AGENDA

CONTRA COSTA COUNTY Medical Services (CCRMC) Joint Conference Committee

Monday, July 28, 2025 **1:00 PM** **Location: Building 1 Conference Room, Contra Costa Reg. Med Center - 2500 Alhambra Ave.,Martinez | https://cchealth.zoom.us/j/93778341474 | Call in: +16465189805,,93778341474# Or Office of Supervisor Gioia or Supervisor Carlson (see notes for location)**

Office of Supervisor Gioia, 11780 San Pablo Ave., Suite D, El Cerrito, CA 94530
Office of Supervisor Carlson, 2255 Contra Costa Blvd., Suite 202, Pleasant Hill, CA 94523

Agenda Items: Items may be taken out of order based on the business of the day and preference of the Committee

1. Roll Call and Introductions

Voting Board of supervisors: Chair Supervisor John Gioia, Vice Chair Supervisor Ken Carlson; Medical executive committee members: Dr. Tarun Bhandari, Dr. Dayana Carcamo-Molina;

Non-voting: CCRMC Medical Staff President Dr. Sarah Mcneil; CCRMC past medical staff president Dr. Kristin Moeller; Contra Costa Interim Director Health Services Dr. Ori Tzvieli; Chief Financial Officer Brian Buchanan; CCRMC Chief Executive Officer David Culberson; CCRMC Chief Medical Officer Dr. Sergio Urcuyo; CCRMC Interim Chief Nursing Officer Helena Martey, RN; Shannon Abella CCRMC Interim Chief Operations Officer

2. Approval of Minutes - May 27, 2025 **25-3044**

Attachments: II. CCRMC JCC Minutes 05.27.25

3. Public Comment

At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to two minutes or less. Under State law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Board consideration.

4. Administrative Update **25-3045**

Attachments: IV. A - CAPH Federal Medical Update
IV. B - Finance Report - July
IV. C - HR Work Group Update
IV. D - Parking Structure Update
IV. E - CCRMC Seismic Project
IV. F - Hospital & Health Centers Operations Update
IV. G - Operational Agenda & Policies

Erica Murray, MPA, President and CEO California Association of Public Hospitals and Health Systems (CAPH); Cecilia Arriera, Interim Deputy CFO; David Culberson, Chief Executive Officer, Contra Costa Regional Medical Center and Health Clinics; Leah Carlon, MPH, CPHRM, Health Care Risk Manager

5. Medical Staff Update **25-3040**

Attachments: V. A - Medical Staff General Updates (informational only)
V. B - CCRMC JCC Expedited Priveleges Subcommittee Members
V. C - CCRMC JCC Expedited Privileges - new applicant approvals
V. D - Patient Care Agenda & Policies 7-28-25

Sarah McNeil, MD, Medical Staff President

6. Quality and Safety Update **25-3041**

Attachments: VI. A - Regulatory Review

Roberto Vargas, MPH, CPHQ, LSSBB, Director of Safety and Performance Improvement

7. Adjourn

8. The next meeting is currently scheduled for Monday September 22, 2025 1:00pm-3:00pm PST.

The Committee will provide reasonable accommodations for persons with disabilities planning to attend the Committee meetings. Contact the staff person listed below at least 72 hours before the meeting. Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the County to a majority of members of the Committee less than 96 hours prior to that meeting are available for public inspection at Building 1 at Contra Costa Regional Medical Center, 2500 Alhambra Ave, Martinez, CA 94553 during normal business hours. Staff reports related to items on the agenda are also accessible online at www.contracosta.ca.gov. Public comment may be submitted via electronic mail on agenda items at least one full workday prior to the published meeting time.

For Additional Information Contact: Corticha Flucus Corticha.Flucus@cchealth.org

1025 ESCOBAR STREET
MARTINEZ, CA 94553

CONTRA COSTA COUNTY

Staff Report

File #: 25-3044 **Agenda Date:** 7/28/2025 **Agenda #:** 2.

Advisory Board: Medical Services (CCRMC) Joint Conference Committee
Subject: Approval of Minutes - May 27, 2025
Presenter: Chair - Supervisor John Gioia

Information: Approval of Minutes - May 27, 2025

Recommendation(s)/Next Step(s):
Approval of Minutes - May 27, 2025

CONTRA COSTA HEALTH

JOINT CONFERENCE COMMITTEE

MINUTES

May 27, 2025 from 1:00 – 3:00 PM
Contra Costa Regional Medical Center
2500 Alhambra Avenue, Martinez, CA – Building 1 First Floor Conference Room

VOTING MEMBERS PRESENT: Supervisor John Gioia, District I; Supervisor Ken Carlson, District IV; Dayana Carcamo-Molina MD; Tarun Bhandari MD; NON-VOTING MEMBERS PRESENT: David Culberson, Chief Executive Officer; Sergio Urcuyo, MD, Chief Medical Officer; Sarah McNeil MD, Medical Staff President; Helena Martey RN, Interim Chief Nursing Officer; GUESTS PRESENT: Andrea Sandler MD, Associate Ambulatory Care Medical Director, Director of Ambulatory Nursing Operations Gabriela Sullivan MD, Ambulatory and Specialty Medical Director; Nancy Hendra RN, Director of Ambulatory Care Nursing Infection Prevention & Control Program; Jasmin Contreras RN, Director, Safety and Performance Improvement; Leah Carlon, Health Care Risk Manager, Safety & Performance Improvement; Emily Parmenter, Strategic Initiatives, Garibay, Lieutenant Chief of Security; Julia Surges, Corticha Flucus

AGENDA ITEM	ACTION
I. **CALL TO ORDER AND INTRODUCTIONS** Meeting Chair – Supervisor John Gioia, District I • Meeting called to order at **1:00 PM** by Supervisor Gioia • Location of meeting at three locations under the Brown Act: CCRMC Building 1 Conference Room; Supervisor Carlson office in Pleasant Hill; Public may attend meeting remotely VIA Zoom Webinar or Call In. • Agenda has been posted outside Supervisors' offices and CCRMC. Public is invited to attend publicly or remotely.	Inform
II. **APPROVAL OF MINUTES – March 24, 2025** Supervisor Gioia *In open session, voting members of Contra Costa Regional Medical Center Joint Conference Committee voted to accept the March 24, 2025 Joint Conference Committee minutes.* No public comment.	Motion: By: Carlson Seconded by Carcamo-Molina Ayes: Gioia, Carlson, Carcamo-Molina Abstain: None
III. **PUBLIC COMMENT** Supervisor Gioia *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to two minutes or less. Under State law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Board consideration.* No public comment.	Inform

IV. **ADMINISTRATIVE UPDATE** David Culberson, Chief Executive Officer, Contra Costa Regional Medical Center and Health Clinics; Roberto Vargas, MPH, CPHQ, LSSBB, Director of Safety and Performance Improvement A. SCORE Survey, November 2024 Safety, Communication, Operational Reliability and Engagement (SCORE) • Cultural Strengths • Cultural Opportunities • Engagement Strengths • Engagement Opportunities Insight to Action • Staff Engagement: Sharing results across all departments and teams, hosting facilitates discussions to reflect on team-level insights • Action Planning • Emphasis: feedback mechanisms from local leadership, supporting staff participation in decision making and improving resilience and well-being supports • Accountability: Actions plans will include timelines, responsible parties, progress will be monitored and shared with staff and executive leadership B. Hospital Operations Update • Leadership Introduction; Helena Martey, RN,MSN CCRMC Interim Chief Nursing Officer; Shannon Abella, MPH, CCRMC Interim Chief Operating Officer; Sergio Urcuyo, MD, Chief Medical Officer; Cecila Arriera, Interim Deputy Chief Financial Officer, Contra Costa Health • CCRMC Martinez Campus Parking current estimates for 200 additional parking spots. ○ Lot C $42-47 Million ○ Hillside location $80-96 Million ○ Estimated Construction Time 2 years • Public Works to develop Project Work Request *Supervisor Gioia- What's the status on the allotment? The board will need more detailed information.* *D. Culberson informed the board that CCRMC executive team is working with the Public Works Department to develop a Specific Work Plan. A Project Work Request of $500k for the first phase (Assessment and Design). Explained more time is needed and preparation to come to the board.* *Supervisor Gioia requested that CCRMC return to the board with detailed information and a full presentation so we can understand the need for more funding to complete the project.*	Inform A, B & D

C. Operational Policy Review • Summary of changes D. Index of operational policies showing changes made	Motion: By: Carlson Seconded by Carcamo-Molina Ayes: Gioia, Carlson, Bhandari, Carcamo-Molina Abstain: None
No public comment.	
VI. **MEDICAL STAFF UPDATE** Sarah McNeil, M.D., Medical Staff President A. Medical Staff General Updates • Medical Staff partnership with the Director's office B. Patient Care Policy Review	Inform A Motion: By Carlson Seconded: Carcamo-Molina Ayes: Gioia, Carlson, Carcamo-Molina, Bhandari Abstain: None
VII. **SAFETY AND QUALITY UPDATE** Jasmin Contreras, LP.D, MSN, MBA, RN, PHN, HACP, Director of Safety and Performance Improvement A. External Performance Rating, Designation • Leapfrog Hospital Safety Grade CCRMC has maintained "A" for Spring 2025 • Age-Friendly Health Systems *Supervisor Gioia asks to explain the ranking.* No Comment.	Inform
VIII. **Adjourn at 1:43 PM**	Inform
IX. **NEXT MEETING: July 28, 2025**	

Minutes approved by Chair: Supervisor John Gioia, District I

_____ _____

Supervisor John Gioia **Date**

Minutes by Corticha Flucus

1025 ESCOBAR STREET
MARTINEZ, CA 94553

CONTRA COSTA COUNTY

Staff Report

File #: 25-3045 **Agenda Date:** 7/28/2025 **Agenda #:** 4.

Advisory Board: Medical Services (CCRMC) Joint Conference Committee
Subject: Administrative Update
Presenter(s): Erica Murray, MPA, President and CEO California Association of Public Hospitals and Health Systems (CAPH); Cecilia Arriera, Interim Deputy CFO; David Culberson, Chief Executive Officer, Contra Costa Regional Medical Center and Health Clinics; Leah Carlon, MPH, CPHRM, Health Care Risk Manager

Information:

A. CAPH Federal Medical Update (**information only)** - guest presentation with updates related to the Federal Impact to California's Public Health Care Systems

B. Finance Report (**informational only**) - review of finance report from CFO's office

C. HR Work Group Update (**action: defer**) - report from work group to be presented at next meeting, September 2025

D. Parking Structure Update (**informational only**) - providing updates on status of parking structure project and next steps

E. Seismic Update (**informational only**) - providing updates on status of required seismic updates on CCRMC campus

F. Hospital & Health Centers Operations Update (**information only**) - providing updates regarding leadership changes, continuous regulatory survey preparations, joint projects with the health plan, federal and state budgets, and capital equipment

G. Operational Policy Review (**action: approve**) - summary of changes for approved operational policies

Recommendation(s)/Next Step(s):

A. CAPH Federal Medical Update **- Information only**
B. Finance Report **- Information only**
C. HR Work Group Update - **Action:** ***defer***
D. Parking Structure Update **- Information only**
E. Seismic Update **- Information only**
F. Hospital & Health Centers Operations Update **- Information only**
G. Operational Policy Review - **Action:** ***approve***

CAPH

Federal & State Policy Update

IMPLICATIONS FOR PUBLIC HEALTH CARE SYSTEMS

Erica Murray, President & CEO,
California Association of Public Hospitals and Health Systems (CAPH)

July 28, 2025

Objectives

1. Provide updates on
   - Impact from H.R. 1/Budget Reconciliation
   - Potential Further Federal Action
   - State Budget Decisions: Past & Future

2. Answer Questions

H.R. 1 IMPLEMENTATION TIMELINE

2025

OCTOBER 1, 2025

DSH Cuts Take Effect: $8 billion in annual Disproportionate Share Hospital (DSH) cuts move forward as scheduled.

DECEMBER 31, 2025

Rural Relief Fund: States must apply to CMS for funding under this program.

JULY 4, 2025

Limits on SDPs:
State Directed Payments (SDPs) submitted after this date are capped at 110% of the "total published Medicare rate" for non-expansion states and 100% for expansion states.

Existing SDPs are grandfathered and exempt from these limits until January 1, 2028.

Uniformity Requirements Take Effect:
States must restructure provider taxes to apply the same rate to Medicaid and non-Medicaid services or risk losing federal funding.

Family Planning Provider Ban: One-year ban on federal Medicaid funding to providers mainly offering family planning (aimed at Planned Parenthood).

2026

EARLY 2026

180 days after enactment; around January 1, 2026
HHS must issue guidance on new six-month Medicaid eligibility checks.

OCTOBER 1, 2026

Reduction in FMAP for Emergency Services for Undocumented Childless Adults
Federal match for emergency care for undocumented adults drops from 90% to 50%.

2027

JANUARY 1, 2027

1115 Waiver Budget Neutrality:
All new 1115 demonstrations must meet federal budget neutrality requirements.

Medicaid Community Engagement (Work) Requirements:
States must begin enforcing work requirements for adults ages 19–64. ***States showing good faith effort may receive exemptions through December 31, 2028.***

Medicaid Eligibility Redeterminations:
States must begin conducting eligibility checks for expansion adults every six months.

Medicaid Retroactive Coverage Limitations:
Retroactive coverage reduced to one month for expansion enrollees, two months for traditional enrollees.

2028

JANUARY 1, 2028

State Directed Payment (SDP) Phase-Down Begins:
Grandfathered SDPs begin 10% annual reductions until reaching 100% of Medicare rates

OCTOBER 1, 2028

Provider Tax Reductions Begin:
Expansion states must reduce provider taxes from 6% to 3.5% by FY 2032; long-term care excluded. Non-expansion states capped at current rates.

New Copay Requirements:
$35 copays required for expansion adults over 100% FPL.

CAPH CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS & HEALTH SYSTEMS

Rev. 7/15/2025

Takeaways/Lessons Learned from H.R. 1

- Moderate Republicans were key in preventing across-the-board FMAP reductions
- Senate Parliamentarian's ruling regarding the FMAP penalty were also hugely impactful
- But overall, the conventional wisdom regarding strength of red state concerns was disproven
  - Already seeing pushback, e.g, Hawley bill
- Re SDPs:
  - CA's PHS extremely fortunate to have secured significant increases ($1.B net) in Jan 2025
  - CMS has tremendous discretion in interpreting language (e.g., what does it mean exactly to be capped? What constitutes a new program that would be subject to Medicare limits?)
    - Anticipating federal guidance
- Will need to consider alternative funding sources

CAPH

Other Real & Potential Executive Actions

Medicaid DSH Cuts (Oct 1, 2025)

- Have been successfully delayed or eliminated since 2014
- Strong bipartisan support
- Included in House version of H.R. 1, but stripped in Senate
- For CCHS, $44M in federal funding annually

Second Budget Reconciliation

- Freedom Caucus members seek further FMAP reductions, ACA rollbacks

Possible Federal Regulations:

- Former CMS officials have confirmed that Admin seeks to issue “MFAR 2,” a proposed reg that would curtail our ability to use IGTs to finance Medicaid

Other Real & Potential Executive Actions, Cont'd

CalAIM Waiver Renewal (Dec 2026)

- CA's 1115 waiver, including the Global Payment Program, will likely be denied

  For CCHS:

  - $8.8M in Safety Net Care Pool (federal) at stake
  - ~$22M of DSH funding at risk (half of $44M total)

Federal Workforce Challenges

- DOGE efforts and CMS staffing cuts may slow waiver/SPAs review and implementation timelines

Equity & Gender-Affirming Care

- Executive actions targeting equity-focused programs and GAC

State Budget Negotiation Overview: Major Issues

Governor's May Revise Proposal	Legislative Response
Enrollment Freeze for UIS adults (as of 1/1/26)	Modify to clarify no "age out" and establish a 6-month re-enrollment grace period
Elimination of FQHC PPS Rates for UIS patients (as of 1/1/26) Services reimbursed at either applicable fee schedule, FFS rate, or negotiated managed care rate	Delay implementation of FQHC PPS payment elimination until 1/1/27
$100 monthly premium (as of 1/1/27)	$30 monthly premium for UIS adults (19-59)
Dental & Long-Term Care Benefit Reductions (as of 1/1/26)	Rejects LTC elimination; Delays dental elimination to 1/1/27
Sweeps most MCO Tax Buckets to the General Fund (leaves the $150M for PHS)	Same

Final Agreement – For Now

Freezes enrollment for UIS adults 19+; includes a 3-month re-enrollment grace period that requires repayment of any unpaid premiums, beginning January 1, 2026
Eliminates FQHCs PPS rate for UIS patients, delayed to July 1, 2026
$30 monthly premium, delayed to July 1, 2027)
Maintains Long-Term Care Benefits for UIS patients
Elimination of state-only dental for UIS patients delayed to July 1, 2026
Sweeps most MCO Tax Buckets to the General Fund (maintains the $150M for PHS)

CAPH

State Advocacy Strategy: A Two Phased Approach

- **Phase I: Education & Immediate Impacts to the State's Budget**
  - **Objective:**
    - Provide general education to the Legislature regarding the substantial impacts of HR 1 to California's PHSs, highlighting the impacts of the state budget cuts, funding lost with the GPP disallowance, and advocating to ensure there are no additional cuts to PHSs.
  - **Timing:**
    - Timing on the immediate actions is unclear – the Legislature may try to address this as soon as August, the Governor could call a special session this fall, or the Legislature could potentially wait until January.
  - **Considerations:**
    - Expectation that MCO tax no longer allowed due to new requirements in H.R. 1-potentially as much as a $3.5b gap in state General Fund in this year's budget.

- **Phase II: 2026 & Beyond (Implementation, Defense, & Delay Tactics)**
  - **Objective:**
    - Because most of the other provisions in H.R. 1 take effect in 2026 or later, Phase II of our advocacy will be focused on implementing specific provisions, defending against further cuts, and working to delay specific provisions.
  - **Considerations:**
    - State will need to deal with both implementation and the significant cuts in federal funding

Coalition Working to Develop Alternative to UIS Changes

- CAPH is working with provider, plan and county partners to explore a more affordable, sustainable coverage option for UIS adults to preserve access to care amid budget constraints.

- Currently seeking to secure foundation support for policy, actuarial, legal and other technical expertise to develop several potential options/structures to consider

- Legislative leaders eager to be involved

- Work likely to continue through the fall

Phase One Advocacy Strategy: Key Messages

PHS Are the Ultimate Safety Net Backstop & Must Be Protected

- Patients mainly on Medi-Cal or uninsured
- Provide important access to care, including primary and specialty care—PHS have more than 150 clinics
- provide broader community services—trauma, burn centers, workforce training
- Section 17000 requirements

PHS Are Already Facing Enormous Federal Medicaid Cuts – Don’t Make It Worse

- Explain implications for access to care in our communities
  - Service reductions/closures
  - Potential loss of broader community services
  - Increased wait time at emergency departments

Questions?

CCRMC Joint Conference Finance Report

JULY 2025

CONTRA COSTA HEALTH

FY 24/25 Preliminary Operational Forecast*

CONTRA COSTA HEALTH

CC - Hospital	FY 2024 ACTUAL	FY 2025 FORECAST	FY 2025 BUDGET	VARIANCE (FY 2025 FORECAST V FY 2024 ACTUAL) ($)	VARIANCE (FY 2025 FORECAST V FY 2024 ACTUAL) (%)	VARIANCE (FY 2025 FORECAST v FY 2025 BUDGET) ($)	VARIANCE (FY 2025 FORECAST v FY 2025 BUDGET) (%)
Revenue							
Gross Revenue	$ 803,793,839	$ 855,878,417	$ -	$ 52,084,578	6.1%	$ -	-
Contractuals & Bad Debt	(414,216,589)	(464,009,121)	-	(49,792,532)	(10.7%)	-	-
Net Revenue	**389,577,250**	**391,869,296**	**614,341,073**	**2,292,046**	**0.6%**	**-**	**-**
Contractual & Bad Debt %	*(51.5%)*	*(54.2%)*	-				
Net Patient Revenue %	*48.5%*	*45.8%*	-				
Supplemental Revenue	260,624,684	322,488,409	-	61,863,725	19.2%	322,488,409	-
Total Net Patient Revenue	**650,201,934**	**714,357,705**	**614,341,073**	**64,155,771**	**9.0%**	**100,016,632**	**16.3%**
Governmental Support & Realignment Revenue	32,289,212	33,009,382	32,498,963	720,170	2.2%	510,419	1.6%
Grants & Donations	6,964,573	6,457,624	14,736,152	(506,950)	(7.9%)	(8,278,528)	(56.2%)
Charges to Gen Fund Units	69,056,677	59,586,575	61,861,401	(9,470,102)	(15.9%)	(2,274,826)	(3.7%)
Other Revenue	21,734,729	25,892,704	37,350,422	4,157,974	16.1%	(11,457,718)	(30.7%)
Total Other Revenue	**130,045,192**	**124,946,284**	**146,446,938**	**(5,098,908)**	**(4.1%)**	**(21,500,654)**	**(14.7%)**
Total Operating Revenue (ex Subsidies)	**780,247,126**	**839,303,989**	**760,788,011**	**59,056,863**	**7.0%**	**78,515,978**	**10.3%**
Expenses							
Salaries, Wages, & Benefits	556,008,749	577,507,099	569,829,172	(21,498,350)	(3.7%)	(7,677,927)	(1.3%)
Professional Fees & Purchased Services	138,159,990	146,636,653	155,390,613	(8,476,663)	(5.8%)	8,753,960	5.6%
Supplies & Drugs	63,734,756	67,843,516	60,050,031	(4,108,760)	(6.1%)	(7,793,485)	(13.0%)
Other Expenses	58,589,190	69,166,778	68,898,573	(10,577,587)	(15.3%)	(268,204)	(0.4%)
Total Operating Expenses	**816,492,686**	**861,154,046**	**854,168,389**	**(44,661,360)**	**(5.2%)**	**(6,985,657)**	**(0.8%)**
Expenses as a % of Operating Revenue	*104.6%*	*102.6%*	*112.3%*				
EBIDA	**(36,245,560)**	**(21,850,057)**	**(93,380,378)**	**14,395,503**	**65.9%**	**71,530,321**	**76.6%**
EBIDA (%)	*(4.6%)*	*(2.6%)*	*(12.3%)*				
Interest Expense	3,705,959	1,418,409	1,435,257	2,287,550	161.3%	16,848	1.2%
Interest Income	(5,861,384)	(10,357,468)	(5,761,352)	4,496,084	43.4%	4,596,116	79.8%
Depreciation Expense	16,837,772	14,484,184	166,717	2,353,588	16.2%	(14,317,467)	(8,587.9%)
Net Income (excl. Subsidy)	**(50,927,907)**	**(27,395,181)**	**(89,221,000)**	**23,532,725**	**85.9%**	**61,825,819**	**69.3%**
Subsidy (+)	115,245,000	117,003,000	116,253,000	1,758,000	1.5%	750,000	0.6%
Net Income (incl. Subsidy)	**64,317,093**	**89,607,819**	**27,032,000**	**25,290,725**	**28.2%**	**62,575,819**	**231.5%**
Expenditure Transfers (-)	64,700	-	-	64,700	100.0%	-	-
Capital Expenditures (-)	-	15,317,000	27,032,000	(15,317,000)	(100.0%)	11,715,000	43.3%
Total Net Expenditures	**$ 64,252,394**	**$ 74,290,819**	**$ -**	**$ 10,038,425**	**13.5%**	**$ 74,290,819**	**100.0%**

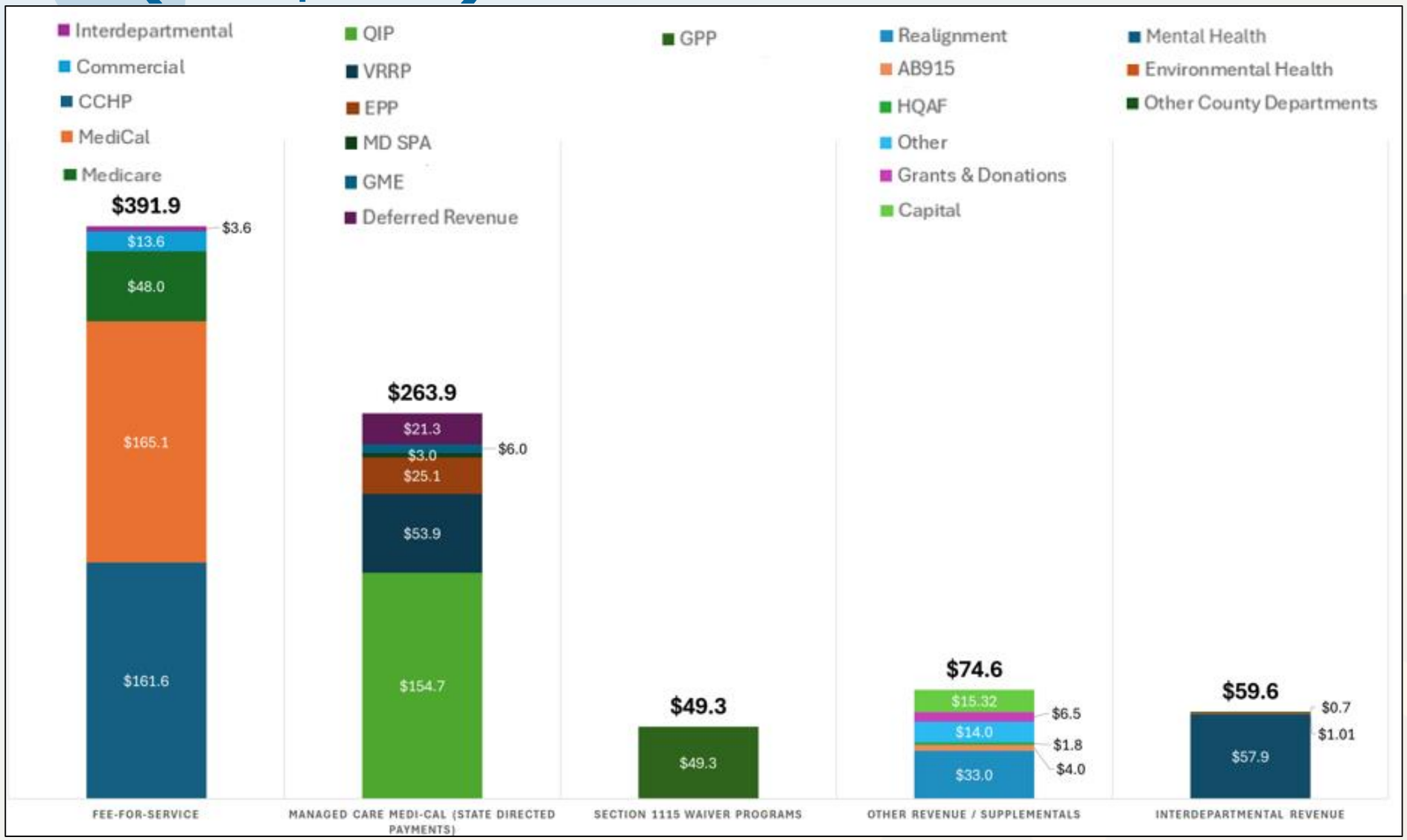
*Note: FY 2024 actual Capital Expenditures totaling $9 million are excluded, as these amounts were reclassified to the Balance Sheet at year end

Key Takeaways

*Preliminary annual forecast based on May YTD actuals and June projections. Figures are subject to change as additional reconciliations and adjustments are still in progress including YE adjustments posted by the Auditor Controller (Depreciation, Benefit accruals, Interest true-ups, etc.)

