TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
March 26, 2015 – 11:30 o'clock a.m.
Assembly Room 1 - 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	**4 Hours**	
	a. 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		
	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. 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		
	d. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	e. Conference with Legal Counsel – Potential Litigation (Authority Government Code Section 54956.9(d) (2 Matters)		
	f. Conference with Labor Negotiators (Authority: Government Code Section 54957.6) Agency Negotiator: Tim Moran Employee organization: SEIU		

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. Appointment of Public Employee: Chief Compliance Officer		
	h. Approval of prior Closed Session Minutes		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)		
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	Community Update – ***NICU Reaches Across the Miles to Families*** – Presentation by Dr. Hamid Movahhedian and Nancy Myers, NICU Manager	10 min.	S. Schultz
13	Introductions – a) Tina Dhillon-Ashley, M.D. b) Tannaz Adib, M.D.	10 min.	J. Raimo
14	Report from TCHD Auxiliary – Sandy Tucker, President	5 min.	Standard
15	Report from Chief Executive Officer	10 min.	Standard
16	Report from Chief Financial Officer	10 min.	Standard
17	New Business - None		
18	Old Business a. Approval of Resolution No. 772, A Resolution of the Board of Directors of Tri-City Healthcare District Ratifying and Confirming the Declaration of the Official Intent of the District to Reimburse Itself from the Proceeds of Debt for Capital Expenditures, Certain Preliminary Expenditures and Costs of Issuance Temporarily Funded from Revenues or Other Sources, as Previously Approved by this Board	10 min.	General Counsel/S. Young
19	Chief of Staff a. Consideration of March 2015 Credentialing Actions Involving the Medical Staff – New Appointments Only	5 min.	Standard
20	Consideration of Consent Calendar (1) Medical Staff Credentials for March, 2015 (2) 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.***	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	A. Human Resources Committee Director Kellett, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes) 1. 8610-455 – Confidentiality 2. 8610-429 – Alcohol and Drug Testing of Employees 3. 8610-436 – Photo Identification 4. 8610-473 – Premium and Specialty Program Pay 5. 8610-475 – Employee Compensation 6. 8610-477 – Employee Health & Safety 7. 8610-480 – Staff Requests to Not Participate in Care 8. 8610-481 – Employee Advancement		HR Comm.
	B. Employee Fiduciary Retirement Subcommittee Director Kellett, Subcommittee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes *No meeting held in March, 2015*		Emp. Fid. Subcomm.
	C. Community Healthcare Alliance Committee Director Nygaard, Committee Chair Open Community Seats - 2 (Committee minutes included in Board Agenda packets for informational purposes)		CHAC Comm.
	D. Finance, Operations & Planning Committee Director Dagostino, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes.) 1. **Policies & Procedures** a. Medi-Cal Treatment Authorization Request (TAR) Requirements b. Audits for Third Party Insurance c. Plan to Manage and Estimate Project Cost 2. Approval of a Physician Medical Director Agreement for Surgical Services for a term of 15 months beginning April 1, 2015 through June 30, 2016 at a cost of $2,400 per month for an annual (12 month) amount of $28,800 and a term cost of $36,000. 3. Approval of an agreement for the purchase of 110 IsoGel Mattresses and five air pumps for a total cost of $326,701.		FO&P Comm.

	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. Patient Valuables Liability and Control 2. **Administrative Policies & Procedures** a. Disclosure of Unanticipated Adverse Outcomes to Pt. Fam 275 b. Mandatory Reporting Requirements 236 c. Outsourcing Sterile Compounding d. Smoke-Free Environment 205 e. Space and Office Allocation Standards 289 3. **Unit Specific** **Emergency Department** a. EZ-IO Intraosseous (Io) Infusion System **Neonatal Intensive Care (NICU)** a. Education Plan, NICU b. Eye Examination c. Orientation of the Professional Nursing Staff to the NICU **Outpatient Infusion Center** a. Chemotherapy Administration Procedure Infusion Center **Women & Newborn Services** a. Pitocin Administration for Induction/Augmentation of Labor		PAC Comm.
	F. Governance & Legislative Committee Director Schallock, Committee Chair Open Community Seats - 0 (Committee minutes included in Board Agenda packets for informational purposes.) 1. **Rules & Regulations** Division of General Vascular Surgery Rules & Regulations		Gov. & Leg. Comm.
	G. Audit & Compliance Committee Director Finnila, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for information only) 1. Recommendation of engagement proposal by Moss Adams to perform the 2015 year-end audit		Audit, Comp. & Ethics Comm.

	Agenda Item	Time Allotted	Requestor
	(3) Minutes – Approval of a) February 24, 2015 – Special Board of Directors Meeting b) February 26, 2015 – Regular Board of Directors Meeting c) March 5, 2015 – Special Board of Directors Meeting		Standard
	(4) Meetings and Conferences - None		Standard
	(5) Dues and Memberships - None		Standard
21	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
22	Reports (Discussion by exception only) (a) Dashboard - Included (b) Construction Report – None (c) Lease Report – (February, 2015) (d) Reimbursement Disclosure Report – (February, 2015) (e) Seminar/Conference Reports 1) CHA Legislative Day – Director Dagostino/Chairman Schallock 2) Governance Institute - Chairman Schallock	0-5 min.	Standard
23	Legislative Update	5 min.	Standard
24	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
25	Additional Comments by Chief Executive Officer	5 min.	Standard
26	Board Communications (three minutes per Board member)	18 min.	Standard
27	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session **(Includes 10 minutes for recess to accommodate KOCT tape change)**	**2 hours**	
28	Oral Announcement of Items to be Discussed During Closed Session (If Needed)		
29	Motion to Return to Closed Session (If Needed)		
30	Open Session		
31	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
32	Adjournment		

RESOLUTION NO. 772

RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT (THE "DISTRICT") RATIFYING AND CONFIRMING THE DECLARATION OF THE OFFICIAL INTENT OF THE DISTRICT TO REIMBURSE ITSELF FROM THE PROCEEDS OF DEBT FOR CAPITAL EXPENDITURES, CERTAIN PRELIMINARY EXPENDITURES AND COSTS OF ISSUANCE TEMPORARILY FUNDED FROM REVENUES OR OTHER SOURCES, AS PREVIOUSLY APPROVED BY THIS BOARD

WHEREAS, Tri-City Healthcare District (the "District") is a California health care district duly organized and existing under the laws of the State of California, particularly the Local Health Care District Law, constituting Division 23 of the Health and Safety Code of the State of California (the "Law"); and

WHEREAS, at its meeting held June 26, 2014, the Board of Directors of the District (the "Board"), duly approved the capital lease of the Siemens Artis Q angiography system, including related construction, equipment and systems (collectively, the "Project"), in an aggregate principal amount then calculated at $2,133,335 (the "Board Approval"); and

WHEREAS, the District therefore contemplates the issuance, execution and delivery of said capital lease in the form of a capital lease-purchase agreement (the "Lease-Purchase Agreement") with Siemens Financial Services, Inc., or its permitted designee or assignee; and

WHEREAS, the District has paid, beginning no earlier than April 27, 2014 (being sixty days prior to the date of the Board Approval), and will continue to pay, on and after the date hereof, certain expenditures (the "Expenditures") in connection with the Project; and

WHEREAS, the District has determined that those moneys previously advanced no earlier than April 27, 2014, and to be advanced on and after the date of the adoption of this Resolution to pay the Expenditures have been and do remain available only for a temporary period, and it remains and will remain necessary to reimburse the District for the Expenditures from the proceeds of one or more issues of tax-exempt bonds to be issued in the form of the Lease-Purchase Agreement (the "Bonds"); and

WHEREAS, the District intends that this Resolution, together with the Board Approval hereby ratified and confirmed, be determined to constitute the District's declaration of official intent under Treasury Regulations § 1.150-2 to reimburse the District with a portion of the proceeds of such Bonds for certain expenditures in accordance with the Internal Revenue Code of 1986, as amended; and

WHEREAS, the District has not made and is not making said declaration of official intent to reimburse as a matter of course or in amounts substantially in excess of the amounts expected to be necessary for the Project, and does not have a pattern of failure to reimburse actual original expenditures covered by prior declarations of intent to reimburse, including without limitation the Board Approval;

NOW, THEREFORE, this Board of Directors of Tri-City Healthcare District does hereby find, resolve and order as follows:

Section 1. The foregoing recitals are true and correct.

Section 2. Ratification of Declaration of Official Intent. The District hereby ratifies and confirms the Board Approval, and in furtherance thereof, hereby ratifies, confirms and further declares its official intent:

(a) that the issuance by the District of the Bonds for the Project be in an aggregate principal amount reasonably expected not to exceed $2,133,335.00, subject to adjustment in accordance with the terms of the Lease-Purchase Agreement;

(b) that the District be reimbursed from the proceeds of the Bonds for the Expenditures with respect to the Project made on and after April 27, 2014, and the District hereby ratifies and confirms its reasonable expectation as of the date of the Board Approval that it will reimburse the Expenditures with the proceeds of the Bonds;

(c) that the Board Approval, as ratified and confirmed by this Resolution, be determined to constitute declarations of official intent under Treasury Regulations § 1.150-2 promulgated under the Code; and

(d) that the District will make or cause to be made a written allocation that evidences the District's use of proceeds of the Bonds to reimburse an Expenditure no later than 18 months after the later of the date on which the Expenditure is paid or the Project is placed in service or abandoned, but in no event more than three years after the date on which the Expenditure is paid.

Section 3. Effective Date. This Resolution shall take effect immediately upon its adoption.

ADOPTED, PASSED AND APPROVED this 26th day of March, 2015, at a regular meeting of the Board of Directors, at which a quorum was present and acting throughout, at Oceanside, California, by the following vote:

AYES:

NOES:

ABSTAIN/ABSENT:

By:_____
Chairperson, Board of Directors

ATTEST:

By:_____
Secretary, Board of Directors

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

TO: Larry Schallock, Chairperson

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

DATE: March 26, 2015

SUBJECT: Medical Executive Committee Credentialing Recommendations – New Appointments

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The attached Medical Staff New Appointments Credentials report was reviewed and approved at Credentials Committee on March 11, 2015. Their recommendations were reviewed and approved by the Medical Executive Committee on March 23, 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
March 11, 2015

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 03/26/2015 – 02/28/1017)
Medical Staff – Appoint to Provisional Staff and grant privileges as delineated:
Ebrahimi-Adib, Tannaz, MD – Obstetrics/Gynecology
Johnson, Ebunoluwa, MD – Emergency Medicine
Pritchard, Amy M., DO – Emergency Medicine
Wrotslavsky, Philip, DPM – Podiatric Surgery/Surgery

Allied Health Professionals – Appoint to Allied Health Professional Staff and grant privileges as delineated:
None

INITIAL APPLICATION WITHDRAWAL: (Voluntary unless otherwise specified)
Medical Staff:
Brown, Justin M., MD – Neurosurgery/Surgery

Allied Health Professionals:
None

TEMPORARY PRIVILEGES:
Medical Staff/Allied Health Professionals:
Ebrahimi-Adib, Tannaz, MD – Obstetrics/Gynecology

TEMPORARY MEDICAL STAFF MEMBERSHIP:
Medical Staff:
None

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

TO: Larry Schallock, Chairperson

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

DATE: March 26, 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 March 11, 2015. Their recommendations were reviewed and approved by the Medical Executive Committee on March 23, 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
March 11, 2015

Attachment B

REAPPOINTMENTS (Effective Dates: 04/01/2015 – 03/31/2017)
MEDICAL STAFF

Blumenfeld, Andrew M., MD **Medicine/Neurology**
Reappoint to Active Staff status and grant privileges as delineated
Relinquish:
- Chemo-Denervation

Goelitz, Brian W., MD **Radiology/Interventional Radiology**
Reappoint to Active Staff status and grant privileges as delineated
Add:
- Pain Management Core Privileges
  - Epidural Procedures
  - Joint Injections
  - Sympathetic blocks

Greider, Bradley W., MD **Surgery/Ophthalmology**
Reappoint to Active Staff status and grant privileges as delineated
Add:
- Argon laser
- YAG laser
- Diode laser

Helmy, Marwah, MD **Radiology/Teleradiology**
Reappoint from Provisional Staff status to Associate Staff status and grant privileges as requested

Helton, Derek A., MD **Radiology**
Reappoint to Active Staff status and grant privileges as requested

Leshaw, Steven M., MD **Medicine/Dermatology**
Reappoint from Courtesy Staff status to Affiliate Staff status
Add:
- Refer and Follow

Relinquish:
- Consultation
- Perform medical history and physical examination, including via telemedicine
- Biopsy less than 5 cm
- Biopsy of nail unit
- Burns, first degree: simple treatment less than 100 sq cm
- Destruction, pre-malignant and benign less than 10 cm
- Graft, punch less than 1 cm
- Incision less than 5 cm
- Paring & curettement less than 5 cm
- Repair, simple less than 10 cm anywhere except face
- Shaving less than 5 cm
- Destruction, malignant less than 10 cm (F)
- Destruction, pre-malignant and benign < 10 cm (F)
- Fungal/scabies scraping (F)

- Graft, punch < 1 cm (F)
- Intralesional injection (F)

Muhtaseb, Talal R., MD **Obstetrics/Gynecology**
Reappoint to Active Staff status and grant privileges as delineated:
Add:

- Gynecology (Endoscopy-Laparoscopy Surgery)
  - Resection of other uterine masses, Endoscopic/Laparoscopic
  - Surgical with or without D&C, Endoscopic/Laparoscopic
  - Thermal balloon ablation, Endoscopic/Laparoscopic
  - Treatment of ectopic pregnancy, Endoscopic/Laparoscopic
  - Tubal occlusion for sterilization, Endoscopic/Laparoscopic

Newman, Jeffrey L., MD **Family Medicine**
Reappoint to Active staff status and grant privileges as requested.
Unsupervised to Proctor Status for low/no activity:

- Admit pediatric patients
- Perform Pediatric history & physical, including via telemedicine
- Admit gynecologic patients
- Gynecologic consultation, including via telemedicine (F)
- Gynecologic history & physical, including via telemedicine (F)

Pardo, Patricia E., MD **Anesthesiology**
Reappoint to Courtesy staff status and grant privileges as delineated:
Add:

- Evaluate and treat patients with anesthesia related problems

Relinquish:

- Admit patients (under Core Pain Privileges)

Pountney Levesque, Marlene E., MD **Obstetrics/Gynecology**
Reappoint to Active staff status and grant privileges as delineated:
Add:

- Endometrial ablation

Sahagian, Gregory A., MD **Medicine/Neurology**
Reappoint to Active staff status and grant privileges as delineated:
Relinquish:

- Chemo-Denervation

Shafqat, Jon P., DDS **Surgery/Oral & Maxillofacial Surgery**
Reappoint to Associate staff status and grant privileges as requested.
Unsupervised to Proctor Status for low/no activity:

- Management of pathology
- Dental implantology
- Orthognathic Surgery

Smith, Mark D., MD **Surgery/Ophthalmology**
Reappoint to Active Staff status and grant privileges as delineated

Smith, Richard C., MD **Medicine/Infectious Disease**
Reappoint to Active Staff status and grant privileges as requested.

Smith, Ryan S., DO **Emergency Medicine**
Reappoint to Active Staff status and grant privileges as requested.

ALLIED HEALTH PROFESSIONALS (Effective Dates: 04/01/2015 – 03/31/2017)

Ahumada Alejandro G., AuD **Surgery**
Reappoint to Allied Health Professionals and grant privileges as requested.

Alston, Vickie, S., CNM **Ob/Gyn**
Reappoint to Allied Health Professionals and grant privileges as requested.

Amaral, Polly E., AuD **Surgery**
Reappoint to Allied Health Professionals and grant privileges as requested.

King, John F., AuD **Surgery**
Reappoint to Allied Health Professionals and grant privileges as requested.

Lees, Shannon E., AuD **Surgery**
Reappoint to Allied Health Professionals and grant privileges as requested.

Woelke, Dianne M., CNM **Ob/Gyn**
Reappoint to Allied Health Professionals and grant privileges as requested.

RESIGNATIONS (Effective March 31, 2015, unless otherwise specified)

Voluntary:

Czvik, Jospeph F., MD	Medicine/Internal Medicine
Thio, Andrew H., MD	Anesthesiology/Pain Medicine
Uslander, Robert L., MD	Family Medicine
Wagner, Jeanine, NP	Medicine **(Effective 02/22/2015)**

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
March 11, 2015

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS (Effective Date: 03/26/2015, unless specified otherwise)

Venor, Kristen, CNM – Obstetrics/Gynecology
Add:

- First assist at c-section only (specific tasks of retraction, suction, ligation, clamping, sponging, and cutting sutures)

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
March 11, 2015

Attachment B

PROCTORING RECOMMENDATIONS (Effective 03/27/2015, unless otherwise specified)

Grove, Jay R., MD	**General Vascular Surgery/Surgery**
Release from proctoring:	Robotic surgery – Multiple port (da Vinci)
Hanna, Karen J., MD	**General Vascular Surgery/Surgery**
Release from proctoring:	Robotic surgery – Multiple port (da Vinci)
Sadler, Charlotte A., MD	**Emergency Medicine**
Release from proctoring:	General patient care

TRI-CITY MEDICAL CENTER
HUMAN RESOURCES COMMITTEE
OF THE BOARD OF DIRECTORS
March 10, 2015

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

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 March 10, 2015 meeting. Director Dagostino moved and Ginny Carson 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 October 14, 2014 meeting. Director Reno moved and Ginny Carson seconded the motion. The motion was carried unanimously with		Chair Kellett

Topic	Discussion	Action Follow-up	Person(s) Responsible
	Director Laura Mitchell abstaining due to her absence in the October 14, 2014 meeting.		
5. Old Business			
None			
a. New Business			
a. B.O.D Dashboard- Stakeholder Experience	The Stakeholder Experience pillar- Employee Satisfaction rates were reviewed & discussed.	Clinical and non-clinical staff committee headed by Sharon and Esther to raise Pt. Satisfaction scores in place.	Chair Kellett
b. Review HR Metrics	Quinn Abler, HR Director presented the quarterly metrics. Quarterly headcount and annual turnover rates by union & overall. TCHD turnover rates are overall low & within national benchmarks and fluctuate throughout the year but stay consistent overall.		Esther Beverly
c. Policy Discussion/Action Policy 8610-455 Confidentiality	The Committee reviewed Policy 8610-455. Chair Kellett called for a motion to send Policy 8610-455 to the Board of Directors for approval. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-455 to be sent to Board of Directors for approval at the March 2015 meeting	Esther Beverly
Policy 8610-429 Alcohol and Drug Testing of Employees	The Committee reviewed Policy 8610-429. Chair Kellett called for a motion to send Policy 8610-429 to the Board of Directors for approval. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-429 to be sent to Board of Directors for approval at the March 2015 meeting	
Policy 8610-436 Photo Identification	The Committee reviewed Policy 8610-436. Chair Kellett called for a motion to send Policy 8610-436 to the Board of Directors for approval. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-436to be sent to Board of Directors for approval at the March 2015 meeting	
	The Committee reviewed Policy 8610-473. Chair Kellett called for a motion to send Policy 8610-473 to	Policy 8610-473 to be sent to Board of	

Topic	Discussion	Action Follow-up	Person(s) Responsible
Policy 8610-473 Premium and Specialty Program Pay	the Board of Directors for approval. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.	Directors for approval at the March 2015 meeting	
Policy 8610-475 Employee Compensation	The Committee reviewed Policy 8610-475. Chair Kellett called for a motion to send Policy 8610-475 to the Board of Directors for approval. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-475 to be sent to Board of Directors for approval at the March 2015 meeting	
Policy 8610-477 Employee Health and Safety	The Committee reviewed Policy 8610-477. Chair Kellett called for a motion to send Policy 8610-477 to the Board of Directors for approval. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-477 to be sent to Board of Directors for approval at the March 2015 meeting	
Policy 8610-480 Staff Requests to Not Participate in Care	The Committee reviewed Policy 8610-480. Chair Kellett called for a motion to send Policy 8610-480 to the Board of Directors for approval. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-480 to be sent to Board of Directors for approval at the March 2015 meeting	
Policy 8610-481 Employee Advancement	The Committee reviewed Policy 8610-481. Chair Kellett called for a motion to send Policy 8610-481 to the Board of Directors for approval. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-481 to be sent to Board of Directors for approval at the March 2015 meeting	
b. Work Plan	The work plan was reviewed and updated.		Chair Kellett
c. Committee Communications	None		Chair Kellett
d. Date of next meeting	**April 14, 2015**		Chair Kellett
e. Adjournment	Chair Kellett adjourned the meeting at 1:30 p.m.		Chair Kellett

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 12/02 **SUBJECT:** Confidentiality

REVISION DATE: 2/03, 10/05; 10/08; 05/11 **POLICY NUMBER:** 8610-455

Administrative Policies & Procedures Committee Approval:	**02/11**
Executive Council Approval:	**02/11**
Human Resources Committee Approval:	**05/11**
Board of Directors Approval:	**05/11**

A. **PURPOSE:**

1. To ensure confidential patient and employee information is protected in accordance with Tri-City Healthcare District's (TCHD) legal and ethical responsibilities.

B. **DEFINITIONS:**

1. **Confidential Patient Information:** Any information about a patient including medical treatment, medical condition, and diagnoses, any demographic information, collected from an individual that (a) is created or received by a health care provider, health plan, employer or health care clearinghouse; and (b) 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 or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Confidential Patient Information includes patient identifiable information.
2. **Confidential Personnel Information:** Any information related to an employee, including social security number, home address, telephone numbers, emergency contacts, life insurance coverage and beneficiaries, benefits, salary or wages, resumes and applications for employment, reviews, warnings, and/or disciplinary action, and any other form or document found in an employee's personnel file.
3. **Confidential Employee Medical Information:** Any medical information relating to an employee including health insurance application form, life insurance application form, requests for medical leave, personal accident reports, worker's compensation reports, OSHA injury or illness reports, and any other form or document which contains private medical information related to a specific employee, and any other form or document found in an employee's personnel file.
4. **TCHD Proprietary and Confidential Information:** Information and physical material not generally known or available outside TCHD and information and physical material entrusted to TCHD in confidence by third parties. Examples includes but are not limited to Confidential Patient Information, Confidential Employee Information, Confidential Employee Medical Information, TCHD's financial information, company competitive information, TCHD-developed intellectual property, business e-mail messages, and information about TCHD's affiliates, vendors and suppliers.
5. Confidential Patient Information, Confidential Personnel Information, Confidential Employee Medical Information, and TCHD Proprietary and Confidential Information shall be collectively referred to as "Confidential Information" for the purposes of this policy.
6. Workforce Members: Includes employees, non-employees (volunteers, contractors, students, and vendors), physicians (including residents and physician assistants), physician's employees providing services at TCHD.
7. Applicability This policy applies to all of TCHD's Workforce Members to whom TCHD Confidential Information is disclosed and whose conduct in the performance of work for TCHD is under the direct control of TCHD or its employees, whether or not they are paid by TCHD.
   a. Confidentiality Statement Access to TCHD's information systems and any Confidential Information is contingent upon execution of a Confidentiality Acknowledgement

Agreement Form ("CAAF") upon hire, appointment or initiation of service. The CAAF, which may be amended at TCHD's discretion is available on the shared drive and its terms are fully incorporated as if set forth separately herein.

8. Minimum Disclosures Necessary When using, disclosing or requesting Confidential Information, reasonable efforts must be made to limit the amount of protected health information (PHI) disclosed to be the minimum amount of information necessary to accomplish the requestor's intended purpose. This restriction does not apply to disclosing medical records for treatment. This requirement will be incorporated into all policies and processes that are established for access, use and/or disclosure of Confidential Information.
9. Business Associate Agreements A Business Associate Agreement is required in non-employee relationships where a person or entity performs duties, functions or any other activity on behalf of TCHD, that will or may involve the access and use of any Confidential Information. This agreement will provide for protection of Confidential Information in accordance with State and Federal law.
10. Safeguarding of Information: Confidential Information collected, generated, and/or stored by TCHD shall be maintained in such a manner as to prevent its unauthorized disclosure. Disclosure of Confidential Information shall be restricted to those who possess a need to know those who have been authorized to know or as may be required by State and/or Federal Law.
11. Viewing or obtaining information not needed for job completion (regardless of the medium of storage) constitutes unauthorized disclosure of that information and a violation of this policy. TCHD characterizes as unacceptable any activity through which an individual:
    a. Allows or participates in access, use or disclosure of Confidential Information not needed for his or her job;
    b. Removes Confidential Information, including medical records;
    c. Without authorization, deletes, shreds, destroys, alters, dismantles, disfigures, prevents rightful access to or otherwise interferes with the integrity of Confidential Information and/or information resources;
    d. Obtains information outside of approved channels without obtaining documented authorization to access such information.
12. **Violation of Policy:** Violators of this Policy shall be subject to disciplinary action by TCHD and reporting to the Licensing Board up to, and including, loss of privileges and/or termination. Individuals who access, use or disclose Confidential Information without proper authorization, will be subject to disciplinary action by TCHD and may, under certain circumstances, incur personal liability in connection with such unauthorized conduct.
13. Individuals whose relationship with TCHD terminates (whether voluntarily or involuntarily) will continue to be obligated to maintain confidentiality as defined in this policy and as provided for in the CAAF. Individuals must surrender all access keys, access codes, and return any originals or copies of documents containing Confidential Information in their custody or control no later than the last day of employment or other affiliation with TCHD.

C. **PROHIBITIONS:**

1. Disclosure of Confidential Patient Information regardless of intent, in any form including verbal, written or electronic form, to individuals not involved in the care or treatment of TCHD patients to individuals who are involved or know the patient but have no need to know the information or in a setting where that information could be overheard by individuals who have no need to know, for example in elevators, lobbies, waiting rooms, hallways, dining rooms, etc.
2. Disclosure of Confidential Personnel and/or Employee Medical Information to any third party, whether or not a TCHD employee, who does not have a legitimate need to know such information constitutes a violation of this policy. A legitimate need to know such information may arise in connection with, and including but not limited to disciplinary actions to be taken against an employee, an employee's own emergency, and/or efforts to obtain treatment or care for an employee.
3. Intentional or Unintentional Disclosure: Or in a setting where information can be read or transferred from an unattended computer monitor or in violation with TCHD's Acceptable Use of Information and Computing Resources Policy is prohibited and constitutes a violation of this policy.

D. **RESPONSIBILITIES:**

1. TCHD's Workforce Members shall be responsible for maintaining the confidentiality of all Confidential Information entrusted to it and for reporting known or suspected unauthorized use, access or disclosure of Confidential Information. Minimum responsibilities include:
   a. Understanding and following policies and department specific procedures appropriate to individual role and responsibilities;
   b. Protecting information from unauthorized access, use, disclosure and transmission;
   c. Maintaining safeguards for protection of information;
   d. Reporting and/or securing Confidential Information found unattended or unsecured;
   e. Reporting individuals who share passwords or who use other's passwords and/or access codes.
2. Department Supervisors shall:
   a. Determine appropriate levels of access to Confidential Information for all of TCHD's Workforce to ensure adequate performance of duties while ensuring the minimum disclosures necessary to achieve this objective.
   b. Establish safeguards to protect privacy and security of information.
   c. Evaluate the need for Business Associate Agreements as appropriate.
   d. Know and follow procedures to report unauthorized disclosures of Confidential Information and other violations.
   e. Adhere to Human Resource policies for disciplinary action.
   f. Establish consistent procedures for appropriate disposal of documents or items containing Confidential Information.
   g. Periodic monitoring of compliance with TCHD policies pertaining to confidentiality, privacy and security.
   h. Provide on-going education and training on privacy and security policies and procedures.
   i. Notify the appropriate departments of the termination of employment or relationship of any Workforce member.

E. **PROCESS:**

1. Each member of TCHD's Workforce shall execute the CAAF as follows:
   a. Upon hire/credentialing/initiation of service (volunteers and contracted).
   b. With each employee performance evaluation or credentialing renewal.
2. Executed CAAFs shall be maintained in files in either Human Resources Department or Medical Staff Services as appropriate.
   a. CAAFs for students shall be maintained in the Education Department.
   b. CAAFs for volunteers shall be maintained in the Auxiliary Department.
3. All members of TCHD's Workforce must report suspected violations of confidentiality through the existing compliance reporting channels:
   a. Supervisor;
   b. Quality Review (QRR) Report;
   c. Patient Representative;
   d. TCHD Values Line;
   e. TCHD Privacy Officer; and/or
   f. Human Resources
4. All members of TCHD's Workforce must apply standard safeguards to work processes, including:
   a. Limiting unauthorized persons from viewing, accessing or having access to Confidential Information whether in hard copy, electronic form or in any other format;
   b. Limiting the display of patient names to first and last initials or first name and last initials on white boards used for patient tracking, in public view.
   c. Limiting exposure of patient's name and other Confidential Information to public view.
   d. Preventing Confidential Information from being left unattended in public areas;
   e. Limiting viewing of computer screens containing patient identifiable information to the public.
   f. Preventing disposal of documents or other items containing Confidential Information in the regular trash and disposing of such items in accordance with TCHD policy (i.e. shred or medical waste systems.)

g. Limiting discussions of Confidential Information to those necessary to the performance of one's duties or in order to provide patient care and ensuring that such discussions take place in private areas. Discussing any Confidential Information in public areas, hallways, elevators, cafeterias, restrooms etc. is strictly prohibited.
h. Maintaining strict confidentiality of passwords/access codes.
i. Establishing and/or maintaining the physical security of Confidential Information, utilizing access controls, and locking storage cabinets.
j. Confidential Information may not be transmitted or removed from the premises, either physically or electronically, without authorization from Department Director/Designee.

F. **REFERENCES:**

1. 1974 Federal Privacy Act
2. JCAHO Accreditation Manual
3. Health & Safety Code 199.20
4. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
5. California State Confidentiality of Medical Information Act (CMIA)
6. California Code of Regulations, Title 22, Section 70707(b)(8)

G. **RELATED POLICIES:**

1. Code of Conduct
2. AP 518 – Notice of Privacy Practices
3. AP 515 – Use and Disclosure of Protected Health Information – Patient Records
4. AP 513 – Disclosure of Protected Health Information
5. AP 522 – Faxing of Protected Health Information
6. AP 524 – Disclosure of Information to Public and Media
7. AP 511 – Business Associate Agreement
8. AP 602 – Network Access
9. AP 603 – Internet Access
10. AP 604 – Email Access
11. AP 528 – Accounting for Disclosures of Protected Health Information
12. AP 237 – Hospital Record Retention
13. AP 609 – Disciplinary action for breaches of confidentiality of Restricted Electronic information
14. AP 427 – Fair Treatment for Supervisory and Management Employees
15. AP 428 – Fair Treatment for Non-Management

H. **FORM REFERENCED WHICH CAN BE LOCATED ON THE INTRANET:**

1. Confidentiality Acknowledgement/Agreement Form

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 5/86	**SUBJECT:** Alcohol and Drug Testing for Employees
REVISION DATE: 02/11; 04/12	**POLICY NUMBER:** 8610-429

Administrative Policies & Procedures Committee Approval:	**03/12**
Human Resources Committee Approval:	**04/12**
Board of Directors Approval:	**04/12**

A. **PURPOSE:**

It is the goal of Tri-City Healthcare District ("TCHD") to create a healthy and safe work environment in order to deliver the best and most cost-efficient service. It is the responsibility of TCHD employees to cooperate in efforts to protect the life, personal safety, and property of co-workers, patients, and members of the public. Substance abuse has been found to be a contributing factor to absenteeism, substandard performance, increased potential for accidents, poor morale, and impaired public relations. It is the goal of this policy to prevent substance abuse in the workplace. Employees must take all reasonable steps to abide by and cooperate in the implementation and enforcement of this policy.

B. **POLICY:**

1. Alcohol and/or drug abuse on the job will not be tolerated for any employee.

2. Alcohol or drug use off the job that negatively affects an employee's performance or negatively impacts TCMC, its employees, staff, patients or its mission, in any way, will not be tolerated.

3. Violation of this Policy may result in disciplinary action, up to and including termination of employment.

4. This Policy sets forth the procedures to be followed where reasonable suspicion exists that an employee may be under the influence of drugs or alcohol.

    a. Reasonable Suspicion means a belief based upon objective facts sufficient to lead a reasonably prudent person to suspect that an employee is under the influence of drugs or alcohol so that the employee's ability to perform the functions of the job is impaired or so that the employee's ability to perform his/her job safely is reduced. For example, any of the following, alone or in combination, may constitute reasonable suspicion:

        i. Changes to employee's manner or disposition;

        ii. Changes to employee's appearance, including, but not limited to glassy eyes, eye dilation, shaking, or erratic movement;

        iii. Changes in an employee's behavior, including involvement in verbal or physical altercations;

        iv. Unsteady walking and movement;

        v. Slurred speech or alcohol odor on breath;

        vi. An accident involving the employee;

b. An employee's possession of drugs or alcohol;

c. Failure to follow TCHD's procedure for wastage of controlled drugs or an employee's abuse of TCHD's Pyxis Pharmacy override system; and/or

d. Objective information obtained from another employee, law enforcement official, security service, or other person believed to be reliable.

C. **USE OF LEGAL/PRESCRIBED DRUGS:**

1. Using or being under the influence of any legally obtained drug while performing TCHD business or while in a TCHD facility is prohibited to the extent that such use or influence affects job safety or efficiency, or interferes with an employee's essential job functions.

2. No legal drug shall be possessed or used by any employee other than the employee for whom the drug was prescribed by a licensed medical practitioner. A legal drug shall be used only in the manner, combination and quantity prescribed.

3. If an employee is using a legal drug during work hours that could result in the employee being under the influence as defined above, it is the employee's responsibility to advise his/her supervisor of the use or influence of the prescription drug before beginning work and to advise his/her supervisor of the specific impairments that may result.

   a. The employee may work his/her assigned shift if his/her supervisor TCHD determines that the employee does not pose a safety threat and that job performance is not likely to be affected by use of the drug.

   b. The employee's supervisor will place the employee on paid Administrative Leave if the supervisor determines either:

      i. before the employee's shift starts, that the nature of the employee's position means that the risk that the employee may become under the influence while on duty is unacceptable; or

      ii. during the course of the shift, that the employee has come under the influence.

   c. Employees who are placed on paid Administrative Leave may be requested by TCHD to give their physician written authorization to provide information to TCHD regarding expected effects of prescribed medication.

      i. TCHD may consult with the prescribing physician to learn the expected effect of the drug and/or require a written statement from the physician that continued working will be safe and efficient.

      ii. Disclosures made to TCHD under an employee's written authorization will be confidential and will be disclosed to and used by TCHD staff only to the extent permitted by law.

   d. TCHD retains the right to direct an employee to submit to a fitness for duty examination by a physician selected by TCHD.

4. Marijuana is an illegal substance under federal law and will be treated as an illegal drug under this policy. California law does not prescribe that an employer must employ an individual who uses marijuana even for medicinal purposes. Accordingly, TCHD reserves the right to terminate the employment of any individual who reports to work under the influence of marijuana or who tests positive for marijuana.

D. **DISCIPLINE:**

1. Employees who violate this policy shall be subject to disciplinary action up to and including termination. Discipline may be imposed regardless of whether an employee is charged with and/or convicted of a crime relating to any violation of this policy.

2. Conduct violating this policy includes, but is not limited to:

   a. Reporting for work or being at work under the influence of alcohol or drugs;

   b. The illegal use, possession, transfer, purchase or illegal sale, or the attempted illegal use, possession, transfer, purchase or illegal sale of drugs during work hours or while on TCHD premises;

   c. The use or attempted use of alcohol in any manner during work hours or while on TCHD premises;

   d. Using TCHD property or premises to manufacture alcohol or drugs;

   e. Criminal conviction for the use, possession, transportation, transfer, purchase, theft or sale of illegal drugs whether or not on TCHD premises;

   f. Failure to report in writing any conviction under D.2.e. within five days of such conviction;

   g. Refusal to submit to a drug or alcohol test when requested to do so by a manager or lead Human Resources Officer; or his/her (designee).

   h. Failure to provide, within 24 hours of a positive drug test, bona fide verification of a current valid prescription in the employee's name for any potentially impairing legal drug identified in the drug test.

3. Violations of this policy that may constitute criminal conduct will be reported to the appropriate law enforcement agency and State licensing agencies and the California Department of Public Health Services, as required by law.

E. **PROCEDURES FOR ALCOHOL OR DRUG TESTING OF EMPLOYEES:**

1. These procedures are to be used by Directors, managers, and supervisors for testing employees where they have a reasonable suspicion that the employee may be under the influence of alcohol and/or drugs.

   a. If a Director, manager, or supervisor has reasonable suspicion that an employee is under the influence of alcohol or drugs, or has otherwise violated this policy, the Director, manager or supervisor shall document the bases of suspicion. If possible, the Director/manager/supervisor shall ask another Director/manager/supervisor witness the behavior and independently document it.

   b. The Director/manager/supervisor shall then accompany the employee to a private office, room, or other area and advise the employee that his/her behavior or performance warrants a medical examination and alcohol and drug test.

   c. The examination and test will be conducted in the employee health department by the Employee Health Nurse, administrative coordinator or an emergency department physician. The Administrative Coordinator is to be contacted when Employee Health Services is closed.

2. If the employee agrees to an alcohol and drug test, the following procedures should be carried out:

a. The employee shall be asked to read and sign an Authorization for Testing form and an Authorization for Release and Use of Testing Information (both forms are maintained by Employee Health); and

b. If the results of the test(s) administered are negative or inconclusive no further action will be taken by TCHD with regard to the violation of this policy.

