
    e. The Safety Officer collaborates with the Environment of Care managers, department heads, the Director of Regulatory Compliance and Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed and updated to meet all applicable laws and regulations as necessary.
    f. The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff is able to describe or demonstrate how job related risks are to be managed or eliminated as part of daily work. In addition the Safety Officer evaluates the degree to which staff members understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.
    g. Information about staff knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Environmental Health & Safety Committee. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

F. **REFERENCES:**

1. The Joint Commission/NFPA Life Safety Book for Health Care Organizations (2013)

TRI-CITY MEDICAL CENTER Safety Policies & Procedures	**Section:** LIFE SAFETY MANAGEMENT **Subject:** Life Safety Management Plan **Policy Number:** 3000 Page 1 of 4
Department: Hospital Wide	**EFFECTIVE:** 11/87 **REVIEWED:** 3/00; 4/06, 4/09 **REVISED:** 4/03, 5/12

1.0 ~~PURPOSE:~~

~~1.1 To provide a fire-safe environment for all Medical Center employees, medical staff, patients, and visitors.~~

~~2.0 POLICY:~~

~~2.1 The Medical Center will provide a system of protecting all personnel on the premises from fire, smoke and other products of combustion in conjunction with its Mission Statement.~~

~~3.0 PROCEDURE:~~

~~3.1 Employees will know department-specific instructions regarding fire plans and implement them as necessary.~~

~~3.1.1 Employees will know where oxygen shutoffs are located in their areas.~~

~~3.1.2 Employees will know the location of fire extinguishers and evacuation routes in their departments.~~

~~3.1.3 The emergency number "66" is to be dialed to report a fire.~~

~~3.1.4 The unattached buildings on the main hospital campus (Business Management Services, MRI, Facilities Services, Annex, P.E.T., Lithotripsy) will dial "66" to report a fire.~~

~~3.1.5 All buildings off the main hospital campus will dial "911" for assistance in a fire.~~

~~3.2 Hospital-wide, all employees will know the location of the fire alarms and fire extinguishers and how to use them.~~

~~3.2.1 General instructions for ALL employees:~~

~~3.2.1.1 Keep telephone lines clear for fire control.~~

~~3.2.1.2 DO NOT use elevators.~~

~~3.2.1.3 Make sure all fire, corridor, and room doors are closed.~~

~~3.2.1.4 Clear all corridors and exits of unnecessary traffic and obstructions.~~

~~3.2.1.5 If away from assigned unit, all nursing personnel will remain where they are and wait for further instructions.~~

~~3.2.1.6 All other personnel will remain where they are if off the unit and await emergency assignment as needed (exception: Fire Response Team).~~

~~3.2.1.7 Reassure patients, if they are aware of the fire that the alarm has been turned in to the Fire Department, the Emergency Plan is in effect, and there is help to assist as needed.~~

~~3.2.1.8 **R.A.C.E.**~~

~~3.2.1.8.1 **R** escue patients immediately from fire/smoke area.~~
~~3.2.1.8.2 **A**larm box pulled, emergency number "66" called (give exact location).~~
~~3.2.1.8.3 **C**ontain the smoke or fire by closing all doors to rooms and corridors.~~
~~3.2.1.8.4 **E**xtinguish the fire (if safe to do so).~~

~~3.3 The main oxygen shut-off valve is located in Facilities Management Building.~~

~~3.4 The hospital and all buildings which serve to treat patients and are under the ownership or control of the Governing Body will maintain compliance with the appropriate provisions of the 1991 edition of the Life Safety Code of NFPA.~~

~~3.4.1 See Life Safety Code Compliance Policy and Interim Construction Policy.~~

~~4.0 INSPECTION, TESTING AND MAINTENANCE OF FIRE ALARM SYSTEMS:~~

~~4.1 All circuits of the Fire Alarm System and Fire Detection Systems will be inspected and tested quarterly and in addition outside vendor who is contractedly annually to perform an inspection of all master signals, area alarms, automatic pressure switches, shut off valves, flexible connections, outlets and purity from source in accordance with NFPA and Joint Commission standards..~~

~~4.2 All components will have annual preventive maintenance.~~

~~4.3 See Fire Alarm System Testing and Inspection Policy, Life Safety Code Compliance Policy, Smoke Detector Test Form, Pull Station Test Form, Fire Alarm Monitor Test Form and Quarterly Fire Alarm System Check Form.~~

~~4.4 The control of all designated fans and/or dampers in air handling and smoke management systems and transmission of fire alarm signal to the local fire department will be kept in reliable and functional~~

~~condition at all times.~~

~~4.5 All automatic fire extinguishing systems are to be inspected and tested annually.~~

~~4.6 All portable fire extinguishers are clearly identified, inspected monthly, and maintained annually.~~

~~4.6.1 See Life Safety Code Compliance Policy, Fire Extinguisher Check Policy, Fire Extinguisher Log Form and Types of Fire Extinguishers.~~

~~4.7 Purchases of hospital furnishings and equipment will be reviewed to determine if they meet fire retardant characteristics and flame spread necessary for continued fire safety.~~

~~4.7.1 See Materials and Equipment Purchases policy.~~

~~4.8 The hospital conducts annual functional tests of battery powered exit lights for 90 minutes. The hospital conducts monthly evaluations of nuclear powered exit signs and are verified for expiration dates and replaced accordingly.~~

~~4.9 A comprehensive plan to correct any Life Safety Deficiencies which occur or are identified by any sources will be developed immediately in writing and will address:~~

~~4.9.1 All Life Safety Code deficiencies.~~

~~4.9.2 Corrective actions (plan for improvement).~~

~~4.9.3 Total cost of actions and specific funding information.~~

~~4.9.4 A reasonable schedule for completion.~~

~~4.9.5 To be coordinated with available funding.~~

~~4.9.6 All interim life safety measures have been implemented and are currently enforced.~~

~~4.10 See Life Safety Code Compliance Policy and Life Safety Interim Construction Policy.~~

~~5.0 ORIENTATION AND EDUCATION TO LIFE SAFETY PROGRAM:~~

~~5.1 All Medical Center employees will know their roles and responsibilities in the event of a fire alarm.~~

~~5.1.1 Use and function of fire alarm systems.~~

~~5.1.2 Containing smoke/fire utilizing building compartmentalization.~~

~~5.2 In addition to the initial hospital orientation and department specific orientation, employees will annually complete the "Fire Safety" module in the Computer Based Learning program.~~

~~5.3 Physicians, licensed independent practitioners, and contracted employee's roles and responsibilities will be the same as employees at the point of origin of a fire as well as when they are away from a fire's point of origin.~~

~~5.4 All volunteers and students will be oriented to **R.A.C.E.** and will take direction from their supervisor in the event of a fire.~~

~~**6.0 COMMUNICATION:**~~

~~7.1 During emergency events employees will be informed of the emergency via the public address system.~~

~~**7.0 PERFORMANCE STANDARDS:**~~

~~6.1 The Life Safety Program will be evaluated annually for its effectiveness.~~

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Equipment Management

SUBJECT: **Medical Equipment Management Plan**

ISSUE DATE: ~~**POLICY NUMBER: 5000**~~
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s): **05/15**
Environmental Health and Safety Committee Approval Dates(s): **06/15**
Professional Affairs Committee Approval Date(s): **06/15**
Board of Directors Approval Date(s):

A. SCOPE:

1. The Medical Equipment Management Program is designed to assure proper selection, of the appropriate medical equipment to support a safe patient care and treatment environment. The Program will assure effective preparation of staff responsible for the use, maintenance, and repair of the equipment, and manage risks associated with the use of medical equipment technology Finally, the Program is designed to assure continual availability of safe, effective equipment through a program of planned maintenance, timely repair, ongoing education and training, and evaluation of all events that could have an adverse impact on the safety of patients or staff as applied to the building and services provided at ~~Tri-City Medical Center~~**Tri-City Healthcare District.**
2. The program is applied to Tri-City Healthcare District medical center and offsite care locations. \
3. The Medical Equipment Management Plan describes the processes it implements to manage the effective, safe, and reliable operation of medical equipment as well as provide a safe environment for patients, staff members, visitors, and other individuals in the hospital. Directly or indirectly, the Medical Equipment Management Plan involves every person in the hospital who uses, maintains, or is associated with medical equipment.

B. FUNDAMENTALS (RISKS):

1. The sophistication and complexity of medical equipment continues to expand. Selecting new medical equipment technology requires research and a team approach.
2. Patient care providers need information to develop an understanding of medical equipment limitations, safe operating conditions, safe work practices, and emergency clinical interventions during failures.
3. Medical equipment may injure patients or adversely affect care decisions if not properly maintained.

C. OBJECTIVES:

1. The Objectives for the Medical Equipment Program are developed from information gathered during risk assessment activities, annual evaluation of the previous year's program, performance measures, and environmental tours. The Objectives for this Plan are:
   a. To increase training, both formal and informal for all resident technicians.
   b. Develop departmental rounds to ensure medical equipment safety within the facility.
   c. Keep the medical equipment inventory current and accurate.
   d. Minimize risks to patients, users, and the environment
   e. Maintain the highest level of availability of medical equipment to clinical users.
   f. Reduce the need for premature replacement of equipment
   g. Comply with applicable laws, regulations, standards, and codes.

h. Continually seek opportunities for quality improvement and cost reduction.
i. Reduce unnecessary workload that does not produce positive impact of care delivery.

D. ORGANIZATION & RESPONSIBILITY:

1. The Hospital Governing Board receives regular reports of the activities of the Medical Equipment Management Program from the Environmental Health and Safety Committee. They review the reports and, as appropriate, communicate concerns about identified issues, and regulatory compliance. They provide support to facilitate the ongoing activities of the Medical Equipment Program.
2. The Chief Operating Officer (COO) receives regular reports of the current status of the Medical Equipment program through the Environmental Health & Safety Committee. The COO reviews the reports and, as necessary, communicates concerns about key issues and regulatory compliance to the medical staff, nursing, Clinical Engineering, and other appropriate staff.
3. The Manager of Clinical Engineering with COO support assures that the Medical Equipment Program is implemented in all key clinical areas. The program manages a variety of activities, including tracking of rental or leased equipment, warranty repairs, and contract services. The Program also assists in the management of the activities of specialty service contractors providing services to other departments, such as radiology, laboratory, respiratory care, and surgery and anesthesia.
4. The Manager of Clinical Engineering implements the in-house medical equipment maintenance program and tracks maintenance provided by original equipment manufacturers, and other contractors who provide maintenance and repair services for specific items of equipment.
5. Department heads orient new staff to their department and, as appropriate, specific uses of medical equipment. When requested, the Clinical Engineering Technicians provides assistance.
6. Individual staff members are responsible for learning and following job and task specific procedures for safe medical equipment operation.

E. PERFORMANCE ACTIVITIES:

1. The performance measurement process is one part of the evaluation of the effectiveness of the Medical Equipment Program. Performance measures have been established to measure important aspect of the Medical Equipment Program.
2. The following fundamental performance indicators will be monitored:
   a. SM completion rate benchmark is 95% or greater.
   b. Repair completion rate within 30-days benchmark is 85% or greater.
   c. Critical/High Risk Equip SM Mthly Completion rate is 100%.
   d. Use Error Percentages
   e. Could not Duplicate Percentages per year
   f. Equipment found without PM Safety Sticker <1%
3. As they occur:
   a. Safe Medical Device Act of 1990 (SMDA)
   b. Incident investigations
   c. Device recalls and alerts

F. PROCESSES FOR MANAGING MEDICAL EQUIPMENT:

1. The hospital plans activities to minimize risks in the environment of care – EC.01.01.01 EP7
   a. The hospital has a written plan for managing medical equipment. The organization develops and maintains the Medical Equipment Management Plan to effectively manage the medical equipment risks of the staff, visitors, and patients at Tri-City Healthcare District.
2. The hospital manages safety and security risks- EC.02.01.01 EP11
   a. The hospital responds to product notices and recalls. The Manager of Clinical Engineering responds and acts on medical equipment notices and recalls. Any notices or recalls (OEM voluntary or FDA) which are affected on any devices or equipment in the facility will be acted on immediately and reported to the EHSC meeting. The Department

Director (owner of the equipment) and Risk Manager will be notified of the notice or recall and action taken. The notice or recall will be annotated on the EHSC medical equipment report until the issue is resolved. This will also be discussed at the EHSC meeting to all members.

3. The hospital manages medical equipment risks - EC.02.04.01 EP1
   a. The hospital solicits input from individuals who operate and service equipment when it selects and acquires medical equipment. Tri-City Healthcare District utilizes a capital committee to select and assure the proper equipment is selected. The Capital Committee is made up of (at a minimum) Information Technology, Clinical Engineering, Nursing, Facility Management, Finance and Materials Management.
4. The hospital manages medical equipment risks - EC.02.04.01 EP2
   a. The hospital maintains a written inventory of all medical equipment. Tri-City Healthcare District maintains an electronic and written inventory of all medical equipment. This includes all Critical/High Risk equipment. The Manager of Clinical Engineering evaluates new types of equipment before initial use to determine whether to include this equipment in the inventory.
   b. Written criteria are used to identify risks associated with medical equipment. The risks include, equipment function, physical risks associated with use, and equipment incident history as it relates to patient safety. The risks identified are used to assist in determining the strategies for maintenance, testing, and inspection of medical equipment. In addition, the identified risks are used to guide the development of training and education programs for staff that use or maintain equipment.
   c. Equipment requiring a program of planned maintenance is listed as part of a maintenance inventory. The list includes equipment maintained by in-house staff as well as equipment maintained by vendors.
5. The hospital manages medical equipment risks - EC.02.04.01 EP3
   a. The hospital identifies high-risk medical equipment on the inventory for which there is a risk of serious injury or death to a patient or staff member should the equipment fail.
      i. Note: High-risk medical equipment includes life-support equipment. The Manager of Clinical Engineering identifies the activities used for maintaining, inspecting, and testing all of the medical equipment in the inventory used for the diagnosis, care, treatment, and monitoring of patients thus assuring safety and maximum useful life. The determination of the appropriate activity is made as part of the initial evaluation of equipment. Critical/High Risk equipment is identified and scheduled according to manufacturer recommendations. They are tracked using IDesk.
   b. Potential activities selected to ensure reliable performance include:
      i. Predictive maintenance based on manufacturer's recommendation
      ii. Reliability-centered maintenance based on equipment history
      iii. Interval-based inspections based on specified intervals between tests, inspections, or maintenance activity
   c. Tri-City Healthcare District's Clinical Engineering Department follows manufacturer's recommendations for predictive (scheduled) maintenance including frequency and task (or the activity that requires MORE frequent inspections). Any changes of maintenance strategy and specific tasks shall be based on the experience accumulated locally or elsewhere, upon approval of the Environment of Care/Safety Committee or appropriate hospital authority.
6. The hospital manages medical equipment risks - EC.02.04.01 EP4
   a. The hospital identifies the activities and associated frequencies, in writing, for maintaining, inspecting, and testing all medical equipment on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations or with strategies of an alternative equipment maintenance (AEM) program. The Manager of Clinical Engineering identifies the frequencies for inspecting, testing, and maintaining medical equipment on the inventory in accordance with

Manufacturers' recommendations. The frequency of scheduled (planned) maintenance is determined based on manufacturer recommendations, risk levels, and current hospital experience. The frequency of maintenance is determined at the time of initial evaluation of the medical equipment.

b. A work order is used to manage the work for each scheduled maintenance event. Work orders are issued for maintenance performed by in-house staff and by contractors. The Manager of Clinical Engineering manages the work order generation and completion process via IDesk. The Clinical Engineering Technicians perform assigned work orders and review prior to filing. Work done by outside contractors is tracked to assure the work is completed in accordance with the terms of a contract.

c. In addition, other departments manage performance testing and daily user maintenance of sterilizers.

7. The hospital manages medical equipment risks - EC.02.04.01 EP5
   a. The hospital's activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers' recommendations:
      i. Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining must be in accordance with the manufacturer recommendations, or otherwise establishes more stringent maintenance requirements
      ii. Medical laser devices
      iii. Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes)
      iv. New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies Note: Maintenance history includes any of the following documented evidence:
         1) Records provided by the hospital's contractors
         2) Information made public by nationally recognized sources
         3) Records of the hospital's experience over time
   b. The Manager of Clinical Engineering identifies the frequencies for inspecting, testing, and maintaining medical equipment on the inventory in accordance with Manufacturers' recommendations. The frequency of scheduled (planned) maintenance is determined based on manufacturer recommendations, and can be more often based on risk levels, and current hospital experience. The frequency of maintenance is determined at the time of initial evaluation of the medical equipment.
   c. A work order is used to manage the work for each scheduled maintenance event. Work orders are issued for maintenance performed by in-house staff and by contractors. The Manager of Clinical Engineering manages the work order generation and completion process via IDesk.
8. The hospital manages medical equipment risks - EC.02.04.01 EP6
   a. A qualified individual(s) uses written criteria to support the determination whether it is safe to permit medical equipment to be maintained in an alternate manner that includes the following:
      i. How the equipment is used, including the seriousness and prevalence of harm during normal use
      ii. Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm
      iii. Availability of alternative or back-up equipment in the event the equipment fails or malfunctions
      iv. Incident history of identical or similar equipment
      v. Maintenance requirements of the equipment
   b. The Manager of Clinical Engineering assists in the development of written procedures that are followed when medical equipment fails. These procedures include emergency clinical interventions and the location and use of backup medical equipment. The leader of each department that uses Critical/High Risk medical equipment develops and trains

staff about the specific emergency procedures to be used in the event of failure or malfunction of equipment whose failure could cause death or irreversible harm to the patient dependent on such equipment.

c. These emergency response procedures provide clear, specific instructions for staff responding to an emergency and provide information about notifying appropriate administrative staff of the emergency, actions required to protect patients from harm, contacts for spare equipment or repair services, and contacts to obtain additional staff to manage the emergency.

d. Each department leader maintains copies of applicable emergency procedures in accessible locations in their departments. Departmental staff receives orientation and ongoing education and training about the emergency procedures.

e. Each department Director/Manager reviews the department specific medical equipment emergency procedures annually.

9. The hospital manages medical equipment risks - EC.02.04.01 EP7

a. The hospital identifies medical equipment on its inventory that is included in an alternative equipment maintenance program. The Manager of Clinical Engineering will bring any alternative equipment maintenance programs to the Environmental Health & Safety Committee for approval before using the alternative measures. There are no alternative maintenance programs currently being used.

10. The hospital manages medical equipment risks - EC.02.04.01 EP8

a. The hospital monitors and reports all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990. The Risk Manager is responsible for monitoring and reporting all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990. The Risk Manager collects information about potentially reportable events through the incident reporting and investigation process. The Risk Manager and appropriate clinical staff conduct investigations of medical equipment incidents to determine if the incident is reportable under criteria established by the Food and Drug Administration. Clinical Engineering will help in the investigation only when instructed by Risk Management.

b. The Risk Manager uses the Sentinel Event Process to investigate and document reportable incidents. The Risk Manager reports for the Environmental Health & Safety Committee on those incidents determined to be reportable. The Risk Manager is also responsible for completing all reports and handling other communications with medical equipment manufacturers and the FDA required by the Safe Medical Devices Act.

c. Appropriate changes in processes and training are made through the performance improvement process. The changes are communicated to all appropriate staff

11. The hospital manages medical equipment risks - EC.02.04.01 EP9

a. The hospital has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment. The Manager of Clinical Engineering assists in the development of written procedures that are followed when medical equipment fails. These procedures include emergency clinical interventions and the location and use of backup medical equipment. The leader of each department that uses Critical/High Risk medical equipment develops and trains staff about the specific emergency procedures to be used in the event of failure or malfunction of equipment whose failure could cause death or irreversible harm to the patient dependent on such equipment.

b. These emergency response procedures provide clear, specific instructions for staff responding to an emergency and provide information about notifying appropriate administrative staff of the emergency, actions required to protect patients from harm, contacts for spare equipment or repair services, and contacts to obtain additional staff to manage the emergency.

c. Each department head maintains copies of applicable emergency procedures in

accessible locations in their departments. Departmental staff receives orientation and ongoing education and training about the emergency procedures.

d. Each department Director/Manager reviews the department specific medical equipment emergency procedures annually.

12. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP1
    a. Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. (See also EC.02.04.01, EP 2). The Clinical Engineering staff will test all medical equipment on the inventory before initial usage and perform safety, operational, and functional checks. The inventory includes, equipment owned by Tri-City Healthcare District, leased, and rented from vendors. These inspection, testing and maintenance documents are maintained in the Clinical Engineering Department for review. The Manager of Clinical Engineering manages the program of scheduled inspection and maintenance.
13. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP2
    a. The hospital inspects, tests, and maintains all high-risk equipment. These activities are documented. (See also EC.02.04.01, EPs 3 and 4; PC.02.01.11, EP 2). The Manager of Clinical Engineering assures that scheduled testing (inspects, tests and maintains) of all Critical/High Risk equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Environmental Health & Safety Committee. If the monthly rate of completion falls below 100%, the Manager of Clinical Engineering will present an analysis to determine the cause of the problem and make recommendations for addressing it. These inspection, testing, and maintenance documents are maintained in the Clinical Engineering Department for review.
14. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP3
    a. The hospital inspects, tests, and maintains non–high-risk equipment identified on the medical equipment inventory. These activities are documented. The Manager of Clinical Engineering assures that scheduled testing (inspects, tests and maintains) of all Non Critical/Non High Risk equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Environmental Health & Safety Committee. If the monthly rate of completion falls below 95%, the Manager of Clinical Engineering will present an analysis to determine the cause of the problem and make recommendations for addressing it. These inspection, testing and maintenance documents are maintained in the Clinical Engineering Department for review.
15. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP4
    a. The hospital conducts performance testing of and maintains all sterilizers. These activities are documented. The Manager of Clinical Engineering is responsible for the maintenance and documentation of maintenance of all types of sterilizers used at Tri-City Healthcare District. Maintenance documentation to include SMs are maintained in IDesk (the Clinical Engineering Medical Equipment Database) and filed into the equipment file for review.
    b. Records of load testing (performance) and regular user maintenance are maintained by Sterile Processing Department (SPD) and Perioperative Services Department, respectively.
16. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP5
    a. The hospital performs equipment maintenance and chemical and biological testing of water used in hemodialysis. These activities are documented. The Manager of Clinical Engineering is responsible for managing the service and maintenance of the dialysis units performed by Fresenius. The service maintenance records are also entered into IDesk the Clinical Engineering shop medical equipment database and filed into the equipment file for review.
    b. Engineering is responsible for managing the chemical and biological testing of water

used in hemodialysis at Tri-City Healthcare District by Fresenius. The program of maintenance includes, regular cleaning and disinfection of all dialysis equipment, and testing for compliance with biological and chemical standards for the dialysis water supply. Documentation of the testing and maintenance activities is maintained in the Dialysis storage room for review.

17. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP14
    a. Qualified hospital staff inspect, test, and calibrate nuclear medicine equipment annually. The dates of these activities are documented. The Manager of Clinical Engineering assures that scheduled inspecting, testing, and calibrating (for the service and Scheduled Maintenance) of the Nuclear Medicine Camera and related equipment is performed in a timely manner at least annually. The service maintenance records are also entered into I-Desk the Clinical Engineering shop medical equipment database and filed into the equipment file for review.
18. The hospital collects information to monitor conditions in the environment. EC.04.01.01 EP1
    a. The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
        i. Medical or laboratory equipment management problems, failures, and use errors
            1) Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities.
            2) Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, or services, or to prevent similar incidents, are not lost as a result of following the legal process. Medical/Laboratory equipment management problems, failures, and use errors will be reported to the EHSC by Clinical Engineering on the EHSC report. All use errors will have in-service education and follow-up.
19. The hospital collects information to monitor conditions in the environment. EC.04.01.01 EP10
    a. Based on its process(es), the hospital reports and investigates the following: Medical/laboratory equipment management problems, failures, and use errors. (See also EC.04.01.03, EP 1) Medical/Laboratory equipment management problems, failures, and use errors will be reported to the EHSC by Clinical Engineering on the EHSC report.
20. The hospital collects information to monitor conditions in the environment. EC.04.01.01 EP12
    a. The hospital conducts environmental tours every six months in patient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks. (See also EC.04.01.03, EP 1).Clinical Engineering participates on the multi-disciplinary team which conducts environmental safety tours every 6-months in patient care areas and annually in non-patient care areas at Tri-City Healthcare District .
21. The hospital collects information to monitor conditions in the environment - EC.04.01.01 EP15
    a. Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness. On an annual basis, Manager of Clinical Engineering evaluates the objectives, scope, performance, and effectiveness of the Plan to manage the medical equipment risks to the staff, visitors, and patients at Tri-City Healthcare District. The basis for the evaluation will include but not be limited to the medical equipment performance standards and the EHSC Committee reports on medical equipment issues (supported from IDesk). The goal of the annual evaluation is to continually improve processes and outcomes to improve the patient experience.
22. The hospital addresses NPSG.06.01.01 - Improve the safety of clinical alarm systems. (EP 1-3 are completed) (EP 4-5 will be accomplished in 2015)
    a. EP 1 - Leaders establish alarm safety as a hospital priority.
    b. EP 2 - Prepare an annual inventory of alarms used in the hospital and identify the default

alarm settings. (For more information, refer to Standard EC.02.04.01)

c. EP 3 - Based on the annual inventory, identify the most important alarms to manage.
d. EP 4 - Establish policies and procedures for managing the alarms identified in EP 3 above that at a minimum address the following:
   i. Whether specific alarms are needed or unnecessarily contribute to safety concerns
   ii. When alarms can be disabled
   iii. When alarm parameters can be changed
   iv. Who in the organization has the authority to make decisions about disabling alarms and changing alarm parameters
   v. Monitoring and responding to alarms
   vi. Checking individual alarms for accurate settings, proper operation, and detectability
e. EP 5 - Educate staff about alarm policies and procedures.

G. INFECTION CONTROL

1. Clinical Engineering staff will observe the hospitals infection-control policies and procedures, including current CDC hand hygiene guidelines, in order to minimize the risk of cross-contamination to patients and clinicians. In addition, Clinical Engineering employees are required to follow the blood borne pathogens exposure control plan (including training, universal precautions, engineering and safe work practices, personal protective equipment usage, and post-exposure evaluation and follow-up) developed by aramark Healthcare Technologies as required by OSHA per 29 CFR 1910.1030.

H. PATIENT INFORMATION PRIVACY (HIPAA):

1. As a service provider, Clinical Engineering staff do not use or disclose protected health information (PHI), as defined by the Health Insurance Portability and Accountability Act of 1996 – HIPAA, specifically the Standards for Privacy of Individually Identifiable Health Information. Any disclosure of protected health information to Clinical Engineering staff that occurs in the performance of their duties (such as what may occur while repairing a piece of medical equipment) is limited in nature, occurs as a by-product of the maintenance duties, and cannot be reasonably prevented. Such disclosures are incidental and permitted by the HIPAA Privacy Rule (45 CFR 164.502(a)(1)).
2. On the other hand, Clinical Engineering staff shall follow policies and procedures established by client to protect PHI, including attending required training and assisting clients in identifying privacy risks and practicing risk reduction measures. Specifically, the Technology Managers and CE staff is instructed to:
   a. Assist in identifying and recommending preventive measures for PHI theft risks for medical devices that are exposed to non-authorized employees, patients and visitors
   b. Work with the Information Technology department to remove all PHI from equipment that is sent out for repair or disposal
   c. Not use or disclose any information (oral, transmitted, or recorded in any form or medium) that relates to the health (past, present, or future) of or provision of healthcare to an individual

I. EMERGENCY PREPAREDNESS AND MANAGEMENT:

1. Clinical Engineering staff will observe the client's emergency preparedness and management policies and procedures in order to provide care to the population served by the client in the case of local, regional, and national emergencies.