- YTD volumes increases observed across the system compared to PY:
  - Inpatient admissions (3.8%)
  - Psych admissions (9.1%)
  - Clinic visits (6.3%)
- Expenditures are rising, but at a slower rate than volume growth

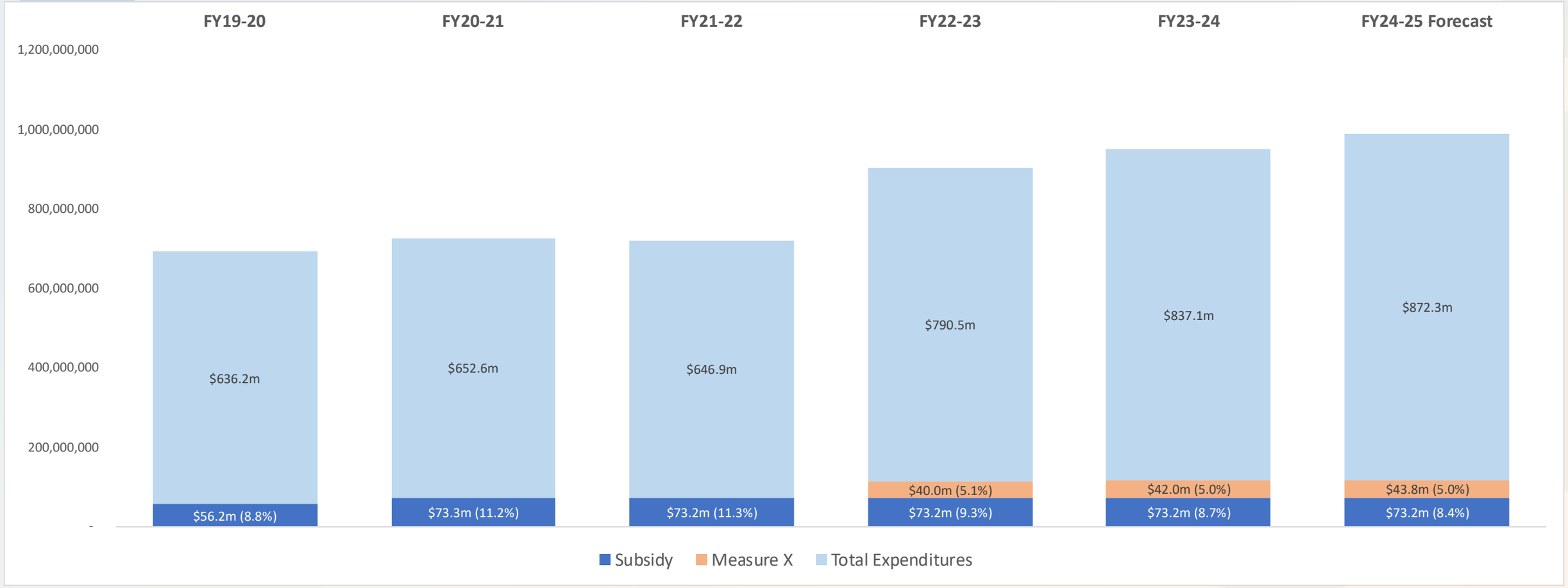
FY 24/25 Forecasted Revenue by Source (In $M's)



Key Takeaways

- **FY25/26 EF1 Total Forecasted Operating Revenue** from all sources is **$839.3M**
- **Fee-For-Service (FFS)** revenues total **$391.9M,** including CCHP ($161.6M), Medi-Cal ($165.1M), Medicare ($48M), Commercial ($13.6M), and Detention ($3.6M)
- **State Directed Payment Program** account for **$263.9M**, inclusive of: QIP ($154.7M), Rate Range ($53.9M), EPP ($25.1M), MD SPA ($3M), GME ($6M), and Deferred Revenue to be recognized ($21.3M)
- **1115 Waiver Programs (GPP)** contribute **$49.3M** to total revenue
- **Other Revenues and Supplementals** total **$74.6M,** including: State Realignment ($33M), AB915 ($4M), HQAF ($1.8M), Grants & Donations ($6.5M), Other Miscellaneous Revenue ($14M), and Capital revenue ($15.3M)
- **Interdepartmental Revenue** is **$59.6M,** consisting of: Mental Health ($57.9M), Environmental Health ($0.7M), and Other County Departments ($1.01M)

CCRMC 5-Year Expenditure and County Subsidy Trend



	FY19-20	FY20-21	FY21-22	FY22-23	FY23-24	FY24-25 Forecast
County Support %	**8.8%**	**11.2%**	**11.3%**	**14.3%**	**13.8%**	**13.4%**
YOY Expenditure Growth	-	**2.6%**	**-0.9%**	**22.2%**	**5.9%**	**4.2%**
YOY Subsidy Growth	-	**30.4%**	**-0.1%**	**54.6%**	**1.8%**	**1.5%**

*Percentages represent the proportion of NCC and Measure X relative to total expenditures
*Excludes $80m one-time Measure X funds received in FY21-22
*Excludes capital expenditures

HR Work Group Update – defer to September meeting

Contra Costa Regional Medical Center and Health Centers

Joint Conference Committee

July 28, 2025

CONTRA COSTA HEALTH

The following is a summary of activities for a new parking structure on the Martinez Campus of Contra Costa Regional Medical Center.

1. Project Development Team

   Contra Costa Regional Medical Center and Health Centers (CCRMC) is working with Public Works Capital Project (PWCP) leadership, Vanir Construction Management, and tBP/Architecture to develop a proposal for a new parking structure on the Martinez campus. The structure is needed to address the chronic shortage of parking spaces for the hospital, lab and Martinez Health Center. Further evidence of the need is shown by the fact that we had 3 CCRMC employees hit in crosswalks while crossing Alhambra/Berrellesa over the past 10 years (2 in past year).

   The Facility Master Plan, completed in Spring 2024 shows a shortage of 216 spaces. The estimated number of needed spaces is 988 compared with current availability of 772. If hospital or clinic operations grow in the future, we expect that shortage to grow further.

2. Structure Location and Size

   The plan is for at least 400 new parking spaces to be built in a new building on Lot C, an employee parking lot along Alhambra Avenue. The exact number of spaces will be determined by a commissioned parking study. In 2015, a consultant hired by PWCP, International Parking Design, completed a feasibility study; that report will be updated to reflect current visitor and employee activity. The building configuration, including the number of floors and set-back options, will be developed once the parking study is completed.

3. Initial Cost Estimate

   The initial cost estimate for approximately 400 new parking stalls is $40 million. Project funding has not been identified at this time, as initial allocation of $80M from measure X was all used up for seismic work (now estimated to total close to $140M). The time required to complete the construction is not known either, but initial estimates are approximately two years.

4. Employee Parking During Construction

   Alternate parking locations for employees will need to be identified due to the loss of nearly 300 spaces from Lot C during the construction period. CCRMC is exploring options together with public works.

5. Next Steps

   CCRMC will work with PWCP and the contracted specialists to develop a detailed project scope, building configuration, and cost estimate. An update regarding the parking structure project will be reported at the next Joint Conference Committee in September 2025.

CCRMC Seismic Project Update

Contra Costa Regional Medical Center and Health Centers

Joint Conference Committee

July 28, 2025

David Culberson, CEO

CONTRA COSTA HEALTH

CCRMC Seismic Project Update

- Initial Measure X Estimate For Five Structures (Facility Master Plan: Spring 2024)

• Public Health Lab	$25 M
• Parking Structure	$15 M
• Interventional Radiology	$5 M
• Psychiatric Emergency Services	$5 M
• Medical Office Building	$30 M
• Total	$80 M

CCRMC Seismic Project Update

- Seismic Compliance, With January 1, 2030, Deadline, Identified as CCRMC Highest Project Priority
- Food Service is a Mandated Service for Hospital Inpatients
- Scope Includes Three Distinct Projects:
  - Food Service/Cafeteria Building Replacement (SPC)
  - Sprinkler Line Bracing (NPC-4)
  - Water, Wastewater, and Fuel Storage (NPC-5)

CCRMC Seismic Project Update

- Measure X Funding Approved by Board of Supervisors October 22, 2024
  - Food Services Building Replacement $25-52 M
  - Public Health Lab $28-55 M
  - Total $80 M

CCRMC Seismic Project Update

- Revised Food Service Replacement Project Cost Estimates Developed in June 2025
- Development Team Included CCRMC, Public Works Capital Projects, Vanir Design, TrueBeck Construction
- Recommended Project Scope:
  - Three-story Replacement Facility to Prioritize Income-Generating Usage
    - Location Will Be Current Ward E Building
  - First Floor: Food Service and Cafeteria
  - Second Floor: Dietary and Other Office Space
  - Third Floor: Meeting Rooms, Unfinished Space, Morgue

CCRMC Seismic Project Update

- Revised Seismic Project Cost Estimate
  - Design/Build/Engineering $90 M
  - Soft Costs $20-25 M
  - Subtotal $110-115 M
  - NPC 4&5 $30 M
  - Total Seismic Project Estimate $140-145 M

CCRMC Seismic Project Update

- Significant Revisions Effecting Initial Estimate
  - Duplication and Rerouting of Electrical Systems $18 M
    - And Communication Fiber
  - Third Floor Addition $5-9 M
  - Cost Inflation 5% Annually
  - Loading Dock Reconfiguration
  - OSHPD Compliant Corridor For Food Delivery

The following is a summary of the seismic project activities for Contra Costa Regional Medical Center (CCRMC) through July 15, 2025.

1. Initial Project Scope: Measure X
   CCRMC leadership developed an initial estimate of $80 M to complete five structures in the Spring of 2024 as part of a facility Master Plan project. Those newly constructed buildings included:

Public Health Lab	$25 M
Parking Structure	$15 M
Interventional Radiology	$5 M
Psychiatric Emergency Services (PES)	$5 M
Medical Office Building	$30 M
Total	$80 M

2. Seismic Compliance Project
   In October 2024, CCRMC, Health Services Department (HSD), and Public Works Capital Projects (PWCP) identified the Food Service Building and two other seismic compliance projects as the highest priority due to state-mandated construction completion deadline of January 1, 2030. There are three separate projects under the seismic scope-of-work:

   1. Food Services/Dietary/Cafeteria Building (Structural Performance Category: SPC),
   2. Sprinkler Line Bracing in main hospital (Non-Structural Category: (NPC-4), and
   3. Water, Fuel, and Wastewater Storage (NPC-5).

   Initial work with PWCP and the Facility Master Plan architect, Vanir Construction, estimated the construction cost of the Food Services building to be $25-52 million.

3. Measure X Funding

On October 22, 2024, the Contra Costa Board of Supervisors (BoS) approved Measure X funding of a total of $80 million to CCRMC and Public Health following a receipt of a report from CCRMC and HSD. The allocation only included the Food Services Building and a new Public Health Lab.

Food Services Building Construction	$25-52 M

Public Health Lab	$28-55 M
Total	$80 M

4. Seismic Project Cost Estimate Development

   On March 25, 2025, TrueBeck Construction (TrueBeck) was awarded a Design/Build Entity contract by the BoS to develop conceptual design and construction documents. TrueBeck began working with CCRMC, PWCP, HSD and Vanir Construction to develop a set of architectural plans to be submitted to the State of California by December 31, 2025. Part of the conceptual design includes development of expected project costs. In late June 2025, the estimated project cost of a three-story Food Service replacement building and the two Non-Structural Category (NPC) components is $140-145 million.

Design Build (Food Services Building)	$90 M
Soft-Costs	$20-25 M
Sub-Total	$110-115
NPC 4&5 (Sprinkler Line, Water Storage)	$30 M
Total Seismic Project Estimate	$140-145 M

   An Authorization to Proceed has been issued to the Design/Build Entity to develop conceptual and construction documents to meet the mandated 2025 submission deadline. CCRMC and PWCP are working with all parties to identify areas where the cost can be reduced so the project can be developed in as cost-effective a manner as possible.

   CCRMC will provide the Joint Conference Committee with updates at each upcoming session regarding the development and implementation of this important project.

Hospital & Health Operations Update

Contra Costa Regional Medical Center and Health Centers

Joint Conference Committee

July 28, 2025

David Culberson, CEO

CONTRA COSTA HEALTH

Operational Updates

- Leadership and Key Position Recruitment
- Preparation for Surveys
- Joint Projects with Contra Costa Health Plan (CCHP)
- Federal and State Budgets
- Capital Equipment

The following is a summary of significant operational developments at Contra Costa Regional Medical Center for the quarter ending June 30, 2025.

1. Leadership and Key Position Recruitment

   Contra Costa Regional Medical Center and Health Centers (CCRMC) continues to fill and interview for important leadership positions. Two physician leaders have been appointed to new roles: Dr. Sergio Urcuyo, CCRMC Chief Medical Officer, and Dr. Geena Jester, Hospital Medical Director.

   Recruitment and interviews are ongoing for the Chief Nursing Officer (CNO) and Chief of Plant Operations (CPO) positions. Helena Martey, RN, MSN, is currently the Interim CNO for CCRMC.

   Shannon Abella, MS, is currently working as the Interim Chief Operations Officer (COO). Recruitment to fill the permanent COO position is awaiting salary adjustment. A salary survey has been submitted to CAO office, and we are awaiting their response.

   CCRMC is working to provide additional resources to the Medical Staff Office for Provider Practice Management activities and to the Appointment Unit to maintain optimal performance in the scheduling of patients across the Ambulatory Care Clinics.

2. Preparation for Surveys

   CCRMC is preparing for its triennial survey by The Joint Commission (TJC) and any unannounced visits by external agencies. The next Joint Commission visit is planned for January 2026, but TJC is expected to be on-site at any time after October 2025.

3. Joint Projects with Contra Costa Health Plan

   CCRMC is working closely with Contra Costa Health Plan (CCHP) on several joint projects including the Dual Special Needs Plan (DSNP) and quality measures.

4. Federal and State Budgets

   CCRMC leadership is working with the Health Services Department, California Association of Public Health Systems to determine the effects of recently approved federal and state budgets on Medi-Cal eligibility and enrollment, supplemental funding, and routine revenues for all its services.

5. Capital Equipment

   Several capital equipment purchases in patient care areas are being pursued to provide adequate access to needed clinical services. Recent acquisitions or initiatives to acquire new capital equipment include ophthalmoscopes in three ambulatory sites for retinal scans, radiological/fluoroscopic system replacement for the hospital, vital signs monitoring for anesthesia machines, and pulmonary function testing equipment for the West County Health Center. A full list of capital items purchased in Fiscal Year 2024-2025 will be presented at the next Joint Conference Committee in September 2025.

Operational Policy Agenda 7-28-25

**** Indicates policy is pending Medical Executive Committee's approval on 7/21/25.***

Title	Area	Revised?	Summary of Changes
Contra Costa Regional Medical Center Joint Conference Committee Expedited Privileges Subcommittee Charter *	Hospital & Health Centers	Revised	*Edits are not tracked due to the document being created in PolicyStat for the 1st time.* Expedited Privileges. A subcommittee of JCC for the purpose of reviewing and approving off-cycle candidates with Category 1 applications (no concerns).The process of granting privileges outside the standard schedule due to various circumstances such as recruitment needs, changes in service demand, or urgent staffing requirements.
Contra Costa Regional Medical Center & Health Centers Medical Staff Rules and Regulations	Hospital & Health Centers	Unchanged	N/A
Policy for Escalation	Hospital & Health Centers	Revised	Updated language to indicate both clinical and safety concerns with the escalation pathways. Updated language to include both hospital and clinics. Reformatted for ease of understanding.
Policy for Code of Conduct	Ambulatory Care	Revised	Added "designated MOU" and provided clarification regarding break times, removed P&P numbering, and minor rewording and reformatting.

Status Pending PolicyStat ID 18477428

Origination	07/2025
Last Approved	N/A
Effective	Upon Approval
Last Revised	07/2025
Next Review	3 years after approval
Owner	Heather Cedermaz: Family Nurse Practitioner
Area	Hospital & Health Centers

Contra Costa Regional Medical Center Joint Conference Committee Expedited Privileges Subcommittee Charter

Purpose

The Contra Costa Regional Medical Center (CCRMC) Joint Conference Committee (JCC) establishes this charter for the review and approval of expedited credentialing of medical staff members for Category 1 applications by a JCC Expedited Credentialling Subcommittee. It outlines the roles, responsibilities, and processes for the Subcommittee to ensure compliance with regulatory standards and to maintain high-quality patient care.

Scope

This charter applies to all CCRMC and Clinics medical staff members and applicants with a Category I initial and reappointment application who are seeking credentials in an expedited procedure via the use of the Subcommittee.

Definitions

A. **Category I applications must be complete and have no issues on record that would cause them to have a category II application as outlined in the Medical Staff Bylaws.**

B. **On-Cycle Credentialing**: The regular monthly process of credentialing files via Medical Staff Office (MSO), the Credentials Committee (CC), and the Medical Executive Committee (MEC) meetings.

C. **Off-Cycle Credentialing**: The process of granting privileges outside the standard schedule due to various circumstances such as recruitment needs, changes in service demand, or urgent staffing requirements.

Membership

A. The Expedited Credentialing Subcommittee will consist of three members, two of whom must be voting members of the CCRMC JCC.

B. Members of the Subcommittee will be appointed by the CCRMC JCC for two-year terms every 2 years. Vacancies on the Subcommittee will be filled by appointment of the Chair of the CCRMC JCC to complete the remaining term of the vacant seat.

C. **Composition**: The Subcommittee shall consist of three members:

1. CCRMC Chief Medical Officer (CMO) or Chief Executive Officer (CEO); and
2. 2 members who are voting members of the CCRMC JCC.

Procedure

A. Medical Staff Office (MSO) staff will determine if expedited credentialing is warranted based on the following criteria:

1. There is a staffing need, and
2. Completed application for initial appointment, reappointment or request for additional privileges is turned into the MSO timely and before JCC convenes, and it is identified as a category 1 application. Application processing includes the following guidelines:
    a. On-cycle: staff is not needed until after MEC
    b. Off-cycle: Completed application is turned into MSO at a time when it cannot be processed through the regular committee cycle;
3. If application is off cycle:
    a. Department Chair and Credentials Committee Chair meet on behalf of the Credentials Committee for approval;
    b. Special MEC meeting called for approval of application(s); and
    c. JCC Expedited Credentialling Subcommittee reviews application for approval on behalf of JCC and Board Of Supervisors.

B. **Review Applications**:

1. To qualify for expedited credentialing, all applications for both on-cycle and off-cycle must be considered Category 1 as defined above.
2. Applications will not be considered for expedited credentialling if the applicant has submitted an incomplete application or if the Medical Executive Committee makes a final recommendation that is adverse or has limitations.
3. The following situations will be evaluated on a case-by-case basis and usually result in ineligibility for the expedited process:
    a. There is a current challenge or a previously successful challenge to licensure or registration,
    b. The applicant has received an involuntary termination of medical staff membership at another hospital,

c. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.

d. There has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

C. **Decision Making**:

1. If any group (Credentials Committee, MEC, JCC Subcommittee) believes that an application is not category I, they will **not** proceed with expedited credentialing and the file will go through the non-expedited credentialling approval process.
2. If expedited credentialing occurs, the governing body (JCC) must still review the expedited files at the next regularly scheduled meeting.
3. A unanimous decision by the Subcommittee is required for approval of all applications considered under the Expedited Credentialing process.

D. **Monitoring and Quality Assurance**:

1. The JCC Expedited Credentialing Subcommittee will produce meeting minutes for review in regular JCC meetings.
2. All approved files will be included in subsequent BoS credential procedures.
3. MSO will report out to MEC every year about the number of expedited credentials completed, both on- and off-cycle.

Meeting Frequency

A. The subcommittee shall meet twice monthly as needed: once following each MEC meeting to address on-cycle requests and once during the first half of month to address any off-cycle requests.

Review and Amendments

A. This Charter shall be reviewed annually and amended as necessary to reflect changes in regulations, best practices, and institutional policies.

B. Any proposed amendments to this Charter must be approved by the CCRMC Joint Conference Committee.

Confidentiality

A. All personnel documents pertaining to credentialing decisions are confidential and shall be treated as such in accordance with applicable laws and institutional policies during the committee.

Compliance

A. This Charter will comply with all relevant federal, state, and local laws, as well as accreditation standards set forth by regulatory bodies.

References

A. CMS section 482.12

B. The Joint Commission Standard MSO 06.01.11 EP01

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Credentialing Committee	Heather Cedermaz: Family Nurse Practitioner	07/2025
	Heather Cedermaz: Family Nurse Practitioner	07/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18412761**

Origination	05/2025
Last Approved	N/A
Effective	Upon Approval
Last Revised	06/2025
Next Review	1 year after approval

Owner	Sarah Mcneil: OBGYN Fam Med Adv Obst Ex
Area	Hospital & Health Centers

Contra Costa Regional Medical Center & Health Centers Medical Staff Rules and Regulations

Medical Executive Committee Approved: June 2025

Adoption Date (approved by Board):

Amendment Date(s) (approved by Board)

Table of Contents

ARTICLE I. INTRODUCTION

1.1 INTRODUCTION

These Rules and Regulations are adopted by the Medical Executive Committee and approved by the County Board of Supervisors of Contra Costa Medical Center & Health Centers (collectively referred to as Contra Costa Health or "CCH") to further define the general policies contained in the Contra Costa Medical Center & Health Centers Medical Staff Bylaws ("Bylaws"), and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges (collectively referred to as "Practitioners" as defined within the Bylaws). Hospital policies concerning the delivery of health care may not conflict with these Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict. These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Bylaws. This article supersedes and replaces all other Medical Staff rules and regulations, or policies and procedures, pertaining to the subject matter thereof.

ARTICLE II. ADMISSION AND DISCHARGE

2.1 ADMISSIONS

2.1.1 General

Patients are admitted to the hospital only on the decision of a licensed practitioner permitted by the state of California to admit patients to a hospital.

a. **Admitting Privileges:** A patient may be admitted to the hospital only by a practitioner on the Medical Staff with admitting privileges.

b. **Admitting Diagnosis:** Except in an emergency, no patient will be admitted to the hospital until a provisional diagnosis or valid reason for admission has been written in the medical record. In the case of emergency, the admitting diagnosis will be recorded as soon as possible.

c. **Admission Priority and Procedure:** The Hospital "Policy for Admission, Unit Transfer, and Discharge" shall be followed.

2.1.2 Inpatient Psychiatric Services

a. The hospital policies for admission shall be followed for admission to the inpatient psychiatric unit, including specific psychiatry "Policy for Admission Criteria to Inpatient Psychiatry," "Inpatient Psychiatry – Medical/Physical Care of Patients," and "Procedure for Admission Process to Inpatient Psychiatric Service from Psychiatric Emergency Services (PES)."

2.2 EMERGENCY PATIENTS

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that for all patients who present to the Emergency Department, the Hospital must, at a minimum, provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. Practitioners should follow the hospital Policy for EMTALA.

2.2.1 Emergency Department Call Coverage

a. **Call Schedule:** The Hospital is required to 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 emergency medical condition. The Department/Division Chairs shall provide the hospital with a list of physicians who are scheduled to provide call coverage to respond to medical emergencies.

b. **Response Time:**

   i. It is the responsibility of the on-call physician, or designee, to respond in an appropriate time frame.

   ii. The on-call physician, or designee, should respond to calls from the Emergency Department no longer than twenty (20) minutes by telephone, unless a shorter time is required by contract or accrediting body. The on-call physician or designee must arrive at the Hospital, if requested to see the patient, in a timeframe based on the communication between the ED practitioner and the on-call physician. Specialties that provide telemedicine coverage shall see the patient based on the timeframes defined by contract and/or agreed upon between the ED practitioner and the on-call

telemedicine physician.

iii. In areas of dispute, the ED physician decision rules. If there is disagreement on the timeframe, the ED practitioner shall define the timeframe.

iv. If the on-call physician does not respond to being called or paged, the physician's documented designee shall be contacted. If the physician's designee does not respond to being called or paged, the Administrative Director should be contacted. Any violations of EMTALA will be reported in compliance with the policy.

v. Teaching services are expected to respond in the same timeframes or sooner in lieu of the on-call physician when appropriate.

c. **Substitute Coverage:** It is the on-call physician's responsibility to change the online call schedule through communication with the Department or Division leadership when there is enough time to do so as determined by the hospital. Short timeframes require the on-call physician to arrange for coverage and notify the Emergency Department if they are unavailable to take call when assigned. Failure to notify the Emergency Department of alternate call coverage may result in the initiation of disciplinary action.

2.2.2 Patients Not Requiring Admission

In cases where the Emergency Department consults with the on-call physician and no admission is deemed medically necessary, the Emergency Department physician shall implement the appropriate care/treatment and discharge the patient with arrangements made for appropriate follow-up care. If the Emergency Department physician and the consultant agree that the outpatient visit can serve in lieu of the consultant coming into the Emergency Department, an appropriate outpatient follow-up care plan shall be developed.

If the consultant, in disagreement with the emergency physician, feels 1) that inpatient admission is not warranted, or 2) the patient requires transfer to another facility, then the consultant, at the request of the emergency physician, is required to assess the patient and make appropriate arrangements and document their decision.

2.2.3 Patient Follow-up After Discharge from the ED

The ED will coordinate or provide information about follow-up care with an appropriate practitioner at CCHS or an external provider as appropriate.

2.2.4 Guidelines for Call Coverage

The following rules should be used in developing service policies regarding call coverage obligations:

a. The hospital shall have physician coverage to comply with basic emergency medical service capability requirements.[1]

b. Call duties, to supply basic stabilization and disposition of the patient, should be based on the practitioner's core privileges and training.

[1] Title 22, § 70413. Basic Emergency Medical Service, Physician on Duty, General Requirements.

c. The Medical Executive Committee in consultation with Administration shall determine which specialties are required to have call schedules (in addition to the basic medical service capability requirements),
d. Emergency duties may be divided by specialty or subspecialty.
e. Call is assigned by the Department or Division Leadership.
f. Call coverage is documented in an electronic call roster (e.g., Amion).
g. If a physician is on-call at more than one hospital simultaneously, they must have an agreed upon back-up physician named to provide coverage in case of emergencies.
h. Physicians must be listed by name on the call roster (they cannot be listed by group).
i. Departments or specialties that do not provide 24/7/365 call coverage shall work with Administration to communicate the coverage schedule to the Emergency Department and develop a back-up plan when coverage is not available.[2]

2.2.5 Failure to Meet Call Obligations

All failures to meet call responsibilities shall be reported to the Department Chair and the Medical Executive Committee. Recurrent failure to meet call obligations may result in corrective action per the Medical Staff Bylaws.