3. If the employee refuses to consent to a medical examination, alcohol and drug test, the following procedures should be carried out:

a. The Director/manager/supervisor shall explain to the employee that the requested medical examination, alcohol and drug test is used to establish the employee's compliance with this policy and/or fitness to perform his/her job;

b. The Director/manager/supervisor shall inform the employee that his/her refusal to consent to a medical examination, alcohol and drug test will be interpreted as a deliberate failure to comply with a reasonable request and the employee will be subject to discipline up to and including termination. The employee should also be advised that he/she will not be allowed to use evidence of alcohol or drug abuse as a mitigating factor regarding any discipline imposed for misconduct or unsatisfactory job performance; and

c. The employee will be immediately placed on administrative leave if he/she refuses to consent to a medical examination and alcohol and drug test. If an employee refuses to submit to a medical exam and/or alcohol and drug test this refusal will not serve to reduce the discipline for misconduct or unsatisfactory job performance resulting from a positive test.

4. If the employee refuses to cooperate in the testing process in such a way that prevents completion of the test, or interferes with a test by adulterating or diluting the specimen, substituting the specimen with that from another person or sending an impostor to be tested, the employee will be subject to the same consequences as if he or she had been tested and the result had been positive.

5. If the drug or alcohol screen is positive, the employee will be placed immediately on administrative leave and arrangements will be made to transport the employee home.

a. If a positive drug screen identifies a legal drug, the employee may be requested to provide within 24 hours a bona fide verification of a valid current prescription in the employee's name for the drug identified in the drug screen.

b. A positive alcohol and/or drug test result will be confirmed.

c. A chain of custody of the tested blood, urine or other sample will be established and maintained by the testing clinic or laboratory.

d. Laboratory reports and/or test results shall not be placed in an employee's personnel file. Laboratory reports and/or the results shall be maintained in a separate confidential medical records file in the Employee Health Department. Laboratory reports and/or test results shall be disclosed only to individuals on a need to know basis and to the employee upon request.

e. Upon request the employee may have the original sample retested at an approved forensic accredited laboratory of their choice. This retest will be at the employee's expense.

F. **PROCEDURES FOR ALCOHOL AND DRUG TESTING OF APPLICANTS:**

1. As part of TCHD's employment screening process, applicants must pass a test for controlled substances, under the procedures described in Section E.2. of this Policy. The offer of employment is conditioned on a negative test result. Job announcements will contain notice of TCHD's drug testing policy and identify the positions subject to pre-employment testing.

2. A positive result for a drug and/or alcohol analysis may result in the applicant not being hired.

   a. If a drug screen is positive at a pre-employment physical, the applicant may be requested to provide within 24 hours a bona fide verification of a valid current prescription in the employee's name for the drug identified in the drug screen.

   b. If the applicant does not provide acceptable verification, or the drug may impair the applicant's ability to perform essential job functions, the applicant may not be hired.

G. **RELATION TO DISABILITIES:**

1. Nothing in this Policy shall affect TCHD's obligation to not discriminate and to reasonably accommodate those individuals with alcohol or drug dependencies, who have completed a rehabilitation program in accordance with applicable state and federal laws. Employees and applicants should be aware that none of these laws prohibit TCHD from taking disciplinary action against employees who are currently using illegal drugs, misusing legal drugs or abusing alcohol.

2. Employees who believe they have a drug or substance abuse prolem should be aware of the counseling services that are available through TCHD's Employee Assistance Program ("EAP"). Information about EAP services is available in the Employee Handbook and from Employee Health.

H. **INSPECTION BASED ON REASONABLE SUSPICION OF POSSESSION OF ILLEGAL DRUGS:**

1. To promote an alcohol and drug free, safe, productive and efficient workplace, TCHD reserves the right to search or inspect all property which it owns or controls to determine the presence of alcohol or drugs.

   a. TCHD expressly reserves the right to inspect TCHD owned or controlled property including, but not limited to, buildings, break areas, lunch rooms, restrooms, loading docks, lockers, desks, filing cabinets, tool boxes, vehicles, packages, containers and other articles within the work area.

   b. TCHD shall neither physically search the person of an employee nor search the personal possessions of employees without freely given consent by the employee that is witnessed by the lead Human Resources official or his/her designee.

2. If the lead Human Resources Officer or his/her designee has reason to believe that an employee may have illegal drugs in his/her possession in an area not jointly or fully controlled by TCHD he/she shall notify the appropriate law enforcement agency.

I. **PROCEDURES:**

1. Employee Health Procedures provide detailed guidelines for testing listed in this policy and can be found in the Health and Safety Manual, available in Employee Health. (see 4.1.7)

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 10/87	**SUBJECT:** Photo Identification
REVISION DATE: 01/09; 04/12	**POLICY NUMBER:** 8610-436

Administrative Policies & Procedures Committee Approval:	**03/12**
Human Resources Committee Approval:	**04/12**
Board of Directors Approval:	**04/12**

A. **PURPOSE:**

To provide guidelines for appropriate photo identification of all TCHD employees while on duty.

B. **POLICY:**

1. For purposes of security, safety, access control and customer satisfaction, all employees will be provided a photo identification (ID) badge by Employee Health Services. The badge must be clearly visible and worn above the waist at all times during duty hours while on hospital premises.

2. The ID badge is the method of identification for access control onto hospital premises during emergency situations. The ID badge should be kept with the employee at all times in case of disaster or emergency.

3. Employee ID is required in order to take advantage of TCHD employee discounts (i.e., cafeteria discounts, payroll deductions at Employee Health Services, gift shop, etc).

4. Employees are responsible for acquiring their photo ID badge from Employee Health Services on their first day of employment.

5. Disfiguring of the photo ID badge is not allowed.

6. Lost badges will be replaced in Employee Heath at the employee's expense. If this occurs on the weekend or holiday, employee must go to security to obtain temporary badge.

7. Upon termination, the employee's photo ID badge must be submitted to his/her manager or Human Resources.

8. Failure to wear a photo ID badge properly when on duty may result in disciplinary action up to and including termination.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Human Resources

ISSUE DATE: 03/04 **SUBJECT:** Premium & Specialty Program Pay

REVISION DATE: 09/08; 04/12 **POLICY NUMBER:** 8610-473

Administrative Policies & Procedures Committee Approval:	**04/12**
Human Resources Committee Approval:	**04/12**
Board of Directors Approval:	**04/12**

A. **PURPOSE:**

1. To establish premium and specialty program pay plans for Tri-City Healthcare District (TCHD) employees in order to support staffing requirements.

B. **POLICY:**

1. TCHD recognizes that staffing requirements may be best met by the establishment of premium and specialty pay plans designed to compensate employees for the inconvenience of working non-traditional hours or to meet special staffing needs.
2. TCHD has established premium pay plans as described below for which all non-exempt employees are eligible. With administrative approval, specific job codes and/or designated exempt employees may also be eligible.
   a. Holiday Premiums
      i. TCHD observes the following holidays: New Year's Day, Presidents' Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day, and Christmas Day
      ii. TCHD pays holiday premiums in order to compensate eligible employees for working on observed holidays.
      iii. Holiday premium is 50% of the employee's base hourly rate for working on New Year's Day, July 4th, Labor Day, Thanksgiving Day, and/or Christmas Day.
      iv. Holiday premium is 10% of the employee's base hourly rate for working on President's Day, and/or Memorial Day.
      v. Employees covered by a Collective Bargaining Agreement ("CBA") will be paid in accordance with their CBA.
   b. On-Call and Call-Back
      i. TCHD compensates employees for being available to return, or for actually returning, to work during scheduled non-working hours for designated staffing needs.
      ii. Acceptance of On-Call shifts may be mandatory in some areas.
      iii. On-Call hours will be paid for the duration of a designated on-call shift at an established hourly rate.
   c. Employees returning to work as Call-Back hours will be compensated at 1½ times their regular rate of pay. (Refer to Pay Practice #473.04 for details). Shift Premiums will be paid in accordance with established levels.
      i. TCHD compensates employees in designated job codes and areas of the facility where evening and/or night shifts are required. The amount of shift premium pay will be established as a flat rate and paid for eligible hours actually worked on an evening or night shift.
3. In addition to premium pays, specialty program pay may be established from time to time to meet special targeted needs of TCHD. Specialty program pay may include, but is not limited to, charge differential, report in pay, special shift pay, sign-on bonus, referral bonus, relocation allowance, or as directed by Union member's collective bargaining unit. Specialty program pay may be

established by the lead Human Resources Officer or his/her designee with the approval of the Chief Executive Officer.

4. The lead Human Resources Officer or his/her designee, with approval from the Chief Executive Officer, has authority and responsibility for administration of this policy.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Management of Human Resources

ISSUE DATE: 04/04 **SUBJECT:** Employee Compensation

REVISION DATE: 03/12; 04/12 **POLICY NUMBER:** 8610 – 475

Administrative Policies & Procedures Committee Approval:	**03/12**
Human Resources Committee Approval:	**04/12**
Board of Directors Approval:	**04/12**

A. **PURPOSE:**

1. To establish and maintain a total compensation program for Tri-City Healthcare District (TCHD) employees to include pay and benefits which is reviewed periodically to ensure internal equity, external competitiveness, fair and effective administration, and financial feasibility.

B. **POLICY:**

1. Compensation policies and practices will be structured to attract, retain, reward, and motivate high quality and highly performing employees.
2. The compensation program will be administered fairly and without discrimination of any kind, in accordance with applicable State and Federal laws.
3. The compensation programs may include individual performance based on merit pay as well as incentive award programs based on organizational performance.
   a. The Merit Award program is designed to reward individual employee job performance based upon an annual assessment through the Performance Appraisal program. The degree and form of the merit pay award structure may vary from year to year.
   b. TCHD reserves the right to implement and design an incentive program to reward eligible employees for reaching individual and organizational strategic goals and objectives. The programs are administered according to the provisions of the program guidelines. The program guidelines are reviewed annually. The Board of Directors has sole discretion for approval of changes to plan guidelines and payments. TCHD is committed to pay program that is market competitive and internally equitable. TCHD is committed to a market-based, competitive total compensation program. Its goal is to compensate employees at or above the average pay rates paid by comparable local and regional employers. Annual market assessments will be conducted in accordance with appropriate survey procedures. Final decisions regarding position placement within the pay line structure must consider, in addition to market data, organizational needs, and position relationships within job families, internal equity, and financial feasibility.
4. As part of its total compensation program, TCHD is committed to providing a market-competitive employee benefits program that is designed to meet the varying needs of employees with regard to health and welfare, retirement, and paid time off, as well as miscellaneous additional benefits designed to enhance employee total compensation.
   a. Health and welfare benefits are provided through a Section 125 Flexible Benefits Plan (medical, dental, vision, chiropractic, and prescription insurance, basic life and accidental death and dismemberment insurance, supplemental life and dependent life insurance, and flexible spending accounts). Benefited employees are eligible to participate in the Flexible Benefits Plan. The Plan is administered in accordance with the provisions of the plan document and applicable insurance contracts.
   b. Retirement benefits are provided through three plans sponsored by TCHD: National Security and Retirement Program, Money Accumulation Pension Plan, and Deferred Compensation Plan. Eligibility varies by Plan and is outlined in the applicable plan

documents. Each Plan is administered in accordance with the provisions of the applicable plan documents.

c. Paid Time Off benefits are provided as outlined in Policy #433, Paid Time Off.

d. TCHD reserves the right to change or terminate its benefits plans at any time.

5. Compensation policy and related practices and procedures are reviewed periodically and may change for a variety of reasons, including financial feasibility and market competiveness. Benefit plan documents shall be reviewed and amended annually.

6. The lead Human Resources official, with approval from the Chief Executive Officer, has authority and responsibility for administration of this policy.

7. Compensation for union represented positions will be determined by the negotiated collective bargaining agreement. Scheduled increases and amounts will be determined by the agreements.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Management of Human Resources

ISSUE DATE: 03/05 **SUBJECT:** Employee Health and Safety

REVISION DATE: 02/09; 04/12 **POLICY NUMBER:** 8610 – 477

Administrative Policies & Procedures Committee Approval:	**03/12**
Human Resources Committee Approval:	**04/12**
Board of Directors Approval:	**04/12**

A. **SAFETY POLICY STATEMENT:**

Employee health and safety is a major concern to Tri-City Healthcare District (TCHD). Every reasonable precaution is taken to provide employees with a safe place to work. Injury prevention is largely an individual responsibility so it is every employee's responsibility to think and act safely at all times.

B. **PURPOSE:**

To provide a safe and healthy working environment for all employees, to reduce the likelihood of work-related injuries, and to ensure proper treatment to employees who sustain an occupational injury or illness.

C. **POLICY:**

1. TCHD has established the following programs to ensure a safe and healthy working environment for all employees.

   a. Injury/Illness Prevention Program outlines the information that is available to employees regarding safety. The purpose of this program is to prevent work-related accidents and illnesses, identify, evaluate and correct workplace hazards and to provide ongoing safety training and communication programs designed to instruct employees in safe work practices. All employees are required to attend safety orientation before their first day of scheduled work unless authorized by the area Vice President or Director. TCHD has an Environment of Care Manual and an Infection Control Manual to provide employees with information to make them aware of safe work practices.

   b. Employee Occupational Accident and Illness Program ensures proper treatment to employees who sustain an occupational injury or illness. Employees who incur an injury or illness because of an occupational accident must report the injury to his/her supervisor immediately and to Employee Health Services by the next business day. If Employee Health Services is closed, the injured employees should report to the TCMC Emergency Department for treatment and must report their injury to Employee Health Services by the next business day. The injured employee's supervisor will ensure that an illness/injury investigative report is completed and that the employee has signed the report. The investigative report is then forwarded to Employee Health Services.

   c. Modified Duty Program provides a process to reasonably accommodate a physician's restrictions for employees who are injured on the job. This program also allows employees, who are receiving workers' compensation benefits, to remain productive while protecting their injury as it heals. Before an employee starts a temporary, modified duty assignment, the employee must meet with Employee Health Services. Employees on modified duty will be paid at their regular pay rate prior to the injury.

d. Ergonomic Program ensures proper medical management to eliminate and/or reduce the risk of repetitive motion injuries associated with employment activities. Employees may receive training to help identify potential ergonomic risks with work activities. The purpose of this training is to ensure that management and employees are sufficiently informed about the ergonomic hazards to which they may be exposed and are thus able to participate activel y in their own protection.

e. Post Offer Exam and Annual Health Review Programs have been established to ensure compliance with health and safety regulations. All employees are required to have an annual health review. It is the employee's responsibility to comply with this requirement. The completion of the annual review and testing is a requirement of continued employment. Failure to meet this requirement each year may result in termination of employment. (AP #424 – Coaching and Counseling for Performance Improvement)

f. Accidents to Auxilians Program ensures' proper treatment to members of the Auxiliary who are injured while performing duties as an Auxilian. Auxilians should report to Employee Health Services if they are injured while on duty no later than the next business day. If Employee Health Services is closed, Auxilians should proceed to the TCHD Emergency Department. Auxilians who are injured must complete an investigation report, which is available in Employee Heath Services.

g. Employee Health Services and the Environmental Health and Safety Committee, with approval from the Chief Executive Officer, has authority and responsibility for administration of this policy. Employee Health Services and the Environmental Health and Safety Committee, will develop practices and procedures to support the administration of this policy.

D. SAFETY AND INJURY PREVENTION PROCEDURES:

1. The following Employee Health procedures provide detailed procedures for the programs listed in Section 3.0 and can be found in the Health and S afety Manual.

   a. 400.1 Injury/Illness Prevention P rogram
   b. 400.2 Employee Occupational Accident and Illness
   c. 400.3 Modified Duty
   d. 400.4 Ergonomics
   e. 400.5 Post Offer Exam and Annual Health Revi ew
   f. 400.6 Accidents to Auxilians

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 08/10	**SUBJECT:** STAFF REQUESTS NOT TO PARTICIPATE IN CARE
REVISION DATE: 04/12	**POLICY NUMBER:** 8610-480

Administrative Policies & Procedures Committee Approval:	03/12
Human Resources Committee Approval:	04/12
Board of Directors Approval:	04/12

A. **POLICY:**

It is the policy of the Tri-City Healthcare District (TCHD) to review and approve, as appropriate, employee requests not to participate in specific aspects of patient care due to an employee's religious or cultural beliefs.

B. **PROCEDURE:**

1. TCHD shall make reasonable efforts to accommodate such requests. The accommodation of such requests must not negatively impact patient care.

2. Treatments or procedures generally known to be in conflict with a person's religious or cultural beliefs may include:

    a. Administration of blood and blood products;

    b. Sterilization procedures;

    c. Treatment or procedures designed to bring about the termination of pregnancy;

    d. Organ procurement for transplant; and/or

    e. Withholding or withdrawing of life support or life sustaining measures.

3. Employees shall provide treatment and care to all persons in need without regard to disability, race, creed, color, gender, national origin, lifestyle, or ability to pay.

4. Employees shall be given a copy of the Staff Requests Not to Participate in Care policy for review during the new hire processing appointment.

5. An employee who believes that a specific aspect of patient care or treatment is in conflict with his/her beliefs, and who desire not to participate in that aspect of patient care or treatment, shall submit a Staff Request Not to Participate in Care form to his/her supervisor as soon as the employee knows there is a conflict with the employee's belief and the care he/she is being required to provide.

6. Upon receiving such requests, supervisors, in consultation with appropriate clinical management personnel, shall determine what effect, if any, granting employee requests shall have on the delivery of proper patient care.

7. The Supervisor shall attempt to modify the employee's assignment based on request.

8. If it is determined that employee's requests may be granted without negatively effecting patient care, including treatment, the Supervisor shall grant the request.

    a. Supervisors shall devise specific and appropriate mechanisms to ensure that patient care, including treatment, shall not be negatively affected.

9. If it is determined the employees' request may not be granted, without negatively effecting patient care, including treatment, supervisors shall consult with Human Resources and inform employees that they shall participate in patient care until properly relieved from such duty.

    a. If an accommodation is not possible, the employee shall be permitted to explore other job opportunities within the hospital where an accommodation might be possible.

10. An employee who does not agree to provide appropriate care, treatment or services in an emergency because of religious, cultural or personal beliefs shall be placed on administrative leave from his or her current position, and the incident will be reviewed.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 07/11 **SUBJECT:** Step Progression

NEW POLICY DATE: 04/12 **POLICY NUMBER:** 8610-481

Administrative Policies & Procedures Committee Approval:	**03/12**
Human Resources Committee Approval:	**04/12**
Board of Directors Approval:	**04/12**

A. **PURPOSE:**

1. The purpose of this policy is to provide employees who acquire additional educational, experiential, licensure, or certification requirement to advance from Step 1 to Step 2 in that same job classification. Such step progression will alleviate the need to post a new job opening. Eligible positions will be reviewed periodically. In each job description, the requirements for transition to the next step must be clearly articulated.

B. **POLICY:**

1. In order for an employee to be eligible to progress from Step 1 to Step 2 in his/her job category, he/she must be in the current benefited or per diem position for six months.
2. The employee must not have any written warnings in his/her file for the previous six months.
3. In order to advance to the next level of progression, the employee initiates the process described by this Policy and must complete an Employee Transfer Request (ETR).
4. He/She must also attach any documentation that demonstrates his/her qualifications or eligibility for the position.
5. The employee must sign an attestation statement to verify the information is accurate.
6. The employee must also sign an acknowledgement that he/she will adhere to the Service Standards.
7. Employees advanced under this Policy must adhere to Policy No. 430, monitoring Licenses, Professional Registrations, and Certificates.
8. Employees covered under a recognized collective bargaining agreement will be subject to the terms and conditions of their respective contract.

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

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
March 12, 2015 Assembly Room 1

MEMBERS PRESENT: Board of Directors Chairman Larry Schallock, Director James Dagostino, Director Julie Nygaard, Dr. Victor Souza, Linda Allington, Marilyn Anderson, Xiomara Arroyo, Carol Brooks, Mary Lou Clift, Marge Coon, Gigi Gleason, Marilou de la Rosa Hruby, Robin Iveson, Linda Ledesma, Jack Nelson, Don Reedy, Bret Schanzenbach

NON-VOTING MEMBERS: Tim Moran, CEO; David Bennett, Sr. VP & CMO; Jodie Wingo, Sr. Director Marketing; Roma Ferriter, Audrey Lopez, Fernando Sanudo

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

MEMBERS ABSENT: Rosemary Eshelman, Gina McBride, Barbara Perez, Laura Vines

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CALL TO ORDER	The March 1, 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 March 12, 2015 agenda. The motion was seconded by member Robin Iveson and unanimously approved.		
PUBLIC COMMENTS & ANNOUNCEMENTS	No public comments were made.		
RATIFICATION OF MINUTES	Member Gigi Gleason motioned to approve the February 12, 2015 meeting minutes. The motion was seconded by Director Jim Dagostino and unanimously approved.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
March 12, 2015 Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
NEW BUSINESS	**TCMC UPDATE:** Tim Moran, CEO, provided an update regarding development of the 2015/16 Strategic Plan for the Medical Center. Mr. Moran noted that the plan will emphasize key issues such as stabilization and growth, specifically growth in the area of Primary Care Physicians. The plan will address the following issues: Recruitment: Approximately 30 Primary Care Physicians and Specialists, including Obstetricians, will be actively recruited. Campus Redevelopment: Mr. Moran noted that the Board of Directors recently authorized the selection of an Architectural Firm to guide the creation of a long-range campus plan. Currently five (5) different firms are being evaluated. Once a selection has been made, primary areas of focus will include: • Evaluation of the current campus layout and how existing structures can be incorporated into a long-range plan. • Upgrading of the emergency room and creation of a parking structure. Both of these issues are critical for patient satisfaction and the community. • Women's service – OB & Neonatal.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
	H-CAPS / Patient Satisfaction Scores: Mr. Moran stated that there are 8-9 key areas of focus when caring for patients. Among them are: • Overall patient satisfaction • Recommendations • Communication • Prescription medication communication and education • Cleanliness • Discharge instructions Member Gigi Gleason requested clarification regarding the Patient Satisfaction Surveys, asking who within the system is responsible to answer a patient's request for contact. Mr. Moran noted that Press-Ganey should be returning calls to patients. Gigi stated that she has requested a call-back on several surveys issued by Press -Ganey, and has not yet received a follow up from them. Mr. Moran said that this was good input and will be looked into. Director Nygaard asked committee members if they would be interested in reviewing the Strategic Plan once it is created. The members indicated that they are interested in reviewing the plan.	Follow up with Press-Ganey regarding return phone calls.	To be determined by Mr. Moran or designated other.
GUEST ELAINE VELKEY, CANCER SURVIVOR	Becky Orozco, Brand Management Specialist for Tri-City Marketing, introduced guest Elaine Velkey, a colorectal cancer survivor. Ms. Velkey shared her story of receiving her cancer diagnosis, the actions taken in response to her diagnosis, and her life now as a cancer survivor.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
	Ms. Velkey also expressed her appreciation for the support she received during the process, and her desire to educate others about the importance of colorectal cancer screening.		
CANCER PRESENTATION BY DR. WARREN PAROLY, CHAIR, TCMC'S DEPARTMENT OF ONCOLOGY	Jamie Johnson, Sr. Manager of Marketing introduced Dr. Warren Paroly, the Chairman of the Department of Oncology at Tri-City Medical Center. Dr. Paroly presented information on cancer, including risk factors and treatment as follows: • The public perception of "cancer screening" can be very different from the way screening is viewed by the medical and insurance industries. • There is a reality of cost vs. length or quality of life that must be a factor when the industry is reviewing screening options for patients. • Cancer screenings generally only show if cancer is present in a particular area of the body, thereby allowing the patient to make a decision about future actions. These typical screenings cannot actually change the situation for the patient during the screening process. Colonoscopies are uniquely different in that they are one of the only procedures where surgical action can be taken during the actual screening process to remove pre-cancerous polyps, thereby improving the patient's condition and chances of not acquiring the disease in the future.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
	• Dr. Paroly noted that the main factors involved in a colon cancer diagnosis are diet and lifestyle, citing a study where migrants from countries with a low rate of colon cancer, after migrating to the United States, assumed a higher risk of colon cancer within one generation due to adopting the nutrition and lifestyle of the American people. • Dr. Paroly noted that the community surrounding Tri-City Medical Center is very fortunate to have a great group of MD's who are experts in the area of colon cancer. As the conclusion of his presentation, Dr. Paroly asked if there were any audience questions. Some questions posed included: Q: In the 50+ age group, after a colonoscopy is performed, how long should the patient wait for the next exam? Dr. Paroly noted that generally speaking, it's around 7 years, however if the test is abnormal or if polyps were present, then the patient may need to go back within a few years to repeat the exam. The patient's Physician will provide guidelines based on the patient's condition and family history. Q: What is the minimum age to begin colorectal exams? Dr. Paroly stated that the minimum age is 50 years unless the patient has high risk factors. If so, the minimum age could drop to the 30's or 40's. For example, if the patient's parent developed colon cancer at age 48, then the patient should possibly begin colorectal exams as early as age 38.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
	Director Nygaard stated that she hopes this information is shared with the friends and family members of those present so that more people can be made aware of the importance of these exams.		
GRANT APPLICATIONS	Member Gigi Gleason shared that 9 grant applications were received as of March 3, 2015. As of March 6th, 63 grant applications had been received, doubling the amount of applications submitted in 2014. Director Nygaard noted that it is good that so many applications were submitted, but that it also highlights the great needs present in the communities we serve. Gigi Gleason thanked Jodie Wingo, Celia Garcia and Susan McDowell from the Marketing Department for their efforts in receiving and organizing the grant paperwork. The Marketing group returned their thanks to Gigi for her tremendous help, participation and efforts in getting the information sorted and organized. Gigi noted that the committee will provide their recommendations in May.	Committee Review of Submitted Grant Applications	Review Committee Members
OLD BUSINESS **BEHAVIORAL HEALTH SUB COMMITTEE**	Member Gigi Gleason noted that the Behavioral Health Sub Committee has not met since the February CHAC meeting, and will provide an update at the April meeting.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
March 12, 2015 Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
COMMITTEE COMMUNICATIONS	Member Linda Allington stated that she attended the recent A-fib Conference and that the presentation was very insightful and well received. Member Bret Schanzenbach noted that Vista's St. Patrick's Day celebration will be held this Sunday, March 15th. Also, the Meet the Leaders event, with keynote speaker Congressman Darrell Issa, will be held on Friday, March 27th at the Shadowridge Golf Club. Tickets information is available online if anyone is interested. Member Don Reedy stated that the Carlsbad Chamber of Commerce and the Oceanside Museum of Art will be hosting a Welcome Reception on March 17th for Sunita Cooke, Ph.D., the new President of Mira Costa College. Member Don Reedy also communicated with the group his commendation for Dr. Paroly as a great Physician. It was also noted that Physician's Day is fast approaching, and it would be nice to send a thank-you note to your Doctor if so inclined.		
PUBLIC COMMENTS	No Public Comments.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
March 12, 2015 Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
DATE & TIME OF NEXT CHAC MEETING	The next Community Healthcare Alliance Committee meeting will be held on Thursday, April 9, 2015 from 12:30pm – 2:00pm.		
ADJOURNMENT	The meeting was adjourned at 1:38pm.		

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
March 17, 2015

Members Present	Dr. James Dagostino, Director Kellett, Director Julie Nygaard, Dr. Marcus Contardo, Dr. Frank Corona, Kathleen Mendez, Robert Knezek, Wayne Lingenfelter
Non-Voting Members:	Tim Moran, CEO, Steve Dietlin, CFO, Wayne Knight, Sr. VP, Medical Services
Others Present:	Director Laura Mitchell, Director RoseMarie Reno, Frank Gould, Jane Dunmeyer, Ray Rivas, David Bennett, Carol Smyth, Sharon Schultz, Steve Matthews, Glen Newhart, Joni Penix, Mary Diamond, Charlene Carty, Jane Mitchell, Lou Montulli, Chris Miechowski, Tom Moore, Steve Young, Jody Root, Procopio
Absent:	Dr. John Kroener, William McGaughey, Steve Harrington

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Dagostino called the meeting to order at 12:33 pm.		
2. Approval of Agenda		**MOTION** **It was moved by Director Nygaard, Dr. Kellett seconded, and it was unanimously approved that the agenda of February 17, 2015 be approved.**	
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 February 17, 2015		Minutes ratified. **MOTION** **It was moved by Dr. Contardo, Director Nygaard seconded, with Dr. Kellett abstaining, that the minutes of February 17, 2015, be approved as written.**	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
5. Old Business	None		
6. b. Policy Review: • Medi-Cal Treatment Authorization Request (TAR) Requirements	**Medi-Cal Treatment Authorization Request (TAR) Requirements** ***Purpose:*** To ensure the appropriate approved Treatment Authorization Request (TAR) has been received for Medi-Cal admissions. This policy was presented in redline version, by Ray Rivas. Discussion ensued, however, there were no additional changes or modifications recommended to this policy.	**MOTION** **Director Nygaard moved, Mr. Lingenfelter seconded, and it was unanimously approved to recommend the Board of Directors approve the Medi-Cal Treatment Authorization Request (TAR) Requirements policy, as presented.**	Ray Rivas
• Audits for Third Party Insurance	**Audits for Third Party Insurance** ***Purpose:*** Cooperate with reasonable third-party payor audits performed in accordance with the provisions set forth herein. This policy was presented in redline version by Ray Rivas. Some discussion ensued, however, there were no changes or modifications recommended to the policy.	**MOTION** **Mr. Lingenfelter moved, Dr. Kellett seconded, and it was unanimously approved to recommend the Board of Directors approve Audits for Third Party Insurance, as presented.**	Ray Rivas / Joni Penix

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
• Plan to Manage and Estimate Project Cost	**Plan to Manage and Estimate Project Cost** ***Purpose:*** To create a policy and process for all hospital personnel to submit an accurate project cost proposal to administration for request for approval. This policy was presented by Chris Miechowski in redline version. Some discussion ensued, however, there were no changes or modifications recommended to the policy.	**MOTION** **Director Nygaard moved, Dr. Kellett seconded, and it was unanimously approved to recommend the Board of Directors approve Plan to Manage and Estimate Project Cost, as presented.**	Chris Miechowski
b. Physician Agreement – Medical Director, Surgery	Mary Diamond presented the physician agreement for the Medical Director, Surgery. This role will provide medical leader-ship, while acting as a liaison to Perioperative Services. It is expected that this directorship will be filled by a physician currently on staff. Mr. Moran explained that this medical director would help improve efficiency, clarify some cost issues and help achieve goals with 100% compliance. Director Nygaard requested that this item be added to the Work Plan, with quarterly follow-up.	**MOTION** **Dr. Kellett moved, Dr. Contardo seconded, and it was found in the best interest of the public health of the communities served by the District to approve the Medical Director - Surgery Agreement for a term of 15 months starting April 1, 2015, and ending on June 30, 2016 at $2,400 per month for an annual (12 month) amount of $28,800 and a term cost of $36,000.** *(Barbara Hainsworth will add this item to the Work Plan)*	Mary Diamond / Sharon Schultz Barbara Hainsworth

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
c. Proposal for Patient Bed Mattresses – ~~Stryker~~	Tom Moore presented this agenda item, for the replacement of 110 mattresses and 5 air pumps. He requested that the write-up be amended to remove Stryker as the exclusive vendor. This modification would permit obtaining proposals from other vendors, for a potential reduction in the overall replacement costs of these items.	**AMENDED MOTION** **Dr. 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 the purchase agreement with Stryker Medical OR, as amended, another vendor, for the purchase of 110 IsoGel or comparable mattresses, and 5 air pumps for a total cost of not more than $326,701.**	Tom Moore / Mary Diamond
d. Renewal On-Call Coverage Agreement – Pulmonary Services • Frank Corona, M.D. • Safouh Malhis, M.D. • Martin Nielsen, M.D. • Mark Yamanaka, M.D.	Sharon Schultz presented the renewal of On-Call Coverage Agreement – Pulmonary Services. Some discussion ensued, during which Director Nygaard clarified that the total amount was based on the actual days of call coverage. It was also clarified that the amount calculated was for 366 days, due to 2016 being a Leap Year. In addition, it was requested that the Motion be amended to read: "Not to exceed a daily rate of $897 and a total ***"collective"*** cost . . . "	**MOTION** **Dr. Kellett moved, Kathy Mendez seconded, with Dr. Corona abstaining.** **It was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Doctors Frank Corona, Safouh Malhis, Martin Nielsen and Mark Yamanaka as ED On-Call Coverage Physicians for a term of 12 months beginning July 1, 2015 and ending June 30, 2016. Not to exceed a daily rate of $897 and a total collective cost for the term of $328,302.00, split between multiple panel physicians.**	Sharon Schultz
e. Financials – February 2015	Steve Dietlin presented the financials ending February 28, 2015 (dollars in thousands) **Fiscal Year to Date** Operating Revenue $221,353 Operating Expense $221,870		Steve Dietlin

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	EROE $ 2,456 EBITDA $ 13,122 **TCMC –Key Indicators –FYTD** Avg. Daily Census 195 Adjusted Patient Days 75,498 Surgery Cases 4,425 Deliveries 1,771 ED Visits 46,940 **Current Month** Operating Revenue $ 26,062 Operating Expense $ 26,453 EROE $ 370 EBITDA $ 1,652 **Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R (in millions) $ 42.7 Days in Net A/R 49.0 **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		
f. Work Plan – Information Only	Director Dagostino reported that these agenda items were for review only, but Committee members were welcome to ask questions.		

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
• Aionex Bed Board • Dashboard	**Aionex Bed Board** Upon reviewing the Aionex Executive Summary and the accompanying spreadsheet, some discussion ensued. Sharon Schultz relayed that the lack of improvement in the current statistics could be attributed to the months of January and February being some of the busiest times of the year. She also conveyed that she has been working with Case Management to assist with discharges, and turn-around times for available patient beds. Director Nygaard reiterated a request that this item remain as a monthly agenda item on the work plan. **Dashboard** No discussion ensued.	*(It was confirmed that this item will remain as a monthly Work Plan item).*	Sharon Schultz
7. Comments by Committee Members		None	Chair
8. Date of next meeting	April 21, 2015		Chair
9. Community Openings	None		Chair
10. Oral Announcement of items to be discussed during closed session. (Government Code Section 54957.7)			Chair

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
11. Motion to go in to Closed Session		**MOTION** **Director Nygaard moved, Dr. Contardo seconded and it was unanimously approved to go into Closed Session at 1:32 pm.**	
15. Open Session		**MOTION** **Dr. Contardo moved, Dr. Corona seconded and it was unanimously approved to go into Open Session at 1:54 p.m.**	
16. Report from Chairperson of any action taken in Closed Session (Authority: Government Code, Section 54957.1)	No report made.		
17. Adjournment	Meeting adjourned 1:55 pm.		

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE:	**4/99**	**SUBJECT:**	**MEDI-CAL TREATMENT AUTHORIZATION REQUEST (TAR) REQUIREMENTS**
REVISION DATE:	**5/03; 1/06; 9/10**	**POLICY NUMBER:**	**8610-268**

Administrative Policies & Procedures Committee Approval:	~~12/10~~2/15
~~**Executive Council Approval:**~~	~~01/11~~
Finance & Operations Committee Approval:	01/11
Board of Directors Approval:	01/11

A. **PURPOSE:**

1. To ensure the appropriate approved Treatment Authorization Request (TAR) has been received for all Medi-Cal admissions.

B. **DEFINITIONS:**

1. Medi-Cal Pending Patients: Patients who have applied to California Department of Public Health (CDPH) for assistance and have not been approved. These patients are considered cash paying and the hospital's deposit/payment policies apply.
2. Medi-Cal Eligible Patients: Patients who have provided valid proof of eligibility by way of a CDPH 1410 form and/or verification on the Medi-Cal Point of Service (POS) ~~system.~~ Online website (eTAR).
3. Approved TAR: A treatment authorization request, which has been submitted by the physician's office and has been approved by the field office. An approved TAR is required in advance of all elective and urgent procedures.

C. **POLICY:**

1. All Medi-Cal approved elective admissions or procedures requiring a TAR will have one obtained by the treating physician's office prior to the scheduled date of service.
2. Registration will follow the usual procedures for admission ensuring that the approved TAR has been received. Case Management and Registration will coordinate any questionable admissions to insure TARs are appropriate and timely.
3. It will be the responsibility of the Registration Department to notify Surgical Services of any change. Surgery Scheduling informs the physician's office a TAR is required prior to the services being rendered and if TAR is not received within 48 hours of the scheduled time the case will be rescheduled.
4. If Medi-Cal TAR is approved with a share of cost:
   a. Registration is responsible for verifying a patient's share of cost has been met. If the share of cost has not been met, Registration shall request payment in full or contact the in-house Preadmitter ~~Insurance Specialists~~ to make appropriate payment arrangements with the patient. In accordance with hospital policy, payment arrangements will not extend beyond a six month period.
   ~~b. Once satisfactory arrangements have been made to collect the share of cost, the SOC will be cleared by registration or the insurance specialists in accordance with hospital policy.~~
   b. Medi-Cal pending admits will be handled as cash. The hospital policy regarding deposits and payment apply. ~~Med Assist~~ Eligibility vendor ~~Health Advocates~~ will, as needed, screen patients and continue to follow up to secure applications and/or ensure eligibility.

D. **PROCESS:**

1. ~~Case Management~~ Case Management will perform initial clinical review utilizing ~~InterQual~~ standardized criteria at Hospital points of entry (ED, Procedural Areas etc) and Case Management ~~shall~~ will contact the admitting / treating physician to discuss the case ~~if the procedure normally requires~~to determine appropriate level of care: ~~inpatient~~Inpatient or Observation level of care.

2. Case Management - performs concurrent daily clinical review for Managed Medi-Cal – (Molina, CHG for example and APRDRG clinical review for standard Medi-Cal beneficiaries)
   a. Case Manager's clinical reviews are documented in ~~Allscripts~~ Case Management system under

"TAR (Medi-Cal) REVIEW"

b. Registration Staff presents the "TAR (Medi-Cal) REVIEW" Case Management with the E-TAR

3. Case Management will facilitate communication with treating physician to clarify any issues surrounding appropriate level of care (Inpatient versus Observation versus 10-Bed-Call) and obtain appropriate physician orders.

