TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
August 27, 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: December 31, 2015		

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

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

	Agenda Item	Time Allotted	Requestor
	g. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: December 31, 2015		
	h. Conference with Legal Counsel – Existing Litigation (Authority Government Code Section 54956.9(d)1, (d)4 (1) John Young, M.D. vs. TCHD Case No. 37-2009-00099935-CU-WM-NC (2) Lockton Companies vs. TCHD Case No. 37-2015-00013956-CU-BC-NC (3) Medical Acquisitions Company vs. TCHD Case No: 2014-00009108 (4) TCHD vs. Medical Acquisitions Company Case No: 2014-00022523		
	j. Public Employee Evaluation Title: Chief Executive Officer (Authority: Government Code, Section 54957)		
	k. Approval of prior Closed Session Minutes		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)		
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	Special Recognitions – 1) NICU – 5 years CLABSI Free – Nancy Myers, Manager, NICU and Dr. Hamid Movahhedian 2) National Hospital Organ Donation Campaign – Gold Recognition – Merebeth Richins	5 min. 5 min.	S. Schultz S. Schultz
13	Marketing Update	15 min.	D. Bennett
14	Report from TCHD Foundation	8 min.	Standard
15	Report from Chief Executive Officer	10 min.	Standard

	Agenda Item	Time Allotted	Requestor
16	Report from Chief Financial Officer	10 min.	Standard
17	New Business a. Consideration to certify the results of the card count by the neutral party to determine the majority of employees within the Clinical Laboratory Scientists and Medical Laboratory Technicians voted to be represented by United Food and Commercial Workers	5 min.	Chair
	b. Consideration to approve renewal of the 2016 Employee Benefits – Presentation by BB&T	15 min.	HRC Comm.
	c. Consideration to approve equipment lease between Tri-City Healthcare District and Primary Care Medical Group, Inc.	10 min.	W. Knight
	d. Consideration to approve Resolution No. 775, a Resolution of the Tri-City Healthcare District Authorizing the Chief Executive Officer to Award Certain Emergency Contracts	5 min.	FOP Comm.
	e. Consideration to amend the employment agreement with the Chief Executive Officer	5 min.	Chair
	f. Consideration to appoint Mr. Leslie Schwartz to a two-year term on the Audit, Compliance & Ethics Committee a two-year term	5 min.	Audit, Comp/Ethics Comm.
	g. Consideration to appoint Ms. Gwen Sanders to a two year term on the Human Resources Committee	5 min.	HRC Comm.
	h. Consideration to appoint Mr. Joe Quince to a two-year term on the Human Resources Committee	5 min.	HRC Comm.
18	Old Business - None		
19	Chief of Staff a. Consideration of August 2015 Credentialing Actions Involving the Medical Staff – New Appointments Only b. Medical Staff Credentials for August, 2015	5 min.	Standard
20	Consideration of Consent Calendar (1) Board Committees ***(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.*** ***(2) All items listed were recommended by the Committee.*** ***(3) Requested items to be pulled <u>require a second</u>.*** **A. Human Resources Committee** Director Kellett, Committee Chair Open Community Seats – 2 (Committee minutes included in Board Agenda packets for informational purposes.) 1) <u>Approval of Administrative Policies & Procedures</u> a. #8610-406 – Employment of Relatives b. #8610-454 – Severance Plan	5 min.	Standard HR Comm.

	Agenda Item	Time Allotted	Requestor
	c. #8610-457 – New Hire Orientation d. #8610-458 – Competency e. #8610-472 – Employment Status and Benefits Eligibility f. #8610-483 – Conflict of Interest Acceptance of Gifts		
	B. Employee Fiduciary Retirement Subcommittee Director Kellett, Subcommittee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes.)		Emp. Fid. Subcomm.
	C. Community Healthcare Alliance Committee Director Nygaard, Committee Chair Open Community Seats – 1 (Committee minutes included in Board Agenda packets for informational purposes		CHAC Comm.
	D. Finance, Operations & Planning Committee Director Dagostino, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes		FO&P Comm.
	1. Approval of Administrative Policy #8610-285 – Charity Care, Uncompensated Care, Community Service		
	2. Approval of Board Policy #15-013 – Policies and Procedures Including Bidding Regulations Governing Purchases of Supplies & Equipment, Procurement of Professional Services and Bidding for Public Works Contracts		
	3. Approval of Administrative Policy# 8610-208 – Petty Cash Funds (DELETED)		
	4. Approval of an agreement with Supplemental Registries for an estimated amount of $550,000/month for a term of 12 months, beginning July 1, 2015 through June 30, 2016 for an annual cost not to exceed $6,600,000 and a total cost for the term not to exceed $6,600,000.		
	5. Approval of the capital purchase of the Talyst Automated Pharmacy Carousel System and the 60 month maintenance support agreement for a total cost not to exceed $575,000, with additional facility modifications not to exceed $120,000.		
	6. Approval of an agreement with the lowest bidder for supply of ground gas for a term of three years, beginning August 2015 through July 2018 for an approximate annual cost of $376,267 and an approximate total cost for the term of $1,096,447.		
	7. Approval of an engagement with McCarthy Building Companies, Inc. for an initial project expenditure not to exceed $495,000 to develop a Master Plan as the first step toward addressing the seismic requirements of SB1953 to		

	Agenda Item	Time Allotted	Requestor
	bring TCMC into compliance before 2030. 8. Approval of an agreement with the Department of the Navy to provide Medical Resident trainees for a term of 53 months beginning September 1, 2015 through January 31, 2020 at no cost to TCHD. 9. Approval of an agreement with Midwest Television/CBS-8/KFMB for a monthly cost of $12,572.75 for a term of 12 months, beginning July 1, 2015 through June 30, 2016 for an annual/term cost of $150,873. 10. Approval of an agreement with ABC-10/KGTV for a monthly cost of $16,425 for a term of 12 months, beginning July 1, 2015 through June 30, 2016 for an annual/term cost of $197,100. 11. Approval of an agreement with NBC-7/NBCOTS for a monthly cost of $22,300 for a term of 12 months, beginning July 1, 2015 through June 30, 2016 for an annual/term cost of $276,600. 12. Approval of an agreement with Entravision for a monthly cost of $7,074.48 for a term of 12 months, beginning July 1, 2015 through June 30, 2016 for an annual/term cost of $84,893.75. 13. Approval of an agreement with the San Diego Business Journal for a monthly cost of $10,000 for a term of 12 months, beginning July 1, 2015 through June 30, 2016, for an annual/term cost of $120,000. 14. Approval of an agreement with the Union Tribune for a monthly cost of $17,250 for a term of 12 months, beginning July 1, 2015 through June 30, 2016 for an annual/term cost of $207,000. 15. Approval of an agreement with Roche Diagnostic Corp. for a term of 12 months beginning September 1, 2015 through August 31, 2016, not to exceed an annual expense for the term of $538,000. 16. Approval to authorize Charles McGraw, MD as ED On Call Coverage Physician for a term of 23 months beginning August 16, 2015 through June 30, 2017, not to exceed a daily rate of $600 and a total cost for the term of $411,000.		
	E. Professional Affairs Committee Director Dagostino, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes.) 1) **<u>Patient Care Services Policies and Procedures</u>:** a. Code Blue and Emergency Care b. High Level Disinfection Procedure c. Incentive Spirometer (IS) Instruct and Monitoring d. Patient Leave of Absence, Temporary Policy		PAC Comm.

	Agenda Item	Time Allotted	Requestor
	2) **Administrative Policies** a. Policy Approval – Administrative b. Incident Report-Quality Review Report (QRR) 396 3) **Unit Specific** **Emergency:** a. LWOT, AMA or Elopement Policy **Pharmacy:** a. Transdermal Fentanyl Patch Prescribing and Use **Staffing:** a. Monitoring Registry Files Policy b. Registry Badge Process c. Registry Contract, Orientation Packets and Audits **Pre-Printed Orders:** a. Adult Parental Nutrition Orders **F. Governance & Legislative Committee** Director Schallock, Committee Chair Open Community Seats - 0 (Committee minutes included in Board Agenda packets for informational purposes.) 1) **Rules & Regulations** a. Division of Cardiothoracic Surgery b. Department of Medicine c. Department of Allergy & Dermatology d. Division of Gastroenterology e. Division of Neurology f. Division of Oncology g. Division of Psychiatry h. Division of Pulmonology i. Department of Emergency Medicine j. Department of Family Medicine k. Division of Ophthalmology l. Division of Podiatric Surgery m. Division of Subspecialty n. Department of Surgery o. Division of Urology 2) Approval of Board Policy 14-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson **G. Audit & Compliance Committee** Director Finnila, Committee Chair Open Community Seats – 1 (Committee minutes included in Board Agenda packets for informational purposes 1. **Administrative Policies & Procedures**: a. #8610-524 - Disclosure of Information to Public and Media b. #8610-591 – HIPAA Mitigation		Gov. & Leg. Comm. Audit, Comp. & Ethics Comm.

	Agenda Item	Time Allotted	Requestor
	c. #8750-557 – Communicating & Reporting Compliance Concerns: Confidential Reporting d. Verification of Identify and Authority of Persons Requesting Protected Health Information (PHI), including Personal Representatives (2) Minutes – Approval of a) July 30, 2015 – Special Board of Directors Meeting b) July 30, 2015 – Regular Board of Directors Meeting c) August 13, 2015 - Special Board of Directors Meeting (3) Meetings and Conferences – None (4) Dues and Memberships a) ACHD - $45,000,00		 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 – Included (c) Lease Report – (July, 2015) (d) Reimbursement Disclosure Report – (July, 2015) (e) Seminar/Conference Reports - None	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)**	**3 hours/ 15 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		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 18, 2015
PROPOSAL FOR: Medical Office Equipment Lease

Type of Agreement		Medical Directors		Panel	x	Other: Equip. Lease
Status of Agreement	x	New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor Name: Tri-City Primary Care Medical Group

Area of Service: Primary Care Clinic
(1926 Via Centre Drive, Suite A, Vista, CA 92081)

Term of Agreement: 53 months Beginning: 8/1/2015 - Ending: 12/31/2019

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$ 5,004.44	**$ 60,053.28**	**$ 265,235.32**

Description of Services/Supplies:

- Lease medical equipment, furniture, I.T./Communications for Primary Care Clinic
- Use: 5 days per week, with weekends as needed.
- The interest rate TCHD is receiving is the exact interest rate Tri-City Primary Care Medical Group has received.
- The Primary Care Physician Clinic in its entirety was approved by the Board on January 30, 2014.

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

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

Motion:

I move that TCHD Board of Directors authorize the agreement with Tri-City Primary Care Medical Group for leasing medical office equipment for a term of 53 months, beginning August 1, 2015 and ending December 31, 2019, for an annual cost of $60,053.28, and a total cost for the term of $265,235.32.

RESOLUTION NO. 775

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE TRI-CITY HEALTH CARE DISTRICT AUTHORIZING THE CHIEF EXECUTIVE OFFICER TO AWARD CERTAIN EMERGENCY CONTRACTS

WHEREAS, the Board of Directors of the Tri-city Healthcare District (the "District") wishes to give the Chief Executive Officer additional authority to exercise in the event of an unforeseen event causing an emergency, to enter into certain contracts not exceeding $250,000, and take certain actions, subject to certain terms and conditions; and

WHEREAS, the Board of Directors may, by a minimum four-fifths (4/5) vote, delegate authority to the Chief Executive Officer to award contracts and to take actions to repair or replace a public facility, and directly related and immediate actions required by an emergency, without following the competitive bidding process; and

WHEREAS, California Public Contact Code § 1102 defines an "emergency" to include a sudden and unexpected occurrence that poses a clear and imminent danger, requiring immediate action to prevent or mitigate the loss or impairment of life, health, property, or essential public services; and

WHEREAS, the Board of Directors desires, by way of this Resolution, to delegate limited emergency authority to the Chief Executive Officer pursuant to California Public Contract Code § 22050;

NOW THEREFORE, BE IT RESOLVED:

1. The Chief Executive Officer is hereby authorized to take immediate action and award contracts not exceeding $250,000 (two hundred fifty thousand dollars) and take actions to repair or replace a public facility and directly related immediate actions required, when, in his opinion, an unforeseen event has resulted in an emergency as defined by Public Contract Code § 1102, without seeking competitive bids. Following the use of this authority, the Chief Executive Officer shall give notice of the emergency within 48 hours to the Board of Directors, and endeavor to set a special meeting to discuss the emergency as soon as practicable to review the actions taken in the manner required by Public Contract Code §22050. The Chief Executive Officer's failure to give notice or schedule a meeting of the Board shall not affect the validity of any contract made under this paragraph.

2. The authorization granted herein shall only apply to emergency contracts for the repair or replacement of public facilities, and procurement or commitment of necessary equipment, services, and supplies required to address an unforeseen event resulting in an emergency. During any period the Chief Executive Officer is absent from the District or otherwise unavailable due to illness or other cause the Chief Operating Officer may exercise the powers of the Chief Executive Officer under this resolution. In addition, the Chief Executive Officer and Chief Operating Officer may delegate the authority granted by this resolution to an non-elected officer or employee of the District.

3. In the event no special meeting has been held pursuant to paragraph 1, and the Chief Executive Officer has exercised his emergency authority under this resolution, the Board of Directors shall review the actions taken within seven (7) days, or at its next regularly scheduled meeting if that meeting will occur within fourteen (14) days of the making of the contract. At that meeting, the Chief Executive Officer shall report the reasons justifying the emergency actions and why they could not be delayed by the competitive bidding process, and why the actions taken were necessary to respond to the emergency.

4. At every regularly scheduled meeting thereafter, the Board of Directors shall review the emergency actions in order to determine, by at least a four-fifths (4/5) vote at each meeting, whether there is a need to continue the actions, until such time that the actions are terminated. The Board shall terminate the actions at the earliest possible date that conditions warrant so that the remainder of the emergency actions may be completed by the competitive bidding process.

5. This resolution supplements any authorization granted under any other Board policy or motion.

PASSED AND ADOPTED on the __ day of _____, by the following vote:

AYES:
NOES:
ABSENT:
ABSTENTIONS:

TRI-CITY HEALTH CARE DISTRICT

By: _____
Chair of the Board of Directors

Attest:

By: _____
Secretary of the Board of Directors

3537 Normount Rd.
Oceanside, CA 92056
July 15, 2015

Teri Donnellan, Executive Assistant
Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056

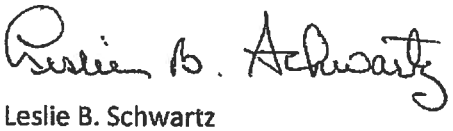
Dear Ms Donnellan,

This is in response to Sunday's San Diego Union-Tribune ad for the opening on the Audit/Compliance/Ethics Committee. My family and I have resided in North County for thirty-nine (39) years and in Oceanside for the last thirty-two (32). Our family has benefited from the excellent health care that Tri-City provides to the district and I am hoping to be able to give back in continuing that service.

As you will see by my resume, I have spent the last forty (40) years in the health care arena in either a business or hospital setting. I have had to deal with a number of regulatory agencies in those years and have spent considerable time preparing, analyzing and auditing financial information along with preparing and participating in regulatory agency audits.

Thank you for the opportunity to present my qualifications for this position. I would consider it a privilege to contribute to the mission of Tri-City Medical Center.

Sincerely,



Leslie B. Schwartz

Enclosure

Leslie B. Schwartz
3537 Normount Rd.
Oceanside, CA 92056

Home:(760) 758-4345
Cell: (760) 470-9589

EXPERIENCE:

Clinical Laboratory Scientist (7/92 to 11/14)
Chemistry Laboratory Retired 11/01/14 after 22 yrs
Palomar Medical Center

From 9/92 to 12/09, worked as a Per Diem covering weekends for employees on PTO. From 12/09 until 11/14 covered for employee PTO and MLAs.

- Responsible for diagnostic testing in general chemistry, immunochemistry and respiratory samples.
- Responsible for the maintenance and troubleshooting of diagnostic instrumentation.
- Insured all STAT testing meets the departments turnaround objectives.
- Insured that the appropriate medical staff are notified and documented for all critical results.
- Responded to all incoming inquiries in a timely and professional manner.

Documentation Systems Manager (4/04 to 11/09)
Technical Service Retired 11/30/09 after 33 yrs
Diagnostic Development Center

Responsible for monitoring and release of all new controlled development and manufacturing documents and the maintenance of all released development and manufacturing documents and procedures.

- Managed and evaluated the performance of eleven (11) employees.
- Developed and monitored departmental budget.
- Insured all new product documents were released per schedule.
- Responsible for hiring and firing of departmental staff.
- Provided upper management with information on document progress in meeting development and manufacturing goals.

Staff Development Scientist (9/99 to 4/04)
MSDS and Labeling Support
Diagnostic Division Manufacturing

Responsible for development, maintenance, and monitoring of MSDS and labeling to support new and existing products of the Diagnostic Divisions products.

- Review and verify product formulations to determine % by weight. Assess these formulations against OSHA, WHMIS and EU regulations to determine appropriate labeling and MSDS requirements.
- Assess product formulations against DOT, TDG, IMO, IATA and ADR regulations to determine proper classification and requirements for worldwide multi-modal shipping.
- Assess product formulations against EAR and Schedule B coding to assure proper classification.

- Provide support to Development and Manufacturing for hazardous assessment of new raw material to be used in new and existing products.
- Develop and maintain relationship with OEM vendors of inbound raw materials and products for MSDS's and labeling.
- Maintain appropriate raw material and product records.
- Monitor worldwide health & safety and transportation regulations for changes affecting current policies and procedures. Update for policies and procedures when significant changes are found.

Project Manager (1/93 to 9/99)
Current Business Systems Development
Clinical Chemistry Development Center
Diagnostic Division

Responsible for managing the development of Clinical Chemistry and Immunochemistry Menu Expansion and Line Maintenance Projects. Worked closely with Program Management to assure projects were technically released on schedule and met the requirements of the product definition.

- Provided Development input into Project Justifications and Current Business Proposals with schedules, budgets and project requirements.
- Manage the multi-functional teams from inception through product delivery.
- Insure all FDA and ISO required design control elements have been met and that all documentation met company standards.
- Provided product post release support as needed to insure customer satisfaction.

Manager, Development Administration (3/91 to 12/92)
Product Development
Diagnostic Systems Group

Responsible for all Product Development administrative functions, reporting to the Vice President of Product Development.

- Monitored performance against budget for all departments and projects.
- Responsible for the Administration and Development capital budgets.
- Approved all temporary personnel requisitions.
- Coordinated the Strategic Plan implementation.
- Coordinated all department and project space allocation.

Manager Financial Planning & Analysis (3/90 to 2/91)
DSG Finance
Diagnostic Systems Group

Responsible for financial planning and analysis within the Research and Development area, reporting to the Financial Planning Manager, DSG.

- Responsible for financial forecasting and planning.
- Monitored performance against budget for all departments and projects and recommended corrective action.

- Evaluated and tracked capital requirements with the emphasis on internal hardware unit placement.
- Compiled and presented yearly R&D financial budget to the group Vice President.

Manager, Manufacturing Administration (10/87 to 2/90)
Manufacturing
Diagnostic Systems Group

Responsible for all Manufacturing administrative functions, reporting to the Vice President of Manufacturing.

- Responsible for the Manufacturing Administration budget.
- Coordinated and tracked performance against budget for capital expenditures.
- Provided financial reporting to the Manufacturing departments.
- Handled special projects as assigned by the Vice President of Manufacturing and the Vice President of DSG.

Reagent Manufacturing Engineer (10/86 to 9/87)
Technical Operations - Carlsbad
Diagnostic Systems Group

Various Other Position (11/76 to 10/86)

PROFESSIONAL MEMBERSHIP & CREDENTIALS:

- Member, Society for Chemical Hazard Communication
- Member, Dangerous Goods Advisory Council
- Member, American Society for Clinical Pathologists
- Clinical Laboratory Scientist, State of California Department of Health
- Medical Technologist, American Society for Clinical Pathologists

EDUCATION:

- MBA, Marketing/Finance, National University, San Diego, CA, 1981
- B.Sc., Microbiology/Chemistry, University of Houston, Houston, TX, 1974

REFERENCES:

- Upon request

5-18-15

Gwen Sanders

4215 Galbar Street Oceanside, CA, 92056 (760) 726 - 1837

Professional Objective

Actively pursuing a volunteer position with Tri City Healthcare District Board of Directors Human Resources Committee

Summary of Qualification

- **Highly Knowledgeable** of state and federal policies, procedures, and have the ability to understand policies and procedures.
- **Expertise** in employee arbitration processes.
- **Competency** in the formulation and implementation of policy issues.
- **Ability** to assess requirements and facilitate compliance.
- **Capability** to contribute to continuous improvement and success within the Tri City Healthcare District.
- **Results** oriented supervisor and coordinator with exceptional organizational skills.
- **Effective** interpersonal skills with proven performance records.
- **Intent** on surpassing, not merely meeting, adequate performance standards
- **Capability** of Lobbying Politicians

Relevant Experience

Community

President - Future Pioneers
Vice President - North County NAACP
Treasurer - North County NAAcp
Chairperson - Committee of Equity
Chairperson - Legislative Committee
Consultant - Telephone Pioneers
Chairperson - The City of Oceanside Community Relations Commission (EEO / ADA)

Professional

Over 30 successful years with AT&T in positions of increasing responsibility

- Customer Service Representative
- Directory Sales Representative
- Phone Center Service Representative
- Staff Clerk
- Residence Orders Correction Center

Trained In

Diversity
Ethnic / Racial Differences

GWEN SANDERS

4215 Galbar Street Oceanside, CA 92056 (760)726—1837

Native born Californian, I received my first 12 years of education in El Centro California. I also attended Imperial Valley College and Mira Costa Community College with my Major being Elementary Education. I chose Elementary Education to follow in my mothers foot steps. I done volunteer work in the past with the school district as a room mother. I also fund raised for the PTA which resulted in placing McGruff the crime fighting dog in the Vista School District.

The attributes that I will bring to the Committee are...

Strong Public Relations Skills, The Ability to Quickly Assess a Need, Proficient in Oral Communication, I Possess Exceptional Organization Skills and Flexibility, I am Willing to the Extra Efforts to Ensure Maximum Efficiency, My Dedication To Top Level Performance, Coupled With My Outgoing Personality Are Qualities That I Offer You.

GWEN SANDERS

4215 Galbar Street Oceanside, CA 92056 (760)726—1837

Summary of Qualifications

Open to new ideas, exceptionally dedicated, proactive in the community customer-focused Professional with a high level of integrity and commitment to excellence in every endeavor. Thirty Nine years with SBC/Pacific Bell/AT&T. Held several official positions within the North County NAACP, a member of Oceanside's CRC (Community Relations Commission). Demonstrated success as a liaison between the CRC and the Police and Fire Commission. Leading team members by creating cohesive and consist methodologies within cultural coalitions.

Trained in continued

- Sexual Harassment in work place
-Consulting & Interviewed Technician

CWA

-Job Steward, Chair of Committee on Equity, Legislative Committee, Lobby Politicians.

Achievements

-Awarded LifeTime of achievement and meritorious service to humanity award from 38th Senatorial district (2011)
-On the board of CWA retired member
-On the board of the NC retired Military Association
-Awarded City of Oceanside Senior Volunteer Award (2007)
- Awarded City of Oceanside Dr. King Jr. Civic Award (2003)
- Awarded Community Involvement Award (2002)
-Awarded CWA Outstanding Service Award (1995)
-Awarded North County NAACP Woman of The Year (1994)
-Elected The Central Committee

Gwen Sanders

4215 Galbar Street Oceanside, CA, 92056 (760) 726 - 1837

References:

Willie Little	(760) 757 - 1459
Ann McBride	(760) 791 - 5810
Betty Williams	(760) 271 - 4669
Monica Lopez	(760) 270 - 6840
Inez Williams	(760) 213 - 9207

Received
6-24-15

June 22, 2015

Dear Ms. Donnellan

Please consider me for the Community Member opening on the Tri-City Healthcare District Board of Directors Human Resources Committee. See enclosed resume' for a summary of my related work experience. I am an Auxillary volunteer Escort at the TCMC on Friday mornings and could make myself available for a get acquainted meeting. I look forward to hearing from you.

Regards,

Joe Prince

#7218 Wisteria Way
Carlsbad, CA 92011

(760) 438-3241
joeque2u@roadrunner.com

Joe Quince

Objective

Interesting Part-Time Work

Experience

1981-2003 Air Products and Chemicals, Inc., Carlsbad, CA
Human Resources Manager

Recruiting: Recruited B.S – Ph.D. level candidates in a variety of professional fields.

Employee Relations: Handled difficult and sensitive employee relations matters – employee/management coaching and counseling, conflict resolution, progressive disciplinary actions, terminations, reductions-in-force, resolution of sexual harassment, and discrimination cases.

Wage and Salary Administration: Actively participated in setting starting salaries and amount of promotion increases, managed annual performance appraisal and merit increase process, and performed salary surveys as needed.

Training: Provided training to employees, supervisors and managers on a variety of subjects including: wage and salary administration; progressive discipline process; prevention of sexual harassment; and; Zenger-Miller's Frontline Leadership training.

1968-1981 Eli Lilly and Company, Indianapolis, IN
Sales Rep, Compensation Analyst, Personnel Rep, Projects Administrator

Successfully completed a number of developmental assignments with this Pharmaceutical Industry leader.

Education

San Diego State University, San Diego, CA
B.S. Business Management with a major in Personnel Mgt.
Graduated cum laude.

Community Service

Volunteer "Job Coach" with Brother Benno Foundation, and volunteer Tutor in the Adult Literacy Program at the Carlsbad Library. Sing with the North County Musicmen a cappella chorus, and a performing quartet called Sound Design. Active member of Tri-City Hospital Auxiliary. Perform volunteer duties on a weekly basis.

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
August 12, 2015

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 08/28/2015 – 07/31/2017)
Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 08-28-15 through 07-31-2017:

Cohen, David N., MD/Cardiology
Recommend appointment to the Provisional staff with privileges in Cardiology as delineated on the privilege card **WITH** proctoring for all privileges.

DEMBITSKY, Zachary Y., MD/ Emergency Medicine
Recommend appointment to the Provisional staff with privileges in Emergency Medicine as delineated on the privilege card **WITH** proctoring for all privileges.

DESADIER, Laura L.K., DO/Neurology
Recommend appointment to the Provisional staff with privileges in Neurology as delineated on the privilege card **WITH** proctoring for all privileges.

GE, Xupeng, MD /Anesthesiology
Recommend appointment to the Provisional staff with privileges in Anesthesiology as delineated on the privilege card **WITH** proctoring for all privileges.

GUSTAFSON, Corey G., DO/ Emergency Medicine
Recommend appointment to the Provisional staff with privileges in Emergency Medicine as delineated on the privilege card **WITH** proctoring for all privileges.

GUY, Moltu J., MD/Anesthesiology
Recommend appointment to the Provisional staff with privileges in Anesthesiology as delineated on the privilege card **WITH** proctoring for all privileges.

HOBSON, Margaret D., MD/Dermatology
Recommend appointment to the Provisional staff with privileges in Dermatology as delineated on the privilege card **WITH** proctoring for all privileges.

KRUETH, Stacy B., MD/Anesthesiology
Recommend appointment to the Provisional staff with privileges in Anesthesiology as delineated on the privilege card **WITH** proctoring for all privileges.

LEONARD, Lisa, MD /Obstetrics/Gynecology
Recommend appointment to the Provisional staff with privileges in Obstetrics/Gynecology as delineated on the privilege card **WITH** proctoring for all privileges.

LI, Xiangli, MD/Internal Medicine
Recommend appointment to the Provisional staff with privileges in Internal Medicine as delineated on the privilege card **WITH** proctoring for all privileges.

RUBIN, Ashley G., MD/Dermatology
Recommend appointment to the Provisional staff with privileges in Dermatology as delineated on the privilege card **WITH** proctoring for all privileges.

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
August 12, 2015

Attachment A

WACLAWSKI, Richard J., MD/Anesthesiology
Recommend appointment to the Provisional staff with privileges in Anesthesiology as delineated on the privilege card **WITH** proctoring for all privileges.

WILKE, Lindsey W., DPM/Surgery/Podiatry
Recommend appointment to the Provisional staff with privileges in Podiatric Surgery as delineated on the privilege card **WITH** proctoring for all privileges.

INITIAL APPOINTMENT TO THE ALLIED HEALTH PROFSSIONAL STAFF
The following practitioner has applied for Allied Health Professional status. Following review of the practitioner's files and all required documentation, the committee voted to recommend appointment to the Allied Health Professional Staff with practice prerogatives as delineated on the privilege card with proctoring for all privileges:

NUNEZ, Blanca E., PA-C
Physician Assistant in the Neurosurgery Department (s): Dr. Mark S. Stern sponsoring physician.
Initial to AHP staff with practice prerogatives as reflected on the prerogatives card WITH proctoring

STEWART-GARBRECHT, Eleanor P., CNM
Certified Nurse Midwife in the Obstetrics Department (s): Dr. Raheleh Esfandiari sponsoring physician.
Initial to AHP staff with practice prerogatives as reflected on the prerogatives card WITH proctoring.

INITIAL APPLICATION WITHDRAWAL: (Voluntary unless otherwise specified)
Medical Staff:
TSAI, Tony P., MD - Anesthesiology

Allied Health Professionals:
None

TEMPORARY PRIVILEGES: Medical Staff/Allied Health Professionals:

LI, Xiangli, MD/Internal Medicine effective 8/12/2015

TEMPORARY MEDICAL STAFF MEMBERSHIP: Medical Staff:
None

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
August 12, 2015

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS (Effective Date: 08/28/2015, unless specified otherwise)

PRIVILEGE RELATED CHANGES

Dhillon-Ashley, Tina M.D./OB-GYN/Provisional
Add:
- Assist in Robotic Surgery (da Vinci)

Ebrahimi Adib, Tannaz M.D./OB-GYN/Provisional
Add:
- Assist in Robotic Surgery (da Vinci)

Ku, Tina, M.D./Ophthalmology/Provisional
Relinquish:
- Forensic Outpatient Clinic Privileges

Lister, Crystal, CNM/Allied Health Professional
Add:
- Surgical First Assist at Cesarean Deliveries

Jamshidi-Nezhad, Mohammad, D.O./General and Vascular Surgery/Active
Add:
- Placement of Vagal Nerve Stimulator

Packard, Lori PA-C/Allied Health Professional
Add:
- PA – Physician Assistant 8/14 Privilege card

Add Supervising Physician(s):
- Orna Gil, MD
- William Jurewitz, MD

Stern, Mark, M.D./Neurosurgery/Active
Add:
- Mazor Robotic Surgery

Scheinberg, Robert, MD/Dermatology/Consulting
Add:
- Refer and Follow

Remove:
- Consultation, including via telemedicine (F); Biopsy less than 5 cm; Biopsy of nail unit; Destruction, pre-malignant and benign less than 10 cm; Graft, punch less than 1 cm; Incision less than 5 cm; Nail and matrix excision; Nail avulsion; Nail bed reconstruction with graft; Nail debridement; Nail fold wedge excision; Paring & curettement less than 5 cm; Repair of nail bed; Repair, simple less than 10 cm anywhere except face; Shaving less than 5 cm; Destruction, malignant less than 10 cm (F)

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
August 12, 2015

Attachment B

Ventrella, Stephanie PA-C/Allied Health Professional
Add:

- Radiology – Physician Assistant

STAFF STATUS CHANGES

Scheinberg, Robert, MD/Dermatology/Consulting

- Physician requested to be changed to Affiliate Staff Status

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
August 12, 2015

Attachment C

PROCTORING RECOMMENDATIONS (Effective 08/28/2015, unless otherwise specified)

Chase, Nicole PAC — **Allied Health**
Release from proctoring: Lumbar Puncture and Reduction of Major Joints

Corona, Frank M.D. — **Pulmonary Medicine**
Release from proctoring: Percutaneous Tracheostomy

Hajnik, Christopher M.D. — **Orthopedic Surgery**
Release from proctoring: Total Joint Arthroplasty

Hermann, Linda PAC — **Allied Health**
Release from proctoring: Central IV Access, General Patient Care

Jeswani, Sunil M.D. — **Neurosurgery**
Release from proctoring: Para&Intraspinal procedures, including cordotomy and Complex Spine Procedures with instrumentation

Lister, Crystal CNM — **Allied Health**
Release from proctoring: Management of uncomplicated labor inclusive of pelvic examination, amniotomy, external and internal monitoring, and analgesia using intramuscular and intravenous narcotics and potentiators.

Matthews, Oscar M.D. — **Cardiology**
Release from proctoring: Consultations & Percutaneous Angioplasty (PTCA), including stents

Narla, Vinod M.D. — **Anesthesiology**
Release from proctoring: General Anesthesia

Nuckols, Matthew M.D. — **Anesthesiology**
Release from proctoring: General Anesthesia

Phillips, Jason M.D. — **Urology**
Release from proctoring: Greenlight Laser

Roher, Alexander M.D. — **Anesthesiology**
Release from proctoring: General Anesthesia

Serdarevic, Hanna M.D. — **Anesthesiology**
Release from proctoring: General Anesthesia and Regional Anesthesia

Theilsen, April PAC — **Allied Health**
Release from proctoring: Endotracheal Intubations

Varshney, Neeta M.D. — **Ophthalmology**
Release from proctoring: General Ophthalmology Category

Ventrella, Stephanie PAC — **Allied Health**
Release from proctoring: Endotracheal Intubations and Reduction of Major Joints

At the June 10, 2015 the following providers were granted reappointment for a period of **7/1/2015-7/31/2017**. This was a clerical error; the reappointment period should be from **7/1/2015-6/30/2017**.

Afra, Robert, MD	Orthopedic Surgery	Consulting
Ajir, Mahyar, DO	Family Medicine	Affiliate
Alaoui, Jannah F., CNM	Certified Nurse Midwife	Allied Health Professional
Bayudan Inocelda, Andrew G., PAC	Physician Assistant	Allied Health Professional
Birhanie, Melaku T., MD	Internal Medicine	Active
Brockman, Joe B., PAC	Physician Assistant	Allied Health Professional
Burke, Michael S., MD	Interventional Radiology	Active
Crespo, Christopher N., PAC	Physician Assistant	Allied Health Professional
Deemer, Andrew R., MD	General and Vascular Surgery	Active
Dillman, Ariana N., MD	Emergency Medicine	Active
Etedali, Elaheh, DO	Family Medicine	Affiliate
Frakes, Laurie A., MD	Oncology	Active
Hodsman, Hugh K., MD	Family Medicine	Affiliate
Jamshidi-Nezhad, Mohammad, DO	General and Vascular Surgery	Active
Johnson, William H., MD	Diagnostic Radiology	Active
Ku, Tse-Sun, MD	Anesthesiology	Active
Lozano Jr., Jesus, MD	Anesthesiology	Courtesy
Noud, Michael J., MD	Interventional Radiology	Active
Patel, Kiran R., MD	Diagnostic Radiology	Active
Patel, Yogesh V., MD	Pain Medicine	Courtesy
Paveglio, Kathleen A., MD	Cardiology	Active
Purcott, Kari L., MD	Obstetrics & Gynecology	Active
Quintela, Eileen R., MD	Anesthesiology	Active
Stark, Erik S., MD	Orthopedic Surgery	Active
Tom, Clifford C., MD	Anesthesiology	Active
Tomaneng, Neil, MD	Emergency Medicine	Active
Worman, Scott L., MD	Family Medicine	Active

The following providers were given a term of 3/1/2014-2/28/2016; unfortunately, 2016 is a leap year so the correct time frame needs to be **3/1/2014-2/29/2016** to keep our records consistent with our process.

Bobzien, Bonnie R., MD	Pathology - Anatomic	Active
Bruno, Gillian, MD	Internal Medicine	Active
Fatayerji, Nabil I., MD	Neonatology	Active
Fazzino, Dolores L., RNFA	Registered Nurse First Assistant	Allied Health Professional
Halford, Jonathan M., MD	Anesthesiology	Provisional
Jaramillo, Mary D., MD	Internal Medicine	Active
Kaska, Serge C., MD	Orthopedic Surgery	Active
LaFata, John A., MD	Internal Medicine	Active
Li, Yaohui, MD	Anesthesiology	Active
MacMurray, Michael L., MD	Internal Medicine	Affiliate
O'Brien, Mark C., DO	Internal Medicine	Active
Sherman, Christopher L., DO	Orthopedic Surgery	Provisional
Verma, Vishal, MD	Diagnostic Radiology	Associate

TRI-CITY MEDICAL CENTER
HUMAN RESOURCES COMMITTEE
OF THE BOARD OF DIRECTORS
August 11, 2015

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

Topic	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	Chair Kellett called the meeting to order at 12:35 p.m.		Chair Kellett
2. Approval of the agenda	Chair Kellett called for a motion to approve the edited agenda of August 11, 2015 meeting. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.		Chair Kellett
3. Comments from members of the public	Chair Kellett read the paragraph regarding comments from members of the public.		Chair Kellett
4. Ratification of Minutes	Chair Kellett called for a motion to approve the minutes of the June 9, 2015 meeting. Director Reno moved and Ginny Carson seconded the motion. The motion was carried unanimously.		Chair Kellett

Topic	Discussion	Action Follow-up	Person(s) Responsible
5. Old Business			
a. Employee Health & Wellness/Clinic	Rudy Gastelum, EHS Director updated the committee on the status of the employee wellness program. Rudy discussed incentives, active participant count, successes, challenges and overall program redesign. The committee reviewed 2016 goals.		
6. New Business			
a. B.O.D Dashboard- Stakeholder Experience	The Stakeholder Experience pillar- Employee Satisfaction rates were reviewed and discussed.		Chair Kellett
b. Interview of Community Candidates for Open Community Seats on Human Resources Committee	Both candidates were interviewed separately and briefly by the committee. Based on their experience Mr. Quince & Mrs. Sanders where chosen by the committee to fill the two open community member seats for the Human Resources Committee. Chair Kellett called for a motion to approve the two candidates- Mr. Quince & Mrs. Sanders as community members. Director Reno moved and Director Mitchell seconded the motion. The motion was carried unanimously.		Chair Kellett
c. Benefits Renewal Proposal	The 2016 Benefits Renewal Proposal was discussed.		Esther Beverly
d. ED & HMO Copay	Proposed employee copays for ED & HMO were reviewed and discussed.		Esther Beverly
e. Press Ganey Partnership Survey Results Summary	Lisa Daul, Press Ganey presented the Employee results summary. Lisa summarized the overall scores, trending, highest & lowest scoring questions. The committee reviewed the opportunities for improvement and significant comments made by employees. The committee discussed recommendations and next steps.		Esther Beverly

Topic	Discussion	Action Follow-up	Person(s) Responsible
f. Retail Pharmacy	The committee summarized the proposed retail pharmacy services i.e. in-hospital, patient satisfaction boost and readmission rates decrease. Opportunities & benefits compliance was also discussed.		Esther Beverly
g. Discuss Cafeteria Hours (employees, visitors)	The committee discussed cafeteria hours and confirmed that the current hours of operation have been in effect for several years. Availability of items for all shifts was discussed.	COO to look into cold items available for select floors during closed hours	Esther Beverly
h. Discuss to Clarify CA Paid Sick Leave	The CA Paid Sick Leave updates were discussed and clarified.	HR to include in Handbook & NHO	Esther Beverly
i. Exempt Employees PTO Usage	Esther addressed PTO usage per policy 8610-433.	HR to send PTO policy to Director Reno & Mitchell	Esther Beverly
j. Discuss 25 Year Meal Stipend Program	The committee reviewed the opportunities for improvement and challenges of the 25 Year Meal Stipend Program. The committee discussed recommendations and next steps.		Esther Beverly

Topic	Discussion	Action Follow-up	Person(s) Responsible
k. Policy Discussion/Action Policy 8610-406 Employment of Relatives	The Committee reviewed Policy 8610-406. Chair Kellett called for a motion to send Policy 8610-406 to the Board of Directors for approval. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-406 to be sent to Board of Directors for approval at the August 2015 meeting	Esther Beverly
Policy 8610-454 Severance Plan	The Committee reviewed Policy 8610-454. Chair Kellett called for a motion to send Policy 8610-454 to the Board of Directors for approval. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-454 to be sent to Board of Directors for approval at the August 2015 meeting	
Policy 8610-457 New Hire Orientation	The Committee reviewed Policy 8610-457. Chair Kellett called for a motion to send Policy 8610-457 to the Board of Directors for approval. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-457 to be sent to Board of Directors for approval at the August 2015 meeting	
Policy 8610-458 Competency	The Committee reviewed Policy 8610-458. Chair Kellett called for a motion to send Policy 8610-458 to the Board of Directors for approval. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-458 to be sent to Board of Directors for approval at the August 2015 meeting	
Policy 8610-472 Employment Status and Benefits Eligibility	The Committee reviewed Policy 8610-472. Chair Kellett called for a motion to send Policy 8610-472 to the Board of Directors for approval. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-472 to be sent to Board of Directors for approval at the August 2015 meeting	
Policy 8610-483 Conflict of Interest Acceptance of Gifts	The Committee reviewed Policy 8610-483. Chair Kellett called for a motion to send Policy 8610-483 to the Board of Directors for approval. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-483 to be sent to Board of Directors for approval at the August 2015 meeting	

Topic	Discussion	Action Follow-up	Person(s) Responsible
l. 8610-257- Cellular Phones and Other Electronic Digital Devices Review	The committee reviewed policy 8610-257.		Esther Beverly
7. Work Plan	The work plan was reviewed.		Chair Kellett
8. Committee Communications	None		Chair Kellett
9. Date of next meeting	**September 8, 2015**		Chair Kellett
10. Adjournment	Chair Kellett adjourned the meeting at 2:00 p.m.		Chair Kellett

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Management of Human Resources

ISSUE DATE: 7/80 **SUBJECT: Employment of Relatives**

REVISION DATE: 05/12 **POLICY NUMBER:** 8610 – 406

Human Resources Committee Approval:	**08/12**
Board of Directors Approval:	**08/12**

A. **PURPOSE:**

1. To define guidelines for employment of related individuals who may be employed by the District at the same time.

B. **DEFINITIONS:**

1. "Relative" or "related" for purposes of this Policy is defined as: a spouse, parent, brother, sister, legal guardian, child, stepchild, aunt, uncle, niece, nephew, first cousin, grandparent, grandchild, mother-, father-, brother- or sister- in-laws, or any person involved in a legally binding relationship or guardianship with the employee, and/or residing in the home of the employee.

2. "Supervisor," "Supervision," "Supervisory Role" for the purpose of this Policy means those individuals holding the following positions: Member of the Board of Directors, CEO, COO/CNE, Vice President, Director, Manager, Supervisor, or Lead.

3. "Official" is defined as the CEO and a member of the Board of Directors.

C. **POLICY:**

1. Tri-City Healthcare District (TCHD) will accept and consider applications for employment from relatives, as defined above. The applicant must identify any individual who is a close relative already employed by TCHD at the time he/she applies for employment. (See Administrative Policy #462 Conflict of Interest)

2. An individual is precluded from employment with TCHD when an official has an economic interest in an individual's personal finances and those of the individual's immediate family. A governmental decision will have an effect on this economic interest if the decision will result in the personal expenses, income assets, or liabilities of the official or the individual's family increasing or decreasing. (Regulations of the Fair Political Practices Commission, Title 2, Division 6, California Code of Regulations, section 180703.5.)

3. Applicants who are relatives of a TCHD employee will not be eligible for employment with TCHD in a situation where potential problems of supervision, safety, security or morale exist including conflicts, claims of partiality in treatment at work, and personal conflicts from outside of the work environment that can be carried over into working relationships.

4. The relative cannot work within the chain of command/responsibility of the current TCHD employee at any level.

5. The relative cannot have direct influence over a relative's pay or financial data or exert influence on decisions concerning the status of employment, promotion, or compensation.

6. When a relationship exists between two employees that could present an actual or potential conflict of interest, TCHD may take appropriate action which may include reassignment, changing shifts, transfers or if necessary, possible termination.

7. Two relatives may not work in the same department or work unit, regardless of the supervisory status of either employee, or the lack of supervisory status between them.

   a. Float needs and/or patient care may supersede the above.

   b. Employees who may be deemed related under this Policy but who were employed with TCHD prior to August 1, 2012, will be "grandfathered" such that relatives may work in the same work unit or department, so long as a supervisory relationship does not exist between the employees.

8. TCHD has the right to reassign an employee, and limit the working relationship between the relatives, in the event that any relationship interferes with the running of a department/care unit.

Formulation Date 7/80 Review Dates 11/94; 10/97 Revised Dates 3/92; 11/00; 3/03; 7/05

Administrative Authority President/CEO Approval Date_____

Reviewer Human Resources Medical Staff Authority M.E.C. Approval Date_____

Vice President_____ Approval Date_____

Governing Body

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE:	**07/96**	**SUBJECT: Severance Plan**	
REVISION DATE:	**09/13**	**POLICY NUMBER: 8610-454**	
Human Resources Committee Approval:			**09/12**
Board of Directors Approval:			**09/12**

A. **PURPOSE:**

1. To provide continued compensation for a specified period of time to eligible Tri-City Healthcare District (TCHD) employees whose employment is affected when a separation occurs as a result of reduction in force; business decline; department, program or hospital reorganization; or other business reason.

B. **ELIGIBILITY:**

1. Benefited Employees - All benefited employees may be eligible for a severance benefit under this policy. Temporary or per diem employees shall not be eligible for severance benefits under this policy. Employees with signed employment agreements that include a severance arrangement shall be subject to the terms of those agreements in lieu of the provisions of this plan.
2. Subject to B.4. below, eligible employees (as described in B.1., above) shall be entitled to severance pay when:
   a. Their employment is not terminated for cause but for reasons beyond their control due to reduction of work force; business decline; department, program or hospital reorganization or other business reason; or
   b. They elect to participate in and are selected for a voluntary reduction-in-force.
3. Severance shall NOT be payable under this plan in any of the following circumstances:
   a. Where an employee who has had his/her position eliminated is offered and declines alternative benefited TCHD employment that is not less than 70% of his/her current base hourly compensation and scheduled pay period hours .
   b. Where an employee who is terminated by TCHD due to the outsourcing or transfer of operations is offered and declines benefited TCHD employment at a facility which is not more than 35 miles farther from the employee's residence than the site of his/her present employment.
   c. Where an employee has been terminated for cause.
4. TCHD may require as a condition for payment to an otherwise eligible employee, that he/she execute and deliver a Settlement Agreement and General Release in a form acceptable to TCHD.

C. **PAYMENT OF SEVERANCE:**

1. Payment of severance will begin on the first pay date following separation or following the execution and non-revocation of the Settlement Agreement and General Release described at B.4., above, or as otherwise provided in such Settlement Agreement and General Release.
2. Amount and distribution of severance payment for benefited employees:
   a. An eligible employee will receive a severance at his/her final base rate of pay, less applicable required withholding and deductions as identified in the attached Severance Schedule set forth below.
   b. For non-exempt employees, a "week's salary" shall be defined as an amount equal to the product of the employee's final base hourly rate of pay multiplied by the number of

hours the employee was regularly scheduled to work each week at the time of his/her termination of employment with the District. For exempt employees, a week's salary shall be determined by multiplying his/her monthly salary by twelve and dividing that number by fifty-two.

c. The severance payments provided under this Plan will be paid out in equal installments consistent with TCHD's normal pay dates. Lump sum payments, if applicable, will be made at the end of the severance period.

d. TCHD will pay the cost of COBRA (medical, vision and dental) benefits for one month for the employee only. Such coverage shall be effective the first day of the month following the employee's termination date and shall cease at the end of the last day of that month.

D. DISCONTINUANCE OF SEVERANCE PAYMENTS:

1. Severance benefits under this plan are not available to an employee's beneficiaries or to his/her estate.
   a. Employees who are rehired by TCHD in a regular position before receiving all their severance payments will not receive their remaining severance payments.

E. CHANGES TO TRI-CITY HEALTHCARE DISTRICT SEVERANCE PLAN:

1. This Plan is entirely voluntary on the part of TCHD, which has the right to and may terminate or amend it at any time, with or without notice to employees.
2. Plan variations, amendments or the decision to terminate the Plan can be made only by either the TCHD Board of Directors or the TCHD Chief Executive Officer or his/her designated representative.
3. If the Plan is amended or terminated, all employees' rights under this Plan, except for those who were terminated and had already begun receiving payments under the Plan, will be governed exclusively by the new plan document or will cease to exist in the case of a plan termination.

F. **SEVERANCE SCHEDULE**

Service	NE Ex non mgr	Mgr	Director
	# Weeks	# Weeks	# Weeks
Less than 1 Year	2	3	4
1	2	3	4
2	2	3	4
3	3	4	5
4	4	5	6
5	5	6	7
6	6	7	8
7	7	8	9
8	8	9	10
9	9	10	11
10	10	11	12
11	10	11	12
12	10	11	12
13	10	11	12
14	10	11	12
15	10	11	12
16	10	11	12
17	10	11	12
18	10	11	12
19	10	11	12
20+	10	11	12
Other	1 month COBRA paid by TCMC for single coverage		

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE:	**09/97**	**SUBJECT:**	**New Hire Orientation**
REVISION DATE:	**09/12**	**POLICY NUMBER:**	**8610-457**
Human Resources Committee Approval:		**09/12**	
Board of Directors Approval:		**09/12**	

A. **POLICY:**

1. The Tri-City Healthcare District (TCHD) New Hire orientation program is an important component of acquiring and maintaining professional competency. All new hires, travelers/registry shall undergo TCHD orientation conducted under the Human Resources Department to acquaint them with the Hospital's mission, goals and operations. In addition, new employees, travelers/registry shall be oriented to their relevant department or unit. Except as otherwise provided in this Policy, no employee, travelers/registry may begin providing care, treatment or services at TCHD without completing both the TCHD and department or unit specific orientation.
2. Hospital Orientation:
   a. All new employees are required to attend TCHD New Hire Orientation.
      i. Orientation is required prior to employee starting work unless exempted by the Chief Human Resources Officer or designee. Attendance is mandatory and employees shall be paid for the time spent in new hire orientation.
      ii. If an employee must start on a non-New Employee Orientation start week he/she must complete the TCHD off-cycle start: New Employee Checklist within the first day.
   b. Contract Staff
      i. All contract personnel, nursing and non-nursing, must complete TCHD orientation materials as specified in their agreements, prior to being scheduled to work at TCHD.
      ii. Travelers/long term contract personnel may be required to attend the TCHD new hire orientation.
3. If an employee fails to complete any portion of his/her new hire orientation after 30 days he/she will be subject to disciplinary action, up to termination. (Administrative Policy, # 424 Coaching and Counseling for Work Performance Improvement)
4. TCHD New Hire orientation is scheduled one time per month.
5. Hospital orientation includes, but is not limited to, a review of the following:
   a. Mission, Vision, Value and Ethics
   b. Patient rights and ethical aspects of care
   c. Patient care philosophy
   d. Compliance training
   e. Environment of Care
   f. Infection control training
   g. Blood borne pathogens exposure control plan
   h. TB exposure control plan
   i. Universal reporting
   j. Risk management reporting
   k. Performance improvement philosophy
   l. Patient safety

m. HIPAA and Patient Privacy
n. Cultural diversity and sensitivity
o. Harassment Prevention

6. Departmental/unit specific orientation includes, but is not limited to the following:
   a. Departmental specific competencies, policies, procedures
   b. Departmental documentation
   c. Technical Skills
   d. Non-Technical Skills
   e. Standards of Care/Patient Assessment
   f. Critical Thinking for Care of Specific Populations
   g. Emergency Procedures
   h. Other job and unit specific competencies, safety and infection control as appropriate to the unit /department.
   i. Individual performance objectives, job duties, the performance appraisal

   Competency to perform job responsibilities will be assessed, demonstrated and maintained in the department. (See Policy 458).
7. The Netlearning Modules (computer based learning modules) are also used to orient staff. They must be completed within 30 days of hire and then on an annual basis.
8. Managers may require further orientation as remediation for employees who do not successfully complete annual competency evaluations.
9. Designated nursing employees are required to participate in nursing orientation and computer training coordinated by the Professional Education Department.

   Employees who transfer within the organization:
   a. Employees who transfer to a new department or service must receive department orientation before assuming any duties upon the transfer. Competency to perform job responsibilities will be assessed, demonstrated signed by the employee and manager.
10. Employees who are required to "Float":
    a. Employees who float to another department within their float pods as identified by Department Specific Policies and/or Patient Care Services Policy VIII.F, "Floating" will not be required to complete specific departmental/unit orientation.
    b. Employees who float to another department outside of their float pod will be required to complete departmental/unit specific orientation and their documents must be maintained on file.
    c. Employees who maintain a 2nd position will be required to complete departmental/unit specific orientation for their 2nd position. Their documents must be maintained on file.
11. Forensic staff:
    a. All forensic staff are oriented to the following: how to interact with patients; procedures for responding to unusual clinical events and incidents; the hospital's channels of clinical, security and administration communication; and distinctions between administrative and clinical seclusion and restraint.

FORMS REFERENCED WHICH CAN BE LOCATED ON THE INTRANET

1. Department Orientation Checklist
2. Verification of Employees Orientation Completion
3. TCMC Emergency Start-Up: New Employee Checklist

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 09/97	**SUBJECT: Competency**
REVISION DATE: 09/12	**POLICY NUMBER:** 8610-458
Human Resources Committee Approval:	09/12
Board of Directors Approval:	09/12

A. **PURPOSE:**
Tri-City Health District ("TCHD") will maintain staff, student, contract staff and volunteer competency through initial orientation and, as appropriate, with ongoing education, training and competency evaluations.

B. **POLICY:**
The competency of TCHD employees shall be assessed, maintained, demonstrated, and improved in a systematic on-going process. Competency assessment allows for a measurable assessment of the person's ability to perform required activities for his/her job as assessed by a qualified individual. Information used as part of competence assessment may include data from performance evaluations, performance improvement, and aggregate data on competency, as well as assessment of learning needs. Competency assessment for staff, students, volunteers, and contract/registry staff who work in the same capacity as staff providing care, treatment and services is based on the following:

1. Populations served and services provided
2. Defined competencies to be required
3. Defined competencies to be assessed during orientation
4. Defined competencies that need to be assessed and reassessed on an ongoing basis, based on techniques, procedures, technology, equipment, or skills needed to provide care, treatment and services.

C. **MEASUREMENT OF KNOWLEDGE:**
The measurement of knowledge is verified prior to hire, addressed during orientation, and evaluated annually. Evaluation may include any of the following methods: 1) education & training; 2) licensure, 3) certification, 4) direct observation, 5) work experience, 6) self-evaluation, 7) verbal and/or written examinations, 8) return demonstrations, 9) interviews and 10) peer reviews. Employee-specific feedback may be collated from patient compliments/complaints, quality reports, in-service program educational results and/or recommendations by members of the health care team.

Guidelines for Measurement of Knowledge

1. New Hire Hospital Orientation period - For new hire process and requirements for Hospital Orientation – Refer to Administrative Policy # 457, New Hire Orientation.
2. Department/Unit specific orientation:
   a. Employees new to a job or service, including transfers, will receive Department/Unit Orientation pursuant to Administrative Policy # 457. Directors/Managers/Supervisors will verify that the education and training of employees are consistent with applicable laws/regulations and that required licensure, certifications and registrations are current.
   b. An individual with the educational background, experiences or knowledge related to the skills being reviewed assesses competence.
   c. Upon completion of Department/Unit Orientation, the Administrative Policy # 457 addendum Department Orientation Checklist will be sent to Human Resources, with a copy to the Education Department.
   d. Clinical competencies and skills checklists are maintained on the TCHD Intranet.

e. Managers will provide remediation for employees who do not successfully complete annual competency evaluations or require additional orientation pursuant to Administrative Policy # 457.

f. The competency skills checklists for clinical and non-clinical positions identify the competencies that the employee is expected to complete successfully during his/her orientation. The Department/Unit orientation competencies may include the following:
   i. Departmental specific competencies
   ii. Departmental documentation
   iii. Technical Skills
   iv. Non-Technical Skills
   v. Standards of Care/Patient Assessment
   vi. Critical Thinking for Care of Specific Populations
   vii. Emergency Procedures

3. On-going
   a. Defined competencies that need to be assessed and reassessed on an ongoing basis may include low volume, high risk and new procedures, technology, equipment or skills needed to provide care, treatment and services.
   b. Competencies will be assessed using various methods, including, but not limited to, annual skills labs, in-services, 1:1 training, education, computer based learning and on-line web education. In addition, in-services are offered throughout the year, as additional policies/procedures are updated, to inform employees accordingly
   c. Ongoing education and training may be provided for the following learning needs:
      i. To maintain and improve competence in the care and needs of the population served and to comply with applicable laws and regulations.
      ii. To increase an employee, student or volunteer's knowledge of work-related issues, techniques, procedures, technology, equipment, or skills needed to provide care, treatment and services.
      iii. To emphasize specific job related aspects of safety, and infection prevention and control.
      iv. To incorporate methods of team training, when appropriate.
      v. To reinforce the need to report unanticipated adverse events and ways to do so.
      vi. To respond to learning needs identified through performance improvement findings and other data analysis (such as data from staff surveys, performance evaluations, or other needs assessment).
      vii. To support staff when job responsibilities or duties change.
   d. Supervision and consultation are available to direct care staff to maintain and enhance their knowledge, skills, and attitudes in providing care, treatment, and services.
   e. Manager or Department Educator documents ongoing education.
      i. Non-nursing departments can track annual competency on the Annual Department Specific Employee Competency Verification Record. (Attachment 2)

4. Annually
   a. Annual Skills Lab with validation and/or demonstration for high risk, problematic and low frequency procedures, practices and skills
   b. NetLearning mandatory training modules will be assigned based on specific position and job duties.
   c. The competency checklist for clinical positions identifies the competencies that the employee is expected to complete successfully during the orientation period as well as the competencies that an employee is expected to review on an annual basis.
   d. Transfers within the hospital:
      i. Employees will complete the receiving department or unit's orientation process and competencies, pursuant to Administrative Policy #457.

D. **PLANNING:**

1. TCHD aggregates the competency assessment results on an annual basis. The results of the competency assessments may be used in the following ways:
   a. The competency self-assessment evaluations are used to plan staff education programs in order to continually improve the performance and competency of employees.
   b. Competencies for the clinical providers privileged by the medical staff will be under the medical staff reporting process.
   c. The competency aggregate data results will be linked to the educational plan and budgetary process.
   d. Priorities with respect to training, recruitment, and other related matters will be established based upon these results.

E. **COMPETENCIES OF LEADERSHIP AND MANAGEMENT:**
1. Physical capability required to carry out the essential job responsibilities as identified on the Physical, Mental, and Environmental grid of each job description.
2. Competencies and other performance criteria as determined by the Manager and his/her Supervisor.
3. Managers who (1) work in a dual position as a manager and function in the same capacity as their non-management staff positions during any part of their scheduled shift or (2) maintain a second position in a non-management role must complete Hospital or Department/Unit Orientation as required for non-management employees in the same position pursuant to Administrative Policy # 458.

F. **NURSING REGISTRY AND TRAVELER STAFF:**
1. Registry staff
   a. Refer to Staffing and Resource Center policy manual (9.c. and Letter of Competency (LOC)).
   b. Registry agencies maintain staff clinical competencies and provide validation to TCHD via a letter of clinical competency. The Letter of Competency must meet all criteria specified in the agency contract.
2. Traveler staff
   a. Refer to Staffing and Resource center policy manual; 8.B. Section 5.
   b. The agency will forward any required information to TCHD.
   c. Traveler staff is required to attend new hospital and nursing orientation, unit/department orientation and competencies and complete competency checklists.
3. Traveler staff maintains competency checklists with their agencies. Travelers must complete department specific competency checklists within the first month of hire.
4. Students
   a. Clinical Affiliation Nursing School contracts include the responsibility to provide training for the students in compliance with TCHD and regulatory standards. TCHD will provide resources to coordinate this function. Student competencies will be evaluated by instructors and competency communicated to appropriate TCHD staff.
   b. Non-nursing students' contracts include the responsibility to provide training for the students in compliance with TCHD and regulatory standards. TCHD will provide resources to coordinate this function.

G. **NON-NURSING, PATIENT CARE REGISTRY, TRAVELERS AND/OR CONTRACT STAFF:**
1. Travelers
   a. Employee files are maintained within the Staffing Resource Center.
2. Agency (per diem)
   a. Registry personnel competency is maintained by the agency.
   b. Orientation manuals are maintained in the department.
   c. Employee files are maintained within the department.

H. **VOLUNTEERS:**

1. Following application to the TCHD hospital auxiliary, each volunteer is provided with orientation materials, including, but not limited to, the following:
   a. Welcome letter
   b. Mission Vision and Values
   c. Patient rights, ethics
   d. Cultural diversity and sensitivity
   e. Senior application
   f. Junior application
   g. Department descriptions
   h. Department vacancies
   i. Policies and procedures
   j. Dress code
   k. Confidentiality Acknowledgement
   l. HIPAA privacy and security rules and reporting
   m. Emergency Codes/Fire Safety
   n. Code of Conduct Book
   o. Life Safety/Infection Control
   p. Benefits
   q. TB skin tests
   r. Membership
2. Department Orientation
   a. A department chairman contacts the applicant for an interview.
   b. The following are completed during this period.
      i. A department specific training is scheduled.
3. Annual refresher program
   a. The educational material is linked to (but limited to) updates, enhancement of skills, procedures to provide volunteer care and/or services in order to sustain and improve/enhance skills toward becoming more proficient and/or efficient.
   b. Volunteers are encouraged to complete an annual self-evaluation of job responsibilities/competencies, which contains at least the following:
      i. Physical, mental and environmental grid
      ii. Confidentiality and HIPAA forms
      iii. Infection control
      iv. Emergency code summary
      v. Dress code
      vi. Safety

I. **ATTACHMENTS/REFERENCED FORMS WHICH CAN BE LOCATED ON THE INTRANET:**

1. Verification of Employment Orientation

J. **REFERENCES:**

1. Joint Commission Hospital Accreditation Standard Manual
2. Human Resources Procedure Manual, Transfers (Internal)
3. Administrative Policy # 457 New Hire Orientation
4. Meeting the Competency Challenge in Healthcare Human Resources (2000); MA: C & R Publications, Inc.
5. Terry, Ruth Ann. Executive Officer (11/90). Interim Permittee functions, *Board of Registered Nursing*, Sacramento, California. Approved 11/90.

Tri-City Medical Center

VERIFICATION OF JOB COMPETENCIES AND JOB ORIENTATION COMPLETION

Must be completed and signed by Manager and employee at the conclusion of the Employee's orientation phase.

Employee Name: _____ EID: _____

Employee Title: _____ DOH: _____

Department: _____

The above mentioned employee has the ability to carry out assigned responsibilities safely and competently as evidenced by the completion of the key job related competencies and the individual's orientation to the Department/Unit. This individual is aware of resources available in the event additional support/training is required at any future date.

Manager Signature: _____ Date: _____

Employee Signature: _____ Date: _____

Forward original to HR Department.
Forward copy to Education.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Human Resources

ISSUE DATE: 09/08 **SUBJECT:** Employment Status and Benefits Eligibility

REVISION DATE: 09/12 **POLICY NUMBER:** 8610-472

Human Resources Committee Approval: 09/12
Board of Directors Approval: 09/12

A. **PURPOSE:**

1. To identify and define the various types of employment status and associated benefits eligibility utilized at Tri-City Healthcare District (TCHD)

B. **POLICY:**

1. TCHD has established the following employment statuses:
   a. Regular – an employee who is regularly scheduled to work an established number of hours. Regular employees may be:
      i. Full-time – regularly scheduled to work 80 hours per pay period (72 hours per pay period if working 12 hour shifts)
      ii. Part-time – regularly scheduled to work less than full-time.
      iii. Per Diem – an employee who is used on an "as needed" basis and does not normally work a regular schedule but who agrees to be available to work a minimum number of hours as established in their Per Diem Scheduling Agreement.

   b. Weekend Professional -Staff who are regularly scheduled to work six (6) out of eight (8) weekend shifts per four (4) week schedule are classified as Weekend Professionals. A weekend professional can be classified as benefited (Full Time, Part Time), or Per Diem.

      i. Weekend professional Per Diem: The Weekend Professional Per diem employee must work the six (6) out of eight (8) weekend shifts per four week schedule and are paid at 10% above the per diem rate. The employee will receive this elevated rate only when he/she works on the weekend. Each shift that is worked on a non-weekend day will be paid at the regular per diem rate.
      ii. Weekend Benefited (Full Time & Part Time): The Weekend Professional benefited employee must work the six (6) out of eight (8) weekend shifts per four week schedule and are paid at 10% above the factored rate and the employee will receive the rate every shift he/she works. The benefited Weekend Professional employee must make up the balance of their hours through the week.

   c. Temporary – an employee who agrees to work in a specific position for a designated period of time, generally not to exceed six months.

2. Eligibility to participate in TCHD employee benefits programs is based on employment status:
   a. A regular employee must be routinely scheduled a minimum of 48 hours per pay period (.6 FTE) to be benefit eligible. Regular benefited employees are eligible for health and welfare benefits, paid time off, all retirement plans (National Security Retirement Program, Money Accumulation Pension Plan, and 457 (b) Deferred Compensation Plan), and statutory benefits.

b. Regular employees who elect non-benefited status or who are not routinely scheduled a minimum of 48 hours per pay period are eligible for two retirement plans (National Security Retirement Program and 457(b) Deferred Compensation Plan) and statutory benefits.

c. Per Diem employees are eligible for two retirement plans (National Security Retirement Program and 457(b) Deferred Compensation Plan) and statutory benefits.

d. Per Diem Weekend Professional employees are eligible for two retirement plans (National Security Retirement Program and 457(b) Deferred Compensation Plan), limited time off and statutory benefits.

e. Temporary employees are eligible for statutory benefits.

f. Employees who are on an approved leave of absence are eligible for continuation of all their current health/welfare benefits, statutory benefits and those governed by regulations that apply to the particular type of leave involved. While on leave of absence employee health insurance premiums will continue to be deducted from employee's PTO pay until their 12 weeks in a rolling calendar year of health insurance has been exhausted. If the employee exhausts their PTO during leave, the employee is responsible for paying those premiums.

g. Terminated employees are not eligible for benefits, except as provided in approved severance arrangements and/or through legally mandated continuation such as COB RA.

3. The Chief Human Resources Officer, with approval from the Chief Executive Officer, has authority and responsibility for administration of this policy. Practices and procedures to support the administration of this policy, including requirements for changing status, will be developed by the Chief Human Resources Officer.

Tri-City Medical Center
Oceanside, California

Human Resource Manual

ISSUE DATE: 08/12	**SUBJECT: Conflicts of Interest and Acceptance of Gifts**
REVISION DATE: 08/12	**POLICY NUMBER: 8610-483 (Former Policies 8610-462 & 8610-425)**
Human Resources Committee Approval:	
Governance Committee Approval:	**10/14**
Board of Directors Approval:	**11/14**

A. **PURPOSE:**

1. This policy (1) helps policy-making managers and other employees avoid actual, potential, and perceived conflicts of interest; (2) establishes procedures designed to ensure conflicts are properly disclosed and resolved; and (3) provides guidance regarding the acceptability of gifts and gratuities.
2. This policy does not apply to acceptance of gifts from pharmaceutical vendors. Employees and their Immediate Family Members are prohibited from accepting gifts from pharmaceutical vendors. For TCHD's pharmaceutical vendor policy, see Pharmacy Services Policy Manual, Policy No. 8390-10025: "Pharmaceutical Vendors".

B. **GENERAL POLICIES:**

1. TCHD's policy-making mangers and other employees must devote their best efforts and attention to the performance of their duties and obligations at TCHD, and must avoid and promptly disclose conflicts of interest.
2. Employees shall not use TCHD information, property, or labor for personal gain, or disclose or use TCHD's confidential information for any purpose inconsistent with their official duties.
3. Employees and their Immediate Family Members are prohibited from accepting monetary gifts or gratuities, or non-monetary gifts costing more than $50, for their own personal benefit, from anyone doing business with, or seeking to do business with, the District.
4. Employees are prohibited from soliciting gifts for their own personal benefit, of any amount or kind, from anyone doing business with, or seeking to do business with, the District.
5. Employees who receive honoraria (money) for speaking on behalf of the District or for participating in surveys in the course of their duties on behalf of the District must give the money to Tri-City Hospital Foundation to the extent they exceed associated travel expenses.
6. At the discretion of a department manager or director, gifts such as flowers or food that can be consumed or shared by the employee's coworkers, may be accepted provided the total cost is not greater than $50 per person. This policy does not preclude employees from sending flowers or modest gifts to one another for the condolence of a death or to celebrate a special occasion.
7. Vendors, patients, visitors, physicians, and employees who wish to show their appreciation or support of TCHD and its employees by means of a substantial gift should be referred to the Tri-City Hospital Foundation.

