TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
May 28, 2015 – 1:30 o'clock p.m.
Classroom 6 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 1, 2, 3
4002 Vista Way, Oceanside, CA 92056

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

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors.	3 min.	Standard
4	Oral Announcement of Items to be Discussed During Closed Session (Authority: Government Code Section 54957.7)		
5	Motion to go into Closed Session		
6	Closed Session	**2 Hours**	
	a. Conference with Labor Negotiators (Authority: Government Code Section 54957.6) Agency Negotiator: Tim Moran Employee organization: SEIU		
	b. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: October 31, 2015		
	c. Conference with Legal Counsel – Potential Litigation (Authority Government Code Section 54956.9(d) (2 Matters)		
	d. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	e. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: October 31, 2015		
	f. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: 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. Appointment of Public Employee: Chief Compliance Officer (Authority: Government Code, Section 54957)		
	h. Conference with Legal Counsel – Existing Litigation (Authority Government Code Section 54956.9(d)1, (d)4 (1) Francisco Valle vs. TCHD Case No. 37-2015-00015754-CU-OE-NC (2) TCHD vs. Burlew Case No. 37-2014-00034015-CU-NP-NC (3) Larry Anderson Employment Claims (4) Medical Acquisitions Company vs. TCHD Case No: 2014-00009108 (5) 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	Special Presentations (1) Recognition of Nurses of the Year: a) Camille Bryan, RN ICU Inpatient Nurse of the Year b) Anna Wong-Yee, RN Home Health Outpatient Nurse of the Year c) Luz Leal, ACT 1 North Patient Care Support Staff of the Year	10 min.	Chair

	Agenda Item	Time Allotted	Requestor
13	Report from TCHD Auxiliary – Sandy Tucker, President	10 min.	Standard
14	Report from TCHD Foundation – Glen Newhart, Executive Director/Vice President	10 min.	Standard
15	Report from Chief Executive Officer	10 min.	Standard
16	Report from Chief Financial Officer	10 min.	Standard
17	New Business – a. Consideration to approve the FY2015-2016 Community Healthcare Grant Awards – Ms. Gigi Gleason and Mr. Don Reedy	20 min.	CHAC Comm.
	b. Consideration of a Physician Recruitment Agreement with Xiangli Li, MD, PhD	5 min	J. Raimo/FOP
	c. Consideration to approve amendment to Article II, Section 8 of the Bylaws	10 min.	Gov. Comm.
	d. Consideration of process for selection of Facilitator for Board Workshop	10 min.	Chair
18	Old Business - None		
19	Chief of Staff a. Consideration of May 2015 Credentialing Actions Involving the Medical Staff – New Appointments Only	5 min.	Standard
20	Consideration of Consent Calendar (1) Medical Staff Credentials for April, 2015 (2) Board Committees ***(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.*** ***(2) All items listed were recommended by the Committee.*** ***(3) Requested items to be pulled require a second.*** **A. Human Resources Committee** Director Kellett, Committee Chair Open Community Seats – 0 *No meeting held in May, 2015* **B. Employee Fiduciary Retirement Subcommittee** Director Kellett, Subcommittee Chair Open Community Seats – 0 *No meeting held in May, 2015* **C. Community Healthcare Alliance Committee** Director Nygaard, Committee Chair Open Community Seats - 2 (Committee minutes included in Board Agenda packets for informational purposes)	5 min.	Standard HR Comm. Emp. Fid. Subcomm. CHAC Comm.

	Agenda Item	Time Allotted	Requestor
	D. Finance, Operations & Planning Committee Director Dagostino, Committee Chair Open Community Seats – 1 (Committee minutes included in Board Agenda packets for informational purposes.) 1. Approval of physician agreement with Dr. Arvin Mirrow for Outpatient Behavioral Health Services coverage for a term of 36 months beginning July 1, 2015 through June 30, 2018 not to exceed an average of 16 hours per month or 192 hours annually, at an hourly rate of $125.00 for an annual cost of $24,000 and a total cost for the term of $72,000. 2. Approval of ED On Call Agreements with Drs. Frank Corona, Safouh Malhis, Martin Nielsen and Mark Yamanaka for a term of 12 months beginning July 1, 2015 through June 30, 2016, no to exceed a daily rate of $897.00 and a total collective cost for the term of $328,302.00, split between panel physicians.		FO&P Comm.
	E. Professional Affairs Committee Director Dagostino, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes.) 1) **Patient Care Services Policies and Procedures:** a. Code Pink Resuscitation Standardized Procedure b. Interdisciplinary Plan of Care IPOC c. Lift Team Technician d. Midline Catheter, Adults 2) **Administrative Policies & Procedures** a Dr. Strong 221 b. Portable Space Heaters, Use of 247 3) **Unit Specific** **Infection Control** a. IC 4 Healthcare Associated Infections, Defined **NICU** b. Nutritional Care and Assessment for Infants Admitted to NICU **Pharmacy** c. Adverse Drug Event_Discern Alert Rules d. Antibiotic Stewardship e. Antimicrobial Susceptibility Report f. Authorized Access to the Pharmacy g. Bedside Medication Storage h. Discharge Prescriptions i. Emergency Crash Cart Security and Accountability j. Flumazenil (Romazicon) in the Treatment of Benzodiazepine Overdose k. Formulary System l. Hours of Operation		PAC Comm.

	Agenda Item	Time Allotted	Requestor
	m. Medication Ordered STAT and at Specified Time n. Patients Use of Herbals and Natural Remedies o. Pharmacological Abbreviations- Unapproved **Rehabilitation** p. 613 Physical Therapy Assistant Supervision **Women and Newborn Services** q. Bottle Feeding Procedure r. Circumcision s. Trial of Labor after Cesarean (TOLAC) Vaginal Birth after Cesarean Birth (VBAC) t. WNS Disaster Response Plan **Environment of Care** **Safety Management** u. 1001 Environmental Health and Safety By-Laws v. 1021 Patient Age Related Hazards w. 1023 Visitor Safety x.1030 Disposing of Recalled Products y. 1041 Safety Walk Through Program **Life Safety Management** i. 3000- Life Safety Management Plan **Hazard Material Management** ii. 6000 Hazardous Material and Waste Management iii. 6001 Hazardous Substance Inventory List iv. 6002 Hazardous Materials Waste Training v. 6003 Hazardous Waste & Materials Responsibilities vi. 6004 Hazardous Waste & Material-Ordering, Receiving and Storage vii.6005 Receiving Safety Data Sheets (SDS) viii.6007 Hazardous Waste & Materials Storage ix. 6009 Hazardous Materials Management x. 6010 Handling & Use of Gas Cylinders xi .6011 Radioactive Contaminated Waste Handling At Storage Area xii.6012 Battery Management And Disposal **Formulary** xiii. Request for Formulary Status Evaluation Criteria for Use for Miacaicin **F. Governance & Legislative Committee** Director Schallock, Committee Chair Open Community Seats - 0 (Committee minutes included in Board Agenda packets for informational purposes.) **Medical Staff Policies & Procedures:** a. 8610-568 – CPOE Power Plan: Revisions & Additions **Rules & Regulations** a. Division of Orthopedic Surgery		Gov. & Leg. Comm.

	Agenda Item	Time Allotted	Requestor
	G. Audit & Compliance Committee Director Finnila, Committee Chair Open Community Seats – 0 *No meeting held in May, 2015* (3) Minutes – Approval of a) April 30, 2015 – Regular Board of Directors Meeting (4) Meetings and Conferences - None (5) Dues and Memberships - None		Audit, Comp. & Ethics Comm. Standard Standard Standard
21	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
22	Reports (Discussion by exception only) (a) Dashboard - Included (b) Construction Report – None (c) Lease Report – (April, 2015) (d) Reimbursement Disclosure Report – (April, 2015) (e) Seminar/Conference Reports 1) ACHD Annual Meeting – Directors Nygaard/Mitchell 2) AHA Annual Meeting – Directors Schallock/Dagostino	0-5 min.	Standard
23	Legislative Update	5 min.	Standard
24	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board.	5-10 minutes	Standard
25	Additional Comments by Chief Executive Officer	5 min.	Standard
26	Board Communications (three minutes per Board member)	18 min.	Standard
27	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session **(Includes 10 minutes for recess to accommodate KOCT tape change)**	**2 hours/ 45 min.**	
28	Oral Announcement of Items to be Discussed During Closed Session (If Needed)		
29	Motion to Return to Closed Session (If Needed)		
30	Open Session		
31	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
32	Adjournment		

COMMUNITY HEALTHCARE ALLIANCE COMMITTEE
May 14, 2015

CONTACT: Director Julie Nygaard
Committee Chair

COMMUNITY ACTIVITY REPORT ITEM: Consideration to approve the recommendations made by the Community Healthcare Alliance Committee (CHAC) for the 2015-2016 Grant Year as found in Table #1.

BACKGROUND: Tri-City Healthcare District is committed to working collaboratively to improve the health and well-being of our community. Each year the Board of Directors of the Tri-City Healthcare District allocates funds for healthcare-related projects of non-profit agencies. These agencies in turn use these funds to serve the residents of the communities serviced by Tri-City Medical Center.

In the 2015-2016 Grant Year, a total of $475,000.00 was approved for allocation. This amount includes unused grant money left over from 2014-2015, which at the time, was approved by the Board of Directors to be applied to the 2015-16 grant allocation funds.

At its May 14, 2015 meeting, the CHAC Committee voted to recommend to the Board of Directors the organizations noted in Table #1 as the recipients of the grant awards for the 2015-16 year.

RECOMMENDATIONS: The Community Healthcare Alliance Committee has recommended the Board approve the following:

- That the amounts suggested by the Grant Review Panel for the 2015-2016 grant period shown in Table #1 be accepted.

The recipient recommendations have been provided to the Board of Directors for their review and approval.

Table #1

ORGANIZATION	AMOUNT REQUESTED	AMOUNT FUNDED
Alzheimer's Association of SD/Imperial Chapter	$20,000.00	$12,000.00
American Diabetes Association	$66,707.33	$22,000.00
BILY San Diego	$2,300.00	$2,300.00
Boys & Girls Club Carlsbad	$13,161.00	$7,500.00
Boys & Girls Club Oceanside	$20,000.00	$12,000.00
Boys & Girls Club Vista	$10,000.00	$7,500.00
CSUSM Foundation	$22,000.00	$17,000.00
Emilio Nares Foundation	$5,318.00	$5,318.00
Fraternity House, Inc.	$30,000.00	$14,000.00
Hospice of the North Coast	$50,000.00	$30,000.00
Impact Young Adults	$79,726.60	$24,960.00
KOCT O'side Community TV Corporation	$45,100.00	$45,100.00
New Haven Youth & Family Services	$20,000.00	$10,000.00
North County LGBTQ Resource Center	$21,300.00	$13,500.00
North County Lifeline	$21,500.00	$19,000.00
Operation HOPE – Vista, Inc.	$10,200.00	$10,200.00
Parkinson's Association of San Diego	$100,000.00	$55,705.00
San Diego County Medical Society Foundation	$63,237.00	$63,237.00
Solutions for Change	$37,500.00	$37,500.00
Vista Community Clinic	$61,037.00	$31,037.00
Women's Resource Center	$20,143.00	$20,143.00
Wounded Warriors Homes, Inc.	$15,000.00	$15,000.00
Totals	**$734,229.93**	**$475,000.00**

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: May 19, 2015
Physician Recruitment Proposal – Xiangli Li, MD, PhD

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

Physician Name: Xiangli Li, MD, PhD (CV attached)

Areas of Service: Internal Medicine

Key Terms of Agreement:

Effective Date:	July 1, 2015 or the date Dr. Li becomes a credentialed member in good standing of the Tri-City Healthcare District Medical Staff
Community Need:	TCHD Physician Needs Assessment shows significant community need for an Internal Medicine Physician
Income Guarantee:	Not to exceed a two-year income guarantee with loan to be forgiven over a three-year forgiveness period provided physician continues to practice within service area
Service Area:	Area defined by the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients
Income Guarantee:	$200,000 annually ($400,000 for two years)
Sign-on Bonus:	$15,000
Relocation:	$10,000 (Not to Exceed)
Total Not to Exceed:	$415,000 (Loan Amount)

Medical Group:
Xiangli Li, M.D., Ph.D. will join the North County Internal Medicine Group with Jeffrey O. Leach, M.D., and Jon A. LeLevier, M.D. at their office located at 2067 W. Vista Way, #200, Vista, CA 92083.

Requirements:

Business Pro Forma: Must submit a two-year business pro forma for TCHD approval relating to the addition of this physician to the medical practice, including proposed incremental operating income and expenses. TCHD may suspend or terminate income guarantee payments if operations deviate more than 20% from the approved pro forma and are not addressed as per agreement.

Expenses: The agreement specifies categories of allowable incremental professional expenses (expenses incurred by Group as a sole result of the new physician) such as incremental billing costs, additional medical and office supplies, etc. If the incremental monthly expenses exceed a maximum, the excess amount will not be included.

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

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Dir., Business Development/Physical Medicine

Motion:
I move that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the public health of the communities served by the District to approve a total expenditure not to exceed $425,000 over two years in order to facilitate this Internal Medicine physician practicing medicine in the communities served by the District. This will be accomplished through a Physician Recruitment Agreement (not to exceed a two-year income guarantee) with Xiangli Li, M.D., Ph.D. and North County Internal Medicine Group.

Xiangli Li, MBBS, MM, PhD

8 Witherspoon Street, Nutley, NJ 07110
Xiangli.li@gmail.com
Cell Phone: 858-337-6549
Permanent resident of USA

SUMMARY:
Mature, patient and responsible Internal Medicine senior resident with enthusiasm in primary patient care.
Extensive knowledge and experience in medical diagnosis and patient care services in various settings, including inpatient and outpatient clinics, private/state/ government owned hospital and clinics.

OBJECTIVE: To obtain a Full-time Internal Medicine Physician position in San Diego area

PROFESSIONAL EXPERIENCE

Internship and Residency
Internal Medicine
Rutgers University New Jersey Medical School, Newark, NJ — July 2012- present
As a senior resident, responsibilities included direct patient care and supervising medical students and interns in the intensive care unit, medical floor and clinics in University hospital, Hackensack Medical center, VA hospital East Orange NJ and the North Hudson County Clinics.

Postdoctoral Fellow — July 2008-June 2012
Division of Rheumatology, Allergy and Clinical immunology
University of California San Diego, School of Medicine, La Jolla, CA
Lead and coordinated research projects.

Research Associate — Jan 2005-June 2008
Department of Immunology and Microbial science
The Scripps Research Institute, La Jolla, CA
Lead and coordinate research projects.

Residency and Clinical Fellowship — Sept 1995- July 1998
Residency in Internal Medicine and Endocrinology clinical fellowship
Ruijin Hospital, Shanghai Second Medical University
Shanghai, China

PROFESSIONAL LICENSE
Physicians and Surgeons License in California, 2014 active

EDUCATION:
University of North Carolina at Chapel Hill — Aug 1998- Dec 2003
School of Public Health
Degree granted: **PhD in Nutrition**

Shanghai Second Medical University — Aug 1995- July 1998
(Current Shanghai Jiao Tong University Medical school)
Shanghai, China
Degree granted: **Master in Internal Medicine**

Shanghai Railway Medical University — Sept 1990-July 1995
(Current Medical School of Shanghai Tongji University)
Shanghai, China
Degree granted: **Bachelor of Medicine in Medicine**

CERTIFICATION

2011 USMLE Step 1: 232, March 29, 2011
2011 USMLE Step 2 CS: Passed (May 14, 2011)
2011 USMLE Step 2 CK: 240, August 2, 2011
2012 USMLE Step 3: 226, May 15, 2012
2014 BLS (Rutgers University, May 1,2014)
2014 ACLS (Rutgers University, May 1, 2014)

PROFESSIONAL MEMBERSHIP

American College of Physicians (ACP) 2013-present

SELECTED ARTICLES:

Li X, Murray, F, Koide N, Goldstone J, Chen J, Bertin S, Fu G, Weinstein LS, Chen M, Corr M, Eckmann L, Insel PA, and Raz E. Divergent role of Gαs in CD4 T cells on Th subset differentiation and their inflammatory profile. Journal of Clinical Investigation, 2012 Mar 1; 122(3):963-73

Lee S, Li X, Kim JC, Lee J, Gonzalez-Navajas JM, Rhee JH and Raz E. Type I IFN is required for maintaining Foxp3 expression and Treg function during T cell-mediated colitis. Gastroenterology 2012 Jul;143 (1):145-54

Li X, Makarov SS: Persistent activation of NF-kappa B controls an undifferentiated, invasive phenotype of primary fibroblast-like synoviocytes in arthritic joints. Proc Natl Acad Sci U S A. 2006 Nov 14; 103 (46):17432-7.

Li T, Lange L, Li X, Susswein L, Bryant B, Malone R, Lange E, Huang TT, Stafford D, Evans JP. Polymorphisms in the VKORC1 gene are strongly associated with warfarin dosage requirements in patients receiving anticoagulation. J Med Genetics. 2006 Sep;43(9):740-4.

Li, X, Bradford B, Bunzendahl H, Thurman RG, Goyer SM, Makarov SS: CD14 mediates innate immune response to anthropathogenic peptidoglycan-polysaccharide complex. Arthritis Research & Therapy; 2004 April;6(3):R273-81

Li X, Bradford BU, Wheeler MD, Stimpson SA, Pink HM, Brodie TA, Schwab JH, Thurman RG. Dietary glycine prevents peptidoglycan polysaccharide-induced reactive arthritis in the rat: role for glycine-gated chloride channel. Infection & Immunity, 2001 Sep; 69 (9):5883-91

AWARDS AND HONORS

- NIH T32 training grant for Asthma and Allergic diseases, 2011-2012
- Postdoctoral Fellowship awarded by Arthritis Foundation 2005-2008
- A. Hughes Bryan Outstanding Doctoral Student Award, School of Public Health, UNC at Chapel Hill, 2003 – 2004
- Travel Award by Arthritis Foundation, Arthritis Research Conference 2003
- Scholarship awarded by Shanghai Second Medical University, 1996
- "Excellent Graduate in Universities of Shanghai" honor awarded by Shanghai Higher Education Bureau, 1995

REFERENCES

Available upon request

Procopio®

www.procopio.com

MEMORANDUM

Procopio, Cory, Hargreaves & Savitch LLP
525 B Street, Suite 2200
San Diego, CA 92101
T. 619.238.1900
F. 619.235.0398

TO: **Board of Directors**
Tri-City Healthcare District

FILE NO: **116569.004**

FROM: **Gregory V. Moser**
General Counsel

CC: **Tim Moran**
Chief Executive Officer

DATE: **May 13, 2015**

RE: **Proposed Amendment to Board Bylaws to Provide for Added Regular Meetings**

At its May 12, 2015 meeting, the Governance & Legislative Committee recommended that the Board of Directors take action to establish additional regular meetings to cope with the additional workload the board is experiencing. We recommend amendment of the Bylaws to expressly allow the Board to schedule regular meetings on a monthly basis in addition to meetings on the last Thursday of each month.

During its discussion, the Committee noted that the current workload of the Board is resulting in a number of special meetings, as well as some very lengthy regular board meetings. Establishing a regular schedule which provides for two regular board meetings a month, for example, would allow for shorter regular meetings and fewer special meetings.

If the proposed bylaw change is adopted, a new meeting schedule would need to be approved setting additional regular meetings. This is required at least annually under the Brown Act.

We recommend that Article III, Section 8 of the Bylaws be revised to read as follows:

Section 8. Regular Meetings.

Regular meetings of the Board of Directors of the District shall be scheduled for the last Thursday of each calendar month at a time determined by the Board of Directors at least annually, in Assembly Room 3 of the Eugene L. Geil Pavilion, Tri-City Medical Center, 4002 Vista Way, Oceanside, California. **The Board may adopt a schedule of additional monthly regular meetings**. The Board of Directors may, from time to time, change the time, the day**s** of the month of such regular meetings and the location**s** (provided the location**s are** within the boundaries of the District) as dictated by holiday schedules or changing circumstances. (H&S Code § 32104; Gov. Code § 54954.)

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

TO: Larry Schallock, Chairperson

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

DATE: May 28, 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 May 6, 2015. Their recommendations were reviewed and approved by the Medical Executive Committee on May 18, 2015. This report is forwarded to the Board of Directors with recommendations for approval:

SUBMITTED BY:

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

GOVERNING BOARD DISPOSITION:

Approved: ☐

Denied: ☐

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

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
May 6, 2015

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 05/28/2015 – 04/30/2017)
Medical Staff – Appoint to Provisional Staff and grant privileges as delineated:

Delgado, George, MD	Family Medicine/Palliative Care
Desadier, Jason M., DO	Emergency Medicine
Warda, Gregory R., MD	Pediatrics/Neonatology

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

Lister, Crystal J., CNM	Obstetrics/Gynecology – Certified Nurse Midwife
McDonald, April C., NP	Pediatrics/Neonatology – Nurse Practitioner

INITIAL APPLICATION WITHDRAWAL: (Voluntary unless otherwise specified)
Medical Staff:
Tse, Tommy H., MD Anesthesiology

Allied Health Professionals:
None

TEMPORARY PRIVILEGES:
Medical Staff/Allied Health Professionals:

McDonald, April C., NP	Pediatrics/Neonatology – Nurse Practitioner
Seif, David, MD	Anesthesiology

- Cardiac anesthesia
  Transesophageal Echocardiography (TEE)

TEMPORARY MEDICAL STAFF MEMBERSHIP:
Medical Staff:

Velyvis, John, MD	Surgery/Orthopedic Surgery – Proctor for Blue Belt Navio Case 05/06/2015

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

TO: Larry Schallock, Chairperson

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

DATE: May 28, 2015

SUBJECT: Medical Executive Committee Credentialing Recommendations – Reappointments

---

The attached Medical Staff Reappointments Credentials report was reviewed and approved at Credentials Committee on May 6, 2015. Their recommendations were reviewed and approved by the Medical Executive Committee on May 18, 2015. This report is forwarded to the Board of Directors with recommendations for approval:

SUBMITTED BY:

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

GOVERNING BOARD DISPOSITION:

Approved: ☐

Denied: ☐

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

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
May 6, 2015

Attachment B

REAPPOINTMENTS: (Effective Dates 06/01/2015 – 05/31/2017)

Medical Staff:

Athill, Charles A., MD **Medicine/Cardiology**
Reappoint to Courtesy Staff status and grant privileges as requested

Bengs, Christopher J., MD **Family Medicine**
Reappoint to Courtesy Staff status and grant privileges as requested

Bernhardt, Chad M., MD **Emergency Medicine**
Reappoint to Active Staff status and grant privileges as requested

Bobick, Brian S., DPM **Surgery/Podiatric Surgery**
Reappoint to Active Staff status and grant privileges as requested

Castro, Jorge L., MD **Pediatrics**
Reappoint from Active Staff to Consulting Staff status and grant privileges as delineated:
Relinquish:
- Attendance at C-sections and vaginal deliveries, including newborn resuscitation
- Intubation, Infant
- Intubation, Pediatric
- Laryngoscopy

Lumbar Puncture

Chabala, James V., MD **Family Medicine**
Reappoint to Active Staff status and grant privileges as requested

Conant, Reid F., MD **Emergency Medicine**
Reappoint to Active Staff status and grant privileges as requested

Day, Richard B., MD **Medicine/Internal Medicine**
Reappoint to Active Staff status and grant privileges as requested

Dougherty, Colin M., MD **Emergency Medicine**
Reappoint to Active Staff status and grant privileges as requested

Eli, Bradley A., DMD **Surgery/Subspecialty Surgery**
Reappoint from Provisional to Consulting Staff status and grant privileges as delineated:
Add:
- Consultation (Oral & Maxillofacial Surgery)

Relinquish:
- History & Physical Examination (General Dentistry)

Farhoomand, Kaveh S., DO **Medicine/Internal Medicine**
Reappoint to Active Staff status and grant privileges as delineated:
Relinquish:

Lumbar Puncture

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
May 6, 2015

Attachment B

Forman, Michael H., MD **Emergency Medicine**
Reappoint to Active Staff status and grant privileges as requested

Fortuna, Robert B., MD **Radiology/Teleradiography**
Reappoint to Associate status and grant privileges as requested

Jacobs, Robert D., MD **Surgery/Otolaryngology**
Reappoint from Active Staff to Associate Staff status and grant privileges as delineated
Relinquish:
- Pediatric Endoscopic Sinus Surgery
- Transantral Ligation Vessels
- Osleoplatic Frontal Ablation
- Advanced Endoscopic Frontal Sinus Procedures
- Maxillectomy, Partial
- Maxillectomy, Total
- Orbital Exenleration

Kakimoto, William M., MD **Radiology/Diagnostic Radiology**
Reappoint to Active Staff status and grant privileges as requested

Karp, Michael W., MD **Pediatrics**
Reappoint to Active Staff status and grant privileges as requested

Kazem, Fatima, MD **Radiology/Teleradiography**
Reappoint to Associate status and grant privileges as requested

Ly, Justin Q., MD **Radiology/Teleradiography**
Reappoint from Provisional Staff to Associate Staff status and grant privileges as requested

Moradi, Amir, MD **Surgery/Otolaryngology**
Reappoint from Courtesy Staff status to Associate Staff status and grant privileges as requested
Unsupervised to Proctor Status – (due to low activity)
- Perform History & Physical examination, including via telemedicine (F)
- Intermediate Plastic and Reconstructive Surgery of Head and Neck (Crossover)
- Advanced Plastic and Reconstructive Surgery of Head and Neck (Crossover)

Relinquish:
- Rhytidectomy

Novak, Loren S., DO **Family Medicine**
Reappoint to Active Staff status and grant privileges as requested

Ordas, Dennis M., MD **Medicine/Psychiatry**
Reappoint to Active status and grant privileges as requested

Paduga, Remia S., MD **Medicine/Neurology**
Reappoint to Active Staff status and grant privileges as requested

Ransom, Mark S., MD **Anesthesiology**
Reappoint to Courtesy Staff status and grant privileges as requested

Sarkaria, Paul D., MD **Medicine/Cardiology**
Reappoint to Active Staff status and grant privileges as requested

Seufert, Kevin T., MD **Family Medicine**
Reappoint to Affiliate Staff status and grant privileges as requested

Spiegel, David A., MD **Medicine/Cardiology**
Reappoint to Active Staff status and grant privileges as requested

Allied Health Professionals:

Brownsberger, Richard N., PAC **Radiology/Physician Assistant**
Reappoint to Allied Health Professionals and grant privileges as requested.

Folkerth, Jean M., RNFA **Surgery/Registered Nurse First Assistant**
Reappoint to Allied Health Professionals and grant privileges as requested.

Pidding, Apryl D., NP **Medicine/Nurse Practitioner**
Reappoint to Allied Health Professionals and grant privileges as requested.

Pregerson, Heather A., PAC **Radiology/Physician Assistant**
Reappoint to Allied Health Professionals and grant privileges as requested.

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

RESIGNATIONS: (Effective date 05/31/2015 unless otherwise noted)

Voluntary:

Espiritu, Yvette M., PA-C	Medicine/Cardiology **(effective 04/17/2015)**
Lo Sasso, Barry E., MD	Pediatrics/Pediatric Surgery
Lowe, Lisa G., MD	Emergency Medicine
Monson, Mark L., DDS	Surgery/Oral & Maxillofacial Surgery
Tamas, Laszlo, MD	Surgery/Neurosurgery **(effective 04/14/2015)**
Willard, Gary, MD	Family Medicine/Wound Care **(effective 05/14/2015)**

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
May 6, 2015

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS (Effective Date: 05/28/2015, unless specified otherwise)

Hermann, Linda, PA-C Emergency Medicine
Add:

- Limited abdominal and cardiac ultrasonography
- Ultrasound guidance for approved procedures
- Limited obstetrical ultrasonography

Seif, David, MD Anesthesiology
Add:

- Cardiac anesthesia
- Transesophageal Echocardiography (TEE)

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
May 6, 2015

Attachment B

PROCTORING RECOMMENDATIONS (Effective 05/28/2015, unless otherwise specified)

Forbes, Beth, RNFA Release from proctoring	**Surgery/General & Vascular Surgery** Assist during robotic-assisted surgery (da Vinci)	**100% Complete**
Hermann, Linda, PA-C Release from proctoring:	**Emergency Medicine** Reduction of major joints	
Maeda, Andrew, MD Release from proctoring:	**Anesthesiology** General anesthesia Regional anesthesia	**100% Complete**
McWhirter, Robert W., MD Release from proctoring:	**Emergency Medicine** General patient care	
Slater, Madeline L., MD Release from proctoring	**Medicine/Infectious Disease** Admit Patients Consultation, Infectious Diseases History & Physical examination	**100% Complete**
Willett, Brie, PA-C Release from proctoring:	**Emergency Medicine** General patient care Reduction of major joints Thoracentesis and paracentesis	
Wiltse, Lisa, MD Release from proctoring:	**Anesthesiology** General anesthesia	

Human Resources Committee
(No meeting held in
May, 2015)

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

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
May 14, 2015 Assembly Room 1

MEMBERS PRESENT: Board of Directors Chairman Larry Schallock, Director James Dagostino, Director Julie Nygaard, Dr. Victor Souza, Carol Brooks, Mary Lou Clift, Marge Coon, Gigi Gleason, Darryl Hebert, Carol Herrera, Marilou de la Rosa Hruby, Robin Iveson, Linda Ledesma, Gina McBride, Don Reedy, Roma Ferriter, Audrey Lopez.

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

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

MEMBERS ABSENT: Linda Allington, Marilyn Anderson, Xiomara Arroyo, Rosemary Eshelman, Jack Nelson, Barbara Perez, Bret Schanzenbach, Laura Vines, Fernando Sanudo

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CALL TO ORDER	The May 14, 2015 Community Healthcare Alliance Committee meeting was called to order at 12:35pm by Director Julie Nygaard.		
APPROVAL OF MEETING AGENDA	Director Jim Dagostino motioned to approve the May 14, 2015 agenda. The motion was seconded by member Audrey Lopez and unanimously approved.		
PUBLIC COMMENTS & ANNOUNCEMENTS	No public comments were made.		
RATIFICATION OF MINUTES	Director Jim Dagostino motioned to approve the April 9, 2015 meeting minutes. The motion was seconded by Gigi Gleason and unanimously approved.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
May 14, 2015 Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
NEW BUSINESS	**TCMC UPDATE:** CEO Tim Moran updated the group as follows: **LEAPFROG:** Tim Moran noted that TCMC is one of only 4 hospitals in the county that recently received an "A" rating from Leapfrog (a national, non-profit watchdog group measuring hospital quality and safety). Tim noted that this excellent rating validates of the work of TCMC employees who keep patients safe and the hospital operating well. **CAMPUS PLAN:** Tim Moran and Steve Dietlin, Executive VP & CFO, have been working on the long-term campus plan in light of imposed seismic requirements and needed upgrades to the Emergency Room, parking areas and increased bed capacity. Steve is working closely with the Architect regarding requirements and financing needs. **MOB:** Tim noted that final determinations are expected by the end of the year. **PRIMARY CARE**: Tim deferred Primary Care to David Bennett, Sr. VP & CMO. David noted that Primary Care is a critical part of TCMC's success strategy and a major focus of the Marketing Department and the hospital in general. David previewed the most recent television commercial produced to highlight Dr. Belen Clark and TCMC's Primary Care Physicians. Tim Moran noted that our challenge will be to give all PCP's an equal amount of promotion and attention in the advertising campaigns. David agreed, and noted that the Marketing Department is working to ensure		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
NEW BUSINESS Con't	that all TCMC Primary Care Physicians are kept informed and provided opportunities to be part of the marketing process. David also noted that we are currently building a database of grateful patients to use in our advertising campaign. Robin Iveson complimented Marketing on their successful TV ads. Director Julie Nygaard noted that the improved marketing techniques are having a great impact on the surrounding communities.		
CHAC Grant Review Committee Recommendations	Gigi Gleason and Don Reedy addressed the group regarding the recent work and recommendations of the CHAC Grant Review Committee. Gigi provided an overview of the responsibilities and work of the committee and Don explained the committee's guidelines and standards for grant applications, why certain applications are eliminated, and how awarded applicants fit TCMC's community goals. In light of full disclosure, David Bennett noted that his participation in the process was as an observer only, not as a voting member. Gigi Gleason related the following: • Grant money left over from the 2014 allocations was applied to the 2015 allocation, bringing the total amount to $475,000.00.		

<table>
<tr><th>TOPIC</th><th>DISCUSSION</th><th>ACTION FOLLOW UP</th><th>PERSON(S) RESPONSIBLE</th></tr>
<tr><td>CHAC Grant Review Committee Recommendations Con't</td><td>

A total of 64 grant applications were received, twice the number received in any previous year
All grant recipients from 2014 complied with the Final Report requirements
The following organizations were disqualified due to errors / factors in the submission process:

1. Aviara Oaks Elementary PTA
2. Bread of Life Rescue Mission
3. Brother Benno Foundation, Inc.
4. Calavera Hills Middle School
5. Got Your Back San Diego
6. Silver Age Yoga Community Outreach, Inc.
7. T.E.R.I., Inc.
8. Trauma Intervention Programs of San Diego

The following organizations were recommended for funding by the committee:

<table>
<tr><th>ORGANIZATION</th><th>AMOUNT FUNDED</th></tr>
<tr><td>Alzheimer's Association of SD/Imperial Chapter</td><td>$12,000.00</td></tr>
<tr><td>American Diabetes Association</td><td>$22,000.00</td></tr>
<tr><td>BILY San Diego</td><td>$2,300.00</td></tr>
<tr><td>Boys & Girls Club Carlsbad</td><td>$7,500.00</td></tr>
<tr><td>Boys & Girls Club Oceanside</td><td>$12,000.00</td></tr>
</table>
</td><td></td><td></td></tr>
</table>

TOPIC	DISCUSSION		ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CHAC Grant Review Committee Recommendations Con't	**ORGANIZATION**	**AMOUNT FUNDED**		
	Boys & Girls Club Vista	$7,500.00		
	CSUSM Foundation	$17,000.00		
	Emilio Nares Foundation	$5,318.00		
	Fraternity House, Inc.	$14,000.00		
	Hospice of the North Coast	$30,000.00		
	Impact Young Adults	$24,960.00		
	KOCT O'side Community TV Corporation	$45,100.00		
	New Haven Youth & Family Services	$10,000.00		
	North County LGBTQ Resource Center	$13,500.00		
	North County Lifeline	$19,000.00		
	Operation HOPE – Vista, Inc.	$10,200.00		
	Parkinson's Association of San Diego	$55,705.00		
	San Diego County Medical Society Foundation	$63,237.00		
	Solutions for Change	$37,500.00		
	Vista Community Clinic	$31,037.00		
	Women's Resource Center	$20,143.00		
	Wounded Warriors Homes, Inc.	$15,000.00		
	Director Jim Dagostino motioned to forward the CHAC Grant Review Committee's recommendations to the Board of Directors. The motion was seconded by Gina McBride.			
	Linda Ledesma and Robin Iveson abstained.			

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
May 14, 2015 Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
BEHAVIORAL HEALTH SUB-COMMITTEE	Sr. Director Jodie Wingo updated the group about the Behavioral Health Workgroup meeting that took place on May 6th. It was a very productive meeting. 2 psychologists from the community were present, as well as Dr. Carola Hauer and Ingrid Stuiver PhD from TCMC. There was discussion about the "Every Mind Matters" grant that Dr. Hauer and Ingrid applied for to get funding for the Crisis Stabilization Unit. It was also discussed that the CSU will include a walk-in clinic that will address the needs of youth and families. Next Steps: -This fits in perfectly to the workgroup's mission. Jodie Wingo, Dr. Hauer and Ingrid Stuiver will look at internal operations status and needs and will report back at the next work group meeting. -Once internal processes are in place for referrals and the status of the grant and clinic is known, the next steps will involve getting personnel to work the walk-in clinic, set up a referral network and market the services to schools and parents. Next meeting TBD		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
May 14, 2015 Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PUBLIC COMMENTS	Director Dagostino noted that he and Director Larry Schallock recently attended a conference in Washington D.C. whose focus was on the issue of Mental Health. Both were able to speak to the Legislature regarding this issue and its impact within the community. Linda Ledesma relayed that San Diego County's Juvenile Hall will be opening its doors to the public on Saturday, May 16th. Tours will be available in both English and Spanish. Gina McBride noted that copies of the current Carlsbad Business Journal publication were available to pick up after the meeting. Marilou de la Rosa Hruby relayed that the Filipino-American Cultural Organization will be holding their annual event on Saturday, June 6th from 10:00-4:00pm at the Oceanside Civic Center Library. Don Reedy noted that Saturday, May 16th, the Oceanside Chamber of Commerce will be hosting Operation Appreciation for all active-duty military personnel and their families.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
May 14, 2015 Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PUBLIC COMMENTS Con't	Glen Newhart, VP Foundation Development, relayed that TCMC will be hosting "Tails on the Trails" sponsored by the Tri-City Hospital Foundation and Tri-City Hospital Auxiliary, on May 30th from 9:00 – 2:00pm. Glen also noted that the TCMC Auxiliary was recently recognized for their outstanding work and achievements by the American Hospital Association. Sandy Tucker was available to accept the award on behalf of the Auxiliary team.		
DATE & TIME OF NEXT CHAC MEETING	The next Community Healthcare Alliance Committee meeting will be held on Thursday, June 11, 2015 from 12:30pm – 2:00pm.		
ADJOURNMENT	The meeting was adjourned at 1:50pm.		

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
May 19, 2015

Members Present	Dr. James Dagostino, Director Kellett, Director Julie Nygaard, Dr. John Kroener, Dr. Marcus Contardo, Dr. Frank Corona, Kathleen Mendez, Robert Knezek, Steve Harrington
Non-Voting Members Present:	Tim Moran, CEO, Steve Dietlin, CFO, Kapua Conley, COO, Wayne Knight, Sr. VP, Medical Services
Others Present:	Director Laura Mitchell, Carol Smyth, Glen Newhart, Tom Moore, Ray Rivas, Jeremy Raimo, Sarah Jayyousi, Miava Sullivan, Andrea Benton, Kathy Topp, Jody Root, Procopio, Barbara Hainsworth
Members Absent:	Wayne Lingenfelter

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Dagostino called the meeting to order at 12:30 pm.		
2. Approval of Agenda		**MOTION** **It was moved by Director Nygaard, Dr. Corona seconded, and it was unanimously approved to accept the agenda of May 19, 2015 with the following change: Item 6c., the write-up for Physician Agreement for Non-Exclusive, Weekend Remote and On-Call Psychiatry Services-UCSD Health System, 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 April 21, 2015		Minutes ratified. **MOTION** **It was moved by Director Kellett, Dr. Corona seconded, that the minutes of April 21, 2015, be approved as written.**	
5. Old Business	None		
6. a. Physician Agreement- Outpatient Behavioral Health Services – Arvin Mirow, M.D.	Sarah Jayyousi presented the renewal of the physician agreement for Dr. Arvin Mirow at the same rate, to provide professional guidance and oversight for the Behavioral Health Services Department including: • Intensive Outpatient Program, Dual Diagnosis and afternoon program. • Provide patient and staff education and educate provider and community members on availability and efficacy of Intensive Outpatient Program services. • Respond to insurance authorization calls • Complete reports requested by patients, including disability • Sign off on all treatment changes. • Facilitate weekly treatment team meetings and evaluate appropriateness for continued stay. • Assist clinical staff in appropriate discharge placement and follow-up care.	**MOTION** **Director Kellett moved, Dr. Kroener seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Mirow as the Coverage Physician for a term of 36 months beginning July 1, 2015 and ending June 30, 2018, not to exceed an average of 16 hours per month or 192 hours annually, at an hourly rate of $125.00 for an annual cost of $24,000 and a total cost for the term of $72,000.**	Sarah Jayyousi

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
b. Physician Recruitment Proposal – Xiangli Li, M.D., PhD	Jeremy Raimo provided a Powerpoint presentation pertaining to the Physician Recruitment Proposal for Xiangli Li, M.D., PhD. She is to become a credentialed member in good standing of the Tri-City Healthcare District Medical Staff. He further explained that the TCHD Physician Needs Assessment reflects a significant need for an Internal Medicine physician. He also reported that this proposal is a standard physician recruitment contract, and that Dr. Li has obtained a medical license for the State of California. Jeremy also introduced and recognized Miava Sullivan for her assistance in research and preparation of FOP write-up documents for his area.	**MOTION** **Director Kellett moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the public health of the communities served by the District to approve a total expenditure not to exceed $425,000 over two years in order to facilitate this Internal Medicine physician practicing medicine in the communities served by the District. This will be accomplished through a Physician Recruitment Agreement (not to exceed a two-year income guarantee) with Xiangli Li, M.D., Ph.D. and North County Internal Medicine Group.**	Jeremy Raimo
c. Physician Agreement for Non-Exclusive, Weekend Remote and On-Call Psychiatry Services	This write-up was pulled at the outset of the meeting by Wayne Knight, citing that it was not ready to move forward at this time.	**PULLED**	Sharon Schultz / Wayne Knight
d. Financials	Steve Dietlin presented the financials ending April 30, 2015 (dollars in thousands) **Fiscal Year to Date** Operating Revenue $277,971 Operating Expense $278,559 EROE $ 3,091 EBITDA $ 16,332		Steve Dietlin

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	TCMC –Key Indicators – FYTD Avg. Daily Census 193 Adjusted Patient Days 94,025 Surgery Cases 5,577 Deliveries 2,165 ED Visits 58,767 **Current Month** Operating Revenue $ 28,102 Operating Expense $ 28,151 EROE $ 343 EBITDA $ 1,620 **Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R (in millions) $ 43.1 Days in Net A/R 49.4 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable • TCMC-Average Daily Census-Total Hospital-Excluding Newborns • TCMC-Adjusted Patient Days • TCMC-Emergency Department Visits • TCHD-EROE and EBITDA		
e. Work Plan – Information Only	Director Dagostino reported that these agenda items were for review only, but Committee members were welcome to ask questions.		

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
• Aionex Bed Board • Dashboard	**Aionex Bed Board** In Sharon Schultz's absence, Kathy Topp reviewed the Aionex Executive Summary and the accompanying spreadsheet; significant discussion ensued. Due to the amount of interest and questions pertaining to the Aionex System, Mr. Moran suggested that a representative from the Multi-Disciplinary Task Force, which oversees the Aionex Bed Board system attend a future Finance, Operations and Planning meeting. **Dashboard** No discussion held.		Sharon Schultz / Kathy Topp
7. Comments by Committee Members		None	Chair
8. Date of next meeting	June 16, 2015		Chair
9. Community Openings	(1 Opening) Due to the resignation of Mr. William McGaughey from the Finance, Operations and Planning Committee on April 21, 2014, Teri Donnellan has been advised, and notices have been posted to seek a replacement.		Chair
17. Adjournment	Meeting adjourned 1:17 pm.		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: May 19, 2015
Physician Agreement - Arvin Mirow, M.D.

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

Physicians Name: Arvin Mirow, M.D.
Area of Service: Outpatient Behavioral Health Services
Term of Agreement: 36 months, beginning July 1, 2015 - ending June 30, 2018
Maximum Totals:

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	36 month (Term) Cost
$125.00	16	192	$2,000	$24,000	$72,000

Position Responsibilities:

- Provide professional guidance and oversight for the Outpatient Behavioral Health Services Department, including, Intensive Outpatient Program, Dual Diagnosis and afternoon program.
- Provide supervision for the clinical operation of the Department and programs.
- Provide patient and staff education and educate providers and community members on availability and efficacy of Intensive Outpatient Program services at Hospital.
- Respond to insurance authorization calls.
- Complete reports requested by patients, including disability.
- Sign off on all treatment changes, including increase in days, extension of treatment, etc.
- Facilitate weekly treatment team meetings and evaluate appropriateness for continued stay.
- Assist clinical staff in the appropriate discharge placement and follow-up care provision.
- Assist in evaluation of patients and determination for the need for inpatient admission.
- Physician shall maintain time sheets and data of hours worked, and submit signed sheets at end of each month to Department manager for review.
- Physician shall provide a written 30-day notice for absences to assist in the rescheduling of patients.
- Physician shall identify an MD to cover OPBHS needs during their absence. Beyond four weeks of absence per year, the physician must obtain coverage for another physician to be physically present in OPBHS to conduct patient admissions and see patients.
- Complete all FI and Joint Commission and governing agency requirements related to dictating weekly to monthly progress notes, initial assessments, evaluation for extension of treatment, and changes in frequency of treatment.

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

Person responsible for oversight of agreement: Sharon Schultz, CNE

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Mirow as the Coverage Physician for a term of 36 months beginning July 1, 2015 and ending June 30, 2018 not to exceed an average of 16 hours per month or 192 hours annually, at an hourly rate of $125.00 for an annual cost of $24,000 and a total cost for the term of $72,000.

Table 6: Hourly Rate Compensation

	Providers	Groups	Mean	Std Dev	25th %tile	Median	75th %tile	90th %tile
Anesthesiology: All	17	13	$154	$53	$100	$150	$206	$237
Cardiology. Electrophysiology	5	5	$176	$64	$118	$175	$235	*
Cardiology: Invasive	15	7	$178	$46	$150	$175	$215	$250
Cardiology. Invasive-Interventional	35	16	$182	$52	$150	$157	$237	$250
Cardiology: Noninvasive	17	12	$167	$42	$150	$150	$191	$248
Critical Care Intensivist	12	9	$136	$36	$115	$145	$152	$190
Emergency Medicine	30	14	$158	$31	$150	$166	$173	$199
Endocrinology/Metabolism	5	5	$122	$32	$98	$114	$150	*
Family Medicine (with OB)	13	7	$145	$9	$142	$150	$150	$150
Family Medicine (without OB)	55	23	$133	$41	$100	$125	$150	$191
Gastroenterology	10	7	$160	$30	$138	$150	$176	$225
Geriatrics	3	3	*	*	*	*	*	*
Hematology/Oncology	10	7	$167	$47	$130	$167	$200	$245
Hospice/Palliative Care	4	3	*	*	*	*	*	*
Hospitalist	41	19	$118	$21	$100	$125	$130	$147
Hyperbaric Medicine/Wound Care	8	7	$148	$9	$143	$150	$150	*
Infectious Disease	29	14	$156	$42	$135	$150	$150	$235
Internal Medicine: General	45	21	$137	$62	$100	$125	$150	$175
Internal Medicine: Pediatric	3	2	*	*	*	*	*	*
Nephrology	10	7	$139	$46	$100	$135	$158	$234
Neurology	28	17	$143	$31	$130	$150	$150	$187
Obstetrics/Gynecology	33	16	$149	$36	$125	$150	$186	$186
Occupational Medicine	2	2	*	*	*	*	*	*
Orthopedic Surgery: All	28	19	$165	$47	$126	$150	$192	$250
Orthopedic (Nonsurgical)	3	2	*	*	*	*	*	*
Pathology	5	5	$139	$32	$113	$133	$168	*
Pediatrics	29	14	$124	$36	$100	$125	$150	$167
Physiatry (Physical Medicine & Rehabilitation)	8	6	$140	$29	$125	$135	$150	*
Psychiatry	27	12	$126	$26	$105	$127	$150	$154
Pulmonary Medicine	48	20	$149	$28	$125	$150	$170	$200
Radiation Oncology	12	12	$204	$64	$156	$191	$237	$331
Radiology: All	8	7	$159	$57	$125	$146	$160	*
Rheumatology	2	2	*	*	*	*	*	*
Sleep Medicine	9	9	$139	$32	$115	$134	$163	*
Surgery General	25	16	$182	$40	$150	$180	$206	$252
Surgery: Cardiovascular	10	7	$208	$80	$182	$240	$250	$297
Surgery. Neurological	7	5	$292	$89	$270	$280	$350	*
Surgery: Trauma	9	8	$156	$28	$128	$150	$180	*
Surgery. Vascular (Primary)	4	4	*	*	*	*	*	*
Surgery: All Other	33	15	$157	$52	$128	$150	$195	$243
Urgent Care	2	1	*	*	*	*	*	*
Urology	6	5	$179	$29	$163	$183	$200	*
Surgical Other Specialty	1	1	*	*	*	*	*	*
Nonsurgical Other Specialty	5	4	$117	$32	$83	$130	$143	*

Table 2: Total Annualized Compensation by Organization Ownership

	Physician Owned			Hospital/IDS Owned		
	Providers	Groups	Median	Providers	Groups	Median
Anesthesiology: All	53	15	$42,848	11	10	$37,800
Cardiology. Electrophysiology	3	3	*	2	2	*
Cardiology: Invasive	9	5	$25,000	11	6	$22,458
Cardiology: Invasive-Interventional	22	12	$30,960	24	9	$30,000
Cardiology: Noninvasive	9	7	$21,336	20	12	$23,700
Critical Care: Intensivist	1	1	*	13	11	$60,000
Dermatology	1	1	*	0	0	*
Emergency Medicine	25	4	$40,000	23	15	$80,000
Endocrinology/Metabolism	2	2	*	6	6	$17,750
Family Medicine (with OB)	7	4	$12,600	13	7	$48,000
Family Medicine (without OB)	45	8	$12,000	85	27	$20,000
Gastroenterology	18	11	$12,500	7	5	$20,000
Geriatrics	0	0	*	3	3	*
Hematology/Oncology	11	4	$12,420	12	10	$27,998
Hospice/Palliative Care	4	2	*	9	7	$6,000
Hospitalist	14	6	$40,000	58	25	$40,000
Hyperbaric Medicine/Wound Care	0	0	*	10	8	$19,600
Infectious Disease	27	7	$24,000	12	10	$37,250
Internal Medicine: General	34	11	$17,998	72	25	$29,400
Internal Medicine: Pediatric	2	1	*	2	1	*
Nephrology	17	4	$85,281	10	8	$27,500
Neurology	10	6	$41,200	25	16	$24,700
Obstetrics/Gynecology	6	6	$12,420	42	19	$25,000
Occupational Medicine	4	2	*	5	4	$25,000
Ophthalmology	2	2	*	0	0	*
Orthopedic Surgery: All	35	18	$25,000	19	17	$42,000
Orthopedic (Nonsurgical)	2	1	*	1	1	*
Pathology	8	2	*	8	8	$20,985
Pediatrics	20	8	$2,778	28	16	$19,539
Physiatry (Physical Medicine & Rehabilitation)	3	3	*	10	7	$26,900
Psychiatry	1	1	*	36	18	$35,000
Pulmonary Medicine	32	8	$41,000	32	17	$19,000
Radiation Oncology	6	2	*	11	11	$38,400
Radiology: All	17	6	$5,556	9	7	$60,000
Rheumatology	2	1	*	3	3	*
Sleep Medicine	6	3	$12,000	14	14	$33,530
Surgery: General	20	10	$27,500	23	15	$50,000
Surgery: Cardiovascular	8	6	$43,713	13	7	$32,000
Surgery: Neurological	5	3	$34,200	4	4	*
Surgery: Trauma	0	0	*	14	9	$34,500
Surgery: Vascular (Primary)	2	2	*	6	6	$50,200
Surgery: All Other	17	8	$33,120	21	12	$30,000
Urgent Care	4	3	*	6	4	$17,500
Urology	8	5	$42,500	3	3	*
Surgical Other Specialty	1	1	*	1	1	*
Nonsurgical Other Specialty	3	2	*	5	4	$63,606

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 17, 2015
PHYSICIAN AGREEMENTS for Pulmonary Call Panel

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

Physicians Name: Frank Corona, MD

Area of Service: ED On-Call - Pulmonary

Term of Agreement: 12 months Beginning 7/1/15 Ending 6/30/16

Maximum Totals: For entire ED On-Call Area of Service Coverage, split between multiple physicians.

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$897	FY 2016 - 366	$328,302.00	$328,302.00

Position Responsibilities:

- Provide 24/7 patient coverage for pulmonary specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete medical records in accordance with all Medical Staff, accreditation and regulatory requirements
- Conduct medical rounds on those patients under physician's care as clinically appropriate

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

Person responsible for oversight of agreement: Sharon Schultz, CNE

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Frank Corona, MD as an ED On-Call Coverage Physicians for a term of 12 months beginning July 1, 2015 and ending June 30, 2016. Not to exceed a daily rate of $897 and a total collective cost for the term of $328,302.00, split between multiple panel physicians.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 17, 2015
PHYSICIAN AGREEMENTS for Pulmonary Call Panel

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

Physicians Name: Safouh Malhis, MD

Area of Service: ED On-Call - Pulmonary

Term of Agreement: 12 months Beginning 7/1/15 Ending 6/30/16

Maximum Totals: For entire ED On-Call Area of Service Coverage, split between multiple physicians.

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$897	FY 2016 - 366	$328,302.00	$328,302.00

Position Responsibilities:

- Provide 24/7 patient coverage for pulmonary specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete medical records in accordance with all Medical Staff, accreditation and regulatory requirements
- Conduct medical rounds on those patients under physician's care as clinically appropriate

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

Person responsible for oversight of agreement: Sharon Schultz, CNE

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Safouh Malhis, MD as an ED On-Call Coverage Physicians for a term of 12 months beginning July 1, 2015 and ending June 30, 2016. Not to exceed a daily rate of $897 and a total collective cost for the term of $328,302.00, split between multiple panel physicians.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 17, 2015
PHYSICIAN AGREEMENTS for Pulmonary Call Panel

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

Physicians Name: Martin Nielsen, MD

Area of Service: ED On-Call - Pulmonary

Term of Agreement: 12 months Beginning 7/1/15 Ending 6/30/16

Maximum Totals: For entire ED On-Call Area of Service Coverage, split between multiple physicians.

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$897	FY 2016 - 366	$328,302.00	$328,302.00

Position Responsibilities:

- Provide 24/7 patient coverage for pulmonary specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete medical records in accordance with all Medical Staff, accreditation and regulatory requirements
- Conduct medical rounds on those patients under physician's care as clinically appropriate

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

Person responsible for oversight of agreement: Sharon Schultz, CNE

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Martin Nielsen, MD as an ED On-Call Coverage Physicians for a term of 12 months beginning July 1, 2015 and ending June 30, 2016. Not to exceed a daily rate of $897 and a total collective cost for the term of $328,302.00, split between multiple panel physicians.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: March 17, 2015
PHYSICIAN AGREEMENTS for Pulmonary Call Panel

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

Physicians Name: Mark Yamanaka, MD

Area of Service: ED On-Call - Pulmonary

Term of Agreement: 12 months Beginning 7/1/15 Ending 6/30/16

Maximum Totals: For entire ED On-Call Area of Service Coverage, split between multiple physicians.

