Mayers Memorial Hospital District	# Quality Committee Meeting **Wednesday, March 8** *(12:00 pm)*		
Meeting called by:	Vasquez	**Type of meeting:**	BOD Committee
		Board Clerk:	Valerie Lakey
Attendees:	Beatriz Vasquez, PhD, Committee Chair, Board Member Laura Beyer, Board Member Louis Ward, CEO	Tom Watson, MD, Chief of Staff Sherry Wilson, CNO, Quality Designee Jack Hathaway, Director of Quality	
Please bring:	Agenda & Attachments		

----- Agenda Topics -----

Meeting Called to Order		Vasquez	
Requests from audience to speak to issues/agenda items		Vasquez	
Approval of Minutes – February 8, 2017 (Attachment)	A	Vasquez	Action
Departmental Reports (Pharmacy, Dietary, Maintenance, Personnel, Purchasing) • Report on quality data • Report on quality issues and/or quality projects		Earnest, Garcia, Burks, Mee, Sweet	Report
Quarterly Reports • Compliance		Hathaway	Reports
Standing Reports: Monthly— • SNF Events/Survey • Quality – Performance Improvement • Infection Control • PRIME • Administrative Report		Wilson Hathaway Lee Hathaway Ward	Report Report Report Report Report
New Business: **Policies for Approval** • Antimicrobial Stewardship Program • Controlled Substance Storage • Discharge Planning Record - MMH228 • MEC-Governing Board Endorsement for Physician Appointment and Privileges • Patient Assessment Record MMH157 • Reporting Concerns and/or Filing a Grievance Brochure • Utilization Review and Discharge Planning	B		Action
Announcements, Other, Future Agenda Items		Vasquez	Discussion
Closed Session Announcement, Government Code 54962, Medical Staff: • Chief of Staff Report (Health & Safety Code §32155)		Watson, Wilson, Overton	Reports/Action
Reconvened to Open Session – Report Action(s)		Vasquez	
Announcements: Next meeting: Wednesday, April 12, 2017 – Fall River			
Adjournment		Vasquez	

Posted
03/01/2017

MAYERS MEMORIAL HOSPITAL DISTRICT
QUALITY COMMITTEE MEETING
MINUTES – FEBRUARY 8, 2017

DRAFT
Attachment A

QC Attendance	Other Staff Present	Absent
Beatriz Vasquez, PhD, Board Chair	Valerie Lakey	
Laura Dolman-Beyer, BOD Committee	Barbara Spalding	
Sherry Wilson	Adam Dendauw	
Jack Hathaway	Chris Hall	
Dr. Tom Watsom		

(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.)

SUBJECT	DISCUSSION	
CALL TO ORDER	The meeting was called to order at 12:03 pm by Vasquez in Fall River Mills	
Public Request to Speak	None	
Opening Remarks by Chairman Vasquez		
Minutes	Minutes from the January 11, 2017 quality committee meeting were approved. **M/S/C (Ward, Hathaway).** ***All Approved***	**Approved**
Department Reports	**SNF, Sherry Wilson:** We are still under isolation Precautions in Burney (3 types of viruses have gone through the facility) Census is down because can't accept admits. We will be beginning the Point Click Care EHR system. This system will help with quality and reduce errors on paper charts. Staff will be visiting a facility in Redding that is using the system. All departments using the system will be trained (Dietary, etc). It will take about 90 minutes per patient to input each data (initially). We will be re-doing some of the forms. There have been two reportable falls with fractures. The state has been here on one of them. We have not received the 2567 on the visit. **Lab, Chris Hall:** Discussion of staff - issues with ordering tests. There is a step that can be missed. Hall is currently looking for a way to track and correct. Hall has completed some QRR's to report each issue. There was a question about how it impacts patients. Hall with work with Hathaway. There have been issues with the faxing. MVHC is tracking missing reports. There were issues with the TOC line. Provided a list of tests for BioFire – will allow for fast turnaround on lab testing. **Finance, Travis Lakey:** (Written Report) Reviewed successes and challenges. Vasquez had questions about the District Hospital Leadership	**Reports**

	Forum. **Volunteer Services, Barbara Spalding:** Spalding is in the process of collecting new HIPAA forms from volunteers. Direct supervisors are helping to collect forms. Application process and background checks are the same as they have been. A few policies have been changed and will go through the process for approval. Volunteer handbook is being redone. Six step process to improve volunteer process. Mission and value based. Policies up to date. Volunteer position descriptions. Annual reorientation instead of every two years. Volunteer meetings happen occasionally. Volunteer hours are tracked electronically.	
Quarterly Reports	**Patient First/CMS Core Measures, Jack Hathaway:** (see Power Point) Safety reports will be given to Hathaway to track data. Tracking Acute and SNF data (see graphs). It was suggested to compare our data with other facilities. Discussed the CALHIN Network	**Reports**
Standing Reports	**SNF – Sherry Wilson:** See above **Administrative – Louis Ward:** TimeClock Plus – better manage employees and track who is working and when. We will be completely electronic February 19th. Will be using an evaluation software to "have a process" and an easier way to track goals, scorecards, etc. The current process is all paper. Wage scale is tied to evaluations. There is also the opportunity of peer evaluations (committees, etc.) It will provide notifications. SEMSA - will be meeting with MMHD and SEMSA staff regarding transition. Employee Meetings went well – talked a lot about employee benefits. Paragon 14 update will be complete within the next couple of months. New server, back-up system. Clinical side will be different with changes. It is required for Meaningful Use Stage 3. Moving forward on telemedicine. Dr. Bab may be helping. Hired a consultant through Partnership grant. Will be a service to the community. Hoping to begin by July 1st. TeleMed2U **Quality – Jack Hathaway:** Discussed the No Smoking policy – Dr. Watson asked how it was going. Enforcement will go into effect March 1st. **Infection Control – Shelley Lee:** (Written report) Dr. Watson reported.	

	Norovirus outbreak in the fall. Tail end of respiratory virus. The new BioFire testing has allowed for faster specific diagnosis. Antimicrobial stewardship. Hathaway talked about a seasonal training for methods to not spread viruses. **PRIME – Adam Dendauw/Jack Hathaway:** Developed PRIME flow chart and binder to facilitate identifying and tracking patients. Smoking, Hypertension or combo. 30 patients – have to see them two times a year. Can use inpatient and outpatient. Will be a part of admission evaluation and could be a part of discharge for qualifying patients. Have to see 30 patients within 6 months for the first visit.	
Announcements, Other, Future Agenda Items	Beyer suggested we look into how to re-engage new moms, infants – maybe telemedicine pediatrics, nutrition, classes, etc. Vasquez talked about ACHD Education committee. Discussed a program through Stanford Tie in the Quality portion of the Strategic Plan to Quality meetings. Template for managers for department reports. Track a pattern for quality data. Louis, Val & Jack will come up with a template.	**Discussion**
Closed Session	**Adjourned to Closed Session at 2:10 pm** **(Beyer, Hathaway) – To Approve Privileges - *Approved All*** **Physician Reappointment** Michel Dillon, MD – EmCare ER Physician **Physician Appointment** Chuck Colas, DO – Emcare ER Physician	
Announcements;	Next meeting: Wednesday, March 8, 2017 in Fall River Mills	
Adjournment	Meeting adjourned 2:12 pm	