~~1.~~4. Case Management will facilitate communication with Utilization Management Medical Director for issues regarding medical necessity and to coordinate MD to MD communication

~~2. Case Management shall coordinate activities between the patients' physician until a final decision is made at which time Case Management will notify the Registration Department of the outcome.~~

~~a. If the final decision is to admit the patient, the patient's physician will be required to have an approved TAR prior to admission. Registration will monitor and notify all parties.~~

~~b. It may be necessary for Registration and/or Case Management to complete the TAR for the physician, have it signed and delivered to field office.~~

~~3.~~5. Registration is responsible for notifying Surgical Services of any changes.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE:	**10/96**	**SUBJECT:**	**AUDITS FOR THIRD PARTY INSURANCE**
REVISION DATE:	**10/99; 8/02; 12/02; 12/03; 11/08; 9/10**	**POLICY NUMBER:**	**8610-255**

Administrative Policies & Procedures Committee Approval:	**~~12/10~~02/15**
~~Executive Council Approval:~~	**~~01/11~~**
Finance & Operations Committee Approval:	**01/11**
Board of Directors Approval:	**01/11**

A. **PURPOSE:**

1. Cooperate with reasonable third-party payor audits performed in accordance with the provisions set forth herein

B. **POLICY:**

1. To ensure all medical billing audits are performed efficiently and effectively, thereby, promoting the accuracy and integrity of hospital charges. A comprehensive medical billing audit program will serve to:

C. **PROCEDURE:**

1. **GENERAL INFORMATION:**
   a. The scope of a medical billing audit is limited to verifying that charges on the detailed hospital bill are accurate, represent services rendered to the patient, and are ordered by a physician. However, services or items may be provided based upon standard hospital practices and/or Nursing protocols and procedures.
   b. The audit does not assess the "reasonableness" of the charges, or medical necessity related to patient bills. A review of medical necessity for the services provided may be performed, but the billing audit process does not encompass these tasks.
   c. Documentation—In concert with the position taken by the American Hospital Association's (AHA) publication, Billing Audit Guidelines (1992), the hospital does not attempt to make the patient's Medical Record a duplicate bill. Rather, the purpose of the Medical Record is to reflect clinical data on diagnosis, treatment, and outcome. Charges on patient bills may be substantiated by Nursing protocol and/or standard hospital practices, which are not reflected in the Medical Records. Furthermore, Ancillary departments may have information or documentation not contained in the Medical Record that may be used to substantiate charges. In a business relationship, the hospital will act in good faith during the course of all transactions involving a patient's account, and the same is expected of all outside parties acting on behalf of the patient.
2. **HOSPITAL AUDITOR RESPONSIBILITIES:**
   a. The hospital will designate an individual to be responsible for coordinating all medical billing audit activities (i.e., Patient Account Auditor; hereafter referred to as Chart Auditor). Medical billing audit activities are prompted via both internal and external processes, and include concurrent, focus, miscellaneous, patient request, and insurance defense audit types. In addition to coordinating all internal audit activities, (i.e., concurrent, focus, and miscellaneous audits), the Chart Auditor will serve as the primary liaison between the hospital and all outside parties requesting patient account audits. All medical billing audit activities are to be documented and logs maintained within the hospital. All audit-related account adjustments are to be processed only after appropriate facility-level sign off

approval has been obtained. All audit related account adjustments are to be signed and dated by the requestor. Principles related to segregation of duties dictate that audit-related account adjustments shall not be processed by the requestor. All audit-related account adjustment documents are to be maintained in accordance with applicable hospital record retention policies.

3. **THIRD-PARTY PAYOR (INSURANCE DEFENSE) AUDITS:**

a. Tri-City Medical Center will have a Chart Auditor on staff or a person assigned the responsibility to properly conduct third-party payor (insurance defense) audits. This person will serve as the primary liaison between the hospital and any outside audit party. Direct contact by the payor/outside audit parties with department heads is strictly prohibited. All questions regarding clarification of charging practices and protocols are to be directed to the Chart Auditor to prevent disruption of the normal flow of operation within the hospital.

b. The hospital Chart Auditor must have a current Charge Description Master (CDM) in order to provide accurate billing to the Third-Party Auditor. He/she will submit all audit adjustments to the Chart Auditor at the conclusion of the audit.

c. Third-party payor (Insurance Defense) audits of patient accounts will be conducted in accordance with all policies and procedures set forth herein. The costs incurred, and utilization of resources imposed on the hospital in connection with such audits, must not be unduly borne by other patients. Therefore, these policies and procedures, along with associated fees and requirements, will be strictly enforced so that all reasonable audits can be performed efficiently. Involved parties must be aware that specific managed care contract language which references audit procedures is legally binding for the duration of the contract.

d. Third-party payor audits are not a forum for addressing questions concerning the level or scope of care, medical necessity, or the pricing structure of items or services delivered by the hospital. Qualified personnel and mechanisms exist to deal with these issues outside the scope of the medical billing audit process, and, therefore, will not be considered during the course of the audit.

4. **WRITTEN NOTICE OF INTENT TO AUDIT:**

a. Any intent to audit an account requires written notice from the outside audit party to the hospital Chart Auditor within four months of patient discharge. Under no circumstances will telephone contact alone be sufficient means to initiate the audit process.

i. The written notice must state the reason the claim was selected for audit and must contain the following information:

1. Name of patient
2. Patient account number
3. Dates of service
4. Name of insurance carrier requesting an audit
5. Name of firm and name of person, if known, who will perform the audit
6. Total charges to be audited

ii. Written notice of intent to audit will not be considered if received more than four months after patient discharge. The onsite audit must be scheduled and completed within 60 days of receipt of intent to audit. These guidelines are to be used for all external entities, unless there is a signed contract in place that has language specific to the audit process, and then the contract will supersede the audit policy.

iii. Audits requested by Third-Party Audit Company representatives on behalf of an insurance carrier will not be scheduled or conducted until the hospital Chart Auditor is in receipt of a signed and dated copy of the Business Associate Contract between the insurance carrier and the Third-Party Audit Company. Auditors who contractually represent Third-Party Audit Companies must provide written proof of their contractual relationship before an audit will be scheduled or conducted.

iv. All audits must be conducted on site. The hospital's Chart Auditor must ensure that only the portion of the Medical Record that applies to the account being audited is provided for onsite review. Under no circumstances is any portion of a patient's Medical Record to be provided to, reviewed, or considered by Third-Party Audit

personnel unless a contrary audit procedure (a) is expressly set forth in the managed care contract that applies to the account, or (b) is required by applicable federal, state, or local law. The Third-Party Audit personnel shall be required to furnish to the Chart Auditor written evidence proving that the exceptions referred to in clauses (a) and (b) of the previous sentence apply to the account under audit, or such exceptions shall not apply to the audit. A complete Medical Record may not be copied for the purpose of offsite reviews.

v. A single account may not be audited by a third party more than once. Any additional third-party requests for an audit will be denied. The findings of the first audit will be used as the results for any additionally requested audits.

vi. It is hospital policy to allow no offsite audits. All audits are conducted on site under the direction and coordination of the hospital Chart Auditor.

b. Account Status Requirements
   i. Payment of 100% of policy benefits must be received prior to scheduling the audit.
   ii. The Medical Record must be complete prior to conducting the audit.
   iii. Audits will not be performed on interim bill claims.

c. Audit Fees
   i. An auditing fee is required by the hospital if an internal audit of the account has previously been performed. The minimum audit fee of ~~$450.00~~ [hl] $1,000.00 must be received prior to, or upon commencement of the onsite audit, irrespective of any pre-audit payment of policy benefits.

d. Disclosure Authorization
   i. Specific state regulations determine procedures for release of records containing sensitive information. Consult Medical Records' policy for handling of these records.

e. Pre-Audit Procedure
   i. The hospital should respond to the written notice of intent to audit by supplying the Third-Party Auditor with a written copy of the Tri-City Medical Center Third-Party Audit Policy Statement (refer to Exhibit A).
   ii. A log must be maintained by the hospital documenting dates and recipients of all audit policies sent to outside parties.
   iii. Onsite audits are not to be scheduled until the hospital receives written acknowledgement that the Third-Party Auditor agrees to abide by the Tri-City Medical Center Third-Party Audit Policy Statement.
   iv. All requests by Third-Party Auditors to reschedule or cancel a previously scheduled audit must be received prior to the date of the audit. All such requests must be made in writing exclusively through the hospital Chart Auditor and are subject to a minimum re-schedule fee of $150.00. This fee may be charged to the carrier or its agent if notice is not received within ten days of the originally scheduled audit date. An audit may be rescheduled only once.
   v. Should the auditor fail to appear as scheduled, the audit may not be re-scheduled.

f. Audit Process
   i. All accounts, without exception, are to be pre-audited in their entirety by the hospital Chart Auditor prior to the date of the scheduled audit.
   ii. To document the audit, an itemization of under and overcharges must be individually completed by both auditors and signed at the conclusion of the audit. All parties will agree to recognize, record, and present any identified unsupported or unbilled charges.
   iii. An onsite exit conference will be conducted at the conclusion of each audit. Once both parties agree, in writing, to the audit findings, audit results are final.
   iv. A final written report of the audit findings is to be submitted to the hospital by the Third-Party Auditor within ten business days of the exit conference.
   v. Both unbilled (undercharges) and unsupported (overcharges) charges must be provided in the final report. These results must be detailed by description and price, and summarized by department.
   vi. Upon receipt of the written report, the hospital will advise the payor whether the results are accepted or will be contested.

vii. If necessary, the hospital will submit an additional bill that itemizes previously unbilled charges identified in the audit.

viii. Charges submitted to the Chart Auditor are required to be itemized by line item. The Business Office is to be notified of the date the audit was completed and the total adjustment to the bill.

ix. If indicated, a net refund or adjustment of charges will be completed by the Business Office within the regular course of business.

g. Personal/Non-Covered/Unbillable Items

i. Some charges may be considered personal, non-covered, or unbillable pursuant to the terms and conditions of a particular contract between the payor and the hospital. If identified as such via specific current contract language, these items are to be listed separately from the audit and not included in stated overcharges. Under no circumstances is it acceptable to apply government regulations/methodologies to non-government accounts, unless so stipulated by contract.

Exhibit A: Sample Copy

TRI-CITY MEDICAL CENTERTHIRD-PARTY AUDIT POLICY STATEMENT

The hospital wishes to cooperate with any commercial audits of patient accounts that are reasonable and that are performed in accordance with the provisions set forth herein. These policies and procedures, along with the associated fees and charges, are necessary so all audits can be performed efficiently, and the costs imposed on the hospital, in connection with such audits, will not be unduly borne by other patients.

In concert with the position taken by the AHA, the hospital does not attempt to make the patient's Medical Record a duplicate patient bill. Rather, the purpose of the Medical Record is to reflect clinical data on diagnosis, treatment, and outcome. Charges on patient bills may be substantiated by Nursing protocol and/or standard hospital practices, which are not reflected in the Medical Records. Furthermore, Ancillary departments may have information or documentation not contained in the Medical Record that can be used to substantiate charges. Moreover, questions regarding scope of care or medical necessity and/or issues relating to the cost of particular items or services are, as defined by the joint guidelines for billing audits, inappropriate in the forum of a charge audit.

POLICY DESCRIPTION

Policy 1

The hospital requires written notice of intent to audit be received within four months from the date of the discharge bill. Audit requests received after four months from the discharge bill will not be considered. Onsite audits are to be scheduled and completed within 60 days of receipt of intent to audit.

Policy 2

Written notice must state the reason for audit, and identify name of patient, account number, dates of service, carrier requesting audit, name of firm and name of person, if known, who will perform the audit, and total charges to be audited.

Policy 3

Audits requested by Third-Party Audit Company representatives on behalf of an insurance carrier will not be scheduled or conducted until the hospital Chart Auditor is in receipt of a signed and dated copy of the Business Associate Contract between the insurance carrier and the Third-Party Audit Company. Auditors who contractually represent Third-Party Audit Companies must provide written proof of their contractual relationship before an audit will be scheduled or conducted.

Policy 4

Upon receipt of written notice, the hospital will respond by sending the TRI-CITY MEDICAL CENTER Third-Party Audit Policy Statement. Audits will not be scheduled until the hospital receives written acknowledgement that the Third-Party Auditor agrees to abide by the policy.

Policy 5

All audits will be conducted on site. Offsite reviews of photocopied records are unacceptable. Under no circumstances is any portion of a patient's Medical Record that does not pertain to the dates of service for the account being audited to be provided to, reviewed, or considered by the Third-Party Audit personnel unless a contrary audit procedure (a) is expressly set forth in the managed care contract that applies to the account, or (b) is required by applicable federal, state, or local law. The Third-Party Audit personnel shall be required to furnish to the Chart Auditor written evidence proving that the exceptions referred to in clauses (a) and (b) of the previous sentence apply to the account under audit, or such exceptions shall not apply to the audit.

Policy 6

A single account may not be audited by a third party more than once. Any additional third-party requests for audit will be denied. The findings of the first audit will be used as the results for any additionally requested audits.

Policy 7

Tri-City Medical Center personnel will provide copies of the discharge bill. All requests for itemized statements and UB-04's will be approved.

Policy 8

The Medical Record must be complete prior to conducting the audit. Payment of 100 % of policy benefits must be received prior to scheduling the audit. Audits will not be performed on interim bill claims.

Policy 9

Audit fees will be imposed in the absence of pre-audit payment of policy benefits. A minimum fee of ~~$450~~[h2]~~.00~~ $1,000.00 is required on any account previously audited internally. This fee is irrespective of any pre-audit payment of policy benefits.

Policy 10

All requests by Third-Party Auditors to reschedule or cancel a previously scheduled audit must be received prior to the date of the audit. All such requests must be made in writing exclusively through the hospital Chart Auditor and are subject to a minimum re-schedule fee of $150.00. This fee may be charged to the carrier or its agent if notice is not received within days of the originally scheduled audit date. An audit may be rescheduled only once. No-shows will not be rescheduled.

Policy 11

Third-Party Auditors will report to the hospital Chart Auditor upon arrival at the facility. To prevent disruption of hospital operations, Third-Party Auditors are prohibited from making direct contact with hospital department personnel. All questions regarding clarification of charging practices and/or protocols are to be directed exclusively to the hospital Chart Auditor.

Policy 12

An itemization of under and overcharges must be individually completed by both auditors and signed at the conclusion of the audit. All parties will agree to recognize, record, and present any identified unsupported or unbilled charges.

Policy 13

An onsite exit conference will be conducted at the conclusion of each audit. Once both parties agree, in writing, to the audit findings, audit results are final. A final written report of the audit findings is to be submitted to the hospital by the Third-Party Auditor within ten business days of the exit conference. Both unbilled (undercharges) and unsupported (overcharges) charges must be provided in the final report.

Policy 14

Upon receipt of the written report, the hospital will advise the payor whether the results are accepted or will be contested.

Policy 15

If necessary, the hospital will submit an additional bill that itemizes previously unbilled charges identified in the audit. If indicated, a net refund or adjustment of charges will be completed by the hospital Business Office within the regular course of business.

Policy 16

Some charges may be considered personal, non-covered, or unbillable pursuant to the terms and conditions of a particular contract between the payor and the hospital. If identified as such via specific current contract language, these items are to be listed separately from the audit and not included in stated overcharges. Under no circumstances is it acceptable to apply government regulations/methodologies to non-government accounts, unless so stipulated by contract.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 10/02

SUBJECT: PLAN TO MANAGE AND ESTIMATE PROJECT COST

REVISION DATE: 02/03; 04/06; 06/09; 07/11

POLICY NUMBER: 8610-277

Administrative Policies & Procedures Committee Approval: ~~06/11~~02/15

~~**Executive Council Approval:** 06/11~~

Finance & Operations Committee Approval: 07/11

Board of Directors Approval: 07/11

A. **PURPOSE:**

To create a policy and process for all hospital personnel to submit an accurate project cost proposal to administration for request for approval.

B. **POLICY:**

1. Once a project has been discussed within a department, a Director/Manager will accurately describe the scope of the project and submit a Renovation Request Form to his/her Vice-President for scope approval. Project must be reviewed by Facilities and Information ~~Services~~ Technology for feasibility. Upon review and approval by the Executive Council of the project scope the written request will be submitted to the Facilities Department for cost analysis.
2. After receiving direction from Executive Council, the Facilities Department will:
   a. Meet with all personnel involved to determine the complete construction scope of the project.
   b. Provide an initial estimated cost and projected completion time to Administration and to the Space Planning Committee, if needed.
3. If Executive Council's decision is to approve a further investigation of the potential project, the following items will take place:
   a. If the project scope warrants, an architect will be called in to begin design development.
   b. If the project scope warrants, a construction manager will be called in to value engineer and put together a project budget, as well as manage the construction of the project.
4. Facilities will keep Administration abreast of design and budget details as the project develops.
5. After a complete scope and preliminary design have been established, a project budget will be finalized, a capital purchase requisition (CPR) will be submitted by the Facilities Department with the total estimated project cost to the Capital Budget Committee for review and approval. Any necessary bidding or bidding provisions will be finalized and necessary Board approvals will be completed.
6. Upon Administration/Board approval, the approved CPR will be submitted by the Facilities Department to the Finance Department for approval and assignment of a budget number.
7. Once the project has been approved and assigned a budget number, it will be assigned a project number (CIP Number) and construction administration will begin.
8. If the project scope changes at any point during the project, Administration must give written approval for the additional architectural/engineering fees and construction costs associated with these changes. This supplemental CPR will follow the same process of approval as the original project request.
9. If approved, the supplemental CPR will be submitted to Administration for review and approval. Any associated costs will be added to the total project budget.
10. During the fiscal year budget development process, the Facilities Department will utilize both in-house estimating resources as well as outside contractor resources to develop budget estimates Administration can depend on for the next fiscal year.
11. Once Administration and the Finance Department have approved a project, it is the responsibility of the area's Director/Manager to coordinate the project's progress and schedule all project related meetings. If any other departments are affected or involved, it is the responsibility of the Director/Manager to keep everyone informed of progress and responsibilities.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: MARCH 17, 2015
PHYSICIAN AGREEMENT – MEDICAL DIRECTOR, SURGERY

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

Physicians Name: Medical Director, Surgery
Area of Service: Surgery
Term of Agreement: April 1, 2015 thru June 30, 2016

Maximum Annual Total: $28,800

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	15 month (Term) Cost
$150	16	192	$ 2,400	$28,800	$36,000

New Position requested to provide Medical Leadership/Liaison to Perioperative Services

Position Responsibilities:

- Clinical and Administrative Consultation for Department
- Participates in the decisions made by OR Committee and works to facilitate successful implementation
- Works with Medical staff to resolve physician/staff conflicts or performance problems
- Oversees effective implementation of pre-admission testing and clearance processes
- Serves as liaison between Perioperative Services and physicians to achieve compliance with regulations
- Be physically available on a day to day basis to help coordinate and monitor Operating Room Services

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

Person responsible for oversight of agreement: Mary Diamond, Sr. Director Nursing, Sharon Schultz, CNE

Motion:

I move that Finance Operations and Planning Committee Recommend that TCHD Board of Directors authorize the Medical Director -Surgery Agreement for a term of 15 months starting April 1, 2015 and ending on June 30, 2016 at $2,400 per month for an annual (12 month) amount of $28,800 and a term cost of $36,000.

EXHIBIT A

MEDICAL DIRECTOR DUTIES AND RESPONSIBILITIES

Position Summary: The Medical Director of Surgery, in collaboration with the Nursing Director of Surgical Services, Chief of Surgery, and Chief of Anesthesia, is responsible for physician leadership to support and improve the quality of care delivery in within the operating rooms and its supporting areas.

Major Position Responsibilities:

- Provides clinical and administrative 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;
- Be physically available on a day to day basis to help coordinate and monitor Operating Room services;
- Participates in decisions made by the Operating Room Committee related to the Department and works to facilitate their successful implementation;
- Is delegated authority by the OR Committee to make changes that will improve patient safety and efficiency;
    - The OR committee will delegate authority to the Medical Director to hold Physicians accountable for Block utilization;
    - Criteria for consequences of time not used needs to be enforced;
        - i.e. if a Physician's Block utilization is <65% for 3 consecutive months, the Block will be taken away.
- Establish and evaluate policies, procedures, and protocols for the Department for patient care and medical developments, including new treatment modalities, drug information and other relevant developments;
- Works with Medical Staff to resolve physician-staff conflicts or performance problems;
- Mediates clinical care and administrative issues within the Department;
- Oversees the effective implementation of pre-admission testing and clearance processes for patients who are scheduled for surgery;
- Serves as liaison between Perioperative Services and physicians to achieve compliance with the Hospital and Medical Staff Bylaws, the recommendations of the Joint Commission, and the requirements of all federal, state and municipal statues, regulations, ordinances and directives governing the provision of healthcare services and the practice of medicine, including, but not limited to, Medicare Conditions of Participation, and California Health & Safety Code 120 et seq., and the regulations promulgated thereunder applicable to licensed healthcare facilities, and patient privacy and consent laws.
- Collaborates with Quality Improvement to review performance improvement issues and implement recommendations as determined by the Quality Improvement Committee;
- As permanent member of the Operating Room Committee, continually evaluates and improves the Operating Room utilization, productivity, and efficiency by reviewing data trends on a monthly basis;
- Collaborates with Pharmacy Services to assure physician and nursing compliance with appropriate handling of medications and controlled substances;
- Ensures that all medical services provided by Department are consistent with Hospital's mission and vision;
- Attends necessary meetings, not to exceed the hours limit set forth in Section 4.1 in order to accomplish each of the above duties, rendering reports, recommendations, and evaluations as may be reasonably requested by Hospital.

EXHIBIT B

Metrics for Measured Outcome Performance

Reduction in first case late starts from 40% to 20%. Late start is defined as any first case not in the OR by 0715 (0815) Thursday).

Increased utilization of block time from current 3rd quarter average of 63% to an average of 75%.

Reduction in TAT for "close to cut' for to follow cases of the same surgeon from current of 63 minutes to 50 minutes.

100% compliance with 'time out' at start of procedure.

100% compliance of not closing until the sponge count is accurate.

RESTRICTED EQUATED HOURLY RATES TABLES

RESTRICTED EQUATED HOURLY RATES

Anesthesiology						
Restricted Equated Hourly Rates	n Orgs	25th Percentile	Mean	Median	75th Percentile	90th Percentile
Overall	11	$61.09	$116.00	$106.64	$150.00	$220.00
Trauma Center	8	$96.13	$134.65	$114.16	$185.00	isd
Non-Trauma Center	3	isd	isd	isd	isd	isd
Level I Trauma Center	6	$106.64	$144.81	$114.16	$220.00	isd
Trauma Coverage	5	$85.62	$116.95	$106.64	$114.16	isd
Non Trauma Coverage	6	$61.09	$115.21	$96.08	$150.00	isd

isd=insufficient data

Critical Care/Intensivist						
Restricted Equated Hourly Rates	n Orgs	25th Percentile	Mean	Median	75th Percentile	90th Percentile
Overall	13	$53.18	$87.52	$82.07	$108.75	$141.67
Trauma Center	7	$53.18	$97.08	$83.33	$141.67	isd
Non Trauma Center	6	$50.23	$76.38	$74.37	$96.77	isd
Level I Trauma Center	5	$53.18	$97.49	$77.08	$141.67	isd
Trauma Coverage	3	isd	isd	isd	isd	isd
Non-Trauma Coverage	10	$53.18	$89.27	$79.58	$112.52	$152.08

isd=insufficient data

Hospitalist						
Restricted Equated Hourly Rates	n Orgs	25th Percentile	Mean	Median	75th Percentile	90th Percentile
Overall	10	$68.00	$92.36	$96.05	$122.95	$135.46
Trauma Center	5	$76.71	$92.92	$85.63	$108.33	isd
Non-Trauma Center	5	$68.00	$91.81	$106.48	$122.95	isd
Level I Trauma Center	3	isd	isd	isd	isd	isd
Trauma Coverage	1	isd	isd	isd	isd	isd
Non-Trauma Coverage	9	$68.00	$93.11	$106.48	$122.95	isd

isd = insufficient data

Internal Medicine						
Restricted Equated Hourly Rates	n Orgs	25th Percentile	Mean	Median	75th Percentile	90th Percentile
Overall	5	$60.00	$64.78	$65.00	$70.00	isd
Trauma Center	2	isd	isd	isd	isd	isd
Non Trauma Center	3	isd	isd	isd	isd	isd
Level I Trauma Center	2	isd	isd	isd	isd	isd
Trauma Coverage	0	isd	isd	isd	isd	isd
Non Trauma Coverage	5	$60.00	$64.78	$65.00	$70.00	isd

isd = insufficient data

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 17, 2015
PROPOSAL for PATIENT BED MATTRESSES

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

Vendor Name:

Area of Service: Nursing

Term of Agreement: Capital Equipment Purchase – Mattresses for Patient Beds

Maximum Totals:

Total Cost
$326,701

Description of Services/Supplies:

- IsoGel Mattresses to replace 110 Patient Bed Mattresses
- Mattresses have an air bladder option, decreasing the need to rent specialty beds
- Advanced design assists with prevention of HAPU

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

Person responsible for oversight of purchase: Tom Moore, Supply Chain Management / Mary Diamond, Sr. Director, Nursing

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the capital purchase of 1110 patient bed replacement mattresses and air pumps, not to exceed $330,000.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
March 19, 2015

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

Non-Voting Members Present: Sharon Schultz, CNE/Sr. VP.

Others present: Jody Root, General Counsel, Jami Piearson, Director of Quality and Regulatory, Patricia Guerra, Jami Fluellen, Mary Diamond, Jenessa French, Scott Livingstone, Priya Joshi, Terri Vidals and Karren Hertz.

Members absent: Dr. Marcus Contardo, Tim Moran, CEO.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Dagostino, called the meeting to order at 12:10 p.m. in Assembly Room 1.		Director Dagostino
2. Approval of Agenda	The group reviewed the agenda. There were no additions or modifications made to the agenda.	Motion to approve the agenda was made by Director Finnila and seconded by Dr. Corona.	Director Dagostino
3. Comments by members of the public on any item of interest to the public before committee's consideration of 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 February 2015.	Director Dagostino called for a motion to approve the minutes of the February 19, 2015.	Minutes ratified. Dr. Johnson moved and Dr. Corona seconded the motion to approve the minutes for the January meeting of PAC.	Director Dagostino
5. New Business a. Quality Outcomes Dashboard	Jami Piearson reported that the following measures are being discussed in this committee as these are the indicators that are currently reported to CMS: • AMI 30-Day Readmission • Heart Failure (HF) 30-Day Readmission • Pneumonia (PN) 30-Day Readmission • Hip-Knee 30-Day Readmission • Hospital-wide 30-Day Readmission • COPD 30-Day Readmission • Stroke 30-Day Readmission • Patient Safety Indicators – PSIs • Hospital-Acquired Conditions – HACs • Infection Control Indicators • ED Measures These measures except for the ED measures will be reported on a quarterly basis as the trending will be more significant and accurate if they are reported quarterly versus monthly.	**ACTION:** The committee made a recommendation to present the data in graphs form for better presentation.	Administration/ Jami/ Marcia

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. Patient Valuables Liability and Control	Director Finnila made a clarification that the family is signing off on who took what when it comes to patient valuables.	*The Patient Care Services policy and procedure was approved. Dr. Corona moved and Dr. Johnson seconded the motion to approve this policy.	Patricia Guerra
Administrative Policies and Procedures: 1. Disclosure of Unanticipated Adverse Outcomes to Patients/ Families	No discussion was held on this policy.	*The Administrative policies will move forward for Board approval. Director Finnila moved the motion and Director Mitchell seconded to move forward for Board approval.	Patricia Guerra
2. Mandatory Reporting Requirements 236	A brief discussion was held on the following sub topics concerning this policy: • Sexual acts involving patients who are non-consenting • Communication with medical staff of the disclosure • Verbal threats are not reportable • 45 days requirement on the completion of RCA		
3. Outsourcing Sterile Compounding	There was an editorial change in this policy. Terri Vidals from Pharmacy also explained in detail the outsourcing component involved in this policy.	**ACTION:** The policy will be revised to reflect editorial changes proposed by the Committee.	

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Smoke Free Environment	Director Dagostino made a minor clarification on how staff deal with the smoking policy in the TCHD campus.		
5. Space and Office Allocation 289	No discussion on this policy.		
Unit Specific Policies and Procedures:			
Emergency			
1. EZ-IO Intraiosseus (Io) Infusion System	The contraindication mentioned was briefly clarified as requested by Director Finnila.	*The ED policy was approved as moved by Dr. Corona and seconded by Director Mitchell .	Patricia Guerra
NICU			
1. Education Plan, NICU	The policy statement and the procedure was differentiated.	*The NICU policies were approved and are moving forward for Board approval. Director Mitchell moved and Director Finnila seconded the motion.	Patricia Guerra
2. Eye Examination	The infant's age for eye exam requirement was clarified by Director Mitchell.		
3. Orientation of the Professional Nursing Staff to the NICU	Sharon explained the training requirements for a NICU nurse which will take about a year to complete.		
Outpatient Infusion Center			
1. Chemotherapy Administration Procedure infusion Center	There was a discussion on how a physician needs to be present during a chemotherapy in the infusion center.	*This policy is approved and is moving forward for Board approval as moved by Dr. Corona and seconded by Director Mitchell.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Rehabilitation Services 1. 613 Physical Therapy Assistant Supervision	This policy was pulled out and will be brought back for discussion at a later date.		Patricia Guerra
Women and Newborn Services 1. Pitocin Administration for Induction/ Augmentation of Labor	The term "immediately available" was taken out as recommended by ACOG guidelines. Sharon Davies was brought in to shed some light on the issue of having an OB physician be onsite when a patient gets administered Pitocin.	*This policy was approved and is moving forward for Board as moved by Director Finnila and seconded by Dr. Corona.	Patricia Guerra
7. Closed Session	Director Dagostino asked for a motion to go into Closed Session.	Director Finnila moved, Director Mitchell seconded and it was unanimously approved to go into closed session at 12:50 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 2:30 PM		Director Dagostino

PROFESSIONAL AFFAIRS COMMITTEE
March 19th, 2015

CONTACT: Sharon Schultz, CNE

Patient Care Services Policies & Procedures		
1. Patient Valuables Liability and Control	3 year review, practice change	Forward to BOD for approval
Administrative Policies & Procedures		
1. Disclosure of Unanticipated Adverse Outcomes to Pt Fam 275	3 year review	Forward to BOD for approval
2. Mandatory Reporting Requirements 236	3 year review	Forward to BOD for approval
3. Outsourcing Sterile Compounding	New	Forward to BOD for approval with revisions
4. Smoke-Free Environment 205	3 year review	Forward to BOD for approval
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Unit Specific		
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1. EZ-IO Intraosseous (Io) Infusion System	3 year review	Forward to BOD for approval with revisions
Neonatal Intensive Care (NICU)		
1. Education Plan, NICU	3 year review	Forward to BOD for approval
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3. Orientation of the Professional Nursing Staff to the NICU	3 year review	Forward to BOD for approval
Outpatient Infusion Center		
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Rehabilitation Services		
1. 613 Physical Therapy Assistant Supervision	3 year review, practice change	Pulled for further review
Women and Newborn Services		
1. Pitocin Administration for Induction/Augmentation of Labor	3 year review, practice change	Forward to BOD for approval

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES~~Administrative Policy Manual~~

ISSUE DATE: **01/76** **SUBJECT:** **Patient Valuables, Liability and Control**

REVISION DATE: **9/91; 6/94; 6/97; 5/00; 6/03; 4/06; 6/09; 02/11;** **POLICY NUMBER:** **8610-317**

Clinical Policy & Procedures ~~Administrative Policies & Procedures~~ Committee Approval: **~~12/10~~10/14**
Nurse Executive Council Approval: **~~01/11~~ 10/14**
Professional Affairs Committee Approval: **~~02/11~~03/15**
Board of Directors Approval: **02/11**

A. **PURPOSE:**

1. To establish a consistent method for the collection and disbursement of patient valuables during the admitting process. In the event that a patient arrives to the floor in possession of valuables, this policy provides prudent and reasonable safekeeping of these items. The following items are considered valuable:
   a. Money
   b. Credit cards
   c. Jewelry
   d. Watches
   e. Hearing aids
   f. Eyeglasses
   g. Dentures

B. **POLICY:**

1. All patients are strongly encouraged during the admission process to leave items of value at home or to send them home with family members. If this task is accomplished on the nursing unit, **documentation needs to be completed on the Valuables/Belongings section of the Admission Assessment – Patient History powerform in Cerner.** ~~a note to that effect should be made in the patients' medical record.~~

~~1.~~**a. Patients may retain their eyeglasses, hearing aids, and dentures as needed while in the hospital, however, these valuables will be the responsibility of the patient and/or family.**

2. Patients will be informed that the District will not be responsible for valuables kept in patient rooms or at the bedside. ~~A note to that effect should be made in the medical record~~.

~~3. ACCEPTING VALUABLES FROM A PATIENT/GUARDIAN IN THE EMERGENCY DEPARTMENT~~

~~a.~~**3.** Under no circumstances will a weapon be accepted from a patient for storage in hospital safe. In these instances, security should be notified.

~~b.~~**4.** If decision made to admit the patient, the nurse will first strongly encourage the patient to send valuables home with the family/friend.

5. If the patient is unable to remove any piece of jewelry due to physical constraints, the jewelry will be secured with tape as appropriate

6. If sending valuables home is unacceptable to the patient, the nurse will call Security personnel.

~~c.~~

C. **PROCEDURE**

1. The responding Security Officer will first encourage the patient to send the item(s) home with a family member for safe keeping.

2. If the patient is unable or unwilling to send the item(s) home for safe keeping, the Officer

will bring a grey UniVault bag to the location of the patient.

3. The Officer will collect the item with the Patient's Nurse as a witness to the collection process.
   a. Once the item is collected, the Officer will inventory the item(s) and write a complete and accurate description of the item(s) on the outside of the UniVault bag using a sharpie or other permanent type marker, then place the item(s) in the bag securing it.
   b. Only valuables will be collected and placed in the bag (i.e. if the patient is securing a wallet, the valuables are removed from it in the patient's presence, and placed in the UniVault bag, then the wallet is returned to the patient.)
   c. All information on the bag must be filled out completely, and signed by the patient. If the patient is unable to sign, the Patient's nurse will sign as a witness.
   d. The top flap portion of the bag is to be removed and filled out, then given to the patient as receipt of collection.
   e. Two (2) copies of the completed inventoried bag must be made by placing the bag directly on a copy machine, one copy is to be given to the Patient's Nurse to be included in the Patient's chart, and the second copy is to be placed in the "For Copies Only" tray located on the counter above the Small (Drop) Safe in the Lost and Found office.
   f. The Officer must verify the patient's phone number with the patient (not collected from the chart) to ensure current and accurate contact information.
4. All applicable information will be logged into the Patient Valuables Property Logbook #4 including the Patient's name, Phone number, and bag serial number. The bag will be placed in the slot and dropped with the Officer verifying the bag fully dropped in.
5. Documentation of the UniVault bag number must be documented in Cerner on the Valuables/Belongings powerform.
6. Returning Patient Valuables.
   a. When requested to return a Patient's Valuables, every attempt will be made to ensure that the item is being returned to the proper owner.
   b. The Officer will collect the UniVault Receipt from the owner, or if it has been lost or misplaced, will receive the copy of the bag from the Patient's Chart.
   c. The Officer will take the UniVault Receipt or chart copy and contact the Cashiering Department or Administrative Supervisor (After Hours) to meet and open the Small (Drop) Safe to collect the Patient's Valuables.
   d. The Officer will return to the floor and in the presence of the Patient and Nurse, will cut the bag open on the dotted line of the bag.
   e. The Officer will inventory the contents of the UniVault Bag and compare them to the Inventory listed on the outside of the bag while checking off the inventory items.
   f. When the Patient is satisfied that all their Valuables are accounted for, the Officer will have the Patient sign the UniVault Bag and the copy.
   g. The Officer will make two copies of the signed inventory sheet and give to the Patient's nurse to be included in the Patient's chart as a permanent record of receipt.
   h. The Officer will return the signed UniVault Bag and the signed inventory sheet and place both in the "For Copies Only" tray located on the counter above small (Drop) safe.
   i. The Lost and Found Administrator will collect the signed receipts and attach them to the copy filed in Lost and Found, and file them together in the Disposition section of Patient Valuables filing cabinet.
7. Destruction of Patient Valuables Property

~~d.~~**a. If any Patient Valuables items are not claimed within 180 days, the items will be disposed of in a manner specified by the Director of the Risk, Legal, and Regulatory Department.**

~~C.~~D. LIMITATIONS AND LIABILITY

~~a.~~**1.** The limitation on liability does not extend to those situations in which the hospital or its employees are responsible for a loss when valuables are given to the hospital for safekeeping. Although, the extent of possible liability is limited by statute to $500.00, unless a written receipt for a greater amount has been given to the patient (Civil Code, Section 1859). The amount of liability for those items whose use or availability are required while hospitalized that have been lost or damaged due to willful wrongdoing or negligence on the part of the hospital or its employees shall not exceed $1,000 (Civil Code 1859).