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$897	FY 2016 - 366	$328,302.00	$328,302.00

Position Responsibilities:

- Provide 24/7 patient coverage for pulmonary specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete medical records in accordance with all Medical Staff, accreditation and regulatory requirements
- Conduct medical rounds on those patients under physician's care as clinically appropriate

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

Person responsible for oversight of agreement: Sharon Schultz, CNE

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Mark Yamanaka, MD as an ED On-Call Coverage Physicians for a term of 12 months beginning July 1, 2015 and ending June 30, 2016. Not to exceed a daily rate of $897 and a total collective cost for the term of $328,302.00, split between multiple panel physicians.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
May 21, 2015

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

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

Others present: Greta Proctor, General Counsel, Marcia Cavanaugh, Director of Risk Mgt. and Quality, Jami Piearson, Director of Quality and Regulatory, Patricia Guerra, Sharon Davies, Priya Joshi, Kathy Topp, Kerry Moriarty-Homsy, Nancy Myers, Sharon Davies, Tori Hong, Kevin McQueen 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 12:02 p.m. in Assembly Room 1.		Director Dagostino
2. Approval of Agenda	The group reviewed the agenda. There were three (3) policies that were pulled out by Gen. Counsel Jody Root: 1. Business Visitor Visitation Requirements 203 2. Equipment Transfer, Storage Trade-in and Disposal 200 3. Ordering of DME Equipment (NICU Specific Policy)	Motion to approve the revised agenda was made by Director Dagostino and seconded by Director Finnila.	Director Dagostino

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Dagostino read the paragraph regarding comments from members of the public.		Director Dagostino
4. Ratification of minutes of April 2015.	Director Dagostino called for a motion to approve the minutes of the April 16, 2015.	Minutes ratified. Director Finnila moved and Director Mitchell seconded the motion to approve the minutes from April 2015.	Karren Hertz
5. New Business a. Quality Outcomes Dashboard **Consideration and Possible Approval of Policies and Procedures**	The dashboard for Core Measures data was presented by Jami Piearson. This report which has internal calculations are not publicly reported. *Note on HF rate: Jami stated that the charts were extensively reviewed and there were no issues found. It was also noted that the current mortality rate for the hospital is 1.4. Sharon briefly discussed the **T**elebridge—how it helps reduce readmissions and enhance great outcomes for CVHI. It supposedly proposes major benefit to the highest risk patient.	**ACTION:** There was a recommendation to put the legend in each page of the dashboard for easy reference. Jami also mentioned that Administration should be notified if there are any other changes or modifications that need to be done on this data.	Jami Piearson

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Patient Care Policies and Procedures: 1. Code Pink Resuscitation Standardized Procedure	Director Mitchell clarified the definition of Code Caleb which is defined as resuscitation for infants 30 days or less. This policy only applies to inpatient and outpatient infants in the ED, and not on offsite facilities.	*The Patient Care Services policies and procedures were approved with the exception of some minor edits. Director Finnila moved and Dr. Worman seconded the motion to approve these policies.	Patricia Guerra
2. Interdisciplinary Plan of Care IPOC	There was no discussion on this policy.		
3. Lift Team Technician	There were some editorial corrections done and also, the Lift team duties were clarified as turning and lifting patients according to adjunct therapies as needed by patients.		
4. Midline Catheter, Adults	Director Mitchell made a clarification on high powered injection used with contrast in midline catheter insertions. Tricia Guerra also mentioned that she is changing all "swab caps" to port protectors in this policy going forward.		
Administrative Policies and Procedures: 1. Dr. Strong 221	General Counsel Greta Proctor suggested that "Security Stat" should be a policy statement and not a definition. The term "flipped" was changed to "repositioned" and also hold (5150) was added.	*The Administrative policies will move forward for Board approval. Director Finnila moved and Director Mitchell seconded the motion.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
2. Portable Space Heaters, Use of 247	There was no discussion made on this policy.		
3. Signage 215	A detailed discussion was held as Dr. Johnson suggested that there should be a distinction between directional (way-finding) and educational signage throughout the hospital. Administration will be in charge of making signages in the hospital to be more consistent and accurately checked before posting.	**ACTION:** It was agreed that this policy need to be pulled out for further review.	Administration
4. Solicitation and Distribution on District Property 210	There was a recommendation to create a separate policy as there is a need to stipulate what was not covered in this policy and the Board policy as well with regards to solicitation.(e.g.political solicitation)	**ACTION:** As per Director Finnila's recommendation, this policy was being pulled out for further review.	Administration
Unit Specific Policies and Procedures:			
<u>Infection Control</u>			
1. IC 9 Cleaning and Disinfection	The term hydrotherapy was clarified as the Tri-City Wellness Center still uses this therapy for some patients. The word "dripping" was also changed to saturated. More updated references was requested by Director Mitchell.	**ACTION:** This policy is being pulled out for further review. *The Infection Control policies were approved with the exception of IC 9 and are moving forward for Board approval. Dr. Corona moved and Dr. Worman seconded the motion.	Patricia Guerra
2. IC 4 Healthcare Associated Infections, Defined	There was no discussion on this policy.		
<u>NICU</u>			

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Nutritional Care and Assessment for Infants Admitted to NIC	Director Mitchell asked for the low birth weight to be specified and also to modify "retardation" and used restriction instead.	*The NICU policy was approved and is moving forward for Board approval. Director Mitchell moved and Dr. Corona seconded the motion.	Patricia Guerra
Pharmacy			
1. Adverse Drug Event_Discern Alert Rules	There was no discussion on this policy.	*The Pharmacy policies were approved and are moving forward for Board approval. Director Mitchell moved and Dr. Corona seconded the motion.	Patricia Guerra
2. Antibiotic Stewardship	It was noted that the physician leader for the antibiotic stewardship is the Infection Control doctor who is Dr. Smith.		
3. Antimicrobial Susceptibility Report	There was no discussion on this policy.		
4. Authorized Access to the Pharmacy	There was no discussion on this policy.		
5. Bedside Medication Storage	There was no discussion on this policy.		
6. Discharge Prescriptions	Tori Hong clarified that the hospital is not licensed to give medications to 340B patients at this time.		
7. Emergency Crash Cart Security and Accountability	There was no discussion on this policy.		
8. Flumazenil (Romazicon) in the Treatment of Benzodiazepine Overdose	There was no discussion on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
9. Formulary System	There was no discussion on this policy.		
10. Hours of Operation	There was no discussion on this policy.		
11. Medication Ordered STAT and at Specified Time	There was no discussion on this policy.		
12. Patients Use of Herbals and Natural Remedies	It was briefly mentioned that there are some issues sometimes arising from patient bringing in their natural herbal remedies.		
13. Pharmacological Abbreviations- Unapproved	There was no discussion on this policy.		
Rehabilitation			
1. 613 Physical Therapy Assistant Supervision	There were some minor edits for this policy concerning Nifty After Fifty.	*The Rehabilitation policy was approved and is going forward for Board approval as moved by Director Finnila and seconded by Dr. Corona.	Patricia Guerra
Women and Newborn Services			
1. Bottle Feeding Procedure	The title of this policy was changed to formula feeding procedure as recommended by Director Mitchell.	*The WNS policies were approved as moved by Dr. Worman and seconded by Dr. Corona.	Patricia Guerra
2. Circumcision	More updated references was requested for this policy.		
3. Trial of Labor after Cesarean (TOLAC) Vaginal Birth after Cesarean Birth (VBAC)	Dr. Johnson clarified that the guidelines for TOLAC stated in this policy are criteria and not exclusion; physician in house was emphasized by Dr. Worman and Director Mitchell explained further the meaning of "prior disruption of the uterine wall".		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. WNS Disaster Response Plan	It was clarified that there is a separate disaster plan for WNS since it was observed that infant abduction is highly noted during a disaster.		
ENVIRONMENT OF CARE			
Safety Management 1. 1001 Environmental Health and Safety By-Laws	There was a modification made on the EHSC committee meeting; it should be quarterly or more often at the discretion of the Safety Officer.	*The Safety Management policies except for Policy 1020 were approved and are moving forward for Board approval as moved by Dr. Worman and seconded by Director Finnila.	Patricia Guerra
2. 1020 General Hospital Safety and Patient Management	It was discussed that cleanliness should be added to the purpose of this policy as it relates to the general safety of the hospital.	**ACTION**: This policy is being pulled out further review and modifications.	
3. 1021 Patient Age Related Hazards	There was no discussion on this policy.		
4. 1023 Visitor Safety	There was no discussion on this policy.		
5. 1030 Disposing of Recalled Products	There was no discussion on this policy.		
6. 1041 Safety Walk Through Program	The meeting was revised to be bi-annual, not annual as stated in this policy.		
Life Safety Management		*The Life Safety Management	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. 3000- Life Safety Management Plan	There was no discussion on this policy.	policy was approved and is moving forward for Board approval as moved Director Finnila and seconded by Dr. Corona.	
Hazard Material Management 1. 6000 Hazardous Material and Waste Management	There was no discussion on this policy.	*The Hazard Material Management policies were approved and are moving forward for Board approval as moved by Director Finnila seconded by Dr. Worman.	Patricia Guerra
2. 6001 Hazardous Substance Inventory List	There was no discussion on this policy.		
3. 6002 Hazardous Materials Waste Training	There was no discussion on this policy.		
4. 6003 Hazardous Waste & Materials Responsibilities	There was no discussion on this policy.		
5. 6004 Hazardous Waste & Material-Ordering, Receiving and Storage	There was no discussion on this policy.		
6. 6005 Receiving Safety Data Sheets (SDS)	There was no discussion on this policy.		
7. 6007 Hazardous Waste & Materials Storage	There was no discussion on this policy.		
8. 6009 Hazardous Materials Management	Director Finnila posed a question regarding the amount of liquid specified for the spills as stated in this policy. Dr. Johnson explained that usually the container of these liquids have specified amounts so this		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	stipulation should be retained as mentioned in the policy.		
9. 6010 Handling & Use of Gas Cylinders	There was no discussion on this policy.		
10. 6011 Radioactive Contaminated Waste Handling At Storage Area	There was no discussion on this policy.		
11. 6012 Battery Management And Disposal	There was no discussion on this policy.		
7. Closed Session	Director Dagostino asked for a motion to go into Closed Session.	Director Finnila moved, Dr. Johnson seconded and it was unanimously approved to go into closed session at 1:05 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
10. Comments from Members of the Committee	No Comments.		Director Dagostino
11. Adjournment	Meeting adjourned at 2:25 PM		Director Dagostino

PROFESSIONAL AFFAIRS COMMITTEE
May 21st, 2015

CONTACT: Sharon Schultz, CNE

Patient Care Services Policies & Procedures		
1. Code Pink Resuscitation Standardized Procedure	3 year Review	Forward to BOD for approval
2. Interdisciplinary Plan of Care IPOC	3 year Review	Forward to BOD for approval
3. Lift Team Technician	3 year Review	Forward to BOD for approval with revisions
4. Midline Catheter, Adults	3 year Review	Forward to BOD for approval
Administrative Policies & Procedures		
1. Business Visitor Visitation Requirements 203	3 year Review	Pulled for further review
2. Dr. Strong 221	3 year Review	Forward to BOD for approval with revisions
3. Equipment Transfer, Storage Trade-in, and Disposal 200	3 year Review	Pulled for further review
4. Portable Space Heaters, Use of 247	3 year Review	Forward to BOD for approval
5. Signage 215	3 year Review	Pulled for further review
6. Solicitation and Distribution on District Property 210	3 year Review	Pulled for further review
Unit Specific		
Infection Control		
1. IC 9 Cleaning and Disinfection	3 year Review	Pulled for further review
2. IC 4 Healthcare Associated Infections, Defined	3 year Review	Forward to BOD for approval
NICU		
1. Nutritional Care and Assessment for Infants Admitted to NIC	3 year Review	Forward to BOD for approval with revisions
2. Ordering of DME Equipment	3 year Review	Pulled for further review
PHARMACY		
1. Adverse Drug Event_Discern Alert Rules	Delete	Forward to BOD for approval
2. Antibiotic Stewardship	3 year Review	Forward to BOD for approval
3. Antimicrobial Susceptibility Report	Delete	Forward to BOD for approval
4. Authorized Access to the Pharmacy	Delete	Forward to BOD for approval
5. Bedside Medication Storage	3 year Review	Forward to BOD for approval
6. Discharge Prescriptions	3 year Review	Forward to BOD for approval
7. Emergency Crash Cart Security and Accountability	3 year Review	Forward to BOD for approval
8. Flumazenil (Romazicon) in the Treatment of Benzodiazepine Overdose	Delete	Forward to BOD for approval

PROFESSIONAL AFFAIRS COMMITTEE
May 21st, 2015

CONTACT: Sharon Schultz, CNE

Pharmacy		
9. Formulary System	3 year Review	Forward to BOD for approval
10. Hours of Operation	3 year Review	Forward to BOD for approval
11. Medication Ordered STAT and at Specified Time	3 year Review	Forward to BOD for approval
12. Patients Use of Herbals and Natural Remedies	3 year Review	Forward to BOD for approval
13. Pharmacological Abbreviations- Unapproved	Delete	Forward to BOD for approval
Rehabilitation		
1. 613 Physical Therapy Assisstant Supervision	3 year Review	Forward to BOD for approval
Women and Newborn Services		
1. Bottle Feeding Procedure	3 year Review	Forward to BOD for approval with revisions
2. Circumcision	3 year Review	Forward to BOD for approval with revisions (reference)
3. Trial of Labor after Cesarean (TOLAC) Vaginal Birth after Cesarean Birth (VBAC)	3 year Review	Forward to BOD for approval
4. WNS Disaster Response Plan	3 year Review	Forward to BOD for approval
Environment of Care		
Safety Management Policies		
1. 1001 Environmental Health and Safety By-Laws	3 year Review	Forward to BOD for approval with revisions
2. 1020 General Hospital Safety and Patient Management	3 year Review	Pulled for further review
3. 1021 Patient Age Related Hazards	3 year Review	Forward to BOD for approval
4. 1023 Visitor Safety	3 year Review	Forward to BOD for approval
5. 1030 Disposing of Recalled Products	3 year Review	Forward to BOD for approval
6. 1041 Safety Walk Through Program	3 year Review	Forward to BOD for approval
Life Safety Management		
1. 3000- Life Safety Management Plan	3 year Review	Forward to BOD for approval
Hazard Material Management		
1. 6000 Hazardous Material and Waste Management	3 year Review	Forward to BOD for approval
2. 6001 Hazardous Substance Inventory List	Delete	Forward to BOD for approval
3. 6002 Hazardous Materials Waste Training	3 year Review	Forward to BOD for approval
4. 6003 Hazardous Waste & Materials Responsibilities	3 year Review	Forward to BOD for approval
5. 6004 Hazardous Waste & Material-Ordering, Receiving and Storage	3 year Review	Forward to BOD for approval
6. 6005 Receiving Safety Data Sheets (SDS)	Delete	Forward to BOD for approval
7. 6007 Hazardous Waste & Materials Storage	Delete Incorporated into 6004	Forward to BOD for approval

PROFESSIONAL AFFAIRS COMMITTEE
May 21st, 2015

CONTACT: Sharon Schultz, CNE

Hazard Material Management Continued		
1. 6009 Hazardous Materials Management	3 year Review	Forward to BOD for approval
2. 6010 Handling & Use of Gas Cylinders	3 year Review	Forward to BOD for approval
3. 6011 Radioactive Contaminated Waste Handling At Storage Area	3 year Review	Forward to BOD for approval
4. 6012 Battery Management And Disposal	3 year Review	Forward to BOD for approval
Request for Formulary Status Evaluation		
1. Criteria for Use for Miacalcin	New	Forward to BOD for approval, reviewed at April 16th PAC

STANDARDIZED PROCEDURE: CODE PINK RESUSCITATION

I. **POLICY:**

A. **Function:** Management of impending or actual cardiopulmonary arrest in the pediatric patient.

B. **Circumstances:**

1. Setting: Tri-City Medical Center
2. Supervision: None required. However, upon arrival of a physician the Code Pink team will follow physician orders instead of the Standardized Procedure.
3. Patient contraindications: Patients with a written "No Code Order." A Code Pink will be called on any ~~potential, actual~~ apneic and/or pulseless **children ~~pediatric patient~~ greater than 30 days of age through 13 ~~completed~~ years**~~infan(one month or less in age) and child (one month to child without signs of puberty)~~ in the main hospital building, the Cardiac ~~Wellness~~ **Rehabilitation b~~B~~**building, **Business Administration Management (BAM) b~~B~~uilding,** and the M**agnetic** R**esonance** I**maging(MRI)** building. ~~(excluding neonates in Women's & Children's Services and Neonatal Intensive Care Unit.)~~

C. **A Code Caleb will be activated ~~in the event of an emergency~~ for the resuscitation and stabilization needs of the high-risk neonate/ infant up to 30 days old.~~60 days in the Emergency Department (ED).~~ Please see Patient Care Services ~~Policy IV.ZZ~~ Code Caleb Team Mobilization.**

~~II. **PROCEDURE (CHILDREN AGED 30 DAYS OR LESS [adjusted gestational age]):**~~

~~A. **Data Base:**~~

~~1. Subjective: None~~
~~2. Objective: Apnea or gasping/ineffective respirations and/or HR less than 100 bpm.~~
~~3. Diagnosis: Bradycardia, **c**Cardiopulmonary arrest, or respiratory distress/arrest at delivery or within the neonatal period.~~
~~4. Plan:~~
~~a. Initiate Standardized Procedure as appropriate and initiate Code Pink (dial 66 on the telephone.)~~
~~b. Assessment: Patient will be reassessed after each intervention.~~
~~c. Record Keeping: Events are to be recorded on the **Neonatal Resuscitation** Cardiopulmonary Arrest Record.~~

~~B. **Respiratory Distress/Arrest:**~~

~~1. Provide warmth.~~
~~2. Establish patent airway.~~
~~3. Position supine with head in neutral or slightly extended position.~~
~~4. Adequate suction PRN for secretions~~
~~5. Oxygen administration and positive pressure ventilations **(PPV)** if needed.~~
~~6. Assist with intubation as appropriate.~~
~~7. Obtain STAT **Arterial Blood Gas (ABG)** and chest x-ray as needed.~~

~~C. **Heart rate less than 60 beats per minute (bpm) (Bradycardia):**~~

~~1. Initiate compressions.~~
~~2. Begin bag/mask ventilation with 100% oxygen.~~
~~3. Establish venous access with Normal Saline (NS) flush.~~

~~D. **Venous Access:**~~

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Pharmacy and Therapeutics	Department of Pediatrics	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
3/00, 8/07, 2/10, 6/11;**9/14**	01/11;9/13; **9/14**	03/11;9/13; **10/14**	06/11;9/13; **9/14**	**11/14**	06/11; 2/14; **3/15**	06/11;2/14; **3/15**	5/15	06/11; 2/14

1. Establish intravenous**(IV)** access with NS at TKO rate (to be used for resuscitation medications or fluids as necessary). Consider **Intraosseous (IO)**O; umbilical vein pending arrival of **neonatologist.** .
2. If hypovolemia suspected (suspected blood loss **history**, poor perfusion, pale, weak pulse) administer IV fluids of NS at 10 mL/kg slow **Intravenous push (**IVP) over 5-10 minutes.

E. **Medications for Bradycardia:**

1. Epinephrine

Indicated when heart rate remains less than 60 bpm despite 30 seconds **PPV**assisted ventilation and another 30 seconds of coordinated compressions and ventilations.

Recommended route is IV/IO. Consider endotracheal (ET) route while IV access is being obtained.

a.

b. Endotracheal dosing: **(0.5mL/kg – 1.0 mL/kg of 1:10,000 concentration)**0.1 mg/kg (0.1 ml/kg of 1:1000 concentration). Administer every 3 - 5 minutes during arrest until IV/IO access achieved, then begin first IV/IO dose.

c. IV/IO dosing: 0.01 mg/kg (0.1 mL/kg **- 0.3 mL/kg**) of 1:10,000 concentration). Administer every 3 – 5 minutes during arrest, max IV/IO individual dose 1 mg.

d. Recommended route is IV/IO. Consider ET route while IV access is being obtained.

e. Recommended dose: 0.1 - 0.3 mL/kg (0.3 - 1 mL/kg if giving ET)

f. Rate of administration is rapid IIVP.

F. **Symptomatic Hypoglycemia**

1. Obtain bedside capillary or venous glucose. If glucose < 45 mg/dl then treat with **D10 W bolus.** 10% dextrose.

a. IV/IO **Bolus:**infusion: **2mL/ kg D10W bolus, at a rate of 1mL per minute.** 0.5 - 1.0 gram/kg 10% dextrose (0.1g/ml). Dose: 5 - 10 ml/kg per the Broselow™ Pediatric Emergency Tape.

IV maintenance: Begin IV infusion of D10W at 80mL/kg/day.

III.II. PROCEDURE (CHILDREN GREATER THAN 30 DAYS OLD THROUGH 13 YEARS) AGED 31 DAYS TO AGE 14WITHOUT SIGNS OF PUBERTY):

A. **Data Base:**

1. Subjective: None
2. Objective: Significant acute change in neurologic status, status epilepticus **u**Unresponsive, absent respirations status asthmaticus and/or rhythm disturbances (monitored patient) absent pulse, acutely hypotensive or absent blood pressure.
3. Diagnosis: Impending/Actual Cardiopulmonary arrest
4. Plan:
   a. Initiate Standardized Procedure as appropriate and initiate Code Pink. (dial 66 on the telephone)
   b. Assessment: Patient will be reassessed after each intervention.
   c. Record Keeping: Events are to be recorded on the Cardiopulmonary Arrest Record and clinical notes.

B. **Respiratory Distress/Arrest:**

1. Establish patent airway.
2. Administer oxygen to maintain O_2 saturation greater than 95%.
3. Begin **Positive Pressure Ventilation (PPV)** ventilation with 100% oxygen as necessary, to support PPV ventilation, monitoring adequate rise and fall of chest, breath sounds, color, and work of breathing.
4. Assist with intubation as appropriate.
5. Have **a**Adequate suction readily available

6. Obtain STAT Arterial Blood Gas (ABG)s and chest X-ray as needed.

~~6.~~**C. Heart Rate less than 60 bpm (Bradycardia):**

~~7.~~**1. Initiate chest compressions.**

~~8.~~**2. Begin PPV with 100%oxygen**

~~9.~~**3. Obtain Intravenous(IV) access**

~~10.~~**a. Establish IV access with Normal Saline (NS) at to keep open (TKO) rate. (May be used for resuscitation medications or fluid bolusing as needed.)**

~~11.~~**b. Get Intraosseous (IO) device ready for placement by physician if IV access is unobtainable. (Must be placed by a physician)**

~~12.~~**c. Give fluid bolus for hypotension Systolic blood pressure less than [70 + (age in years times 2)] NS 20 mL/kg, Can repeat times 2 if lungs remain clear.**

~~13.~~**4. Medications for Bradycardia:**

a. **Epinephrine**

~~14.~~**i. Indicated when heart rate remains less than 60 and patient is hypotensive.**

~~15.~~**ii. Recommended route is IV/IO. Consider endotracheal (ET) route while IV access is being obtained.**

~~16.~~**iii. ET DOSING: (0.5 mL/kg of 1:10,000 concentration) Administer every 3- 5 minutes during arrest until IV/IO access is achieved.**

~~17.~~**iv. IV/IO DOSING: (0.1 mL/kg of 1: 10,000 concentration) Give every 3-5 minutes during arrest. Maximum dose is 1 mg.**

~~18.~~**v. Rate of administration is rapid.**

~~19.~~**D. Symptomatic Hypoglycemia:**

~~20.~~**1. Obtain bedside blood glucose value. If glucose level is less than 60 mg/dl then treat with D25W 2 mL/kg via slow intravenous push (IVP). OR D10W 5 mL/kg slow IVP OR D50 W 1mL/kg via slow IVP.**

~~21.~~**E. Hypotension:**

~~22.~~**1. IV/IO bolus for hypotension (SBP less than [70 + (age in years times 2)]. Administer NS 20 mL/kg. May repeat times 2 if lungs remain clear.**

~~23.~~**F. Cardiac Rhythm Disturbances/ Shock:**

~~24.~~**1. Follow American Heart Association (AHA) 2010 Pediatric Advance Life Support (PALS) guidelines**

a. **BLS for healthcare providers**

~~25.~~**b. Pediatric Bradycardia with a pulse Algorithm**

~~a.~~**c. Pediatric Tachycardia with Pulses and Poor Perfusion Algorithm**

~~b.~~**d. Pediatric Pulseless Arrest Algorithm**

~~c.~~**e. Septic Shock Algorithm**

f. Treatment of Shock Algorithm

~~26.~~

~~C. **Venous Access:**~~

~~1. Establish intravenous access with NS at TKO rate (to be used for resuscitation medications or fluids as necessary).~~

~~2. Consider IO pending arrival of physician. (Insertion of Intraosseous device is done by physician only)~~

~~3. Bolus for hypotension (SBP less than [70 + (Age in years x 2)] NS 20 mL/kg, may repeat x 2 if lungs remain clear.~~

~~4. **50**Obtain bedside blood glucose or serum glucose.~~

~~D. **Symptomatic Hypoglycemia:**~~

~~1. Obtain bedside glucose. If glucose < 70 mg/dl then treat with **via slow IVP slow IVP OR D50W 1ml/kg via slow IVP.**25% dextrose.~~

~~a. IV/IO infusion: 0.5 - 1.0 gram/kg 25% dextrose (0.25 g/ml). Dose: 2 - 4 ml/kg per the Broselow™ Pediatric Emergency Tape.~~

~~E. **Hypotension:**~~

~~1. IV/IO bolus for hypotension (SBP less than (70 + (Age in years x 2)) administer NS 20 ml/kg, may repeat x 2 if lungs remain clear.~~

~~F. **Cardiac Rhythm Disturbances / Shock:**~~

~~1. Follow AHA (2010) Pediatric Advanced Life Support Guidelines~~

~~a. BLS for healthcare providers~~

~~b. Pediatric Bradycardia with a pulse Algorithm~~

~~c. Pediatric Tachycardia with Pulses and Poor Perfusion~~

~~d. Pediatric Pulseless Arrest Algorithm~~

~~e. Septic Shock Algorithm~~

~~f. Treatment of Shock.~~

~~IV.~~III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. RN with current California license and working in the Emergency Department.

B. Education: Pediatric Advanced Life Support (PALS), or Emergency Nurse Pediatric Course (ENPC)

C. Initial Evaluation: Before an RN may initiate the Code Pink Standardized Procedure, the RN must be observed in the management of a pediatric resuscitative effort and demonstrate successful skills in PALS or the ENPC course.

D. Ongoing Evaluation: Annually

~~V.~~IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.

B. Review: Every two (2) years.

~~VI.~~V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All Emergency Department Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Code Pink Resuscitation Standardized Procedure.

ISSUE DATE:	**8/01**	**SUBJECT:**	**Interdisciplinary Plan of Care (IPOC)**
REVISION DATE:	**6/03, 6/05; 1/08; 05/11; 05/12**	**POLICY NUMBER:**	**IV.G**

Clinical Policies & Procedures Committee Approval:	**~~05/12~~01/15**
Nursing Executive Council Approval:	**~~05/12~~03/15**
Medical Executive Committee Approval:	**~~06/12~~03/15**
Professional Affairs Committee Approval:	**~~07/12~~05/15**
Board of Directors Approval:	**07/12**

A. **POLICY:**

1. An IPOC shall be initiated (electronically or paper per unit practice) by the primary Registered Nurse (RN) within four hours of a patient's arrival to a patient care area.
2. The IPOC shall include standards of care identified as appropriate based on the patient's diagnosis, medical condition, and/or need.
   ~~2.~~**a. For inpatient's with a long length of stay (one month or greater), spending time outdoors will be considered**
3. The IPOC shall have measurable outcomes with specific interventions to meet the patient's inpatient and discharge needs.
4. The following factors shall be considered when developing and/or updating the IPOC:
   a. Disease process/physician's order
   b. Biophysical
   c. Psychosocial
   d. Spiritual/cultural
   e. Functional
   f. Safety
   g. Knowledge deficit
   h. Discharge needs
   i. Referrals to interdisciplinary departments
   j. Additional aspects obtained from the patient assessment
5. The primary RN shall discuss the IPOC with the patient and their caregiver every shift, and PRN.
6. The IPOC shall be reviewed and updated every shift, and as needed. The primary RN shall:
   a. Consider the appropriateness of interventions not addressed within the last 48 hours, discontinue as needed
7. When a patient is transferred to another nursing unit, the receiving RN shall review the existing plans for appropriateness and update or discontinue plans initiated on the transferring as needed. The receiving RN shall initiate additional plans as needed based on the patient's transferring assessment.
8. The patient's discharge needs shall be assessed on admission, every shift, and PRN.
9. The IPOC shall be updated prior to discharge ensuring all open outcomes are addressed.

B. **REFERENCES:**

~~9.~~**1. The Joint Commission Handbook (2014), Standard PC.02.02.11**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 4/00

SUBJECT: Lift Team Technician

REVISION DATE: 6/03, 9/05; 6/08; 08/11, ~~1/1512/14~~

POLICY NUMBER: VI.J

Clinical Policies & Procedures Committee Approval: ~~07/1102/154~~/15
Nursing Executive Council Approval: ~~07/1102/154~~/15
Professional Affairs Committee Approval: ~~0811~~05/15
Board of Directors Approval: 08/11

A. **POLICY:**

1. Tri-City Healthcare District (TCHD) is committed to providing a safe environment for patients and staff. To minimize the risk of workplace injuries associated with the handling of patients, TCHD shall implement and maintain a safe patient handling policy for all patient care units.
2. This will include a lift team and safe patient handling procedures with mechanical lifting devices for every total body lift of non-ambulatory patients weighing more than 50 pounds.
   a. TCHD personnel shall not be required to lift non-ambulatory patients weighing more than 50 pounds by themselves, except in an urgent or emergent situation.
3. ~~A~~ Lift Team Technician**s** (LTT) **are** ~~shall be~~ available **for lifting assistance in the hospital** ~~24 hours per day, 7 days per week to assist with patient lifting and handling~~.
   a. **When a LTT is not available on a unit or outpatient area, the Assistant Nurse Manager (ANM)/Relief Charge Registered Nurse (RN) or Supervisor shall obtain assistance with lifts from other patient care areas** ~~**unit nursing units or outpatient departments**~~ **as well as other unit staff.**
   b. **LTT duties in Women and Newborns Services and Surgical Services are provided by the peri-operative aides as well as other unit staff.**

~~4. Lift Team Technicians (LTT) shall be hired into designated inpatient and outpatient areas.~~

~~5.~~**4. LTT shall remain on their designated units during working hours unless instructions are received from the unit's Clinical Manager (CM), ANM, Relief Charge RN, or Supervisor.**

~~6.~~**5. LTT shall remain in their designated areas during Rapid Response (RR), Code Blue, and Dr. Strong alerts to assist as needed.**
   a. **LTT assigned to the Intensive Care Unit shall accompany the RR or Code Blue RNs as directed.**

~~7.~~**6.** RNs and Advanced Care Technicians (ACTs) are expected to assist in the transfer and repositioning of ambulatory patients not requiring full body lift (i.e., bed to chair/wheelchair, bed to commode, or floor to bed.)

~~8.~~**7. A RN or ACT shall be present when patients require repositioning by a LTT**

~~9.~~**8. LTTs shall follow the practices of their unit for the following:**
   a. **Change of shift task**
      i. **Obtain a brief shift hand-off to identify the patient's requiring repositioning**
      ii. **Assist with answering telephones and call lights during the RN and ACT shift hand-off on Acute Care Services and the Telemetry unit**
   b. **Patient rounding times**
      i. **Scheduled rounds shall occur at least every two hours on assigned units**
      ii. **Write your initials on the patient education/rounding board in the appropriate time space after repositioning a patient**
   c. **Floor assignments when a unit is comprised on more than one floor**
      i. **Womens and Newborn Services**

1) **Assist with the transport of patients from the Emergency Department when notified per department practices i.e., pager system**

ii. **Acute Care Services (ACS)**

1) **One LTT will be assigned to 4 Pavilion (4P) and One LTT will be assigned to 1 North (1N) on the day shift.**
2) **One LTT will be assigned to 2P and One LTT will be assigned to 1N on the night shift.**
   a) **Both LTTs will alternate tasks on the floor without an assigned LTT.**

~~i.~~iii. **Intensive Care Unit:**

1) **One LTT will be assigned to the 1East and One LTT will be assigned to 1West when rounds are completed**
2) **LTTs shall work together as needed**

~~ii.~~iv. **Telemetry Unit:**

1) **One LTT will be assigned to the second floor**
2) **One LTT will be assigned to the fourth floor**
3) **Both LTT will collaborate to assist with task on the third floor**

d. Break and meal times

i. **Follow unit practices**

ii. **Acute Care Services**

1) **LTTs will sign up for their lunch/break times on the LTT logs at the beginning of the shift**
2) **LTTs will notify all ACS floors of their lunch/break times**

~~ii.~~iii. **Telemetry**

1) **Sign-up for break by documenting your name in an allotted time on the break sheet.**
2) **One LTT will be on the unit all times**

~~10.~~**9.** The LTT personnel shall use a mechanical lifting device, when available, for every total body transfer. Equipment available may include:

a. Mechanical vertical or horizontal lifts
b. Full Length Slide Boards
c. Gait Belts
d. Mechanical Weighing Devices
e. Glide mat

~~11.~~**10.** The Lift Team shall be called for all lifts as specified in this policy on their assigned units.

a. Lifts are defined as total body transfers to and from:

i. Bed to chair/wheelchair
ii. Bed to gurney
iii. Bed to commode
iv. Floor to bed
v. Bed or chair to scale
vi. Any other lift where total body movement of the non-ambulatory patient is required.

~~12.~~**11. Patient Safety**

a. Prior to leaving a patient's room ensure the following:

i. Patient's room is clean and uncluttered
ii. Bedside tray within patient's reach
iii. Call button, television remote control and patient's other personal items are within their reach
iv. Patient's bed is in low position with upper side rails in the up position
v. Patients are covered with a blanket or per their preference
vi. Ask if there is anything they can get for the patient

~~13.~~**12. Performs the following task as directed by an RN and assist ACTs as directed by RN:**

a. Assist ACTs and RNs with the following:
- **i. Admission and daily weights**
- **ii. Positioning patients during baths**
- **iii. Ambulating patients to bathroom that are potential risk for falls and the patient requires more assistance than one RN or ACT**

b. Answers telephones and patient call lights during the RN shift hand-off, Protected Time, Quiet Time and PRN as directed by RN or per unit practices

c. Answers patient's call lights and relays message to RN or ACT

d. Transport specimens to the lab

e. Transport patient belongings or equipment to other nursing departments

f. Pick up medications (not controlled substances) from the pharmacy department and transport to nursing unit as directed by a RN

g. Obtain blood products from Transfusion Services

h. Transfers inpatients to other inpatient nursing departments

i. Transports discharged patients to personal vehicles

j. Keeps halls free from clutter and equipment and ensures equipment is not placed or blocks fire doors or entrance to patient's room

k. Assist with positioning patients during bedside procedures and treatments as delegated by RNs

~~14.~~**13.** The Lift Team shall respond to a priority lift **(in their designated area or when delegated by a CM, ANM/Relief Charge or Supervisor)** immediately or as soon as it is safe to leave their current patient assignment.

~~15.~~**14.** Personnel who do not comply with this policy may be subject to discipline under Administrative Policy, Employee Health and Safety.

B. **RELATED DOCUMENTS**

1. Lift Team Helpful Hints (ICU, Telemetry, and ACS)

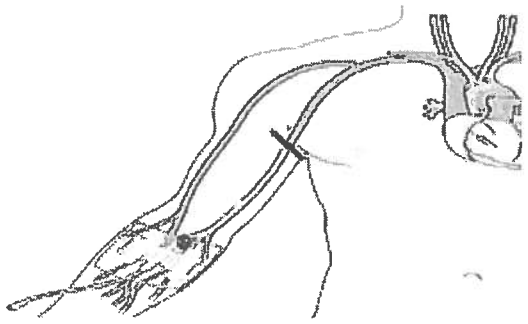
Lift Team Helpful Hints (ICU, Telemetry, and ACS)

TIME	TASKS	HELPFUL HINTS
0700-0759 And 1900-1930	1. Obtain Shift Hand-off ~~2.~~ Remain near nurs**es'**~~ing~~ station~~s~~ during RN shift hand-off to assist with answering- telephones and patient call lights	**Breakfast** ➢ Ask patients the following questions prior to leaving their rooms: 1. Would you like to sit in the chair or dangle on the side of the bed for breakfast? 2. Can I get you anything before I leave? 3. Ensure patients are covered with a blanket 4. Document initials and patient position on patient education board 5. Position code: • L = Left Side • R = Right Side • S- Supine ➢ Telemetry Unit -also informed 2nd LTT ➢ **Lunch and Dinner** ➢ Ask patients the following prior to repositioning or assisting -or leaving room: 1. Would you like to be repositioned? 2. Would you like to sit in the chair or dangle on the side of the bed for lunch? **Dinner?** 3. Would you like to take a walk before or after lunch? **Dinner?** 4. Can I get you anything before I leave? ➢ **Rapid Response (RR), Code Blue, Dr. Strong** • Assist on assigned unit only • ICU LTT assist RR and Code **Blue** RNs as directed
0800- until 1900 And 2000-0700	1. Begin Rounding **(round every 2 hours)** 2. Note the patients who will require assistance with repositioning ~~or ambulating~~ **every two hours** **3. Note the patients who will require assistance ambulating** ~~3.~~**4.** Knock prior to entering a patient's room ~~4.~~**5.** Introduce yourself to patient ~~5.~~**6.** Write your name on patient's education board ~~6.~~**7.** Assist ACT with weights, repositioning patients. ~~7.~~**8.** Assist ACT as directed by RN with: • Assisting patients to chairs for meals • Repositioning positions for meals • Assist ~~ACT~~ with repositioning ~~patients during~~ **for** hygiene care ~~8.~~**9.** Perform duties assigned by RNs ~~9.~~**10.** Assist with discharges, transfers, and admissions ~~10.~~	
Breaks	1. Take break**s** as assigned 2. Inform RNs and ACTs prior to leaving the floor for break ~~3.~~ Inform 2nd LTT, if applicable	
PRN Task **examples**	~~1. Rounds every two hours~~ ~~2. Assist with every two hour turns~~ ~~3.~~**1.** Assist with answering call lights and telephones during Protected Time and Quiet Time ~~4. Assist with discharges, transfers, and admissions~~ ~~5.~~**2.** Remove unused equipment from halls**, ensure fire doors are not blocked with equipment** ~~6.~~**3.** Ensure halls are free of clutter **4. Ask RNs or ACTs if new admissions or transfer patients require assistance with** ~~R~~repositioning **or ambulating** ~~patients, assist with ambulation~~ ~~7.~~	

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**MIDLINE CATHETER, ADULTS**
Purpose:	To outline the following nursing responsibilities for patients with or requiring midline catheter placement: 1. Assisting with the insertion of a midline catheter 2. Assessment 3. Maintenance 4. Documentation 5. Flushing 6. Blood specimen collection 7. Dressing changes 8. Removal
Supportive Data:	1. Infusion Nursing Standards of Practice 2. Standards of Care for Adults 3. Central Venous Access Procedure 4. Infection Control Manual Bloodborne Pathogen Exposure Control Plan (I.C.10)
Equipment:	1. Central Line Change Kit 2. Saline Flush Syringes 3. SwabCaps©

A. DEFINITION

1. Midline Catheter
   a. A short term peripheral venous access catheter for selected IV therapies and blood sampling
   b. A midline catheter is typically 8 inches (range 3 -10 inches) long
   c. Midlines catheters do not extend beyond the axillary line and do not extend into the vena cava; see illustration below
      i. A midline catheter is not a Peripherally Inserted Central Catheter (PICC)
      ii. A Midline catheter is not a centrally inserted catheter i.e., central line



B. POLICY

1. A Physician or a Physician Assistant (PA) will determine if a single or double lumen midline catheter is required.
   a. The primary RN will consult with a Physician or a PA to identify the need for a midline catheter versus a PICC
2. Midline catheters may be inserted by a Physician or a PA in the patient's room when one or more of the following criterion is met:
   a. Patient has poor or limited peripheral access
   b. Patient skin condition and vein integrity limits insertion of a peripheral catheter by nursing

Clinical Policies & Procedures	Nursing Executive Committee	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/14	6/14	9/14	9/14	10/14	05/15	

c. Physician order may be obtained after consulting with a Physician or a PA
d. Two unsuccessful attempts to insert a peripheral catheter by one Registered Nurse (RN) and a reassessment by a 2nd RN who is also unable to insert a peripheral catheter
e. Patient requires minimum of one (1) week to 28 days of intravenous (IV) therapy for hydration solutions, isotonic or near isotonic drugs and solutions, pain medications, antibiotics compatible to a midline catheter, blood products, or frequent blood sampling

3. Midline catheters shall be labeled with a midline catheter sticker.

~~3.~~**4.** Midline catheters are contraindicated:
a. Presence of device related infection, bacteremia, or septicemia is known or suspected
b. Post irradiation of prospective site
c. High powered injection unless the catheter is labeled as high-powered
d. IV solutions that may be only infused using a centrally inserted line
e. Vesicants or caustic intravenous (IV) solutions i.e., IV chemotherapy
f. **Total Parenteral Nutrition (TPN)**
g. IV solutions with:
i. pH less than 5 or greater than 9
ii. Greater than 10% dextrose
iii. Greater than 5% protein
h. IV medications**: administration of dopamine, vancomycin, nafcillin/oxacillin and phenytion through a midline catheter should be avoided when possible and is contraindicated based on the pH of the drug.**
i. Consider Central Line placement
~~h.~~**ii.** The list is not inclusive, contact pharmacy for assistance with identifying IV solutions and medications appropriate for a midline catheter
~~i. Dopamine~~
~~ii. Vancomycin~~
~~iii. Nafcillin~~
~~iv. Oxacillin~~
~~v. Phenytoin~~

~~4.~~**5.** X-rays are not required for placement confirmation

C. PROCEDURE FOR BEDSIDE INSERTION

1. Verify Physician order
2. Verify patient per Patient Care Services (PCS), Identification, Patient
3. Assist Physician or PA as directed
4. The primary RN shall document the insertion of the midline catheter in the Electronic Health Record (EHR) i.e., catheter location, site condition, dressing, date and time of insertion etc.
~~4.~~**5. Ensure midline catheter is labeled with a midline catheter sticker.**

D. ASSESSMENT

1. Monitor site and catheter position after insertion for the following:
a. Minor bleeding is anticipated within the first 24 hours of insertion
b. If excessive bleeding occurs, do not remove existing dressing as this can dislodge any clot that has begun to form. Instead, apply pressure and notify the PA
2. Monitor IV and catheter position every four hours for the first 24 hours, if no minor or excessive bleeding observed, continue to assess per the Standards of Care
a. Peripheral IV site shall be assessed on admission, ongoing, and transfer from other nursing unit
3. Document assessment findings in the EHR

E. CARE AND MAINTENANCE

1. Assess site every shift, with flushing, prior to and after the administration of medications and PRN

~~1.~~**a. Assess blood flow before and after administration of medications**

2. Use 10 mL syringe for flushing and medication administration
3. Review the Standards of Care: Infusion Therapy for detailed information on the following:
   a. SwabCap
      i. Do not reuse the SwabCap, a new one should be used each time it is removed, every 8 hours with routine IV flushing and PRN.
   b. Neutral Displacement Connector (MicroClave)
   c. Tubing changes
   d. Infusion Therapy: Nursing Interventions
4. Flush with minimum of 10 mL syringe of normal saline:
   a. Before and after medication administration
   b. After IV fluids
   c. For maintenance
   d. Before and after blood draws
   e. After blood backs up in the tubing

F. BLOOD SPECIMEN COLLECTION

1. Maintain a closed system by drawing blood directly from the neutral displacement connector when possible; except when drawing blood cultures.
2. Use aseptic technique (with sterile gloves, mask and sterile field) if the neutral displacement connector is removed for a blood draw.
3. Procedure
   a. Identify patient per TCMC policy
   b. Turn off any continuous infusions, disconnect as needed, and ensure all clamps are open
   c. Perform hand hygiene and don clean non-sterile gloves
   d. Remove SwabCap from the neutral displacement connector (Microclave) if used
      i. If a SwabCap is not present on injection port, use alcohol pad to vigorously cleanse the neutral displacement connector or injection port and the area where valve connects to end of catheter. Repeat three times using a new alcohol pad each time
   e. Allow injection port to dry, do not fan or blow on port to speed drying
   f. Flush with 10 mL normal saline; wait 2 minutes
   g. Draw off and discard 5 mL of blood
      i. Prior to drawing blood cultures, disconnect tubing or neutral displacement connector, attach 10 mL syringe to hub, and collect discard blood
      ii. To draw blood culture, follow aseptic technique, use a new 10 mL syringe, and collect blood directly at the hub. Reconnect tubing or replace with a new neutral displacement connector
   h. Clean the neutral displacement connector with an alcohol wipe immediately before and after each access to remove bacteria and prevent blood from accumulating
   i. Allow to dry, do not fan or blow on site to speed drying
4. For Direct Transfer Method
   a. Insert safety vacutainer blood collection device into the neutral displacement connector using a slight clockwise turning motion
   b. Insert blood specimen collection tube and activate vacuum by fully engaging the blood tube
5. For Indirect Transfer Method
   a. Attach new 10 mL luer lock syringe(s) to collect blood as needed
      i. A safety transfer device must be used to fill the vacuum tube from a syringe
   b. Remove device or syringe and wipe away blood residual
   c. Flush with normal saline and reconnect to infusions, if required
   d. Re-clamp lines as appropriate

e. Remove gloves, perform hand hygiene, and don a second pair of gloves
f. Document your Cerner logon, date and time of lab draw on the specimen label(s)
g. Place label(s) on specimen collection tube(s) at patient's bedside
h. Place specimen collection bag in the designated area for lab to pick up or use tubing system

G. DRESSING CHANGES

1. Change the original dressing one day after insertion if newly inserted midline catheter has a gauze dressing
2. Change transparent dressings with Biopatch disk every 7 days
   a. Gauze dressings (including transparent dressings with gauze underneath) shall be changed every two days
3. Change dressings as needed if they become loose, soiled, or moist
4. Use the Central Line dressing change kit; the kit has the supplies required for changing a midline catheter dressing
5. Explain the procedure to patient
6. Use Standard Precautions during dressing change (Refer to Infection Control Policy IC.5 *Standard and Transmission Based Precautions)*
7. Avoid talking over site and have the patient turn away from the site to prevent contamination
8. Perform hand hygiene, don clean non-sterile gloves, and remove the dressing and discard
9. Assess insertion site for:
   a. Signs of infection i.e., redness, or purulent drainage
   b. Ensure the securement device and/or sutures are intact
   c. Ensure the catheter is not kinked, leaking, or otherwise compromised.
10. Remove non-sterile gloves and perform hand hygiene
11. Open sterile supplies and don sterile gloves and sterile mask
12. Perform hand hygiene and don sterile gloves
13. Apply chloraprep using a gentle back-and-forth motion for 30 seconds to cleanse exit site and allow site to air-dry for at least 30 seconds
14. Cleanse catheter tubing from exit site to distal end
15. Allow antiseptic to air dry (do not blow on or fan site) before redressing
16. Replace securement device if needed per manufacturer's guidelines
17. Apply transparent dressing with Biopatch
    a. Place Biopatch disk around catheter with blue side up and white foam side next to skin at exit site
    b. To ensure easy removal, place Biopatch disk with the catheter resting on or near the radial slit. The edges of the slit must touch the skin to ensure efficacy
    c. Center transparent dressing over exit site and the Biopatch disk
    d. Write date of dressing change and your initials legibly with a permanent black marker directly on the transparent dressing, allowing time for the ink to dry

H. DOCUMENTATION

1. Document assessments, care and maintenance, and dressing changes in the EHR per the Standards of Care
2. Document patient education provided and patient and/or caregiver responses in the EHR

I. REMOVAL

1. Removal of the catheter requires a Physician order
2. Perform hand hygiene per TCMC policy
3. Assemble equipment and supplies
4. Remove dressing and discard
5. Remove sutures, if present

6. Grasp catheter near insertion site
7. Remove slowly, do not use excessive force
8. If resistance is felt, stop removal, and notify PA or ordering physician and document interventions in the EHR
9. Document removal of catheter and patient's tolerance in the EHR

J. POTENTIAL COMPLICATIONS

1. Notify the ordering Physician for any sign and symptoms of catheter related complications, which may include one or more of the following:
   - a. Infection:
     - i. Fever
     - ii. Chills
     - iii. Swelling, erythema or drainage at insertion site
   - b. Phlebitis:
     - i. Warmth, tenderness, erythema, palpable venous cord
   - c. Thrombosis:
     - i. Leakage from the site
     - ii. Decreased flow rate of infusion pump inability to draw or infuse
     - iii. Edema in areas distal or proximal to the site
     - iv. Swelling in shoulder and neck area or jaw, shoulder or chest pain
   - d. Malposition catheter:
     - i. Lack of blood return
     - ii. Complaints of pain or discomfort in the arm or jaw during infusion
     - iii. Leaking at catheter site
     - iv. Complaints of hearing a swishing sound during infusion
   - e. Catheter breakage:
     - i. Leakage of IV fluid from catheter, hole in the catheter, catheter fracture
       - 1) In the event of catheter breakage, a tourniquet shall be placed high on the upper arm so that venous flow (not arterial flow) is obstructed
       - 2) Check vital signs and radial pulse every 5 minutes while the tourniquet is in place
       - 3) Any distress or change in condition should be immediately brought to the attention of the Physician

K. RELATED DOCUMENTS:

1. **Infection Control Policy IC.5 *Standard and Transmission Based Precautions***

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 07/85

SUBJECT: DOCTOR STRONG

REVISION DATE: 5/88; 10/96; 10/98; 10/99; 4/02; 5/03; 4/06; 6/09; 6/11; 6/12

POLICY NUMBER: 8610-221

Administrative Policies & Procedures Committee Approval:	**~~06/12~~3/15**
Medical Executive Committee Approval:	**04/15**
Professional Affairs Committee Approval:	**05/15**
Board of Directors Approval:	**07/12**

A. **PURPOSE:**

1. To provide for safe management of the violent patient or visitor by Tri-City Healthcare District Staff.

B. **DEFINITIONS:**

1. Response Team – All on-duty designated staff from the Security Department and Lift Team.
2. "Security Stat" – Used by the Behavioral Health Unit (BHU) to notify security of dangerous behavior in progress.

C. **POLICY:**

1. **Security Stat is used by the Behavioral Health Unit (BHU) to notify security of dangerous behavior in progress.**

~~1.~~**2.** When a Medical Center employee observes, detects or is notified of any person who may place staff, patients or visitors at risk for harm, then he/she will evaluate the situation, and if necessary call for Dr. Strong. (Dialing "66").

~~2.~~**3.** A "Dr. Strong" is paged overhead when an emergency situation arises involving persons who:

a. Become violent on the hospital premises.
b. Exhibit signs of drug or alcohol intoxication and volatile behavior.
c. Threaten violence to staff or others.
d. Threaten or exhibit self-injurious behavior.
e. Are on a court hold and attempt to leave **(including all holds)**.

~~3.~~**4.** A "Dr Strong" should NOT be paged for any of the following reasons:

a. Patient fell out of bed.
b. Assistance in lifting a patient.
c. Any other reasons that are not the product of violent or potentially violent behavior.

~~4.~~**5.** When possible, patients should not be restrained face down. In the event this is determined to be the only safe mode of restraint, the patient should be ~~flipped~~ **repositioned** face up as soon as reasonably possible.

~~5.~~**6.** As soon as possible after a patient is restrained, a medical professional shall assess the patient to ensure vitals, no trauma or injuries.

D. **PROCESS:**

1. The staff member who initiates the distress call will dial "66" (District's emergency call line) and state to the PBX operator:
   a. ~~This is a~~ Dr. Strong ~~call:~~**on** unit/dept/location ~~call by~~ **provide** name of caller.
   b. Panic buttons are to be used when necessary in designated locations.
   c. Each Dr. Strong call will be announced three (3) times over the paging system as well as over the Security Radio.
2. The staff member who initiates the Dr. Strong call will remain in the area where help was summoned, if his/her safety is not in jeopardy. This staff member will:

a. Brief team as to situation.
b. Direct team to exact location and person(s) involved.
c. Get necessary equipment.
d. Clear area of onlookers.

3. Response Team
   a. All Response Team members will be required to attend hospital training on **Non-Violent Crisis Intervention (NVCI) for effective aggression management using the least amount of force necessary to maintain control.**
   b. There will be a designated leader of the Response Team. In the Emergency Department and BHU, a staff member of that Unit will take charge. In other areas, the Security Officer will take charge. (If a Security Officer is not present, the staff nurse of the Response Team will take charge).
   c. When physical restraint has been deemed necessary and an order is given, the team leader will assign limb-holds to members.
   d. Physical restraint must be conducted with patient and staff safety in mind.
   e. The team will not remove their hold from the person until instructed by the team leader.
   f. It is the responsibility of the Security Officers to assess whether police force is needed; and, if necessary, to notify the Oceanside Police Department.
4. Facing someone with a weapon
   a. Any situation involving a person with a weapon becomes the responsibility of Security and the local police.
   b. The use of the panic button is not advised due to the large number of staff required to respond to this signal. This could escalate a violent situation.
   c. A staff member not in immediate danger may attempt to dial "66" for Security.
   d. It is the responsibility of the staff to evacuate patients and themselves from the area.
   e. No confrontation of the violent patient should be made except by members of the security staff or by law enforcement officers.
   f. When calling the police for assistance because a patient has a "weapon", tell the police dispatcher what kind of weapon (gun, knife, explosive, etc).

