TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
October 29, 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 Employee organization: UFCW		
	b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	c. Conference with Legal Counsel – Potential Litigation (Authority Government Code Section 54956.9(d) (2 Matters)		
	d. Public Employee Performance Evaluation Title: General Counsel (Authority: Government Code, Section 54957)		
	e. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: October 29, 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
	f. Conference with Real Property Negotiators Property: 4120 Waring Road Agency Negotiators: Tim Moran, Wayne Knight Negotiating Parties: RangeComm, LLC; Mainstreet Realty, LLC Under negotiation: Terms of Sale		
	g. Conference with Legal Counsel – Existing Litigation (Authority Government Code Section 54956.9(d)1, (d)4 (1) Steven D. Stein v. Tri-City Healthcare District Case No. 12-cv-02524BTM BGS (2) Medical Acquisitions Company vs. TCHD Case No: 2014-00009108 Case No. 2014-00022523		
	h. Approval of prior Closed Session Minutes		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)		
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	Special Recognitions – 1) James C. Esch, M.D. 2) Terry A. Haas, M.D. 3) Jeffrey O. Leach, M.D. 4) Jon A. LeLevier, M.D. 5) Martin M. Nielsen, M.D.	15 min.	Chair
13	Introduction of Xiangli Li, M.D. – North County Internal Medicine Group	5 min.	Chair/ W. Knight
14	Report from TCHD Foundation	5 min.	Standard
15	Report from Chief Executive Officer	10 min.	Standard
16	Report from Chief Financial Officer	10 min.	Standard

	Agenda Item	Time Allotted	Requestor
17	New Business		
	a. Consideration to approve Primary Care Provider (PCP) Agreement	10 min.	J. Raimo/FOP
	b. Consideration of appointment of Chief Executive Officer and Chief Operating Officer as managers for Tri-City Real Estate Holding & Management Company, LLC	10 min.	W. Knight
18	Old Business - None		
19	Chief of Staff a. Consideration of October 2015 Credentialing Actions Involving the Medical Staff – New Appointments Only b. Medical Staff Credentials for October 2015 – Reappointments	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 require a second.*** **A. Human Resources Committee** Director Kellett, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes) **B. Employee Fiduciary Retirement Subcommittee** Director Kellett, Subcommittee Chair Open Community Seats – 0 *No meeting held in October,2015* **C. Community Healthcare Alliance Committee** Director Nygaard, Committee Chair Open Community Seats – 2 (Committee minutes included in Board Agenda packets for informational purposes **D. Finance, Operations & Planning Committee** Director Dagostino, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes) 1) Approval of an agreement with Rady Children's Specialists of San Diego for Retinopathy of Prematurity Testing for a term of 12 months, beginning November 1, 2015 through October 31, 2016 for an annual cost of $31,020 and a total cost for the term of $31,020. 2) Approval of an Emergency Department On Call Agreement	5 min.	Standard HR Comm. Emp. Fid. Subcomm. CHAC Comm. FO&P Comm.

	Agenda Item	Time Allotted	Requestor
	for Psychiatry with Dr. Ruchira Densert beginning November 1, 2015 through June 30, 2017 at a daily rate of $1,000 for an annual cost of $243,000 for FY 2016, and $365,000for FY2017, and a total cost for the term of $608,000. 3) Approval of an agreement with Macro Helix for Macro Helix 340B Architect Module for term of 60 months, for an annual cost of $30,600 and a total cost for the term of $153,000. **E. Professional Affairs Committee** Director Dagostino, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes.) 1. **Patient Care Services** a. Administration of Vitamin K Aquamephyton Injection and Erythromycin Ophthalmic Ointment to Newborns - Standardized Procedure b. Administration of Pediatric Hepatitis B Vaccine and Immunoglobulin (HBIG) to Newborns- Standardized Procedure c. Advance Healthcare Directive- Policy d. Blood Glucose Newborn Monitoring- Standardized Procedure e. Care of the Newborn- Standardized Procedure f. Deceased Patient Care and Disposition Procedure g. Disaster Call Back List- Policy h. Hypoglycemia Management in the Adult Patient- Standardized Procedure i. Newborn Hypoglycemia During Transition to Extrauterine Life for NICU- Standardized Procedure (DELETE) i. Pneumococcal and Influenza Vaccine Screening and Administration - Standardized Procedure k. Transporting Ventilator Patients- Procedure l. Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD) Standardized Procedure 2) **Administrative Policies & Procedures** a. Failure Mode and Effects Abnalysis (FMEA) 389 b. Solicitation and Distribution of Literature on District Property 210 (DELETE) 3) **Unit Specific** **Environment of Care** **Section 1 Safety Management** a. Risk Assessment Policy 1040 **Section 3 Life Safety** a. Exit Doors b. Fire Plan- Code Red 3305 c. Fire Safety Hazards		PAC

	Agenda Item	Time Allotted	Requestor
	Section 5 Hazardous Materials a. Reporting Hazmat Incidents **Emergency Operations Procedures Manual** a. Authority to Implement the Disaster Plan for TCMC 4070 (DELETE) b. Disaster Control Center Implementation Plan Emergency Department Specific 4002 (DELETE) c. Disaster Plan for Media Control 4007 (DELETE) d. Disaster Plan rehab Area, Minor Care (Walking Wounded) 4055 (DELETE) e. Emergency removal of Patients Using Manual Carries: Hospital Wide 4005 (DELETE) f. General Information for Discharging Patients 4006 (DELETE) g. Medical Staff Disaster Plan 4045 (DELETE) h. Toxic External Air 4011 (DELETE) **Engineering** **Section 1 General Administrative** a. Engineering Hours of Service- 1006 **Section 4: Equipment** a. Utility Management Plan- 4003 **Section 8: Emergency Preparedness** a. Code Green Policy- 8007 **Infection Control** a. Blood borne Pathogen Exposure Control Plan- IC 10 **Pharmacy** a. General and Concentrated Electrolytes Policy **Rehabilitation Services** a. Supervision Requirements of Minors During Outpatient Rehabilitation b. Use of Encrypted Email for Outpatient Rehab Services		
	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 Neurosurgery b. Division of Psychiatry c. Division of General & Vascular Surgery 2) Approval of Board Policy 14-039–Comprehensive Code of Conduct 3) Approval of Board Policy 14-038 Liability Insurance Requirements		Gov. & Leg. Comm.

	Agenda Item	Time Allotted	Requestor
	G. Audit & Compliance Committee Director Finnila, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes.) 1) **<u>Approval of Administrative Policies & Procedures</u>**: a. 8610-519 – Alternative Means of Communicating PHI in the Designated Record Set b. 8610-262 – Ethics in Provision of Services c. 8610-294 – Legal Documents (2) Minutes – Approval of a) September 24, 2015 – Regular Board of Directors Meeting b) September 17, 2015 – Special Board of Directors Meeting c) October 13, 2015 – Special Board of Directors Meeting (3) Meetings and Conferences – None (4) Dues and Memberships		Audit, Comp. & Ethics Comm. Standard Standard Standard
21	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
22	Reports (Discussion by exception only) (a) Dashboard - Included (b) Construction Report – None (c) Lease Report – (September, 2015) (d) Reimbursement Disclosure Report – (September, 2015) (e) Seminar/Conference Reports - 1) CHA Governance Forum – Chairman Schallock	0-5 min.	Standard
23	Legislative Update	5 min.	Standard
24	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board	5-10 minutes	Standard
25	Additional Comments by Chief Executive Officer	5 min.	Standard
26	Board Communications (three minutes per Board member)	18 min.	Standard
27	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session **(Includes 10 minutes for recess to accommodate KOCT tape change)**	**2 hrs/ 45 min.**	
28	Oral Announcement of Items to be Discussed During Closed Session (If Needed)		
29	Motion to Return to Closed Session (If Needed)		
30	Open Session		
31	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
32	Adjournment		

Xiangli Li, MBBS, MM, PhD

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

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

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

PROFESSIONAL EXPERIENCE

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

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

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

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

PROFESSIONAL LICENSE
Physicians and Surgeons License in California, 2014 active

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

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

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

CERTIFICATION

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

PROFESSIONAL MEMBERSHIP

American College of Physicians (ACP) 2013-present

SELECTED ARTICLES:

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

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

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

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

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

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

AWARDS AND HONORS

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

REFERENCES

Available upon request

Tri-City Healthcare District Board of Directors

Tri-City Real Estate Holding and Management Company, LLC

Appointment and Ratification of New Managers

Background

Upon Tri-City Healthcare District (TCHD) Board of Director approval to form a limited liability company to hold and manage real property, Tri-City Real Estate Holding and Management Company LLC (the "Company" or LLC) was formed November 1, 2011. The LLC has two "members" identified as: TCHD (99% interest) and Tri-City Hospital Foundation (1% interest).

The LLC Operating Agreement identified Larry Anderson, Casey Fatch and Alex Yu as the initial "managers" of the LLC, with a vote of the majority of the managers required to take any action. A majority of the members by affirmative vote or written consent may fill the vacancy of any manager. In 2013, FOB recommended and the TCHD Board approved the appointment of the Chief Financial Officer of TCHD (Steve Dietlin) to replace Alex Yu as manager of the LLC. Two manger vacancies remain open, and it is recommended that the TCHD Board of Directors appoint as new managers of the LLC: the Chief Executive Officer of TCHD (Tim Moran) to fill the vacancy of Larry Anderson, and the Chief Operating Officer of TCHD (Kapua Conley) to fill the vacancy of Casey Fatch. As a result, the following officers of TCHD will be managers of the LLC: Chief Executive Officer (Tim Moran), Chief Operating Officer (Kapua Conley) and Chief Financial Officer (Steve Dietlin).

Recommendation

It is recommended that TCHD appoint the Chief Executive Officer of TCHD (Tim Moran) to fill the vacancy of Larry Anderson as manager of the LLC, and the Chief Operating Officer of TCHD (Kapua Conley) to fill the vacancy of Casey Fatch as manager of the LLC. It is further recommended that TCHD ratify the appointment of the Chief Financial Officer of TCHD (Steve Dietlin) to replace Alex Yu as manager of the LLC.

Motion

I move that the TCHD Board of Directors: (1) appoint the Chief Executive Officer of TCHD (Tim Moran) and the Chief Operating Officer of TCHD (Kapua Conley) to serve as managers of the Company, and (2) ratify the appointment of the Chief Financial Officer of TCHD (Steve Dietlin) to serve as manager of the Company.

WRITTEN CONSENT OF MEMBER
OF
TRI-CITY REAL ESTATE HOLDING AND MANAGEMENT COMPANY LLC
A California Limited Liability Company

The undersigned, being a member of Tri-City Real Estate Holding and Management Company LLC, a California limited lability company (the "Company"), acting pursuant to the California Limited Liability Company Act and the Operating Agreement of the Company, hereby adopt the following resolutions and consent to the actions authorized thereby:

Appointment of Managers

WHEREAS, the following individuals were designated as the initial Managers of the Company, and the following individuals have vacated their positions as Managers of the Company: Larry Anderson, Casey Fatch and Alex Yu.

WHEREAS, it is in the best interest of the Company to appoint the following officers of the undersigned as new Managers of the Company: the Chief Executive Officer of Tri-City Healthcare District (Tim Moran), the Chief Operating Officer of Tri-City Healthcare District (Kapua Conley) and the Chief Financial Officer of Tri-City Healthcare District (Steve Dietlin).

WHEREAS, the undersigned, in March 2013, appointed the following officer of the undersigned as a new Manager of the Company: the Chief Financial Officer of Tri-City Healthcare District (Steve Dietlin).

RESOLVED, that undersigned appoint the following officer of the undersigned as new Managers of the Company, until their successors are appointed: the Chief Executive Officer of Tri-City Healthcare District (Tim Moran), and the Chief Operating Officer of Tri-City Healthcare District (Kapua Conley).

RESOLVED, that undersigned ratify the appointment of the following officer of the undersigned as a new Manager of the Company, until his successor is duly appointed: the Chief Financial Officer of Tri-City Healthcare District (Steve Dietlin).

RESOLVED, that the new Managers have the authority to bind the Company as set forth in the Operating Agreement of the Company.

Therefore, pursuant to the resolutions adopted hereby, the new Managers of the Company shall be as follows:

Manager	Chief Executive Officer (Tim Moran)
Manager	Chief Operating Officer (Kapua Conley)
Manager	Chief Financial Officer (Steve Dietlin)

This Written Consent of Member may be executed in any number of facsimile, electronic or original counterparts, each of which shall be deemed an original and all of which, taken together, shall constitute one and the same instrument

IN WITNESS WHEREOF, the undersigned has executed this Written Consent of Member effective as of the date set forth below.

MEMBER:

Dated _____, 2015

Tri-City Healthcare District,
a California healthcare district

By: _____
Name: Tim Moran
Title: Chief Executive Officer

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
October 13, 2015

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 10/30/2015– 09/30/2017)

Any items of concern will be "red" flagged in this report. 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 10-30-15 through 09-30-2017:

- **HENNINGER, Christopher S., DMD/Dentistry**
- **JOSEPH, Stephanie P., MD/Neurology**

INITIAL APPLICATION WITHDRAWAL: (Voluntary unless otherwise specified)

Medical Staff:

- **MOASIS, Ghassan A., MD – Cardiothoracic Surgery**

TEMPORARY PRIVILEGES: Medical Staff/Allied Health Professionals:

None

TEMPORARY MEDICAL STAFF MEMBERSHIP: Medical Staff:

None

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
October 14, 2015

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 11/01/2015 – 10/31/2017)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 11/1/2015 through 10/31/17, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- ADAMCZAK, Joanna E., M.D./Maternal & Fetal Medicine/Provisional
- AGUILAR TABORA, Lesly G., M.D./Neurology/Provisional
- AMANI, Ramin M.D./Pediatrics/Active
- BHASKER, Kala R., M.D./Family Medicine/Provisional
- CASELE, Holly L., M.D./Maternal & Fetal Medicine/Provisional
- CATANZARITE, Valerian A., M.D./Maternal & Fetal Medicine/Provisional
- FAN, John W., M.D./Teleradiology/Provisional
- HALL, Andrew, M.D/Medicine/Affiliate
- HALIM, Neil L., M.D./Family Medicine/Courtesy
- HARDY, Tyrone M.D./Neurosurgery/Active
- MANNIS, Steven H., M.D./Clinical Research Physician/Consulting
- MELLGREN, Sally G., M.D./Ophthalmology/Courtesy
- MITRUKA, Surindra N., M.D./Cardiothoracic Surgery/Provisional
- NURSE, Lesley A., M.D./Obstetrics & Gynecology/Active
- PARK, Ronald E., M.D./Pediatrics/Courtesy
- PASHMFOROUSH, Mohammad, M.D., PHD/Cardiology/Provisional
- SHAHIDI-ASL, Mahnaz M.D./Pathology – Anatomic/Active
- VARGAS, Michael J., M.D./Cardiology/Active

RESIGNATIONS: (Effective date 10/31/2015 unless otherwise noted)

Voluntary:

- Fatayerji, Nabil M.D — Neonatology
- Ghosh, Kris M.D. — GYN Oncology - Deceased
- Greisman, John J., MD — Urology – Deceased
- Idemundia, Ann O. M.D. — Pediatrics
- Mazur, Paul, MD — Cardiothoracic Surgical
- Mirpourian, Nabat, NP — Cardiology
- Mortin, Melissa, NP — Neurology
- Ostrovsky, Anna, MFT — Psychiatry
- Parikh, Parag P., MD — Surgery
- Zamfirescu-Alexander, MD — Pulmonary

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
October 14, 2015

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS (Effective Date: 10/30/2015, unless specified otherwise)

PRIVILEGE RELATED CHANGES

- Reisman, Bruce M.D./Otolaryngology

STAFF STATUS CHANGES

- Leach, Jeffrey O. M.D./Internal Medicine/Affiliate

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
October 14, 2015

Attachment C

PROCTORING RECOMMENDATIONS (Effective 10/30/2015, unless otherwise specified)

- **Bielawski, Anthony M.D.** — **Emergency Medicine**
- **Choi, James M.D.** — **Anesthesiology**
- **Krueth, Stacy M.D.** — **Anesthesiology**
- **Lau, Kenneth M.D.** — **Anesthesiology**
- **McGraw, Charles M.D.** — **Radiology**
- **Waclawski, Richard M.D.** — **Anesthesiology**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE INITIAL CREDENTIALS REPORT
October 14, 2015

Attachment A

INITIAL APPOINTMENT TO THE ALLIED HEALTH PROFESSIONAL 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:

- **SCHROLL, Kristy M., PA-C**

INITIAL APPLICATION WITHDRAWAL: (Voluntary unless otherwise specified)

Allied Health Professionals:

- **MCCRAY, Dana T., AuD**

TEMPORARY PRIVILEGES: Allied Health Professionals:

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – 1 of 3
October 14, 2015

Attachment B

BIENNIAL REAPPRAISALS: (Effective Dates 11/01/2015 – 10/31/2017)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 11/1/2015 through 10/31/17, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- **DEATRICK, Veronica N.P./Allied Health Professional Supervising Physician Manish Sheah, MD**
- **HICKS, Gayle E., PHD/Allied Health Professional Supervising Physician Kenneth Ott, MD**
- **WALLACE, Stephanie, PAC/Allied Health Professional Supervising Physician Orna Gil, MD**

RESIGNATIONS: (Effective date 10/31/2015 unless otherwise noted)

- **Mirpourian, Nabat, NP/Allied Health Professional**
- **Ostrovsky, Anna MFT/Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE – Part 3 of 3
October 14, 2015

Attachment C

PROCTORING RECOMMENDATIONS (Effective 10/30/2015, unless otherwise specified)

- **Allen, Matthew PA-C** — **Allied Health Professional**
- **Chase, Nicole PA-C** — **Allied Health Professional**
- **Hermann, Linda PA-C** — **Allied Health Professional**
- **McQueen, Paula CNM** — **Allied Health Professional**
- **Rice, William PA-C** — **Allied Health Professional**

TRI-CITY MEDICAL CENTER
HUMAN RESOURCES COMMITTEE
OF THE BOARD OF DIRECTORS
October 13, 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, Gwen Sanders
Non-Voting Members Present:	Tim Moran, CEO; Kapua Conley, COO; Sharon Schultz, CNE; Esther Beverly, VP of HR; Cheryle Bernard-Shaw, CCO
Others Present:	Frances Carbajal, Quinn Abler
Members Absent:	Joe Quince

Topic	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	Chair Kellett called the meeting to order at 12:35 p.m.		Chair Kellett
2. Approval of the agenda	Chair Kellett called for a motion to approve the agenda of October 13, 2015 meeting. Director Mitchell moved and Gwen Sanders 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 August 11, 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			
None			
6. New Business			
a. B.O.D Dashboard- Stakeholder Experience	The Stakeholder Experience pillar- Employee Satisfaction rates were reviewed & discussed.		Chair Kellett
b. Supervision Letter	Sharon Schultz, CNE briefed the committee on the licensed social workers supervision needs for the balance of the required hours for licensure in the state.		Sharon Schultz
c. Review HR Metrics	Quinn Abler, HR Director presented the quarterly metrics. Quarterly headcount and annual turnover rates by each union & overall. TCHD turnover rates are overall low & within national benchmarks and fluctuate throughout the year but stay consistent overall.		Esther Beverly
d. Review Training & Education Topics	Esther presented the Leadership Development Training. The most recent LDI focused on the Press Ganey Employee Partnership Survey results and provided leaders with the necessary tools and training to roll-out the survey results to the staff. Esther also briefed the committee on the Patient Experience/HCAHPS training sessions which focused on HCAHPS, patient whiteboards, hourly rounding, AIDET, the importance of customer service (first impressions, elevator etiquette, phone etiquette), and doing the right thing for patients. At the end of each session employees were asked to re-commit to Tri-City's SUCCESS standards and sign a pledge.		Esther Beverly

Topic	Discussion	Action Follow-up	Person(s) Responsible
e. Key Grievance/ ER-LR Data	Esther explained current status on CNA & SEIU grievances and non-represented employee Fair Treatment Process. The committee discussed the current process for dealing and following up with grievances &/or employee issues.		Esther Beverly
f. Policy Discussion/Action Policy 8610-408 Absences and Tardiness	The Committee reviewed Policy 8610-408 and agreed to the proposed revisions. Chair Kellett called for a motion to send Policy 8610-408 with revisions to the Board of Directors for approval. Ginny Carson moved and Director Mitchell seconded the motion. The motion was carried unanimously.	Policy 8610-408 to be sent to Board of Directors for approval after HR meets & confers with the unions	Esther Beverly
Policy 8610-415 Dress and Appearance Philosophy	The Committee reviewed Policy 8610-415. The committee discussed the proposed revised verbiage. It was decided the policy should be tabled and revised for the next meeting.	Policy 8610-415 was tabled	
Policy 8610-433 Paid Time-Off Program	The Committee reviewed Policy 8610-433 and agreed to the proposed revisions. Chair Kellett called for a motion to send Policy 8610-433 with revisions to the Board of Directors for approval. Director Mitchell moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-433 to be sent to Board of Directors for approval after HR meets & confers with the unions	
Policy 8610-455 Confidentiality	The Committee reviewed Policy 8610-455. The committee discussed the proposed revised verbiage. It was decided the policy should be tabled and revised for the next meeting.	Policy 8610-455 was tabled	
7. Work Plan	The work plan was reviewed.		Chair Kellett
8. Committee Communications	None		Chair Kellett
9. Date of next meeting	**November 10, 2015**		Chair Kellett
10. Adjournment	Chair Kellett adjourned the meeting at 2:30 p.m.		Chair Kellett

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

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
October 8, 2015 Assembly Room 1

MEMBERS PRESENT: Board of Directors Chairman Larry Schallock; Director/CHAC Chairperson Julie Nygaard, Director James Dagostino, Dr. Victor Souza, Carol Brooks, Carol Herrera, Darryl Hebert, Gigi Gleason, Guy Roney, Linda Ledesma, Marge Coon, Mary Lou Clift, Marilou de la Rosa Hruby, Roma Ferriter, Rosemary Eshelman, Xiomara Arroyo

NON-VOTING MEMBERS: David Bennett, Sr. VP & CMO; Kapua Conley, COO; Cheryle Bernard-Shaw, CCO

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

MEMBERS ABSENT: Barbara Perez, Bret Schanzenbach, Don Reedy, Gina McBride, Jack Nelson, Marilyn Anderson, Audrey Lopez, Fernando Sanudo.

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CALL TO ORDER	The October 8, 2015 Community Healthcare Alliance Committee meeting was called to order at 12:33pm by Director and CHAC Chair Julie Nygaard.		
WELCOME NEW MEMBER	Chair Julie Nygaard welcomed the newest CHAC member, Guy Roney, Carlsbad Mayoral Appointee, to the CHAC Committee.		
APPROVAL OF MEETING AGENDA	Director Jim Dagostino motioned to approve the October 8, 2015 agenda. The motion was seconded by Carol Brooks and unanimously approved.		
PUBLIC COMMENTS & ANNOUNCEMENTS	No public comments were made.		
RATIFICATION OF MINUTES	Director Jim Dagostino motioned to approve the September 10, 2015 meeting minutes. The motion was seconded by Gigi Gleason and unanimously approved with no corrections.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
October 8, 2015 Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
COO Update	Chief Operations Officer Kapua Conley updated the group regarding Tri-City Medical Center's current areas of focus, including the following: 1. TCMC's recently released television commercial featuring former NFL player, Willie Buchanon. Kapua noted that he has received very good feedback and felt the project was a good collaboration between Drs. Helgager and Halim and the hospital. 2. SDNEDC's Panel Discussion held on September 29th. The meeting focused on aging baby-boomers and Behavioral Health issues. Kapua noted that the event provided the community with a realistic perspective of the types of challenges the medical community will be facing in the future. 3. NICU and Labor and Delivery renovations, noting that mock up rooms should be completed soon so donors can see what is proposed for the new areas. 4. Baile de Esperanza, TCMC's Foundation fundraiser gala, is set for November. Funds raised will go towards improvements in the NICU department. 5. Campus redevelopment plans continue.		

TOPIC		ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
COO UPDATE (Con't)	6. The Board and Administration's Strategic Retreat took place in September. A Consultant from the Camden Group facilitated the discussion regarding positioning TCMC for future success in the ever-changing healthcare environment, with special emphasis on Clinical Integration, IT Infrastructure and Bundled Payments. 7. Kapua noted an earlier successful interview with a potential Oncology Physician, with a strong focus on Women's health, who is looking to relocated to Southern California. 8. Tri-City recently had their second follow up meeting with local EMS personnel in Vista, Oceanside and Carlsbad, to improve collaboration, off-loading methods and patient flow. Kapua noted that TCMC will be opening the BHU wing in the ER at the end of the month to free up needed ER beds, and extending hours of operation of the A-side station to increase flow in anticipation of the upcoming flu season. 9. ICD-10 transition underway. 10. TCMC is preparing for the anticipated soon arrival of the Joint Commission.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
October 8, 2015 Assembly Room 1

TOPIC		ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CMO UPDATE	Sr. VP and Chief Marketing Officer, David Bennett, updated the group noting the following: 1. Preparations are currently underway for the creation and mailing of the 2015 TCMC Annual Report to district residents. 2. Medicare Open Enrollment runs from October 15th through December 7th. A highly visible billboard with enrollment information was recently installed at 78 W near TCMC. 3. David noted that CEO Tim Moran has worked diligently to address former Nifty After Fifty member concerns over the closure of the NAF businesses in Oceanside and Vista. Tim has helped the group successfully find a new Oceanside and Vista location. TCMC has also provided grant funds and donated the former NAF equipment back. Marilou de la Rosa Hruby suggested looking into an Adult Daycare for the North County area, noting that the closest areas now are Fallbrook and Encinitas.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
October 8, 2015 Assembly Room 1

TOPIC		ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PRESENTATION	Monica Trudeau, Director of Tri-City Home Health, addressed the group about Home Health and its value to the patient and hospital. Topics included: 1. Home Health overview and its relationship to TCMC. 2. How patients are referred to Home Health by their Physician 3. Medicare coverage – Part A and Part B 4. Skilled services covered, including: a. Nursing b. Physical Therapy c. Speech Therapy d. Occupation Therapy e. Medical Social Services f. Certified Home Health Aides 5. Requirements of qualification: a. Intermittent skilled nursing care b. Homebound certification by an MD c. The Home Health agency must be Medicare certified 6. Qualifications of Tri-City Home Health to perform services 7. Home Health Transitional Care 8. Re-admission rates – it was noted that quality Home Health care following a hospital visit can greatly reduce hospital re-admission rates. 9. Outcome measures, including improvements in: a. Ambulation b. Bed Transferring c. Bathing d. Pain Interfering With Activity e. Shortness of Breath f. Acute Care Hospitalization		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
October 8, 2015 Assembly Room 1

TOPIC		ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PRESENTATION (Con't)	Kapua Conley noted that Tri-City Home Health achieved a satisfaction rating of 97% nationally – an exceptional achievement in the industry.		
CHAC COMMITTEE VACANCY	Member Laura Vine's service time for the CHAC committee expired in August of 2015. Chairperson Julie Nygaard requested a motion to renew member Laura Vine's term for another two years. Jim Dagostino motioned for the renewal, which was seconded by Gigi Gleason with no objections.		
COMMITTEE COMMUNICATIONS	Rosemary Eschelman noted that HHS is conducting a series of open sessions for feedback and input on mental health, alcohol and drug programs currently provided. Rosemary provided a flyer noting dates and times of upcoming sessions. Rosemary also thanked David Bennett and the Marketing Department for funding the "Students Make Healthy Choices" red ribbons for the Carlsbad Unified School District. Roma Ferriter stated that North County Health Services is preparing for Open Enrollment and the upcoming 5K Run / Walk on October 25th. Xiomara Arroyo provided information about Well Fargo's "Get Smart About Credit" program during the month of October. Linda Ledesma provided information on the Youth Enrichment program to be held at Valley Middle School library on October 15th.		

TOPIC		ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
COMMITTEE COMMUNICATIONS (Con't)	Carol Herrera noted that member Fernando Sanudo will be honored the evening of October 8, 2015, by the Vista Unified School District Superintendent, for his contributions to the District. Darryl Hebert took a moment to relay a personal experience his family recently had with Scripps Encinitas, noting that once his family member became a patient at Tri-City Medical Center, their experience improved and he and his family reaffirmed the great care provided at TCMC.		
ADJOURNMENT	The meeting was adjourned at 1:59pm.		

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
October 20, 2015

Members Present	Director James Dagostino, Director Cyril Kellett, Director Julie Nygaard, Dr. John Kroener, Carlo Marcuzzi, Wayne Lingenfelter,
Non-Voting Members Present:	Tim Moran, CEO, Steve Dietlin, CFO, Kapua Conley, COO, Wayne Knight, Sr. VP, Medical Services
Others Present	Tom Moore, David Bennett, Colleen Thompson, Sharon Schultz, Tori Hong, Ray Rivas, Jeremy Raimo, Mary Diamond, Jane Dunmeyer, Jody Root, (Procopio)
Members Absent:	Dr. Marcus Contardo, Dr. Frank Corona, Cheryle Bernard Shaw, Kathleen Mendez, Steve Harrington, Tim Keane

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Dagostino called the meeting to order at 12:31 pm.		
2. Approval of Agenda		**MOTION** **It was moved by Director Kellett, Mr. Lingenfelter seconded, and it was unanimously approved to accept the agenda of October 20, 2015.**	
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Dagostino read the paragraph regarding comments from members of the public.		Director Dagostino
4. Ratification of minutes of September 15, 2015		Minutes were ratified **MOTION** **It was moved by Director Nygaard, Director Kellett seconded, that the minutes of September 15, 2015, be**	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		approved without any modifications requested.	
5. Old Business			
6. New Business			
a. Finance, Operations & Planning Meeting Discussion • For December 15, 2015	Director Dagostino solicited input from those in attendance, whether there are any anticipated initiatives pending that would require holding a Finance, Operations & Planning meeting in December. After some discussion, it was determined that the December meeting would be cancelled.	**No motion required, per legal advisor Jody Root**	Director Dagostino
b. Rady Children's Specialists Agreement for NICU ROP Testing	Mary Diamond explained this proposal is a renewal agreement with Rady Children's Specialists to provide ophthalmic consultation services for the NICU, and retinopathy of prematurity testing. She further explained that ROP testing is mandated by the State of California. Discussion ensued.	**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 agreement with Rady Children's Specialists of San Diego for Retinopathy of Prematurity Testing for a term of 12-months, beginning November 1, 2015, and ending October 31, 2016, for an annual cost of $31,020, and a total cost for the term of $31,020.**	Mary Diamond
c. Physician Agreement for ED On-Call Coverage • Ruchira Densert, M.D.	Kapua Conley presented the proposal for Emergency Department On-Call Psychiatry coverage. He emphasized this would provide 24/7 patient	**MOTION** **Director Nygaard moved, Director Kellett seconded, and it was unanimously approved that the Finance, Operations**	Kapua Conley

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	coverage for all psychiatry specialty services, in accordance with Medical Staff Policy #8710-520. This write-up is adding a new physician, to an existing panel, with no increase in expense. Discussion ensued.	**and Planning Committee recommend that the TCHD Board of Directors authorize the Ruchira Densert, M.D., as ED On-Call Coverage Physician for a term of 20 months, beginning November 1, 2015, and ending June 30, 2017, at a daily rate of $ 1,000 for an annual cost of $243,000 for FY 2016, and $365,000 for FY 2017, and a total cost for the term of $608,000.**	
d. Macro Helix 340B Architect Module	Tori Hong presented the proposal for Macro Helix 340B Architect Module. She explained that TCMC is currently using Sentry DS for a monthly cost of $6,160, and an annual cost of $73,920. Implementing Macro Helix would offer a savings of $43,320 per year. In addition, Macro Helix 340B Architect would manage the 340B program, as well as any contract pharmacies. It would also track all 340B eligible dispenses and facilitates purchasing these items on the 340B account. Director Nygaard recommended that the verbiage in the write-up be edited to reflect approval request, vs. presumptive approval.	**MOTION** **Director Kellett moved, Dr. Kroener seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Macro Helix for Macro Helix 340B Architect Module for a term of 60 months, for an annual cost of $30,600, and a total cost for the term of $153,000.** Write-up to be amended by Barbara Hainsworth	Tori Hong
e. Financials	Steve Dietlin presented the financials ending September 30, 2015 (dollars in thousands) **Fiscal Year to Date** Operating Revenue $ 83,908 Operating Expense $ 83,421		Steve Dietlin

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	EROE $ 1,656 EBITDA $ 5,220 **TCMC –Key Indicators – FYTD** Avg. Daily Census 189 Adjusted Patient Days 28,275 Surgery Cases 1,690 Deliveries 681 ED Visits 17,006 **Current Month** Operating Revenue $ 27,666 Operating Expense $ 27,900 EROE $ 182 EBITDA $ 1,357 **Net Patient A/R & Days in Net A/R By Fiscal Year** FY Avg. Net Patient A/R (in millions) $ 41.1 FY Avg. Days in Net A/R 46.0 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable • TCMC-Average Daily Census-Total Hospital-Excluding Newborns • TCMC-Adjusted Patient Days • TCMC-Emergency Department Visits • TCHD-EBITDA and EROE, Quarterly		
i. Work Plan – Information Only	Director Dagostino reported that these agenda items were for review only, but Committee members were welcome to ask questions.		

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Prior to Work Plan update presentations, Director Dagostino solicited input from committee members, regarding those items scheduled for update at the December meeting, now slated for cancellation. It was agreed that the December Work Plan items would be moved to the January 2016 meeting.		
• Construction Report (quarterly)	Kapua Conley gave a brief overview of the items listed on the Construction Report.		Kapua Conley
• Infusion Center (quarterly)	No formal presentation was given. Brief discussion ensued, with Sharon Schultz addressed questions raised.		Sharon Schultz
• Aionex Bed Board / Throughput (bi-monthly)	Kapua Conley provided a single-slide PowerPoint presentation, on the current Patient Throughput Initiatives being vetted for implementation.		Kapua Conley
• Dashboard	Steve Dietlin briefly reviewed the Dashboard financials.		Steve Dietlin
• Medical Director, Surgery	Mary Diamond gave a PowerPoint presentation reflecting the quarterly results for the Medical Director, Surgery. This information is geared to improve the efficiency and delivery of care in the		Mary Diamond

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	operating room. The performance metrics for evaluation are as follows: • Block Time • Turnover Time • First Case On-Time Starts • Compliance with Time-Out procedure Mary responded to questions, and reported that there has been improvement in these specific areas of evaluation. She emphasized that it can be challenging to see significant advancement due to numerous contributing factors, and outlined that each is being addressed, as it is identified.		
7. Comments by Committee Members		None	Chair
8. Date of next meeting	November 17, 2015		Chair
9. Community Openings (none)			
10. Oral Announcement of items to be discussed during closed session (Government Code Section 54957.7)			Jody Root
11. Motion to go into Closed Session		**MOTION** **Director Kellett moved, Mr. Lingenfelter seconded, and it was unanimously approved to go into Closed Session at 1:24 pm**	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
16. Open Session		**MOTION** **Director Kellett moved, Dr. Kroener seconded, and it was unanimously approved to go into Open Session at 1:43 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 1:44 pm		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 20, 2015
Rady Children's Specialists Agreement for NICU ROP Testing

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

Vendor's Name: Rady Children's Specialists of San Diego

Area of Service: NICU - Retinopathy of Prematurity Testing

Term of Agreement: 12 months, Beginning, November 1, 2015 - Ending, October 31, 2016

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$2,585	$31,020	$31,020

Description of Services/Supplies:

- Ophthalmic Consultation Services for NICU-Retinopathy of Prematurity Testing
- Requested increase of $385 (17.5%) per month, $4,620 per year

Document Submitted to Legal:	X	Yes		No		Not Applicable
Approved by Chief Compliance Officer:	X	Yes		No		Not Applicable
Is Agreement a Regulatory Requirement:	X	Yes		No		Not Applicable

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

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Rady Children's Specialists of San Diego for Retinopathy of Prematurity Testing for a term of 12-months, beginning November 1, 2015, and ending October 31, 2016, for an annual cost of $ 31,020, and a total cost for the term of $ 31,020.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 20, 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: Ruchira Densert, M.D.

Area of Service: Emergency Department On-Call: Psychiatry

Term of Agreement: 20 months, Beginning, November 1, 2015 – Ending, June 30, 2017

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

- New physician to existing panel. No increase in expense

Rate/Day	Days per Year	Annual Cost	20 month (Term) Cost
$ 1,000	FY 2016: 243 FY 2017: 365	$243,000 $365,000	$243,000 $365,000
		Total:	**$608,000**

Position Responsibilities:

- Provide 24/7 patient coverage for all psychiatry 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		Not Applicable
Approved by Chief Compliance Officer:	X	Yes		No		Not Applicable
Is Agreement a Regulatory Requirement:	X	Yes		No		Not Applicable

Person responsible for oversight of agreement: Sherry Miller, MSS Manager; Kirkpatrick (Kapua) Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Ruchira Densert, MD, as ED On-Call Coverage Physician for a term of 20 months, beginning November 1, 2015, and ending June 30, 2017, at a daily rate of $ 1,000 for an annual cost of $243,000 for FY 2016, and $365,000 for FY 2017, and a total cost for the term of $608,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 20, 2015
PROPOSAL FOR: Macro Helix 340B Architect Module

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

Vendor's Name: Macro Helix

Area of Service: Pharmacy

Term of Agreement: 60 months, Beginning, January 2016 – Ending, December 2020

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$2,550	$30,600	$153,000

Description of Services/Supplies:

- TCMC currently utilizes Sentry DS; monthly cost = $6,160/month; annual cost = $73,920
- Macro Helix would offer $43,320 in savings per year
- The Macro Helix 340B Architect would fully manage the 340B program for the hospital, and any contract pharmacies (as applicable).
- The 340B Architect hospital module would be capable of identifying and tracking all 340B eligible dispenses, and would facilitate the purchase of these items on the 340B account.
- Full audit support would be included: policy and procedure templates, audit guides, support for an actual audit, and annual mock audits provided by Macro Helix.
- Macro Helix offers a contract pharmacy module that would assist with building and implementing contract pharmacy networks.
- The 340B Architect retail module would be able to identify all eligible scripts, assist with inventory replenishment, and would be able to invoice the contract pharmacy, as well as provide audit support, etc.

Document Submitted to Legal:	X	Yes		No		Not Applicable
Approved by Chief Compliance Officer:	X	Yes		No		Not Applicable
Is Agreement a Regulatory Requirement:		Yes	X	No		Not Applicable

Person responsible for oversight of agreement: Tori Hong, Director of Pharmacy / Sharon Schultz, Chief Nurse Executive / Steve Dietlin, Chief Financial Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Macro Helix for Macro Helix 340B Architect Module for a term of 60 months, for an annual cost of $30,600, and a total cost for the term of $153,000.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
October 15, 2015

Members Present: Director Jim Dagostino (Chair), Director Ramona Finnila, Director Laura Mitchell 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, Kathy Topp, Kerry Moriarty-Homsy, Tori Hong, Nancy Lam, Melinda Ruiz, Sharon Davies, April Lombardo, Kevin McQueen, John Pledger, Chris Miechowski, Sherry Miller , Steve Young, Priya Joshi, Patricia Guerra and Karren Hertz.

Members absent: Dr. Gene Ma, Dr. Scott Worman, Dr. James Johnson, Cheryle Bernard-Shaw.

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 Finnila and seconded by Director Mitchell.	Director Dagostino
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Dagostino read the paragraph regarding comments from members of the public.		Director Dagostino

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of September 2015.	Director Dagostino called for a motion to approve the minutes of the September 17, 2015.	Minutes ratified. Director Finnila moved and Director Mitchell seconded the motion to approve the minutes from September 2015.	Karren Hertz
5. New Business a. Quality Outcomes Dashboard	The outcomes dashboard for September was presented to the committee. The VTE Warfarin Therapy Discharge Instructions showed a decline for August 2015. This can be attributed to an accident; however, it was noted that the hospital-wide falls rate is better all throughout the hospital for this period.	Informational.	Jami Piearson
Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. Administration of Vitamin K Aquamephyton Injection and Erythromycin Ophthalmic Ointment to Newborns - Standardized Procedure 2. Administration of Pediatric Hepatitis B Vaccine and Immunoglobulin (HBIG) to	No discussion on this policy. The Hepatitis B testing was considered to be appropriate to be administered to babies within 24 hours.	**ACTION:** The Patient Care Services policies and procedures were approved with the exception of the policy on the Release of the Deceased. Dr. Contardo moved and Director Finnila seconded the motion to approve these policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Newborns- Standardized Procedure			
3. Advance Healthcare Directive- Policy	Special mention was directed at the advanced directives prepared my military lawyers—as stated in the policy, they are free and exempt from State requirements as to form, substance, or recording.		
4. Blood Glucose Newborn Monitoring- Standardized procedure			
5. Care of the Newborn- Standardized Procedure	There was a clarification on the amount of milk needed for the bottle feeding for a newborn, if necessary. The verbage on chorioamniotitis was also modified for proper interpretation.		
6. Deceased Patient Care and Disposition- Procedure			
7. Disaster Call Back List- Policy			
8. Hypoglycemia Management in the Adult Patient- Standardized Procedure	It was identified that there is a Pyxis profile in the units as addressed in this policy.		
9. Newborn Hypoglycemia During Transition to Extrauterine Life for NICU- Standardized Procedure			
10. Pneumococcal and			

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Influenza Vaccine Screening and Administration - Standardized Procedure			
11. Release of Deceased – Procedure	Director Mitchell requested for the term coroner to be changed to medical examiner. After a brief discussion, the committee agreed to pull this policy for further discussion by the Legal Dept.	**ACTION:** This policy is being pulled out for further review.	Patricia Guerra
12. Transporting Ventilator Patients- Procedure			
13. Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD) Standardized Procedure			
Administrative Policies and Procedures			
1. Failure Mode and Effects Abnalysis (FMEA) 389	No discussion on this policy.	**ACTION:** The Administrative policies and procedures were approved and are moving forward for Board approval. Director Mitchell moved and Director Finnila seconded the motion to approve these policies.	Patricia Guerra
2. Solicitation and Distribution of Literature on District Property 210	There was a brief discussion on the separation of this policy as it relates to the Union activities which need to go to HR and then the solicitation part as an administrative policy.		
<u>Unit Specific</u>			
Environment of Care			
Section 1 Safety Management			
1. Risk Assessment Policy 1040		**ACTION:** The Section 1 policy for EOC were approved as moved	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
		by Director Finnila and seconded by Director Mitchell.	
Section 3 Life Safety 1. Exit Doors 2. Fire Plan- Code Red 3305 3. Fire Safety Hazards	There was a request to change the LIP to Allied Health Practitioners for consistency purposes. There was also a question if benzene is still in use nowadays.	**ACTION:** The Section 3 policies were approved as moved by Director Mitchell and seconded by Director Finnila.	Patricia Guerra
Section 5 Hazardous Materials 1. Reporting Hazmat Incidents	There was no discussion on this policy.	**ACTION:** The Section 5 policy was approved as moved by Director Mitchell and seconded by Director Finnila.	Patricia Guerra
Emergency Operations Procedures Manual 1. Authority to Implement the Disaster Plan for TCMC 4070 2. Disaster Control Center Implementation Plan Emergency Department Specific 4002 3. Disaster Plan for Media Control 4007 4. Disaster Plan rehab Area, Minor Care (Walking Wounded) 4055 5. Emergency removal of Patients Using Manual Carries: Hospital Wide 4005 6. General Information for	There were no discussions as all of these policies were deletions. They have been incorporated into the unit specific policies of the ED.	**ACTION:** The deletion of the policies on the Emergency Operations Procedures Manual were approved as moved by Director Mitchell and seconded by Director Finnila.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Discharging Patients 4006 7. Medical Staff Disaster Plan 4045 8. Toxic External Air 4011			
Engineering			
Section 1 General Administrative 1. Engineering Hours of Service- 1006		**ACTION:** The Section 1 policy on Engineering was approved ; Director Mitchell moved and Director Finnila seconded the motion to approve this policy.	Patricia Guerra
Section 4: Equipment 1. Utility Management Plan- 4003	There was a discussion on the creation of a master map highlighting the locations of all the water valves in the campus. This will be helpful in the utility management plan of the hospital. As of current, Steve Berner has the list of the water valves in the facility.	**ACTION:** The Section 4 policy on Engineering was approved ; Director Mitchell moved and Director Finnila seconded the motion to approve this policy.	Patricia Guerra
Section 8: Emergency Preparedness 1. Code Green Policy- 8007		**ACTION:** The Section 8 policy on Engineering was approved ; Director Mitchell moved and Director Finnila seconded the motion to approve this policy.	Patricia Guerra
Infection Control 1. Bloodborne Pathogen Exposure Control Plan- IC 10	Dr. Contardo mentioned that there is related data for this on the policy on Hazardous Materials. There was also a mention on the issue of histology, as well as the fact that	**ACTION:** The Infection Control policy was approved as Director Finnila moved and seconded by Dr. Contardo.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Pharmacy 1. General and Concentrated Electrolytes Policy	this policy because of its extensiveness needs to be reviewed yearly instead of every 3 years.	**ACTION:** The Pharmacy policy was approved ; Director Finnila moved and Director Mitchell seconded the motion to approve this policy.	Patricia Guerra
Rehabilitation Services 1. Supervision Requirements of Minors During Outpatient Rehabilitation 2. Use of Encrypted Email for Outpatient Rehab Services		**ACTION:** The Rehab policies and procedures were approved and are moving forward for Board approval. Director Mitchell moved and Director Finnila seconded the motion to approve these policies.	Patricia Guerra
7. Midwife Discussion	Director Dagostino brought up the topic of midwife discussion. There was an issue previously on the presence of a physician in case a medical emergency arise on a delivery done by a midwife. Sharon Davies clarified that in the Mother/Baby unit, a physician is always present to serve as a back –up every time a midwife delivers a baby at the hospital. Sherry Miller, who was representing Dr. Ma also reiterated that midwives are aware of "high-risk" deliveries and the need for a presence of a physician.	**ACTION:** Sherry Miller stated that Dr Ma will talk to North County Health Services about the policy on midwives. Dr Ma will also review the policy and also review the particular chart. If any actions needs to be taken he will refer to the appropriate Committee.	Director Dagostino
8. 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

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
9. Return to Open Session	The Committee return to Open Session at 2:25 PM.		Director Dagostino
10. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Dagostino
11. Comments from Members of the Committee	No Comments.		Director Dagostino
11. Adjournment	Meeting adjourned at 2:24 PM		Director Dagostino

PROFESSIONAL AFFAIRS COMMITTEE
October 15th, 2015

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Administration of Aquamephyton Injection and Erythromycin Ophthalmic Ointment to Newborns Standardized Procedure	2 year review, practice change	Forward to BOD for approval
2. Administration of Pediatric Hepatitis B Vaccine and Immunoglobulin (HBIG) to Newborns Standardized Procedure	2 year review, practice change	Forward to BOD for approval
3. Advance Health Care Directive Policy	3 year review, practice change	Forward to BOD for approval with revisions
4. Blood Glucose Newborn Monitoring -	NEW	Forward to BOD for approval
5. Care of the Newborn Standardized Procedure	practice change	Forward to BOD for approval with revisions
6. Deceased Patient Care and Disposition Procedure	3 year review, practice change	Forward to BOD for approval
7. Disaster Call Back List Policy	3 year review, practice change	Forward to BOD for approval
8. Hypoglycemia Management In the Adult Patient Standardized Procedure	2 year review, practice change	Forward to BOD for approval
9. Newborn Hypoglycemia During Transition to Extrauterine Life	DELETE	Forward to BOD for approval
10. Pneumococcal and Influenza Vaccine Screening and Administration Standardized Procedure	2 year review, practice change	Forward to BOD for approval with revisions
11. Release of Deceased Procedure	3 year review, practice change	Pulled for further review
12. Transporting Ventilator Patients Procedure	3 year review, practice change	Forward to BOD for approval
13. Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD) Standardized Procedure	2 year review, practice change	Forward to BOD for approval
Administrative Policies & Procedures		
1. Failure Mode and Effects Analysis (FMEA) 389	3 year review, practice change	Forward to BOD for approval
2. Solicitation and Distribution of Literature on District Property 210	DELETE	Forward to BOD for approval
Unit Specific		
Environment of Care		
Section 1 Safety Management		
1. Risk Assessment Policy 1040	3 year review, practice change	Forward to BOD for approval
Section 3 Life Safety		
1. Exit Doors	NEW	Forward to BOD for approval
2. Fire Plan – Code Red 3305	3 year review, practice change	Forward to BOD for approval with revisions

PROFESSIONAL AFFAIRS COMMITTEE
October 15th, 2015

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
3. Fire Safety Hazards	NEW	Forward to BOD for approval with revisions
Section 5 Hazardous Materials		
1. Reporting Hazmat Incidents	NEW	Forward to BOD for approval
Emergency Operations Procedures Manual		
1. Authority to Implement the Disaster Plan for TCMC 4070	DELETE	Forward to BOD for approval
2. Disaster Control Center Implementation Plan Emergency Department Specific 4002	DELETE	Forward to BOD for approval
3. Disaster Plan for Media Control - 4007	DELETE	Forward to BOD for approval
4. Disaster Plan Rehab Area, Minor Care (Walking Wounded) 4055	DELETE	Forward to BOD for approval
5. Emergency Removal of Patients Using Manual Carries Hospital Wide 4005	DELETE	Forward to BOD for approval
6. General Information for Discharging Patients 4006	DELETE	Forward to BOD for approval
7. Medical Staff Disaster Plan 4045	DELETE	Forward to BOD for approval
8. Toxic External Air 4011	DELETE	Forward to BOD for approval
Engineering		
Section 1: General Administrative		
1. Engineering Hours of Service - 1006	3 year review, practice change	Forward to BOD for approval
Section 4: Equipment		
1. Utility Management Plan - 4003	3 year review, practice change	Forward to BOD for approval with revisions
Section 8: Emergency Preparedness		
1. Code Green Policy - 8007	3 year review, practice change	Forward to BOD for approval
Infection Control		
1. Bloodborne Pathogen Exposure Control Plan - IC 10	3 year review, practice change	Forward to BOD for approval with revisions
Pharmacy		
1. General and Concentrated Electrolytes Policy	3 year review, practice change	Forward to BOD for approval
Rehabilitation Services		
1. Supervision Requirements of Minors During Outpatient Rehabilitation	3 year review, practice change	Forward to BOD for approval
2. Use of Encrypted Email for Outpatient Rehab Services	NEW	Forward to BOD for approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: ADMINISTRATION OF VITAMIN K ~~AQUAMEPHYTON~~ INJECTION AND ERYTHROMYCIN OPHTHALMIC OINTMENT TO NEWBORNS

A. **POLICY:**

1. Function: To provide guidelines for Women and ~~Children's~~**Newborn** Services (~~WCS~~**WNS**) nurses administering ~~Aquamephyton~~**Vitamin K** and Erythromycin Ophthalmic Ointment to newborns.
2. Circumstances:
   a. Setting: Labor and Delivery, Newborn Nursery and Neonatal Intensive Care (NICU)
   b. Requires that a Registered Nurse (RN) administer **Vitamin K** ~~Aquamephyton~~ and Erythromycin Ophthalmic Ointment.
3. Consent:
   a. The RN shall obtain verbal parental consent prior to administration of the **Vitamin K** ~~Aquamephyton~~ injection and the Erythromycin Ophthalmic Ointment to the newborn.
      i. If the parent or legal guardian declines the **Vitamin K** ~~Aquamephyton~~ injection and Erythromycin Ophthalmic Ointment refer to documentation guidelines. In the Medication Administration Record (MAR) this will be documented as "refusal".
4. Documentation:
   a. The newborn's patient record
      i. Refer to Tri-City Medical Center Patient Care Services **(PCS)** policy Medication Administration~~, IV.I~~.
      ii. When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the electronic health record as a standardized procedure. ~~Orders will be entered into the Electronic Medical **Health** Record (EMR**EHR**) by the RN as a "Standardized Procedure" order~~.
      ~~ii.~~**1) Not required if a screening process triggers the order**
      iii. Document given or "refused" in the MAR
         1) If refused complete Refusal or Newborn Eye Prophylaxis and/or Refusal of Vitamin K form(s), original to be kept with the patient chart and one copy to be given to the parent or legal guardian and notify Pediatrician of refusal(s).

B. **PROCEDURE:**

1. The RN will administer **Vitamin K** ~~Aquamephyton~~ 1 mg IM and Erythromycin Ophthalmic Ointment to the newborn within two hours of birth.
2. ~~The RN will administer Aquamephyton 1 mg IM and Erythromycin Ophthalmic Ointment in accordance with the Tri-City Medical Center Patient Care Services Medication Administration Policy.~~

C. **REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:**

1. Current California RN license and working in Women's and Children's Services/NICU.
2. Initial Evaluation: Orientation
3. Ongoing Evaluation: Annually

Department Review	Clinical Policies & Procedures	Department of Pediatrics	Nursing Executive Committee	Pharmacy and Therapeutics	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/05, 6/07; 9/09, 5/11; 07/13	6/07; 9/09; 07/13, **04/15**	**05/15**	8/07; 11/09; 7/13; **4/15**	7/07; 12/09; 9/13, **05/15**	8/07; 12/09, 09/13, **09/15**	8/07; 2/10, 10/13, **09/15**	**10/15**	12/05, 8/07; 2/10; 6/11;10/13

D. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

1. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
2. Review: Every two (2) years.

E. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

1. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform the Administration of **Vitamin K** ~~Aquamephyton~~ Injection and Erythromycin Ophthalmic Ointment to Newborns Standardized Procedure

F. **RELATED DOCUMENTS:**

1. **PCS Medication Administration**

PATIENT CARE SERVICES~~STANDARDIZED PROCEDURE MANUAL~~

STANDARDIZED PROCEDURE: ADMINISTRATION OF PEDIATRIC HEPATITIS B VACCINE AND HEPATITIS B IMMUNOGLOBULIN (HBIG) (Hyper B SD®) TO NEWBORNS

A. **POLICY:**

1. Function: To provide guidelines for the Women~~'s~~ and ~~Children's~~ **Newborn** Services (~~WCS~~**WNS**) Registered Nurse administering Pediatric Hepatitis B vaccine and Hepatitis B Immunoglobulin (HBIG) (Hyper B SD®) to newborns.
2. Circumstances:
   a. Setting: Labor & Delivery ~~Room (LDR) / Labor & Delivery Recovery Post-Partum (LDRP)~~, Newborn Nursery, Mother-Baby, Neonatal Intensive Care Unit (NICU)
   b. Supervision: None required.
   c. Requires that an RN complete administration Pediatric Hepatitis B vaccine and Hepatitis B Immunoglobulin (HBIG) (Hyper B SD®) to newborns.
3. Consent:
   a. The RN shall obtain verbal parental consent prior to administration of the Pediatric Hepatitis B vaccine and/or Hepatitis B Immunoglobulin (HBIG) (Hyper B SD®) to the newborn.
      i. Prior to giving consent, the parent or patient's legal guardian shall receive written information about Hepatitis B according to **Tri City Medical Center** (TCMC) Patient Care Services Policy: Vaccination Administration. This will be documented in the ~~E~~**e**lectronic ~~Medical H~~**health** ~~R~~**r**ecord (~~EMR~~**EHR**) in the education form.
      ii. If the parent or legal guardian declines the Pediatric Hepatitis B vaccination and or HBIG (Hyper B SD®) injection, the RN shall contact the Pediatrician immediately for those infants of mothers with positive or unknown Hepatitis B results. Refer to ~~G.2.c.d. for other~~ notification and documentation guidelines. **Document refusal** ~~I~~**i**n the Medication Administration Record (MAR) ~~this will be documented as "refusal".~~

B. **PROCEDURE:**

1. When the mother is Hepatitis B Surface Antigen (HBsAg) ~~⊕~~ (positive):
   a. The RN will administer Pediatric Hepatitis B vaccine and HBIG (Hyper B SD®) ~~soon~~ after birth (within 12 hours of birth), regardless of weight.
2. When the mother is Hepatitis B Surface Angtigen (HBsAg) ~~Ø~~ (negative):
   a. The RN will administer Pediatric Hepatitis B vaccine, within 12 hours of birth regardless of weight, for infants going to the mother-baby unit.
   b. Infants going to the NICU should be given Pediatric Hepatitis B vaccine~~,~~
      i. **By** ~~at 1 –~~ 30 days of chronological age if medically stable, or
      ii. ~~a~~**A**t discharge if before 30 days of chronological age, and/or
      ~~1.~~**iii.** ~~t~~Transfer to the mother-baby unit prior to maternal/infant discharge.
3. When the mother's Hepatitis B Surface Angtigen (HBsAg) status is unknown:
   a. Give Pediatric Hepatitis B vaccine, soon after birth (within 12 hours of birth), regardless of weight.
   b. Obtain STAT Hepatitis B screen.
      i. If maternal Hepatitis B Surface Antigen (HBsAg) status is determined to be HBsAg positive, give HBIG (Hyper B SD®) as soon as possible. If the maternal status is still unknown by discharge, give HBIG (Hyper B SD®) prior to discharge.

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Department of Pediatrics	Pharmacy and Therapeutics	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
12/05, 8/07, 4/09, 06/11; 07/13	12/05, 8/07, 4/09, 06/11; 07/13	03/11;7/13; 4/15	**05/15**	06/11;9/13, **05/15**	06/11;09/13, **09/15**	06/11;10/13, **09/15**	**10/15**	06/11;10/13

1) NICU infants < 2000g: if the mother's HBsAg result is not available within 12 hrs of birth, give HBIG (Hyper B S/D®) **aAs sSoon aAs pPossible** ~~(ASAP)~~
2) NICU infants ≥ 2000g: Administer HBIG (Hyper B S/D®) within 7 days if the mother's HBsAg result is positive, or if maternal status remains unknown by discharge give prior to discharge

4. The RN will administer Pediatric Hepatitis B vaccine and Hepatitis B Immunoglobulin (HBIG) (Hyper B SD®) in accordance with the Tri-City Medical Center Patient Care Services Policies:
   a. Medication Administration ~~(Policy- IV.I)~~
   b. Vaccination Administration ~~(Policy # IV.I.10)~~
5. Pediatric Hepatitis B vaccine dose is 5 - 10 mcg*/0.5 mL, administered intramuscularly. (*Note: Hep B mcg dosage varies depending on manufacturer)
6. Hepatitis B Immunoglobulin (HBIG) (Hyper B SD®) dose is 0.5 mL, administered intramuscularly at the opposite thigh from the vaccination site.
7. Documentation
   a. The newborn's ~~patient record~~ **EHR**
      i. Refer to TCMC Patient Care Services Vaccinations Administration Policy.
   b. Immunization Record
      i. Document newborns receipt of immunization on the Immunization Record.
      ii. **T**he Immunization Record shall be given to the newborn's parent(s) upon discharge of the newborn.
      iii. If the parent declines the immunization after receiving the Vaccine Information Sheet, document in the newborn'**s** ~~patient's record~~ **EHR**. In the Medication Administration Record (MAR) this will be documented as "refusal".
         1) Still give parent immunization record at discharge.
      iv. Document tests, treatments, and physician notification in the ~~medical record~~ **EHR**.
      v. ~~Orders will be entered into the Electronic Medical~~ **Health** ~~Record (EMR~~**EHR**~~) by the RN as a "Standardized Procedure" order~~**When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the electronic health record as a standardized procedure.**
         ~~v.~~**1) Not required if a screening process triggers the order.**

C. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**
1. Current California RN license working in Women's and Children's Services/NICU.
2. Education: Registered Nurse
3. Initial Evaluation: Orientation
4. Ongoing Evaluation: Annually

D. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**
1. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
2. Review: Every two (2) years.

E. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**
1. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Administration of Pediatric Hepatitis B Vaccine and Hepatitis B Immunoglobulin (HBIG) (Hyper B SD®) to Newborns Standardized Procedure.

F. **RELATED DOCUMENTS:**
1. Patient Care Services Policy: Vaccination Administration
2. Patient Care Services Policy: Medication Administration

G. **REFERENCES:**
1. Tschudy, M. & Archara, K (2012). *The Harriet Lane Handbook (19th Ed.)* Philadelphia, PA

~~B. Allred, N., Darling, N., Jacques- Carroll, L., & Mast, E. (2008). National Center for Immunization and Respiratory Disease: Newborn Hepatitis B Vaccination Coverage among Children Born January 2003- June 2005, United States. MMWR Weekly, 57 (30), 825-828.~~

2. Simpson, K. & Creehan, P. (20~~14~~9). AHWONN: Perinatal Nursing. Philadelphia, PA
3. Immunization Action Coalition (2012). Guidance for Developing Admission Orders in Labor & Delivery and Newborn Unit to Prevent Hepatitis B Virus Transmission. Retrieved July 30, 2013 from http://www.cdc.gov/mmwr

ISSUE DATE: 12/91

SUBJECT: ADVANCE HEALTH CARE DIRECTIVE

REVISION DATE: 2/92, 8/92, 11/96, 6/97, 10/00, 6/01, 8/01, 5/03, 8/06, 01/10, 06/11

POLICY NUMBER: 8610-354

~~Administrative~~ Clinical Policies & Procedures Committee Approval:	~~02/11~~08/15
Nurse Executive Council Approval:	~~06/11~~09/15
Medical Executive Committee Approval:	09/15
Professional Affairs Committee Approval:	~~06/11~~10/15
Board of Directors Approval:	06/11

A. **PURPOSE:**

1. To ensure that when a patient is admitted for care through Tri-City Healthcare District (TCHD) or visits an outpatient setting, each patient's ability and right to participate in medical decision-making is recognized and maximized. This policy reflects compliance with the Joint Commission ~~Standard RI.01.05.01~~ and the Federal Patient Self-determination **Law**~~Act~~ and the California Code.
   a. Advanced directives prepared by military lawyers are exempt from State requirements as to form, substance, or recording.

B. **DEFINITIONS:**

1. For purposes of this policy, the following terms shall be interpreted in accordance with their respective definitions as set forth below.
2. Advance Directive or Advance Healthcare Directive – an individual healthcare instruction or a Power of Attorney for Healthcare. [Probate Code Section 4605] Individual Healthcare Instruction or Individual Instruction – A patient's written or verbal direction concerning a healthcare decision. [Probate Code Section 4623]
3. Medical Decision-Making - decisions regarding authorization for treatment, the withholding of treatment or the withdrawal of treatment (including life-sustaining procedures) obtained from the patient or, in the event of the patient becomes incompetent, from the patient's surrogate decision-maker.
4. Life-Sustaining Procedure - any medical procedure or intervention, including the administration of fluids and nutrition by artificial means, that when administered to a patient, will serve only to prolong the process of dying or prolong a permanent unconscious condition.
5. Permanent Unconscious Condition - an incurable and irreversible condition that within reasonable medical judgment renders the patient in an irreversible coma or a persistent vegetative state.
6. Terminal Condition - an incurable or irreversible condition that without the administration of life-sustaining treatment will within reasonable medical judgment result in death within a relatively short time.
7. Agent or Surrogate Decision-Maker - someone who acts in the patient's stead (substitutes in judgment for the patient) to determine what the patient would likely have decided if he/she were able to decide for him/herself. This agent may be formally appointed (through the Health Care Decisions Act or through conservatorship or guardianship proceedings) or, in the absence of a formal appointment, may be informally authorized by virtue of a relationship with the patient (i.e., the patient's next of kin or in the absence of next of kin, close friend).
8. Conscience Objection - objection to a particular course of treatment or care based on an individual's moral ethical and/or religious beliefs or affiliations.
9. DNR (Do Not Resuscitate) Order – a physician's order to the effect that in the event of

respiratory or full cardiopulmonary arrest, ~~no code will be announced over the public address system, nor any attempt made to resuscitate the patient.~~**no basic or advanced life support will be administered.**

10. Pre-hospital DNR - This is a pre-hospitalization Do Not Resuscitate (DNR) or no-code request from the patient, agent or surrogate decision maker to emergency medical service providers. The request may be made on a completed, approved Emergency Medical Services Pre-hospital DNR Form, an approved DNR medallion or bracelet, or a valid DNR order from the patient's medical record from a long term care facility where the patient resides.
    a. **If patient requests assistance initiating a Pre-hospital DNR enter a referral for Social Services consult in the EHR.**
11. POLST form – Physician Order for Life-Sustaining Treatment form means a request regarding resuscitative measures that directs a healthcare provider regarding resuscitative and life-sustaining measures.
    a. **If patient requests assistance initiating a POLST, enter a referral for Social Services consult in the EHR.**

C. **POLICY:**

1. It is the policy of TCHD to recognize and respect patient self-determination. Patients are encouraged to be active participants in decision-making regarding their care through education and inquiry. It is hoped that such education and inquiry about advanced directives will, in turn, motivate patients to communicate their preferences and values in that regard, in advance, to their loved ones and to health care providers. Thereafter, the patient's expressed wishes will guide surrogates/agents and health care providers in medical decision-making for the patient if that patient becomes temporarily or permanently incompetent, or incapacitated.
2. It is the policy of TCHD to treat a patient in accordance with a POLST form (See Patient Care Services policy POLST).
3. As an institution, TCHD supports and encourages patient self-determination and, to the best of its ability, acts in support of a patient's Advance Directive as long as the directive is within the legal parameters of sanctioned medical practice. TCHD does not support the practice of physician-assisted suicide. TCHD may decline to comply with an instruction or decision that requires medically ineffective healthcare or healthcare contrary to generally accepted healthcare standards. ~~[Probate Code Section 4735]~~
4. If a patient arrives at TCHD Emergency Department experiencing respiratory or cardiac arrest and ~~this~~ **the** patient has with them a pre-hospital DNR form, an approved DNR medallion or bracelet, or a valid DNR order from the long term care facility where the patient resides, no chest compressions, assisted ventilations, intubation, defibrillation or cardiotonic medications are to be initiated, unless the patient or surrogate decision maker instruct the staff to do otherwise. The Emergency and Attending Physicians will be notified of the existence of the DNR request and a copy of the form or request will be placed in the patient's medical record. Documentation to the patient's medical record regarding patient's DNR status will be completed.
5. It is the right of any physician or health care provider to withdraw from care of a patient based on the provider's own conscience or moral objection to a particular treatment, or withdrawal of treatment, plan. If this occurs, it is the responsibility of the physician and/or the hospital staff to assist ~~that~~ **the** patient/family with identifying a new physician or health care provider. ~~(See Health and Safety Code 7190).~~
6. Inquiry and Documentation Regarding Advance Directive - As soon as reasonably possible during the admission process, patient registration, Emergency Department patient registration or nursing staff member will inquire of all patients, 18 years of age or older, whether or not the patient has completed an Advance Directive for health care. If patient ~~is~~ **lacks capacity** ~~incompetent or incapacitated~~, the patient's surrogate decision maker/agent, will be asked during every admission whether or not the patient has completed an Advance Directive for health care.
    a. **Review document for special requests.**
7. The patient's nurse will be responsible for accurately completing the Advance Directive screen in the electronic **health**~~medical~~ record (~~eMR~~**EHR**), as part of the admission process.