~~b. Security will process unclaimed valuables after 180 days maintained in the hospital safe in accordance to Civil Code Section 1862.5.who will witness the valuables with the nurse, obtain patient signature on the valuables envelope and place the envelope in the safe located in the Emergency Department Registration area.~~

~~c. On a daily basis, Security will move valuables from the emergency department registration safe to the main valuables safe located in the Patient Representative office. If locking the valuables is unacceptable to the patient, the nurse will verbally reiterate that the hospital is not responsible for valuables kept with the patients. The nurse will document this conversation in the emergency department medical record that this explanation was given to the patient.~~

~~d. If the patient is unconscious in the emergency department, the nurse will contact Security to process the valuables.~~

~~2. ACCEPTING VALUABLES FROM A PATIENT/GUARDIAN DURING THE ADMITTING PROCESS~~

~~a. In the event that the patient will not send valuables home with a relative or friend during the admitting process, Security will complete the following:~~

~~b. Fill in patient number on valuables envelope and on the receipt enclosed within. Receipts are to be in quadruplicate.~~

~~i. WHITE: Administrative Copy; to be placed in envelope with valuables.~~

~~ii. PINK: Patient Copy; to be retained by patient and surrendered when valuables are claimed.~~

~~iii. YELLOW: Security Copy; to be filed by designated Security supervisor in control file after receiving valuables.~~

~~iv. GREEN: Nursing Unit Copy; to be discarded by nursing at day of discharge.~~

~~c. List valuables on receipt. Amount of money must be listed in detail and all other items described. Describe jewelry as to appearance making no assumptions as to quality or value (i.e., a gold colored ring with a clear glass setting).~~

~~d. Have patient read both envelope and receipt and sign both in presence of a Security employee. When patient is unable to sign, Security employee will sign for patient in the presence of one other District employee who will sign as a witness.~~

~~e. Seal envelope after verifying contents with patient or family member.~~

~~f. Security will deliver SEALED envelope and all remaining receipt copies to the valuables safe.~~

~~g. Never leave patients valuables envelope unattended. Call Security IMMEDIATELY. Return signed quadruplicate receipt (green copy) to nursing unit and attach to patients medical chart.~~

~~h. Security receiving valuables envelope will be responsible until receipt has been acknowledged by signing the Security valuables daily control register.~~

~~i. Security will record receipt of valuables envelope in the Security valuables daily control register, which contains the following information:~~

~~i. Patient's name and number.~~

~~ii. Name of person signing for patient (when applicable).~~

~~iii. Name of witnesses.~~

~~iv. Name of Security personnel.~~
~~v. Date and time received by Security.~~
~~vi. Log number.~~
~~vii. Signature of Security supervisor to acknowledge receipt of valuables.~~
~~viii. Date & time received by Security.~~
~~ix. Complete the valuables log book.~~

~~j. Security will place valuables envelope in the valuables safe in the Patient Representative office. Daily access to this compartment is limited to appropriate staff.~~

~~3. SECURING VALUABLES IF PATIENT ARRIVES TO THE NURSING UNIT WITH ITEMS~~

~~a. If a patient arrives to the floor with valuables, the nurse completing the database will again strongly encourage the patient to send these valuables home with a family member or trusted friend. If the patient is unable to remove any piece of jewelry due to physical constraints, the jewelry will be secured with tape when appropriate.~~

~~b. If sending valuables home is unacceptable to the patient, the valuables will be locked in the valuables safe. If locking the valuables in the safe is unacceptable to the patient, the nurse will verbally reiterate that the hospital is not responsible for valuables kept in the patient's room and document in a focus note that this explanation was given to the patient.~~

~~c. If a patient arrives to the floor in an unconscious state, the nurse completing the database will call Security to send a representative to the unit to process the valuables. The Security representative will sign for the patient and the nurse will sign as a witness. If Security personnel are unavailable, the nurse should contact the Operations Manager/designee for assistance.~~

~~d. If the patient agrees to lock the valuables in the safe, the nurse completing the database will call Security to send a representative to the unit to process the valuables.~~

~~e. If Security is unable to respond to the floor in a timely manner, the Security Representative will contact the Unit Operations Manager/Director for assistance in the collection of valuables.~~

~~f. The nurse completing the database will sign the envelope in addition to the Security representative or designee~~

~~g. If the patient is unable to sign, the Security representative or designee will sign for the patient and the nurse will sign as a witness.~~

~~h. The nurse completing the database will note on the database that valuables were sent to Security.~~

~~i. The nurse discharging the patient will check the database to verify if valuables were locked in the safe. If valuables are noted on the database to be in the security safe, Security will be called to bring those valuables to the floor and return those items to the patient. During the hours when Security is not available, the Administrative Supervisor will intervene.~~

~~4. RETURNING VALUABLES TO A PATIENT/GUARDIAN~~

~~a. Patient/guardian must present receipt for return of valuables to their nurse who will present it to Security or his/her designee.~~

~~b. Security or designee will remove envelope from safe and triplicate copy from control file, and open envelope in the presence of patient. Security should first remove receipt from envelope and check patient number, signature, and inventory list against patients' receipt.~~

~~c. Individual items should then be removed from envelope, checked off of original receipt, and returned to patient.~~

~~d. When all items have been returned, patient should sign original receipt.~~

~~e. Security should retain original receipt, as the copy of record, and file same in safe for future reference. All other copies should be destroyed. Security should record return of valuables in the Valuables log by recording date, time, and the office supervisor's signature.~~

~~f. When patient wishes to withdraw only part of his valuables from the safe, the above procedure must be followed. The remaining valuables would be placed in the safe using a new envelope and receipts following the same method outlined above.~~

~~D.~~E. RELATED DOCUMENTS:

1. Administrative Policy # 202 Lost and Found Articles
2. Administrative Policy # 280 Unclaimed Property – Financial
3. ~~Administrative Policy~~ **Patient Care Services** # 318 Patient Complaints and Grievances

~~E.~~F. REFERENCES

1. Title 22, California Code of Regulations, Section 70755
2. CHA Consent Manual (**2015**~~2009~~) pages 22.1-22.2

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 10/02

SUBJECT: DISCLOSURE OF UNANTICIPATED ADVERSE OUTCOMES TO PATIENTS/FAMILIES

REVISION DATE: 04/06; 07/09; 06/11; 09/14

POLICY NUMBER: 8610-275

Administrative Policies & Procedures Committee Approval:	**~~04/11~~01/15**
~~Executive Council Approval:~~	**~~06/11~~**
Medical Executive Committee Approval:	**02/15**
Professional Affairs Committee Approval:	**~~06/11~~03/15**
Board of Directors Approval:	**06/11**

A. **PURPOSE:**

1. This policy and procedure provides guidance and direction regarding communication of outcomes of treatment, including unanticipated outcomes.

B. **DEFINITIONS:**

1. Disclosure – Communication to patients or patients' families, of information regarding the unanticipated adverse outcome.
2. Unanticipated Adverse Outcome – An adverse result that differs significantly from the anticipated result of a treatment or procedure equivalent.
3. Treating physician - physician responsible for ongoing patient care.
4. Physician-related - An adverse event, unanticipated outcome, or error which is primarily the responsibility of the physician.
5. Hospital-related - Same as B.4 but an adverse event, unanticipated outcome, or error is primarily the responsibility of nursing, other hospital staff, or other non-physician, non-AHP.

C. **POLICY:**

1. It is TCHD's policy to support the right of patients and/or their families to be notified when an unanticipated significant event occurs. Patients will be provided with sufficient information necessary to make an informed decision about the outcomes of treatment, including outcomes of treatment that differ significantly from anticipated outcomes. TCHD will assure that any unanticipated adverse outcome is promptly communicated to the patient or the patient's family.

D. **PROCESS:**

1. Reporting
   a. It is the responsibility of all employees to report any unanticipated adverse outcome immediately to their immediate supervisor and Risk Management. This information will be received, and any subsequent evaluation of the facts of the event will be conducted, in a non-punitive manner. However, failure to report such events may subject the individual to progressive discipline as outlined in Human Resources polic**ies.** ~~y.~~
      i. **A RL Solutions Incident Report**~~A Quality Review Report, (QRR/RL)~~ will be completed and maintained by the hospital in accordance with appropriate hospital policies.
   b. It will be the responsibility of the Chief Nurse Executive/Director of Regulatory Compliance to develop and submit the initial report to the California Department of Public Health (CDPH), as well as serve as **a** liaison with that agency during the subsequent investigation process.

c. Reporting to regulatory agencies (i.e., CDPH, **Centers for Medicare/Medicare Services** (CMS), **The Joint Commission** (TJC), **Occupational Safety and Administration** (OSHA), etc.) will be done in compliance with regulations and as required by law.

2. Immediate Actions of Staff
   a. The individual identifying the event will take the following steps:
      i. Assure that all necessary action is taken to mitigate the extent of the harm to the patient that may be caused by the adverse event.
      ii. Immediately notify the patient's treating Physician, the Nurse Manager/Department Manager and Risk Management.
      iii. Complete a ~~Quality Review Report (QRR/RL)~~ **RL Solutions Incident Report** per hospital policy.
      iv. Participate in any investigation initiated to determine the cause of the event to **and to** determine actions that may prevent future like occurrences (as appropriate).
   b. Risk Management, with the cooperation of the Department Director will conduct such investigation as is indicated by the hospital's relevant policies. All reports of unanticipated adverse outcomes will be documented by Risk Management and evaluated for further action, including disclosure of the outcome to the patient and/or the patient's family as appropriate.
      i. Risk Management will discuss the Disclosure with the interdisciplinary team to assure consistency and support.

3. Disclosure
   a. Once it has been determined that an unanticipated adverse outcome has occurred, disclosure is necessary. Risk Management and Department Director, in consultation with the treating Physician will determine the most appropriate time and manner for disclosure. Disclosure may need to occur prior to all the facts being determined.
   b. Risk Management/Department Director, and treating Physician or their designees should participate in the disclosure process. It is TCHD's philosophy that the treating physician has ultimate responsibility for disclosure of unanticipated adverse outcomes, that the treating Physician should be encouraged to accept this responsibility, and that hospital leadership should provide necessary support to enable the treating Physician to perform this responsibility. In cases where the unanticipated adverse outcome is associated with non-physician staff, the duty to disclose will rest with responsible hospital leadership with the most thorough knowledge of the event. However, the treating physician will be made aware of the disclosure prior to the disclosure occurring.
   c. If there is disagreement or uncertainty on either the means or need for disclosure, the Hospital President/CEO or designee in conjunction with the Chief of Staff will make the final determination.
   d. Disclosure will include the following elements:
      i. A clear explanation of the unanticipated adverse outcome to the patient and, when appropriate the family; Disclosure will be limited to a factual explanation of the circumstances; speculative comments will be avoided.
      ii. A clear explanation of the investigation that will take place to learn as much as possible about the event, and plans to discuss the matter further with the patient or family as more facts become known.
      iii. Adequate explanation to ensure patients' understanding of unanticipated adverse outcome and prognosis
      iv. Information regarding resources available to support and comfort the patient and/or family.
      v. Expressions of empathy to include as appropriate an expression of sympathy for the patient's inconvenience, distress or discomfort.
   e. If the patient's clinical condition or care may be negatively impacted by the notification after the event, then the discussion should be held with the patient's family, if

appropriate. If this is not practical, notification will be deferred until a later time. However, the notification should take place prior to discharge.

f. If the unanticipated significant event is reported or discovered after discharge, the patient and/or family should be notified as soon as information about the event and it's impact on the patient's health has been determined, as well as any actions that need to be taken by the patient/family member.

4. Disclosure process will not include the following elements:
   a. Acceptance of liability.
   b. Placement of fault.
   c. Statements of causation or other actions that may be inappropriate given the status of the investigation.
   d. Confidential information as determined by State or Federal law.
5. Documentation
   a. The Risk Manager or other appropriate individual participating in the disclosure shall document the disclosure of unanticipated adverse outcomes. This documentation should contain a brief statement that the disclosure has occurred and shall include the following elements:
      i. A full description of the facts of the event, without conjecture as to the cause or attribution of fault. Care will be taken to ensure that opinion is not documented.
      ii. A note outlining the substance of the disclosure discussions with the patient, family member or surrogate about the event, including dates, times, and a list of who was present.
      iii. Treatment and follow up plans as indicated
      iv. The identity of any interpreter whose services may have been used.
      v. In cases where a decision is made to withhold some or all of the information about the event, the reason(s) for this decision.
      vi. Any follow-up discussions with the patient, family member or surrogate should be similarly noted.
   b. Documentation within the medical record should be limited to the medical facts of the case and a brief note stating simply that disclosure occurred.
6. Waiving of Cost and Charges
   a. The purpose of this procedure is to establish guidelines for billing and account resolution when the Business Office is notified to hold or not bill a portion of the account.
   b. The process for this will be a coordinated effort between Administration, Risk Management and the Chief Financial Officer; who are the only individuals authorized to waive charges.
   c. When an unanticipated adverse event has occurred, the Business Office must ensure that no bills are submitted for reimbursement from the patient or third party payer for charges related to the event. Bills may be placed on hold until this determination is made.
   d. The appropriate entities will be notified. The final decision will be based on the confirmation of the event, investigation, outside regulatory agencies, and administrative review.
   e. The Director of Patient Business Services will be the contact person at this facility.

E. RELATED DOCUMENTS

1. **Administrative Policy 8610-236 "Mandatory Reporting Requirements"**

~~E.~~F. REFERENCES:

1. TJC 20**14** ~~11~~
2. Adverse Event Reporting, CDPH
3. California Hospital Association Consent Manual **2014**

REPORTABLE ADVERSE EVENTS:

ADVERSE EVENT includes any of the following:

Surgical Events

1. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. This does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. This does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
5. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Product or Device Events

6. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.
7. Patient death or serous disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but it not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Patient Protection Events

9. An infant discharged to the wrong person.
10. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision making capacity.
11. A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for the admission to the health facility.

Care Management Events

12. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.
13. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
14. A maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.

15. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.
16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subparagraph, "hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.
17. A Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
18. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.
19. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock.
20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
21. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.
22. A patient death associated with a fall while being cared for in a health facility.
23. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.

Criminal Events

24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
25. The abduction of a patient of any age.
26. The sexual assault of a patient within or on the grounds of a health facility.
27. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.
28. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

[*Note: An "adverse event" is defined as the incidents described in items 1 through 27, above. Thus, it is not clear that this category requires the reporting of any events not noted above. If a hospital has an adverse event that causes the death or serious disability of a patient, personnel, or visitor but is not listed above, legal counsel should be consulted to determine whether it is reportable.]*

"Serious Disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE:	**7/91**	**SUBJECT:**	**MANDATORY REPORTING REQUIREMENTS**
REVISION DATE:	**12/91; 11/94; 2/95; 3/96; 4/97; 7/99; 6/02; 5/03; 7/09; 06/11**	**POLICY NUMBER:**	**8610-236**

Administrative Policies & Procedures Committee Approval:	**~~05/11~~02/15**
~~Executive Council Approval:~~	**~~06/11~~**
Professional Affairs Committee Approval:	**~~06/11~~03/15**
Board of Directors Approval:	**06/11**

A. **PURPOSE:**

1. To objectively and systematically monitor and evaluate quality and appropriateness of patient care, pursue opportunities to improve patient care, assure patient safety and resolve identified quality/risk issues on an ongoing basis. To identify and prevent serious injury, actual or potential, harm to a patient or visitor of Tri-City Health Care District (TCHD). Incident reporting enhances the quality of patient care and reduces healthcare and medical liability.
2. This policy/procedure consists of the following areas for reporting:
   a. Sentinel Events
   b. Unusual Occurrences (Title 22)
   c. Adverse Unexpected Events

B. **SENTINEL EVENTS:**

1. **PURPOSE:** The purpose of this section is to describe the nature of a sentinel event and to provide a process for identifying, investigating, and reporting sentinel events.

C. **DEFINITIONS:**

1. Sentinel Event: is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation that for which a recurrence would carry a significant chance of a serious adverse outcome [sometimes referred to as a "near miss"].
   a. The sentinel event definition includes any occurrence that meets any of the following criteria:
      i. The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition, or;
      ii. The event is one of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):
         1) Suicide of any patient receiving care, treatment or services in a staffed around-the-clock care setting or within 72 hours of discharge
         2) Unanticipated death of a full-term infant
         3) Abduction of any patient receiving care, treatment or services
         4) Discharge of an infant to the wrong family
         5) Sexual abuse, including rape
         6) Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
         7) Invasive procedure or surgery on the wrong patient, wrong procedure, or wrong site.
         8) Unintended retention of a foreign object in a patient after surgery or other invasive procedure

9) Severe neonatal hyperbilirubinemia (bilirubin greater than 30 mg/dL)
10) Prolonged fluoroscopy with cumulative dose greater than 1500 rads to a single field, or any delivery of radiotherapy to the wrong body region or greater than 25% above the planned radiotherapy dose.

2. Near Miss is a term used to describe any process variation which did not affect the outcome but for which a recurrence carries a significant chance of serious adverse outcome.
3. Root Cause Analysis is a process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.

D. **POLICY:**

1. It is the District's policy to investigate any sentinel event, serious adverse event, or serious "near miss" from an interdisciplinary perspective and take action to reduce the risk of recurrence. Each serious adverse event will be intensively assessed through the use of the Root Cause Analysis (RCA) process. An action plan, based on the RCA is developed to implement improvements to reduce risk; the action plan is implemented and the effectiveness monitored.
2. The Risk Manager or Senior Administrative Designee shall coordinate the implementation of the improvement or correction plan, the monitoring of the effectiveness of the plan and reporting of progress to the Executive Council.
3. A report of each RCA shall be communicated to the Quality Assurance/Performance Improvement/Patient Safety Committee (QA/PI/PS) of the Medical Staff, for periodic reporting to the Board of Directors via the Professional Affairs Committee (PAC).
4. RCAs shall not be reported to the Joint Commission, nor to any external agency or organization, except upon specific, written advice of legal counsel. The Sentinel Event investigation and reporting process, including development of the RCA, is intended to remain within the bounds of Medical Staff Peer Review, subject to all applicable protections from discovery, including Evidence Code § 1157 and Attorney-Client and Attorney Work Product privileges.

E. **PROCESS:**

1. Each potential sentinel event will be investigated to the extent necessary to determine all the relevant facts and circumstances. The Risk Manager or Senior Administrative Designee shall compare the facts and circumstances to the Sentinel Event definition, and make a preliminary determination whether the potential event appears to qualify as a sentinel event. In order to make this determination, the Risk Manager or Senior Administrative Designee has the discretion to convene an Ad Hoc committee, composed of physicians, hospital staff and consultants, if necessary, to assist in determining if a sentinel event has occurred.
2. If the potential event is determined to qualify as a sentinel event, the RCA process commences immediately and shall be completed within 45 days of notification of the event.
3. If the potential event fails to qualify as a sentinel event, the matter may be closed or referred for additional study using performance improvement methods.
4. The RCA shall be documented on a "Root Cause Analysis" form and made part of a permanent file to be maintained by the Risk Manager. The RCA shall not be filed in the Medical Record.
5. The RCA report's conclusions and recommendations, if any, shall be communicated to the involved departments/services for development of a plan of action or plan of correction.
6. The Director of Risk Management and/or the Director of Regulatory Compliance, or Senior Administrative Designee shall coordinate the implementation of the improvement or correction plan, the monitoring of the effectiveness of the plan and reporting of progress to the **Administrative Team Meeting** ~~Executive Council~~.

F. **REPORTING TIMEFRAMES:**

1. The first person to identify an adverse event will notify his/her supervisor as soon as it is safe to do so.
2. The supervisor must assure that serious adverse events are reported the Director of Risk Management, Chief Nurse Executive, and the Director of Regulatory Compliance. These individuals will assure that the event is then reported to the Chief Executive Officer, Chief Operating Officer, etc as appropriate.
3. Based on the circumstances, a decision will be made to report the event to the appropriate

regulatory agencies.

4. All events requiring notification of regulatory agencies, such as the California Department of Public Health, will be completed in a timely manner.
5. The patient's primary and/or involved physician is notified.
6. The appropriate Medical Staff Leader for the department is notified.

G. **COMMUNICATION:**

1. Information related to the reportable event is communicated to the physician and staff involved in the care of the patient as soon as possible.
2. Physicians and staff involved in the reportable event may be included in the RCA and Action Plan.
3. The appropriate Medical Staff Leader will be notified prior to reporting the event whenever possible.
4. Reported events are communicated to the appropriate medical staff Quality Review committees, the Medical Executive Committee, and the Board of Directors.
5. Critical events may be reported in an expedited manner by Administration via verbal or electronic methods.
6. A report of each RCA shall be communicated to the QA/PI/PS of the Medical Staff, for periodic reporting to the Board of Directors via the Professional Affairs Committee (PAC).

H. **UNUSUAL OCCURRENCES (TITLE 22)**

1. **DEFINITIONS:**

~~2.~~**a.** Unusual Occurrence**:** (Title 22, Section 70736) – any condition or event which has jeopardized, or could jeopardize, the health, safety, security or well being of any patient, employee or any other person while in the facility. These shall include, but not be limited to the following:

- ~~a.~~**i.** An epidemic outbreak of any disease, prevalence of communicable disease, whether or not such disease is required to be reported by Title 17, California Administrative Code, Section 2500, or epidemic infestation by parasites or vectors
- ~~b.~~**ii.** Poisonings
- ~~c.~~**iii.** Fires
- ~~d.~~**iv.** Physical injury to any person, which would require treatment by a physician
- ~~e.~~**v.** Death of a patient, employee or visitor from unnatural causes
- ~~f.~~**vi.** Sexual acts involving patients who are non-consenting
- ~~g.~~**vii.** Physical assaults on patients, employees or visitors
- ~~h.~~**viii.** All instances of patient abuse
- ~~i.~~**ix.** Actual or threatened walkout, or other curtailment of services or interruption of essential services provided by the facility

I. **PROCEDURE:**

1. In accordance with State of California standards, the following provisions have been established. An occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel or visitors, shall be reported as soon as reasonably practical, either by telephone or by any other practical means to the local health officer and to the California Department of Public Health (CDPH~~.~~) **and as applicable to county of San Diego Behavioral Health Services or the Department of Health Care Services.**
2. The District shall furnish other pertinent information related to such occurrences as may be required by CDPH or health officers.
3. In the event of a disruption of services, the Administrator or designee shall be responsible for immediate reporting.

J. **ADVERSE UNEXPECTED EVENTS:**

1. **PURPOSE:** This section complies with the requirements of SB 1301 (CA Health & Safety Code §§ 1279.1, 1279.2, 1279.3, and 1280.4) mandating the reporting of "adverse events" to the California Department of Public Health (CDPH).

K. **POLICY:**

1. It shall be the policy of Tri-City Medical Center (TCMC) to report an adverse event, as defined in Health & Safety Code § 1279.1, to the CDPH **and as applicable to county of San Diego Behavioral Health Services or the Department of Health Care Services** not later than 5 days after the adverse event has been detected; or, in the event of an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel or visitors, not later than twenty-four (24) hours after the adverse event has been detected. TCMC shall inform the patient or the party responsible for the patient of the adverse event by the time the report to CDPH is made.

L. **PROCESS:**

1. All adverse events shall be reported without delay to the Director of Risk Management and to the Director of Regulatory Compliance, or in their absence, to the COO, CNE, or in his/her absence, to the CEO for analysis and determination if such adverse event needs to be reported to CDPH **and as applicable to county of San Diego Behavioral Health Services or the Department of Health Care Services**. The Director of Risk Management shall notify the attending physician(s) and the Chief of Staff, or his designee, that a report of a potential adverse event has been received. These physicians and the CEO, CNE,COO or their designees shall be consulted and provide input regarding the reportability of the event, so long as such consultation and input does not prevent timely reporting to CDPH **and as applicable to county of San Diego Behavioral Health Services or the Department of Health Care Services**. In the event that an adverse event qualifies for reporting to CDPH, the report shall be made on a form, specifically designed for such reporting and individually identifiable patient information shall be safeguarded, in terms of privacy and confidentiality, consistent with applicable law.
2. In every situation, the attending physician shall be the preferred individual to disclose the adverse event to the patient/family. Only where the attending physician is unable to or unwilling to make this disclosure will a Medical Staff Officer, or some other designee, disclose the event to the patient/family. The date, time, and circumstances of disclosure shall be recorded in the patient's permanent medical record.
3. The Department Director/Manager/designee shall be notified of the event. In addition, if the patient is a research patient, the Director of Clinical Research shall be notified.
4. The Director of Risk Management is responsible for ensuring that a thorough investigation of the adverse event is completed, which may include a root cause analysis.
5. The adverse significant event shall be reported in the ~~electronic Quality Review Report (QRR)~~ in the RL Solutions ~~module~~**Incident Report**.

M. **CALIFORNIA STATE REPORTABLE ADVERSE EVENTS:**

1. Surgical events, including the following:
   a. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
   b. Surgery performed on the wrong patient.
   c. The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.
   d. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
   e. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.
2. Product or device events, including the following:
   a. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally

detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.

b. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.

c. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

3. Patient protection events, including the following:

a. An infant discharged to the wrong person.

b. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capacity.

c. A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.

4. Care management events, including the following:

a. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

b. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

c. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.

d. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.

e. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subparagraph, "hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.

f. A Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.

g. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.

5. Environmental events, including the following:

a. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock.

b. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.

c. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.

d. A patient death associated with a fall while being cared for in a health facility.

e. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.

6. Criminal events, including the following:

a. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.

b. The abduction of a patient of any age.

c. The sexual assault on a patient within or on the grounds of a health facility.

d. The death or significant injury of a patient or staff member resulting from a physical assault

that occurs within or on the grounds of a facility.

7. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

*"**Serious Disability**" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than 7 days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

N. **ATTACHMENTS:**

1. Reporting Grid

O. **REFERENCES:**

1. California Hospital Association Consent Manual 2014

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Adverse Drug Reaction (ADR)	**ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting**	**Attending Physician/Investigational Drug Pharmacists/Principal Investigator of Clinical Trial/** Sub Investigator **of Clinical Trial/Clinical Research Coordinator**	**Clinical Trial Site/Principal Investigator of Clinical Trial, Sub Investigator of Clinical Trial/Clinical Research Coordinator**	**All ADRs must be documented in the research participants medical and research record.**	**Policy:Clinical Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010**
Adverse Event (AE)	**ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting**	**Attending Physician/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial/Clinical Research Coordinator**	**Clinical Trial Site/Principal Investigator of Clinical Trial, Sub Investigator of Clinical Trial/Clinical Research Coordinator**	**Aes are to be captured in the case report forms and as part of the medical records. There are no special reporting requirements for AEs at TCMC.**	**Policy:Clinical Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010**
Animal Bites		Emergency Department, Business Office	Humane Society	Phone Call	Emergency Dept.
Assault & Battery to On-Duty Health Care Personnel	A.B. #508 CA Penal Code # 240,242	Security Department	Local Law Enforcement Professional & Regulatory Services (P&RS), Employee Health, Dept. of Health	Phone Call within 72 hours of occurrence. Employee Injury Report	Admin. Policy #241
Assault Victims Domestic Violence	CA Penal Code 11160/11161 CCR Title 11, Section 920	Emergency Department, Business Office Registrars, Social Service Department, Nursing Staff, Security, Risk Management	Local Law Enforcement	Phone police immediately and written report - 2 working days	Admin. Policy #310
Cancer/Reportable Neoplasms	Title 17, California Code of Regulations, Section 2593	Oncology Data Registrar	California Department of Public Health (CDPH) Cancer Prevention Section	Within six months of diagnosis	~~Medical Records Dept~~**Oncology Registry/CNE.**
Certification of Birth	Health and Safety Code Section 10101	Birth Certificate Clerk Medical Records Department	San Diego County Registrar	Within 10 days of birth	Medical Records Dept.
(Suspected) Child Abuse	Penal Code: 11164-11174.3	Social Service Department Health Practitioner, Child Care Custodian	Child Protective Services or Local Law Enforcement	Immediately by Phone-And Within 36 Hours in Writing	Admin. Policy #308 Social Service Dept. #308

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Chromosomal Defects in Fetus or Infant	Title 17 CCR 6532	Lab performing the analysis or physician making diagnosis	CDPH	Within 30 days of diagnosis using form provided by CDPH	Women's & Children's Services
(Illegal) Drug Use - non employee	CA Penal Code, Section 11-160	Security Dept.	Oceanside Police	Telephone and written report	Admin. Policy #236
(Suspected) Elder and Dependent Adult Abuse	Penal Code: Section 368 Welfare & Institution Code #15600--15637	Social Service Department Health Practitioner, Care Custodian	Occurring in a LTC Facility report to Long Term Care Ombudsman or Local Law Enforcement; All others to County Adult Protective Services	Telephone Report-Immediately Written Report-Within 2 Working Days	Admin. Policy #309 Social Service Dept. #309
Infectious Diseases (Reportable *) (See Reporting Responsibility Table)	Title 17, Chapter 4, CCR 2500 Health & Safety Code 3125	Nursing Staff Emergency Department, Infection Control Practitioner, Laboratory - Microbiology & Chemistry	Infection Control Practitioner Public Health Department	Phone immediately to Public Health depending on disease. Fax information to Public Health using PM 110.	Infection Control #110
Lapses in Consciousness/Seizures	Health & Safety Code 3125 Section 410 Title 17, CCR 2500	Physician	Local Health Officer who reports to DMV	Fax information to Public Health using PM 110.	Physician Protocol
Mental Health holds beyond 24 hours (ED) (Unusual Occurrence)	Title 22 Section 70737, 71535	Health Care Practitioner Administration Manager Emergency Department	CDPH	Phone after 24 hour mark followed by letter to CDPH	Emergency Dept., Mental Health Unit
Missing Patient		Security Department	Local Law Enforcement Agencies	Telephone immediately within reasonable time frame (given situation)	Admin. Policy #305
Multiple bee stings (Unusual occurrence)	Title 22 CCR 70737	Emergency Department Nursing Staff	County of San Diego, CDPH	Phone call immediately to CDPH written report	Admin. Policy #228
Needle stick Injury/BS Exposure	Fed and Cal OSHA Rec. Blood borne Path.	Supervisor	Employee Health or ED	Immediate Supervisor Investigative Report. Employee Health uses separate injury log for needle sticks.	Employee Health Services/ Infection Control
Neural Tube Defects in a Fetus	Title 17, California Code of Regulations, Section 6531	Medical Records Department	CDPH Alpha-Feto Protein Screening Program	Within 30 days of initial diagnosis	Women's & Children's Services

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Newborn Abandonment: Voluntary surrender (abandonment of newborns up to 72 hours old)	SB 1368	Health Care Practitioner	Child Protective Services	As soon as possible; no later than 48 hours	Admin. Policy #380
Newborn Screening Test refusal (PKU)		Women's & Children's Services Representative	CDPH Genetic Disease Branch	Prior to infant discharge Fill out form #NBS-PR	Women's & Services
Occupational Injuries/Illnesses	Labor Code 3209.3 CCR Title 8 S - 14003	Physician	Employer & Employees Insurer	Written Report within 5 working days	Physician Protocol Employee Health Services
Outbreaks or undue prevalence of infectious or parasitic disorder	Title 17, Chapter 4 CCR 2502	Any healthcare provider (physicians, PA, RN, nurse midwife, or Infection Control Practitioner)	Local Health Officer	Phone, fax or mail information to Public Health using the CMR form found in the IC Manual.	Infection Control #IC.12
Patient Death	Title 22 72549 HSC 10250	Health Care Practitioner; Physician	Medical Examiner CDPH at a time and manner as requested, Pt. Reps – TCMC	Phone immediately Complete form 8720-37	PCS Policy IV.Z , PCS Procedure
Patient death due to unusual circumstances, i.e. suicide	Title 22 Section 70737, 71535	Health Care Practitioner Administration	Local law enforcement officer, medical examiner and CDPH. CMS and regional CDPH	Local law enforcement contacted prior to medical examiner. CDPH as soon as practical confirmed in writing. Incident report on file by facility for 1 year.	Admin Policy #228 PCS Policy IV.Z , PCS Procedure
Patient death while patient in seclusion or restraint for behavior management	42 CFR Section 482.13(f)(f) Reporting is required whether or not R/S was the cause of death Title 22, CCR Section 70737(a) Section 71535	Director of Regulatory Compliance	Centers for Medicare and Medicaid Services (CMS) CDPH	As soon as aware. By telephone: (415) 744-3726 or fax (415) 744-2692	Admin Policy #228 PCS Policy IV.Z , PCS Procedure

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Patient death while in medical surgical restraint	Title 22, CCR, Section 70737(a) Section 71535	Director of Regulatory Compliance	CDPH	As soon as reasonably practical, by phone: (800) 824-0613 Followed by letter: 7575 Metropolitan Drive Suite 104 San Diego, CA 92108	PCS Policy IV.Q
Patient Injury/Death due to ~~faulty equipment~~**Device Malfunction**	Safe Medical Device Act **21 CFR 803**	Health Practitioner Director of Risk Management	~~Medical Device & Lab product Problem reporting Program — FDA~~**MFR-Serious Injury FDA&MFR-Death or FDA if MFR is unknown**	Within 24 hours via form **FDA3500A** and phone ~~800-638-6725~~**301-796-6670. E-mail: MDRPOLICY@FDA.HHS.GOV. Annual Summary of Medical Device Related Death and Serious Injury Report to FDA on Form FDA 3419 by January 1st of each year as described in 803.33**	Admin. Policy #201
Patient Transfer Violation	(COBRA) Health and Safety Code 1317 through 1317.99 Title 42 U.S.C. Section 139 dd	Director of Regulatory Compliance	CDPH HCFA	7 days 72 hours	Admin. Policies 228, 506; PCS Policy VI.D
Pesticide Poisoning	Title 8 CCR 14003	Emergency Department Health Care Practitioner	Emergency Department Mgr. Local Health Officer Co. Dept. of Agric. Deputy Agricultural Commissioner	Phone call within 24 hours	Emergency Dept.
PKU Specimen not obtained		Unit Representative where infant was a patient	California Department of Public Health Genetic Disease Branch	When patient transferred, expires Fill out form # (BS - No - 90)	Women's & Children's Services
Rhesus Hemolytic (RH) Disease – Newborn	Title 17 CCR Section 6510 Title 22 CCR 70737	Health Care Practitioner	CDPH - Women's & Children's Services Office physician who made diagnosis	Use reporting form "A case report of RH Disease of Newborn"	Women's & Children's Services
Reye Syndrome	HSC Section 304.5	Attending Physician	CDPH	Within 7 days of diagnosis using reporting form "CBC Reye Syndrome..."	Physician Protocol

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Serious Adverse Event (SAE) as related to Clinical Research	**ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting**	**Attending Physician/Principal Investigator of Clinical Trial/** Sub Investigator **of Clinical Trial**	**Clinical Trial Site/Principal Investigator/**Sub Investigator/**Clinical Research Coordinator**	**Report Immediately to Attending Physician and Clinical Trial Site personnel. All SAEs must be documented in the research participants medical and research record.**	**Policy: Clinical Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010**
Threat to kill	Tarasoff	Psychotherapist/Health Care Practitioner	Intended victim and local law enforcement	Immediately by telephone	Behavioral Health Unit, Social Service Dept.
Unusual occurrences that threaten the welfare of the patient, staff or visitors (i.e., allegation of staff sexual misconduct)	Title 22 Section 70737, 71535	Health Care Practitioner Administration Director of Regulatory Compliance	CDPH Local law enforcement as appropriate	As soon as reasonably practical - confirmed in writing Occurrence on file by facility for 1 year	Admin. Policy #228
Adverse effect of a vaccine	National Childhood Vaccine Injury Act	Health Care Provider	VAERS Hotline 800-822-7967	After administration by telephone	Infection Control

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual

ISSUE DATE: NEW

SUBJECT: OUTSOURCING STERILE COMPOUNDING

REVISION DATE:

POLICY NUMBER: NEW

Administrative Policies & Procedures Committee Approval:	**11/14**
Pharmacy and Therapeutics Committee Approval:	**01/15**
Medical Executive Committee Approval:	**02/15**
Professional Affairs Committee Approval:	**03/15**
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish guidelines for selection and quality review of outsourced sterile compounding services.

B. **PERSONNEL:**

1. Pharmacy Management
2. Hospital Administration
3. Medical Staff

C. **BACKGROUND:**

1. There are various environmental influences and market forces that may contribute to a facility's decision to consider outsourcing sterile compounding services. ~~Healthcare organizations~~**Tri City Health Care District (TCHD) when** considering outsourcing should at **a** minimum conduct an internal needs assessment, a cost analysis, and a comprehensive review of prospective compounding facilities/vendors for regulatory compliance, quality and patient safety measures. The organization should examine the long-term consequences of outsourcing and the short term outcome expectations during a contract's performance period.

D. **POLICY:**

1. Pharmacy Services in collaboration with key hospital stakeholders will assess the organizational needs and capabilities for sterile compounding.
2. If the organization deems it necessary to contract with an outsourced sterile compounding vendor for services, Pharmacy Services will contact prospective compounding facilities with a request for proposal (RFP).
3. Based on the compounding vendor's assessment results and the nature of the product(s), the medical staff (via the Pharmacy and Therapeutics Committee or equivalent), in conjunction with hospital leadership, determines when and if disclosure of the compounding source prior to medication administration is required.
4. The organization will not contract to outsource the preparation of copies of commercial products available on the current market unless drug is in shortage or becomes unavailable.
5. The organization will establish contract service expectations and at a minimum perform annual management reviews of selected indicators to ensure that services provided are safe and effective and comply with all applicable state, federal and regulatory requirements for licensure, labeling and patient confidentiality.
6. The contract agreement to outsource sterile compounding services and the sterile compounding vendor is reviewed and approved by medical staff as a function of the Pharmacy and Therapeutics Committee and/or Medical Executive Committee.