C. **DEFINITIONS**:

1. Conflict of Interest. A conflict of interest occurs when an individual is in a position to control or influence a business decision and has a personal, financial, or other competing interest in the outcome of the decision.
2. A competing interest arises when an individual, or his/her immediate family member, stands to gain or lose - directly or indirectly - as a result of the outcome of the matter or decision.

3. Immediate Family Member. This term means a spouse or civil union partner, natural or adoptive parent, child, or sibling: stepparent, stepchild, stepbrother or stepsister, father-in law, mother-in-law, son-in-law, daughter-in-law, brother-in- law, or sister-in-law: grandparent or grandchild: and the spouse of a grandparent or grandchild.

D. **EXAMPLES:**

1. The following is a non-exhaustive list of examples of Conflicts of Interest:
   a. An employee is a partner in an entity seeking to do business with TCHD.
   b. A manager provides confidential information to a patient to encourage a lawsuit against TCHD.
   c. An employee suggests TCHD hire a firm owned by her spouse to create hospital signage.
   d. An employee purchases property for the purpose of selling it to TCHD.
   e. A manager pressures a subordinate to hire a friend or relative.
   f. An employee commits TCHD to contract with a bank in exchange for a decreased interest rate on her car loan.

E. **PROCEDURES:**

1. All employees who believe they may have a Conflict of Interest, as described in this policy with respect to any District matter or decision must bring this concern to the immediate attention of the Compliance Officer, or the Values Line (800) 273-8452.
2. The Compliance Officer will review all Conflict of Interest disclosures and provide a written determination and instruction with respect to compliance with this policy.
3. The failure to fully, accurately, and promptly disclose actual, potential, or perceived Conflicts of Interest may result in disciplinary action, up to and including termination.

F. **SCOPE OF POLICY:**

1. This policy establishes rules for employee conduct that supplement and do not replace or excuse non-compliance with conflict of interest laws applicable to policy-making management and other employees of the District under California or Federal laws.
   a. Review of a disclosure by and receipt of instructions from the Compliance Officer do not relieve any employee from adherence to other applicable laws and policies governing local healthcare district employees, including but not limited to:
   b. Limits on positions and ownership interests in competing hospitals (Health & Safety Code section 32110);
   c. Disclosure and disqualification from participating in governmental decisions as a designated person under the District's conflict of interest code under the Political Reform Act;
   d. Prohibitions on making contracts which may affect personal finances under Government Code section 1090;
   e. Use of confidential information for personal gain under Government Code section 1098;
   f. Engaging in inconsistent, incompatible, or conflicting employment activities or enterprises, as proscribed by Government Code section 1126.

TRI-CITY MEDICAL CENTER
EMPLOYEE FIDUCIARY RETIREMENT PLAN SUB COMMITTEE
OF THE BOARD OF DIRECTORS
August 11, 2015

Voting Members Present:	Chair Dr. Cyril Kellett, Director Rosemarie Reno, Ginny Carson
Non-Voting Members Present:	Tim Moran, CEO; Kapua Conley, COO; Esther Beverly, VP of HR; Cheryle Bernard-Shaw, CCO
Others Present:	Quinn Abler, Maureen Peer, Dena' Baker, Gary Allen, Eduardo Repetto, Frances Carbajal
Members Absent:	

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

Topic	Discussion	Action Follow-up	Person(s) Responsible
5. **Old Business**			
None			
6. **New Business**			
a. Lincoln Quarterly Update	Maureen Peer, Lincoln Relationship Manager presented executive summary which included an update from Lincolns quarter results. Key plan statistics, plan asset growth, contributions, earnings, participation rates, average deferral rates and account balances where also reviewed.		Esther Beverly
b. Prudent Quarterly Update	Gary Allen, Prudent Investment Advisor presented the quarter plan growth results. Gary explained the risk based model portfolios with glide path overlay. Dena' Baker from Prudent updated the committee on employee participation. Dena' described highlights and the growing enrollment, participation rate and great communication and relationship between TCHD employees and Prudent investment advisors. Eduardo Repetto, Prudent Guest Speaker presented target date funds, current trends, regulatory issues and an overview of Dimensional's next generation target date income funds.		Esther Beverly
c. Discuss Lincoln Contract Increase	The 2016 Lincoln contract increase was reviewed and discussed.		

Topic	Discussion	Action Follow-up	Person(s) Responsible
7. Comments made from the Committee	None		Chair Kellett
8. Date of next meeting	**December 8, 2015**		Chair Kellett
9. Adjournment	Chair Kellett adjourned the meeting at 12:30 p.m.		Chair Kellett

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
August 13, 2015 Assembly Room 1

MEMBERS PRESENT: Board of Directors Chairman Larry Schallock; Director/CHAC Chairperson Julie Nygaard, Director James Dagostino, Dr. Victor Souza, Mary Lou Clift, Marge Coon, Gigi Gleason, Darryl Hebert, Marilou de la Rosa Hruby, Linda Ledesma; Bret Schanzenbach; Guy Roney

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

OTHERS PRESENT: Steve Dietlin, CFO; Susan McDowell, CHAC Coordinator; Celia Garcia, CHAC Coordinator

MEMBERS ABSENT: Linda Allington, Marilyn Anderson, Xiomara Arroyo, Carol Brooks, Rosemary Eshelman, Carol Herrera, Gina McBride, Jack Nelson, Barbara Perez, Don Reedy, Laura Vines, Audrey Lopez

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CALL TO ORDER	The August 13, 2015 Community Healthcare Alliance Committee meeting was called to order at 12:35pm by Director and CHAC Chair Julie Nygaard.		
APPROVAL OF MEETING AGENDA	Director Jim Dagostino motioned to approve the August 13, 2015 agenda. The motion was seconded by Director Larry Schallock and unanimously approved.		
PUBLIC COMMENTS & ANNOUNCEMENTS	No public comments were made.		
RATIFICATION OF MINUTES	Director Jim Dagostino motioned to approve the June 11, 2015 meeting minutes (no CHAC meeting in July). The motion was seconded by Gigi Gleason and unanimously approved with no corrections.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
August 13, 2015 Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PRESENTATION	Tim Moran, CEO Tri-City Medical Center Overview Steve Dietlin, CFO Tri-City Medical Center Financial Review David Bennett, CMO Tri-City Medical Center Marketing Review		
Tim Moran CEO	Tim Moran acknowledged the group noting that CHAC meetings are one of the only gatherings of people that truly represent the entire district served by Tri-City Medical Center. Tim presented an overview of the past year as follows: 1. Tri-City Medical Center is only one (1) of four hospitals in San Diego County to receive an "A" rating from The Leapfrog Group. Our closest competitors received ratings of "B" and "C". 2. Administration and Marketing have worked closely together over the past year to increase market share and improve our branding and image. Efforts have been successful.		

TOPIC		ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PRESENTATION	3. Tri-City Medical Center produced an economic impact of over $193 million dollars back into the community it serves during FY 2015 through: • Salaries • Benefits • Charity • Uncompensated Care • Capital Improvements • Community Grants • Educational Programs • Event Sponsorships 4. While the Affordable Care Act (ACA) is a well-intended effort, the future impact of its implementation is difficult to predict. New governmental systems of payment and reimbursement are in the works, and the outcomes of their enactment are not yet known. Tri-City Medical Center is committed to quality care despite the uncertainty of the financial impact. 5. The ACA has created a surge in patient activity in the Emergency Department, i.e. patients presenting with minor conditions and an increase of behavioral health issues. 6. Key Initiatives are: • Strategic plans to ensure the advancement of the health and wellbeing of the community members we serve.		

TOPIC		ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PRESENTATION	• Investing in the recruitment of Physicians • Affiliation opportunities • Completion of the campus plan, including an improved ED and parking structure 7. The current focus for Leadership includes: • Primary Care Physicians • Retrofit or redesign – ED, Parking Structure • OB / NICU • Behavioral Health and Urgent Care adjacent to the new ED 8. Tim Moran noted that a new Governmental payment system is being proposed where hospitals will receive a pre-specified payment amount for a particular procedure, i.e. knee replacement. With this payment, the hospital will then be responsible to provide and pay for all related services for a period of 90 days following the procedure. This will include payment to all providers, follow up care, etc.		
PRESENTATION **Steve Dietlin CFO**	A May Financial Update was presented by CFO Steve Dietlin. This information was previously reviewed by FOB and the hospital Board of Directors. 1. The operating revenue for TCMC to date is currently below budget with operating expenses being slightly higher than budget. 2. The Average Daily Census remains consistent at 192-193.		

TOPIC		ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PRESENTATION	3. There are no unexpected variances for Adjusted Patient Days, Surgery Cases, Deliveries or ED Visits. 4. The recent changes in healthcare reimbursement laws, combined with proposed future changes, make it very difficult to anticipate future revenue based on current practice. 5. Net days in Patient Accounts Receivables averages 45-55. 6. There has been no sharp decline in ED visits since the passing of the ACA. In fact, ED visits increased for a period of time after passage of the ACA as people continued to use the ED for non-emergency issues.		
PRESENTATION **David Bennett CMO**	CMO David Bennett addressed the group regarding Marketing and Brand Awareness as follows: 1. TCMC is working to attract more physicians and patients to increase revenue and community involvement. 2. The Marketing Department is working to build brand awareness and visibility in the district we serve through television, radio, billboards and print advertising. 3. TCMC continues to sponsor more than 90 events and galas per year to improve visibility and perception within our community.		

TOPIC		ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PRESENTATION	4. Much of 2013 was spent on damage control to improve the community's perception of TCMC's internal issues with Leadership, which unfortunately detracted from the excellent medical care being given to patients during this same time. 5. Marketing's current and future focus remains on: • Growth and PCP recruitment • Building the PCP network • Continued patient-centered care • Quality programs at TCMC • Wellness Center membership and programs 6. Marketing is professionally driven to focus on: • Prime time programing on ABC, NCB, CBS & Entravision • Print media in the Union Tribune, San Diego Business Journal, Coast News and miscellaneous community magazines • Billboard campaigns • Email blasts • Radio spots on KFMB (CBS) • Community sponsorships and events • Increased Social Media focus, including: * New TCMC Website * Facebook * Twitter * You Tube * Google +		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
August 13, 2015 Assembly Room 1

TOPIC		ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PRESENTATION	Director and CHAC Chair Julie Nygaard thanked the presenters and noted that TCMC is on a good path with great plans for the future. A member of the committee also expressed gratitude to the TCMC Board of Directors for their part in the successful transformation of the community's perception of the hospital's leadership.		
COMMITTEE COMMUNICATIONS	• Bret Schanzenbach presented the group with the latest copy of "Vista Magazine" and announced that the Vista Optimist Foundation will be presenting Summer Fest this Saturday, August 15th from 5:30 – 10:30pm. • COO Kapua Conley thanked the Oceanside Fire Department, Station 7, for allowing him to participate in a ride-along this past week. He noted it was a great experience to see their work first hand. • Roma Ferriter noted that NCHS will be celebrating Health Week. The event will have interesting events for adults and kids and will include health screenings. • Gigi Gleason reminded the group that the Heritage Ball at the Mission San Luis Rey is this Saturday, August 15th, noting there are apx. 20 tickets still available if anyone is interested in attending.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
August 13, 2015 Assembly Room 1

TOPIC		ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
NEW COMMITTEE MEMBER	Director Julie Nygaard welcomed new committee member, Guy Roney, to the CHAC committee and thanked him for his commitment of service to the committee and community.		
DATE & TIME OF NEXT CHAC MEETING	The next CHAC meeting is scheduled for Thursday, September 10, 2015.		
ADJOURNMENT	The meeting was adjourned at 1:47pm.		

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
August 18, 2015

Members Present	Dr. James Dagostino, Director Cyril Kellett, Director Julie Nygaard, Dr. John Kroener, Dr. Marcus Contardo, Kathleen Mendez, Carlo Marcuzzi, Steve Harrington, Wayne Lingenfelter, Tim Keane
Non-Voting Members Present:	Tim Moran, CEO, Steve Dietlin, CFO, Kapua Conley, COO, Cheryle Bernard-Shaw, CCO, Wayne Knight, Sr. VP, Medical Services
Others Present:	Director Laura Mitchell, Director RoseMarie Reno, Frank Gould, Sharon Schultz, Steve Young, David Bennett, Jane Dunmeyer, Randy Burns (McCarthy), Ray Rivas, Phil Soule, Charlene Carty, Colleen Thompson, Glen Newhart, Tori Hong, Kathy Topp, Tom Moore, Carol Smyth, Scott Worman, M.D., Chris Miechowski, Mary Diamond, Jenelle Lovelady, Jeremy Raimo, Rosemary Mervosh, Joni Penix
Members Absent:	Dr. Frank Corona

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Dagostino called the meeting to order at 12:36 pm.		
2. Approval of Agenda	Director Dagostino stated that the Vivify Update, item 6.s., was to be pulled from the agenda.	**MOTION** **It was moved by Dr. Contardo, Ms. Mendez seconded, and it was unanimously approved to accept the agenda of August 18, 2015 with the following change: Item 6.s. the Vivify Update, was to be pulled from the agenda.**	
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 June 16, 2015		Minutes ratified. **MOTION** **It was moved by Director Kellett, Dr. Kroener seconded, that the minutes of June 16, 2015, be approved as written, with Mr. Marcuzzi and Mr. Keane abstaining.**	
5. Old Business	None		
6.a.Introduction – New Community Members • Carlo Marcuzzi • Tim Keane	Director Dagostino introduced Mr. Marcuzzi and Mr. Keane as the new community members, and welcomed them to the Finance, Operations & Planning Committee.		Chair
b. Policy Review • Charity Care, Uncompensated Care, Community Service, #8610-285	**Charity Care, Uncompensated Care, Community Service** ***Purpose:*** 1. The Hospital desires to have a clear, well-communicated and documented financial assistance policy consistent with its mission and values, and in compliance with government accounting standards, Federal and State regulations. 2. California acute care Hospitals must comply with Health & Safety Code Section 127400 et seq, hereinafter referred to as the	**MOTION** **Director Nygaard moved, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors approve the policy Charity Care, Uncompensated Care, Community Service, with the addition of "sexual orientation" included in item B.2.**	Ray Rivas

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	California Fair Pricing Law, including requirements for written policies providing discounts and charity care to financially-qualified patients. This policy is intended to exceed the legal requirements detailed in the California Fair Pricing Law. This policy was presented in redline version, by Ray Rivas. Discussion ensued and Director Nygaard made the recommendation that "sexual orientation" be added to Item B.2.		
• Policies and Procedures Including Bidding Regulations Governing Purchases of Supplies and Equipment, Procurement of Professional Services, and Bidding for Public Works Contracts, #145-013	**Policies and Procedures Including Bidding Regulations Governing Purchases of Supplies and Equipment, Procurement of Professional Services, and Bidding for Public Works Contracts, #145-013** This policy was presented in red line version by Chris Miechowski. Discussion ensued, however, no changes or modifications were recommended to this policy.	**MOTION** **Mr. Lingenfelter moved, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors approve the Bidding Policy as written / revised.**	Chris Miechowski

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• Petty Cash Funds, #8610-208	**Petty Cash Funds Policy, 8610-208** This policy was present in red line version by Charlene Carty. This policy is to be deleted, as it is no longer used. Discussion ensued, but it was agreed to recommend deletion of this policy.	**MOTION** **Director Nygaard moved, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors approve the deletion of the Petty Cash Funds policy.**	Charlene Carty
c. Board Resolution, # 775	**A Resolution of the Board of Directors of the Tri-City Health Care District Authorizing the Chief Executive Officer to Award Certain Emergency Contracts.** Board Resolution, #775 was presented by Kapua Conley as an adjunct to Board Policy, # 145-013, referred to as the "Bidding Policy". Discussion ensued, and it was recommended to approve Board Resolution, #775.	**MOTION** **Mr. Lingenfelter moved, Ms. Mendez seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors approve Board Resolution, #775 in support of the Bidding Policy, #145-013.**	Kapua Conley
d. Registry Spend for Nursing and Allied Health Proposal	Kathy Topp presented the Registry Spend for Nursing and Allied Health Proposal. She stated the increase is requested to support increase in registry rates, and to maintain a competitive edge for limited resources. They are also planning ahead to utilize supplemental staffing while we work to fill vacant and FMLA/LOA positions, support increasing specialty unit census, plan for winter census increases and flu season Discussion ensued.	**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 approve the agreement with Supplemental Registries for an estimated amount of $550,000/month for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016 for an annual cost not to exceed $ 6,600,000, and a total cost for the term not to exceed $6,600,000.**	Kathy Topp

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e. Talyst Automated Pharmacy Carousel Proposal	Tori Hong presented this proposal for construction costs required to enable replacement of the Talyst pharmacy carousel. She explained TCMC currently has an older Talyst carousel that was purchased in 2007, and is at the end of service life. This unit is the "heart" of TCHD's Pharmacy operations and the current unit is no longer supported by the vendor, and TCMC is at risk, if this highly mechanical unit should require repairs. Mr. Moran recommended that this write to be amended to reflect a wording change from "including" to "excluding" in the fourth bullet-point of this write-up. Discussion ensued.	**MOTION** **Director Nygaard moved, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors approve additional facility modifications not to exceed $120,000 for the Talyst Automated Pharmacy Carousel System.** **Write up to be amended by Barbara Hainsworth.**	Tori Hong
f. Renewal of Contract for Supplier of Natural Gas Proposal	Chris Miechowski explained this request is to seek approval to engage into a contract with a supplier of natural gas. He added that an exact expense of the contract is unavailable, as the gas market fluctuates every day. It was noted that this write up is to be amended to reflect that it is a New Agreement, vs. a renewal-New Rates, for 36 months starting September 1, 2015, instead of August 1, 2015. In addition, Dr. Contardo requested a clarification of ground gas vs. natural gas. The write up will be	**MOTION** **Dr. Contardo moved, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with the lowest responsive bidder for supply of natural gas for a term of 3-years, beginning August 2015 and ending July 2018 for an approximate annual cost of $ 376,267, and an approximate total cost for the term of $ 1,096,447.** **Write up to be amended by Barbara Hainsworth.**	Chris Miechowski / Kapua Conley

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	amended to reflect natural gas, instead of ground gas.		
g. Master Planning Services Agreement Proposal (McCarthy)	Wayne Knight gave a brief historical overview to support this write up. It was further explained that Development of the Master Plan will be the first steps in the Design/Build process, for addressing seismic issues to bring TCMC into compliance with SB 1953 before 2030. Discussion ensued.	**MOTION** **Director Nygaard moved, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors approve an engagement with McCarthy Building Companies, Inc., for an initial project expenditure not to exceed $495,000 to develop a Master Plan as the first step toward addressing the seismic requirements of SB 1953, to bring TCMC into compliance before 2030.**	Wayne Knight
h. Naval Hospital Camp Pendleton – Resident Agreement	Sharon Schultz explained this agreement would provide Resident(s) trainees per rotation, and the number and assignment would be mutually agreed upon between Naval Hospital Camp Pendleton (NHCP) and TCMC contracted Hospitalist. In addition, the Residents/Trainees would be supervised by the TCMC contracted Hospitalists. It was noted that this would be a New Agreement, and the write up is to be modified to reflect this information.	**MOTION** **Director Kellett moved, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the Department of the Navy to provide Medical Resident trainees for a term of 53 months beginning September 1, 2015, and ending January 31, 2020, at no cost to TCHD.** **Write up to be amended by Barbara Hainsworth.**	Sharon Schultz
i. CBS 8 KFMB / Midwest Television Advertising Proposal	Director Dagostino stated that a single motion would be used for the following 6 media agreements, 6.i. through 6.n.	**MOTION** **Dr. Contardo moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the**	David Bennett

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	David Bennett explained this media agreement was for televised advertising on CBS-8 and KFMB, in pre-approved target market spots. It is an agreement renewal, which reflects a savings for TCMC, from the previous agreement.	**TCHD Board of Directors authorize the agreement with Midwest Television / CBS-8 / KFMB for a monthly cost of $12,572.75 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016, for an annual/term cost of $150,873.**	
j. ABC-10 / KGTV Television Advertising Proposal	David Bennett explained this is a brand new media agreement for televised advertising with ABC-10 / KGTV, for pre-approved targeted market spots.	**MOTION** **Dr. Contardo moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with ABC-10 / KGTV for a monthly cost of $16,425 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016 for an annual/term cost of $197,100.**	David Bennett
k. NBC-7 (NBCOTS) Television Advertising Proposal	David Bennett explained that this media agreement was for televised Advertising on NBC-7 in pre-approved, targeted market spots. It is an agreement renewal, which reflects a savings for TCMC, from the previous agreement.	**MOTION** **Dr. Contardo moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with NBC-7 / NBCOTS for a monthly cost of $22,300 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016, for an annual/term cost of $276,600.**	David Bennett
l. Entravision Spanish Television Advertising Proposal	David Bennett explained that this media agreement was for televised Spanish advertising on Telemundo, Univision and Pulpo, in pre-approved, targeted market spots. It is an agreement renewal, which	**MOTION** **Dr. Contardo moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the**	David Bennett

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	reflects a savings for TCMC, from the previous agreement.	**agreement with Entravision for a monthly cost of $7,074.48 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016 for an annual/term cost of $84,893.75.**	
m. San Diego Business Journal Print Advertising Proposal	David Bennett explained that this media agreement was for print advertising in the San Diego Business Journal. It is an agreement renewal, which reflects a savings for TCMC, from the previous agreement.	**MOTION** **Dr. Contardo moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with the San Diego Business Journal for a monthly cost of $10,000 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016, for an annual/term cost of $120,000.**	David Bennett
n. Union Tribune Advertising Proposal	David Bennett explained that this media agreement was for print advertising in the Union Tribune newspaper. It is an agreement renewal, which reflects a savings for TCMC, from the previous agreement.	**MOTION** **Dr. Contardo moved, Director Nygaard seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with the Union Tribune for a monthly cost of $17,250 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016 for an annual/term cost of $207,000.**	David Bennett
o. Roche Diagnostics Agreement Proposal	Steve Young explained that this agreement would provide histology disposable agent supplies, as well as various supply kits used in the pathology slide production process. He cited that while there is a 10% increase included in the new agreement, there has not been an increase in the prior 6-years.	**MOTION** **Dr. Contardo moved, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the Agreement with Roche Diagnostics Corp for a term of 12 months starting September 1, 2015 and ending on August 31, 2016.**	Steve Young

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		Amount not to exceed an annual expense for the Term of $ 538,000.	
p. Physician Agreement for ED On-Call Coverage, Interventional Radiology • Charles McGraw, M.D.	Kapua Conley explained that Dr. McGraw is currently a member of the TCMC Medical Staff, who would like to be added to the ED On-Call coverage rotation for Interventional Radiology, in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)	**MOTION** **Director Kellett moved, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Charles McGraw, MD as ED On-Call Coverage Physician for a term of 23 months, beginning 8/16/2015 and ending 6/30/2017. Not to exceed a daily rate of $600 and a total cost for the term of $411,000.**	Kapua Conley
q. Financials	Steve Dietlin presented the financials ending July 31, 2015 (dollars in thousands) **Fiscal Year to Date** Operating Revenue $ 28,413 Operating Expense $ 27,964 EROE $ 862 EBITDA $ 2,046 **TCMC –Key Indicators – FYTD** Avg. Daily Census 184 Adjusted Patient Days 9,382 Surgery Cases 599 Deliveries 215 ED Visits 5,764 **Current Month** Operating Revenue $ 28,413 Operating Expense $ 27,964 EROE $ 862 EBITDA $ 2,046 **Net Patient A/R & Days in Net A/R By Fiscal Year**		Steve Dietlin

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Net Patient A/R (in millions) $ 42.4 Days in Net A/R 46.7 **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		
r. Work Plan – Information Only	Director Dagostino reported that these agenda items were for review only, but Committee members were welcome to ask questions.		
• Wellness Center (semi-annual)	David Bennett gave a brief update on the Wellness Center and areas of membership increase through various incentive programs. Procopio's Legal representative Jody Root advised that it was his recommendation that certain incentives be reviewed by the Audit and Compliance Committee.		David Bennett
• Construction Report (quarterly)	No discussion was held.		Chris Miechowski
• Infusion Center (quarterly)	No discussion held.		Sharon Schultz

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• Aionex Bed Board (monthly) / Throughput	Kathy Topp gave a brief PowerPoint update from the hospital-wide Throughput Committee. Discussion ensued. Director Nygaard recognized the improvement efforts, and recommended that the Aionex Bed Board updates now occur bi-monthly instead of monthly. In addition, Kathy Topp noted that the date on the introductory page of the PowerPoint should be changed to reflect August 2015, not June 2015.	**MOTION** **Director Nygaard moved, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the Work Plan be updated to reflect the Aionex Bed Board will now report bi-monthly instead of monthly, with the next update in October 2015.** **Barbara Hainsworth will modify the Work Plan to reflect this motion, and will make the correction to the introductory page of the PowerPoint presentation.**	Kathy Topp / Kapua Conley
• Dashboard (monthly)	No discussion held.		
• Medical Director, Surgery (quarterly)	Mary Diamond gave a brief PowerPoint presentation on the First Quarter outcome performance of the Medical Director, Surgery. Contract Performance Metrics reviewed: • Block Time • Turnover Time • First Case, On-Time Starts • Compliance with Time Out Procedure		Mary Diamond
s. Update / Progress Report • ICD-10 Transition Update	Colleen Thompson gave a brief PowerPoint presentation of the ongoing preparations for the anticipated implementation of ICD-10, on October 1, 2015, and the impact it will have on various areas/departments.		Colleen Thompson

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• Vivify Update	Director Dagostino announced at the outset of the meeting that this item would be pulled from the agenda.	**PULLED**	Jay Motokawa
7. Comments by Committee Members		None	Chair
8. Date of next meeting	September 15, 2015		Chair
9. Community Openings (none)			
10. Oral Announcement of items to be discussed during closed session (Government Code Section 54957.7)			Chair
11. Motion to go into Closed Session		**MOTION** **Director Nygaard moved, Director Kellett seconded, and it was unanimously approved to go into Closed Session at 2:53 pm**	
16. Open Session		**MOTION** **Director Kellett moved, Dr. Contardo seconded, and it was unanimously approved to go into Closed Session at 3:38 pm**	
17. Report from Chairperson of any action taken in Closed Session (Authority: Government code, section 54957.1)	No report made.		
18. Adjournment	Meeting adjourned 3:39 pm		

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual District Operations

ISSUE DATE: 09/96

SUBJECT: CHARITY CARE, UNCOMPENSATED CARE, COMMUNITY SERVICE

REVISION DATE: 8/97, 5/99, 8/04, 4/06, 2/07, 1/10, POLICY NUMBER: 8610-285 10/10, 9/13
Administrative Policies & Procedures Committee Approval: 09/13
Finance & Operations Committee Approval: ~~06/14~~08/15
Board of Directors Approval: 06/14

A. **PURPOSE:**

1. The Hospital desires to have a clear, well-communicated and documented financial assistance policy consistent with its mission and values, and in compliance with government accounting standards, Federal and State regulations.
2. California acute care Hospitals must comply with Health & Safety Code Section 127400 et seq, hereinafter referred to as the California Fair Pricing Law, including requirements for written policies providing discounts and charity care to financially-qualified patients. This policy is intended to exceed the legal requirements detailed in the California Fair Pricing Law.

B. **POLICY:**

1. As a benefit to the community, it is the policy of the Hospital to provide free, or partially free, health care services to community members who have demonstrated that they are either financially or medically indigent. The Hospital gives consideration to eligible patients residing within its community and to patients, whether or not they have insurance and regardless of income level, if there are exceptional circumstances.
2. Patients will be treated fairly and respectfully regardless of their ability to pay. The Hospital does not discriminate against any person on the grounds of race, creed, color, national origin, sexual orientation or on the basis of disability or age.
3. Business Office staff will provide interested patients with financial counseling including assistance applying for local, state and federal health programs. Uninsured and underinsured patients will be informed of and assisted in applying for charity/discounted care.
4. Any patient, or legal representative of the patient, seeking financial assistance, shall provide information concerning health benefit coverage, financial status and other pertinent documentation that is necessary to make a determination regarding the patient's status relative to the hospital's charity care policy, discounted payment policy, or eligibility for local, state or federal programs. All information provided by, or for, the patient will be confidential and the dignity of the patient will be maintained during this process.
5. The Hospital and/or outside agents working on behalf of the Hospital, shall not use wage garnishments or a lien on the patient's primary residence, if the patient or the patient's legal representative, are communicating and cooperating with the Hospital and it has been determined that the patient is eligible for charity care or discounted care.

6. An emergency physician, as defined in Section 127450 of California Health & Safety code Chapter 2.5 of Division 107, who provides emergency medical services in a hospital that provides emergency care, is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level. This statement shall not be construed to impose any additional responsibilities upon the hospital.

C. **DEFINITIONS AND ELIGIBILITY:**

1. Charity – Health services for which the Hospital policies determine the patient is unable to pay. Charity care results from the Hospital's policy to provide health care services free of charge, or in circumstances where the patient has insurance, the self-pay balance free of charge to individuals who meet the hospital's charity criteria. Charity care is measured on the basis of revenue forgone, at full established rates. Charity care does not include contractual write-offs.
   a. Catastrophic Charity Care - 100% write-off of the patient's liability for a patient with High Medical Cost.
   b. Full Charity Care – 100% write-off of the patient's undiscounted responsibility.
   c. Partial Charity Care – Partial write-off of the patient's undiscounted responsibility.
   d. Special Circumstance Charity Care – Patients who do not meet other charity criteria or who are unable to follow specified hospital procedures to receive a full or partial charity care write-off of charges.
   e. The following is a non-exhaustive list of some situations that may qualify for special circumstance charity care:
      i. Bankruptcy – patients who are in bankruptcy for self pay balances
      ii. Homeless patients – reasonable efforts have been made to locate and contact the patient and such efforts have been unsuccessful
      iii. Deceased patients without an estate
      iv. MediCal/Medicaid denials – patients who qualify for MediCal/Medicaid are also presumed to qualify for full charity care. This includes patient's whose MediCal/Medicaid coverage is limited or restricted. This does not include Share of Cost (SOC) amounts. SOC amounts must be paid by the patient before the patient is eligible for MediCal/Medicaid.
2. Federal Poverty Level (FPL) – Poverty guidelines, updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code.
~~3. High Medical Cost – An insured patient with high medical costs (coinsurance, deductible, and/or~~
3. ~~reached a lifetime limit, non-covered relating to services not medically necessary) and the patient does not receive a discounted rate from the hospital as a result of the patient's third party coverage.~~ High medical costs means.
   a. Annual out-of-pocket costs incurred by the patient, at the Hospital, that exceed 10 percent of the patient's family income in the prior 12 months.
   b. Annual out-of-pocket medical expenses ~~by the patient~~ that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.
4. Patient's Family and Determination of Family Income –For persons 18 years of age and older: spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not. For persons under 18 years of age: parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative. Documentation of family income shall be limited to recent pay stubs and tax returns. The patient's assets or the assets of the patient's family may not be considered.

5. Reasonable payment ~~formula~~ plan – Monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. " Essential living expenses" means expenses for all of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses including insurance, gas and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

D. **PROCEDURES:**

1. Any uninsured patient who indicates an inability to pay will be screened for charity care. Additionally, at the discretion of the Hospital, any insured patient who indicates an inability to pay their liability, after their insurance has paid, will be screened for charity care. Charity care will be granted based upon the following suggested income levels.

Income Level	Discount Amount
Up to 350% of FPL	100% Discount
351% to 500% FPL	75% Discount
Over 500% of FPL,	Case by Case Discounts
High Medical Cost	100% Discount
Special Circumstance	Case by Case Discounts

All patients who are registering without insurance will be registered as a self-pay or MediCal/Medicaid-pending patient, and a MediCal/Medicaid application should be taken. Elective patients who have a large deductible and/or coinsurance obligation will meet with a financial counselor and complete the Confidential Patient Financial Statement (CPFS) (Attachment A). If the patient does not qualify for charity or MediCal/Medicaid, payment will be required in advance of the service. If a charity determination is made and partial payment is required, payment is due in advance of the service unless other arrangements are pre-arranged with the Hospital financial counselor. ~~Charity determinations over $2,000 require the approval of the Director of Revenue Cycle Operations.~~ Charity determinations over $25,000 require the approval of the Chief Financial Officer or his/her designee.

All patients with a self -pay balance of $25 or less and an age of greater than 120 days will be written off to charity.

2. Application- Except in those instances where the Hospital has determined that minimal application and documentation requirements apply, in order to qualify for charity care, a CPFS should be completed.
   a. Family Members – Patient will be required to provide the number of family members in their household. (See 3.4)
   b. ~~Income Calculation – Patient will be required to provide their household's yearly gross income. Adult patient's yearly income on the CPFS means the sum of the total yearly gross income of the patient and the patient's spouse or domestic partner. Minor patient's yearly income on the CPFS means income from the patient, the patient's mother and/or father and/or domestic partner and/or legal guardian.~~
      (1) For purposes of determining eligibility for discounted payment, documentation of income shall be limited to recent pay stubs or income tax returns.
   c. ~~Income verification – Patients will be required to verify the income set forth in the CPFS. Income documentation will include IRS Form W-2, wage and earnings statement, paycheck stub, tax returns, telephone verification by employer of the patient's income, bank statements, or other appropriate indicators of income. Current participation in a Public Benefit Program including Supplemental Security Income (SSI), Social Security Disability, Unemployment Insurance Benefits, Medicaid, County Indigent, Food Stamps, WIC or other similar indigence related programs can be used to verify indigence.~~

(2) For purposes of determining eligibility for charity care, documentation of assets may include information on all monetary assets, but shall not include statements on retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. AThe ~~hospital~~ Hospital may require waivers or releases from the patient or the patient's family, authorizing the ~~hospital~~ Hospital to obtain account information from the financial or commercial institutions, or other entities that hold or maintain the monetary assets, to verify their value.

d. Documentation Unavailable – Where the patient is unable to provide documentation verifying income, the following procedures shall be followed:

i. Expired patients: Expired patients may be deemed to have no income.

ii. Written Attestation: Patient can sign the CPFS attesting to the accuracy of the income information provided iii. Verbal Attestation: The Hospital financial counselor may provide written attestation that the patient verbally verified the income calculation. Some attempt should be made to document the patient's yearly income before taking a verbal attestation.

3. Patients unwilling to disclose any financial information as requested by the Hospital financial counselor. The patient will be advised that unless they comply and provide the information, no further consideration for charity care processing will be made and standard Accounts Receivable follow-up will ensue.

4. Extended Payment Plans, without interest charges, will be made available and negotiated between the Hospital and the patient to allow the patient ~~Patients~~ who is~~are~~ eligible for partial charity ~~shall be permitted to make interest free payments of the discounted amount~~ to pay over an extended period of time. The patient's family income and essential living expenses will be considered when negotiating an extended payment plan. If the Hospital and the patient cannot agree to a payment plan, the hospital will use the "reasonable payment plan" ~~formula~~ to determine the payment plan.

5. California Health Benefit Exchange – The Hospital will obtain information as to whether the patient may be eligible for the California Health Benefit Exhange. Information will be provided to a patient that has not shown proof of third party coverage, a statement that the patient may be eligible for coverage through the California Health Benefit Exhange or other State- or county-funded health coverage program.

6. If the patient applies, or has a pending application, for another health coverage program concurrent with an application for charity care or a discounted payment program, neither the charity care, discounted payment program, or health care coverage program applications preclude eligibility for the other program.

~~4.~~ 7. All internal and external collection activity will be based on the written procedures contained herein. The Hospital will maintain a written agreement from any external agency that collects debt, that the external agency will adhere by the Hospital's standards and practices. Specifically, the external collection agency will comply with the definition and application of the Hospital's reasonable payment plan, defined herein.

E. **NOTICE:**

1. Timeframe - There is no rigid limit on the time when the charity determination will be made. In some cases, a patient eligible for charity care may not be identified prior to the initiation of external collection action. The Hospital's collection agencies shall be made aware of this procedure so that the agency knows to refer back to the Hospital patient accounts that may be eligible for charity care.
2. Once a full or partial charity determination has been made, a written notification will be sent to the applicant advising them of the Hospital's decision.

F. **COMMUNICATION:**

1. Information provided to patient – During registration, or as soon thereafter as practicable, the Hospital shall provide:

a. All uninsured patients with written information regarding the Hospital's charity care policies and the appropriate contact information for the patient to obtain further information about these policies. The Hospital will provide the patient with a referral to a local consumer assistance center.

b. At the request of the patient, the Charity application will be provided.

c. Patient statements to ~~uninsured~~ patients who have not provided proof of third-party coverage will include information about charity care, the California Health Benefit Exchange and other State- or county-funded health coverage, as well as Medicare, Medi-Cal, Healthy Families and California Children's Services. The patient statement will indicate how the patient may obtain applications for coverage through the California Health Benefit Exchange and other State- or county funded health coverage programs, and the Hospital will provide these applications . Further, t~~T~~his information will have standard language informing patients that they may request financial screening to determine eligibility for charity care. Finally, t~~T~~o the extent possible, these communications will be in the primary language of the patient.

~~c.~~d. The patient statement will include information on the availability of charity care and discounted payments from the emergency room physiciahns.. The statement will include contact information for the emergency room physician who treated the patient.

2. Postings and Other Notices – ~~Information about charity care shall also be provided by posting notices in a visible manner in the admitting and registration locations.~~

Notice of the hospital's policy for financially qualified and self-pay patients shall be clearly and conspicuously posted in locations that are visable to the public, including, but not limited to, all of the following:

1) Emergency Department
2) Admissions Office
3) Other Outpatient Settings
4) Billing Office

G. **REFERENCE:**

1. California Health and Safety Code, Section 127400, et. seq.

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #145-013 (FOP)

POLICY TITLE: Policies and Procedures Including Bidding Regulations Governing Purchases of Supplies and Equipment, Procurement of Professional Services, and Bidding for Public Works Contracts

Government Code section 54202 requires the District to adopt policies and procedures, including bidding regulations, governing purchases of supplies and equipment by the District. In addition, with limited exceptions, Health & Safety Code section 32132 requires the District to competitively bid contracts involving expenditures of more than Twenty Five Thousand Dollars ($25,000) for materials and supplies to be furnished, sold, or leased to the District, as well as contracts involving expenditures of more than Twenty Five Thousand Dollars ($25,000) for work to be done. Finally, Government Code section 4525 et seq. requires the District to select firms to provide certain professional services on the basis of demonstrated competence and on the professional qualifications necessary for the satisfactory performance of the services required.

The following policies and procedures governing purchases of supplies and equipment, procurement and bidding for public works contracts, and procurement of professional services are hereby adopted.

I. FORMAL BIDDING REQUIREMENTS

A. Contracts Requiring Formal Bids – Materials, Supplies, and Work to be Done Involving Expenditure of More Than $25,000.

Unless exempted by this Policy or applicable law (including, for example, bidding exemptions for medical or surgical equipment or supplies and professional services), any contract for work to be done or for materials and supplies to be furnished, sold, or leased to the District shall be awarded through the "formal" bidding procedures specified in this Section "I" (Formal Bidding Requirements) if they involve an expenditure of more than Twenty Five Thousand Dollars ($25,000). (H&S Code § 32132(a).) Unless otherwise provided by law or this policy, such contracts involving an expenditure of Twenty Five Thousand Dollars ($25,000) or less may be made ~~without soliciting or securing bids~~through the procedures specified in Section "II" or "III" of this policy. As used herein, "work to be done" includes, among other things, general maintenance work and public works contracts. Statutes requiring bidding, and exceptions from competitive procurement requirements for certain types of contracts are summarized in the table attached hereto and incorporated herein as Exhibit A for easy reference.

B. Bid Procedures.

1. Preparation of Bid Package.

Before entering into any contract which requires formal bidding, the District shall prepare or cause to be prepared a bid package. Unless exempted by the President/CEO or his/her designee pursuant to Section "VI" (Flexibility and Waiver of Policy Requirements) below, the bid package shall include a notice inviting bids, instructions to bidders, bid form, which shall include a provision as to the method for determining the lowest bidder, whether on: 1. Base bid alone; 2. Identified alternates; 3. Prioritized order of alternates within identified budget; or 4. Other "fair manner," contractors qualification statement contract form, conditions of the contract, required bonds and other forms, drawings, and full, complete, and accurate plans and specifications, giving such directions as will enable any competent supplier or contractor to ascertain and carry out the contract requirements. The bid package shall also contain a statement that no gratuities of any kind will be accepted, including meals, gifts or trips, and violation of this condition may constitute immediate disqualification.

The President/CEO or his/her designee shall endeavor to include all required contract documents in the bid package. To the extent that the President/CEO or his/her designee determines, pursuant to Section "V" (Flexibility and Waiver of Policy Requirements) below, that any required contract document cannot be incorporated into the bid package, its terms shall be negotiated with the lowest responsible bidder prior to the award of the contract.

To the extent possible, the plans and specifications shall also be reviewed and approved by the District's authorized representative prior to their insertion in the bid package.

2. Notice Inviting Bids – Contents.

All bid packages shall include a notice inviting bids. The notice inviting bids shall include, among other things determined necessary for a particular contract by the President/CEO or his/her designee, information as to the type, quality and quantity of materials, supplies or work to be provided, the contract performance schedule, the project location, the basis for determining the lowest bidder, whether on: 1. Base bid alone; 2. Identified alternates; 3. Prioritized order of alternates within identified budget; or 4. Other "fair manner," a contact person, and other bid requirements and information regarding how to obtain a bid package, the place where bids are to be received, and the time by which they are to be received. For contracts involving public works projects, the notice inviting bids shall also contain any other information required by state law or Section "IV" (Provisions Applicable to Public Works Contracts) of this Policy.

3. Notice Inviting Bids - Distribution by Mail, Posting or Other Means.

The District shall distribute the notice inviting bids by appropriate means as determined by the President/CEO or his/her designee in a manner to permit reasonable competition consistent with the nature and requirements of the proposed contract. The President/CEO, or his/her designee may require that, except in cases of emergency or where not practicable, all suppliers and contractors who have notified the District in writing that they desire to bid on contracts, and all suppliers and contractors which the District would like to bid on contracts, shall be furnished with the notice inviting bids by postal or electronic mail.

The President/CEO, or his/her designee, may also require that in addition to notifying all such persons by mail or electronic mail, the District shall post the notice inviting bids in one or more public places typically used by the District. It shall be posted in sufficient time in advance of the bid opening to allow bidders to bid, as determined by the President/CEO or his/her designee. The notice shall remain posted until an award has been made. Notice may also be made by internet, telephone, facsimile, telegram, personal contact, letter, or other informal means.

4. Notice Inviting Bids - Advertising/Publication.

The District shall advertise/publish the notice inviting bids by appropriate means as determined by the President/CEO or his/her designee in a manner to permit reasonable competition consistent with the nature and requirements of the proposed contract. ~~The~~ For example, the President/CEO or his/her designee may require that, except in cases of emergency or where circumstances require that less notice be given, the notice inviting bids shall be published ~~once a week for at least two (2) consecutive weeks, as follows:~~on the District's website and, in the case of a public works project also furnished to one or more contractor plan rooms or services.

~~In a newspaper of general circulation published in San Diego County; or~~

~~In trade journals or papers of general circulation as the President/CEO, or his/her designee, deems proper.~~

For cost efficiency purposes, the published notice inviting bids need not be as detailed as that provided by other means, including by mail, posting or inclusion in the bid package, but should contain the legally and practically required essential contents of the notice, including but not limited to, where and how to obtain the complete bid package, Labor Code notice provisions, and bonding requirements.

5. Bid Form.

As part of the bid package, the District shall furnish to each bidder an appropriate bid form prepared by the District for the type of contract being

let. Bids not presented on forms so furnished, or exact copies thereof, shall be rejected as non-responsive. Bidders shall be required to execute and submit the contract in the form provided in the bid package as part of their bid.

6. Presentation of Bids.

All bids shall be presented under sealed cover. Upon receipt, the bid shall be date and time stamped.

7. Withdrawal of Bids.

Bids may be withdrawn at any time prior to the time fixed in the public notice for the opening of bids only by written request made to the person or entity designated in charge of the bidding procedure. The withdrawal of a bid does not prejudice the right of the bidder to timely file a new bid. Except as authorized by law for public works contracts (Pub. Contract Code § 5100 et seq.), no bidder may withdraw its bid after opening for the period of time indicated in the bid package.

C. Award of Contracts.

1. Opening of Bids.

On the day named in the public notice, the District shall publicly open the sealed bids.

The Board of Directors is under no obligation to accept the lowest responsive and responsible bid received, since the District has absolute discretion in the acceptance of bids and reserves the right to reject all bids if it is desires. The Board of Directors also reserves the right to determine the conditions of responsibility including matters such as delivery date, product quality, and the service and reliability of the supplier.

2. Responsible Bidder.

The District's determination of whether a bidder is responsible shall be based on an analysis of each bidder's ability to perform, financial statement (if required), experience, past record and any other factors it shall deem relevant. If the lowest bidder is to be rejected because of an adverse determination of the bidder's responsibility based on the District's staff review, the bidder shall be entitled to be informed of the adverse evidence and afforded an opportunity to rebut that evidence and to present evidence of responsibility. In such event, the District shall give the rejected bidder and the bidder to be awarded the contract at least five (5) working days' notice of a public board meeting at which the responsibility issue shall be considered by the Appeals Panel. No other notice, other than that required for Agenda descriptions by the Ralph M. Brown Act, shall be

required. The Board may, in its discretion, continue its consideration and determination of the issue to future meetings of the Board within the time authorized for the award of the contract. The Board's decision shall be conclusive.

3. Bid Challenges.

If any bidder wishes to challenge a potential bid award, he shall file a written objection within five (5) calendar days following bid opening. The written objection shall include specific reasons why the District should reject the bid questioned by the bidder. The District may, in its discretion, consider the protest during the public meeting at which the contract award is to be considered, or it may consider it at a prior meeting. The District shall give the challenging bidder and the bidder to be awarded the contract at least five (5) working days' notice of the board meeting at which the challenge shall be considered by the Board or the Appeals Panel. No other notice, other than that required for Agenda descriptions by the Ralph M. Brown Act, shall be required. The Board may, in its discretion, continue its consideration and determination of the issue to future meetings of the Board within the time authorized for the award of the contract. The Board's decision shall be final.

~~Notice to Bidders Not Awarded the Contract: Return of Bid Security.~~

~~Whenever a contract is not to be awarded to a bidder, such bidder shall be notified by email or regular mail not more than five (5) working days after the award of the contract to another bidder. The bid security supplied by the bidder shall be returned with the notice.~~

D. Emergencies.

~~The District may award any contract for work to be done or for materials and supplies to be furnished, sold, or leased to the District without soliciting or securing bids if the CEO, CFO, COO or designee determines that an emergency exists as provided for in Health & Safety Code section 32136 as it may be amended from time to time. In the event the President/CEO determines that it is not practicable to convene a meeting of the Board of Directors before need to take action on an emergency may arise, he/she shall have the authority to make the determination that an emergency exists and award the required contract, subject to confirmation by the Board of Directors. The President/CEO shall convene a meeting of the Board as soon as possible. In the event that Board disagrees with the President/CEO's emergency finding, it may direct the termination of the contract, payment of any funds to which the contractor or supplier is legally entitled under the circumstances, and solicitation of bids as required under this Policy and state law.~~

The Board of Directors has adopted a resolution pursuant to Public Contract Code section 22050 authorizing the Chief Executive Officer (or the Chief Operating Officer if the Chief Executive Officer is unavailable, or a non-elected officer or employee of the District upon delegation of such authority by the Chief Executive Officer or Chief Operating Officer) to take immediate action and award certain emergency contracts not exceeding $250,000 (Two Hundred Fifty Thousand Dollars) without seeking competitive bids ("Emergency Contract Resolution"). The scope of such delegation and authority, including the process for such award and subsequent review by the Board of Directors, is set forth in the Emergency Contract Resolution. In the event that the Emergency Contract Resolution is rescinded, revoked, modified, amended, replaced, or superseded, this policy shall be read and interpreted consistent with the most recent action by the Board of Directors regarding authority to award emergency contracts even if this policy has not yet been amended to conform to such Board action. This is in addition to the District's authority under Health & Safety Code section 32136 as it may be amended from time to time.

II. GROUP PURCHASING ORGANIZATIONS ("GPO").

The District may participate as a member of any organization described in Section 23704 of the Revenue and Taxation Code ("GPO"). Any purchases made, or services rendered, by the GPO on behalf of the District are not subject to the bidding requirements pursuant to Section 32123 of the Health and Safety Code and are not subject to the formal bidding requirements or informal competitive purchasing procedures established by this policy. (H&S Code § 32132(e).)

III. INFORMAL COMPETITIVE PURCHASING PROCEDURES

A. Contracts Requiring Informal Competitive Procurement Procedures.

All contracts subject to this Policy and not subject to Sections I or II shall be awarded in accordance with this Section III (Informal Competitive Purchasing Procedures).

B. Requirements for Specific Types of Contracts.

1. Certain Professional Services (Professional Architecture, Landscape Architectural, Engineering, Environmental, Land Surveying, Construction Management).

Contracts for professional services, as defined in Government Code section 4526, as it may be amended from time to time, may be awarded without following the "formal" bidding procedures, but shall meet the "informal" competitive purchasing procedures specified in Section III" (Informal Competitive Purchasing Procedures) of this Policy or comply with Board Policy No. 14-023. (Gov. Code § 4525 et seq.) In no event shall a contract for professional services be awarded based solely upon the lowest cost to the District.

a. Proposals Submitted for Construction Project Management Services

Any individual or firm proposing to provide construction project management services shall provide evidence that the individual or firm and its personnel carrying out onsite responsibilities have expertise and experience in construction project design review and evaluation, construction mobilization and supervision, bid evaluation, project scheduling, cost-benefit analysis, claims review and negotiation, and general management and administration of a construction project. (Gov. Code § 4529.5.)

b. Maximum Participation of Small Business Firms

In selecting professional services of private architectural, landscape architectural, engineering, environmental, land surveying, or construction management firms, the selection procedures shall assure maximum participation of small business firms, as defined by the Director of General Services pursuant to Section 14837. (Gov. Code § 4526.)

2. Electronic Data Processing and Telecommunications Goods and Services.

Contracts for electronic data processing and telecommunications goods and services shall be awarded through the "informal" competitive purchasing procedures specified in Section "III" (Informal Competitive Purchasing Procedures of this Policy); provided, that such contracts may be made without soliciting or securing bids when they involve an expenditure of $25,000 or less or when the Board determines either that: (1) the goods and services proposed for acquisition are the only goods and services which can meet the District's need; or (2) the goods and services are needed in cases of emergency where immediate acquisition is necessary for the protection of the public health, welfare, or safety.

3. Professional Financial, Economic, Accounting, Legal or Administrative Services.

Contracts for the professional services set forth in Government Code section 53060, which include but are not limited to special services and advice in financial, economic, accounting, legal or administrative professional services may be procured through the "informal" competitive purchasing procedures specified in Section "III" (Informal Competitive Purchasing Procedures) of this Policy or in any other manner as deemed to be in the best interest of the District as determined by the Board, or the President/CEO.

4. Clinical Services Agreements.

All clinical services agreements (e.g., anesthesiology, pathology, radiology, emergency, hospitalists) shall be subject to competitive selection procedures based on recommendations from ~~in-house~~ General ~~e~~Counsel and/or outside special healthcare counsel. Such contracts may be procured through the Informal Competitive Purchasing Procedures of this Policy or in any other manner as deemed to be in the best interest of the District as determined by the President/CEO

C. Informal Competitive Purchasing Procedures.

1. Contracts Exceeding $1,000,000.

a. The President/CEO or his/her designee will issue a formal Request for Proposal for any individual contract award (not required to be bid by statute) exceeding One Million Dollars ($1,000,000) unless a written sole source justification will be provided to the Board of Directors and Board committee as part of the contract approval process.

b. Preparation of Request for Proposals.

The President/CEO or his/her designee shall prepare or cause to be prepared a written request for proposals ("RFP"). Unless exempted by the President/CEO or his/her designee pursuant to Section "V" (Flexibility and Waiver of Policy Requirements) below, the RFP shall include at least the following information: (1) the specific nature or scope of the goods and/or services being sought; (2) the type of project contemplated, if applicable; (3) the estimated term of the contract; (4) the specific experience expected of the consultant or supplier; (5) the time, date and place for submission of the RFP; (6) a contact person who can answer questions of the consultants or supplier during the bidding process; (7) a contract form; and (8) the evaluation criteria to be utilized in the selection of the consultant or supplier.

The President/CEO or his/her designee shall endeavor to include all required information in the RFP. To the extent that the President/CEO or his/her designee determines, pursuant to Section "VI" (Flexibility and Waiver of Policy Requirements) below, that any required information cannot be incorporated into the RFP, its terms shall be negotiated with the successful consultant or supplier prior to the award of the contract.

c. Circulation of Request for Proposals.

The District shall attempt to obtain and consider completed RFP's from at least three (3) qualified sources.

2. Contracts Greater than or Equal to $250,000 and Less Than or Equal to $1,000,000.

The President/CEO or his/her designee shall obtain at least three (3) quotes from vendors for any proposed individual contract award (not otherwise required by statute to be bid) between Two Hundred Fifty Thousand Dollars ($250,000) and One Million Dollars ($1,000,000), unless a written sole source justification is provided to and approved by the President/CEO. The approved sole source justification will be provided to the Board of Directors and Board committee as part of the contract approval process.

3. Contracts Less Than $250,000.

a. Unless otherwise required by applicable law or this Policy, contracts less than Two Hundred Fifty Thousand Dollars ($250,000) may be awarded without soliciting bids or proposals from multiple vendors. Agreements for legal services shall be approved by the Board or its designee pursuant to Board Policy No. 14-023.

b. Contracts for electronic data processing and telecommunications goods and services with a cost to the District of more than Twenty-Five Thousand Dollars ($25,000) and less than Two Hundred Fifty Thousand Dollars ($250,000) shall be awarded after obtaining quotes from a minimum of three (3) vendors. Contracts with a cost of Two Hundred Fifty Thousand Dollars ($250,000) or more shall be subject to the procedures stated in Section III.C. (Informal Competitive Purchasing Procedures), subsections 2 and 3, as applicable.

D. Award of Contracts.

1. Electronic Data Processing and Telecommunications Goods or Services Exceeding $25,000.

When the District awards a contract pursuant to this Section "III" (Informal Competitive Purchasing Procedures) for electronic data processing and telecommunications goods or services with a cost to the District of more than Twenty Five Thousand Dollars ($25,000), the contract award shall be based on the proposal which provides the most cost effective solution to the District's requirements, as determined by the specified evaluation criteria. The evaluation criteria may provide for the selection of a consultant or supplier on an objective basis other than cost alone (H&S Code § 32138(c).)

2. Other Contracts.

When the District awards any other contract pursuant to this Section "III" (Informal Competitive Purchasing Procedures), the contract award shall be based on the proposal which is in the best interests of the District. In addition, unless exempted pursuant to Government Code section 4529, contracts for professional architectural, landscape architectural, engineering, environmental, land surveying, construction management and any other services specified in Government Code section 4526, as it may be amended from time to time, shall be awarded on the basis of demonstrated competence and on the professional qualifications necessary for the satisfactory performance of the services required. In no event shall a contract for such professional services be awarded on the basis of cost alone. (Gov. Code § 4525 et seq.)

IV. PROVISIONS APPLICABLE TO PUBLIC WORKS CONTRACTS

A. Prequalification May Be Required Prior to Bidding on Public Works Contracts.

~~It is the policy of the District that all bidders on public works to be undertaken by the District must be pre-qualified prior to submitting bids for public works. It is mandatory that all Licensed Contractors who intend to submit bids fully complete~~ On a case-by-case basis based on the complexity and estimated cost of a contract, as determined by the President/CEO or his designee, the District may require all prospective bidders, including not only contractors also subcontractors, to prequalify by fully completing a pre-qualification questionnaire available from the District, provide~~e~~ing a current Dunn & Bradstreet report and bond rating, ~~provide~~ and providing all materials requested by the District's Notice of Prequalification of Bidders, and be approved by the District to be on the final Bidders list. A financial statement shall not be required from a prospective bidder who has qualified as a Small Business Administration entity pursuant to paragraph (1) of subdivision (d) of Section 14837 of the Government Code, when the bid is no more than twenty-five percent (25%) of the qualifying amount provided in pa ragraph (1) of subdivision (d) of Section 14837 of the Government Code.

~~No~~ If prequalification is required by the District, no bid will be accepted from a ~~Contractor~~ bidder that has failed to comply with these requirements. If two or more business entities submit a bid on a project as a Joint Venture, or expect to submit a bid as part of a Joint Venture, each entity within the Joint Venture must be separately qualified to bid.

~~Pre-qualification applications may be submitted four times each year: (1) from January 1 through January 10; (2) from April 1 through April 10; (3) from July 1 through July 10; and (4) from October 1 through October 10. The District will make all prequalification decisions within ten (10) business days of each quarterly closing date for submissions.~~

The President/CEO, or his designee, shall adopt and apply, on behalf of the District, a uniform system of rating bidders on the basis of the completed questionnaires and financial statements, in order to determine both the minimum requirements permitted for qualification to bid, and the type and size of the contracts upon which each prospective bidder shall be deemed qualified to bid. The uniform system of rating prospective bidders shall be based on objective criteria.

The District will use the information and documents submitted by ~~Contractors~~ prospective bidders as the basis of rating ~~Contractors~~ prospective bidders in respect to the size and scope of contracts upon which each ~~Contractor~~ prospective bidder is qualified to bid. The District reserves the right to check other sources available.

~~The District's decision will be based on objective evaluation criteria. Pre-qualification approval will remain valid for one (1) calendar year from the date of notice of qualification, except that the District reserves the right during that calendar year to adjust, increase, limit, suspend or rescind the pre-qualification ratings based on subsequently learned information and after giving notice of the proposed action to the Contractor and an opportunity for a hearing consistent with the hearing procedures described below for appealing a pre-qualification determination.~~

~~The Contractor's~~ The prospective bidder's inclusion on the final Bidder's list does not preclude the District from a post-bid consideration and determination on a specific project of whether a bidder has the quality, fitness, capacity and experience to satisfactorily perform the proposed work, and has demonstrated the requisite trustworthiness.

The pre-qualification packages should be submitted under seal and marked "CONFIDENTIAL" to Tri-City Healthcare District Facilities Department by the date and time specified in the quarterly Notice of Prequalification issued by the District.

The pre-qualification packages submitted by ~~Contractors~~ prospective bidders are not public records and are not open to public inspection. All information provided will be kept confidential to the extent permitted by law, although the contents may be disclosed to third parties for the purpose of verification, investigation of substantial allegations, and in the process of an appeal hearing. State law requires that the names of contractors applying for pre-qualification status shall be public records subject to disclosure, and the first page of the questionnaire will be used for that purpose.

Each questionnaire must be signed under penalty of perjury in the manner designated at the end of the form, by an individual who has the legal authority to bind the ~~Contractor~~ prospective bidder on whose behalf that person is signing. If any information provided by a ~~Contractor~~ prospective bidder becomes inaccurate,

the ~~Contractor~~ prospective bidder must immediately notify the District and provide updated accurate information in writing, under penalty of perjury.

The District reserves the right to waive minor irregularities and omissions in the information contained in the pre-qualification application submitted, to make all final determinations, and to determine at any time that the pre-qualification procedures will not be applied to a future public works project. The District shall notify each ~~Contractor~~ prospective bidder submitting an application for prequalification in writing by first-class mail or email within ten (10) days after the District's decision as to prequalification. ~~If a~~ Upon request of the prospective bidder, the District shall provide notification to the prospective bidder ~~is disqualified, the District shall include with the notice of disqualification~~ in writing of the basis for the prospective bidder's disqualification and any supporting evidence that has been received from others or adduced as a result of an investigation by the District. ~~There is no appeal from a finding that a contractor is not pre-qualified because of a failure to submit required information, but re-application during one of the designated time periods is permitted.~~

After receiving notice of the basis for disqualification, the prospective bidder (except where disqualified for failure to submit required information) may file a written protest to the disqualification within seventy-two (72) hours of its receipt of notice of disqualification. Receipt shall be deemed to be two (2) days after mailing of the notice. The written objection shall include specific reasons, facts, supporting documentation and legal authorities explaining why the ~~District should not disqualify the~~ prospective bidder should be found qualified.. The written objection must be filed with:

Tri-City Healthcare District
~~Legal Affairs and Compliance~~
Facilities Department
4002 Vista Way
Oceanside, CA 92056

Unless a ~~Contractor~~ prospective bidder files a timely appeal, the ~~Contractor~~ prospective bidder waives any and all rights to challenge the ~~qualification~~ prequalification decision of the District, whether by administrative process, judicial process or any other legal process or proceeding.

If the ~~Contractor~~ prospective bidder gives the required notice of appeal and requests a hearing, the hearing shall be conducted no later than ten (10) business days after the District's receipt of its Notice of Appeal. The hearing so provided shall be conducted by a panel to which the District's Board of Directors has delegated responsibility to hear such appeals (the "Appeals Panel"). At the hearing, the ~~Contractor~~ prospective bidder will be given the opportunity to present information and present reasons in opposition to the pre-qualification determination. At the conclusion of the hearing or no later than three (3) business

days after completion of the hearing, the Appeals Panel will render its decision. ~~The date for submission and opening of bids for a specific project will not be delayed or postponed to allow for completion of an appeal process.~~

Prospective bidders shall be allowed to dispute their proposed prequalification rating prior to the closing time for receipt of bids. In the event that the District circulates bid packages before the completion of a pending appeal, the District will provide the prospective bidder with a bid package only after the prospective bidder has made payment therefore in an amount equal to the District's cost of printing and reproduction of the bid package, if any. The District will reimburse the prospective bidder for such amount if the prospective bidder successfully appeals the disqualification determination and is found to be qualified to submit a bid. The Appeals Panel shall render its decision on the pending appeal prior the closing time for receipt of bids.

B. Bid Security.

All bids shall be accompanied by bid security in an amount equal to at least ten percent (10%) of the total bid price. The security shall be in a form as follows:

1. Cashier's or Certified Check in the required amount; or

2. Bidder's Bond executed by an admitted surety insurer and made payable to the District.

Any bid not accompanied by one of the foregoing forms of bidder's security shall be rejected as non-responsive.

~~The bid security for all other unsuccessful bidders shall be returned to them within five (5) working days after the contract is awarded.~~

C. License and Registration Requirement.

The notice inviting bids and plans shall identify the required contractor's license classification. (Pub. Cont. Code § 3300.) In every completed bid, and in all construction contracts and subcontracts, shall be included the license number of the contractor and all subcontractors working under him. No project may be awarded to a contractor which is not licensed pursuant to state law or which utilizes subcontractors not so licensed.

Additionally, all contractors and subcontractors listed on a bid proposal for a public works project must be registered with the California Department of Industrial Relations ("DIR") pursuant to Labor Code section 1725.5 (with limited exceptions from this requirement for bid purposes only under Labor Code section 1771.1(a)). No contractor or subcontractor may be awarded a contract for public work on a public works project unless registered with the DIR.

D. Insurance.

All contracts shall require insurance of the type, in amounts and with provisions approved by District Legal Counsel. All contractors awarded contracts shall furnish the District with original certificates of insurance and endorsements effecting coverage required by the contract. The certificates and endorsements for each insurance policy shall be signed by a person authorized by that insurer to bind coverage on its behalf, and shall be on forms supplied or approved by the District. All certificates and endorsements must be received and approved by the District before work commences, or sooner if indicated by the contract documents. The District shall reserve the right to require complete, certified copies of all required insurance policies, at any time.

At a minimum, all general liability and automobile insurance policies shall contain the following provisions, or contractor shall provide endorsements on forms supplied or approved by the District to add the following provisions to the insurance policies: (1) the District, its directors, officers, employees and agents shall be covered as additional insureds with respect to the work or operations performed by or on behalf of the contractor, including materials, parts or equipment furnished in connection with such work; and (2) the insurance coverage shall be primary insurance as respects the District, its directors, officers, employees and agents, or if excess, shall stand in an unbroken chain of coverage excess of the contractor's scheduled underlying coverage. Any insurance or self-insurance maintained by the District, its directors, officers, employees and agents shall be excess of the contractor's insurance and shall not be called upon to contribute with it in any way.

At a minimum, all workers' compensation and employers' liability policies shall contain the following provision, or contractor shall provide endorsements on forms supplied or approved by the District to add the following provision to the insurance policies: (1) the insurer shall agree to waive all rights of subrogation against the District, its directors, officers, employees and agents for losses paid under the terms of the insurance policy which arise from work performed by the contractor.

At a minimum, all policies shall contain the following provisions, or contractor shall provide endorsements on forms supplied or approved by the District to add the following provisions to the insurance policies: (l) coverage shall not be canceled except after thirty (30) days prior written notice by mail has been given to the District; and (2) any failure to comply with reporting or other provisions of the policies, including breaches of warranties, shall not affect coverage provided to the District, its directors, officials, officers, employees and agents. Insurance carriers shall be qualified to do business in California and maintain an agent for process within the state. Such insurance carrier shall have not less than an "A" policyholder's rating and a financial rating of not less than "Class VII" according to the latest Best Key Rating Guide.

All insurance required by the contract shall contain standard separation of insureds provisions. In addition, such insurance shall not contain any special limitations on the scope of protection afforded to the District, its directors, officers, employees or agents.

All builders'/all risk insurance policies shall provide that the District be named as loss payee. In addition, the insurer shall waive all rights of subrogation against the District. The making of progress payments to the contractor shall not be construed as creating and insurable interest by or for the District, or as relieving the contractor or its subcontractors of any responsibility for loss from any direct physical loss, damage or destruction covered by the builders'/all risk policy occurring prior to final acceptance of the work by the District.

The District shall not be liable for loss or damage to any tools, machinery, equipment, materials or supplies of the contractor. The contractor shall supply to the District an endorsement waiving the insurance carrier's right of subrogation against the District for all policies insuring such tools, machinery, equipment, materials or supplies.

E. Contract Terms.

All contract terms, including, but not limited to, the contract form, general conditions and special conditions, shall include any applicable mandatory public works provisions and shall be approved by District Legal Counsel.

F. Changes in Plans and Specifications.

Every contract shall provide that the District may make changes in the plans and specifications for the project after execution of the contract. Bid procedures as set forth in this Policy need not be secured for change orders which do not materially change the scope of the project, as set forth in the original contract, if the contract was made after compliance with bidding requirements, and if each individual's change order does not total more than five percent (5%) of the original contract. (H&S Code § 32132(c).)

All changes or amendments to the original contract must be in writing and signed by both the contractor and a duly authorized representative of the District.

V. AUTHORITY TO AWARD CONTRACTS

The President/CEO may award contracts within his/her signatory authority as provided in the Approval and Authorization Matrix, and consistent with Board Policy No. 14-023 and this Policy, unless Board of Directors approval is required by law. All contracts exceeding the President/CEO's signature authority shall be awarded by the Board of Directors only.

VI. FLEXIBILITY AND WAIVER OF POLICY REQUIREMENTS

In recognition of the fact that the contracting and procurement needs of the District may from time to time render certain procedures or requirements herein impracticable, the President/CEO or his/her designee is authorized to permit or waive deviations from this Policy, to the extent permitted by law, upon making a written finding that such deviations are in the District's best interests in consultation with District Legal Counsel as to legal issues involved.

Additionally, provisions required by Section "IV" (Provisions Applicable to Public Works Contracts) to be included in public contracts (e.g. requirements for performance bonds, insurance, etc.) may be included in other contracts, if appropriate.

VII. CONFLICTS OF INTEREST

As to all contracts covered by this policy, any practices which might result in unlawful activity including, but not limited to, rebates, kickbacks, or other unlawful consideration, are prohibited. No employee may participate in the selection process when the employee has a relationship with a person or business entity seeking a contract when disqualified under the provisions of Section 87100 of the Government Code or other provisions of law. (See, Gov. Code § 4526.) Additionally, all employees must comply with the District's Code of Conduct, including restrictions on accepting gifts and entertainment.