TRI-CITY MEDICAL CENTER Safety Policies & Procedures	**Section:** EQUIPMENT MANAGEMENT **Subject:** Equipment Management Plan **Policy Number:** 5000 Page 1 of 5
Department: Hospital-Wide	**EFFECTIVE:** 10/94 **REVISED:** 3/97; 7/00; 5/03, 5/08

1.0 ~~DEFINITION OF MEDICAL EQUIPMENT:~~

~~1.1 SELECTION AND ACQUISITION~~

~~1.1.1 Medical equipment purchases are made by the department director after collaboration with the nursing staff, medical staff, the purchasing department, and biomedical engineering.~~

~~1.1.1.1 **Hospital-wide Equipment**~~

~~This equipment will be approved through the product standardization committee based on input from the following sources:~~

~~1.1.1.1.1 Purchasing Department - may provide bids from three vendors based on negotiation, contracts in place and ECRI report of reliability and repairs history.~~

~~1.1.1.1.2 Clinical Departments - Clinical Practice Council will evaluate equipment for clinical application, ease of use, cost (of equipment and related disposables).~~

~~1.1.1.1.3 Education Department - provides input by sitting on both the product standardization committee and Nursing Practice Council.~~

~~1.1.1.1.4 Medical Staff - will give input through that department Director regarding equipment used jointly by employees and physicians.~~

~~1.1.1.1.5 Biomedical Engineering - will evaluate for maintenance and special mechanical/ electrical requirements, and risk factors relating to use.~~

~~1.1.1.2 **Department Specific Equipment**~~

~~1.1.1.2.1 Purchasing Department - may provide bids from up to three vendors based on negotiation, contracts in place and ECRI report of reliability and repairs history. Once approved (see AP&P 252 & 253) the purchasing department will order the approved equipment, and asset information will be sent to the Account Department.~~

~~1.1.1.2.2 Department Directors - will collaborate with the users (nurses, technicians, or physicians) to evaluate equipment relating to cost of equipment and related disposables, ease of use, and care, educational requirements, maintenance requirements, and credentialing requirements. The Department Director is responsible for budgeting and requisitioning of equipment. Refer to Administrative Policy and Procedure #252.~~

~~1.1.1.2.3 Medical Staff - requests by the medical staff for capital equipment will come through the department or division to the department director. The director will then collaborate with the physicians on all of the above issues.~~

~~1.1.1.2.4 Administration and Board of Directors - capital equipment will be approved by Administration and the Board of Directors annually during the budget approval process.~~

~~1.1.1.2.5 Biomedical Engineering - will evaluate for maintenance and special mechanical/ electrical requirements, and risk factors relating to use.~~

~~2.0 IDENTIFICATION, EVALUATION, AND INVENTORY OF MEDICAL EQUIPMENT~~

~~The Biomedical Engineering Department receives all medical equipment from the Materials Department before being delivered to the specified department.~~

~~2.1 Evaluation~~

~~Refer to procedure *"Incoming Inspection of New, Loaner, or Rental Equipment"* for risk criterions' identification. Each piece of equipment will generate an inspection report form. The equipment is inspected for:~~

~~2.1.1 Equipment function~~
~~2.1.2 Clinical application~~
~~2.1.3 Preventive maintenance requirements~~
~~2.1.4 Probability of equipment failure~~
~~2.1.5 Environmental use classification~~

~~3.0 MAINTENANCE~~

~~3.1 All equipment (after initial inspection and risk criteria identification) is entered into the TAMIS computer program, including the due dates for preventive maintenance testing. Refer to Procedure *"Preventive Maintenance (PM) Checks for Hospital-Owned Patient Care Equipment"* for assigning of maintenance duties by the month, including prioritization.~~

~~3.2 Parameters for testing of equipment are kept in the *Profile* Maintenance software. The equipment is listed either by device type or manufacture, name, referenced by the data control number assigned to the equipment.~~

~~3.3 Each Biomed tech laptop computer shows the equipment testing parameters during the actual preventive maintenance testing.~~

~~4.0 HAZARD NOTICES AND RECALLS~~

~~4.1 Hazard notices and recalls are issued by the Risk, Legal and Regulatory Services Department from "Hospital Technology Alerts", and letters from manufacturers. When there is a device or medical equipment in the Biomedical equipment listing, the Biomed staff will remove that equipment from use and follow the manufacturer's specifications for repair~~

~~or return of that equipment.~~

~~5.0 MEDICAL DEVICE INCIDENTS~~

~~5.1 Equipment device problems resulting in serious illness, injury, or death to a patient or medical personnel associated with the equipment, are to be reported to the Biomedical Engineering Department according to Administrative Policy & Procedure #201.~~

~~5.2 The equipment is picked up and isolated until direction is received from Risk, Legal and Regulatory Services as to the disposition of the device, according to Safety Policy #1046.~~

~~6.0 EQUIPMENT MANAGEMENT PROBLEMS~~

~~6.1 All medical equipment problems and failures are entered into the computer as work order to notify the Biomedical department or called to the Biomed department by the hospital staff experiencing difficulty with the equipment. The equipment is to be labeled using a **RED DEFECTIVE STICKER** (attachment A) needing repair, and isolated until picked up by Biomed.~~

~~6.2 After picking up the defective equipment, the Biomed department will assess the equipment's condition and/or if user error.~~

~~6.3 After assessment, the equipment will either be repaired in the department, or returned to the manufacturer for repair. In case of user error, the department manager will be apprised of the need for in-service for the personnel experiencing difficulties.~~

~~6.4 Equipment that is old, or needs replacement instead of repair, will generate a request to the respective department manager for resolution.~~

~~7.0 MEDICAL EQUIPMENT ORIENTATION AND EDUCATION~~

~~7.1 All new rental medical equipment coming into the facility will have a check list completed by the company representative outlining the use, care, required preventive maintenance, emergency procedure for failure, and the process for reporting problems and failures for repair or return, and defining user error. Refer to Procedures entitled *"Incoming Inspection of New, Loaner or Rental Equipment"*, and *"Safety Check in of Rental Equipment from Prime Vendors"*.~~

~~8.0 EMPLOYEE PERFORMANCE STANDARDS~~

~~8.1 Biomed staff are evaluated at orientation for their technical skills and annually thereafter.~~

~~8.2 The evaluation encompasses knowledge of equipment: competency evaluations; quality checks ongoing assessment by the senior tech; correctly following procedures relative to equipment repair; and accurate reporting of problems to the Department Head or Supervisor. Also evaluated is completion of assignments in a timely manner (i.e., inspections, PM's and Testing)~~

~~8.3 Monthly reports are submitted by the Biomed Tech II to the Department Manager/Designee Supervisor. These reports include all PM's completed, repairs, time involved, and costs. Explanations of missed or incomplete PM's are due at that time.~~

~~9.0 EQUIPMENT EMERGENCY PROCEDURES~~

~~9.1 All equipment in the facility is identified by a sticker which denotes the responsible department. (Biomedical Engineering, Communications, Facilities Management).~~

~~9.2 Some equipment is contracted out to American Biomedical Group, Inc., (ABGI) on a contract maintenance program. All ABGI covered equipment have an ABGI sticker. For all ABGI equipment, Administrative Policy and Procedure #254 covers servicing during normal and off duty hours.~~

~~9.3 If equipment that is procured from MDC and is a common device (i.e. infusion pumps), the department experiencing problems with the equipment will enter an order to MDC for a replacement. A work order to Biomed will also be placed requesting repair of the isolated non-functioning equipment.~~

~~9.4 Any intra-departmental equipment that is malfunctioning will be replaced by another similar device immediately, or the patient moved to another available room to complete the procedure, (i.e., x-ray).~~

~~9.5 If the equipment is not functioning before a procedure, and is identified as such, the procedure will be not be started until properly functioning equipment is available.~~

~~9.6 In case of equipment malfunction and repair or replacement is not immediately available, the physician will decide to continue or discontinue the procedure.~~

~~9.7 When a piece of medical equipment fails during off duty hours of the Biomedical Department, the Facilities Engineer on duty will assess the situation and call in a Biomed Tech if necessary. The department supervisor will also make an assessment of the need for the equipment to be repaired. If so determined, the supervisor will call the appropriate company for repair.~~

~~9.8 The lists of equipment, and who is to repair, is to be kept in each individual departmen~~**department** t.

TRI-CITY MEDICAL CENTER
PHARMACY AND THERAPEUTICS COMMITTEE

Request for Formulary Status Evaluation:

Admission { X } **Deletion { }**

Date: 1/21/2015 **Requestor:** Dr. Nayaar Siddique

Trade Name: sprycel **Generic Name:** dasatinib

Dosage form(s): Oral tablet (20mg, 50mg, 70mg, 80mg, 100mg, 140mg)

Indication:

1. Newly diagnosed adults with Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase
2. Adults with chronic, accelerated or myeloid or lymphoid blast phase Ph+ CML with resistance or intolerance to prior therapy including imatinib
3. Adults with Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL) with resistance or intolerance to prior therapy

Efficacy:

- Achieved higher molecular response rates (52%) compared to imatinib (34%) in 1 year and continued response rates (69%) compared to imatinib (56%) in 3 years
- Achieved faster molecular response rates compared to imatinib
- 91% Overall Survival at 2 years in imatinib resistant patients
- Less than 5% of patients resistant or intolerant to imatinib transformed to accelerated phase or blast crisis within a minimum of 5 years of follow-up while on study.

Safety:

Propensity for medication error: Unknown

Abuse potential: None

Sentinel event potential: Moderate to severe- antineoplastic drug

Black box warning: None

Cost comparison with similar Formulary products:

Drug **Cost**

Drug/Dosage Form	Dosage Form	GPO Contract Price	340B pricing	Usual Dosing Regimen	Cost/Dose
Imatinib (Gleevec)	100mg tab 400mg tab	$80.73 $290.91	$4.00 $28.42	400mg or 600mg daily	$290.91-$484.38/ $12.00-$24.00
Dasatinib (Sprycel)	100mg tab 140mg tab	$304.28 $304.28	$55.37 $68.59	100mg or 140mg daily	$55.37-$304.28

Other considerations:
Warnings and Precautions:
1. May cause severe thrombocytopenia, neutropenia, and anemia. Myelosuppression was generally reversible and usually managed by dose interruption, dose reduction or discontinuation.
2. In vitro data suggests potential for QT prolongation. Maximum mean changes in QTc from baseline ranged from 7.0 to 13.4 ms. Correct hypokalemia and hypomagnesemia prior to administration.
3. Strong 3A4 inhibitors and grapefruit juice may increase plasma concentrations of dasatinib.
4. Fluid retention was severe in up to 10% of patients. Severe ascites, pulmonary edema, and generalized edema were each reported in <1 % of patients.
5. Congestive heart failure, left ventricular dysfunction, myocardial infarction was reported in 7% of 258 patients.
6. Pulmonary Hypertension
7. Embryo-fetal toxicity
8. Hazardous agent- use appropriate precautions for handling and disposal (NIOSH 2014).

Recommendation:
Based on the review of clinical trials, dasatinib has been shown to be effective in all-phase CML and Ph+ ALL. In addition, it is used as a therapy option for patients resistant or intolerant to imatinib therapy. The recommendation is to add dasatinib (SPRYCEL) to the TCMC formulary for use in patients with all-phase CML and Ph+ALL.

Process/Plan to monitor Patient Responses:
1. Bone marrow biopsy and bone marrow aspiration to measure cytogenetic response every 1 to 3 months
2. CBC weekly for first two months of therapy then monthly thereafter as clinically indicated
3. Monitor for signs and symptoms of bleeding, infection, pleural effusion, and edema
4. Monitor for signs and symptoms of pulmonary arterial hypertension prior to and during therapy

References:

1. Bristol Myers Squibb, SPRYCEL® Package Insert. December, 2006
2. http://www.pbm.va.gov
3. Talpaz M, Shah NP, Kantarjian H et al. Dasatinib in Imatinib-Resistant Philadelphia Chromosome-Positive Leukemias. N Engl J Med. 2006;354:2531-2541
4. Ottmann O, Dombret H, Martinelli G et al. Blood. 2007;110(7):2309-2315
5. Apperley JF, Cortes JE, Kim DW et al. J Clin Oncol 2009;27:3472-3479
6. Kantarjian H, Shah NP, Hochhaus A et al. N Engl J Med. 2010;362:2260-2270

DRAFT

Governance & Legislative Committee Meeting Minutes
Tri-City Healthcare District
June 2, 2015

Members Present:	Larry W. Schallock, Chairperson; Director Ramona Finnila; Director RoseMarie V. Reno; Blake Kern, Community Member; Eric Burch, Committee Community Member; Dr. Paul Slowik, Committee Community Member
Non-Voting Members:	Greg Moser, General Counsel; Tim Moran, CEO; Kapua Conley, COO
Others Present:	Teri Donnellan, Executive Assistant; Sherry Miller, Manager, Medical Staff Office; Esther Beverly, VP/Human Resources; Jane Dunmeyer, Community Member
Absent:	Dr. Marcus Contardo, Physician Member; Dr. Henry Showah, Physician Member; Al Memmolo, Community Member

	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	The meeting was called to order at 12:30 p.m.in Assembly Room 3 at Tri-City Medical Center by Chairman Schallock, Committee Chairman.		
2. Approval of Agenda	**It was moved by Director Reno to approve today's agenda as presented. Dr. Paul Slowik seconded the motion. The motion passed unanimously.**	Agenda approved.	
3. Comments from members of the public	Chairman Schallock read the Public Comments announcement as listed on today's Agenda. Director Finnila explained per discussion at last month's meeting an amendment to the Bylaws was brought forward to the Board for consideration to allow for an additional regularly scheduled Board meeting a month, however the motion was not seconded and therefore the motion died.	Information only	
4. Ratification of prior Minutes	**It was moved by Director Reno and seconded by Mrs. Blake Kern to ratify the minutes of the May 12, 2015 Governance & Legislative Committee. The minutes were approved unanimously.**	Minutes ratified.	Ms. Donnellan
6. Old Business - None	There was no Old Business for discussion.	None.	

Topic	Discussion	Action Follow-up	Person(s) Responsible

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7. New Business a. Medical Staff Rules & Regulations 1. Division of Pediatric Rules & Regulations	The committee discussed the Division of Pediatric Rules and Regulations. Mrs. Blake Kern recommended several minor grammatical changes which were accepted by the committee. Discussion was also held regarding Section F. Classifications of Newborns. Ms. Sherry Miller, Medical Staff Manager explained this section is formatted in such a way that is consistent with other Medical Staff Rules and Regulations and is understandable to physicians. **It was moved by Director Reno to recommend approval to the Board of Directors the Division of Pediatric Rules & Regulations as presented and modified. Dr. Paul Slowik seconded the motion. The motion passed unanimously** *Ms. Miller left the meeting at 12:37 p.m.*	. Recommendation to be sent to the Board of Directors to approve Division of Pediatric Rules & Regulations as presented and amended; item to appear on next Board agenda and included in Board Agenda packet.	Ms. Donnellan
b. Consideration of limits on political activities of employees	Director Finnila stated she requested policies related to political activities of employees be addressed due to the fact that individuals have been found in the past to have used the hospital as a starting point for political activities. Mr. Moser explained a series of policies and related statutes are contained in today's agenda packet with respect to political activity. Director Finnila gave the committee a brief overview of Board Policy #14-028 - Authorizing Directors to Represent The District In Advocacy and its purpose. Mr. Moser stated there are no statutes that interface with Board Policy #14-028 and he does not recommend any revisions to the policy. With regard to Board Policy #14-041 – Board Policy on	No revisions necessary to Board Policy #14-028. Mr. Conley to coordinate scheduling of	Mr. Conley/Ms.

Topic	Discussion	Action Follow-up	Person(s) Responsible
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	Public Information, discussion was held regarding the need for an Emergency Preparedness Report. Mr. Conley will arrange for a presentation on Emergency Preparedness by our Safety Officer at a future Board meeting. Ms. Esther Beverly, VP/Human Resources provided background information related to Administrative Policy 8610-210 Solicitation and Distribution. She explained the policy has not been in effect for the past couple of years; however it was determined that there was a need to have a policy of this nature in place. Ms. Beverly explained the policy was brought forward to the Professional Affairs Committee at their May meeting, however was pulled for further review. Ms. Beverly explained that the policy is a challenge due to the fact that it hasn't been strictly enforced and to begin enforcing the policy during union negotiations may be viewed as retaliatory.	an Emergency Preparedness Report to the Board.	Donnellan
	Director Finnila questioned whether the policy should address convening of political groups on campus. Mr. Moser stated that Board Policy 14-043 External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms addresses permitted and prohibited uses of the meeting rooms. Mr. Moser suggested Ms. Beverly conduct an inventory of groups and events that utilize meeting space and ensure we are compliant from a first amendment standpoint prior to amending the policy.	Ms. Beverly to conduct inventory of groups and events that utilize district meeting space and provide this information to Mr. Moser to amend Board Policy 14-033.	Ms. Beverly/General Counsel
	Discussion was held as to whether Administrative Policy 8610-210 falls under the purview of District Operations, Human Resources or the Board of Directors. Mr. Moser suggested that Administrative Policy 8610-210 Solicitation and Distribution be converted to a Board Policy for consistency within the organization and cross reference pertinent Board Policies. Mr. Moran requested electronic communications also be	Mr. Moser to convert Administrative Policy 8610-210 to a new Board Policy and cross-reference pertinent Board Policies. Draft policy to be brought forward to the July committee for review.	General Counsel General Counsel

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	addressed in the solicitation policy. The committee directed Mr. Moser to develop a new Board Policy based on the guidelines discussed, include applicable statutes as necessary and bring back to the committee for review at the July meeting. Ms. Beverly noted a change in the policy will require vetting by the Union prior to final Board approval. *Ms. Beverly left the meeting at 1:23 p.m.*		
c. Review and discussion of Board Policy 14-031 Members on Board Committees; Conflict of Interest	Director Reno stated she had requested Board Policy 14-031 be placed on today's agenda to discuss the term of community members on Board Committees and to ensure committees follow the policy and restrict community member terms to a two-year term, with an option to renew the appointment for one additional two-year term. Discussion was held regarding community member appointments at the Community Healthcare & Alliance Committee which can be done by two methods: 1) Appointment by a third party, i.e. Mayor's Office, School District, etc. and 2) Appointment by the committee, i.e. Vista Resident or Oceanside Resident. It was suggested that the policy be clarified to reflect appointments to the CHAC committee differ from other Board committees and the term expiration does not apply to third party appointees. Discussion was held regarding vacancies on committees that occur due to a member's term expiring and the potential for a lack of candidates. It was recommended that a committee member be allowed to serve past their term until a new member has been appointed to the committee to avoid vacancies on the committee. Discussion was held as to whether a community member must be a U.S. citizen. Mr. Moser stated the policy also provides that the community member reside in the boundaries of the District. The committee directed General Counsel to revise the	Board Policy 14-031 to be amended as discussed and brought back to the committee for review.	General Counsel

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	policy as discussed and bring back to the July meeting for review.		
d. Review and recommendation on Grant Guidelines	Director Reno stated she had requested review of the Grant Guidelines be placed on today's agenda to ensure the Grant Committee follows the Application Process listed on page 2 of the Grant Guidelines and it does not become a lengthy cumbersome process. Director Reno also noted the importance of the collaborative programs working alongside the District. Director Reno stated in her opinion, a Board member should not be signing the form letter that is sent out to prospective grant applicants and suggested the letter be signed by a member of Administration. Mr. Moser commented that he does not see an issue with the Chairperson of the Committee signing this type of letter on behalf of the Committee. Mr. Moser also commented that the Guidelines should address whether the applicant has any contracts with the hospital to avoid any potential referral issues. Mr. Moser stated the District has hired a new Compliance Officer who will join Tri-City on July 1st and she will work to address issues related to the Grant Guidelines and process.	Grant Committee Guidelines and processes will be deferred to the Compliance Officer for review.	Compliance Officer
7. Discussion regarding Current Legislation	Chairman Schallock reported a rally is taking place today on the steps of the State Capitol as part of a comprehensive advocacy effort to encourage the Legislature to include increased Medi-Cal funding in the upcoming state budget negotiations. Chairman Schallock also reported all bills must pass out of their respective houses by Friday, June 5th to continue moving forward this year. *Director Finnila left the meeting at 1:46 p.m.* Director Reno suggested Administration collaborate with	Information only.	

Topic	Discussion	Action Follow-up	Person(s) Responsible
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	Vista Community Clinic and North County Health Services on Behavioral Health efforts. Mr. Moran stated Administration has had ongoing discussions with both entities.		
8. Review of FY2015 Committee Work Plan	The FY2015 Committee Work Plan was included in today's meeting packet for reference. Chairman Schallock reported the Board's Workshop originally scheduled for June 4th has been cancelled and will be rescheduled in August.	Information only.	
9. Committee Communications	There were no committee communications.		
10. Community Openings – None			
11. Confirm date and time of next meeting	The committee's next meeting is scheduled for Tuesday, July 7th, at 12:30 p.m.		
12. Adjournment	Chairman Schallock adjourned the meeting at 1:48 p.m. p.m.		

I. **MEMBERSHIP**

The Department of Pediatrics consists of physicians who are board certified by the American Board of Pediatrics or are board-eligible; having completed an ACGME approved residency in Pediatrics, and who are actively progressing towards certification. Pediatricians who admit and care for neonates in the Neonatal Intensive Care Unit (NICU) must be members of the Division of Neonatology.

II. **FUNCTIONS**

The general functions of the Department of Pediatrics shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Department and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee (MEC) guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Department clinical practice;

D. Review and evaluate Department member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice.

E. Submit written minutes to ~~the QA/PI/PS~~ Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Department review and evaluation activities, actions taken thereon, and the results of such actions, and;
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it including proctoring~~.~~;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend/ or request~~Request~~ Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

I. Approve On-Going Professional Practice Evaluation (OPPE) ~~Indicators~~indicators and formulate thresholds; and

Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. **DEPARTMENT MEETINGS;**

The Department of Pediatrics meets quarterly and no less than three (3) times per year or at the discretion of the Chair

Twenty-five percent (25%) of the Active Department members, but not less than five (5) members, shall constitute a quorum at any meeting.

IV. **DEPARTMENT OFFICERS**

A. The Department shall have 3 officers: a Chairperson, a Vice-Chairperson, and a Quality Review Representative. The officers must be members of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Department. The Vice-Chairperson shall be the Chairperson-Elect and may also serve as the Quality Review Representative.

B. The Chairperson and Vice-Chairperson shall be elected every year by the Active members of the Department who are eligible to vote. The Chair shall be elected by a simple majority of the members of the Department. The notice for elections is given at least one month prior to the meeting date.

C. The Department Chair shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses ~~his/her their~~ Medical Staff~~medical staff~~ membership or clinical privileges in the department. Department officers shall be eligible to succeed themselves if elected.

D. The Vice-Chairperson succeeds the Chairperson after his/her term has expired unless there is an objection by a majority of the Active members of the Department who are eligible to vote.

E. The Quality Review Representative serves a one-year term and is elected by the Active members of the Department who are eligible to vote. The Quality Review Representative serves as the Chair of the Pediatric Quality Review Committee (QRC), and attends Medical Staff QA/PI/PSC meetings. Every effort will be made to appoint members to the QRC from each major group and a representative from the unassigned call panel for ED.

V. DUTIES OF THE DEPARTMENT CHAIR

A. The Department Chair shall assume the following responsibilities:

1. Be accountable for the professional and administrative activities of the Department;
2. ~~Continuing surveillance~~ Ongoing monitoring of the professional performance of all individuals who have delineated clinical privileges in the Department.
3. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege ~~card~~ form.
4. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;
5. Recommend clinical privileges for each member of the Department;
6. Assure that the quality, safety and appropriateness of patient care provided by members of the Department are monitored and evaluated; and
7. Other duties, as recommended from the Medical Executive Committee.

VI. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.

B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.

C. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.

D. Requests for privileges in the Department of Pediatrics are evaluated based on the ~~physician's~~ practitioner's education, training, experience, demonstrated professional competence and judgment, active clinical performance, documented cases of patient care and are granted based on department specified criteria. Recommendations for privileges are made to the Credentials Committee and to the Medical Executive Committee. Practitioners practice only within the scope of their privileges as defined within these Rules and Regulations.

E. **Nurse Practitioners:** Nurse practitioner means a registered nurse who posseses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary care and who has been prepared in a program. The nurse

practitioner shall function under standardized procedures or protocols covering the care delivered by the nurse practitioner. The nurse practitioner and his/her supervising physician who shall be a pediatrician will develop the standardized procedure or the protocols with the approval of the Department of Pediatrics.

~~D.~~

E.F. Classifications of Newborns:

1. Level 1: Newborns greater than 2000 grams and 35 6/7 weeks GA, without any of the diagnoses or symptoms listed in VI (E)(2).
2. Level 2: Newborns needing intermediate or continuing care; criteria as follows:
   - i. Weight greater than 2000 grams at birth, r/o sepsis during an observational period, if consistently stable without additional signs of illness.
   - ii. Tachypnea, TTN, or other mild respiratory illness, otherwise stable, with oxygen needs <40%, and no oxygen needs over six (6) hours.
   - iii. Hypoglycemia (without other risk factors such as suspected sepsis or respiratory distress) with a normal exam and stable vital signs, responsive to oral therapy.
   - iv. Feeding problems in a newborn greater than 2000 grams and 35 6/7 weeks gestational age (GA), with no concerns about GI perforation or anomalies.
3. Hyperbilirubinemia requiring phototherapy, unlikely to require an exchange transfusion, otherwise stable, currently 35 6/7 weeks GA and 2000 grams.

If the infant status changes to meet the Level 3 criteria (per NICU unit-specific policy "Admission and Discharge Criteria for the NICU"), a neonatology consult is required. The consultation will be requested by the attending pediatrician who, in collaboration with the neonatologist, will determine if care should be transferred to a neonatologist.

<table>
<tr><th>Pediatrics Privileges</th><th>Initial Appointment</th><th>Proctoring</th><th>Reappointment (every 2 years)</th></tr>
<tr><td>Admit patients, Level 1 and Level 2 newborns</td><td rowspan="3">Training and evidence of current NRP/NALS or PALS certification</td><td rowspan="3">Six (6) cases</td><td rowspan="2">Evidence of current NRP/NALS or PALS certification</td></tr>
<tr><td>Consultation</td></tr>
<tr><td>Newborn care, Level 1 and Level 2</td></tr>
<tr><td>Perform medical history and physical examination (Newborn), including via telemedicine (F)</td><td>Training</td><td>N/A</td></tr>
<tr><td>Attendance at C-sections & vaginal deliveries, including newborn resuscitation</td><td>Training and evidence of current NRP/NALS certification</td><td>One (1)</td><td>Evidence of current NRP/NALS certification</td></tr>
<tr><th colspan="4">Invasive Pediatrics Procedures</th></tr>
<tr><td>Lumbar puncture</td><td>Training</td><td rowspan="2">Five (5) cases from Invasive Procedures</td><td>N/A</td></tr>
<tr><td>Laryngoscopy</td><td>Training and evidence of current</td><td>Evidence of current NRP/NALS</td></tr>
</table>

Pediatrics Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
	NRP/NALS certification	category	certification
Circumcision	Training		N/A
Intubation, Infant	Training and evidence of current NRP/NALS certification		Evidence of current NRP/NALS certification
Intubation, Pediatric	Training and evidence of current PALS certification		Evidence of current PALS certification
Suprapubic aspiration	Training		N/A
Pediatric Cardiology Privilege Category			
Consultation, Pediatric Cardiology, to include neonates	Successful completion of a residency in Pediatrics and a fellowship training program in Neonatology or Pediatric Cardiology	Two (2) cases from this category	Ten (10) cases from this category
Cardiac defibrilation, to include neonates			
Echocardiography, to include neonates			
Elective cardioversion, to include neonates			
Electrocardiography (EKG/ECG), to include neonates			
Pericardiocentesis, to include neonates			
Holter monitor – 12 years and older	Successful completion of a residency in Pediatrics and a fellowship training program in Pediatric Cardiology		
Treadmills - 12 years and older			
Pediatric Surgery Privilege Category			
Consultation, Pediatric Surgery, to include neonates	Board certified by the American Board of Surgery in Pediatric Surgery	One (1) case	Evidence demonstrating activity performing pediatric surgery at another healthcare facility

Pediatrics Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Other			
Moderate sedation	See Policy 8710-517 and evidence of current NRP/NALS certification	See Policy 8710-517	See Policy 8710-517 and evidence of current NRP/NALS certification

VII. **REAPPOINTMENT OF CLINICAL PRIVILEGES**

A. Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the physician will be required to undergo proctoring for all procedures that were not satisfied. The physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. **PROCTORING OF PRIVILEGES**

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Department Chair to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Department will act as proctors. An associate may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Department Chair. It is the responsibility of the Department Chair to inform the monitored member whose proctoring is being continued whether the deficiencies noted are based on current clinical competence, practice behavior, or the ability to perform the requested privilege(s). Colleagues who cover on-call for an assigned proctor should be aware, accessible, and amenable to providing proctoring in the place of that member, if needed.

C. **THE MONITOR MUST BE PRESENT FOR THE PROCEDURE FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE PRACTITIONER'S COMPETENCE.**

D. In elective cases, arrangements shall be made prior to scheduling ~~(~~i.e., the proctor shall be designated at the time the case is scheduled~~)~~.

E. The member shall have free choice of suitable consultants and assistants.

F. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

G. A form shall be completed by the proctor and should include comments on diagnosis, procedural technique, and overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Medical Staff Office.

H. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

I. Members of other departments, such as the Emergency Department or Anesthesiology Department, can proctor an appropriate procedure, but cannot proctor admissions.
J. It is the responsibility of the member to notify a proctor when one is needed.

IX. EMERGENCY ROOM COVERAGE

A. Department members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520.
B. Any member who elects to provide follow-up care in his/her office must do so without regard to the patient's ability to pay and must provide a minimum level of care sufficient to respond to the patient's immediate needs.
C. Provisional or Courtesy Staff may participate on the unassigned call panel at the discretion of the Department chair.

X. DEPARTMENT QUALITY REVIEW AND MANAGEMENT

The Department of Pediatrics will have a Quality Review Committee (QRC) comprised of no less than four (4) Department members. The QRC chair is the Department's representative to the Medical Staff ~~QA/PI~~Medical Quality Peer Review Committee. QRC members are able to succeed themselves. The QRC will meet at least four (4) times per year. Refer to Section II "FUNCTIONS" above as applicable.

A. General Function
The QRC provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by the Department members and to pediatric patients in the hospital.

XI. NICU M&M COMMITTEE

The Department of Pediatrics will have an NICU Mortality & Morbidity (M&M) Committee that meets at least quarterly to discuss neonatal cases and issues related to neonatal care. The NICU M&M shall be composed of the members of the Neonatology Division. Representatives from the Department of Obstetrics/Gynecology and nursing shall be invited. The Committee shall maintain a record of its activities and report to the Department of Pediatrics QRC.