E. **PROCEDURE:**

1. Proposals and Required Documents:
   a. The prospective compounding vendor will submit the following information with their proposals:
      i. A brief history of the compounding vendor and service, including its mission, vision, and values.
      ii. The location of the compounding vendor's offices and other facilities that would provide services to the organization.
      iii. The compounding vendor's regular business hours or hours of operation and emergency and after-hours contact information.
      iv. Assurance that all pharmacists employed at the compounding facility are licensed and competent as required by state and federal rules and regulations
      v. Evidence of the following documentation regarding the compounding vendor:
         1. Proof of current liability insurance.
         2. Current accreditation or certification certificates, if applicable.
         3. State pharmacy and/or wholesaler licensure and other appropriate licenses.
         4. Licensure documents if the compounding facility is registered with FDA as a drug manufacturer or device manufacturer.
         5. Current DEA registration as a manufacturer or wholesaler.
         6. Licensure of pharmacists employed and verification that there is documented training and competency assessments on file and available for review.
         7. Registration of pharmacy technicians employed and verification that there is documented training and competency assessments on file and available for review, if applicable.
         8. Pharmacist and pharmacy technician training manuals on file and available for review.
         9. Standard operating procedures manual on file and available for review.
         10. Policies and procedures for sterility testing on file and available for review
         11. Policies and procedures for pyrogen and endotoxins testing on file and available for review, if applicable
         12. Examples of the quality control reports include trending reports for the last year as well as detailed reports for the last quarter.
         13. Stability and sterility documents and clinical references, as well as any materials that are used to determine beyond-use dates
      vi. A history of the results of all accreditation or regulatory surveys conducted of the compounding vendor's sites, including copies of significant regulatory actions.
      vii. Experience (e.g., years of experience in providing sterile compounding services, total number of clients served current number of clients).
      viii. A list of the services that the compounding vendor can provide and the normal terms of service, including but not limited to delivery cycles, availability and cost of emergency preparation and delivery, remedies for failure to perform to the contract and the infrastructure available for electronic ordering.
      ix. A list of the sterile compounding services that the compounding vendor cannot provide and the reasons for its inability to provide them.
      x. Disclosure as to whether the compounding vendor has had product liability lawsuits filed against it for preparations it compounded. If so, the vendor's disclose of the suites and the outcome (e.g. favorable for or against the company).

xi. A description of the compounding vendor's formal procedures for conducting recalls and a listing or their product recall history to include date of recall, description on preparations, and reason for the recall.

b. Site Visit and Compounding Vendor Assessment
   i. An organization representative with current knowledge of USP 797 sterile compounding requirements will make a site visit to the compounding vendor's facility (ies), initially and periodically, to assess and evaluate regulatory and quality requirements, the compounding environment as well as compounding and medication safety procedures.
   ii. An audit check list is used to evaluate outsource vendors of compounded sterile products.

c. Evaluation and Selection
   i. Proposals and site visit findings are evaluated and compared with respect to services, experience, quality and safety standards, references and cost. The compounding vendor must at a minimum be able to:
      1. Provide assurance that each compounded sterile preparation meets applicable state and federal labeling requirements and is sterile and free of pyrogens, endotoxins and unintended particulate matter, according to professionally established and accepted quality monitoring data.
      2. If compounding high risk level preparations, provide documentation of the end product testing processes used to determine that compounded sterile preparations are sterile and free of pyrogens, endotoxins, and unintended particulate matter.
      3. Deliver preparations in tamper-resistant packaging and in containers that will maintain proper storage temperature and (when required) protection from light during delivery and storage.
      4. Provide, upon request, batch records for any compounded sterile preparation.
      5. Provide quarterly information on its compliance with contract requirements and other quality assurance programs.

d. Contract Negotiation and Agreement
   i. The contract clearly describes all aspects of the outsourcing agreement and is executed as defined by organizational policy.
   ii. Review of the proposal and clarification of contract provisions includes the Director of Pharmacy Services and, as indicated, the organization's risk management and legal counsel.
   iii. The contract agreement and sterile compounding vendor is reviewed and approved by medical staff as a function of the Pharmacy and Therapeutics Committee and/or Medical Executive Committee.

e. Evaluation of Sterile Compounding Vendor's Performance
   i. On a regular basis as part of the organization's quality assurance program, the sterile compounding vendor's performance and compliance with the terms of the contract are evaluated.
   ii. Based on quarterly quality reports submitted by the vendor, Pharmacy Services in collaboration with other key hospital leadership will perform objective and subjective evaluations of the measurable standards of performance specified in the contract.
   iii. Annually, or more frequently if indicated by performance outcomes, a summary of the sterile compounding vendor's performance expectations and outcomes are reported to and reviewed by the medical staff as a function of the Pharmacy and Therapeutics Committee and/or Medical Executive Committee.

F. **REFRENCES:**

1. American Society of Health System Pharmacists ASHP Guidelines on Outsourcing

Sterile Am J Health-System Pharm.2010; 67:757-65 (Accessed November 2012)
2. Pharmacy Compounding Accreditation Board (PCAB) Accreditation Manual (Accessed November 2012)
3. American Society of Health System Pharmacists Sterile Compounding Resource Center (Accessed November 2012)
4. ISMP Medication Safety Alert: Moving Forward for Safer Sterile Compounding, November 1, 2012 Volume 17 Issue 22
5. The Joint Commission Standards MM.02.01.01 EP1; LD.04.03.09
6. Center for Medicare and Medicaid Services (CMS) §482.25(b)(9); §482.12(e)
7. Healthcare Facility Accreditation Program (HFAP) 25.01.11
8. DNV National Integrated Accreditation for ~~Healthcare Organizations~~**Tri City Health Care District (TCHD)** (NIAHO –DNV) MM.2; GB.3

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
~~District Operations~~

ISSUE DATE: 11/08 **SUBJECT:** SMOKE-FREE ENVIRONMENT

REVISION DATE: 4/12 **POLICY NUMBER:** 8610-205

Administrative Policies & Procedures Committee Approval:	**~~04/12~~01/15**
Medical Executive Committee	**02/15**
Professional Affairs Committee Approval:	**~~05/12~~03/15**
Board of Directors Approval:	**05/12**

A. **PURPOSE:**

1. The purpose of this policy is to describe the Tri-City Healthcare District (TCHD) smoke-free environment.
2. Smoking of tobacco is a known danger to health and a cause of material discomfort and a health hazard to those who are present in areas where tobacco is being smoked. The United States Surgeon General has concluded that smoking tobacco can lead to numerous diseases for the smoker as well as others, as there is no risk-free level of exposure to second-hand smoke, the smoke created by another individual smoking tobacco.
3. The policy recognizes the health, safety and comfort benefits of smoke-free air, and the District's responsibility to establish and maintain an optimally healthy, safe environment for its patients, employees and visitors. Effective November 20, 2008 TCHD will become a smoke free campus.

B. **SCOPE:**

1. This policy is in effect during and after work hours and applies to all individuals working, visiting, or receiving medical care within all of the District's inpatient and outpatient facilities. It includes all property and buildings owned or leased by TCHD including parking areas.

C. **DEFINITIONS:**

1. District premises: All property and buildings owned or leased by TCHD including parking lots.
2. Tobacco products: Any product containing tobacco intended to be lit, burned, or heated to produce smoke as well as any device used to smoke the tobacco, including but not limited to a pipe, cigar, or cigarette, (including electronic cigarettes).
3. **Electronic cigarette: Any electronic device designed or intended to produce smoke or vapors for inhalation.**

D. **POLICY:**

1. **Prohibition of Tobacco Use**
   a. Smoking **of any kind** is prohibited on all TCHD owned and/or leased locations/premises; entrances and exits and in all TCHD owned and/or leased vehicles. In addition, use of all tobacco products, which produce smoke **or vapor**, is prohibited.
2. **Communication of Policy**
   a. Signs bearing the message "Smoke-Free Campus" are posted at strategic locations around the property (as applicable), and each building owned or leased in full will display a decal that states "Smoke Free Facility." No ashtrays or smoking shelters are provided on the campus property.
   b. Patients and their families/friends will be informed of this policy upon arrival or as soon thereafter, as is medically appropriate.
   c. Patients will be informed of the smoking policy on admission.
   d. All employees are authorized to communicate this policy with courtesy and diplomacy to other employees, medical staff, patients, and visitors.

3. **Tobacco Cessation Programs**
   a. TCHD is committed to providing support to all TCHD employees who wish to stop using smoking products. **T**CHD is committed to ensuring that TCHD employees have access to smoking cessation assistance.
   b. Supervisors are encouraged to refer employees and other personnel to Employee Health for information on available services.
4. **Responsibilities**
   a. Adherence to this policy is the responsibility of all individuals working, visiting, or receiving medical care within TCHD as cited above. Compliance with this policy is mandatory and will be strictly enforced. Policy violations by employees will be subjected to the standard TCHD disciplinary actions.
   b. Employees who choose to use smoking products must do so on their own time ~~(refer to C.1.a – b and C.2).~~
   c. Respectful monitoring of this policy will be shared by all TCHD staff and Security.
5. **Enforcement - Employees**
   a. This policy will be enforced through administrative action by supervisors and managers.
   b. Any person who observes violations of the policy is encouraged to report these violations to their supervisor and/or security. Once the employee's supervisor has been notified of a violation by an employee under their direction, the supervisor is responsible for discussing the violation with the employee and taking appropriate disciplinary action. The same disciplinary approach should be applied that is used in addressing violations of other TCHD policies.
6. **Enforcement – Patients and Visitors**
   a. Patients, visitors, and any other guests who fail to comply with this policy will be reminded that TCHD is a smoke-free facility and will be advised of resources available to assist with compliance while they are on TCHD property.
   b. Patients will not be permitted to smoke during hospitalization. Refer to Patient Care Policy, *Patient Smoking* for management of patients refusing to comply with this policy.

E. RELATED DOCUMENTS:

~~7.~~**1.** Administrative Policy 424: Coaching and Counseling for Work Performance Improvement
~~E.~~**2.** Administrative Policy 234: Security Department Incident Notification

F. REFERENCES:

~~3.~~**1.** Centers for Disease Control and Prevention. *Healthy Workforce Initiative:* Implementing a Tobacco-Free Campus Initiative – United States 2004. Available at: www.**cdc**.gov/nccdphp/dnpa/hwi/toolkits/**tobacco**/index.htm

2. The Joint Commission (2011). *Keeping your hospital Property Smoke-Free: Successful strategies for effective policy enforcement and maintenance*. Retrieved from: http://www.jointcommission.org/assets/1/18/Smoke_Free_Brochure2.pdf

~~2.~~**3. The Joint Commission (2015). Caution: E-Cigarettes pose potential hazards: Follow standards and update smoking policies to maintain compliance. *The Joint Commission Perspectives***

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
District Operations

ISSUE DATE: 02/07 **SUBJECT: Space and Office Allocation**

REVISION DATE: 07/09 **POLICY NUMBER:** 8610-289

Administrative Policies & Procedures Committee Approval:	**~~07/09~~02/15**
~~Operations Team Committee Approval:~~	**~~07/09~~**
Professional Affairs Committee Approval:	**~~08/09~~03/15**
Board of Directors Approval:	**08/09**

A. **PURPOSE:**

1. Establish guidelines with regard to space allocation throughout the facility including off site locations. Office of Statewide Health Planning and Development (OSHPD) space shall be utilized for Patient Care revenue producing functions whenever possible.

B. **POLICY:**

1. All requests for space shall be sent in writing using the Request for Space/Project Form to the Facilities Management department. ~~The Space Planning Committee meets as needed to review requests~~. **Director of Facilities will review and approve any requests and depending on the scope will discuss with the C-Suite members as necessary**
2. Manager/Director levels and above should have private offices to facilitate staff confidentiality.
   a. All other personnel requiring space shall share office space that meets Occupational Safety and Health Administration (OSHA) space guidelines.
   b. No one shall have more than one office in any TCMC building or buildings.
   c. Temporary offices located in any converted patient rooms must have the ability to be reverted back to a patient room within 24 hours.
3. A request for office furniture, carpet, computers, etc. must be approved ~~by the appropriate Manager/Director or Vice President~~ **according to the Signature Authority #232 Policy** and must be reflected on the ~~Space Allocation Request~~**Request for Space/Project form**.
   a. An inventory of potentially usable office furniture will be kept by Facilities staff and should be reviewed prior to ordering any furniture.
   b. An ergonomic review prior to ordering office furniture is recommended.
4. Storage space shall be kept to a minimum to avoid clutter and possible fire code and/or safety violations.
   a. Furniture or equipment that is no longer useful should be disposed of according to district guidelines **per Administrative Policy #200 Equipment Transfer, Storage, Trade-In, and Disposal** and not kept in storage indefinitely. **Once equipment or furniture is deemed unusable and needs to get disposed, the parent department will place the equipment or furniture in the dumpster located by the loading dock. If you need assistance, a work order needs to be submitted to the Environmental Services Department through the intranet.**
5. There can be no storage in the corridors.

C. **~~FORMS REFERENCED WHICH CAN BE LOCATED ON THE INTRANET:~~**

1. Request for Space/Project

D. **RELATED DOCUMENTS**

1. **Administrative Policy #232 Signature Authority**
2. **Administrative Policy #200 Equipment Transfer, Storage, Trade-In, and Disposal**

TRI-CITY MEDICAL CENTER
REQUEST FOR SPACE / PROJECT

INSTRUCTIONS: **Complete this form and forward original to Joe Kasper. All requests will be reviewed by the Space Planning Committee.**

Date Submitted: _____ Extension: _____

Submitted By: _____ Department: _____

Department Director: _____ Cost Center: _____

Square Footage of Space in Need _____

Will this space require new and/ or relocated equipment? YES ☐ NO ☐ If yes

EQUIPMENT DESCRIPTION: _____

SPACE DESCRIPTION OF NEED: Please provide as much detail as possible. (Provide attachments)

Based on the descriptions below, the priority level of request is: _____ (A, B or C).

PRIORITY:
A) Needed for regulatory compliance / continuation of the service
B) Needed to support growth or to upgrade service
C) Desired to enhance departmental services

DIRECTOR'S SIGNATURE _____

VICE PRESIDENT'S SIGNATURE _____

FOR COMMITTEE USE ONLY: **DATE RECEIVED:** _____

REVIEWED BY: _____

RETURN TO FACILITIES FOR RESEARCH & ESTIMATE: ☐ **Yes** ☐ **No**

FACILITIES USE ONLY: DATE RECEIVED: _____

ESTIMATED COST: (Based on above description) $ _____

COMMITTEE APPROVED: ☐ **Yes** ☐ **No** **DATE:** _____

SIGNATURE:

_____

Return to Facilities Management

Tri-City Medical Center	Emergency Department
PROCEDURE:	**EZ-IO INTRAOSSEOUS (IO) INFUSION SYSTEM**
Purpose:	To outline the procedure on use and care of Intraosseous infusions
Supportive Data:	Intraosseous infusion has been proven to be a safe and effective way to administer medications, fluids and blood products in both adults and pediatric patients that require rapid access for fluid resuscitation and standard IV access has not been achieved in a timely manner.
Equipment:	Vidacare adult or pediatric Intraosseous Infusion Systems, EZ-IO drill device, appropriate size IO needle for age, local anesthetic (optional but should be considered if the patient is conscious), Chlorhexidine prep, syringe for aspiration, normal saline flush syringe for irrigation, dressing supplies, EX connect extension tubing, IV tubing and fluids, pressure infusion bag, rapid infuser or Alaris pump and for removal of IO device a 10mL syringe, gauze and medical tape.
~~Issue Date:~~	~~Revision Date(s): 08/07; 02/11~~

A. **DEFINITIONS:**

1. Intraosseous (IO) infusion is indicated when rapid access to the circulation for administration of medications is needed and other standard attempts to obtain IV access have failed. IO infusion should be given any time intravenous (IV) cannulation is either too difficult or too time consuming to accomplish. IO needles are recommended for any age group.

B. **POLICY:**

1. The use of the EZ-IO drill and needle for insertion is performed by a physician or physician assistant only.
2. Infusion through and removal of the IO after insertion is within nursing scope of practice.
3. DO NOT leave the EZ-IO catheter in for more than 24 hours. The IO catheter must be removed within 24 hours after initial insertion. Wristband, which is included in the kit, is placed on the patient at time of insertion indicating the time the catheter must be removed.

C. **PROCEDURE:**

1. Insertion of an IO using the EZ-IO is performed only by a physician or physician assistant only.
2. The physician will select the appropriate site for insertion of the IO needle.
3. Nursing should position the patient (depending on the site) and stabilize the area for insertion.
4. Cleanse the area with Chlorhexidine antiseptic solution (Chloraprep).
5. The physician may use local anesthetic (20-40mg of 2% Lidocaine) for patient comfort as necessary.
6. The physician will insert the IO 15G x 1" needle for adult or 15G x 0.6" for pediatric, using the Vidacare EZ-IO device.
7. After insertion, the placement is confirmed by aspirating blood or marrow contents with a syringe. Syringe bolus (flush) of IO device with 10ml normal saline should infuse easily without resistance.
8. Connect the EZ connect tubing (included in the EZ-IO needle kit). The end with the angle attaches to the IO device catheter and the straight end to the standard IV tubing.
9. Secure tubing and catheter. Apply a sterile dressing.
10. Apply yellow ID wristband from manufacturer that is included with the needle kit (states "EZ-IO device in leg. Must be removed within 24 hours).
11. While every attempt will be made to remove IO catheters prior to admitting patients to **Intensive Care Unit (ICU~~ACCU~~)**, there may be the occasion when the catheter must remain until another route may be established, such as standard IV access or appropriate central access device.
12. Pediatric patients may be transferred to other facilities with the IO device in place.
13. Removal of the catheter is accomplished by following the steps listed below:
    a. Supporting the patient's limb with the catheter.

Department Review	Department of Emergency Medicine	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
10/14	11/14	01/15	02/15	03/15	08/07; 02/11

b. While maintaining aseptic technique connect a sterile 10ml luer-lock syringe to the hub of the catheter to provide a handle to withdraw the IO catheter device from the bone.
c. Rotate the syringe and catheter clockwise while gently pulling. DO NOT ROCK the IO catheter while removing. Rocking or bending the catheter with a syringe may cause the catheter to separate from the hub.

D. **SAFETY:**

1. Contraindications and Cautions:
   a. An IO is not recommended in any fractured extremities because of the risk of fluid and medication infiltrating into the surrounding tissue.
   b. To decrease the risk of infection, avoid placing the IO line through burned or infected tissue.
   c. General contradictions may include patients with bone disorders, such as osteoporosis and osteogenesis imperfecta.
   d. Do not infuse marrow toxic medications, (such as certain antibiotics) via the IO route.
2. Age Specific Considerations:
   a. IO access is widely recommended for use in pediatric population (AHA, 2002).
   b. It is now recommended in the management of adult patients who are critically ill (Waisman & Waisman, 1997l Frascone et al., 2001).
3. Complications:
   a. Unsuccessful attempts to penetrate the bony cortex or bending the needle by use of excessive force delays vascular access.
   b. Puncture of the posterior cortex as a result of excessive pressure during insertion of the needle.
   c. Fluid leakage from the infusion site. Fluid extravasation may occur, especially if the insertion was difficult or both cotices were penetrated. This fluid extravasation may lead to compartmental syndrome.
   d. Fat embolism resulting from use of high-pressure volume infusions.
   e. Potential osteomyelitis, which appears to be associated with prolonged continuous infusions.
   f. Clot formation within the bone marrow needle, causing slowing of the rate of infusion. The use of a pressure bag often alleviates this issue.
   g. Tibial fractures.

E. **REFERENCE LIST:**

1. Semonin-Holleran, R (2004); *Intraosseous Access* (pg.302-307), 3rd edition,
2. In Proehl, J.A. *Emergency Nursing Procedures*, Saunders; AHA, 4th edition (2008),
3. *Pediatric Advance Life Support manual*, Dallas Author; AHA, (2011),
4. *Advanced Cardiac Life Support manual*, Dallas Author; Stanley, R. (2011),
5. *Intraosseous Infusion* (pg.475-485), In Roberts J.R. & Hedges, J.R (Eds),
6. *Clinical Procedures in Emergency Medicine*, 6th edition (2013), Philadelphia, W.B. Saunders.
7. Lewis GC, Crapo SA, William JG. *Critical skills and Procedures in Emergency Medicine- Vascular Access Skills and Procedures*. Emerg Med Clin N Am 2013;31:59-86 Retrieved from: Http://dx.doi.org/10.1016/j.emc.2012.09.006
8. Ibrahim M, Cairney K. *Intraosseous (IO) Infusion as a Means of Vascular Access*. British J of Resuscitation. Autumn:23-6 (2012)
9. Rogers J, Fox M. *The Safety of Intraosseous Vascular Access*. Emergency Medicine Patient Safety Foundation Forum. Fall 18-21(2012)
10. Weiser G, Hoffmann Y, Galbraith R, Shavit I. *Current Advances in Intraosseous Infusion – A Systematic Review*. Resuscitation; 83(1):20-6. doi:1016/j.resusitation.2011.07.020 (2012)

SUBJECT: **EDUCATION PLAN, NICU**

ISSUE DATE: 8/12
REVISION DATE(S):

Department Approval Date(s):	**02/15**
Division of Neonatology Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**03/15**
Board of Directors Approval Date(s):	**8/12**

A. **PURPOSE:**

1. To determine educational needs of NICU staff members and to develop an education plan based on the identified needs.

B. **DEFINITIONS:**

1. Educational Needs Assessment Survey:
   a. A survey to determine staff areas of interest and needs in learning and preferred methods to meet new learning needs.
2. Education Plan:
   a. A formal written description of the education goals derived from the needs identified in the survey and the yearly plan for meeting those objectives.
3. Education Calendar:
   a. A schedule that contains the educational activities planned for the fiscal year July 1 – June 30.

C. **SCOPE AND RESPOSIBILITY:**

1. Scope: this policy applies to the Neonatal Intensive Care Unit of Tri-City Medical Center.
2. Responsibility: it is the responsibility of the clinical nurse specialist, assistant nurse manager(s) and clinical operations manager to implement this policy in the process of development, review, revision, approval and communication of the education plan as identified within the policy.

D. **POLICY:**

1. An educational needs assessment survey will be developed and conducted annually by the CNS and the professional practice council and will be used in developing an education plan for **NICU nursing**~~their~~ staff.
2. The educational needs assessment survey ~~will~~ evaluate**s nursing** staff input on areas of interest in learning, preferred methods of learning and preferred times for educational activities.
3. ~~An education binder (may be hardcopy and/or electronic) will be maintained for the NICU and will include the current yearly:~~
   a. ~~Education plan.~~
   b. ~~Educational needs assessment survey and results.~~
   c. ~~Educational calendar and any revisions.~~
4. ~~A hard copy education binder will be kept in the CNS office with a back up copy in the TCMC education department.~~

E. **PROCEDURE:**

1. The CNS will develop a yearly staff educational needs assessment survey.

2. **The results of the needs assessment and the education plan are presented to the nursing staff.** ~~Staff members will receive a copy of the educational needs assessment survey in their mailbox yearly by June 1.~~
3. ~~Staff members will complete the survey and return to the CNS mailbox by June 20.~~
4. ~~The CNS and a representative of the professional practice committee will tally the survey and post the results for the staff by July 15.~~
5. The CNS in conjunction with the professional practice committee will write an education plan to address the staff learning needs~~. and will post it in the NICU on the education board, and publish it in NUCU~~.
6. Using the results of the survey, the CNS in conjunction with the professional practice committee will develop an educational calendar to start July 1 and finish June 30 of the next year.
7. The educational calendar will be posted in the NICU to assure accessibility for staff.

F. ~~**EXTERNAL LINKS:**~~

G. **REFERENCES:**

1. CCS Manual of Procedures, Chapter 3.25, CCS Standards for Neonatal Intensive Care Units; Chapter 3.25-30-33. (1999)

~~H. **APPROVAL PROCESS**~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Medical Executive Committee~~
~~4. Professional Affairs Committee~~
~~5. Board of Directors~~

PROCEDURE:	**EYE EXAMINATIONS FOR RETINOPATHY OF PREMATURITY AND/OR OTHER HIGH RISK EYE DISORDERS**
Purpose:	Retinopathy of Prematurity (ROP) is a disorder in the development of the vessels of the retina. The clinical result is visual impairment, including at its worst, blindness. Timely treatment may save an infant's sight. Therefore, it is essential that premature infants be examined by an ophthalmologist prior to discharge and/or according to the timetable spelled out in the criteria below to determine if this disorder is present.
Equipment:	NICU Eye Exam Instrument Kit **Sucrose and pacifier** **Eyedrop (mydriatic/cycloglegic) medication**

A. **CRITERIA FOR EXAMINATION**

1. All infants less than ≤1500 grams birth weight or ≤30~~2~~ weeks gestation ~~should~~ **will** have an ophthalmology examination between 4-6 weeks **chronologic** ~~postnatal~~ age or by 31 weeks post**menstrual** ~~conception~~ age, whichever comes first.
2. **Select** ~~All~~ infants **with a birth weight between 1500 and 2000 grams or gestational age of** greater than **30 weeks** ~~1500 grams~~ who have had an unstable clinical course placing them at high risk for eye problems (as determined by the attending neonatologist) **will** ~~should~~ have an eye examination at 4 ~~to 6~~ weeks **chronologic** ~~postnatal~~ age.

B. **POLICY~~PRIOR TO THE PROCEDURE~~**

1. The RN shall:
- **a. Confirm that an order has been placed by the physician for an eye exam.**
- **b. Note the exam on the Neonatal Discharge Sheet**
- **c. Educate parents on the reason for** Retinopathy of prematurity (**ROP**) **examinations and provide educational handouts. Instruct them at discharge the importance of timely follow-up if outpatient examinations are indicated.**

~~1.~~**2.** The unit secretary shall:
- a. Contact the ophthalmologist office to schedule examination when the order is **entered**~~written~~.
- b. Complete the following on the ROP Ophthalmic Examination Record including:
  - i. Date of examination
  - ii. Birth Weight
  - iii. Gestational age at birth
- c. Copy the patient face sheet
- d. Note the exam ~~on the Neonatal Worksheet, Neonatal Discharge Sheet, and in the~~**in the** unit logbook following the exam.

~~2.~~**3.** The ophthalmologist shall:
- a. Call the day assistant nurse manager/relief charge nurse with a time for examinations for the following day or the day of the examination.
- b. ~~The ophthalmologist shall u~~**U**se equipment provided by TCMC. The assistant nurse manager/relief charge shall ensure that the equipment is in the NICU prior to the examination.

~~3. The unit secretary, according to the eye exam list, shall complete a consultation form.~~

4. The physician performing the exam **shall:**
- ~~4.~~**a.** ~~, o~~**O**n the night before eye exams or the morning of the eye examination, shall order the eye drops to be instilled.
  - ~~a. Be aware that infants can experience apnea, bradycardia, and feeding intolerance as a result of the eye drops.~~

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/09, 6/11, 8/12	12/14	n/a	02/15	03/15	

~~5. If the examination shall occur near the time of an infant's feed, it is prudent to delay the feed until the procedure has been completed. If the infant is receiving feeds by the continuous method, turn off the pump 15 minutes prior to the examination. Resume all feeds when procedure has been completed. If the infant is experiencing any untoward effects, consult with the physician.~~

C. **PROCEDURE:**

~~6.~~**1.** Wash hands, put on gloves.

~~7.~~**2.** Confirm patient identity using two-identifier system. ~~Refer to Patient Care Services "Identification, Patient" (IV.A) policy~~

3. ~~Using 2x2s if necessary, p~~**P**ull the lower lid downward**, using 2x2s if necessary,** and instill two drops of Cyclomydril into the lower conjunctival sack, then release lid. Wipe away any excess with a sterile 2x2. **Repeat for other eye. Repeat eye drop instillation process per physician ordered interval.**

a. Be aware that infants can experience apnea, bradycardia, and feeding intolerance as a result of the eye drops.

~~8.~~**b. If the examination shall occur near the time of an infant's feed, it is prudent to delay the feed until the procedure has been completed. If the infant is receiving feeds by the continuous method, turn off the pump 15 minutes prior to the examination. Resume all feeds when procedure has been completed. If the infant is experiencing any untoward effects, consult with the physician**

~~9. Repeat step 7 to the other eye.~~

~~10.~~**4.** Remove gloves and wash hands.

~~11. Repeat steps 6 to 9 as ordered, five to ten minutes after first instillation.~~

~~12.~~**5.** Discard the individual bottle of eye drops.

6. Assist ophthalmologist with the examination and ensure that gowning and hand washing policies are observed.

~~13.~~**a. The eye examination is painful and stressful for the neonate therefore non-pharmacological comfort measures should be taken such as sucrose pacifier and swaddling.**

7. Observe patient for bradycardia, usually caused by pressure on the baby's eyes. Document in detail any episode.

~~14.~~**8. Care should be taken to protect the eyes from bright light for 4-6 hours after mydriasis.**

~~15.~~**9.** The examining ophthalmologist, based on retinal findings, shall recommend follow up examinations.

~~C. EXTERNAL LINKS:~~

D. **REFERENCES**

1. AAO/AAP (**2013**~~2006~~). Screening Examination of Premature Infants for Retinopathy of Prematurity.*Pediatrics*, **131:1**~~117~~, **189-195**~~572-576~~.

2. Ikuta, L.M. & Beauman, S.S. (Eds.). (2011). Policies, Procedures, and Competencies for Neonatal Nursing Care. National Association of Neonatal Nurses.

3. Verklan, M. T. & Walden, M. (2010). Core Curriculum for Neonatal Intensive Care Nursing, 4th ed. St. Louis: Elsevier Saunders.

~~1. John Hopkins Hospital, Department of Pediatrics Policy and Procedures.~~

~~E. APPROVAL PROCESS~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Medical Executive Committee~~
~~4. Professional Affairs Committee~~
~~5. Board of Directors~~

Tri-City Medical Center
Oceanside, California

WOMEN'S & CHILDREN'S SERVICES MANUAL – NICU

SUBJECT: ORIENTATION OF THE PROFESSIONAL NURSING STAFF TO THE NICU

ISSUE DATE:
REVISION DATE(S): 8/12

Department Approval Date(s):	**2/15**
Division of Neonatology Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**03/15**
Board of Directors Approval Date(s):	**8/12**

A. **POLICY:**

1. A competency-based orientation (CBO) system is used for orientation to the NICU.
2. The orientation is offered over a period of time determined by the new staff RN's (orientee) individual needs, based on new staff RNs individual assessment, preceptor assessment, the NICU RN skills checklist and educational needs identified.

B. **PROCEDURE:**

1. A NICU staff RN (preceptor) who has completed the preceptor course is selected and conducts the orientation.
2. The preceptor and orientee ~~should~~ work the same schedule and **are** ~~be~~ given the same assignment~~s~~. If primary preceptor is not available, an alternate preceptor **is** ~~will be~~ assigned by management/CNS.
3. Orientation includes but is not limited to the following:
   a. Policies, procedures, standards of care, clinical pathways, and quality control checks.
   b. The initiation of CPR and emergency measures.
   c. The recognition, interpretation and documentation of signs and symptoms, and identification of those requiring notification of a physician or **licensed independent practitioner (LIP)** ~~APN~~.
   d. Policies and practice in IV therapy, fluids, electrolytes, and blood collection and administration.
   e. Specialized nursing procedures and the operation of equipment specific to the needs of the patients in the NICU.
   f. The psychological, social, cultural, developmental, and educational needs of patients and families.
   g. Equipment and electrical safety.
   h. Infection Control.
4. In addition the CBO program includes:
   a. Unit in-services as offered.
   b. A neonatal resuscitation class that is offered by ~~the~~ educational services and is required for employment.
   c. Orientation to electronic **health**~~medical~~ record (E**H**~~M~~R) and, computerized physician order entry (CPOE)~~, as needed~~.
   d. Assignment of an RN to act as a resource for the new nurse at the completion of orientation for transition as needed.
   e. On-going competency-based evaluation in the NICU.
   f. A meeting of the preceptor, the new RN, and the CNS ~~every two weeks~~ to evaluate the orientation process.

C. **REFERENCES:**

1. CCS Manual of Procedures, Chapter 3.25, CCS Standards for Neonatal Intensive Care Units; Chapter 3.25-2-12. (1999)

~~D. **APPROVAL PROCESS**~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Medical Executive Committee~~
~~4. Professional Affairs Committee~~
~~5. Board of Directors~~

Tri-City Medical Center	Distribution: Outpatient Infusion Center
PROCEDURE:	**CHEMOTHERAPY ADMINISTRATION**
Purpose:	To outline the chemotherapy competent nurse's responsibility when administering a chemotherapeutic agent: A. Notification of a Chemotherapy Order B. Safe Handling C. Requirements Prior to Administering a Chemotherapeutic Agent D. Patient Preparation E. Documentation F. Administrating Intravenous and Intramuscular Chemotherapy I. IV Push II. IV Continuous or Intermittent III. Intramuscular and Subcutaneous G. Administering Oral Chemotherapy
Supportive Data:	See References
Equipment:	See Equipment Lists for specific administration methods

A. **SAFE HANDLING:**

1. Many drugs used in the treatment of cancer (i.e. chemotherapy) are considered to be hazardous to health care workers. The term hazardous refers to drugs/chemicals that require special handling because of potential health risks. Therefore, it is imperative that those who work with chemotherapy drugs adhere to this procedure, the pharmaceutical companies recommendations, the Material Safety Data Sheet that pertains to the particular hazardous agent and the Tri-City Medical Center's (TCMC) **Patient Care Services (PCS)** Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids procedure as well as the TCMC's **PCS** procedure for Disposal of Chemotherapy Waste.
2. Transporting Chemotherapy Agents
   a. Transport syringes containing chemotherapy in a sealed container, with the luer lock end syringe capped.
   b. All chemotherapy agents will be placed in a leak proof sealable bag labeled "Chemotherapy" and then placed in the designated impervious carrying receptacle that is also labeled "chemotherapy" before agent can be transported.
   c. A spill kit will be available at all times in case of a potential chemotherapy spill.
   d. In case of an accidental spill or exposure please see ~~Tri-City Medical Center's (~~TCMC~~)~~ **PCS** Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids procedure as well as the TCMC's **PCS** procedure for Disposal of Chemotherapy Waste.

B. **REQUIREMENTS PRIOR TO ADMINISTERING A CHEMOTHERAPEUTIC AGENT:**

1. **A physician must be on the premises of the outpatient infusion center at all times if chemotherapy is being infused into a patient(s)**.
2. Chemotherapy may only be administered by a **Chemotherapy Competent Registered Nurse**. A Chemotherapy Competent Registered Nurse is defined by the following requirements:
   a. Has taken and passed an Oncology Nursing Society approved chemotherapy course.
   b. Has completed competency validation by a TCMC chemotherapy competent nurse on all chemotherapy areas of the **TCMC**~~Tri-City Medical Center~~'s RN Outpatient Infusion Center's Skills Checklist.
3. All chemotherapy orders from a physician must be written on the TCMC approved Chemotherapy Order Form. All sections of the TCMC approved Chemotherapy Order Form must be completed for the chemotherapy order to be valid. Verbal or telephone orders for any

Department Review	~~Clinical Policies & Procedures~~	~~Nurse Executive Committee~~	Division of Oncology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
2/13, **10/14**	~~3/13~~	~~3/13~~	**11/14**	**01/15**	3/13; **2/15**	3/13; 3/15	3/13

antineoplastic agents are not permitted at TCMC (~~TCMC~~**per PCS** Medication Administration policy ~~IV.I~~). Chemotherapy Orders that are received via fax on a TCMC approved Chemotherapy Order Form are acceptable. Any chemotherapy order or clarification of a chemotherapy order from a physician that has been received verbally or via telephone will not be recognized as a valid chemotherapy order. Telephone orders from the physician related to start/stop times for the chemotherapy and pre-medications are acceptable. Pharmacy may verify chemotherapy drug and dose via phone per the TCMC ~~pharmacy~~ **Pharmacy** policy "Chemotherapy, **Prescribing, Processing**~~Writing~~ and Preparation" ~~8390-4204~~.

4. All patients at TCMC that have an order for any antineoplastic agent to be administered while in our care, must have a TCMC approved consent form completed in full prior to the administration of any antineoplastic agent.

C. PATIENT PREPARATION

1. Set up continuous pulse oxymetry for all patients receiving monoclonal antibodies.
2. Explain to the patient and family/caregivers who will administer the chemotherapy, the route, and the planned sequence of events.

D. DOCUMENTATION

1. The administering Chemotherapy Competent Nurse will complete a Cerner Chemotherapy Administration AdHoc Form on every chemotherapy agent administered.
2. All chemotherapy agents will require a second electronic signature by a Chemotherapy Competent Registered Nurse (preferred) or a Registered Nurse (if a second chemotherapy competent nurse is unavailable) verifying accuracy of the chemotherapy agent and order on the Cerner Electronic Medication Administration Record (EMAR) by using their Compass password.

E. ADMINISTERING INTRAVENOUS (IV), INTRAMUSCULAR (IM) AND SUBCUTANEOUS (SQ) CHEMOTHERAPY

1. IV, IM and SQ chemotherapy orders and agents will be verified two times for accuracy before administration. Accuracy will be determined by verifying:
   a. Date /Time of Administration
   b. Patient Name
   c. Chemotherapy Agent
   d. Dose
   e. Diluents /Volume (If applicable)
   f. Rate of Administration (If applicable)
   g. Route
   h. Patient's Height and Weight
   i. Patient's body surface area (BSA)-If applicable
2. **VERIFICATION # 1 -Pharmacy/ Nurse**
   a. A TCMC pharmacist will co-sign with a Chemotherapy Competent Registered Nurse on the TCMC Pharmacy/Nurse Chemotherapy Verification Form that the chemotherapy agent that was delivered to the nursing unit is accurate.
3. **VERIFICATION #2- Nurse/Nurse**
   a. A second verification for accuracy will be completed by two Chemotherapy Competent Registered Nurses (preferred) and documented on the Cerner Chemotherapy Administration AdHoc Form. After this the two chemotherapy competent nurses will verify two patient identifiers and the Alaris pump guardrails and settings for accuracy at the patient's bedside or chair before administration. If a second Chemotherapy Competent Registered Nurse is not available a TCMC registered nurse may co-sign to verify the accuracy of the chemotherapy agent and order.
4. All intravenous Vesicant Chemotherapy will only be administered via a Central Venous Catheter and should never be administered peripherally.
5. All intravenous chemotherapy will be administered through an Alaris IV pump using the oncology profile and specific guardrail for the chemotherapy agent.