Minutes By: Valerie Lakey

Finance Quality Report February FY 17

Accomplishments

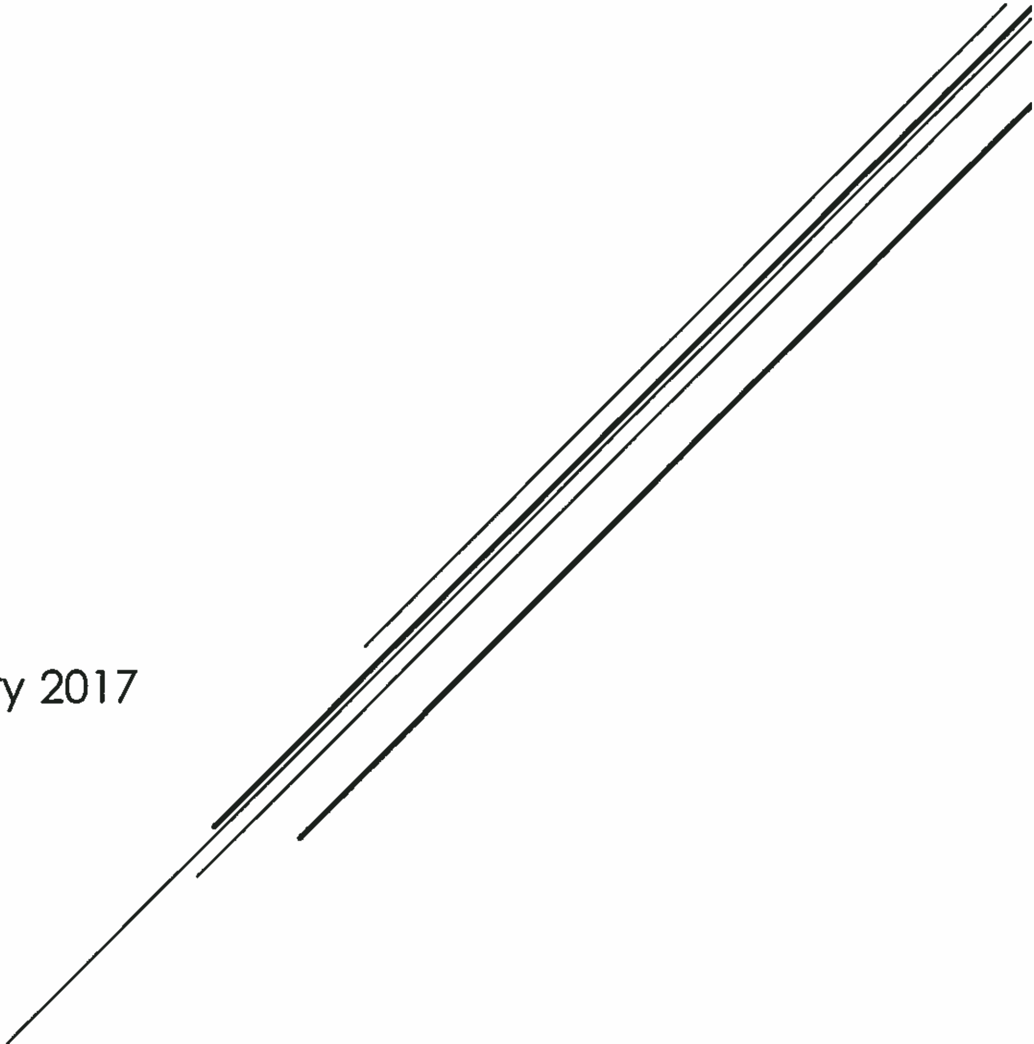
- A member of the subcommittee of District Hospital Leadership Forum which determines how QAF and Prime funding is allocated to the district hospitals in the state.
- Utilized all known additional funding opportunities to their fullest potential to increase our cash position.
- Paid down a considerable amount of debt over the last couple of years.
- Worked with USDA to get us to a point where we had a fundable project.

Challenges

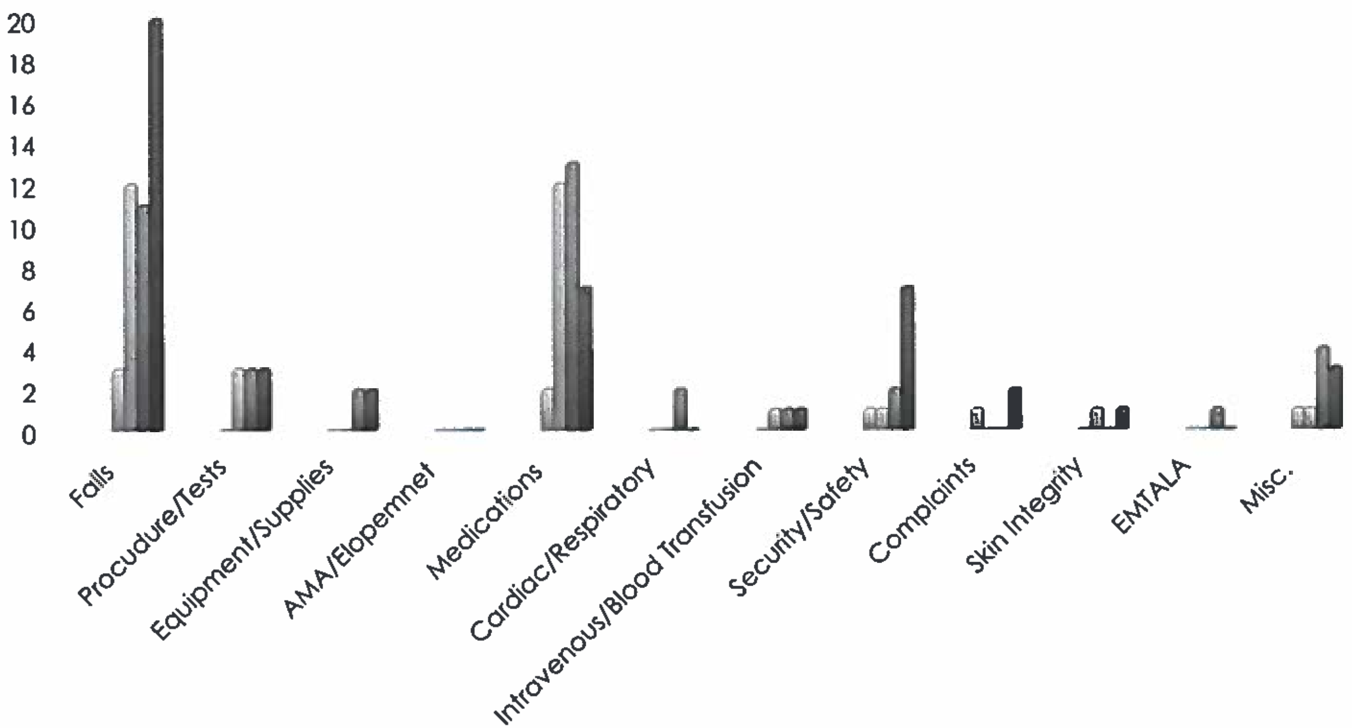
- Adapting to new programs and payment methodologies with new administrations.
- Training a new AP/Benefits person to replace a long term employee. It's been going well but requires more oversight than before.
- Finding an accountant to train with and eventually replace my controller who has 30+ years of experience at Mayers.