APPROVALS:
Department of Pediatrics: ~~6/11/14~~5/05/15
Medical Executive Committee:
Board of Directors:

Tri-City Medical Center
Audit, Compliance & Ethics Committee
June 18, 2015
Assembly Room 1
8:30am-10:30am

Members Present:	Director Ramona Finnila (Chair); Director Larry W. Schallock; Director Laura Mitchell; Jack Cummings, Community Member; Barton Sharp, Community Member; Carlos Marcuzzi, Community Member
Non-Voting Members:	Steve Dietlin (CFO); Kapua Conley, COO
Others Present:	Diane Racicot, General Counsel; Teri Donnellan, Executive Assistant; Pamela Alm, Sr. Administrative Assistant
Absent:	Dr. Frank Corona, Medical Staff; Kathryn Fitzwilliam, Community Member; Tim Moran, CEO

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairperson Finnila.		
2. Approval of Agenda	**It was moved by Mr. Cummings and seconded by Director Schallock to approve the agenda as presented. The motion passed unanimously.**	**Agenda approved.**	Ms. Donnellan
3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item	There were no public comments.		
4. Ratification of minutes-April 16, 2015	**It was moved by Mr. Cummings and seconded by Mr. Sharp to approve the minutes of the April 16, 2015 meeting as presented. The motion passed unanimously.**	**Minutes ratified.**	Ms. Donnellan
5. New Business A. Fiscal 2015 Financial Statement Audit Entrance – Moss Adams	Mr. Steve Dietlin, CFO introduced Mr. DeVon Wiens, Partner and Ms. Mary Nguyen, Senior Manager with Moss Adams who presented the FY2015 Audit Entrance. Mr. Wiens and Ms. Nguyen presented information on the following:	**Information Only – Presentation to be included in Board agenda packet.**	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	➢ Engagement Service Team ➢ Required Communication to Those Charged with Governance ➢ Scope of Services ➢ Areas of Audit Emphasis - Internal Controls - Existence - Valuation - Completeness ➢ Risks Discussion ➢ Consideration of Fraud ➢ Prior Year Internal Control Matters ➢ Audit Timeline ➢ Audit Expectations ➢ Recent Accounting Developments The committee had extensive discussion and asked numerous questions. *Ms. Kathy Topp and Ms. Colleen Thompson joined the meeting at 9:00 a.m.* Mr. Wiens also questioned if the committee had areas of concern. The committee indicated they were comfortable with the scope of services described today. Mr. Wiens stated he expects to bring the results of the Audit to the committee at their September, 2015 meeting. Mr. Wiens and Ms. Nguyen exited the meeting at 9:19 p.m.		
B. Review and Discussion of current financial statements	Mr. Dietlin gave a brief report on the Fiscal YTD financial results as follows (dollars in Thousands): • Net Operating Revenue – $308,004 • Operating Expense – $307,273 • EROE - $4,904 • EBITDA – $19,468	**Information Only**	CFO

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	Other Key Indicators for the current year included the following: • Average Daily Census - 192 • Adjusted Patient Days – 103,398 • Surgery Cases – 6,142 • Deliveries – 2,383 • ED Visits – 64,537 • Net Patient Accounts Receivable – $43.2 million • Days in Net Account Receivable – 49.4 Mr. Dietlin noted we expect Net Days in Patient Accounts Receivable to increase slightly due to an expected two week delay in government reimbursement. Mr. Dietlin also presented graphs which reflected Net Days in Patient Accounts Receivable, Average Daily Census excluding Newborns, Adjusted Patient Days, Emergency Department Visits, EROE and EBITDA.		
C. Review and Discussion of Administrative Policies & Procedures: 1) 8610-503 (585) –HIPPA Administrative Requirements 2) 8750-510 – Disposal of Confidential Records (Formerly Disposal of Individually Identifiable Information) 3) 8610-511 – Business Associate Agreement	Ms. Kathy Topp, Director of Education & Clinical Information and Colleen Thompson, Director of Medical Records attended today's meeting to address the Administrative Policies & Procedures on today's agenda. *Director Schallock left the meeting at 10:00 a.m.* The committee reviewed each of the policies individually and made minor additions and revisions. With regard to policy 8610-518, it was suggested that the Notice of Privacy Practices be a separate form and not an attachment to the policy. With regard to Administrative Policy & Procedure 8750-557, it was recommended that the policy be pulled pending further review by the Chief Compliance Officer.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
4) 8610-514 – Privacy: Designated Record Set 5) 8610-518 – Notice of Privacy Practices 6) 8610-520 – Amendment to Protected Health Information 7) 8610-528 – Accounting of Disclosures of Protected Health Information 8) 8610-505 – Confidential Reporting Line (Values Line) 9) 8710-555 – Communicating and Reporting Compliance Concerns: In General 10) 8750-556 – Communicating and Reporting Compliance Concerns: Reporting of Suspected Misconduct/Potential Irregularities 11) 8750-557 – Communicating and Reporting Compliance Concerns (Values Line)	**It was moved by Director Finnila and seconded by Mr. Marcuzzi to recommend approval of Administrative Policies & Procedures as presented and amended and pull Policy 8750-557 for further review. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to approve Administrative Policies as presented and amended and pull Policy 8750-557; items to appear on next Board agenda and included in Board Agenda packet.**	Ms. Donnellan
6. Old Business A) Chief Compliance Officer Update	Chairperson Finnila reported Cheryle Bernard-Shaw has accepted the position of Chief Compliance Officer and will join Tri-City on July 1st. Ms. Bernard-Shaw will be introduced at next month's meeting.	**Information only.**	

7. Oral Announcement of Items to be Discussed during Closed Session (Government Code Section 54957.7)	Chairperson Finnila make an oral announcement of the item listed on the agenda to be discussed during closed session which included approval of closed session minutes.		
8. Motion to go Into closed session	**It was moved by Mr. Cummings and seconded by Director Mitchell to go into closed session. The motion passed unanimously.**		
9. Open Session	The committee returned to open session at 10:27 a.m. with all committee members present with the exception of Director Schallock.		
10. Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) 11.	Chairperson Finnila reported no action was taken in closed session.		
12. Date of Next Meeting	Chairperson Finnila stated the Committee's next meeting will be held on July 16, 2015.	**The committee's next meeting is scheduled for July 16, 2015.**	Ms. Alm
13. Adjournment	Chairperson Finnila adjourned the meeting at 10:30 a.m.		Chair

TRI-CITY HEALTHCARE DISTRICT

Communication with Those Charged with Governance

FY 2015 Audit Entrance Meeting

June 18, 2015

Presented by:
DeVon Wiens, Partner
Mary Nguyen, Senior Manager

MOSS-ADAMS LLP
Certified Public Accountants | Business Consultants

Acumen. Agility. Answers.

Members of the Audit Committee of
Tri-City Healthcare District

Dear Audit Committee:

We are pleased to present and discuss with you our audit plan for Tri-City Healthcare District for the year ending June 30, 2015.

We welcome any questions or input you may have regarding our audit plan. We look forward to working with you and consider you to be an important client in our audit practice.

Very truly yours,

Moss Adams, LLP

MOSS ADAMS LLP

AGENDA

- Engagement Service Team
- Required Communication to Those Charged with Governance
- Scope of Services
- Areas of Audit Emphasis
- Risks Discussion
- Consideration of Fraud
- Prior Year Internal Control Matters
- Audit Timeline
- Audit Deliverables
- Audit Expectations
- Recent Accounting Developments

ENGAGEMENT SERVICE TEAM

Name	Role	Contact
DeVon Wiens	Partner, Engagement Reviewer	DeVon.Wiens@mossadams.com 949-221-4060
Brian Conner	Partner, Concurring Reviewer	Brian.Conner@mossadams.com 209-955-6114
Mary Nguyen	Assurance Senior Manager	Mary.Nguyen@mossadams.com 949-623-4186
Annie Norviel	Assurance Manager	Annie.Norviel@mossadams.com 858-627-1484

REQUIRED COMMUNICATIONS TO THOSE CHARGED WITH GOVERNANCE

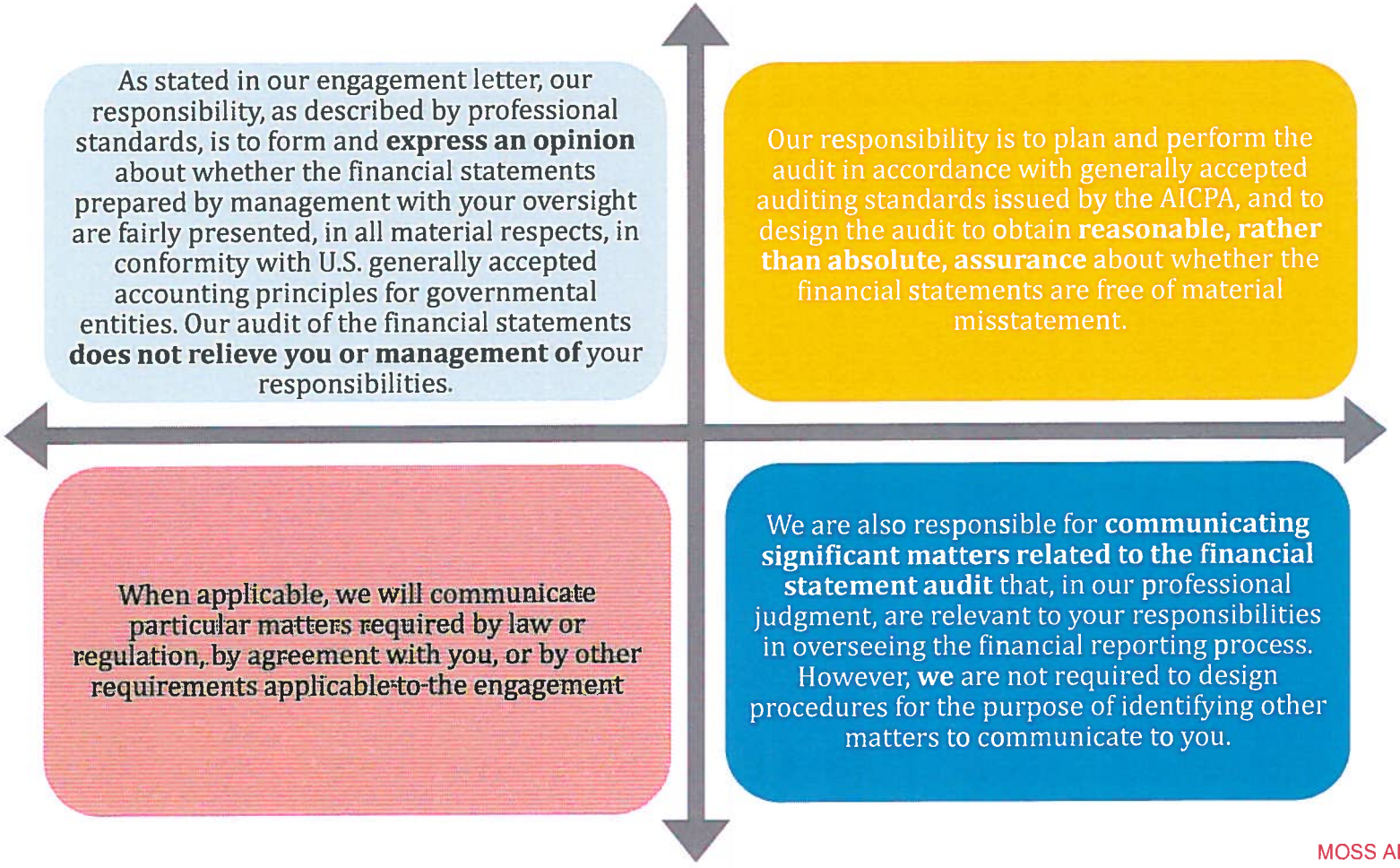
NOW

- Auditor's Responsibility Under Auditing Standards Generally Accepted in the United States of America
- Planned Scope and Timing of the Audit

LATER

- Significant Audit Findings
- Qualitative Aspects of Accounting Practices
- Difficulties Encountered in Performing the Audit
- Corrected and Uncorrected Misstatements
- Disagreements with Management
- Management Representations
- Management Consultations with Other Independent Accountants
- Other Audit Findings or Issues

AUDITOR'S RESPONSIBILITIES IN A FINANCIAL STATEMENT AUDIT



CONCEPT OF MATERIALITY

MATERIALITY

Is the amount of a misstatement that could influence the economic decision of users, taken on the basis of the financial statements

MATERIALITY

Is calculated using certain **quantitative** (e.g. total assets or net position) and **qualitative factors** (e.g. covenants, expectations or industry factors)

MATERIALITY

Is used in developing or identifying:

- Significant risk areas
- Nature, timing, extent/scope of test work
- Conclusions on findings/misstatements

SCOPE OF SERVICES

Relationships between Moss Adams and Tri-City Healthcare District

- Annual consolidated financial statement audit as of and for the year ended June 30, 2015
- Assist management with drafting the consolidated financial statements as of and for the year ended June 30, 2015

AREAS OF AUDIT EMPHASIS – PATIENT REVENUE/RECEIVABLES

- Internal Controls
  - We will test internal controls over patient charges, billings, cash collections, and write offs of accounts.
- Existence
  - We will test the existence and validity of the patient receivable balances (on a sample basis) by tracing to supporting documentation such as medical records, billing records and cash receipts.
- Valuation
  - We will test realization of patient receivables by examining subsequent cash receipts, performing a look-back analysis to the June 30, 2014 patient accounts receivable balance, and by analyzing write-offs and the valuation allowances (contractual and bad debt).

AREAS OF AUDIT EMPHASIS (CONT.) – COST REPORT SETTLEMENTS

- Existence/Valuation/Completeness
  - We will obtain and test the roll-forward of cost report balances by open year from June 30, 2014 to June 30, 2015 and trace any changes to supporting documents.
  - We will test the validity of the data used by management to estimate cost report receivables/payables.
  - We will evaluate the assumptions made and positions taken by management in filing the cost report and preparing the estimated cost report receivable/payable.
  - We will evaluate the impact of correspondence with CMS and Medi-Cal on open cost report years.

AREAS OF AUDIT EMPHASIS (CONT.) – MANAGED CARE PROGRAM LIABILITIES

- Completeness/Valuation
  - We will evaluate the effectiveness of Management's methods to determine these liabilities.
  - We will test the internal controls over the medical claims adjudication and payment process.
  - We will test the propriety of the data and computations used by management to estimate the medical claims payable reserve.
  - We will complete a look-back analysis with respect to the prior year balances based on claims paid subsequent to June 30, 2014.

AREAS OF AUDIT EMPHASIS (CONT.) – SELF INSURANCE LIABILITIES

- Completeness/Valuation
  - We will evaluate the effectiveness of Management's methods to determine these liabilities.
  - We will evaluate the qualifications of the specialists.
  - We will verify that the appropriate reserve is recorded.
  - We will complete a look-back analysis with respect to the prior year balances based on claims paid subsequent to June 30, 2014.

AREAS OF AUDIT EMPHASIS (CONT.) – LINE OF CREDIT AND TERM LOANS

- Completeness/Valuation
  - We will confirm with the lender the outstanding balances as of year end.
  - We will recalculate compliance with financial covenants.
  - We will inquire of management and evaluate compliance with non-financial covenants.
  - We will assess the appropriateness of the accounting classification and related debt disclosures.

RISKS DISCUSSION

What are your views regarding:

- Tri-City Healthcare District's objectives, strategies and business risks that may result in material misstatements
- Significant communications with regulators
- Attitudes, awareness, and actions concerning
  - Tri-City Healthcare District's internal control and importance
  - How those charged with governance oversee the effectiveness of internal control
  - Detection or the possibility of fraud
  - Other matters relevant to the audit

Areas of concern?

CONSIDERATION OF FRAUD IN FINANCIAL STATEMENT AUDIT

Auditor must consider and address fraud in order to "improve the likelihood that auditors will detect material misstatements due to fraud in a financial statement audit."

Planning "Brainstorming" Team Discussion

Gathering Information Needed to Identify Risks of Material Misstatement Due to Fraud:

- Interviews of personnel;
- Documenting understanding of internal control;
- Consideration of unusual or unexpected relationships identified in planning and performing the audit

Procedures to be performed:

- Examine general journal entries for non-standard transactions;
- Evaluate the Organization's policies and accounting for revenue recognition;
- Test and analyze the significant accounting estimates for biases; and
- Evaluate the business rationale of significant unusual transactions.

PRIOR YEAR INTERNAL CONTROL MATTERS

- During the prior year audit, we noted no material weaknesses.

AUDIT TIMELINE

- Planning and Internal Control Testing – Week of May 25, 2015
- Begin Final Fieldwork – August 3, 2015
- End Final Fieldwork – August 21, 2015
- Audit Results Presentation – September 2015 (Date TBD)
- Issue Opinion – September 2015 (Date TBD)

AUDIT DELIVERABLES

Report of Independent Auditors on the consolidated financial statements for the year ended June 30, 2015

Report to Those Charged With Governance (communicating required matters and other matters of interest)

Report to Management (communicating internal control related matters identified in an audit)

AUDIT EXPECTATIONS

Tri-City Healthcare will:

- Have no adjusting journal entries after beginning of field work.
- Close books and records before beginning of field work.
- Provide auditor requested information in CAP schedule no later than August 3, 2015
- Designate a qualified, responsible official to oversee the audit and financial statements

Moss Adams will:

- Communicate proposed adjustments with management when identified.
- Communicate control deficiencies with management when identified.
- Discuss any additional fees over estimate in engagement letter with management.

RECENT ACCOUNTING DEVELOPMENTS

- GASBS 69 – Government Combinations and Disposals of Government Operations (effective for combinations and disposals in periods beginning after December 15, 2013 – early adoption encouraged)

- GASBS 70 – Accounting and Financial Reporting for Non-exchange Financial Guarantees (effective date for reporting periods beginning after June 15, 2013)

- GASBS 72 – Fair Value Measurement and Application (effective date for periods beginning after June 15, 2015 – early adoption encouraged)

NEW STANDARDS

GASBS 69: Government Combinations and Disposal of Government Operations

- No previous guidance issued by GASB. Statement is aimed to provide guidance for these transactions to address arrangements specific to governments.
- Requires additional disclosure and specific presentation.

NEW STANDARDS

GASBS 70: Accounting and Financial Reporting for Non-exchange Financial Guarantees

- Statement is aimed to provide accounting and financial reporting guidance for these transactions extended or received by a state or local government
- Specifies the information required to be disclosed by governments that extend non-exchange financial guarantees

NEW STANDARDS

GASBS 72: Financial Reporting for Fair Value Measurements

- Requires disclosures to be made about fair value measurements, the level of fair value hierarchy, and valuation techniques

Tri-City Medical Center

Caring Hands. Our Symbol and Our Promise.

THANK YOU!

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

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AUDIT AND COMPLIANCE COMMITTEE
June 18th, 2015

Administrative Policies & Procedures	Number	Reason	Recommendations
1. HIPAA Administrative Requirements	8610-503 (585)	3 year review, revised	Forward to BOD for approval with revisions
2. Disposal of Confidential Records (Formerly Disposal of Individually Identifiable Information)	8750-510	3 year review, revised	Forward to BOD for approval with revisions
3. Business Associate Agreement	8610-511	3 year review, revised	Forward to BOD for approval with revisions
4. Privacy: Designated Record Set	8610-514	3 year review, revised	Forward to BOD for approval with revisions
5. Notice of Privacy Practices	8610-518	3 year review, revised	Forward to BOD for approval with revisions
6. Amendment to Protected Health Information	8610-520	3 year review, revised	Forward to BOD for approval
7. Accounting of Disclosures of Protected Health Information	8610-528	3 year review, revised	Forward to BOD for approval with revisions
8. Confidential Reporting Line (Values Line) - DELETE	8610-505	DELETE	Forward to BOD for approval
9. Communicating and Reporting Compliance Concerns, In General - DELETE	8750-555	DELETE	Forward to BOD for approval
10. Communicating and Reporting Compliance Concerns: Reporting of Suspected Misconduct/Potential Irregularities	8750-556	3 year review, revised	Forward to BOD for approval with revisions
11. Communicating and Reporting Compliance Concerns (Values line)	8750-557	3 year review, revised	Pulled for further review

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 11/12 | **SUBJECT: HIPAA Administrative Requirements**

REVISION DATE: 5/15 | **POLICY NUMBER: 8610-~~503~~585**

Administrative Policies & Procedures Committee Approval:	**~~09/13~~ 05/15**
~~**Professional Affairs Committee Approval:**~~	
Audit and Compliance Committee Approval:	**06/15**
Board of Directors Approval:	**12/13**

A. **PURPOSE:**

1. This policy describes Tri-City Healthcare District's (TCHD) responsibilities ~~under~~**related to the administrative requirements of the Health Insurance Portability and Accountability Act (**HIPPA**) Privacy Rule.**~~, identifies the roles and responsibilities of privacy officials, and describes mandatory training requirements~~.

B. **DEFINITIONS:**

1. **Business Associate Agreement: an Addendum to an applicable Services Agreement between the District and a Business Associate that outlines the specific obligations of the Business Associate related to the Use or Disclosure of District PHI.**
~~1.~~2. **Disclosure: the release, transfer, provision of, access to or divulging of PHI outside TCHD.**
~~2.~~3. **Protected Health Information: individually identifiable health transmitted or maintained in paper or electronic form that is created or received by TCMC AND**
   a. **Relates to the past, present, or future physical or mental health or condition of an individual; OR**
   b. **Relates to the provision of health care to an individual; OR**
   ~~3.~~**c. Relates to the past, present, or future payment, AND**
   ~~a.~~**d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual**
4. **Use: the sharing, application, utilization, examination or analysis of PHI within TCHD**
~~4.~~5. **Workforce: means employees, volunteers, trainees and other persons whose conduct, in the performance of work for TCHD is under the control of TCHD whether or not they are paid by TCHD.**

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

1. TCHD is a covered entity as defined by the ~~Health Insurance Portability & Accountability Act (~~HIPAA~~)~~ Privacy Rule and **implementing** regulations.~~ promulgated there under. Thus~~ TCHD **shall comply with HIPAA requirements to:** ~~must~~
   a. ~~(i) d~~**D**esignate Privacy and Security Officials ~~who will serve as the HIPAA-required contact people,~~
   b. ~~(ii) p~~**Provide HIPAA-required training~~;~~**
   c. ~~(iii) i~~**Implement HIPAA policies and procedures~~;~~**
   d. ~~(iv) i~~**Implement appropriate administrative, technical and physical safeguards to protect PHI~~;~~**
   e. ~~(v) i~~**Impose sanctions for failures to comply with TCHD Privacy Policies or requirements of privacy laws~~;~~**

f. ~~(vi) m~~**Mitigate harmful effects of a Use or Disclosure in violation of TCHD Privacy Policies and privacy laws**~~; and~~

g. ~~(vii) r~~**Refrain from intimidating or retaliatory acts against individuals for exercising their rights under HIPAA.**~~.~~

2. The designated Privacy and Security Officials will be responsible for the functions required by the HIPAA Security and Privacy Rules and this Policy.

~~1.~~**D. PROCEDURE:**

1. Designation of Privacy Officer and Responsibilities.

a. TCHD shall designate a Privacy Officer to fulfill the responsibilities of the privacy official under the HIPAA Privacy Rule and this Policy.

~~2.~~**b.** The responsibilities of the TCHD Privacy ~~and Security~~ Officer**s** ~~shall~~ include:

~~a.~~**i.** ~~Overseeing~~ **Oversight** ~~all~~ **of** ongoing activities related to compliance with TCHD's ~~Patient~~ Privacy Policies **and applicable federal and state privacy laws including, without limitation**, HIPAA, **the** California Confidentiality of Medical Information Act (CMIA), and ~~the regulations promulgated there under, including training and oversight.~~ **and Health and Safety Code Section 1280.15.**

~~b. Maintaining current knowledge of applicable privacy laws.~~

ii. Development and revision of ~~Updating~~ TCHD Privacy Policies and Notice of Privacy Practices (NPP) as necessary to comply with **HIPAA and other** applicable law**s**.

iii. Receipt, investigation and documentation of every complaint which an individual makes regarding TCHD's privacy policies, or Uses or Disclosures of PHI.

iv. Train and educate Workforce members on TCHD's privacy policies, HIPAA and other privacy laws.

~~c.~~**v. Oversee retention of HIPAA documentation as required under the Privacy Rule and in accordance with TCHD's Records Retention and Destruction Policy.**

~~d.~~**vi.** Coordinat**ion**~~ing~~ with Legal, Risk, and other departments as needed to provide a response to individual complaints, identify and mitigate potential violations, respond to breaches, provide further information about matters covered by the NPP, and apply and document appropriate sanctions for failures by **W**~~w~~orkforce members to comply with applicable policies and laws.

~~i.~~**vii.** Report~~sing~~ to executive management **and**/or the Board **of Directors,** as appropriate.

2. Designation of Security Officer and Responsibilities.

a. TCHD shall designate a Security Officer to fulfill the responsibilities of the security official under the HIPAA Security Rule and this Policy.

b. The responsibilities of the HIPAA Security Officer include:

i. Oversight ~~of~~ ongoing activities related to compliance with TCHD's Security Policies and applicable federal and state privacy laws including, without limitation, HIPAA, the California Confidentiality of Medical Information Act (CMIA), and ~~and~~ Health and Safety Code Section 1280.15.

ii. Development and revision of TCHD Security Policies as necessary to comply with HIPAA and other applicable laws.

iii. Train and education of Workforce members on TCHD's security policies, HIPAA and other privacy laws.

iv. Coordination with Legal, Risk, Compliance Officer and other departments as needed to provide a response to individual complaints, identify and mitigate potential violations, respond to breaches and apply and document appropriate sanctions for failures by Workforce members to comply with applicable policies and laws.

v. Reports to executive management and/or the Board of Directors, as appropriate.

3. Mandatory **Workforce** Training
   a. ~~All employees and members of~~ TCHD's ~~w~~**W**orkforce must be trained regarding TCHD's ~~patient p~~**P**rivacy **and Security P**~~p~~olicies, and any relevant department procedures necessary to complete their assigned job functions prior to gaining access to PHI, **and as** soon **as possible** after joining TCMC, but no later than 60 days thereafter. **Education includes on-line education modules.** When significant changes occur in the job description of current ~~employees~~ **Workforce members** or to policies and/or procedures, the affected ~~w~~**W**orkforce members will be retrained or made aware of the changes as soon as possible.
   b. Each department is responsible to determine whether other personnel such as individuals under affiliation agreements, staff of a business associate, or a contracted organization that is not a business associate are required to complete TCHD's Privacy training, sign a confidentiality agreement, **and**/or execute a **B**~~b~~usiness ~~a~~**A**ssociate ~~a~~**A**greement. Each respective Department is also responsible for ensuring maintenance of these documents (or records) in accordance with TCHD policy.
   c. TCHD shall retain documentation demonstrating that each Workforce member has completed his/her required privacy training as necessary and appropriate to carry out functions within TCHD and the applicable Department.
   ~~c. Documentation Retention of Privacy training – Required Documentation. HIPAA requires TCHD to document and retain the following for six years:~~
      ~~i. Business Associate Agreements are maintained in MediTract.~~
      ~~ii. Authorizations – all signed patient Authorizations; and, if appropriate, verification of the person's right to sign on behalf of the patient.~~
      ~~iii. Partial or complete waiver of Authorizations for research purposes – certification from the researcher requesting PHI that the IRB has approved a waiver of authorization and met the HIPAA-required criteria for a waiver of authorization.~~
      ~~iv. All patients' requests for restrictions.~~
      ~~v. Access or copying of the designated record set – document the Designated Record Set (DRS) that is subject to access by individuals and the titles of the people or offices responsible for receiving and processing requests for access by individuals; document responses to requests for access or copying as required.~~
      ~~vi. Amendment – document the titles of people or offices responsible for processing requests for amendments by individuals, document responses to requests for amendment.~~
      ~~vii. Accounting of disclosures – document the information required to be provided if an accounting of disclosures is requested.~~
      ~~viii. Personnel designations – document the privacy official and contact person or office who is responsible for receiving complaints.~~
      ~~ix. Training – documentation demonstrating that each workforce member has completed his/her required privacy training as necessary and appropriate to carry out functions within TCHD and the applicable department.~~
      ~~x. Complaints/Investigations – document all complaints received and their disposition, if any.~~
      ~~xi. Sanctions – document any sanctions that are applied against members of the workforce who fail to comply with privacy policies and procedures, if any.~~
      ~~xii. Any other communication, action, activity, or designation that, under the Privacy Rule, must be maintained in writing or otherwise documented.~~

~~4. TCHD's Privacy Officer will receive, document, and investigate every complaint which an individual makes regarding TCHD's privacy policies, or uses or disclosures of PHI.~~

4. TCHD will undertake appropriate actions to enforce TCHD's Privacy **and Security** Policies, including applying appropriate disciplinary sanctions against members of its workforce who fail to comply. The type of sanction applied shall vary depending on the severity of the violation,

whether the violation was intentional, whether the violation indicates a pattern or practice of improper access, use, or disclosure of PHI, and similar factors. Sanctions taken may include termination.

5. **TCHD will implement other HIPAA administrative requirements as set forth in TCHD privacy policies.**

E. REFERENCES:

1. **45 Code of Federal Regulations (CFR) Section ~~Section~~ 160.103**
2. **45 CFR Section ~~Section~~ 164.308(a)(2)**
3. **45 CFR Section ~~Section~~ 164.530**
4. **TCHD Records Retention and Destruction Board Policy # 14-008.**
5. Health and Safety Code Section 1280.15

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 7/00

SUBJECT: Disposal of Confidential Records ~~Individually Identifiable Information~~

REVISION DATE: 12/05; 01/09, ~~5/15~~

POLICY NUMBER: 8610-510

Administrative Policies & Procedures Committee Approval:	05/15~~1/09~~
~~Operations Team Committee Approval:~~	~~01/09~~
~~Professional Affairs Committee Approval:~~	~~02/09~~
Audit and Compliance Committee Approval:	06/15
Board of Directors Approval:	02/09

A. **PURPOSE:**

1. The purpose of this Policy is to establish guidelines for the destruction and disposal of Confidential Records (including those containing Protected Health Information) in accordance with state laws and HIPAA when, and to the extent that, such Confidential Records are otherwise permitted to be destroyed and disposed of under TCHD's Records Retention and Destruction Policy.~~To establish guidelines for destruction and disposal of individually identifiable information. To prevent inadvertent disclosure of confidential information~~.

B. **DEFINITION:**

1. Confidential Records: ~~means,~~ for purposes of this Policy, patient medical records and other documents and records, regardless of form, containing PHI, and other personal information that could identify a patient (including records, documents, and tangible items that contain names, social security numbers, contact information, insurance policy information, etc.) and employment records.
~~1.~~2. Disclosure: the release, transfer, provision of, access to or divulging of PHI outside ~~TCMC~~TCHD.
3. Electronic Media: ~~means~~ the electronic storage media on which date is or may be recorded electronically including devices in computers (hard drives) and any removable or transportable digital memory medium, such as magnetic tape or disk, optical disk, flash drive, portable device, digital memory card and transmission media used to exchange information already in electronic storage media (such as internet, extranet, dial-up lines, etc.)
4. Electronic Protected Health Information or "EPHI": ~~means~~ PHI that is transmitted by Electronic Media or Maintained in Electronic Media.
5. Protected Health Information (PHI): individually identifiable health transmitted or maintained in electronic format that is created or received by ~~TCMC~~TCHD AND
   a. Relates to the past, present, or future physical or mental health or condition of an individual; OR
   b. Relates to the provision of health care to an individual; OR
   c. Relates to the past, present, or future payment, AND
   d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual
6. Use: the sharing, application, utilization, examination or analysis of PHI within ~~TCMC~~TCHD
7. Workforce member: ~~means~~ employees, volunteers, trainees, and other persons whose conduct in the performance of work for TCHD is under the direct control of TCHD whether or not they are paid by TCHD.