6. If two chemotherapy drugs must run simultaneously, each drug must run ~~threw~~ **through** two different brains (A and B) on the Alaris pump.
7. Peripheral Non-Vesicant Chemotherapy Administration-Start a new peripheral IV if site is more than 24 hours old. Avoid flexion joint sites. Preferably select a large vein between wrist and elbow. Avoid veins in the hand, wrist and antecubital fossa. Tape IV site so it can be monitored.
8. Extravasation Prevention
    a. Blood return must be checked prior to administration of any chemotherapy agent.
    b. Inspect IV site for signs and symptoms of the following before administration:
        i. Peripheral
            1) Redness
            2) Inflammation
            3) Infiltration
            4) Patient comfort level at IV site
        ii. Central Venous Catheters (CVC)
            1) Erythema
            2) Swelling
            3) Drainage
            4) Leakage
            5) Venous thrombosis of the ipsilateral chest (CVC located in the chest region).
9. Verify that the patient has signed a TCMC approved consent form for chemotherapy administration.
10. Don PPE in the following order before spiking a pre-filled chemotherapy IV bag, when manipulating a syringe that contains a chemotherapy agent or anytime there is a risk for exposure to chemotherapy or body fluid containing chemotherapy:
    a. Face shield or splash goggles
    b. N-95 mask
    c. First pair of chemo gloves
    d. Chemo gown with the cuffs over the first pair of gloves
    e. Second pair of chemo gloves over the cuffs of the gown
11. **IV Push Procedure:**
    a. Don two pair of chemotherapy safe gloves.
    b. Examine the chemotherapy pre-filled IV syringe for leakage or damage in the medication room before administration.
    c. Verification #1 & #2 (see section ~~F~~ **E** of this procedure) should be completed.
    d. Assemble equipment
        i. Extravasation Kit
        ii. Personal Protective Equipment (PPE) (Face shield or splash goggles, N95 mask, chemotherapy gown, 2 pairs of chemotherapy gloves). It is recommended to wear a face shield anytime there is a potential for chemotherapy splashing.
        iii. Chemotherapy puncture- proof waste disposal container
        iv. Leak-proof bag marked "Chemotherapy Waste"
        v. Plastic –backed absorbent pad
        vi. Sterile gauze
        vii. 3 Alcohol Prep Pads
    e. Review all manufacture's recommendations (located in the TCMC Drug Formulary or package insert) pertaining to the administration, pre-medication, IV fluid compatibility, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.
        i. Extravasation is a possible risk from vesicant administration. If extravasation occurs, the nurse must take immediate action. Follow TCMC's **PCS** Chemotherapy Extravasation Procedure.
    f. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent (Patient information located in Micromedix and educational

pamphlets located on 2 Pavilion) , chemo safety for body fluids and when to notify the nurse for signs and symptoms of:

i. Extravasation
   1) Burning
   2) Pain
   3) Heat
   4) Ulceration
   5) Swelling

ii. ~~Signs and symptoms of h~~**H**ypersensitivity and anaphylaxis
   1) Uneasiness
   2) Tightness of the chest
   3) Shortness of breath-with or without wheezing
   4) Hives or rash
   5) Local or generalized itching
   6) Periorbital or facial edema
   7) Lightheadedness or dizziness

g. **Administer** IV Chemotherapy ~~shall be administered~~ with no other IV medications or IV fluids running except for the mainline compatible IV fluid used during the IV push chemotherapy administration.

h. Label the IV pump and the IV push chemotherapy syringe with a TCMC approved "Chemotherapy" identification sticker before administration.

i. Inspect IV site and check patient's IV for blood return.

j. Don PPE in the following order before administration:
   i. Face shield or splash goggles
   ii. N-95 mask
   iii. First pair of chemo gloves
   iv. Chemo gown with the cuffs over the first pair of gloves
   v. Second pair of chemo gloves over the cuffs of the gown

k. Place plastic –backed absorbent pad under the patient's arm to prevent drug contact with patient's skin.

l. Use two patient identifiers prior to administration per the **TCMC**~~Tricity Medical Center~~'s **PCS**~~Patient Care Service~~ Medication Administration **Policy**~~Procedure~~.
   ~~m.~~**i.** A second Chemotherapy Competent Registered Nurse (preferred) will verify:
      ~~i.~~**1)** Chemotherapy agent and order for accuracy
      ~~ii.~~**2)** Two patient identifiers at the patient's bedside or chair
      ~~iii.~~**3)** Document as a witness in Cerner on the EMAR.

~~n.~~**m.** Use~~ing the~~ alcohol prep pads~~,~~**to** clean the patient's IV access port three times

~~o.~~**n.** Wrap sterile gauze around IV ports during IV push to reduce the potential for spraying

~~p.~~**o.** Inject drug into distal port of IV with free flowing solution at the prescribed rate (minimum of 100ml/hour). Verify blood return every 2-3ml of drug administration.

~~q.~~**p.** Flush line with 10-20ml of IV solution between administration of drugs or prior to discontinuing IV.
   i. Prevents incompatibility reaction and avoids exposure to anti-neoplastic agents.

~~r.~~**q.** Dispose of syringes in the puncture proof container labeled "Chemotherapy waste".

~~s.~~**r.** Recheck IV lines to be sure lines are leading to patient and are connected to the correct IV port.

~~t.~~**s.** Remove PPE in the following order and place in a chemotherapy waste bag and seal
   i. Outer pair of gloves
   ii. Chemo gown
   iii. Face Shield or splash goggles
   iv. N-95 mask
   v. Final pair of gloves

~~u.~~**t.** See TCMC **PCS** Disposal of Chemotherapy Waste Procedure for proper disposal of contaminated materials

12. **IV Continuous or Intermittent Procedure:**
    a. Don~~ning~~ two pair of chemotherapy gloves, examine the Chemotherapy pre-filled IV bag and tubing for leakage or damage in the medication room before administration.
    b. Verification #1 & #2 (see section ~~F.~~ **E** of this procedure) should be completed.
    c. Assemble equipment for use during administration.
        i. Extravasation Kit
        ii. Personal Protective Equipment (PPE) (Face shield or goggles, N-95 mask, chemotherapy disposable gown, two pairs of chemotherapy gloves).
        iii. Chemotherapy puncture proof waste disposal container
        iv. Leak-proof bag marked "Chemotherapy Waste"
        v. "Chemotherapy" identification stickers
        vi. Disposable plastic –backed absorbent liner
        vii. Plastic tape
        viii. 3 Alcohol Prep Pads
    d. Review all manufacture's recommendations pertaining to the administration (located in the TCMC Drug Formulary or package insert), pre-medication, IV fluid compatibility, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.
        ~~e.~~**i.** Extravasation is a possible risk from vesicant administration. If extravasation occurs, the nurse must take immediate action. Follow TCMC's **PCS** Chemotherapy Extravasation Procedure.
    ~~f.~~**e.** Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent (Patient information located in Micromedix and educational pamphlets located on 2 Pavilion), chemo safety for body fluids and when to notify the nurse for signs and symptoms of:
        i. Extravasation
            1) Burning
            2) Pain
            3) Heat
            4) Ulceration
            5) Swelling
        ii. ~~Signs and symptoms of h~~**H**ypersensitivity and anaphylaxis
            1) Uneasiness
            2) Tightness of the chest
            3) Shortness of breath-with or without wheezing
            4) Hives or rash
            5) Local or generalized itching
            6) Periorbital or facial edema
            7) Lightheadedness or dizziness
    ~~g.~~**f.** **Administer** IV Chemotherapy ~~shall be administered~~ on a single Alaris IV pump with no other IV medications or IV fluids running except for the mainline compatible flush bag for the IV chemotherapy agent.
    ~~h.~~**g.** Don PPE in the following order before administration:
        i. Face shield or splash goggles
        ii. N-95 mask
        iii. First pair of chemo gloves
        iv. Chemo gown with the cuffs over the first pair of gloves
        v. Second pair of chemo gloves over the cuffs of the gown
    ~~i.~~**h.** Prime all IV tubing with a compatible IV fluid before administering the chemotherapy intravenously if not already done by pharmacy.
    ~~j.~~**i.** **Program the Alaris pump** ~~A~~at the patient's bedside, ~~program the Alaris pump~~ using the appropriate chemotherapy drug guardrail profile with the witnessing second Chemotherapy Competent Nurse (preferred).
        i. Power on the Alaris IV pump and select New Patient.

ii. Select the Outpatient Profile.
iii. Enter the patient's medical record number.
iv. Select Channel letter that will be used.
v. Select Guardrail Drugs.
vi. Select the appropriate chemotherapy agent to be administered from the Alaris Oncology Drug Guardrail List.
vii. Verify and confirm correct dosing program.
viii. Review Clinical Advisory Warning on the Alaris IV pump and Confirm when read.
ix. Input the Drug Amount, Diluent Volume, BSA (if applicable). Verify dose and select Next.
x. Input Rate and Volume to be infused (VTBI).

~~k.~~**j.** Use two patient identifiers prior to administration **TCMC**~~Tricity Medical Center's~~ **PCS** ~~Patient Care Service~~ Medication Administration **Policy**~~Procedure~~.

~~l.~~**i.** A second Chemotherapy Competent Registered Nurse (preferred) will verify:
1) Chemotherapy agent and order for accuracy
2) Two patient identifiers at the patient's bedside or chair
3) Verifying the Alaris guardrail settings for accuracy
4) Document as a witness in Cerner on the EMAR.

~~m.~~**k.** Label the IV pump and the IV chemotherapy bag with a TCMC approved "Chemotherapy" identification sticker before administration.

~~n.~~**l.** Inspect IV site and check patient's IV for blood return.

~~o.~~**m.** Use disposable plastic –backed absorbent liner under the IV

~~p.~~**n.** Use~~ing~~ the alcohol prep pads **to**~~,~~ clean the patient's IV access port three times.

~~q.~~**o.** Securely attach the IV tubing to the patient's venous access device or, if using a secondary set, to the primary tubing

~~r.~~**p.** Tape the two IV connections together

~~s.~~**q.** Review dose and then select Start to begin infusion on the Alaris pump.

~~t.~~**r.** When infusion is complete, don PPE as instructed ~~(viii)~~.

~~u.~~**s.** Dispose of contaminated IV tubing and IV bags in a sealed chemotherapy waste bag and place in a puncture- proof chemotherapy waste container

~~v.~~**t.** Remove PPE in the following order and place in a chemotherapy waste bag and seal:
i. Outer pair of gloves
ii. Chemo gown
iii. Face Shield or splash goggles
iv. N-95 mask
v. Final pair of gloves

~~w.~~**u.** See TCMC **PCS** Disposal of Chemotherapy Waste Procedure for proper disposal of contaminated materials

13. **Intramuscular (IM) and Subcutaneous (SQ) Procedure**

a. Don~~ning~~ two pair of chemotherapy gloves, examine the chemotherapy pre-filled IV syringe for leakage or damage in the medication room before administration.

b. Verification #1 & #2 (see section ~~F~~ **E** of this procedure) should be completed.

c. Assemble equipment for use during administration.
i. Personal Protective Equipment (PPE) (Face shield or goggles, N-95 mask, chemotherapy disposable gown, two pairs of chemotherapy gloves).
ii. Chemotherapy puncture- proof sharps waste container
iii. Leak-proof bag marked "Chemotherapy Waste"
iv. "Chemotherapy" identification sticker
v. Appropriate size sterile needle (Use smallest needle possible)
vi. 2x2
vii. Alcohol Prep Pads
viii. Band-Aid

d. Review all manufacture's recommendations pertaining to the administration (located in the TCMC Drug Formulary or package insert), pre-medication, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.

e. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent (Patient information located in Micromedix and educational pamphlets), chemo safety for body fluids and when to notify the nurse for signs and symptoms of:
   i. Signs and symptoms of hypersensitivity and anaphylaxis
      1) Uneasiness
      2) Tightness of the chest
      3) Shortness of breath-with or without wheezing
      4) Hives or rash
      5) Local or generalized itching
      6) Periorbital or facial edema
      7) Lightheadedness or dizziness

f. Label chemotherapy syringe with a TCMC approved "Chemotherapy" identification sticker before administration.

g. Don PPE in the following order before administration:
   1) Face mask or Splash Goggles
   2) N-95 mask
   3) First pair of chemo gloves
   4) Chemo gown with the cuffs over the first pair of gloves
   5) Second pair of chemo gloves over the cuffs of the gown

h. Remove cap and connect sterile needle of the appropriate size for administering the drug.

i. Do not expel air from the syringe or prime the needle.

j. Use two patient identifiers prior to administration **TCMC**~~Tricity Medical Center~~'s **PCS**~~Patient Care Service~~ Medication Administration **Policy**~~Procedure~~.
   ~~k.~~**i.** A second Chemotherapy Competent Registered Nurse (preferred) will verify:
      ~~i.~~**1)** Chemotherapy agent and order for accuracy
      ~~ii.~~**2)** Two patient identifiers at the patient's bedside or chair
      ~~iii.~~**3)** Document as a witness in Cerner on the EMAR.

~~l.~~**k.** Review the manufacturers injection site recommendation

~~m.~~**l.** Cleanse injection site with alcohol prep pads

~~n.~~**m.** After administering the drug, do not re-cap and do not massage injection site.

~~o.~~**n.** Place the syringe with the needle attached directly into the puncture- proof chemotherapy waste container.

~~p.~~**o.** Remove PPE in the following order and place in a chemotherapy waste bag and seal
   i. Outer pair of gloves
   ii. Chemo gown
   iii. Face Shield or splash goggles
   iv. N-95 mask
   v. Final pair of gloves

~~q.~~**p.** See TCMC **PCS** Disposal of Chemotherapy Waste Procedure for proper disposal of contaminated materials

~~r.~~**q.** Monitor injection site for signs and symptoms of bleeding, redness, and rash post injection.

~~s.~~**r.** Educate patients going home after injection to access the injection site twice a day for bleeding and signs and symptoms of infection.

RELATED DOCUMENTS:

1. **PCS Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids Procedure**
~~F.~~**2. PCS Chemotherapy Extravasation Procedure**

3. **PCS Disposal of Chemotherapy Waste Procedure**
4. **PCS Medication Administration Policy**
5. **Pharmacy Chemotherapy, Prescribing, Processing and Preparation Policy**

G. **REFERENCES:**

1. National Institute for Occupational Safety and Health, (2004). Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings, Retrieved from the NIOSH website October 2014, at http://www.cdc.gov/niosh/docs/2004-165/#c.
2. Oncology Nursing Society, (2014). Chemotherapy and Biotherapy Guidelines, Fourth Edition.
3. Mafrica, Leonard. Safe Handling of Hazardous Drugs. Oncology Nursing Society. (2011)
4. ~~Tri-City Medical Center (2006) Medication Administration Policy IV.I~~
5. ~~Tri-City Medical Center (2009) Chemotherapy Exposure, Spills and Handling of Linens Contaminated with Chemotherapeutic Agents and Bodily Fluids, Accidental Exposure to Radioactive I-131 Body Fluids~~

Tri-City Medical Center	Distribution:	Women's and **Newborn's**~~Newborn~~ Services
PROCEDURE:	**PITOCIN ADMINISTRATION FOR INDUCTION/ AUGMENTATION OF LABOR**	
Purpose:	To promote safe and effective use of oxytocin, and to outline the nursing management of the patient requiring continuous oxytocin infusion for induction or augmentation of labor. This procedure is to be implemented for all patients undergoing induction/augmentation of labor. ~~Verify that the admitting physician or designated substitute is within 30 minutes of the hospital prior to implementing this procedure.~~	
Supportive Data:	Induction is defined as the stimulation of labor by artificial means. Oxytocin is the drug used in the medical induction of labor and is also used to augment existing contraction patterns that may not be adequate for progression of labor **to include trial of labor after Cesarean candidates.**~~.~~ ~~Using the lowest dose for administration of oxytocin to achieve or augment labor is recommended by ACOG for women attempting VBAC, since the rate of uterine rupture increases for women with a uterine scar or prior cesarean birth (AAP/ACOG, 2007; Simpson, K.R., 2008).~~	
Equipment:	1. Pre-mixed, labeled Normal Saline solution with Oxytocin 20 units, 1000 mL bag (Pyxis) 2. IV administration tubing **(Portless device is recommended)** 3. Needleless access device 5. Alaris Infusion pump 6. Color-coded Oxytocin Labels for labeling pump and tubing	

A. **POLICY STATEMENT:**

1. Responsibility for the decision to use oxytocin requires a p**rovider**~~hysician~~ order.
2. P**rovider** ~~hysician~~ or RN must evaluate patient immediately prior to administration of oxytocin:
   a. Cervical status, including dilation, effacement, station
   b. Fetal presentation
   c. FHR assessment
   d. Uterine activity
   e. Indication for oxytocin use
3. **An Obstetrician** ~~MD~~ able to perform **an** emergency cesarean section must be ~~immediately~~ available.

B. **INDICATIONS AND CONTRAINDICATIONS:**

1. Indications for induction may include the following:
   a. Chorioamnionitis
   b. Fetal demise
   c. Pregnancy-induced hypertension
   d. Premature rupture of membranes
   e. Postterm pregnancy
   f. Fetal compromise:
      i. Oligohydramnios
      ii. Severe fetal growth restriction
      iii. Isoimmunization
      ~~iv. Abnormal antenatal testing~~
      ~~v.~~**iv.** Previous stillbirth
   g. Preeclampsia or eclampsia
   h. Maternal medical condition:
      i. Diabetes mellitus
      ii. Renal disease
      iii. Chronic pulmonary disease

Review/Revision Date	~~Medical~~ Department of OB/GYN~~Review~~	Pharmacy and Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
6/94; 6/96; 4/00; 3/03; 5/09, 06/13, 05/14	6/09, 07/13, 4/14	01/15	2/15	3/15	6/03, 7/09

iv. Chronic hypertension

i. Logistics:

i. History of rapid labor.

ii. Distance from the hospital.

iii. Psychosocial indication

2. Induction may be considered, but necessitate special precautions, on a case-by-case basis for the following conditions:
   a. One or two previous low transverse cesarean delivery ~~– requires adherence to low-dose administration of oxytocin (refer to A.10.a-d, and TOLAC/VBAC policy)~~
   b. Maternal heart disease
   c. Multifetal pregnancy
   d. Polyhydramnios
   e. Presenting part above the pelvic inlet
   f. Severe hypertension
   g. Abnormal fetal heart rate patterns not necessitating emergent delivery
3. Contraindications:
   a. Vasa previa
   b. Complete placenta previa
   c. Non-vertex presentation (viable fetus)
   d. Umbilical cord prolapsed
   e. Previous invasive transfundal (upper segment) uterine surgery
   f. Known lateral extension of the uterine incision following cesarean delivery
   g. Other maternal or fetal condition for which spontaneous labor and vaginal delivery is contraindicated

C. **PROCEDURE:**

1. The L&D RN shall:
   a. Verify ~~physician~~ **provider** order for administration of oxytocin for induction/augmentation of labor.
   b. Assist the patient to a position of comfort, preferably the left or right lateral position**,to increase uterine perfusion**~~.~~
   c. **Perform** Maternal-Fetal assessment:
      i. Maternal Assessment:
         1) Assess baseline maternal temperature, pulse, respirations, and blood pressure.
         2) In the absence of ruptured membranes assess cervical **status to include:** dilatation, effacement, station, consistency and position of cervix prior to beginning infusion.
         3) Assess uterine activity, including palpation of contraction(s).
   d. **Perform** Fetal Assessment **per Fetal Heart Rate Surveillance Policy**:
      i. **Review** 30-minute reassuring fetal heart rate tracing**, Category I.**
      ii. Confirmation of vertex presentation and fetal position.
      iii. Notify p**rovider** ~~hysician~~ if the fetal heart rate tracing **interpretation is a category II or III.**~~is non-reassuring.~~
   e. Assemble equipment:
      i. This procedure requires a patent intravenous line.
      ii. Premixed oxytocin solution contains 20 Units in 1000 mL of Normal Saline solution.
   f. Clearly label the following with color-coded labels:
      i. IV Oxytocin/Pitocin bag
      ii. IV tubing ~~at~~ the point as it enters the infusion pump
      ~~i.~~**iii.** IV tubing at the point it enters the IV port.
2. Induction/Augmentation of labor:

a. Begin infusion at 0.5 ~~mU~~ **milliunits/min** to 2 ~~mU per minute~~**milliunits/minute per provider order**.

b. **Titrate** ~~Increase~~ dosage by 1 ~~to 2~~ **milliunit/min**~~mU per minute~~ **every 30 minutes or** ~~every 15 to~~**per provider order.** ~~r30 minutes~~ until adequate **contraction pattern to achieve** progress of labor. **(~~P~~Pitocin may not be titrated in less than 15 minute intervals)** ~~is established~~**.Ssee titrating medication below in 2d).** ~~and/or contractions occur every 2-3 minutes and of moderate quality.~~

c. Administration of oxytocin exceeding 20 ~~mU per minute~~**milliunits/min** requires p**rovider**~~hysician~~ assessment and a **provider**~~physician~~ order.

d. Titrating Medication: Adequate progress of labor and/or uterine activity is defined as:

i. **Three to five (3-5) c**~~C~~ontraction**s in a 10 minute period with a maximum, not to exceed 5 contractions in a 10 minute period (tachysystole)** ~~duration of 45 to 90 seconds~~.

ii. Contraction **duration of 40 -90 seconds.** ~~frequency of every 2 to 3 minutes~~.

iii. Moderate to strong contraction intensity by palpation **with.**~~-~~adequate resting tone by palpation.

iv. If using an Intrauterine Pressure Catheter (IUPC) **an amplitude of at least 50 mm/Hg above the resting tone** is desired. The resting tone shall be less than 20 mm/Hg.

e. ~~Induction/Augmentation of labor for TOLAC/VBAC:~~

i. ~~Begin infusion at 0.5 mU to 1 mU per minute.~~

ii. ~~Increase dosage by 1 mU per minute every 30 to 60 minutes, using lowest dose necessary to induce labor.~~

iii. ~~**Low dose** administration of **oxytocin may not exceed 10 mU** per minute.~~

iv. ~~Refer to WCS Policy #7400-410: "Trial of Labor after Cesarean (TOLAC), Vaginal Birth after Cesarean Birth (VBAC)" for mandatory guidelines and additional assessment requirements.~~

3. Nursing assessment:

a. Continuous electronic fetal monitoring shall be maintained when oxytocin is used.

b. The fetal heart rate and uterine contraction pattern should be evaluated and documented at the start of the oxytocin infusion, ~~15 minutes after initiation,~~ after any rate increase or decrease and every 30 minutes during maintenance. **(See Fetal Heart Rate Surveillance Policy)**

~~i. Baseline FHR, including:~~
~~ii. Variability.~~
~~iii. Presence or absence of FHR accelerations.~~
~~iv. Presence or absence of decelerations, and interventions as appropriate.~~
~~v. Uterine activity~~
~~vi. Contraction frequency~~
~~vii. Duration~~
~~viii. Intensity by palpation or intrauterine pressure catheter (IUPC)~~
~~ix. Uterine resting tone by palpation or IUPC~~
~~x.~~**i.** ~~Maternal response to labor, including analgesia's effect with contractions, ie, epidural, etc.~~

c. Monitor the ~~patient~~ **patient per intrapartum standards of care and** for the following complications:

i. Uterine **T**~~t~~achysystole~~, uterine relaxation < 30 seconds~~

1) Defined as > 5 contractions in a 10 minute window averaged over 30 minutes ~~and documented as with or without non-reassuring FHR pattern~~

ii. Uterine **R**~~r~~upture

iii. Non-**R**~~r~~eassuring **F**~~f~~etal **S**~~s~~tatus**. Category II, progressing to a Category III or a Category III Tracing.** ~~s~~

iv. Water **I**~~i~~ntoxication

v. Cord **P**~~p~~rolapse

vi. Precipitous **L**labor

~~d. Ongoing maternal assessment should also include:~~

~~i. Assess maternal pulse, respirations, and blood pressure a minimum of every 30 minutes.~~

~~ii. Assess maternal temperature every 2 to 4 hours.~~

~~1) Every four hours if membranes are intact.~~

~~2) Every two hours if membranes are ruptured.~~

~~iii. Assess intake and output every hour.~~

~~iv. Notify physician if urinary output ≤ 30 mL per hour and/or ≤ 120 mL per 4 hr interval.~~

~~e.~~**d.** Assess for signs of uterine rupture:

i. **Fetal Heart Rate with Category II progressing to III or category III tracing and/or a prolonged deceleration.**

ii. Uterine tachysystole **OR complete loss of uterine activity**~~, uterine relaxation < 30 seconds.~~

1) ~~Defined as > 5 contractions in a 10 minute window averaged over 30 minutes and documented as with or without non-reassuring FHR pattern~~

iii. Abdominal pain and rigidity~~.~~

iv. Hypotension, tachycardia~~.~~

v. Vaginal bleeding~~.~~

vi. **Loss of fetal station**

vii. **Mis-shaped abdominal wall/ increased fundal height**

~~f.~~**e.** Assess for signs and symptoms of water intoxication:

i. Headache.

ii. Nausea and vomiting.

iii. "Feeling sick".

iv. Mental confusion.

v. Decreased urinary output **(< 30 cc per hour and/or less than 120 per 4 hour interval)**~~.~~ ~~(Refer to D.12.a)~~

vi. Hypotension.

vii. Tachycardia.

viii. Heart rate irregularities.

ix. Abnormal lung sounds:

~~1.~~**x.** Rales

4. **Decrease Oxytocin per provider order for:**

a. **Uterine Tachysystol**

b. **Contractions lasting 2 minutes or mor**e

c. **Contractions of normal duration occurring within 1 minute of each other**

d. **Insufficient return of uterine resting tone between contractions via palpation OR if IUPC resting tone pressure is greater than 25 mmHg**

e. ~~Stopping and re-starting infusion:~~

5. Discontinue **oxytocin** ~~infusion~~ **per provider order** and notify p**rovider** ~~hysician~~ for any of the following:

a. **Category II progressing to Category III and/or Category III**~~Non-reassuring~~ fetal heart rate **findings**~~response~~.

b. **Prolonged FHR deceleration**

c. Uterine tachysystole **with FHR changes**~~, uterine relaxation < 30 seconds.~~

~~d. Defined as > 5 contractions in a 10 minute window averaged over 30 minutes and documented as with or without non-reassuring FHR pattern~~

~~e.~~**d.** Suspected uterine rupture.

~~iii.~~**e.** Suspected water intoxication.

f. RN is not available to evaluate ~~clinically~~ the effects of oxytocin at least every **30**~~15~~ minutes.

6. **Intervention considerations for oxytocin induced tachysystole per provider orders:**

a. **For uterine tachysystole episodes with FHR Category I tracing:**
   i. **Maternal repositioning**
   ii. **Give IV fluid bolus of 500 mL of Lactated Ringers Solution**
   iii. **If uterine activity is not within normal limits after 10 minutes, may decrease oxytocin rate by half**
   iv. **If uterine activity continues to evidence tachysystole after the rate was halved, discontinue oxytocin until uterine activity is less than 5 contractions in 10 minutes.**

b. **For uterine tachysystole episodes with FHR Category II:**
   i. **Decrease oxytocin rate by half**
   ii. **Maternal Repositioning**
   iii. **Give IV fluid bolus of 500 mL of Lactated Ringers Solution**
   iv. **Consider oxygen at 10L/min via non-rebreather mask if the first interventions trialed did not resolve the indeterminate tracing**
   v. **If uterine activity remains in a tachysystole pattern, discontinue the oxytocin and notify the provider of the actions taken and patient/ FHR response.**

c. **For uterine tachysystole with FHR Category III:**
   i. **Discontinue oxytocin infusion**
   ii. **Maternal repositioning**
   iii. **Give IV fluid bolus of 500 mL of Lactated Ringers Solution**
   iv. **Give oxygen at 10 L/min via non-rebreather facemask**
   v. **If no uterine contraction response, ready 0.25 mg terbutaline for subcutaneous administration per provider order**

d. **The**~~Restart~~ **oxytocin** infusion **may be restarted per provider order:**
   i. **If Pitocin is off less than 30 minutes, restart Pitocin at one half (1/2) the discontinued rate**
   ii. **If Pitocin is off greater than 30 minutes, restart Pitocin at the original start rate order rate.** ~~at initial dose and titrate per step 8, 9 or 10 above.~~

D. **DOCUMENTATION:**

1. Document initial and subsequent maternal vital signs, and fetal heart rate status **in the Electronic Medical Record (EMR)**~~on the Patient Care Record~~.
2. Document abnormal maternal and fetal assessments, including all interventions **in the EMR**~~on the patient medical record.~~
3. Document adverse events associated with this infusion on the patient **EMR**~~medical record.~~
4. Document infusion rate and times of dosage changes on the patient **EMR**~~medical record~~.
5. ~~Document the maximum pitocin per mU used during the induction/augmentation in the patient medical record.~~
6. ~~6.~~

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14. Wing, D.A. (2008) Induction of labor in women with prior cesarean delivery. Retrieved from www.uptodate.com 4/06/09.
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DRAFT

Governance & Legislative Committee Meeting Minutes
Tri-City Healthcare District
March 3, 2015

Members Present: Larry Schallock, Chairperson; Director RoseMarie V. Reno; Director Ramona Finnila; Blake Kern, Community Member; Al Memmolo, Community Member; Eric Burch, Committee Community Member; Dr. Paul Slowik, Committee Community Member; Dr. Marcus Contardo, Physician Member; Dr. Henry Showah, Physician Member

Non-Voting Members: Jody Root, General Counsel

Others Present: Teri Donnellan, Executive Assistant; Sharon Schultz, CNE, Jane Dunmeyer, Community Member

Absent: Tim Moran, CEO

	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	The meeting was called to order at 12:35 p.m. in Assembly Room 3 at Tri-City Medical Center by Director Schallock, Committee Chairman.		
2. Approval of Agenda	**It was moved by Dr. Henry Showah to approve today's agenda as presented. Mr. Eric Burch 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.	There were no public comments.	
4. Ratification of prior Minutes	**It was moved by Director Finnila and seconded by Mrs. Blake Kern to ratify the minutes of the December 2, 2014 Governance & Legislative Committee. The minutes were approved with Director Reno abstaining from the vote.**	Minutes ratified.	Ms. Donnellan
5. Old Business	Chairman Schallock reported Medical Staff Policy #8710-519 Suspension for Delinquent Medical Record and #8710-518 Medical Record Documentation Requirements were scheduled to come back to the committee, however both policies are still under review by General Counsel, hospital and Chief of Staff and will	Medical Staff Policy #8710-519 Suspension for Delinquent Medical Record and #8710-518 Medical Record Documentation Requirements to be placed on the April agenda.	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	come forward for review by the committee at the April meeting.		
6. New Business a. Review of Proposed Approach to Review of Medical Staff Board Reports	Chairman Schallock explained the chart included in today's meeting packet related to Medical Staff Reports is being discussed today as the Board has responsibility and ultimate authority over Medical Staff Initial and Reappointments, relinquishing of Medical Staff membership or privileges, Medical Staff Bylaws, Rules and Regulations and Policies as well as physician Peer Review. General Counsel, Mr. Jody Root stated that previously these items were approved by the Board via the Board's Consent Calendar and this method provided limited oversight. He further explained that under this structure the Medical Staff items would be approved by the Board as action items and Peer Review would be reported to the Board by the Chief of Staff in Closed Session. In addition, Board members would have the opportunity to ask questions related to physician privileges during the closed session quality report. Director Reno noted ACHD also agrees with more Board oversight in these matters. Director Finnila stated the Board welcomes any insight and opinions committee members may have with respect to Board oversight. Ms. Sharon Schultz, CNE explained the Governing body has certain obligations with regard to credentialing, as recommended by CMS and they include individual character, competence, training, experience and judgment. Dr. Marcus Contardo, Chair of the Professional Behavior Committee provided an overview of the Medical Staff's process with respect to Peer Review and physician behavioral issues. He explained the Physician Well Being Committee deals with chemical dependency, emotional turbulence, emotional crisis and individuals who are amenable to assistance. They may counsel and refer to an appropriate therapist and it is not a	Information only.	

Topic	Discussion	Action Follow-up	Person(s) Responsible
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	punitive process. Dr. Contardo stated the Professional Behavioral Committee deals with physicians who do not want to be helped and often ends in a confrontational review process that can take years to resolve and may result in a hearing and appellate steps before the Board and physicians are at risk of losing Medical Staff privileges. He noted physicians who are successfully helped by well being are handled confidentially and do not lose their membership or privileges at the hospital. Dr. Contardo explained the case or peer review process is a separate process in which charts that may "fall out" of the normal standards are reviewed by the Quality Review Department. He further explained that the results of these reviews are brought back to the Medical Executive Committee and Board and may include a change in practice patterns. Mr. Root explained the series of steps that are taken to determine if a physician is granted privileges. Dr. Contardo noted this can be a lengthy process and it is ultimately the Board as a Governing body who grants or denies physician privileges. Dr. Contardo stated both state and federal law requires the hospital to report certain events and it is extremely important that the Medical Staff and the Board screen physicians as fully as possible to avoid any untoward circumstances later on. General Counsel stated physician names are not disclosed to the Board during the peer review process to avoid influencing the Board's decision should the Board need to take action against a physician.		
b. Medical Staff Policies: 1 Supervision of Residents/Fellows/Medical Students 8710-513	Dr. Henry Showah explained the rotation process for residents in the Emergency Room. Ms. Sharon Schultz explained we also have residents from Camp Pendleton who follow the hospitalists. In addition, from time to time Medical Students will shadow a surgeon. Dr. Showah questioned the need for the medical staff member to countersign orders, history and physicals, discharge summaries and progress notes of the resident. General Counsel Mr. Root will report back on whether this	Supervision of Residents/Fellows/Medical Students policy #8710-513 to be referred back to the Medical Staff for further review and revisions brought back to the April meeting. General Counsel to report back on the requirement of a physician to	Ms. Donnellan General Counsel

Topic	Discussion	Action Follow-up	Person(s) Responsible
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	requirement is self-imposed by the hospital or a requirement by statute. Dr. Contardo questioned the credentialing process followed prior to bringing a resident on board. Ms. Sharon Schultz, CNE stated there is a process that the Medical Staff follows and she will report back to the committee on that process next month. Mr. Eric Burch questioned the need for the verbiage listed in #3. Sports Medicine Fellow Rotation, letters a. and b. The committee agreed #3 a. and #3 b. are not relevant to the implication of the policy and should be removed. The committee noted several punctuation/formatting errors. It was recommended the policy be sent back to the Medical Staff for further review.	countersign orders of Residents.	
c. Rules & Regulations 1. Division of General Vascular Surgery Rules & Regulations	The committee noted a general deficiency of punctuation in the Division of General Vascular Surgery Rules & Regulations presented. There was also a concern with the format as presented. It was recommended the Division of General Vascular Surgery Rules & Regulations be referred back to the Medical Staff for further review.	Division of General Vascular Surgery Rules & Regulations to be referred back to the Medical Staff for further review and revisions brought back to the April meeting.	Ms. Schultz
7. Discussion regarding Current Legislation	Chairman Schallock reported the legislature is back in session however we have no information yet on the bills that have been submitted. Chairman Schallock noted CHA Legislative Days are scheduled for March 10-11th in Sacramento, CA. Director Finnila reported LAFCO is looking at Hospital District boundaries to determine if they are appropriate. She stated that Director Nygaard has been appointed to a LAFCO committee and concerns related to District boundaries could be directed to her or Mr. Michael Ott,	Information only.	

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	Executive Officer with LAFCO. Chairman Schallock spoke regarding the question of the Shadowridge area being included in the Tri-City district. He explained the District would not receive any property tax money as a result of incorporating Shadowridge into the District and that the District would only benefit financially if we had a bond. Chairman Schallock also explained Shadowridge could appeal the decision and an appeal by 20-50% of the Shadowridge population would force a public vote.		
8 Review of FY2015 Committee Work Plan	The FY2015 Committee Work Plan was included in today's meeting packet for reference. Chairman Schallock stated he plans to share some information from the Governance Institute at a future meeting. He also noted the Board is in the process of scheduling a Board Workshop and in the fall will be conducting a self evaluation. Director Finnila suggested standardized guidelines be developed to outline the steps the Board is taking in evaluation of quality of care oversight. Ms. Sharon Schultz, CNE explained we utilize the mechanism suggested by CMS and the Joint Commission.	Ms. Schultz will bring forward a one page summary outlining the Board's duties in oversight as prescribed by CMS and the Joint Commission.	Ms. Schultz
9. Committee Communications	Director Reno introduced herself to committee members.	None	
10. Community Openings – None			
11.Confirm date and time of next meeting	The committee's next meeting is scheduled for Tuesday, April 7, 2015, at 12:30 p.m.	Committee will meet on April 7, 2015.	
12. Adjournment	Chairman Schallock adjourned the meeting at 1:19 p.m.		

I. **MEMBERSHIP**

The Division of General and Vascular Surgery consists of physicians who are Board Certified or in the first thirty-six (36) months of Board Eligibility and actively pursuing certification by the American Board of Surgery, or able to demonstrate comparable ability, training and experience.

II. **FUNCTIONS OF THE DIVISION**

The general functions of the Division of General and Vascular Surgery 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 Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee 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 Division clinical practice.

D. Review and evaluate Division member adherence to:
   1. Medical Staff policies and procedures
   2. Sound principles of clinical practice

E. Submit written minutes to the QA/PI Committee and Medical Executive Committee concerning:
   1. Division review and evaluation of 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/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509).

I. Approve On-Going Professional Practice Evaluation Indicators, and

J. Formulate recommendations for Division rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. **DIVISION MEETINGS**

The Division of General and Vascular Surgery shall meet at the discretion of the Chief, but at least quarterly. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the QA/PI Committee, and then to the Medical Executive Committee.

Twenty-five percent (25%) of the Active Division members, but not less than two (2) members, shall constitute a quorum at any meeting.

IV. **DIVISION OFFICERS**

The Division shall have a Chief who shall be a member 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 Division.

The Division Chief shall be elected every year by the Active Staff members of the Division who are eligible to vote. If there is a vacancy for any reason, the Department Chairman shall designate a new Chief, or call a special election. The Chief shall be elected by a simple majority of members of the Division.

The Division Chief 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 Medical Staff membership or clinical privileges in that Division. Division officers shall be eligible to succeed themselves.

V. **DUTIES OF THE DIVISION CHIEF**

The Division Chief shall assume the following responsibilities:

A. Be accountable for all professional and administrative activities of the Division.
B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division.
C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form.
D. Recommend to the Department of Surgery and the Medical Executive Committee the criteria for clinical privileges in the Division.
E. Recommend clinical privileges for each member of the Division.
F. Assure that the quality, safety, and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Other duties as recommended by the Department of Surgery or 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. **Physician Assistants** – In accordance with Department of Surgery rules and regulations.
E. **Registered Nurse First Assist (RNFA)** – In accordance with Department of Surgery rules and regulations.
F. **Forensic Outpatient Site-Specific Privileges** – Privileges annotated with an (F) indicates privileges that may be performed at either Tri-City Medical Center or the Forensic Outpatient Clinic.