8. A copy of the Advance Directive, if available, will be placed in the patient's medical record.
9. If the Advance Directive is unavailable at the time of admission, reasonable efforts will be made to obtain a current copy for the patient's medical record.
10. If a patient revises their Advance Directive during their hospital stay the following needs to occur:
    a. Place revised, Advance Directive in the patient's medical record.
    b. Update the ~~eMR~~**EHR** to reflect that the Advance Directive has been revised.
    c. The revised Advance Directive will be scanned into the patient's ~~eMR~~**EHR** by the Medical Records Department.
11. Upon readmission to an inpatient status and Advance Directive status of "Yes, on file TCMC" or "Copy placed on paper chart", the Medical Records department will locate the paper Advance Directive and scan into the ~~eMR~~**EHR** and update Advance Directive Status to "Scanned into ~~eMR~~**EHR**."
12. If a patient decides to complete a formal, written Advance Directive document after admission, but during their hospital stay, the staff member assisting the patient with the Advance Directive information will have the responsibility of ensuring that a copy of the completed advanced directive is placed in the patient's medical record and that the Advance Directive screen in the ~~eMR~~**EHR** is updated to reflect the change in Advance Directive status.
13. The patient may revoke an existing Advance ~~Directive orally~~**Directive verbally**, at any time.
14. Provide Patient Rights Information
    a. As part of the admission process, the patient,~~ or~~ if the patient **lacks capacity**~~is incompetent~~, the patient's surrogate decision-maker/agent, will be given written information regarding an individual's rights to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, even if that treatment is life-sustaining. Such information shall be consistent with that promulgated and/or required by the California Department of Public Health. ("Your Right to Make Decisions about Medical Treatment" is the brochure used to provide this information.)
    b. If the patient **lacks capacity**~~is incompetent~~ at the time of admission, the required written information about Advance Directives and patients' rights to make decisions about medical treatment will be provided to the family, significant other and/or surrogate decision maker if applicable.
    c. If, during his or her hospital stay, a~~n incompetent~~ patient **who lacks capacity** regains his or her ability to understand advance directive and patient rights information, hospital staff must provide the patient with this information as soon as practicably possible.
    d. Patients or families may file a complaint with the California Department of Public Health, Licensing and Certification District Office at 1-800-824-0613 concerning non-compliance with their Advance Directive. Tri-City Healthcare District staff is to provide patients/families with this number upon request or complaint. ~~[42 C.F.R. 489.102 (a) (4)].~~
15. Provide Policy Information
    a. At the time of admission, or thereafter, information about Advance Directives shall be offered to each patient/agent and the offer of information shall be made a part of the admission~~s~~ record~~s~~. Provisions of care shall never be conditional upon a patient's completion of an Advance Directive.
    b. Information, provided to patients and families includes:
        ~~c.~~**i.** Any limitations the Medical Center may have on honoring specific requests based on conscience objection.
        ~~d.~~**ii.** Any differences between Tri-City Healthcare District - conscience objection policies and those that may be raised by individual physicians.
        ~~e.~~**iii.** The legal authority, which supports the hospital's conscience objections.
        ~~f.~~**iv.** The range of medical conditions or procedures affected by the conscience objections.
16. Educate Patient and Surrogate Decision-Maker/Agent - To the extent the patient or his surrogate decision-maker/agent requests additional information about Advance Directives, or TCHD's policies regarding Advance Directives, such requests should be referred to the attending physician, nurse, social worker, chaplain, patient representative, ~~Bioe~~**E**thics Committee or

Administration as appropriate, depending upon the kind of information sought. Any such inquiries or requests, and the answers or referrals offered in response, as well as any follow-up action undertaken for such a referral, should be documented within the patient's medical record.

17. Educate Staff - In order to assure that questions from the patient and/or surrogate decision-maker/agent regarding Advance Directives are appropriately referred and answered and, more importantly, in order to assure that patient participation in medical decision-making is maximized, and that care is provided consistent with patient values and directives (though not in any way conditioned upon the existence of such directives), educational information about Advance Directives and TCHD's policies will be provided (this may be in written form or through in service education programs) to the medical, allied health professional and hospital staff during hospital orientation.
18. Educate Community - In order to assure ~~that~~ the community served by Tri-City Healthcare District is ~~educated about~~**aware of** advance directives, ~~education shall be available through community forums and/or~~ written materials ~~made~~ **are** available at the Medical Center ~~(posted or for distribution)~~.

D. **OUTPATIENT SETTINGS:**

1. ~~It is the policy of Tri-City Medical Center to disregard advance directives or any DNRs in the outpatient setting. Stated differently, any~~ **Any** patient who comes to the hospital for outpatient care will be presumed to desire full resuscitative efforts, in the event of an arrest. Outpatients will not be asked if they have an advance directive, nor will information about advance directives be offered to outpatients.
2. Exceptions ~~to the general rule:~~:
   - **a.** A patient who volunteers information about his or her advance directive, and provides a copy of a valid advance directive or DNR at the time of outpatient care, may request that outpatient staff honor his or her advance directive. Such requests will be honored.
   - ~~a.~~**b. A patient who requests assistance in formulating an Advanced Directive will be referred to appropriate resource.**
   - ~~b.~~**c.** Outpatient surgery patients shall be treated as inpatients.
   - ~~c.~~**d.** Outpatient chemotherapy patients shall be treated as inpatients.
   - ~~d.~~**e.** Emergency department patients shall be treated as inpatients.

~~E. **RESPONSIBILITY/ROLES IN IMPLEMENTING PROCEDURE:**~~

~~1.~~**3.** ~~The matter of who or what department is responsible for implementing the steps in the procedure outlined above will depend on who is most qualified to undertake the responsibility, the circumstances of the admission (emergency, non-emergency or scheduled), and the extent of the educational need. With this in mind, staff must work together in a collaborative way to ensure the objectives inherent in the above procedure are carried out. If a staff member considers him/herself to be unqualified to assume responsibility for implementing the requirements or intent of this policy, he/she should seek advice from his/her supervisor as to how to ensure that the philosophy and values of the Medical Center, the spirit of this legislation and the legal requirements of the Patient Self Determination Act are met~~.

~~F.~~**E. FORMS/RELATED DOCUMENTS ~~REFERENCED THAT CAN BE LOCATED ON THE INTRANET~~:**

1. Physician Order for Life-Sustaining Treatment form **- Sample**
2. Pre-Hospital Do Not Resuscitate (DNR) Form – ~~Ex~~**S**ample
3. ~~Your Right To Make Decisions About Medical Treatment~~

~~G.~~**F. REFERENCES:**

1. **The Comprehensive Accreditation Manual, (2015), The** Joint Commission ~~Standard No. RI.01.05.01 (2006 ed.)~~
2. ~~Administrative Policy #302 – Patient Rights & Responsibilities~~
3. **California Hospital Association** Consent Manual – Advance Healthcare Directives **2015**~~2009.~~
4. ~~"Your Right To Make Medical Decisions" brochure~~

~~5. "Your Rights as a Patient/Making Medical Decisions About Your Treatment" handout~~

Physician Orders for Life-Sustaining Treatment (POLST) Sample

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2009)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name

First /Middle Name

Date of Birth Date Form Prepared

A Check One

CARDIOPULMONARY RESUSCITATION (CPR): ***Person has no pulse and is not breathing.***

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)
(Section B: Full Treatment required)

When not in cardiopulmonary arrest, follow orders in **B** and **C**.

B Check One

MEDICAL INTERVENTIONS: ***Person has pulse and/or is breathing.***

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antibiotics only to promote comfort. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Do Not Transfer to hospital for medical interventions. Transfer*** if comfort needs cannot be met in current location.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

_____

C Check One

ARTIFICIALLY ADMINISTERED NUTRITION: ***Offer food by mouth if feasible and desired.***

☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube.

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

D

SIGNATURES AND SUMMARY OF MEDICAL CONDITION:

Discussed with:

☐ Patient ☐ Health Care Decisionmaker ☐ Parent of Minor ☐ Court Appointed Conservator ☐ Other:

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name	Physician Phone Number	Date
Physician Signature (required)	Physician License #	

Signature of Patient, Decisionmaker, Parent of Minor or Conservator

By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Signature (required)	Name (print)	Relationship (write self if patient)
Summary of Medical Condition	Office Use Only	

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY			
Patient Name (last, first, middle)		Date of Birth	Gender: M F
Patient Address			
Contact Information			
Health Care Decisionmaker	Address		Phone Number
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professional

Completing POLST

- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a physician and the patient/decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or medical treatments may prohibit a person from residing in a residential care facility for the elderly.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- Treatment of dehydration prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding POLST

- A person with capacity can, at any time, void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new POLST form.
- To void POLST, draw a line through Sections A through D and write "VOID" in large letters. Sign and date this line.
- A health care decisionmaker may request to modify the orders based on the known desires of the individual or, if unknown, the individual's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.

For more information or a copy of the form, visit **www.capolst.org**.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

4.

EMERGENCY MEDICAL SERVICES
PRE-HOSPITAL DO NOT RESUSCITATE (DNR) FORM SAMPLE

1._____ requests limited emergency care as herein described.
(Print Name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.
I understand this decision will not prevent me from obtaining other emergency medical care by pre-hospital emergency medical care personnel and/or medical care directed by a physician prior to my death.
I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.
I give permission for this information to be given to the pre-hospital emergency care providers, doctors, nurses, or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

_____ _____
Patient/Surrogate Date

_____
Surrogate's Relationship to Patient

_____ _____ _____
Witness Signature Print Name Date

I affirm this directive is the expressed wish of the patient/surrogate, is medically appropriate, and a copy of this form is in the patient's permanent medical record.
In the event of a cardiac or respiratory arrest, no chest compressions, assisted ventilation, intubation, defibrillation, or cardiotonic medications are to be initiated.

_____ _____
Physician's Signature Date

_____
Print Name

_____ _____
Address Phone Number

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY.

PRE-HOSPITAL DNR REQUEST FORM
Approved by the San Diego Medical Society
P.O. Box 23581
3702 Ruffin Rd
San Diego, CA 92193-3581
(619) 569-1334
Medic Alert Foundation, Turlock, CA 95381

White Copy: To be kept by patient
Canary Copy: To be kept in Patient's permanent medical record
Pink Copy: If authorized DNR medallion desired, submit this form with Medic Alert enrollment form to:

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: BLOOD GLUCOSE NEWBORN MONITORING

I. **POLICY:**

A. **Function:** To screen blood glucose (BG) levels in at-risk late preterm (36 0/7-36 6/7), ~~and~~ **at-risk** term **or symptomatic term** infants in order to correct or manage neonatal hypoglycemia.

B. **Circumstances:** Infants 36 0/7-36 6/7 weeks up to term, infants at high risk

1. Setting: Labor and Delivery (L&D), Transition Nursery and Mother Baby

C. **Background:** Neonatal glucose concentrations decrease after birth, to as low as 30 mg/dL during the first 1 to 2 hours after birth, and then increase to higher concentrations, generally above 45 mg/dL by 12 hours after birth.

D. See Patient Care Services (PCS) Glucose POC Testing using the Nova Stat Strip Blood Glucose Meter Procedure for step by step instructions for blood glucose machine.

II. **PROCEDURE:**

A. Identify infants at risk and implement monitoring as appropriate.

1. ~~Infants that are at risk include that need the~~ POC BG is performed for **the**~~teh~~ ~~are~~ the following **at risk infants**:
   a. Infants of diabetic mothers (IDM)
   b. Large for gestational age (LGA) infants (greater than or equal to 4 kg or 8lbs; 13 oz)
   c. Small for gestational age (SGA) infants (less than or equal to 2.5 kg or 5 lbs; 9 oz)
   d. Late Preterm infants (36 0/7 to 36 6/7 weeks gestation-the gestational age that would be kept in these areas versus transferring to NICU)
   e. Post-term infants (greater than 42 weeks gestation)
   f. Intrauterine Growth Restriction (IUGR) infants
2. Monitoring is based on hours of age and risk factors

B. Feed at risk infants by 1 hour of age

1. Utilize breastfeeding first and then if being formula fed do not give more than 10 mL at a time in the first 24 hours of life.

C. Perform initial screen 30 minutes after the initial feeding by performing heel stick per PCS Collection of Blood Specimen by Skin Puncture procedure.

1. If initial screen is less than 25 mg/dL~~ patient~~, call provider for orders to transfer to NICU
2. If initial screen 25 mg/dL- 45 mg/dL-feed and re-check in 1 hour.
3. If initial screen is greater than 45 monitor POC BG before feedings.

D. Monitor at risk infants by performing **the** follow**ing**~~s~~:

1. Symptomatic Infant: (irritability, tremors, jitteriness, exaggerated Moro reflex, high-pitched cry, seizures, lethargy, floppiness, cyanosis, apnea, poor feeding) do the following:
   a. Perform a POC BG
   b. Stat serum glucose
   c. If POC BG less than 45 mg/dL, call provider for orders to transfer to NICU
2. IDM and LGA infants prior to each feed from 4 hours of age to 12 hours of age
3. Late Preterm infants (36 0/7-36 6/7 weeks gestation) or SGA prior to each feed from 4 hours of age to until 24 hours of age
4. Continue feeds every 2 to 3 hours and perform POC BG prior to every feed

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Department of Pediatrics	Pharmacy and Therapeutics	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
NEW 12/14	03/15	04/15	05/15	05/15	09/15	09/15	10/15	

a. POC BG less than 35 mg/dL
   i. STAT serum glucose
   ii. Call provider for orders to transfer to NICU

5. POC BG is greater than 35 mg/dL, but less than 45 mg/dL
   a. Re-feed
   b. Repeat POC BG prior to next feeding
   c. If POC BG less than 45 call PROVIDER for further feeding and/or fluid orders and continue to check blood sugar prior to next feed.

III. **DOCUMENTATION**:

1. Blood glucose results in the electronic health record (EHR)
2. Patient assessment and response to feeding or interventions
3. Any complications or adverse side effects
4. Provider notification and follow-up orders for any critical lab value.
5. When administering medications or implementing orders from a standardized procedure the nurse shall enter the orders electronically unless a screening process triggers the appropriate order(s).

IV. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**

A. Current California RN license.
B. Education: on hire
C. Initial Evaluation: on hire
D. Ongoing Evaluation: annually

V. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
B. Review: Every two (2) years.

VI. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE**:

A. All healthcare providers in Women and Newborn Services who have successfully completed requirements as outlined above are authorized to direct and perform.

VII. **RELATED DOCUMENTS:**

A. PCS Glucose POC Testing using the Nova Stat Strip Blood Glucose Meter Procedure
B. PCS Collection of Blood Specimen by Skin Puncture procedure

VIII. **REFERENCES:**

A. American Academy of Pediatrics. (2011). Postnatal Glucose Homeostasis in Late Preterm and Term Infants. Pediatrics. 127(3): 575-579. Retrieved online from pediatrics.aapublications.org.

STANDARDIZED PROCEDURE: CARE OF THE NEWBORN

A. **POLICY:**

1. Function: To define the care and immediate treatment post-delivery for the newborn weighing greater than or equal to 2000 grams that is equal to and are greater than 35 6/7 weeks gestational age.
2. Circumstances:
   a. Setting: ~~LDR LDRP,~~ **Labor and Delivery,** Newborn Nursery, **and** Mother-Baby
   b. Supervision: None required. Physician's office/answering service will be notified of delivery time and date.
   c. Requires that an RN provide immediate care to administer medications, provide nutrition and/or nutritional support, and to perform procedures, laboratory and diagnostic tests that are considered to be routine care to the well born term or near term newborn infant.
   d. The ~~WCS~~**Women and Newborn Services (WNS)** RN must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.

B. **PROCEDURE:**

1. Newborns greater than or equal to 2000 grams and who are greater than 35 6/7 weeks gestational age shall receive:
   a. Prophylactic treatment of eyes (Erythromycin ophthalmic ointment) and medication to normalize coagulation (Vitamin K) within 2 hours of delivery time.
      i. Refer to Patient Care Services (PCS) standardized procedure (SP) Administration of ~~Aquamephyton~~**Vitamin K** Injection and Erythromycin Opthalmic Ointment to the Newborns.
      ii. Exception: Parents who refuse verbal consent
   b. The newborn shall receive Hep B vaccine or Hep B vaccine/HBIG immunoglobulin injection if indicated according to the mother's HBsAg status and within 12 hours of delivery time.
      i. Refer to PCS SP: Administration of Pediatric Hepatitis B Vaccine and ~~PCS SP~~ Hepatitis B Immunoglobulin (Hbig) (Hyper B Sd®) to Newborns
      ii. Exception: Parents who refuse verbal consent
2. Infant nutrition:
   a. Breastfeeding
      i. Initiate feedings as soon as possible but no longer than 2 hours following delivery.
         1) If cesarean delivery, as soon as possible (ASAP) when mother and infant are reunited.
         2) If mother and infant are separated for longer than 3 hours, initiate breast-pumping
            a) Refer to ~~WCS~~**WNS** procedure: Breast Pumping and Milk Storage
         3) Assess and attempt to feed every 2-3 hours and on demand
         4) No supplementation of formula unless ordered by provider, requested by mother or as per other procedures where supplementation is required.
            a) Refer to PCS SP ~~Newborn Hypoglycemia During Transition to Extrauterine Life.~~**Blood Glucose Newborn Monitoring.**
         5) Obtain lactation consult as clinically indicated

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Department of Pediatrics	Pharmacy & Therapeutics	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
~~NEW~~04/15	8/12, 11/13, 4/15	8/12~~;~~,11/13, 4/15	05/15	9/12,11/13, 05/15	11/12, 2/14, 09/15	4/13, 2/14, 09/15	10/15	4/13;2/14

a) Refer to ~~WCS~~**WNS** policy: Infant **F**eeding

b. Bottle-feeding
   i. Offer bottle with formula of mother's choice, 20 Kcal/ounce, by 3 hours of age
      1) Assess feeding status every 3-4 hours, offer formula PRN and on demand
      2) Refer to ~~WCS~~**WNS** procedure: Bottle-Feeding

3. Procedures:
   a. Newborn hearing screen.
      ~~i. Prior to discharge, but at least 12 hours post-delivery~~
      ~~ii.~~**i. Ensure hearing screen is ordered per** ~~Refer to WCS~~**WNS** policy: Hearing Screening-Newborn and Infant
   b. Obtain Total Serum Bilirubin at approximately 24 hours of age or sooner if baby visually appears to have jaundice.
      i. If greater than or equal to 95th percentile (high risk zone) on Bhutani's curve (per hours of age) notify provider.
      ii. Notify provider of Total Serum Bilirubin prior to discharge if he/she is not already aware of the result and the baby will not be rounded on/seen again by a pediatrician prior to discharge.
   c. If infant C~~c~~**oombs positive, order CBC with manual differential, retic count, and total serum bilirubin STAT and call provider with results**~~at 12 hours after delivery~~**.**
      i. Contact physician immediately upon return of test results.

~~1. Transcutaneous bilirubin screen for assessment of jaundice or as universal screen around 24 hours, prior to discharge, or if baby visually jaundiced.~~
~~a. Obtain TcB~~
~~i. If greater than or equal to 95th percentile on Bhutani's curve (per hours of age), obtain ASAP cord blood screen results.~~
~~1) If Coomb's positive, order CBC with manual differential, reticulocyte count, total and direct bilirubin~~
~~2) Notify provider of all results~~
~~ii. If TcB greater than or equal to 95th percentile on Bhutani's curve (per hours of age) obtain ASAP total and direct serum bilirubin.~~
~~1) Notify provider immediately if the ASAP total serum bilirubin result is greater than or equal to the 95th percentile on Bhutani's curve~~
~~iii. If bilirubin level is between the 75th and 95th percentile, repeat TcB in 6 hours~~
~~1) If repeat TcB remains between the 75th and 94th percentile, notify provider for further orders.~~
~~2) If TcB increases to greater than or equal to the 95th percentile, obtain asap total and direct serum bilirubin~~
~~a) Call provider for total serum bilirubin greater than or equal to the 95th percentile.~~

~~b.~~**d.** All infants meeting criteria will have a car seat challenge performed prior to discharge as per ~~WCS~~**WNS/Neonatal Intensive Care Unit (**NICU**)** procedure: Car Seat Challenge Test.

~~c.~~**e.** All infants meeting criteria will have neonatal abstinence scoring performed as per ~~WCS~~**WNS**/NICU procedure: Neonatal Abstinence Scoring.

~~d.~~**f.** All infants will have pulse oximetry done after 24 hours of life or prior to discharge per PCS SP Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD).

4. Laboratory tests:
   a. Point of care glucose testing
      i. ~~Positive risk factors or symptoms of hypoglycemia~~
      ii. ~~Refer~~ **Perform per** ~~to~~ PCS **Blood Glucose Newborn Monitoring**~~SP Newborn Hypoglycemia During Transition to Extrauterine Life~~ Standardized Procedure

b. Toxicology
   i. Obtain a urine specimen if mother has a positive toxicology screen, a positive history of substance use, is suspected of substance use or with diagnosis, has had less than or equal to three prenatal visits, or suspicion of placental abruption
      1) If positive for cocaine, amphetamines and or opiates, lab will perform a confirmation
   ii. Obtain a urine specimen on all babies assigned to Neonatology
c. Cord blood screen (Direct Coombs and blood typing) ASAP
d. Newborn metabolic screen prior to discharge but at least ~~12 hours following delivery~~**24 hours following delivery**.
   i. Refer to PCS procedure: Newborn Screen, Collection of Specimen
e. If Mother is GBS positive and received no treatment or 1 dose only of antibiotics less than 4 hours prior to delivery
   i. Perform CBC with manual differential and blood culture on newborn between 6 - 12 hours of age
      1) Notify provider of CBC with manual differential results if abnormal
         a) Abnormal CBC for infant, at least one of the following:
            i) WBC greater than 35,000 or less than 9,000
            ii) ANC less than1500
            iii) Platelet Count **less than**< 120,000

5. Call provider immediately ~~if the mother of the baby or fetus exhibited signs of~~**for maternal/infant signs of chorioamnionitis/infection** ~~chorioamniotitis~~ or the following symptoms prior to delivery.
   a. Maternal temperature greater than or equal to 100.4 degrees Fahrenheit plus two or more of the following:
      i. Maternal tachycardia (greater than 100 bpm)
      ii. Fetal tachycardia (greater than 160 bpm)
      iii. Uterine tenderness
      iv. Foul smelling amniotic fluid
      v. Maternal leukocytosis (greater than 15,000 WBC)
      ~~vi. Mother received 2 or more antibiotics, (i.e. ampicillin, gentamicin, flagyl, clindamycin)~~

~~6. Call provider immediately if maternal temperature greater than 101.0 degrees Fahrenheit (significant for chorioamnionitis) antepartum, intrapartum or a few hours post delivery.~~

C. **DOCUMENTATION:**

1. Document assessment, actions and provider notification/response in electronic ~~medical~~ **health** record (EH~~M~~R) as appropriate.
2. **When administering medications or implementing orders from a standardized procedure, the Registered Nurse s~~S~~hall enter the medication/order into the electronic health record as Standardized Procedure**
   a. **Not required if a screening process triggers the order.**
3. Utilizing CPOE, select the Standardized Procedure (SP) power plan SP Newborn Admit.
4. Type in provider's name and select "Standardized Procedure" as the order communication type.
5. Initiate, sign and refresh Newborn Medications power plan prior to birth in order to readily access medications in Pyxis.
6. Prior to administration of vaccines provide a copy of the Center for Disease Control (CDC) Vaccine Information Statements (VIS) to the newborn's mother/legal guardian and document in Cerner. Document the name and edition date of the VIS in the "comments" section of the e-mar and in care plan.
7. Document administration and injection sites of medications on the ~~Cerner~~ **Cerner electronic Medication Administration Record** (eMAR). Including: manufacturer, lot number and expiration date for all vaccines administered.

8. Document administration of vaccine on the yellow California Immunization Record card. Give this record to the mother/legal guardian with instructions to take the card with her/him to all infant healthcare provider visits at discharge.
9. Document patient (mother/legal guardian) teaching in the education section of the ~~EMR~~**EHR**.
10. ~~TcB and t~~**T**otal ~~and direct~~ serum bilirubin will be documented in the ~~EMR~~**EHR**.
11. Document newborn screen specimen collection in ~~EMR~~**EHR**.
12. Document newborn hearing screen in ~~EMR~~**EHR**.
13. Document car seat challenge, if appropriate, in ~~EMR~~**EHR**.
14. Document neonatal abstinence score, if appropriate in ~~EMR~~**EHR**
15. Document the universal blood saturation screening in the ~~EMR~~**EHR**.

D. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**

1. Current California RN license working in Women's and Children's Services.
2. Education: Registered Nurse
3. Initial Evaluation: Orientation
4. Ongoing Evaluation: Annual

E. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

1. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
2. Review: Every two (2) years.

F. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

1. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform "Care of the Newborn" Standardized Procedure.

G. **RELATED DOCUMENTS:**

1. PCS Procedure: Newborn Screen, Collection of Specimen
2. PCS SP Administration of ~~Aquamephyton~~**Vitamin K** Injection **and Erythromycin Ophthalmic Ointment to Newborns**
3. PCS SP ~~Administration of Pediatric Hepatitis B Vaccine~~ **Administration of Hepatitis B Vaccine and Immunoglobulin (HBIG) to Newborns Standardized Procedure**
4. PCS SP Erythromycin Opthalmic Ointment to the Newborns
5. PCS SP Hepatitis B Immunoglobulin (Hbig) (Hyper B Sd®) to Newborns
6. PCS SP ~~Newborn Hypoglycemia During Transition to Extrauterine Life~~**Blood Glucose Newborn Monitoring**
7. PCS SP: Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD)
8. ~~WCS~~**WNS** Policy: Infant Feeding
9. ~~WCS~~**WNS** Procedure: Bottle-Feeding
10. ~~WCS~~**WNS** procedure: Breast Pumping and Milk Storage
11. ~~WCS~~**WNS**/NICU Procedure: Car Seat Challenge Test
12. ~~WCS~~**WNS**/NICU Procedure: Neonatal Abstinence Scoring

H. **REFERENCES:**

1. Thureen, Deacon, Hernandez, Hall. Assessment and care of the well newborn 2nd edition. St. Louis, Missouri: Elsevier Saunders 2005. pp 91-92.
2. AWHONN Core curriculum for Maternal-Newborn Nursing 4th edition. St Louis, Missouri: Elsevier Saunders 2007. pp 427- 429.
3. Gilstrap, L.C. ed, et al. Guidelines for Perinatal Care, 7th Edition. AAP & ACOG 2012.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**DECEASED PATIENT CARE AND DISPOSITION**
Purpose:	To outline the nursing responsibilities for preparing the deceased for the morgue, transporting to the morgue, and placement into a cooler compartment.
Equipment:	Shrouding kit, morgue gurney, Chux for newborns, Maximal Barrier Protection (cap, mask, gown, gloves and large drape)

A. **PROCEDURE:**

1. If there will be Medical Examiner (ME) involvement, prepare body for viewing per ME guidelines.
2. After ensuring that there will be no ME involvement, remove all lines/equipment, tubes, and valuables (give to family or put in safe) from the body. **See Patient Care Services (PCS) Policy – Patient Valuables, Liability and Control.**
   a. Tie a knot in lines you are unable to remove.
   b. Place non-sterile dressing over wounds and discontinued invasive line sites and tape firmly.
3. Close patient's eyes and place a pillow under their head for family viewing.
4. Ensure identification band is accurate and in place.
5. Accommodate family religious/culture preference requests if legal and safe.
   a. Specifically ask if any family member wishes to view the deceased before placing in post-mortem bag.
   b. Deceased may stay in the room awaiting family member's arrival, but if room cannot be occupied for extended period other arrangements can be made.
   c. Discuss with the Manager /Administrative Supervisor if there are concerns or questions.
6. If corneal donation is a consideration, initiate the following within two hours of pronouncement of death:
   a. Close the eyes
   b. Elevate the head (a pillow roll is acceptable)
   c. Place a light ice pack over the closed eye lids immediately after death – crushed ice cubes (equivalent of two ice cubes) in an exam glove is placed over the bridge of the nose
7. After family viewing, obtain morgue packet.
   a. Do not use chin straps or strings to bind the deceased patient's chin, wrists or ankles.
   b. Affix Patient Identification Labels to three tags ensuring information is legible; ensure information matches patient identification band.
8. For adults, place one tag around the ~~big~~ **great** toe after verifying the name on the tag with the patient's hospital identification band. Place one tag on the outside of white post-mortem bag tied to the zipper. Place one tag on a labeled hospital personal belongings bag with the room number and name clearly visible.
   a. If patient is contagious, attach a red biohazard tag to the zipper on the outside of the post-mortem bag.
9. If there are dentures, put them in the mouth. If unable to do so, place in a labeled denture cup and send home with family. If family refuses, keep with Release of Deceased form.
10. Place unclothed body into the white post-mortem bag with the head at the bottom of the bag so after it is zipped, the zipper will be at the patient's feet.
    a. If family requests patient be clothed in his garments, this is allowed (mortuary to be notified). If there is drainage, contain with a Chux.
11. Close the bag and zip up completely. The matching of the toe tag and tag on zipper will identify the patient. The deceased is now ready for transport to the morgue.

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Medical Executive Committee	Professional Affairs Committee	Board of Directors
3/03, 5/07, 6/09, 3/12	3/12, 8/15	3/12, 09/15	3/12, 09/15	5/12, 10/15	5/12

a. Special covered gurney in morgue to be used for transport.

12. Obtain and sign for the morgue key from **Private Branch Exchange (**PBX**)** (office located on lower level). Retrieve the special covered morgue transport gurney. Transport the patient to the morgue on the covered gurney and place the deceased feet first into the cooler compartment.
    a. Leave special gurney in morgue when not in use. Use lower level of hospital for transport as much as possible.
13. If all cooler compartments are full, ~~notify the Patient Representative (Ext. 7466) 0700-1600, Monday – Friday or~~ notify the Administrative Supervisor by cell phone 760-644-6968~~, 1900-0700, weekends and holidays~~.
14. Return key back to PBX and sign the key back in.
15. Make one copy of the completed Release of Deceased to put in medical record. Take the original report to the Administrative Supervisor or the Patient Representative.

B. **FETAL DEATHS:**

1. Refer to Patient Care Services procedure Deceased Newborn/Stillborn, Care of.

~~C. **RELEASE OF DECEASED TO FAMILY MEMBER:**~~

~~1. A decedent may be released for transportation by a family member only after the family has produced a properly completed death certificate, a burial permit and has provided valid transportation.~~

~~2. Death Certificate:~~

~~a. A death certificate must be obtained (blank form from a mortuary or other facility), properly completed by the attending physician, filed with California Department of Public Health **and Human Services** by the family member, and presented to Tri-City Medical Center (TCMC).~~

~~3. Burial Permit~~

~~a. The family member must obtain and present to TCMC, a burial permit from the mortuary or cemetery at the point of destination, stating that said mortuary or cemetery will accept delivery of the decedent by the family member.~~

~~4. Valid Transportation:~~

~~a. The family member must provide proof to California Department of Public Health **and Human Services** that the decedent was properly embalmed and/or place in a hermetically sealed coffin. The decedent cannot be transported in an airplane or across state lines without proof of a hermetically sealed coffin.~~

~~D.~~C. **FORMS/RELATED DOCUMENTS:**

1. **PCS Manual - Patient Valuables, Liability and Control**
2. **PCS Manual – Deceased Newborn Stillborn, Care of Procedure**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 4/03 **SUBJECT:** Disaster Call Back List

REVISION DATE: 4/05, 5/09; 4/12 **POLICY NUMBER:** XI.G

Clinical Policies & Procedures Committee Approval:	**~~04/12~~08/15**
Nursing Executive Council:	**~~04/12~~09/15**
Professional Affairs Committee Approval:	**~~06/12~~10/15**
Board of Directors Approval:	**06/12**

A. **POLICY:**

1. The Staffing Resource Center shall maintain an up-to-date Disaster Call Back List for the inpatient nursing units and the Emergency Department.
   a. A copy of the list shall be placed in the Disaster Call Back book which shall be kept in the Staffing Resource Center.
      i. Quarterly, a designated Staffing Resource Representative ~~shall~~ **will print** ~~run~~**a current employee list for all inpatient units and the Emergency Department.** ~~an updated phone list from Lawson Workforce Management Staffing and Scheduling.~~
      ii. Once the updated lists are printed, the phone lists shall be placed in the Disaster Call Back Book. Old versions shall be discarded in the confidential bin.

2. Any Department that has several staffing changes prior to the quarterly update is encouraged to send an updated phone list to the Staffing Resource Center.

~~2.~~**3.** All other departments will be responsible for maintaining a disaster call back list and communication process for their department.

PATIENT CARE SERVICES~~STANDARDIZED PROCEDURE MANUAL~~

STANDARDIZED PROCEDURE: HYPOGLYCEMIA MANAGEMENT IN THE ADULT PATIENT

A. Function: Management of the adult patient with hypoglycemia.
B. Circumstances:
   1. Setting: Tri-City Medical Center
~~C. Definition: Hypoglycemia is defined as blood glucose less than 70 mg/dL.~~
~~D.~~**C.** Excludes: Patients on intravenous insulin infusion.

II. **ASSESSMENT~~PROCEDURE~~:**
A. Assess patient for hypoglycemia:
   1. Blood glucose less than 70 **mg**/dL with or without symptoms
   2. Early adrenergic symptoms may include pallor, diaphoresis, tachycardia, shakiness, hunger, anxiety, irritability, headache, dizziness
   3. Later neuroglycopenic symptoms may include confusion, slurred speech, irrational or uncontrollable behavior, extreme fatigue, disorientation, loss of consciousness, seizures, pupillary sluggishness, decreased response to noxious stimuli.

III. **TREATMENT FOR DIABETIC PATIENT:**
~~B.~~**A.** Treat~~ment~~ if the ~~capillary blood glucose~~ **point of care (POC) blood glucose** is less than 70 mg/dL:
   1. If patient is conscious and able to tolerate oral intake, give one 15 gram tube of glucose gel.
   2. If patient is NPO or unable to tolerate oral intake or has a decreased level of consciousness, administer:
      a. 30 mL of 50% Dextrose intravenously (IV) at a rate of 10mL per minute.
      b. If no IV access, Glucagon 1 mg subcutaneously (SQ) or intramuscularly (IM)
   3. Recheck ~~capillary blood glucose~~**POC blood glucose** 15 minutes after treatment. If still less than 70 mg/dL:
      a. Repeat above treatment
      b. Obtain serum blood glucose to verify that the treatment was effective.
   4. Notify the attending physician immediately only if treatment is ineffective, otherwise notify physician of hypoglycemic episode(s) prior to next dose of scheduled insulin or hypoglycemic agent.

~~C.~~**B.** Treatment of serum (lab draw) blood glucose if less than 70mg/dL:
   1. Because serum blood glucose is resulted at least 40 minutes (or more) after the blood is drawn, recheck with ~~capillary blood glucose~~**POC blood glucose** prior to treatment. If less than 70 mg/dL, treat as outlined above.

IV. **TREATMENT FOR NON-DIABETIC PATIENT AND OUTPATIENTS:**
A. Treat if the POC blood glucose is less than 70 mg/dL:
   1. If patient is conscious and able to tolerate oral intake, give one 15 gram tube of glucose gel.
   2. If patient is NPO or unable to tolerate oral intake or has a decreased level of consciousness, administer:
      a. 30 mL of 50% Dextrose intravenously (IV) at a rate of 10mL per minute.
      b. If no IV access, Glucagon 1 mg subcutaneously (SQ) or intramuscularly (IM)
   3. Recheck POC blood glucose 15 minutes after treatment. If still less than 70 mg/dL:

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Diabetic Task Force	Pharmacy and Therapeutics	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
08/12	09/12, 4/15	09/12, 4/15	05/15	11/12, 05/15	01/13, 09/15	02/13, 09/15	10/15	02/13

a. Notify provider for subsequent orders
b. Obtain serum blood glucose to verify that the treatment was effective.

4. Notify the attending physician immediately only if treatment is ineffective, otherwise notify physician of hypoglycemic episode(s) prior to next dose of scheduled insulin or hypoglycemic agent.

~~D.~~B. Treatment of serum (lab draw) blood glucose if less than 70mg/dL:

1. **Because serum blood glucose is resulted at least 40 minutes (or more) after the blood is drawn, recheck with POC blood glucose prior to treatment. If less than 70 mg/dL, treat as outlined above.**

V. TREATMENT FOR PREGNANT PATIENT:

A. Treat if the POC blood glucose is less than 60 mg/dL during all phases of pregnancy:

1. **If patient is conscious and able to tolerate oral intake, give one 15 gram tube of glucose gel.**
2. **If patient is NPO or unable to tolerate oral intake or has a decreased level of consciousness, administer:**
   a. 30 mL of 50% Dextrose intravenously (IV) at a rate of 10mL per minute.
   b. If no IV access, Glucagon 1 mg subcutaneously (SQ) or intramuscularly (IM)
3. **Recheck POC blood glucose 15 minutes after treatment. If still less than 60 mg/dL:**
   a. Repeat above treatment
   b. Obtain serum blood glucose to verify that the treatment was effective.
4. **Notify ~~the~~ attending physician immediately only if treatment is ineffective, otherwise notify physician of hypoglycemic episode(s) prior to next dose of scheduled insulin or hypoglycemic agent.**

~~E.~~B. Treatment of serum (lab draw) blood glucose if less than 60 mg/dL:

1. **Because serum blood glucose is resulted at least 40 minutes (or more) after the blood is drawn, recheck with POC blood glucose prior to treatment. If less than 60 mg/dL, treat as outlined above.**

I. DOCUMENTATION:

A. Document the following:

1. Document patient symptoms, glucose values, treatments, and patient's response to treatment and physician notification in the medical record.
2. ~~On a physician order sheet write, "*Name of medication, dose and route* administered per the Hypoglycemia Management in the Adult Patient Standardized Procedure" and scan to pharmacy.~~
2. **When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the electronic health record as a standardized procedure.**
   ~~3.~~a. Not required if a screening process triggers the order.
~~4.~~3. Document administration of medications on the Medication Administration Record

II. REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:

A. Current California RN license.
B. Education and Training: Blood glucose analysis training using blood glucose monitoring device including hypoglycemia management.
C. Initial Evaluation: Orientation
D. Ongoing Evaluation: Annual blood glucose monitoring device review with return demonstration and hypoglycemia management.

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.

IV. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

A. All Registered Nurses (RNs) who have successfully completed requirements as outlined above are authorized to direct and perform Hypoglycemia Management Standardized Procedure.

V. **REFRENCE:**

A. California Diabetes and Pregnancy Program Sweet Success: Guidelines for Care. 2012. California Department of Public Health.

~~A.~~**B.** Rule of 15 endorsed by the ADA and Mayo Clinic, Complete Nurses Guide to Diabetes Care, second edition, ADA, 2009.

Retire Standardized Procedure-replace with the Blood Glucose Newborn Monitoring Standardized Procedure

Oceanside, California

~~WOMEN'S AND NEWBORN'S SERVICES~~

~~STANDARDIZED PROCEDURE: NEWBORN HYPOGLYCEMIA DURING TRANSITION TO EXTRAUTERINE LIFE FOR NICU~~

~~I. **POLICY:**~~

~~A. Function: To provide guidelines for early identification and appropriate management of the infant with a low blood glucose level. Efforts should be made to initiate early breastfeeding within the first 30-60 minutes after birth to decrease the risk of hypoglycemia.~~

~~1. The MCH RN must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.~~

~~B. Circumstances:~~

~~1. Setting: Labor & Delivery, Mother/Baby, and/or Newborn Nursery at Tri-City Medical Center~~

~~2. Supervision: None~~

~~3. Patient Contraindications: None~~

~~C. Definition: Newborn hypoglycemia is defined as a blood glucose level of less than or equal to 44mg/dL.~~

~~D. The parameters for screening are as follows:~~

~~1. High Risk Newborn infants, irrespective of symptoms~~

~~a. Infants born to diabetic mothers, both diet controlled and medication controlled.~~

~~b. Term infants with birth weight greater than or equal to 4 kg (8 lbs; 13 oz)~~

~~c. Term infants with birth weight less than or equal to 2.5 kg (5 lbs; 9 oz)~~

~~d. Infants less than or equal to 37 weeks gestation or greater than or equal to 42 weeks gestation.~~

~~e. Infants who have had traumatic deliveries and / or Apgar Score less than or equal to 7 at 5 minutes or those requiring resuscitation per AAP/AHA/NRP (American Academy of Pediatrics/American Heart Association/Neonatal Resuscitation Program guidelines.~~

~~f. The smaller of discordant twins (defined as greater than or equal to 20% weight difference between infants)~~

~~2. The newborn infants exhibiting the following signs and symptoms or conditions (symptomatic hypoglycemia)~~

~~a. Temperature less than or equal to 97 degrees axillary~~

~~b. Hypertonia, hypotonia or lethargy~~

~~c. Jittery movements or seizure-like activity~~

~~d. Abnormal cry~~

~~e. Poor feeding~~

~~f. Diaphoresis~~

~~g. Tachypnea greater than 60, or apnea~~

~~h. Infants with suspected polycythemia~~

~~i. Suspected sepsis~~

~~E. Blood Glucose Monitoring of High-Risk Newborn Infants:~~

~~1. Perform bedside blood glucose as follows:~~

~~a. Within 30 minutes of delivery or immediately if symptomatic~~

~~b. At 1 hour of age~~

~~c. At 2 hours of age~~

~~d. Then, before feedings (feedings should be offered at least every 2-3 hours)~~

~~2. If bedside glucose greater than or equal to 45 X 4 according to above testing schedule, no further testing is required unless the infant becomes symptomatic.~~

~~3. If the bedside glucose is less than or equal to 44 at any time, follow the management~~

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Department of Pediatrics	Pharmacy and Therapeutics	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Commitee	Board of Directors
8/06; 9/09; 5/12	05/12, 03/15	05/12, 03/15	05/15	05/12, 05/15	09/12, 09/15	10/12, 09/15	10/15	10/12

guideline as outlined below.

F. Blood Glucose Monitoring of Non-High Risk Newborn Infants exhibiting signs and symptoms suggestive of hypoglycemia
1. Perform bedside blood glucose.
2. If glucose is greater than or equal to 45 mg/dL, no further testing is required unless symptomatic. Notify physician of signs and symptoms and glucose results.
a. **Note:** Signs and symptoms suggestive of hypoglycemia are not exclusive only to hypoglycemia. These signs and symptoms may indicate other medical conditions in the newborn. Physician notification and follow-up regarding the presence of these signs and symptoms is warranted to evaluate other potential causes.
3. If glucose is between 31 and 44mg/dL:
a. Draw stat lab glucose and repeat bedside glucose on a different meter.
b. If RR is less than 60, breastfeed or formula feed 15–20mL
c. If RR is greater than or equal to 60 do not feed due to increased risk of aspiration. Contact attending physician
i. If attending physician fails to respond to calls regarding management of newborn hypoglycemia within 30 minutes, RN shall contact neonatologist for immediate consultation.
4. If glucose is less than or equal to 30 mg/dL:
a. Draw stat lab glucose and repeat bedside glucose on a different meter.
b. If repeat lab or bedside glucose is less than or equal to 30 mg/dL, notify neonatologist and transfer infant to NICU for a higher level of care.
c. If repeat lab or bedside glucose is 31-44 mg/dL, breastfeed or formula feed. Repeat bedside glucose in 30 minutes. Notify physician.

II. **NEWBORN HYPOGLYCEMIA MANAGEMENT PROCEDURE:**
A. Infants born to medication-controlled diabetic mothers
1. If bedside glucose is 31-44 and infant is asymptomatic
a. Formula-fed infants: Feed with 15-20 mL formula.
b. Breast-fed infants: Breastfeed and supplement with 10-15 mL of expressed breast milk or formula.
c. Re-check bedside glucose in 30 minutes
i. If greater than or equal to 45, continue bedside glucose monitoring as above until 4 consecutive bedside blood glucose levels of greater than or equal to 45 mg/dL are achieved.
ii. If less than or equal to 44 or infant feeds poorly, call attending physician
2. If the bedside glucose screen is 31-44, and the infant is symptomatic
a. Draw stat lab glucose and repeat bedside glucose from the same sample.
b. If RR less than or equal to 59 and infant is able to feed, give 20-30 mL formula or expressed breast milk. If unable to feed, may gavage.
c. If RR greater than or equal to 60, do not feed due to increased risk of aspiration. Notify neonatologist, transfer infant to NICU for a higher level of care than can be provided in Newborn Nursery, and notify attending physician.
d. Contact the attending physician. If attending physician fails to respond to calls regarding management of newborn infant hypoglycemia with 30 minutes, RN should contact the neonatologist for immediate consultation.
3. If the bedside glucose screen is less than or equal to 30, regardless if the infant is symptomatic or not:
a. Notify the neonatologist, transfer infant to NICU for a higher level of care than can be provided in the Newborn Nursery. The neonatologist will notify the attending physician of transfer.
B. All high-risk infants, including infants born to diet-controlled diabetic mothers.
1. If infant is symptomatic and/or bedside glucose is less than or equal to 30:

a. Draw stat lab glucose and repeat bedside glucose from the same sample on second meter.
b. If repeat bedside glucose on second meter is less than or equal to 30:
i. Notify neonatologist, transfer infant to NICU for a higher level of care than can be provided in Newborn Nursery. The neonatologist will notify the attending physician of transfer.

2. If bedside glucose is 31-44 and infant is asymptomatic
a. Start breastfeeding, or formula feeding with 15-20 mL.
b. Re-Check bedside glucose in 30 minutes
i. If greater than or equal to 45, continue bedside glucose monitoring as above
ii. If less than or equal to 44, or infant feeds poorly, call attending physician

3. If the bedside glucose screen is 31-44, and the infant is symptomatic
a. Contact the attending physician.
b. Draw stat lab glucose and repeat bedside glucose from the same sample
c. Breastfeed or give formula 15-20 mL if RR less than 60 and infant is able to feed.

C. Special Considerations for Breastfeeding Infants:
1. When supplementation is indicated, supplementation at the breast is the preferred method. Alternative methods to nipple feeding include dropper, syringe, cup, and finger feeding.

D. Documentation
1. Document blood glucose readings, interventions, and evaluation in the newborn's patient care record.

III. REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:

A. Current California RN license.
B. Initial Evaluation: Orientation
C. Ongoing Evaluation: Ongoing

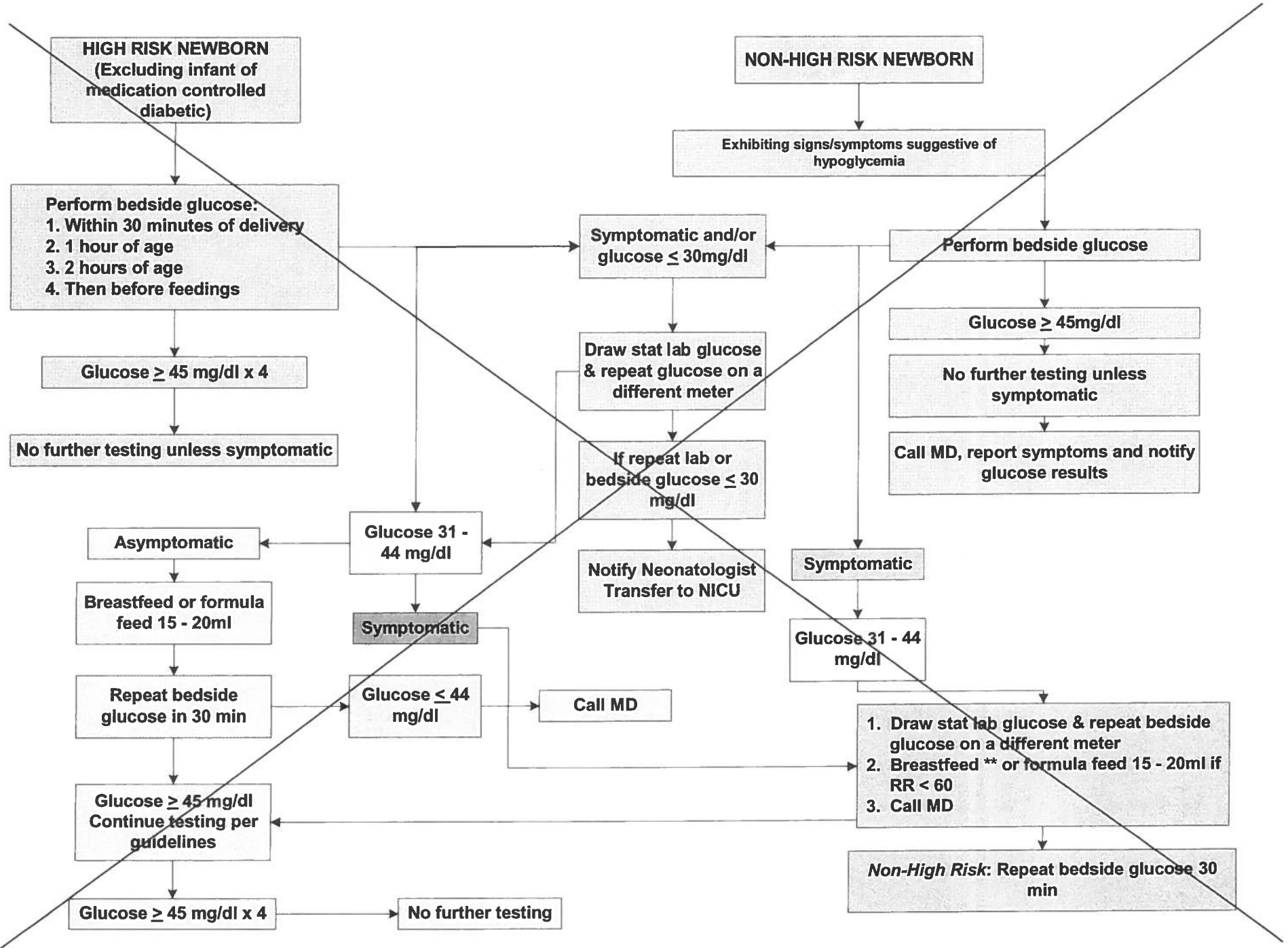
IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This standardized procedure was developed and approved through collaboration with an authorized representative from Nursing Administration, Administration, and Medical Staff.
B. Review: Every two (2) years
1. Nursing Administration
2. Interdisciplinary Practice Committee
3. Medical Executive Committee
4. Board of Directors

V. REFERENCES:

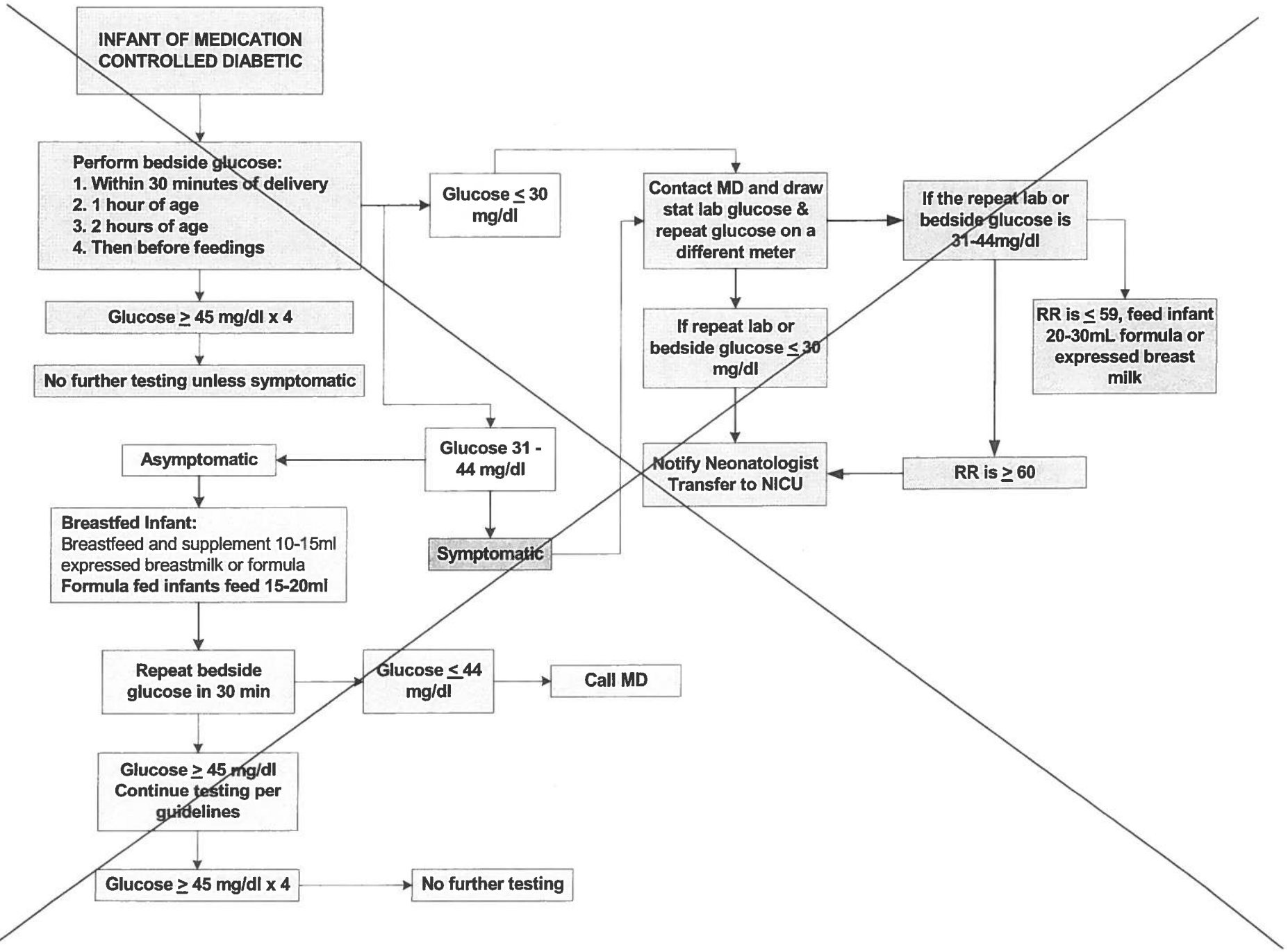
A. American Academy of Pediatrics AAP/ACOG. (2007). Guidelines for Perinatal Care, 6th Edition
B. Besuner, P. (2007). *AWHONN Templates for Protocols and Procedures for Maternity Services, 2nd Edition*. Association of Women's Health, Obstetric and Neonatal Nurses: Washington, D.C
C. Mattson, S., & Smith, J.E. (Eds.) (2004) Core Curriculum for Maternal-Newborn Nursing (4th Ed.). Saunders: Philadelphia, PA.
Merenstein, G.B., Gardner, S.L. (2006). Handbook of Neonatal Intensive Care. (6th Ed.). Mosby & Elsevier: St. Louis, MO
D. Simpson, K., & Creehan, P. (2008). Perinatal Nursing (3rdEd). Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Lippincott Williams and Wilkins, PA
E. Verklan, M.T., Walden, M. (2004). Core Curriculum for Neonatal Intensive Care Nursing (3rd Ed.). Elsevier & Saunders: St. Louis, MO

Newborn Hypoglycemia Algorithm



Newborn Hypoglycemia Algorithm

**Infant of medication controlled diabetic mother: supplement with 10-15ml expressed breast milk or formula



PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: PNEUMOCOCCAL AND INFLUENZA VACCINE SCREENING AND ADMINISTRATION

I. **POLICY:**

A. Function:

1. To provide guidelines to the Registered Nurse (RN) when administering Pneumococcal and/or Influenza Vaccine(s) to the appropriate patient(s) as indicated per criteria set forth by the Pharmacy and Therapeutics Committee and the Medical Executive Committee.
2. To provide guidelines when a physician does not want the patient to receive the vaccine(s).

B. Circumstances for Pneumococcal Vaccine:

1. Setting: Tri-City Medical Center
2. Supervision: None required
3. Exclusions: Immunization in Labor and Delivery and women currently pregnant will be according to physician orders and not this standardized procedure
4. Patient indications:
   a. Pneumococcal Vaccine Risk Assessment for all patients 6 years and older.
   b. The Pneumococcal Vaccine should be given if any of the following indications are met:
      i. Age 65 or older and never received Pneumococcal vaccine or is unsure
      ii. Age 6 to 64 and have never been vaccinated ~~with~~:
         1) Chronic cardiovascular disease
         2) Chronic renal failure, or nephrotic syndrome
         3) Chronic pulmonary disease
         4) Diabetes mellitus
         5) Sickle cell
         6) Alcoholism
         7) Cirrhosis
         8) Chronic liver disease
         9) Cerebrospinal fluid leaks
         10) Splenic dysfunction or absence
         11) Cochlear implants
         12) Immunocompromised, including those with HIV infections, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, malignancy
         13) Immunosuppressive therapy (including long term systemic corticosteriods)
         14) Age 19 through 64 years who is a smoker or has asthma.
   c. If the patient does not meet any of the above indications, patient is NOT at high risk. Do not immunize.
5. The Pneumococcal Vaccine should NOT be routinely given without a physician's order if the patient:
   a. Has a contraindication:
      i. Less than 6 years of age
      ii. Had a previous reaction to the Pneumococcal vaccine

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Infection Control Committee	Pharmacy and Therapeutics	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
3/06, 1/15	12/11, 2/15, 06/15	12/1, 07/15	07/15	1/12, 07/15	1/12, 09/15	2/12, 09/15	10/15	2/12

iii. Age 6 – 18 and have received a conjugate vaccine within last 8 weeks
iv. Received a bone marrow transplant within the past 12 months
v. Is currently receiving a scheduled course of chemotherapy or radiation therapy

b. Ordered not to have vaccine by physician
c. Refuses or advocate refuses

6. If no exclusion criteria identified, then immunize

C. Circumstances for Influenza Vaccine:
1. Setting: Tri-City Medical Center
2. Supervision: None required
3. Exclusions: Immunization in Labor and Delivery will be according to physician orders and not this standardized procedure
4. Patient indications
a. Influenza Vaccine Risk Assessment for all patients 6 months of age and older:
b. The Influenza Vaccine should be given to patients admitted and/or discharged during the normal flu season until the vaccine is no longer available, if any of the following indications are met:
i. Age 6 months and older
ii. Women who will be pregnant during the influenza season (October through March) NOTE: Influenza vaccine is not contraindicated at any stage of pregnancy
iii. Women who are knowingly pregnant shall receive single-dose preservative free* vaccine (*Not to exceed 1mcg of Thimerosal per 0.5mL dose.) [A]
1) Pharmacy to provide single-dose syringe/vial for knowingly pregnant women if available
iv. Influenza immunization history is unknown by patient or advocate
5. The Influenza Vaccine should NOT be given if the patient:
a. Has contraindication
i. Has allergy to eggs or reaction to prior influenza vaccine (i.e.,anaphylactic allergic reaction)
ii. Had ~~previous~~ diagnosis of Guillian-Barre Syndrome **within six (6) weeks of vaccination** (will be left up to the individual healthcare provider to decide if recommended)
iii. Received bone marrow transplant within past ~~12~~ **six (6)** months
iv. Had a previous influenza immunization this flu season)
b. Ordered not to have vaccine by physician
c. Refuses or advocate refuses
6. If no exclusion criteria identified, then immunize

II. **PROCEDURE:**
A. During the initial assessment, the RN will complete the Pneumococcal /Influenza Vaccination Adult Immunization Assessment Screen in Cerner to determine whether or not the vaccinations are indicated according to the following criteria:
1. If the patient meets any inclusion criteria and no exclusion criteria, the RN will inform the patient/advocate that they are eligible for the vaccination(s), give the patient/advocate the vaccination information sheet(s), and plan to administer the vaccination(s).
2. If the RN is unsure of whether the patient is a candidate for the vaccine(s), the physician should be contacted for specific orders.
B. Unless the physician has signed an order to withhold the Pneumococcal and/or Influenza vaccine, remove the age appropriate dose assigned by pharmacy from the Pyxis Medication station and administer the vaccine(s).
C. For patients in the Emergency Department, the Pneumococcal and/or Influenza vaccine should be administered at the time the physician order is received.

III. **DOCUMENTATION**:

A. Document the vaccine administration in the medical record.
B. Document vaccine lot number and site of administration.
C. Document that the Vaccination Information Sheet was given to the patient.
D. Document refusal of immunizations.
E. When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the electronic health record
1. **Not required if a screening process triggers the order**

IV. **PATIENT EDUCATION:**

A. If the patient meets inclusion criteria, the RN will review the Pneumococcal and Influenza Vaccine Information sheet(s) with the patient and give the patient a copy.
B. For transfers to skilled nursing facilities and other hospitals, print and send a copy of the Immunization Tab indicating vaccine(s) administered, with a copy of the Medical Record.

V. **REQUIREMENTS FOR R.N. INITIATING STANDARDIZED PROCEDURE:**

A. Current California RN license
B. Initial evaluation: Orientation
C. Ongoing evaluation: Ongoing

VI. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
B. Review: Every 2 years or review procedure per Hospital policy.

VII. **CLINICIANS AUTHORIZED TO PERFORM STANDARDIZED PROCEDURE:**

A. All RNs who have successfully completed requirements as outlined above are authorized to direct and perform Administration of Pneumococcal and/or Influenza Vaccine.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**TRANSPORTING VENTILATOR PATIENTS**
Purpose:	Establish a standard of care for transporting continuous ventilator patients.
Supportive Data:	AARC Clinical Practice Guideline (RespirCare 2002), Intra-hospital transport of Critically Ill ventilated patients; 2005 Nov; Critical Care Medicine, Guidelines for the inter- and intra-hospital transport of critically ill patients; 2004 Jan; Critical Care Medicine. Egan's Fundamentals of Respiratory Care, 2013, 10th edition, pgs 1038-1039/
Equipment:	Manual resuscitator bag with reservoir, mask and PEEP attachment (if needed), pulse oximeter, and cardiac monitor depending on patient's condition. Full oxygen cylinder, gas source in the area to which patient is being transported. Suction source in the area to which patient is being transported. Transport vent, if applicable.