C. POLICY

1. **TCHD Confidential Records must be destroyed and disposed of in a manner that preserves the confidentiality of the information contained in them. TCHD Workforce members, Medical Staff, and applicable business associates shall ensure that reasonable safeguards are in place to limit incidental, and avoid prohibited, Uses and Disclosures of PHI and other personal information including in connection with the disposal and destruction of Confidential Records. TCHD Workforce members, Medical Staff, and applicable business associates shall carry out destruction and disposal of Confidential Records in compliance with state laws, HIPAAA and this Policy. Confidential Records may only be destroyed and disposed of when, and as, permitted under TCHD's Records Retention and Destruction Policy #14-008..**

D. PROCEDURES:

1. **Confidential records may include the following:**
   a. **Medical records including, individual components such as laboratory results, provider notes, and orders, test results, schedules, referral slips, research records, etc.**
   b. **Patient menus**
   c. **Patient admission and demographic information documents**
   d. **Billing information, records, and reports**
   e. **Receipts**
   f. **Communications with caregivers**
   g. **Patient identification bracelets**
   h. **Department and committee reports such as those related to quality, risk management, peer review etc.**
   i. **Department patient logs**
   j. **Reports to regulators**
   k. **Incident reports**
   l. **Employment record**
2. **Duty to Safeguard Confidential Records**
   a. **TCHD shall take reasonable steps to destroy or arrange for the destruction of Confidential Records as provided by this Policy. Responsibility for proper disposal of Confidential Records resides with Medical Records/Health Information and Information Technology departments.**
   b. **Confidential Records (including PHI or other personal information) in any form may not be abandoned or disposed of in TCHD dumpsters, garbage cans, or other containers that are accessible to the public or other unauthorized persons.**
   c. **TCHD may contract with a business associate to perform services related to the proper destruction and disposal of Confidential Records in accordance with the TCHD's Business Associate Policy. Such vendors shall provide TCHD with certifications demonstrating appropriate proof of destruction and/or disposal as applicable to their respective contracted services.**
   d. **Destruction and disposal of Confidential Records is subject to TCHD's Records Retention and Destruction Policy No. 14-008 which addresses, in part the schedule for retention and destruction of medical records and other TCHD business records.**
   e. **Confidential Records that are subject to an investigation, audit and/or litigation hold shall not be destroyed or disposed of as provided in Records Retention and Destruction Policy No. 14-008.**
   f. **TCHD Workforce Members who are responsible for disposing of Confidential Records or for supervising others who dispose of Confidential Records must receive training on disposal obligations.**
   g. **TCHD shall document the destruction and disposal of Confidential Records pursuant to TCHD's policies.**

3. Confidential Records – Paper/Hard Copy and Other (Non-Electronic Media)
   a. Confidential Records in paper/hard copy shall be destroyed in a manner that renders PHI and other personal information unreadable, indecipherable and otherwise not capable of being reconstructed. PHI and other personal information that is contained in paper/hard copy Confidential Records including, but not limited to, the categories identified below, must be shredded prior to disposal. The form of such Confidential Records includes printed e-mails, facsimiles, correspondence, labels and file covers as well as originals and copies.
   b. For purposes of the shredding requirements in Section (a) above, TCHD requires that TCHD Workforce members, Medical Staff, and applicable business associates use one of the following processes to destroy PHI in paper/hard copy form:
      i. On-site shredding [in designated Department shredders] to destroy PHI prior to removal and disposal from TCHD premises which shall be done by a certified disposal vendor
      ii. PHI shall be placed in accessible, secured bins identified as "Shred: bins which are picked up by a certified disposal vendor for on-site recycling/destruction. Shred bins should not be used for non-identifiable/non-confidential information, hazardous waste, sharps, linen, medications, tissue, food products, garbage, glass, aluminum or corrugated cardboard.
4. Confidential Records – Labeled Prescription Bottles
   a. PHI on labeled prescription bottles shall be collected and maintained in Pharmaceutical waste containers which are located in various clinical areas of the hospital for collection and disposal by TCHD's certified disposal vendor.
   b. Pharmaceutical waste containers may also be used for the disposal of prescription bottles reflecting a patient's name/PHI.
5. Confidential Records – Electronic Media
   a. TCHD shall ensure that EPHI stored on computers and facsimile machines is destroyed in accordance with this Policy before disposal, reuse or return to a third party leasing company.
   b. Confidential Records in the form of Electronic Media shall be destroyed before disposal by clearing (using software or hardware products to overwrite media with non-sensitive data), purging (degaussing exposing the media to a strong magnetic field) ~~or~~ pulverization~~,~~ or shredding.
6. Confidential Records Used Offsite
   ~~2.~~a. Confidential Records used off TCHD's campus or other facilities (if and as permitted by TCHD policies) must be returned to TCHD for destruction and disposal in accordance with the procedures set forth in this Policy.

~~3.~~E. ENFORCEMENT AND COMPLIANCE

1. Non-compliance with this Policy could result in potential penalties to TCHD under state and federal laws. TCHD Workforce member, Medical Staff, and applicable business associates who violate this policy are subject to discipline up to and including terminations in accordance with TCHD sanction policies.

F. REFERENCES:

1. 45 Code of Federal Regulations (CFR) Section 160.103
2. 45 CFR Section 164.31(d)(2)(i)
3. 45 CFR Section 164.530 (c)
4. California~~,~~ Civil Code Sections 56.36 and 56.101
5. California. Civil Code Sections 1798.8-1798.84
6. California~~,~~ Health & Safety Code Section 1280.15
7. TCHD Records Retention Policy No. 14-008

8. TCHD Business Associate Policy No. 8610-511

~~4. "Individually identifiable" information is defined by Senate Bill 19 as medical information that includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the individual's name, address, e-mail address, telephone number, or social security number. Individually identifiable information also includes information that alone or in combination with other publicly identifiable information, (such as voter registration, property ownership records, or OSHPD data) reveals the individual's identity. All medical information, whether in electronic or physical form, is subject to this definition.~~

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

~~1. Tri-City Healthcare District (TCHD) employees shall ensure that identifiable information is disposed of in a manner that preserves confidentiality, whether using a conventional shredder or "Shred-It" bins.~~

~~2. All individually identifiable information must be shredded before disposal. Identifiable information includes, but is not limited to:~~

~~a. Individual components of the medical record, such as laboratory results, ABG results, surgery and schedules~~

~~b. Patient menus~~

~~c. Billing information~~

~~d. Receipts, or copies of receipts~~

~~e. Communications between caregivers, including fax and e-mail~~

~~f. Patient identification bracelets~~

~~g. Addressograph plates~~

~~3. TCMC employees are responsible for appropriate disposal of individually identifiable information. Departments using "Shred-It" bins or pharmaceutical waste containers may dispose of the following materials:~~

~~a. Paper products~~

~~b. Envelopes with cellophane~~

~~c. Labels~~

~~d. Post-it papers~~

~~e. File folders with plastic tabs or metal hangers~~

~~f. Floppy disks~~

~~g. Overhead transparencies~~

~~h. Plastic page protectors~~

~~i. Patient wrist bands~~

~~j. Addressograph plates~~

~~4. "Shred-it" bins should not be used for:~~

~~a. Non-identifiable/non-confidential information~~

~~b. Hazardous waste~~

~~c. Sharps~~

~~d. Linen~~

~~e. Medications~~

~~f. Tissue~~

~~g. Food products~~

~~h. Garbage~~

~~i. Glass~~

~~j. Aluminum~~

~~k. Corrugated cardboard~~

~~5. Departments using alternatives to "Shred-it" bins should refer to manufacturer's instructions for operation and suitability of materials to be shredded.~~

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 10/02 **SUBJECT:** Business Associate Agreement

REVISION DATE: 12/02; 06/06; 06/09; ~~5/15~~ **POLICY NUMBER:** 8610-511

Administrative Policies & Procedures Committee Approval:	**~~06/09~~05/15**
~~**Operations Team Committee Approval:**~~	~~**06/09**~~
~~**Professional Affairs Committee Approval:**~~	~~**07/09**~~
Audit and Compliance Committee Approval:	**06/15**
Board of Directors Approval:	**07/09**

A. **PURPOSE:**

1. According to the terms of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, **as amended** ("HIPAA") and regulations promulgated there-under by the U.S. Department of Health and Human Services (the "HIPAA Regulations"), the **T**ri-City Healthcare District ("District" **or "TCHD"**) is ~~defined as~~ a "Covered Entity".

~~1.~~**2.** District ~~has entered~~ **enters** into ~~A~~agreements with various **persons and** entities **to provide functions or activities regulated by HIPAA on behalf of the District (e.g. data analysis, utilization review) and such functions or activities require the person/entity to create, receive, maintain or transmit PHI. The District also enters into agreements with persons or entities performing services for the District which require the District to Disclose PHI in order for the contracting party to perform a service (e.g. legal, accounting, etc.)**~~, hereinafter referred to as "Business Associates".~~ **. These contracting parties are "Business Associates" under HIPAA.**~~Under the terms of these Agreements, Business Associates provide certain services to District, and District must disclose certain information to Business Associates, some of which may constitute Protected Health Information. District is required to obtain contractual commitments from Business Associates to safeguard the privacy of Protected Health Information.~~

~~2.~~**3.** **T**his Policy summarizes the obligations of District and Business Associates to meet HIPAA requirements.

B. **DEFINITIONS:**

1. **Business Associate: means, a person or organization who, on behalf of the District, performs certain functions or activities or services that require the Business Associate to create, receive, maintain or transmit PHI on behalf of the District or where the District needs to Disclosure PHI to Business Associate for the services.**

2. **Business Associate Addendum or BAA: is an Addendum to an applicable Services Agreement between the District and a Business Associate that outlines the specific obligations of the Business Associate related to the Use or Disclosure of District PHI.**

3. **Covered Entity: includes health care providers like the District that transmit health information in electronic form in connection with certain standard transactions (e.g. claims processing).**

4. **Data Use Application: describes the purpose, controls and safeguards agreed to by the Business Associate and Covered Entity.**

5. **Designated Record Set: those documents whether maintained in paper, film or electronic formats, that comprise the individual patient's medical record as approved by the Medical Executive Committee, that ~~compriss~~comprises the individual patient's billing records, and any documents used in whole or in part by Tri-City Healthcare District to make decisions about individuals including copies from another health care provider's designated record**

set.

6. ~~"~~Protected Health Information (PHI)~~"~~: ~~means individually identifiable health information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual.~~**[Replace]individually identifiable health information transmitted or maintained in paper or electronic other form that is created or received by ~~TCMC~~TCHD AND**
   - **a. Relates to the past, present, or future physical or mental health or condition of an individual.**
   - **b. Relates to the provision of health care to an individual**
   - **c. Relates to the past, present, or future payment, AND**
   - **d. identifies the individual OR**
   - **~~1.~~e. With respect to which there is a reasonable basis to believe the information can be used to identify the individual**

~~2. "Covered Entity": means District, **includes** a health care providers **like the District that transmit health information in electronic form in connection with certain standard transactions (e.g. claims processing)**.~~

~~3. "**Business Associate:" means,** a person or organization **who**, on **behalf of the** District, **performs a certain functions or activitiesy involving the use or disclosure of** PHI **or services that require the Business Associate to create, receive, maintain or transmit PHI on behalf of the District or where the District needs to Disclosure PHI to Business Associate for the services**.~~

~~4. "Business Associate Addendum **or BAA**": is an Addendum to **an** each **applicable Services** Agreement between **the** District and **a** Business Associate that outlines the specific **obligations** requirements with **of the** Business Associate prior to the disclosure of **related to the Use or Disclosure of District** PHI.~~

~~"Designated Data**Record** Set": **[Replace]**~~

~~5. is a group of records, from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual, and which is used to make decisions about the individual.~~

7. ~~"Data Use Application": describes the purpose, controls and safeguards agreed to by the Business Associate and Covered Entity.~~

~~6.~~**8. Services Agreement: An agreement between the District and a third party whereby the third party performs a function, activity or service on behalf of the District. Services Agreements that require the District to Disclose PHI for such functions, activities or services require Business Associate Addendums.**

C. **POLICY:**

1. **The** District and each Business Associate ~~intend to~~ **shall** protect the privacy and provide for the security of PHI disclosed to Business Associate in compliance ~~with the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") and regulations promulgated there under by the U.S. Department of Health and Human Services (~~ the ~~"~~HIPAA Regulations~~")~~.
2. **If the District enters into a Services Agreement with a party that is a Business Associate under HIPAA, the District will enter into a BAA with such party before Disclosing PHI to it.**
3. **The District will require that Business Associates ensure that agreements subcontractors that receive, maintain or transmit PHI on behalf of the Business Associates for purposes of Business Associates' BAAs with the District are subject to the same requirements as those in the District's BAA.**

~~1.~~**4. The District also complies with and requires its Business Associates to comply with applicable state laws and regulatory requirements that may be more stringent that HIPAA such as those requiring notification of breaches of PHI.**

~~2.~~**D. PROCESS:**

~~3.~~**1.** As part of the HIPAA Regulations, the Privacy Rule requires District to enter into a contract

containing specific requirements with Business Associate prior to the disclosure of PHI. These requirements **include**~~are~~**, but may not be limited to the following. The BAA shall contain all BAA contractual requirements under the Privacy Rule.**~~:~~

a. In conjunction with District, Business Associate must establish the permitted ~~u~~**U**ses and ~~d~~**D**isclosures of PHI by the Business Associate. HIPAA permits the use of PHI for proper management and administration.

b. Business Associate must refrain from ~~u~~**U**sing or **D**~~d~~isclosing the PHI other than as permitted by the ~~contract~~ **BAA** or as required by law.

c. Business Associate must use appropriate safeguards to prevent ~~u~~**U**se or **D**~~d~~isclosure of the information other than as provided for in the ~~contract~~ **BAA**.

~~c.~~**d. Business Associate shall have implemented a security program that includes administrative, technical and physical safeguards designed to prevent unauthorized Use or Disclosure of electronic PHI as required by the Security Rule set forth in subchapter C of Part 45.**

~~d.~~**e.** Business Associate must report **to the District** any ~~u~~**U**se or **D**~~d~~isclosure **of PHI** not provided for in the **BAA or any unauthorized or unlawful access, any security incident and/or Breach of PHI.** ~~contract~~.

~~e.~~**f.** Business Associate must ensure that agents and subcontractors that receive ~~protected health information~~**PHI** from the Business Associate agree to the same restrictions and conditions that apply to the Business Associate.

g. Business Associate shall cooperate with the District in fulfilling requests by individuals for access to their PHI that are approved by the District. If Business Associate maintains ~~protected health information~~ **PHI** received from District **in a Designated Record Set**, Business Associate must **make available**~~provide that~~ **that** information ~~in accordance~~ **in order to comply** with an individual's right to access, inspect, and copy their health information.

~~f.~~**h. If** Business Associate **maintains PHI in a Designated Record Set, it** must also provide that information in accordance with an individual's right to have the District make amendments to ~~protected health information~~**PHI**.

i. Business Associate must provide information required to make an accounting of disclosures of PHI, where such disclosures were made for purposes not related to treatment, payment, and healthcare operations.

~~g.~~**j. Business Associate must agree to make its internal practices, books and records related to the Use and Disclosure of PHI received from or created for the District available to HHS for the purpose of determining the District's compliance with HIPAA.**

k. Business Associate must return ~~and~~**or** destroy all PHI in any form at the termination of the Agreement **unless there is a determination that return or destruction is infeasible pursuant to the HIPAA Regulations**.

~~h.~~**l. The Business Associate Addendum shall authorize termination of it by the District if the District determines that the Business Associate has violated a material term of the Business Associate Addendum.**

~~4.~~**2.** ~~For each Agreement between District and Business Associate, in which District must disclose PHI to Business Associate, District and Business Associate must execute a HIPAA Business Associate Addendum.~~ Attached to this policy is the District-approved standard HIPAA Business Associate Addendum. **T**his Addendum, or a version of the Addendum modified to provide specific safeguards for the privacy **and security** of PHI, must be executed.

~~5.~~**3.** When required, Business Associate and District will also execute a Data Use Application.

~~6.~~**4.** The **Contract Manager** ~~Director of Materials~~ **or other District employee responsible for Services Agreements**, will assure that a HIPAA Business Associate Addendum is executed concurrently with execution of each new ~~A~~**Services A**greement between District and **a party that is identified as a** Business Associate **and before any PHI is Disclosed by the District or used, created or transmitted by the Business Associate on behalf of the District**.

~~7.~~**5.** The executed HIPAA Business Associate Addendum is filed with the original **Services**

~~A~~**A**greement in District Administrative Offices.

~~D.~~**E. REFERENCES:**

1. ~~The complete HIPAA Privacy Rule, annotated to reflect final modifications dated August 14, 2002, may be viewed at http://www.hipaadvisory.com/~~
2. ~~Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA")~~
   ~~Title 45 of the Code of Federal Regulations ("CFR") - **Part 160 and Part 164 Subparts A and E (HIPAA Privacy Rule)**~~
3. ~~**Title 45 CFR Part 160 and Part 164 Subparts A and C (HIPAA Security Rule)**~~
4. ~~PART 160—GENERAL ADMINISTRATIVE REQUIREMENTS~~
   a. ~~Subpart A—General Provisions~~
5. ~~**45 CFR** 160.103 Definitions (includes Covered Entity and Business Associate)~~
6. ~~PART 164—SECURITY AND PRIVACY~~
7. ~~**Subpart E—Privacy of Individually Identifiable Health Information**~~
8. ~~**45 CFR 164.502(a)(3) and (e) Uses and disclosures of protected health information: General rules.**~~
9. ~~164.504**(e)** Uses and disclosures: Organizational requirements.~~
10. ~~**45 CFR 164.10** 164.510 Uses and disclosures requiring an opportunity for the individual to agree or to object.~~
11. ~~**45 CFR 164.512**164.512 Uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required.~~
12. **45 Code of Federal Regulations (CFR) Section 164.524** ~~164.524 Access of individuals to protected health information.~~
13. **45 CFR Section 164.526** ~~164.526 Amendment of protected health information.~~
14. **45 CFR Section 164.528** ~~164.528 Accounting of disclosures of protected health information.~~
15. **45 CFR Section 164.530** ~~164.530 Administrative requirements~~

~~E.~~**F. FORMS~~ATTACHMENTS:**

1. Business Associate Addendum
2. Instructions - Data Use Application
3. HIPAA – Business Associate Data Use Application

HIPAA BUSINESS ASSOCIATE ADDENDUM

This HIPAA BUSINESS ASSOCIATE ADDENDUM ("Addendum") is entered into as of _____, 200__ (the *"Execution Date"*), by and between Tri-City Healthcare District, a health care district organized under the Local Health Care District Law of the State of California ("Hospital") and _____, an individual ("Contractor").

Hospital owns and operates a general acute care hospital that is located at 4002 Vista Way, Oceanside, California.

Hospital is a "covered entity" under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, as such, must enter into so-called "business associate" contracts with its contractors that may have access to patient medical information in either paper or electronic form.

Pursuant to that certain [_____ Agreement] by and between Hospital and Contractor, dated as of [_____, 200___] (the "Agreement"), Contractor may have access to patient medical information from Hospital.

Hospital and Contractor are committed to complying with HIPAA and Regulations promulgated there under by the U.S. Department of Health and Human Services (the "HIPAA Regulations") as well as any substantive changes made to HIPAA or the HIPAA Regulations pursuant to the American Recovery and Reinvestment Act of 2009 as they become effective or as otherwise amended from time to time (collectively these changes, HIPAA and the HIPAA Regulations shall hereinafter be referred to as the "HIPAA Laws"), the California Medical Information Act ("CMIA"), contained in the California Civil Code Section 56 *et seq*., the Patient Access To Medical Records Act ("PAMRA") contained in the California Health and Safety Code, Section 123100 *et seq*., California Health and Safety Code Section 1280.15 ("Section 1280.15") and other California patient privacy laws.

E. Contractor acknowledges and agrees that all Protected Health Information that is created or received by Hospital and disclosed or made available in any form, including paper record, audio recording, and electronic display by Hospital or its operating units to Contractor, or is created or received by Contractor on Hospital's behalf, shall be subject to the Agreement and this Addendum.

F. If Contractor requests a "Designated Data Set" from Hospital, Contractor must complete a Data Use Application (Instructions and Application attached to this Addendum) and submit a completed Data Use Application with this signed Addendum.

NOW, THEREFORE, in consideration of the recitals, conditions and promises herein contained, the parties do hereby agree as follows:

Defined Terms.

~~(a) Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the HIPAA Laws. A reference in this Addendum to a section in the HIPAA Regulations, means the section of the Code of Federal Regulations (CFR) as in effect or as amended, and for which compliance is required.~~

~~(b) Unauthorized or Unlawful Access shall mean the inappropriate review or viewing of patient medical information without a direct need for diagnosis, treatment or other lawful use as permitted by HIPAA, CMIA or by other statutes or regulations governing the lawful access, use or disclosure of medical information.~~

~~(c) Designated Data Set is a group of records, from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual, and which is used to make decisions about the individual.~~

~~(d) Data Use Application describes the purpose, controls and safeguards agreed to by the Contractor and Hospital.~~

~~Billing and Collecting. If Contractor provides billing and collecting services to Hospital or otherwise conducts any Standard Transactions on behalf of Hospital, Contractor shall comply with this Section. Contractor shall comply with 45 CFR Parts 160 and 162 (the "Transaction Rule"), including: (a) Contractor shall not change the definition, data condition, or use of a data element or segment in a standard of the Transactions Rule (a "Standard"); (b) Contractor shall not add any data elements or segments to the maximum defined data set; (c) Contractor shall not use any code or data elements that are either marked "not used" in the Standard's implementation specification or are not in the Standard's implementation specification(s); and (d) Contractor shall not change the meaning or intent of the Standard's implementation specification(s).~~

~~Use, Disclosure and Unauthorized or Unlawful Access.~~

~~Contractor shall not use or disclose Protected Health Information in any form, including electronic form ("PHI"), other than as permitted or required by this Addendum or as permitted or required by law.~~

~~Contractor shall not permit Unauthorized or Unlawful Access to PHI.~~

~~Except as otherwise limited in this Addendum, Contractor may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Hospital as specified in the Agreement or for Contractor's internal operational purposes, provided that such use or disclosure would not violate the HIPAA Regulations or California law if done by Hospital.~~

~~If the Agreement is to be performed in California, the Contractor shall not further disclose any PHI (including to subcontractors) received from the Hospital or maintained by the Contractor, unless required or permitted under California law.~~

~~Disclosure Accounting. In the event that Contractor makes any disclosures of PHI that are subject to the accounting requirements of 45 CFR Section 164.528, Contractor~~

~~promptly shall report such disclosures to Hospital in writing. Such notice shall include the name of the individual and company affiliation to whom the PHI was disclosed and the date of the disclosure. Contractor shall maintain a record of each such disclosure, including the date of the disclosure, the name and, if available, the address of the recipient of the PHI, a brief description of the PHI disclosed and a brief description of the purpose of the disclosure. Contractor shall maintain this record for a period of six (6) years and make such records available to Hospital upon request in an electronic format so that Hospital may meet its disclosure accounting obligations under 45 CFR Section 164.528.~~

~~Access to PHI by Individuals. Contractor shall cooperate with Hospital to fulfill all requests by individuals for access to the individual's PHI that are approved by Hospital. Contractor shall cooperate with Hospital in all respects necessary for it to comply with 45 CFR Section 164.524. If Contractor receives a request from an individual for access to PHI, Contractor immediately shall forward such request to Hospital, who shall be solely responsible for determining the scope of PHI and Designated Record Set with respect to each request by an individual for access to PHI. If Contractor maintains PHI in a Designated Record Set on behalf of Hospital, Contractor shall permit any individual, upon notice by Hospital, to access and obtain copies of the individual's PHI in accordance with 45 CFR Section 164.524. Contractor shall make the PHI available in the format requested by the individual and approved by Hospital, unless the PHI is not readily producible in such format, in which case the PHI shall be produced in hard copy format. Contractor shall not charge Hospital or the individual any fees for such access to PHI. If Contractor does not hold any information as part of a Designated Record Set, this Section shall not apply to Contractor.~~

~~Amendment of PHI. Contractor shall incorporate all amendments to PHI received from Hospital within five (5) business days of receipt. Contractor shall provide written notice to Hospital within five (5) business days of completing such amendment(s). Such notice shall confirm that Contractor has made the amendment(s) to PHI as directed by Hospital and shall contain any additional information necessary for Hospital to provide adequate notice to the individual in accordance with 45 CFR Section 164.526. If Contractor does not hold any information as part of a Designated Record Set, this Section shall not apply to Contractor.~~

~~Access to Contractor's Books and Records. Contractor shall make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by Contractor on behalf of Hospital, available to the Secretary of the Department of Health and Human Services ("Secretary") for purposes of determining Hospital's compliance with the HIPAA Laws. Contractor shall provide to Hospital a copy of any PHI that Contractor provides to the Secretary concurrently with providing such PHI to the Secretary. Contractor also shall make its internal practices, books and records available within five (5) business days of a request by Hospital for inspection for purposes of determining compliance with this Agreement.~~

~~Security Safeguards. Contractor shall implement a documented information security program that includes administrative, technical and physical safeguards designed to prevent the accidental or otherwise unauthorized use or disclosure of PHI. Contractor~~

~~**shall require any agents, affiliates, subsidiaries or subcontractors, with access to electronic PHI related to Hospital in any way, to agree in writing to the same requirements under this Section. Moreover, Contractor shall implement administrative, physical, and technical safeguards and policy, procedure, and documentation requirements consistent with the requirements of 45 CFR Sections 164.308, 164.310, 164.312, and 164.316 by February 17, 2010.**~~

~~**Reporting and Mitigating. Contractor shall immediately report, but in no event later than 24 hours, any unauthorized or unlawful access, use or disclosure of PHI not provided for or permitted by this Addendum of which the Contractor becomes aware. Moreover, in the event that Contractor becomes aware that PHI has been or reasonably believes has been accessed, acquired or disclosed as a result of a "breach," as the term is defined by the HIPAA Laws or Section 1280.15, Contractor will notify Hospital of the breach, including the identification of each individual who has been or is reasonably believed to have been affected by the breach. Contractor's notification to Hospital shall be provided in accordance with HIPAA Laws and Section 1280.15 and guidance as it may be provided by the Secretary and the California Office of Health Information Integrity. Contractor shall use its best efforts to mitigate the deleterious effects of any unlawful access, use or disclosure of PHI not authorized by this Addendum or any Security Incident.**~~

~~**Term and Termination.**~~

~~**The Term of this Addendum shall be effective as of _____, 200_ and shall terminate when all of the PHI provided by Hospital to Contractor, or created or received by Contractor on behalf of Hospital, is destroyed or returned to Hospital, or, if it is infeasible to return or destroy the PHI, protections are extended to such information, in accordance with Section 11 below.**~~

~~**If Hospital becomes aware of any material breach of this Addendum by Contractor, Hospital shall provide Contractor with written notice of such breach and such breach shall be cured by Contractor within thirty (30) business days of such notice. If such breach is not cured with such time period, Hospital shall immediately terminate this Addendum.**~~

~~**On or after February 17, 2010, if Contractor becomes aware of any material breach of this Addendum by Hospital, Contractor shall provide Hospital with written notice of such breach and such breach shall be cured by Hospital within thirty (30) business days of such notice. If such breach is not cured with such time period, Contractor shall immediately terminate this Addendum.**~~

~~**Contractor acknowledges and agrees that Hospital may be required by HIPAA Laws to report a breach to the Secretary of the U.S. Department of Health and Human Services.**~~

~~**The Agreement shall automatically terminate upon termination of this Addendum for any reason whatsoever.**~~

~~**Effect of Termination.**~~

~~Upon termination or expiration of this Addendum, Hospital shall direct Contractor to either return or destroy all PHI that Contractor obtained, created or maintained pursuant to the Agreement on behalf of Hospital. If Hospital determines at that time that the return or destruction of PHI is not feasible, Contractor shall extend the protections provided under this Addendum to such PHI, and limit further use or disclosure of the PHI to those purposes that make the return or destruction of the PHI infeasible.~~

~~Upon termination or expiration of this Addendum, Contractor shall recover all PHI that is in the possession of Contractor's agents, affiliates, subsidiaries or subcontractors. If Contractor believes at that time that it is infeasible for the Contractor to recover all PHI in the possession of Contractor's agents, affiliates, subsidiaries or subcontractors, Contractor shall provide written notice to Hospital regarding the nature of the unfeasibility. Upon a determination by Hospital that such recovery is infeasible, Contractor shall require that its agents, affiliates, subsidiaries and subcontractors agree to the extension of all protections, limitations and restrictions required of Contractor hereunder. If Hospital determines that it is feasible to make such recovery, Contractor shall recover all PHI in the possession of Contractor's agents, affiliates, subsidiaries or subcontractors.~~

~~If Contractor or Contractor's agents, affiliates, subsidiaries or subcontractors retain any PHI pursuant to this Section 11, the terms of this Addendum shall continue to apply to the PHI retained by Contractor or any of Contractor's agents, affiliates, subsidiaries or subcontractors, even after termination of the Agreement.~~

~~Prohibition of Sale of PHI. Contractor may not directly or indirectly receive remuneration in exchange for any PHI without a valid authorization specifically indicating that the PHI may be sold to the entity receiving the PHI unless the sale is otherwise authorized by the HIPAA Laws.~~

~~Indemnification. Each party shall indemnify, defend and hold harmless the other party and its agents, employees, contractors, officers and directors against: (i) any and all liability arising out of such party's failure to comply with the terms of this Addendum, and any injury, loss, fines, claims, or damages arising from the negligent operations, acts, or omissions of such party or its employees relating to or arising out of this Addendum; and (ii) any and all costs and expenses, including reasonable legal expenses, incurred by or on behalf of the other party in connection with the defense of such claims.~~

~~Contractor's Compliance with HIPAA. Hospital makes no warranty or representation that compliance by Contractor with this Addendum, the HIPAA Laws or California law will be adequate or satisfactory for Contractor's own purposes or that any information in Contractor's possession or control, or transmitted or received by Contractor, is or will be secure from unauthorized use or disclosure. Contractor is solely responsible for all decisions made by Contractor regarding the safeguarding of PHI.~~

~~Continuing Agreement. Except as expressly modified by this Addendum, the Agreement shall continue in full force and effect. In the event of any conflict between any provision of this Addendum and any provision of the Agreement, the provision of this Addendum shall control.~~

~~**Assignment; Binding Effect. This Addendum shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns. Unless otherwise provided in the Agreement, Contractor may not assign the rights or obligations under the Agreement without the express written consent of Hospital; however, Hospital may assign its rights and obligations under this Agreement to any successor or affiliated entity without the consent of Contractor.**~~

~~**Affiliates, Agents, Subsidiaries and Subcontractors. Contractor shall require any agents, affiliates, subsidiaries or subcontractors, with access to PHI related to Hospital in any way, to agree in writing to the same use and disclosure restrictions imposed on Contractor by this Addendum. Unless the Agreement permits Contractor to subcontract its services, Contractor shall not subcontract any of its services under the Agreement without first obtaining Hospital's prior written consent.**~~

~~**Compliance with Laws. The parties shall comply with all applicable laws, ordinances, codes and regulations of federal, state and local governments, applicable to the performance of the Agreement and this Addendum.**~~

~~**Governing Law. Unless provided otherwise in the Agreement, this Addendum shall be construed in accordance with and governed by the laws of the State of California, except the conflicts of laws provisions which would require the application of the laws of any other jurisdiction.**~~

~~**Headings. The headings in this Addendum are intended solely for convenience of reference and shall be given no effect in the construction or interpretation of this Agreement.**~~

~~**No Third-party Beneficiary Rights. Unless provided otherwise in the Agreement, the parties do not intend to confer and this Addendum shall not be construed to confer any rights or benefits to any person, firm, physician, corporation or entity other than the parties.**~~

~~**Data Ownership. Contractor acknowledges and agrees that all PHI that Contractor obtains, creates or maintains pursuant to the Agreement, on behalf of Hospital or for Contractor's internal use, is the property of Hospital and Contractor has no ownership rights with respect thereto.**~~

~~**Severability. If any provision of this Addendum is determined to be illegal or unenforceable, that provision shall be severed from this Addendum and/or the Agreement, as applicable, and such severance shall have no effect upon the enforceability of the remainder of the Agreement.**~~

~~**Counterparts. This Addendum may be executed in one or more counterparts, each of which shall be deemed to be an original, and all of which together shall constitute one and the same instrument.**~~

25. Amendment of Data Use Application. The Data Use Application may be modified or amended by mutual agreement of the parties at any time without amending the Agreement or this Addendum.

IN WITNESS WHEREOF, the parties have executed this Addendum as of the Execution Date.

"HOSPITAL"

Tri-City Healthcare District, a health care district organized under the Local Health Care district Law of the State of California

By: _____

_____, **[Chief Executive Officer]**

"CONTRACTOR"

_____, **an individual**

Signature: _____

Print Name: _____

Title: _____

~~**Instructions – Data Use Application**~~

~~**Tri-City Healthcare District (TCHD)**~~

~~**TCHD may disclose a Designated Data Set of Protected Health Information (PHI) according to a Business Associate Addendum, if TCHD obtains satisfactory assurance that the recipient of the PHI will use or disclose the information only for limited purposes.**~~

~~**Please complete the Data Use Application, explaining your receipt and use of TCHD PHI, by answering the following questions:**~~

- ~~**State the purpose of the information and how the Designated Data Set of PHI will be used to accomplish that purpose.**~~
- ~~**Provide the specific purpose for the use and disclosure of this data.**~~
- ~~**Identify who can use and receive the data.**~~
- ~~**Provide an adequate assurance of safeguards that prevent unapproved use or disclosure.**~~
- ~~**Identify your plan (how and when) to destroy the Designated Data Set of PHI.**~~

~~HIPAA Business Associate - Data Use Application~~

~~Principal Recipient of Protected Health Information~~

~~Company Name and Contact:~~

_____

~~Address:~~ _____

~~Phone #~~ _____ **~~Fax #~~** _____

~~E-mail:~~ _____

~~This Application is executed as part of the Business Associate Addendum, to reflect additional specifications relating to the use or disclosure of the Designated Data Set of Protected Health Information (PHI). This Application may be amended from time to time as needed.~~

~~1.~~ ~~The purpose of the information~~ **~~and how the Designated Data Set of Protected Health Information will be used to accomplish that purpose:~~** _____

~~2.~~ ~~The specific purpose for the use and disclosure~~ **~~of this data:~~** _____

~~3.~~ **~~Identification of~~** ~~who can use and receive~~ **~~the data:~~** _____

~~4.~~ ~~Safeguards~~ **~~that prevent unapproved use or disclosure:~~** _____

5. The plan (how and when) to destroy **the Designated Data Set of Protected Health Information:**

6. Additional Terms. **[This section may include specifications for disclosure format, method of transmission, use of an intermediary, use of digital signatures or PKI, authentication, additional security or privacy specifications, de-identification or re-identification of data and other additional terms.]**

7. Person Completing This Application:

Signature:

Print Name:

Title:

Date Signed:

HIPAA BUSINESS ASSOCIATE ADDENDUM

This HIPAA BUSINESS ASSOCIATE ADDENDUM ("Addendum") is entered into as of _____, 20___ (the *"Execution Date"*), by and between Tri-City Healthcare District, a health care district organized under the Local Health Care District Law of the State of California ("Hospital") and _____ ("Contractor").

A. Hospital owns and operates a general acute care hospital that is located at 4002 Vista Way, Oceanside, California.

B. Hospital is a "covered entity" under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and, as such, must enter into so-called "business associate" contracts with its contractors that may have access to patient medical information in either paper or electronic form.

C. Pursuant to that certain _____ Agreement by and between Hospital and Contractor, dated as of _____, 20___ (the "Agreement"), Contractor may have access to patient medical information from Hospital.

D. Hospital and Contractor are committed to complying with HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act, Public Law 111-05 ("HITECH Act") and their implementing regulations ("the HIPAA Regulations) as they become effective or as otherwise amended from time to time (collectively these changes, HIPAA and the HIPAA Regulations shall hereinafter be referred to as the "HIPAA Laws"), the California Medical Information Act ("CMIA"), contained in the California Civil Code Section 56 *et seq.*, the Patient Access To Medical Records Act ("PAMRA") contained in the California Health and Safety Code, Section 123100 *et seq.*, California Health and Safety Code Section 1280.15 ("Section 1280.15") and other California patient privacy laws.

NOW, THEREFORE, in consideration of the recitals, conditions and promises herein contained, the parties do hereby agree as follows:

1. <u>Defined Terms</u>.

(a) Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the HIPAA Laws. A reference in this Addendum to a section in the HIPAA Regulations, means the section of the Code of Federal Regulations (CFR) as in effect or as amended, and for which compliance is required.

(b) Unauthorized or Unlawful Access shall mean the inappropriate review or viewing of patient medical information without a direct need for diagnosis, treatment or other lawful Use as permitted by HIPAA, CMIA or by other statutes or regulations governing the lawful access, Use or Disclosure of medical information.

(c) Designated Data Set is a group of records, from which information is retrieved by the name of the individual or by some identifying number, symbol, or other

identifying particular assigned to the Individual, and which is used to make decisions about the Individual.

(d) Data Use Application describes the purpose, controls and safeguards agreed to by the Contractor and Hospital.

2. Billing and Collecting. If Contractor provides billing and collecting services to Hospital or otherwise conducts any Standard Transactions on behalf of Hospital, Contractor shall comply with this Section. Contractor shall comply with 45 CFR Parts 160 and 162 (the "Transaction Rule"), including: (a) Contractor shall not change the definition, data condition, or use of a data element or segment in a standard of the Transactions Rule (a "Standard"); (b) Contractor shall not add any data elements or segments to the maximum defined data set; (c) Contractor shall not use any code or data elements that are either marked "not used" in the Standard's implementation specification or are not in the Standard's implementation specification(s); and (d) Contractor shall not change the meaning or intent of the Standard's implementation specification(s).

3. Contractor's Obligations

(a) Contractor acknowledges and agrees that all Protected Health Information that is created or received by Hospital and Disclosed or made available in any form, including paper record, audio recording, and electronic display by Hospital or its operating units to Contractor, or is created, received, maintained or transmitted by Contractor on Hospital's behalf, shall be subject to the Agreement and this Addendum.

(b) Contractor shall not Use or Disclose Protected Health Information in any form, including electronic form ("PHI"), other than as permitted or required by this Addendum or required by law.

(c) Contractor shall not permit Unauthorized or Unlawful Access to PHI.

(d) Except as otherwise limited in this Addendum, Contractor may Use or Disclose PHI to perform functions, activities, or services for, or on behalf of, Hospital as specified in the Agreement or for Contractor's internal operational purposes, provided that such Use or Disclosure would not violate the HIPAA Regulations or California law if done by Hospital.

(e) The Contractor shall not further Disclose any PHI (including to subcontractors) received from the Hospital or maintained by the Contractor, unless permitted by this Addendum and, in such cases, only if such Disclosure is required or permitted under California law.

(f) The Contractor shall not Disclose PHI to a health plan for payment or health care operations purposes if the Individual has requested this special restriction and has paid out-of-pocket in full for the health care item or service to which the PHI solely relates.

(g) Except as otherwise provided for in this Addendum, Business Associate may use Protected Health Information for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate. (See 45 C.F.R. §164.504(e)(4)(i)).

(h) Except as otherwise provided for in this Agreement, Business Associate may Disclose Protected Health Information for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that Disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is Disclosed that it will remain confidential and Used or further Disclosed only as Required By Law or for the purpose for which it was Disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been Breached. (See 45 C.F.R. §164.504(e)(4)(ii)).

(i) To the extent that Contractor is to carry out one or more of Hospital's obligations under Subpart E of 45 CFR Part 164, Contractor shall comply with the requirements of Subpart E that apply to Hospital in the performance of the obligations.

4. Disclosure Accounting. In the event that Contractor makes any Disclosures of PHI that are subject to the accounting requirements of 45 CFR Section 164.528, Contractor promptly shall report such Disclosures to Hospital in writing. Such notice shall include the name of the individual and company affiliation to whom the PHI was Disclosed and the date of the Disclosure. Contractor shall maintain a record of each such Disclosure, including the date of the Disclosure, the name and, if available, the address of the recipient of the PHI, a brief description of the PHI Disclosed and a brief description of the purpose of the Disclosure. Contractor shall maintain this record for a period of six (6) years and make such records available to Hospital upon request in an electronic format so that Hospital may meet its Disclosure accounting obligations under 45 CFR Section 164.528.

5. Access to PHI by Individuals. Contractor shall cooperate with Hospital to fulfill all requests by Individuals for access to the Individual's PHI that are approved by Hospital. Contractor shall cooperate with Hospital in all respects necessary for it to comply with 45 CFR Section 164.524. If Contractor receives a request from an Individual for access to PHI, Contractor immediately shall forward such request to Hospital, who shall be solely responsible for determining the scope of PHI and Designated Record Set with respect to each request by an individual for access to PHI. If Contractor maintains PHI in a Designated Record Set on behalf of Hospital, Contractor shall permit any Individual, upon notice by Hospital, to access and obtain copies of the individual's PHI in accordance with 45 CFR Section 164.524. Contractor shall make the PHI available in the format requested by the Individual and approved by Hospital. If Business Associate maintains the PHI in a Designated Record Set in electronic form and an Individual requests a copy of such information in electronic format, Business Associate shall provide such information in electronic format to Hospital in order for it to comply with its obligation. Contractor shall not charge Hospital or the Individual any fees for such access to PHI. If Contractor does not hold any information as part of a Designated Record Set, this Section shall not apply to Contractor.

6. Amendment of PHI. Contractor shall incorporate all amendments to PHI received from Hospital within five (5) business days of receipt. Contractor shall provide written notice to Hospital within five (5) business days of completing such amendment(s). Such notice shall confirm that Contractor has made the amendment(s) to PHI as directed by Hospital and shall contain any additional information necessary for Hospital to provide adequate notice to the Individual in accordance with 45 CFR Section 164.526. If Contractor does not hold any information as part of a Designated Record Set, this Section shall not apply to Contractor.

7. Access to Contractor's Books and Records. Contractor shall make its internal practices, books and records relating to the Use and Disclosure of PHI received from, or created or received by Contractor on behalf of Hospital, available to the Secretary of the Department of Health and Human Services ("Secretary") for purposes of determining Hospital's compliance with the HIPAA Laws. Contractor shall provide to Hospital a copy of any PHI that Contractor provides to the Secretary concurrently with providing such PHI to the Secretary. Contractor also shall make its internal practices, books and records available within five (5) business days of a request by Hospital for inspection for purposes of determining compliance with this Agreement.

8. Security Safeguards. Contractor shall implement a documented information security program that includes administrative, technical and physical safeguards designed to prevent the accidental or otherwise unauthorized Use or Disclosure of PHI. Contractor shall require any agents, affiliates, subsidiaries or subcontractors, with access to electronic PHI related to Hospital in any way, to agree in writing to the same requirements under this Section. Moreover, Contractor shall implement administrative, physical, and technical safeguards and policy, procedure, and documentation requirements consistent with the requirements of 45 CFR Sections 164.308, 164.310, 164.312, and 164.316.

9. Reporting and Mitigating. Contractor shall immediately report, but in no event later than 24 hours, any Security Incident including any Unauthorized or Unlawful Access, Use or Disclosure of PHI or Breach of Unsecured PHI not provided for or permitted by this Addendum of which the Contractor becomes aware. Moreover, in the event that Contractor becomes aware that PHI has been or reasonably believes has been accessed, acquired or Disclosed as a result of a "Breach," or Unauthorized or Unlawful Access as those terms are defined by the HIPAA Laws or Section 1280.15, Contractor will notify Hospital of the Breach and/or Unauthorized or Unlawful Access, Use or Disclosure, including the identification of each Individual who has been or is reasonably believed to have been affected thereby. Contractor's notification to Hospital shall be provided in accordance with HIPAA Laws and Section 1280.15 and guidance as it may be provided by the Secretary and the California Office of Health Information Integrity. Contractor shall use its best efforts to mitigate the deleterious effects of any Unlawful Access, Use or Disclosure of PHI not authorized by this Addendum or any Security Incident.

10. Term and Termination.

(a) The Term of this Addendum shall be effective as of the Execution Date and shall terminate when all of the PHI provided by Hospital to Contractor, or

created or received by Contractor on behalf of Hospital, is destroyed or returned to Hospital, or, if it is infeasible to return or destroy the PHI, protections are extended to such information, in accordance with Section 11 below.

(b) If Hospital becomes aware of any material breach of this Addendum by Contractor, Hospital shall provide Contractor with written notice of such breach and such breach shall be cured by Contractor within thirty (30) business days of such notice. If such breach is not cured with such time period, Hospital shall immediately terminate this Addendum.

(c) If Contractor becomes aware of any material breach of this Addendum by Hospital, Contractor shall provide Hospital with written notice of such breach and such breach shall be cured by Hospital within thirty (30) business days of such notice. If such breach is not cured with such time period, Contractor shall immediately terminate this Addendum.

(d) Contractor acknowledges and agrees that Hospital may be required by HIPAA Laws to report a Breach to the Secretary of the U.S. Department of Health and Human Services and Unauthorized or Unlawful Access, Use or Disclosure of PHI to the State.

(e) The Agreement shall automatically terminate upon termination of this Addendum for any reason whatsoever.

11. Effect of Termination.

(a) Upon termination or expiration of this Addendum, Hospital shall direct Contractor to either return or destroy all PHI that Contractor obtained, created or maintained pursuant to the Agreement on behalf of Hospital. If Hospital determines at that time that the return or destruction of PHI is not feasible, Contractor shall extend the protections provided under this Addendum to such PHI, and limit further Use or Disclosure of the PHI to those purposes that make the return or destruction of the PHI infeasible.

(b) Upon termination or expiration of this Addendum, Contractor shall recover all PHI that is in the possession of Contractor's agents, affiliates, subsidiaries or subcontractors. If Contractor believes at that time that it is infeasible for the Contractor to recover all PHI in the possession of Contractor's agents, affiliates, subsidiaries or subcontractors, Contractor shall provide written notice to Hospital regarding the nature of the unfeasibility. Upon a determination by Hospital that such recovery is infeasible, Contractor shall require that its agents, affiliates, subsidiaries and subcontractors agree to the extension of all protections, limitations and restrictions required of Contractor hereunder. If Hospital determines that it is feasible to make such recovery, Contractor shall recover all PHI in the possession of Contractor's agents, affiliates, subsidiaries or subcontractors.

(c) If Contractor or Contractor's agents, affiliates, subsidiaries or subcontractors retain any PHI pursuant to this Section 11, the terms of this Addendum

shall continue to apply to the PHI retained by Contractor or any of Contractor's agents, affiliates, subsidiaries or subcontractors, even after termination of the Agreement.

12. Prohibition of Sale of PHI. Contractor may not directly or indirectly receive remuneration in exchange for any PHI without a valid Authorization specifically indicating that the PHI may be sold to the entity receiving the PHI unless the sale is otherwise authorized by the HIPAA Laws.

13. Indemnification. Each party, to the extent allowable under the California Tort Claims Act, shall indemnify, defend and hold harmless the other party and its agents, employees, contractors, officers and directors against: (i) any and all liability arising out of such party's failure to comply with the terms of this Addendum, and any injury, loss, fines, claims, or damages arising from the negligent operations, acts, or omissions of such party or its employees relating to or arising out of this Addendum; and (ii) any and all costs and expenses, including reasonable legal expenses, incurred by or on behalf of the other party in connection with the defense of such claims.

14. Contractor's Compliance with HIPAA. Hospital makes no warranty or representation that compliance by Contractor with this Addendum, the HIPAA Laws or California law will be adequate or satisfactory for Contractor's own purposes or that any information in Contractor's possession or control, or transmitted or received by Contractor, is or will be secure from unauthorized Use or Disclosure. Contractor is solely responsible for all decisions made by Contractor regarding the safeguarding of PHI.

15. Continuing Agreement. Except as expressly modified by this Addendum, the Agreement shall continue in full force and effect. In the event of any conflict between any provision of this Addendum and any provision of the Agreement, the provision of this Addendum shall control.

16. Assignment; Binding Effect. This Addendum shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns. Unless otherwise provided in the Agreement, Contractor may not assign the rights or obligations under the Agreement without the express written consent of Hospital; however, Hospital may assign its rights and obligations under this Agreement to any successor or affiliated entity without the consent of Contractor.

17. Affiliates, Agents, Subsidiaries and Subcontractors. Contractor shall require any agents and subcontractors which creates, receives, maintains or transmits PHI related to Hospital on its behalf, to agree in writing to the same Use and Disclosure restrictions and conditions imposed on Contractor by this Addendum including the requirement that such agents and subcontractors implement reasonable and appropriate administrative, physical and technical safeguards to protect such PHI. Business Associate shall incorporate, when applicable, the relevant provisions of this Addendum into each subcontract to such agents and subcontractors including the requirement to report Security Incidents, Breaches and Unauthorized or Unlawful Access, Use and Disclosures to Business Associate. Unless the Agreement permits Contractor to subcontract its services, Contractor shall not subcontract

any of its services under the Agreement without first obtaining Hospital's prior written consent.

18. Compliance with Laws. The parties shall comply with all applicable laws, ordinances, codes and regulations of federal, state and local governments, applicable to the performance of the Agreement and this Addendum.

19. Governing Law. Unless provided otherwise in the Agreement, this Addendum shall be construed in accordance with and governed by the laws of the State of California, except the conflicts of laws provisions which would require the application of the laws of any other jurisdiction.

20. Headings. The headings in this Addendum are intended solely for convenience of reference and shall be given no effect in the construction or interpretation of this Agreement.

21. No Third-party Beneficiary Rights. Unless provided otherwise in the Agreement, the parties do not intend to confer and this Addendum shall not be construed to confer any rights or benefits to any person, firm, physician, corporation or entity other than the parties.

22. Data Ownership. Contractor acknowledges and agrees that all PHI that Contractor obtains, creates or maintains pursuant to the Agreement, on behalf of Hospital or for Contractor's internal use, is the property of Hospital and Contractor has no ownership rights with respect thereto.

23. Severability. If any provision of this Addendum is determined to be illegal or unenforceable, that provision shall be severed from this Addendum and/or the Agreement, as applicable, and such severance shall have no effect upon the enforceability of the remainder of the Agreement.

24. Counterparts. This Addendum may be executed in one or more counterparts, each of which shall be deemed to be an original, and all of which together shall constitute one and the same instrument.

25. Data Use Application. If Contractor requests a "Designated Data Set" from Hospital, Contractor must complete a Data Use Application (Instructions and Application attached to this Addendum) and submit a completed Data Use Application with this signed Addendum. The Data Use Application may be modified or amended by mutual agreement of the parties at any time without amending the Agreement or this Addendum.

IN WITNESS WHEREOF, the parties have executed this Addendum as of the Execution Date.

HOSPITAL
Tri-City Healthcare District, a health care district organized under the Local Health Care district Law of the State of California

By:_____
Chief Executive Officer

CONTRACTOR

Signature:_____

Print Name:_____

Title:_____

Instructions – Data Use Application

Tri-City Healthcare District (TCHD)

TCHD may Disclose a Designated Data Set of Protected Health Information (PHI) according to a Business Associate Addendum, if TCHD obtains satisfactory assurance that the recipient of the PHI will Use or Disclose the information only for limited purposes.

Please complete the Data Use Application, explaining your receipt and use of TCHD PHI, by answering the following questions:

- **State the purpose of the information and how the Designated Data Set of PHI will be used to accomplish that purpose.**
- **Provide the specific purpose for the Use and Disclosure of this data.**
- **Identify who can Use and receive the data.**
- **Provide an adequate assurance of safeguards that prevent unapproved Use or Disclosure.**
- **Identify your plan (how and when) to destroy the Designated Data Set of PHI.**

HIPAA Business Associate - Data Use Application

Principal Recipient of Protected Health Information

Company Name and Contact:

_____

Address: _____

Phone # _____ **Fax #** _____

E-mail: _____

This Application is executed as part of the Business Associate Addendum, to reflect additional specifications relating to the Use or Disclosure of the Designated Data Set of Protected Health Information (PHI). This Application may be amended from time to time as needed.

1. The purpose of the information and how the Designated Data Set of Protected Health Information will be used to accomplish that purpose: _____

_____

_____

_____

_____

_____

2. The specific purpose for the use and disclosure of this data: _____

_____

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_____

3. Identification of who can use and receive the data: _____

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_____

4. Safeguards that prevent unapproved use or disclosure: _____

_____

_____

_____

_____

_____

5. The plan (how and when) to destroy the Designated Data Set of Protected Health Information: _____

_____

6. Additional Terms. [This section may include specifications for disclosure format, method of transmission, use of an intermediary, use of digital signatures or PKI, authentication, additional security or privacy specifications, de-identification or re-identification of data and other additional terms.] _____

7. Person Completing This Application:

Signature: _____

Print Name: _____

Title: _____

Date Signed: _____

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 3/03

SUBJECT: PRIVACY: DESIGNATED RECORD SET

REVISION DATE: 9/05; 11/08, ~~5/15~~

POLICY NUMBER: 8610-514

Administrative Policies & Procedures Committee Approval:	**~~11/08~~5/15**
~~Operations Team Committee Approval:~~	**~~12/08~~**
~~Professional Affairs Committee Approval:~~	**~~01/09~~**
Audit and Compliance Committee Approval:	**06/15**
Board of Directors Approval:	**01/09**

A. **PURPOSE:**

1. To define Tri-City Healthcare District's Designated Records Set
2. **To identify the HIPAA Privacy regulations and TCHD policies that address the Designated Record set.**

B. **POLICY:**

1. The Tri-City Healthcare District (TCHD) Designated Record Set is defined as those documents, whether maintained in paper, film or electronic formats, that comprise the individual patient's medical record as approved by the Medical Record Committee, that comprise the individual patient's billing records, and any documents used in whole or in part by Tri-City Healthcare District to make decisions about individuals including copies from another health care provider's designated record set.
2. **HIPAA refers to the Designated Record Set in addressing patient rights. Patients have a right to inspect and copy the Designated Record Set as set forth in Policy 8610-516. Patients have a right to request an amendment of PHI~~O~~ in the Designated Record Set as set forth in Policy No. 8610-520.**

~~2.Retention Period: All components of TCHD's Designated Record Set must be maintained for no less than ten (10) years following the most recent treatment episode for the adult, and for a period of no less than three (3) years past the age of majority (18) for minors or ten (10) years following such discharge. Except if a request for disclosure of the information is received from the patient or the patient's legal representative, the information requested must be preserved for six (6) years past the date of disclosure.~~

~~3.It is the policy of Tri-City Healthcare District to maintain the demographic, administrative, clinical, lab and medical imaging, operative and procedure documentation from the Designated Record Set indefinitely. These documents will be stored/maintained per Medical Records/Health Information Department policy.~~

~~4.All microfilmed records shall be destroyed in such a manner as to make future use or disclosure unreasonable under normal circumstances, and such destruction must be documented. Documentation of destruction shall be maintained indefinitely by the medical records department.~~

3. All information in the Designated Record Set is protected health information (PHI), and is subject to TCHD's Privacy – Use and Disclosure Policy.

C. **PROCESS:**

1. Medical Record: all TCHD Medical Record content must be approved by the **Physician IT Council and Medical Executive** ~~Medical Records~~ Committee, and includes the following types of documents:
   a. Demographic and payor documents.
   b. Administrative documents.

c. Patient consent and authorization forms.
d. Clinical information from Licensed Independent Practitioners including Discharge Summaries, History and Physical Reports, Consultations, and miscellaneous procedure reports.
e. Physician Orders.
f. Progress Notes.
g. Laboratory and Medical Imaging reports.
h. Operative and Pathology Reports.
i. Reports from ancillary services.
j. Nursing care documentation.

2. Billing Records: All billing record forms must be approved by the Chief Financial Officer or designees. The content of the TCHD individual billing records include:
   a. Universal Billing Form
   b. Itemized Statement
   c. Collections correspondence
3. Other Information Sources to be included in Designated Record Set. For the most part, this documentation will be maintained by the originating department or the Medical Records/Health Information Department.
   a. X-ray films and electronic medical images.
   b. Photographs and videos used for the delivery or monitoring of care and treatment. (Intra-procedure photos or videos, wound photos, etc.)
   c. Copies of records from other providers.
   d. Monitor strips and recordings (e.g. ECG, Fetal Monitor strips)
   ~~d.~~

~~d.~~**D. REFERENCES:**

~~4.~~**1. 45 Code of Federal Regulations (CFR) Section 164.501**
~~5.~~**2. 45 CFR Section 164.524**
~~d.~~**3. 45 CFR Section 164.526**
~~d.~~**4. Amendment to Protected Health Information 8610-520.**

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 12/02 **SUBJECT: Notice of Privacy Practices**

REVISION DATE: 9/05, ~~53/15~~ **POLICY NUMBER:** 8610-518

Administrative Policies & Procedures Committee Approval:	**~~11/08~~05/15**
~~**Operations Team Committee Approval:**~~	~~**12/08**~~
~~**Professional Affairs Committee Approval:**~~	~~**01/09**~~
Audit and Compliance Committee Approval:	**06/15**
Board of Directors Approval:	**01/09**

A. **PURPOSE:**

1. To establish policy for documenting the acknowledgment of the patient's receipt of the Notice of Privacy Practices in accordance with the Health Information Portability and Accountability Act of 1996 (HIPAA) which gives patients the right to know the **U**~~u~~ses and **D**~~d~~isclosure of their protected health information.

B. **DEFINITIONS:**

1. **Disclosure: the release, transfer, provision of, access to or divulging of PHI outside Tri-City Healthcare District (TCHD).**
2. **Notice of Privacy Practices or NPP: TCHD~~TCMC~~'s written notice to individuals of Uses and Disclosures of PHI as required by 45 Code of Federal Regulations (CFR) Section 164.520.**
~~2.~~3. **Protected Health Information (PHI): individually identifiable health transmitted or maintained in paper or electronic form that is created or received by** TCHD **AND**
   a. **Relates to the past, present, or future physical or mental health or condition of an individual; OR**
   b. **Relates to the provision of health care to an individual; OR**
   ~~B.~~c. **Relates to the past, present, or future payment, AND**
   ~~C.~~d. **Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual**
~~1.~~4. **Use: the sharing, application, utilization, examination or analysis of PHI within TCHD**
Workforce: means employees, volunteers, trainees and other persons whose conduct in the performance of work for TCHD is under the control of TCHD whether or not they are paid by ~~TCMC~~TCHD.

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

1. In accordance with HIPAA, all patients **have a right to adequate notice of the Uses and Disclosures of PHI that may be made by ~~TCMC~~TCHD.**
2. **~~TCMC~~TCHD communicates Uses and Disclosures of PHI that may be made by ~~TCMC~~TCHD in its Notice of Privacy Practices.**
3. **~~TCMC~~TCHD** must **make the Notice of Privacy Practices available to patients as described in this Policy.**
4. **As provided under HIPAA, ~~TCMC~~TCHD is required to abide by the terms of the Notice that is currently in effect.**

D. **PROCEDURES~~S~~:**

1. **~~TCMC~~TCHD must make the NPP available as follows:**
   a. **~~TCMC~~TCHD must make the NPP available on request to any patient.**
   b. **Where ~~TCMC~~TCHD has a direct treatment relationship with an individual, it must also provide the NPP no later than the date of the first service delivery except for**

emergency treatment situations where the NPP can be provided as soon as practicable after the emergency treatment situation.

~~1. receive the Notice of Privacy Practice (attached) after 4/13/2003 or when the content of the Notice has been significantly changed, and document acknowledgement that it has been received.~~

2. **T**he ~~Notice~~ **NPP** will also be posted on the ~~TCMC~~**TCHD** Website **and will be made**~~,~~ available at all registration sites, in Administration, and with the Patient Representative. Registration or other points of entry to the Medical Center listed below will be the primary sites where this process takes place. Since a patient's condition or location may preclude documenting the acknowledgement at the time of registration or entry into the Medical Center, all Medical Center staff share the responsibility of ensuring ~~that the~~ acknowledgement **of the Notice** ~~is signed~~.
   a. Homecare
   ~~b. Hospice~~
   ~~c.~~**b.** Outpatient Rehabilitation
   ~~d.~~**c.** Outpatient Behavioral Health
   ~~e. Occupational Medicine~~
   ~~f.~~**d.** Obstetrics
3. **NPP Exception:** Lab specimens are an exception to this ~~p~~**P**olicy. No Notice of Privacy **Practices** will be offered because specimens are covered under the Indirect Treatment Relationship provision.
   ~~g.~~**a. Amendment of NPP: If the NPP is revised, ~~TCMC~~TCHD shall make the revised NPP available on request on or after the effective date of the revision in accordance with D.1 through D.3 above.**
4. **~~TCMC~~TCHD must document the patient's acknowledgment of receipt or good faith efforts to obtain the acknowledgement.**
   a. The Condition of Admissions document includes a section reflecting patient's acknowledgement that a NPP~~otice of Privacy Practice~~ has been offered and online access is available via ~~TCMC~~TCHD website is communicated. Patients will be asked to initial the Conditions of Admission acknowledgement referencing the most current version of the NPP, even if they have signed an acknowledgement of a previous version.
   ~~3.~~**b.** If the patient receives the N**PP**~~otice~~ and the acknowledgement section of the Conditions of Admissions is not initialed, ~~TCMC~~**TCHD** personnel must document good faith efforts to obtain it and the reason for lack of signature.