Reviewed by the FO&P Committee: 11/21/06
Approved by the Board of Directors: 12/14/06
Reviewed by the FO&P Committee: 11/27/07
Approved by the Board of Directors: 12/13/07
Reviewed by the FO&P Committee: 11/16/10
Approved by the Board of Directors: 12/16/10
Approved by the FO&P Committee: 6/18/14
Approved by the Board of Directors: 6/26/14

EXHIBIT A

BIDDING AND COMPETITIVE PROCUREMENT REQUIREMENTS

Category	Bidding or Competitive Procurement Requirement
Materials and supplies to be furnished sold or leased to the district involving an expenditure of more than $25,000	Bidding required. (See Health & Safety Code § 32132, subd. (a).) This is the general rule, some specific exceptions apply as listed below. Emergency Exception: Bidding not required if board of directors first determines that an emergency exists warranting such expenditure due to fire, flood, storm, epidemic, or other disaster and is necessary to protect the public health, safety, welfare, or property. (See Health & Safety Code § 32136.)
Work involving an expenditure of more than $25,000 (including public works)	Bidding required. (See Health & Safety Code § 32132, subd. (a).) Emergency Exception: Bidding not required if board of directors first determines that an emergency exists warranting such expenditure due to fire, flood, storm, epidemic, or other disaster and is necessary to protect the public health, safety, welfare, or property. (See Health & Safety Code §32136.) Change Orders - Bids are not necessary for change orders that do not materially change the scope of the work if the contract was awarded through bidding and each individual change order does not total more than 5 percent of the contract. (See Health & Safety Code § 32132, subd. (c).)
Medical or surgical equipment or supplies	Bidding does not apply. (See Health & Safety Code § 32132, subd. (b).) This includes only equipment or supplies commonly, necessarily, and directly used by, or under the direction of, a physician and surgeon in caring for or treating a patient in a hospital. (See Health & Safety Code § 32132, subd. (d).)
Electronic data processing and telecommunications goods and services	If the cost is less than or equal to $25,000, no bidding requirements. (See Health & Safety Code § 32132, subd (b).) If the cost is more than $25,000, must be procured

Category	Bidding or Competitive Procurement Requirement
	through competitive means as described by statute. (See Health & Safety Code § 32138.) Exception: Competitive means not required if the board determines either that (1) the goods and services proposed for acquisition are the only goods and services which can meet the district's need, or (2) the goods and services are needed in cases of emergency where immediate acquisition is necessary for the protection of the public health, welfare, or safety. (See Health & Safety Code § 32138, subd. (a).)
Professional services	Competitive bidding does not apply. (See Health & Safety Code § 32132, subd. (b); see also Gov. Code § 53060.) Architectural, landscape architectural, engineering, environmental, land surveying and construction management services must be selected on the basis of demonstrated competence and on the professional qualifications necessary for the satisfactory performance of the services required. (See Gov. Code § 4525 et seq.) Exception: These provisions do not apply where the District head determines that the services needed are more of a technical nature and involve little professional judgment and the requiring bids would be in the public interest. (See Gov. Code § 4529.)
Energy conservation contracts	District may enter into such contracts after a public hearing and findings required by statute. (See Gov. Code § 4217.10 et seq.)

Tri-City Health Care District
Oceanside, California

DELETE – No longer using Petty Cash.

Administrative Policy Manual

ISSUE DATE: 9/87 **SUBJECT: PETTY CASH FUNDS**

REVISION DATE: 7/93; 11/00; 1/06; 1/09 **POLICY NUMBER:** 8610-208

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

A. **PURPOSE:**

1. ~~To set forth guidelines which establish the use and authorization of petty cash funds within the District.~~

~~B. **POLICY:**~~

~~Petty cash funds may be requested for minor expenditures of an urgent nature when properly submitted and approved. Petty cash fund may be used only for items costing less than $50.00. They are not to be used for Education and Travel expenses. Petty cash funds will be established at the direction of the Chief Financial Officer. Each fund shall have one person designated as the primary custodian of the fund.~~

~~C. **PROCESS:**~~

1. ~~All petty cash funds are to be kept in a vault or locked cash boxes within the work area..~~
2. ~~The primary custodian is responsible for:~~
   a. ~~Safeguarding cash in fund.~~
   b. ~~Disbursing funds when presented with properly completed and approved petty cash requests.~~
   c. ~~Obtaining signature of person requesting cash on the "received by" line on the petty cash request.~~
   d. ~~Summarizing petty cash requests by department and expense type and submitting summary and requests to Accounts Payable for audit and reimbursement. This is to be done as needed to maintain a sufficient cash balance in the fund.~~
3. ~~Petty Cash Requests~~
   a. ~~Must be filled out completely with amount, date, expenditure description, department, and expense account to be charged.~~
   b. ~~The "Approved by" line must be signed by a department manager or administrative head.~~
   c. ~~Documentation for the expenditure must be attached.~~

4.1. ~~The fund custodian is responsible for ensuring that all proper documentation is attached.~~

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 18, 2015
Registry Spend for Nursing and Allied Health Proposal

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

Vendor Name: Multiple Local and Travel Supplemental Staffing Registries

Area of Service: Nursing and Allied Health Areas

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

Maximum Totals:

Estimated Monthly Cost	Estimated Annual Cost	Total Term Cost NTE
$550,000	$6,600,000	$6,600,000

Description of Services/Supplies:

- Previous Board approval in November, 2014 for supplemental clinical staff for $5,000,000 for support from November, 2014 through June, 2015
- Actual spend during this time was $ 3.9 million
- Actual spend for FY15 for supplemental staff was $6.0 million
- Increase requested to support increase in registry rates to maintain competitive edge for limited resources
- Planning ahead to utilize supplemental staffing while we work to fill vacant and FMLA/LOA positions, support increasing specialty unit census, plan for winter census increases and flu season

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

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Supplemental Registries for an estimated amount of $550,000/month for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016 for an annual cost not to exceed $ 6,600,000, and a total cost for the term not to exceed $ 6,600,000.

AMENDED

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 18, 2015
Talyst Automated Pharmacy Carousel Proposal

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

Vendor Name: Talyst
Areas of Service: Pharmacy
Term of Agreement: Capital Equipment Purchase - Automated Pharmacy Carousel System
60 Month Maint. Support Agreement – Dec 1, 2014 – Nov 30, 2019

Maximum Totals:

Monthly Support Cost	Annual Support Cost	Total Purchase Price and Support Cost
$4,200	Proposed $ 50,400	Equipment Purchase: $ 340,298 60 month Support: $ 231,000 (Includes 5 free months)

Total 60 month cost: **$571,298**

Additional construction costs:

Item	Cost
Architectural Design Fees	$30,057.60
OSHPD (estimates)	$13,971.22
Construction (estimates)	$23,800.00
Contingency 10%	$48,387.39
Total	**$116,216.21**

***This proposal was originally approved for a total cost not to exceed $575,000 at the FOP meeting on November 18, 2014. The proposal is returning to FOP to include construction costs.**

Description of Services/Supplies:

- Automated drug management system that secures products, tracks inventory levels, and counts/dispenses doses.
- We currently have an older Talyst carousel that was purchased in 2007 and is at the end of service life. This unit is the "heart" of TCHD's Pharmacy operations and the current unit is no longer supported by the vendor and we are at risk if the highly mechanical unit needs repairs.
- This is a like-for-like swap which means there will be very minimal facility modifications required to install the new system, per Talyst vendor
- Two other comparison bids were obtained to validate the market price of the Talyst quote.
    - RxWorks - $683,024 excluding necessary facility modifications
    - Swisslog - $618,000 excluding necessary facility modifications
    - Both of these vendors would require significant structural modifications

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

Person responsible for oversight of purchase: Tori Hong, Director, Pharmacy / Sharon Schultz, CNE

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the capital purchase of the Talyst Automated Pharmacy Carousel System and the 60 month maintenance support agreement for a total cost not to exceed $575,000, with additional facility modifications not to exceed $120,000.

AMENDED

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 18, 2015
Renewal of Contract for Supplier of Natural Gas Proposal

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

Vendor's Name: Lowest Responsive Bidder

Area of Service: Engineering / Facilities

Term of Agreement: 36 months, Beginning, September 1, 2015 - Ending July 31, 2018

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$31,356	$376,267	$1,096,447

Description of Services/Supplies:

- This request is for an approval to engage into a contract with a supplier of natural gas. We cannot come to the board with an exact expense of the contract as the gas market fluctuates every day and depending on the date the RFP (Request for Proposal) ends that will be the rate we will have an option to engage into. The market has been very stable so these numbers should be the maximum the market would get to by the RFP completion. The market is nearly at a 5 year low and will save TCMC anywhere between $257,124 and $449,994 during the 3-year term. Many customers are tempted to "wait" the market out in the hopes it will drop to the 3 or 5 year lows. However, if the market did drop it would only save Tri-City about $24,000. However, if the market were to go up to the 3 or 5 year high instead of the low during the "waiting" then that would mean a loss of $155,000.

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

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with the lowest responsive bidder for supply of natural gas for a term of 3-years, beginning September 2015 and ending July 2018 for an approximate annual cost of $ 376,267, and an approximate total cost for the term of $ 1,096,447.

Price Probability and Savings Analysis

Total Annual Usage	Historical Commodity Cost (Feb 14 - Jan 15)
81,411	$451,190

Tri City Medical Center 4002
Vista Way Oceanside CA 92056 Account # 62007490028

	1 Year Contract		2 Year Contract		3 Year Contract	
	Price Probability LOW	Price Probability HIGH	Price Probability LOW	Price Probability HIGH	Price Probability LOW	Price Probability HIGH
	$3.25	$3.97	$3.37	$4.09	$3.49	$4.21
Annual Cost	$290,467.13	$354,638.02	$301,192.07	$365,541.71	$311,917.01	$376,266.65
Savings Against Historical Commodity Cost	**$160,722.88**	**$96,551.98**	**$149,997.94**	**$85,648.29**	**$139,273.00**	**$74,923.36**

Carlos E. Lopez II, R.E.P., C.E.P.
Director of Business Development
Off: 714-485-4122 | C: 714-501-8335
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ecom-energy

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 18, 2015
Master Planning Services Agreement Proposal

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

Vendor Name: McCarthy Building Companies, Inc.
Area of Service: Tri-City Medical Center
Term of Agreement: 6 months, Beginning, September 1, 2015 - Ending, February 29, 2016

Maximum Totals:

Total Term Cost
$ 495,000

Description of Services/Supplies:
Development of Master Plan for first step in the Design/Build process for addressing seismic issues to bring TCMC into compliance with SB 1953 before 2030

- Identify locations for cost-effective location for structures needed to meet determined space program
- Determine whether to renovate, expand or build a new ED and locate accordingly on campus
- Determine future parking needs and location of structure
- Evaluate Central Plant and determine if new or expanded equipment/space is required, locate accordingly
- Assess acute care goals, determine if new, expanded, renovated, and/or repurposed space is solution; locate accordingly
- Determine SB 1953 compliance requirements and incorporate into final Master Plan

Plan sequence of construction to ensure ongoing operation of hospital during construction

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

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

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 an engagement with McCarthy Building Companies, Inc., for an initial project expenditure not to exceed $495,000 to develop a Master Plan as the first step toward addressing the seismic requirements of SB 1953 to bring TCMC into compliance before 2030.

McCARTHY

9275 SKY PARK COURT, SUITE 200 SAN DIEGO, CALIFORNIA 92123 (858) 784-0347 www.mccarthy.com

July 2nd, 2015

Mr. Wayne Knight
Executive Director Healthcare Reform and Contracting
Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056

RE: Tri-City Medical Center Master Plan Proposal

Dear Mr. Knight:

On behalf of McCarthy Building Companies, Inc. (McCarthy) I'd like to thank you for selecting us for this exciting project. **With more than 150 years of healthcare experience in executing master plan services, design-build, and design-bid-build healthcare projects,** McCarthy brings the most experienced and qualified experts to Tri-City Medical Center (TCMC) for the successful execution of your Master Plan. To ensure this success, we have added Cuningham Group Architecture, Inc. (Cuningham) to our team as our architectural partner. **Collectively, our team has successfully completed two master plans, and eight healthcare projects valued at more than $500 million.**

Together, we are committed to TCMC's success and realize that true success will only be achieved by the team that can ultimately deliver the best possible solution to you, the user groups, staff, patients, visitors, and the surrounding community.

Through our early discussions with TCMC, we understand the following are the initial goals for your campus:

1. Renovate, expand or build a new emergency department.
2. Build a parking structure.
3. Asses the acute care goals of the hospital and determine if new, expanded, renovated, and or repurposed space is the solution.
4. Ensure SB 1953 compliance by 2030.

In addition to McCarthy and Cuningham, we have proposed bringing on additional experts to our design-build Master Plan team, which include: Degenkolb, Structural Engineer; Duffoe Consulting Engineers, Mechanical Engineer; exp, Electrical Engineer; Burkett & Wong, Civil Engineer and Survey; Dieli Murawka Howe, Food Service Consultant; Metroplan, Entitlement Consultant; LLC, Traffic Consultant; Criterion, Medical Equipment Consultant; and Southern California Soils and Testing, Geotech Consultant. **Our team has the ability to successfully evaluate the goal of TCMC in a collaborative environment, and develop the best Master Plan possible to meet those goals.**

We can complete this Master Plan effort in six months assuming we can schedule all the meetings necessary, in a timely fashion, in order to receive the proper approvals.

Within this Master Plan proposal, we have included the following items

1. **Master Planning Overview** - below and on the following pages, we have identified the value of master planning, our approach, the process, and our first impression of the key issues that are driving the need for expansion at TCMC.
2. **Master Plan Contract and General Conditions** – we have attached a sample contract and general conditions, which also includes our scope of services for the Master Plan – we would like to meet with you to review these documents in greater detail.

3. **Master Plan Fee Proposal - Phase I Services** – below, we have highlighted our lump sum fee proposal for the Master Plan that includes all of our design-build team members:

Company	Role	Expense
McCarthy	Master Planning	81,000
Cuningham	Architecture	234,000
Degenkolb	Structural	13,500
Duffoe Consulting Engineers	Mechanical	36,000
exp	Electrical	27,000
Burkett & Wong	Civil	9,000
Dieli Murawka Howe	Food Service	13,500
Metroplan	Entitlements	10,800
LLG	Traffic	17,100
Criterion	Medical Equipment	27,000
Expenses	Printing	26,100
		495,000

In addition to the items identified in our Master Plan proposal, we will provide the following items to TCMC at a later time once we have a more in-depth conversation with you:

1. **Design and Preconstruction Phase II Services** – once the Master Plan is approved, this would be the next step to start designing the various components of the emergency department, the parking structure, the acute care building, and any buildings that need to meet SB 1953 by 2030.
2. **Construction Phase III Services** – we will provide a fee percentage, general conditions, construction administration, insurance, bonds, etc. based on the master planning construction values. This range will provide TCMC with clarity for the construction of various future building projects on campus, or as a whole in providing construction for the entire master plan.

Mater Planning Overview

Value of Master Planning

TCMC has been through the "master planning" process several times in the past. The previous exercises were based on the standard parameters of a typical master plan. Demographic projections, service line analysis, space needs, and simple block diagrams. Many times these master plans produced lofty goals, unrealistic expectations, and unbuildable solutions, and often end up on someone's shelf never to be implemented.

This team's focus for this Master Plan is very different. The key driver of the team's effort will be focused on the strategy of "How" and "Where" a project should be implemented from both a logistical perspective as well as a realistic, affordable capital expenditure program. The true value of the following master plan is simple.

Set a road map for the future of the campus:

- To meet the clinical needs
- To right size the overall bed count
- Meet SB-1953 seismic requirements by 2030
- Address future growth beyond 2030
- A phased approach
- A realistic design solution which is buildable and minimizes impact to the existing operations

- Define the constraints and opportunities related to the regulatory agencies and any off-site improvements which may be triggered by new expansion projects

A Unique Approach

Our team's efforts will represent a significant departure from the typical master plan approach. This process will be a true team effort from the TCMC leadership team and the design-build team with a focus on the realistic constraints to master planning. The selection of McCarthy, and our partnership with Cuningham, as a design-build team is a unique approach for a master plan. McCarthy is one of the country's leading health care construction companies and has delivered a realistic approach to evaluating master planning concepts from the perspective of constructability, project timelines/schedules, facility disruption, and capital budgeting. Cuningham is the largest healthcare design firm in San Diego and works globally.

Process

The success of this master planning effort will be based on the collaboration between the TCMC leadership team and the design-build team. The process will include weekly Owner-Architect-Contractor (OAC) meetings to keep all team members up to speed on issues and findings throughout the entire master planning process. TCMC would be well served by forming a leadership committee that meets monthly with the design-build team to review progress, provide the Master Plan team with direction, and build consensus leading to the final master planning document.

The Master Plan process is focused on the following:

I. Define the key issues that are driving the need for expansion
II. Identify all site locations suitable for the expansion
III. Evaluate location for build ability and functional adjacencies
IV. Create test-to-fit block plan layouts and patient / staff / materials flow diagrams
V. Establish phasing approach
VI. Develop a realistic budget
VII. Build a phased approach schedule / timeline

Key Drivers for Expansion

The efforts for this Master Plan are intended to address the key issues affecting TCMC's ability to serve the community's health needs. Working with the master planning committee, the team will define these key priorities:

<u>Define Inpatient Bed Capacity / Need / Location:</u>

With 2030 approaching, the campus needs a plan to address the inpatient beds which are currently housed in the Central and South Towers which are non-compliant structures.

<u>Improve and Expand Diagnostic and Treatment Services:</u>

As the hospital has expanded with additional inpatient beds, the diagnostic services have either been left in non-compliant space or had no major expansion to meet the needs of the patient volumes. As a focus of this effort, the team will right size these services and define a phased approach to migrating these services to compliant space by 2030.

<u>Improve and Expand Support Services:</u>

Similar to the diagnostic and treatment services, the support areas have been deferred as the campus has continued to grow. Many of these required services are also housed in non-compliant spaces which will need to be addressed prior to 2030. The focus of this effort will be to not just replace these services but to evaluate the current operations and implement more streamlined operations and efficiencies.

Address Parking Issues:
With almost every major medical campus, parking is a significant issue. Parking is difficult and nearing capacity. Lack of parking creates significant patient dissatisfaction and access to services. The Master Plan will identify a location for a parking structure.

Campus Infrastructure:
There are significant SB-1953 issues that need to be addressed. We will review them with an eye toward affordability:

- Develop a phased approach
- Phased capital expenditure
- Address the real needs: "You can't fix everything"
- Cost effective planning
- Maximize use of existing facilities

Identify Site Locations Suitable for Expansion:
Our partners at Cuningham have already made progress on the location for the garage and emergency department but of course, a more in-depth study is needed. We need to determine exactly what essential services are in the seismically non-complaint space so we can find them complaint homes and we need to locate the beds needed to stay operational in 2030.

Established Phased Approach:
One of the team's key drivers to the Master Plan is to develop a phased approach. A phased approach allowed the team to align your capital expenditures with the primary needs. The team will establish phases in the Master Plan.

Develop a Realistic Budget
The team will develop a master project budget broken into the phased approach representing both the construction cost and the overall project cost for each phase. Utilizing the information about the existing site conditions, the test-to-fit space plans, and the recent data base of construction costs, the team is confident that the budgets provided are achievable. The team will involve the local subcontractor market to validate and confirm pricing and escalation to provide an extra level of confidence in the budget. The budget also will allow for anticipated expenses such as environmental impact and conditional use reports and approvals, on-site and off-site infrastructure improvements, development fees, and permitting fees.

In summary, the entire team will work hard to find the most appropriate solutions which are realistic and achievable.

On behalf of McCarthy, thank you and we look forward to working with you.

Sincerely,

McCarthy Building Companies, Inc.
Robert Betz, Executive Vice President

AMENDED

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 18, 2015
Naval Hospital Camp Pendleton - Resident Agreement

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

Agreement Name: Department of the Navy / Camp Pendleton

Area of Service: Inpatient Care – Family/Internal Medicine

Term of Agreement: 53 months, Beginning, September 1, 2015 - Ending January 31, 2020

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	53 month (Term) Cost
$ 0	160	1920	$ 0	$ 0	$ 0

Agreement Responsibilities:

- Provide Resident(s) trainee per rotation, number and assignment to be mutually agreed upon between Naval Hospital Camp Pendleton (NHCP) and TCMC contracted Hospitalist.
- NHCP Trainee(s) will be supervised by the TCMC contracted Hospitalists.
- There will be no training expense.
- TCMC will not use (NHCP) trainees or faculty in any publicity.
- It is understood that TCMC will generate bills for services rendered by the trainees.

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

Person responsible for oversight of agreement: Sherry Miller, Medical Staff / Sharon Schultz RN, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize The Department of the Navy to provide Medical Resident trainees for a term of 53 months beginning September 1, 2015, and ending January 31, 2020, at no cost to TCHD.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: AUGUST 18, 2015
CBS-8 / KFMB / Midwest Television Advertising Proposal

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

Vendor Name: Midwest Television – KFMB / CBS - 8

Area of Service: Marketing

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

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost	Cost Difference from Previous FY
$ 12,572.75	$ 150,873.00	$ 150,873.00	($ 149,027)

Description of Services/Supplies:

- Televised advertising on CBS-8 and KFMB, in pre-approved target market spots.

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

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Midwest Television / CBS-8 / KFMB for a monthly cost of $12,572.75 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016, for an annual/term cost of $150,873.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: AUGUST 18, 2015
ABC-10 / KGTV - Television Advertising Proposal

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

Vendor Name: KGTV – ABC 10 - Television Advertising

Area of Service: Marketing

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

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost	Cost Difference from Previous FY
$16,425	$150,100	$150,100	$ 0

Description of Services/Supplies:

- Televised Advertising on ABC-10 / KGTV in Pre-Approved Targeted Market Spots

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

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with ABC-10 / KGTV for a monthly cost of $16,425 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016 for an annual/term cost of $197,100.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: AUGUST 18, 2015
NBCOTS – NBC 7 Television Advertising Proposal

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

Vendor Name: NBC Owned Television Stations (NBCOTS) NBC-7 Television Advertising

Area of Service: Marketing

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

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost	Cost Difference from Previous FY
$ 23,000	$ 276,600	$ 276,600	($ 18,550)

Description of Services/Supplies:

- Televised Advertising on NBC-7 in pre-approved, targeted market spots.

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

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with NBC-7 / NBCOTS for a monthly cost of $22,300 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016, for an annual/term cost of $276,600.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: AUGUST 18, 2015
Entravision Spanish Television Advertising Proposal

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

Vendor Name: Entravision Television Advertising (Spanish)

Area of Service: Marketing

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

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost	Cost Difference from Previous FY
$ 7,074.48	$ 84,893.75	$ 84,893.75	($ 123,700)

Description of Services/Supplies:

- Televised Spanish advertising on Telemundo, Univision and Pulpo in pre-approved targeted market spots.

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

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Entravision for a monthly cost of $7,074.48 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016 for an annual/term cost of $84,893.75.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: AUGUST 18, 2015
San Diego Business Journal Print Advertising Proposal

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

Vendor Name: San Diego Business Journal

Area of Service: Marketing

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

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost	Cost Difference from Previous FY
$ 8,333	$ 100,000	$ 100,000	($ 20,000)

Description of Services/Supplies:

- Print advertising in the San Diego Business Journal

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

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with the San Diego Business Journal for a monthly cost of $10,000 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016, for an annual/term cost of $120,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: AUGUST 18, 2015
Union Tribune Print Advertising Proposal

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

Vendor Name: Union Tribune

Area of Service: Marketing

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

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost	Cost Difference from Previous FY
$ 17,250	$ 207,000	$ 207,000	($ 104,890)

Description of Services/Supplies:

- Print advertising in the local Union Tribune newspaper.

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

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with the Union Tribune for a monthly cost of $17,250 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016 for an annual/term cost of $207,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 18, 2015
Roche Diagnostics Agreement Proposal

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

Vendor Name: Roche Diagnostics (Tissue Products Agreement)

Area of Service: Laboratory

Term of Agreement: 12 months Beginning, September 1, 2015 - Ending August 31, 2016

Monthly Cost	Annual Cost	Total Term Cost
$ 44,834	$ 538,000	$ 538,000

Description of Services/Supplies:

- Histology disposable agent supply products.
- Various supply kits used in the pathology slide production process.
- Spend averages approximately $21.00 per slide. Minimum of 25,000 slides produced annually.
- 10% price increase included in new agreement. No price increase in the prior 6 years.
- Prior 12 month spend $489,000.

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

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

Motion:

I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the Agreement with Roche Diagnostics Corp for a term of 12 months starting September 1, 2015 and ending on August 31, 2016. Amount not to exceed an annual expense for the Term of $ 538,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 18, 2015
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE

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

Physician's Name: Charles McGraw, MD

Area of Service: ED On-Call: Interventional Radiology

Term of Agreement: 23 months, Beginning, August 16, 2015 – Ending, June 30, 2017

Within Hourly and/or Annualized Fair Market Value: YES

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

Rate/Day	Days per Year	Annual Cost	12 month (Term) Cost
$600	FY2016: 320 FY2017: 365	$192,000 $219,000	$192, 000 $219,000

Position Responsibilities:

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

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

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Charles McGraw, MD as ED On-Call Coverage Physician for a term of 23 months beginning 8/16/2015 and ending 6/30/2017. Not to exceed a daily rate of $600 and a total cost for the term of $411,000.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
August 20, 2015

Members Present: Director Jim Dagostino (Chair), Director Ramona Finnila, Director Laura Mitchell, Dr. Gene Ma, Dr. James Johnson and Dr. Marcus Contardo.

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

Others present: Jody Root, General Counsel, Jami Piearson, Director of Quality and Regulatory, Marcia Cavanaugh, Sr. Director for Quality, Cli. Risk Mgt. & Patient Safety, April Lombardo, Bruce Bainbridge, Kevin McQueen, Patricia Guerra, Kathy Topp, Andrea Hanson, Steve Sims, Debra Mendez, Candice Parras, Kerry Moriarty-Homsy and Karren Hertz.

Members absent: Dr. Scott Worman.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Dagostino, called the meeting to order at 12:05 p.m. in Assembly Room 1.		Director Dagostino
2. Approval of Agenda	The group reviewed the agenda and there were no additions or modifications.	Motion to approve the agenda was made by Director Mitchell and seconded by Director Finnila.	Director Dagostino
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Dagostino read the paragraph regarding comments from members of the public.		Director Dagostino

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of July 2015.	Director Dagostino called for a motion to approve the minutes of the July 16, 2015.	Minutes ratified. Dr. Johnson moved and Director Finnila seconded the motion to approve the minutes from July 2015. Direction Dagostino abstain since he was not present in last month's meeting.	Karren Hertz
5. New Business a. Quality Outcomes Dashboard	Jami reported that our quality outcomes and process measures are currently doing well. For the Falls outcome measure, it was mentioned that we are going to implement the TST tool from Joint Commission to improve the scores for this category.	Informational.	Jami Piearson
b. Formulary Evaluation	Andrea Hanson presented the drug Abilify Maintena, as a maintenance treatment of Schizophrenia in stabilized adult patients. This drug is for an off- label use and is very helpful in preventing relapse and consequently, readmission for patients with Schizoprenia.	**ACTION:** Director Finnila approved and Director Mitchell seconded the motion to use this once- monthly drug for treatment of Schizophrenia.	Andrea Hanson
Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:**			

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Code Blue and Emergency Care	No discussion on this policy.	**ACTION:** The Patient Care Services policies and procedures were approved with the exception of some minor edits. Director Mitchell moved and Dr. Ma seconded the motion to approve these policies.	Patricia Guerra
2. High Level Disinfection Procedure	Director Finnila proposed to add the word "clean" on the lint-free cloth used to dry the exterior of an item; as one of the steps used in disinfecting. The distinction between a clean procedure and sterile procedure was also briefly mentioned as well as disinfecting versus sterilizing.		
3. Incentive Spirometer (IS) Instruct and Monitoring	Director Mitchell posed a question regarding nurses doing spirometer testing. It was stated that RNs can do it but they cannot bill for it.		
4. Patient Leave of Absence; Temporary Policy	The TCMC will be replaced with TCHD in this policy.		
Administrative Policies			
1. Policy Approval- Administrative	There was no discussion on this policy.		
2. Incident Report- Quality review report (QRR) 396	The word "timely' was added to the part of mechanism for reporting. The algorithm for reporting and responding to unusual occurrences was edited to add some people that will be notified on these circumstances. The word "for assessment" was also added by Risk Management. Also we drew the line from QUAPI Committee to BOD in order to have better communication with the BOD.	**ACTION:** The Administrative policies and procedures were approved with the exception of some minor edits. Director Finnila moved and Dr. Ma seconded the motion to approve these policies.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Unit Specific			
Emergency Dept. 1. Glidescope Set-up and Cleaning Procedure	This policy was pulled as it will be standardized thus becoming a patient care services policy.	**ACTION:** The unit-specific policy for ED on LWOT was approved. The Glidescope policy was pulled out to be brought back as a PCS policy.	Patricia Guerra
2. LWOT, AMA and Elopement Policy	There was no discussion on this policy.		
Pharmacy 1. Transdermal Fentanyl Patch Prescribing and Use	Andrea Hanson explained further the issues on patients who use this patch. The use of this drug is prevalent and special precautions and monitoring are needed at all times in the ED and other units as well.	**ACTION:** The Pharmacy was approved ; Director Mitchell moved and Director Finnila seconded the motion to approve these policies.	Patricia Guerra
Staffing 1. Monitoring Registry Files Policy 2. Registry Badge Process 3. Registry Contract, Orientation Packets, and Audits	These policies, which describe the changes brought about by a new application concerning registry, will be going to HR Committee after approval.	**ACTION:** The Staffing policies were all approved and moving forward to HR Committee. Director Mitchell moved and Director Finnila seconded the motion to approve these policies.	Patricia Guerra
Pre-Printed Orders 1. Adult Parenteral Nutrition Orders	Director Mitchell had an inquiry if the fat emulsion is combined with the bag. Director Finnila clarified the process for this order:	**ACTION:** The pre-printed order was approved as Director Mitchell moved and seconded by Dr. Ma.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	• The MD asked for a nutrition consult • Nutritional consultant and pharmacist collaborate • MD takes advise and do a pre-printed		
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Dr. Johnson moved, Dr. Contardo 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 2:25 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 2:24 PM		Director Dagostino

PROFESSIONAL AFFAIRS COMMITTEE
August 20th, 2015

CONTACT: Sharon Schultz, CNE

Patient Care Services Policies & Procedures		
1. Code Blue and Emergency Care	2 year review, practice change	Forward to BOD for approval
2. High Level Disinfection Procedure	3 year review, practice change	Forward to BOD for approval with revisions
3. Incentive Spirometer (IS) Instruct and Monitoring	NEW	Forward to BOD for approval
4. Patient Leave of Absence, Temporary Policy	3 year review, practice change	Forward to BOD for approval
Administrative Policies		
1. Policy Approval - Administrative	3 year review	Forward to BOD for approval
2. Incident Report-Quality Review Report (QRR) 396	3 year review, practice change	Forward to BOD for approval with revisions
Unit Specific		
Emergency		
1. GlideScope Set-up and Cleaning Procedure	3 year review	Pulled for further review – convert to PCS Procedure
2. LWOT, AMA or Elopement Policy	Practice change	Forward to BOD for approval
Pharmacy		
1. Transdermal Fentanyl Patch Prescribing and Use	3 year review, practice change	Forward to BOD for approval with revisions
Staffing		
1. Monitoring Registry Files Policy	Practice change	Forward to BOD for approval
2. Registry Badge Process	Practice change	Forward to BOD for approval with revisions
3. Registry Contract, Orientation Packets and Audits	Practice change	Forward to BOD for approval
Pre-Printed Orders		
1. Adult Parental Nutrition Orders	Practice change	Forward to BOD for approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES~~STANDARDIZED PROCEDURES MANUAL~~

STANDARDIZED PROCEDURE: CODE BLUE AND EMERGENCY CARE ~~(CARDIOPULMONARY ARREST)~~

I. **POLICY:**

A. Function: Management of ~~cardiopulmonary arrest~~**Code Blue and emergency care** in the adult (14 years or older) patient including **cardiopulmonary arrest (CPA),** cardiac dysrhythmias, ~~respiratory distress~~**acute respiratory compromise (ARC)**, and hypotension associated with volume deficit.

B. Circumstances:

1. Setting: Tri-City Medical Center
2. Supervision: None required. However, upon arrival of a physician or Code Blue Registered Nurse (RN), nursing staff will follow orders of the Code Blue RN and ultimately orders from physician.
3. Patient contraindications – Patients with written orders contrary of the Standardized Procedure. Patients with Special Considerations:
   ~~i.~~**a.** No Code – A no-code is synonymous with "no resuscitation" or "do not resuscitate" and allow a natural death

C. Definitions:

1. Cardiopulmonary Arrest (CPA)- any pulseless cardiac arrests requiring chest compressions and or defibrillation, or cardiac events with pulse requiring chest compression for poor perfusion

~~1.~~**2.** Cardiac Dysrhythmias – Any sustained tachy or brady dysrhythmias ~~that~~ ~~requires~~**requiring** immediate intervention due to life threatening potential or that **may** result in the patient becoming symptomatic.

~~2.~~**3.** ~~Respiratory Distress~~**Acute respiratory compromise (ARC)** – Any decrease in respiratory rate, depth, and/or decrease in oxygenation ~~that requires~~ **requiring** immediate intervention due to life threatening potential or that **may** ~~results~~ in a patient becoming symptomatic.

~~3.~~**4.** Hypotension associated with volume deficit – Any decrease in blood pressure of 30 - 40 mmHg or more from pre-operative/pre-procedural levels or less than 80 mmHg systolic associated with signs of absolute or relative fluid loss.

D. Data Base:

1. Subjective – Patient complains of dizziness, lightheadedness, chest pains, shortness of breath, or confusion.
2. Objective – Decreased level of consciousness or unresponsive, respirations labored or absent and/or pulse absent, rhythm disturbances (if patient is monitored), low or absent blood pressure.
3. Diagnosis -- Life threatening emergency.
4. Plan:
   a. Initiate Standardized Procedure as appropriate and notify attending physician
   ~~a.~~**i. Notify** ~~/~~anesthesiologist in Post-Anesthesia Care Unit (PACU)
   b. Initiate **standardized procedure/**advanced life support as appropriate and call Code Blue by dialing 66 on the telephone~~,~~ ~~r~~requesting a "Code Blue" announcement and provi~~ded~~ding patient location.
5. Assessment -- Patient will be reassessed after each intervention.

Revision Dates	Clinical Policies & Procedures	Nurse Executive Council	Pharmacy and Therapeutics	Critical Care Committee	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
3/00; 1/05; 12/05; 5/08, 6/11;7/13; **9/14**	03/11;7/13;**914**	03/11;10/14	06/11;9/14	**02/15**	06/11; **04/15**	06/11; **05/15**	**08/15**	6/11

6. Record Keeping -- Events are to be recorded in the ~~Medical Record~~ **electronic health record (EHR) (in the emergency event record)** and the Cardiopulmonary Arrest Record. White copy to remain on chart.

II. **PROCEDURE:**

A. CARDIAC DYSRHYTHMIAS
1. Continuous cardiac monitoring.
2. Administer oxygen to maintain SpO_2 greater than or equal to **95%**
3. Establish IV access with normal saline (NS) solution.
4. Notify attending physician/anesthesiologist in PACU prior to initiation of treatment if situation permits. Otherwise, contact appropriate physician after therapy is started.

B. ASYSTOLE OR PULSELESS ELECTRICAL ACTIVITY (PEA)
1. Initiate CPR at a rate of at least 100/minute ratio 30:2 and call Code Blue.
2. Establish IV access with NS.
3. Confirm asystole in more than one lead.
4. Administer Epinephrine 1:10,000 1 mg IV, repeat every 3-5 minutes.~~ or Vasopressin 40 units IV single dose to replace first or second dose of epinephrine.~~
5. Obtain ABGs.

C. VENTRICULAR FIBRILLATION AND PULSELESS VENTRICULAR TACHYCARDIA
1. Initiate CPR at a rate of at least 100/minute ratio 30:2 and call Code Blue.
2. Defibrillate with 200 joules. Resume CPR immediately after shock for 5 cycles or 2 minutes.
3. Establish IV access with NS.
4. Administer all medications during CPR or before or after defibrillation.
5. Epinephrine: 1:10,000 1 mg IV, repeat every 3 - 5 minutes. ~~or Vasopressin 40 units IV single dose to replace first or second dose of epinephrine.~~
6. Pause CPR briefly (less than 10 seconds) to check rhythm after 5 cycles or 2 minutes of CPR.
7. Defibrillate with 200 joules and resume CPR for 5 cycles (2 minutes)
8. Consider antiarrhythmics:
   a. Amiodarone 300 mg IVP once.
   b. In 3 – 5 minutes, consider,
      i. Additional 150 mg of Amiodarone IV
      ii. Lidocaine 1.5 mg/kg IV push first dose, then 0.5 ~~- 0.75~~ mg/kg, repeat in 5 minutes up to a total of 3 doses or total dose of 3 mg/kg.
9. Defibrillate with 200 joules and resume CPR for 5 cycles or 2 minutes
10. Consider Magnesium sulfate 2 grams in 100 mL D5W administered over 2 minutes for torsades de pointes. Identify and treat cause.
11. After return of spontaneous circulation (ROSC), begin continuous infusion of medication effective in dysrhythmia suppression as recommended below:
    a. Amiodarone 1 mg/min x 6 hours, then 0.5 mg/min maintenance drip
    b. Lidocaine drip (2 gm in 500 mL D5W) at 1~~ – 4~~ mg/min

D. BRADYCARDIA:
SYMPTOMATIC: Serious signs and symptoms such as chest pain, shortness of breath, decreased level of consciousness, or hypotension are present and believed to be related to **a** slow **heart** rate.
1. Administer oxygen to maintain ~~Sp02~~ **SpO_2 greater than or equal to 95%**~~greater than 95%.~~
2. Establish IV access with NS.
3. Atropine 0.5 mg IV push, repeat every 3 - 5 minutes up to a total of 3 mg.
4. Initiate transcutaneous pacing (TCP) at rate of 80 and **m**~~M~~A of 80.
   a. Ensure 1:1 capture is obtained
   b. Set safety margin 10 **m**~~M~~A above initial capture

5. **Consider dopamine 5 mcg/kg/min. The Code Blue RN ~~M~~may titrate in increments of 2 mcg/kg/min every 5 minutes ~~for goal HR~~to maintain heart rate greater than 60bpm up to 20 mcg/kg/min as Blood Pressure tolerates. Or start Epinephrine 2 mcg/min. The Code Blue RN ~~M~~may titrate in increments of 2 mcg~~/kg~~/min every 5 minutes to maintain heart rate greater than 60bpm ~~for goal HR~~ up to 20 mcg/min as BP tolerates.**

E. TACHYCARDIA – UNSTABLE PULSE PRESENT:
UNSTABLE: Heart rate is greater than 150 bpm and serious signs and symptoms such as chest pain, shortness of breath, decreased level of consciousness, altered mental status, hypotension, or acute heart failure are present and believed to be related to rapid rate. Prepare to perform immediate synchronized cardioversion.
1. Institute oxygen therapy to maintain **SpO_2**~~$Sp0_2$~~ greater than or equal to 95%.
2. Establish IV access with NS.
3. Notify Respiratory Care Practitioner **(RCP)**
4. Consider sedation if the patient is conscious, but do not delay cardioversion
5. Ensure the defibrillator pads and monitor leads are attached to the patient and the defibrillator is in synchronization mode
6. Synchronized ~~C~~**c**ardiovert**sion** with the following initial dose. Select synchronization mode with each increase in joules.
   a. Narrow Regular QRS Complex**:** Cardiovert with 50 – 100 joules
   b. Narrow Irregular QRS Complex**:** Cardiovert with 120 – 200 joules
   c. Wide Regular QRS Complex**:** Cardiovert with 100 – 200 joules
   d. Wide Irregular QRS Complex. Do not use synchronized function. Defibrillate with 200 joules.
7. Call Code Blue, if appropriate

~~TACHYCARDIAS (Stable, Regular QRS Complex Pulse Present):~~

F. **TACHYCARDIAS STABLE (Regular QRS Complex Pulse Present):**
1. Narrow Regular QRS Complex:
   a. Attempt Vagal maneuvers (bear down, cough)
   b. Adenosine 6 mg rapid IV push repeat in 1 - 2 minutes with 12 mg IV push if needed.
2. Undifferentiated Regular Monomorphic Wide QRS Complex
   a. Adenosine 6 mg rapid IV push, repeat in 1 – 2 minutes with 12 mg IV push if needed
   b. Amiodarone 150 mg IV over 10 minutes seek expert consultation for maintenance infusion

G. TACHYCARDIA (Stable Irregular QRS Complex Pulse Present)
1. Identify rhythm as atrial fibrillation or atrial flutter or multifocal atrial tachycardia
   a. Narrow Irregular QRS Complex
      i. Seek expert consultation to control rate with diltiazem or beta blockers
   b. Wide Irregular QRS Complex
      i. Amiodarone 150 mg IV over 10 minutes
      ii. Seek expert consultation to control rate

H. CHEST PAIN (Related to coronary artery occlusion or spasm)
1. Assess pain quantity, quality, location, radiation, time of onset and precipitating factors.
2. Apply oxygen at 4 L/min via nasal cannula.
   a. Supplemental oxygen is not needed for patients without evidence of respiratory distress if the ~~SPO_2~~ **SpO_2** is **greater than or equal to 95%**~~greater than or equal to 94%.~~
3. Administer Nitroglycerin 0.4 mg sublingual every 5 minutes PRN for chest pain up to 3 doses. Hold if SBP is less than 90 mmHg.
   a. If Nitroglycerin is ineffective in relieving chest pain and patient has no contraindications, administer Morphine 1 ~~– 2~~ mg IV push times 1.
      i. Use with caution in unstable angina/non-STEMI.

4. Obtain STAT 12-lead ECG and review for ischemic changes.

I. ~~RESPIRATORY DISTRESS/ARREST~~**Acute Respiratory Compromise** (With pulse)
1. Open patient's airway and administer one breath approximately every 6 seconds via bag mask.
2. Administer oxygen to maintain ~~$Sp0_2$~~ **SpO_2 greater than or equal to 95%**~~greater than 95%.~~
3. Call ~~Rapid Response or~~ Code Blue if appropriate.
4. Establish IV.
5. Administer Naloxone (Narcan) 0.4 mg IV if patient has a patient controlled analgesia (PCA) or receiving narcotics.
6. Obtain STAT ABGs and chest x-ray as indicated.
7. Assist with intubation as appropriate.

J. HYPOTENSION ASSOCIATED WITH VOLUME DEFICIT
1. Administer oxygen to maintain **SpO_2**~~$Sp0_2$~~ **greater than or equal to 95%**~~greater than 95%.~~
2. Establish large bore IV access with normal saline solution.
3. Infuse 250 ~~– 500~~ mL normal saline or lactated ringers; repeat every 10 minutes up to a total of 1000 mL.
4. After fluid bolus, consider vasopressors to maintain systolic blood pressure greater than 90 mmHg
   ~~a. Dopamine 2 – 20 mcg/kg/min continuous IV infusion~~
   a. ~~Norepinephrine 0.5 to 30 mcg/min continuous IV infusion~~**Dopamine 5 mcg/kg/min. The Code Blue RN ~~M~~may titrate in increments of 2 mcg/kg/min every 5 minutes for SBP> 90mmHg or MAP >65mmHg up to 20 mcg/kg/min**
   b. **Norepinephrine 2 mcg/min. The Code Blue RN ~~M~~may titrate in increments of 2 mcg/min every 5 minutes for SBP >90mmHg or MAP > 65mmHg up to 30 mcg/min.**

~~III. REQUIREMENTS FOR INTENSIVE CARE UNIT (ICU) RN INITIATING INTERVENTIONS:~~
~~A. Current California RN license.~~
~~B. Education: Successful completion of Basic ECG course, ACLS course (with a current course completion card) and Critical Care Skills Lab.~~
~~C. Experience: Before an RN can respond to a Code Blue, an experienced Code Blue RN must observe the RN in the management of an actual Code Blue.~~
~~D. Initial Evaluation: During initial Critical Care Skills Lab or in Department Orientation.~~
~~E. Ongoing Evaluation: Annually~~

~~IV. REQUIREMENTS FOR TELEMETRY RN INITIATING INTERVENTIONS:~~
~~A. Current California RN license.~~
~~B. Education: Successful completion of Basic ECG course, ACLS course (with a current course completion card) and Telemetry Skills Lab.~~
~~C. Experience: Initial job requirement.~~
~~D. Initial Evaluation: During initial Telemetry Skills Lab or Department Orientation.~~
~~E. Ongoing Evaluation: Annually~~

~~V. REQUIREMENTS FOR POST ANESTHESIA CARE RN INITIATING INTERVENTIONS:~~
~~A. Current California RN license.~~
~~B. Education: Successful completion of Basic ECG course, ACLS course (with a current course completion card) and PANS Skills Lab.~~
~~C. Experience: Initial job requirement.~~
~~D. Initial Evaluation: During Orientation period.~~
~~E. Ongoing Evaluation: Annually~~

~~VI. REQUIREMENTS FOR ENDOSCOPY, CARDIAC CATH LAB AND INTERVENTIONAL RADIOLGOY RN'S INITIATING INTERVENTIONS:~~

~~A. Current California RN license~~
~~B. Education: ACLS course (with a current course completion card) and Endoscopy RN Skills Lab.~~
~~C. Experience: Initial job requirement.~~
~~D. Initial Evaluation: During orientation period.~~
~~E. Ongoing Evaluation: Annually.~~

~~VII.~~III. 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.
C. Standardized Procedure follows American Heart Association (2010) Advanced Cardiac Life Support Guidelines.

~~VIII.~~IV. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All ACLS-certified Registered Nurses **from the following clinical areas:**
1. **Intensive Care Unit**
2. **Telemetry**
3. **Post Anesthesia Care Unit**
4. **Endoscopy, Cardiac Cath Lab and Interventional Radiology** who have successfully completed requirements as outlined **below**~~above~~ are authorized to direct and perform the **Code Blue and Emergency Care (Cardiopulmonary Arrest)** Standardized Procedure.
5. **Emergency Department**

V. REQUIREMENTS FOR RNs INITIATING INTERVENTIONS:

A. Current California RN license.
B. Education: Successful completion of Basic ECG course, ACLS course (with a current course completion card).
C. Experience: Initial job requirement.
D. Initial Evaluation: During initial Critical Care Skills Lab or in Department Orientation.
~~A.~~E. Ongoing Evaluation: Annually during Skills Validations ~~Lab~~ with standardized procedure test.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**HIGH LEVEL DISINFECTION**
Purpose:	To disinfect semi-critical patient care equipment between uses
Equipment:	Personal protective equipment (gloves, eye protection, impervious gown, face shield or simple surgical mask) Container with enzymatic detergent solution Sponge or soft, lint-free cloth Brush Cidex **ortho-phthalaldehyde** (OPA) Tap Water 70% isopropyl alcohol or equivalent
~~Definitions:~~	~~1. Critical equipment: items that enter sterile tissue or the vascular system and must be sterile when used (i.e., surgical instruments, implants and needles).~~ ~~2. Semi-critical equipment: items that come in contact with non-intact skin or mucous membranes, should receive a minimum of high-level disinfection (i.e. vaginal and rectal probes, respiratory therapy equipment, bronchoscopes, gastrointestinal endoscopes and accessories).~~ ~~3. Non-critical equipment: items that come into contact only with intact skin and should receive intermediate level disinfection, low-level disinfection or cleaning (i.e. tourniquets, blood pressure cuffs).~~

A. **DEFINITIONS:**

1. Critical equipment: items that enter sterile tissue or the vascular system and must be sterile when used (i.e., surgical instruments, implants and needles).
2. Semi-critical equipment: items that come in contact with non-intact skin or mucous membranes, should receive a minimum of high-level disinfection (i.e. vaginal and rectal probes, respiratory therapy equipment, bronchoscopes, gastrointestinal endoscopes and accessories).
3. Non-critical equipment: items that come into contact only with intact skin and should receive intermediate level disinfection, low-level disinfection or cleaning (i.e. tourniquets, blood pressure cuffs).

B. POLICY:

~~B.~~**1.** The department manager has the responsibility to oversee the High Level Disinfection (HLD) process in his/her department with consultation from Infection Prevention.

~~1.~~**2.** High level disinfection:

a. The destruction of all forms of microbial life, except large numbers of spores
b. Used for reprocessing semi-critical patient care items
c. Can be done on lumuned and other submersible items in an automated reprocess
d. Manual soaking must be done on items that cannot be totally submersed.

~~2. Authorized staff to perform high level disinfection:~~

~~a.~~**3.** The following staff are authorized to perform high level disinfection outside of the Sterile Processing area **including but not limited to**:

~~i.~~**a.** Endoscopy Registered Nurses (RN's)
~~ii.~~**b.** Respiratory Therapists**, Equipment Respiratory Technician**
~~iii.~~**c.** Ultrasound Technicians
~~iv.~~**d.** Cardiology Technicians
~~v.~~**e.** Anesthesia Technicians
~~vi.~~**f.** Endoscopy Technicians
~~vii.~~**g.** Surgical RN's
~~viii.~~**h.** Surgical Technicians

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Infection Control Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
2/06, 5/07; 6/09;9/11; 8/12; **4/15**	08/12; **06/15**	08/12, 07/15	**07/15**	10/12, **07/15**	11/12, **08/15**	12/12

~~3.~~**4.** Education, Training, and Competency Validation:

a. Initial

~~a.~~**i.** An orientation and training program will be provided to all staff prior to performing High Level Disinfection. Clinical educators, clinical managers, or any other competent staff member will provide this training. Validation of competence will be accomplished through individual return demonstration of skills. Competency records will be maintained in unit specific staff files.

b. Annual

~~b.~~**i.** All staff performing HLD will complete an annual Computer Based Learning (CBL) module.

~~c.~~**ii.** Staff who **perform**~~use an Automated Endoscope Reprocessor for~~ HLD will complete an annual competency~~ on the machine~~.

~~d.~~**1) Additional training will be provided on an as needed basis**

C. **PROCEDURE:**

1. **Pre-cleaning**~~Preparing the item for cleaning~~:

a. Don personal protective equipment

b. Remove ~~Immediately after removing~~ the item from the patient, **immediately** wipe the insertion tube with the wet cloth or sponge soaked in **an** ~~the freshly prepared~~ enzymatic or detergent solution **(commercially packaged or freshly prepared)**. ~~Note that~~ t**Discard the**~~he~~ cloth/sponge ~~should be disposed of, sterilized or high-level disinfected between cases.~~**after use.**

~~a.~~**i. Pre-cleaning is the first and most important step in removing the microbial burden from an item. Retained debris may inactivate or interfere with the capability of the active ingredient of the chemical solution to effectively kill and/or inactivate microorganisms.**

c. Suction the enzymatic/detergent solution through the channels.

~~b.~~**d.** Transport the item to the reprocessing area in an enclosed container **with a Biohazard label**. ~~Note that r~~**R**eprocessing should occur in a room separate from the procedure room.

~~a. Place the item into the enzymatic or detergent solution.~~

2. Cleaning **equipment:**

~~2.~~**a. Follow** ~~according to~~ **manufacturer's instructions.**

~~b. Manual cleaning of item is necessary immediately after removing the item from the patient and prior to manual disinfection. This is the first and most important step in removing the microbial burden from an item. Retained debris may inactivate or interfere with the capability of the active ingredient of the chemical solution to effectively kill and/or inactivate microorganisms.~~

b. Don personal protective equipment

~~a.~~**c.** Fill a sink or basin with freshly made solution of water and a low-sudsing enzymatic detergent compatible with the item.

~~c.~~**i.** Dilute and use according to the detergent manufacturer's instructions.~~ Note that:~~

~~i.~~**ii.** Fresh detergent solution should be used for each item to prevent cross-contamination.

~~ii.~~**iii.** Low-sudsing detergents are recommended such that the device can be clearly visualized during the cleaning process to preclude personnel injury and to allow for complete cleaning of surfaces. Excessive sudsing can inhibit good fluid contact with the device surfaces.

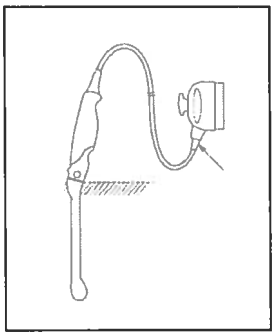
d. Leak test equipment according to manufacturer's instructions.

e. Perform manual cleaning of equipment according to manufacturer's instructions.

~~d.~~**i.** Immerse the item.

1) EXCEPTION: Non-Immersible probes shall only be immersed up to the connector (for example see diagram below)

~~i.~~



~~e.~~**ii.** Wash all debris from the exterior of the item by brushing and wiping the instrument while submerged in the detergent solution. Whenever practical, leave the item submerged in the detergent solution when performing all subsequent cleaning steps. Note that the item should be left under water during the cleaning process to prevent splashing of contaminated fluid.

~~f.~~**iii.** Use a small, soft brush to clean all removable parts. Use non-abrasive and lint-free cleaning tools to prevent damage to the item.

~~g.~~**iv.** Clean all non-removable, non-~~-~~submersible parts according to manufacturer's instructions.

~~h.~~**v.** Continue brushing until there is no debris visible on the brush **as needed**.

1) Dispose of single-use brushes after each use.

~~i. Clean and high-level disinfect reusable brushes between cases~~**uses.** ~~Note that r~~**R**~~eusable brushes should be inspected between uses and replaced when worn, frayed, bent, or otherwise damaged.~~

~~j.~~**vi.** Soak the item for the period of time specified by the label of the enzymatic detergent. If, due to time constraints, it is not possible to complete the reprocessing immediately, the item should be brushed and allowed to soak in a detergent solution until it can be thoroughly reprocessed. Follow manufacturer's recommendations for the maximum liquid exposure time.

~~3.~~**f.** Rinse ~~After Cleaning~~**equipment after cleaning, according to manufacturer's instructions.**

~~a.~~**i.** Thoroughly rinse the item with clean water to remove residual debris and detergent.

~~b.~~**ii.** Dry the exterior of the item with a **clean** soft, lint-free cloth to prevent dilution of the liquid chemical germicide used in subsequent steps.

g. Follow manufacturer's instructions for High Level Disinfection using an Automated Endoscope Reprocessor (AER).

~~4.~~**3. Manual** High Level Disinfection

a. **Use** Cidex OPA ~~is ready to use~~ directly from the manufacturer's original container and no activation is required.

i. Expiration Dating:

1) Cidex OPA has a <u>14 day reuse life</u> once it has been poured into a **secondary container** (soaking basin~~(s)~~ /-tray~~(s)~~).

a) Record the date Cidex OPA was poured into the **secondary container** ~~soaking basin(s) / tray(s)~~ and the expiration date on: the lid(s) of the basin(s)-/-tray(s) and on the Cidex OPA Log Sheet for each basin-/-tray used.

2) Any Cidex OPA that remains unused in the manufacturer's original container is good for 75 days from the date that its container is opened. Record the date that the container was opened directly on the container.

ii. Temperature Recording

1) When the Cidex OPA has been poured into ~~the soaking basin/tray~~**a secondary container**, record (on Cidex OPA Log Sheet) the temperature each time the Cidex OPA is used. Temperature must be 68° F or higher for manual disinfection.

iii. Minimum Effective Concentration (MEC) Testing

1) Cidex OPA must be tested prior to <u>each</u> use (test each time a new set of instruments / devices is placed in soaking basin / tray) for appropriate concentration using Cidex OPA Test Strips.
2) Cidex OPA Test Strips are good for 90 days after the test strip container is opened.
   a) Label test strip container with date opened and expiration date.
   b) Tightly re-cap test strip bottle after each use.
3) Completely submerge the indicating pad of the test strip in the Cidex OPA ~~in the soak basin / tray~~.
4) Hold the test strip in the solution for 1 second, and then remove the test strip.
   a) Do not swirl the strip.
5) Remove excess solution from the test strip by standing the strip upright on a paper towel.
6) Read the results in 90 seconds. Do not read past 90 seconds. Pad will be completely purple to indicate effective solution.
7) If any blue remains on the indicator pad apart from the top line, solution is ineffective and must be discarded.
8) Record results ~~(+)~~ (Pass or ~~(-)~~ Fail), on the Log Sheet.

iv. Quality Control of Test Strips

1) Cidex OPA test strips must be tested for efficacy each time a new ~~case~~**container** of test strips is ~~received~~**opened. Repeat the quality control testing of the test strips at 30 days and 60 days if the container is still in use**. Results must be recorded on the Cidex OPA Log. Testing is carried out as follows:
   a) Open new bottle of test strips and record lot # on Cidex OPA Log Sheet.
   b) Open a ~~fresh~~ container of Cidex OPA.
   c) Dilute one part Cidex OPA solution with one part tap water. Example: one ounce Cidex OPA to one ounce tap water.
   d) Submerge 3 Cidex OPA test strips in undiluted Cidex OPA solution and 3 Cidex OPA test strips in the diluted Cidex OPA solution for 1 second. Remove the test strips and read the results in 90 seconds.
   e) The test strips that were placed in the full strength Cidex OPA should turn purple. The test strips in the diluted Cidex OPA will either remain the same or have an incomplete color change. Refer to the color chart.
   f) Record ~~on the Cidex OPA Log~~ the **test** results ~~of the test~~**on the Cidex OPA log sheet**.
   g) If the test strips fail the test, repeat the test with fresh Cidex OPA solution and test strips from another bottle. If they fail, notify Materials Management. Return the test strips to Materials Management and re-order test strips.

b. Immerse the item in a container of ~~high-level disinfectant~~**Cidex OPA**.

i. EXCEPTION: Non-Immersable probes shall only be immersed up to the connector.

~~k.~~**ii.** The container must be of a size to accommodate the item without overflowing, and must be used in conjunction with a device to contain the chemical vapors.

~~l.~~**iii.** To prevent damage to the item, the item should not be soaked with other sharp instruments that could potentially damage the item.

~~m.~~**iv.** Complete microbial destruction cannot occur unless all surfaces are in complete contact with the chemical.

~~n.~~**v.** Use the ~~high-level disinfectant~~**Cidex OPA** in a device used to minimize chemical vapor exposure. Note that:

~~i.~~**1)** Exposure to chemical vapors may present a health hazard.

~~ii.~~**2)** The reprocessing area should have engineering controls to ensure good air quality.

~~o.~~**vi.** Soak the item in the ~~high-level disinfectant~~**Cidex OPA** for the time/temperature required to achieve HLD. Use a timer to verify soaking time. Document device and time. Cidex OPA requires 12 minutes minimum at room temperature.

~~5.~~**c.** Rinse After Disinfection

~~a.~~**i.** Thoroughly rinse all surfaces of the item with copious amounts of clean water (2 gallons per rinse). Repeat rinsing with fresh rinse water for a total of 3 times. ~~Note that:~~

1) Tap water is acceptable for non-endoscopic devices.

~~i.~~**2)** **Use sterile water or filtered potable water for endoscopic devices.**

~~ii.~~**3)** Rinsing prevents exposure and potential injury of skin and mucous membranes from chemical residue.

~~iii.~~**4)** Fresh water should be used for each item and each rinse.

~~iv.~~**5)** The device should be totally immersed for a minimum of 1 minute with each rinse.

~~v.~~**6)** Discard rinse water for each rinse. Do not reuse water for any other purpose.

~~6.~~**4.** Drying

a. Wipe item with clean cloth **to remove residual moisture and flush channels with pressurized air.**~~or allow to dry with air. Note that:~~

i. Bacteria such as *Pseudomonas aeruginosa* have been identified in both tap and filtered water, and may multiply in a moist environment.

ii. Wipe item with alcohol **per manufacturer's instructions for use**

1) 70% isopropyl alcohol is used to assist in drying of surfaces.

2) Use alcohol that has been properly stored in a closed container between uses. Alcohol rapidly evaporates when exposed to air, and cannot be relied upon to assist in the drying process if below the recommended percentage level.

~~2)~~**3)** **AER may automatically perform alcohol flush; refer to AER manufacturer's instructions for use.**

iii. Alcohol wipe should be used even when sterile water is used for rinsing.

iv. Dry the exterior of the item with a soft, clean lint-free **cloth**~~towel~~.

~~7.~~**5.** Storage

a. Store the item in a well-ventilated, dust-free area.

~~b.~~**i.** A storage area with good ventilation will encourage continued air-drying of the surfaces, and prevent undue moisture build-up, thus discouraging any microbial contamination.

~~c.~~**ii.** Correct storage of the item will prevent damage to the exterior of the instrument by protecting it from physical impact. Padding may be used.

~~8.~~**6.** Disposal

a. **Add a**~~A~~ neutralizing agent ~~is added~~ to Cidex OPA in accordance with the manufacturer's recommendations prior to disposal.

D. **FORMS ~~REFERENCED THAT CAN BE FOUND ON THE INTRANET~~:**

1. ~~Cidex OPA Log Sheet~~ **Olympus Dual Scope Disinfector (DSD) Sample Log**

E. **REFERENCES:**

1. ~~B Nelson et al. (2003).~~ Multi-Society ~~g~~**G**uideline ~~for~~**on** ~~r~~**R**eprocessing ~~f~~**F**lexible ~~g~~**G**astrointestinal Endoscopes. Vol~~24~~**73**, No ~~7~~**6: 2011**~~. ICHE~~.
2. W**.** A. Rutala, PhD, MPH**, D.J. Weber, MD, MPH** (200~~5~~**14**). Cleaning, disinfection, and sterilization in healthcare facilities. APIC Text of Infection Control & Epidemiology, Chapter ~~21~~**31**.
3. Cidex OPA manufacturer's ~~have written instructions~~**instructions for use**.
4. Standards of Infection Control in Reprocessing of Flexible Gastrointestinal Endoscopes. SGNA 200~~8~~**9**.
5. AORN Perioperative **Guidelines for** ~~Standards and Recommended~~ Practices~~s~~, 201~~1~~**5** Edition.

Tri-City Medical Center
ADVANCED HEALTH CARE FOR YOU

OLYMPUS DUAL SCOPE DISINFECTOR (DSD) SAMPLE LOG

QC OF TEST STRIPS TO BE COMPLETED WHEN OPENING A NEW VIAL OF TEST STRIPS, 30 DAYS, 60 DAYS DISCARD TESTS STRIPS AT 90 DAYS					
TEST STRIP LOT NUMBER	TEST STRIP DATE OPENED	TEST STRIP EXPIRATION DATE	QC PERFORMED (CIRCLE ONE)	TEST RESULT PASS OR FAIL	TESTED BY (INITIALS)
			INITIAL 30 DAY 60 DAY		

INSTRUCTIONS FOR USE

Pre-Disinfection:

1. Leak test, brush, and clean endoscope
2. Place scope into tray and begin cycle following DSD instructions
3. Record required items in boxes below

Post-Disinfection:

1. Confirm the cycle met parameters per manufacturer's recommendations.
2. Parameters not met require repeating the load in another station.
3. Failure to meet parameters- Notify Engineering Department

PROCESSING LOG

Patient Sticker Procedure & Physician	Time	Temperature	Cidex OPA Test Strip (Pass or Fail)	Leak Test (Pass or Fail)	Alcohol Rinse Complete (Yes/No)	Item Description or Scope #	Operator's Initials

SAMPLE

Tri-City Medical Center	Patient Care Services
POLICY:	**INCENTIVE SPIROMETER (IS) INSTRUCT AND MONITORING**
Purpose:	To identify the Respiratory Care Practitioner (RCP) and Registered Nurse (RN) roles for providing instructions and monitoring patients requiring an IS.

A. DEFINITION:

1. Incentive Spirometer – a device used to encourage and assist patients at risk for pneumonia, post-operative pulmonary complications, and patients with declining pulmonary status to breathe deeply to achieve normal vital capacity. The device provides a visual feedback to patients about the depth of their breaths.

B. POLICY:

1. A physicians order is required for an IS.
2. Patients at risk for postoperative pulmonary complications (i.e., patients undergoing surgical procedures involving abdomen or thorax and patients with conditions predisposing to development of atelectasis, including immobility and abdominal binders) should have an order for an IS. Examples include but are not limited to the following:
   a. Abdominal Surgery
   b. Thoracic Surgery
   c. Prolonged bed rest
   d. Post-operative patients with Chronic Obstructive PulmonaryDisease (COPD)
   e. Presence of a thoracic or abdominal binder
   f. Restrictive lung defeat associated with a dysfunctional diaphragm or involving respiratory musculature
   g. Patients with an inspiratory capacity of less than (<) 2.5 liters
   h. Patients with neuromuscular disease
   i. Patients with pain level interfering with their ability to take deep breaths
3. RCPs and RNs will work collaborative to ensure patients are provided instructions for the use of an IS.
   a. RCPs will provide the initial education and two follow-up treatments with education.
      i. If RCP is unavailable to provide initial education, the primary RN assigned to the patient is responsible for ensuring education is provided.
   b. RCPs and RNs will use the teach-back method to assess the patient's understanding of the instructions provided.
4. RCPs and RNs will review Mosby's Skills: Incentive Spirometry Procedure.

C. PROCEDURE:

1. RCP Role
   a. Identify patient's predicted volume based on gender, age, and height.
   b. Mark the predicted volume with a permanent marker on the IS to inform the patient and RNs.
      i. Approximate the patient's predicted value using clinical judgment when the patient's age and height are not within the predicted values chart.
   c. Inform patient the mark represents the goal they should achieve
   d. Instruct patient to cough to expectorate phlegm.
      i. Ensure patients with surgical incisions splint using a pillow.
   e. Provide hand-off to the RN after the initial education and the two subsequent treatments are completed.
   f. Document in the Electronic Health Record (EHR)
      i. Patient's responses to the treatments
      ii. Patient's ability to participate with their therapy

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Division of Pulmonary	Medical Executive Committee	Professional Affairs Committee	Board of Directors
NEW	9/14	10/14	05/15	**06/15**	**08/15**	

iii. Hand-off provided

2. RN Role
   a. Obtain hand-off from RCP
   b. Ensure education is provided if task not completed by RCP
   c. Review Mosby's Incentive Spirometry Procedure for the following:
      i. Indications and contraindications
      ii. Expected and unexpected outcomes
      iii. Education topics
      iv. Patient instructions for use of the IS
   d. Encourage patient to use IS at least 5-10 times every hour while awake or as ordered.
   e. Assess patient's understanding of the instructions for using an IS using teach-back
   f. Document the use of IS each shift as appropriate
      i. Education provided to patient
      ii. Patient's response to using the IS
         1) Volumes achieved
         2) Frequency of use
      iii. Patient's ability to participate
3. Hand-off Process
   a. RCP and RN hand-off shall consist of the following:
      i. Patient's response to therapy
      ii. Predicted volume
      iii. Actual volume
      iv. Additional information appropriate to patient

D. REFERENCE LIST:

1. Agency of Healthcare Research and Quality (AHRQ). (nd). National guideline clearinghouse: Incentive spirometry, 2011. Retrieved from http://www.guideline.gov/content.aspx?id=34793
2. American Association for Respiratory Care (AARC). (2011). Clinical practice guidelines, incentive spirometry: 2011. *56(10):* 1600-4
3. Elsevier Inc. (2006-2014). Mosby's skills: Incentive spirometry. Retrieved from Tri-City Medical Center (TCMC) Intranet.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 8/01

SUBJECT: Patient Leave of Absence, Temporary

REVISION DATE: 12/01, 6/02, 6/03, 8/05; 9/07; 03/11

POLICY NUMBER: III.C

Clinical Policies & Procedures Committee Approval:	**~~01/11~~04/15**
Nursing Executive Council Approval:	**~~01/11~~04/15**
Medical Executive Committee Approval:	**~~02/11~~05/15**
Professional Affairs Committee Approval:	**~~03/11~~08/15**
Board of Directors Approval:	**03/11**

A. **PURPOSE:**

1. It may be necessary for a patient to be temporarily absent from the hospital for medical ~~or other~~ reasons. ~~This policy defines the process for those events.~~

B. **POLICY:**

~~1. There are two conditions under which a temporary absence may occur;~~
~~a. Temporary absence pass (very restricted, must be approved by Case Management or the California Department of Corrections and Rehabilitation authority for Forensic patients)~~
~~b. Temporary absence transfer for medical procedures~~
~~2.~~**1.** All temporary absences require a physician order.
~~3.~~**2.** It must be understood by the patient that he/she is not discharged from the hospital.
~~4.~~**3.** The day on which the patient began a leave of absence is treated as a day of discharge, and is not counted as an inpatient day **unless the patient returns to the facility by midnight of the same day.**

C. **PROCEDURE:**

1. During the course of the stay, it is the physician's responsibility to provide written documentation in the order or progress notes regarding:
   ~~a. Reason(s) for the temporary absence~~
   ~~b. Expected duration of absence in hours (for temporary absence passes)~~
   ~~c.~~**a.** Stability of patient for transfer in the case of absence for medical procedures

~~2. One of the two specified forms shall be utilized to verify consent for the patient's temporary absence. The two forms are:~~
~~a. Temporary Absence Pass~~**Release**
~~b. Transfer for Medical Procedure~~

~~3.~~**2.** **Prior** ~~When absence is due~~ to transfer for **medical procedures:** ~~the following steps shall be employed:~~
   a. The patient or patient representative will sign "Consent for Transfer for Medical Treatment"
   b. The transferring unit shall schedule the procedure with the appropriate department(s) at the receiving location or hospital (i.e., CT scan, echocardiogram).
   c. The physician shall designate mode of transport (i.e., ambulance) and level of transport (i.e. Basic Life Support or Critical Care Transport Ambulance).
      i. Oncology patients being transported for Radiation Therapy can only be transported via ambulance.
         1) For forensic patients, custody staff will accompany patient.
   d. The transferring unit shall make transportation arrangements.

e. Copies of pertinent components of the medical record shall accompany the patient.