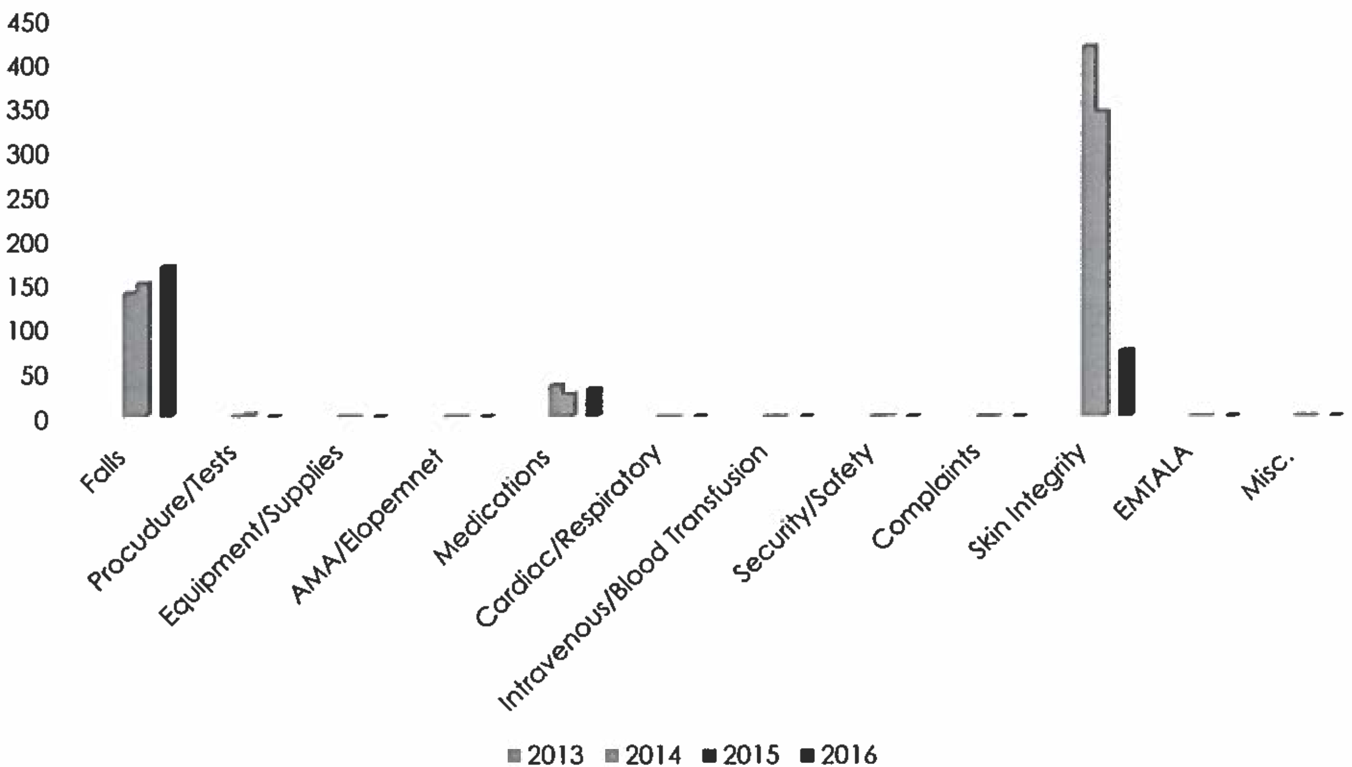
QUALITY UPDATE

Mayers Memorial Hospital District February 2017



ACUTE QUALITY TRENDS





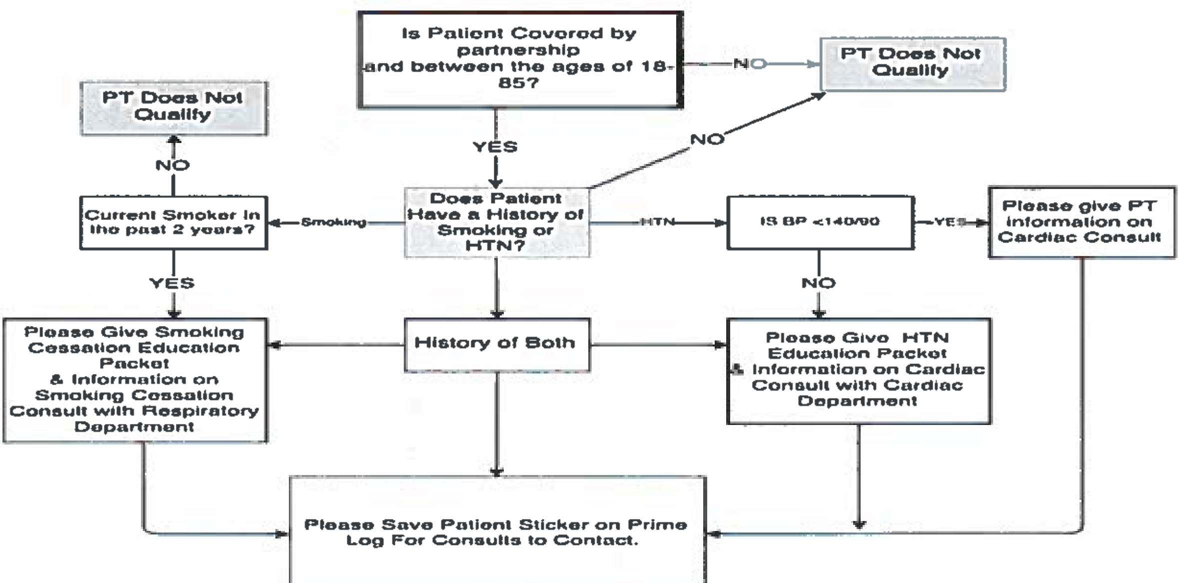
SKILLED NURSING QUALITY TRENDS

- We agree to:
- Work to reduce overall patient harm by 20% focusing on 30 day all cause readmissions and promoting antibiotic stewardship specifically looking to reduce C.Difficle
- Submit all requested data
- Collaborate with other hospitals
- Receive onsite assistance from CalHIIN

- CalHIIN agrees to:
- Provide no cost tech assistance in furtherance of the goals of the program
- Conduct in person training
- Provide access to subject matter experts
- Provide us with data on progress towards goals
- Provide access to resources
- Facilitate collaboration

CALHIIN

PRIME UPDATE



PRIME FLOW

4th QUARTER INFECTION REPORT FOR 2016 (Includes Acute, ED and SNF)

ACUTE	October		November		December		TOTAL
	CA	HAI	CA	HAI	CA	HAI	
Urinary Tract (see below for delineation)	6	1	11	1	7	0	25
*Sympomatic Urinary Tract Inf. (SUTI) HAI	NA	1	NA	1	1	0	2
*Catheter Associated (CAUTI) HAI	0	0	0	0	0	0	0
Skin & Soft Tissue	3	0	3	0	0	0	6
Pneumonia	2	0	4	0	10	0	16
Gastrointestinal Tract	1	0	1	0	1	0	3
Eye, Ear, Nose & Throat	1	0	0	0	0	0	1
Blood	1	1	0	0	3	0	5
Osteomyelitis	2	0	1	0	0	0	3
Employee Illness Trends	INA		INA		INA		
Station 1 Hand Hygiene Compliance		95%		71%		85%	
Totals	16	2	20	1	22	0	
Inpatient Days	168		198		202		568

ER	October	November	December	TOTAL
Urinary Tract	4	7	18	29
Skin & Soft Tissue	8	6	0	14
Respiratory Tract	1	2	1	4
Gastrointestinal Tract	0	0	0	0
Eye, Ear, Nose & Throat	0	0	0	0
Blood	0	0	3	3
Totals	13	15	22	50
Employee Illness Trends	INA	INA	INA	
ER Patients	316	312	325	

SNF-FRM	October	November	December	TOTAL
Hand Hygiene Compliance	INA	INA	64%	
Urinary Tract	1	0	0	1

Respiratory Tract	0	0	0	0
Skin and Soft Tissue	1	0	0	1
Eye, Ear, Nose & Throat	1	0	0	1
Totals	3	0	0	3
Employee Illness Trends	6 GI	2 GI	INA	
Patient Days SNF	979	921	893	

SNF-Burney Annex	October	November	December	TOTAL
Hand Hygiene Compliance	INA	INA	INA	
Urinary Tract	2	0	2	4
Respiratory Tract	0	1	0	0
Skin and Soft Tissue	3	0	0	3
Eye, Ear, Nose & Throat	0	0	0	0
Patient Days SNF	832	840	868	2540
Totals				
Employee Illness Trends	3 GI & 3 Resp	3 Resp & 3 GI	5 Gold Symptoms	

SNF-Burney Unit	October	November	December	TOTAL
Hand Hygiene Compliance	INA	INA	INA	
Urinary Tract	1	0	0	1
Respiratory Tract	1	1	0	2
Eye, Ear, Nose & Throat	0	1	0	1
Skin and Soft Tissue	0	1	0	1
Other	0	0	0	0
Patient Days SNF	604	570	523	1697
Totals	2	3	0	5
Employee Illness Trends Other Departments	12 "Flu"	3 "Sick"	9 "Sick"	24
Environmental Services Rounds with EVS Manager & IC Manager * areas identified corrected by EVS staff*	5	2	4	11
Shasta County Public Health Department Reporting	0	0	1	
Sharps Injury	0	0	0	

Blood or Body Fluid Exposure	0		0		1		
NHSN Monthly Report							
Number of PICC Days	24		0		0		24
Number of Foley Catheter Days	6		28		10		44
CAUTI	0		0		0		0
Non-catheter associated UTI	1		1		1		3
CLABSI	0		0		0		0
C-DIFF	0		0		0		0
MRSA BSI	0		0		2		2
VRE BSI	0		0		1		1
Number Cases Performed	cases	# SSI	Cases	# SSI	Cases	# SSI	
Total Shoulder	0	0	1	0	0	0	1
HIP/KNEE	2	0	2	0	0	0	4
Appendectomy	0	0	0	0	0	0	0
Cholecystectomy	1	0	0	0	0	0	1
Hernia	2	0	1	0	5	0	8
Small Bowel Resection	0	0	0	0	0	0	0
Other, Dilation & Excision of Abcess	0	0	1	1	0	0	2

*Information Not Available at Time of Report (INA)

ATTACHMENT B

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

ANTIMICROBIAL STEWARDSHIP PROGRAM

PURPOSE:

To establish an Antimicrobial Stewardship Program (ASP) at Mayers Memorial Hospital District to help optimize clinical outcome and patient safety while minimizing the unintended consequences of antimicrobial use by utilizing the available resources to ensure appropriate antimicrobial drug product selection, dosing, route of administration, and duration of therapy.