A. **PROCEDURE:** Registered Nurses (RNs) and Respiratory Care Practitioners (RCP) competent to care for ventilated patients are authorized to perform this procedure. ~~Licensed Vocational Nurses (LVNs), Emergency Medical Technicians (EMTs) or Respiratory Equipment~~ **Assistants** ~~may also assist.~~

1. **T**wo people are required to transport a ventilator patient, a qualified RN and ~~an~~ RCP.
2. The responsibilities of the RCP shall include:
   a. Ensure a resuscitator bag and ~~mask are~~**mask is** available.
   b. Ensure adequate oxygen in cylinder for transport.
   c. Attach a PEEP valve to the resuscitator bag or the transport vent if PEEP required is greater than 5 cmH20.
   d. Attach resuscitation bag or transport ventilator to the patient, ventilating patient at previously noted rate and minute volume.
   e. At destination, connect ventilator to gases and Power, if applicable. Ensure ventilator is functioning properly and patient is being adequately ventilated.
   f. Maintain airway security and patency.
   g. Provide the RN with ~~your~~ **RCP** pager number or cell phone number.
   h. Document in the medical record.
   i. Disconnect the ventilator air and oxygen hoses and electrical cord after the patient is connected to the manual resuscitator.
   j. Move the ventilator to the designated area.
   ~~h.~~**k. Connect oxygen, air (if available), and electrical sources – must be connected to red emergency power outlet.**
3. **T**he responsibilities of the RN shall include:
   a. Oversee the transport.
   b. Stay with the patient throughout the procedure unless a qualified RN is present (i.e.: Interventional Radiology, Cardiac Cath Lab).
   c. Monitor patient safety.
   d. Document in the medical record

~~4. Additional assistance may be provided by a RCP, LVN, EMT, or Respiratory Equipment Technician t~~**Assistant** ~~to:~~

~~a. Disconnect the ventilator air and oxygen hoses and electrical cord after the patient is connected to the manual resuscitator.~~

~~b. Move the ventilator to the designated area.~~

~~c. Connect oxygen, air (if available), and electrical sources – must be connected to red emergency power outlet.~~

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Division of Pulmonary	Medical Executive Committee	Professional Affairs Committee	Board of Directors
7/88,7/97,7/03, 4/04, 4/06, 6/09, **12/14**	08/11, **12/14**	08/11, **12/14**	**08/15**	10/11, **09/15**	11/11, **10/15**	12/11

B. **REQUIRED OBSERVATIONS AND DOCUMENTATIONS**

1. RN and RCP to document the transport in the **electronic** ~~medical~~ **health** record **(EHR)**.
2. The RCP will chart the ventilator check **in the** ~~**electronic medical record**~~**EHR**. ~~See "Patient Assessment and Standard Ventilator Check" for required monitoring.~~

PATIENT CARE SERVICES~~STANDARDIZED PROCEDURES MANUAL~~

STANDARDIZED PROCEDURE: UNIVERSAL BLOOD SATURATION SCREENING FOR CRITICAL CONGENITAL HEART DISEASE (CCHD)

A. **POLICY:**

1. To provide guidelines for universal blood saturation screening for all newborns who are discharged from Tri-City Medical Center
   a. The RN must adhere to the policies of the institution and remain within the scope of practice as stated by the Nurse Practice Act of the State of California
2. Circumstances:
   a. Setting: Labor & Delivery, Mother/Baby, Admission Nursery, and or Neonatal (NICU).
   b. Supervision: None
   c. Contraindications: None
3. Rationale: Pulse oximetry is a simple, non-invasive way to rule out CCHD in the newborn. In a joint statement the American Academy of Pediatrics (AAP) and American Heart Association (AHA) state: "Routine pulse oximetry performed on asymptomatic newborns after 24 hours of life, but before hospital discharge may detect CCHD. Routine pulse oximetry performed after 24 hours in hospitals with on-site pediatric cardiovascular services incurs very low cost and risk of harm."
4. Inclusion criteria for NICU: Screen is to be done when baby is not on oxygen for approximately 12 hours at the discretion of the neonatologist
5. Exclusions:
   a. **A~~a~~n infant that has had an Echocardiogram performed**
   b. Transferred to another facility prior to test (out born)
   ~~5.~~c. An inborn baby who died before screening performed

B. **PROCEDURE:**

1. Give parent/significant other parent education sheet at the time of the test or when parent/significant other available.
2. If **the test is** refused have parent read and sign Refusal form for Newborn Oxygen Saturation Screening for CCHD, document the refusal in the electronic medical record (EMR) and notify provider.
3. Gather supplies and or equipment needed to perform the test.
4. Pair the pulse oximetry screening with another standard of care screening performed at 24 hours of age, such as hearing screening. If early discharge is planned, screening should occur as late as possible.
   a. If baby discharged at less than 24 hours – perform the test as close to discharge as possible
      i. Pass: notify Pediatrician of result for further follow-up
      ii. Fail: follow steps below for fail
5. Conduct the screening in a quiet area. If possible, have the parent available to quiet and soothe the infant.
6. ~~If possible, C~~conduct the screening **if possible** while the infant is quiet, awake, and calm.
   a. Do not attempt to perform pulse oximetry on an infant while he or she is sleeping, crying or cold as oxygen saturations may be affected.
7. Use a clean pulse ox probe for each infant screened.

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Department of Pediatrics	Pharmacy & Therapeutics Committee	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/12, 07/13	07/12, 07/13, 4/15	08/12, 7/13, 4/15	05/15	05/15	09/12, 09/13, 09/15	09/15	09/12,10/13, 10/15	09/12,10/13

8. Perform pulse oximetry on the right hand and one foot after 24 hours of age; measurements should be taken in parallel or one after the other.
   a. Premature infants should have the screening performed when medically appropriate.
   b. In NICU the test will be performed at 24-48 hours of life unless an Echocardiogram is performed or baby on oxygen within the last 12 hours at the discretion of the neonatologist
9. Ensure all readings are accurate by using the pulse oximetry equipment confidence indicators.
   a. Pass-If the oxygen saturation is greater than or equal to 95% in either extremity, with a less than or equal to 3% difference between the two, the infant will "pass" the screening test and no additional evaluation will be required unless signs or symptoms of Congenital Heart Disease (CHD) are present.
   b. Fail-If the pulse oximetry reading is less than 90% in either the hand or the foot, transfer the infant to the NICU for further evaluation.
      i. Immediately notify the Neonatologist in NICU and the infant's physician should be notified.
      ii. Infectious and pulmonary pathology should be excluded.
10. Rescreen-If oxygen saturations are less than 95% in both the hand and foot or there is a greater or equal to 3% difference between two measures separated by one hour transfer the infant to the NICU
    a. The infant's physician should be notified.
    b. Infectious and pulmonary pathology should be excluded.

~~A. Obtain an echocardiogram and cardiology consult.~~

11. When administering medications or implementing orders from a standardized procedure, the Registered Nurse (RN) shall enter the medication/order into the electronic health record as a standardized procedure. .

a. Not required if a screening process triggers the order

~~11.~~**12.** Documentation~~:~~

a. ~~Document the e~~**E**ducation given and verbalized to parent(s) or guardian(s)~~,~~

b. Results of screening

i. **P**~~p~~ulse oximetry reading~~,~~ (preductal and postductal)~~,~~

ii. **I**~~i~~f parent or guardian refused the screening~~,~~

iii. **I**~~i~~f infant passed, failed~~,~~

iv. **H**~~h~~ad an Echocardiogram performed~~,~~

v. **T**~~t~~ransferred to NICU~~,~~

~~T~~transferred to another facility prior to test (out born) or

~~A~~an inborn baby who died before screening performed,

~~R~~refusal for the screen,

vi. **F**~~f~~ailure information to the parents~~,~~

~~interventions,~~

~~E~~evaluations ~~of interventions~~ and

~~a.~~**c.** **P**~~p~~rovider notifications in the newborn's electronic medical record.

C. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**

1. Current California RN license.
2. Initial Evaluation: **Orientation**
3. Ongoing Evaluation: **Annually**

~~3.~~

D. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

1. Method: This standardized procedure was developed and approved through collaboration with an authorized representative from Nursing Administration, Administration and Medical Staff.
2. Review: **Every two** ~~Y~~**y**ear~~sly~~
   ~~a. Nursing administration~~
   ~~b. Interdisciplinary Practice Committee~~
   ~~c. Medical Executive Committee~~

~~d. Board of Directors~~

E. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

1. Women~~'s~~ and **Newborn**~~Children~~ Services RNs

F. **REFERENCES:**

1. Advances in Neonatal Care, (2012), A Nurse-Driven Algorithm to Screen Congenital Heart Defects in Asymptomatic Newborns.~~, 12,~~
2. American Academy of Pediatrics,(2012), Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease , Pediatrics, 129, 190-192.
~~2.~~3. **American Academy of Pediatrics, (2013), Oxygen Saturation Nomogram in Newborns Screened for Critical Congenital Heart Disease; 131, e 1803-1810.**
~~B. American Academy of Pediatrics (2009), Role of Pulse Oximetry in Examining Newborns for Congenital Heart Disease: A Scientific Statement from AHA and AAP~~
~~3.~~4. American Academy of Pediatrics, (2013), Strategies for Implementing Screening for Critical Congenital Heart Disease, Pediatrics, 128, e1259-e1267.
~~4.~~5. Advisory Committee on Heritable Disorders in Newborns and Children. (2010, October 15). Letter to the Secretary of the U.S. Department of Health and Human Services. Retrieved April 25, 2011, from www.hrsa.gov/heritabledisorderscommittee/correspondence/October15th2010letter.htm.
~~5.~~6. Congenital Heart Disease Screening **T**oolkit, A toolkit for Implementing Screening, 2nd edition, Children's National Medical Center, 2011.
~~C. de-Wahl Granelli A., Wennergren M., Sandberg K., Mellander, M., Bejlum, C., Inganäs, L., et al. (2009). Impact of pulse oximetry screening on the detection of duct dependent congenital heart disease: A Swedish prospective screening study in 39,821 newborns. *British Medical Journal, 338,* a3037; PMID: 19131383;doi:10.1136/bmj.a3037.~~
~~6.~~7. Hoffman J. I. E. (2011). It's time for routine neonatal screening by pulse oximetry. *Neonatology. 99,* 1-9.
~~D. Knapp, AA, Metterville, DR, Kemper, AR, Prosser, L, Perrin, JM. Evidence review: Critical congenital cyanotic heart disease, Final Draft, September 3, 2010. Prepared for the Maternal and Child Health Bureau, Health Resources and Services Administration.~~
~~7.~~8. Kemper AR, Mahle WT, Martin GR, Cooley WC, Kumar P, Morrow WR, Kelm K, Pearson GD, Glidewell J, Grosse SD, Lloyd-Puryear M, Howell RR. Strategies for Implementing Screening for Critical Congenital Heart Disease. *Pediatrics.* 2011; 128:e1-e8

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 8/04 **SUBJECT:** Failure Mode & Effects Analysis (FMEA)

REVISION DATE: 7/06; 8/10 **POLICY NUMBER:** 8610-389

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

A. **PURPOSE:**

1. To **improve safety and reduce the risk of errors Tri-City Healthcare District (TCHD) selects one high risk process and conducts a** proactive~~ly~~ **high risk assessment** ~~evaluate and address vulnerabilities in patient safety related health care processes~~.

B. **POLICY:**

1. **TCHD**~~Tri-City Medical Center (TCMC)~~ utilizes the Failure Mode and Effects Analysis (FMEA) method. The Patient Safety Committee oversees the FMEA process.
2. Processes selected for FMEA application represent a high-risk or high-vulnerability area, utilizing available information about sentinel events and other high risk and/or critical path issues known to occur in health care institutions that provide similar care and services. This selection is based on:
   a. Identified and/or suspected areas of patient safety improvement opportunities at **TCHD**~~Tri-City Medical Center~~, based on review of information sources available within the facility.
   b. Information published periodically by the Joint Commission that identifies the most frequently occurring types of sentinel events and patient safety risk factors.
   c. Other recognized sources that identify high risk and high-occurring vulnerabilities, such as the National Quality Forum's Safe Practices for Better Healthcare, the Institute for Safe Medication Practices (ISMP) information, Food and Drug Administration databases and advisories.
   ~~c.~~**d. New processes affecting patient care before they are implemented**
3. At least one high-risk process is assessed **every eighteen months**~~annually~~ using the FMEA methodology.
4. **The Patient Safety Committee**~~Quality Outcomes Committee~~ approves the prioritization of FMEA initiation and reports to~~ the Executive Council~~, the Quality Assurance /Performance Improvement/~~Patient Safety~~ (QA/PI/~~PS~~) Committee, ~~to the Medical Executive Committee, and~~ to the Professional Affairs Committee~~ of the Board~~ **and then the Board of Directors**.
5. Patient Safety Committee (PSC) recommends an interdisciplinary team and team leader to implement the FMEA based on the scope of the project.

C. **REFERENCE:**

1. **The Comprehensive Accreditation Manual** Joint Commission (2015) – Leadership Standard ~~04.04.05 EP10~~

DELETE Policy 8610-210 -This was made Board Policy #15-027 on the approval of the Board of Directors on 9/24/2015.

1.0 PURPOSE

To avoid disruption of healthcare operations or disturbance of patients, and to maintain appropriate order and discipline, any solicitations or distribution of literature on Tri-City Healthcare District (TCHD) property will be subject to this policy.

2.0 DEFINITION

Working time includes the working time of both the employee doing the soliciting or distributing and the employee to whom the soliciting or distributing is directed. Working time does not include break periods, meal times or any other specified periods during the workday when employees are properly not engaged in performing their work tasks.

3.0 POLICY

Any and all solicitations and or distributions of literature among Tri-City Healthcare staff, patients and the public or at TCHD Property and facilities are subject to the following rules:

3.1 Solicitation or Distribution by Non-employees: Persons and organizations who are not employed by TCHD may not solicit or distribute literature, on TCHD property, at any time, for any purpose.

3.2 Solicitation by TCHD Employees: TCHD employees may not solicit at any time, for any purpose, in immediate patient care areas, such as patients' rooms, operating rooms, and places where patients receive treatment, such as x-ray and therapy areas, or in any other area that would cause disruption of health care operations or disturbance of patients, such as corridors in patient treatment areas, and rooms used by patients for consultations with physicians or other health care providers, or meetings with families or friends.

3.3 No Solicitations for Profit by TCHD Employees: Solicitations or distributions in any way connected with the sale of any goods or services for profit is strictly prohibited at any time among TCHD staff, patients or visitors, or in any place where TCHD services are performed.

3.4 Distribution by TCHD Employees: Employees may not distribute literature, during working time (see definition above), for any purpose. Employees may not distribute literature, at any time, for any purpose in TCHD working areas. Working areas are all areas on TCHD property except cafeteria(s), employee lounges, TCHD lobbies, and TCHD parking areas.

Formulation Date 4/83 Review Dates 11/94, 2/05 Revised Dates 5/88; 9/00; 2/03

Administrative Authority President/CEO Approval Dates_____

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

Vice President_____ Approval Date_____

Governing Body

~~3.4 Notice of Intent to Solicit or Distribute Literature: In order to ensure the maintenance of order and discipline in the workplace, TCHD requires that prior to soliciting or distributing literature for any purpose an employee who intends to engage in solicitation and or distribution of literature must identify him or herself and notify the Human Resources Department of his or her intent before engaging in such activity.~~

~~3.5 Posting on TCHD Bulletin Boards: TCHD maintains bulletin boards located throughout its facilities for the purpose of communicating with its employees. Postings on these boards are limited to TCHD-related material including statutory and legal notices, safety and disciplinary rules and procedures, and other TCHD items. All postings require the approval of the Human Resources Department. No postings will be permitted for any other purpose.~~

~~TRI-CITY MEDICAL CENTER~~ ~~Safety Policies & Procedures~~	~~Section: SAFETY MANAGEMENT~~ ~~Subject: Risk Assessment Program~~ ~~Policy Number: 1040 Page 1 of~~
~~Department: Hospital Wide~~	~~EFFECTIVE: 11/87~~ ~~REVIEWED: 1/90; 1/94, 6/08,~~ ~~REVISED: 1/97; 7/00; 4/03, 10/05, 6/11~~

SUBJECT: Risk Assessment Policy

ISSUE DATE: 11/87 **POLICY NUMBER: 1040**
REVIEW DATE(S): 01/90, 01/94, 06/08
REVISION DATE(S): 01/97, 07/00, 04/03, 10/05, 06/11

Department Approval Date(s): 09/15
Environmental Health and Safety Committee Approval Date(s): 09/15
Professional Affairs Committee Approval Date(s): 10/15
Board of Directors Approval Date(s):

A. POLICY:
1. It is the policy of the Tri-City Healthcare District to conduct a Risk Assessment of the healthcare environment to evaluate potential and existing hazards and recommend and implement protective measures associated with various tasks performed in each area of the hospital, off-site facilities and campus grounds.

B. PURPOSE:
1. The risk assessment is used to evaluate the impact of the environment of care on the ability of the organization to perform clinical and business activities. The impact may include disruption of normal functions or injury to individuals.

C. RESPONSIBILITY:
1. The Director of Safety/EOC Officer is responsible for managing the risk assessment process. The responsibilities include:
   a. Participating in the selection of Risk Assessment Team members.
   b. Scheduling area assessments
   c. Managing the documentation of the risk assessment process

D. PRACTICE:
1. A risk assessment of all existing programs will be conducted as part of the evaluation of the EC programs.
2. The risk assessment will be reviewed periodically or as deemed necessary.
3. A risk assessment of all new services and of all areas undergoing major renovation, alteration, or conversion will be conducted prior to occupancy and/or use.

4. **The risk assessment findings will be used to identify protective measures necessary for ensuring personnel / occupant safety and serve as a data source for confirmation during Hazard Surveillance/EOC tours.**
5. **The risk assessment will be submitted to the Environmental Health & Safety Committee (EHSC) for review, updates and changes.**

E. PURPOSE:

1. **This procedure describes the actions required to initiate and conduct an initial risk assessment and the actions required to re-evaluate a risk assessment as part of the annual evaluation of the EC programs.**

F. INITIAL RISK ASSESSMENT:

1. **An initial risk assessment is required for all areas not having had a risk assessment conducted within the last 3 years.**
   a. **An initial risk assessment is required whenever a new building is constructed, the organization purchases an existing building, or an area undergoes significant renovation or conversion of use.**
2. **Each department or area requiring an initial risk assessment is evaluated using an appropriate risk assessment form(s). *(See Risk Assessment Tool)***
3. **The evaluator completes the form by identifying the risks related to the environment and the activities conducted in the area. Each risk is scored using the numerical values:1-5 rating scale or color coded scale included in the form.**
   a. **To determine the appropriate score for each identified risk, the reviewer will consider information obtained through a physical tour of the facility, regulatory inspections, historical incident reports, accident & injury statistics, previous safety committee minutes, hazard surveillance reports, interviews with department heads & staff members, as well as the current best demonstrated practices.**
4. **The Director of Safety/EOC Officer is responsible for identifying an appropriate Risk Assessment Team and scheduling the evaluation of the affected areas.**
5. **The completed risk assessment, including the sections on the form for recommended protective measures required including but not limited to, training, personal protective equipment, policies/procedures, and comments and changes will be presented to the EHCSC for review and approval.**
   a. **Should any situations that constitute immediate danger be discovered during the course of the risk assessment process, they will be reported immediately to the Director of Safety/EOC Officer and the appropriate department manager for appropriate corrective action and resolution.**

~~A.~~G. FORM(S):

1. **Risk Assessment Scoring Grid**
2. **Risk Assessment Tool**

H. REFERENCE(S):

1. **The Joint Commission: EC 02.01.01 EP 1&3**

~~A. POLICY:~~

~~1. The Tri-City Medical Center Risk Assessment Program is designed to evaluate the impact on patient care as it relates to safety of the buildings, grounds, internal physical system, and safe practices of hospital employees.~~
~~2. The Quality Assessment and Improvement Plan for the Environmental Health and Safety Committee is~~
~~1. designed to monitor the level of safety compliance at the hospital, and to identify any situations that detract from our goal of providing a safe and secure environment for our patients, employees, medical staff, and visitors. Inherent in our monitoring is the~~

obligation to take corrective action when a problem is detected, and to provide follow-up to corrective actions taken.

B. **PROCEDURE:**

1. The Risk Assessment Program is carried out using the Quality Improvement Tracking Tool, Injury Investigation Policy, the Safety Surveillance Program, and reports from various agencies such as insurance companies, state or county health agencies and fire agencies.
    1. The Environmental Health and Safety Committee will review the Tri-City Medical Center performance on indicators selected by that group, and forward the findings and recommendations to the appropriate department.
    2. The Environmental Health and Safety Committee is responsible for making revisions to the
        i. indicators as needed.
    3. Responsibility for the monitoring of specific indicators is outlined on the indicator, as are the time-frames for reporting.
2. Quality Assessment and Improvement Indicators:
    1. Indicators are to be selected based on information concerning safety, i.e., problem identification.
    2. Indicators will be formulated to monitor hospital-wide readiness to handle
        i. critical situations such as fires or other disasters.

C. **ATTACHMENTS:**

1. TCMC Departmental Risk Assessment Forms.
2. Matrix of Completed Risk Assessments.

Risk Assessment Scoring Grid

Scoring (color-coded)	**Criteria**
5 (pink)	A high-risk area with possible life threatening or disabling consequences, as well as some history of associated incidents with serious injury.
4 (violet)	A high or significant risk area with possible life threatening or disabling consequences and no history of associated incidents with serious injury.
3 (yellow)	A moderate risk of minor injury or inconvenience to patients, visitors, or staff.
2 (green)	A minimal risk of minor injury or inconvenience to patients, visitors, or staff.
1 (blue)	Virtually no risk of injury or inconvenience to any one.

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Life Safety Management

SUBJECT: Exit Doors

ISSUE DATE: NEW
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**08/15**
Environmental Health and Safety Committee Approval Dates(s):	**09/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**10/15**
Board of Directors Approval Date(s):	

A. **POLICY:**

1. It is the policy of the Tri City Healthcare District to ensure that all designated exit doors throughout the organization and off site buildings are free from obstruction and clear for access by patients, staff or visitors in an emergency situation.

B. **PROCEDURE:**

1. All designated exit doors (including stairwells) will not be locked at any time in the path of egress.
2. All stairwells will not contain any items (with the exception of evacu-chairs) or be utilized for storage at any time.
3. All exit stair doors and designated exit doors leading to outside the facility will be kept free from obstructions and all panic bars will be maintained in working order. The exit doors are to be fully functional and capable of opening to complete width.
4. All exit door vision panels (windows) will be maintained free from decorations, mirrors, hangings, or any other type of obstruction.
5. Exit access corridors will maintain a minimum width of 44 inches or 36 inches where serving an occupant load of less than 50 occupants.
6. Egress pathways outside of all exit doors will remain clear to the public way.
7. It is the duty of all TCMC staff members to ensure designated exit doors, corridors and stairwells are kept free from obstructions which may hamper the safe exit of any staff, patients or visitors from the facility. If any staff member observes an obstruction prohibiting a safe exit, they are to immediately remove it or contact the department supervisor for assistance.

SUBJECT: Fire Plan – Code Red

ISSUE DATE:	**11/87**	**POLICY NUMBER: 3005**
REVIEW DATE(S):	**11/90, 11/93, 11/97, 4/06, 6/12**	
REVISION DATE(S):	**11/94, 3/00, 4/03, 10/11, 4/13**	

Department Approval Date(s):	**08/15**
Environmental Health and Safety Committee Approval Dates(s):	**09/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**10/15**
Board of Directors Approval Date(s):	

A. **PURPOSE:**

1. Tri-City ~~Medical Center's~~**Healthcare District's** Code Red Policy will insure the protection of patients, employees, visitors and property from fire, smoke and other products of combustion.

B. **POLICY:**

1. All employees will be familiar with Tri-City ~~Medical Center's~~**Healthcare District's** Fire Policy, and **when applicable,** the Department Specific Fire Policy for the area in which they work. All staff must know what to do in case of a fire, how to ~~turn in~~**initiate** an alarm, the location of the fire extinguishers **and alarm pull stations** in his or her department, and the operation of the fire extinguishers.
   a. Employees must be familiar with the acronym **RACE:**
      i. **R:** Rescue - remove anyone from immediate danger, closing fire and room doors and calling out for assistance.
      ii. **A:** Alarm - activate the nearest fire alarm **(pull station)** ~~or~~ **and** ~~notify~~ **call** PBX operators by dialing "66" **and notify them of the "Code Red"fire**. ~~Outpatient~~ **All** off campus locations dial "911".
      iii. **C:** Contain - close all remaining doors.~~ in the fire area~~.
      iv. **E:** Extinguish - extinguish the fire if it can be done without endangering yourself or others.
   b. Supervisors are responsible for showing new employees the location of extinguishers and ~~hose cabinets~~**alarm pull stations** ~~on the first~~**during** department orientation. ~~day~~. ~~The employee must perform a mock return demonstration of the extinguisher's use. All Tri-City Medical Center extinguishers are designated for all types of fires.~~ Remember the acronym **PASS** for extinguisher use:
      i. **P: PULL the pin**
      ii. **A: AIM the nozzle at the base of the fire**
      iii. **S: SQUEEZE the handle**
      iv. **S: SWEEP back and forth across the base of the fire**

C. **PROCEDURE:**

1. **WHEN A FIRE ALARM SOUNDS:**
   a. The hospital operator will announce on the overhead page system **"Code Red"** and give location of the fire. **Do Not** call the operator to obtain information about the fire.
   b. If you are away from your assigned area when the alarm sounds, stay where you are and wait for further instructions from the overhead page system.
   c. The hospital's Fire Response team will consist of designated personnel in Facilities Services, Environmental Services and Security Services. Upon hearing the alarm, these staff members are to stop their work and go immediately to the area indicated by the

overhead page system.

d. The Senior Engineer will take immediate charge of the Fire Response Team. In his **or her** absence, the Engineer on duty will take command. This team is subject to the direction of the Administrator and/or City Fire Captain upon his or her arrival.

e. Patients are not to be evacuated from floors without the order of the Incident Commander or designee. If it is apparent to the Department Director/or designee that evacuation is absolutely necessary for patient safety, and if it is not possible to obtain the authoritative order, he or she may elect to evacuate patients.

f. Engineering will clear the fire alarm after the fire is secured.

g. Clinical personnel on other units should remain at their stations. All other personnel should remain in their work areas unless their assistance is requested.

h. The Hospital PBX Operator will announce on the overhead page system **"Code Red All Clear"** when fire is secure.

2. **CODE RED IN YOUR AREA:**

a. **AVOID PANIC:** The greatest danger in most fires is panic. Do not alarm patients by excited motions. **Never shout "Fire!"** Patients look to you for protection. Appear calm and move with assurance.

b. Remove patients and other persons from immediate danger.

c. Go to the nearest fire alarm pull ~~box~~ **station** and ~~"~~**pull the handle~~it~~ to activate the alarm~~"~~.**

d. Dial "66" to report **"Code Red."** Give location, size, extent of fire, and material burning, if known. Facilities off campus dial "911".

e. Extinguish fire if possible - if it is safe, use a fire extinguisher to attempt to bring fire under control. If fire is out of control, close doors to room/area and shut off oxygen if possible. Move patients to the other side of the fire door away from the fire. Allow no one except the fire department to enter.

f. Check for smoke and flames in other rooms then close all doors.

g. Stand by to assist as needed.

3. **FIRE IN PATIENT'S ROOM:**

a. Patient's bed in flames: Remove the patient from bed to a safe place such as another bed, chair or hallway. Depress the nurse call button in the bathroom for immediate assistance. Do not take a smoldering bed out of the room.

b. Close the patient's room door once the patient is out.

c. Activate the fire alarm **pull station** nearest to the fire.

d. Call PBX Operator, dial "66". Give exact location of the fire, including the room number.

4. **AREA NOT EVACUATED UNDER FIRE CONDITIONS:**

a. Provide maximum protection:

i. Instruct people to stay in their rooms with the door closed.

ii. Reassure patients of their safety.

iii. Place a wet blanket or linens at the base of the doors of all occupied room to prevent smoke from entering room.

b. **If safe to do so o**~~O~~ne employee must remain in the corridor to assist fire department upon their arrival.

5. **EVACUATION: Always use stairs, never the elevator, during a fire.**

a. If evacuation is ordered for an area, the following are methods to be used:

i. Blanket Carry

ii. Two Person Carry

b. Once a room has been evacuated, it should be marked "empty" by placing a pillow in front of the door. Only firefighters may enter the room after that.

c. Remove Medical Records if possible.

d. Evacuation plans are posted throughout the facility. They include evacuation routes and the location of alarms and firefighting equipment.

6. **BE ALERT FOR FIRE HAZARDS:**

a. Never prop open fire doors.

DRAFT

b. Hallways must be kept clear at all times.
~~c. Smoking is only permitted outside of the facility in designated areas.~~
~~d.~~**c.** Never place flammable liquids or oxygen near an ignition source.
~~i.~~**d.** Do not use unapproved appliances - appliances brought from outside source must be cleared by Facilities Management.
e. Good housekeeping is the best guarantee against fire. Do all you can to maintain order and cleanliness in the interest of fire protection. Make it a habit to watch for fire hazards.
f. Do not allow stored items to obstruct sprinkler heads. (18" minimum clearance)
g. If you see or smell smoke, report it immediately for investigation. Early detection means prompt extinguishing of fire.

7. **DUTIES OF PERSONNEL**
a. Be completely familiar with the Fire Safety Program and your responsibilities~~. in the program.~~
b. Participate in all fire drills and practice sessions as required.
c. Attend all fire training classes when assigned.
d. Learn the fire alarm code and how to report a fire - Dial "66". ~~Outpatient~~ **All** off campus locations dial "911".
e. Learn the locations of and how to operate the fire alarm ~~boxes~~ **pull stations** and fire extinguishers.
f. Be acquainted with panic control and evacuation procedures.
g. Observe the "No Smoking" rules. ~~and restricted areas.~~
h. Never store flammable liquids in your desk or cabinet.
i. Report any defective wiring - such as frayed cords, loose or broken plugs, blown fuses, etc.
j. Properly dispose of waste or rags used with cleaning solvents.
~~k.~~ Do not use ~~special~~ **portable** heating units. **These units, particularly portable types are not permitted anywhere on the hospital premises unless approved by Engineering, No portable heaters are allowed in patient care areas.** ~~until all safety factors have been complied with~~
~~i.~~**k.** ~~(i.e., portable heaters, electric coffee makers, etc.)~~
l. California Department of Corrections Rehabilitation Unit (CDCR) – 3 North South.
i. If necessary, fire response will be coordinated via CDCR staff for custody patients evacuation.
m. Special Needs Unit – Behavioral Health Unit (BHU) due to special needs population (Psychiatric patients) emergency exit doors are locked for patient safety. **BHU Department policy requires staff to have unit access keys with them at all times for emergency evacuation. In addition, when the BHU unit goes into a Code Red situation all electronic locks automatically "unlock" as part of the fire systems and staff are instructed to control BHU patient movement during emergent evacuation. All patient and staff will evacuate through the large yard area on the North East corner of the unit. In addition, if further evacuation is necessary they will continue with controlled evacuation of patients via exit gate towards pulmonary rehab gym parking area.**
n. Switchboard personnel:
i. If the fire is in the area of the PBX office you would follow the steps outlined in the general instructions section.
ii. If the fire is not threatening the PBX office you would initiate the steps below:
1) Upon receipt of a call notifying PBX of a Code Red/Fire, or when the fire alarm is activated, you will immediately:
a) Notify the Fire Department, giving the address and location of the fire in the hospital.
b) Notify all personnel through the use of the public

DRAFT

address system. Use the following code:
i) "Attention, Please – CODE RED and specific location." Repeat the page three (3) times.

2) Prepare the Switchboard for emergency operations only, restricting calls.
3) Notify:
   a) Director of Safety/EOC
   b) Administrator On-call
   c) Administrative Supervisor on duty
   d) Security Manager or Lead
   e) Director of Engineering
   f) Emergency Department Charge Nurse
   g) Other key personnel, as needed
4) Carry out administrative orders as directed.
5) If PBX system is inoperative, use the RED phones system or cell phones.

o. ~~Licensed Independent~~ Practitioners, Allied Health Professionals, Volunteers & Non Staff Personnel:

~~m.~~i. Tri-City Healthcare District believes strongly in the principle of life safety. The organization recognizes as a practical matter that members of the medical staff/Allied Health Professionals and many volunteers and students are not present much of the time and are not likely to be a reliable resource during a fire response. Therefore, the medical staff, volunteers, and students do not have a specific defined role in the fire response plan. They are instructed to remain in the area they are located at the time an alarm sounds and to render assistance under the direction of the manager or employees of the area as needs arise.

SUBJECT: **Fire Safety Hazards**

ISSUE DATE: **NEW**
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**08/15**
Environmental Health and Safety Committee Approval Dates(s):	**09/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**10/15**
Board of Directors Approval Date(s):	

A. **POLICY:**

1. Hazards that personnel shall recognize and correct, or cause to be corrected, or prevent from existing, are as follows:
   a. Careless Smoking - Be careful to observe all "No Smoking" rules and regulations. This includes any product containing tobacco intended to be lit, burned, or heated to produce smoke as well as any device used to smoke the tobacco, including but not limited to a pipe, cigar, or cigarette, (including electronic cigarettes & vapor devices).
   b. Exit Ways - Do not permit the obstruction of aisles, doorways, fire escapes or allow their use as storage places.
   c. Combustible Waste - All combustible waste shall be placed in all metal containers with tight fitting covers; so that any fire occurring will be kept entirely within the container. When materials capable of spontaneous ignition are stored, they shall be kept in separate containers until safely disposed ~~of~~.
   d. Fire Doors - The proper operation of fire doors is necessary to protect or isolate one section of the building from another, thus providing protection to other areas and persons within the building. Keep all fire doors properly closed, except those equipped to close automatically. Fire doors wedged or propped open are of no value in preventing the spread of fire.
   e. Flammable Liquids - (Such as acetone, alcohol, benz~~e~~ine, and ether) Limit the amount on hand to a minimum working supply. If possible, keep in metal container. Where safety cabinets or storage rooms are available, keep these materials in them and maintain the door to such storage in the closed position. No smoking, open flame or sparking device shall be allowed around flammable liquids or compressed gas. Oxygen and nitrous oxide shall not be stored with flammable gases, such as cyclopropane and ethylene, or with flammable liquids.
   f. Electrical Hazards - Report promptly any frayed, broken or overheated electrical cords or electrical equipment. Do not operate light switches, or connect or disconnect equipment where any part of your body is in contact with metal fixtures or is in water. Specially built equipment is in use in the operating and delivery rooms to eliminate electric sparks, and to control static electricity.
   g. Acids - All concentrated or corrosive acids must be handled with extreme care. Avoid storing these materials on high shelves, or in locations where they are likely to be spilled or the containers broken. Organic acids and inorganic acids shall not be stored together. Any spillage shall be immediately diluted or neutralized and cleaned up.
   h. Electric Heaters - These units, particularly the portable type, are not permitted anywhere

on the hospital premises unless approved by Engineering. No portable heaters are allowed in patient care areas.

i. Heat generating devices or substances such as candles, toasters, toaster ovens, hot plates, electric blankets, heating pads, propane fueled devices, strand lights and oil lamps are not appropriate for the hospital environment and are not allowed on hospital property. Persons who do not comply with these directions will be subject to the disciplinary process.

B. **AFFECTED AREAS/PERSONNEL:**

1. **Governing Board; Medical Staff; All Hospital Employees; Volunteers; Vendors**~~OVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS;~~

C. **REFERENCE(S):**

1. The Joint Commission
2. NFPA
3. CA State Fire Marshall

SUBJECT: Reporting Hazmat Incidents

ISSUE DATE: NEW
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**09/15**
Environmental Health and Safety Committee Approval Dates(s):	**09/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**10/15**
Board of Directors Approval Date(s):	

A. **POLICY:**

1. It is the policy of Tri City Healthcare District to implement processes for reporting and investigating hazardous materials and waste spills and exposures.

B. **RESPONSIBLE PARTIES:**

1. Employee that discovers the spill
2. Manager or Director of the area
3. Director of Safety/ Environment of Care (EOC)
4. Director of Risk Management
5. The Director of Safety/EOC will maintain and document information concerning hazardous materials and waste spills and the Director of Employee Health will maintain information and documentation on hazardous material and waste exposures within Tri City Healthcare District owned or operated facilities.

C. **PROCEDURES:**

1. All hazardous material and waste spill or exposures must be reported, even if no bodily harm or property loss resulted, utilizing the RL Solutions QRR reporting system
2. The discovering employee is responsible for completing the report online immediately following the event.
3. The manager or director is responsible for reviewing the report and performing an investigation as needed within three business days.
4. The Director of Safety/EOC is responsible for final review of the spills and the Director of Employee Health is responsible for final review of the exposures.
5. The Director of Safety/EOC is responsible for tracking, trending and analyzing the records of spills
6. The Director of Safety/EOC will report the information, tracking and trending, and results of investigations for spills and exposures quarterly to the Environmental Health and Safety Committee.

DELETE- incorporated into Purpose and Authority

Tri-City Medical Center
Oceanside, California

Emergency Preparedness Management

EFFECTIVE DATE: 6/03

SUBJECT: Authority to Implement the Disaster Plan for TCMC

REVISION DATE: 11/05

POLICY NUMBER: 4070: Page 1 of 8

REVIEW DATE: 12/05

Department Approval Date(s): 07/15
Environmental Health and Safety Committee Approval Dates(s): 08/15
Professional Affairs Committee Approval Date(s): 10/15
Board of Directors Approval Date(s):

~~1.0 POLICY~~

~~To provide guidelines for line of authority and process to be initiated by the Tri-City Medical Center during an internal or external disaster.~~

~~2.0 AUTHORITY AND CONTROL~~

~~2.1 The Chief Executive Officer/designee, Emergency Room Physician on duty, or the Emergency Department Director has the authority to activate the Disaster Plan. The Chief Executive Officer, or the Administrative Coordinator (between the hours of 7p-7a Mondays thru Fridays, and 24 hours on weekends and holidays) will be notified immediately and apprised of the nature and extent of the disaster. The Chief Executive Officer or designee, assumes the role of Incident Commander and activation of "Code Orange". Once the "Code Orange" code has been called, the Hospital Emergency Incident Command System (HEICS) becomes the Standard Operating procedures, until the Code Orange has been cleared.~~

~~2.2 Radio Communication from the 800 MHz console will be received in the Emergency Department and information transferred by two-way radio to the Incident Command Center (ICC). The ICC will be managed by the Incident Commander and located in the French Classrooms.~~

~~2.3 The emergency Department Physician on duty will assume responsibility for directing all medical activities until the arrival of the Medical Staff Chief or his/her designated relief. The Medical Staff Chief will be notified as soon as possible for consult, and to assume medical authority.~~

~~2.4 At the direction of the Incident Commander, the PBX operator shall page the termination of the disaster code as follows: **"CODE ORANGE SECURED. ALL PERSONNEL RETURN TO DUTY"**, three (3) times in succession.~~

~~3.0 NOTIFICATION OF CODE ORANGE ACTIVATION TEAM (KEY OFF-DUTY PERSONNEL, PHYSICIANS, AND SUPPORTIVE AGENCIES)~~

~~3.1 The PBX operator , at the direction of the Incident Commander, will notify the following Code Orange Activation Team members of the disaster and its extent.~~

~~3.1.1 Chief Executive Officer/Administrative Coordinator after hours and weekends~~
~~3.1.2 Emergency Department Director/Emergency Charge Nurse~~
~~3.1.3 All Area Vice Presidents~~
~~3.1.4 Sr. Directors Patient Services~~
~~3.1.5 Director, Media Relations~~
~~3.1.6 Dir. Engineering/Duty Engineer~~
~~3.1.7 Safety Officer~~
~~3.1.8 Security Supervisor/Lead Security Officer~~ ~~3.1.9 Base Hospital Nurse Coordinator/MICN~~

~~3.2 The Incident Commander at his/her discretion, will request assistance from the following supportive agencies to obtain supplies, equipment or personnel:~~

3.2.1 Police Department (911)
3.2.2 Fire Department (911)
3.2.3 Red Cross (291-2620)
3.2.4 County Office of Defense & Disaster Preparedness (565-3490)
3.2.5 San Diego County Medical Society (565-8888) for additional Physicians
3.2.6 San Diego City Office of Emergency Management Services Authority (EMSA) (Answering Service 236-6878)
3.2.7 San Diego Blood Bank (296-6393)
3.2.8 KSDO or KFMB Radio may be notified to inform hospital staff to report to the hospital or to deliver other information.
3.2.9 HAM Radio Operators (predesignated by EMSA)

4.0 NOTIFICATION OF OFF-DUTY PERSONNEL

4.1 Each Department Manager or their designated relief shall be responsible for notifying needed off-duty personnel, per the emergency call back procedures, to report immediately to the hospital.
4.2 Updated home phone numbers of department personnel shall be maintained in each department.
4.3 In case of a major disaster, i.e., earthquake, with many casualties, all off-duty employees should report to the Labor Pool located in the Assembly Room 3. Physicians arriving for duty should report to the Medical Labor Pool (Physician Dining Room) Physician Unit Leader/deignee for assignments.

5.0 DETERMINATION OF AVAILABLE BEDS AND EXPANSION POTENTIAL

5.1 The Staffing Office shall immediately determine the number of available beds and transmit this information to the Command Post via emergency message form.
5.2 The Administrative Coordinator 24/7 will receive the Unit Census forms for patients to be discharged, transferred or relocated to a area within the Hospital.
5.3 At the discretion of Administration, and/or Incident Commander, all elective admissions, treatments, and procedures will be postponed or canceled until the Code Orange is secured.

6.0 COMMUNICATIONS

6.1 The 800 MHz console is located in the Emergency Department and will be utilized to communicate with area hospitals.
6.2 The 800 MHz console has a twenty-four hour capability covering most county, public service, and emergency radio frequencies and "hot line". It is the primary county-wide radio control station for coordinating emergency medical system utilization of the emergency administrative (secondary) and paramedic networks. 6.3 Communications from the scene will rely on the networks found in the county EMS plan.
6.4 Hospital Communications will be carried out utilizing messengers drawn from the Command Post and two- way radios. Radios will be dispersed to:
6.4.1 Command Post (ICC)
6.4.2 Triage Area(s)
6.4.3 Logistics Command Center
6.4.4 Planning Command Center
6.4.5 Finance Command Center
6.4.6 Operations Command Center
6.4.7 PBX (keeps one in office always)
6.4.8 Delayed and Minor Treatment Areas
6.4.9 Decontamination Area
6.5 There are 29 RED Disaster Emergency Phones located on selected nursing units and other areas of the hospital to assist with Hospital communications during a phone system failure.
6.5.1 Administration
6.5.2 Behavioral Health Unit
6.5.3 Emergency Department
6.5.4 Incident Command Center
6.5.5 Lab
6.5.6 Lift Team
6.5.7 Materials Mgmt.
6.5.8 Nursing Units
6.5.9 PBX
6.5.10 Plant Operations
6.5.11 Radiology
6.5.12 Staffing Office
6.5.13 Surgery
6.6 Note: Off-site areas are communicated with via two-way radios and/or cellular phones.

7.0 PERSONNEL ASSIGNMENTS

7.1 All personnel will remain in, or report to, their assigned departments until further instructions are given. Nursing should prepare to deploy Code Orange staff to the labor pool, IC, or for the arrival of patients.

7.2 Managers, after evaluating their department's staffing needs, will send at least one staff member to the Labor Pool (located in the Assembly Room 3).

7.3 As personnel are requested from specific areas, the Labor Pool will assign employees as directed by the incident command staff.

8.0 RECORDS AND IDENTIFICATION OF CASUALTIES

8.1 Identification:

8.1.1 Pre-numbered disaster packets are stored in the Emergency Department.

8.1.2 One person from the Admitting Department will report to the Triage Area to register patients. Additional Admitting Department personnel will report to the Finance Command Center.

8.1.3 Any available personnel from Medical Records will respond to the Labor Pool.

8.1.4 Pre-assigned disaster patient numbers correlate with the Ident-A-Band number and will be used as the patient's identification. Patients pronounced dead will also receive an identification number.

8.1.5 Ident-A-Bands will be securely attached to the patient, either on the wrist or the ankle, while the patient is in the Triage Area.

8.1.6 The removable portion (triage section) of the nurse's flow sheet will be forwarded to the Patient Status Assistant to document patient information. Upon completion, this information will be sent to the Command Post personnel, who will be responsible for casualty reports.

9.0 HANDLING OF CASUALTIES

9.1 Receiving and sorting of casualties will be accomplished at the triage site. For treatment of contaminated patients, refer to the Radiation Treat Policy #4065, or Code Orange Chemical Decontamination Policy # 4070.

9.2 In the event the Emergency Department is nonfunctional, an alternative triage site will be utilized.

9.3 All casualties will be triaged according to: immediate, delayed, minor/walking wounded, deceased. The triage nurse will supervise this function.

9.4 Skin marking pencils shall be used to write the treatment area designation on the patient. Casualties will be marked on the forehead or on the back of the right hand.

9.5 Consider using helicopter teams for Diversion/Deployment

Areas: 9.5.1Mercy Air (1-800-222-3456)

9.5.2 Astrea (619-448-2068)

9.6 A "Patient's Personal Property Envelope" is contained in the Disaster Box. Patient's valuables, such as jewelry, money, etc., shall be placed in this envelope and locked in the hospital safe in the Admitting Department.

9.7 A "Personal Belongings Bag" marked with the patient's name and disaster number will be kept with the patient.

10.0 MORGUE

10.1 Refrigerated trucks should be considered for mass casualty.

10.2 A security officer shall be assigned to this area to insure that the remains are released only to authorize persons.

10.3 Records of remains released will be kept.

11.0 SUPPLIES, EQUIPMENT, DRUGS, LINEN, ETC.

11.1 Basic supplies, drugs and equipment needed in a disaster situation are maintained by Materials Distribution, Pharmacy, and Environmental Services.

11.2 Upon notification of the disaster, this equipment will be available upon request to the Material/supplies Unit Leader.

11.3 Supplies and drugs will be issued only to authorized and recognized personnel or authorities. Written records of items dispensed will be maintained by the Material/Supplies Unit Leader for supplies and Pharmacy Unit Leader for drugs.

11.4 Materials Distribution, Environmental Services and Pharmacy will maintain lists of outside sources where supplies, equipment and drugs can be obtained on a 24-hour basis.

11.5 Supplies and equipment obtained from outside sources will be brought to Material/Supplies Unit Leader. 11.6 Flashlights are located on each unit.

12.0 BLOOD, PLASMA, PLASMA EXPANDERS

12.1 Immediately upon notification of the disaster situation, the person in charge of the Laboratory will determine the blood supply by type and transmit this information to the Incident Command staff.

12.2 Additional blood and plasma determined to be necessary for the disaster may be secured from the San Diego Blood Bank.

12.3 Immediately upon notification of the disaster situation, the person in charge of the Pharmacy will determine the supply of plasma volume expanders by type and transmit this information to the Incident Command Staff.

13.0 FOOD/WATER

13.1 Guest Services is responsible for the procurement, preparation, serving and control of the food products. 13.2 The cafeteria is designated as the Disaster Feeding Area.

13.3 Alternate methods of preparing and serving food in case of power failure will be predetermined by the Director of Food Services.

13.4 The Guest Services Department shall maintain a list of outside sources of food suppliers, which are available on a 24 hour basis. Meals ready to eat are available through Food services

13.5 Water supply/distribution (See Water Supply Shortage Plan).

14.0 UTILITIES/ENGINEERING

14.1 The maintenance and continuation of needed utilities (electrical power, gas, water, and sewage) will be the responsibility of the Director of Facilities or designee.

14.2 Predetermined alternate methods of supplying the hospital with essential utilities have been established in the Disaster Utilities Plan.

14.3 The local Police Department maintains direct communication lines with the city's major utility companies for assistance in reestablishing the hospital's utility requirements in the event of a failure.

15.0 ELEVATORS

15.1 If so instructed by the Incident Commander, the Facilities Department shall assure that all elevators are brought to the first floor and that the controls are placed in the "Independent Service" ON position. This will hold the elevators for use.

16.0 HELICOPTERS

16.1 Facilities for landing helicopters are available at Tri-City Medical Center.

17.0 SECURITY

17.1 The Security Leader will assign personnel to act as guards in the following areas: 17.1.1 All hospital entrances
17.1.2 Store rooms
17.1.3 Pharmacy
17.1.4 Morgue

17.2 Security will maintain traffic control.

18.0 NEWS MEDIA

18.1 The Public Information Officer will be responsible for any statements made to the press.

18.2 All members of the press must identify themselves to the Public Information Officer before any information concerning the disaster is released.

18.3 Casualty lists will be transmitted to the Public Information Officer Representative from the Command Post when available.

18.4 At the discretion of the Public Information Officer, the Press Photographers may take general situation photos only; direct facial photographs are not allowed.

19.0 SOCIAL SERVICES

19.1 Social Services will assist relatives and friends of casualties and direct them to the determined location for all information concerning casualties.

19.2 Social Services will obtain information from the Patient Status Assistant and keep family and friends advised. 19.3 Social Services will provide crisis intervention counseling when appropriate to patients, families, and friends. 19.4 Outside telephone inquires concerning the disaster will be directed to the Public Information Officer.

20.0 CLERGY

20.1 Members of the clergy, after presenting identification, will be allowed in the hospital to render assistance to patients and relatives as needed.

21.0 AUXILIARY

21.1 The president of the Auxiliary will be responsible for notifying Auxiliary members to report to the hospital. 21.2 Members of the Auxiliary will report to the Labor Pool for assignment.

22.0 HANDLING OF CONTAMINATED PATIENTS

22.1 See "Emergency Procedure for Radiation (4065) and Code Orange Chemical Decontamination (4070).

23.0 EVACUATION

23.1 The Incident Commander or designee shall be authorized to order evacuation of patients and personnel from the hospital. If possible, this decision should be in consult with Medical Staff Chief and Administration. Refer to the Evacuation Plan.

Tri-City Medical Center

Oceanside, California

Emergency Preparedness Management

DELETE- incorporated into Emergency Operations Plan

EFFECTIVE DATE: 11/88

SUBJECT: Disaster Control Center Implementation Plan: Emergency Department Specific

REVISION DATE: 1/94, 3/97, 6/03, 11/05

POLICY NUMBER: 4002 Page 1 of 2

CROSS REFERENCE:

REVIEW DATE: 11/91

Department Approval Date(s):	**07/15**
Environmental Health and Safety Committee Approval Dates(s):	**08/15**
Professional Affairs Committee Approval Date(s):	**10/15**
Board of Directors Approval Date(s):	

~~1.0 PURPOSE:~~

~~To provide Administrative control of the Medical Center in the event of a disaster. The Chief Executive Officer/designee maintains overall control and authority of the Medical Center.~~

~~2.0 PERSONNEL:~~

~~2.1 Chief Executive Officer (CEO)~~
~~2.2 COO/CNE~~
~~2.3 Senior Director/DON~~
~~2.4 Chief of Staff~~
~~2.5 Chairman of Disaster Committee~~
~~2.6 Administrative Secretary~~
~~2.7 Hospital Safety Officer~~

~~3.0 PROCEDURE:~~

~~3.1 DISASTER ALERT PHASE~~

~~3.1.1 In the event of a Disaster Alert Phase, the CEO/designee will:~~

~~3.1.1.1 Notify Administrative Staff advising them of the disaster circumstances.~~

~~3.1.1.2 Review the Administrative disaster plan.~~

~~3.2 DISASTER ACTIVATION PHASE~~

~~3.2.1 The CEO will order implementation of this plan when he considers it appropriate to the circumstances reported to him.~~

~~3.2.2 Activation of this plan will occur only with the authority of the CEO or his designee. The initial activation will be done by authorizing the PBX operator to announce "CODE ORANGE.~~

~~3.2.2.1 Normal working hours:~~

~~CEO, CNE/COO, Chief of Staff, Senior Director ED and Hospital Safety Officer representatives shall report to the Incident Command Center (IC). All department managers report to their respective departments.~~

~~3.2.2.2. After normal working hours:~~

~~CEO or designee will issue directions to the Administrative Coordinator on duty.~~

~~3.2.3 The CEO delegates authority to other members of Administration and the disaster control team to:~~

~~3.2.3.1 Set up the Incident Command Center (IC).~~

3.2.3.2 **External Notification**: Establish a communication network throughout the Medical Center and community via Medical Operations center at the San Diego County Emergency Operations Center.

Internal Notification: to County Agencies will be through QA Net and Dispatchers.

3.2.4 The Incident Command Center will direct the disaster operation by using the HEICS protocols:

3.2.4.4 Receiving disaster status reports from the Incident Commander/designee.

3.2.4.10 Administrative authority in time of a disaster is vested in CEO/designee and medical treatment authority is vested in the Chief of Staff/ED Medical Director.

3.2.4.11 Should discontinuance or disruption of Medical Center services occur, notification to the local DHS Office.

DELETE- incorporated into Emergency Operations Plan

TRI-CITY MEDICAL CENTER **Safety Policies & Procedures**	**Section:** **Emergency Preparedness Management** **Subject:** **Disaster Plan For Media Control** **Policy Number:** 4007 Page 1 of 2
Department: Marketing & Public Relations	**EFFECTIVE:** 10/88 **REVISED:** 9/93; 3/97; 5/00

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Dates(s): **08/15**
Professional Affairs Committee Approval Date(s): **10/15**
Board of Directors Approval Date(s):

~~**1.0 PURPOSE:**~~

~~To ensure appropriate release and flow of information to the media in the event of a disaster.~~

~~**2.0 PERSONNEL:**~~

~~2.1 Incident Commander~~
~~2.2 Public Information Officer~~
~~2.3 Security~~

~~**3.0 RESPONSIBILITY:**~~

~~3.1 The Public Information Officer as assigned by the Incident Commander is the designated spokesperson for the Medical Center and, in conjunction with the Incident Command Center, will:~~
~~3.1.1 Control all contact with the news media. 3.1.2 Set up Press room.~~
~~3.1.3 Control the designated Press rooms. Authorize press releases and press conferences in coordination with the Incident Command Center.~~
~~3.2 News releases will be issued with authorization from the Incident Command Center.~~
~~3.3 The press may enter the Medical Center through a designated entrance.~~

~~**4.0 PRECAUTIONS:**~~

~~4.1 Press will be appropriately identified.~~
~~4.2 Press will remain in their specified area.~~
~~4.3 Photographs and television coverage must be appropriately authorized by Incident Command Center or Public Information Officer.~~

~~**5.0 AUTOMATIC REVIEW:**~~

~~This policy/procedure will be reviewed annually and updated as needed. It is the responsibility of the Public Information Officer to:~~
~~5.1 Orient and educate public relations staff to the Media Disaster Plan.~~
~~5.2 Maintain an updated version of the Disaster Plan and call-back roster.~~

Tri-City Medical Center
Oceanside, California

DELETE- incorporated into Scope of Response

Emergency Preparedness Management

EFFECTIVE: 10/88

SUBJECT: Disaster Plan: Rehab Area, Minor Care (Walking Wounded)

REVISION DATE: 10/93; 3/97; 2/00; 11/02; 4/03; 10/05

POLICY NUMBER: 4055 Page 1 of 4

REVIEW DATE: 10/91; 10/94

Department Approval Date(s):	**07/15**
Environmental Health and Safety Committee Approval Dates(s):	**08/15**
Professional Affairs Committee Approval Date(s):	**10/15**
Board of Directors Approval Date(s):	

~~1.0 **PURPOSE:**~~

~~To provide guidelines for the Rehabilitation Services/1 North personnel in the event of a disaster/**CODE ORANGE/CODE YELLOW** and activation of the Hospital Emergency Incident Command System (HEICS). HEICS calls for immediate activation of the Command Center and is built on criticality/needs requirements to handle the incident. The Physical Therapy Gym (located on 1 North) will be utilized for the walking wounded.~~

~~2.0 **PERSONNEL:**~~

~~Nursing Director of Acute Care~~
~~Services Charge RNs and Therapy~~
~~personnel Department Staff~~

~~3.0 **PROCEDURE:**~~

~~In the event of a "Code Orange", the Director or their designee will take action to provide personnel for the walking wounded area, as well as staff needed for the labor pool.~~
~~The Director will ensure the following:~~

- ~~Review the Department Disaster Plan and call-back protocol.~~
- ~~Inventory equipment and supplies.~~
- ~~Secure appropriate personnel, including two (2) runners from the command center, as well as appointment of one (1) staff member to the Incident Command Center (French Room) with the completed personnel inventory form.~~
- ~~Employees away from the Department will immediately return to the Department. In the event that the disaster is in the Department, employees should report to the labor pool (French Room).~~
- ~~Activate the call-back protocol.~~
- ~~Clear patients from the PT Gym and cancel therapies until otherwise notified.~~
- ~~Prepare the Gym area for walking wounded, securing supplies, pillows, blankets, etc. Place signs in hallways to indicate walking wounded area and to direct patient flow.~~
- ~~Notify the command center and Emergency Department of the Department's readiness.~~
- ~~An Emergency Department nurse and physician will report to the Physical Therapy Gym with other personnel, as needed.~~
- ~~Submit periodic reports to the command center, including updates on the number and status of patients, supplies, etc. Patients will arrive from triage area with an escort, identification tags, and a status report.~~
- ~~The Department will be expected to assist in the management of disaster victims. Personnel will be requested to respond to triage areas via labor pool.~~

4.0 AUTOMATIC REVIEW:

This Policy & Procedure will be reviewed bi-annually and updated as needed.

- All new employees will receive education on the Department's Disaster Plan as part of their orientation.
- An annual review of the Department's Disaster Plan will be given by the Department Director.
- Emergency Call-Back list will be updated on an ongoing basis and published quarterly for all staff.

OCCUPATIONAL HEALTH & REHABILITATION SERVICES DISASTER FACT SHEET

1. In the event of a major disaster at Tri-City Medical Center, you should:
   - Report to your home department if you are on duty. If you are called in because you are off duty, go to the area designated by the person who called. This will probably be the labor pool.
   - Know where the fire extinguisher are in your area.
   - Keep your photo ID with you at all times. You will need this to get through Security at the Thunder Drive entrance.
2. Some things you could do to prepare for a disaster include:
   - Bring a flashlight to work to keep in your work area.
   - Review rescue carries and evacuation procedures.
   - Remember the elevators probably will not work.
   - Know that the phone system will probably be out of service initially.
   - Bring an extra pair of comfortable shoes, a 3-day supply of your own medications, and snack foods. We may be here without outside assistance for several days.
   - Each department is responsible for maintaining up-to-date departmental plans and call-back rosters.
3. A few of the plans for a major disaster include:
   - "Code Orange/Code Yellow" — PBX operator will announce 3 times over the Hospital public address system: "Code Orange/Code Yellow". Each department will activate their Disaster Plan. Call-backs will begin. The Directors will review Departmental disaster plans, inventory supplies and equipment.
   - The Director will determine plans for keeping staff at the department or sending them elsewhere in the Hospital, depending on the disaster situation and the needs of the individual departments. The 1 North Physical Therapy Gym is designated as the triage area for the walking wounded.
   - Should the disaster occur between 8:00 AM and 4:30 PM, all personnel will return to the Department and await assignment by the Director or their designee. Some staff will be assigned to call back off- duty personnel. Others will be assigned to take inventory of equipment and supplies, or assist with the walking wounded. The Director will maintain contact, by phone or by the use of messengers, with the Control Center.
   - Should the disaster occur after 4:30 PM, the Director will initiate the call-back protocol. The Director will maintain contact by phone with the Control Center. If the phones are out of order, in which case call-back cannot be initiated, the Director will take inventory of supplies and equipment and await further instructions.
   - Once communication is established with the Control Center, hourly updates (or more frequent ones, depending on the situation's urgency) should be sent from the Department to the Control Center and back.
   - The Control or Command Center will most likely be in the French Conference Rooms.

Tri-City Medical Center
Oceanside, California

DELETE- incorporated into Emergency Operations Plan

Emergency Preparedness Management

EFFECTIVE DATE: 11/88

SUBJECT: Emergency Removal of Patients Using Manual Carries: Hospital Wide

REVISION DATE: 3/97, 6/00, 4/03, 12/05

POLICY NUMBER: 4005 Page 1 of 3

CROSS REFERENCE:

REVIEW DATE: 4/91, 4/94

Department Approval Date(s):	**07/15**
Environmental Health and Safety Committee Approval Dates(s):	**08/15**
Professional Affairs Committee Approval Date(s):	**10/15**
Board of Directors Approval Date(s):	

~~**1.0 PURPOSE:**~~

~~To provide guidelines for Patient Carry Methods when evacuation has been directed. Under emergency conditions, the speed in which patients must be moved from the building may be of paramount importance. The method or carry used in any particular situation will vary with the conditions surrounding the emergency. Things to consider are:~~

~~1.1 Condition of the patient.~~
~~1.2 Nature of emergency.~~
~~1.3 Weight and size of patient (or staff person).~~
~~1.4 Height of bed.~~
~~1.5 Number of patients to be relocated.~~
~~1.6 Number of staff members available to assist.~~

~~**2.0 MANUAL CARRIES**~~

~~2.1 BLANKET DRAG~~

~~Equipment: One blanket per patient, one or two staff.~~
~~2.1.1 Unfold the blanket.~~
~~2.1.2 Place patient face up, diagonally on blanket.~~
~~2.1.3 If patient is wearing shoes, remove them. This eliminates the possibility of heels catching on stairs and floor obstructions.~~
~~2.1.4 Lift corner of blanket nearest to patient's head. This keeps patient's head off floors.~~
~~2.1.5 Utilizing one or both hands, drag patient, HEAD FIRST, to place of safety.~~
~~2.1.6 Patient evacuation down stairways can be accomplished rapidly by this method. Remember the head goes first.~~
~~2.1.7 This can be done by one or two staff.~~

~~2.2 PACK STRAP METHOD~~

~~Equipment: One staff member.~~
~~2.2.1 Pull patient to sitting position.~~
~~2.2.2 Grasp patient's right wrist with your left hand and his left wrist with your right hand.~~
~~2.2.3 Duck you head under patient's arm without releasing wrists.~~
~~2.2.4 Place your back against his chest so that your shoulders are lower than his armpits.~~
~~2.2.5 Pull the patient's arms over your shoulders and across your chest for leverage.~~
~~2.2.6 Keep the patient's wrists firmly grasped with either one or both hands.~~
~~2.2.7 Lean forward slightly; straighten your knees; and transport to safety.~~

2.3 KNEEL DROP METHOD (TO BLANKET)

Equipment: One, two or three staff members and blanket.

2.3.1 Unfold blanket.

2.3.2 Face bed.

2.3.3 Lower body on both knees in kneeling position.

2.3.4 For two staff, one staff member kneels at the patient's chest and the other at the patient's knees. For three staff members, one staff kneels at patient's chest, another at hip level and the last at patient's knees.

2.3.5 Grasp patient's knees with one arm; his head and shoulders with the other.

2.3.6 Do not lift.

2.3.7 Pull patient straight out from bed until his body contacts your chest.

2.3.8 Allow his/ her head to slide down your body to the cushion formed by your knees.

2.3.9 Ease to blanket and remove patient from room.

2.4 EXTREMITY METHOD

Equipment: Two staff personnel.

2.4.1 First staff member works his/her hands and arms from behind patient under patient's armpits; then grips his/her own wrists across the patient's chest.

2.4.2 The second staff member pulls the patient's ankles out from the bed, then backs up between patient's knees and grasps both knees under his or her arms.

2.4.3 Lift patient and remove to safety.

2.5 HIP METHOD

Equipment: One staff member.

2.5.1 Turn patient on side facing staff personnel.

2.5.2 Staff member sits on bed.

2.5.3 Place your back against patient's abdomen.

2.5.4 Grasp knees with one arm and slide your other arm down and across the patient's back under free arm.

2.5.5 Grip patient under the armpit.

2.5.6 Straighten your knees.

2.5.7 Draw patient up on you hips and carry to safety.

2.6 CRADLE DROP METHOD (TO BLANKET)

Equipment: One or two staff personnel and blanket

2.6.1 Unfold blanket on floor.

2.6.2 Face bed.

2.6.3 Lower your body with one knee up and one knee on floor. Upper-most knee should be at right angle to patient's knees, rigid, and touching bed. If two staff are used, the second staff member places knee nearest bed at right angle to patient's shoulder blades.

2.6.4 Grasp patient's knees with one arm and his neck and shoulders with the other.

2.6.5 Do not attempt to lift patient.

2.6.6 Simply pull patient toward you and ease him/her toward the floor.

2.6.7 Your raised knee will support his knees and legs and your arm will support his shoulders and head.

2.6.8 The cradle formed by your arm and knee will protect his back.

2.6.9 Ease patient to blanket and remove to safety.

2.7 SWING METHOD

Equipment: Two staff.