3. Receiving facility

~~f.~~**a.** The receiving medical facility shall obtain an additional informed consent from the patient or patient representative when appropriate.

~~g.~~**b.** The receiving physician/staff shall be responsible for continuing medical care.

~~h.~~**c.** Following completion of the testing/procedure(s), the receiving medical facility shall arrange for appropriate return transportation of the patient and components of the medical record.

~~i.~~**d.** The physician sending the patient back to TCMC shall document the patient's condition prior to departure.

~~j.~~**e.** Consent for the return trip is not necessary unless a change in mode of transportation is indicated.

~~4. When absence is due to **a temporary absence releasepass**, the following steps shall be employed:~~

~~a. The patient or patient representative shall sign "Temporary Absence Release"~~

~~b. The pass shall have an expected duration in hours, or expected return time.~~

~~c. The patient shall not be discharged and his/her bed shall be held in reserve.~~

~~d. The nurse must document the time the patient left, the mode of transportation, patient condition and understanding of the **release**pass, and the patient's duty to return at the prescribed time.~~

~~e. Upon the patient's return from the **release**pass, the nurse shall document the return time, the patient's condition, and a brief assessment.~~

~~f. If the patient fails to return at the prescribed time, the nurse shall notify the physician, document the patient's failure to return, and the physician notification.~~

~~i. Contact the Risk Manager if patient does not return from Leave of Absence as expected.~~

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

1. Consent to Transfer for Medical Treatment Sample Form

~~2. Temporary Absence Release~~

Consent to Transfer for Medical Treatment Sample Form

FORM 9-3

CONSENT TO TRANSFER FOR MEDICAL TREATMENT

Patient's Name: _____

Your/The patient's attending physician is Dr. *(physician name)* _____ _____. The physician who will perform the procedure(s) described below is Dr. *(physician name)* _____. The facility at which the procedure(s) will be performed is *(facility name)* _____ _____.

Your/the patient's physician has recommended that you/the patient should be transferred to *(name of receiving facility)* _____ where the following procedure(s) will be performed *(name of procedure)* _____ _____ by or under the supervision of Dr. *(name of receiving physician)* _____ and you have separately given your consent for the performance of this procedure(s).

Upon your consent, arrangements will be made to transfer you/the patient from this hospital to the facility named above. Before you give consent, you have the right to be informed of any risks or complications which may result from transferring you/the patient.

Your/the patient's physician has recommended that the method of transportation which will be used to transfer you/the patient will be *(specify method of transportation)* _____ _____ and, except in those cases in which an employee of the hospital accompanies a patient during the transfer, the hospital does not assume any responsibility for your/the patient's care during the transfer or during your/the patient's absence from the hospital.

TEMPORARY ABSENCE RELEASE FOR TRANSFER TO ANOTHER FACILITY

Having given my permission to the attending physician(s) and obtained his/her permission to be absent from the hospital for the performance of a medical procedure(s) at *(name of receiving facility)* _____ _____ from *(time)* _____, *(date)* _____ _____ to *(approximately) (time)* _____, *(date)* _____, I assume all responsibility for myself, or *(name of patient)* _____, who is my *(relationship)* _____ during the temporary absence and I hereby release *(name of transferring hospital)* _____ _____, its employees and the attending physician(s) from all responsibility during this absence and for my/the patient's condition as a result thereof.

(over)

Form 9-3 Consent to Transfer for Medical Treatment

My signature below constitutes my acknowledgment that (1) I have read and agree to the foregoing; (2) that the plans for my/the patient's transfer and the procedure(s) to be performed following the transfer have been adequately explained to me by my/the patient's physician; (3) that I have received all of the information I desire concerning such plans and procedure(s); and (4) that I consent to my/the patient's transfer to the facility named above for the performance of the medical procedure.

The physicians involved in your care are not employees or agents of the hospital. They are independent medical practitioners.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 01/07	**SUBJECT:** POLICY APPROVAL - ADMINISTRATIVE
REVISION DATE: 07/09; 7/12	**POLICY NUMBER:** 8610-240

Administrative Policies & Procedures Committee Approval:	**~~07/12~~07/15**
Professional Affairs Committee Approval:	**~~08/12~~08/15**
Board of Directors Approval:	**08/12**

A. **PURPOSE:**
To define Tri-City Healthcare District's (TCHD) process for the approval of policies.

B. **DEFINITIONS:**
1. Policy: A policy is a formal, approved, written description of how a governance, management, or clinical care process is defined, organized, or carried out. A policy covers broad principles or complex standards requiring Board approval and may have significant legal, regulatory, or financial implications.
   a. Documents that may support the policy, including but not limited to practices, procedures, pre-printed orders, and chart forms, are not defined for the purposes of this policy.

C. **POLICY:**
1. Policies are:
   a. Reviewed or revised every three years or as required by change in regulation, research, or organizational processes.
   b. Developed in collaboration with the medical staff:
      i. If relevant to medical staff activities.
      ii. And in collaboration with nursing leadership if relevant to direct patient care.
   c. Consistent with professional references, applicable regulations, legal requirements, accreditation standards, and the mission and philosophy of the organization.
   d. Pre-approved by Board Committees prior to submission to the Board:
      i. The Human Resource Committee approves all administrative policies that relate to human resource issues.
      ii. The Finance, Operations, and Planning Committee approve all administrative policies that relate to finance issues.
      ~~ii.~~**iii. The Audit, Compliance and Ethics Committee approve all administrative policies that relate to compliance and privacy issues.**
      ~~iii.~~**iv.** The Governance/Legislative Committee approves all policies that relate to the Board of Directors issues**, Medical Staff By-Laws and Medical Staff Rules and Regulations**.
      ~~iv.~~**v.** The Professional Affairs Committee approves all others.
   e. All policies are submitted to the Board of Directors for final approval.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 06/11

SUBJECT: **Incident Report - QUALITY REVIEW REPORT (QRR) RL Solutions** ~~**Reporting and Responding to Unusual Occurrences**~~

REVISION DATE:

POLICY NUMBER: 8610-396

Clinical~~Administrative~~ Policies & Procedures Committee Approval:	~~**05/11**~~**01/15**
Nurse Executive Committee~~Council~~ Approval:	~~**06/11**~~**02/15**
Professional Affairs Committee Approval:	~~**06/11**~~**08/15**
Board of Directors Approval:	**06/11**

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

1. ~~Tri-City Medical Center will have an electronic early warning system to track, trend, and respond to events that may have an impact or potential impact on patients/visitors/employees.~~ **Hospital has an electronic early warning system to track, trend, and respond to events that may have an impact, or potential impact, on patients/visitors/employees/medical staff.** Reporting and responding to ~~unusual~~ **these** occurrences is a method performed to objectively and systematically monitor and evaluate quality and appropriateness of patient care. This procedure helps to identify and investigate near miss and serious incidents to insure patient safety and resolve quality/risk issues on an ongoing basis enhancing the quality of patient care and reducing health care and medical liability. **These incidents may include unusual occurrences, adverse events, and sentinel events.**

B. **DEFINITIONS:**

1. Unusual Occurrence: Any event that deviates from regular operations or standards and results in, or could have resulted in (near miss), an adverse outcome for patient or visitors.
2. Quality Review Report (~~ORR~~**QRR**)/RL Solutions Incident Report (RL): An online system designed to collect data/information regarding ~~unusual occurrences~~**events that may have an impact or potential impact on patients/visitors/employees/medical staff**. This online electronic system includes reporting of employee injuries and disputes, patient compliments and complaints, medication errors, and cardiopulmonary resuscitation information. The ~~ORR~~**QRR**/RL is subject to all privileges and exemption from disclosure provided in applicable law. Documentation on the ~~ORR~~**QRR**/RL is protected and confidential under Attorney-Client Privilege ~~and Evidence Code 1157~~.
3. ~~Significant~~ **Adverse** Event: An occurrence that ~~results in injury to patients or visitors~~**causes the death or serious disability of a patient, personnel, or visitor, and as listed in Section 1279.1, et seq., of the Health and Safety Code**.
4. Sentinel Event: an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome.

~~C. **PROCEDURE:**~~

~~1. Complete QRR **RL Solutions** for events that may have an impact or potential impact to the patient or non patient.~~

~~2. Examples of when to complete a QRR **RL** for patient related events that have a direct or potential impact (but is not limited to):~~

~~a. Falls (all falls, even if you did not witness)~~

~~b. Burns~~
~~c. Equipment issues (that may have caused illness or injury to a patient)~~
~~d. Medication **error** events / Adverse drug reactions~~
~~e. Treatment/test procedures~~
~~f. Accidental injuries to the patient, even if minor~~
~~g. Behavioral issues, such as leaving against medical advice (AMA), elopement from the hospital, angry and aggressive behavior~~
~~h. Patient and family complaints that are not quickly resolved~~
~~i. A decubitus ulcer that progressed to a Stage III during hospitalization of the patient~~
~~j. Any decubitus ulcer that is present on admission~~
~~k. Lost or damaged personal and valuable property of patient~~
~~l. Privacy issues~~
~~m. Other significant events, such as blood transfusion errors; errors that will cause the patient to have an extended time in the hospital; wrong patient identification causing unnecessary lab, procedure, etc; unexpected surgical procedures without consent; unexpected returns to surgery; unexpected patient outcomes that are adverse to the patients condition~~
~~n. Serious patient delays in treatments, late medications, test results, etc~~
~~o. Consent issues~~

~~3. Examples of when to complete a QRR **RL** for non-patient related events that have a direct or potential impact (but is not limited to):~~
~~a. Physician complaints/conflicts~~
~~b. Interdepartmental issues/conflicts~~
~~c. Equipment/supply problems not involving a patient~~
~~d. Damage to property~~
~~e. Volunteer/Visitor falls, injuries, events~~
~~f. Staffing issues/safety concerns~~

~~4. The QRR **RL** will be routed as appropriate. Acknowledgement and/or follow up by the Director/Manager shall be initiated and/or completed within 72 hours of entry of the QRR**RL**.~~

~~5. Information contained in the QRR **RL** is confidential and when used properly, is protected from legal discovery under Attorney-Client Privileges (California Evidence Code 954).~~
~~a. To maintain confidentiality, the computerized document:~~
~~i. Must not be printed and/or photocopied~~
~~ii. Must not be included or mentioned in the patient record~~
~~iii. Must not be disclosed or provided to the California Department of Public Health~~
~~iv. Must not be shared or disclosed to any patient, visitor, or any other third party~~
~~b. Copies of the QRR **RL** shall not be sent to any physician or medical staff committee. The Risk Manager will approve a summary for medical staff review in its place.~~

~~6. Definitions of severity of injuries are as follows: (NOTE: Medication/fluid event severity scale differs)~~
~~a. Level 0: Near Miss, Potential - Requires no occurrence-related therapy treatment or diagnostic procedures or tests, and does not extend the duration of hospitalization. No harm to patient.~~
~~b. Level 1: No Harm - No harm to patient, but if incident had progressed, it would be possible for an adverse outcome to occur.~~
~~c. Level 2: Temporary Minor - Insignificant or non-disabling injury requiring closer observation. Does not require medication or increased length of stay. May have temporary disability. Management of occurrence is short-term and does not result in any residual problems. May require diagnostic tests (lab work, x-rays).~~
~~d. Level 3: Moderate Harm - Requires physician ordered or initiated treatment or therapy. May result in hospitalization, or increase in acuity.~~
~~e. Level 4: Major harm - Significant injury/possible permanent disability. Requires prolonged or indefinite medical intervention. May result in long-term alteration of lifestyle or wage earning ability.~~
~~f. Level 5: Death - Errors that cause or contribute to the death of a patient.~~

~~g. Level 6: Not Applicable - Does not apply to situation~~

~~7. Data~~

~~a. QRRs **RLs** are used for follow up, risk identification, and tracking and trending analysis.~~

~~b.~~**a.** ~~For Information Technology issues (i.e. passwords, scope), complete a work order via the intranet (Tamis system).~~

~~D.~~C. POLICY~~MECHANISM FOR REPORTING~~:

1. Reporting will ~~**shall**~~**can** be done via the RL Solutions Module in the hospital intranet by any hospital employee. The incident report is called **the RL Report (RL) or** the Quality Review Report (QRR). **Medical Staff member can initiate a QRR/RL by contacting the Medical Staff office.**
2. All non-hospital employees (i.e. travelers, registry, and contracted service individuals) shall report events up through their chain of command
3. All members of the healthcare team and all employees of Tri-City Medical Center are responsible for participating in the identification of ~~unusual occurrences~~**incidents that should be reported by initiating a QRR/RL**.
4. When ~~a unplanned~~**such an** event occurs, the patient care provider or hospital employee shall do the following:
   a. Perform the necessary interventions to support the patient's clinical condition
   b. Perform the necessary interventions to contain the risks to others
   c. Notify the patient's attending physician. Notification of physician and any new orders as a result of occurrence will be documented by the clinician in the patient's medical record
   d. Preserve any information related to the event including physical evidence
   e. Preservation of the information includes the documentation of facts regarding the event on a QRR/RL and the Medical Record as indicated
   f. Notify immediate supervisor of the event and Risk Management of any significant, or sentinel events.

   ~~a. Submit a QRR/RL to Risk Management through the electronic RL Solutions System.~~
5. The employee ~~or physician~~ who is directly involved, or discovers an event/situation, should complete a QRR/RL with as much detail as possible of ~~the unusual occurrence(s)~~**the incident**.
6. ~~Written d~~**D**ocumentation on the QRR/RL should be **timely,** objective, informative, and factually describe what happened and any follow-up. Subjective comments should not be made
7. The ~~QRR~~**QRR**/RL will help identify patterns or trends and/or significant quality of care issues, which in turn, provide a focus for performance improvement, patient safety, and risk management.
8. To maintain confidentiality this document should not be referenced or filed in the medical record, left unattended, copied, shared with patient or visitor, filed or referenced in the employees personnel file, or removed from premises.

~~E.~~D. PROCEDURE:

1. Action steps to complete a QRR/RL: ~~Reporting Unusual Occurrences~~
   a. Enter RL Solutions from the TCMC Intranet
   b. Log in to RL Solutions with your employee #. Your password is "rl" (lower case letters)
   c. Select the icon for the category/type of incident or occurrence. The icons include: (See **RL Solutions Icon Wall Sample**~~Attached Picture, Attachment A~~)
      i. Airway Management
      ii. AMA/Elopement
      iii. Patient/Visitor Complaints
      iv. Diagnosis/Treatment
      v. Care/Service Coordination
      vi. Diagnostic Test
      vii. Fall Event
      viii. Infection Control/Surgical Site Infection
      ix. Lab Specimen/Test
      x. Line Tube/Vascular

xi. Maternal/Childbirth
xii. Medication Event
xiii. Adverse Drug Reaction
xiv. Safety/Security/Conduct
xv. Skin/Tissue
xvi. Surgery/Procedure
xvii. Privacy
xviii. Blood/Blood Products
xix. Employee/Affiliate Event
xx. Environment of Care
xxi. Equipment and Product
xxii. ID/Documentation/Consent
xxiii. Professional Conduct
xxiv. Restraint/Supportive Device

d. Complete all the mandatory information fields. The mandatory fields have a green asterisk. Additional attachments may be added to this form.

e. Press the "Submit Button". You will receive a number which has been assigned to the incident. This is the RL number.

2. Action Steps: Responding to ~~QRR/RL's~~**QRR/RLs**: (See **Reporting of and Responding to Unusual Occurrences**~~Attachment B~~)

a. All QRR/RLs go to Risk Management for assessment. Risk Management routes the QRR/RL to appropriate Director/Manager. QRR/RLs involving physicians go to Medical Staff Office. Director/Manager must acknowledge receipt of the QRR/RL and follow-up with these within 72 hours of receipt of the QRR/RL.

b. Only employees receive the QRR/RL. The QRR/RL should not be a part of the medical record, and shall not be printed. The incident may be recorded in the medical record as appropriate. If the Medical Staff Office Manager believes a summary of the incident requires peer review or other Medical Staff action, the Manager may share a summary of the incident, but not the QRR/RL, with the appropriate Medical Staff officer, committee, or department in accordance with Medical Staff Policy 8010-509.

~~f.~~**c. Unusual occurrences,** ~~Sentinel~~ **sentinel** events and other ~~significant~~ **adverse** events will be immediately reported to Risk Management and the appropriate administrative office(s). If the event occurs after office hours, the Administrator on-call will determine emergency contact of Risk Management. The completion of the QRR/RL should not delay or interfere with appropriate follow through. Risk Management will perform an investigation on any occurrence that is identified as a potential risk. Documentation of this follow-up will be made on QRR/RL

~~g.~~**d.** Any events involving actual or alleged abuse, neglect, battery, assault, sexual misconduct, or mistreatment of patient or staff should be reported on the QRR/RL and sent to Risk Management along with a call to Risk Management immediately by the persona preparing the QRR/RL for investigation and follow-up. Risk Management/designee will convene a team of individuals as indicated to investigate and ensure appropriate investigation, reporting, and follow-up. Refer to the following Administrative and Patient Care Services Policies in the Reference Section:

i. **Administrative Policy:** Assault and Battery Reporting Process, 8610-241
ii. **Administrative Policy:** Assault Victims/Domestic Violence Reporting Requirements, 8610-310
iii. **Administrative Policy:** Disclosure of Unanticipated Adverse Outcomes to Patients/Families, 8610-275
iv. **Administrative Policy:** Mandatory Reporting Requirements, 8610-236
v. **Administrative Policy:** Reporting Suspected Child Abuse/Neglect, 8610-308
vi. **Administrative Policy:** Reporting Suspected Dependent Adult/Elder Abuse/Neglect, 8610-309

vii. ~~Responding to and Reporting Unusual Occurrences, 8610-228~~
viii. ~~Medication Error Reporting, IV.I.1~~

~~h.~~**e.** Risk Management will take the necessary actions (report to regulatory body, insurance carriers, etc.) after the completion of the investigation.

~~i.~~**f.** Risk Management shall initiate a Legal Hold on the encounter and alert the appropriate departments (i.e. Information Technology, Medical Records, Patient Financial Services, etc.)

~~j.~~**g.** Risk Management is responsible for forwarding physician-specific events to the Medical Staff Office. The Medical Staff office determines if the event is to be peer reviewed.

~~k.~~**h.** Risk Management will contact the appropriate department for information purposes or follow-up.

~~l.~~**i.** Information will be trended and monitored to identify patterns or trends that have or may jeopardize patient/visitor safety. Variables will be analyzed and corrective action instituted to reduce the probability of occurrence or reoccurrence, and improve performance. Employees and medical staff are encouraged to identify opportunities for improvement in the QRR/RL review process.

~~m.~~**j.** If Risk Management determines an event required a Root Cause Analysis (RCA), Risk Management will collaborate with the Director of Performance Improvement to convene a team. The RCA will incorporate reduction strategies and measurement of process and systems improvements to reduce risk.

~~F.~~E. FORMS/RELATED DOCUMENTS~~ATTACHMENTS~~:

1. RL **Solutions** Icon Wall ~~(Attachment A)~~
2. Reporting of and Responding to Unusual Occurrences ~~Process Flow Diagram (Attachment B)~~
3. **Administrative Policy: Assault and Battery Reporting Process, 8610-241**
4. **Administrative Policy: Assault Victims/Domestic Violence Reporting Requirements, 8610-310**
5. **Administrative Policy: Disclosure of Unanticipated Adverse Outcomes to Patients/Families, 8610-275**
6. **Administrative Policy: Mandatory Reporting Requirements, 8610-236**
7. **Administrative Policy: Reporting Suspected Child Abuse/Neglect, 8610-308**
8. **Administrative Policy: Reporting Suspected Dependent Adult/Elder Abuse/Neglect, 8610-309**

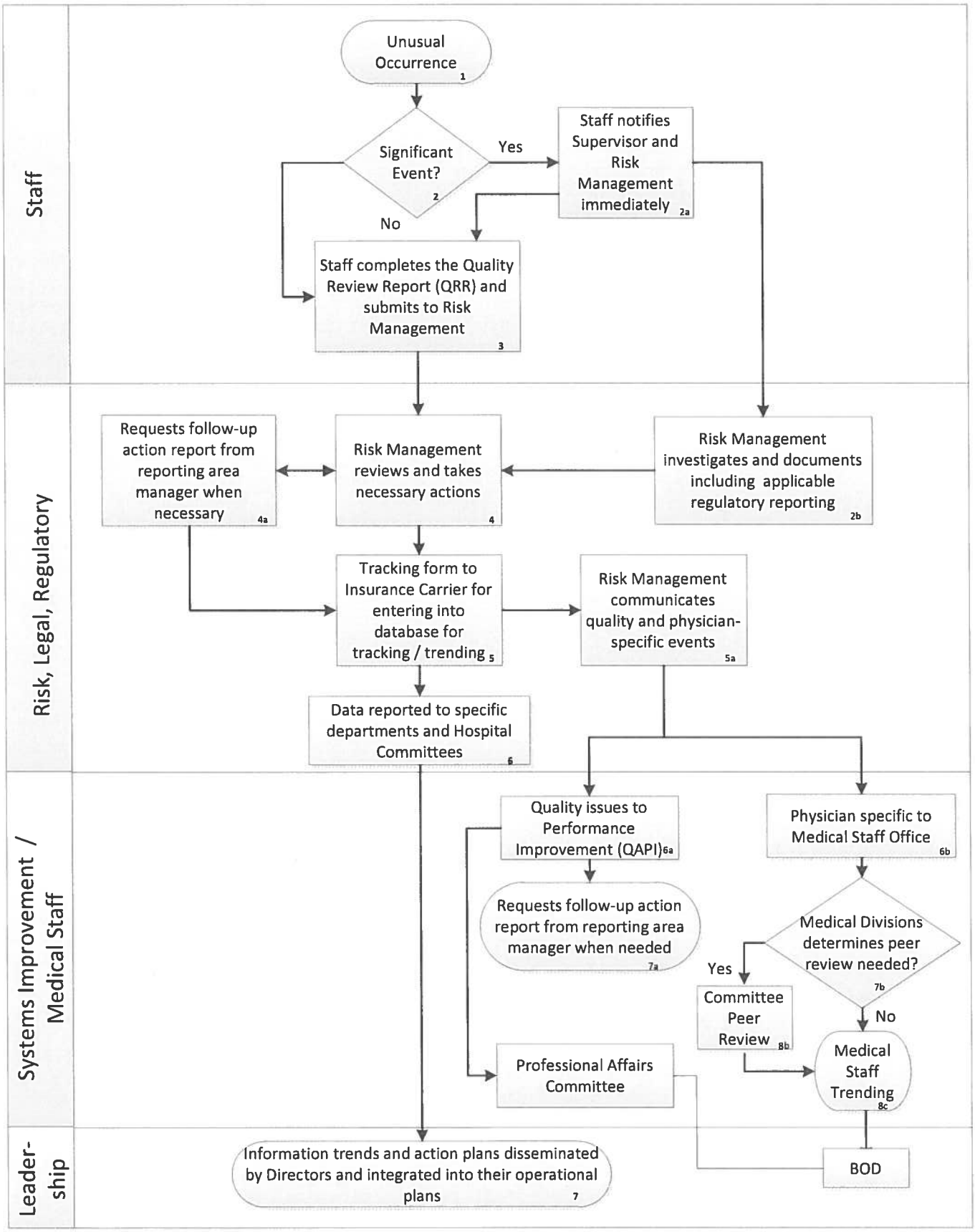
~~2.~~**9. Medical Staff Policy 8010-509**

~~G.~~F. REFERENCES:

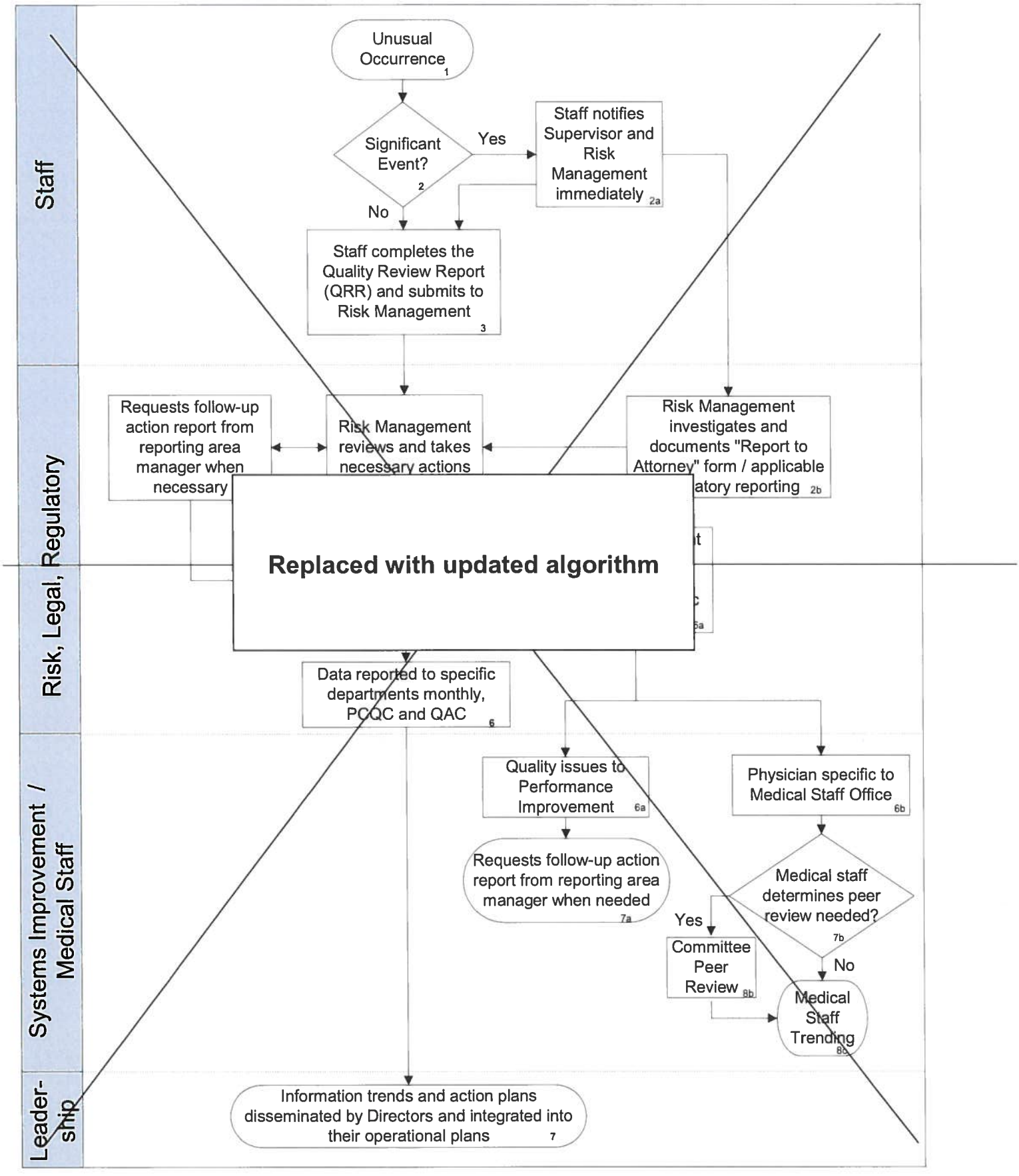
1. California Evidence Codes 954~~-1157~~
2. California Hospital Association Consent Manual **(2015)**

RL Solutions Wall Icon Sample

Reporting of and Responding to Unusual Occurrences



~~Reporting of and Responding to Unusual Occurrences~~



Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT

SUBJECT: Leave Without Treatment (LWOT), Against Medical Advice (AMA), or Elopement

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

Department Approval Date(s):	**10/14**
Department of Emergency Medicine Approval Date(s):	**11/14**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**01/15**
Professional Affairs Committee Approval Date(s):	**08/15**
Board of Directors Approval Date(s):	

A. **DEFINITIONS:**
1. To define and provide guidelines for the management and documentation of patients who leave without treatment (LWOT), against medical advice (AMA) or elope.

B. **POLICY:**
1. All patients who request to leave the Emergency Department (ED) prior to evaluation by a physician or completion of treatment will be encouraged to stay.
2. Patients who leave the ED AMA will be requested to sign the appropriate form.
3. Appropriate steps will be taken to locate patients who elope.

C. **PROCEDURES:**
1. Leaving without treatment (LWOT): Patients who have been **registered for treatment,** ~~seen by the triage nurse~~ but not seen by the ED physician. Treatment may or may not have been started in triage.
   a. All patients who express the desire to leave before being seen by the ED physician will be encouraged to stay. As appropriate, a request may be made to the ED physician to speak with the patient.
   b. ~~All patients~~ **Patients** who leave the ED prior to seeing a physician and have been assessed by the triage nurse or leave before seeing the triage nurse will have an ED clinical record started which will include the following:
      i. Name
      ii. Chief complaint
      iii. Admit status/mental status/airway/skin
      iv. Triage classification/Registered Nurse signature/time
      v. Vital signs
      vi. Any treatment started in triage
      vii. When known, the narrative is to include the reason and time the patient left without being seen.
      viii. The narrative must explain the reasons for inability to collect any of the above information.
   c. For minors who leave the department prior to seeing a physician:
      i. Every attempt must be made to contact the parents or guardian to inform them of the minor's presence in the ED.
      ii. Document the contact or the attempt to contact the parents or guardian.

iii. The exception to the above are minors who are emancipated or on active military duty. Other exceptions are when the complaint involves a sexual disease, pregnancy, sexual assault and drug or alcohol related problems.

d. For patients who are not oriented or who are expressing suicidal/homicidal ideation, consult with the physician on duty to determine if a 5150 hold is appropriate.

e. Have patients sign "Withdrawal of Request for Medical Service."

2. Against Medical Advice (AMA): Patients who have been seen by the ED physician and who decide to leave before treatment is completed.
   a. When a patient expresses the desire to leave AMA, the ED physician shall be informed and every effort shall be made to encourage the patient to remain in the ED.
   b. The ED physician must attempt to provide the patient with information regarding the potential consequences of the action to include the risks involved in leaving, the benefits of continuing the treatment, and any alternatives so that the patient can make an informed decision.
   c. Whenever a patient demands to leave before treatment is completed or contrary to the advice of the ED physician, a "Leaving Hospital Against Medical Advice" form shall be completed.
   d. If the patient refuses to sign this form, the notation "patient refuses to sign" shall be made in the space provided for the patient's signature. The witness shall sign his/her name, the exact time, and date.
   e. A competent adult that is not on any legal hold or court ordered quarantine or detention may not be detained against his/her wishes.
   f. Precautions shall be taken to assure the patient leaves the hospital in a safe manner.
   g. Documentation on the patient's chart shall include a summary of the events that led to the incident, attempts to encourage the patient to complete treatment, and any patient discharge instructions that were given.

3. Elopement – **non-5150**: Patients who have been seen by the physician and left the ED without informing staff.
   a. When it is discovered that a patient has left the ED without informing the staff, the ED AUM and/or Charge RN shall be notified immediately. The patient's family, primary physician, Manager/Director or Operations Supervisor shall be notified as appropriate.
   ~~4.~~**b.** Attempts shall be made to locate the patient. Hospital security and/or law enforcement shall be notified as appropriate.
   ~~a.~~**c. Documentation on the patient's chart shall include a summary of the events that led to the incident, attempts to locate patient, and who was notified of the patient's elopement**

D. **DOCUMENTATION**

~~1.~~ Documentation on the patient's chart shall include a summary of the events ~~that led to~~ **surrounding** the incident, attempts to locate patient, and who was notified of the ~~patient's elopement~~ **event**

E. **FORMS:**

1. AMA Form (8723-1001-Englisgh and 8723-1003-Spanish)
2. LWOT Form (7010-1026-English)

F. **REFERENCES:**

~~1. California Consent Manual 2010~~

2. California Hospital Association, *EMTALA – A Guide to Patient Anti-Dumping Laws, 8th ed.* ~~Guidelines to EMTALA, Edition 2009~~ **(2012)**

~~2.~~**3. Title 22, California Code of Regulations, Section 70707(b)(10)**

Tri-City Medical Center
Oceanside, California

PHARMACY~~POLICY~~ MANUAL

ISSUE DATE: 9/11

SUBJECT: Transdermal Fentanyl Patch Prescribing and Use

REVISION DATE: 3/15

POLICY NUMBER: 8390-6020

Departmental Approval Date(s):	**05/15**
Pharmacy & Therapeutics Committee Approval Date(s):	**10/11, 05/15**
Medical Executive Committee Approval Date(s):	**11/11, 07/15**
Professional Affairs Committee Approval Date(s):	**08/15**
Board of Directors Approval Date(s):	**12/11**

A. **PURPOSE**:
1. **To provide a guideline summarizing safe use practices to reduce the preventable harm to patients in the hospital setting**
2. ~~To outline the steps required for the appropriate prescribing of transdermal fentanyl patches for patients at Tri-City Medical Center.~~

B. **POLICY**:
1. Due to the Food and Drug Administration (FDA) black box warning, this policy and procedure restricts prescribing to opioid-tolerant patients **for the management of persistent, moderate to severe chronic pain that requires continuous, around the clock opioid administration for an extended period of time AND cannot be managed by other means such as nonsteroidal anti-inflammatory drugs, opioid combination products, or immediate-release opioids. Fentanyl patch use in non-opioid tolerant patients has resulted in fatal respiratory depression.**
2. **Fentanyl patches are not to be used to treat sudden, occasional or mild pain, or pain after surgery**
~~1.~~**3.** **Fentanyl patches should not be prescribed for opioid naïve patients receiving comfort care measures or end of life management** Patients must meet the Tri-City Medical Center Criteria for use of Fentanyl Transdermal System (see appendix II) **and follow dosing guidelines** in order to receive fentanyl patches.
~~2. Stipulates monitoring parameters for the appropriate use in hospitalized patients.~~
~~3.~~**4.** ~~Shall not apply to end of life management or patients on comfort care measures.~~

C. **PROCEDURE**:
1. **Prescribing:**
   a. Upon receiving an ~~new~~ order for fentanyl patches the pharmacist ~~will~~ **shall** evaluate the following:
      i. Determine if patient is continuing therapy for chronic pain
      ii. Determine if the patient is opioid tolerant, defined as:
         1) Taking oral morphine 60 mg/day or oral hydromorphone 8 mg/day or oral oxycodone 30 mg/day OR (another opioid at a dose comparable to a fentanyl patch see appendix I) for ~~greater than~~ 7 days **or longer**
      ~~i.~~**iii.** Determine if the patient has any **absolute** contraindications for use:
         ~~ii.~~**1)** Patients who are not opioid tolerant as defined above
         ~~iii.~~**2)** Management of postoperative pain
         ~~iv.~~**3)** Management of mild pain or intermittent pain
         ~~v.~~**4)** Management of acute pain or if opioid analgesia is only needed for a short period of time (~~less~~ than 7 days)
      ~~iii.~~**iv.** **Determine if the patient has any relative contraindications for use:**

~~vi.~~1) **Concomitant use with ketoconazole, erythromycin, nefazodone, diltiazem or grapefruit juice requires careful monitoring~~.~~ and ~~M~~may require adjustment in fentanyl dosage.**

~~a.~~2) **Transdermal fentanyl may not be appropriate for patients with fever, diaphoresis, cachexia, morbid obesity, and ascites, all of which may have a significant impact on the absorption, blood levels, and clinical effects of the drug**

b. **Pharmacist will then verify the following and if necessary, change dose of fentanyl patch based on Fentanyl Dose Conversion Guideline ~~(Appendix I)~~:**

i. **Fentanyl patch is prescribed at the lowest dose needed for pain relief.**

~~vii.~~ii. **First-time doses (new starts) should not exceed 25mcg/hr unless recommended by pain specialist or approved by Clinical Manager. Fentanyl patch 12 mcg/hr should be considered for elderly or frail patients.**

~~viii.~~iii. **Consider concomitant opiates and other medications known to have additive CNS or ~~R~~respiratory depression effects in evaluating the appropriateness of the dose**

~~ix.~~1) **Discontinue or taper all other around-the-clock or extended release opioids when initiating therapy with fentanyl transdermal patch**

~~x.~~iv. **In selecting an initial dose, attention should be given to the following:**

~~xi.~~1) **Daily dose, potency, and characteristics of the opiate the patient has been taking previously**

~~1)~~2) **Reliability of dose conversion guidelines to predict the potency of the fentanyl dose needed**

~~b.~~3) **Patient's medical status**

4) **To account for incomplete cross-tolerance, a 25% dose reduction is needed when switching among opiates in patients whose pain is well controlled. No reduction is necessary in patients with poorly controlled chronic pain. For patients who have acute pain but whose chronic pain is otherwise controlled, a 25% dose reduction is still needed.**

v. **Frequencies of q48h are generally not recommended**

~~c.~~1) **Frequencies of Q48h may be appropriate for a small number of adult patients and may be evaluated on a case-by-case basis. Such frequencies will not be allowed for new starts unless approved by the Clinical Manager.**

~~xii.~~vi. **During dose titration, increasing dosages shall not be made prior to 72 hours after initiation of therapy, and not prior to 6 days after dose changes**

~~xiii.~~1) **Titrate dose based on the daily dose of supplemental opioids required by the patient on the second or third day of the initial application**

~~xiv.~~2) **Dose should be increased in 25 mcg increments. Larger increments may be considered for some patients on high doses if prescribed and followed by pain specialist**

~~xv.~~3) **Dose increases are not appropriate for patients who have acute pain but whose chronic pain is otherwise controlled. Such pain should be managed by appropriate use of breakthrough analgesia**

~~b.~~vii. **When discontinuing transdermal fentanyl and not converting to another opioid, use a gradual downward titration, such as decreasing the dose by 50% every 6 days to reduce risk of withdrawal symptoms**

~~2)~~1) **For disposal of fentanyl patches see Patient Care Services Controlled Substances Management Policy**

~~i.~~c. The pharmacist reviewing the order will document the following ~~in Cerner~~:

~~ii.~~i. **Verification of inclusion criteria~~Reason why patient meets criteria~~**

~~iii.~~ii. **Initial dose and date/time of initiation~~What initial dose was started and what day~~**

~~iv.~~iii. **Validation of inpatient and outpatient drug dosing history (including last refill information)**

~~v.~~**iv.** Any potential drug interactions
~~c.~~**v.** Discussions with prescriber, **if any** ~~if order is inappropriate~~

~~d. Pharmacist will then verify and if necessary change dose of fentanyl patch based on Fentanyl Dose Conversion Guideline (Appendix I)~~

~~e. Increasing dosages may not be made prior to 72 hours after initiation of therapy, and not prior to 6 days after dose changes~~

~~4. Frequencies of q48h are not permitted~~

~~a.~~**2. Dispensing and Labeling**:

~~b.~~**a.** Fentanyl pat**ches will been set up as** a patient specific medication
~~c.~~**b.** Do not cut patch warning will be placed in MAR notes
~~5.~~**c.** Tall man lettering will be used fentaNYL

~~a.~~**3. Monitoring**:

~~b.~~**a.** Pharmacist will assess for signs and symptoms of opioid**-related side effects** ~~overdose (alertness, respiratory or cardiac compromise~~**confusion, sedation, respiratory depression, hemodynamic instability) throughout the use of the fentanyl patch or until patient discharge, with special emphasis on the initial 24 hours after patch placement or after dose increases.** ~~for the first 72 hours of initiation or dose changes and document in Cerner®~~

~~c. Pharmacist will review orders for opioid reversal agents and document outcomes in Cerner®~~

~~d. Outcomes will be reported to Pharmacy and Therapeutics Committee on a quarterly basis~~

b. If a patient is showing symptoms of excessive opioid-related side effects (respiratory ~~d~~istress; shallow breathing; tiredness; extreme sleepiness, or sedation; inability to think, talk or walk normally; feeling faint, dizzy, or confused),~~

i. Notify the patient's primary Registered Nurse or call a Rapid Response based on the patient's condition

~~e.~~**ii. ~~c~~Contact provider for orders to remove/adjust dose of the fentanyl patch and/or adjust breakthrough pain medication. Upon discontinuation, approximately 17 hours are required for a 50% decrease in fentanyl levels.**

D. RELATED DOCUMENTS:

1. **Fentanyl (Duragesic) Dose Conversion Guidelines**
2. **Tri-City Medical Center Criteria for Use of Fentanyl Transdermal System**
~~f.~~**3. Patient Care Services Controlled Substances Management Policy**

E. REFERENCES:

1. **ISMP Medication Safety Alert! Community/Ambulatory Care Edition. Volume 13, Issue 3. March 2014**
2. **Acute Care ISMP Medication Safety Alert! Ongoing, Preventable Fatal Events with Fentanyl Transdermal Patches are Alarming! June 28, 2007.**
3. **CHA Medication Safety Committee High Alert Medication Guideline- Fentanyl Transdermal Patch. April 2011.**
~~2.~~**4. Grissinger, Matthew. Inappropriate Prescribing of Fentanyl Patches is Still Causing**
5. Alarming Safety Problems. Pharmacy and Therapeutics. 2010; 35(12): 653-654.
~~3.~~**6. Lexicomp, Inc. (Lexi-DrugsTM). Lexicomp. April 27, 2015.**

~~APPENDIX I~~

FENTANYL (DURAGESIC) DOSE CONVERSION GUIDELINES

Current Analgesic	Daily dose mg/day	Daily dose mg/day	Daily dose mg/day	Daily dose mg/day
Oral morphine	60 – 134	135 – 224	225 - 314	315 - 404
IM/IV morphine	10 – 22	23 – 37	38 – 52	53 – 67
Oral oxycodone	30 – 67	67.5 – 112	112.5 – 157	157.5 – 202
IM/IV oxycodone	15 – 33	33.1 – 56	56.1 – 78	78.1 – 101
Oral codeine	150 – 447	448 – 747	748 – 1047	1048 – 1347
Oral hydromorphone	8 – 17	17.1 - 28	28.1 – 39	39.1 – 51
IV hydromorphone	1.5 – 3.4	3.5 – 5.6	5.7 – 7.9	8 – 10
IM meperidine	75 – 165	166 – 278	279 – 390	391 – 503
Oral methadone	20 – 44	45 – 74	75 – 104	105 – 134
IM methadone	10 – 22	23 – 37	38 – 52	53 – 67
Recommended Fentanyl Transdermal System Dose	**25 mcg/hr**	**50 mcg/hr**	**75 mcg/hr**	**100mcg/hr**

~~APPENDIX II~~

Tri-City Medical Center Criteria for use of Fentanyl Transdermal System

INCLUSION CRITERIA (patient must meet all of the criteria below)

☐ Continuation of therapy for chronic pain

☐ Patient is opioid tolerant, defined as:
Taking oral morphine 60 mg/day or oral hydromorphone 8 mg/day or oral oxycodone 30 mg/day OR (another opioid at a dose comparable to a fentanyl patch see appendix I) for ~~greater than~~ 7 days **or greater**

EXCLUSION CRITERIA (patient may not receive if any criteria below are met)

☐ Patients who are not opioid tolerant as defined above

☐ Management of postoperative pain

☐ Management of mild pain or intermittent pain

☐ Management of acute pain or if opioid analgesia is only needed for a short period of time (less than 7 days)

Tri-City Medical Center
Oceanside, California

Staffing ~~Resource Center~~ Manual

SUBJECT: Monitoring Registry Files

ISSUE DATE: **4/03**
REVISION DATE: **4/04, 1/05, 12/05, 4/07, 12/13**
REVIEW DATE: **6/03, 4/10, 12/13**

Department Approval Date(s): **07/15**
Professional Affairs Committee Approval Date(s): **08/15**
Board of Directors Approval Date(s): **02/14**

A. **POLICY:**

1. A file **in Shiftwise** will be maintained for all Agencies and their staff in the Staffing Resource Center.
2. Each file **in Shiftwise** will contain:
   a. **All Required documentation such as, License/Certification, Credentials, Testing, Immunizations,** ~~Current Letters of Competencies~~, ~~for all Registry staff~~, **Orientation Checklist,** ~~and~~ **etc.**
   b. Signed Compass Security Form **and Pyxis** ~~(not required for Sitter only positions)~~
   c. Performance evaluations from the Nursing Departments

~~a.~~**3. Manual files will contain:**

~~c.~~**a.** Current Contract with Tri-City **Healthcare District (TCHD)**~~Medical Center~~
~~d.~~**b.** Current Rate Addendum with **TCHD** ~~Tri-City Medical Center~~
~~e.~~**c.** Copy of Current Agency Insurance coverage (General, Professional, and Workman's Compensation)
~~f.~~**d.** Copy of Annual Audit and Summary Letter
~~g.~~**e.** Any Miscellaneous Letters or Correspondence with the Agency.
~~(a) All files will be purged once a year.~~
~~h.~~**f.** One year of current information must be maintained on record in the Staffing Resource Center at all times.
~~i.~~**g.** Purged files will be maintained on record for 6 years in a data storage facility of choice.
~~j.~~**h.** A list of files in storage, their contents, and box # will be maintained on file in the Staffing Resource Center.

Tri-City Medical Center
Oceanside, California

Staffing Manual

SUBJECT: Registry Badge Process

ISSUE DATE: 12/2013
REVISION DATE(S):
REVIEW DATE(S):

Department Approval Date(s):	**08/15**
Professional Affairs Committee Approval Date(s):	**08/15**
Board of Directors Approval Date(s):	**02/14**

A. **PURPOSE:**

1. It is the policy of Tri-City **Healthcare District (TCHD)**~~Medical Center (TCMC)~~ that all Supplemental Staff are required to wear the **TCHD**~~TCMC~~ issued identification badge ("badge") at all times while present at any **TCHD** ~~TCMC~~ facilities.

B. **POLICY:**

1. Badges must be maintained in good condition. The placement of pins and unauthorized stickers on the badge is prohibited.
2. In no instance should a **TCHD** ~~TCMC~~ issued badge be loaned to someone else or be out of the possession or control of the person the badge was issued to.
3. Violation of this policy may result in discipline in accordance with applicable **TCHD** ~~TCMC~~ Hospitals Human Resource policies.
4. Badges are the property of **TCHD**~~Tri-City Medical Center~~ and must be returned to the Staffing Resource Office at the end of each shift or upon request.
5. Security has the right to confiscate badges classified as lost, expired or in possession of an individual other than the person to whom the badge is issued.

C. **BADGE DISPLAY**

1. Badge holders must wear the ID badge at all times while on property owned or under the control of the institution.
2. The badge must be worn on the upper chest and be clearly visible to someone facing the wearer. The badge must be worn horizontally so that patients, guests and fellow employees can easily read it.
3. Badges are non-transferable and are to be used only by the person to whom it is issued.

D. **PROCEDURE:**

1. Registry Staff
   a. Staff will report directly to the staffing office to sign in and obtain a facility badge.
   b. Registry staff shall wear their **TCHD** ~~TCMC~~ issued badge along with their Registry issued badge with a personal photo displayed.
   c. Registry RN's will use the **TCHD** ~~TCMC~~ badge with scanning capability for the care of patients.
   d. Upon completion of the shift, registry staff shall return to the Staffing Resource Office to sign-out **in Shiftwise**~~in the registry log book~~ and return the **TCHD** ~~TCMC~~ issued badge.
   e. Staffing Office shall maintain a log of **TCHD** ~~TCMC~~ issued badges and document the checking-out and checking-in of issued badges.

f. Should Registry Staff not return the **TCHD** ~~TCMC~~ issued badge, the terms of the registry contract shall be enforced. Registry staffs are responsible for complying with the **TCHD** ~~TCMC~~ badge process.

2. Traveler Staff
   a. Upon completion of compliance requirements as stated in the contractual agreement with the **T**ravel agency, travelers will obtain a **TCHD** ~~TCMC~~ issued badge from the Employee Health Department.
   b. **T**raveler will return the badge to the Staffing Office or Manager or Director of the Department the traveler is assigned to at the end of the assignment or upon request.

~~3. EMT Students~~
   ~~a. Students shall report to Staffing Resource Office 15 minutes prior to the start of their shift. Check in with staffing clerk and sign-in to the log book.~~
   ~~b. Student is responsible for listing the hours of the shift and note meal break taken. This is mandatory for 12 hour shifts.~~
   ~~c. Student shall be issued a TCMC badge. The terms of the EMT contract shall be enforced for turning in badges in an appropriate manner.~~
   ~~d. Upon completion of the shift, student shall return to the staffing office to sign-out and return the TCMC issued badge.~~
   ~~e. Staffing Resource Office shall maintain a log of TCMC issued badges and document the checking-out and checking-in of issued badge~~

E. **RESOURCES:**

1. Badge Log Form

Tri-City Medical Center
Oceanside, California

Staffing Manual

SUBJECT: Registry Contracts, Rate Addendums, Orientation Packets and Audits

ISSUE DATE: 4/03
REVISION DATE: 4/04, 1/05, 12/05, 4/07,
REVIEW DATE: 6/03, 1/05, 4/10, 12/13

Department Approval Date(s): 07/15
Professional Affairs Committee Approval Date(s): 08/15
Board of Directors Approval Date(s): 02/14

A. **POLICY:**

1. Registry Contracts:
   a. All Registries- will sign a Tri-City Healthcare District **(TCHD)** Standardized Contract & Rate Addendum Sheet.
   b. All Registries will sign a **TCHD**~~Tri-City Healthcare District~~ HIPAA Business Agreement.
   c. The contract, rate addendum, and business agreement will be updated previous to expiration date.
   d. These forms will be maintained on record in the Staffing Resource Center.
   e. All Registries will maintain a current **TCHD**~~Tri-City Healthcare District~~ Orientation Manual.
   f. All Registries will have their employees complete the required training, documentation, and receive the generalized Hospital Orientation Packet for Non-TCMC Employees.

2. Shiftwise Contracts

a. All registries will obtain and maintain a current contract with Shiftwise our current vendor management system.

~~a.~~**b. All Registries will upload and maintain required documents specified in the contract in Shiftwise.**

~~2.~~**3.** Registry Audits:
   a. Annually the Staffing Project Coordinator will complete an Audit of each Registry.
   b. This is to ensure compliance with Joint Commission, California Department of Public Health and Occupational Safety and Health Administration.
   c. Any deficiency will be noted and forwarded to the Registry for correction.
      i. A letter acknowledging corrections and if possible, copies of these corrections are to be sent to Staffing within a specified time frame.
   d. All audit information will be maintained on file in the Staffing Resource Center for one year.
   e. Previous years audit information will be backfiled for 6 years.

~~B. REFERENCES:~~
~~1. Non TCMC Orientation Policy~~
~~2.~~**4.** ~~Non TCMC Orientation Packet~~

Orders Required

1. **Hang time will be at 2100 for all TPN and fat emulsions**
2. **Orders written after 1400 may not be incorporated until the following day**
3. **Hang 10% Dextrose in Water at same rate as TPN if TPN infusion is stopped or runs out before new bag available**
4. **Insulin will not be added to any TPN per policy**
5. **All changes must be done with use of pre-printed orders set**

☐ **CLINICAL PHARMACY SERVICES NUTRITION CONSULT PER DR.** _____

☐ **CENTRAL LINE:** ~~**PLACED, SITE**~~: _____ ☐ **PERIPHERAL LINE**_____ **Cyclic TPN** _____

INFUSION VOLUME _____ (mL/24 hrs) **OR** **INFUSION RATE** _____ mL/hr

~~**Cycle TPN**~~ _____

Standard Central TPN (Clinimix-E) 5/20 **Rate:** _____ mL/hr **Contents:** Dextrose 20% Amino Acid 5% Sodium Chloride 10mEq/L Sodium Acetate 25mEq/L Potassium Phosphate 15 mM/L Magnesium Chloride 5 mEq/L Calcium Chloride 4.5 mEq/L **ADDITIVES:** ☐ 10 mL Adult Multi-Vitamin **(contains 150 mcg Vitamin K)** ☐ **13** mL Trace Elements-5 **Concentrate** ~~(recommended dose)~~ **OR** ☐ **10** mL **Addamel N daily (Call MD if liver disease)**~~of Trace Elements-5 (liver disease)~~ ☐ Cyanocobalamin 1000 mcg/month(1st day of Month)	☐ **RENAL FORMULA Central TPN (Clinimix) 5/20** **Rate:** _____ mL/hr **Contents:** Dextrose 20% Amino Acid 5% **** No electrolytes are in this bag**** Sodium Chloride may be added if severe hyponatremia is present (≤130 mg/dL) 75 to 150 mEq Sodium recommended ☐ _____ mEq/~~day~~**Liter Sodium Chloride** ☐ _____ mEq/~~day~~**Liter Sodium Acetate** **ADDITIVES:** ☐ 10 mL Adult Multi-Vitamin **(contains 150 mcg Vitamin K)** ☐ **13** mL Trace Elements-5 **Concentrate MWF OR** ~~(recommended dose)~~ ☐ **10** mL **Addamel N MWF** ~~of Trace Elements-5~~ **(recommended dose)**~~liver disease~~) ☐ Cyanocobalamin 1000 mcg/month(1st day of month)
LABORATORY MONITORING (with AM labs) ☐ CHEM- 7 ☐ CHEM-12 ☐ Phosphorus ☐ Magnesium ☐ Calcium ☐ **Amylase** ☐ **Lipase** ☐ **Triglyceride** ☐ **Pre-Albumin** ☐ **Ionized Calcium** ☐ **Accuchecks Q6H (while on TPN)**~~Other~~_____	**FAT EMULSION 20%** **RATE: Infusion via "Y" site at 25 mL/H** ☐ No change to prior order **Volume:** ☐ 100 mL (200 Kcal) ☐ 250 mL (500 Kcal) **Frequency:** ☐ Daily ☐ Every other day ☐ M-F ☐ 3x per week on days _____

☐ Read Back all T.O./V.O.orders Nurse's – Signature Date Time	Physician's – Signature Date Time
Tri-City Medical Center 4002 Vista Way • Oceanside • CA • 92056 **ADULT PARENTERAL NUTRITION ORDERS** **Page 1 of 4**	Affix Patient Label

Day #_____

CUSTOM TPN

INFUSION VOLUME _____ (mL/24 hrs) **OR** **INFUSION RATE** _____ mL/hr

Cycle TPN _____

AMINO ACID FINAL CONCENTRATION:

Amino Acid _____ gm/24 H **OR** ☐ 4.25% ☐ 5%
☐ 7.5% ☐ Other _____%

DEXTROSE FINAL CONCENTRATION:

Dextrose _____ gm/24 H **OR**

☐10% ☐ 20% ☐ 25% ☐ Other:_____ %

FAT EMULSION 20%

RATE: Infusion via "Y" site at 25 mL/H

☐ No change to prior order

Volume: ☐ 100 mL (200 Kcal) ☐ 250 mL (500 Kcal)

Frequency: ☐ Daily ☐ Every other day ☐ M-F

☐ 3x per week on days _____

ADDITIVES:

Calcium Gluconate	mEq/~~day~~**Liter**
Magnesium Sulfate	mEq/~~day~~**Liter**
Potassium Acetate	mEq/~~day~~**Liter**
Potassium Chloride	mEq/~~day~~**Liter**
Potassium Phosphate	m~~M~~Eq/~~day~~**Liter**
Sodium Acetate	mEq/~~day~~**Liter**
Sodium Chloride	mEq/~~day~~**Liter**
Sodium Phosphate	mM/~~day~~**Liter**
Multi-Vitamin-12 **(includes 150 mcg Vit K)**	☐ 10 mL/day
*Trace Elements-5 ☐ **13** mL **daily** **disease) OR** ~~(liver disease)~~	☐ **1ml** ~~☐ 1 mL~~ **MW**
***Addamel N**	☐ **10mL daily** ☐ **10mL MWF (renal)**
Cyanocobalamin (1st day of month)	☐ 1000 mcg/month

Average daily maintenance requirements:

- Sodium: 60-150 mEq
- Potassium: 60-120 mEq
- Chloride: 60-150 mEq
- Acetate: 80-120 mEq
- Calcium: 10-15 mEq
- Phosphorous: 20-40 mM
- Magnesium: 8-23 mEq

LABORATORY MONITORING (with AM labs) ~~**ROING**~~ ☐ **Accu-checks Q6H (while on TPN)**

☐ CHEM- 7 ☐ CHEM-12 ☐ Phosphorus ☐ Magnesium ☐ Calcium

☐ **Triglyceride** ☐ **Pre-Albumin** ☐ **Amylase** ☐**Lipase** ☐ **Ionized Calcium** ~~☐~~
~~Other_____~~

☐ Read Back all T.O./V.O.orders

Nurse's – Signature Date Time

Physician's – Signature Date Time

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

ADULT PARENTERAL NUTRITION ORDERS
Page 2 of 4

Affix Patient Label

STANDARD TPN AND RENAL FORMULATION MACRONUTRIENTS

Amino Acid 5% and Dextrose 20%

Rate (mL/hr)	24-hour volume (mL)	Protein (grams)	Protein (Kcal)	Dextrose (grams)	Dextrose (Kcal)	Total Kcal
30	720	36	144	144	490	634
35	840	42	168	168	571	739
40	960	48	192	192	653	845
42	1000	50	200	200	680	880
45	1080	54	216	216	734	950
50	1200	60	240	240	816	1056
55	1320	66	264	264	898	1162
60	1440	72	288	288	979	1267
65	1560	78	312	312	1061	1373
70	1680	84	336	336	1142	1478
75	1800	90	360	360	1224	1584
80	1920	96	384	384	1306	1690
84	2000	100	400	400	1360	1760
85	2040	102	408	408	1387	1795

TPN ORDERING INFORMATION

INFUSION RATE	• Initiate at slow rate (approx. 40-50 mL/hr) • Usual goal rate 65-85 mL/hr • To discontinue TPN, decrease rate by 50% every 2 hours until 40 mL/hr then discontinue
DEXTROSE	• For custom TPN start with 10-15% dextrose • Maintain blood sugars less than 180 mg/dL before increasing rate of TPN or percent dextrose • Do not exceed 5 mg/kg/min
PROTEIN	• For custom TPN in non-acutely ill patients start with 4.25% amino acids • For critically ill patients or nutritionally depleted use 5-6% amino acids
ELECTROLYTES	Average daily maintenance requirement: • Sodium: 60-150 mEq • Potassium: 60-120 mEq • Chloride: 60-150 mEq • Acetate: 80-120 mEq • Calcium: 10-15 mEq • Phosphorous: 20-40 mM • Magnesium: 8-24 mEq

GUIDELINES FOR INTIATION OF TOTAL PARENTERAL NUTRITION

CALORIC AND FLUID REQUIREMENTS	**1. Calculate dosing body weight** a. Ideal body weight (IBW) i. Men: 50kg + 2.3 (Height in inches – 60) ii. Women: 45.5kg + 2.3 (Height in inches – 60) b. If actual weight (TBW) is 20% below IBW, use TBW c. Use IBW for obese patients 18-22 Kcal/kg IBW or 11-14 Kcal/kg TBW **2. Estimate daily caloric requirement in normal patients** a. 20-35kcal/kg i. Consider lower range in elder (greater than 65 Y/O) ii. Generally, critically ill patients require 25-30 kcal/kg daily iii. Consider higher range for nutritionally depleted **3. Estimate daily fluid requirement in normal patients** a. 30-40 ml/kg OR 1 mL/Kcal Account for fluid intake from other sources including maintenance fluids and intravenous medications
MACRONUTRIENT REQUIREMENTS	**1. LIPIDS** a. Dedicate 20-30% of total caloric needs to lipids b. *Intralipids 20%*® contains 2 kcal/ml c. In critically ill septic patients, limit to 20% of total calories d. *Intralipids 20%*® approximately 250ml twice weekly is needed to prevent essential fatty acid deficiency e. While considering caloric needs, *Intralipids 20%*® should not exceed 5-12.5 **ml**/kg/d to minimize metabolic adverse consequences **2. PROTEIN** a. Determine requirement based on metabolic and disease state conditions as follows: i. Maintenance: 0.8-1 g/kg ii. Catabolic patients: 1.2-2 g/kg iii. Chronic renal failure (renal replacement therapy): 1.2-1.5 g/kg iv. Acute renal failure + catabolic: 1.5-1.8 g/kg b. Protein provides 4 kcal/g **3. Dextrose** a. Use dextrose to meet remainder caloric needs b. Dextrose provides 3.4 Kcal/g c. For glucose intolerant patients, start with maximum of 150g/day d. While considering caloric needs, dextrose should not exceed 7g/kg/day to minimize adverse metabolic consequences Consider all sources dextrose when calculating total goal

Example Calculation

1. Calculate caloric goal (20-35 kcal/kg/day): 70kg x 30 kcal = 2100 kcal/day
2. Calculate protein goal (Catabolic 1.2-2 g/kg): 70 kg x 1.4 kcal = 98 g
3. 98 g protein x 4 kcal/g = 392 kcal
4. Calculate lipid goal (20-30% of caloric goal): 2100 kcal x 25% = 525 kcal
   525 kcal x (ml/2 kcal) = 262 ml
   Use 250 ml since this size is available
5. Meet remaining caloric needs with dextrose: 2100 – 392 – 525 = 1183 kcal
   1183 kcal x (g / 3.4 kcal) = 348 g
6. Goal TPN **approximately** = 348 g dextrose, 98g protein, Intralipids 20% 250 ml

DRAFT

Governance & Legislative Committee Meeting Minutes
Tri-City Healthcare District
August 4, 2015

Members Present: Larry W. Schallock, Chairperson; Director Ramona Finnila; Director RoseMarie V. Reno; Blake Kern, Community Member; Eric Burch, Community Member; Dr. Paul Slowik, Community Member; Dr. Marcus Contardo, Physician Member; Dr. Henry Showah, Physician Member; Dr. Gene Ma, Chief of Staff

Non-Voting Members: Greg Moser, General Counsel; Tim Moran, CEO; Kapua Conley, COO; Cheryle Bernard-Shaw, CCO

Others Present: Teri Donnellan, Executive Assistant; Sherry Miller, Manager, Medical Staff Office; Esther Beverly, VP/Human Resources; Robin Iveson, Community Member; Jane Dunmeyer, League of Women Voters, Laura Mitchell, Board Member

Absent: Al Memmolo, Community Member

	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order/Introduction	The meeting was called to order at 12:30 p.m.in Assembly Room 3 at Tri-City Medical Center by Chairman Schallock, Committee Chairman. Chairman Schallock introduced and welcomed Dr. Gene Ma, Chief of Staff.		
2. Approval of Agenda	**It was moved by Dr. Showah to approve today's agenda as presented. Dr. Contardo seconded the motion. The motion passed unanimously.**	Agenda approved.	
3. Comments from members of the public	Chairman Schallock read the Public Comments announcement as listed on today's Agenda.	Information only	
4. Ratification of prior Minutes	**It was moved by Ms. Blake Kern and seconded by Dr. Contardo to ratify the minutes of the July 7, 2015 Governance & Legislative Committee. The minutes were approved unanimously.**	Minutes ratified.	Ms. Donnellan
6. Old Business – a. Continued discussion of proposed new Board Policy 15-027 Solicitation and Distribution of	In follow-up to discussion at last month's meeting, Mr. Moser distributed a revised policy that reflected the comments based on that discussion.	General Counsel to draft amendments to Board Policy 15-027 as suggested and bring forward to the September	General Counsel

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

Literature on District Properties	Ms. Esther Beverly, VP/Human Resources stated she has met with the President of the Auxiliary who explained that the Auxiliary has traditionally sponsored many sale events including, scrubs, leather goods, books, etc. and in turn received a percentage of the sales. Ms. Beverly stated the Auxiliary is no longer interested in sponsoring such events due to the amount of work involved and low return on investment. In addition, the Gift Shop currently sells many of the items offered at these events. Ms. Beverly stated the Auxiliary has expressed an interest in continuing to sponsor their annual bake sale. Mr. Moser explained that under this draft a sales event such as a bake sale may be permissible if it is sponsored by the Auxiliary and approved by Human Resources. Mr. Moser also explained he referenced Board Policy 14-043 which reflects that "uses of assembly rooms, classrooms and conference rooms will be limited to those public agencies, non-profit organizations, associations and other groups which further the health care needs of the public within the District, and those directly related to programs and operations which are supported, sponsored by, or affiliated with the District". Mr. Moser noted the title of the policy was also revised to include the distribution of goods as well as literature. Mr. Moser stated the policy recognizes that the Medical Staff areas are excluded from the policy. Mr. Moser also confirmed that there will be areas of the hospital designated for solicitation materials by the Union. It was suggested that the title of the policy also include political activities as referenced in the policy. The committee directed General Counsel to amend the policy to address union and political solicitations and bring back to the committee for review. Ms. Beverly confirmed a "meet and confer" with the union will take	committee meeting.	

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

	place prior to bringing the policy forward to the Board for approval.		
b. Review and discussion o f amendments to Board Policy 14-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson	In follow-up to discussions at the June meeting, Mr. Moser explained the revision reflects a four-hour time limit restriction for closed session of Regular meetings only. **It was moved by Chairman Schallock to recommend approval of amended Board Policy 14-010 Board Meeting agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson. Director Reno seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve amended Board Policy 14-010 Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson; item to appear on next Board agenda and included in Board Agenda packet. .	Ms. Donnellan
6. New Business a. Medical Staff Rules & Regulations 1. Division of Cardiothoracic Surgery	Ms. Sherry Miller, Manger of the Medical Staff explained the extensive list of Medical Staff Rules & Regulations are being reviewed today to comply with Joint Commission standards. Ms. Miller stated with the exception of Neurosurgery, the main change in all policies was to replace the term QA/PI Committee to read Medical Quality Peer Review Committee throughout each. Chairman Schallock noted the term did not get replaced in some of the Rules and Regulations. The committee reviewed the Division of Cardiothoracic Surgery Rules & Regulations. It was recommended the word QA/PI Committee be revised to read Medical Quality Peer Review Committee throughout. No other changes were suggested.	Recommendation included in motion under agenda item #16.	
2. Department of Medicine	The committee reviewed the Department of Medicine Rules & Regulations. It was recommended that the section on Privileges be broken down further to reflect the difference in the sponsoring physician and physician assistant. Dr. Ma clarified for Director Reno that the Department of Medicine does not have any Midwives.	Recommendation included in motion under agenda item #16	

Topic	Discussion	Action Follow-up	Person(s) Responsible
			DRAFT
3. Division of Allergy & Dermatology	The committee reviewed the Division of Allergy & Dermatology Rules & Regulations. It was recommended the word QA/PI Committee be revised to read Medical Quality Peer Review Committee throughout. No other changes were suggested.	Recommendation included in motion under agenda item #16.	
4. Division of Gastroenterology	The committee reviewed the Division of Gastroenterology Rules & Regulations. No revisions were suggested.	Recommendation included in motion under agenda item #16.	
5. Division of Neurology	The committee reviewed the Division of Neurology Rules & Regulations. No revisions were suggested.	Recommendation included in motion under agenda item #16.	
6. Division of Oncology	The committee reviewed the Division of Oncology Rules & Regulations. It was recommended the word QA/PI Committee be revised to read Medical Quality Peer Review Committee throughout. No other changes were suggested.	Recommendation included in motion under agenda item #16.	
7. Division of Psychiatry	The committee reviewed the Division of Psychiatry Rules & Regulations. No revisions were suggested. Mr. Ma confirmed the addition of the Behavioral Health Suite in the Emergency Department will not have any impact on these Rules & Regulations as written.	Recommendation included in motion under agenda item #16.	
8. Division of Pulmonology	The committee reviewed the Division of Pulmonology Rules & Regulations. No revisions were suggested.	Recommendation included in motion under agenda item #16.	
9. Department of Emergency Medicine	The committee reviewed the Department of Emergency Rules & Regulations. It was recommended the word QA/PI Committee be revised to read Medical Quality Peer Review Committee throughout. Dr. Ma and Dr. Contardo provided clarification on Hospital Admitting Orders and the sentence related to removal of foreign bodies.	Recommendation included in motion under agenda item #16.	
10. Department of Family Medicine	The committee reviewed the Department of Family Medicine Rules & Regulations. There were no revisions suggested, however, Director Reno expressed concern related to Midwives. Ms. Miller explained that the Midwives have their own Allied Health Rules & Relations and perform under the direction of the Medical Staff but	Recommendation included in motion under agenda item #16.	