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 11/94

SUBJECT: PORTABLE SPACE HEATERS, USE OF

REVISION DATE: 5/03; 01/09; 11/09

POLICY NUMBER: 8610-247

Administrative Policies & Procedures Committee Approval:	~~11/09~~4/15
~~**Operations Team Committee Approval:**~~	~~12/09~~
Professional Affairs Committee Approval:	~~01/10~~05/15
Board of Directors Approval:	01/10

A. **PURPOSE:**

1. The purpose of this policy is to provide for the safety of the patients, staff and visitors of the Medical Center.

B. **POLICY:**

1. Use of portable space heaters in patient care areas is prohibited.
2. Use of portable space heaters in all other areas of the Medical Center is strictly limited. -The heaters must be of oil filled type, are either Underwriters Laboratories (UL) approved or listed, and must be approved by the Director of Facilities or designee.

SUBJECT: Healthcare Associated Infections, Defined **POLICY~~STANDARD~~ NUMBER: IC. 4**

ISSUE DATE: 9/2001
REVISED: 9/03, 10/06, 4/10
~~NEXT REVIEW DATE: 4/2017~~
Department Approval Date(s): **04/14**
Infection Control Committee Approval Date(s): **~~04/10~~04/14**
Pharmacy and Therapeutics Approval Date(s): **n/a**
Medical Executive Committee Approval Date(s): **04/15**
Professional Affairs Committee Approval Date(s): **05/15**
Board of Directors Approval Date(s):

~~CROSS REFERENCE:~~
~~Philosophy IC. 1~~
~~Surveillance Program IC. 2~~
~~Epidemiologic Investigation of a Suspected Outbreak IC. 3~~
~~APPROVAL: Infection Control Committee 4/2010~~

A. **DEFINITION(S)**:

1. The Hospital Infections Program, Center for Infectious Diseases, CDC, developed a set of definitions for surveillance of healthcare associated infections (HAI). The definitions were introduced into hospitals participating in the National Nosocomial Infections study (NNIS) in 1987, and modified by the National Healthcare Safety Network (NHSN) in 2006. There have been modifications based on comments from infection control personnel to reflect changes in medical technology. The following are the current definitions for healthcare associated infections used by the CDC-NHSN. By adopting these criteria, we are able to compare our infection rates with national data.

~~1.~~**a. The NHSN definitions defined below are updated at least annually by CDC; therefore the definitions outlined below may not be the most current definitions. Infection control department always uses the current definitions outlined by NHSN to determine a HAI.**

2. For an infection to be defined as a HAI, there must be no evidence that the infection was present or incubating at the time of hospital admission. An infection that is associated with hospital care and becomes evident after hospital discharge may also be considered healthcare acquired according the criteria. Infections that are associated with a complication or extension of infection(s) already present on admission, unless a change in pathogen or symptoms strongly suggest that acquisition of a new infection are considered community acquired. Infection in an infant that is known or proved to have been acquired transplacentally (e.g., herpes simples, rubella, or syphilis) and becomes evident shortly after birth will not be considered to be acquired in the facility.

3. Surgical Site Infections - *CRITERIA* for defining a Surgical Site Infection (SSI)
   a. Superficial Incisional SSI
   b. Infection occurs within 30 days after the operation
      and
   c. Infection involves only skin or subcutaneous tissue of the incision
      and
   d. At least *one* of the following:
      i. Purulent drainage, with or without laboratory confirmation, from the superficial incision.

ii. Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision.
iii. At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat *and* superficial incision is deliberately opened by surgeon, *unless* incision is culture-negative.
iv. Diagnosis of superficial incisional SSI by the surgeon or attending physician.

e. Do *not* report the following conditions as SSI:
i. Stitch abscess (minimal inflammation & discharge confined to the points of suture penetration).
ii. Infection of an episiotomy or newborn circumcision site.
iii. Infected burn wound.
iv. Incisional SSI that extends into the fascial and muscle layers (see deep incisional SSI).
v. *Note:* Specific criteria are used for identifying infected episiotomy and circumcision sites and burn wounds. Not included in this indicator.

4. Deep Incisional SSI
a. Infection occurs within 30 **or 90** days after the operation ~~if no implant is left in place or within 1 year if implant is in place and the infection appears to be related to the operation~~ **(where day 1= the procedure date)** ***and***
b. infection involves deep soft tissues (e.g., fascial and muscle layers) of the incision ***and***
c. At least *one of* the following:
i. Purulent drainage from the deep incision but not from the organ/space component of the surgical site.
ii. A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (**greater than** >38°C), localized pain, or tenderness, unless site is culture-negative.
iii. An abscess or other evidence of infection involving the deep incision is found on direct examination, during re-operation, or by histopathologic or radiologic examination.
iv. ~~4. Diagnosis of a deep incisional SSI by a surgeon or attending physician.~~
d. Notes*:*
i. ~~1.~~ Report infection that involves both superficial and deep incision sites as deep incisional SSI.
ii. ~~2.~~ Report an organ/space SSI that drains through the incision as a deep incisional SSI.

5. Organ/Space SSI
a. Infection occurs within 30 **or 90** days after the operation ~~if no implant is left in place or within 1 year if implant is in place and the infection appears to be related to the operation~~ **(where day 1= the procedure date)** ***and***
b. Infection involves any part of the anatomy (e.g., organs or spaces), other than the incision, which was opened or manipulated during an operation
and
c. At least *one* of the following:
i. Purulent drainage from a drain that is placed ~~through a stab wound ‡~~ into the organ/space.
ii. Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space.
iii. An abscess or other evidence of infection involving the organ/space that is found on direct examination, during re-operation, or by histopathologic or radiologic examination
and
~~iv. 4. Diagnosis of an organ/space SSI by a surgeon or attending physician.~~

~~v.~~iv. **Meets at least one criterion for a specific organ/space infection site according to NHSN surveillance definitions.**

6. Ventilator Associated ~~Pneumonia~~ **Events** - Intensive Care Units~~s~~
   - a. **Ventilator-Associated Condition (VAC)**
     - i. **Patient has a baseline period of stability or improvement on the ventilator, defined by greater than or equal to (≥) 2 calendar days of stable or decreasing daily minimum FiO2 or PEEP values.**
       And
     - ii. **After a period of stability or improvement on the ventilator, the patient has at least one of the following indicators of worsening oxygenation:**
       - 1) **Increase in daily minimum FiO2 of greater than or equal to (≥) 0.20 (20 points) over the daily minimum FiO2 in the baseline period, sustained for greater than or equal to (≥) 2 calendar days.**
       - 2) **Increase in daily minimum PEEP values of greater than or equal to (≥) 3 cmH2O over the daily minimum PEEP in the baseline period, sustained for greater than or equal to (≥) 2 calendar days.**
       - ~~1)~~3) **Note:**
         - a) **Daily minimum defined by lowest value of FiO2 or PEEP during a calendar day that is maintained for at least 1 hour.**
         - ~~a)~~b) **FiO2 or PEEP values. The baseline period is defined as the two calendar days immediately preceding the first day of increased daily minimum PEEP or FiO2.**
   - b. **Infection-related Ventilator-Associated Complication (IVAC)**
     - i. **Patient meets criteria for VAC**
       and
     - ii. **On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, the patient meets both of the following criteria:**
       - 1) **Temperature greater than (>) 38 °C or less than (<) 36°C, OR white blood cell count greater than or equal to (≥) 12,000 cells/mm3 or less than or equal (≤) 4,000 cells/mm3. ~~And~~**
       - 2) **A new antimicrobial agent(s)* is started, and is continued for greater than or equal to (≥) 4 calendar days.**
   - c. **Possible Ventilator-Associated Pneumonia VAP**
     - i. **Patient meets criteria for VAC and IVAC**
       and
     - ii. **On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, one of the following criteria is met:**
       - 1) **Purulent respiratory secretions (from one or more specimen collections)**
         - a) **Defined as secretions from the lungs, bronchi, or trachea that contains greater than (>) 25 neutrophils and less than (<) 10 squamous epithelial cells per low power field [lpf, x100].**
         - b) **If the laboratory reports semi-quantitative results, those results must be equivalent to the above quantitative thresholds.**
         - c) **See additional instructions for using the purulent respiratory secretions criterion in the VAE Protocol.**
       - 2) ~~**OR**~~
       - 3) **Positive culture (qualitative, semi-quantitative or quantitative) of sputum**
         - a) **Endotracheal aspirate**
         - b) **Bronchoalveolar lavage**

~~a)~~c) Lung tissue, or protected specimen brushing

~~ii.~~iii. Excludes the following:

1) Normal respiratory/oral flora, mixed respiratory/oral flora or equivalent
2) Candida species or yeast not otherwise specified
3) Coagulase-negative Staphylococcus species
4) Enterococcus species

d. Probable Ventilator-Associated Pneumonia VAP

i. Patient meets criteria for VAC and IVAC
ii. And
iii. On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, ONE of the following criteria is met:

1) Purulent respiratory secretions (from one or more specimen collections and defined as for possible VAP) and one of the following:
   a) Positive culture of endotracheal aspirate, greater than or equal to (≥) 10^5 CFU/ml or equivalent semi-quantitative result
   b) Positive culture of bronchoalveolar lavage, greater than or equal to (≥) 10^4CFU/ml or equivalent semi-quantitative result
   c) Positive culture of lung tissue, greater than or equal to (≥) 104CFU/g or equivalent semi-quantitative result
   d) Positive culture of protected specimen brush*, greater than or equal to (≥) 103CFU/ml or equivalent semi-quantitative result
   e) Same organism exclusions as noted for Possible VAP.

~~OR~~

2) One of the following (without requirement for purulent respiratory secretions):
   a) Positive pleural fluid culture (where specimen was obtained during thoracentesis or initial placement of chest tube and NOT from an indwelling chest tube)
   b) Positive lung histopathology
   c) Positive diagnostic test for Legionellaspp.
   ~~a)~~d) Positive diagnostic test on respiratory secretions for influenza virus, respiratory syncytial virus, adenovirus, parainfluenza virus, rhinovirus, human metapneumovirus, coronavirus

~~Two or more serial chest radiographs with at least one of the following:~~
~~1.New or progressive and persistent infiltrate~~
~~2.Consolidation~~
~~3.Cavitation~~
~~AND~~
~~at least one of the following:~~
~~1.Fever (>38C or >100.4F) with no other recognized cause~~
~~2.Leukopenia (<4000 WBC/mm3) or leukocytosis (>12,000 WBC/mm3)~~
~~3.For adults >70 years old, altered mental status with no other recognized cause~~

~~AND EITHER OF THE FOLLOWING~~

~~At least two of the following:~~ ~~1.New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements~~ ~~2.New onset or worsening cough, or dyspnea, or tachypnea~~	~~At least one of the following:~~ ~~1.New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements~~ ~~2.New onset or worsening cough, or dyspnea, or tachypnea~~

~~3.Rales or bronchial breath sounds~~ ~~4.Worsening gas exchange (e.g., O2 desaturations [e.g., PaO2/FiO2 <240], increased oxygen requirements, or increased ventilation demand)~~ ~~1.~~	~~3.Rales or bronchial breath sounds~~ ~~4.Worsening gas exchange (e.g. O2 desaturations [e.g., PaO2/FiO2 < 240]7, increased oxygen requirements, or increased ventilation demand)~~ ~~AND at least one of the following:~~ ~~1.Positive growth in blood cultures not related to another source of infection~~ ~~2.Positive growth in culture of pleural fluid~~ ~~3.Positive quantitative cultures from minimally contaminated LRT specimen (e.g., BAL or protected specimen brushing) > 5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram stain)~~ ~~4.Histopathologic exam shows at least one of the following evidences of pneumonia:~~ ~~a.Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli~~ ~~b.Positive quantitative cultures of lung parenchyma~~ ~~c.~~**a.** ~~Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae~~

7. Primary Bloodstream Infections **(BSI)** related to Central Lines – Intensive Care Units
   a. Catheter-Associated BSI
      i. Vascular access device that terminates at or close to the heart or one of the great vessels. An umbilical artery or vein catheter is considered a central line.
      ii. BSI is considered to be associated with a central line if the line was in **place and** ~~use~~ **accessed** ~~during the 48-hour period~~ **greater than (>) 2 calendar days** before development of the BSI. ~~If the time interval between onset of infection and device use is >48 hours, there should be compelling evidence that the infection is related to the central line.~~

~~Note:~~
~~1)~~

~~A primary bloodstream infection meets at least one of the following criteria:~~
~~*Criterion 1:* Patient has a recognized pathogen cultured from one or more blood cultures~~
~~*and*~~
~~Organism cultured from blood is *not* related to an infection at another site.~~

~~*Criterion 2:* Patient has at least one of the following signs or symptoms:~~
~~fever (>38 °C), chills, or hypotension and signs and symptoms and positive laboratory results are not related to an infection at another site and common skin contaminant (i.e., diphtheroids [*Corynebacterium* spp.], *Bacillus* [not *B. anthracis*] spp., *Propionibacterium* spp., coagulase-negative staphylococci [including *S. epidermidis*], viridans group streptococci, *Aerococcus* spp., *Micrococcus* spp.) is cultured from two or more blood cultures drawn on separate occasions.~~

~~I.~~

8. Urinary Tract Infections **(UTI)**, device related
   ~~II.~~**a. Catheter- Associated UTI**
      i. **A UTI where an indwelling urinary catheter was in place for greater than (>) 2 days on the day of the infection, with day of device placement being Day 1, *and* an indwelling urinary catheter was in place on the day of the infection or the day before. If an indwelling urinary catheter was in place for**

greater than (>) 2 days and then removed, the UTI criteria must be fully met on the day the device was discontinued or the next day.

~~ii. Note: * Follow current NHSN guidelines for Catheter-Associated Urinary Tract Infection Event~~

~~Symptomatic urinary tract infection (device-related). At least one of the following criteria is meet~~

~~At least three of the following four signs or symptoms:~~

~~Fever (> 100.4°F) **OR** chills~~

~~Flank pain **OR** suprapubic pain **OR** tenderness **OR** frequency **OR** urgency~~

~~Worsening of mental status/functional status~~

~~changes in urine character (e.g. New bloody urine, foul odor, increased sediment) AND urinalysis or culture not done.~~

~~At least two of the four above signs or symptoms AND at least one of the following:~~

~~Urinalysis with pyuria (urine specimen with ≥ 10 wbc/mm^3 or ≥ 3 wbc/high power field of unspun urine) AND positive nitrite and /or positive leukocyte esterase~~

~~Presence of organisms by culture ≥ 10^5 cfu/ml of urine AND no more than two different uropathogens.~~

9. **Home Care**
   a. The CDC Definitions do not contain criteria related to home care acquired infections. The Association for Professionals in Infection Control and Epidemiology has written guidelines to address the different practice setting and we have adopted those definitions (see home care policy).

B. **REFERENCES:**

1. National Healthcare Safety Network (NHSN) **Surveillance** Definitions ~~of~~ **for Specific Types of Infections** ~~infection; Resource Library. Retrieved March 25, 2010 from http://www.cdc.gov/nhsn/library.html~~**January 2014 www.cdc.gov/nhsn/PDFs/pscManual/17pscNosInfDef_current.pdf**

~~2. CDC Definitions of nosocomial surgical site infections, 1992: a modification of CDC definitions of surgical wound infections. The Hospital Infections Program, Center for Infectious Diseases, Centers for Disease Control and Prevention, Public Health Service, U.S. Department of Health and Human Services.~~

~~3. Draft Definitions for surveillance of infections in home health care. Embry, F & Chinnes, L. Chair. Am J Infect Control 2000; 28: 449-53.~~

~~4.~~**2.** Centers for Disease Control and Prevention. Guidelines for the Prevention of Intravascular Catheter-Related Infections. MMWR ~~2002;51(No. RR-10)~~ **2011 http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf**

C. **RELATED DOCUMENTS**

1. **Infection Control Philosophy IC.1**
2. **Infection Control Surveillance Program IC.2**
3. **Infection Control Epidemiologic Investigation of a Suspected Outbreak IC.3**

SUBJECT: NUTRITIONAL CARE AND ASSESSMENT FOR INFANTS ADMITTED TO NICU

ISSUE DATE: 09/07
REVISION DATE: 11/07; 7/08; 11/08, 4/09, 06/11, 8/12

Department Approval Date(s):
Division of Neonatology Approval Date(s): 03/15
Pharmacy and Therapeutics Approval Date(s): n/a
Medical Executive Committee Approval Date(s): 04/15
Professional Affairs Committee Approval Date(s): 05/15
Board of Directors Approval Date(s):

A. **POLICY:**

1. Function
   a. A systematic method for the registered dietician to collaborate with the physician in the assessment of nutrition status of patients, the education of patients regarding nutritional therapies, and the provision of appropriate medical nutrition therapy given the patient's medical diagnosis and assessed nutritional requirements.
2. Circumstances
   a. Setting – all patients admitted to or being treated at Tri-City Medical Center's neonatal intensive care unit.
   b. Supervision – none required.
3. Referrals for a nutrition assessment are generated if certain criteria are met via the neonatal admission assessment in Compass Power Chart.
4. Registered dieticians (RD) will assess nutritional status of triggered patients within 48 hours of referral, considering age of patient, disease status, nutrition history, medical history, medical therapies/treatments and laboratory values.
5. Registered dieticians (RD) may assess nutrition status of any patient and implement an appropriate nutrition care plan, to include evaluation and recommendations for enteral and parenteral nutrition support, addition of supplements, and education of patients/families regarding appropriate nutrition intervention for a particular disease state.

B. **DEFINITIONS:**

1. Malnourished or nutritionally at-risk:
   a. Acute weight loss of greater than 10% of body weight
   b. Weight below 3rd percentile on the growth chart
   c. Decreased percentile scores of height and/or weight
   d. Low birth weight **(less than 2500 grams)** or prematurity **(less than 37 weeks)**
   e. Inadequate provision or tolerance of nutrients
   f. Chronic lung disease/bronchopulmonary dysplasia
   g. Congenital heart disease
   h. Necrotizing enterocolitis (NEC)
   i. Short bowel syndrome
   j. Small for gestational age (SGA)
   k. Intrauterine growth **restriction**~~retardation~~ (IUGR)
   l. Rickets of prematurity
   m. Cholestasis
   n. Failure to thrive
   o. Inadequate weight gain (≤ 20 gm) after day of life 14
   p. Inappropriate or inadequate weight gain x 4 days after day of life 14

C. **PROCEDURE:**

1. The registered dietician shall provide nutrition assessment, consultation, and/or medical nutrition therapy for patients, families, and for medical professionals providing care in the Neonatal Intensive Care Unit (NICU). Referrals for nutrition assessment are generated if certain criteria are met via the admission database, requested by physician and/or identified during multidisciplinary rounds.
2. Referrals for nutrition assessment are generated if the following criteria are met upon completion of the NICU admission database and patient history, as requested by physician and/or as identified during multidisciplinary rounds, or at any point during the NICU stay.
   a. Extremely Low Birth Weight (ELBW) less than 1000gm
   b. Very Low birth Weight (VLBW) less than 1500gm
   c. Chronic lung disease/bronchopulmonary dysplasia
   d. Congenital heart disease
   e. Necrotizing enterocolitis (NEC)
   f. Short bowel syndrome
   g. Small for gestational age
   h. Intrauterine growth retardation
   i. Rickets of prematurity
   j. Cholestasis
   k. Patients on TPN for more than **five**~~three~~ days
   l. Intolerance to enteral feeds
   m. Failure to thrive
   n. Inadequate weight gain (less than or equal to 20 grams) after day of life 14
   o. Inappropriate or inadequate weight gain for 4 days after day of life 14
3. The dietician will complete the assessment with consideration of:
   a. Nutrition order (TPN versus gavage feedings versus nipple feedings versus breastfeeding)
   b. Diagnosis
   c. Chronological age and/or gestational age
   d. Weight
   e. Length
   f. Head circumference as appropriate
   g. Food allergies
   h. Birth weight, if available
   i. History of weight changes
   j. Potential drug nutrient interactions
   k. Laboratory and biochemical values
   l. Psychosocial, physiological, social and/or environmental issues
   m. Clinical assessment changes
   n. Any other general nutrition concerns
4. Clinical dietician will document nutrition assessment in the progress notes of the medical record. Assessments will be based on information provided by admission assessment, review of history and physical, physician notes, other disciplines' notes, and interview with parents, nursing, or other members of health care team.
   a. Nutrition order
   b. Diagnosis
   c. Age (gestational age and adjusted age)
   d. Weight, length
   e. Macronutrient and micronutrient requirements
   f. Food allergies
   g. Laboratory and biochemical values: pertinent to assessment
   h. History of weight changes
   i. Feeding problems
   j. Psychosocial, physiological, social and/or environmental issues
5. Clinical dietician will also calculate the following:
   a. Weight for height percentile or weight for age/weight for height percentile
   b. Head circumference percentile

c. Weight change percentile (postnatal growth for the premature infant should mimic inutero fetal growth rates ~1.5% (18g/kg) increase per day
d. Estimation of calories is based upon the neonate's age, weight, disease state, and nutrition status
e. Grams of protein per day
f. Fluid requirements

6. A nutrition care plan will be developed and individualized based on assessment and will meet the specific needs of the patient. Goals will be individually determined with delineation of methods of achievement of goals and time frames. Goals will be documented in the infant's medical record.

Energy, Protein, Fluid Requirements of the Preterm Infant			
	Protein g/kg/d	Kcal/Kg/d	Water ml/kg/d
Preterm fed enterally	2.5 – 4	105 – 130	120 – 200*
Preterm fed parentally	3 – 4	90 – 120	140 – 160*

*Dependent upon clinical condition (i.e. less with PDA or BPD)

7. Clinical dietician will confer with physician, RN, and/or pharmacist regarding pertinent factors affecting nutrition status (i.e. medication, I&O, intake, etc.).
8. Clinical dietician will provide follow-up for patients assessed at risk daily and will:
   a. Document at least every seven (7) days depending on medical status and nutritional status and revise therapy as indicated.
   b. Follow-up assessment is documented on the progress notes of the medical record, to include nutrient intake, tolerance to feedings, weight changes, laboratory parameters, and I&O.
   c. Follow-up assessments may be triggered sooner as warranted by change in nutritional status and/or medical condition.
9. Clinical dietician will provide nutrition counseling and education, explaining rationale to parent(s) as ordered by physician, as requested by nursing, family, or as deemed appropriate by RD.
   a. Documentation of education is completed in the physician progress notes.
   b. Education may include, but is not limited to, formula preparation, appropriate recommendations related to infant feedings and formulas. Referrals for outpatient medical nutrition therapy will be generated as appropriate, i.e. specialty formulas, feeding issues, and growth concerns.

D. REFERENCES:

1. Nutritional Needs of the Preterm Infant: **2nd** Ed. Tsang, RC, **2005**~~1993~~.
~~1.~~**2.** The A.S.P.E.N. Nutrition Support Practice Manual, 2nd ed., ed. Merritt, R. 2005.
~~2.~~**3.** The Science and Practice of Nutrition Support: A Case Based Core Curriculum, " ed. Gottschlich, MM, 2001.

~~E. APPROVAL PROCESS~~

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

Tri-City Medical Center
Oceanside, California

DELETE - No longer needed as a policy, use as a reference guide for IT Pharmacist

PHARMACY POLICY MANUAL

ISSUE DATE: 6/06 **SUBJECT:** Adverse Drug Event/Discern Alert Rules Appendix I

REVISION DATE: 2/09, 12/09 **POLICY NUMBER:** 8390-10024

Department Approval Date(s): 03/15
Pharmacy & Therapeutics Committee Approval: 6/06, 12/09, 1/12, 03/15
Medical Executive Committee Approval: 6/06, 12/09, 1/12, 05/15
Professional Affairs Committee Approval Date(s): 05/15
Board of Directors Approval: 6/06, 12/09, 1/12

A. **Appendix I:**

1. List of ADE Rules:
   a. ADE_ANTIDOTE_2- Asynchronous alert that prints when a STAT order is placed for a typical rescue medication (example: diphenhydramine, methylprednisolone, naloxone). Notifies the pharmacist that an adverse drug reaction may have occurred.
   b. ADE_ASYNC_MRSA_1- Asynchronous alert that prints when a bacterial culture results positive for Methicillin Resistant Staphylococcus Aureus (MRSA) and the patient is not on Vancomycin. The pharmacist should contact the physician immediately and suggest an appropriate antibiotic.
   c. ADE_ASYCN_DAPTOMYCIN- Asynchronous alert triggers for elevated CPK results to ensure the proper monitoring of Daptomycin in relation to possible myopathy. Prints an alert to the pharmacist with the manufacture recommendations for weekly CPK levels and more frequently if patient is also on statin.
   d. ADE_ASYCN_EPOGEN_1- Asynchronous alert that triggers when a patient with an active order for erythropoietin also has a hemoglobin result greater than 12.
   e. ADE_ASYNC_HEPATICSTATIN_2- Asynchronous alert that prints when a patient currently on an HMG-CoA reductase inhibitor (Statin) and their SGOT > 100, SGPT > 100 or CPK > 269. This may indicate the patient has developed hepatic toxicity or myopathy from the medication. This alert is in the form of a Clinical Pharmacy Note. Once the alert is evaluated and the pharmacist has determined that it is significant then the alert is placed into the progress note section of the medical record.
   f. ADE_ASYNC_HIT_1- Asynchronous alert that looks for platelets less than 100,000 or a drop of 100,000 within two consecutive labs and the patient is on LMWH or heparin. This rule helps monitor for and detect heparin-induced thrombocytopenia.
   g. ADE_ASYNC_HYPOGLYCEMIA- Asynchronous alert looking for documented blood sugar results less than 60 and the patient has an active order for antidiabetic agent(s).
   h. ADE_ASYNC_INRANTICOAGTX_2- Asynchronous alert that is looking for an increase in INR of greater than 0.7 between two consecutive results or an INR greater than 3. Rule will print out lab results along with any current orders for anticoagulation.
   i. ADE_ASYNC_ORGANNOANTIBIOTIC- Asynchronous alert that prints when a culture result is positive for bacteria that is resistant to the patient's current antibiotics or in cases where the culture is positive and the patient is not on any antibiotic.
   j. ADE_ASYNC_PTTLEVELHEPARIN_2- Asynchronous alert that prints to notify the pharmacist there is a patient on heparin with a PTT level that is outside of the therapeutic window (less than 65 seconds or greater than 95 seconds). This alert will print the instant the lab has resulted.
   k. ADE_ASYNC_RCMDMKIDNEY_3- This rule evaluates the patient when a diagnostic test is ordered with radiographic contrast. The alert fires if the hematocrit is greater than 50 (signs of dehydration), the CrCl is less than 60 mL/min (sign of renal compromise) and/or if the patient has an active order for metformin (drug interaction with contrast) and then prints along with the requisition in radiology.
   l. ADE_ASYNC_RCMETFORM_1- Similar to ADE_ASYNC_RCMDMKIDNEY_3, but alerts the pharmacist specifically that a diagnostic test has been ordered with contrast on a

patient with an active order for metformin. The intent of this rule is to stop the metformin 24 hours prior to the actual test.

m. ADE_ASYNC_VRE_2- Asynchronous alert that prints when a bacterial culture results positive for Vancomycin Resistant Enterococcus (VRE) and the patient is not on linezolid or quinapristin/dalfopristin. The pharmacist should contact the physician immediately and suggest an appropriate antibiotic.

n. ADE_BBW – Notifies the pharmacist when entering a medication with a Black Box warning. These include drugs on the Black Box Warning Policy and Procedure. Pharmacists are to refer to the policy for required actions.

o. ADE_CREATCHANGEDRUG_T- Asynchronous alert that prints when there is a 20% increase in serum creatinine or creatinine clearance and the patient is on a nephrotoxic medication.

p. ADE_CREATRENALDRUG- Asynchronous alert that prints when there is a serum creatinine > 1.5 or creatinine clearance < 30 and the patient is on a medication that requires dosage adjustment for decreased renal function.

q. ADE_DIGOXIN_LAB_1- Synchronous alert that appears on screen when digoxin is ordered for a patient and the patient has either a low potassium level, low magnesium level, or high digoxin level. This rule also looks for recent orders for potassium and magnesium supplements that would indicate that the electrolyte problem is being addressed.

r. ADE_KETORELDKINDEY_1- Synchronous alert that appears on screen when the pharmacist attempts to order ketorolac in a dose greater than 15mg on a patient that is older than 65 years. Doses greater than 15mg in this age population has been shown to cause acute renal failure.

s. ADE_LABMETORIM_3- Asynchronous alert that prints when a patient has a current order for metformin and has a lab result of pH < 7.34 or lactic acid level > 20. This may indicate the patient is developing lactic acidosis from the metformin. This rule also notifies the pharmacist if there is a current order for a diagnostic test with contrast that may interact with the metformin and cause acute renal failure.

t. ADE_RENALDRUGCREAT_1- Synchronous alert that appears on screen when a medication that requires adjustment for decreased renal function is being added to a patient who's serum creatinine is > 1.5 or has a creatinine clearance < 30. This alert notifies the pharmacist that dosage adjustment is required before the medication order is entered.

u. ADE_STATINHEPATIC_3- Synchronous alert that prints when a HMG-CoA reductase inhibitor (Statin) is ordered for a patient that has a pH< 7.34, lactic acid level > 20 or CPK > 269. This alert is in the form of a Clinical Pharmacy Note. Once the alert is evaluated and the pharmacist has determined that it is significant then the alert is placed into the progress note section of the medical record.

v. ADE_SYN_ANTICOAGTXINR_4- Synchronous alert that appears on screen when an order for warfarin is entered and the patient has an INR > 3 or there has been an increase of greater than 0.7 between two consecutive INR results. Also alerts if heparin or LMWH are entered and the INR is >3.

w. ADE_SYN_CLOZAPINELAB_1(not in production)- Synchronous alert that appears on screen when ordering clozapine if the patient has a WBC less than 3.5 or an ANC less than 2 or does not have an active order for CBC with diff.

x. ADE_SYN_DAPTOMYCIN- Synchronous alert that appears on screen when ordering daptomycin and there is a CPK level greater than 769. This also triggers a printed Clinical Note to be placed in the chart for the physician.

y. ADE_SYN_EPOGEN_1- Synchronous alert that appears on screen when ordering erythropoietin and the patient's hemoglobin is greater than 12.

z. ADE_SYN_FORM- Simple rule to allow the pharmacist to quickly bring up the Clinical Pharmacy Intervention form directly from the Med Manager application.

aa. ADE_SYN_HEPARINPTTLEVEL_2- Synchronous alert that appears on screen when any coagulation modifiers are entered and the patient has a PTT greater than 60 seconds.

bb. ADE_SYN_HIT_1- Synchronous alert that appears on screen whenever heparin or LMWH is ordered and the patients' platelet level is less than 100,000.

cc. ADE_SYN_IMANTICOAG- Synchronous alert that appears on screen to alert the pharmacist when a medication with the route of intramuscular (IM) and the patient is on an anticoagulant. This route of administration is contraindicated when a patient is on heparin, low molecular weight heparin or warfarin.

dd. ADE_SYN_INVESTIGATIONAL- Synchronous alert that appears on screen when a medication on the exclusion criteria is entered on a patient in an active investigational trial. Each rule is specific for a particular study. This rule is used in some way for every investigational study to alert the pharmacist that they are accessing a study patient.

ee. ADE_SYN_IT_ANTICOAG- Synchronous alert that warns the pharmacist that the patient may have had an intrathecal narcotic within the last 24 hours when ordering low molecular weight heparin (LMWH). This rule looks for the preservative free morphine used for one-time spinal shots created by the anesthesiologist. Using LMWH is contraindicated due to increased risk of intrathecal bleeding.

ff. ADE_SYN_KAYEX_KCL- This alert fires when the pharmacist enters an order for kayexalate and the patient has an active order for potassium chloride. Prompts the pharmacist to call the MD to discontinue any potassium supplements.

gg. ADE_SYN_METFORMINLAB_3- Synchronous alert that appears on screen to alert the pharmacist when entering an order for metformin that the patient has an active order for a diagnostic test with contrast or has a pH < 7.34 or a lactic acid level > 20. This will prevent a metformin-radio contrast dye drug interaction that could result in acute renal failure or avoid making a lactic acidosis condition worse.

hh. ADE_PRASUGREL_BBW- This rule looks for incoming orders for prasugrel in patients older than 75 (not recommended) and/or weight less than 60kg (requires a decrease in dose). Reflected in BBW PP.

ii. ADE_SYN_PREGLAC_1- when the nurse indicates that the patient is either pregnant or lactating in the Admission Assessment, this synchronous alert appears on screen when the pharmacist opens that patient's profile in Med Manager. This will alert the pharmacist that special screening of medications must take place.

jj. ADE_SYN_RCMDMKIDNEY_RX- On screen alert that appears when the pharmacist enters the IV contrast and the patient has a hemoglobin level greater than 50, CrCl less than 60 or an active order for metformin.

kk. ADE_SYN_RCMDMKIDNEY_GAD- Alert that shows on screen and prints with the requisition when an MRI test is entered with contrast on a patient with CrCl less than 60 or Scr greater than 1.5.

ll. ADE_SYN_RCMDMKIDNEY_GADRX- Similar to ADE_SYN_RCMDMKINEY_GAD only it fires when the pharmacist is entering the order for gadolinium.

mm. ADE_SYN_RCMDMKIDNEY_T- Similar to ADE-SYN_RCMDMKIDNEY_RX except that the alert fires on screen for the user entering the order and prints at the nursing station and at two radiology printers.

nn. ADE_SYN_ROCEPHIN_TPN- Alerts the pharmacist if either there is an active order for TPN when entering ceftriaxone or vise versa. The TPN entry is only used for charting and billing purposes at Tri-City Medical Center therefore does not evoke the Multum calcium drug interaction.

oo. PHA_ANTICOAGULATION_DRG- This rule creates an order for the nurses to educate the family when an anticoagulant is ordered for the first time.

pp. PHA_ANTIPHYSHOTIC_DRG- This rule creates an order for the nurses to obtain a consent for psychiatric medications when any anti-psychotic is ordered for the first time.

qq. PHA_NO_ALLERGIES- Synchronous alert that appears on screen when the pharmacist opens that patient's profile in Med Manager and they either do not have allergies listed or the allergies are free text. Free text allergies will not be caught by Multum's drug-allergy program.

rr. PHA_ASYNC_CENTRALINE- Printed alert that looks for patients with active orders for CVP line or PICC line dressing changes that do not have orders for saline flush. Pharmacists are to enter the saline flush orders per standing procedure/maintenance of central lines.

ss. PHA_CHEMOTHERAPYNOTIFY- This alert sends a text message to the charge nurse of the Oncology unit when a chemotherapy order has been entered on a patient that is not located on the Oncology floor. The text includes the patient name, location and chemotherapy agent.

tt. PHA_COUGH_COLD_FDA- This is an on screen alert that fires when any cough or cold preparation is entered on a patient less than 2 years of age. The pharmacist is required to contact the physician and notify them of the FDA recommendation.

uu. PHA_ED_TO_ICU- Requested by the ED physicians, this rule creates an order if an ED patient is started on dopamine, dobutamine, phenylephrine, norepinephrine or nitroglycerin continuous infusions.

vv. PHA_EXCIPIENT_ALLERGY- This rule catches allergies out of the scope of Multum. It includes allergies to eggs, peanuts, thimersol, sulfites, fish and castor oil.

ww. PHA_EXPENSIVEDRUGNOTIFY- This rule sends an email to the Clinical Specialist and Pharmacy Buyer when an expensive medication has been ordered for a patient. Examples include IVIG, Factor IX, snake antivenin.

xx. PHA_PHARMACYNOTES- This rule alerts the pharmacist when the patient's chart is opened in Med Manager and contains a special consideration (e.g. No heparin, mix IVPB in NS etc).

yy. PHA_POMREMINDER_1- This alert prints for the Pharmacy Courier when the nurse is completing the Discharge Instructions and there is documentation that the patient has their medications stored in the pharmacy.

zz. PHA_TUSSIONEX_FDA- This on screen alert fires when the pharmacist attempts to enter an order for Tussionex on a patient that is less than 6 years old.

Tri-City Medical Center
Oceanside, California

~~POLICY~~ PHARMACY MANUAL

ISSUE DATE: 10/10

SUBJECT: ~~Antibiotic~~ Antimicrobial Stewardship Program

REVISION DATE: 3/15

~~**POLICY NUMBER: 8390-6018**~~

Department Approval Date(s):	3/15
Medical Staff Department/Division Approval Date(s):	n/a
Pharmacy & Therapeutics Committee Approval Date(s):	10/10, 3/15
Medical Executive Committee Approval Date(s):	10/10, 4/15
Professional Affairs Committee Approval Date(s):	05/15
Board of Directors Approval Date(s):	10/10

A. **PURPOSE:**

~~1. Antibiotic stewardship is a process used to achieve two primary goals:~~
~~a. to minimize adverse effects and events secondary to the use of antimicrobial agents~~
~~b. to reduce, minimize, and/or prevent the emergence of resistant microorganisms.~~
~~2. A secondary goal of decreasing the cost of antibiotic drug expenditures is a consequence of the 2 primary goals. Antibiotic stewardship is a multi-faceted approach in which Infection control, medical staff, microbiology, infectious diseases, clinical informatics, hospital administration and pharmacy work together to achieve these goals.~~

1. **To provide a process in order to promote judicious use of antimicrobials**
2. **The goals of the Antimicrobial Stewardship Program (ASP) include, but are not limited to:**
   a. **Minimize adverse effects and events secondary to the use of antimicrobial agents**
   b. **Reduce, minimize, and/or prevent the emergence of resistant microorganisms**

B. **POLICY:**

1. **A physician supervised multidisciplinary antimicrobial stewardship workgroup shall evaluate the judicious use of antimicrobials in accordance with guidelines established by the federal government and professional organizations.**
2. **Antimicrobial stewardship activities, outcomes, and all quality indicators shall be reported quarterly by the Infectious Disease physician or pharmacist to the Pharmacy & Therapeutics Committee and Infection Control.**

~~B. **DEFINITIONS**:~~

~~1. **Antibiotic stewardship** is the optimal use of antimicrobial agents so as to prevent or minimize adverse effects of antimicrobials and prevent the emergence of resistant microbes.~~
~~2. **Antibiotic surveillance** is the process of prospectively and retrospectively reviewing the use of antibiotic agents. The prospective process may involve contacting the prescriber with recommendations for optimizing current antibiotic therapy on an individual patient. The retrospective review will include medication use evaluations (MUEs) presented to a Medical staff Committee for their review and recommendations.~~
~~3. **The Pharmacy & Therapeutics Committee** will be the medical staff committee through which these activities are reported.~~
~~4. **Restricted antimicrobial** is an antibiotic agent that the medical staff has determined should be restricted in use (either by prescriber or clinical indication). Please see pharmacy policy "Restricted Antimicrobials".~~

~~C. **ELEMENTS OF ANTIBIOTIC STEWARDSHIP:**~~

~~1. Medical Staff~~

~~a. Formulary review of antimicrobial agents~~
~~b. Policy and procedures~~
~~c. Prescribing~~
~~d. Retrospective reviews (MUEs)~~

~~2. Infection Control~~
~~a. Infection Control Activities~~
~~b. Quality indicators (C. difficile, MDRO, device related infections, procedure related infections, etc)~~
~~c. Education~~

~~3. Pharmacy~~
~~a. Pharmacist review of all antibiotic orders~~
~~b. Renal dose adjustments~~
~~c. IV to Oral route conversion program~~
~~d. Prospective reviews (in conjunction with Infectious diseases)~~
~~e. Prepares retrospective reviews (MUEs)~~
~~f. Restricted antibiotic surveillance~~
~~g. Education~~

~~4. Infectious Diseases~~
~~a. Prospective reviews (in conjunction with Pharmacist)~~
~~b. Leadership~~
~~c. Education~~

~~5. Information Systems~~
~~a. Cerner antibiotic ADE prevention rules (see V. below)~~
~~b. Computerized alerts & warnings~~
~~c. Data generation and reporting~~

~~6. Microbiology~~
~~a. Culture and sensitivity reporting/alerting~~
~~b. Annual antibiogram~~

~~7. Administration~~
~~a. Financial support of program~~

C. PROCEDURE:

1. ANTIMICROBIAL STEWARDSHIP WORKGROUP:

a. Clinicians
i. A single physician leader, knowledgeable in the area of infectious diseases, responsible for program outcomes
ii. A pharmacist leader, knowledgeable in the area of infectious diseases, will co-lead the program

b. Infection Control
i. Infection Control Activities
ii. Quality indicators (*C. difficile*, MDRO, device related infections, procedure related infections, etc)

c. Information Systems
i. Computerized alerts & warnings
ii. Data generation and reporting

d. Microbiology
i. Culture and sensitivity reporting/alerting
ii. Annual antibiogram

e. Administration
i. Financial support of program

2. ANTIMICROBIAL STEWARDSHIP ACTIVITIES:

a. Prospective audit and feedback conducted by pharmacist leader in conjunction with physician leader

i. This process involves prospectively reviewing the use of antimicrobial agents and contacting the prescriber with recommendations for optimizing current antimicrobial therapy on an individual patient.

b. Development and implementation of a restricted antibiotic policy (Refer to Pharmacy policy "Restricted Antimicrobials")

c. Surveillance and trending of antimicrobial use patterns and quality indicators

d. Education to clinicians and staff
   i. Development of evidence based, institution-specific guidelines for the treatment of common infections

e. Other activities:
   i. IV to Oral route conversion program
   ii. Renal dose adjustment of antimicrobials
   iii. Preparation of retrospective reviews (i.e. Medication Use Evaluation)

~~D. **REPORTING:**~~

~~All reporting of quality indicators and other criteria associated with antibiotic use and antibiotic stewardship will occur quarterly at the Pharmacy & Therapeutics Committee of the medical staff.~~

~~E. **CERNER ANTIBIOTIC SPECIFIC ADE PREVENTION RULES:**~~

~~1. ADE_ASYNC_MRSA_1- Asynchronous alert that prints when a bacterial culture results positive for Methicillin Resistant Staphylococcus Aureus (MRSA) and the patient is not on Vancomycin. The pharmacist should contact the physician immediately and suggest an appropriate antibiotic.~~

~~2. ADE_ASYCN_DAPTOMYCIN- Asynchronous alert triggers for elevated CPK results to ensure the proper monitoring of Daptomycin in relation to possible myopathy. Prints an alert to the pharmacist with the manufacture recommendations for weekly CPK levels and more frequently if patient is also on statin.~~

~~3. ADE_ASYNC_ORGANNOANTIBIOTIC- Asynchronous alert that prints when a culture result is positive for bacteria that is resistant to the patient's current antibiotics or in cases where the culture is positive and the patient is not on any antibiotic.~~

~~4. ADE_ASYNC_VRE_2- Asynchronous alert that prints when a bacterial culture results positive for Vancomycin Resistant Enterococcus (VRE) and the patient is not on linezolid or quinapristin/dalfopristin. The pharmacist should contact the physician immediately and suggest an appropriate antibiotic.~~

~~5. ADE_CREATCHANGEDRUG_T- Asynchronous alert that prints when there is a 20% increase in serum creatinine or creatinine clearance and the patient is on a nephrotoxic medication.~~

~~6. ADE_CREATRENALDRUG- Asynchronous alert that prints when there is a serum creatinine > 1.5 or creatinine clearance < 30 and the patient is on a medication that requires dosage adjustment for decreased renal function.~~

~~7. ADE_RENALDRUGCREAT_1- Synchronous alert that appears on screen when a medication that requires adjustment for decreased renal function is being added to a patient who's serum creatinine is > 1.5 or has a creatinine clearance < 30. This alert notifies the pharmacist that dosage adjustment is required before the medication order is entered.~~

~~8. ADE_SYN_DAPTOMYCIN- Synchronous alert that appears on screen when ordering daptomycin and there is a CPK level greater than 769. This also triggers a printed Clinical Note to be placed in the chart for the physician.~~

~~9. ADE_SYN_ROCEPHIN_TPN- Alerts the pharmacist if either there is an active order for TPN when entering cefTRIAXone or vise versa. The TPN entry is only used for charting and billing purposes at Tri-City Medical Center therefore does not evoke the Multum calcium drug interaction.~~

~~10. PHA_NO_ALLERGIES- Synchronous alert that appears on screen when the pharmacist opens that patient's profile in Med Manager and they either do not have allergies listed or the allergies are free text. Free text allergies will not be caught by Multum's drug-allergy program.~~

DELETE – duplicate policy, information in Microbiology Lab policy

Tri-City Medical Center
Oceanside, California

PHARMACY POLICY MANUAL

~~ISSUE DATE: 06/90~~ ~~SUBJECT: Antimicrobial Susceptibility Report (JCAHO IC.6.2)~~

~~REVISION DATE: 07/06~~ ~~POLICY NUMBER: 8390-10016~~

~~Department Approval Date(s):~~	03/15
~~Pharmacy & Therapeutics Committee Approval:~~	~~02/03, 07/06, 07/09, 1/12~~, 03/15
~~Medical Executive Committee Approval:~~	~~02/03, 07/06, 07/09, 1/12~~, 04/15
Professional Affairs Committee Approval Date(s):	05/15
~~Board of Directors Approval:~~	~~02/03, 07/06, 07/09, 1/12~~

~~A. **POLICY**:~~

~~The Microbiology lab prepares, distributes and publishes the antimicrobial susceptibility report (antibiogram). Prior to distribution the Pharmacy and Therapeutic Committee and Infection Control Committee provide input and approval. The antibiogram is a tabulation of susceptibility data received form the Microbiology Laboratory. Percent susceptibility is determined for systemic antibiotic levels as defined by national standards. The purpose is to help practitioners identify local trends in antibiotic effectiveness.~~

~~B. **PROCEDURE**:~~

~~1. Susceptibility trends are every six months to demonstrate changes in bacterial incidence and resistance.~~
~~2. Antibiotic cost indexes are included for reference.~~
~~3. The antibiograms are distributed to all members of the medical staff.~~

Tri-City Medical Center
Oceanside, California

DELETE - Blended with Hours of Operation Policy

PHARMACY POLICY MANUAL

ISSUE DATE: 11/85	SUBJECT: Authorized Access to the Pharmacy
REVISION DATE: 01/90, 01/2000, 07/06	POLICY NUMBER: 8390-4403
Department Approval Date(s):	03/15
Pharmacy & Therapeutics Committee Approval:	06/05, 07/06, 07/09, 1/12, 03/15
Medical Executive Committee Approval:	06/05, 07/06, 07/09, 1/12, 04/15
Professional Affairs Committee Approval Date(s):	05/15
Board of Directors Approval:	06/05, 07/06, 07/09, 1/12

A. **POLICY**:

1. Only Authorized Persons Shall Be Allowed in the Pharmacy:
   a. Access to the main Pharmacy is limited to the Pharmacist and his/her staff during Pharmacy operating hours. Medical staff, nursing service, administrative, Environmental Services and other personnel are authorized admission only in conjunction with their duties and under supervision of Pharmacy staff.

[v1]

Tri-City Medical Center
Oceanside, California

PHARMACY~~POLICY~~ MANUAL

ISSUE DATE: 09/91 **SUBJECT:** Bedside Medication Storage

REVISION DATE: 01/97, 07/00, 04/05, 07/06, 01/12, 3/15 ~~**POLICY NUMBER: 8390-5103**~~

Department Approval Date(s):	**3/15**
Medical Staff Department/Division Approval Date(s):	**3/15**
Pharmacy & Therapeutics Committee Approval Date(s):	**2/03, 04/05, 07/06, 07/09, 1/12, 03/15**
Medical Executive Committee Approval Date(s):	**2/03, 04/05, 07/06, 07/09, 1/12, 04/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	**2/03, 04/05, 07/06, 07/09, 1/12**

A. **POLICY**:

1. ~~No M~~medications **shall not be stored at bedside.** ~~will be left at the bedside.~~
   a. **Exception: as delineated in Patient Care Services Policy Self-Administered Continuous Subcutaneous Infusion of Insulin (Insulin Pump Therapy) for the Acute Care Patient**

Tri-City Medical Center
Oceanside, California

PHARMACY~~POLICY~~ MANUAL

ISSUE DATE: 01/98	**SUBJECT: Discharge Prescriptions**
REVISION DATE: 02/03, 06/05, 07/06	**~~POLICY NUMBER: 8390-3119~~**
Department Approval Date(s):	**03/15**
Medical Staff Department/Division Approval Date(s):	**n/a**
Pharmacy & Therapeutics Committee Approval:	**02/03, 06/05, 07/06, 07/09, 1/12, 03/15**
Medical Executive Committee Approval:	**02/03, 06/05, 07/06, 07/09, 1/12, 04/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval:	**02/03, 06/05, 07/06, 07/09, 1/12**

A. **POLICY**:

1. The hospital does not provide discharge medications, unless an extreme emergency exists. Discharge prescriptions may be an important component of the continuum of the patient's care. This hospital is committed to assisting the patient/family in obtaining access to appropriate pharmaceutical care during the discharge process.
2. If an emergency exists, no drugs supplied by the hospital shall be taken from the hospital unless a prescription or medical record order has been written for the medication. The medication must be properly labeled and prepared by the Pharmacist in accordance with state and federal laws, for use outside of the hospital.
3. The patient may be provided printed material describing the effects of the discharge medications ordered by the physician. Drug leaflets for discharge information may be accessed at nursing units using the Micromedex system.
4. Depending on risk and other factors, the patient and/or family may receive education about anticipated discharge medications prior to the day of discharge. Such education will be provided by either the nurse or Pharmacist. Documentation of such education will appear in the discharge instructions area of the medical record.
5. The Hospital may assist in extraordinary cases, hardship cases or when the medication is difficult to obtain elsewhere. It should be noted however, that discharge prescriptions are not a payable benefit of most health care insurance plans. The patient/family holds the financial responsibility for discharge prescriptions.
6. No person other than a pharmacist or an individual under the direct supervision of a pharmacist shall dispense medication for use beyond the immediate needs of the patients.

Tri-City Medical Center
Oceanside, California

PHARMACY~~POLICY~~ MANUAL

ISSUE DATE: 01/90

SUBJECT: Emergency Medication Tray for Crash Cart~~Crash Cart Security and Accountability~~

REVISION DATE: 05/94, 03/97, 10/99, 08/02/ 06/05, 07/06, 07/09, 3/15

~~**POLICY NUMBER: 8390-2203**~~

Department Approval Date(s):	**03/15**
Medical Staff Department/Division Approval Date(s):	**n/a**
Pharmacy & Therapeutics Committee Approval Date(s):	**02/03, 06/05, 07/06, 7/09, 1/12, 03/15**
Medical Executive Committee Approval Date(s):	**02/03, 06/05, 07/06, 7/09, 1/12, 04/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	**02/03, 06/05, 07/06, 7/09, 1/12**

A. **POLICY**:

1. This hospital maintains mobile supplies of emergency equipment and medications (crash carts) in-patient care areas of the hospital and at designated off-site clinics. The Code Blue Committee determines which medications will be stocked in these carts and ~~T~~the Pharmacy and Therapeutics Committee approves final recommendations. **T**he ~~Pharmaceutical Services~~**Pharmacy** Department is responsible for the integrity and security of medications contained in the crash carts.

B. **PROCEDURE**:

1. The emergency drug supply is stored in a clearly marked portable container ~~which is sealed by the Pharmacist with a seal which must be broken to gain access to the drugs~~. **T**he contents of the container are ~~listed on the outside cover~~ **listed and visible on or within the container** and include the earliest expiration date of the drugs within.

2. The emergency medication tray will be filled by pharmacy personnel.

3. The emergency medication tray will be checked by a pharmacist or pharmacist intern.

4. The pharmacy personnel checking the emergency medication tray will verify contents, quantities, and expiration dates, then lock the tray with a lock that must be broken in order to gain access to the medications.