POLICY:

The purpose of this program is to establish procedures for the implementation and maintenance of an Antimicrobial Stewardship Program at Mayers Memorial Hospital District to optimize clinical outcomes and comply with the following mandates:

- California Department of Public Health, California Health and Safety Code Sections 1288.5, 1288.8 and 1288.85, requiring general acute care hospitals to develop a process for evaluating the judicious use of antibiotics to improve quality and patient safety;
- The Joint Commission's 2010 National Patient Safety Goal (07.03.01) requiring implementation of evidence-based practices to prevent health care associated infections due to multidrug resistant organisms in acute care hospitals, including by not limited to, methicillin-resistant *Staphylococcus aureus, Clostridium difficile,* vancomycin-resistant *Enterococcus*, and multi-drug resistant Gram-negative bacteria.

The Antimicrobial Stewardship Program will consist of, but not limited to, members representing infectious diseases physician, pharmacist, clinical laboratory scientist with expertise in microbiology, infection preventionist, and registered nurse. Members of the Antimicrobial Stewardship Program have the following responsibilities:

- Ensure that policies and procedures established by the Antimicrobial Stewardship Program are consistent with regulatory requirements established by the state government and professional best-practice organizations;
- Develop and review policies, procedures, and clinical guidelines related to appropriate use of antimicrobial agents;
- Evaluate effectiveness of intervention efforts, including monitoring of antimicrobial medication usage and clinical outcomes;
- Ensure that data collected is reported to the Infection Control/Antimicrobial Steward Program Committee, the Pharmacy and Therapeutics Committee, the Quality Improvement Committee, and the Medical Staff.

Antimicrobial medication use will be monitored by a pharmacist Monday through Friday for appropriate use, dose, and duration of therapy; however all members of the Antimicrobial Stewardship Program are expected to be familiar with the basic procedures and responsibilities created by this policy.

The Antimicrobial Stewardship Program will meet no less than four times a year.

PROCEDURE:

To help promote and measure the appropriate use of antimicrobial agents, optimize clinical outcomes, minimize toxicity and other adverse events associated with antimicrobial use *Clostridium difficile* diarrheal infections and the emergence of antimicrobial-resistant organisms, and improve the cost-effectiveness of antimicrobial use, the following multidisciplinary approach is performed by the Antimicrobial Stewardship Program:

1. **Adopt a specific antimicrobial stewardship policy and procedures:**

   A. The Antimicrobial Stewardship Program policy will be reviewed by the Infection Control/Antimicrobial Stewardship Program Committee, the Medicine/Pharmacy and Therapeutics Committee, the Quality Improvement/Utilization Review Committee, and the Board of Directors as needed.

2. **Have a physician-supervised multidisciplinary Antimicrobial Stewardship Program:**

   A. ~~A. J. Weinhold,~~ Tom Watson,M.D., is the physician supervising the Antimicrobial Stewardship Program at Mayers Memorial Hospital District.

3. **Support of the Antimicrobial Stewardship Program is provided by a physician or pharmacist with antimicrobial stewardship training from a recognized professional organization or post graduate education:**

   A. Keith Earnest is the pharmacist providing support for the Antimicrobial Stewardship Program at Mayers Memorial Hospital District and he has completed a Postgraduate Year One (PGY1) pharmacy residency program at an acute care institution accredited by the American Society of Health System Pharmacists (ASHP) with rotations in Infectious Diseases and Critical Care.

   B. ~~J. Weinhold~~Tom Watson, M.D. is the physician providing support for the Antimicrobial Stewardship Program at Mayers Memorial Hospital District and she has completed AMA/AOA Approved Primer on Healthcare Epidemiology Infection Control and Antimicrobial Stewardship - Course.

4. **Antimicrobial Stewardship Program activities are routinely reported to hospital quality improvement committees:**

   The following metrics will be summarized and presented to the Infection Control/Antimicrobial Stewardship Program Committee, the Medicine/Pharmacy and Therapeutics Committee, the Medical Executive Committee, and the Board of Directors, as appropriate:

- Total dollars of antibacterial used in previous two months
- Total dollars of antifungal used in the previous two months
- Number of non-formulary or restricted agents used in the previous two months
- Number of inappropriate combinations of antibiotics or redundant coverage for suspected infections in the previous two months
- Average duration of therapy defined by Days of Therapy (DOT) for each high cost drug (i.e., daptomycin, linezolid, tigecycline, and ceftaroline) in the previous two months
- Tracking of intervention

5. **Develop an annual antibiogram using Clinical and Laboratory Standards Institute guidelines, distributed to medical staff, and follow-up education is provided:**

6. **Formulary restriction with preauthorization is implemented:**

7. **Adopt the following institutional work process and empiric antibiotics of choice guidelines:**

   A. **Monday through Friday the pharmacist will use the automatic "Active Pts on Antibiotics" report printout to obtain a list of all patients actively on antimicrobial agents**
   - From the daily report the pharmacist will identify opportunities to optimize antimicrobial therapy by assessing the following parameters and using the institutional empiric antimicrobial guidelines as a reference:
     - Inappropriate choice of antibiotic for suspected infections
     - Inappropriate combinations of antibiotics or redundant coverage for suspected infections
     - Use of non-formulary or restricted agents without prior approval from pharmacy
     - Inappropriate dosing of therapy based on patient renal function
     - Inappropriate route of therapy based on patient clinical assessment for potential conversion from intravenous to oral therapy
     - Duration of therapy defined by Days of Therapy (DOT) for each high cost drug (i.e., daptomycin, linezolid, tigecycline, and ceftaroline)
     - Assess for opportunity to de-escalate therapy when culture and/or sensitives results are available
     - Number of recommendations by pharmacist to providers that are accepted
   - If current treatment plan is justified, then no intervention will be made. If there are opportunities for optimization, then the pharmacist will contact the prescriber either by telephone or in person to discuss recommendations and document all pharmacy interventions in the MASTER ASP file.

   B. **Provide Institutional Guidelines for the Management of Common Infections**
   - Pharmacist may use the institutional empiric antimicrobial guidelines established by evidence-based medicine to help standardize antibiotic usage and reinforce the principles of antimicrobial stewardship while optimizing patient care by assessing the rationale behind the current treatment regimen, including antibiotic selection, dosing, route and duration.

- The institutional empiric antimicrobial guidelines are reviewed and updated as needed by the Antimicrobial Stewardship Program members and presented for approval to the Medicine/Pharmacy and Therapeutics Committee, the Medical Executive Committee, and the Board of Directors to ensure ASP recommendations are consistent with national best-practices guidelines.

C. **Assess for Intravenous to Oral antibiotic therapy**

- From the daily report the pharmacist will review all patients on the following selected antimicrobial agents with high oral bioavailability and equivalent potency for meeting specific criteria for the therapeutic interchange from intravenous to oral therapy:

Azithromycin	Erythromycin	Ciprofloxacin
Metronidazole	Doxycyclin	Levofloxacin
Fluconazole	Sulfamethoxazole/Trimethoprim	

- The sequential therapy process will help decrease the length of hospitalization without adversely affecting patient outcome while reducing the risk of intravascular catheter infection, decreasing hospital cost and providing greater patient comfort and easier ambulation.
- If there are opportunities for intravenous to oral conversion, the pharmacist will contact the prescriber either by telephone or in person to discuss recommendations and document all pharmacy interventions.