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

	are not part of the Medical Staff. Ms. Miller further explained the Midwives are included under Allied Health to provide fair hearing rights under controversial circumstances.		
11. Division of Neurosurgery	The committee reviewed the Division of Neurology Rules & Regulations. It was recommended the word QA/PI Committee be revised to read Medical Quality Peer Review Committee throughout. It was also recommended that the section on Physician Assistants be broken down further to differentiate between Physician Assistants and Supervising Physicians. Ms. Miller provided clarification on the number that is listed in the column entitled Proctoring. Dr. Ma explained that certain privileges are categorized and "bundled" together and therefore 50 cases may not be an unreasonable number. Ms. Miller stated the Credentialing Office may also consider using cases performed at other facilities, which is a common practice. Dr. Contardo expressed concern with the substantial number of changes related to the Neurosurgeon's Privileges. It was recommended that the Neurosurgery Rules & Regulations be sent back to the Division for clarification and brought back to the committee in September.	Neurology Rules & Regulations to be re-evaluated at the Division level and brought back to the Committee in September.	Ms. Miller
12. Division of Ophthalmology	The committee reviewed the Division of Ophthalmology Rules & Regulations. It was recommended the word QA/PI Committee be revised to read Medical Quality Peer Review Committee throughout. Mr. Moran requested clarification on section IX. Emergency Department On-Call. Dr. Contardo explained the Medical Staff Bylaws reflect the obligations of Emergency Department On-Call for all Medical Staff physicians and the Bylaws supersede the Department or Division Rules & Regulations when	Recommendation included in motion under agenda item #16.	

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

	discrepancies arise.		
13. Division of Podiatric Surgery	The committee reviewed the Division of Podiatric Surgery Rules & Regulations. It was recommended the word QA/PI Committee be revised to read Medical Quality Peer Review Committee throughout.	Recommendation included in motion under agenda item #16.	
14. Division of Subspecialty Surgery	The committee reviewed the Division of Subspecialty Surgery Rules & Regulations. It was recommended the word QA/PI Committee be revised to read Medical Quality Peer Review Committee throughout.	Recommendation included in motion under agenda item #16.	
15. Department of Surgery	The committee reviewed the Division of Subspecialty Surgery Rules & Regulations. It was recommended that the section on Physician Assistants be broken down further to differentiate between Physician Assistants and Supervising Physicians. Chairman Schallock asked a general question with regard to Obstetrics and Midwives. Ms. Miller suggested the Allied Health Rules & Regulations as well as Department of Obstetrics Rules & Regulations be brought back to the September meeting for review by the committee.	Recommendation related to the Department of Surgery Rules & Regulations included in motion under agenda item #16. Allied Health Rules & Regulations and Division of Obstetrics Rules & Regulations will be placed on the September agenda.	Ms. Donnellan
16. Division of Urology	The committee reviewed the Division of Urology Rules & Regulations. It was recommended the word QA/PI be revised to read Medical Quality Peer Review Committee throughout. No other revisions were suggested. **It was moved by Director Reno to approve the following Medical Staff Rules & Regulations: Division of Cardiothoracic Surgery, Department of Medicine, Division of Allergy & Dermatology, Division of Gastroenterology, Division of Neurology, Division of Oncology, Division of Psychiatry, Division of Pulmonology, Department of Emergency Medicine, Department of Family Medicine, Division**	Recommendation to be sent to the Board of Directors to approve the following Medical Staff Rules & Regulations: Division of Cardiothoracic Surgery, Department of Medicine, Division of Allergy & Dermatology, Division of Gastroenterology, Division of Neurology, Division of Oncology,	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible
			DRAFT
	of Ophthalmology, Division of Podiatric Surgery, Division of Subspecialty Surgery, Department of Surgery and Division of Urology the presented today with the revisions previously noted with the exception of the Neurosurgery Rules & Regulations. Dr. Showah seconded the motion. The motion passed unanimously.	Division of Psychiatry, Division of Pulmonology, Department of Emergency Medicine, Department of Family Medicine, Division of Ophthalmology, Division of Podiatric Surgery, Division of Subspecialty Surgery, Department of Surgery and Division of Urology as presented and amended; items to appear on next Board agenda and included in Board Agenda packet.	
7. Discussion regarding Current Legislation	There was no discussion regarding current legislation.	None.	
8. Review of FY2016 Committee Work Plan	The FY2016 Committee Work Plan was included in today's meeting packet for reference.	Information only.	
9. Committee Communications	Chairman Schallock stated legal has not completed their review of the Medical Staff Bylaws and we expect the Bylaws to come forward next month for the committee's review.	Medical Staff Bylaws to be placed on the September agenda.	Ms. Donnellan
10. Community Openings – None	There are currently no openings on the committee.		
11. Confirm date and time of next meeting	The committee's next meeting is scheduled for Tuesday, September 1, at 12:30 p.m.		
12. Adjournment	Chairman Schallock adjourned the meeting at 1:30 p.m.		

I. **MEMBERSHIP**

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

II. **FUNCTIONS**

A. The general functions of the Division of Cardiothoracic 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 hospital 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 recommendations regarding continuing medical education programs pertaining to clinical practice;
4. Review and evaluate division adherence to:
   i Medical Staff policies and procedures;
   ii Sound principles of clinical practice;
5. Submit written minutes to the ~~QA/PI/PS Committee~~Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   i Division's review and evaluation of activities, actions taken thereon, and the results of such action; and
   ii Recommendations 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, safety, and clinical performance or opportunities to improve patient care are identified;
8. Approval of On-Going Professional Practice Evaluation Indicators; and
9. 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 Cardiothoracic Surgery shall meet as often as necessary or at the discretion of the chair, but in no event shall it meet less than 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. Minutes shall be transmitted to the ~~QA/PI/PS Committee~~Medical Quality Peer Review Committee and then to Medical Executive Committee.

B. Twenty-five percent (25%) of the Active Division members, but not less than two 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 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 an officer for any reason, the Department Chairman shall designate a new officer, or call a special election. The Chief shall be elected by a simple majority of members of the Division present, if a quorum is present.

C. The Division Chief shall serve a one-year term, which coincides with the medical staff year unless he/she resigns, be removed from office, or lose medical staff membership or clinical privileges in that Division. Division officers shall be eligible to succeed themselves.

V. **DUTIES OF THE DIVISION CHIEF:**

A. The Division Chief shall assume the following responsibilities of the Division:

1. Be accountable for all professional administrative activities of the Division;
2. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
3. Recommend to the Department of Surgery and the Medical Executive Committee the criteria for clinical privileges in the Division;
4. Recommend clinical privileges for each member of the Division;
5. Assure that practitioner's practice only within the scope of their privileges as defined within their delineated privilege card;
6. Assure that the quality, safety and appropriateness of patient care provided within the hospital are monitored and evaluated; and
7. Other duties as designated by the Department of Surgery, ~~QA/PI/PS Committee~~Medical Quality Peer Review Committee or the Medical Executive Committee.

VI. **REAPPOINTMENT 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.

VII. **DIVISION CATEGORIZATION OF SURGICAL PRIVILEGES**

A. All new physicians requesting staff privileges shall be placed in one of the defined categories of presumed surgical competence. Assignment of Provisional surgical privileges applicable thereto shall become effective immediately upon the physician's approval for staff membership by the Board of Directors. All privileges are accessible on the Tri-City intra-net and paper copies are maintained in the Medical Staff office.

B. The categories and 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.)

C. The Division of Cardiothoracic Surgery has established the following classifications of surgical privileges.

1. Cardiac & Thoracic Surgery
   Board certified, board eligible, or can demonstrate comparable ability, training and experience. With application, must submit list of open-heart cases within previous year;
2. Laser Privileges:
   Physicians applying for privileges to use the laser in surgery must submit:
   - i A certificate indicating successful completion of a laser surgery course that should provide at least two hours of hands-on use of the laser equipment. Separate training must be documented for each wavelength of laser for which the physician is applying for privileges;
   - ii Copies of two previous procedures performed with any type of surgical laser, if available;
   - iii The first two laser cases must be proctored by a physician who has been granted laser privileges and who has completed proctoring;

iv Proctoring reports will be reviewed by the Chief of Cardiothoracic Surgery regularly and then reported to the Department of Surgery;

v Transmyocardial Laser Revascularization (TMR): Completion of an FDA approved instruction course in the use of CO_2 Laser for TMR.

3. Thoracoscopy and Video Assisted Thoracic Surgery:
The councils of the American Association for Thoracic Surgeons have formed a Joint Committee on thoracoscopy and video assisted thoracic surgery and the following are the recommended guidelines:

i In order to ensure optimal quality patient care, thoracoscopy and video assisted thoracic surgery should be performed only by thoracic surgeons who are qualified through documented training and experience, to perform open thoracic surgical procedures and manage their potential complications. The surgeon must have the judgment, training and capability to proceed immediately to a standard open thoracic procedure if necessary;

ii The preoperative and postoperative care of patients treated by thoracoscopy and video assisted surgery should be the responsibility of the operating surgeon.

iii It is recommended that thoracoscopy and video assisted thoracic surgery techniques be learned through appropriate instruction;

iv As part of a formal approved thoracic surgical residency or fellowship program which includes structured and documented experience in these procedures

v For the practicing thoracic surgeon, completion of a course approved by the joint commission, with hands-on laboratory experience, plus observation of these techniques performed by thoracic surgeons experienced in such procedures;

vi The granting of privileges to perform thoracoscopy and video assisted thoracic surgery and proctoring shall be carried out as delineated in the rules and regulations.

4. Physician Assistants
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.

5. RNFA
A registered nurse renders direct patient care as part of the perioperative role by assisting the surgeon in the surgical treatment of the patient. The responsibility of functioning as first assistant must be based on documented knowledge and skills acquired after specialized preparation and formal instruction. The setting is inpatient or outpatient operating room at Tri-City Medical Center. RNFA is under the direct supervision of the primary surgeon.

VIII. REQUIREMENTS FOR REAPPOINTMENT

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

A. Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the 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).

Refer to grid for procedure list(s) and associated numbers required to satisfy competency.

PROCEDURES	Number of Cases Required for initial appointment	Number of Cases Required for Proctoring	Number of Cases Required for reappointment Every 2 years
Thoracoscopy and Video assisted Thoracic Surgery	2	2	10
Laser Surgery (yag; CO_2) to include TMR	2	2	
Cardiac Surgery	6	6	24
a. Intra-Cardiac and Valve Surgery b. Extra-Cardiac Surgery for Traumatic Injury Repair (thoracic) c. Thoracic Aneurysmectomy d. Coronary Artery Bypass Procedure e. Infarctectomy			
Thoracic Surgery	5	5	6
a. Trachea and bronchi-All procedures b. Thorax- Chest wall Aspiration c. Thorax- Chest Wall Drainage d. Thorax – major Excisional Procedures of the Chest wall e. Diaphragm- All Procedures f. Esophagus- all Procedures g. Lungs- All procedures h. Mediastinum-Excision of tumors/cysts, etc i. Heart and Pericardium-Repair of Wounds j. Pericardium - All procedures k. Placement of Permanent Epicardial and Endocardial Pacing Systems			
Additional Privileges			
a. Admit patients b. Intra-Cardiac Cardio-converter Defibrillator c. Sedation	NA 2 Per MS Policy # 517	NA 2 Per MS Policy # 517	NA 2 Per MS Policy # 517

IX. **INITIAL CREDENTIALING FOR CORE ROBOTIC ASSISTED SURGICAL PRIVILEGES:**

A. For surgeons with prior da Vinci experience:

1. Physicians must have privileges to perform the underlying procedure as an open and thoracoscopic procedure;
2. If residency/fellowship training included robotic surgery training, provide:
   - i Letter from program director certifying competency for the requested privilege(s) and in the use of the da Vinci device as primary surgeon; and
   - ii Documentation (i.e., copies of operative reports or hospital report) of a minimum of ten (10) da Vinci cases as primary surgeon (may be core or advanced cases);
   - iii For surgeons with prior da Vinci experience at an outside institution, provide:

a. Documentation (i.e., copies of operative reports or hospital report) of ten (10) cases as primary surgeon beyond proctoring and within the previous 24-month period must be submitted for review (may be core or advanced cases);

B. For surgeons without prior da Vinci experience:

1. Physicians must have privileges to perform the underlying procedure as an open and thoracoscopic procedure;
2. Documentation of completion of an Intuitive Training Program (certificate of completion required) or comparable program (copy of certificate and curriculum required), which includes didactic and hands-on training including cadaver, animal lab, or simulator (See Phase II-Preparation and System Training of Surgeon Clinical Pathway-Intuitive Surgery). A minimum of one (1) live case observation.

PROCEDURES	Initial	Proctoring*	Cases for Reappointment Every 2 years
CORE PRIVILEGES Closed Cardiac cases: •Epicardial pacer lead placement •Left internal mammary artery/right internal mammary artery takedown, off-pump coronary artery bypass graft •Transmyocardial laser revascularization •Pericardial window Basic Thoracic Cases: •Thymectomy •Lung biopsy •Mediastinal exploration (lymph nodes, mass) •Pericardial cysts •Diaphragm plication •Esophageal myotomy for achalasia	See statement above.	1 if prior experience; 4 if no prior experience	10, beyond proctoring If less than 10, but greater than or equal to 5, the next 2 cases must be successfully performed with a robotic privileged surgeon on staff within the same specialty, or an outside proctor. If less then 5 cases, additional certified hands-on training must be obtained (simulator, cadaver or animal lab) AND the next 2 cases must be successfully performed with a robotic privileged surgeon on staff or outside proctor.
ADVANCED CARDIAC ASD/Cardiac Tumor Resection	•Unrestricted CORE privileges; •Training in Aortic	First 1 case	10

PROCEDURES	Initial	Proctoring*	Cases for Reappointment Every 2 years
Mitral Valve Repair	Endo-Balloon (if technique to be used); •Endoscopic Suturing Skills Training (simulator or live case). •Unrestricted CORE privileges; •Case log of 10 successful mitral repairs (non-robotic); •Training in Aortic Endo-Balloon (if technique used); •Endoscopic Suturing Skills Training (simulator or live case).	First 3 cases	
ADVANCED THORACIC Pulmonary Resection (other than wedge resection) Esophageal Resection (other than enucleation)	•Unrestricted CORE privileges	First 1 case	10

*Proctoring must be completed within a one-hundred-eighty (180) day period following granting of the privilege by a robotic-credentialed surgeon (preferably in their field). Additional training will be required prior to scheduling further cases if proctoring has not been completed within the specified time frame. Proctoring requirements include a letter of proficiency from the elected proctor that includes satisfactory outcomes of the procedure, assessment of intraoperative and postoperative complications, and review of pathology reports if indicated. Proctor may recommend to the Chair of the Department or Chief of the Division that additional training and/or proctoring be completed.

X. **CRITERIA FOR ASSISTING IN ROBOTIC-ASSISTED SURGERY**

For privileges to assist in robotic-assisted surgery (for MD/DO, PA, and RNFA):

A. Unrestricted surgical assisting privileges; and

B. Documented experience in robotic assisting (i.e., copies of ten operative reports or hospital report of ten cases as robotic assistant) or completion of Intuitive Training Program for assistants (including on-line module and on-site training by Intuitive or a robotics-trained assistant);

C. Proctoring: A minimum of six (6) cases must be proctored by the primary surgeon

NOTE:

Consistent with the TCMC Medical Staff Policy # 8710-563, for all physicians granted robotic-assisted surgery privileges, the first ten (10) cases will be reviewed for evaluation of case selection, OR time, blood loss, conversion to open procedure, complications, length of hospital stay, etc.

XI. **PROCTORING OF PRIVILEGES**

Each new medical staff member granted initial surgical privileges shall be evaluated by a proctor in each surgical case until his or her surgical privilege status is established by a recommendation from the Division and subsequently the Credentials Committee and the Medical Executive Committee and final approval by the Board of Directors. Medical Staff members requesting additional or new privileges will be proctored as aforementioned in grid. This is to include extensive surgical cases treated in the Emergency Department.

A. Selection of Proctors

1. All active staff members of the Division of CTS will act as proctors to monitor quality of performance of medical care with assigned privileges. An associate of the new medical staff member may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief and it is the Division Chief's responsibility 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;
2. The new medical staff member shall select an appropriate member from the Cardiothoracic Surgery Division to proctor his/her operative case. He or she shall contact the proctor and inform him or her of his or her plans for the case. **THE PROCTOR MUST BE PRESENT IN THE OPERATING ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE SURGEON'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (i.e. H&P, Op Note) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE SURGEON'S COMPETENCE;**
3. 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 proctor shall be contacted prior to, and designated at, the time of scheduling;
4. The new medical staff member shall have free choice of suitable consultants and assistants.

B. **Reports of Proctors**

1. A form shall be prepared on which will be spaces for comment by the proctor on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall, impression and recommendation (i.e. qualified, needs further observation, not qualified). Blank forms will be available from the Operating Room Supervisor and/or the Medical Staff office;
2. Forms will be made up by 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;
3. 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 within one week after the patient's discharge from the hospital

C. **Length of Proctoring Period**

1. The applicant shall be observed by proctor in each surgical case as set forth in the above grid;
2. When the required number of cases have been proctored, the Division Chief must approve or disapprove extension of surgical privileges or may extend the proctoring to its next meeting;

3. It will be 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.

XII. **EMERGENCY DEPARTMENT CALL**

A. Medical Staff Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the medical staff. Reference Policy #8710-520;~~.~~

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

C. 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 surgical problem there is no obligation on the part of the physician to provide care.

Approvals:

Cardiothoracic Surgery Division Approval: ~~4/19/13~~04/23/15
Surgery Department Approval: ~~4/19/13~~6/18/15
Medical Executive Committee Approval: ~~5/20/13~~7/27/15
Governance Committee Approval: _____
Board of Directors Approval: ~~5/30/13~~

I. MEMBERSHIP

A. The Department of Medicine consists of physicians in the Divisions of:
   1. Allergy and Dermatology
   2. Cardiology
   3. Gastroenterology
   4. Internal Medicine
      a. Infectious Disease
      b. Nephrology
      c. Physiatry
      d. Rheumatology
   5. Hematology / Oncology
   6. Neurology
   7. Psychiatry
   8. Pulmonary Medicine

II. FUNCTIONS

The general functions of the Department of Medicine, carried out through the functions of the Division shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety and appropriateness of care and treatment provided to patients within the division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the department;

C. Conduct, participate in and make recommendations regarding continuing Medical education programs in clinical practice;

D. Review and evaluate departmental adherence to:
   1. Medical Staff Policies and procedures;
   2. Sound principles of clinical practice.

E. Submit minutes to the ~~QA/PI/PS Committee~~Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Department's review and evaluation of activities, actions taken thereon, and the results of such action;
   2. Recommendations for maintaining and improving the quality of patient care and patient safety provided in the department and the hospital;
   3. Recommend / Request Focused Professional Practice Evaluation as indicated for Medical Staff members (pursuant Medical Staff Policy 509);
   4. Approval of On-Going Professional Practice Evaluation Indicators.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care and clinical performance, patient safety or opportunities to improve patient care are identified;

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

III. DEPARTMENT MEETINGS

A. The Department of Medicine shall meet quarterly or at the discretion of the chairman. The functions of the Department are carried out through the Divisions; including the monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients. Regular reports shall be transmitted to the Medical Executive Committee;

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

IV. DEPARTMENT OFFICERS

A. The Department shall have a Chairman and a Vice-Chairman who shall be members of the Active Medical Staff and shall be qualified by training, experience and demonstrate ability in at least one of the clinical areas covered by the Department;

B. The Department Chairman shall serve a one-year term, which coincides with the medical staff year unless they resign, be removed from office, or lose their medical staff membership or clinical privileges in that Department. Department officers shall be eligible to succeed themselves). Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department.

V. DUTIES OF THE DEPARTMENT CHAIRMAN

A. The Department Chairman shall assume the following responsibilities of the Department:
   1. Be accountable for all professional administrative activities of the Department;
   2. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department;

B. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;

C. Recommend clinical privileges for each member of the Department; and

D. Assure that practitioner's practice only within the scope of their privileges as defined within their delineated privilege card;

E. Assure that the quality, safety and appropriateness of patient care provided within the Department are monitored and evaluated through Ongoing Professional Practice Evaluation;

F. Continuously assess and improve the quality and safety of care provided in the Department;

G. Other duties may be assigned, in accordance with the Medical Staff Bylaws.

VI. PRIVILEGES

A. Requests for privileges in the Department of Medicine shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance and the documented results of patient care and proctoring;

   Practitioner's practice only within the scope of their privileges as defined within the respective Division's Rules and Regulations. Recommendations for privileges are made to the Credentials and Medical Executive Committees;

B. The Department of Medicine has established the following classifications of medical privileges:

1. Physicians 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 consultations when:
   a. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness;
   b. Unexpected complications arise which are outside this level of competence;
   c. Specialized treatment or procedures are contemplated in which they are not familiar;
2. Physician Assistants 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;
   a. A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients;
   b. 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;
   c. 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;
   d. 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;
   e. The supervising physician must see patient cared for by the physician assistant at least once during the hospital stay or as delineated by the Division Rules and Regulations;
   f. A physician assistant may not admit or discharge patients.
   g. Refer to the AHP rules and regulations for further delineation of sponsoring physicians supervision requirements;
   h. Medical / Surgical Units: Documentation of an examination of the patient by the sponsoring physician(s) every third day if care is given by the Allied Health Professional(s);
   i. Non-Scheduled Admission(s): Examination of the patient by the sponsoring physician(s) the same day as care is given by the AHP;
   j. The Department of Medicine requires a physician co-signature as delineated in the AHP's Rules and Regulations:
   k. Order(s)and telephone Order(s) may be immediately implemented and physician co signature required within 24 hours of AHP's order;
   l. Any medical record of any patient cared for by a physician assistant for whom the physician's prescription has been transmitted or carried out shall be reviewed and countersigned and dated by the supervising physician within 24 hours;
   j. The sponsoring physician must review and authenticate any progress note within the medical record of any patient(s) documented by a physician assistant within 24 hours;

l. Non-Scheduled admissions: the sponsoring physician(s) must dictate the H&P within 24 hours;
m. ACCU/AMC Units: Examination of the patient by the sponsoring physician(s) the same day as care is given by the Allied Health Professional(s).

3. Nurse Practitioners: Nurse practitioner means a registered nurse who posses' additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary care and who has been prepared in a program. The nurse practitioner shall function under standardized procedures or protocols covering the care delivered by the nurse practitioner. The nurse practitioner and his/her supervising physician who shall be a Member of the Department of Medicine will develop the standardized procedure or the protocols and be approved by the Department of Medicine;
   a. Proctoring and privileges requested are delineated for Allied Health Professionals/Mid Level Practitioner within the Allied Health Rules and Regulations and each retrospective Division (s) specified criteria.

VII. REQUIREMENTS FOR INITIAL APPOINTMENT AND REAPPOINTMENT

A. Active certification by the appropriate certifying board or demonstration of comparable ability, training and experience shall satisfy the requirements for receiving cognitive privileges for all categories as well as for admitting privileges to Tri-City Medical Center;
B. Privileges requested are granted based on Division specified criteria;
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).

VIII. SPECIAL PROCEDURES / PRIVILEGES

A. The applicant will be responsible for checking all procedures he/she wishes to perform and for listing his/her qualifications, training, and experience concerning the requested procedures in accordance with criteria established by various Divisions of the Department of Medicine, copies of which are available in the Medical Staff Office.;
   1. The medical privileges granted each physician will be recorded and a copy of which will be forwarded to the applicant with his medical staff appointment;
   2. Pain Management Privileges are delineated per Medical Staff Policy # 541;
   3. Surgical Assist Privileges as delineated per Medical Staff Policy #536;
   4. Each practitioner's privileges will be assessable on Tri-City's Intra-net (MD-Staff) which is located in each patient care area. A paper copy is maintained within the Nursing Administration Office and the Main Operating Room.

IX. PROCTORING

A. Each new applicant granted initial or additional privileges shall be evaluated by a proctor as delineated by the Divisions of the Department of Medicine. If enough cases have not

been admitted, or evaluation of the applicant's performance cannot be completed in the first year, then an additional year of provisional staff will be recommended;

B. At the discretion of the retrospective Division Chair(s) the decision to assign further proctoring of cases is based on current clinical competence, practice behavior, and the ability to perform the requested privilege(s);

C. Supervision of the applicant by the proctor will emphasize concurrent chart review and include direct observation of procedural techniques. The applicant must notify his / her proctor at the time a procedure is scheduled or planned. If the proctor is not available, the applicant must notify another physician in the appropriate subspecialty area. If the procedure must be done emergently without proctoring, the proctor must be informed at the earliest appropriate time following the procedure;

D. All active staff members of the Department of Medicine will act as proctors as delineated by the Divisions of the Department of Medicine to monitor performance of medical care and compliance with assigned privileges;

E. Specific proctoring requirements are outlined in each respective Division's Rules and Regulations.

X. EMERGENCY DEPARTMENT CALL

A. Medical Staff department members shall participate in the Emergency Department Call Roster or consultation panel as determined by the medical staff. Refer to Medical Staff Policy and Procedure #520;

B. While serving on the Emergency Department Call Roster, each member shall respond to requests from the Emergency Department by examining and treating patients in the Emergency Department, unless the member and Emergency Department physician agree that such care may be provided in the member's office. Any member who elects to provide care in his office must do so without regard to the patient's ability to pay, and must provide a minimum level of care sufficient to respond to the patient's immediate needs;

C. It is the policy of the Emergency Department that when it is discovered that a patient has been previously treated by a staff member, that member will be given the opportunity to provide further care;

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

E. Provisional or courtesy member(s) are able to serve on the Emergency Call panel at the discretion of the Department Chair or Division Chief.

APPROVALS:
Department of Medicine: 4/23/13 07/01/15
Medical Executive Committee: 4/23/13 07/27/15
Governance Committee
Board of Directors: 5/30/13

Revised: 01/04, 01/06, 02/07, 06/08; 5/13; 7/15

I. **MEMBERSHIP**

The Division of Dermatology and Allergy consists of physicians who are board certified (or its equivalent) by the American Board of Allergy and Immunology or the American Board of Dermatology.

II. **FUNCTIONS OF THE DIVISION**

A. Conduct patient care review for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the Division;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to clinical practice;

D. Review and evaluate Division adherence to:

1. Medical Staff Policies and Procedures;
2. Sound principles of clinical practice.

E. Submit minutes to the ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee and Medical Executive Committee concerning:

1. Division review and evaluation activities, actions taken thereon, and the results of such action;
2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital;

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety, and clinical performance or opportunities to improve patient care are identified;

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy # 8710-509);

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

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

III. **DIVISION MEETINGS**

A. The Division of Dermatology and Allergy shall meet at least annually or at the discretion of the Chief. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the ~~QA/PI/PS~~ Medical Quality Peer Review Committee, and then to the Medical Executive Committee.

B. 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 members of the Division who are eligible to vote. If there is a vacancy of any officer(s) for any reason, the Department Chairman

shall designate a new Chief, or call a special election. The Chief shall be elected by a simple majority of the members of the Division.

C. The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, are removed from the office, or loses his/her Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

V. DUTIES OF THE DIVISION CHIEF

The Division Chief shall assume the following responsibilities:

A. Be accountable for all professional and administrative activities of the Division;
B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege card;
D. Recommend to the Department of Medicine and the Medical Executive Committee the criteria for clinical privileges in the Division;
E. Recommend clinical privileges for each member of the Division;
F. Assure the quality, safety and appropriateness of patient care provided within the Division are monitored and evaluated;
G. Other duties as recommended from the Department of Medicine or the Medical Executive Committee.

VI. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.
B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.
C. Requests for privileges in the Division of Dermatology and Allergy shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance and the documented results of patient care and proctoring. Practitioners shall practice only within the scope of their privileges. Recommendations for privileges are made to the Credentials Committee and Medical Executive Committee.
D. Standards are established by the Division with the ultimate goal of rendering safe, quality, patient care, and containing costs.
E. Allergy or Dermatology Residency Training: Physicians are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training in Allergy or Dermatology. 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.
F. Members of the Division of Dermatology and Allergy may apply to perform the following privileges/procedures:

PRIVILEGES/PROCEDURES – PROCTORING NOT REQUIRED			
Procedures	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
Admit patients	N/A	2 (admits or	N/A

		consults)	
Consultation	N/A	2 (admits or consults)	N/A
Perform medical history & physical examination	N/A	Eligible for release from proctoring once initial two (2) admits or consults have been proctored.	N/A
Biopsy < 5 cm	Training	N/A	N/A
Biopsy of nail unit	Training	N/A	N/A
Burns, first degree: simple treatment < 100 sq cm	Training	N/A	N/A
Destruction, pre-malignant and Benign < 10 cm	Training	N/A	N/A
Graft, punch < 1 cm	Training	N/A	N/A
Incision < 5 cm	Training	N/A	N/A
Nail and matrix excision	Training	N/A	N/A
Nail avulsion	Training	N/A	N/A
Nail bed reconstruction with Graft	Training	N/A	N/A
Nail debridement	Training	N/A	N/A
Nail fold wedge excision	Training	N/A	N/A
Paring & curettement < 5 cm	Training	N/A	N/A
Repair of nail bed	Training	N/A	N/A
Repair, simple < 10 cm-anywhere except face	Training	N/A	N/A
Shaving < 5 cm	Training	N/A	N/A
PROCEDURES - PROCTORING REQUIRED			
Procedures	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
Debridement < 100 sq cm	Training	1	1
PROCEDURES - OUTPATIENT FORENSIC CLINIC			
Procedures	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
Biopsy < 5 cm	Training	N/A	N/A
Biopsy of nail unit	Training	N/A	N/A
Debridement < 100 sq cm	Training	1	1
Destruction, malignant < 10 cm	Training	1	1
Destruction, pre-malignant and benign < 10 cm	Training	N/A	N/A
Fungal/scabies scraping	Training	N/A	N/A
Graft, punch < 1 cm	Training	N/A	N/A

Intralesional injection	Training	N/A	N/A
Mohs Micrographic Surgery (MMS)	See criteria below.	3	5
Nail avulsion	Training	N/A	N/A
Shaving < 5 cm	Training	N/A	N/A

Mohs Micrographic Surgery (MMS):
Initial:

1. Applicants must complete an ACGME/AOA-accredited residency program in dermatology that included MMS training or an approved MMS fellowship training program.
2. Documentation that applicant has performed a minimum of 100 MMS procedures in the past 24 months.
   Proctoring: Three (3) cases
   Reappointment: Five (5) MMS procedures within the past 24 months.

Laser Privileges
Initial: Physicians applying for privileges to use the laser in surgery must submit:

1. Documentation of applicable laser training in the respective residency program (with competency verified by Program Director); or
2. Documentation of completion of an appropriate course, eight to ten hours in length (with 40% of the course time allocated to practical sessions). Copy of certificate of completion of course specific to type of laser and copy of course outline required.

Procedures	Initial Appointment	Proctoring	Reappointment (every 2 years)
Argon	See above criteria	2	2
CO2	See above criteria, plus proof of one (1) completed case.	1	1
KTP	See above criteria, plus proof of one (1) completed case.	2	2
Nd: YAG	See above criteria, plus proof of two (2) completed cases.	2	N/A

VII. **REAPPOINTMENT**
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).

VIII. **PROCTORING OF PRIVILEGES**

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Division Chief to the Credential Committee and to the

Medical Executive Committee, with final approval by the Board of Directors. Procedure proctoring is as set forth in the table above.

B. All Active members of the Division will act as proctors. An associate may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief.

C. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).

D. 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.

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

IX. **EMERGENCY DEPARTMENT CALL**

A. Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520.

B. Provisional or Courtesy member(s) are able to serve on the Emergency Call Roster by their Chief of the Division. The care provided by an on-call physician will not create an obligation to provide further care.

Approvals:

Division of Dermatology & Allergy: ~~4/23/13~~06/25/2015
Department of Medicine: ~~4/23/13~~06/25/2015
Medical Executive Committee: ~~5/20/13~~07/27/2015
Governance Committee: _____
Board of Directors: ~~5/30/13~~

TRI-CITY HOSPITAL DISTRICT Rules and Regulations	Section: Medical Staff Subject: Division of Gastroenterology Page 1 of 5

I. **MEMBERSHIP**

The Division of Gastroenterology consists of physicians who are board certified (or its equivalent) in Gastroenterology by the American Board of Internal Medicine or in the process of obtaining certification and will provide care for digestive disorders for patients 18 years of age and older.

II. **FUNCTIONS OF THE DIVISION**

The general functions of the Division of Gastroenterology, carried out through the members shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety and appropriateness of care and treatment provided to patients within the division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the Division;

C. Conduct, participate in, and make recommendations regarding continuing medical education programs pertinent to clinical practice;

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

E. Submit written minutes to the ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee and Medical Executive Committees concerning:
   1. The Division's review and evaluation of activities, actions taken thereon, and the results of such action; and
   2. Recommendations for maintaining and improving the quality of patient care and patient safety provided in the hospital;

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety, clinical performance or opportunities to improve patient care are identified;

H. Recommend/Request Focused Professional Practice Evaluation as indicated for Medical Staff members (pursuant to Medical Staff Policy #8710-509);

I. Approval of On-Going Professional Practice Evaluation Indicators;

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

III. **DIVISION MEETINGS**

The Division of Gastroenterology shall meet at least annually or at the discretion of the Chief. The functions of the Division are carried out through the Division's members and committees thereof, including the monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients. Regular reports shall be transmitted to the Medical Executive Committee.

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

IV. **DIVISION OFFICERS**

The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in gastroenterology.

The Division Chief shall be elected every year by the Active members of the Division who are eligible to vote at the Division meeting. If there are vacancies of any officer for any reason, the Department Chairman shall designate a new officer(s), or call for a special election.

The Division Chief shall serve a one year term which coincides with the medical staff year unless he/she shall sooner resign, be removed from office, or lose medical staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

V. **DUTIES OF THE DIVISION CHIEF**

The Division Chief shall assume the following responsibilities of the Division:

A. Be accountable for all professional and administrative activities of the Division.
B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
C. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Division;
D. Assure that practitioner's practice only within the scope of their privileges as defined within their delineated privilege card;
E. Recommend clinical privileges for each member of the Division.
F. Assure that the quality, safety, and appropriateness of patient care provided within the Division are monitored and evaluated;
G. Other duties as assigned in accordance with the Medical Staff Bylaws.

VI. **PRIVILEGES**

A. All members of the Division of Gastroenterology are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training. 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;
B. Requests for privileges in the Division of Gastroenterology shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance and the

documented results of patient care and proctoring. Practitioner's practice only within the scope of their privileges. Recommendations for privileges are made to the Credentials Committee and Medical Executive Committee. All medical staff privileges are located on the Tri-City Medical Center's Intra-Net;

C. Standards for privileging are established by the Division with the ultimate goal of rendering safe quality patient care. Privileges may to be requested in each major category of endoscopy. The granting of privileges will be based on an applicant's knowledge, training and experience in the overall management of gastrointestinal disease, as well as demonstrated competence in performing endoscopic procedures;

D. Applicants must have completed a formal fellowship or residency training in gastroenterology;

E. Following granting of privileges, the member will be proctored in accordance with existing policy;

F. Attendance at continuing medical education programs related to endoscopy is required for the periodic reappraisal and renewal of endoscopic privileges. The Division also encourages attendance at appropriate local and national meetings and courses.

PROCEDURES	Cases Required		
	Initial	Proctoring	Reappointment
Admit patients	Training		N/A
Consultation	Training		
Perform history and physical examination	Training		
Colonoscopy	100	2	*
Endoscopic retrograde cholangiopancreatography (ERCP) (diagnostic and therapeutic)	75	2	20
Esophageal dilation	15	2	*
Esophageal stent placement	10	2	*
Esophagogastroduodenoscopy (EGD)	100	2	*
Flexible sigmoidoscopy	Combination of 50 colonoscopy and 50 flexible sigmoidoscopy	2	*
Liver Biopsy	5	2	*
Nonvariceal hemostasis (upper and lower)	20 (includes 10 active bleeders)		*
Percutaneous endoscopic gastrostomy (PEG)	10	2	*
Pneumatic dilation for achalasia	5	2	*
Snare polypectomy	20	2	*
Tumor ablation	20	2	*
Variceal hemostasis (upper and lower)	15 (includes 5	2	*

	active bleeders)		
Moderate sedation	Refer to MS policy # 8710-517	Refer to MS policy # 8710-517	Refer to MS policy # 8710-517

- * = 100 total cases (representative blend) required per reappointment cycle

VII. **PRIVILEGES FOR NON-GASTROENTEROLOGISTS**

Non-gastroenterologists may be granted certain privileges as follows:

A. Liver Biopsy –New Medical Staff member must provide proof of training and documentation of a minimum of five (5) cases performed. Initial five (5) liver biopsies performed at Tri-City Medical Center are to be proctored by a medical staff member who holds the privilege within the Division of Gastroenterology or is an Interventional Radiologist;

B. Flexible sigmoidoscopy, with flexible sigmoidoscope of 60 cm. length or shorter, must provide the same proof of training as a gastroenterologist and be proctored by a gastroenterologist for the first five (5) cases performed.

VIII. **PROCTORING OF PRIVILEGES**

A. Each new medical staff member granted initial privileges or medical staff member granted additional privileges shall be evaluated by a proctor;

B. Supervision of the new medical staff member by the proctor will emphasize concurrent or retrospective chart review and include direct observation of procedural techniques. The new medical staff member must notify his proctor at the time a procedure is scheduled or planned. If the proctor is not available, the applicant must notify another physician in the appropriate subspecialty area. If the procedure must be done as an emergency without proctoring, the proctor must be informed at the earliest appropriate time following the procedure;

C. All active medical staff members of the Division of Gastroenterology will act as proctors to monitor quality of performance of medical care of assigned privileges. Additional cases may be proctored as recommended by the Division Chief.

IX. **REAPPOINTMENT**

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).

Suggested Objective Performance Criteria for the Evaluation of Technical Skills in Gastrointestinal Endoscopy, as Proposed by the ASGE

PROCEDURE	PERFORMANCE CRITERIA
EGD	Esophageal intubation Pyloric intubation
Colonscopy	Intubation of splenic flexure Intubation of cecum Intubation of terminal ileum (desirable skill)
Flexible Sigmoidoscopy	Visualization of splenic flexure Retroflexion
ERCP	Cannulation of desired duct Opacification of desired duct Stent placement Sphincterotomy Stone extraction
EUS	Intubation of esophagus Intubation of pylorus Imaging of desired organ or lesion Successful lesion biopsy Tumor staging in agreement with surgical findings or findings of EUS trainer and with accuracy similar to that reported in literature
All procedures	Accurate recognition of normal and abnormal findings Development of appropriate endoscopic/medical treatment in response to endoscopic findings
Polypectomy Esophageal dilation Esophageal motility Hemostasis PEG Pneumatic dilation Tumor ablation Esophageal stent	Successful performance

X. **EMERGENCY DIVISION CALL**

Division members shall participate in the Emergency Division Call Roster or consultation panel as determined by the Medical Staff (Reference Medical Staff Policy #8710-520).

Provisional or courtesy staff members may be assigned to the Emergency Division Call Roster at the discretion of the Chief of the Division.

Approvals:

Division of Gastroenterology: ~~4/23/13~~06/25/15
Department of Medicine: ~~4/23/13~~06/25/15
Medical Executive Committee: ~~5/20/13~~07/27/15
Governance Committee
Board of Directors: ~~5/30/13~~

I. **MEMBERSHIP**

A. The Division of Neurology consists of physicians who are Board Certified or in the first thirty-six (36) months of Board Eligibility and are actively pursuing certification by the American Board of Psychiatry and Neurology.

II. **FUNCTIONS**

The general functions of the Division of Neurology shall include:

A. Conduct patient care review for the purpose of analyzing and evaluation of the quality, safety and appropriateness of care and treatment provided to patients within the division and develop indicators for use in the evaluation of patient care;

B. Recommend to the Department of Medicine and to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the division;

C. Conduct, participate in and make recommendation regarding continuing medical education programs pertinent to division clinical practice;

D. Review and evaluate division adherence to:

1. Medical Staff Policies and Procedures; and
2. Sound principles of clinical practice;~~.~~

E. Submit written reports to the Department of Medicine, the ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee and Medical Executive Committee concerning:

1. The division's review and evaluation of activities, actions taken thereon, and the results of such action; and
2. Recommendations for maintaining and improving the safety and quality of care provided in the hospital;~~.~~

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;~~.~~

G. Recommend/request Focused Professional Practice Evaluation (FPPE) as indicated for Medical Staff members (pursuant Medical Staff Policy 509);

H. Approve On-Going Professional Practice Evaluation (OPPE) indicators;

I. Take appropriate action when important problems in patient care and clinical performance or opportunities to improve patient care are identified;

J. Formulate recommendations for Division Rules and Regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Department of Medicine and the Medical Executive Committee.

III. **DIVISION MEETINGS**

A. The Division of Neurology shall meet no less than annually, or at the discretion of the division chief. The division will consider the findings from the ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the Department of Medicine, ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee and then to the Medical Executive Committee;~~.~~

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

IV. **DIVISION OFFICERS**

A. The Division of Neurology shall have a Chief who is a member of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in Neurology;~~.~~

B. Division members shall elect the Division Chief every year by the Active Staff Members of the Division. If there are vacancies of any officer for any reason, the Department Chairman shall

designate a new officer(s), or call a special election. The chief shall be elected by a simple majority of members of the Division;

C. The Division Chief shall serve a one year term which coincides with the medical staff year unless they resign, are removed from office, or lose their medical staff membership or clinical privileges in that division. Division officers shall be eligible to succeed themselves.

V. DUTIES OF THE DIVISION CHIEFS

A. The Division Chief shall assume the following responsibilities of the Division:

1. Be accountable for all professional administrative activities of the Division; Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division; Recommend to the Department of Medicine and the Medical Executive Committee the criteria for clinical privileges in the division; Recommend clinical privileges for each member of the Division;
2. Assure that the quality, safety and appropriateness of patient care provided within the division are monitored and evaluated;
3. Assure that practitioner's practice only within the scope of their privileges as defined within their delineated privilege card;
4. The Chief of the Division of Neurology shall attend the Department of Medicine Division Chiefs meeting; and
5. Other duties as assigned in accordance with the Medical Staff Bylaws.

VI. PRIVILEGES

A. Requests:

1. Request for general clinical privileges in the Division of Neurology shall be evaluated on the basis of the requesting physician's education, training, competence, judgment, character, experience (as demonstrated by treatment of at least **one-hundred (100) typical Neurology patients** within the past **six (6) months**) – excluding physicians just completing a ACGME American Board of Neurology Residency Program;
2. Recommendations for privileges are made to the Credentials Committee, Medical Executive Committee, and to the Board of Directors. Physicians shall practice only within the scope of the privileges as defined within the department's rules and regulations and stated on the privilege card;
3. All medical staff privileges are located on the Tri-City Medical Center's Intranet;

Privileges	Initial	Proctoring	Reappointment
Lumbar Puncture	Training	1	N/A
EEG Interpretation	Training	N/A	N/A
Nerve Conduction Velocities	Training	N/A	N/A
Electromyography	Training	N/A	N/A
Somatosensory Potentials	Training	N/A	N/A
Brain Stem Evoke Potential	Training	N/A	N/A
Visual Evoke Potential	Training	N/A	N/A
Intrathecal Medications	Training	1	1

NeuroThera Laser	Completion of an approved instruction course in the use of Neuro Thera Laser	N/A	N/A

B. Classifications:

1. The Division of Neurology has established the following classifications of privileges:

i **Physicians – Neurology**

a. The Division of Neurology consists of physicians who are Board Certified or in the first thirty-six (36) months of Board Eligibility and are actively pursuing certification by the American Board of Psychiatry and Neurology and 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 their level of competence;
3. Specialized treatment or procedures are contemplated with which they are not familiar;

ii **Nurse Practitioner:**

a. Nurse practitioner means a registered nurse who posses' additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary care and who has been prepared in a program. The nurse practitioner shall function under standardized procedures or protocols covering the care delivered by the nurse practitioner. The nurse practitioner and his/her supervising physician who shall be a neurologist will develop the standardized procedure or the protocols with the approval of the Division of Neurology;

iii **Physician Assistant:**

a. 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 care for by that physician assistant. The supervising physician must have approval from the Medical Board of California to act as a supervising physician. The supervising physician shall review, countersign, and date within seven (7) days the medical record of any patient for whom the physician assistant issues or carries out a drug order and shall also review, audit, and countersign every medical record written by the physician assistant within 30 days of the encounter.

VII. **REQUIREMENTS FOR INITIAL**

A. Members of the Division who are Board Eligible when initially granted privileges, and who were 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.

VIII. **REAPPOINTMENT**

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).

IX. **PROCTORING**

A. Each new medical staff member granted initial or additional privileges shall be evaluated by a proctor as delineated by the Division of Neurology. If enough cases have not been admitted, or evaluation of the new medical staff member's performance cannot be completed in the first year, then an additional year of provisional staff will be recommended;~~.~~

B. Supervision of the new medical staff member by the proctor will emphasize concurrent or retrospective chart review and include direct observation of procedural techniques. The new medical staff member must notify his proctor at the time a procedure is scheduled or planned. If the proctor is not available, the new medical staff member must notify another physician in the appropriate subspecialty area. If the procedure must be done as an emergency without proctoring, the proctor must be informed at the earliest appropriate time following the procedure;~~.~~

C. All active staff medical staff members of the Division of Neurology will act as proctors to monitor quality of performance of medical care with assigned privileges. An associate of the new medical staff member may monitor 50 % of the required proctoring. Additional cases may be proctored as recommended by the Division Chief:

D. A report shall be completed on which the proctor will address the patient's diagnosis, the overall impression and a recommendation (i.e. qualified, needs further observation, not qualified)

E. Forms will be made up by the new medical staff member admitting the patient and immediately forwarded to the proctor for completion. It is the responsibility of the new medical staff member to notify the proctor of each case;~~.~~

F. 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 within one week after the patient's discharge from the hospital;~~.~~

G. Length of the Probationary Period:

1. Each new medical staff member(s) to the Division of Neurology granted initial membership status will have his or her initial six (6) in-hospital cases proctored by a member of the Division.

X. **EMERGENCY DEPARTMENT CALL**

A. Medical Staff Division Members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Please refer to Medical Staff Policy and Procedure #520;~~.~~

B. Courtesy or provisional staff may participate in the Emergency Department Call Roster at the discretion of the division chief.

APPROVALS:

Division of Neurology:		~~4/23/13~~ 07/01/2015
Department of Medicine:		~~4/23/13~~ 07/01/2015
Medical Executive Committee	:	~~5/20/13~~ 07/27/2015
Governance Committee		
Board of Directors Approval:		~~5/30/13~~

I. MEMBERSHIP

The Division of Oncology consists of physicians who are board certified or in the first thirty-six (36) months of board eligibility and actively pursuing certification by the American Board of Internal Medicine/Hematology, American Board of Internal Medicine/Medical Oncology, American Board of Radiology/Radiation Oncology, or the American Osteopathic Board of Internal Medicine/Oncology.

II. FUNCTIONS OF THE DIVISION

The general functions of the Division of Oncology shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Division clinical practice;

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

E. Submit written minutes to the ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Division review and evaluation activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital;~~.~~

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

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

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

III. DIVISION MEETINGS

The Division of Oncology shall meet at least annually or at the discretion of the Chief. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the ~~QA/PI/PS~~ Medical Qualituy Peer Review Committee, and then to the Medical Executive Committee.

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

IV. DIVISION OFFICERS

The Division shall have a Chief who is a member of the Active Medical Staff and shall be qualified by training and experience, and demonstrate ability in at least one of the clinical areas covered by the Division.

The Division Chief shall be elected every year by the Active members of the Division who are eligible to vote. If there is a vacancy for any reason, the Department Chairman shall designate a new Chief, or call a special election. The Chief shall be elected by a simple majority of the members of the Division.
The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

V. DUTIES OF THE DIVISION CHIEF

The Division Chief shall assume the following responsibilities:

A. Be accountable for all professional and administrative activities of the Division;
B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
C. Assure that practitioner's practice only within the scope of their privileges as defined within their delineated privilege card;
D. Recommend to the Department of Medicine and the Medical Executive Committee the criteria for clinical privileges in the Division;
E. Recommend clinical privileges for each member of the Division;
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Other duties as recommended from the Department of Medicine or the Medical Executive Committee.

VI. REQUESTS FOR PRIVILEGES/PROCEDURES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office;
B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated;
C. Privilege requests in the Division of Oncology shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance and documented results of patient care and proctoring. Practitioners practice only within the scope of their privileges. Recommendations for privileges are made to the Credentials Committee and Medical Executive Committee;
D. Procedures that may be performed by practitioners caring for oncology patients are included below. The applicant will be responsible for requesting privileges for all procedures he/she wishes to perform, and for listing his/her qualifications, training and experience concerning the requested procedures in accordance with established criteria;
E. Privileges designated with "(OPIC)" may also be performed at the Outpatient Infusion Center at 3617 Vista Way, Oceanside, CA, 92056.

PHYSICIAN

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Admit patients	Training	Three (3)	N/A
Consultation (OPIC)	Training	Three (3) which include evaluation of chemotherapy	N/A

		management, indications for performing bone marrow study, hematology work up and management, and the technique of use of the Jamshidi core biopsy needle.	
Perform medical history and physical examination	Training	N/A	N/A
Moderate Sedation	Per Policy 8710-517	Per Policy 8710-517	Per Policy 8710-517
MEDICAL ONCOLOGY			
Thoracentesis	Training	One (1)	One (1)
Paracentesis	Training	One (1)	One (1)
Bone Marrow	Training	One (1)	One (1)
Lumbar Puncture	Training	One (1)	One (1)
Plasmapheresis	Training	One (1)	One (1)
RADIATION ONCOLOGY			
All routine radiation therapy procedures	Training	N/A	N/A
Brachytherapy, interstitial (permanent or temporary)	Documentation of the performance of five (5) cases	One (1)	Two (2)
Brachytherapy, intracavitary	*Documentation of the performance of two (2) cases*	One (1)	One (1)
Teletherapy	Training	One (1)	One (1)

PHYSICIAN ASSISTANT

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
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. (OPIC)	Training	Ten (10) from category	N/A
Order or transmit an order for x-ray, other studies, therapeutic diets, physical/rehab therapy, occupational/speech therapy, respiratory therapy, and nursing services. (OPIC)	Training		N/A
Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures. (OPIC)	Training		N/A
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. (OPIC)	Training		N/A

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. (OPIC)	Training		N/A
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. (OPIC)	Training		N/A
Initiate and facilitate the referral of patients to the appropriate health facilities, agencies and resources of the community. (OPIC)	Training		N/A
Administer medications to a patient, or transmit orally, or in writing on a patient's record, a prescription from his or her supervising physician to a person who may lawfully furnish such medication or medical device. The supervising physician's prescription, transmitted by the physician assistant, for any patient cared for by the physician assistant, shall be based either on a patient-specific order by the supervising physician or on written protocol which specifies all criteria for the use of a specific drug or device and may contraindications for the selection. A physician assistant shall not provide a drug or transmit a prescription for a drug other than that drug specified in the protocol, without a patient specific order from a supervising physician. At the direction and under the supervision of a physician supervisor, a physician assistant may hand to a patient of the supervising physician a properly labeled prescription drug prepackaged by a physician, a manufacturer, as defined in the Pharmacy Law, or a pharmacist. In any case, the medical record of any patient cared for by the physician assistant for whom the physician's prescription has been transmitted or carried out shall be reviewed and countersigned and dated by a supervising physician within seven (7) days. A physician assistant may not administer, provide or transmit a prescription for controlled substances in Schedules II through V inclusive without patient-specific authority by a supervising physician. (OPIC)	Training		N/A
Perform surgical procedures without the personal presence of the supervising physician that are customarily performed under local anesthesia. Prior to delegating any such surgical procedures, the supervising physician shall review documentation, which indicates that the physician assistant is trained to perform the surgical procedures. All other surgical procedures requiring other forms of anesthesia may be	Training	Ten (10)	N/A

performed by a physician assistant only in the personal presence of an approved supervising physician. In addition, ten (10) proctored cases will be required.			
Iliac Crest Biopsy / Aspiration	Training	Three (3)	N/A

NURSE PRACTITIONER

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Facilitate patient admission and discharge	Training	N/A	N/A
Perform History & Physical examination	Training	Five (5)	N/A
Record and document daily on progress notes	Training	N/A	N/A
Make daily rounds on sponsoring physician's patients	Training	N/A	N/A
Collaborate on the assessment, diagnosis, evaluation, and management plan for patients	Training	N/A	N/A
In collaboration with sponsoring physician, order or transmit and order for x-ray,other studies, therapeutic diets, physical and rehab therapies, occupational therapy, respiratory therapy, speech-language pathology and nursing services.	Training	N/A	N/A
Administer pharmacological interventions intrinsic to sponsoring physician or subspecialty consult	Training	Five (5)	N/A
Administeroxygen	Training	N/A	N/A
Administer medical devices intrinsic to sponsoring physician or subspecialty consult	Training	N/A	N/A

PHYSICIST (MEDICAL/RADIATION)

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Design treatment plan (including consideration of dose limiting structures)	Training	First five (5) cases	N/A
Coordinate treatment simulations and tumor localizations using specified imaging devices such as CT and MRI	Training		N/A
Supervise, perform, or assist in planning of beam modifying devices and/or molds, casts and other immobilization devices	Training		N/A
Implement treatment plan (using correct immobilization devices, field arrangement and other treatment variables)	Training		N/A
Perform accurate calculations for delivery of Radiation Oncologist's prescribed dose	Training		N/A
Supervise, perform, or assist in application of specific methods of dosimetry to include ion chamber, TLD, film measurement as directed by the Medical Physicist	Training		N/A
Assist in intracavitary and interstitial brachytherapy procedures and in subsequent calculations of dose distribution	Training		N/A

VII. REAPPOINTMENT

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).

VIII. CLASSIFICATIONS

The Division of Oncology has established the following classifications of medical privileges:

A. PHYSICIANS - Medical Oncologists

Physicians are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training in Medical Oncology. 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;

B. PHYSICIANS - Radiation Oncologists

Physicians are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training in Radiation Oncology 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. PHYSICIAN ASSISTANT – Refer to AHP Rules and Regulations for further delineation of sponsoring physician's supervision responsibilities and credentialing criteria.

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 patients cared for by that physician assistant;

D. NURSE PRACTITIONER – Refer to AHP Rules and Regulations for further delineation of sponsoring physician's supervision responsibilities and credentialing criteria.

Nurse Practitioner means a registered nurse who ~~possesses~~possesses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health and illness needs in primary care and who has been prepared in a graduate nursing program. The nurse practitioner shall function under standardized procedures covering the care delivered by the nurse practitioner. The nurse practitioner and his/her supervising physician who shall be an oncologist will develop the standardized procedure or the protocols to be approved by the Division of Oncology;

E. PHYSICIST (Medical/Radiation) - Refer to AHP Rules and Regulations for further delineation of sponsoring physician's supervision responsibilities and credentialing criteria;

The physicist is a member of the radiation oncology team who has knowledge of the overall characteristics and clinical relevance of radiation oncology treatment machines and equipment, is cognizant of procedures commonly used in brachytherapy and has the education and expertise necessary to generate radiation dose distributions and dose calculations in collaboration with the Radiation Oncologist. The physicist will be supervised by his/her Medical Staff Sponsor. The physicist shall be proctored for a minimum of his/her first five (5) cases. The physicist can be proctored by his/her Medical Staff Sponsor, or another Radiation Oncologist who is a member in good standing of the Medical Staff, or another physicist who has already successfully completed their proctoring status.

IX. PROCTORING OF PRIVILEGES

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors;

B. All Active members of the Division will act as proctors. An associate may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief;

C. Evaluation of the member by the proctor shall include concurrent or retrospective chart review and may include direct observation of procedural techniques;

D. The member must notify his/her proctor at the time of a case admission or procedure. If the proctor is not available, the member must notify another physician assigned to the member. If the admission or procedure is being performed on an emergent basis and no proctor is available, an appropriate proctor must be informed at the earliest appropriate time following the procedure;

E. All members for oncology/hematology privileges will be monitored as outlined in the privilege table above;

F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports;

G. A form shall be completed by the proctor, and should include comments on workup, diagnosis, preparation, technique, judgment, overall impression and recommendation (i.e., qualified, needs further observation, not qualified);

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

X. EMERGENCY DEPARTMENT CALL (*Medical Oncologists Only*)

Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520.

Provisional or Courtesy staff members may participate on the unassigned ED call panel at the discretion of the Division Chief.

Approvals:

Division of Oncology:	~~4/23/13~~ 06/26/2015
Department of Medicine:	~~4/23/13~~ 06/26/2015
Medical Executive Committee:	~~5/20/13~~ 07/27/2015
Governance Committee	
Board of Directors:	~~5/30/13~~

I. **MEMBERSHIP**

A. The Division of Psychiatry consists of physicians who are certified or eligible (i.e., meet the criteria to apply/become certified) by the American Board of Psychiatry and Neurology and possess the necessary skills to evaluate and manage complex psychiatric problems. Physicians must become board certified within five (5) years of first appointment to the Medical Staff. The Members of the Division of Psychiatry will diagnose and provide management of acute, chronic and emergency medical conditions in psychiatry provided in the inpatient, emergency room and outpatient settings.

B. Consultative services at the request of other staff physicians.

II. **BASIC ELIGIBILITY REQUIREMENTS**

A. Basic eligibility requirements for the Division of Psychiatry shall include provisions listed above, as well as the following:

1. All members of the Division of Psychiatry shall have completed an accredited residency in Psychiatry.

III. **FUNCTIONS OF THE DIVISION**

The general functions of the Division of Psychiatry, carried out through the medical staff members shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety and appropriateness of care and treatment provided to patients by Division members and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges to practitioners within the Division;

C. Conduct, participate in and make recommendations regarding Continuing Medical Education (CME) programs in clinical practice;

D. Review and evaluate Division adherence to:

1. Medical Staff Policies and Procedures;
2. Sound principles of clinical practice;

E. Submit minutes to the ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee and the Medical Executive Committee concerning: Division's review and evaluation of activities, actions taken thereon, and the results of such action;

F. Make recommendations for maintaining and improving the quality of patient care and patient safety provided in the hospital;

G. Recommend/Request Focused Professional Practice Evaluation as indicated for Medical Staff members (pursuant to Medical Staff Policy 8710-509);

H. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

I. Take appropriate action when important problems in patient care, patient safety, and clinical performance or opportunities to improve patient care are identified;

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

K. Approval of On-Going Professional Practice Evaluation Indicators

IV. **DIVISION MEETINGS:**

A. The Division of Psychiatry shall meet no less than annually, or at the discretion of the Division Chief. The functions of the Division are carried out through the Division's medical staff members and committees thereof, including the monitoring and evaluation of the quality and

appropriateness of the safety, care and treatment provided to patients. Reports shall be transmitted to the Department of Medicine and to the Medical Executive Committee;

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

V. **DIVISION OFFICERS**

A. The Division shall have a Chief who shall be an Active Medical Staff member and a member of the Psychiatry Division;

B. The Active members of the Division who are eligible to vote shall elect the Division Chief every year. If there are vacancies of any officer for any reason, the Department Chairman shall designate a new officer(s), or call a special election;

C. The Division Chief shall serve a one-year term, which coincides with the medical staff year unless they resign, be removed from office, or lose their medical staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves;

1. Duties of the Division Chief:
   - i Be accountable for all professional administrative activities of the Division;
   - ii Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
   - iii Recommend to the Department of Medicine and the Medical Executive Committee the criteria for clinical privileges in the Division;
   - iv Recommend clinical privileges for each medical staff member of the Division;
   - v Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege card;
   - vi Assure that the quality, safety, and appropriateness of patient care provided by Division members are monitored and evaluated through Ongoing Professional Practice Evaluation;
   - vii Continuously assess and improve the quality and safety of care provided by Division members;
   - viii Other duties as may be assigned, in accordance with the Medical Staff Bylaws.

VI. **PRIVILEGES**

A. Requests for privileges in the Division of Psychiatry shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance and the documented results of patient care and proctoring. Practitioners practice only within the scope of their privileges as defined within the Division's Rules and Regulations. Recommendation for privileges is made to the Credentials Committee, and the Medical Executive Committee;

B. All members of the Division of Psychiatry are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training. 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 psychiatric 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.

Procedure	Initial	Proctoring	Reappointment
H&P	Training	3 H&P's either as IP or OP	4 every two years

VII. **REAPPOINTMENT**

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).

VIII. **PROCTORING:**

A. Requirements:

1. Each new member to the Division of Psychiatry will have his or her initial three (3) cases proctored by a member of the Division. These cases may be from any one of the following sources: admissions to the Tri-City Behavioral Health Unit; consults on the medical/surgical floors or in the Emergency Department at Tri-City Medical Center; admissions to the Tri-City Outpatient Behavioral Health Services programs; admissions or consults at other hospitals; consults at skilled nursing facilities; and outpatient cases. A standardized form will be used in the proctoring procedure;
2. Supervision of the medical staff member by the proctor will include concurrent or retrospective chart review. All Active members of the Division of Psychiatry will act as proctors to monitor quality of performance of medical care of assigned privileges. An associate of the new member may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief.

IX. **EMERGENCY DEPARTMENT CALL**

A. Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the medical staff. Please refer to Medical Staff Policy #8710-520.
B. The medical director, or designee, shall cover all emergency consultation needs for the medical center, including emergency room coverage;
C. Should there be insufficient numbers of Active members to provide Psychiatric coverage for the Emergency Department the Division Chief may assign Provisional or Courtesy staff members to participate in the Emergency Department call roster panel;
D. If a call schedule is used, it is the responsibility of the staff member to participate on those days.
E. The on-call psychiatrist is responsible to the Emergency Department, for 24 hours commencing at 0700 hours;
F. The Emergency Department shall determine which psychiatrist to call. Once contacted by the Emergency Department, the psychiatrist is responsible to provide service in accordance with the Medical Staff Rules and Regulations and Policies and Procedures;
G. Emergency Department coverage does include inpatient medical consultation. If the physician is on call for ER, then he/she is also on call throughout the facility;
H. If a dispute arises and a bona fide psychiatric emergency exists and the on-duty psychiatrist chooses not to do the consultation, the Medical Director or his designee, or the Chief of Psychiatry or his designee, will be contacted to provide the consultation.

X. **CONSULTATIONS**

A. A staff psychiatrist who has been contacted by the attending physician may provide inpatient psychiatric consultations;
B. It is the attending physician's responsibility to contact the psychiatric consultant and arrange for consultation;

C. It is not the responsibility of the nursing staff to obtain psychiatric consultation;
D. The care of the patient is not automatically transferred to the consultant, but remains the responsibility of the attending physician. The consultant and the attending physician shall agree at what time that change of his responsibilities should occur;
E. Both the attending physician and psychiatrist transfer the primary care of a patient only upon written order;
F. Consultations shall be done in a timely manner, i.e., within 24 hours after contact between physicians has been established, or by other arrangements by the respective physicians.

XI. **RESTRAINT OR SECLUSION**

A. Refer to hospital Patient Care Services Policy

XII. **PEER REVIEW**

A. The Psychiatric Division shall hold peer review meetings as needed, but at least annually. Only staff psychiatrists shall be in attendance at the peer review meetings. This shall include all members of the Division. Only Active members shall have voting privileges;
B. The purpose of peer review is to provide a forum for discussion of the safe, quality of evidence-based practice of psychiatry at Tri-City Medical Center;
C. Reported violations of psychiatric staff and medical staff behavior, in regards to staff psychiatrists, shall be reviewed. If there is reported conduct, ethical or clinical judgment issues, or non-compliance with the Medical Staff Bylaws, recommendations and findings will be reported to the Medical Executive Committee for review and action.;
D. All information and documents in peer review meetings are confidential and shall not be discussed outside the meeting.

XIII. **FREQUENCY OF VISITS**

A. The attending member must write progress notes at least six days per week on all acute patients in the hospital until the member designates transfer of the patient to a skilled nursing care level (Medical Staff Rules & Regulations – 6/7 days).

XIV. **CO-TREATMENT BY CLINICAL PSYCHOLOGISTS**

A. Clinical psychologists, as Allied Health Professionals, may participate in providing co-treatment to patients in the Behavioral Health Unit, Rehab Unit, and the acute hospital. Co-treatment is the process which allows a clinical psychologist to work in collaboration with the hospital interdisciplinary treatment team in providing clinical services to patients in Tri-City Medical Center. In addition, the clinical psychologist may provide co-treatment to patients with other attending members of the medical staff to patients admitted or treated at Tri-City Medical Center;
B. Clinical co-treatment services will be limited to psychotherapy and psychological assessments. Psychologists will be encouraged to participate in interdisciplinary treatment planning meetings;
C. The attending psychiatrist will maintain all responsibilities and rights to admit, discharge and medically treat and attend these patients. The writing of formal orders will be the responsibility of the attending psychiatrist. Involuntarily detained patients, who are being seen by both a psychiatrist and a psychologist in collaborative treatment, may be authorized for early release by the treating psychologist, but only in consultation with the psychiatrist, and the psychiatrist does not object. If the psychologist and the psychiatrist disagree, the patient shall not be released early, unless the Medical Director overrules the psychiatrist or psychologist opposing the release. If the Medical Director happens to be the attending psychiatrist, then the Chief of the Division of Psychiatry overrules and makes the final decision;

D. The attending psychologist has the option of working with any attending psychiatrist or any other attending physician who is a member of the Medical Staff at Tri-City Medical Center. If a psychologist presents a patient for admission and does not request a specific psychiatrist, the patient will be assigned the psychiatrist on emergency call at the time. Co-treatment with a psychiatrist can only occur if the attending psychiatrist approves it;

E. The attending psychologist and attending psychiatrist will work as a team in providing psychotherapeutic treatment to the patient they are co-treating and will work together to arrange the schedule of therapy sessions;

1. The attending psychologist will be required to document each of the therapy visits in the progress notes of the medical records;
2. The attending psychiatrist must write progress notes on each patient at least six days per week;
3. The attending psychologist, as well as the attending psychiatrist, will be encouraged to attend interdisciplinary team meetings on a weekly basis during the patient's hospital stay;

F. Each new psychologist will receive an orientation and introduction to Tri-City Medical Center and the Behavioral Health Unit by the Medical Director. In addition, psychologists will undergo a preceptorship during their first five co-treatment cases. A psychologist, who is an Allied Health Professional in good standing, with consultation from the Medical Director, may serve as preceptor.

XV. RESTRAINT ASSESSMENT

Physicians, clinical psychologists or nurse practitioners credentialed by the medical staff may serve as restraint evaluators and within one hour after the initiation of the behavior restraint or seclusion, must evaluate the patient's physical or psychological status in person. The supervising psychiatrist must work with the Behavioral Unit staff and must report any death that occurred while a patient was in a behavior restraint or in seclusion to CMS within one day of patient death.

XVI. MARRIAGE AND FAMILY THERAPIST INTERN

A. Initial criteria: master's or doctoral degree in counseling psychology; current registration with the California Board of Behavioral Sciences as an intern; six (6) months of related clinical experience; current BLS certification;

B. Proctoring: First five (5) cases;

C. Privileges Scope: Co-treatment to patients in the Behavioral Health Unit, Acute Rehab Unit and Acute Hospital under the supervision of an attending psychiatrist;

D. Privileges:

1. Conducts individual and group therapy, and documents therapy sessions in the medical record;
2. Develops treatment plans and documents them in the medical record;
3. Completes discharge instructions;
4. Performs psychiatric assessments in the ED and other units throughout TCMC.

XVII. NURSE PRACTITIONER

Nurse practitioner means a registered nurse who possesses additional preparation and skills in the care of mental health patients. The nurse practitioner shall function under standardized procedures covering the care delivered by the nurse practitioner. The nurse practitioner and his/her supervising physician, who shall be a psychiatrist, will develop the standardized procedures, which are subject to the approval of the Division of Psychiatry and other committees as designated by the Medical Staff.

APPROVALS:

Psychiatry Division:	~~06/19/14~~06/26/2015
Medicine Department:	~~06/19/14~~06/26/2015
Medical Executive Committee:	~~06/23/14~~07/27/2015
Governance Committee	
Board of Directors:	~~06/26/14~~

I. MEMBERSHIP

The Division of Pulmonary consists of physicians who are board certified or actively in the process of obtaining certification by the American Board of Internal Medicine in Pulmonary Disease, and possess the necessary skills to evaluate and manage complex medical problems, expected of a Pulmonary specialist.

II. FUNCTIONS OF THE DIVISION

The general functions of the Division of Pulmonary shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Division clinical practice;

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

E. Submit written minutes to the ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Division review and evaluation activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital;~~.~~

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

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

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

III. DIVISION MEETINGS

The Division of Pulmonary shall meet at least annually or at the discretion of the Chief. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the ~~QA/PI/PS~~ Medical Quality Peer Review Committee, and then to the Medical Executive Committee.

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

IV. DIVISION OFFICERS

The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Division.

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

The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

V. DUTIES OF THE DIVISION CHIEF

The Division Chief shall assume the following responsibilities:

A. Be accountable for all professional and administrative activities of the Division;
B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege card;
D. Recommend to the Department of Medicine and the Medical Executive Committee the criteria for clinical privileges in the Division;
E. Recommend clinical privileges for each member of the Division;
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Continuously assess and improve the quality and safety of care provided in the Division;
H. Other duties as recommended from the Department of Medicine or the Medical Executive Committee.