2.7.1 With a staff person on each side of the patient, pull patient to a sitting position.

2.7.2 Both staff pass one arm under patient's arm and across his back and secure a firm grip on each other's shoulders.

2.7.3 The other arm is then passed under the patient's knees, one nurse with palm up, the other palm down; grasp wrists.

2.7.4 Lift with arms and shoulders and remove to safety.

2.7.5 This is a good method for transporting wheelchair patients.

2.8 PATIENT WITH BROKEN BACK, NECK OR PELVIS (STRETCHER OR LITTER METHOD)

~~Equipment: Six staff and stiff stretcher or blanket-covered boards.~~

~~2.8.1 Three staff on each side of the patient.~~

~~2.8.2 If patient is on the floor, kneel on one knee with knee nearest patient's feet on floor.~~

~~2.8.3 Two staff at patient's head form cup behind head of patient by each interlacing the fingers of one hand.~~

~~2.8.4 Remaining hand of these staff and the hands of the other staff are then to be placed alternately on each side patient's body toward the spine area.~~

~~2.8.5 All staf lift together on command and place patient on litter, stiff stretcher, or blanket-covered board.~~

~~2.8.6 Patients should be transported feet first.~~

~~Refer to Attachment A.~~

DELETE- incorporated into Scalable Events

TRI-CITY MEDICAL CENTER **Safety Policies & Procedures**	**Section:** **Emergency Preparedness Management** **Subject:** **General Information For Discharging of Patients** **Policy Number:** 4006 Page 1 of 2
Department: **Case Management**	**EFFECTIVE:** 5/87 **REVISED:** 11/93; 3/97; 5/00

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Dates(s): **08/15**
Professional Affairs Committee Approval Date(s): **10/15**
Board of Directors Approval Date(s):

~~**1.0 PURPOSE:**~~
~~To accommodate the orderly discharge of hospital patients who are medically stable for discharge, in preparation for receiving victims of a disaster.~~
~~**2.0 LOCATION:**~~
~~Patients will be discharged from the Admitting Lobby on the first floor of the Pavilion. Final departure of patients into vehicles will be from the first floor Pavilion north door, designated as "Patient Discharge".~~
~~**3.0 PERSONNEL:**~~
~~3.1 Medical Staff Director~~
~~3.2 Chief Nurse Executive~~
~~3.3 Business Office Manager~~
~~3.4 Business Office Staff~~
~~3.5 Security~~
~~3.6 Other Personnel from Labor Pool as needed~~
~~3.7 Bed Coordinator~~
~~**4.0 PROCEDURE:**~~
~~4.1 In the event of a disaster, the Medical Staff Director, in coordination with the Command Center, Nursing and Business Offices will assess and prepare for the discharge of those patients who are medically stable to be discharged.~~
~~4.1.1 The Medical Staff Director/designee maintains final authority in disaster situations in determination of patient discharge status.~~
~~4.1.2 The Medical Staff Director/designee is located in the Command Center and is responsible for maintaining a discharge readiness status consistent with the magnitude of need for available beds.~~
~~4.1.3 The Chief Nurse Executive is responsible for providing and assisting the Medical Staff Director. This responsibility includes making available current patient occupancy status, assisting in defining the projected needs of beds in response to the specific circumstances, and coordination with the Emergency Department and all Directors/Designee in maintaining current and ongoing occupancy status throughout the disaster response. The Bed Coordinator will keep the Chief Nurse Executive appraised of bed availability on a thirty minute continuing cycle throughout the disaster, unless the Chief Nurse Executive otherwise directs.~~
~~4.1.4 The Business Office Department Director is responsible for all preparation required in discharging designated patients. The Department Director/Designee will maintain the current and potential discharge response status through communication with the Bed Coordinator, and is responsible for maintaining a departmental plan which will result in the discharge of patients and the appropriate maintenance of records~~

~~and documents. Additionally, the Department Director/Designee will coordinate with Security, Business Office staff and other designated personnel in the smooth flow of discharged patients.~~

~~4.1.5 Vehicular traffic flow of discharged patients is from the "Patient Discharge" door, east to Thunder Drive.~~

DELETE- incorporated into Emergency Operations Plan

TRI-CITY MEDICAL CENTER **Safety Policies & Procedures**	**Section:** **Emergency Preparedness Management** **Subject:** Medical Staff Disaster Plan **Policy Number:** 4045 Page 1 of 2
Department: Medical Staff	**EFFECTIVE:** **REVIEWED:** 3/97 **REVISED:** 4/03; 10/05

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Dates(s): **08/15**
Professional Affairs Committee Approval Date(s): **10/15**
Board of Directors Approval Date(s):

~~1.0 PURPOSE~~

~~To insure continuance of efficient Medical Staff response during a disaster and to maintain adequate availability of personnel in the event of disaster.~~

~~2.0 INTRODUCTION~~

~~Due to the varying types and magnitudes of emergency events, Tri-City Medical Center has adopted the command structure of Hospital Emergency Incident Command Systems (HEICS). Once the decision~~
~~has been made to activate the disaster plan, the HEICS becomes the standard operating procedure.~~

~~3.0 NOTIFICATION~~

~~3.1 The complete plan is located in the TCMC Safety and Disaster Plan Manual located in the Incident Command Center and the Medical Staff Office.~~

~~3.2 The Medical Staff will be notified of the Disaster Plan Activation from the PBX operator announcing "CODE ORANGE" or "CODE YELLOW" using the overhead page.~~

~~4.0 PHYSICIAN RESPONSIBILITIES~~

~~4.1 The Emergency Department Physician on duty will assume the role of Medical Care Director as described in the HEICS procedure and assume responsibility for directing all medical activities until the arrival of the Medical Staff Chief or his/her designated relief. Following notification of a disaster, the Emergency Department MD will respond to the Incident Command Center. (French Room 1)~~

~~4.2 The Medical Staff Chief will be notified as soon as possible for consult, and to assume authority as Medical Staff Care Director.~~

~~*4.3 The Medical Staff designee upon granting disaster privileges pursuant to Temporary Privileges, Policy 515; 3.2 will utilize the Medical Staff Disaster Plan process for physician(s) being granted Disaster Privileges.*~~

~~4.4 After the Medical Staff Chief has assumed authority as Medical Care Director, the Medical Staff Chief will assign the Emergency Department Physician additional duties based on needs of the disaster.~~

~~4.5 All in-house physicians will report to the Physician Labor Pool located in *Physicians Dining Room,* and *appropriate name badge provided.*~~

~~*4.6 All non-Medical Staff members who are granted disaster privileges will respond to the Physician Labor Pool in Physicians Dining Room and appropriate name badge provided.*~~

~~4.7 The Medical Staff Care Director will assess MD need based on the virtue of the disaster and assign responsibilities accordingly.~~

~~4.8 Offsite physicians who are designated to respond via callback procedures will respond to the Physician Labor Pool in French Room 3, *Physicians Dining Room* and *appropriate name*~~

~~*badge provided*~~.

~~4.9 The Medical Staff Care Director will determine if call-back is necessary and assign the Medical Staff Unit Leader to activate the call-back procedure. The Director of Medical Staff Support and Patient Care Management or designee is responsible to coordinate the call-back.~~

~~4.10 The Medical Staff Unit Leader will assign the Director of Medical Staff Support and Patient Care Management or designee~~ ~~*the responsibility to credential volunteer physician(s) or Allied Health Professionals per Medical Staff Policy & Procedure 515.*~~

DELETE- No longer required

TRI-CITY MEDICAL CENTER **Safety Policies & Procedures**	**Section:** Disaster Manual **Subject:** Toxic External Air **Policy Number:** 4011 Page 1 of 2
Department: Hospital Wide	**EFFECTIVE:** 11/87 **REVISED:** 10/93, 4/97, 6/00, 6/03, 12/05 **REVIEWED:** 11/90

Department Approval Date(s): 07/15
Environmental Health and Safety Committee Approval Dates(s): 08/15
Professional Affairs Committee Approval Date(s): 10/15
Board of Directors Approval Date(s):

~~**1.0 PURPOSE**~~

~~To define a procedure for protecting patients, staff and visitors from the effects of a potentially toxic external atmosphere.~~

~~**2.0 GENERAL INFORMATION**~~

~~2.1 Toxic External Atmosphere: Atmosphere contaminated by chemical cloud, smoke, or other pollutants to the extent that it becomes a significant threat to life or health.~~

~~2.2 Designated Receiving Area: Surge Capacity Tent~~

~~**3.0 PROCEDURE**~~

~~3.1 If any employee becomes aware of potential external toxic atmosphere they are to notify Engineering immediately at ext. 7148 and/or the EOC/Safety Officer.~~

~~3.2 If Engineering suspects or confirms that the hospital is in or expected to be in a toxic external atmosphere, Facilities Services will alert the Hospital Administrator or *Administrative Coordinator. The Hospital Administrator or Administrative Coordinator will determine if notification of the State Department of Health Services is necessary (unless the problem is widespread and has been widely publicized).~~

~~3.3 Engineering/designee will request that the Hospital Administrator or Administrative Coordinator authorize PBX apprise employees in the affected areas of the situation via the HEICS message form or 'red' disaster phones. PBX will also announce that no one is to leave the building or open doors to the outside. PBX will also be instructed to notify the following ancillary areas:~~

~~3.3.1 MRI Bldg.~~
~~3.3.2 Outpatient Physical Therapy~~
~~3.3.3 Outpatient Imaging~~
~~3.3.4 Outpatient Nuclear Medicine~~
~~3.3.5 Home Health~~
~~3.3.6 Partial Hospitalization Program~~
~~3.3.7 Outpatient Services~~
~~3.3.8 Annex Bldg.~~
~~3.3.9 Work Partners~~
~~3.3.10 Open MRI~~
~~3.3.11 PET~~
~~3.3.12 Lithotripsy~~
~~Other mobile services~~

~~3.4 Engineering/designee will alert the Emergency Department Director/designee that all foot and ambulance traffic from the outside is to be re-directed to the Surge Capacity tent, and that all entry and exit doors are to be secured.~~

~~3.5 Engineering/designee will shut down all air handlers in the building.~~

~~3.6 Engineering/designee will contact the Security Department and request that barricades and directional signs be placed in front of all primary entrances except that leading to the Surge~~

~~capacity tent adjacent to the Emergency Department.~~

~~3.7 When Hospital administrator or Administrative Coordinator receives an "all clear" from Facilities, Hospital Administrator or Administrative Coordinator will instruct PBX to announce that the air has been cleared and doors may now be opened.~~

Tri-City Medical Center
Oceanside, California

ENGINEERING
GENERAL ADMINISTRATIVE

~~TRI-CITY MEDICAL CENTER~~ ~~Safety Policy & Procedure~~ ~~Engineering Department~~	~~Section: UTILITY MANAGEMENT~~ ~~Subject: Engineering Hours of Service~~ ~~Policy Number: 1006 Page 1 of 2~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 4/16/90~~ ~~REVISED: 9/94; 1/97: 5/00; 5/03, 6/06, 6/09, 8/11, 6/12~~

SUBJECT: Engineering Hours of Service

ISSUE DATE: 4/90 **POLICY NUMBER**: 1006
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 6/09, 8/11, 6/12

Department Approval Date(s): **08/15**
Environmental Health and Safety Committee Approval Date(s): **09/15**
Professional Affairs Committee Approval Date(s): **10/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To define the normal hours of service of the Engineering Department and the procedure for obtaining service outside those hours.

B. **GENERAL INFORMATION:**
1. Emergency Services are those engineering services needed to resolve problems or conditions which pose a threat to patient or employee safety or which may significantly affect the ability of a department or area to carry out an essential function.

C. **POLICY:**
1. The Engineering Department will be available to provide emergency service 24 hours a day, 7 days a week, including holidays.
2. The department will provide routine services and will respond to non-emergent requests for services during its normal hours of services, as specified below.

D. **HOURS OF SERVICE:**
1. Emergency Service - 24 hours per day, 7 days a week.
   a. Contact: Engineering Office at extension 7148. Monday through Friday ~~0800-1630~~**0730-1600** hours.
      i. Outside above hours, the Duty Engineer may be contacted through the Engineering Office extension 7795 or by pager through the hospital operator.
2. Door key access: Call the Security Office at extension 3366.
3. Routine ~~and~~ /Non-emergency Services **and Projects:**
   a. ~~Contact: Plant/Engineering through Engineering Office Monday through Friday 0800-1630, extension 7148~~ **Submit a work order on the Intranet.**

~~b. Projects: Monday through Friday 0730-1600 at extension 3977.~~

4. Administrative and other Services:
   a. Contact: Director of Engineering, Monday through Friday, 0730-1600 at extension ~~7555~~**7709**.
   b. ~~Engineering Manager~~**Maintenance Supervisor**, Monday through Friday, 0730-1600 at extension 7559.
   c. ~~Engineering~~ **Central Plant** Supervisor, Monday through Friday, 0730-1600 at extension 7120.

Tri-City Medical Center
Oceanside, California

ENGINEERING
EQUIPMENT

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Utility Management Plan~~ ~~Policy Number: 4003 Page 1 of 3~~
~~Department: Engineering Department~~	~~EFFECTIVE: 9/94~~ ~~REVISED: 2/97; 5/00; 5/03, 06/06; 5/09; 6/12~~

SUBJECT: Utility Management Plan

ISSUE DATE: 9/94 **POLICY NUMBER**: 4003
REVIEW DATE(S):
REVISION DATE(S): 2/97, 5/00, 5/03, 6/06, 5/09, 6/12, 6/15

Department Approval Date(s):	**08/15**
Environmental Health and Safety Committee Approval Date(s):	**09/15**
Professional Affairs Committee Approval Date(s):	**10/15**
Board of Directors Approval Date(s):	

A. **EXECUTIVE SUMMARY:**

1. The Environment of Care and the range of patient care services provided to the patients served by Tri-City ~~Medical Center~~**Healthcare District (TCHD)** present unique challenges. The specific utility system risks of the environment are identified by conducting and maintaining a proactive risk assessment. A Utility Systems Management Plan based on various risk criteria including risks identified by outside sources such as, The Joint Commission (TJC) is used to eliminate or reduce the probability of adverse patient outcomes.
2. The Utility Systems Management Plan describes the risk and daily management activities that ~~Tri-City Medical Center~~**TCHD** has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people, coming to the organization's facilities. The management plan and the Utility Systems Management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
3. The program is applied to the ~~Tri-City Medical Center~~**TCHD** and all outlying facilities operated and or owned by ~~Tri-City Medical Center~~**TCHD**. The Utilities Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of ~~Tri-City Healthcare District~~**TCHD**. The plan also affects all staff, volunteers, medical staff and associates including contracted services of ~~Tri-City Medical Center~~**TCHD**.

B. **PRINCIPLES:**

1. Utility systems play a significant role in supporting complex medical equipment and in providing an appropriate environment for provision of patient care services.
2. Orientation, education, and training of operators, users, and maintainers of utility systems is an essential part of assuring safe effective care and treatment are rendered to persons receiving

services.

3. Assessment of needs for continuing technical support of utility systems and design of appropriate calibration, inspection, maintenance, and repair services is an essential part of assuring that the systems are safe and reliable.

C. **OBJECTIVES:**

1. Design, operate and maintain utility systems serving the buildings that house the healthcare services of ~~Tri-City Medical Center~~**TCHD** to provide a safe, comfortable, appropriate environment that supports patient care and business operations.
2. Perform recommended maintenance to maximize system service life and reliability.
3. Manage the Utility Systems Management program to assure compliance with The Joint Commission requirements.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. The Director of Engineering assures that an appropriate utility system maintenance program is implemented. The Director of Engineering also collaborates with the Director of Safety/EOC to develop reports of Utility Systems Management performance for presentation to the Environmental Health and Safety Committee (EHSC) on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other utility systems issues.
2. The Hospital's Board of Directors receives regular reports of the activities of the Utility Systems Management program from the EHSC. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Director of Engineering and appropriate clinical staff. The Board of Directors collaborates with the **Chief Executive Officer** (CEO) and other senior managers to assure budget and staffing resources are available to support the Utility Systems Management program.
3. The Hospital's **Chief Operating Officer** (COO) or designee receives regular reports of the activities of the Utility Systems Management program. The COO or designee collaborates with the Director of Engineering and other appropriate staff to address utility system issues and concerns. The COO or designee also collaborates with the Director of Engineering to develop a budget and operational objectives for the program.
4. The facility maintenance technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe reliable performance of utility systems in a timely manner. In addition, the technicians and service company staff perform necessary repairs.
5. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

E. **PROCESSES OF THE UTILITY SYSTEMS PLAN:**

1. **UM.EC.01.01.01 EP8 – Plan for the Safe, Reliable, Effective Operation of Utility Systems**
   a. The Utility Systems Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other individuals coming to the facilities of ~~Tri-City Medical Center~~**TCHD** that may experience an adverse event while being monitored, diagnosed, or treated with any type of medical equipment or being housed in an environment supported by the utility systems of ~~Tri-City Medical Center~~**TCHD**.
2. **UM.EC.02.05.01 EP1 – Design and Installation of Utility Systems**
   a. The Director of Engineering works with qualified design professionals, project managers and the intended end users of the space of ~~Tri-City Medical Center~~**TCHD** to plan, design, construct, and commission utility systems that meet codes and standards and the operational needs of the patient care and business activities of ~~Tri-City Medical Center~~**TCHD**. The construction and commissioning procedures are designed to assure

compliance with codes and standards and to meet the specific needs of the occupants of every space. In addition, the design process is intended to assure performance capability meets current needs and sufficient additional capacity is available to manage unusual demands and to help assure that future demands on utility systems can be met.

3. **UM.EC.02.05.01 EP2 – Determining System Risks and Developing and Inventory of Utility Systems and Equipment**
   a. All utility systems components and equipment are included in a program of planned calibration, inspection, maintenance, and testing. The components and equipment are inventoried at the time of installation and acceptance testing. The inventory is maintained on an ongoing basis by the Plant Operations staff. The inventory includes utility system equipment maintained by the Engineering and Maintenance staff and equipment maintained by vendors.
4. **UM.EC.02.05.01 EP3 – Maintenance Strategies**
   a. The Director of Engineering evaluates all utility system equipment to determine the appropriate maintenance strategy for assuring safety and maximum useful life. The Director of Engineering uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance strategy for assuring safety and maximizing equipment availability and service life. The strategies may include fixed interval inspections, variable interval inspections, preemptive maintenance, predictive maintenance, and corrective maintenance.
5. **UM.EC.02.05.01 EP4 – Inspection, Testing, and Maintenance Intervals**
   a. The Director of Engineering uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance intervals for assuring safety and maximizing equipment availability and service life.
   b. A maintenance management system is used to schedule and track timely completion of scheduled maintenance and service activities.
   c. The Director of Engineering is responsible for assuring that the rate of timely completion of scheduled maintenance and other service activities meets regulatory and accreditation requirements.
6. **UM.EC.02.05.01 EP5 – Management of Water Systems**
   a. The Director of Engineering and the Infection Preventionist are responsible for identifying needs for procedures and controls to minimize the potential for the spread of infections through or by the utility systems.
   b. Each clinical care service and support service is evaluated to determine the potential for hospital-acquired illness. Each potential is further evaluated to determine what role physical barriers and utility systems can play in contributing to or minimizing the potential.
   c. The Director of Engineering and the Infection Preventionist are responsible for developing procedures and controls to manage any identified potential for growth and/or transmission of pathogenic organisms in the domestic hot water system, cooling tower water, and other potential sources of waterborne pathogens.
   d. The procedures may include periodic testing or treatment to control the risk and to inhibit the growth and spread of waterborne pathogens.
7. **UM.EC.02.05.01 EP6 – Management of Ventilation Systems**
   a. The Director of Engineering and the Infection Preventionist are responsible for designing procedures and controls for monitoring the performance of air handling equipment. The procedures and controls address maintenance of air flow rates, air pressure differentials in critical areas, and managing the effectiveness of air filtration systems.
   b. Air handling and filtration equipment designed to control airborne contaminants including vapors, biological agents, dust, and fumes is monitored and maintained by Plant Maintenance.
   c. The performance of all new and altered air management systems is verified by a qualified service provider. At a minimum flow rates and pressure relationships are

measured as part of the commissioning of all new building projects and major space renovations.

d. Periodic measurements of air volume flow rates and pressure relationships are tested in sensitive areas throughout the hospital. When the measured system performance cannot be adjusted to meet code requirements or occupant needs, the Director of Engineering and Infection Preventionist develops, when appropriate, a temporary Infection Control Risk Management plan to minimize the potential impact of the deficient performance.

8. **UM.EC.02.05.01 EP7 – Mapping of Utility Systems**
   a. The Director of Engineering is responsible for maintaining up-to-date documentation of the distribution of all utility systems. The documents include as-built and record drawings, one line drawing's, valve charts, and similar documents. The documents include original construction documentation and documentation of renovations, alterations, additions, and modernizations. Hard copies of the documentation are maintained in the Plant Operations department. Documents that are available in electronic format are maintained on the Engineering Shared Drive.
9. **UM.EC.02.05.01 EP8 – Labeling of Controls for System Shutdown and Recovery**
   a. The Director of Engineering is responsible for assuring that current documents showing the layout of utility systems and the locations of controls that must be activated to implement a partial or complete shut-down of each utility system are available at all times.
   b. The documents must include the original layout of the systems and all modifications, additions, and renovations that affect the process for implementing a partial or complete shutdown of a system. The documents must include information that can be used to identify specific controls. The controls must be identified by a label, numbered tag or other device that corresponds to the information on the documents.
10. **UM.EC.02.05.01 EP9 – 13 – Emergency Procedures**
    a. The Director of Engineering and appropriate clinical caregivers collaborate to identify life-critical medical equipment supported by the utility systems. Life-critical equipment is defined as equipment, the failure or malfunction of which would cause immediate death or irreversible harm to the patient dependent on the function of the equipment.
    b. The Director of Engineering and the caregivers are responsible for developing appropriate resources to manage the response to the disruption of the function of the identified life-critical equipment. The resources are designed to minimize the probability of an adverse outcome of care.
    c. The resources must include but are not limited to information about the availability of spare or alternate equipment, procedures for communication with staff responsible for repair of the equipment, and specific emergency clinical procedures and the conditions under which they are to be implemented.
    d. Copies of applicable emergency procedures are included in the emergency operations manual of each clinical department. Training addressing the medical equipment emergency procedures is included in the department or job related orientation process. All utility systems emergency procedures are reviewed annually.
11. **UM.EC.02.05.03 EP1 – 6 and EC.02.05.07 EP1 - 10 – Inspection, Testing, and Maintenance of Emergency Power Systems**
    a. The Director of Engineering is responsible for identifying all emergency power sources and for developing procedures and controls for inspection, maintenance, and testing to assure maximum service life and reliability. ~~Tri-City Medical Center~~**TCHD** uses battery-powered lights, engine driven generators, and large UPS stored energy systems to provide power for emergency lighting, operation of critical systems, and operation of information systems equipment.
    b. Each required battery powered emergency lighting device is tested for 30 seconds each month and for 90 minutes annually.
    c. The Emergency Power Supply Systems (EPSS) supply power for emergency exits, patient ventilation, fire and life safety equipment, public safety, communications, data and

processes that if disrupted would have serious life safety or health consequences. Each required EPSS system is tested in accordance with the code requirements for the class of device.

d. The Director of Engineering is responsible for assuring that appropriate inspection, maintenance, and testing of the essential electrical system is done. Each motor/generator set serving the emergency power system is tested under connected load conditions 12 times a year. All automatic transfer switches are tested as part of each scheduled generator load test.

e. Testing parameters are recorded and evaluated by the Plant Operations staff. All deficiencies are rectified immediately or a temporary secondary source of essential electrical service is put in place to serve the needs to critical departments or services until the primary system can be restored to full service.

f. If a failure during a planned test occurs, a full retest will be performed after appropriate repairs are made and essential electrical system is functional again.

g. Each diesel engine powered motor/generator not loaded to 30% or more of its nameplate capacity during connected load tests undergoes further evaluation to determine if the exhaust gas temperature reaches or exceeds the manufacturer's recommended temperature to prevent wet stacking. Each diesel engine failing to meet the temperature recommendation will be exercised annually by connecting it to a dynamic load bank and performing the three step test process specified by NFPA 99 and NFPA 110.

h. Batteries, fuel stored on site, controls, and other auxiliary emergency power equipment is inspected, maintained, and tested as required. The Administrative Director of Facilities, Engineering staff and contracted service providers are responsible for assuring the reliability of each component part of the emergency power systems by performing all required calibration, inspection, maintenance, and testing in a timely manner.

12. **UM.EC.02.05.05 EP1 - Utility Systems Inventory and Initial Testing**

a. The Director of Engineering establishes and maintains a current, accurate, and separate inventory of all utility systems equipment included in a program of planned inspection or maintenance. The inventory includes equipment owned by ~~Tri-City Medical Center~~**TCHD** and leased or rented equipment.

b. The Director of Engineering is responsible for implementation of the program of planned inspection and maintenance. All utility systems equipment is tested for performance and safety prior to use.

13. **UM.EC.02.05.05 EP3 - Testing of Life Support Equipment**

a. The Director of Engineering assures that scheduled testing of all utility systems that play a role in life support is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Director of Engineering will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

14. **UM.EC.02.05.05 EP4 - Testing of Infection Control Support Equipment**

a. The Director of Engineering assures that scheduled testing of utility systems equipment that supports critical infection control processes is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Director of Engineering will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

15. **UM.EC.02.05.05 EP5 - Testing of Non-Life Support Equipment**

a. The Director of Engineering assures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Facilities will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

16. **UM.EC.02.05.09 EP1 - Medical Gas System Testing**
    a. All medical gas systems are maintained and periodically tested to assure system performance. All testing and inspection is done in accordance with the requirements of the current edition of NFPA 99.
17. **UM.EC.02.05.09 EP2 - Modifying / Repairing Medical Gas Systems**
    a. When a new medical gas system is installed or an existing system is breached for any reason, the Director of Engineering coordinates certification of the system by a qualified service provider. The certification testing is done in accordance with the requirements of the current edition of NFPA 99. The Director of Engineering maintains a permanent record of all certification testing.
18. **UM.EC.02.05.09 EP3 - Labeling & Accessibility of Medical Gas Controls**
    a. The Director of Engineering is responsible for assuring that all medical gas system control valves and monitoring stations are identified appropriately.
    b. In addition, the Director of Engineering is responsible for assuring that each monitoring station and valve is accessible. Accessibility is evaluated during scheduled environmental tours. Deficiencies are reported to the appropriate manager for resolution.
19. **EC.04.01.01 EP1 – 11 – The hospital monitors conditions in the environment**
    a. The Sr. Director of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Director of Safety/EOC works with the Sr. Director of Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions. Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported.
    b. The completed reports are forwarded to the Sr. Director of Risk Management who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.
    c. In addition, the Sr. Director of Risk Management and the Director of Safety/EOC collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the EHSC and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Director of Safety/EOC provides summary information related to incidents to the CEO or designee and other leaders, including the Board of Directors, as appropriate.
    d. The Director of Safety/EOC coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of ~~Tri-City Medical Center~~**TCHD**. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the six EC functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.
    e. The EHSC and the Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.
    f. The Director of Safety/EOC and the Environmental Health and Safety Committee and the Patient safety Committee prepare a quarterly report to the leadership of ~~Tri-City Medical Center~~**TCHD**. The quarterly report summarizes key issues reported to the Committees and their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders of management responsibilities have been carried out.
20. **EC.04.01.01 EP15 – Every twelve months the hospital evaluates each Environment of Care Management Plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.**

a. The Director of Safety/EOC coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.
b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, benchmarking programs, findings of external reviews or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the EHSC by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.
c. In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Director of Safety/EOC.
d. The results of the annual evaluation are presented to the EHSC. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, organizational leaders, the Board of Directors, the Patient Safety Committee, and others as appropriate. The manager of each Environment of Care program is responsible for implementing the recommendations in the report as part of the performance improvement process.

21. **EC.04.01.03 EP1 – 3 - Analysis and actions regarding identified environmental issues**
a. The EHSC receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

22. **EC.04.01.05 EP1 – 3 – Improving the Environment**
a. When the leadership of the hospital, performance improvement, or patient safety concurs with the EHSC recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The EHSC works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
b. The EHSC also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, performance improvement, and patient safety leadership.

23. **LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1 and EC.03.01.01 EP1 – 3 – Orientation and Ongoing Education and Training**
a. Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, contract staff and to each new medical staff member at the time of their employment or appointment.
b. In addition, all current employees, as well as volunteers, physicians, and students participate in an annual update of the orientation program as deemed appropriate. The update addresses changes the procedures and controls, laws and regulations, and the state of the art of environmental safety.
c. The Human Resources Department with assistance from the Education Department coordinates the general orientation program. New staff members are required to attend

the first general orientation program after their date of employment. The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.

d. New staff members are also required to participate in orientation to the department where they are assigned to work.

e. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.

f. The Director of Safety/EOC collaborates with the Environment of Care managers, department heads, the Director of Performance Improvement, the Director of Infection Control, and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care Program and revised as necessary.

g. The Director of Safety/EOC gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work.

h. In addition the Director of Safety/EOC evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

i. Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the EHSC. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

F. **AFFECTED PERSONNEL / AREAS:**

1. *GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS; CONTRACT SERVICES AND STAFF;*

G. **REFERENCES:**

1. The Joint Commission

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

~~1. This Tri-City Medical Center's Utility Management Plan will provide and maintain a utility management program that promotes a safe, controlled and comfortable environment of care. Tri-City Medical Center's Utility Management Plan includes the following:~~

~~B. **ASSESS AND MINIMIZE RISKS OF UTILITY FAILURES:**~~

~~1. The Utilities Management Program is designed to assure operational reliability, assess risks, respond to failures and train users and operators of the utility system components.~~

~~C. **ENSURE OPERATIONAL RELIABILITY OF UTILITY SYSTEMS:**~~

~~1. There is a comprehensive preventative maintenance program which includes a written testing and maintenance programs for all utility components included in the program at established intervals as recommended by manufacturer. It is the responsibility of the Director of Engineering to keep the preventative maintenance program accurate and ongoing.~~

~~). **CRITERIA ARE ESTABLISHED FOR IDENTIFYING, EVALUATING AND TAKING INVENTORY OF CRITICAL OPERATING COMPONENTS OF SYSTEMS TO BE INCLUDED IN THE UTILITY MANAGEMENT PROGRAM:**~~

~~1. The Utilities Management Program shall include equipment that meet the following criteria:~~

a. Equipment maintains the climatic environment in patient care areas.
b. Equipment that constitutes a risk to patient life support upon failure.
c. Equipment is a part of a building system which is used for infection control.
d. Equipment that is part of the communication system which may affect the patient or the patient care environment.

2. Equipment is an auxiliary or ancillary part of a system control or interface to patient care environment, life support or infection control.
3. The following systems are included in the Utilities Management Program:
a. Electrical Distribution System
b. Emergency Power System
c. Vertical and Horizontal Transport (elevators)
d. Heating, Ventilation and HVAC Systems
e. Plumbing and Water Delivery Systems
f. Boilers and Steam Delivery Systems
g. Medical Gas Distribution
h. Medical and Surgical Vacuum and Air Delivery Systems
i. Communication Systems
j. Sewage Removal Systems

E. **INSPECTION, TESTING AND MAINTAINING OF CRITICAL OPERATING COMPONENTS:**
1. There is a scheduled maintenance system, which is used to schedule, monitor and document the testing and maintenance of each utility system at predetermined levels.

F. **DEVELOP AND MAINTAIN CURRENT UTILITY SYSTEMS OPERATIONAL PLANS ENSURING RELIABILITY, MINIMIZE RISKS AND REDUCE FAILURES:**
1. A comprehensive preventative maintenance program which includes written testing and maintenance programs for all utility components included in the program at established intervals as recommended by manufacturer is in place. It is the responsibility of the Director of Engineering to keep the preventative maintenance program accurate and ongoing.

G. **INVESTIGATION AND REPORTING INCIDENTS AND CORRECTIVE ACTIONS OF UTILITY SYSTEMS MANAGEMENT PROBLEMS, FAILURES AND USER ERRORS:**
1. Engineering will respond to and correct all identified problems within the scope of their operations in a timely manner. Evidence of the actions taken to resolve identified problems can be located in the Engineering's Daily Log, the completed work orders file, the utilities management failure, user error log and additionally the problem resolution log.

H. **UTILITY MANAGEMENT PLAN INCLUDES AN ORIENTATION AND EDUCATION PROGRAM:**
1. Tri-City Medical Center's Engineering personnel will be required to attend an orientation upon hire and regularly scheduled in-services that specifically address training the users and maintainers of utilities equipment. All users/maintainers of equipment shall be tested for competency according to the components of their job specifications.

I. **PERFORMANCE STANDARDS:**
1. There is a systematic, interdisciplinary and interdepartmental process to monitor, assess, evaluate and improve the quality of services provided by the Engineering.

J. **EMERGENCY PROCEDURES FOR UTILITY SYSTEM DISRUPTIONS AND FAILURES:**
1. Written procedures are developed that specify the action to be taken during the failure of major utility services. The written procedures include a call system for summoning essential personnel and outside assistance when required.

Tri-City Medical Center
Oceanside, California

ENGINEERING
EMERGENCY PREPAREDNESS

~~TRI-CITY MEDICAL CENTER~~ ~~Safety Policy & Procedure~~	~~Section: UTILITY MANAGEMENT~~ ~~Subject: CODE GREEN POLICY~~ ~~Policy Number: 8007 Page 1 of 2~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 8/91~~ ~~REVISED: 3/94; 3/97; 5/00; 5/03, 5/06; 5/09; 6/12~~

SUBJECT: Code Green Policy

ISSUE DATE: 8/91 **POLICY NUMBER:** 8007
REVIEW DATE(S):
REVISION DATE(S): 3/94, 3/97, 5/00, 5/03, 5/06, 5/09, 6/12

Department Approval Date(s): **08/15**
Environmental Health and Safety Committee Approval Date(s): **09/15**
Professional Affairs Committee Approval Date(s): **10/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish guidelines to follow in the event of an oxygen system failure

B. **POLICY:**
1. The responsibility of providing emergency sources of oxygen in the event of a failure of the normal oxygen supply system is coordinated between Engineering and Pulmonary Services with the support of Security, Nursing, and notification by PBX. Department Directors will be notified and further activation of the disaster call back tree will be implemented depending upon the scope of the event and the available personnel. Documentation of the emergency with all pertinent details and outcomes, including any adverse patient reactions, will be completed by the above.

C. **RESPONSIBILITY:**
1. PULMONARY SERVICES is responsible for:
   a. Notifying the PBX operator (66) of Code Green and location
   b. Providing patients with oxygen from portable tanks and manually ventilating them if necessary in coordination with nursing
   c. Initially activating the emergency H-cylinder back-up system for the affected area
   d. Coordinating action plan with Engineering
   e. Monitoring continued use and need for more H-cylinders
   f. Communicating the situation to the Department Director and activating the Disaster Call Back as necessary
2. ENGINEERING DEPARTMENT is responsible for:
   a. Troubleshooting and repairing the oxygen system
   b. Determining if designated valves need closing and for the proper actuation of the appropriate valves

c. Coordinating action plan with Pulmonary Services
d. Aiding in the replenishment of H-cylinders
e. Notifying the oxygen supply company and arranging for additional oxygen
f. Communicating the situation to the Department Director and activating the Disaster Call Back as necessary

3. NURSING SERVICES is responsible for:
   a. Notifying PBX (66) of O2 pressure alarm and location if Facilities is unaware.
   b. Oversight of clinical issues; communicating patient oxygen needs to **Respiratory Care Practitioners** (RCP)~~s~~
   c. Assisting RCPs in providing E cylinders and/or manually bagging patients as necessary
   d. Communicating the situation to the Department Director and activating the Disaster Call Back as necessary
4. SECURITY is responsible for:
   a. Providing immediate response to affected area
   b. Providing a spare walkie-talkie to the RCP Supervisor or Lead in that affected area
   c. Assisting Engineering (back-up for night shift)
   d. Communicating the situation to the Department Director and activating the Disaster Call Back as necessary
5. PBX OPERATOR is responsible for:
   a. Announcing CODE GREEN and LOCATION on the overhead paging system
   b. Beeping the Pulmonary Supervisor/Lead Therapist, Engineering, and Nursing Supervisor immediately upon notification of CODE GREEN with the message 2222

D. **PROCEDURE:** ~~(See attachments for Department Specific Procedures)~~

1. CODE GREEN and location is communicated by PBX Operator who pages Engineering, Pulmonary and ~~Nursing~~ **Administrative** Supervisor
2. Security and Pulmonary respond to affected area; Security provides walkie talkie to RCP Supervisor/Lead
3. **Once the Engineers have shut down the affected zone valves, the RCPs shall place the emergency H-cylinder connector into an available wall outlet and slowly open the cylinder valve to re-pressurize the zone.**~~RCP Supervisor/Lead or RCP assigned to affected area back-pressures the area and re-checks wall meter for re-pressurization~~
4. RCP Supervisor communicates and coordinates action plan with Engineering via channel 1 on walkie talkie
5. RCPs communicate with nursing in affected area to assure that patient O_2 needs are met
6. H-cylinders are monitored for ~~use~~**pressure levels**; Engineering assists with additional H-cylinders and vendor ordering if needed
7. CODE GREEN is deactivated with notification from Engineering that the system has been charged to full operating pressure utilizing normal or alternate bulk oxygen sources.

E. **LOCATIONS OF EMERGENCY CYLINDERS:**

1. Pavilion: Rooms 277&278 (2 oxygen H-cylinders in each room).
2. South Tower; 1st room on left in ILU – code 0106 (4 H-cylinders).
3. Middle Tower: Pulmonary 2 South – 1 H-cylinder
4. NICU: 1 Air H-cylinder and 1 oxygen H-cylinder in ABG lab.
5. 1 North /Rehab: Dirty utility room – 2 oxygen H-cylinders.
~~F.~~**6. Emergency Room: Dirty utility room – code 7720 – 3 oxygen H-cylinders.**

Tri-City Health Care District
Oceanside, California

Infection Control Policy Manual

ISSUE DATE:	**9/01**	**SUBJECT:**	**Bloodborne Pathogen Exposure Control Plan**
REVISION DATE:	**9/02; 9/03; 9/04; 9/05; 10/06, 10/07; 10/08; 10/09; 10/10; 10/12**	~~**POLICY NUMBER: IC.10**~~	

Infection Control Department Approval:	**07/15**
Infection Control Committee Approval:	~~**10/20, 12/14**~~**07/15**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	~~**11/12, 05/14**~~**09/15**
Professional Affairs Committee Approval:	**10/15**
Board of Directors Approval:	**11/12, 06/14**

A. **INTRODUCTION:**

1. Legal mandates and regulatory agencies such as the California code of Regulation Title 8, Occupational Safety and Health Administration and the Centers of Disease Control and Prevention have set standards and published guidelines for the implementation of the Bloodborne Pathogen Exposure Control Plan.

B. **PURPOSE:**

1. The purpose of the Bloodborne Pathogens Exposure Control Plan is to reduce occupational exposure and transmission of Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), Human Immunodeficiency Virus (HIV) and other bloodborne pathogens. The second purpose is to satisfy the Occupational Safety and Health Administration (OSHA) regulations (29 CFR 1910.1030). Our plan outlines the steps we take to protect our employees from the health hazards associated with bloodborne pathogens and to provide appropriate treatment and counseling after an exposure.

C. **SCOPE:**

1. This plan applies to all inpatient and outpatient services of Tri-City ~~Medical Center~~**Healthcare District (TCHD)**

D. **AVAILABILITY TO EMPLOYEES:**

1. To help them with their efforts, our facility's Bloodborne Exposure Control Plan is available to our employees at any time. T**he policy can be accessed** ~~Copies are kept~~ in the Infection Control Manual ~~in every department and~~ **located** on the Intranet. Information is presented in the new employee orientation and during annual reviews.

E. **PROGRAM ADMINISTRATION:**

1. Employee Health Services is responsible for the implementation, maintenance, and administration of the Injury Prevention Program. In conjunction with the infection preventionist, she/he will review and update the Exposure Control Plan at least annually and whenever necessary to include new or modified tasks and procedures.
2. To assist the **Director of Safety/** ~~**and**~~ Environment of Care **(EOC)** ~~Officer~~ in carrying out their duties, the Environmen**tal Health and Safety (EHSC)** ~~of Care~~ Committee and following specific people will be contacted as needed.
   a. Infection Preventionist
   b. Employee Health
   c. Staff Educator
   d. Engineering
   e. Human Resources

f. Environmental Service Managers

3. Department Directors, Managers, and Supervisors are responsible for compliance in their respective areas. They work directly with the **Director of Safety/EOC**~~Environment of Care Officer~~, the Infection Control Department, **Education Department,** Employee Health Nurse and our employees to ensure that proper exposure control procedures are followed.
   a. Managers will support activities that encourage the active involvement of employees in education and safety programs. Managers will oversee employees so that initial training and annual review of bloodborne pathogens are completed prior to annual job evaluations.
   b. Registry and contract staff are oriented to the hospital's exposure control plan prior to working.
   c. Annually, managers will complete the template "Safer Work Practices" (see Appendix A) with input from employees with respect to the procedures performed in their respective work areas or departments related to safe work practices, engineered safety devices and personal protective equipment (PPE).
   d. Managers will counsel employees who do not use safe practices, PPE, and/or safety devices.
   e. Managers will review **q**~~Q~~uality **r**~~R~~eview **r**~~R~~eports **(RL Solutions)** their employees complete to document why they did not use an available safety device.
4. The **Director/**Manager of Education and Training Services has been selected to be the facility's Education/Training Coordinator. He/she is responsible for providing information and training to all employees with potential for exposure to bloodborne pathogens including:
   a. Developing and scheduling suitable education/training programs.
   b. Periodically reviewing training programs with the Environment of Care Officer, Employee Health, Infection Control, and Department Managers/Supervisors to include appropriate new information.
   c. Training records are maintained for three years and available for examination and copying to our employees, as well as OSHA representatives. The records contain the following information, dates of all training sessions, contents/summary of the training sessions, and names and qualifications of the instructors as well as the names and job titles of employees attending.
5. Materials Management and Environmental Services will provide all necessary personal protective equipment (PPE), engineering controls (e.g., sharps containers and sharps safety devices), labels, and red bags as required by the standard.
6. Products Standardization Committee has been identified as the multi-disciplinary group with primary responsibility for introducing sharps safety products to ~~Tri-City Medical Center~~**TCHD**. The committee will provide guidance in product selection, seeking to provide cost-effective safety devices.
   a. Review and selection Sharps Safety Products will follow established routes and include input from non-managerial employees responsible for direct patient care who are potentially exposed to contaminated sharps and injury. See Appendix B and C.
   b. Product Selection will follow a hierarchy of risk (i.e. high-risk procedures and devices targeted first). The committee will act on recommendations from Environment of Care or Infection Control Committees related to health care injuries and need for alternative product.
   c. All products will be judged by specific criteria and selection will be guided by user recommendations.
   d. See Appendix D for a table of safety devices that have been adopted.
7. Employees who are determined to have occupational exposure to blood and other potentially infectious materials (OPIM) must comply with the procedures and work practices deemed appropriate. They are actively involved in reviewing and updating the exposure control plan with respect to the procedures performed in the course of their work.
   a. Our employees are expected to complete initial bloodborne pathogens training and annual review.
   b. They participate in updating the bloodborne pathogen standard with respect to the procedures performed in their work area or department. "Safer Work Practices" (Appendix

A).

c. Licensed healthcare professionals are required to complete a **q**~~Q~~uality **r**~~R~~eview **r**~~R~~eport **(RL Solutions)** when they do not use available Sharps safety devices during the care of a patient. The report will outline their determination of why using an engineering control would have jeopardized the patient's safety or the success of a medical, dental, or nursing procedure.

d. Employees will participate in the trial and selection of new safety devices.

8. **T**he ~~Environment of Care Committee~~**EHSC** will compile and trend the information gathered above. August has been selected as the regular month for annual plan update.
   a. Safety rounds are conducted on an annual or biannual (for patient care units or departments) schedule.
   b. Information from the annual "Safer Work Survey" is compiled by the ~~Environment of Care Officer~~**Director of Safety/EOC** or designee and reported to Environment of Care, Infection Control, and Products Standards Committees.
   c. Risk, Legal and Regulatory Services forwards information from incident and Quality Review Reports to the ~~Environment of Care Officer~~**Director of Safety/EOC** as appropriate.
   d. The information will be used to update the Exposure Control Plan with respect to:
      i. Areas where engineering controls are currently employed.
      ii. Areas where engineering controls can be updated.
      iii. Areas currently not employing engineering controls, but where engineering controls could be beneficial.
   e. Area Safety Representatives will support safe work practices by participating in education efforts and reporting concerns.
9. Employee Health, assisted by Work Partners, Emergency Department, and Infection Control, will be responsible for ensuring that all medical actions required are performed and that appropriate employee health and OSHA records are maintained. See the Employee Health Services policy "Occupational Exposure to Blood/Body Fluid Secretions."
   a. Hepatitis B vaccination series is available at no cost and employees are encouraged to be vaccinated. See the Employee Health Policy "Hepatitis B Vaccine Immunization Protocol."
   b. Exposure incidents are evaluated to determine if the case meets OSHA's Record keeping Requirements (29 CFR 1904). **T**he maintenance of the OSHA log is an Employee Health responsibility. ~~The addition of a specific Sharps Injury Log was completed in 1999. See Employee Health Policy "Post Exposure Follow-up."~~
   c. Medical records are maintained for each employee with occupational exposure in accordance with 29 CFR 1910.20, "Access to Employee Exposure and Medical Records." These confidential records are kept in Employee Health for at least the duration of employment plus 30 years and are provided upon request of the employee or to anyone having written consent of the employee within 15 working days.
   d. Employee Health identifies products involved in contaminated sharps injuries and reports this information to Material Management so that the number of those devices ordered in the previous year can be reported to the ~~Environment of Care Committee~~**EHSC**.
   e. Recommendations are made to the Product Standardization Committee- when a need for a safety device or alternative product is detected.
   f. Recommendations are made to service or department managers when issues related to unsafe work practices are identified. Referrals are made to appropriate Medical Staff Chairpersons.
   g. Employee Health will present sharps Injury data specific to ~~TCMC~~ **TCHD at the Infection Control Committee meeting annually** ~~during the July PPD screening program. The purpose is to solicit input from staff users on work practice performance improvements related to sharps injuries~~ (i.e. safety devices, work practice changes or engineering).

F. **EXPOSURE DETERMINATION:**

1. The State of California (Cal/OSHA) requires employers to perform an exposure determination concerning which employees may incur occupational exposure to blood or other potentially

infectious materials (OPIM). The exposure determination is made without regard to the use of personal protective equipment (i.e., employees are considered to be exposed even if they wear personal protective equipment).

2. See Appendix E for a list of the job classifications in our facility where all or some employees handle human blood and OPIM, which may result in possible exposure to bloodborne pathogens.
3. Since not all of the employees in these categories would be expected to incur exposure to blood OPIM, examples of tasks/procedures that would cause these employees to have occupational exposure are listed in Appendix E.

G. ENGINEERING CONTROLS:

1. One of the key aspects to our Exposure Control Plan is the use of Engineering Controls to eliminate or minimize employee exposure to bloodborne pathogens. On December 17, 1998 the Cal/OSHA Standards Board adopted emergency regulation revisions to Title 8, Section 5193 to meet mandates of Assembly Bill 1208. On January 2001, Federal OSHA was instructed to add sharps safety to national requirements. The major purpose of the revisions is to increase protection from sharps injuries by supplying employees with engineered sharps safety devices.
   a. If available, needleless systems are required for withdrawal of body fluids after the initial venous or arterial access is established administration of medications or fluids, and other procedures with potential for exposure to a contaminated needle.
   b. If needleless systems are not used then needles with engineered sharps injury protection are required for withdrawal of body fluids, accessing a vein or artery, administration of medication or fluids, and other procedures with potential for exposure to blood or OPIM.
   c. Other sharp devices with potential for contamination with blood or body fluids (e.g. scalpels, lancets, broken capillary tubes, and drills) are also required to have engineered sharps protection.
   d. ~~Tri-City Medical Center~~**TCHD** is exempt from implementation if at least one the following is applicable.
      i. The device is not available in the marketplace.
      ii. A licensed healthcare professional directly involved in a patient's care determines that the use of the engineering control will jeopardize patient care or safety.
      iii. An objective product evaluation has been completed indicating that the device is not more effective in reducing sharps injuries than the device currently used by ~~Tri-City Medical Center~~**TCHD**;
      iv. There is a lack of sufficient information to determine whether a new device on the market will effectively reduce the chances of a sharps injury and an objective product evaluation is being conducted.
   e. See the table on Appendix D for a review of the Sharps Safety Devices that have been adopted.
   f. Contaminated needles and other contaminated sharps are not sheared or broken. They are not bent, recapped, or removed unless it can be demonstrated that there is no feasible alternative. Recapping or needle removal is accomplished using a mechanical device or a one-handed technique.
   g. Containers for contaminated sharps are easily accessible to personnel and located as close as is feasible to the area where sharps are used or can be reasonably anticipated to be found.
      i. Contaminated reusable sharps are placed in appropriate containers immediately, or as soon as possible, after use.
      ii. Sharps containers have the following characteristics: rigid, puncture-resistant, portable, if it is necessary to ensure easy access by user, color-coded and labeled with a biohazard warning label, and leak-proof on the sides and bottom. These containers lock when closed and do not reopen easily
      iii. The sharps containers for single use items are disposable and are not opened, emptied, or manually cleaned. In the event of a special circumstance when it would be necessary to access the container, it would be reprocessed or decontaminated.

iv. The containers are maintained upright throughout use and are replaced as needed when ¾ full. A contract service is responsible for replacing containers as needed.

h. In addition to the engineering controls identified on these lists, the following engineering controls are used throughout our facility.

i. Hand washing facilities and waterless hand cleansers are readily accessible to employees with potential for exposure.

ii. Specimen containers are leak-proof. No special label/color coding is required for intra-facility specimens as Standard Precautions are utilized in the handling of all specimens and containers are recognizable as containing specimens.

~~ii.~~**iii.** Secondary containers are used if the specimen could puncture primary container or outside contamination.

H. WORK PRACTICE CONTROLS:

1. In addition to engineering controls, our facility uses a number of Work Practice Controls to help eliminate or minimize employee exposure to bloodborne pathogens.

a. Employees follow Standard Precautions with every patient. As a result, we treat all human blood and the following other potentially infectious materials (OPIM) as if they are known to be infectious for HBV, Hepatitis C Virus (HCV), HIV, and other bloodborne pathogens:

i. Semen
ii. Vaginal Secretions
iii. Peritoneal fluid
iv. Tissue and Organs
v. Amniotic fluid
vi. Synovial fluid
vii. Pleural fluid
viii. Saliva with visible blood
ix. Pericardial fluid
x. Cerebrospinal fluid

b. Eating, drinking, smoking, applying cosmetics or lip balm and handling contact lenses is prohibited in work areas where there is potential for exposure to bloodborne pathogens.

i. Food and drink ~~is~~ **are** not kept in refrigerators, freezers, on countertops or in other storage areas where blood or other potentially infectious materials are present.

ii. For example, eating and drinking is not allowed at nurses stations, in patient rooms, on patient bedside tables, or other places where patients, specimens, or dirty instruments/devices might have touched.

c. Mouth pipetting/suctioning of blood or other infectious materials is prohibited.

d. All procedures involving blood or other infectious materials are performed to minimize splashing, spraying or other actions generating droplets of these materials.

e. Equipment, which becomes contaminated, is cleaned with a hospital-approved disinfectant as soon as possible.

i. If shipping of equipment for repairs is required, the device will be cleaned or an appropriate biohazard-warning label is attached to any contaminated equipment, identifying the contaminated portions.

ii. Information regarding the contamination is conveyed to all affected employees, the equipment manufacturer, and the equipment service representative.

I. PERSONAL PROTECTIVE EQUIPMENT:

1. The employee's 'last line of defense' against bloodborne pathogens. Because of this, our facility provides (at no cost to our employees) the Personal Protective Equipment that they need to protect themselves against such exposure. See Appendix F for tasks/PPE suggested. This equipment includes, but is not limited to:

a. Gloves
b. Fluid resistant gowns
c. Glove liners

d. Laboratory coats
e. Face shield
f. Resuscitation bags
g. Masks
h. Hoods
i. Safety glasses/goggles
j. Shoe covers
k. Mouthpieces
l. Pocket masks

2. Personal Protective Equipment is stocked on supply carts, Pyxis dispensing stations, or available from Materials Management.
   a. Reusable PPE is cleaned, laundered, or decontaminated as needed. The hospital provides laundry services for laboratory coats designated as PPE.
   b. Single-use PPE (or equipment that cannot, for whatever reason, be decontaminated) is disposed in the regular waste container. Only items **saturated and/or** dripping with blood are disposed of in 'red-bag' trash.
3. Protective clothing (such as gowns and aprons) is worn whenever potential exposure to the body is anticipated. See Appendix F.
   a. Any garments penetrated by blood or other infectious materials are removed immediately or as soon as feasible and all personal protective equipment is removed prior to leaving a work area.
   b. Surgical caps/hoods and/or shoe covers/boots are used in any instances where gross contamination is anticipated (such as autopsies, deliveries, and orthopedic surgery).
4. Gloves are worn as outlined in Standard Precautions and Appendix F.
   a. Hypoallergenic gloves, glove liners, and similar alternatives are readily available to employees who are allergic to the gloves our facility normally uses.
   b. Utility gloves are decontaminated for reuse. If they are cracked, peeling, torn or exhibit other signs of deterioration they are discarded.
5. Masks and eye protection (such as goggles, face shields, etc.) are used whenever splashes or sprays may generate droplets of infectious materials. See Standard and Transmission Based Precautions and Appendix F.

J. **ENVIRONMENTAL SERVICES:**

1. Environmental Services plays an important role in maintaining our facility in a clean and sanitary condition and is an important part of our Bloodborne Pathogens Compliance Program.
2. The Supervisor of Environmental Services is responsible for setting up our cleaning and decontamination schedule and making sure it is carried out within our facility.
3. To facilitate this, we have set up a written schedule for cleaning and decontamination of the various areas of the facility. See the Environmental Services Unit Specific Standards.
   a. All employees are responsible for maintaining a clean work area, equipment, and have hospital-approved disinfectants readily available to use on small spills. Environmental Services is called for assistance as needed with larger spills or special cleaning.
   b. All equipment and surfaces are cleaned and decontaminated after contact with blood or other potentially infectious materials. Patient care equipment and devices are cleaned between patients and after the completion of medical procedures. Work surfaces that may have been contaminated are cleaned at the end of the work shift.
   c. All pails, bins, cans and other receptacles intended for use are routinely inspected, cleaned and decontaminated as soon as possible if visibly contaminated.
   d. Potentially contaminated broken glassware is picked up using mechanical means (such as dustpan and brush, tongs, forceps, etc.). Only broken glass is placed in a Sharps Container.
4. **All regulated waste is safely handled by staff according to ~~TCMC~~TCHD policies and procedures.** ~~We are also very careful in our facility in handling regulated waste.~~ Disposal of all regulated waste is in accordance with California, State, and local regulations. See the Environment of Care Manual (formerly Safety Manual) - Waste Management Plan section and

~~IC.10.1~~**Infection Control Policy** Waste Management.

a. See the Decision Table for Medical Waste in Appendix G

5. Environmental Services is responsible for the collection and handling of our facility's contaminated waste until our outside contractors pick it up for off-site processing. Environmental services aides hold the bags away from their bodies when removing use heavy gloves to protect their hands from possible sharps injury and do not push down on trash in garbage containers.
6. Regulated waste is placed in containers that are closable, constructed to contain all contents, and prevent leakage. They are labeled or color-coded (see Labels to follow) and closed prior to removal to prevent spillage or protrusion of contents during handling.
7. All used linen is presumed contaminated and placed in appropriate containers labeled 'soiled linen'. All linen is handled as little as possible and is not sorted or rinsed where it is used. Plastic bags are used to contain potential contaminants and these soiled linen bags are transported in secondary containers to prevent leakage.
   a. Employees who contact contaminated linen wear appropriate protective equipment (gloves and gowns if soiling of clothes is possible).
   b. Plastic soiled linen bags can be taken into a patient's room to contain used linen. These bags are then placed in the hamper or directly in the soiled linen room.
   c. Linen hampers lined with the plastic bags can also be used. When hampers are ¾ full, nursing staff will remove the bag, tie it off, and take it to the soiled linen room.
   d. Environmental Services is responsible for the collection and handling of our facility's contaminated waste until pick-up by our outside contractors for off-site processing.

K. RELATED DOCUMENTS:

~~8.~~**1. Infection Control Manual:** Hand Antisepsis ~~IC.8~~
~~9.~~**2. Infection Control Manual:** Standard and Transmission Based Precautions ~~IC.6~~
~~10.~~**3. Environment of Care Manual:** Hazardous Waste Management
~~11.~~**4.** Employee Health **and Wellness**~~Services~~ Policy~~ies IC.7.1~~**: Occupational Exposure to Blood/Body Fluid Secretions**
~~1.~~**5. Employee Health and Wellness Policy:**~~Administrative Policy #401 Human Resources –~~ Injury Prevention Program
~~2.~~**6.** Environment of Care Manual: **Hazardous Material and Waste Management and Communication Plan**

K. REFERENCES:

1. Cal OSHA BBP Standard §5193. Bloodborne Pathogens, Subchapter 7. General Industry Safety Orders Group 16. Control of Hazardous Substances Article 109. Hazardous Substances and Processes 1998.
2. Medical Waste Management Act, California Health and Safety Code, Sections 117600 – 118360 California Medical Waste Management Program Information Copy — January 2000 www.cadhs.gov
3. **Grota, P. (Ed.). (2014) APIC Text of Infection Control and Epidemiology (4th ed). Washington DC: Association for Professionals in Infection control and Epidemiology, Inc.**
~~3. APIC Text of Infection Control and Epidemiology. Washington, DC; 2009~~
4. Wenzel, RP & Nettleman, MD, Principles of Hospital Epidemiology in: Mayhall G. ed. Hospital Epidemiology and Infection Control. 2nd ed. Philadelphia: Lippincott, Williams & Wilkins; 1999:1357 - 1366.
~~4.~~**5. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf**
~~5.~~**6.** ~~Lee, J & Murphy, R Occupational Exposure to Blood in: APIC Text of Infection Control and Epidemiology. Washington DC; 2000~~

TRI-CITY ~~MEDICAL CENTER~~HEALTHCARE DISTRICT
SAFER WORK SURVEY

The Centers for Disease Control and Prevention (CDC) estimates that between 100,000 and 1,000,000 sharps injuries occur each year. Various studies have estimated the risk of developing occupationally acquired bloodborne pathogen infections: HCV (3% - 10%), HBV (2% - 40%), and HIV (0.3%) following sharps exposure. The risk of transmission increases if a device visibly contaminated with blood causes the percutaneous injury, is used to puncture the vascular system, or causes deep injury.

1. Safety Devices

Do you have suggestions for sharp devices with built in protection that would make your job safer?
Comments: _____

2. Safe Work Practices

Do you have suggestions for adoption of safer user actions? (Examples: neutral or safe zone for sharps, second layer of gloves, and avoid handling dirty trays)
Comments: _____

3. Personal Protective Equipment

Do you have suggestions for use of personal protective equipment? (Examples: double gloving, heavy leather gloves for trash handling, effective eye and face protection)
Comments: _____

~~TCMC~~**TCHD**: Products Standardization Committee
Product Evaluation

1. Manufacturer of Product_____
2. Name of Product_____
3. Distributed by_____Sales Rep_____
4. Description of Use_____
5. Will this device replace a high-risk device (hollow-core, blood-filled, or capable of deep injury)? ☐ Yes ☐ No
6. Product would be used? ☐ House-wide ☐ Lab ☐ OR ☐ Specialty Unit _____
7. What items would this replace?_____
8. Cost _____Standard item cost_____
9. Has ~~TCMC~~ **TCHD** rejected the device in the past? ☐ Yes ☐ No _____
10. Does the device have a passive safety mechanism? ☐ Yes ☐ No
11. Can the safety mechanism be activated with one hand? ☐ Yes ☐ No
12. Can the user tell when the safety mechanism has been activated? ☐ Yes ☐ No
13. Are minimal changes in technique and use required? ☐ Yes ☐ No

_____

14. Is this product dependent on other products or items? ☐ Yes ☐ No
    Identify:_____
15. Is the device compatible with products currently in use? ☐ Yes ☐ No
16. Does the system/device require a minimal number of parts? ☐ Yes ☐ No
17. Is the product available in typical size ranges? ☐ Yes ☐ No
18. Is the product on contract ☐ Yes ☐ No
19. Product rep available for 24hrs/day in-service? ☐ Yes ☐ No
20. Does the manufacturer supply free trial products? ☐ Yes ☐ No
21. Does the manufacturer have adequate supply capability? ☐ Yes ☐ No

APPROPRIATE FOR TRIALS ☐ **REJECTED** ☐

COMMENTS_____

_____

_____

_____

~~TCMC~~TCHD: User Product Evaluation

Name_____ Date_____

Dept/Unit_____

How would you rate this product compared to other similar products you have used?

CRITERIA	BETTER	SAME	WORSE
Easy to open package			
Ease of assembly			
Ease of use			
Comfortable feel for user			
Length of time required for use			
Activation of safety feature			
Safety feature can't be defeated			
Has minimum failure rate and functions as intended			
Good for use with different patients			
Safe for healthcare workers			
Safe for patients			
Patients complaints			
Doctors complaints			
Easy to dispose			
Compatible with other products			
Will reduce the risk of injury			
Reasonable number of parts			
Available in the sizes you need			

How many times did you use the product?_____

Would you recommend purchasing this device? ☐ Yes ☐ No

Is there another safety device you would rather use? ☐ Yes ☐ No

Specify:_____

Comments? _____

_____

_____

_____

_____

_____

PRODUCT TYPE	SPECIFIC DEVICE	M/M EVAL.	RECOMMENDATION	USER EVAL. DATES	IMPLEMENTATION & COMMENTS
1. **Needleless IV**	All I.V. Tubing Alaris Needleless I.V. System	N/A	Alaris I.V. needleless system and tubing recommendation by Nursing Operations Managers Council.	2/2005	3/2005, Alaris Medley pumps w/ Guardrails introduced as standard. Contractual changes for pump and product changes. Minimum 5-year agreement.
2. **ABG Kits**	1-ml ABG Kit 3-ml ABG Kit	N/A	Pulmonary Department selection of Sims Portex products	5/2001	reviewed 10/2005
3. **Blood Lancet**	Heel stick, Tenderfoot Fingerstick, Glucolet	N/A	Products utilized hospital-wide.	< 1996 1/2001	< 1996 1/2001 1/2002 reviewed 10/2005
4. **IV Starts** • Angiocaths • Butterfly	Insyte Autoguards, various Gauges Saf-T E-Z Set, various gauges	N/A N/A	Nursing Council selection to replace Johnson & Johnson I.V. Catheters with Becton Dickinson products Nursing Council selection to replace Becton Dickinson non-safety products w/ Becton Dickinson safety products	10/2000 10/2000	10/2000 reviewed 10/2005 10/2000. Catalog changes, 08/2001 reviewed 10/2005

PRODUCT TYPE	SPECIFIC DEVICE	M/M EVAL.	RECOMMENDATION	USER EVAL. DATES	IMPLEMENTATION & COMMENTS
Pre-filled syringe	*Code Drugs* *Vit K* *Hepatitis B vaccine*	*Dec 2002*	Recommends/stocks Sims needles as alternative and Product Standards approved Safety standard approved	07/01	07/01 *8/31/2002* reviewed 10/2005
6. Blood Collection • Tubes • Vaccutainer • Butterfly needle • Needle/Syringe • Cord blood	Vaccutainer Tubes w/ Top	N/A	Laboratory selection of Becton Dickinson products to replace rubber stopper tops	< 1992	< 1992
	Vaccutainer Eclipse Blood Ion Needle	N/A	Laboratory selection of Becton Dickinson products to replace Bio-plexes puncture Guard	< 2000	2000
	Vaccutainer Safety-lok Blood Collection Set		Laboratory selection of Becton Dickinson products to Replace non-safety butterfly	< 1999	2000
	Safety-glide, various gauges		Nursing and Laboratory selection of Becton Dickinson products to replace Non-safety products. Safety standard approved	< 09/01 05/01 07/01 *8/02*	09/2001 05/01 07/01 reviewed 10/2005

• blood culture • line sampling • transfer device	Bactec Media Bottles See Needleless System Diff-safe blood dispenser blood *BD- Blood transfer devices*	N/A N/A N/A	Laboratory selection of Becton Dickinson product BD Luer-Lok Access device/ BD SafetyLok Blood Collection Set; BD Luer-Lok Tip Syringes	< 1996 09/2001 < 1996	On going < 1996: Used in Phlebotomy to eliminate use of needles to make slides. Changed in 2001 Reviewed 11/9/05 LLT Changed to BD luer loc access devices for direct draw 4/1/08
7. IV injections Regular syringes Pre-filled syringes Contrast in Dx. Imag	Refer to Needleless System Safety-lok, various gauges	N/A	Nursing Council selection of Becton Dickinson products	< 9/01	09/2001
8. Scalpel	Personna Safety Scalpel Personna Safety Blades	N/A N/A	Safety blades in Microbiology & Cytology ER, SPD, ACCU recommended change to Persona safety scalpels	01/2001 09/2001	03/2002 Reviewed 11/2005 LLT 03/2002 Reviewed 8/08
9. Suture needle	Safe work practices adopted. Stapling devices used when possible.				
10. Non coring needle for implanted vascular access	Bard Smith	N/A	Provide safety device only for non-coring needles	3/08	4/08

JOB CLASSIFICATIONS WHERE 'ALL' OR 'SOME' EMPLOYEES
HANDLE HUMAN BLOOD AND OTHER POTENTIALLY INFECTIOUS MATERIALS.