D. **Assess for Renal Dose Adjustment**

- From the daily report the pharmacist will identify opportunities for patients with renal insufficiency to ensure safe and efficacious dosing regimens for the following selected antimicrobial agents and contact the prescriber either by telephone or in person to discuss renal dose adjustment recommendations and document all pharmacy interventions.

Antimicrobial Agents		
Acyclovir	Cefpodoxime	Meropenem
Amoxicillin	Ceftazidime	Nitrofurantoin
Amoxicillin/Clavulanate	Cephalexin	Oseltamivir
Ampicillin	Ciprofloxacin (PO/IV)	Penicillin G and VK (IV/PO)
Ampicillin/Sulbactam	Clarithromycin	Piperacillin/Tazobactam
Cefazolin	Daptomycin	Tetracycline
Cefepime	Fluconazole (IV/PO)	Trimethoprim/Sulfamethoxazole (PO/IV)
Cefotaxime	Gentamicin	Valacyclovir (IV/PO)
Cefotetan	Imipenem/Cilastatin	Vancomycin
Cefoxitin	Levofloxacin (IV/PO)	

- Renal function assessment is based on calculated creatinine clearance using Crockcroft-Gault equation. Pharmacist will assess indication, renal function (serum creatinine and estimated

creatinine clearance), and isolates (if available) on all patients on the selected antimicrobial agents listed above.

- Determine Patient's Dosing Weight: Performed automatically in Paragon.
- Determine Patient's Estimated Creatinine Clearance: Performed automatically in Paragon.
- For patient's on dialysis, determine the type of dialysis method:
  - Hemodialysis (HD)
  - Peritoneal Dialysis (PD)
  - Continuous Venovenous Hemofiltration (CVVH)
  - Continuous Venovenous Hemodialysis (CVVHD)
- Refer to Lexicomp or MICOMEDEX for renal dose adjustment guidelines.

REFERENCES

Lexi-Comp ONLINE [Internet Database]. Hudson, OH: Lexi-Comp Inc. 1978 – [cited 2015 May 12]. Available from: http://online.lexi.com

MICOMEDEX Healthcare Series [Internet Database]. Greenwood Village, CO: Thomson Reuters Inc. 1974 – [cited 2015 May 12]. Available from: http://www.thomsonhc.com

Pablos AI, Escobar I, Albinana S, Serrano O, Ferrari JM, Herroeros de Tejada A. Evaluation of an antibiotic intravenous to oral sequential therapy program. *Pharmacoepidemiology and drug safety.* Jan 2005; 14(1):53-59.

COMMITTEE APPROVALS:

IC: 7/26/16
Quality:

Appendix A: Formulary Drug Addition, Deletion, and One-Time/Patient Specific Use

- ☐ Request for Formulary Drug Addition
- ☐ Request for Formulary Drug Deletion
- ☐ Request for One-Time/Patient Specific Use

Please fill in all information below:

Drug generic name:	Drug brand name:
Dosage form:	Strength:
Therapeutic indications:	Similar existing formulary drugs:
Reason for using this drug as opposed to existing formulary medication:	
If applicable, state the reason the request medication should replace the existing formulary drugs:	
Requesting physician:	Date of request:

Please return completed form to the Pharmacy Department at fax (530)336-6201. Email questions to kearnest@mayersmemorial.com

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FOR PHARMACY USE ONLY: ☐ High Risk Medication

Action taken by the Pharmacy and Therapeutics Committee:

Chairman of Pharmacy and Therapeutics Committee Date

AppendixB: Suggested Empiric Antimicrobial Agents of Choice 2015

Note: All medications list may not be on the formulary

Aspiration Pneumonia
Ceftriaxone 2g IV Q24H (CAP), PLUS Metronidazole 500mg IV Q6H. OR Zosyn 3.375g IV Q6H. CONSIDER adding Vancomycin 20mg/kg IV LD (then per Pharmacy Protocol) OR Linezolid 600mg IV Q24H.

Community-Acquired Pneumonia (CAP)
Non-ICU: *Option 1:* Ceftriaxone 2g IV Q24H, PLUS Azithromycin 500mg IV/PO Q24H or Doxycycline 100mg IV/PO Q24H *Option 2:* Levofloxacin 750mg IV/PO Q24H **ICU:** *Option 1:* Ceftriaxone 2g IV Q24H PLUS Azithromycin 500mg IV Q24H *Option 2:* Ceftriaxone 2g IV Q24H PLUS Levofloxacin 750mg IV Q24H * If CA-MRSE infection suspected (e.g. post-influenza, drug use or colonization), CONSIDER adding Vancomycin 20mg/kg IV LD (the per Pharmacy Protocol) OR Linezolid 600mg IV Q24H.

Healthcare Associated Pneumonia (HCAP)
Zosyn 3.375g IV Q6H OR Imipenem 500mg IV Q6H, PLUS Vancomycin 20mg/kg IV LD (then per Pharmacy Protocol) OR Linezolid 600mg IV Q12H. CONSIDER addition of Levofloxacin 750mg IV Q24H or Tobramycin per Pharmacy Protocol for additional Gram negative coverage. * Linezolid RESTRICTED to cases with proven MRSA infection or high risk (E.g. MRSA colonization). MUST discontinue Linezolid at 48H if no MRSA in culture. * Treatment length for HCAP 8 days (14 days preferred if documented *Pseudomonas* or *Acinetobacter*). * HCAP is defined as pneumonia with onset 48 hours after hospital admission. Other risk factors: hospitalization for ≥2 days in the preceding 90 days, home infusion therapy, chronic dialysis within 30 days, home wound care, family member with MDR pathogen.

Complicated Skin and Soft Tissue Infections
Cellulitis/Abscess: *For Strep:* Penicillin G 2-3 million units IV Q4H, PLUS Clindamycin 600mg IV Q8H. *Unknown/Staph:* Nafcillin 2g IV Q4H OR Cefazolin 1g Q8H OR Vancomycin 20mg/kg IV LD (then per Pharmacy Protocol) OR Ceftaroline 600mg IV Q12H. **Wound Infection:** Vancomycin 20mg/kg IV LD (then per Pharmacy Protocol), PLUS Ceftriaxone 2g IV Q24H OR Zosyn 3.375g IV Q6H OR Levofloxacin 750mg IV Q24H. *Alternative:* Ceftaroline 600mg IV Q12H

Appendix B: Suggested Empiric Antimicrobial Agents of Choice 2015 cont.

Complicated Skin and Soft Tissue Infections cont.
<u>Diabetic/Ischemic Foot Infection:</u> *Option 1:* Levofloxacin 750mg IV Q24H OR Ceftriaxone 2g IV Q24H OR Cefepime 2g IV Q12H PLUS Metronidazole 500mg IV Q8H OR Clindamycin 600mg Q8H. *Option 2:* Zosyn 3.375g IV Q6H Each option, CONSIDER adding Vancomycin 20mg/kg IV x 1 (then per Pharmacy Protocol).

Complicated Intra-Abdominal, Biliary Tract, Pancreatitis
A. <u>Community-Acquired/Normal Host:</u> *Preferred:* Ceftriaxone 2g IV Q24H, PLUS Metronidazole 500mg IV Q8H *Alternative:* Levofloxacin 750mg IV Q24H, PLUS Metronidazole 500mg IV Q8H *Alternative:* Tigecycline 100mg IV x 1, then 50mg IV Q12H **B. <u>Community-Acquired/Compromised Host/High Severity:</u>** *Option 1:* Zosyn 3.375g IV Q6H *Option 2:* Cefepime 2g IV Q12H PLUS Metronidazole 500mg IV Q8H **C. <u>Healthcare Associated:</u>** Same as "B", PLUS CONSIDER adding Vancomycin 20mg/kg IV LD (then per Pharmacy Protocol) **D. <u>Type 1 Hypersensitivity Penicillin Allergy:</u>** Tigecycline 100mg IV x 1, then 50mg IV Q12H, PLUS Levofloxacin 750 IV Q12H (if "B" or "C" above). **E. <u>Pancreatitis:</u>** Routine prophylactic IV Imipenem on admission is not recommended (Ann Surg 2007;245:674). Antibiotics indicated only if admission/repeat CT shows ≥ 30% pancreatic necrosis.