~~1.~~**5. The first to expire medication, date of expiration, and lock number of the lock used to seal the tray will be included on a label which will be placed on the crash cart medication drawer.**

~~2. The nurse will inspect the seal's integrity on every shift. The Pharmacist will inspect the drug supply monthly as part of a monthly unit inspection.~~

6. Prior to placing the final lock on the crash cart, ~~P~~pharmacy personal will inspect IV solutions placed in the ~~court~~ **cart** by Sterile Procedures Department personnel. ~~prior to planning the lock on the crash cart drawers.~~

~~3.~~**7. In an effort to confirm the integrity of the crash cart, when performing monthly area unit inspections, the pharmacy personnel performing the inspection will confirm the lock number on the crash cart matches the lock number recorded on the current crash cart checklist. If there is any question of integrity at that time the most appropriate person to address the matter will be notified.**

Tri-City Medical Center
Oceanside, California

DELETE – no longer needed as drug information, other resources available

PHARMACY~~POLICY~~ MANUAL

~~ISSUE DATE: 04/97~~ ~~SUBJECT: Flumazenil (Romazicon) in the Treatment of Benzodiazepine Overdose~~

~~REVISION DATE: 09/00, 07/06~~ ~~POLICY NUMBER: 8390-10012~~

~~Department Approval Date(s):~~ 03/15
~~Medical Staff Department/Division Approval Date(s):~~ n/a
~~Pharmacy & Therapeutics Committee Approval:~~ ~~02/03, 07/06, 07/09, 1/12~~, 03/15
~~Medical Executive Committee Approval:~~ ~~02/03, 07/06, 07/09, 1/12~~, 04/15
~~Professional Affairs Committee Approval Date(s):~~ 05/15
~~Board of Directors Approval:~~ ~~02/03, 07/06, 07/09, 1/12~~

~~A. PURPOSE:~~
~~To provide information regarding the use of Flumazenil in the treatment of benzodiazepine overdose.~~

~~B. INDICATIONS:~~
~~For complete or partial reversal of the effects of benzodiazepine overdose.~~

~~C. CONTRAINDICATIONS:~~
~~1. Patients with symptoms of Tricyclic antidepressant overdosage.~~
~~2. Patients receiving benzodiazepines for a life threatening condition (control of intracranial pressure or status epilepticus)~~
~~3. Known hypersensitivity to benzodiazepine.~~

~~D. DOSING GUIDELINES:~~
~~1. Overdose:~~
~~a. May give directly IV undiluted:~~
~~i. 0.2mg (2cc) over 15 seconds IV push, wait 45 seconds; if desired response or consciousness not seen, may repeat with a 0.3mg (3cc) over 15 seconds. Wait 30 seconds for response then repeat with a 0.5mg (5cc) over 30 seconds. May repeat every 60 seconds to a total dose of 3mg. For children the dose is 0.01 mg/kg (max of 0.2mg), repeated every 45 seconds to a maximum cumulative dose of 1mg~~
~~2. Over sedation:~~
~~a. Reversal of sedative effects:~~
~~i. 0.2mg (2cc) over 15 seconds. Wait 45 seconds. If adequate reversal is not achieved, give additional 0.2mg over 15 seconds. May repeat at 1 minute interval up to a maximum of 1mg.~~

~~E. PRECAUTION:~~
~~1. The use of Romazicon has been associated with the occurrence of seizures. These are most frequent in patients who have been on benzodiazepines for long term sedation or in overdose cases with patients showing signs and symptoms of tricyclic antidepressant overdose.~~
~~2. Flumazenil has a short (less than 30 minutes) duration of action. In those patients with overdosage from long acting benzodiazepine, repeat dosage may be required.~~

Tri-City Medical Center
Oceanside, California

PHARMACY ~~POLICY~~ MANUAL

ISSUE DATE: 12/11 **POLICY:** Formulary System

REVISION DATE: 3/15

Department Approval Date(s):	**03/15**
Medical Staff Department/Division Approval Date(s):	**n/a**
Pharmacy & Therapeutics Committee Approval:	**01/12, 03/15**
Medical Executive Committee Approval:	**02/12, 04/15**
Professional Affairs Committee Approval:	**05/15**
Board of Directors Approval:	**02/12**

A. **PURPOSE**:
1. To address the process for addition, removal, and restriction of pharmaceutical agents at Tri City Medical Center (TCMC).
2. The formulary system is operated under the auspices of the Pharmacy and Therapeutics (P&T) Committee to promote rational, cost-effective use of medications at Tri-City Medical Center.

B. **DEFINITIONS**:
1. Formulary System: An ongoing process **through which a healthcare** ~~whereby an~~ organization~~s~~ **establishes policies regarding the use of medications, therapies, and drug-related devices and identifies those that are most medically appropriate and cost-effective to best serve the health interests of a given patient population.** ~~pharmacy and medical staff, working though the P&T Committee, evaluate and select from among the medication products available those considered most useful in patient care. These products then are routinely available for use within the organization.~~
2. Formulary: ~~A continually revised compilation of drug products, important ancillary information regarding their use, and relevant organizational policies and procedures.~~**a continually updated list of medications and related information, representing the clinical judgment of physicians, pharmacists, and other experts in the diagnosis, prophylaxis, or treatment of disease and promotion of health. A formulary includes, but is not limited to, a list of medications and medication-associated products or devices, medication-use policies, important ancillary drug information, decision-support tools, and organizational guidelines.**

C. **ROLE OF THE PHARMACY AND THERAPEUTICS COMMITTEE:**
1. The P&T Committee is responsible for overseeing the effective and efficient operation of the formulary system. The Committee is responsible to the Medical Staff as a whole, and its policy recommendations are subject to approval by the Executive Committee as well as to the normal administrative approval process. The Committee assists in the formulation of broad professional policies relating to medications in the hospital, including their evaluation, selection, procurement, storage, distribution, administration, and use.
2. It is the responsibility of the P&T Committee to provide integrity to the formulary system by assuring **current, consistent prescribing practices of**~~that~~ medications designated as "formulary" medications **and** ~~listed in the formulary are~~ **such medications are routinely** stocked in the pharmacy, **unless mechanisms for more rapid resupply or transfer is in place.** ~~and current prescribing practices are consistent.~~

D. **FORMULARY DESIGNATION:**

1. Only those considered to be most **cost-effective** ~~advantageous~~ in patient care shall be designated as formulary medications.
2. **T**he P&T Committee shall at minimum evaluate the following before designating a medication as formulary:
   a. Indications for use
   b. Effectiveness
   c. Drug interactions
   d. Potential for errors and abuse
   e. Adverse drug events
   f. Sentinel event advisories
   g. Population(s) served (e.g., pediatrics, geriatrics)
   h. **Contraindications and Precautions**~~Other risks~~
   i. Costs **compared to formulary alternatives**
3. The organization shall have the appropriate capability to monitor patients' response to medications before the product will be added to the formulary, dispensed, or administered.
4. These medications are listed in the formulary; only formulary medications are routinely stocked and available from the pharmacy.
5. Only those medications that have been approved by the Food and Drug Administration (FDA) shall be considered for formulary addition. Therefore, investigational medications do not meet criteria for formulary addition.
6. The Department of Pharmacy is responsible for selecting, from available generic equivalents, those medications to be dispensed pursuant to a physicians order for a particular drug product. Generally, this choice is consistent with competitive bids awarded TCMC by group purchasing organizations.
7. Medications designated **on the formulary** ~~as available (formulary) for dispensing or administration are~~ **shall be** reviewed at least annually based on emerging safety and efficacy information**, cost-effectiveness data, and inventory control standards**.
   a. Pharmacy shall report the result of the annual review of the formulary to the P&T Committee
8. ~~The Department of Pharmacy shall maintain an approved formulary list on the intranet which shall include the medication name and strength.~~
9. **~~9.~~8. The Department of Pharmacy shall maintain an approved formulary list in Cerner**

E. **ADDITION OF PHARMACEUTICAL AGENTS TO FORMULARY:**

1. It shall be the responsibility of the requesting practitioner (MD, DO, PharmD) to complete all paperwork necessary for addition of pharmaceutical agents to the **T**CMC formulary.
2. Pharmacy shall be responsible for determining acquisition costs, costs of therapy, and cost comparisons for therapeutically equivalent agents.
3. Pharmacy shall arrange for the requested pharmaceutical agent to be presented at the Pharmacy and Therapeutics committee in a timely fashion for review and approval to the formulary.
4. The requesting practitioner may provide written recommendations to the P&T committee or be present at the P&**T** committee when the pharmaceutical agent is being presented for review.
5. Requesting practitioners must disclose any and all "conflicts of interest" related to the pharmaceutical agent being requested to the Pharmacy and **T**herapeutics Committee.
6. Pharmacy shall notify **all affected prescribers and/or departments**~~practitioners~~ **once a medication** ~~if drug~~ is approved through **P&T**~~the pharmacy and therapeutics newsletter~~.

F. **REMOVAL OF AGENTS FROM THE FORMULARY:**

1. Pharmacy shall consult with all necessary practitioners with an expertise related to the pharmaceutical agent before requesting removal at the Pharmacy and **T**herapeutics Committee.
   a. Pharmacy shall document all communications with practitioners in this matter
2. Pharmacy shall notify all appropriate TCMC committees**/departments** of the proposal for removal of a **medication** ~~n agent one month before~~**prior to** presentation at the Pharmacy and Therapeutics Committee.

3. Agents proposed by the Department of Pharmacy for removal from the formulary shall be presented at the Pharmacy and Therapeutics Committee.
4. The Department of Pharmacy shall present to the Pharmacy and Therapeutics committee evidenced based reasons for removal of agents from the formulary that include cost savings **and**~~,~~ pharmaceutical and therapeutically equivalent alternatives already on TCMC formulary.
5. Pharmacy shall notify **all affected prescribers and/or departments**~~practitioners~~ **once a medication** ~~if drug~~ is removed **from the formulary** ~~through the pharmacy and therapeutics newsletter~~.

G. **RESTRICTION OF FORMULARY AGENTS:**

1. The department of pharmacy will work with TCMC physicians to create criteria for use for pharmaceutical agents both formulary and non-formulary.
2. Formulary medications may be considered for restriction by the Pharmacy and Therapeutics Committee when they meet one or more of the following criteria:
   a. The drug has limited therapeutic use that requires expertise in that area
   b. Inappropriate use might result in excessive or unnecessary expenditures
   c. The medication is a high risk agent with potential problems due to adverse effects or toxicity
   d. Other reasons as deemed appropriate by the Pharmacy and Therapeutics Committee
3. Formulary medications may be restricted to use, either by a medical service (e.g., oncology), prescribing criteria (e.g., specific indications), or patient care area (e.g., Intensive Care Unit).
4. A current list of restricted medications will be maintained on the Department of Pharmacy website.
5. Physician requesting the use of a medication outside its established restriction shall fill out the Pharmacotherapy Utilization form (See Appendix 1).
6. Pharmacy service shall create a method to administer restricted agents outside their restriction when necessary. This may involve one or more of the following:
   a. Case by case review of each request within the pharmacy, and if necessary input a Pharmacy and Therapeutics Committee chairperson.
   b. Obtaining a consult from an authorized prescriber.
   c. Moving a patient to the needed area for proper treatment.
7. Pharmacy shall notify all **affected prescribers,** ~~appropriate~~ TCMC ~~committees~~ **departments and/or committees** of the proposal to restrict a pharmaceutical agent ~~one month before~~**prior to** presentation at the Pharmacy and Therapeutics committee.

H. **FORMULARY STATUS OF NEW MEDICATIONS:**

1. New medications approved by the FDA, but not yet considered for formulary addition by the Pharmacy and Therapeutics Committee shall be considered non-formulary until the P+T Committee has reviewed these medications. Prior to the P+T Committee deliberation, use of the medications shall conform to the non-formulary medication use process.

I. **OBTAINING NON-FORMULARY MEDICATIONS:**

1. When a non-formulary medication is prescribed, a pharmacist shall contact and inform the prescribing physician that the medication is non-formulary and not stocked in the pharmacy. **T**he pharmacist shall inform the physician of other formulary alternatives available.
2. If the physician determines that the non-formulary medication is needed~~,~~**, approval must be obtained from the Clinical Pharmacy Manager. For tracking purposes,** the physician **or pharmacist** must fill out the Pharmacotherapy Utilization form documenting why the medication is needed (See Appendix1). The medication will then be obtained by pharmacy for a specific patient.
3. Non-formulary medications are normally obtained within 24 hours, but may take longer depending on when the order is received and product availability. The P&T Committee may deem some products not to be ordered, dispensed, or stocked, even on a non-formulary request basis.

J. **MONITORING OF NON-FORMULARY MEDICATION PRESCRIBING:**

1. The Clinical Pharmacy Manager shall compile and analyze data regarding non-formulary medication use **as appropriate**~~on an annual basis~~ and report findings to the P&T Committee.
2. The Committee shall determine appropriate action necessary to maintain the integrity of the formulary system. This may include:
   a. Reconsidering a medication formulary addition
   b. Undertaking educational efforts to reduce inappropriate prescribing
   c. Imposing prescribing restriction

K. **FORMS/RELATED DOCUMENTS:**

1. **Pharmacotherapy Utilization Form**

:

~~**Appendix 1**~~

Tri City Medical Center Department of Pharmacy Services
Pharmacotherapy Utilization Form

☐ Non-formulary use

☐ Use outside of restriction

Condition being treated: _____

Drug Requested and dosage form: _____

Dosage: _____

Rationale for use (indicated why current TCMC formulary agents are inappropriate): _____

_____

Estimated duration of therapy: _____

Physician signature: _____ Print Name:_____

Service:_____ Pager Number: _____

Pharmacy Use Only

Pharmacist Comments (with justification):_____

_____

☐ Approved ☐ Not Approved

☐ No need to order drug ☐ Please order drug supply

Action taken if not approved:_____

Pharmacist Signature: _____ Print Name: _____

ISSUE DATE:	**01/72**	**SUBJECT:**	**Hours of Operation and Authorized Access to the Pharmacy**
REVISION DATE:	**01/75, 01/80, 01/90, 01/00, 07/06, 03/15**	**~~POLICY NUMBER: 8390-4402~~**	
Department Approval Date(s):		**03/15**	
Medical Staff Department/Division Approval Date(s):		**n/a**	
Pharmacy & Therapeutics Committee Approval:		**06/05, 07/06, 07/09, 1/12, 03/15**	
Medical Executive Committee Approval:		**06/05, 07/06, 07/09, 1/12, 04/15**	
Professional Affairs Committee Approval Date(s):		**05/15**	
Board of Directors Approval:		**06/05, 07/06, 07/09, 1/12**	

A. **POLICY**:

1. As approved by the medical staff committees and Tri-City Medical Center administration, the Pharmacy hours of operation will be seven (7) days per week, 24 hours per day.
2. **Access to the Pharmacy is limited to the Pharmacy staff.**
   a. **Medical staff, nursing staff, administrative, environmental services and other personnel are authorized admission only in conjunction with their duties and under supervision of Pharmacy staff.**

Tri-City Medical Center
Oceanside, California

PHARMACY~~POLICY~~ MANUAL

ISSUE DATE: 01/75	**SUBJECT:** ~~Delivery of~~ Medications Ordered STAT and at Specified Time Intervals
REVISION DATE: 03/06, 04/08, 3/15	**POLICY NUMBER:** 8390-3107
Department Approval Date(s):	03/15
Medical Staff Department/Division Approval Date(s):	n/a
Pharmacy & Therapeutics Committee Approval:	06/05. 03/06, 03/08, 07/09, 1/12, 03/15
Medical Executive Committee Approval:	06/05. 03/06, 03/08, 07/09, 1/12, 4/15
Professional Affairs Committee Approval Date(s):	05/15
Board of Directors Approval:	06/05. 03/06, 03/08, 07/09, 1/12

A. **POLICY**:

1. STAT medications from the Pharmacy will be delivered to the requesting area within 30 minutes or less from time of receipt of STAT order in the Pharmacy Department.

B. **PROCEDURE:**

1. The Pharmacy Department will be notified of STAT medications via **a CPOE order entered as STAT by the ordering prescriber or via** telephone**/verbal communication** immediately followed by a scanned **telephone/verbal or electronic** medication order.
2. ~~The pharmacist will input the order; either prepares the medication or delegate preparations of the medication and the courier or technician will immediately deliver to the floor.~~
3. ~~2.~~ **If the medication is not available via Pyxis Medstation, the medication will be delivered to the appropriate patient care area, directly to the primary nurse.**
4. ~~The courier or technician delivering the medication will contact the nurse or caregiver taking care of the patient and give the medication to the caregiver.~~
5. ~~3.~~ Medications ordered at specified time intervals shall be adjusted to standard hours as per "Medication Administration Times" policy as soon as possible, unless attending physician specified otherwise.
6. ~~4.~~ For non-formulary orders, back ordered medication and/or out of stock STAT medication orders, the pharmacist will contact the **primary** RN and the prescriber to explain the delay and offer potential alternatives.

Tri-City Medical Center
Oceanside, California

PHARMACY~~POLICY~~ MANUAL

ISSUE DATE: 02/03

SUBJECT: Patients' Use of Herbals and Natural Remedies

REVISION DATE: 06/05, 03/06, 3/15

~~**POLICY NUMBER: 8390-3117**~~

Department Approval Date(s):	**03/15**
Medical Staff Department/Division Approval Date(s):	**n/a**
Pharmacy & Therapeutics Committee Approval Date(s):	**02/03, 06/05, 03/06, 07/09, 1/12, 03/15**
Medical Executive Committee Approval:	**02/03, 06/05, 03/06, 07/09, 1/12, 04/15**
Professional Affairs Committee Approval:	**05/15**
Board of Directors Approval:	**02/03, 06/05, 03/06, 07/09, 1/12**

A. **POLICY**:

1. Due to **clinically significant drug-drug interactions and unproven efficacy, continuation of herbals and natural remedies are not recommended during hospital admission**~~It is the policy of this hospital to control all medications brought into the hospital by patients. For the safety of the patient, herbals and "natural" remedies will be considered medications and will require the same procedures as prescribed medications~~.
2. ~~During the admitting process, the patient will be asked if any medications are taken routinely. This will include herbals and other "natural" or homeopathic substances.~~
3. ~~3.~~**2. The admitting nurse shall encourage the patient to send a**~~A~~ll medications ~~will be sent~~ home **with a responsible family member or patient representative.** ~~as soon as possible with a family member~~.
4. ~~4.~~**3.** If **the medication(s) cannot be sent home, they shall be** ~~this is not possible, they are~~ stored in the Pharmacy Department until discharge.
4. If the "natural" remedy is prescribed by the physician and the patient wishes to continue taking the substance while in the hospital, **the medication shall be ordered via CPOE as a "Patient Own Med."**
5. **The medication shall be identified, labeled, and dispensed in accordance to California State Law and Patient Care Services Policy Medications Brought in by the Patient.**
   a. ~~The physician must order its use, specifying the name, strength and directions for administration.~~
   b. ~~The herbal must be properly labeled based on California regulations.~~
   c. ~~The medication must be identified by a pharmacist or physician.~~
   d. ~~Administration of the substance is documented on the medication record.~~
6. As with other medications brought from home, herbals are returned to the patient upon discharge.

B. **RELATED DOCUMENT(S):**

~~6.~~**1. Patient Care Services Policy Medications Brought in by the Patient**

Tri-City Medical Center
Oceanside, California

DELETE – duplication, see PCS Use of Unapproved Abbrevations

PHARMACY~~POLICY~~ MANUAL

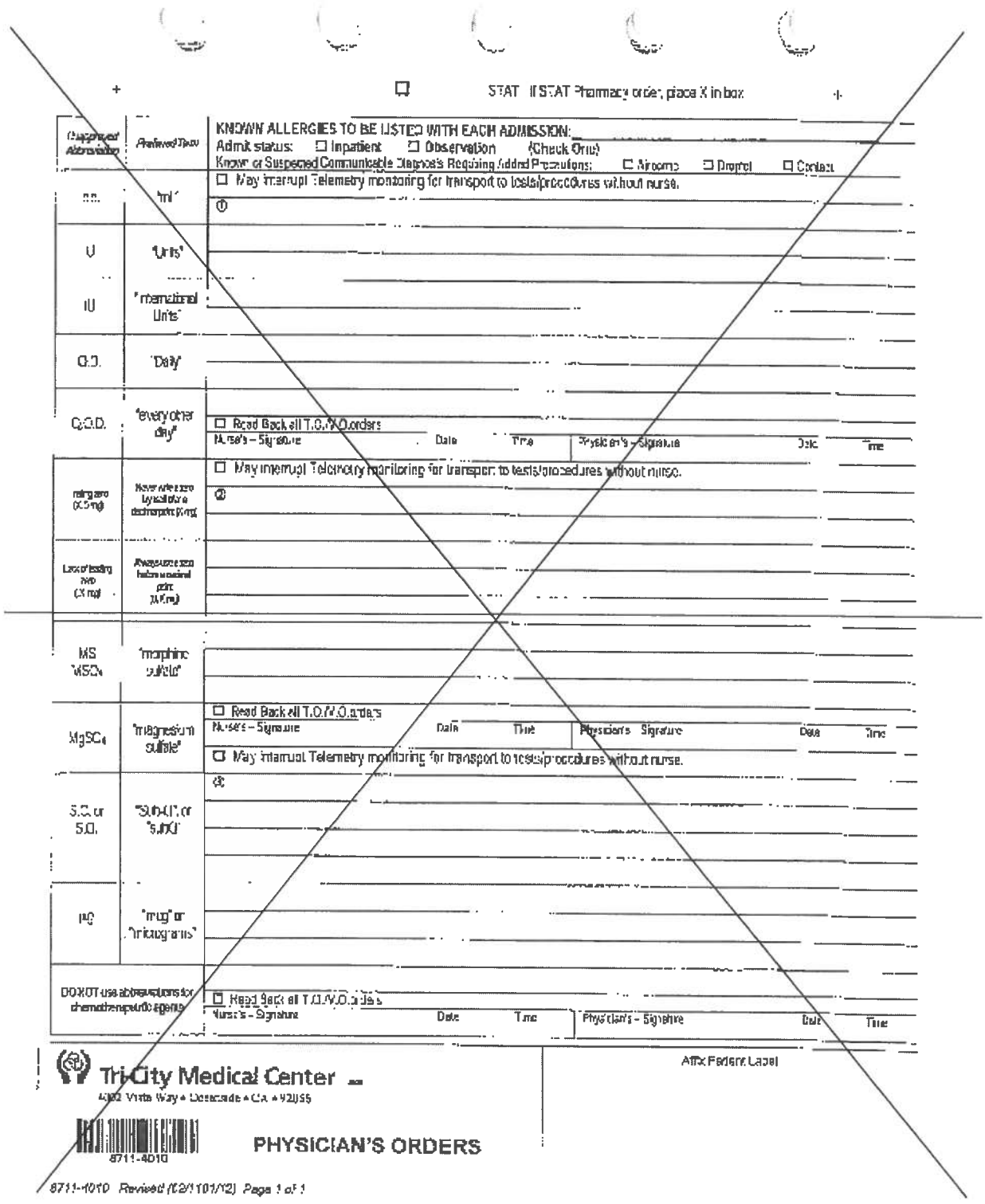
~~ISSUE DATE: 06/05~~ ~~SUBJECT: Pharmacological Abbreviations - Unapproved~~

~~REVISION DATE: 07/06~~ ~~POLICY NUMBER: 8390-3103~~

Department Approval Date(s):	03/15
Medical Staff Department/Division Approval Date(s):	n/a
~~Pharmacy & Therapeutics Committee Approval:~~	~~07/06, 07/09, 1/12~~
~~Medical Executive Committee Approval:~~	~~07/06, 07/09, 1/12~~,
Professional Affairs Committee Approval:	05/15
~~Board of Directors Approval:~~	~~07/06, 07/09, 1/12~~

~~A. **POLICY**:~~
~~An unacceptable abbreviation list has been developed and approved by the P&T Committee (list attached).~~

~~B. **PROCEDURE**:~~
~~1. A list of unacceptable abbreviations is readily available to all staff members who are authorized to make entries into the medical record and to all those who have to interpret those entries.~~
~~2. A list of unacceptable abbreviations are located on each physician order form.~~
~~a. See attachment:~~



STAT If STAT Pharmacy order, place X in box

Suggested Abbreviation	Preferred Term
c.c.	"ml"
U	"Units"
IU	"International Units"
Q.D.	"Daily"
Q.O.D.	"every other day"
mg zero (X.5 mg)	"Never write zero by itself for a dose in mg"
Lead (trailing zero) (X mg)	"Always use a zero before a decimal point (X.mg)"
MS MSO_4	"morphine sulfate"
$MgSO_4$	"magnesium sulfate"
S.C. or S.D.	"SQ/Q.D. or "sub/Q"
µg	"mcg" or "micrograms"
DO NOT use abbreviations for chemotherapeutic agents	

KNOWN ALLERGIES TO BE LISTED WITH EACH ADMISSION:

Admit status: ☐ Inpatient ☐ Observation (Check One)

Known or Suspected Communicable Diagnosis Requiring Added Precautions: ☐ Airborne ☐ Droplet ☐ Contact

☐ May interrupt Telemetry monitoring for transport to tests/procedures without nurse.

①

☐ Read Back all T.O./V.O. orders

Nurse's - Signature | Date | Time | Physician's - Signature | Date | Time

☐ May interrupt Telemetry monitoring for transport to tests/procedures without nurse.

②

☐ Read Back all T.O./V.O. orders

Nurse's - Signature | Date | Time | Physician's - Signature | Date | Time

☐ May interrupt Telemetry monitoring for transport to tests/procedures without nurse.

③

☐ Read Back all T.O./V.O. orders

Nurse's - Signature | Date | Time | Physician's - Signature | Date | Time

Affix Patient Label

Tri-City Medical Center

4002 Vista Way • Oceanside • CA • 92056

8711-4010

PHYSICIAN'S ORDERS

8711-4010 Revised (02/11/01/12) Page 1 of 1

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

SUBJECT: Physical Therapy Assistant Supervision **POLICY NUMBER: 613**

ISSUE DATE: 2/97
REVISION DATE(S): 1/06, 1/09, 4/12
REVIEW DATE: 3/00, 1/03

Department Approval Date(s):	
Department Approval Date(s):	**05/14**
Department of Medicine Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	

~~**ISSUE DATE: 2/97**~~	~~**SUBJECT: PHYSICAL THERAPY ASSISTANT SUPERVISION**~~
~~**REVISION DATE: 1/06, 1/09, 4/12**~~	~~**STANDARD NUMBER: 613**~~
~~**REVIEW DATE: 3/00, 1/03**~~	~~**CROSS REFERENCE:**~~
	~~**APPROVAL:**~~

This Policy / Procedure applies to the following Rehabilitation Services' locations:

- ☑ 4002 Vista Way, Oceanside, CA
- ☑ 2124 El Camino Real, Suite 100, Oceanside, CA
- ☑ 6250 El Camino Real, Carlsbad CA
- ☑ **510 Hacienda Drive 108A, Vista, CA**
- ☑ **3861 Mission Avenue B25, Oceanside, CA**

A. **PURPOSE**

1. To comply with **the Physical Therapy Regulations California Code of Regulations Title 16 Division 13.2 Article 4 Section 1398.44** ~~Section 1398.44 of Medical Board Laws and Regulations~~ for adequate supervision of Physical Therapy Assistants.

B. **POLICY**

1. The Physical Therapy Staff will be responsible to follow the progress of each patient, provide direct care to the patient, and to assure that the physical therapy assistant does not function autonomously.

C. **PROCEDURE**

1. Adequate supervision shall include all of the following:
   a. The supervising physical therapist shall be readily available in person or by telecommunication to the physical therapy assistant at all times while the physical therapy assistant is treating patients. The supervising physical therapist shall provide supervision of the assigned patient care rendered by the physical therapy assistant.
   b. The supervising physical therapist shall initially evaluate each patient and document in the patient's record, along with his or her signature, the evaluation and the plan of care.

c. The supervising physical therapist shall formulate and document in each patient's record, along with his or her signature, the treatment program goals and plan based upon the evaluation and any other information available ~~and any other information available to the supervising physical therapist~~. This information shall be communicated verbally or in writing by the supervising physical therapist to the physical therapy assistant prior to initiation of treatment by the physical therapy assistant. The supervising physical therapist shall determine which elements of the treatment plan may be assigned to the physical therapy assistant. Assignment of these responsibilities must be commensurate with the qualifications, including experience, education, and training of the physical therapy assistant.

d. The supervising physical therapist shall re-evaluate the patient if necessary, and modify the treatment goals and plan as needed. The re-evaluation shall include treatment to the patient by the supervising physical therapist. The re-evaluation shall be documented and signed by the supervising physical therapist in the patient's record and shall reflect the patient's progress toward the treatment goals and when the next re-evaluation shall be performed.

e. The physical therapy assistant shall document each treatment in the patient's record, along with his or her signature. The physical therapy assistant shall document in the patient's record and notify the supervising physical therapist of any change in the patient's condition not consistent with planned progress or treatment goals. The change in condition necessitates a re-evaluation by a supervising physical therapist before further treatment by the physical therapy assistant.

~~a. With 7 days of the care being provided by the physical therapy assistant, the supervising physical therapist shall review, co-sign and date all documentation by the physical therapy assistant or conduct a weekly case conference and document it in the patient's record. Co-signing by the supervising physical therapist indicates that the supervising physical therapist has read the documentation and, unless the supervising physical therapist indicates otherwise, he or she is in agreement with the contents of the documentation.~~

~~b. There shall be a regularly scheduled and documented case conference between the supervising physical therapist and the physical therapy assistant regarding the patient. The frequency of the conferences is to be determined by the supervising physical therapist based on the needs of the patient, the supervisory need of the physical therapy assistant, and shall be at least every 30 calendar days.~~

~~c.~~D. REFERENCES

1. **Physical Therapy Regulations California Code of Regulations Title 16 Division 13.2 Article 4 Section 1398.44**~~Verbatim from CA PT **Regulations** practice act Article **Section** 4 1398.44~~

Tri-City Medical Center	Distribution: WOMEN AND NEWBORN SERVICES
PROCEDURE:	**FORMULA ~~BOTTLE~~ FEEDING PROCEDURE**
Purpose:	To outline an alternative method of meeting an infant's nutritional needs.
Supportive Data:	Use of commercially prepared, iron-fortified formula is an alternative method of providing neonatal nutrition. Use of formula is indicated for newborns when the mother is choosing not to breastfeed, or when the mother or the infant's medical or social condition warrants bottle-feeding with formula or pumped breast milk.
Equipment:	1. Appropriate commercially prepared formula. 2. Appropriate type of sterile nipple.

A. **PROCEDURE:**

1. Perform hand hygiene
2. Verify type of formula to feed newborn. Formula may be given at room temperature.
3. Assess newborn's physiologic readiness (behavioral cues) for initiation of feedings by assessing:
   a. Vital signs
   b. Activity – exhibiting rooting, sucking, or crying behaviors
   c. Muscle tone
4. Change diaper if necessary and wrap infant in blankets – perform hand hygiene after diapering and prior to feeding.
5. Newborn should be held during feedings in a semi-upright position (45 degree angle) with close physical contact and contingent responsiveness (nurturance). Do not prop bottles or use products that hold a bottle in a newborn's mouth.
   a. Propping the bottle for feeding has been associated with reflux of milk into the Eustachian tubes
6. Insert nipple into newborn's mouth, keeping the nipple full of formula in order to decrease swallowing of air.
   a. Assess if infant initiates and sustains suck and swallow coordination
   b. Assess if color and respiratory effort remain stable throughout feeding
7. Burp newborn after every half ounce (15 mL) or halfway through the feeding.
8. Allow 20 minutes for a feeding and feed on demand, or at least every four hours, or as ordered by physician.
   a. Normal infant feeding is:~~ 15-30 ml~~
      i. 1st 24 hours: 2-10 ml/feed
      ii. 24-48 hours 5-15 ml/feed
      iii. 48-72 hours 15-30 ml/feed
      ~~a.~~iv. 72-96 hours 30-60 ml/feed
9. **Discard** ~~A~~any formula remaining in the feeding bottle~~ should be discarded~~.
10. ~~Keep newborn upright after feeding for a minimum of 15 minutes before placing infant in supine position to sleep.~~
11. **~~11.~~10.** Assess for signs of formula intolerance:
    a. Encourage parents to be alert for signs/symptoms prior to and after discharge, signs include:
       i. Constipation
       ii. Fussiness
       iii. Abdominal cramps
       iv. Excessive spit-up or vomiting
       v. Notify pediatrician for signs of intolerance (formula type or brand alternative)

Review/Revision Date	~~Clinical Policies & Procedures~~ Department of OB/GYN	~~Nurse Executive Committee~~	Department of Pediatrics~~Medical Department Review~~	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
7/03, 7/09	~~02/13~~n/a	~~02/13~~	8/09, 3/15	n/a	05/13, 4/15	06/13, 05/15	06/13

B. **DOCUMENTION:**

1. Document type and amount of formula for each feeding on newborn patient care record.
2. Document any abnormal events associated with this procedure in nurse's notes.

C. **REFERENCES:**

~~1. American Academy of Pediatrics AAP/ACOG. (2007). Guidelines for Perinatal Care, 6th Edition~~
~~2. Dixon & Stein. (2005). "Dancing Together", Encounters with Children: Pediatric Behavior and Development, 4th Ed: Mosby, Elsevier. Retrieved 7/6/09 from www.mdconsult.com .~~
~~3.~~**1.** The Academy of Breastfeeding Medicine Protocol Committee. Clinical Protocol #3: Hospital Guidelines for the Use of Supplementary Feedings in the Healthy Term Breastfed Neonate, Revised 2009.
~~4.~~**2.** ~~3.~~ Mattson, S., & Smith, J.E. (Eds.) (20**11**~~04~~) Core Curriculum for Maternal-Newborn Nursing (4th Ed.) Philadelphia: Saunders.
~~5.~~**3.** Simpson, K., & Creehan, P. (20**14**~~08~~). Perinatal Nursing (~~3rd~~**4th**Ed). Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Lippincott Williams and Wilkins, PA

Tri-City Medical Center	Distribution: Women & Newborn Services
PROCEDURE:	**CIRCUMCISION**
Purpose:	To outline the nursing responsibilities in assisting the physician with circumcision of male infants.
Supportive Data:	Assisting physicians performing circumcision ensures infant safety by maintaining the sterile field and the patency of the infant's airway. There is considerable evidence that newborns who are circumcised without analgesia experience pain and physiologic stress. Neonatal physiologic responses to pain include changes in heart rate, blood pressure, oxygen saturation, and cortisol levels (AAP Policy statement, 1999). Swaddling, sucrose by mouth, and acetaminophen administration may reduce the stress level but is not sufficient for operative pain and cannot be recommended as a sole method of analgesia. Ring blocks and dorsal penile blocks have proved to be more effective as analgesia methods vs. local anesthesia and combination preparations of Lidocaine and prilocaine that provide some anesthesia benefit (AAP/ACOG, 2007; NANN, 2006).
Equipment:	1. Circumcision board with leg and arm restraints 2. Circumcision pack 3. Povidone-iodine solution4. Have available: a. Tuberculin syringe b. 1% Lidocaine without epinephrine and/or preservatives c. Surgicele or Vaseline gauze d. Polysporin ointment 5. Gomco: Sizes 1.1, 1.3, and 1.45 6. Plastibell: Sizes 1.1, 1.2, 1.3, 1.4, and 1.5 7. 2x2 gauze 8. Oral Sucrose (24%) 9. Pacifier

A. **POLICY**:

1. Criteria for Circumcision:
   a. Stable transition to extrauterine environment exhibited.
   ~~b. NICU:~~
      ~~i. In the NICU an order must be written by the neonatologist for the infant to be circumcised.~~
      ~~ii. The infant should weigh a minimum of 1600 grams.~~
      ~~iii. The infant should demonstrate cardiovascular stability.~~
      ~~iv. The infant should demonstrate respiratory stability.~~
2. Pre-procedural feedings for the infant will be at the discretion of the attending physician.
3. **Circumcisions are performed in areas away from visitors.**
4. **Parent's presence during the procedure is at the physician's discretion.**
~~3.~~**5. Oxygen and suction equipment should be readily available.**

B. **PROCEDURE:**

1. Verify physician order.
2. Confirm presence of informed consent and properly completed TCMC "Operative or other Procedures" consent form.
3. Pre-procedure assessment:
   a. Before circumcision, an RN should complete and initial assessment and history. It is important to document the following:
      i. Absence of obvious congenital or other related anomaly of the genitourinary tract.
      ii. Signs or symptoms of infection.

Review/Revision Date	Department of OB/GYN	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
10/06, 05/08, 2/10	8/07, 2/10	03/15	3/15	8/07, 4/15	9/07, 05/15	9/07, 4/10

iii. Respiratory distress.
iv. Hypothermia.

b. The physician performing the circumcision should notify the nursery of the pending circumcision prior to the procedure to facilitate analgesic administration.

4. The RN shall:

a. Obtain a circumcision set.

b. Protectively contain the infant on the circumcision board.

~~b.~~ **c. Prep the infant to the physician's preference and assist with the procedure as needed.**

~~4.~~**5.** Analgesic Administration:

a. Verify order and dosage for analgesic ~~(liquid oral acetaminophen)~~.

b. Administer oral analgesia if ordered, prior to procedure **and consider onset of action**.

~~i. Onset of action of acetaminophen is 20 minutes.~~

c. Sucrose on a pacifier may be administered as a comfort measure.

~~5. Preparation:~~

~~a. Circumcisions are performed in areas away from visitors.~~

~~b. Parent's presence during the procedure is at the physician's discretion.~~

~~c. Oxygen and suction equipment should be readily available.~~

6. Process:

a. The RN shall:

i. Identify the patient using two patient identifiers.

ii. Implement Universal protocol:

1) Call a "time out "to verify:
2) Name of infant/mother, date and time of birth.
3) Name of physician performing the procedure.
4) Type of procedure (e.g. Gomco, Mogen, Plastibell).
5) Planned analgesia.
   a) Dorsal Penile Nerve Block
   b) Other **(ie: liquid oral acetaminophen)**
6) Comfort measures
   a) Sucrose on a pacifier
   b) Physiologic positioning on a padded environment
   c) **Analgesia** ~~Acetaminophen~~ given preoperatively **if ordered**

iii. Document "time out" was performed in the infant's medical record
1) Refer to TCMC PCS Procedure: "UNIVERSAL PROTOCOL"

~~7. Procedure: The RN shall:~~

~~a. Obtain a circumcision set.~~

~~b. Protectively contain the infant on the circumcision board.~~

~~c. Prep the infant to the physician's preference and assist with the procedure as needed.~~

~~8.~~**7.** Post-procedure:

a. Use Surgicele postoperatively for excessive bleeding per physician order.

b. Notify physician if bleeding persists or Surgicele must be reapplied.

c. Complete the charge-billing sheet for the procedure.

~~d. Enter the procedure in the circumcision log.~~

~~9.~~**8.** The physician performing the procedure is responsible for the procedure and should be notified of any problems that arise following the procedure.

~~10.~~**9.** The infant may be discharged home 2 hours after the circumcision or as ordered by physician.

C. **DOCUMENTATION:**

1. Documentation should include the following:

a. Date and time of the procedure.

~~a.~~**b. Preprocedure Checklist**

~~b.~~**c.** Name of the physician performing the procedure.

~~c.~~**d.** Type of procedure (i.e., Gomco, Mogen, or Plastibell, including size).

~~d.~~**e.** Anesthesia or pain medication given.
~~e.~~**f.** Infant tolerance of the procedure to included pain scores (NPASS), 15 min and 30 min after the procedure.
~~f.~~**g.** Site assessment, including any bleeding, 15 min and 30 min after the procedure
~~g.~~**h.** Infant's first void after the procedure.
i. If infant is discharge without voiding, instruct parents to notify physician if infant unable to void within 12 hours or as instructed by physician.

D. **POST- CIRCUMCISION CARE:**

1. Explain circumcision care to the parents or guardian and record ~~on the discharge teaching record~~ **in the electronic medical record (EMR)**.
2. The infant's caregiver should apply Polysporin/Petroleum ointment to the penis with each diaper change for the first 3 days following the procedure.
3. Soap should be avoided for the first three days.

E. **REFERENCES:**

1. AAP & ACOG, (**2012**~~2007~~) Guidelines for Perinatal Care, **7**~~6~~th Edition. Washington, DC.
2. Association of Women's Health, Obstetric and Neonatal Nursing (2006) Improving Neonatal Skin Care. (2nd edition) Washington, D.C.
3. Altimer, L. (2006) NANN Guidelines. Neonatal Nursing Policies, Procedures, Competencies, and Clinical Pathways. *Circumcision*. Glenview, IL
4. Besuner, P. (2007). AWHONN Templates for Protocols and Procedures for Maternity Services, 2nd Edition. Association of Women's Health, Obstetric and Neonatal Nurses: *Circumcision*. Washington, D.C.
5. Kraft, N. (2003) A pictorial and video guide to circumcision without pain. *Advances in Neonatal Care, 3(2), 50-64.*
6. Hockenberry, M.J., & Wilson, D. (2006). *Wong's Nursing Care of Infants and Children*. (8th Ed.) St. Louis: Mosby.
7 Merenstein G. & Gardner, S. (2006). Handbook of Neonatal Intensive Care, 6th Ed. Mosby, pp. 209-210.
8. Mosbys Online – OB: "Circumcision: Assisting"; "Circumcision: Post Procedure Care" (2009)

ISSUE DATE: 9/04

SUBJECT: Trial of Labor after Cesarean (TOLAC), Vaginal Birth after Cesarean (VBAC)

REVISION DATE: 11/05; 4/09, 10/13

~~**Clinical Policies & Procedures Committee Approval:**~~	
~~**Patient Care Quality Committee Approval:**~~	
Medical Department Approval:	~~01/14~~5/09, 04/15
Medical Executive Committee Approval:	04/15
Professional Affairs Committee Approval:	05/15
Board of Directors Approval:	5/09

A. **PURPOSE:**

1. To define parameters for trial of labor after cesarean, vaginal birth after cesarean, to include physician availability.
2. To identify the criteria for trial of labor after cesarean/vaginal birth after cesarean.
3. To identify contraindications to trial of labor after cesarean/vaginal birth after cesarean.
4. To identify physician and nursing responsibilities when caring for patients attempting trial of labor after cesarean/vaginal birth after cesarean.

B. **DEFINITIONS:**

1. Cesarean delivery:
   a. Delivery of a fetus through an abdominal incision.
2. Trial of labor after cesarean (TOLAC):
   a. Labor during a pregnancy after a previous cesarean delivery with the goal of having a vaginal birth.
3. Vaginal birth after cesarean (VBAC):
   a. Successful vaginal delivery after a previous cesarean section.
4. Immediately available per A**merican** C**o**ngress **of** O**bstetrics and** G**ynecology (ACOG) d**~~D~~efinition:
   a. Physician **should be** immediately available throughout active labor **to provide emergency care and an** ~~capable of~~monitoring labor and performing an emergency Cesarean Section **if needed**~~. Physician should remain in-house to manage the VBAC~~.
   b. Anesthesiologist **in house.**~~immediately available~~.
   c. Adequate support staff to ~~immediately~~ perform an emergency Cesarean Section **is immediately available**.
5. ~~Immediately A~~**a**vailable back-up support:
   ~~a.~~ It is the responsibility of the attending physician to ensure that arrangements have been made with another obstetrician for back-up coverage**.** ~~in-house or in the office within walking distance from the hospital.~~
   ~~b.~~**a. The usual o**~~O~~n-call anesthesia is available **within 30 minutes or next available** ~~in-house,~~ as back-up support in the event that the attending OB anesthesiologist is occupied with **a** ~~another~~ patient procedure **and another case arises**.

C. **CRITERIA FOR TOLAC/VBAC:** ~~**TRIAL OF LABOR AFTER CESAREAN/VAGINAL BIRTH AFTER CESAREAN:**~~

1. One prior low transverse cesarean section OR two prior low transverse cesarean sections with a previous vaginal birth
2. Vertex presentation of fetus

3. Less than 42 week's gestation
4. Clinically adequate pelvis
5. No history of:
   a. Prior disruption of uterine wall – ie, surgeries, acreta and its variants.
   b. Uterine scar dehiscence.
   c. Uterine rupture.
6. Onset of spontaneous labor.
7. **If** ~~Elective~~ induction of labor **is initiated for a** ~~in~~ VBAC/TOLAC - **a favorable cervix and/or mechanical cervical softening techniques shall be considered.** ~~on a case-by-case for a live birth, based on:~~
   ~~a. Cervical exam, favorable cervix with a preferred Bishop score of ≥ 5 or more.~~
      ~~i. Low-dose oxytocin per WCS Procedure "Oxytocin Administration for Induction/Augmentation of labor".~~
   ~~b. Amniotomy, followed by oxytocin.~~
      ~~i. Low-dose oxytocin per WCS Procedure "Oxytocin Administration for Induction/Augmentation of labor".~~
   ~~c. Mechanical cervical softening, using transcervical Foley catheter, followed by oxytocin.~~
8. Uses of prostaglandins, Cervidil (PGE2) or Misoprostil (PGE1) for cervical ripening or induction of labor are ~~prohibited.~~**contraindicated.**
9. Exception: use of PGE_1 and/or PGE_2 prostaglandins, Misoprostol, Cervidil may be used on patients with fetal demise, and a prior single transverse lower segment cesarean delivery. Refer to "Dinoprostone (Cervidil) Use for Cervical Ripening" procedure. Refer to "Misoprostol Use for Cervical Ripening" procedure.
10. May use the intrauterine pressure catheter (IUPC) for judicious titration of oxytocin.

D. **CONTRAINDICATIONS TO TOLAC/VBAC: ~~TRIAL OF LABOR AFTER CESAREAN/VAGINAL BIRTH AFTER CESAREAN:~~**

1. Inability to perform emergency cesarean delivery:
   a. Surgeon unavailability.
   b. Anesthesiologist unavailability.
   c. Insufficient nursing and ancillary staff to care for patients.
   d. Insufficient surgical capability to accommodate patient needs.
2. Greater than two previous cesarean deliveries, regardless of incision location.
3. Breech presentation of fetus.
~~4. Multiple gestation.~~
~~5.~~**4.** Medical or obstetric complication that precludes vaginal delivery.
~~6.~~**5.** Post-term pregnancy (42 weeks or greater).
~~7. Suspected fetal macrosomia.~~
~~8.~~**6.** Prior classical, **T**-shaped, other transfundal uterine surgery/scar.
~~9. Unknown uterine scar – refer to E.3.a.~~
~~10.~~**7.** Contracted maternal pelvis.

E. **PHYSICIAN RESPONSIBILITIES:**

1. Informed consent and the plan of management shall be documented on the prenatal record during a prenatal visit and prior to patient's arrival to labor and delivery.
   a. Getting this document signed in the hospital might be rushed and may be difficult to confirm that the risks and benefits have been discussed in the manner that constitutes informed consent for a laboring patient whose decision making capacity may be altered by pain and/or medication(s).
2. The documentation in the prenatal record shall reflect specific risks, benefits and ~~that alternatives~~**that alternatives** were discussed per the ACOG selection criteria for ~~VBAC~~ **TOLAC** candidacy.
   a. This documentation should reflect that the physician and patient are in agreement for:
      i. The plan of management.

ii. The delivery mode.

b. If this consent is not available upon admission, a hospital consent form shall be signed by the patient, or the patient's legally authorized representative, as evidence of the informed consent process noted in the patient's prenatal record.

i. The hospital consent is not in lieu of the informed consent process that occurs in a prenatal visit between the obstetrician and his/her patient.

3. Documentation of the location of the prior c-section of incision shall be included in the plan of management on the hospital record, if not documented on the prenatal record.

a. If the location of the prior c-section uterine scar is not available to the attending physician, the physician must document in his plan of management why s/he felt it appropriate to continue with a VBAC/TOLAC on the hospital progress notes and on the informed consent signed by the patient.

~~4. A pre-determined agreement for a repeat cesarean delivery shall not be altered by the physician assuming the care of a patient who presents in active labor.~~

~~a. Agreement between the patient and her physician for a repeat cesarean section is documented on the prenatal record and/or verbalized by the patient upon admission to Labor and Delivery.~~

~~b. With **one exception**, a patient who presents in active labor with imminent delivery.~~

~~5.~~**4.** The laboring patient may elect to have a repeat cesarean birth vs. the documented "Prenatal record" plan for TOLAC upon admission to labor and delivery and/or at any point during her labor.

~~6.~~**5.** When scheduling an induction of labor for a ~~VBAC~~ **TOLAC** patient from the physician's office/clinic, it is the responsibility of the attending physician to inform the labor and delivery charge nurse that the patient is a previous c-section so that appropriate nursing staff can be scheduled to maintain the 1:1 staffing requirement.

~~7.~~**6.** Obstetrician is immediately available during a patient's **TOLAC**~~trial of labor after cesarean.~~. If the attending OB is occupied with another patient procedure or is other wise unavailable, an additional Obstetrician must be **immediately** ~~readily~~ available to assume care of the VBAC patient's labor and delivery. Note: "**immediately** ~~readily~~ available" is defined as ~~immediately available,~~ either in-house or- **within 5 minutes walking distance.**~~within 5 minutes walking distance from his/her office~~.

~~8.~~**7.** Anesthesiologist dedicated to OB is ~~always~~ in-house, and is immediately available during a patient's **TOLAC.**~~trial of labor after cesarean~~. **The OB Anesthesiologist is to be notified when there is a TOLAC patient on the unit.** Back up support is available with on-call anesthesia.

~~9.~~**8.** If the individual obstetrician elects to use a PGE_1 (Misoprostil), and/or PGE_2 (Prepidil/Cervidil) prostaglandin for a fetal demise, the physician must insert the agent.

F. **NURSING RESPONSIBILITIES:**

1. Verify with the patient that the informed consent discussion with the attending physician took place, and ensure that all questions have been clearly answered by the physician.
2. Ensure procedural consent for TOLAC/ VBAC is signed and in patient health record.
3. Nurse to patient ratio during TOLAC/VBAC is 1:1.
   a. A nurse and a scrub nurse or tech with obstetrical surgical circulating experience will be immediately available.
4. Continuous electronic fetal monitoring, including close maternal monitoring of the uterine activity pattern is initiated and maintained during TOLAC/VBAC.

~~5. If oxytocin is used to augment labor, please reference the Procedure "Oxytocin Administration for Induction/Augmentation o0f Labor" D.10.a-c. Recommendation per ACOG guidelines (2006b), use of low dose administration of oxytocin to augment adequate labor as follows:~~

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

~~b. Increase dosage by 1 mU per minute every 30 to 60 minutes until adequate progress of labor is established and/or contractions occur every 2-3 minutes and of moderate quality.~~

~~c. Administration of oxytocin should **not to exceed 10 mU** per minute.~~

~~6.~~**5.** ~~Obtain~~**Labor". Obtain** labs on admission: CBC, Type and Screen.

~~7.~~**6.** Maintain vascular access at all times during TOLAC/VBAC:
a. Intravenous line is required – a saline lock is not acceptable.

~~8.~~**7.** Assess for signs of scar separation/ uterine rupture:
a. Variable FHR deceleration that evolves into late deceleration.
b. Bradycardia.
c. Blood-stained amniotic fluid.
d. Hematuria
e. Vaginal bleeding.
f. Alterations in uterine contractions.
g. Abdominal pain that continues between contractions
h. Loss of fetal station on examination

G. **CHAIN OF COMMAND:**

1. Staff nurse
2. Shift Supervisor/Charge Nurse
3. Clinical Manager/Designee
4. Director/Designee
5. Chairman, Department of Obstetrics/Gynecology
6. Chief of Staff
7. Immediate Past Chief of Staff
8. Chief of Staff - Elect

H. **REFERENCES:**

1. AAP & ACOG, (201**2**~~07~~) Guidelines for Perinatal Care, **7**~~6~~th Edition.
~~2. ACOG Committee Opinion, *Induction of Labor for Vaginal Birth after Cesarean Delivery*, Number 342 Vol. 108, No.2, August 2006.~~
~~3.~~**2.** American Colle**geongress** of Obstetricians and Gynecologists (~~2004~~**2010**). Vaginal birth after previous cesarean delivery. *ACOG Practice Bulletin*. Number 5**5**4. Washington, DC: Author.
~~4.~~**3.** Besuner, P. AWHONN **T**emplates for Protocols and Procedures for Maternity Services, 2nd Edition (2007).
~~5. Creasy, R.K., Resnik, R et al: Maternal-Fetal Medicine Principles and Practice, 5th Edition (2004) Saunders.~~
~~6. Dodd, J et al: Planned elective repeat cesarean section versus planned vaginal birth for women with a previous cesarean birth, *Cochrane Database Syst Rev* Issue 4, 2004.~~
~~7.~~**4.** Gilbert, E.S. Manual of High Risk Pregnancy & Delivery, 4th Edition (2007), Mosby.
~~8. Institute for Clinical Systems Improvement: *Health care guideline: Management of Labor,* 2005, ICSI. Retrieved from http://www.icsi.org~~
~~9.~~**5.** Simpson, K.R. (2008). *Cervical Ripening & Induction & Augmentation of Labor*, 3rd Edition
~~10.~~**6.** Simpson, K. R., & Creehan, P. A. (2008). AWHONN's Perinatal **N**~~n~~ursing. Philadelphia, PA: Wolters Kluwer / Lippincott Williams & Wilkins.
~~11.~~**7.** Wing, D.A. (2008) Induction of labor in women with prior cesarean delivery. Retrieved from www.uptodate.com 4/06/09.
~~12.~~**8.** Wing, D.A. (2008) Induction of labor. Retrieved from www.uptodate.com 4/06/09.

ATTACHMENT A:

1. **Bishop Score**:
   a. The Bishop score is a scoring system based on a cervical exam. When the Bishop score is 5 or more, the likelihood that the patient will have a vaginal birth is the same as that of natural labor. Induction of labor with a low Bishop score has been associated with failure of induction, prolonged labor, and a high cesarean section rate.
   b. Bishop Score (reference assessment):

Factor	0	1	2	3
Dilatation	Closed	1-2cm	3-4cm	>5cm
Effacement	0-30%	40-50%	60-70%	>80%
Station	-3	-2	-1/0	+1/+2
Consistency	Firm	Medium	Soft	----
Position	Posterior	Mid	Anterior	----

SUBJECT: Women and Newborn Services (WNS) Disaster Response Plan

ISSUE DATE: NEW
REVISION DATE(S):

Department Approval Date(s):	**02/15**
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):	**05/15**
Board of Directors Approval Date(s):	

A. **DEFINITION:**
1. HEICS- Hospital Emergency Incident Command System- Contains standard operating procedures that direct the hospital's response to various disaster events.

B. **POLICY:**
1. Due to the varying types and magnitudes of emergency events, Tri-City Medical Center (TCMC) has adopted the HEICS system to help direct and manage disaster response. Depending on the extent of the event, Women's and Newborn's Services(WNS) will continue to provide care to those patients already admitted and would be expected to continue to evaluate obstetrical patients with clinical needs during the disaster.
2. All scheduled procedures to include surgeries, inductions and/or outpatient testing will be evaluated based on medical need and canceled, as appropriate.
3. The operating rooms and recovery area in the WNS may be utilized by the main operating room personnel and other surgical specialties during the disaster event, if a surge in surgical services is anticipated.
4. In order to anticipate patient surges and/or staffing requirements house wide, the WNS leadership team in collaboration with the Chairman of the Obstetrics and Pediatrics Departments may need to review patients eligible for early discharge, as directed by the HEICS Command Center
5. All visitors should be asked to leave, if possible.

