

**TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
April 30, 2015 – 10:00 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	5 Hours	
	a. Appointment of Public Employee: Chief Compliance Officer (Authority: Government Code, Section 54957)		
	b. Conference with Labor Negotiators (Authority: Government Code Section 54957.6) Agency Negotiator: Tim Moran Employee organization: SEIU		
	c. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	d. 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		
	e. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: October 31, 2015		
	f. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: June 30, 2015		

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

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

	Agenda Item	Time Allotted	Requestor
	g. Conference with Legal Counsel – Potential Litigation (Authority Government Code Section 54956.9(d) (1 Matters))		
	h. Conference with Legal Counsel – Existing Litigation. (Authority Government Code Section 54956.9(d)1, (d)4 (1) Crystal Farber vs. TCHD Case No. 37-2014-17222-CU-OE-NC (2) Jennifer Randall vs. TCHD, et al. (DOI 2/29/2012) Case No. 37-2013-00036540-CU-CR-NC (3) Larry Anderson Employment Claims (4) TCHD vs. Burlew Case No. 37-2014-00034015-CU-NP-NC (5) Medical Acquisitions Company vs. TCHD Case No: 2014-00009108 (6) TCHD vs. Medical Acquisitions Company Case No. 2014-00022523		
	i. Approval of prior Closed Session Minutes		
	j. Public Employee Evaluation Title: Chief Executive Officer (Authority: Government Code, Section 54957)		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)		
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	Introduction of Kapua Conley, Chief Operating Officer	3 min.	Chair
13	Recognition of Renee Salas, Event Coordinator – American Cancer Society San Diego Volunteer Award	3 min.	Chair
14	Community Update – Second Quarter Marketing Update – David Bennett, Chief Marketing Officer	10 min.	D. Bennett

[illegible]

	Agenda Item	Time Allotted	Requestor
	<p>D. Finance, Operations & Planning Committee Director Dagostino, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes.)</p> <ol style="list-style-type: none"> 1. Approval of a Medical Director Agreement with Drs. Sharon Slowik and Janet Whitney for the Outpatient Wound Clinic, Hyperbaric Medicine and Inpatient Wound Care Program, for a term of 14 months beginning May 15, 2015 through June 30, 2016, not to exceed an average of 40 hours per month or 480 hours annually, at an hourly rate of \$190 and a total for the term of \$102,600. 2. Approval of an Emergency Department On Call Panel Agreement with Drs. Manish V. Sheth, Mark Melden, and Robert A. Zalewski-Zaragoza for a term of 15 months, beginning April 1, 2015 through June 30, 2016 at a rate of \$1,000 per shift and a total term cost of \$457,000. 3. Approval of an Amendment with Active Acquisition for management of the Wellness Center for a month to month term beginning April 1, 2015 through December 31, 2015, for an average monthly cost of \$217,500, not to exceed a term total of \$1,957,500. <p>E. Professional Affairs Committee Director Dagostino, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes.)</p> <ol style="list-style-type: none"> 1) <u>Patient Care Services Policies and Procedures:</u> <ol style="list-style-type: none"> a. Confidential Patient b. D-Stat Rad-Band Topical Hemostat c. Missing Patient d. Skin & Wound Care Policy e. Spiritual Care of the Patient 2) <u>Administrative Policies & Procedures</u> 8610-237 – Hospital Records Retention 3) <u>Unit Specific</u> <ol style="list-style-type: none"> <u>A. Neonatal Intensive Care (NICU)</u> <ol style="list-style-type: none"> 1. Intrafacility Transport of the NICU Patient 2. NICU Disaster Procedure 3. NICU Placement: Overflow to Alternate Location (Temporary Overflow) 4. Peripherally Inserted Central Catheters and Midline Catheters, Dressing Change, Maintenance, and Removal of <u>B. Pulmonary</u> <ol style="list-style-type: none"> 1. CP Staffing Guidelines in the NICU 		<p>FO&P Comm.</p> <p>PAC Comm.</p>

	Agenda Item	Time Allotted	Requestor
	<p>C. <u>Women and Newborn Services</u> 1. Infant Safety and Security</p> <p>D. <u>Pre-Printed Orders</u> 1. Chemotherapy Orders 2. Intraoperative Anesthesia Medication Orders 3. NICU: Pre-Eye Exam Medication Orders</p> <p>F. <u>Governance & Legislative Committee</u> Director Schallock, Committee Chair Open Community Seats - 0 (Committee minutes included in Board Agenda packets for informational purposes.)</p> <p><u>Medical Staff Policies & Procedures:</u> 1. #8710-518 – Medical Record Documentation 2. #8710-513 – Supervision of Residents/Fellows/Medical Students 3. #8710-519 – Suspension for Delinquent Medical Records</p> <p>G. <u>Audit & Compliance Committee</u> Director Finnilla, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for information only)</p> <p>1. <u>Compliance Policies:</u> a) #8750-535-Compliance Officer b) #8750-536 - Compliance Officer Authority/Duties and Responsibilities c) #8750-532 - Compliance Program Overview d) #8750-533 - Compliance Program Generally; Compliance Program Scope and Objectives e) #8750-534 - Compliance Program Generally; Compliance with Laws; Conflict of Authorities f) #8610-526 - Rights to Request Privacy Protection for Protected Health Information</p>		<p>Gov. & Leg. Comm.</p> <p>Audit, Comp. & Ethics Comm.</p>
	(3) Minutes – Approval of a) March 26, 2015 – Regular Board of Directors Meeting b) April 16, 2015 – Special Board of Directors Meeting		Standard
	(4) Meetings and Conferences - None		Standard
	(5) Dues and Memberships - None a) Trustee Magazine Subscription- \$55.00/subscription b) Healthcare Compliance Association - \$295.00/subscription		Standard
22	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
23	Reports (Discussion by exception only) (a) Dashboard - Included (b) Construction Report – Included (c) Lease Report – (March, 2015) (d) Reimbursement Disclosure Report – (March, 2015)	0-5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	(e) Seminar/Conference Reports 1) ACHD Legislative Days – Director Nygaard		
24	Legislative Update	5 min.	Standard
25	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
26	Additional Comments by Chief Executive Officer	5 min.	Standard
27	Board Communications (three minutes per Board member)	18 min.	Standard
28	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session (Includes 10 minutes for recess to accommodate KOCT tape change)	2 hours/ 22 min.	
29	Oral Announcement of Items to be Discussed During Closed Session (If Needed)		
30	Motion to Return to Closed Session (If Needed)		
31	Open Session		
32	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
33	Adjournment		



FINANCE, OPERATIONS & PLANNING COMMITTEE

DATE OF MEETING: April 21, 2015

PROPOSAL FOR: Insurance Brokerage Services

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

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

Area of Service: Insurance Brokerage Services

Term of Agreement: 36 months Beginning 4/01/15 Ending 3/31/18

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
\$37,500	\$450,000	\$1,350,000

Description of Services/Supplies:

- TCHD retains insurance brokerage services for the annual placement of workers' compensation, property and casualty, and employee benefits programs.
- BB&T was retained as TCHD's broker of record for a one-year period commencing April 1, 2014 for a total cost not to exceed \$430,000.
- BB&T submitted proposals to continue as TCHD's broker of record for a one-year term total cost not to exceed \$500,000 or a three-year term cost not to exceed \$475,000 annually and \$1,425,000 for the three-year term.
- Management then negotiated a three-year term cost, subject to FO&P recommendation and BOD approval, not to exceed \$450,000 annually and \$1,350,000 for the three-year term.

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

Person responsible for oversight of agreement: Steve Dietlin, Chief Financial Officer; Sharon Shultz, CNE; Esther Beverly, VP, Human Resources

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize management to retain BB&T to serve as Tri-City Healthcare District's insurance broker of record for workers' compensation, property and casualty, and employee benefits programs for a term of three years, beginning April 1, 2015 and ending March 31, 2018. Total compensation to BB&T, inclusive of insurance carrier commissions and payments from TCHD shall not exceed \$450,000 annually and \$1,350,000 for the three-year term.



FINANCE, OPERATIONS & PLANNING COMMITTEE

DATE OF MEETING: April 21, 2015

GE 512 CT SCANNER

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

Vendor Name: General Electric HealthCare
Area of Service: Radiology - CAT SCAN
Term of Agreement: 60 month lease @3.91% - 1 dollar buyout at lease end.
Maximum Totals:

Description	Unit Cost (monthly)	One-Time Fee	Total Cost + Tax
512 CT Scanner	\$38,467		\$2,308,020
CT Contrast Injector		\$55,251	\$55,251
PACS Integration Services		\$11,500	\$11,500
PACS MR 12 Upgrade		\$28,400	\$28,400
Construction Expense		\$485,000	(Not to exceed) \$485,000
	Total 5-Year Cost		\$2,888,171

Description of Services/Supplies:

- Replace existing single slice CT unit installed in 1996.
- Equipment sourcing/procurement based on evaluation of current technology, existing vendor installed equipment and status of best in class technology. Equipment evaluation vendors included Toshiba and Siemens CT systems. The GE 512 CT scanner provides the best solution for image quality and clinical capabilities.
- Expand CT access for inpatient and ED patient with significant improvements to patient flow.
- Dramatic radiation reduction tools.
- Provide State-of-the-art imaging technology such as one beat heart scanning, advanced neuro imaging and cancer planning imaging to name a few.
- TCMC first facility in San Diego County, 2 San Diego installs forthcoming, 25 nationwide.
- Funding Support: \$50K from the Auxiliary and \$500K from the Foundation.

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

Person responsible for oversight of agreement: Steve Young, Sr. Director Ancillary Services/ Sharon Schultz, CNE

Motion:

I move that Finance, Operations and Planning Committee recommend TCHD Board of Directors authorize the lease agreement for the GE 512 CT scanner for a 60 month term starting (est.) 11/1/2015 ending 10/31/2020 at \$38,467 per month, total term lease expense \$2,308,020, construction expense not to exceed \$485,000, and hardware and interfaces expense of \$95,251 for a total term expense of \$2,888,171.

TO: Larry Schallock, Chairperson
FROM: Scott Worman, M.D., Chief of Staff
DATE: April 30, 2015
SUBJECT: Medical Executive Committee Credentialing Recommendations – New Appointments

The attached Medical Staff New Appointments Credentials report was reviewed and approved at Credentials Committee on April 8, 2015. Their recommendations were reviewed and approved by the Medical Executive Committee on April 27, 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
For and on behalf of the TCHD Board of Directors

Date

**TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
April 8, 2015**

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 04/30/2015 – 03/31/2017)

Medical Staff – Appoint to Provisional Staff and grant privileges as delineated:

Andrade, Kristine E., MD	Radiology/Teleradiology
Bielawski, Anthony, MD	Emergency Medicine
Frederiksen, Ryan A., MD	Radiology/Teleradiology
Furubayashi, Jill K., MD	Radiology/Teleradiology
Serdarevic, Hanna H., MD	Anesthesiology

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

Chase, Nicole J., PAC	Emergency Medicine
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INITIAL APPLICATION WITHDRAWAL: (Voluntary unless otherwise specified)

Medical Staff:

Pearson, Lawrence, MD	Obstetrics/Gynecology
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Allied Health Professionals:

None

TEMPORARY PRIVILEGES:

Medical Staff/Allied Health Professionals:

Hajnik, Christopher	Surgery/Orthopedic Surgery
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- Blue Belt Navio PFS (BBN) guided knee arthroplasty
- Assist in Blue Belt Navio PFS (BBN) guided knee arthroplasty

Rypins, Eric B., MD	Surgery/General & Vascular Surgery
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- Colonoscopy

Walters, Janet, RN, RNFA	Surgery/General & Vascular Surgery
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- Assist during robotic surgery (da Vinci)

TEMPORARY MEDICAL STAFF MEMBERSHIP:

Medical Staff:

None

TO: Larry Schallock, Chairperson
FROM: Scott Worman, M.D., Chief of Staff
DATE: April 30, 2015
SUBJECT: Medical Executive Committee Credentialing Recommendations – Reappointments

The attached Medical Staff Reappointments Credentials report was reviewed and approved at Credentials Committee on April 8, 2015. Their recommendations were reviewed and approved by the Medical Executive Committee on April 27, 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
For and on behalf of the TCHD Board of Directors

Date

C

Closure of simple lacerations

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
April 8, 2015

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS (Effective Date: 04/30/2015, unless specified otherwise)

Cowan, John, PA-C Surgery/General & Vascular Surgery

Add:

- Assist during robotic surgery (da Vinci)

Hajnik, Christopher, MD Surgery/Orthopedic Surgery

Add:

- Blue Belt Navio PFS (BBN) guided knee arthroplasty
- Assist in Blue Belt Navio PFS (BBN) guided knee arthroplasty

Rypins, Eric B., MD Surgery/General & Vascular Surgery

Add:

- Colonoscopy

Walters, Janet, RN, RNFA Surgery/General & Vascular Surgery

Add:

- Assist during robotic surgery (da Vinci)

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
April 8, 2015

Attachment B

PROCTORING RECOMMENDATIONS (Effective 04/30/2015, unless otherwise specified)

Hanna, Karen J., MD	General Vascular Surgery/Surgery
Release from proctoring:	Advanced general and abdominal surgery

Mingrone, Christopher S., MD	Anesthesiology 100% Complete
Release from proctoring:	General anesthesia
	Regional anesthesia

Ventrella, Stephanie H., PA-C	Emergency Medicine
Release from proctoring:	Repair of complex lacerations

Willett, Brie A., PA-C	Emergency Medicine
Release from proctoring:	Lumbar puncture

**TRI-CITY MEDICAL CENTER
HUMAN RESOURCES COMMITTEE
OF THE BOARD OF DIRECTORS
April 14, 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:	Tim Moran, CEO; Kapua Conley, COO; Sharon Schultz, CNE/CCO; Esther Beverly, VP of HR
Others Present:	Frances Carbajal, Quinn Abler
Members Absent:	Sydelle Gale, Dr. Gene Ma, Henry Holloway, Salvador Pilar

Topic	Discussion	Action Follow-up	Person(s) Responsible
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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 April 14, 2015 meeting. Director Reno moved and Director Mitchell seconded the motion. The motion was carried unanimously.		Chair Kellett
3. Comments from members of the public	Chair Kellett read the paragraph regarding comments from members of the public.		Chair Kellett
4. Ratification of Minutes	Chair Kellett called for a motion to approve the minutes of the March 10, 2015 meeting. Director Reno moved and Ginny Carson seconded the motion with ratification of removing Director Dagostino from the March approval of agenda. The		Chair Kellett

Topic	Discussion	Action Follow-up	Person(s) Responsible
5. Old Business	motion was carried unanimously.		
None			
6. New Business			
a. B.O.D Dashboard- Stakeholder Experience	The Stakeholder Experience pillar- Employee Satisfaction rates were reviewed & discussed.		Chair Kellett
b. Review Training & Education Topics	<p>Esther presented the Leadership Development Training. The LDI's have focused on gaining a better understanding of managing change at a department and organizational level, the importance of holding employees accountable to the expectations of the SUCCESS standards for an improved patient experience & customer/patient satisfaction and coaching and counseling for work performance. The next LDI will focus on the Press Ganey Employee Partnership Survey results and will provide leaders with the necessary tools and training to roll-out the survey results to the staff.</p> <p>Esther also briefed the committee on the Patient Experience/HCAHPS training that will be mandatory for all employees to attend.</p>		Esther Beverly
c. Key Grievance/ER-LR Data	Esther explained current status on CNA & SEIU grievances and non-represented employee fair treatment process. The committee discussed the current process for dealing and following up with grievances &/or employee issues.		Esther Beverly
d. Policy Discussion/Action Policy 8610-451 TCHD Non-Employee Orientation and Identification	The Committee reviewed Policy 8610-451. Chair Kellett called for a motion to send Policy 8610-451 to the Board of Directors for approval. Director Reno moved and Ginny Carson seconded the motion. The motion was carried unanimously.	Policy 8610-451 to be sent to Board of Directors for approval at the April 2015 meeting	Esther Beverly
Policy 8610-471 Diversity Awareness	The Committee reviewed Policy 8610-471. Chair Kellett called for a motion to send Policy 8610-471 to the Board of Directors for approval. Director Reno	Policy 8610-471 to be sent to Board of Directors for approval at	

Human Resources Committee

2

March 10th, 2015

Topic	Discussion	Action Follow-up	Function(s) Responsible
	moved and Director Mitchell seconded the motion. The motion was carried unanimously.	the April 2015 meeting	
7. Work Plan	The work plan was reviewed and updated.		Chair Kellett
8. Committee Communications	None		Chair Kellett
9. Date of next meeting	June 9, 2015		Chair Kellett
10. 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: 9/97

**SUBJECT: Non-TCHD Worker's Orientation and
Identification Badge Process, Non-
Employees**

REVISION DATE: 04/12

POLICY NUMBER: 8610-451

Human Resources Committee Approval:

05/12

Board of Directors Approval:

05/12

A. PURPOSE:

1. To establish guidelines for non-employees orientation and identification badge processes while on Tri-City Healthcare District's ("TCHD") premises.

DEFINITIONS:

1. Dependent Practitioners: are providers of medical care to patients, under supervision. They can be an employee of a staff physician or contracted for their services by Tri-City Healthcare District (TCHD).
2. Contract Workers: are providers of various types of non-medical/non patient care services under the supervision of the Director contracting the service whose services are contracted by TCHD and supervised by the TCHD department contracting for those services.
3. Vendors: are short-term visitors to TCHD for the purpose of conducting business (usually present less than 4 hours). They are not required to complete the Tri-City Health Care District Non-Employee Orientation. They are required to check in with REPTrax vendor Management System kiosk in the lobby or with Materials Management to be issued a temporary vendor badge. Non-TCHD workers of contracted services will be required to complete the Tri-City Health District Non-Employee orientation and training packet.
4. Auxiliary Department: members are volunteers who provide support to TCHD. They are required to complete the TCHD Auxiliary Volunteer Orientation and receive identification badges.
5. Students and Interns: personnel trained under their institution. They will be identified by a badge issued by their institution as applicable. Students must complete TCHD orientation and training provided in conjunction with their education institution and will be assigned TCHD identification badges as outlined in .6.a Professional Education Department Student Guidelines below: Students/guests, Levels 1 and 2 must contact the Marketing Department before beginning an observation or tour. Students, Levels 3 must contact the Professional Education Department before beginning a training program. OIG screening is not required for students and interns.

Professional Education Department Student Guidelines

- a. **Level 1: Student Tours/Guests - Non-clinical**
 - i. At TCHD no more than 4 hours
 - ii. TCHD paper identification badge required
 - iii. Includes visits by dignitaries, gift presentations, and holiday carolers
Accompanied by Department tour guide or member of the Marketing Department
 - iv. HIPAA and Confidentiality training will be provided
 - v. Review and sign Confidentiality Acknowledgement & Agreement Short Form (Level 1 & 2).
 - vi. Does NOT require Hospital Orientation for Non-TCHD Employees
 - vii. No TB test required

- b. Level 2: Shadow Students/Guests (with or without Affiliation Agreement)
 - i. At TCHD less than/up no more than one day
 - ii. TCHD paper identification badge required
 - iii. Must stay with assigned preceptor/guide at all times
 - iv. HIPAA Patient Privacy and Confidentiality training will be provided
 - v. Review and sign Confidentiality Acknowledgement & Agreement Short Form (Level 1 & 2)
 - vi. Basic department orientation required
 - vii. Does NOT require Hospital Orientation for Non-TCHD Employees
 - viii. No TB test required
 - ix. No direct patient contact
- c. Level 3: Students: Non-clinical experiences and clinical Patient Contact experiences (must have Affiliation Agreement with student's school)
 - i. At TCHD more than 1 day
 - ii. TCHD temporary identification badge required, with expiration date assigned
 - iii. Need to complete TCHD Student Orientation checklist
 - iv. Must review Hospital Orientation for Non-TCHD Employees, complete Competency Safety test, and sign social media agreement and sign Confidentiality Acknowledgement & Agreement form prior to starting externship
 - v. Need proof of TB test current within 1 year
 - vi. Need proof of influenza vaccination received during current flu season (Oct.-Mar)
 - vii. Need proof of background check and drug screen
- d. Level 4: Volunteer Interns — no patient contact (no Affiliation Agreement with school)
 - i. At TCHD more than 1 day
 - ii. TCHD temporary identification badge required, with expiration date assigned
 - iii. Need to complete TCHD Student Orientation checklist
 - iv. Must review Hospital Orientation for Non-TCHD Employees, complete Safety test, sign social media agreement, and sign Confidentiality Acknowledgement & Agreement form prior to starting externship.
 - v. Need proof of TB test current within 1 year.
 - vi. Need proof of influenza vaccination received during current flu season (Oct-Mar)
 - vii. Need proof of background check and drug screen
- e. Level 5: Contracted IT and Engineering/Facility vendors will perform work activity on systems related to data systems, engineering systems and construction related work activity. These individuals will have limited patient contact; however their work activity may require access to patient care areas. All work activity in patient areas will be assessed by Hospital Safety Officer and Infection Control Preventionist to identify patient risk. In areas where limited repairs are necessary and no patient contact will be anticipated risk assessments are not required.

C. **POLICY:**

- 1. Contract service employees may be independent or dependent practitioners. Independent practitioners must be credentialed and approved for clinical privileges through the Medical Staff Office. Dependent practitioners working for an agency must be authorized by the appropriate organizational representative. Contract service employees may also be persons contacted to provide non-medical services. Students may be clinical or non-clinical. The following elements, as appropriate, will be verified by the contracting agency or organization:
 - a. Education and training are consistent with applicable legal and regulatory requirements and hospital policy;
 - b. Licenses, certifications, or registrations are current;
 - c. Each individual's knowledge and experience are appropriate for his or her assigned responsibilities;
 - d. Effective and safe use of all equipment;

- e. Each individual is identified by a non-employee identification badge that he/she must wear at all times they are present at TCHD;
2. Contract service employees responsible for the assessment, treatment, or care of patients will be competent to fulfill their responsibilities as appropriate to the ages of patients served and to produce the results expected from clinical interventions. Contract employees whose daily duties are conducted at TCHD are required to report to Employee Health and comply with any health requirements. Facility and IT contracted employees that are on site for more than 4 hours duration will be required to participate in the Non TCHD Work Orientation and Identification process with the required completion of hospital Non Contract Orientation Program.
3. When a contract is established between TCHD and an agency, organization, or individual, it is recommended that it will be the responsibility of the agency or individual to provide the information as required by the job description. Legal Services will review all contracts. Audits of agency records will be conducted periodically to ensure compliance.
4. Orientation — Medical practitioners will receive initial orientation specific to their scope of practice prior to working in the unit assigned. Non-TCHD workers will receive initial orientation for the hospital and department in which they will be providing service.
 - a. Hospital orientation will include a self-learning packet and a written test.
 - b. Dependent practitioners (Nursing Registry) will complete a self-learning packet and test and return the completed test to the Registry. The Registry will fax a Letter of Competency to the TCHD Resource Staffing Center. A TCHD identification badge will be issued by the Staffing Resource Center. Badges will be issued and returned daily.
 - c. After completing the written test, the non-TCHD worker will take the completed test to Employee Health Services for correcting.
 - d. It is the responsibility of Employee Health Services to maintain all files pertaining to nonTCHD workers.
 - e. Employee Health Services will not give any non-TCHD worker an identification badge unless they have successfully passed the written test.
5. Completion of Assignment — Upon completion of the assignment at TCHD, the individual will return his/her TCHD identification badge to Employee Health Services.

D. ENFORCEMENT:

1. TCHD's Security personnel reserve the right to approach and questions individuals who fail to display the appropriate identification regarding the name of the individual, the individual's purpose for being on campus, the TCHD personnel/department that authorized the individual's presence on campus and the purpose for which the individual is on the TCHD premises. When appropriate, Security may direct the individual as to the proper channel and procedure for obtaining a badge in connection with this policy.
2. For the safety, security and welfare of all visitors, patients and staff, all acts of noncompliance of this policy can result in the removal of the visitor-individual from the premises.

E. REFERENCES:

1. Tri-City Healthcare District's Hospital Orientation for Non-TCHD Employees
2. Tri-City Healthcare District Confidentiality Acknowledgement & Agreement Short Form (Levels 1 and 2)
3. Tri-City Healthcare District Confidentiality Acknowledgement & Agreement Form
4. Element Packet for Hospital Orientation for Non-TCHD Employees

Administrative Policy Manual

ISSUE DATE: 12/02

SUBJECT: Diversity

REVISION DATE: 06/12

POLICY NUMBER: 8610-471

Administrative Policies & Procedures Committee Approval: 04/12

Human Resources Committee Approval: 06/12

Board of Directors Approval: 06/12

A. PURPOSE:

1. To create an environment where differences among people are valued and appreciated and are treated with dignity and respect; thus comprising a workforce consisting of individuals with diverse competencies, values, backgrounds, ethnicity and experiences who realize their maximum potential within a multicultural organization.
2. To further facilitate employees and volunteers working together respectfully to foster appreciation for their unique and diverse talents and perspectives and how together employees and volunteers contribute to the mission, vision and effective achievement of the business goals of Tri-City Healthcare District (the "District").

B. DEFINITION:

1. Multicultural Diversity refers to the unique characteristics that distinguish people as individuals and identify them as belonging to a recognizable group or groups. Diversity transcends concepts of race, ethnicity, socio-economic status, gender, transgender, spiritual and religious beliefs, education, sexual orientation, disability, beliefs language, body language, social customs and age.

C. POLICY:

1. Diversity at all levels among employees and among volunteers requires to display sensitivity and respect for the needs of others including visitors, customers, employees, volunteers, and patients and their families, friends, support persons, and surrogate decision makers.
2. The District values diversity among staff and will recruit, retain, and promote at all levels of the organization in order to meet the needs of our unique population. The District's culture and practices contribute to a workplace which values diversity and encourages employees and volunteers to provide service excellence in carrying out their responsibilities. .
3. TCMC expects employees and volunteers to treat each other with dignity, fairness, and respect regardless of their differences. This includes how they treat physicians, visitors, patients and their families, friends, support persons, and surrogate decision makers and those who provide on-site vendor services.
 - a. Employees and volunteers will support diversity through the District's mission statement, values, ethics statement, and it will be supported by the Service Excellence initiative.
 - b. Commitment to workplace values is measured and documented in employee performance evaluations.

- c. Administrative policies and procedures support respect and diversity including Administrative Policies # 424, Code of Conduct and Work Performance Improvement, and # 403, Harassment Reporting.
- 4. The District will offer diversity education and training to support and facilitate diversity awareness and positive recognition of the unique talents among the District's diverse staff.
- 5. The District places a high value on diversity and inclusion. We believe that diversity and inclusion are essential to organizational effectiveness and excellence, and that services are enhanced when organizations are a reflection of the communities they serve. The objectives are: :
 - a. To create a diverse and inclusive workplace environment that promotes mutual respect, acceptance and cooperation among employees and volunteers.
 - b. To support an environment where all employees and volunteers are valued, supported and empowered.
 - c. To plan and coordinate activities which deepen the appreciation and celebration of differences, including but not limited to race, ethnicity, age, gender, sexual orientation, disability, and geographic diversity .
 - d. To facilitate high quality, high-standard initiatives providing opportunities for capacity building through diversity and inclusion.
 - e. To provide a communication link to employees and volunteers at all levels of the organization.
 - f. To promote excellence in healthcare, and patient safety and satisfaction by recognizing the diversity of the District's patient population, and the diversity of patients' families, friends, support persons, and surrogate decision makers, and by promoting cultural diversity, awareness, and sensitivity among employees and volunteers.

"All employees that are a member of a union must follow the terms of the collective bargaining agreement."

**TRI-CITY MEDICAL CENTER
EMPLOYEE FIDUCIARY RETIREMENT PLAN SUB COMMITTEE
OF THE BOARD OF DIRECTORS
April 14, 2015**

Voting Members Present:	Chair Dr. Cyril Kellett, Director Rosemarie Reno
Non-Voting Members Present:	Tim Moran, CEO; Kapua Conley, COO; Esther Beverly, VP of HR
Others Present:	Quinn Abler, Maureen Peer, Dena' Baker, Gary Allen, Frances Carbajal
Members Absent:	Sydelle Gale, Henry Holloway

Topic	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	Chair Kellett called the meeting to order at 11:00 a.m.		Chair Kellett
2. Approval of Agenda	Chair Kellett called for a motion to approve the April 14, 2015 meeting agenda. Director Reno moved to approve and Chair Kellett seconded the motion. The motion was carried unanimously.		Chair Kellett
3. Comments by members of the public on any item of interest to the public before Committee's consideration of the item	Chair Kellett read the paragraph regarding comments from members of the public.	No public comments	Chair Kellett
4. Ratification of Minutes	Chair Kellett called for a motion to approve the minutes of the December 9, 2014 meeting. Director Reno moved to approve and Chair Kellett seconded the motion. The motion was carried unanimously.		Chair Kellett

Topic	Discussion	Action Follow-up	Person(s) Responsible
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5. Old Business			
None			
6. New Business			
a. Lincoln Quarterly Update	<p>Maureen Peer, Lincoln Relationship Manager presented executive summary which included an update from Lincolns quarter results. Key plan statistics, plan asset growth, contributions, earnings, participation rates, average deferral rates and account balances where also reviewed.</p> <p>Maureen also discussed Lincoln's available communication, education, online resource center, retirement goal calculator and mobile app.</p>		Esther Beverly
b. Prudent Quarterly Update	<p>Gary Allen, Prudent Investment Advisor presented the first quarter plan growth results. Gary explained the benefits in the highly diversified model portfolios that minimize the potential negative short term impact that anyone may have on a participant portfolio.</p> <p>Dena' Baker from Prudent summarized the employee level participation. Dena' described highlights and the growing enrollment, participation rate and great communication and relationship between TCHD employees and investment advisors.</p>		Esther Beverly
7. Comments made from the Committee	None		Chair Kellett

Topic	Discussion	Action Follow-up	Person(s) Responsible
8. Date of next meeting	August 11, 2015		Chair Kellett
9. Adjournment	Chair Kellett adjourned the meeting at 12:30 p.m.		Chair Kellett

**Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
April 9, 2015 Assembly Room 1**

MEMBERS PRESENT: Board of Directors Chairman Larry Schallock, Director James Dagostino, Director Julie Nygaard, Marilyn Anderson, Xiomara Arroyo, Mary Lou Clift, Gigi Gleason, Don Reedy, Marilou de la Rosa Hruby, Robin Iveson; Linda Ledesma, Jack Nelson, Bret Schanzenbach, Laura Vines

NON-VOTING MEMBERS: David Bennett, Sr. VP & CMO; Jodie Wingo, Sr. Director Marketing; Fernando Sanudo

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

MEMBERS ABSENT: Linda Allington, Carol Brooks, Marge Coon, Rosemary Eshelman, Darryl Hebert, Carol Herrera, Gina McBride, Barbara Perez, Roma Ferriter, Audrey Lopez

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CALL TO ORDER	The April 9, 2015 Community Healthcare Alliance Committee meeting was called to order at 12:34pm by Director Julie Nygaard.		
APPROVAL OF MEETING AGENDA	Director Jim Dagostino motioned to approve the April 9, 2015 agenda. The motion was seconded by member Gigi Gleason and unanimously approved.		
PUBLIC COMMENTS & ANNOUNCEMENTS	No public comments were made.		
RATIFICATION OF MINUTES	Member Bret Schanzenbach motioned to approve the March 12, 2015 meeting minutes. The motion was seconded by Robin Iveson and unanimously approved.		

**Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
April 9, 2015 Assembly Room 1**

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
<u>NEW BUSINESS</u>	<p>TCMC UPDATE: CEO Tim Moran was not available (out of town) to provide an update for TCMC.</p> <p>MARKETING DEPARTMENT UPDATE: Director Julie Nygaard requested that SR. VP / CMO David Bennett update the group regarding the TCMC Marketing Department. David noted that the current focus is on Physician recruitment. To this end, the department is presently developing new commercial spots highlighting TCMC affiliated Physicians and patients and increasing efforts and programs to actively recruit new Physicians.</p> <p>INTRODUCTION OF KAPUA CONLEY: Julie Nygaard introduced new COO, Kapua Conley, to the group. Kapua was welcomed by the group after a brief address noting his experience in the healthcare industry.</p>		
<p>GUEST SPEAKER Ingrid Stuver, Ph.D.</p> <p>"Clinical Research at TCMC"</p>	<p>Ingrid Stuver, Ph.D., presented information about current Clinical Research projects at TCMC, including the following:</p> <ul style="list-style-type: none"> • Drug • Device • Biological • Radiation • Nutritional Supplementation • Humanitarian Device Exemption • Exempted Studies 		

**Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
April 9, 2015 Assembly Room 1**

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
GUEST SPEAKER Ingrid Stuver, Ph.D. "Clinical Research at TCMC" (con't)	<p>Disease areas currently being studied include:</p> <ul style="list-style-type: none"> • Flu • Abscesses • C-diff • Stroke • Vascular Occlusions • Cancer • Diabetes • Hep-C • Herpes Zoster • Robotic Spine Surgery <p>Ingrid noted that the Hep-C vaccine is showing signs of <i>curing</i> the disease when injected – this is a very rare occurrence as most vaccines only help with the symptoms of the disease, but do not produce a cure.</p> <p>Ingrid also shared information regarding a TCMC pilot program for RN Protected Time, noting that there were significant and positive impacts of RN PT on 1N and 2P at TCMC due to this study. Due to these positive results, the program is being considered for hospital-wide implementation.</p> <p>Ingrid addressed audience questions and stated that anyone interested in more information concerning clinical trials can go to clinicaltrials.gov.</p>		

**Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
April 9, 2015 Assembly Room 1**

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
GRANT APPLICATIONS	Member Gigi Gleason shared that the committee is continuing its review of the 64 grant applications submitted, and will be meeting at the end of April to make their recommendations.	Committee Review of Submitted Grant Applications	Review Committee Members
<u>OLD BUSINESS</u> BEHAVIORAL HEALTH SUB COMMITTEE	Member Gigi Gleason noted that the Behavioral Health Sub Committee has met and are currently considering ways to advance forward without incurring large expenses. Gigi noted that more details will be available at the May meeting.		
COMMITTEE COMMUNICATIONS	<p>Member Bret Schanzenbach relayed that the Heroes of Vista event will be held this Saturday at the California Center for the Arts in Escondido. Bret relayed that this event recognizes individuals in the community that have gone above and beyond in the roles in which they serve.</p> <p>Bret also thanked Tri-City Medical Center for its sponsorship and contributions to the Heroes event.</p> <p>Member Marilou de la Rosa Hruby reminded the group of several events coming up in the near future for Casa de Amparo, the Moonlight Amphitheater and Filipino American Festival.</p> <p>Member Xiomara Arroyo noted that April is Financial Literacy Month. As such, Wells Fargo is holding a Teen Financial Education Day on Saturday, April 25th to help younger members of the community with their financial education and future.</p>		

**Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
April 9, 2015 Assembly Room 1**

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
COMMITTEE COMMUNICATIONS (con't)	Linda Ledesma shared with the group that Fernando Sanudo was recently recognized as Latino Champion for Medicine at the recent North County Latino awards.		
DATE & TIME OF NEXT CHAC MEETING	The next Community Healthcare Alliance Committee meeting will be held on Thursday, May 14, 2015 from 12:30pm – 2:00pm.		
ADJOURNMENT	The meeting was adjourned at 1:28pm.		