~~4. If the patient never receives the Notice when receiving services, TCMC personnel must mail a copy of the Notice to the patient and document good faith efforts to obtain it and the reason for lack of signature.~~

   ~~5.~~**c.** **T**he Notice of Privacy Practice acknowledgment need only be documented once, unless there is a significant content change in the Notice. Each new version of the Notice requires the patient to initial a new acknowledgement.

~~6.~~**5.** ~~TCMC~~**TCHD** has the right to change the N**PP**~~otice~~ at any time **including for the purpose of amending it to conform to changes in the law**. The effective date of the N**PP**~~otice~~ is ~~in the upper right hand~~ **located on the first page of the NPP**~~corner~~. ~~The current Notice will be posted in the Medical Center. Patients will be asked to initial the Conditions of Admission acknowledgement referencing the most current version of the Notice, even if they have signed an acknowledgement of a previous version.~~

6. **Retention of NPP:**
   ~~7.~~**a.** The completed Conditions of Admission acknowledgement will be kept in the patient's medical record for the encounter for which it was signed. ~~In addition, documentation of the patient's receipt of the acknowledgement will be housed in the computer system. A patient's signature documenting acknowledgment of receipt of the Notice is required~~.
   ~~8.~~**b.** ~~TCMC~~**TCHD** will retain the required documentation **related to the NPP** for at least 6 years from the date of creation or the date when it was last in effect whichever is later.

~~9. As provided under HIPAA, TCMC is required to abide by the terms of the Notice that is currently in effect.~~

~~10.~~**7.** **Training on NPP:** All employees of the Medical Center will be trained on and knowledgeable of the contents of the Notice because it documents how ~~the Medical Center~~ **TCMC**~~**C**~~**TCHD** will handle **Uses and Disclosures of its** patient~~'~~s**'** protected health information.

~~E. ATTACHMENTS:~~

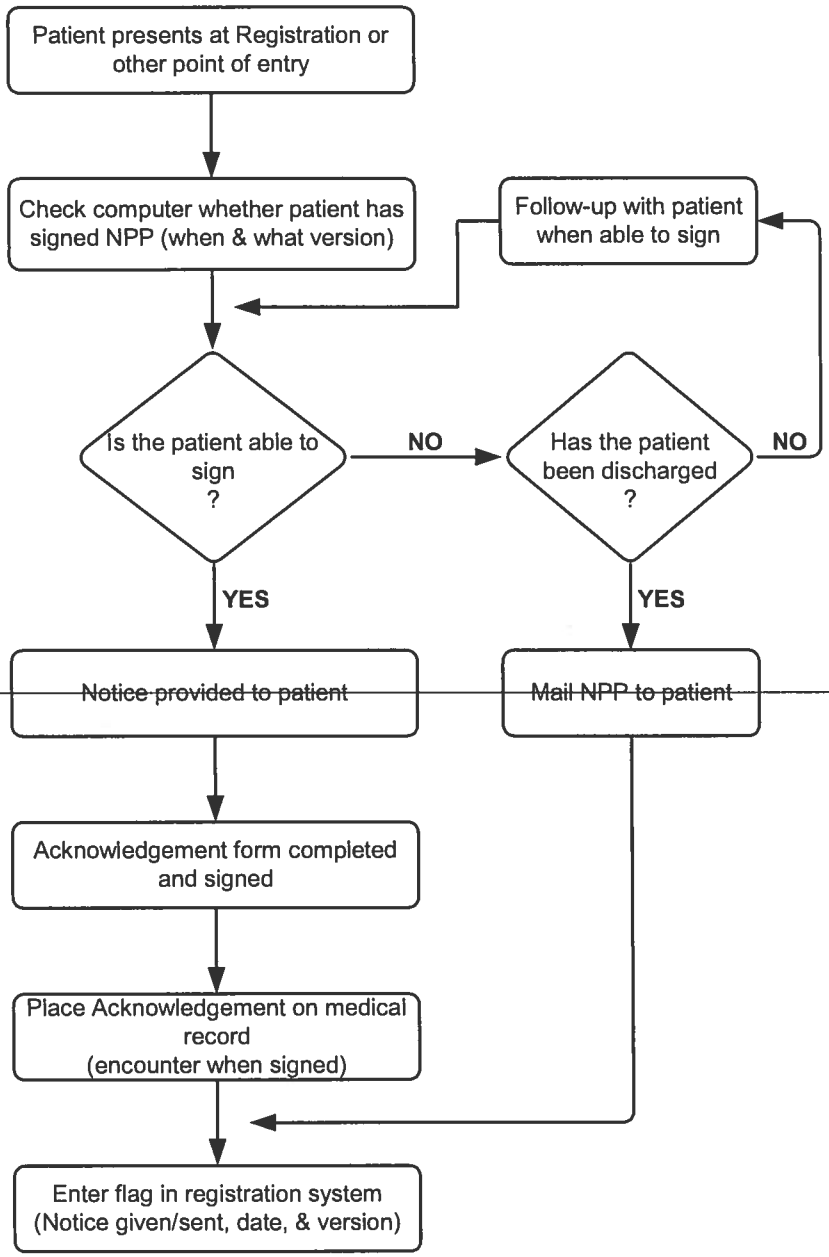
~~1.~~**8.** ~~Notice of Privacy Practice Work Flow~~

~~2.~~ Notice of Privacy Practices

~~F.~~**E. REFERENCES:**

1. ~~Federal Register~~ **45 Code of Federal Regulations (CFR)** section 164.520
2. ~~Department Specific Procedures (see 2.2)~~

NOTICE OF PRIVACY PRACTICE WORKFLOW



Notice-PrivacyPracticeWorkflow
12/31/02-km/ac

NOTICE OF PRIVACY PRACTICES

Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056

Effective: 9/23/13

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Privacy Officer, (760-940-3030).

[redacted]

This notice describes our hospital's practices and that of:

- **Any health care professional authorized to enter information into your hospital chart.**
- **All departments and units of the hospital.**
- **Any member of a volunteer group we allow to help you while you are in the hospital.**
- **All employees, staff and other hospital personnel.**

[redacted]

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the hospital. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the hospital, whether made by hospital personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- **Make sure that medical information that identifies you is kept private (with certain exceptions);**
- **Give you this notice of our legal duties and privacy practices with respect to medical information about you; and**
- **Follow the terms of the notice that is currently in effect.**

[redacted]

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

DISCLOSURE AT YOUR REQUEST

We may disclose information when requested by you. This disclosure at your request may require a written authorization by you.

FOR TREATMENT

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other hospital personnel who are involved in taking care of you at the hospital. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the hospital also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and X-rays. We also may disclose medical information about you to people outside the hospital who may be involved in your medical care after you leave the hospital, such as skilled nursing facilities, home health agencies, and physicians or other practitioners. For example, we may give your physician access to your health information to assist your physician in treating you.

FOR PAYMENT

We may use and disclose medical information about you so that the treatment and services you receive at the hospital may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give information about surgery you received at the hospital to your health plan so it will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also provide basic information about you and your health plan, insurance company or other source of payment to practitioners outside the hospital who are involved in your care, to assist them in obtaining payment for services they provide to you.

FOR HEALTH CARE OPERATIONS

We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the hospital and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many hospital patients to describe what additional services the hospital should offer, what services are not needed and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other hospital personnel for review and learning purposes. We may also combine the medical information we have with medical information from other hospitals to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

FUNDRAISING ACTIVITIES

We may use information about you, or disclose such information to a foundation related to the hospital, to contact you in an effort to raise money for the hospital and its operations. You have the right to opt out of receiving fundraising communications. If you receive a fundraising communication, it will tell you how to opt out.

HOSPITAL DIRECTORY

We may include certain limited information about you in the hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (e.g., good, fair, etc.) and your religious affiliation. Unless there is a specific written request from you to the contrary, this directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This information is released so your family, friends and clergy can visit you in the hospital and generally know how you are doing.

MARKETING AND SALE

Most uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of medical information, require your authorization.

TO INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE

We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. Unless there is a specific written request from you to the contrary, we may also tell your family or friends your condition and that you are in the hospital.

In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you arrive at the emergency department either unconscious or otherwise unable to communicate, we are required to attempt to contact someone we believe can make health care decisions for you (e.g., a family member or agent under a health care power of attorney).

FOR RESEARCH

Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, as long as the medical information they review does not leave the hospital.

AS REQUIRED BY LAW

We will disclose medical information about you when required to do so by federal, state or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

[redacted]

ORGAN AND TISSUE DONATION

We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

MILITARY AND VETERANS

If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

WORKERS' COMPENSATION

We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

PUBLIC HEALTH ACTIVITIES

We may disclose medical information about you for public health activities. These activities generally include the following:

- **To prevent or control disease, injury or disability;**
- **To report births and deaths;**
- **To report regarding the abuse or neglect of children, elders and dependent adults;**
- **To report reactions to medications or problems with products;**
- **To notify people of recalls of products they may be using;**
- **To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.**
- **To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;**
- **To notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.**

HEALTH OVERSIGHT ACTIVITIES

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

LAWSUITS AND DISPUTES

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

LAW ENFORCEMENT

We may release medical information if asked to do so by a law enforcement official:

- **In response to a court order, subpoena, warrant, summons or similar process;**
- **To identify or locate a suspect, fugitive, material witness, or missing person;**
- **About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;**
- **About a death we believe may be the result of criminal conduct;**
- **About criminal conduct at the hospital; and**
- **In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.**

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS

We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

INMATES

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose medical information about you to the correctional institution or law enforcement official. This disclosure would be necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution.

MULTIDISCIPLINARY PERSONNEL TEAMS

We may disclose health information to a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

SPECIAL CATEGORIES OF INFORMATION

In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described in this notice. For example, there are special restrictions on the use or disclosure of certain categories of information — e.g., tests for HIV or treatment for mental health conditions or alcohol and drug abuse. Government health benefit programs, such as Medi-Cal, may also limit the disclosure of beneficiary information for purposes unrelated to the program.

[redacted]

You have the following rights regarding medical information we maintain about you.

RIGHT TO INSPECT AND COPY

You have the right to inspect and obtain a copy of medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include some mental health information.

To inspect and obtain a copy of medical information that may be used to make decisions about you, you must submit your request in writing to the Medical Records / Health Information department, (760-940-3025). If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and obtain a copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

RIGHT TO AMEND

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the hospital.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- **Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;**
- **Is not part of the medical information kept by or for the hospital;**
- **Is not part of the information which you would be permitted to inspect and copy; or**
- **Is accurate and complete.**

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach

it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

RIGHT TO AN ACCOUNTING OF DISCLOSURES

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations (as those functions are described above), and with other exceptions pursuant to the law.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

In addition, we will notify you as required by law following a breach of your unsecured protected health information.

RIGHT TO REQUEST RESTRICTIONS

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request, except to the extent that you request us to restrict disclosure to a health plan or insurer for payment or health care operations purposes if you, or someone else on your behalf (other than the health plan or insurer), has paid for the item or service out of pocket in full. Even if you request this special restriction, we can disclose the information to a health plan or insurer for purposes of treating you.

If we agree to another special restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and 3) to whom you want the limits to apply, for example, disclosures to your spouse.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

RIGHT TO A PAPER COPY OF THIS NOTICE

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website: http://www.tricitymed.org

To obtain a paper copy of this notice, please contact:

Privacy Officer

Tri-City Medical Center

(760-940-3030)

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the hospital. The notice will contain the effective date on the first page, in the top right-hand corner. In addition, each time you register at or are admitted to the hospital for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the hospital, contact:

Customer Relations Department
Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056
Telephone: 760-940-7466

***All complaints must be submitted in writing**

You will not be penalized for filing a complaint.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 01/03

SUBJECT: Amendment to Protected Health Information

REVISION DATE: 04/03, 12/05

POLICY NUMBER: 8610-520

Administrative Policies & Procedures Committee Approval:	**~~01/09~~05/15**
~~Operations Team Committee Approval:~~	**~~01/09~~**
~~Professional Affairs Committee Approval:~~	**~~02/09~~**
Audit and Compliance Committee Approval:	**06/15**
Board of Directors Approval:	**02/09**

A. **PURPOSE:**

1. To establish the mechanism for patients to request amendments to their health information in the medical record if they believe his/her information is inaccurate, incomplete, or incorrect.

B. **DEFINITIONS:**

1. **Business Associate: ~~means,~~ a person or organization who, on behalf of ~~the~~ Tri-City HealthCare District (TCHD), performs certain functions or activities or services that require the Business Associate to create, receive, maintain or transmit PHI on behalf of the ~~District~~ TCHDor where the District needs to Disclosure PHI to Business Associate for the services.**
2. **Designated Record Set: those documents, whether maintained in paper, film or electronic formats, that comprise the ~~i~~Individual's ~~patient's~~ medical record as approved by the Medical Executive Committee, that comprise the ~~i~~Individual's ~~patient's~~ billing records, and any documents used in whole or in part by ~~Tri-City Healthcare District~~ TCHDto make decisions about individuals including copies from another health care provider's designated record set.**
3. **Individual: ~~means~~ the person who is the subject of protected health.**

B. POLICY:

1. **~~Tri-City Healthcare District~~ (TCHD) shall respond to patients' requests for amendments to their health information in accordance with HIPAA requirements.**
2. **Patients shall submit requests for amendment in writing and provide a reason to support the requested amendment.**

~~C.~~

~~D.~~**C. ~~POLICY~~ PROCEDURES:**

1. Adult patients **and emancipated minors** have the right to request an amendment to their Protected Health Information (PHI) created by ~~Tri-City Medical Center (TCMC)~~ **TCHD** at any time while the organization maintains the information.
2. ~~TCMC~~**TCHD** will provide notification of agreement or denial of the patient's request no later than 60 days from receipt of the request. One 30-day extension may be obtained.
3. Direct all patients who request to make an amendment to their health record to the Medical Records/Health Information Department.
4. Notify patients that their request must:
   a. Be submitted in writing, provide form (Request to Amend Protected Health Information)
   b. Written addendum added to their record is limited to 250 words or less
   c. Include a reason for the requested amendment
   d. Identify others who patient believes need the amendment

5. To obtain a 30-day extension for the ~~Medical Center~~ **TCHD** response to a requested amendment, Medical Records Director/Privacy Officer will notify patients, within 60 days of their amendment request via the Response to Request to Amend Protected Health Information letter:
   a. ~~The Medical Center~~**TCHD**'s need for a 30-day extension for responding to their request
   b. Reason for extension
   c. Date by which request will be processed.

~~6.~~ The Medical Records/Health Information Department ~~will~~**may** coordinate review of submitted amendment request with ~~the Director of Legal Services~~ **legal counsel**. The physician or clinical staff involved may be consulted on the request to:
   a. Determine impact on care of the patient.
   b. Identify ~~b~~**B**usiness ~~a~~**A**ssociates who may have relied or could potentially rely on the amended information to the detriment of the patient.
   c. Provide a recommendation for agreement or denial of requested amendment.

7. Agreement with requested amendment
   a. Director of Medical Records/Privacy Officer will notify patient of agreement for their request via the Response to Request to Amend Protected Health Information letter.
   b. Request that the patient identify others who they believe need the amendment, and for permission to send the amendment to those identified.
      i. **T**he Notification of Amendment to Protected Health Information is to be completed and sent to all parties identified by the patient for which permission has been obtained.
   c. Identify all portions of the medical record that are the subject of the accepted amendment.
   d. Add the amendment to the medical record. Corrections may be documented by drawing a line through the incorrect information, recording the correct information and recording your name and date next to the change.
   e. Obtain ~~a~~**A**uthorization from the patient for release of information to each ~~b~~**B**usiness ~~a~~**A**ssociate identified by the patient ~~or Director of Legal Services~~.

8. Denial of requested amendment
   a. Document reason for denial of the request for amendment via the Response to Request to amend Protected Health Information letter:
      i. A reason was not included to support patient's request ~~**unless the individual provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment.**~~
      ii. PHI in the medical record is accurate and complete based upon review completed within the Medical Center
      iii. PHI was not created by ~~TCMC~~**TCHD, unless the Individual provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment.**
      iv. PHI is not part of the **Designated Record Set** ~~patient's medical record~~**.**
      v. **Would not be available under** Federal/State law ~~forbids making the PHI in question available~~ to the patient for inspection (i.e. psychotherapy notes)

   b. Consult **with** the Legal Services Department **regarding written notice of denial to the patient. TCHD~~MC~~ shall provide a timely, written denial to the patient which shall include:**
      ~~b.~~i. Basis for denial may file the statement;
      ii. Patient's right to submit a written statement that, if the patient does not submit a written statement disagreeing with the denial and how the patient may file the statement;
      iii. A statement that, if the patient does not submit a statement, the patient may request that ~~TCMC~~TCHD provide the patient's request for amendment and the denial with any further disclosures of PHI that is subject of the amendment;
      ~~c.~~iv. A description of how the patient may complain to ~~TCMC~~TCHD or the Secretary pursuant to the complaint procedures (including the name or title

and telephone number of the contact person or designated office). to prepare written notice to the patient to include basis for denial~~.~~

~~d.~~**c.** Inform the patient that they have the right to resubmit disagreement with the denial at which time a rebuttal statement must be provided to the patient. (Statement of Disagreement/Request to Include Amendment Request and Denial with Future Disclosures form)

~~e.~~**d.** ~~TCMC~~**TCHD may provide a written rebuttal to the patient's statement of disagreement. In such cases,** ~~TCMC~~**TCHD shall provide a copy of the rebuttal to the patient who submitted the statement of disagreement.** ~~**In such cases, TCMC shall provide a copy of the rebuttal to the patient who submitted the statement of disagreement.**~~

9. Amendments added to the health record will be included in disclosures of health information to any third party. In addition, include the communications of corrections, denial, rebuttals, etc. with all future disclosures.

~~10.~~**a. If a statement of disagreement has been submitted by the patient, TCHD must include the material appended or, at the election of** TCHD**, an accurate summary of any such information, with any subsequent disclosure of the PHI to which the disagreement relates.**

~~11.~~**b. If the patient has not submitted a written statement of disagreement, TCHD must include the patient's request for amendment and its denial, or an accurate summary of such information with any subsequent disclosure of PHI only if the patient has requested such action**

~~12.~~**c. When a subsequent disclosure is made with respect to 9a or 9b, using a standard transaction that does not permit the additional material to be included with the disclosure, TCHD may separately transmit the material to the recipient of the standard transaction.**

~~a.~~**d.** Amendment communications **tare scanned to the electronic health record to the encounter to which the amendment applies.** ~~**(Administrative**will be filed beneath the facesheet of the patient's most current medical record and any records referenced in the amendment~~.

~~b.~~**e.** Medical Records/Health Information Release of Information team members ~~to~~**must** include this information when complying with future requests for release of records **if as required above.**~~.~~

~~13.~~**10.** Receipt of information in the addendum that contains defamatory or otherwise unlawful language, and the inclusion of that language in the record shall not, in and of itself, subject the health care provider to liability in any civil, criminal, administrative or other proceeding.

~~14.~~**11.** When ~~TCMC~~**TCHD** is in receipt of notification of amendment from another health care provider that a patient's PHI has been amended the following steps will be taken:

a. The amendment and notification will be appended to the patient's medical record

b. ~~TCMC~~**TCHD** will inform its business associates that may use or rely on that patient's PHI of the amendment so that they may make the necessary revisions based on the amendment.

~~15.~~**12.** Verbal requests to correct/amend financial or demographic data will be accepted. Completion of the Request to Amend Protected Health Information form will not be necessary.

~~E.~~D. REFERENCES:

1. Cali**fornia**~~.~~ Health & Safety Code § 123111
2. **42 Code Federal Regulations (CFR) Section 164.306**

~~2.~~**3. 42 CFR Section 164.530**

~~**42 CFR 164.306**~~

4. 42 CFR ~~Sections~~ **Section** 164.526~~,~~

~~3.~~**5. 42 CFR Section 160.103**

~~4.~~**6. Administrative Policy – Compliance** ~~**AP&P**~~**Privacy: Designated Record Set** ~~**No.**~~ **8610-514**

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 4/03

SUBJECT: Accounting of Disclosures of Protected Health Information (PHI)

REVISION DATE:

POLICY NUMBER: 8610-528

Administrative Policies & Procedures Committee Approval:	**~~01/09~~05/15**
~~**Operations Team Committee Approval:**~~	~~**01/09**~~
~~**Professional Affairs Committee Approval:**~~	~~**02/09**~~
Audit and Compliance Committee Approval:	**06/15**
Board of Directors Approval:	**02/09**

A. **PURPOSE:**

1. To outline steps to be taken ~~to support the provision of the HIPAA Privacy regulations that~~ **when** a patient **exercises his or her** ~~has a~~ right to request an accounting of ~~d~~**D**isclosures made regarding ~~their~~ **his or her** Protected Health Information.

B. **DEFINITIONS:**

1. Disclosure: – the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.
2. Individual: **the person who is the subject of protected health.**
3. **Limited Data Set: is information that may be Disclosed to an outside party without a patient's authorization if certain conditions are met as provided by Health Insurance Portability and Accountability Act (HIPAA).**
4. **Protected Health Information (PHI): individually identifiable health transmitted or maintained in paper or electronic other form that is created or received by TCMC AND**
   - **a. Relates to the past, present, or future physical or mental health or condition of an individual; OR**
   - **b. Relates to the provision of health care to an individual; OR**
   - **c. Relates to the past, present, or future payment, AND**
   - **d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.**
5. **Research: ~~insert~~a systemicatic investigation including research development, testing and evaluation designed to develop or contribute to generalizable knowledge.**

~~3. Protected Health Information (PHI) – individually identifiable health information that:~~
   - ~~a. Relates to the past, present, or future physical or mental health or condition of an individual~~
   - ~~b. Relates to the provision of health care to an individual~~
   - ~~c. Relates to the past, present, or future payment for the provision of health care to an individual~~
   - ~~d. Identifies the individual.~~

C. **POLICY:**

1. Tri-City Healthcare District (TCHD) must furnish, upon request by the ~~i~~**I**ndividual who is the subject of the Protected Health Information (PHI), an accounting of certain ~~d~~**D**isclosures of the ~~i~~**I**ndividual's PHI made by ~~Tri-City Medical Center (TCMC)~~ **it** and its Business Associates in the six years prior to the date on which the accounting is requested.
2. **Patients have a right to an accounting of D~~d~~isclosures of PHI except where not required by HIPAA as described as ~~in E~~excepted by HIPAA~~ions~~. TC~~MC~~HD shall provide the ~~i~~Individual with the written accounting in the time and manner required by HIPAA as described in this**

Policy.

~~2.~~**3.** **TCHD is required to provide** ~~Application of~~ **an** ~~A~~accounting of Disclosures **including related to the following Disclosures:**

a. **T**o the Secretary of Health and Human Services for compliance investigation purposes.
b. Disclosures not permitted by law or authorized by patient (i.e. Unintentional **D**~~d~~isclosures).
c. Related to child abuse, neglect, or domestic violence.
d. For judicial and administrative proceedings.
e. For law enforcement purposes (this entity may request that we delay ~~d~~**D**isclosure)~~.~~.
f. For certain public health activities including:
   i. Disclosures for the purpose of preventing or controlling disease.
   ii. Disclosures related to victims of child abuse or neglect.
g. Health oversight activities.
h. About decedents.
i. For purposes of cadaver organ donation.
j. For research we are allowed to conduct without a patient's authorization.
k. To avert a serious threat to health or safety.
l. For specialized government functions.
m. **T**o correctional institutions.
n. For worker's compensation.
o. For certain marketing and fundraising exceptions.

~~3.~~**4.** **TC~~M~~~~C~~HD is not required to provide an accounting for the following types of ~~d~~Disclosures:** ~~Accounting of Disclosures Exceptions~~

a. To the individual or patient representative.
b. To carry out treatment, payment, and healthcare operations.
c. Pursuant to an authorization of the individual.
d. With patient's verbal agreement to:
   i. Include information in facility directory
   ii. Disclose information to:
      1) Next of kin
      2) Personal friend
      3) Person involved in individual's care
e. Incidental to a permitted use or ~~d~~**D**isclosure.
f. For national security or intelligence purposes.
g. To correctional institutions or law enforcement officials.
h. Disclosures made prior to the compliance date.
i. As part of a Limited Data Set (LDS).

D. **PROCEDURES:**

1. **T**imeframe for Providing Accounting of Disclosures
   ~~2.~~**a.** TCHD must act on a request for an accounting of ~~d~~**D**isclosures no later than 60 days from the date that the request is received. ~~I~~
   ~~3.~~**b.** **I**f TCHD is unable to comply within 60 days, the deadline can be extended by 30 days, ~~yet we are~~ **however, TCHD is** obligated to state in writing~~,~~ to the requestor the reason for the delay, and the day by which ~~we~~**TCHD** will fulfill the request. ~~.~~
   ~~a.~~**c.** Information to be included will reflect ~~d~~**D**isclosures made for the last six (6) years beginning April 14, 2003.
~~4.~~**2.** Required Content of Accounting of Disclosures
   a. **T**CHD will provide the following information for each accounting:
      i. **T**he date of the **D**~~d~~isclosure.
      ii. The name of the entity or person that received the PHI and if known, the address of such person or entity.
      iii. A brief description of the PHI ~~d~~**D**isclosed.
      iv. A brief statement of the purpose of the ~~d~~**D**isclosure that reasonably informs the individual of the basis for the ~~d~~**D**isclosure; or in lieu of such a statement:

1) A copy of the individual's written authorization for the ~~d~~**D**isclosure OR
2) A copy of the written request for a **D**~~d~~isclosure permitted under the Privacy Rule, if any.

~~5.~~**3.** How to Respond to Request for Accounting of Recurring Disclosures

a. If, during the period covered by the accounting, TCHD has made multiple ~~d~~**D**isclosure**s** of PHI to the same person or entity for a single purpose related to investigations or compliance with the Privacy Rule, under the public policy ~~d~~**D**isclosures (that do not require consent or authorization), ~~for~~ pursuant to a single authorization from the ~~i~~**I**ndividual, TCHD may satisfy the accounting requirement for multiple ~~d~~**D**isclosures by providing:
   i. The date of the first ~~d~~**D**isclosure during the accounting period.
   ii. The name of the entity or person that received the PHI and if known, the address of such person or entity.
   iii. A brief description of the PHI ~~d~~**D**isclosed.
   iv. A brief statement of the purpose of the ~~d~~**D**isclosure that reasonably informs the individual of the basis for the ~~d~~**D**isclosure; or in lieu of such a statement:
      1) A copy of the ~~i~~**I**ndividual's written authorization for the ~~d~~**D**isclosure OR
      2) A copy of the written request for a ~~d~~**D**isclosure permitted under the Privacy Rule, if any.
   v. **T**he frequency, periodicity or number of ~~d~~**D**isclosures made during the accounting period.
   vi. The date of the last such **D**~~d~~isclosure during the accounting period.

~~6.~~**4.** Disclosures of PHI for Research purposes

~~7.~~**a.** **T**he accounting will be referenced to a specific IRB protocol with reference to the patient to notify the Privacy Officer for specific information relating to the protocol.

~~a.~~**b.** Information relating to the protocol must include the following and will be prepared by the Research Coordinator:
   ~~b.~~**i.** Name of the protocol.
   ~~i.~~**ii.** Description and purpose of ~~r~~**R**esearch and criteria used for selecting particular records.
   ~~c.~~**iii.** Brief description of type of PHI ~~d~~**D**isclosed as part of the **R**~~r~~esearch.
   ~~d.~~**iv.** Date or period of time during with ~~d~~**D**isclosure(s) occurred, including date of last **D**~~d~~isclosure during accounting period.
   ~~e.~~**v.** Name, address, telephone number of entity that sponsored the ~~r~~**R**esearch and of the researcher to whom the information was disclosed.
   ~~f.~~**vi.** Statement the PHI of the ~~i~~**I**ndividual may or may not have been disclosed for a particular protocol or other **R**~~r~~esearch activity.
   ~~g.~~**vii.** Offer to assist the requestor with contacting the entity that sponsored the **R**~~r~~esearch and the researcher.

~~8.~~**5.** Applicable Fees

a. TCHD may not charge a fee for providing an accounting, unless the ~~i~~**I**ndividual makes more than one request within a 12-month period. In cases of multiple requests, the individual will be charged clerical costs of $4.00 per quarter hour plus $0.10 cents per printed page.

~~a.~~**b.** **The patient may withdraw Request for an Accounting throughu written notification to the Privacy Officer.**

~~9.~~**6.** Maintaining a Log of Accountings of Disclosures

a. The Privacy Rules require that the following information be documented by TCHD:
   i. Information to be included in an accounting.
   ii. Accounting provided to the requesting ~~i~~**I**ndividual.
   iii. **T**itles of persons or office (Medical Records/Health Information) responsible for processing requests for accountings by ~~i~~**I**ndividuals.
   iv. Individuals who complete ~~d~~**D**isclosures of PHI are required to complete an Accounting of Disclosures Form and submit it to the Privacy Officer for data entry and tracking capabilities.