Sepsis of Unknown Etiology
<u>Community-Acquired/Normal Host:</u> Levofloxacin 750mg IV Q24H or Gentamicin (5-7mg/kg), PLUS Ceftriaxone 2g IV Q24H, PLUS Vancomycin 20mg/kg IV LD (then per Pharmacy Protocol). **<u>Healthcare Associated/Compromised Host:</u>** Levofloxacin 750mg IV Q24H or Tobramycin (5-7mg/kg IV), PLUS Zosyn 3.375g IV Q8H OR Cefepime 2g IV Q12H, PLUS Vancomycin 20mg/kg IV LD (then per Pharmacy Protocol).

Appendix C: Intravenous to Oral Conversion Guidelines

Inclusion Criteria	✓ Patients improving clinically ✓ Tolerating food or enteral feeding (diet ordered or tolerating ≥ 60% goal tube feeds) ✓ Able to adequately absorb oral medications via the oral, gastric tube, or nasogastric tube route ✓ Not displaying signs of shock, not on vasopressor blood pressure support ✓ Tolerating other medications orally **Additional requirement for Anti-infective Agents:** ✓ Afebrile for at least 24 hours (temperature ≤ 100°F or ≤ 37.8°C) ✓ Signs and symptoms of infection improved with improving or stable WBC
Exclusion Criteria	✓ Persistent diarrhea, nausea and/or vomiting ✓ Patient with the following GI conditions: • Ileus or suspected ileus with o active bowel sounds • History of malabsorption syndrome • Proximal resection of small intestines • High nasogastric tube output or requiring GI suctions > 500mL/day • Active GI bleed ✓ Cystic fibrosis ✓ Moderate to severe mucositis **Additional requirements for Anti-infective Agents:** ✓ Patient has a serious or life threatening infection: • Meningitis, endocarditis, intracranial abscess, osteomyelitis, septicemia • Inadequately drained abscesses • Severely immunocompromised (e.g. AIDS, solid organ transplant, bone marrow transplant)

Anti-Infective Regimens	Equivalent Oral Regimens
Azithromycin 250 mg IV Q24H	Azithromycin 250 mg PO Q24H
Azithromycin 500 mg IV Q24H	Azithromycin 500 mg PO Q24H
Ciprofloxacin 200 mg IV Q24H	Ciprofloxacin 250 mg PO Q24H
Ciprofloxacin 200 mg IV Q12H	Ciprofloxacin 250 mg PO Q12H
Ciprofloxacin 400 mg IV Q24H	Ciprofloxacin 500 mg PO Q24H
Ciprofloxacin 400 mg IV Q12H	Ciprofloxacin 500 mg PO Q12H
Ciprofloxacin 400 mg IV Q8H	Ciprofloxacin 750 mg PO Q12H
Clindamycin 300 mg IV Q8H	Clindamycin 300 mg PO Q8H
Clindamycin 300 mg IV Q6H	Clindamycin 300 mg PO Q6H
Doxycycline 100 mg IV Q12H	Doxycycline 100 mg PO Q12H
Erythromycin 500 mg IV Q6H	Erythromycin 500 mg PO Q6H
Erythromycin 1000 mg IV Q6H	Erythromycin 500 mg PO Q6H
Fluconazole 100 mg IV Q24H	Fluconazole 100 mg PO Q24H
Fluconazole 200 mg IV Q24H	Fluconazole 200 mg PO Q24H
Fluconazole 400 mg IV Q24H	Fluconazole 400 mg PO Q24H
Fluconazole 800 mg IV Q24H	Fluconazole 800 mg PO Q24H
Levofloxacin 750 mg IV Q24H	Levofloxacin 750 mg PO Q24H
Metronidazole 250 mg IV, frequency	Metronidazole 250 mg PO, same frequency
Metronidazole 500 mg IV, frequency	Metronidazole 500 mg PO, same frequency
Trimethoprim/Sulfamethoxazole 5-15 mg TMP/kg/day IV	Trimethoprim/Sulfamethoxazole 5-15 mg TMP/kg/day PO

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY & PROCEDURE

CONTROLLED SUBSTANCE STORAGE RECEIVING, TRACKING AND DOCUMENTING

ORIGINATING DATE: 06/25/09
REVIEW DATE:
REVISION DATE:
MANUAL(S): SNF, Pharmacy

DEFINITION:
For all intents and purposes, the word "patient(s)" refers to all customers receiving health care services in our facilities, including inpatients, outpatients, residents and clients.

Controlled Substance: scheduled drugs (CII - CV), antibiotics, muscle relaxants, tramadol and any other substance the DON deems to be high risk for diversion.

POLICY:
Receiving and tracking of controlled substances is done in a consistent manner to prevent and detect diversion.

PROCEDURE:

1. Receiving (Narcotic Delivery Form)
    a. Open medication box. If controlled substances are present, find the Narcotic Delivery Form.
    b. Reconcile all controlled substances received with controlled substances sent.
    c. Verify receipt by signing the Narcotic Delivery Form.
    d. Have the Charge Nurse verify receipt by co-signing the form.
    e. Copy the form and retain
    f. Return the signed original to the pharmacy.
2. Narcotic Count Sheets
    a. Complete a Narcotic Count Sheet for each cassette.
    b. Controlled substance cassettes are labeled (1 of 2, 2 of 2, etc.) if more than 30 tablets are filled.
    c. Be sure to document the cassette number (e.g., 1 of 2) on the Narcotic Count Sheet.
3. Disposition of Cassettes
    a. Determine which cassettes will be stored in the medication cart and which cassettes will be stored in the storage box.
    b. Note: Only the Charge Nurse has access to the storage box. Cassettes are added or removed by the Charge Nurse and a witnessing nurse.
4. Storage Box (located in Med Room)

a. For each cassette added, document the following on the storage count sheet.
    i. Resident name
    ii. Drug
    iii. Cassette number
    iv. Total cassettes of that drug
b. The entire contents of the storage box is inventoried with each opening.
c. Document the inventory on the storage count sheet
d. The count sheets for each storage cassette are kept in a separate binder in the med room and transferred with the cassette when the cassette is moved to the cart.
e. A green lock is removed with each opening and a new lock is replaced when the box is locked.
f. Document the lock number removed/replaced on the storage count sheet
g. The green lock number is verified and documented on the cart medication book with each key transfer.

COMMITTEE APPROVAL(S):

P & P: 10/21/09
Quality: 11/17/09

Author: KE
File/Path Name: P:\Policies and Procedures\Pharmacy\Controlled Substance Storage.doc

MAYERS MEMORIAL HOSPITAL DISTRICT
DISCHARGE PLANNING RECORD

Admit Date: ____________
Status: Acute/Swing
Chief Complaint:______________________________Medical Insurance: ____________

Admitting Diagnosis: ____________________________Medical Insurance : ____________

Lives with: ____

Known Pre-admission services: ____

Family Contact: ______________________________Telephone: __________________

Conserved? Name: ____________________________DPOA:______________________

Discharge Concerns: Dietary/Financial/Environment/Substance Abuse/Mental Health/Abuse-Neglect/Educational-Cultural. Describe: ____

____

____

____

Referrals: Agency____________________Contact____________________Date________

Discharge Goal: ____

Disposition after discharge: ☐ Swing ☐ MSNF ☐ SNF ☐ Home ☐ Other: __________

____

SNF Administrator notified: Contact________________________Date______________

Discharge Planner: __________________________________Date: ________________

ADDITIONAL NOTES/COMMENTS/ACTION:

(Including: date, time, who, what, when, where, why, how often, name and phone number(s) of contacts)

____

____

____

____

____

Patient Identification Label

MAYERS MEMORIAL HOSPITAL DISTRICT
DISCHARGE PLANNING RECORD

ADDITIONAL NOTES/COMMENTS/ACTION (con't)
(Including: date, time, who, what, when, where, why, how often, name and phone number(s) of contacts)

Patient Identification Label

MAYERS MEMORIAL HOSPITAL DISTRICT

ENDORSEMENTS

, MD, has applied for provisional medical staff appointment and privileges in **{Specialty}.** Appropriate documents have been submitted, reviewed and substantiated.