2.2.6 Qualified Medical Personnel for Screening Examinations

Only physicians are deemed to be Qualified Medical Personnel (QMP) for purposes of (1) performing an appropriate medical screening examination of an individual presenting to CCH to determine whether the individual suffers from an emergency medical condition, and (2) completing the required physician certification for transfer of a patient with an emergency medical condition including active labor who has not been stabilized to another facility for treatment at the direction of the Responsible Physician.

2.3 TRANSFERS

2.3.1 Transfers To and From Other Acute Care Facilities

Patients who are transferred to or from another hospital must follow the Hospital policies including "Policy for Patient Transfers to Other Facilities" and "Policy for Accepting Patient Transfers from Outside Facilities and Referrals from Contra Costa Health Centers," and ensure EMTALA compliance.

2.3.2 Transfers Within the Hospital

Patients may be transferred from one patient care unit to another in accordance with the priority established by the Hospital. All practitioners actively providing care to the patient will be notified of all transfers. Hospital policies must be followed including "Policy for Admission, Unit Transfer, and Discharge."

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[2] §489.24(j) - Availability of On-call Physicians In accordance with the on-call requirements specified in §489.20(r)(2), a hospital must have written policies and procedures in place: (1) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control.

2.4 PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS

The attending physician, or designee, is responsible for providing the Hospital with necessary information to assure the protection of the patient from self-harm and to assure the protection of others. Practitioners caring for patients who are a danger to themselves and/or others should follow "Procedure for Assault Precautions" policy and "Suicide Risk Screening, Evaluation, and Precautions in Psychiatric Units" policy.

2.5 DISCHARGE ORDERS AND INSTRUCTIONS

Patients will be discharged or transferred only upon the authenticated order of the attending physician, or designee, who shall provide, or assist Hospital personnel in providing, written discharge instruction in a form that can be understood by all individuals and organizations responsible for the patient's care. See Section 3 for the elements of the Discharge Summary. The discharge instructions should include, if appropriate based on age and condition:

a. A list of all medications the patient is to take post-discharge
b. Dietary instructions and modifications
c. Medical equipment and supplies
d. Instructions for pain management
e. Any restrictions or modification of activity
f. Follow up appointments and continuing care instructions
g. Referrals to rehabilitation, physical therapy, and home health services, and
h. Recommended lifestyle changes, such as smoking cessation.

2.6 DISCHARGE AGAINST MEDICAL ADVICE

Should a patient or a patient and their legally authorized representative leave the hospital against the advice of the attending physician, or without a discharge order, hospital policies "Procedure for Patient Leaving Against Medical Advice (AMA)," "Absent Without Leave (AWOL)" and "Access to Outdoors" shall be followed. The attending physician shall be notified that the patient has left against medical advice.

2.7 DISCHARGE PLANNING

Discharge planning is a formalized process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken to ensure that a patient remains in the hospital only for as long as medically necessary. All practitioners are expected to participate in the discharge planning activities established by the Hospital and approved by the Medical Executive Committee.

2.8 DISCHARGING FROM THE PSYCHIATRIC UNIT

The patient, patient's family, physicians, other licensed practitioners, clinical psychologists, and staff involved in the patient's care, treatment, and services shall participate in planning the patient's discharge or transfer. Psychiatry policies "Policy for Discharge Planning / After-Care Plan for Inpatient Psychiatry" and "PES Discharge Process and After Visit Summary" should be followed.

ARTICLE III. MEDICAL RECORDS

3.1 GENERAL REQUIREMENTS

The attending physician is responsible for the preparation of the physician components of the medical record to ensure a complete and legible medical record for each patient.

All practitioners with privileges are required to utilize the electronic health record (EHR), unless a "rare user" exception has been granted, to meet regulatory requirements and provide efficiencies in delivering healthcare to the community. All practitioners will complete EHR training, and comply with security guidelines, per the hospital's policy on use of the EHR.

The medical record must be complete within thirty (30) days after the patient's discharge unless a shorter timeframe is defined by policy.[3] Hospital policies on medical record documentation shall be followed, including "Authority to Make Medical Record Entries", and "Procedure for Medical Record Content."

3.2 AUTHENTICATION

All clinical entries in the patient's medical record will be accurately dated, timed, and authenticated (signed) with the practitioner's legible signature or by approved electronic means.[4]

3.3 CLARITY, LEGIBILITY, AND COMPLETENESS

All handwritten entries in the paper medical record shall be made in ink and shall be clear, complete, and legible. Orders which are, in the opinion of the authorized individual responsible for executing the order, illegible, unclear, incomplete, or improperly documented (such as those containing prohibited abbreviation and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering practitioner immediately.

3.4 ABBREVIATIONS AND SYMBOLS

The use of abbreviations can be confusing and may be a source of medical errors. However, the Medical Staff recognizes that abbreviations may be acceptable to avoid repetition of words and phrases in written documents. The use of abbreviations and symbols in the medical record must be consistent with the following rules:

3.4.1 Prohibited Abbreviations, Acronyms, and Symbols

The Medical Executive Committee shall adopt a list of prohibited abbreviations and symbols that may not be used in medical record entries or orders; these are noted in the policy on prohibited abbreviations, Pharmacy Policy Unacceptable Abbreviations and Symbols List.[5]

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[3] TJC RC.01.03.01-01: The hospital defines the time frame for completion of the medical record, which does not exceed 30 days after the patient's discharge.
[4] TJC RC.01.02.01: Entries in the medical record are authenticated.
[5] TJC IM.02.02.01-03: The hospital follows its list of prohibited abbreviations, acronyms, symbols, and

dose designations, which includes those listed in this document.

At a minimum, the following abbreviations, acronyms, symbols, and dose designations are prohibited:

- U,u
- IU
- Q.D., QD, q.d., qd
- Q.O.D., QOD, q.o.d, qod
- Trailing zero (X.0 mg)
- Lack of leading zero (.X mg)
- MS
- MSO4
- MgSO4

3.4.2 Situations Where Abbreviations Are Not Allowed

Abbreviations, acronyms, and symbols may not be used on informed consents.

3.5 ADMISSION HISTORY AND PHYSICAL EXAMINATION

3.5.1 Time Limits

Time limits for performance of the medical history and physical examination are noted in Part I, Section 2 of the medical staff bylaws. For the inpatient psychiatric unit, a psychiatric evaluation must be completed within sixty (60) hours of admission or registration.[6]

3.5.2 Who May Perform and Document the Admission History and Physical Examination

All medical staff with H&P privileges are allowed to perform admitting and outpatient history and physical examinations regardless of specialty.

b. Advanced Practice Providers (e.g., CRNA, NP, PA) may also complete the required history and physical examination if they possess the necessary privileges.[7]

c. For residents and practitioners requiring supervision or collaboration, a physician with privileges shall review and countersign the history and physical examination record within twenty-four (24) hours.[8]

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[6] TJC PC.01.02.13-07: Each patient receives a psychiatric evaluation completed within sixty (60) hours of admission.
[7] TJC MS.03.01.01-08: The medical staff requires that a physician or other licensed practitioner who has been granted privileges by the hospital to do so perform a patient's medical history and physical examination and required updates.
[8] TJC MS.03.01.01-10: The organized medical staff defines when a medical history and physical examination must be validated and countersigned by a physician with appropriate privileges.

d. **Examinations by Practitioners without Privileges:** The hospital may accept a history and physical examination performed within thirty (30) days prior to admission by a practitioner without current hospital membership or privileges as long as a practitioner with current hospital membership or privileges endorses the findings and enters an interval note within twenty-four (24) hours after admission and prior to any operative or other invasive procedure involving general or major regional anesthesia.

3.5.3 Compliance with Documentation Guidelines

a. The documentation of the admission history and physical examination shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority.

b. **Complete History and Physical Exam:** A complete history and physical examination is required for all admissions, all operative or invasive procedures requiring anesthesia (general, regional, MAC, or deep/moderate sedation), and all observation patients. A complete history and physical examination report must include the following information, as age appropriate and based on the patient's condition:

i. Chief complaint or reason for the admission or procedure
ii. A description of the present illness
iii. Past medical history, including current medications, allergies, past and present diagnoses, illnesses, operations, injuries, treatment, and health risk factors;
iv. An age-appropriate social history;
v. A pertinent family history;
vi. A review of systems;
vii. Physical examination and relevant physical findings; and
viii. Diagnosis or problem list with a plan of care.

c. Behavioral and Emotional Assessment[9]

Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:

i. A psychiatric evaluation
ii. Psychological assessments, including intellectual, projective, neuropsychological, and personality testing
iii. Complete neurological examination at the time of the admission physical examination, when indicated

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[9] TJC PC.01.02.13-06

d. Focused History and Physical Examination/Outpatient Assessment: A focused history and physical examination or outpatient assessment, is used for those outpatients who are undergoing invasive procedures under local anesthesia or conscious sedation should include, as age appropriate and based on the patient's condition:[10]

i. Elements that are immediately pertinent to the chief complaint or presenting problem, including a physical examination of the area of interest for the planned procedure and surrounding structures, if applicable,
ii. Medications and known allergies,
iii. An examination of the heart, lungs, and neurological status, and
iv. Additional assessment as deemed necessary for the safe and effective treatment of the patient.

A brief history and physical may be appropriate in lieu of a comprehensive history and physical, in the following types of care environments: radiology, endoscopy, emergency medicine, and oncology services. The decision must be documented and based on the patient's age, diagnosis, type and number of procedures to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure.[11]

e. **Exceptions:**

i. A clinically pertinent note may be substituted for a history and physical for the purpose of emergency surgery or prior to other urgent interventions involving general or major regional anesthesia.
ii. A patient's prenatal records may serve as the history and physical examination for vaginal deliveries as long as there is a documented visit within the thirty (30) days prior to admission. However, an update note should be added to the prenatal record after admission and prior to any procedure requiring general or major regional anesthesia.
iii. An assessment may be substituted for a pre-surgical history and physical examination to the extent allowed for low-risk patients and procedures.

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[10] TJC MS.03.01.01-11: The organized medical staff defines the scope of the medical history and physical examination when required for non-inpatient services.
[11] TJC MS.03.01.01-19: If the medical staff chooses to develop and maintain a policy for the identification of specific patients to whom the assessment requirements would apply, in lieu of a comprehensive medical history and physical examination, the policy is based on the following: patient age, diagnosis, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure. Nationally recognized guidelines and standards of practice for assessment of particular types of patients prior to specific outpatient surgeries and procedures. Applicable state and local health laws.

f. **Interval Note:**

i. An update or interval note should be entered in the medical record whenever the history and physical examination was performed prior to admission or registration for surgery.

ii. Such update or interval note shall document any significant changes reported by or observed in the patient since the pre-admission / pre-registration history and physical examination.

iii. The note should be documented in the medical record within twenty-four (24) hours following admission, and prior to any operative or invasive procedure requiring general or major regional anesthesia.

iv. The interval note may be entered by any practitioner otherwise privileged to complete a history and physical examination as described above.

3.5.4 Responsibility for the Admission History and Physical Examination

The admitting practitioner entering the admission order, or designee with privileges to complete the exam, is responsible for completing the admission history and physical examination.

3.5.5 Admissions for Emotional and Behavioral Disorders[12]

The admitting practitioner is responsible for documenting the 1) reason for admission as stated by the patient and/or others involved in the patient's care, 2) onset of the patient's illness and circumstances leading to admission, and 3) inventory of the patient's strengths and disabilities (such as psychiatric, biopsychosocial problems requiring treatment/intervention) written in a descriptive manner on which to base a treatment plan.

The admitting practitioner shall also assess and document the following:

a. Current mental, emotional, and behavioral functioning

b. Maladaptive or other behaviors that create risk to the patient or others

c. Mental status examination

3.6 PREOPERATIVE DOCUMENTATION

3.6.1 Policy

Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to:

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[12] TJC PC.01.02.13: The hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.

a. all invasive procedures performed in the Hospital's surgical suites;

b. certain procedures performed in the Interventional Radiology Department, and

c. certain procedures performed in other treatment areas (such as bronchoscopy, gastrointestinal endoscopy, transesophageal echocardiography, therapeutic nerve blocks, and elective electrical cardioversion).

When a history and physical examination is required prior to a procedure, and the procedure is not deemed an emergency, the procedure will be cancelled if an H&P is not completed.[13]

In cases of procedures performed by dentists, the pre-anesthesia evaluation may suffice for the update to the history and physical examination.

3.7 PROGRESS NOTES

The attending physician or designee shall see the patient and record a daily progress note, unless a more frequent requirement is documented in a unit policy. Progress notes documented by residents/fellows in training require co-signature by a supervising physician, or designee.

There should also be a progress note for each significant patient encounter, on all hospitalized patients. Progress notes must document the reason for continued hospitalization.

In the Inpatient Psychiatric Unit, progress notes shall be documented at least weekly for the first two (2) months and at least once a month thereafter, and must contain recommendations for revisions in the treatment plan as indicated as well as a precise assessment of the patient's progress in accordance with the original or revised treatment plan.[14]

3.8 OPERATIVE / PROCEDURE REPORTS

Operative reports will be written or dictated immediately after surgery,[15] and prior to transferring the patient to the next level of care. Operative/procedure reports will include:[16]

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[13] TJC RC.02.01.03-03: The patient's medical history and physical examination are recorded in the medical record before an operative or other high-risk procedure is performed. See also PC.01.02.03-04 and 05.
[14] TJC RC.02.01.01-07
[15] TJC RC.02.01.03-05: An operative or other high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.
[16] TJC RC.02.01.03-06 includes the list of required information in the operative report.

a. Names of the physician or other licensed practitioner(s) who performed the procedure and his or her assistant(s)

b. The name of the procedure performed

c. A description of the procedure

d. Any estimated blood loss

e. Any specimen(s) removed

f. The postoperative diagnosis

3.9 IMMEDIATE POST-OPERATIVE / PROCEDURE NOTES

If there is a delay in getting the operative/procedure report in the medical record due to an unforeseen emergency, a brief operative/procedure note is recorded in the medical record, prior to transfer to the next level of care, outlining the procedure performed. Operative/procedure notes will include:[17]

a. Names of the physician or other licensed practitioner(s) who performed the procedure and his or her assistant(s)

b. The name of the procedure performed

c. A description of each procedure finding

d. Any estimated blood loss

e. Any specimen(s) removed

f. The post-operative diagnoses

3.10 PRE-ANESTHESIA NOTES AND PRE-SEDATION ASSESSMENTS[18]

3.10.1 Pre-anesthesia notes

a. Anesthesia consists of general anesthesia and spinal or major regional anesthesia, does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuro-muscular function. Cardiovascular function may be impaired.

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[17] TJC RC.02.01.03-07 addresses the requirements of the post-operative progress note.
[18] TJC PC.03.01.03-01: Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered the hospital conducts a pre-sedation or pre-anesthesia patient assessment.

b. Moderate sedation is a drug-induced depression of consciousness during which patients respond to purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from a pain stimulus is not considered a purposeful response. No interventions are required to maintain a patient airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

c. Deep sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance and maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

d. The pre-anesthesia evaluation must be completed and documented within forty-eight (48) hours immediately prior to any inpatient or outpatient surgery or procedure requiring anesthesia, or moderate/deep sedation services. The delivery of the first dose of medication(s) for the purpose of inducing anesthesia, as defined above, marks the end of the forty-eight (48) hour time frame. [19]

In accordance with current standards of anesthesia care, some of the individual elements contributing to the pre-anesthesia evaluation may be performed prior to the forty-eight (48) hour timeframe. However, under no circumstances may these elements[20] be performed more than thirty (30) days prior to surgery or a procedure requiring anesthesia services. A review of these elements must be conducted, and any appropriate updates documented, within the forty-eight (48) hour timeframe.

3.10.2 Pre-sedation assessments

Pre-sedation assessments should comply with the Hospital policy, including "Procedure for Moderate Sedation Administration by Non-Anesthesiologists."

3.11 ANESTHESIA RECORD

A record of anesthesia that conforms to the policies and procedures developed by the Department of Anesthesia shall be made for each patient receiving sedation or anesthesia at any anesthetizing location.

3.12 POST-ANESTHESIA NOTES AND POST-SEDATION NOTES[21]

Post-anesthesia and post-sedation notes shall be placed in the record within twenty-four (24) hours after the completion of a procedure involving anesthesia or sedation. The note shall contain the requirements in the appropriate hospital policy.

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[19] TJC PC.03.01.03-18: A pre-anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia services.
[20] 482.52(b)(1): Interpretive Guidelines - Elements that must be performed within 48-hours are medical history, drug and allergy history, medical interview, and exam.

3.13 CONSULTATION REPORTS

a. Consultation orders shall be entered into the EHR.

b. The documentation in the consultation report shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority. Consultation reports will demonstrate evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion, and recommendations. This report will be made part of the patient's record.

c. The consultation report should be completed and entered in the patient's chart no later than twenty-four (24) hours after receipt of notification of the consult request, unless a later timeframe is agreed upon and documented in the medical record.

d. If a consultation is performed by an APP who cannot practice independently in the state of California or a resident/fellow in training, the supervising physician should review and add an addendum with their assessment and recommendations in a timely manner and not more than twenty-four (24) hours after the consult is completed.

e. If a full consultation report is not immediately available after the consultation, a note should be documented in the record containing the consultant's assessment and plan for the care of the patient. When operative procedures are involved, the consultation report, except in emergency situations so verified on the record, will be recorded prior to the operation/procedure.

3.14 INPATIENT PSYCHIATRIC UNIT CARE PLANS

The written plan of care shall be based on the patient's short and long-term goals and the time frames, settings, and services required to meet the goals. The written care plan includes the responsibilities of each team member[22] and the following:

a. A substantiated diagnosis
b. Documentation to justify the diagnosis and the treatment and rehabilitation activities carried out
c. Documentation that demonstrates all active therapeutic efforts
d. The specific treatment modalities used to treat the patient

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[21] TJC PC.03.01.07-07: A post-anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services. TJC PC.03.01.07-08: The post-anesthesia evaluation for anesthesia recovery is completed in accordance with law and regulation and policies and procedures that have been approved by the medical staff.
[22] TJC PC.01.03.01-05/06/43

3.15 FINAL DIAGNOSES

The final diagnoses will be recorded in full, dated and signed by the discharging practitioner in the discharge summary, transfer note, or death summary of the patient. If pertinent diagnostic information has not been received at the time the patient is discharged, the discharging practitioner will be required to document such in the patient's record.

3.16 DISCHARGE SUMMARIES

At the time of the patient's discharge or transfer, the patient or their representative shall be informed about the care, treatment, and services provided to the patient.[23] The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. All discharge summaries, including the Death Summary, are the responsibility of the discharging physician, or designee. Documentation should be completed within twenty-four (24) hours of discharge All discharge summaries completed by APPs who are not permitted to practice independently in California and residents/fellows in training must be cosigned.

a. Content: Information for service providers shall include:[24]

i. The reason for the patient's discharge or transfer
ii. The patient's physical and psychosocial status
iii. A summary of care, treatment, and services provided
iv. The patient's progress toward goals
v. A list of community resources or referrals made or provided
vi. The patient's treatment preferences

b. Content: The discharge summary shall contain[25]

i. The reason for hospitalization
ii. The procedures performed
iii. The care, treatment, and services provided
iv. The patient's condition and disposition at discharge
v. Information provided to the patient and family
vi. Provisions for follow-up care

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[23] TJC PC.04.02.01
[24] TJC PC.04.02.01-01: At the time of the patient's discharge or transfer, the hospital informs other service providers who will provide care, treatment, and services to the patient about the elements noted.
[25] TJC RC.02.04.01-03: In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the elements noted.

c. Death Summary: A discharge summary is required on all inpatients who have expired and will include:

i. Reason for admission,
ii. Summary of hospital course,
iii. Cause of death, and
iv. Final diagnoses.

3.17 CLINIC DOCUMENTATION AND IN-BASKET MANAGEMENT

3.17.1 See Appendix A.

3.18 STUDENTS, RESIDENTS, AND FELLOWS IN TRAINING

3.18.1 Residents shall be permitted to function clinically only in accordance with the written training protocols developed by the Graduate Medical Education Committee (GMEC) and the Medical Executive Committee (MEC).

3.18.2 The post-graduate education program director or committee must communicate periodically with the MEC.[26]

3.19 ACCESS AND CONFIDENTIALITY

A patient's medical record is the property of the Hospital. If requested, protected health information (PHI) contained in the record will be made available to any privileged practitioner attending the patient, to practitioners at other hospitals, and to others in accordance with the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH) and state information privacy and security laws. See hospital policies on confidentiality and protected health information.

3.20 INCOMPLETE/DELINQUENT MEDICAL RECORDS

Penalties for noncompliance with medical record completion requirements are outlined in "CCHS Provider Notification and Suspension of Privileges Process" (see Appendix A).

3.21 COPY AND PASTE FUNCTIONALITY

Previously documented information that is carried forward, imported, or supplied by use of a template must be reviewed and edited to accurately reflect the services provided during the current encounter.

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[26] TJC MS.04.01.01-05: There is a mechanism for effective communication between the committee(s) responsible for professional graduate education and the organized medical staff and the governing body.

ARTICLE IV. STANDARDS OF PRACTICE

4.1 ORDERS

4.1.1 Verbal/Telephone Orders

Verbal/telephone orders are discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner to write the order or enter it in the EHR. Verbal orders are given directly from the ordering practitioner to the recipient hospital staff; telephone orders are given directly from the ordering practitioner to the recipient hospital staff via telephonic communication means. Verbal/telephone orders must be given to an authorized individual[27] and comply with Hospital Pharmacy "Policy for Telephone, Verbal, and Written Orders for Medication," "Policy for Verbal and Written Orders," and "Policy for Medication Preparation."

4.1.2 Orders from sources other than the Electronic Health Record

Orders should be entered in the EHR except in cases when the EHR is not available including during downtime. In this case, the Hospital downtime policies should be followed. Orders transmitted by facsimile, written/printed on paper, or other forms of transmittal other than the electronic health record shall be considered properly authenticated and executable provided that:

a. The order is legible, clear, and complete

b. The identity of the patient is clearly documented

c. The order contains the name of the ordering practitioner, address and a telephone number for verbal confirmation, the time and date of transmission, and the name of the intended recipient of the order, as well as any other information required by federal or state law, and

d. The order contains the practitioner's signature.

e. The order may be executed by hospital policy or by a privileged practitioner.

4.1.3 Medication Reconciliation

Medication reconciliation is performed when the patient:

a. is admitted,

b. following surgery (OR/PACU to the unit),

c. is transferred to or from a unit,

d. is transferred to, and readmitted from, another hospital or health care facility, or

e. is discharged.

New orders shall be specifically written following surgery or the transfers noted above.

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[27] RC.02.03.07-01: The hospital identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation. RC.02.03.07-02: Only authorized staff receive and

record verbal orders.

4.1.4 Drugs and Medications

Orders for drugs and medications must follow "Hospital Pharmacy Policy for Prescribing & Ordering", "Policy for Verbal and Written Orders", and "Policy for Telephone, Verbal, and Written Orders for Medications".

4.2 CONSULTATIONS

4.2.1 The following circumstances may prompt consultation or management by a physician or other licensed practitioner:[28]

a. Treatments needs are outside of the scope of privileges of the attending physician,

b. Doubt exists as to the diagnosis or choice of therapeutic measures to be utilized,

c. In unusually complicated situations where specific skills of other practitioners may be needed, and

d. When requested by a patient or their representative and deemed appropriate by the attending physician.

4.2.2 Any qualified practitioner with clinical privileges may be requested for consultation within their area of expertise. The attending physician, or designee, will provide written authorization in the EMR requesting the consultation, permitting the consulting practitioner to attend or examine their patient. The referring practitioner can determine if the consulting physician, or their designee, is necessary to perform the consultation.

a. Every consultation request should contain the reason for the consultation and the urgency of the consultation; the following timeframes should be followed:

i. Routine consultation – within twenty-four (24) hours,

ii. Urgent/STAT consultation – based on the conversation between the referring and consulting practitioners

b. Practitioner-to-practitioner communication is required for all non-routine consultations (i.e. Urgent or STAT priority).

c. Consultations may be done in timeframes longer than twenty-four (24) hours if appropriate for the patient and their medical condition.

d. Consultants are not required to perform daily visits, unless the patient's condition warrants it.

e. APPs may perform the consultation, including ordering diagnostics or therapeutics.

f. Residents may perform the consultation, including ordering diagnostics or therapeutics. The supervising physician will cosign the resident consultation note.

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[28] TJC MS.03.01.03-04: The organized medical staff, through its designated mechanism, determines the circumstances under which consultation or management by a Doctor of Medicine or Osteopathy, or other licensed practitioner, is required.

4.3 DEATH IN HOSPITAL

4.3.1 Pronouncing and Certifying the Cause of Death

In the event of a Hospital death, the deceased shall be pronounced dead by a physician within a reasonable time. For inpatients, the attending physician is responsible for certifying the cause of death and completing the Death Certificate within fifteen (15) hours and prior to release of the body from the Hospital, in accordance with law.[29] The "Hospital Procedure for Patient Expiration" must be followed. In cases of fetal demise or neonatal death, the "Hospital Policy for Fetal Demise/Neonatal Death" must be followed.

4.3.2 Organ Procurement

When death is imminent, physicians should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable. "Hospital Policy for Anatomical Donations for Tissue and Organ Transplantation" should be followed.

4.4 AUTOPSY

Unless the Medical Examiner exercises jurisdiction, it is the responsibility of the attending physician to consider and order autopsies. It is the responsibility of the attending physician to consider an autopsy in all cases of unusual deaths, in cases of medico-legal, or of special educational interest. A provisional diagnosis and the complete autopsy report will be completed as soon as possible. See "Policy for Patient Expiration" and "Policy for Autopsy Protocol".

4.5 ADVANCED PRACTICE PROVIDERS

4.5.1 Overview

Advanced Practice Providers (APPs) are defined in the Medical Staff Bylaws.

4.5.2 Guidelines for Advanced Practice Providers (APP)

a. Health care services delivered by APPs to patients under their care must be within the scope of each practitioner's authorized practice, as defined by state law.

b. The APP is responsible for coordinating and managing the care of their patients, in collaboration with specialists and other qualified medical professionals, and ensuring the quality of health care provided to patients.

c. The role of the APP in the delivery of care shall be defined through mutually agreed upon Scope of Practice Guidelines that are developed by the Interdisciplinary Practice Committee and approved by the Medical Executive Committee.