'ALL' EMPLOYEES	'SOME' EMPLOYEES (TASKS PERFORMED WITH RISK)
Administrative Coordinator Advanced Care Technician	Case Managers/ Clinical Social Worker (during patient interviews or family conferences)
Biomedical Tech Mechanic I & II	Chaplain (during patient or family ministrations)
Cardiac Rehabilitation Coordinator	Food Service Worker (during tray delivery, pick-up, or cleaning)
Certified Nursing Assistant	Clinical Dietician
EEG Tech and EEG coordinator	Security Officer
EKG Tech	
Environmental Service Aide and Supervisor	
Emergency Medical Technician	
Employee Health Nurse Occupational Health Nurses & Manager	
Infection Control Specialist	
Laboratory Assistant/Phlebotomist Operations Manager Clinical Laboratory Scientist **Histology Lab Tech**	
Licensed Vocational Nurse	
Lift Team	
Nurse Practitioner Physicians Assistant	
Occupational Therapist and Rehab Aid	
OR Tech/Sterile Processing Tech/Perioperative Aide/Surgical Instrument Aide	
Perfusionist	
Phlebotomist	
Physical Therapist	
Physicians	
Pulmonary Services Operations Manager	
Radiology Operations Manager & Tech	
Registered Nurse	
Rehabilitation Services Manager	
Respiratory Care Practitioner I, II & III	
Security Officer	
Wound Care Nurses	

Standard Precautions
Personal Protective Equipment Table

R = Required A = Available N/A = Not Applicable	Exposed Body Parts						Contamination of Clothing								
	Hands			Face			Soiling			Saturation			Dripping		
	Gloves			Face Shield or Mask & Goggles			Cloth Gown			Water-proof Gown			Shoe Covers		
	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A
REMOVING, OPENING AND MANIPULATING OR ASSISTING WITH THE REMOVAL OF HOLLOW CORE BLOOD OR BODY FLUID FILLED TUBES, NEEDLES OR CATHETERS															
• Abdominal paracentesis catheter • Angiograph catheter • Bronchoscope (as above & to clean) • Central venous catheter • Chest tube/vent • Endoscope (as above & to clean) • Intravascular catheters • Thoracentesis • Urine catheter	*			*				*			*			*	
ASSISTING WITH PROCEDURES															
Angiography	*			*					*	*				*	
Bone marrow asp/bx	*				*			*			*				*
Bronchoscopy ~~(R/O TB)~~	*			N95				*			*				*
Bronchoscopy (R/O TB)	*			PAPR				*			*				*
Central venous catheter insertion	*				*			*			*				*
Chest tube/vent placement	*				*			*			*				*
Childbirth	*			*					*	*				*	
Endoscopy	*			*			*				*				*
Intubation	*			*				*			*				*
L.P. (holding R/O meningitis)	*			*				*			*				*
Morgue Release	*					*			*						*
Proctosigmodoscopy	*				*			*			*				*
Suture or stapling (within 3 ft. of wound)	*			*				*			*			*	
Assisting with Surgery														*	
Thoracentesis ass.	*				*			*			*				*
SPECIMEN COLLECTION															
ABG	*				*			*			*				*
Blood glucose test	*				*			*			*				*
Clean catch urine specimen	*				*			*			*				*
Dipstick urine test	*				*			*			*				*
Gastric occult. blood test	*			*				*			*				*
Nose/throat (R/O infection)	*			*				*			*				*
Sputum for AFB or TB culture	*			N95				*			*				*
Stool	*				*			*			*				*
Stool occult blood test	*				*			*			*				*
Urine	*				*			*			*				*
Urine specific gravity	*				*			*			*				*
Vaginal or urethral	*				*			*			*				*
Venipuncture for blood	*				*			*			*				*
Wound or wound drainage	*				*			*			*				*

R = Required A = Available N/A = Not Applicable	Exposed Body Parts						Contamination of Clothing								
	Hands			Face			Soiling			Saturation			Dripping		
	Gloves			Face Shield, Mask & Goggles			Cloth Gown			Water-proof Gown			Shoe Covers		
	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A
SPECIMEN PROCESSING	*			per S.O			Lab coat								
CLINICAL TASKS															
Ambu bag: usage	*			*				*			*				*
Bladder irrigation	*			*				*			*				*
Blood or blood products administration	*				*			*			*				*
Blood warmer	*				*			*			*				*
Cleaning used instruments	*			*				*			*				*
Urine catheter: insert	*				*			*			*				*
Colostomy irrigation	*			*				*			*				*
Condom catheter application	*				*			*			*				*
Contact lense care	*				*				*			*			*
Dressing change	*				*			*			*				*
Emerson pump: use	*				*			*			*				*
Endoscope / Bronchoscopy cleaning	*			*			*				*				*
Enema administration	*			*				*			*				*
Enteral feeding tube (insert or manipulate)	*			*				*			*				*
Fecal disimpaction	*			*				*			*				*
Fecal or gastric occult blood test	*				*			*			*				*
Foley cath insertion	*				*			*			*				*
Gastric lavage	*			*					*	*					*
Hemovac drains-manipulate, empty / DC	*			*				*			*				*
Injections	*				*				*			*			*
Intravenous catheter insertion	*				*			*				*			*
J-P drain care	*				*			*			*				*
Nasogastric tube insertion and DC	*			*				*			*				*
Neonatal suck evaluations (latex-free)	*				*			*				*			*
1st. Newborn bath	*			*				*			*				*
Normal Saline or Heparin lock irrigation	*				*			*				*			*
O2 therapy w/ mucus membrane touch	*				*				*			*			*
Open suctioning of airway or airway tube	*			*				*			*				*
Oral care	*			*				*				*			*
Oral/nasal airway insertion or DC	*			*				*			*				*
Pleur-evac care	*				*			*			*				*
Postural drainage	*				*			*			*				*
Rectal tube insertion	*				*			*			*				*
Resp. Tx, cough inducing	*			*				*				*			*
Restraint placement		*			*			*				*			*
Seizing patient		*			*			*				*			*
Sputum Induction for AFB ~~or tuberculosis~~	*			N95				*				*			*
Sputum Induction for AFB R/O tuberculosis	*			PAPR				*				*			*
Total parenteral nutrition administration	*				*			*				*			*
Urine bag emptying	*			*				*				*			*
Vital signs and Weighing patients		*			*			*				*			*
Wound care (without irrigation)	*				*			*			*				*
Wound irrigation Pulsevac Tx	*			*				*			*				*

Decision Table for Medical Waste

Type of Waste	Red Bag	Regular Bag	Sharps Container
Fluid blood, blood elements, vials of blood, specimens for culture, used culture media, and stock cultures.	X		
Bloody body fluids or disposable drapes dripping **and/or saturated** with bloody body fluids such as CSF, synovial, pleural, pericardial, amniotic.	X		
Bloody body fluid filled containers from nursing units, ED, PACU, outpatient areas not treated with Premicide.	X		
Materials used to clean up fluid blood or bloody body fluid spills that are dripping **and/or saturated**.	X		
Surgical specimens.	X		
Wound dressings, bandages, and wrappings dripping **and/or saturated** with blood.	X		
Food waste such as soda cans, paper cups, cutlery, including food or service items from isolation rooms.		X	
Empty urine and stool containers, empty colostomy and urinary drainage bags, empty bedpans, breathing circuits, surgical drapes.		X	
Gastric washings, dialysate, vomitus, feces, urine, diapers. Please empty in toilet.		X	
Tracheal and bronchial secretions, sputum, IV tubing without the needles.		X	
Soiled but not dripping **and/or saturated** items such as dressings, bandages, cotton balls, peripads, chux, cotton swabs.		X	
Suction Canisters, treated with solidifying agent.	X		
Used gloves, aprons, masks, goggles, and respirators.		X	
Broken glass, guide wires.			X
Uncapped Needle/syringe units, needles, scalpels, vials from live, or attenuated vaccines.			X

Tri-City Medical Center
Oceanside, California

~~POLICY~~ PHARMACY MANUAL

ISSUE DATE: 4/12 **SUBJECT: General and Concentrated Electrolytes Policy**

REVISION DATE: ~~**POLICY NUMBER: 8390 -2114**~~

Department Approval Date(s):	**7/15**
Pharmacy and Therapeutics Approval Date(s):	**5/12, 07/15**
Medical Executive Committee Approval Date(s):	**6/12, 09/15**
Professional Affairs Committee Approval Date(s):	**10/15**
Board of Directors Approval Date(s):	**6/12**

A. **PURPOSE:**

1. To provide an organization—wide drug safety policy to prevent medication errors associated with concentrated electrolytes as recommended by the Institute for Safe Medication Practices (ISMP) and The Joint Commission (TJC). **These guidelines and procedures are to be followed by all personnel involved in the intravenous administration of concentrated electrolytes.**
2. This policy addresses the non-emergent prescribing, administration, **dispensing,** and storage of intravenous electrolytes for maintenance and replacement supplementation. In addition, this policy will address prescribing of hypotonic and hypertonic solutions

B. **POLICY**:

1. There shall be safety measures **in place** to minimize the potential for medication errors regarding the ~~following~~ **ordering, preparation, labeling, distribution, administration, storage, and monitoring of all** intravenous electrolytes.~~:~~
   - **a. Concentrated electrolyte solutions include, but are not limited to: potassium chloride, potassium phosphate, potassium acetate, 3% sodium chloride, 23.4% sodium chloride,** sodium acetate, and sodium phosphate.~~Potassium Chloride, Potassium Acetate, Potassium Phosphate, Sodium Chloride, Sodium Phosphate, Sodium Bicarbonate, Calcium Chloride, Calcium Gluconate, Magnesium Sulfate (exception 50% vials in emergency drug trays and Potassium Chloride vials in perfusion carts)~~
   - **b. This policy shall also encompass the safe use of all other intravenous electrolytes including, but are not limited to: calcium chloride, calcium gluconate, magnesium sulfate, sodium bicarbonate, and sterile water for injection.**
2. **Tri-City Medical Center maintains supplies of concentrated electrolytes in the Pharmacy Department. Concentrated electrolytes will not be stocked in patient care areas.**
   - **a. 3% hypertonic saline shall not be stored in ~~automatic~~automated dispensing machines (ADM) and shall be dispensed patient specific from the pharmacy one bag at a time.**
   - **b. 23.4% hypertonic saline shall not be stored in an ADM and shall be dispensed patient specific from the pharmacy. To prevent accidental infusion, pharmacy shall dispense one VIAL at a time and shall never dilute further and/or dispensed in a bag to prevent accidental infusion**
     - **i. Can only~~Must~~ be ordered ~~and administered~~ by a neurologist or neurosurgeon**
   - **c. Large volume (1000~~ml~~mL or larger) sterile water for injection shall not be stored in patient care areas and will not be dispensed without additives to avoid hemolysis**
   - **d. Exceptions:**
     - **i. Potassium chloride vials may be stored in perfusion carts only**
     - **ii. Pre-mixed mini-bags for electrolyte replacement pursuant to approved protocol are available in automated dispensing machines (ADM). Different strengths shall be separated to avoid look-a-like errors**

iii. **Magnesium sulfate vials, calcium chloride and/or calcium gluconate vials/syringes are stored in emergency medication trays and automated dispensing machines for emergency use only**

3. **The number of drug concentrations available at Tri-City Medical Center are standardized whenever possible and limited to the minimum required to meet patient care needs.**
4. **All orders for concentrated electrolyte solutions must be entered electronically into Cerner.**
   a. **Exceptions: verbal/telephone orders followed by a written order will be accepted during an emergency**
5. **When infusion of concentrated electrolytes are required for patient use, only commercially prepared products (whenever possible), with patient-specific labeling, shall be dispensed.**
6. **Solution orders that require admixture (i.e. there is not a pre-mixed solution ready for administration available) will be prepared by Pharmacy and delivered to the patient care area of use on a per patient basis.**
7. **Route of electrolyte administration is dependent on the specific electrolyte, concentration, and urgency. (Appendix II: Dosing and Administration Guidelines)**
8. **All intravenous electrolytes shall be administered with an electronic infusion device (i.e. Alaris Smart Pump) and will not be given via IV Push.**
   a. **Exception: Calcium chloride may be administered via slow IV push in central line during code blue only; calcium gluconate may be administered via slow IV push in a large vein over 5 to 10 minutes; magnesium sulfate may be administered via slow IV push not to exceed 150mg/min (may administer over 1 to 2 minutes in patients with persistent pulseless VT or VF with known hypomagnesemia) and must be diluted to a concentration ≤ 20%**
9. **Hypertonic solutions MUST be administered via central line with an electronic infusion device. If a central line is not available then, the largest patent vein should be utilized until a central line is placed**

C. **PROCEDURE:**

1. Prescribing
   a. Pharmacy shall require prescriber's orders for maintenance electrolytes to specify the name of the electrolyte, name of diluent, concentration, and infusion rate (e.g. D5 ½ NS with 20 mEq KCl/liter at 20 ~~mL~~**mL** per hour).
   b. Pharmacy shall require prescriber's orders for bolus electrolytes to specify the name of the electrolyte, dose (in mEq, mmoL, or mg), concentration of electrolyte, administration rate (dose/hour or ~~mL~~**mL**/hour), and route of administration
   c. For children less than or equal to 13 years of age, the prescriber's order shall include patient's weight in kg, dose of electrolyte on a per kg basis, and volume of electrolyte to be administered.
   d. Dosing of electrolyte in obese patients (i.e. actual -weight > 130% IBW or BMI > 30 kg/m2) should be based on an adjusted body weight when weight based dosing is required.(Consult pharmacist for weight adjustment calculations).
   e. Electrolyte replacement in patients that are asymptomatic should be treated with oral supplement **whenever possible** if there is a functional gastrointestinal tract. EXCEPT IN THE CASE OF MAGNESIUM. (**Appendix IV: Selected Available Oral Electrolyte Replacement Products**
   f. Pharmacy shall provide the prescriber with **a** selection of **standardized** ~~pre-mixed~~ electrolyte **solutions to order from**~~containing maintenance or bolus infusion solutions~~. Tri City Medical Center-Intravenous Electrolyte Administration Guide (**Appendix I: Selection of standardized** ~~**pre-mixed**~~ **solutions available at TCMC).**
   g. In the event that one of the ~~above alternatives~~ **standardized solutions** cannot satisfy the patient's needs, a pharmacist will contact the prescriber to assure that the requested solution is clinically indicated. Only then will the solution be compounded.

h. In the event of an order for a hypotonic or hypertonic solution, the order will be discussed with prescriber to assure the solution is clinically indicated. It will be dispensed on a patient specific basis following dosing guidelines.
   i. Serum osmolarity range 240-340 mOsm/L
      1) Hypotonic solution-lower osmolarity than serum
      2) Hypertonic solution-higher osmolarity than serum
   ii. Sterile water for injection or 0.225% sodium chloride will not be dispensed without additives in order to avoid hemolysis

2. Administration
   a. Potassium Administration Guidelines:
      i. Potassium shall not be administered IV push. It ~~and~~ shall be administered via a slow infusion, diluted with a suitable volume of solution.
      ii. Potassium shall never be added to an infusing IV, as doing so results in the pooling of potassium and a resultant bolus concentration of the drug being administered.
      iii. Patients with concomitant hypomagnesemia should have the magnesium deficit corrected prior to potassium supplementation to prevent refractory hypokalemia
      iv. Administration of Potassium in Non-Critical Care setting:
         1) Potassium Intermittent Infusions "Piggybacks"
            a) Maximum infusion rate via peripheral line is 10 mEq/hour. Maximum infusion rate via central line is 20 mEq/hour and must be on continuous ECG monitoring.
         2) Potassium large volume continuous infusions (1000~~ml~~mL or more)
            a) Maximum concentration of potassium is 40 mEq/liter of solution with a maximum infusion rate of 10 mEq/hour (20 mEq/hour if the patient is on continuous ECG monitoring)
         3) Doses up to 200mEq in 24 hours generally should not be exceeded.
      v. Administration of Potassium in Critical Care setting
         1) Maximum concentration and infusion rates are recommended as listed above
         2) Exceptions: Depending upon the estimated potassium deficiency and the urgency of the situation [for example: severe hypokalemia (potassium below 2.5 mEq/L), cardiac arrhythmias, diabetic ketoacidosis] rare patients require a concentration, dosage and/or rate of administration which temporarily exceeds those guidelines stated above.
            a) Maximum concentration of potassium is 80 mEq/liter in a critical care setting on continuous ECG monitoring.
            b) Maximum rate of potassium infusion is established at 40mEq per hour, which requires continuous ECG monitoring in critical care settings. Doses up to 200mEq in 24 hours generally should not be exceeded.
      vi. Potassium level must be checked after administration of 60mEq potassium prior to administration of additional potassium.
   b. Potassium Phosphate and Sodium Phosphate Administration Guidelines:
      i. Intravenous phosphate is potentially dangerous, since it can precipitate with calcium and produce a variety of adverse effects including hypocalcemia, renal failure, and potentially fatal arrhythmias
         1) Phosphate solutions shall not be infused via the same IV catheter as calcium containing solutions
      ii. Potassium phosphate or sodium phosphate shall not be administered IV push and shall be administered via a slow infusion, diluted with a suitable volume of solution.

iii. In situations of hypophosphatemia requiring parenteral administration of intravenous phosphate, it may be necessary to administer concentrated solutions of potassium phosphate or sodium phosphate
  1) The salt chosen depends on the patient's serum sodium and potassium levels
    a) Potassium phosphate should not be used if serum potassium GREATER than 4.5 mEq/L. Sodium phosphate should not be used if serum sodium is GREATER than 145 mEq/L
    b) If both potassium and phosphate replacement required, subtract the mEq of potassium given as potassium phosphate from total amount of potassium required (7 mmol of Potassium phosphate = 10 mEq of potassium)
  2) Maximum phosphate concentration for peripheral line administration = 7 mmol/100~~ml~~mL (10 mEq of potassium/100~~ml~~mL, if using potassium phosphate)
  3) Maximum phosphate concentration for central line administration = 15 mmol/100~~ml~~mL (20 mEq of potassium/100~~ml~~mL, if using potassium phosphate)
  4) Maximum infusion rate of phosphate 7 mmol/hr (10 mEq/hr potassium, if using potassium phosphate) via peripheral line or central line without cardiac monitoring
  5) Maximum infusion rate of phosphate up to 14 mmol/hr (20 mEq/hr potassium, if using potassium phosphate) via central line with cardiac monitoring in the Critical Care Setting
  6) Potassium level must be checked after administration of ~~40~~60mEq potassium (27 mmol phosphate) prior to administration of additional potassium.

c. Sodium Chloride 3% Administration Guidelines:
  i. Sodium chloride 3% is available in 500~~ml~~mL bag (3g NaCl/100~~ml~~mL = 15g NaCl/500~~ml~~mL = 513 mEq NaCl/1000~~ml~~mL = 1027 mOsm/1000 ~~ml~~mL)
  ii. Use of Hypertonic Saline (Sodium Chloride 3%) is primarily reserved for patients for:
    1) Treatment of increased intracranial pressure
    2) Treatment of cerebral edema
    3) Clinical signs of cerebral herniation
    4) Treatment of acute and chronic euvolemic symptomatic hyponatremia
  iii. Central line preferred due to high osmolarity. For emergent situations, peripheral (large bore vein with good blood flow) may be utilized
  iv. Usual Dosing:
    1) Bolus: 100-250~~ml~~mL over 15-20 minutes
    2) Infusion: 5-150 ~~ml~~mL/hr (start at 5-30 ~~ml~~mL/hr)
      a) Rate of correction should generally not exceed 10-12 mEq/L in first 24 hours and 18 mEq/L in first 48 hours to prevent osmotic demyelination syndrome
  v. Bolus doses of hypertonic saline may only be prescribed by Neurology, Neurosurgery, Critical Care or Pulmonary physicians and shall be reserved for administration in critical care settings.
    1) Exception: Any location in emergent situation with continuous monitoring pending transfer to critical care area
  vi. Administration of hypertonic saline continuous infusions shall be reserved for critical care areas and telemetry. Administration is not permitted on acute care, L&D, and post-partum floors.
    1) Exception: Any location in emergent situation with continuous monitoring pending transfer to critical care or telemetry unit.
  vii. All orders require renewal by MD after every 500~~ml~~mL administered

viii. The provider will determine the overall sodium replacement goal, initial sodium goal for the first four (4) hours of the intervention, and rate of correction
  1) The plasma sodium [Na+] should be raised at a rate of 1 to 2 mEq/L per hour in patients with severe symptoms (seizures, coma, evidence of brainstem dysfunction)
  2) The plasma sodium [Na+] should be raised by no more than 10-12 mEq/L in 24 hours and no more than 18 mEq/L in 48 hours
  3) The pharmacist shall have the ability to hold any hypertonic saline infusion whereby the sodium [Na+] has increased by GREATER than 12 mEq/L in a 24 hour period OR GREATER than 18 mEq/L in a 48 hour period per pharmacy protocol
    a) Exceptions: hypertonic saline infusions for cerebral edema, herniation or any brain condition
  4) The pharmacist must contact the prescriber immediately upon holding of the hypertonic saline infusion and for further orders

ix. The pharmacist shall verify the indication for all hypertonic saline infusions

x. The pharmacist will verify the calculations regarding the dose and rate of the infusion ordered by the provider via the following process:
  1) Determine the overall sodium replacement goal and the initial sodium replacement goal as documented by the Provider
  2) Determine the actual serum sodium level of the patient
  3) Calculate the total body sodium deficit by:
    a) [0.6 for males or 0.5 for females] x Weight** (in kg) x (Desired Na - Patient's Na)
      i) Note: For weight > 30% of ideal body weight (IBW), use adjusted weight. Adjusted weight = 0.5 x (ABW-IBW) + IBW up to maximum of 100 kg
  4) Verify the replacement rate for the first 24 hours
    a) [0.6 for males or 0.5 for females] x Desired increase in Serum Na x _____kg = mEq sodium to be replaced
      i) Note: Not to exceed an increase of 10-12 mEq/L in a 24 hour period or 18 mEq/L in 48 hours
    b) 3% sodium chloride contains 513 mEq/L sodium and 513 mEq/L chloride
    c) Volume of 3% sodium chloride to be infused = ____ mEq sodium to be replaced/(513) x 1000 = _____ ~~mL~~mL/24 hours
    d) Rate (~~mL~~mL/hour) = total number of ~~mL~~mL per 24 hours
  5) See Appendix V for Quick Estimation for Asymptomatic Hyponatremia
  6) See Appendix VI for Quick Estimation for Chronic Hyponatremia

xi. The order should be assessed periodically by the prescriber for continued therapy (every 12 hours is recommended)

xii. Recheck electrolytes (serum sodium, chloride, potassium, bicarbonate, serum osmolarity) and clinical status every 2 to 4 hours, with a minimum of every 4 hours

xiii. Precautions:
  1) Severe neurologic complications may result from rapid changes in serum sodium concentration and serum osmolality
  2) Patients with a history of cirrhosis or alcoholism may be at increased risk for osmotic demyelination syndrome with rapid sodium correction
  3) Rapid withdrawal of hypertonic saline infusion may result in rebound cerebral edema
  4) Plasma volume expansion may worsen pre-existing heart failure or cause pulmonary edema

5) **Administration of hypertonic saline via peripheral line may result in phlebitis and skin necrosis**

~~3)~~

D. **RELATED DOCUMENTS:**

1. **Maintenance Solutions Containing Potassium**
2. **Guidelines for Dosing & Administration of Electrolyte Replacement**
3. **Osmolarity of Selected IV Fluids**
4. **Selected Available Oral Electrolyte Replacement Products**
5. **Quick Estimation for Asymptomatic Hyponatremia**
6. **Quick Estimation for Symptomatic Hyponatremia**

~~i.~~

~~b. Route of electrolyte administration is dependent on the specific electrolyte, concentration, and urgency. (**Appendix II: Dosing and Administration Guidelines**)~~

~~c. Use an infusion device to administer all replacement electrolytes. **Do not give IV Push.**~~

~~d. Hypertonic solutions MUST be administered via central line with an electronic infusion device. If a central line is not available then, the largest patent vein should be utilized until a central line is placed~~

~~e. Final sodium chloride osmolarity should at minimum approximate 154 mOsm /liter and not exceed 1100 mOsm/liter for peripheral line administration. (Appendix III: Osmolarity of Common Administered IV Fluids)~~

~~Appendix I~~

MAINTENANCE SOLUTIONS CONTAINING POTASSIUM

Solution	KCl content (mEq/L)	Volume		Solution	KCl content (mEq/L)	Volume
1/2NS	20	1000 ~~mL~~mL		D5 1/2 NS	10	1000 ~~mL~~mL
NS	20	1000 ~~mL~~mL		D5 1/2 NS	20	1000 ~~mL~~mL
NS	40	1000 ~~mL~~mL		D5 1/2 NS	30	1000 ~~mL~~mL
D5W	20	1000 ~~mL~~mL		D5 1/2 NS	40	1000 ~~mL~~mL
D5 NS	20	1000 ~~mL~~mL				

Multi-electrolyte MAINTENANCE SOLUTIONS

Solution	Content	Volume
Lactated Ringer's Injection	K 4 mEq/L, Na 130 mEq/L, Ca 3 mEq/L, Cl 109 mEq/L, Lactate 28 mEq/L	1000 ~~mL~~mL
Dextrose 5% in Lactated Ringer's Injection with 20 KCl	Dextrose 5%, K 24 mEq/L, Na 130 mEq/L, Ca 2.7 mEq/L, Cl 129 mEq/L, Lactate 28 mEq/L	1000 ~~mL~~mL
Dextrose 5% in Lactated Ringer's with 40 KCl Injection	Dextrose 5%, K 44 mEq/L, Na 130 mEq/L, Ca 2.7 mEq/L, Cl 149 mEq/L, Lactate 28 mEq/L	1000 ~~mL~~mL

Solutions Available for BOLUS ADMINISTRATION*

Solution (all provided in D5W or NS)	Electrolyte Content	Volume	Route of Administration
Calcium chloride 10 mg/~~ml~~mL	1 gram	100 ~~mL~~mL	Central only
Calcium gluconate 10 mg/~~ml~~mL	1 gram	100 ~~mL~~mL	Peripheral or Central
Magnesium sulfate 10 mg/~~ml~~mL	1 gram	100 ~~mL~~mL	Peripheral or Central
Magnesium sulfate 40 mg/~~ml~~mL	4 gram	100 ~~mL~~mL	Central only
Potassium acetate 0.1 mEq/~~ml~~mL	10 mEq potassium	100 ~~mL~~mL	Peripheral or Central
Potassium acetate 0.2 mEq/~~ml~~mL	20 mEq potassium	100 ~~mL~~mL	Central only
Potassium chloride 0.1 mEq/~~ml~~mL	10 mEq potassium	100 ~~mL~~mL	Peripheral or Central
Potassium chloride 0.2 mEq/~~ml~~mL	10 mEq potassium	50 ~~mL~~mL	Central only
Potassium phosphate 0.1 mEq/~~mL~~mL	7.5 mmol phosphate=11 mEq potassium	100 ~~mL~~mL	Peripheral or Central
Potassium phosphate 0.1 mEq/~~ml~~mL	15 mmol phosphate = 22 mEq potassium	250 ~~mL~~mL	Peripheral or Central
Potassium phosphate 0.2 mEq/~~ml~~mL	30 mmol phosphate = 44 mEq potassium	500 ~~mL~~mL	Peripheral or Central

Sodium phosphate 0.1 mEq/~~ml~~**mL**	7.5 mmol phosphate=10 mEq of sodium	100 ~~mL~~**mL**	Peripheral or Central
Sodium phosphate 0.1 mEq/~~ml~~**mL**	15 mmol phosphate = 20 mEq of sodium	250 ~~mL~~**mL**	Peripheral or Central
Sodium phosphate 0.2 mEq/~~ml~~**mL**	30 mmol phosphate = 40 mEq of sodium	500 ~~mL~~**mL**	Peripheral or Central

~~Appendix II.~~ Guidelines for Dosing & Administration of Electrolyte Replacement
****This is meant to serve as a reference please see TCMC electrolyte replacement protocol ****

Potassium Acetate and Potassium Chloride Bolus Dosing and Administration (IV)				
Serum Level	**Adult Dose**	**Pediatric Dose**	**Infusion Rate**	**Hourly Maximum**
3.0 - 3.5 mEq/L	10 mEq	0.2 - 0.3 mEq/kg/dose	Over 1 - 2 hours	10 mEq
2.5 - 3.0 mEq/L	20 – 40 mEq	0.5 mEq/kg/dose*	Over 1 - 2 hours	20 mEq*
<2.5 mEq/L	40 - 80 mEq	1 mEq/kg/dose*	Over 2- 4 hours	20 mEq*

- Patients with renal insufficiency should receive less than or equal to 50 % of the dose.
- Check a magnesium level especially in patients with hypokalemia and hypocalcemia.
  - Magnesium deficiency should be corrected to facilitate the correction of hypokalemia.

Potassium Phosphate and Sodium Phosphate Bolus Dosing and Administration (IV)			
Serum Phosphate Level	**Adult Dose**	**Pediatric Dose**	**Infusion Rate**
Mild, 2.3-2.7 mg/dL	7.5 mmoL	0.08 mmol/kg/dose	Over 2 hours
Moderate, 1.5-2.2 mg/dL	15 mmoL	0.16-0.24 mmol/kg/dose	Over 4-6 hours
Severe, <1.5 mg/dL	30 mmoL	0.36 mmol/kg/dose	Over 6 hours

- Equivalencies : 3mmol/~~mL~~**mL** phosphate = 285 mg/~~mL~~**mL**
  4.4 mEq/~~ml~~**mL** potassium = 170 mg/ ~~mL~~**mL**
- Risk of calcium-phosphate precipitation when infused in the same IV catheter as solutions containing Calcium!

Magnesium Sulfate Bolus Dosing and Administration (IV)				
Serum Magnesium Level	**Adult Dose**	**Pediatric Dose**	**Infusion Rate**	**Hourly Maximum**
Mild/ Moderate: 1 - 1.5 mg/dL	1-4 gram	25-50 mg/kg/dose	Over 2-4 hours	1 gram
Severe: < 1 mg/dL	4-8 gram	50 mg/kg/dose	Over 4-8 hours	1 gram

- Equivalencies: 1gram **Magnesium Sulfate** = 8.2 mEq magnesium
- Adult total dose should not exceed 12 gram over 12 hours

Calcium Dosing and Administration (IV)		
Dosing	**Adult Dose**	**Pediatric Dose**
Intermittent	Mild: 1-2 gram over 30 -60 minutes	Calcium chloride:10-20 mg/kg/dose

	Severe: 1 gram of Calcium chloride or 3 gram of calcium gluconate over 10 minutes;	Calcium gluconate: 50-100 mg/kg/dose Administration: over 30 - 60 minutes
Continuous Infusion (Severe hypocalcemia)	500 mg - 1 gram/hour	Calcium chloride: 5-10 mg/kg/hr Calcium gluconate:10 -20 mg/kg/hr

~~**KEYPOINT:** Calcium chloride should be administered via a central line to avoid extravasation and tissue necrosis~~

- **Equivalencies**: 1 gm calcium chloride = 13.6 mEq (elemental calcium)
  1 gm calcium gluconate = 4.56 mEq (elemental calcium)
- Corrected calcium for low albumin:[(4 - alb) x 0.8] + calcium level
- Risk of calcium-phosphate precipitation when infused in the same IV catheter in solutions containing phosphate!
- Potential risk for cardiac arrhythmias associated with rapid calcium infusion.
- Blood products preserved with citrate may cause hypocalcemia: Administer 1.35 mEq of calcium for each 100 ~~mL~~**mL** of blood transfused
- **Not for IM or SubQ administration (severe necrosis and sloughing may occur).**
- **Avoid rapid administration (do not exceed 100mg/min except in emergency situations)**
- **For intermittent IV infusion, infuse diluted solution over 1 hour or no greater than 45-90 mg/kg/hour (0.6-1.2 mEq/kg/hr); administration via central or deep preferred; do not use scalp, small hand or foot veins for IV administration.**
- **Monitor ECG if calcium is infused faster than 2.5 mEq/minute; stop the infusion if the patient complains of pain or discomfort.**
- **Warm solution to body temperature prior to administration.**

Sodium Bicarbonate

- Metabolic acidosis: sodium bicarbonate dosage should be based on blood gases and pH measurements.
- HCO_3 dose (mEq) = 0.5 X weight (kg) X (24 – serum HCO_3 (mEq/L)) or use following equations:

Pediatrics HCO_3 dose (mEq) = 0.3 X weight (kg) X base deficit (mEq/L)

Adults HCO_3 dose (mEq) = 0.2 X weight (kg) X base deficit (mEq/L)

KEYPOINT: Neonates & infants use 0.5 mEq/~~ml~~**mL** solution-.

- Maximum rate of administration should not exceed 1 mEq/kg/hr. Rapid or excessive administration of sodium bicarbonate may produce tetany -or cerebral edema/hemorrhage especially in infants.
- Recommendations for the addition of sodium bicarbonate to IV fluids:

IV stock solution	Volume	Maximum Sodium Bicarbonate Addition	Resultant Na + concentration
0.45 % NaCl	500 ~~mL~~**mL**	37.5 mEq (0.75 vial)	152 mEq/L
0.45 % NaCl	1000 ~~mL~~**mL**	75 mEq (1.5 vials)	152 mEq/L

D5 W	500 ~~mL~~**mL**	75 mEq (1.5 vials)	150 mEq/L
D5W	1000 ~~mL~~**mL**	150 mEq (3 vials)	150 mEq/L
D5 0.45% NaCl	500 ~~mL~~**mL**	37.5 mEq (0.75 vials)	152 mEq/L
D5 0.45 % NaCl	1000 ~~mL~~**mL**	75 mEq (1.5 vials)	152 mEq/L
D10W	500 ~~mL~~**mL**	75 mEq (1.5 vials)	150 mEq/L
D10W	1000 ~~mL~~**mL**	150 mEq (3 vials)	150 mEq/L

Each vial/amp of sodium bicarb contains 50 meq of sodium

- Addition of sodium bicarbonate to IV fluids should not result in a hypertonic solution.
- Sodium bicarbonate should not be added to 0.9 % sodium chloride containing solutions.
- **Exceptions: Preparation and dispensing of hypertonic sodium bicarbonate solutions require discussion with prescriber and approval by Clinical Manager. Also see Sodium Chloride 3% Administration Guidelines above.**

~~Appendix III:~~ Osmolarity of Selected IV Fluids

Solution	mOsm/liter
½ Normal Saline (0.45% NaCl)	154
Normal Saline (0.9% NaCl)	308
Dextrose 5% in Water	252
Dextrose 10 % in Water	505
Dextrose 5% and 0.2% NaCl	321
Dextrose 5% and 0.45% NaCl	406
Dextrose 5% and 0.9 % NaCl	560
Dextrose 5% and 0.2% NaCl with 20 mEq KCl	361
Dextrose 5% and 0.45% NaCl With 20 mEq KCl	447
Lactated Ringers	273
Dextrose 5% and Lactated Ringers	525

- Consult with pharmacist and/or standard references for osmolarity of other solutions.
- Sterile water for injection or 0.225% sodium chloride will not be dispensed without additives to avoid hemolysis

~~Appendix IV.~~ Selected Available Oral Electrolyte Replacement Products

Phosphate Replacement PO* Products				
Formulation	**mg PO_4**	**mmol PO_4**	**mEq Na^+**	**mEq K^+**
K-Phos Neutral	250	8	13.1	1.1

Potassium Replacement Products (PO)		Comments
Formulation	**Strengths**	
Potassium chloride (Extended release capsule)	10 mEq ER (Micro-K)	• Oral route preferred over IV • Do not crush extended release products • Need to correct hypomagnesemia in order to correct potassium levels • Excess chloride salts may cause metabolic acidosis • Excess acetate salts may cause metabolic alkalosis
Potassium chloride (Liquid)	20mEq/15~~mL~~**mL** 40mEq/30 ~~mL~~**mL**	
Potassium chloride (Effervescent table)	25 mEq effervescent	

Calcium Replacement PO Products				
Formulation	**Strength**	**Route**	**Elemental Calcium (mEq/dL)**	**Elemental Calcium (%)**
Calcium acetate (Tablet)	667 mg (169 mg Elemental)	I.V. or Oral[B]	12.7	25
Calcium carbonate (Tablet/Suspension)	650 mg 1250 mg/5~~ml~~**mL**	Oral[B]	20	40

~~Appendix V:~~ Quick Estimation for Asymptomatic Hyponatremia

IBW kg	40 kg	50 kg	60 kg	70 kg	≥ 80 kg
Estimated Rate of 3% to correct Serum Na 8mEq/L/24h (~~ml~~mL/hr)	13 ~~ml~~mL/hr	16 ~~ml~~mL/hr	20 ~~ml~~mL/hr	23 ~~ml~~mL/hr	26 ~~ml~~mL/hr

~~Appendix VI:~~ Quick Estimation for Symptomatic Hyponatremia

IBW kg	40 kg	50 kg	60 kg	70 kg	≥ 80 kg
Initial rate of 3% NaCl to increase Na by approx 3-5 mEq/L	80~~ml~~mL/hr x 2hrs STAT Na level at 2 hours	100 ~~ml~~mL/hr x 2hrs STAT Na level at 2 hours	120~~ml~~mL/hr x 2hrs STAT Na level at 2 hours	140~~ml~~mL/hr x 2hrs STAT Na level at 2 hours	160~~ml~~mL/hr x 2hrs STAT Na level at 2 hours
If seizures do not resolve continue 3% NaCl	80~~ml~~mL/hr	100~~ml~~mL/hr	120~~ml~~mL/hr	140~~ml~~mL/hr	160~~ml~~mL/hr
Maintenance rate (patient not seizing) for the 1st 24 hours	↓ Infusion to 7~~ml~~mL/hr x 22 hrs Serial Na levels Q4h	↓ Infusion to 9~~ml~~mL/hr x 22 hrs Serial Na levels Q4h	↓ Infusion to 11~~ml~~mL/hr x 22 hrs Serial Na levels Q4h	↓ Infusion to 13~~ml~~mL/hr x 22 hrs Serial Na levels Q4h	↓ Infusion to 15~~ml~~mL/hr x 22hrs Serial Na levels Q4h
3% NaCl may be continued until serum Na >120.					

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

SUBJECT: Supervision Requirements of Minors During Outpatient Treatment

ISSUE DATE: 01/07
REVISION DATE(S): 01/09

Department Approval Date(s):	06/15
Department of Medicine Approval Date(s):	n/a
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	09/15
Professional Affairs Committee Approval Date(s):	10/15
Board of Directors Approval Date(s):	

~~**ISSUE DATE:** 10/07~~ ~~**SUBJECT: SUPERVISION REQUIREMENTS OF MINORS DURING OUTPATIENT REHABILITATION**~~

~~**REVISION DATE:**~~ ~~**STANDARD NUMBER:**~~
~~**REVIEW DATE:** 1/09~~ ~~**CROSS REFERENCE:**~~
~~**APPROVAL:**~~

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

- ~~4002 Vista Way, Oceanside, CA~~
- ~~2124 El Camino Real, Oceanside, CA~~
- ~~6250 El Camino Real, Carlsbad CA~~

~~PURPOSE~~

~~1. To establish guidelines for parent/guardian presence during outpatient rehabilitation treatment of minors.~~

A. POLICY:

~~2.~~**1.** Parent/Guardian shall accompany their minor child for all outpatient treatments until the child reaches the age of 18 years. Parent/Guardian shall be present at the child's session or remain in the waiting area for the duration of the session. The level of parent participation depends on the child's age and prior agreement with the treating therapist.

2. Exceptions may be made to this rule with prior signed consent by the minor's parent authorizing treatment in absence of the parents' presence. This may apply to teenagers that are driving themselves to their appointments (i.e. minor children age 16 and older). Other limited (single-visit) exceptions may be considered for emergencies and would have to be arranged between the parent and therapist for agreement on feasibility of the treatment session without the parent's presence at the facility.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

SUBJECT: Use of Encrypted Email

ISSUE DATE: NEW
REVISION DATE(S):

Department Approval Date(s):	**07/15**
Department of Medicine Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**09/15**
Professional Affairs Committee Approval Date(s):	**10/15**
Board of Directors Approval Date(s):	

A. **PROCEDURE:**

1. Outpatient Rehab services will utilize an encrypted email ID created by the Information Technology Department.
2. A common email password will be provided to all front office staff so that they have access to the secure email address.
   a. The common email password will be changed when any current team member terminates from duties relating to accessing the secure email account.
3. Upon Patient/Physician Office request for submission of orders, authorizations, etc. via email the Front Office team member will forewarn the caller via a scripted message as follows:
   a. "There is an inherent risk whenever information is shared electronically via an unencrypted email format such as that from personal email accounts. By requesting to send us your medical information by this means, you are accepting this risk".
4. Our Front office will then provide the email address to the Individual/Office
1. ~~Patient/Physician Office emails their documents to OP Rehab Services~~
5. OP Rehab team member accesses the secure email folder to access the patient documents.
6. A confirmation email is sent back to the Patient/Physician Office upon receipt of the email to the secure TCMC email address.
7. Front Office team member directs the documents received to the fax server for access by team members completing the Scheduling and Registration process.
8. Front Office team member deletes the received email from the secure email folder.

DRAFT

Governance & Legislative Committee Meeting Minutes
Tri-City Healthcare District
October 6, 2015

Members Present:	Larry W. Schallock, Chairperson; Director Ramona Finnila; Director RoseMarie V. Reno; Eric Burch, 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; Kapua Conley, COO; Cheryle Bernard-Shaw, CCO
Others Present:	Teri Donnellan, Executive Assistant; Teri Bowen, Senior Medical Staff Coordinator; Jim Dagostino, Board Member; Robin Iveson, Community Member; Jane Dunmeyer, Community Member
Absent:	Dr. Paul Slowik, Community Member; Tim Moran, CEO; Blake Kern, Community Member; 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.		
2. Approval of Agenda	**It was moved by Director Finnila to approve today's agenda as presented. Dr. Showah 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 Director Finnila and seconded by Dr. Ma to ratify the minutes of the September 1, 2015 Governance & Legislative Committee. The minutes were approved unanimously.** With regard to Board Policy 15-027 Prohibition on Political Activities, Solicitation Distribution of Literature and Goods on District Properties Chairman Schallock questioned if it would be possible to craft an exemption to the policy for things that are for the benefit of the hospital and run by the hospital.	Minutes ratified. General Counsel to draft exemption to Board Policy 15-027 Prohibition on Political Activities, Solicitation Distribution of Literature and Goods on District Properties and bring back to the next meeting.	General Counsel
5. Old Business – a. Medical Staff Rules & Regulations			

Topic	Discussion	Action Follow-up	Person(s) Responsible
			DRAFT
1) Division of Neurosurgery	Per discussion at last month's meeting, amendments to the Division of Neurosurgery Rules and Regulations were discussed. Discussion was held regarding the variance in the number of years (3-5) to obtain certification. Ms. Bowen stated the number of years varies by division. There was extensive discussion related to proctoring. Dr. Ma explained there are a small number of active Neurosurgeons in the division and a fair amount of cases that have to be proctored. He further explained that the term Associate does not imply their quality of care is any less. Dr. Contardo noted inconsistencies in section IX, subparagraph D and section X. related to Emergency Department call. It was recommended the Neurosurgery Rules & Regulations be referred back to the Division for clarification	Neurosurgery Rules & Regulations to be sent back to the Division for clarification and brought forward to the committee at their next meeting.	Medical Staff Office
2) Division of Psychiatry	Dr. Contardo questioned if there should be reference in the Procedure section for ECT. Ms. Bowen stated she did not believe ECTs are performed at the hospital but would follow-up and report back. Director Finnila questioned why the attending physician has to wait an hour before a restraint can be used. General Counsel clarified a restraint can be used "within the hour". Mr. Moser referred to additional administrative policies related to restraint assessment. It was suggested that we ensure the policies conform with Joint Commission and CMS Standards. It was suggested the Psychiatry Rules & Regulations be referred back to the Division for response.	Psychiatry Rules & Regulations to be sent back to the Division for clarification and brought forward to the committee at their next meeting.	Medical Staff Office
3) Allied Health	Discussion of the Allied Health Rules & Regulations was deferred pending a meeting of the group.	Information only.	

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

	Dr. Gene Ma, Chief of Staff stated per discussion at last month's meeting he inquired with North County Health Services regarding their criteria for midwifery. Dr. Ma stated the information provided to him did not detail inclusion criteria for midwifery and it appears it is left to the discretion of the physician. Director Reno questioned who provides oversight of the Midwife. Chairman Schallock stated this topic of discussion has been referred to the Professional Affairs Committee due to the fact that it relates to quality of care. Dr. Ma stated he will request NCHS give their consent to share their policies related to midwifery.		
b. Review and discussion of amendment to Board Policy 14-042 – Duties of the Board of Directors	In follow-up to discussion at last month's meeting, General Counsel stated Board Policy 14-042 – Duties of the Board of Directors was amended to cross reference Board Policy 14-023 which describes the Board's responsibilities for decision making on legal matters, including the hiring of General Counsel and the Chief Compliance Officer. **It was moved by Director Finnila to recommend approval of the amendments to Board Policy 14-042 Duties of the Board of Directors, as presented. Dr. Showah seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve amended Board Policy 14-042 Duties of the Board of Directors; item to appear on next Board agenda and included in Board Agenda packet.	Ms. Donnellan
c. Review and discussion of amendment to Board Policy 14-039 – Comprehensive Code of Conduct	In follow-up to discussion at last month's meeting, General Counsel stated language related to *exparte contacts* was deleted and a simpler explanation was included. Director Finnila expressed concern that the language intimates that all Board Members are receiving the same information at the same time, such as at a meeting of the Board rather than a committee of the Board. General Counsel stated this language applies to a quasi judicial decision that is affecting one decision, not a contractor decision. Director Finnila emphasized that all major financial decisions should come to full Board rather than to a committee of the Board.	Recommendation to be sent to the Board of Directors to approve amended Board Policy 14-039 – Comprehensive Code of Conduct; item to appear on next Board agenda and included in Board Agenda packet	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

	Discussion was held regarding section I. paragraph #2 related to the language "behave as if they are fiduciaries". General Counsel stated the language is written to protect public officials from some liabilities. **It was moved by Dr. Contardo to recommend approval of the amendments to Board Policy #14-039 – Comprehensive Code of Conduct. Dr. Showah seconded the motion. The motion passed unanimously.**		
6. New Business a. Medical Staff Rules & Regulations 1. Division of General and Vascular Surgery	Dr. Ma pointed out the verbiage "Documentation to indicate malpractice coverage includes bariatric surgery" on page 8 of 12 of the Rules & Regulations should NOT be stricken. Dr. Contardo commented that there are 143 separate procedures however the proctoring requirement is only 10 cases. Ms. Teri Bowen explained these are "bundled privileges" and refers to 10 cases within the bundle. Dr. Contado also commented that Urology and ENT procedures are performed by surgeons that are not General and Vascular and perhaps should be reflected in the Rules & Regulations of their own division. Ms. Bowen stated she did not know the history of these Rules & Regulations but would report back on her findings. **It was moved by Dr. Contardo to recommend approval of the Division of General and Vascular Surgery Rules & Regulations as presented and amended. Director Reno seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve the Division of General & Vascular Surgery Rules & Regulations as amended; item to appear on next Board agenda and included in Board agenda packet.	Ms. Donnellan
b. Review and discussion of Board Policy 14-038 Liability Insurance Requirements	Per discussion at last month's meeting, General Counsel stated Board Policy #14-038 was amended to include Allied Health Professionals. Director Finnila suggested verbiage contained in section II. B. line 1 be revised to read "must provide a current certificate of		

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

	insurance or other acceptable evidence of liability coverage to the hospital". Dr. Contardo noted in section II A., line one the word "with" should NOT be stricken. Director Reno questioned if the policy applies to midwives. General Counsel stated Allied Health Professionals does include midwives. Ms. Bowen explained often times a supervising physician may also cover a midwife under their malpractice insurance. **It was moved by Director Finnila to recommend approval of the amendments to Board Policy 14-038 Medical Staff Liability Insurance Requirements contingent upon approved by the Medical Executive Committee. Dr. Contardo seconded the motion. The motion passed unanimously**.	Recommendation to be sent to the Board of Directors to approve amended Board Policy 14-038 – Liability Insurance Requirements pending approval by the Medical Executive Committee; item to appear on next Board agenda and included in Board Agenda packet	MEC Ms. Donnellan
c. Review and discussion of proposed Medical Staff document flow process	Review and discussion of proposed Medical Staff document flow process was pulled by the Chair.	Proposed Medical Staff document flow process to be placed on a future agenda.	Ms. Donnellan
d. Review and discussion of Governance & Legislative Committee Charter	Chairman Schallock stated the Committee's Charter was included on today's agenda to incorporate the Medical Staff document flow process and would be brought forward in conjunction with the flow charts. Director Finnila requested clarification on Section I. 1. j related to executive succession plans. General Counsel stated Board Policy #14-037 describes succession planning for the Chief Executive Officer and the policy could be cross-referenced in the Charter. Director Finnila suggested there be succession planning in place for all staff that the Board hires which includes the CEO, CCO and General Counsel. Mr. Moser suggested the Board's succession planning policy come back to the committee for discussion of succession planning for the three positions described. With regard to Section I. 1. l. Dr. Ma stated the question remains as to in what sequence the Medical Staff Bylaw amendments go to the Board. Again, Chairman		

Topic	Discussion	Action Follow-up	Person(s) Responsible
			DRAFT
	Schallock stated this issue would be addressed in conjunction with the Medical Staff document flow process previously discussed. **It was moved by Director Finnila to amend the Charter to cross-reference Board Policy #14-037 CEO Succession Planning Policy in section I. 1. j. and bring Board Policy #14-037 back to the committee for discussion. Dr. Contardo seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve the Charter as amended; item to appear on next Board agenda and included in Board agenda packet. Board Policy #14-37 CEO Succession Planning Policy to be placed on the Committee's next agenda for discussion.	Ms. Donnellan Ms. Donnellan
7. Discussion regarding Current Legislation	Chairman Schallock reported the Governor is still in the process of signing bills.	Information only.	
8. Review of FY2016 Committee Work Plan	The FY2016 Committee Work Plan was included in today's meeting packet for reference. Chairman Schallock noted all Board Committees will review their Charters in the spring. Chairman Schallock also noted the Board will hold a Workshop on November 12th.	Information only.	
9. Committee Communications	Director Finnila commented on alternative ways to finance developments such as the Infrastructure Financing District wherein the District would form a district of low income housing around the hospital and receive a lower financing interest rate.	Information only.	
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, November 3, at 12:30 p.m.		
12. Adjournment	Chairman Schallock adjourned the meeting at 1:28 p.m.		

I. MEMBERSHIP

The Division of Neurosurgery consists of physicians who are ~~B~~board ~~C~~certified or are actively progressing towards ~~pursuing~~ certification by the American Board of Neurological Surgery and obtain board certification within sixty (60) months of appointment to the Medical Staff (for physicians who were granted such privileges on or after June 1, 1991)~~(effective retroactive to 2000)~~, or be able to demonstrate comparable ability, training and experience.

II. FUNCTIONS OF THE DIVISION

The general functions of the Division of Neurosurgery shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating~~on~~ the quality, safety and appropriateness of care and treatment provided to patients ~~within the hospital~~ by members of the Division and develop criteria for use in the evaluation of patient care~~;~~.

B. Recommend ~~to the Department of Surgery and~~ to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the ~~division~~hospital~~,~~.

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Division clinical practice~~;~~.

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

E. Submit written ~~reports~~ minutes to the ~~Department of Surgery,~~ the QA/PI/PS Committee and Medical Executive Committee concerning:
   1. ~~The division's~~ Division review and evaluation ~~of~~ activities, actions taken thereon, and the results of such actions; ~~and~~
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital~~;~~.
   3. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring~~;~~.
   4. Take appropriate action when important problems in patient care, safety and clinical performance or opportunities to improve patient care are identified~~;~~.
   5. Recommend/Request Focused Professional Practice Evaluation as indicated ~~for Medical Staff members~~ (pursuant to Medical Staff Policy 8710-509)~~;~~.
   6. ~~Approval of~~ Approve On-Going Professional Practice Evaluation Indicators~~; and~~.
   7. Formulate recommendations for Division ~~R~~rules and ~~R~~regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the ~~Department of Surgery and the~~ Medical Executive Committee.

III. DIVISION MEETINGS

The Division of Neurosurgery shall meet ~~no less than annually, or~~ at the discretion of the ~~division c~~Chief, ~~but~~ at least annually. The ~~d~~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 ~~Department of Surgery,~~ QA/PI/PS Committee, and then to the Medical Executive Committee. ~~The Division Chief is required to attend the Department Meetings to review the reports.~~

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 Chief of the Division of Neurosurgery ~~shall have a Chief who~~ shall be ~~is~~ 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~~Neurosurgery~~.

The Division Chief shall be elected ~~by division members~~ every year by the Active ~~Staff M~~members of the Division who are eligible to vote. If there ~~are vacancies of~~ is a vacancy for any officer for any reason, the Department Chairman shall designate a new ~~officer(s)~~Chief, or call a special election. The ~~c~~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 ~~m~~Medical ~~s~~Staff year unless ~~they~~ he/she resigns, is~~be~~ removed from office, or loses ~~their~~ his/her ~~m~~Medical ~~s~~Staff membership or clinical privileges in the ~~that d~~Division. Division officers shall be eligible to succeed themselves.

V. DUTIES OF THE DIVISION CHIEFS

The Division ~~Chief,~~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. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form~~card~~;~~.~~
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 ~~within the division~~ by members of the Division are monitored and evaluated; ~~and~~
G. Other duties as ~~designated by~~ recommended from the Department of Surgery, QA/PI/PS Committee or the Medical Executive Committee.

VI. CLASSIFICATIONS

The Division of Neurosurgery has established the following classifications of surgical privileges:

A. Physicians/Surgeons

~~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 sixty (60) months of his/her appointment to the Medical Staff if recently out of training or fellowship, or otherwise obtain Board Certification within thirty-six (36) months, if out previously with no more than five (5) years after completing written boards for Neurosurgery. Failure to obtain timely certification shall be considered in making division recommendations regarding applications for reappointment and renewal of clinical privileges.~~

Division of Neurosurgery members 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 a sub-specialist. Such physicians may act as consultants to others and may, in turn, be expected to request consultation when:

1. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness;

2. Unexpected complications arise which are outside this level of competence;
3. Specialized treatment or procedures are contemplated with which they are not familiar.

A member of the Division of Neurosurgery may admit, consult or dictate histories and physicals in the Rehabilitation Unit for the following diagnoses: spinal cord injury (non-ventilator dependent), traumatic brain injury, CVA, neurological disorders, and orthopedic procedures.

B. ~~Physician Assistant~~Supervising Physician~~s~~

~~1. A Physician Assistant may only provide those medical services, which he/she is competent to perform and which are consistent with the physician assistant's education, training and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant.~~

~~2.~~1. A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients;~~.~~

~~3.~~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.

~~4. A physician assistant may not admit or discharge patients.~~

~~The Physician Assistant must adhere to the Allied Health Practitioner (AHP) Rules & Regulations.~~

~~5. Refer to the AHP rules and regulations for further delineation of sponsoring physicians' supervision requirements.~~

C. Physician Assistants

1. A Physician Assistant may only provide those medical services, which he/she is competent to perform and which are consistent with the physician assistant's education, training and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant;
2. A physician assistant may not admit or discharge patients;
3. The Physician Assistant must adhere to the Allied Health Practitioner (AHP) Rules & Regulations.

~~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.~~

~~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.~~

~~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)~~

~~Non-Scheduled Admission(s): Examination of the patient by the sponsoring physician(s) the same day as care is given by the AHP~~

~~Physician Assistants under the supervision directly of a designated neurosurgeon shall be allowed, per the AHP rules and regulations of Tri-City Medical Center to:~~

~~Make rounds;~~

~~Write orders;~~

~~Assist in surgery;~~

~~Dictate discharge and transfer summaries;~~

~~Provide initial assessment for consults provided that the assessment and consultation be done within timely fashion as per standard practice at Tri-City Medical Center for consultations.~~

~~C.~~D. Nurse Practitioners as Surgical First Assist

1. The Nurse Practitioner is a Registered Nurse who is a nationally certified Perioperative Nurse (CNOR) through the Association of Peri-Operative Registered Nurses (AORN) or certified by the State of California Board of Registered Nursing as a Nurse Practitioner and has successfully completed an AORN-approved Registered Nurse First Assist (RNFA) course.
2. The Nurse Practitioner practices under the supervision of the surgeon during the preoperative, intraoperative, and postoperative phases of the perioperative experience.
3. The Nurse Practitioner functions under standardized procedures and must adhere to the Allied Health Practitioner (AHP) Rules & Regulations.

VII. ~~INITIAL APPOINTMENT & REAPPOINTMENT AND RENEWAL OF CLINICAL PRIVILEGES~~

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.

~~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.~~

B. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.

~~Neurosurgery~~ Privileges	~~Requirements for Initial Granting of Privileges~~Initial Appointment	Proctoring ~~Required~~	~~Requirements for renewal of Privileges Q 2 years~~Reappointment (every 2 years)
Admit patients Consultation, including via telemedicine (F) History and physical examination, including via telemedicine (F)	~~Training~~Successful completion of an ACGME- or AOA-accredited residency or fellowship in Neurosurgery	~~NA~~Proctoring considered complete upon successful completion of proctoring for the General Neurosurgery Privileges	~~NA~~Included in the reappointment requirements for the General Neurosurgery Privileges
GENERAL NEUROSURGERY PRIVILEGES			
CRANIAL/SKULL BASE CATEGORY: Ablative surgery for epilepsy ~~Cranial and Intracranial procedures, including shunts~~ All types of craniotomies, craniectomies, and reconstructive procedures	1. Successful completion of an ACGME- or AOA-accredited residency in neurological surgery. 2. Documentation of	Six (6) cases, at least two (2) cases must be proctored for each of the 3 categories ~~category~~ of privileges	All General Neurosurgery Privileges: Fifty (50) cases reflective of the privileges requested

~~Neurosurgery~~ Privileges	~~Requirements for Initial Granting of Privileges~~Initial Appointment	Proctoring ~~Required~~	~~Requirements for renewal of Privileges Q 2 years~~Reappointment (every 2 years)
(including microscopic) on the skull, including surgery on the brain, meninges, pituitary gland, and cranial nerves and including surgery for cranial trauma and intracranial vascular lesions	one-hundred (100) cases from the previous twenty-four (24) months representative of the privileges requested.	granted (cranial/ skull based; spine; and/or nervous system).	
Arteriography and angiography and complex interventional cases*	~~10 / 2 years~~	~~2~~	~~04~~
Management of congenital anomalies, such as encephalocele, meningocele, and myelomeningocele			
Shunts (VP, ventriculoatrial, ventriculopleural, subdural peritoneal, and lumbar subarachnoid/peritoneal [or other cavity])			
Tracheostomy	~~4 / 2 years~~	~~No~~	~~2~~
Transsphenoidal procedures for lesions of the sellar or parasellar region, fluid leak, or fracture			
Ventricular shunt operation for hydrocephalus, revision of shunt operation, and ventriculocisternostomy			
Ventriculography	~~0~~	~~No~~	~~0~~
SPINE CATEGORY:			
Correction costoclavicular Compression and related procedures	~~1 / 2 years~~	~~No~~	~~0~~
Discography and intradiscal/percutaneous disc treatments			
Epidural steroid injections for pain			
Implantables (intrathecal or			

~~Neurosurgery~~ Privileges	~~Requirements for Initial Granting of Privileges~~Initial Appointment	Proctoring ~~Required~~	~~Requirements for renewal of Privileges Q 2 years~~Reappointment (every 2 years)
epidural infusion pumps with tunneled catheter, spinal cord stimulator)			
Insertion of subarachnoid or epidural catheter with reservoir or pump for drug infusion or cerebrospinal fluid withdrawal			
Intradiscal electrothermal annuloplasty			
Laminectomies, laminotomies, and fixation and reconstructive procedures of the spine and its contents, including instrumentation			
Lumbar puncture, cisternal puncture, ventricular tap, and subdural tap			
Myelography	~~3 / 2 years~~	~~2~~	~~1~~
Nucleoplasty			
Percutaneous and subcutaneous implantation of neurostimulator electrodes			
Posterior fossa-microvascular decompression procedures			
Radiofrequency thermocoagulation ablation (RFTC)			
Sacral fusion			
Spinal cord surgery for decompression of spinal cord or spinal canal, for intramedullary lesion, intradural extramedullary lesion, rhizotomy, cordotomy, dorsal root entry zone lesion, tethered spinal cord, or other congenital anomalies (e.g., diastematomyelia)			

~~Neurosurgery~~ Privileges	~~Requirements for Initial Granting of Privileges~~Initial Appointment	Proctoring ~~Required~~	~~Requirements for renewal of Privileges Q 2 years~~Reappointment (every 2 years)
Surgery for intervertebral disc disease			
~~Complex spine procedures requiring instrumentation~~	~~10 / 2 years~~	~~2~~	~~8~~
~~Cranial and Intracranial procedures, including shunts~~	~~10 / 2 years~~	~~2~~	~~8~~
~~Para and Intraspinal Procedures, including cordotomy~~	~~10 / 2 years~~	~~4~~	~~8~~
NERVOUS SYSTEM CATEGORY:			
Autonomic Nervous Systems Surgery	~~1 / 2 years~~	~~No~~	
Biopsy: nerve, muscle			
Cranial nerve blocks – all types			
Peripheral nerve ~~surgery primary repairs~~ procedures, including temporary and permanent blocks, decompressive procedures, and reconstructive procedures on the peripheral nerves	~~5 / 2 years~~	~~No~~	~~2~~
~~Peripheral Nerve Blocks Temporary and Permanent~~	~~3 / 2 years~~	~~No~~	~~2~~
~~Peripheral Nerve Surgery Delayed and Immediate Nerve Grafts~~	~~1 / 2 years~~	~~No~~	~~2~~
Selective blocks for pain, chemo-denervation, stellate ganglion blocks, intra-muscular phenol Injections, and nerve blocks			
Sympathetic nervous system			
SPECIAL PROCEDURES:			
~~Kyphoplasty~~Vertebral augmentation	Per MS Policy # 534	Per MS Policy # 534	Per MS Policy # 534
Sedation:	Per MS policy 517	Per MS policy	Per MS policy 517

~~Neurosurgery~~ Privileges	~~Requirements for Initial Granting of Privileges~~Initial Appointment	Proctoring ~~Required~~	~~Requirements for renewal of Privileges Q 2 years~~Reappointment (every 2 years)
Moderate		517	
Laser privileges: • Argon	Documentation of completion of training for specific energy source(s) to be used. Or, if training completed greater than two years prior to privilege request, submit case logs from previous twenty-four (24) months identifying specific energy source used.	One (1) case for each energy source	Two (2) cases

~~VIII. LASER PRIVILEGES~~

~~Copy of certificate of completion of course specific to type of laser and copy of course outline required.~~

~~*The American Society for Laser Medicine and Surgery (ASLMS) recommends:~~

~~A. The physicians have interventional privileges in their specialty before (or in conjunction with) requesting laser privileges.~~

~~B. Training in respective Residency Program (competency verified by Program Director) or completion of an appropriate course, eight to ten hours in length ("40% of the course time allocated to practical sessions"). Longer courses/additional practical sessions may be indicated for different wavelengths/different applications or delivery instruments.~~

~~Criteria~~	~~Argon Laser~~
~~Initial Criteria~~	~~ASLMS # 2~~
~~Reappointment Criteria~~	~~One per year~~
~~Proctoring~~	~~Two~~

VIII. 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).

X. PROCTORING OF PRIVILEGES

Each new ~~m~~Medical ~~s~~Staff member granted initial privileges, or Medical Staff member requesting additional ~~surgical~~ privileges shall be evaluated by a proctor ~~in each surgical case~~ as indicated until his or her ~~surgical~~ privilege status is established by a recommendation from the ~~Division, the~~ Department of Surgery~~,~~ 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.~~

A. All ~~a~~Active ~~staff~~ members of the Division ~~of Neurosurgery~~ 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 responsibility of the Division Chief to inform the ~~monitored applicant~~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.

~~A.~~B. The member is responsible for arranging a proctor.

~~B.~~C. The new medical staff member shall select an appropriate member from the Neurosurgery Division to proctor his/her operative case. He or she shall contact the monitor and inform him of his plans for the case.

~~C.~~D. 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.

~~D.~~E. The ~~new medical staff~~ member shall have free choice of suitable consultants and assistants. The proctor may assist the surgeon.

~~X. REPORTS OF PROCTORS~~

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.

~~A.~~G. A ~~report~~ form shall be completed by the proctor, and should include comments on ~~which the proctor will address the patient's~~ preoperative workup, diagnosis, ~~the procedure performed, the~~ preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and ~~a~~ 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.

~~B.~~H. Forms will be made ~~up by~~ available to the ~~new medical staff~~ member ~~admitting~~ scheduling the ~~patient~~ 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 ~~of~~ for each case.

~~C.~~I. 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~~.

~~XI. LENGTH OF THE PROBATIONARY PERIOD~~

~~The new medical staff member shall be observed by proctor as defined in the table above for an indefinite period. A proctor may be scheduled as a consultant.~~

~~XII.~~X. EMERGENCY DEPARTMENT CALL

~~Medical Staff~~ Division ~~M~~members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. ~~with individual scheduling by the division chief. Refer to Policy #520.~~ The care provided by an on-call physician will not create an obligation to provide further care. Refer to Medical Staff Policy and Procedure 8710-520.

Provisional ~~or Courtesy~~ staff members may participate ~~in~~on the Emergency Department Call ~~panel~~ Roster at the discretion of the Chief of the Division ~~Chief or Department Chair~~.

Approvals:
Division of Neurosurgery: 06/11/2015
Department of Surgery: 06/18/2015
Medical Executive Committee: 07/27/2015
Governance Committee:
Board of Directors:

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~~ QA/PI/PS 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
Admit Consult	Training	3 ~~H&P's either~~	4 every two years

H&P			~~as~~cases either IP or OP within the first six (6) months	

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.~~1. 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. A standardized proctoring form will be used in the procedure.

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:	06/26/2015 08/13/2015
Medicine Department:	06/26/2015 08/13/2015
Medical Executive Committee:	07/27/2015 08/24/2015
Governance Committee	~~08/04/2015~~ 10/06/2015
Board of Directors:	~~06/26/14~~

I. MEMBERSHIP

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

II. FUNCTIONS OF THE DIVISION

The general functions of the Division of General and Vascular Surgery shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care.

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital.

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Division clinical practice.

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

E. Submit written minutes to the QA/PI Committee and Medical Executive Committee concerning:
   1. Division review and evaluation of activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring.

G. Take appropriate action when important problems in patient care, patient safety, and clinical performance or opportunities to improve patient care are identified

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509).

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

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

III. DIVISION MEETINGS

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

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

IV. DIVISION OFFICERS

The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Division.

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

The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in that Division. Division officers shall be eligible to succeed themselves.

V. **DUTIES OF THE DIVISION CHIEF**

The Division Chief shall assume the following responsibilities:

A. Accountability for all professional and administrative activities of the Division.
B. Ongoing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division.
C. Ensuring practitioners practice only within the scope of the privileges defined within their delineated privilege form.
D. Recommendations to the Department of Surgery and the Medical Executive Committee the criteria for clinical privileges in the Division.
E. Recommendations of clinical privileges for each member of the Division.
F. Ensuring that the quality, safety, and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Other duties as recommended by the Department of Surgery or the Medical Executive Committee.

VI. **PRIVILEGES**

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.
B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.
C. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.
D. **Physician Assistants** – In accordance with Department of Surgery rules and regulations.
E. **Registered Nurse First Assist (RNFA)** – In accordance with Department of Surgery rules and regulations.
F. **Forensic Outpatient Site-Specific Privileges** – Privileges annotated with an (F) indicates privileges that may be performed at either Tri-City Medical Center or the Forensic Outpatient Clinic.

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

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

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

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

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

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Advanced Head & Neck Surgery: • Parotid gland • Salivary glands & ducts • Thymectomy	• Basic General Surgery privileges which effectively covers the need for board certification. • Twenty (20) advanced head and neck procedures during the previous twenty-four (24) months.	Two (2) cases from this category	Ten (10) cases from this category
ADVANCED PERIPHERAL VASCULAR SURGERY:			
• Aortic, aorto-iliac, aorto-femoral bypass • Axillary-femoral bypass • Bypass of upper extremity vessel • Carotid – Subclavian bypass • Celiac/superior mesenteric axis endarterectomy, repair or bypass • Embolectomy or thrombectomy • Endarterectomy, carotid • Endarterectomy or bypass, vertebral • Endarterectomy, repair or bypass, renal artery • Exploration, repair, thrombectomy, or embolectomy of abdominal aorta, iliac, femoral or infrageniculate artery • Femoral to femoral bypass • Femoral to infrageniculate bypass • Femoral to popliteal bypass • Repair of aortic branches • Repair of iliac, femoral, popliteal, or mesenteric aneurysm • Repair of infra or suprarenal aortic aneurysm • Repair of upper extremity vessel • Retroperitoneal exposure for spine vertebral body procedures, includes incidental vascular procedures* • Upper and lower extremity deep or superficial vein procedures • Upper or lower extremity fistula, autogenous or artificial placement of central venous	• Basic General Peripheral Vascular Surgery privileges which effectively covers the need for board certification. • Forty (40) vascular cases within the previous twenty-four (24) months (With application, submit list of major procedures done in two (2) years preceding application. Include indications, results, morbidity and mortality data and operative reports.) • *If only Retroperitoneal exposure for spine vertebral body procedures privilege is requested, documentation of five (5) cases within the previous twenty-four (24) months <u>and</u> documentation of current privileges in vascular or trauma surgery at a healthcare facility. All other privileges in the category must be crossed out.	• Five (5) cases from this category • * If only Retroperitoneal exposure for spine vertebral body procedures privilege is requested, two (2) cases	• Twenty (20) vascular cases from this category • *If only Retroperitoneal exposure for spine vertebral body procedures granted, five (5) cases <u>and</u> documentation of current privileges in vascular or trauma surgery at a healthcare facility. All other privileges in the category must be crossed out.

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
catheter placement			
SPECIAL PRIVILEGES:			
Bariatric Surgery: • Roux en Y gastric bypass, open and laparoscopic • Sleeve gastrectomy, open and laparoscopic • Adjustable gastric banding, open and laparoscopic • Revisional metabolic and bariatric surgery, open and laparoscopic • Biliopancreatic diversion, with or without duodenal switch, open and laparoscopic • Bariatric Endoscopy	• Completion of General Surgery residency program. • Privileges to perform Basic and Advanced Abdominal surgery and advanced laparoscopy. • Completion of a Bariatric and Metabolic Surgery fellowship, or Minimally Invasive fellowship with documentation of rotation in Bariatrics and the performance of a minimum of five (5) cases within the previous twenty-four (24) months, or case logs documenting the performance of a minimum of fifteen (15) bariatric cases and (10) Bariatric Endoscopy cases within the previous twenty-four (24) months. • ~~Commitment to participate in TCMC's Bariatric Committee and comply with Medical Staff policy 8710-572.~~ • Documentation to indicate malpractice coverage includes bariatric surgery.	Three (3) Bariatric cases and Three (3) Bariatric EGD Cases	• Fifteen (15) cases within the previous twenty-four (24) months • ~~Participatation in TCMC's Bariatric Committee as evidenced by compliance with Medical Staff policy 8710-572.~~
Colonoscopy	Completion of an ACGME accredited training program in General Surgery or Colon and Rectal surgery within the previous twenty four (24) months. If training was completed greater than twenty four (24) months ago, documentation of a refresher training course in lower endoscopy or documentation of fifty (50) cases within the	Two (2) cases if training was completed within the previous twenty-four (24) months prior to granting of privileges or if training was completed	Ten (10) cases

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

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

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
	course, or have performed at least five (5) TIF procedures in the previous twelve (12) months		
Placement of Vagal Nerve Stimulator	1. Basic General Surgery privileges which effectively covers the need for board certification. 2. Documentation of performing five (5) vagal nerve stimulator cases in the previous twenty-four (24) months 3. Must have Carotid Endarterectomy privileges.	Two (2) cases	Five (5) cases

VII. **REQUIREMENTS FOR REAPPOINTMENT**

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

B. Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the physician will be required to undergo proctoring for all procedures that were not satisfied. The physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. **PROCTORING OF PRIVILEGES**

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated, until his or her privilege status is established by a recommendation from the Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

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

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

D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).

E. The member shall have free choice of suitable consultants and assistants. The proctor may assist the surgeon.

F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

G. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Operating Room Supervisor and/or the Medical Staff Office.

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

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

IX. **EMERGENCY DEPARTMENT CALL:**

A. Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520.

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

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

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

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

APPROVALS:

General & Vascular Surgery Division: ~~6/11/2015~~ 9/10/2015
Surgery Department: ~~06/18/2015~~ 10/1/2015
Medical Executive Committee: ~~06/22/2015~~
Governance Committee: ~~07/07/2015~~ 10/6/2015
Board of Directors: ~~07/30/2015~~

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #14-039

POLICY TITLE: Comprehensive Code of Conduct

The following is the Board-approved Code of Conduct for District Board Meetings:

I. PURPOSES AND GOALS OF CODE OF CONDUCT.

Effective leadership requires the Board to foster effective communication throughout the organization. Effective communication is necessary to encourage the delivery of safe, high quality care, as well as compliance with ethical and legal imperatives. Effective communication occurs best in an atmosphere of mutual respect, in which patients, physicians, hospital staff and members of the public, as well as members of the Board, feel valued and free to express themselves. Effective communication requires thorough preparation for meetings, adherence to approved procedures for the conduct of meetings, including compliance with time limits and courteous conduct during debate and discussion. Effective communication requires an atmosphere free from threats, intimidation, abusive behavior, violence, harassment, and other dangerous or disorderly conduct.

The Board believes that at a minimum, its members must behave as if they are fiduciaries who are expected to honor the same duties of loyalty and care expected of their peers who serve on the boards of non-profit hospitals. Board members should act professionally at all times.

This Code of Conduct is intended to describe: (1) minimum expectations for conduct at, and surrounding Board meetings; (2) how Board members are provided the resources needed for effective, informed governance; (3) rules for ensuring the fairness of proceedings; and to (4) prescribe consequences for misconduct which does not contribute to effective leadership of TCMC, including making Board members ineligible for receipt of discretionary perquisites of office within the jurisdiction of the Board.

II. MINIMUM EXPECTATIONS FOR CONDUCT OF BOARD MEETINGS

1. Once the Board has a quorum, the meeting should immediately commence. Time periods announced by the Chair for recesses shall be strictly observed.

2. For each agenda item on which there is anticipated action, at the discretion of the Chair or upon request by any Board member, consideration may commence with a staff presentation or other report or public comments, or with a motion and a second. Board discussion shall be permitted following any presentation or public comments, except that:

a. any Board member who must abstain from participation in a matter because of a legal conflict of interest shall ask the Chair for permission to announce the conflict prior to consideration of the item; and

b. any Board member who has had any ~~*ex parte* contacts~~ discussions or received information prior to the meeting with respect to an agenda item which will affect~~ing the~~ substantial legal rights of a party appearing before the Board such as regarding credentialing of a health care provider, proposed imposition of sanctions on a Board member, or another ~~on a~~ quasi-judicial matter, shall, prior to consideration of the item, ask the Chair for permission to describe the nature of those contacts. Disclosing such information helps ensure ~~so that the party may evaluate the potential partiality and appearance of~~ fairness of ~~the Board member's participation in decisionmaking regarding that matter~~ Board decisions by ensuring that, to the extent possible, all involved have the same information regarding the matter. In case of doubt, a Board member shall err on the side of disclosing~~disclosure of the *ex parte* contacts~~ relevant information obtained outside of the meeting, including who provided the information and in what circumstances.

c. If the requestor for an item is listed as "Standard," any member may make the first motion. If the anticipated action is based on a recommendation from a Board committee, the first motion should normally be made by the Chair of that committee. If a particular member is listed as the requestor for the item, the first motion on the item should normally be made by that member.

3. If there is no motion on an action item, or if a motion is made and there is no second, the Chair should move to the next agenda item without further comment from the Board members.

4. For each agenda item that has received a motion and a second, the Chair should ask each member in turn as to whether that member wishes to address the motion, starting with the maker of the motion.

5. Each member will be recognized by the Chair and shall be allotted up to 3 minutes to speak to the motion, once recognized. Time for questions and answers addressed by a member to staff or to other Board members is included in the three minutes, unless the Chair grants an exception. Members who anticipate that this time will be insufficient shall, whenever feasible: (1) submit written statements at any time; (2) submit written questions to the Chair and CEO at least 48 hours in advance of a regular meeting when feasible (see II, B, above); or (3) request additional time. Only the member who has been recognized may speak on the motion during that time. Once a member is recognized, a

timekeeper selected by the Chair will start the three-minute clock upon the direction of the Chair. A person other than the Chair shall operate the time clock under the direction of the Chair. Upon expiration of the allotted time, the timekeeper shall notify the Chair by word or sign. Time limits are to be consistently and strictly enforced.

6. When the member's three-minute time allotment has concluded, the Chair should immediately recognize the next member in turn to determine if he/she wishes to speak. When recognized, the member should start speaking and the prior speaker shall promptly yield the floor

7. Once the Chair has offered each member the opportunity to be heard, the Chair may offer a second round of comments. The Chair should again offer each member a three-minute opportunity to speak.

8. Unless recognized by the Chair, Board members shall not address members of the public who come forward to speak, and should not enter into a dialogue or debate. Members of the public shall be recognized to speak in accordance with Board Policy No. 10-018.

9. Agenda materials are intended to provide answers to as many questions as possible regarding agenda items, prior to the Board meetings. Board members are expected to review the agenda materials thoroughly, prior to the Board meetings, and to timely request additional information or clarification in advance whenever feasible—generally prior to any regular meeting. Questions from Board members at the meetings should be for the purposes of seeking clarification and/or additional information regarding particular agenda items and/or agenda materials.

10. Board members should be courteous and respectful of all meeting participants, including the Chair. Board members shall comply with the legitimate orders of the Chair regarding the orderly conduct of the business before the Board.

11. Conduct while attending Board meetings and other meetings and events related to the Board and Board committees, and while engaged in other Board-related business, which is unsafe, disruptive or which constitutes threats, intimidation, abusive behavior, violence, harassment, and other dangerous or disorderly conduct, willful disturbance of the meeting or which otherwise violates Penal Code section 403 is prohibited. Board members shall comply with, and are subject to the District Harassment policy, which is set forth in Exhibit "A" to this Policy.

12. Board members and other persons shall comply with all applicable Board Policies pertaining to the conduct of board meetings, including but not limited to Board Policy #07-010 (Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings) #07-22

(Maintenance of Confidentiality) and Board Policy 10-018 (Public Comments at the Tri-City Healthcare District Board of Directors Meetings/Committee Meetings).

13. Board Members should attend every Board Meeting and remain for the entirety of each meeting, including returning to the meeting after exclusion from closed session or any portion thereof. The Board Chair shall make an oral announcement of any departure from the meeting and the reason, if available.

III. BREACHES OF ORDER AT MEETINGS; SANCTIONS.

The Board has a right to make and enforce rules to ensure the conduct of the public's business in an efficient and orderly manner, and without disruption by members of the public or members of the Board. At the same time, the public and Board members shall be free to criticize the policies, procedures, programs and services of the organization, and the acts and omissions of the Board.

Notwithstanding any other policy of the Board, violations of this policy during a Board meeting may be enforced, as follows:

1. The Chair shall call to order, by name, any person who is in violation of any of the rules of conduct established under this policy, and Board Policy No. 10-018, which is committed in the immediate view and presence of the Board. The Chair shall request that person refrain from any further violation, warn that a repetition may violate Penal Code section 403 and result in removal from the meeting, and may specifically state that any further violation may constitute contempt of the Board.

2. If the person repeats the violation or proceeds to violate any other provision of this policy in the immediate view and presence of the Board (such as by refusing to yield the floor or otherwise disrupting proceedings), the Chair may call a recess of the meeting, stating that the reason for the delay is due to the misconduct of the Board member or other person. If following such recess, the Board member or other person persists in willfully interrupting the meeting such that order cannot be restored, the Chair, with the concurrence of the Board, shall order the disruptive Board member or other person removed from the meeting room by District security personnel, or, as to Board members, may request a motion under paragraph 3. If removal of a Board member is ordered, the Board member shall be entitled to adjourn to attend the balance of the meeting by telephone at the meeting location or other location consistent with the Brown Act, notwithstanding the provisions of any other Board policy.

3. In the alternative, if a Board member repeats the violation or proceeds to violate any other provision of this policy in the immediate view and

presence of the Board, or, following a return from recess of the meeting if called, the Chair may call for a motion holding the Board member in contempt. Such a motion shall take precedence over any other motion, and shall describe the action or actions constituting the violation of this policy. If such a motion is made and seconded, each board member shall have an opportunity to discuss the motion in accordance with this policy. If the motion is passed, the Board member shall be advised by the Chair that he or she has been held in contempt. A second motion may then be made to prescribe the sanction or sanctions to be imposed, which may include, but shall not be limited to, one or more of the following:

a. A statement of censure, identifying the misconduct;

b. Removal of the offending Board member from membership on one or more Board committees, or, if chair of any committee, removal from that position, for a specified period, or if no period is specified, until the annual election of Board officers;

c. Removal of the offending Board member from holding any Board office currently held;

d. Removal of the offending Board member from the meeting room and offering the member the right to adjourn to attend the balance of the meeting by telephone at the meeting location or another location consistent with the Brown Act (notwithstanding the provisions of any other Board policy) ; provided that the offending Board member may also be required to attend one or more future meetings by teleconference;

e. A determination that no compensation shall be earned by the offending Board member for attendance at the meeting at which the contempt occurred;

f. A determination that the offending Board member shall not be provided any defense or indemnity in any civil actions or proceedings arising out of or related to the member's misconduct or the agenda items whose consideration was wilfully disrupted or prejudicially delayed by the misconduct, based upon the Board member's actual malice;

g. Rendering the offending Board member ineligible to receive any advances or reimbursement of expenses to attend future conferences or meetings otherwise permitted under Board Policy #07-020 (except those previously-approved for which expenses have been incurred prior to the time of the finding of contempt),

for a period of time or subject to conditions specified in the motion;

h. Referral of the matter to the County Criminal Grand Jury pursuant to Government Code section 3060.

i. Referral of the matter to the Fair Political Practices Commission or other prosecuting authority with jurisdiction over the matter.

4. Following the outcome of a motion for sanctions, the Chair shall direct that the order of the Board be carried out by security, the Chief Executive Officer, and/or General Counsel, as appropriate.

5. In the event violations of this Policy occur in a closed session, the Chair may suspend the closed session and return to open session for the purpose of commencing the enforcement process contemplated by this section. All proceedings under this section III shall occur in open session.

IV. VIOLATIONS OF BOARD POLICIES OUTSIDE OF BOARD MEETINGS.

1. Board members shall not act on behalf of, nor represent themselves as speaking on behalf of, the Board without the Board's express authorization.

2. When a violation of a Board policy by a member of the Board is alleged to have occurred outside of a Board meeting, the Chair or any member of the Board may request that an item be placed on the agenda to consider what sanctions may be appropriate, if any. In such instances, evidence of the misconduct shall be presented by the requesting member. The Board member accused of misconduct shall have an opportunity to present evidence and respond to the allegations made. Formal rules of evidence shall not apply.

3. After consideration of the evidence presented, the Board may take such actions as it may deem appropriate, including but not limited to those described in section III of this policy, other than paragraph III(e) .

V. AUTHORITY OF ADMINISTRATION TO PROVIDE FOR SECURITY.

1. The District Administration is authorized and directed to develop and implement policies and procedures designed, engage employees or contractors to provide security, consistent with applicable law, to promote a secure and orderly environment for Directors, employees, staff, and members of the public. These policies and procedures will include a process for notifying the District Administration in the event that any person feels that he or she has been subjected to conduct which violates this Policy.

2. The District Administration is authorized and directed to take lawful and appropriate action and to pursue lawful and appropriate remedies against any person found to have violated this Policy.

VI. BOARD ORIENTATION AND TRAINING

1. Every Board member shall participate in an orientation and training to be offered by Tri-City Healthcare District within 60 days of election, re-election to office, or assuming office, as a condition to receiving compensation or allowance of expenses.

2. The required orientation and training shall be offered at times and places convenient to the Board member.

3. The orientation and training shall include:

   a. A tour of the facilities owned or operated by Tri-City Healthcare District

   b. An explanation of Board policies, procedures, committee structure and bylaws, and delivery of a copy of the current Board policies, procedures and bylaws

   c. Briefings delivered by members of the management team regarding:

      i. Health care finance

      ii. District financial management and budgeting practices

      iii. Compliance laws and regulations, including conflict of interest rules under State and Federal law and the accreditation process

      iv. Areas of health care and specialties offered

      v. Medical staff organizations and relationship with the hospital

      vi. Nursing policies, staffing and practices

      vii. The roles and responsibilities of each department

      viii. Legal responsibilities of Board members

4. This orientation and training shall supplement the training required by law under AB 1234.

Reviewed by the Gov/Leg Committee: 1/13/10
Approved by the Board of Directors: 1/28/10
Reviewed by Gov/Leg Committee: 4/13/11
Approved by the Board of Directors: 4/28/11
Reviewed by Gov/Leg Committee: 9/14/11
Approved by the Board of Directors: 9/29/11
Reviewed by Gov/Leg Committee: 4/11/12
Approved by the Board of Directors: 4/26/12
Approved by the Board of Directors: 5/31/12
Reviewed by the Gov/Leg Committee: 6/04/13
Approved by the Board of Directors: 6/27/13
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #14-038

POLICY TITLE: Medical Staff Liability Insurance Requirements (Joint Policy with MEC)

I. PURPOSE:

A. To require professional liability insurance or approved form of financial security.

II. POLICY:

A. Consistent with ~~Article VIII of~~ the Tri-City Healthcare District Bylaws and ~~Article IV, Section 4.5-1(g) of~~ the Tri-City Medical Center Medical Staff Bylaws, Rules and Regulations, every Practitioner on the medical staff ~~or with privileges to attend patients at Tri-City Medical Center~~, and every Allied Health Professional, must, ~~as a condition of holding staff membership or attending privileges,~~ either carry professional liability insurance with an insurance company admitted to transact business in California in limits of not less than one million dollars ($1,000,000.00) per occurrence or claim/three million dollars ($3,000,000.00) annual aggregate, or furnish an approved form of equivalent financial security as described below in Subsection 3.

1. The Medical Executive Committee may, without the need to obtain the approval of the Staff, modify the foregoing limits from time to time as may be appropriate to meet the needs of the Hospital and the medical staff and to reflect developments in the insurance industry, with the approval of the Board of Directors.

B. Each insured Practitioner or Allied Health Professional must ~~cause~~ provide a current certificate of insurance or other acceptable evidence of liability coverage to be furnished to the Hospital. The certificate or other evidence of liability coverage must specify the expiration date of the policy and the amount of insurance.

1. If the insurance policy or other coverage is restricted in any manner, the Practitioner or Allied Health Professional must furnish a copy of such restrictions to the Hospital.

2. The Practitioner or Allied Health Professional shall not perform at the Hospital any procedure excluded from the insurance policy or other coverage. The Practitioner or Allied Health Professional shall immediately notify the Hospital if the Practitioner's or Allied Health Professional's insurance or equivalent coverage expires, is reduced

below the limits then in effect at the Hospital, or is canceled or terminated.

C. For purposes of this policy, an "approved form of equivalent financial security" means either:

1. Insurance coverage that is written by or issued in connection with the Practitioner's or Allied Health Professional's membership in a cooperative, as defined in Section 1280.7 of the California Insurance Code; or successor legislation with minimum coverage conforming to the then applicable requirements; or

2. Insurance coverage from an irrevocable trust established by an incorporated professional group to insure its members against damages and defense costs arising out of malpractice claims or litigation, and which has been actuarially determined to meet minimum coverage requirements then applicable.

3. Self insurance coverage established by an incorporated professional group or other entity to insure the Practitioner or Allied Health Professional against damages and defense costs arising out of malpractice claims or litigation and which has been actuarially determined to meet minimum coverage requirements then applicable.

D. These "approved" forms of equivalent security shall be subject to review and approval by the Medical Executive Committee and Board of Directors.

Reviewed by the Gov/Leg Committee: 1/13/10
Approved by the Board of Directors: 1/28/10
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Reviewed by the MEC:
Addressed by the Gov/Leg Committee:
Approved by the MEC:
Approved by the Board of Directors:

Tri-City ical Center
Audit, Compliance & Ethics Committee
October 15, 2015
Assembly Room 3
8:30 a.m-10:30 a. m.

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; Leslie Schwartz, Community Member
Non-Voting Members:	Steve Dietlin (CFO); Tim Moran (CEO); Kapua Conley, COO; Cheryle Bernard-Shaw, CCO
Others Present:	Diane Racicot, General Counsel; Teri Donnellan, Executive Assistant; Kathy Topp, Director of Education and Clinical Informatics; Colleen Thompson, Director of Medical Records, HIM and Privacy Officer
Absent:	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.		
2. Approval of Agenda	**It was moved by Director Schallock and seconded by Mr. Schwartz to approve the agenda as presented. The motion passed unanimously.**	**Agenda approved.**	Ms. Donnellan
3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item	There were no public comments.		
4. Ratification of minutes – September 22, 2015	**It was moved by Director Schallock and seconded by Mr. Schwartz to approve the minutes of the September 22, 2015 meeting as presented. The motion passed unanimously.**	**Minutes ratified**	Ms. Donnellan
5. New Business			
A) Review and discussion of Administrative Policies &	Ms.Thompson stated Policy 8610-519 – Patient Requests to Receive Communications of Protected Health Information		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
Procedures 1. 8610-519 – Patient Requests to Receive Communications of Protected Health Information (PHI) by Alternative Means or at Alternate Locations	(PHI) by Alternative Means or at Alternate Locations simply gives the patient the ability to receive their PHI information at an alternate address or phone number. Minor grammatical changes were suggested. **It was moved by Director Mitchell to recommend approval of Policy 8610-519 – Patient Requests to Receive Communications of Protected Health Information (PHI) by Alternative Means or at Alternate Locations as presented and amended. Mr. Sharp seconded the motion. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to approve Policy 8610-519 – Patient Requests to Receive Communications of Protected Health Information (PHI) by Alternative Means or at Alternate Locations as presented and amended; item to appear on Board agenda and included in Board agenda packet.**	Ms. Donnellan
2. 8610-262 – Ethics in Provision of Services	Ms. Topp stated Policy 8610-262- Ethics in Provision of Services is presented for its 3-year review. She explained there were no major changes in content and cross-references were simply updated. In response to a question related to the media, Ms. Topp explained all media inquiries are directed to the Director of Marketing. General Counsel explained there are strict rules in a separate policy that allows patients to opt in or opt out of the patient directory. **It was moved by Director Mitchell to recommend approval of Policy 8610-262 – Ethics in Provision of Services as presented. Ms. Fitzwilliam seconded the motion. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to approve Policy 8610-262 – Ethics in Provision of Services as presented; item to appear on Board agenda and included in agenda packet.**	Ms. Donnellan

3. 8610-294 – Legal Documents	Ms. Topp stated the main modifications to Policy 8610-294 relate to section B. Summons, Complaints, Garnishments and Subpoenas to ensure there is a screening mechanism in place and the District receives the documents that are served appropriately. Minor grammatical and formatting corrections were suggested. **It was moved by Mr. Schwartz to recommend approval of Policy 8610-294 Legal Documents as presented and amended. Mr. Sharp seconded the motion. The motion passed unanimously.** *Ms. Kathy Topp and Ms. Colleen Thompson left the meeting at 8:53 a.m.*	**Recommendation to be sent to the Board of Directors to approve Policy 8610-294 – Legal Documents as presented and amended; item to appear on Board agenda and included in agenda packet.**	Ms. Donnellan
B) FY2016 Financial Statement Audit	Chairperson Finnila stated the FY2016 Financial Statement Audit was placed on today's agenda to give the committee the opportunity to look at the options of firms to perform the FY2016 Financial Statement Audit. Mr. Dietlin explained the committee needs to consider whether or not to consider a new financial statement auditor and it is important to make this decision prior to field work and the planning phase. He explained the RFP process and the firms that the committee may consider including the "big four" as well as those firms in the next tier. The committee had extensive discussion regarding the advantages and disadvantages of an RFP process versus continuing with Moss Adams. Committee members were in agreement that if Moss Adams were to continue it is important to rotate partners in the interest of best practice. Mr. Dietlin confirmed that most firms encourage a rotation in the managing partner every 5-7 years to provide a fresh set of eyes on the books. **It was moved by Mr. Cumming to authorize Mr. Dietlin to negotiate a one year extension with Moss Adams to perform the FY2016 Audit to include a change in partner**	**Mr. Dietlin to negotiate a one year extension with Moss Adams to perform the**	Mr. Dietlin

	based on best practice. Mr. Schwartz seconded the motion. The motion passed unanimously. The committee expressed an interest in interviewing the potential managing partner(s).	**FY2016 Audit to include a change in partner.**	
6. Old Business A) Review and Discussion of Amendments to Administrative Policy & Procedure: 1. 8610-525 – Use and Disclosure of Protected Health Information (PHI) for Fundraising	Director Finnila stated Policy 8610-525 has been pulled from today's agenda in order to flush out some of the concerns of the committee. General Counsel stated she expects the policy will be ready to come back to the committee next month and Foundation Chief Development Officer, Mr. Glen Newhart will be invited to the meeting.	**Policy 8610-525 – Use and Disclosure of Protected Health Information (PHI) for Fundraising to be brought back to the November meeting for discussion.**	K. Topp/ G. Newhart
7. Oral Announcement of Items to be Discussed during Closed Session (Government Code Section 54957.7)	Chairperson Finnila made an oral announcement of the items listed on the agenda to be discussed during closed session which included approval of closed session minutes and two matters of potential litigation.		
8. Motion to go Into closed session	**It was moved by Ms. Fitzwilliam and seconded by Director Mitchell to go into closed session at 9:39 a.m. The motion passed unanimously.**		
9. Open Session	The committee returned to open session at 10:34 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 November 19, 2015.	**The committee's next meeting is scheduled for November 19, 2015.**	
12. Committee Communications	Mr. Cumming requested a brief update on ICD 10 since the October 1st implementation. Mr. Dietlin stated we will know more by the end of the month, however he does expect the days in A/R to increase and there will likely be an impact on	**Information only.**	

	cash flow.		
13. Adjournment	Chairperson Finnila adjourned the meeting at 10:40 a.m.		

AUDIT, ETHICS AND COMPLIANCE COMMITTEE
October 15th, 2015

Administrative Policies & Procedures			Recommendations
1. ALTERNATIVE MEANS OF COMMUNICATING PROTECTED HEALTH INFORMATION (PHI) **(PATIENT REQUESTS TO RECEIVE COMMUNICATIONS OF PROTECTED HEALTH INFORMATION (PHI) BY ALTERNATIVE MEANS OR AT ALTERNATE LOCATIONS)**	8610-519	**Revision**	Forward to BOD for approval with revisions
2. Ethics in Provision of Services	8610-262	**3 year review, revised**	Forward to BOD for approval
3. Legal Documents	8610-294	**3 year review, revised**	Forward to BOD for approval with revisions
4. Use and Disclosure of Protected Health (PHI) Information for Fundraising	8610-525	**3 year review, revised**	Pulled for further review

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 03/03

SUBJECT: ~~ALTERNATIVE MEANS OF COMMUNICATING PROTECTED HEALTH INFORMATION (PHI)~~ **PATIENT REQUESTS TO RECEIVE COMMUNICATIONS OF PROTECTED HEALTH INFORMATION (PHI) BY ALTERNATIVE MEANS OR AT ALTERNATE LOCATIONS**

REVISION DATE: 03/06; 02/09

POLICY NUMBER: 8610-519

Administrative Policies & Procedures Committee Approval:	**~~02/09~~09/15**
~~**Operations Team Committee Approval:**~~	~~**02/09**~~
~~**Professional Affairs Committee Approval:**~~	~~**03/09**~~
Audit, Ethics and Compliance Committee Approval	**10/15**
Board of Directors Approval:	**03/09**

A. **PURPOSE:**

1. To set guidelines for **accommodating reasonable requests by Tri-City Healthcare District (TCHD) patients to receive communications of**~~in accordance with federal regulations for providing alternative means of communicating~~ protected health information (PHI) **by alternative means or at alternate locations**~~ with Tri-City Healthcare District (TCHD) patients~~.

B. **DEFINITIONS:**

1. **Protected Health Information (PHI): Individually identifiable health information transmitted or maintained in 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.**

C. **POLICY:**

1. **TCHD will permit patients to request and TCHD will accommodate reasonable requests by patients to receive confidential communications by alternative means or at alternative locations.**
2. **Patient requests for confidential communications by alternative means or at alternative locations must be made in writing as described in this Policy.**

D. **PROCEDURES:**

1. TCHD will ~~provide~~**permit** patients ~~with an opportunity~~ to request **that** ~~confidential~~ communications **of PHI** by alternative means **or alternative locations which**~~. Alternative means~~ may include:
   a. Alternative phone numbers. **(For example, a patient may wish to designate a specific phone number for communications).**

b. Alternative addresses~~, such as a business address~~. **(For example, a patient who does not want his or her family to know about a medical condition may request that communications be directed to his or her workplace address instead of a home address).**

c. **By closed envelope instead of postcard.**

2. **TCHD determines the reasonableness of the request based on the administrative difficulty of complying. TCHD may not require an explanation from the patient as to the basis for the request as a condition of providing communications on a confidential basis.**
3. Requests for alternative communications made after registration must be submitted in writing to the Registration Manager. Termination of the request will require submitting a separate signed form.
4. At the time of registration or at the point of entry, patients or their representatives will be asked if they wish to receive communications by alternative means **or at alternative locations**.
   a. **T**hose that do request alternative means of communication must complete and sign the Request for Restriction on the Manner/Method of Confidential Communications form.
   b. When wishing to terminate the **request**~~agreement~~, the Termination of Special Restriction form must be completed and signed.
   c. Registration staff will complete the appropriate fields in **Cerner and** Affinity upon receipt of request.
   d. Both forms, upon completion, are to be forwarded to Medical Records/Health Information for inclusion in patient's record.
5. Requests for special communications after the visit date can be directed to the Privacy Officer, who will mail the form to the requesting individual.
   a. Upon receipt, the information will be forwarded to the Registration Manager for input in to both C**erner**~~ompass~~ and Affinity.
   b. Upon completion, forms will be forwarded to Medical Records/Health Information for inclusion in the patient's record.
6. **TCHD may condition the provision of reasonable accommodation on, if and when appropriate, information as to how payment, if any, will be handled and specification of an alternative addresses or other method of contact.**

E. **REFERENCES:**

1. **45 CFR Section 164.522(b)(1)**

F. **FORMS:**

1. **Request for Restriction on the Manner/Method of Confidential Communication**

Name: _____ Date: _____
(Last) (First) (MI)

Address: _____

Telephone Number: _____

Date of birth:_____ Social Security #: _____
(Optional)

You may request to receive confidential communications of your protected health information (PHI) by alternative means or at alternative addresses. For example, you may not want your appointment notices or your bill to go to your home.

We may not ask you the reason for your request. We will accommodate all reasonable requests.

If you make a special request, you must give us an alternative address or other method of contacting you. Please specify how or where you wish to be contacted by marking the box and recording the detailed information. ☐

Address:_____

Phone Number: _____

Signature of patient or representative:_____

If representative, give relationship:_____

For more information about your privacy rights, see the "Notice of Privacy Practices" on our website at tri-citymed.org or in the Medical Records/Health Information Department or by sending a written request to our Privacy Officer.

If you believe your privacy rights have been violated, you may file a complaint with the Medical Center or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

To file a complaint with the **Tri-City Healthcare District**~~Medical Center~~, contact our Privacy Officer at:
Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056
Attn: Privacy Officer
Values Line (800) 273-8452

REQUEST FOR RESTRICTION ON THE MANNER/METHOD OF CONFIDENTIAL COMMUNICATIONS

Tri-City Medical Center
4002 Vista Way
Oceanside, California 92056

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 7/97 **SUBJECT: ETHICS IN PROVISION OF SERVICES**

REVISION DATE: 4/00; 5/02; 12/02, 12/03, 6/09, 05/12 **POLICY NUMBER:** 8610-262

Administrative Policies & Procedures Committee Approval: ~~10/12~~09/15
Audit, Ethics and Compliance Committee Approval:
~~**Professional Affairs Committee Approval:** 11/12~~
Board of Directors Approval: 12/12

A. **PURPOSE:**

1. Tri-City Healthcare District (TCHD) recognizes its responsibility to create a workplace culture based on ethical principles and to use those principles as a guide in determining how best to serve the needs of its patients and the community it serves. TCHD relies on its mission, values and philosophy statement, strategic plan, Code of Conduct, Compliance Plan and other guiding documents to provide a consistent, ethical framework for its business services and patient care operations.

B. **DEFINITIONS:**

Ethical Tenet	Right	Responsibility
Beneficence Accountability	To respectful care	Advocacy
Autonomy	To Self-determination (To Privacy/Confidentiality)	Informed consent
Veracity Patient teaching	To truthful information	Informed consent
Justice	To Equal consideration for treatment	Collaboration to meet needs alternative choices
Fidelity	To deliver the care that is indicated/ordered	Competency/ Credentialing/ Appropriate services

C. **POLICY:**

1. It is the basic responsibility of employees, medical staff and others to work cooperatively. To provide optimum patient care, proper functioning of the healthcare team, and efficient management of business. Employees will conduct themselves utilizing the tenets included in the TCHD Mission and Value statements and Code of Conduct in the performance of their duties and their interactions with others. It is also the expectation that employees will fully demonstrate and model the Professional Code of Ethics established by their professional organization or licensing body.
2. Supply contracts are approved or rejected based on best-value practices and the potential for conflict of interest.
3. TCHD is committed to truth in advertising.
4. Patients with emergencies are treated without regard for ability to pay. The rights of all patients are valued without regard to race, color, creed/religion, sex, and national origin/ancestry.
5. Services are provided in a considerate and respectful manner, with regard to privacy and age specific needs allowing for expressions of personal values and beliefs as long as these do not jeopardize the safety or well being of others.
6. Billing practices have been developed so that customers are billed only for those services and care provided; bills include dates of service and itemized charges. Billing is based on appropriate regulatory and other accepted standards.
7. Media policies and procedures have been established to ensure that patient rights and privacy are protected. At no time will any member of news media be allowed to obtain any type of

information (verbal or written), without prior authorization from the Director of Marketing and Communications.

8. The hospital's code of ethical business and professional behavior protects the integrity of clinical decision making, regardless of how the hospital compensates or shares financial risk with its leaders, managers, clinical staffs and licensed independent practitioners.

D. **REFERENCES:**

~~1. Administrative Policies # 302, 318, 354, 384, 515, and 528~~

1. **Administrative Policy Manual: Accounting of Disclosures of Protected Health Information (PHI) #8610-528**
2. **Administrative Policy Manual: Advance Health Care Directive #8610-354**
3. **Administrative Policy Manual: Patient Complaints & Grievances #8610-318**
4. **Administrative Policy Manual: Use and Disclosure of Protected Health Information: Records #8610-515**
5. Code of Conduct
6. **Patient Care Services Policy Manual: Patient Rights & Responsibilities #8610-302**
7. Physician Referral Service Protocol
8. Code of Ethics on the TCMC Intranet

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 08/11 **SUBJECT:** Legal Documents

REVISION DATE: 10/14 **POLICY NUMBER:** 8610-294

Administrative Policies & Procedures Committee Approval:	**~~11/14~~09/15**
Audit, Ethics and Compliance Committee Approval	**10/15**
~~Executive Council Approval:~~	**~~08/11~~**
~~Professional Affairs Committee Approval:~~	**~~09/11~~**
Board of Directors Approval:	**09/11**

A. **PURPOSE:**

1. This policy enables Tri-City Healthcare District (TCHD) to comply with procedural deadlines for responding to l~~L~~egal d~~D~~ocuments, by ensuring TCHD is sufficiently informed of legal proceedings against it. This policy identifies the proper protocols for service of l~~L~~egal d~~D~~ocuments for (TCHD) and its employees.
2. Employees who improperly handle l~~L~~egal d~~D~~ocuments could disadvantage TCHD in legal proceedings and may be subject to discipline for violating this policy.
3. **Except as provided herein, TCHD employees must not accept legal documents on behalf of TCHD or any TCHD employee, physician, or independent contractor.**
4. **All inquiries regarding this policy shall be directed to Risk Management.**

. **SUMMONS, COMPLAINTS, GARNISHMENTS AND SUBPOENAS:**

~~C.~~1. **DEFINITIONS:**

~~1. **Legal Documents** – include Summons, Complaints, Garnishments, and Subpoenas~~

~~2.~~a. **Summons** – a l~~L~~egal d~~D~~ocument that notifies an individual or entity that a lawsuit has commenced and the individual or entity must respond.

b. ~~**Civil** **Complaint** – a l~~L~~egal d~~D~~ocument that sets forth the claims in a lawsuit and relief sought.

~~3.~~c. **Garnishment – an order issued by a court declaring that money or property (usually wages) be seized to pay a debt.**

~~4.~~d. **Subpoena** – an order issued by a court or attorney for the production of records, documents, or tangible things, or for the appearance of a person at a Deposition or in court.

~~5.~~e. **Deposition** – a proceeding in which an individual provides out of-court testimony under oath.

~~6.~~f. **Service** – the process of delivering ~~L~~legal d~~D~~ocuments.

~~7.~~g. **Process Server** – an individual who Serves ~~L~~legal d~~D~~ocuments upon a person or entity.

2. **ACCEPTING SERVICE OF SUMMONS, COMPLAINTS, GARNISHMENTS AND SUBPOENAS**

~~a.~~ **Process Servers seeking to serve legal documents will~~should~~ be directed first to Security. ~~An employee who is uncertain about the correct department to which a Process Server should be directed should direct the Process Server to Security.~~**

~~b. **Once Security is present, Risk Management shall accept any Summons, Complaint, Garnishment or Subpoena from a Process Server on behalf of TCHD and on behalf on any individual employee who has provided prior authorization, including Subpoenas directed to "Persons Most Knowledgeable" or "Persons Most Qualified" at TCHD.~~ Once Security is present, Risk Management shall accept any Summons, Complaint, Garnishment or Subpoena from a Process Server on behalf of TCHD or any TCHD board officer or clerk of the board in his or her official capacity (such as**

"Board Secretary"), including Subpoenas directed to "Persons Most Knowledgeable" or "Persons Most Qualified" at TCHD.

i. Risk Management will forward Subpoenas for medical records and patient bills to the Medical Records Department.

ii. Risk Management will forward Subpoenas for employee records to Human Resources.

iii. Risk Management will forward Garnishments and Subpoenas for payroll documents to the Payroll Department.

c. Risk Management shall not accept any Summons, Complaint, Garnishment or Subpoena on behalf of the Medical Staff, including Medical Board Subpoenas for credentialing.

d. Risk Management shall not accept any Summons, Complaint, Garnishment or Subpoena on behalf of the Tri-City Hospital Foundation.

e. Under no circumstances are Process Servers allowed onto patient care floors or into patient care areas for the purpose of serving Legal Documents.

f. In keeping with other TCHD privacy policies, TCHD employees must not provide information about other employees, physicians or independent contractors to Process Servers. This includes information about the employees', physicians', or independent contractors' shifts, department of employment, home address, home, cellular or office telephone number, or TCHD email address.

~~8.~~g. A Process Server who attempts service of a Summons, Complaint, Garnishment or Subpoena against an employee, physician, or independent contractor, or a Subpoena that requires the appearance of an employee, physician, or independent contractor, shall be informed of TCHD's policy against the acceptance of such documents, asked to leave the premises, and escorted from the premises by Security if he or she refuses to leave voluntarily.

~~D.~~C. OTHER CLAIMS AND REQUESTS FOR INFORMATIONS:

1. It is the responsibility of any person making a claim for money or damages that is not a Summons, Complaint, Garnishment or Subpoena, such as claims presented on TCHD's board-approved claim form, any other standard claim form, in a letter, or in any other document, to present such claim to the Board Clerk, Secretary of the Board or Chair of the Board per California Government Code Section 915.
   a. Any other TCHD employee who receives a claim for money or damages that is not a Summons, Complaint, Garnishment or Subpoena, such as claims presented on TCHD's board-approved claim form, any other standard claim form, in a letter, or in any other document, shall forward such claim to Risk Management only. Risk Management shall follow the Government Code in addressing the claim.
2. As provided in Board Policy ~~14-026~~ 10-026, only the office of the CEO may accept requests for public records.
   ~~a. Other TCHD employees shall not accept requests for public records.~~

D. REFERENCES:

1. California Government Code Section 915
~~3.~~2. Board of Directors Policy #10-026 – Request For Inspection of Public Records Policy

~~E. POLICY:~~

~~Unless stated otherwise below:~~

~~1. Process Servers are not permitted on TCHD premises for the purpose of Serving Legal Documents. Under no circumstances are Process Servers allowed onto patient care floors or into patient care areas for the purpose of serving Legal Documents.~~

2. In keeping with other TCHD privacy policies, TCHD employees must not provide information about other employees, physicians or independent contractors to Process Servers. This includes information about the employees', physicians', or independent contractors' shifts, department of employment, home address, home, cellular or office telephone number, or TCHD email address.
3. TCHD employees must not accept Legal Documents on behalf of TCHD or any TCHD employee, physician, or independent contractor. Process Servers seeking to serve legal documents should be directed to the proper person or department as indicated below.

F. **PROCEDURES FOR SERVICE OF LEGAL DOCUMENTS:**

1. The following departments and/or individuals are authorized to accept Service of the Legal Documents specified:
   a. Legal Affairs and Compliance is authorized to accept Legal Documents on behalf of TCHD and individual employees who have provided prior authorization, Subpoenas directed to "Persons Most Knowledgeable" or "Persons Most Qualified" at TCHD, and other Legal Documents that could be accepted by other departments.
   b. Medical Records Department is authorized to accept Subpoenas for medical records and patient bills.
   c. Human Resources is authorized to accept Subpoenas for employee records.
   d. Payroll Department is authorized to accept wage garnishments and Subpoenas for payroll documents.
   d.**Medical Staff is authorized to accept Medical Board Subpoenas for credentialing.**
2. A Process Server who attempts service of a Civil Complaint against an employee, physician, or independent contractor, or a Subpoena that requires the appearance of an employee, physician, or independent contractor, shall be informed of TCHD's policy against the acceptance of such Documents, asked to leave the premises, and escorted from the premises by security if s/he refuses to leave voluntarily.
3. An employee who is uncertain about the correct department to which a Process Server should be directed should direct the Process Server to Legal Affairs and Compliance.
4.**3.** All inquiries regarding this policy shall be directed to the Legal Affairs and Compliance Department.

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

September 24, 2015 – 1:30 o'clock p.m.
Assembly Room 1 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 1:30 p.m. on September 24, 2015.

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

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

Also present were:

Greg Moser, General Legal Counsel
Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Steve Dietlin, Chief Financial Officer
Esther Beverly, VP/Human Resources
Cheryle Bernard-Shaw, Chief Compliance Officer
Dr. Gene Ma, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 1:30 p.m. in Assembly Room 1 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

   Chairman Schallock stated agenda item 6. g. (1) Steven D. Stein vs. Tri-City Healthcare District is being pulled from the closed session and items 20 1). D. 8. Approval of an agreement with Federal Heath Sign Company for the construction of an Electronic Digital Media Display Pylon Sign for a total cost not to exceed $380,000, contingent upon final approval by the City of Oceanside and 20 4. G. 1) c. Policy 8610-525 – Use and Disclosure of Protected Health Information (PHI) for Fundraising have been pulled.

   Director Dagostino called for a Point of Order requesting clarification if the two open session items are pulled for discussion or pulled to be sent back to the respective committees. Chairman Schallock stated both items will be sent back to the respective committee.

It was moved by Director Dagostino to approve the agenda as amended. Director Kellett seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

Chairman Schallock read the Public Comments section listed on the September 24, 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. Greg Moser made an oral announcement of the items listed on the September 24, 2015 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; three Reports Involving Trade Secrets; Conference with Legal Counsel regarding one matters of Potential Litigation; Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Conference with Legal Counsel regarding one matter of Existing Litigation and Approval of Closed Session Minutes.

5. Motion to go into Closed Session

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

6. The Board adjourned to Closed Session at 1:35 p.m.

8. At 3:37 p.m. in Assembly Rooms 1, 2 and 3, Chairman Schallock announced that the Board was back in Open Session.

The following Board members were present:

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

Also present were:

Greg, 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
Cheryle Bernard-Shaw, Chief Compliance Officer
Dr. Gene Ma, Chief of Staff
Teri Donnellan, Executive Assistant

Richard Crooks, Executive Protection Agent

9. Chairman Schallock stated no action was taken in closed session, however the Board will be returning to closed session at the conclusion of this meeting to conduct unfinished business.

10. Director Reno led the Pledge of Allegiance.

Chairman Schallock noted the following items were pulled from the agenda:

- 6 g. (Conference with Legal Counsel – Existing Litigation)
  (1) Steven D. Stein vs. Tri-City Healthcare District;

- 20 (1) D. 8. Approval of an agreement with Federal Heath Sign Company for the construction of an Electronic Digital Media Display Pylon Sign for a total cost not to exceed $380,000, contingent upon final approval by the City of Oceanside; and

- 20 (1) G. 1) c. 8610-525 – Use and Disclosure of Protected Health Information (PHI) for Fundraising.

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. Special Recognitions:

(1) Lucky 13 Triple Crown Champion Presentation

Chairman Schallock stated the Lucky 13 are the individuals who ran in the Carlsbad Half Marathon, La Jolla Half Marathon and America's Finest City Half Marathon, thereby achieving the Triple Crown.

Ms. Tina Knight, one of the Lucky 13 members read a touching letter from a fellow team member that reflected how grateful the team felt for the life changing fitness experience provided to them by Tri-City. Ms. Knight and fellow team members presented a plaque to Mr. Moran and Tri-City to express their appreciation. A plaque was also presented to Mr. David Bennett and the Marketing Team for their support. Ms. Knight introduced Mr. Paul Carey, the team's coach, counselor, motivator and leader.

Mr. Carey stated he is the Coordinator for the Lucky 13 and wished to take this opportunity to thank Mr. Moran, Mr. David Bennett and the entire Marketing Team for their support. Mr. Carey stated he has never been so proud to work for a company and so proud of what he does. He stated it was an honor and a privilege to change the lives of so many people.

No action was taken.

13. Community Update

1) Emergency Preparedness Update – Kevin McQueen

Mr. Kevin McQueen, Director of Safety and Environment of Care stated the objective of today's presentation is to provide information to the TCHD Board of Directors and the public on TCHD's preparedness and capabilities to manage or assist with internal and external disaster/emergency events and secondly, to update the TCHD Board of Directors and public on Emergency Management activities and operational plans. Mr. McQueen explained that both the Joint Commission and California Department of Public Health require Emergency Management Planning in healthcare facilities to ensure that hospitals have a comprehensive plan that describes how it will respond to emergencies in its community or in the facility that would affect the delivery of medical services. Mr. McQueen reviewed examples of External Events such as mass-casualty, terrorist event and wild fires as well as Internal Events such as a fire within the facility, an active shooter or loss of power.

Mr. McQueen explained the TCHD Emergency Operations Plan addresses the four phases of Emergency management including:

1. Preparedness
2. Response
3. Mitigation
4. Recovery

In addition the TCHD Emergency Operations Plan addresses the annual Hazard Vulnerability Analysis (HVA) and looks at situations that would pose a threat to Tri-City or impact us from the outside.

Mr. McQueen reviewed some of the activities the hospital takes to assure readiness and identify resources used in an emergency situation which include staff training, practice exercises and collaboration with local agencies. Mr. McQueen provided examples of the TCMC Emergency Management Inventory that is available in the event of a disaster situation which includes but is not limited to decontamination shower/tents, portable power generators, HEPA filtration system, cots, portable water heaters, pharmaceuticals and medical supplies.

Mr. McQueen explained the Federal Government provides funds to the county of San Diego that are disbursed to the hospitals depending on size and need. He stated the money is used to offset some of the costs of doing disaster preparedness. Mr. McQueen stated TCMC has purchased "Meals Ready to Eat" and have an enormous supple of water that is essential is almost every major disaster that will enable the hospital to hold its own for 72-96 hours.

Mr. McQueen spoke regarding the 2014 Wild Fires and the statewide event in preparing for EBOLA. Mr. McQueen also reported that in 2015 we had a partial system failure with our landline phones, however we had a multitude of communication devices in place, i.e. radios, cell phones. He noted two additional drills are planned for October and November.

Mr. McQueen stated TCMC also participates with San Diego Regional Disaster planning process which includes:

- Annex D – Multi-Casualty
- Annex P – Emergency Plan for Terrorism

With regard to communication, Mr. McQueen stated the ability to get communication out to our staff has improved tremendously.

Lastly, Mr. McQueen explained the activities that the hospital implements to return to normal operations after an emergency incident which include the following:

- Memos of Understanding with vendors to resupply critical care equipment and supplies within 24 hours;

- Set up alternative means to meet essential building utility needs (back-up generators, alternative communications, possible alternative care sites); and

- Complete after action reports to identify opportunities for improvement that are shared with the Hospital Association of San Diego & Imperial County to adopt best practices by all area hospitals.

Directors asked a multitude of questions that Mr. McQueen responded to.

Chairman Schallock stated that he is a member of the Medical Reserve Response Corp. and many times when they do training in San Diego, Mr. McQueen is there. He expressed his appreciation to Mr. McQueen for taking his time, often on Saturdays to be a part of this.

No action taken.

14. Report from TCHD Auxiliary – Sandy Tucker, President

Ms. Sandy Tucker reported as of the end of August, volunteers have contributed 52,488 hours. She noted our advocate volunteers are giving out the new Patient Handbook which they requested as they greet everyone who comes into the hospital.

Ms. Tucker stated Pet Therapy will begin a new program on October 1st where new patients can request a visit from a dog. She noted the Pet Therapy Team will have someone available every day of the week.

Ms. Tucker reported on other events as follows:

- The Annual *Tails on the Trails* will be held on May 21, 2016, in partnership with the Foundation.

- October 8th the Auxiliary will host the San Diego & Imperial Council of Hospital Volunteers from 10-11:30 a.m. in which Mr. Tucker will speak on the HAVES award. In addition, Mr. Richard Hart, Chair of the CA Hospital Association (Volunteers) will present disaster planning for California hospitals.

Ms. Tucker explained the Telecare Department is made up of 19 volunteers who call patients who have been discharged or community members who are alone and assure them that someone cares. She stated she is hoping that the new brochure will generate more participation in this area.

Director Finnila suggested Ms. Tucker reach out to the City's program "We Are Not Alone".

No action was taken.

15. Report from Chief Executive Officer

Mr. Tim Moran, Chief Executive Officer stated he was extremely pleased to have the opportunity to participate with the Board and physician leaders in a recent meeting to talk about some of the challenges that we face. He stated he got a feeling of unity and purpose and would like to keep that theme going forward.

Mr. Moran stated three things we are focusing on in connection with that include the following:

1. Information Technology needs for the future;

2. Clinical integration - fundamentally creating ways of communicating together across the continuum of care for our patients and

3. Bundled payments which will be a huge shift in how we do business.

With regard to seismic requirements, Mr. Moran reported the architects have finalized the seismic workaround of what we will need to do for addressing the seismic issues we have.

Mr. Moran reported work groups have been organized and have started working on the Campus Development Plan

Mr. Moran stated quality care and patient safety are always foremost in our minds and he invited Ms. Sharon Schultz, CNE to share some good news of some recognitions we have received.

Ms. Schultz stated that in the U.S. News, 2016 Edition of Best Hospitals, Tri-City Medical Center was the only hospital in San Diego County that has won four awards: 1) Get with the Guidelines for Heart Failure, 2) Get with the Guidelines for Stroke, 3) The Mission Lifeline for our Heart Attack Receiving Center and 4) the Stroke Honor Roll.

Mr. Moran thanked Director Reno for bringing this news article to our attention.

Ms. Schultz also reported that an envelope was received from a group of 3rd grade students who have been studying about how to be helpful in the community. The students chose to make cheerful cards for patients who might need a cheerful word to help lift their spirits. Ms. Schultz stated the cards are very cute and thoughtful and will be given to our patients to put a smile on our patient's faces.

No action was taken.

16. Report from Chief Financial Officer

Mr. Steve Dietlin reported on the two months of FY 2016 ended August 31, 2015 as follows:

- Net Operating Revenue – $56.242
- Operating Expense – $55,521

- EROE - $1,474
- EBITDA – $3,863

Other Key Indicators for the current year driving those results included the following:

- Average Daily Census – 184
- Adjusted Patient Days – 18,663
- Surgery OP Cases – 512
- IP Surgery Cases - 636
- Deliveries – 429
- ED Visits – 11,532

Mr. Dietlin also reported on the current month as follows:

- Operating Revenue - $27,829
- Operating Expense - $27,557
- Net Patient Accounts Receivable $41.6
- Days in Net Accounts Receivable – 46.2

Mr. Dietlin stated Days in Net A/R are the lowest that we have seen in quite some time, however, he expects that number to increase over the next couple of months with the implementation of ICD 10 which is occurring on October 1st. Mr. Dietlin stated he believes the district is adequately prepared and there has been a multitude of education and dual coding, etc., however we still anticipate that there may be payment delays associated with that which may not necessarily impact revenue but the stream of payments may be somewhat delayed.

Mr. Dietlin also presented graphs which reflected trends in Net Days in Patient Accounts Receivable, Average Daily Census excluding Newborns, Adjusted Patient Days, and Emergency Department Visits.

Mr. Dietlin stated that once a year we have a financial statement audit in which independent auditors come in and audit the financial statement results that we are reporting internally. He stated for FY15 that audit is wrapping up and the draft report was brought to the Audit, Compliance & Ethics Committee on Tuesday and the committee recommended that it come forward to the Board. Mr. Dietlin stated there were no proposed adjustments or material weaknesses identified and we received an unmodified opinion which are all good things for the District.

Director Dagostino expressed his appreciation to Mr. Dietlin for steering our financial ship. Mr. Dietlin stated the financial results are the result of everyone's work in the hospital and it takes physicians, patients and the 2100 staff and the work of the Board.

Chairman Schallock echoed Director Dagostino's comments and noted the first two months of financials are impressive as well and everyone should be commended. Mr. Dietlin noted the importance of flexing down and managing expenses with drops in volume.

No action was taken.

17. New Business

a. Consideration of the FY2015 Audit

Mr. Dietlin stated Moss Adams is our independent Auditor and Mr. Devon Wiens, partner on the job is here today to give an update on the audit process.

Mr. Wiens stated the auditors completed their internal quality control review which consists of making sure all of our documentation is signed off and issued the financial statements about an hour ago pending acceptance by the Board. Mr. Wiens provided a summary of the highlights that were presented to the Audit, Compliance & Ethics Committee on Tuesday. He explained Moss Adams is an an independent party that expresses an opinion that the financial statements are free of material error. Mr. Wiens stated there were no audit adjustments this year and no uncorrected misstatements or past adjustments. He further explained that there were no material weaknesses or significant deficiencies in internal controls. Mr. Wiens stated Mr. Dietlin and his team took responsibility for drafting the notes and disclosures that you see in the financial statements and the auditors had very few changes to the actual financial statement which is the way it should be for a public organization such as ours. Mr. Wiens noted one change in the report from last year relates to a bill that was written by the state controller and is a reiteration of procedures and policies that are in their professional standards and are embedded in the accounting principles that the district is following and is just affirmation that the Auditors complied with that particular rule.

Director Reno commented that the audit report was very well done. She expressed her appreciation to Mr. Dietlin and his team. Director Reno questioned if this audit encompasses an internal audit. Mr. Wiens clarified that this is strictly an external audit.

Director Finnila stated we have some very strict internal controls and thanks to Mr. Dietlin and his team and our new Compliance Officer they take a very critical look at how our systems are working with each other. Director Finnila also expressed her appreciation to Ms. Charlene Carty and Ms. Anh Nguyen of our Finance Department who work closely with Moss Adams in the audit process.

Director Finnila stated the Audit Committee had the opportunity to ask Mr. Wiens any critical questions regarding the audit and processes in the absence of staff and our staff passed with flying colors

Lastly, Director Finnila stated the audit committee minutes which are available at the back table provide a detailed analysis of what was looked at by the auditors. She stated it was a collaborative effort on behalf of staff and Moss Adams.

It was moved by Director Finnila that the TCHD Board of Directors accept the Fiscal Year 2015 Audit as recommended by the Audit, Compliance & Ethics Committee. Director Dagostino seconded the motion

The vote on the motion was as follows:

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

17. b. Consideration to appoint Mr. Jack Cumming to a second two-year term on the Audit Compliance & Ethics Committee

It was moved by Director Finnila that the Tri-City Healthcare District Board of Directors appoint Mr. Jack Cumming to an additional two year term on the Audit, Compliance & Ethics Committee as recommended by the Committee. Director Dagostino seconded the motion.

The vote on the motion was as follows:

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

18. Old Business – None

19. Chief of Staff

a. Consideration of September 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on September 21, 2015.

It was moved by Director Dagostino to approve the September 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on September 21, 2015. Director Kellett seconded the motion.

The vote on the motion was as follows:

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

b. Consideration of September 2015 Recredentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on September 21, 2015.

It was moved by Director Dagostino to approve the September 2015 Recredentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on September 21, 2015. Director Finnila seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard Reno and Schallock**

NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

20. Consent Calendar

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

It was moved by Director Reno to pull items 20 (1) D. 1) Approval of an agreement with ABC-10/KGTV for a monthly cost of $12,508 for a term of 12 months beginning July 1, 2015 through June 30, 205 for an annual cost of $150,000 and 20 (1) D. 2) Approval of an agreement with the San Diego Business Journal for a monthly cost of $8,333 for a term of 12 months beginning July 1, 2015 through June 30, 2016 for an annual cost of $100,000.

The vote on the motion minus the items pulled was as follows:

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

The vote on the main motion was as follows:

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

21. Discussion of items pulled from Consent Agenda

Director Reno who pulled item 20 (1) D. 1) Approval of an agreement with ABC-10/KGTV for a monthly cost of $12,508 for a term of 12 months beginning July 1, 2015 through June 30, 205 for an annual cost of $150,000 questioned if this is an additional television agreement. Mr. David Bennett explained he has added ABC due to the fact that NBC lost their Direct TV license so the coverage for NBC is greatly reduced and he replaced NBC with ABC for a lower amount.

Director Reno who pulled item 20 (1) D. 2) Approval of an agreement with the San Diego Business Journal for a monthly cost of $8,333 for a term of 12 months beginning July 1, 2015 through June 30, 2016 for an annual cost of $100,000 questioned how many issues we get for the $100,000. Mr. Bennett stated it is a weekly magazine that has a distribution in San Diego of approximately 40,000 actual papers and close to 30,000 website ads. Mr. Bennett stated the journal comes out once a week and Tri-City has a half a page every other weekend in their magazine. Mr. Bennett added the Journal also assists us with interviews for any type of article we want to put into the magazine.

It was moved by Director Reno to approve items 20 (1) D. 1) Approval of an agreement with ABC-10/KGTV for a monthly cost of $12,508 for a term of 12 months beginning July 1, 2015 through June 30, 205 for an annual cost of

$150,000 and 20 (1) D. 2) Approval of an agreement with the San Diego Business Journal for a monthly cost of $8,333 for a term of 12 months beginning July 1, 2015 through June 30, 2016 for an annual cost of $100,000. Director Nygaard seconded the motion.

The vote on the motion was as follows:

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

22. Reports (Discussion by exception only)

Chairman Schallock reported he attended the CHA Governance Forum in Sacramento yesterday and will have a written report at the next meeting. Chairman Schallock commented that two major topics of discussion at the forum related to the unresolved issue of free standing Emergency Rooms and the fact that Behavioral Health continues to be a statewide issue.

Director Dagostino commented that San Clemente hospital is owned by a larger institution and is not a free standing hospital and it was the institution that made the decision to close that hospital.

23. Legislative Update

Chairman Schallock stated the legislature is out of session and many bills that were healthcare related have gone to the second year of the calendar.

24. Comments by members of the Public

Chairman Schallock recognized Ms. Kimberly Stone.

Ms. Stone gave a brief update on the senior fitness issue. She stated TCMC is now in a position to transfer the ownership equipment of the Nifty after Fifty sites to the City of Vista and the City of Oceanside. Ms. Stone explained that the City of Vista has agreed to accept the equipment and install in their community center. However, the City of Oceanside has a lack of funding and is not able to allow us to place any equipment there. Ms. Stone stated a second choice was the Club 55 however there is also a lack of funding available to rehabilitate that building. She stated efforts will continue with hopes of a resolution soon.

Chairman Schallock recognized Ms. Cindy Bravo, OB Tech in Mother Baby Unit and member of member of the Union. Ms. Bravo spoke regarding top executive salaries. She respectfully requested that Administration and the Board work collaboratively with the union to make safety and quality patient care our top priority.

25. Additional Comments by Chief Executive Officer

Mr. Moran did not have any additional comments.

26. Board Communications

Director Nygaard did not have any comments.

Director Mitchell did not have any comments.

Director Reno read a statement of praise relative to the retirement of Dr. Martin Nielsen and suggested that he be honored with a plaque for his dedication and years of service.

Director Kellett reiterated Mr. Moran's comments related to the Leadership Conference with the Medical Staff. He stated it worked out exceedingly well and was extremely beneficial.

Director Kellett expressed his appreciation to Mr. Dietlin for his incredible job as Chief Financial Officer and another clean audit.

Director Finnila commented briefly on Mr. Moran's topics of discussion at the Leadership Conference that included IT integration, bundled payments and clinical integration.

Director Finnila stated that the Medical Staff and all who work at Tri-City put patient care as their number one priority. She noted we are moving forward within a budget with goals and objectives and continually strive to be better.

Director Dagostino reiterated the comments by others on the Leadership Conference with the physicians, stating it was an eye opening experience that seemed to be greatly appreciated by all in attendance.

27. Report from Chairperson

Chairman Schallock echoed Director Reno's comments related to Dr. Nielsen. Chairman Schallock stated we also have several other outstanding physicians retiring at the end of the month including Dr. Jon LeLevier, Dr. Jeffrey Leach, Dr. James Esch and Dr. Terry Haas.

Chairman Schallock commented on the Special Meeting that was held recently with the Medical Staff Leadership which was attended by over 60 physicians, Administrative Staff and the Board. He stated it was a truly enlightening experience and a fruitful day.

Chairman Schallock reported on Initiative Prop 30 related to MediCal reimbursement. He stated it is on the 2016 ballot to make those increases permanent.

Chairman Schallock recognized Director Nygaard who was appointed as the Chair of the Finance Committee for ACHD this year. Chairman Schallock also noted Director Laura Mitchell is on ACHD's Education Committee and he is pleased we have Board members serving on these ACHD committees as they can bring back helpful information to the full Board.

Lastly, Chairman Schallock stated Saturday is Prescription Take Back Day which is a national program with selected drop off sites for unwanted prescriptions. He encouraged the community to drop off their outdated prescriptions beginning at 10:00 a.m. in the Tri-City parking lot.

28. Oral Announcement of Items to be Discussion in Closed Session

Chairman Schallock reported the Board would be returning to Closed Session to complete unfinished closed session business.

29. Motion to return to Closed Session.

Chairman Schallock adjourned the meeting to closed session at 5:00 p.m.

30. Open Session

At 6:34 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 no action was taken in closed session.

32. There being no further business Chairman Schallock adjourned the meeting at 6:35 p.m.

_____
Larry Schallock, Chairman

ATTEST:

_____
Ramona Finnila, Secretary

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

September 17, 2015 – 3:00 o'clock p.m.
Assembly Rooms 2&3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 3:00 p.m. on September 17, 2015.

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

Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry Schallock

Absent was Director Jim Dagostino, DPT, PT

Also present were:

Tim Moran, Chief Executive Officer
Steve Dietlin, Chief Executive Officer
Sharon Schultz, Chief Nurse Executive
David Bennett, Chief Marketing Officer
Esther Beverly, Vice President/Human Resources
Wayne Knight, SVP, Medical Affairs
Glen Newhart, Vice President/Foundation
Gene Ma, M.D., Chief of Staff
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 3:12 p.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Schallock led the Pledge of Allegiance.

2. Approval of the Agenda

   It was moved by Director Nygaard to approve the agenda as presented. Director Finnila seconded the motion. The motion passed unanimously (6-0-0-1) with Director Dagostino 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. Root made an oral announcement of items listed on the September 17, 2015 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one (1) Report Involving Trade Secrets, one matter of Potential Litigation and Conference with Labor Negotiators.

5. Motion to go into Closed Session

It was moved by Director Finnila and seconded by Director Kellett to go into Closed Session. The motion passed unanimously (6-0-0-1).

6. Chairman Schallock adjourned the meeting to Closed Session at 3:15 p.m.

7. The Board returned to Open Session at 5:25 p.m. All Board members were present with the exception of Director Dagostino.

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

Chairperson Schallock reported no action had been taken in Closed Session.

10. New Business

a. Consideration of amendments to 2013 Revolver and Term Loan Agreements authorized by Resolution No 762

It was moved by Director Finnila to approve the amendments to the Credit and Security Agreements with MidCap in substantially the form presented to us today, as recommended by the Chief Financial Officer. Director Nygaard seconded the motion.

The vote on the motion was as follows:

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

11. There being no further business, Chairman Schallock adjourned the meeting at 5:30 p.m.

_____
Larry W. Schallock
Chairman

ATTEST:

_____
Ramona Finnila
Secretary

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

October 13, 2015 – 6:00 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 6:00 p.m. on October 13, 2015.

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

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

Also present were:

Tim Moran, Chief Executive Officer
Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Cheryle Bernard-Shaw, Chief Compliance Officer
Gene Ma, M.D., Chief of Staff Elect
Jody Root, General Legal Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 6:00 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 the Agenda

   It was moved by Director Nygaard to approve the agenda as presented. Director Kellett seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairman Schallock read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Oral Announcement of Items to be discussed during Closed Session

   Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Mr. Root made an oral announcement of items listed on the October 13, 2015 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter of Potential Litigation, one Report Involving Trade Secrets and Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees.

5. Motion to go into Closed Session

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

6. Chairman Schallock adjourned the meeting to Closed Session at 6:05 p.m.

7. The Board returned to Open Session at 9:15 p.m. All Board members were present.

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

9. Chairperson Schallock reported no action had been taken in Closed Session.

10. New Business

a. Consider Affiliation with Health System

It was moved by Director Kellett that the TCHD Board of Directors authorize the CEO, with input from General Counsel, to execute an Affiliation Agreement with The Regents of the University of California on behalf of University of California San Diego Health System and School of Medicine consistent with the attached terms. Director Dagostino seconded the motion.

The vote on the motion was as follows:

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

11. There being no further business, Chairman Schallock adjourned the meeting at 9:20 p.m.

_____
Larry W. Schallock
Chairman

ATTEST:

_____
Ramona Finnila
Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Employee Satisfaction

Partnership™
"Satisfaction + Engagement"
Mean = 66.1 (-1.0)
Percentile = 28th (from 13th)

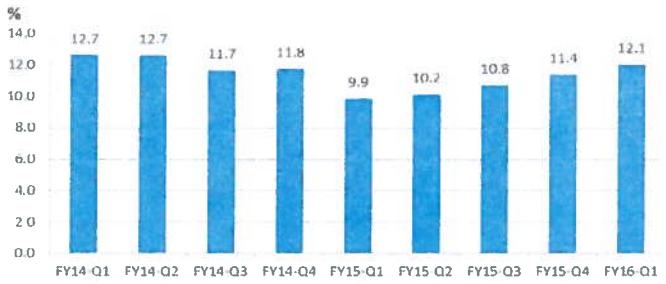
Satisfaction
"what do I get?"
Mean = 61.9 (-1.2)
Percentile = 27th (from 13th)

Engagement
"what do I give?"
Mean = 71.8 (-0.5)
Percentile = 31st (from 12th)

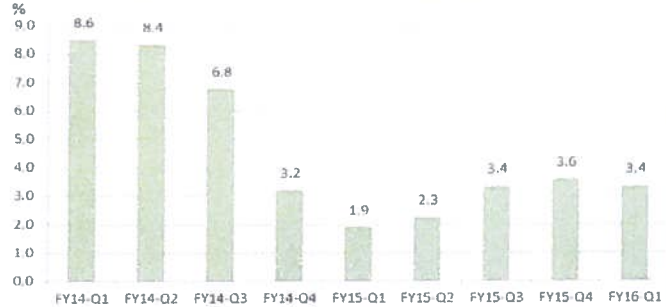
National 90th Mean Scores

Partnership:	79.9
Satisfaction:	77.1
Engagement:	83.6

Voluntary Employee Turnover Rate

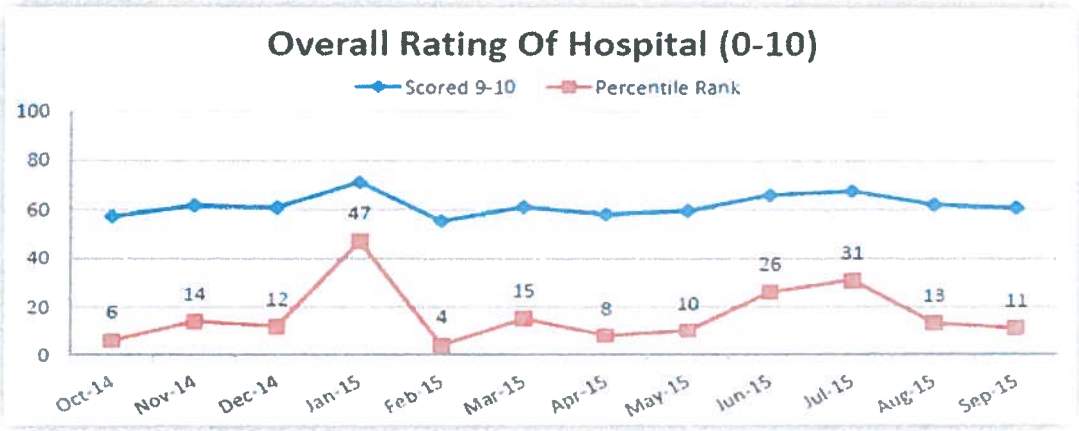


Involuntary Employee Turnover Rate



HCAHPS (Top Box Score)

Hospital Consumer Assessment of Healthcare Providers & Systems



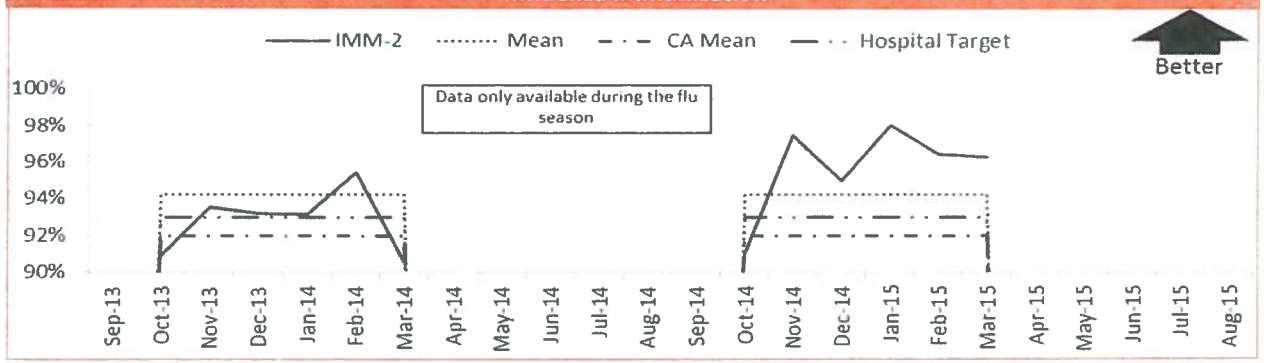
Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Process of Care Measures (Core Measures)

Centers for Medicare & Medicaid (CMS)

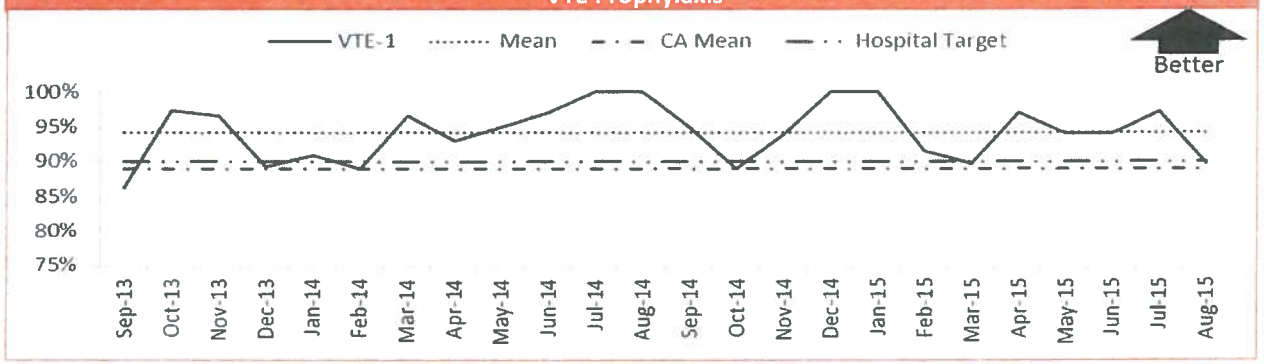
Influenza Immunization



Action Plan

Continue to monitor

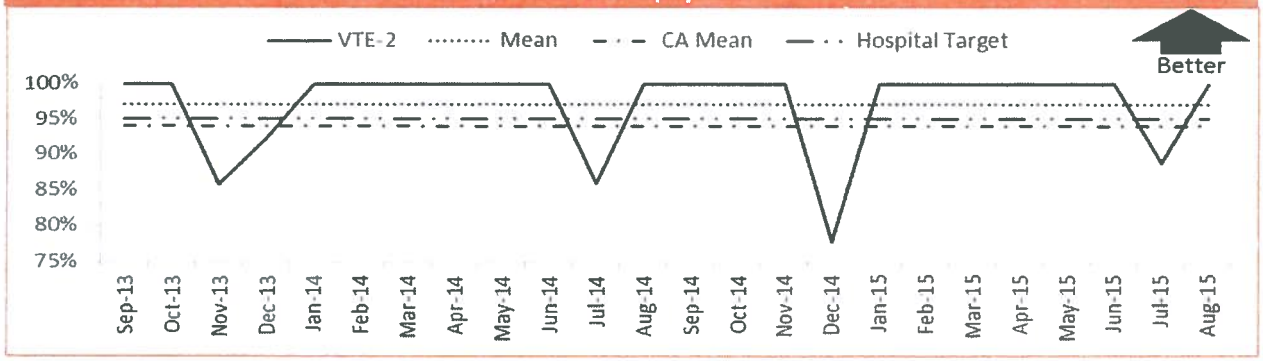
VTE Prophylaxis



Action Plan

Continue to monitor

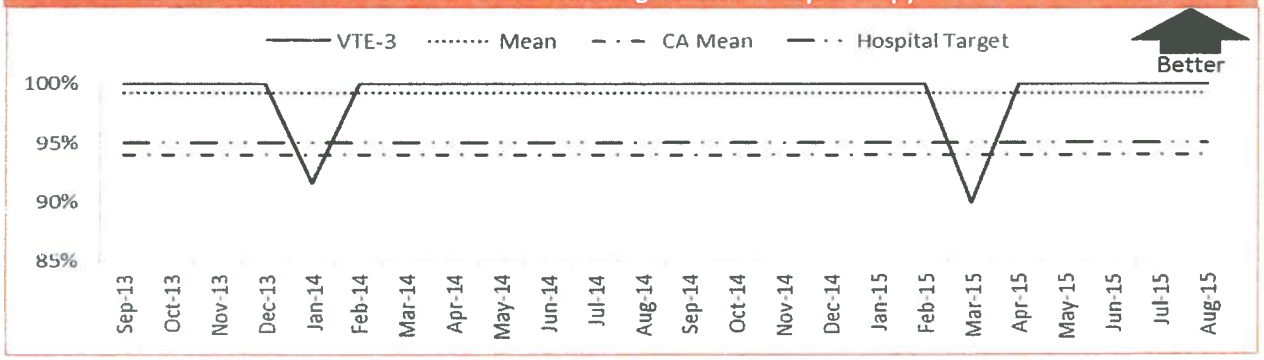
ICU VTE Prophylaxis



Action Plan

Continue to monitor

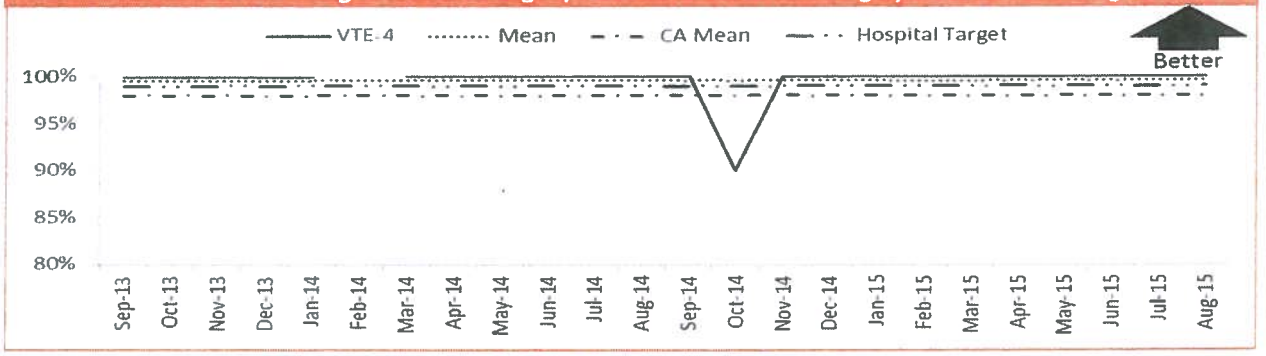
VTE Patients with Anticoagulation Overlap Therapy



Action Plan

Continue to monitor

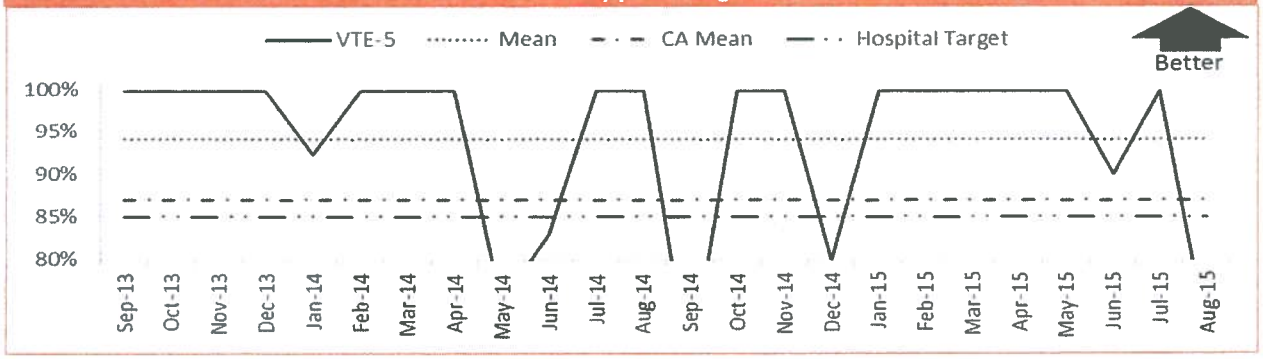
VTE Patients Receiving UFH with Dosages / Platelet Count Monitoring by Protocol or Nomogram



Action Plan

Continue to monitor

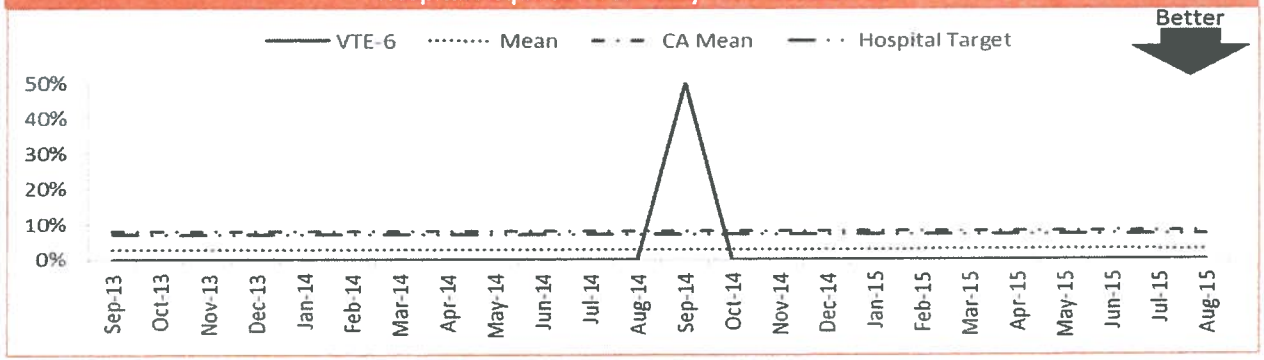
VTE Warfarin Therapy Discharge Instructions



Action Plan

Continue to monitor

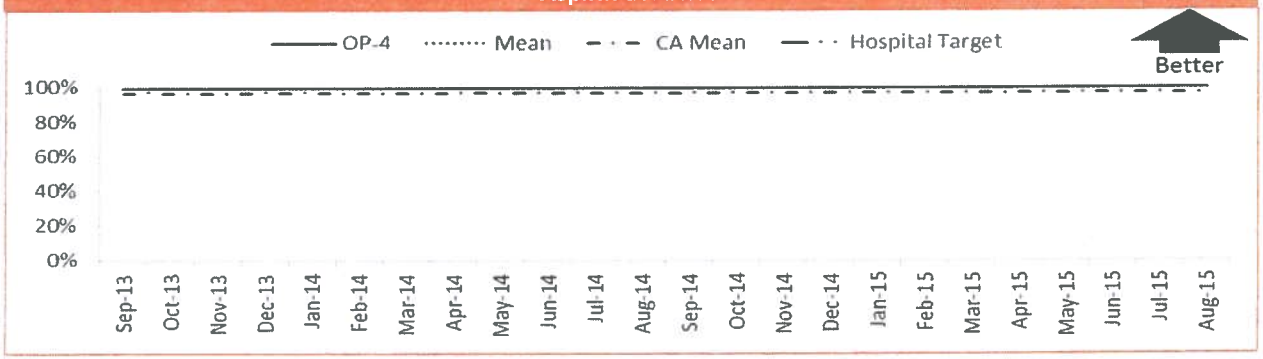
Hospital Acquired Potentially Preventable VTE



Action Plan

Continue to monitor

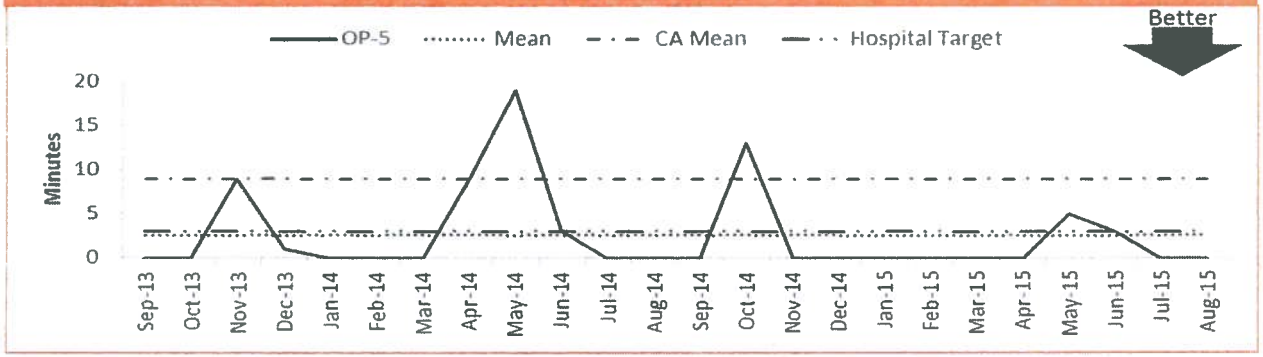
Aspirin at Arrival



Action Plan

Continue to monitor

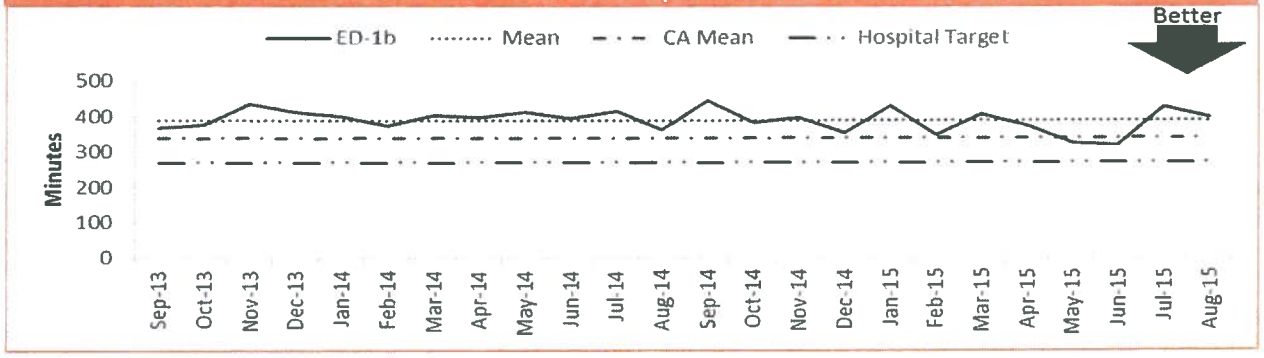
Median Time to ECG



Action Plan

Continue to monitor

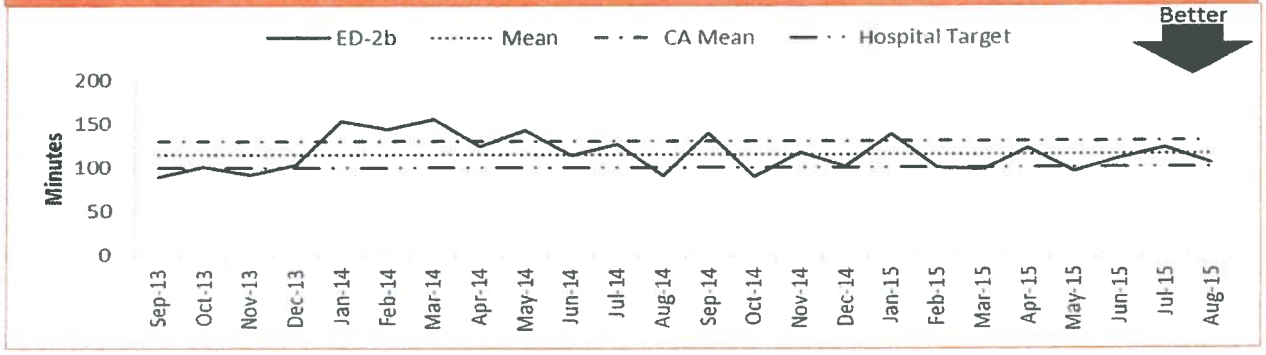
Median Time from ED Arrival to ED Departure for Admitted ED Patients



Action Plan

Continue to monitor

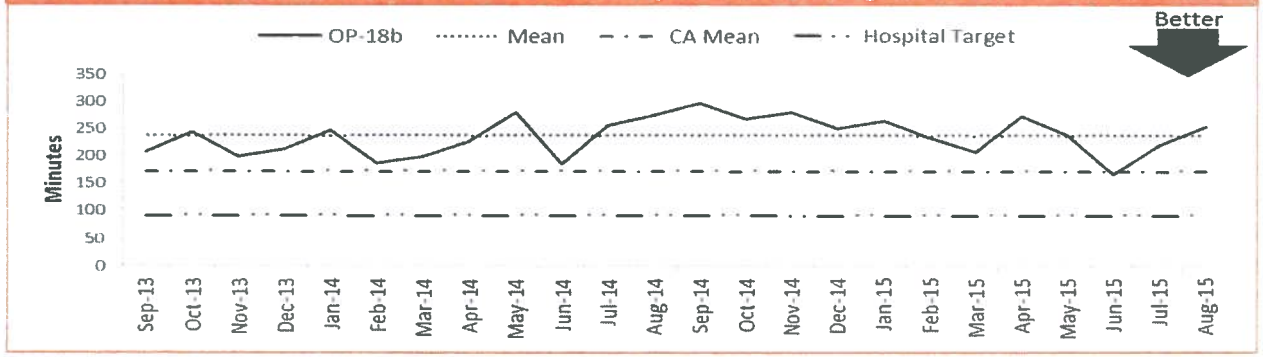
Median Time from Admit Decision to ED Departure Time for Admitted ED Patients



Action Plan

Continue to monitor

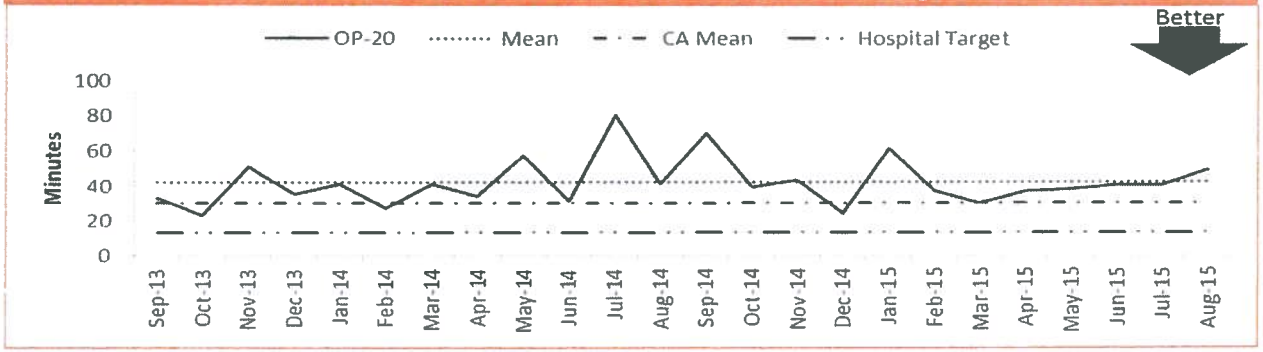
Median Time from ED Arrival to ED Departure for Discharged ED Patients



Action Plan

Continue to monitor

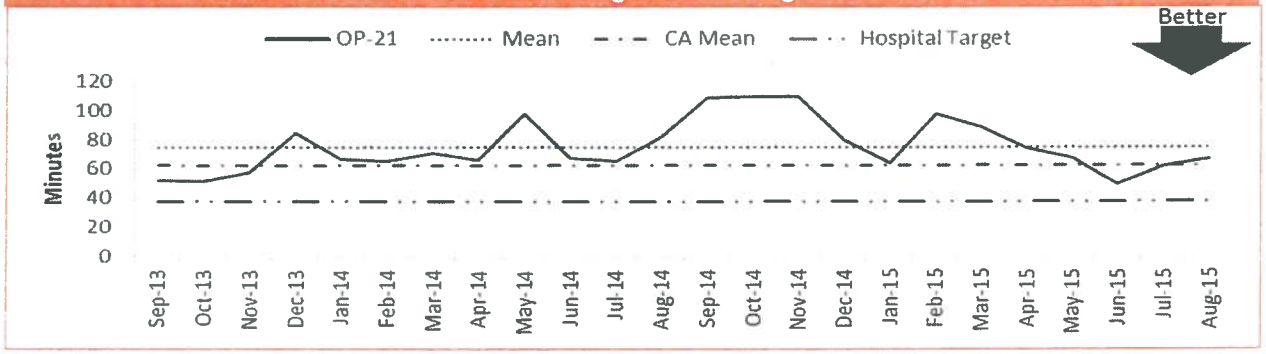
Median Time from ED Arrival to Provider Contact for ED Discharged Patients



Action Plan

Continue to monitor

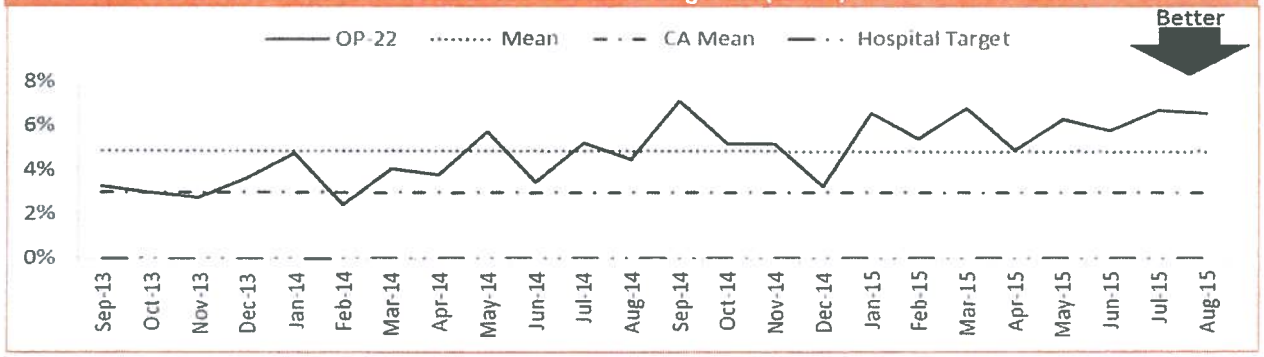
Median Time to Pain Management for Long Bone Fracture



Action Plan

Continue to monitor

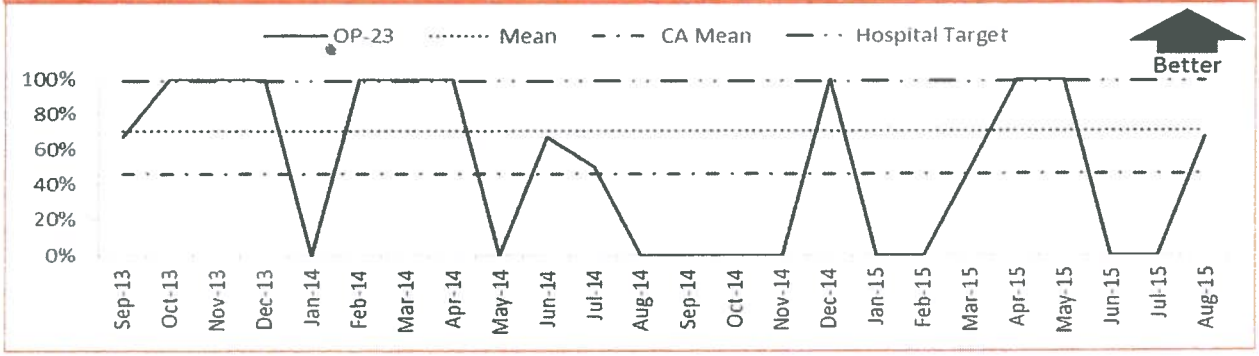
Patient Left Before Being Seen (LWOT)



Action Plan

Continue to monitor

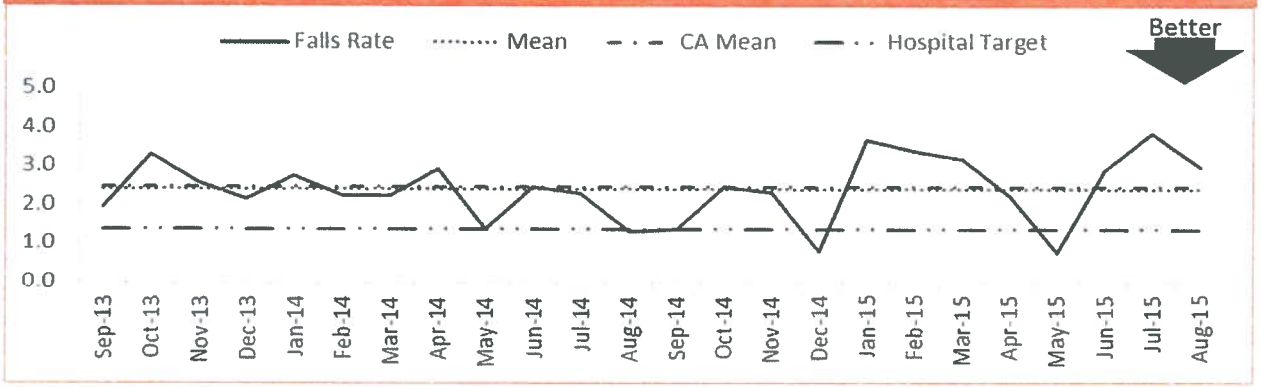
Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival



Action Plan

Continue to monitor

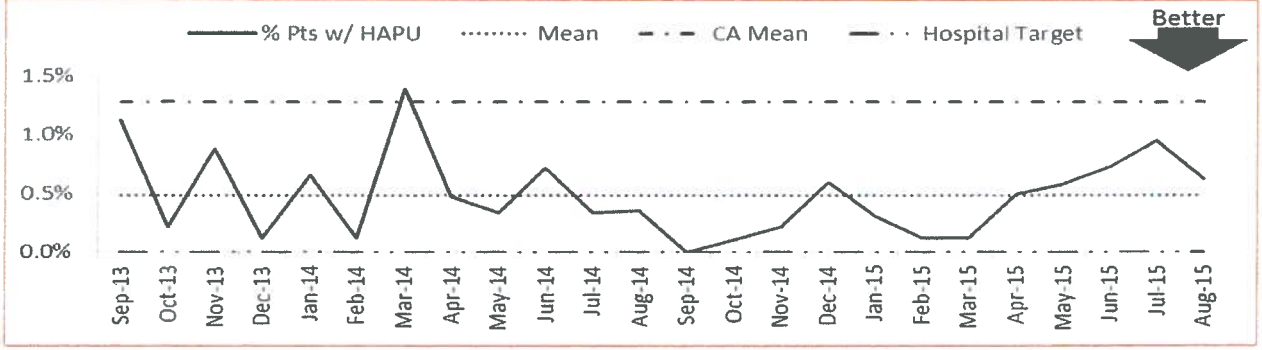
Hospital Wide Falls Rate Per 1000 Pt Days



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

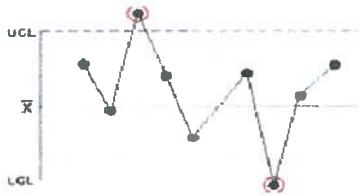
Legend

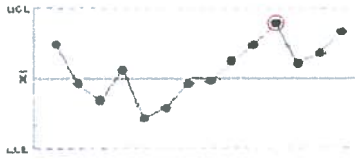
- Hospital Mean
- Hospital Rate
- Hospital UCL
- CA Mean

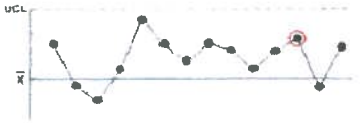
Hospital Mean is the average value we can expect based on the data collected.

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

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY16	46.7	45.7	45.7										46.0	48-52
FY15	46.3	48.8	48.5	48.9	49.0	48.9	51.0	50.6	50.6	51.0	49.9	46.4	47.9	48-52

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY16	83.6	85.8	92.1										87.2	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	83.7	78.8	75-100

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY16	$862	$612	$182										$1,656	$146
FY15	$368	($348)	$112	$568	$556	$632	$198	$370	$292	$343	$1,814	($471)	$132	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY16	3.03%	2.20%	0.66%										1.97%	0.17%
FY15	1.33%	-1.32%	0.41%	1.93%	1.99%	2.20%	0.70%	1.42%	1.02%	1.22%	6.04%	-1.61%	0.16%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY16	$2,046	$1,817	$1,357	$123									$5,343	$4,103
FY15	$1,761	$988	$1,456	$1,888	$1,896	$1,983	$1,498	$1,652	$1,591	$1,620	$3,136	$724	$4,204	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY16	7.20%	6.53%	4.90%										6.22%	4.90%
FY15	6.38%	3.75%	5.37%	6.42%	6.77%	6.91%	5.34%	6.34%	5.58%	5.76%	10.44%	2.48%	5.18%	

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY16	6.13	6.05	5.91										6.03	6.04
FY15	5.93	5.89	6.01	6.09	6.39	6.28	5.89	5.69	6.18	6.17	5.89	6.26	5.94	

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	TTM Jun	Covenant	
FY16	1.88	1.96	2.15										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	1.81	1.10	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY16	$30.7	$33.4	$36.1										
FY15	$27.7	$21.4	$19.9	$18.8	$18.9	$22.2	$19.9	$16.4	$13.4	$17.8	$26.4	$35.3	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	49	28	30										107
FY15	35	32	46	48	35	33	39	35	31	35	37	27	433

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	20	19	15										54
FY15	14	9	22	24	18	21	19	13	21	19	19	20	219

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	9	10	8										27
FY15	6	10	9	8	12	11	9	7	16	14	6	7	115

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	16	19	13										48
FY15	10	7	10	12	13	7	11	8	9	21	11	15	134

Performance compared to prior year: Better Same Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	40	36	37										113
FY15	45	51	32	43	49	27	33	43	37	39	40	41	480

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	19.9	19.6	17.6										19.1
FY15	23.3	26.5	27.1	21.2	22.8	19.1	18.3	17.5	19.6	16.9	17.5	17.9	20.7

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	7.1	4.9	5.6										5.8
FY15	5.2	3.5	4.3	5.0	4.3	7.2	7.0	6.0	6.5	5.1	5.9	5.1	5.4

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	13.3	11.1	14.3										12.9
FY15	13.2	18.2	19.7	18.1	15.6	16.4	18.3	21.5	14.3	13.9	11.7	13.5	16.2

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	183.9	183.4	199.7										188.8
FY15	190.8	195.0	195.1	195.6	189.2	187.9	203.3	199.8	188.0	186.3	181.5	179.7	191.0

Performance compared to prior year: Better Same Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	215	214	252										681
FY15	246	263	244	233	194	233	199	159	208	186	218	198	2581

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	16	9	19										44
FY15	16	19	12	19	17	11	15	8	12	22	23	21	195

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	7	3	7										17
FY15	4	6	2	1	4	8	1	15	4	3	5	1	54

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	7	14	4										25
FY15	10	9	10	10	12	12	12	5	12	10	6	13	121

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	1.65	1.63	1.60										1.63
FY15	1.64	1.63	1.58	1.58	1.56	1.58	1.58	1.63	1.62	1.63	1.65	1.66	1.61

Building Operating Leases
Month Ending September 30, 2015

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term Ending	Services & Location	Cost Center
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.50	(a)	$ 18,600.00	02/01/15	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)	$ 239,250.00	07/01/13	06/30/28	**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	01/01/13	12/31/15	**Performance Improvement** 3927 Waring Road, Ste.D Oceanside, Ca 92056	8756
Golden Eagle Mgmt 2775 Via De La Valle, Ste 200 Del Mar, CA 92014 V#81553	4,307	$0.95	(a)	$ 5,964.82	05/01/13	04/30/16	**Vacant Building** 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	09/01/12	08/31/17	**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	07/01/11	07/01/16	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083	7320
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 [illegible]anside, Ca 92056 [illegible]1250	4,760	$3.55	(a)	$ 22,900.00	10/01/12	10/01/22	**Chemotherapy/Infusion Oncology Office** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
[illegible]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	03/03/18	**Vacant Building** 510 Hacienda Drive Suite 108-A Vista, CA 92081	9550
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	6,123	$1.37		$ 7,958.99	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		$ 12,725.68	01/01/12	12/31/16	**Vacant Bank Building Property** 4000 Vista Way Oceanside, Ca 92056	8462 Until operational
Total				**$ 334,962.17**				

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

Education & Travel Expense
Month Ending September 30, 2015

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8340	DIETICIAN BOOK	80315	207.70	77946	KELLI GECEWICZ
8390	ICAAC 2015 CONF	90115	825.00	82350	MANUEL ESCOBAR
8390	NPP CONFERENCE	90315	353.17	10894	LAURA BALL
8510	NOTARY CLASS	71715	464.93	28765	SYLVIA E. GALLEGOS
8620	HEALTHCARE COMPLIANCE CONF	83115	2,922.88	81163	LAURA MITCHELL
8710	ACDIS CONFERENCE	62415	1,323.32	82505	QUOC TRAN
8720	HQI CONFERENCE	82415	450.00	14365	SHARON SCHULTZ
8723	DECISION MAKING	82615	185.00	80739	SCOTT LIVINGSTONE
8740	CHEMO ADMIN REC	91015	139.00	79898	MICHAEL CINI
8740	ACLS RENEWAL	91015	150.00	80037	MELISSA P. MENDOZA
8740	ACLS RENEWAL	90215	150.00	80055	MARIA EVANGELISTA
8740	ACLS RENEWAL	91015	150.00	80155	SHAUNNA HILL
8740	ACLS RENEWAL	82015	150.00	80156	CHRYSTALLE BECHTOLD
8740	ACLS RENEWAL	91015	150.00	80402	ELIZABETH SCHMIERER
8740	ACLS RENEWAL	90215	150.00	80476	MYRNA UBINA
8740	ACLS RENEWAL	82015	175.00	6595	AKI D'ETTA
8740	PCCN COURSE	82015	200.00	12376	IMELDA A. GLEED
8740	PERIOP 101	93015	2,207.90	9999	JENNIFER STEPHENSON

**This report shows payments and/or reimbursements to employees and Board Members in the Education & Travel expense category in excess of $100.00.
**Detailed backup is available from the Finance department upon request.

EVALUATION FORM

SEMINAR: GOVERNANCE FORUM
LOCATION: SACRAMENTO DATE: SEPTEMBER 23, 2015

REASON TO ATTEND: COMMITTEE MEMBER

IMPORTANT TOPICS:

Statewide, Behavioral Health issues continue to be a major problem and concern. Judith Yates explained some of the steps taking place in San Diego. In August, the county with HASDIC established a Behavioral Health Continuum of Care Initiative Policy Committee. The committee is to develop an operational vision and the current resource gaps to address the needs of these individuals. The complexities of the problems from mental health to substance abuse are huge. I did explain the re-arranging some of the beds in the ER to separate these patients from the medically ill patients. However the problem far exceeds the hospital as the community as a whole needs to be involved. We were told that the Orange County Grand Jury this summer issued a paper holding the Board of Supervisors accountable for correcting the problem. As a result, the supervisors have created an Ad-Hoc committee with supervisors actively involved to begin to address the problem.

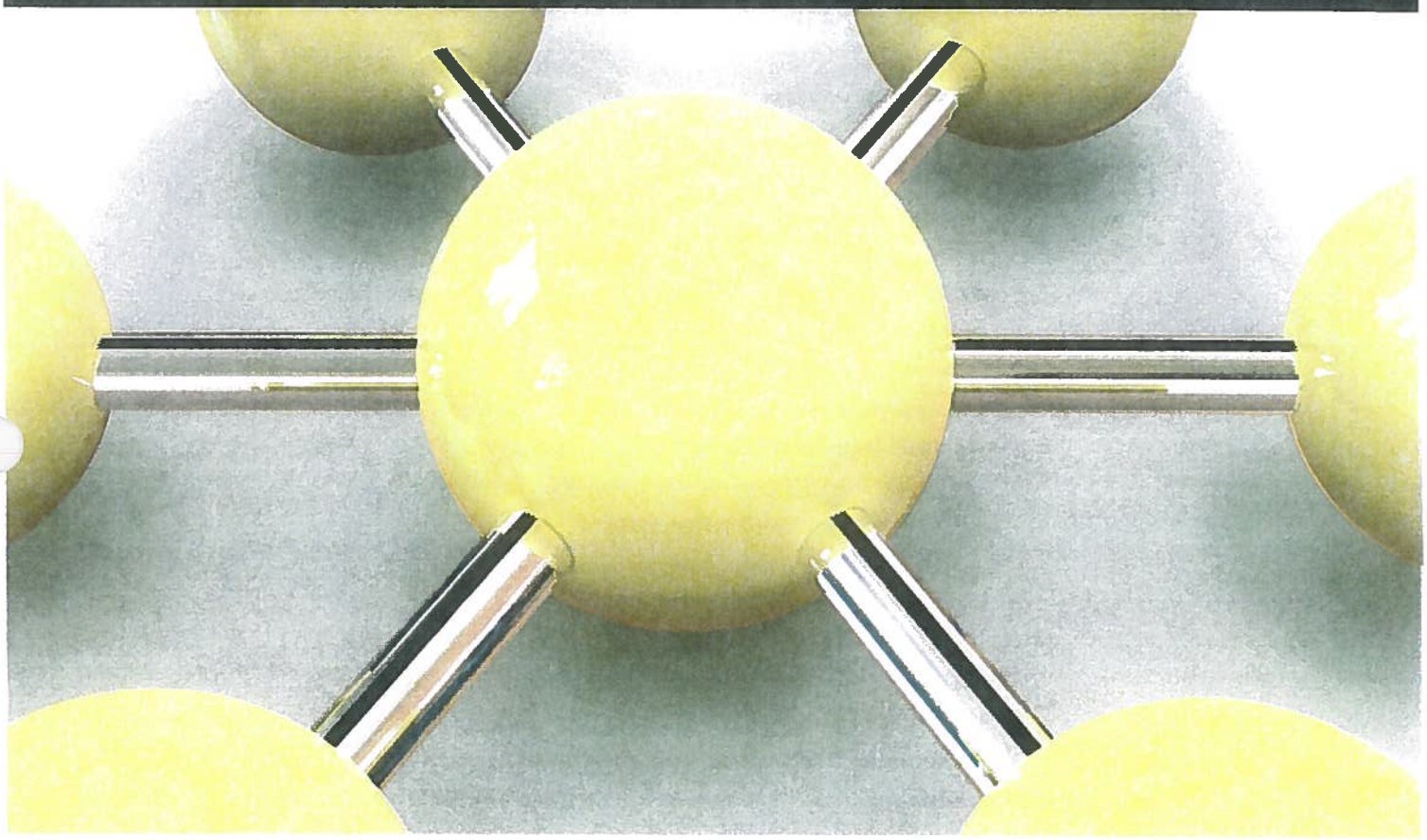
There was some discussion on "Business Imperatives Expanding Board Oversight". (see handout attached) Understanding population management and the changes it brings will result in how health care is delivered, where and by whom. See the other handouts on Population Management. CHA has prepared videos with explanations. It can be purchased for viewing at one site so it was suggested as many Board members and Administrators select a date for viewing.

The last area of discussion was on "Equity of Care". In that arena, hospitals are urged to reduce disparities – it can be content discussion as part of hospital orientation for employees to including diversity goals as part of the strategic plan. The goal is enhanced performance excellence and improved community health.

Larry W. Schallock

POPULATION HEALTH MANAGEMENT

A comprehensive, five-part certificate program for California hospital leaders



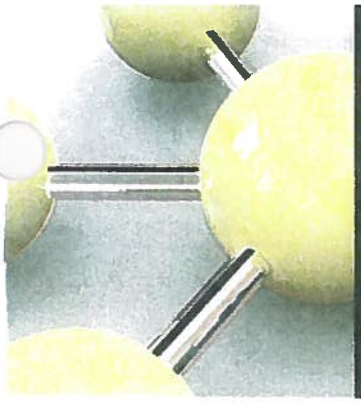
Webinar 1 Issue Brief:

A Framework for Population Health Management

April 28, 2015

CALIFORNIA HOSPITAL ASSOCIATION

KaufmanHall



POPULATION HEALTH MANAGEMENT

Webinar 1 Issue Brief:

A Framework for Population Health Management

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California Hospital Association
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Sacramento, CA 95814
www.calhospital.org

Introduction

Governance and leadership teams of California's hospitals and health systems must have the knowledge and skills needed to succeed under population health management (PHM). To help ensure success, California Hospital Association, in collaboration with Kaufman, Hall & Associates, LLC, is offering this five-part program titled "Population Health Management." The program provides participants with an understanding of the key components of PHM. Each module features an Issue Brief and webinar for executives and professionals in a wide range of organizations.

This Issue Brief and its associated webinar launch the series. They provide an overview of PHM and a framework for its pursuit by hospitals and health systems. Subsequent Issue Briefs and webinars will offer detail on PHM business imperatives, clinical priorities, technology requirements, and leadership roles, metrics, and structures.

For additional information about the program visit: www.calhospital.org/population-health-web.

"Population health management is the direction health care is moving. Those who commit early to building the competencies and infrastructure required to advance population health can position or reposition themselves to achieve a sustainable role. Whether you are already immersed in PHM or just formulating your strategy, this program provides practical, boots-on-the-ground tools. I encourage all hospital leadership teams – from small, rural facilities to large urban hospitals – to consider participating in this program."

Anne McLeod
Senior Vice President, Health Policy and Innovation
California Hospital Association

For more information about this Issue Brief, please contact:

California Hospital Association
Anne McLeod, Senior Vice President, Health Policy and Innovation
amcleod@calhospital.org

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Webinar 1 Issue Brief:
A Framework for Population Health Management

From Providing Care to Managing Health

A major transformation is underway in health care, as the nation moves to enhance patient care quality, access, and experience, and reduce costs. Significant change is being driven by a variety of forces, including nontraditional competitors,[1] increasing consumerism, innovative technology, changing workforce demands, and intense pressures from employers and public and private payers, which signal the unsustainability of health care's volume-based business model.[2]

The nature of such change is now more revolutionary than evolutionary, threatening and transforming business as usual for all participants. In particular, hospital-centric service delivery likely will not meet the ease-of-access and lower-cost requirements of consumers who are shopping for health services much as they would retail purchases. Such consumers, employers, and other stakeholders are moving the health care marketplace with lightning speed from the patient sick-care model to a consumer- and population health management-focused model.

The term "population health management" as used throughout this Issue Brief is defined on the following page.

Five Drivers of the Population Health Management Imperative

1. ***Macroeconomic issues are driving real change:*** The long-run economic health of the nation depends on having a less costly, and more efficient and effective health care delivery system. Triple Aim goals of achieving better care for individuals, better health for populations, and lower per capita costs are front and center. Coordinated care management for identified populations has a proven track record of meeting these goals.

2. ***Employer and insurance markets are transforming:*** Employers are moving employees from defined benefit to defined contribution, high-deductible health plans (HDHPs); insurers are moving to performance-based payment arrangements. Public exchanges, as mandated by the Affordable Care Act, are accelerating the spread of HDHP-like plans.

3. ***Consumerism is increasing:*** HDHPs put decisions regarding health care purchases firmly in the consumer's court, effectively changing health care from a wholesale transaction to a retail transaction in a more transparent market shaped to meet customer needs. Employers, providers, payers, and consumers are looking for improved health care value.

4. ***Well-funded competitors are emerging:*** New and nontraditional entities are blurring the lines and roles of industry stakeholders. Insurers and retail pharmacies are moving into the care-provision space. Health systems are acquiring health plans or partnering to achieve insurance capabilities. Vertical and horizontal consolidation is reshaping the industry, creating very large, well-capitalized entities that can organize care delivery for population health management.

5. ***Innovative technology is changing care delivery:*** Virtual/telehealth companies and mobile apps are redefining access to the health care experience and its costs. Web, mobile, and other technology-driven offerings shift health and care services from inpatient and outpatient facilities to in-home "anywhere care and anywhere health."

Source: Kaufman, Hall & Associates, LLC

The Rationale and Vision for Population Health Management

California is at the forefront of this transformation by virtue of its size and unique demographic profile. The economic realities of these factors, coupled with the longstanding prevalence of health maintenance organizations (HMOs), have spurred the state's historical vanguard role in integrating the delivery and financing of health care services. Key models that emerged over time include delegated risk models for organizing care delivery, such as those led by large independent practice associations (IPAs) comprised of individual and small-group physicians. Early development and sustained prevalence of HMO insurance by Kaiser Permanente and other commercial insurers, as well as managed care initiatives of large employers and CalPERS,[3] have spanned many decades.

Common payment systems in California — such as capitation and global budgeting — focus on quality, access, and cost, thus aligning the systems with the emerging population health/value-based care construct. Value-based arrangements, as pursued at the national and state level by public and private payers, reward providers for meeting quality and outcome targets while lowering costs, and penalize providers that don't meet such goals. The Centers for Medicare & Medicaid Services (CMS), the nation's largest payer whose payments constitute a significant portion of most hospital revenue streams, aims to ensure that value-driven "alternative payment models" constitute 50 percent of its payments by year-end 2018.[4] A consortium of major providers and commercial insurers recently targeted an even higher goal of 75 percent by 2020.[5]

The Definition of Population Health Management

Population health management has many definitions, but the most succinct defines PHM as an approach to improving health and the quality of care delivered while managing the cost of care. Other definitions appearing in the professional literature address PHM's clinical and service-delivery considerations and can offer a helpful starting point for hospital positioning/repositioning strategies as described in this Population Health Management program.

The clinically oriented definition: "PHM considers the health outcomes of a group of individuals, including the distribution of such outcomes within the group."[a] It encompasses the following:

- The identification and surveillance of individuals at risk of developing disease or those with chronic diseases
- Interventions in early disease stages to improve health outcomes and reduce costs by preventing illness or slowing progression of chronic illness to acute stages

The service delivery-oriented definition: "Population health management occurs when a health care system or network of providers works in a coordinated manner to improve the overall health, health outcomes, and well-being of patients across all defined care settings under risk-bearing arrangements."[b] The health care system or network of providers may work under contractual arrangements with another entity, such as an insurer.

Three factors are critical to the success of the PHM model:

- A clinically integrated physician network
- Incentive structures that reward high performance
- Risk contracts

This Issue Brief provides detail on each factor.

*Note: *How a "group of individuals" is identified varies based on whether a public health agency, provider organization, government or commercial payer, or other stakeholder is defining the "grouping."*

a Kindig, D., Stoddart, G.: "What is Population Health?" *Am J Public Health* 93(3): 380-383, March 2003.
b Hill, G., Sarafir, G., Hagan, S.: "Population Health Management — Hill's Handbook to the Next Decade in Healthcare Technology." Citi Research, May 14, 2013.

Population health management thus is *the* business challenge and opportunity for tomorrow's hospitals and health systems, and the means to transform health care from a silo-like treatment of services to coordinated care across the care continuum. PHM is the direction health care is moving, so simply stated, if participating in Medicare or Medicaid, all hospitals and health systems in California and nationwide are in the PHM business. Those that commit early to building the competencies and infrastructure required to advance population health can position or reposition themselves to achieve a sustainable role in this paradigm. Organizations that stand on the sidelines hoping that solely the old model will endure will be excluded from delivery networks and/or contracts. Such organizations are likely to find their financial and clinical strength — and their market presence — diminishing as competitors reshape the delivery system in their communities.

Key Competencies

PHM has significant business and economic dimensions for hospitals and health systems. These include responsibility for physician engagement; quality, access, and cost of care; incentive structures that reward high performance related to these measures; and patient and family education/engagement on healthy behaviors and lifestyle.

To meet and sustain PHM goals of coordinated and managed care across the continuum, hospitals and health systems must have strong capabilities in nine areas. These areas are particularly important to establishing the organization's value to consumers, payers, clinicians, employers, and other stakeholders. A brief description of each follows.

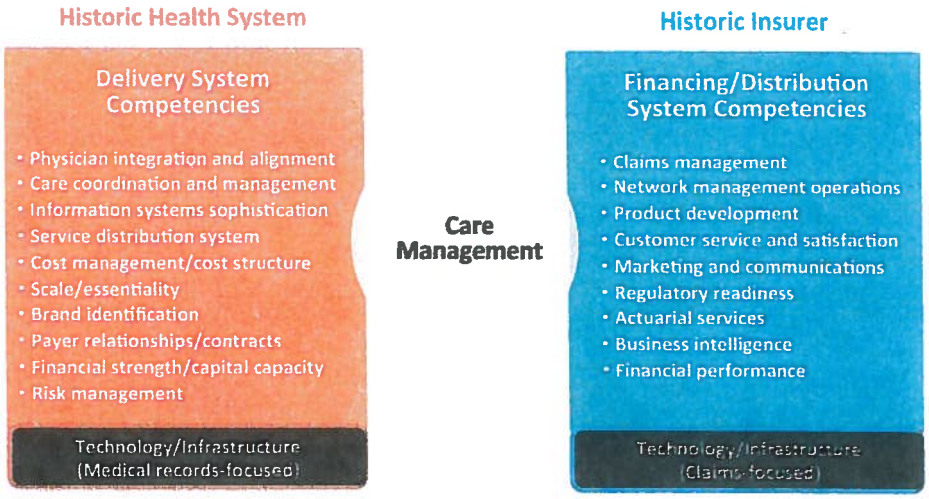
- **Network strength (development, configuration, and relevance):** A robust network — with hospitals, physicians, post-acute providers, and other providers — has an appropriate breadth of specialist and primary care offerings, scope of geographic coverage, and overall accessibility.
- **Clinical integration (CI):** Patient care services that are coordinated across people, functions, activities, processes, and sites maximize the value of services delivered.[6] Clinical and economic integration/alignment of physicians, nurses, and other providers across the care continuum furthers organizational goals around quality improvement, cost reduction, and strategic and financial sustainability. CI typically is achieved through the use of strong incentive structures and contracting mechanisms that reward improvements related to these metrics.
- **Operational efficiency:** Considerations include operating costs, structural costs, service rationalization, and clinical variation.
- **Clinical care management:** This is characterized by team-based, coordinated care delivery that includes utilization management, referral management, transitions of care, chronic disease management programs, and use of evidence-based practices and protocols to better manage patient care, especially for high-risk, high-use patients.
- **Clinical and business intelligence:** To set appropriate goals and intervention targets, clinical and business data must be collected, analyzed, and applied.
- **Financial strength:** Strong cash flows and a solid balance sheet enable organizations to invest in what is needed to compete, while managing overall enterprise risk.

"Business model disruption leaves a changed market in its wake, positively transforming businesses that can make the shift to a new model, reducing the relevance of many businesses that stick with the old model, and forcing the most vulnerable entities out of business."

- **Purchaser relationships (and managed care contracting):** Considerations include size and scope of arrangements, level of consumer engagement, strategic pricing, and ability to accept and distribute risk, incentives, and prepaid claims.
- **Customer service and consumer engagement:** Differentiation and recognition in the market is achieved through consumer engagement and strong brand presence.
- **Leadership and governance:** Deep bench strength of clinical, administrative, and governance leadership drives operational, strategic, and cultural change.

Some of these functions historically have been "housed" in the provider domain, while insurers traditionally managed other functions. Care management responsibilities often lie in between the two domains, historically resulting in fragmented care management capabilities (Figure 1).

FIGURE 1: *The Distinct Historic Competencies of Health Systems and Health Plans/Insurers*



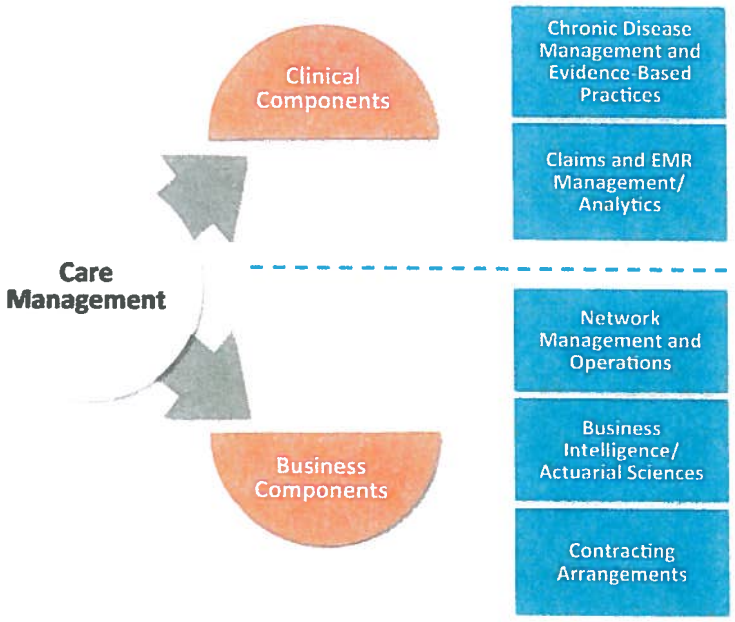
Source: Kaufman, Hall & Associates, LLC

PHM changes the demands on, and the relationships between, traditional industry participants. Comprehensive care management is required to meet PHM goals. This function spans the development of healthy behaviors by populations in the community, management of chronic diseases in home and community settings, treatment of acute illnesses in hospitals, and provision of services in post-acute, ambulatory, and home settings.

Comprehensive care management has *clinical components*, such as use of evidence-based practices, and claims and medical record management and analytics. The latter provides clinical decision support related to quality, outcomes, cost, utilization, and other information critical to health and healthy behaviors by defined populations in the community. Comprehensive care management also includes *business components*, such as delivery network management and operations, business intelligence and actuarial services, and contracting arrangements (Figure 2).

Ownership of these care management competencies historically has varied depending upon the contractual arrangements and related level of performance and/or financial risk that the particular insurer and health system chose to assume for the population served.

FIGURE 2: *The Clinical and Business Components of Effective Care Management*



Source. Kaufman, Hall & Associates, LLC

In some instances, physician organizations, including IPAs, have developed their own sophisticated care management infrastructures as they assume responsibility for the total cost of care for a population segment. In other instances, insurers have advanced their own care management capabilities for specific populations, assuming full provider risk and insurance risk for doing so. See "Types of Risk Assumed by Hospitals and Health Systems," page 7.

For example, in California under the Coordinated Care Initiative, health plans are assuming insurance risk (and provider risk in those instances when there are not subcapitation arrangements with providers) to provide dual eligibles and Medi-Cal beneficiaries with access to covered medical, behavioral, and long-term care services.[7] The plans receive monthly capitation payments from CMS and the state, but providers might be paid on a fee-for-service (FFS) or capitated basis.

Today, many sophisticated hospital systems that want to manage the total cost of delivered care are developing or enhancing such capabilities through partnership or affiliation arrangements with a health plan, a risk-bearing provider organization, and/or a managed care company. A Knox-Keene license[8] is required of health systems to contract with California health plans and assume full delegated risk for services.