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
April 21, 2015

Members Present	Dr. James Dagostino, Director Kellett, Director Julie Nygaard, Dr. John Kroener, Dr. Frank Corona, Kathleen Mendez, Robert Knezek, Steve Harrington, Wayne Lingenfelter
Non-Voting Members Present:	Tim Moran, CEO, Steve Dietlin, CFO, Kapua Conley, COO, Wayne Knight, Sr. VP, Medical Services
Others Present:	Director Laura Mitchell, Director RoseMarie Reno, David Bennett, Carol Smyth, Sharon Schultz, Quinn Abler, Glen Newhart, Jan Dunnmeyer, Tom Moore, Esther Beverly, Charlene Carty, Marcia Cavanaugh, Steve Young, Jody Root, Procopio, Denise Hujing, BB&T Tim Mooney, BB&T Wes Justyn-BB&T
Members Absent:	Dr. Marcus Contardo, William McGaughey

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Dagostino called the meeting to order at 12:32 pm.		
2. Approval of Agenda		<u>MOTION</u> It was moved by Director Nygaard, Director Kellett seconded, and it was unanimously approved to accept the agenda of April 21, 2015 with the following changes: Both Item 6a. the Charity Care policy and the Finance, Operations and Planning charter listed on the Work Plan, will be pulled.	
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	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
4. Ratification of minutes of March 17, 2015		Minutes ratified. MOTION It was moved by Director Kellett, Dr. Corona seconded, with Steve Harrington abstaining, that the minutes of March 17, 2015, be approved as written.	
5. Old Business	None		
6. a. Policy Review: <ul style="list-style-type: none"> Charity Care, Uncompensated Care, Community Service 		MOTION This item was pulled from the agenda	Ray Rivas
b. Co-Medical Director Agreement – Wound Care and Hyperbaric Oxygen Therapy	Sharon Schultz presented the co-medical director for Wound Care and Hyperbaric Oxygen Therapy agreement. This role will be for consultations on wound interventions with recommendations, Plan of Care for ongoing treatment. Duties to include: <ul style="list-style-type: none"> Establishing guidelines, protocols & standards for quality patient care & the monitoring of quality outcomes. Assuring accuracy of medical record compliance for all physician disciplines within the service. Providing educational training for medical, nursing & ancillary staffs on a continuous basis. Assuring compliance with CMS requirements for care, documentation and correct 	MOTION Dr. Corona moved, Dr. Kroener seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. Sharon Slowik and Janet Whitney as Co-Medical Directors for the Outpatient Wound Clinic, Hyperbaric Medicine and Inpatient Wound Care Program, for a term of 14 months beginning May 15, 2015 and ending June 30, 2016. Not to exceed an average of 40 hours per month or 480 hours annually, at an hourly rate of \$190 and a total for the term of \$102,600.	Sharon Schultz

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	<p>coding initiatives.</p> <ul style="list-style-type: none"> Conducting clinical data collection and research in wound care. <p>Discussion ensued with several questions raised, and answered.</p>		
c. Psychiatric On-Call – Panel, Emergency Department	<p>Sharon Schultz presented the Psychiatric On-Call Panel agreement for the Emergency Department. The responsibilities of this role will be for consultations and admissions.</p> <p>It was the recommendation of Procopio's legal representative Jody Root, that the write up be modified to be reflected as a panel agreement.</p>	<p>MOTION Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Manish V. Sheth, Dr. Mark Melden, Dr. Robert A. Zalewski-Zaragoza, for Emergency Department Psychiatric On-Call scheduling, for a term of 15 months, beginning April 1, 2015 and ending on June 30, 2016 at a term cost of \$457,000.</p> <p><i>(Barbara Hainsworth to make the modifications to the write-up, and forward to Teri Donnellan)</i></p>	Sharon Schultz / Kapua Conley, COO
d. GE 512 CT Scanner	<p>Steve Young provided a PowerPoint presentation and short video on the General Electric 512 CT scanner. This item would be a replacement for the current aged equipment. He explained that this scanner would provide state-of-the-art imaging technology, and would be the 1st installed in San Diego County, and the 25th nationwide.</p> <p>He emphasized that the new machine is would improve patient flow in the ED, and would enhance</p>	<p>MOTION Director Nygaard 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 lease agreement for the GE 512 CT scanner for a 60 month term starting (est.) 11/1/2015 ending 10/31/2020 at \$38,467 per month, total term lease expense \$2,308,020, construction expense not to exceed \$485,000, and hardware and interfaces</p>	Steve Young

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	<p>the quality of patient care.</p> <p>He conveyed that this purchase would receive funding support of \$50,000 from the Auxiliary, and \$500,000 from the TCHD Foundation.</p>	<p>expense of \$95,251 for a total term expense of \$2,888,171.</p>	
e. Active Acquisition Partners	<p>David Bennett presented a month-to-month proposal for the Wellness Center management with Active Acquisition, LLC. This agreement will provide him with the opportunity to evaluate other management vendors, and to encourage performance improvement with the current vendor and increase their membership recruitment efforts.</p>	<p><u>MOTION</u> Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the Amendment with Active Acquisition for management of the Wellness Center for a month to month term beginning April 1, 2015, and ending December 31, 2015, for an average monthly cost of \$217,500, not to exceed \$1,957,500 term total.</p>	David Bennett
f. Insurance Brokerage Services (BB&T)	<p>Steve Dietlin presented this proposal negotiated by management, to retain BB&T brokerage services for a three-year term cost, not to exceed \$450,000 annually, and \$1,350,000 for the three-year term.</p> <p>A representative from BB & T made a presentation describing the plan for evaluating all TCMC insurance renewals for 2015-2016.</p>	<p><u>MOTION</u> Director Kellett moved, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize management to retain BB&T to serve as Tri-City Healthcare District's insurance broker of record for workers' compensation, property and casualty, and employee benefits programs for a term of three years, beginning April 1, 2015, and ending March 31, 2018. Total compensation to BB&T, inclusive of insurance carrier commissions and</p>	Steve Dietlin Sharon Schultz Esther Beverly

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible																														
		payments from TCHD shall not exceed \$450,000 annually and \$1,350,000 for the three-year term.																															
g. Financials	<p>Steve Dietlin presented the financials ending March 31, 2015 (dollars in thousands)</p> <p><u>Fiscal Year to Date</u></p> <table><tr><td>Operating Revenue</td><td>\$249,870</td></tr><tr><td>Operating Expense</td><td>\$250,408</td></tr><tr><td>EROE</td><td>\$ 2,747</td></tr><tr><td>EBITDA</td><td>\$ 14,712</td></tr></table> <p><u>TCMC –Key Indicators – FYTD</u></p> <table><tr><td>Avg. Daily Census</td><td>194</td></tr><tr><td>Adjusted Patient Days</td><td>84,933</td></tr><tr><td>Surgery Cases</td><td>4,977</td></tr><tr><td>Deliveries</td><td>1,979</td></tr><tr><td>ED Visits</td><td>53,048</td></tr></table> <p><u>Current Month</u></p> <table><tr><td>Operating Revenue</td><td>\$ 28,516</td></tr><tr><td>Operating Expense</td><td>\$ 28,539</td></tr><tr><td>EROE</td><td>\$ 292</td></tr><tr><td>EBITDA</td><td>\$ 1,591</td></tr></table> <p><u>Net Patient A/R & Days in Net A/R</u></p> <p><u>By Fiscal Year</u></p> <table><tr><td>Net Patient A/R (in millions)</td><td>\$ 42.8</td></tr><tr><td>Days in Net A/R</td><td>49.2</td></tr></table> <p>Graphs:</p> <ul style="list-style-type: none">• TCMC-Net Days in Patient Accounts Receivable• TCMC-Average Daily Census-Total Hospital-	Operating Revenue	\$249,870	Operating Expense	\$250,408	EROE	\$ 2,747	EBITDA	\$ 14,712	Avg. Daily Census	194	Adjusted Patient Days	84,933	Surgery Cases	4,977	Deliveries	1,979	ED Visits	53,048	Operating Revenue	\$ 28,516	Operating Expense	\$ 28,539	EROE	\$ 292	EBITDA	\$ 1,591	Net Patient A/R (in millions)	\$ 42.8	Days in Net A/R	49.2		Steve Dietlin
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Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	<p>Excluding Newborns</p> <ul style="list-style-type: none"> • TCMC-Adjusted Patient Days • TCMC-Emergency Department Visits • TCHD-EROE and EBITDA 		
h. Work Plan – Information Only	Director Dagostino reported that these agenda items were for review only, but Committee members were welcome to ask questions.		
<ul style="list-style-type: none"> • Finance, Operations and Planning Committee Charter • Construction Report (Quarterly) • Infusion Center (Quarterly) • Aionex Bed Board • Dashboard 	<p>Construction Report Wayne Knight explained that this report reflects numerous projects that are in various stages of completion; discussion ensued.</p> <p>Infusion Center Discussion ensued.</p> <p>Aionex Bed Board Sharon reviewed the Aionex Executive Summary and the accompanying spreadsheet; discussion ensued.</p> <p>Dashboard No discussion held.</p>	<p>This Work Plan item was pulled from the agenda.</p> <p><i>(In the future, this Work Plan item will now be overseen by Kapua Conley, COO).</i></p>	<p>Director Dagostino</p> <p>Wayne Knight</p> <p>Sharon Schultz</p> <p>Sharon Schultz</p>
7. Comments by Committee Members		None	Chair

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
8. Date of next meeting	May 19, 2015		Chair
9. Community Openings	None		Chair
10. Oral Announcement of items to be discussed during closed session. (Government Code Section 54957.7)			Chair
11. Motion to go in to Closed Session		<u>MOTION</u> Director Kellett moved, Director Nygaard seconded and it was unanimously approved to go into Closed Session at 2:00 pm.	
15. Open Session		<u>MOTION</u> Director Kellett moved, Dr. Kroener seconded and it was unanimously approved to go into Open Session at 2:06 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 2:07 pm.		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 21, 2015
Co-Medical Director Agreement - Wound Care and Hyperbaric Oxygen Therapy

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

Name: Drs. Sharon Slowik and Janet Whitney

Area of Service: For coverage of Outpatient Wound Care Clinic, Hyperbaric Medicine and Inpatient Wound Care Program

Term of Agreement: Fourteen (14) month term, beginning May 15, 2015 through June 30, 2016

Rates and Totals: Hourly Rate of \$190; 40 hours per month / 540 hours per contract.
New agreement, as previous Medical Director is leaving the State of California on May 15th

Rate / Hour	Hours per Month	Hours per Year	Monthly Cost	Max. Annual Cost	14 month (Term) Cost
\$190	40 (20 hrs. in May 2015)	480	\$ 7,600	\$ 91,200	\$ 102,600

Position Responsibilities:

1. Consultation on wound interventions with recommendations
2. Plan of Care for ongoing treatment
3. Duties as the Outpatient Wound Care Medical Director to include:
 - Establishing guidelines, protocols, and standards for quality patient care the monitoring of quality outcomes
 - Assuring accuracy of medical record compliance for all physician disciplines within the service
 - Providing educational training for medical staff, nursing staff and ancillary staff on a continuous basis
 - Assuring compliance with CMS requirements for care, documentation and correct coding initiatives
 - Conducting clinical data collection and research in wound care

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

Person responsible for oversight of agreement: Sharon Schultz, CNE; Kim Posten, RN Manager.

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Sharon Slowik and Janet Whitney as Co-Medical Directors for the Outpatient Wound Clinic, Hyperbaric Medicine and Inpatient Wound Care Program, for a term of 14 months beginning May 15, 2015 and ending June 30, 2016. Not to exceed an average of 40 hours per month or 480 hours annually, at an hourly rate of \$190 and a total for the term of \$ 102,600.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 21, 2015
Psychiatric On-Call Panel - Emergency Department

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

Physician Names: Manish V. Sheth, M.D.; Mark Melden, D.O.; Robert A. Zalewski-Zaragoza, M.D.

Area of Service: Inpatient Behavioral Health – ED On-Call

Term of Agreement: Fifteen (15) months; beginning 4/01/15 – ending 6/30/16

Totals:

Rate per Shift	Number of Months	Average Monthly Payment	15 Month (Term) Cost
\$ 1,000	15	\$ 30,000	\$ 457,000

Position Responsibilities:

Consultation and Admission

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

Person responsible for oversight of agreement: Kapua Conley, COO

Motion:

I move that Finance Operations and Planning Committee Recommend that TCHD Board of Directors authorize Manish V. Sheth, M.D.; Mark Melden, D.O.; Robert A. Zalewski-Zaragoza, M.D. for Emergency Department Psychiatric On-Call scheduling for a term of 15 months, beginning April 1, 2015 and ending on June 30, 2016 at a term cost of \$457,000.

Table 1: On-Call Physician Compensation — Daily Rate

	Providers	Groups	Mean	Std Dev	25th %tile	Median	75th %tile	90th %tile
Anesthesiology: All	25	2	*	*	*	*	*	*
Cardiology: Electrophysiology	4	2	*	*	*	*	*	*
Cardiology: Invasive	13	7	\$628	\$419	\$200	\$633	\$1,000	\$1,340
Cardiology: Invasive-Interventional	44	11	\$739	\$290	\$500	\$775	\$981	\$1,100
Cardiology: Noninvasive	5	4	\$436	\$214	\$219	\$450	\$647	*
Critical Care: Intensivist	2	2	*	*	*	*	*	*
Emergency Medicine	35	2	*	*	*	*	*	*
Family Medicine (with OB)	8	2	*	*	*	*	*	*
Family Medicine (without OB)	3	2	*	*	*	*	*	*
Gastroenterology	24	7	\$335	\$219	\$200	\$200	\$500	\$700
Hospitalist	8	1	*	*	*	*	*	*
Infectious Disease	1	1	*	*	*	*	*	*
Internal Medicine: General	9	3	\$450	\$428	\$123	\$400	\$500	*
Nephrology	3	1	*	*	*	*	*	*
Neurology	29	9	\$461	\$70	\$438	\$500	\$500	\$500
Obstetrics/Gynecology	35	16	\$464	\$280	\$219	\$500	\$500	\$726
Ophthalmology	6	4	\$583	\$621	\$100	\$300	\$1,275	*
Orthopedic Surgery: All	167	40	\$1,016	\$519	\$800	\$1,000	\$1,050	\$1,910
Otorhinolaryngology	27	11	\$325	\$155	\$200	\$300	\$375	\$615
Pediatrics	29	6	\$237	\$46	\$207	\$250	\$250	\$250
Psychiatry	13	8	\$572	\$336	\$208	\$550	\$1,000	\$1,000
Pulmonary Medicine	11	6	\$801	\$386	\$690	\$690	\$897	\$1,582
Radiology: All	90	3	\$1,224	\$624	\$500	\$1,500	\$1,500	\$2,000
Surgery: General	123	26	\$854	\$562	\$450	\$755	\$1,000	\$1,500
Surgery: Cardiovascular	22	5	\$1,026	\$470	\$649	\$725	\$1,600	\$1,600
Surgery: Neurological	29	12	\$1,532	\$588	\$1,000	\$1,600	\$1,750	\$2,300
Surgery: Trauma	24	8	\$1,249	\$601	\$660	\$1,375	\$1,400	\$2,400
Surgery: Vascular (Primary)	19	12	\$731	\$567	\$500	\$625	\$750	\$1,400
Surgery: All Other	41	16	\$787	\$476	\$463	\$725	\$925	\$1,400
Urology	61	13	\$411	\$255	\$228	\$300	\$732	\$840
Surgical Other Subspecialty	1	1	*	*	*	*	*	*
Nonsurgical Other Specialty	1	1	*	*	*	*	*	*

Table 2: On-Call Physician Compensation — Holiday Rate

	Providers	Groups	Mean	Std Dev	25th %tile	Median	75th %tile	90th %tile
Anesthesiology: All	16	1	*	*	*	*	*	*
Cardiology: Electrophysiology	4	2	*	*	*	*	*	*
Cardiology: Invasive	8	3	\$450	\$351	\$200	\$300	\$850	*
Cardiology: Invasive-Interventional	35	5	\$813	\$248	\$650	\$800	\$1,000	\$1,200
Emergency Medicine	1	1	*	*	*	*	*	*
Gastroenterology	30	4	\$1,255	\$875	\$200	\$2,000	\$2,000	\$2,000
Internal Medicine: General	6	3	\$777	\$380	\$615	\$700	\$900	*
Neurology	22	2	*	*	*	*	*	*
Obstetrics/Gynecology	32	4	\$245	\$268	\$125	\$125	\$200	\$500
Ophthalmology	4	2	*	*	*	*	*	*
Orthopedic Surgery: All	52	15	\$1,071	\$648	\$525	\$1,000	\$1,200	\$2,350
Otorhinolaryngology	5	2	*	*	*	*	*	*
Pediatrics	15	3	\$413	\$456	\$250	\$250	\$250	\$1,160
Psychiatry	1	1	*	*	*	*	*	*
Pulmonary Medicine	1	1	*	*	*	*	*	*
Radiology: All	85	2	*	*	*	*	*	*
Surgery: General	35	10	\$822	\$820	\$450	\$500	\$925	\$2,600
Surgery: Cardiovascular	6	2	*	*	*	*	*	*
Surgery: Neurological	9	3	\$1,765	\$469	\$1,366	\$1,750	\$2,300	*
Surgery: Trauma	16	4	\$2,172	\$609	\$2,000	\$2,000	\$2,600	\$2,800
Surgery: Vascular (Primary)	2	2	*	*	*	*	*	*
Surgery: All Other	20	6	\$941	\$721	\$500	\$725	\$1,000	\$2,585
Urology	4	2	*	*	*	*	*	*

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 21, 2015
PROPOSAL FOR: Wellness Center Management

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

Vendor Name: Active Acquisition, LLC

Area of Service: Wellness Center

Term of Amendment: Month to Month – Beginning, 4/01/15 – Ending, 12/31/15

Totals:

Average Monthly Cost	Expected Term Maximum
\$ 217,500	\$ 1,957,500

Description of Services/History: Management of Wellness Center – Need approval for Second Amendment to extend Limited Term Operating Agreement for month to month basis.

- Original Agreement with Club One, dated October 2011
- Limited Term Operating Agreement dated February 28, 2014 to May 31, 2014 with Active Acquisition, after acquiring Club One and their contracts
- First Amendment to extend Operating Agreement through, March 31, 2015

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

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Amendment with Active Acquisition for management of the Wellness Center for a month to month term beginning April 1, 2015 and ending December 31, 2015, for an average monthly cost of \$217,500, not to exceed \$1,957,500 term total.

DRAFT

**Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
April 16, 2015**

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

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

Others present: Rick Barton, General Counsel, Marcia Cavanaugh, Director of Risk Mgt. and Quality, Jami Pierson, Director of Quality and Regulatory, Patricia Guerra, Jami Fluellen, Kathy Topp, Pamela Alm, Melinda Ruiz, Bruce Bainbridge, Richard Cornwell, Nancy Myers, and Karren Hertz.

Members absent: None.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Dagostino, called the meeting to order at 12:08 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 Dr. Worman and seconded by Dr. Contardo.	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 March 19, 2015.	Minutes ratified. Director Finnilla moved and Director Mitchell seconded the motion to approve the minutes for the March meeting of PAC.	Director Dagostino
5. New Business a. Quality Outcomes Dashboard	<p>The dashboard for Core Measures data was presented. Jami thoroughly explained that the data contained in this report are internal calculations only and they are ultimately different from the data in Hospital Compare. They are not publicly reported and is solely used for internal workgroup only.</p> <p>It was also noted that the national rate for mortality should have been a range instead of a rate.</p> <p>The Infection Control indicators, on the otherhand, looked no different compared to other local hospitals. This was identified as a reporting versus coding issue. Jami also differentiated the Ventilator Associated Pneumonia, Ventilator Associated Conditions and Ventilator Associated infections as it relates to the hospitals' reimbursement factor. ED data indicators remains the same as of the last reporting.</p>	<p>ACTION: The indicators reported in this data will be presented in graphs next time as they are more visually informative and can be discussed more accurately at that point.</p>	Jami Pearson

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
<p>b. Request for Formulary Status Evaluation Criteria for Use for Miacalcin</p> <p>Consideration and Possible Approval of Policies and Procedures</p> <p>Patient Care Policies and Procedures:</p> <ol style="list-style-type: none"> 1. Confidential Patient 	<p>Andrea Hanson reported on the drug called Miacalcin, a peptide hormone that functionally antagonizes the effects of parathyroid hormone. This type of injection has had a recent spike increasing the cost per vial from \$65 to almost \$1000 per vial after the original manufacturer was purchased by another pharmaceutical.</p> <p>This drug is not considered as the 1st line of treatment and is just an adjunctive therapy. The Pharmacy Dept. only keeps 39 vials a year; the department has reduced their levels to reduce waste.</p> <p>Shelf life for this drug is 1 year; this is not on the approved medication list but this drug is approved by the P & T Committee.</p> <p>Director Finnilla had a question what would be the scenario if there is more than one confidential patient in the hospital. It was noted that a 2nd identifier, such as a unique Financial # will be used in case of multiple confidential patients.</p>	<p>ACTION: The motion to approve the use of this drug was moved by Dr. Corona and was seconded by Director Finnilla.</p> <p>*The Patient Care Services policies and procedures were approved with the exception of the policy on midline catheters which was pulled out. Dr. Contardo moved and Dr. Johnson seconded the motion to approve these policies.</p>	<p>Andrea Hanson</p> <p>Patricia Guerra</p>

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
2. D-Stat Rad Band Topical Hemostat	Dr. Johnson made a recommendation to change the radial sheath to radial artery catheter. He also suggested to use "radial artery compression device" all throughout the policy for consistency purposes.	ACTION: The policy will be revised to reflect editorial changes proposed by the Dr. Johnson.	
3. Midline Catheter, Adults	This policy is being pulled out due to some concerns on blood draw and medications that are infused to the patients as brought about by one physician.	ACTION: This will be brought back to the committee in the next few months.	
4. Missing Patient	It was clarified that the ANM is the first person to know when a patient is missing.		
5. Skin and Wound Care Policy	A brief discussion was held on this policy; it was emphasized that each patient with skin issue should be checked out by staff at the end of every shift. Clarification on normal and really low BMI was also mentioned for patients who are susceptible to skin breakdown.		
6. Spiritual Care of the Patient	The chapel is open 24 hours a day, 7 days a week although the Chaplains are only available on certain specific hours.		
Administrative Policies and Procedures: 1. Hospital Records Retention #237	There was no discussion held on this policy.	*The Administrative policy will move forward for Board approval. Director Finnila moved and Dr. Worman seconded the motion.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
2. WND Disaster Response Plan	tagging (Carseat or stroller) will not work on the area where the Lactation consultant is. The distinctive badge with teddy bear differentiates the staff working in WNS dept. as a security measure for babies. This policy was pulled for further review and clarification.		
<u>Pre-Printed Orders</u> 1. Chemotherapy Orders 2. Inpatient Pre-Surgical 3. Intraoperative Anesthesia Medication Orders 4. NICU: Pre-Eye Exam Medication Orders 5. Outpatient Pre and Post Operative Orders	Dr. Johnson pulled out the inpatient and outpatient pre-printed orders for further review. The rest of the pre-printed orders were approved.	*The pre-printed orders with the exception of the inpatient and outpatient surgical orders were approved and are moving forward for Board approval as moved by Dr. Worman and seconded by Director Finnilla.	Patricia Guerra
7. Closed Session	Director Dagostino asked for a motion to go into Closed Session.	Director Finnilla moved, Director Mitchell seconded and it was unanimously approved to go into closed session at 1:05 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

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
10. Comments from Members of the Committee	No Comments.		Director Dagostino
11. Adjournment	Meeting adjourned at 2:25 PM		Director Dagostino



PROFESSIONAL AFFAIRS COMMITTEE
April 16th, 2015

CONTACT: Sharon Schultz, CNE

<u>Patient Care Services Policies & Procedures</u>		
1. Confidential Patient	3 year review	Forward to BOD for approval
2. D-Stat Rad-Band Topical Hemostat	NEW	Forward to BOD for approval with revisions
3. Midline Catheter, Adults	NEW	Pulled for further review
4. Missing Patient	3 year review	Forward to BOD for approval with revisions
5. Skin & Wound Care Policy	3 year review, practice change	Forward to BOD for approval with revisions
6. Spiritual Care of the Patient	3 year review	Forward to BOD for approval
<u>Administrative Policies & Procedures</u>		
1. Hospital Records Retention #237	3 year review	Forward to BOD for approval
<u>NICU</u>		
1. Intrafacility Transport of the NICU patient	3 year review	Forward to BOD for approval with revisions
2. NICU Disaster Procedure	3 year review	Forward to BOD for approval
3. NICU Placement: Overflow to Alternate Location (Temporary Overflow)	3 year review	Forward to BOD for approval
4. Peripherally Inserted Central Catheters and Midline Catheters, Dressing Change, Maintenance, and Removal of	3 year review	Forward to BOD for approval
<u>Pulmonary</u>		
1. RCP Staffing Guidelines in the NICU	3 year review	Forward to BOD for approval
<u>Women and Newborn Services</u>		
1. Infant Safety and Security	3 year review	Forward to BOD for approval with revisions
2. WNS Disaster Response Plan	NEW	Pulled for further review
<u>Pre-Printed Orders</u>		
1. Chemotherapy Orders	3 year review, format change	Forward to BOD for approval
2. Inpatient Pre-Surgical	3 year review, practice change	Pulled for further review
3. Intraoperative Anesthesia Medication Orders	3 year review, practice change	Forward to BOD for approval
4. NICU: Pre-Eye Exam Medication Orders	3 year review, practice change	Forward to BOD for approval
5. Outpatient Pre and Post Operative Orders	3 year review, practice change	Pulled for further review



PATIENT CARE SERVICES Administrative Policy Manual

ISSUE DATE: 07/99

SUBJECT: Unidentified or Confidential Patient

REVISION DATE: 05/03; 04/06; 04/09

POLICY NUMBER: 8610-374

Administrative Policies & Procedures Committee Approval:	05/09
Clinical Policies and Procedures Committee Approval:	03/15
Operations Team Nurse Executive Committee Approval:	05/09 03/15
Professional Affairs Committee Approval:	06/09 04/15
Board of Directors Approval:	06/09

A. **PURPOSE:**


1. To identify a patient in a timely manner in order to treat a patient in an emergent situation or to protect a patient's safety if his/her location were known.

B. **POLICY:**

1. Criteria for creating **unidentified** patient (**Jane/John Doe**):
 - a. Register the patient in Cerner using "John Doe or Jane Doe".
 - b. Update demographic information in both ~~Cerner~~ **Cerner** and Affinity as it becomes available.
2. Criteria for creating a confidential patient:
 - a. Tri-City Medical Center (TCMC) staff ~~has~~ **have** identified patient as a possible victim of violence, or other situation where the patient's life is in danger, if his/her location was known.
 - b. Admitting/Registration will register patient as "John Doe" or "Jane Doe" using all of the patient's correct information except for name.
 - i. If the patient has been to TCMC in the past, notify the unit's ~~Shift Supervisor~~ **Assistant Nurse Manager (ANM)/designee/relief charge** of the patient's correct Medical Record Number.
 - ii. Notify Security, Risk Management and Social Services. When it is determined that a security risk no longer applies the unit ~~Shift Supervisor~~ **ANM/designee/relief charge** will contact Registration to make the necessary edits to the patient's name.
 - iii. Change name of the patient only after patient is no longer a security risk.
 - c. If a patient would like to be considered "confidential" for reasons other than safety they must access Administrative Policy # 526, Right to Request Privacy Restriction for Protected Health Information.

C. **REFERENCE RELATED DOCUMENTS:**

1. Administrative Policy # 524 Disclosure of Information to Public and Media
2. Administrative Policy # 526 Right to Privacy Restriction for Protected Health Information

 Tri-City Medical Center	Patient care services
PROCEDURE: D-STAT® RAD-BAND TOPICAL HEMOSTAT	
Purpose:	To ensure continuity and patient safety using the D-Stat Rad-Band Topical Hemostat trans-radial (TR) band following radial artery catheterization by defining device application and removal, nursing assessment requirements, device complications and nursing interventions to resolve or minimize complications.
Supportive Data:	D-Stat® Rad-Band Topical Hemostat (Model 3501) Package Insert- Instructions for Use, Vascular Solutions, Inc. Vascular Solutions D-Stat Rad-Band Topical Hemostat Tips for Optimal Performance Vascular Solutions D-Stat Rad-Band Topical Hemostat Clinical Deployment Steps
Equipment:	D-Stat Rad-Band Pad Adjustable Retention Strap with foam comfort pads Pulse Oximeter with probe Small Tegaderm or Manufacturer's Adhesive Bandage 2x2 Gauze Dressing Wrist Positioning Splint

A. **DEFINITIONS:**

1. D-Stat Rad-Band Topical Hemostat: A radial artery compression device with a hemostat pad used to control surface bleeding from arterial access sites after ~~sheath~~ **radial artery catheter** removal. For the purpose of this document, the D-Stat Rad-Band will be called a radial compression device.
2. D-Stat Pad: A pad containing thrombin and calcium chloride in a suspension that converts fibrinogen directly into fibrin.
3. Arterial Occlusion – A blockage of blood flow through an artery
4. Non-Occlusive Pressure Applied to an Artery – manual pressure or pressure applied with the use of a mechanical device that does not block (prevent) the flow of blood through an artery.
5. Occlusive Pressure Applied to an Artery – manual pressure or pressure applied with the use of a mechanical device that blocks the flow of blood through an artery

B. **POLICY**

1. The radial ~~sheath~~ **artery catheter** may be removed by the procedural ~~staff~~ or a ~~competent~~ Registered Nurse (RN) on the receiving unit prior to applying the radial **arterial** compression device.
2. The RN on the receiving unit is responsible for monitoring, weaning, and removing the radial **arterial** compression device post procedure. ~~Only competent RNs may remove the device.~~
3. The D-Stat Rad-Band strap may not be used to apply occlusive pressure to the radial artery at any time.
4. The D-Stat Rad Band pad may not be placed into a blood vessel and **is** contraindicated for patients with sensitivity to bovine-derived materials.

C. **PROCEDURE:**

1. Application of the Radial **Arterial** Compression Device
 - a. Remove the introducer ~~sheath~~ **radial artery catheter** while applying non-occlusive manual compression by placing the D-Sat Rad-Band pad directly over the source of bleeding
 - b. Tighten the D-Stat Rad-Band by pulling on the retention strap until the device is secure on the patient's wrist and cessation of bleeding is observed, but the presence of pulses are still present
 - c. Do not apply occlusive pressure using the D-Stat Rad
 - d. Check pulses, **both proximal and distal to the D-Stat Rad Band**, frequently to ensure arterial flow is present and loosen the retention strap as necessary

Clinical Policies and Procedures	Nurse Executive Committee	Pharmacy & Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
01/15	02/15	03/15	2/15	4/15	

2. Post-Application of the D-Stat Rad-Band

- a. On arrival to nursing care area
 - i. Mark retention strap at the current position. Marking the retention strap indicates the appropriate position to maintain hemostasis
 - ii. Palpate radial pulse and assess perfusion of hand
 - iii. Assess site for the presence of bleeding e.g., new or an increase presence of blood on the hemostat pad, blood oozing around pad and/or the presence of a hematoma
 - iv. Assess site with each set of vital signs
- b. Implement continuous pulse oximetry
 - i. Place the probe on index finger or thumb of affected wrist distal to radial **arterial** compression device during compression and weaning of device.
 - ii. Check pulse oximetry waveform:
 - 1) If pulse oximetry waveform is lost, decrease pressure slowly by loosening the retention strap until waveform returns.
 - 2) If pulse oximetry waveform is lost and bleeding is present see management of bleeding
- c. Vital Signs
 - i. Assess vital signs every 15 minutes times 6, then every 30 minutes times 4, then every two hours times two, then per Standards of Care.
- d. Neurovascular Assessments
 - i. Perform a neurovascular assessment with vital signs and site assessments

3. Management of Bleeding

- a. Ensure device is in the proper position
- b. Tighten retention strap to the position marked when patient arrived to unit or until hemostasis is achieved. Do not occlude the radial pulse.
 - i. Notify the procedure Physician immediately if unable to regain hemostasis
- c. Palpate for the presence of a radial pulse. A palpable radial pulse must be present at all times.
- d. Do not tighten retention strap to occlude radial pulse
- e. Uncontrolled bleeding:
 - i. Remove radial **arterial** compression device, elevate arm while applying manual pressure to stop the bleeding. Notify Physician immediately.