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[29] Cal. Health & Saf. Code § 102800: Attending to complete the death certificate within fifteen (15) hours.

d. Consultation, either in person or through telecommunication systems or other means, shall be available at all times.

e. Patients should be made aware whether they are being cared for by a physician or APP.

f. Ongoing Professional Performance Evaluations will be completed on schedule for the APP with the supervising physician or department/division chair as established by MEC policy. The supervising or specialty physician is responsible for clarifying and familiarizing the APP with supervision methods and style of delegating patient care.

g. A record of all supervising or delegating physicians is kept on file by the Medical Staff office, as applicable, and reviewed regularly through the credentialing process.

4.5.3 Supervising/Delegating Practice Agreements

Advanced Practice Providers that require supervision or collaboration must have a written Supervision/ Collaboration Agreement on file in the Medical Staff Office that describes health care-related tasks which may be performed by the APP. This document must be signed by the APP and the supervising/ collaborating physician. Changes to the APP's supervising/collaborating physician will be updated through the credentials process.

4.5.4 Supervising/Delegating Physician

a. A physician may not supervise more APPs than is allowed by state law.

b. A physician who fails to fulfill the responsibilities defined in this section and/or in a sponsorship agreement for the supervision of, or collaboration with, an APP shall be subject to appropriate corrective action as provided in the Medical Staff Bylaws.

4.5.5 Medical Record Documentation

Advanced Practice Provider medical record documentation is addressed in Section 3, and in policies "Authority to Make Medical Record Entries" and "Procedure for Medical Record Content".

4.6 INFECTION PREVENTION AND CONTROL

All practitioners are responsible for complying with "Infection Prevention" policies and procedures in the performance of their duties, including hand hygiene.

ARTICLE V. PATIENT RIGHTS

5.1 PATIENT RIGHTS

All practitioners shall respect the patient rights as delineated in "Hospital Policy for Patients' Rights."

5.2 INFORMED CONSENT

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make their own determination regarding medical treatment. The practitioner's obligation is to present the medical facts accurately to the patient, or the patient's surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical and legal obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner that results in the patient's authorization or agreement to undergo a specific medical intervention. Informed consent should follow the "Hospital Policy for Consent to Medical Treatment."

5.3 ADVANCE DIRECTIVES AND DO NOT ATTEMPT RESUSCITATION

Hospital policies delineate the responsibilities, procedure, and documentation that must occur regarding Advance Directives, when withdrawing or withholding life-sustaining treatment, and when initiating or cancelling a Do Not Resuscitate order. See "Policy for Do Not Resuscitate (DNR)," "Policy for Advance Health Care Directive (Patient Self-Determination Act)," and "Policy for Pre-Hospital Do Not Resuscitate Orders."

5.4 DISCLOSURE AND REPORTING OF UNANTICIPATED OUTCOMES

Hospital policies delineate the responsibilities, procedure, and documentation that must occur when an unanticipated outcome does occur. See policy "Adverse Event Reporting."

5.5 RESTRAINTS AND SECLUSION

The Hospital policy "Procedure for Denial of Patient Rights" delineates the responsibilities, procedure, and documentation that must occur when ordering restraints or seclusion.

5.6 INVESTIGATIONAL STUDIES

Investigational studies and clinical trials conducted at the Hospital must be approved in advance by the Institutional Review Board. When patients are asked to participate in investigational studies, Hospital policy should be followed.

ARTICLE VI. SURGICAL CARE

6.1 TISSUE SPECIMENS

Specimens removed during the operation will be sent to the Hospital pathologist who will make such examination as may be considered necessary to obtain a tissue diagnosis. Certain specimens are exempt from pathology examination, as defined in "Policy for Specimen Exempted from Submission for Pathology Examination and Specimens not Routinely Examined Histologically." The pathologist's report will be made a part of the patient's medical record.[30]

6.2 VERIFICATION OF CORRECT PATIENT, SITE, AND PROCEDURE[31]

The physician/surgeon has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention will be identified by an ID with the patient's name and a second identifier as chosen by the hospital. Hospital policy "Universal Protocol Procedure", shall be followed.

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[30] TJC PC.03.01.08: The medical staff approves a policy in coordination with Pathology and the Laboratory regarding specimens removed during surgical procedures.
[31] UP.01.01.01-02: Conduct a pre-procedure verification process. The expectation of this element of performance is that the standardized list is available and is used consistently during the pre-procedure verification.

ARTICLE VII. RULES OF CONDUCT

7.1 DISRUPTIVE BEHAVIOR

Practitioners are expected to conduct themselves in a professional and cooperative manner in the Hospital. Disruptive behavior is behavior that is disruptive to the operations of the Hospital or could compromise the quality of patient care, either directly or by disrupting the ability of other professionals to provide quality patient care. "Policy for Appropriate Workplace Behavior" shall be followed.

7.2 IMPAIRED PRACTITIONERS

Reports and self-referrals concerning possible impairment or disability due to physical, mental, emotional, or personality disorders, deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs or alcohol shall be referred to the Medical Staff Assistance Committee.

7.3 TREATMENT OF FAMILY MEMBERS

The following is based on the AMA *Code of Medical Ethics*' Opinion on Physicians Treating Family Members. In general, practitioners should not treat themselves or their family members. Family members are deemed to include spouses, domestic partners, parents, parents-in-law, children, stepchildren, and siblings.

In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians are discouraged to serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

7.4 MEDICAL RECORDS OF SELF AND FAMILY MEMBERS

Practitioners shall follow the "Confidentiality of Patient/Client Information" policy and "Confidentiality/ Security of Electronic Patient Information" policy, regarding access, use, and disclosure to protected health information of themselves or family members to maintain compliance with HIPAA and state privacy laws. Practitioners must utilize the Patient Portal or the traditional release of records process to access their own, or their family member's, medical records. See Procedure for "Removal, Retention, and Destruction of Protected Health Information" policy.

7.5 COMPLIANCE WITH HOSPITAL HEALTH REQUIREMENTS

All practitioners must comply with the Hospital's policy on testing, vaccinations, and all other infection control measures.

7.6 COMMUNICATION METHODS

All practitioners must maintain a currently accessible county e-mail address on file in the Medical Staff Office, as well as a current cell phone number.

All practitioners must use the accepted method of communication regarding clinical care as determined

by the MEC and department leadership (eg: Epic Chat, cell phone, etc).

ARTICLE VIII. FUNCTIONS OF THE MEDICAL STAFF

8.1 Description of Medical Staff Functions

The Medical Staff is responsible for the oversight of the quality of patient care, treatment, and services provided by physicians and other licensed practitioners privileged through the medical staff process.[32] In addition, the medical staff is responsible for the leadership and oversight of activities related to patient safety.[33] To ensure appropriate oversight, the Medical Staff, acting as a whole or through committees, participates in hospital committees or medical staff committees that address the following:

1) governance, 2) medical care evaluation/performance improvement/patient safety activities, 3) hospital performance improvement and patient safety programs, 4) credentials review, 5) information management, 6) emergency and disaster preparedness, 7) strategic planning, 8) bylaws review, 9) nominating process, 10) infection prevention and control, 11) pharmacy and therapeutics, 12) practitioner health, 13) utilization management 14) continuing education, and 15) collaboration with administration and nursing.

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[32] TJC MS.03.01.01
[33] TJC MS.03.01.01-04/05

ARTICLE IX. MEDICAL STAFF COMMITTEES

9.1 General

Committees, designation, substitution, meetings, special meetings, quorum, and attendance are all outlined in the Bylaws. The committees listed below report to the MEC, and address the medical staff's responsibility to oversee and participate in hospital and medical staff functions.[34]

9.2 Credentials Committee

The Credentials Committee details are documented in Part III, Section 1 of the Medical Staff Bylaws.

9.3 Peer Review Oversight Committee (PROC)

The details of this committee are documented in the Peer Review Oversight Committee Charter. (see attachments)

9.4 Administrative Affairs (Bylaws) Committee

9.4.1 Composition: Chair and at least one (1) other member of the Medical Staff.

9.4.2 Meetings: The committee shall meet at least biennially, or more often to address required or requested amendments.

9.4.3 Responsibilities: The committee shall be responsible for making recommendations relating to revisions and updating the Bylaws and Rules & Regulations; receiving all correspondence regarding any suggestions of changes or additions to the Bylaws or Rules & Regulations and acting on these suggestions; and being responsible for a comprehensive review of the Bylaws and Rules & Regulations biennially.

9.5 Ambulatory Policy Committee

9.5.1 Composition: Chair, DFAM Chair or designee, at least one Allied Health Professional, ideally one representative from Ob/Gyn, Surgery, Pediatrics, and Specialty Medicine, anyone with special expertise needed on an ad-hoc basis. Non-voting members: Ambulatory Care Medical Director, Chief Nursing Officer or designee. Regional representation (Martinez, Concord, East County, Far East County, West County, North Richmond) is strongly recommended.

9.5.2 Meetings: The committee shall ideally meet monthly, but at minimum ten (10) times per year.

9.5.3 Responsibilities: Sets Medical Staff policy in the health centers and acts as a liaison with Nursing and Administration for coordination of policies and procedures under joint Medical Staff-Administration or Medical Staff-Nursing purview. APC develops policies to resolve issues that affect more than one Medical Staff Department and focuses on policies and projects that relate to quality of care, the efficiency of the health centers and patients that relate to quality care, the regulatory compliance. APC coordinates its activities with PSPIC and receives quality assurance reports suggestive of or requiring changes in policies and procedures from individual Medical Staff Departments and from the Ambulatory Subcommittee of PSPIC.

[34] Title XXII 70703(d): the medical staff bylaws and rules shall include the following functions: executive review, credential, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting medical staff members impaired by chemical dependency and/or mental illness.

9.6 Ethics Committee

9.6.1 Composition: Chair and at least 4 members from a multidisciplinary representation of clinical services, lay members, hospital administration. The Committee is encouraged to invite other professional or community members to be utilized when discussing issues involving their particular clinical, ethnic, religious or other background.

9.6.2 Meetings: The committee will meet regularly (at least six (6) times yearly) and will also provide a mechanism for other meetings as necessary to perform case consultation functions.

9.6.3 Responsibilities: The Bioethics Committee provides a multi-disciplinary forum for the development of guidelines for consideration of cases and issues having bioethical implications; development and implementation of procedures for the review of such cases; development and/or review of institutional policies regarding care and treatment in cases or issues having bioethical implications; consultation with concerned parties to facilitate and education of the hospital staff regarding bioethical matters. The committee chair will report to the Medical Executive Committee.

See "Ethics Committee Policy" for additional committee guidelines.

9.7 Continuing Medical Education Committee

9.7.1 Composition: A Chairperson appointed by the Medical Staff President, subject to MEC approval; at least two additional Medical Staff Members; and, if available, the Medical Librarian, without vote.

9.7.2 Meetings: at least twice a year, and more frequently as needed

9.7.3 Purpose: The Continuing Medical Education Committee (CMEC) directs the development of CME programs in response to quality assurance findings and needs of Medical Staff, in collaboration with nursing staff. The committee apprises the Medical Staff of outside education opportunities. The CMEC also analyzes the status and needs of, and makes recommendations regarding, the medical library services via provider journal subscriptions. The CMEC supports the provider simulation lab to help Medical Staff learn and keep up procedural skills. Simulated procedures can help providers get/maintain privileging. The CMEC Chair will coordinate with departments who will utilize the lab, and with Professional Development on upkeep and expansion.

9.8 Cancer Committee

See Committee Charter (see attachments)

9.9 Medical Staff Assistance Committee

See Committee Charter (see attachments)

9.10 Inter-Disciplinary Practice Committee

See Committee Charter (see attachments)

9.11 Patient Care Policy and Evaluation Committee (PCP&E)

See Committee Charter (see attachments)

9.12 Patient Safety and Performance Improvement Committee

9.12.1 Composition: Chair appointed by the Medical Staff President, subject to MEC Approval; Medical Staff President; CCRMC CEO; Director of Pharmacy; CMO; CNO; Ambulatory Care Medical Director; COO; CQO; past Medical Staff President; Chair of PCP&E; Patient Safety Officer; Director of Safety and Performance Improvement; Medical Director of Quality and Safety; Hospital Medical Director, Specialty Medical Director; Hospital Regulatory Compliance Officer; Quality Manager Program Coordinator; two medical staff representatives, appointed by the Medical Staff President, subject to MEC approval; one medical staff member representative from the Behavioral Health Division, appointed by the Medical Staff President, subject to MEC approval

9.12.2 Meetings: The committee shall ideally meet monthly, but at minimum 10 times per year.

9.12.3 Responsibilities: The Patient Safety and Performance Improvement Committee (PSPIC) has the authority and responsibility for implementing and directing the Quality Management Program for the Hospital. It is responsible for setting the quality management standards, determining criteria by which care will be measured, setting priorities for which aspects of care will be monitored, and analyzing the quality-of-care studies, indicators, utilization reports, grievances, survey data, and risk management information. A systematic, multi-disciplinary improvement process is followed. It develops an annual plan for performance improvement activities (Quality Management Plan).

Appendix A

CCRMC Provider Notification and Suspension of Clinical Privileges Process

Current support of In Basket management for providers:

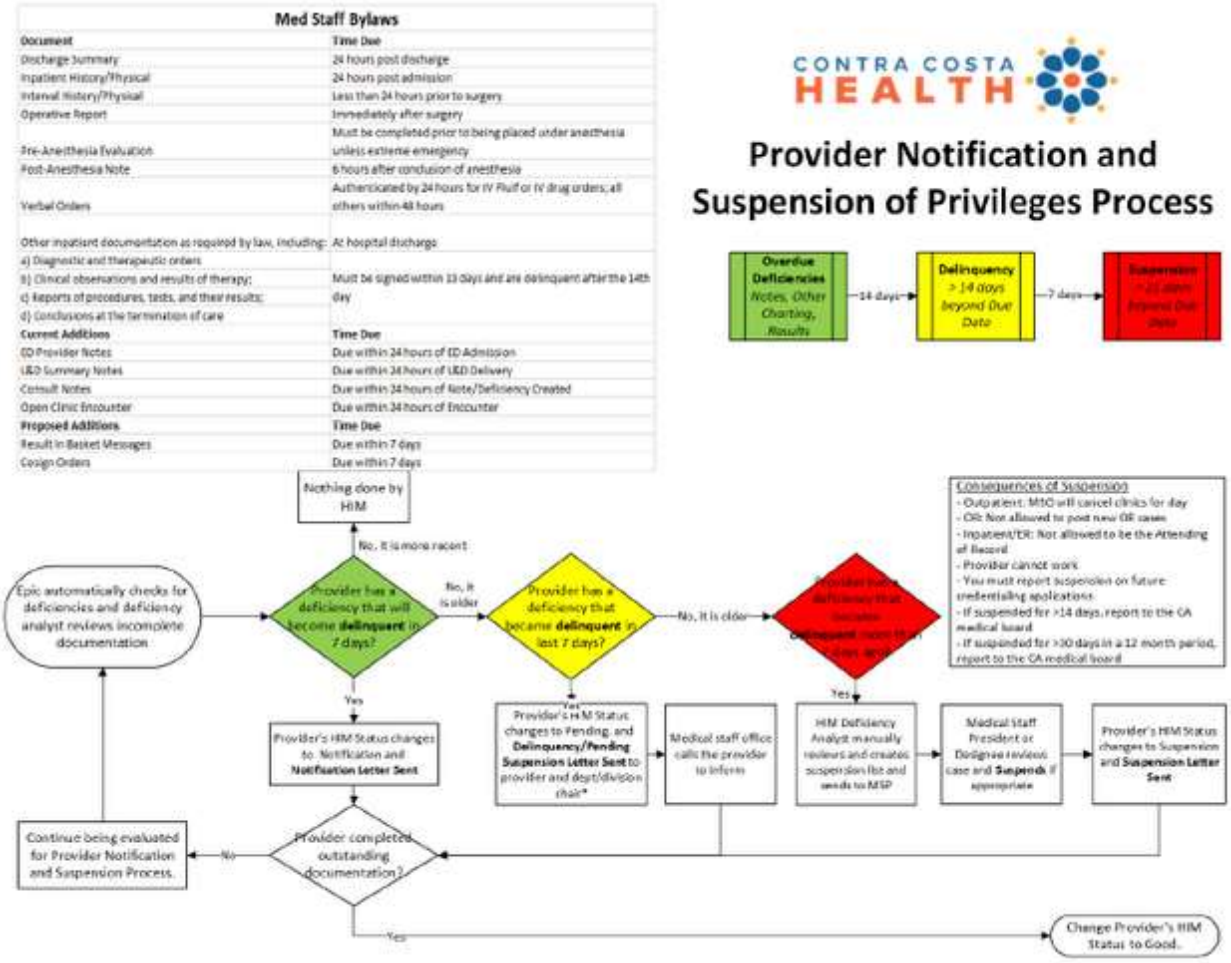
- Medical Staff Office (MSO) can schedule Dragon voice recognition software training upon request
- MSO can help you schedule Super User sessions and cancel clinic for this
- Once you reach delinquency, Health Information Management (HIM) will automatically notify you and your dept/division chair per the attached algorithm
- A human in the MSO will call you once you are one week away from suspension
- Your department/division chair can help you navigate work-life balance, assist adjusting your schedule if possible, and make a referral to the Medical Staff Assistance Committee
- Primary care health home team will help PCPs address messages, prior authorizations, etc.
- As a reminder to PDOCC (Physicians' and Dentists' Organization of Contra Costa) members: MOU (Memorandum of Understanding) changes have helped to increase clinical admin time, and add telephone clinics, and bill for extra telephone encounters
- Future state: Superusers can set you up with AI note writing upon request

* Please remember: If you feel you are falling behind, and might be in danger of a suspension, be PROACTIVE. Call HIM and come up with a plan to get the support you need!

Resources

Your Deficiency Team

- Your Department Chair
- Medical Staff President/Designee
- HIM Deficiency Analyst
- HIM Director



Attachments

- Cancer Committee Charter
- Inter-Discpilinary Practice Committee Charter
- Medical Staff Assistance Committee Charter
- Patient Care Policy and Evaluation Committee
- Peer Review Oversight Charter

Approval Signatures

Step Description	Approver	Date

Joint Conference Committee	John Gioia: Board of Supervisor	Pending
	Sarah Mcneil: OBGYN Fam Med Adv Obst Ex	06/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18266034**

Origination	09/2008
Last Approved	N/A
Effective	Upon Approval
Last Revised	05/2025
Next Review	3 years after approval
Owner	Leah Carlon: Health Care Risk Manager
Area	Hospital & Health Centers

Policy for Escalation

POLICY STATEMENT:

Issues that indicate the need for immediate clinical or safety intervention shall be promptly communicated to ~~a practitioner responsible for the~~the clinical care team and/or appropriate administrative leadership. Employees of Contra Costa Regional Medical Center and Health Centers have the responsibility and authority to immediately intervene to protect the safety of a patient~~'s care~~ to prevent a medical error or harm to a patient, employee, or visitor. ~~Employees of Contra Costa Regional Medical Center have the responsibility and authority to immediately intervene to protect the safety of a patient to prevent a medical error or harm to a patient.~~

(Authority to Intervene to Protect Patient Safety and to Report Safety Concerns)

GUIDELINES:

A. All hospital and health center employees, contractors, and providers are obliged to escalate any concern they have over the safety or wellbeing of any patient, staff member, or visitor, through immediate intervention or through the chain of notification.

B. Time Frames for Escalation of Concerns:

1. Critical Concerns (concerns that may represent a life-threatening situation or a situation that may lead to serious impairment or disability):

~~a. Immediate escalation / intervention should occur for critical concerns~~

~~b. The concerned team member should "Speak Up" to "Stop the Line". Phrases used to intervene may include:~~

~~i. "Stop the Line",~~

~~ii. "Stop"~~

~~iii. "This is not safe", or other phrases to obtain the immediate attention of team member(s).~~

a. Immediate escalation / intervention should occur for critical concerns:

i. Contact the immediate Supervisor and/or Nurse Program Manager, Ambulatory Care Clinical Services Manager or their designee, or Department Manager via phone or messaging of the employee involved.

a. Immediate Supervisor or Manager will escalate through either their Director or the Health Care Risk Manager to the Executive team.

ii. Submit SERS

iii. Contact the Safety Office/Deputy. For people not physically located in the hospital or clinic, contact local sheriff or police department for immediate concerns for threats or actions of physical harm including suicidal or homicidal intention.

b. The concerned team member should "Speak Up" to "Stop the Line". Phrases used to intervene may include:

i. "Stop the Line",

ii. "Stop"

iii. "This is not safe", or other phrases to obtain the immediate attention of team member(s).

c. The team members should immediately re-evaluate the safety of the situation and attempt to restore safety.

i. If all members of the care team including the Charge Nurse do not come to a resolution, leadership should be consulted (e.g., the Medical Director, the Nurse Program Manager, Medical Center Supervisor, Ambulatory Care Clinical Services Manager or their designee, Department Manager, etc.)

2. ~~The team members should immediately re-evaluate the safety of the situation and attempt to restore safety.~~Other patient, visitor or staff safety concerns should be escalated within a clinically appropriate time frame.

3. ~~If all members of the care team including the Charge Nurse do not come to a resolution~~Concerns regarding conditions that have the potential to affect safety should be escalated, ~~the Chief of the department~~and reported through the Safety Event Reporting System (SERS), ~~the Nurse Program Manager or Medical Center Supervisor should be consulted~~within a reasonable time frame appropriate to the condition reported, such as the same day the condition is discovered.

~~a. Other patient, visitor or staff safety concerns should be escalated within a clinically appropriate time frame.~~

~~b. Concerns regarding conditions that have the potential to affect safety should be escalated, and reported through the event reporting system, within a reasonable time frame appropriate to the condition reported, such as the same day the condition is discovered.~~

4. When an employee is aware of or is the recipient of inappropriate behavior by a patient/family member(s)/significant other which contributes to an "incident," that employee should document the incident in the SERS, within a reasonable time frame appropriate to the incident reported, such as the same day the incident occurs, and notify their Supervisor/Manager as well as the Safety Office/Deputy, if appropriate.

C. Physician Response to Immediate Clinical Concerns: Physicians are expected to respond to concerns (by telephone or in person):
   a. Within 15 minutes of a STAT or EMERGENT request
   b. Within a clinically appropriate time frame for other requests

D. General Chain of Notification:
   1. Safety concerns should be escalated until resolved to the satisfaction of the team member through the following steps (when applicable):
      a. Patient Care Concerns:
         i. The Nurse with immediate responsibility for the care of the patient
         ii. The Physician responsible for the care of the patient
         iii. The Medical Center Supervisor
   2. The team member with the concern should also inform and seek the assistance of appropriate supervisory and support personnel, such as the Charge Nurse, Nurse Program Manager, or Rapid Response Team. Use of the chain of notification does not exclude collaboration with other team members as appropriate.
      a. Environment / Equipment Concerns:
         i. The department supervisor or manager
         ii. The Medical Center Supervisor
         iii. The Director or Chief of the Service / Area

E. Event Reporting: Event reports are used to improve systems and processes in order to reduce the chance of error or to address conditions that can impact safety. An event report should be completed whenever an unresolved concern exists, ~~such as~~including but not limited to:
   1. An error has occurred
   2. A high potential for error exists
   3. An unsafe condition exists
   4. Safety procedures cannot be followed
   5. A condition exists that interferes with the ability to provide care
   6. An attempt to resolve an immediate concern is unsuccessful at any level (e.g. unable

to contact the physician for a critical concern within 15 minutes)

7. Patient, employee, or visitor harm has occurred
8. Adverse and Sentinel Events

RELATED LINKS:

SERS (Safety Event Reporting System) Event / Incident Reporting System: Login

APPROVALS:

Clinical Practice Committee: 2/2016
Patient Care Policy & Evaluation Committee: 3/2016
Medical Executive Committee: 4/2016

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
CCRMC Chiefs	David Culberson: County Hosp Exec Dir-Exem	06/2025
	Leah Carlon: Health Care Risk Manager	05/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18105450

Origination	09/2012
Last Approved	N/A
Effective	Upon Approval
Last Revised	05/2025
Next Review	3 years after approval
Owner	Kelley Taylor: Ambulatory Care Clin Supv
Area	Ambulatory Care

Policy for Code of Conduct

POLICY STATEMENT:

Ambulatory Care staff are expected to adhere to the following guidelines as delineated in this policy:

Staff should maintain a professional, customer (internal and external) focus and demeanor ~~at all times~~always. Staff are expected to adhere to the Ambulatory Care ~~"~~"Service Excellence Principles~~"~~" and Communication Guidelines. Staff are expected to take~~"~~", upon hire, "Customer Service Class & Communication Class~~"~~" or as directed by the Ambulatory Care Clinical Supervisor, through HSD Personnel. Lack of adherence may lead to disciplinary action.

GUIDELINES:

A. Compliance with established policies, including, but not limited to those of:
    1. County
    2. Health Services Department
    3. Hospital and Health Centers Division
    4. Ambulatory Care
    5. Laws and Regulations governing Ambulatory Care and Healthcare.

B. Ambulatory Care staff are expected to:
    1. Inform patients of, and advocate for the rights of patients.
    2. Assist peers in caring for our patients.
    3. Participate in quality and performance improvement efforts.

4. Hold themselves **accountable** for doing the work of Ambulatory Care.
5. Take responsibility for keeping him/~~herself~~her updated on department meeting minutes, communication book entries, postings, newsletter, memos, email and other management disseminated information. Attend all mandatory clinical classes, Human Resource training classes and complete all assigned all eLearning modules that are assigned.
6. Conduct personal business on own time.
7. Avoid using the Internet for non-job-related functions and personal use. Sign an Internet Policy agreement yearly to comply with this adherence. Use of all county devices including but limited to secure chat, tiger text, email to only be use for county related business.
8. Be at assigned workstation and ready to begin work at the start of shift and after designated breaks and lunch times.
9. If you have not received pre-approval for time off or away from workstation, you are then expected to be at your workstation at the start of your shift.
10. Limit break times to that time that is recognized according with your position and union.
    a. Take one break during the first 4 hours of shift and one break during second 4 hours of shift according to your designated MOU. There is no combining breaks and lunch. For breaks that were missed the manager or designees must be notified in at least one hour advance.
    b. Breaks must be coordinated with teammates to ensure adequate provider coverage and always provide ~~for~~ patient safety ~~at all times~~.
    c. ~~**Hosp Policy 508, "Hand-Off Communication**~~"Hospital Policy for Hand-Off Communication shall be followed (relevant patient information must be communicated prior to leaving for break and on return).
11. Always obtain permission from the Clinical Services Manager or designee if it is necessary to leave work prior to the end of the shift, or any other time~~;~~. such as a pre-approved physician appointment. If you are an employee with a personal medical appointment, that has been granted pre-approval time off, please follow the appropriate process of registering and fulfilling your appointment as all patients of our health system.
12. To ensure the safety and health of all our employees, there should be no food or beverages in any clinical areas with a reasonable risk of patient contamination.
13. Adhere to the established dress code, including:
    a. ~~Wearing name tag at all times.~~Always wear your county issued name tag.
    b. Avoid wearing excessive jewelry or personal effects that may become a hazard in the performance of duties.
    c. Avoid excessive use of perfumes and/or ~~colognes~~cologne.
    d. No open-toed shoes in clinical areas or areas in which clinical operations may occur at any time.

e. Adhering to Infection Control hand hygiene policy regarding fake nails and nail polish in clinical areas~~.~~

f. Professional attire (i.e., clothing that is not provocative or excessively revealing).