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Admit Patients Consultation, including via telemedicine (F) Perform Medical History & Physical Examination, including via telemedicine (F)	Board certification, or in the first 36 months of Board eligibility and actively pursuing certification by the American Board of Surgery, or demonstrated comparable ability, training or experience.	Completion of General Surgery proctoring satisfies proctoring for these privileges	N/A
BASIC GENERAL SURGERY PRIVILEGES			
• Anal canal biopsy (F) • Anoscopy (F) • Arterial catheterization for monitoring	• Board certification, or in the first 36 months of Board eligibility and	Ten (10) cases	Sixty (60) cases from this category

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
• Basic advancement flaps: rotational and myocutaneous (excluding TRAM and micro-vascular) • Biopsy / excision skin & soft tissue lesions (F) • Central venous catheter placement • Chemical destruction of anal warts (F) • Cricothyroidotomy • Debridement of wound, soft tissue infection • Excision of neuroma, neurofibroma, neurilemoma • Excision of skin, soft tissue neoplasm • I&D abscess (F) • Intraoperative Endoscopy, concomitant to surgical procedure • Minor laceration repair • Neurorrhaphy - Suture of Nerve • Paracentesis • Parathyroidectomy • Radical neck dissection, modified • Right heart catheterization for monitoring • Rigid proctoscopy (F) • Rubber band ligation of internal hemorrhoids (F) • Sentinel lymph node biopsy • Sigmoidoscopy, includes rigid or flexible • Thoracentesis • Thyroidectomy • Tracheostomy • Tube thoracostomy **Abdomen and Perineum Surgery:** • Abdominal perineal resection • Abdominal wall repair, inguinal or femoral hernia, laparoscopic • Adrenalectomy, open • Anal sphincterotomy • Anti-reflux procedures, open	actively pursuing certification by the American Board of Surgery, or demonstrated comparable ability, training or experience. • One-hundred (100) general surgery procedures, reflective of the scope of privileges requested, during the previous twenty-four (24) months or demonstrate successful completion of an ACGME/AOA-accredited residency or clinical fellowship within the previous (24) months.		

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
• Appendectomy, open or laparoscopic • Cholecystectomy, open or laparoscopic • Choledochoenteric anastamosis • Colostomy, closure • Colostomy, creation, open or laparoscopic • Common bile duct exploration, transcystic, open or laparoscopic • Diagnostic laparoscopy with or without biopsy • Drainage of anorectal abscess • Drainage of intra-abdominal abscess • Drainage of pseudocyst • Enterolysis • Esophageal diverticulectomy, open • Esophagogastrectomy • Exploratory laparotomy • Fasciotomy • Gastrectomy, partial or total • Hemorrhoidectomy • Hernia, abdominal wall, to include: femoral, inguinal, incisional, lumbar, spigelian, ventral, open or laparoscopic • Hernia, repair of diaphragmatic or hiatal, open • Ileostomy creation or closure • Intestine resection (small or larger intestine), open or laparoscopic • Liver biopsy, open or laparoscopic • Lymphadenectomy • Lysis of adhesions, open or laparoscopic • Pilonidal cystectomy • Repair of anorectal fistula • Repair of rectal prolapse • Splenectomy, open • Ulcer surgery, (Omental patch, V&A, V&O, V&GJ, HSV, etc), open • Vagus transection, for peptic ulcer disease			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Breast Surgery: • Axillary dissection • Biopsy, incisional or excisional • Breast abscess, drainage of • Intraoperative needle localization • Intraoperative ultrasound • Mastectomy, partial • Mastectomy, total • Mastopexy **Urogenital Surgery:** • Bladder repair, incidental • Hydrocelectomy, incidental • Hysterectomy, incidental • Nephrectomy, incidental • Orchiectomy, incidental • Partial cystectomy, incidental • Salpingo-oophorectomy, incidental or in an acute abdominal emergency • Ureteral repair, incidental • Skin grafting			
BASIC PERIPHERAL VASCULAR SURGERY PRIVILEGES			
• Amputation, digital • Amputation, foot • Amputation, knee, above • Amputation, knee, below • Ligation of perforating veins (open or minimally invasive using laser or ablation using radiofrequency) • Operations for venous ulceration/split thickness skin grafting (STSG) • Sympathectomy - (Including vascular ischemia) • Vein ligation or stripping of varicose veins/phlebectomy • Portal Decompression: • Mesocaval shunt • Portocaval shunt • Splenorenal shunt	Board certification by the American Board of Surgery, or in the first 36 months of Board eligibility, or can demonstrate comparable ability, training and experience. Ten (10) cases within the previous twenty-four (24) months.	One (1) case	Five (5) cases
ADVANCED GENERAL SURGERY PRIVILEGES:			
Advanced Breast Surgery: Oncoplastic repair	• Basic General Surgery privileges which effectively covers the need for board certification. • For Oncoplastic Repair	Three (3) cases	Ten (10) cases

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
	privileges: Documentation of ten (10) CME credits relating to oncoplastic repair within the previous twenty-four (24) months, OR current oncoplastic repair privileges at another institution, OR completion of a Breast fellowship, OR ten (10) cases performed during residency training or within the previous twenty-four (24) months.		
Advanced Laparoscopic:: • Adrenalectomy , laparoscopic • Antireflux/fundoplication procedures (e.g. laparoscopic Nissen/Toupet), laparoscopic • Cholecystenteric anastomosis, laparoscopic • Choledochoenteric anastomosis, laparoscopic • Colostomy closure, laparoscopic • Esophageal procedures, laparoscopic • Gastric resection , laparoscopic • Hepatic resection , laparoscopic • Hernia repair, diaphragmatic or hiatal, laparoscopic • Pancreatic procedures, laparoscopicSplenectomy, laparoscopic • Ulcer surgery (Omental patch, V&A, V&O, V&GJ, HSV, etc), laparoscopic	• Basic General Surgery privileges which effectively covers the need for board certification. • Forty (40) advanced general and abdominal procedures during the previous twenty-four (24) months.	Three (3) cases from this category	Twenty-four (24) cases from this category
Advanced Abdominal:			
• Esophagectomy, including thoracoabdominal approach • Hepatic lobectomy, open • Hepaticoenterostomy • Pancreatic procedures, open or laparoscopic	• Basic General Surgery privileges which effectively covers the need for board certification. • Two (2) advanced abdominal procedures during the previous twenty-four (24) months.	One (1) case from this category	Two (2) cases from this category
Advanced Head & Neck Surgery:	• Basic General Surgery	Two (2) cases	Ten (10) cases

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
• Parotid gland • Salivary glands & ducts • Thymectomy	privileges which effectively covers the need for board certification. • Twenty (20) advanced head and neck procedures during the previous twenty-four (24) months.	from this category	from this category
ADVANCED PERIPHERAL VASCULAR SURGERY:			
• Aortic, aorto-iliac, aorto-femoral bypass • Axillary-femoral bypass • Bypass of upper extremity vessel • Carotid – Subclavian bypass • Celiac/superior mesenteric axis endarterectomy, repair or bypass • Embolectomy or thrombectomy • Endarterectomy, carotid • Endarterectomy or bypass, vertebral • Endarterectomy, repair or bypass, renal artery • Exploration, repair, thrombectomy, or embolectomy of abdominal aorta, iliac, femoral or infrageniculate artery • Femoral to femoral bypass • Femoral to infrageniculate bypass • Femoral to popliteal bypass • Repair of aortic branches • Repair of iliac, femoral, popliteal, or mesenteric aneurysm • Repair of infra or suprarenal aortic aneurysm • Repair of upper extremity vessel • Retroperitoneal exposure for spine vertebral body procedures, includes incidental vascular procedures* • Upper and lower extremity deep or superficial vein procedures • Upper or lower extremity fistula, autogenous or artificial placement of central venous catheter placement	• Basic General Peripheral Vascular Surgery privileges which effectively covers the need for board certification. • Forty (40) vascular cases within the previous twenty-four (24) months (With application, submit list of major procedures done in two (2) years preceding application. Include indications, results, morbidity and mortality data and operative reports.) • *If only Retroperitoneal exposure for spine vertebral body procedures privilege is requested, documentation of five (5) cases within the previous twenty-four (24) months and documentation of current privileges in vascular or trauma surgery at a healthcare facility. All other privileges in the category must be crossed out.	• Five (5) cases from this category • * If only Retroperitoneal exposure for spine vertebral body procedures privilege is requested, two (2) cases	• Twenty (20) vascular cases from this category • *If only Retroperitoneal exposure for spine vertebral body procedures granted, five (5) cases and documentation of current privileges in vascular or trauma surgery at a healthcare facility. All other privileges in the category must be crossed out.
SPECIAL PRIVILEGES:			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Bariatric Surgery: • Roux en Y gastric bypass, open and laparoscopic • Sleeve gastrectomy, open and laparoscopic • Adjustable gastric banding, open and laparoscopic • Revisional metabolic and bariatric surgery, open and laparoscopic • Biliopancreatic diversion, with or without duodenal switch, open and laparoscopic	• Completion of General Surgery residency program. • Privileges to perform Basic and Advanced Abdominal surgery and advanced laparoscopy. • Completion of a Bariatric and Metabolic Surgery fellowship, or Minimally Invasive fellowship with documentation of rotation in Bariatrics and the performance of a minimum of five (5) cases within the previous twenty-four (24) months, or case logs documenting the performance of a minimum of fifteen (15) bariatric cases within the previous twenty-four (24) months. • Commitment to participate in TCMC's Bariatric Committee and comply with Medical Staff policy 8710-572. • Documentation to indicate malpractice coverage includes bariatric surgery.	Three (3) cases	• Fifteen (15) cases within the previous twenty-four (24) months • Participatation in TCMC's Bariatric Committee as evidenced by compliance with Medical Staff policy 8710-572.
Colonoscopy	Completion **ACGME accredited training program in** ~~of~~ General Surgery ~~residency~~ or Colon and Rectal surgery ~~residency or fellowship~~ within the previous ~~two~~ **twenty four** (~~2~~24) ~~years~~**months**. If training was completed greater than ~~two years~~**twenty four (24) months** ago, documentation of **a refresher training course in lower endoscopy or documentation of** fifty	**If training was completed within the previous twenty-four (24) months prior to granting of privileges or if training was completed more than twenty-four**	Ten (10) cases

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
	(50) cases within the previous twenty-four (24) months is required.	months prior to granting privileges but documentation of fifty (50) cases was provided, ~~T~~two (2) cases If training was completed greater than twenty-four (24) months prior to granting of privileges and a refresher course was taken, seven (7) cases	
Upper endoscopy (EGD) – intraoperative/as integral part of operation (i.e., Heller myotomy, gastric bypass), or as preoperative evaluation or as follow-up for specific operative procedures	Initial: Completion of ACGME-accredited training program in General Surgery or Colon and Rectal Surgery within the previous twenty-four (24) months. If training was completed greater than twenty-four (24) months ago, documentation of a refresher training course in upper endoscopy or documentation of fifty (50) cases within the previous twenty-four (24) months is required.	If training was completed within the previous twenty-four (24) months prior to granting of privileges or if training was completed more than twenty-four months prior to granting privileges but documentation of fifty (50) cases	Seven (7) cases within the previous twenty-four (24) months

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
		was provided, two (2) cases If training was completed greater than twenty-four (24) months prior to granting of privileges and a refresher course was taken, seven (7) cases	
Endovenous Ablative Therapy	Documentation of completion of product-sponsored training, which included the performance/interpretation of twenty (20) endovenous ablative therapy procedures	Three (3) cases	Five (5) cases
Endovascular Repair of Aortic Aneurysms	Per policy 8710-503	Per policy 8710-503	Per policy 8710-503
Fluoroscopy	Per policies 8710-528 and 8710-528A	Per policies 8710-528 and 8710-528A	Per policies 8710-528 and 8710-528A
KTP Laser	Documentation of completion of training for specific energy source(s) to be used. Or, if training completed greater than two years prior to privilege request, submit case logs from previous 24 months identifying specific energy source used.	Two (2) cases	Two (2) cases
Moderate Sedation	Per policy 8710-517	Per policy 8710-517	Per policy 8710-517
Robotic Surgery – (da Vinci) • Multiple Port • Single Port • Assist in robotic surgery	Per policy 8710-563	Per policy 8710-563	Per policy 8710-563
Transoral Esophagogastric Fundoplication (TIF)	1. Completion of ACGME accredited residency program and possess board certification or board eligibility in	Three (3) cases	Six (6) cases

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
	Surgery; and 2. Documentation of completion of product-sponsored training course, or have performed at least five (5) TIF procedures in the previous twelve (12) months		
Placement of Vagal Nerve Stimulator	1. Basic General Surgery privileges which effectively covers the need for board certification. 2. Documentation of performing five (5) vagal nerve stimulator cases in the previous twenty-four (24) months.	Two (2) cases	Five (5) cases

VII. **REQUIREMENTS FOR REAPPOINTMENT**

A. Active certification by the Division of General Vascular Surgery or demonstration of comparable ability, training and experience shall satisfy the requirements for receiving cognitive privileges for all categories as well as for admitting privileges to Tri-City Medical Center.

B. 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 Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Division will act as proctors. An associate may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the Division Chief to inform the monitored member whose proctoring is being continued whether the deficiencies noted are in: a) preoperative b) operative, c) surgical technique and/or, d) postoperative care.

C. **THE MONITOR MUST BE PRESENT IN THE OPERATING ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE APPLICANT MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E. H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE SURGEON'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. The proctor may assist the surgeon.

F. When the required number of cases has been proctored, the Division Chief 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 preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Operating Room Supervisor and/or the Medical Staff Office.

H. Forms will be made available to the member scheduling the case for surgery and immediately forwarded to the proctor for completion. It is the responsibility of the new member to notify the Operating Room Supervisor of the proctor for each case.

I. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

IX. **EMERGENCY DEPARTMENT CALL:**

A. Division 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. It is the policy of the Emergency Department that when a patient indicates that a staff member has previously treated him or her, that member will be given the opportunity to provide further care.

C. The member of the Division will then determine whether to provide further care to an emergency room patient based upon the circumstances of the case. If a member declines, the on-call physician will provide any necessary emergency special care.

D. The care provided by an on-call physician should be completed with regard to the particular problem that the physician was called to treat. The care provided by an on-call physician will not create an obligation to provide further care.

E. Provisional or Courtesy staff may participate in the Emergency Call panel at the discretion of the Division Chief or Department Chair.

APPROVALS:
General & Vascular Surgery Division: 8/28/14
Surgery Department: 9/12/14
Medical Executive Committee: 9/22/14
Board of Directors: 9/25/14

Tri-City Medical Center
Audit, Compliance & Ethics Committee
March 19, 2015
Assembly Room 3
8:30am-10:30am

Members Present:	Director Ramona Finnila (Chair); Director Larry W. Schallock; Director Laura Mitchell; Jack Cumming, Community Member; Kathryn Fitzwilliam, Community Member
Non-Voting Members:	Steve Dietlin (CFO)
Others Present:	Sharon Schultz, CNE; Colleen Thompson, Director/Medical Records; Joni Penix, Director of Revenue Cycle Operations; Jeremy Raimo, Senior Director, Business Development; Diane Racicot, General Counsel; Teri Donnellan, Executive Assistant
Absent:	Tim Moran (CEO); Frank Corona, M.D. Physician Member; Carlo Marcuzzi, Community Member; Barton Sharp, Community Member

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	The meeting was called to order at 8:35 a.m. in Assembly Room 3 at Tri-City Medical Center by Director Finnila, Chairperson. Attendees and committee members introduced themselves.		
2. Approval of Agenda	Chairperson Finnila suggested the committee go directly into closed session to allow guests to give their report and exit the meeting. It was moved by Mr. Jack Cumming and seconded by Ms. Kathryn Fitzwilliam to approve the agenda as modified. The motion passed unanimously.	**Modified Agenda approved.**	
7. Motion to go into Closed Session.	It was moved by Ms. Kathryn Fitzwilliam and seconded by Mr. Jack Cumming to go into Closed Session at 8:39 a.m. The motion passed unanimously.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
10. Open Session	The committee returned to open session at 9:05 a.m. with committee members, Mr. Dietlin, Ms. Racicot and Ms. Donnellan in attendance.		
11. Report from Chairperson on any action taken in closed session (Government Code, Section b 54957.1)	Chairperson Finnila reported no action was taken in closed session.		
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- January 15, 2015	It was moved by Director Mitchell and seconded by Director Schallock to approve the minutes of the January 15, 2015 meeting as presented. The motion passed with Mr. Cumming abstaining from the vote.	**Minutes ratified.**	
5. New Business - None			
6. Old Business A) Consideration of engagement proposal by Moss Adams to perform the 2015 year-end audit	Chairperson Finnila reported at the January meeting the committee recommended that management negotiate a one-year extension with Moss Adams to perform the 2015 year-end audit. Mr. Steve Dietlin reported Moss Adams has submitted an engagement proposal to perform the 2015 year-end audit for a fee that is in line and comparable with that of last year's audit. He explained Moss has been our auditor of record for the past five years and have a mandatory partner rotation after seven years. The committee noted it would be in the best interest of both the District and Moss Adams for a new partner to be introduced during the audit process to gain familiarity in the event Moss is selected to perform next year's audit. It was recommended by Mr. Jack Cumming that the Board approve the engagement proposal by Moss Adams to perform the 2015 year-end audit as presented by Mr. Dietlin.	**Recommendation to be sent to the Board of Directors to approve the engagement proposal by Moss Adams to perform the 2015 year-end audit; item to appear on next Board agenda.**	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	Ms. Kathryn Fitzwilliam seconded the motion. The motion passed unanimously.		
B. Compliance Officer Update	Director Schallock reported the Board interviewed and offered a position to a candidate out of state. The candidate declined the position due to some personal issues that could not be worked out in a timely manner. Director Schallock stated the Board hopes to interview another candidate in the near future.	**Information only.**	
12. Date of Next Meeting	Chairperson Finnila stated the Committee's next meeting will be held on April 16, 2015 with a quarterly review of financials and a Value's Line Report.	**The committee's next meeting is scheduled for April 16, 2015.**	Ms. Donnellan
13. Adjournment	Chairperson Finnila adjourned the meeting at 9:19 a.m.		Chair

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

February 24, 2015 – 4:00 o'clock p.m.
French Rooms 1, 2, & 3
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 4:00 p.m. on February 24, 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 Reno
Director Larry Schallock

Also present were:

Tim Moran, Chief Executive Officer
Steve Dietlin, Chief Financial Officer
Esther Beverly, VP/Human Resources
Jody Root, General Legal Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 4:00 p.m. in French Rooms 1, 2 & 3 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 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. Oral Announcement of Items to be discussed during Closed Session

   Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Mr. Root made an oral announcement of item listed on the February 24, 2015 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter related to the Appointment of Public Employee: Chief Compliance Officer.

5. Motion to go into Closed Session

It was moved by Director Nygaard and seconded by Director Dagostino to go into Closed Session. The motion passed unanimously (7-0).

6. Chairman Schallock adjourned the meeting to Closed Session at 4:03 p.m.

7. The Board returned to Open Session at 5:48 p.m. All Board members were present.

8. Report from Chairperson on any action taken in closed session.

   Chairman Schallock reported the meeting has been continued to Thursday, February 26. 2015 at 1:30 p.m.

9. There being no further business, Chairman Schallock adjourned the meeting at 5:48 p.m.

_____
Larry W. Schallock
Chairman

ATTEST:

_____
Ramona Finnila
Secretary

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

February 26, 2015 – 1:30 o'clock p.m.
Classroom 6 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Regular Meeting and an Adjourned Special 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 February 26, 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 Reno
Director Larry Schallock

Also present were:

Greg Moser, General Legal Counsel
David Powell, Legal Associate
Tim Moran, Chief Executive Officer
Steven L. Dietlin, Chief Financial Officer
Dr. Scott Worman, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meetings 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 Reno to approve the agenda as presented. Director Nygaard seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairman Schallock read the Public Comments section listed on the January 29, 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 items listed on the January 29, 2015 Regular Board of Directors Meeting Agenda and January 29, 2015 Adjourned Special Meeting Agenda to be discussed during Closed Session which included two matters of potential litigation, Conference with Labor Negotiators, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees, one Report Involving Trade Secrets; Public Employee Performance Evaluation of General Counsel; Appointment of Public Employee: Chief Compliance Officer; approval of closed session minutes and four matters of existing litigation.

5. Motion to go into Closed Session

It was moved by Director Reno and seconded by Director Dagostino to go into Closed Session. The motion passed unanimously (7-0).

6. The Board adjourned to Closed Session at 1:32 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 Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Director Kellett was absent

Also present were:

Greg Moser, General Legal Counsel
David Powell, Legal Associate
Tim Moran, Chief Executive Officer
Steven Dietlin, Chief Financial Officer
Sharon Schultz, RN, Chief Nurse Executive
Esther Beverly, VP, Human Resources
Dr. Scott Worman, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairman Schallock 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.

10. Chairman Schallock noted all Board members were present with the exception of Director Kellett. Director Reno 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 23.

12. Community Update

American Hospital Association Award for Volunteer Excellence – Tails on the Trails Walk-A-Thom – Ms. Sandy Tucker, Auxiliary President

Ms. Sandy Tucker, Auxiliary President reported the Auxiliary was chosen by the American Hospital Association as a 2015 winner of the AHA's Hospital Awards for Volunteer Excellence (HAVE) for their "Tails on the Trails" Walk-a-Thon in the fundraising category. She explained the Auxiliary submitted their entry based on the success of last year's program and were chosen based on their innovative approach to fundraising that benefits the healthcare organization and the community. Ms Tucker recognized the individuals responsible for coming up with the idea and submission of the award including Mary Gleisberg and Deena Di Stefano, Paula Ballweber, Linda Hosaka, past President, Connie Jones and First Vice President, Pat Morocco. Ms. Tucker showed a brief video from the AHA's website related to the HAVE awards. Ms. Tucker stated both she and Deena Di Stefano will be attending the American Hospital Association's 2015 Annual Meeting Recognition Breakfast in Washington, D.C. on May 4th where recipients of the award will be recognized. Ms. Tucker noted the 214 winners from across the country are listed on the American Hospital Association's website and the Auxiliary is extremely honored to have been chosen.

Ms. Tucker reported this year the Auxiliary is working with the Foundation to put on their second "Tails on the Trails" Walk-A-Thon which will be held on May 30th at Mance Buchanon Municipal Park in Oceanside with registration beginning at 8:30 a.m.

Directors congratulated Ms. Tucker and the Auxiliary on their award and the innovative program.

No action taken.

13. Foundation

Mr. Glen Newhart, Executive Director and Vice President of Development stated registration is now open for the dog walk at www.northcountydogwalk.com.

Mr. Newhart reviewed upcoming activities with the Foundation in addition to the Walk-A-Thon including the following:

- *Fashion that Heals* - the Foundation's annual spring fundraiser which will be held on May 2nd and feature employee and physician models.
- 27th Annual Golf Tournament which will be held on September 21st.

Mr. Newhart spoke regarding the Corporate Council and stated that it is an opportunity for hospital vendors and partners to mix with fellow vendors and business members of the community.

Lastly, Mr. Newhart invited Trustees Jennifer Paroly and Joseph Sfeir to present three checks on behalf of the Foundation which included the following:

1) $40,682.00 for furniture to upgrade the Emergency Department waiting area;

2) $48,940 (first installment of a $500,000 commitment) towards the design of the 512 slice CT project; and

3) $68,176.00 for fetal monitors in Women's Services.

Mr. Newhart explained the Foundation exists to raise money all monies raised benefit the hospital. He expressed his appreciation to Mr. Moran for his continued support and attendance at community events that helps to raise awareness.

Chairman Schallock expressed his appreciation to the Foundation, Corporate Council and the vendors for their continued support of the various programs that are put on to benefit our patients.

14. Report from Chief Executive Officer

Mr. Tim Moran, Chief Executive Officer reported on three key areas:

1) Primary Care Initiative –

Mr. Moran stated the Board agreed to a primary care strategy more than a year ago and in January we opened doors to an initial primary care network that includes Drs. Ferber, Novak, Baroudi and Clancy. Mr. Moran noted the importance of building a primary care base that allows patients to get well close to home.

2) Campus Development –

Mr. Moran reported the Board authorized him to engage an architectural firm to address our seismic, parking issues and challenges with our Emergency Room. He stated the first component of the campus development will be an overall look at the campus and what we need to do. Mr. Moran stated short term we are looking to address our challenges with our Emergency Department.

With regard to architect selection, Mr. Moran stated we are looking at five firms which include Co-Architects, DPR, Cunningham Group, Mascari-Warner and McCarthy Building Companies and the finalists will make presentations for the Board's input and recommendation.

2) OB and Neonatal Intensive Care Unit –

Mr. Moran stated we are re-examining our efforts to work with women of child bearing age to address our OB and Neonatal Intensive Care unit.

Lastly, Mr. Moran reported the management team is doing follow-up from the Strategic Planning work session and will be bringing a draft of the Strategic Plan for the upcoming year. Mr. Moran stated key elements of the plan will entail furtherance of our primary care strategy, Service Line advancement and physician recruitment to address not only our primary care needs but also the specialty services we provide.

No action was taken.

15. Report from Chief Financial Officer

Mr. Dietlin reported on the Fiscal YTD financial results as follows (dollars in Thousands):

- Net Operating Revenue – $195,291
- Operating Expense – $195,417
- EROE - $2,086
- EBITDA – $11,470

Other Key Indicators for the current year included the following:

- Average Daily Census - 194
- Adjusted Patient Days – 66,347
- Surgery Cases –3,873
- Deliveries – 1,612
- ED Visits – 41,242

- Net Patient Accounts Receivable – $42.4
- Days in Net Account Receivable – 48.8

From an operating performance perspective, Mr. Dietlin reported the following for the current month:

- Operating Revenue - $28,076
- Operating Expense - $28,324
- EBITDA - $1,499
- EROE - $198

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.

No action was taken.

16. New Business

a. Approval of Resolution No. 770 – A Resolution of the Board of Directors of Tri-City Healthcare District Providing Workers' Compensation coverage for certain District Volunteers.

It was moved by Director Dagostino to approve Resolution No. 770 - A Resolution of the Board of Directors of Tri-City Healthcare District Providing Workers' Compensation coverage for certain District Volunteers. Director Finnila seconded the motion.

Ms. Esther Beverly, VP/Human Resources stated there was concern that we did not have volunteers covered under our Workers' Compensation plan with BB&T and it was necessary to do so to comply with the California Labor Code.

Mr. Moser explained the District is generally self-insured for Workers Compensation but we had never formally adopted a Resolution to cover the volunteers so this Resolution has been designed to cover that gap.

Director Reno questioned why the Resolution did not pass through the Human Resources Committee prior to coming to the Board. Mr. Moser explained the Resolution was brought to the Board in the interest of time to comply with the California Labor Code.

AYES:	**Directors:**	**Dagostino, Finnila, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

17. Old Business - None

18. Chief of Staff

Dr. Worman reported

a. Consideration of January 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on January 26, 2015.

Dr. Worman provided a report on a project that the Board approved in September of last year. He stated the partnership the Board approved with AirStrip, Vivify Health and CureMetrix is moving forward on time and in some instances under budget. Dr. Worman expressed his appreciation to Administration and the Board for their support in moving forward in the technological information age.

It was moved by Director Dagostino to aapprove the February 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on February 23, 2015. Director Finnila seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

19. Consent Calendar

It was moved by Director Nygaard to approve the Consent Calendar. Director Finnila seconded the motion.

It was moved by Director Reno to pull the minutes of the January 29, 2015 Regular and Special Board of Directors Meeting, January 27, 2015 Special

Meeting and February 5, 2015 Special Meeting. Director Dagostino seconded the motion.

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

AYES:	**Directors:**	**Dagostino, Finnila, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

The vote on the main motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Kellett**

20. Discussion of items pulled from Consent Agenda.

Director Reno who pulled the Minutes stated she would be abstaining from the January 27th and February 5th Special Meeting minutes and is voting "no" on the January 29th Special Meeting minutes and voting "yes" on the January 29th Regular Meeting minutes.

It was moved by Director Nygaard to approve the minutes as presented. Director Dagostino seconded the motion.

The vote on the motion is as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Mitchell, Nygaard and Schallock**
NOES:	**Directors:**	**Reno (no as noted)**
ABSTAIN:	**Directors:**	**Reno (abstain as noted)**
ABSENT:	**Directors:**	**Kellett**

21. Reports (Discussion by exception only)

22. Legislative Update

Chairman Schallock reported initial bills are due to the Legislature this week and will be reviewed by ACHD.

23. Comments by members of the Public

Mr. Michael Slavinski read a letter into the record regarding Quality.

24. Additional Comments by Chief Executive Officer

Mr. Moran did not have any additional comments.

25. Board Communications

Director Nygaard requested a report from staff on what we are doing with respect to the "Super Bug" and disinfecting our equipment.

Ms. Sharon Schultz, CNE stated we have been watching and following the media regarding occurrences at other facilities for the "Super Bug". She stated we have a meticulous cleaning process which is the most important part prior to sterilization and are waiting to hear if there are any further recommendations from the CDC or APIC which is an Infection Control professional association. Ms. Schultz noted we have not had any infections of this nature for the past several years.

Director Nygaard reported she has recently been appointed to the Special District's Advisory Committee for LAFCO and has learned that LAFCO is currently doing a study of all county hospital district boundaries and will be providing a summary report to each District for their comments.

Director Mitchell had no comments.

Director Reno had no comments.

Director Finnila stated the Board is becoming very involved in quality healthcare issues. She stated the Service Lines that we examined in our strategic workshop are being given close scrutiny as to how we can make them better.

Director Finnila also spoke regarding a misconception that patients and their families may have regarding nurses' time spent on computers in the patient's room. She explained there is a new coding system in which nurses must comply with and document the patient's data electronically. Director Finnila stated it is extremely important that documentation is done in a clear and concise manner for the continuum of care for the patient.

Director Dagostino spoke regarding budgetary controls that have been put in place by the government to promote patient safety and the importance of keeping our quality indicators up.

26. Chairman Schallock reported as a result of our needs assessment we are actively recruiting new physicians including Obstetricians who are actively seeking patients. Chairman Schallock reported with regard to Primary Care, our new clinic includes two physicians from a practice in Vista, one physician came back from Sharp Mission Park and the fourth physician was recruited from Illinois. In addition, a surgery group has recently opened a practice with one physician from Oceanside, one from Palomar and a retired Navy physician who was recruited not only as a Bariatric surgeon but also to provide additional surgical services. Chairman Schallock stated you will continue to see ongoing recruiting efforts to bring new physicians to serve the community.

Chairman Schallock recognized Mr. Jerry Salyer who passed away earlier this year. Mr. Schallock stated Mr. Salyer was very active in the Oceanside community, past Chairman of the Oceanside Chamber of Commerce and always very interested in Tri-City Medical Center. Chairman Schallock stated Mr. Salyer also ran for the Tri-City Healthcare District Board of Directors and helped with the bond measure. Most recently, Mayor Woods appointed Mr. Salyer to the hospital's Community Healthcare &

Alliance Committee. Chairman Schallock noted a memorial service is scheduled in honor of Mr. Salyer on Saturday at Heritage Park.

27. 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.

28. Motion to return to Closed Session.

Chairman Schallock adjourned the meeting to closed session at 4:29 p.m.

29. Open Session

At 6:49 p.m. Chairman Schallock reported the Board was back in open session. All Board members were present.

30. Report from Chairperson on any action taken in Closed Session.

Chairperson Schallock reported no action was taken in closed session.

31. There being no further business Chairman Schallock adjourned the meeting at 6:49 p.m.

_____
Larry Schallock, Chairman

ATTEST:

_____
Ramona Finnila, Secretary

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

March 5, 2015 – 9:00 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 9:00 a.m. on March 5, 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
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
Gene Ma, M.D., Chief of Staff Elect
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 9:00 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 the Agenda

   It was moved by Director Finnila 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. Root made an oral announcement of items listed on the March 5, 2015

Special Board of Directors Meeting Agenda to be discussed during Closed Session which included three (3) Reports Involving Trade Secrets and Appointment of Public Employee: Chief Compliance Officer.

5. Motion to go into Closed Session

It was moved by Director Finnila and seconded by Director Dagostino to go into Closed Session. The motion passed unanimously (7-0).

6. Chairman Schallock adjourned the meeting to Closed Session at 9:05 a.m.

7. The Board returned to Open Session at 3:29 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 3:29 p.m.

_____
Larry W. Schallock
Chairman

ATTEST:

_____
Ramona Finnila
Secretary

Tri-City Medical Center
ADVANCE

Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	35	32	46	50	35	34	39	35					306
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					140
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					72
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					78
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					323
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					22.0
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					5.3
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					17.6
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					194.5
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					1771
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					117
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					41
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					80
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					1.60
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

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg	Goal Range
FY15	46.3	48.8	47.9	48.9	49.0	48.9	51.0	50.6					49.0	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					78.5	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					$2,456	$838
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%					1.11%	0.38%
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

ADVANCED HEALTH CARE FOR YOU

Financial Information

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budget
FY15	$1,761	$988	$1,456	$1,888	$1,896	$1,983	$1,498	$1,652					$13,122	$12,632
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%					5.93%	5.72%
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 Avg	YTD Budget
FY15	5.93	5.89	6.01	6.09	6.39	6.28	5.89	5.69					6.03	6.14
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						1.10
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					
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

Employee Satisfaction

Partnership™
"Satisfaction + Engagement"
Mean = 66.1 (-1.0)
Percentile = 28th (from 13th)

Satisfaction
"what do I get?"
Mean = 61.9 (-1.2)
Percentile = 27th (from 13th)

Engagement
"what do I give?"
Mean = 71.8 (-0.5)
Percentile = 31st (from 12th)

National 90th Mean Scores

Partnership:	79.9
Satisfaction:	77.1
Engagement:	83.6

Voluntary Employee Turnover Rate (Annual Rate - Rolling Quarters)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY15
FY15			9.9%			9.8%							9.8%
FY14			12.1%			12.2%			11.7%			11.4%	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%			2.2%							2.2%
FY14			6.9%			8.0%			6.8%			3.2%	3.2%

HCAHPS (Top Box Score)

Hospital Consumer Assessment of Healthcare Providers & Systems

Benchmark Source: Hospital Compare

Benchmark Period: 1/1/2013-12/31/2013

"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%							71%	76%	73%	76%	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%							77%	79%	79%	80%	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%							78%	76%	78%	81%	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%							79%	79%	82%	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%							63%	62%	66%	64%	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%							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%							70%	71%	70%	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	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	65%	63%	59%	64%	56%	54%	62%												
FY14	65%	64%	61%	62%	56%	69%	65%	53%	55%	52%	62%	62%	60%	64%	63%	62%	65%	61%	64%

"Discharge Information"

	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	88%	81%	86%	85%	82%	84%	88%												
FY14	85%	80%	76%	84%	79%	88%	80%	77%	86%	80%	89%	86%	83%	84%	81%	87%	83%	84%	86%

Performance compared to prior year: Better Same Worse

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Outcome of Care Measures

Center for Medicare & Medicaid Services (CMS)

Readmission Rate Outcome of Care Measure - Medicare Patients only (Risk-Standardized Rate, all readmits including to other hospitals)

Measure	For Period	TCMC Rate	National Rate
AMI 30-Day Readmission	Jul 2010 - Jun 2013	16.7%	17.8%
Heart Failure (HF) 30-Day Readmission	Jul 2010 - Jun 2013	22.1%	20.7%
Pneumonia (PN) 30-Day Readmission	Jul 2010 - Jun 2013	16.7%	17.3%
Hip-Knee 30-Day Readmission	Jul 2010 - Jun 2013	5.1%	5.2%
Hospital-wide 30-Day Readmission (unplanned)	Jul 2010 - Jun 2013	15.5%	15.6%
COPD 30-Day Readmission	Jul 2010 - Jun 2013	21.3%	20.7%
Stroke 30-Day Readmission	Jul 2010 - Jun 2013	11.9%	13.3%

AMI 30-Day Readmission (Internal Calculations using CMS methodology, non risk-standardized, not including readmits to other hospitals) - Quarterly

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15			14.3%			0.0%							8.0%
FY14			4.2%			16.7%			9.7%			25.0%	14.4%

HF 30-Day Readmission (Internal Calculations using CMS methodology, non risk-standardized, not including readmits to other hospitals) - Quarterly

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15			3.4%			25.0%							14.8%
FY14			6.7%			14.7%			12.8%			10.0%	11.2%

PN 30-Day Readmission (Internal Calculations using CMS methodology, non risk-standardized, not including readmits to other hospitals) - Quarterly

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15			0.0%			12.5%							7.7%
FY14			0.0%			16.0%			16.3%			13.2%	12.8%

COPD 30-Day Readmission (Internal Calculations usIng CMS methodology, non risk-standardized, not including readmits to other hospitals) - Quarterly

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15			14.3%			20.0%							17.2%
FY14									15.4%			19.0%	

Performance compared to prior year: Better | Same | Worse

Mortality Rate Outcome of Care Measure - Medicare Patients only (Risk-Standardized Rate, all mortalities including deaths after discharge)

Measure	For Period	TCMC Rate	National Rate
AMI 30-Day Mortality	Jul 2010 - Jun 2013	15.9%	14.9%
Heart Failure (HF) 30-Day Mortality	Jul 2010 - Jun 2013	14.5%	11.9%
Pneumonia (PN) 30-Day Mortality	Jul 2010 - Jun 2013	11.3%	11.9%
COPD 30-Day Mortality	Jul 2010 - Jun 2013	9.2%	7.8%
Stroke 30-Day Mortality	Jul 2010 - Jun 2013	17.7%	15.3%

Complication Measure - Medicare Patients only (Risk-Standardized Rate, following elective primary total kip and / or knee replacement)

Measure	For Period	TCMC Rate	National Rate
Hip-Knee Complication Rate	Jul 2010 - Jun 2013	3.1%	3.3%

Patient Safety Indicators (PSIs)

Agency for Healthcare Research and Quality (AHRQ)

Measure	For Period	TCMC Rate	National Rate
Composite Value Score	Jul 2011 - Jun 2013	0.97%	0.88%

Hospital-Acquired Conditions (HACs)

Centers for Medicare & Medicaid Services (CMS)

Measure	For Period	TCMC Rate	Payment Reduction Threshold
Composite Value Score	Jul 2011 - Jun 2013	6.7%	7.0%

Performance compared to Nation: Better | Same | Worse

Infection Control Indicators

National Healthcare Safety Network (NHSN)

Catheter-Associated Urinary Tract Infection (CAUTI) per 1,000 Catheter Days (Quarterly) — NHSN Mean 1.4

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15			1.6			1.0							1.3
FY14			1.0			0.8			0.8			1.8	0.7

Central Line Associated Bloodstream Infection (CLABSI) per 1,000 Line Days (Quarterly) — NHSN Mean 1.2

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15			0.6			1.1							0.9
FY14			1.6			0.7			0.8			6.7	1.2

Ventilator Associated Conditions (VAC) per 1,000 Ventilator Days - Tier 1 (Quarterly) — NHSN Mean N/A

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15			8.8			9.1							9.0
FY14			2.4			4.6			9.8			6.7	6.3

Infection-related Ventilator Associated Conditions (IVAC) per 1,000 Ventilator Days - Tier 2 (Quarterly) — NHSN Mean N/A

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15			0.0			4.5							2.4
FY14			0.0			1.5			4.2			3.3	2.5

Possible and Probably VAP per 1,000 Ventilator Days - Tier 3 (Quarterly) — NHSN Mean N/A

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15			0.0			3.0							1.6
FY14			2.4			0.0			0.0			0.0	0.4

Performance compared to prior year: Better | Same | Worse

Emergency Department (ED)

Left without Treatment (LWOT)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	5.2%	4.5%	7.1%	5.2%	5.1%	3.3%	6.6%						5.3%
FY14	2.6%	3.3%	3.3%	3.0%	2.7%	3.6%	4.8%	2.4%	4.0%	3.8%	5.8%	3.5%	3.6%

Transfers out of the ED

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	1.83%	2.36%	2.56%	2.38%	2.42%	2.74%	2.30%						2.37%
FY14	2.68%	2.75%	2.58%	2.09%	2.44%	2.93%	2.61%	2.53%	2.15%	2.57%	2.16%	2.48%	2.49%

Door to Bed Assignment - Median Time in min.