E. REFERENCES:

1. **42 Code of Federal Regulations (CFR) Section 160.103**
2. **42 CFR Section 164.528**

Tri-City Health Care Distri
Oceanside, California

Delete: Duplicative of Policy # 557

Administrative Policy Manual
Compliance

~~**ISSUE DATE: 5/99**~~ ~~**SUBJECT: Confidential Reporting Line (Values Line)**~~

~~**REVISION DATE: 4/03; 12/05; 01/09; 02/11**~~ ~~**POLICY NUMBER: 8610-505**~~

Administrative Policies & Procedures Committee Approval:	**~~12/10~~05/15**
~~**Executive Council Approval:**~~	~~**01/11**~~
~~**Professional Affairs Committee Approval:**~~	~~**02/11**~~
Audit and Compliance Committee Approval:	**06/15**
Board of Directors Approval:	**02/11**

A. ~~**PURPOSE:**~~

1. ~~To ensure availability of a confidential reporting process.~~
2. ~~To ensure compliance with the Office of the Inspector General and office of Civil Rights Privacy Program Guidance.~~
3. ~~To establish guidelines for utilization of the Confidential Reporting Line (Values Line).~~

B. ~~**POLICY:**~~

1. ~~The Values Line is available 24 hours a day, 365 days a year at 1-800-273-8452.~~
2. ~~Callers may choose to voluntarily identify themselves. If the caller wishes to remain anonymous, his/her identity will be protected.~~
3. ~~Callers may report without fear of retaliation or retribution.~~
4. ~~Call tracking, tracing, or recording will not be utilized.~~
5. ~~Corrective and/or disciplinary action will be based on the results of a complete investigation.~~
6. ~~A communications specialist answers each call.~~
7. ~~The caller may be asked questions by the communications specialist to clarify the concern and ensure accuracy.~~
8. ~~The call is assigned a priority rating.~~
   a. ~~"A" priority: An "A" priority call requires immediate action and notification of the Compliance Officer, Privacy officer or designee. An "A" priority call involves an allegation of threat to person, place, or environment. Follow-up date is one day after the original call.~~
   b. ~~"B" priority: A "B" priority call is one that requires verbal notification to the Compliance Officer, or Privacy Officer or designee during normal business hours or on the next business day if received after normal business hours. Follow-up date is 5 business days after the original call.~~
   c. ~~A "C" priority call does not require an immediate response. Follow-up date is 21 days after the original call.~~
9. ~~The call is assigned a designation as Compliance or Privacy issue for follow-up by the individual as identified below:~~
   i. ~~Compliance Issue~~
      1) ~~Compliance Officer~~
      2) ~~Privacy Officer~~
      3) ~~Director of Legal Services~~
      4) ~~Chief Operating Officer/Chief Nurse Executive~~
      5) ~~Risk Manager~~
      6) ~~Director of Human Resources~~
   ii. ~~Privacy Issue~~
      1) ~~Privacy Officer~~
      2) ~~Compliance Officer~~
      3) ~~Director of Legal Services~~

4) Chief Operating Officer/Chief Nurse Executive
5) Risk Manager
6) Director of Regulatory Compliance

10. The caller is then assigned a control number for follow-up.
11. The caller is assigned a follow-up date, established according to the priority of the caller's concern. This allows time for an investigation of the concern and provides a method for the Compliance or Privacy officer to communicate (anonymously if necessary) with the caller.
12. During the follow-up, the caller is provided with an opportunity to report additional information and/or receive a status of their call disposition.
13. Calls will be classified as follows:
    a. Compliance
        i. Conflict of Interest
        ii. Environment
        iii. Employee concerns
        iv. Fraud and abuse
        v. Harassment-Bias
        vi. Harassment -sexual
        vii. Human relations or employee concerns
        viii. Policy violation
        ix. Safety violation
        x. Substance abuse-Alcohol
        xi. Substance abuse-Drugs
        xii. Time abuse
        xiii. Theft
        xiv. Workplace violence
        xv. Other
    b. Privacy
        i. Patient Violation
        ii. Employee Violation
        iii. Physician Violation
        iv. Privacy violation
        v. Privacy Questions
        vi. Other
14. Monthly reports and statistics will be generated by a contracted third party and forwarded to both the Compliance and Privacy officers.
15. After hours, on holidays and weekends, a contracted third party notifies one of the following of a priority "A" issue.
    a. Risk Manager
    b. Compliance Officer;
    c. Privacy Officer;
    d. Director of Legal Services;
    e.a. Chief Operating Officer/Chief Nurse Executive

Tri-City Health Care Dis
Oceanside, California

Administrative Policy Mar
Compliance ~~Program Mar~~

DELETE: Incorporated into Policy #556 Communicating and Reporting Compliance Concerns

~~**ISSUE DATE: May 31, 2012**~~ ~~**SUBJECT: Communicating and Reporting Compliance Concerns; In General**~~

~~**REVISION DATE:**~~ ~~**POLICY NUMBER: 8750-555**~~

Administrative Policy & Procedures Committee Approval: **05/15**
Audit and Compliance Committee Approval: **06/15**
Board of Directors Approval: **May 31, 2012**

~~A. PURPOSE:~~

~~Policy 8750-555 sets forth Tri-City Healthcare District's commitment to develop and shall foster a culture of open communication regarding Compliance Program matters so that questions are freely asked and suspected misconduct and irregularities are reported.~~

~~B. GENERAL POLICY:~~

~~District is committed to developing and maintaining open lines of communication regarding Compliance Program matters in an effort to prevent and detect violations of applicable laws and regulations, the Code of Conduct and the Compliance Program Policies and Procedures. Such communication shall occur without fear of retribution or retaliation. It also can be effected on an anonymous basis.~~

~~C. QUESTIONS RELATING TO MONITORING COMPLIANCE:~~

~~Any questions about Policies 8750-555 through 8750-557 should be directed to the Chief Compliance Officer.~~

~~D. AUDIT AND DOCUMENTATION:~~

~~The District shall audit and document compliance with Policies 8750-555 through 8750-557, pursuant to Policy 8750-553. Relevant documentation shall be maintained in the District's compliance files, consistent with District's document retention policies.~~

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE:

SUBJECT: Communicating and Reporting Compliance Concerns; Reporting of Suspected Misconduct/Potential Irregularities

REVISION DATE: 5/12

POLICY NUMBER: 8750-556

Administrative Policies & Procedure Committee Approval Date(s): 05/15
Audit and Compliance Committee Approval Date(s): 06/15
Board of Directors Approval Date(s): 05/12

A. **PURPOSE:**

1. ~~Policy 8750-556~~ **This Policy sets forth the commitment of Tri-City Healthcare District (TCHD) to develop and foster a culture of open communication regarding Compliance Program matters so that questions are freely asked and suspected misconduct and irregularities are reported.** ~~provides (1) a statement of Tri-City Healthcare District's **TCHD's** policy with respect to the reporting of **such** suspected misconduct or potential compliance irregularities, and (2) to ensure that the District's practices are consistent with the stated policy.~~

B. **POLICY~~IES~~:**

~~C.~~**1.** ~~District~~ **TCHD shall develop and maintain open lines of communication regarding Compliance Program matters in an effort to prevent and detect violations of applicable laws and regulations, the Code of Conduct and the Compliance Program Policies and Procedures. Such communication shall occur without fear of retribution or retaliation. It also can be made on an anonymous basis.**

2. **TCHD employees have a duty to report suspected misconduct or other activity that the employee in good faith believes violates or may violate any laws, regulations, District Policies and Procedures or the TCHD Code of Conduct.**

~~B.~~**C. PROCEDURES FOR REPORTING SUSPECTED MISCONDUCT AND FOLLOW-UP ACTIONS:**

1. Reporting Required:~~.~~

~~1.~~**a.** ~~**All District**~~ **TCHD employees** ~~**have a duty to**~~ **shall report any suspected misconduct or any other activity, practice or arrangement that the employee in good faith believes violates or may violate any laws, regulations, District Policies and Procedures or its Code of Conduct**~~.~~

2. To Whom.
   a. Reporting of potential compliance irregularities must be made to the employee's direct supervisor~~,~~ **or** the Compliance Officer~~,~~ or the Values Line.
   b. Reporting of suspected employee misconduct should be reported to the employee's direct supervisor, Human Resources, or the Values Line.

~~C.~~**D. FORM OF REPORT - PROCEDURE**.

1. Reports of suspected misconduct or potential irregularity may be made either in writing or orally.
2. Written reports include reports made via regular mail or email. Such reports should

be sent addressed to the Compliance Officer at Tri-City Healthcare District, 4002 Vista Way, Oceanside, CA 92056, or to the employee's supervisor.

3. Oral reports include reports made in-person or via telephone. Oral reports may be made to District's Confidential Reporting Line (Values Line) at 1-800-273-8752. The confidential Reporting Line is operated by an independent third party and shall be available 24 hours per day, 7 days per week. Employees do not need to provide their names when making a report, although they are encouraged to do so to facilitate any appropriate or necessary follow up. An interview specialist will log the employees concern and assign a reference number. If the employee calls back and provides the reference number, he or she will be able to obtain an update on the status of the matter.
4. Anonymity. Reports, whether written or oral, may be made anonymously. However, employees are encouraged to identify themselves when reporting, as it often is easier to assess the issues or concerns raised in a report when there isthe ability to ask the reporting employee follow-up questions.
5. **Compliance Officer Actions.**
   - **a. The Compliance Officer shall document follow-up action taken as a result of any written or oral reports.**
   - **~~a.~~b. The Compliance officer shall keep confidential (to the extent possible)the identity of the person(s) who report suspected misconduct.**
   - **c. The Compliance officer shall provide to the CEO and the Board, as appropriate, a quarterly summary of any action taken in response to reports that have been verified as compliance or legal violations.**
   - **d. The Compliance Officer shall make available every report of suspected misconduct to any independent review team charged with conducting annual Compliance Reviews. An Independent review teal shall provide a summary of all reports of suspected misconduct in its findings and conclusions to the Compliance Officer and the CEO**

~~D.~~E. DOCUMENTATION:

1. The Compliance Officer shall maintain, in appropriately designated Compliance Program files, copies of any written reports submitted pursuant to Policy 8750- 556.
2. The Compliance Officer shall document any oral reports submitted pursuant to Policy 8750-556 and shall maintain such documentation in the Compliance Program files.
3. The Compliance Officer shall maintain copies of all reports submitted to the Confidential Reporting Line (Values Line) in the Compliance Program files.
4. In conformity with generally accepted compliance review procedures, final copies of work papers, notes and other documentation generated in connection with every written or oral report shall be maintained in the Compliance Program files.
5. The Compliance Officer shall document follow-up action taken as a result of any written or oral reports and shall maintain such documentation in the Compliance Program files.
6. The Compliance Officer shall keep confidential (to the extent possible) the identity of the person(s) who reports suspected misconduct.
7. The Compliance Officer shall provide to the CEO and the Board, as appropriate, a quarterly summary of any action taken in response to reports that have been verified as compliance or legal violations.
8. The Compliance Officer shall make available every report of suspected misconduct to any independent review team charged with conducting Annual Compliance Reviews. An independent review team shall provide a summary of all reports of suspected misconduct in its findings and conclusions to the Compliance Officer and the CEO.
9. All documentation enumerated above shall be maintained consistent with the District's document retention policies.

F. QUESTIONS RELATING TO MONITORING COMPLIANCE::

1. **Any questions about Policies 8750-556 and 8750-557 should be directed to the Chief Compliance Officer.**

G. **AUDIT AND DOCUMENTATION:**

1. **TCHD shall audit and document compliance with Policies 8750-556 and 8750-557, pursuant to Policy 8750-553. Relevant documentation shall be maintained in the District's compliance files, consistent with the District's document retention policies.**

H. **RELATED DOCUMENTS:**

1. **Administrative Policy 8750 553 Monitoring Compliance Auditing and Reporting – Compliance Reviews and Audits**
2. **Administrative Policy 8750 557 Communicating and Reporting Compliance Concerns (Values Line)**

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

May 28, 2015 – 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 May 28, 2015.

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

Director James Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, M.D.
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry Schallock

Also present were:

Greg Moser, General Legal Counsel
Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Esther Beverly, VP/Human Resources
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 Dagostino to approve the agenda as presented. Director Kellett seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairman Schallock read the Public Comments section listed on the May 28, 2015 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, Mr. Moser made an oral announcement of the items listed on the May 28, 2015 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; three Reports Involving Trade Secrets; Conference with Legal Counsel regarding two matters of potential litigation; Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Appointment of Public Employee: Chief Compliance Officer; Conference with Legal Counsel regarding five matters of Existing Litigation; Approval of Closed Session Minutes and Public Employee Evaluation: Chief Executive Officer.

5. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Nygaard to go into Closed Session. The motion passed unanimously (7-0).

6. The Board adjourned to Closed Session at 1:35 p.m.

8. At 3:38 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 James Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Greg Moser, General Legal Counsel
Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operations 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 stated no action was taken in closed session, however the Board will be returning to closed session at the conclusion of this meeting to conduct unfinished business.

Chairman Schallock reported earlier this afternoon agenda item 20 D. 2) Approval of ED On Call Agreements with Drs. Frank Corona, Safouh Malhis, Martin Nielsen and Mark Yamanaka for a term of 12 months beginning July 1, 2015 through June 30, 2016, not to exceed a daily rate of $897.00 and a total collective cost for the term of $328,302.00, split between panel physicians was pulled from the agenda for additional review.

10. Chairman Schallock noted all Board members were present. Director Dagostino 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 24.

12. Special Presentations:
(1) Recognition of Nurses of the Year

Ms. Sharon Schultz stated every year we acknowledge our nurses during Nurse's week and choose a nurse of the year from the inpatient and outpatient settings as well as one from of our support staff.

Ms. Schultz invited Ms. Monica Trudeau, Director of Home Health to introduce Ms. Anna Wong-Yee, Outpatient Nurse of the Year.

Ms. Trudeau introduced Ms. Anna Won-Lee. She stated Ms. Won-Lee stands out among her peers and is a leader who creates a highly superior patient experience. Ms. Trudeau read excerpts from patients who praised Ms. Won-Lee for her outstanding care and compassion. Ms. Trudeau stated Ms. Won-Lee is very deserving of this recognition and is proud to have her part of her team.

Ms. Schultz invited Ms. Diane Sikora, Manager for I North to introduce Ms. Luz Leal, ACT, Patient Care Support Staff of the Year for 1 North. Ms. Sikora spoke regarding her personal experience while working with Ms. Leal and her ability to make a very human connection with patients. Ms. Sikora stated Ms. Leal is very deserving of this recognition and thanked Ms. Leal for being on her team.

Ms. Schultz stated Ms. Camille Bryan was awarded Inpatient Nurse of the Year but was unable to be here today.

Chairman Schallock read an e-mail that Ms. Bryan sent in her absence. She stated it has been a privilege to work in the ICU and is extremely proud to be a nurse at Tri-City where she believes the care is exceptional.

Ms. Schultz stated Ms. Bryan is very deserving of this recognition. She stated that not only does she go out of her way in the patient setting but also works on many of the nursing practice issues.

Directors acknowledged the recipients of today's awards as well as the many fine nurses here at Tri-City.

13. Report from TCHD Auxiliary – Sandy Tucker, President

Ms. Sandy Tucker expressed her gratitude to the Marketing Department for the Appreciation Luncheon that was held recently. She stated the Department Chair and Co-Chairs were recognized at the luncheon for their hard work and dedication and without them the Auxiliary would not exist.

Ms. Tucker reported the Auxiliary currently has 667 volunteers with a total of 33,230 volunteer hours.

Ms. Tucker explained this year the Auxiliary purchased white boards for the ER and five lift machines for the patient floors and at the June meeting will decide where to spend the remainder of their annual gift to the hospital.

Ms. Tucker stated many of the volunteers have taken on additional responsibilities to lighten the load of the Gift Shop. Ms. Tucker recognized those individuals and described their role in the running of the Gift Shop.

Ms. Tucker reported our annual Scholarship Awards Night was held on Thursday May 7th. Scholarships totaling $140,500 were awarded to 18 Junior Volunteers, 22 Mira Costa nursing students, 32 Palomar nursing students and three nursing students from Cal State San Marcos. Ms. Tucker explained the Arygcos Family Foundation gave an additional $72,000 the evening of the awards which resulted in each recipient receiving an additional $1,000.

Ms. Tucker reported he Auxiliary is in their final week of preparation for the second annual *"Tails on the Trails"* charity dog walk. To date 135 dogs are registered along with 10 sponsors, 20 vendors and five food trucks. Ms. Tucker noted the UT is also coming to cover the event.

Lastly, Ms. Tucker expressed her appreciation to Directors Schallock and Dagostino for joining her in Washington, D.C. for the HAVE Award Presentations. Ms. Tucker stated she was very pleased to accept the award on behalf of the Auxiliary and she gave a special thanks to Ms. Mary Gleisberg and Ms. Deena DiStefano for writing the proposal. Ms. Tucker stated the award will be placed in the glass case in the lobby following today's meeting.

Director Reno commented that this is the first time in the history of Tri-City Healthcare District that we have given $140,000 in scholarships and she expressed the Board's appreciation for the Auxiliary's countless hours and their loyalty.

Director Kellett stated he had the pleasure of attending the Scholarship Awards dinner and meeting Mr. and Mrs. Arygcos. He congratulated the Auxiliary on the fine job they did in screening the applicants.

Chairman Schallock commented on the excellent speech Ms. Tucker gave in Washington, D.C. about the many activities of the Auxiliary and the Scholarship program.

No action was taken.

14. TCHD Foundation – Glen Newhart, Executive Director/Vice President

Mr. Glen Newhart, Executive Director and Vice President of the Foundation, along with Mr. Kevin Stotmeister, Foundation Board Chair presented the Board with the following checks:

1) $119,236.00 for the EPIQ 7 Ultrasound System.

2) $456,060.00 which represents the balance of the Foundation's commitment to the GE Revolution 512 Slice CT Scanner project.

Directors expressed their appreciation to the Foundation for their efforts in bringing this state of the art equipment to the Medical Center.

Mr. Newhart also reported that the *Fashion that Heals* annual fundraiser held earlier this month raised over $100,000 toward their next project, the NICU and Women's Services remodel.

No action was taken.

15. Report from Chief Executive Officer

Mr. Tim Moran, Chief Executive Officer stated at the request of the Board he would be giving an educational talk along with Dr. Scott Worman to educate residents in the District who do not have a healthcare background.

Mr. Moran spoke on a relatively new concept, Hospitalists. He explained the Hospitalist plays a critical role in the care of our patients and we have one of the best in Dr. Worman who is not only our Chief of Staff but also a Hospitalist.

Dr. Worman explained a Hospitalist is a primary care physician who works solely in the hospital and does not have a private practice. He went on to state that the Hospitalist is not there to replace the patient's primary care physician. It is their job to take care of the patient in the hospital and communicate effectively with their primary care physician. Dr. Worman stated the Hospitalists at Tri-City make an effort to follow the patient through their stay rather than pass patients off from one Hospitalist to another which allows them to expedite the care of the patient and provide a safer environment.

Mr. Moran also gave an update on Behavioral Health. He explained that we anticipate working in collaboration with the county's mental health people to tackle this difficult problem.

Mr. Moran stated Director Nygaard will be giving an update on LAFCO during her remarks.

No action was taken.

16. Report from Chief Financial Officer

In Mr. Dietlin's absence, Mr. Ray Rivas reported on the Fiscal YTD financial results as follows (dollars in Thousands):

- Net Operating Revenue – $277,971
- Operating Expense – $278,559
- EROE - $3,091
- EBITDA – $16,332

Other Key Indicators for the current year included the following:

- Average Daily Census – 193
- Adjusted Patient Days – 94,025
- Surgery Cases – 5,577

- Deliveries – 2,165
- ED Visits – 58,767

- Net Patient Accounts Receivable – $43.1
- Days in Net Account Receivable – 49.4

From an operating performance perspective, Mr. Rivas reported the following for the current month (dollars in Thousands):

- Operating Revenue - $28,102
- Operating Expense - $28,151
- EBITDA - $1,620
- EROE - $343

Mr. Rivas also presented graphs which reflected Net Days in Patient Accounts Receivable, Average Daily Census excluding Newborns, Adjusted Patient Days, Emergency Department Visits.

Director Reno asked questions with regard to a possible discrepancy on the Dashboard. Mr. Rivas indicated he would forward Director Reno's questions on to Mr. Steve Dietlin for a response.

No action was taken.

17. New Business

a. Consideration to approve the FY2015-2016 Community Healthcare Grant Awards – Ms. Gigi Gleason and Mr. Don Reedy

It was moved by Director Nygaard that the TCHD Board of Directors approve the FY2015-2016 Community Healthcare Grant Awards in the amount of $475,000.00 Director Dagostino seconded the motion.

Mr. David Bennett, Chief Marketing Officer introduced Ms. Gigi Gleason and Mr. Don Reedy, Grant Committee members. Mr. Bennett recognized the hard work of the Grant Committee in reviewing the applications.

Mr. Reedy briefly described the Grant Guideline process that was followed explicitly. He explained all awards go to non-profits and three areas of focus this year were access to healthcare, Diabetes and Mental Health.

Ms. Gigi Gleason stated only eight of the 64 grants submitted were disqualified. Additionally, all of last year's awardees turned in year-end reports as required.

Director Reno requested clarification on the $63,000 grant to the San Diego County Medical Society's Foundation. Ms. Gleason explained this year's grant request is a collaborative with TCMC, the American Cancer Society and Vista Community Clinic to reduce the colorectal cancer death rate in the TCHD region by increasing colorectal cancer diagnostic services and treatment among low income uninsured North County residents.

Director Reno also requested clarification on the $2,300 grant to BILY San Diego.

Ms. Gleason explained BILY (Because I Love You) is a non-profit volunteer parent support group that works closely with the Carlsbad Police Department and local family counselors for referrals.

Director Nygaard also explained North County LBGTQ Resource Center's goal is to enhance mental health services in order to address the high risk of suicide and substance abuse and to create a reliable and permanent mental health resource for LGBT families and where TCHD residents can go and receive a mental health evaluation.

Director Reno expressed concern in lack of grant awards to the local community clinics.

It was suggested that in the future the agenda packet include a summary sheet of the grant recipients explaining the service offered by the organization and the grant request.

Director Nygaard congratulated the Grants Committee on their efforts in prioritizing the grant requests and the fairness in which it was handled.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Reno**
ABSENT:	**Directors:**	**None**

b. Consideration of a Physician Recruitment Agreement with Xiangli Li, MD, PhD

It was moved by Director Dagostino that the TCHD Board of Directors find it in the best interest of the public health of the communities served by the District to approve a total expenditure not to exceed $425,000 over two years in order to facilitate this Internal Medicine physician (Xiangli, Li, MD, PhD) practicing medicine in the communities served by the District. Director Nygaard seconded the motion.

Mr. Wayne Knight, SVP described a succession plan that allows two of our long time physicians to retire with the recruitment of Dr. Xiangli Li. Mr. Knight provided background information on Dr Li and noted she has done post op work at UCSD. Mr. Knight commented on the shortage of internal medicine physicians and noted recruitment of this physician is a step in the right direction.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

c. Consideration to approve amendment to Article II, Section 8 of the Bylaws

It was moved by Director Finnila that the TCHD Board of Directors approve an amendment to Article II, Section 8 of the Bylaws.

There was no second to the motion.

The motion failed.

d. Consideration of process for selection of Facilitator for Board Workshop

Chairman Schallock reported the June 4th Board Workshop has been postponed and will likely be rescheduled in August. Chairman Schallock noted the Board will also need to do a Self-Assessment this year which can be done either at the August Workshop or at a separate Special Meeting. Chairman Schallock requested Board members submit Facilitator recommendations for consideration.

No action taken.

18. Old Business – None

19. Chief of Staff

Consideration of May 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on May 18, 2015.

It was moved by Director Dagostino to approve the May 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on May 18, 2015. Director Nygaard seconded the motion.

Dr. Worman had no comments.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

20. Consent Calendar

It was moved by Director Nygaard to pull item 20 E. 3. p. Policy 613 Physical Therapy Assistant Supervision. Director Kellett seconded the motion.

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

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**

NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

The vote on the main motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

21. Discussion of items pulled from Consent Agenda

Director Nygaard who pulled item 20 E. 3. p. Policy 613 Physical Therapy Assistant Supervision explained this policy refers to the Nifty after Fifty locations which are currently under evaluation for sustainability. Director Nygaard requested a Nifty after Fifty update at the June Board meeting and requested the policy be tabled pending that discussion.

It was moved by Director Nygaard to table Policy 613 Physical Therapy Assistant pending an update on the Nifty after Fifty program. Director Kellett seconded the motion.

The vote on the motion is as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

22. Reports (Discussion by exception only)

23. Legislative Update

Chairman Schallock gave a brief report on the AHA Annual Meeting he recently attended in Washington, D.C. He stated that although there were no legislators at the conference due to the House in recess, the healthcare aids were extremely knowledgeable. Chairman Schallock stated he and Director Dagostino spoke with the aids regarding Behavioral Health and the need for federal funding.

Chairman Schallock stated he and Director Dagostino also spoke with the aids regarding the RAC audits in which a hired organization comes in and reviews Medicare billing typically for short term stays. He explained if a billing appears incorrect it is pulled by the auditor and can take up to two years to resolve. An attempt is being made to put through Congress to charge a fixed fee rather than a percentage for those billings that are pulled.

Chairman Schallock also discussed the 30 day readmission penalty hospitals can incur for patients who return to the hospital within 30 day of admission. He explained

the difficulty in monitoring patients once they leave the facility. Director Dagostino stated a proposal is underway to identify those patients that are likely to be readmitted due to co-morbidities and removing those individuals from the 30 day readmission factor.

Mr. Moran reported ACHD issued a press release today that the California State Assembly has voted to adopt Bill 69 by Assemblyman Chavez declaring May 2015 Healthcare District Month.

24. Comments by members of the Public - None

25. Additional Comments by Chief Executive Officer

Mr. Moran did not have any additional comments.

26. Board Communications

Director Nygaard reported on a recent LAFCO meeting regarding study of District Spheres of Influence. She stated LAFCO intends to conduct an individual study of each District and have expressed an interest in keeping the "donut holes" within the District they reside in.

Director Nygaard also commented on the wonderful care provided by Tri-City Medical Center and she expressed appreciation for the hard work our staff are doing.

Director Mitchell reported she along with Director Nygaard recently attended the ACHD Annual Meeting in Monterey, CA. She learned of many rural areas that no longer have hospitals and their issues with isolation and geography.

Director Reno expressed her appreciation to the Auxiliary and their generous scholarships given to the nurses.

Director Finnila spoke on an interesting report that saved a county $600/year and millions of prescription costs for the low income people by collecting old and unused medications and repackaging them to the low income individuals who cannot afford medications. Director Finnila also commented on the importance of disposing of medications properly and not putting them in the water supply.

Director Kellett did not have any comments.

Director Dagostino assured everyone that this Board is looking outside of Vista, Oceanside and Carlsbad and will be proactive in making decisions about the future.

27. Report from Chairperson

Chairman Schallock reported at the recent AHA Annual meeting, the California delegation included CEOs and legislative affair individuals and he and Director Dagostino were the only Directors there that were either appointed or elected. Chairman Schallock stated he believes that this brought a different point of view of the community interest and involvement.

Chairman Schallock commented that he was pleasantly surprised at the amount of money the Auxiliary was able to give out in Scholarships this year and stated it helps the students meet their career goal.

Chairman Schallock also expressed appreciation to the Foundation for their generous donations.

28. 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.

29. Motion to return to Closed Session.

Chairman Schallock adjourned the meeting to closed session at 5:00 p.m.

30. Open Session

At 6:03 p.m. Chairman Schallock reported the Board was back in open session. All Board members were present.

31. Report from Chairperson on any action taken in Closed Session.

Chairperson Schallock reported the Board approved an appeal in the most recent ruling in the matter of Medical Acquisitions Company vs. TCHD by a unanimous vote of (5-0) with Directors Reno and Mitchell absent.

32. There being no further business Chairman Schallock adjourned the meeting at 6:03 p.m.

_____
Larry Schallock, Chairman

ATTEST:

_____
Ramona Finnila, Secretary

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

June 11, 2015 – 6:00 o'clock p.m.
Assembly Rooms 2&3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 6:00 p.m. on June 11, 2015.

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

Director Jim Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry Schallock

Also present were:

Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Steve Dietlin, Chief Executive Officer
Sharon Schultz, Chief Nurse Executive
David Bennett, Chief Marketing Officer
Esther Beverly, Vice President/Human Resources
Wayne Knight, SVP, Medical Affairs
Glen Newhart, Vice President/Foundation
Scott Worman, M.D., Chief of Staff
Charlene Carty, Director of Finance
Robin Sleeman, Sr. Financial Analyst
Kim Wallace, Sr. Financial Analyst
Greg Moser, General Legal Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 6:00 p.m. in Assembly Rooms 2&3 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 the Agenda

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

3. Public Comments – Announcement

   Chairman Schallock read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Open Session

1) Board of Directors Public Workshop for the purposes of review, discussion and possible action of the Operating & Capital Budgets for Fiscal Year 2016 and Strategic Plan Executive Summary

Mr. Steve Dietlin, CFO stated he would be presenting a high level summary of the information that was contained in the budget binder which includes a budget summary, key indicators, and capital budget summary. He expressed his appreciation to Ms. Charlene Carty, Director of Finance and Financial Analysts Ms. Robin Sleeman and Ms. Kimberly Wallace for their assistance in preparing the budget.

Mr. Dietlin reviewed the following projected figures (dollars in Thousands) for Budget FY2016:

- Gross Revenue - $1,510,827
- Operating Revenue - $347,458
- Operating Expense - $342,916
- EROE - $9,767
- EBITDA - $26,360

Key Patient Indicators for FY 2016 Budget were projected as follows:

- Average Daily Census – 200.5
- Adjusted Patient Days – 115,995
- Paid FTEs – 1,927
- Paid FTEs per AOB – 6.1

Key Ancillary Department Indicators for FY2016 Budget were projected as follows:

- ED Visits – 70,970
- Deliveries – 2,972
- Surgery IP Cases – 3,889
- Surgery OP Cases – 3,001

Mr. Dietlin reviewed the significant anticipated budgeted operational items which included:

- 16% increase in Deliveries and Gynecological Services
- 14% Increase in joint surgeries
- Increase in neurological surgeries
- 10% increase in inpatient Forensics business
- 23% increase in Acute Rehab admits
- Impact of the Primary Care Physician Strategy

Mr. Dietlin, Mr. Moran and Mr. Knight explained the rationale behind forecasting these assumptions.

Mr. Dietlin presented the FY2016 Capital Budget Summary as follows:

- Committed Capital Carry-Forward - $5,760
- Prioritized Capital Equipment & Renovations - $7,700
- Contingency - $1,500
- Total Planned Expenditures - $14,960
- Equipment Financing $7,370
- Funded by Foundation $1,200
- Funded Through Operations –$6,390

- Total Planned Funding - $14,960

With respect to the Prioritized Capital Equipment & Renovation, Mr. Dietlin explained the items are listed by cost rather than the order of importance, however all items are considered a priority.

Directors commented that the budget appears to be slightly more aggressive than last year's budget. Mr. Dietlin explained the budget is based on assumptions which include managed care increases, market share is retained and there is growth.

Directors stressed the importance of not only retaining our market share but growing that market share.

With regard to salaries and benefits, Mr. Dietlin explained the number is comprised of contracted bargaining increases, market adjustments and the addition of patient volume.

Ms. Beverly stated employee benefits are very competitive compared to other hospitals in the county.

There was a brief discussion related to Nifty after Fifty and the viability of the program. Mr. Moran indicated a proposal would be coming forward to the Finance, Operations & Planning Committee next week regarding the Nifty after Fifty.

Discussion was also held related to the Strategic Plan Executive Summary and the Strategic Initiatives. Directors requested a quarterly assessment of the Strategic Initiatives with the first one scheduled for October.