MEDICAL EXECUTIVE COMMITTEE RECOMMENDATIONS:

☐ Appointment recommended based on review of his individual character, professional performance, experience, judgment and clinical and/or technical skills, as well as his additional training, i.e., Continuing Medical Education (CME) courses.

☐ Appointment **not** recommended based on: ______________________________

____

____

____

____

______________________________ ______________
Chief of Staff - A. J. Weinhold, MD Date

BOARD QUALITY COMMITTEE RECOMMENDATION:

BOARD QUALITY COMMITTEE RECOMMENDATION TO BOD: Upon review, the appropriate documents have been submitted, reviewed and substantiated. Based on recommendation of the Medical Executive Committee and evaluation of the education, training, experience, demonstrated professional competence and judgment, and clinical performance (as confirmed by peers knowledgeable of the applicant's professional performance), BQC:

☐ Concurs ☐ Does NOT concur with the Medical Executive Committee's recommendation.
☐ Back to Medical Staff for to clarify the following:

____

____

____
Board Quality Committee (Signature) Date

GOVERNING BOARD:

☐ **GRANTS** ☐ **DOES NOT GRANT** ______________ **PRIVILEGES**

______________________________ ______________
Board President Date

Approvals: MEC: 1/11/17

MAYERS MEMORIAL HOSPITAL DISTRICT

DATE:

Where multiple choices are provided, only checked boxes apply

	NURSES NOTES
NEURO: **LOC** ☐ Alert ☐ Cooperative ☐ Lethargic ☐ Comatose **Orientation** ☐ Person/place/time ☐ Confused **Speech** ☐ Clear ☐ Slurred ☐ Aphasic **Responds to** ☐ Spontaneous ☐Voice ☐ Touch/pain **Pupils** ☐ PERRLA ☐ Sluggish ☐ Unequal	
CARDIOVASCULAR: **Pulse** ☐Regular ☐ Irregular (Apical/Radial) ☐ Murmer **Color** ☐ Normal for skin type ☐ Other: ____________ **Edema** ☐Absent ☐Non-Pitting ☐ Pitting: + ________ **Skin Temp** ☐Hot ☐Warm ☐Cool ☐Dry ☐Diaphoretic **Using** ☐ DVT Cuffs ☐ TED Hose **Monitor/Telemetry** (Rhythm):	
RESPIRATORY: **Respirations** ☐ Even/Unlabored ☐ SOB **Breath Sounds** ☐ Clear ☐ Wheezes ☐ Crackles ☐ Decreased **Cough** ☐ None ☐Productive ☐Non-productive **Incentive Spirometry:** q ___hours w/a **O2** ________liters/min via: ☐NC ☐Mask **Chest Tube** ☐ N/A ☐ Left ☐ Right **Sputum:** (Describe)	
MUSCULO-SKELETAL: **Movement of Extremities** ☐ Equal ☐ Weak ☐ Paralysis: L R **CSMP** = ☐ positive ☐ negative **Gait** ☐ Steady ☐ Unsteady **Uses:** ☐ WC ☐ Cane ☐ Walker **Grips** ☐ Equal ☐ Strong ☐ Weak ☐ Flaccid **Ice/Heat:** (Describe) ☐ Polar Care/ice pack ☐ Bair/k-pad **Ambulation:** ________times ☐ independent ☐ 1 or 2 assist **Distance:** __________ feet (circle)	
GASTRO-INTESTINAL: **Abdomen** ☐ Soft ☐Firm ☐Distended ☐Tender **Bowel Sounds** ☐ Active☐ Hyperactive ☐Hypoactive ☐Absent **Motility** ☐Nausea ☐Vomiting ☐Flatus **BM** ☐ Normal ☐Constipation ☐ Diarrhea ☐ Incontinent **NG Suction** ☐Intermittent ☐Continuous ☐ Clamped **NG Drainage** ☐ Color:____________________ **Colostomy Stoma** ☐ Intact ☐Reddened ☐Excoriated	
GENITO-URINARY: **Bladder** ☐Non-distended ☐ Distended ☐Void ☐ Incontinent **Urine** ☐ Clear ☐ Cloudy ☐ Color______________ **Catheter** ☐ None ☐ Foley ☐ Brief ☐ Urostomy **Other** ☐Vaginal Discharge ☐ Menses ☐ Penile Discharge **Specimen sent** ☐ UA	

Patient Identification Label

PATIENT ASSESSMENT RECORD

Attached to policy Assessment & Reassessment of the Medical/Surgical Patient

MAYERS MEMORIAL HOSPITAL DISTRICT

DATE:

Where multiple choices are provided, only checked boxes apply

IV STATUS:

Site ☐ Peripheral ☐ Saline Lock ☐ Central ☐ PICC

Location: ____________________

Condition: ☐ intact ☐ re-started

Dressing: ☐ Dry/intact ☐ Changed

Pump: ☐ Alaris

Stryker: __________ml out; **Transfused:** __________ml in

SKIN:

☐ Intact ☐ Wound ☐ Incision ☐ Other: __________

WOUND ☐ N/A ☐ Wound Location __________

Dressing: Type__________ ☐ Changed x ____

WOUND APPEARANCE

Drainage: Amt/Type:__________

Incision: ☐ N/A ☐ Closed ☐ Staples ☐ Steri-strips ☐ Sutures

Surrounding skin: ☐ Intact ☐ Other : __________

Tubes/drains: Describe: __________

NUTRITION:

Diet Type ☐ NPO ☐ TPN ☐ Oral Diet: __________

Feeds: ☐ Self ☐ Partial Assist ☐ Total Assist

Enteral Feeding Route: NG-Tube G-Tube J-Tube Formula: __________ Strength: __________

☐ Bolus ☐Continuous ☐ Pump

Residual Check Performed: ☐ Yes ☐ Amount: ________

Patency Check: ☐ Patent ☐ Not-patent, flushed

SHIFT REASSESSMENT @ _______ ☐ **NO CHANGE, or**

Comments: __________

____

____

____

PAIN: **Pain Scale: No Pain 0-1-2-3-4-5-6-7-8-9-10 Worst Pain**

Time	Pain Level	Medication given	Pain Level

NURSES NOTES

____

SAFETY:

Morse Fall Scale #:

☐ No Risk

☐ Low Risk - Standard Fall Precautions Implemented

☐ High Risk – High Risk Precautions Implemented

Bed in low position/wheels locked ☐ Call light in reach

☐ PCA Pump Used

Signature: **Time:**

APPROVALS: OP Med: 7/12/12; M/P&T: 8/1/13; P&P, 9/4/13

Permanent Part of Medical Record

Patient Identification Label

PATIENT ASSESSMENT RECORD

Attached to policy Assessment & Reassessment of the Medical/Surgical Patient

Mayers Memorial Hospital

TO: Patients, Residents, Family Members and/or Visitors

It is our desire that you be treated in a caring, respectful manner. We will make every effort to meet your expectations of care and service in a timely, reasonable and consistent manner. If we fail to meet your expectations, please take a moment to let us know.

To report your concern, ask to speak to the nursing supervisor or hospital administration. They will work to resolve the complaint or describe the actions necessary to pursue resolution. Our goal is to handle complaints quickly - within 1 business day

If a previous complaint about care was not resolved or involved issues of abuse, neglect or noncompliance with the Centers for Medicare and Medicaid Services and/or Hospital Conditions of Participation, you may wish to file a more formal complaint. These types of complaints can take up to seven (7) days to resolve.