14. Comply with policy regarding notification of unplanned absences (See ~~AC Policy #2006, "Unplanned Absences~~Ambulatory Care's Policy for Unplanned Absences,~~"~~" for specific details.)

15. ~~Be responsible for~~It is the employees responsibility for always having a ~~current~~current license ~~(if applicable) on file with the Clinical Service Manager at all times~~, for staff that require a license, and an active BLS.

    a. All licenses must be presented to the Clinical Services Manager who will ~~in~~ turn forward to the ~~ANSOS/Staffing Coordinator~~Staffer to enter update in Shift Select.

    b. Failure to have a current license on file will prohibit you from working and could result in disciplinary action.

16. ~~Remain~~Always remain productive ~~at all times~~.

    a. When workload and usual tasks are completed, it is expected that you will support other colleagues or notify your immediate supervisor for additional job-related assignments. Keep all personal conversations out of workstation to maintain HIPPA compliance.

C. Code of Conduct

1. Ambulatory Care staff are expected to:

    a. Maintain a professional~~,~~ customer (internal and external) focus and demeanor ~~at all times~~always.

    b. Treat patients, co-workers, Health Center staff and the public with courtesy, respect and responsiveness.

    c. Maintain sensitivity and respect for the differences of co-workers and patients in the work environment, including but not limited to culture, gender, sexual preferences, religious or spiritual beliefs or lack thereof, race, ethnicity, age and national origin & demonstrate cultural humility.

    d. ~~Demonstrate cultural humility.~~

    e. Demonstrate zero-tolerance for boisterous, suggestive or profane language. (These are absolutely prohibited.) Be respectful of unnecessary noise and avoid having loud conversations not related to patient care, in all patient care areas.

    f. Be familiar with and adhere to Ambulatory Care~~'~~s ~~"~~"Service Excellence Principles~~"~~" in all customer encounters (both internal and external).

RELATED LINKS:

CCHSD Policy #117-A, "Service Excellence."

CCHSD Policy #223, "Violence in the Workplace Policy."

CCHSD Policy #271, "Appropriate Workplace Behavior Policy."

CCHSD Policy #271A, "Co-Worker Code of Conduct Guidelines."

APPROVALS:

Ambulatory Clinical Practice Committee: 6/19/2017, 2/2018

Ambulatory Policy Committee: 7/2017, 11/2018, 6/2022

/Medical Executive Committee: 8/2017, 11/2018, 7/2022

Joint Conference Committee

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Ambulatory Policy Committee	Laura R. Colebourn [LC]	05/2025
Ambulatory Clinical Practice Committee	Helena Martey	05/2025
	Kelley Taylor	05/2025

Standards

No standards are associated with this document

File #: 25-3040 **Agenda Date:** 7/28/2025 **Agenda #:** 5.

Advisory Board: Medical Services (CCRMC) Joint Conference Committee
Subject: Medical Staff Update
Presenter: Sarah McNeil, MD, Medical Staff President

Information:

A. Medical Staff General Updates (**informational only**) - providing updates related to SCORE survey and addressing provider burn out while improving patient access
B. CCRMC JCC Expedited Privileges Subcommittee members (**action: appoint**) - per Subcommittee charter, appoint members for subcommittee
C. CCRMC JCC Expedited Privileges new applicant approvals (**action: approve**) - approve new applicants for privileges per expedited privileges process
D. Patient Care Policy Review (**action: approve**) - summary of changes for approved clinical policies

Recommendation(s)/Next Step(s):

A. Medical Staff General Updates - **Informational only**
B. CCRMC JCC Expedited Privileges Subcommittee members - **Action**: *Appoint*
C. CCRMC JCC Expedited Privileges new applicant approvals - **Action**: *Approve*
D. Patient Care Policy Review - **Action**: *Approve*

Medical Staff General Updates

Contra Costa Regional Medical Center and Health Centers

Joint Conference Committee

July 28, 2025

Dr. Sarah McNeil, Medical Staff President

CONTRA COSTA HEALTH

General Updates

- SCORE survey
- Projects:
  - Increasing patient access
  - Decreasing provider burnout

CCRMC JCC Expedited Privileges

Contra Costa Regional Medical Center and Health Centers

Joint Conference Committee

July 28, 2025

CONTRA COSTA HEALTH

Appoint Subcommittee Members

- Charter Membership guidelines:

Membership

A. The Expedited Credentialing Subcommittee will consist of three members, two of whom must be voting members of the CCRMC JCC.

B. Members of the Subcommittee will be appointed by the CCRMC JCC for two-year terms every 2 years. Vacancies on the Subcommittee will be filled by appointment of the Chair of the CCRMC JCC to complete the remaining term of the vacant seat.

C. **Composition**: The Subcommittee shall consist of three members:

   1. CCRMC Chief Medical Officer (CMO) or Chief Executive Officer (CEO); and
   2. 2 members who are voting members of the CCRMC JCC.

CCRMC JCC Expedited Privileges: new applicant approvals

Contra Costa Regional Medical Center and Health Centers

Joint Conference Committee

July 28, 2025

CONTRA COSTA HEALTH

New applicants to approve

Applicant	Department/Specialty	Staff Category	Reviewer	Comments
Bhargava, Samhita, MD	Pediatrics-Outpatient	Active	Cedermaz	Off-Cycle Temp Privileges
Yeang, Calvin, MD	IM-Cardiology	Active	Cedermaz	Off-Cycle Temp Privileges
Carter, Inanna, MD	Hospitalist	Active	Moeller	Board Eligible-Ins, Hipaa
Jones, Mackenzie T. MD	Psychiatry/Psychology	Active	Saud	Needs temp priv. start date 8/5
Kang, Tyler, MD	IM-Hem/Onc	Courtesy	Saud	

Patient Care Policy Agenda 7-28-25

* ***Indicates policy is pending Medical Executive Committee's approval on 7/21/25.***

Title	Area	Revised?	Summary of Changes
Policy for Chaperones for Sensitive Physical Exams	Ambulatory Care	Revised	Minor reformatting
Policy for Radiation Exposure Monitoring	Diagnostic Imaging	Revised	Added DI Leadership approval date of 4/2025
Policy for Radiation Safety/Alara Program	Diagnostic Imaging	Revised	Added DI Leadership approval date of 4/2025
Policy for Occupational Exposure Limits to Radiation	Diagnostic Imaging	Revised	Minor formatting.
Policy for CT Exam Event/Incident Action Level Reporting	Diagnostic Imaging	Unchanged	No Comment Provided
Policy for CT Patient Exposure Recording and Reporting	Diagnostic Imaging	Unchanged	No Comment Provided
Policy for Department Radiation Safety Guidelines	Diagnostic Imaging	Unchanged	No Comment Provided
Policy for Mobile Fluoroscopic Equipment C-Arm Spacer Exemption	Diagnostic Imaging	Unchanged	No Comment Provided
Policy for Radiation Exposure to Pregnant Patients	Diagnostic Imaging	Unchanged	No Comment Provided
Policy for Radiation Safety Committee	Diagnostic Imaging	Unchanged	No Comment Provided
Policy for Radiation Safety Program	Diagnostic Imaging	Unchanged	No Comment Provided
Policy for Anatomical Donations for Tissue and Organ Transplantation *	Hospital & Health Centers	Revised	Removed fetus > 28 weeks verbiage
Policy for Patients' Rights	Hospital & Health Centers	Revised	Updated Section A to match our Patient Rights posters - this is up to date per CHA patient rights and regulatory requirements. Had to add #'s 24 and 25 to match Pt Right attachments. All other changes are for formatting. Updated the Patient Rights attachments in English and Spanish to current versions, including the new CCH logo and branding. No substantive changes from 2022 poster updates.
Serving Arrest Warrants on Hospitalized Patients	Hospital & Health Centers	Revised	Sentence structure
Policy for Assistance Animals at Contra Costa Regional Medical Center and Health Centers *	Infection Control	Revised	Policy updated to reflect changes made to state laws regarding Assistance Animals.
Management of Reusable Instruments Prior to Return to the Sterile Processing Department	Infection Control	Revised	Formatting changes for PolicyStat guidelines (changing step L from saying step 1-8 to say step A-H) Minor verbiage changes for flow/clarity. Updated approval dates for IC Committee and PCP&E.

Title	Area	Revised?	Summary of Changes
Policy for Wound Dressing Changes/Packing *	Nursing	Revised	Reviewed and updated by wound educator. Updated best practices related to infection control procedures and assessment. References updated.
Policy for Critical Congenital Heart Disease Screening	Perinatal	Revised	Updated guidelines: only one retest, threshold, per AAP. Updated reference.
Contact List for Disaster Fan-Out Procedures *	Pharmacy	Revised	Contact names and phone numbers were updated- Approvals section deleted.
Policy for Emergency Procurement of Drugs - Borrowing and Loaning *	Pharmacy	Revised	Removed old approvals. Approval workflow changed.
Policy for Emergency Resources *	Pharmacy	Revised	Cardinal health- pharmacy distribution contact list updated- 2025. In addition, removed approval section and deleted previous outdated Cardinal Contact List
Policy for Pharmacy ccLink Downtime Plan *	Pharmacy	Revised	Removed process for Fentanyl patch as it is no longer stored in Omnicells on the units. Approvals section deleted. BCA Downtime Procedures no longer available. Omnicell content is not printed but provided electronically to the MCS.
Policy for Pharmacy Disaster Fan-Out Procedures *	Pharmacy	Revised	Removed verbiage about pager as pagers are no longer used. Thank you
Policy for 340B Drug Discount Program	Pharmacy	Revised	language to prevent duplicate discounts for Out of State Medicaid claims by excluding them from billing
Policy for Infusion Pump System	Pharmacy	Revised	Removed "Alaris" pump brand name. Removed procedure section and created a new "Procedure" document.
Policy for Reporting Diversion of Controlled Substances	Pharmacy	Revised	Added link to new Board of Pharmacy Online reporting tool
Policy for Titrating Medications	Pharmacy	Revised	Added: If medication is titrated off but order is still active, the nurse may restart to meet the titration goal parameter with reference to the last infusion dose/rate or per provider order. Revised: The provider will be notified as soon as reasonably possible. All titration adjustments should be recorded in the medical record including supporting documentation.
Policy for Pharmacy Security *	Pharmacy	Unchanged	No Comment Provided
Policy for Anticoagulation Program in Ambulatory Care	Pharmacy	Unchanged	No Comment Provided
Policy for Bioterrorism Preparedness	Pharmacy	Unchanged	No Comment Provided
Policy For Neonatal High Flow Nasal Cannula *	Respiratory	New	Created a policy to reflect ezisting standard procedures, replaced NICU with level II nursery.
Policy for Continuous Nebulizer Therapy *	Respiratory	Revised	Minor formatting changes.

Status Pending PolicyStat ID 18105229

Origination	12/2011	Owner	Kelley Taylor: Ambulatory Care Clin Supv
Last Approved	N/A	Area	Ambulatory Care
Effective	Upon Approval		
Last Revised	04/2020		
Next Review	3 years after approval		

Policy for Chaperones for Sensitive Physical Exams

POLICY STATEMENT:

To specify how chaperones for sensitive (genital, breast or rectal) exams should be offered, provided, declined, and documented. To provide policy that is patient centered, supported by the established ethical and legal principals, and consistent with the recommendations of the American Academy of Pediatrics, The American College of Obstetrics and Gynecology, and the American Academy of Family Practice.

GUIDELINES:

A. All patients aged 12 and over undergoing a genital, rectal or breast exam should be offered a chaperone for the exam, and their response should be documented by staff.

B. Either a staff member or a family member/guardian is an acceptable chaperone, depending upon the patient's request. The name of the chaperone in the exam room should be documented in ccLink.

C. Patients declining a chaperone are not required to have one unless the examining provider determines it is indicated. This should be documented in ccLink.

D. Provider preference is one indication for a chaperone.

E. If a chaperone is indicated and declined, the provider is not obligated to do the exam, and should discuss with the patient their options, including seeking care elsewhere. This should be documented by the provider in ccLink.

F. This policy applies uniformly to all staff and patients. It does not differ with patient, provider, or chaperone gender.

~~NURSE RESPONSIBILITY:~~

~~A. At the point that it is apparent that a sensitive exam is intended (either on arrival, or when the provider expresses this intention):~~

~~1. The staff member rooming or preparing the patient will ask the patient (or parent/guardian if the patient is under 12 years old) in a private setting whether they would like a chaperone present for the exam and document the response. If a patient under the age of 12 years declines a chaperone, the provider is notified, and documentation is made.~~

~~B. It is recommended that staff members serve as chaperones for sensitive exams.~~

~~PROVIDER RESPONSIBILITY:~~

NURSE RESPONSIBILITY:

A. At the point that it is apparent that a sensitive exam is intended (either on arrival, or when the provider expresses this intention):

1. The staff member rooming or preparing the patient will ask the patient (or parent/guardian if the patient is under 12 years old) in a private setting whether they would like a chaperone present for the exam and document the response. If a patient under the age of 12 years declines a chaperone, the provider is notified, and documentation is made.

A. It is recommended that staff members serve as chaperones for sensitive exams.

PROVIDER RESPONSIBILITY:

A. Providers performing sensitive exams should ensure a chaperone is present if requested.

B. Providers should make clear to the staff they work with, their preferences regarding chaperones.

C. The examining provider should document the presence and name, or absence of, a chaperone in ccLink.

D. Alternatives to undergoing the exam, including seeking care elsewhere, should be given and documented by providers to patients who refuse a chaperone that the provider has determined is indicated.

~~DOCUMENTATION IN CCLINK SHOULD INCLUDE:~~

DOCUMENTATION IN CCLINK SHOULD INCLUDE:

A. The name, title, or relationship of the chaperone is present in the room during the exam.

B. If the patient declines a chaperone and the exam is done without a chaperone.

C. If the patient declines a chaperone, the provider requires a chaperone and the exam is not done.

D. Options for care discussed with the patient.

REFERENCES:

Committee on Practice and Ambulatory Medicine

Pediatrics May 2011, 127 (5) 991-993; DOI: https://doi.org/10.1542/peds.2011-0322

APPROVALS:

Ambulatory Care Policy Committee: 12/2011, 5/2013, 4/2017, 4/2020

Ambulatory Care Committee: 12/2011, 5/2013, 4/2017, 4/2020

Medical Executive Committee: 1/2012, 5/2013, 5/4017/ 4/2020

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Ambulatory Policy Committee	Laura R. Colebourn [LC]	05/2025
Ambulatory Clinical Practice Committee	Helena Martey	05/2025
	Kelley Taylor	05/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17982690

Origination	04/2019
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2025
Next Review	1 year after approval

Owner	Angela Womble: Chief Radiologic Technologist
Area	Diagnostic Imaging

Policy for Radiation Exposure Monitoring

POLICY STATEMENT:

To describe the radiation monitoring program implemented to track individuals who are occupationally exposed to ionizing radiation.

GUIDELINE:

A. According to the Code of Federal Regulations (10 CFR 20.1502), monitoring is required for:
    1. Any individual who is likely to receive an annual dose from radiation producing equipment in excess of 10% of the annual occupational limit (500mRem).
    2. Any minor who is likely to receive an annual dose from radiation producing equipment:
        a. A deep dose equivalent in excess of 100 mRem.
        b. A lens dose equivalent in excess of 150 mRem.
        c. A shallow dose to the skin or extremities equivalent to in excess of 500 mRem.
    3. Any individual entering a high or very high radiation area.
    4. Declared pregnant workers who are likely to receive radiation exposure during their entire pregnancy and receive a deep dose equivalent in excess of 100 mRem. (See "Declared Pregnant Worker Policy.")

B. Dosimeters are used to measure the radiation dose that individuals receive while attending patients undergoing therapeutic or diagnostic procedures while working with radiation generation devices (e.g., X-ray, CT, Fluoroscope cases) and radioactive materials.

1. CCRMC uses dosimeter badges to measure the amount of radiation exposure that employees receive while working.
2. If the dosimeter badge is exposed to radiation it will record the exposure on the filter inside of the dosimeter.
    a. When the dosimeter badge is analyzed (monthly), the results will show if the exposure received was static or dynamic.
        i. Static readings indicate that the dosimeter was not being worn when exposed. This can occur when leaving the dosimeter in a car or exam room when not worn.
        ii. Dynamic readings indicate that the dosimeter was worn at the time of exposure and the dose is valid.
3. The radiation dose will be calculated by the contracted vendor (LANDAUER).

C. All individuals who are occupationally exposed to ionizing radiation or radioactive materials on a regular basis will be issued a dosimeter badge.
    1. The following groups have been established along with the frequency of exposure reporting:
        a. Group 1: Radiology technologists (Monthly)
        b. Group 2: Surgery (Monthly)
        c. Group 3: Radiologists (Monthly)

D. Personnel who are exposed to radiation on an occasional basis will only be issued a dosimeter if requested. Examples include: physicians, OR nurses, secretarial staff who work in the clinic but do not work with patients, and nurses working in Interventional Radiology (IR).

E. Dosimeters are assigned to and worn by only one individual. While engaged in hospital work, all individuals who are assigned dosimeters shall always wear the dosimeter while in the presence of ionizing radiation.

F. All dosimeters are to be stored in a radiation-free area when not being worn.

G. Personnel monitors must be processed by a laboratory accredited by the National Voluntary Laboratory Accreditation Program for Personnel Dosimetry Processors (10CFR 20.1501 (c))

H. Individuals are responsible for returning the dosimeter for processing within 7 days of the end of the monitoring period to the assigned representative under the supervision of the Radiation Safety Officer (RSO).
    1. All lost, damaged or inadvertently exposed radiation monitors shall be promptly reported to the RSO.
    2. Late dosimeters may not be read as accurately as dosimeters returned on time. A control badge accompanies the badges while in transit to and from the dosimetry vendor. When a badge is returned late it cannot be processed with the control badge, and a correct exposure may not be reported.
    3. Individuals who habitually lose or return a late dosimeter will be subject to disciplinary action.

I. A monthly report will be generated providing radiation exposure data on all individuals where monitoring is required.
    1. The report will contain, in pursuant of CCR Title 17 section 30255:
        a. Individual information such as: the name of the individual, Social Security number or date of birth, exposure information.
        b. The statement, "This report is furnished to you under the provisions of the California State Department of Public Health Regulations: Standards for Protection Against Radiation. You should preserve this report for future reference."

J. Results of radiation dose monitoring will be reviewed by the RSO and recorded on NRC Form 5 or equivalent. Individuals will receive a written annual report of their occupational radiation dose if:
    1. The individual's occupational dose exceeds 100 mRem total effective dose equivalent or 100 mRem to any individual organ or tissue; or
    2. The individual requests his/her annual dose report.

K. CCR Title 17, section 30255 requires CCRMC to provide a radiation exposure report in the following situations:
    1. At the request of an individual who is terminating employment that involved exposure to radiation or radioactive materials, the Radiation Safety Officer, or their designee shall provide at termination to each worker, or to the worker's designee, a written report regarding the radiation dose received by that worker from operations of the user during the current year or fraction thereof.
        a. If the most recent individual monitoring results are not available at that time, a written estimate of the dose must be provided together with a clear indication that this is an estimate.
    2. At the request of an individual formerly employed at CCRMC who had their radiation exposure monitored:
        a. The report shall be provided within 30 days from the time the request is made, or within 30 days after the exposure to the individual has been determined, whichever is later.
        b. The report shall cover the period that the individual's activities involved exposure to radiation and include the dates and locations of where the individual worked.

L. Wearing of dosimeters (all applicable individuals):
    1. Dosimeters are to be worn at the collar. If lead aprons are used, wear the dosimeter outside of the apron at the collar.
    2. Ring dosimeters are to be worn on the finger where the most radiation exposure is expected.
    3. Protect dosimeters from impact, puncture or compression.

M. Storage of Dosimeters:

1. Store dosimeters in the designated location that contains the control dosimeter.
2. Do not take dosimeters home.
3. All lost dosimeters should be reported to your manager immediately.

N. Dosimetry Reporting:
    1. At the end of the wear period, return the dosimeter to assigned representative under the supervision of the RSO.
        a. Medical Imaging individuals will return their dosimeters at the beginning of each month.
        b. All other hospital personnel will return their dosimeters at the beginning of the newest quarter (e.g., January 1st, April 1st, July 1st, October 1st).
    2. The Radiation Safety Officer will review all exposure records and notify you if you are over the exposure limit. (Refer to "Occupational Exposure Limit to Radiation.")
    3. Exposure records will be posted in your department, so you may review your individual exposure results.
    4. You will receive a written annual report of your occupational radiation dose from the RSO when required or requested as stated in "II – K" above.

O. Radiation exposure requests (RSO or designee):
    1. At the time of termination:
        a. Provide a written report to the requesting individual with the radiation dose received by that individual during the current year or fraction thereof.
        b. If the most recent individual monitoring results are not available at that time, a written estimate of the dose must be provided together with a clear indication that this is an estimate.
    2. At the request of a former employee:
        a. Provide a radiation exposure report to the former employee within 30 days from the time the request is made, or within 30 days after the exposure to the individual has been determined, whichever is later.

REFERENCES:

A. CA Code of Regulations, Title 17, Division 1, Chapter 5, Subchapter 4 "Radiation", Group 3 Article 2, section 30255. (Accessed 2.27.24 PC)

B. Code of Federal Regulations (CFR) Title 10, Part 20, sections: 20.1201 "Occupational dose limits for adults", 20.1502 "Conditions requiring individual monitoring of external and internal occupational dose", and 20.2106 "Records of individual monitoring results". Edition 1.1.2021. (Accessed 1.27.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, 4/2024, 4/2025

Patient Care Policy & Evaluation Committee: 9/2022, 6/2024
Medical Executive Committee: 12/2022, 6/17/2024
Joint Conference Committee: 11/14/2024

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17982848

Origination	06/2006	Owner	Angela Womble: Chief Radiologic Technologist
Last Approved	N/A	Area	Diagnostic Imaging
Effective	Upon Approval		
Last Revised	04/2025		
Next Review	1 year after approval		

Policy for Radiation Safety/Alara Program

POLICY STATEMENT:

To keep the potential for radiation exposure of patients, staff, and visitors to a minimum by using established safeguards and educating the health care workers about the dangers of radiation exposure. Radiation exposure of patients, staff and visitors will be as minimal as possible.

GUIDELINES:

A. Regulating Agency: California Department of Health Services, Cal/OSHA – title 17, Nuclear Regulatory Commission.

B. Responsibilities:

1. Radiation Safety Officer: Administers the Radiation Safety Program to safeguard the interests of its employees, patients, and public.
2. Managers and Supervisors: Responsible to ensure that their employees are trained on an annual basis on radiation safety procedures and put safeguards in place to reduce exposures.
3. All Employees: To know, understand and practice safety techniques when working around radiation sources, and to use personal protective equipment when appropriate.

C. Radiation Safety "ALARA" – Health care workers are required to keep the radiation exposure "As Low As Reasonably Achievable" (ALARA).

D. Radiation Symbol: Whenever this symbol (red symbol on a yellow background) Is displayed, permission must be granted to enter that area.

E. Reducing Exposure Time – by keeping the exposure time to a minimum, the potential for risk is decreased.
    1. Distance – Increasing the distance between the source of radiation, and staff will reduce the potential for exposure.
    2. Shielding: By using personal protective equipment (PPE) (shields, lead aprons, glasses, etc.), the risk to exposure is reduced. However, shielding is not needed for most Nuclear Medicine studies.

F. Exposure Limits and Records: Exposure limits are set by the state safety standards.
    1. A staff member's individual exposure records will be available to them, and any overexposures will be investigated and reported.
    2. The exposure records are part of the employee's permanent record and will be available to them upon termination of their employment.
    3. Only certain health care workers need to be monitored.

G. Questions and Concerns regarding radiation safety issues should be referred to the supervisor or Manager. The Radiation Safety Officer (RSO) may also be contacted for further inquiry.

RELATED LINKS:

Radiation Studies - CDC: ALARA
Ionizing Radiation - Control and Prevention | Occupational Safety and Health Administration (osha.gov)

REFERENCES:

California Code of Regulations, Title 17, Subchapter 4.7 "Nuclear Medicine Technology" (Accessed 2.24.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, 4/2024, 4/2025
Patient Care Policy & Evaluation Committee: 9/2022, 6/2024
Medical Executive Committee: 9/2022, 6/2024
Joint Conference Committee: 11/14/2024

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025

Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17981673

Origination	06/2008
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2025
Next Review	1 year after approval

Owner	Angela Womble: Chief Radiologic Technologist
Area	Diagnostic Imaging

Policy for CT Exam Event/Incident Action Level Reporting

POLICY STATEMENT:

To provide a guideline for reporting CT action level events in which the administration of radiation results exceeds the threshold criteria defined in Senate Bill 1237 and CDPH Information Notice California Health and Safety Code, Section 115113.

GUIDELINES:

Diagnostic Imaging Staff should follow the policy and procedure below for reporting to the department an event in which the administration of radiation results in any of the following:

A. Repeating of a CT examination more than once, unless otherwise ordered by a physician or radiologist, if one of the following dose values is exceeded:
    1. 0.05 Sv (5 rem) effective dose
    2. 0.5 Sv (50 rem) to an organ or tissue
    3. 0.5 Sv (50 rem) shallow dose to the skin.

B. A CT X-ray Examination for any individual for whom a physician did not provide approval for the examination if one of the following dose values is exceeded:
    1. 0.05 Sv (5 rem) effective dose
    2. 0.5 Sv (50 rem) to an organ or tissue
    3. 0.5 Sv (50 rem) shallow dose to the skin.

C. A CT X-ray for an examination that does not include the area of the body that was intended to be imaged by the ordering physician or radiologist if one of the following dose values is

exceeded:

1. 0.05 Sv (5 rem) effective dose
2. 0.5 Sv (50 rem) to an organ or tissue
3. 0.5 Sv (50 rem) shallow dose to the skin.

D. CT or therapeutic exposure that results in unanticipated permanent functional damage to an organ or a physiological system, hair loss, or erythema, as determined by a qualified physician.

E. A CT or therapeutic dose to an embryo or fetus that is greater than 50 mSv (5 rem) dose, that is a result of radiation to a known pregnant individual unless the dose to the embryo or fetus was specifically approved, in advance, by a qualified physician.