Chairman Schallock questioned if the budget includes allocation for the Community Healthcare Grants and the Vista Community Clinic Emergency Department Collaborative. Mr. Dietlin stated the budget includes $300,000 for healthcare community grants and $100,000 for the Vista Community Clinic collaborative.

It was suggested the Board adjourn to closed session for discussion of Trade Secrets that are relevant to the budget.

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

Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Mr. Moser made an oral announcement of item listed on the June 11, 2015 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included a Report Involving Trade Secrets.

It was moved by Director Dagostino and seconded by Director Finnila to go into closed session. The motion passed unanimously (7-0).

The Board adjourned to closed session at 6:48 p.m.

At 7:16 p.m. the Board returned to open session with all Board members present.

8. Report from Chairperson on any action taken in Closed Session.

Chairperson Schallock reported no action had been taken in Closed Session however the Board will return briefly to closed session following the open session.

Discussion continued briefly with regard to the Budget.

With regard to Intangible and other Assets, Mr. Dietlin stated $9.7 million is associated with the Medical Office Building deposits and there is an assumption that the Medical Office Building will be placed into service during Fiscal year 2016.

Discussion was held regarding the Marketing budget and how it has changed. Mr. David Bennett, CMO explained there has been a significant reduction ($600,000) in salaries, media and press.

It was moved by Director Reno to approve the 2015 Operating and Capital Budget as presented. Director Finnila seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Chairman Schallock explained that Administration plans to bring data reports related to the Strategic Plan's timeline on a quarterly basis.

Mr. Moran questioned if the Board was interested in adopting the Strategic Plan as presented. Chairman Schallock noted the previous motion did not include the Strategic Plan.

It was moved by Director Nygaard to adopt the Strategic Plan as presented in today's Executive Summary. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Chairman Schallock and fellow Board members expressed their appreciation to Mr. Dietlin and his staff as well as Administration for putting together a concise, easy to understand and well thought out budget.

5. Motion to go into Closed Session

   It was moved by Director Dagostino and seconded by Director Kellett to go into Closed Session. The motion passed unanimously (7-0).

6. Chairman Schallock adjourned the meeting to Closed Session at 7:27 p.m.

7. The Board returned to Open Session at 7:40 p.m. All Board members were present.

8. Report from Chairperson on any action taken in Closed Session.

Chairperson Schallock reported no action had been taken in Closed Session.

9. There being no further business, Chairman Schallock adjourned the meeting at 7:30 p.m.

Larry W. Schallock
Chairman

ATTEST:

Ramona Finnila
Secretary

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

June 12, 2015 – 10:00 o'clock a.m.
Assembly Rooms 2&3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 10:00 a.m. on June 12, 2015.

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

Director Jim Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie Reno
Director Larry Schallock

Also present were:

Greg Moser, General Legal Counsel
Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Steve Dietlin, Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
David Bennett, Chief Marketing Officer
Wayne Knight, SVP, Medical Services
Glen Newhart, EVP, Foundation
Dr. Scott Worman, Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 10:00 a.m. in Assembly Rooms 2&3 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 Nygaard to approve the agenda as presented. Director Dagostino seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairman Schallock read the Public Comments section listed on the Board 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, Mr. Greg Moser, made an oral announcement of items listed on the June 12, 2015 Special Board of Directors Meeting Agenda to be discussed during Closed Session

which included Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees..

5. Motion to go into Closed Session

It was moved by Director Dagostino and seconded by Director Kellett to go into Closed Session. The motion passed unanimously (7-0).

6. Chairman Schallock adjourned the meeting to Closed Session at 10:08 a.m.

7. The Board returned to Open Session at 2:02 p.m. with attendance as listed above.

8. Report from Chairperson on any action taken in Closed Session.

   Chairman Schallock reported no action had been taken in closed session.

9. There being no further business, Chairman Schallock adjourned the meeting at 2:02 p.m.

_____
Larry W. Schallock
Chairman

ATTEST:

_____
Ramona Finnila
Secretary

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60514

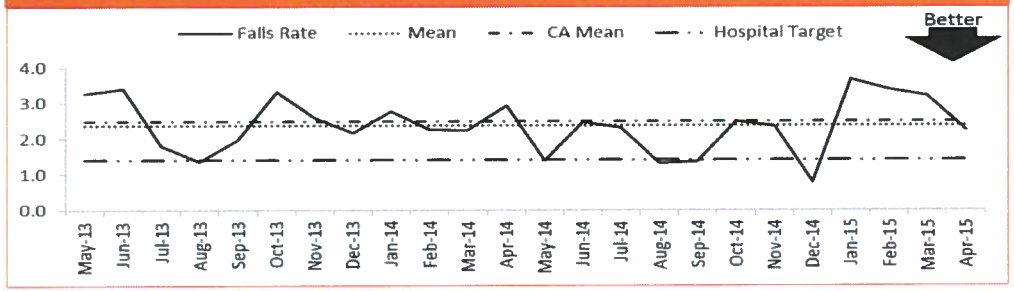
Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Process of Care Measures (Core Measures)

Centers for Medicare & Medicaid (CMS)

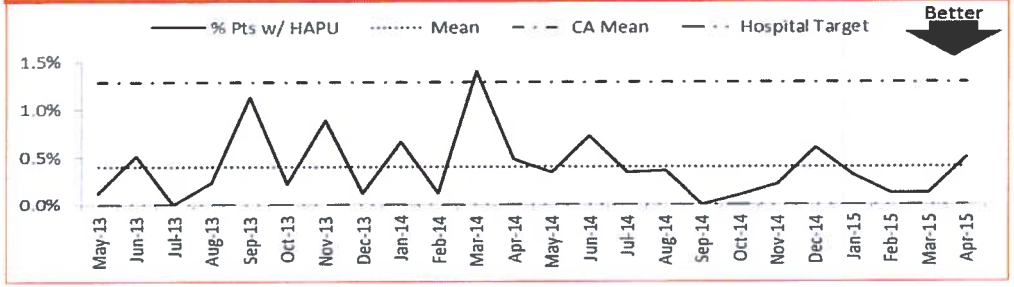
Hospital Wide Falls Rate Per 1000 Pt Days



Action Plan

In January the S.A.F.E. units were closed due to increased focus on meeting productivity targets. An initial spike in falls was noted with a steady decline being seen over the past couple of months. If the rate does not fall to pre-January averages then consideration of re-opening the S.A.F.E. units may need to be considered

Hospital Wide % Patients with HAPU



Action Plan

Increase Skin & Wound Champions on all units (model after Telemetry)
Created workgroup with tool to determine if HAPU is Avoidable vs. Unavoidable
Continue with HAPU Case Reviews
Continue with mandatory yearly RN Wound Class
Implementation of PowerPlans for standardized wound care per policy

Control Chart Interpretation

Legend

- Hospital Mean
- Hospital Rate
- Hospital UCL
- CA Mean

Hospital Mean is the average value we can expect based on the data collected.

Hospital Rate is the actual value.

Hospital UCL (Upper Control Limit) is the highest level of quality that is still considered "normal" given the data history. It is usually 3 standard deviations from the mean.

Description	Indication
One point is more than 3 standard deviations (UCL) from the mean.	One sample (two shown in this case) is grossly out of control.
Six (or more) points in a row are continually increasing (or decreasing).	A trend exists. Procedures in place have an effect on outcomes either positive or negative.
8 (or more) points in a row are on the same side of the mean	Some prolonged bias exists.

Tri-City Medical Center

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Employee Satisfaction

Partnership™
"Satisfaction + Engagement"
Mean = 64.2 (-1.9)
Percentile = 27th (from 28th)

Satisfaction
"what do I get?"
Mean = 59.6 (-2.3)
Percentile = 26th (from 27th)

Engagement
"what do I give?"
Mean = 70.2 (-1.6)
Percentile = 32nd (from 31st)

National 90th Mean Scores

Partnership:	79.2
Satisfaction:	76.3
Engagement:	82.7

Voluntary Employee Turnover Rate (Annual Rate - Rolling Quarters)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY15
FY15			9.9%			10.2%			10.8%				
FY14			12.7%			12.7%			11.7%			11.8%	11.4%

Involuntary Employee Turnover Rate (Annual Rate - Rolling Quarters)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY15
FY15			1.9%			2.3%			3.3%				
FY14			8.6%			8.4%			6.8%			3.2%	3.2%

HCAHPS (Top Box Score)

Hospital Consumer Assessment of Healthcare Providers & Systems

Benchmark Source: Hospital Compare

Benchmark Period: 7/1/2013-6/30/2014

"Overall Rating of Hospital"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	66%	60%	61%	57%	62%	61%	71%	55%	61%	58%				70%	78%	73%	77%	68%	71%
FY14	60%	63%	58%	71%	65%	75%	61%	64%	64%	63%	65%	59%	64%						

Performance compared to prior year: Better | Same | Worse

"Recommend The Hospital"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	73%	69%	66%	61%	57%	61%	65%	63%	60%	63%				76%	80%	78%	81%	70%	71%
FY14	63%	67%	67%	78%	65%	77%	65%	69%	65%	61%	72%	64%	68%						

"Communication with Nurses"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	79%	77%	72%	71%	69%	75%	78%	66%	73%	69%				78%	79%	78%	82%	75%	79%
FY14	76%	72%	74%	84%	73%	81%	74%	76%	68%	69%	73%	75%	74%						

"Communication with Doctors"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	80%	71%	77%	75%	76%	76%	80%	78%	76%	75%				79%	82%	83%	82%	78%	82%
FY14	75%	75%	78%	79%	80%	85%	73%	77%	73%	75%	80%	81%	78%						

"Response of Hospital Staff"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	63%	76%	74%	62%	62%	72%	71%	52%	62%	57%				63%	62%	66%	65%	62%	68%
FY14	63%	65%	66%	72%	69%	73%	64%	62%	61%	64%	68%	56%	65%						

"Hospital Environment"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	60%	57%	53%	55%	59%	59%	59%	57%	57%	56%				60%	67%	65%	63%	61%	68%
FY14	54%	53%	56%	59%	58%	59%	62%	62%	55%	56%	62%	64%	58%						

"Pain Management"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	74%	68%	68%	66%	64%	69%	72%	68%	62%	62%				71%	72%	71%	76%	69%	71%
FY14	75%	60%	73%	76%	71%	76%	75%	70%	63%	60%	66%	64%	68%						

Performance compared to prior year: Better Same Worse

"Communication about Medicines"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY
FY15	65%	63%	59%	64%	56%	54%	62%	56%	60%	58%			
FY14	65%	64%	61%	62%	56%	69%	65%	53%	55%	52%	62%	62%	60%

Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
64%	64%	65%	66%	62%	65%

"Discharge Information"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY
FY15	88%	81%	86%	85%	82%	84%	88%	88%	91%	83%			
FY14	85%	80%	76%	84%	79%	88%	80%	77%	86%	80%	89%	86%	83%

Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
83%	83%	88%	85%	84%	86%

Performance compared to prior year: Better Same Worse

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg	Goal Range
FY15	46.3	48.8	47.9	48.9	49.0	48.9	51.0	50.6	50.6	51.0	49.9		49.4	48-52
FY14	49.0	48.7	48.0	49.9	51.3	52.5	53.2	50.3	48.2	48.1	49.1	48.3	49.7	48-52

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg	Goal Range
FY15	78.1	77.1	81.2	77.9	79.5	77.6	79.5	77.0	84.3	82.6	82.8		79.8	75-100
FY14	78.0	87.4	90.8	90.5	91.5	89.8	82.8	73.4	87.4	83.3	81.1	75.2	84.3	75-100

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budget
FY15	$368	($348)	$112	$568	$556	$632	$198	$370	$292	$343	$1,814		$4,905	$5,648
FY14	($467)	($406)	$845	$83	$4,171	$214	($45)	($279)	($511)	$788	($264)	$257	$4,385	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budget
FY15	1.33%	-1.32%	0.41%	1.93%	1.99%	2.20%	0.70%	1.42%	1.02%	1.22%	6.04%		1.59%	1.82%
FY14	-1.77%	-1.55%	3.23%	0.30%	16.29%	0.81%	-0.16%	-1.05%	-1.99%	2.82%	-0.96%	1.00%	1.37%	

Tri-City Medical Center

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Financial Information

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budget
FY15	$1,761	$988	$1,456	$1,888	$1,896	$1,983	$1,498	$1,652	$1,591	$1,620	$3,136		$19,468	$21,988
FY14	$1,160	$1,081	$2,278	$1,620	$5,653	$1,717	$1,655	$1,188	$1,012	$2,307	$1,124	$1,121	$21,917	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budget
FY15	6.38%	3.75%	5.37%	6.42%	6.77%	6.91%	5.34%	6.34%	5.58%	5.76%	10.44%		6.32%	7.09%
FY14	4.40%	4.11%	8.71%	5.95%	22.08%	6.49%	5.89%	4.45%	3.94%	8.25%	4.10%	4.34%	6.85%	

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budget
FY15	5.93	5.89	6.01	6.09	6.39	6.28	5.89	5.69	6.18	6.17	5.89		6.03	6.13
FY14	6.03	6.00	6.05	6.06	6.22	5.93	5.75	5.86	6.09	6.04	5.95	5.99	6.01	

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		Covenant
FY15	1.55	1.60	1.52	1.49	1.20	1.24	1.32	1.45	1.53	1.51	1.77			1.10
FY14	-	-	1.45	1.69	2.50	2.37	2.08	1.94	1.78	1.78	1.50	1.45		1.05

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY15	$27.7	$21.4	$19.9	$18.8	$18.9	$22.2	$19.9	$16.4	$13.4	$17.8	$26.4		
FY14	$17.7	$21.6	$20.2	$19.3	$27.1	$27.3	$22.0	$21.9	$23.6	$24.5	$30.7	$32.6	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	35	32	46	48	35	33	39	35	31	35	37		406
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	9	22	24	18	21	19	13	21	19	19		199
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	10	9	8	12	11	9	7	16	14	6		108
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	7	10	12	13	7	11	8	9	21	11		119
FY14	14	10	15	4	16	16	10	10	12	7	14	9	137

Performance compared to prior year: Better | Same | Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	45	51	32	43	49	27	33	43	37	39	40		439
FY14	20	41	27	35	44	32	50	33	29	38	35	35	419

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	23.3	26.5	27.1	21.2	22.8	19.1	18.3	17.5	19.6	16.9	17.5		20.9
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	3.5	4.3	5.0	4.3	7.2	7.0	6.0	6.5	5.1	5.9		5.5
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	18.2	19.7	18.1	15.6	16.4	18.3	21.5	14.3	13.9	11.7		16.4
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	195.0	195.1	195.6	189.2	187.9	203.3	199.8	188.0	186.3	181.5		192.0
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

Performance compared to prior year: Better | Same | Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	246	263	244	233	194	233	199	159	208	186	218		2383
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	19	12	19	17	11	15	8	12	22	23		174
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	6	2	1	4	8	1	15	4	3	5		53
FY14	7	10	8	12	13	5	12	7	13	8	9	2	106

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	10	9	10	10	12	12	12	5	12	10	6		108
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	1.63	1.58	1.58	1.56	1.58	1.58	1.63	1.62	1.63	1.66		1.61
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

Building Operating Leases
Month Ending May 31, 2015

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	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)	$ 4,149.39	8/1/12	7/31/15	**Dr Dhruvil Gandhi** 2095 West Vista Way,Ste.106 Vista, Ca 92083	8460
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.50	(a)	$ 18,600.00	2/1/15	10/31/18	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA	7090
Tri-City Wellness, LLC 6250 El Camino Real Carlsbad, CA 92009 V#80388	Approx 87,000	$4.08	(a)	$ 232,282.00	7/1/13	6/30/28	**Wellness Center** 6250 El Camino Real Carlsbad, CA 92009	7760 - 90.65% 7597 - 4.86% 7777 - 4.49% 9520 - 77.25% 7893 - 12.53%
GCO 3621 Vista Way Oceanside, CA 92056 #V81473	1,583	$1.50	(a)	$ 3,398.15	1/1/13	12/31/15	**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	(a)	$ 5,993.14	5/1/13	4/30/18	**Nifty After Fifty** 3861 Mission Ave, Ste B25 Oceanside, CA 92054	9551
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)	$ 9,126.93	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)	$ 9,811.17	7/1/11	7/1/16	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083	7320
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 V#81250	4,760	$3.55	(a)	$ 22,900.00	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	(a)	$ 4,936.59	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		$ 8,202.55	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		$ 13,009.26	1/1/12	12/31/16	**Vacant Bank Building Property** 4000 Vista Way Oceanside, Ca 92056	8462 Until operational
Total				**$ 332,409.18**				

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

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending May 31, 2015

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
7420	ESA PROJECT OSC	43015	1,155.39	81163	OSCAR CHAVEZ
8402	VHA FORUM	43015	206.08	81163	TOM MOORE
8620	AHA MEETING - TRAVEL EXP	43015	360.68	81163	LARRY SCHALLOCK
8620	CA CONGRESSIONAL ACTION PRGM	43015	395.00	81163	LARRY SCHALLOCK
8740	ACLS RENEWAL	50815	100.00	81376	KIMBERLY LEMIEUX
8740	ACLS RENEWAL	50815	125.00	82419	LORI ROACH
8740	CSHE ANNUAL INST	50815	200.00	12307	STEVE BERNER
8740	ANIA CONFERENCE	50115	200.00	67036	KATHY TOPP
8740	ICD-10 CM BOOT	41015	200.00	82406	CAROLINA ALVARADO
8740	RN TO BSN	50815	2,500.00	82012	CHRISTINA HART

**This report shows payments and/or 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.

EVALUATION FORM

SEMINAR: GOVERNANCE FORUM
LOCATION: SACRAMENTO, CA DATE: JUNE 10, 2016

REASON TO ATTEND: COMMITTEE MEMBER

IMPORTANT TOPICS:

Initially, I sat in on the Senate Committee on Governance and Finance which was to consider AB 1290 regarding Design Build for a small critical care access hospital in the Sierras. Unfortunately this bill was last on the agenda and after an hour of discussion on another bill on the agenda I left to attend my meeting. The discussion on this bill is included and ultimately approved by the committee. We have attempted to attach Tri-City to this legislation or will introduce as "urgency" legislation in the next session.

The committee discussed the current significant topics around the state. Three topics that stand out are (1) the use of Emergency Rooms for primary care services for those who have Medi-cal coverage. The shortage of primary care physicians in this arena is significant and patients have no where to go due to limited access or extremely long wait times to get an appointment. (2) The on-going problems with access for Behavioral Health patients. The Emergency Room continues to be the primary access unless the patient has good insurance or the financial means to pay at a private treatment center. It was stated that 1/3rd of patients are true mentally ill while the others need short help such as a crisis stabilization unit or having some service available for treatment (see discussion on Assembly Bill 1300 included). Ventura County has no new beds for pediatric/adolescent patients and so they are directed to the hospital and the hospital has to figure out how to handle the patients. In Tulare County, the Board of Supervisors directs patients to the hospitals for resolution. The San Diego situation was reviewed including the recent discussion of leasing out part of one facility to patients of another county. All hospitals in this county are working with HASDIC to find a better resolution to the problem. (3) A new item brought up from Northern California hospitals is the wait time in ER's for transferring patients from paramedics to the hospital staff. Factors discussed included staffing, ER overcrowding and timely discharge to free up bed space. Protocols are being discussed that might speed up the process.

The California budget needs to be approved by the legislature by June 15th. Then the legislature and Governor will need to resolve their differences. The Governor's proposal does not anticipate revenues as high as the legislature. Funding for cuts in the past to healthcare are trying to be restored by the compromise with the Governor. Only time will tell how the healthcare funding is affected.

Larry W. Schallock

SENATE COMMITTEE ON GOVERNANCE AND FINANCE

Senator Robert Hertzberg, Chair
2015 - 2016 Regular

Bill No:	AB 1290	**Hearing Date:**	6/10/15
Author:	Dahle	**Tax Levy:**	No
Version:	5/18/15	**Fiscal:**	No
Consultant:	Weinberger		

DESIGN-BUILD CONTRACTING FOR THE MAYERS MEMORIAL HOSPITAL DISTRICT (URGENCY)

Allows the Mayers Memorial Hospital District to use design-build contracting.

Background and Existing Law

The Local Agency Public Construction Act requires local officials to invite bids for construction projects and then award contracts to the lowest responsible bidder. This **design-bid-build** method is the traditional, and most widely-used, approach to public works construction. This approach splits construction projects into two distinct phases: design and construction. During the design phase, the local agency prepares detailed project plans and specifications using its own employees or by hiring outside architects and engineers. Once project designs are complete, local officials invite bids from the construction community and award the contract to the lowest responsible bidder.

State law also allows some state and local officials to use the **design-build** method to procure both design and construction services from a single company before the development of complete plans and specifications. Under design-build, a public agency contracts with a single entity - which can be a single firm, a consortium, or a joint venture - to design and construct a project. Before inviting bids, the agency prepares documents that describe the basic concept of the project, as opposed to a complete set of drawings and specifications of what will be constructed. In the bidding phase, the agency typically evaluates bids on a best-value basis, incorporating technical factors, such as qualifications and design quality, in addition to price.

Until January 1, 2025, all counties and cities can use the design-build method to construct buildings and related improvements and other specified types of public works that cost more than $1 million (SB 785, Wolk, Chapter 931, Statutes of 2014). The Legislature also has authorized some special districts to construct projects using the design-build method, including three local health care districts:

- The Sonoma Valley Healthcare District can use the design-build process when contracting for the construction of a building and improvements directly related to a hospital or health facility building at the Sonoma Valley Hospital (SB 1699, Wiggins, 2008). Following SB 1699's enactment, the Sonoma Valley Health Care District's voters approved a $35 million bond to finance earthquake safety improvements to bring the hospital's emergency room into compliance with the state's seismic safety standards for hospitals. The District's upgraded facility, which was constructed using design-build contracts, opened in 2013.

- The Last Frontier Healthcare District can use the design-build process when contracting for the construction of a building and improvements directly related to a hospital or health facility building at the Modoc Medical Center (SB 268, Gaines, Chapter 18, Statutes of 2014).
- In addition to extending design-build contracting authority for cities and counties through 2024, last year's Wolk bill also authorized the Marin Healthcare District to use the design-build process when contracting for the construction of a building and improvements directly related to a hospital or health facility building at the Marin General Hospital.

The Mayers Memorial Hospital District (MMHD) serves a rural northern California area that includes portions of four counties: Lassen, Modoc, Shasta and Siskiyou. MMHD's hospital, located in Fall River Mills (Shasta County), is more than 50 years old and does not meet state seismic safety standards for hospital buildings. To continue to provide hospital services to the surrounding communities, MMHD must construct a new facility by January, 2020. To speed the construction process and reduce costs, MMHD officials want the Legislature to grant them the same design-build contracting authority that state law grants to the Sonoma, Marin, and Last Frontier healthcare districts.

Proposed Law

Assembly Bill 1290 allows the Mayers Memorial Hospital District's board of directors, notwithstanding any other law, to use the design-build procedure to construct a building or improvements directly related to the construction of a hospital or health facility building at the Mayers Memorial Hospital District. AB 1290 specifies that the District must use the design-build procedure that current law establishes for local agencies and provides that statutory references to a "local agency" means the Mayers Memorial Hospital District and its board of directors.

AB 1290 requires that a hospital building project using the design-build process authorized by the bill must be reviewed and inspected in accordance with the standards and requirements of the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983.

The bill finds and declares the Legislature's intent that health care districts use the design-build process solely for buildings associated with hospitals and health care and not for other infrastructure, including, streets, highways, public rail transit, roads, bridges, and water resources facilities.

State Revenue Impact

No estimate.

Comments

1. Purpose of the bill. When it comes to public works projects, taxpayers want local officials to hold down costs, but they also want to be sure that their tax dollars are spent wisely. While the traditional contracting process minimizes opportunities for public officials to award construction contracts based on subjective factors, it also can be more time consuming and more expensive than the design-build method. Faced with a seismic retrofit deadline, the Mayers Memorial Hospital District wants to use design-build contracting to gain more control over the bidding

process and the final outcomes of its anticipated hospital construction project. The District anticipates that the design-build method will shorten the construction process and reduce the project's overall costs, thereby benefitting taxpayers and helping to ensure that the District will meet its retrofit deadline.

2. Not so simple. Legislators have been cautious about allowing local governments, and special districts in particular, to use the design-build contracting method. A 2005 Legislative Analyst's Office (LAO) report questioned whether design-build is the best construction delivery process for specialized buildings like hospitals. LAO suggested that design-build is best suited for "straightforward" design and construction projects, but not for complex projects that require builders to accommodate more unique design preferences. A 2014 LAO report on how counties have used design-build contracting finds that some counties prefer using design-build for simple projects, while others indicate that design-build is useful for specialty projects and large, complex projects. Sonoma Valley Healthcare District is the only local government to have used the design-build method for hospital construction. Because hospitals are highly specialized structures that must meet complex construction and seismic standards, it remains unclear whether the design-build contracting method is appropriate for constructing hospital buildings.

3. Good for one, good for all? If AB 1290 becomes law, Mayers Memorial Hospital District would be the fourth healthcare district to obtain design-build contracting authority. In light of the fact that many of California's 80 healthcare districts confront similar fiscal challenges and deadlines to comply with seismic safety standards, it is likely that MMHD will not be the last health care district to seek design-build contracting authority. An early version of SB 1699 (Wiggins, 2008), before it was amended to apply only to Sonoma Valley Healthcare District, would have granted design-build contracting authority to all healthcare districts. Legislators may wish to consider whether it makes sense to grant design-build authority to healthcare districts on a case-by-case basis, or whether legislation granting authority to all healthcare districts may be justified.

4. Special legislation. The California Constitution prohibits special legislation when a general law can apply (Article IV, §16). AB 1290 contains findings and declarations explaining the need for legislation that applies only to the Mayers Memorial Hospital District.

5. Urgency. Regular statutes take effect on January 1 following their enactment; bills passed in 2015 take effect on January 1, 2016. The California Constitution allows bills with urgency clauses to take effect immediately if they're needed for the public peace, health, and safety. AB 1290 contains an urgency clause declaring that it is necessary for its provisions to go into effect immediately to allow the District to comply with health regulations, seismic requirements, and meet increasing demand for health care services at the earliest possible time.

Assembly Actions

Assembly Local Government Committee:	9-0
Assembly Floor:	75-0

Support and Opposition (6/4/15)

Support: Mayers Memorial Hospital District; Association of California Healthcare Districts; Shasta County Board of Supervisors.

Opposition: Unknown.

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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

Assembly Bill 1300 (Ridley-Thomas)
Improving Involuntary Treatment for All in Mental Health Care

The Problem

California law authorizes individuals to temporarily be held against their will for assessment if certain professionals believe that, due to a mental disorder, that individual is a danger to himself or herself, a danger to others, or gravely disabled. The law for placing a 72-hour mental health involuntary hold on individuals is meant to protect the patient and the public from harm. But in fact, that law, part of Section 5150 of the Welfare and Institutions code, hasn't been updated to reflect the changes in mental health treatment since its enactment a half century ago.

The result is a patchwork system of care and fragmented application of due process laws in California's 58 counties. There is effectively no consistent statewide policy of the 72-hour involuntary hold process, often known in popular shorthand as a "5150," which puts people at risk. The lack of a legal framework results in unequal detainment of individuals, a disproportionate dependence on hospital emergency departments, and patients left languishing for hours, days or sometimes weeks awaiting psychiatric assessment and treatment.

For hospitals, this means unwarranted draining of precious resources, including staff and beds, which compromises the true mission of the emergency room. Medical professionals are forced to monitor individuals who do not need emergency medical treatment or would be best served by a mental health professional outside of an emergency room setting, leaving the patients who truly need care waiting in line.

On average, there are an estimated 800 individuals on a 5150 hold at hospital emergency departments statewide on any given day. According to published research, approximately 70 percent of individuals brought to hospital emergency rooms don't meet the threshold for requiring hospital-based inpatient psychiatric care and can be better served in community-based treatment settings.

The Solution – Guidelines that Protect Due Process and Support Local Governments

Assembly Bill (AB) 1300 (Ridley-Thomas, D-Los Angeles) is designed to correct these flaws and modernize the law by providing clear guidelines for everyone to follow when determining when an involuntary detention period starts, ends or can be discontinued and who can make those determinations. It will ensure that individuals are given due process, safeguarding their civil rights, and can avoid unwarranted hospital detention. AB 1300 reforms also help focus the delivery of mental health services to those who actually need it and will improve the communication and care coordination for patients between hospitals and county mental health plans.

AB 1300 reforms update and strengthen existing law:

- Specifies that the 72-hour period begins at the time a person is initially detained
- Gives California counties the authority to designate community clinics, not just hospitals, to assess the mental health needs of individuals

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- Supports healthcare access for rural communities by allowing assessments to be done remotely, through a telehealth system
- Expedites the decision-making process by authorizing county departments of behavioral health to appoint a liaison to work with hospitals when individuals are transported to hospitals that do not provide inpatient psychiatric services
- Gives clear authority to an emergency room physician to expedite the determination of whether a person in custody requires a 72-hour hold

AB 1300's Accountability and Transparency Supports California's Health Care System

The public has a strong interest in protecting peoples' rights. No one should face involuntary detention for up to 72 hours without a timely assessment and evaluation of whether he or she meets the criteria for a behavioral health hold. AB 1300 will ensure the safety of the public-at-large and hospital personnel by removing obstacles to the delivery of critical mental health services to those who need them, while also protecting the interests of individuals and their families.

A First Step to Reform

The mental health delivery system in California has evolved since the 1970s from most care being provided in large state hospitals to a focus on community-based care. AB 1300 will more closely align the involuntary detention process with our current community delivery system, focusing on timely assessment, recovery and improved patient outcomes.

AB 1300 does not add financing or more treatment capacity. While it isn't a comprehensive solution, it is a critical first step to addressing many significant challenges in the delivery of mental health services. This measure is incremental by design and does not add new mandates or requirements for more beds or services. The California Hospital Association supports efforts to develop a more comprehensive solution and will work with stakeholders in the future to address these equally important issues.

AB 1300 is reflective of the California Hospital Association's longstanding commitment to supporting and improving mental health services and the involuntary treatment laws. In 2003, CHA published a first-of-its-kind Mental Health Law Manual. In 2004, CHA played a significant role and was instrumental in assuring the passage of Proposition 63, intended as one of the most significant expansion of mental health services in California history. And from 2005 to the present day, CHA has held annual training sessions statewide for hospitals and county mental health staff on the involuntary commitment standards.

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