- Request a "Grievance Form" from Administration, the Performance Improvement Office, and/or SNF (Skilled Nursing Facility).
- Complete and deliver (or request assistance in delivering) the form to one of the above mentioned department(s).
- To make a verbal complaint, ask to speak to the nursing supervisor or hospital administration at 336-5511, extension 1141

If you choose, you may also voice your concern/complaint anonymously by calling the Mayers Memorial Hospital **HOTLINE** at **530-336-5511, extension 1141**

You also have the right to file a complaint with any (or all) of the following organizations:

- California Department of Health Services, Licensing & Certification
  Chico District Office
  1367 E. Lassen Avenue, #B-1
  Chico, CA 95926
  Phone: 530-895-6711 or
  800-554-0350
- Medicare
  State Number:
  805-383-2038
  San Francisco, California

  Federal Number:
  410-786-5994
  Baltimore, Maryland
- Long-Term Care Ombudsman:
  530-223-6191 or
  800-231-4024
  Redding, California

Reference: §482.13(a)(2)
Form - Reporting Concerns and/or Filing a Grievance
01/26/2017

THE CARING STAFF OF MAYERS MEMORIAL HOSPITAL FEEL HONORED WHEN WE RECEIVE COMPLIMENTS FROM OUR PATIENTS AND/OR THEIR FAMILY MEMBERS AND FRIENDS

♦♦♦♦♦♦♦♦♦♦♦♦♦♦

WE ALSO APPRECIATE IT WHEN SOMEONE TAKES THE TIME TO LET US KNOW HOW WE COULD HAVE IMPROVED THEIR VISIT.

♦♦♦♦♦♦♦♦♦♦♦♦♦♦

IF YOU HAVE A CONCERN ABOUT THE CARE YOU RECEIVED, PLEASE BRING IT TO OUR ATTENTION BY ANY OF THE METHODS WE HAVE OUTLINED IN THIS BROCHURE.

MAYERS MEMORAL HOSPITAL WANTS TO KNOW IF YOU ARE NOT SATISFIED WITH THE CARE/TREATMENT YOU RECEIVED.

IF WE FAILED TO MEET YOUR EXPECTATIONS, PLEASE ASK TO SPEAK WITH A NURSING SUPERVISOR OR HOSPITAL ADMINISTRATION.

A COMPLAIN IS CONSIDERED RESOLVED ONLY AFTER YOU ARE SATISFIED WITH THE ACTION(S) TAKEN ON YOR BEHALF.

FURTHER INFORMATION IS AVAILABLE IN THIS HANDOUT.

MMH

Mayers Memorial Hospital

REPORTING CONCERNS AND/OR FILING A GRIEVANCE

Mayers Memorial Hospital
P.O. Box 459
43563 State Highway 299 East
Fall River Mills, CA 96028

530-336-5511, Extension 1141
Quality Improvement Department

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

UTILIZATION REVIEW AND DISCHARGE PLANNING

Page 1 of 4, plus the following attachment(s):
Discharge Planning Record – MMH228
Concurrent Review Worksheet –MMH229
Notice of Medicare Provider Non-Coverage – Form No. CMS-10123

DEFINITION:

Patient: For all intents and purposes, the word "patient(s)" refers to all customers receiving health care services in our facilities, including inpatients, outpatients, residents and clients.

Discharge Planning: "A process used to decide what a patient needs for a smooth move from one level of care to another (Medicare)." A discharge plan is a careful review of all the options a patient has for a "safe and adequate discharge" as is required by Medicare
This process is ideally an interdisciplinary, on-going process beginning before or at the time of admission. The discharge planning process does not require a physician's order, however only a physician can authorize a hospital discharge or transfer to another level of care.
The plan encompasses the patient's needs and is the result of, but not limited to, information obtained at the time of admission, the nursing assessment, the admission and concurrent reviews, the physician, patient and family.
Discharge planning is a short-term plan to get the patient out of the hospital or to another level of care but not a blueprint of the future. Patient/families are encouraged to make long-term plans for themselves/loved ones in the event that care needs exceed the family/caregiver resources (e.g., placement in skilled nursing facility).

Discharge Planner: A nurse, social worker, administrator or other professional who is responsible to ensure a "safe and adequate discharge".

"Safe and Adequate": Medicare requires that discharges from hospitals be "safe and adequate". This means that the patient must not be discharged to a situation that presents with immediate dangers to their health and well-being and that arrangements have been made for appropriate follow-up care.
Family Caregiver: a person who helps someone who is ill, disabled, or elderly. "Family" includes both relatives and friends. Help may be direct care, household help, financial assistance, management of other services, emotional support, and other responsibilities.

POLICY:

The Utilization Review/Discharge Plan at Mayers Memorial Hospital District (MMHD) assures a monitoring system for the effective and efficient utilization of available health care resources and ensures a safe and adequate discharge. The Discharge Planner collaborates with Adult Protective Services, the County Public Guardian's Office, and Law Enforcement Agencies, as necessary, to arrange placement or services for patients who are victims of abuse/neglect that present at the hospital.

Mayers is licensed to provide care to patients via several different modes or *Levels of Care*, including Outpatient, Observation, Inpatient, Swing and Skilled Nursing. All admissions, concurrent stays and discharges are reviewed for appropriateness of levels of care and the treatment authorization and continued stay requirements of Medicare, Medi-cal, and other payors. Source of payment is not a determinant for review.

As Mayers is a Critical Access Hospital, and therefore not under the Prospective Payment System but rather fee-for-service, patient admissions and lengths of stays are determined by the attending physician, in collaboration with hospital staff, based on patient need and insurance criteria for lengths of stay.

The Quality Improvement Committee has the authority and responsibility to ensure that the Utilization Review Plan is carried out. The Quality Improvement Committee reports to the Medical Executive Committee, Governing Board and Administration any issues/problems/ concerns related to Utilization Review, as the Committee deems appropriate.

PROCEDURE:

1. A multi-disciplinary team reviews all inpatients and observation patients daily (Monday-Friday) and discusses appropriateness of services being provided and discharge planning needs.
2. Based on the discussion of the team and a focused review of the medical record, as appropriate, the Discharge Planner assesses the discharge planning needs of the patient and family as early as possible and works with the attending physician to facilitate transfer to appropriate levels of care, including discharge. This planning is documented on the *Discharge Planning Record* – MMH228 and is a permanent part of the medical record (see attached).
3. The Discharge Planner/Utilization Review Coordinator communicates with insurance companies, Medicare, and Medi-cal personnel as necessary to provide them with clinical updates, initial and concurrent reviews, and other needed information as requested to facilitate payment on behalf of the patient for the hospital stay. These discussions are documented on the Mayers *Utilization Review/Discharge Planning Concurrent Review Worksheets*—MMH229, which are not a part of the permanent medical record and are kept by the Discharge Planner (see attached).

4. The discharge planner may give a written notice of "Hospital-Issued Notice of Non-Coverage" (HINN) (*Notice of Medicare Provider Non-Coverage,* see attached) when it appears that the care the patient is receiving is
   a. Not medically necessary;
   b. Not delivered in the most appropriate setting;
   c. Is custodial in nature.
5. Patients/families can appeal any discharge decision. Patients/families are given "An Important Message from Medicare" upon admission by the business office that explains their rights. This has the number of the local Peer Review Organization (PRO) that will review a case that the patient/family wishes to appeal. The appeal has to be made by the family as soon as the HINN is given. Other insurance companies have similar appeals processes.
6. Discharge planner, social worker and nursing staff shall direct patient/family to the Business Office for financial arrangements for all "private pay" patients.
7. Working with the patient/family, the discharge planner (and nursing staff) can arrange for needed durable medical equipment and oxygen; specialized training for family caregivers; skilled nursing facility information; and referral to other resources that may assist with patient/caregiver needs, such as In-home Support Services; and transportation home.
8. The discharge planner may facilitate patient/family conferences that discuss:
   a. The patient's condition, and any changes that may have occurred as a result of treatment at the hospital.
   b. Any likely symptoms, problems, or changes that may occur when the patient is home.
   c. The patient's care plan, the caregiver's needs, and any adjustments that must be made to meet these needs.
   d. The potential impact of caregiving on the caregiver; warning signs of stress; techniques for reducing stress.

REFERENCES:

A Family Caregiver's Guide to Hospital Discharge Planning. National Alliance for Caregiving and the United Hospital Fund of New York.

Quality Improvement Organization Manual . Chapter 7: Denials, Reconsiderations, Appeals. Centers for Medicare and Medicaid Services. (7/18/03).

Discharge Planning for the Older Adult. DHHS, National Guideline Clearinghouse (2003).

COMMITTEE APPROVALS:

M/P&T: 10/12/2016
HIM:
QA: