MAYERS MEMORIAL HEALTHCARE DISTRICT

Board of Directors
Regular Meeting Agenda
October 29, 2024 @ 1:00 PM
Mayers Memorial Healthcare District
Burney Annex Boardroom
20647 Commerce Way
Burney, CA 96013

Mission Statement
Leading rural healthcare for a lifetime of wellbeing.

In observance of the Americans with Disabilities Act, please notify us at 530-336-5511, ext 1264 at least 48 hours in advance of the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations. The District will make every attempt to accommodate your request.

						Approx. Time Allotted
1	**CALL MEETING TO ORDER**					
2	2.1	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS** Persons wishing to address the Board are requested to fill out a "Request Form" prior to the beginning of the meeting (forms are available from the Clerk of the Board, 43563 Highway 299 East, Fall River Mills, or in the Boardroom). If you have documents to present for the members of the Board of Directors to review, please provide a minimum of nine copies. When the President announces the public comment period, requestors will be called upon one-at-a time, please stand and give your name and comments. Each speaker is allocated five minutes to speak. Comments should be limited to matters within the jurisdiction of the Board. Pursuant to the Brown Act (Govt. Code section 54950 et seq.) action or Board discussion cannot be taken on open time matters other than to receive the comments and, if deemed necessary, to refer the subject matter to the appropriate department for follow-up and/or to schedule the matter on a subsequent Board Agenda.				
3	**APPROVAL OF MINUTES**					
	3.1	Regular Meeting –September 23, 2024		***Attachment A***	**Action Item**	1 min.
4	**DEPARTMENT/QUARTERLY REPORTS/RECOGNITIONS:**					
	4.1	Resolution 2024.14 –September Employee of the Month		***Attachment B***	**Action Item**	2 min.
	4.2	Safety Quarterly	Dana Hauge	***Attachment C***	Report	2 min.
	4.3	Respiratory Therapy	David Ferrer	***Attachment D***	Report	2 min.
	4.4	Employee Housing	Joey Marchy	***Attachment E***	Report	2 min.
	4.5	Construction	John Morris	***Attachment F***		
5	**BOARD COMMITTEES**					
	5.1	**Finance Committee**				
		5.1.1 Committee Meeting Report: Chair Humphry			Report	5 min.
		5.1.2 September 2024 Financial Review, AP, AR and Acceptance of Financials			**Action Item**	5 min.
		5.1.3 Mobile MRI Commitment		***Attachment G***	**Action Item**	5 min.
	5.2	**Quality Committee**				
		5.2.1 October Quality Meeting Committee Report			Report	5 min.

6		**NEW BUISNESS**			
	6.1	Policy and Procedure Summary 10-1-2024	***Attachment H***	**Action Item**	2 min
		Policies and Procedures: 340B Inventory Management 340B Noncompliance/Medical Breach 340B Patient Eligibility/Definition 340B Prevention of Duplicate Discounts 340B Prime Vendor Program Enrollment and Updates 340B Program Agreement 340B Program Compliance, Monitoring/Reporting 340B Roles and Responsibilities Disbursement of Funds			
	6.2	Employee Stipend – Cell Phone and Mileage EMTALA – Central Log Policy 02.01.00 EMTALA – Medical Screening Examination and Stabilization 02.01.00 EMTALA On-Call Policy 02.01.00 EMTALA Reporting Policy 02.01.00 EMTALA Signage 02.01.00 EMTALA Transfer Policy 02.01.00 2024 HHS Poverty Guidelines Infection Control Management of Personnel Linen and Laundry Handling Surface Sampling Standard Operating Procedure Ultraviolet Light Disinfection	***Attachment I***	**Action Item**	5 min.
	6.3	Continuing Education for the Board		Discussion	5 min.
	6.4	Tour of the Burney Facility		Information	15 min.
7		**ADMINISTRATIVE REPORTS**			
	7.1	Chief's Reports – ***Written reports provided. Questions pertaining to written report and verbal report of any new items***	***Attachment J***		
	7.1.1	Director of Operations- Jessica DeCoito		Report	5 min.
	7.1.2	Chief Financial Officer – Travis Lakey		Report	5 min.
	7.1.3	Chief Human Resources Officer – Libby Mee		Report	5 min.
	7.1.4	Chief Public Relations Officer – Val Lakey		Report	5 min.
	7.1.5	Chief Clinical Officer – Keith Earnest		Report	5 min.
	7.1.6	Chief Nursing Officer – Theresa Overton		Report	5 min.
	7.1.7	Chief Executive Officer – Ryan Harris		Report	5 min.
8		**OTHER INFORMATION/ANNOUNCEMENTS**			
	8.1	Board Member Message: Points to highlight in message		Discussion	2 min.
9		**MOVE INTO CLOSED SESSION**			

	9.1	Hearing (Health and Safety Code §32155) – Medical Staff Credentials **MEDICAL STAFF REAPPOINTMENT** Stephen McKenzie, MD Javeed Siddiqui, MD (T2U) Frederic Gorin, MD (UCD) Matthew Chow, MD (UCD) Katherine Park, MD (UCD) Richard Granese, MD (T2U) **MEDICAL STAFF APPOINTMENT** Adrian Mora, MD (Dir. Radiology) David Pleasure, MD (UCD) Norman Malik, MD (Dir Radiology) Happy Shaw, FNP (MVHC		
	9.2	Conference with legal counsel regarding pending litigation (§54956.9)	Discussion/ **Action Item**	20 min.
10	**RECONVENE OPEN SESSION**			
11	**ADJOURNEMENT:** Next Meeting December 4, 2024			

Posted: 10/24/2024

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Chief Executive Officer
Ryan Harris

MAYERS MEMORIAL HEALTHCARE DISTRICT

Board of Directors
Regular Meeting
Minutes
September 23, 2024 @ 1pm
Fall River Boardroom

These minutes are not intended to be a verbatim transcription of the proceedings and discussions associated with the business of the board's agenda; rather, what follows is a summary of the order of business and general nature of testimony, deliberations and action taken.

CALL MEETING TO ORDER: Abe Hathaway called the regular meeting to order at 1:00 PM on the above date.

BOARD MEMBERS PRESENT:	**STAFF PRESENT:**
Abe Hathaway, President	Ryan Harris, CEO
Jeanne Utterback, Vice President	Travis Lakey, CFO
Tami Humphry, Treasurer	Valerie Lakey, CPRO
Jim Ferguson, Director	Keith Earnest, CCO
Lester Cufaude, Director	Kristi Shultz, Retail Pharmacy Manager
ABSENT:	Daryl Schneider, Cardiac Rehab/PT Manager
Libby Mee, CHRO	Tanya Walters, Team Mayers MVP
Theresa Overton, CNO	Jack Hathaway, Director of Quality
	Jessica DeCoito, Director of Operations

2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS:**			
3	**APPROVAL OF MINUTES**			
	3.1	A motion/second carried; Board of Directors accepted the minutes of August 28, 2024.	***Utterback, Ferguson***	***Approved by All***
4	**DEPARTMENT/OPERATIONS REPORTS/RECOGNITIONS**			
	4.1	Resolution 2024.13 –August Employee Of The Month: Tanya Walters. Motion Moved, Seconded And Approved.	**Utterback, Humphry**	***Approved By All***
	4.2	Pharmacy: Written report submitted. Les asked Keith the reason why Mayers does not provided specific pneumonia shots and shingles shots to the community. Keith explained that we do not yet have the freezer space but we will, in the Master Planning renovation. Ryan will follow up regarding the pneumonia shots. Keith explained the "Glove Tips" bi annual testing, to ensure that bacteria is not being transferred. Les also asked for an explanation regarding copay with Mayers Pharmacy versus Burney Rite Aide. Les will provide the information necessary for Kristi Shultz to review the reason why.		
	4.3	Retail Pharmacy: Written report submitted. Kristi explained the lag in the previous TPA contract within Retail Pharmacy.		
	4.4	Cardiac Rehab/PT: Written report submitted. Daryl explained that a part time PT is interested in coming aboard, starting October 14 2024. She explained this will bring down the need for travel registry. PT visits continue to trend upward.		
5	**BOARD COMMITTEES**			
	5.1	**Finance Committee**		
		5.1.1 Committee Report: Financials were approved and projects will be discussed. Travis explained that the AR days are slightly down. He explained that weekly revenue cycle meetings are being held to mitigate this- including 4 outsourced billers and the in-house billers are receiving training.		

		The Rural Health Clinic billing will also be brought in house. Jeanne asked about the DIR fees and Travis explained that they are slowly being worked on.		
	5.1.2	August 2024 Financial Review Motion moved, seconded and approved.	***Humphry, Ferguson***	***Approved by All***
	5.2	**Quality Committee**		
	5.2.1	September Quality Meeting Committee Report: Les explained that I2I was discussed in the meeting, in relation to Quality Improvement. Jack showed the department data in Teams and how the trends can be seen every month. Jack will take the data from all departments and combine them for the Board to see- including the Quality sub committee that will provide the data necessary. Ryan also mentioned that the Hospital Relicensing Survey crew is on-site, reviewing every department except the RHC and Skilled Nursing.		
6	**OLD BUSINESS**			
	6.1	Master Planning Update and Budget: Jessica and Ryan explained that the square footage has decreased, medical trailers for some imaging services instead of brick and mortar and the ceased expansion of the Burney Rural Health Clinic- to reach the budget needed. The PIN 74 project is included in the budget- the air conditioning back up generators.	***Utterback, Ferguson***	***Approved by All***
	6.2	Board By-laws: Jessica explained that the version provided is simply an "easier to read" version, including the changes proposed and the wordage needed for ACHC. Jeanne pointed out that in some sentences, the by-laws include "hospital" instead of "district". Section 4.1.2, page 15- Les asked that the wordage "among the board" to "to the board". It was agreed that Ryan will the Board Members a tour of the Burney campus next meeting and Fall River Campus the meeting after that. Les will provide the Board with the documentation regarding the State responsibilities of the Board. Motion made, seconded and approved with the amendments discussed.	***Humphry, Utterback***	***Approved by All***
7	**NEW BUISNESS**			
	7.1	Policies and Procedures	***Hathaway, Ferguson***	***Approved by All***

Page Number:	Policy Name:
41-42	Core Privileges Licensed Marriage & Family Therapist Privileg
43-49	Emergency Exit Plan - Fall River
50-52	Emergency Notification Plan for Skilled Nursing Facilities
53-55	Infectious Disease Core Privileges
56-72	Medical Equipment Management Plan
73-75	Obtaining Surgical Informed Consent
76-78	Perioperative Use Of Sequential Compression Sleeves
79	Separation of Hazardous Materials Storage Areas Policy
80-84	Standing Orders - Administering Phizer-BioNTech Covid 19 Va
85-88	Standing Orders - Administering Influenza Vaccine to Adults
89-92	Standing Orders - Administering Pneumococcal Vaccines to A
93-94	Using Standing Orders for Administering Vaccines

	7.3	October's Board Meeting Date change from October 30th to 29th: Motion made, seconded and carried.	***Utterback, Ferguson***	***Approved by All***
	7.4	Ignite the Patient Experience:		

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		Ryan explained that an outside company group will come in to work with ELT, Physicians, NP's and the Board regarding patient experience on November 20th with a working lunch. The Board agreed to be present at the workshop, to be involved.		
	7.5	Conflict of Interest Policy: Jessica explained that any revisions needed, she can end to FPPC. Les will review the policies noted in the policy itself. The policy was pushed to to next Board meeting.		
	7.6	PIN 74 Project- Burney Annex: Back up air conditioning generator that gocuses on the residents , rather than most of the building. This work was due to be completed in January 2024, however the plans were not approved in time. Motion was made, seconded and carried to approve the budget.	***Utterback, Cufaude***	***Approved by All***
	7.7	I2I Proposal: Ryan explained that he is proposing a 3 year contract, at $76,000 per year because of the importance needed for quality improvement. This program will help Jack and others meet the standards of quality easier, on an annual basis. Motion was made, seconded and carried to approve the budget.	***Cufaude, Utterback***	***Approved by All***
8	**ADMINISTRATIVE REPORTS**			
	8.1	**Chief's Reports: written reports provided in packet**		
		8.1.1 **DOO:** Written report submitted. Jessica explained the status of the solar panel project- being pushed back due to plan review and flood plain revision. The water at the Lodge was tested and the results came back clean. She explained that the Food and Nutrition team loved their appreciation lunch and would like to do it a few times per year.		
		8.1.2 **CFO:** Written report submitted. Travis explained that we are currently searching for commercial bank loans, for the Master Planning additions needed.		
		8.1.3 **CHRO:** Written report submitted. Libby and Val will be in charge of the patient experience project. Ryan updated the Board about progress, regarding the potential Physician candidates.		
		8.1.4 **CPRO:** Written report submitted. Val explained the bill that was vetoed regarding the healthcare building expansion bill. Since, strategies include individual hospitals writing their own bills to submit to the Senate or to do nothing. She explained why Prop 35 is important to vote "yes" on. She explained that Laura Beyer is continuing to work on grants. She explained that Phase 1 and 2 of the TCCN building plans have been approved.		
		8.1.5 **CCO**: Written report submitted. Jeanne asked if the new lab machine has been purchased and Ryan confirmed. Keith explained that our facility went above the 3% Blood Culture Contamination Rate so our lab and IP are receiving education regarding contamination.		
		8.1.6 **CNO**: Written report submitted. Ashley explained the 3 Fall River interns starting this week- 2 in Nursing and 1 in HR.		
		8.1.7 **CEO:** Written report submitted. Daryl Schneider proposed holding a "Provider Appreciation Event" on October 9th for community physicians, ELT and managers. Ryan met with the CEO of Mountain Valleys, regarding emergency dental services for our community and grant collaboration. Ambulance and Emergency Helicopter in the area were discussed.		
9	**OTHER INFORMATION/ANNOUNCEMENTS**			
	9.1	Board Member Message: Mayers Foundation "Denim and Diamonds fundraiser, community events at TCCN with the new website, thanking entire Mayers team regarding the work going towards ACHC.		
	9.2	Board Governance Tool Kit: review and discussion took place on Board Education Programming.		
10	**Move into Closed Session: 3:00 pm**			
	10.1	Hearing (Health and Safety Code §32155) – Medical Staff Credentials		***Approved by All***

MEDICAL STAFF REAPPOINTMENT

Kelly Kynaston, MD (T2U) – Telemedicine
Tom Watson, MD – Active

MEDICAL STAFF APPOINTMENT

Matthew Kilpatrick, MD – (Redding Pathologists) Pathology
Jonathan Hester, MD (TCR) – Radiology
Thomas Powierza, MD (TCR) - Radiology

	10.2 Conference with legal counsel regarding pending litigation (§54956.9)
11	**Reconvene Open Session: 4:05 pm**
12	**Adjournment: 4:05 pm.** Next Meeting October 29, 2024.

I, _____, Board of Directors _____, certify that the above is a true and correct transcript from the minutes of the regular meeting of the Board of Directors of Mayers Memorial Healthcare District

_____ _____

Board Member Board Clerk

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RESOLUTION NO. 2024-14

**A RESOLUTION OF THE BOARD OF TRUSTEES
OF MAYERS MEMORIAL HEALTHCARE DISTRICT RECOGNIZING**

Logan Young

As September 2024 EMPLOYEE OF THE MONTH

WHEREAS, the Board of Trustees has adopted the MMHD Employee Recognition Program to identify exceptional employees who deserve to be recognized and honored for their contribution to MMHD; and

WHEREAS, such recognition is given to the employee meeting the criteria of the program, namely exceptional customer service, professionalism, high ethical standards, initiative, innovation, teamwork, productivity, and service as a role model for other employees; and

WHEREAS, the MMHD Employee Recognition Committee has considered all nominations for the MMHD Employee Recognition Program;

NOW, THEREFORE, BE IT RESOLVED that, Logan Young is hereby named Mayers Memorial Healthcare District Employee of the Month for September 2024; and

DULY PASSED AND ADOPTED this 29th day of October by the Board of Trustees of Mayers Memorial Healthcare District by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

_____
Abe Hathaway, President
Board of Trustees, Mayers Memorial Healthcare District

ATTEST:

_____
Ashley Nelson
Clerk of the Board of Directors

Department Reporting
Managers Meeting and Regular Board Meeting

Manager & Department:

Dana Hauge, Safety and Security, EP

Reporting Month & Year:

October, 2024

Summary:

Overall the program has been effective and has had many busy days, all with positive growth measures. New programs and process's are proving to show measures that help the programs move forward.

Top Projects (1-3):

1. Safety & Security: We are increasing camera coverage for safety and surveillance purposes. Additional cameras have been ordered to fill in the gaps on the eastern side of the campus. We are waiting for the project to be completed once the cameras are installed and configured. This project has been a great display of teamwork with the IT department.
2. ACHC Plans and Training: The required plans from ACHC that govern the Safety, Security, and Emergency Preparedness programs have successfully gone through the policy process and have been distributed for awareness education. Work begins on accessory policys.
3. HBEDS: In partnership with the emergency department, we are part of a new program the state is introducing. This program allows us to see the available staffed and non-staffed beds in real-time from other facilities, and they will be able to see ours. It is updated every 15 minutes and is connected to our EM-Resource program. Starting in November, we will be required to report bed numbers daily, and this program will do that for us. It will significanlty drop transfer times, and will include behavioral health beds and hopefully LTC beds in the future.

Wins (1-2):

1. In September I was able to participate in the CHA Disaster conference as a committee member. The conference highlighted the need for partnerships, Decon training and pediatric surge and preparedness. I was able to solidify relationships with our county public health, state public health and regional emergency managers. We have a large network to rely on. I also returned with increased knowledge on preparedness topics related to our direct needs.
2. I was also able to attend and help facilitate a functional evacuation drill with Modoc Medical Center, CDPH and our RDMHS partners. It was a great way to merge knowledge with one of our partner facilities. As a facilitator of the event, I was able to compare our programming and use that to increase our preparedness, as well as help theirs.

Challenge (1):

Our challenges lie with teaching the new process and policies as we have so many new lengthy plans. Ensuring the safety of our facility lies with educated staff, who are ready to respond effectively and efficiently. This also relies on an initiative-taking safety culture that we are slowly building up to be the best it can be. This challenge is related to the volume of education being presented at this time.

Department Reporting
Managers Meeting and Regular Board Meeting

Manager & Department:

David Ferrer... Respiratory Therapy

Reporting Month & Year:

10/2024

Summary:

Maryann has passed her PfT cert. exam. We've both passed the exam for Mask fit testing, so we are both cert. Our Blood gas analyzer is uploading results straight into cerner. This allows physicians faster access to pt results. Both of us needed more baby experience. So i have gained per-diem employment at banner-lassen medical center and am acquiring more baby experience and in turn will teach my coworker. We are in need of New PFT testing equipment within the next year. Our maintenance agreement for our current equipment will soon expire this coming year, therefore it will no longer be supported. We are mask fit testing the entire district

Top Projects (1-3):

1. Finish the blood gas analyzers programing to upload to cerner
2. Purchase new Pulmonary function testing (PFT) equipment
3. Marketing our PFT capabilities
4. Mask fit testing the entire hospital staff

Wins (1-2):

Our Blood gas analyzer is up and running and reporting
Maryann is certified in PFT testing

Challenge (1):

Obtaining new PFT equipment

Department Reporting
Managers Meeting and Regular Board Meeting

Manager & Department:

Joey Marchy Employee Housing

Reporting Month & Year:

10/2024

Summary:

Employee Housing encompasses the Pit River Lodge facility and the Riverview House On-Call sleeper. We deal with the lodging needs for staff and guests of MMHD. Throughout the year we have seen lodging needs increase so much so that an additional housekeeper has been added and now there is housekeeping staff on site 7 days a week. This change has helped us lodge more staff.

Top Projects (1-3):

1. I have registered for classes through the American Water College too get a certification in water distribution and treatment. This certification will conclude after passing two online courses and hands-on mentorship with Fall River CSD. The goal of this projects is for me to be able to conduct our own water tests for the lodge and provide in-house water treatments services for our water systems.

2. My second project is to compile a working document for the lodge that Management and Maintenace can refer too that will list all structures at the lodge and map out all water, electrical, and septic systems. Due to the age of the facility this document will help plan future improvements and help to avoid any potential surprise system failures. This project will include working with local professionals.

3.) Lastly is to successfully complete The Healthcare Leadership Institute courses provided by MMHD.

Wins (1-2):

1.) Last week (September 29th- Oct 5th) was our busiest week on record for the short-term housing. We hosted 33 lodgings out of our 14 available spots during the week. These lodgings included a mixture of permanent staff, registry staff, contracted staff, VIP guests of MMHD, and Shasta College students.

2.) Our continual water system problem over the last 3 months has finally been resolved. There were multiple factors affecting our water distribution but step by step we got them resolved and we are currently in the clear.

Challenge (1):

Obviously, the main challenge as of late has been our pump and well obstacles. Meeting the water needs of tenants, housekeeping staff, and Shasta County was no easy feat and required a lot of pivoting between arising problems.

Department Reporting
Managers Meeting and Regular Board Meeting

Manager & Department: John Morris
Construction

Reporting Month & Year: Sept. 2024

Summary: The Fall River (FR) clinic design has been submitted to Shasta Country for permitting. Permitting efforts for the Fall River Solar project are ongoing. The Master Planning Phase 1 expansion budget has been approved and is moving toward the bidding phase.

Top Projects (1-3):

1. Fall River Clinic Remodel – Conversion of the existing Business office to a one (1) procedure room and two (2) exam room brick and mortar clinic.
2. Master Planning – Phase 1 expansion. Acute, Pharmacy and Purchasing in Fall River; Ambulatory surgery and Maintenance building in Burney.
3. FR Solar – Solar grid on FR bluff. PG&E transformer replacement.

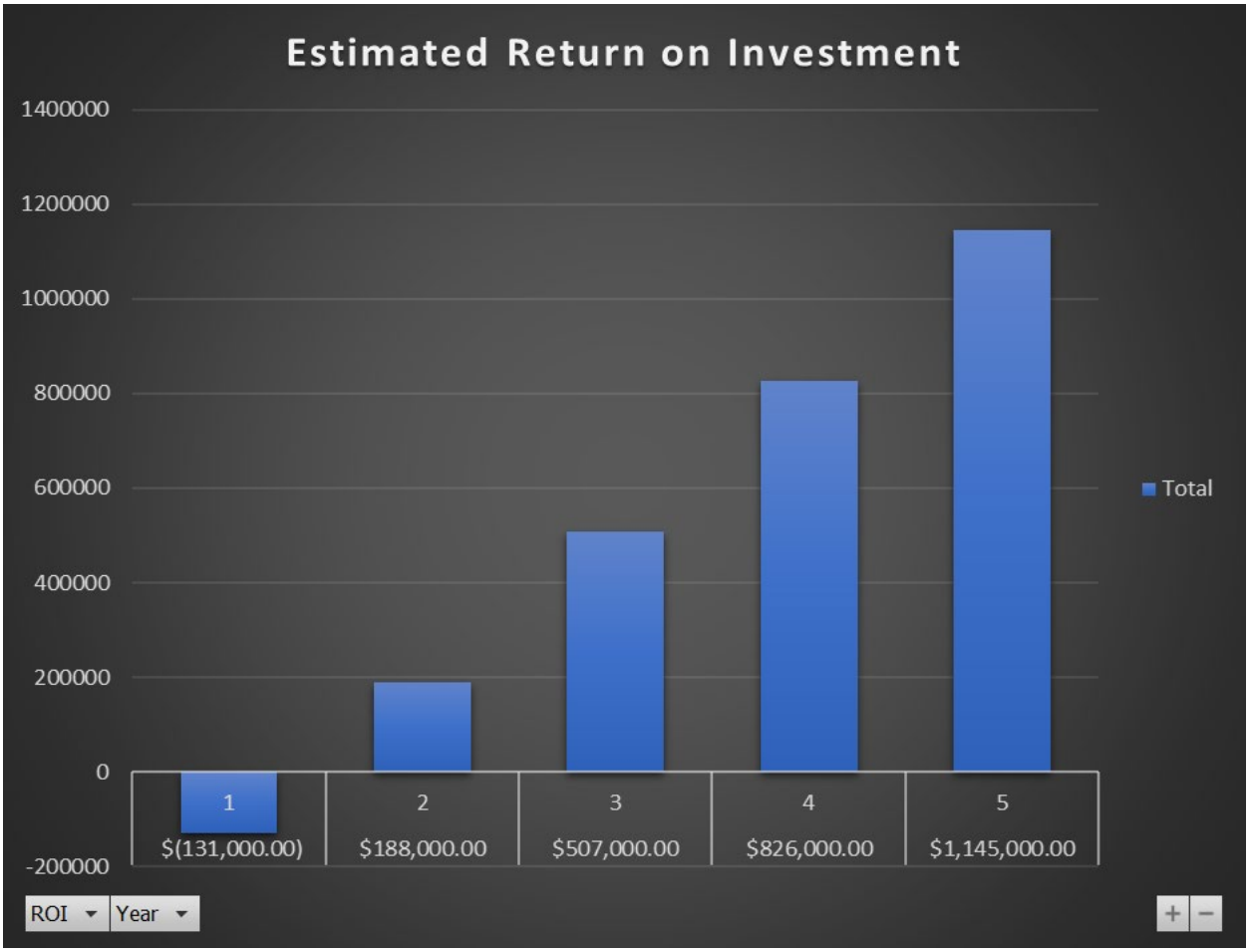
Wins (1-2):

1. The FR Clinic design was completed in September. The design is complete and initiating the bid process is the next step.
2. The Master Planning Phase 1 expansion is moving toward the next step which is the bid process.

Challenge (1):

1. The project team is working through solar project permitting issues. MMHD has applied pressure through more frequent updates from the contractor and issued a letter reminding the contractor of the contractual obligations and penalties if the construction completion date is not met. This is a proactive effort to not only begin to document the delays but to begin communication with the solar contractor to ensure that their understanding of the contract matches MMHD's so that, if the project does go to the liquidated damages phase, there is already an understanding of the terms.

Proforma Financial Statement					
Northern California District Hospital Joint MRI Venture					
Description	Amount	Notes			
Capital Expenditure Per Facility	$450,000.00	Estimated to be the Maximum Commitment			
Estimated Annual Operating Cost Per Facility	$ 50,000.00	Based on other facilities that currently have MRI Services in the group			
Estimated Net Income	$319,000.00	Based on other facilities net revenue taking payor mix and volumes into account.			
ROI Table					
Year	Net Income	Cumulative Net Income	Capital Expenditure	ROI	
1	$319,000.00	$ 319,000.00	$ 450,000.00	$ (131,000.00)	
2	$319,000.00	$ 638,000.00	$ 450,000.00	$ 188,000.00	
3	$319,000.00	$ 957,000.00	$ 450,000.00	$ 507,000.00	
4	$319,000.00	$ 1,276,000.00	$ 450,000.00	$ 826,000.00	
5	$319,000.00	$ 1,595,000.00	$ 450,000.00	$ 1,145,000.00	



The following are the New, Revised and Retired Policies and Procedures that have been approved by the Policy and Procedure Process. These policies and procedures have been put in the appropriate hospital manuals.

Date
October 7, 2024

For Quarter Ending
September 30, 2024

Department	Document	New/Revised/Retired
Acute - Med Surg	Bedside Mobility Assessment	Revised
Acute - Med Surg	Discharge Planning -- Social Services	Revised
Acute - Med Surg	Medicare Outpatient Observation Notice (MOON)	Revised
Acute - Med Surg	Medicare Outpatient Observation Notice (MOON) Spanish	Revised
Administration	Mayers Organization Chart	Retired
Dietary	Calorie Count Proc & Form	Retired
Dietary	Compartment Sink Monitor (Chemical Sanitation)	Retired
Dietary	Compartment Sink Monitor (Hot Water Sanitation)	Retired
Dietary	Consistent-Carbohydrate Diet	Retired
Dietary	Consultation Agreement Policy	Retired
Dietary	Daily-Monthly-Weekly Cleaning Schedule	Retired
Dietary	Diet for Spanish Culture Influence	Retired
Dietary	Dishmachine Temperature Log (High Temperature)	Retired
Dietary	Dishmachine Temperature Log (Low Temperature)	Retired
Dietary	Emergency Food Supply and Menus	Retired
Dietary	Employee In-Service Education	Retired
Dietary	Finger Food Diets	Retired
Dietary	Food & Beverage Request Form	Retired
Dietary	Food Service Evaluation Checklist	Retired
Dietary	Freezer Temperature Monitoring	Retired
Dietary	General Employment Policies	Retired
Dietary	Holiday and Special Event Menus	Retired
Dietary	List of Menu Substitutes	Retired
Dietary	Menu Substitution Record	Retired
Dietary	Monthly Dietary Sanitation Inspection	Retired
Dietary	Regional Dietary Consultant	Retired
Dietary	Sample Diets Menu	Retired
Dietary	Sample Form O_Portion Size	Retired
Dietary	Sample Menu	Retired
Dietary	Sanitation and Food Service Checklist	Retired
Dietary	Sodium and Sugar Diets	Retired
Dietary	Tray Cards	Retired
Disaster Plans	Emergency Operations Plan: Resources and Assets	New
Disaster Plans	Suggested Disaster and Emergency Menu	Retired
Disaster Policies	Emergency Procedure for Laboratory	Revised
Disaster Policies	Food and Nutrition in a Disaster	New
Disaster Policies	Hazard Vulnerability Analysis Tool	Revised
Disaster Policies	Medical Records Tracking During Emergency	Revised
Disaster Policies	Privileging of Licensed Independent Practitioners During an Emergency or Disa	Revised
Human Resources	Disposal of Surplus or Excess Properties	Revised
Human Resources	Employee Handbook	Revised
Human Resources	Performance Evaluation	Revised
Human Resources	Respiratory Therapist Call-Back	Retired
Human Resources	Retention Bonus Opt-In and Authorized Deduction Agreement MMH750	Retired
Human Resources	Worker' Compensation Claim Form DWC1	Revised
Human Resources	Workers Compensation Insurance	Retired
Imaging	Changing Ortho-Phthalaldehyde Solution in Imaging	Retired
Imaging	Imaging Competency Assessment	Retired
Imaging	Lead Apron Inspection MMH647	Retired

Department	Document	New/Revised/Retired
Imaging	Lead Apron Policy	Retired
Imaging	Ortho-Phthalaldehyde Quality Control	Retired
Imaging	Ultrasound Transducer (Probe) Cleaning	Retired
Infection Control	Appendix B - TB Risk Classifications MMH300	Retired
Infection Control	Gloves Using	Revised
Infection Control	Hand Hygiene	Revised
Infection Control	Isolation Precautions	Revised
Infection Control	Mandatory MRSA Screening	Revised
Infection Control	Scabies Appendices MMH475	Revised
Infection Control	Table I Factors affecting treatment decisions during the medical and diagnostic	Retired
Infection Control	Table II Indications for two-step tuberculin skin tests (TSTs) MMH509	Retired
Infection Control	Table III Ventilation Recommendations for selected areas in new or renovated h	Retired
Lab	Blood Culture Collection	New
Lab	Blood Glucose Monitoring - Roche ACCU-CHEK Inform II Blood Glucose Me	Retired
Lab	Microbiology Critical Results	New
Lab	One Step Fentanyl Test Dip Card (Urine)	New
Lab	Roche ACCU-CHEK II Glucose Monitoring System Glucometer Helpful Hints	Retired
Lab	ROCHE Accu-Chek Inform II Nursing Tips	Retired
Lab	Selection of Blood and Components for Transfusion	New
Lab	Wet Mount	New
Long Term Care	Narcotic Control Sheet for Transdermal Patches MMH582D	Revised
Long Term Care	NURSES RECORD ADMISSION ASSESSMENT MMH137	Revised
Long Term Care	Psychotropic Drug Evaluation MMH234	Revised
Long Term Care	Resident Transfer-Discharge Summary-Plan MMH609	Revised
Long Term Care	Side Rail Use Assessment Form MMH689	Revised
Long Term Care	SNF Antibiotic Control Sheet MMH644	Revised
Maintenance	Biomedical Medical Device Recall Notification	Retired
Maintenance	Electrical Safety - Biomedical	Retired
Maintenance	Inventory and Inspection of New Equipment - Biomedical	Retired
Medical Staff	Core Privileges in Oncology	Revised
Medical Staff	Orthopedic Surgery Core Privileges	Revised
Medical Staff	Radiology Core Privileges	Revised
Operations	Utility Systems Management Plan	New
Pharmacy - Acute	Contraband (Illicit) Drugs and Devices	Revised
Pharmacy - Acute	Covid-19 Pfizer Ages 12 & Up Standing Orders	Retired
Pharmacy - Acute	Covid-19 Pfizer Ages 5 - 11 Standing Orders	Retired
Pharmacy - Acute	Drug-Nutrient Interaction Key MMH544	Retired
Pharmacy - Acute	Fentanyl (Duragesic) Patch Disposal Acute	Revised
Pharmacy - Acute	Handling Hazardous Drugs - Acute	Revised
Pharmacy - Acute	Hospital Pharmacy Security	Revised
Pharmacy - Acute	List of IV Guidelines	Retired
Pharmacy - Acute	Monthly Licensed Pyxis; Inspection Form MMH748	Revised
Pharmacy - Acute	Patient Request for Non-Safety Caps on Prescription Containers MMH642	Revised
Pharmacy - Acute	Pharmacy Nursing Action Notice Form MMH940	Retired
Pharmacy - Acute	Sanitizing Barrier Isolator During COVID 19	Retired
Pharmacy - Sterile Compoun	Beyond Use Dating of Compounded Sterile Products (CSP)	Revised
Pharmacy - Sterile Compoun	Beyond Use Dating, Sterile Compounding:	Retired
Quality & Performance Impr	Annual Performance Improvement Project	Revised
Respiratory Therapy	Easyone Manual	Revised
Respiratory Therapy	Vmax Manual	Revised
Retail Pharmacy	340B Contract Pharmacy Operations	New
Retail Pharmacy	340B Contract Pharmacy Oversight & Monitoring	New
Retail Pharmacy	340B Covered Entity Eligibility	New
Retail Pharmacy	340B DRUG DISCOUNT PROGRAM AND COMPLIANCE	New
Retail Pharmacy	340B Education and Competency	New
Retail Pharmacy	340B Enrollment Recertification, and Change Requests	New
Retail Pharmacy	340B Referral Program	New
Safety Plans	Fire Drill Incident Critique, MMH777	New

Department	Document	New/Revised/Retired
Safety Plans	Fire Safety Management Plan	New
Safety Plans	Fire Safety Response Plan	New
Safety Plans	Hazardous Materials and Waste Plan	New
Safety Plans	Heat Illness Plan	New
Safety Plans	Security Management Plan	New
Safety Policies	Fire Safety Management Plan	Retired
Safety Policies	Safe Patient Handling Policy	New
Safety Policies	Slips, Trips and Falls Program	New
Safety Policies	Smoke and Tobacco Free Campus	Revised
Social Services	Patient Trust Account Cash Withdrawal Request Spanish MMH49S	Revised
Surgery	Cleaning, Disinfection and Storage of Endoscopes	Revised
Surgery	Register of Surgical Procedures	Revised
Surgery	Sterile Supplies: Event Related Shelf Life & Storage	New
Telemedicine	Adult Neurology ER Cart	Revised
Telemedicine	Chart Note Processing	Revised
Telemedicine	Confidentiality for Mental Health Chart Notes	Revised
Telemedicine	Pediatric Critical Care Cart	Revised

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: 340B Inventory Management		POLICY #340B001
DEPARTMENT/SCOPE: 340B Program		Page 1 of 4
REVISION DATE:	EFFECTIVE DATE: 7/1/2024	
AUDIENCE: Retail Pharmacy Staff	APPROVAL DATE:	
OWNER: K. Shultz		APPROVER: K. Earnest

POLICY: Covered entities must be able to track and account for all 340B drugs to ensure the prevention of diversion and to ensure the proper procurement and inventory management of 340B drugs.

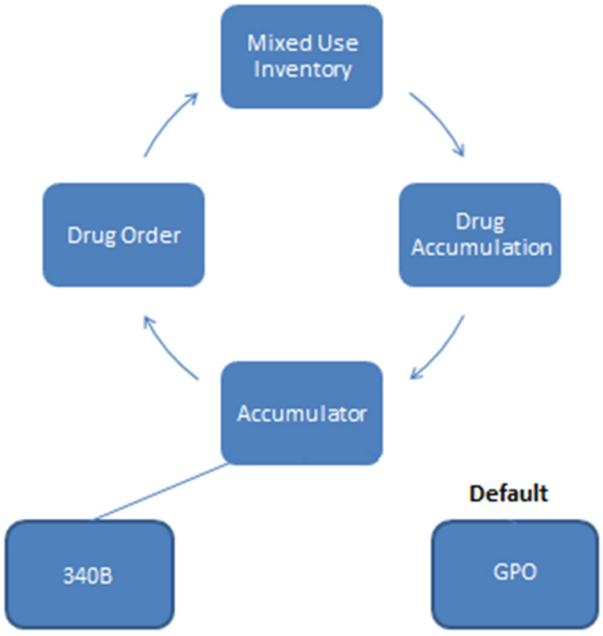
340B inventory is procured and managed in the following settings:

- Contract pharmacy

Mayers Memorial Hospital District uses Virtual mixed-use replenishment inventory (i.e., neutral) Pharmacists and technicians dispense 340B drugs only to patients meeting all the criteria in [Refer to Mayers Memorial Hospital Policy and Procedure "340B Patient Eligibility/Definition" Policy# 340B006]

PROCEDURE:

Mixed-use inventory replenishment system (340B/non-340B) is maintained at Contract Pharmacy(ies).



1. Identifies all accounts used for purchasing drugs in each practice setting (parent site, off-site locations, in-house retail pharmacies, contract pharmacies), for 340B and non-340B/GPO.
2. Purchases mixed-use inventory (according to eligible accumulations).
3. Administers/dispenses drugs to patients.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: 340B Inventory Management	POLICY #340B001
DEPARTMENT/SCOPE: 340B Program	Page 2 of 4
REVISION DATE:	EFFECTIVE DATE: 7/1/2024
AUDIENCE: Retail Pharmacy Staff	APPROVAL DATE:
OWNER: K. Shultz	APPROVER: K. Earnest

4. Split-billing software accumulates drug utilization based on patient status, patient location, and provider information. This accumulation occurs at the 11-digit NDC level and a full package size is accumulated before replenishment.

340B	**Non-340B/GPO**
Patients met 340B patient definition and received services on an outpatient basis in a 340B registered/participating hospital clinic.	• GPO/inpatient class of trade: Inpatient status determined by hospital at the date/time of administration. • GPO/outpatient class of trade: Offsite/unregistered outpatient clinics • Products that do not have an 11-digit NDC match on the 340B contract but are otherwise eligible for 340B purchase. • Products that currently are not available (e.g., drug shortages) such that an 11-digit NDC match is not available. • Non-340B eligible outpatients, e.g.: o Administration or dispensing occurred at a clinic within four walls of parent, but not 340B eligible. o Non-patient of the CE seen at an entity-owned retail pharmacy open to the public. o Medicaid carve-out outpatients. • Lost charges or wasted product

5. Replenishment drug order(s) are placed according to eligible accumulations.

Key points to address appropriate access to wholesaler accounts and split-billing software include the following:

- The names and types of pharmacy ordering accounts.
- The process the entity uses for determining how accumulations are identified as 340B eligible.
- The eligibility filters process for mapping, maintenance, and updating (location eligibility, health care record, patient status; provider eligibility, Medicaid carve-in/-out status).
- Basis for replenishment order (e.g., patient administration data to the 11-digit NDC); reporting elements (frequency).
- Plan for accurate data capture (e.g., time stamps, conversions from “pharmacy system units” to “split-billing units”).
- NDC–charge description/drug master (CDM) crosswalk updates.
- Hospital EHR–split-billing system interface; frequency of patient eligibility and order data updates; manual creation of purchase orders directly from manufacturer/incorporation of purchase data to the purchase history; PAR levels.

- Procedures for accumulation when there are lost charges, procedures for decrementing accumulation for manufacturer and wholesaler returns and unused returns to stock, 340B priced product is not available, or waste.
- Explanation of charge on dispensing vs. charge on administration and NDC match.

1. Mayers Memorial Hospital District identifies all pharmacy purchasing accounts.
2. Mayers Memorial Hospital District identifies which accounts are used for each 340B-eligible location to purchase 340B drugs.
3. Mayers Memorial Hospital District places 340B and non-340B/GPO drug orders based on orders created from the split-billing system.
    a. 340B drugs are ordered at an 11-digit NDC level.
    b. Appropriate processes are in place to ensure proper ordering, tracking, and adjusting of accumulators for controlled substances.
4. Contract Pharmacy receives shipment from McKesson and identifies the 340B medications to the invoices then stickers medications to identify which medications have come from the 340B entity.
5. Mayers Memorial Hospital District and contract Pharmacy verifies quantity received with quantity ordered.
    a. Identifies inaccuracies.
    b. Resolves inaccuracies.
    c. Documents resolution of inaccuracies.
6. Mayers Memorial Hospital District documents manual manipulations to the 340B split-billing accumulator, including reason for manual manipulation.
7. Mayers Memorial Hospital District reconciles purchasing records with dispensing records Weekly to ensure that covered outpatient drugs purchased through the 340B Program are used only for 340B eligible patients or replenished for an eligible 340B patient.
    a. Mayers Memorial Hospital District resolves inventory discrepancies when 340B drugs are dispensed to ineligible patients by documenting and contacting the vendor to return the medication that was not eligible and received out of compliance.
8. Mayers Memorial Hospital District staff reports significant discrepancies (excessive quantities based on utilization or product shortages) to Mayers Memorial Hospital District's management as soon as possible but no later than 1 business day.
9. Mayers Memorial Hospital District maintains records of 340B-related transactions for a period of 7 years in a readily retrievable and auditable format located in the Hudson Headwaters system.
    a. These reports are reviewed by the 340B Coordinator bi-weekly as part of its 340B oversight and compliance program.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	340B Inventory Management	POLICY #340B001
DEPARTMENT/SCOPE:	340B Program	Page 4 of 4
REVISION DATE:		EFFECTIVE DATE: 7/1/2024
AUDIENCE: Retail Pharmacy Staff		APPROVAL DATE:
OWNER: K. Shultz		APPROVER: K. Earnest

REFERENCES:

340B PVP Education Tool: Controlled Substance Ordering System (CSOS) Compliance Considerations may be used to articulate compliance solutions in this area.

COMMITTEE APPROVALS:

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	340B Noncompliance/ Material Breach	POLICY # 340B012
DEPARTMENT/SCOPE:	340B Program	Page 1 of 1
REVISION DATE: 07/23/2024		EFFECTIVE DATE: 07/01/2022
AUDIENCE: Retail Pharmacy Staff		APPROVAL DATE:
OWNER: K. Shultz		APPROVER: K. Earnest

DEFINITIONS:

Materiality: A convention within auditing/accounting pertaining to the importance/significance of an amount, transaction, and/or discrepancy.

Threshold: The point that must be exceeded, as defined by the covered entity, resulting in a material breach. Examples of thresholds include:

a. X% of total 340B purchases or impact to any one manufacturer.
b. $X (fixed amount), based on total outpatient or 340B spend, or impact to any one manufacturer.
c. X% of total 340B inventory (units).
d. X% of audit sample.
e. X% of prescription volume/prescription sample.

POLICY:

Covered entities are responsible for contacting HRSA as soon as reasonably possible if there is any material breach by the covered entity or any instance of noncompliance with any of the 340B Program requirements. To define Mayers Memorial Hospital District's material breach of 340B compliance and self-disclosure process.

PROCEDURE:

1. Mayers Memorial Healthcare District established threshold of what constitutes a material breach of 340B Program compliance.
    a. Mayers Memorial Healthcare District ensures that identification of any threshold variations occurs among all its 340B settings, including contract pharmacies.
2. Mayers Memorial Hospital District assesses materiality monthly.
    a. Mayers Memorial Healthcare District maintains records of materiality assessments.
3. Mayers Memorial Healthcare District reports identified material breach immediately to HRSA and applicable manufacturers and understands that repayment of the covered outpatient drug that was in violation may be required and/or removal from the 340B program.
    a. Maintain records of material breach violations, including manufacturer resolution correspondence, as determined by organization policy.

REFERENCES:

340B PVP Education Tool: Establishing Material Breach Threshold
340B PVP Education Tool: Self-Disclosure to HRSA and Manufacturer Template

COMMITTEE APPROVALS:

Finance: 9/23/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	340B Patient Eligibility/Definition	POLICY # 340B006
DEPARTMENT/SCOPE:	340B Program	Page 1 of 2
REVISION DATE: 07/23/2024		EFFECTIVE DATE: 07/01/2022
AUDIENCE: Retail Pharmacy Staff		APPROVAL DATE:
OWNER: K. Shultz		APPROVER: K. Earnest

DEFINITIONS:

Administer: Give a medication to an individual, typically in a hospital or a clinic, based on a health care provider's order.

Dispense: Provide a medication, typically in a hospital or a clinic, based on a health care provider's order to be administered to a patient.

Inpatient status: Mayers Memorial Hospital District defines inpatient status as a person who is formally admitted into the hospital with a doctor's order.

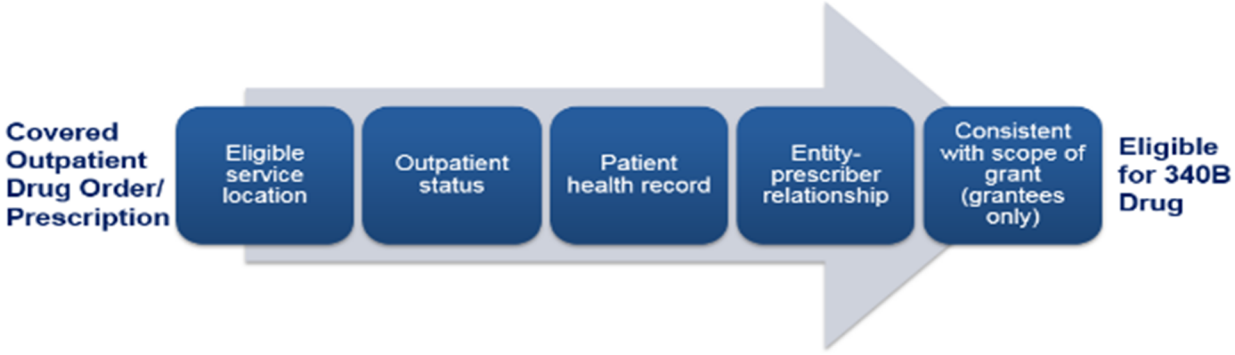
Outpatient status: Mayers Memorial Hospital District defines Outpatient status as a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services from the hospital in outpatient settings.

Prescribe: Provide a prescription for a medication to an individual to be filled at an outpatient pharmacy.

POLICY:

According to the Final Notice Regarding Section 602 of the Veterans Health Care Act of 1992 Patient and Entity Eligibility, 340B drugs are to be provided only to individuals eligible to receive 340B drugs from covered entities.

PROCEDURE:



1. Mayers Memorial Hospital District validates site eligibility. [Refer to Mayers Memorial Hospital District's Policy and Procedure "Covered Entity Eligibility"]

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: 340B Patient Eligibility/Definition		POLICY # 340B006
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AUDIENCE: Retail Pharmacy Staff	APPROVAL DATE:	
OWNER: K. Shultz	APPROVER: K. Earnest	

2. Mayers Memorial Hospital District determines patient status.
    a. Patient is outpatient status at the time the medication is administered/dispensed/prescribed.
        i. Outpatient status is determined by ensuring the patient is registered in the system and receiving health care in an eligible setting at the covered entity and receives a health care service from an eligible provider.

3. Mayers Memorial Hospital District maintains records of individual's health care in the facilities electronic Health record system One Content and Cerner.

4. Mayers Memorial Hospital District determines provider eligibility.
    a. The provider is either employed by the covered entity or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the care provided remains with Mayers Memorial Hospital District. The qualified Prescriber list is updated at the time a change occurs and is uploaded into Hudson Headwaters (340B Third Party Administrator). The prescriber list contains Eligible Prescriber, verified Medicaid enrollment, NPI number, and DEA number. This list is reviewed monthly to ensure accuracy. The EHR is uploaded to Hudson Headwaters. Prescribers are considered eligible for prescribing 340B medications if credentialed by Mayers Memorial Hospital District and the health care service provided by prescriber remains under the responsibility of care in an eligible location under Mayers Memorial Hospital District.

5. Mayers Memorial Hospital District determines patient's Medicaid status [Refer to Mayers Memorial Hospital District's Policy and Procedure "Prevention of Duplicate Discounts"]

SPECIAL CONSIDERATIONS:

- Refer to Mayers Memorial Hospital District's Policy and Procedure "Prevention of Duplicate Discounts"
- Refer to Mayers Memorial Hospital District's Policy and Procedure "Covered Entity Eligibility"

COMMITTEE APPROVALS:

Finance: 9/23/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	340B Prevention of Duplicate Discounts	POLICY #340B005
DEPARTMENT/SCOPE:	340B Program	Page 1 of 1
REVISION DATE: 07/23/2024		EFFECTIVE DATE: 07/01/2022
AUDIENCE: Retail Pharmacy Staff		APPROVAL DATE:
OWNER: K. Shultz		APPROVER: K. Earnest

POLICY:

42 USC §256b(a)(5)(A)(i) prohibits duplicate discounts; that is, manufacturers are not required to provide a discounted 340B price and a Medicaid drug rebate for the same drug. Covered entities must have mechanisms in place to prevent duplicate discounts.

PROCEDURE:

Mayers Memorial Healthcare District has elected to purchase drugs for its Medicaid patients through other mechanisms and carve out Medicaid.

Medicaid Carve-Out (FFS)

1. Mayers Memorial Healthcare District does not dispense or administer 340B purchased drugs to Medicaid patients AND Mayers Memorial Hospital District provides non-340B drugs instead and subsequently bills Medicaid for those non-340B drugs (carve out).
    a. Mayers Memorial Hospital District has answered “no” to the question, “Will the covered entity dispense 340B purchased drugs to Medicaid patients AND subsequently bill Medicaid for those dispensed 340B drugs?” on 340B OPAIS.

Medicaid Managed Care (MCO)

Covered entities are encouraged to work closely with their state to prevent duplicate discounts for Medicaid managed care claims. Mayers Memorial Hospital District has proper mechanisms in place to ensure duplicate discounts are prevented by verifying that the Medicaid Exclusion File is accurate and reflects the practice of the entity, clearly Identify and flag all plans that are categorized as Medicaid in the system and perform transaction testing to identify and prevent duplicate discounts.

Contract Pharmacies

1. Mayers Memorial Healthcare District’s contract pharmacies carve-out Medicaid FFS.
2. Mayers Memorial Healthcare District has followed the states guideline to ensure a process to prevent duplicate discounts for Medicaid MCO.

COMMITTEE APPROVALS:

Finance: 9/23/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	340B Prime Vendor Program Enrollment and Updates	POLICY #340B004
DEPARTMENT/SCOPE:	340B Program	Page 1 of 2
REVISION DATE: 07/23/2024		EFFECTIVE DATE: 07/01/20222
AUDIENCE: Retail Pharmacy Staff		APPROVAL DATE:
OWNER: K. Shultz		APPROVER: K. Earnest

DEFINITIONS:

340B Prime Vendor Program (PVP)- The purpose of the PVP is to develop, maintain, and coordinate a program capable of distribution, facilitation, and other activities in support of the 340B Program. The PVP is a voluntary program for 340B covered entities and serves its participants in three primary roles:

1. Negotiating sub-340B pricing on pharmaceuticals.
2. Establishing distribution solutions and networks that improve access to affordable medications; and
3. Providing other value-added products and services.

POLICY:

The purpose of the Prime Vendor Program (PVP) is to improve access to affordable medications for covered entities and their patients.

PROCEDURE:

Enrollment in PVP:

1. Mayers Memorial Hospital District completes online 340B Program registration with HRSA.
2. Mayers Memorial Hospital District completes online PVP registration (https://www.340bpvp.com/register/apply-to-participate-for-340b/).
3. PVP staff validates information and sends confirmation email to Mayers Memorial Hospital District.
4. Mayers Memorial Hospital District logs in to www.340bpvp.com, selects username/password.

Update PVP Profile:

1. Mayers Memorial Hospital District accesses www.340bpvp.com.
2. Mayers Memorial Hospital District clicks Login in the upper right corner.
3. Mayers Memorial Hospital District inputs PVP log-in credentials.
    a. In the upper right corner:
        i. Click “My Profile” to access page. https://members.340bpvp.com/webMemberProfileInstructions.aspx.
4. Mayers Memorial Hospital District clicks “Continue to My Profile” to access page https://members.340bpvp.com/webMemberProfile.aspx.
    a. Find a list of your facilities
        i. Click on the 340B ID number hyperlink to view or change profile information for that facility.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	340B Prime Vendor Program Enrollment and Updates	POLICY #340B004
DEPARTMENT/SCOPE:	340B Program	Page 2 of 2
REVISION DATE: 07/23/2024		EFFECTIVE DATE: 07/01/20222
AUDIENCE: Retail Pharmacy Staff		APPROVAL DATE:
OWNER: K. Shultz		APPROVER: K. Earnest

b. Update HRSA Information:
    i. Complete the 340B Change Form as detailed above.
        a. After 340B OPAIS has been updated, the PVP database will be updated during the nightly synchronization.

5. Mayers Memorial Hospital District updates the 340B Prime Vendor Program (PVP) Participation Information:
    a. Edit Mayers Memorial Hospital District's DEA number, distributor and/or contacts.
    b. Click submit.

COMMITTEE APPROVALS:

Finance: 9/23/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: 340B Program Agreement	POLICY #340B003
DEPARTMENT/SCOPE: 340B Program	Page 1 of 1
REVISION DATE: 07/23/2024	EFFECTIVE DATE: 07/01/2022
AUDIENCE: Retail Pharmacy Staff	APPROVAL DATE:
OWNER: K. Shultz	APPROVER: K. Earnest

DEFINITIONS:
Definitions of terms may be found in (Appendix: 340B Glossary of Terms).

POLICY:
This document contains the written policies and procedures that Mayers Memorial Hospital District uses to oversee the 340B Program operations, provide oversight of contract pharmacies, and maintain a compliant 340B Program.**Section 340B of the Public Health Service Act (1992)** requires drug manufacturers participating in the Medicaid Drug Rebate Program to sign a pharmaceutical pricing agreement (PPA) with the Secretary of Health and Human Services**.**

a. This agreement limits the price that manufacturers may charge certain covered entities for covered outpatient drugs.

The 340B Program is administered by the federal Health Resources and Services Administration (HRSA) in the Department of Health and Human Services (DHHS).

Upon registration in the 340B Office of Pharmacy Affairs Information System (340B OPAIS), Mayers Memorial Hospital District:

a. Agrees to abide by specific statutory requirements and prohibitions.
b. May access 340B drugs

340B Policy Statements

1. Mayers Memorial Hospital District complies with all requirements and restrictions of Section 340B of the Public Health Service Act including, but not limited to, the prohibition against duplicate discounts/rebates under Medicaid, and the prohibition against transferring drugs purchased under 340B to anyone other than a patient of the entity. (Public Law 102-585, Section 602, 340B Guidelines, 340B Policy Releases).
2. Mayers Memorial Hospital District uses any savings generated from 340B in accordance with 340B Program intent.
3. Mayers Memorial Hospital District has systems/mechanisms and internal controls in place to reasonably ensure ongoing compliance with all 340B requirements.
4. Mayers Memorial Hospital District maintains auditable records demonstrating compliance with the 340B Program.
    a. These reports are reviewed by Mayers Memorial Hospital District every quarter as part of its 340B oversight and compliance program.

REFERENCES:
Public Law 102-585, Section 602, 340B Guidelines, 340B Policy Releases).

COMMITTEE APPROVALS:
Finance: 9/23/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	340B Program Compliance, Monitoring/Reporting	POLICY # 340B008
DEPARTMENT/SCOPE:	340B Program	Page 1 of 1
REVISION DATE: 07/23/2024		EFFECTIVE DATE: 07/01/2022
AUDIENCE: Retail Pharmacy Staff		APPROVAL DATE:
OWNER: K. Shultz		APPROVER: K. Earnest

POLICY:

Covered entities are required to maintain auditable records demonstrating compliance with the 340B Program requirements.

PROCEDURE:

1. Mayers Memorial Healthcare District develops an annual internal audit plan approved by the internal compliance officer or as determined by organizational policy.
2. Mayers Memorial Healthcare District reviews 340B OPAIS to ensure the accuracy of the information for the parent site, off-site locations, and contract pharmacies.
3. Mayers Memorial Healthcare District reviews the Medicaid Exclusion File (MEF) to ensure the accuracy of the information for the parent site, off-site locations, and contract pharmacies.
4. Mayers Memorial Healthcare District ensures compliance with the GPO Prohibition.
5. Mayers Memorial Healthcare District reconciles purchasing records and dispensing records to ensure that covered outpatient drugs purchased through the 340B Program are dispensed or administered only to patients eligible to receive 340B drugs and that any variances are not the result of diversion.
6. Mayers Memorial Healthcare District reconciles dispensing records to patients' health care records to ensure that all medications dispensed were provided to patients eligible to receive 340B drugs. Mayers Memorial Hospital will select 25 records from a drug utilization file and perform the audit bi-weekly.
7. Mayers Memorial Healthcare District reconciles dispensing records and Medicaid billing practices to demonstrate that Mayers Memorial Hospital District's practice is following the Medicaid billing question on 340B OPAIS.
8. Mayers Memorial Healthcare District's 340B Oversight Committee reviews the internal audit results monthly.
    a. Assess whether audit results are indicative of a material breach [Refer to Mayers Memorial Hospital District's Policy and Procedure "340B Noncompliance/Material Breach"]
9. Mayers Memorial Healthcare District maintains records of 340B-related transactions for a period of 7 years in a readily retrievable and auditable format located within the Pharmacy system and Hudson Headwaters.

SPECIAL CONSIDERATIONS:

Refer to Mayers Memorial Hospital District's Policy and Procedure "340B Noncompliance/Material Breach"]

COMMITTEE APPROVALS:

Finance: 9/23/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: 340B Roles and Responsibilities	POLICY # 340B011
DEPARTMENT/SCOPE: 340B Program	Page 1 of 4
REVISION DATE: 07/23/2024	EFFECTIVE DATE: 07/01/2022
AUDIENCE: Retail Pharmacy Staff	APPROVAL DATE:
OWNER: K. Shultz	APPROVER: K. Earnest

POLICY:

Covered entities participating in the 340B Program must ensure program integrity and compliance with 340B Program requirements. To identify Mayers Memorial Hospitals key stakeholders and determine their roles and responsibilities in maintaining 340B Program integrity and compliance.

PROCEDURE:

1. Mayers Memorial Healthcare District's key stakeholders' roles and responsibilities with the 340B Program are to follow the robust guidelines that are established to support the 340B program, ensure 340B compliance, have the necessary training and resources available that pertain to their responsibilities as listed below, ensure that the program is functioning in accordance to the federal requirements-as well as the organizations documented policies and procedures.
2. Mayers Memorial Healthcare District has established a 340B Oversight Committee that is responsible for the oversight of the 340B Program.
3. Mayers Memorial Healthcare District's 340B Oversight Committee:
    a. Meets monthly or sooner if needed.
    b. Reviews 340B rules/regulations/guidelines to ensure consistent policies/procedures/oversight throughout the entity.
    c. Identifies activities necessary to conduct comprehensive reviews of 340B compliance.
        i. Ensures that the organization meets compliance requirements of program eligibility, patient definition, 340B drug diversion, and duplicate discounts via ongoing multidisciplinary teamwork.
        ii. Integrates departments such as information technology, legal, pharmacy, compliance, and patient financial services to develop standard processes for contract/data review to ensure program compliance.
    d. Oversees the review process of compliance activities, as well as taking corrective actions based on findings.
        i. 340B Oversight Committee assesses whether the results are indicative of a material breach.
    e. Reviews and approves work group recommendations (process changes, self-monitoring outcomes, and resolutions).

The following Mayers Memorial Healthcare District staff are potential key players in the 340B Program, including governance and compliance, and should be standing members of the 340B Oversight Committee. Mayers Memorial Hospital District will identify who serves as the entity's authorizing official and primary contact for the 340B Program. These individuals should be the sponsors of the 340B Oversight Committee.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: 340B Roles and Responsibilities	POLICY # 340B011
DEPARTMENT/SCOPE: 340B Program	Page 2 of 4
REVISION DATE: 07/23/2024	EFFECTIVE DATE: 07/01/2022
AUDIENCE: Retail Pharmacy Staff	APPROVAL DATE:
OWNER: K. Shultz	APPROVER: K. Earnest

1. Chief Executive Officer (CEO)
   - Responsible as the authorizing official in charge for the compliance and administration of the program
   - Responsible for attesting to the compliance of the program through recertification.

2. Chief Financial Officer (CFO)
   - Responsible for above in many cases
   - Must account for savings and use of funds to provide care for the indigent under the indigent care agreement.
   - Potentially responsible for attesting to the compliance of the program through recertification.

3. Director of Pharmacy
   - Accountable agent for 340B compliance
   - Agent of the CEO or CFO responsible to administer the 340B Program to fully implement and optimize appropriate savings and ensure that current policy statements and procedures are in place to maintain program compliance.
   - Maintains knowledge of the policy changes that affect the 340B Program, including, but not limited to, HRSA rules and Medicaid changes.
   - Monitors any changes in eligibility/information.
   - Be aware of products covered by 340B and Prime Vendor Pricing
   - Works with medical staff to use effective therapeutic classes that optimize savings with good clinical outcomes.
   - Responsible for establishing distribution accounts and maintaining those accounts, I.e., WAC account, 340B account, and GPO account.
   - Responsible for ordering all drugs from the specific accounts as specified.
   - Responsible for maintenance and testing of tracking system.
   - Maintain system databases to reflect changes in the drug formulary or product specifications.
   - Manage purchasing, receiving, and inventory control processes.
   - Assure appropriate safeguards and system integrity.
   - Assure program compliance.
   - Review and Refine 340B cost savings report detailing purchasing, and replacement practices, as well as dispensing patterns.
   - Often responsible as the primary contact for the 340B Program
   - Designs the annual plan to cover all changes in the 340B Program from the preceding year.

4. Pharmacy 340B Coordinator/Program Specialist
   - Accountable agent for 340B compliance

SUBJECT/TITLE: 340B Roles and Responsibilities	POLICY # 340B011
DEPARTMENT/SCOPE: 340B Program	Page 3 of 4
REVISION DATE: 07/23/2024	EFFECTIVE DATE: 07/01/2022
AUDIENCE: Retail Pharmacy Staff	APPROVAL DATE:
OWNER: K. Shultz	APPROVER: K. Earnest

- Day-to-day manager of the 340B Program
- Responsible for maintenance and testing of tracking software.
- Responsible for documentation of policies and procedures
- Maintains system databases to reflect changes in the drug formulary or product specifications.
- Manages purchasing, receiving, and inventory control processes.
- Continually monitors product minimum/maximum levels to effectively balance product availability and cost-efficient inventory control.
- Ensures appropriate safeguards and system integrity.
- Performs annual inventory and monthly cycle counts.
- Ensures compliance with 340B Program requirements for qualified patients, drugs, providers, vendors, payers, and locations.
- Monitors ordering processes, integrating most current pricing from wholesaler, and analyzes invoices, shipping, and inventory processes.
- Designs and maintains an internal audit plan of the compliance of the 340B Program.
- Engage Pharmacy in conversations that impact reimbursement.
- Responsible for inventory management.
- Responsible for segregation, removal, and/or return of 340B drugs, including reverse distributor transactions.

5. 340B Committee (representatives from pharmacy, IT, Finance, Administration)
    - Responsible for communication of all changes to the Medicare cost report regarding clinics or revenue centers
    - Responsible for communication of all changes to Medicaid reimbursement for pharmacy services/products that affect 340B status.
    - Responsible for modeling all managed care contracts (with/without 340B)
    - Engages pharmacy in conversations that affect reimbursement.
    - Responsible for annual or semiannual physical inventory of pharmacy items.
    - Supports the pharmacy software selection of tracking software to manage the 340B Program.
    - Defines process and access to data for compliant identification of outpatient utilization for eligible patients.
    - Archives the data to make them available to auditors when audited.
    - Aware of products covered by 340B and Prime Vendor Program pricing.
    - Works with the medical staff to use effective therapeutic classes that optimize savings with good clinical outcomes.
    - Responsible for reconciliation of lend and borrow transactions.

SPECIAL CONSIDERATIONS:

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: 340B Roles and Responsibilities		POLICY # 340B011
DEPARTMENT/SCOPE: 340B Program		Page 4 of 4
REVISION DATE: 07/23/2024	EFFECTIVE DATE: 07/01/2022	
AUDIENCE: Retail Pharmacy Staff	APPROVAL DATE:	
OWNER: K. Shultz		APPROVER: K. Earnest

Refer to Mayers Memorial Hospital District's Policy and Procedure "340B Noncompliance/Material Breach."

COMMITTEE APPROVALS:

Finance: 9/23/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Disbursement of Funds	POLICY #
DEPARTMENT/SCOPE:	Page 1 of 1
REVISION DATE: 7/13/2017, 8/3/2021, 7/18/2024	EFFECTIVE DATE: 12/19/2016
AUDIENCE: Finance Staff	APPROVAL DATE:
OWNER: T. Lakey	APPROVER: T. Lakey

POLICY:

It is the policy of the Mayers Memorial Healthcare District's Board of Directors to prudently disburse funds of the District in order to maintain Board-level oversight.

The objective is to maintain Board-level oversight of financial transactions and require Board Approval only on projects of infrequent, high dollar amount and unbudgeted disbursements.

It is intended that this policy cover all accounts and disbursement activities of the District.

GUIDELINES:

Authorized signers on District bank accounts are to be all board members, the Chief Executive Officer and the Chief Financial Officer.

Checks over $250,000 are to have to a secondary approval in the AP system.

Checks payable to a check signer are to be approved in the AP process by either CEO, CFO, or CHRO who isn't the recipient of check.

PROCEDURE

Payables:
At a weekly accounts payable meeting, the CEO, CFO, or CHRO review the current payables.
The agreed upon payables are then authorized by the CEO, CFO or CHRO.
The checks are signed electronically with the Board member signature image on file.
Check Summary is reviewed by the CFO or Controller, and then mailed.

Payroll:
Checks are entered by the HR Department
Reviewed and signed off by Controller

REFERENCE

Beach Cities Health Districts P&P #6140 Disbursement of Funds approved 11/03/2010

COMMITTEE APPROVALS:

Chiefs: 10/4/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Employee Stipend – Cell Phone and Mileage	POLICY # HR5
DEPARTMENT/SCOPE:	Human Resource/Employee	Page 1 of 1
REVISION DATE n/a		EFFECTIVE: 7/30/2024
AUDIENCE: Employee		APPROVAL DATE:
OWNER: Libby Mee – Chief Human Resources Officer		APPROVER: R. Harris

POLICY:

Mayers Memorial Healthcare District recognized some employees may be required to use their personal cell phone in order to most efficiently perform their job duties. Additionally, as part of their regular job duties, they may be required to regularly travel back and forth between the Burney and Fall River campuses. Per the Administration's discretion, these employees will be paid a monthly stipend for personal cell phone and travel.

PROCEDURE:

Cell Phone Reimbursement
Mayers Memorial Hospital District will reimburse employees a fixed amount that is more than adequate to cover reasonable costs associated with their cell phone usage for business purposes. The current reimbursement rate is:

$50 per month for Executive Leadership
$20 per month for applicable staff positions

Mayers Memorial Hospital District reserves the right to periodically modify the reimbursement rate.

Employees that do not receive a stipend are not required to use their personal cell phone for work.

Mileage Reimbursement
Mayers Memorial Healthcare District has identified certain job classifications that require regular, mandatory travel between locations in Burney, CA and Fall River Mills, CA. Applicable staff will receive a monthly stipend equivalent to (4) four round trips paid at the current federal standard mileage rate.

Employees that do not receive a monthly stipend, or that travel more than the standard stipend amount, must submit a Mileage Expense form to obtain reimbursement for travel.

COMMITTEE APPROVALS:
Chiefs: 8/12/2024

SUBJECT/TITLE:	EMTALA – Central Log Policy 02.01.00	POLICY #COM028
DEPARTMENT/SCOPE:	Compliance	Page 1 of 2
REVISION DATE: n/a		EFFECTIVE DATE: 7/1/2024
AUDIENCE: All Hospital Staff		APPROVAL DATE:
OWNER: J. Hathaway		APPROVER: R. Harris

The definitions in the EMTALA Policy apply to this and all other hospital EMTALA policies.

PURPOSE:

To establish guidelines for tracking the care provided to each individual seeking care in a dedicated emergency department ("ED") for a medical condition or seeking care in areas on hospital property other than an ED for an emergency medical condition ("EMC") as required of any hospital with an emergency department by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

POLICY:

The hospital will maintain a Central Log containing information on each individual who comes on the hospital campus requesting assistance or whose appearance or behavior would cause a prudent layperson observer to believe the individual needed examination or treatment, whether he or she left before a medical screening examination ("MSE") could be performed, whether he or she refused treatment, whether he or she was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred or discharged.

The Central Log includes the patient logs from the traditional ED and, either by direct or indirect reference, patient logs from any other areas of the hospital that may be considered DEDs or where an individual may present for emergency services or receive an MSE, such as Labor and Delivery.

PROCEDURE:

1. The hospital maintains the Central Log in an electronic format.
2. All ancillary logs maintained by all hospital departments, including the EDs, labor & delivery, behavioral health, pediatric EDs, and catheterization labs, are incorporated by reference and become part of the facility's EMTALA Central Log.
3. The Central Log, including all additional logs incorporated into the Central Log by reference, shall be maintained in the same manner and with the same central core of information. The logs must contain at a minimum, the name of the individual, the date, time and means of the individual's arrival, the individual's age, the individual's sex, the individual's record number, the nature of the individual's complaint, the individual's disposition, the individual's time of departure, and whether the individual:
   - refused treatment,
   - was refused treatment,
   - was transferred,
   - was admitted and treated,
   - was stabilized and transferred,
   - was discharged, or
   - expired.

SUBJECT/TITLE:	EMTALA – Central Log Policy 02.01.00	POLICY #COM028
DEPARTMENT/SCOPE:	Compliance	Page 2 of 2
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AUDIENCE: All Hospital Staff		APPROVAL DATE:
OWNER: J. Hathaway		APPROVER: R. Harris

4. A log entry for all individuals who have come to the hospital seeking medical attention or who appear to need medical attention must be made by the appropriate individual. Further, in non-ED departments of the hospital where an individual may present with an EMC, the department will provide the necessary information from the point of contact to the ED for logging purposes.

5. The Central Log of individuals who have come to the hospital seeking medical attention or who appear to need medical attention will be available within a reasonable amount of time for surveyor review and must be retained for a minimum of five years from the date of disposition of the individual.

6. Duplicate accounts created for the same patient who visits the hospital on more than one occasion must be consolidated so that only one medical record number per patient exists in the Central Log.

REFERENCES:
42 U.S.C. § 1395dd

COMMITTEE APPROVALS:
Quality

SUBJECT/TITLE:	EMTALA – Medical Screening Examination and Stabilization 02.01.00	POLICY #COM024
DEPARTMENT/SCOPE:	Compliance	Page 1 of 15
REVISION DATE: n/a		EFFECTIVE DATE: July 1, 2024
AUDIENCE: All Hospital Staff		APPROVAL DATE:
OWNER: J. Hathaway		APPROVER: R. Harris

SCOPE:

This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only. The definitions in the Company EMTALA Policy apply to this and all other facility EMTALA policies.

PURPOSE:

To establish guidelines for providing appropriate medical screening examinations ("MSE") and any necessary stabilizing treatment or an appropriate transfer for the individual as required by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

POLICY:

An EMTALA obligation is triggered when an individual comes to a dedicated emergency department ("DED") and:

1. the individual or a representative acting on the individual's behalf requests an examination or treatment for a medical condition; or
2. a prudent layperson observer would conclude from the individual's appearance or behavior that the individual needs an examination or treatment of a medical condition.

Such obligation is further extended to those individuals presenting elsewhere on hospital property requesting examination or treatment for an emergency medical condition ("EMC"). Further, if a prudent layperson observer would believe that the individual is experiencing an EMC, then an appropriate MSE, within the capabilities of the hospital's DED (including ancillary services routinely available and the availability of on-call physicians), shall be performed. The MSE must be completed by an individual (i) qualified to perform such an examination to determine whether an EMC exists, or (ii) with respect to a pregnant woman having contractions, whether the woman is in labor and whether the treatment requested is explicitly for an EMC. If an EMC is determined to exist, the individual will be provided necessary stabilizing treatment, within the capacity and capability of the facility, or an appropriate transfer as defined by and required by EMTALA. Stabilization treatment shall be applied in a non-discriminatory manner (*e.g.*, no different level of care because of an individual's race, color, ethnicity, religion, ancestry, national origin, citizenship, age, sex, marital status, sexual orientation (including gender identification), genetic information, preexisting medical condition, physical or mental disability, insurance status, economic status, ability to pay for medical services or any other category protected by law, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient).

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OWNER: J. Hathaway		APPROVER: R. Harris

PROCEDURE:

1. **When an MSE is Required**
   A hospital must provide an appropriate MSE within the capability of the hospital's emergency department, including ancillary services routinely available to the DED, to determine whether or not an EMC exists: (i) to any individual, including a pregnant woman having contractions, who requests such an examination; (ii) an individual who has such a request made on his or her behalf; or (iii) an individual whom a prudent layperson observer would conclude from the individual's appearance or behavior needs an MSE. An MSE shall be provided to determine whether or not the individual is experiencing an EMC, or a pregnant woman is in labor. An MSE is required when:
   a. The individual ***comes to a DED*** of a hospital and a request is made by the individual or on the individual's behalf for examination or treatment for a medical condition, including where:
      i. The individual requests medication to resolve or provide stabilizing treatment for a medical condition.
      ii. The individual arrives as a transfer from another hospital or health care facility. Upon arrival of a transfer, a physician or qualified medical person ("QMP") must perform an appropriate MSE. The physician or QMP shall provide any additional screening and treatment required to stabilize the EMC. The MSE of the individual must be documented. This type of screening cannot be performed by the triage nurse. If an EMC is determined to exist and the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under EMTALA ceases.

      Note: The MSE and other emergency services need not be provided in a location specifically identified as a DED. The hospital may use areas to deliver emergency services that are also used for other inpatient or outpatient services. MSEs or stabilization may require ancillary services available only in areas or facilities of the hospital outside of the DED.
   b. The individual arrives on the ***hospital property other than a DED*** and makes a request or another makes a request on the individual's behalf for examination or treatment for an EMC.
      i. Screening where the individual presented: If an individual is initially screened in a department or location on-campus other than the DED, the individual may be moved to another hospital department or facility on-campus to receive further screening or stabilizing treatment without such movement being a transfer. The hospital shall not move the individual to an off-campus facility or department (such as an urgent care center or satellite clinic) for an MSE.
      ii. Transporting to the DED: The hospital may determine that movement of an individual to the hospital's DED may be necessary for screening. However, common sense and individual

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judgment should prevail. When determining how best to transport the individual to the DED (means of transport, accompanying qualified personnel, equipment, etc.), the following factors should be taken into account but shall not be determinative:

- Whether the hospital DED has the personnel and resources necessary to render adequate medical treatment to all existing patients in the DED,
- Whether responding to the emergency could send hospital personnel into harm's way or unreasonably endanger or jeopardize the lives or health of such personnel, and
- Whether non-hospital paramedics, emergency medical technicians, or other qualified personnel are more appropriate to respond.

iii. Transporting to other hospital property: The facility may direct individuals to other hospital-based facilities that are on hospital property and operated under the hospital's provider number. However, the hospital should not move an individual to a hospital-based facility located off-campus, such as a rural health clinic or physician office, for an MSE or other emergency services. Individuals should only be moved to the hospital-based on-campus facility when the following conditions are met:

- all persons with the same medical condition are moved to this location regardless of their ability to pay for treatment,
- there is a bona fide medical reason to move the individual, and
- QMP accompany the individual.

Note: Unless outpatient testing is associated with an individual presenting to the DED with a request for an emergency medical screening, it should not be performed in the emergency department. Individuals presenting for outpatient testing should be registered as outpatients and not as emergency patients.

Note: Anyone may make the request for an MSE, or treatment described in both a. and b. above. Specifically,

- A minor (child) can request an examination or treatment for an EMC. Hospital personnel should not delay the MSE by waiting for parental consent. If, after screening the minor, it is determined that no EMC is present, the staff may wait for parental consent before proceeding with further examination and treatment. **Note:** For additional information regarding the treatment of minors, please consult your operations counsel.
- Emergency Medical Services (EMS) personnel may request an evaluation or treatment on an individual's behalf.

  Example: If an individual is on a gurney or stretcher or in an ambulance or on a helipad at the hospital and EMS personnel, the individual, or a legally responsible person acting on the individual's behalf, requests examination or treatment of an EMC from hospital staff, an MSE must be provided.

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c. The individual arrives ***on the hospital property***, either in the DED or property other than the DED, ***and no request is made*** for evaluation or treatment, but the appearance or behavior of the individual would cause a prudent layperson observer to believe that the individual needed such examination or treatment.
d. An individual is in a ***ground or air ambulance*** for purposes of examination and treatment for a medical condition at a hospital's DED, and the ambulance is either:
   i. *owned and operated by the hospital,* even if the ambulance is not on hospital grounds, or
   ii. neither owned nor operated by the hospital, but *on hospital property*.
e. A ***community-wide plan*** exists for specific hospitals to treat certain EMCs (*e.g.*, psychiatric, trauma, physical or sexual abuse). Prior to transferring the individual to the community plan hospital, an MSE must be performed, and any necessary stabilizing treatment rendered.
f. If a ***law enforcement official*** requests hospital emergency personnel to provide ***medical clearance*** for incarceration, the Hospital has an EMTALA obligation to provide an MSE to determine if an EMC exists. If an EMC is found to exist and is stabilized, the Hospital has met its EMTALA obligations and additional requests for assessment or testing are not required. All facilities must remain in compliance with federal and state HIPAA regulations.
g. If a ***law enforcement official*** brings a person who is exhibiting behavior that suggests that he or she is intoxicated to the DED for ***drawing of the blood alcohol*** and asks for an MSE, or if a prudent layperson observer would believe that the individual needed examination or treatment for a possible EMC, then an MSE must be performed. This is required because some medical conditions could present behaviors similar to those of an inebriated individual.
h. If an individual presents to a facility which does not have the capability to perform a rape kit when one is needed, the hospital's obligation is to provide an appropriate MSE without disturbing the evidence and transfer the individual to a hospital that has the capability to gather the evidence. The transfer must occur only in compliance with hospital policies and procedures that are Medicare Hospital Conditions of Participation (CoP) and licensure compliant.
i. ***Born Alive Infant***. When an infant is born alive in the DED, if a request is made on the infant's behalf for screening for a medical condition or if a prudent layperson would conclude based on the infant's appearance or behavior that the infant needed examination or treatment for a medical condition, the hospital and physician must provide an MSE. If the infant is born alive elsewhere on the hospital's campus and a prudent layperson observer would conclude based on the born alive infant's appearance or behavior that the infant was suffering from an EMC, the hospital and medical staff must perform an MSE to determine whether or not an EMC exists. If an EMC exists, the hospital must provide for stabilizing treatment or an appropriate transfer.
j. ***Off-Campus Provider-Based Emergency Department.*** **An off-campus provider based-emergency department is a department of the hospital, located no more than 35 miles from the main hospital, that meets all the provider-based requirements, holds the same Medicare provider number as the main hospital and is licensed by the state as an Emergency**

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Department. If an individual presents to an off-campus provider-based emergency department (should not be referred to as a "free-standing" emergency department), he or she must be provided an appropriate MSE just as he or she would if the presentation was at the main campus emergency department. Should the individual require additional screening for stabilizing care by a physician specialist, he or she will be moved to the main campus or another non-HCA facility for the additional care required. Such movement would be via an appropriate transport vehicle as designated by the ED Physician with appropriate equipment and personnel as determined by the ED Physician.

2. **When an MSE is NOT Required**
   a. If an individual **presents to a DED** in the following circumstances only**, no MSE is required by EMTALA:**
      i. ***The individual requests services that are NOT examination or treatment for an EMC,*** *such as preventive care services or drugs that are not required to stabilize or resolve an EMC.*
         Example: An individual presents to the DED and tells the clerk that he needs a flu shot because it is now flu season. The hospital is not obligated to provide an MSE under EMTALA because the request for a flu vaccine is a preventive care service.
      ii. ***The individual requests services that are NOT for an EMC such as gathering of evidence for criminal law cases*** (sexual assault, blood alcohol). When the request made is only to collect evidence, not to analyze the results or otherwise examine or treat the individual, no EMTALA obligation exists.

      iii. ***When an individual appears for non-emergency tests*** or pursuant to a previously scheduled visit. The hospital must ensure and document that no EMC was present or that no request was made to examine or treat the individual for an EMC.
         a) When an individual presents to the DED for medical care that is, by its nature, clearly unlikely to involve an EMC, the individual's statement that he or she is not seeking emergency care, together with brief questioning by QMP, is sufficient to establish that there is no EMC.
         b) A QMP is not required to question or examine the individual if the individual presents to the DED solely to fill a physician's order for a non-emergency test. The QMP should, however, question the individual to confirm that no EMC exists if the individual requests treatment for a non-emergency condition unrelated to the physician's order.
            Example: A physician refers an individual to the emergency department for occupational medicine testing.
   b. If the individual is in a ***ground or air ambulance*** which is:
      i. *owned and operated* by the hospital and *operated under community-wide EMS protocols or EMS protocols "mandated by State law" that direct it to transport* the individual to a

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hospital other than the hospital that owns the ambulance (i.e., to the closest appropriate facility). In this case, the individual is considered to have "come to the emergency department of the hospital" to which the individual is transported, at the time the individual is brought onto hospital property; or

ii. *not owned by the hospital and not on the hospital's property* even if the ambulance personnel contact the hospital by telephone or telemetry communications and inform the hospital that they want to transport the individual to the hospital for examination and treatment; or

iii. *owned but not operated by the hospital* as where a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance directs its operation and the ambulance is not on hospital property.

Note: A hospital may deny access to individuals when it is in "official diversionary" status because it does not have the capability or capacity to accept any additional emergency individuals at the time. The hospital shall develop and adopt written criteria that describe the conditions under which any or all of the hospital's emergency services are deemed to be at maximum capacity.

Caution: If the ambulance staff disregards the hospital's instructions and brings the individual on to hospital property, the individual has come to the emergency department and the hospital must perform an appropriate MSE. Should a hospital which is not in official diversionary status fail to accept a telephone or radio request for transfer or admission, the refusal could represent a violation of other Federal or State regulations.

Note: The hospital shall maintain written records documenting the date and time of the start and end of each period of diversionary status.

c. ***Use of hospital-owned helipad on hospital property for patient transport.*** No MSE is required for individuals being transported by local ambulance services or other hospitals to tertiary hospitals throughout the state through use of a ***hospital-owned helipad on the hospital's property*** by local ambulance services or other hospitals as long as the sending hospital conducted the MSE prior to transporting the individual to the helipad for medical helicopter transport to a designated recipient hospital. The sending hospital is responsible for conducting the MSE prior to transfer to determine if an EMC exists and implementing stabilizing treatment or conducting an appropriate transfer.

Caution: If the individual's condition deteriorates while being transported to the helipad or while at the helipad, the hospital at which the helipad is located must provide another MSE and stabilizing treatment within its capacity if requested by medical personnel accompanying the individual.

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If, as part of the EMS protocol, EMS activates helicopter evacuation of an individual with a potential EMC, the hospital with the helipad does not have an EMTALA obligation if they are not the recipient hospital, unless a request is made by EMS personnel, the individual, or a legally responsible person acting on the individual's behalf for the examination or treatment of an EMC.

d. ***Off campus, non-DED.*** If an individual requests emergency care in a hospital department off the hospital's main campus that does not meet the definition of a DED, EMTALA does not apply, and the hospital department is not obligated to perform an MSE. However, the off-campus department must have policies and procedures in place as to how to handle patients in need of immediate care.

3. **Extent of the MSE**
   a. **Determine if an EMC exists.** The hospital must perform an MSE to determine if an EMC exists. It is not appropriate to merely "log in" or triage an individual with a medical condition and not provide an MSE. Triage is not equivalent to an MSE. Triage entails the clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital in order to prioritize when the individual will be screened by a physician or other QMP.
   b. **Definition of MSE.** An MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC or not. It is not an isolated event. The MSE must be appropriate to the individual's presenting signs and symptoms and the capability and capacity of the hospital.
   c. **An on-going process.** The individual shall be continuously monitored according to the individual's needs until it is determined whether or not the individual has an EMC, and if he or she does, until he or she is stabilized or appropriately admitted or transferred. The medical record shall reflect the amount and extent of monitoring that was provided prior to the completion of the MSE and until discharge or transfer.
   d. **Judgment of physician or QMP.** The extent of the necessary examination to determine whether an EMC exists is generally within the judgment and discretion of the physician or other QMP performing the examination function according to algorithms or protocols established and approved by the medical staff and governing board.
   e. **Extent of MSE varies by presenting symptoms.** The MSE may vary depending on the individual's signs and symptoms:
      i. Depending on the individual's presenting symptoms, an appropriate MSE can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as (but not limited to) lumbar punctures, clinical laboratory tests, CT

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scans and other diagnostic tests and procedures.

ii. *Pregnant Women:* The medical records should show evidence that the screening examination includes, at a minimum, on-going evaluation of fetal heart tones, regularity and duration of uterine contractions, fetal position and station, cervical dilation, and status of membranes (*i.e.,* ruptured, leaking and intact), to document whether or not the woman is in labor. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife or other QMP acting within his or her scope of practice as defined by the hospital's medical staff bylaws and State medical practice acts, certifies in writing that after a reasonable time of observation, the woman is in false labor. The recommended timeframe for such physician certification of the QMP's determination of false labor should be within 24 hours of the MSE, however, the medical staff bylaws, rules and regulations can provide guidance on the timeframe.

iii. *Individuals with psychiatric or behavioral symptoms:* The medical records should indicate both medical and psychiatric or behavioral components of the MSE. The MSE for psychiatric purposes is to determine if the psychiatric symptoms have a physiologic etiology. The psychiatric MSE includes an assessment of suicidal or homicidal thoughts or gestures that indicates danger to self or others, and, as applicable, an assessment of the patient's inability to provide or utilize food, shelter, or clothing due to a mental disorder.

Non-discrimination. The hospital must provide an MSE and necessary stabilizing treatment to any individual regardless of an individual's race, color, ethnicity, religion, ancestry, national origin, citizenship, age, sex, marital status, sexual orientation (including gender identification), genetic information, preexisting medical condition, physical or mental disability, insurance status, economic status, ability to pay for medical services or any other category protected by law, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

4. **Who May Perform the MSE**
   a. Only the following individuals may perform an MSE:
      i. A qualified physician with appropriate privileges.
      ii. Other qualified licensed independent practitioner (LIP) with appropriate competencies and privileges; or
      iii. A qualified staff member who:
         - is qualified to conduct such an examination through appropriate privileging and demonstrated competencies.
         - is functioning within the scope of his or her license and in compliance with state law and applicable practice acts (*e.g.*, Medical or Nurse Practice Acts);
         - is performing the screening examination based on medical staff approved guidelines, protocols, or algorithms; and

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- is approved by the facility's governing board as set forth in a document such as the hospital bylaws or medical staff rules and regulations, which document has been approved by the facility's governing body and medical staff. It is not acceptable for the facility to allow informal personnel appointments that could change frequently.

b. **Qualified Medical Personnel.** QMPs may perform an MSE if licensed and certified, operating under the supervision of a physician, approved by the hospital's governing board through the hospital's by-laws, and only if the scope of the EMC is within the individual's scope of practice.
   i. The designation of QMP is set forth in a document approved by the governing body of the hospital. Each individual QMP approved to provide an MSE under EMTALA must be appropriately credentialed and must meet the requirements for annual evaluations set forth in the protocol agreements with physicians and the State's medical practice act, nurse practice act or other similar practice acts established to govern health care practitioners. Only appropriately credentialed APRNs, PAs and physicians may perform MSEs in the DED.
   ii. **Psychiatric QMP.** The ED physician shall consult the QMP providing the behavioral assessment for psychiatric purposes but shall remain the primary decision-maker with regard to transfer and discharge of the individual presenting to the DED with psychiatric or behavioral emergencies. Should an individual with a psychiatric or behavioral emergency present to a behavioral department of a hospital that meets the requirements of a DED, that department is responsible for ensuring that the individual has the appropriate MSE, including any behavioral examination, and providing necessary stabilizing treatment.
   iii. **Labor and Delivery QMP.** QMPs in the labor and delivery DED may be appropriately-approved RNs and must communicate their findings as to whether or not a woman is in labor to the obstetrician on call, the laborist, or the ED physician.
   iv. **Limitations.** The hospital has established a process to ensure that:
      a) a physician examines all individuals whose conditions or symptoms require physician examination.
      b) an ED physician on duty is responsible for the general care of all individuals presenting themselves to the emergency department; and
      c) the responsibility remains with the ED physician until the individual's private physician or an on-call specialist assumes that responsibility, or the individual is discharged.

5. **No Delay in Medical Screening or Examination**
   a. **Reasonable Registration Process.** An MSE, stabilizing treatment, or appropriate transfer will not be delayed to inquire about the individual's method of payment or insurance status or conditioned on an individual's completion of a financial responsibility form, an advance beneficiary notification form, or payment of a co-payment for any services rendered. The facility must render emergency services and care without first questioning the patient or any other person as to his or her ability to pay therefor. The patient or his/her legally responsible relative or

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guardian are required to provide insurance or credit information, or sign an agreement to pay, promptly after the services are rendered. The hospital may seek non-payment information from the individual's health plan about the individual, such as medical history. In the case of an individual with an EMC, once the hospital has conducted the MSE and has initiated stabilizing treatment, it may seek authorization for all services from the plan as long as doing so does not delay completion of the stabilizing treatment.

b. **Managed Care.** For individuals who are enrolled in a managed care plan, prior authorization from the plan shall NOT be required or requested before providing an appropriate MSE and initiating any further medical examination and necessary stabilizing treatment.
c. **EMS.** A hospital has an obligation to see the individual once the individual presents to the DED whether by EMS or otherwise. A hospital that delays the MSE or stabilizing treatment of any individual who arrives via transfer from another facility, by not allowing EMS to leave the individual, could be in violation EMTALA and the Hospital CoP for Emergency Services. Even if the hospital cannot immediately complete an appropriate MSE, the hospital must assess the individual's condition upon arrival of the EMS service to ensure that the individual is appropriately prioritized based on his or her presenting signs and symptoms to be seen for completion of the MSE.
d. **Contacting the individual's physician.** An ED physician or non-physician practitioner may contact the individual's personal physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to medical treatment and screening of the individual, so long as this consultation does not inappropriately delay services.
e. **Financial Responsibility Forms.** The performance of the MSE and the provision of stabilizing treatment will NOT be conditioned on an individual's completion of a financial responsibility form, an advance beneficiary notification form, or payment of a co-payment for any services rendered.
f. **Financial Inquiries.** Individuals who inquire about financial responsibility for emergency care should receive a response by a staff member who has been well trained to provide information regarding potential financial liability. The staff member who provides information on potential financial liability should clearly inform the individual that the hospital will provide an MSE and any necessary stabilizing treatment, regardless of his or her ability to pay. Individuals who believe that they have an EMC should be encouraged to remain for the MSE.

Note: There is no delay in the provision of an MSE or stabilizing treatment if: (i) there is not an open bed in the DED; (ii) there are not sufficient caregivers present to render the MSE and/or stabilizing treatment; and (iii) the individual's condition does not warrant immediate screening and treatment by a physician or QMP.

6. **Refusal to Consent to Treatment**
   a. **Written Refusal – Partial Refusal of Care or Against Medical Advice.** If a physician or QMP

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has begun the MSE or any stabilizing treatment and an individual refuses to consent to a test, examination or treatment or refuses any further care and is determined to leave against medical advice, after being informed of the risks and benefits and the hospital's obligations under EMTALA, reasonable attempts shall be made to obtain a written refusal to consent to examination or treatment using the form provided for that purpose or document the individuals refusal to sign the Partial Refusal of Care or the Against Medical Advice. The medical record must contain a description of the screening and the examination, treatment, or both if applicable, that was refused by or on behalf of the individual.

b. **Waiver of Right to Medical Screening Examination.** If an individual refuses to consent to examination or treatment and indicates his or her intention to leave prior to triage or prior to receiving an MSE or if the individual withdrew the initial request for an MSE, facility personnel must request that the individual sign the Waiver of Right to Medical Screening Examination Form that is part of the Sign-In Sheet or document on the Sign-In Sheet the individual's refusal to sign the Waiver of Right to Medical Screening Examination Form.
c. **Documentation of Information.** If an individual refuses to sign a consent form, the physician or nurse must document that the individual has been informed of the risks and benefits of the examination and/or treatment but refused to sign the form.
d. **Documentation of Unannounced Leave.** If an individual leaves the facility without notifying facility personnel, this must be documented upon discovery. The documentation must reflect that the individual was at the facility and the time the individual was discovered to have left the premises. Triage notes and additional records must be retained. If the individual leaves prior to transfer or leaves prior to an MSE, the information should be documented on the individual's medical record. If an individual has not completed a Sign-In Sheet, an ED staff member should complete a sheet and if the individual's name is not known a description of the individual leaving should be entered on the form. All individuals presenting for evaluation or treatment must be entered into the Central Log.

7. **Stabilizing Treatment Within Hospital Capability**
The determination of whether an individual is stable is not based on the clinical outcome of the individual's medical condition. An individual has been provided sufficient stabilizing treatment when the physician treating the individual in the DED has determined, within reasonable clinical confidence, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an EMC of a woman in labor, that the woman has delivered the child and placenta; or in the case of an individual with a psychiatric or behavioral condition, that the individual is protected and prevented from injuring himself/ herself or others. For those individuals who are administered chemical or physical restraints for purposes of transfer from one facility to another, stabilization may occur for a period of time and remove the immediate EMC, but the underlying medical

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condition may persist and, if not treated for longevity, the individual may experience exacerbation of the EMC. Therefore, the treating physician should use great care when determining if the EMC is in fact stable after administering chemical or physical restraints.

a. **Stable.** The physician or QMP providing the medical screening and treating the emergency has determined within reasonable clinical confidence, that the EMC that caused the individual to seek care in the DED has been resolved although the underlying medical condition may persist. Once the individual is stable, EMTALA no longer applies. (The individual may still be transferred; however, the "appropriate transfer" requirement under EMTALA does not apply.)

b. **Stabilizing Treatment Within Hospital Capability and Transfer.** Once the hospital has provided an appropriate MSE and stabilizing treatment within its capability, an appropriate transfer may be effected by following the appropriate transfer provisions. (See Transfer Policy.) If there is a disagreement between the physician providing emergency care and an off-site physician (*e.g.*, a physician at the receiving facility or the individual's primary care physician if not physically present at the first facility) about whether the individual has been provided sufficient stabilized treatment to effect a transfer, the medical judgment of the transferring physician takes precedence over that of the off-site physician.

   Refer to the hospital's Transfer Policy for additional directions regarding transfers of those individuals who are not medically stable. If a hospital has exhausted all its capabilities and is unable to stabilize an individual, an appropriate transfer should be implemented by the transferring physician.

c. **Stabilizing Treatment and Individuals Whose EMCs Are Resolved.** An individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his or her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care with the discharge instructions. The EMC that caused the individual to present to the DED must be resolved, but the underlying medical condition may persist. Hospitals are expected within reason to assist/provide discharged individuals with the necessary information to secure follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital.

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8. **When EMTALA Obligations End**
The hospital's EMTALA obligation ends when a physician or QMP has made a decision:
   a. That no EMC exists (even though the underlying medical condition may persist);
   b. That an EMC exists, and the individual is appropriately transferred to another facility; or
   c. That an EMC exists, and the individual is admitted to the hospital for further stabilizing treatment; or
   d. That an EMC exists, and the individual is stabilized and discharged.

Note: A hospital's EMTALA obligation ends when the individual has been admitted in good faith as an inpatient, whether or not the individual has been stabilized. An individual is considered to be an inpatient when the individual is formally admitted to the hospital by a physician's order. A hospital continues to have a responsibility to meet the patient's emergency needs in accordance with hospital CoPs. A patient in observation status is not considered admitted as an inpatient, therefore, EMTALA obligations continue.

9. ***EMTALA Waivers and Requirements During Pandemics and Other Declared Emergencies.***
   a. Alternative Screening Sites on Campus for Screening during a Pandemic (No Waiver Required.) For the screening of influenza like illnesses, the hospital may establish an alternative screening site(s) on campus. Individuals may be redirected to these sites AFTER being logged in. The redirection and logging can take place outside the entrance to the DED. However, the person doing the directing must be qualified (*e.g.*, an RN or QMP) to recognize individuals who are obviously in need of immediate treatment in the DED. The MSEs must be conducted by qualified personnel.
   b. Alternative Screening Site Off-Campus (No Waiver Required.) The hospital may encourage the public to go to an off-campus hospital-controlled site <u>for the screening of influenza like illness</u>. However, the hospital may NOT tell an individual who has already come to the DED to go to the off-site location for the MSE. The off-campus site for influenza like illnesses should not be held out to the public as a place that provides care for EMCs in general on an urgent, unscheduled basis.
   c. EMTALA Waivers.
      i. A hospital operating under an EMTALA waiver will not be sanctioned for an inappropriate transfer or for directing or relocating an individual who comes to the DED to an alternative off-campus site, for the MSE if the following conditions are met:
         1. The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period (as those terms are defined in the hospital's EMTALA Transfer Policy).

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2. The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan.
3. The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.
4. The hospital is located in an emergency area during an emergency period; and
5. There has been a determination that a waiver of sanctions is necessary.

ii. An EMTALA waiver can be issued for a hospital only if:
1. The President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act; and
2. The Secretary of HHS has declared a Public Health Emergency (PHE); and
3. The Secretary invokes his or her waiver authority including notifying Congress at least 48 hours in advance; and
4. The waiver includes a waiver of EMTALA requirements, and the hospital is covered by the waiver.

iii. In the absence of CMS notification of area-wide applications of the waiver, the hospital must contact CMS and request that the waiver provisions be applicable to the hospital.

iv. In addition, in order for an EMTALA waiver to apply to the hospital and for sanctions not to apply, (i) the hospital must activate its disaster protocol, and (ii) the State must have activated an emergency preparedness plan or pandemic preparedness plan in the emergency area, and any redirection of individuals for an MSE must be consistent with such plan.

v. Even when a waiver is in effect, there is still the expectation that everyone who comes to the DED will receive an appropriate MSE, if not in the DED, then at the alternate care site to which they are redirected or relocated.

Except in the case of waivers related to pandemic infectious disease, an EMTALA waiver is limited in duration to 72 hours beginning upon activation of the hospital's disaster protocol. In the case of a PHE involving pandemic infectious disease, the general EMTALA waiver authority will continue in effect until the termination of the declaration of the PHE. However, the waiver may be limited to a date prior to the termination of the PHE declaration, as determined by CMS. If a State emergency/pandemic preparedness plan is deactivated in the area where the hospital is located prior to the termination of the PHE, the hospital no longer meets the conditions for an EMTALA waiver, and the hospital waiver would cease to be in effect as of the deactivation date. Likewise, if the hospital deactivates its disaster protocol prior to the termination of the PHE, the

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hospital no longer meets the conditions for an EMTALA waiver, and the hospital waiver would cease to be in effect as of the deactivation date.

REFERENCES:
42 U.S.C. § 1395dd

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The definitions in the EMTALA Policy apply to this and all other hospital EMTALA policies.

PURPOSE:

To establish guidelines for the hospital, and its personnel to be prospectively aware of which physicians, including specialists and sub-specialists, are available to provide additional medical evaluation and treatment necessary to stabilize individuals with emergency medical conditions ("EMCs") in accordance with the resources available to the hospital as required by EMTALA, 42 U.S.C. § 1395dd, and all Federal and State regulations and interpretive guidelines promulgated thereunder.

POLICY:

The hospital must maintain a list of physicians on its medical staff who have privileges at the hospital or if it participates in a community call plan, a list of all physicians who participate in such plan. Physicians on the list must be available after the initial examination to provide treatment necessary to stabilize individuals with EMCs who are receiving services in accordance with the resources available to the hospital. The cooperation of the hospital's medical staff members with this policy is vital to the hospital's success in complying with the on-call provisions of EMTALA. The hospital should make its privileged physicians aware of their legal obligations as reflected in this policy and the Medical Staff Bylaws and should take all necessary steps to ensure that physicians perform their obligations as set forth herein and in each document.

PROCEDURE:

Develop an On-Call Schedule. The facility's governing board must require that the medical staff be responsible for developing an on-call rotation schedule that includes the name and direct telephone number or direct pager of each physician who is required to fulfill on-call duties. Practice group names and general office numbers are not acceptable for contacting the on-call physician. Individual physician names with accurate contact information, including the direct telephone number or direct pager where the physician can be reached, are to be put on the on-call list. The hospital MUST be able to contact the on-call physician with the number provided on the list. If the on-call physician decides to list an answering service number as the preferred method of contact, his/her mobile phone number must be provided to the hospital as a backup number to reach the on-call physician. The backup number will be used by hospital and Transfer Center personnel when the On-Call Physician does not respond to calls in a timely manner. Each physician is responsible for updating his or her contact information as necessary. Each hospital shall provide a copy of the daily on-call schedule to the Transfer Center.

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The on-call schedule may be by specialty or sub-specialty (*e.g.*, general surgery, orthopedic surgery, hand surgery, plastic surgery), as determined by the hospital and implemented by the relevant department chairpersons. The Medical Executive Committee ("MEC") shall review the on-call schedule and make recommendations to the CEO when formal changes are to be made or when legal and/or perational issues arise.

The hospital shall keep local Emergency Medical Services advised of the times during which certain specialties are unavailable.

Only physicians that are available to physically come to the ER may be included on the on-call list. A physician available via telemedicine does not satisfy the on-call requirements under EMTALA.

Records. The hospital must keep a record of all physicians on-call and on-call schedules for at least five years. Any on-call list must reflect any and all substitutions from the time of first posting of the list. These records may be in electronic or hardcopy format.

Maintain a List. Each hospital must maintain a list of physicians who are on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an EMC. The Medical Staff Bylaws or appropriate policy and procedures must define the responsibility of on-call physicians to respond, examine, and treat patients with an EMC. Factors to consider in developing the on-call list include: the level of trauma and emergency care afforded by the hospital; number of physicians on the medical staff who are holding the privileges of the specialty; other demands on the physicians; frequency with which the physician's services are required; and the provisions the hospital has made for situations where the on-call physician is not available or not able to respond due to circumstances beyond his or her control. The hospital is expected to provide adequate specialty on-call coverage consistent with the services provided at the hospital and the resources the hospital has available.

California hospitals with licensed basic emergency departments must have internal medicine (which may include hospitalists), imaging, pathology, surgical and anesthesia physician coverage at all times.

In addition, the on-call list requirement applies to any hospital with specialized capabilities that is participating in the Medicare program regardless of whether the hospital has a DED. Specialty Hospitals must have appropriate on-call specialists available for receiving those individuals transferred pursuant to EMTALA. Hospitals should verify that the privileges of each on-call physician are current as to the procedures that each on-call physician is able to perform and the services that each on-call physician may provide.

The on-call list maintained for the main hospital Emergency Department shall be the on-call list for the hospital, including any Off-Campus Provider-based Emergency Departments.

Physician's Responsibility. The hospital has a process to ensure that when a physician is identified as being "on-call" to the DED for a given specialty, it shall be that physician's duty and responsibility to assure the following:

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1. Immediate availability, at least by telephone, to the ED physician for his or her scheduled "on-call" period, or to secure a qualified alternate who has privileges at the hospital if appropriate.
2. Arrival or response to the DED within a reasonable timeframe (generally, response by the physician is expected within 30 minutes). The ED physician, in consultation with the on-call physician, shall determine whether the individual's condition requires the on-call physician to see the individual immediately. The determination of the ED physician or other practitioner who has personally examined the individual and is currently treating the individual shall be controlling in this regard.
3. The on-call physician has a responsibility to provide specialty care services as needed to any individual who comes to the Emergency Department either as an initial presentation or upon transfer from another facility.
4. The on-call physician has a responsibility to notify the Medical Staff Coordinator of changes to the on- call schedule.

Authority to Decline Transfers. The on-call physician does not have the authority to refuse an appropriate transfer on behalf of the facility.

Only the CEO, Administrator-on-Call ("AOC"), or a hospital leader who routinely takes administrative call has the authority to verify that the facility does not have the capability and capacity to accept a transfer. Any transfer request which may be declined must first be reviewed with this individual before a final decision to refuse acceptance is made. This requirement applies to all transfer requests, regardless of whether the transfer request is facilitated by a Transfer Center representative or the facility's CEO designee or ED physician. For purposes of this requirement, a Nursing Supervisor, House Supervisor or other similarly titled position is not considered to be an equivalent of the AOC.

Financial Inquiries. Medical Staff Members who are on-call and who are called to provide treatment necessary to stabilize an individual with an EMC may not inquire about the individual's ability to pay or source of payment before coming to the DED and no facility employee, including Transfer Center employees, may provide such information to a physician on the phone.

Members of the hospital medical staff who serve on-call cannot refuse to respond to call on the basis of an individual's race, color, gender identity, ethnicity, religion, ancestry, national origin, citizenship, age, sex, marital status, sexual orientation (including gender identification), genetic information, preexisting medical condition, physical or mental disability, insurance status, economic status, ability to pay for medical services or any other category protected by law, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

Physician Appearance Requirements. If a physician on the on-call list is called by the hospital to provide emergency screening or treatment and either fails or refuses to appear within a

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reasonable timeframe, the hospital and that physician may be in violation of EMTALA as provided for under section 1867(d)(1)(C) of the Social Security Act. If a physician is listed as on-call and requested to make an in-person appearance to evaluate and treat an individual, that physician must respond in person within a reasonable amount of time. For those physicians who do not respond within a reasonable amount of time, the Chain of Command Policy should be initiated.

If, as a result of the on-call physician's failure to respond to an on-call request, the hospital must transfer the individual to another facility for care, the hospital must document on the transfer form the name and address of the physician who refused or failed to appear.

Call by Non-Physician Practitioners. The ED physician must be able to first confer with the on-call physician. Midlevel practitioners (usually physician assistants or advanced practice registered nurses) who are employed by and have protocol agreements with the on-call physician, may appear at the hospital and provide further assessment or stabilizing treatment to the individual only after the on-call physician and ED physician confer and the on-call physician so directs the licensed non-physician practitioner to appear at the hospital. The ED physician and the on-call physician must jointly approve the decision to have a non-physician practitioner respond to call instead of the on-call physician. The individual's medical needs and capabilities of the hospital, along with the State scope of practice laws, hospital bylaws, and rules and regulations, must be thoroughly reviewed prior to implementing this process. The designated on-call physician remains ultimately responsible for providing the necessary services to the individual in the DED regardless of who makes the first in-person visit. If the ED physician does not believe that the non-physician practitioner is the appropriate practitioner to respond and requests the on-call physician to appear, the on-call physician must come to the hospital to see the individual.

Selective Call and Avoiding Responsibility. Medical Staff Members may not relinquish specific clinical privileges for the purpose of avoiding on-call responsibility. The Governing Board is responsible for assuring adequate on-call coverage of specialty services in a manner that meets the needs of the community in accordance with the resources available to the hospital. Exemptions for certain medical staff members (*e.g.*, senior physicians) would not per se violate EMTALA-related Medicare provider agreement requirements. However, if a hospital permits physicians to selectively take call ONLY for their own established patients who present to the DED for evaluation, then the hospital must be careful to assure that it maintains adequate on-call services, and that the selective call policy is not a substitute for the on-call services required by the Medicare provider agreement.

Providing Elective Surgeries or Other Therapeutic or Diagnostic Procedures While On-Call. The hospital shall have in place policies and procedures to ensure that specialty services are available to meet the needs of any individual with an EMC if the hospital permits on-call physicians to schedule elective surgeries during the time that they are on-call. An on-call physician who undertakes an elective surgery while on-call must arrange for an appropriate physician with comparable hospital privileges to serve as back-up to provide on-call coverage and notify the facility of such determination. The facility will

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ensure that the DED is familiar with the back-up arrangement for any physician performing elective procedures.

Simultaneous Call. Physicians are permitted to have simultaneous call at more than one hospital in the geographic area; however, the physician must provide the hospital with the physician's on-call schedule so that the hospital can have a plan in place to meet its EMTALA obligation to the community. This plan could include a back-up call by an additional physician or the implementation of an appropriate transfer. An on-call physician may not choose which hospital in which to treat a patient purely for the physician's convenience (*e.g.*, if a physician is on-call for both Hospitals A and B, is at Hospital B, but requested to come to Hospital A by the Hospital A ED physician, the on-call physician is obligated to treat the patient at Hospital A).

Back-up Plans and Transfers. The hospital shall have in place a written plan for transfer and/or back-up call coverage by a physician of the same specialty or subspecialty for situations in which a particular specialty is not available or the on-call physician cannot respond due to circumstances beyond the physician's control. The ED physician shall determine whether to attempt to contact another such specialist or immediately arrange for a transfer. The hospital must be able to demonstrate that hospital staff is aware of and able to execute the back-up procedures.

Appropriate transfer agreements shall be in place for those occasions when an on-call specialist is not available within a reasonable period of time to provide care for those individuals who require specialty or subspecialty physician care, and a transfer is necessary. A list of facilities with which the hospital has transfer arrangements and the specialties represented shall be available to the individual or Transfer Center responsible for facilitating the transfer. The transfer agreements shall not include financial provisions for EMTALA transfers.

Transfer to Physician's Office. When a physician who is on-call is in his or her office, the hospital may NOT refer individuals receiving treatment for an EMC to the physician's office for examination and treatment. The physician must come to the hospital to examine the individual if requested by the treating physician.

REFERENCES

42 U.S.C. § 1395dd

COMMITTEE APPROVALS:

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PURPOSE:

The purpose of this policy is to ensure that all reports related to potential EMTALA violations are properly made.

POLICY:

As required by provisions of EMTALA, the Hospital must report certain types of known or suspected EMTALA violations to CMS and to other appropriate state agencies. It is the policy of the hospital to voluntarily self-report certain types of EMTALA violations.

PROCEDURE:

Please refer to the Emergency Medical Treatment and Patient Transfer Policy for a complete list of definitions pertaining to this policy.

The Hospital's medical staff members and employees have the following reporting obligations:

1. Violations By Another Hospital: The Hospital's medical staff members and employees who know of an apparent violation of the EMTALA transfer laws on the part of another Hospital, in its capacity as either a transferring or receiving Hospital, will immediately report such violation to Hospital administration. Hospital administration will report the suspected violation to CMS or to the state survey agency.

   Such violations typically involve a situation where the Hospital has reason to believe it may have received an individual who has been transferred from another hospital in violation of the EMTALA transfer requirements, (i.e., without doing any one of the following: 1) providing treatment within its capacity to minimize the risks of the transfer; 2) contacting the receiving Hospital and confirming that it has the capacity to treat the patient and accepts the patient; 3) transporting the patient by appropriate means and with qualified personnel; or 4) sending a copy of the patient's medical records).

2. Violations By the Hospital: The Hospital's medical staff members and employees who know of an apparent violation of the EMTALA transfer laws on the part of the Hospital, in its capacity as either a transferring or receiving Hospital, will immediately report such violation to Hospital administration.

   Hospital will consult with Legal, when the Hospital believes an apparent violation may be reported to a federal or state survey agency, either by another Hospital, a patient, Hospital staff, or the matter should be reported by the Hospital itself.

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3. An on-call physician who fails or refuses to come to the Hospital within a reasonable period of time, as requested, to evaluate or stabilize the patient, must be reported to Hospital administration. The Hospital will consult with Legal, to determine if a self-report is appropriate. All such self-reports should be reviewed and approved by Legal prior to filing with the appropriate federal or state agency.

4. It is expected that any Hospital Medical Staff member or employee who knows of or suspects an EMTALA violation will report it immediately to Hospital administration.

COMMITTEE APPROVALS:

Quality:

MAYERS MEMORIAL HEALTHCARE DISTRICT

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The definitions in the Hospital EMTALA Policy, LL.EM.001, apply to this and all other hospital EMTALA policies.

PURPOSE:

To establish guidelines for providing all individuals with the opportunity to be aware of and view their right to medical screening examination ("MSE") and stabilization for an emergency medical condition ("EMC") as required of any hospital with an emergency department by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

POLICY:

All emergency departments and any other place likely to be noticed by all individuals entering the emergency department and those individuals waiting for examination and treatment in areas of the hospital other than the traditional emergency department such as the entrance area, admitting areas, waiting rooms, and treatment areas located on hospital property must post conspicuously, appropriate signage notifying individuals of their right to an MSE and stabilization or treatment for an EMC and required services for women in labor as specified under EMTALA as well as information indicating whether or not the hospital participates in the Medicaid program.

PROCEDURE:

The hospital will post signage that, at a minimum, meets the following requirements:

a) Signage must be conspicuously posted in any place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than the traditional emergency department (*e.g.*, entrance, admitting area, waiting room, labor and delivery, and other treatment areas located on hospital property):
b) Signage must be readable from anywhere in the area.
c) Wording on signage must be clear and in simple terms in a language(s) that is / are understandable by the population the hospital serves.

The contents of the signage must:

a) indicate whether or not the hospital participates in a Medicaid program approved under a State plan under Title XIX.
b) specify the rights of individuals with EMCs to receive an MSE and necessary stabilization and treatment for any EMC regardless of the ability to pay; and
c) specify the rights of women in labor who come to the emergency department for health care services.

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The signage content must include the following language:

IT'S THE LAW!
If you have a medical emergency or are in labor, even if you cannot pay or do not have medical insurance or you are not entitled to Medicare or Medicaid, you have the right to receive, within the capabilities of this hospital's staff and facilities:
An appropriate medical screening examination;

Necessary stabilizing treatment (including treatment for an unborn child); and

If necessary, an appropriate transfer to another facility.

This hospital (does/does not) participate in the Medicaid program. *

The emergency department signage for California hospitals must include the name, address, and telephone number of the regional office of the California Department of Public Health, Licensing and Certification Division.

The signs must be posted in the predominant language(s) spoken in the hospital service area.

REFERENCE:
42 U.S.C. § 1395dd

COMMITTEE APPROVALS:
Quality:

SUBJECT/TITLE:	EMTALA Transfer Policy 02.01.00	POLICY #COM023
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This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only.

The definitions in the EMTALA Policy apply to this and all other facility EMTALA policies.

PURPOSE:

To establish guidelines for either accepting an appropriate transfer from another facility or providing an appropriate transfer to another facility of an individual with an emergency medical condition (EMC), who requests or requires a transfer for further medical care and follow-up to a receiving facility as required by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

POLICY:

Any transfer of an individual with an EMC must be initiated either by a written request for transfer from the individual or the legally responsible person acting on the individual's behalf or by a physician order with the appropriate physician certification as required under EMTALA. EMTALA obligations regarding the appropriate transfer of an individual determined to have an EMC apply to any emergency department ("ED") or dedicated emergency department ("DED") of a hospital whether located on or off the hospital campus and all other departments of the hospital located on hospital property.

A hospital with specialized capabilities or facilities (including, but not limited to burn units, shock-trauma units, neonatal intensive care units, dedicated behavioral health units, or regional referral centers in rural areas) shall accept from a transferring hospital an appropriate transfer of an individual with an EMC who requires specialized capabilities if the receiving hospital has the capacity to treat the individual. The transferring hospital must be within the boundaries of the United States.

The transfer of an individual shall not consider an individual's race, color, ethnicity, religion, ancestry, national origin, citizenship, age, sex, marital status, sexual orientation (including gender identification), genetic information, preexisting medical condition, physical or mental disability, insurance status, economic status, ability to pay for medical services or any other category protected by law, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

The CEO must designate in writing an administrative designee by title responsible for accepting transfers in conjunction with a receiving physician. The CEO administrative designee, in

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conjunction with the receiving physician, *e.g.*, ED physician, has authority to accept the transfer if the hospital has the capability and capacity to treat the individual.

Note: Movement of an individual to another part of the same hospital is not considered a transfer for EMTALA purposes.

1. **Transfer of Individuals Who Have Not Been Stabilized**

   a. If an individual who has come to the emergency department has an EMC that has not been stabilized, the hospital may transfer the individual only if the transfer is an appropriate transfer and meets the following conditions:
      i. The individual or a legally responsible person acting on the individual's behalf requests the transfer, after being informed of the hospital's obligations under EMTALA and of the risks and benefits of such transfer. The request must be in writing and indicate the reasons for the request as well as indicate that the individual is aware of the risks and benefits of transfer; or
      ii. A physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of the woman in labor, to the woman or the unborn child, from being transferred. The certificate must contain a written summary of the risks and benefits upon which it is based; or
      iii. If a physician is not physically present in the DED at the time the individual is transferred, a qualified medical person ("QMP") has signed a certification after a physician in consultation with the QMP, agrees with the certification and subsequently countersigns the certification. The certification must contain a written summary of the risks and benefits upon which it is based.
      Note: The date and time of the physician or QMP certification should match the date and time of the transfer.

   b. A transfer will be an appropriate transfer if:
      i. The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child.
      ii. The receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to accept the transfer and to provide appropriate medical treatment.
      iii. The transferring hospital sends the receiving hospital copies of all medical records related to the EMC for which the individual presented that are available at the time of transfer as well as the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

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and

iv. The transfer is effected through qualified personnel and transportation equipment as required including the use of necessary and medically appropriate life support measures during the transport.

Hospitals that request transfers must recognize that the appropriate transfer of individuals with unstabilized EMCs that require specialized services should not routinely be made over great distances, bypassing closer hospitals with the necessary capability and capacity to care for the unstabilized EMC.

c. Higher Level of Care. A higher level of care should be the more likely reason to transfer an individual with an EMC that has not been stabilized. The following are examples of a higher level of care:

i. A receiving hospital with **specialized capabilities or facilities** that are not available at the transferring hospital (including, but not limited to burn units, shock-trauma units, neonatal intensive care units, dedicated behavioral health units, or regional referral centers in rural areas) must accept an appropriate transfer of an individual with an EMC who requires specialized capabilities or facilities if the hospital has the capacity to treat the individual.

ii. If there is a local, regional, or state plan for hospital care for designated populations such as individuals with psychiatric disorders or high-risk neonates, the transferring hospital must still provide an MSE and stabilizing treatment prior to transferring to the hospital so designated by the plan.

2. **Additional Transfer-Related Situations**

a. Diagnostic Facility. If an individual is moved to a diagnostic facility located at another hospital for diagnostic procedures not available at the transferring hospital and the hospitals arrange to return the individual to the transferring hospital, the transfer requirements must still be met by the sending hospital. The receiving hospital is not obligated to meet the EMTALA transfer requirements when implementing an appropriate transfer back to the transferring hospital. The recipient hospital will send or communicate the results of the tests performed to the transferring hospital.

b. Off-Campus hospital-based facilities to nonaffiliated hospital. A transfer from a hospital-based facility located off-campus to a nonaffiliated hospital must still comply with the requirements of an appropriate transfer as defined by EMTALA. A Memorandum of Transfer must be used in such situations.

Note: Off-Campus Provider-based EDs or DED. The movement of a patient from an off-campus provider-based ED or DED to the main hospital ED is a

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movement and not a transfer.

c. Pre-Existing Transfer Agreements. Appropriate transfer agreements should be in place and in writing between the hospital, including any outpatient or other off-campus departments where care is provided and other hospitals in the area where the outpatient or off-campus departments are located. Even if there are pre-existing transfer agreements between transferring and receiving hospitals, a physician certification is required for any medically indicated transfer for an unstable individual. Transfer Agreements shall not include financial provisions for transfer but may include reciprocal provisions for transferring the individual back to the original transferring hospital when the higher level of care is no longer required.

d. Transfers for High-Risk Deliveries. A hospital that is not capable of handling the delivery of a high-risk woman in labor must still provide an MSE and any necessary stabilizing treatment as well as meet the requirements of an appropriate transfer even if a transfer agreement is in place. In addition, a physician certification that the benefits of transfer outweigh the risks of transfer is required for the transfer of the woman in labor.

e. Diversion/Exceeded Capacity. If the transferring hospital has the capability but lacks the capacity to treat the individual, then the individual would likely benefit from the transfer, and it would be permissible if all other conditions of an appropriate transfer are met. In addition, the hospital may transfer an individual due to bed shortage or overcrowding, if it has exhausted all its capabilities, even if the individual does not require any specialized capabilities of the receiving hospital. The receiving hospital must accept the transfer of the individual if it has the capacity and capability to do so. In communities with a community-wide emergency services system, the receiving hospital must accept the individual being transferred from a hospital on diversionary status if it has the capacity and capability. After acceptance, the receiving hospital may attempt to validate that the transferring hospital has, in fact, exhausted all its capabilities prior to transfer.

f. Lateral Transfers. Transfers between hospitals of comparable resources and capabilities are not permitted unless the receiving facility offers enhanced care benefits to the patient that would outweigh the risks of the transfer. Examples of such situations include a mechanical failure of equipment or no ICU beds available.

g. Women in Labor. For a woman in labor, a transfer may be made only if the woman in labor or her representative requests the transfer, and if a physician signs a certification that the benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risks to the individual or the unborn child. A hospital cannot cite State law or practice as the basis for transfer. A woman in labor who requests transfer to another facility may not be discharged against medical advice to go to

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the other facility. The risks associated with such a disposition must be thoroughly explained to the patient and documented. If the patient still insists on leaving to go to another facility, the facility should take all reasonable steps to obtain the patient's request in writing and take all reasonable steps to have the patient transported using qualified personnel and transportation equipment. Transporting a woman in labor by privately-owned vehicle is not an appropriate form of transportation.

h. Observation Status. An individual who has been placed in observation status is not an inpatient, even if the individual occupies a bed overnight. Therefore, an individual placed in an observation status who came to the hospital's DED for example, does not terminate the EMTALA obligations of that hospital or a recipient hospital toward an individual who remains in unstable condition at the time of transfer. The EMTALA obligation does not end until the patient has been stabilized, appropriately transferred, discharged, or admitted as an inpatient. Therefore, any transfer of a patient in observation status who initially presented to a DED must meet all the requirements of an EMTALA transfer.

3. **Authority to Decline a Transfer Request**

The ED physician, working in conjunction with the CEO, Administrator-on-Call (AOC), or a hospital leader who routinely takes administrative call has the authority to decline a transfer request based on a determination that the facility does not have the capability and/or capacity to accept such transfer. This requirement applies to all transfer requests, regardless of whether the transfer request is facilitated by a Transfer Center representative or the facility's CEO designee or ED physician. For purposes of this requirement, a Nursing Supervisor, House Supervisor, or other similarly titled position is not considered to be an equivalent of the AOC.

4. **Authority to Conduct a Transfer**

The transferring physician is responsible for determining the appropriate mode of transportation, equipment and attendants for the transfer in such a manner as to be able to effectively manage any reasonably foreseeable complication of the individual's condition that could arise during the transfer. Only qualified personnel, transportation, and equipment, including those life support measures that may be required during transfer shall be employed in the transfer of an individual with an unstable EMC. If the individual refuses the appropriate form of transportation determined by the transferring physician and decides to be transported by another method, the transferring physician is to document that the individual was informed of the risks associated with this type of transport and the individual should sign a form indicating the risks have been explained and the individual acknowledges and accepts the risks. All additional requirements of an appropriate transfer are to be followed by the transferring hospital.

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PROCEDURES:

1. **Transfers of Individuals Who Are Not Medically Stable**

Requirements Prior to Transfer. After the hospital has provided medical treatment within its capability to minimize the risks to the health of an individual with an EMC who is not medically stable, the hospital may arrange an appropriate transfer for the individual to another more appropriate or specialized facility. Evaluation and treatment shall be performed, and transfer shall be carried out as quickly as possible for an individual with an EMC which has not been stabilized or when stabilization of the individual's vital signs is not possible because the hospital does not have the appropriate equipment or personnel to correct the underlying process. The following requirements must be met for any transfer of an individual with an EMC that has not been stabilized:

a. Minimize the Risk. Before any transfer may occur, the transferring hospital must first provide, within its capacity and capability, medical treatment to minimize the risks to the health of the individual or unborn child.

b. Individual's Request or Physician's Order. Any transfer to another medical facility of an individual with an EMC must be initiated either by a written request for transfer from the individual or the legally responsible person acting on the individual's behalf or by a physician order with the appropriate physician or QMP and Physician certification as required under EMTALA. Any written request for a transfer to another medical facility from an individual with an EMC or the legally responsible person acting on the individual's behalf shall indicate the reasons for the request and that he or she is aware of the risks and benefits of the transfer.

c. Request To Transfer Made to Receiving Facility. The transferring hospital must call the receiving hospital or the Transfer Center if the facility is part of a Transfer Center network to verify the receiving hospital has available space and qualified personnel for the treatment of the individual. The receiving hospital must agree to accept the transfer and provide appropriate treatment. The transferring hospital must obtain permission from the receiving hospital to transfer an individual. This may be facilitated by a Transfer Center. Such permission should be documented on the medical record by the transferring hospital, including the date and time of the request and the name and title of the person accepting transfer. The transferring physician shall ensure that a receiving hospital has appropriate services and has accepted responsibility for the individual being transferred. If utilizing the services of a Transfer Center, the Transfer Center may assist in determining whether the receiving hospital has the appropriate services.

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d. Document the Request. The transferring hospital must document its communication with the receiving hospital, including the request date and time and the name of the person accepting the transfer.

e. Send Medical Records. The transferring hospital must send to the receiving hospital copies of all medical records available at the time of transfer related to the EMC and continuing care of the individual. The transferring hospital may provide the Face Sheet with the appropriate information to the Transfer Center to assist Transfer Center in facilitating the transfer. But, the Transfer Center generally may not provide any information to, or respond to questions from, to the receiving facility or physician at the receiving facility, from the Face Sheet regarding whether or not the patient has insurance, or the type of insurance, or other information regarding the patient's ability to pay for services prior to acceptance of the patient except as required by a state or local plan for providing care to certain patient populations where insurance coverage is a determining factor in where the patient may receive care. Documentation sent to the receiving hospital must include:

- Copies of the available history, all records related to the individual's EMC, observations of signs or symptoms, patient's condition at the time of transfer, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests, monitoring and assessment data, any other pertinent information, and the informed written consent for transfer of the individual or the certification of a physician or QMP.
- The name and address of any on-call practitioner who refused or failed to appear within a reasonable time to provide necessary stabilizing treatment; and
- The individual's vital signs which should be taken immediately prior to transfer and documented on the Memorandum of Transfer Form.
- Copies of available records must accompany the individual; and
- Copies of other records not available at the time of transfer must be sent to the receiving hospital as soon as practical after the transfer.

Medical and other records related to individuals transferred to or from the hospital must be retained in their original or legally reproduced form in hard copy, microfilm, or electronic media for a period of five years from the date of transfer.

f. Physician Certification of Risks and Benefits. A physician must sign an express written certification that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the unborn child, from being transferred. The certification should meet the following requirements:

- The certification must state the reason for transfer. The narrative rationale need

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not be a lengthy discussion of the individual's medical condition as this can be found in the medical record but should be specific to the condition of the patient upon transfer.

- The certification must contain a complete picture of the benefits to be expected from appropriate care at the receiving facility and the risks associated with the transfer, including the time away from an acute care setting necessary to effect the transfer.
- The date and time of the physician certification should closely match the date and time of the transfer.
- Certifications may not be backdated.

g. QMP Certification. If a physician is not physically present at the time of the transfer, a QMP may sign the certification, after consultation with a physician, and transfer the individual as long as the medical benefits expected from transfer outweigh the risks. If a QMP signs the certification, a physician shall countersign it within 24 hours or a reasonable time period specified by the hospital bylaws, rules or regulations.

h. Send Memorandum of Transfer. A Memorandum of Transfer must be completed for every patient who is transferred to another separately licensed hospital. The Memorandum of Transfer and the patient's medical record must be sent with the patient at the time of the transfer. A copy of the Memorandum of Transfer shall be retained by the transferring hospital and incorporated into the patient's medical record.

2. **Transfers that are requested by the individual but not medically indicated.**

If a medically unstable individual, or the legally responsible person, requests a transfer to another hospital that is not medically indicated, the individual or the legally responsible person must first be fully informed of the risks of the transfer; the alternatives (if any) to the transfer; and the hospital's obligations to provide further examination and treatment sufficient to stabilize the individual's EMC.

Components of the Individual's Request for Transfer. The transfer is appropriate only when the request meets all of the following requirements:

- is in writing and indicates the reasons for the request.
- contains a statement of the hospital's obligations under EMTALA and the benefits and risks that were outlined to the person signing the request.
- indicates that the individual is aware of the risks and benefits of the transfer.
- is made part of the individual's medical record, and a copy of the request should be sent to the receiving facility when the individual is transferred; and

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- is not made through coercion or by misrepresenting the hospital's obligations to provide an MSE and treatment for an EMC or labor.

Note: Once the transfer is accepted, the Memorandum of Transfer and the patient's medical record must be sent with the patient.

3. **Refusal to Consent to Transfer**

If an individual, or the legally responsible person acting on the individual's behalf, refuses to consent to the hospital's offer to transfer the individual to another facility for services the hospital does not provide and informs the individual, or the legally responsible person, of the risks and benefits to the individual of the transfer, all reasonable steps must be taken to secure a written refusal from the individual or the person acting on the individual's behalf. The individual's medical record must contain a description of the proposed transfer that was refused by the individual or the person acting on the patient's behalf, a statement that the individual was informed of the risks and benefits and the reason for the individual's refusal to consent to the transfer.

4. **Transfer of Individuals Who Are Medically Stable**

EMTALA does not apply to an individual who has been medically stabilized. The hospital has no further EMTALA obligation to an individual who has been determined not to have an EMC or whose EMC has been stabilized or who has been admitted as an inpatient.

a. Any individual who has been medically stabilized may be transferred upon request or pursuant to a physician's order via a pre-arranged transfer or treatment plan according to hospital policy.

   California law prescribes specific requirements for post-stabilization services and/or transfer for a patient who is a member of a health plan that does not contract with the hospital. Among the requirements, the hospital must contact the health plan for prior authorization for post-stabilization services. The plan must respond within 30 minutes and may authorize further services or arrange for a transfer. If the patient refuses a transfer, the hospital must provide the patient with a statutorily prescribed written notice of financial responsibility for further services rendered to the patient. There are additional requirements for notification of the health plan if an emergency psychiatric patient with a stabilized psychiatric EMC is transferred to another hospital for an admission. If a patient with a stabilized EMC is transferred to another hospital for "non- medical reasons," the transfer must comply with standards requiring the acceptance by a receiving hospital and physician, transfer of patient records (including a "transfer summary" setting forth certain information

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related to the patient and the transfer), use of appropriate transport, personnel and equipment for the transfer, and the identification by the patient of a "preferred contact person" to be notified of the transfer; the hospital must attempt to contact the preferred contact person, or if not identified, then the next of kin to alert the person of the transfer.

If the patient with a stabilized EMC is a homeless person, the hospital may not cause the transfer or transport of the homeless person to a social services agency, homeless shelter or health care provider that is located outside the county of the hospital unless the hospital has notified and received authorization from the agency, shelter, or provider to accept the person.

b. **Document Stable Condition**. The stability of the individual is determined by the ED physician or QMP in consultation with the physician**.** After it is determined that the individual is medically stable, the physician or QMP must accurately and thoroughly document the parameters of such stability.

   i. A woman who is in labor is considered to be stabilized only after she has been delivered of the child and the placenta.

   ii. An individual presenting with psychiatric symptoms is considered to be stabilized when he/she is protected and prevented from harming self or others.

   iii. If there is a disagreement between the treating physician and an off-site physician (*e.g*., a physician at the receiving facility or the individual's primary care physician if not physically present at the first facility) about whether the individual is stable for transfer, the medical judgment of the physician who is treating the individual at the transferring facility DED takes precedence over that of the off-site physician.

5. **Recipient Hospital Responsibilities**

a. A participating hospital that has specialized capabilities or facilities (including, but not limited to burn units, shock-trauma units, neonatal intensive care units, dedicated behavioral health units, or regional referral centers in rural areas) may not refuse to accept an appropriate transfer from a transferring hospital within the boundaries of the United States, of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

b. The requirement to accept an appropriate EMTALA transfer applies to any Medicare-participating hospital with specialized capabilities, regardless of whether the hospital has a DED.

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c. The recipient hospital's EMTALA obligations do not extend to individuals who are inpatients at another hospital.

d. If an individual arrives through the DED as a transfer from another hospital or health care facility, the hospital has a duty to have a physician or QMP, not a triage nurse, perform an appropriate MSE to determine whether the patient's condition deteriorated during the transport. The MSE must be documented in the medical record.

e. A recipient hospital with specialized capabilities that delays the treatment of an individual with an EMC who arrives as a transfer from another facility could be in violation of EMTALA, depending on the circumstances of the delay.

f. An individual on an EMS stretcher in the DED must be provided with an MSE without delay. EMTALA regulations apply as soon as the individual arrives on the facility's campus even if the EMS service has not formally turned the individual over to the DED care providers.

g. The receiving hospital may handle the receipt and subsequent assessment of the transferred emergency patient in a number of ways, including:
   i. For example, the transferring facility may contact the individual or department designated by the CEO as the coordinator for transfers such as the House Supervisor or the Transfer Center. After the receiving hospital's designated transfer coordinator is contacted, this individual or Transfer Center will then coordinate any transfer requests with the Administrator On-Call and the ED Physician as necessary. Once it has been determined that the receiving facility has agreed to accept the patient, the patient may be transferred directly to a designated specialty unit such as a SICU, PICU, Cardiac Catheterization Lab, Burn Center, or other Specialty Unit if there is capacity and a physician with the appropriate specialty credentials is available to assess the patient within a reasonable timeframe (generally, within 30 minutes). Upon acceptance into the specialty unit as an inpatient, the Conditions of Participation govern the patient's care, including the history and physical and establishment of a plan of care.

   ii. If the receiving facility participates in a community wide cardiac or stroke alert system inclusive of pre-hospital patient management by EMS Services under the direction of a qualified physician that allows for diagnosis of an emergent medical condition prior to arrival at the receiving facility, the EMS service may take the patient directly to the Interventional Radiology Suite or the Cardiac Catheterization Lab if the stroke or cardiac alert team, including the appropriately credentialed physician, is present upon arrival of the patient. The awaiting physician in the Unit would perform the additional evaluation and treatment and document such findings in

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the medical record. The Interventional Radiology Suite or Cardiac Cath Lab would be responsible for ensuring the registration as an emergency patient thus ensuring the patient appears on the Central/EMTALA log.

iii. If a facility's transfer coordinator receives a request from a transferring hospital and no specialty bed is available but the DED has capacity and capability to further treat and stabilize the individual and an on-call physician is available, the receiving facility should accept the transfer as an ED-to-ED transfer. If the Emergency Department of the receiving hospital has exceeded its capacity and capability with individuals waiting to be seen and patients being held on stretchers in the hallways because no beds are available, then the receiving ED can refuse the transfer based upon no capacity and capability if that has been their practice in the past based on the same capacity.

iv. Each specialty unit shall be responsible for entering the transferred patient's name and pertinent data into the appropriate log as per hospital policy.

6. **Review Process for Any Refused Transfers**

For those situations in which the hospital refuses to accept a transfer from another facility, the hospital and Transfer Center must have in place a procedure to review potential refusals and/or to monitor any refusals of transfer from other facilities.

7. **Reporting Potential EMTALA Violations**

See Policy 02.01.00 EMTALA Reporting Policy.

8. **Declared Emergencies**

Sanctions under EMTALA for an inappropriate transfer during a national emergency do not apply to a hospital with a DED located in an area that has been declared a national emergency area. Please review the requirements for transfers during a National Emergency contained in the EMTALA – Definitions and General Requirements Policy, LL.EM.001, and consult with the hospital's Disaster and Emergency Preparedness Plan as well as Operations Counsel for additional guidance.

a. **Waiver of Sanctions**. Sanctions under EMTALA for an inappropriate transfer or for directing or relocating an individual who comes to the DED to an alternative off-campus site for the MSE during a national emergency do not apply to a hospital with a DED located in an emergency area if the following conditions are met:

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i. the transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.
ii. the direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency ("PHE") that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan.
iii. the hospital does not discriminate on the basis of an individual's source of payment or ability to pay.
iv. the hospital is located in an emergency area during an emergency period; and
v. there has been a determination that a waiver of sanctions is necessary.

b. **Waiver Limitations**.
i. An EMTALA waiver can be issued for a hospital only if:
- the President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act.
- the Secretary of HHS has declared a PHE; and
- the Secretary of HHS invokes his or her waiver authority including notifying Congress at least 48 hours in advance.

ii. In the absence of CMS notification of area-wide applications of the waiver, the hospital must contact CMS and request that the waiver provisions be applicable to the hospital.
iii. In addition, in order for an EMTALA waiver to apply to the hospital and for sanctions not to apply: (i) the hospital must activate its disaster protocol; and (ii) the State must have activated an emergency preparedness plan or pandemic preparedness plan in the emergency area, and any redirection of individuals for an MSE must be consistent with such plan.
iv. Even when a waiver is in effect, there is still the expectation that everyone who comes to the DED will receive an appropriate MSE, if not in the DED, then at the alternate care site to which they are redirected or relocated.
v. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that if a PHE involves a pandemic infectious disease, the waiver will continue in effect until the termination of the application decision of a PHE or a limitation by CMS. However, the waiver may be limited to a date prior to the termination of the PHE declaration, as determined by CMS. If a State emergency/pandemic preparedness plan is deactivated in the area where the hospital is located prior to the termination of the PHE, the hospital no longer meets the conditions for an EMTALA waiver, and the hospital waiver would cease to be in effect as of the deactivation date. Likewise, if the hospital deactivates its disaster protocol prior to the termination of the PHE, the hospital no longer meets the conditions for an EMTALA waiver, and the hospital waiver would cease to be in effect as of the deactivation date.

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vi. All other EMTALA-related requirements continue to apply, as do similar State law requirements, even when a hospital is operating under an EMTALA waiver. For example, a hospital's obligation to accept an appropriate transfer of an individual under EMTALA cannot be waived if the hospital has the capabilities and capacity to accept such transfer (as discussed in this Policy

REERENCES:
42 U.S.C. § 1395dd

COMMITTEE APPROVALS:
Quality

Emergency Medical Condition (EMC) Identified: (Mark appropriate box; have physician certify if **I.c** or **I.d** selected and then go to Section II.)

PHYSICIAN

I. MEDICAL CONDITION: Diagnosis: _____

a. ☐ **No Emergency Medical Condition Identified**: This patient has been examined and an EMC has not been identified.
Screening Physician Signature: _____ *Date:* ___/___/___ *Time:* _____ *AM/PM*

b. ☐ **Unstable Patient, Request for Transfer**: The patient has been examined and an EMC has been identified and the patient is not stable. The hospital has the capability and capacity to provide the care needed but the patient has specifically requested to be transferred to another facility after being notified that the hospital can and is willing to provide the care needed to stabilize and treat the EMC.

c. ☐ **Patient Stable For Transfer**: The patient has been examined and any medical condition stabilized such that, within reasonable clinical confidence, no material deterioration of this patient's condition is likely to result from or occur during transfer.

d. ☐ **Patient Unstable**: The patient has been examined, an EMC has been identified and patient is not stable, but the transfer is medically indicated and in the best interest of the patient.

I.c and I.d Physician Certification: *I have examined this patient and based upon the reasonable risks and benefits described below and upon the information available to me, I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to this patient's medical condition that may result from effecting this transfer.*
Physician Signature: _____ *Date:* ___/___/___ *Time:* _____ *AM/PM*
Signature applies to any checked boxes.

II. REASON FOR TRANSFER:

☐ Medically Indicated ☐ Patient Requested (see patient request documentation: Section VII)

☐ On-call physician refused or failed to respond within a reasonable period of time

On-Call Physician Name: _____ Address _____

III. RISKS AND BENEFITS FOR TRANSFER:

Medical Benefits:	**Medical Risks :**
☐ Obtain level of care/ service unavailable at this facility.	☐ Deterioration of condition in route
Service: _____	☐ Worsening of condition or death if you stay here.
☐ Medical Benefits outweigh the risks.	☐ Risk of traffic delay/accident resulting in condition deterioration or death.
☐ Other _____	☐ Other _____

IV. MODE/SUPPORT DURING TRANSFER AS DETERMINED BY PHYSICIAN:

Mode of transportation for transfer: ☐ BLS ☐ ALS ☐ Helicopter ☐ Neonatal Unit ☐ Other _____
Agency: _____ Name/Title of accompanying hospital employee if required: _____
Support/Treatment during transfer: ☐ Cardiac Monitor ☐ Oxygen: _____ ☐ IV Pump
☐ IV Fluid: _____ Rate: _____ ☐ Restraints – Type: _____ ☐ Other: _____ ☐ None

Transferring Physician Signature if different from Certifying Physician: _____ Date: ___/___/___ Time: ____ AM/PM
If no physician immediately available, transfer authorized by Qualified Medical Provider per Dr. _____
QMP Signature _____ Date: ___/___/___ Time: ____ AM/PM
Authorizing Physician Signature _____ Date: ___/___/___ Time: ____ AM/PM

NURSING

V. RECEIVING FACILITY AND INDIVIDUAL: The receiving facility has the capability for the treatment of this patient (including adequate equipment and medical personnel) and has agreed to accept the transfer and provide appropriate medical treatment.

Receiving Facility: _____ Person accepting TXFR: _____ Date: ___/___/___ Time: ____ AM/PM

Receiving MD _____ Date: ___/___/___ Time: ____ AM/PM

Questions regarding Medication Reconciliation Information may be directed to _____ or Transferring Physician.

VI. ACCOMPANYING DOCUMENTATION sent via: ☐ Patient/Responsible Party ☐ Fax ☐ Transporter

Documentation includes: ☐ Copy of Medical Record ☐ Lab/ EKG/ X-Ray ☐ Copy of Transfer Form
☐ Medication Reconciliation Information ☐ Advanced Directive ☐ Other _____

Report given to: (Person/title): _____
Time of Transfer: _____ Date: _____ Nurse Signature: _____ Transferring Unit: _____
Vital Signs Just Prior to Transfer: Temp: _____ Pulse _____ R _____ BP _____ spO2% _____ FHT _____ Time: ____ AM/PM

PATIENT

VII. PATIENT CONSENT TO MEDICALLY INDICATED TRANSFER or PATIENT REQUEST FOR TRANSFER (Mark appropriate box a. or b.):

a. ☐ I hereby **CONSENT TO TRANSFER** to another facility. I understand that it is the opinion of the physician responsible for my care that the benefits of transfer outweigh the risks of transfer. I have been informed of the risks and benefits of this transfer.

b. ☐ I hereby **REQUEST TRANSFER** to _____. I understand and have considered the hospital's EMTALA responsibilities that have been explained to me, the medical risks and benefits of transfer and the physician's recommendation. I make this request upon my own suggestion and not that of the hospital, physician or anyone associated with the hospital. I agree to accept the risks associated with my decision.

The reason I request transfer is: _____

Signature of: ☐ Patient ☐ Responsible Person _____ Relationship to patient _____

Witness _____ Title _____ Date: ___/___/___ Time: ____ AM/PM

PATIENT LABEL

MAYERS MEMORIAL HEALTHCARE DISTRICT

2024 HHS POVERTY GUIDELINES

Persons in Family or Household	300% US Poverty Level 80% Discount	350% of US Poverty Level 60% Discount	400% of US Poverty Level 40% Discount
1	$45,180	$52,710	$60,240
2	$61,320	$71,540	$81,760
3	$77,460	$90,370	$103,280
4	$93,600	$109,200	$124,800
5	$109,740	$128,030	$146,320
6	$125,880	$146,860	$167,840
7	$142,020	$165,690	$189,360
8	$184,520	$184,520	$210,880
For each additional person, add	$5380		

To determine discount eligibility:

1. Count the number of persons in your family/household
    a. For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not
    b. For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative
2. Calculate the household income
3. Sliding across the row corresponding to the number of persons in your family/household above, stop in the first bucket that has an amount greater than the household income
4. At the top of that column, the % discount is displayed

MAYERS MEMORIAL HEALTHCARE DISTRICT

REPAYMENT SCHEDULE

TOTAL PT LIABILITIES	MAX REPAYMENT TERM	MIN MONTHLY PAYMENT
$50.00 OR LESS	IN FULL	IN FULL
$ 51 - 100	2 months	$40
$ 101 - 300	3	$55
$ 301 - 600	6	$75
$ 601 - 1,000	9	$100
$ 1,001 - 3,000	12	$150
$ 3,001 - 6,000	15	$250
$ 6,000 AND OVER	18	$350

To determine repayment schedule parameters:

1. Determine which row applies to your “TOTAL PT LIABILITIES” amount by putting the amount in the appropriate range above.
2. Sliding to the right, the repayment of the discounted Total Patient Liabilities must be performed within the corresponding parameters.
3. In the event the patient does not agree with the parameters set forth above, the Patient Financial Counselor will use the formula for a "Reasonable Payment Plan" described in subdivision (i) of Section 127400 of the California Health and Safety Code, and iterated below:
    a. "Reasonable Payment Plan" means monthly payments shall not exceed 10 percent of the patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means, for purposes of this formula, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.
    b. In order to establish the monthly payment based on the "Reasonable Payment Plan," the patient shall provide an itemization and proof of essential living expenses and attach them to the Discount Payment/Charity Application.

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DEFINITIONS:

- **Healthcare personnel (HCP):** All paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.
  Types of HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., laboratory, clerical, dietary, environmental services, laundry, security, engineering and facilities management, and volunteer personnel).
- **Employee Health (EH):** The group, department, or program that addresses many aspects of health and safety in the workplace for HCP, including the provision of clinical services for work-related injuries, exposures, and illnesses. In healthcare settings, EH addresses workplace hazards including communicable diseases; slips, trips, and falls; patient handling injuries; chemical exposures; HCP burnout; and workplace violence. EH is also responsible for prevention of diseases within the workforce, including, but not limited to, screening and testing for tuberculosis, vaccine administration, and respirator medical evaluations and fit testing.

PURPOSE:

This policy outlines the Mayers Memorial Hospital Employee Health (EH) infection prevention program, which is designed to prevent and control the spread of communicable diseases among healthcare personnel (HCP). By ensuring excellent compliance with this policy, the spread of communicable diseases among HCP is minimized.

RATIONALE:

The prevention of infectious disease transmission among HCP and patients is a critical component of safe healthcare delivery. EH provides occupational infection prevention and control expertise to Mayers Memorial HCP. Required elements of the EH infection control program include risk reduction of healthcare-acquired infections through a HCP immunization program and through the implementation of evidence-based protocols to manage HCP infectious exposures and illnesses. Implementation of the procedures outlined within this policy reduces the risk of transmission of infectious diseases from potentially infectious HCP to patients, other HCP, and others.

POLICY

It is the policy of Mayers Memorial to prevent and control the spread of infections through the timely and effective management of communicable diseases and exposures among HCP. The facility will:

- Determine restrictions from duty of HCP who are suspected or confirmed of having certain communicable diseases.
- Provide treatment, prophylaxis, and surveillance as needed to HCP who are exposed to infectious agents in the workplace.

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The scope of this policy includes HCP in both inpatient and outpatient locations. This policy includes students, residents, fellows, volunteers, and HCPs who have patient contact and/or contact with the environment where care is delivered to patients. All HCP are expected to comply with this policy, including all assigned responsibilities herein and relevant to their individual roles at the facility.
As additional scientific knowledge is made available, this policy will be updated accordingly, and HCP will be expected to comply with the updated expectations in procedures and responsibilities.

PROCEDURES:

Management of Personnel Exposed to Communicable Diseases

- HCP who are exposed to a communicable disease will report the incident to their supervisor.
- The supervisor will notify Employee Health and infection prevention program of the exposure.
- Responsibilities for initial evaluation and the treatment plan for specific personnel are as follows:
    - Facility employees, licensed independent practitioners, students, and volunteers will receive an initial evaluation by EH.
    - Contractors and visitors will be referred to the emergency department or their primary care physician for initial evaluation of occupational exposures.
    - Facility employees, licensed independent practitioners, students, and volunteers will receive ongoing treatment and evaluation from EH (per individual hospital coverage policies).
    - All others (e.g., contractors and visitors) will be referred to their primary care physician for ongoing treatment and evaluation.

Management of Personnel Call-ins for Communicable Diseases

- HCP calls in sick to their supervisor or central scheduler.
- The supervisor determines if illness is possibly communicable, and date last worked.
- Supervisor notifies EH via email or voice mail.
- EH health investigates if illness is communicable and possible return to work.
- EH notifies Infection Prevention if there is a possible exposure risk.

Responsibilities

All Personnel

- Will follow this policy and all instructions provided by their supervisor, EH, the infection prevention and control program, and the local health department.
- Failure to comply with this policy may subject the personnel to discipline according to human resources policy, up to and including loss of privileges and termination.
- Will follow Standard Precautions and Transmission-Based Precautions to prevent exposure to blood and body fluids and other communicable diseases.
- Will report to EH for an evaluation and ability to work determination if self-reporting or confirmed as having signs and symptoms consistent with a communicable disease listed in Appendix A.

Employee Health Services

- Will respond to communicable disease and exposure notification and management at (phone number or contact procedure)
- Will provide post-exposure evaluation and treatment for communicable diseases as outlined in this policy.

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- Will identify work restrictions as outlined in this policy and communicate restrictions to personnel and management.
- Will collaborate with the infection prevention and control program to manage communicable diseases and exposure investigations.
- Will report EH data on personnel screenings, incidents of communicable diseases, and exposure investigations to the infection prevention and control committee.
- Will document work-related injuries and illnesses on the appropriate Occupational Safety and Health Administration (OSHA) injury and illness logs.
- Will ensure off-hour coverage for assessment, treatment, or prophylaxis coverage via either access to an emergency contact or arrangement with the emergency department.

Infection Prevention and Control Program

- Will collaborate with EH to manage communicable diseases and exposure investigations.
- Will determine if a communicable disease exposure occurred by establishing an evidence-based exposure and case definition.
- Will contact supervisors to obtain a list of exposed personnel.
- Will coordinate with the local public health department on communicable disease reporting and restrictions as governed by state or provincial law (e.g., regulations specific to food handlers or HCP).
- Will notify EH when exposure occurs.
- Will notify visitors and patients of potential exposures as appropriate.

Supervisory Personnel

- Will ensure that personnel with confirmed or suspected communicable diseases are evaluated and cleared for work by EH.
- Will compile a list of exposed personnel and patients.
- Will refer personnel who may have had exposure to a communicable disease to EH for screening and follow-up.

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COMMITTEE APPROVALS:

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P&P: 10/2/2024

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Appendix A.

Work Restrictions for Personnel Exposed to or Having Infectious Communicable Diseases

Disease/problem	Work restriction	Duration
Conjunctivitis	Restrict from patient contact and contact with the patient's environment.	For duration of symptoms or until purulent discharge ceases.
COVID-19	For most up-to-date information on personnel exclusions from duty, refer to CDC guidelines Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | COVID-19 | CDC	HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and At least 24 hours have passed since last fever without the use of fever-reducing medications, and Symptoms (e.g., cough, shortness of breath) have improved. *Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later
Cytomegalovirus	No restriction.	
Diarrheal diseases • Acute stage (diarrhea with other symptoms)	Exclude from patient contact, contact with the patient environment, and food handling.	Until 24 hours after symptoms resolve.
Diarrheal diseases • Convalescent stage, *Salmonella* spp.	Restrict from care of high-risk patients and food handling.	Consult with local public health regarding work restrictions and required stool cultures, if applicable.
Diphtheria • Active infection	Exclude from duty.	For HCP with respiratory diphtheria infection, restrict until antimicrobial therapy is completed AND 2 pairs of nasal AND pharyngeal cultures, obtained ≥24 hours apart, are negative. For HCP with cutaneous diphtheria infection or other diphtheria infection manifestations, determine the duration of exclusion from work in consultation with federal, state, and local public health authorities.

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REVISION DATE: n/a		EFFECTIVE DATE: 9/11/2024
AUDIENCE: All hospital staff		APPROVAL DATE:
OWNER: Keith Earnest		APPROVER: Keith Earnest

Disease/problem	Work restriction	Duration
Diphtheria • Postexposure (regardless of vaccination status)	Exclude from duty. Administer postexposure prophylaxis in accordance with CDC recommendations. Obtain nasal and pharyngeal swabs for diphtheria culture and review results for return-to-work eligibility.	If nasal AND pharyngeal cultures are negative for toxin-producing *Corynebacterium diphtheriae*, HCP may return to work while completing postexposure antibiotic therapy. If nasal OR pharyngeal cultures are positive for toxin-*producing C. diphtheriae,* complete postexposure antibiotic therapy. HCP may return to work when: • Postexposure antibiotic therapy is completed AND • At least 24 hours after completion of postexposure antibiotic therapy, two consecutive pairs of nasal AND pharyngeal cultures, obtained at least 24 hours apart, are negative for toxin-producing C. diphtheriae. Implement daily monitoring for the development of signs and symptoms of diphtheria for 7 days after the last exposure.
Enteroviral infections (e.g., hand foot and mouth disease)	Exclude from duty.	Until symptoms resolve.
Emerging pathogens (e.g., Ebola) or active outbreak pathogen	Monitored by EH and exclude from duty at the discretion of EH and the infection prevention and control program.	Until cleared by EH to return.
Epstein-Barr virus (HBV), causative agent of mononucleosis	No restriction.	
Hepatitis A Hepatitis B[a] • HCP living with HBV who do not perform Category III/ exposure-prone procedures	Exclude from patient contact, contact with patient's environment, and food handling. No restriction.[b] HCP living with HBV who do not perform Category III/ exposure-prone procedures[c] should not be prohibited from participating in patient-care activities solely on the basis of their HBV infection.	Until 7 days after onset of jaundice.

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AUDIENCE: All hospital staff		APPROVAL DATE:
OWNER: Keith Earnest		APPROVER: Keith Earnest

Disease/problem	Work restriction	Duration
Hepatitis B[a] • HCP living with HBV whose circulating viral loads can be consistently suppressed to less than >1,000 IUs (international units)	No restrictions[b] are recommended, so long as the HCP: • is not detected as having transmitted infection to patients; • obtains advice from an Expert Review Panel about continued practice; • is followed by a personal physician who has expertise in the management of HBV infection and who is allowed by the HCP to participate in or communicate with the oversight panel about the individual's clinical status; • is monitored on a periodic basis (e.g., every 6 months) to assure that the viral load remains >1,000 IUs, with results shared with the oversight panel; and • agrees, in writing, to follow the recommendations of the oversight panel.	As determined by the Expert Review Panel.
Hepatitis B[a] • HCP living with HBV and who, despite appropriate treatment, have circulating viral loads ≥1,000 IUs	Exclude from exposure-prone invasive (Category III) procedures[c] until viral burdens are less than >1,000 IUs. When viral burdens decrease to less >1,000 IUs, consult the guidance in the row above.	As determined by the Expert Review Panel.
Hepatitis C[a]	No restriction.[b]	

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OWNER: Keith Earnest		APPROVER: Keith Earnest

Disease/problem	Work restriction	Duration
• HCP living with HCV who do not perform Category III/ exposure-prone procedures	HCP living with HCV who do not perform Category III/ exposure-prone procedures[c] should not be prohibited from participating in patient-care activities solely based on their HCV infection.	
Hepatitis C[a] • HCP living with HCV who received treatment resulting in "undetectable" circulating HCV-RNA levels	No restrictions[b] if the individual: • has not been previously identified as having transmitted infection to patients following definitive therapy resulting in a sustained virologic response (SVR); • provides the oversight panel with records and laboratory results (or permits the HCP's personal physician to provide records and laboratory results) confirming receipt of treatment and SVR; and • has achieved SVR by remaining HCV RNA negative for 12 weeks following the completion of therapy.	As determined by the Expert Review Panel.
Hepatitis C[a] • HCP living with HCV and who, despite appropriate antiviral treatment, continue to have detectable circulating HCV RNA >2,000 IU/mL	Exclude from exposure-prone invasive (Category III) procedures[c] until circulating HCV-RNA levels are "undetectable" and meet the conditions in the row above.	As determined by Expert Review Panel.
Herpes simplex • Genital	No restriction.	

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Disease/problem	Work restriction	Duration
Herpes simplex • Hands (herpetic whitlow)	Restrict patient contact and contact with the patient's environment.	Until lesions heal and are crusted.
Herpes simplex • Orofacial	Evaluate the need to restrict from care of high-risk patients. Evaluate according to lesion location and severity.	
HIV[a] • HCP living with HIV who do not perform Category III/ exposure-prone procedures	No restriction.[b] HCP living with HIV who do not perform Category III/ exposure-prone procedures[c] should not be prohibited from participating in patient-care activities solely based on their HIV infection.	
HIV[a] • HCP living with HIV whose confirmed viral load is below 200 copies/mL	No restrictions[b] are recommended so long as the HCP: • has not been previously identified as having transmitted infection to patients while receiving appropriate suppressive therapy; • obtains advice from an oversight panel about recommended practices to minimize risk of exposure events; • is followed by a physician who has expertise in the management of HIV infection and who is allowed by the individual to participate in or communicate with the oversight panel about the individual's clinical status;	As determined by Expert Review Panel.

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OWNER: Keith Earnest		APPROVER: Keith Earnest

Disease/problem	Work restriction	Duration
	• is monitored on a periodic basis (e.g., every 6 months) to assure that the HIV RNA remains below the level of detection, with results provided to the oversight panel; • is followed closely by their physician and the oversight panel In instances in which fluctuations in HIV viremia occur, including appropriate retesting as discussed above to reevaluate the HCP's viral load; and • agrees, in writing, to follow the recommendations of the oversight panel.	
HIV[a] • HCP living with HIV and who, despite appropriate antiretroviral treatment, have a confirmed viral load >200 copies/mL	Exclude from exposure-prone invasive (Category III) procedures[c] until viral burdens are less than >200 copies/mL and meets the conditions in the row above.	As determined by Expert Review Panel.
Influenza (seasonal)	Exclude from duty if active fever (>38°C or 100.4°F) and/or other symptoms such as upper respiratory infection, myalgia, chills, headache.	Until fever-free without medication for at least 24 hours and all other acute symptoms resolve. Exclude from care of immunocompromised patients for a full 7 days from symptom onset or until resolution of symptoms, whichever is longer.
Measles • Active	Exclude from duty.	Until 4 days after the rash appears. For immunocompromised healthcare personnel with known or suspected measles, exclude from work for the duration of their illness.
Measles	Exclude from duty and administer postexposure prophylaxis in accordance	From day 5 through day 21 postexposure and/or 4 days after the rash appears.

Disease/problem	Work restriction	Duration
• Postexposure (in susceptible personnel) • Postexposure (one MMR vaccine received)	with CDC and ACIP recommendations (https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mmr.html). Work restrictions are not necessary for healthcare personnel who received the first dose of MMR vaccine ***prior to exposure***. They should receive their second dose of MMR vaccine as soon as possible (at least 28 days after their first dose).	Implement daily monitoring for signs and symptoms of measles from the 5th day after their first exposure through the 21st day after their last exposure
Measles • Postexposure (non-susceptible personnel)	No restriction.	Postexposure prophylaxis is not necessary. Implement daily monitoring for signs and symptoms of measles from the 5th day after their first exposure through the 21st day after their last exposure.
Meningococcal infection • Active	Exclude from duty.	Exclude from work until 24 hours after the start of effective antimicrobial therapy.
Meningococcal infection • Postexposure	No restriction. Administer antimicrobial prophylaxis to HCP, regardless of vaccination status, who have an exposure to *Neisseria meningitidis*.	
Multi-drug-resistant organisms (MDROs)	Consult infection prevention and control. Exclusion is determined after careful evaluation, including whether there is the presence of active infection.	Until appropriate treatment and symptoms resolve.
Mumps • Active	Exclude from duty.	For 5 days after the onset of parotitis. Without parotitis, exclude from work for 5 days after onset of their first symptom.
Mumps • Postexposure (susceptible personnel)	Exclude from duty.	Exclude from work from the 10th day after their first exposure through the 25th day after their last exposure.

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OWNER: Keith Earnest		APPROVER: Keith Earnest

Disease/problem	Work restriction	Duration
• Postexposure (with one MMR dose)	No restriction for healthcare personnel who received the first dose of MMR vaccine ***prior to exposure*** but they should receive their second dose of the MMR vaccine as soon as possible (at least 28 days after their first dose).	Implement daily monitoring for signs and symptoms of mumps infection from the 10th day after their first exposure through the 25th day after their last exposure.
Mumps • Postexpsoure (non-susceptible personnel)	No restriction.	Implement daily monitoring for signs and symptoms of mumps from the 10th day after their first exposure through the 25th day after their last exposure.
Norovirus	Exclude from duty	For additional 2 days after symptoms fully resolve.
Parvovirus (e.g., fifth disease)	Exclude from caring for patients with anemia, pregnancy, or immunocompromised if active infection or after an exposure.	From the 4th through 14th day after exposure or if active disease until rash develops.
Pediculosis (e.g., lice)	Exclude from duty.	Until treated and observed to be free of adult and immature lice.
Pertussis (e.g., whooping cough) • Active infection (suspected or confirmed)	Exclude from duty.	Exclude symptomatic healthcare personnel with known or suspected pertussis from work for 21 days from the onset of cough, or until 5 days after the start of effective antimicrobial therapy.
Pertussis • Postexposure of asymptomatic HCP who are likely to interact with persons at increased risk for severe pertussis	Restriction is dependent upon receipt of postexposure prophylaxis. If asymptomatic HCP is not receiving postexposure prophylaxis, restrict from contact (e.g., furlough, duty restriction, or reassignment) with patients and other persons at increased risk for severe pertussis. Work restrictions are not necessary for asymptomatic HCP who have an exposure to pertussis and receive postexposure prophylaxis,	For 21 days after the last exposure (if asymptomatic HCP is not receiving postexposure prophylaxis).

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Disease/problem	Work restriction	Duration
	regardless of their risk for interaction with persons at increased risk for severe pertussis.	
Pertussis • Postexposure of asymptomatic HCP who are not likely to interact with persons at increased risk for severe pertussis	No restriction. Administer postexposure prophylaxis OR implement daily monitoring for 21 days after the last exposure for development of signs and symptoms of pertussis.	
Polio	Exclude from duty.	Until symptoms resolve.
Rabies • Suspected or confirmed infection	For HCP who have a suspected or confirmed rabies virus infection, exclude from work in consultation with federal, state, and local public health authorities.	As determined in consultation with federal, state, and local public health authorities.
Rabies • Postexposure (asymptomatic personnel)	No restriction. Administer postexposure prophylaxis in accordance with CDC and ACIP recommendations and in consultation with federal, state, and local public health authorities.	
Rubella • Active	Exclude from duty.	Until 7 days after rash appears.
Rubella • Postexposure (susceptible personnel)	Exclude from duty.	From the 7th day after their first exposure through the 23rd day after their last exposure.
Rubella • Postexposure (non-susceptible personnel)	No restriction.	Implement daily monitoring for signs and symptoms of rubella from the 7th day after their first exposure through the 23rd day after their last exposure.
Scabies	Exclude from duty.	Until treated and cleared by medical evaluation.
Smallpox	Exclude from duty.	Until disappearance of scabs, typically about 3 weeks.
Staphylococcus aureus • Active, draining skin lesions	Restrict from patient care, surgical environment, contact with patient's environment, or food handling.	Until drainage can be contained in a dressing or until lesions heal.

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OWNER: Keith Earnest		APPROVER: Keith Earnest

Disease/problem	Work restriction	Duration
(including MRSA/MSSA)		
Staphylococcus aureus • Carrier/colonization	No restriction unless personnel are epidemiologically linked to transmission of the organism.[b]	Discretion of EH and/or the infection prevention and control program.
Streptococcal infection, Group A • Active	Restrict from patient care, contact with patient's environment, and food handling.	Until 24 hours after the start of effective antimicrobial therapy, provided that any draining skin lesions can be adequately contained and covered. For draining skin lesions that cannot be adequately contained or covered (e.g., on the face, neck, hands, wrists), exclude from work until the lesions are no longer draining.
Streptococcal infection, Group A • Colonization	No restriction with known or suspected group A Streptococcus colonization, unless they are epidemiologically linked to transmission of the organism in the healthcare setting.	See below, Streptococcal infection, Group A - Epidemiologically linked
Streptococcal infection, Group A • Epidemiologically linked colonization	Exclude from duty.	Administer chemoprophylaxis in accordance with CDC recommendations AND exclude from work until 24 hours after the start of effective antimicrobial therapy AND obtain a sample from the affected site for group A Streptococcus testing 7 to 10 days after completion of chemoprophylaxis; if positive, repeat administration of chemoprophylaxis and again exclude from work until 24 hours after the start of effective antimicrobial therapy.
Streptococcal infection, Group A • Exposure	No restriction.	
Tetanus	No restriction.	
Toxoplasmosis	No restriction.	
Tuberculosis • Active disease	Exclude from duty.	Until completion of 2 weeks of appropriate therapy, clinical improvement is documented, and laboratory results confirm non-infectious status [link to TB Prevention and Exposure Management Plan].
Tuberculosis • Latent disease	No restriction.	Personnel must perform the evaluation for TB symptoms annually in EH.

Disease/problem	Work restriction	Duration
Varicella (chicken pox) • Active	Exclude from duty.	Until all lesions have dried and crusted; or, for those who only have non-vesicular lesions that do not crust, exclude from work until no new lesions appear within a 24-hour period.
Varicella (chicken pox) • Postexposure (susceptible personnel) • Postexposure (with one dose of varicella vaccine received prior to exposure)	Exclude from duty. Administer postexposure prophylaxis in accordance with CDC and ACIP recommendations. No restriction for healthcare personnel who received one dose of the varicella vaccine ***prior to exposure*** if they receive the second dose of vaccine within 5 days after exposure.	From day 8 through 21 after last day of exposure (through day 28 if VZIG is administered) postexposure. Implement daily monitoring for signs and symptoms of varicella from the 8th day after the first exposure through the 21st day after the last exposure.
Varicella (chicken pox) • Postexposure (non-susceptible personnel)	No restriction. Postexposure prophylaxis is not necessary	Implement daily monitoring for signs and symptoms of varicella from the 8th day after the first exposure through the 21st day after the last exposure.
Varicella-zoster (shingles) • Localized, in a healthy person	Cover lesions; when feasible, exclude from direct care of patients at high risk for severe varicella.[d] If lesions cannot be covered (e.g., on hands or face), exclude from duty.	Until all lesions dry and crust. Until all lesions dry and crust.
Varicella-zoster (shingles) • Disseminated or localized in immunosuppressed person	Exclude from duty.	Until all lesions have dried and crusted.
Varicella-zoster (shingles) • Postexposure (susceptible personnel) • Postexposure (with one dose of varicella vaccine received prior to exposure)	Exclude from duty. Administer postexposure prophylaxis in accordance with CDC and ACIP recommendations. No restriction for healthcare personnel who received one dose of the varicella vaccine ***prior to exposure*** if they receive the second dose of	From day 8 through 21 after last day of exposure (through day 28 if VZIG is administered) postexposure. Implement daily monitoring for signs and symptoms of varicella from the 8th day after the first exposure through the 21st day after the last exposure.

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AUDIENCE: All hospital staff		APPROVAL DATE:
OWNER: Keith Earnest		APPROVER: Keith Earnest

Disease/problem	Work restriction	Duration
	vaccine within 5 days after exposure.	
Viral respiratory infections • Acute, febrile illness	If active fever (>38°C or 100.4°F), exclude from duty. If no active fever, consider excluding from the care of high-risk patients[e] and contact with their environment during community outbreaks of RSV and influenza.	Until fever-free without medication for at least 24 hours. If symptomatic but no active fever, restrict until acute symptoms resolve.

Abbreviations: CDC, Centers for Disease Control and Prevention; HBV, hepatitis B virus; HCP, healthcare personnel; HCV, hepatitis C virus; HIV, human immunodeficiency virus; MRSA, methicillin-resistant *Staphylococcus aureus*; MSSS, methicillin-susceptible *Staphylococcus aureus*; EH, Employee Health Services; RSV, respiratory syncytial virus.

[a]Both HCP and those involved in the oversight of HCP living with HBV/HCV/HIV should be aware of state and local laws governing these issues. See Henderson D, Dembry L, Sifri C, et al. SHEA white paper: the management of healthcare workers who are infected with hepatitis B virus, hepatitis C virus, and/or human immunodeficiency virus. *Infect Control Hosp Epidemiol*. 2022;43(2):147-155. doi:10.1017/ice.2020.458

[b]Unless epidemiologically linked to transmission of infection.

[c]Category III procedures are described in Reitsma AM, Closen ML, Cunningham M, et al. Infected physicians and invasive procedures: safe practice management [correction in *Clin Infect Dis*. 2005;41(1):136]. *Clin Infect Dis*. 2005;40(11):1665-1672. doi:10.1086/429821

[d]Those susceptible to varicella and who are at increased risk of complications of varicella, such as those in protective environments.

[e]High-risk patients as defined by the Advisory Committee on Immunization Practices for complications of influenza. Guidance is updated annually. See https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Linen and Laundry Handling		POLICY #
DEPARTMENT/SCOPE: Infection Control		Page 1 of 2
REVISION DATE: n/a		EFFECTIVE DATE: 6/19/2024
AUDIENCE:	Laundry staff	APPROVAL DATE:
OWNER: K. Earnest		APPROVER: K. Earnest

PROCEDURE:

Best practices for linen (and laundry) handling:

- Always wear reusable rubber gloves before handling soiled linen (e.g., bed sheets, towels, curtains).
- Never carry soiled linen against the body. Always place it in the designated container.
- Carefully roll up soiled linen to prevent contamination of the air, surfaces, and cleaning staff. Do not shake linen.
- If there is any soiled excrement on the linen, such as feces o r vomit, scrape it off carefully with a flat, firm object and put it in the commode or designated toilet/latrine before putting linen in the designated container.
- Place soiled linen into a clearly labeled, leak-proof container(e.g., bag, bucket) in the patient care area. Do not transport soiled linen by hand outside the specific patient care area from where it was removed.
- Reprocess (i.e., clean and disinfect) the designated container for soiled linen after each use.
- If reusable linen bags are used inside the designated container, do not overfill them, tie them securely, and launder after each use.
    - Soiled linen bags can be laundered with the soiled linen they contained.

The effectiveness of the laundering process depends on many factors, including:

- Time and temperature
- Mechanical action
- Water quality (ph., hardness)
- Volume of the load
- Extent of soiling
- Model/availability of commercial washers and dryers

Always use and maintain laundry equipment according to the manufacturer's instructions.

Always launder soiled linens from patient care areas in a designated area, which should:

- Be a dedicated space for performing laundering of soiled linen
- No contain any food, beverage, or personal items
- Have floors and walls mad of durable materials that can withstand the exposures of the area (e.g., large quantities of water and steam)
- Have a separation between the soiled linen and clean linen storage areas, and ideally should be at negative pressure relative to other areas
- Have handwashing facilities have SOPs and other job aids to assist laundry staff with procedures.

Best practices for personal protective equipment (PPE) for laundry staff:

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SUBJECT/TITLE: Linen and Laundry Handling		POLICY #
DEPARTMENT/SCOPE: Infection Control		Page 2 of 2
REVISION DATE: n/a		EFFECTIVE DATE: 6/19/2024
AUDIENCE:	Laundry staff	APPROVAL DATE:
OWNER: K. Earnest		APPROVER: K. Earnest

- Practice hand hygiene before application and after removal of PPE.
- Wear tear-resistant reusable rubber gloves when handling and laundering soiled linens.
- If there is risk of splashing, for example, if laundry is washed by hand, laundry staff should always wear gowns or aprons and face protection (e.g., face shield, goggles) when laundering soiled linens.

Best practices for laundering soiled linen:

- Follow instructions from the washer/dryer manufacturer.
- Use hot water (70-80° C for 10 min [158-175°F]) and an approved laundry detergent
    - Disinfectant are generally not needed when soiling is a low levels.
    - Use disinfectant on a case by case basis, depending on the soiled linen (e.g., linens from an area on contact precautions).
- Dry linens completely in a commercial dryer

Manual reprocessing steps

If laundry services with hot water are not available, reprocess soiled linens manually according to the following:

1. Immerse in detergent solution and use mechanical action (e.g., scrubbing) to remove soil.
2. Disinfect by one of these methods:
    - Immersing the linen in boiling water or
    - Immersing the linen in disinfectant solution for the required contact time and rinsing with clean water to remove residue
3. Allowing to fully dry, ideally in the sun.

Best practices for management of clean linen:

- Sort, package, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items.
- Each floor/ward should have a designated room for sorting and storing clean linens.
- Transport clean linens to patient care areas on designated carts or within designated containers that are regularly (at least once daily) cleaned with a neutral detergent and warm water solution.

REFERENCES:

CDC Healthcare-Associated Infections Appendix D – Linen and Laundry Management
Best Practices for Environmental Cleaning in Global Healthcare Facilities with Limited Resources

COMMITTEE APPROVALS:

IC: 9/12/2024
P&P: 10/2/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Surface Sampling Standard Operating Procedure	POLICY #PH039
DEPARTMENT/SCOPE:	Pharmacy	Page 1 of 2
REVISION DATE: n/a		EFFECTIVE DATE: 9/5/2024
AUDIENCE: All Pharmacy Staff		APPROVAL DATE:
OWNER: K. Earnest		APPROVER: K. Earnest

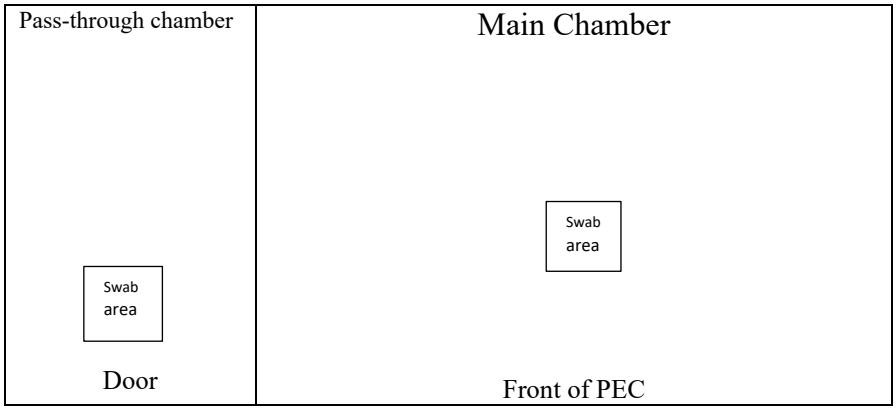
With attachment:
Surface Sampling Culture Worksheet MMH780

POLICY:

Surface sampling of PEC is conducted monthly.

PROCEDURE:

1) Obtain wet swab from laboratory. (Starswab II®--Microorganism collection and transport system for aerobes and anaerobes.)
2) Garb per garbing sequence.
3) Sterile gloves are worn in PEC when performing surface sampling.
4) Open the swab inside the PEC.
5) Insert the swab into the collection tube to wet the swab or wet with sterile water.
6) Swab the center of the work surface and the transfer chamber.
    a. Swab location-an area approximately 10 cm by 10 cm. See diagram.



    b. Swab technique—in parallel overlapping strokes, swab left to right followed by parallel overlapping strokes forward and backward. Insert swab into tube with media.
7) Clean the work surface and surface of the transfer chamber with disinfectant followed by sterile 70% IPA.
8) Label the swabs and transport to lab with completed culture worksheet.
9) Lab staff plates each swab on a tryptic soy agar (TSA) plate and a Sabauraud dextrose agar (SDA) plate.

SUBJECT/TITLE:	Surface Sampling Standard Operating Procedure	POLICY #PH039
DEPARTMENT/SCOPE:	Pharmacy	Page 2 of 2
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AUDIENCE: All Pharmacy Staff		APPROVAL DATE:
OWNER: K. Earnest		APPROVER: K. Earnest

10) The plates are incubated at 30º – 35º C for no less than 48 hours; then the plate are incubated at 20º -25º C for no less than 5 additional days.
11) Results are documented on the culture worksheet and entered into the EHR.
12) Action Levels:

ISO Class	Surface Sampling Action Levels (cfu/media device)
5	>3

13) If the sample reaches the action level the microorganism should be identified.
14) If the sample reaches the action level corrective action must be taken. The corrective action should be dependent on the cfu count and the microorganism recovered. Data collected in response to corrective actions must be reviewed to confirm that the actions taken have been effective. Some examples of corrective action include:
    a. Process or facility improvements.
    b. Personnel training.
    c. Cleaning and disinfecting.
    d. HEPA filter replacement and or repair.
15) The corrective action plan must be documented.

REFERENCES:

Settineri F. Part 1 - Best Practices for Air and Surface Sampling. Pharmacy Purchasing & Products. March 2020: 20-22

United States Pharmacopeia and National Formulary (USP 797 General Chapter). United States Pharmacopeial Convention; 11-1-2023 Sections 6.3.2, 6.3.3.

COMMITTEE APPROVALS:

P&P: 10/2/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Ultraviolet Light Disinfection	POLICY #
DEPARTMENT/SCOPE: Infection Control	Page 1 of 2
REVISION DATE: n/a	EFFECTIVE DATE: 7/2/2024
AUDIENCE: Environmental Services Staff	APPROVAL DATE:
OWNER: K. Earnest	APPROVER: K. Earnest

DEFINITIONS:

Ultraviolet (UV) light disinfection technology is a nonchemical approach to disinfection.

POLICY:

Ultraviolet (UV) light disinfection is an effective method for reducing the risk of infection in healthcare settings. This policy outlines the guidelines and procedures for using UV light devices in our hospital.

This policy applies to all hospital staff who use or operate UV light devices.

The purpose of this policy is to:

1. Ensure safe and effective use of UV light for disinfection.
2. Minimize the risk of harm to patients, staff, and visitors.
3. Standardize procedures across all hospital departments.

PROCEDURE:

1. **Device Selection and Maintenance**
   A. Only hospital-approved UV disinfection devices shall be used.
   B. Devices must be regularly inspected, calibrated, and maintained according to manufacturer guidelines.
   C. Report any malfunction or damage promptly to the maintenance department.

2. **Pre-Disinfection Preparation**
   A. Ensure the room is unoccupied.
   B. Remove any items that may block UV light exposure.
   C. Close blinds and curtains to prevent UV exposure to external areas.

3. **Personal Protective Equipment (PPE)**
   A. Staff operating UV devices must wear appropriate PPE, including gloves and eye protection.
   B. PPE must be donned before entering the room and removed after disinfection.

4. **Room Disinfection**
   A. Follow manufacturer instructions for device setup and operation.
   B. Position the device to cover all surfaces, including high-touch areas.
   C. Set the appropriate exposure time based on room size and device specifications.
   D. Activate the device and leave the room promptly.
   E. Do not re-enter the room until the disinfection cycle is complete.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Ultraviolet Light Disinfection	POLICY #
DEPARTMENT/SCOPE: Infection Control	Page 2 of 2
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AUDIENCE: Environmental Services Staff	APPROVAL DATE:
OWNER: K. Earnest	APPROVER: K. Earnest

5. Post-Disinfection

A. Ventilate the room after UV exposure.
B. Inspect surfaces for any residual contamination.
C. If any visible contamination remains, Environmental Services Department will repeat the disinfection process.

6. Documentation

Include details such as date, time, room number, and device used.

7. Training and Education

All staff involved in UV disinfection shall receive training on device operation, safety precautions, and policy compliance.

8. Monitoring and Compliance

The Environmental Services Department will monitor compliance with this policy.

REFERENCES

Memarzadeh F. A Review of Recent Evidence for Utilizing Ultraviolet Irradiation Technology to Disinfect Both Indoor Air and Surfaces. Appl Biosaf. 2021 Mar 1;26(1):52-56.

Scott R, Joshi LT, McGinn C. Hospital surface disinfection using ultraviolet germicidal irradiation technology: A review. Healthc Technol Lett. 2022 May 28;9(3):25-33.

COMMITTEE APPROVALS:

Infection Control: 9/12/2024

Director of Operations Report
Prepared by: Jessica DeCoito, DOO

Facilities, Engineering, Other Construction Projects

- On October 8, the Fire Life Safety Surveyor from CDPH showed up for the Acute survey. Our team spent the day walking through the facility and providing documentation. We received our 2567 (statement of deficiencies) with minor deficiencies, most of which have already been addressed. The Plan of Corrections (POC) was submitted on Thursday, October 24 and we have until November 6 to correct all deficiencies. I would like to shout-out to Tyler Wolter on the Maintenance team for stepping in to address the Surveyor's questions while Alex was attending a Healthcare Construction Conference. And thank you to Alex for jumping on the phone to answer the questions we could not.
- Alex Johnson attended a Healthcare Construction conference through ASHE (American Society for Healthcare Engineering) in Chicago the week of October 7. Alex is working towards achieving the Certified Healthcare Facility Manager exam through ASHE. This conference is aiding in the development of his knowledge in the healthcare facility environment, which ultimately benefits our facility and the care of our residents and patients.
- Our Criteria Document meetings continue to take place weekly. The second draft of the use permit has been sent to Shasta County for review. We will begin working with Legal to create the Request for Proposals for a Project Management Firm that to manage the Master Planning project.
- The Fall River Rural Health Clinic drawings were sent to the County for review. Once the County approves the drawings, we will work with Legal to assemble a Bid package to get a contractor on board to conduct the work.
- The Solar Project is still in a holding pattern as we await the review from the County – expected return date of October 25th. Veregy was onsite to do a site walk on the campus before they updated the grading plan.
- The Burney Fire Alarm Panel project was inspected and tested on Friday, October 11th with sign off from the IOR. AND we received the great news on October 14th that HCAI signed off on our fire watch! That's a total of 419 days, 7 hours and 55 minutes from August 23, 2023, at 8:20 am to October 15, 2024, at 4:15 pm. Our team was instrumental in conducting the Fire Watch every day for this past year – a huge shout out to them on their diligence and patience. On October 22nd, we had contractors and HCAI onsite for the final testing on backup battery test. The battery test passed but we found one horn strobe that needs to be replaced. Once Hue & Cry replace that strobe, we can have the IOR onsite to finalize the project.
- In a successful meeting with ACHC and our consultant, it was discovered that we do not need to install a fire-rated roll down door in our FR Dietary space. We are working with architects on de-rating fire walls in that space which cancels our project with HCAI and still meets accreditation requirements with ACHC.

Dietary

- On the week of September 23rd, a team of surveyors was onsite to conduct the Acute survey which included the FR Dietary department. This was an extensive survey conducted by a

Registered Dietician. We received a lengthy list of deficiencies. Susan and Alex's teams went straight to work on the corrections, addressing most concerns the week of survey. The POC was submitted on Thursday, October 17th and all deficiencies have been completed as of Friday, October 25th.

- One deficiency that will require additional time and resources is providing our menus with nutritional analysis', including our disaster menu. Susan, Jen and I have engaged in conversations and demos with a company called MealSuite that would help provide the nutritional analysis we need for both SNF residents and Acute care patients. We have also looked at Nutricopia for a similar service. This is developing and more will be provided at the next meeting.

Human Resources

October 2024

Submitting by Libby Mee – Chief Human Resource Officer

The Human Resource/Payroll/Benefit department currently supports 310 active employees.

The team continues to work with specialized companies to provide additional recruitment resources for our Chief Medical Officer (CMO), Emergency Department Providers, Rural Health Clinic Provider, Pharmacist, Hospitalist/NP, and Skilled Nursing positions. We are currently utilizing interim professionals in the Pharmacist, Infection Prevention, Hospitalist and Skilled Nursing Director of Nursing roles.

Over the last month, we have successfully filled the Infection Prevention RN and Physical Therapist positions.

Annual Compliance

We have successfully completed the annual compliance for Employee Evaluations and Re-Orietation. We are in our final month of compliance for Employee Health, consisting of annual physical, TB screening, FIT testing and updating immunization records.

ACHC

In preparation for the ACHC accreditation, we are auding employee files for compliance and continue to work on implementing the new Kahuna compliance software system, that will help us seamlessly track and monitor compliance across all our learning software systems.

Nursing Program

Due to new regulations that will change the staffing ratios in our Skilled Nursing Facilities, we are exploring alternative ways to look at our RN recruitment. We had previously discussed an LVN program for our current CNAs but are now looking at RN programs. Currently, we have had conversations with members of the California Hospital Association, Shasta College Nursing Administration and local hospitals Chief Nursing Officers and Human Resource Professionals to discuss partnerships in this initiative. We have also committed to participating in a meeting with the Board of Nursing to express the hardships and difficulties that the current RN programs face and how they negatively impact rural facilities.

2024 Hospital Quality Institute and Hospital Council Annual Conference

I recently attended the 2024 HQI and Hospital Council Annual Conference. The primary theme for this year was Advancing Innovation: Embracing AI's Role in Patient Safey. Though there were many impactful sessions, I look forward to utilizing concepts from the session about Speak-Up Culture and the workforce session about Building the Profession of the Future,

preparing healthcare leaders to embrace the disruption that is coming in the near future and to use innovative solutions to drive change.

Fall River Joint Unified School District Partnership
We recently had the pleasure of meeting with the new superintendent of the school district. In this meeting, we were asked if we would be interested in being a work experience site for students interested in career paths that do not require a college degree. Positions and departments that were discussed were Ambulance, Information Technology and the Kitchen. Mayers expressed their support and look forward to working with the school as they explore the grant opportunities for the program implementation.

Employee Insurance Updates and Open Enrollment
We have successfully finalized updated to our employee insurance programs for next year and will hold Open Enrollment for eligible participants in the first two weeks of November for the 2025 coverage year. In listening to staff's frustrations and concerns, we have made changes to our Dental and Pharmacy coverage as well has have streamlined some enrollment processes.

Chief Public Relations Officer – Valerie Lakey
October 2024 Board Report

Legislation/Advocacy

This is the best review of the recent legislative session for legislation: The governor had until Sept. 30 to sign or veto bills. The 2025-26 legislative session will convene with an organizational session on Dec. 2. Please see CHA's 2024 **Legislative Scorecard** and ***Bill Tracker*** for information on legislation.

Grants

- Application submitted for a CA state Cybersecurity Grant for a total of $250k – awaiting decision.
- Pre-application submitted for CA state Prop 1 Behavioral health funding for addition of clinic space. A pre-application discussion in November with grant technical assistance will then be approved to submit the full application for approx. $950k.
- Additional grant rounds for program funding from Prop 1 will be upcoming soon. A significant amount of funding will go through counties – I am attending an info session this week in Redding regarding Shasta County's plans for their Prop 1 funding.
- Research for capital grant funding continues for FR Arts building
- Attending a 9-week online grant training seminar offered through the National Organization of State Offices of Rural Health
- Attended a seminar outlining some of the upcoming federal health-related grants. Many release dates are currently up in the air until after the election. Researching which ones are a good fit to apply.
- Attending the FLEX program webinar on Oct 22 to discuss upcoming program rounds and requirements.
- Departmental Awards and Employee Scholarship applications are both due November 1. The board committee will review them on November 5.
- North State Giving Tuesday is December 3rd. Both MHF and TCCN are registered on the NSGT platform, and campaigning/advertising will begin soon. Please join us to support, cheer, and make phone calls on the day if you can.

Public Relations/Marketing

Department Marketing: We have successfully completed meetings with the outpatient department managers to strategize marketing efforts to achieve this year's strategic goals and QIP measures. The managers provided valuable insights, which helped shape a comprehensive project plan. A consistent marketing strategy is being developed alongside a clinic visit schedule to ensure our efforts are well-coordinated and impactful.

We have a solid plan for targeted marketing to support the QIP initiatives. Specific outreach lists have been established for critical areas, including mammograms, colonoscopies, and well-child visits. These targeted efforts will help drive engagement and improve patient outcomes.

Commercial Spot: The commercial is now live! You can view it here: https://youtu.be/irfGLI7x7Ns. To maximize its reach and impact, we're building a comprehensive social media and advertising campaign around this new commercial. The campaign will highlight our key messages and services, ensuring our community stays informed and engaged. Stay tuned for more updates as we roll out this exciting initiative!

Community: The Provider Mixer was a great success, with strong participation from referral-based department managers and five representatives from Pit River Health Center in attendance. The event provided a valuable opportunity for our managers to engage with these providers and discuss the range of services offered across their departments, fostering stronger connections and potential future collaborations.

Strategic Goals: Work is underway on the Communication and Growth Pillars. In addition to marketing efforts, we are actively evaluating surveys and collaborating with a consultant to develop a comprehensive strategy. We have established a Referral Project Team, which will hold its first meeting on November 7, 2024, to initiate a thorough review of our referral process. As part of this initiative, we are bringing in consultant Jen Miley, who will guide us through an in-depth assessment of the current system. Together, we will map the existing workflow, identify areas for enhancement, and implement changes aimed at streamlining this essential aspect of patient care, ultimately ensuring a more efficient and seamless patient experience.

The initial meeting will focus on evaluating our strengths, identifying opportunities for improvement, and setting the stage for developing a referral process that consistently delivers a positive experience for every patient.

Additionally, we are excited to introduce a one-time event, "Ignite the Patient Experience," designed to equip staff with practical tools and strategies for enhancing patient interactions. Although some team members may participate in both the Referral Project and Ignite the Patient Experience programs, please note that these initiatives are separate and distinct yet aligned in their goals to improve patient care.

Mayers Healthcare Foundation

Golf Tournament – August 3, 2024

The annual golf tournament was tremendously successful, with a great turnout and beautiful weather. Sponsors showed strong support again, although golfer participation was slightly lower than in previous years, possibly due to an increasing number of similar tournaments in the area. Looking ahead to the 25th-anniversary tournament next year, we aim to make it another exceptional event and have already received interest from one of our longstanding sponsors.

- **Financial Overview:**
  - **Income:** $27,675.50
  - **Expenses:** $8,298.13
  - **Net Proceeds:** $19,377.37
  - **Distribution of Proceeds:** 25% to EDJ ($4,844.35) and 75% to TCCN ($14,533.02)

Annual Appeal

Work has begun on this year's annual appeal, with a target release date set between November 11th and 16th. The appeal will highlight the remarkable achievements of MHF and contributions

made to MMHD over the past year. We welcome any suggestions or specific content you'd like to see featured.

North State Giving Tuesday (NSGT)

We are registered for this annual fundraising event, scheduled for December 3, 2024. We look forward to another successful year and will provide further details about the proceeds soon.

Denim & Diamonds Hospice Winter Gala – January 25, 2025

This year's gala, themed "A Night at the Saloon," will take place on January 25. We have secured Grazerz Grub & Pub (formerly Fall River Hotel) as our caterer and bar vendor. Cindy and her team, who have extensive catering experience in the Sonora area, will bring a wonderful atmosphere and culinary excellence to the event. Cornerstone Bank has generously contributed as the Event Sponsor, supporting the entertainment provided by "The Billies" (also known as "Lucky Buck"), a country band.

- **Ticket Sales:** Raffle and dinner tickets for the car are already on sale. Please share the event details with friends and family to ensure no one misses out on this exciting night.

Tri-County Community Network

Children's Programs

1. **Community Engagement and Partnerships (September-October)**
   Bright Futures has been actively fostering community connections and building partnerships with agencies throughout the Inter-Mountain area.
   - In September, a free Child Car Seat Safety event was held at the Burney Fire District parking lot. Nine parents received assistance with proper car seat installation from Pit River Health Services staff. Additionally, seven car/booster seats donated by Shasta Public Health Services were distributed to families in need, while First 5 Shasta provided goodie bags for the children.
   - In October, Bright Futures began collaborating with Shasta Head Start in McArthur and participated in Shasta Head Start-Burney's Fall Walk. The program will also be involved in Burney Elementary School's Walk to School event on October 24.

   Bright Futures continues to deliver services to Transitional Kindergarten programs at Fall River, Burney, and Big Valley elementary schools, Shasta Head Start in Burney, Round Mountain's preschool, Munik'chun Daycare, and the libraries in Burney and Fall River. On average, services are provided to 150 children aged 0-5 each month.

   - **Triple P Parenting Support:** Offered through Family Advocate Kiely, parenting support services are widely promoted on social media, at parenting events, and through FRJUSD community networks.
2. **BOTVIN Life Skills Training (LST)**
   The program has launched in local elementary schools, beginning with 4th graders

learning skills to boost self-esteem, make informed decisions, and understand the risks of smoking. The 4th-grade curriculum is expected to conclude by early December, followed by an 8-week program for 5th-graders. Approximately 200 students from grades 4 to 6 will participate with the Shasta County Asset Forfeiture grant funding.

Grants and Grant Programs

1. **Parent Cafés Collaboration**
   TCCN is partnering with Pathways to Hope to bring Parent Cafés to the region. With two well-attended cafés reaching 18 caregivers, discussions on expanding this initiative are ongoing. Future events will be funded by the Bright Futures grant, with staff members Marrisa and Kiely scheduled to undergo Parent Café training in December, funded by the Community Foundation of the North State.
2. **Community Foundation of the North State Grant ($10,000)**
   Awarded in June, the grant will be utilized by December 31 to enhance the Intermountain Community Center, including new foyer furniture, a weekly senior coffee hour, and community health education workshops.

Funded Events (September-October 2024)

- **Immunization and Backpack Giveaway (September):** Sixteen children received vaccinations, accompanied by educational materials for parents.
- **Caregivers Workshop (September):** In partnership with HBI, ten seniors attended a session on healthy aging presented by Kelsi Halvarson.
- **Back-to-School Night and Well-Child Checkups:** Thirty-one children were referred for checkups.
- **Senior Sip and Social (October):** Launched on October 17, this program is set to continue weekly through May 2025.

Upcoming Events

- **Diabetes Clinic (November 15, 2024):** In collaboration with MMH Rural Clinic, this event will feature glucose checks, lab work, foot exams, blood pressure checks, nutrition counseling, and eye exams at the Flower Building and the mobile clinic.
- **Heart Health Month (February 2025):** Activities will include a community CPR class, hands-only CPR sessions at FRH and BHS, a digital cookbook giveaway, and a presentation at the Senior Sip and Social, conducted in collaboration with MMH Cardiac Rehab.

Partnerships

1. **SMART Employment Services**
   Continuing the partnership with SMART, TCCN hosted a successful pop-up event on October 3, assisting three community members with employment support services at the temporary McArthur office.
2. **Reviving the IMAGE Program (Intermountain Action Growth and Education)**
   The second IMAGE meeting on September 10 saw increased participation from community stakeholders, setting the groundwork for a community needs assessment. The

November meeting will focus on drafting the assessment questionnaire and compiling a list of community partners.

Website Update

The newly launched website includes a community calendar, health resources, employment and housing information, and an educational library. New content is added regularly through regular updates.

Community Events Schedule

- Weekly children's activities for ages 0-5 (Bright Futures)
- BOTVIN Life Skills Training: Mondays and Tuesdays at Fall River Elementary, Wednesdays and Thursdays at Burney Elementary, continuing through May 2025
- Senior Sip and Social: Thursdays through May 2025
- **Apple Bash (November 4, 10 AM – 12 PM):** George Ingram Hall
- **Family Movie Night (November 11, 5 PM – 8 PM):** Fall River Lions Hall
- **IMAGE Meeting (November 12, 11 AM – 12:30 PM):** Burney Board Room

Intermountain Community Center Renovation Update

Phases 1 and 2 of the remodel have received approval from the Burney Fire Department and are under review by Shasta County. Phase 3 has been submitted and is awaiting fire department approval.

September Board Report
Clinical Division
10/21/2024

Retail Pharmacy

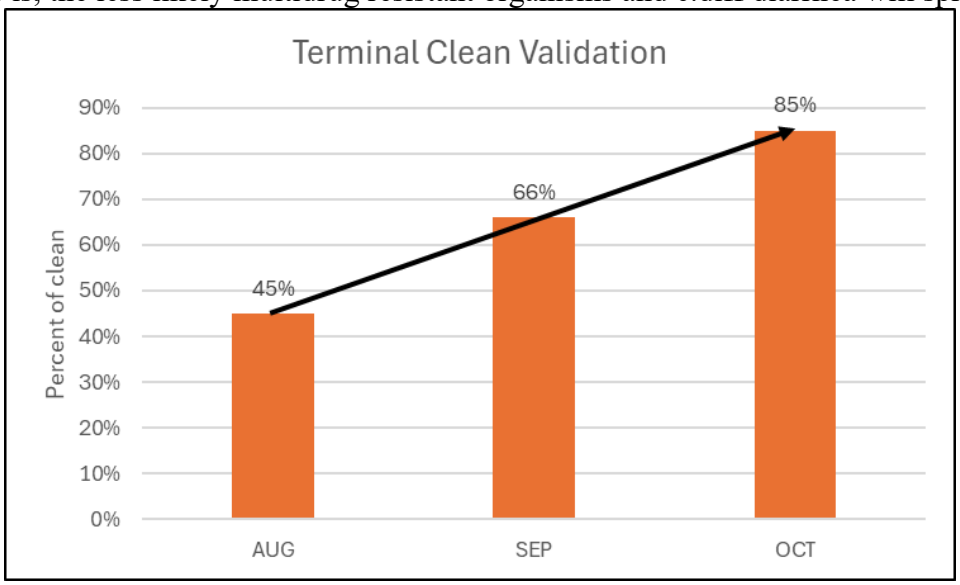
- **CalRecycle Compliance Audit:** On October 16th, CalRecycle (California's Department of Resources Recycling and Recovery) completed their audit of our Pharmaceutical and Sharps Waste Stewardship Program. Although we were previously unaware that our Retail Pharmacy was required to comply with this regulation, we passed the audit. We were provided with the necessary tools and guidance to ensure ongoing compliance moving forward.
- **Financial Audit Update:** Following a thorough audit of our Retail Pharmacy's finances, it was discovered that certain deposits were not correctly reflected in our account. The Business Office has since recoded these deposits, ensuring they are now accurately attributed to Retail Pharmacy.
- **Flu Shots:** Flu shots are currently available at the Retail Pharmacy by appointment only.
- **FDA DSCSA Delay:** The FDA has delayed the Drug Supply Chain Security Act (DSCSA) requirements, with the new compliance date set for November 2025.

Hospital Pharmacy

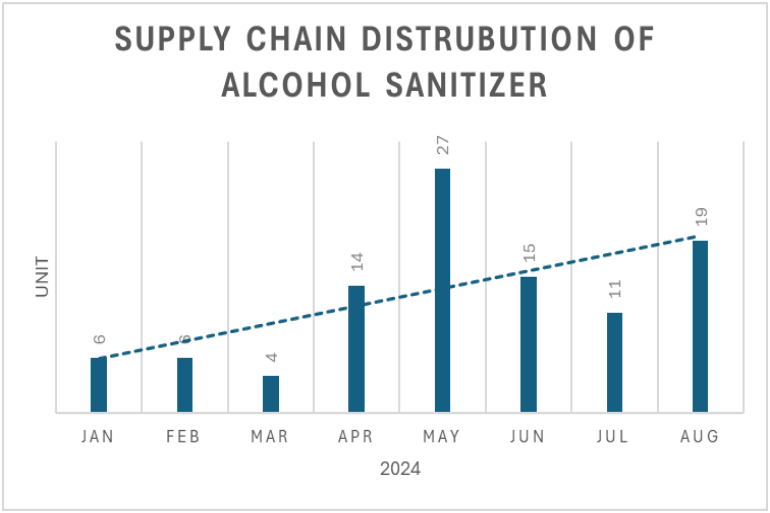
- Due to damage to factories, infrastructure, and supply chain due Hurricane Helene, IV fluids are allocated. Dana Hauge, Safety Officer, Rachel Morris, Purchasing Manager, and Katrina Williams, CPhT, worked to quickly inventory and secure our current supply. We locked in whatever amount was allocated. A plan was quickly implemented to handle the shortage, including giving medications via IV push instead of IV piggyback whenever possible. We are navigating the shortage well at this point.
- IT and remote pharmacy are testing a replacement camera that will work on a secure internet connection (https) for remote drug verification after hours.
- The CDPH acute care survey took place the week of September 23rd. A pharmacy inspector spent September 24th in the pharmacy. The issues appearing on the 2567 included:
  - The lack of a "Medication Administration" policy. Plan of correction: This policy was written by Moriah Padilla, DON-Acute. Education to pharmacy staff complete.
  - Lack of dating of medications with shortened in the acute medication room. Plan of correction: The policy was updated. Materials in place in the medication room to help nursing with dating and pharmacy is performing a quality project in this area.
  - Missing medication contents list on the exterior of the crash carts. Plan of correction: Medication lists copied on color paper, laminated and taped to the carts. Quality project in place to monitor improvements.

Infection Prevention

- Mayers welcomes Kristin Stephenson, RN, to the infection preventionist role. She will become certified in the next two years. Amy Marinski, our registry infection preventionist, has created a orientation and training plan for the role.
- Amy Marinski, Infection Preventionist, worked with a representative of PDI to provide in services to environmental services personnel. PDI is a company that manufactures many of our cleaning supplies. Amy is performing quality assurance and training for environmental services personnel with verification by fluorescence. The table shows the effectiveness of terminal cleaning improving. The more effective our terminal cleaning process is, the less likely multidrug resistant organisms and c.diff diarrhea will spread.



- IP, nursing, and environmental services worked quickly to contain an outbreak at the Burney Facility in Memory Care. All necessary reporting was made to the state and county.
- An indirect measure of hand washing compliance is the amount of hand sanitizer used. Since Mayers implemented an emphasis on hand washing, the use of hand sanitizer has increased.



Laboratory

- The Quantiferon analyzer should arrive in the next 3 weeks. Validation for the analyzer will take 30-45 days. During validation, the CLS staff will be trained. Sophia Rosal, CLS, Laboratory Manager, will also be writing the Policies and Procedures. Dr Morris, Laboratory Director, also needs to sign off on everything before go live.
- New sensitivity cards for gram negative organisms and extended spectrum beta lactamases (ESBL) have arrived. Validation of the cards has started. The CERNER interface will also need to be validated.
- Sophia Rosal, CLS, laboratory manager, is working with infection prevention and nursing on reducing the blood culture contamination rate through staff tracking, general training, and one-on-one training. She will continue to monitor. Early results are positive. The standard is to be under 3%. Mayers numbers are small making the rate highly variable. In September, there were 24 cultures performed.

Blood Contamination Rate	
Month	**Cont Rate**
Jan	3.51%
Feb	3.17%
Mar	2.86%
Apr	1.92%
May	0.00%
Jun	4.30%
Jul	1.92%
Aug	3.70%
Sep	0.00%
Oct	
Nov	
Dec	

Respiratory Therapy

- Annual Report October 2024.
- As part of the plan of correction to the 2567, the policy on Incentive Spirometry has been updated. Education has started and monthly auditing for compliance is in place.

Imaging

- MMHD now has accreditation for the CT scanner! Harold Swartz, Imaging Manager, will next work on the Low Dose CT Registry.
- Harold completed the Fuji PACS training (4-day course) the week of October 14. Due to a delay in software implementation the go-live is now late November.
- Harold has updated the outpatient order forms, which is now in the approval process.
- The imaging department will be using an iPad so patients can sign IV consent and patient pregnancy forms electronically.

Physical Therapy / Cardiac Rehab

- Craig North, PT, started 10/14/2024 and is working two days a week. This will enable the department to see more patients and eventually decrease wait times.
- As of 10/21/2024 the next available evaluation is 4 weeks out. Scheduling is quick to fill cancelations with evaluations to get patients in quicker. Currently there are 15 evaluations scheduled. Every referral has been called.
- Maintenance has installed 8 electric heaters as the gas line is waiting to be repaired.
- Daryl Schneider, PT manager, worked with Tara Dillinger, Cerner consultant, on authorization reports. Cerner doesn't have a tracker of authorizations so manual reports are needed.

NURSING SERVICES BOARD REPORT

October 2024-Reporting for September

CNO Board Report

- We had one single suspected case of scabies at the Annex resulting in isolation for this resident and the roommate. No other reported cases were identified. The team did a great job in the prevention of any further cases.
- I attended the NRHA Rural Health Clinic & Critical Access Hospital Conference with CEO, Ryan Harris in September.
- CAH Relicensing Survey: Following our recent CAH relicensing survey, we were pleased with the overall positive outcome, especially in our Acute Services. The hard work being done with ACHC closely aligned with many aspects of the survey, and it was gratifying to see the dedication of our staff reflected in the quality of care provided to patients. While a few areas for improvement were identified, we have already begun developing streamlined action plans to address them, and we are confident these adjustments are within our capabilities. Additionally, we are refining workflows to ensure full compliance with CMS standards.

SNF
Monthly Board Report

- Census- (77) Fall River- 33 Burney Annex- 24 Memory Care- 20
    - Completed three home/facility visits with admission dates pending.
- Unit Assistant due to test on 11/25.
- Hired a full-time RN. Interview with an LVN 10/15.
    - Continuing with recruitment efforts.
- Two residents continue on precautions due to suspected scabies.
- No CDPH visits this month. Several self-reports pending review.
- Six staff members completed Dana's de-escalation training.

Acute
September 2024 Dashboard

- Acute ADC: 1.84
- Acute ALOS: 3.8
- Swingbed ADC: 2.84
- Swingbed ALOS: 12.57
- OBS Days: 1

September Staffing

- **Staffing Requirements:** We have successfully filled all key positions, requiring 8 full-time equivalent (FTE) RN/LVNs, 2 part-time equivalent (PTE) RNs, 4 FTE CNAs, and 2 FTE Ward Clerks to maintain optimal department operations.

- **Utilization of NPH Staff:** We are currently utilizing 0 FTE NPH RN/LVN. The occasional shift is being filled when our per diems are unavailable. We started the month with 2 FTE NPH RN/LVNs but reduced this to 0 by the end of the month.

Updates

- **ACHC Accreditation Progress:** This month, we have made significant strides in our ACHC accreditation efforts by finalizing the content for our in-person training sessions scheduled for October and early November. Additionally, we have successfully assigned Relias modules to staff, ensuring they engage with the materials ahead of the upcoming training events.
- **Audit Tool for PI Measures:** This month, we are concentrating on the completion of individualized care plans as part of our ongoing efforts with the audit tool for ACHC-required PI measures. We have collaborated with the charge nurse to develop targeted training and reinforcement strategies to enhance compliance in this area. Additionally, considering our state survey results, we will be updating the audit tool to incorporate the findings from the survey.

Emergency Services

September 2024 Dashboard

- Total treated patients: 349
- Inpatient Admits: 14
- Transferred to higher level of care: 25.
- Pediatric patients: 61
- AMA: 3
- LWBS: 4
- Present to ED vis EMS: 45

Staffing: Required 8 FTE RN, 2 PTE RN's, 2 FTE Tech's, 1 PTE Tech

- Utilized 3 FTE contracted travelers.
    - One FTE – Days on LOA
- ED Manager covering gaps in shifts coverage between travelers. She continues her role as Clinical Project Manager for Cerner/ Learning Coordinator
    - Several high-level calls with Wipfli consultants- Onsite visit scheduled for the week of October 14th
    - Continued resource for the clinical areas in the facility

Open positions:

- FTE Days- Lillian Consiglio started her 6-month orientation in the ED. She will be shadowing at SRMC ED starting October 2nd and continuing through February.
- FTE NOC- Open

Updates:

- Centering staff education around ACHC guidelines
    - Policy sign offs each month
    - 8-hour in person education scheduled for 10/30 and 11/6

- Continue to improve chart check processes to increase captured revenue and avoid late charging, while improving charting standards.
- 8-hour de-escalation training scheduled for 10/9 and 10/10
- In alignment with ACHC standards, we have completed a comprehensive Ligature Risk Assessment and Mitigation Plan, developed in collaboration with safety, facilities, and departmental staff.
- In partnership with MHOAC, we have enrolled in the California Hospital Bed Capacity Project, set for implementation in Fall 2024. This initiative is designed to automate bed reporting, enhance patient outcomes, improve emergency coordination, and optimize hospital resource utilization without adding administrative burdens.

Ambulance Services
September 2024 Board Report

- 61 Ambulance requests
- 12 Transfers
- We are actively recruiting per diem EMT's and Paramedics. We hired one local EMT, no per diem paramedics have applied.
- Both the ambulance and emergency department are working together to prepare for winter transfers when aircraft are not available. We are putting together some cross training of both departments equipment and staff to utilize nurses on transfers as allowed by SSV and to use EMS in the ED to assist with patient care when we cannot transfer patients out.

Outpatient Surgery
September 2024 Board Report
Referrals:

16 - Referrals received
7 – Scheduled
4 – Rejected (BMI > 45, Medically complex, or Procedure not performed)
1 – Pending insurance clearance
4- Called patient and unable to reach or patient does not want to schedule at this time.
0 – Needs Nurse review
11 – Outstanding/ Pending referrals received prior to September

Pending Reason breakdown:

5 - previously scheduled and cancelled (unable to reach, needs medical clearance, or patient does not want to reschedule at this time).
6 – Unable to reach patient or patient does not want to schedule at this time.

Procedures Performed	**September**	
Colonoscopy	0	
EGD	0	
Colonoscopy/ EGD Combo	0	
EGD + balloon dilation	0	

Total cases Performed	**Monthly Total:**	**0 ***

*** Surgeon tested positive for Covid-19 the day before September cases were scheduled. We had to cancel and reschedule all 20 procedures for the month of September.**

- We continue to perform Endoscopy procedures 1 week per month (3 days).
- Referrals continue to come in from local clinics, 16 referrals were received in September. 4 referrals were for minor general surgery cases and were rejected as we are only performing endoscopic GI procedures at this time.
- **Training and Certification**: Scrub tech is scheduled to take her certification exam on October 7th. Surgery manager is working toward CNOR certification exam and requirements. Completed Exam prep course on 9/28. All Relias training modules have been assigned and we are working through staff competency checks.
- **Department Development:** Continuing work to meet ACHC, AORN, and AIMI standards of practice. Surgery manager is building department documentation/ policy binder.
- Surgery manager has been working to update all policies and procedures and create structured orientation.
- State Survey of the Surgical department on September 29th with no specific deficiencies found. Working with Director of Acute Services to meet hospital-wide changes and policy updates based on survey findings.

Outpatient Medical
Updates this month for October

- Census OPM:
    - September 106 patients
    - August 96 patients
    - July 104 patients.

- Joined in on the provider appreciation gathering. I think this event was well done. Was hoping for some MVHC representation but was thankful for the relationships with Pit River. I thought this was a great idea. Maybe we could do another in the Spring with more providers in FR?
- Staff has gone to the de-escalation training offered. Great reminder of communication skills, teamwork, and working through some real case scenarios.
- Continue to work with Tara from Wipli on weekly calls. I look forward to having her onsite so we can work through real-time issues. Continue to work on proper orders on Cerner for reoccurring patients and changing appointments.
- IT and the pharmacy team worked with Pyxis and was able to get our patients properly populated in the system. There is still a ticket in because we are unable to find OPM patients in other Pyxis machines. IT continues to follow up on this.
- Continued work on policies. Making some strides with needed policy changes with other departments ie. Lab for blood and blood products, and Quality with consents.
- Upcoming employee leave. Our candidate didn't work out and HR has posted the position on Medifis. No new candidates at this time.

- Met this month with Marketing. Emphasized the importance of educating discharge planners of our services at MMHD and overall trying to gain more privilege providers in OPM. The streamlining of the referral process will be on the radar for new privileged providers.
- IP infection prevention is working on utilizing the ultraviolet light to help lower the risk of microbes in OPM, especially after high census days such as wound clinic. So far Environmental Services has conducted this twice. IP has been in the OPM rooms to test cleaning with a solution and light.
- OPM employees are keeping up on the heavy load of Relias and Safety requirements.
- Have an ACHC training day planned to join with Acute in November to stay up on the latest requirements for OPM.

Social Services
Board Report- September 2024

- We did not have any admissions as we were on hold due to COVID at the Burney Campus.

Updates:

- Both Candlelight dinners were well attended by LTC families at both campuses.
- Will be participating in De-Escalation training on 10/10/24.

Activities
Board Report- September 2024

- Residents went to Hereford ranch on an outing.
- Residents went to the Alpine frosty in Burney
- Residents went on local shopping trips to Safeway and dollar general.
- Residents participated in Live music at both facilities.
- Residents had a wonderful candlelight dinner. Lots of families attended at both locations.
- The casino outing was rescheduled, and the residents went to the sundial bridge.

Respectfully Submitted by Theresa Overton, CNO

Chief Executive Officer Report
Prepared by: Ryan Harris, CEO

ACHC Accreditation
The team had a productive meeting with ACHC surveyors and feels confident in submitting our application. Finishing touches are being made to the packet by our consultant prior to submission. The team and I are eager to move forward with the final stage of our accreditation process.

Provider Search Update
We are actively continuing our search for providers. We are currently in contract negotiations with one provider who will serve in our ER as well as a hospitalist. Unfortunately, both the Rural Health Clinic (RHC) physician and the CMO candidates have accepted positions elsewhere.

Collaboration

- Provider Mixer
    - The provider mixer held on October 9th was a tremendous success, and I want to express my appreciation to Pit River Health for having multiple providers in attendance. Several positive outcomes emerged from the event: some of our own staff had not previously met our providers in person, Pit River was unaware that we had a draw room in our clinic and has since started directing patients to it, our pharmacy was not in their system, and therefore they had not been sending prescriptions to us before this event. Additionally, we learned about the extensive mental health services they offer, which could benefit our patients in the future. These are just a few highlights from the event, and I look forward to organizing more mixers in the future to foster collaboration within our healthcare community.
- Jointly owned MRI
    - The Northern Section CEO group, which includes Modoc Medical Center, Mayers Memorial Healthcare District, Seneca Healthcare District, Plumas District Hospital, and Eastern Plumas Healthcare, is meeting regularly to discuss the mobile MRI initiative. This month, I will be seeking the board's commitment to allow the group to negotiate for a new MRI and trailer. While we are still working out the details regarding the ownership of the unit, we would like to initiate negotiations with vendors, as the CEOs of the group are requesting a commitment of up to $500,000 for this initiative from each of our boards. As it may likely take over a year before we can have the unit operational, we would like to start negotiates sooner rather than later. In the meantime, the group is considering contracting with a vendor to bridge the gap. Further discussions will take place during the upcoming board meeting.

Conferences
Our Chief Nursing Officer, Clinic Manager, and I attended the National Rural Hospital Association (NRHA) conference on Rural Health Clinics and Critical Access Hospitals from September 23 to 27. This conference provided an excellent opportunity for networking, meeting with both existing and new vendors, and addressing topics relevant to rural health clinics and critical access hospitals. Additionally, our Chief Human Resources Officer and I participated in the annual HQI and Hospital Council conference, which focused on the emergence of AI in healthcare, along with other initiatives.

One key topic from this conference that warrants consideration is the BETA Heart program and the concept of a just culture. This initiative could serve as a strategic priority for next year, aligning with our ongoing focus on enhancing patient experience. A particularly impactful session for me was on fostering a "speak-up" culture; when leaders truly listen, it encourages others to step forward. I have recommended that our leadership team read a related book, as I believe it will assist us in our efforts to enhance our organizational culture.

Master Planning Projects
This month, Travis and I had a follow-up meeting with USDA to advance our financing application with USDA. Additionally, we met with three banks to discuss private lending options for the projects. We are also beginning the request for proposals (RFP) for a project management firm to assist us with the larger master plan projects. We are also starting our RFP for the Fall River clinic once the county approves the drawings.

IV Fluid Shortage
The current IV supply shortage, caused hurricane Helene, has significantly impacted hospitals across the country. Disruptions in manufacturing and distribution chains have led to increased rationing of essential intravenous supplies and medications. Many healthcare facilities are experiencing difficulties in obtaining these critical resources, forcing them to implement conservation strategies and prioritize patient care. Hospitals are collaborating to monitor supply levels closely and share best practices while advocating for quicker restoration of normal production and distribution channels. I want to thank Katrina for her quick response in securing additional supplies right after the hurricane and for monitoring allocations to ensure we have enough resources. Moriah and Rachel’s team also acted swiftly by implementing inventory checks and conservation strategies, which have helped us maintain a stable supply. I would also like to thank Dana our Safety and Security Director for ensuring effective communication during this event.

Expanding Recognition
I am excited to announce that we will be expanding our employee recognition program this year. In addition to honoring our Employee of the Year, we will also recognize an Executive of the Year, which will include members of the executive leadership and director teams. We will also introduce a Leader of the Year award for our management team and a Department of the Year award. Our entire team does an outstanding job, and I am thrilled that we will now acknowledge contributions at all levels of the organization.

Surveys
Our team performed exceptionally well during both the Hospital Licensure Survey and the Fire Life Safety Survey, achieving minimal findings. Although there is always room for improvement, the hard work our team has put in over the past year for ACHC accreditation truly stood out. My primary concern following the survey is the condition of our aging kitchen. While we have made the necessary improvements for our plan of correction, it is crucial that we continue our efforts to replace it with a more modern and improved facility for the benefit of our residents, patients, and staff.

Other Information
Our teams have initiated the implementation of I2I, which will enhance our success in the QIP program and our overall quality initiatives. We have started our partnership with ConferMed, enabling our rural health clinic providers to connect with various specialists as needed. This platform will allow for real-time consultations, leading to faster and more effective decision-making in patient care. Additionally, we are looking into improving our EHR to enhance communication with patients regarding scheduling, referrals, and outgoing information. We are currently evaluating several vendors to support this initiative, which aligns with our commitment to prioritizing the patient experience.