C. **PROCEDURE:**
1. NOTIFICATION:
   a. The Department will be notified of the disaster plan activation from the **Private Branch Exchange**~~Public Broadcasting System~~ (PBX) operator, who will announce "CODE ORANGE" using the overhead paging system.
   b. The Director of WNS shall report to the HEICS Command Center located in French Room number 1, to receive information about the disaster and directions from the Incident Commander.
2. RESPONSIBILITIES:
   a. WNS Director- Depending on the type of disaster anticipated, the director may be:
      i. Given an assignment as a HEICS Leadership role
      ii. Asked to implement the department staffing "Call Back" process to determine available staffing resources

iii. Asked to notify the Chairman of the Obstetrics (OB) and Pediatrics Departments to discuss discharge coordination of eligible patients, potential staffing challenges, clinical challenges, and evacuation possibilities.
iv. Required to communicate updates to their departments

b. **Assistant Nurse Managers (ANM) / Charge Nurses** shall remain on the units to manage the current patient census, staffing needs, plan for possible patient influx and/or patient evacuation requirements. Additional duties can include:
i. Assigning a staff member to report to the Incident Command Center to obtain information about what is expected.
ii. Counting and submitting accurate unit census and immediate bed availability to the Incident Command Center as requested.
iii. Starting to evaluate patients who may be eligible for early discharge and discussing options with the Department Chairmen, as indicated
iv. Canceling all scheduled procedures and outpatient testing.
v. Determining staffing requirements and reassigning personnel to the labor pool, as appropriate.
vi. Collaborating with the OB and Pediatric Department Chairmen to determine the order of evacuation based on patient acuity status.
1) Usually the most stable patients (able to ambulate), are moved first, followed by those needing a little bit of assistance and the final group is the most critical, requiring high assistance.
vii. Assigning the Obstetrical Surgical Technicians, Acute Care Technicians, and/or Peri-operative Aides to gather required supplies for evacuation, as indicted.
viii. Obtaining disaster supply containers for evacuation possibility.

c. **Primary Nurses** shall remain the unit to manage patient assignments, care coordination and assist the ANM/Charge nurse to determine which patients may be eligible for discharge. Additional duties can include:
i. Assisting with routine patient assessments, monitoring, admission and discharge teaching needs.
ii. Helping to ready patients for evacuation, as indicated.
iii. Collaborating with ANM/ Charge Nurse about equipment and medication needs for patients being evacuated
iv. Reporting to the labor pool for reassignment of duties, as directed

d. **OB Surgical Technicians** shall remain on the unit to assist with care coordination, supply acquisition and patient transport, if evacuated. Other duties can include:
i. Providing surgical support to the Main Operating Room, if requested
ii. Gathering supplies and disaster management supply tub if evacuation is suspected.
iii. Helping to evacuate patients to an identified location, as directed
iv. Acting as a runner for communication updates, supplies, etc...
v. Assisting the nurses, as directed.

e. **Unit Secretaries** shall begin "Call Back" process if directed, and these other duties:
i. Keeping track of patient flow: admissions to the unit, transfers, transports and discharges.
ii. Acts as a runner for communication

f. Other Staff shall assume duties as assigned by the ANM/ Charge nurse.

3. EVACUATION CONSIDERATIONS:
a. Patient evacuations shall be determined by the Incident Command Center.
b. Ideally, the most stable patients (ambulatory) should be considered first. The WNS evacuation procedure would follow the Disaster Manual recommendations. Stable patients may include, but are not limited to:
i. Postpartum patients and their newborns (Infants may be transported in their mothers' arms while being moved to the evacuation area.
ii. Low Risk labor patients without regional anesthesia

iii. High Risk patients/higher acuity status may require more equipment, supplies, and personnel to assist with evacuation and would be moved last.
iv. Permanent transport to a higher level of care via ambulance coordination would need to be arranged per Patient Care Services policies

D. **RELATED DOCUMENT(S):**

1. Hospital Emergency Preparedness Management, Emergency Operations Plan Policy # 4001, Safety Policies and Procedures
2. Evacuation Plan, Policy #7010-4004 Emergency Management Manual

E. **REFERENCE LIST:**

1. Hospital Incident Command System (HICS), San Mateo County Health Services Agency, Emergency Medical Services
2. Simpson, K.R, and Creehan, P.A. (2014), Perinatal Nursing (4th Ed.).Philadelphia, Lippincott Williams and Wilkins
3. The Joint Commission (2014), 2015 Hospital Accreditation Standards. Washington, D.C, The Joint Commission

Tri-City Medical Center
Oceanside, California

Environment of Care
Safety Management

SUBJECT: Environmental Health And Safety ~~Of Care~~ Committee ~~By-Laws~~Charter **POLICY NUMBER: 1001**

ISSUE DATE: 11/87
REVISION DATE(S): 1/97, 7/00

Department Approval Date(s):	**04/15**
Environmental Health and Safety Committee Approval Date(s):	**04/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	

A. **PURPOSE**

1. The purpose of the Environmental **Health and Safety** ~~of Care~~ Committee **(EHSC)** is to serve as a communication center for various departments and individuals who are responsible for the environment. The individuals on the committee are expected to help develop, implement, evaluate, and maintain the organization-wide safety programs and to review policies and procedures. The ~~Environment of Care Committee~~ **EHSC** also reviews the results of semiannual emergency preparedness drills or the implementation of the emergency preparedness program during actual emergencies.

B. **FUNCTION:**

1. Ensures that the newly constructed and existing environments of care are designed and maintained to comply with the Life Safety Code.
2. Develops written policies and procedures to enhance safety **and cleanliness** within the Medical Center and its grounds.
3. ~~Reports hospital safety statistics and sentinel events in writing~~ **Provides reports to the** ~~to~~ Board of Directors, Administration, Medical and Nursing Staff and all pertinent departments and services.
4. Hospital safety policies and department specific safety policies are reviewed as frequently as necessary, but at least every three years.
5. Maintains ongoing hazard surveillance programs including response to product safety recalls.
6. Oversees the planning and execution of disaster and fire drills. Insures drills are conducted according to ~~JCAHO~~ **The Joint Commission**, Local, State, and Federal requirements.
7. Reviews ~~all~~ **summary** reports of accidents or injuries to patients, visitors, or employees at ~~least monthly~~**the meeting**. Identifies risks and makes recommendations.
8. Oversees safety orientation and continuing education of employees in collaboration with the Education Department.
9. Periodically inspects Medical Center premises for assuring compliance with safety policies.
10. Oversees maintenance of a current reference library of pertinent documents and publications dealing with facets of hospital safety.

C. **SCOPE OF AUTHORITY:**

1. The ~~Environment of Care Committee (EOC)~~ **EHSC** is empowered ~~to strive~~ to provide a safe, functional, and effective environment for patients, staff members, and other individuals in the hospital. The Hospital Safety Officer will ~~conduct an annual~~ review ~~of~~ all Environment of Care Management Plans for: Scope, Objectives, Performance and effectiveness. ~~This assessment will be submitted to the EOC Committee in the first quarter following the closure of the previous~~

~~year~~. An Executive Summary report ~~by Exception~~ will be submitted at the end of the fiscal year to the ~~EOC~~ **EHSC** Committee.

D. **MEMBERSHIP:**

1. The ~~Environment of Care Committee~~ **EHSC** Membership will include all levels of hospital management and employees who have a primary responsibility for the safety, health, and ~~well being~~**well-being** of patients, visitors, and hospital staff. The core membership will include, but is not limited to, representation from Administration, Facilities, Laboratory, Risk Management, Employee Health, Food Services, Nursing, Environmental Services and Infection Control.

E. **OFFICERS:**

1. The Safety Officer is appointed by Administration for an indefinite term. The Safety Officer has the authority to intervene whenever conditions exist that poses an immediate threat to life, health, or threaten damage to equipment or buildings. ~~The Chairman and Co-Chairman, are elected, the position of secretary will be appointed. The terms of office will be held for a triennial period to coincide with accreditation~~.

F. **DECISION MAKING**

1. Decisions will be made by consensus of members present

G. **SUB-COMMITTEES:**

1. The Disaster Preparedness Committee and the Radiation Safety Committee are sub-committees of the ~~Environment of Care Committee~~ **EHSC** ~~and will report to the Environment of Care Committee on a monthly basis~~

H. **REPORTING MECHANISM:**

1. ~~Minutes~~ **Reports** will be submitted ~~monthly~~ to the Quality Assurance **Performance Improvement** Committee **(QAPI)** and ~~quarterly~~ to the Board of Directors.

I. **ATTENDANCE:**

1. Membership implies a commitment to attend all meetings or send a representative if unable to attend.

J. **MEETING DATE AND TIME:**

1. The ~~Environment of Care Committee~~ **EHSC** meets **quarterly or more often as the direction of the Safety Officer** ~~on the first Wednesday of each month~~. ~~The meeting is called to order at 12:00 p.m., and is scheduled for 60 minutes of business~~

Tri-City Medical Center
Oceanside, California

Environment of Care
Safety Management

SUBJECT: Patient Age Related Hazards **POLICY NUMBER: 1021**

ISSUE DATE: 11/87
REVISION DATE(S): 5/96, 1/97, 7/00

Department Approval Date(s):	**04/15**
Environmental Health and Safety Committee Approval Dates(s):	**04/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	

A. **POLICY**

1. In order to ensure a safe environment for patients of all ages, the following procedures will be followed by the affected departments.

B. **~~PROCEDURE~~GUIDELINES**

1. Pediatric Patients
   a. Side rails are to remain up on all beds used for pediatric patients. Padded restraints may be used if called for by the ~~Pediatrician~~ **physician** in charge.
   b. Pillows should be firm and offer support. Light plastic wrappings are never permitted on sheets and pillows.
   c. Children receiving heat treatments of any kind are to be kept under close supervision.
   d. Baby scales will be placed on a table top when in use to prevent the infant from falling to the floor.
   e. No child is to be left unsupervised while he or she is eating.
   f. Small candies and toys are not to be accessible to a small child lest he or she chokes or inserts them into a body orifice.
   g. When a small child has finished eating, the feeding equipment will be removed and the child be returned to his or her crib immediately.
   h. Toys should be suitable for the age and condition of the child. Children should not be given any toys made of glass or having sharp edges, flaking paint, or parts that can be detached and swallowed.
   i. ~~Toys are never to be left in the cribs of sleeping children~~.
   j. ~~Toys are to be stored in proper storage areas and never left on the floor~~.
   ~~k. Toys are to be repaired if there is potential for a safety hazard. If they are not repairable, they will be discarded.~~
   ~~l.~~**k.** All cleaning supplies will be kept in locked cabinets when not in use.
   ~~m.~~**l.** ~~Medication carts will be kept locked always~~.
2. Elderly Patients:
   a. Patient rooms and halls should be kept clear of furniture or equipment that may lead to falls. Floors are to be kept clean and dry.
   b. Lighting should be adequate and without a glare.
   c. Beds will remain in the lowest possible position and the call button will be within easy reach.
   d. ~~Implement and enforce Patient Management Protocol for all patients~~
   e. Handrails must be available in showers and baths.
   f. Patients and family should be instructed in safety measures and rationale to prevent injury.

g. Instruct patient and family to call for assistance before getting out of bed if at risk for falls. Advise patients to:
   i. Ask for help when needed.
   ii. Rise slowly and keep necessary items within reach.
   iii. Use wheelchairs, canes and walkers properly.
   iv. Use handrails if needed.
   v. Wear non-skid footwear when walking.

Tri-City Medical Center
Oceanside, California

Environment of Care
Safety Management

SUBJECT: Visitor Safety **POLICY NUMBER: 1023**

ISSUE DATE: 11/87
REVISION DATE(S): 1/97, 7/00

Department Approval Date(s):	**04/15**
Environmental Health and Safety Committee Approval Dates(s):	**04/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	

A. **POLICY**

1. Tri-City ~~Medical Center~~ **Healthcare District** recognizes its responsibility to visitors, vendors and contractors who are on its premises to protect their health and well-being
   a. Internal safety: while the visitor is within the confines of the building.
   b. External safety: while the visitor is anywhere on hospital grounds including the parking lot.

B. **~~PROCEDURE~~GUIDELINES**

1. Any hospital visitor who has an accident on the premises is entitled to immediate first-aid and whatever is necessary to preserve life.
2. If the injured visitor requires hospitalization, he will be assigned to an attending staff physician. If the visitor desires hospitalization elsewhere, arrangements will be made for transfer
   a. The report of injury ~~(on a Quality Review form)~~ **(RL Solutions incident report)** is to be completed by the Department Director **(or designee)** in whose area the accident occurred. **Security should be notified as soon as possible so that a security incident report investigation can be completed.** All records of visitor accidents will be reviewed by ~~the Environment of Care Committee~~**Risk Management Department.**
3. Visitors with bare feet are not permitted in the Hospital.
4. The hospital is a non-smoking ~~facility~~**campus.** ~~, Smoking is permitted in designated outdoor areas only~~**including all electronic and vapor style devices.**

C. **RELATED DOCUMENTS:**

~~4.~~**1. Administrative Policy Incident Report – RL Solutions**
~~5.~~**2. Administrative Policy Smoke Free Environment 205**

Tri-City Medical Center
Oceanside, California

Environment of Care
Safety Management

SUBJECT: Disposing of Recalled Products **POLICY NUMBER: 1030**

ISSUE DATE: 11/87
REVISION DATE(S): 1/97, 7/00

Department Approval Date(s):	**04/15**
Environmental Health and Safety Committee Approval Dates(s):	**04/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	

A. POLICY

1. It is the policy of Tri-City ~~Medical center~~ **Healthcare District** tto prevent the use of defective/recalled products to maintain the health and safety of employees, medical staff, patients and visitors. The following procedure will be followed when disposing of a recalled product
   a. Isolate all recalled products awaiting disposition in a secure area of the department.
   b. Label the recalled products "Do Not Use" to prevent them from being used.
   c. ~~Remove recalled items from the premises as quickly as possible.~~ **Notify Risk Management and Supply Chain management for directions on disposal.**
   d. ~~If product was not identified on "Product Recall Routing Form" notify Quality Resource Services, via Quality Review Form, of actions taken~~

Tri-City Medical Center
Oceanside, California

Environment of Care
Safety Management

SUBJECT: Safety Walk-Through Program **POLICY NUMBER: 1041**

ISSUE DATE: 11/87
REVISION DATE(S): 7/96, 4/97, 7/00, 6/11

Department Approval Date(s):	**04/15**
Environmental Health and Safety Committee Approval Dates(s):	**04/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	

A. **POLICY**

1. The Safety Officer will ensure that the ongoing hospital-wide program to collect and evaluate the information regarding hazards and safety practices covers each hospital building's department or service, interior or exterior

B. **~~PROCEDURE~~GUIDELINES**

1. The Environmental Health and Safety Committee **(EHSC)** members/or designee will survey **clinical** patient care areas ~~by~~**bi**-annually (at ~~six-month intervals~~ **least twice per calendar year**), **and non-clinical care areas annually (at least once per calendar year),** ~~The Safety Officer will survey non-patient cre areas on at least an annual basis~~
2. As necessary, results of inspections will be forwarded to the ~~Environmental Health and Safety Committee~~**(EHSC)** for discussion and ~~resolution at the next meeting~~ **action plans as needed**.
   a. Inspection reports submitted to the ~~Environmental Health and Safety Committee~~ **EHSC** will contain a ~~copy of the department's Safety Profile Checklist, Safety Questionnaires (from a sampling of department's staff), and~~ **summary report of the findings from Environment of Care (EOC) rounding** ~~the~~ Walk-through Inspection Sheet. Problems identified during the walk-through will be reported through the TAMIS System **or direct e-mails to the appropriate department leader (eEngineering, Environmental Services (EVS, or Bio~~M~~medical)** if repairs are needed.
   b. Issues that cannot be resolved at the time of inspection, or through a Work Order, will be communicated to the Department Director via the ~~Environmental Health and Safety Committee.~~**EHSC.**
   c. ~~Safety survey~~ **EOC rounding** ~~Q~~**q**uestionnaires will be **entered into the Verge data system and** forwarded to the ~~Environmental Health and Safety Committee~~ **EHSC** for ~~scanning and~~ review ~~by the Safety Officer~~. The results of the ~~scanned survey~~**Verge data** will be reported to the ~~Environmental Health and Safety Committee~~ **EHSC** for trending and identification of the department specific educational needs.

Tri-City Medical Center
Oceanside, California

Environment of Care
Life Safety Management

SUBJECT: Life Safety Management Plan **POLICY NUMBER: 3000**

ISSUE DATE: 11/87
REVISION DATE(S): 4/03, 5/12

Department Approval Date(s):	**04/15**
Environmental Health and Safety Committee Approval Date(s):	**05/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	

A. **PURPOSE:**

1. To provide a fire-safe environment for all ~~Medical~~**Tri-City Healthcare District (TCHD)** ~~Center~~ employees, medical staff, patients, and visitors.

B. **POLICY:**

1. ~~The Medical Center~~ **TCHD** will provide a system of protecting all personnel on the premises from fire, smoke and other products of combustion in conjunction with its Mission Statement.

C. **PROCEDURE:**

1. Employees will know department-specific ~~instructions~~ **roles** regarding fire plans and implement them as necessary.
   a. Employees will know where oxygen shutoffs are located in their areas.
   b. Employees will know the location of fire extinguishers and evacuation routes in their departments.
   c. The emergency number "66" is to be dialed to report a fire.
   d. The unattached buildings on the main hospital campus ~~(Business Management Services, MRI, Facilities Services, Annex, P.E.T., Lithotripsy)~~ will dial "66" to report a fire.
   e. All buildings off the main hospital campus will dial "911" for assistance in a fire.
2. Hospital-wide, all employees will know the location of the fire alarms and fire extinguishers and how to use them.
   a. General instructions for ALL employees:
      i. Keep telephone lines clear for fire control.
      ii. DO NOT use elevators.
      iii. Make sure all fire, corridor, and room doors are closed.
      iv. Clear all corridors and exits of unnecessary traffic and obstructions.
      v. If away from assigned unit, all nursing personnel will remain where they are and wait for further instructions.
      vi. All other personnel will remain where they are if off the unit and await emergency assignment as needed (exception: Fire Response Team).
      vii. Reassure patients, if they are aware of the fire that the alarm has been turned in to the Fire Department, the Emergency Plan is in effect, and there is help to assist as needed.
      viii. **R.A.C.E.**
         1) **R**escue patients immediately from fire/smoke area.
         2) **A**larm box pulled, emergency number "66" called (give exact location).
         3) **C**ontain the smoke or fire by closing all doors to rooms and corridors.
         4) **E**xtinguish the fire (if safe to do so).
   b. The main oxygen shut-off valve is located in Facilities Management Building.

3. The hospital and all buildings which serve to treat patients and are under the ownership or control of the Governing Body will maintain compliance with the appropriate provisions ~~of the 1991 edition~~ of the Life Safety Code of **the National Fire Protection Association** (NFPA).
   a. See ~~Life Safety Code Compliance Policy and Interim Construction Policy~~ **Policy #5011 Interim Life Safety Program**.

D. **INSPECTION, TESTING AND MAINTENANCE OF FIRE ALARM SYSTEMS:**

1. All circuits of the Fire Alarm System and Fire Detection Systems will be inspected ~~and tested quarterly and in addition~~**by a certified** outside vendor who is contracted~~ly~~ annually to perform an inspection of all master signals, area alarms, automatic pressure switches, shut off valves, flexible connections, outlets and purity from source in accordance with NFPA and Joint Commission standards..
2. ~~All components will have annual preventive maintenance~~.
3. ~~See Fire Alarm System Testing and Inspection Policy, Life Safety Code Compliance Policy, Smoke Detector Test Form, Pull Station Test Form, Fire Alarm Monitor Test Form and Quarterly Fire Alarm System Check Form~~.
4. The control of all designated fans and/or dampers in air-handling and smoke-management systems and transmission of fire alarm signal to the local fire department will be kept in reliable and functional condition at all times.
5. All automatic fire-extinguishing systems are to be inspected **and tested as required by NFPA and Joint Commission Standards** ~~and tested annually~~.
6. All portable fire extinguishers are clearly identified, inspected monthly, and maintained annually.
   a. ~~See Life Safety Code Compliance Policy, Fire Extinguisher Check Policy, Fire Extinguisher Log Form and Types of Fire Extinguishers~~.
7. Purchases of hospital furnishings and equipment will be reviewed to determine if they meet fire retardant characteristics and flame spread necessary for continued fire safety.
   a. ~~See Materials and Equipment Purchases policy~~.
8. The hospital conducts annual functional tests of battery powered exit lights for 90 minutes. **T**he hospital conducts monthly evaluations of nuclear powered exit signs and are verified for expiration dates and replaced accordingly.
9. A comprehensive plan to correct any Life Safety ~~Deficiencies~~ **deficiencies** which occur or are identified by any sources will be developed immediately in writing and will address:
   a. All Life Safety Code deficiencies.
   b. Corrective actions (plan for improvement).
   c. Total cost of actions and specific funding information.
   d. A reasonable schedule for completion.
   e. ~~To be coordinated with available funding~~.
   f. All interim life safety measures have been implemented and are currently enforced.

~~10. See Life Safety Code Compliance Policy and Life Safety Interim Construction Policy.~~

E. **ORIENTATION AND EDUCATION TO LIFE SAFETY PROGRAM:**

1. All **TCHD** ~~Medical Center~~ employees will know their roles and responsibilities in the event of a fire.~~ alarm.~~
   a. Use and function of fire alarm systems.
   b. Containing smoke/fire utilizing building compartmentalization.
2. In addition to the initial hospital orientation and department specific orientation, employees will annually complete the "Fire Safety" module in the Computer Based Learning program.
3. Physicians, licensed independent practitioners, and contracted employee's roles and responsibilities will be the same as employees at the point of origin of a fire as well as when they are away from a fire's point of origin.
4. All volunteers and students will be oriented to **R.A.C.E.** and will take direction from their supervisor in the event of a fire.

F. **COMMUNICATION:**

1. During emergency events employees will be informed of the emergency via the public address

system.

G. **PERFORMANCE STANDARDS:**

1. The Life Safety Program will be evaluated annually for its effectiveness.

H. **REFERENCES:**

1. Life Safety Code – NFPA
2. Policy #5011 Interim Life Safety Program

Tri-City Medical Center
Oceanside, California

Environment of Care
Hazard Material Management

SUBJECT: Hazardous Material and Waste Management and Communication Plan **POLICY NUMBER: 6000**

ISSUE DATE: 11/87
REVISION DATE(S): 9/94, 7/97, 9/00, 4/03, 12/10

Department Approval Date(s):	**04/15**
Environmental Health and Safety Committee Approval Dates(s):	**04/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	

A. **DEFINITIONS OF HAZARDOUS MATERIALS**:

1. Those materials that by their nature are a potential threat to the health and safety of persons coming into contact with them.
   a. Corrosives - having a pH less than or equal to 2 or greater than or equal to 12.5 and liquids that corrode steel at a rate of greater than .25 inch per year.
   b. Toxics (EP Toxicity) - a waste whose constitutes have a tendency to leach or migrate when disposed of in an improperly designed landfill; able to cause illness, death or restrict awareness enough to present a danger.
   c. Flammable liquids (ignitable) - flammable gases, oxidizers, liquids with a flash point of less than 140F, and solids that ignite spontaneously through absorption of moisture or friction.
   d. Reactive (Explosives) - substances that are unstable and readily undergo violent change, react violently with water, form potentially explosive mixtures with water, capable of detonation when exposed to a strong initiating source, generate significant quantities of toxic gas when exposed to water or in the case of cyanide or sulfide bearing waste, pH conditions between 2 and 12.5.
   e. Pharmaceutical waste and Expired Medications - Expired or unusable parenteral/oral liquids; dextrose/saline I.V. admixtures/solutions containing: antibiotics, multivitamins, dopamine, dobutamine, electrolytes epinephrine, epi-cal, heparin, insulin, lidocaine, lorazepam, magnesium sulfate, meperidine, midazolam, morphine, nitroglycerin, norepinephrine, oxytocin, theophylline, TPN; Maalox, Mylanta, alcohol containing liquids with less than 24% alcohol. Expired Unusable Pharmaceuticals: Intact expired or unusable medications.

B. **PURPOSE**

1. The purpose of the management plan is to define how hazardous materials and waste are identified, labeled, handled, whose responsibility they are, how training and communication is managed, and how monitoring occurs.

C. **POLICY**

1. Tri-City Medical Center is committed to providing a safe and healthy environment for all employees, medical staff, patients and visitors by establishing ongoing mechanisms for controlling and monitoring the use of hazardous materials and waste in compliance with State and Federal regulations.
2. Right ~~T~~to Know Law
   a. Employees and contractors are to be provided with information about the known and suspected health hazards that may result from working with Hazardous and Infectious

Materials. While performing duties at Tri-City Medical Center, employees and contractors shall be informed so they can make a more knowledgeable and reasoned decision with respect to any associated personal health hazards.

b. General Orientation: New employees will be informed of "Right to Know Law" during the Safety portion of Employee Orientation.
   i. Employees have the right to refuse to work with a hazardous substance if they have not been provided with Material Safety Data Sheet information.
   ii. Employees, former employees, or applicants may not be terminated or discriminated against in any way for exercising any rights they are given under the law.
   iii. Instructional signs informing employees of their rights under the law are posted.

c. Department Specific Orientation: At the time of initial assignment, all employees will receive training on any chemical which is known to be present in the workplace in such a manner that employees may be exposed under normal conditions of use or in a foreseeable emergency. If an employee is not ordinarily in a position to be exposed to hazardous chemicals, he or she need not be trained.

d. Contracting for Outside Services:
   i. Departments that obtain outside services through contracts or service agreements will insure that the contractor has been informed of all hazardous materials to which their employees may be exposed. The department will insure that the contracted employee has completed the Non Tri-City Medical Center Employee Orientation Program. (See Attachment)

D. **~~PROCEDURES~~GUIDELINES**:

1. Method ~~Of~~ **of** Identification ~~Of~~ **of** Hazardous Material:
   a. Material is identified as hazardous by evaluation produced by Manufacturer, information disseminated from a reliable source, or by professional knowledge and experience.
   b. Directors of Engineering, Surgery, Nutrition, EVS, will submit a list of substances determined to be hazardous by this policy. This list will be updated as new products determined to be hazardous are introduced to the department. ~~(See Attachment)~~
   c. Labels are required on all hazardous substances to identify the hazardous material(s) contained therein and to provide warning about the type of hazard and the type of precautions required. This includes all containers with toxic substances in a concentration greater than or equal to 1% of the total composition, or 0.1% if carcinogens; unless specifically exempted.
2. ~~Material~~ Safety Data Sheets (~~MSDS~~**SDS**)-3 E Company Fax on Demand:
   a. Request an ~~MSDS~~**SDS** when assistance is needed with medical emergencies, chemical spills, and employee
      i. **Emergency Request** – Immediate to 15 minutes: Poisoning, chemical exposure, chemical spill, human or environmental contamination, fire.
      ii. **Immediate to 30 minutes:** Regulatory Agency Request (OSHA, EPA, ~~JCAHO~~**The Joint Commission**).
      iii. **Immediate to 3 hours:** Employee request (non-emergency)
      iv. **Standard Request** – Immediate ~~5~~**to** 24 hours: Customer Request, Contractor Request.
      v. **Mail Request** – Rush: mailed within 24 hours – Standard: mailed within 3 business days: Request of 10 or more ~~Material~~ Safety Data Sheets.
   ~~3.~~**b.** To initiate ~~MSDS~~**SDS** request follow the following procedure:
      ~~a.~~**i.** Call Toll Free: ~~(800) 457-8346~~**1-800-451-8346 or 760-602-8703**, to request up to nine ~~MSDS~~**SDS**.
      ~~b.~~**ii.** Fax **request** to ~~(619) 677-0270~~ **760-602-8888** ~~to request~~**for orders and numbers on** ~~MSDS~~**SDS** of ~~any number~~**SDS sheets**
      ~~c.~~**iii. DO NOT FAX EMERGENCY ~~MSDS~~SDS REQUESTS – CALL IMMEDIATELY**
   ~~4.~~**c.** To request a ~~MSDS~~**SDS** complete the attached request form then call, fax or mail to 3 E Company. Provide as much of the following information as possible:
      ~~a.~~**i.** Product name.

~~b.~~**ii.** Manufacturer name.
~~c.~~**iii.** Product number.
~~d.~~**iv.** UPC Code (if available).
~~e.~~**v.** Be specific when request is for a product. Separate ~~MSDS~~**SDS** are maintained for products that have even very minor differences from others (e.g. colors, aerosol vs. pourable, concentrated vs. ready – to use).

~~5.~~**3.** Employee Training:

a. Department directors are responsible for providing training to employees on hazardous materials in their work area at the time of their initial assignment/ or reassignment and when a new hazard is introduced into their work area. All employees must complete the Annual Computer Based Learning (CBL's) modules which include a section on Hazardous Materials/**Global Harmonization**/Right-to-know training. The CBL instructions include the following items:
   i. Employee rights under the law.
   ii. Explanation of the ~~Material Safety Data Sheet (MSDS~~**SDS**)
   iii. Explanation of the labeling system **and pictograms**
   iv. Explanation of methods used to identify hazards and how to detect the presence of toxic substances in the work place, and routes of entry into the body.
   v. Safety and control devices to include personal protection.
   vi. Location of hazardous substance list.
   vii. Emergency procedures for spill control.
   viii. Review of blood-borne diseases and potential for transmission.
   ix. Types of protective equipment and proper use.
   x. Situations requiring use of protective equipment.
   xi. Review of concept of standard precautions as it applies to the employees specific work practices.
   xii. Review of methods to determine and designate infectious waste and linen along with instructions for proper disposal.
   xiii. Training in proper handling of needles and sharps along with proper disposal
   xiv. Training in completion of Employee Health Injury Report to indicate exposure to potential infectious agents.
   xv. Department Directors will ensure that all employees annually complete the Computer Based Learning module on Hazardous Materials. ~~The department will maintain employee training records that must include content and attendance~~.

~~6.~~**4.** Hazardous Chemical Waste & Infectious Medical Waste Disposal

a. General Disposal Guidelines:
   i. Disposal methods must comply with all federal, state and local regulations. Flammable materials are not to be disposed of into the drainage system.
   ii. Wear appropriate protective equipment (i.e. gloves, safety glasses, lab coat and respirator where applicable).
   iii. Date must be filled in on the substance's hazardous material storage label upon final use or disposal. All Chemical Waste will placed into the Chemical Waste Storage Shed for final disposal.
   iv. All empty discarded containers will be disposed of according to the manufacturer instructions and/or in accordance with Federal, State and local regulations.
   v. ~~Tri-City Medical Center~~ **Tri-City Healthcare District** is contracted with an outside company ~~(Onyx Environmental)~~ for the disposal of hazardous materials and waste in accordance with local, State and Federal regulations.
   vi. Medical Infectious Waste will be placed into the RED Bio-Hazardous Container or Sharp Container and collected by the EVS Department and placed into the Bio-Hazardous Waste Storage shed until collected by the Waste Disposal Vendor final disposal (See Infection Control Manual).
   vii. Waste Pharmaceuticals – Refer to AP&P # 276 **Handling of Pharmaceutical Waste, Expired Medications & Expired IV Solutions**.

b. Monitoring:

i. Waste Gas Levels (Surgical Suites):
ii. Waste gas levels in surgical areas are to be tested at least quarterly.
iii. Testing is to be conducted by an independent testing company contracted by Tri-City ~~Medical Center~~ **Healthcare District**.
iv. Results of such testing are to be kept on file by the respective departments.
v. Results of the quarterly testing should be posted along with the maximum permitted levels of the gas~~s~~es tested for employee review.
vi. In the event levels exceed permitted levels, the Engineering Department and the Environment of Care/Safety Officer shall be notified in order that corrective measures can be taken.

c. Airflow Testing:
i. Airflow and air changing systems will be monitored and tested by the Engineering Department on an as needed basis. All new equipment is to be certified at the time of installation.
ii. Areas using or storing hazardous materials must have adequate ventilation in order to comply with room air change and flow standards as governed by the California Building Codes.
iii. Fume hoods should be utilized when using volatile or gaseous-forming hazardous materials to insure that gas levels remain at safe levels and do not affect air quality, fumehoods should remain running at all times.

d. Radiation
i. All monitoring of radiation levels will be conducted according to departmental policies per State regulations by the Radiation Safety Officer.

e. Formaldehyde Testing
i. Air monitoring for formaldehyde will be conducted annually. Methods will be in accordance with OSHA regulations and will be of two (2) types: 1) Personal and 2) Area.
ii. Engineering controls will be utilized to reduce airborne concentrations whenever feasible.
iii. Employees working with solutions of 1% or more formaldehyde will utilize protective equipment as follows:
1) Safety Glasses.
2) Gloves.
3) Disposable chemical resistant Lab coats.

f. Work Test Area~~:~~.
i. Work areas suspected of containing airborne hazardous materials will be evaluated and tested immediately by Engineering Department and or the Environment of Care/Safety Officer.
ii. Levels exceeding permitted safe limits will be reported to the Safety Officer.
iii. A consultation with Administration, EOC/Safety Officer and the Director of the department involved will be made to determine whether or not work can continue in the affected area or to determine steps to be taken to insure employee safety.

g. Employee Monitoring ~~A~~and Medical Testing:
i. A Flammable Storage Cabinet will be provided for flammable materials in order to prevent the spreading of fire. Further, flammable liquids will be stored away from flammable gasses. Thus, in the event of fire the possibility of explosion is reduced and containment is readily achieved.
ii. Appropriate medical testing will be conducted to determine the effects of the exposure and in order that an effective diagnosis and proper treatment can be conducted.
iii. Testing will be done under the supervision of a licensed qualified physician.

h. Storage ~~And~~ **and** Transportation:
i. A Flammable Storage Cabinet will be provided for flammable materials in order to prevent the spreading of fire. Further, flammable liquids will be stored away from flammable gas~~s~~es. Thus, in the event of fire the possibility of explosion is reduced

and containment is readily achieved.

ii. All openings will be controlled with approved self-closing fire doors.

iii. Every inside storeroom will have a mechanical exhaust system that provides at least six complete air changes per hour. The Hazardous Material Storage Building has a switch that controls the ventilation system as well as the lights.

iv. Cylinders will be stored at least 20 feet from flammable and combustible liquids and other ignitable.

v. Cylinders will be stored separately (rooms) from flammable material

vi. Hazardous wastes/materials will not be stored with nonhazardous waste in order to prevent accidental contamination.

vii. Incompatible materials will be stored away from each other.

viii. Materials will be transported in approved safety containers or in their original shipping packages.

ix. No hazardous material will be transported to and stored in areas other than work or storage areas.

x. Materials will be transported in amounts comparable to regulated daily or weekly limits.

xi. Materials will not be transported and then stored in unapproved areas or in an unsafe manner.

xii. All materials packaged and shipped for outside disposal must comply with **Department of Transportation** (DOT) ~~(Department of Transportation)~~ regulations.

xiii. Daily limits will be stored in approved safety cabinets.

i. **E**mergency Response Procedures:

i. Various hazardous chemicals are used throughout the hospital which could pose a threat of danger if a moderate or major spill should occur. The following procedure is outlined in the event that such a chemical spill occurs within the hospital environment. All personnel will be familiar with the proper procedure for handling these events to minimize the risk towards patients, visitors and staff members.

1) Areas of concern:

a) Laboratory - Large variety of chemicals.

b) Pharmacy - Large variety of chemicals.

c) Materials Management - Cleaning supplies and hospital chemical supplies.

d) Environmental Services - Cleaning supplies and solvents.

e) Radiology - Materials used in x-ray development and radioactive material.

f) Food and Nutrition - Degreasers and cleaning supplies.

g) Respiratory –Disinfectants ~~(steris)~~.

h) Facilities Management - Large variety of chemicals.

i) Sterile Processing Department – Disinfectants.

j) Surgical Services – Tissue Fixative.

j. Chemical Spills:

i. Immediately ~~Alert~~ **alert** personnel in area.

ii. Evacuate and seal off areas from a safe distance; if flammable are involved, eliminate ignition source if possible. Allow no one to enter area until Environmental Services, Security, and the Environment of Care/Safety Officer has been notified and arrives on scene.

iii. If at this time an evacuation is necessary the Hospital Evacuation Procedure will be implemented. The Environment of Care/Safety Officer will consult with Management and area personnel as to proper containment, identification, and disposal procedure as prescribed by the EPA or other written instructions that provide measures that are approved by law or ordinance.

iv. Notification of the fire department will depend on the type of the spill and the potential danger involved.

v. If a minor spill of flammable, corrosives, toxics or reactive occurs and there is no

immediate danger to employee(s) then:

1) Contact Environmental Services who will contain spill per department specific policy and who will contact the Environment of Care/Safety Officer.

k. Treatment Of Contaminated Area:

i. Wash area immediately.

ii. Clothing contamination: Take item of clothing off immediately to prevent soaking. through and contaminating skin. This includes all clothing affected.

iii. First Air:

1) If skin/eye/mouth area(s) have been contaminated, flush affected area with large amounts of water for at least 15 minutes.

2) Do not try to neutralize.

a) Go to the Emergency Department immediately after flushing affected area.

3)

~~l. ANNUAL EVALUATION:~~

~~i. The Hazardous Materials Management Plan will be evaluated by, the Environment of Care/Safety Officer annually for its objective, scope, performance and effectiveness.~~

E. REFERENCES

1. **AP&P # 276 Handling of Pharmaceutical Waste, Expired Medications & Expired IV Solutions**

ATTACHMENT I

HAZARDOUS SUBSTANCE INVENTORY LIST

SUBSTANCE	TRADE NAME	AREA OF USE	MSDS NO

HAZARDOUS MATERIAL AND WASTE DEPARTMENT REPORTING FORM

Department:_____ Date:_____

PLEASE LIST THE HAZARDOUS MATERIALS/WASTE USED OR GENERATED IN YOUR DEPARTMENT AND RETURN FORM TO ENVIRONMENT OF CARE COMMITTEE.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are there material safety data sheets for each product? Yes No If not please explain:

_____
_____
_____

Are there material safety data sheets posted in both the areas of storage and the areas of use? Yes No If not please explain:

_____
_____
_____

Are all hazardous materials properly labeled? Yes No

Have employees received training in hazardous materials handling? Yes No

_____
Signed

DELETE

TRI-CITY MEDICAL CENTER Safety Policies & Procedures	Section: Hazardous Material Management Subject: Hazardous Substance Inventory List Policy Number: 6001 Page 1 of 1
Department: Hospital Wide	EFFECTIVE: REVISED: 3/97; 7/00

ATTACHMENT I

HAZARDOUS SUBSTANCE INVENTORY LIST

SUBSTANCE	TRADE NAME	AREA OF USE	MSDS NO

HAZARDOUS MATERIAL AND WASTE DEPARTMENT REPORTINF FORM

Department: _____ Date: _____

PLEASE LIST THE HAZARDOUS MATERIALS/WASTE USED OR GENERATED IN YOUR DEPARTMENT AND RETURN FORM TO ENVIRONMENT OF CARE COMMITTEE.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are there material safety data sheets for each product? Yes No If not please explain

_____

_____

_____

Are there material safety data sheets posted in both the areas of storage and the areas of use?

Yes No If not please explain:

_____

_____

_____

Are all hazardous materials properly labeled? Yes No

Have employees received training in hazardous materials handling? Yes No

_____

Signed

Tri-City Medical Center
Oceanside, California

Environment of Care
Hazardous Materials Management

SUBJECT: Hazardous Material Waste Training Procedures **POLICY NUMBER: 6002**

ISSUE DATE: 10/94
REVISION DATE(S): 8/97, 7/00, 4/03

Department Approval Date(s):	**04/15**
Environmental Health and Safety Committee Approval Dates(s):	**04/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	

A. **PURPOSE**

1. To outline the process for training personnel who are required to handle hazardous chemicals.

B. **POLICY**

1. All employees who handle hazardous materials and waste are trained in ~~MSDS~~**SDS** which contain the following:
   a. The Hazard Communication/**Global Harmonization**/Right to Know Law.
   b. Symptoms associated with overexposure to hazardous materials.
   c. First Aid treatment.
   d. How to read ~~Material~~ Safety Data Sheets.
   e. Use of personal protective equipment. Location, availability, type, use and limitations.
   f. Standard operating procedures.
   g. Hazards of chemicals to workers involved in non-routine tasks such as in the cleaning.
   h. Emergency procedures.
   i. Storage practices.
   j. Identify what and where hazardous chemicals are found in the work area.

C. **EMPLOYEE RESPONSIBILITIES**

1. Obey established safety rules.
2. Use personal protective equipment as required.
3. Inform your supervisor of:
   a. Any symptoms of overexposure that may possibly be related to hazardous chemicals.
   b. Missing labels on containers.
   c. Malfunctioning safety equipment.
   d. Any damaged containers or spills must be reported immediately.

D. **DOCUMENTATION:**

1. All documentation is tracked and maintained in NetLearning.
~~1. Directors validate completion of training via educational reports.~~
~~2. Attachment B may be used for Departments whose training is not tracked through the Education Department or as an additional resource.~~
~~3.~~**2.** ~~Attachment A may be used as a guideline to develop educational training programs~~.

TRAINING PROGRAM:

To develop specific training for individual jobs, the following guidelines should be used:

1. List all jobs and associated occupations that handle hazardous chemicals.

2. Identify any areas where an industrial hygiene or occupational health evaluation may be needed.

3. Perform the training.

4. Document all personnel training.

5. Evaluate effectiveness of training.

6. Review training procedure periodically, especially prior to performing non-routine tasks.

Attachment A

HAZARDOUS MATERIAL TRAINING ACKNOWLEDGMENT

Employee Orientation

Cal/OSHA CCR Title 8 Section 5193
"Blood borne Pathogens"

Cal/ OSHA CCR Title 8 GISO Section 5194
Hazard Communication – "Right-to-Know"

In addition to training on my Rights Program under the law, I have…

- Been instructed in basic concepts of proper safe work regarding blood borne pathogens and the proper methods of self-protection.
- Been instructed on how to read an MSDS and chemical warning labels.
- Knowledge of where MSDS's are kept and that I have access to these at all times.
- Additionally:

I understand the necessary precautions to be taken when dealing with dangerous substances in my work area.

I understand that I am required to use personal protective equipment provided by my department, and which is suitable to my assigned tasks.

I am immediately to report any incident or accident to my Supervisor.

Employee Signature _____ Date _____

Manager/Supervisor _____ Date _____

Tri-City Medical Center
Oceanside, California

Environment Of Care
Hazardous Material Management

SUBJECT: Hazardous Waste & Materials Responsibilities **POLICY NUMBER: 6003**

ISSUE DATE: 10/94
REVISION DATE(S): 3/97, 7/00, 4/03, 11/10

Department Approval Date(s):	**03/15**
Environmental Health and Safety Committee Approval Date(s):	**5/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	

A. **PURPOSE**

1. To designate responsibility in each department to provide information about hazardous waste and materials in the workplace to maintain the safety of all employees, medical staff, patients and visitors of the Healthcare District.

B. **POLICY**

1. The Healthcare District will provide a safe and healthy environment for all employees, medical staff, patients and visitors.

C. **~~PROCEDURE~~GUIDELINES**

1. Environment of Care/Safety Officer/Designee:

a. Will obtain and disseminate information regarding Hazardous Communication/**Global Harmonization/** Right-to-Know Legislation.

b. Will coordinate action plans for compliance with other members of ~~the Environment of Care Committee~~**the Environmental Health and Safety Committee (EHSC)**.

c. Will request hazardous chemical inventories those departments that have been identified as high use departments:~~.~~ (~~Eng~~**Facilities**, **Environmental Services (**EVS), Dietary, Lab, **Sterile Processing Department (SPD)**, Surgery~~)~~

d. Will coordinate with the Employee Health and Education Departments to provide training programs and continuing education for new and existing employees.

e. Will obtain copies of all hazardous materials and waste related ~~Quality Review reports~~ **RL Solutions Incident Reports** for review by the ~~Environment of Care Committee~~**EHSC**.

f. Will maintain a copy of:

i. The list of hazardous chemicals for identified department.

ii. **Occupational Safety and Health Administration** (OSHA) Standards and Interpretations.

iii. Part 1910. Occupational Safety Health Studies. Subpart C- General Safety and Health Provisions.

iv. 1910.20- Access to Employee exposure and medical.

g. Environment of Care/Safety Officer/designee will include a general statement in the hospital orientation to all new personnel regarding exposure to hazardous chemicals and explain that detailed orientation will follow in individual departments.

h. ~~Environment of Care/Safety Officer/designee will, as required, ensure that the orientation training program has been given and records kept of the dates.~~ Notice of employee rights will be posted in Human Resources, and Employee Health Services.

2. Department Directors/Designee will review area with supervisors to develop a composite list of all chemicals currently being used and store.
   a. Will submit a hazardous materials inventory list to the Safety Officer.
   b. Will review operations with supervisors to determine jobs which will require Hazard Communication Training.
   c. Will arrange for training of all involved employees in coordination with a hospital-wide training program.
   d. Will notify the Environment of Care/Safety Officer of any change affecting hazardous materials being used.
   e. Maintain copies of ~~Material~~ Safety Data Sheets and Chemical Inventory.
   f. ~~Will ensure up-to-date records are maintained on all employees required to work with hazardous materials~~.
   g. Provide information to outside contractors:
      i. Before the work begins, department directors will inform outside contractors and their personnel about the potential hazards to which they may be exposed at the work site and protective measures to prevent exposures.
      ii. The following should be made available when requested:
         1) Chemical inventory for the area(s) in which they will be working.
         2) ~~Copies of~~ **Access to** appropriate ~~Material~~ Safety Data Sheets.
         3) Any additional safety information for contractors to utilize in training their personnel.
3. ~~Material Management~~ **Supply Chain** will assist Department Directors/Designees in obtaining ~~Material~~ Safety Data Sheets on all hazardous materials used in their areas.
   a. Will ensure that supplier's samples include ~~Material~~ Safety Data Sheets for the use of operating personnel in evaluating the product.
   b. Will identify suppliers who fail to cooperate in providing ~~Material~~ Safety Data Sheets and report this information to the appropriate person.
   c. Will follow established safe practices for receiving hazardous substances that include the following provisions:
      i. Ensure ~~M~~**Safety Data Sheets** are received with initial shipment of a hazardous material.
      ii. Ensure labels are affixed to containers.
      iii. Store hazardous materials in designated locations.
      iv. Use prescribed personal protective equipment when handling hazardous material.

Tri-City Medical Center
Oceanside, California

Environment Of Care
Hazardous Material Management

SUBJECT: Hazardous Waste & Material-Ordering, Receiving and Storage **POLICY NUMBER: 6004**

ISSUE DATE: 10/94
REVISION DATE(S): 5-97, 7/00, 4/03, 4/05

Department Approval Date(s):	**03/15**
Environmental Health and Safety Committee Approval Dates(s):	**05/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	

A. **PURPOSE:**

1. To ensure that hazardous materials are ordered, received, ~~and~~ handled **and stored** in **a** safe and an expeditious manner **preventing injury to patients or personnel.**

B. **POLICY:**

1. All hazardous materials which are regularly ordered and stocked within the hospital are set up in the purchasing and inventory system.
2. **All hazardous materials are received into the department by appropriate personnel and stored in a supply closet or chemical storage cabinet. They are properly labeled with a description of the hazard they represent.**
   a. **Since storage space may be limited, acid and alkali products may be stored together if they are suitably separated.**
3. **Par levels have been established for these hazardous chemicals, and purchases are made upon these levels.**
4. **Storage areas are kept under lock and key until they are needed. The following are the approved Hazardous Materials Storage areas:**
   a. **All Environmental Services (EVS) Storage Closets**
   b. **Laboratory Area**
   c. **Waste Storage Area**
   d. **Morgue**
   e. **Engineering**
   f. **Sterile Processing Department**
   g. **Surgical Services**
   h. **Biomedical**
5. **The storage areas for hazardous chemicals are cleaned and organized routinely.**
6. **Hazardous waste storage and processing areas will be free of clutter and effectively separate from patient care, food preparation and serving areas.**

C. **PROCEDURE:**

1. It will be the responsibility of the user department to notify ~~Materials Management~~ **Supply Chain** that it is a hazardous material they wish to order.
   ~~a. User departments will be responsible for indicating hazardous materials by writing it on the face of the requisition.~~
   ~~b.~~**a.** User departments will be responsible for notifying ~~Materials Management~~ **Supply Chain** of any hazardous item, which has not been denoted as such.
2. It will be the responsibility of receiving personnel to monitor the labeling and packaging of all materials, which have been denoted as hazardous on the purchase order.
   a. These materials must have labeling which explicitly states:

i. Identity of the hazardous chemical
ii. Appropriate warning signs
iii. Name and address of the chemical company

b. Any deficiencies will be reported to the Environment of Care/Safety Officer.
c. The vendor/manufacturer will be notified of any deficiency and corrective action will be requested.
d. Receiving personnel will be responsible for obtaining and affixing appropriate labeling when not provided by the manufacturer.

~~3. Materials Management **Supply Chain** will be responsible for obtaining current Material Safety Data Sheets for requesting departments and forwarding MSDS to that department.~~

~~4.~~**3.** Inventory levels of all hazardous materials will be routinely reviewed for appropriateness as a part of the overall inventory management program of the Healthcare District.

~~5.~~**4.** Receiving personnel will be knowledgeable of all hazardous materials coming across the receiving dock and will assure that they are handled and transported appropriately.

~~6.~~**5.** A warning label will be placed on the shelf or in the storage area in the warehouse where hazardous materials are kept.

MSDS REQUEST

NAME: _____

TITLE: _____

WORK AREA: _____

JOB FUNCTION: _____

THE SUBSTANCE TO WHICH I AM ROUTINELY EXPOSED, AND FOR WHICH I AM REQUESTING A COPY OF A MATERIAL SAFETY DATA SHEET...

_____

(Employee must use a separate request form for each Material Safety Data Sheet requested)

MY REASON FOR REQUESTING THIS INFORMATION IS... _____

_____

_____ _____

(EMPLOYEE SIGNATURE) (DATE)

* * * * * *

_____ I have received a copy of the MSDS _____

_____ (CHEMICAL NAME)

_____ _____

(EMPLOYEE SIGNATURE (DATE)

_____ A copy of the MSDS for _____ which you have requested, is not available. We are making every effort to obtain a copy from our supplier.

_____ _____

(DIRECTOR, MATERIALS MANAGEMENT) (DATE)

_____ _____

(DEPARTMENT DIRECTOR) DATE)

_____ _____

(EMPLOYEE SIGNATURE) DATE)

DELETE- No longer needed

TRI-CITY HEALTHCARE SERVICES **Safety Policies & Procedures**	**MATERIALS MANAGEMENT** **Subject: Receiving Material Safety Data Sheets (MSDS)** **Policy Number:** 6005 Page 1 of 2
Department: Hospital-Wide	**Effective:** 10/94 **Reviewed:** 10/96; 10/05 **Revised:** 5/97; 7/00; 4/03

1.0 POLICY:

When Materials Management receives an MSDS on a new or existing product used in the Healthcare District, the following process is to be followed:

1.1 The Director of Materials Management will dispense a copy of the MSDS to all departments using the product.

1.2 All departments holding a Master Hazardous Materials Book will be given a copy of the MSDS.

1.2.1 Materials Management
1.2.2 Facilities Services
1.2.3 Emergency Department
1.2.4 Employee Health Services

1.3 When the MSDS is received by a department:

1.3.1 The Department Director/Designee places the copy in the Hazardous Materials Book located in the department (placed under the department using the product).

1.3.2 The Department Director/designee will inform personnel via verbal notice or written memo regarding the new product and any precautions/safety equipment required in using the material.

MSDS REQUEST

NAME:_____

TITLE:_____

WORK AREA:_____

JOB FUNCTION:_____

THE SUBSTANCE TO WHICH I AM ROUTINELY EXPOSED, AND FOR WHICH I AM REQUESTING A COPY OF A MATERIAL SAFETY DATA SHEET.

_____

(Employee must use a separate request form for each Material Safety Data Sheet requested)

MY REASON FOR REQUESTING THIS INFORMATION IS:_____

_____ _____

(EMPLOYEE SIGNATURE) (DATE)

******

_____I have received a copy of the MSDS_____

(CHEMICAL NAME)

_____ _____

(EMPLOYEE SIGNATURE) (DATE)

_____A copy of the MSDS for _____ which you have requested, is not available. We are making every effort to obtain a copy from our supplier.

_____ _____

(COMPLIANCE MANAGER) (DATE)

_____ _____

(EMPLOYEE SIGNATURE) (DATE)

TRI-CITY HEALTHCARE DISTRICT Safety Policies & Procedures	Delete: Combined into 6004 Hazardous Waste & Material Ordering, Receiving and Storage Subject: Hazardous Waste & Materials Storage Policy Number: 6007 Page 1 of 1
Department: Hospital-Wide	Effective: 10/94 Reviewed: 10/96; 7/05 Revised: 3/97; 7/00; 4/03

1.0 PURPOSE:

To provide a policy whereby hazardous waste and materials can be stored in a safe manner, preventing injury to patients or personnel.

2.0 POLICY:

It is the policy of Tri-City Healthcare District to protect the health and safety of all employees medical staff, patients, and visitors by providing guidelines for storing hazardous waste and materials.

2.1 All hazardous materials are received into the department by appropriate personnel and stored in a supply closet or chemical storage cabinet. They are properly labeled with a description of the hazard they represent.

2.1.1 Since storage space may be limited, acid and alkali products may be stored together if they are suitably separated.

2.2 Par levels have been established for these hazardous chemicals, and purchases are made based upon these levels.

2.3 Storage areas are kept under lock and key until they are needed. The following are the approved Hazardous Materials Storage areas:

2.3.1 All EVS Storage Closets
2.3.2 Laboratory Area
2.3.3 Waste Storage area
2.3.4 Morgue
2.3.5 Engineering
2.3.6 SPD
2.3.7 Surgical Services

2.4 The storage areas for hazardous chemicals are cleaned and organized routinely.

2.5 Hazardous waste storage and processing areas will be free of clutter and effectively separate from patient care, food preparation and serving areas.

Tri-City Medical Center
Oceanside, California

Environment of Care
Hazardous Materials Management

SUBJECT: Hazardous Materials Management **POLICY NUMBER: 6009**

ISSUE DATE: 10/94
REVISION DATE(S): 5/94, 7/00, 4/03

Department Approval Date(s):	**03/15**
Environmental Health and Safety Committee Approval Date(s):	**05/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	

A. **PURPOSE:**

1. To ensure that departmental personnel are prepared to properly respond to the spill of a hazardous material.

B. **POLICY:**

1. EVS personnel will clean blood borne pathogen spills.
2. The following equipment will be used by the **Environmental Services** (EVS) department to clean-up large blood spills:
   a. Absorbents
   b. Face shields
   c. Plastic bags and containers
   d. Head covers (for use in the case of splashes or drops). impervious shoe covers/gowns
   e. More elaborate equipment ~~which~~ may be required for certain emergencies~~,~~ and **would**~~is~~ **be obtained** ~~available~~ from other departments~~., include:~~
   ~~f. Wetvac vacuum - environmental services~~

~~g.~~**C. PROCEDUREGUIDELINES:**

~~3.~~**1.** In the case of a **Chemical Spill, the** ~~Material~~ Safety Data Sheet for that material should be quickly obtained and proper procedure followed.
   a. In general the response should be as follows:
      i. If the spill is over 500 m**L**~~l~~ the Safety Officer **or designee** will contact the **hazardous** ~~W~~**w**aste ~~D~~**d**isposal ~~V~~**v**endor ~~ONYX Environmental~~ to respond to clean up the spill. If **the vendor** ~~ONYX~~ is not available the **Private Branch Exchange (PBX)** operator will notify **the** Oceanside Fire Department. ~~via 911~~ and request assistance.
      ii. Evacuate the personnel in the area.
      iii. Put absorbent material (paper-towel) on the spill if the product is in liquid form (and if this can be done safely).
      iv. Notify the Environmental Services Supervisor and the Environment of Care **(EOC)**/Safety Officer.
   b. Environmental Service personnel will contact the EOC/Safety Officer if the chemical spill is over 500 **mL**~~cc.~~ ~~and in-serviced annually regarding hazardous spills.~~

~~4.~~**2.** **F**ormaldehyde Spills
   a. Laboratory and Surgical Services employees are instructed to clean up small quantity spills associated with Formaldehyde. ~~(refer to attachment #1)~~

~~5.~~**3.** Radioactive Material Spills
   a. The Radiation Safety Officer (RSO) will be notified and will clean-up all Radioactive Spills.

Tri-City Medical Center
Oceanside, California

Environment of Care
Hazardous Material Management

SUBJECT: Handling & Use of Gas Cylinders **POLICY NUMBER: 6010**

ISSUE DATE: 10/94
REVISION DATE(S): 5/97, 7/00, 4/03

Department Approval Date(s):	**03/15**
Environmental Health and Safety Committee Approval Date(s):	**05/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	

A. **PURPOSE:**

1. The purpose of this policy is to define safe process for the handling and use of compressed gas cylinders.

B. **POLICY:**

1. Only personnel trained in proper handling of cylinders, cylinder trucks, cylinder supports and cylinder valve protection caps will be permitted to use or transport such equipment.
   a. All cylinders will be transported on a proper cylinder truck or cart, constructed for the intended purpose, self-supporting, and provided with appropriate chains or stays to retain cylinders in place.
2. Gas cylinder valve protection caps will be secured tightly in place unless the cylinder is connected for use.
3. Cylinders will be stored in accordance with all applicable **National Fire Protection Association** (NFPA) standards. **Partial and full cylinders will be separated.**
4. Portable liquid oxygen reservoirs ***will not*** be stored in a tightly closed space such as a closet.
5. When small size (A, B, C, D, or E) cylinders are in use, they will be attached to a cylinder stand or to therapy apparatus of sufficient size to render the entire assembly stable.
6. Cylinders will not be dropped, dragged, rolled or picked up by the valve cap.
7. Free standing cylinders will be properly chained or supported in a proper cylinder stand or cart. They will not be chained to portable or movable apparatus such as beds and oxygen tents, or supported by radiators, steam pipes and heat ducts.
8. Very cold cylinders will be handled with care to avoid injury.
9. Cylinders will not be handled with hands, gloves or other materials contaminated with oil or grease.
10. Contents of cylinders will be identified by reading the label prior to use. Labels will not be defaced, altered, or removed. Cylinders without labels will not be used.
11. Cylinders will be tagged to reflect their capacity: **FULL, IN USE, EMPTY.** Cylinders not appropriately tagged will be considered in use. **Exception to the tagging rule is "Walk-About" style E-cylinders where the cylinders have permanent regulators and are always fully pressurized. Assessment of gas contents is accomplished by looking at the pressure gauge (any E-cylinder with the gas gauge needle in the red section on the dial is considered empty).**
12. Empty cylinders will be handled as if they were full.
13. **Mixing or transferring of compressed gas from one cylinder to another is prohibited.**
14. Gas cylinder valves will be opened and connected in accordance with ~~approved procedure~~ **steps below:**
    ~~a. Opening and Connecting Cylinder Valves:~~
    a. Make certain that apparatus and cylinder valve connections and cylinder wrenches are free of foreign materials.

b. Turn the cylinder valve outlet away from personnel. Stand to the side-not in front or in back. Before connecting the apparatus to the cylinder valve, momentarily open the cylinder valve to eliminate dust.
c. Make connections of apparatus to cylinder valve. Tighten connection nut securely with appropriate wrench.
d. Release the low pressure adjustment screw of the regulator completely.
e. *Slowly* open the cylinder valve to full open position.
f. *Slowly* turn in the low pressure adjustment screw on the regulator until the proper working pressure is obtained.
~~b.~~g. Open the valve to the utilization apparatus.

15. ~~Mixing or transferring of compressed gas from one cylinder to another is prohibited~~.

~~C. **PROCEDURE:**~~

~~1. Opening and Connecting Cylinder Valves:~~

~~a. Make certain that apparatus and cylinder valve connections and cylinder wrenches are free of foreign materials.~~
~~b. Turn the cylinder valve outlet away from personnel. Stand to the side--not in front or in back. Before connecting the apparatus to the cylinder valve, momentarily open the cylinder valve to eliminate dust.~~
~~c. Make connections of apparatus to cylinder valve. Tighten connection nut securely with appropriate wrench.~~
~~d. Release the low pressure adjustment screw of the regulator completely.~~
~~e. *Slowly* open the cylinder valve to full open position.~~
~~f. *Slowly* turn in the low pressure adjustment screw on the regulator until the proper working pressure is obtained.~~
~~g. Open the valve to the utilization apparatus.~~

Tri-City Medical Center
Oceanside, California

Environment of Care
Hazardous Material Management

SUBJECT: Radioactive Contaminated Waste Handling at Storage Area **POLICY NUMBER: 6011**

ISSUE DATE: 7/93
REVISION DATE(S): 7/96, 7/97, 7/00, 4/03

Department Approval Date(s):	**03/15**
Environmental Health and Safety Committee Approval Date(s):	**05/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	

A. **PURPOSE:**

1. In order to ensure that waste material generated by Tri-City Healthcare District does not contain any radioactive contamination, all biohazard and medical waste will be screened with scintillation detectors before placing into the containers to be picked up by a certified waste management company.

B. **POLICY:**

1. Biohazardous (Red Bag) Waste:
   a. Appropriate protective equipment, i.e., disposable surgical mask with wraparound splash guard visor, plastic aprons, and gloves, must be worn by all Environmental Service personnel when handling biohazardous waste to be screened for radioactivity and then placed into the storage units. Any contaminated disposable equipment must be placed in the containers before closing and locking the storage unit.
   b. All Environmental Services (EVS) personnel must pass the biohazardous waste (red) bags over the radiation detection monitor located in the waste handling area before placing the red bags into a biohazard barrel for disposal.
   c. Personnel **MUST** allow the bag to rest on the detector for 10 seconds in order for the detector to be activated.
   d. If **NO ALARM** is produced, personnel may proceed to place the red bag into the waste storage barrel.
   e. If an **ALARM** is generated, the EVS employee must contact their supervisor immediately.
   f. The supervisor will unlock the storage area #1 or #2 and secure the red bag in the storage locker. The radioactivity placard must be posted.
   g. As soon as possible, the Radiation Safety Officer (RSO), Nuclear Medicine technologist, or radiation safety designee will take measurements of the barrels in holding using the hand-held survey meter and attempt to determine the source of the radioactivity. When the material has decayed to background level it must be handled as biohazard medical waste for disposal.
2. Medical (Solid) Waste:
   a. All EVS personnel must position the wagon used to transport the bags of trash to the compactor area on the platform next to the compactor door between the two scintillation detectors for monitoring before disposal.
   b. Personnel must verify that there is power to the monitoring system. Personnel **MUST** allow the wagon to reside there for a minimum of 10 seconds in order for the detector to be activated.
   c. If **NO ALARM** is produced, personnel may proceed to remove the bags from the wagon and place them in the compactor.

d. If an **ALARM** is generated, personnel must contact their supervisor immediately.
e. The EVS supervisor must log the date, time, and route of the pickup that triggered the alarm. This information will be monitored for trends and problems.
f. The EVS personnel must take the wagon to the biohazard trailers and must individually check the bags in the wagon for radioactivity utilizing the scintillation detectors at the biohazard processing area. (see Procedure A) The bags, which are radioactive, must be isolated from the others. The supervisor will unlock the liquid waste safety storage area #1 or #2 and the radioactive bag(s) must be secured until decayed to background. The radioactivity placard must be posted. The remainder of the waste must be monitored again at the compactor before disposal to ensure no other radioactive contamination.

3. Discipline:
   a. **ANY** observed occurrences of improper handling of waste including failure to follow protocol, deliberate disregard for safety precautions, or tampering with the monitoring system will result in disciplinary action in accordance with AP # 424, Coaching and Counseling for Work Performance Improvement.
4. Imaging Services Department Only
   a. Monitoring Equipment-The radiation detection monitors are Ludlum model 3530 Medical Waste Radiation Detection Monitor.
      i. Background at Tri-City Healthcare District is approximately 10-20 uR/hr.
      ii. The red light/alarm trigger will be set to activate at approximately two times background or no more than 50 uR/hr.
   b. The hand-held survey meter is a Victoreen Thyac V digital count rate and survey meter (190) with a scintillation detector model 489-50. This will be used to monitor trash in the storage area.
      i. background at Tri-City Healthcare District is approximately 10-20 uR/hr
   c. Any reading greater than 50 ur/hr must be held for further decay.

Tri-City Medical Center
Oceanside, California

Environment of Care
Hazardous Material Management

SUBJECT: Battery Management and Disposal **POLICY NUMBER: 6012**

ISSUE DATE: 3/98
REVISION DATE(S): 6/00, 4/03

Department Approval Date(s):	**03/15**
Environmental Health and Safety Committee Approval Date(s):	**05/15**
Professional Affairs Committee Approval Date(s):	**05/15**
Board of Directors Approval Date(s):	

A. **PURPOSE:**
1. To define the process of control and disposal of used batteries in compliance with State and Federal laws and regulations.

B. **POLICY:**
1. All batteries, including lead acid, gellcell, nicad, mercury carbon zinc, silver oxide, and lithium or alkaline are to be disposed of according to this policy. Batteries shall not be disposed in regular trash containers.
2. Standard Batteries:
   a. All used standard batteries will be stored in containers provided by Environment of Care/Safety Officer and held in the user department for pickup by Environmental Services.
   b. Battery terminals must be covered with a piece of tape and kept in the separate compartments in battery storage container while waiting for pickup.
   c. Battery storage containers can be ordered using the Work Order System in Affinity.
3. Specialty Batteries:
   a. Engineering will insure collection and storage of all specialty batteries throughout the facility. These batteries include lead acid, gellcell, nicad, lithium, mercury, carbon zinc, and silver oxide.
   b. Engineering will make proper identification of batteries, which require special disposal requirements.
4. Storage and Disposal:
   a. Leaking batteries must be placed in double plastic bags/containers by Engineering and will require immediate disposal.
   b. Central Storage for used batteries in Compactors Compound maintained by Engineering.
      i. Engineering will ensure that batteries are properly segregated for storage and pickup.
      ii. Engineering will contract/arrange with authorized battery handling company (ies) for the disposal of batteries.

Miacalcin Injectable Drug Use Criteria

Miacalcin is a peptide hormone similar to human calcitonin; functionally antagonizes the effects of parathyroid hormone. Calcitonin directly inhibits osteoclastic bone resorption; promotes the renal excretion of calcium, phosphate, sodium, magnesium, and potassium by decreasing tubular reabsorption; increases the jejunal secretion of water, sodium, potassium, and chloride.

In March 2014, as a result of a meta-analysis of 21 randomized, controlled clinical trials with calcitonin-salmon (nasal spray or investigational oral formulations), changes to the safety labeling were approved by the FDA to caution against the increased risk of malignancies with long-term use (trials ranged from 6 months to 5 years) in calcitonin-salmon treated patients compared to placebo-treated patients. The benefits for the individual patient should be carefully considered. Similar risk for other routes (SubQ, IM).

Previously manufactured by Novartis, Miacalcin injection has had a recent price spike increasing the cost per vial from $65 to almost $1000 per vial after being purchased by Sebela Pharmaceuticals. Fortical (Miacalcin intranasal) can be purchased for $56 per inhaler.

FDA Approved Indications:

1. Symptomatic Paget's disease (osteitis deformans): 100 units daily given IM or SubQ. Due to risks associated with long-term use, Canadian labeling recommends limiting therapy to ≤ 3 months in most patients; under exceptional circumstances (impending pathological fracture), therapy may be extended to ≤ 6 months
2. Hypercalcemia (adjunctive therapy): 4 units/kg every 12 hours given IM or SubQ. After 1 to 2 days, may increase up to 8 units/kg every 12 hours. If the response remains unsatisfactory after 2 more days, may further increase up to a maximum of 8 units/kg every 6 hours
3. Postmenopausal osteoporosis (adjunctive therapy): Limited to women > 5 years postmenopause. 100 units daily given IM or SubQ or Fortical (Miacalcin intranasal) 200 units (1 spray) in one nostril daily

Off-label Uses Considered Medically Necessary:

1. Treatment of acute pain in individuals who present with an osteoporotic vertebral compression fracture on imaging with correlating clinical signs and symptoms suggesting an acute injury (0 to 5 days after identifiable event or onset of symptoms) and who are neurologically intact. **Level II studies used Fortical (Miacalcin intranasal) 200 units (1 spray) in one nostril daily.** Calcitonin treatment is considered medically necessary for 4 weeks for this indication. Although calcitonin has proven efficacy in the management of acute back pain associated with a recent spinal fracture, there is no convincing evidence to support the use of calcitonin for chronic pain associated with older fractures of the same origin

Recommendations:

1. *Use bisphosphonates and/or intranasal calcitonin when medically possible.* Injectable miacalcin has a very defined/limited inpatient use and its inhaled counterpart (Fortical) or bisphosphonates are appropriate alternatives.

Limit Miacalcin injectable to the following conditions:

1. Symptomatic Paget's Disease: Bisphosphonates are considered first line. Miacalcin is limited to patients who are nonresponsive or intolerant to alternative therapy.
2. Adjunctive therapy for immediate short-term management of Severe hypercalcemia (corrected serum calcium >14 mg/dL (3.5 mmol/L): limited to 48 hours for symptomatic patients in combination with a bisphosphonate (pamidronate 90mg IV over 60-90 minutes or zoledronic acid 4mg IV given over 15 minutes) and saline hydration

It is recognized that all patients should be treated as individuals. Therefore, for exclusions, miacalcin injectable may be used if approved by the Pharmacy Clinical Manager, if indicated for optimal patient care

DRAFT

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

Members Present:	Larry Schallock, Chairperson; Director Ramona Finnila; Director RoseMarie V. Reno; Blake Kern, Community Member; Eric Burch, Committee Community Member; Al Memmolo, Community Member; Dr. Paul Slowik, Committee Community Member; Dr. Marcus Contardo, Physician Member; Dr. Henry Showah, Physician Member
Non-Voting Members:	Greg Moser, General Counsel; Tim Moran, CEO; Kapua Conley, COO
Others Present:	Teri Donnellan, Executive Assistant; Sherry Miller, Manager, Medical Staff Office; Marla Kozina, Credentialing Specialist; Jane Dunmeyer, Community Member; Robin Iveson, Community Member
Absent:	Dr. Marcus Contardo, Physician Member

	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	The meeting was called to order at 10:00 a.m.in Assembly Room 2 at Tri-City Medical Center by Chairman Schallock, Committee Chairman.		
2. Introduction	Chairman Schallock introduced Mr. Kapua Conley, COO who joined the organization on April 1st and Ms. Sherry Miller, Manager, Medical Staff Office who also joined the organization in April.		
3. Approval of Agenda	Chairman Schallock suggested an additional, related Board Policy be discussed at today's meeting (Board Policy 14-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson) in conjunction with agenda item 7 c. Review of Board Policy 14-040 – Activities for Which Board Compensation is Available. General Counsel Mr. Moser agreed the two policies address the agenda item as posted and it is permissible to discuss both policies. **It was moved by Director Schallock to approve today's agenda as presented. Director Reno seconded the motion. The motion passed**	Agenda approved.	

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

	unanimously.		
4. Comments from members of the public	Chairman Schallock read the Public Comments announcement as listed on today's Agenda.	There were no public comments.	
5. Ratification of prior Minutes	**It was moved by Director Reno and seconded by Dr. Showah to ratify the minutes of the April 7, 2015 Governance & Legislative Committee. The minutes were approved with Director Finnila, Dr. Slowik and Mr. Memmolo abstaining from the vote.**	Minutes ratified.	Ms. Donnellan
6. Old Business - None			
7. New Business a. Medical Staff Policies & Procedures 1. 8610-568 – CPOE Power Plan: Revisions & Additions b. Rules & Regulations 1. Division of Orthopedic Surgery Rules & Regulations	 The committee discussed Medical Staff Policy #8710-568 CPOE Power Plan Revisions/Additions. It was suggested section D. 3. be revised to read "Revisions will be reviewed **for approval** by the appropriate physician…services." It was also suggested that section D. 8 be revised to reflect all medical power plans are reviewed by both the Medical Executive Committee and the Board of Directors. Additional recommendations included the addition of a period to item B. 2. and capitalization of Power Plan throughout the policy. The committee reviewed the Division of Orthopedic Surgery Rules and Regulations. Several grammatical revisions were suggested including the following: ➢ II. 9. Revise to read "**Approve** On-Going Professional …;" ➢ IV. C. Revised last sentence to read "Division **Chief** shall be…themselves." ➢ V. A. 1. Revised to read "**Accountable**...Division;" ➢ V.A. 2. Revised to read "**Ongoing monitoring** of the…Division." ➢ VA. 3. Revised to read "**Assure** practitioners…form;" ➢ VA. 4. Revised to read "**Recommend** to	.	

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

	the…Division;" ➢ VA. 5. Revised to read "**Recommend clinical…**Division;" ➢ VA.6. Revised to read "**Assure** the quality…; " and ➢ VIII. Strike dash in one-hundred **It was moved by Director Finnila to approve Medical Staff Policies & Procedures #8610-568 – CPOE Power Plan: Revisions & Additions and Division of Orthopedic Surgery Rules & Regulations as presented and revised as indicated. Director Reno seconded the motion. The motion passed unanimously.** *Ms. Sherry Miller and Ms. Marla Kozina left the meeting at 10:21 a.m.*	Recommendation to be sent to the Board of Directors to approve Medical Staff Policies & Procedures #8610-568 – CPOE Power Plan: Revisions & Additions and Division of Orthopedic Surgery Rules & Regulations; items to appear on next Board agenda and included in Board Agenda packet.	Ms. Donnellan
c. Review of Board Policy 14-040 – Activities for Which Board Compensation is Available	Chairman Schallock explained the April Regular Board of Directors meeting ran considerably long due to the fact that candidates were interviewed for the Chief Compliance Officer position for approximately three hours. The question was later raised as to whether the meeting could have been divided into two separate meetings. General Counsel explained meetings of this nature could be posted as both a Special Meeting and Regular Meeting which would allow Board members to be compensated for two separate meetings. Mr. Moser stated the Board's policy speaks to the maximum time frame for an open session meeting but does not address the maximum time allotment for closed session meetings. Director Reno stated inordinately lengthy meetings compromises the efficiency of the Board in making important decisions. It was also suggested that agenda items such as Evaluation and Appointment of Public Employees and Strategic Planning should be agendized as a Special Meeting. It was suggested that the Board consider scheduling a second Regular meeting each month to conduct such business as described above and have the flexibility to	General Counsel to draft amendment to Article III Section 8. Of the Bylaws to allow flexibility in the scheduling of Regular Board Meetings; item to appear on May Regular Board agenda.	General Counsel/ Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

	cancel the second meeting if it is not needed. Mr. Moser explained that the Board approves a meeting schedule of all Regular Board Meetings at the beginning of the year and it would not be a problem to adopt a schedule that would include two Regular Board meetings. Mr. Moser explained the benefits of Regular Meetings, however noted the posting time is 72 hours rather than 24 hours for a Special Meeting. The committee directed General Counsel to draft an amendment to the Bylaws that would allow flexibility in adopting a new schedule of Board meetings and bring this amendment directly to the Board for their consideration at the May Regular Board meeting. With regard to compensation, Mr. Moser clarified that Board members are paid $100 per Committee or Board meeting regardless of the number of meetings held in a single day with a maximum of $500 per month. Discussion was held regarding the Roles and Powers of the Chairperson as outlined in Board Policy 14-010 and his/her authority to act on behalf of the Board. Director Reno suggested the Board be advised before acting on behalf of the Board. Mr. Moser explained the Chair is permitted (and required) to report actions taken to Board members at regular meetings however, there can be no discussion on an item unless it is placed on a Board Meeting agenda or Special Board meeting agenda. Lastly, Director Reno suggested Committee Chairs contact Board members who sit on each respective committee to inquire as to agenda items for that month's committee's agenda. Director Reno also asked that Committee notify the Board's assistant immediately regarding cancellation of committee meetings.	Board Committee's support staff will inquire as to agenda items from Board members prior to finalizing committee agendas. Board Committee's support staff will advise the Board's assistant immediately upon cancellation of a committee meeting.	Ms. Donnellan Ms. Donnellan
8. Discussion regarding Current	Chairman Schallock gave a brief report on some of the	Information only.	

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

Legislation	issues discussed at the AHA Annual Meeting which he and Director Dagostino attended this past week in Washington, D.C.		
9. Review of FY2015 Committee Work Plan	The FY2015 Committee Work Plan was included in today's meeting packet for reference.	Information only.	
10. Committee Communications	Director Reno reported the CHA is hosting a webinar "OSHPD Proposed a New Seismic Design Category: SPC-4D" which may be beneficial for Board members and staff alike, in light of our campus development plan activities.	Information received on the webinar will be disbursed to Board members and applicable administrative staff.	Ms. Donnellan
12. Community Openings – None			
13.Confirm date and time of next meeting	The committee's next meeting is scheduled for Tuesday, June 2nd, at 12:30 p.m.		
14. Adjournment	Chairman Schallock adjourned the meeting at 10:50 a.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: May 28, 2015

SUBJECT: Medical Executive Committee Recommendations

The following documents were reviewed and approved by the Governance Committee on May 12, 2015. These documents are forwarded to the Board of Directors with recommendations for approval.

Medical Staff Policies:
1. CPOE Power Plan: Revisions & Additions, 8710-568

Department/Division Rules & Regulations:
1. Division of Orthopedic Surgery Rules & Regulations

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 Date
For and on behalf of the TCHD Board of Directors

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 12/2012

SUBJECT: CPOE Power Plan Revisions/Additions

REVISION DATE: 3/15

POLICY NUMBER: 8710-568

Physician Information Technology Committee Approval:	**04/15**
Medical Executive Committee Approval:	**11/12**
Governance Committee Approval:	**05/15**
Board of Directors Approval:	**12/12**

A. **PURPOSE:**

1. To provide a process for revising existing CPOE Power Plans or implementing new ones.

B. **DEFINITIONS:**

1. CPOE – Computerized Physician (or Provider) Order Entry
2. Power Plan – A grouping of orders that can be implemented together to facilitate the ordering process.

C. **POLICY:**

1. All Power Plans must be created in the approved format and must be approved as prescribed in the procedure below.

D. **PROCEDURE:**

1. Physicians may customize existing Power Plans that have been moved to their personal folder.
2. Requests for revisions (by physician, pharmacy, or nursing) to an existing Power Plan or a new Power Plan shall be submitted to IT. Requests must be in writing and must provide the exact language to be included in the Power Plan.
3. Revisions will be reviewed **and approved** by the appropriate physician specialty designee as well as nursing, pharmacy and ancillary services.
4. Revisions will be built in the Cert domain for testing by all disciplines that are affected and will be signed off by Medical Staff Department/Division representative(s) prior to building the changes in the production domain.
5. The new/revised Power Plan/orders will be implemented and appropriate staff educated as needed.
6. A list of all new/revised Power Plan/order revisions will be forwarded to Physician Information Technology Committee (PITC) for information.
7. PITC will forward the list of all new or revised Power Plans/orders to Medical Executive Committee as an informational item on their agenda.
8. **All medical Power Plans must be reviewed and approved by the Medical Executive Committee and the Board of Directors every three years.**

I. MEMBERSHIP

A. The Division of Orthopedic Surgery consists of physicians who are ~~B~~board ~~C~~certified or in the first thirty-six (36) months of ~~B~~board ~~E~~eligibility and **are** actively **progressing towards certification**~~, pursuing certification~~ by the American Board of Orthopedic Surgery, or able to demonstrate comparable ability, training and experience.

II. FUNCTIONS OF THE DIVISION

A. The general functions of the Division of Orthopedic Surgery shall include:

1. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients within the D~~d~~ivision and develop criteria for use in the evaluation of patient care;~~.~~
2. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital~~.~~;
3. Conduct, participate in and make ~~regarding~~ recommendations regarding continuing medical education programs ~~in~~ **pertinent to Division** clinical practice;~~.~~
4. Review and evaluate ~~d~~**D**ivision **member** adherence to:
   - i Medical Staff ~~P~~**p**olicies and ~~P~~**p**rocedures
   - ii Sound principles of clinical practice
5. Submit written minutes to the ~~QA/PI~~**Medical Peer Review**~~/PS~~ Committee and Medical Executive Committee concerning:
   - i Division~~'s~~ review and evaluation of activities, actions taken thereon, and the results of such action**s**; and
   - ii Recommend**ations** for maintaining and improving the quality and safety of care provided in the hospital.
6. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;~~.~~
7. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;~~.~~
8. Recommend/~~Request~~ **request** Focused Professional Practice Evaluation **(FPPE)** as indicated ~~for Medical Staff members~~ (pursuant **to** Medical Staff Policy **8710-**509)~~.~~;
9. ~~Approval~~ **Approve** ~~of~~ On-Going Professional Practice Evaluation **(OPPE)** ~~Indicators~~**indicators**;~~ and~~
10. Formulate recommendations for Division rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. DIVISION MEETINGS

A. The Division of Orthopedic Surgery shall meet ~~as often as necessary but in no event shall they meet less than~~ **at the discretion of the Chief, but at least** annually. The Division will consider the findings from the ongoing monitoring and evaluation of the quality**, safety,** and appropriateness of the care and treatment provided to patients**.**

~~A.~~**B.** Minutes shall be transmitted to the Department of Surgery, ~~QA/PI/PS~~ **Medical Peer Review** Committee, and ~~then~~ to **the** Medical Executive Committee.

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

IV. DIVISION OFFICERS

A. The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in **at least one of** the clinical areas covered by the Division.

B. The Division Chief shall be elected every year by the Active ~~Staff~~ members of the Division who are eligible to vote. If there is a vacancy ~~of any officer~~ for any reason, the Department Chairman shall designate a new ~~officer~~**Chief**, or call a special election. The Chief shall be elected by a simple majority of **the** members of the Division ~~present at the May meeting, if a quorum is present~~.

C. The Division Chief shall serve a one-year term, which coincides with the ~~m~~**M**edical ~~s~~**S**taff year unless he/she resigns, ~~be~~**is** removed from office, or lose**s** ~~his/her m~~**M**edical ~~s~~**S**taff membership or clinical privileges in **the**~~that~~ Division. **The** Division ~~officers~~ **Chief** shall be eligible to succeed ~~themselves~~**him/herself if elected**.

V. DUTIES OF THE DIVISION CHIEF

A. The Division Chief shall assume the following responsibilities ~~of the Division~~:

1. ~~Be accountable~~**Accountable** for all professional **and** administrative activities of the Division;~~.~~
2. ~~Continuing~~ **Ongoing monitoring**~~surveillance~~ of the professional performance of all individuals who have delineated clinical privileges in the Division;~~.~~
3. ~~Assure~~ **Assure** ~~that~~ practitioners practice only within the scope of their privileges as defined within the~~ir~~ delineated privilege ~~card~~**form;**~~.~~
4. Recommend to the Department of Surgery and the Medical Executive Committee ~~the~~ criteria for clinical privileges in the Division;~~.~~
5. Recommend clinical privileges for each member of the Division;~~.~~
6. ~~Assure~~ **Assure** ~~that~~ the quality, safety**,** and appropriateness of patient care provided **by members of** ~~within~~ the Division are monitored and evaluated;~~,~~ and
7. Other duties as recommended ~~from~~ **by** the Department of Surgery or the Medical Executive Committee.

VI. REAPPOINTMENT AND RENEWAL OF CLINICAL PRIVILEGES

~~A. Any member of the Division who was Board Eligible when initially granted surgical privileges, and who was granted such privileges on or after June 1, 1991, shall be expected to obtain Board Certification within thirty-six (36) months of his/her appointment to the Medical Staff. Failure to obtain timely certification shall be considered in making Division recommendations regarding applications for reappointment and renewal of clinical privileges.~~

A. All privileges are **accessible on the TCMC Intranet** ~~assessable on the Tri-City Medical Center's Intra-net MD software~~ and a paper copy is **maintained in the Medical Staff Office.** ~~in the main operating room and the nursing administration office.~~

B. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.

~~B.~~**C.** Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VII. **CLASSIFICATIONS~~DIVISION CATEGORIZATION OF SURGICAL PRIVILEGES~~**

~~A. The Division of Orthopedic has established the following classifications of surgical privileges:~~

~~B.~~**A.** Members of Division of Orthopedics are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training, such as in the broad field of internal medicine although not necessarily at the level of sub-specialist. Such physicians may act as consultants to others and may, in turn, be expected to request consultation when:

1. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness.
2. Unexpected complications arise which are outside this level of competence.
3. Specialized treatment or procedures are contemplated with which they are not familiar.

~~C. The applicable privileges are as follows: (In all instances where Board certified or eligible is stated, this refers to the applicable American Board for the surgery specialty.)~~

~~VIII.~~ **PRIVILEGES ~~REQUIREMENT FOR OBTAINING PRIVILEGE~~**

~~IX. Criteria: *Board Certified within the first 36 months of Board Eligibility, actively pursuing certification by the American Board of Orthopedic Surgery, or able to demonstrate comparable ability, training and experience. Documentation of training must be provided for additional privileges requested and proctoring of the additional privileges.~~

~~X.~~**VIII.** ~~**Arthroscopy: Prerequisite would include evidence of training in residency and/or, fellowship of arthroscopic experience, documented by Director of Program and/or documented past case experience, including operative reports and/or documentation of continuing education course in arthroscopic surgery which includes motor skill which is approved for CME Credit and 20 cases submitted from the last 12 months.~~

Orthopedic Surgeon Privileges			
Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
Admit patients	**As required for Basic Orthopedic Surgery Category privileges*** ~~N/A~~ ~~N/A~~		
BASIC ORTHOPEDIC SURGERY CATEGORY			
Amputations: • Elective • Traumatic	**1. Successful completion of an ACGME- or AOA-accredited residency in orthopedic surgery.** **~~1.~~2. Documentation of one hundred (100) cases from the previous twenty-four (24) months representative of the privileges requested.*** ~~& 10 cases within the last 12 months or a list from the residency program~~	**Six (6) cases from this category**	**Fifty (50) cases from this category reflective of the privileges requested**
Arthrodesis of Extremities		~~2~~	~~4~~
Arthroscopy surgery for knee, shoulder, elbow, hand, ankle,	~~** and or list from Residency~~	~~2~~	~~4~~

Orthopedic Surgeon Privileges			
Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
wrist & hip joints			
Biopsy (bone/soft tissue)			
Bone Grafting, **with or without allografts**		~~2~~	4
Dislocation: • External Fixation • Internal Fixation			
Fasciotomy and fasciectomy			
Foreign body removal			
Fractures: • External Fracture Fixation **(includes Taylor Spatial Frame)** • Fracture treatment of hand* • Internal Fracture Fixation • Pelvic Fracture Care (open/closed) • **Hip hemiarthroplasty***		~~N/A~~	4
Ligament Reconstruction	~~2.~~ ~~*~~	~~2~~	4
Management of infections and inflammations of bones, joints, and tendon sheaths			
Manipulation **of** joints			
Minor total joint Arthroplasty: • Fingers • Toes		~~N/A~~	~~N/A~~
Nerve repair of hand*			
Osteotomy		~~2~~	4
Reconstruction of non-spinal congenital musculoskeletal anomalies			
Repair lacerations	~~*~~ ~~*~~	~~N/A~~	~~N/A~~
Skin grafts: • **Muscle and** tendon **release,** repair, **and fixation** (flexor & extensor tendon repair of hand)* • **Tendon transfer** • **Tendon reconstruction (free graft, staged)** • **Treatment of infections**			
Soft tissue/bony mass management (debridement, **flaps (non-microvascular)**)			
Treatment of cartilage injuries			

Orthopedic Surgeon Privileges			
Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
(i.e. autologous chondrocyte implantation (ACI) and osteoarticular transfer system (OATS)/osteochondral allograft) **Total Joint Arthroplasty:** • Ankle • Hip **(includes resurfacing)** • Knee • Shoulder • Wrist **Treatment of trauma**	~~* & 10 cases within the last 12 months or a list from the residency program~~	~~2~~	4
ADVANCED ORTHOPEDIC SURGERY PRIVILEGES			
Hand Surgery: • Fracture treatment of hand • **Microsurgical ~~N~~nerve repair and graft** of hand • Microvascular replantation • Microvascular/tissue transfer • **Neurorrhaphy** • **Removal of soft tissue mass, ganglion on the palm or wrist, flexor sheath or similar mass** • **Repair of rheumatoid arthritis deformity** • Vascular lesion repair of extremities • Vein graft to vascular lesion in extremities	1. **Successful completion of a fellowship in hand surgery, or successful completion of an ACGME- or AOA-accredited residency in orthopedic surgery and demonstrate significant clinical experience in hand surgery through documentation of twenty-five (25) hand cases within the previous twenty-four (24) months;** 2. **If hand fellowship was completed more than twenty-four (24) months prior to application, documentation of twenty-five (25) hand cases from the previous twenty-four (24) months is required.** ~~* & 10 cases within the last 12 months or a list from the residency program~~	**Two (2) cases from this category**	**Ten (~~4~~10) cases from this category**
Spine ~~section~~ Surgery: • **Assessment of the neurologic function of the**	1. **Successful completion of spine fellowship; or**	**Two (2) cases from this category**	**Ten (10) cases from this category**

Orthopedic Surgeon Privileges			
Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
spinal cord and nerve roots • Cervical Discectomy • **Closed reduction of fractures and dislocations of the spine** • **Interpretation of imaging studies of the spine** • Laminectomy • **Management of traumatic, congenital, developmental, infectious, metabolic, degenerative, and rheumatologic disorders of the spine** • **Open reduction of internal/external fixation of fractures and dislocations of the spine (includes pedicle screws, plating, cages)** ~~• Pedicel screw~~ ~~• Plating~~ ~~• Spinal fixation~~ **Spinal Arthrodesis:** • **Cervical** • **Lumbar** • **Thoracic**	**successful completion of an ACGME- or AOA-accredited residency in orthopedic surgery and demonstrate significant clinical experience in spine surgery through documentation of twenty-five (25) spine cases within the previous twenty-four (24) months;** **~~1.~~2. If spine fellowship was completed more than twenty-four (24) months prior to application, documentation of twenty-five (25) spine cases from the previous twenty-four (24) months is required.~~*& 10 cases within the last 12 months or a list from the residency program~~**		
~~**Spinal Arthrodesis:**~~ ~~• Cervical~~ ~~• Thoracic~~ ~~• lumbar~~	~~*~~	~~2~~	~~4~~
~~**Fracture Treatment of the Spine:**~~ ~~• Closed~~ ~~• Open~~	~~*~~	~~N/A~~	~~4~~
~~**Fracture treatment of the Cervical:**~~ ~~• Open~~ ~~• Closed~~	~~*~~	~~N/A~~	~~N/A~~
Peripheral nerve surgery	**1. Basic Orthopedic Surgery Privileges** **~~1.~~2. Documentation of ten (10) cases in the previous twenty-four (24) months.**	**Two (2) cases**	**Ten (10) cases**

Orthopedic Surgeon Privileges			
Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
~~Kyphoplasty~~**Vertebral Augmentation**	Per Medical Staff Policy 8710-534		
~~Chymopapaine~~	~~*~~	~~N/A~~	~~N/A~~
Blue Belt Navio PFS (BBN) guided knee arthroplasty	The surgeon must be currently privileged to perform underlying procedure without BBN guidance, AND have one of the following: --- a. Documentation of training in residency/fellowship and log of ten (10) cases; OR --- b. Certificate of completion of BBN or comparable hands-on training program and documentation of ten (10) cases beyond proctoring from another institution; OR --- c. Certificate of completion of BBN or comparable hands-on training program.	--- a. One (1) case concurrently proctored by a BBN credentialed/ experienced/ faculty physician. --- b. One (1) cases concurrently proctored by a BBN credentialed/ experienced/ faculty physician. --- c. Three (3) cases concurrently proctored by BBN credentialed/ experienced/ faculty physician.	Four (4) cases
Assisting at Blue Belt Navio PFS (BBN) guided knee arthroplasty	One of the following: a. Currently privileged to perform BBN-guided knee arthroplasty; OR b. Currently privileged to assist in surgery AND	One (1) case concurrently proctored by a BBN credentialed/ experienced/ faculty physician.	Four (4) cases

Orthopedic Surgeon Privileges			
Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
	documentation of completion of BBN or comparable hands-on training program.	If the assistant is privileged to perform BBN-guided knee arthroplasty and has been released from proctoring in the surgeon role, no additional proctoring is required in the assistant role.	
Laser privileges: • CO2 • KTP • Argon[tp1]	**Documentation of completion of training for specific energy source(s) to be used. Or, if training completed greater than two years prior to privilege request, submit case logs from previous twenty-four (24) months identifying specific energy source used.**	**One (1) case for each energy source**	**Two (2) cases**
Mazor Surgery: • Mazor Robotic Surgery • Assist in Mazor robotic surgery	Per Medical Staff Credentialing Policy 8710-566		
Moderate Sedation	Per Medical Staff Policy 8710-517		
Pain Management	**Per Medical Staff Policy 8710-541**		
Procedures Outpatient Forensic Clinic:			
• Aspiration of joints • Casting and splinting • Closed reduction of fractures using local anesthesia • Foreign Body Removal • Implant removal, small (i.e. K-wires) • Injections into joints or tendon sheaths • Minor I&D abscess or hematoma • Repair lacerations • Soft Tissue Management (Debridement)	**As required for Basic Orthopedic Surgery Category privileges**	**Proctoring complete when released from specialty-specific proctoring** ~~N/A~~	N/A

*** Indicates privileges required for participation on the Orthopedic ED-Call Schedule.**

~~1. Laser Privileges:~~

~~Initial Criteria*~~	~~CO_2~~	~~Argon~~	~~KTP~~	~~Other~~
~~Reappointment~~	~~2~~	~~2~~	~~2~~	~~2~~
~~Proctoring~~	~~At least 1~~	~~At least 1~~	~~At least 1~~	~~At least 1~~

~~*Copy of certificate of completion of course specific to type of laser and copy of course outline required.~~

~~*The American Society for Laser Medicine and Surgery (ASLMS) recommends:~~

- ~~The physicians have interventional privileges in their specialty before (or in conjunction with) requesting laser privileges.~~
- ~~Training in respective Residency Program (competency verified by Program Director) or completion of an appropriate course, eight to ten hours in length ("40% of the course time allocated to practical sessions"). Longer courses/additional practical sessions may be indicated for different wave lengths/different applications or delivery instruments.~~

~~**Clinical Privilege White Paper – Procedure 93 "Transmyocardial Laser Revascularization"~~

~~XL~~IX. ALLIED HEALTH PROFESSIONALS

A. Physician Assistants

1. A Physician Assistant may only provide those medical services, which he/she is competent to perform and which are consistent with the physician assistant's education, training and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant.
2. A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.
3. A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physicians specialty or usual customary practice and with the patient's health and condition.
4. A physician assistant may not admit or discharge patients.
5. ~~A supervising physician shall observe or review evidence of the physician assistant performance of all tasks and procedures to be delegated to the physician assistant until assured competency.~~
6. ~~A physician assistant may initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care (under the direct supervision of the medical physician).~~

Physician Assistant Privileges			
Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
A physician assistant may also act as first or second assistant in surgery, under supervision of an approved supervising physician.	Per AHP Rules and Regulations	Per AHP Rules and Regulations	**Fifty (50) cases**~~N/A~~
Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans, record and present pertinent data in a manner meaningful to the physician.			

Order or transmit an order for x-ray, other studies, therapeutic diets, physical/rehab therapy, occupational/speech therapy, respiratory therapy, and nursing services.			
Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures.			
Recognize and evaluate situations that call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.			
Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases.			
Initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care, including patients at home.			
Initiate and facilitate the referral of patients to the appropriate health facilities, agencies and resources of the community.			
Order and administer medications. A physician assistant may not administer, provide or transmit a prescription for controlled substances in schedules II through V without patient-specific authority by a supervising physician. A physician assistant may not order chemotherapy agents.			
Assist in Mazor robotic surgery	Per Medical Staff Credentialing Policy 8710-566		

B. Orthopedic Surgery Technician – **As outlined in the privilege table below.**

1. ~~An orthopedic surgery technician must be certified by the National Board for Certification of Orthopedic Technologists, maintain current BLS certification, and obtain 120 continuing education units/6 years.~~ [tp2]
2. ~~Under the direct supervision of a physician, an orthopedic surgery technician may perform intraoperative retractions, intraoperative homeostasis, intraoperative wound closure and other services as specified in the delineation of privileges.~~ [tp3]

Orthopedic Surgery Technician Privileges			
Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
Intraoperative Retractions: • Retract Tissue or organs by use of hand • Place or hold surgical retractors • Pack sponges into body cavity to hold tissues or organs out of the operative field • Manage all instruments in the operative field	Per AHP Rules and Regulations	Per AHP Rules and Regulations	~~Not applicable~~**Fifty (50) cases**
Intraoperative Homeostasis: • Aspiration of blood and other fluids from the operative site • Sponge wounds or other areas of dissection • Clamp bleeding tissues or vessels • Cauterize and approximate tissue • Place hemoclip or ligating sutures on vessels or tissue • Connect drainage			
Intraoperative Wound Closure: • Apply surgical dressing • Care and removal of drains			
Other: • Assist with applying casts, braces, or plaster splints			

~~XII.~~X. PROCTORING OF PRIVILEGES

A. Each new Medical Staff member granted initial **privileges,** or **Medical Staff member requesting** additional ~~surgical~~ privileges shall be evaluated by a proctor ~~in each surgical case~~ **as indicated** until his **or her** ~~surgical~~ privilege status is established by a recommendation from the Division **Chief to**~~, the Department of Surgery,~~ Credentials Committee and **to** the Medical Executive

Committee**, with final approval by the Board of Directors**. ~~This is to include extensive surgical procedures treated in the Emergency Department.~~

~~B. Selection of Proctors:~~

B. The member is responsible for arranging a proctor.

C. All ~~a~~**A**ctive ~~staff~~ members of the Division ~~of Orthopedics~~ will act as proctors ~~to monitor quality of performance of medical care with assigned privileges~~. An associate of the **physician being proctored** ~~new medical staff member~~ may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief. ~~and~~ **i**It is the responsibility of the Division Chief to inform the monitored ~~new medical staff~~ member~~,~~ whose proctoring is being continued~~,~~ whether the deficiencies noted are in: a) preoperative, b) operative, c) surgical technique and/or, d) postoperative care**.**

D. ~~From the list of proctors the new medical staff member shall select an appropriate member from the Division of Orthopedics to proctor his/her operative case. He or she shall contact the monitor and inform him or her of his or her plans for the case.~~ **THE MONITOR MUST BE PRESENT IN THE OPERATING ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE~~ENSURE~~ HIMSELF/HERSELF OF THE ~~APPLICANT SURGEON'S~~ MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ~~ENSURE~~ ASSURE HIMSELF/HERSELF OF THE ~~APPLICANT~~ SURGEON'S COMPETENCE.**

E. In elective cases, ~~all such~~ arrangements shall be made prior to scheduling (i.e.**,** the proctor shall be designated at the time the case is scheduled ~~for surgery or for admission non-operative cases~~). ~~In emergency cases, the monitor shall be contacted prior to, and designated at, the time of scheduling.~~

F. The ~~new medical staff~~ member shall have free choice of suitable consultants and assistants. **The proctor may assist the surgeon.**

~~G. Reports of Proctors~~

G. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

H. A form shall be ~~prepared on which will be spaces for comment~~ **completed** by the proctor**, and should include comments** on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall, impression and recommendation (i.e.**,** qualified, needs further observation, not qualified). Blank forms will be available from the Operati**ng**~~ve~~ Room Supervisor and/or the Medical Staff ~~o~~**O**ffice.

I. Forms will be made ~~up by~~ **available to** the ~~new medical staff~~ member scheduling the case for surgery and immediately forwarded to the proctor for completion. It is the responsibility of the ~~new medical staff~~ member to notify the Operating Room Supervisor of the proctor for each case.

J. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office ~~for filing in the individual physician's confidential file~~.

~~K. Length of Probationary Period~~

~~L. The new medical staff member shall be observed by proctor in each surgical case for an indefinite period as aforementioned above.~~

~~M. It will be the responsibility of the Division Chief to inform the monitored new medical staff member whose probationary period is being continued, whether the deficiencies noted are in:~~

~~i Preoperative~~

~~ii Operative,~~

~~iii Surgical technique and/or,~~

~~iv Postoperative care.~~

~~XIII.~~XI. EMERGENCY DEPARTMENT CALL

A. ~~Medical Staff~~ Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the ~~m~~**M**edical ~~s~~**S**taff. Refer to **Medical Staff** Policy #**8710-**520.

B. The care provided by an on-call physician should be completed with regard to the particular problem that the physician was called to treat. For future different orthopedic problems, there is no obligation on the part of the physician to provide care.

~~B.~~**C. Provisional staff members may participate on the Emergency Department Call Roster at the discretion of the Chief of the Division.**

APPROVALS:

Division of Orthopedic Surgery:	**03/15**
Department of Surgery:	**04/15**
Medical Executive Committee:	
Board of Directors:	

Audit, Compliance & Ethics Committee
(No meeting held in
May, 2015)

TRI-CITY HEALTHCARE DISTRICT
MINUTES 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
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 10:00 a.m. on April 30, 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
Steven L. Dietlin, Chief Financial Officer
Kapua Conley, Chief Operating Officer
Esther Beverly, VP/Human Resources
Laura Musfeldt, Vice President, Senior Executive Search
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 10:00 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 Nygaard to approve the agenda as presented. Director Dagostino seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairman Schallock read the Public Comments section listed on the April 30, 2015 Regular Board of Directors Meeting Agenda.

   There were no public comments.

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

Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Mr. Moser made an oral announcement of the first item listed on the April 30, 2015 Regular Board of Directors Meeting Agenda to be discussed during the morning session of Closed Session which included Appointment of Public Employee: Chief Compliance Officer.

5. Motion to go into Closed Session

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

6. The Board adjourned to Closed Session at 10:02 a.m.

At 1:30 p.m. the Board moved to Classroom 6 to continue Closed Session with all Board members present.

Oral Announcement of Items to be discussed during Closed Session

Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Mr. Moser made an oral announcement of the remaining items listed on the April 30, 2015 Regular Board of Directors Meeting Agenda to be discussed during the Closed Session which included Conference with Labor Negotiators; Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; three Reports Involving Trade Secrets, one matter of Potential Litigation; six matters of Existing Litigation; approval of closed session minutes; and Public Employee Evaluation of the Chief Executive Officer.

8. At 3:30 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
Kapua Conley, Chief Operations Officer
Sharon Schultz, RN, Chief Nurse Executive
Esther Beverly, VP, Human Resources
Dr. Scott Worman, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairman Schallock stated no action was taken in closed session, however the Board will be returning to closed session at the conclusion of this meeting to conduct unfinished business.

10. Chairman Schallock noted all Board members were present. Director Finnila led the Pledge of Allegiance.

11. Chairman Schallock read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 24.

12. Introduction of Kapua Conley, Chief Operating Officer

Chairman Schallock introduced Mr. Kapua Conley, Chief Operating Officer who joined the organization on April1st.

Mr. Conley stated he is extremely grateful for the opportunity to work with the Board and the C-Suite. He has seen many positive changes over the past year and looks forward to contributing to our future success.

13. Recognition of Renee Salas, Event Coordinator – American Cancer Society San Diego Volunteer Award

Chairman Schallock recognized Ms. Renee Salas, Event Coordinator and expressed his appreciation for her efforts in the American Cancer Society Relay for Life which took place recently at Mira Costa College. Chairman Schallock stated Ms. Salas was also recognized by the American Cancer Society with the Spirit Award for her volunteer activities. Chairman Schallock noted Team Tri-City raised $5,000 and expressed appreciation for those who took the time and volunteered for this worthy cause.

14. Community Update

Second Quarter Marketing Update – David Bennett, Chief Marketing Officer

Mr. David Bennett, Chief Marketing Officer presented the marketing quarterly update for April 2015. Mr. Bennett stated our concentration and goal is to increase revenue through building brand awareness, visibility and brand redevelopment which will result in an increase in Market Share, attract new primary care physicians and attain a substantial increase in positive community visibility and perception. Mr. Bennett presented billboards that will run from January – June, 2015 which focus on the following:

- Nationally Recognized Cardiovascular Care (Heart Health Month)
- Women's Health Services
- Primary Care Physician Network Campaign

Mr. Bennett stated that in addition to the billboards, print ads for Heart Health Month resulted in 52 heart screenings performed by the Cardiovascular Health Institute. Print Ads and Mailings were also done for Mother/Baby and NICU Services and a mailer went out to 3,500 senior residences within a five mile radius of the centers promoting the Nifty after Fifty program.

With regard to our marketing efforts at the Wellness Center, Mr. Bennett reported a contract has been executed with the Wellness Center to reintroduce a Cancer Fitness Program. A Parkinson's Fitness Program is being discussed with the Parkinson's Association, a Bressi Ranch residents "open house" is planned, we are rolling out a Corporate program with visits to all major Carlsbad employers and our Finance Department is looking at the impact of reducing membership rates to attract new members.

Community events from January to June 2015 include the following:

- Heroes of Vista
- Carlsbad Chamber Awards
- Encinitas Street Fair
- Operation Appreciation
- Strawberry Festival
- Filipino Cultural Day

Ms. Jodie Wingo, Senior Director of Marketing and Public Relations spoke regarding two Webinars, one of which was presented by Dr. El-Sherief and Dr. Phillips to discuss heart disease and male urology issues and a Webinar which was launched April 15th presented by Dr. Karen Hanna to discuss medical weight loss and surgical weight loss options. Ms. Wingo noted the public can find out about future webinars in the newspaper and through social media.

Ms. Wingo also discussed the results of digital ads in the San Diego UT which went to a database of 50,000 geo-targeted email addresses.

Ms. Jamie Johnson, Manager for Marketing spoke regarding our Social Media Results which includes Face Book and Twitter.

Directors were impressed with Mr. Bennett and his Marketing Team's efforts and the avenues we have chosen to attract new patients and give care close to home.

No action taken.

15. TCHD Foundation – Glen Newhart, Executive Director/Vice President

Mr. Glen Newhart reported this past weekend the North Coast Church partnered with the Foundation to do a project here on campus called "The Pines", an employee break area. Mr. Newhart stated the church donated $50,000 worth of labor and materials while the Foundation donated $13,000 in materials to complete the project. Mr. Newhart stated a ribbon cutting ceremony was held on April 27th to open "The Pines" to Tri-City Medical Center's employees and visitors.

Ms. Ellen Stotmeister reported on Saturday, May 2nd the 4th Annual "Fashion That Heals" event will take place at 10:00 a.m.at the Sheraton Carlsbad Resort. Ms. Stotmeister stated the event focuses on women's issues and this year's funds are being donated to expand and enhance the Neonatal Intensive Care Unit. Ms. Stotmeister stated those who are unable to attend the event may support the cause by participating in the "Pick A Purse" raffle in which ten designer bags are stuffed with coupons and certificates and each purse will be worth $,1,100.

Mr. Newhart stated the next event for the Foundation in partnership with the Tri-City Auxiliary is the "Tails on the Trails" Walk-A-Thon scheduled for Saturday, May 30th at Mance Buchanon Municipal Park.

Lastly, Mr. Newhart encouraged the community to check their mailbox for the debut of the Foundation's Quarterly Newsletter "For Good" which includes great stories of how the hospital is doing and more importantly how the community can take part and be an active participant at Tri-City.

Director Finnila suggested our volunteers who worked on "The Pines" project be invited to attend our Volunteer Appreciation luncheon.

No action was taken.

16. Report from Chief Executive Officer

Mr. Tim Moran, Chief Executive Officer commented on the Marketing presentation and stated Tri-City has a high level functioning marketing service that is research based and to the extent possible we try to target our efforts in parallel and support of the hospital's strategic plan.

Mr. Moran stated Tri-City has been recognized by the Mazor organization for completing our 500th robotic case. Mr. Moran noted we are the only provider in San Diego county, which utilize the Mazor Robot and we are extremely proud of that accomplishment and the surgeons who work with us at Tri-City.

With regard to our campus development plan, Mr. Moran reported we are working to negotiate a contract with our general contractor and architect.