RELATED LINKS:

DI 1212 Procedure for CT Exam Event/Incident Action Level Reporting

REFERENCES:

A. Assembly Bill 510, Senate Bill 1237 and Senate Bill 38 (Accesses 2.27.24 PC)

B. California Health and Safety Code, Division 104, Part 9 "Radiation", Section 115113 (Accessed 2.27.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, 4/2024, 4/2025.
Patient Care Policy & Evaluation Committee: 9/2022, 6/2024
Medical Executive Committee: 9/2022, 6/17/2024
Joint Conference Committee: 11/14/2024

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17983274

Origination	12/2011
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2024
Next Review	1 year after approval
Owner	Angela Womble: Chief Radiologic Technologist
Area	Diagnostic Imaging

Policy for CT Patient Exposure Recording and Reporting

POLICY STATEMENT:

To ensure proper reporting procedures are met in an event in which the administration of radiation results in patient exposure.

GUIDELINES:

Diagnostic Imaging staff will follow the procedure below on reporting radiation exposure, based on Senate Bill 1247.

A. The dose of radiation shall be recorded on every CT study produced during a CT examination.
B. The CT Technologist will send each CT study and dose report page to PACS, which lists the total dose of radiation to the patient.
C. As part of the Physicist's annual survey of the CT scanner, the displayed dose shall be verified to ensure that the displayed dose is within 20% of the true measured dose.

REFERENCES:

Information Notice Regarding Senate Bill (SB) 1237, California Health and Safety (H&S) Code Section 115113 CDPH Letterhead (ca.gov) (Accessed 2.25.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, 4/2024, 4/2025
Patient Care Policy & Evaluation Committee: 9/2022, 6/2024

Medical Executive Committee: 9/2022, 6/2024
Joint Conference Committee: 11/14/2024

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17983249

Origination	05/2001
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2024
Next Review	1 year after approval

Owner	Angela Womble: Chief Radiologic Technologist
Area	Diagnostic Imaging

Policy for Department Radiation Safety Guidelines

POLICY STATEMENT:

To provide radiation safety guidelines for staff. CCRMC Diagnostic Imaging staff will follow the safety guidelines outlined below as required by the Department of Health Services, Radiologic Health Branch.

GUIDELINES:

A. Only authorized persons should be allowed in rooms with radiation sources.

B. Doors to X-ray should be kept closed whenever machines are energized.

C. Always knock before entering a closed X-ray room. Observe warning lights which indicate that a machine is in operation.

D. A distance of at least 6 feet should be maintained between the source of radiation and the portable lead screen if the latter is used instead of a fixed screen.

E. The operator of radiographic equipment should always be in a shields position.

F. Only the required persons should be in X-ray or fluoroscopic rooms during the procedures. A chaperone, as one is necessary, should be placed in a low-dose rate area.

G. Never leave a patient unattended in an X-ray or fluoroscopic room.

H. If necessary to hold a patient during an exposure, the employee or relative should be required to wear a protective apron or gloves, and to keep out of the primary beam.

I. The radiographic field should never be larger than clinically necessary.

J. Appropriate shielding should be used on all patients to protect them from unnecessary radiation. It is particularly important to provide proper shielding for children, pregnant women, and other patients under 45 years of age.

K. Protective apparel should be worn when indicated by the radiographic work being done.

L. Protective apparel must be worn during all fluoroscopic procedures.

M. Protective apparel should be tested for leakage at regular intervals.

N. When using a mobile X-ray unit, the operator should wear a protective apron and should be at least 6 feet from the patient.

O. Personal monitoring devices such as film badges must be properly worn if they are to be of any value.

P. Mobile X-ray units for use in hazardous areas, e.g. operating and delivery rooms, should be Underwriters' Laboratories approved for such areas and should be properly connected and grounded.

Q. Extraneous equipment such as desks, chairs, etc. should be kept at a minimum in radiographic rooms.

R. Keep equipment and furniture out of the line of traffic, especially in darkened rooms.

S. Equipment with mechanical or electrical defects should not be used, and such defects should be reported to your supervisor.

T. Carts should be used to transfer cassettes to and from the darkroom.

U. Carts or stands for film cassettes should be kept in good condition and should never be overloaded.

V. Authority to release information about patients is restricted to certain hospital personnel. Report any query about a patient's condition from an outsider to your supervisor.

W. Always use the correct waste receptacle for discarding disposable syringes and needles.

X. Care should be used in the handling of darkroom chemicals. Any spills should be washed with clear water immediately.

Y. Before doing maintenance work on an automatic film processor, the power should be turned off.

REFERENCES:

A. California Code of Regulations, Title 17, Subchapter 4. "Radiation" and Subchapter 4.5 "Radiation Technology" (Accessed 2.24.24 PC)

B. CCRMC Hospital Policy #365, "Radiation Safety Program"

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, 4/2024, 4/2025

Patient Care Policy & Evaluation Committee: 9/2022, 6/2024

Medical Executive Committee: 9/2022, 6/17/2024

Joint Conference Committee: 11/14/2024

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17983281

Origination	03/2019
Last Approved	N/A
Effective	Upon Approval
Last Revised	06/2024
Next Review	1 year after approval
Owner	Angela Womble: Chief Radiologic Technologist
Area	Diagnostic Imaging

Policy for Mobile Fluoroscopic Equipment C-Arm Spacer Exemption

POLICY STATEMENT:

To provide guidelines for Diagnostic Imaging personnel for general radiation safety with reference to the specific policies in the radiation safety manual. The operator of radiation-producing equipment must be aware of and comply with all applicable requirements of the California Radiation Control Regulations and the Radiologic Technology Regulations (Title 17).

GUIDELINES:

A. The operator must be aware of and comply with all applicable requirements of the California Radiation Control Regulations and the Radiologic Technology regulations (Title 17).

B. Definitions:

1. Fluoroscopy: Medical procedure that makes a real-time video of the movements inside a part of the body by passing x-rays through the body over a period of time. Search Results | CDC
2. C-ARM: When using the C-ARM, use the spacer (cone) on exams/anatomy that will not interfere with the OR table. Anatomy that will exclude the use of spacer (cone) are: Cervical spine, Thoracic spine, Lumbar spine, Thoracic region, Abdominal region, Pelvis region, and Femora. The spacer (cone) shall be reinstalled upon completion of the examination(s) for which removal is authorized.

REFERENCES:

A. California Code of Regulations, Title 17, Division, Chapter 5, Subchapter 4 "Radiation", Group 3, Article 4, 30307. "Fluoroscopic Installations" (Accessed 2.25.24 PC)

B. Search Results | CDC "Radiation in Healthcare: Fluoroscopy" (Accessed 2.25.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 12/2022, 12/2023, 4/2024, 4/2025
Patient Care Policy & Evaluation Committee: 6/2024
Medical Executive Committee: 6/17/2024
Joint Conference Committee: 11/14/2024

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17982359**

Origination	04/2019	Owner	Angela Womble: Chief Radiologic Technologist
Last Approved	N/A	Area	Diagnostic Imaging
Effective	Upon Approval		
Last Revised	06/2024		
Next Review	1 year after approval		

Policy for Occupational Exposure Limits to Radiation

POLICY STATEMENT:

To describe the occupational exposure limits to radiation set by regulatory guidelines, the ALARA ("As Low As Reasonably Achievable") principle, and CCRMC Radiation Safety Committee.

GUIDELINES:

A. International Commission on Radiological Protection (ICRP) Occupational dose limits:

1. Occupational dose limits have been established based on the recommendations of the ICRP. The dose limits recommended by the ICRP are used worldwide to ensure safety and radiation protection of radiation workers and the general public. Federal and State regulations follow the dose limits recommended by the ICRP.
2. The following table shows the annual maximum permissible occupational doses allowed by 10 Code of Federal Regulations (CFR) Part 20 and adopted by Title 17, California Code of Regulations (CCR):

Organ, Tissue	Occupational Dose mRem/year
Whole body	5000
Lens of the eye	15000
Shallow dose (skin and extremities)	50000

B. ALARA Program:

1. The ALARA program, monitored and maintained by the Radiation Safety Committee, strives to ensure that occupational radiation exposures are kept "As Low As Reasonably Achievable." This program has established investigation/notification

levels for exposures below those of limits set by State and Federal regulatory agencies in order to minimize risk.

2. The following table shows the annual occupational dose limits set by Medical Imaging in accordance with the ALARA principle.

Organ, Tissue	Occupational Dose mRem/year
Whole Body	125
Lens of the eye	375
Shallow dose (skin and extremities)	1250

3. The Radiation Committee has established two investigation/notification levels for quarterly exposures that exceed the limits set by the ALARA program.
4. In the event an employee or physician exceeds any of the dose limits set by the Radiation Safety Committee, the individual will receive a letter from the RSO providing details of the exposure, and further action will take place depending on the level of exposure.
5. The investigational levels that have been adopted are listed in Table 1 below:
Table 1: Investigational Levels [(millirem (mR) per quarter)]

Organs	Level I (mR)	Level II (mR)
Whole Body Deep (total effective dose equivalent)	125	375
Lens of Eye	375	1125
Whole Body Shallow	1250	3750
Extremity	1250	3750

Note: Investigational level 1 and II are $1/10^{th}$ and $3/10^{th}$ of applicable regulatory limits.

6. Quarterly doses that are less than Investigational Level 1 as described in Table I require no further action., except when deemed appropriate by the Radiation Safety Officer
7. Quarterly doses equal to or greater than Level 1, but less than Level II as described in Table I:
    a. The Radiation Safety Officer will send a notification letter to each individual whose quarterly dose equals or exceeds Investigational Level I but is less than Level II.
    b. For employees, a notification letter will also be sent to the department manager/director for further follow-up.
        i. The department manager/director will investigate in a timely manner the causes of all personnel doses equaling or exceeding Level I but less than Level II and, if warranted, will initiate corrective action.
        ii. The department manager will report back to the Radiation Safety Officer with the results of their investigation.

c. The RSO will keep documentation of the report sent by the department manager/director.

d. The Radiation Safety Officer will report, at the next Radiation Safety Committee meeting, the individuals who exceeded the quarterly doses equal to or greater than Level I but less than Level II.

i. The Radiation Safety Committee minutes will contain the names and quarterly doses of the individuals mentioned at the meeting.

8. Quarterly doses equal to or greater than Level II:

a. The Radiation Safety Officer or designee will send a notification letter to each individual whose quarterly dose equals or exceeds Investigational Level II.

b. The Radiation Safety Officer, and, if applicable, the department manager/ director will investigate in a timely manner the causes of all personnel doses equaling or exceeding Level II and, if warranted, will take action.

c. A report of the investigation and any action taken will be presented to the Radiation Safety Committee at its first meeting following completion of the investigation.

i. The committee minutes will contain the names and quarterly doses of the individuals discussed as well as any details regarding the investigation or any actions that were taken.

~~RELATED LINKS:~~

RELATED LINKS:

The RSO will send a "Radiation Exposure Notification" (Attachment A) to all individuals who exceed the quarterly dose limits set by the Radiation Safety Committee.

~~Attachment A~~Attachment A: Radiation Exposure Notification

REFERENCES:

A. CA Code of Regulations, Title 17, Division 1, Chapter 5, Subchapter 4 "Radiation", Group 3 Article 1, section 30253. (Accessed 2.27.24 PC)

B. Code of Federal Regulations (CFR) Title 10, Part 20, sections: 20.1101 "Radiation protection programs", 20.1202 "Compliance with requirements for summation of external and internal doses", and 20.1502 "Conditions requiring individual monitoring of external and internal occupational dose". Edition 1.1.2021. (Accessed 1.27.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, 4/2024, 4/2025
Patient Care Policy & Evaluation Committee: 6/2024
Medical Executive Committee: 6/17/2024
Joint Conference Committee: 11/14/2024

Attachments

A: Radiation Exposure Notification

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

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Origination	05/2001
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2024
Next Review	1 year after approval
Owner	Angela Womble: Chief Radiologic Technologist
Area	Diagnostic Imaging

Policy for Radiation Exposure to Pregnant Patients

POLICY STATEMENT:

To ensure optimal environment for fetal growth and protection. No fetus will be exposed to unnecessary radiation.

GUIDELINES:

A. Pregnancy signs are posted throughout the department to notify personnel if a patient is pregnant.

B. All female patients in childbearing years will be asked regarding the possibility of pregnancy prior to beginning the examination.

C. Patients who indicate they are pregnant may not have a radiologic examination until a Radiologist or attending physician has been consulted.

D. If the Radiologist or attending physician deems the exam to be necessary, the patient must have the following:

1. Consent on the DI request for the "exam during pregnancy" signed.
2. Abdomen double shielded.
3. Only a limited view taken unless otherwise instructed by Radiologist.

REFERENCES:

https://www.cdc.gov/nceh/radiation/emergencies/prenatalphysician.htm (Accessed 2.24.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, 4/2024, 4/2025
Patient Care Policy & Evaluation Committee: 9/2022, 6/2024
Medical Executive Committee: 9/2022, 6/17/2024
Joint Conference Committee: 11/14/24

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

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Origination	05/2001
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2024
Next Review	1 year after approval

Owner	Angela Womble: Chief Radiologic Technologist
Area	Diagnostic Imaging

Policy for Radiation Safety Committee

POLICY STATEMENT:

Policy ensures that all individuals who work with or in the vicinity of radioactive material or radiation-producing machines have sufficient training and experience to enable them to perform their duties in accordance with California State regulations and the conditions of the Radioactive Materials license.

GUIDELINES:

To ensure that all radioactive materials and radiation-producing machines are used in accordance with State regulations.

A. A Radiation Safety Committee will be established.

B. The committee will meet on a quarterly basis and minutes of these meetings shall be maintained.

C. Radiation Safety Committee should be composed of representatives of all departments in which personnel directly or indirectly work with radiation.

D. The regulations require that a licensee authorized for two or more different types of use of radioactive material (i.e., material for Imaging Studies and Therapeutic Procedures) shall establish a Radiation Safety Committee to oversee all uses of permitted radioactive material (10CFR35.24{f}).

E. The committee will include an authorized user of each type of use permitted by the license, the Radiation Safety Officer, a representative of the technical staff, and a representative of management who is neither an authorized user nor a Radiation Safety Officer.

F. The committee may include other members whom the licensee considers appropriate.

G. The Radiation Safety Committee responsibilities will include:

1. Reviewing annually procedures for uses, storage, disposal and transport of radioisotopes; and address all other relevant areas.
2. Ensuring that all individuals who work with or in the vicinity of radioactive material or radiation machines have sufficient training and experience to enable them to perform their duties safely and in accordance with California State regulations and the conditions of the radioactive materials license.
3. Ensuring that all uses of radioactive material and of radiation machines are conducted in a safe manner and in accordance with California State regulations and the conditions of the radioactive materials license.
4. The Radiation Safety Committee shall assist the Radiation Safety Officer in implementing the radiation protection program and any remedial action to correct deficiencies identified in the program.
5. Maintaining written records of all committee meetings, action and recommendations, and decisions.
6. Ensure that the radioactive material license is amended when necessary, prior to any changes in facilities, equipment, policies, procedures and personnel.

REFERENCES:

A. California Code of Regulations, Title 17, Subchapter 4. "Radiation" (Accessed 2.24.24 PC)

B. Code of Federal Regulations, Title 10, Chapter 1, Part 35, Subpart B, 35.24. "Authority and responsibilities for the radiation protection program." eCFR :: 10 CFR 35.24 -- Authority and responsibilities for the radiation protection program. (Accessed 2.24.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023 4/2024, 4/2025
Patient Care Policy & Evaluation Committee: 9/2022, 6/2024
Medical Executive Committee: 9/2022, 6/2024
Joint Conference Committee: 11/14/24

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025

Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

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Next Review	1 year after approval
Owner	Angela Womble: Chief Radiologic Technologist
Area	Diagnostic Imaging

Policy for Radiation Safety Program

POLICY STATEMENT:

To provide guidelines for Diagnostic Imaging personnel and Public Health Dental Personnel using the Airbex Nomad devices for general radiation safety with reference to the specific policies in the radiation safety manual. The operator of radiation-producing equipment must be aware of and comply with all applicable requirements of the California Radiation Control Regulations and the Radiologic Technology Regulations (Title 17).

GUIDELINES:

A. Licentiate of the Healing Arts is defined as Physicians and Surgeons licensed by the Medical Board of California, Osteopathic Physicians and Surgeons licensed by the Osteopathic Medical Board of California, Podiatrists licensed by the Board of Podiatric Medicine, or Chiropractors licensed by the California Board of Chiropractic Examiners.

B. Per regulations (CCR, Title 17, Section 30400) define fluoroscopy as "a radiological examination utilizing fluorescence for the observation of the transient image."

C. No occupationally exposed employee shall be used to hold X-ray patients or Image Cassettes except in an emergency; and no person shall be regularly used to hold patients (section 30308c1).

D. Careful collimation shall be used to restrict the X-ray beam to the size of the Image Cassette, or smaller (section 30308c3).

E. The operator must make use of the appropriate operator protection devices provided: lead apron, lead shield, etc. (section 30307 & 30308).

F. Personnel monitoring devices must be worn when they are required. The monitoring device

must be worn on the collar outside of the apron when a lead apron is worn (section 30276 & 30309).

G. The operator is responsible for clearing the X-ray room of non-essential persons prior to generating X-rays (section 30308c2).

H. X-ray Procedures: (Sections 30307, 30308, 30309)

1. Protective aprons shall be worn in the fluoroscopic room by the operating staff.
2. The operator of a mobile X-ray unit shall stand at least six feet from the patient and well away from the useful beam. The operator should wear a protective apron.
3. No radiologic technologist may operate a fluoroscope unless they have a fluoroscopy certificate and are in the presence of a certified Supervisor (physician).
4. Dental technicians using the handheld Airbex Nomad device have a protective shield that protects the operator from radiation.

I. Gonadal shielding of not less than 0.5 mm lead equivalent shall be used for patients who have not passed the reproductive age during radiographic procedures in which the gonads are in the direct beam, except for cases in which this would interfere with the diagnostic procedures.

REFERENCES:

California Code of Regulations, Title 17, Subchapter 4. "Radiation" and Subchapter 4.5 "Radiation Technology" (Accessed 2.24.24 PC)

APPROVALS:

Diagnostic Imaging Leadership: 8/2022, 8/2023, ***4/2024, 4/2025***
Patient Care Policy & Evaluation Committee: 9/2022, 6/2024
Medical Executive Committee: 9/2022
Joint Conference Committee: 11/2024

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Angela Womble	04/2025

Standards

No standards are associated with this document

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Owner	Grace Ma: Nursing Program Manager
Area	Hospital & Health Centers

Policy for Anatomical Donations for Tissue and Organ Transplantation

POLICY STATEMENT:

To insure that hospital deaths are considered for possible anatomical donations in conformance with Assembly Bill (AB) 1689, the California Uniform Anatomical Gift Act. To provide a mechanism for the procurement and donation of organs and tissues. This policy applies to donation and procurement after brain death. For policy and procedures relating to organ donation after circulatory/cardiac death (DCD), see Policy #612C.

A. Except in the case where the useful life of the part does not permit, a reasonable search (for at least 12 hours) will be made for possible consenting authority for organ and tissue donation. This search to locate other persons should be documented in the medical record.

B. The Donor Network West (DNW) will be notified of any patient who has died in the hospital (including a stillborn infant ~~or~~and fetus ~~28 weeks or older~~) or whose death is imminent for possible anatomical donations.

GUIDELINES:

A. Procedure:

1. At or near the time of death, the deceased individual's next-of-kin (or other individual) will be asked, by Donor Network West staff, whether the deceased was an organ donor or if the family is a donor family. Donor Network West staff will work collaboratively with CCRMC staff regarding the suitability of a potential donor.
2. Medical Social Services will assist in conducting a reasonable search for possible

consenting authority for organ and tissue donation.

3. Nursing Unit
    a. Charge Nurse or designee will notify the Medical Center Supervisor of the impending death and the need to call Donor Network West.
    b. If organs are to be retrieved, the Operating Room is to be notified by the charge nurse or medical center supervisors after consent for donation is obtained.
    c. The potential donor information worksheet will be initiated to gather information such as the patient's name, medical record number, name of next-of-kin, status of donor authorization, and disposition of the body.
    d. In case of Operating Room (OR) deaths, the potential donor information worksheet will be initiated by the OR Nurse and given to the Medical Center Supervisor to complete the process.

4. Consent for Donation
    a. At the time of death or near the time of death, the family of the deceased shall be asked about the possibility of organ donations by DONOR NETWORK WEST in collaboration with CCRMC staff. Approaching the donor family will be done with sensitivity so as not to impose on their grieving process.
    b. Approval for donation must be obtained by the most reasonably available next-of-kin: (a) the spouse or domestic partner, (b) an adult son or daughter, (c) either parent, (d) an adult brother or sister, (e) adult grandchildren, (f) grandparents, (g) any adult who exhibited special care and concern for the decedent during the decedent's lifetime, (h) a guardian or conservator of the decedent at the time of death, (i) any other person authorized or under obligation to dispose of the body. Immediate acceptance of a family's decision to decline the option to donate organs or tissues will be acknowledged; for un-emancipated minor donors between 15- 18 years of age, only upon written consent of parent or guardian
    c. Donor Network West, or Tissue Bank, staff will obtain the consent from the next-of-kin in person, or on the telephone. A copy of the consent form or transcription of the telephone conversation will be sent to Medical Records for documentation.

5. Notification to Donor Network West
    a. Donor Network West will be notified of a potential organ donors/ at the first indication of irrecoverable illness/ injury, imminent death, prior to family discussion regarding withdrawal life sustaining measure, prior to formal brain death evaluation. For potential tissue donors, DNW will be notified within 1 hour of asystole. Its services are available twenty-four hours of the day, seven days a week, to handle any type of donation and can assist the hospital staff with any questions that arise.
    b. The patient's physician, registered nurse, or designee will (1) notify Donor

Network West at 1-800-55-DONOR who will arrange for organ removal and, (2) inform the Executive Director of CCRMC and CCHCs of the anatomical donation. The Unit/Department shall arrange for all fees to be billed to the Donor Network West.

c. The process for ensuring that charges are billed to the Donor Network West at the time of declaration of brain death is as follows:

i. Notify Admissions Registration at 925-370-5160 to add Specialty Billing Value: Donor Network West to the patient's inpatient encounter which flags the Hospital Account Record (HAR) with a Do Not Bill (DNB) for Patient Accounting to review.

6. Organ Donation: Definitions of Terms

a. Organ donation can take place when death has been established, and the potential donor is maintained on organ support systems. Contraindications for donation will vary with each organ system; therefore, each potential donor is evaluated on an individual basis. See DONOR NETWORK WEST Referral Guide for additional criteria information

b. Brain Death: Two physicians must independently confirm brain death, and both physicians must document in the progress records of the chart that the patient is neurologically dead. The Checklist for Determination and Declaration of Brain Death (MR 209) may be completed in lieu of progress notes. Neither physician may be a member of the transplant team.

c. A brain death is evidenced by an individual who has sustained irreversible cessation of all functions of the entire brain, including the brainstem, as determined by accepted medical standards. The California Brain Death Statute of 1974 (California Health and Safety Code 7180) states, "A person shall be pronounced dead if it is determined by a physician that the person has suffered a total and irreversible cessation of brain function." The Donor Network West Organ/Tissue Donation Referral Guide may be used to obtain additional details.

7. Donor Maintenance: The donor must be maintained on organ support systems until the transplant team can arrive to remove the organs in surgery.

8. Donation after - Circulatory /cardiac Death: See Policy #612C "Organ Donation after Cardiac Death" for policy and procedures relating to organ donation from a patient who has not been diagnosed as brain dead but will be pronounced dead on the basis of irreversible cessation of circulatory and respiratory functions.

9. Imminent Death: A severely brain injured, ventilator patient, with either clinical findings consistent with a Glasgow Coma Score (GCS) of </=5, or a plan to discontinue mechanical/pharmacological support.

a. Early Referral for Timely Notification: Referral by a hospital to the Organ Procurement Organization (OPO) at the first indication of irrecoverable illness/ injury, prior to family discussion regarding withdrawal life sustaining measure, prior to formal brain death evaluation.

b. Early Referral for Timely Notification of Potential Tissue Donors: Referral

from hospital to the Donor Network within 1 hour of asystole for evaluation of potential tissue donor eligibility.

10. Hospital Reimbursement
    a. All charges that are incurred from the time the patient is declared neurologically dead, including operating room fees, shall be billed to the: DONOR NETWORK WEST -
    b. Notify admissions of the time of brain death declaration (for financial accounting).
11. Tissue Donation
    a. The following are general criteria for tissue donors:
        i. All death: Every hospital death will be evaluated as a potential tissue/eye donor.
        ii. Eye Donations: If used for transplant purposes, the eyes must be recovered within 12 hours after cardiac death. The eye enucleation procedure is performed by a staff member of the Tissue Bank who is trained and authorized by law.
12. Other Tissue Donations: These tissues can be recovered within 24 hours after cardiac death. Potential tissue donors must be placed in refrigeration -immediately after cardiac death. Tissue recovery is performed by the staff of the tissue bank. The tissue bank staff prefers a sterile environment; however, a non-sterile environment, i.e., pathology department, morgue or coroner's office, may be used if necessary.
13. Coroner Authorization:
    If the deceased falls under the jurisdiction of the coroner, the coroner must be advised that a request for anatomical donation has been made; his/her authorization must be obtained before proceeding with the organ and/or tissue donation. Donor Network West will obtain this authorizations.
14. For whole body donation, please refer to The Donor Network West Organ/Tissue Donation Referral Guide (available on nursing units).
15. All dead-on arrival (DOA) cases will be assessed using the same procedures above.
16. Medical Records: On a quarterly basis, copies of the death log will be sent to the Donor Network West for bi-annual audits.
17. Donor Network West/-will provide information regarding referral rates to Administration on a quarterly basis. This information will be shared with appropriate committees within CCRMC.

RELATED LINKS:

Death Procedure (MR 211)
Checklist for Determination and Declaration of Brain Death (MR 209)
DONOR NETWORK WEST – Consent for Organ and Tissue Donation (brought by Donor Network West)

REFERENCES:

A. California Health and Safety Code "Uniform Anatomical Gift Act" Sections 7150 – 7151.40
B. The Routine Death Notification Legislation (42 CFR Part 482)
C. Designated Organ Procurement Organization (OPO): DONOR NETWORK WEST Resource Manual
D. Contra Costa Regional Medical Center Hospital Policy #503, Patient Expiration
E. TJC TS.01.01.01 "The hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs and tissues."

APPROVALS:

Clinical Practice Committee: 2/2018, 10/2022
Patient Care Policy & Evaluation Committee: 7/2012, 3/2018, 11/2022
Medical Executive Committee: 5/2018, 11/2022
Joint Conference Committee: 3/2023

Attachments

Potential Donor Information Worksheet

Tissue Donor Referral

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
Clinical Practice Committee	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	06/2025
	Grace Ma: Nursing Program Manager	06/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17966886

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Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2025
Next Review	3 years after approval
Owner	Leah Carlon: Health Care Risk Manager
Area	Hospital & Health Centers

Policy for Patients' Rights

POLICY STATEMENT:

Contra Costa Regional Medical Center and Health Centers is committed to service excellence in providing high quality, service and respect and responsiveness to all. Patients are entitled to considerate and respectful care regardless of race, religion, education, sex, sexual orientation, gender identity, cultural background or financial status in accordance to State and Federal Regulations. The same rights equally apply to the person who has legal responsibility to make medical care decisions on behalf of the patient. Patients or their legal representative have the responsibility to comply with set expectations that are outlined for both inpatient and outpatient services.

GUIDELINES:

A. The rights of patients and their legal representatives include but are not limited to the right to (See Attachment A):

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your personal values and beliefs.
2. Has a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.
3. Know the name of the licensed health care practitioner who has primary responsibility for coordinating your care and the names and professional relationship of other physicians and non-physicians who will see you.
4. Receive information about your health status, course of treatment, prospect for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to participate in the development and implementation

of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.

5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedures as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure of treatment. (Policy No. 619 "Patient Self-Determination Act")
6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of members of the medical staff, to the extended permitted by law.
7. Be advised if the hospital/licensed health care practitioner proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.
8. Reasonable responses to any reasonable requests made for service.
9. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decision. You may request or reject the use of any or all modalities to relieve pain, including opiate medication, if you suffer from sever chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic intractable pain with methods that include the use of opiates.
10. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Practitioners who provide care, whether in the hospital setting or in our clinics, shall comply with these directives. All patient's rights apply to the person who has legal responsibility to made decisions regarding medical care on your behalf.
11. 1Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.
12. Confidential treatment of all communications and records pertaining to your care in the hospital or health centers. You will receive a separate ~~(Notice of Privacy Practices)~~Notice of Privacy Practices that explains your privacy rights in detail and how we may use and disclose your protected health information.
13. Receive care in a safe setting, free from verbal or physical abuse or harassment. You have the right to access protective services including notifying government agencies of neglect or abuse.

14. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience, or retaliation by staff.
15. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.
16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements following discharge from the hospital. Upon your request, a friend or family member may be provided this information also.
17. Know which hospital or health center rules and policies apply to your conduct while a patient.
18. Designate visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:
    a. No visitors allowed.
    b. The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.
    c. You have told the health facility staff that you no longer want a particular person to visit.
    However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors. The health facility must inform your (or your support person, where appropriate) of your visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability. (Policy No. 603 "Partners in Care Welcoming Policy")
19. Have your wishes considered, if you lack decision-making capacity, for the purpose of determining who may visit. The method of that consideration will be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household and any support person pursuant to federal law.
20. Examine and receive an explanation of the hospital's or health center's bill regardless of the sources of payment.
21. Exercise these rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, educational background, economic status ore the source of payment for care.
22. File a grievance. If you want to file a grievance with the hospital or health center, you may do so by writing or calling:
    a. Patient Relations Department, 2500 Alhambra Ave., Martinez, CA. 94553 (925) 370-5144. (Policy No. 616)
    b. Contra Costa Health Plan members should contact the Contra Costa Health Plan at 1-877-661-6230.
    c. If the response to your complaint is unsatisfactory, you have the right to

file a grievance with the Grievance Committee. Each grievance will be reviewed and responded to within 30 days. The written response will contain the name of the person to contact at the facility, the steps taken to investigate the grievance, the results of the grievance process and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the Utilization Review Department.

23. File a complaint with the California Department of Public Health (CDPH) regardless of whether you use the hospital and health center's greivance process:
    a. California Department of Public Heealth (CDPH), 850 Marina Bay Parkway, Bldg P, 1st Floor, Richmond, CA 94804-6403 (510) 620-3900.
24. File a complaint with the Department of Fair Employment and Housing at www.dfeh.ca.gov, (800) 884-1684 or (800) 700-2320 (TTY) or 2218 Kausen Dr., #100, Elk Grove, CA 95758.
25. File a complaint with the Medical Board of California at www.mbs.ca.gov/consumers/complaints, (800) 633-2322 or 2005 Evergreen ST., #1200, Sacramento, CA 95815.

B. ~~Designate visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:~~
    1. ~~No visitors allowed.~~
    2. ~~The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.~~
    3. ~~You have told the health facility staff that you no longer want a particular person to visit.~~
    4. ~~However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors. The health facility must inform your (or your support person, where appropriate) of your visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability. (Policy No. 603 "Partners in Care Welcoming Policy")~~
    5. ~~Have your wishes considered, if you lack decision-making capacity, for the purpose of determining who may visit. The method of that consideration will be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household and any support person pursuant to federal law.~~
    6. ~~Examine and receive an explanation of the hospital's or health center's bill regardless of the sources of payment.~~
    7. ~~Exercise these rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, educational background, economic status ore the source of payment for care.~~

C. ~~File a complaint:~~

1. ~~If you want to file a complaint with the hospital or health center, you may do so by writing or calling. Patient Relations Department, 2500 Alhambra Ave., Martinez, CA. 94553 (925) 370-5144. (Policy No. 616)~~
2. ~~Contra Costa Health Plan members should contact the Contra Costa Health Plan at 1-877-661-6230.~~
3. ~~If the response to your complaint is unsatisfactory, you have the right to file a grievance with the Grievance Committee. Each grievance will be reviewed and responded to within 30 days. The written response will contain the name of the person to contact at the facility, the steps taken to investigate the grievance, the results of the grievance process and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the Utilization Review Department.~~
4. ~~File a complaint with the Department of Public Health Center for Healthcare Quality Licensing and Certification Program – Santa Rosa / Redwood Coast District Office, 2170 Northpoint Parkway, Santa Rosa, CA 95407. Phone 707-576-6775 and Fax 707-576-2418~~

D. Service Provided Are Not Free:

1. If you do not have health insurance or program coverage for you or your family, you may be eligible for Medi-Cal, Healthy Families, California Children's Services, Basic Health Care, the Health Coverage Initiative, or other health coverage programs.
2. If you are not eligible for any health coverage program, or if you are liable for high medical costs after your insurance pays, you may be eligible for a discount on your medical bill by the CCHS Policy 707-C Discount Payment Program or the CCHS Policy 708-C Charity Care Program.
3. Contact the Financial Counseling Department at 1-800-771-4270 for further information and application assistance. Financial Counselors are available Monday-Friday from 7 A.M. to 6 P.M. California Health and Safety Code 127410.

E. Our mission is to provide safe and effective health care to those in need. To better serve you, we ask that you:

1. Be considerate of other patients, staff and visitors.
2. Provide an accurate and complete description of past medical history, illnesses, medications, hospitalizations, and present condition.
3. Cooperate with physicians and ~~other~~others caring for you.

F. Notification of Patients' Rights

1. The Registration Department will offer the Patients' Rights and Notice of Privacy Practices to the patient or patient's designee when a Consent to Services and Conditions of Services and of Admission form is required during the registration process or upon request. The response will be documented on the Consent to Services and Conditions of Services and on Admission form, and scanned in the patient's Electronic Health Record.

2. A summary of the Patients' Rights is available in the Patient Handbook which is included with admission information.
3. Patients' Rights posters are prominently displayed on hospital units, health centers, Admissions Office and Emergency Department waiting ~~arears~~areas.

RELATED LINKS:

Consent to Services and Conditions (English)
Consent to Service and Conditions (Spanish)
Notice of Privacy Practices/HIPAA (English)
Notice of Privacy Practices/HIPAA (Spanish)

REFERENCES:

A. California Health and Safety Code, Title 22, Section 70707
B. CMS Quality Standards: Hospital Conditions of Participation for Patient Rights, Code A0038
C. CCRMC & HCs Policies and Procedures: "Patient Grievance/Complaint"

APPROVALS:

Clinical Practice Committee: 10/2019
Patient Care Policy & Evaluation Committee: 8/2017, 11/2019
Medical Executive Committee: 9/2017, 6/2018, 12/2019

Attachments

Patients' Rights English

Patients' Rights Spanish

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	06/2025
Clinical Practice Committee	Ira-Beda Sabio	05/2025

Standards

No standards are associated with this document

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Last Approved	N/A
Effective	Upon Approval
Last Revised	03/2025
Next Review	3 years after approval

Owner	Adalberto Garibay: Deputy Sheriff-40 Hour
Area	Hospital & Health Centers

Serving Arrest Warrants on Hospitalized Patients

POLICY STATEMENT:

To provide guidance ~~to~~ regarding arrest warrants for hospitalized patients. The responsibility of providers and staff is to protect patient privacy and security. No arrest warrant will be served on a patient during the hospitalization. Staff may coordinate with the Hospital Security Office – who will coordinate with the outside Law Enforcement agency – to serve an arrest warrant after discharge. This means the discharged patient would be taken into physical custody.

GUIDELINES:

A. The Hospital may disclose limited information about the presence of an individual on a particular unit in the hospital to a law enforcement agency when the purpose is to identify or locate a suspect, fugitive, material witness, or missing person.

B. Staff will not disclose any information to outside law enforcement agencies, and instead will refer any requests to verify if a particular individual is on a particular unit of the Hospital to our Hospital Security Office (HSO).

C. If the HSO determines the agent/agency is authentic and the reason is a valid arrest warrant, then the HSO will request verification (if the patient is on a particular unit on a particular day) from the Unit Charge Nurse/Lead, then disclose limited information for the purposes of identification and location of a person with a valid arrest warrant to the outside law enforcement agent/agency. The HSO will communicate back to the Charge Nurse/Lead if a disclosure was made and to which agent/agency.

D. The Charge Nurse/Team Lead will share the information about a verified/confirmed arrest warrant with the Social Worker/Mental Health Clinical Specialist, Nurse Program Manager (NPM) or Medical Center Supervisor (MCS), and with the attending physician. Information will

be communicated forward from shift to shift.

E. A patient may only be discharged by physician's order or if a patient signs out Against Medical Advice (AMA). When an estimated discharge date and time is known, the Charge Nurse/Team Lead will notify the Hospital Security Office so that the arrest warrant can be served at the time of the patient's discharge. The Hospital Security Office will coordinate so that a Hospital Security Officer can be standing by at the time of the arrest.

F. The Hospital Security Office will communicate the following guidelines for the arrest to Law Enforcement officials: They will be asked to handcuff (if necessary) and receive custody of the patient in an area outside the unit if at all possible. This will be done to minimize the embarrassment and stress of the arrest, and in an attempt to maintain the dignity of the individual.

REFERENCES:

A. California Code of Regulations, Title 22, Section 70707.

B. California Regulatory Code CFR 164.512, (f)(1) and (f)(2): "Permitted Disclosures: Limited information for identification and location purposes: A covered entity may disclose protected health information in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person."

C. The Joint Commission (TJC) 2024 Standard RI.01.01.01

APPROVALS:

Reviewed: 7/97, 1/02, 7/07, 2/15, 04/22

Revised: 02/24

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	06/2025
Clinical Practice Committee	Ira-Beda Sabio	05/2025
	Adalberto Garibay	02/2025

Standards

No standards are associated with this document

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Effective	Upon Approval
Last Revised	07/2025
Next Review	3 years after approval

Owner	Kathy Ferris: Infection Prevention & Control Manager
Area	Infection Control

Policy for Assistance Animals at Contra Costa Regional Medical Center and Health Centers

POLICY STATEMENT:

Contra Costa Regional Medical Center and Health Centers comply with the requirements of the Americans With Disabilities Act (ADA) and all applicable California State laws.

~~Service~~Assistance animals (as defined by California law) will be permitted into any area of the hospital or health center that is unrestricted to patients or visitors provided that the ~~service~~ animal does not pose a threat~~,~~ and the presence of the animal does not require a fundamental alteration in the policies, practices or procedures in that area. Certain animals will be prohibited if they are not allowed to be owned in California or they carry pathogens that may cause harm to others.

GUIDELINES:

A. ~~The Americans with Disabilities Act defines a service animal as dogs that are individually trained to do work or perform tasks for people with disabilities. The work or task must be directly related to the person's disability. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.~~

B. While the Americans with Disabilities Act defines a service animal as dogs or miniature horses that are individually trained to do work or perform tasks for people with disabilities. California has adopted laws that refer to “Assistance Animals”. An assistance animal is divided into two categories: Service Animals and Support Animals.

1. Service Animals are trained to perform specific tasks to assist individuals with disabilities, including individuals with mental health disabilities. Service animals do not need to be professionally trained or certified but may be trained by the individual

with a disability or another individual.

2. Support Animals that provide emotional, cognitive, or other similar support to an individual with a disability. A support animal does not need to be trained or certified. Support animals may also be known as comfort or emotional support animals. No breed, size, or weight limitations may be applied to an Assistance Animal. An individual may have more than one Assistance Animal

C. The work or task must be directly related to the person's disability.

D. ~~A service~~An assistance animal will be permitted into any area of the hospital or health center that is open to inpatients, outpatients, or visitors provided that the service animal does not pose a threat or that the presence of the animal would not require a fundamental alteration in the policies, practices, or procedures of that area. ~~Service~~Assistance animals are not allowed in the following locations~~.~~:

1. Areas where equipment/supplies are cleaned or stored.
2. Areas where medications are prepared or stored
3. Areas where food is prepared or stored
4. Areas where invasive procedures are performed. (e.g. OR, GI, L&D, Health Center Procedure Rooms, Post Anesthesia Care Unit, Psychiatric Emergency Services, Inpatient Psychiatric Unit, Diagnostic Imaging -certain procedures, Nursery and Infusion Clinic)

~~Any animal entering CCRMC or Health Centers must be always on a leash and under control of the owner. Service animals are expected to be clean, healthy, and controlled by their owner. The animal is expected to have evidence of a rabies immunization and/or license as required by county law.~~

E. Any assistance animal entering CCRMC or Health Centers must be always on a leash or in an enclosure. Certain assistance animals may need to be off leash in order to perform their task. However, they must be under the control of the handler at all times. For a list of animals not allowed in county facilities please see attachment IC 239C.

F. If a patient with ~~a service~~an assistance animal is to be admitted, notify the Medical Center Supervisor at the time of bed request so that appropriate bed assignment can be made~~.~~

G. The patient is responsible for feeding and toileting of their ~~service~~assistance animal. If the patient is not able to provide this care, ~~they~~he/she may bring a family member or friend who will be responsible for these activities while the patient is hospitalized or receiving care at CCRMC or Health Centers. CCRMC employees will not be assigned responsibility for caring for ~~service~~assistance animals.

H. If there is no family member or friend who can assist the patient and the patient consents; Animal Control may be contacted, they have agreed to board the animal until patient is able to pick up the animal or a friend/family member can pick up the animal. The phone number for animal control is 925 646-2441 (an officer is available 24/7 to respond and pick up the animal.

I. Patients will be provided with a handout outlining the policy at CCRMC and Health Centers

RELATED LINKS:

Procedure for the Management of Service Animals at Contra Costa Regional Medical Center and Health Centers

~~IC 238A Guidelines for Patients with Service Animals~~Guidelines for Patients with Service Animals

Animals Not Permitted in County Facilities

REFERENCES:

A. Americans with Disabilities Act, Service Animals, Last updated 2/28/2020

B. ~~Price Esq, Sarah "Legal Briefings Service Animals under the ADA" November 2010 California Health and Safety Code Section 30850~~California Code of Regulations, Title 2 Div 4.1 Chapter 5 Civil Rights Council Subchapter 9 Nondiscrimination in State-supported Programs and Activities.

C. Murthy et al, ~~"~~"Animals in Healthcare Facilities: Recommendations to Minimize Potential Risks~~"~~ ~~**Infection Control and Hospital Epidemiology**~~" Infection Control and Hospital Epidemiology, May 2015 Vol. 36 No. 5

APPROVALS:

Infection Prevention & Control Committee: 7/22, 5/25
Patient Care Policy & Evaluation Committee: 8/22
Medical Executive Committee: 9/22

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
Infection Prevention & Control Committee	Kathy Ferris: Infection Prevention & Control Manager	06/2025
	Kathy Ferris: Infection Prevention & Control Manager	06/2025

Standards

No standards are associated with this document

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Effective	Upon Approval
Last Revised	03/2025
Next Review	3 years after approval
Owner	Kathy Ferris: Infection Prevention & Control Manager
Area	Infection Control

Management of Reusable Instruments Prior to Return to the Sterile Processing Department

POLICY STATEMENT:

At Contra Costa Regional Medical Center and Health Centers, re-usable instruments will be wiped down or rinsed to remove all visible soil, placed in a covered rigid container with a bio-hazard symbol and transported to the Soiled Utility Room. Once in the Soiled Utility Room, the instruments will be kept moist by using a sterile transport gel while awaiting pick-up by Sterile Processing Technician.

In the Operating Room, during the operation, instruments will be managed according to accepted operating room practice. At the end of the procedure, instruments will be kept moist for return to the Sterile Processing Department for cleaning, disinfection and sterilization.

Appropriate Personal Protective Equipment (PPE) will be worn by personnel when using transport gel, cleansers and disinfectants.

GUIDELINES:

Ambulatory Care

A. After procedure, gel hands and don gloves
B. Discard any disposable supplies into appropriate ~~trash~~ container.
    1. Gauze or gloves into appropriate ~~Sharps should be discarded into sharps disposal box~~container.
    2. Sharps should be discarded into sharps disposal box.
    3. Any vials or ampules containing medication should be discarded in appropriate

container.

C. Place the instruments in the transport rigid container marked with the Biohazard symbol ~~and~~for transport ~~them~~ to the soiled utility room. ~~Remove and discard gloves and perform hand hygiene.~~

D. Remove and discard gloves and perform hand hygiene.

E. ~~Perform~~After hand hygiene has been performed, don gloves and wipe down the countertop/ mayo stand and transport container with Super Sani-wipe (Purple Top), or if unavailable, the AF3 wipe (Gray top) is also acceptable~~)~~.

F. Doff gloves, perform hand hygiene, and transport container to soiled utility room.

G. Once in the soiled utility room, ~~Don~~don PPE (gown, mask, eye protection and gloves) prior to cleaning and spraying instruments with Pre Klenz.

H. Rinse and wipe the instruments to remove any obvious debris.

I. Open hinged instruments and place the opened instrument(s) into the large bio-hazard container.

J. Be sure to cover the instrument completely. The spray will initially appear foam-like and will then become a clear gel.

K. Replace cover on the biohazard tray. Remove PPE and perform hand hygiene .

L. If there are additional instruments ~~being placed into~~that require transport, wipe down the transport container ~~at a later~~before leaving the Soiled Utility room, and repeat steps A through H each time~~; repeat step #1 through #6 each time~~ instruments ~~are placed in the container~~need to be added.

M. The soiled utility room container will be picked up on a regular basis by Sterile Processing Department technician.

N. The transport container may be rinsed, wiped dry and ~~the wipe~~then wiped with either the Super Sani Wipe (Purple top) or the AF3 wipe (gray top). Observe recommended ~~contact~~dwell time before it is re-used.

Special Procedures Room

A. After the procedure, gel hands and don gloves and discard disposable supplies into appropriate trash container.

1. Sharps should be discarded into sharps disposal box
2. Any vials or ampules containing medication into appropriate container
3. Discard disposable instruments in appropriate container
4. Dispose of any residual liquids in cups.

B. At the end of the procedure, re-usable instruments will be placed in a covered rigid container with Biohazard label on the lid and kept moist using either of the two methods listed below.

1. Open hinged instruments and a blue towel moistened with sterile water may be placed over the instruments before they are transported to the decontamination room in the Sterile Processing Department (SPD).

2. Open hinged instruments and spray with Pre-Klenz.
3. Contact SPD to pick-up the instruments.

C. If instrument pick-up may be delayed, it may be useful to use the Pre-Klenz spray to keep instruments moist for an extended period of time.

Hospital Nursing Units and ED

A. After procedure, gel hands and don gloves, and wipe down the countertop/mayo stand with Super Sani-wipe (Purple Top) -if unavailable, the AF3 wipe (Gray top) is also acceptable).
B. Place the instruments in the transport rigid container marked with the Biohazard symbol and transport them to the soiled utility room.
C. Once in the soiled utility room Don PPE (gown,mask,eye protection and gloves)
    1. Remove gross soil by wiping with paper towel or gauze moistened with water.
    2. Vaginal Speculums should be rinsed and disassembled.
    3. Open all hinged instruments
D. If the instrument(s) is sharp or pointed, or heavily soiled, place container in sink and rinse thoroughly with water, making sure all instruments are open.
E. Place the opened instrument into the bio-hazard container.
F. While still wearing the PPE, spray the instrument(s) with Pre-Klenz. Be sure to cover the instrument completely. The spray will initially appear foam-like; it will then form a gel to keep the instruments moist.
G. Replace cover on the rigid biohazard container. Remove PPE and gloves, gel hands.
H. If additional instruments are being placed into container at a later time, repeat step #1 through #7 each time instruments are placed in the container
I. Container will be picked up on a regular basis by Sterile Processing Department technician.
J. The transport container may be rinsed, wiped dry and the wipe with either the Super Sani Wipe (Purple top) or the AF3 wipe (gray top). Observe recommended contact time before it is re-used.

Perinatal Labor and Delivery

A. At the end of the delivery,. place the instruments in the transport rigid container marked with the Biohazard symbol and transport them to the soiled utility room.
B. Place the container in the sink and don appropriate PPE (gown, gloves and mask with eye protection).
C. Remove the instruments, ensure that the instrument is open and rinse under running water. After rinsing, place the instrument into the rigid biohazard container.
D. While still wearing the PPE, spray the instrument(s) with Pre-Klenz. Be sure to cover the instrument completely. The spray will initially appear foam-like; it will then form a gel to keep the instruments moist.
E. Repeat steps above each time instruments are added to the Biohazard container.

F. Should the container become full prior to regular rounds by the SPD staff, call x5360 to arrange to have the instruments picked up.

Operating Room/Procedure Room

A. During the operation/procedure, instruments will be managed according to accepted OR practice.

B. At the end of the case, instruments will be placed in the appropriate tray with lid for transport to sterile processing. A blue towel moistened with sterile water will be placed over the instruments before they are transported to the decontamination room in the Sterile Processing Department (SPD).

C. If instrument pick-up may be delayed, it may be useful to use the Pre-Klenz spray to keep instruments moist for an extended period of time.

RELATED LINKS:

IC 246A Steris Label
IC 246B Pre-Klenz Safety Data Sheet
IC 249 Procedure for the Management of Dental Instruments Prior to Return to Sterile Processing

REFERENCES:

A. Association for the Advancement of Medical Instrumentation (AAMI) ST79 A1, A2, A3 and A4, 2013

B. CalOSHA Bloodborne Pathogen Standard (8CCR 5193)

C. Steris, "Pre-Klenz" Instructions for Use

APPROVALS:

Infection Prevention & Control Committee: 11/16, 9/22, 12/24
Patient Care Policy & Evaluation Committee: 10/22, 1/25
Medical Ethics Committee: 10/22

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [TT]	05/2025

Infection Prevention & Control Committee	Kathy Ferris	04/2025
	Kathy Ferris	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18277899**

Origination	06/2004	Owner	Ira-Beda Sabio: Director, Inpatient Nursing OP
Last Approved	N/A	Area	Nursing
Effective	Upon Approval		
Last Revised	06/2025		
Next Review	3 years after approval		

Policy for Wound Dressing Changes/Packing

POLICY STATEMENT:

To provide guidelines for dressing or packing wound appropriately and to prevent contamination and cross-infection during dressing changes.

Dressing changes will be performed using standard precautions and as ordered by the practitioner in ccLink.

Do not remove surgical dressings without provider's orders.

GUIDELINES:

A. Identify patient using at least two patient identifiers.
B. Determine need for pain medication before beginning procedure.
C. Perform hand hygiene; prepare supplies; don clean gloves.
D. Remove soiled dressings and dispose of dressing and packing.
    1. Moisten dressing if adherent to wound.
E. Examine dressings for wound drainage: amount, color consistency, and presence of odor
F. Dispose of dressing and packing in biohazard bin.
G. Remove and discard gloves.
H. Perform hand hygiene and don clean gloves.
I. Assess wound site.
    1. Identify location of wound.

2. ~~Observe wound bed appearance.~~Assess wound bed, margins and periwound skin condition.
3. Check wound size, shape, depth~~, margins~~.
4. Observe exudates or drainage.
5. Evaluate presence of pain.

J. Remove soiled gloves, and discard.

K. ~~Don~~Perform hand hygiene and don clean gloves.

L. Clean wound with saline solution (use if wound culture ordered), sterile water or wound cleanser, per order. Pat wound with 4x4 gauze.

M. Obtain wound culture (if ordered) after cleansing wound with sterile saline. Do not take specimen from exudate or eschar.

N. If tunneling present, loosely pack tunneling area of wound if present before filling the base of the wound.
    1. Place packing material in wound: using a sterile gloved hand or a clean gloved hand with either sterile forceps or sterile cotton tipped applicator, gently guide enough packing material into the wound cavity, undermining, sinus or tunnel to fill the dead tissue without causing the wound tissue to stretch or bulge.

O. Use only one piece or length of packing wherever possible. Leave "tail" end visible.

P. Fill rest of wound with dressing as ordered. Then cover with a dry dressing.

Q. Remove and dispose gloves; dispose soiled instruments. Perform hand hygiene.

RELATED LINKS:

Patient Care Record in ccLink
Wound documentation tab in ccLink

REFERENCES:

TJC Standard PC.01.02.05, "Qualified staff or licensed independent practitioners assess and reassess the patient."

~~Iwamoto, P., Post, M., & Oregon Patient Safety Commission (2014, October 2). Aseptic Technique. In *Basic Principles of Infection Prevention Practice*. Retrieved 9 20 2022, from http://text.apic.org/toc/basic-principles-of-infection-prevention-practice/asepticteчnique#book_section_584~~

Perry,A., Potter, P. & Ostendorf,W., and Laplante, N. (~~2018~~2022). Clinical nursing skills & techniques ~~pp.1016-1017~~ (10th ed). Elsevier.

Wound Ostomy and Continence Nurses Wound Committee and the Association for Professionals in Infection Control and Epidemiology, Inc. 2000 Guidelines Committee. (2011). *Clean vs. Sterile Dressing Techniques for Management of Chronic Wounds: A Fact Sheet.* Wound, Ostomy and Continence Nurses

Society.

APPROVALS:

Clinical Practice Committee: 2/2018, 10/2022
Patient Care Policy & Evaluation Committee: 3/2018, 11/2022
Medical Executive Committee: 5/2018, 11/2022
Joint Conference Committee: 3/2023

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	07/2025
Clinical Practice Committee	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	06/2025
	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	06/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17910747

Origination	09/2012	Owner	Cita Richeson: Nursing Program Manager
Last Approved	N/A	Area	Perinatal
Effective	Upon Approval		
Last Revised	06/2025		
Next Review	3 years after approval		

Policy for Critical Congenital Heart Disease Screening

POLICY STATEMENT:

~~Pulse ox~~Critical Congenital Heart Disease (CCHD) screening will be performed ~~before discharge from the Nursery~~on infants after they turn 24 hours of age, ~~after~~and are not supported by oxygen. If the infant ~~turns 24 hours of age. If the infant~~ was born prematurely, the screening will be performed when medically appropriate. ~~Pulse~~The use of pulse oximetry, or "pulse ox," for screening is a simple, non-invasive, and painless test that is used to measure CHD and the percent oxygen saturation of hemoglobin in the arterial blood and the pulse rate.