4. Removal of Radial **arterial** Compression Device

- a. Maintain the radial **arterial** compression device in place for 30 minutes prior to weaning and may remain in place for a maximum of 1 hour with wrist positioning splint in place for 2 hours or as ordered by the Physician.
- b. Observe site for hemostasis (no bleeding noted or the formation of a new hematoma)
- c. Hold the band at a 45 degree angle close to the retainer to allow small, incremental adjustments to be made.
- d. Loosen the retention strap one (1) click at a time every 15 minutes times four (4) by compressing the protruding tab on the clasp and slowly loosen the strap to the desired tension
 - i. If hemostasis is achieved, decrease one (1) click every 5-10 minutes until the retention strap is loose
 - ii. Assess for signs of bleeding i.e., oozing or hematoma with each click, if present reapply pressure by adjusting the retention band until bleeding stops ensuring a palpable pulse is present.
 - iii. Reassess for achievement of hemostasis in 10 minutes, obtain vital signs
- e. Assess for hemostasis, if achieved and tension on the retention strap is completely released:
 - i. Secure the radial **arterial** compression device D-Stat pad by applying slight compression directly on the retainer while sliding the retention strap out of the side groove of the retainer

- ii. Hold the tab of the D-Stat pad with one hand. With the other hand slowly pull the retainer back leaving the D-Stat pad in place, be careful not to disrupt the clot.
 - iii. Apply the D-Stat adhesive bandage or a tegaderm over the D-Stat pad
 - 1) If the D-Stat pad is removed, apply a 2x2 gauze then apply a tegaderm
 - 2) Do not stretch the adhesive dressing or tegaderm during application as tension can cause skin trauma
 - 3) Do not leave the D-Stat pad in place for more than 24 hours; 24 hours or greater may result in skin irritation
 - iv. Immobilize affected arm using the wrist positioning splint for 2 hours post removal of the radial **arterial** compression device or as ordered
- f. Removing the D-Stat Pad
 - i. Remove dressing within 24 hours or prior to discharge. Do not disrupt the clot
 - ii. Apply a small amount of saline to the D-stat pad to remove easily when stuck to the skin so as not to disrupt the clot.
 - iii. Apply a Ban-Aid to puncture site or leave open to air if ordered
- 5. Reportable Conditions
 - a. Notify the procedure Physician immediately if any of the following occur:
 - i. Unable to achieve hemostasis after repositioning device and tightening the retention strap
 - ii. New onset of distal pain, numbness, tingling, duskiness, bleeding, unable to palpate the radial pulse, or circulation to the hand appears compromised
 - iii. Patient complaint of chest pain or pressure not relieved with ordered treatment
 - iv. New onset arrhythmias
- 6. Documentation
 - a. Document the following in the Electronic Health Record (EHR):
 - i. All assessments
 - ii. Vital signs with pulse oximetry results
 - iii. Neurovascular assessments
 - iv. Dressing changes
 - v. Physician Notification
 - vi. Education provided – use Krames Custom Education leaflet Radial Artery Cardiac Catheterization /Angioplasty Discharge Instructions

PATIENT CARE SERVICES~~Administrative Policy Manual~~

ISSUE DATE: 03/90

SUBJECT: Missing Patient

REVISION DATE: 9/91; 12/96; 6/99; 5/03; 4/06
6/09; 6/11

POLICY NUMBER: 8610-305

Administrative Clinical Policies & Procedures Committee Approval:	04/1403/15
Nurse Executive Committee Council Approval:	06/1403/15
Professional Affairs Committee Approval:	06/1404/15
Board of Directors Approval:	06/11

A. **PURPOSE:**

1. To define the process and responsibilities governing the protection of missing patients.

B. **POLICY:**

1. In the event that a patient cannot be located, an immediate search plan will be implemented, coordinating the combined effort of Clinical and Security personnel.
2. When a patient is deemed missing, an organized search will be made, escalating in intensity, as deemed appropriate by the nurse or supervisory staff in charge of this patient's unit.
3. To initiate the search the ~~Nurse in Charge~~ **Assistant Nurse Manager (ANM)/designee/relief charge** will contact:
 - a. The Clinical Manager/Administrative Supervisor.
 - b. Security - Inform Security of all patient identifying information including:
 - i. If patient is on a 5150 hold or 72 hour hold.
 - ii. If patient is on conservatorship of any kind if patient is confused, incompetent and/or at risk for harm.
 - c. Director of the Unit/Service, ~~Chief Operating Officer~~/Chief Nurse Executive and the Administrator on call.
4. Nursing will coordinate an immediate search of patient's unit, utilizing the "Nursing: Missing Patient Search Checklist."
 - a. This search will include: the surrounding stairwells, (entire flight up, and entire flight down), surrounding bathrooms/showers, treatment rooms, waiting rooms, supply rooms and elevator areas.
5. Security will, simultaneously, conduct a search of the hospital grounds utilizing the "Security: Missing Patient Search Checklist."
 - a. Areas included are: All waiting rooms, lobbies, gift shops, designated smoking areas, cafeteria, all restrooms within immediate area of patients' unit (other than on patient floor) and exterior grounds.
6. The Security Department will contact other designated Medical Center employees including: Facilities Services, List Team Personnel, Courtesy Shuttle and **Public Branch Exchange (PBX)**.
7. Open communication between Security and Clinical Manager or designee will be maintained throughout the entire search.
8. If patient is located, notify PBX immediately. PBX will contact Security via radio and Clinical Manager or designee by phone (~~beeper~~).
 - a. Search will be continued by all personnel until such time they are requested to discontinue.
 - b. Patients shall be returned to unit if they are on a hold, under conservatorship or are confused. (If unsure, if a patient can leave AMA or is at risk, detain the patient until a determination is made with the assistance of Nursing, Social Services, Behavioral Health

Service staff, or a Hospital Administrator).

9. If patient is not located within a reasonable amount of time, the Clinical Manager will contact the Director of Risk Management.
 - a. The Clinical Manager will delegate someone to contact listed relatives for information regarding possible whereabouts of patient.
 - b. The Clinical Manager will ensure MD notification (and psychiatrist if one is involved).
 - c. The Security Department will be responsible to notify the appropriate law enforcement agencies as indicated. Examples of high-risk patients include: frail, elderly, those on 72-hour hold, and confused patients.
 - d. Social Services will be contacted as indicated.

C. **REFERENCED FORMS WHICH CAN BE LOCATED ON THE INTRANET FORMS/RELATED DOCUMENTS:**

1. Missing Patient Search Checklist - Nursing
2. Missing Patient Search Checklist - Security

TRI-CITY MEDICAL CENTER
NURSING: MISSING PATIENT SEARCH CHECKLIST

PATIENT: _____

UNIT ROOM # _____

PATIENT DESCRIPTION: _____

LOCATION/DESCRIPTION	DATE/TIME	SEARCHED BY	REMARKS
PATIENT'S UNIT	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
STAIRWELLS	_____	_____	_____
UP: _____	_____	_____	_____
DOWN: _____	_____	_____	_____
_____	_____	_____	_____
BATHROOM/SHOWER	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
TREATMENT ROOM	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
SUPPLY ROOM	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
WAITING ROOMS	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
ELEVATOR AREA	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Reviewed By: _____
 Reviewed By: _____ Date/Time: _____
 Reviewed By: _____



Tri-City Medical Center Security Department

Missing Patient Search Checklist

Patient Name:	Location Missing from:	Current Date:	Time Notified:
Patients Last Known Location		Date Last Seen:	Time Last Seen:
Description of Missing Patient:			

Locations Checked:

Lobbies/Waiting Rooms:	Results:
_____	_____
_____	_____
_____	_____

Exterior/Smoking Areas:	Results:
_____	_____
_____	_____
_____	_____

Stairwells:	Results:
_____	_____
_____	_____
_____	_____

Public Areas:	Results:
_____	_____
_____	_____
_____	_____

Other Locations:	Results:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 1/06

SUBJECT: Skin & Wound Care Policy

REVISION DATE: 9/06, 12/08, 7/09, 12/09, 6/10; 10/13 POLICY NUMBER: IV.D

Clinical Policies & Procedures Committee Approval: 08/1002/14

~~Patient Care Quality Committee Approval~~ Nursing Executive Council Committee Approval: 09/10 02/14

Department Family Medicine: 08/14

Medical Executive Committee Approval: 09/10

Professional Affairs Committee Approval: 11/104/15

Board of Directors Approval: 12/10

A. **PURPOSE:**

1. The purpose of this policy is to define **healthy maintenance of skin integrity**, alteration in skin integrity and the process for assessment, treatment and documentation. For the purpose of this policy surgical wounds are considered acute wounds which proceed through an orderly and timely healing process not requiring interventions to heal. The surgeon provides orders for the care of the acute wound.
2. **To Prevent Pressure Ulcers a comprehensive visual and tactile skin inspection upon admission, regularly, and as needed. Identify risk factors of pressure ulcer development utilizing the Braden Risk Assessment identify alterations in skin integrity and implement pressure ulcer prevention and nursing interventions to protect patient.**
 - a. Remove all garments, protectors, dressings (including wound vac dressings), and removable devices, as medically stable, to assess the skin.
 - b. Assess splints, casts, tubes and other devices as potential sites for pressure ulcer development.
 - c. Maintenance of healthy skin integrity through clean and dry skin using non friction bathing standards with slightly warm non-irritating, non-sensitizing, ph- balanced every day and after each incontinence episode. Keep skin well hydrated and moisturized.

B. **DEFINITIONS:**

1. **Arterial Ulcer** – a wound which fails to heal secondary to insufficient arterial perfusion, commonly located on areas exposed to repetitive trauma (i.e. lateral malleolus, phalangeal heads, between the toes, or on tips of toes) and typically has a “punched” out appearance.
2. **Diabetic Ulcer** – a wound which fails to heal as a result of elevated glucose levels resulting in altered nerve function in the lower extremities. Commonly located on pressure points of the feet such as the plantar surface and the metatarsal heads.
3. **Eschar** – black or brown necrotic devitalized tissue (scab-like covering).
4. **Friction** – sanding away of surface layer of skin occurring with repetitive rubbing, often seen under restraints or on elbows/heels, or where skin is fragile and macerated.
5. **Maceration** – erythematous or “water-logged” skin secondary to diaphoresis or incontinence, may also be seen around a percutaneous tube that is leaking.
6. **Full Thickness** – tissue damage involving total loss of epidermis and dermis and extending into the subcutaneous tissue and possibly muscle **excluding pressure ulcers**.
7. **Partial Thickness** – tissue damage to the epidermis and part of the dermis **excluding pressure ulcers**. Abrasions, skin tears, and blisters **and shallow craters** are examples of partial thickness wounds..
8. **Pressure Ulcer** – localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

- a. **Suspected Deep Tissue Injury (DTI) Depth Unknown--** Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or *shear*. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.~~Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue~~
- b. **Category/Stage I: Non-blanchable erythemaStage I --** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons.~~Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.~~
- c. **Category/Stage II: Partial thicknessStage II –** Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanguinous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.
 *Bruising indicates deep tissue injury.~~Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.~~
- d. **Category/Stage III: Full thickness skin lossStage III –** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are *not* exposed. Slough may be present but does not obscure the depth of tissue loss. *May* include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.~~Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.~~
- e. **Category/Stage IV: Full thickness tissue lossStage IV –** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable.~~Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.~~
- f. **Unstageable/Unclassified: Full thickness skin or tissue loss –** depth unknown -- Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema

or fluctuance) eschar on the heels serves as “the body’s natural (biological) cover” and should not be removed. ~~Full thickness loss in which the base of the ulcer is covered with slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed.~~

9. **Shear** – the mechanical force that is parallel to the skin which can damage deep tissue such as muscle. Tissues attached to the bone are pulled in one direction, whereas surface tissues remain stationary. Shearing occurs when the head of the bed (HOB) is elevated and the patient slides downward in bed.
10. **Sinus Tract** – may also be referred to as tunneling; course or path of tissue destruction occurring in any direction from the surface or edge of wound resulting in dead space with potential for abscess formation.
11. **Skin Tear** – a traumatic wound resulting from separation of the epidermis from the dermis. Skin tears without tissue loss may be linear type or flap type. Skin tears with tissue loss may be partial or complete.
12. **Slough** – loose, stringy, non-viable tissue, may be white, tan, or yellow.
13. **Undermining** – area of tissue destruction extending under intact skin along the periphery of a wound, commonly seen in shear injuries.
14. **Venous Ulcer** – a wound that has failed to heal secondary to venous insufficiency, commonly located on the medial aspect of lower leg and ankle or superior to the medial malleolus, will typically appear with irregular margins and surrounding skin will have brown/black discoloration, there may be evidence of healed ulcer.
15. **Wound** – a disruption of normal structure and function of the integumentary system. Wounds are classified as acute, chronic, or refractory.
 - a. **Acute** – a wound which occurs suddenly (i.e. trauma or surgery) and heals in an orderly and predictable cascade of events.
 - b. **Chronic** – an acute wound which fails to heal normally (i.e. dehiscent surgical wound) or a wound that is not healing secondary to a loss of perfusion or some other breakdown in tissue integrity (i.e. nutritional status, infections, or elevated glucose levels).
 - c. **Refractory** – a wound which shows no measurable progress for two consecutive weeks despite appropriate management.

C. **POLICY:**

1. **Skin (Integumentary) Assessment**

- a. Braden Risk Assessment shall be completed **with all hospital department nursing assessments, upon orders for inpatient admission, and admission. Reassessments will be upon unit specific standards and PRN** ~~upon admission and once every shift.~~
- b. Skin condition shall be assessed **with all hospital department nursing assessments, upon orders for inpatient admission, and admission. Reassessments will be upon unit specific standards and PRN** ~~upon inpatient admission, once every shift and PRN.~~
 - i. **Outpatient Areas: (Emergency Department and Procedural Areas)**
 - 1) **Should assess high risk patient populations for the skin integrity at pressure points which will be affected by patient positioning during the procedure. Application of prophylactic Composite dressing ie: sacral dressing, heel dressing should be considered.**
 - ii. **For any area that has dressing (including wound vac) upon admission, the dressing should be removed, area assessed, skin condition documented and appropriate dressing applied.**
 - i-1) **VAC dressings should be removed and a saline dressing can be used until the Wound Team can be consulted to replace.**
- b-c. Skin Assessment shall be **comprehensive (visual and tactile) including** but is not limited to:
 - i. Skin Turgor
 - ii. Mucous membranes color and description
 - iii. Skin Color
 - iv. Skin Temperature
 - v. Skin Moisture

- vi. ~~Integumentary~~ **Presence of :**
 - 1) ~~Presence of a~~ Any skin abnormality **including partial or full thickness wounds**
 - 2) ~~Presence of~~ Pressure Ulcer (DTI / Stage I / 2 / 3 / 4 or Unstageable)
 - 3) ~~Presence of~~ Skin Tear
 - 4) ~~Presence of~~ Surgical Incision
 - 4) ~~Vascular Ulcers~~
- vii. ~~Location of all above wounds~~ **any skin abnormality including partial or full thickness wounds, pressure ulcers, surgical incisions, skin tears or surgical incisions, diabetic, venous and arterial ulcers and description of skin abnormality** wounds and surrounding tissue, description and drainage.
- d. Assess skin abnormality for signs and symptoms of infection. If any new infection is identified, notify physician.
- e-e. Photograph all **skin abnormality including partial or full thickness wounds, pressure ulcers, skin tears or non-surgical wounds / skin tears / pressure ulcers** on admission, at least once every 7 days, ~~and with changes~~ **and new discovery**. Photos shall include:
 - i. Measuring guide with the following information: length, width, depth, and location of wound
 - ii. Date of photograph
 - iii. Patients initials
 - iv. Medical record number
- 2. **Documentation:**
 - a. Braden Risk Assessment and skin ~~nursing~~ **interventions to protect patient**
 - b. Integumentary ~~—review of the skin assessment~~ **including any skin abnormalities**
 - c. Dressing changes
 - e-i. **Write date, time, initials, and stage on the dressing prior to application.**
 - d. Skin Care Treatments
- 3. **Identify patients at risk for skin breakdown**
 - a. Braden Risk Assessment Score ≤ 18
 - a-i. **Implement interventions in areas of deficit**
 - b. Immobility
 - c. Dry chapped skin
 - e-d. **Over hydrated skin**
 - d-e. Renal / Hepatic impairment
 - e-f. Low albumin levels
 - f-g. Surgery lasting 4 or more hours
 - g-h. Diabetic
 - i. Sepsis / Infection
 - j. **Patients with really low a BMI (for example less than 19)**
 - h-k. **Spinal Cord Injury**
- 4. **Skin protection / wound prevention guidelines and intervention options**
 - a. Maintain healthy skin moisture (strengthen skin integrity)
 - i. Clean incontinent episodes quickly to keep skin dry.
 - ii. Use Shield pads to clean perineum after stool & urine.
 - iii. Use ~~Nutrashield~~ **protective barrier** moisture lotion to prevent chaffing.
 - iv. Keep irritating substances off the skin i.e. acidic stool.
 - v. Use a single underpad for incontinent patients to absorb moisture.
 - vi. Avoid adult diapers except **on incontinent patients except during transport or during ambulation.** ~~when ambulating patients who are incontinent~~
 - vii. Use pH balanced non-rinse cleanser (Sage Comfort wipes)
 - b. Reduce friction and shearing
 - i. Use drawsheet when repositioning patient in bed.
 - ii. Lift patients off bed when repositioning (to reduce drag).
 - iii. Evaluate for appropriate assist devices (trapeze bar).

- iv. Consider use of specialty mattresses for patients at high risk, **in addition to turning, position and offloading patient every 2 hours.**
 - 1) Isoflex
 - 2) Air II – **for patients with moisture problems, incontinence and only 2 intact turning surfaces.**
 - 3) Dolphin – **for patients with flaps/grafts or with only 1 intact turning surface.**
 - 2)4) Bari Bed – **for patients greater than 35000 pounds or difficulty turning and positioning.**
- c. Reduce pressure and shearing
 - i. Maintain proper alignment / body position.
 - ii. HOB less than 30 degrees if not contraindicated for patient.
 - iii. Gatch knee of bed to prevent sliding down in bed.
 - iv. Consider floating/elevating heels with pillow or heel protectors under ankles.
 - v. Off load pressure areas
 - vi. Avoid foam rings or donuts
 - vii. When sidelying avoid positioning on trochanter and turn off the back at 30 degree angle.
 - vii.viii. **Consider applying preventative silicone composite dressing to high risk areas.**
- d. Maintain mobility to reduce pressure areas on patient
 - i. Reposition immobile patients at least every 2 hours.
 - ii. Encourage/assist ambulatory patients to change positions in bed.
 - iii. Reposition patients in chair every 30 minutes
 - iv. Do not place patient on reddened areas until redness has completely resolved.
- e. Care for incontinent patients
 - i. Offer frequent toileting, **cued voiding or timed voiding**
 - ii. ~~and~~ **Every 1 hour observation of incontinent episodes and immediate cleansing of area after each episode**
 - ii.iii. Cleanse with comfort shield perineal care
 - iii.iv. Avoid diapering except when ambulating **and during transport**
 - iv.v. Use one incontinent pad (avoid chux) on top of draw sheet
 - v.vi. Use incontinence skin barriers / creams / ointments and skin protectants to protect and maintain intact skin
 - vi.vii. Consider using containment device to contain urine / stool
- f. Nutrition
 - i. Initiate nutrition consult for patients at high risk
 - ii. Consider nutrition supplement per physician's order if at high risk
 - iii. Offer fluids with each turn unless contraindicated
 - iv. Multi-vitamins per physician's order

D. PROCEDURE TREATMENT

- 1. **Stage 1, Stage 2, and Suspect Deep Tissue Injury**
 - a. **Apply silicone composite dressing ie: sacral dressing, heel dressing** ~~Border to Low moisture Stage 1 area. Write date, time, Initials, and Stage on the dressing prior to application.~~
 - b. **Reassess Stage 1, Stage2, or Suspect Deep Tissue Injury Area by peeling back silicone composite dressing ie: sacral dressing, heel** ~~Border~~ **dressing with assessments per standards of care.**
 - c. **For Pressure Ulcers in high moisture areas apply barrier paste and leave open to air**
 - d. **Position patients off area of Pressure Ulcer**
- 2. **Stage 3**
 - a. **Cleanse wound with normal saline.**
 - b. **Assess for tunnels, tracts, or undermining**
 - c. **Culture wound after cleansing if ordered**

- d. If clean and shallow, fill visible wound bed with calcium alginate
- e. If infected, cleanse, culture and fill cavity with silver impregnated calcium alginate (silver) vs (calcium alginate)
- f. If tracts, tunnels or undermining moisten kerlix roll with anasept gel and fill cavity, tracts, tunnels, or undermining with kerlix.
- g. Cover wound with ~~Borders~~silicone composite dressing
- h. Change daily and if dressing becomes saturated with drainage
3. Stage 4
 - a. Cleanse wound with normal saline
 - b. Assess for tunnels, tracts, or undermining and supporting structures: muscle, bone, tendon, or joint capsule
 - c. Culture wound after cleansing
 - d. If clean and shallow, fill visible wound bed with calcium alginate. If infected, cleanse, culture and fill cavity with silver impregnated calcium alginate (silver) vs (calcium alginate)
 - e. If tracts, tunnels, undermining, or non visible wound bed moisten kerlix roll with anasept gel and fill cavity, tracts, tunnels, or undermining with kerlix.
 - f. Cover wound with ~~Borders~~silicone composite dressing
 - g. Change every 12 hrs and if dressing becomes saturated with drainage
 - h. Order Dolphin air fluidized bed
4. Unstageable – unable to determine staging of pressure ulcer
 - a. Relieve excessive moisture, pressure and/or shear
 - b. Enter a referral to the WOCN via Cerner
 - c. If only necrotic tissue (eschar) is present, cover the wound with dry gauze dressing until specific orders are given, or consult is obtained from WOCN
 - d. For wound with a draining necrotic tissue (eschar/slough), follow Stage IV treatment options, silver or calcium alginate changing every 12 hrs and if dressing becomes saturated with drainage, until specific orders are given, or consult is obtained from WOCN
5. Skin Tear
 - a. Cleanse wound area gently with normal saline.
 - b. Approximate skin edges
 - c. Apply silcon contact layer
 - i. Change silcon contact layer every five days
 - d. Wrap area with kerlix and secure with tape. Avoid tape to skin.
 - i. Change kerlix every twenty-four (24) and as needed for saturation
 - e. If unable to use kerlix, apply silicone composite dressing~~Border~~
 - i. Change ~~Borders~~silicone composite dressing every twenty-four (24) and as needed saturation
6. Partial Thickness Wound
 - a. Cleanse wound area gently with normal saline.
 - b. Apply ~~Borders~~silicone composite dressing
 - i. Change dressing every three (3) days and prn saturation
 - c. If dressing does not adhere or requires replacement more than every three (3) days, consult wound team. May apply silicone composite Mepilex foam and kerlix until wound team consult obtained. Change silicone composite foamMepilex daily.
7. Full Thickness
 - a. Cleanse wound area gently with normal saline.
 - b. Apply silver to wound void
 - c. Apply ~~Borders~~silicone composite dressing
 - i. Change ~~Borders~~silicone composite dressing every three (3) days and as needed saturation
 - 1) Home Care patients change dressing every 3-5 days.
 - d. If wound appears infected, obtain order from physician to culture wound prior to silver application

8. **Medical Device Related Pressure Ulcer Preventions**
 - a. **Assess skin under medical device every shift when medical device is removable or adjustable**
 - b. **Choose the correct size of medical device(s) to fit the individual**
 - c. **Cushion and protect the skin with dressings in high risk area (i.e. nasal bridge)**
 - i. **Prophylactic silicone composite dressing application ie: sacral dressing, heel dressing to high risk area.**
 - 1) **Peel back every shift and assess skin**
 - a) **If skin is not intact consult WOCN**
 - 2) **Change silicone composite dressing every five (5) days and as needed if saturated**
 - d. **Avoid placement of device(s) over sites of prior or existing pressure ulceration**
 - e. **Ensure staff know the correct use of device(s) and prevention of skin breakdown**
 - f. **Be aware of edema under device(s) and potential for skin breakdown**
 - g. **Confirm that device(s) are not placed directly under an individual who is bedridden or immobile**

E. INCONTINENCE SKIN CARE

1. **Urinary**
 - a. **Preventive**
 - i. **Perform pericare daily and as necessary with each incontinent episode using incontinence cleanser followed by application of moisture barrier cream/ointment.**
 - ii. **Use of an absorptive wicking pad ~~brief/diaper~~ or containment device (i.e. external catheter) may be necessary.**
 - b. **Dermatitis/irritated red skin**
 - i. **Perform pericare daily and as necessary with each incontinent episode using incontinence cleanser followed by application of moisture barrier cream/ointment.**
 - ii. **Containment device may be indicated.**
 - iii. **Optimal to avoid use of absorptive brief/diaper.**
 - iv. **Consult WOCN if no positive response to treatment in forty-eight (48) to seventy-two (72) hours.**
 - c. **Fungal infection**
 - i. **Assess for presence of fungal infection. Signs and symptoms include erythema, maceration and satellite lesions; at times the infection presents as solid plaques of moist, red areas. The chief symptom is pruritus at the site.**
 - ii. **Apply anti-fungal product**
 - iii. **Containment device may be indicated.**
 - iv. **Optimal to avoid use of absorptive brief/diaper.**
 - v. **Consult WOCN if no positive response to treatment in forty-eight (48) to seventy-two (72) hours.**
2. **Fecal**
 - a. **Preventive**
 - i. **Perform pericare daily and as necessary with each incontinent episode using incontinence cleanser followed by application of moisture barrier cream/ointment.**
 - ii. **For frequent loose stooling and enzymatic drainage, use of a containment device (i.e. Dignicare Stool Management System / pouch) is indicated to protect skin [see PCS Stool Management (Rectal Tube) Dignicare Stool Management Procedure]**
 - b. **Denuded/Excoriated Skin**
 - i. **Perform pericare daily and as necessary with each incontinent episode using incontinence cleanser followed by application of moisture barrier cream/ointment every 1 – 2 hours.**

- ii. If skin is not broken, use of a containment device i.e. Dignicare Stool Management System / pouch) is indicated to protect skin [see PCS Stool Management (Rectal Tube) Dignicare Stool Management Procedure]
- iii. If skin is broken, apply thick layer of Barrier paste 1/8 inch thick. Reapply paste every 1 -2 hours and PRN stooling
- D.iv. Consult WOCN if no positive response to treatment in forty-eight (48) to seventy-two (72) hours.

1. ~~Treatment for Deep Tissue Injury (DTI)~~

- a. ~~Initiate wound nurse consult and notify physician~~
- b. ~~Off load area of suspected DTI and surrounding tissue~~
- c. ~~Apply non-sting skin prep barrier to affected area~~

2. ~~Stage I pressure ulcer – persistent redness~~

- a. ~~Avoid massaging over reddened area.~~
- b. ~~Gently clean the affected area.~~
- c. ~~Apply skin prep/barrier to affected area.~~
- d. ~~Off load area~~

3. ~~Stage II pressure ulcer or partial thickness wounds~~

- a. ~~Initiate wound nurse consult and notify physician.~~
- b. ~~Gently clean the affected area with normal saline.~~
- c. ~~If wound appears as a blister:~~
 - i. ~~Apply skin prep/barrier product to area surrounding affected area; allow to dry.~~
 - ii. ~~Apply transparent dressing to blister without tension or wrinkling.~~
 - iii. ~~Change dressing only if dislodged or blister fluid has been reabsorbed or if blister has broken and fluid is leaking out under dressing.~~
- d. ~~If wound appears as shallow crater:~~
 - i. ~~Swab peri-wound skin with skin barrier (ie. cavilon or skin prep)~~
 - ii. ~~Apply thin layer of hydrogel (ie. duoderm wound gel)~~
 - iii. ~~Cover with non-adherent dressing (ie. adaptive or telfa)~~
 - iv. ~~Wrap with gauze roll~~
 - v. ~~Change daily~~
 - vi. ~~If patient is incontinent:~~
 - 1) ~~Apply skin prep/barrier product to area surrounding affected area; allow to dry.~~
 - 2) ~~Photograph and measure wound before applying hydrocolloid dressing (ie. duoderm wafer) centering over wound.~~
 - 3) ~~Change dressing every 3 – 5 days or sooner if drainage leaks or dressing becomes dislodged.~~

- e. ~~Write date, time and initials on each dressing.~~
- f. ~~If difficulty with dressing staying in place, and/or wound is secondary to incontinence and pressure, or there is no improvement within 72 hours, obtain physician order to initiate Xenaderm ointment BID.~~
 - i. ~~Discontinue use if wound deteriorates to a full-thickness wound.~~

4. ~~Stage III/IV pressure ulcer or full thickness wounds~~

- a. ~~Initiate wound nurse consult and notify physician.~~
- b. ~~Gently clean the affected area with normal saline.~~
- c. ~~Apply skin prep/barrier product to area surrounding affected area; allow to dry.~~
- d. ~~If wound has minimal or no drainage:~~
 - i. ~~Place wound gel (hydrogel / silvasorb) to wound bed.~~
 - ii. ~~Cover with gauze dampened with normal saline ensuring that any dead space is packed lightly, including any sinus tracts or undermining.~~
 - iii. ~~Cover with dry gauze.~~
 - iv. ~~Secure dressing edges with tape appropriate to patient's clinical condition (consider paper tape or soft cloth tape).~~

- v. ~~Change dressing daily and PRN depending on amount of drainage or if dressing becomes dislodged.~~
- e. ~~If wound has moderate to large amount of drainage:~~
 - i. ~~Loosely pack wound, including any dead space, such as sinus tracts or undermining with calcium alginate.~~
 - ii. ~~Cover with foam to manage drainage.~~
 - iii. ~~Secure dressing edges with tape appropriate to patient's clinical condition (consider paper tape or Hypafix).~~
 - iv. ~~Change dressing daily and PRN depending on amount of drainage or if dressing becomes dislodged.~~
 - f. ~~Write date, time and initials on each dressing.~~
 - g. ~~Hydrogel ointment may be initiated for wound bed that is covered with slough and/or moderate amounts of necrotic tissue.~~
 - i. ~~Apply skin prep/barrier product to area surrounding affected area; allow to dry.~~
 - ii. ~~Apply thick layer of Hydrogel using gloved hand.~~
 - iii. ~~Cover with gauze dampened with normal saline.~~
 - iv. ~~Apply single layer of dry gauze and secure dressing edges with tape appropriate to patient's clinical condition (consider paper tape or soft cloth tape).~~
 - v. ~~Change dressing daily.~~
- 5. **Unstageable wound covered with hard, black eschar, without signs of infection (i.e. erythema, warmth, foul odor)**
 - a. ~~Initiate wound nurse consult and notify physician.~~
 - b. ~~Gently clean the affected area with normal saline.~~
 - c. ~~Apply skin prep/barrier product to area surrounding affected area; allow to dry.~~

E. Treatment of skin tears

- 1. ~~Skin tear with none to moderate drainage with no signs of infection~~
 - a. ~~Gently clean the affected area with normal saline.~~
 - b. ~~If skin flap remains, gently use gloved hand to approximate, apply steri-strips to secure edges in place.~~
 - c. ~~Swab intact peri-wound skin with skin barrier product (i.e. cavilon or skin prep).~~
 - d. ~~Cover with absorbent film dressing (i.e. tegaderm absorbent dressing)~~
 - e. ~~Write date, time and initials on each dressing.~~
 - f. ~~Change every 5 to 7 days or prn leakage. Change sooner if signs and symptoms of infection are noted.~~
 - g. ~~May use crinkled gauze (i.e. kerlix) with 5 x 9 dressings to pad and protect area from trauma~~
- 2. ~~Skin tear with moderate to large drainage with no signs of infection:~~
 - a. ~~Gently clean the affected area with normal saline.~~
 - b. ~~If skin flap remains, gently use gloved hand to approximate, apply steri-strips to secure edges in place.~~
 - c. ~~Cover with oil emulsion gauze (i.e. adaptive)~~
 - d. ~~Cover with foam and secure with roll gauze, taping gauze to itself. Do not tape gauze to skin.~~
 - e. ~~May use stretch net to secure dressing in place on extremity.~~
 - f. ~~Write date, time and initials on each dressing.~~
 - g. ~~Change daily or as needed.~~
- 3. ~~Skin tear with active signs and symptoms of infection, purulent drainage, peri-wound red streaks, and/or odor:~~
 - a. ~~Gently clean the affected area with normal saline.~~
 - b. ~~If skin flap remains, gently use gloved hand to approximate, apply steri-strips to secure edges in place.~~
 - c. ~~Apply silver wound gel (i.e. silvasorb)~~
 - d. ~~Cover with emulsion gauze (i.e. adaptive)~~

- e. ~~Cover with single layer of gauze or wrap with roll gauze, taping gauze to itself. Do not tape gauze to skin.~~
- i. ~~May use stretch net to secure dressing in place on extremities.~~
- f. ~~Write date, time and initials on each dressing.~~
- v. ~~Change daily or PRN.~~
- 3. **Consultation and referral to wound team**
 - g-a. **Consult when the condition necessitates:**
 - i. **Chronic pressure ulcer history longer than 2 weeks, hospital acquired pressure ulcer, any stage 3, stage 4, suspect deep tissue injury, or any full thickness wounds.**
- 4. **Pressure redistribution surface/Specialty bed selection**
 - a. **Assure the appropriate selection of pressure redistribution support surface. All mattresses require scheduled turning and positioning to prevent pressure ulcers.**
 - b. **Isoflex mattress are indicated for high risk patients, stage 1-4 and DTI**
 - c. **Air II Mattress (rental) are indicated for moisture related issues with pressure ulcers and high need of pressure re-distribution. Avoid linens and padding on bed.**
 - d. **Bari Air (rental) are indicated for patients greater than 350 pounds, low air loss**
 - e. **Dolphin Air Fluidized Mattress (rental) are indicated for patients with stage 3 and 4 pressure ulcers, paraplegic and quadriplegic patients spinal cord injury patients, and patients after a surgical flap pressure ulcer repair.**
- 5. **Education:**
 - a. **Educate family and patient on pressure ulcer prevention and treatment per hospital policies; Educational Handout -"How to Help Prevent and Manage Pressure Ulcers" and "It's Time To Take The Pressure Off!"**
- 6. **Call provider:**
 - a. **With discovery of a pressure ulcer**
 - b. **Immediately if the patient exhibit signs or symptoms of super infection related to pressure ulcer or the following symptoms in the wound present.**
 - c. **Wound appears to be deteriorating**
 - d. **Increased necrosis of tissue in or around the wound**
 - e. **Increased drainage or odor**
 - f. **Progressive or noted peri-wound erythema**
- 7. **Evaluate for possible referral to the TCMC Center for Wound Healing and Hyperbaric Medicine upon discharge.**

4.

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- 4. 3M Skin Health Program
- 5. www.npuap.org 2008.
- 6. www.ihl.org 2010.

G. FORMS/RELATED DOCUMENTS:

- 1. **Mattress Selection Guide (Bed Guide)**
- 2. **Pressure Ulcer Wound Dressing Selection (Includes Staging and Products)**
- ~~Product Guide~~
- 6. ~~Pictures~~

MATTRESS SELECTION GUIDE (Bed Guide)

	Braden 15-18 Mild Risk	Braden 13-14 Moderate Risk	Braden 10-12 High Risk	Braden 1-9 Severe Risk
No Pressure Ulcer	<ul style="list-style-type: none"> ➤ Iso flex ➤ If pain on Isoflex or moisture issues: Air 2 (Rental) 	<ul style="list-style-type: none"> ➤ Iso flex ➤ If pain on Isoflex or moisture issues: Air 2 (Rental) 	<ul style="list-style-type: none"> ➤ Iso flex ➤ If pain on Isoflex or moisture issues: Air 2 (Rental) 	<ul style="list-style-type: none"> ➤ Air 2 (Rental) *Moisture Issues *Pain on Isoflex *Cachectic
Pressure Ulcer Stage I More than 1 positioning option	<ul style="list-style-type: none"> ➤ Isoflex 	<ul style="list-style-type: none"> ➤ Isoflex 	<ul style="list-style-type: none"> ➤ Isoflex 	<ul style="list-style-type: none"> ➤ Air 2 (Rental)
Pressure Ulcer Stage II More than 1 positioning option	<ul style="list-style-type: none"> ➤ Isoflex ➤ Isoflex 	<ul style="list-style-type: none"> ➤ Isoflex ➤ Isoflex 	<ul style="list-style-type: none"> ➤ Isoflex ➤ Isoflex 	<ul style="list-style-type: none"> ➤ Air 2 (Rental) ➤ Air 2 (Get Auth)
Pressure Ulcer Stage III More than 1 positioning option	<ul style="list-style-type: none"> ➤ Isoflex ➤ Isoflex 	<ul style="list-style-type: none"> ➤ Isoflex ➤ Isoflex 	<ul style="list-style-type: none"> ➤ Isoflex ➤ Isoflex 	<ul style="list-style-type: none"> ➤ Air 2 (Rental) ➤ Air 2 (Rental)
Pressure Ulcer Stage IV	<ul style="list-style-type: none"> ➤ Air 2 (Rental) ➤ Air 2 (Rental) 	<ul style="list-style-type: none"> ➤ Air 2 (Rental) ➤ Air 2 (Rental) 	<ul style="list-style-type: none"> ➤ Air 2 (rental) ➤ Air 2 (Rental) 	<ul style="list-style-type: none"> ➤ Air 2 (Rental) ➤ Air 2 (Rental)
More than 1 positioning option Deep Tissue Injury	<ul style="list-style-type: none"> ➤ Dolphin (Get Auth) 	<ul style="list-style-type: none"> ➤ Dolphin (Rental) 	<ul style="list-style-type: none"> ➤ Dolphin (Rental) 	<ul style="list-style-type: none"> ➤ Dolphin (Rental)
Large Surface	<ul style="list-style-type: none"> ➤ Isoflex ➤ Air 2 (Get Auth) 	<ul style="list-style-type: none"> ➤ Isoflex ➤ Air 2 (Rental) 	<ul style="list-style-type: none"> ➤ Isoflex ➤ Air 2(Rental) 	<ul style="list-style-type: none"> ➤ Air 2 (Rental) ➤ Air 2 (Rental)
Unstable Only 1 positioning option Stage 2,3,4 Multiple Wounds Limited turning options Dx: Para or Quad	<ul style="list-style-type: none"> ➤ Isoflex ➤ Air 2(Rental) ➤ Dolphin (Rental) ➤ Dolphin (Rental) ➤ Dolphin (Rental) ➤ Dolphin (Rental) 	<ul style="list-style-type: none"> ➤ Isoflex ➤ Air 2(Rental) ➤ Dolphin (Rental) 	<ul style="list-style-type: none"> ➤ Isoflex ➤ Air 2 (Rental) ➤ Dolphin (Rental) 	<ul style="list-style-type: none"> ➤ Air 2 (Rental) ➤ Dolphin (Rental)

04/2015

* Air II beds, Dolphins, and Isoflex mattress all require patient turning and positioning at least q 1-2 hrs to prevent redness*

**To Prevent Pressure Ulcer Injury: Implement Braden Interventions ** Any patient that is a paraplegic or Quadriplegic requires a Dolphin Bed

B/Y/R	Pressure Ulcer Prevention†	Stage I	Stage II	Stage III	Stage IV	Suspected Deep Tissue Injury (sDTI)	Unstageable	Eschar on heels (Colors may vary)
Wound Appearance								
Important!	Ensure that all anatomic sites at risk are protected from pressure: offload by repositioning at intervals appropriate for the patient!							
Exudate Level	None	Low	Shallow	Shallow/Deep	None	Closed to Shallow	Closed	to Heavy
Depth	None	Low	Shallow	Shallow/Deep	None	Closed to Shallow	Closed	to Heavy
Treatment Objective	Protect	Protect	Protect, Absorb, and fill dead space	Protect, Absorb, and fill dead space	Protect	Protect	Protect/Absorb	Protect/Absorb
Suggested Products and Change Rates	For Braden 18 or less or if otherwise at high risk: Mepilex® Border Sacrum** or Mepilex® Border or Mepilex® for device related (up to 3 days/as needed) Peel Back Dressing Each Shift: Assess & Document Skin Condition	Cover choices: Mepilex® Border or Mepilex® Border Sacrum† (Up to 3 days / as needed)	Heavy to Moderate Exudate: Fill with: Calcium Alginate-Melgisorb® (Up to 3 days/as needed) Lower exudate: Mepilex® Border or Mepilex® Border Sacrum† (Up to 3 days / as needed) Infection Suspected: Fill with: Silver Calcium Alginate-Silvercel® (Up to 3 days/as needed)	Heavy to Moderate Exudate: Fill with: Calcium Alginate-Melgisorb® (Up to 3 days/as needed) Lower exudate: Mepilex® Border or Mepilex® Border Sacrum† (Up to 3 days / as needed) Infection Suspected: Fill with: Silver Calcium Alginate-Silvercel® (Up to 3 days/as needed)	Cover choices: Mepilex® Border or Mepilex® Border Sacrum† (Up to 3 days / as needed)	Cover choices: Mepilex® Border or Mepilex® Border Sacrum† (Up to 3 days / as needed)	Cover choices: Mepilex® Border or Mepilex® Border Sacrum† (Up to 3 days / as needed)	Cover choices: Mepilex® Border or Mepilex® Border Sacrum† (Up to 3 days / as needed) Paint with Betadine® apply dry gauze dressing
Notations	* Depending on Location: Use multilayered Mepilex® Border if possible. Choose product depending on location. ** Dressings with Safetac® technology DO NOT require use of skin barrier products.							
	Consult Wound Team							

CATEGORY/STAGE 11

UNSTAGEABLE

REFERENCES

Scar tissue in the periwound area
Rolled, contracted edges with or without undermining
Red [granulating or hyper-granulating] or pink
(non-granulating) wound tissue
Location in relationship to underlying structures

Scar tissue in the periwound area
Rolled, contracted edges with or without undermining
Red [granulating or hyper-granulating] or pink
(non-granulating) wound tissue
Location in relationship to underlying structures

UNSTAGEABLE¹

REFERENCES

CATEGORY/STAGE II

-

UNSTAGEABLE¹



REFERENCES

- Pressure illustrations courtesy of NPUAP.org



PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 12/01

SUBJECT: Spiritual Care of the Patient

REVISION DATE: 6/03, 1/04, 4/06, 8/08, 4/11

POLICY NUMBER: IV.N

Clinical Policies & Procedures Committee Approval: 02/4403/15

Nursing Executive Council Approval: 03/4403/15

Professional Affairs Committee Approval: 04/4404/15

Board of Directors Approval: 04/11

A. **POLICY:**

1. Healthcare providers may not impose their own values on patients, nor may they represent themselves as spiritual advisers, but may interact in a non-judgmental and supportive way as patients express their spiritual concerns.
2. When appropriate, healthcare providers advise the patient or family of spiritual services available (i.e., the hospital chaplain, other members of the religious community).
 - a. If the patient or family wishes, healthcare providers may call a member of the clergy to visit the patient or family.
3. The social worker and hospital chaplain may work together when responding to the emotional and spiritual needs of patients and families.
4. The primary service and activity of the chaplains is to meet with the patients, their families, and healthcare providers.
5. The Pastoral Care Department may be utilized at any time by patients, families, or staff. The chaplains are present in the hospital from 8:00am – 4:00 pm, Monday through Friday and may be reached through the operator. At all other times a chaplain is on-call for emergencies and may be contacted through the Administrative Supervisor.
6. The chaplaincy staff shall assist in arranging sacraments and religious rites for patients in accordance with the patient's denominational and religious traditions.
7. The professional staff shall facilitate support by the patient's/family's personal clergy if requested. All local clergy are welcomed and assisted in the Pastoral Care office.
8. Requests for Pastoral Care visitation and reception of the sacraments shall be documented in the medical record.
9. Pastoral counseling is available for patients, faculty, and staff by making a referral or appointment with one of the chaplains.
10. Trained Pastoral Care volunteers shall visit patients on a regular basis.
11. The chapel is available to all faiths for prayer and quiet time.

Administrative Policy Manual

ISSUE DATE: 04/93

SUBJECT: HOSPITAL RECORDS RETENTION

REVISION DATE: 6/02; 4/03; 6/06; 05/09; 08/12

POLICY NUMBER: 8610-237

Administrative Policies & Procedures Committee Approval:

06/1403/15

Professional Affairs Committee Approval:

07/1404/15

Board of Directors Approval:

09/12

A. **PURPOSE:**

1. To identify a hospital records retention schedule, which meets Tri-City Medical Center's **Healthcare District** needs and the requirements for regulatory standards.

B. **POLICY:**

1. Tri-City Medical Center **Healthcare District** may at its discretion, pursuant to this policy and applicable law, follow the California Hospital Association "Hospital Records Guide" recommended guidelines. The guide is not designed to serve as a substitute for legal counsel. If there are differences of opinion or where law is unclear, legal counsel should be consulted.
2. Each hospital department is required to establish its own internal hospital records retention policy, which should be appended to the Department's Policy Manual.

C. **REFERENCE:**

1. A CHA "Record Retention schedule" is available on the intranet.
2. **Board Policy #14-008 Records Retention and Destruction**

**PROCEDURE: INTRAFACILITY TRANSPORT OF THE NICU PATIENT**

Purpose: Establish a standard of care for transporting NICU patients to other departments within TCMC.

Equipment:

1. Transport isolette
2. Manual resuscitator bag with reservoir
3. Neopuff resuscitator
4. Pulse oximeter
5. Cardiac monitor
6. Full oxygen cylinder
7. Gas source in the area to which patient is being transported

Issue Date: 9/07

Revision Date: 6/09, 6/11, 8/12

A. PROCEDURE:

1. ~~NICU assistant nurse manager (ANM)~~ **Designated member of leadership team**, relief charge nurse or unit secretary will call the receiving department prior to transfer to insure department's readiness for patient.
2. NICU patients will be transported in transport isolette with a NICU nurse. Patients requiring mechanical ventilation will be accompanied by the NICU RN and RCP.
3. The interdisciplinary team (Physician, **licensed independent practitioner (LIP)-RN, RN, RCP**) will determine if the acuity warrants additional personnel such as the RCP or the Physician/**LIP**.
4. Confirm patient identity using two-identifier system. Refer to Patient Care Services "Identification, Patient" policy
5. The RN is responsible for:
 - a. Overseeing the transport.
 - b. Staying with the patient throughout the procedure.
 - c. Ongoing patient monitoring and safety.
 - d. Monitoring oxygen flow and oxygen saturation if not accompanied by a RCP.
 - e. Documentation in the patient's medical record.
6. The RCP is responsible for:
 - a. Attaching Neopuff resuscitator to the full oxygen cylinder.
 - b. Ensuring a mask is present.
 - c. Managing oxygen flow and oxygen saturation.
 - d. Maintaining airway security and patency.
 - e. Monitoring ventilator for correct connections and proper function.
 - f. Documentation in patient's medical record.
7. Family centered care: The parents are invited to accompany the patient on transport. If they are unable to attend, the Physician/**LIP** and NICU RN will update the parents about the patient's clinical status.

B. DOCUMENTATION:

1. The transport will be documented in the patient's medical record.
2. The RCP will document the ventilator check for intubated patients.

C. REFERENCES:

1. Riley, L. E., & Stark, A. R. (Eds.). (2012). *Guidelines for Perinatal Care 7th Edition*. American Academy of Pediatrics and The American College of Obstetricians and Gynecology.
2. ~~Altier, L., Brown, B., & Tedeschi, L. (2006). *Neonatal nursing policies, procedures, competencies, and clinical pathways, 4th ed.* Glenview, IL: National Association of Neonatal Nurses~~

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
1/15	1/15	n/a	3/15	4/15	6/9; 6/11; 6/12

3. **Ikuta, Linda M., and Sandra S. Beaman, eds. (2011). Policies, Procedures, and Competencies for Neonatal Nursing Care. Glenview, IL: National Association of Neonatal Nursing Care**

D. **APPROVAL PROCESS**

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

**PROCEDURE: NICU DISASTER PROCEDURE**

Purpose: Disasters in the NICU will be handled in a safe, orderly process.

Equipment:

- Color-coded Triage bands
- Evacuation Vest
- Evacuation Back packs

A. POLICY:

- Refer to hospital policy for additional information (Code Orange).
- All areas of the hospital have posted floor plans, which include fire exits, stairwells, alarm stations, and extinguishers. Every employee and volunteer working these areas should review the diagrams.
- If hospital evacuation becomes necessary, the order comes from the incident commander. ~~see policy 4004~~
- If an area of the NICU is in immediate danger the NICU **leadership team manager/ANM/NICU** charge nurse may initiate evacuation. ~~See policy 40004~~
- The persons in charge of carrying out the NICU evacuation are the attending neonatologist and the NICU **leadership team manager/ANM/NICU** charge nurse.
- Each infant ~~is~~ will be assigned a color-coded triage band for evacuation purposes.
- Triage bands for each infant will be identified daily by the charge nurse.
- A colored magnet delineating the correct color triage band will be placed by the infant's name on the assignment board.

B. PROCEDURE:

- The NICU **leadership team manager/ANM/NICU** /charge nurse:
 - Send a designated staff member to the incident command center.
 - The command center ~~will~~ designates a disaster leader who will be responsible for the triage and utilization of staff for evacuation of the infants.
 - Initiate the disaster call list
 - Consult with the neonatologist in charge to review the patients and determine the order of evacuation based on acuity. (~~See the TRAIN Guidelines below~~)

Triage by Resource Allocation for IN-patients [TRAIN]⁵

Transport	Blue	BLS	ALS	CCT	Specialized
Life Support	Stable	Stable	Minimal	Moderate	Maximal
Mobility	Stable	Wheelchair	Wheelchair or Stretcher	Transport Rig	Immobile
Nutrition	Stable	Enteral	Partial Parenteral	Complete TPN	NPO & TPN
Pharmacy	Stable	Stable	IV Fluids	IV Drip x1	IV Drip x2

Move table to related document

Life Support	Minimal =	Heed or Low Flow Cannula O2, chest tube, etc.
	Moderate =	CPAP/BiPAP/Hi-Flow, Conventional Ventilator, Peritoneal Dialysis, Externally paced, wt ≤ 3 kg, continuous nebulizer treatments, etc.
	Maximal =	Highly specialized equip., e.g., HFOV, ECMO, iNO, CVWH, Berlin Heart, wt ≤ 1.5 kg, etc.
Mobility	Car/Carseat =	able to ride in automobile with age-appropriate restraints
	Transporting =	age-appropriate rig with equipment for transferring to ambulance
	Immobile =	Unsafe to move without special equipment e.g., neurosurgical/bariatric

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
	if affect Medical Staff activities or patient care, if not n/a	n/a	if affect Medical Staff activities or patient care, if not n/a	4/15	

- d. **Facilitate Eevacuation** to the designated area will occur in the following order **per Triage by Resource Allocation for IN-patients (TRAIN)**:
- Blue bands - evacuate to designated area and discharge patients home as appropriate. If infant must be transported may be transported in a car seat.
 - Green bands - evacuate to designated area and transport to another facility as appropriate, via wheel chair or stretcher.
 - Yellow bands – evacuate to designated area and transfer to another facility via wheelchair or stretcher
 - Orange bands - evacuate to designated area and transfer to another facility via transport rig
 - Red bands – last to be evacuated to designated area and first to be transferred to another facility via transport rig. These infants may need specialized equipment for transport.
 - Teddy Bear** White bands-final evacuation from the NICU. Evacuated to the designated morgue area

Triage by Resource Allocation for IN-patients [TRAIN]^c

Transport	Car	BLS	ALS	CCT	Specialized
Life Support	None	Stable	Minimal	Moderate	Maximal
Mobility	Car	Stretcher	Stretcher	Stretcher	Stretcher
Nutrition	SLPs	Enteral	Continuous Enteral or Partial Parenteral	Complete TPN	NPO & TPN
Pharmacy	PO Meds	PO Meds	IV Fluids	IV Drip x1	IV Drip x2

Move table to related document

Life Support	Minimal =	Hood or Low Flow Cannula O2, chest tube, etc.
	Moderate =	CPAP/BiPAP/Hi-Flow, Conventional Ventilator, Peritoneal Dialysis, Externally paced, wt ≤ 3 kg, continuous nebulizer treatments, etc.
	Maximal =	Highly specialized equipt., e.g., HFOV, ECMO, iNO, CVVH, Berlin Heart, wt ≤ 1.5 kg, etc.
Mobility	Car/Carseat =	able to ride in automobile with age-appropriate restraints
	Transport rig =	age-appropriate rig with equipment for connecting to ambulance
	Immobile =	Unsafe to move without special equipment e.g., neurosurgical/bariatric

- e. Designate 2-ancillary staff to assist in taking emergency supplies to the evacuation site. ~~(once site is determined by the Incident Commander).~~
- f. Designate a nursing coordinator ~~(ideally the CNS)~~ for the evacuation site and instruct that person to go to the site with the first infants.
- The nursing coordinator will reevaluate infants once they have reached the evacuation site :
 - If infant condition changed during the evacuation the nursing coordinator will reband the infant at that time with the appropriate colored band.
 - If the infant condition is unchanged band originally place on the infant will remain in place
 -
- g. **Facilitate injured staff is to be being** evacuated with the first evacuated infants.
2. Attending Neonatologist:

- a. Collaborate with the NICU **leadership team**/manager/ANM/NICU charge nurse in triaging infants.
- b. Assign neonatologist coordinator to go to the evacuation site with the first infants if available.
- c. Assist with the evacuation of the sicker infants.
3. Unit Secretary:
 - a. Assist with communication and telephone calls under the direction of the NICU **leadership team**/manager/ANM/NICU charge nurse.
 - b. Bring patient census/assignment sheet and ensure patient's' medical charts are taken to the evacuation site when ordered to leave the NICU.
4. Support Staff:
 - a. Report to NICU **leadership team** /manager/ANM/NICU charge nurse to receive instructions for assisting with evacuation.
 - b. Attend to maintaining clear aisles for mobilization of equipment and supplies needed for evacuation.
5. Respiratory Care Department:
 - a. Organize oxygen and compressed air cylinders for the evacuation site and for shutting off the zone valves as the areas are evacuated.
 - b. Immediately shut off the compressed air and oxygen zone valves to the area in the event of a fire.
 - i. Patients requiring oxygen or mechanical ventilation must be switched to E-cylinder oxygen. ~~This must be done even if the fire appears small, until the situation has been evaluated by the Fire Department personnel and the area is declared safe.~~
6. Preparing infants for evacuation:
 - a. Ensure each infant has identification band on limb.
 - b. Assign triage band as appropriate and place on each infant.
 - c. Discontinue continuous nasogastric feeding, aspirate stomach and clamp tube.
 - d. Disconnect from all monitoring devices.
 - e. **If situation is critical, d**Disconnect all peripheral IVs, arterial, and percutaneous lines if ~~situation is critical~~. Attach syringes with flush solution. Ensure that all connections are secure to prevent infant from bleeding during evacuation.
 - f. Attempt to bring IV pumps to maintain/resume fluid delivery.
 - g. Disconnect chest tube drainage system from suction and place on Hemlich valve seal.
 - h. Take patient chart with patient.
 - i. Employ the evacuation vests and backpacks to evacuate infants if a vertical evacuation is ordered.
7. Utilize the evacuation routes designated in the hospital disaster plan to evacuate the NICU. Evacuation may be:
 - a. Horizontal – from one area to another on the same floor, infants may be transported on their warming tables, isolettes, and cribs.
 - b. Vertical – from one floor to another floor or outside of building, least sick infants may be transported using apron.
8. Evacuate patients in the following order:
 - a. Infants requiring 1:3 level of care (blue and green triage bands)
 - b. Infants requiring 1:2 level of care (yellow and orange triage bands)
 - c. Infants requiring 1:1 level of care (red triage bands)
9. For evacuation to another facility, transfer orange and red banded infants first **depending on availability of medical transportation..**
10. **Do not use elevators for evacuation unless authorized by on-the-scene Fire Department personnel.**
- ~~9. Remain at designated evacuation site and do not return to the evacuated area unless ordered to do so by the incident commander~~
- ~~10. Do not use elevators for evacuation unless authorized by on-the-scene Fire Department personnel.~~

11. Remain at designated evacuation site and do not return to the evacuated area unless ordered to do so by the incident commander.
12. Assess and stabilize infants as soon as evacuation site has been reached.
13. Make arrangements to transport to other NICUs as soon as possible.
14. Protect patient's medical records and move them to evacuation site. When possible, patients should have their medical record with them when moved to another location. If not, NICU **leadership team/manager/ANM/NICU charge nurse** is to delegate the unit secretary or another person to gather the charts and remove them to a safe area.
15. Reassure all patients and visitors that the emergency plan is in operation and not to be alarmed. Keep calm and follow directions.
16. Care of the NICU (power failure or medical gas failure)
 - a. Notify Bio Engineering, Respiratory Care Department, and the neonatologist at the first indication of problems with electrical power or medical gases.
 - b. Communication – Utilize walkie-talkies in the event in-house phone lines are down.
 - c. Lighting – Use flashlights located in the unit whenever power is out and visibility is impaired.
 - d. Ventilation:
 - i. Initiate hand ventilation by the RN or RCPD for all infants requiring mechanical ventilation in the event of power failure.
 - ii. RN will initiate and Respiratory Care will provide necessary back up.
 - e. Suction:
 - i. Use battery operated suction devices for ETT suctioning of intubated patients or use DeLee suction traps if wall suction is not operational.
 - ii. Maintain chest tube system to Heimlich valve.
 - iii. Thermoregulation – cover infant with blankets. If unable to maintain temperature, place infant on covered chemical mattress or cover infant with thermal blanket and plastic wrap.
 - f. Maintaining infusion:
 - i. Check pump power. If it is not working, locate another pump with a functional battery.
 - ii. Give slow IV pushes of appropriate IV fluids to maintain IV patency not to exceed the hourly IV rate if no battery-powered pumps are available.
 - iii. Advance continuous feedings manually.
 - g. Monitoring vital signs:
 - i. Use battery powered monitors and pulse oximeters for infants who require continuous monitoring.
 - ii. Assess respiratory status and heart rate with a stethoscope, assess infant's color.
 - h. Once power and/or gases are restored – ensure that patients are safely attached to support devices and that all equipment is functional.

C. **DOCUMENTATION:**

1. Complete patient assessment with a description of interventions used to maintain life support during disaster and/or power/gas failure.
2. Documentation **is completed** will be on paper.

D. **RELATED DOCUMENTS:**

2-1. **Triage by Resource Allocation for IN-patient (TRAIN)**

D.E. **REFERENCES:**

1. TCMC Disaster Manual
2. Cohen, R., Murphy, B., Ahern, T., & Hackel, A. (2010). Regional disaster planning for neonatology. *Journal of Perinatology*, 30:709-711.
3. Franck L., Epstein B., & Adams S. (1993). *Disaster preparedness for the ICU: Evolution and testing one unit's plan*. *Pediatric Nursing*, 19, 122-127.

4. Phillips, P, Niedergesaess, Y, Powers, R, Brandt, R. Disaster preparedness: Emergency Planning in the NICU. Neonatal Network. 2012;31(1) 5-15.
5. Prade K. (1998). Development of an NICU – Specific Disaster And Evacuation Plan – One Hospital's Experience. Neonatal Network, 17, 65-69.

**PROCEDURE: NICU PLACEMENT: OVERFLOW TO ALTERNATE LOCATION (TEMPORARY OVERFLOW)**

Purpose: To define the circumstances, criteria and process used when the Neonatal Intensive Care Unit (NICU) is at or near peak capacity and overflow bed space may be required outside the NICU.

Supportive Data: California Code of Regulations Title XXII, #70483 #70487 #70307; CCS Manual of Procedures Chapter 3.25.1/G.

Equipment: See Appendix A- **Equipment List for NICU Patients in Alternate Areas**

Issue Date: 9/10 **Revision Date:** 8/12

A. POLICY:

1. When NICU census nears peak capacity, Tri-City Medical Center management, in collaboration with NICU physician/**licensed independent practitioner (LIP)**-leaders, will evaluate options for placement of NICU patients in alternate locations where appropriate licensed beds are available.
2. Appropriate space, equipment and supplies for NICU patients will be provided as specified by the CCS Manual of Procedures pages 17-21.
3. Rooms will be appropriately supplied and equipped prior to moving patients.
4. NICU nursing ratios will be maintained and medical management procedures followed.
5. A minimum of 2 RNs will be present when NICU patients are placed in the assigned area.
6. NICU patients placed in the temporary location outside the NICU will remain under NICU medical and nursing care and supervision.
7. **A member of the NICU Leadership team** ~~NICU Assistant Nurse Manager (ANM)~~/Relief charge nurse, in collaboration with physician/**LIP** as needed, are responsible for the identification of patients who may be appropriate for alternate patient placement.
8. Eligibility criteria includes:
 - a. Levels 1-6 as described in Patient Classification in the NICU
 - b. No pending surgery procedure
 - c. Determination of the attending Physician/**LIP**
 - d. Infusing intravenous fluids via peripherally inserted venous (PIV) and peripherally inserted central catheters (PICC). Maximum in these criteria will not exceed 50% of the patient population.
9. Exclusion criteria
 - a. Oxygen delivery via nasal cannula, CPAP, hood or ventilatory device
 - b. Determination of the attending Physician/**LIP**.
10. Quality Assurance
 - a. NICU patients placed in the temporary location outside the NICU will receive the same standard of nursing and medical care as patients cared for in the NICU.
 - i. The NICU relief charge nurse will round hourly in the overflow area and be immediately available by cell phone.
 - ii. All equipment/supplies will be the same in the main NICU and the temporary location. The designated temporary location will meet Title XXII requirements for Newborn Intensive Care Nursery
 - iii. Random assessments will be performed by the NICU leadership- to assure the quality of the clinical medical and nursing care of the NICU patient placed in the temporary location outside the NICU

B. PROCEDURE:

1. When bed space in the NICU nears peak capacity, the NICU will begin the process of identifying appropriate locations for patient placement outside the NICU as follows:

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
1/15	1/15	n/a	3/15	4/15	8/12

- a. **A member of the NICU Leadership team** ~~The NICU ANM/Relief charge nurse will alert the NICU Nurse Manager of increasing census.~~
- b. The NICU Manager will alert the Director of Women's and **Newborn Children's Services** and the Director of Regulatory Compliance of the imminent need for the NICU to locate alternate bed space outside the NICU.
- c. Alternate location for NICU patient placement will be **in the designated NICU Overflow. Rooms N1, N2, and N3.**
- d. ~~The ANM/Relief charge nurse of the alternate areas will arrange for terminal cleaning of the rooms. and will notify the NICU ANM/Relief charge nurse when the rooms are available.~~
2. ~~The ANM/Relief charge nurse will identify patients to be moved in collaboration with the Physician/LIP as needed.~~
3. The following steps will be implemented to ensure a safe move into an environment that is consistent with NICU standards
 - a. ~~The NICU ANM/Relief charge nurse will ensure that the~~ **NICU Overflow is ready** ~~equipment listed in Appendix A is available and appropriately placed.~~
 - b. Pharmacy, Materials, and Respiratory Therapy will be notified of the move by **a member of the NICU leadership team** ~~the NICU ANM/Relief charge nurse.~~
 - c. ~~The NICU ANM/Relief charge nurse will notify the Unit Secretary of the patients to be moved and their destination.~~
 - d. An RN will move the first patient in its own bed to the prepared room to the assigned area and will reconfirm that the appropriate equipment is in place, plugged in, and functioning appropriately.
 - i. The NICU technician may be utilized to help move beds/equipment. An RN must accompany all NICU patients.
 - e. The RN will then ensure that the patient is connected to the appropriate monitors (cardio-respiratory and/or pulse oximeters) with the appropriate alarm limits set.
 - f. The RN will remain with the patient until appropriate transfer with handoff is made to the assigned RN.
 - g. Additional patients will be moved according to the procedure described above.
 - h. ~~The NICU ANM/Relief charge nurse in conjunction with the NICU staff~~ **Social Worker** ~~will notify families of the move as soon as possible.~~
4. When the NICU census is no longer near peak capacity, NICU patients will return to the NICU following the steps described in #3 a-h.
5. ~~Documentation of the patient relocation will be complete by the ANM/Relief charge nurse and the NICU Unit Secretary.~~

C. RELATED DOCUMENTS:

1. **Equipment List for NICU Patients in Alternate Area**

G.D. REFERENCES REFERNECES:

1. California Code of Regulation, Title 22: Social Security, Volume 28, Revised, November 29, 1996. Barclays Law Publishers, South San Francisco, CA.

D. APPROVAL PROCESS

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

Equipment List for NICU Patients in Alternate Areas ~~Appendix A~~

Equipment for NICU Patients in Alternate Areas outside the NICU

- Patient bed (bassinet, isolette or crib for each patient)
- Neonatal cardio-respiratory monitor for each occupied bed
- Patient scale
- Diaper scale
- Diaper receptacle with a cover, foot control and disposable liner
- Hamper with disposable liner for soiled linen
- Sharps disposal
- Oxygen/suction/air outlet each per patient station
- Suction equipment and resuscitation bags for all patients
- Flow meters
- Neonatal crash cart stocked and checked by NICU staff
- Medications for patients
- Locked medication drawers/cart
- NICU-appropriate supply cart w/ NICU supplies (IV start equipment, etc.)
- Linen
- Developmental positioning aids
- Diapers
- Formula
- Breast milk for patients
- Breast pumps and screens
- Refrigerator/freezer
- Thermometers
- Stethoscopes
- Evacuation vest
- Computer
- Lifescan devices
- Patient paperwork/charts/education files

**PROCEDURE: PERIPHERALLY INSERTED CENTRAL CATHETERS AND MIDLINE CATHETERS: DRESSING CHANGE, MAINTENANCE, AND REMOVAL OF**

Purpose: To provide guidelines for dressing change, maintenance, blood sampling from, and removal of peripherally inserted central catheters (PICC) and midline catheters (MLC) in neonates.

Equipment: See each section for required equipment

Issue date: 9/07 **Revision date(s):** 6/09, 11/09, 6/11, 8/12

A. PICC OR MLC DRESSING CHANGE:

1. **Policy:**
 - a. The PICC or MLC dressing only needs to be changed when it has become excessively soiled, damp or non-occlusive. Once any opening on the dressing exposes the site, sterility has been violated and the dressing must be replaced with a new occlusive dressing. Because the excess catheter is coiled and secured with transparent dressing, special attention must be given when removing the old dressing to avoid dislodging the catheter.
2. **Equipment:**
 - a. PICC dressing change kit
 - b. Cap (2)
 - c. Mask (2)
 - d. Non-sterile gloves
 - e. Sterile gloves
 - f. Sterile towels
 - g. Adhesive skin closure strips
 - h. Transparent dressings (2)
 - i. 2% chlorhexidine gluconate swabs

B. PROCEDURE:

1. Perform hand hygiene.
2. Don mask, cap, and non-sterile gloves. Assistant also dons mask, cap, and gloves.
3. Organize supplies utilizing dressing change kit as sterile field.
4. Position patient using developmentally supportive methods and immobilize the infant securely. Have a second person hold the infant, if necessary. Place the extremity with the PICC onto a sterile towel.
5. Remove the old transparent dressing carefully taking care not to dislodge or tear the catheter. Peel the edges from the periphery to the insertion site. You should have a finger over the insertion site (on top of the transparent dressing) at all times to prevent the catheter from dislodging.
6. Change to sterile gloves.
7. Remove the adhesive skin closures carefully. Use chlorhexidine gluconate swabs to clean the area and remove any blood, allowing it to air dry for 30 seconds. Wipe skin with saline or sterile water and let dry.
8. Assess site for presence of erythema, edema, tenderness and/or drainage; assess integrity of catheter.
9. Note measurement at insertion site
10. Apply dressing:
 - a. Secure catheter at insertion site with sterile adhesive skin closure strip (if not already done).

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/09; 11/09; 06/11; 8/12; 12/14	12/14	n/a	03/15	04/15	

- b. Coil the external catheter in small concentric circles (avoid kinks) and secure with a second sterile adhesive skin closure strip.
 - c. Cut sterile gauze to fit and place under hub to avoid skin irritation/breakdown. Secure hub with sterile adhesive skin closure strip.
 - d. Place transparent dressing over the insertion site, length of catheter and hub
11. Secure the exit site:
12. Apply sterile adhesive skin closure strip using chevron technique (v-shaped pattern) and secure to skin above transparent dressing. Document the dressing change on PICC line documentation sheet and in the patient's medical record.
13. If there is any question of PICC catheter movement with the dressing change notify the MD. AP and lateral chest x-rays may be necessary to confirm placement.

C. MAINTENANCE OF THE PICC OR MLC:

1. All mainline fluids infusing through a PICC should be heparinized.
 - a. On double lumen PICC lines, the medication port is infused with normal saline/1u Heparin/mL or TPN at minimum of 0.5 mL per hour.
 - b. PICC's placed to heparin lock will be flushed with 0.5 mL (10 units per mL) flush every 4 hrs using a pulsatile method. Excessive pressure should never be applied when manually flushing the catheter. Use of 1 mL and 3 mL syringes may cause excessive pressure; use of a 5 mL syringe or greater is required.
2. Assessment:
 - a. There is a daily assessment and documentation by the physician of necessity to continue using a PICC catheter.
 - b. Check that the fluid being administered through the line is appropriate for the tip location (up to 25% dextrose for central placement and up to 12.5% for a midline catheter).
 - c. Examine the dressing for adherence of occlusive, non-restrictive, transparent dressing and security of the catheter. Confirm that the hub is secure and that bending or twisting is not possible. All PICC dressings that become non-occlusive should be changed not reinforced.
 - d. Observe the extremity for redness, swelling, drainage, palpable cord, or blanching of the patient's hand or fingers.
 - e. Examine the tip location for signs of edema; for central placement, assess the chest and back, and for peripheral placement, assess the extremity or neck.
 - f. Assess the entire IV setup for security of connections.
 - g. Examine the internal lumen of the IV tubing closest to the patient for evidence of fungal growth (white fluffy material).
 - h. Confirm the rate of infusion or that a heparin lock is ordered.
3. Hourly site checks should be documented in the medical record and should include the following:
 - a. Description of site; any edema or circulatory compromise of the extremity.
 - b. Description of the area of tip location (chest or back with central placement, extremity or neck with peripheral placement).
 - c. Description of dressing and occlusiveness.
 - d. Infusion rate and product, if not heparin locked.
 - e. Clinical status of patient.
4. Reportable Conditions:
 - a. Leak in catheter or tubing
 - b. Breakage or accidental removal of catheter
 - c. Drainage, swelling, altered circulation, or redness at the insertion site, the extremity or the area of the tip location.
 - d. A red, palpable cord.
 - e. Signs of increasing respiratory distress
 - f. Pallor, faint heart sounds, bradycardia, or progressive hypotension
 - g. Signs of fungal growth in any portion of the catheter

D. PICC TUBING CHANGE:

1. Equipment:
 - a. Mask
 - b. Cap
 - c. Non-sterile gloves
 - d. Sterile gloves
 - e. IV tubing, filter, medication tubing (as needed)
 - f. Sterile gauze sponges
 - g. 1:1 heparinized normal saline
 - h. Transfer set
 - i. 5ml or 10ml syringes
2. Procedure:
 - a. Perform hand hygiene.
 - b. Don mask, cap, and non-sterile gloves.
 - c. Prime new IV tubing.
 - d. Change to sterile gloves.
 - e. Set up sterile field utilizing glove wrapper. Place gauze sponges, 2% chlorhexidine gluconate swabs and 10 ml syringe on field.
 - f. Using sterile technique, draw up 1:1 heparinized normal saline into syringe.
 - g. Use sterile gauze sponges to hold tubing.
 - h. Swab connection sites with 2% chlorhexidine gluconate using friction for 30 seconds, and then let dry for 30 seconds.
 - i. Disconnect old IV tubing.
 - j. Flush each lumen of PICC using a pulsatile method with 1 ml of 1:1 heparinized normal saline in a 5 ml or 10 ml syringe.
 - k. Connect new IV tubing keeping all connections sterile.
 - l. Ensure IV fluids are running at proper rate.
 - m. Place appropriate date-change stickers on IV tubing.
 - n. Document tubing change in the patient's medical record.

E. TO DRAW BLOOD CULTURE:

1. Procedure:
 - a. Perform hand hygiene.
 - b. Verify written order from physician to obtain blood culture.
 - c. Confirm patient identity using two-identifier system. Refer to Patient Care Services "Identification, Patient" (IV.A) policy.
 - d. Position patient using developmentally supportive methods and immobilize the patient securely.
 - e. Pause the infusion pump
 - f. Don sterile gloves and place a sterile 4x4 under the injection port and prep with chlorhexidine gluconate swabs using vigorous friction prior to each entry. (The inside sleeve of the sterile glove package can also be used to create a sterile field).
 - g. Flush with at least 0.5 mL of normal saline.
 - h. Using a 3mL syringe, withdraw one mL to obtain specimen. This will culture the entire system, not just the blood.
 - i. Put specimen in blood culture bottle.
 - j. Using a 5mL or 10mL syringe, flush the catheter well using a pulsatile method with 1:1 heparinized normal saline using at least twice the volume of the catheter and extension set (approximately 1 mL).
 - k. Resume infusion.
 - l. Perform hand hygiene.
 - m. Document in patient's medical record.

F. **ROUTINES OF CARE:**

1. The following routines of care may only be deviated from with a written physician's order.
 - a. The PICC or MLC (midline catheter) may be used for administering medications following aseptic procedure, with the exception of phenytoin sodium (Dilantin™).
 - b. Blood products should not be infused through a PICC or MLC without a written order.
 - c. PICC or MLC caps are changed only when it is necessary to remove the cap in order to obtain a blood culture from the line.
 - d. Never use a 1 mL syringe for IV push with a PICC or MLC. The pressure generated by a 1 mL syringe is excessive and may rupture the catheter.
 - e. Connect all lines with Luer-locking devices to prevent accidental disconnection.
 - f. Check all infusates for precipitates to reduce the risk of occlusion.

G. **SUSPECTED OCCLUSION:**

1. Examine the entire length of the IV and tubing for kinking, patency, or occlusion in isolette doors or other bedside equipment.
2. Consider other causes:
 - a. A kink of the catheter under the dressing.
 - b. A leak in the catheter
 - c. Blood backing up.
 - d. Precipitate of infusate.
 - e. Fungal occlusion.
3. With unexplained occlusions requiring removal of the catheter, send the catheter tip for culture per physician's order.
4. Observe for leaks by checking the dressing for dampness or drainage of blood or IV fluid.
5. Clear a blood occlusion by infusing heparinized saline directly into the catheter with a 5 mL or larger syringe.

H. **REMOVAL OF A PICC:**

1. Equipment:
 - a. Cap
 - b. Mask
 - c. Non-sterile gloves
 - d. Sterile gloves
 - e. 2% chlorhexidine gluconate swabs
 - f. Sterile gauze
 - g. Hemostat
2. Procedure:
 - a. Perform hand hygiene.
 - b. Verify written order from physician to remove PICC.
 - c. Confirm patient identity using two-identifier system. Refer to Patient Care Services "Identification, Patient" (IV.A) policy
 - d. Position patient using developmentally supportive methods and immobilize the patient securely.
 - e. Put on cap, mask, and non-sterile gloves.
 - f. Remove transparent dressing by peeling the edges from the periphery to the insertion site.
 - g. Put on sterile gloves and use the glove wrapper as a sterile field.
 - h. While applying chlorhexidine gluconate swabs apply gentle traction on the catheter and remove it.
 - i. If the catheter becomes stuck, apply a warm compress for 30 minutes and then firmly massage the catheter along the vein track and attempt to remove the catheter. Notify the attending physician if still having difficulty removing the catheter.
 - j. If the catheter is severed during removal, use a hemostat to grasp any visible catheter to prevent loss. Immediately apply a tourniquet to the extremity and check the patient's

circulation frequently. Notify the attending physician and obtain an order for an x-ray of the appropriate body part to determine where the severed portion of the catheter is located.

- k. Refer to the PICC insertion documentation for the measurement of total catheter length and measure the length of catheter removed.
- l. Apply pressure with sterile gauze to control any bleeding.
- m. Once bleeding has stopped, clean the area with chlorhexidine gluconate swabs and allow to air dry for 30 seconds. It is then removed with saline wipes.
- n. Document the removal of the PICC line in the patient's medical record.

I. **REFERENCES:**

- 1. Marino, C., Aslam, M. Kamath, V., Rosenberg, H.K., Rajegowda, B.K. (2006). Life threatening complication of peripherally inserted catheter (PICC) in a newborn. *Neonatal Intensive Care*, 19(2), 63-65.
- 2. Nobuhara, K.K., Gilbert, J.C., & MacDonald, M.G. (2002). General principles of central venous (3rd Ed., pp 195-213). Philadelphia: Lippincott, Williams & Wilkins.
- 3. Pettit, J. (2002). Assessment of infants with peripherally inserted catheters: Part I. Detecting the most frequently occurring complications. *Advances in Neonatal Care*, 2, 304-315.
- 4. Pettit, J. (2003a). Assessment of infants with peripherally inserted catheters: Part II. Detecting less frequently occurring complications. *Advances in Neonatal Care*, 3, 14-26.
- 5. Pettit, J. (2003b). Assessment of the infant with a peripherally inserted device. *Advances in Neonatal Care*, 3, 230-240.
- 6. Pettit, J. & Wyckoff, M. (2007). *Peripherally inserted central catheters: Guidelines for practice*. Glenview, IL: National Association of Neonatal Nurses.
- 7. CPQCC quality improvement toolkit, hospital-acquired infection prevention.
- 8. Mosby's Nursing skills 2014

J. **APPROVAL PROCESS:**

- 1. ~~Clinical Policies & Procedures Committee~~
- 2. ~~Nurse Executive Council~~
- 3. ~~Medical Executive Committee~~
- 4. ~~Professional Affairs Committee~~
- 5. ~~Board of Directors~~
- 9.



PULMONARY SERVICES

SUBJECT: RCP Staffing Guidelines in the NICU

ISSUE DATE: 8/06

REVISION DATE(S): 12/08, 6/11, 10/14

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):	4/15
Board of Directors Approval Date(s):	1/10, 5/12

A. DEFINITION(S):

1. ~~Respiratory Care Practitioner RCP~~
2. ~~Neonatal Intensive Care Unit NICU~~
3. ~~Neonatal Resuscitation Program NRP~~
4. ~~California Children's Services CCS~~

B.A. POLICY: ~~NICU staffing Guidelines for RCPs are as follows:~~

1. To be qualified to work as a **Respiratory Care Practitioner (RCP)** in the **Neonatal Intensive Care Unit (NICU)**, the RCP must be licensed by the state of California and have evidence of current successful Neonatal Resuscitation program (NRP) certification. Also, these RCP's must have completed additional education requirements as demonstrated by the following: 1) Completion of a formal neonatal respiratory therapy course at an approved school of respiratory therapy that includes didactic and clinical course work; or 2) Completion of a minimum of 20 hours of didactic and four weeks of precepted neonatal clinical experience in a hospital-based course at a facility with a NICU equivalent to a Community or Regional NICU
2. One RCP qualified to work in NICU will be assigned to cover that area every shift, 7 days/week.
3. If there is a neonate on ventilator support, one qualified RCP will be dedicated entirely to the NICU. That is, they will be immediately available to the NICU at all times.
4. If the NICU respiratory patient workload increases (based on acuity of patients or numbers of patients in the NICU) to the point where additional Respiratory staff are needed, the NICU RCP will notify the Lead RCP and/or the Pulmonary manager to obtain the extra staff. The need for additional staff will be determined by the NICU RCP in consultation with the neonatologist, as appropriate. The Lead RCP will reassign other qualified RCPs (those that have a NRP card) to the NICU and/or call in additional staff as needed.

D. REFERENCES:

1. **California Children's Services (CCS)** Policy and Procedure requirements for a Community NICU. California Children's Services Manual of Procedures, 1999.



WOMEN AND NEWBORN SERVICES POLICY MANUAL (WNS)

SUBJECT: INFANT SAFETY AND SECURITY

ISSUE DATE: 9/91

REVISION DATE(S): 10/91, 8/94, 9/00, 6/03, 8/09, 06/13

Department Approval Date(s):	01/15
Department of OB/GYN Approval Date(s):	n/a
Department of Pediatrics 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):	06/1304/15
Board of Directors Approval Date(s):	06/13

A. PURPOSEPOLICY:

1. To protect infants from removal by unauthorized persons.
2. Refer to Patient Care Services procedure: "Infant Identification. Follow the procedure regarding banding of infants and mothers.
3. Procedures which address the safety and security of infants will be followed by all staff working at Tri-City Medical Center (TCMC).
4. To ensure that when the infant is removed from nursery and then released to:
 - a. Banded birth mother or birth father/significant other or the intended legal parent(s)
 - b. Identification band numbers must be presented to nursery staff
 - c. The number given must match the number on the infant's identification band before the infant is released.
 - d. If there is any question about the number given, hospital staff shall accompany baby to the mother's room and confirm identification band numbers at that time.
5. To ensure newborn infant is only removed from mother's care (hospital room) by authorized ~~Women's and Children's Services~~**Women and Newborn Services' (WCSWNS)** staff, ~~WCSWNS~~ staff will wear TCMC photo identification badges with distinctive TCMC ~~Women's and Children's Services~~**Women and Newborn Services'** logo.
 - a. Mothers will be instructed upon admission regarding the method of identifying ~~WCSWNS~~ photo ID badges.
 - b. Staff without women's and children's photo ID badges, (i.e., floats, students, outside registry) will wear temporary name tags that shall be distributed by the employee health staff and/or shift supervisor/designee
 - i. Temporary name badge shall include staff name, shift, date and the distinctive ~~WCSWNS~~ logo.
 - ii. These name tags will be collected by the shift supervisor/designee at the end of the shift and destroyed.
6. Mothers will be instructed to release their infant only to ~~WCSWNS~~ staff wearing this identification. This instruction will be discussed initially in OB education classes, and then reviewed and reinforced upon admission to the ~~WCSWNS~~ unit through direct instruction and information sheets.
7. Newborn infants will be transferred **outside the department** through halls only in bassinets, attended by two ~~WCSWNS~~ staff members.
 - a. Anyone carrying an infant in arms in hallways will be questioned.
 - b. This information shall be explained by the registered nurse verbally and on preprinted information sheets upon admission to Labor and Delivery and again when transferred to the Mother-Baby unit after delivery.

8. To insure the safety of the mother-baby couplet, all visitors shall be closely monitored by the ~~WCSWNS~~ staff and volunteers.
 - a. **An occupied stroller is allowed on Women and Newborn Services, but not in the NICU area.**
 - a-b. Car seats and ~~infant strollers~~ are not permitted in the following areas **unless bringing a car seat in for a car seat challenge:**
 - i. Labor and delivery
 - ii. Newborn nursery
 - 1) Receiving nursery
 - iii. Postpartum
 - b-c. Car seats may be allowed at the time and date of discharge or in the specified areas for pre-scheduled car seat challenge tests, newborn hearing screening or lactation consultation appointments.
9. ~~WCSWNS~~ staff education will include the following:
 - a. Upon hire and updated yearly, staff shall be instructed in the above policy.
 - b. Staff shall be monitored for compliance by the shift ~~supervisor~~ **Assistant Nurse Manager**/or designee on each shift.
 - c. Instructions shall include creating an awareness of the risk of infant abduction and what to look for when observing activity on the unit, i.e., individuals loitering, persons in uniform without appropriate identification badges.
 - d. Instruction shall include appropriate action(s) to take when discrepancies in practice or questionable individuals are observed on the unit.
 - e. A risk assessment shall be conducted annually by the environment of care officer and submitted to EOC committee. Individual staff members will be counseled for noncompliance during assessment periods.
10. Infant abduction:
 - a. In the event of a suspected infant abduction, the attending staff nurse will immediately:
 - i. Call "Code Adam" by dialing 66- (~~Ssee~~ **Patient Care Services Code Adam Policy** ~~TCMC Administrative Policy #369~~).

B. RELATED DOCUMENTS:

- ~~i-1.~~ **1. Patient Care Services Code Adam Policy**

☐ Inpatient ☐ Outpatient

Cycle# _____

DIAGNOSIS/REGIMEN/MNEMONIC: _____

ALLERGIES: _____

CURRENT Height. _____ (in) _____ (cm) Weight. _____ (kg) _____ (lbs) BSA _____ (M²) CrCl _____

Cumulative Dose (If Applicable) _____

CHEMOTHERAPY AGENTS

Note: Diluent/Volume/and Rate of Administration per Standard of Practice unless otherwise stated in Chemo Instructions

Start Chemo Date:	Agent	Mg/M ² dose	Mg dose	Route of Administration	Frequency (continuous, every _ hrs, day 1,3,5, etc.)	Duration (X_days, X_doses)
				<input type="checkbox"/> Infusion <input type="checkbox"/> Sub Q <input type="checkbox"/> IVPB <input type="checkbox"/> PO <input type="checkbox"/> Intrathecal <input type="checkbox"/> IVP <input type="checkbox"/> Intraperitoneal (IP)		
				<input type="checkbox"/> Infusion <input type="checkbox"/> Sub Q <input type="checkbox"/> IVPB <input type="checkbox"/> PO <input type="checkbox"/> Intrathecal <input type="checkbox"/> IVP <input type="checkbox"/> Intraperitoneal (IP)		
				<input type="checkbox"/> Infusion <input type="checkbox"/> Sub Q <input type="checkbox"/> IVPB <input type="checkbox"/> PO <input type="checkbox"/> Intrathecal <input type="checkbox"/> IVP <input type="checkbox"/> Intraperitoneal (IP)		
				<input type="checkbox"/> Infusion <input type="checkbox"/> Sub Q <input type="checkbox"/> IVPB <input type="checkbox"/> PO <input type="checkbox"/> Intrathecal <input type="checkbox"/> IVP <input type="checkbox"/> Intraperitoneal (IP)		
				<input type="checkbox"/> Infusion <input type="checkbox"/> Sub Q <input type="checkbox"/> IVPB <input type="checkbox"/> PO <input type="checkbox"/> Intrathecal <input type="checkbox"/> IVP <input type="checkbox"/> Intraperitoneal (IP)		

Chemo Instructions or reasons for dose modifications: _____

Pre-medications: _____

Hydration: _____

Anti-emetics: _____

Lab/Diagnostic Test(s): _____

☐ Notify MD with Lab/Diagnostic test(s) prior to chemo administration

☐ Access Mediport

☐ Place PICC Line

☐ Heparinize Mediport PRN

☐ Infuse via Periph IV

Nurse's – Signature

Date Time

Physician's – Signature

Date Time



Tri-City Medical Center

4002 Vista Way • Oceanside • CA • 92056

8711-4010



CHEMOTHERAPY ORDERS

Page 1 of 1

PHYSICIAN'S ORDERS

Affix Patient Label

ALLERGIES: _____**MEDICATIONS:** To be infused IV at direction of anesthesiologist

- ☐ Dexmedetomidine 200 mcg in NS 50 ml
- ☐ Dexmedetomidine 400 mcg in NS 100 ml
- ☐ Diltiazem 125 mg in NS 125 ml
- ☐ Dobutamine 500 mg in D5W 250 ml
- ☐ Epinephrine 4 mg in NS 250 ml
- ☐ Esmolol 2.5 gm in NS 250 ml
- ☐ Insulin 100 units in NS 100 ml
- ☐ Lidocaine 2 gm in D5W 500 ml
- ☐ Milrinone 20 mg in D5W 100 ml
- ☐ Nicardipine 25 mg in NS ~~250ml~~ **200ml**
- ☐ Nitroprusside 50 mg in D5W 250 ml
- ☐ Norepinephrine 4 mg in NS 250 ml
- ☐ Norepinephrine 8 mg in NS 250 ml
- ☐ Phenylephrine 50 mg in NS 250 ml
- ☐ Phenylephrine 100 mg in NS 250 ml
- ☐ Vasopressin 100 units in D5W 100 ml

☐ Other: _____☐ Other: _____☐ Other: _____☐ Other: _____☐ Other: _____

Nurse's – Initials

**Tri-City Medical Center**

1002 Vista Way • Oceanside • CA • 92056

8711-4010

**Intraoperative Anesthesia
Medication Orders**

Physician's – Signature

Date

Time

Affix Patient Label

PROCEDURE: _____

DIAGNOSIS: _____

ALLERGIES: _____

STATUS: ☐ INPATIENT ☒ ~~OBSERVATION~~

ADMIT TO: ☐ NICU

CODE STATUS: ☐ Full

☒ ~~No Resuscitation for hospital duration*~~

~~*Requires notation in Progress Notes.~~

MEDICATIONS:

- ☐ Give cyclomydril 1% ophthalmic drops 1 drop both eyes at _____
- ☐ Repeat in ~~5~~**10** minutes at _____
- ☐ Repeat again in ~~5~~**10** minutes at _____

☐ Read Back all T.O./V.O.orders

Nurse's – Signature

Date Time



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8711-4010



**NICU: PRE-EYE EXAM
MEDICATION ORDERS**

Page 1 of 1

Physician's – Signature

Date

Time

Affix Patient Label

Governance & Legislative Committee Meeting Minutes
Tri-City Healthcare District
April 7, 2015

Members Present:	Larry Schallock, Chairperson; Director RoseMarie V. Reno; Blake Kern, Community Member; Eric Burch, Committee Community Member; Dr. Henry Showah, Physician Member		
Non-Voting Members:	Greta Proctor, General Counsel; Kapua Conley, COO		
Others Present:	Teri Donnellan, Executive Assistant; Sharon Schultz, CNE, Jane Dunmeyer, Community Member		
Absent:	Director Ramona Finnila; Al Memmolo, Community Member; Dr. Paul Slowik, Committee Community Member; Dr. Marcus Contardo, Physician Member; Tim Moran, CEO		
	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	<p>The meeting was called to order at 12:30 p.m. in Assembly Room 3 at Tri-City Medical Center by Director Schallock, Committee Chairman.</p> <p>Chairman Schallock noted Committee members Director Ramona Finnila, Al Memmolo and Dr. Paul Slowik are unable to attend today's meeting.</p> <p>Chairman Schallock introduced Mr. Kapua Conley, COO who joined the organization on April 1st. Mr. Conley spoke regarding his background and experience.</p> <p>Chairman Schallock also introduced Ms. Pamela Alm, Senior Administrative Assistant to Mr. Conley who recently relocated to the area from Seattle, Washington.</p>		
2. Approval of Agenda	It was moved by Dr. Showah to approve today's agenda as presented. Director Reno 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	It was moved by Mrs. Blake Kern and seconded by	Minutes ratified.	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible
DRAFT			
Minutes	<p>Mr. Eric Burch to ratify the minutes of the March 3, 2015 Governance & Legislative Committee. The minutes were approved unanimously.</p>		
<p>5. Old Business</p> <p>a. Medical Staff Policies & Procedures</p> <p>1. #8610-519 – Suspension for Delinquent Medical Records</p>	<p>In follow-up to a previous meeting, Ms. Schultz explained Medical Staff Policy #8610-519 Suspension for Delinquent Medical Records has been revised to reflect clear and concise verbiage with regard to steps taken for delinquent medical records. Ms. Schultz clarified in section B. 11. the Chief of Staff may authorize additional time to complete the records due to a physician's illness or vacation. Ms. Schultz also explained Section C. has been revised to read "Medical Staff Suspension Monitoring" to accurately reflect the process.</p>	See recommendation in #2 below.	Ms. Donnellan
<p>2. #8710-513 – Supervision of Residents/Fellows/Medical Students</p>	<p>In follow-up to last month's meeting, Ms. Schultz stated section B. 3. a) and b) of Policy 8710-513 were revised to remove the advertisement language for Sports Medicine. It was also suggested the parenthesis be removed from the words "w/supervision" in section B. 1. c. v. and the letter "f" be removed from Section E. 2. following the word "annually".</p> <p>Discussion was held regarding the format of Section C. Rotation Description. Dr. Showah explained that the policy was drafted in this way to reflect the various expectations of each rotation.</p> <p>It was moved by Director Reno to recommend approval of Medical Staff Policy 8610-519 Suspension for Delinquent Medical Records and 8710-513 Supervision of Residents/Fellows/Medical Students as presented and amended as described. Dr. Henry Showah seconded the motion. The motion passed unanimously.</p>	<p>Recommendation to be sent to the Board of Directors to approve Medical Staff Policy 8610-519 Suspension for Delinquent Medical Records and 8710-513 Supervision of Residents/Fellows/Medical Students as presented and amended as described; items to appear on next Board agenda and included in Board Agenda packet.</p>	Ms. Donnellan
b. Rules & Regulations	In follow-up to last month's meeting, Mr. Schultz brought	Formatting and grammatical revisions	Ms. Schultz
Governance & Legislative Committee Meeting	-2-	April 7, 2015	

Topic	Discussion	Action Follow-up	Person(s) Responsible
1. Division of General & Vascular Surgery	forward the complete Division of General and Vascular Surgery Rules and Regulations which reflects not only the requested revisions but the entire set of Rules and Regulations. Ms. Schultz stated that in the interest of time this document was brought forward to the Board at the March meeting for approval and is here today for information. Committee members suggested further formatting and grammatical revisions. Ms. Schultz agreed to make formatting and grammatical revisions as needed, however, the content of the policy remains unchanged and was approved by the Board of Directors at their March meeting.	will be made as needed whereupon document will be considered in final form.	DRAFT
6. New Business a. Medical Staff Policies & Procedures 1. 8610-518 – Medical Record Documentation	<p>Ms. Sharon Schultz reported Medical Staff Policy #8610-518 - Medical Record Documentation was reviewed in conjunction with #8610-519 – Suspension for Delinquent Medical Records by Administration, General Counsel and the Medical Staff. Ms. Schultz clarified for Committee members the term "Do Not Use Abbreviations". Mr. Burch questioned if it would be beneficial to have the policy in more generic terms rather than reference a specific system, i.e. Cerner. Ms. Schultz confirmed Cerner will be the system in place for the foreseeable future. Discussion was also held regarding our Medication Reconciliation process. Ms. Schultz explained the Discharge Planner places a follow-up phone call to the patient within 24 hours following discharge to ensure patient understands his/her medications and post hospital care plan. In addition, Nurse Managers provide patients with their business card so that patients may call with follow-up questions upon returning home if needed. Ms. Schultz concurred the patient's understanding of their medications is often times questionable. She stated we are transitioning to 8x10 discharge folders to assist patients in keeping their discharge instructions organized and accessible. Committee members requested a second look at grammar and punctuation prior to moving the policy forward.</p> <p>It was moved by Director Reno to recommend</p>	<p>Recommendation to be sent to the Board of Directors to approve Medical Staff Policy 8610-518 Medical Record Documentation following a clean-up of grammar/punctuation; item to appear on next Board agenda and included in Board Agenda packet.</p>	
Governance & Legislative Committee Meeting			

Topic	Discussion	Action Follow-up	Person(s) Responsible
DRAFT			
	<p>approval of Medical Staff Policy 8610-518 – Medical Record Documentation following final review of grammar/punctuation by Administration. Dr. Showah seconded the motion. The motion passed unanimously.</p> <p>Ms. Sharon Schultz exited the meeting at 1:00 p.m.</p>		
7. Discussion regarding Current Legislation	<p>Chairman Schallock reported AB579 authorizes a closing general acute care hospital's emergency department to continue providing services under the license of another general acute care hospital if located within 15 miles of the Emergency Department and all federal and state requirements are met. Chairman Schallock stated this bill is of interest due to the closure of the hospital in San Clemente and the need to provide emergency care services for that patient population. Mr. Conley stated this is not a new model and creates a safety net for the community. He further explained that there are different regulations for an Emergency Department vs. an Urgent Care Center.</p> <p>Chairman Schallock also reported on SB483 which requires a general acute care hospital that provides observation services, as defined, to apply for approval from the State Department of Public Health to provide these services as supplemental services and limits the amount of observation time to a maximum of 24 hours. Chairman Schallock stated that CHA does not want hospitals to support this bill as it does not follow the federal guidelines.</p> <p>Mr. Conley explained the term "observation" is a status rather than a diagnosis. Dr. Henry Showah explained the Emergency Department has a culture of thoroughly working patients upfront and this culminates into a more accurate diagnosis.</p>	Information only.	
8 Review of FY2015 Committee Work Plan	The FY2015 Committee Work Plan was included in today's meeting packet for reference.	Information only.	

Topic	Discussion	Action Follow-up	Person(s) Responsible
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DRAFT

	<p>Director Reno noted the importance of informing the public of our Strategic Plan at the appropriate time.</p> <p>Director Reno questioned the timing of the Board's self-assessment. Chairman Schallock responded that the Board will perform their self-assessment in the fall on non-election years and will be scheduled as a Special Meeting for that specific purpose.</p>		
9. Committee Communications	Director Reno welcomed Mr. Conley to Tri-City.	None	
10. Community Openings – None			
11. Confirm date and time of next meeting	The committee's next meeting is scheduled for Tuesday, May 12, 2015, at 10:00 a.m. due to attendance by Board members at various legislative events.	Committee will meet on May 12, 2015 at 10:00 a.m.	
12. Adjournment	Chairman Schallock adjourned the meeting at 1:24 p.m.		



Medical Staff Office
Tri-City Medical Center

4002 Vista Way, Oceanside, CA 92056-4506 • (760) 940-3001

TO: Governance Committee of the Board of Directors
Larry Schallock, Chairperson

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

DATE: April 30, 2015

SUBJECT: Medical Executive Committee Recommendations

The following documents were reviewed and approved by the Governance Committee on April 7, 2015. These documents are forwarded to the Board of Directors with recommendations for approval.

Medical Staff Policies:

1. Medical Record Documentation , 8710-518
2. Supervision of Residents/Fellows/Medical Students, 8710-513
3. Suspension for Delinquent Medical Records, 8710-519

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

SUBMITTED BY:

Scott Worman, M.D., Chief of Staff

Date

GOVERNING BOARD DISPOSITION:

Approved: ☐

Denied: ☐

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

Date





MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 7/01

SUBJECT: Medical Record Documentation
Requirements

REVISION DATE: 7/07, 3/08, 9/08, 6/09, 9/09
11/09; 7/11; 05/12; 08/12, 2/15

POLICY NUMBER: 8710-518

Medical Executive Committee Approval:

09/12

Governance Committee Approval:

03/15

Board of Directors Approval:

08/11, 06/12; 09/12

A. **PURPOSE:**

1. To establish the policy, procedure, and responsibilities for the completion of medical records.

B. **POLICY:**

1. It is the policy of Tri-City Medical Center that all medical records are current, authenticated, legible, and complete.
2. The intent does not support delay of care or rendering of services to the patient.

C. **RESPONSIBILITIES:**

1. General responsibilities are delegated as indicated in the following subsections:
 - a. Hospital administration, with medical staff approval, will determine the criteria for current, authenticated, legible, and complete medical records.
 - b. The Medical Records/Health Information Department will monitor records to aid the physicians and other medical services in the Medical Center in trying to ensure that medical records meet the requirements for completeness as set in this policy.

D. **PROCEDURE:**

1. Electronic signature:
 - a. It is expected that all members of the medical staff will authenticate documents maintained in Cerner electronically through use of a physician identifier. ~~This process replaces the practice of signing hard copy documents maintained in the medical record.~~
 - b. All members of the medical staff will be required to complete an Electronic Signature Certification Statement to document their acknowledgement of the proper use of their identifier in the authentication of documents.
 - c. Dictated reports will be transcribed into the Medical Records Chartscript transcription system. Upon completion of transcription the report will be saved and sent electronically to the Cerner system (Clinical Notes folder).
 - d. Paper-based documents will be scanned to the Clinical Notes section in Powerchart (Cerner) and will be signed electronically, if not already signed
 - e. The Report Status in Cerner will be reflected as "Transcribed"
 - i. Transcribed status reflects that the dictating physician has not yet authenticated the document.
 - f. Physicians will utilize the Cerner Message Center function to authenticate transcribed documents in a timely manner.
 - g. The Message Center feature supports the following actions to be taken by the physician:
 - i. Sign/Review
 - 1) Physician reviews the transcribed/scanned document and selects the OK button that updates the status of the report from "Transcribed" to "Auth (Verified)."
 - 2) Only the responsible physician is eligible to sign a transcribed report.

- a) Physician Assistants will sign their reports in addition to the report being signed by the supervising physician.
 - b) Resident reports will be signed by the supervising physician.
 - c) **All mid-level practitioners (e.g., Nurse Practitioners, Midwives)** ~~Nurse Practitioners~~ sign their reports in addition to the report being signed by the supervising physician.
 - ii. Modify/Sign
 - 1) Physician may modify the transcribed document PRIOR to signature to correct/clarify any elements of the report.
 - 2) Modifications are to follow the structure of new information being Bolded and deleted information noted as a Strike-through
 - 3) Once modified and signed any new revisions to the document are noted as an Addendum
 - iii. Refuse
 - 1) Physician identifies that he/she is not responsible for the report as well as a reason for refusal and redirects the report to Medical Records/Health Information (**Med Rec Inbox**) for review and reassignment of the deficiency to the correct physician.
 - 2) Electronic signature of the transcribed and scanned reports by the physician will update the Medical Records/Health Information Profile system to eliminate the signature deficiency assigned by the department.
- 2. **Written Signatures**
 - a. It is expected that all members of the medical staff will utilize acceptable written signatures, including credentials (e.g., MD, ~~or~~ PA, **NP, CNM**) for all paper documents being authenticated.
 - i. This expectation relates to orders submitted for outpatient ancillary services as well as emergency, day surgery, and inpatient documentation.
 - b. Acceptable written signatures are as follows:
 - i. Legible full signature
 - ii. Legible first initial and last name
 - iii. Illegible signature over a typed or printed name
 - iv. Illegible signature where the letterhead or other information on the page indicates the identity of the signer
 - 1) Example: an illegible signature appears on a prescription. The letterhead lists multiple physicians' names. One of the names is circled.
 - v. Initials over a typed or printed name
 - vi. Unsigned handwritten orders where other entries on the same page in the same handwriting are signed
 - c. Unacceptable written signatures are as follows:
 - i. Signature stamps alone
 - 1) These are not recognized as valid authentication for Medicare signature purposes and may result in payment denials by Medicare.
 - ii. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement.
 - iii. Unsigned typed note with provider's typed name
 - iv. Unsigned typed note without provider's typed/printed name
 - v. Unsigned handwritten note, the only entry on the page
- 3. The following criteria must be met before a chart is considered complete:
 - a. A medical record must be legible for each patient; its content shall be pertinent and current. This record shall include:
 - i. Identification data
 - ii. Legal status if mental health patient;

- iii. Emergency care given prior to arrival if any;
 - iv. Findings of assessment;
 - v. Conclusions or impressions from history and physical;
 - vi. Diagnosis or diagnostic impression;
 - vii. Reasons for admission or treatment;
 - viii. Goals of treatment and treatment plan;
 - ix. Known advance directives;
 - x. Informed consent for procedures and treatment;
 - xi. Diagnostic and therapeutic procedures and tests and their results;
 - xii. Operative and other invasive procedures performed;
 - xiii. Progress notes;
 - xiv. Reassessments if needed;
 - xv. Clinical observations;
 - xvi. Response to care;
 - xvii. Consultation reports;
 - xviii. Every medication ordered; every dose administered and any adverse reaction;
 - xix. Every medication dispensed to inpatient at discharge or to ambulatory patient;
 - xx. All relevant diagnoses established during care;
 - xxi. Any referrals/communications to other providers.
4. All patient medical record entries must be legible, completed, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided.
- a. All handwritten documentation is to be without the use of **Do Not Use Unapproved** Abbreviations.
 - i. A reference of **Unapproved Do Not Use** Abbreviations is available in multiple locations.
 - 1) Physician Order Forms
 - 2) Progress Notes
 - 3) TCMC Intranet – Administrative Policy 367
5. A complete history and physical examination shall be recorded by the attending physician within twenty-four (24) hours of admission and/or prior to any surgical or invasive procedure.
- a. When the report is dictated it must be completed within twenty (20) hours of admission to allow for transcription and charting of the document.
 - b. Legible, handwritten history and physicals are acceptable provided they meet the documentation requirements.
 - c. All history and physical examinations will be validated and authenticated by the attending physician with appropriate privileges.
6. The history and physical shall include the following elements:
- a. Chief complaint;
 - b. Personal history;
 - c. Family history;
 - d. History of present illness;
 - e. All important findings resulting from an assessment of all systems of the body;
 - f. Physical examination;
 - g. Plan of treatment.
7. **A medical history and physical examination must be completed no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical must be completed and documented by a physician, an ~~or~~maxillofacial oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.**
- a. **An updated examination of the patient, including any changes in the patient's condition must be completed and documented within 24 hours after admission or registration. This is to occur, ~~but~~ prior to surgery or for a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration.**

- b. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, ~~an~~ oral maxillofacial ~~or~~ maxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy.
- c. If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record the:
 - i. H&P was completed
 - ii. H&P was reviewed
 - iii. The patient was examined and "No Change" has occurred in the patient's condition since the H&P was completed.,
- ~~h.d.~~ A history and physical older than twenty-four (24) hours yet within thirty (30) days of admission must be accompanied by an interim note which documents any changes to the history and/or physical exam. This updated examination must be completed and documented in the patient's medical record within twenty-four (24) hours after admission. The Physician Pre-Procedure Documentation form must be recorded on the patient's medical record prior to patient admission to the Operating Room or Procedural areas regardless of the date and time the history and physical was completed.
- ~~i.e.~~ A history and physical document completed outside Tri-City Medical Center is required to reflect date and time of the examination.
 - i. Dictated documents **are** to reflect the date and time of both **the** dictation and transcription.
- ~~7. A previous history and physical is sufficient for a patient readmitted within thirty (30) days for the same condition. A copy of the old history and physical must accompany the new chart in these cases and a documented update note shall be recorded to reflect the patient's physical status upon readmission. It is the physician's responsibility to request the old history and physical from Medical Records/Health Information for inclusion in the current chart. This updated note must be completed and documented in the patient's medical record within twenty-four (24) hours after admission.~~
- 8. A history and physical dictated over 30 days prior to admission is not valid and must be re-dictated ~~or rewritten.~~
- 9. When the required history and physical examination is not recorded on the chart before the time stated for the operation, the operation shall be canceled until the surgeon has documented a history and physical in writing or documented that such a delay would constitute a hazard to the patient.
- 10. A Limited History and Physical (Short form) may be completed for outpatient procedures and when the patient's length of stay is less than forty-eight (48) hours.
 - a. The following outpatient procedures require a documented history and physical:
 - i. Heart Cath
 - ii. Interventional Radiology/Invasive Imaging
 - iii. Outpatient Observation
 - iv. Same Day Surgery
 - v. Endoscopy
 - ~~vi.~~ **Pain Management**
 - ~~vii.vi.~~ Wound Care Center
 - b. PICC line procedures performed on outpatients require a copy of the physician order to support the patient's diagnosis and medical necessity for the procedure.
 - b.c. Diagnostic Imaging procedures (IMAGS) without anesthesia do not require a History and Physical.**
 - e.d.** A post-anesthesia evaluation for anesthesia recovery must be completed and documented by an anesthesiologist.
- 11. Dentists who are members of the Medical Staff may only admit patients if a physician member of the Medical Staff conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry) and assumes responsibility for the care of the patient's

medical problems present at the time of admission or which may arise during hospitalization which are outside the limited license practitioner's lawful scope of practice.

- a. A history and physical completed by the medical physician in addition to the history and physical completed by the dentist are necessary to be documented on the chart prior to any surgical procedure.
- b. A qualified oral surgeon or podiatrist with specifically delineated clinical privileges may admit patients without significant underlying or potentially complicating medical problems, may perform the history and physical examination of those patients, and may assess the medical risks of proposed surgical procedures for such patients.
 - i. Completion of a history and physical examination by an oral surgeon or podiatrist who has the special privileges will NOT require completion of a history and physical by another qualified physician.

12. Medication reconciliation:

- a. Admission
 - i. The admitting physician is **required to review, to complete and reconcile Admission authenticate the Medication Reconciliation information in Cerner collected upon admission of the patient within 24 hours. collected upon admission of the patient.**
 - ii. **If new information is later obtained, the physician or nurse may update the Medication by History List in Cerner.**
- b. Transfer
 - i. All medications will be reviewed and revised as appropriate when patient is being transferred to the next level of care.
 - 1) Electronic Orders
 - a.) ~~Complete online Transfer Orders process~~ **The physician will access the Transfer Medication Reconciliation function and will reconcile each medication on the active medication list to either be continued or not continued for the next level of care.**
 - 2) Written Orders
 - a) ~~—~~ **The physician from the SENDING unit shall print out the Transfer Reconciliation Order form and place as the first sheet under the Physician Order tab section of the Patient's medical record. The physician may use this form as the actual order form or handwrite any changes on a pre-printed physician order form or the generic blank physician order form. Complete paper Medication Reconciliation report for transfer**
 - b)a) Rewrite applicable orders
- c. Discharge
 - i. All medications will be reviewed against HOME medications **in Cerner. to create a final discharge medication list.**
 - 1) Electronic Orders
 - a) **The physician will reconcile each medication on the active medication list and home list to either be continued or not continued upon discharge. New medications will be added as required. Discharge Medication Reconciliation application will be completed and authenticated.**
 - a)b) Prescriptions to be completed
 - i) ePrescribe – electronic prescription transmitted to the patient's pharmacy
 - ii) Printed on the unit and handed to the patient
 - iii) Handwritten on personal (physician's) prescription pad
 - 2) Written Orders

- a) Physician ~~will print the out~~ **Discharge-Medication Reconciliation report Form from Cerner** for discharge, updates as appropriate for discharge, and signs. **The Order sheet will be placed as the first sheet under the Physician Order tab section of the patient's medical record.**
 - b) Physician handwrites prescriptions on personal (physician's) prescription pad.
 - c) Nursing updates physician medication changes on the electronic Medication List through the Medication Reconciliation tool.
13. Daily progress notes must be documented by the attending member on all acute patients in the hospital.
- a. Progress notes for Behavioral Health unit patients, will be written six days per week by the attending member.
 - b. All members of the medical staff will document progress notes in any of the following methods:
 - i. Written on the progress notes form placed in the patient's active record;
 - ii. Electronic note may be a Progress Note typed by the physician or a Progress Note generated using a voice recognition software application (e.g. Dragon)
 - 1) Physicians who create an electronic progress note in Clinical Notes will need to document the following in the hardcopy Progress Notes, "Note recorded in EMR."
 - c. All Progress Note entries shall be timed, dated, and electronically signed by the physician recording the note. Electronic notes shall be signed electronically.
 - i. The electronic Progress Note shall not be printed, signed and placed in the hard copy chart (this is duplicate documentation that may require both documents to be maintained in the legal record (i.e. scan document as well as maintain electronic version).
 - d. Progress Notes recorded by Residents and/or Physician Assistants are required to be co-signed by the attending physician member.
 - e. Interdisciplinary Notes recorded by the other care providers are available in the Cerner system for review by the physician.
 - i. These notes are recorded by non-physicians within the Power Note application in the Cerner system.
 - f. Physician evaluation of Occupational Health patients (Work Partners) and Wound Care Center patients may result in an electronic note captured directly into the Cerner system.
 - i. Voice Recognition/Dragon application may be utilized by practitioners in these areas to generate a note summarizing the patient's history, assessments, and treatments.
 - ii. These notes will be authenticated by the examining physician and will be displayed as part of Clinical Notes.
14. Consent for Photography will be obtained from the patient when a patient will be photographed while receiving treatment at the Medical Center. The term "Photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.
15. All surgical operations, invasive and diagnostic procedures (including blood transfusions) shall be performed with documented informed consent except in an emergency. The informed consent for hysterectomies and sterilization procedures must meet specific requirements as set forth in Title XXII.
- a. **The informed consent documented will include the following:**
 - i. **Discussion about potential benefits, risks, and side effects of the patient's proposed care, treatment, and services.**
 - ii. **The likelihood of the patient achieving his or her goals**
 - iii. **Any potential problems that might occur during recuperation**
- ~~15.~~ 16. Physicians shall discuss a patient's Do Not Resuscitate (DNR) status with the patient and/or decision-maker prior to a surgery or procedure that requires anesthesia. The discussion shall

- include possible temporary suspension of the DNR status during the surgery or procedure. The DNR status shall be reevaluated immediately after the procedure. This discussion shall be documented in the medical record and an appropriate order entered/written.
- ~~16-17.~~ A pre-sedation or pre-anesthesia assessment is performed for each patient before beginning moderate or deep sedation and before anesthesia induction within forty-eight (48) hours prior to surgery.
- ~~17-18.~~ A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours after surgery for an inpatient.
- ~~18-19.~~ Operative or other high risk procedure reports shall be dictated immediately after surgery and shall include:
- a. Pre-operative diagnosis
 - b. Date of procedure
 - i. If the procedure is canceled, the operative report should include the reason and time of the cancellation.
 - c. Anesthesia type
 - d. A detailed account of the findings;
 - e. Technical procedure performed
 - f. Estimated blood loss
 - g. Specimen removed;
 - h. Post-operative diagnosis;
 - i. Name of the primary surgeon and any assistants.
 - j. Complications
 - k. Patient status
- ~~19-20.~~ An Operative Note shall be **documented** ~~written~~ immediately following surgery or other high-risk procedures. Use of the pre-printed Operative Note is necessary to document all required elements.
- a. Procedure performed
 - b. Pre-Operative diagnosis
 - c. Post-Operative diagnosis
 - d. Patient status
 - e. Estimated blood loss
 - f. Name of primary surgeon and any assistants
 - g. Anesthesia type
 - h. Specimen collected
 - i. Complications
 - j. Findings
- ~~20-21.~~ An intraoperative anesthesia record containing the following elements shall be completed by an anesthesiologist:
- a. Name and hospital ID number of the patient
 - b. Name of anesthesiologist who administered the anesthesia
 - c. Vital signs reflecting patient status just prior to induction**
 - ~~c-d.~~ Name, dosage, route, and time of administration of drugs and anesthesia agents
 - ~~d-e.~~ Techniques used and patient position(s), including the insertion/use of any intravascular or airway devices
 - ~~e-f.~~ Names and amounts of IV fluids, including blood or blood products
 - ~~f-g.~~ Time-based documentation of vital signs as well as oxygenation and ventilation parameters, and
 - ~~g-h.~~ Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.
- ~~21-22.~~ The Operative Note shall be completed and signed by the surgeon prior to the patient being discharged or transferred from PACU.
- ~~22-23.~~ All orders, including verbal orders, must be dated, timed, and authenticated.
- a. All orders shall be completed, legible, dated and signed within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.

- ~~23-24.~~ Medical Records/HIM will assign a deficiency to unsigned orders via the Inbox/Message Center.
- ~~24-25.~~ It is acceptable for physicians involved in the care of the patient to sign orders given by other physicians unless they object to the order. A physician may proxy Message Center to another physician for coverage purposes.
- Verbal orders are to be used infrequently, only to meet the care needs of the patient when it is impossible or impractical for the ordering practitioner to write/enter the order without delaying treatment. Every effort is to be made by the ordering physician to enter orders into Cerner or in writing when he/she is present on the nursing unit.
 - All orders for treatment shall be entered/written. An order for treatment is considered written if dictated by a member or his designee to a registered nurse and signed by the attending member through the Message Center. When orders are dictated over the telephone, they shall be signed by the responsible physician within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.
 - Physician orders for neonatal and pediatric populations will contain weight based dosing (e.g., mg/kg) along with the calculated dose and the patient's current weight with the exception of the following defined medication classes:
 - Medications that are not determined by the patient's weight (e.g., iron sulfate).
 - Vaccines
 - Intravenous fluids
 - Medication doses that if weight based would equal or exceed normal adult doses.
- ~~25-26.~~ When a patient is transferred from one level of care to another the physician is required to complete one of the following options:
- Electronic Orders
 - Utilize the Merge View in Cerner to review and update all orders for the next level of care.
 - Complete the Transfer Medication Reconciliation function
 - Written Orders
 - Rewrite all orders OR document the following, "I have reviewed all orders, and they are appropriate for this patient at this level of care."
 - The physician is not required to rewrite orders when a patient is undergoing one of the following minor procedures and returns to the same level of care
 - Heart Catheterization
 - Interventional procedures including PICC line placement
 - Endoscopy including bronchoscopies
 - Inpatient dialysis
 - 5) Pain management**
 - A registered nurse may write the order on paper or enter the order into Cerner with the comment that the communication was by verbal order. These orders as entered will be reviewed and signed by the ordering physician.**
- ~~26-27.~~ Consultations and recommendations shall include examination of the patient and a review of the patient's record by the consultant. The consultation shall be made a part of the patient's record. When operative procedures are involved, a consultation, except in an emergency, shall be recorded prior to the operation.
- ~~27-28.~~ Current obstetrical records shall include complete prenatal records, including a copy of the actual lab reports. The prenatal record may be a legible permanent copy of the attending practitioner's office record transferred to the Medical Center before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.
- ~~28-29.~~ All patients evaluated by an Emergency Department physician are to have a documented report outlining the history of present illness, assessment, and treatment rendered.
- Records for patients evaluated by both a resident and an ED physician will include documentation by each of the evaluators. The attending ED physician is responsible for authenticating ED reports dictated by a resident.

- b. Records for patients evaluated by an ED Physician Assistant (PA) will include only documentation by the PA which will be authenticated/signed by both the PA and ED supervising physician.
- ~~29-30.~~ All clinical entries in the patient's medical record shall be accurately dated and authenticated.
- ~~30-31.~~ Discharge/Depart Process
 - a. Electronic orders for discharge and follow-up care (including: activity, diet, equipment, follow-up, and medications) will be entered into the Depart Process application.
 - b. Written orders for discharge and follow-up care (including: activity, diet, equipment, and follow-up) will be recorded on the Physician Order sheet.
 - i. Nursing will enter into the Depart Process application
 - ii. Medication orders must be entered by the physician for Discharge Medication Reconciliation process (see section D.11.c.2)
- ~~31-32.~~ A Discharge Summary shall be ~~written or~~ dictated at all deaths regardless of length-of-stay, and in addition on all patients hospitalized over forty-eight (48) hours, except for normal obstetrical deliveries, and normal newborn infants. A discharge summary must contain:
 - a. **Discharge Diagnosis**
 - ~~a-b.~~ Reason for hospitalization
 - ~~b-c.~~ Significant findings
 - ~~c-d.~~ Procedures performed and treatment given
 - ~~d-e.~~ Condition on discharge
 - f. Instructions given to the patient or patient representative
 - i. **Follow-up instructions**
 - ii. **Diet instructions**
 - ~~e-g.~~ **Discharge medications**
 - h. A written or dictated discharge note is acceptable for patient with a length-of-stay less than forty-eight (48) hours, normal obstetrical deliveries, and normal newborn infants.
 - i. **Requirements of the Note include:**
 - 1) **Discharge Diagnosis**
 - 2) **Follow-up instructions**
 - 3) **Diet Instructions**
 - ~~4) Discharge Medications~~
 - ~~f.i.~~ Physicians having a Discharge Summary that requires dictation will be notified via the **Message Center in Cerner.** ~~incomplete Discharge Summary letter sent at the beginning of each month. This letter serves as notification to the physician of the charts that need to be completed by the last day of the month.~~ All physicians will be **required to complete all pending dictations and/or signature within 14 days of discharge.** ~~provided with a minimum of fourteen (14) days to complete their Discharge Summaries.~~
- ~~32-33.~~ Physicians will be notified of outstanding charts requiring signature **via their Message Center as well as via letter and call to their office.** ~~once per month in addition to the notification of dictations to be completed.~~
 - a. Physicians **will be** ~~may be fined and/or~~ suspended per Medical Staff Policy #8710-519 for Delinquent Medical Records and Medical Staff Bylaws Section 6.~~43-4(a).~~
- ~~33-34.~~ Late Entry
 - a. Documentation shall be recorded timely within the patient's medical record. When this is not possible a late entry will be made with the following required elements documented:
 - i. The date and time of the observation
 - ii. A note clearly identifying the documentation as "Late Entry"
 - b. It is not permitted to have entries "backdated" or "predated".
 - c. The chart shall be completed within **fourteen** ~~thirty (1430)~~ days of discharge; it is expected no Late Entries will appear after this time period.

MEDICAL STAFF POLICY MANUAL

ISSUE DATE:	1/01	SUBJECT:	Supervision of Residents/ Fellows/Medical Students
REVISION DATE:	8/02, 8/04, 6/06, 3/08; 10/11; 9/13 1/15	POLICY NUMBER:	8710 – 513
Graduate Medical Education Approval:		09/1301/15	
Medical Executive Committee Approval:		10/1302/15	
Board of Directors Approval:		01/12; 10/13	

A. POLICY

1. All Emergency Medicine, Family Medicine, and/or Internal Medicine residents and Sports Medicine Fellows and activities of Residents, Fellows and Students are under the supervision of the Director of the Residency Program(s) and a designated Medical Staff member(s) who are member(s) of Tri-City Medical Center (TCMC) Medical Staff. Each person is expected to follow the Tri-City Healthcare District standards of service excellence and applicable policies.

B. JOB DESCRIPTION BY PROGRAM

1. **Internal Medicine Family Medicine Rotation**
 - a. **ATTITUDES:** The resident should develop attitudes that encompass:
 - i. Awareness that Internal Medicine is a major portion of the fund of knowledge of a family physician.
 - ii. Assessment of the patient's and family's understanding of the medical disorder. This should also include the value of non-intervention and when to use it.
 - iii. Assessment of the impact of the medical disorder, its evaluation, and its treatment on the patient and the family.
 - iv. Enlistment of the family support systems in patient treatment and compliance.
 - v. Recognition of limitations and when to seek appropriate consultation and referral.
 - b. **KNOWLEDGE:** The resident should develop knowledge of the pathophysiology, recognition, and management of the following common problems in adult medicine.
 - Hypertension
 - Type 1 Diabetes Mellitus
 - Type 2 Diabetes Mellitus
 - Myocardial Infarction
 - Coronary Artery Disease
 - Stable and unstable angina
 - Congestive heart failure
 - Lipid disorders
 - Obesity
 - Common Arrhythmias
 - Asthma
 - COPD
 - GI Bleeding
 - Gastroesophageal reflex / Peptic ulcer disease
 - Irritable bowel syndrome
 - Anemia
 - Drug ingestions and overdoses
 - Thrombophlebitis
 - Alcoholism and detoxification
 - Hepatitis

- Mononucleosis
 - Pneumonia
 - Sepsis
 - Meningitis
 - Tuberculosis
 - Chronic bronchitis
 - Arthritis (Osteoarthritis and Osteoporosis)
 - Pulmonary embolism
 - Renal disease
 - Fever of unknown origin
 - Stroke
 - Fluid and electrolyte abnormalities
 - Envenomation
 - Abnormal liver function tests
 - Syncope
 - Smoking cessation
 - Pre-operative evaluation
- c. **SKILLS:** The resident should demonstrate the ability to:
- i. Evaluate the patient with a medical illness, including performance of adequate history and physical examination.
 - ii. Learn more complex diagnostic and therapeutic skills.
 - iii. Demonstrate proficiency in performing arterial puncture and arterial line placement, lumbar puncture, bone marrow biopsy, paracentesis, thoracentesis, arthrocentesis.
 - iv. Perform and interpret exercise tolerance testing.
 - v. Perform central vein catheterization including Swan – Ganz catheter insertion, (w/supervision)
 - vi. Manage patients requiring ventilatory assistance.
 - vii. Interpret EKGs.
 - viii. Interpret X-rays.
 - ix. Order and properly utilize laboratory and radiological studies.
 - x. Appropriately use anticoagulants.
 - xi. Know personal limitations.
 - xii. Request appropriate consultation.
- d. **IMPLEMENTATION:** Training in Adult Medicine is accomplished as follows –

PGY I (4 wk block)	Med Ward	Med Ward	ICU	FP Inpatient Service
PGY II	Med Ward / ICU	Med Clinic	Cardiology	Hosp / Geri
PGY III	Med Ward (Tri-City)	HIV/Endocrine	Neurology	FP Inpatient Service

- i. Residents are advised to use their elective time wisely in selecting other areas of subspecialty medicine for which they have an interest. Longitudinal experience is maintained through the resident's family practice continuity patients as well as through attendance at morning and noon conferences.
2. **Emergency Department Rotation:** (refer to Medical Staff Policy & Procedure #8710-513E)
3. **Sports Medicine Fellow Rotation:**
- a. San Diego Sports Medicine (SDSM) also hosts a nationally respected Orthopaedic Fellowship program that provides advanced training for new Orthopaedic Surgeons, while conducting high-level research. ~~SDSM offers a full range of services including Sports and Team Medicine, Workers Compensation/Injured Worker care, Total Joint Replacement and Revision, Arthroscopic Reconstruction of the Knee and Shoulder, and Foot and Ankle Reconstruction.~~
 - b. ~~Patient care at SDSM is the most advanced in the area. The physicians conduct and participate in national and international seminars, conferences and research studies. The primary goal at SDSM is to provide excellent patient care. In addition, all staff members are committed to the delivery of efficient, state of the art orthopaedic care, while~~

~~maintaining a friendly and caring environment.~~

4. **Medical Student Rotation:**

- a. Medical Students are unlicensed persons prohibited from making a diagnosis, treatment or operating upon a patient except when prescribed as part of their course of study in an approved medical school.
- b. Tri-City Medical Center has become part of an approved teaching program by means of an affiliation agreement with various medical schools. Preceptor rotations within the scope of this policy are periods of observation and do not constitute part of the course of study.
- c. Each Medical Student must have an identified preceptor who is a member of the Medical Staff. The preceptor(s) shall direct and supervise the Medical Student at all times.

C. **ROTATION DESCRIPTION:**

1. **Family Medicine and Internal Medicine Rotation**

- a. Third year residents shall spend 4 weeks on the Internal Medicine service at Tri-City Medical Center.
- b. The residents shall be supervised either directly or indirectly by the attending physicians responsible for the Internal Medicine service. The level of supervision shall be determined by the responsible attending physician.
- c. The resident shall be present Monday to Friday during the assigned 4-week block. Work hours should be arranged by the attending staff, but should generally involve daytime shifts without over night call.
- d. The resident duties should include performing history and physicals, daily rounds and routine ward care including discharge planning of patients admitted to the Internal Medicine service. Residents should be given opportunities to perform typical inpatient procedures under the supervision of the attending staff. These procedures would include, but are not limited to, arterial line placement, paracentesis, thoracentesis, exercise stress testing, endotracheal intubation, and cardioversion.
- e. Resident evaluation should be an ongoing process throughout the four weeks. For residents performing below standards, written notification to the resident and the Director for Residency Training should be done at the two week point. A written evaluation shall be completed in a timely manner using the standard form provided on all residents.

2. **Emergency Department Rotation** (Refer to Medical Staff Policy & Procedure #8710-571)

3. **Sports Medicine Rotation**

- a. All orders, history and physical, discharge summaries and progress notes written by Sports Medicine Fellows shall be reviewed by the Medical Staff member(s).
- b. The medical care provided by the Sports Medicine Fellow shall be discussed with the designated Medical Staff member(s) on a frequent basis. The Fellow must document this in the medical record.
- c. The scope of activities shall be the same as that of the supervising physicians. Sports Medicine Fellows may be the first assist at surgery, consistent with appropriate departmental rules and regulations.

4. **Medical Student Rotation (3rd/4th year)**

- a. Prior to a surgical rotation, the Medical Student shall complete an orientation to include a Sterile Technique and Surgical Safety Module (including Fire Prevention). Prior to an Emergency Medicine Rotation, the Medical Student shall complete an orientation to include introduction to the ER environment, overview of EHR, introduction of HIPAA, role in the department, and general policies of the ED. **Prior to an Ob/Gyn rotation, the medical students shall complete the OR orientation as well as a Labor and Delivery orientation.**
- b. Medical Students may perform and document written histories, physical examinations, and progress notes with the patient's permission and under the direct supervision of the attending physician. These must be countersigned by the attending physician.
- c. Medical Students cannot write orders, enter electronic orders, or give any verbal orders to RNs.
- d. Medical Students may make rounds with the preceptor and participate in the examination

of that medical staff member's patients. **Protocols for examining female patients with a chaperone present must be followed.**

- e. Students on a surgical rotation may scrub and participate in surgery under the direct supervision of a preceptor surgeon to aid in learning surgical disease and principles. This includes placing and holding retractors, suctioning, suturing (above the fascia), and dissecting. Students on an emergency medicine rotation may participate in ED procedures under the direct supervision of a preceptor to aid in learning. This includes simple suturing, assisting with reductions and splinting, simple incision and drainage, lumbar puncture, ultrasound techniques, assist with central lines, assist with para/thorax/arthrocentesis.
- e-f. **Medical students on an Ob/Gyn rotation may evaluate obstetric and gynecologic patients. They may perform breast and pelvic exams; obstetrical exams and cervical exams in labor; and write notes in the medical record. The students may be present in the operating room and are able to assist in major or minor gynecological surgical procedures under the direct supervision of a preceptor surgeon to aid in learning Ob/Gyn disease and principles. This includes placing and holding retractors, suctioning, suturing (above the fascia), and dissecting. The students may also participate in vaginal and cesarean deliveries.**
- f-g. Patients shall be informed and sign consent of their knowledge of presence of Medical Students in the hospital caring for them under attending physician.
- g-h. Medical Students are not authorized to dictate or access the EMR.

D. **SUPERVISION DESCRIPTION:**

1. **First Year Residents**

- a. First year residents are unlicensed physicians, and the mechanism for their supervision is more direct than for second and third year residents.
 - i. Orders
 - 1) First year residents may write orders, however they must be countersigned by a supervising licensed independent practitioner prior to implementation.
 - 2) Staff member(s) shall review all orders written by first year residents. If a nurse or other hospital employee has any question about an order written by a first year resident, the supervising higher level resident or Medical Staff member(s) may be contacted directly.
 - ii. Other Care
 - 1) History and physical, discharge summary, and progress notes may be written or dictated by first year residents and shall be countersigned by a supervising licensed independent practitioner.
 - 2) All medical care provided by a first year resident shall be discussed with the designated Medical Staff member(s).
 - 3) The resident must document in the progress notes that the patient was seen and/or discussed with the attending Medical Staff member(s).
 - 4) The scope of activities shall be the same as that of the supervising physicians. Residents may be the first assistant at surgery, consistent with departmental rules and regulations.

2. **Second and Third and Fourth Year Residents**

- a. All orders, history and physical, discharge summaries and progress notes written by second, third and fourth year residents shall be reviewed and countersigned by the Medical Staff member(s).
- b. If a nurse or other hospital employee has any question about an order written by a second, third and fourth year resident, the supervising higher level resident, or Medical Staff member(s) may be contacted directly.
- c. The medical care provided by residents shall be discussed with the designated Medical Staff member(s) on a frequent basis. The resident must document this in the medical record.
- d. Second, third and fourth year residents shall supervise such care depending upon the

judgment of the Medical Staff member(s). The scope of activities shall be the same as that of the supervising physicians. Residents may be the first assist at surgery, consistent with appropriate departmental rules and regulations.

3. **Sports Medicine Fellows**

- a. All orders, history and physical, discharge summaries and progress notes written by Sports Medicine Fellows shall be reviewed by the Medical Staff member(s).
- b. If a nurse or other hospital employee has any question about an order written by a sports medicine fellow the supervising Medical Staff member(s) may be contacted directly.
- c. The medical care provided by the Sports Medicine Fellow shall be discussed with the designated Medical Staff member(s) on a frequent basis. The Fellow must document this in the medical record.
- d. The scope of activities shall be the same as that of the supervising physicians. Sports Medicine Fellow may be the first assist at surgery, consistent with appropriate departmental rules and regulations.

4. **Emergency Department Residents:** (Refer to Medical Staff Policy & Procedure #8710-571)

5. **Medical Students**

- a. All activities of 3rd and 4th year Medical Students including documentation of histories, physicals, and progress notes shall be under the direct supervision of an identified preceptor who is a member of the Hospital Medical Staff and shall be co-signed.

6. **Medical Staff Attending:**

- a. The designated Medical Staff member(s) shall be ultimately responsible for all care provided by Medical Students, Residents, and Sports Medicine Fellows and making decisions regarding each resident's progressive involvement and independence with specific patient care activities in accordance with this Policy and Procedure.
- b. Medical Staff member(s) shall write a daily progress note on each patient for which they are responsible. The note should reflect physical examination of the patient and include the physical assessment of current status, diagnostic and therapeutic plan.
- c. Documentation requirement(s) for Emergency Department Residents refer to Administration policy and procedure #351.
- d. Documentation requirement(s) for the Sports Medicine Fellow, the Medical Staff member(s) shall supervise the dictation of the Operative Report within the required time frame and Medical Staff member(s) shall co-sign Operative Report and all other Medical Record documentation including History and Physicals, Discharge Summaries and physician orders.

E. **GENERAL OVERSIGHT:**

1. Information regarding the safety and quality of patient care, treatment, and services provided to patients by a resident shall be discussed at the Graduate Medical Education (GME) Committee.
2. Reports shall be presented to the Medical Executive Committee and the Board at least annually.
3. The Medical Staff Director/Supervisor of each resident/student/fellowship program shall be responsible for communicating directly with the affiliated training institution regarding medical student/resident/fellow activities (as well as for reporting to GME committee) regarding quality of care, treatment, services and education needs of the participants.

F. **REFERENCES:**

1. The Joint Commission Hospital Accreditation Standards

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 7/01

SUBJECT: Suspension for Delinquent Medical Records

REVISION DATE: 3/05, 4/06, 3/07, 7/07, 3/08, 9/09,
10/14; 3/15

POLICY NUMBER: 8710 – 519

Medical Executive Committee:
Governance Committee Approval:
Board of Directors Approval:

10/14
04/15

A. POLICY:

1. It is the policy of Tri-City Medical Center and its Medical Staff that all medical records are completed in a timely manner, in accordance with Medical Staff Policy 8710-518, *Medical Record Documentation Requirements*, applicable laws, and accreditation standards.

B. PROCEDURE:

1. Applicable TCMC departments shall enforce pre-procedure requirements for History and Physical exam, as outlined in Medical Staff Policy 8710-518, *Medical Record Documentation Requirements*.
2. In order to facilitate timely medical record completion and appropriate practitioner notification, the TCMC IT Department shall develop and implement such automated notification mechanisms as requested by the Medical Records/HIM Department.
3. The Medical Records/HIM Department is responsible for reviewing medical records and identifying deficiencies of dictations and signatures, as outlined in *Medical Record Documentation Requirements*.
4. The practitioner is responsible for identifying any error(s) in assigned dictations/signatures by "refusing" the item within the Cerner Message Center, and indicating the appropriate practitioner if possible.
5. The Medical Records/HIM Department will run a weekly report to identify dictations and signatures that are not complete following patient discharge.
 - a. A letter **under the Chief of Staff's signature** will be initiated to each practitioner weekly when the practitioner has any deficiencies aged 7 days from discharge. A second communication will be sent at 10 days post discharge.
6. Each week the Medical Records/HIM Department will submit to the Chief of Staff (via the Medical Staff Office) a list of verified deficiencies.
7. ~~As directed by the Chief of Staff, the~~ **The** Medical Staff Office shall:
 - a. **Call the physician to give verbal notice of the impending suspension.**
 - ~~a.b. prepare~~ **Prepare** and send **a written** Notice of Automatic Limited Suspension ~~the suspended practitioner shall also be contacted by the Medical Staff Office and advised of the limited suspension~~ **to the physician.**
- ~~7.8.~~ Limited suspension shall apply to the practitioner's right to admit, treat or to provide services to new patients in the hospital, but shall not affect the right to continue to care for a patient the practitioner has already admitted or has scheduled to treat or to perform any invasive procedure. Obligations to fulfill ED On-Call duties as per existing schedule shall remain in effect.
- ~~8.9.~~ Practitioners whose privileges have been suspended for delinquent records may admit patients only in life threatening situations, when no other physician of the appropriate specialty is available.

- 9-10. In the case of a patient care emergency, ~~The the~~ suspension may be lifted by the Chief of Staff or his/her designee, otherwise the suspension shall continue until the medical records are completed ~~or suspension lifted by the Chief of Staff or his designee.~~**
- 11. If the physician is on vacation or has an illness when ~~Bona fide vacation or illness may constitute an excuse, subject to the approval of the Medical Executive Committee;~~ his or her records become delinquent, with Chief of Staff approval, such physician shall have ~~records must be completed within~~ five (5) days of returning to practice from vacation or illness to complete the records.**

C. MEDICAL STAFF SUSPENSION MONITORING:

1. The Medical Staff Office shall notify Medical Records/HIM, IT, Surgery, Administration, Admitting, Cardiology and Radiology of the automatic suspension.
 - a. Each of these departments is responsible for enforcing the suspension.
 - b. Any questions shall be directed to the Chief of Staff via the Medical Staff Office.
2. The Medical Records/HIM Department shall notify the Medical Staff Office when a suspended practitioner has completed all deficiencies.
3. The Medical Staff Office shall notify the practitioner and applicable departments that the suspension has been lifted.
4. Days on suspension shall be tracked in the Medical Staff's credentialing database and considered at the time of OPPE and reappointment.
5. The Medical Executive Committee will serve as the intermediary in resolving suspension/delinquency status questions from physicians and will assist the Medical Records Department in communications with practitioners who have disputes regarding the actions of this policy.
6. Practitioners indicating an intent to resign will be advised to complete all outstanding dictations and signatures before departure, as failure to do so will make them ineligible for "good standing" affiliation verifications. ~~The Chief of Staff has the discretion to make exceptions where there are extenuating circumstances subject to Medical Executive Committee approval (e.g., sudden illness, military deployment)~~

D. REFERENCES:

1. Medical Staff P&P 8710-518: Medical Record Documentation Requirements
2. Medical Staff Bylaws: Article VI, § 6.4-4

Tri-City Medical Center
Audit, Compliance & Ethics Committee
April 16, 2015
Assembly Room 3
8:30am-10:30am

Members Present:	Director Ramona Finnilla (Chair); Director Larry W. Schallock; Director Laura Mitchell; Jack Cumming, Community Member; Kathryn Fitzwilliam, Community Member; Carlo Marcuzzi, Community Member; Barton Sharp, Community Member
Non-Voting Members:	Steve Dietlin (CFO); Tim Moran (CEO; Kapua Conley (COO)
Others Present:	Diane Racicot, General Counsel; Teri Donnellan, Executive Assistant; Pamela Alm, Senior Administrative Assistant; Marcia Cavanaugh, Senior Director of Clinical Risk Management, Quality & PI; Daniel Martinez, SVP, IT
Absent:	Frank Corona, M.D. Physician Member

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	The meeting was called to order at 8:30 a.m. in Assembly Room 3 at Tri-City Medical Center by Director Finnilla, Chairperson. Attendees and committee members introduced themselves.		
2. Approval of Agenda	Chairperson Finnilla stated the closed session will be held prior to open session to allow presenters to give their report and exit the meeting. It was moved by Director Schallock and seconded by Director Mitchell to approve the agenda as presented. The motion passed unanimously.	Agenda approved.	

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
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. Oral Announcement of items to be discussed during closed session.	Mr. Dietlin make an oral announcement of the items listed on the agenda to be discussed during closed session which included two matters of potential litigation and approval of closed session minutes.		
5. Motion to go into Closed Session	It was moved by Director Mitchell and seconded by Director Schallock to go into Closed Session at 8: 35 a.m. The motion passed unanimously.		
8. Open Session	The committee returned to open session at 9:11 a.m. with committee members, Mr. Moran, Mr. Dietlin, Mr. Conley, Ms. Racicot, Ms. Alm and Ms. Donnellan in attendance. Also in attendance were Ms. Colleen Thompson, Director of Medical Records/HIM & Registration and Ms. Kathy Topp, Director of Education, Clinical Informatics & Staffing.		
9. 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.		
10. Ratification of minutes- March 19, 2015	It was moved by Ms. Kathryn Fitzwilliam and seconded by Director Schallock to approve the minutes of the March 19, 2015 meeting as presented. The motion passed unanimously.	Minutes ratified.	
11. New Business A. Administrative Compliance Policies 1) Compliance Officer 8750-535 2) Compliance Officer Authority/Duties and Responsibilities – 8750-536	Ms. Kathy Topp introduced herself to the Committee and stated she is here today to provide information on the Compliance Policies listed on today's agenda. She explained the policies are coming forward today in the absence of a Compliance Officer and Internal Compliance Committee and the committee can expect to see additional policies in the coming months. Ms. Topp introduced Ms.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
<p>3) Compliance Program Overview 8750-532</p> <p>4) Compliance Program Generally; Compliance Program Scope and Objectives 8750-533</p> <p>5) Compliance Program Generally; Compliance with Laws; Conflict of Authorities 8750-534</p> <p>6) Rights to Request Privacy Protection for Protected Health Information 8610-526</p>	<p>Colleen Thompson who is here today in her role as Privacy Officer to provide information on policy #8610-526 – Rights to Request Privacy Protection for Protected Health Information.</p> <p>General Counsel, Ms. Racicot explained there were an extensive number of compliance policies that were approved in 2012, some of which had concepts that were repeated in multiple policies. Ms. Racicot stated we have begun a review of the policies and those presented today have been combined and condensed with other policies and may be updated to reflect current changes in the law, however, there were no material substantive changes made. She stated that when the Compliance Officer comes on board, he/she may make additional changes to these policies.</p> <p>Ms. Racicot further explained the compliance policies were designed and written to follow the law and give the Compliance Officer discretion and power to have resources available to do the job. She explained the term “Effective Compliance Program” refers to a program that is meaningful and follows the seven effective steps of a compliance program and the goal is true implementation of these resources, i.e., policies, Values Line and Board participation.</p> <p>Ms. Topp stated Policy 8750-536 – Compliance Officer Authority/Duties and Responsibilities, Policy 8750-533 – Compliance Program Generally; Compliance Program Scope and Objectives and Policy 8750-534 – Compliance Program Generally; Compliance with Laws; Conflict of Authorities have been deleted and merged into Policies 8750-532 - Compliance Program Overview and 8750-535 – Compliance Officer as presented.</p> <p>Ms. Colleen Thompson explained the Privacy Officer is responsible for reviewing requests for privacy protection which is explained in Policy 8610-526 – Rights to Request Privacy Protection for Protected Health Information. Ms. Thompson provided examples of requests for privacy</p>		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	<p>protection and the grounds in which the requests may be accommodated or denied.</p> <p>Committee members asked general questions which were answered and clarified by Ms. Topp and Ms. Thompson. It was recommended the word "agents" be added to Policy #8750-535 for consistency throughout the policy.</p> <p>It was moved by Mr. Jack Cumming and seconded by Mr. Barton Sharp to recommend approval of Compliance Policies 8750-535, 8750-532 and 8610-526 as presented and amended and delete policies 8750-536 8750-533 and 8750-534 as described. The motion passed unanimously.</p> <p>In closing, Ms. Topp stated we are on track to have all policies reviewed to comply with Joint Commission.</p> <p>Ms. Topp and Ms. Thompson exited the meeting at 9:31 a.m.</p>	<p>Recommendation to be sent to the Board of Directors to approve Compliance Policies 8750-535, 8750-532 and 8610-526 as presented and amended and delete policies 8750-536 8750-533 and 8750-534 as described; items to appear on next Board agenda and included in Board Agenda packet.</p>	Ms. Donnellan
12. Old Business A) Chief Compliance Officer Update	Chairperson Finnila reported the Board will be interviewing candidates at their April meeting.	Information only.	
13. Date of Next Meeting	Chairperson Finnila stated the Committee's next meeting will be held on May 21, 2015.	The committee's next meeting is scheduled for May 21, 2015.	Ms. Donnellan
13. Adjournment	Chairperson Finnila adjourned the meeting at 9:36 a.m.		Chair

Audit and Compliance Committee
April 16th, 2015

[illegible]

Administrative Policy Manual

ISSUE DATE: May 31, 2012

SUBJECT: ~~Compliance Officer: Introduction;~~
General Policies

REVISION DATE: December 13, 2012

POLICY NUMBER: 8750-535

Administrative Policies and Procedures Committee Approval Date(s): 04/15

Audit and Compliance Committee Approval Date(s): 04/15

Board of Directors Approval: December 13, 2012

A. PURPOSE:

1. This policy provides for the appointment of, **and sets forth the general duties and responsibilities of, Tri-City Healthcare District's (the District's) Compliance Officer.**

B. GENERAL POLICY:

1. The Compliance Officer ("CO"), ~~hired by the Board,~~ shall advise the Board and Chief Executive Officer regarding the design and implementation of the ~~organization's~~ **agency's** ethics and compliance programs. The Compliance Officer shall report directly to the Board regarding material legal and compliance risks and mitigation efforts. ~~The Compliance Officer shall have such other duties as assigned by the Chief Executive Officer, as set forth in Policy 8750-536 (Compliance Officer Authority/Duties and Responsibilities).~~ In the event that the CO ceases to be a District employee or is removed or resigns from the position of CO, the Board shall promptly appoint an interim CO until such time as an appropriate permanent CO may be identified and engaged.

C. HIRE OF COMPLIANCE OFFICER:

1. ~~As set forth above,~~ **The** CO shall be hired by the District's Board of Directors and Chief Executive Officer.
2. The Chief Executive Officer shall cause the hiring of the CO to be recorded in writing and properly and effectively announced to the District's employees, members of the Medical Staff and other affected individuals, including, but not limited to, contractors who furnish patient care or related services to the District and/or its patients.
3. The Compliance Officer shall have the duties and responsibilities set forth ~~in Policy 8750-536 (Compliance Officer Authority/Duties and Responsibilities).~~ **below.**
4. The Compliance Officer shall have direct access and report directly to ~~Tri-City's~~ **the District's** Board of Directors, Audit and Compliance Committee, and Chief Executive Officer regarding the status of the Compliance Program and any material developments affecting the Compliance Program. Such reports shall occur as frequently, as needed in the best interests of ~~Tri-City~~ **the District**, but in any event no less than on a quarterly basis.
5. For administrative purposes, the CO shall report directly to the Chief Executive Officer.

D. QUALIFICATIONS OF COMPLIANCE OFFICER

1. The Compliance Officer shall have credentials and experience appropriate for understanding ~~Tri-City~~ **the District's** mission and operations, and for executing the duties and responsibilities set forth in **Section D. Policy 8750-536** ~~(Compliance Officer Authority/Duties and Responsibilities).~~

2. The Compliance Officer shall demonstrate high integrity, good judgment, assertiveness, and an approachable demeanor, when working with -the District's Board, senior management-, employees, Medical Staff, and relevant contractors and agents.
3. The Compliance Officer must have sufficient time to dedicate to the Compliance Officer position and its attendant duties and responsibilities. The CO also shall have sufficient resources to perform his/her duties and responsibilities.

E. AUTHORITY OF COMPLIANCE OFFICER; REVIEW OF FINDINGS

1. The CO shall have the authority to access and review all District records and other documents (whether in paper or electronic form) and interview all District employees, as necessary to discharge his or her duties and responsibilities.
2. The CO shall have sufficient management authority, responsibility, and resources to permit the performance of his/her duties.
3. The CO shall have the authority to report to the District Chief Executive Officer, Board of Directors, and Audit & Compliance Committee regarding compliance matters at any time.
4. The CO shall have direct access to all senior management.
5. With approval of the Board of Directors or Chief Executive Officer, the CO shall have authority to engage qualified outside counsel and consultants to assist him/her achieve the objectives of the Compliance Program.
- 4.6. The District may commission an independent review to verify any findings of the CO.

F. SPECIFIC DUTIES AND RESPONSIBILITIES OF COMPLIANCE OFFICER

1. The CO will be responsible for, among other things:
 - a. Advising the Board of Directors and the Chief Executive Officer regarding the design and implementation of the District's Compliance Program.
 - b. Overseeing and monitoring the implementation and operation of the District's Compliance Program, including staff supervision as necessary.
 - c. Overseeing and monitoring changes and/or updates in relevant state and federal health care program laws and regulations.
 - d. Reporting on a regular basis (at least quarterly) to the Chief Executive Officer, Audit & Compliance Committee, and Board of Directors regarding compliance issues and the status of the District Compliance Program.
 - e. Monitoring various guidance, alerts and other communications issued by federal or state government agencies, including the U.S. Department of Health and Human Services, the Federal Trade Commission, and the U.S. Department of Justice.
 - f. Developing written Policies to implement the Compliance Program and address existing and new compliance risk areas.
 - g. Amending the Compliance Program (including the Code of Conduct and Policies), as necessary.
 - h. Overseeing the meetings, work plans, and operations of the Internal Compliance Committee.
 - i. Developing, coordinating, and documenting the ~~TCH~~ District's compliance-related educational and training programs.
 - j. Seeking to ensure awareness of and compliance with applicable laws and policies on the part of Directors, employees, members of the Medical Staff, contractors, and agents.
 - k. Ensuring new employees and contractors are screened to determine eligibility for employment in their respective positions.
 - l. Ensuring new employees receive the Code of Conduct and training.
 - m. Coordinating internal and external compliance reviews or audits of the District's business operations and practices.

- n. **Reviewing District business arrangements to ensure compliance with applicable laws, regulations, and policies. This may be accomplished by conferring with legal counsel, as appropriate.**
- o. **Responding to compliance inquiries.**
- p. **Ensuring the District's Confidential Reporting Line (Values Line) and other lines of communication are operating effectively and that compliance concerns are documented and addressed in a prompt and appropriate manner.**
- q. **Ensuring exit interviews of departing employees are conducted to elicit information concerning potential violations of laws, regulations or the District's Policies.**
- r. **Investigating suspected violations of applicable laws, regulations and policies and recommending corrective action, as appropriate.**
- s. **Consulting with Board and regulatory counsel, as appropriate.**

ISSUE DATE: May 31, 2012 SUBJECT: Compliance Officer Authority/Duties
and Responsibilities

REVISION DATE: December 13, 2012 POLICY NUMBER: 8750-536

Board of Directors Approval: December 13, 2012

A. PURPOSE:

This policy sets for the general duties and responsibilities of Tri-City Healthcare District's Compliance Officer.

B. AUTHORITY OF COMPLIANCE OFFICER; REVIEW OF FINDINGS:

1. ~~The Compliance Officer (CO) shall have the authority to access and review all District records and other documents (whether in paper or electronic form) and interview all District employees, as necessary to discharge his or her duties and responsibilities.~~
2. ~~The CO shall have sufficient management authority, responsibility, and resources to permit the performance of his/her duties.~~
3. ~~The CO shall have the authority to report to the District Chief Executive Officer, Board of Directors, and Audit & Compliance Committee regarding compliance matters at any time.~~
4. ~~The CO shall have direct access to all senior management.~~
5. ~~With approval of the Board of Directors or Chief Executive Officer, the CO shall have authority to engage qualified outside counsel and consultants to assist him/her achieve the objectives of the Compliance Program.~~
6. ~~The District may commission an independent review to verify any findings of the CO.~~

C. SPECIFIC DUTIES AND RESPONSIBILITIES:

1. ~~The CO will be responsible for, among other things:~~
 - a. ~~Advising the Board of Directors and the Chief Executive Officer regarding the design and implementation of the District's Compliance Program.~~
 - b. ~~Overseeing and monitoring the implementation and operation of the District's Compliance Program, including staff supervision as necessary.~~
 - c. ~~Overseeing and monitoring changes and/or updates in relevant state and federal health care program laws and regulations.~~
 - d. ~~Reporting on a regular basis (at least quarterly) to the Chief Executive Officer, Audit & Compliance Committee, and Board of Directors regarding compliance issues and the status of the District Compliance Program.~~
 - e. ~~Monitoring various guidance, alerts and other communications issued by federal or state government agencies, including the U.S. Department of Health and Human Services, the Federal Trade Commission, and the U.S. Department of Justice.~~

- f. ~~Developing written Policies to implement the Compliance Program and address existing and new compliance risk areas.~~
- g. ~~Amending the Compliance Program (including the Code of Conduct and Policies), as necessary.~~
- h. ~~Overseeing the meetings, work plans, and operations of the Internal Compliance Committee.~~
- i. ~~Developing, coordinating, and documenting the TCHD's compliance-related educational and training programs.~~
- j. ~~Seeking to ensure awareness of and compliance with applicable laws and policies on the part of Directors, employees, members of the Medical Staff, and contractors.~~
- k. ~~Ensuring new employees and contractors are screened to determine eligibility for employment in their respective positions.~~
- l. ~~Ensuring new employees receive the Code of Conduct and training.~~
- m. ~~Coordinating internal and external compliance reviews or audits of the District's business operations and practices.~~
- n. ~~Reviewing District business arrangements to ensure compliance with applicable laws, regulations, and policies. This may be accomplished by conferring with legal counsel, as appropriate.~~
- o. ~~Responding to compliance inquiries.~~
- p. ~~Ensuring the District's Confidential Reporting Line (Values Line) and other lines of communication are operating effectively and that compliance concerns are documented and addressed in a promptly and appropriately.~~
- q. ~~Ensuring exit interviews of departing employees are conducted to elicit information concerning potential violations of laws, regulations or the District's Policies.~~
- r. ~~Investigating suspected violations of applicable laws, regulations and policies and recommending corrective action, as appropriate.~~
- s. ~~Consulting with Board and regulatory counsel, as appropriate.~~

Administrative Policy Manual

ISSUE DATE: May 31, 2012

SUBJECT: Compliance Program Overview

REVISION DATE: December 13, 2012

POLICY NUMBER: 8750-532

Department Approval Date(s):

Administrative Policies and Procedure Committee Approval Date(s): 3/15

Audit and Compliance Committee Approval Date(s): 4/15

Board of Directors Approval: 5/12

A. PURPOSE:

1. This policy- provides an overview of Tri-City Healthcare District's Healthcare Compliance Program ("Compliance Program") **and the scope and objectives of the Compliance Program.** As set forth below, the Compliance Program is comprised of Tri-City's ~~the District's~~ Code of Conduct, General Compliance Policies ("General Policies"), and Specific Compliance Policies ("Specific Policies"). The General and Specific Policies are referred to collectively as the "Policies").

B. INTRODUCTION:

1. Tri-City Healthcare District owns and operates Tri-City Medical Center, a licensed 397-bed, general acute care hospital organized under the California Health & Safety Code § 32000, et. seq., which is governed by a publicly elected Board of Directors (the "Board"), representing the residents of Carlsbad, Oceanside and Vista. As set forth in the Code of Conduct, ~~Tri-City's the District's~~ mission is to **advance the health and wellness of those we serve** ~~provide high quality medical care in a prompt, courteous, compassionate, cost-effective and ethical manner.~~ An integral component of this mission is the District's unequivocal commitment to operating in compliance with applicable federal and state laws and regulations and to demonstrate good corporate citizenship. Both to reflect and achieve this commitment, the District has developed and implemented a formal Compliance Program, as described in this Policy.

C. POLICIES:

1. The District's Compliance Program supplements laws, regulations and other governmental rules. As a general matter, laws, regulations, and other governmental rules control ~~over~~ the standards set forth in the Compliance Program unless the Compliance Program imposes stricter requirements than these authorities.
2. The District's Code of Conduct provides ethical and compliance guidance on a broad range of conduct. ~~These~~ The District's Compliance Policies provide guidance in more detail regarding ethical and appropriate conduct, and are intended to be consistent with the general principles established in the Code of Conduct.

D. SCOPE:

1. Unless otherwise limited, the ~~TCHD's~~ Compliance Program applies to:
 - a. ~~All members of the TCHD~~ The District's Board of Directors and members of ~~TCHD's~~ the District's committees;
 - b. All employees, including officers and managers; and

- c. All members of the ~~TCHD's~~ District's Medical Staff and ~~TCHD's~~ District's allied health professionals, and their respective agents, including independent contractors who or which provide health care or related services in any of the the District ~~TCHD's~~ facilities, including facilities that are owned and/or operated through joint ventures or under arrangements, for such time periods in which they furnish patient care or other related services at ~~TCHD~~ the District and/or with respect to the furnishing of patient care or related services to ~~TCHD~~ the District or any of its patients.

E. OBJECTIVES:

1. The primary objective of the the District ~~TCHD's~~ Compliance Program is to promote ethical and lawful conduct and to ensure compliance with both the letter and the spirit of applicable healthcare laws and regulations.
 - a. In particular, ~~TCHD~~ the District's Compliance Program is modeled after the voluntary "Compliance Program Guidance for Hospitals," initially published by the U.S. Department of Health and Human Services ("HHS"), Office of Inspector General ("OIG") in February 1998, and supplemented in the "OIG Supplemental Compliance Program Guidance for Hospitals" published in January 2005.
- a.2. ~~TCHD~~ The District's Compliance Program includes the seven elements identified by the OIG as fundamental to an effective compliance program:
 - a. Implementing written policies and standards of conduct;
 - b. Designating a Compliance Officer and establishing an Internal Compliance Committee;
 - c. Conducting effective training and education regarding policies, procedures and practices;
 - d. Developing effective lines of communication regarding compliance concerns;
 - e. Enforcing policies and standards through well-publicized disciplinary guidelines;
 - f. Conducting internal monitoring and auditing; and
 - g. Responding promptly to detected compliance irregularities and implementing appropriate corrective action.
3. A second, but equally important, objective is to ensure maintenance and enforcement of high standards of individual and organizational ethical and legal business practices throughout ~~TCHD~~ the District. This facilitates ~~TCHD~~ the District's ability to carry out its health care mission in a manner consistent with its values, principles and mission.

B.F. COMPLIANCE PROGRAM COMPONENTS:

- 2.1. **CODE OF CONDUCT:** The District has adopted a written Code of Conduct to govern the District's interactions including patients, their families, providers of care, vendors, federal, state and local regulators, payors and the public in general. The Code of Conduct is a critical part of and is incorporated by reference into the Compliance Program
- 3.2. **GENERAL POLICIES:**
 - a. The District has General and Specific Compliance Program policies. General Policies address the fundamental requirements of an effective Compliance Program. Specific Policies provide more detailed guidance on compliance with applicable federal and state laws and regulations.

~~1. The Compliance Program covers General Policies and Specific Policies.~~

b. General Policies include the following:

- i. Compliance Program -Overview;
- ii. Compliance Officer;
- iii. Hiring and Employment;
- iv. Education and Training;
- v. Monitoring Compliance/Auditing and Reporting;
- vi. Communicating and Reporting Compliance Concerns;
- vii. Responding to Compliance Issues; and

~~G.viii.~~ Development, Revision and Approval of Standards of Conduct and Policies.

~~b.c. . SPECIFIC POLICIES INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING~~
Specific Policies Include, but are not limited to the following:

- i. Physician Arrangements;
- ~~i.~~ii. Conflicts of Interest;
- ~~ii.~~iii. Document Retention
- iv. Gifts and Other Non-Monetary Compensation.

3. RESOLUTION OF CONFLICTS:

- a. **Some of the Policies that make up the District's Compliance Program summarize various government laws, regulations and guidelines. Such Policies should not be read or used as substitutes for the actual laws or regulations to which they relate. In other words, the District's Policies may supplement, and clarify, applicable laws and regulations.**
- b. **In the event of an inconsistency between any Policy in the Compliance Program Manual and applicable laws or regulations, you are to (1) follow the applicable law or regulation unless the District's policy imposes stricter requirements and (2) report the inconsistency to the Compliance Officer.**
- c. **If you are unsure as to the appropriate standard, do not guess. Rather, please ask your supervisor or the Compliance Officer. Asking questions is perfectly acceptable, indeed encouraged.**



Administrative Policy Manual

ISSUE DATE: May 31, 2012 SUBJECT: Compliance Program
Generally;
Compliance Program
Scope and Objectives

REVISION DATE: December 13, 2012 POLICY NUMBER: 8750-533

Board of Directors Approval: December 13, 2012

A. PURPOSE:

This policy sets forth the scope and objectives of Tri-City Healthcare District's (TCHD) Compliance Program.

B. SCOPE:

Unless otherwise limited, the TCHD's Compliance Program applies to:

1. All members of the TCHD's Board of Directors and members of TCHD's committees;
2. All employees, including officers and managers; and
3. All members of the TCHD's Medical Staff and TCHD's allied health professionals, and their respective agents, including independent contractors who or which provide health care or related services in any of the TCHD's facilities, including facilities that are owned and/or operated through joint ventures or under arrangements, for such time periods in which they furnish patient care or other related services at TCHD and/or with respect to the furnishing of patient care or related services to TCHD or any of its patients.

C. OBJECTIVES:

1. The primary objective of the TCHD's Compliance Program is to promote ethical and lawful conduct and to ensure compliance with both the letter and the spirit of applicable healthcare laws and regulations.
 - a. In particular, TCHD's Compliance Program is modeled after the voluntary "Compliance Program Guidance for Hospitals," initially published by the U.S. Department of Health and Human Services ("HHS"), Office of Inspector General ("OIG") in February 1998, and supplemented in the "OIG Supplemental Compliance Program Guidance for Hospitals" published in January 2005.

2. ~~TCHD's Compliance Program includes the seven elements identified by the OIG as fundamental to an effective compliance program:~~
 - a. ~~Implementing written policies and standards of conduct;~~
 - b. ~~Designating a Compliance Officer and establishing an Internal Compliance Committee;~~
 - c. ~~Conducting effective training and education regarding policies, procedures and practices;~~
 - d. ~~Developing effective lines of communication regarding compliance concerns;~~
 - e. ~~Enforcing policies and standards through well-publicized disciplinary guidelines;~~
 - f. ~~Conducting internal monitoring and auditing; and~~
 - g. ~~Responding promptly to detected compliance irregularities and implementing appropriate corrective action.~~
3. ~~A second, but equally important, objective is to ensure maintenance and enforcement of high standards of individual and organizational ethical and legal business practices throughout TCHD. This facilitates TCHD's ability to carry out its health care mission in a manner consistent with its values, principles and mission.~~

Administrative Policy Manual

ISSUE DATE: May 31, 2012 SUBJECT: Compliance Program
Generally;
Compliance with
Laws; Conflict of
Authorities

REVISION DATE: December 13, 2012 POLICY NUMBER: 8750-534

Board of Directors Approval: December 13, 2012

A. PURPOSE:

~~This policy sets forth guidance regarding Tri-City Healthcare District's compliance with applicable laws and regulations and to resolve any conflicts of authorities.~~

B. GENERAL POLICY:

- ~~1. The District's Compliance Program supplements laws, regulations and other governmental rules. As a general matter, laws, regulations, and other government rules control over the standards set forth in the Compliance Program unless the Compliance Program imposes stricter requirements than these authorities.~~
- ~~2. The District's Code of Conduct provides ethical and compliance guidance on a broad range of conduct. These Compliance Policies provide guidance in more detail regarding ethical and appropriate conduct, and are intended to be consistent with the general principles established in the Code of Conduct.~~

C. SPECIFIC POLICIES:

- ~~1. Some of the Policies that make up the District's Compliance Program summarize various government laws, regulations and guidelines. Such Policies should not be read or used as substitutes for the actual laws or regulations to which they relate. In other words, the District's Policies may supplement, and clarify, applicable laws and regulations.~~
- ~~2. In the event of an inconsistency between any Policy in this Compliance Program Manual and applicable laws or regulations, you are to (1) follow the applicable law or regulation unless the District's policy imposes stricter requirements and (2) report the inconsistency to the Compliance Officer.~~
- ~~3. **If you are unsure as to the appropriate standard, do not guess. Rather, please ask your supervisor or the Compliance Officer. Asking questions is perfectly acceptable, indeed encouraged.**~~

Administrative Policy Manual

ISSUE DATE: 03/03

SUBJECT: Rights to Request Privacy Protection
for Protected Health Information

REVISION DATE: 03/06; 02/09; 3/15

POLICY NUMBER: 8610-526

Administrative Policies & Procedures Committee Approval:	02/0903/15
Audit and Compliance Committee Approval Date(s):	4/15
Operations Team Committee Approval:	02/09
Professional Affairs Committee Approval:	03/09
Board of Directors Approval:	03/09

A. **PURPOSE:**

To establish a policy and procedure to comply with a patient's right to request restrictions on the use and disclosure of their protected health information (PHI) in compliance with applicable laws.

B. **DEFINITIONS:**

1. **Disclosure:** the release, transfer, provision of, access to or divulging of PHI outside Tri-City Healthcare District (TCHD).
- 1.2. **Protected Health Information (PHI):** individually identifiable health transmitted or maintained in electronic/other format that is created or received by TCMCTCHD-AND
 - a. Relates to the past, present, or future physical or mental health or condition of an individual; OR
 - b. Relates to the provision of health care to an individual; OR
 - c. Relates to the past, present, or future payment, AND
 - d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- 2.3. **Treatment, Payment, and Healthcare Operations (TPO):**
 - a. ~~Use: applies to internal sharing of individually identifiable health information~~
 - b. ~~Disclosure: applies to the external release of, or access to, the information~~
 - e.a. **Treatment:** providing, coordinating or managing a patient's care by one or more providers, including: coordinating or management of health care by a provider and a third party; consultations between providers about a patient; or the and-referrals of a patient from one provider to another.
 - d.b. **Payment:** activities related to paying or being paid for services rendered including, without limitation:
 - i. ~~Includes:~~
 - 1)i. Eligibility and coverage determinations
 - 2)ii. Billing
 - iii. Claims management
 - 3)iv. Collection activities
 - 4)v. Medical necessity and Utilization managementreview.
 - e.c. **Health care operations:** broad range of activities related to covered functions including, without limitation:such-as
 - i. Quality assessment and improvement
 - i.ii. Provider credentialing
 - ii.iii. Patient education and training
 - iii.iv. Health practitioner training
 - iv.v. Contracting for health care services
 - v.vi. Medical review
 - vi.vii. Legal services

- vii.viii. Auditing functions
 - viii-ix. Business planning and development
 - x. Business management and general administrative activities.
- ix.4. **Use: the sharing, application, utilization, examination or analysis of PHI within TCMCTCHD.**

C. **POLICY:**

1. TCMCTCHD must permit an individual to request a restriction of PHI to carry out treatment, payment or health care operations and disclosures to family members, other relatives or close personal friends otherwise permitted under 45 C.F.R. & **Section 164.501(b)** and TCMCTCHD Policy No. 8610-515.
2. TCMCTCHD is not required to agree to a requested restriction except as provided in Section C.6.
3. All decisions made on requested restriction shall be documented in writing and returned to the patient.
4. If TCMCTCHD agrees to a restriction TCMCTCHD may not use or disclose PHI in violation of such restriction.
 - a. If the individual who requested the restriction is in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment, TCMCTCHD may use the restricted PHI, or disclose such information to a health care provider, in order to provide treatment to the individual.
 - b. If restricted PHI is disclosed to a health care provider for emergency treatment, TCMCTCHD must request that the health care provider not further use or disclose the information outside the treatment episode.
5. A restriction agreed to by TCMCTCHD, is not effective to prevent uses or disclosures of PHI that are permitted or required by law without individual authorization.
6. TCMCTCHD must agree to the request of an individual to restrict the disclosure of PHI about the individual to a health plan if
 - a. The disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and
 - b. The PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid TCMCTCHD in "full."

D. **PROCESS:**

1. Request for restriction- An individual may request a restriction as follows:
 - a. A patient/patients representative must submit a written request for restriction of PHI to TCMCTCHD's Privacy Officer.
 - b. The written request must include:
 - i. What the individual wants to limit
 - ii. Whether use is limited to treatment, payment or health care operations
 - iii. To whom the individual wants the use and disclosure limit to apply
2. Termination of restriction - TCMCTCHD may terminate its agreement to a restriction under the following conditions:
 - a. The individual may- submit a written request for termination of a restriction of PHI to TCMCTCHD's Privacy Officer in writing.
 - b. The individual orally agrees to termination of the restriction and the oral agreement is documented.
 - c. TCMCTCHD informs the individual in writing that it is terminating its agreement to a restriction.
 - i. Such termination is only effective with respect to PHI created or received after the patient/patients representative has been informed.
 - ii. Such termination is not effective for PHI restricted under Section C.6 above.
3. Documentation of restriction or termination of restriction:
 - a. Patients who request a restriction of their protected health information will be provided with the *Request for Special Restriction* form to be completed, signed and submitted to TCMCTCHD's Privacy Officer.
 - b. When wishing to terminate the agreement, the *Termination of Special Restriction* form

must be completed, signed and submitted to TCMCTCHD's Privacy Officer.

4. TCMCTCHD shall maintain documentation of such restrictions/termination of restrictions in accordance with Policy No. 8610-237 ~~Record Retention. ECORD RETENTION P&P_8610-~~

E. **REFERENCES:**

1. 45 C.F.R Section 164.501 (b)
2. 45 C.F.R. & Section 164.522
3. Board Policy #14-008 Records Retention and Destruction
4. Hospital Records Retention Policy #8610-237
5. Use and Disclosure of Protected Health Information Records Policy #8610-515

**TRI-CITY HEALTHCARE DISTRICT
MINUTES 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
4002 Vista Way, Oceanside, CA 92056**

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 11:30 a.m. on March 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 V. Reno
Director Larry Schallock

Also present were:

Greg Moser, General Legal Counsel
Tim Moran, Chief Executive Officer
Sharon Schultz, Chief Nurse Executive
Steven L. Dietlin, Chief Financial Officer
Esther Beverly, VP/Human Resources
Wayne Knight, SVP of Healthcare Reform/Contracting
Glen Newhart, Executive Director and Vice President of Foundation
Dr. Scott Worman, Chief of Staff
Dr. Gene Ma, Chief of Staff Elect
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 11:30 a.m. in Assembly Room 1 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 Dagostino seconded the motion. The motion passed unanimously (7-0).

It was moved by Chairman Schallock to amend the agenda to add a closed session Existing Litigation matter related to a lawsuit filed March 25, 2015 by Mr. Larry Anderson. Director Dagostino seconded the motion. The amended motion passed unanimously (7-0).

3. Public Comments – Announcement

Chairman Schallock read the Public Comments section listed on the March 26, 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 March 26, 2015 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included three Trade Secrets with a disclosure date of October 31, 2015; Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees, two matters of Potential Litigation, Conference with Labor Negotiator related to SEIU, Appointment of Public Employee: Chief Compliance Officer, one matter of Existing Litigation and Approval of Closed Session Minutes.

5. Motion to go into Closed Session

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

6. The Board adjourned to Closed Session at 11:35 a.m.
8. At 3:39 p.m. in Assembly Rooms 1, 2 and 3, Chairman Schallock announced that the Board was back in Open Session.

The following Board members were present:

Director James Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Greg Moser, General Legal Counsel
Tim Moran, Chief Executive Officer
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. Director Kellett 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

NICU Reaches Across the Miles to Families – presented by Dr. Hamid Movahhedian, Ms. Sharon Davies, Director of Women's Services and Nancy Myers, NICU Manager.

Chairman Schallock introduced Dr. Hamid Movahhedian, Ms. Sharon Davies, Director of Women's Services and Ms. Nancy Myers, NICU Manager who are here today to describe how the Neonatal Intensive Care Unit reaches across the miles to families.

Dr. Movahhedian reported Tri-City Medical Center was the first hospital in San Diego County to implement the NicView camera which has allowed thousands of military dads to see their newborn for the first time in the NICU. Dr. Movahhedian expressed his appreciation to Muriel and Hans Schiff who donated the first 24 cameras and the Foundation for their support. He presented a brief video which showed the NicView camera in action.

Ms. Sharon Davies briefly explained how the NicView has impacted so many lives for our patients and their families.

Ms. Nancy Myers spoke regarding her first experience with a military dad deployed in Afghanistan and the fact that he was able to see his newborn baby within an hour after the birth and admission to the NICU. Ms Myers described the immense value of this system for all of the parents and families that support our parents from around the world.

Discussion was held regarding our large military population. Ms. Myers stated Camp Pendleton is aware that we have the ability to do this for any military family that has a delivery at Tri-City as well as the need to have an NICU admission. Although we have not had an opportunity to work with Balboa, the main obstetrical service for our military population, Ms. Myers stated we have had communication with Kaiser, Sharp and UCSD with regard to utilization of this camera and the value that it has had for our families here in San Diego County.

No action taken.

14. Introductions
 - a) Tina Dhillon-Ashley, M.D.
 - b) Tannaz Adib, M.D.

Chairman Schallock invited Mr. Wayne Knight, SVP to introduce two of the physicians who recently joined our staff.

Mr. Knight introduced two of Dr. Penvose's new colleagues, Dr. Tina Dhillon-Ashley, who comes to us from Fresno with over 10 years experience in private practice and

Dr. Tannaz Adib who comes to Tri-City from Hollywood, Florida with over 12 years experience in private practice. Mr. Knight stated both physicians will be working at Radiance OBGYN Medical Group.

Mr. Knight stated that on behalf of Mr. Jeremy Raimo and the entire Business Development Team, he is pleased we were able to recruit these fine physicians.

Dr. Dhillon-Ashley expressed her appreciation to our outstanding Marketing and Recruitment team who are dedicated in bringing physicians to the community. Dr. Dhillon-Ashley stated she is excited to join the practice and the community.

Dr. Adib expressed her appreciation and excitement in joining Radiance OBGYN Medical Group and stated she is looking forward to serving the community.

14. Auxiliary

Ms. Sandy Tucker, President of the Auxiliary presented a brief report, reviewing the following:

- Auxiliary Refreshers are now complete and volunteers have been updated with the latest information.
- The Auxiliary has given \$5,120 to the Emergency Department to purchase white boards for every room in the Department.

Ms. Tucker introduced two Auxiliary members who work in distinct areas and offer an invaluable service.

Ms. Susan Harris spoke regarding the benefits of Pet Therapy, noting clinical studies have shown animals reduce blood pressure, lower the heart rate and speed healing. She stated the program provides comfort and companionship to the patients as well as the staff at Tri-City Medical Center. Ms. Harris explained the certification process which is vetted every six months and includes a K9 Good Citizen patch. Departments that have benefited from our Pet Therapy program include but are not limited to BHU, Acute Rehabilitation, outpatient BHU Outpatient Pediatric Rehabilitation, Physical Therapy and Occupational Therapy.

Mr. Bob Davis, Coordinator of Mended Hearts in North County explained Mended Hearts is a National Volunteer Organization that offers support to cardiac patients and their families. He described the role of the volunteers – visiting cardiac patients and holding group meetings and how Mended Hearts offer hope to patients and their families while in the hospital. Other benefits include a lower readmission rate and reduced patient anxiety. Mr. Davis explained Mended Hearts has an extensive training program and certification program and all volunteers are certified hospital visitors.

15. Report from Chief Executive Officer

Mr. Tim Moran, Chief Executive Officer reported the hospital continues on a stable basis financially, in spite the challenges that we have in front of us.

Mr. Moran provided a recap on what has been happening in our community with regard to Behavioral Health. He stated we have started on a path to address strategically the issues we face in our Emergency Room with patients who are suffering from Behavioral Health issues. Mr. Moran stated we have had discussion with the county regarding a crisis stabilization unit and the county has recently released an RFI for interested providers. Mr. Moran stated he anticipates the process will likely be that those organizations that have expressed an interest and responded to the RFI will likely submit an RFP and when that process is done hopefully the county will have more of an effort to address issues at the crisis stage that are impacting providers and the patients that are experiencing these issues.

Mr. Moran stated we have had concerns regarding our Behavioral Health Inpatient Unit and the number of psychiatrists we have available to see our patients. He believes we are now in a position to move forward with an arrangement to help continue services in our Behavioral Health Unit as we look for longer term solutions. Mr. Moran stated mental health is a statewide concern and is of crisis proportion for many providers.

Mr. Moran stated with the introduction of Drs. Tina Dhillon-Ashley, M.D. and Tannaz Adib, we saw firsthand evidence of our vibrant recruitment efforts. Mr. Moran explained Mr. Wayne Knight and the Leadership team is working on recruitment efforts that address primary care and a number of the specialty areas where we know we have needs in our community. Mr. Moran stated as we move forward you will see us come back in a more formalized plan to address physician recruitment.

Mr. Moran reported the Primary Care Network with physicians Drs. Baroudi, Clancy, Novak and Ferber is off to a great start and patients have been pleased not only with their care but with the atmosphere. As the success of the program unfolds, it will be further encouragement to extend that strategy elsewhere in our community.

With regard to our Strategic Plan, Mr. Moran stated a formalized plan will be brought forward in the near future that will focus on addressing quality concerns, in particular patient satisfaction, physician recruitment and involvement of our key service lines.

Lastly, Mr. Moran reported the Board recently gave authorization to move forward with a Campus Development Plan. He stated we have identified five architects and will be bringing the top three back to the Board for final selection. Mr. Moran noted the plan will focus on our seismic concerns, Emergency Department renovation, parking and the NICU.

16. Report from Chief Financial Officer

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

- Net Operating Revenue – \$221,353
- Operating Expense – \$221,870
- EROE - \$2,456
- EBITDA – \$13,122

Other Key Indicators for the current year included the following:

- Average Daily Census - 195
- Adjusted Patient Days – 75,498
- Surgery Cases – 4,425
- Deliveries – 1,771
- ED Visits – 46,940

- Net Patient Accounts Receivable – \$42.7 million
- Days in Net Account Receivable – 49.0

From an operating performance perspective, Mr. Dietlin reported the following for the current month (dollars in Thousands):

- Operating Revenue - \$26,062
- Operating Expense - \$26,453
- EBITDA - \$370
- EROE - \$1,652

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.

Director Reno asked questions with regard to the Payor Mix charts which Mr. Dietlin confirmed are included in the monthly financial book.

Director Reno also requested clarification from Mr. Dietlin related to the term “trailing”. Mr. Dietlin provided a detailed explanation.

Mr. Dietlin stated we do expect further cuts in reimbursement and anticipate continued pressure in value based purchasing. Mr. Dietlin stated we are projecting sequestration to continue and that impact is approximately \$200,000 a month.

No action was taken.

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

It was moved by Director Nygaard to approve 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. Director Dagostino seconded the motion.

Mr. Steve Young, Senior Director of Ancillary Services explained when the project was approved by the Board in June of 2014, Siemens had not asked for a statement related to tax status.

General Counsel explained this is an IRS requirement for tax exemption. He clarified that the District is not taking on any new expenditures, it is simply for IRS record keeping purchases.

Mr. Young described the system, stating it is a fluoroscopy system with the ability to do CAT scan technology and create three dimensional images. He further explained that the system is used for minimally invasive surgical procedures and patients will experience a much shorter recovery time. Mr. Young noted there will be a dedicated team here to support the system 24 hours/day, seven days per week. Mr. Young stated we have received full OSHPD approval and pending a few logistics will be ready to bring the contractors in.

The vote on the motion was as follows:

AYES:	Directors:	Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

19. Chief of Staff

Consideration of March 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on March, 2015.

It was moved by Director Dagostino to approve the March 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on March 23, 2015. Director Nygaard seconded the motion.

Dr. Worman commented that the Medical Staff continues to work hard to integrate the newer technologies to adapt to the changing landscape. He stated that all these technologies add new challenges and opportunities in terms of monitoring quality and making sure patients are in a safe environment and getting the right treatment at the right time. Dr. Worman stated we are developing new ways of integrating all of our quality activities into a more robust system and the Medical Staff appreciates Administration and the Board's open dialogue in these matters.

The vote on the motion was as follows:

AYES:	Directors:	Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

19. Consent Calendar

It was moved by Director Reno to approve Consent Calendar. Director Finnila seconded the motion.

It was moved by Director Reno to remove items 19 D. Finance, Operations & Planning Committee and item 19 F. Governance & Legislative Committee. Director Kellett seconded the motion.

The vote on the main motion minus the item pulled was as follows:

AYES:	Directors:	Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

The vote on the main motion was as follows:

AYES:	Directors:	Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

20. Discussion of items pulled from Consent Agenda.

Director Reno who pulled item 19 D. Finance, Operations & Planning Committee stated the minutes reflect there was discussion of the Pulmonary contract, however it is not listed on the Consent Agenda. Mr. Dietlin responded that this item is under further review and will be brought back to a future meeting.

It was moved by Director Kellett to approve the items listed under item 19 D. Finance, Operations & Planning Committee. Director Dagostino seconded the motion.

The vote on the motion is as follows:

AYES:	Directors:	Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

Director Reno who pulled item 19 F. Governance & Legislative Committee questioned if Director Nygaard was recently appointed to the LAFCO committee. Director Nygaard explained it is a community advisory committee and appointment to the committee was made through the LAFCO Board.

It was moved by Director Dagostino to approve the items listed under item 19 G. Governance & Legislative Committee. Director Nygaard seconded the motion.

The vote on the motion is as follows:

AYES:	Directors:	Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

21. Reports (Discussion by exception only)

Director Dagostino commented on the Dashboards contained in today's meeting packet and explained these Dashboards contain new parameters that the hospital will be measuring.

Chairman Schallock stated he attended the CHA Governance Committee Forum in conjunction with CHA Legislative Days, a report of which is included in today's meeting packet.

Chairman Schallock also spoke regarding a potential EBOLA incident which occurred at another hospital and the impact it had on other hospitals in the community. Both Director Dagostino and Chairman Schallock noted the importance of more global thinking as hospitals become interdependent on each other during times of crisis.

Chairman Schallock gave a brief oral report on the Governance Institute Conference which he attended last week in Orange County. He stated that a speaker on the conference commented on the fact that Board members will need to work harder, smarter, faster and longer. Chairman Schallock stated the conference also included discussion related to cyber security and the fact that Boards need to be familiar with what policies we have in place related to cyber security.

Director Finnila commented that a Cyber Security report will be coming forward to the Audit Committee at next month's meeting.

Chairman Schallock commented on the fact that one of the speakers at the conference was promoting 5-10 year strategic plans.

Director Reno commented that the Board and Administration has done a significant amount of work in regard to Strategic Planning compared to previous administrations.

Lastly, Chairman Schallock stated speakers at the conference had very favorable comments related to ACOs as reimbursements are going to continue to decline and the cost of labor and supplies will continue to go up.

22. Legislative Update

Chairman Schallock reported he attended CHA Legislative Days along with Mr. Tim Moran and Director Dagostino, a report of which is included in today's meeting packet. Chairman Schallock also reported on legislative issues related to hospital closures and free standing emergency rooms, specifically San Clemente Hospital and Drs. Hospital in Northern California and the vast number of patients that will have difficulty accessing emergency services.

23. Comments by members of the Public

There was no comments by members of the public.

24. Additional Comments by Chief Executive Officer

Mr. Moran did not have any additional comments.

25. Board Communications

Director Nygaard did not have any comments.

Director Mitchell did not have any comments.

Director Reno spoke regarding the passing of Mrs. Evelyn Pace, one of our founders of the Tri-City Hospital Auxiliary. Director Reno also commented on several TCMC physicians who promoted this hospital and are no longer with us. Director Reno expressed her desire to work with the Marketing Department to preserve some of these memories.

Ms. Sandy Tucker, President of the Auxiliary stated she has the book which holds the first set of minutes which reflect the formation of the Auxiliary.

Director Kellett spoke regarding his excellent care during a recent hospitalization.

Director Finnila stated that tomorrow we will be honoring our fine physicians at our Doctor's Day celebration between 11:00 a.m. – 1:00 p.m.

Director Dagostino stated it was his pleasure to join Chairman Schallock and Mr. Moran in Sacramento for CHA Legislative Days where they worked collaboratively on government relations.

26. Chairman Schallock reiterated Director Finnila's comments regarding Doctors' Day. He recognized all the physicians for their care and concern, skills and expertise in providing care to the patients who come into our facility and the community we serve.

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 4:54 p.m.

29. Open Session

At 6:00 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 6:00 p.m.

ATTEST:

Larry Schallock, Chairman

Ramona Finnila, Secretary

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

**April 16, 2015 – 6:00 o'clock p.m.
Assembly Rooms 2&3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056**

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 6:00 p.m. on April 16, 2015.

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

Director James J. Dagostino, DPT, PT
Director Ramona Finnila
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Director Cyril F. Kellett, MD was absent.

Also present were:

Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Steve Dietlin, Chief Finance Officer
Sharon Schultz, Chief Nurse Executive
David Bennett, Chief Marketing Officer
Wayne Knight, SVP, Medical Affairs
Chris Miechowski, Director, Facilities
Greg Moser, General Legal Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 6:00 p.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Schallock led the Pledge of Allegiance.

2. Approval of Agenda

It was moved by Director Reno and seconded by Director Dagostino to approve the agenda as presented. The motion passed unanimously.

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. Moser, made an oral announcement of item listed on the April 16, 2015

Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Reports Involving Trade Secrets with a disclosure date of April 16, 2015.

5. Motion to go into Closed Session

It was moved by Director Dagostino and seconded by Director Nygaard. to go into Closed Session. The motion passed (6-0-1) with Director Kellett absent.

6. Chairman Schallock adjourned the meeting to Closed Session at 6:04 p.m.
7. The Board returned to Open Session at 9:46 p.m. All Board members were present with the exception of Director Kellett.

8. Report from Chairperson on any action taken in Closed Session.

Chairman Schallock reported no action had been taken in closed session.

9. Open Session

- a) Consideration of selection of architect for design of new facility at 4002 Vista Way, Oceanside, CA 92056

There was no discussion on this agenda item.

10. There being no further business, Chairman Schallock adjourned the meeting at 9:46 p.m.

Larry W. Schallock
Chairman

ATTEST:

Ramona Finnila
Secretary

Trustee.

RENEWAL INVOICE

Health Forum
P.O. Box 47890
Plymouth MN 55447

INVOICE #6721
DATE: MARCH 13, 2015

TO:

CEO
TRI-CITY MEDICAL CENTER
4002 VISTA WAY
OCEANSIDE, CA 92056-4506

Make Check Payable & Remit To:
Health Forum
P.O. Box 47890
Plymouth MN 55447



INVOICE #	PURCHASE ORDER	EFFORT #	EXPIRE	TERM
6721		RNE8	NOV/DEC 14	10 / YR

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Suite 250
Minneapolis, MN 55435
888-580-8373 * 952-988-0141 * Fax 952-988-0146

Tuesday, April 07, 2015
Invoice # 583886

DUES RENEWAL INVOICE

RoseMarie Reno
Board Chairwoman
Tri-City Healthcare District
4002 Vista Way
Oceanside, CA 92056

Membership # 00127016 Expiration Date: 05/01/2015

Dear RoseMarie:

HCCA values you as a member. Your membership is due for renewal. By renewing now, you will be assured of participation in the ever increasing benefits of being a member of HCCA. We continually strive to make your membership in HCCA the best compliance investment you can make.

I look forward to your continued participation in HCCA. And, as always, we welcome your suggestions, comments and questions.

Sincerely,
John Falcetano, HCCA President

Amount Due: \$295.00

Payment Due: Upon Receipt

---Please remit this portion with your payment-----

Please take a moment to update your contact information:

RoseMarie Reno
Board Chairwoman
Tri-City Healthcare District
4002 Vista Way
Oceanside, CA 92056

Phone: (760) 940-3347

Email: donnellantl@tcmc.com

Membership #: 00127016
Invoice #: 583886

Amount Due: \$295.00

- ☐ Check enclosed payable to HCCA
☐ Charge my VISA, MasterCard, American Express (Fax today for faster service)

Card# _____ Exp. Date: _____

Signature: _____

Online: www.hcca-info.org

By Fax: 952-988-0146

Over the phone: (952)988-0141



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	National
	Jul	Aug	Sep	Oct	Rate	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%				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%				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%				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 hip 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)												
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY15			1.6			1.0						1.4
FY14			1.0			0.8			0.8			1.8
												YTD
												1.3
												0.7

Central Line Associated Bloodstream Infection (CLABSI) per 1,000 Line Days (Quarterly)												
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY15			0.6			1.1						1.2
FY14			1.6			0.7			0.8			6.7
												YTD
												0.9
												1.2

Ventilator Associated Conditions (VAC) per 1,000 Ventilator Days - Tier 1 (Quarterly)												
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY15			8.8			9.1						N/A
FY14			2.4			4.6			9.8			6.7
												YTD
												9.0
												6.3

Infection-related Ventilator Associated Conditions (IVAC) per 1,000 Ventilator Days - Tier 2 (Quarterly)												
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY15			0.0			4.5						N/A
FY14			0.0			1.5			4.2			3.3
												YTD
												2.4
												2.5

Possible and Probably VAP per 1,000 Ventilator Days - Tier 3 (Quarterly)												
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY15			0.0			3.0						N/A
FY14			2.4			0.0			0.0			0.0
												YTD
												1.6
												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%	5.4%	4.0%	3.8%	5.8%	3.5%	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%	2.29%	2.15%	2.57%	2.16%	2.48%	2.36%
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	35	26	26	36	22	35
FY14	16	17	21	18	18	20	31	24	26	26	36	22	22

Performance compared to prior year:

Better	Same	Worse
--------	------	-------



Tri-City Medical Center

ADVANCED HEALTH CARE
FOR YOU

Employee Satisfaction



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%	55%	64%	63%	65%	59%	64%	71%	76%	73%	76%	68%	71%
FY14	60%	63%	58%	71%	65%	75%	61%	64%	64%	63%	65%	59%	64%	71%	76%	73%	76%	68%	71%

Performance compared to prior year:

Better Same Worse

"Recommend The Hospital"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	73%	69%	66%	61%	57%	61%	65%	63%	69%	61%	72%	64%	68%	77%	79%	79%	80%	70%	71%
FY14	63%	67%	67%	78%	65%	77%	65%	69%	65%	61%	72%	64%							

"Communication with Nurses"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	79%	77%	72%	71%	69%	75%	78%	66%	76%	68%	73%	75%	74%	78%	76%	78%	81%	75%	79%
FY14	76%	72%	74%	84%	73%	81%	74%	76%	68%	69%	73%	75%							

"Communication with Doctors"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	80%	71%	77%	75%	76%	76%	80%	78%	73%	75%	80%	81%	78%	79%	79%	82%	82%	78%	82%
FY14	75%	75%	78%	79%	80%	85%	73%	77%	73%	75%	80%	81%							

"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%	67%	62%	72%	71%	52%	61%	64%	68%	56%	65%	63%	62%	66%	64%	62%	68%
FY14	63%	65%	66%	72%	69%	73%	64%	62%	61%	64%	68%	56%							

"Hospital Environment"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	60%	57%	53%	55%	59%	59%	59%	57%	55%	56%	62%	64%	58%	60%	67%	65%	63%	61%	68%
FY14	54%	53%	56%	59%	58%	59%	62%	62%	55%	56%	62%	64%							

"Pain Management"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	74%	68%	68%	66%	64%	69%	72%	68%	63%	60%	66%	64%	68%	70%	71%	70%	76%	69%	71%
FY14	75%	60%	73%	76%	71%	76%	75%	70%	63%	60%	66%	64%							

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%	56%	55%	52%	62%	62%	60%	64%	63%	62%	65%	61%	64%
FY14	65%	64%	61%	62%	56%	69%	65%	53%	55%	52%	62%	62%							

"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%	88%	86%	80%	89%	86%	83%	84%	81%	87%	83%	84%	86%
FY14	85%	80%	76%	84%	79%	88%	80%	77%	86%	80%	89%	86%							

Performance compared to prior year:

Better
Same
Worse



Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg	Goal Range
FY15	46.3	48.8	47.9	48.9	49.0	48.9	51.0	50.6	50.6	48.1	49.1	48.3	49.2	48-52
FY14	49.0	48.7	48.0	49.9	51.3	52.5	53.2	50.3	48.2	48.1	49.1	48.3	49.7	48-52

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg	Goal Range
FY15	78.1	77.1	81.2	77.9	79.5	77.6	79.5	77.0	84.3	83.3	81.1	75.2	79.1	75-100
FY14	78.0	87.4	90.8	90.5	91.5	89.8	82.8	73.4	87.4	83.3	81.1	75.2	84.3	75-100

TCHD EROE \$ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budget
FY15	\$368	(\$348)	\$112	\$568	\$556	\$632	\$198	\$370	\$292	\$788	(\$264)	\$257	\$2,748	\$1,442
FY14	(\$467)	(\$406)	\$845	\$83	\$4,171	\$214	(\$45)	(\$279)	(\$511)	\$788	(\$264)	\$257	\$4,385	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budget
FY15	1.33%	-1.32%	0.41%	1.93%	1.99%	2.20%	0.70%	1.42%	1.02%	2.82%	-0.96%	1.00%	1.10%	0.58%
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%	

TCHD EBITDA \$ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budget
FY15	\$1,761	\$988	\$1,456	\$1,888	\$1,896	\$1,983	\$1,498	\$1,652	\$1,591				\$14,713	\$14,762
FY14	\$1,160	\$1,081	\$2,278	\$1,620	\$5,653	\$1,717	\$1,655	\$1,188	\$1,012	\$2,307	\$1,124	\$1,121	\$21,917	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budget
FY15	6.38%	3.75%	5.37%	6.42%	6.77%	6.91%	5.34%	6.34%	5.58%				5.89%	5.92%
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	6.18				6.04	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	1.53				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, in Excess of Covenant Requirement)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY15	\$27.7	\$21.4	\$19.9	\$18.8	\$18.9	\$22.2	\$19.9	\$16.4	\$13.4			
FY14	\$17.7	\$21.6	\$20.2	\$19.3	\$27.1	\$27.3	\$22.0	\$21.9	\$23.6	\$24.5	\$30.7	\$32.6



Tri-City Medical Center

ADVANCED HEALTH CARE
FOR YOU

Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	35	32	46	50	35	34	39	35	31	34	34	41	337
FY14	28	27	28	32	38	25	25	40	31	34	34	41	383

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	14	9	22	24	18	21	19	13	21	19	16	14	161
FY14	14	7	13	17	16	16	12	18	19	19	16	14	181

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	6	10	9	8	12	11	9	7	16	8	7	11	88
FY14	5	8	8	9	9	13	9	7	9	8	7	11	103

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	10	7	10	12	13	7	11	8	9	7	14	9	87
FY14	14	10	15	4	16	16	10	10	12	7	14	9	137

Performance compared to prior year:

Better	Same	Worse
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Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	45	51	32	43	49	27	33	43	37	38	35	35	360
FY14	20	41	27	35	44	32	50	33	29	38	35	35	419

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	23.3	26.5	27.1	21.2	22.8	19.1	18.3	17.5	19.6	21.3	21.9	24.9	21.7
FY14	19.3	21.7	22.0	17.6	19.8	19.9	18.1	22.4	24.3	21.3	21.9	24.9	21.1

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	5.2	3.5	4.3	5.0	4.3	7.2	7.0	6.0	6.5	4.0	4.2	5.0	5.4
FY14	4.7	4.8	4.0	3.5	4.6	3.8	3.7	6.1	5.7	4.0	4.2	5.0	4.5

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	13.2	18.2	19.7	18.1	15.6	16.4	18.3	21.5	14.3	11.0	12.1	14.0	17.2
FY14	12.4	13.5	16.7	19.3	16.0	16.8	17.2	18.6	10.1	11.0	12.1	14.0	14.8

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	190.8	195.0	195.1	195.6	189.2	187.9	203.3	199.8	188.0	193.1	198.1	199.0	193.8
FY14	181.9	179.2	184.2	197.9	188.6	196.4	202.2	210.9	187.7	193.1	198.1	199.0	193.1

Performance compared to prior year:

Better Same Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	246	263	244	233	194	233	199	159	208				1979
FY14	226	223	237	229	224	220	229	188	177	208	218	197	2576

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	16	19	12	19	17	11	15	8	12				129
FY14	22	15	18	18	15	18	27	11	20	14	12	16	206

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	4	6	2	1	4	8	1	15	4				45
FY14	7	10	8	12	13	5	12	7	13	8	9	2	106

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	10	9	10	10	12	12	12	5	12				92
FY14	6	9	12	11	9	6	10	15	10	7	12	16	123

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	1.64	1.63	1.58	1.58	1.56	1.58	1.58	1.63	1.62				1.60
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
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Tri-City Medical Center

ADVANCED HEALTH CARE
FOR YOU

Construction Report
As of March 2015

Project	CEO, Capital Committee, or Board Approval Date	Bid Close Date Design/ Construction	% of Design Complete	Project Start or Estimated Project Start Date	Estimated Construction Completion Date	% of Construction Complete	Total Budget	Actual Expenditures *	Remaining Budget	Total Amount Committed	Total Budget less Amount Committed	Status / Comments
Nurse Call System - Phase 1 (Design Only)	January 2012 FOP	TBD No Bids Solicited at this time	100%	Unknown	Unknown	0%	\$ 300,000	\$ 97,337	\$ 202,663	\$ 97,337	\$ 202,663	Submitted for approval
Angio Lab Renovation	September 2012 Capital Committee	January 8, 2014 Multiple Contractors	100%	June-15	October-15	0%	\$ 513,851	\$ 120,345	\$ 393,506	\$ 120,345	\$ 393,506	Siemens Lease Agreement submitted to leg for review 4/20/15
		TBD						\$ 40,290	\$ 13,672	\$ 40,290	\$ 13,672	
		No Bids Solicited at this time						\$ 40,290	\$ 13,672	\$ 40,290	\$ 13,672	
CT Scan Remodel	June 2013 Board	May 1, 2014	98%	Unknown	Unknown	0%	\$ 53,962	\$ 40,290	\$ 13,672	\$ 40,290	\$ 13,672	Construction is 100% complete. PFIs are closed ahead of deadline with Joint Commission.
Joint Commission Plans for Improvement 74 Fire Doors	June 2014 Board	Spooners	NA	July-14	August-14	100%	\$ 652,191	\$ 668,850	\$ (16,659)	\$ 660,161	\$ (7,970)	Project is 100% Complete
ICCP Clinic Design Build out	September 2014 Board	Professional Services	100%	March-14	January-15	100%	\$ 612,752	\$ 568,407	\$ 44,345	\$ 573,604	\$ 39,148	Project is 100% Complete
Renovation of Cardiac Wellness Center	July 2014 Capital	SFEIR	NA	August-14	August-14	100%	\$ 38,363	\$ 31,122	\$ 7,241	\$ 33,379	\$ 4,984	Project is 100% Complete
		NA						\$ 29,972	\$ 2,412	\$ 20,490	\$ 11,894	Project is 100% Complete
		No Public Bid Required						\$ 29,972	\$ 2,412	\$ 20,490	\$ 11,894	Project is 100% Complete
Replace Flooring at Forensics	October 2014 Capital	NA	NA	November-14	November-14	100%	\$ 32,384	\$ 29,972	\$ 2,412	\$ 20,490	\$ 11,894	Project is 100% Complete
Renovation C-Suite	November 2014 Capital	NA	NA	December-14	January-15	100%	\$ 59,444	\$ 59,949	\$ (505)	\$ 59,949	\$ (505)	Project is 100% Complete
Replacement of Surgical Lights OR #2	November 2014 Capital	No Public Bid Required	NA	December-14	January-15	100%	\$ 138,566	\$ 18,230	\$ 120,336	\$ 19,620	\$ 118,946	Pending delivery of materials
Replacement of Surgical Lights OR #2	November 2014 Capital	No Public Bid Required	100%	June-15	July-15	0%	\$ 138,566	\$ 18,230	\$ 120,336	\$ 19,620	\$ 118,946	Pending delivery of materials
Total Construction Projects		No Public Bid Required	100%	June-15	July-15	0%	\$ 2,401,513	\$ 1,634,502	\$ 767,011	\$ 1,625,175	\$ 657,392	

* "Actual Expenditures" excludes capitalized interest.

** Estimated completion is based on actual physical project progress and not on amounts invoiced to the District

**Building Operating Leases
Month Ending March 31, 2015**

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning 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		\$ 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		\$ 5,831.13	5/1/13	4/30/18	Nifty After Fifty 3861 Mission Ave, Ste B25 Oceanside, CA 92054	9551
Investors Property Mgmt. Group c/o Leavitt Family Trust 6250 El Camino Real, Ste. 206 Oceanside, Ca 92054 V#81028	5,214	\$1.65	(a)	\$ 9,126.93	9/1/12	8/31/17	OP Physical Therapy, OP OT & OP Speech Therapy 2124 E. El Camino Real, Ste. 100 Oceanside, Ca 92054	7772 - 76% 7792 - 12% 7782 - 12%
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	7,247	\$1.22	(a)	\$ 9,811.17	7/1/11	7/1/16	Outpatient Behavioral Health 510 West Vista Way Vista, Ca 92083	7320
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)	\$ 22,900.00	10/1/12	10/1/22	Chemotherapy/Infusion Oncology Office 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056	7086
Ridgeway/Bradford CA LP DBA: Vista Town Center PO Box 19068 Irvine, CA 92663 V#81503	3,307	\$1.10		\$ 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		\$ 7,949.11	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		\$ 12,824.94	1/1/12	12/31/16	Vacant Bank Building Property 4000 Vista Way Oceanside, Ca 92056	8462 Until operational
Total				\$ 338,863.41				

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

**Education & Travel Expense**
Month Ending March 31, 2015

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6185	FAILSAFE CERT PROGRAM	122214	750.00	82368	INSKEEP, LINDST
8620	ACHD MTG	22315	666.32	55410	ROSEMARIE RENO
8620	CAHHS HLTH CONFERENCE	13115	470.00	81163	DAGOSTINO, SCHALLOCK
8620	CHA SEMINAR	13115	207.20	81163	LAURA MITCHELL
8620	CHA SEMINAR	13115	258.20	81163	ROSEMARY RENO
8620	CHA SEMINAR	22815	258.20	81163	JAMES DAGOSTINO
8620	CHA SEMINAR	31315	304.70	81515	JAMES DAGOSTINO
8620	CHA SEMINAR	31115	595.76	78591	LARRY W. SCHALLOCK
8620	GOVERNANCE FORUM	31715	159.24	78591	LARRY W. SCHALLOCK
8680	HEALTHCARE MINISTRY ASSOCIATION	33015	1,125.00	34626	DURAN, PHILLIPS, WESTBROOK
8700	CONSENT LAW SEMINAR	312152	330.00	14365	COLLEEN THOMPSON
8740	ACLS / BLS RENEWAL	22715	125.00	80617	CARISSA DAMARA
8740	ACLS / BLS RENEWAL	22715	150.00	78966	FELICIA NEUMEYER
8740	ACLS RENEWAL	21915	110.00	81488	YVONNE R. FERNANDEZ
8740	ACLS RENEWAL	21215	150.00	82376	BARBARA HORNICK
8740	CARDIO SURGERY COURSE	21915	200.00	21962	DAN DAVIDSON
8740	DIALECTICAL BEHAVIOR THERAPY COURSE	21215	199.99	79713	SODABEH MILLER
8740	ESSENTIAL CLINICAL ANATOMY	22715	125.00	81938	ALAN CHRISTOPHERSON
8740	HABITS OF HAPPY	21915	113.00	78830	WINNIE MADRID
8740	NUTRITION IN CRITICAL CARE COURSE	21915	200.00	77946	KELLI GECEWICZ
8740	RN TO BSN	21215	2,500.00	28741	LORI FISHER
8758	CONSENT LAW SEMINAR	312152	660.00	14365	PIERSON, CAVANAUGH

**This report shows payments for and/or reimbursements to employees and Board Members in the Education & Travel expense category in excess of \$100.00.

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

Seminar Title : ACHD Annual Legislative Day

Location Sacramento, CA

Dates April 13-14

Reason for attending;

ACHD choose Assemblyman Rocky Chavez to be their Legislator of the Year. I attended to Leg Day activities and helped introduce him at the dinner in his honor. He had been a great advocate for our hospital.

As well as honoring Assemblyman Chavez ACHD put a very good legislative day update which included a day of preparation on effective advocacy for a visit to our local legislators. Critical legislation that was focused on this year for support was

AB366 (Bonita) and AB243 (Hernandez) Both of these bills are focused on increases to Medical Payments for inpatient hospital reimbursements and prohibits the rate reduction enacted in AB97. If enacted, This legislation ensures that patients will continue to receive high quality patient care and hospital will receive reimbursement for providing services to California's underserved populations. While all of the legislators that I visited with were supportive of the bills there is doubt that the State Budget will include any increases. There is increased money in the budget but there is also repayment demands with prop 98 and a number of others.

AB 1124 (Perea) directs the Administrative Director of the Division of Workers Compensation to establish a formulary (similar to HMO's formulary) for the purpose of prescribing prescription medications. Division of Workers' Compensation would create a closed formulary that would reduce inappropriate proscribing and cut costs for employers. The State could save over \$124 million to \$420 million and there would be improved clinical outcomes.

The one bill opposed this year was AB 305 (Gonzalas) It would prohibit a physician from making an apportionment determination based on pregnancy, breast cancer, menopause or osteoporosis as a pre-existing condition for workers' compensation claims. If this bill is enacted it would result in biases in this apportionment law and significant increased costs to California's employers. It is bad legislation.

I also had an opportunity to address our issue with Behavioral Health. I spoke with our new Lobbyist Group for ACHD, Hurst Brooks Espinosa, LLC. They suggested it might be a good idea for us to do a joint Behavioral health application with Palomar to the County including services at both our hospital. It is an interesting idea.

I had appointments with Senator Patricia Bates, Assemblyman Rocky Chavez, Assembly member Marie Waldron and Senator Joel Anderson.

There was also an interesting Briefing on Telehealth and the use of robots to provide care in rural areas. It was pretty amazing.

We also had a briefing on Vaccinations: it happens that this week the legislature was hearing testimony on the measles epidemic and whether the shots will be required. The Capital was filled with people on that issue. (AB277)

It is always good to touch base with our legislators. We are lucky to have some good ones that understand our issues.



ACHD
ASSOCIATION OF CALIFORNIA
HEALTHCARE DISTRICTS

April 6, 2015

Andrew Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: California's Medi-Cal 2020 Waiver Renewal – SUPPORT

Dear Mr. Slavitt:

On behalf of the Association of California Healthcare Districts (ACHD), I write in support of California's Medicaid Section 1115 Waiver renewal – Medi-Cal 2020. California has crafted a visionary and cross-cutting Medicaid Section 1115 Waiver renewal proposal that will bolster the State's efforts to transform health care delivery, improve quality and improve health outcomes.

ACHD represents 78 Healthcare Districts throughout California, in both urban and rural settings. The Districts offering a variety of services aimed at improving community health including acute hospital care, community grant making, chronic disease management education, senior services, ambulance services, primary care clinics, dental clinics, nutritional counseling, physical education, long term care/skilled nursing, and senior housing. In many instances, Healthcare Districts are the sole source of health care in the community – serving as an integral part of the safety net for the State's uninsured and underinsured.

There are a number of ACHD priorities that intersect with DHCS's waiver concept paper, including:

- **Access to Care.** ACHD supports proposals to expand workforce training for addressing workforce shortages, increasing culturally and linguistically diverse providers, and addressing workforce in rural areas. Incentives to increase Medi-Cal provider participation will benefit residents in many of the communities where our Healthcare Districts operate. Twenty-three of the 28 most rural California counties are designated medically underserved or include medically underserved populations, so addressing rural access to care and increasing specialty provider access are crucial for our members.
- **Workforce Development.** The waiver proposal includes a number of initiatives to increase training and expand the healthcare workforce. ACHD supports the inclusion of expanded residency training slots, particularly for rural areas and increasing culturally appropriate care. ACHD also supports the incentives included in the waiver for managed care plans to support



non-physician community providers, including Community Health Workers and Peer Support Specialists.

- **Expanding the Use of Telehealth.** ACHD strongly supports the use of telehealth as a strategy to address provider shortage issues in underserved and rural areas. In many of our healthcare districts, geographic isolation and transportation difficulties are common barriers to obtaining medical care, especially specialty care.
- **Improving Mental Health and Substance Use Disorder Treatment, Delivery and Coordination.** The Medi-Cal 2020 proposal places a strong emphasis on behavioral health issues, which are woven through every initiative. ACHD is supportive of many of the proposals, including:
 - ❖ The managed care proposals aimed at increasing coordination and integration of primary and behavioral health services will improve health outcomes and allow persons with mental health and substance use disorder treatment needs to better navigate managed care plans and county mental health systems.
 - ❖ The proposal to incentivize the use of community health workers and peer support specialists will be particularly helpful in further improving care coordination between the primary health and behavioral health needs of patients.
 - ❖ Similarly, the housing proposal aimed at improving care coordination for individuals experiencing homelessness will also have a significant impact on improving care and outcomes for individuals with behavioral health needs.
- **Support for District Hospitals.** ACHD supports the creation of the Public Safety Net System Transformation and Improvement Program as a successor to the Delivery System Reform Incentive Payment program. The Public Safety Net System Transformation and Improvement Program will allow California's 42 Healthcare Districts operating hospitals to participate in delivery system transformation. We appreciate the state's acknowledging the diversity of district hospitals in your proposal and for including a funded planning period. We concur that a planning period will provide district hospitals time to get the tools and technical assistance in place to participate in the Transformation and Improvement Program. Healthcare Districts look forward to the opportunity to expand access to primary care, to improve quality of care and health outcomes, and to increase efficiency at our hospitals.



ACHD
ASSOCIATION OF CALIFORNIA
HEALTHCARE DISTRICTS

For the reasons outlined above, ACHD supports the Medi-Cal 2020 Waiver Renewal. ACHD understands that California's waiver renewal negotiations are just beginning and will be ongoing in the months to come. ACHD is hopeful that California's waiver renewal will position California to continue to be national leader in Medicaid coverage, expansion, transformation and health improvement.

Sincerely,

Kenneth B. Cohen
Executive Director

cc: Victoria Wachino, Acting Deputy Administrator and Director, Center for Medicaid and CHIP Services
Diana Dooley, Secretary, California Health and Human Services Agency
Jennifer Kent, Director, Department of Health Care Services
Mari Cantwell, Deputy Director, Department of Health Care Services
Donna Campbell, Governor's Office
Michael Cohen, Director, Department of Finance

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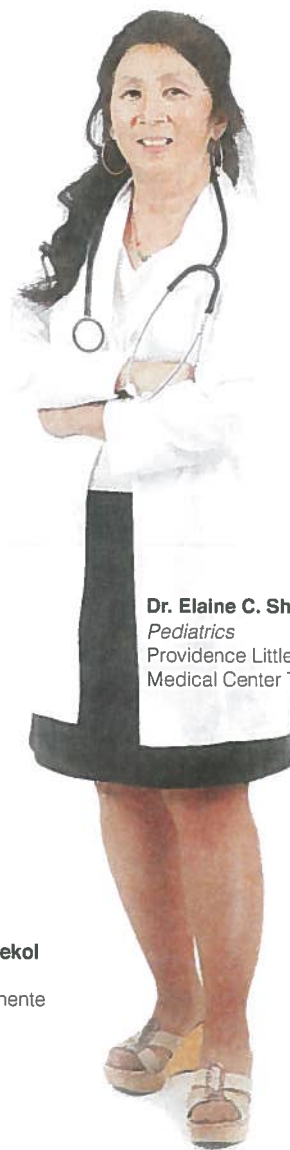
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Dr. Eric N. Milefchik
Infectious Disease Specialist
Torrance Memorial Medical Center



Dr. Lisa H. Stekol
Pediatrics
Kaiser Permanente



Dr. Elaine C. Shoji
Pediatrics
Providence Little Company of Mary
Medical Center Torrance

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