For example, Dignity Health Provider Resources, recently formed by Dignity Health, is seeking a limited Knox-Keene license to contract with California health plans and assume delegated risk for professional, hospital, and other covered services across the spectrum of a patient's care.[9]

MemorialCare Health System, an integrated delivery system in Los Angeles and Orange Counties, with six hospitals, robust physician and outpatient networks, and a Knox-Keene licensed health plan of its own,[10] has secured numerous partnerships with both insurers and providers. It is one of seven health systems that have partnered with Anthem Blue Cross to launch Vivity, a fully insured HMO product for the large-group market in Southern California. The hospitals receive discounted FFS payments from Anthem, share financial gains and losses for the total cost of care through Vivity, and compensate affiliated physicians through capitated payment arrangements.[11]

Given Managed Care, PHM Prospects and Progress in California

At what stage is California, its health care providers, and other stakeholders in managing population health?

California has a long track record of providing "managed" health care that is more efficient and coordinated than what occurs in the rest of the nation. Federal and state legislation — the HMO Act of 1973 and the Knox-Keene Health Care Service Plan Act of 1975 — encouraged risk-based models, which involve health plans, physicians, hospitals, and other providers in active care management. These models, the early presence of Kaiser Permanente,[12] the development of large medical groups, and the formation of integrated health care delivery systems hastened capabilities to manage the total cost of care for specific populations.

Types of Risk Assumed by Hospitals and Health Systems

Risk in PHM contracting arrangements for hospitals and health systems falls into two categories:

- ***Provider risk*** is assumed by the entities delivering health care services, and includes two types:
  - *Clinical or performance risk,* which is the ability to deliver patient care that exceeds the targets for safety, quality, compliance, and other measures defined in the risk contract with the payer
  - *Utilization or financial risk,* which is incurred by a provider organization through acceptance of a fixed payment in exchange for the provision of care anticipated to have an expected level of utilization and cost
- ***Insurance or plan risk*** is assumed by hospitals and health systems that have their own insurance plans, with "ownership" of the members and the overall cost of plan administration and/or care delivery. Hospital- or insurer-owned plans that are contracting with providers for the provision of care under capitated arrangements are not technically taking on *provider risk.*

Source: Kaufman, Hall & Associates, LLC

"Many sophisticated hospital systems that want to manage the total cost of delivered care are developing or enhancing care-management capabilities through partnership or affiliation arrangements."

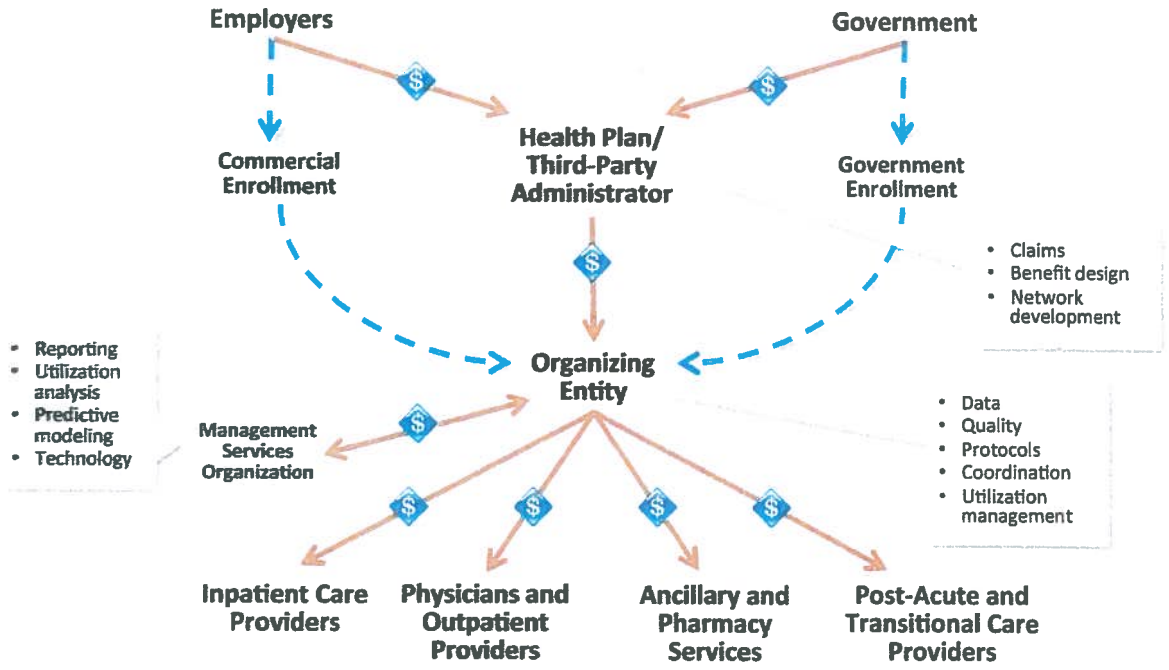
Jody Hill-Mischel and Mark E. Grube

Providers in California's HMO/managed care system have used the delegated risk model to manage and organize care for specific populations across the care continuum (Figure 3).

Historically, large physician organizations (IPAs and medical groups) and integrated health plans have been the primary organizers in this model, with hospitals and health systems forming part of their networks under FFS arrangements. Under this model, physicians and other provider organizations are rewarded for efficient and effective care delivery, particularly the active management of chronic disease and reduction of unnecessary utilization, as consistent with the PHM goals. The IPAs and medical groups typically receive a capitated payment for professional and/or institutional services per enrollee in exchange for the groups' assumption of responsibility for downstream costs, utilization management, and chronic disease care management for assigned enrollees.[13]

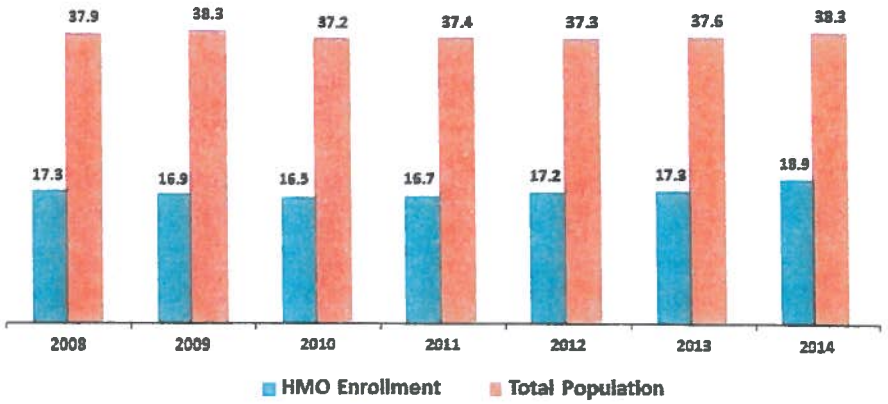
HMO enrollment has been relatively steady and strong in California. While nationwide HMO enrollment of covered workers in employer-sponsored health plans declined to 13 percent in 2014 from a high of 31 percent in 1996,[14] HMOs remain more prevalent and have higher enrollment in California than in other states.[15] HMOs currently capture 49 percent of commercial enrollment in the state,[16] and a similar percentage of combined commercial, Medi-Cal, Medicare/duals, and Healthy Family enrollment (Figure 4).[17] Recent high-deductible health plans and preferred provider organization (PPO) exchange products are attracting employers and consumers nationwide, but managed care plans with Triple Aim goals[18] aligned with PHM likely will remain a durable offering in California.

FIGURE 3: *California's Delegated Risk Model*



Source: Kaufman, Hall & Associates, LLC

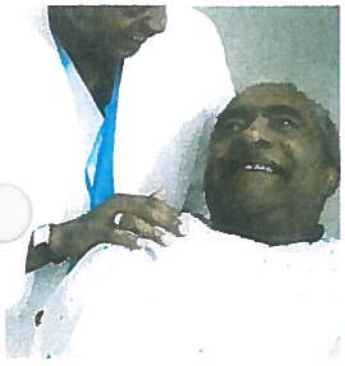
FIGURE 4: *HMO Enrollment and California Population, in Millions*



Source. Data from Cattaneo & Stroud, Inc.. Total of Medical Groups' HMO Enrollment by County with Business Lines (2004-2014). www.cattaneostroud.com/med_group_reports/10-Web.pdf

Managed care has maintained a strong presence in California for numerous reasons, including how the market evolved under the state's corporate practice of medicine law. The law prohibits the direct employment of physicians by hospitals and health systems. Hospitals established medical foundations to more closely align clinically with physicians[19] and physicians grouped into IPAs and other organizations, gaining experience in managing care and assuming risk in HMO and other managed care arrangements with insurers. PPOs did not gain as large a foothold in California as they did in the rest of the nation, because the state had decades of experience with risk enabled HMOs that offered employers and consumers competitive prices for coordinated care with sizeable IPA-driven physician panels.

The long-standing and significant presence of managed care has contributed to California's success in containing costs through the provision of coordinated care.[20] Total health spending per capita in California was 9 percent lower than U.S. spending ($6,238 vs. $6,815) in the most recently reported year.[21] California's inpatient days per 1,000 population also was significantly below national and regional averages under commercial HMO, Medicare HMO, and Medicare FFS plans (Figure 5). The track record likely has resulted, at least in part, from tight utilization controls exerted by HMOs, and the administrative and care management experience gained by providers (chiefly physician-driven organizations) that assumed clinical and utilization/financial risk for patient care under HMO capitation/delegated risk contracts.[22]

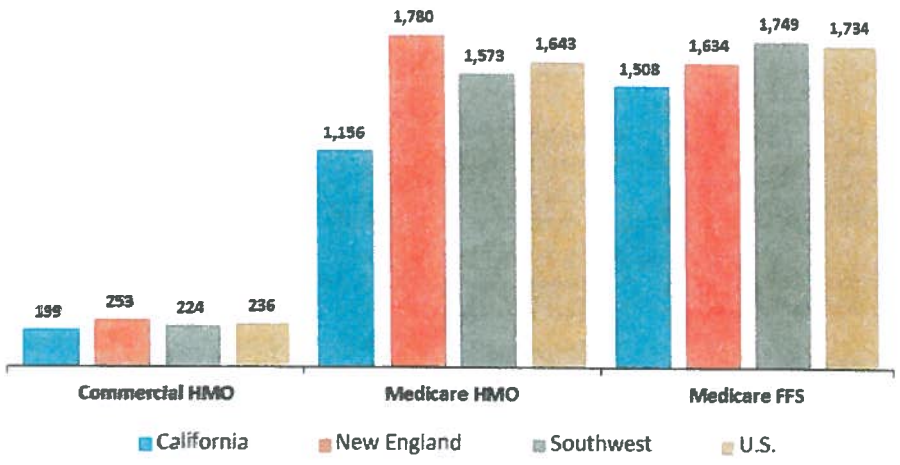


"Business as usual for U.S. hospitals and health systems is out the window. A new problem – learning to manage population health – must be solved."

California's health insurance and delivery markets will continue to evolve. Provider-sponsored HMOs or other insurance products with similar benefit designs declined during the 1990s, but may re-emerge as some sophisticated health systems move to access the full premium dollar while continuing to coordinate care and manage the total cost of care. Given Medi-Cal expansion and continuing growth of Medicare Advantage, HMO usage can be expected to increase for managed government products. PPO products, especially those with HMO-like plan designs, may gain market penetration as employers turn to self-funded PPOs with high deductibles and tiered networks to control their health care expenditures.

On the delivery side, the growth of collaborations to form integrated delivery systems that assemble acute care and other care continuum components with sophisticated and aligned physician organizations under a PHM construct may dissolve the distinction between whether integrated health systems or physician organizations are the organizers of care delivery.

FIGURE 5: *Comprehensive Inpatient Days per Thousand by Select Product Type, CY 2011*



Source: Managed Care Digest Series: California Health Care Data Summary 2013, 6th Edition.

Provider Organization Roles in Future PHM

All new arrangements between hospitals, payers, physicians, and other health care entities in California will need to focus on Triple Aim/PHM goals, emphasizing quality improvement and patient experience in addition to financial efficiencies for specific population segments. As the ability to continue to reduce utilization narrows, systems will compete based on the efficient provision of high quality, accessible care for defined populations.

Different provider roles have emerged and likely will continue to emerge, with variations in capabilities and functions in a PHM network. General categories reflect the organizations' ability to incur risk in managing a specific segment of the population's health — extending from no risk, as is common in a FFS system, to the ability to assume full prepaid payments and/or capitated provider and/or plan risk (Figure 6).

A limited number of sophisticated health systems likely will function as *"population health managers"* to provide a full continuum of services across acuity levels at competitive prices for regional population segments, either directly or through contracted relationships, and assume full provider risk for doing so. Some population health managers also will have a health plan and be able to strengthen their strategic and financial performance by integrating health care financing and delivery, and assuming plan risk.

A larger number of health systems — perhaps called *"population health comanagers"* for comparative purposes — will provide a clinically integrated delivery network of defined scope. They will assume provider risk for the population segment covered by a network owned by another entity that is receiving and administering the premium revenue. These organizations will manage the cost of defined care and health of a population, but have more limited exposure to the financing and product development/distribution risks of a health plan.

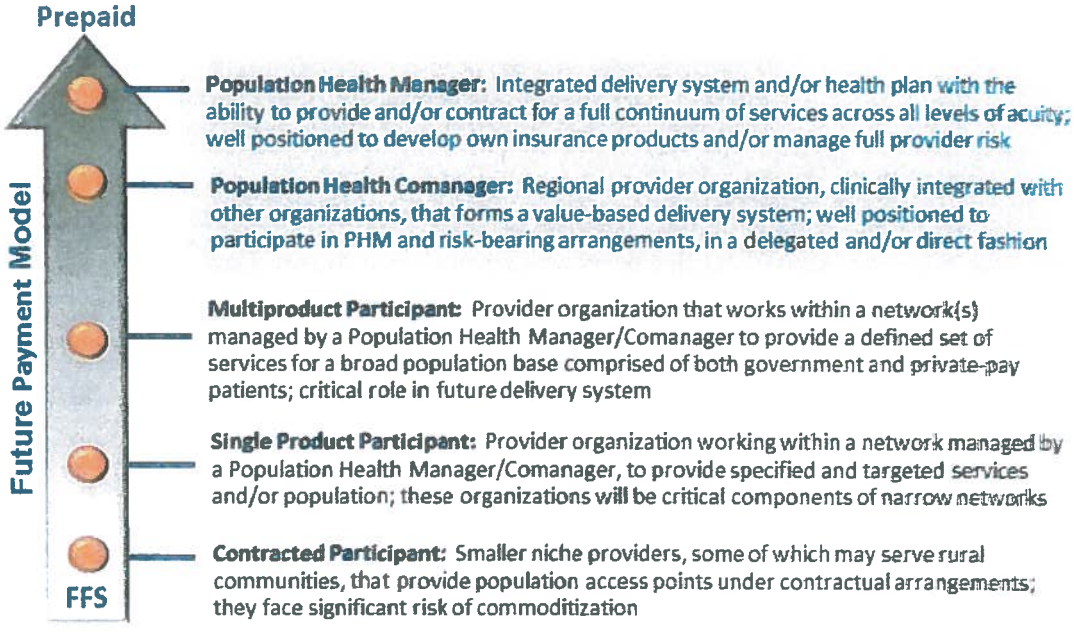
"Single product participant" and *"multiproduct participant"* roles in between will be assumed by community hospitals and health systems that will work within a network managed by a population health manager or comanager to efficiently provide a single service or a portfolio of services to a select or broad group of patients.

Some providers, such as post-acute facilities and critical access hospitals, will be *"contracted participants,"* that offer specified services to target population segments under contracts, working within networks that are managed by larger entities.

Figure 7 summarizes the requirements of each provider role.

An organization's desired PHM role must be firmly grounded in its strategic-financial condition, its organizational competencies, the readiness for PHM in its community, and the current and emerging PHM environment. A key challenge for organizations will be aligning their service delivery model with the insurance plan/product landscape to ensure access to current and future populations/members.

FIGURE 6: *Provider Roles in Population Health Management*



Source: Kaufman, Hall & Associates, LLC

FIGURE 7: *Summary of Provider Roles and Key Characteristics*

Characteristics	Contracted Participant	Single Product Participant	Multiproduct Participant	Population Comanager	Population Manager
Risk/Payment	None, FFS payment	Blend/ episodic	Blend/episodic	Full or partial provider risk; unlikely to assume health plan risk	Full provider risk; may take health plan risk
Clinical Integration	No	Maybe	Likely	Yes	Yes
Network Adequacy/ Market Essentiality	Low	Low	Low to moderate	Moderate	High
Insurance License Ownership	No	No	No	Maybe, but not required	Limited or regular license
Membership Ownership	No	No	No	Maybe, but unlikely	Yes
Examples	• Critical access hospitals • Safety net hospitals • Community hospitals	• Academic medical centers • Children's hospitals • Specialty hospitals • Senior IPAs (e.g., CareMore) • Community health systems		• Integrated delivery networks (e.g., Kaiser) • IPAs (e.g., DaVita HealthCare Partners) • Clinically integrated networks (e.g., Dignity/UCSF/Hill)	

Source: Kaufman, Hall & Associates, LLC

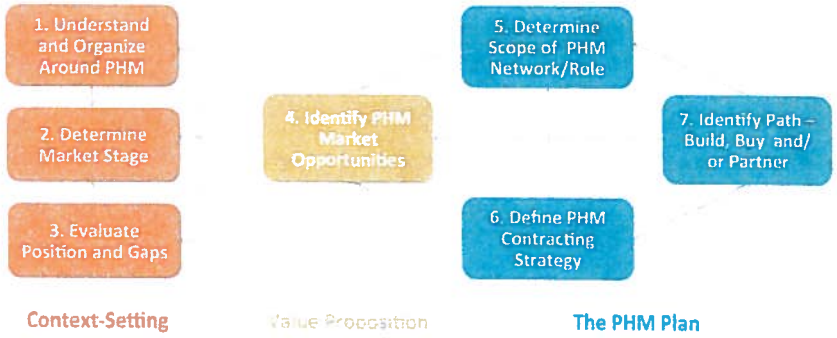
Framework for the Pursuit of PHM

Moving toward PHM is a complex process. The challenge for hospital leadership teams is not to determine *if* a hospital is going to participate in PHM and value-based care delivery, but rather where, when, and how.

A seven-level framework provides detailed guidance on developing a financially sustainable role in PHM through critical inter-related analyses and decisions (Figure 8). This process ensures that the leadership team identifies the *right* PHM role, the *right* PHM market opportunity, the *right* scope of the PHM delivery network achieved through building, buying, or partnering, and the *right* PHM contracting strategy. For organizations that have started the journey, the framework helps their leaders determine the next strategy(ies) to pursue.

Numerous activities described within this framework may be occurring simultaneously as an organization pursues value-based PHM opportunities. Each level is described briefly here, but subsequent Issue Briefs and webinars will address specific levels in greater depth.

FIGURE 8: *The Framework for Pursuit of PHM Opportunities*



Source: Kaufman, Hall & Associates, LLC

Level 1. Understand and Organize Around Population Health Management

During this context-setting stage, hospital and health system leadership teams gain a clear understanding of what population health management is and of the care management imperative that will drive the coordination and management of patient care across the continuum.

Additionally, leadership teams assess the PHM roles providers can play, as described in the previous section, and identify the role or roles that should be explored further given the organization's strengths and weaknesses. There must be clear understanding that, as defined earlier, PHM means working in a coordinated manner to improve the overall health, health outcomes, and well-being of a given population across all defined care settings under risk-bearing arrangements.

Level 2. Determine the Market's Stage and Pace of Change

Market readiness for PHM and how quickly the market is changing can be gauged through analysis of seven characteristics:

- **Level of organization among hospitals and physicians:** Indicators of the level of organization in a market area typically include the extent of hospital consolidation, physician group size, provider network size, degree of clinical integration, and geographic coverage/number of covered lives by specific entities.
- **Employer health care benefits structure:** The shifting of employees into high-deductible/ consumer-driven health plans that are available through traditional insurers and private exchanges is boosting transparency, along with cost sensitivity. Quickly evolving markets have a high penetration of consumer-driven health care purchasing.
- **Enrollment in exchanges and level of insurance product/network sophistication:** Enrollment in public and private exchanges and high deductibles available through tiered-benefit programs also are increasing the level of consumerism and price sensitivity. In many regions, payers are forming tiered or narrow networks for both exchange and traditional insurance offerings, with a focus on lower costs and increased care management.
- **Amount of vertical collaboration and new-entrant activity:** Vertical networks that pair providers and payers typically use integrated care models with new, value-based incentive structures for financing, delivery, and clinical care management. Network inclusion or exclusion has or can have major implications for hospitals and health systems in the covered area.
- **Demand for services:** Lower utilization of inpatient services, shifting demand for ambulatory services, and the proliferation of web or mobile-based services will force providers to reposition themselves. Notwithstanding population aging trends and the newly insured, considerable hospital inpatient utilization is "vulnerable" — i.e., likely to decline further as health care costs are reduced.
- **Supply of providers:** If the number of hospitals, beds, and physicians in a region is too high, providers will experience significant "pricing and/or reimbursement pressure" as utilization falls and demand shifts to ambulatory settings and virtual care delivery. When there is an oversupply of providers, pricing pressure also results from provider willingness to take on discounted FFS arrangements in order to guarantee patient and referral volume.
- **Regulatory environment:** Federal and state legislation and regulations materially affect the way providers conduct business, at times slowing the pace and degree of change. Providers operating in localities where regulatory factors are more abundant and limiting often face challenges in building the structures and relationships necessary to drive value-based care delivery.

The seven market elements described here need *not* be working at the same time to shift a market rapidly for area providers. In some markets, initiatives by one type of stakeholder move the needle significantly. In other areas, new market entrants or new regulations begin and accelerate the process. A single decision by a physician group, payer, or employer can weaken or completely undercut a health system's efforts to gain market share through clinical network development, targeted community outreach, or other initiatives.

Level 3. Evaluate Organizational Position and Competence Gaps

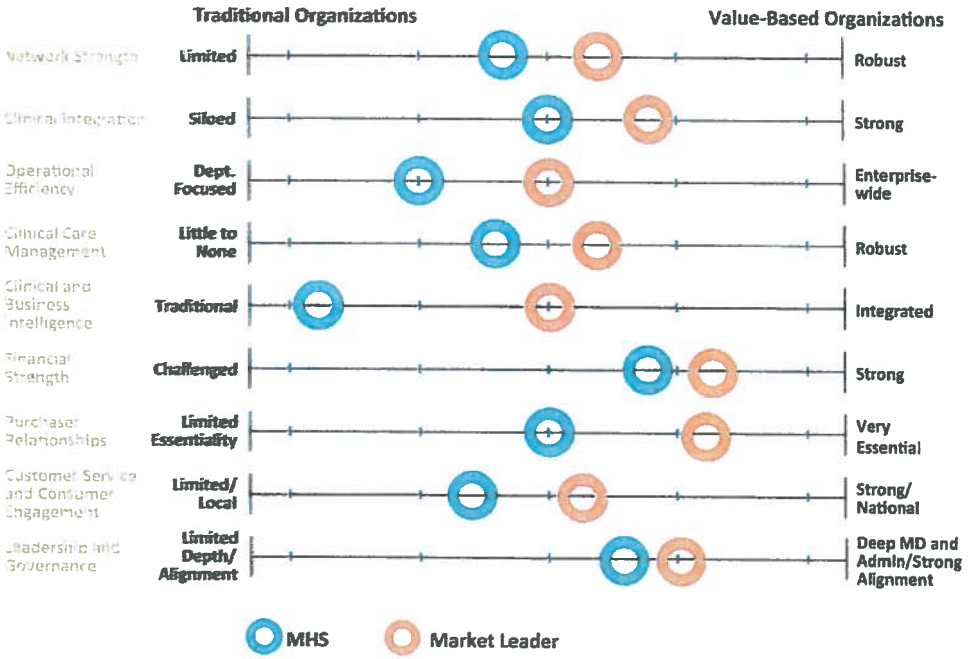
Hospital and health system leadership teams should evaluate the organization's current position relative to the nine critical capabilities described under "Key Competencies," page 4. Identification of appropriate opportunities to manage population health must be based on the organization's competitive strengths and weaknesses in each area.

For example, a multihospital system (MHS) with several physician networks believes that it might be well-positioned as a population comanager in its highly competitive and rapidly developing market. In the example diagramed below, an in-depth assessment compared the system's current performance to that of the market leader along the nine competencies, using qualitative and quantitative measures (Figure 9).

Leadership determined that it would not be realistic to try to develop all of the financing/distribution or care management competencies, but that four areas of focus likely would be required to proactively create new growth opportunities: network development and management; brand and customer service and engagement; clinical and business intelligence capabilities; and purchaser relationships (e.g., employer and payer).

Identification and analysis of potential opportunities to fill these competency gaps would need to be extensive and include other health systems, physician networks, commercial health plans, and self-insured employers.

FIGURE 9: *Sample Assessment of a Multihospital System's (MHS) Current Readiness in Nine Competency Areas*



Source: Kaufman, Hall & Associates, LLC

Level 4. Identify PHM Market Segments and Opportunities

Identifying entry and/or expansion points into the PHM arena is complex and critical work. The strongest organizations will be looking for opportunities to operate a risk-bearing network that spans delivery and financing/insurance plan functions across a care continuum. Most hospitals will be looking for PHM opportunities that will enable them to contract with another entity to provide services and thus foster delivery system growth. Some hospitals will be looking for a mix of the two.

Key variables related to opportunities include:

- The specific patient population, which should be segmented and considered by how it is insured
- The overall insurance market, including available networks, product types, benefit designs, enrollment, pricing, and other items
- The value proposition the organization would offer within its community based upon its unique mix of access, service, quality, and cost

The organization's PHM strategy should be objectively defined within its integrated strategic-financial plan so that risk is effectively managed as the organization transitions to new value-based payment mechanisms.

Level 5. Determine Scope and Scale of Required PHM Network

Effective and sustainable PHM requires the design of a high-performance provider network covering the care continuum (Figure 10). In moving away from FFS care delivery and financing models, organizations must scrutinize their networks, or a network in which they participate, in a different light.

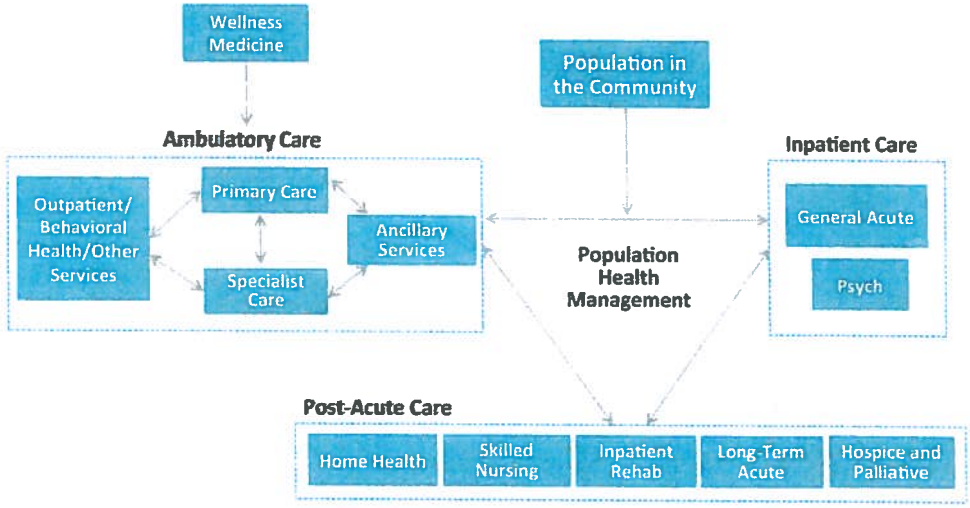
Many traditional criteria for a viable network still apply (e.g., access points, competitive position), but the following four criteria also will need to be assessed on the basis of populations served and insurance plan coverage:

- **Network essentiality (size/scale):** This often is tied to an organization's primary care network, and measured based on the population that can be attributed to the provider network/delivery system. (In fragmented hospital markets such as Los Angeles, health system-developed networks without sufficient size may find health plans unwilling or unable to work with them to develop PHM models.)
- **PHM care continuum (breadth/depth):** Most hospitals and health systems will find it prohibitively expensive to acquire capabilities across the full continuum of care settings; collaborative partnerships and affiliations will be needed.
- **Network performance and outcomes:** Performance will be monitored against specific cost, quality, and access targets in applicable risk contracts.
- **Overall "network adequacy":** This refers to an entity's ability to deliver the benefits promised under the contract terms by providing access in a service area to a sufficient number of in-network physicians, and hospital and other services.

"Commitment to a new view of health care's future requires accepting that hospitals are not assured a position as the controlling hub of healthcare in their communities."

Kenneth Kaufman and Mark E. Shulbe

FIGURE 10: *Coordinating Care in the Continuum of PHM Settings*



Source: Kaufman, Hall & Associates, LLC

Level 6. Define a Contracting Strategy to Support PHM Opportunities

The movement toward value-based care under a PHM construct is not a "one-size-fits-all" mandate. Organizations can take and are taking incremental steps toward managing the total cost of care (i.e., assuming full provider risk) in a "budgeted care" or "prepaid" contracting environment.

The spectrum of provider risk contracting options should be closely evaluated to ensure that the risk model appropriately aligns with an organization's size, sophistication, PHM readiness, start and desired end-point along the risk continuum, and the stage of transition toward value in its market. Leadership teams must start moving their contracts to risk-based arrangements to gain critical experience in meeting PHM objectives. Inaction or inadequate action could impair the organization's ability to meet such objectives longer term.

Arrangements along the risk continuum (Figure 11) extend from no risk to full risk as follows:[23]

- **Fee for Service (FFS):** The predominant model historically, under FFS arrangements, providers are paid for the quantity and intensity of care delivered. Because payment is not dependent upon the quality or cost of care delivered, the provider has neither performance risk nor financial risk. Providers benefit from increases in the number of patients seen and in the number of tests and treatments provided to each patient.
- **Pay for Performance (P4P):** Hospitals, physicians, or other providers receive bonus payments to their FFS reimbursement or have a portion of their pay withheld based on whether they meet preset performance targets. Targets may relate to quality, cost effectiveness, efficiency of care, or other factors.
- **Shared Savings:** The shared savings model offers incentives to reduce health care spending for a defined patient population by giving providers a percentage of net savings realized as a result of their efforts to decrease care costs. Over the long run, shared savings models are difficult to sustain because the savings pool is finite and extracting incremental savings as care improves is challenging.

- **Case Rate (Episode-of-Care or Bundled):** Providers are paid a fixed amount for services required by a patient for a specific procedure or condition, such as a total knee or hip replacement. Providers benefit from the savings they generate through improved efficiencies in care delivery, but payers are likely to provide lower upfront payments for each care episode as efficiencies improve. Providers are at risk for the cost of care delivered if it exceeds the predetermined payment amount, but continue to benefit from seeing a greater volume of patients.
- **Partial Risk:** Under partial capitation or partial risk, a provider typically takes on full financial and clinical risk for a specified set of services (for example, acute care services, but not professional services), receiving a single fixed payment for those services.
- **Shared Risk:** Providers share with the payer both positive and negative financial risk depending on whether the cost of care exceeds the pre-specified payment amount. The level of savings (or losses) depends on the negotiated arrangement between the provider and the payer, and typically is a percentage of the total premium dollar or a proportion of the cost overruns. Because providers take on more downside risk in this model, various contracting mechanisms are often used to limit the provider's financial exposure. These include stop-loss insurance (provider pays a fixed fee to another insurer to accept the risk beyond a specified amount), risk corridors that limit upside and downside risk, and carve-outs for patient populations where the clinical risk may be more difficult for the provider to manage.
- **Full Risk:** Under full-risk "capitation" arrangements, providers receive a single fixed amount per patient per month, or periodically receive a predetermined percentage of the premiums that patients pay to insurers. Providers are able to keep any savings if costs are below the capitated amounts, but are responsible for any cost overruns. Global capitation payments cover all patient services, while partial capitation payments cover only a specified portion of services. The entity contracting with the payer must have downstream network contracts covering the specified continuum of care. Cost savings, after administrative fees, can be distributed per contract agreement.
- **Provider-Sponsored Insurance:** With provider-sponsored insurance, the provider manages not only the total cost of care (full provider risk) but 100 percent of the financial risk for insuring the patient and controlling the full premium dollar. Provider-sponsored insurance represents the greatest level of financial and clinical control because the provider organization controls the clinical aspects of care and care financing and administration.

FIGURE 11: *The Range of Contracting Arrangements on the Risk Continuum*

Source: Kaufman, Hall & Associates, LLC

Hospitals and health systems need to be thoughtful and realistic about the skills and infrastructure needed to manage different types of payment arrangements under PHM. An organization's risk-contracting strategy should be part of its comprehensive business plan, which provides the documentation and analysis necessary to validate capital decision making related to risk contracting and PHM scope.

Level 7. Identify the Appropriate PHM Path for the Organization — Build, Buy, or Partner

Hospitals and health systems should explore options for achieving PHM expertise, whether doing so via one or more of the following means:

- Building competencies and capabilities internally
- Buying or purchasing access to certain competencies or services from another entity
- Partnering with another entity to gain access to required competences

To participate in PHM in a significant way, most hospitals and health systems will need to use the latter two approaches. Whether building, acquiring, or partnering with another entity to develop capabilities and network components, the decisions are complex, interrelated, and highly market- and organization-specific. Key questions required to identify build, buy, or partnership objectives typically include:

- Does the organization need health plan capabilities to achieve its vision?
- If yes, does it need full or limited health plan capabilities?
- Which products should be the organization's focus?
- How broad does the health plan coverage need to be and how broad is it today?
- Is the organization better off building, buying, or partnering to obtain the capabilities needed to provide the product to the intended market?

Potential partners for hospitals and health systems could include many different types of entities, including health plans, health systems, management services organizations, and other types of traditional and nontraditional service companies. As with merger/partnership arrangements in all industries, the degree of integration desired by the partnering organizations has a broad spectrum. This ranges from low (leveraging existing arrangements) to high (full sale to partner) with joint venture, minority interest, and 50/50 partnerships in between.

Implications for California Hospitals and Health Systems

The nation is moving to a care delivery and payment model based on PHM. Hospitals and health systems must establish their vision for the future, and invest in the PHM model through a strategic and planned approach, with awareness that a positive return on investment may take many years or even decades to achieve. For most organizations, partnerships to cover new services and/or geographies are required and must be secured during coming years.

An organization's pursuit of best-fit PHM opportunities for sustainable performance must be founded on a thorough understanding of the PHM model and its implications for providers, payers, consumers, and other stakeholders. Key requirements for California's hospitals include leadership vision and commitment, and the ability to manage the large-scale cultural and operational change needed for rapid health care transformation in their regions. Stay tuned for the next Issue Brief and enjoy the forthcoming webinar.

"Hospitals and health systems need to be thoughtful and realistic about the skills and infrastructure needed to manage different types of payment arrangements under PHM."

Endnotes

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POPULATION HEALTH MANAGEMENT

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Webinar 1 — April 28, 2015
A Framework for Population Health Management

Webinar 2 — June 2, 2015
Business Imperatives of Population Health Management

Webinar 3 — July 14, 2015
Clinical Imperatives of Population Health Management

Webinar 4 — August 25, 2015
Technology for Population Health Management

Webinar 5 — October 6, 2015
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REGISTRATION AND PROGRAM INFORMATION

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Or call CHA Education at (916) 552-7637

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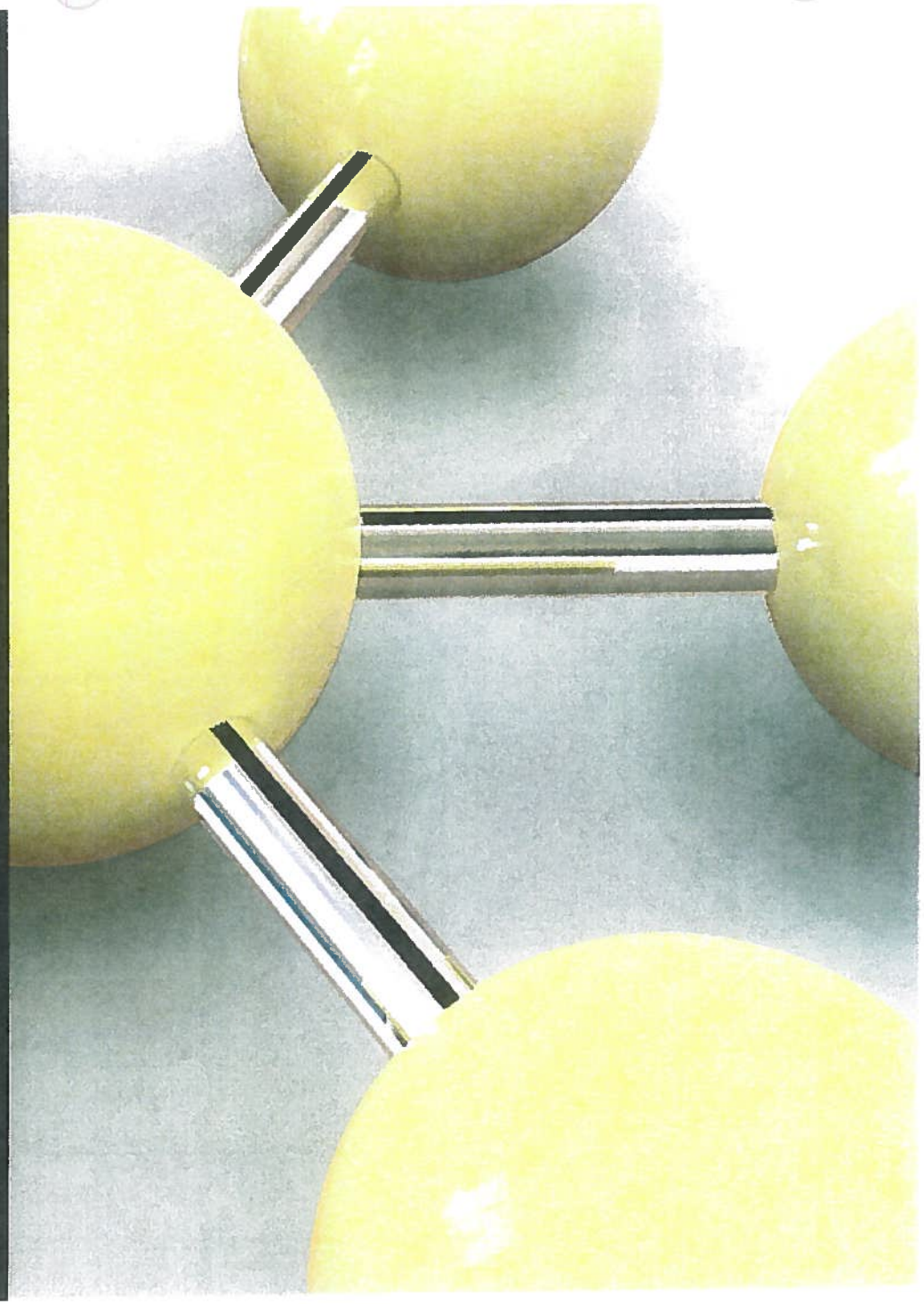

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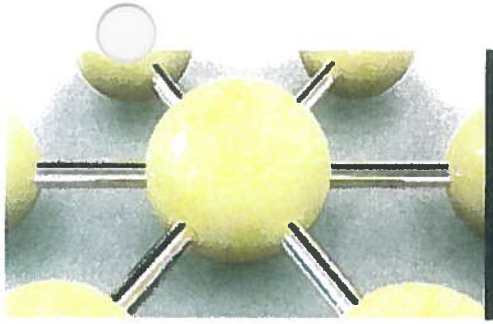
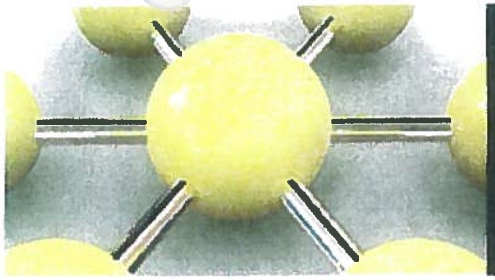


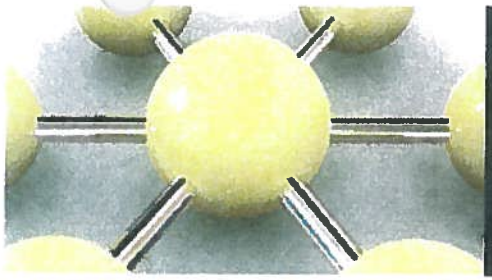
Population Health Management: What Is It?

PHM is an approach to improving health and quality of care while managing costs. This is the direction healthcare is moving, and all stakeholders will need to get on board.

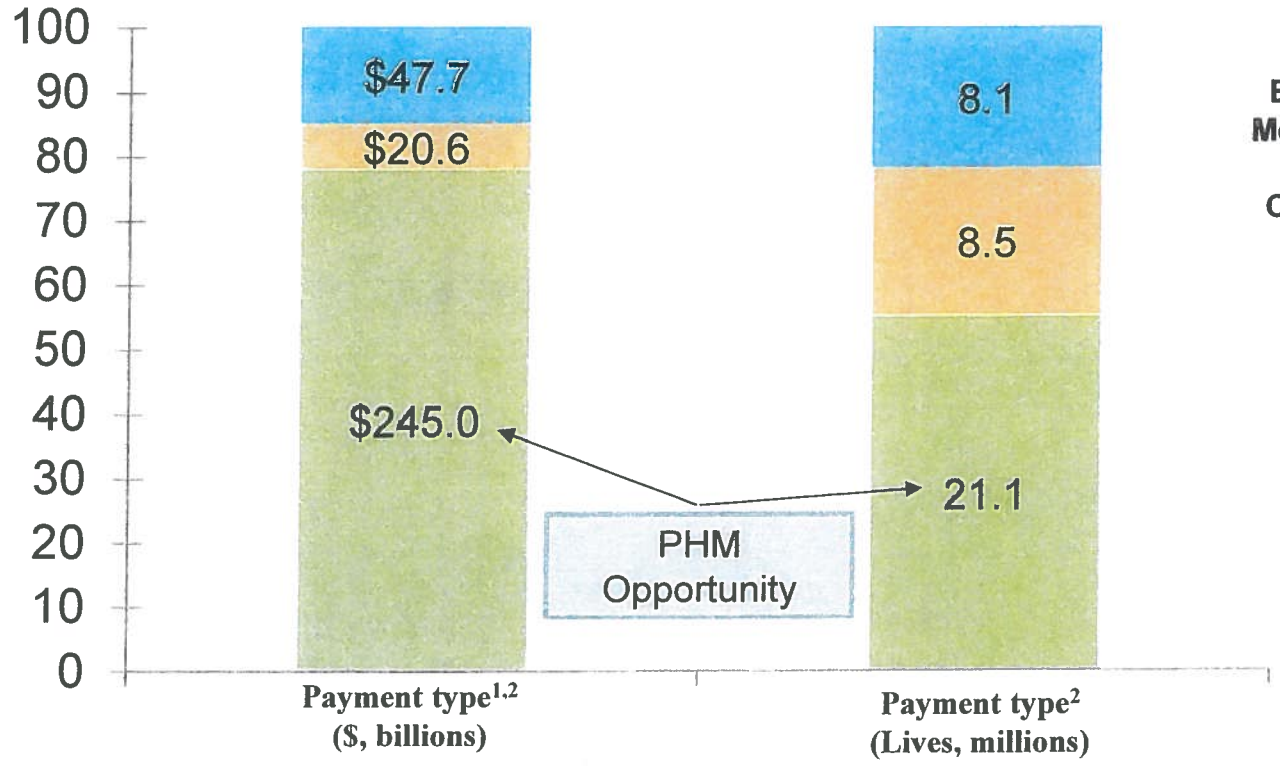


Drivers of PHM

- Macroeconomic issues are driving real change
- Employer and insurance markets are transforming
- Consumerism is increasing
- Well-funded competitors are emerging
- Innovative technology is changing care delivery

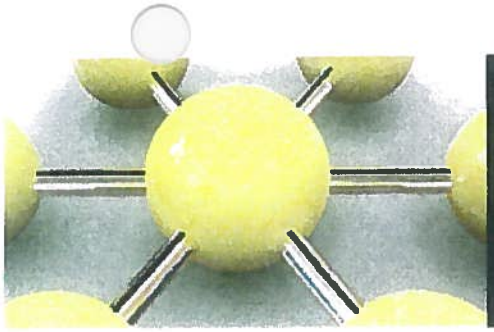


Significant Opportunity Exists for Hospitals to Lead the Population Health Movement in CA



Breakdown of Payment Mechanisms and Delivery System Integration in California, by Lives and Dollars, 2012

Notes: 1. Expenditure estimates are reported in 2012 dollars. 2. Full/dual risk refers to a payment arrangement in which providers accept risk for both professional services and hospital services; Partial risk refers to a payment arrangement in which providers accept professional services risk only.
Source: Scheffler, R.M., Bowers, L.G.: *A New Vision for California's Healthcare System: Integrated Care with Aligned Incentives*. Berkeley Forum and University of California, Berkeley School of Public Health, Feb. 2013.



POPULATION HEALTH MANAGEMENT

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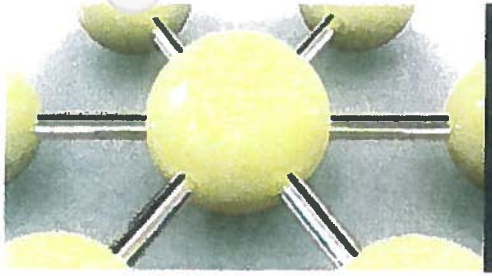
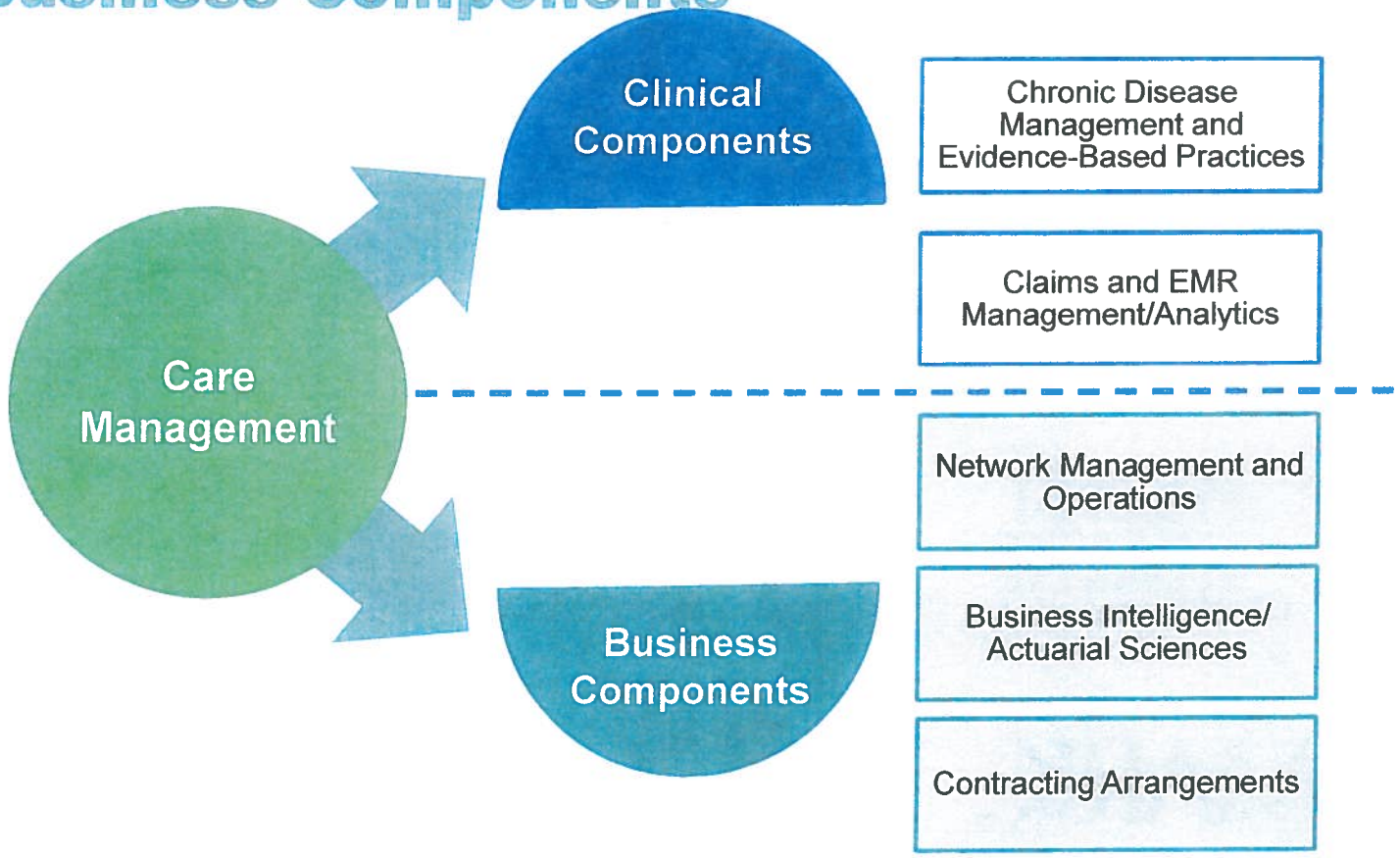
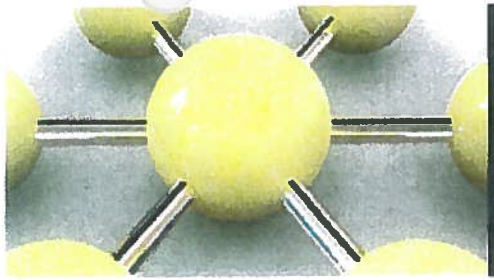
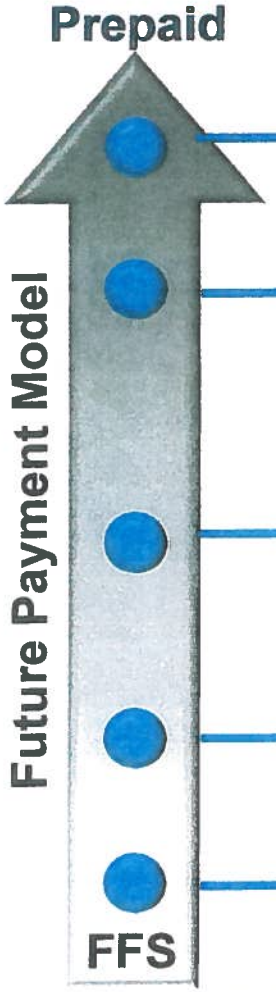


Effective Care Management Has Clinical and Business Components





Provider Roles Vary



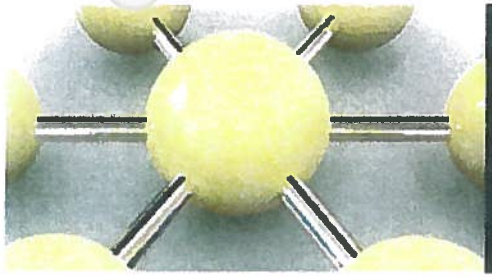
Population Health Manager: Integrated delivery system and/or health plan with the ability to provide and/or contract for a full continuum of services across all levels of acuity; well positioned to develop own insurance products and/or manage full provider risk

Population Health Co-manager: Regional provider organization, clinically integrated with other organizations, that forms a value-based delivery system; well positioned to participate in PHM and risk-bearing arrangements, in a delegated and/or direct fashion

Multiproduct Participant: Provider organization that works within a network(s) managed by a Population Health Manager/Comanager to provide a defined set of services for a broad population base comprised of both government and private-pay patients; critical role in future delivery system

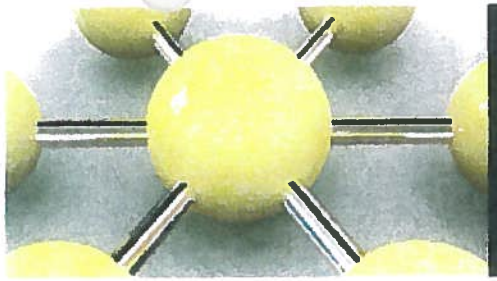
Single Product Participant: Provider organization working within a network managed by a Population Health Manager/Comanager, to provide specified and targeted services and/or population; these organizations will be critical components of narrow networks

Contracted Participant: Smaller niche providers, some of which may serve rural communities, that provide population access points under contractual arrangements; they face significant risk of commoditization



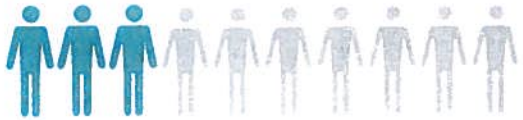
Key Characteristics of Future Roles

Characteristics	Contracted Participant	Single Product Participant	Multiproduct Participant	Population Co-manager	Population Manager
Risk/Payment Model	None, FFS payment	Blend/episodic	Blend/episodic	Full or partial provider risk; unlikely to assume health plan risk	Full provider risk; may take health plan risk
Clinical Integration	No	Maybe	Likely	Yes	Yes
Network Adequacy/ Market Essentiality	Low	Low	Low to moderate	Moderate	High
Insurance License Ownership	No	No	No	Maybe, but not required	Limited or regular license
Membership Ownership	No	No	No	Maybe, but unlikely	Yes
Examples	• Critical access hospitals • Safety net hospitals • Community hospitals	• Academic medical centers • Children's hospitals • Specialty hospitals • Senior IPAs • Community health systems		• Integrated delivery networks • IPAs • Clinically integrated networks	



POPULATION HEALTH MANAGEMENT

Population Segments



Healthy

- Wearable health monitoring technologies, mobile, smartphone-enabled devices
- Reminders for annual wellness check-ups and cancer screening services
- Telehealth services provide easy access and routine interventions
- Patient portals and personal health records – results review and tracking

At-Risk & Stable

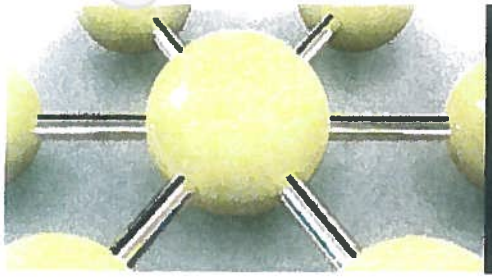
- Health risk assessments, targeted calls, emails, text invitations and routinized contact
- Online education, health coaching and group initiatives prediabetes, blood pressure control, weight management, etc.

Chronic Simple & Complex

- Home monitoring
- Extended team care planning, medication compliance, scheduled reviews and tracking of interventions
- Patient and family member contribution to care team notes
- Predictive and prescriptive views of outcomes and cost

Critical

- 24/7 services needed to keep patients in their home, avoid unnecessary hospitalizations, support family caregivers and reduce the burden on family physicians
- Patients and caregivers benefit from electronic communications of Advanc Directives and Powers of Attorney, specialized care pathways, pain management protocols, etc.
- New initiatives examining the role of tele-hospice



Define the Strategic Roadmap

1. Understand and Organize Around PHM
2. Determine Market Stage
3. Evaluate Position and Gaps

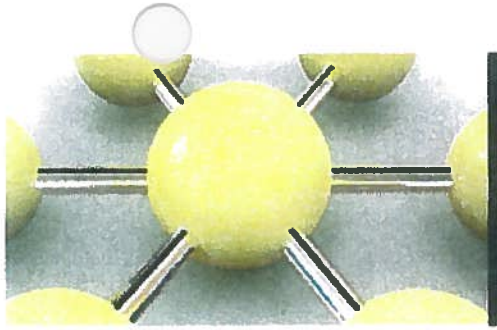
Context-Setting

4. Identify PHM Market Opportunities

Value Proposition

5. Determine Scope of PHM Network/Role
6. Define PHM Contracting Strategy
7. Identify Path –Build, Buy and/or Partner

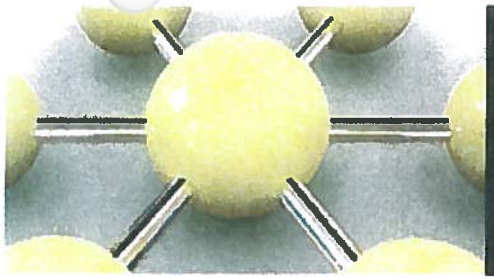
The PHM Plan



Identify Path – Build, Buy, and/or Partner

- Build competencies and capabilities internally
- Buy or purchase access to certain competencies or services from another entity
- Partner with another entity to gain access to required competences

To participate in PHM in a significant way, most hospitals and health systems will need to use the latter two approaches.



POPULATION HEALTH MANAGEMENT

Where is your organization today in the journey toward PHM?

1. Studying, but not yet participating
2. Involved in pilot projects
3. Involved in ongoing initiatives
4. Early adopter and innovator
5. Other

Six Business Imperatives Expand Board Oversight

BY MARK E. GRUBE, KAUFMAN, HALL & ASSOCIATES, LLC

Healthcare's transition to a population health model presents hospitals and health systems with significant business opportunities and challenges. Increasingly, organizations will be responsible for providing defined care to a specific population while managing the population's total cost of care.

The value-driven approach to care delivery and financing focused on population health management (PHM) alters the established business fundamentals. To succeed, healthcare directors and executives must rethink the scope of their enterprise, including where, to whom, and how their organizations provide services, and which services are most appropriate given the unique needs of the populations they serve.

Significant additional board knowledge and oversight will be needed to arrive at a sustainable "solution set" for managing population health. Some organizations are changing board composition to include physicians and members with expertise in quality improvement, risk management, cost reduction, and other key PHM areas; other organizations need to move more rapidly to gain needed experience.[1]

Addressed here are six business imperatives that should be front and center on all board radar screens in developing and implementing their PHM strategy. These imperatives are interrelated and interdisciplinary, crossing strategic, financial, clinical, operational, and capital management domains.

Key Board Takeaways

Below are six business imperatives boards should focus on as they develop and implement their population health management strategy, as well as questions to consider related to each:

1. Physician and clinical alignment:
   - » How do we ensure alignment with employed and independent physicians?
   - » What incentives are available for physicians? Do contractual arrangements clearly delineate the criteria for incentives? How do we address physicians not performing up to defined standards?
   - » How is leakage of patients to non-network physicians prevented? Do physicians clearly understand how attribution works?
2. Contracting strategy:
   - » What's our plan for gaining experience in managing risk through contracting arrangements?
   - » What's our strategy to ensure inclusion in key networks forming in our community?
3. Network optimization:
   - » What role will our organization play in a care delivery network? How are we determining the best combination and location of services and programs?
   - » How are we learning about consumer preferences and purchasing behavior?
4. Operational efficiency:
   - » How are we working with physician practices, post-acute, home care, and other providers to ensure efficiency and deliver value?
   - » What can we do to transform our cost structure to a much lower level?
5. Enabling infrastructure:
   - » Which means are we considering—building, buying, partnering—to gain needed infrastructure quickly?
   - » What process are we using to make capital investment decisions that support the organization's role in PHM? What return do we expect from these investments?
6. Clinical management:
   - » How do/will we prioritize PHM efforts across patient health-risk categories?
   - » What interventions will we develop and implement? How do/will we evaluate the success of these interventions and ensure improvement on an ongoing basis?

Physician and Clinical Alignment

Improved economic and clinical alignment between hospitals and physicians will be essential to:

- Change the way patient care is delivered.
- Enhance patient, family, and provider satisfaction and engagement.
- Improve each element of the value equation (i.e., quality, access, patient experience, and operating/capital efficiency).
- Succeed under value- and/or risk-based arrangements.

Developing a solid hospital–physician alignment plan involves recognizing that one strategy will not be appropriate for all physicians, and that hospitals should offer physicians multiple options.

Finding the right incentives to motivate physicians is vital. Incentives should cover dimensions including financial, access, competition and recognition (e.g., quality ranking scores), and patient care (e.g., improved health outcomes). The most important principle is to develop uniform, readily quantifiable, consensus-driven incentive standards and metrics that have a consistent application across clinicians, locations, and specialties.

As health systems start building their physician networks, they typically have more relaxed (or lower threshold) performance criteria. As their experience grows, they tighten the criteria and are able to be more selective with physician participation. Physicians not performing up to defined standards often opt out or are *not* allowed to continue to participate in the network's value-based contracts.

For success with PHM contracting arrangements, a hospital or health system must have an integrated network of primary care physicians and must ensure accurate attribution of the targeted population segment(s) to this network. *Attribution* in PHM programs is the assignment of an individual to a specific primary care provider, typically based on past medical claims.

Contracting Strategy

Contracting is fundamental to PHM programs as it is the vehicle to delineate what payers or other purchasers and providers will be accountable for. Organizational and market nuances dictate the types of contracting arrangements pursued for targeted population segments, and how far

continued on page 15

1 Kathryn C. Peisert, *Governing the Value Journey: A Profile of Structure, Culture, and Practices of Boards in Transition*, 2013 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.

Six Business Imperatives...

continued from page 16

and quickly an organization moves toward full risk models.

Hospitals and health systems can participate in a variety of value-based or risk contracts, ranging from fee-for-service with incentives (e.g., gain sharing and pay-for-performance) to partial or full risk models (e.g., global payment, partial capitation, or full capitation). Fully integrated health systems will be able to use all types of contracting arrangements that tie payment to performance and outcomes, while small providers will be more limited in the types of arrangements they can secure.

Contracting for PHM will require consideration of the risks and opportunities related to the health/risk characteristics of the populations served by specific insurance products, design of HMO, PPO, and employer-directed plans, contract terms and conditions, narrow and tiered networks requirements, and partnership opportunities related to specific networks, products, and plans.

Hospitals that do not pursue PHM contracting with purchasers soon may find themselves excluded from key networks in their region or may be relegated to the role of a discounted vendor of acute care services.

Network Optimization

Effective and sustainable PHM requires the design and continuance of a high-performance delivery network. This network must cover the care continuum under an optimized contracting strategy, and apply effective approaches to engaging stakeholders, including patients, families, employers, and others. Sophisticated organizations will be developing an optimized network; other organizations will look to participate in an optimized network provided by another entity. To optimize networks, leaders consider:

- **Essentiality and adequacy:** The breadth and depth of care desired by the purchaser, and the ability to handle the projected volume of patients across the defined care settings
- **Service distribution right-sizing:** The elimination of duplication by reconfiguring the network to be highly efficient, deliver consistent quality across all sites, and manage patients in the least-intensive setting possible while still providing the necessary level of care
- **Network growth strategy:** The ability to grow the attributed or accessible managed populations to support organizational infrastructure and associated costs

Consumer engagement ensures both the clinical and business success of managing a population's health within a network. Effective consumer engagement enables an organization to help shape healthy behaviors, achieve the right level of utilization, and steer individuals to the best site of care.

Operational Efficiency

As an organization's sphere of influence widens in a value-based environment, its cost/efficiency focus shifts from the traditional view, involving inpatient and physician-centric entities, to a population health view, involving a broader scope of the care continuum.

Broad strategic thinking about the care patients receive after they leave the hospital's four walls is required of leadership to ensure the right care in the right place, at lower costs and better quality.

Enabling Infrastructure

Managing population health involves major clinical and organizational transformation made possible by investment in areas including:

- Management and governance structures that include a high level of physician involvement and cover contracting, risk assessment, clinical, and operational decision making
- A delivery network of sufficient size and scope
- IT systems that are able to support clinical care management processes, common electronic health record systems, clinical and predictive analytics, and business functions
- Care management and coordination tools and protocols tied to an enterprise-wide decision support and reporting function
- Contracting and risk assessment and management capabilities
- Patient engagement programs to build loyalty and "stickiness"

PHM will require leaders to rethink their infrastructure needs and invest and organize in a way that supports the organization's role and key initiatives in PHM going forward.

Clinical Management

Three clinical imperatives apply to all hospitals and health systems, however large or small a role they play in PHM:

- **Identify, stratify, and prioritize the patient population along the health-risk continuum:** Organizations identify the geography they serve and the contracting arrangements for the patient populations within this geography. They then prioritize their PHM efforts for efficiency and effectiveness across patient health-risk categories.
- **Develop and implement interventions to improve health, access, and outcomes, and to reduce costs:** Hospitals understand the impact of technology and care settings, and recognize the importance of consumer engagement, new provider types, collaborative practice, and evidence-based medicine. They then design and implement prevention initiatives based on population health risk categories, spanning wellness, care transitions, disease management, care coordination, care navigation, and end of life, as appropriate.
- **Evaluate and refine the approaches and interventions:** Hospitals and health systems understand the big-picture objectives of performance improvement and the on-the-ground challenges of selecting and implementing appropriate measures of PHM progress. They select their targets and start moving toward the end goals of effective and efficient PHM.

The degree and pace at which organizations pursue the six business imperatives described here will depend on a variety of internal and external forces. These include organizational readiness with new competencies required for value-based care, overall stage of market evolution, vertical collaboration across health plans and provider organizations, and existing risk contracts and relationships. But population health management is the way U.S. care delivery is going, so all healthcare boards and management teams must work to develop the knowledge and skills to move their organizations in the right direction.

The Governance Institute thanks Mark F. Grube, Managing Director, Kaufman, Hall & Associates, LLC, and Governance Institute Advisor, for contributing this article. *He can be reached at mgrube@kaufmanhall.com.*