VI. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office;
B. All privileges may be performed at Tri-City Medical Center. Privileges annotated with (F) may be performed at the Forensic Outpatient Clinic;
C. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated;
D. Requests for privileges in the Division of Pulmonary shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance and the documented results of patient care and proctoring. Practitioners practice only within the scope of their privileges as defined within the respective Division's Rules and Regulations. Recommendation for privileges is made to the Credentials Committee and the Medical Executive Committee;
E. All members of the Division of Pulmonary are expected to have training, experience, and competence on a level commensurate with that provided by specialty training. 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;
F. Special procedures that may be performed by physicians caring for pulmonary patients are outlined in the list below. The member will be responsible for checking all procedures he/she

wishes to perform and for listing his/her qualifications, training and experience concerning the requested procedures in accordance with established criteria

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Admit patients Consultation, including via telemedicine (F) and sleep tests/polysomnography	Board certified or actively in the process of obtaining certification by the American Board of Internal Medicine in Pulmonary Disease. If training was completed more than 24 months prior to application, documentation of twenty (20) cases within the previous 24 months reflective of the scope of privileges requested is required.	Six (6) inpatient cases (includes five (5) conventional care and one (1) telemetry or ICU case)	N/A
Perform history & physical examination, including via telemedicine (F)		Eligible for release from proctoring once six (6) admits or consult cases have been released from proctoring.	
Arthrocentesis Bronchoscopy with and without biopsy Chest tube insertion Insertion of pulmonary artery catheter Intubation Lumbar puncture Paracentesis Percutaneous arterial catheter insertion Percutaneous central venous catheter Thoracentesis – pleural biopsy		Ten (10) cases from this category	Twenty (20) representative blend of cases
Percutaneous tracheostomy	1. Concomitant bronchoscopy privileges 2. Documentation of hands-on training course required if residency or fellowship training did not include training for percutaneous tracheostomy. If training was completed more than 24 months prior to application, documentation of five (5) cases is required.	Three (3)	Five (5)
Moderate sedation	See policy 8710-517	See policy 8710-517	See policy 8710-517

VII. **REAPPOINTMENT**

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).

VIII. PROCTORING OF PRIVILEGES

A. Each new member to the Division of Pulmonary will have six (6) inpatient cases proctored by a member of the Division. This should include five (5) conventional care cases and one (1) Telemetry or ICU admission~~;~~.

B. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors~~;~~.

C. All Active members of the Division will act as proctors. An associate may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the Division Chief to inform the monitored member whose proctoring is being continued as to the nature of the deficiencies~~;~~.

D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled). If the proctor is not available, the member must notify another physician in the appropriate subspecialty area. If the procedure must be done as an emergency without proctoring, the proctor must be informed at the earliest appropriate time following the procedure~~;~~.

E. Supervision of the member by the proctor will emphasize concurrent or retrospective chart review and may include direct observation of procedural techniques.

F. The member shall have free choice of suitable consultants~~;~~.

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

IX. EMERGENCY DEPARTMENT CALL

Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520.
It is the policy of the Emergency Department that when it is discovered that a member has previously treated a patient, that member will be given the opportunity to provide further care.
Provisional staff members may be assigned to the Emergency Department Call Roster by the Chief of the Division. The care provided by an on-call physician will not create an obligation to provide further care.

APPROVALS:

Division of Pulmonary:	~~5/12/14~~ 06/25/2015
Department of Medicine:	~~5/12/14~~ 06/25/2015
Medical Executive Committee:	~~5/19/14~~ 07/27/2015
Governance Committee:	
Board of Directors:	~~5/29/14~~

I. **MEMBERSHIP:**

The Department of Emergency Medicine consists of physicians who are Board Certified by the American Board of Emergency Medicine or have completed an approved residency in Emergency Medicine, and/or are board eligible through the American Board of Emergency Medicine and actively pursuing Board Certification in Emergency Medicine through that Board. Board certification is required within two (2) years of joining the Department of Emergency Medicine. If Board certification lapses, the physician will have two (2) years to provide proof of recertification; if after the two (2) years proof of recertification has not been received, the physician will be placed on automatic suspension. If proof of recertification is not received within 90 days following the next available testing date, the physician will be automatically terminated.

The department, at its sole discretion, may also admit Physicians Assistants (PA) upon a majority vote of physician members. These PAs must be certified by the National Commission on Certification of Physician Assistants (NCCPA) or be board eligible and actively pursuing Board Certification as Physician Assistants through the NCCPA. Board certification is required within two (2) years of appointment and must be maintained at all times. Each PA must hold a current valid California PA license issued by the Physician Assistant Examination Committee of the State of California. If the California PA license has lapsed, the PA will be placed on automatic suspension until proof of license renewal is received. If the NCCPA certification has lapsed, the PA will have two-hundred (200) days from notification by the Medical Staff Office to provide proof of recertification; if after the two-hundred (200) days proof of recertification has not been received, the PA will be placed on automatic suspension until proof of recertification is received.

Each Physician who wishes to supervise PAs must sign a Delegation of Services Agreement with the PA. Each physician may supervise only two (2) PAs at a time/day (i.e., per clinical shift). Each PA may have more than one supervisory physician.

II. **FUNCTIONS OF THE DEPARTMENT:**

A. 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 Department and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for granting clinical privileges and evaluating the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Department clinical practice;

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

E. Submit written minutes to the ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Department review and evaluation of activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital;~~.~~

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;~~.~~

G. Take appropriate action when important problems in patient care, patient safety, and clinical performance or opportunities to improve patient care are identified;~~.~~

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to

Medical Staff Policy #8710-509.);
I. Approve On-Going Professional Practice Evaluation Indicators; and
J. Supervise the physician assistants' quality of Emergency Department care;
K. Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee and Board of Directors.

III. **DEPARTMENT MEETINGS**

The Department shall meet ten (10) times per year or at the discretion of the Chair. The Department will consider the findings from the ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the ~~QA/PI/PS~~ Medical Quality Peer Review Committee, and then to the Medical Executive Committee.

Twenty five percent (25%) of the Active physician members of the Department, but not less than five (5) members, shall constitute a quorum at any department meeting.

Physician Assistants may attend department meetings. They may participate in a non-voting capacity in peer review and performance improvement or other activities as directed by the Chair. They shall have no vote on Departmental affairs.

IV. **DEPARTMENT OFFICERS**

The Department shall have a Chair and a Vice-Chair who shall be members of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in the clinical areas covered by the Department.

The Department Chair and Vice-Chair shall be elected every year by the Active staff members of the Department who are eligible to vote. If there is a vacancy for any reason, the position shall be filled for the unexpired term through a special election. The Chair shall be elected by a simple majority of the members of the Department.

The Department Chair and Vice-Chair shall serve a one-year term, which coincides with the Medical Staff year unless they resign, are removed from office, or lose their Medical Staff membership or clinical privileges in the Department. Department officers shall be eligible to succeed themselves.

Emergency Department officers may serve a maximum of two (2) consecutive years.

V. **DUTIES OF THE DEPARTMENT CHAIRMAN**

A. The Department Chair, and the Vice-Chair in the absence of the Chair, shall assume the following responsibilities:
B. Be accountable for all professional and administrative activities of the Department.
C. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department;
D. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;
E. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;
F. Recommend clinical privileges for each member of the Department;
G. Assure that the quality, safety, and appropriateness of patient care provided by members of the Department are monitored and evaluated; and

H. Other duties as recommended from the Medical Executive Committee.

VI. **PRIVILEGES**

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.

B. **Initial Criteria - Physicians:**

1. Requests for General Patient Care privileges in the Department of Emergency Medicine shall be evaluated on the basis of the requesting physician's education, training, competence, judgment, character, experience (as demonstrated by treatment of at least one-hundred (100) typical Emergency Department patients within the past six (6) months – excluding physicians who have completed an ACGME American Board of Emergency Medicine Residency Program within the past twelve (12) months), ability to perform in Tri-City Emergency Department, the needs of the department, and the ability to function as a member of the Emergency Department team. Formal documentation of procedure experience may be requested at the discretion of the Department Chair.

C. All new physicians in the Department of Emergency Medicine shall be required to work up to eight (8) night shifts per month (or half of their total shifts if working part time) for at least six (6) years. Physicians shall practice only within the scope of the privileges as defined within the Department's rules and regulations and stated on the privilege form. However, in any emergency situation, an Emergency Medicine Physician may perform any procedure(s) for which he/she has proper training and/or experience, even if not delineated on his/her privilege card. The performance of such procedures may be reviewed by the Department Chair or by the ~~QA/QI/PI~~Medical Quality Peer Review Committee, at the Chair's discretion.

Physician Privilege Table			
General Patient Care Privileges	**Initial - *see statement above***	**Proctoring**	**Reappointment every two years**
As part of General Patient Care Privileges, all physicians are authorized to 1) perform occult blood testing and 2) order diagnostic and therapeutic tests (and other associated testing within their scope of practice, or for any emergency procedure, which, in the physician's judgment, is deemed indicated), services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.			

Physician Privilege Table			
General Patient Care Privileges	**Initial - *see statement above***	**Proctoring**	**Reappointment every two years**
Anesthesia: • Regional anesthesia • Nerve blocks	Training/experience as demonstrated by treatment of at least one-hundred (100) typical Emergency Department patients within the past six (6) months – excluding physicians who have completed an ACGME American Board of Emergency Medicine Residency Program) within the past twelve (12) months	~~First t~~Twenty-five (25) cases of General Patient Care	Two-hundred (200) typical General Patient Care cases (100 must be performed at TCMC)
Cardiac Procedures • CPR/ACLS • Cardioversion/Defibrillation • Transthoracic and transcutaneous pacing • Pericardicentesis • Emergency thoracotomy • Thrombolytic administration • EKG interpretation • ~~U/S guided~~ ~~p~~Pericardiocentesis			
Dermatology: • I&D of abscess • Digital nail removal • Subungual hematoma drainage • Soft tissue aspiration • Laceration repair			
Gastroenterology: • Nasogastric tube insertion • Anoscopy • Thrombosed external hemorrhoids • Paracentesis ~~with/without U/S guidance~~ • Hernia reduction • Digital rectal exam			
General Surgery: • Wound & laceration management • Soft tissue foreign body removal • ~~U/S Guided FAST exam~~			
Neurology/Neurosurgery • Emergency burr hole • Lumbar puncture • Spinal immobilization • Neurologic exam			

Physician Privilege Table			
General Patient Care Privileges	**Initial - *see statement above***	**Proctoring**	**Reappointment every two years**
Orthopedics: • Splinting/Casting • Dislocation management • Emergency fracture management • Extensor tendon repair • Arthrocentesis • Measurement of compartment pressures			
OB/GYN: • Emergency childbirth • Culdocentesis • GYN exam • I & D Bartholin abscess			
Ophthalmology: • Slit lamp examination • Ocular foreign body removal • Ocular irrigation • Tonometry • Fundoscopic exam			
Otolaryngology: • Direct laryngoscopy • Foreign body removal: ear, nose, throat • Peritonsillar abscess drainage • Nasal packing • Nasal cautery • Cerumen removal • Dental nerve block			
Pediatrics: • Advanced airway management of infants/children • Advanced life support for infants/children • Intraosseous line placement for infants/children • Lumbar puncture • Suprapubic bladder aspiration • Management of lacerations • Emergency fracture/ dislocation management			
Respiratory Procedures:			

Physician Privilege Table			
General Patient Care Privileges	**Initial - *see statement above***	**Proctoring**	**Reappointment every two years**
• Advanced airway management/techniques • Surgical airway placement • Mechanical ventilation • Thoracentesis • Tube/Needle thoracostomy • ABG interpretation • BVM ventilation • Bronchodilator treatment			
Urology: • Suprapubic bladder aspiration • Suprapubic cystostomy placement • Foley catheter placement • Management of urinary retention • U/A interpretation			
Vascular Access: • Venous cutdown • Central line placement • Midline catheter placement • Intraosseous line placement • Arterial line placement ~~• Ultrasound guided line placement~~ • Peripheral IV placement			
OTHER			
Base station supervision	Training	N/A	N/A
Sedation: • Moderate • Deep	Per policy Medical Staff #8710-517	Per policy Medical Staff #8710-517	Per policy Medical Staff #8710-517
Emergency ultrasound: • Ultrasound guidance of approved procedures • Limited obstetrical ultrasonography • Limited abdominal ~~and cardiac~~ ultrasonography	Per policy Medical Staff #8710-522	Per policy Medical Staff #8710-522	Per policy Medical Staff #8710-522

A. **Initial Criteria- Physician Assistants:**

1. Requests for physician assistant privileges in the Department of Emergency Medicine shall be evaluated on the basis of the needs of the Emergency Department, the requesting PA's education, training, experience, competence, judgment, character, and ability to perform in the Tri-City Emergency Department, and the PA's satisfaction of

qualifications as outlined in the "Membership" section above;.

2. Physician assistants shall also adhere to the Rules and Regulations for Allied Health Professionals. The Department of Emergency Medicine will review the performance of the physician assistants in order to ensure on-going competency in their field as part of their on-going professional practice evaluation process;.
3. A Physician Assistant may provide those Emergency Department services which are consistent with the physician assistant's education, training, experience and "PA Regulations" which are delegated by a supervising physician who is responsible for the patients cared for by that physician assistant. The Physician Supervision requirement (defined by Business and Professions Code Section 3502) is met by the use of protocols, which allow for some or all of the tasks performed by a PA (see PA Privilege Table below). The supervising physician shall review, countersign, and date within seven (7) days the Emergency Department record of any patient for whom the physician assistant issues or carries out a Schedule II drug order.

Physician Assistant Privilege Table			
General Patient Care Privileges	**Initial**	**Proctoring**	**Reappointment every two years**
As part of General Patient Care Privileges, all physician assistants are authorized to 1) Perform occult blood testing and 2) order x-ray, other studies, therapeutic diets, physical/rehab, occupational/speech, and respiratory therapies, and nursing services unless otherwise indicated.			
Evaluation, emergency management and triage of neonatal, infants, pediatric, adolescents, adults, and geriatric patients	PA may be authorized to perform these privileges when competency is established by the Department of Emergency Medicine, taking into account training and experience.	~~First t~~Twenty-five (25) cases of General Patient Care Privileges	Two-hundred (200) typical General Patient Care cases (100 must be performed at TCMC)
Ordering and/or administration of medicine by all routes (orally, IM, IV, PR, aerosolized, inhaler, other) in the Department, and by prescription			
Take a focused or complete medical history, which will include the Medical Screening Exam, including past medical, family, social history, review of systems, and performing focused or complete physical exam			
Anesthesia: • Subcutaneous local anesthetics • Nerve blocks • Dental nerve block			
Cardiovascular: • Taking of EKG and recognition of gross abnormalities			
Dermatology: • Digital nail removal • Subungual hematoma drainage • Treatment of minor 1st and 2nd degree burns			
Gastroenterology: • Nasogastric intubation and gastric lavage • Performance of anoscopy • Thrombosed external hemorrhoids • Collection of specimens: stool • Removal of foreign bodies from rectum, and other • Hernia reduction • Digital rectal exam			
General Surgery:			

Physician Assistant Privilege Table			
General Patient Care Privileges	**Initial**	**Proctoring**	**Reappointment every two years**
• Incision and drainage of superficial skin infections, abscess • Debridement, suture, and care of superficial wounds/lacerations (including facial lacerations) • Arrest of hemorrhage • Soft tissue aspiration • Removal of foreign bodies from skin and soft tissue, and other • Removal of sutures			
Imaging: • Preliminary interpretation of X-rays			
Neurology/Neurosurgery • Spinal immobilization • Neurologic exam			
Orthopedics: • Strapping and immobilizing of sprains/fractures • Splinting/Casting • Dislocation management • Emergency fracture management • Measurement of compartment pressures			
OB/GYN: • GYN Exam • Incision and drainage of Bartholin's abscess • Performance of pelvic exam and pap smear • Removal of foreign bodies from vagina, and other			
Ophthalmology: • Slit lamp examination • Ocular irrigation • Removal of foreign bodies from eyes, and other • Measure intraocular pressure • Ophthalmic, visualization of fundus			
Otolaryngology:			

Physician Assistant Privilege Table			
General Patient Care Privileges	**Initial**	**Proctoring**	**Reappointment every two years**
• Collection of specimens: nasopharyngeal and throat • Anterior nasal packing for epistaxis • Nasal cautery • Removal of impacted cerumen • Performance of otoscopy and nasoscopy • Peritonsillar abscess drainage • Removal of foreign bodies from ear, nose, throat, and other			
Respiratory Procedures: • Drawing ABGs and interpretation • BVM Ventilation • Bronchodilator treatment			
Urology: • Suprapubic Cystostomy Placement • Catheterization and routine urinalysis • Management of urinary retention			
Vascular Access: • Arterial puncture • Drawing of venous blood from peripheral site and peripheral IV placement			
ASSIST ONLY PROCEDURES	**Initial**	**Proctoring**	**Reappointment every two years**
• Performing CPR, assist • Cardioversion/Defibrillation, assist • Transthoracic and transcutaneous pacing, assist • Emergency childbirth, assist • Blood transfusion, assist • Starting thrombolytic medication, assist • Pericardiocentesis, assist • Surgical airway placement, assist • Open thoracotomy, assist • Emergency C-Section, assist	Training/experience	~~First t~~Twenty-five (25) cases of General Patient Care Privileges (includes cases from non-assist only privileges/procedures)	Included in the above required Two-hundred (200) typical General Patient Care cases (100 must be performed at TCMC)

Physician Assistant Privilege Table			
PROCTORED PROCEDURES	**Initial**	**Proctoring**	**Reappointment every two years**
• Lumbar puncture	PA may be authorized to perform these procedures when competency is established by the Department of Emergency Medicine, taking into account training and experience. Emergency Ultrasound privileges must be held by the PA in order to be eligible for Central IV access, Thoracentesis, or Paracentesis privileges in a non-"assist only" role.	3	Included in the above required Two-hundred (200) typical General Patient Care cases (100 must be performed at TCMC)
• Reduction of major joints		3	
• Repair complex lacerations		3	
• Central IV access		3	
• Arterial Line Access		3	
• Endotracheal intubations		3	
• Thoracentesis and Paracentesis		3 combination of paracentesis & thoracentesis cases	
• Arthrocentesis		3	
• Intraosseous line placement, adult/infants/children		3	
• Tube/Needle thoracostomy		3	
Emergency Ultrasound: • Ultrasound guidance of approved procedures • Limited obstetrical ultrasonography • Limited abdominal ~~and cardiac~~ ultrasonography	Per policy Medical Staff #8710-522	Per policy Medical Staff #8710-522	Per policy Medical Staff #8710-522

VII. **REAPPOINTMENT OF CLINICAL PRIVILEGES**

Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. A minimum of 200 Emergency Room cases are required (100 cases must be from TCMC). For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other Emergency Rooms (up to 100 cases) 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).

VIII. **PROCTORING REQUIRMENTS**

A. Each Medical Staff member or Physician Assistant granted initial privileges, or Medical Staff member or Physician Assistant requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Department Chair to the Credentials Committee and to the Medical Executive Committee, with final approval by the Board of Directors;~~.~~

B. All Active members of the Department shall act as proctors. Additional cases may be proctored as recommended by the Department Chair. It is the responsibility of the Department Chair to inform the monitored member whose proctoring is being continued where deficiencies are noted;~~.~~

C. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

D. A form shall be completed by the proctor, and should include comments on the overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be made available from either the Medical Staff Office or the Emergency Department.

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

IX. HOSPITAL ADMITTING ORDERS

A. No members of the department shall write admitting orders.

X. TELEPHONE ADVICE

A. Members of the Department shall not give telephone advice, except in the following situations:

1. A departmental professional relationship has previously been established with a patient, involving recent treatment of the patient for the problem about which they are seeking advice.
2. To provide advice unrelated to their capacity as a member of the department (and without representation of same) including non-departmental professional relationships.

XI. DEPARTMENT QUALITY REVIEW AND MANAGEMENT

A. The Department will have a Quality Review Committee (QRC). The committee Chairman is the Department's representative on the Medical Staff ~~QA/PI/PS~~ Medical Quality Peer Review Committee. The QRC shall meet at least four (4) times per year, or at the discretion of the QRC Chair.

B. General Function

1. The QRC provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by the department members for the patients seen in the Emergency Department.

C. Specific Functions

1. The QRC is established to:
   a) Identify important elements of Emergency Department patients' care in all areas in which it is provided.
   b) Select and approve the Department's performance monitoring indicators;
   c) Identify relevant information for these indicators which will be integrated and reviewed quarterly by the Emergency Department QRC Committee;
   d) Formulate thresholds for evaluation related to these performance monitoring indicators;
   e) Review and evaluate physician practice if specific thresholds are triggered;
   f) Identify areas of concern and opportunities to improve care, safety and educate Department members based on these reviews;
   g) Highlight significant clinical issues and present the specific information regarding quality of care to the appropriate department member, in accordance with Medical Staff Bylaws;
   h) Request Focused Professional Practice Evaluation if/when questions arise regarding a physician's practice;
   i) Monitor and review the effectiveness of any intervention and document any change;

D. Other functions
1. Assist in the reappointment process through retrospective review of charts;
2. Review any issues related to Emergency Department care that are forwarded for review by other Departments/Divisions;
3. Assist in the collection, organization, review, and presentation of data related to Emergency Department patient care and safety;
4. Review all cases involving unanticipated death(s) in the Emergency Department;

E. Reports
1. Minutes will be transmitted to the ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee and the Medical Executive Committee. The QRC will provide minutes and, as needed, verbal, or written communication to the Department members and to ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee regarding any general educational information gleaned through chart review or the quality review process.

XII. **RESIDENT SUPERVISION**

A. Department members shall supervise Emergency Department care provided by residents in Tri-City Emergency Department, and shall examine and document an Emergency Department patient record for all patients seen by a resident. Department members shall countersign/authenticate all charts and orders by residents according to Medical Staff Policy #8710-518 (Medical Records Documentation Requirements).

APPROVALS:
Emergency Medicine Department: 4/24/13 5/27/2015
~~Interdisciplinary Practice Committee: 5/10/13~~
Medical Executive Committee:~~5/20/13~~ 07/27/2015
Governance Committee
Board of Directors: 5/30/13

I. **MEMBERSHIP**

A. The Department of Family Medicine consists of members who have successfully completed an accredited residency program in Family Medicine and are Board Certified or Board Eligible in Family Medicine, or have successfully completed comparable training. This would include Doctors of osteopathy who have been Board Certified or are Board Eligible by the American Osteopathic Board of General Practitioners or its equivalent. Grandfather clause: Established members of the department who do not meet these criteria may remain members of the Family Medicine Department if they otherwise are in compliance with departmental/medical staff rules and regulations.

II. **RESPONSIBILITIES**

A. The Department of Family Medicine shall be responsible for assuring ethical and professional practice of its staff member(s) and shall be dedicated to safe, quality and high standards of patient care.

III. **SCOPE OF SERVICE**

A. Diagnosis and management of acute, chronic, and emergency medical and surgical conditions;
B. Provision of medical care and service provided in the inpatient, emergency room, and outpatient setting;
C. Performance of invasive and non-invasive diagnostic and therapeutic modalities.

IV. **FUNCTIONS**

A. The general functions of the Department of Family Medicine shall include:
   1. Conduct patient care review for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department;
   2. Recommend to the Medial Executive Committee guidelines for the granting of clinical privileges;
   3. Conduct, participate in, and recommend continuing medical education programs pertinent to the department clinical practice;
   4. Review and evaluate department adherence to:
      i Medical Staff Policies and Procedures;
      ii Sound principles of clinical Medicine;
   5. Submit written minutes to the ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee and Medical Executive Committee concerning:
      i The department's review and evaluation activities, action taken thereon, and the results of such action;
      ii Recommendations for maintaining and improving of the quality of patient care and patient safety provided in the department and the hospital;
      iii Recommend/request Focused Professional Medicine Evaluation as indicated for Medical Staff members (pursuant Medical Staff Policy #509);
      iv Approval of On-going Professional Medicine Evaluation Indicators;
   6. Establish such committees or other mechanisms as necessary and desirable to perform properly the function assigned to it, including proctoring. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;
   7. Formulate recommendations for Department Rules and Regulations reasonable necessary for the proper discharge of its final responsibilities subject to the approval of the Medical Executive Committee.

V. **DEPARTMENT MEETINGS**

A. Frequency:

1. The Department of Family Medicine shall meet at least quarterly and at the discretion of the chair for additional meeting requests. The department will consider findings from the ongoing monitoring and evaluation of the quality and appropriateness of care and treatment provided to patients. Minutes shall be transmitted to the ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee and the Medical Executive Committee on a quarterly basis.

B. Quorum:

1. Twenty-five (25) percent of the active department members, but not less than two members, shall constitute a quorum at any meeting.

VI. **DEPARTMENT OFFICERS**

A. The department shall have a Chairman who shall be members of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in the clinical areas covered by the department.

B. The Department Chairman shall be elected every year by the Active Staff members of the department who are eligible to vote. Vacancies of any office for any reason shall be filled for the unexpired term through a special election.

C. The Department Chairman shall serve one year terms which coincide with the Medical Staff year unless they resign, are removed from office, or lose their Medical Staff membership or clinical privileges within the department. Department officers shall be eligible to succeed themselves.

VII. **DUTIES OF THE DEPARTMENT CHAIRMAN**

A. The Department Chairman, shall assume the following responsibilities of the Department:

1. Be accountable for all professional and administrative activities within the department;
2. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department;
3. Recommend to the Medical Executive Committee the criteria for clinical privileges in the department;
4. Recommend clinical privileges for each member of the department;
5. Assure that the quality and appropriateness of patient care only within the scope of their privileges as defined within their delineated privilege card;
6. Assure that the quality, safety and appropriateness of patient care provided with the Department are monitored and evaluated through Ongoing Professional Medicine Evaluation;
7. Continuously assess and improve the quality of care and safety services provided in the department;
8. Other duties as may be assigned, in accordance with the Medical Staff Bylaws.
9. Attend Medical Executive Committee Meetings.

VIII. **PRIVILEGES:**

A. Requests for privileges in Family Medicine shall be evaluated on the individual applicant's documented training and/or experience, demonstrated abilities, current clinical competence, judgment and character. Practitioners practice only within the scope of their privileges as defined in the departments Rules and Regulations. Recommendations for privileges are made to the Credentials and Medical Executive Committee with the Hospital Board granting final approval in accordance with the Medical Staff Bylaws. All privileges for physicians are maintained on Tri-City Medical Center's Intranet and a hard copy within nursing administration and the main operating room.

IX. **REQUEST FOR PRIVILEGES**

A. Family Medicine:

1. Physicians requesting Family Medicine privileges are qualified to admit and care for patients with medical problems without consultation. They are expected to have training and/or experience on a level commensurate with that provided by a residency in the specialty of Family Medicine or its equivalent, are qualified to write History and Physicals, and Consult notes for inpatients, outpatients, Emergency Room patients, and pre-op. Family Medicine Physicians are expected to ask for consultation when:
   - i Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness;
   - ii Unexpected complications arise which are outside this level of competence;
   - iii Specialized treatment or procedures are contemplated with which they are not familiar.

Privilege	Initial	Proctoring	Reappointment
Admitting	Training	Department requirements	NA
Perform H&P	Training	6 H&P as defined within these R&R's	
Incision and drainage	Training	1	NA
Closure of simple lacerations	Training	1	NA
Excision or biopsy of skin or subcutaneous tumor	Training	1	NA
Removal of foreign body by speculum, forceps or superficial incision	Training	NA	NA
Removal of corneal foreign body by superficial curettage	Training	1	NA
Evacuation of thrombosed hemorrhoids	Training	1	NA
Outpatient Wound Care	Pursuant to MS Policy 523		
Hyperbaric Oxygen Medicine Therapy	Pursuant to MS Policy 523[A]		

B. Pediatric:

1. Physicians requesting pediatric privileges are qualified to care for patients with medical problems without consultation. They are expected to have training and/or experience on a level commensurate with that provided by a residency in the specialty of Family Medicine or its equivalent. Physicians with this classification are required to obtain consultation by a pediatrician or other appropriate sub-specialist if the patient is not responding to the treatment being rendered.

C. Obstetrics and Gynecology:

1. Physicians requesting these privileges are qualified to care for uncomplicated obstetrical and/or gynecological patients. They are expected to have training and or experience on a level commensurate with that provided by residency in Family Medicine. Physicians with

this classification are required to obtain consultation by a Obstetrician or other appropriate sub-specialist if the patient is not responding to the treatment being rendered.

D. Surgical Assistant

1. Physicians requesting basic surgical privileges will be required to provide documentation of training and/or experience, demonstrated abilities, and current competence as stated in the Medical Staff Policy #536.

X. **REAPPOINTMENT**

A. Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the 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).

XI. **PROCTORING OF PRIVILEGES**

A. Family Medicine Privileges

1. Each physician's initial or additional privileges shall be proctored by a member of the Department of Family Medicine for at least six (6) cases or until his/her privilege status is established or by a recommendation from the department;
2. If admitting into ACCU or IMC two (2) of the six (6) must be concurrent ICU/Telemetry cases, all other cases may be concurrently or retroactively reviewed. If at the conclusion of this proctoring process, the Chairman (based on the proctor's evaluation), cannot certify that the practitioner is qualified to perform unsupervised care with respect to the requested privileges, proctoring of additional cases will be required;
3. Physicians applying for History and Physical privileges only, may satisfy proctoring requirements by submitting 6 H&P's for retrospective or concurrent review;
4. Applicants for Medical Staff privileges may utilize proctored cases from a hospital where they are on the Active Staff to meet the proctoring requirements, except for ICU/Telemetry privileges. ICU/Telemetry privileges will not be granted until two (2) cases are proctored satisfactorily at Tri-City Medical Center;
5. Procedural privileges will be renewed if the minimum number of cases is met over a two-year period from any and all institutions where the physician has privileges. If the minimum number of cases is not performed, the physician will be required to undergo proctoring for all procedures that were not satisfied. If proctoring requirements are met, the physician will have his/her privileges renewed for a two-year period. If not the physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s);
6. Supervision
   i Supervision of the applicant by the proctor will emphasize concurrent chart review and include direct observation in the case of procedural techniques;
7. Responsibility of Applicant:
   i The applicant must notify his proctor at the time of a case admission or procedure. If the proctor is not available the applicant must notify another physician. If the admission or procedure is being done on an emergent basis and no proctor is available, an appropriate proctor must be informed at the earliest appropriate time following the procedure;
8. Eligible Proctors
   i All active staff members of the Department of Family Medicine will act as proctors. An Associate of the new applicant may monitor 50% of the required proctoring.

Procedures	Requirement(s) for Initial Granting of Privileges	Proctoring Required*	Requirement(s) for Renewal of privileges
Thoracentesis	Training	0	1
Paracentesis	Training	0	1
Lumbar Puncture	Training	0	1
Venous Cutdown	Training	3	0
Proctosigmoidoscopy	Training	0	1
Transcutaneous Insertion CVP Line	5 cases in training or at another facility	2	1
Insertion Arterial Line	5 cases in training or at another facility	2	1

B. Pediatric Privileges

1. Members requesting pediatric privileges must be proctored for at least two (2) cases by a Family Medicine physician who has been granted pediatric privileges, or a pediatrician. If the Chairman of the Department of Family Medicine cannot certify that the practitioner is qualified for unsupervised care of pediatric patients, additional cases will be required.

Pediatric Privileges	Requirement(s) for Initial Granting of Privileges	Requirement(s) for Renewal of privileges	Proctoring Required*
Lumbar Puncture	Training; 2X/2years	1	*1
IV Administration of Fluids and Electrolytes	Training	NA	N/A
Direct Laryngoscopy	Training	NA	N/A
Newborn Circumcision	Training	1	
Standby for Pediatric Assistance Delivery and C-Section	Training & (NRP required)	NA	
Endotracheal Intubation	Training	1	*1

C. Obstetrical and Gynecological Privileges

1. Obstetrics:

i Members requesting obstetrical privileges must be proctored for at least five (5) cases by an Ob/Gyn or a Family Medicine physician who has been granted obstetrical privileges and has completed proctoring by demonstrating competency in these procedures. If the chairman of the Department of Family Medicine cannot certify that the practitioner is qualified for unsupervised care of obstetrical privileges, additional cases will be required. The following privileges must be proctored by an Obstetrician or Department or Family Medicine physician with OB Privileges:

OB Privileges	Requirement(s) for Initial Granting of Privileges	Requirement(s) for Renewal of privileges	Initial Proctoring Required
Spontaneous, uncomplicated, term delivery	Training	4/yr.	First ten deliveries
Simple Episiotomy	Training	2/2yrs.	2

Spontaneous Removal of Placenta	Training	2/2yrs.	2
Second Degree Lacerations and Fourchette Lacerations	Training	2/2yrs.	2
Third and Fourth Degree perineal Lacerations	Training	2/2yrs.	2
Outlet Forceps	OB	2/2yrs.	2

2. Gynecology
   i Members requesting gynecological privileges must be qualified to medically care for uncomplicated gynecological patients. They must be proctored for at least five (5) satisfactory admissions by a family physician who has been granted gynecological privileges or an Ob/Gyn physician. If the chairman of the Department of Family Medicine cannot certify that the practitioner is qualified for unsupervised care of gynecological patients additional cases will be required.

XII. **EMERGENCY DEPARTMENT CALL**

A. Medical Staff department members will participate in the Emergency Department call Roster or consultation panel as determined by the medical staff (Ref. P&P #520).

B. Provisional or Courtesy Staff can be on the unassigned call panel at the discretion of the Department Chair after membership is approved by the Board of Directors.

C. It is the policy of the Emergency Department that when a patient indicates that he or she has been previously treated by a staff member, that member will be given the opportunity to provide further care. The contact member of the Department of Family Medicine will then determine whether to provide further care to an emergency department patient based upon the circumstances of the case. If the member declines, any necessary and/or special care will be provided by the on-call physician.

XIII. **DEPARTMENT QUALITY REVIEW AND MANAGEMENT**

A. The Department of Family Medicine Quality Review Committee will be combined with the Internal Medicine Quality Review Committee. The combined Quality Review Committee (Q.R.C.) will be comprised of no less than 2 department members for Family Medicine and 2 department members for Internal Medicine. The committee chairman will alternate between the Department of Family Medicine and the Division of Internal Medicine and each department/ division will have a representative to the Medical Staff ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee The Department Chairperson shall appoint the remaining members for a 2-year term. Committee members are able to succeed themselves. At least one member from each department/division will be on the Q.R.C., if possible. The Q.R.C. will meet at least 4 times per year.

1. General Function:
   i The Q.R.C. provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by the department members and to patients in the hospital.

2. Specific Functions:
   i The Q.R.C. is established to:
      a. Identify important elements of patient care in all areas in which it is provided.

b. Establish performance monitoring indicators and standards that are related to these elements of care;~~.~~
c. Select and approve their performance monitoring indicators;~~.~~
d. Integrate relevant information for these indicators, and review quarterly by QRC Committee;
e. Formulate thresholds for evaluation related to these performance monitoring indicators;
f. Review and evaluate physician practice when specific thresholds are triggered;
g. Identify areas of concern and opportunities to improve care, safety and educate department members based on these reviews;~~.~~
h. Highlight significant clinical issues and present the specific information regarding qualify of care to the appropriate department member, in accordance with Medical Staff By-Laws;~~.~~
i. Request, If needed, Focused Professional Practice Evaluation when/if questions arise regarding a physician's practice;~~.~~
j. Monitor and review the effectiveness of any intervention and document any change.

3. Other functions:
   - i Assist in the reappointment process, through retrospective review of charts.
   - ii Review any issues related to Family Medicine that are forwarded for review by other departments;~~.~~
   - iii Assist in the collection, organization, review, and presentation of data related to patient care, safety, and department clinical pathways;
   - iv Review cases involving death(s) in the hospital as applicable by approved departmental indicators.

4. Reports
   - i Minutes are submitted to the Medical Staff ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee and the M.E.C. The Q.R.C. will provide minutes and as needed verbal or written communication regarding any general educational information gleaned through chart review or the Performance Improvement process to the department members and to ~~QA/PI/PS~~Medical Quality Peer Review Committee.

APPROVALS:

Department of Family Medicine:	~~4/23/13~~ 4/28/2015
Medical Executive Committee:	~~5/20/13~~ 7/27/2015
Governance Committee:	
Board of Directors:	~~5/30/13~~

I. **MEMBERSHIP**

The Division of Ophthalmology consists of Physicians who are Board Certified or are in the first thirty-six (36) months of Board Eligibility and actively pursuing certification by the American Board of Ophthalmology (or equivalent Osteopathic board), or able to demonstrate comparable ability, training and experience in Ophthalmology.

II. **FUNCTIONS**

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in, and make recommendations regarding continuing medical education programs pertinent to hospital clinical practice;

D. Review and evaluate Division adherence to:

1. Medical Staff policies and procedures;
2. Sound principles of clinical practice;

E. Submit written minutes to the ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee and Medical Executive Committee concerning:

1. Division review and evaluation of activities, actions taken thereon, and the results of such action; and
2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital;

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

I. Approval of On-Going Professional Practice Evaluation Indicators; and

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

III. **DIVISION MEETINGS**

The Division of Ophthalmology shall meet at least annually or at the discretion of the Chief. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the ~~QA/PI/PS~~ Medical Quality Peer Review Committee, and then to Medical Executive Committee. Twenty-five percent (25%) of the Active Division members, but not less than two members, shall constitute a quorum at any meeting.

IV. **DIVISION OFFICERS**

The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the Division.

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

The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her of Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

V. **DUTIES OF DIVISION CHIEF**

A. The Division Chief shall assume the following responsibilities:
1. Be accountable for all professional and administrative activities of the Division;
2. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
3. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege card;
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 that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
7. Other duties as recommended from the Department of Surgery or the Medical Executive Committee.

VI. **PRIVILEGES**

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office;
B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated;
C. General Ophthalmology Category
1. Initial: Board certified, eligible, or demonstrated comparable ability, training, and experience;
2. Proctoring: Six (6) surgical cases must be proctored from either the General Ophthalmology or Retina and Vitreous Surgery Categories as outlined in the list below;
3. Reappointment: Twenty-four (24) cases required per two-year reappointment cycle;
D. Retina and Vitreous Surgery Category
1. Initial: Board certified, eligible or demonstrated comparable ability, training, and experience, and successful completion of a fellowship in vitreo retinal surgery or the equivalent in training and experience;
2. Proctoring: As stated in the General Ophthalmology Category above;
3. Reappointment: As stated in the General Ophthalmology Category above.

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Admit patients	Training	N/A	N/A
Consultation	Training	N/A	N/A
Perform medical history and physical examination	Training	N/A	N/A
Ocular Examination	Training	N/A	N/A
WHOLE EYE SURGERY:	Training	As stated above	As stated above
• Eye enucleation with or without implant			

• Eye evisceration with or without implant			
• Repair of extensive ocular trauma			
• Revision of Surgical Wounds			
ANTERIOR SEGMENT SURGERY:	Training	As stated above	As stated above
• Cataract Surgery, with or without IOL implant			
• Vitrectomy, anterior approach			
• Refractive Corneal procedures			
• Pterygium Excision Simple			
• Pterygium Excision with Autograft			
GLAUCOMA SURGERY:	Training	As stated above	As stated above
• Seton Procedures			
• Trabeculectomy			
EYELID SURGERY:	Training	As stated above	As stated above
• Ectropion Repair			
• Entropion Repair			
• Blepharoplasty of upper eyelids			
• Blepharoplasty of lower eyelids			
• Total, full thickness, eyelid repair			
VITREOUS AND RETINA SURGERY:	Training	As stated above	As stated above
• Sclerotomy, posterior, foreign body, with or without magnet removal			
• Vitreous and Retina procedures for Retina Subspecialists			
• Aspiration or release of vitreous, subretinal, or choroidal fluid, pars plana approach (posterior sclerotomy)			
SPECIALIZED PROCEDURES:	Training	As stated above	As stated above
• Temporal Artery Biopsy			
• Strabismus Surgery			
• Mid Face Lift through a subciliary lower lid blepharoplasty incision			
• Brow Lift, Coronal			
• Peri-orbital and facial resurfacing procedures including laser and chemical peels			
• Peri-orbital and facial tumescent liposuction and fat transfer			
• Orbital exenteration			

• Orbital Surgery:			
LASER PRIVILEGES:	Completion of an ACGME accredited Residency Program	N/A	Recent use at any facility
• Argon			
• Diode			
• YAG			
Moderate Sedation	See Policy 8710-517		
FORENSIC OUTPATIENT CLINIC SITE-SPECIFIC PRIVILEGES:			
Cultures	Training	N/A	N/A
Foreign body removal	Training	N/A	N/A
Biopsy	Training	N/A	N/A
Eye lash removal	Training	N/A	N/A
Rust ring removal	Training	N/A	N/A

VII. **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;

B. Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the physician will be required to undergo proctoring for all procedures that were not satisfied. The physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. **PROCTORING OF PRIVILEGES**

A. Each medical staff member granted initial, or Medical Staff member requesting additional privileges shall be evaluated by a proctor in each surgical case until his surgical competency is established by a recommendation from the Division Chief to the Credentials Committee and to the Medical Executive Committee, with final approval by the Board of Directors. This is to include extensive surgical cases treated in the Emergency Department;

B. All active members of the Division will act as proctors. An associate may monitor 50% of the required proctoring. At least two (2) different proctors shall be used. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the Division Chief to inform the monitored member whose proctoring is being continued, whether the deficiencies noted are in: a) preoperative, b) operative, c) surgical technique and/or, d) postoperative care;

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

D. In elective cases, arrangements shall be made prior to scheduling (i.e. the proctor shall be designated at the time the case is scheduled);

E. The member shall have free choice of suitable consultants and assistants. The proctor may assist the surgeon;

F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports;

G. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Operating Room Supervisor and/or the Medical Staff Office~~.~~

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

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

IX. EMERGENCY DEPARTMENT ON-CALL

A. Medical Staff Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520~~.~~

B. Courtesy and Provisional Staff members may participate in the Emergency Call panel at the discretion of the Division Chief or Department Chair. The care provided by an on-call physician will not create an obligation to provide further care.

APPROVALS:

Division of Ophthalmology:	~~1/11/13~~ 06/25/2015
Department of Surgery:	~~1/11/13~~ 06/25/2015
Medical Executive Committee:	~~1/28/13~~ 07/27/2015
Governance Committee:	
Board of Directors:	~~1/31/13~~

I. MEMBERSHIP

The Division of Podiatric Surgery consists of physicians who are board certified or board qualified and actively pursuing certification by the American Board of Podiatric Surgery. For those members who were granted such privileges on or before June 1, 1991 must demonstrate comparable ability, training and experience.

~~Podiatrists licensed prior to 1984 must be "ankle licensed." (In all instances where Board Certified or Qualified is stated, this refers to the American Board of Podiatric Surgery).~~

II. FUNCTIONS OF THE DIVISION

The general functions of the Division of Podiatric Surgery shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Division clinical practice;

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

E. Submit written minutes to the ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Division review and evaluation activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital;~~.~~

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

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

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

III. DIVISION MEETINGS

The Division of Podiatric Surgery shall meet at least annually or at the discretion of the Chair. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the ~~QA/PI/PS~~ Medical Quality Peer Review Committee, and then to the Medical Executive Committee.

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

IV. DIVISION OFFICERS

The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training and experience, and demonstrated ability in the clinical areas covered by the Division.

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

The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

V. DUTIES OF THE DIVISION CHIEF

The Division Chief shall assume the following responsibilities:

A. Be accountable for all professional and administrative activities of the Division;
B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;
D. Recommend to the Department of Surgery and the Medical Executive Committee the criteria for clinical privileges in the Division;
E. Recommend clinical privileges for each member of the Division;
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Other duties as recommended from the Department of Surgery or the Medical Executive Committee.

VI. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office;
B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Admit patients	Training	N/A	N/A
Perform history and physical examination, including via telemedicine (F)	Training	Six (6) cases	N/A
Surgical Assistant - Surgical assist for DPM in any podiatric procedures (if licensed prior to 1984), and do not hold special ankle license, may assist DPM or any other surgeon as a	Per Medical Staff Policy #8710-536	Per Medical Staff Policy #8710-536	Per Medical Staff Policy #8710-536

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
surgical assist per Medical Staff Policy #8710-536			
Minor Procedures Category			
Capsulotomy, synovectomy, fasciotomy	Documentation of representative blend of fifty (50) Minor Procedure Category cases within the previous 2 years or list from residency.	Six (6) cases from Minor or Major categories	Six (6) cases from Minor Procedures Category
Casting and taping			
Debridement of wounds and wounds/wound grafts			
Excision of foreign bodies			
Excision of neuroma/soft tissue neoplasms			
Excision of skin lesions with biopsy/skin plasty			
Extracorporeal shock wave therapy			
I & D/debridement of soft tissue infection			
Nerve decompression			
Tenotomy, tenoplasty, tendon transfer			
Treatment of Toenails (F)			
Major Procedures Category			
Arthroplasty	Documentation of representative blend of twenty (20) Major Procedure Category cases within the previous two (2) years **or** list from residency. Partial amputation at/or distal to Chopart's Joint only - In addition to initial requirements. Must also be either licensed prior to1984 or hold special ankle license.	Six (6) cases from the Major Procedures Category	Ten (10) cases from the Major Procedures Category
Bunion/Hallux Valgus Corrections			
Debridement of osteomyelitis			
Excision of bone cyst or tumor			
Excision of sesamoid bones			
Fusions			
Osteotomy			
Partial amputation at/or distal to Chopart's Joint (licensed prior to1984 or holding special ankle license)			
Partial or complete resection of metatarsal or phalanges			
Reduction of fractures/dislocation			
Use of bone grafts, implants &			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
internal/external fixation			
Minor Procedures Forensic Outpatient Clinic			
Treatment of Toenails Skin/Callous Debridement Superficial Wound Debridement Injections	Six (6) from prior two years or activity list from residency.	New appointees - five (5) cases of any combination of the Minor Procedures for the Forensic Outpatient Clinic. Current Division members who hold unrestricted podiatric surgery privileges are considered to have satisfied Forensic Outpatient Clinic proctoring requirements.	N/A

VII. REAPPOINTMENT OF CLINICAL PRIVILEGES

A. Procedural privileges may 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);

B. Any member of the Division who was Board Qualified when initially granted surgical privileges, and who was granted such privileges on or after June 1, 1991, shall be expected to obtain Board Certification by the American Board of Podiatric Surgery. Failure to obtain timely certification shall be considered in making Division recommendations regarding applications for reappointment and renewal of clinical privileges. All privileges are accessible on the Tri-City Medical Center intranet and a paper copy is maintained in the Medical Staff Office.

VIII. PROCTORING OF PRIVILEGES

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Division Chief to the 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. All Active members of the Division will act as proctors. An associate may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the *Division Chief* to inform the monitored

member whose proctoring is being continued whether the deficiencies noted are in: a) preoperative, b) operative, c) surgical technique and/or, d) postoperative care;

C. Supervision of the new member by the proctor will include concurrent or retrospective chart review and direct observation of procedural techniques. The new member shall select an appropriate member from the Division of Podiatric Surgery to proctor his/her operative case. The new member shall contact the monitor and inform him/her of his/her plans for the case. **THE MONITOR MUST BE PRESENT IN THE OPERATING ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE SURGEON'S COMPETENCE.** If the proctor is not available, the applicant must notify another physician with the same privileges to proctor. If the procedure must be done as an emergency without proctoring, the proctor must be informed at the earliest appropriate time following the procedure;

D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled);

E. The member shall have free choice of suitable consultants and assistants. The proctor may assist the surgeon;

F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports;

G. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Operating Room Supervisor and/or the Medical Staff Office;

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

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

IX. EMERGENCY DEPARTMENT CALL

Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520.

Provisional staff members may participate on the Emergency Department Call Roster at the discretion of the Chief of the Division.

APPROVALS:
Division of Podiatric Surgery: ~~5/16/13~~5/21/2015
Department of Surgery: ~~6/24/13~~6/18/15
Medical Executive Committee: ~~7/22/13~~ 07/27/2015
Governance Committee:
Board of Directors: ~~7/26/13~~

I. MEMBERSHIP

The Division of Subspecialty Surgery consists of physicians who practice within the medical specialties of Otolaryngology Head and Neck Surgery, Oral Maxillofacial Surgery and Plastic and Reconstructive Surgery. Members may be board certified by the American Board of Otolaryngology Head and Neck Surgery and/or by the American Board of Plastic and Reconstructive Surgery, or by the American Board of Oral and Maxillofacial Surgery. The Division of Subspecialty Surgery also consists of, dental specialists and/or dentists who are either Board Certified or Board Eligible (i.e. successful completion of an ADA accredited residency program) or are able to demonstrate comparable ability, training and experience. The Division will accommodate general dentists and dental specialists who demonstrate comparable ability, training and experience as required for licensure in California.

II. FUNCTIONS OF THE DIVISION

The general functions of the Division of Subspecialty Surgery shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make regarding recommendations regarding continuing medical education programs pertinent to Division clinical practice;

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

E. Submit written minutes to the ~~QA/PI~~ Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Division review and evaluation of activities, actions taken thereon, and the results of such action; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital;

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend / Request Focused Professional Practice Evaluation as indicated for (pursuant Medical Staff Policy 8710-509);

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

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

III. DIVISION MEETINGS

The Division of Subspecialty Surgery shall meet 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. Minutes shall be transmitted to the ~~QA/PI~~ Medical Quality Peer Review Committee, and then to the Medical Executive Committee.

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

IV. DIVISION OFFICERS

The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training and experience, and demonstrate ability in at least one of the clinical areas covered by the Division.

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

The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from the office, or loses his/her Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

V. DUTIES OF THE DIVISION CHIEF

The Division Chief shall assume the following responsibilities:

A. Be accountable for all professional administrative activities of the Division;
B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
C. Assure that practitioner's practice only within the scope of their privileges as defined within their delineated privilege form;
D. Recommend to the Department of Surgery and the Medical Executive Committee the criteria for clinical privileges in the Division;
E. Recommend clinical privileges for each member of the Division;
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Other duties as recommended from the Department of Surgery or the Medical Executive Committee.

VI. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office;
B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated;
C. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified;
D. Proctoring shall be performed by a member of the Medical Staff at TCMC with the same privileges being proctored.

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Admit patients	Training	Six (6) cases	N/A
Consult, including via telemedicine (F)			
Perform history and physical examination, including via			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
telemedicine (F)			
Use of energy sources as an adjunct to privileged procedures: Argon, KTP, CO_2	1. Documentation of completion of training for specific energy source(s) to be used; or 2. Two (2) cases per energy source requested.	Included in general procedural proctoring	Included in general reappointment volume requirements
Moderate Sedation	See Policy 8710-517	See Policy 8710-517	See Policy 8710-517
Otolaryngology – Head and Neck Privileges			
Basic Otology Category:	1. Successful completion of an ACGME or AOA-accredited residency in otolaryngology 2. Documentation of one-hundred (100) cases from the previous twenty-four (24) months representative of the privileges requested.	Two (2) cases from this category	Fifty (50) cases reflective of the Basic Otolaryngology privileges requested
All forms of surgery on the auditory canal, the tympanic membrane (i.e. tympanoplasty, ossiculoplasty), and the contents of the middle ear			
Mastoidectomy			
Basic Rhinologic Category:		One (1) case from this category	
Caldwell Luc procedure			
Excision of tumor ethmoid/cribriform			
Fracture repair – nose			
Nasal polypectomy			
Septoplasty, and turbinate surgery			
Basic Head and Neck Category:		Two (2) cases from this category	
Excision of lesions of skin, subcutaneous tissue, mucosa			
Extraction of teeth incidental to tumor resection or repair of traumatic injury			
Fracture repair – mandible, closed			
Harvesting and grafting of alloplasts, bone, cartilage, fascia, fat, nerve, or skin			
Ligation of head and neck vessels			
Local skin flap			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
reconstruction, including harvest			
Parathyroidectomy			
Reduction of facial fractures, closed and isolated open			
Repair of branchial cysts, ducts, fistulas			
Repair of lacrimal system			
Repair soft tissue – lacerations, avulsions, abrasions			
Salivary gland and duct surgery			
Skin/Soft tissue flap, including harvest			
Skin grafting procedures, full thickness or split thickness			
Surgery of the lymphatic tissues of the head and neck			
Thyroidectomy			
Basic Orthognathic Surgery Category: • Osteotomy • Grafting • Implantation of the upper and lower jaws for treatment of dentofacial and congenital deformities, and obstructive sleep apnea		One (1) case from this category	
Basic Aerodigestive Tract Category: Bronchoscopy/Endoscopy of the airway (larynx, trachea, and bronchial tree) both diagnostic and therapeutic Endoscopy of the upper digestive tract (nasopharynx, hypopharynx, esophagus), both diagnostic and therapeutic, including endoscopic treatment of Zenker's Lip surgery including lip		One (1) case from this category	

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
shave, partial or total resection with primary repair or by local or distant flaps, Cleft lip, and Pedicle lip flap reconstruction			
Surgery on the oral cavity, including soft palate, tongue, mandible, maxilla			
Surgery of the upper aerodigestive tract			
Tonsillectomy, adenoidectomy			
Tracheotomy			
ADVANCED OTOLARYNGOLOGY PRIVILEGES			
Advanced Otology Category:	1. Successful completion of and ACGME or AOA-accredited residency in otolaryngology 2. Documentation of twenty (20) cases from the previous twenty-four (24) months representative of the privileges requested	One (1) case from this category	Twenty (20) cases reflective of the Advanced Otolaryngology privileges requested
Acoustic Neuroma Surgery			
Surgery of the inner ear and stapes			
Temporal bone resection			
Advanced Rhinologic Category:		One (1) case from this category	
Hypophysectomy			
Orbital exenteration			
Sinus surgery, endoscopic and open			
Advanced Head and Neck Category:		One (1) case from this category	
Cleft/Craniofacial Surgery • Correction of primary cleft lip and palate • Correction of residual deformities, fistulae • Correction of palatal incompetence • Craniofacial reconstruction			
Facial nerve repair, grafting, and facial reanimation			
Facial plastic surgery, including blepharoplasty, chemical peel,			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
dermabrasion, liposuction, mentoplasty, otoplasty, rhinoplasty, rhytidectomy, and implantation of autogenous and homologous grafts, and allografts, and repair of lacerations			
Fracture repair – multiple, open, including LeFort			
Infratemporal fossa/deep parotid lobe tumor excision			
Myocutaneous flap, including harvest			
Neck dissection			
Advanced Aerodigestive Tract Category:		One (1) case from this category	
Composite resection			
Esophageal surgery including diverticulectomy and cervical esophagectomy			
Management of oral sinus cavity and pharyngeal malignancy			
Surgery of the larynx, including biopsy, partial or total laryngectomy, fracture repair			
Tracheal resection			
Special Otolaryngology Privileges:			
Bone anchored hearing aid (BAHA) implant	1. Documentation of completion of training course in bone anchored hearing aid implantation; if training was completed greater than two years prior to privilege request, submit case logs from previous twenty-four (24) months identifying performance of BAHA procedure. 2. Concomitant mastoidectomy privileges	One (1) case	Concomitant mastoidectomy privileges and one (1) case

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Microvascular flaps and grafts/free tissue and bone transfer, including harvest	1. Successful completion of a training program that included training in microvascular surgery 2. Eight (8) cases within the previous 24 months	Two (2) cases	Eight (8) cases
PLASTIC AND RECONSTRUCTIVE SURGERY PRIVILEGES			
Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
Basic Plastic and Reconstructive Surgery Category:	1. Successful completion of an ACGME- or AOA-accredited residency in plastic surgery 2. Documentation of one-hundred (100) cases from the previous twenty-four (24) months representative of the privileges requested	Five (5) representative blend of cases	(50) cases reflective of the privileges requested
Aesthetic (cosmetic) surgery of the head and neck, trunk and extremities: • Abdominoplasty • Contouring (body, facial) • Facial nerve repair, grafting, and facial reanimation • Facial plastic surgery, including blepharoplasty, chemical peel, dermabrasion, liposuction, mentoplasty, otoplasty, rhinoplasty, rhytidectomy, and implantation of autogenous and homologous grafts, and allografts, and repair of lacerations • Endoscopic cosmetic surgery • Vein injection sclerotherapy			
Breast Surgery: • Augmentation, cosmetic and reconstructive and implantation			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
• Biopsy • Breast lift (mastopexy) • Congenital anomalies • Mastectomy (subcutaneous and simple) • Reduction			
Burn management, acute and reconstructive			
Debridement of wound			
Harvesting and grafting of alloplasts, bone, cartilage, fat, fascia, nerve, or skin (full or split thickness)			
Flaps, including harvest: • Local skin flap reconstruction • Myocutaneous flap • Skin/Soft tissue flap			
Lymph node dissection/lymphadenectomy			
Repair soft tissue – lacerations, avulsions, abrasions			
Management of Pathology • Disease limited to oral cavity • Infections of the head and neck region • Management of disease of paranasal sinuses, endoscopic and open techniques • Management of salivary gland disease • Management of oral sinus cavity and pharyngeal malignancy			
Orthognathic Surgery, includes: • Osteotomy • Grafting • Implantation of the upper and lower jaws for treatment of			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
dentofacial and congenital deformities, and obstructive sleep apnea			
Treatment of skin neoplasms, diseases, and trauma: • Removal of benign and malignant lesions of the skin and soft tissue • Reconstruction by tissue transfer, including grafts and flaps, including harvest • Reconstruction of soft tissue disfigurement/scar revisions			
Hand Surgery Category:		Two (2) cases from this category	
Surgery of hand, extremity, and tendon injuries, acquired and developmental: • Congenital anomalies • Dislocation repair and fusion • Dupuytren's contracture • Hand/wrist fractures • Joint reconstruction with spacers • Nerve transplants • Rheumatoid repair • Synovectomy • Tumors of the bones and soft tissues • Tendon, nerve, ligament, and vessel repair to include Carpal Tunnel Syndrome			
Advanced Plastic and Reconstructive Surgery Category:			
Breast reconstruction utilizing pedicled or microvascular free flaps	1. Successful completion of an ACGME- or AOA-accredited residency in plastic surgery 2. Five (5) Advanced	One (1) case	Five (5) Advanced Plastic and Reconstructive Surgery procedures

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Cleft/Craniofacial Surgery • Correction of primary cleft lip and palate • Correction of residual deformities, fistulae • Correction of palatal incompetence • Craniofacial reconstruction	Plastic and Reconstructive Surgery procedures during the previous twenty-four (24) months.		
Reconstruction of congenital and acquired defects of the trunk and genitalia			
Reconstructive microsurgery: • Microvascular flaps and grafts/free tissue and bone transfer, including harvest • Replantation and revascularization of the upper and lower extremities and digits • Reconstruction of peripheral nerve injuries	1. Successful completion of a training program that included training in microvascular surgery 2. Eight (8) cases within the previous 24 months	Two (2) cases	Eight (8) cases
GENERAL DENTISTRY			
Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
Dental implantation General restorative dentistry Simple exodontia Periodontal therapy Surgery of Alveolar structures and lower jaw	1. DDS or DMD 2. Twenty (20) cases within previous 24 months	One (1) case for this category, or proctoring considered complete when released from proctoring for Oral and Maxillofacial Surgery category.	Twenty (20) cases
Local and regional anesthesia	1. General Anesthesia Permit 2. Evidence of (10) cases of regional anesthesia administration within the previous 24 months		
ORAL AND MAXILLOFACIAL SURGERY			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Trauma Surgery limited to: • Midface and upper jaw • Multiple trauma to face, including nasoethmoid, orbital and zygoma fractures • Airway management, including cricothyroidotomy and tracheotomy	1. DDS or DMD 2. Successful completion of a training program in Oral and Maxillofacial Surgery 3. One-hundred (100) Oral and Maxillofacial Surgery cases reflective of the scope of privileges requested within the previous 24 months.	One (1) case	Fifty (50) cases reflective of the scope of privileges requested
Management of Pathology • Disease limited to oral cavity • Infections of the head and neck region • Management of disease of paranasal sinuses, endoscopic and open techniques • Management of salivary gland disease • Management of head and neck malignancy		Two (2) cases	
Reconstructive Surgery • Dental implantology • Facial nerve repair, grafting, and facial reanimation • Reconstructive procedures limited to oral cavity and oropharynx • Reconstructive procedures of facial structures • Harvesting tissues		One (1) case	

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
from distant site, i.e. iliac crest, rib, soft tissue flaps			
Orthognathic Surgery, includes: • Osteotomy • Grafting • Implantation of the upper and lower jaws for treatment of dentofacial and congenital deformities, and obstructive sleep apnea		One (1) case	
TMJ Surgery • Endoscopy • Joint implantation and replacement		One (1) case	
Cleft/Craniofacial Surgery • Correction of primary cleft lip and palate • Correction of residual deformities, fistulae • Correction of palatal incompetence • Craniofacial reconstruction		One (1) case	
Facial plastic surgery, including blepharoplasty, chemical peel, dermabrasion, liposuction, mentoplasty, otoplasty, rhinoplasty, rhytidectomy, and implantation of autogenous and homologous grafts, and allografts, and repair of lacerations	1. Permit to 'perform elective facial cosmetic surgery' from the Dental Board of California 2. Ten (10) representative blend of cases within the previous 24 months	Two (2) cases	Ten (10) cases
Minor Procedures Forensic Outpatient Clinic			
Anterior Nasal Packing (F)	As required for general specialty-specific privileges	Proctoring complete when released from specialty-specific proctoring	N/A
Collection of Specimens: Nasopharyngeal, throat, and			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
wound (F)			
Nasopharyngeal Endoscopic Procedures (F)			
Removal of Impacted Cerumen (F)			

VII. REAPPOINTMENT OF CLINICAL PRIVILEGES

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. PROCTORING OF PRIVILEGES

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors;~~.~~

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

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

D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled);~~.~~

E. The member shall have free choice of suitable consultants and assistants. The proctor may assist the surgeon;~~.~~

F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports;~~.~~

G. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified);~~.~~ Blank forms will be available from the Operating Room Supervisor and/or the Medical Staff Office.

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

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

VIII. EMERGENCY DEPARTMENT CALL

Active Medical Staff Division members may participate in the Emergency Department Call Roster subject to the mandatory Medical Staff Bylaws requirement (Section 3.2-2) as needed or consultation panel as determined by the Medical Staff. Please refer to Medical Staff Policy and Procedure 8710-520.

Consulting and Provisional staff members may participate in the Emergency Department Call Roster at the discretion of the Chief of the Division. The care provided by an on-call physician will not create an obligation to provide further care.

APPROVALS:

Division of Subspecialty Surgery:	~~8/18/14~~ 07/01/2015
Department of Surgery:	~~9/04/14~~ 07/01/2015
Medical Executive Committee:	~~9/22/14~~ 07/27/2015
Governance Committee:	
Board of Directors:	~~9/25/14~~

I. MEMBERSHIP

The Department of Surgery consists of physicians in the Divisions of:

A. Cardiac Thoracic
B. General Vascular
C. Subspecialty
D. Podiatry
E. Urology
F. Neurosurgery
G. Orthopedics
H. Ophthalmology

II. FUNCTIONS OF THE DEPARTMENT

The general functions of the Department of Surgery shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients within the division and approve indicators for use in the evaluation of patient care and on-going professional practice evaluation;

B. Recommend to the Medical Executive Committee granting of clinical privileges and the performance of specified privileges within the Department of Surgery;

C. Conduct, participate in and make recommendations regarding Continuing Medical Education programs to include the Department of Surgery clinical practice;

D. Review and evaluate Surgery Department adherence to:

1. Medical Staff Policies and Procedures;
2. Sound principles of safe clinical practice;

E. Submit minutes to the ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee and Medical Executive Committee concerning:

1. Department's review and evaluation of activities, actions taken thereon, and the results of such action;
2. Recommendations for maintaining and improving the quality and safety of care provided in the department and the hospital;~~.~~

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. ~~G.~~ Take appropriate action when problems in patient care, safety, and clinical performance or opportunities to improve patient care are identified;

H. ~~G.~~ Formulate recommendations for departmental / division rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

~~H.~~J. Recommend/Request Focused Professional Practice Evaluation as indicated for Medical Staff members to include initially appointed members (pursuant Medical Staff Policy #509);

J. Approval of On-Going Professional Practice Evaluation Indicators.

III. DEPARTMENT MEETINGS

The Department of Surgery shall meet quarterly or at the discretion of the chair to consider the findings from the ongoing monitoring and evaluation of the quality, safety and appropriateness of the care and treatment provided to patients. Regular minutes shall be transmitted to the ~~QA/PI/PS Committee~~ Medical Quality Peer Review Committee and the Medical Executive Committee.

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

IV. DEPARTMENT OFFICERS

A. The Department shall have a Chairman and a Vice-Chairman who shall be members of the Active Medical Staff and shall be qualified by training, experience and demonstrate ability in at least one of the clinical areas covered by the Department;~~.~~

B. The Active Staff members of the Department who are eligible to vote at the Department meeting shall elect the Department Chairman and Vice-Chairman every year. Vacancies of any officer for any reason shall be filled by the unexpired term through a special election;~~.~~

C. The Department Chairman and Vice-Chairman shall serve a one-year term, which coincides with the medical staff year unless they resign, be removed from office, or lose their medical staff membership or clinical privileges in that department. Department officers shall be eligible to succeed themselves;~~.~~

V. DUTIES OF THE DEPARTMENT CHAIRMAN

The Department Chairman, and the Vice-Chairman, in the absence of the Chairman, shall assume the following responsibilities of the Department:

A. Be accountable for all professional administrative activities of the Department;

B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department;

C. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;

D. Recommend clinical privileges for each member of the Department;

E. Assure that the quality, safety, and appropriateness of patient care provided within the Department are monitored and evaluated;

F. Continuously assess and improve the quality and safety of care provided in the Department;

G. Assure that practitioner's practice only within the scope of their privileges as defined within their delineated privilege card;

H. Other duties may be assigned, in accordance with the Medical Staff Bylaws.

VI. PRIVILEGES

A. Requests for privileges in the Department of Surgery shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance and the documented results of patient care and proctoring. Practitioner's practice only within the scope of their privileges as defined within the respective Division's Rules and Regulations. Recommendations for privileges are made to the Credentials and Medical Executive Committees;

B. Each practitioner's privileges will be assessable on Tri-City's Intra-net (MD-Staff) which is located in each patient care area. A paper copy is maintained within the Nursing Administration Office and the Main Operating Room;

C. The Department of Surgery has established the following classifications of surgical privileges:

1. The Department of Surgery consists of physicians who are Board Certified or in the first thirty-six (36) months of Board Eligibility and actively, pursuing certification by their retrospective specialty boards or able to demonstrate comparable ability, and training. Such surgeons may act as consultants to others and may, in turn, be expected to request consultations when:

   a. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness;

   b. Unexpected complications arise which are outside this level of competence;

   c. Specialized treatment or procedures are contemplated in which they are not familiar.

VII. PHYSICIAN ASSISTANTS

A. Physician Assistants 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.

   1. A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients;

2. 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;

3. 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;

4. 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;

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

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

7. Requests for additional privileges must be accompanied by documentation of training and/or experience. Proctoring is required for all additional privileges and will be determined by the Department/ Division Chair/Chief;
   a. Harvesting of saphenous vein for use as bypass conduit for cardiac and vascular surgery using endoscopic techniques. This privilege requires approval of Cardiothoracic Surgery Division;
8. Refer to the AHP rules and regulations for further delineation of sponsoring physician's supervision requirements;

9. A physician assistant may not admit or discharge patients;

10. Medical / Surgical Units: Documentation of an examination of the patient by the sponsoring physician(s) every third day if care is given by the Allied Health Professional(s);

11. Non-Scheduled Admission(s): Examination of the patient by the sponsoring physician(s) the same day as care is given by the AHP;

B. The Department of Surgery requires a physician co-signature as delineated in the AHP's Rules and Regulations:

1. Order(s) and telephone Order(s) may be immediately implemented and physician co signature required within 24 hours of AHP's order;

2. Any medical record of any patient cared for by a physician assistant for whom the physician's prescription has been transmitted or carried out shall be reviewed and countersigned and dated by the supervising physician within 24 hours;

3. The sponsoring physician must review and authenticate any progress note within the medical record of any patient(s) documented by a physician assistant within 24 hours;.

4. Non-Scheduled admissions: The H&P must be dictated by the sponsoring physician(s) within 24 hours;.

5. ACCU/AMC Units: Examination of the patient by the sponsoring physician(s) the same day care is given by the Allied Health Professional(s).

VII. REGISTERED NURSE FIRST ASSISTANT

A registered nurse first assistant is a healthcare provider who, under the supervision of a physician, performs a variety of pre, intra and postoperative services for patients undergoing a surgical procedure in the surgical suites. The RN first assistant directly assists the surgeon by controlling bleeding, providing wound exposure, suturing and other surgical tasks. The RN first assistant practices under the supervision of the surgeon during the intraoperative phase of the perioperative experience. The RN first assistant functions under standardized procedures and must adhere to the AHP's rules and regulations.

VIII. REQUIREMENTS FOR INITIAL AND REAPPOINTMENT

A. Active certification by the appropriate certifying board or board eligible within appropriate certifying board or demonstration of comparable ability, training and experience shall satisfy the requirements for receiving privileges for all categories as well as for admitting privileges to Tri-City Medical Center;.

B. Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the 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).

IX. CATEGORIZATION OF SURGICAL PRIVILEGES

A. **Divisions and Privileges**

All new medical staff members requesting staff privileges shall be members of the following divisions based on their training and surgical competence.
The Divisions and 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.)

DIVISIONS	PRIVILEGES	MEDICAL STAFF MEMBERS
Cardiac, Thoracic	Cardiac, Thoracic & Vascular Surgery	Board Certified, or Board Eligible or can demonstrate comparable ability, training and experience. Must submit list of open-heart cases within previous one year.
General Vascular	All Peripheral Vascular Surgery & General Surgical Procedures	Board Certified, or Board Eligible or can demonstrate comparable ability, training and experience. Submit list of major procedures done in previous 2 years preceding application.
NEURO	Neurosurgical Procedures	Board Certified, or Board Eligible or can demonstrate comparable ability, training and experience.
OPHTH	Ophthalmology Procedures	Board Certified, or Board Eligible or can demonstrate comparable ability, training and experience.
ORTHO	Orthopedic Surgical Procedures	Board Certified, or Board Eligible or can demonstrate comparable ability, training and experience.
UROL	Urology Surgical Procedures	Board Certified, or Board Eligible or can demonstrate comparable ability, training and experience
Subspecialty ORAL, ENT	Oral, Dental Otolaryngology, Plastic and Reconstructive Surgical, and Maxillofacial Procedures	Board Certified, or Board Eligible or can demonstrate comparable ability, training and experience.
POD	Podiatry Surgery Procedures	Board Certified, or Board Eligible or can demonstrate comparable ability, training and experience

B. **Cross-Over Surgery Privileges**

1. It will be the responsibility of any surgeon requesting privileges within another specialty or division to do any such procedure to notify the Chief(s) of the division(s);

2. Each division so contacted will then review the individual's qualifications to perform the procedure, Pursuant to Medical Staff Policy # 526 Requesting New Privileges;

3. If the privilege is approved, the medical staff member may then perform the procedure in accordance with the proctoring requirements set forth within the respective divisions or medical staff policy;

4. Qualified proctors for procedures in question shall be any surgeons on the active medical staff at TCMC, who has privileges to do the procedure;

5. In order for the new medical staff member to be removed from proctoring of the procedure the division chief, or the surgical chair must sign off on the proctoring form. At the discretion of the division chief or department chair additional proctoring may be recommended;

6. Current staff members who are on record as doing a given procedure would be grandfathered for that procedure. Any current staff member who would like to begin to do any crossover procedure would be required to follow the above guidelines;

C. **Laser Privileges**: See "Laser Privileges" in each designated division.

X. PROCTORING OF PRIVILEGES

A. **Requirement of Proctors**

Each new medical staff member granted initial surgical privileges shall be evaluated by a proctor for six (6) major surgical cases until his surgical privilege status is established by a recommendation from the Division and subsequently the Department of Surgery and to the Credentials Committee and to the Medical Executive Committee. Each of the divisions within the Department of Surgery will define criteria for proctoring requirements for their defined privileges within their rules and regulations. At the discretion of the respective division chief(s) proctoring may be extended for 1) procedures, 2) intra-operative care, 3) post-operative care, and 4) documentation deficiencies. If a member of the division is unable to proctor assigned privileges, outside proctors will be utilized;

B. **Selection of Proctors**

1. The medical staff member shall select an appropriate member for each surgical case admitted. He shall contact the monitor and inform him of his plans for the case. THE MONITOR MUST BE PRESENT IN THE OPERATING ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEDICAL STAFF MEMBER SURGEON'S COMPETENCE OR MAY REVIEW THE CASE DOUMENTATION (i.e. H&P, Op Note and Video) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE MEDICAL STAFF MEMBER SURGEON'S COMPETENCE. An associate of the new medical staff member may monitor 50 % of the required proctoring;

2. 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;

3. Proctor shall observe the medical staff member in each surgical case for an indefinite period, which will cover at least six major surgical cases;

4. If performance issues are identified on initially appointed member(s) of the Medical Staff, a Focused Professional Evaluation (pursuant Medical Staff Policy # 509) may be initiated.

5. The medical staff member shall have free choice of suitable consultants and assistants.

C. **Reports of Proctors**

1. A form shall be prepared on which will be spaces for comment by the proctor on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e. qualified, needs further observation, not qualified).

2. Forms will be made up by the medical staff member scheduling the case for surgery and immediately forwarded to the proctor for completion. It is the responsibility of the medical staff member to notify the Operating Room Supervisor of the proctor for each case.

3. 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.

XI. EMERGENCY DEPARTMENT CALL:

A, Medical Staff Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the medical staff. Please refer to Medical Staff Policy #520.

B. Provisional or courtesy member(s) are able to serve on the Emergency Call panel at the discretion of the Department Chair or Division Chief.

APPROVALS:
~~**Division of Cardiothoracic Surgery: 8/14/14**~~
~~Interdisciplinary Practice Committee: 8/19/14~~
Department of Surgery: ~~8/18/14~~ 06/18/2015
Medical Executive Committee: ~~8/25/14~~ 07/27/2015
Governance Committee
Board of Directors: ~~8/28/14~~

I. **MEMBERSHIP**

The Division of Urology consists of physicians who are Board Certified or actively pursuing certification by the American Board of Urology, or able to demonstrate comparable ability, training, and experience.

II. **FUNCTIONS OF THE DIVISION**

The general functions of the Division of Urology shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Division clinical practice;

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

E. Submit written minutes to the ~~QA/PI Committee~~ Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Division review and evaluation of activities, actions taken thereon, the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified.

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509)

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

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

III. **DIVISION MEETINGS**

The Division of Urology shall meet 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. Minutes shall be transmitted to the, ~~QA/PI~~Medical Quality Peer Review Committee, and then to the Medical Executive Committee.

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

IV. **DIVISION OFFICERS**

The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in the clinical area covered by the Division.

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

The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

V. **DUTIES OF THE-DIVISION CHIEF**

The Division Chief shall assume the following responsibilities:

A. Be accountable for all professional and administrative activities of the Division;
B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;
D. Recommend to the Department of Surgery and the Medical Executive Committee the criteria for clinical privileges in the Division;
E. Recommend clinical privileges for each member of the Division;
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Other duties as recommended from the Department of Surgery or the Medical Executive Committee.

VI. **PRIVILEGES**

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.
B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.
C. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.
D. Sites:
   1. All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056
   2. Privileges annotated with (F) may be performed at the Outpatient Forensic Clinic(s).

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Admit Patients Consultation, including via telemedicine (F) Perform history and physical examination, including via telemedicine (F)	Successful completion of an ACGME or AOA-accredited residency or fellowship program in urology.	Successful completion of procedure-specific proctoring satisfies proctoring for these privileges	N/A
Basic Urology Privileges			
Abdominal procedure(s), incidental Anterior Exenteration Colporrhaphy Incisional Hernia, incidental Inguinal Hernia, incidental	1. Successful completion of an ACGME or AOA-accredited residency or fellowship program in urology. 2. Documentation of at least	Five (5) cases from the Basic Urology Privileges category	Fifty (50) representative blend of cases

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Lithotripsy	of fifty (50) cases within the previous twenty-four (24) months.		
Surgery of the lymphatic system, including lymph node dissection (inguinal, retroperitoneal, or pelvic)			
Male Genital System – all procedures for: • Scrotum • Testis • Vas Deferens • Penis • Retroperitoneal Surgery			
Radical Cystectomy			
Urinary System – all procedures for: • Kidney • Ureter • Bladder • Prostate • Urethra			
Urodynamics - Foley catheter placement (F)			
Special Urology Privileges			
Laser Privileges: • CO_2 Laser • Diode (Greenlight) Laser • Holmium Laser	1. Documentation of completion of training for specific energy source(s) to be used; or 2. 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	One (1) case for each energy source
Moderate Sedation	Per policy 8710-541	Per policy 8710-541	Per policy 8710-541

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Renal Laparoscopy and/or Laparoscopic Nephrectomy	1. Successful completion of an ACGME or AOA-accredited residency or fellowship program in urology that included training in laparoscopy; or 2. Successful completion of a hands-on training course for renal laparoscopic and/or laparoscopic nephrectomy procedures; or 3. Documentation of at least three (3) renal laparoscopic and/or laparoscopic nephrectomy procedures within the previous twenty-four (24) months (required if training was completed more than two years prior to application).	Three (3) renal laparoscopy and/or laparoscopic nephrectomy procedures	Three (3) renal laparoscopy and/or laparoscopic nephrectomy procedures
Robotic Surgery – da Vinci Robotic Surgery, assist – da Vinci	Per policy 8710-563	Per policy 8710-563	Per policy 8710-563

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Sacral Nerve Stimulation	1. Successful completion of an ACGME or AOA-accredited residency program and board certified or actively pursuing board certification in Urology; or successful completion of a urogynecology fellowship program; AND 2. Documentation of successful completion of a training course in sacral neuromodulation therapy; or documentation of performing at least six (6) sacral neuromodulation therapy stimulator tests and implant procedures within the previous twelve (12) months (required if training was completed more than two years prior to application)	One (1) case	Two (2) cases

VI. **REAPPOINTMENT OF CLINICAL PRIVILEGES:**

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).

IX. **PROCTORING OF PRIVILEGES**

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

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

C. **THE MONITOR MUST BE PRESENT IN THE OPERATING ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE,**

OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE SURGEON'S COMPETENCE.

D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).

E. The member shall have free choice of suitable consultants and assistants. The proctor may assist the surgeon.

F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

G. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Operating Room Supervisor and/or the Medical Staff Office.

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

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

X. EMERGENCY DEPARTMENT CALL

Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the medical staff. Please refer to Medical Staff Policy and Procedure #8710-520.

Provisional staff members may be assigned to the Emergency Department Call Roster at the discretion of the Chief of the Division. The care provided by an on-call physician will not create an obligation to provide further care.

APPROVALS:

Division of Urology:	~~6/26/14~~06/15/2015
Department of Surgery:	~~6/26/14~~06/18/2015
Medical Executive Committee:	~~7/28/14~~07/27/2015
Governance Committee:	
Board of Directors:	~~7/31/14~~

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #14-010

POLICY TITLE: **Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson**

I. BOARD MEETING AGENDA DEVELOPMENT

The Board of Directors Agenda shall be developed by the Chairperson, with the assistance of the President/CEO and General Counsel. Individual Board members may place items on the Agenda through the Board Chairperson. The procedure will be:

A. A Board member shall submit a written description of the Agenda item to the Chairperson or the CEO or the Board Secretary, prior to the time of the Agenda Conference. Recognizing that the Agenda Conference meeting date and time may on occasion change, it is the responsibility of the requestor to confirm the Agenda Conference meeting date to ensure timely submittal of the requestor's Agenda item. Discussion items will be placed on the Board Agenda at the request of any Board member. At the beginning of each calendar year, the Chairperson of the Board of Directors shall set the date and time of the Agenda Conference.

B. A member of the public may submit a written request to the President/CEO, Chairperson or a member of the Board of Directors. The written request shall contain a description of the Agenda item. The member of the public shall be informed if and when the item will appear on the Board Agenda.

C. General Counsel, at the Chairperson's or President/CEO's request, shall contact the Board member, or the public member, to confirm the intent of their request, and will then formulate the Agenda item in a format that conforms with legal requirements.

D. Copies of the Agenda shall be posted on the TCHD website and at other public locations as required by law.

II. EFFICIENCY OF BOARD MEETINGS

The Board of Directors and management shall work cooperatively to prepare for and manage Board meetings in a manner that produces efficient and effective meetings (See Policy #10-39). To achieve that end, the following process will be followed:

A. The Board of Directors shall receive their Board Agenda packet with appropriate written information and materials at least five (5) days prior to a regularly scheduled Board of Directors meeting.

B. Board members who require further information or clarification on Board Agenda packet materials are welcome to contact the President/CEO or General Counsel

with questions prior to the meeting. Responses shall be presented to all Board members at the Board meeting.

C. To facilitate deliberation and action on items at Tri-City Healthcare District Board of Directors meetings, suggested written motions may be developed in advance by members of the Board of Directors or Executive Management. Such suggested written motions shall be included in the Board of Directors Agenda packet with supporting materials for the action item.

III. TIME LIMITS FOR BOARD OF DIRECTOR MEETINGS

A. Regular m~~M~~eetings of the Board of Directors shall be a maximum of three and one half (3½) hours for any ~~one~~ open session and a maximum of four hours (4) for any closed session. Agenda items not addressed during those~~at~~ time periods will be carried forward to a subsequent date, which shall be agreed upon by a majority vote of the Board before adjourning the meeting.

B. The time limits under Section A may be waived by a majority of the Board. The waiver shall be effective only for the meeting~~session~~ in which the waiver is approved. A motion for waiver may specify that the limit will be waived entirely for the balance of the session, will be extended for a specified amount of time of at least one-half (1/2) hour, or will be extended only for so long as the Board requires to address one or more specified items on the Agenda for that session.

IV. ROLE AND POWERS OF CHAIRPERSON

The Chairperson of the Board of Directors shall have the authority to act on behalf of the Board of Directors, as provided in the District Bylaws and these policies.

The Board Chairperson shall report any such actions to the Board of Directors at their next regularly scheduled meeting.

Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05
Reviewed by the Gov/Leg Committee: 11/8/06
Approved by the Board of Directors: 12/14/06
Reviewed by the Gov/Leg Committee: 10/10/07
Approved by the Board of Directors: 12/13/07
Received by the Gov/Leg Committee: 12/01/10
Approved by the Board of Directors: 12/16/10
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Revised by the Gov/Leg Committee:

Tri-City Medical Center
Audit, Compliance & Ethics Committee
August 20, 2015
Assembly Room 3
8:30am-10:30am

Members Present:	Director Ramona Finnila (Chair); Director Larry W. Schallock; Director Laura Mitchell; Jack Cumming, Community Member; Barton Sharp, Community Member; Kathryn Fitzwilliam, Community Member
Non-Voting Members:	Steve Dietlin (CFO); Kapua Conley, COO; Cheryle Bernard-Shaw, CCO
Others Present:	Jody Root, General Counsel; Teri Donnellan, Executive Assistant; Pamela Alm, Sr. Administrative Assistant; James J. Dagostino, DPT, PT; Jane Dunmeyer, League of Women Voters; Maria Eskandanian, Michael Slavinski and Leslie Schwartz
Absent:	Tim Moran, CEO; Dr. Frank Corona, Medical Staff Member

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	The meeting was called to order at 8:30 a.m. in Assembly Room 3 at Tri-City Medical Center by Chairperson Finnila. Chairperson Finnila introduced and welcomed Ms. Cheryle-Bernard-Shaw. Ms. Bernard-Shaw provided a brief summary of her background, stating she has had over 16 years of experience in compliance including hospitals and freestanding healthcare services and most recently a large health system, Sutter Health. Ms. Bernard-Shaw stated she is also a member of the Pennsylvania State Bar. She extended her appreciation for the warm welcome and stated she is looking forward to working at Tri-City.		
2. Approval of Agenda	**It was moved by Director Schallock and seconded by Mr. Cumming to approve the agenda as presented. The motion passed unanimously.**	**Agenda approved.**	Ms. Donnellan
3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item	There were no public comments.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
4. Ratification of minutes – June 18, 2015	Mr. Cumming clarified his name should be "Cumming" rather than "Cummings". **It was moved by Director Schallock and seconded by Director Mitchell to approve the minutes of the August 20, 2015 meeting as presented and amended. The motion passed with Ms. Kathryn Fitzwilliam abstaining from the vote.**	**Minutes ratified**	Ms. Donnellan
5. New Business A. Committee Interviews: Community Member 1. Maria R. Eskandanian	Chairperson Finnila explained there are three candidates present today who will be interviewing for the open community seat on the Audit, Compliance & Ethics Committee: (1) Maria R. Eskandanian (2) Michael Slavinski (3) Leslie Schwartz Chairperson Finnila explained the interview process and noted candidates will be asked to step outside of the room while each candidate is interviewed individually. Each candidate will be allowed approximately ten minutes to provide a summary of their background and answer questions. Mrs. Maria Eskandanian was the first candidate interviewed. Mrs., Eskandanian stated she served on the Board of Governors of Twin Cities Community Hospital in Templeton, CA and brings a wealth of experience in banking. She described her experiences related to the audit process. Committee members asked questions of Mrs. Eskandanian. In closing, Mrs. Eskandanian stated she believes she is qualified to serve on the committee and has an extremely high level of integrity. *Ms. Eskandanian exited the meeting at 8:48 a.m.*		Ms. Donnellan
2. Michael Slavinski	The second candidate interviewed was Mr. Michael Slavinski. Mr. Slavinski stated he is a machine shop owner		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	whose company manufacturers ventilator components. Mr. Slavinski discussed his interest in the Veterans and stated he is an advocate for patient safety. Mr. Slavinski stated he does not have a great deal of experience with audits per se and questioned the committee's role related to Ethics. Committee members asked questions of Mr. Slavinski. Mr. Slavinski expressed his appreciation for the opportunity to interview for the open community seat. *Mr. Slavinski exited the meeting at 9:06 a.m.*		
3. Leslie B. Schwartz	The final candidate interviewed was Mr. Leslie Schwartz. Mr. Schwartz stated he has spent the past forty years in the healthcare area in both a business and hospital setting. He described his experience in auditing for FDA regulations, transportation guidelines and hazardous materials. Committee members asked questions of Mr. Schwartz. In closing Mr. Schwartz reiterated his desire to give back to the hospital and believes his background would be beneficial to the committee *Mr. Schwarz exited the meeting at 9:16 a.m.* At the conclusion of the interviews the Committee provided their impressions of each candidate and were impressed with the qualifications of all three candidates. Upon further discussion, the committee unanimously supported recommending Mr. Leslie Schwartz to the vacant seat on the committee. **It was moved by Mr. Cumming and seconded by Mr. Sharp to recommend Mr. Leslie Schwartz to fill the vacant seat on the Committee. The motion passed unanimously.** Candidates were invited back to the meeting and were advised of the committee's recommendation. Chairperson Finnila invited candidates to stay for the remainder of the meeting.	**Recommendation to be sent to the Board of Directors to appoint Mr. Leslie Schwartz to a two-year term on the Committee; item to appear on Board agenda.**	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
B. Review and Discussion of Administrative Policies & Procedures: 1. 8610-524 – Disclosure of Information to Pubic and Media	Ms. Kathy Topp joined the meeting at 9:20 a.m. General Counsel distributed a memorandum from Counsel Diane Racicot that summarized the revisions to the HIPAA Privacy Polices listed on today's agenda. The committee reviewed Policy 8610-524, Disclosure of Information to Public and Media. Ms. Topp explained that the policy emphasizes that TCHD may not use PHI to respond to the media when a patient puts the PHI "at issue" in the media and TCHD must continue to protect the PHI unless a patient authorization is obtained. Minor typographical corrections were suggested and accepted by the committee. **It was moved by Director Mitchell and seconded by Director Schallock to recommend approval of Policy 8610-524 – Disclosure of Information to Public and Media as presented and amended. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to approve Policy 8610-524 – Disclosure of Information to Public and Media; item to appear on Board agenda and include in agenda packet.**	Ms. Donnellan
2. 8610-525 – Use of Protected Information for Fundraising	Ms. Topp stated she worked with Foundation Vice President Mr. Glen Newhart to standardize definitions that would cross all HIPAA policies. Chairperson Finnila suggested Ms. Bernard-Shaw explain this policy to the full Foundation Board of Directors to emphasize potential HIPAA issues in fundraising activities. Ms. Fitzwilliam suggested there be consistency in policies related to the term "the District" or "TCHD". Ms. Bernard-Shaw stated she has not had a chance to thoroughly review all policies that have come forward previously for review. Ms. Bernard-Shaw expressed concern with the terminology	**Policy 8610-525 – Use of Protected Information for Fundraising will be reviewed with General Counsel and brought back to the September meeting.** **Upon approval of the policy the CCO will educate the Foundation Board on the use of protected information for fundraising.**	General Counsel/CCO CCO

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	contained in section B. Definitions, #7 Permissible Patient Information. The committee also expressed concern that access to patient information is not strict enough. It was recommended that Policy 8610-525 – Use of Protected Information for Fundraising be pulled for further review.		
3. 8610-591 – HIPAA Mitigation	Ms. Topp explained Policy 8610-591-HIPAA Mitigation is a new policy and was developed due to the fact that we did not have a HIPAA Mitigation policy in place. A minor typographical change was suggested in section B. Definitions #4. It was suggested section D. 2. B. iii be revised to reflect sanctions would be imposed and actions taken up to and including termination for violation of TCHD policies. **It was moved by Mr. Cumming and seconded by Director Mitchell to recommend approval of Policy 8610-591 – HIPAA Mitigation as presented and amended. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to approve Policy 8610-591 – HIPAA Mitigation as presented and amended; item to appear on Board agenda and included in agenda packet.**	Ms. Donnellan
4. Verification of Identity and Authority of Persons Requesting Protected Health Information (PHI) including Personal Representatives	The committee reviewed the Verification of Identity and Authority of Persons Requesting Protected Health Information (PHI) Including Personal Representatives policy. It was suggested that section D. Procedure a. items i. and ii be combined into one sentence. It was also suggested the "brackets" ([ ]) shown in section D. a. i. and b. ii be removed. **It was moved by Mr. Cumming and seconded by Director Mitchell to recommend approval of the policy Verification of Identity and Authority of Persons Requesting Protected Health Information (PHI) Including Personal Representatives as presented and amended. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to approve policy Verification of Identify and Authority of Persons Requesting Protected Health Information (PHI)**	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
		Including Personal Representatives; item to appear on Board agenda and included in agenda packet.	
C. Status Report on Compliance Program Plan	Chief Compliance Officer Ms. Bernard-Shaw provided a draft report on the compliance program plan. She explained a comprehensive Compliance Program Plan will come forward for review in October. Ms. Bernard-Shaw reviewed the seven elements of a compliance plan that are verbalized in the US. Sentencing Guidelines as follows: ➢ Element #1: Establish Policies, Procedures and Controls ➢ Element #2: Exercise Effective Compliance and Ethics Oversight ➢ Element #3: Exercise Due Diligence to Avoid Delegation of Authority to Unethical Individuals ➢ Element #4: Communicate and Educate Employees on Compliance and Ethics Programs ➢ Element #5: Monitor and Audit Compliance and Ethics Programs for Effectiveness ➢ Element #6: Ensure Consistent Enforcement and Discipline of Violations ➢ Elements #7: Respond Appropriately to Incidents and Take Steps to Prevent Future Incidents Ms. Bernard-Shaw reviewed the mechanisms she is proposing to address each of the elements. She discussed her plans for an internal compliance committee and the reporting mechanism to this Committee as well as the Board of Directors. Extensive discussion was held regarding Element #3 and the need to do periodic queries (not only at the time of re-credentiaing) to ensure no provider is listed on the OIG exclusion list.	**Information only.**	

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	Ms. Bernard-Shaw explained that although we have a sound educational Compliance program in place, she plans to do targeted training in areas of high risk. Discussion was held regarding the use of the Values Line and the fact that it tends to be utilized for Human Resource issues rather than compliance type issues. Director Mitchell suggested implementing a "decision tree" to refer values line calls to the appropriate area. Chairperson Finnila stated Ms. Bernard-Shaw's draft plan is comprehensive and addresses our areas of risk. Ms. Bernard-Shaw reiterated that she would be presenting a comprehensive Compliance Program Plan in approximately October.		
6. Old Business A) Review and Discussion of Amendments to Administrative Policy & Procedure: 1. 8750-557 – Communicating & Reporting Compliance Concerns; Confidential Reporting	Ms. Kathy Topp reported Policy #8740-557 Communicating & Reporting Compliance Concerns: Confidential Reporting is listed today for a normal 3-year review process. There were no recommended changes to the policy. **It was moved by Director Schallock and seconded by Director Mitchell to recommend approval of AP&P 8750-557 Communicating & Reporting Compliance Concerns; Confidential Reporting as presented. The motion passed unanimously.** *Ms. Kathy Topp left the meeting at 9:53 a.m.*	**Recommendation to be sent to the Board of Directors to approve AP&P 8750-557 Communicating & Reporting Compliance Concerns; Confidential Reporting; item to appear on next Board agenda and included in Board agenda packet.**	Ms. Donnellan
7. Oral Announcement of Items to be Discussed during Closed Session (Government Code Section 54957.7)	Chairperson Finnila made an oral announcement of the item listed on the agenda to be discussed during closed session which included approval of closed session minutes.		
8. Motion to go Into closed session	**It was moved by Mr. Cumming and seconded by Ms. Fitzwilliam to go into closed session. The motion passed unanimously.**		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
9. Open Session	The committee returned to open session at 10:10 a.m. with attendance as listed above.		
10. Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)	Chairperson Finnila reported no action was taken in closed session.		
11. Date of Next Meeting	Chairperson Finnila stated the Committee's next meeting will be held on September 17, 2015.	**The committee's next meeting is scheduled for September 17 2015.**	
12. Committee Communications	Director Schallock requested that Mr. Dietlin provide an update on the Audit. Mr. Dietlin stated the Auditors are in their third week of onsite field work and at this time there are no proposed adjustments from the Auditors.	**Information only.**	
13. Adjournment	Chairperson Finnila adjourned the meeting at 10:20 a.m.		

DRAFT

AUDIT, ETHICS AND COMPLIANCE COMMITTEE
August 20th, 2015

Administrative Policies & Procedures			
1. Disclosure of Information to Public and Media	8610-524	3 year review, revised	Forward to BOD for approval with revisions
2. Use and Disclosure of Protected Information for Fundraising	8610-525	3 year review, revised	Pull for further review
3. HIPAA Mitigation	8610-591	NEW	Forward to BOD for approval with revisions
4. Communicating & Reporting Compliance Concerns (Valuesline)	8750-557	3 year review, revised	Forward to BOD for approval
5. Verification of Identity and Authority of Persons Requesting Protected Health Information (PHI), including Personal Representatives	NEW	NEW	Forward to BOD for approval with revisions

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 3/03

SUBJECT: Disclosure of Information to Public And Media

REVISION DATE: 1/06; 5/09; 8/12

POLICY NUMBER: 8610-524

Administrative Policies & Procedures Committee Approval:	~~09/12~~06/15
Audit, Compliance and Ethics Committee Approval:	~~11/12~~08/15
Board of Directors Approval:	11/12

A. PURPOSE:

1. The purpose of this Policy is to provide guidance on the limitation of Disclosures that may be made by Tri-City Healthcare District (TCHD) of patient Protected Health Information (PHI) to the general public, including the media.

B. DEFINITION(S):

1. Authorization: the written form that complies with HIPAA and state law that is obtained from the Individual or his or her Personal Representative in order for TCHD to Use and Disclose PHI.
2. Business Associate: a person or organization who, on behalf of TCHD, performs certain functions or activities involving the Use or Disclosure of PHI or services that require the Business Associate to create, receive, maintain or transmit PHI on behalf of the TCHD or where TCHD needs to Disclose PHI to Business Associates for the services.
3. Business Associate Addendum or BAA: is an Addendum to an applicable Services Agreement between the District and a Business Associate that outlines the specific obligations of the Business Associate related to the Use or Disclosure of District PHI.
4. Disclosure: the release, transfer, provision of, access to or divulging of PHI outside TCHD.
5. Protected Health Information (PHI): individually identifiable health information transmitted or maintained in paper or electronic form that is created or received by TCHD AND
   a. Relates to the past, present or future physical or mental health or condition of an individual; OR
   b. Relates to the provision of health care to an individual; OR
   c. Relates to the past, present, or future payment, AND
   d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
6. Services Agreement: An agreement between the TCHD and a third party whereby the third party performs a function, activity or service on behalf of TCHD. Services Agreements that require TCHD to Disclose PHI for such functions, activities or services require Business Associate Addendums.
7. Use: the sharing, application, utilization, examination or analysis of PHI within TCHD.
8. Workforce: employees, volunteers, trainees, and other persons whose conduct, in the performance of work for TCHD is under the direct control of TCHD whether or not they are paid by TCHD.

C. POLICY:

1. TCHD shall comply with the restrictions imposed on it by HIPAA related to Disclosure of patient information to the public, including the media.
2. The Public Information Officer (PIO) will coordinate responses to requests from the media concerning patients with the Privacy Officer.

3. **The Privacy Officer is responsible for making determinations involving Disclosures of patient information to the public, including the media.**

D. PROCEDURES:

1. **Requests for Information**
   a. **HIPAA is more restrictive than California law regarding the timing and scope of information that may be provided to the public, including the media, concerning patients. TCHD shall follow the stricter requirements in HIPAA.**
   b. **The PIO will coordinate all responses to media requests involving PHI with the Privacy Officer. The Privacy Officer will identify whether limited medical condition information may be disclosed or whether an Authorization from the patient is required for a response involving disclosure of patient information to the media.**
   c. **TCHD may only release information about a patient if the inquiry specifically contains the patient's name. If an inquiry specifically contains a patient's name, then only limited medical condition descriptions and location information can be released as provided in this policy.**
   d. **The following activities always require prior written Authorization from the patient:**
      i. **Making detailed statements (beyond one-word descriptions as provided in D.1.d below) regarding the patient's medical condition or injury, his or her treatment, prognosis, etc.;**
      ii. **Photographing or videotaping patients; and**
      iii. **Interviewing patients; and**
      iv. **Any other Disclosure of patient information not specifically permitted by this Policy.**
   e. **Patient privacy rights continue to apply after a patient's death. Inquiries must be handled in accordance with this Policy. If a Disclosure is only permitted with an authorization, the deceased patient's Personal Representative must provide a written Authorization.**
   f. **Except for the limited Disclosures permitted under D.1.b., Disclosures to the Public, including the Media, require a patient (or Personal Representative) Authorization, the Privacy Officer shall be responsible for making all other determinations involving Disclosures to the Public, including the Media. The Privacy Officer may consult with legal counsel as necessary and appropriate.**
2. **Media Access to Patients**
   a. **All requests for patient information by the media during normal business hours will be referred to the PIO. The PIO shall confer with the Privacy Officer on all such requests.**
   b. **All requests for patient information made by the media outside of normal business hours will be routed through the PBX operator. If deemed not urgent, the Administrative Supervisor will ask the reporter to call back during normal business hours.**
   c. **All contacts from the media are required to go through the PIO. Reporters who contact staff other than the PIO will be verbally reminded up to three times to contact only the PIO. The unauthorized inquiries will be documented. After three warnings, staff will not acknowledge inquiries by reporters who have received three warnings.**
   d. **The PIO shall accompany media representatives at all times when they are in TCHD facilities.**
   e. **Media requests for writings or records must be sent as official Public Records Act Requests (PRR).**
   f. **TCHD reserves the right to deny any media representatives access to a patient, physician, employee or volunteer if it is determined that the presence of media (including photographers, videographers, reporters and/or other media staff) could aggravate the patient's condition or interfere with hospital care and business.**

3. **Patient Contacts With the Media**
   a. **TCHD must continue to protect a patient's PHI if a patient orf the patient's family member contacts the media and initiates a discussion, complaint or accusation involving their medical condition, treatment at TCHD, or other related matters.**
   b. **While TCHD may attempt to obtain an Authorization from the patient to respond to the media, if no Authorization is obtained, TCHD may not release information. In the event TCHD wishes to respond to such media inquiries, it should consult with legal counsel before doing so.**

E. **REFERENCE LIST:**
1. **45 Code of Federal Register (CFR) Section 160.103**
2. **45 CFR Section 164.510**
3. **45 CFR Section 164.530(e)**

~~A. **PURPOSE:**~~
~~1. This policy provides guidance to staff for the disclosure of information to the media while ensuring and maintaining the following:~~
~~a. Patient confidentiality.~~
~~b. Employees' right to privacy.~~
~~c. Efficiency and effectiveness of staff.~~
~~d. TCHD's competitive position with regards to other hospitals.~~

~~B. **POLICY:**~~
~~1. All health information regarding care of an individual must remain confidential except as allowed by law and TCHD's policies.~~
~~2. When required by law, written consent from patient's, physician's, employee's, volunteer's and visitor's must be obtained prior to recording or filming (photographic, video, electronic or audio media) for external purposes The completed, consent must indicate the intended use of the recording or film. Patients, physicians, employees, volunteers and visitors have the right to request cessation of recording or filming and the right to rescind consent for use up until a reasonable time before the recording or filming is used. To the extent allowed by law, TCHD will require anyone who engages in recording or filming (who is not already bound by the hospital's confidentiality policy) to sign a Consent to Photograph and Authorization for Use or Disclosure Form, a confidentiality statement to protect the patient's identity and confidential information and a Business Associate agreement.~~
~~3. TCHD will cooperate with the media while protecting individual's rights to privacy. All media requests must go through the Public Information Officer (PIO) or designee. . The PIO or designee will escort media visiting the hospital. Security Personnel may be used as additional escorts to the PIO or designee. Media personnel on the premises of TCHD without prior authorization from the PIO or designee will be asked to leave. Patients, employees or visitors may not invite media representatives to their rooms for interviews or photos without consent from the PIO or Director of Public Affairs.~~
~~4. The PIO has the right to participate in all interviews.~~
~~5. TCHD employees are not permitted to serve as spokespeople for the organization or to solicit media coverage without the approval of the PIO or designee.~~

~~C. **MEDIA REQUESTS FOR PATIENT INFORMATION:**~~
~~1. All requests for patient information by the media during normal business hours will be referred to the PIO or designee.~~
~~1. All requests for patient information made by the media outside of normal business hours will be routed through the PBX operator. If deemed urgent, the Administrative Supervisor will contact the Administrator on Call. If it is not deemed urgent, the Administrative Supervisor will ask the reporter to call back during normal business hours.~~
~~2. All contacts from the media must go through the PIO or designee. Reporters who contact staff other than the PIO will be verbally reminded up to three times to contact only the PIO or designee. The unauthorized inquiries will be documented. After three warnings, staff will not acknowledge~~

~~inquiries by reporters who have had three warnings.~~

3. ~~Media requests for information in writing or requests for existing reports must be sent as official "Public Records Request" (PRR).~~
4. ~~TCHD reserves the right to deny any news media access to a patient, physician, employee or volunteer if it is determined that the presence of photographers or reporters would aggravate the patient's condition or interfere with hospital care and business.~~

D. ~~**RELATED POLICIES:**~~

1. ~~Administrative Policy # 516 – Patient Access to Protected Health Information (PHI)~~
2. ~~Administrative Policy # 372 – Consent to Photograph/Videotape~~
3. ~~Environment of Care Policy # 4007 – Disaster Plan for Media Control~~

E. ~~**REFERENCES:**~~

1. ~~Federal HIPAA Regulations, Part 160~~
2. ~~Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970~~
3. ~~Drug Abuse Office and Treatment Act of 1972~~
4. **1.** ~~42 CFR Part 2, 188~~

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: New

SUBJECT: HIPAA MITIGATION

REVISION DATE(S):

POLICY NUMBER: 8610-591

Administrative Policies and Procedures Approval Date(s): 06/15
Audit, Compliance and Ethics Committee Approval Date(s): 08/15
Board of Directors Approval Date(s):

A. **PURPOSE:**

1. The purpose of this Policy is to establish guidelines for mitigation, to the extent practicable of any harmful effects that are known to Tri-City Healthcare District (TCHD) arising from the Use or Disclosure of Protected Health Information in violation of TCHD's policies and procedures or applicable state and federal privacy laws.

B. **DEFINITION(S):**

1. Business Associate: a person or organization who, on behalf of the District, performs certain functions or activities involving the use or Disclosure or activities involving the Use or Disclosure of Protected Health Information (PHI) or services that require the Business Associate to create, receive, maintain or transmit PHI on behalf of the District or where the District needs to Disclose PHI to Business Associates for the services.
2. Disclosure: the release, transfer, provision of, access to or divulging of PHI outside TCHD.
3. Electronic Protected Health Information or EPHI: PHI that is transmitted by Electronic Media or Maintained in Electronic Media.
4. Protected Health Information (PHI): individually identifiable health information transmitted or maintained in paper or electronic form that is created or received by TCHD AND
   a. Relates to the past, present or future physical or mental health or condition of an individual; OR
   b. Relates to the provision of health care to an individual; OR
   c. Relates to the past, present or future payment, AND
   d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
5. Use: the sharing, application, utilization, examination or analysis of PHI within TCHD.
6. Workforce member: employees, volunteers, trainees, and other persons whose conduct, in the performance of work for TCHD is under the direct control of TCHD whether or not they are paid by TCHD.

C. **POLICY:**

1. TCHD shall mitigate, to the extent practicable, any harmful effects that are known to TCHD arising from a Use or Disclosure of a patient's PHI, including EPHI, in violation of TCHD's policies and procedures or applicable state and federal laws.

D. **PROCEDURE:**

1. Investigation and Evaluation
   a. The Chief Privacy Officer or designee will investigate reports of a potential or suspected violation of privacy rights, whether by a Workforce member, Medical Staff, or a Business Associate. If the report is substantiated, the Chief Privacy Officer will consult with the Senior VP Information Technology/Security Officer, the Chief Compliance Officer, Chief

Nurse Executive/Senior VP, Senior Director Clinical Risk Management, Quality and PI, Director of Regulatory Compliance and Quality and/or legal counsel to determine the extent of any harmful effects resulting from the incident.

b. An evaluation will be conducted to determine the nature and extent of any harmful effects. The evaluation will consider the following factors:
   i. Whether any damage occurred;
   ii. The type of damage;
   iii. The nature and extent of PHI (including types of identifiers) that was Use or Disclosed;
   iv. The reason for the Use and Disclosure;
   v. The extent of distribution of the improperly Disclosed PHI, including the identity of recipients;
   vi. The cause of the violation including any TCHD policies and procedures and/or privacy laws that were violated by the Use or Disclosure; and
   vii. Any other information that is relevant to the evaluation.

2. Mitigation Steps
   a. Based on the evaluation, the Privacy Officer and/or the Security Officer shall determine appropriate actions to mitigate harm caused by the violation after consultation with the Chief Compliance Officer, Chief Nurse Executive/Senior VP, Senior Director Clinical Risk Management, Quality and Performance Improvement (PI) Director of Regulatory Compliance and Quality and/or legal counsel.
   b. Mitigation steps may include any of the following actions or a combination of them:
      i. Amend applicable policies and procedures to assure that the violation does not recur;
      ii. Provide focused training and education to person(s) responsible for the violation and/or to a category of Workforce members depending on the scope of the violation and policy changes;
      iii. Impose sanctions and/or disciplinary actions up to and including termination against person(s) responsible for the violation in accordance with TCHD's policies;
      iv. Attempt to recover the improperly Used or Disclosed PHI including EPHI (or obtain confirmation of its destruction) (e.g. misdirected fax, delivery of PHI to wrong patient);
      v. Deactivate/disable access to EPHI (e.g. remotely wipe/lock mobile devices where lost or stolen);
      vi. Identify and correct Information Technology (IT) system or physical space vulnerabilities, if any that contributed to the violation;
      vii. Notify affected Individuals of the violation in accordance with TCHD's security incident/breach response policies and of self-protective actions that may be taken to ameliorate or avoid potential harm (e.g. identity theft); and/or
      viii. Other actions as determined by the Privacy Officer and/or Security Officer in consultation with Executive Management and/or legal counsel.

3. Business Associate Violations
   a. In the event that TCHD learns of a potential or actual violation of a Use or Disclosure of PHI by one of its Business Associates, TCHD must, if practicable, mitigate the harmful effects of such violation. The Privacy Officer and/or Security Officer, in consultation with legal counsel, will contact the Business Associate to develop a mitigation plan.
   b. TCHD will also review whether further action is required under the terms of the Business Associate Agreement and TCHD's policies and procedures based on the nature and extent of the violation (e.g. termination).

E. **REFERENCE LIST:**

1. 45 Code of Federal Register (CFR) Section 160.103
2. 45 CFR Section 164.530(f)
3. TCHD HIPAA Administrative Requirements Policy No. 8610-503

4. TCHD Sanctions Policy No. 8610-531
5. TCHD HIPAA Breach Response Policy No. 8610-546

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance ~~500s~~

SSUE DATE: 5/12

SUBJECT: Communication and Reporting Compliance Concerns (Valuesline)

REVISION DATE(S): 12/12

POLICY NUMBER: 8750-557

Administrative Policies and Procedure Committee Approval:	**05/15**
Audit, Ethics and Compliance Committee Approval:	**08/15**
Board of Directors Approval:	**12/12**

A. **PURPOSE:**

1. This policy:
   - **a.** ~~(1) e~~**E**nsures availability of a confidential reporting process~~;~~
   - **b.** ~~(2) e~~**E**nsures compliance with the U.S. Department of Health & Human Services, Office of Inspector General and Office of Civil Rights ("OCR") Privacy Program Guidance~~; and~~
   - ~~a.~~**c.** ~~(3) e~~**E**stablishes guidelines for utilization of the Confidential Reporting Line (Values Line).

B. **SPECIFIC POLICIES AND PROCEDURES:**

1. The Values Line is available 24 hours per day, 365 days per year at 1-800-273-8452, or www.tricitymed.alertline.com.
2. Callers may choose to voluntarily identify themselves, or to remain anonymous. Employees are encouraged to identify themselves when reporting, as it often is easier to assess the issues or concerns raised in a report when there is the ability to ask the reporting employee follow-up questions.
3. Calls may be made without fear of retaliation or retribution.
4. Call tracking, tracing, or recording will not be utilized.
5. Action will be taken as needed based on the results of the investigation of the complaint. A communications specialist answers each call.
6. The caller may be asked questions by the communications specialist to clarify the concern and ensure accuracy.
7. The call is assigned a priority rating.
   a. "A" priority: An "A" priority call requires immediate action and notification of the Compliance Officer, Privacy Officer or designee. An "A" priority call involves an allegation of threat to person, place, or environment. Follow-up date is one day after the original call.
   b. "B" priority: A "B" priority call is one that requires verbal notification to the Compliance Officer, Privacy Officer or designee during normal business hours or on the next business day if received after normal business hours.
   c. "C" priority: A "C" priority call does not require an immediate response.
8. The caller is then assigned a control number for follow-up.
9. The caller is assigned a follow-up date, established according to the priority of the caller's concern. This allows time for an investigation of the concern and provides a method for the Compliance Officer or Privacy Officer to communicate (anonymously if necessary) with the caller.
10. During the follow-up, the caller is provided with an opportunity to report additional information and/or receive a status of their call disposition.

11. Monthly reports and statistics will be generated by a contracted third party and forwarded to both the Compliance Officer and Privacy Officer.
12. After hours, on holidays and weekends, a contracted third party notifies one of the following of a priority "A" issue:
    i. Chief Nurse Executive
    ii. Chief Operating Officer
    iii. **Chief** Compliance Officer
    iv. ~~Director of Legal Services~~
    v. Privacy Officer
    vi. ~~Risk Manager~~ **Senior Director of Risk Management**

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: NEW

SUBJECT: **Verification of Identity and Authority of Persons Requesting Protected Health Information (PHI), including Personal Representatives**

REVISION DATE(S):

POLICY NUMBER:

Administrative Policies and Procedures Approval Date(s): 07/15
Audit, Compliance and Ethics Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **PURPOSE:**

1. The purpose of this Policy is to define the steps for verifying the identity and legal authority of a person requesting a patient's PHI, including Personal Representatives, prior to Disclosure.

B. **DEFINITION(S):**

1. Authorization: the written form that complies with Health Insurance Portability and Accountability Act H(IPAA) and state law that is obtained from the Individual or his or her Personal Representative in order for TCHD to Use and Disclose PHI.
2. Disclosure: the release, transfer, provision of, access to, or divulging of PHI outside of Tri-City Healthcare District (TCHD).
3. Individual: the person who is the subject of protected health information.
4. Personal Representative: the person who has the authority to act for the Individual in making decisions related to health care under state law (except where an unemancipated minor has the authority to act as an Individual for certain services or circumstances) or, with respect to deceased persons, the person who has the authority to act on behalf of the deceased Individual or the Individual's estate as relevant to such personal representation.
5. Protected Health Information (PHI): individually identifiable health information transmitted or maintained in paper or electronic form that is created or received by TCHD AND
   a. Relates to the past, present or future physical or mental health or condition of an individual; OR
   b. Relates to the provision of health care to an individual; OR
   c. Relates to the past, present, or future payment, AND
   d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
6. Use: the sharing, application, utilization, examination or analysis of PHI within TCHD.

C. **POLICY:**

1. TCHD shall take reasonable steps to verify the identity of a person requesting Disclosure of a patient's PHI and the authority of such person to have access to the PHI where the authority is not known to TCHD.
2. TCHD shall take reasonable steps to verify the legal authority of a patient's Personal Representative where TCHD is required to treat such person as the patient.
3. If, under applicable laws, a Disclosure is conditioned on particular documentation, statements or representations from the person requesting the PHI, TCHD may rely, if such reliance is reasonable under the circumstances, on documentation, statements or representations that, on their face, meet the applicable requirements.

4. TCHD shall obtain any documentation, statements or representations, whether oral or written, from the person requesting PHI when they are a condition of a Disclosure.

D. **PROCEDURE:**

1. Verification of Identity of a Patient
   a. Telephone: A person representing himself or herself as a patient can be verified using the following information:
      i. Demographic information that can be confirmed in TCHD's [system], electronic health record or Patient Accounting system.
      ii. The patient is known to TCHD from prior contact.
   b. In Person: A person representing himself or herself as a patient can be verified by using the following information:
      i. Presentation of identification such as a driver's license or other official photo identification record that would permit TCHD to confirm the identity is that of the patient.
      ii. Verbal statements of demographic information that can be confirmed in TCHD's [system] electronic health record.
      iii. The patient is known to TCHD from prior contact.
   c. Emancipated minor patients: an emancipated minor is deemed equivalent to an adult for purposes of determining who may be given access to his or her PHI. TCHD shall obtain a copy of the minor's Department of Motor Vehicles identification card showing emancipation or a signed Declaration of Emancipation.
   d. Deceased patients: The PHI of a deceased patient is subject to HIPAA privacy protections for as long as TCHD maintains the PHI.
      i. TCHD should obtain a copy of the death certificate if the patient's death is not otherwise directly known to TCHD.
      ii. TCHD shall follow the procedures for verifying the identity of the patient's Personal Representative when responding to requests for Disclosures of PHI of deceased patients.
2. Verification of Identity and Authority of Third Parties
   a. Personal Representative: a Personal Representative may stand in the shoes of the patient and authorize TCHD's Use and Disclosure of PHI to the extent of the Personal Representative's legal authority.
      i. TCHD shall verify the identity of the patient's Personal Representative in the same manner it would a patient as set forth in Sections 1.a and 1.b above.
      ii. The Personal Representative's authority to act for the patient arises from his or her authority under state law to make health care decisions for the patient (or in the case of deceased Individuals it may also be to carry out responsibilities related to the estate). TCHD shall verify the legal authority of the patient's Personal Representative by obtaining and reviewing written documents that support the nature and scope of the Personal Representative's legal authority under state law.
      iii. The Personal Representative shall provide information and/or documents to support his or her authority as follows:
         1) Unless an exception applies, a parent or guardian appointed by the Court or other person acting *in loco parentis* with legal authority to make health care decisions on behalf of the unemancipated minor: Court issued Letters of Guardianship or other legal documents evidencing parental rights to make health care decisions.
         2) Surrogate who is 18 years or older and appointed by the patient to make health care decisions for the patient: The patient must personally inform the supervising provider, orally or in writing, of the appointment and it must be promptly recorded in the record. The surrogate appointment is effective only during the course of treatment or illness or stay or for 60 days whichever is shorter.

3) Agent named under a Power of Attorney for Health Care or Advance Health Care Directive: valid, executed Power of Attorney for Health Care Directive form naming the person requesting PHI as the agent for health care decisions.
   a) The Power of Attorney for Health Care document may specify limitations on an agent's ability to make health care decisions on behalf of the patient. For example, it may only apply for a specific treatment. In such cases, TCHD should not treat the person as the Individual for all purposes such as signing an Authorization for the Disclosure.
   b) The Power of Attorney for Health Care document may contain conditions precedent to the agent's powers such as only applying when the patient is incapacitated. In such cases, TCHD should not treat the agent as the patient's Personal Representative when the patient is not incapacitated.
   c) The Power of Attorney document may only be a General Power of Attorney to manage finances and other business. In such cases, TCHD should not rely on the Power of Attorney as it does not permit the person to make health care decisions for the patient unless it specifically mentions the right to make health care decisions.
4) Guardian or Conservator: Obtain court-issued Letters of Guardianship or conservatorship.
5) Executor or Administrator: Obtain court-issued Letters Testamentary of Letters of Administration.
6) Beneficiary of a deceased patient as defined in Probate Code Section 24: Obtain excerpts of the will identifying the beneficiary.
7) Research Study Subject: To release PHI to site and sponsor representatives on study subject, TCMC must have fully executed study-related patient consent on file.

b. Family, relatives, domestic partners, close friends and other persons designated by the patient who are involved in patient's care or payment of the patient's care and for notification purposes: TCHD may Disclose limited PHI upon verifying the following circumstances:
   i. If the patient is available for, or otherwise available prior to a Use or Disclosure and has the capacity to make health care decisions, TCHD may Use or Disclose PHI if it has the patient's agreement; or it provides the patient with the opportunity to object and the patient does not express an objection; or it can reasonable infer from the circumstance, based on professional judgment, that the patient does not object to the Disclosure. For example, an emergency room nurse may discuss a patient's treatment in front of the patient's friend when the patient asks the friend to come into the treatment room or a patient account representative may discuss the patient's bill with their son who is at TCHD with the patient.
   ii. If the patient is not available, or the opportunity to agree or object is not practicable because of incapacity or emergency circumstances, TCHD may use its professional judgment to determine if the Disclosure is in the best interest of the patient and, if so, only Disclose the PHI that is directly relevant to the person's involvement with the patient's care or payment related to the patient's health care or needed for notification purposes. For example, TCHD may use professional judgment and experience with common practice to make reasonable inferences of the patient's best interest in allowing a person to pick up filled prescriptions, x-rays or similar forms of PHI or may provide information on a patient's condition to their spouse when the patient is unconscious.
   iii. TCHD will not discuss a patient's PHI with family, relatives, domestic partners, and close friends if the patient expressly indicates it may not do so.

iv. When TCHD is permitted to share limited PHI with family, relatives, domestic partner, and close friends as provided above, it should not discuss past medical information that is unrelated to the patient's current condition..

c. Public Officials seeking PHI:

i. Verification of Identity: TCHD may rely, if such reliance is reasonable under the circumstances on the following to verify the identity of a person when the Disclosure of PHI is to a public official or a person acting on behalf of a public official:

1) For in person requests, presentation of an agency identification badge, other official credentials, or other proof of government status;
2) For requests made in writing, the request is on the appropriate government letterhead; and
3) If the Disclosure is to a person acting on behalf of a public official, a written statement on appropriate government letterhead that the person is acting under the government's authority or other evidence or documentation of agency such as a contract for services, memorandum of understanding, or purchase order, that establishes that the person is acting on behalf of the public official.

ii. Verification of Authority: TCHD may rely, if such reliance is reasonable under the circumstances on the following to verify authority when the Disclosure of PHI is to a public official or a person acting on behalf of a public official.

1) A written statement of the legal authority under which the information is requested, or, if a written statement would be impracticable, an oral statement of such legal authority; and
2) If a request is made pursuant to legal process, warrant, subpoena, order, or other legal process issued by a grand jury or a judicial or administrative tribunal is presumed to constitute legal authority for purposes of verification of identity and authority.

d. Exceptions to Recognizing Persons as Personal Representatives

i. TCHD may elect not to treat a person as the Personal Representative of a patient (adult or minor) if the following requirements are satisfied and the election is documented in the patient's record:

1) TCHD has a reasonable belief that:
   a) the patient has been or may be subject to domestic violence, abuse or neglect by such person;
   b) treating such person as the Personal Representative could endanger the patient; AND
2) TCHD, in the exercise of the professional judgment of the health care provider, decides it is not in the best interest of the patient to treat the person as the patient's Personal Representative.
3) TCHD shall consult with Legal Counsel as necessary and appropriate regarding the election decision.

ii. TCHD shall not treat a parent as the Personal Representative of a minor in the following circumstances:

1) If the minor has the authority to consent to medical treatment under state law, he or she is generally the person authorized to have access to medical records regarding the treatment and to decide whether records get released to other persons. If a minor has the right to inspection, then TCHD shall not grant a Personal Representative access to the minor patient's PHI.
2) A court determines or other law authorizes someone other than the parent to make treatment decisions for a minor.
3) A provider makes a good faith determination that a parent or other legal representative who has authority to consent to treatment would have a detrimental effect on the provider's professional relationship with the minor.

4) If the minor has been removed from the physical custody of a parent or guardian in a dependency proceeding, the parent or guardian may not access the minor's mental health information without a court order.

e. Legal Review
   i. TCHD shall consult with Legal Counsel as necessary and appropriate regarding the authority of a Personal Representative, issues involving unemancipated minor rights to access medical records or any other information relevant to this policy.

f. Documentation
   i. TCHD shall retain copies of all documentation obtained for purposes of these verification procedures.

E. **REFERENCE LIST:**

1. 45 Code of Federal Regulations (CFR Section 160.103
2. 45 CFR Section 164.502(g)
3. 45 CFR Section 164.510
4. 45 CFR Section 164.514(h)
5. Cal. Health & Safety Code Section 123110(g)

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

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

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 1:30 p.m. on July 30, 2015.

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

Director Jim Dagostino, DPT, PT
Director Ramona Finnila
Director Laura E. Mitchell
Director RoseMarie Reno
Director Larry Schallock

Absent were Director Cyril F. Kellett, MD and Director Julie Nygaard

Also present were:

Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Steve Dietlin, Chief Financial Officer
Esther Beverly, VP/Human Resources
Cheryle Bernard-Shaw, Chief Compliance Officer
Greg Moser, General Legal Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 1:30 p.m. in Classroom 6 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. .

2. Approval of Agenda

   It was moved by Director Dagostino to approve the agenda as presented. Director Finnila seconded the motion. The motion passed unanimously (5-0-2) with Directors Kellett and Nygaard absent.

3. Public Comments – Announcement

   Chairman Schallock read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Open Session

5. New Business

   a. Consider certification of CNA representation of Case Managers and Readmission Coordinator RN classification

Ms. Esther Beverly, VP of Human Resources reported the District received a petition from CNA to represent the Case Managers and Readmission Coordinator. She stated a Mediator Service was selected to conduct the card count which reflected that the Union was able to seek the number needed to have the Case Managers and Readmission Coordinator recognized and represented by CNA.

Ms. Beverly stated it is the District's opinion that this particular group represents a different bargaining unit and should not be included in the same contract as the nurses. Director Reno stated in her opinion Case Management is a continuation of patient care and does involve patients. Ms. Beverly stated the contract will be negotiated; however the Employee Relations Officer makes the ultimate determination.

It was moved by Director Mitchell that the TCHD Board of Directors certify the results of the Card Count and CNA representation of Case Managers and the Readmission Coordinator RN classification. Director Reno seconded the motion.

The vote on the motion was as follows:

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

b. Consideration of amendment to TCHD Bylaws, Article V. Section 1, Committees

Mr. Moser explained the amendment as written prohibits the use of a written ballot or anything resembling a ballot in deliberations. He clarified that Directors may use scorecards for their personal use.

It was moved by Director Reno to approve the amendment to TCHD Bylaws, Article V. Section 1, Committees as recommended by the Governance & Legislative Committee. Director Mitchell seconded the motion.

The vote on the motion was as follows:

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

6. Comments by members of the public.

There were no comments by members of the public.

7. There being no further business, Chairman Schallock adjourned the meeting at 1:42 p.m.

Larry W. Schallock
Chairman

ATTEST:

Ramona Finnila
Secretary

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

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

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 1:45 p.m. on July 30, 2015.

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

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

Absent were Director Julie Nygaard and Director Cyril F. Kellett, MD

Also present were:

Greg Moser, General Legal Counsel
Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Steve Dietlin, Chief Financial Officer
Esther Beverly, VP/Human Resources
Dr. Gene Ma, Chief of Staff Elect
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 1:45 p.m. in Classroom 6 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

   Chairman Schallock requested the CLABSI NICU Recognition be deferred to the August meeting due to staff unavailability.

   It was moved by Director Dagostino to approve the agenda as modified. Director Reno seconded the motion. The motion passed unanimously (5-0-2) with Directors Kellett and Nygaard absent.

3. Public Comments – Announcement

   Chairman Schallock read the Public Comments section listed on the July 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 items listed on the July 30, 2015 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; four Reports Involving Trade Secrets; Conference with Legal Counsel regarding two matters of Potential Litigation; Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Conference with Legal Counsel regarding two matters of Existing Litigation and Approval of Closed Session Minutes.

5. Motion to go into Closed Session

It was moved by Director Dagostino and seconded by Director Reno to go into Closed Session. The motion passed (5-0-0-2) with Directors Nygaard and Kellett absent.

6. The Board adjourned to Closed Session at 1:44 p.m.

8. At 3:45 p.m. in Assembly Rooms 1, 2 and 3, Chairman Schallock announced that the Board was back in Open Session.

The following Board members were present:

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

Also present were:

Greg Moser, General Legal Counsel
Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Steve Dietlin, Chief Financial Officer
Sharon Schultz, RN, Chief Nurse Executive
Esther Beverly, VP, Human Resources
Dr. Gene Ma, Chief of Staff Elect
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 Directors Kellett and Nygaard are out of town and will not be attending today's meeting. Chairman Schallock 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.

Chairman Schallock asked that speakers be concise and adhere to the three-minute rule.

12. Introductions:

(1) Cheryle Bernard-Shaw - Chief Compliance Officer

Chairman Schallock introduced and welcomed Ms Cheryle Bernard-Shaw, Chief Compliance Officer.

Ms. Bernard-Shaw provided a brief summary of her background, stating she has had over 16 years of experience in compliance including hospitals and freestanding healthcare services and most recently a large health system, Sutter Health.

(2) Gene Ma - Chief of Staff

Chairman Schallock introduced and welcomed Dr. Gene Ma, who will serve as Chief of Staff for the next two years.

Dr. Ma provided a brief summary of his background, stating he has been an Emergency Room physician here at Tri-City for 16 years and it is a tremendous privilege to work at Tri-City Medical Center and represent the Medical Staff.

13. Special Recognitions –

1) NICU - 5 years CLABSI free

Chairman Schallock reported the NICU Recognition was deferred to the August meeting due to unavailability of staff.

2) Robert Veluz – USD MEPH Program "Preceptor of the Year" award

Ms. Sharon Schultz, CNE, introduced Mr. Robert Veluz, one of our very dedicated ICU nurses who also float between the Emergency Department. Ms. Schultz stated Mr. Veluz recently received the USD MEPN Program "Preceptor of the Year" award and he was selected out of all the other nurses in San Diego County to be the preceptor of the year for that Master's entry program in nursing.

Mr. Veluz provided a brief summary of his background, noting he has been a nurse here at Tri-City for 27 years and it is privilege to be a part of this organization. Mr. Veluz stated he is also a Rapid Response nurse. Mr. Veluz thanked the Board for recognizing him today.

Chairman Schallock congratulated Mr. Veluz on behalf of the entire Board of Directors.

14. Report from TCHD Auxiliary – Sandy Tucker, President

Ms. Tucker reported the second annual *Tails on the Tails Walk-a-Thon* netted $8,479.93 which is split 50/50 with the Foundation. Ms. Tucker stated proceeds will be given to the Medical Center's Pet Therapy Department, the Tender Loving Canine Assisted Dogs for Wounded Warriors and to the Angel Care Cancer Center for Companion Animals, a group studying cancer and other life threatening diseases.

Secondly, Ms. Tucker reported a donation by the Argos Foundation allowed the Auxiliary to set aside $15,000 to support our staff with obtaining certification in their specialized area, which included inpatient Obstetrics, Critical Care, Behavioral Health and Respiratory Care.

Ms. Tucker also reported at the Annual Awards and Installation Luncheon three volunteers received their 25-year badge. The highest hour award was given to Irene Higgins, a volunteer with over 14,500 hours of volunteer time.

Lastly, Ms. Tucker reported $43,000 of the money the Auxiliary donated to the hospital in 2014-15 was not spent so it was donated to the NICU project to buy two NICU rooms with naming rights.

Chairman Schallock stated our Auxiliary is extremely helpful to our patients, family members and people in the community and we recognize and appreciate all that they do.

No action was taken.

15. Report from Chief Executive Officer

Mr. Tim Moran, Chief Executive Officer reported there are some recent developments with regard to Behavioral Health that Ms. Sharon Schultz, CNE will expand on and it speaks to the Board's engagement with Behavioral Health to address the concerns of our community.

Ms. Sharon Schultz reported she attended a partner's meeting for Mental Health for San Diego County and learned that Tri-City Medical Center and Palomar were the two north county locations that were going to be awarded a sole source contract for the Crisis Stabilization Unit. Ms. Schultz stated Mr. Moran and the Board have spearheaded those efforts, not only through North County, but up to Sacramento and throughout the state for the needs of our mental health patients. Ms. Schultz stated we expect to begin negotiations with the county in the near future and hope to be up and running a year from now.

Ms. Schultz also reported that four weeks from now we will be opening our Behavioral Health Suite in the Emergency Room to prepare us for a Crisis Stabilization Unit to provide a better place in our Emergency Department to care for the mentally ill away from medical patients. Ms. Schultz believes we can expect faster placements and interventions with the opening of the Suite.

Chairman Schallock stated it has been a challenging journey but we have been in the forefront in trying to find a solution.

Mr. Moran stated Ms. Schultz has been a very strong advocate on our behalf in this effort.

Mr. Moran stated he does not know if the closing of the Palomar Hospital will have any impact on what we are doing with the county, however he has contacted the Director of Health & Human Services to inquire as to whether any of those changes may have any ramifications for us at Tri-City.

Mr. Moran also expressed his appreciation to Ms. Cheryle Bernard-Shaw for accepting the position of Chief Compliance Officer and stated he looks forward to working with her. Additionally, Mr. Moran also welcomed Dr. Ma to his role as Chief of Staff.

Mr. Moran reported we are scheduled for an unannounced visit from the Joint Commission in the fall and have done a lot of work in preparation for their visit including updating our policies and procedures and making sure we have a safe environment for our patients and staff. Mr. Moran stated he believes the Medical Center will be well prepared for the Joint Commission's visit.

With regard to Physician Recruitment, Mr. Moran reported we have two husband/wife teams who intend to come to our Medical Office Building in Carlsbad. In addition an additional team of Primary Care physicians are expected next summer. Mr. Moran stated a more detailed report will be given to the Board next month on new physician recruitment broken down by primary care and specialty areas based on physicians who are retiring in the community or where there is a shortage.

Mr. Moran reported we are in a lengthy court process in determining the value of our Medical Office Building which will be determined in court in May of 2016. He stated we do have possession of the building and are moving forward with such things as traffic mitigation to have the building ready for occupancy. Mr. Moran stated we have engaged Colliers and they are identifying potential tenants.

Director Dagostino commended Mr. Moran and his team on their physician recruitment efforts.

Lastly, Mr. Moran gave an educational talk on the subject of bundled payments. He explained bundled payments refers to a fixed amount that includes all the services that a patient needs for a particular DRG including anesthesiology, the surgeon's fee, any implants, etc., and follow-up rehabilitation or home care for a period of 90 days. Mr. Moran stated the government will be piloting a bundled payment project that will affect approximately 800 hospitals across the United States in 75 different markets and we are starting to be proactive and collect our own data and track patients that have chronic conditions.

Director Reno requested clarification if the bundled payment would include Anesthesiology and Physical Therapy. Mr. Moran responded that these services would be included.

Director Reno commended Mr. Moran on his informative report.

No action was taken.

16. Report from Chief Financial Officer

Mr. Dietlin reported June is our fiscal year end and we are closing out the financial statements and will present draft statements to our Auditors who will arrive on site next week for approximately 3-4 weeks performing detailed audit field work. Mr. Dietlin explained that once we have audited financials they will be presented to the Audit Committee and then the Board for acceptance. Mr. Dietlin stated last year the Auditors found no material weaknesses or proposed adjustments and we look forward to a similar outcome.

Director Reno questioned how many babies are delivered at Tri-City by Midwives and how we are reimbursed. Mr. Dietlin stated he will follow-up with Director Reno on the number of deliveries, however reimbursement depends on the payor and the contract. Mr. Dietlin explained we do not discuss our contracted rates in open session but could bring that information to the Board in closed session if desired.

Director Dagostino further questioned if the room rate is the same regardless of who delivers the baby. Mr. Dietlin explained the room charge is the same across the board but the rate does not dictate what the reimbursement would be. The Midwife or physician would have a separate contract and charge separate from the facility.

No action was taken.

17. New Business

a. Consideration to approve Resolution No. 774, A Resolution of the Board of Directors of Tri-City Healthcare District Confirming the Name Used by the District in Contracts and Other Documents Related to Tri-City Medical Center and Other Affiliated Entities

It was moved by Director Reno that the TCHD Board of Directors approve Resolution No. 774, A Resolution of the Board of Directors of Tri-City Healthcare District Confirming the Name Used by the District in Contracts and Other Documents Related to Tri-City Medical Center and Other Affiliated Entities. Director Dagostino seconded the motion.

General Counsel, Mr. Moser explained we have had some difficulty explaining the relationship between Tri-City Medical Center and Tri-City Healthcare District with certain vendors and the easiest solution is to have a Resolution adopted by the Board reflecting that relationship.

Director Finnila clarified the hospital provides services at various facilities and it is important to adopt this Resolution for clarification.

The vote on the motion was as follows:

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

18. Old Business – None

a. Nifty after Fifty Update

Mr. Moran stated with the approval of the Board at last month's Board meeting we have proceeded to close both of the Nifty after Fifty facilities effective July 31st. Mr. Moran explained the company that manages the operations for us began their reduction in force and plans for removal of signage and equipment have begun to take place. Mr. Moran stated we are looking at sublease agreements with the broker and parties who may be interested in taking over these existing leases and we anticipate moving equipment that is owned by Tri-City moving to our Wellness

Center or other community centers that would benefit from the equipment. Mr. Moran stated when the original presentation was presented to the Board in November 2012 it was projected to lose money in the first year and be self sustaining in the second year and future years and that has not been our experience. Thus, our operating losses led to our recommendation to close the facilities.

Mr. David Bennett, Chief Marketing Officer stated we have done extensive marketing including specific targeting marketing up until March and then the decision was made not to spend District dollars as we realized very little increase in membership. Mr. Bennett stated there are approximately 180-225 active members between both locations. Mr. Bennett stated the District spent approximately $100,000 on marketing, advertising, media print and direct mail. He explained the major focus of the presentation made to Board in November of 2012 was based on physical therapy revenues and this did not materialize.

Director Reno stated physicians have personally told her that they were unaware that the program existed.

Mr. Bennett stated that both he and Mr. Wayne Knight met with medical staff leadership and physician leadership of both IPAs and made it clear that this was a benefit to their members and not a charge to the IPA but was purely voluntary and an option. Mr. Knight stated many physicians refer their patients to either a community based certified physician therapy program or to our internal physician therapy program. Mr. Bennett stated he does not believe it is possible to change physician referral patterns. He stated we will give any Nifty after Fifty member six months free membership at the Wellness Center and negotiate a fair monthly membership for them going forward.

Director Reno stated she was always under the impression there was only going to be one Nifty after Fifty site, rather than two and questioned the possibility of re-establishing one site and perhaps utilizing the Rady's building. Mr. Bennett responded that the total loss between both locations is approximately $50,000 per month and explained why the Rady's building is not an option.

Chairman Schallock stated when this program was presented to the Board, an Orange County model was presented in which insurances were contracted and it was successful. Chairman Schallock concurred that it is beneficial to have the senior population exercising and the importance of keeping people out of the hospital by staying healthy, however the District cannot continue to lose that amount of money each month. He noted his disappointment in the amount of money spent each month and the lack of results.

Director Mitchell asked about the possibility of reinventing the program for the senior fitness aspects.

The Board heard comments from approximately 15 community members who spoke regarding the impending closure of the Nifty after Fifty locations. The individuals commented on their personal experiences with the program and the many benefits to the senior population. Speakers urged the Board to reconsider their decision to close Nifty after Fifty. Community Member Victory Roy requested his letter and petition to keep the centers open be made a part of the official record.

Mrs. Kimberly Stone, also a community member requested that her letter and photos provided today be included as part of the official record. Mrs. Stone also commented on a Public Records Request that has not yet been fulfilled. Mrs. Stone urged a 90 day extension to evaluate other alternatives to closing of the Nifty after Fifty locations.

Community member, Ms. Gigi Gleason commented on the fact that she was eager to have a program like Nifty after Fifty at Tri-City, however over the course of membership things have changed and there is not enough staff to manage the program appropriately. She noted it is not the hospital that manages the program rather Nifty after Fifty corporate

Chairman Schallock expressed his appreciation to all who spoke and their passion for the program.

General Counsel stated Nifty after Fifty is agendaized as an update and therefore no decision can be made, however the Board may direct staff to explore postponing closure.

Discussion was held regarding the forming of an Ad Hoc Committee. General Counsel explained an Ad Hoc Committee must be comprised strictly of Board members and not consist of community members.

Mr. Moran suggested a group be formed to include Mr. Voy and Mrs. Stone to work towards a mutually agreeable solution. He clarified it is not possible to delay tomorrow's closing due to the notices and layoffs that have already taken place.

19. Chief of Staff

a. Consideration of July 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on July 27, 2015.

It was moved by Director Dagostino to approve the July 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on July 27, 2015. Director Reno seconded the motion.

Director Reno requested clarification on the proctoring requirement. Dr. Ma explained the physician must be able to demonstrate current competency and we are changing some of the categories of membership to accurately reflect the "refer and follow" category. He stated that since these are new processes many physicians are being given a six month extension however, if those privileges aren't maintained they will need to be surrendered.

The vote on the motion was as follows:

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

b. Consideration of July 2015 Recredentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on July 27, 2015.

It was moved by Director Dagostino to approve the July 2015 Re-credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on July 27, 2015. Director Reno seconded the motion.

The vote on the motion was as follows:

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

20. Consent Calendar

It was moved by Director Dagostino to approve the Consent Agenda. Director Reno seconded the motion.

Director Finnila noted a typographical error in the Governance Committee minutes related to the month the policies were approved. The minutes will be revised to reflect the policy was approved at the June meeting rather than July.

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

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

21. Discussion of items pulled from Consent Agenda

There were no items pulled from the Consent Agenda.

22. Reports (Discussion by exception only)

23. Legislative Update

There was no legislative update.

24. Comments by members of the Public

Chairman Schallock reported a Special Meeting was held earlier today and members of the public have requested to speak on behalf of items on that agenda. Chairman Schallock reminded speakers of the three minute time allotment.

Chairman Schallock recognized SEIU-UHW members Ms. Aubrey Young, Surgical Tech, Ms. Cindy Bravo, ACT and Ms. Beth Schwartz, Respiratory Therapist. The

individuals voiced concerns over staffing, subcontracting and labor negotiations in general.

Chairman Schallock also recognized Ms. Amalia "Mali" Woods-Drake, Union Representative/Organizer who read comments on behalf of Tom Cobb, MRI Tech and Raul Merida, CT Tech.

Ms. Woods-Drake also requested additional time to make a statement as she did not intend to use her time to speak on behalf of Mr. Cobb and Mr. Merida She stated she and other union members were offended by a comment made by a Board member at a recent Board meeting related to union negotiations being referred to as the "silly season".

25. Additional Comments by Chief Executive Officer

Mr. Moran did not have any additional comments.

26. Board Communications

Director Mitchell did not have any comments.

Director Reno stated the community has spoken and we need to listen to their needs.

Director Finnila clarified her statement at last month's Board meeting stating she did not call demands "silly" but stated we are entering into a silly season where people don't always speak from fact or may not act in the best way.

Director Finnila reported a long time supporter of Tri-City, Marian Hoffman recently passed away. She noted Mrs. Hoffman and her husband helped start the Tri-City Foundation in 1961 and worked for many years to help make Tri-City what it is today and she would like to honor Mrs. Hoffman.

Lastly, Director Finnila spoke regarding the detrimental effects of coming into contact with black mold and urged the public to be extremely careful how you handle black mold and leave it to a professional to handle.

Director Dagostino did not have any comments.

27. Report from Chairperson

Chairman Schallock did not have any additional comments.

29. Additional Comments from Chief Executive Officer

Mr. Moran did not have any additional comments.

28. Oral Announcement of Items to be Discussion in Closed Session

Chairman Schallock reported the Board would be returning to Closed Session to complete unfinished closed session business.

29. Motion to return to Closed Session.

Chairman Schallock adjourned the meeting to closed session at 5:53 p.m.

30. Open Session

At 7:00 p.m. Chairman Schallock reported the Board was back in open session. All Board members were present.

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

Chairperson Schallock reported that the Board authorized taking legal action against Dr. Mazur by a unanimous vote (5-0-2) with Directors Kellett and Nygaard absent.

32. There being no further business Chairman Schallock adjourned the meeting at 7:00 p.m.

_____
Larry Schallock, Chairman

ATTEST:

_____
Ramona Finnila, Secretary

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

August 13, 2015 – 3:30 o'clock p.m.
Assembly Room 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 3:00 p.m. on August 13, 2015.

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

Director Jim Dagostino, DPT, PT
Director Cyril F. Kellett, MD
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie Reno
Director Larry Schallock

Absent was Director Ramona Finnila

Also present were:

Jody Root, General Legal Counsel
Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Steve Dietlin, Chief Financial Officer
Wayne Knight, SVP, Medical Services
Dr. Gene Ma, Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 3:30 p.m. in Assembly Room 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Schallock led the Pledge of Allegiance.

2. Approval of agenda.

   It was moved by Director Kellett to approve the agenda as presented. Director Nygaard seconded the motion. The motion passed unanimously (6-0-0-1) with Director Finnila absent.

3. Public Comments – Announcement

   Chairman Schallock read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Oral Announcement of Items to be discussed during Closed Session

   Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Mr. Jody Root made an oral announcement of items listed on the August 13, 2015 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one Trade Secret, Public Employment Evaluation: CEO and one matter

of Potential Litigation and one matter of Existing Litigation related to Medical Acquisitions Company/Larry Anderson matters.

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 (6-0-0-1) with Director Finnila absent.

6. Chairman Schallock adjourned the meeting to Closed Session at 3:35 p.m.

7. The Board returned to Open Session at 6:05 p.m. with attendance as listed above.

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

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

9. There being no further business, Chairman Schallock adjourned the meeting at 6:05 p.m.

_____
Larry W. Schallock
Chairman

ATTEST:

_____
Ramona Finnila
Secretary

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

July 30, 2015

Tim Moran
Chief Executive Officer
Tri-City Healthcare District
4002 Vista Way
Oceanside, California 92056

Dear Mr. Moran,

Enclosed is your ACHD dues invoice for Fiscal Year 2016 in the amount of $45,000.00. The Association's dues structure groups Districts in tiers based on operating revenues as reported to OSHPD, or in the case of Districts not reporting operating revenues, total assets are used for tier assignment. There are 7 tiers and your District is in tier 1. We are pleased to report that the Association has not raised dues for nearly a decade.

The dues collected by the Association allow us to develop and provide important Member benefits. This year ACHD has significantly enhanced its Advocacy efforts on behalf of the Members through the retention of Hurst Brooks Espinosa (HBE) LLC. HBE brings a combined 45 years advocacy experience in the public sector with a focus on health care, tax, government, insurance, special districts, and state budget. The HBE Partners have long standing relationships with elected and appointed state officials, state cabinet members, department heads, county and other local officials. These relationships greatly enhance our access to key officials on your behalf.

ACHD has also expanded its Sacramento office to provide our Members with an improved experience when conducting business with various elected and appointed State officials. The office provides Members with print, copy, Wi-Fi, and other business related support services, along with the ability to monitor on a "real time" basis, video of Assembly and Senate committee hearings. Please feel free to use this office for your District business needs while you are in Sacramento; just let us know in advance when you will be visiting by contacting Amber King at Amber.king@achd.org or by telephone at (916)266-5207.

As a reminder, ACHD provides an on-line Board Self-Assessment tool as well as an on-line evaluation tool for Chief Executive Officer Evaluations as an exclusive no-cost Member benefit. To access either tool, please visit www.achd.org or contact Sheila Johnston, Member Services Specialist at Sheila.Johnston@achd.org or by telephone at (916) 266-5208.

Please mark your calendars for the following programs:

- Trustee Leadership Development – January 21-22, 2016, Sacramento;
- Legislative Day – April 4-5, 2016, Sacramento, and;
- Annual Meeting – May 3-6, 2016 Monterey

Best regards,

Samuel M. McCreary, PhD
ACHD Board Chair

Kenneth B. Cohen, CHE
Executive Director, ACHD

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

Invoice

Invoice No.	**15004326**
Date	07/07/2015
Terms	Due Upon Receipt

Tri-City Healthcare District
Attn: Accounts Payable
4002 Vista Way
Oceanside, CA 92056

Qty.	Description	Rate	Amount
1	Membership Dues Comments:	45,000.00	45,000.00
		Total	**$45,000.00**

Association of California Healthcare Districts
by check:
P.O. BOX 619084
Roseville, CA 95661

By wire:
Wells Fargo Bank
Account #: 4121-229975
ABA/Routing #: 121000248

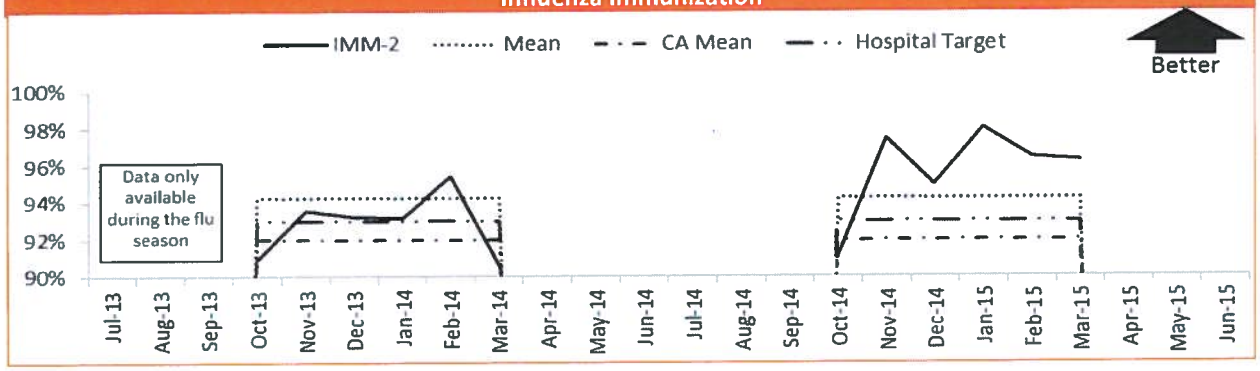
Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Process of Care Measures (Core Measures)

Centers for Medicare & Medicaid (CMS)

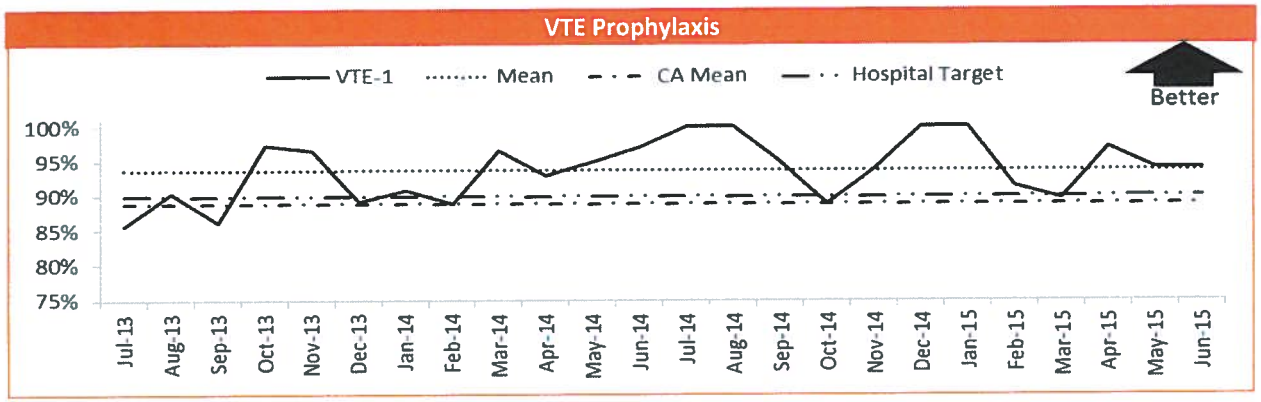
Influenza Immunization



Action Plan

Continue to monitor

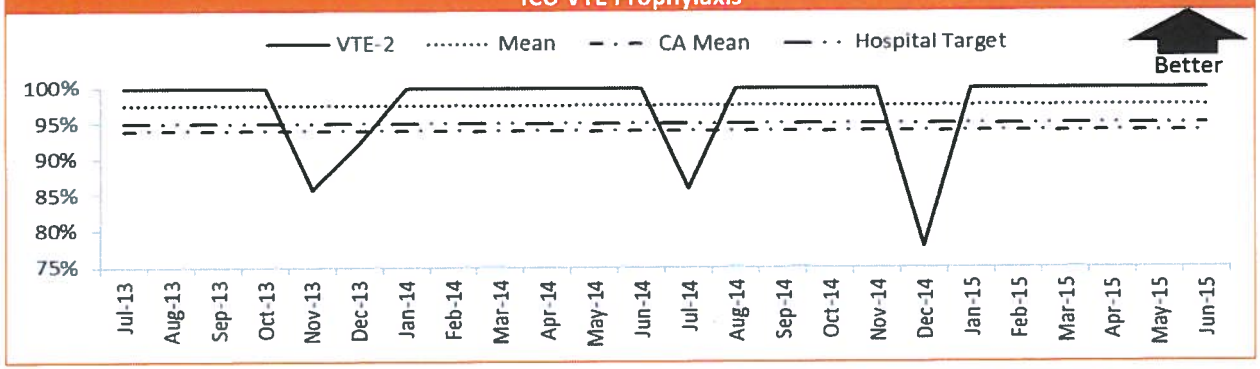
VTE Prophylaxis



Action Plan

Continue to monitor

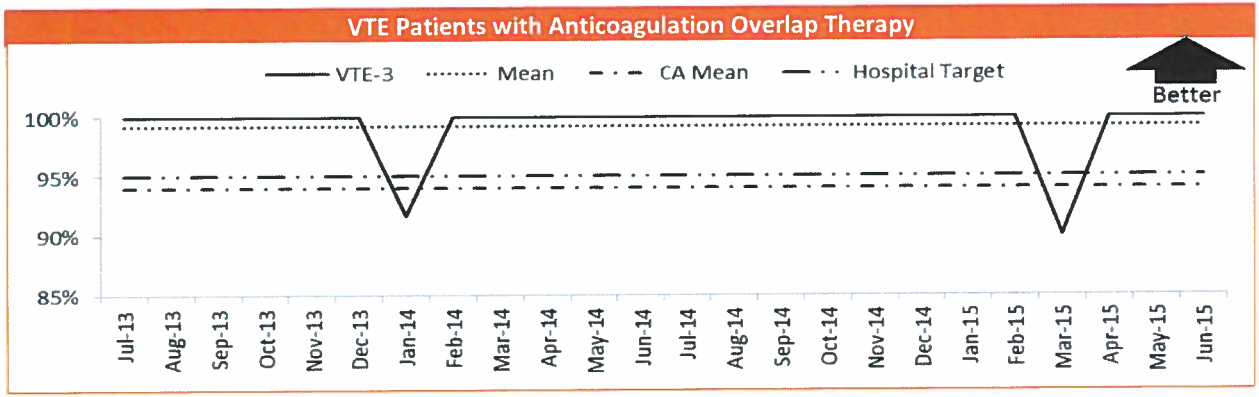
ICU VTE Prophylaxis



Action Plan

Continue to monitor

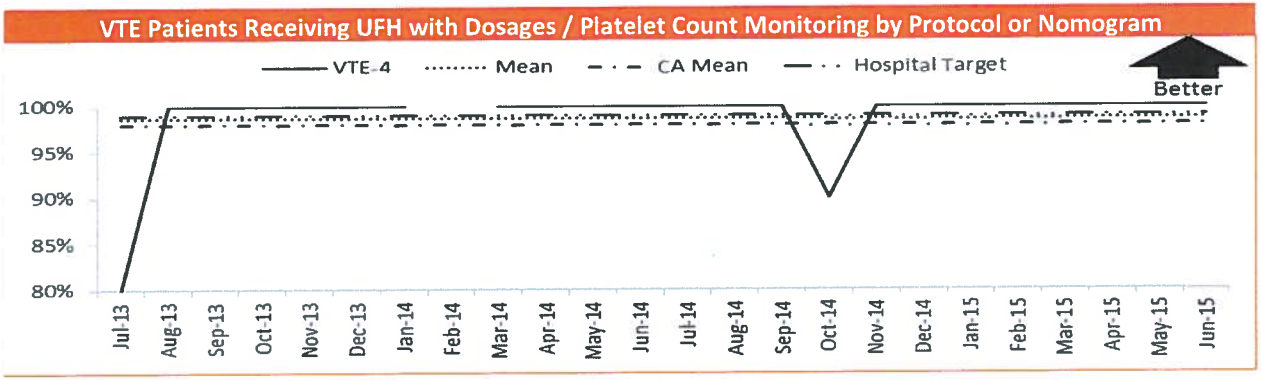
VTE Patients with Anticoagulation Overlap Therapy



Action Plan

Continue to monitor

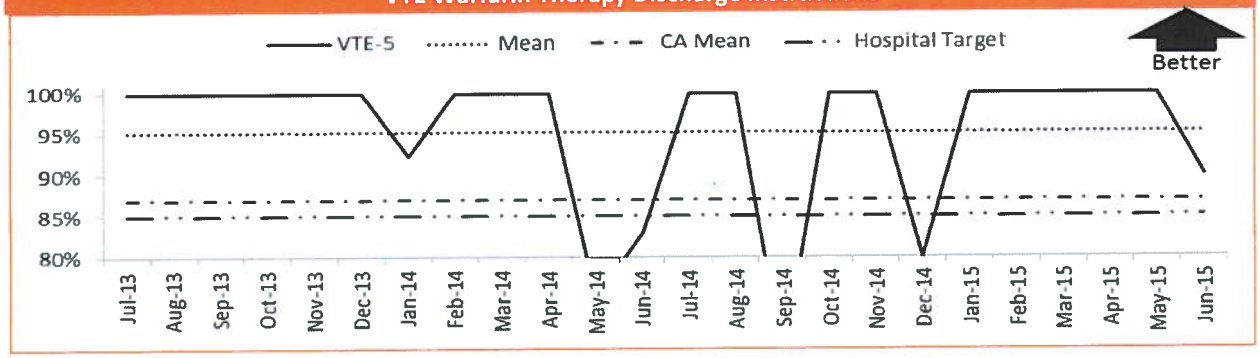
VTE Patients Receiving UFH with Dosages / Platelet Count Monitoring by Protocol or Nomogram



Action Plan

Continue to monitor

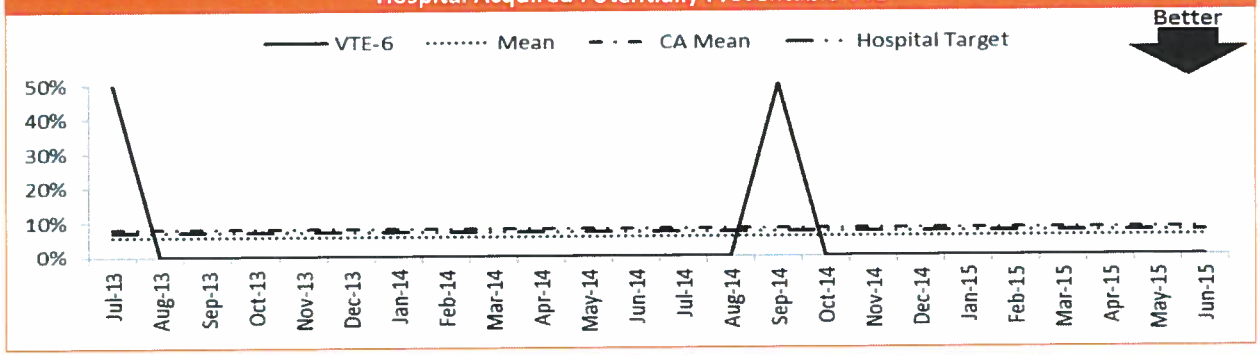
VTE Warfarin Therapy Discharge Instructions



Action Plan

Continue to monitor

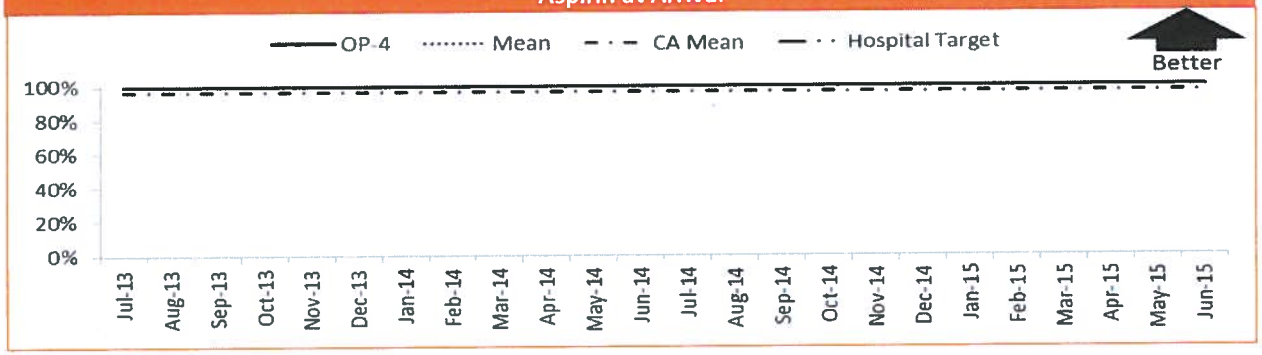
Hospital Acquired Potentially Preventable VTE



Action Plan

Continue to monitor

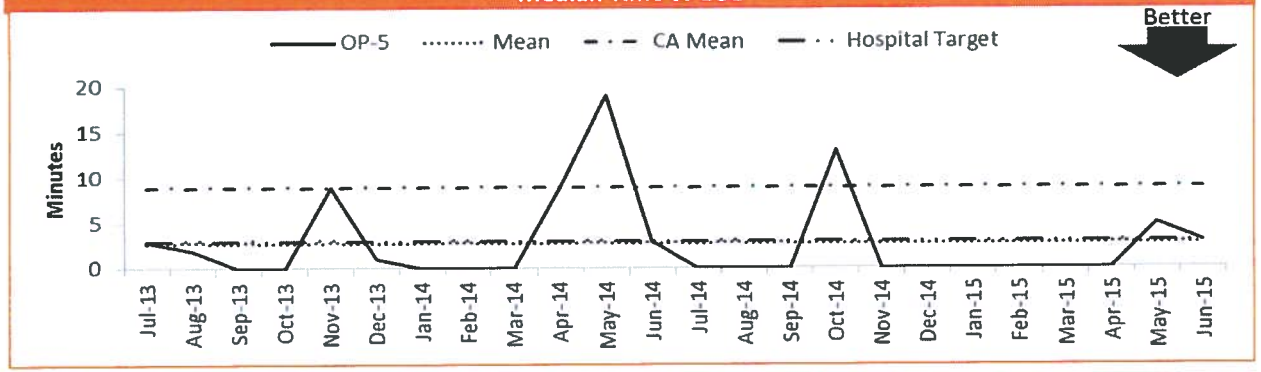
Aspirin at Arrival



Action Plan

Continue to monitor

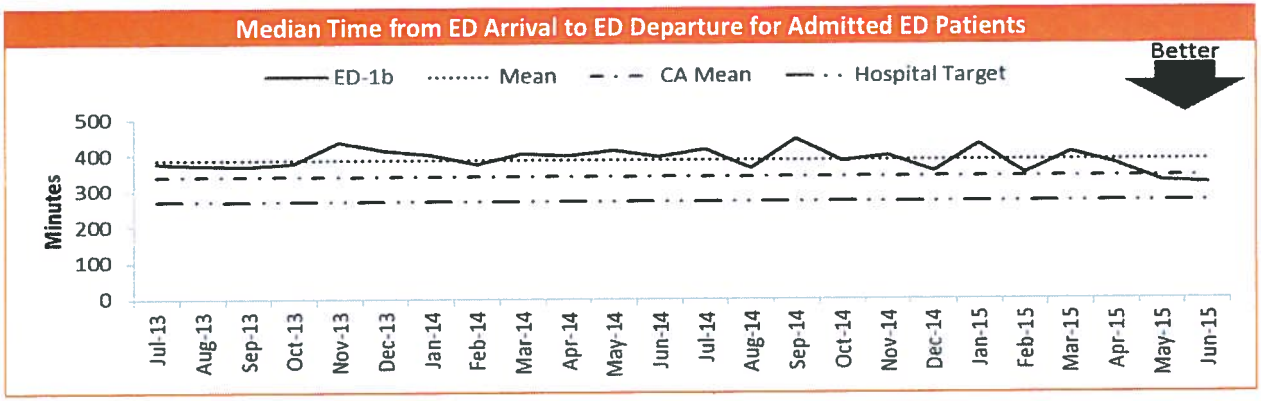
Median Time to ECG



Action Plan

Continue to monitor

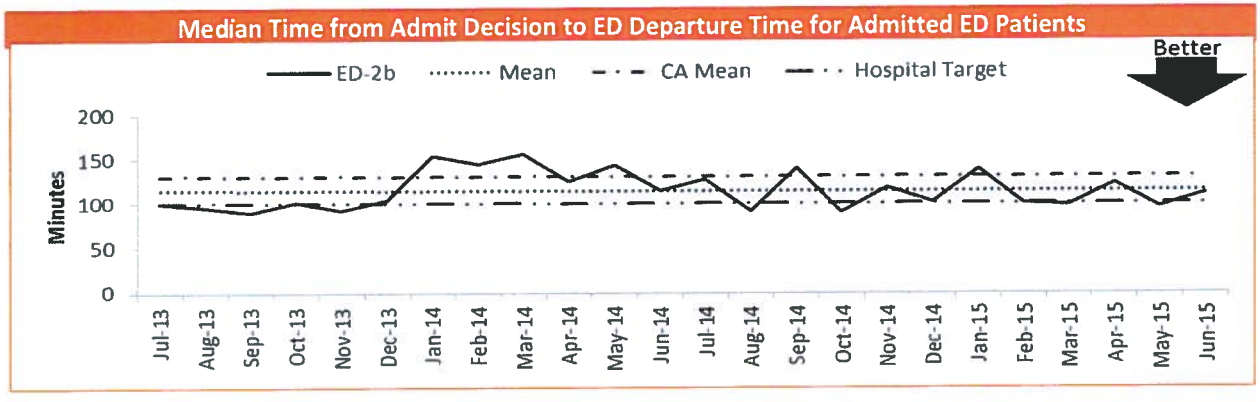
Median Time from ED Arrival to ED Departure for Admitted ED Patients



Action Plan

Continue to monitor

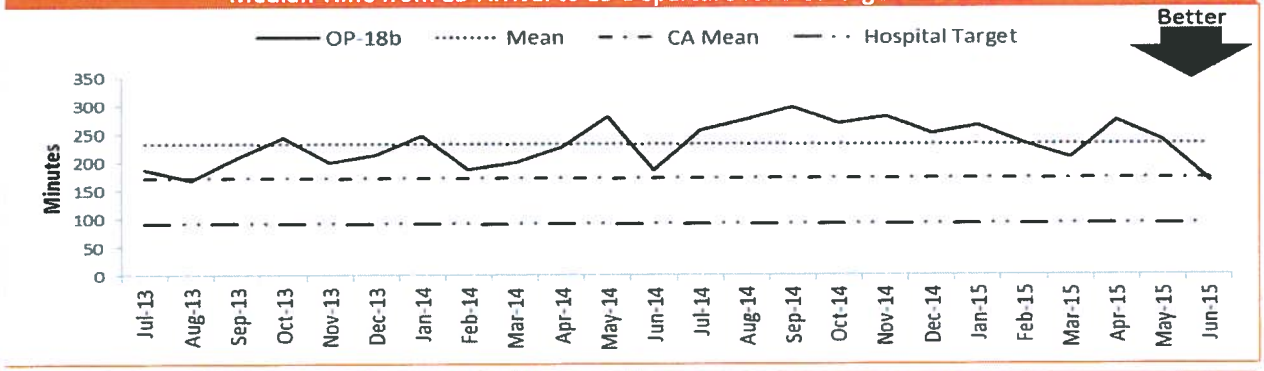
Median Time from Admit Decision to ED Departure Time for Admitted ED Patients



Action Plan

Continue to monitor

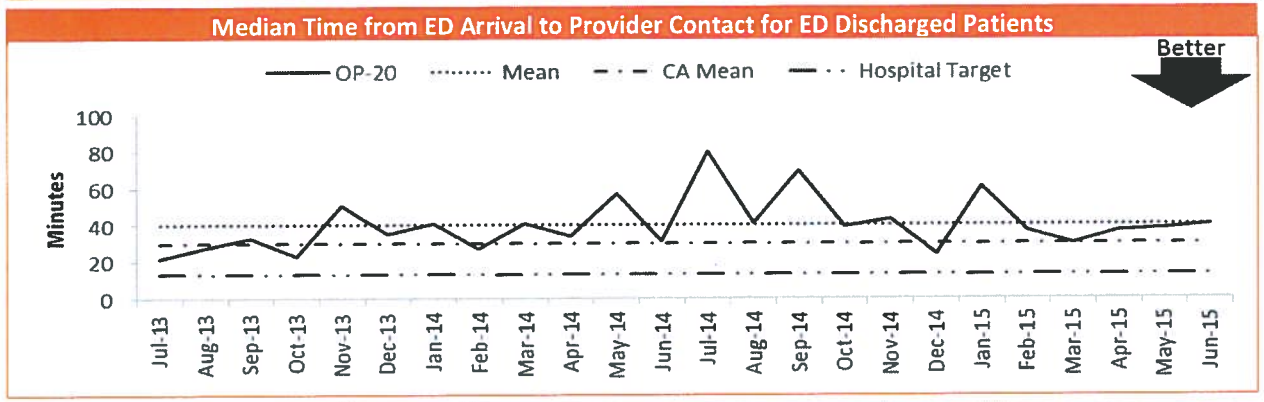
Median Time from ED Arrival to ED Departure for Discharged ED Patients



Action Plan

Continue to monitor

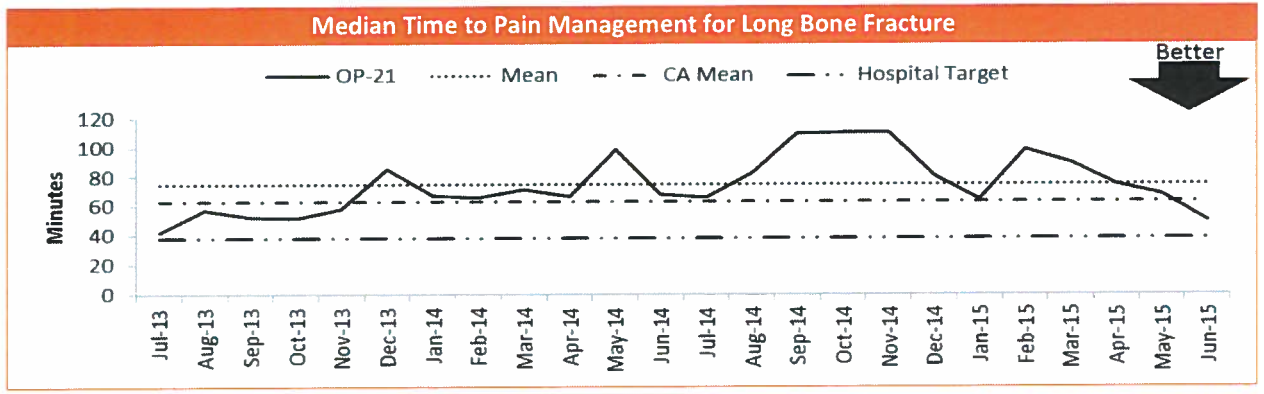
Median Time from ED Arrival to Provider Contact for ED Discharged Patients



Action Plan

Continue to monitor

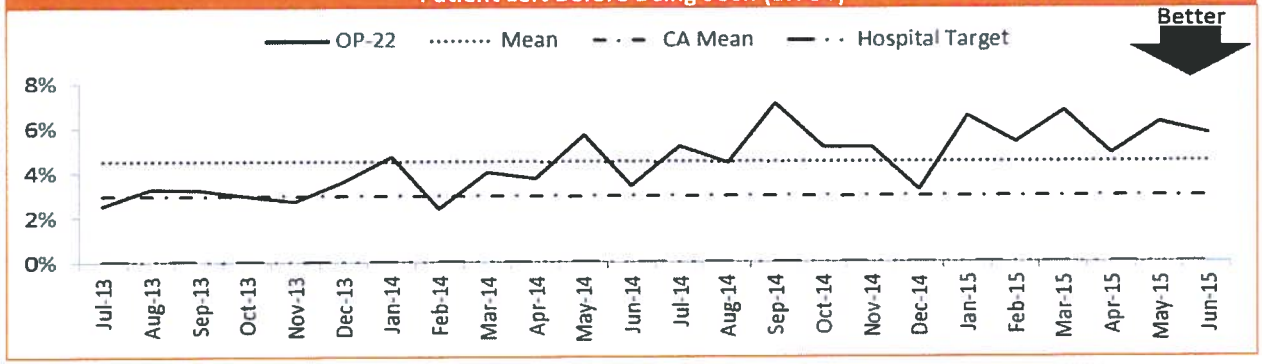
Median Time to Pain Management for Long Bone Fracture



Action Plan

Continue to monitor

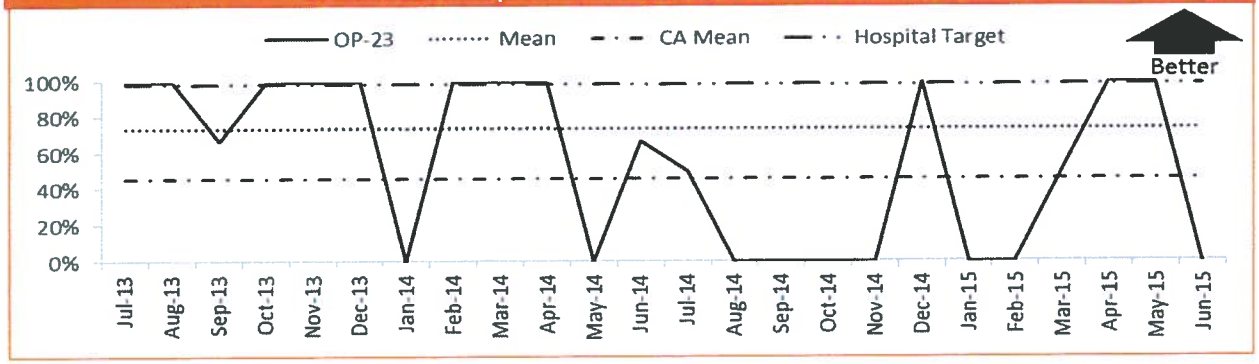
Patient Left Before Being Seen (LWOT)



Action Plan

Continue to monitor

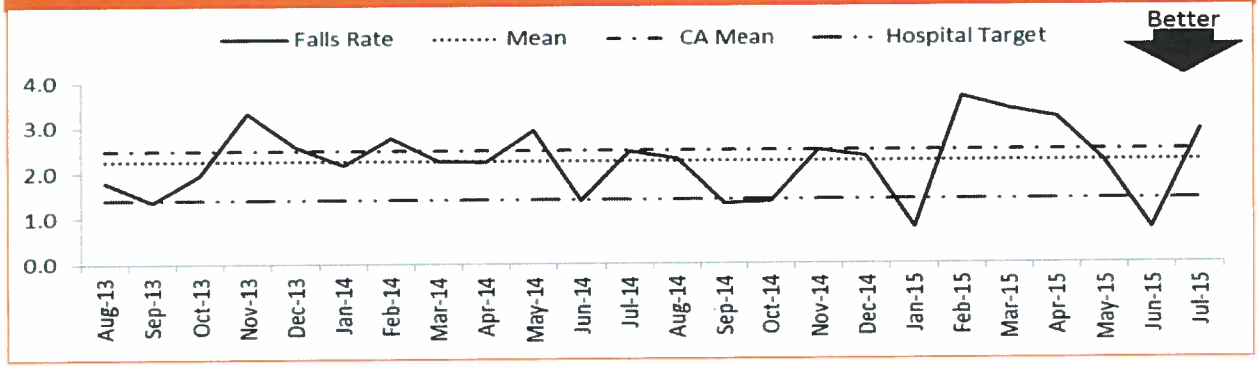
Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival



Action Plan

Continue to monitor

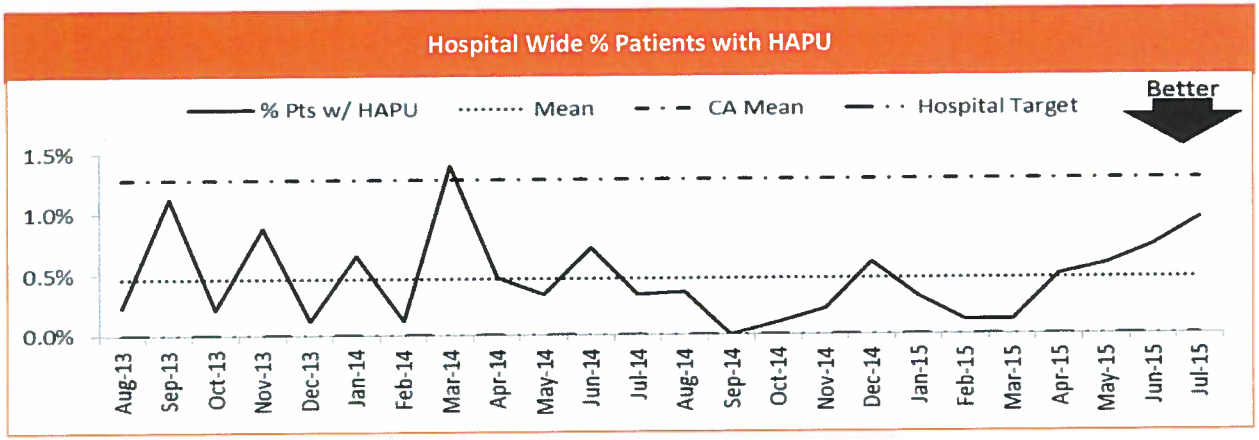
Hospital Wide Falls Rate Per 1000 Pt Days



Action Plan

Continue to monitor

Hospital Wide % Patients with HAPU



Action Plan

Increase Skin & Wound Champions on all units (model after Telemetry)
Created workgroup with tool to determine if HAPU is Avoidable vs. Unavoidable
Continue with HAPU Case Reviews
Continue with mandatory yearly RN Wound Class
Implementation of PowerPlans for standardized wound care per policy

Control Chart Interpretation

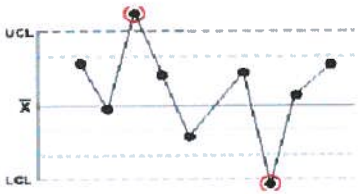
Legend

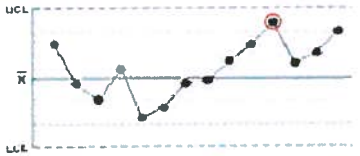
- Hospital Mean
- Hospital Rate
- Hospital UCL
- CA Mean

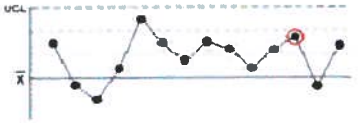
Hospital Mean is the average value we can expect based on the data collected.

Hospital Rate is the actual value.

Hospital UCL (Upper Control Limit) is the highest level of quality that is still considered "normal" given the data history. It is usually 3 standard deviations from the mean.







Description	Indication
One point is more than 3 standard deviations (UCL) from the mean.	One sample (two shown in this case) is grossly out of control.
Six (or more) points in a row are continually increasing (or decreasing).	A trend exists. Procedures in place have an effect on outcomes either positive or negative.
8 (or more) points in a row are on the same side of the mean	Some prolonged bias exists.

Tri-City Medical Center
ADVANCE

Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	49											49
FY15	35	32	46	48	35	33	39	35	31	35	37	406

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	20											20
FY15	14	9	22	24	18	21	19	13	21	19	19	199

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	9											9
FY15	6	10	9	8	12	11	9	7	16	14	6	108

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	16											16
FY15	10	7	10	12	13	7	11	8	9	21	11	119

Performance compared to prior year: Better Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	40											40
FY15	45	51	32	43	49	27	33	43	37	39	40	439

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	19.9											19.9
FY15	23.3	26.5	27.1	21.2	22.8	19.1	18.3	17.5	19.6	16.9	17.5	20.7

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	7.1											7.1
FY15	5.2	3.5	4.3	5.0	4.3	7.2	7.0	6.0	6.5	5.1	5.9	5.4

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	13.3											13.3
FY15	13.2	18.2	19.7	18.1	15.6	16.4	18.3	21.5	14.3	13.9	11.7	16.2

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	183.9											183.9
FY15	190.8	195.0	195.1	195.6	189.2	187.9	203.3	199.8	188.0	186.3	181.5	191.0

Performance compared to prior year: Better Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	215											215
FY15	246	263	244	233	194	233	199	159	208	186	218	2383

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	16											16
FY15	16	19	12	19	17	11	15	8	12	22	23	174

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	7											7
FY15	4	6	2	1	4	8	1	15	4	3	5	53

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	7											7
FY15	10	9	10	10	12	12	12	5	12	10	6	108

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	1.65											1.65
FY15	1.64	1.63	1.58	1.58	1.56	1.58	1.58	1.63	1.62	1.63	1.65	1.61

Performance compared to prior year: Better Worse

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	C/M YTD Avg	Goal Range
FY16	46.7											46.7	48-52
FY15	46.3	48.8	47.9	48.9	49.0	48.9	51.0	50.6	50.6	51.0	49.9	46.3	48-52

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	C/M YTD Avg	Goal Range
FY16	83.6											83.6	75-100
FY15	78.1	77.1	81.2	77.9	79.5	77.6	79.5	77.0	84.3	82.6	82.8	78.1	75-100

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	C/M YTD	C/M YTD Budget
FY16	$862											$862	$25
FY15	$368	($348)	$112	$568	$556	$632	$198	$370	$292	$343	$1,814	$368	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	C/M YTD	C/M YTD Budget
FY16	3.03%											3.03%	0.09%
FY15	1.33%	-1.32%	0.41%	1.93%	1.99%	2.20%	0.70%	1.42%	1.02%	1.22%	6.04%	1.33%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	C/M YTD	C/M YTD Budget
FY16	$2,046											$2,046	$1,330
FY15	$1,761	$988	$1,456	$1,888	$1,896	$1,983	$1,498	$1,652	$1,591	$1,620	$3,136	$1,761	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	C/M YTD	C/M YTD Budget
FY16	7.20%											7.20%	4.73%
FY15	6.38%	3.75%	5.37%	6.42%	6.77%	6.91%	5.34%	6.34%	5.58%	5.76%	10.44%	6.38%	

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	C/M YTD	C/M YTD Budget
FY16	6.13											6.13	6.09
FY15	5.93	5.89	6.01	6.09	6.39	6.28	5.89	5.69	6.18	6.17	5.89	5.93	

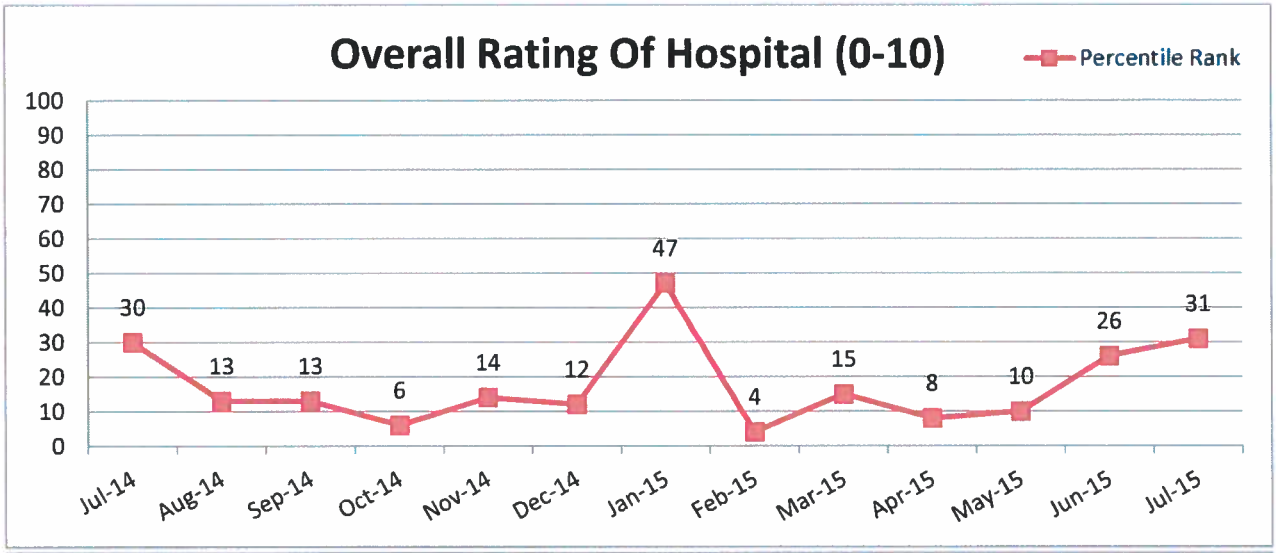
TCHD Fixed Charge Coverage Covenant Calculation

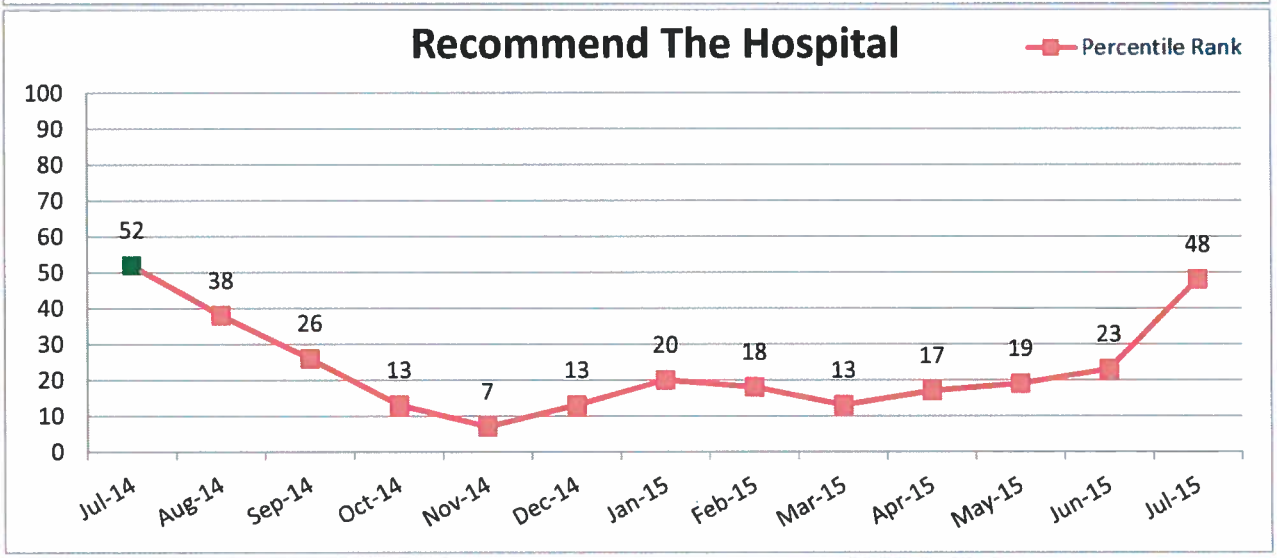
	TTM Jul	TTM Aug	TTM Sep	TTM Oct	TTM Nov	TTM Dec	TTM Jan	TTM Feb	TTM Mar	TTM Apr	TTM May	Covenant	
FY16	1.88											1.10	
FY15	1.55	1.60	1.52	1.49	1.20	1.24	1.32	1.45	1.53	1.51	1.77	1.10	

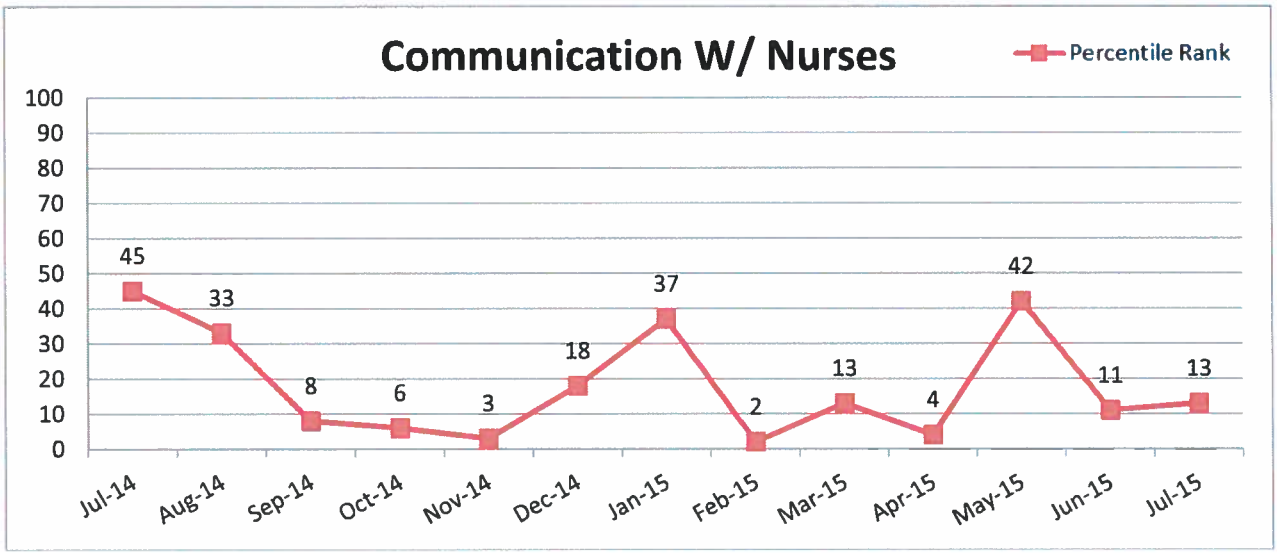
TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
FY16	$30.7										
FY15	$27.7	$21.4	$19.9	$18.8	$18.9	$22.2	$19.9	$16.4	$13.4	$17.8	$26.4

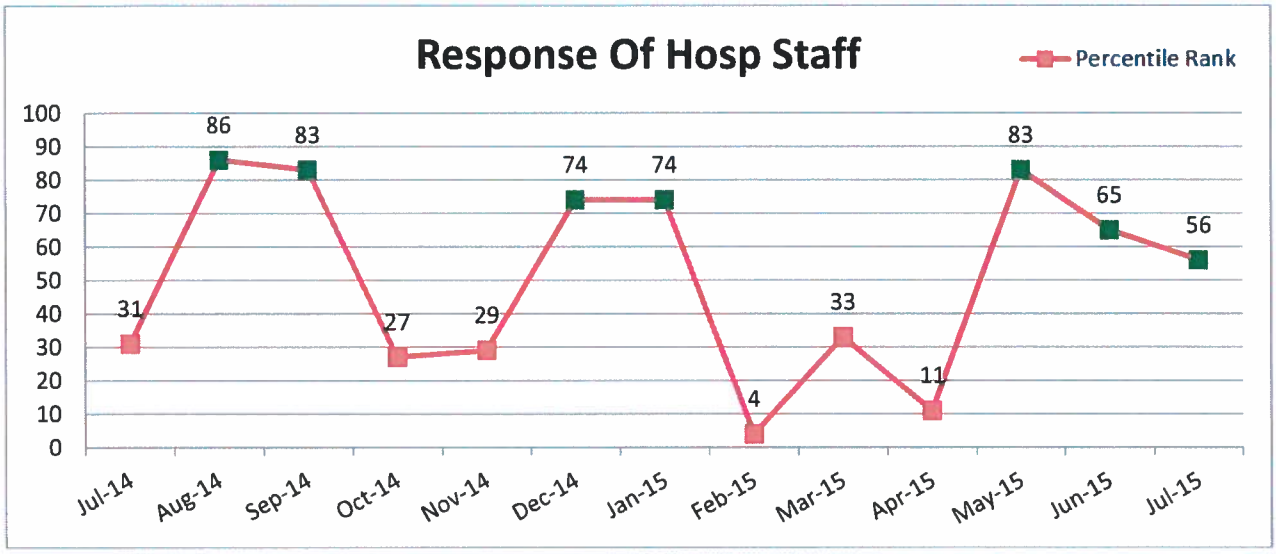
HCAHPS Trending Report - Reporting Period: 7/1/2014 - 7/31/2015

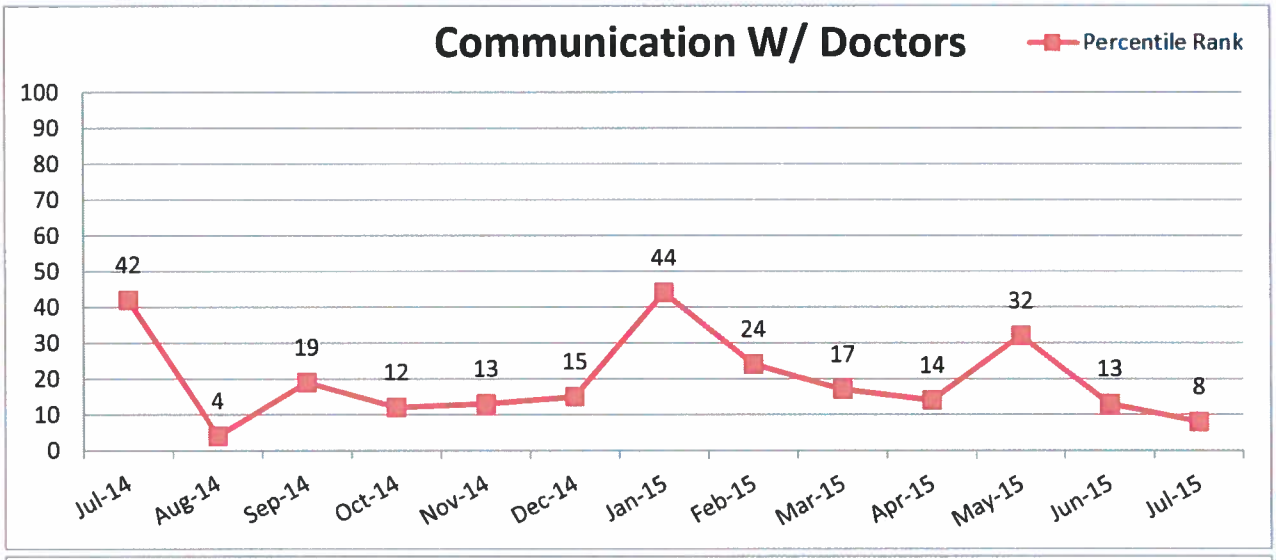


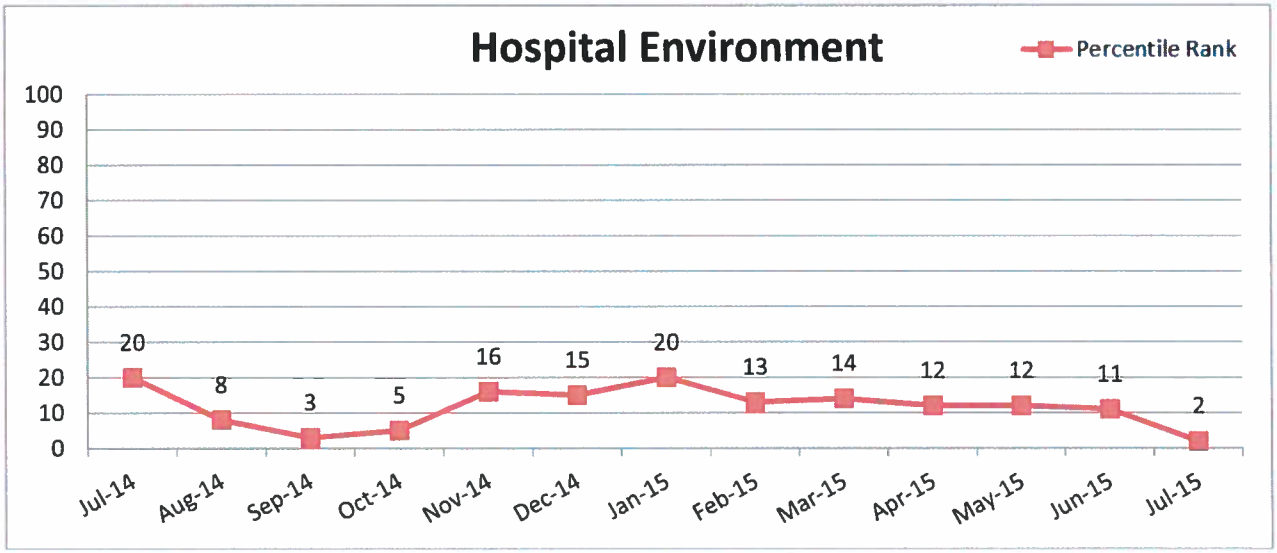




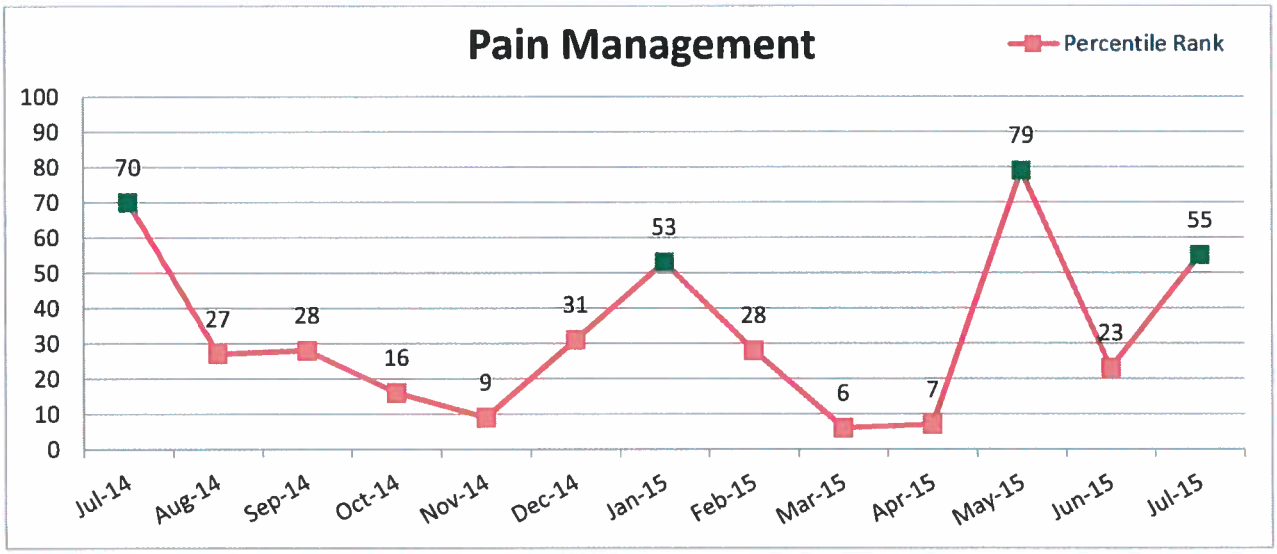
HCAHPS Trending Report - Reporting Period: 7/1/2014 - 7/31/2015

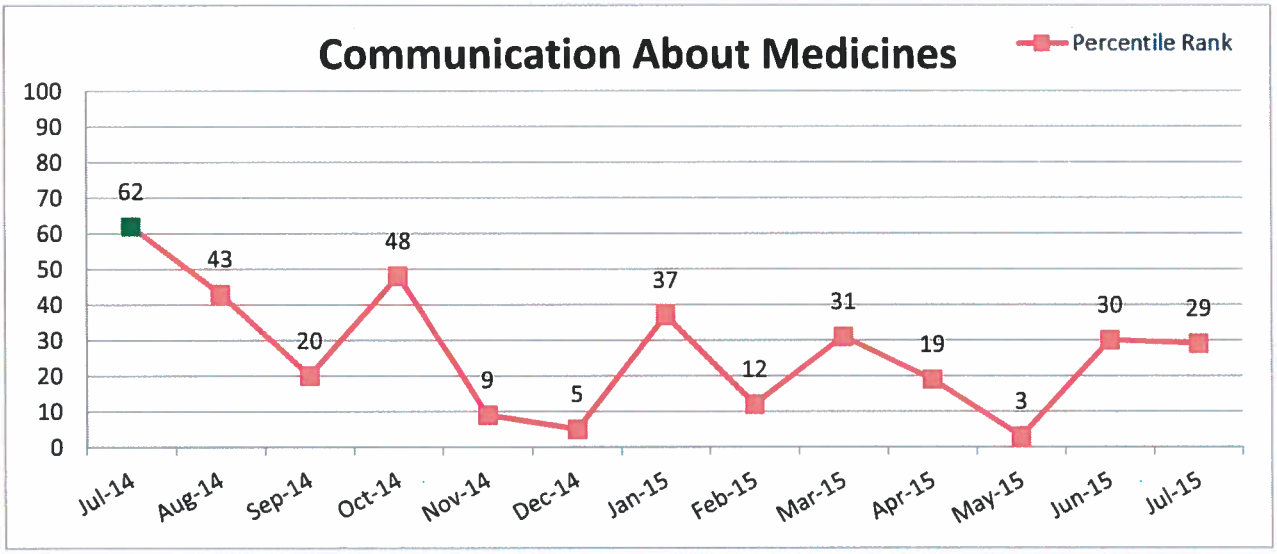


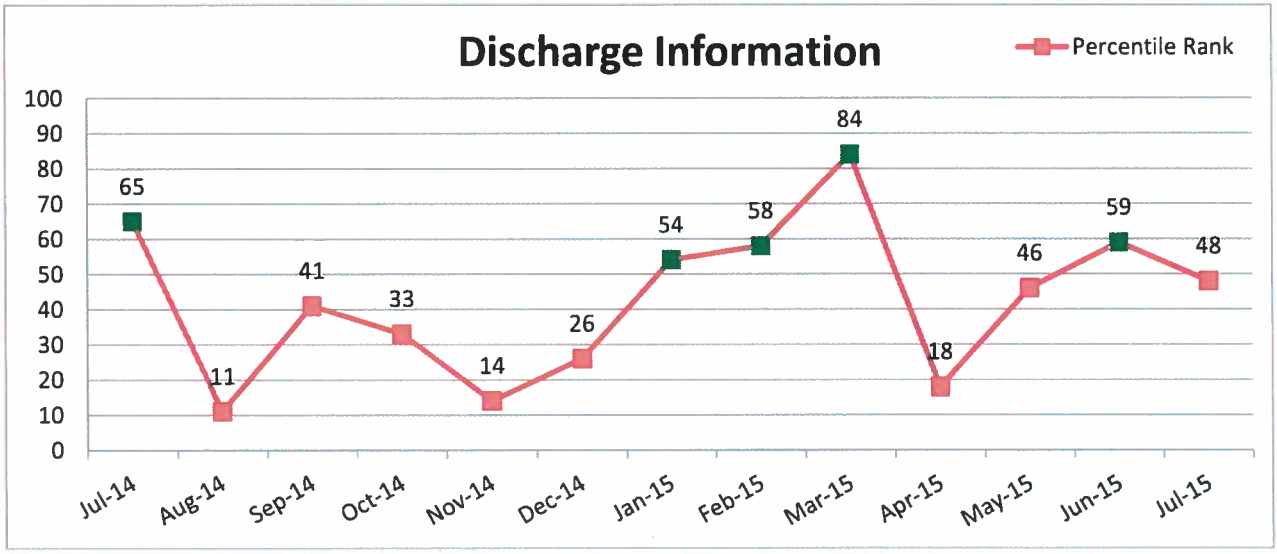




HCAHPS Trending Report - Reporting Period: 7/1/2014 - 7/31/2015







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%			11.4%	11.4%
FY14			12.7%			12.7%			11.7%			11.8%	11.8%

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%			3.6%	3.6%
FY14			8.6%			8.4%			6.8%			3.2%	3.2%

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Construction Report
As of June 2015

Project	CEO, Capital Committee, or Board Approval Date	Bid Close Date Design/ Construction	% of Design Complete	Project Start or Estimated Project Start Date	Estimated Construction Completion Date	% of Construction Complete	Total Budget	Actual Expenditures *	Remaining Budget	Status / Comments
Nurse Call System - Phase 1 (Design Only)	January 2012 FOP	TBD No Bids Solicited at this time	100%	Unknown	Unknown	0%	300,000	97,337	202,663	Submitted for capital budget approval
Angio Lab Renovation	September 2012 Capital Committee	January 8, 2014 Multiple Contractors	100%	July-15	September-15	5%	758,989	198,121	560,868	Construction Started 7/6/15
CT Scan Remodel	June 2013 Board	TBD No Bids Solicited at this time	98%	Unknown	Unknown	0%	50,600	40,290	10,310	1st set of comments came in from OSHPD end of July. Working on OSHPD comments
Replacement of Surgical Lights OR #2	November 2014 Capital	N/A No Public Bid Required	100%	August-15	September-15	0%	22,214	18,230	3,984	Construction starting August 17th
Total Construction Projects							**1,131,803**	**353,978**	**777,825**	

* Actual Expenditures excludes capitalized interest

This report is for construction projects approved by Finance, Operations and Planning Committee

Building Operating Leases
Month Ending July 31, 2015

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term Ending	Services & Location	Cost Center
Gary A. Colner & Kathryn Ainsworth-Colner Family Trust 4913 Colusa Dr. Oceanside, Ca 92056 V#79235	1,650	$1.85	(a)	$ 4,149.39	8/1/12	7/31/15	**Dr Dhruvil Gandhi** 2095 West Vista Way,Ste.106 Vista, Ca 92083	8460
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.50	(a)	$ 18,600.00	2/1/15	10/31/18	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA	7090
Tri-City Wellness, LLC 6250 El Camino Real Carlsbad, CA 92009 V#80388	Approx 87,000	$4.08	(a)	$ 232,282.00	7/1/13	6/30/28	**Wellness Center** 6250 El Camino Real Carlsbad, CA 92009	7760 - 90.65% 7597 - 4.86% 7777 - 4.49% 9520 - 77.25% 7893 - 12.53%
GCO 3621 Vista Way Oceanside, CA 92056 #V81473	1,583	$1.50	(a)	$ 3,398.15	1/1/13	12/31/15	**Performance Improvement** 3927 Waring Road, Ste.D Oceanside, Ca 92056	8756
Golden Eagle Mgmt 2775 Via De La Valle, Ste 200 Del Mar, CA 92014 V#81553	4,307	$0.95	(a)	$ 6,051.79	5/1/13	4/30/16	**Nifty After Fifty** 3861 Mission Ave, Ste B25 Oceanside, CA 92054	9551
Investors Property Mgmt. Group c/o Levitt Family Trust 2181 El Camino Real, Ste. 206 Oceanside, Ca 92054 V#81028	5,214	$1.65	(a)	$ 9,126.93	9/1/12	8/31/17	**OP Physical Therapy, OP OT & OP Speech Therapy** 2124 E. El Camino Real, Ste.100 Oceanside, Ca 92054	7772 - 76% 7792 - 12% 7782 - 12%
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	7,247	$1.22	(a)	$ 10,101.01	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		$ 8,079.83	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		$ 12,865.45	1/1/12	12/31/16	**Vacant Bank Building Property** 4000 Vista Way Oceanside, Ca 92056	8462 Until operational
Total				**$ 332,491.14**				

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

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending July 31, 2015

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6150	PCCN EXAM	70915	175.00	77715	JESSICA MARTIN
6150	PCCN RECERTIFICATION	70915	120.00	79041	TINA WOODEN
6150	PCCN RECERTIFICATION	70915	198.00	80741	SHIRLEY BENTLEY
6150	PCCN RECERTIFICATION	70915	175.00	82463	ANNA MENDOZA
7633	NUANCE TRAINING	60315	1,860.00	77046	JOHN WESTEY BURKE
8390	NPPA CONFERENCE	62915	312.57	78575	LAURA BALL
8390	NPPA CONF REGIS	62915	300.00	78696	LAURA BALL
8460	WEBINAR	31615	75.00	81655	CHRIS MIECHOWSKI
8710	NAT ASSOC MED STAFF	72815MILLER	805.00	78684	SHERRY MILLER
8740	CRITICAL CARE EXPO	61915	200.00	77850	PRISCILLA REYNOLDS
8754	SCAHRM ANNUAL CONF	51915	1,124.22	16119	MARCIA CAVANAUGH

**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.