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	31	32	47	30	33	24	44						34
FY14	16	17	21	18	18	20	31	24	26	26	36	22	22

Performance compared to prior year: Better Same Worse

Building Operating Leases
Month Ending February 28, 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
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		$ 5,699.12	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. PO 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
Medical Acquisition Co., Inc. 2772 Gateway Rd. Carlsbad, Ca 92009 V#80390	3,527	$2.00	(a)	$ 7,054.00	4/1/11	3/30/15	**Human Resources Office** 1211 West Vista Way Vista, Ca 92083	8650
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 V#81250	4,760	$3.55	(a)	$ 22,377.00	10/1/12	10/1/22	**Chemotherapy/Infusion Oncology Office** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
Ridgeway/Bradford CA LP DBA: Vista Town Center PO Box 19068 irvine, CA 92663 V#81503	3,307	$1.10		$ 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		$ 7,867.76	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		$ 12,770.25	1/1/12	12/31/16	**Vacant Bank Building Property** 4000 Vista Way Oceanside, Ca 92056	8462 Until operational
Total				**$ 338,072.36**				

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

Education & Travel Expense
Month Ending FEBRUARY 28, 2015

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8740	MAMMOGRAPHY REVIEW	11615	102.36	78079	NAZITA SANDERS RT (R) (M)
8740	NCC MODULES	20615	125.00	78692	APRIL MCDONALD
8740	ASRT PRACTICES	12315	125.00	82343	MIKE TRACEY
8723	ACHSA MEETING	112014	135.20	78664	TJ GRUNNAN RN
6171	CHEMO AND BIO COURSE	12115	139.00	81429	RACHEL CARNER
8740	CHEMO-BIO CERTIFICATION	11615	197.00	81430	EVELINDA RODRIGUEZ
8740	ADVANCED FETAL COURSE	12315	200.00	81396	JODI WILLIAMS
8740	EVIDENCE BASED COURSE	12315	200.00	82165	ROSEMARIE FINONES
8740	PALS COURSE	13015	200.00	82312	STEVEN ALDEN
7792	CODING-BILLING	10515	230.70	37799	PRIYA JOSHI
8618	2015 CPU USERS CONF	22415	307.39	46515	MELISSA NAIL
8700	HSP COMPLIANCE	121614	434.70	71807	COLLEEN M THOMPSON
8390	ANTIMICROBIAL CONF	11515	449.95	82350	MANUEL ESCOBAR
8390	SNHPA COALITION CONF	111714	850.09	10894	LAURA BALL
7010	MICN TRAINING	110414	1,000.00	78568	D CHAPPELL, T ALIIPULE
8700	CDI BOOT CAMP	122214	1,349.00	81300	ROSEMARY MERVOSH
8740	ADVANCED DIPLOM	20615	2,000.00	82353	LILIANA RIOS
8740	BSN PROGRAM	13015	2,000.00	82355	MARYAM TAYEFEHBAGHERKHAN
8710	IHI ANNUAL FORUM	10515	2,244.30	82340	JAMES JOHNSON, M.D.
8740	RN TO BSN	13015	2,500.00	81431	NATHAN WARREN
8740	BSN PROGRAM	12315	2,500.00	82082	CHRISTINA DINNALL
8740	RN TO BSN	13015	2,500.00	82125	MARIA AVILEZ
8710	PREPARING FOR CPT WEBINAR	22415	4,669.00	31497	MED STAFF SUPPORT
8740	MSN PROGRAM	11615	5,000.00	80022	HEIDI BENSON
8740	MSN-FAMILY NURSE	13015	5,000.00	82351	NATALIE LOTT

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

March 15,2015

Report to TCHD Board of Directors

James Dagostino Vice Chair TCHD Board of Directors

Subject 2015 CHA Health Policy Legislative Day March 10, 2015 and March 11, 2015 Sacramento

Attendees Tri City Larry Schallock Chair TCHD Board, Tim Moran CEO TCHD

The objective of this two day meeting was to be fluent of legislation coming before the California Legislature 2015-2016 and represent CHA's positions to our San Diego Legislators. Tuesday Mr. Schallock and I had Team Leader meetings. Key legislation presented was:

AB 1046 (Support) Community Benefit Requirements

SB 346 (Oppose) Community Benefits Requirements

AB 1300 (Support) Improve Mental Health Care

AB 579 (Support) Access to Emergency Care

SB 243 AB 366 (Support) Halt Retroactive cuts Skilled Nursing

SB 483 (Oppose) Observation Services Ambulatory Surgery

We were instructed on key points on Legislative meetings and preparation for being the team leaders for the meetings. Mr. Schallock and Mr. Moran were Team Leaders. I was an invited guest to "learn".

Mr. Moran, Mr. Schallock and I met with Senator Pat Bates to discuss issues related to TCHD. We apprised her of our Behavioral Health crisis including crisis stabilization, physician staffing, poor Medi-cal reimbursement and related workplace violence. We also discussed our concepts of HUD being our funding source for our Campus Redevelopment Plan. Senator Bates shared that she is a mediator between the citizens of San Clemente and San Clemente Memorial Hospital about the projected closure of that hospital. We had a very productive talk and we have a good alley in Senator Bates.

Wednesday we met with Assemblyman Rocky Chavez to update him on our Behavioral Health crisis. The meeting became a focal point of discussion for representatives of all hospitals in the San Diego region as they too have similar concerns. Scripts, Palomar, Sharp, UCSD and the Hospital Council all spoke with us about their similar problems. So to speak we attracted a crowd at our table and much discussion occurred. The people from Alameda spoke to Tim about Crisis stabilization. All in all we were the lightning rod for the discussion. It became quite clear that we are all interdependent on each other and negative impacts on one will effect all of us. The people from Alameda Hospital spoke with Tim about their Crisis Stabilization Unit. We are pleased that we have Assemblyman Chavez's attention on this matter .

Legislative visits were cordial and our positions were well received.

Personal Observations- Former leaders of Tri City including most recently our Board Chair Larry Schallock have placed Tri City in very favorable light with The California Hospital Association. With Larry's position on Governance Tri City has much input on law and regulation early on and that allows us to better plan our future. Most interesting is that all of our competitors have a dedicated Government Affairs position. Even Palomar has Elly Garner, Government Relations Manager as their paid representative. Tri City uses its Board members and CEO and I believe this is more effective. I would suggest the Board continue to support this meeting as well as the National meeting to enhance Tri City's clout in the law making arena. These opportunities also give Tri City face time with our state and national representatives and as we have discussed we will need help from both of these leaders if we are to accomplish our ambitious goals. The process we used this year of scheduling individual face time for Tri City as well as joining the team to present CHA positions gives TCHD inordinate credibility in the CA healthcare world.

EVALUATION FORM

SEMINAR: GOVERNANCE FORUM and CHA LEGISLATIVE DAY
LOCATION: SACRAMENTO, CA DATE: MARCH 10-11, 2015

REASON TO ATTEND: COMMITTEE MEMBER/UNDERSTAND CURRENT PROPOSED LEGISLATION

IMPORTANT TOPICS:

At the Governance Forum, 3 new Board members were introduced. All 3 have long-term Board experience with their facilities. None have a healthcare background but are well-versed in the issues of their hospital as well as the state. In a discussion regarding more pressing issues mental health continues to be a major concern with the problems of available beds, ER overutilization and poor medi-cal reimbursement. CHA has a bill to address changes in 5150 "holds" as the existing guidelines are nearly 50 years old. Seismic updating of structures is also on the forefront for some in having the necessary funds for building or having to go to the voters for bond funding. As mentioned last meeting, the concern with workplace violence is continuing to be discussed. CalOSHA is looking at some parameters. In addition to ER's, NICU and Med Surgery are other areas of concern. There was some discussion on Ebola and the preparedness of the hospital for a case. Over the past year, CHA has worked to develop a social media role. At this meeting, "Twitter" was discussed as a mechanism to share thoughts, news and information in an abbreviated form. Increasingly more members of the public are using this form of communication and not just the younger generation. An overview of Legislative measures for discussion with legislators as presented with more detail given the next day at the Legislative Day presentation.
CHA Legislative Day: Around 200 CEO's, Board members and other executives were present to meet with legislators regarding current proposed hospital/healthcare bills. It is still very early in the session and there will be modifications in many of the bills over the next months with most being carried over to next year. One speaker was Assembly member Rob Bonta, chair of Assembly Health. One insightful comment is that 1/3rd of all residents in California are on Medi-cal and 50% of all children. It was noted that access to care even with the exchanges is still difficult because of the low Medi-cal reimbursement rates. Free-standing Emergency Rooms is an issue in 2 areas of the state where hospitals are going to close and access to treatment will be affected. Senator Bates is working with officials in San Clemente due to the traffic problems which will occur in trying to get to another hospital. At Doctor's Hospital in the Bay area, the hospital has over 40,000 ER visits/year and no one hospital can absorb that workload. This legislation is a work in progress. Key issue papers are included with this report. Mr. Moran, Director Dagostino and myself had the opportunity to discuss the Behavioral Health matters with our legislators and others. I appreciate the interest and time our legislators gave us to discuss our healthcare concerns. I also participated with the team that visited with Assembly member Lorena Gonzalez as she grew up in Oceanside and Vista and her mother was an RN at Tri-City for about 40 years.

Larry W. Schallock

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Improve California's Mental Health Care — Modernize the Outdated Lanterman-Petris-Short Act

Support AB 1300

- **Enacted in 1967, the LPS Act is outdated and is not compatible with new technologies.**
- **AB 1300 clarifies when an involuntary hold starts, stops or is discontinued, and who may make these decisions.**
- **AB 1300 increases the emphasis on the prompt provision of services in both LPS-designated and non-LPS designated facilities.**
- **AB 1300 will help to reduce hospital emergency room overcrowding, increase public and employee safety, and provide better and more timely care to patients.**

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Issue

The Lanterman-Petris-Short (LPS) Act, the California law that governs involuntary treatment, was enacted in 1967. Since then, significant changes in the community-based mental health delivery system have created an increasing dependence on hospital emergency departments to provide crisis care to individuals in need of mental health treatment. Every patient deserves to receive a prompt evaluation to determine their involuntary/voluntary legal status — as required by current law — rather than waiting for hours, days and sometimes weeks for psychiatric assessment and treatment.

Position

CHA and the California American College of Emergency Physicians (CalACEP) are co-sponsors of AB 1300 (Ridley-Thomas). This bill will make incremental but important improvements to California's outdated Lanterman-Petris-Short (LPS) Act. It will help reduce hospital emergency room overcrowding, increase public safety, and provide better and more timely patient care.

AB 1300 updates the involuntary treatment statute commonly referred to as the LPS Act. The bill will modernize sections 5150, 5151 and 5152 of the Welfare and Institutions Code and provide new guidance for the care and treatment of individuals detained and transported to non-LPS designated emergency departments. The bill also will clarify and better define the involuntary detention process and thereby foster more consistent application of the law on a statewide basis. AB 1300 will help ensure that patients receive the most appropriate care in the least restrictive environment.

Analysis

AB 1300 would bring much-needed clarity to the LPS Act. When the law was established in 1967, all involuntary treatment was provided in larger institutions known as state hospitals, and not by local community-based hospitals, as is the case today. In the 48 years since its passage, significant changes in the tracking, funding and oversight of the law — and the vulnerable population it is intended to serve — have led to fragmented application.

The current LPS Act does not provide appropriate guidance for a patient's involuntary hold at either LPS-designated or non-LPS designated hospitals. Most significantly, the current laws fail to clearly articulate when an involuntary hold starts, stops or is discontinued, and who may make these decisions. The law also fails to recognize that not all communities have involuntary treatment facilities, which may require a patient on an involuntary hold to obtain treatment out of their county of residence and/or when admitted onto a medical floor of a hospital. The law does not address the use of innovative technologies such as tele-medicine and tele-health, which can be used to improve access to the state's short supply of experienced, licensed clinicians.

The time has come to modernize the LPS Act. Individuals in need of mental health services deserve timely treatment and protection of their civil liberties.

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Preserve Access to Emergency Care

Support AB 579

- The new paradigm is moving inpatient to outpatient care and reimbursement from fee-for-service to coordinated care/bundle payments and the sustainability of many hospitals is at risk.
- Resultant closures will reduce the number of EDs and the availability of emergency care in California communities.
- A solution for communities facing closure of their hospital is to preserve emergency care by allowing another hospital to provide an emergency department in that community.
- Preserving emergency care for all Californians is essential to saving lives.

Issue

The Affordable Care Act (ACA) has embraced the goals set forth in the triple aim: improve care, improve health and reduce costs. As a result, hospitals must realign their financial infrastructure to focus less on inpatient volume and more on ambulatory coordinated care and prevention. Many hospitals are vulnerable or at risk, particularly those with high government-sponsored patients or low inpatient volume. As accountable care organizations and other outpatient coordinated care initiatives expand, some hospitals will be forced to close, jeopardizing their communities' access to emergency care. While the need for inpatient beds is decreasing, demand remains high for emergent, urgent and ambulatory services.

A potential solution for a hospital facing closure is for a portion of its facilities to continue to provide emergency care under the license of another hospital. This concept, which is in effect in other states, would permit a community to retain access to essential emergent, urgent and acute services that it would otherwise lose when its local hospital closes.

Position

CHA is sponsoring AB 579 (Obernolte), which will preserve access to emergency health care in communities where a general acute care hospital is closing. The bill will allow the closing hospital's emergency department facilities to continue to provide emergency care under the license of another licensed general acute care hospital. As an emergency care/outpatient department of another licensed general acute care hospital, the facility would be required to comply with the same federal and state requirements to which the acquiring hospital is subject, including the Emergency Medical Treatment and Active Labor Act (EMTALA), Centers for Medicare & Medicaid Services (CMS) hospital-based emergency department (ED) standards, transfer protocols for patients needing admissions or more definitive care, peer and quality review, and seismic standards. Each local emergency services agency would continue to have the authority to determine 911 transport protocols and ensure appropriate transfer of ambulance patients.

Analysis

Between 2001 and 2010, California experienced a net loss of 21 hospitals and 3,190 inpatient beds. With the advancement of health care reform, better clinical and communications technology, increased outpatient care, case management, care coordination and shrinking reimbursements, hospital inpatient capacity has been reduced. As a result, numerous hospitals are under financial strain and facing closure. If a hospital closes, a community may no longer have access to emergency care. California EDs are struggling to keep up with the demand for their services, despite a 12 percent increase in ED beds between 2009 and 2013. If hospitals and their EDs close, the increased pressure on remaining EDs in certain areas will be overwhelming.

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(continued on next page)

Support AB 579

The ACA requires that a new health care delivery system that maintains access and provides essential services for all communities. CHA supports preserving emergency care in a facility under the license of another hospital, rather than forcing a community to lose access to emergency care.

- The new paradigm is moving inpatient to outpatient care and reimbursement from fee-for-service to coordinated care/bundle payments and the sustainability of many hospitals is at risk.
- Resultant closures will reduce the number of EDs and the availability of emergency care in California communities.
- A solution for communities facing closure of their hospital is to preserve emergency care by allowing another hospital to provide an emergency department in that community.
- Preserving emergency care for all Californians is essential to saving lives.

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Halt Retroactive Cuts to Hospital-Based Skilled-Nursing Facilities

Support SB 243 and AB 366

Support Budget Actions to Rescind Medi-Cal Cuts

- DP/SNFs provide essential care to patients with complex medical needs and often are the only skilled-nursing care available in rural areas.
- Pending retroactive application of the AB 97 rates will have devastating financial consequences for these providers, and further erode access to care for vulnerable patients.
- In rural areas, where DP/SNFs provide essential infrastructure to the hospital, these cuts will undermine the financial viability of the hospital as a whole.

Issue

Pending implementation of retroactive rate cuts for hospital-based skilled-nursing facilities (also known as distinct-part skilled-nursing facilities or DP/SNFs) will have devastating consequences for patients, communities and access to essential skilled-nursing care.

Position

CHA is co-sponsoring SB 243 (Hernandez) and AB 366 (Bonta) which will, among other things, stop the Medi-Cal cuts enacted in 2011 by AB 97, including the retroactive application of reduced rates for hospital-based skilled-nursing facility services from June 1, 2011 to September 30, 2013. This issue also will be addressed in State Budget actions.

Analysis

Enacted in 2011, Assembly Bill 97 reduced reimbursement for hospital-based skilled-nursing facilities to 90 percent of 2008-2009 rates, an average effective rate decrease of 25 percent. The reduction in reimbursement was retroactive to June 1, 2011. The 2011 cuts were harmful to patients and crippling to hospitals.

As compared to free-standing facilities, DP/SNFs care for patients of greater medical complexity and are often the only option for patients with specialized medical or behavioral needs, or for individuals living in rural areas. Acute hospital readmissions are lower for patients cared for in hospital-based skilled-nursing facilities, and patients and residents in hospital-based skilled-nursing facilities often have shorter lengths of stay and achieve better outcomes. Medi-Cal beneficiaries make up almost 80 percent of the patients receiving hospital-based skilled-nursing care.

In 2013, the California Legislature recognized the need to preserve the unique services provided by DP/SNFs and acted to eliminate the cuts prospectively. However, DP/SNFs still face the retroactive application of the AB 97 rates for a period of over two years and the recoupment of many millions of dollars.

If the retroactive recoupment, or "clawback," is allowed, these essential providers will face undue hardship and will have to reduce services or staffing. In rural areas, where DP/SNFs often are essential infrastructure in the hospital, the loss in revenue attributable to these cuts will undermine the financial viability of the hospital as a whole.

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Observation Services Standards

Oppose SB 483

- Observation patients should be placed in appropriate departments based on their medical need, not only in designated observation beds.
- Observation of patients should not to be limited to 24 hours. Physicians sometimes need more time to determine the medical condition and the appropriate care.
- This proposed legislation is in direct conflict with the CMS two-midnight (or 48 hour) rule observation status.

Issue

Existing federal and state statutory and regulatory requirements for observation care are both complex and conflicting. SB 483 would add greater discrepancies with federal standards, which could lead to more confusion for both patients and hospitals.

Placing patients in "observation" has been exacerbated by the payment changes implemented by Medicare when classifying patients as inpatient or outpatient. Observation services are typically provided in an outpatient setting and, therefore, paid for under an outpatient fee schedule, which will vary by payor. Unfortunately, there are differences in the definition of an outpatient between California's Title 22 and the federal Centers for Medicare & Medicaid Services (CMS), which leads to differences in how the hospital and patients pay for such services.

Position

CHA opposes SB 483 (Beall). This bill would require hospitals to provide observation care under a new supplemental service and place observation patients in designated observation beds, limited to no more than 24 hours. This bill is nearly identical to SB 1269, which was held in committee by the Legislature in 2014.

Analysis

Hospitals are committed to providing the right care, at the right time, in the right place.

Based on CMS criteria for outpatient status, "observation patients" can be placed in beds located throughout the hospital (e.g. emergency department (ED), intensive care unit, acute-care, general care) according to their medical needs and may be in that hospital bed for more than 24 hours. Because patients who stay overnight assume that they have become inpatients, some hospitals would like the option to designate units with licensed "observation" beds for all observation patients, regardless of medical need.

SB 483 would limit observation service to 24 hours and require observation beds to be identified with signage. Observation services would apply to patients who have unstable or uncertain conditions; have been triaged in the ED and are awaiting inpatient beds; have received outpatient surgical services and procedures; and are inpatients discharged to an observation center.

SB 483 would cost the state over $1 million to implement (according to the Assembly Appropriations Committee analysis of SB 1269), and would lead to higher health care costs for the state and providers.

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Community Benefit Requirements: Improve State and Federal Alignment

Support AB 1046

- California's current community benefit law has been proven so successful, that it has helped establish the framework for the ACA's new national community benefit standard.
- California's nonprofit hospitals have a long history of collaboration with their communities to address local health care needs. It is inherent in their mission.
- AB 1046 more closely aligns federal and state community benefit laws to ensure conformity in the way nonprofit hospitals detail their community benefit investments and report to the federal government.

Issue

For more than 20 years, California's nonprofit hospitals have led the nation in ensuring that vulnerable populations have access to vital health care services and wellness programs that meet the health needs of local communities throughout the state. This successful approach is founded in a state law enacted in 1994, SB 697 (Torres). Since then, hospitals have been detailing in public annual reports the programs they develop in partnership with community groups. These reports highlight services provided directly by hospitals and partnerships with local nonprofit organizations. SB 697 has proven to be so successful that it has helped establish the framework for the Affordable Care Act's (ACA) new national community benefit standard.

Position

CHA is sponsoring AB 1046 (Dababneh) which increases transparency, efficiency and accountability by aligning California's community benefit law more closely with new federal ACA requirements. AB 1046 will streamline reporting mandates and allow hospitals to maintain their focus on local health care needs. AB 1046 improves California's existing community benefit law so nonprofit hospitals' community benefit reports are more understandable to the public, providing even greater transparency and consistency in the reporting and disclosure of the investments nonprofit hospitals make to strengthen the health and well-being of the communities they serve. AB 1046 ensures that the annual reports hospitals file with the Office of Statewide Health Planning and Development (OSHPD) are made publicly available in a timely fashion. AB 1046 will bring California into closer alignment with federal reporting requirements for nonprofit hospitals and provide for more uniform reporting by all states.

Analysis

California's nonprofit hospitals have a long history of collaboration within their communities to address local health care needs. It is a mission they passionately believe in. Nonprofit hospitals reinvest every penny of unspent revenue back into the community. IRS filings reveal that community benefit investments made by nonprofit hospitals total more than $5 billion every year — investments guided by Community Benefit Plans and informed by Community Health Needs Assessments. Nonprofit hospitals' publicly disclosed reports include in-house investments in services such as burn units, neonatal intensive care and life-saving emergency services. They also highlight hospital partnerships with local nonprofits and clinics that provide care to vulnerable populations, such as dental care for low-income children, medical services to the homeless and mobile health vans serving disadvantaged communities. Finally, hospitals supplement the cost to care for individuals enrolled in Medi-Cal, the chronically underfunded state program that provides health care coverage to one-third of California's population. Every year, California hospitals provide more than $13 billion in uncompensated health care services, which includes Medi-Cal payment shortfalls.

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Community Benefit Requirements: Improve State and Federal Alignment (cont.)

Support AB 1046

- California's current community benefit law has been proven so successful, that it has helped establish the framework for the ACA's new national community benefit standard.
- California's nonprofit hospitals have a long history of collaboration with their communities to address local health care needs. It is inherent in their mission.
- AB 1046 more closely aligns federal and state community benefit laws to ensure conformity in the way nonprofit hospitals detail their community benefit investments and report to the federal government.

California continues to lead the nation in implementing the ACA, one of the most significant changes to the health care system in our nation's history. With this historic transition comes the responsibility to ensure modifications and improvements are made to achieve the ACA's goal of access to care for all Americans. AB 1046 is part of the collaborative effort between the state of California and hospitals to make that goal a reality.

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Community Benefit Requirements: New, Unnecessary and Harmful Mandate

Oppose SB 346

- SB 346 imposes vague, unrealistic and costly mandates on nonprofit hospitals.
- SB 346 conflicts with provisions of the ACA.
- The state Department of Finance concluded that SB 346's predecessor, AB 503, "is unnecessary and will likely increase costs to the state."
- This issue was debated in the Legislature the last two years and was clearly defeated both years.

Issue

SB 346 imposes vague, unrealistic and costly mandates on nonprofit hospitals and nonprofit multispecialty clinics. The legislation is unnecessary and conflicts with provisions of the Affordable Care Act (ACA). Costs to state government will increase significantly as will costs to hospitals, which will have to comply with conflicting federal and state reporting requirements. As a result, community benefit programs throughout California will face cutbacks, impacting diverse and vulnerable populations. Finally, SB 346 is nearly identical to similar measures (AB 503 in 2014 and AB 975 in 2013), that were debated and overwhelmingly defeated in the Legislature.

Position

CHA opposes SB 346 (Wieckowski). SB 346 cuts community benefit programs, increases bureaucracy and will increase costs to the state.

Analysis

An analysis by the state Department of Finance concluded that SB 346's predecessor, AB 503, "is unnecessary and will likely increase costs to the state." The analysis notes there is insufficient evidence that hospitals are not reporting adequately on community benefit spending, and finds the bill "misaligns state and federal law," resulting in additional costs. The Senate Appropriations Committee analysis identified costs to OSHPD (California Office of Statewide Health Planning and Development) of approximately $1.1 million in the first fiscal year of implementation with ongoing costs of approximately $975,000 annually.

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CHA health policy legislative day 2015

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Key Issue Papers

This packet includes issue papers on the current top state legislative priorities. The papers are intended to give a snapshot of the key issues, CHA's position on the issue along with a brief analysis.

Most of these top priorities will be discussed in the Health Policy Legislative Day presentations. The documents are placed in the order they will be discussed.

If you would like additional information on a topic, please contact the lead issue manager listed on the paper. Also, the legislative process is very fluid. To track a particular issue frequent CHA's website at www.calhospital.org and go to "Legislation & Advocacy." CHA's members-only site provides current information on the impact of pending legislation of importance to California hospitals.

Community Benefit Requirements: Improve State and Federal Alignment
Support AB 1046 (Dababneh, D-Encino)

Community Benefit Requirements: New, Unnecessary and Harmful Mandate
Oppose SB 346 (Wieckowski, D-Fremont)

Improve California's Mental Health Care – Modernize the Outdated Lanterman-Petris-Short Act
Support AB 1300 (Ridley-Thomas, D-Los Angeles)

Preserve Access to Emergency Care
Support AB 579 (Obernolte, R-Big Bear Lake)

Halt Retroactive Cuts to Hospital-Based Skilled-Nursing Facilities
Support SB 243 (Hernandez, D-Azusa) and
Support AB 366 (Bonta, D-Alameda)
Support Budget Actions to Rescind Medi-Cal Cuts

Observation Services Standards
Oppose SB 483 (Beall, D-San Jose)

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Leadership in Health Policy and Advocacy

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Talking Points — Top Priorities for California Hospitals

The following are talking points for the meetings with your senators and assembly members.

Community Benefit Requirements: Improve State and Federal Alignment

Support AB 1046

- California's current community benefit law has been proven so successful, that it has helped establish the framework for the ACA's new national community benefit standard.
- California's nonprofit hospitals have a long history of collaboration with their communities to address local health care needs. It is inherent in their mission.
- AB 1046 more closely aligns federal and state community benefit laws to ensure conformity in the way nonprofit hospitals detail their community benefit investments and report to the federal government.

Community Benefit Requirements: New, Unnecessary and Harmful Mandate

Oppose SB 346

- SB 346 imposes vague, unrealistic and costly mandates on nonprofit hospitals.
- SB 346 conflicts with provisions of the ACA.
- The state Department of Finance concluded that SB 346's predecessor, AB 503, "is unnecessary and will likely increase costs to the state."
- This issue was debated in the Legislature the last two years and was clearly defeated both years.

Improve California's Mental Health Care — Modernize the Outdated Lanterman-Petris-Short Act

Support AB 1300

- Enacted in 1967, the LPS Act is outdated and is not compatible with new technologies.
- AB 1300 clarifies when an involuntary hold starts, stops or is discontinued, and who may make these decisions.
- AB 1300 increases the emphasis on the prompt provision of services in both LPS-designated and non-LPS designated facilities.
- AB 1300 will help to reduce hospital emergency room overcrowding, increase public and employee safety, and provide better and more timely care to patients.

(continued on next page)

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Talking Points

Preserve Access to Emergency Care

Support AB 579

- The new paradigm is moving inpatient to outpatient care and reimbursement from fee-for-service to coordinated care/bundle payments and the sustainability of many hospitals is at risk.
- Resultant closures will reduce the number of EDs and the availability of emergency care in California communities.
- A solution for communities facing closure of their hospital is to preserve emergency care by allowing another hospital to provide an emergency department in that community.
- Preserving emergency care for all Californians is essential to saving lives.

Halt Retroactive Cuts to Hospital-Based Skilled-Nursing Facilities

Support SB 243 and Support AB 366

Support Budget Actions to Rescind Medi-Cal Cuts

- DP/SNFs provide essential care to patients with complex medical needs and often are the only skilled-nursing care available in rural areas.
- Pending retroactive application of the AB 97 rates will have devastating financial consequences for these providers, and further erode access to care for vulnerable patients.
- In rural areas, where DP/SNFs provide essential infrastructure to the hospital, these cuts will undermine the financial viability of the hospital as a whole.

Observation Services Standards

Oppose SB 483

- Observation patients should be placed in appropriate departments based on their medical need, not only in designated observation beds.
- Observation of patients should not to be limited to 24 hours. Physicians sometimes need more time to determine the medical condition and the appropriate care.
- This proposed legislation is in direct conflict with the CMS two-midnight rule (or 48 hour) observation status.

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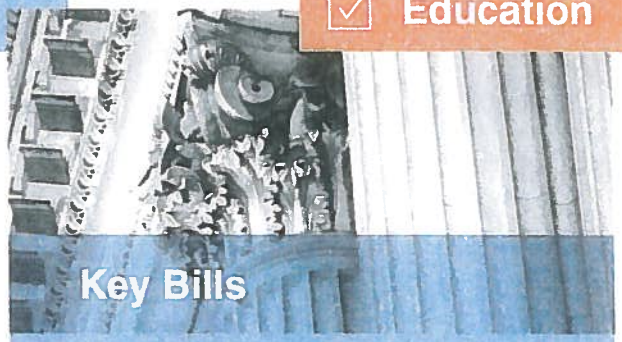

Key Bills

CHA tracks key health care-related bills. For the latest updates, visit www.calhospital.org/key-state-bills.

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Our issue experts have vetted what's most important to California hospitals. Gain an inside perspective on legislative activities, regulatory developments, industry news and more. Benefit from analysis. Know that you can trust the accuracy.

CALIFORNIA HOSPITAL ASSOCIATION

Leadership in Health Policy and Advocacy

CHA health policy legislative day 2015

Tweet Sheet

Sample Tweets

CHA will be **LIVE TWEETING** to highlight lawmaker visits and thank legislators and staff for their time and consideration of critical policy issues.

We encourage you to participate by:

- **FOLLOWING** @CalHospitals and **RETWEETING** messages
- **SHARING** photos
- **TWEETING** to share your experience
- Using the hashtag **#CHALegDay**

TWEET TIPS

- Share photos
- Add Hashtags
  - #CaLeg
  - #CaSenate
  - #CaAssembly

- Great to meet with <<@insert lawmaker username>> in Sacramento today! Enjoyed talking about the issues most important to <<@insert hospital>> #CHALegDay
- Thank you <<@insert lawmaker username>> for meeting with us at the capitol today! Great discussion about critical health care issues #CHALegDay
- Greatly appreciate <<@insert lawmaker username>> meeting with us today. He/She is a champion for hospitals and health care issues! #CHALegDay
- Enjoyed talking with <<@insert lawmaker username>> about the need to restore Medi-Cal and access to care #WeCare4CA
- Proud to talk with <<@insert lawmaker username>> about #SB243 & #AB366. Let's protect care for 12M Medi-Cal recipients under ACA #CHALegDay
- Thank you <<@insert lawmaker username>> for supporting #SB243 & #AB366 to protect timely, quality care for 12M Medi-Cal recipients #CHALegDay
- #SB243 & #AB366 protect the health & safety of some of CA's most at risk patients #CHALegDay
- #AB1046 helps CA continue to set the standard for #CommunityBenefit #CHALegDay
- Enjoyed meeting with <<@insert lawmaker username>> about #AB1046. It's important to address the unique health care needs of communities
- #AB1046 increases transparency and aligns CA #CommunityBenefit reporting laws w/ ACA #CHALegDay

#CHALegDay

CALIFORNIA HOSPITAL ASSOCIATION

Leadership in Health Policy and Advocacy

SENATE

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4	Jim Nielsen	N/A
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9	Loni Hancock	N/A
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11	Mark Leno	@MarkLeno
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13	Jerry Hill	N/A
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43	Mike Gatto	@mikegatto
44	Jacqui Irwin	@jacquiirwin
45	Matt Dababneh	@MattDababneh
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47	Cheryl Brown	@AsmCherylBrown
48	Roger Hernández	@Roger_Hernandez
49	Ed Chau	N/A
50	Richard Bloom	@RichardBloom
51	Jimmy Gomez	@JimmyGomezCA
52	Freddie Rodriguez	N/A
53	Miguel Santiago	N/A
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55	Ling-Ling Chang	@AsmL2Chang
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57	Ian Calderon	@IanAD57
58	Cristina Garcia	@VoteCristina
59	Reggie Jones-Sawyer	@JonesSawyer
60	Eric Linder	@EricLinder
61	Jose Medina	@AsmJoseMedina
62	Autumn Burke	@AsmAutumnBurke
63	Anthony Rendon	@Rendon63rdAD
64	Mike Gipson	@mgipson2014
65	Young Kim	@YKAssembly
66	David Hadley	@DavidHadleyCA
67	Melissa Melendez	@asmMelendez
68	Donald Wagner	@Donald_Wagner
69	Tom Daly	N/A
70	Patrick O'Donnell	@ODonnellUpdate
71	Brian Jones	@AsmBrianJones
72	Travis Allen	@JoinTravisAllen
73	William Brough	@bill_brough
74	Matthew Harper	@AsmHarper
75	Marie Waldron	@ConservtveWoman
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The Financial Value of Your Dues

We are proud to highlight here some key successes achieved on your behalf in 2014. Together, we have a far more powerful presence nationally, statewide and locally than any single hospital or system could have on its own. With your support, our strong leadership and advocacy have yielded the tangible outcomes illustrated here for California hospitals, patients and communities. **For every $1 of dues you paid in 2014, we generated more than $600 of value for hospitals and health systems statewide.**

Your participation in the associations has never been more important. Thank you for your continued support.

C. Duane Dauner
President/CEO, California Hospital Association

Mark Laret
Chair, California Hospital Association
CEO, UCSF Medical Center

Prevented Two Proposed Initiatives

A non-initiative solution with SEIU-UHW kept two ballot initiatives from the November general election. Passage of the pricing initiative would have resulted in an annual loss of at least $12 billion in net patient revenue for most private hospitals.

$12 billion saved

$3.2 billion

Preserved Tax-Exempt Status for Nonprofit Hospitals
(AB 503 and AB 1952)

Defeat of AB 503 and AB 1952 saved nonprofit hospitals from charity care and community benefit mandates estimated to cost $3.2 billion a year.

Hospital Presumptive Eligibility Program

CHA led the development of the Hospital Presumptive Eligibility Program (HPE) with the Department of Health Care Services. To date, more than 157,000 uninsured individuals have been enrolled for Medi-Cal through the HPE program and more than 300 hospitals have been approved to participate, with additional hospitals continuing to apply.

150,000+ insured

2014–2016 Hospital Fee Program

CHA continued to drive the review and approval process for the 2014–2016 hospital fee program, expected to increase Medi-Cal payments to hospitals by $10 billion over three years.

$2.8 billion

Defeated Two Ballot Initiatives
(Proposition 45 and Proposition 46)

Major support from CHA helped defeat two ballot initiatives that threatened health care providers and patients. Proposition 45 would have given sweeping power over rate regulation to the Insurance Commissioner, and Proposition 46 would have increased the MICRA non-economic damages cap. Defeat of Proposition 46 alone saved hospitals $2.8 billion.

CALIFORNIA HOSPITAL ASSOCIATION

Hospital Council of Northern & Central California

HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA

HOSPITAL ASSOCIATION of San Diego and Imperial Counties