Mr. Moran reported we recently received an "A" rating in patient safety from the Leap Frog group. Mr. Moran explained Leap Frog judges organizations in a variety of areas including efforts to make surgery safer, infection control, adequate staffing to deal with safety issues and the use of standard safety procedures. Mr. Moran stated Tri-City was one of only four hospitals in the county that received an "A" rating and that is an accomplishment that is not easily achieved.

Mr. Moran reported on an upcoming LAFCO meeting regarding spheres of influence for the District and he will report back on that public hearing.

Mr. Moran spoke regarding the preparation of our operating budgets for the next fiscal year which will be brought forward in conjunction with our strategic plan in June.

Lastly, with regard to Behavioral Health issues, Mr. Moran invited Ms. Sharon Schultz, CNE to comment on a grant that the hospital has applied for.

Ms. Schultz stated we recently applied for a grant that is aimed at early prevention and access to care in a timely manner for those interventions and to help reduce the stigma of mental health illness through a program that is called "Every Mind Matters", a statewide program that will reach out into their communities to get this to be more of a regional effect for California so we have better response to our patients who really need our help. Ms. Schutlz stated we are looking at developing a Crisis Stabilization

Unit and also a walk in clinic. Mr. Schultz explained initially we were looking at the adult population; however we have expanded our grant to look at adolescents through the adult years to provide services to our community in a more in depth matter.

No action was taken.

17. Report from Chief Financial Officer

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

- Net Operating Revenue – $249,870
- Operating Expense – $250,408
- EROE - $2,747
- EBITDA – $14,712

Other Key Indicators for the current year included the following:

- Average Daily Census – 194
- Adjusted Patient Days – 84,933
- Surgery Cases – 4,977
- Deliveries – 1,979
- ED Visits – 53,048

- Net Patient Accounts Receivable – $42.8
- Days in Net Account Receivable – 49.2

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

- Operating Revenue - $28,516
- Operating Expense - $28,539
- EBITDA - $1,591
- EROE - $292

Mr. Dietlin also presented graphs which reflected Net Days in Patient Accounts Receivable, Average Daily Census excluding Newborns, Adjusted Patient Days, Emergency Department Visits. He stated the EROE and EBITDA graph reflects the trend of the financial results vs. one month.

Director Dagostino commented on the fact that we are keeping our patients safe as reflected by our "A" rating from the Leap Frog as well as being economically efficient.

Mr. Dietlin stated it is very difficult to achieve both goals simultaneously and is a credit to the organization.

No action was taken.

18. New Business

a. Consideration to certify a recognized Employee Organization as the exclusive bargaining representative.

It was moved by Director Dagostino that the TCHD Board of Directors certify the results of the card count, by the neutral party, to determine the majority of employees within the technical classification voted to be represented by SEIU-UHW and reflected in Exhibit "A" attached hereto. Director Finnila seconded the motion.

Ms. Esther Beverly, VP of Human Resources reported on April 16th a card check was conducted by a neutral third party. She stated we verified the majority of employees in the appropriate bargaining unit who have chosen to be represented by SEIU and based on that card count make the recommendation to the Board to recognize SEIU as the bargaining representative.

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**

b. Consideration to retain BB&T Insurance Services to serve as Tri-City Healthcare District's insurance broker of record for worker's compensation, property and casualty, and employee benefits programs

It was moved by Director Finnila that the TCHD Board of Directors approve to retain BB&T Insurance Services to serve as Tri-City Healthcare District's insurance broker of record for worker's compensation, property and casualty, and employee benefits programs for a term of three years, beginning April 1, 2015 through March 31, 2018 for a 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. Director Nygaard seconded the motion.

Mr. Steve Dietlin, CFO stated BB&T was previously retained for a one year term which has just expired and we are recommending BB&T be retained for an additional three years.

Mr. Dietlin introduced Mr. Wes Justyn, Ms. Denise Ewing and Mr. Tim Mooney, all with BB&T.

Director Reno questioned whether BB&T provides indemnification for the Board. Mr. Justyn responded that BB&T does provide insurance for the Board for both indemnity and defense through the Directors and Officers liability.

Mr. Justyn stated he has been honored to work with this hospital and has seen a remarkable change. Mr. Justyn stated the quality of service and leadership is outstanding.

The vote on the motion was as follows:

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

c. Consideration to approve a lease agreement for the GE 512 CT scanner

It was moved by Director Dagostino that the TCHD Board of Directors approve a lease agreement for the GE 512 CT scanner for a term of 60 months with an estimated start date of November 1, 2015 through October 31, 2020, at a monthly cost of $38,467, a total term lease expense of $2,308,020, construction expense not to exceed $485,000 and hardware and interface expense of $95,251 for a total term expense of $2,888,171. Director Finnila seconded the motion.

Mr. Steve Young spoke regarding the proposed purchase and installation of the GE Healthcare Revolution CT, the most advanced computed tomography (CT) scanner on the market which enables radiologists to make the quickest, most accurate diagnoses possible for their patients. He explained the machine can create a full, three dimensional image of an organ in just one pass and will provide more options for the hospital's radiology program. As a designated stroke and heart attack receiving center, the GE Revolution CT will dramatically enhance a physician's ability to quickly diagnose and treat patients. He stated that we expect a 35-50% reduction in Emergency Department testing turnaround times.

Mr. Young showed a brief video that looked at the inside of the scanner and the engineering.

Mr. Young recognized the Foundation who donated $500,000 towards this project and the Auxiliary who has donated $50,000. He stated without their participation in this project it would be difficult to bring this technology to San Diego County.

Director Kellett commented that this machine is the most sophisticated machine in the county and is extremely valuable.

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. Old Business – None

20. Chief of Staff

Consideration of April 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on April 27, 2015.

It was moved by Director Reno to approve the April 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on April 27, 2015. Director Nygaard seconded the motion.

Dr. Worman commented that the Medical Staff is proud to work at Tri-City with its "A" rating from the Leap Frog Group for patient safety. He stated this is a collaborative effort for everyone involved and the Medical Staff are committed to working with everyone to do our part to provide a safe environment for our patients.

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**

21. Consent Calendar

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

It was moved by Director Reno to remove items 21 C. Community Healthcare & Alliance Committee, 21 E. 3) A.1. Intrafacility Transport of the NICU Patient, 21 E. 3) A 2. NICU Disaster Procedure and 21 G. Audit & Compliance 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**

22. Discussion of items pulled from Consent Agenda

Director Reno who pulled item 21 C. Community Healthcare & Alliance Committee questioned if the openings for the two seats on the committee are for community

members. Director Nygaard responded and indicated she would check on the terms of the community members.

Chairman Schallock stated as this item was pulled for discussion only, no vote is necessary.

Director Reno who pulled item 21 E. 3) A. 1.Intrafacility Transport of the NICU Patient requested clarification on the procedure followed for NICU overflow. Ms. Schultz responded that NICU overflow is on the second floor of the Pavilion and the main NICU is located where Telemetry is on the third floor.

Director Reno who pulled item 21 E.3) A. 2. Disaster Procedure requested clarification on the NICU Disaster Procedure. Ms. Schultz explained the protocol for NICU Disasters.

It was moved by Director Finnila to approve items 21 E. 3) A. 1. and 2. 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 21 G. Audit & Compliance Committee suggested the policies be cleaned up to reflect proper grammar.

Chairman Schallock commented that the new Compliance Officer, when hired will also need to review our Compliance policies and may make additional revisions.

It was moved by Director Dagostino to approve item 21 G. with amendments to grammar as described. Director Kellett seconded the motion.

The vote on the motion is as follows:

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

Director Reno noted with regard to item 21 (3) Minutes – she is voting "no" on the March 26, 2015 Regular Meeting minutes and she is in favor of the April 16th Special Meeting minutes.

23. Reports (Discussion by exception only)

24. Legislative Update – no Update

25. Comments by members of the Public

Chairman Schallock reminded speakers of the 3- minute time allotment.

Chairman Schallock recognized Mr. Michael Slavinski who expressed his appreciation for the Wellness Center.

Chairman Schallock also recognized seven individuals who spoke on behalf of the union regarding a campaign to raise Medi-Cal reimbursement rates. Several individuals spoke regarding their personal experiences related to problems with Medi-Cal and urged Tri-City Medical Center to partner with them.

26. Additional Comments by Chief Executive Officer

Mr. Moran did not have any additional comments.

27. Board Communications

Director Nygaard reported she recently attended ACHD Legislative Days and one of the prime goals was to talk with legislators on Assembly Bill 366 which supports an increase in Med-Cal reimbursement rates.

Director Nygaard also reported that Mr. Rocky Chavez was honored and named Legislator of the Year and she had the pleasure of introducing Mr. Chavez.

Director Nygaard reported she attended the Grand Opening of NCHS Pediatrics Health Center on Mesa Drive in Oceanside on April 6th. She stated it is a wonderful addition for our community and pediatric population and was built on budget and ahead of schedule.

Director Reno expressed her enthusiasm for the new CT Scanner and thanked Administration for bringing this new technology to Tri-City Medical Center.

Director Reno stated next week we celebrate Nurses Week and all nurses should be applauded for their loyalty and service to this hospital.

Director Kellett had no comments.

Director Finnila had no comments.

Director Mitchell had no comments.

Director Dagostino reported both he and Chairman Schallock aggressively supported SB243 and AB366 at CHA Legislative Days related to Medi-Cal reimbursement rates.

28. Report from Chairperson

Chairman Schallock stated he is in agreement that Medi-Cal funding is atrocious and affects the patient's quality of care. He stated he is in favor of anything that can be done to increase Medi-Cal reimbursement rates.

Chairman Schallock commented on Administrative Assistant's Day and thanked Ms. Teri Donnellan for her work and efforts in keeping the Board on track.

29. 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.

30. Motion to return to Closed Session.

Chairman Schallock adjourned the meeting to closed session at 5:30 p.m.

31. Open Session

At 7:57 p.m. Chairman Schallock reported the Board was back in open session. All Board members were present.

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

Chairperson Schallock reported no action was taken in closed session.

33. There being no further business Chairman Schallock adjourned the meeting at7:57 p.m.

_____
Larry Schallock, Chairman

ATTEST:

_____
Ramona Finnila, Secretary

Outcome of Care Measures

Center for Medicare & Medicaid Services (CMS)

Readmission Rate Outcome of Care Measure - Medicare Patients only (Risk-Standardized Rate, all readmits incl. to other hospitals) - updated annually

Measure	For Period	TCMC Rate	National Rate
AMI 30-Day Readmission	Jul 2011 - Jun 2014	16.1%	17.0%
Heart Failure (HF) 30-Day Readmission	Jul 2011 - Jun 2014	20.6%	22.0%
Pneumonia (PN) 30-Day Readmission	Jul 2011 - Jun 2014	16.3%	16.9%
Hip-Knee 30-Day Readmission	Jul 2011 - Jun 2014	5.3%	4.8%
Hospital-wide 30-Day Readmission (unplanned)	Jul 2011 - Jun 2014	14.3%	15.2%
COPD 30-Day Readmission	Jul 2011 - Jun 2014	21.2%	20.2%
Stroke 30-Day Readmission	Jul 2011 - Jun 2014	12.2%	12.7%

Mortality Rate Outcome of Care Measure - Medicare Patients only (Risk-Standardized Rate, all mortalities incl. deaths after discharge) - updated annually

Measure	For Period	TCMC Rate	National Rate
AMI 30-Day Mortality	Jul 2011 - Jun 2014	16.1%	14.2%
Heart Failure (HF) 30-Day Mortality	Jul 2011 - Jun 2014	14.5%	11.6%
Pneumonia (PN) 30-Day Mortality	Jul 2011 - Jun 2014	11.0%	11.5%
COPD 30-Day Mortality	Jul 2011 - Jun 2014	9.5%	7.7%
Stroke 30-Day Mortality	Jul 2011 - Jun 2014	16.3%	14.8%

Complication Measure - Medicare Patients only (Risk-Standardized Rate, following elective primary total kip and / or knee replacement) - updated annually

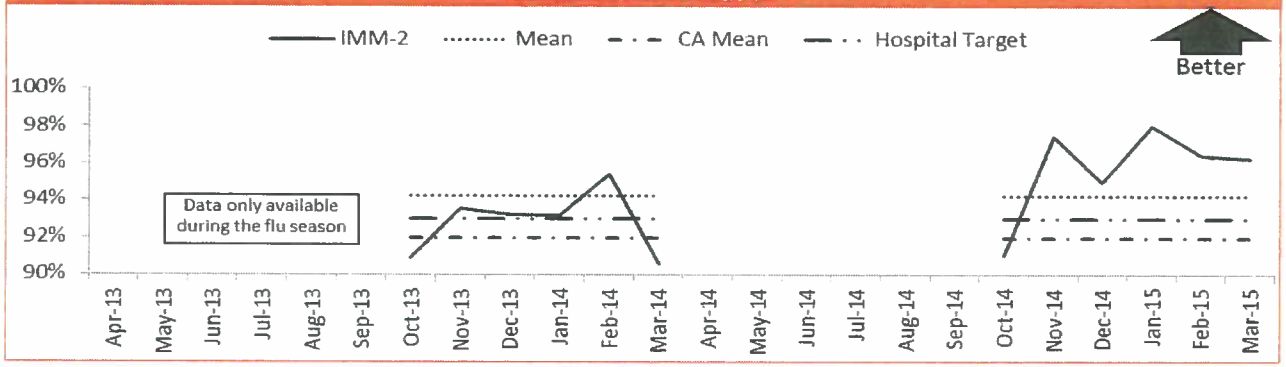
Measure	For Period	TCMC Rate	National Rate
Hip-Knee Complication Rate	Jul 2011 - Jun 2014	2.8%	3.1%

Performance compared to U.S. National Rate: Better | No different | Worse

Process of Care Measures (Core Measures)

Centers for Medicare & Medicaid (CMS)

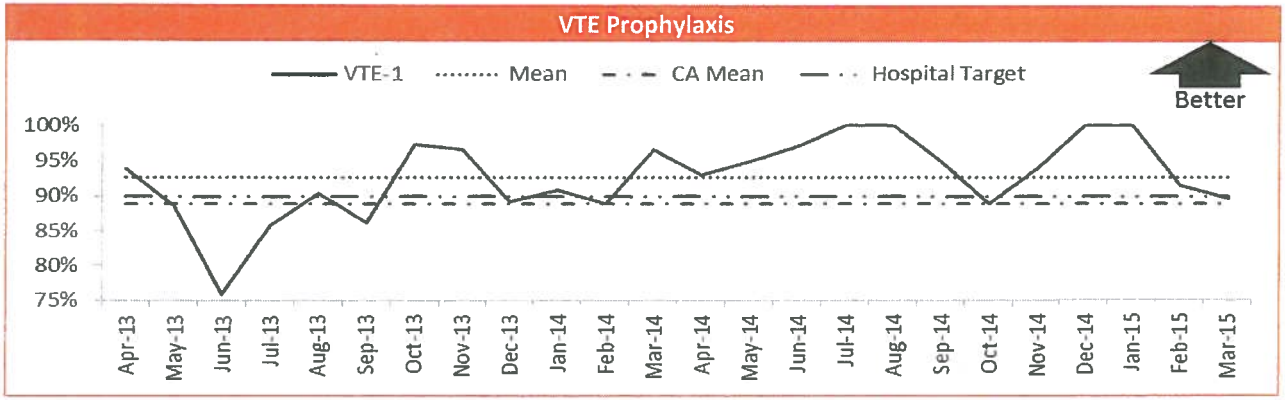
Influenza Immunization



Action Plan

Continue to monitor

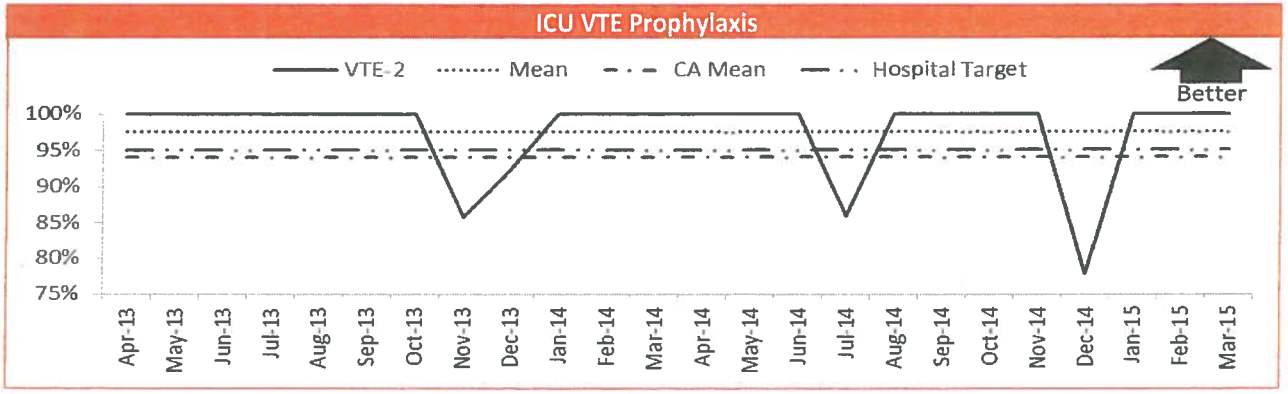
VTE Prophylaxis



Action Plan

Continue to monitor

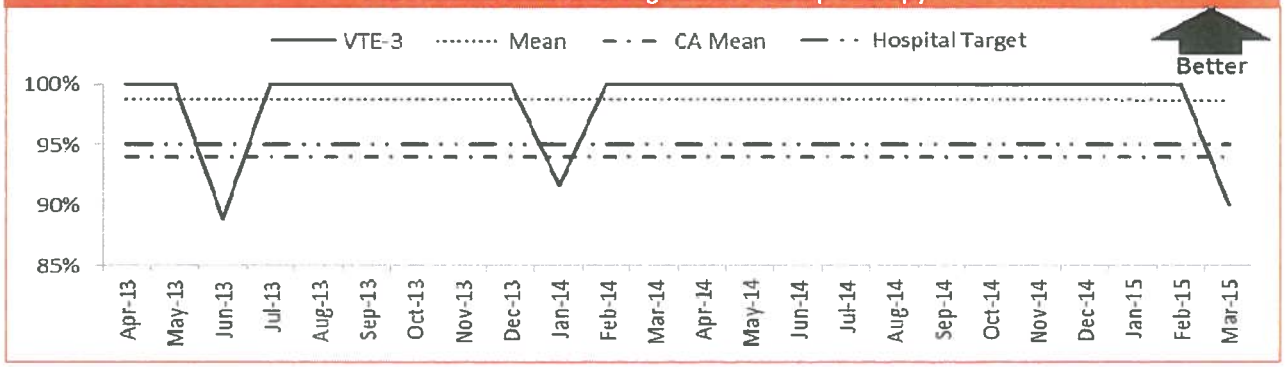
ICU VTE Prophylaxis



Action Plan

Continue to monitor

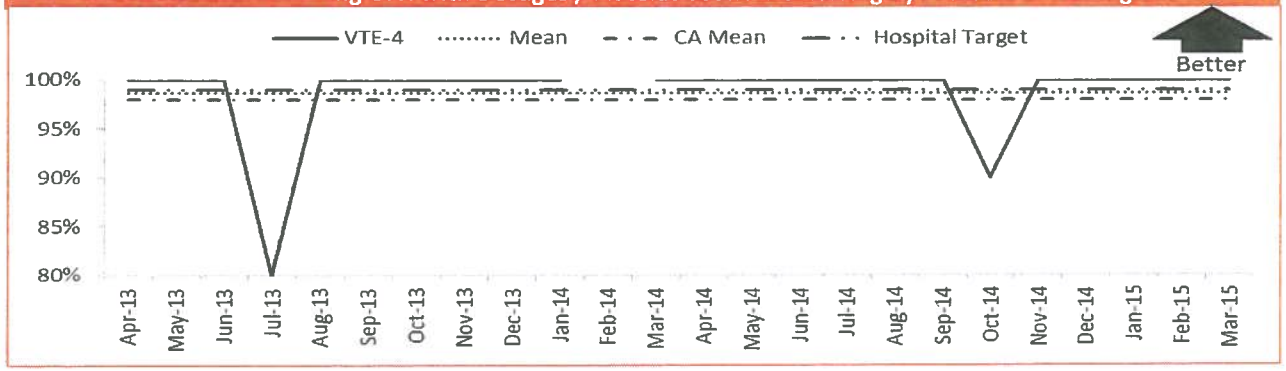
VTE Patients with Anticoagulation Overlap Therapy



Action Plan

First fall out in 12 months. Patient was discharged by a surgeon who was notified of the CMS guidelines.

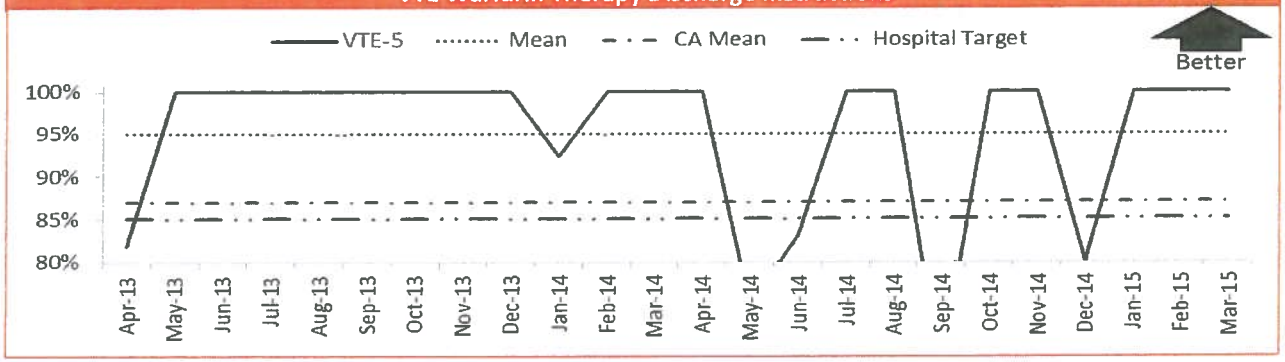
VTE Patients Receiving UFH with Dosages / Platelet Count Monitoring by Protocol or Nomogram



Action Plan

Continue to monitor

VTE Warfarin Therapy Discharge Instructions



Action Plan

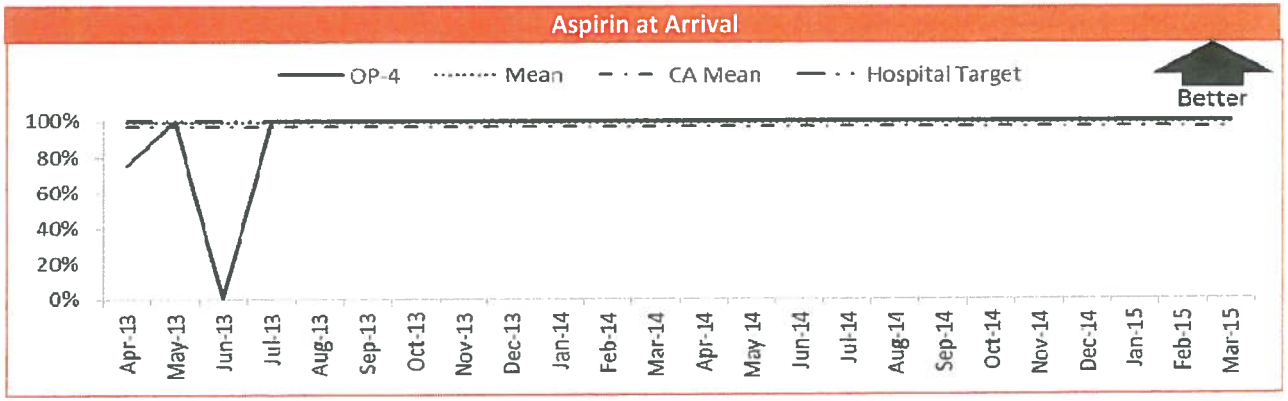
Continue to monitor

Hospital Acquired Potentially Preventable VTE

Action Plan

Continue to monitor

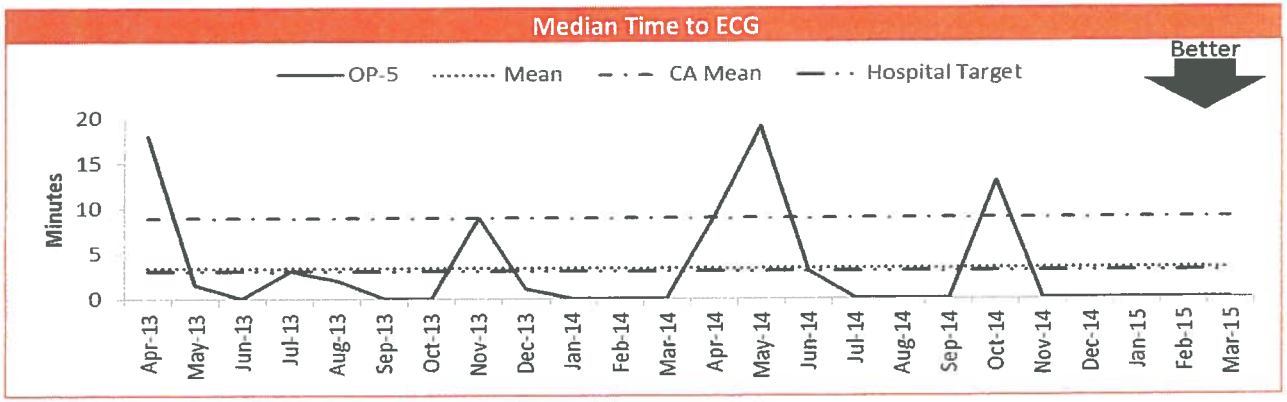
Aspirin at Arrival



Action Plan

Continue to monitor

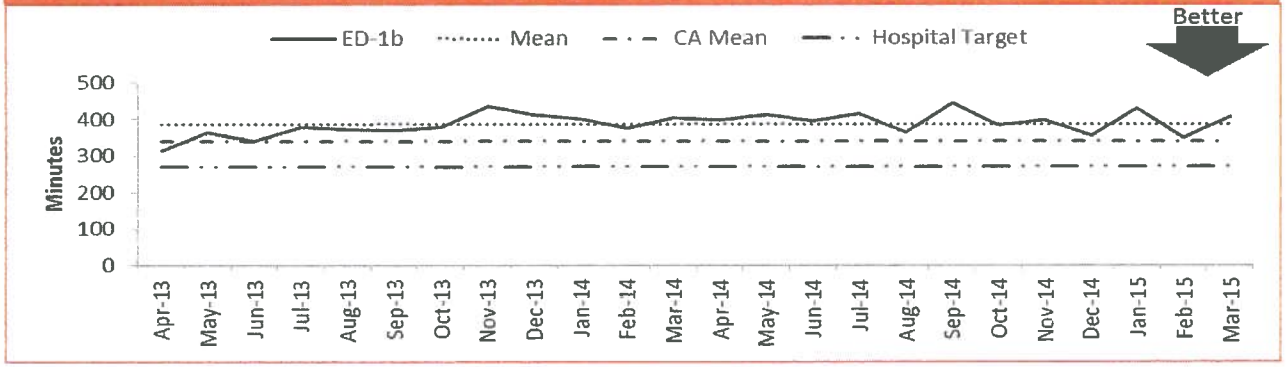
Median Time to ECG



Action Plan

Continue to monitor

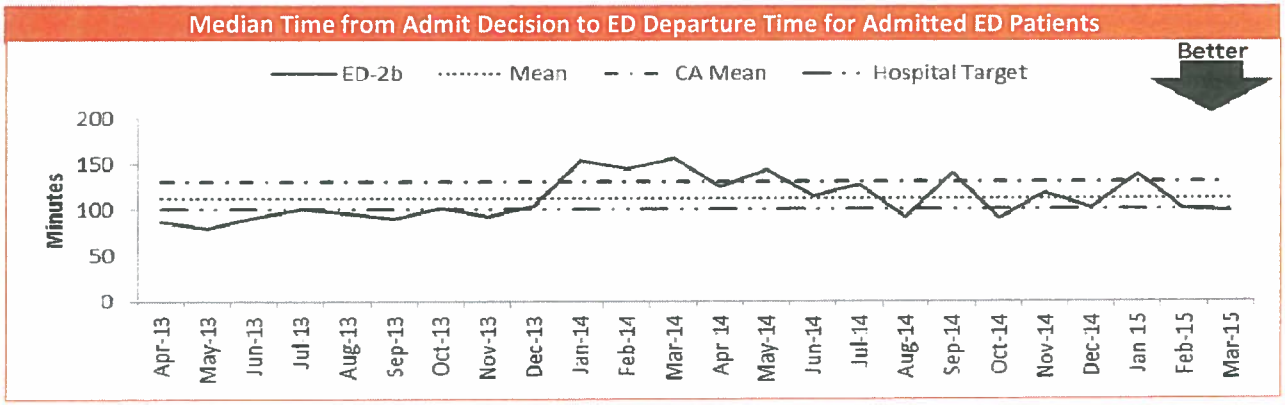
Median Time from ED Arrival to ED Departure for Admitted ED Patients



Action Plan

Being addressed intensively by ED Committee and Patient Throughput committee.

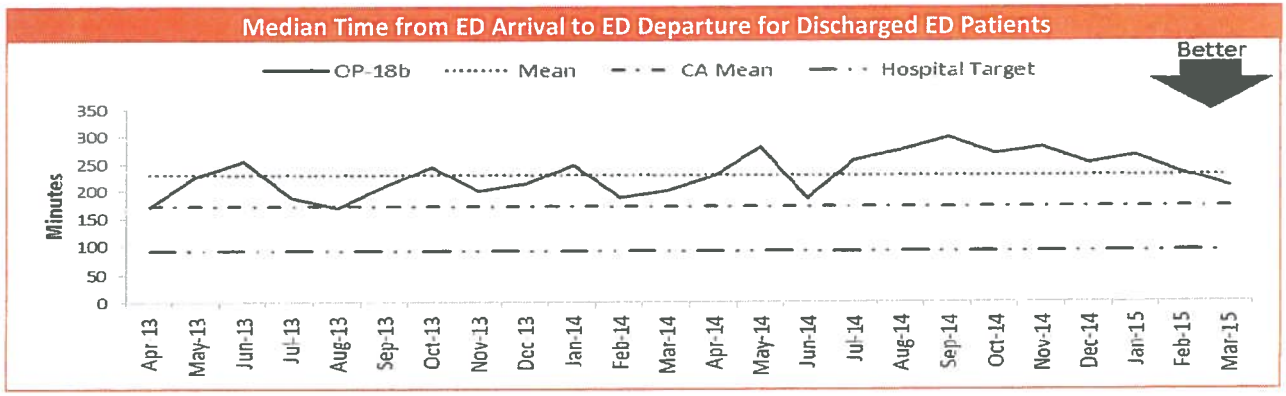
Median Time from Admit Decision to ED Departure Time for Admitted ED Patients



Action Plan

Continue to monitor

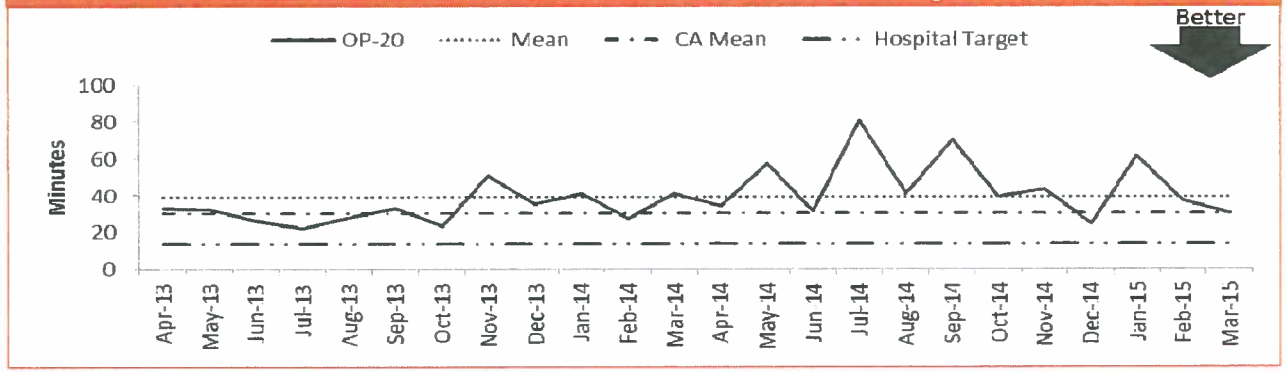
Median Time from ED Arrival to ED Departure for Discharged ED Patients



Action Plan

Being addressed intensively by ED Committee and Patieint Throughput committee.

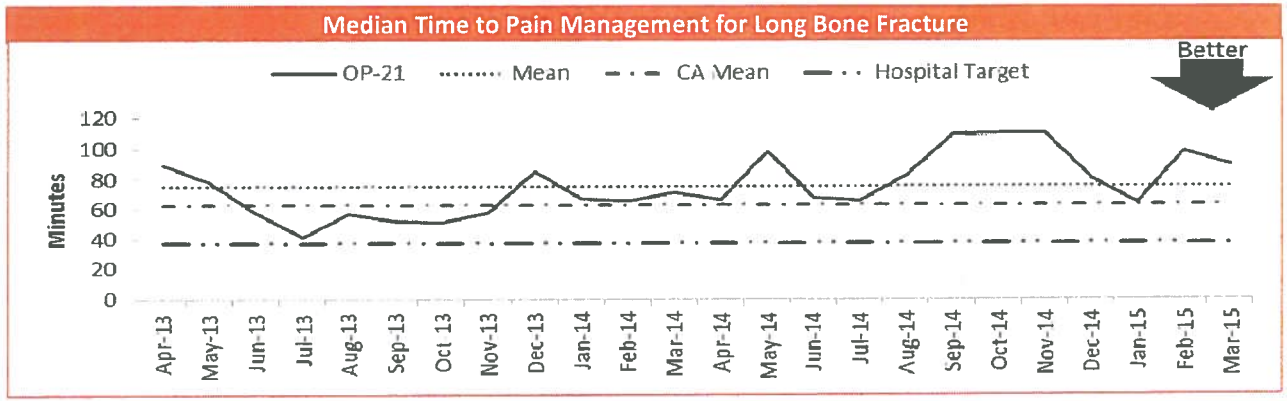
Median Time from ED Arrival to Provider Contact for ED Discharged Patients



Action Plan

Continue to monitor

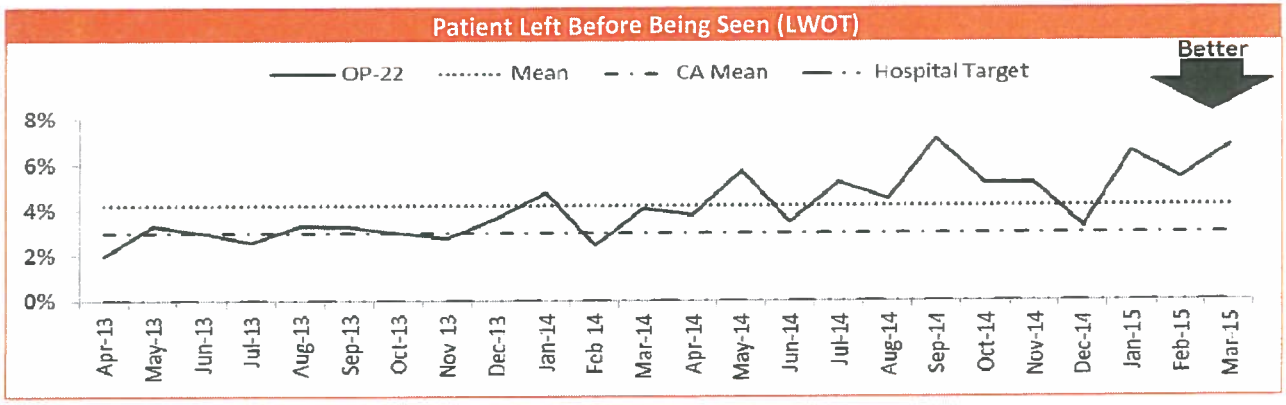
Median Time to Pain Management for Long Bone Fracture



Action Plan

Policy promoting earlier pain medication administration for Long Bone Fracture patients is awaiting approval by Med Exec then Board of Directors.

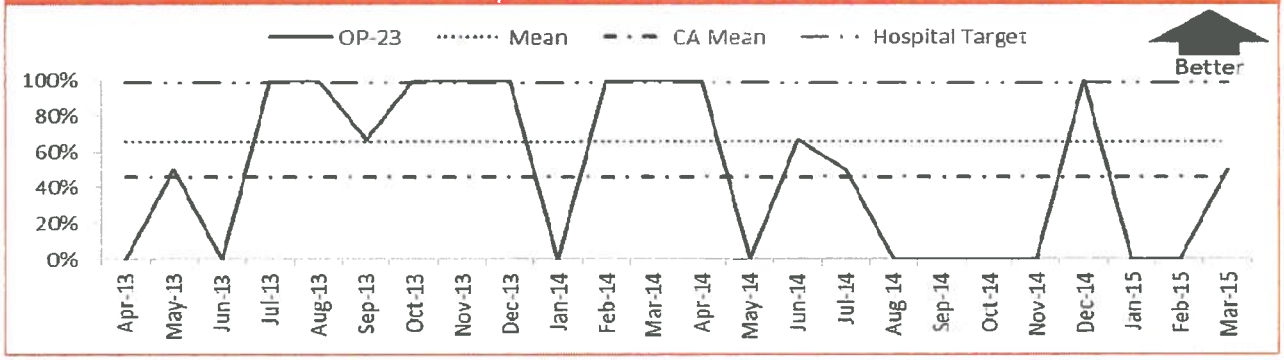
Patient Left Before Being Seen (LWOT)



Action Plan

Being addressed intensively by ED Committee and Patieint Throughput committee. Trial of MD in ED Triage area 3 days/week has been sucessful. Hoping to expand this program.

Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival



Action Plan

Continue to monitor

Employee Satisfaction

Partnership™
"Satisfaction + Engagement"
Mean = 66.1 (-1.0)
Percentile = 28th (from 13th)

Satisfaction
"what do I get?"
Mean = 61.9 (-1.2)
Percentile = 27th (from 13th)

Engagement
"what do I give?"
Mean = 71.8 (-0.5)
Percentile = 31st (from 12th)

National 90th Mean Scores

Partnership:	79.9
Satisfaction:	77.1
Engagement:	83.6

Voluntary Employee Turnover Rate (Annual Rate - Rolling Quarters)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY15
FY15			9.9%			10.2%			10.8%				
FY14			12.7%			12.7%			11.7%			11.8%	11.4%

Involuntary Employee Turnover Rate (Annual Rate - Rolling Quarters)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY15
FY15			1.9%			2.3%			3.3%				
FY14			8.6%			8.4%			6.8%			3.2%	3.2%

HCAHPS (Top Box Score)

Hospital Consumer Assessment of Healthcare Providers & Systems

Benchmark Source: Hospital Compare

Benchmark Period: 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%	61%					71%	76%	73%	76%	68%	71%
FY14	60%	63%	58%	71%	65%	75%	61%	64%	64%	63%	65%	59%	64%						

Performance compared to prior year: Better Same Worse

"Recommend The Hospital"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	73%	69%	66%	61%	57%	61%	65%	63%	60%					77%	79%	79%	80%	70%	71%
FY14	63%	67%	67%	78%	65%	77%	65%	69%	65%	61%	72%	64%	68%						

"Communication with Nurses"

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

"Communication with Doctors"

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

"Response of Hospital Staff"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	63%	76%	74%	62%	62%	72%	71%	52%	62%					63%	62%	66%	64%	62%	68%
FY14	63%	65%	66%	72%	69%	73%	64%	62%	61%	64%	68%	56%	65%						

"Hospital Environment"

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

"Pain Management"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	74%	68%	68%	66%	64%	69%	72%	68%	62%					70%	71%	70%	76%	69%	71%
FY14	75%	60%	73%	76%	71%	76%	75%	70%	63%	60%	66%	64%	68%						

Performance compared to prior year: Better Same Worse

"Communication about Medicines"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	65%	63%	59%	64%	56%	54%	62%	56%	60%										
FY14	65%	64%	61%	62%	56%	69%	65%	53%	55%	52%	62%	62%	60%	64%	63%	62%	65%	61%	64%

"Discharge Information"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	88%	81%	86%	85%	82%	84%	88%	88%	91%										
FY14	85%	80%	76%	84%	79%	88%	80%	77%	86%	80%	89%	86%	83%	84%	81%	87%	83%	84%	86%

Performance compared to prior year: Better Same Worse

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg	Goal Range
FY15	46.3	48.8	47.9	48.9	49.0	48.9	51.0	50.6	50.6	51.0			49.4	48-52
FY14	49.0	48.7	48.0	49.9	51.3	52.5	53.2	50.3	48.2	48.1	49.1	48.3	49.7	48-52

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg	Goal Range
FY15	78.1	77.1	81.2	77.9	79.5	77.6	79.5	77.0	84.3	82.6			79.5	75-100
FY14	78.0	87.4	90.8	90.5	91.5	89.8	82.8	73.4	87.4	83.3	81.1	75.2	84.3	75-100

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budget
FY15	$368	($348)	$112	$568	$556	$632	$198	$370	$292	$343			$3,091	$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%	1.22%			1.11%	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	$1,620			$16,332	$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%	5.76%			5.88%	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	6.17			6.05	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	1.51				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	$17.8			
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	35			372
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			180
FY14	14	7	13	17	16	16	12	18	19	19	16	14	181

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	6	10	9	8	12	11	9	7	16	14			102
FY14	5	8	8	9	9	13	9	7	9	8	7	11	103

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	10	7	10	12	13	7	11	8	9	21			108
FY14	14	10	15	4	16	16	10	10	12	7	14	9	137

Performance compared to prior year: Better Same Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	45	51	32	43	49	27	33	43	37	39			399
FY14	20	41	27	35	44	32	50	33	29	38	35	35	419

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	23.3	26.5	27.1	21.2	22.8	19.1	18.3	17.5	19.6	16.9			21.3
FY14	19.3	21.7	22.0	17.6	19.8	19.9	18.1	22.4	24.3	21.3	21.9	24.9	21.1

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	5.2	3.5	4.3	5.0	4.3	7.2	7.0	6.0	6.5	5.1			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	13.9			16.9
FY14	12.4	13.5	16.7	19.3	16.0	16.8	17.2	18.6	10.1	11.0	12.1	14.0	14.8

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	190.8	195.0	195.1	195.6	189.2	187.9	203.3	199.8	188.0	186.3			193.1
FY14	181.9	179.2	184.2	197.9	188.6	196.4	202.2	210.9	187.7	193.1	198.1	199.0	193.1

Performance compared to prior year: Better Same Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	246	263	244	233	194	233	199	159	208	186			2165
FY14	226	223	237	229	224	220	229	188	177	208	218	197	2576

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	16	19	12	19	17	11	15	8	12	22			151
FY14	22	15	18	18	15	18	27	11	20	14	12	16	206

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	4	6	2	1	4	8	1	15	4	3			48
FY14	7	10	8	12	13	5	12	7	13	8	9	2	106

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	10	9	10	10	12	12	12	5	12	10			102
FY14	6	9	12	11	9	6	10	15	10	7	12	16	123

TCMC Adjusted Factor (Total Revenue/IP Revenue)

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

Building Operating Leases
Month Ending April 30, 2015

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term Ending	Services & Location	Cost Center
Gary A. Colner & Kathryn Ainsworth-Colner Family Trust 4913 Colusa Dr. Oceanside, Ca 92056 V#79235	1,650	$1.85	(a)	$ 4,149.39	8/1/12	7/31/15	**Dr Dhruvil Gandhi** 2095 West Vista Way,Ste.106 Vista, Ca 92083	8460
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.50	(a)	$ 18,600.00	2/1/15	10/31/18	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA	7090
Tri-City Wellness, LLC 6250 El Camino Real Carlsbad, CA 92009 V#80388	Approx 87,000	$4.08	(a)	$ 232,282.00	7/1/13	6/30/28	**Wellness Center** 6250 El Camino Real Carlsbad, CA 92009	7760
GCO 3621 Vista Way Oceanside, CA 92056 #V81473	1,583	$1.50	(a)	$ 3,398.15	1/1/13	12/31/15	**Performance Improvement** 3927 Waring Road, Ste.D Oceanside, Ca 92056	8756
Golden Eagle Mgmt 2775 Via De La Valle, Ste 200 Del Mar, CA 92014 V#81553	4,307	$0.95	(a)	$ 5,840.31	5/1/13	4/30/18	**Nifty After Fifty** 3861 Mission Ave, Ste B25 Oceanside, CA 92054	9551
Investors Property Mgmt. Group c/o Levitt Family Trust 2181 El Camino Real, Ste. 206 Oceanside, Ca 92054 V#81028	5,214	$1.65	(a)	$ 9,126.93	9/1/12	8/31/17	**OP Physical Therapy, OP OT & OP Speech Therapy** 2124 E. El Camino Real, Ste.100 Oceanside, Ca 92054	7772 - 76% 7792 - 12% 7782 - 12%
Melrose Plaza Complex, LP c/o Five K Management, Inc. PO Box 2522 La Jolla, CA 92038 V#43849	7,247	$1.22	(a)	$ 9,811.17	7/1/11	7/1/16	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083	7320
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 V#81250	4,760	$3.55	(a)	$ 22,900.00	10/1/12	10/1/22	**Chemotherapy/Infusion Oncology Office** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
Ridgeway/Bradford CA LP DBA: Vista Town Center PO Box 19068 irvine, CA 92663 V#81503	3,307	$1.10	(a)	$ 4,936.59	10/28/13	3/3/18	**Nifty after Fifty** 510 Hacienda Drive Suite 108-A Vista, CA 92081	9550
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	6,123	$1.37		$ 8,029.53	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		$ 12,877.60	1/1/12	12/31/16	**Vacant Bank Building Property** 4000 Vista Way Oceanside, Ca 92056	8462 Until operational
Total				**$ 331,951.67**				

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

Education & Travel Expense
Month Ending April 30, 2015

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6070	RNC RENEWAL	41615	282.32	78692	APRIL MCDONALD
6150	CAPRA CONFERENCE	22715	1,072.74	28865	RACHEL S GARCIA
6171	ONCOLOGY NURSING	12115	139.00	81815	PEI LIN LU
6183	FAILSAFE PROGRAM	164840	625.00	82368	MICHAEL CINI, CHANNGHIA LE
6185	FAILSAFE PROGRAM	164840	625.00	82368	WINNIFRED GAKUYA, ANNA DELIGHT
6186	FAILSAFE PROGRAM	164840	625.00	82368	JENESSA FRENCH
7290	CAHSAH WORKSHOP	30415EXP2	405.00	14369	CHRISTEN FARRELL
7420	CNDR CERTIFICATE	12315	315.00	37803	JACQUELINE KAHL
7420	MOSBEY SKILLS PERIOP EDUC	2192	4,220.00	26185	SURGERY DEPT
7427	POST ANESTHESIA	30615	194.00	80382	TERI HANSEN
7428	RECERT CPAN	30915	315.00	80547	ALYCE BUDDE
7781	LSVT RENEWAL PROGRAM	21015	150.00	81617	CATHERINE FRAMNESS
7781	NEUROMUSCULAR DISORDERS	30315	189.99	81617	CATHERINE FRAMNESS
8480	CERNER REGULATIONS	42115	1,011.70	19327	KIMBERLY COOK
8610	VHA WEST COAST	33115	231.92	82114	TIM MORAN
8610	CHA HEALTH POLICY	40115	1,286.73	82114	TIM MORAN
8620	AHA MTG - FLIGHT	33115	667.00	81163	DAGOSTINO, JAMES
8620	AHA ANNUAL MEMBERSHIP MTG	33115	801.00	81163	DAGOSTINO, JAMES
8620	ACHD 2015 ANNUAL MTG	33115	800.00	81163	MITCHELL, LAURA
8620	ACHD 2015 LEGLISTIVE DAY	33115	225.00	81163	NYGAARD, JULIE
8620	ACHD 2015 ANNUAL MTG	33115	800.00	81163	NYGAARD, JULIE
8620	AHA ANNUAL MEMBERSHIP MTG	33115	801.00	81163	SCHALLOCK, LARRY
8620	CA CONGRESSIONAL ACTION PRGM	33115	395.00	81163	SCHALLOCK, LARRY
8700	MEDICAL RECORDS	226152	225.00	15106	LEILIANI SAGALE
8700	MEDICAL RECORDS	22615	225.00	15106	TERRI HARTZELL
8700	CLARIFY TIMELINES	22615	988.85	71807	COLLEEN M THOMPSON
8710	CAMSS FORUM	21915	650.00	80940	MARIA KOZINA
8720	CAPRA CONFERENCE	22615	1,420.84	81883	MEREBETH RICHINS
8740	ACLS RENEWAL	33115	100.00	79898	MICHAEL CINI
8740	CHEMOTHERAPY CONF	41715	139.00	80795	MARIA FATIMA MERCADO
8740	CHEMO CERTIFICATION	31315	139.00	82051	MARY JENNIFER CATACUTAN
8740	RADIOGRAPHY OF THE ARM	41715	147.95	79119	MICHAEL WHITBORD
8740	ACLS RENEWAL COURSE	31315	150.00	82392	BLASIUS AVI MANULLANG
8740	ACLS RENEWAL COURSE	41015	150.00	79144	MARIA A BAILEY
8740	ACLS RENEWAL COURSE	32015	150.00	48671	NANCY OKUN
8740	VASCULAR IMAGINING	31315	175.00	79285	KIMBERLY HENTLEY
8740	NACNS 2015 CONFERENCE	31315	200.00	82393	PEGGY HOLUB
8740	MARCH OF DIMES	33115	200.00	12303	YVONNE BERKENKOTTER-ICK
8758	APIC MEMBERSHIP	30315	215.00	79612	KERRY MORIARTY HORNSY

**This report shows payments and/or reimbursements to employees and Board Members in the Education & Travel expense category in excess of $100.00.
**Detailed backup is available from the Finance department upon request.

Name: Julie Nygaard
Date Filled Out 5-10-15

SEMINAR TITLE ACHD 63rd Annual Meeting

LOCATION: MONTEREY CA Date: May 6 to 8th

Identify reason for Attending: Education, Leadership and Effectiveness training

List the major/most important topics of the seminar with a brief explanation:

This year's theme was "Creating the Future of Health Care Districts". It focused on many of the major changes that are taking place right now. Of course, the major change is the focus on quality health care instead of quantity as a basis for payment. Keeping people in the hospital for as little time as possible is the new mantra. Community health care districts will become even more important in the future. It is very important that the whole community is involved in the health and well being of the community. Only 20 per cent of what makes up a healthy community is clinical care, 30 per cent is health behavior, and 40 percent is social and environmental. So we have little control and a lot of responsibility for the health and well being or our constituents.

We heard from Gyre Renwick, West Coast Head of Industry for Health Team, Google, Inc. He is responsible for managing Google's relationships with Health Care Clients. He could be interested in working with us on Behavior Health. They are looking for a project. He talked about how information is changing the future of health care both in the collection of information and also a new devices that will monitor us and report to doctors our daily health. It is a very interesting future that is out there. He talked about a new contact lens that would monitor blood pressure and chemistry and send immediate message to our physicians. Our job is to reduce cost, reduce hospital stays while increasing quality and patient experience.

Julianne Morth, RN MS CPPS gave a very interesting talk about quality and how important it is to the healing process. Safely and quality of care is our fiduciary responsibility. The half life of new medicines in less than two years. It is a lot to keep up with. Providing quality care is a scared trust.

Joesph Flesh is the founder of Purple Binder a internet data base system that is tailored to an individual community to provide timely information on services that are available to citizens in the community. It is easy to access and user friendly. It might be worth talking to him.

Last but not least Paul H Keckley, PH.D spoke about the Affordable Care Act and its impact on us. He writes a weekly health reform newsletter, Pulse Weekly keeping up on what is happening in Washington. He said the ACA is full of problems and that it is a work in progress which is not going away. Seven out of ten millennials are leaning toward a single payer form of health care but no politician will touch it. Voter opinion my change in the future.

This was a very good conference looking towards the future of health care, very comprehensive.. I learned a lot.

Laura E. Mitchell

Evaluation

Association of California Hospital Districts
Annual Meeting
May 6-8, 2015
Monterey, CA

The theme of the conference was *Creating the Healthcare District of the Future.*

Day 1:

Delivery System Reform, presented by David Sayen who formerly was with the Center for Medicare and Medicaid. He described the 4 goals of CMS: better care at lower costs; population health (e.g. Public Health); expanded healthcare; and enterprise excellence.

Coalition Building—Risks and Rewards, presented by Kelly Brooks-Lindsey and Jean Kinney Hurst (Hurst Brooks Espinosa). They discussed local level activities (achieving community goals) and state level activities (achieving a political objective). The presenters talked about breaking out of silos and using the Collective Impact Model: common agenda; shared measurement; mutually reinforcing activities; continuous communication; and backbone support (separate organizations and staff).

Impressions: Both sessions were lively and engaging and I would definitely like to hear the presenters again. The information was presented well and in easily understood language.

Day 2:

There were two presentations in the morning. A panel discussion about *Governance and Community Engagement.* Desert Hospital (Coachella Valley) developed a program to teach children how to swim by the age of nine. The reason for this was the numerous irrigation canals in the area and the high risk for drowning. The program is now being done in conjunction with the local parks and recreation department. This was followed by ACHD business (e.g. electing officers).

I attended the following breakout sessions in the afternoon:

Virtual Doctor's Visits—Advances in Telehealth and Technology Strategies for Payers. Both sessions were very interesting and thought provoking.

Advances in Telehealth presented a system where the patient and the physician were able to communicate directly via a Skype type system. The practitioner with

the patient could do things like use a stethoscope and the physician at the other end would be hearing the same thing the practitioner at the bedside was hearing.

The second sessions was more about insurance and reimbursement and I found it interesting but not as interesting as the telehealth (personal bias as a nurse).

Day 3:

Building Healthy Communities—The role of Social Factors and Population health.

While the topic was of great interest to me (e.g. chronic care management, socioeconomic factors), the presenter seemed ill at ease although he was well prepared.

The Affordable Care Act—The Last Four Years was presented by a very engaging and down to earth speaker who cleared up much of my confusion regarding the ACA. He grabbed a microphone and proceeded to work the room.

Overall, I learned a great deal as a new board member and would like to attend again next year.

CONFERENCE EVALUATION FORM

CONFERENCE TITLE: AHA ANNUAL MEETING DATE: MAY 3 – 6, 2015
LOCATION: WASHINGTON, DC

REASON TO ATTEND:
To attend national conference on current healthcare issues and also to discuss those concerns with our elected representatives and their staff.

IMPORTANT TOPICS AND SPEAKERS:

First on the agenda was the recognition of the Tri-City Hospital Auxiliary with a national award. One of 4 auxiliaries to receive this recognition, Sandy Tucker – President of the Auxiliary – presented the "Tails on the Trails" program as an activity of fund raising for the Pet Therapy program at the hospital. In addition, she talked about the monies donated for scholarship programs for nursing and other educational programs. The gift giving to the hospital for various projects and equipment in the hospital was discussed. I know Director Dagostino and myself were very proud to have the opportunity to be present for this recognition of the many hours of service that the auxilians provide to their fellow citizens in the Tri-City area.

Dr. Tom Frieden, head of the CDC, spoke about the public health challenges with new and increasing resistant organisms to antibiotics. The challenges faced by healthcare workers to treat Ebola, c. difficile or even measles continues to be increasing. It is necessary to detect the problem early, respond quickly and prevent the spread. He re-iterated that basic handwashing is the easiest and best way to avoid spread. There will be more crisis like the recent Ebola outbreak and each facility has to have a basic plan that is in place and utilized with every person who comes in the door seeking treatment.

Jamie Orlikoff was a speaker on Patient Safety and Quality Outcomes. He stated that while there has been a decline in some hospital associated infections others such as urinary tract infections have increased in the past few years. He challenged Board members to know and understand what is safety and quality throughout the hospital. In the handouts are some items that there should be awareness as part of how the hospital QA functions. As an example, he suggested Board members go the surgery suite, gown up and see what the steps are in preparation for a surgical case. He specifically cited instances of wrong site surgeries and seeing what is supposed to happen so that there is not a "never event". One Board member challenged this approach as micro-management but the response was that if the "never event" does happen, the Board is the entity ultimately held accountable by regulatory agencies.

Included in the packet, is a brochure on the 2014 National Health Care Governance Survey. One session was spent discussing the data and at some point our Board may choose to have further discussion in a workshop.

When visiting the legislators offices, a packet of legislation and proposed healthcare topics were discussed. That information is included with this Board packet. Of particular interest were the discussion on RAC audit changes. Currently firms are hired to review short-term billing on Medicare. If the firm disagrees with the billing, payments are held up and the hospital can appeal. The firms receives a fee of 9-12% for any perceived overbilling. Currently in San Diego area (and nationally) these appeals are being granted in the hospitals favor 65-75% of the time. The evaluating firm still is allowed to keep their fee. Legislation is proposed to make the fee a fixed amount and also to have the review based on the information at the time of the billing—not some later date with different information.

The 30-day readmission policy is also under scrutiny. Once a patient leaves the hospital, it has no control over the patient's circumstances in MD follow-up, obtaining and taking medications and other lifestyle situations. Yet if the patient is readmitted in 30 days for select conditions, the hospital can be penalized financially.

Behavioral/Mental Health funding was also on the table for discussion. While Tri-City has been discussing this issue for some time, it is a national concern and any federal funding to address the problem is desired.

This time was my first since going to these meetings that members from our delegation were invited to attend meetings with Senator Boxer or Feinstein. Both Director Dagostino and I attended the session with Sen. Boxer's healthcare staff.

My last comment is that there were about 40 individuals that made up the California delegation to this meeting. Only Director Dagostino and myself were Board members either elected or appointed. There seems to be a direction that hospitals have a Governmental Affairs person on their Administrative staff that does this work. I personally feel that the Board members bring another point of view that is of value to the discussions which take place.

Larry W. Schallock

Medicare Might Become Congress's Favorite Piggy Bank

Lobbying groups fear that the program will be raided whenever lawmakers need cash

BY DYLAN SCOTT
NATIONAL JOURNAL

For a long time, one of Congress's unwritten rules held that lawmakers should try to avoid cutting Medicare to pay for other programs unrelated to health care. That axiom has been flouted in recent years, and a law signed by President Obama just days ago could push it further into the past.

Congress has proposed a $700 million Medicare cut to help pay for extending the Trade Adjustment Assistance program, which funds job training and placement for American workers who have lost their jobs because of foreign trade, into 2021. The bill, a Democratic priority, is moving in tandem with the more high-profile fast-track trade authority bill, part of a deal negotiated by Democratic Sen. Ron Wyden with two top Republicans, Sen. Orrin Hatch and Rep. Paul Ryan.

The size of the cut is a relative drop in the bucket for a program that currently spends about $600 billion annually, but the trade bill still represents a worrisome precedent for lobbying groups because it would use Medicare cuts to pay for non-Medicare-related spending. There is a small health care component to the bill, but it costs much less than the $700 million in offsets taken from the insurance program.

"The thinking behind that is we need to find a way to pay for it," said GOP Rep. Dave Reichert, who introduced the TAA bill in the lower chamber. "It's tough to find pay-fors, so we work hard to find a way to pay for it, and that's what we came up with."

This isn't the first time that Congress has proposed cutting Medicare to fund other programs, but lobbying groups with Medicare interests are scared it will become more and more routine.

Lawmakers approved $1.2 billion in Medicare reductions to help pay for tax-preferred savings accounts for disabled people during last year's lame-duck session. The 2013 Ryan-Murray budget agreement also incorporated some offsets from the program.

One health care lobbyist, who asked to remain anonymous, said Congress is using Medicare as a "f--king piggy bank" to pay for the trade bill, repeatedly pointing out that the insurance program is funded by taxes specifically earmarked for it.

A coalition of provider groups, including the powerful doctor and hospital lobbies, lamented in a letter to senators last week that the trade bill would set "a precedent that we believe is unwise" because it uses "Medicare cuts to pay for non-Medicare related legislation." A seniors' group, the National Committee to Preserve Social Security and Medicare, warned that "the current course being plotted by Congress will lead to a death by a thousand cuts."

The new problem for those who want to protect Medicare cash is, ironically, the "doc fix" deal that Congress overwhelmingly passed this month and many special interests had long sought, which repealed the "sustainable growth rate" formula for physician payments. Before that deal, lobbyists could argue that Congress needed to save any potential Medicare offsets to pay for a temporary or permanent doc-fix patch

that would avert deep payment cuts to doctors, said Julius Hobson, a health care lobbyist with the Polsinelli law firm. The permanent fix costs $210 billion over 10 years.

But that's no longer an issue, and the trade bill signaled to K Street that Congress is becoming more comfortable turning to Medicare to pay for other programs. "Now what you're trying to do is get them to stop," Hobson said.

"It's certainly possible this will happen more and more in the post-SGR world," said Loren Adler, research director at the Committee for a Responsible Federal Budget, which focuses on deficit reduction and entitlement reform.

Part of the reason, he said, is that Congress has already "cut pretty close to the bone" in other areas of the federal budget. That means Medicare, which spends a lot of money but which Congress has historically been reluctant to touch, is becoming a more likely place for lawmakers to find savings.

"Hence they're now turning to Medicare, which, though popular, also presents a lot of opportunities to find savings in not overly controversial ways," Adler said. The cuts in the trade bill, which would increase the 2011 automatic budget cuts known as sequestration in fiscal year 2024, would reduce reimbursements to providers but not directly affect beneficiaries. The latter would be much more of a political risk.

The trade bill presents Democrats with a thorny problem that could recur as long as the GOP controls Congress: They are loathe to vote for any Medicare cuts, but they are also big proponents of TAA; Republicans are more ambivalent about the program. Democratic Sen. Robert Casey described it as a "take-it-or-leave-it" scenario.

It is still possible that House Republicans could negotiate with Democrats to either lessen or eliminate the Medicare cuts in the trade bill, Reichert said. Democratic Sen. Mark Warner has floated an amendment that would swap the Medicare cuts for tougher real-estate tax-reporting requirements that would increase revenue, and Warner told *National Journal* that he thought it would attract bipartisan support if it came up for a vote.

Reichert also emphasized that the cuts wouldn't take effect until the second half of fiscal year 2024. "There's a lot of things that Congress does between 2015 and 2024," he said. "That's 10 years away."

But the long timeline wasn't much solace to those on the other side of the aisle wary of making it a habit.

"Everybody says we'll deal with them when we get there, and then all of a sudden we're there and you have deeper cuts," said Democratic Sen. Ben Cardin. "It's not good."

California Hospital Summary Report

CALIFORNIA HOSPITAL ASSOCIATION

Darrell Issa (R)

Congressional District 49 — 114th Congress

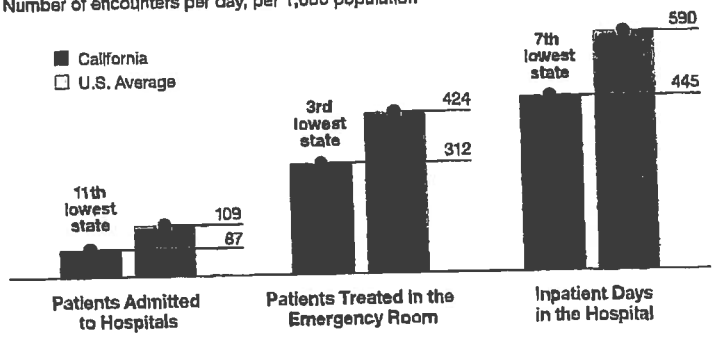
Calendar Year	2010	2011	2012	2013	2014
Number of Full Time Employees	4,532	4,670	4,502	4,485	4,485
Licensed Beds	770	776	776	782	818
Staffed Beds	547	561	500	497	477
Births	4,803	4,203	4,300	4,559	4,566
Patient Days	159,810	160,749	156,787	154,862	158,527
Acute Days	144,808	145,002	140,550	138,838	142,123
Psych Days	5,940	5,996	6,324	6,125	6,270
Chemical Dependency Days	0	0	0	0	0
Rehab Days	9,061	9,751	9,913	9,900	10,134
Long Term Care Days	0	0	0	0	0
% Acute Days	91%	90%	90%	90%	90%
% All Other Days	9%	10%	10%	10%	10%
Outpatient Visits	380,736	387,748	405,026	413,744	402,285
ER Visits	120,553	131,236	141,569	125,492	122,017
Clinic Visits	9,488	7,978	8,970	6,940	6,748
% ER Visits	32%	34%	35%	30%	30%
% All Other Visits	68%	66%	65%	70%	70%
Payer Mix					
Medicare	49.8%	49.8%	49.6%	50.2%	49.6%
Medi-Cal	7.5%	8.2%	8.0%	7.8%	10.9%
Indigent	2.4%	2.1%	2.5%	3.0%	1.3%
Commercial and All Others	40.3%	39.9%	39.8%	39.0%	38.1%
% Inpatient Volume	69%	68%	67%	65%	65%
% Outpatient Volume	31%	32%	33%	35%	35%

Congressional District 49 – Hospitals

- *CHOC Children's at Mission Hospital*
- *Scripps Green Hospital*
- *Scripps Memorial Hospital-Encinitas*
- *Tri-City Medical Center*

Californians' Lower Hospital Use = Lower Health Care Costs

Number of encounters per day, per 1,000 population



Source: American Hospital Association Hospital Statistics, 2014 Edition

Data Source: OSHPD Quarterly Data Files. Includes historical data, e.g., facilities that may have closed between 2010 and 2014.

California Hospital Profiles Report (2015)

Darrell E. Issa (R)

Congressional District 49 - 114th Congress

CALIFORNIA HOSPITAL ASSOCIATION

	System Affiliation	Urban or Rural	Beds	Health Care Services Offered	Total All-Payer Inpatient Acute Care Days	Total All-Payer Inpatient Acute Care Discharges	Total Medicare Revenue (2012)	Total Medicare Margin (2012)	Number of Workers Directly Employed by Hospital	Hospital Workers Salaries and Benefits	Hospital Workers Salaries and Benefits as a Percent of Total Operating Expenditures	Medicare Teaching Status	Medicare DSH Status	Special Medicare Status for Inpatient Services (2015)
California			**68,469**		**14,643,979**	**3,164,593**	**$15,819,687,579**	**-15.5%**	**405,713**	**$46,903,783,988**	**50.8%**			
Darrell E. Issa (R)			**667**		**144,137**	**34,748**	**$200,270,063**	**-18.6%**	**4,198**	**$414,086,649**	**47.2%**			
Children's Hospital At Mission	Not Affiliated	Urban	54	Outpatient	7,821	1,832	$358	-133.2%	89	$9,207,303	19.5%	Non-Teaching	No DSH	Children's Hospital
Scripps Green Hospital	Scripps Health	Urban	173	Inpatient, Outpatient	37,779	10,027	$79,223,254	-20.4%	1,255	$125,411,127	40.2%	Minor Teaching	No DSH	
Scripps Memorial Hospital-Encinitas	Scripps Health	Urban	125	Inpatient, Outpatient, Rehabilitation	33,803	8,721	$43,902,677	-26.8%	1,008	$105,269,217	46.9%	Non-Teaching	No DSH	
Tri-City Medical Center	Not Affiliated	Urban	315	Inpatient, Outpatient, Psychiatric, Rehabilitation, Home Health	64,734	14,168	$77,143,774	-12.0%	1,846	$174,199,002	53.9%	Minor Teaching	High DSH	

Notes:

Sources: Statistics and indicators shown in this report are mainly from the most recent (2011, 2012, or 2013) Medicare cost report obtained from the Healthcare Cost Report Information System (HCRIS) database. Cost report year(s) is determined based on the federal fiscal year (FFY) in which a given cost report begins (e.g., a '2013' cost report is one that begins between October 1, 2012 - September 31, 2013). This report incorporates data from the fourth quarter 2014 update to HCRIS database and includes 2012/2013 data for most hospitals. Impact Files and wage index tables as published by CMS are also utilized.

Blanks indicate instances when data is not available, reliable, or does not apply.

*Indicates that a hospital received a wage index reclassification, out-migration adjustment, or frontier state protection.

**Hospital's with special Medicare payment designations—such as Medicare Dependent Hospital (MDH) or Sole Community Hospital (SCH)—are identified for purposes of their payment designation only. The benefit of this designation is not determined as it relates to hospital-specific versus federal rate calculations.

† Does not include Medicaid or Medicare managed care.

Which of these 21 practices are reliably in place in your organization now?

How do you know?

To get a more complete answer to the question "How safe are we?," leaders must also ask:

- How well are we performing our key safety processes? (Reliability)
- How safe are we today? (Operational Awareness)
- How safe are we going to be tomorrow? (Anticipation and Preparedness)
- How well are we responding to past events? (Integration and Learning)

Vincent, Burnett, and Carthey: The Measurement and Monitoring of Safety. Health Foundation, 2013 UK NHS

Table Conversation:

- Where do key safety processes in YOUR organization fall on the reliability grid?
  - Hand washing?
  - Pre-procedural checklists?
  - Medicines management?
- WHY are these processes not more reliable?

Improvement Concepts Associated with 80-90% Reliability

- Common equipment
- Standard order sets
- Care protocols and pathways
- Written policies/procedures
- Personal check lists
- Feedback to individuals on compliance
- Exhortations to work harder, pay closer attention

Reality Rounds: A Leadership Practice to Improve Implementation of "Vertical' Processes

1. Pick a major safety practice critical to your aims for this year
2. Develop a scripted set of questions designed to expose operational barriers to implementation of that practice, and to drive positive feedback to staff who know and implement the practice
3. Commit the leadership team to round
   - CE 1 hour per month
   - Director 1 hour per week
   - Unit manager 1 hour per day
4. Fix the operational problems you learn about
5. Pick another safety practice, and repeat

Methods to Improve BOARD Oversight of Sensitivity to Operations

- Board members "Go to the Gemba" participate in Executive Safety Walk Rounds – discuss at board meetings
- Staff turnover and absenteeism reports
- Receive and routinely discuss indicators of culture of safety
- Receive and discuss specific examples of corrective action to identified safety issues

House-wide Daily Safety Briefings: A ***Superb*** Leadership Practice to Build "Sensitivity to Operations"

- 15 minute daily meeting of key operational leaders, led by Chief Executive
- Agenda:
  - Quick report on house-wide safety status: "It's been 31 days since our last Serious Safety Event and 5 Days since our last employee lost work day event."
  - Brief scripted report on any safety issues from each manager, including security, facilities, bio-med…
  - Brief follow-up on any previously identified urgent safety issues
- *Note: Generally works best around 830 or 9 am, allows managers to have their own "pre-huddles" with their teams.*
- ***Don't skip Saturday and Sunday!***
- ***Don't ignore nights!***

Sensitivity to Operations

- "Safety is a ***dynamic*** non-event" (Reason)
- Timely Sensing and Responding to
  - Ebbs and flows in volume
  - Staffing problems
  - "Organizational entropy"
  - Unexpected events
    - Equipment failure
    - Natural disaster
    - Epidemic

Patient Safety Processes Ready for Adoption: ***Strongly Encouraged***

1. Preoperative checklists and anesthesia checklists to prevent operative and postoperative events
2. Bundles that include checklists to prevent central line–associated bloodstream infections
3. Interventions to reduce urinary catheter use, including catheter reminders, stop orders, or nurse-initiated removal protocols
4. Bundles that include head-of-bed elevation, sedation vacations, oral care with chlorhexidine, and subglottic suctioning endotracheal tubes to prevent ventilator-associated pneumonia
5. Hand hygiene
6. The do-not-use list for hazardous abbreviations
7. Multicomponent interventions to reduce pressure ulcers
8. Barrier precautions to prevent health care–associated infections
9. Use of real-time ultrasonography for central line placement
10. Interventions to improve prophylaxis for venous thromboembolisms

http://archive.ahrq.gov/clinic/ptsafety

208

Patient Safety Processes Ready for Adoption: ***Encouraged***

1. Multicomponent interventions to reduce falls
2. Use of clinical pharmacists to reduce adverse drug events
3. Documentation of patient preferences for life-sustaining treatment
4. Obtaining informed consent to improve patients' understanding of the potential risks of procedures
5. Team training
6. Medication reconciliation
7. Practices to reduce radiation exposure from fluoroscopy and CT
8. The use of surgical outcome measurements and report cards, such as those from ACS NSQIP
9. Rapid-response systems
10. Use of complementary methods for detecting adverse events or medical errors to monitor for patient safety problems
11. Computerized provider order entry
12. Use of simulation exercises in patient safety efforts

http://archive.ahrq.gov/clinic/ptsafety

Safety Culture & Resilience Interpretation:

Two overall domains of interest:

- **Teamwork Climate** (interaction norms: <60% needs action)
- **Safety Climate** (pt safety norms: <60% needs action)

Three supporting domains:

- **Stress Recognition** (threat awareness/believability barometer: <40% needs action)
- **Resilience** (pace/intensity barometer: <60% needs action)
- **Work Life Balance** (self care norms: descriptive only/no threshold)

Safety Climate Scores Predict ***Clinical*** Outcomes

SAFETY CLIMATE RESULTS

Definition

The perceived level of commitment to and focus on patient safety within a given unit.

Items

1. I would feel safe being treated here as a patient.
2. Medical errors are handled appropriately in this clinical area.
3. I know the proper channels to direct questions regarding patient safety in this clinical area.
4. I receive appropriate feedback about my performance.
5. In this clinical area, it is difficult to discuss errors.
6. I am encouraged by my colleagues to report any patient safety concerns I may have.
7. The culture in this clinical area makes it easy to learn from the errors of others.

Intervention

Safety Climate scores typically predict clinical outcomes. When respondents report a low safety climate, they don't see a real dedication to safety in their work setting. Safety climate is significantly related to both caregiver safety (e.g,. needlesticks, back injuries) and patient safety (e.g,. bloodstream infections, decubitus ulcers) and so low safety climate is critical to address. During interventions, emphasize the importance of keeping lines of feedback and communication open. Let employees know that it is OK to bring errors to the attention of managers and clinical leaders. And, let managers and clinical leaders know that they need to be responsive to error reports and show appreciation for having errors brought to their attention.

DukeMedicine

Teamwork Scores Predict ***Operational*** Outcomes

Teamwork Climate: The perceived quality of teamwork and collaboration within a given unit.

Items

1. Nurse input is well received in this clinical area.
2. In this clinical area, it is difficult to speak up if I perceive a problem with patient care.
3. Disagreements in this clinical area are resolved appropriately (i.e., not who is right, but what is best for the patient).
4. I have the support I need from other personnel to care for patients.
5. It is easy for personnel here to ask questions when there is something that they do not understand.
6. The physicians and nurses here work together as a well-coordinated team.

Intervention

Teamwork Climate scores typically predict operational outcomes, such as staff turnover, delays, etc. A low teamwork climate stems from persistent interpersonal problems among the members of a given unit. If fewer than 60% report good teamwork climate, look at the teamwork items to see which aspect of teamwork pulled down the overall score: was it speaking up, conflict resolution, asking questions to clarify ambiguities, physician-nurse dynamics, etc? Rather than focus on teamwork in general, it is often better to focus on the particular aspect of teamwork that is the biggest struggle for frontline workers, e.g., speaking up with concerns.

To Sum up

- Leaders are responsible for everything in the organization, especially for what goes wrong.
- Leaders can and must ensure that safety is measured, monitored, and continually improved.
- Don't be satisfied with lagging indicators. Measure, monitor and respond to leading indicators.
- Ultimately, the board must lead the development of a strong culture of safety.

Every System is Perfectly Designed to Achieve Exactly the Results it Gets

CHA
California Congressional Action Program
2015

advocating for patients and your hospitals

Key Issue Papers

These papers provide an overview of the current top priorities for California hospitals. California's efforts to improve patient care and outcomes are at risk due to numerous existing and proposed cuts. Despite the rapid pace in which the system is changing under the Affordable Care Act, hospitals and health systems across state are committed to providing high quality, efficient and affordable health care to all Californians.

If you would like additional information on a topic, please contact:

Anne O'Rourke
CHA senior vice president,
federal relations
(202) 488-4494 org
aorourke@calhospital.org

Access to Services at Risk Due to Proposed Site-Neutral Payment Cuts

Improvements Needed in the Hospital Readmissions Program
Support H.R. 1343, S. 668

The Challenges of the Recovery Audit Contractor Program

Support Renewal of California's Five-Year Section 1115 "Medi-Cal 2020" Demonstration Waiver

The Impact of Cuts to California's Disproportionate Share Hospitals

Protect California's Rural Hospitals
Support S. 258/H.R. 169

Modernize the Behavioral Health Delivery System

California Hospitals – Supporting the Affordable Care Act's Goals to Ensure Expanded Coverage

CALIFORNIA HOSPITAL ASSOCIATION
Leadership in Health Policy and Advocacy

CHA
California
Congressional
Action Program
2015

advocating for patients
and your hospitals

Access to Services at Risk Due to Proposed Site-Neutral Payment Cuts

- If not developed carefully, site-neutral payments for services will significantly limit patients' access to care and place an undue burden on hospitals and physicians who care for the most vulnerable populations.
- Hospitals already lose money treating Medicare patients in the hospital outpatient department. Current total Medicare margins in FY 2015 are, on average, negative 9.0 percent and remain negative for the highest performing and efficient providers. Additional cuts will jeopardize patient access to care.
- Any recommendation for site-neutral payments must consider the reforms that are currently underway in the PPS systems. Many of the proposals put forward by MedPAC rely on outdated data and claims. Many of these recommendations will have adverse operational and financial implications for hospitals.

Issue

Recent proposals call for the development and implementation of site-neutral payment systems for Medicare fee-for-service patients. These proposals seek to equalize payments made to different providers for similar services. Under a site-neutral payment system, reimbursement would be determined by the service provided or the patient characteristics and needs, rather than by the care setting. Ideally, a site-neutral system would further align provider payments to support cost-effective, patient-centered care and to eliminate financial incentives to admit patients to more costly levels of care.

Position

If not developed carefully, site-neutral payments for services will significantly limit patients' access to care and place an undue burden on providers who care for the most vulnerable populations.

A successful site-neutral payment policy will adhere to the following principles:

Beneficiary Access Must Be Protected

Medicare beneficiaries require and deserve continued access to all levels of medically necessary care, including hospital-level care. The Medicare Payment Advisory Commission (MedPAC) has noted that in FY 2015, the average hospital will have an overall Medicare margin of negative 9.0 percent, and even relatively efficient providers will experience negative Medicare margins. More specifically, the American Hospital Association estimates that implementing site-neutral proposals for the evaluation and management (E&M) services alone would decrease hospital outpatient department (HOPD) margins to negative 14 percent. If fully implemented, margins would fall to negative 20 percent. Hospitals cannot continue to provide needed services at financial losses. Adopting such polices would jeopardize access to medically necessary care.

Provider Cost Differences Must Be Recognized and Reimbursed

Hospital-based providers have higher costs than non-hospital providers for a number of reasons. For example, as compared to other outpatient settings, HOPDs treat higher severity patients, operate with higher cost structures due to 24/7 emergency stand-by capacity, and incur higher costs associated with the many regulatory requirements, as compared to the physician office setting. To the extent that a payment system does not recognize and accommodate these very real, very costly differences, the result will be further destabilization and erosion of access to care.

Data and Analytics Support Must Be Comprehensive and Accurate

A successful site-neutral payment system will accurately match patient characteristics with resource needs and ensure reimbursement is sufficient to support the delivery of all medically necessary care.

(Continued on next page)

CALIFORNIA HOSPITAL ASSOCIATION

Access to Services at Risk Due to Proposed Site-Neutral Payment Cuts (cont.)

Contact:

Anne O'Rourke,
CHA senior vice president,
federal relations
(202) 488-4494 or
aorourke@calhospital.org

Re-Designed Payment Systems Must Include Regulatory Relief

Medicare providers are currently subject to myriad regulations, many of which are unique to a specific level of care or payment system (i.e., a three-day inpatient stay needed to qualify for skilled nursing facility care). While these regulations were originally developed to support appropriate resource use and access to care, any significant redesign of the reimbursement system must include relief from regulations that have become obsolete and interfere with, rather than support, clinical integration.

Analysis

Several recent proposals for site-neutral payment in both the acute and post-acute setting have been recommended by MedPAC and are under consideration by Congress. Specific provisions under consideration include the following:

- Paying hospitals for E&M services in the HOPD setting at the physician fee schedule (PFS) amount, thereby eliminating any facility fee and reducing the rate of the service provided. California hospitals would experience an estimated $1.24 billion cut in outpatient payments over nine years.
- Paying hospitals for 66 additional ambulatory payment classifications (APCs) at the PFS amount. The list of 66 APCs includes diagnostic tests, minor procedures and imaging services. California hospitals would experience an estimated $721 million cut in outpatient payments over nine years.
- Capping hospital payments for 12 additional APCs at the ambulatory surgical center rate. California hospitals would experience an estimated $757 million cut in hospital outpatient payments over nine years.
- Eliminate payment differences between inpatient rehabilitation facilities and skilled nursing payments for patients with certain specified diagnoses.

Notably, MedPAC has not reconsidered any of the above recommendations despite significant changes adopted by CMS in the CY 2013 outpatient prospective payment system. More specifically, the E&M clinic visit codes reflected five levels of resource intensity. CMS no longer recognizes these five levels and has adopted one payment for a clinic visit. Therefore, there is no more one-to-one coding match between the outpatient prospective payment system and the PFS to implement such a policy. In addition, CMS finalized its policy that identifies five new categories of items and services that are now packaged into the payment for other services in which they are integral, ancillary or supportive. These policy changes significantly impact the payment for the 66 APCs under consideration for site-neutral payment.

For post-acute care, the specific provisions under consideration include:

- Reduce inpatient rehabilitation facility rates to "skilled nursing facility (SNF)-like" levels for patients discharged for a general acute-care hospital with one of two conditions (major joint replacement and hip and femur fracture) who are clinically similar and commonly receive post-acute services in both inpatient rehabilitation facilities and SNFs. Notably, there would be no changes to the SNF payment system for these patients. Earlier this year, MedPAC expanded this policy proposal and recommended that the Secretary of the U.S. Department of Health and Human Services consider additional conditions in addition to major joint and hip and femur fractures to be included for site-neutral payment. MedPAC evaluated a list of 22 Medicare Severity Diagnosis Related Groupers (MS-DRGs) including a mix of orthopedic, cardiac and infections but made no specific condition recommendations, leaving this to the Secretary's discretion. California hospitals would experience a cut of $178 million over nine years if HHS were to proceed in adopting the additional conditions under consideration for the site-neutral policy.
- Set long-term care hospital (LTCH) base payment rates for non-chronically critically ill (CCI) cases equal to those of acute care hospitals and redistribute the savings from LTCH payments to create additional inpatient outlier payments for CCI cases in inpatient prospective payment system (PPS) hospitals. The change should be phased in over a three-year period from 2015 to 2017. While MedPAC acknowledges that significant changes to the LTCH PPS were recently adopted in the Bipartisan Budget Act of 2013, broadly reforming the LTCH PPS by implementing site-neutral payment rates for certain cases beginning in FY 2016, they have not reconsidered this specific recommendation.

CHA
California
Congressional
Action Program
2015

advocating for patients
and your hospitals

The Challenges of the Recovery Audit Contractor Program

- Legislation is needed to improve and streamline the RAC program and should focus on:
  - Removing perverse incentives to review excessive claims;
  - Eliminating the application of the one-year timely filing limit to denials based on patient status; and
  - Holding RACs accountable for their performance.

Issue

The Centers for Medicare & Medicaid Services (CMS) oversees four separate audit contractors focused on improving payment accuracy: Recovery Audit Contractors (RACs), Medicare Administrative Contractors (MACs), Supplemental Medical Review Contractors (SMRCs) and Comprehensive Error Rate Testing Contractors (CERTs). California's hospitals recognize the need for careful review to protect the integrity of the Medicare program; however, the flood of audit contractors has resulted in a surge of redundant audits, unmanageable medical record requests and erroneous payment denials. CHA is pleased with the recent administrative actions taken by CMS that will be implemented in the new round of RAC contracts to limit document requests to account for different claim types and hospital denial rates, allow hospitals 30 days to complete the discussion period before filing an appeal, and prevent RACs from collecting their contingency fees until after an appeal is upheld by a qualified independent contractor. However, additional action is necessary. While the current RAC contractors are continuing to review claims through 2015 under the previous scope of work until litigation is resolved, CMS needs to provide further oversight to ensure its auditing efforts are accurate, timely, transparent and administratively reasonable.

Position

CHA supports legislation to promote appropriate oversight and transparency of audit contractor programs. Legislative action is important to hospitals as they seek to provide high-quality care to all of their patients and act as responsible partners in the Medicare program.

Analysis

Hospitals are experiencing a significant number of inaccurate payment denials, particularly related to RACs. When California hospitals dedicate the time and resources necessary to appeal RAC decisions, they are successful in overturning RAC denials in nearly two out of three cases. Although California hospitals experience significant success in overturning RAC appeals, the average appeal in FY 2015 took nearly 600 days to complete. Because of the extensive time and resources it takes hospitals to appeal each case, many believed they had no other choice than to accept the CMS proposed settlement offer on patient status claims currently in the appeals process. However, despite hospitals settling a number of these cases for pennies on the dollar, the Office of Medicare Hearings and Appeals (OMHA) has not changed its current policy of temporarily suspending the assignment of new requests for at least 24 months for an Administrative Law Judge hearing for those cases that remain in the appeals process.

As previously noted, in December CMS released a number of RAC program changes that will only become effective in the signing of the new contracts, which remain stalled due to litigation initiated by the RACs.

(Continued on next page)

CALIFORNIA HOSPITAL ASSOCIATION

The Challenges of the Recovery Audit Contractor Program (cont.)

Contact:

Anne O'Rourke,
CHA senior vice president,
federal relations
(202) 488-4494 or
aorourke@calhospital.org

Planned legislation must go beyond these modest improvements and change the RAC contingency fee structure to a fixed payment like other Medicare contractors, and prohibits CMS from incorporating incentives into the contracts. It is vital to the integrity of the program to remove the incentives for the RACs to continue to request excessive numbers of medical records that they neither have the qualified staff nor expertise to review in the timelines set forth under the current contracts.

It is also important to implement sliding scale penalties for poor RAC performance, which would be defined as a denial overturn rate at or above 10 percent and require CMS to account in its methodology for the fact that denials and the resulting appeals rarely occur in the same year. This is particularly important as the RAC denial overturn rate can be misleading, and the length of time it takes to complete the appeals process must be factored in. Another important goal would be to eliminate the application of the one-year timely filing limit to denials based on patient status (inpatient admission denied as not reasonable and necessary) and allows providers to rebill within 180 days of a final determination, whether that is a denial by a Medicare contractor or an appeal decision. And finally, limit RACs to making medical necessity determinations only on the basis of the information available to the physician at the time of admission.

Currently, the RAC and MAC programs are permitted to have non-physician auditors review and deny care that a physician determined was medically necessary and to look at the entire medical record. The Medicare Audit Improvement Act of 2013 limits this review significantly.

CHA
California
Congressional
Action Program
2015

advocating for patients
and your hospitals

Improvements Needed in the Hospital Readmissions Program

Support H.R. 1343, S. 688

- The current readmissions program (HRRP) does not recognize that factors outside the hospitals' control have a dramatic influence on the likelihood of a patient returning to the hospital.
- H.R. 1343 and S. 688 would make important adjustments to the HRRP, and allow hospitals to continue to care for and protect their most vulnerable patients
- California's hospitals are committed to reducing preventable readmissions, and this legislation will enable hospitals to focus their efforts on making significant progress in reducing readmissions.

Contact:

Anne O'Rourke,
CHA senior vice president,
federal relations
(202) 488-4494 or
aorourke@calhospital.org

CALIFORNIA HOSPITAL ASSOCIATION

Issue

The Centers for Medicare & Medicaid Services (CMS) is required by the Hospital Readmissions Reduction Program (HRRP) to penalize hospitals for "excess" readmissions. Unfortunately, the current risk adjustment methodologies used by the HRRP do not recognize that factors outside the hospitals' control have a dramatic influence on the likelihood of a patient returning to the hospital. Access to community services and basic necessities, such as food and medicine, are a significant predictor of a patient's successful healing. Initial experience with the HRRP shows that hospitals caring for the poorest patients are most likely to have higher readmissions rates and incur the maximum penalty under the program.

Position

CHA supports H.R. 1343 and S. 688, the Establishing Beneficiary Equity in the Hospital Readmission Program Act. The bipartisan legislation is an important step toward ensuring that hospitals caring for our most vulnerable patients are not unfairly penalized under the HRRP. California's hospitals are committed to reducing preventable readmissions, and this legislation will enable hospitals to focus their efforts on making significant progress in reducing readmissions.

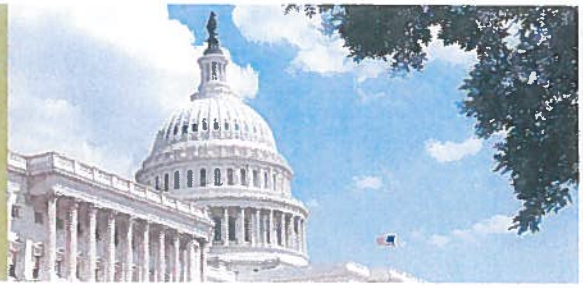
Analysis

There is a broad body of research that shows a clear link between higher readmission rates and markers of low socioeconomic status among hospital patient populations. In fact, both the Medicare Payment Advisory Commission (MedPAC) and the National Quality Forum have recognized the connection and support efforts to address this limitation within the HRRP. The research shows that disadvantaged populations struggle to access community resources — including primary care, mental health services, rehabilitation therapies and even medications — that are known to help prevent readmissions.

H.R. 1343 and S. 688 seek to exclude from the program certain types of patients who are highly likely to return to the hospital for a readmission due to the nature of their conditions. For transplant patients or those with end-stage renal disease or psychiatric disorders, readmissions are both common and necessary as part of delivering comprehensive, quality care; their hospitalizations are often planned, although they may be unrelated to the condition-specific readmission measure.

While California's hospitals are doing all they can to reduce preventable readmissions, the existing program unfairly penalizes hospitals for factors beyond their control and takes away critical resources from the hospitals and patients who need them most. This legislation addresses some of the limitations of the current readmissions measures and, in doing so, will provide a more accurate description of the quality of care provided by those hospitals.

CHA
California
Congressional
Action Program
2015



advocating for patients
and your hospitals

Support Renewal of California's Five-Year Section 1115 "Medi-Cal 2020" Demonstration Waiver

Support Renewal of California's Section 1115 "Medi-Cal 2020" Demonstration Waiver

- CMS' approval of the "Medi-Cal 2020" waiver is critical as it serves as the primary vehicle for continuing the necessary financing framework for the state's public hospitals.
- Medi-Cal — the largest Medicaid program in the nation — now serves over 12 million Californians. One in three Californians will depend on Medi-Cal for their all of their health care needs by 2017.

Contact:

Anne O'Rourke,
CHA senior vice president,
federal relations
(202) 488-4494 or
aorourke@calhospital.org

CALIFORNIA HOSPITAL ASSOCIATION

Issue

On March 27, California submitted its five-year Section 1115 "Medi-Cal 2020" Demonstration waiver renewal proposal to the Centers for Medicare & Medicaid Services (CMS) for approval by Nov. 1, 2015. California's existing five-year "Bridge to Reform" Demonstration waiver expires Oct. 31, 2015. California is requesting $17 billion in federal funds to facilitate delivery system transformation, support long-term sustainability of the Medi-Cal program and ensure the ongoing viability of the safety net, particularly for its remaining uninsured.

Position

CMS' approval of the "Medi-Cal 2020" waiver is critical as it serves as the primary vehicle for continuing the necessary financing framework for the state's designated public hospitals, including the safety net care pool and the Delivery System Reform Incentive Payments (DSRIP). California has led the nation with its historic coverage expansions. California's Medicaid program — Medi-Cal, the largest Medicaid program in the nation — now serves over 12 million Californians, meaning nearly one in three Californians now depend on Medi-Cal for all of their health care needs. While the ACA is expected to reduce California's uninsured rate by at least half, between 2.7 and 3.4 million Californians are projected to remain uninsured by 2019. The waiver remains a major source of funding for California's public hospitals and health systems, representing about 30 percent of their net Medi-Cal revenue. A renewed waiver that provides the same amount of federal funding for public hospitals is absolutely vital to allow them to continue serving some of California's most vulnerable populations.

Analysis

California's "Bridge to Reform" waiver supported California's successful implementation of the ACA's coverage expansions. California successfully transitioned approximately 650,000 individuals into the Medi-Cal program through its innovative Low Income Health Program. In addition, California created the first Delivery System Reform Incentive Payments Program (DSRIP) — a pay-for-performance program that has since been replicated in a number of other states. Because of the successes of the "Bridge to Reform" waiver, California is in a position to focus its efforts on other critical components of health care reform, such as expanding access, improving quality and outcomes, and controlling the cost of care.

Through its "Medi-Cal 2020" waiver renewal proposal, California aims to build on the approaches and successes of its existing waiver, with the goal of expanding and improving the Medi-Cal program through delivery and payment system transformation. Concepts included in the "Medi-Cal 2020" waiver renewal proposal are built around the core objectives of strengthening primary care delivery and access; avoiding unnecessary institutionalization and services by building the foundation for an integrated health care delivery system that incentivizes quality and efficiency; addressing social determinants of health; using the Medi-Cal program as an incubator to test innovative approaches to whole-person care; and addressing Medi-Cal workforce challenges. By 2020, California aims to have a more accountable and sustainable Medi-Cal program for Medi-Cal members and California's safety net population, which has the potential to strengthen California's health care system more broadly.

CHA
California
Congressional
Action Program
2015

advocating for patients
and your hospitals

The Impact of Cuts to California's Disproportionate Share Hospitals

Delay planned Medicare DSH payment cuts to hospitals

- The combination of massive cuts in hospital funding paired with continued high levels of Medicare patients will significantly impact access to medically necessary hospital services for patients across the state.
- ACA will reduce Medicare DSH payments by 75 percent.
- DSH funding will allow disproportionate share hospitals to continue to care for California's most vulnerable patients.

Contact:

Anne O'Rourke,
CHA senior vice president,
federal relations
(202) 488-4494 or
aorourke@calhospital.org

CALIFORNIA HOSPITAL ASSOCIATION

Issue

The Affordable Care Act (ACA) calls for the reduction of Medicare and Medicaid disproportionate share hospital (DSH) payments beginning in 2014. DSH payments are supplemental payments made to qualifying hospitals that care for large numbers of low-income and publicly insured patients. These hospitals absorb significant financial losses in caring for these patients, for whom there is no or low reimbursement. DSH payments help subsidize the hospitals' losses and preserve access to care for all patients in the communities these hospitals serve.

The Bipartisan Budget Act of 2013 and subsequent legislation have delayed the scheduled Medicaid DSH cuts until 2018. While an important first step, it falls short of resolving the challenge for Medicare Disproportionate share hospitals, which also face dramatic payment cuts.

Position

CHA urges Congress to delay the pending Medicare DSH cuts. California's hospitals cannot absorb these cuts.

Analysis

Under the ACA, Medicare DSH payments will be reduced by 75 percent.

Payments to California's hospitals were reduced by more than $360 million in FY 2014 — more than 78 percent of the total $460 million cut across the nation. In FY 2015, California hospitals experienced an additional cut of nearly $170 million. These reductions are most significant in hospitals that provide care to a high volume of seniors, disabled and low-income individuals. The cut to California's Medicare disproportionate share hospitals is, by far, the largest in the nation.

DSH payments have become even more important to California hospitals because the state is experiencing a tremendous growth rate in the population over 65 years of age. At a time when dependence on the Medicare program for seniors and others is escalating, disproportionate share hospitals will be facing massive cuts in funding. This across-the-board 75 percent reduction in Medicare DSH payments was premised on the theory that hospitals across the state will see significant decreases in the number of uninsured patients they treat. California's expansive geography defies any policy decision that creates a one-size-fits-all remedy. A large contingent of disproportionate share hospitals will be responsible for continuing to care for a great number of uninsured people, but with DSH cuts in place, access to care for those uninsured people will be decimated.

The Medicare DSH payment cuts add to the financial insecurity of Medicare disproportionate share hospitals that serve low-income and other vulnerable populations throughout California's diverse communities. The current Medicare DSH cuts should be repealed or delayed.

CHA
California
Congressional
Action Program
2015

advocating for patients
and your hospitals

Protect California's Rural Hospitals

Support S. 258/H.R. 169

- Rural hospitals provide care to nearly 5.2 million Californians and are often the anchor for other health care services — such as skilled nursing, home health and ambulance service.
- Fifty-seven percent of California's rural hospitals lost money in 2014.
- Removal of the 96-hour certification requirement for inpatient CAH services is essential to the sustainability of CAHs.
- Preserving the current mileage and payment structure for CAH certification is vital to preserving access to care.

Contact:

Anne O'Rourke,
CHA senior vice president,
federal relations
(202) 488-4494 or
aorourke@calhospital.org

CALIFORNIA HOSPITAL ASSOCIATION

Issue

California's small and rural hospitals provide health care services to the nearly 5.2 million residents located in rural communities. Rural hospitals often anchor other services in their communities, such as skilled nursing, home health and ambulance services. As businesses, rural hospitals provide economic stability by employing residents, purchasing goods and services, and paying taxes.

In 2012, 57 percent of California's rural hospitals lost money on patient care; 38 percent lost money overall (even considering non-operating revenue). The average operating margin was negative 1.8 percent.

Current proposed policies — such as the 96-hour condition of payment — will adversely affect critical access hospitals (CAHs). Payments to our smallest, most remote hospitals must be protected to preserve access to care in rural communities.

Position

CHA urges Congress to pass The Critical Access Hospital Relief Act (S. 258/H.R. 169), which would remove the 96-hour condition of payment but leave the condition of participation intact. Additionally, CHA advocates for protection of CAH certification requirements related to mileage and Medicare payment of 101 percent of reasonable costs.

CHA urges Congress to continue to support rural health care and protect rural hospital payments.

Analysis

In the FY 2014 final rule for the inpatient prospective payment system, CMS stated that, as a condition of payment, physicians at CAHs must certify that a beneficiary may reasonably be expected to be discharged or transferred within 96 hours after admission. If a physician cannot make that certification, then Medicare Part A payment is inappropriate. CMS has not historically enforced the requirement, but recent guidance related to its two-midnight admissions policy implies that it will, and that would threaten patients' access to longer lengths of stay when needed. While the Critical Access Hospital Relief Act seeks to remove the 96-hour physician certification requirement for inpatient CAH services, it would not remove the requirement that CAHs maintain an average annual length of stay of 96 hours, nor would it affect other certification requirements for hospitals.

CHA
California
Congressional
Action Program
2015

advocating for patients
and your hospitals

Modernize the Behavioral Health Delivery System

- Support pending legislation to reduce barriers to mental health treatment for those who need it most.
- The legislation will improve access, integration and care coordination between and among physical health care and mental health care providers.
- The legislation will encourage program uniformity and consistency of care to individuals in need, including appropriate oversight.

Contact:

Anne O'Rourke,
CHA senior vice president,
federal relations
(202) 488-4494 or
aorourke@calhospital.org

Issue

Individuals with the most serious behavioral health conditions are facing unnecessary barriers to life-saving treatment, putting entire communities at risk. Mental health is a prominent issue to the public, and mental illness is present in all segments of society. But the mental health system in America is broken, made up of a variety of programs long-outdated and policies that hinder access to care, resulting in overcrowded emergency departments, patients languishing while awaiting an appropriate level of care and many going without needed treatment entirely.

This broken system is reflected in California, where 58 counties each have their own programs for addressing mental health care, but no uniformity or consistency of care between them. California's population has grown 20 percent in the past two decades, but the number of psychiatric beds has decreased 30 percent over the same period.

Position

CHA believes strongly that the behavioral health system requires major changes in order to meet our population's needs and support the tenets of the Affordable Care Act's Triple Aim: simultaneously improving the health of the population, enhancing patient experience and outcomes, and reducing per capita cost of care for the benefit of communities.

Analysis

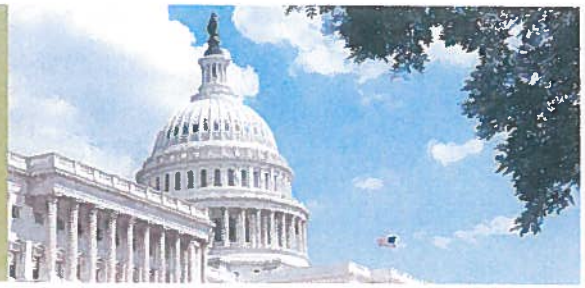
Pending legislation is designed to reduce the barriers to treatment for those who need it most. The legislation will:

- Require states to authorize assisted outpatient treatment in order to receive Community Mental Health Service Block Grant funds;
- Clarify HIPAA to permit a "caregiver" to receive protected health information when a health care provider reasonably believes disclosure to the caregiver is necessary to protect the health, safety or welfare of the patient or the safety of another;
- Remove discriminatory language in Medicaid law commonly referred to as the "IMD exclusion," limiting treatment options for individuals between the ages of 21 and 64;
- Include access to health information technology incentives for acute psychiatric hospitals;
- Support integration and coordination between primary and mental health care; and
- Create an Assistant Secretary for Mental Health and Substance Use within the U.S. Department of Health and Human Services to promote further accountability of mental health services.

It's time to bring behavioral health treatment into the 21st century. This legislation will provide solutions to help address the unique needs of not only those with serious mental illness, but families and communities, caregivers and hospitals.

CALIFORNIA HOSPITAL ASSOCIATION

CHA
California
Congressional
Action Program
2015



advocating for patients
and your hospitals

California Hospitals — Supporting the Affordable Care Act's Goals to Ensure Expanded Coverage

- California leads the nation in enrollment under the Affordable Care Act.
- One in three Californians will depend on the Medi-Cal program for all of their health care needs by 2017.
- Medi-Cal patients deserve access to timely health care services in the right setting.
- Between three and four million California residents will remain uninsured after the ACA is fully implemented. Hospitals will remain one of the most important doors through which individuals access health care, and often the only entry point for the uninsured.

Contact:

Anne O'Rourke,
CHA senior vice president,
federal relations
(202) 488-4494 or
aorourke@calhospital.org

Issue

California leads the nation in enrollment under the Affordable Care Act (ACA). California quickly embraced the coverage expansion provisions of the ACA by expanding Medicaid coverage (known as Medi-Cal in California) to its low-income residents and by becoming the first state in the nation to establish its own state-based marketplace — Covered California. Medi-Cal — the largest Medicaid program in the nation — now serves over 12 million Californians, including approximately one-half of the state's children. Nearly one in three Californians now depend on the Medi-Cal program for all of their health care needs.

Position

California's Medi-Cal expansion is driving increased demand for health care services in its hospitals. Under the ACA's coverage expansions, more than 200,000 additional Medi-Cal patients are being treated in hospitals for acute care each year and Medi-Cal hospital outpatient visits have grown by more than 3.6 million over a year. Data also suggests that the newly enrolled are utilizing health care services at a greater rate than when they were uninsured. At the same time, reduced payments to primary care doctors have limited access to basic medical care. The inability to access primary care is driving an estimated one million Medi-Cal enrollees to hospital emergency rooms for basic health care needs. Medi-Cal patients deserve access to timely health care services in the right setting.

Analysis

Expanding coverage without ensuring access to needed care is a problem that must be remedied. Hospitals, their community partners, and local governments are working overtime to meet the new demand for services. At the same time, the federal government is implementing deep cuts in Medicaid and Medicare funding. California's Medi-Cal reimbursement rates remain some of the lowest in the country, a fact particularly alarming considering the growing number of Medi-Cal beneficiaries.

Additionally, while it is anticipated that the ACA will reduce California's uninsured rate by at least half, it is estimated that three to four million Californians will remain uninsured even after the ACA is fully implemented. While the majority of this population is eligible for coverage through Medi-Cal or a Covered California health plan, many will remain uninsured for a variety of reasons (e.g., affordability or reluctance to enroll in a public program). Hospitals will remain one of the most important doors through which individuals access health care, and often the only entry point for the uninsured.

CALIFORNIA HOSPITAL ASSOCIATION

May 12, 2015

Report to TCHD Board of Directors

James Dagostino Vice Chair TCHD Board of Directors

Subject 2015 AHA/CHA Annul Conference and CHA California Congressional Program 5/2 through 5/6/2015

Attendees Tri City Larry Schallock Chair TCHD Board,

The session targeted for Trustees were relevant. Day one centered on Board responsibility in Quality Programs and measures. Presenter Orlikoff was adamant about board responsibility of the Quality programs.

On Monday TCHD Auxiliary received an award for the Tails on Trails fundraising program. Mr. Schallock and I attended the ceremony, and help promote our program that our Auxiliary created: A great National Award for our little institution.

Two Federal Plenary sessions were presented. The first was a presentation by Dr. Thomas Frieden, MD CDC Director. He spoke about the Ebola reaction by AHA hospitals we were all congratulated by the Director for our speedy reaction. He detailed the problems with overuse of antibiotics. Also presenting was HHS Secretary Sylvia Mathews Burwell. She spoke about the ACA and its successes. I learned nothing new from her presentation. The second plenary session featured Former Senator Bill Bradley and Senator Susan Collins with some noted columnists / writers Ron Fournier and Norm Ornstein. Debate about Washington gridlock was presented. Not much substantive information but entertaining. Two lunch speakers Scott Simon and Sugar Ray Leonard presented different type speeches. Leonard more of the kid who pulled himself up by his bootstraps and Simon about the callousness of physicians when his mother was diagnosed with cancer.

The second Trustee session was presented John Coombs, MD and Debra Stock AHA members and they spoke about the Governance surveys. I got some copies of the survey to share with the Board at our workshop and had some interesting facts. From Tuesday to Wednesday we were a part of the CA Congressional Team and as with CA Legislative Day in March the San Diego team met with our San Diego Congressional leaders and discussed our issues. Day one we became fluent about legislation pending and day two we represented CHA's positions to our San Diego Legislators. Mr. Schallock was Team Leader for Congressman Issa and for my money his presentation of our positions was the best of all of our San Diego delegation. Key legislation presented was:

HR 2156 (Support) Modification of Recovery Audit process. An abusive process that cost Tri City time and effort. When we get decisions that mandate we return money to Medicare we reverse on appeal approx. 70 % of these decisions.

Site Neutral payments (Oppose) I personally think that CHA has a weak argument but we pitched the fact that TCHD has higher cost when providing care then the Out-patient providers.

HR 1343/ SW 688 (Support) the 30 day readmissions program. This law will add a socioeconomic factor that should level the playing field when patients get readmitted. We expressed our thoughts that the whole regulation is unfair but that fell on deaf ears.

Renewal on CA Section 1115 Medical 2020 Demonstration Waiver. A program that allows designated public hospitals to recover money they lose by treating a disproportionate share of Medical patients. Also we spoke about the ACA program's mandate of cutting DSH payments that California Hospitals will have to absorb.

S258/HR 169) Support) Critical Access Hospital Relief Act. Not sig effect on TCHD.

Legislative visits were cordial and our positions were considered. The problem the feds have is they continue to use regulation to control both quality and expenditures. This leads to more data collection by hospitals and therefore requires our staff to spend more time away from patients. We tried to emphasize to be mindful of that fact when creating regulations. I dare say our arguments were not inordinately compelling.

Personal Observations- Former leaders of Tri City including most recently our Board Chair Larry Schallock have placed Tri City in very favorable light with The California Hospital Association. Mr. Schallock and I were the only Trustees to attend the Legislative visits. All other San Diego hospitals have a dedicated Government Affairs position. Even Palomar has Elly Garner, Government Relations Manager as their paid representative. Tri City uses its Board members and Staff to represent us in the governmental arena. I would suggest the Board continue to support these type of meetings to enhance Tri City's clout in the law making venue. These opportunities also give Tri City face time with our state and national representatives and as we have discussed we will need help from both of these leaders if we are to accomplish our ambitious goals.