The pulse ox test will be performed on the right hand (pre-ductal) and one foot (post-ductal). The majority of lesions are "duct" dependent and are best diagnosed prior to when the duct closes with the goal of preventing a life-threatening emergency situation.

GUIDELINES:

A. Pulse oximetry screening is done after 24 hours of age, or when medically indicated, on the right hand and on one foot. ~~The measurements should be taken in parallel or one after the other.~~
    1. ~~If the infant was born prematurely, perform screening when medically appropriate.~~
    2. If early discharge is planned, screening should ~~occur~~be done as late as possible.

B. ~~Conduct screening in quiet area with parent present to soothe and comfort the infant.~~

C. ~~If possible, conduct screening while the infant is awake, quiet, and calm.~~

D. ~~Do not attempt to perform pulse oximetry on an infant while he or she is sleeping, crying or cold as oxygen saturations may be affected.~~

E. The measurements should be taken concurrently or one after the other.

F. If the oxygen saturation is ~~>~~≥ 95% in ~~either extremity~~BOTH sites, AND with a ~~<~~≤ 3% saturation difference ~~between the two,~~ the infant will "pass" the screening test.
No additional evaluation will be required unless signs or symptoms of ~~CHD~~CCHD are present.

G. If the pulse oximetry reading is < 90% in either the hand or foot, the infant should be immediately referred to the physician for additional evaluation.

H. If the oxygen saturations are <95% in ~~both the hand and foot~~either extremity, or there is a > 3% saturation difference between the two ~~on three different measurements each separated by~~, the infant will be retested after one hour~~, the newborn will be referred for additional evaluation~~.

1. If retest does not meet threshold, the infant may be referred for additional evaluation.
2. The infant's physician or nurse practitioner will be notified.
3. If cause of hypoxemia is not clear the pediatrician may consider ordering an echocardiogram and cardiology consultation.

I. Recommendations for ~~Follow~~follow-~~Up~~up are made by our pediatricians following guidelines from our consultants ~~and~~, communication of results, and plan of care with infant's parents.

RELATED LINKS:

Procedure for Critical Congenital Heart Disease Screening
~~Critical Congenital Heart Disease Screening Form~~Addendum A: CCHD Screening Algorithm
Addendum B: Referral Letter to Parents
Addendum C: Refusal Letter

REFERENCES:

~~A. Newborn screening for critical congenital heart defect (CCHD). American Academy of Pediatrics. (2023, July 3). https://www.aap.org/en/patient-care/congenital-heart-defects/newborn-screening-for-critical-congenital-heart-defect-cchd/~~

~~B. The Joint Commission Standard (2024) PC.01.02.01, "The hospital assesses and reassesses its patients.~~

~~APPROVALS:~~

Newborn Screening for Critical Congenital Heart Disease: A New Algorithm and Other Updated Recommendations: Clinical Report | Pediatrics | American Academy of Pediatrics (2025)

A. APPROVALS:

Pediatric Department: 11/12, 04/2025
Clinical Practice Committee: 1/2013
Patient Care Policy and Evaluation Committee: 2/2013, 6/2024
Medical Executive Committee

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	06/2025
Clinical Practice Committee	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	05/2025
	Cita Richeson: Nursing Program Manager	05/2025

Standards

No standards are associated with this document

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Origination	09/2003	Owner	Shideh Ataii: Director Of Pharmacy Svcs
Last Approved	N/A	Area	Pharmacy
Effective	Upon Approval		
Last Revised	06/2025		
Next Review	3 years after approval		

Contact List for Disaster Fan-Out Procedures

PURPOSE STATEMENT:

To provide a mechanism to recall off-duty staff in the event an emergency incident is declared.

PROCEDURE:

A. The Director or designee will continue the fan-out in order of proximity and availability.

B. The number of staff members called in will be at the discretion of the Director of Pharmacy Services and dependent upon the scope of the disaster.

C. Once contacted, staff is expected to report to CCRMC immediately, unless directed otherwise.

~~Inpatient~~Pharmacy Staff:

NAME	Home Phone	Cell Phone	Location
ABELLA, ROSARIO (RN)		510-410-8231	Vallejo
ALAVI, SHIRIN		760-828-2150	Walnut Creek
AL-RAWI, SHAMS		925-567-4570	Walnut Creek
ASCENCION, LISETTE		925-852-4868	Oakley
ATAII, SHIDEH		925-482-4733	Danville
BRODERICK, ETHEL (MDF)		510-375-5356	Martinez
~~CARONE, LORI~~		~~510-575-8637~~	~~Pinole~~
CHAMBERLIN, HOLLY (MDF)		925-207-0156	Martinez
CHOI, SUN		949-293-8497	Pleasant Hill

ELIA, HALA		707-631-4252	Fairfield
EMINUE, GLORY		404-604-0705	~~Vallejo~~Fairfield
EVANS, RONNICA (MDF)		925-577-3418	Pittsburg
FAKURNEJAD, ADEEBEH		925-285-4322	Berkeley
FENG, TRACY		408-368-2027	Martinez
FUNG, SHARON		415-650-8293	Hercules
LAM, ERIC		925-212-4667	Concord
LAI, SHELLY		301-979-1947	Fairfield
LIANG, KENNY		510-520-2699	Concord
LIU, JOE ~~(MDF)~~		415-963-2366	Pacifica
LOLHAM, IVET		925-360-3982	Martinez
LOPEZ, ERICA		415-640-5534	Vallejo
LUO, ANDY		925-698-5698	Pittsburg
MA, ALEX (MDF)		415-937-4718	Antioch
~~MAKEEV, FRANCHESKA~~		~~925-766-6560~~	~~Walnut Creek~~
MALANA, VANESSA		925-642-7883	Pittsburg
MANULAT, NECO (MDF)		650-660-6531	Emeryville
MIRADOR, ROMIE (MDF)		707-319-2784	Vallejo
NG, NHU (BONNIE) (MDF)		408-234-0385	~~Hayward~~Walnut Creek
NGO, PHONG		408-982-7476	Pleasant Hill
OMER, MARYAM		408-708-8585	San Jose
ORELLANA, MARJAN		510-410-6088	Kensington
OUABO, BRIGITTE		661-609-1409	Antioch
PATINO, CHRISTINE		510-677-4527	San Leandro
PAULE, JERICO		707-656-1069	Fairfield
PEREZ, BERNICE		707-315-9748	Benicia
PHAM, KHAI		714-318-8691	Walnut Creek
REYNOSO, JUAN		925-305-0992	Pittsburg
RHEE, GA (MONICA)		707-342-0968	Benicia
RHEE, JOSEPH	707-751-1570		Benicia
~~RIVERA, TROY~~		~~925-768-5868~~	~~Martinez~~
SAHAGUN, CRYSTAL		707-853-7403	Vallejo
SHAH, SONAM		562-980-6535	Concord
SINGH, AMANDEEP (MDF)		925-329-5633	Baypoint

SOTSKOVA, MARINA		925-285-9799	Concord
SPARKS, ANDREA (RN)		510-860-6426	Crockett
TRAN, KRISTIE		408-464-5805	Pleasant Hill
VORA, USHMA		925-788-4343	Clayton
WANG, AMANDA		510-225-8105	Pleasant Hill
WONG, MEILIN		408-219-9236	San Leandro
WONG, CHI HOU (ANTONIO)		650-963-6388	Walnut Creek
WOOD, DENISE		510-807-5578	Walnut Creek

Per Diem Staff:

NAME	Home Phone	Cell Phone	
DO, WILLIAM		714-325-8177	Oakland
KNAUS, ELIZABETH		503-312-2382	San Francisco
MAKEEV, FRANCHESKA		925-766-6560	Walnut Creek
NGUYEN, VICKIE		714-244-2710	~~Walnut Creek~~Lafayette
PARVATANENI, RAO (Ret.)	925-372-9737	925-293-6308	Martinez
PAUL, SUDA (Ret.)	925-376-5165	925-788-1149	Orinda
PECK, RAPHAEL (Ret.)		510-684-8023	Albany
SANCHEZ, LESLIE (NICHOLE)		707-393-1847	Antioch
TUNGOL, ANGELO		415-900-6443	Antioch
VU, HEATHER		510-501-3877	Alameda

Clerical Staff:

NAME	Home Phone	Cell Phone	
MACHA, TATIANA		925-351-5589	Brentwood
~~SEOVIA~~SEGOVIA, IRENE		408-800-8661	Oakley

RELATED LINKS:

Policy for Pharmacy Disaster Fan-Out Procedures

REFERENCES:

A. TJC Standard EM.02.01.01, EM.02.02.01, EM.02.02.07

B. CMS CoP § 482.11(a)(c), 482.12(f), 482.23(c), 482.25(a)(b), 482.41(a)(b), 482.42(a), 482.43(a)(c)(d), 482.55

C. CCRMC Disaster Plan

~~**APPROVALS:**~~

~~Patient Care Policy and Evaluation Committee: 3/2024~~

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
	Shideh Ataii: Director Of Pharmacy Svcs	06/2025

Standards

No standards are associated with this document

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Last Approved	N/A
Effective	Upon Approval
Last Revised	06/2025
Next Review	3 years after approval

Owner	Shideh Ataii: Director Of Pharmacy Svcs
Area	Pharmacy

Policy for Emergency Procurement of Drugs - Borrowing and Loaning

POLICY STATEMENT:

The Pharmacy Department will have an alternate source of drugs in the event of a shortage, or outage of a prescribed medication, or in a disaster/emergency. During pharmacy hours of operation, new drug requests, shortages, outages, or other emergency needs are to be referred to a pharmacist on duty. He/she will discuss with the provider to assess whether or not an available therapeutic/formulary alternative is appropriate. If it is determined that there are no substitutions, the pharmacist will make all attempts to obtain the item from the wholesaler, the manufacturer; or another hospital, retail pharmacy, or distributor depending upon the urgency. After hours, the Medical Center Supervisor (MCS) may make arrangements to borrow the needed medication from a local hospital or contact the pharmacist on call for assistance in obtaining the necessary items.

RELATED LINKS:

Procedure for Emergency Procurement of Drugs – Borrowing & Loaning

REFERENCES:

A. TJC MM.02.01.01
B. CMS CoP § 482.12(f), 482.23(c), 482.25(a)(c), 482.55
C. California Board of Pharmacy Law Business and Professions Code 4128.5

~~**APPROVALS:**~~

~~Patient Care Policy and Evaluation Committee: 3/2022~~
~~Medical Executive Committee:~~
~~Joint Conference Committee:~~

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
	Shideh Ataii: Director Of Pharmacy Svcs	06/2025

Standards

No standards are associated with this document

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Next Review	3 years after approval		

Policy for Emergency Resources

POLICY STATEMENT:

A list of resources will be available in the event a disaster occurs and normal operational procedures/ channels are not available.

GUIDELINES:

A. IV and Chemo Compounding Aseptic Isolator(s) – CAI – and Compounding Aseptic Containment Isolator(s) – CACI:

1. Nuaire	(800) 328-3352
2. Discovery Scientific Solutions (Nuaire local support)	(844) 742-3818
3. Certification and Inspection:	
a. Biomedical Repair	ext 5472
b. AABC Testing & Certification 1430 Koll Circle Suite. 105, San Jose, CA 95112	Office: (844) 296-7198

B. Computer Systems:

1. Omnicell	
590 East Middlefield Road	(800) 474-2355

Mountain View, CA 94043	(415) 846-5698
Customer Support	(800) 910-2220
2. ccLink	
Hospital Information Systems' Help Desk	(925) 957-7272
595 Center St, Ste 210, Martinez, CA 94553	

C. Drug Wholesaler

1. Cardinal Health 3238 Dwight Road, Elk Grove, CA 95758	(916) 394-3000

D. Alarm Systems

1. Denalect 1309 Pine St, Walnut Creek, CA 94596	(925) 935-2680
2. CCC Building Maintenance	(925) 313-7052

E. Order Entry Services

1. RxeSource	(877) 244-5774
184 Technology Dr, Ste 100	(949) 635-9890
Irvine, CA 92618	(949) 433-5903
Fax: (877)-531-9081	

~~RELATED LINKS:~~

~~A. Cardinal Health Emergency Contact List~~

REFERENCES:

A. TJC Standard EC 4.10, MM 2.10

B. CCRMC Disaster Plan

~~APPROVALS:~~

~~Patient Care Policy and Evaluation Committee: 3/2022~~
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~~Joint Conference Committee:~~

Attachments

Cardinal Health- Pharmacy Distribution Contact List.pdf

Approval Signatures

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No standards are associated with this document

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Policy for Pharmacy ccLink Downtime Plan

POLICY STATEMENT:

To provide staff with a plan of what needs to be done when the Electronic Health Record system (ccLink) is not available. Patient care services will not be impacted when the Electronic Health Record system (ccLink) is not available.

GUIDELINES:

A. The following procedures are to be followed for any of the following instances:
   1. Scheduled and unscheduled system unavailability less than 3 hours
      a. **Routine Scheduled (planned) Downtime** is defined as normal scheduled downtime to perform system processing, maintenance and backups.
      b. **Unscheduled (unplanned) Downtime** is defined as system access interrupted due to system or network problems in excess of 5-10 minutes.
   2. Individual module downtime procedures will be followed if isolated modules are not available.

B. **Downtime Notification**
   1. The IS Department will coordinate communication to all departments during downtimes.
   2. Staff will be notified by overhead page that the ccLink system is down.
   3. E-mail will be utilized for notification of any scheduled downtimes and to update areas during extended downtimes.

4. Scheduled downtimes will be communicated at least 24 hours in advance of the actual downtime.
5. All departments will be notified when the system is unavailable and also when the system is again available.
6. During business hours the IS staff will notify all departments
7. After hours the Admissions staff will assist in notification to all departments.
8. Administration will be notified of all unscheduled downtimes.
9. No one should use the system until IS or Admissions staff has contacted the department that the system is available.

C. **Department Responsibility During Computer Downtime**
All departments will do the following to prepare for scheduled downtime:

1. Prepare necessary forms/documents if there is a scheduled downtime
2. Make necessary staffing adjustments during the downtime and after the downtime to allow for time for the re-entry of data.
3. Confirm all staff working are knowledgeable about downtime procedures
4. Communicate appropriately to patients that are seen during the downtime.

D. **Pharmacy Downtime Processes:**

1. A Shadow Read Only (SRO) function will be available on all clinical computers. This will allow access to all screens and content but does not allow data entry. It will display all data up until the point of the downtime.
2. Accessing the BCA-PC will allow printing of the downtime MAR report (automatically and routinely updated in the background). This document will contain a condensed version of the patient's information (which includes allergies and BSI/BMA) and the due times of medications that the patient was on before downtime. On this paper MAR, Pharmacy will be able to view yesterday, today and tomorrow's scheduled due times. Previous administration actions as well as recording users will also appear. If medications were unverified at the time of printing, an alert will appear.
3. Also available on the BCA-PC is a patient-specific downtime medication profile. Like the downtime MAR, it is routinely and automatically updated in the background and can be used as a documentation of orders entered (within 15 minutes) up to the point of the system going down.
4. If the network is available, providers will use the order forms on iSite. If the network is not available, all orders will be hand-written on blank downtime order sheets. The following information must be included:
    a. Patient's name, age, sex, medical record number, location, and admitting diagnosis.
    b. All medication orders must include all legally required information.
5. Orders will be faxed to Pharmacy at 925-370-5345. If the fax is not functional, runners will be utilized to pick up orders.

6. Pharmacy will keep medication orders filled during the downtime. The date and time of the orders will be indicated to allow for proper sequence for entry when ccLink is once again operational.
7. The patient's allergy information, written on the downtime reports, will be entered into ccLink as soon as the computer system is available.
8. The PM shift pharmacist (on weekdays) & DC pharmacist on weekends and holidays to verify orders that were "auto-verified" (when patient is discharged i.e. from the ED etc.) using the "Rx unverified orders" report.
9. Once the order arrives in Pharmacy, labels will be generated from the downtime PC or manually typed and the dispense quantity and time of dispensing will be noted on the paper copy of the prescription/order.
10. All orders will be filed in an alphabetical file for later entry.
11. The ADC will continue to function as a stand-alone system. New patients will need to be manually added and medications will be accessed via override. (See Policy for Pharmacy Department Disaster Plan and Policy for Automated Drug Delivery Systems – Malfunction & Failure)
12. For a planned downtime, run the cart-fill lists from ccLink READ-ONLY icon on the computer desktop to manually print the list and reprint labels. (ccLink READ-ONLY icon > Pharmacy > Cart fill). Saved hard copies of the last cart-fill list will be referenced in an unplanned downtime. The cart-fill list must be reconciled against all new orders.
13. ~~All fentanyl patches will be removed from **all** Omnicells during downtime by the pharmacy department. The patches will be placed back in to Omnicells when the systems are back up by the pharmacy department.~~
14. The clinical pharmacist to check if all baseline INRs were drawn appropriately during downtime.
15. The hospitalist attending in the hospital is to double check the residents/medical staff's orders after hours (i.e. after 7:30 pm M-F and after 6:00 pm on Sat/Sun/ holidays)
16. The pharmacist will email a list of the current Omnicell content to the Medical Center Supervisor (MCS) ~~and put a hard copy in the Night Locker in the pharmacy department~~.

E. **Downtime Recovery:**

1. All orders are to be sorted by patient name and time and entered into ccLink in chronological order.
2. Pharmacy and/or providers will enter all medication orders into ccLink; backdating the time to the time the medication order was written.
3. Orders are to be entered by unit, starting with the ED, then CCU, IMCU, Med-Surg, and OB in that order. Orders are to be entered in chronological order, by patient, starting with STAT and now orders.
4. Pharmacy will run a billing summary for all patients that had medication orders

entered to ensure all doses were billed or credited appropriately.

5. All orders must be entered into ccLink retrospectively. RxeSource may be called upon to help with order entry.

~~RELATED LINKS:~~

~~A. Blank paper order sheets~~

~~B. Procedure for BCA Downtime~~

~~REFERENCES:~~REFERENCES:

A. TJC Standards EM.01.01.01, EM.02.01.01, EM.02.02.01, EM.02.02.09, IM.01.01.01, IM.01.01.03, MM.01.01.01, PC.01.03.01

B. CMS CoP § 482.12(f), 482.13(c), 482.23(c), 482.25(a)(b), 482.41(a)(b)(c), 482.42(a), 482.55

~~APPROVALS:~~

~~Patient Care Policy and Evaluation Committee:3/2022~~

~~Medical Executive Committee:~~

~~Joint Conference Committee:~~

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
	Shideh Ataii: Director Of Pharmacy Svcs	06/2025

Standards

No standards are associated with this document

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Effective	Upon Approval
Last Revised	06/2025
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Owner	Shideh Ataii: Director Of Pharmacy Svcs
Area	Pharmacy

Policy for Pharmacy Disaster Fan-Out Procedures

POLICY STATEMENT:

In the event an emergency incident occurs during pharmacy off hours, the pharmacist on-call will be notified. He/she will begin the fan-out by notifying the Director of Pharmacy and the Inpatient Pharmacist II before immediately reporting to the hospital.

GUIDELINES:

In the event an emergency incident or disaster is declared during off hours, the Pharmacist on-call will be notified via telephone ~~or on-call pager~~ by the appropriate authority.

~~If the pager is used, '911' will be added to the end of the call-back number to alert the pharmacist that the Disaster Plan has been activated.~~

If there is reason to suspect that a disaster situation may exist, the pharmacist on-call should contact the hospital for confirmation and instructions.

The Pharmacist on-call will attempt to contact the Director of Pharmacy and/or Inpatient Pharmacy Supervisor before leaving home to report to the hospital. He/she will report immediately.

Shideh Ataii, Director of Pharmacy (925) ~~648-7728, or (925)~~ 482-4733~~, (Pager: 346-4401)~~

Tracy Feng, Inpatient Pharmacist II (408) 368-2027 or (925) 500-3662

The Director or designee will continue the fan-out in order of proximity and availability (see Contact List for Disaster Fan-Out Procedures).

The number of staff members called in will be at the discretion of the Director of Pharmacy Services and

dependent upon the scope of the disaster.

Once contacted, staff is expected to report to CCRMC immediately, unless directed otherwise.

RELATED LINKS:

Contact List for Disaster Fan-Out Procedures

REFERENCES:

A. TJC Standard EM.02.01.01, EM.02.02.01, EM.02.02.07
B. CMS CoP § 482.11(a)(c), 482.12(f), 482.23(c), 482.25(a)(b), 482.41(a)(b), 482.42(a), 482.43(a)(c)(d), 482.55
C. CCRMC Disaster Plan

~~APPROVALS:~~

~~Patient Care Policy and Evaluation Committee: 3/2022~~
~~Medical Executive Committee:~~
~~Joint Conference Committee:~~

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Medical Executive Committee	Sarah E. Mcneil	Pending
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Owner	Shideh Ataii: Director Of Pharmacy Svcs
Area	Pharmacy

Policy for 340B Drug Discount Program

POLICY STATEMENT:

This policy provides the background, definitions, and general compliance obligations relating to the 340B drug discount program. The policy helps govern decisions regarding all 340B transactions and to ensure they are highly auditable. It is the intent of the 340B Program to permit covered entities "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." 340B is part of an overall comprehensive pharmacy services strategy to: Provide patients affordable access to medications, strategically manage financial aspects of pharmacy services, and ultimately, improve patient health.

GUIDELINES:

The 340B Program is a federal drug discount program authorized under section 340B of the Public Health Service Act and established by Congress under the Veterans Health Care Act of 1992 as part of Public Law 102-585. Section 340B requires drug manufacturers to enter into pharmaceutical pricing agreements (PPAs) with the Secretary of Health and Human Services (HHS) as a condition of Medicaid and/or the Medicare Part B program covering and paying for the manufacturer's covered outpatient drugs. The PPAs specify, among other things, that manufacturers may not sell covered outpatient drugs above 340B ceiling prices to covered entities. The program is administered by the Office of Pharmacy Affairs (OPA), a part of the federal Health Resources and Services Administration (HRSA)/Department of Health and Human Services (DHHS).

The covered entity must register with the Office of Pharmacy Affairs (OPA) in order to participate in the program. Upon registration on the OPA Information System (OPAIS) database as a participant in the 340B program, covered entities agree to abide by specific statutory requirement and prohibitions. A Covered Entity (CE) is the statutory name for a facility or program eligible to purchase discounted drugs through the 340B program. Covered entities include 6 categories of hospitals and 13 categories of non-hospitals. See Glossary of Terms for definitions and acronyms of different qualifying covered entities.

Contra Costa Regional Medical Center and Health Centers is registered in OPAIS as a Disproportionate Share

Hospital (DSH). This category of hospitals is defined under the Social Security Act (42 CFR § 412.106) and eligible to participate in the 340B drug discount program if they meet certain 340B eligibility criteria. A DSH hospital serves a disproportionately large share of low-income patients. The Medicare and Medicaid programs provide additional payments to DSH hospitals to compensate them for the higher costs attributable to treating low-income patients. The Medicare DSH adjustment is a percentage add-on to a hospital's prospective payment and is based on the share of Medicaid patients and supplemental security income (SSI) recipients that the hospital serves on an inpatient basis. For a DSH hospital to qualify for the 340B program, it must have a Medicare DSH adjustment percentage of greater than 11.75%.

Other pertinent definitions in this policy are below:

A. **Parent Site:** The main facility of the covered entity that becomes eligible to use 340B drugs by virtue of the entity's enrollment in the 340B program.

B. **Child Site:** Outpatient clinic that has a different street address than the entity's main facility. It must have a separate OPA registration.

C. **Eligible Patient:** To be eligible to receive 340B-purchased drugs, patients must receive health care services (more than just drugs) from the 340B covered entity such that:

    1. the covered entity has established a relationship with the patient and maintains records of the patient's health care: **and**
    2. the patient receives health care services from a provider who is either employed by the covered entity or provides services under a contractual or other arrangement (e.g. referral for consultation) such that the responsibility for the care remains with the covered entity: **and**
    3. the patient is an outpatient

D. **Mixed-Use Setting:** A location that serves both inpatients and outpatients (e.g., radiology, recovery room, endoscopy, etc.). Provided the location and patient qualify for 340B, the outpatient medications would be purchased at 340B pricing. The medications used on inpatients would not qualify.

E. **Covered outpatient drug**: Defined in Section 1927(k) of the Social Security Act (https://www.ssa.gov/OP_Home/ssact/title19/1927.htm), and summarized as:

    1. An FDA approved prescription drug, an over-the-counter (OTC) drug that is written on a prescription, a biological product that can be dispensed only by a prescription (other than a vaccine), or FDA-approved insulin
    2. See Attachment A for exclusions and not-covered outpatient drugs (NCODs) from this definition

I. *GENERAL RESPONSIBILITIES*

A. As a participant in the 340B Program, Contra Costa Regional Medical Center and Health Centers:

    A. Meets all 340B Program eligibility requirements.

    B. Maintains electronic records (i.e., through SunRx®), that are available to demonstrate compliance.

    C. Has systems/mechanisms and internal controls in place to reasonably ensure ongoing compliance with all 340B requirements.

D. Elects to receive information about the 340B Program from trusted sources, including, but not limited to:

1. The Office of Pharmacy Affairs
2. The 340B Prime Vendor Program, managed by Apexus
3. 340B Health

B. Covered entities are prohibited from selling, giving, or otherwise transferring covered outpatient drugs purchased under the program to anyone other than a "patient" of the covered entity as defined under HRSA guidance.

C. Covered entities are prohibited from requesting payment under Medicaid for a covered outpatient drug purchased under the 340B program if the state claims a Medicaid rebate for the same covered outpatient drug from the manufacturer. If the covered entity plans to bill Medicaid for such drugs, then the entity must provide OPA with a relevant Medicaid billing number(s) and/or National Provider Identifier(s) (NPI).

D. Covered Entities must monitor their continuing eligibility to participate in the 340B program, must inform HRSA if it is determined that the hospital or any of its child sites are no longer eligible (e.g., hospital was sold, services were discontinued), and must cease purchasing 340B drugs for the hospital or its registered outpatient sites once the hospital has concluded such locations are no longer eligible.

E. The main hospital, all off-site hospital outpatient locations that dispense or otherwise use 340B drugs, and all contract pharmacies must be registered with OPA.

F. The 340B information on the OPA website database (https://340bopais.hrsa.gov/home) is reviewed and updated as needed, but no less frequently than annually. CCRMC completes this annual review at the time of the annual recertification and notifies OPA of any changes.

G. DSH hospital enrolled in the 340B program are not allowed to purchase covered outpatient drugs through a GPO or other group purchasing arrangement.

1. Maintains a non-GPO/wholesaler acquisition cost (WAC) account(s).
2. Has tracking systems and safeguards in place (via split-billing software) to prevent GPO violations

H. 340B covered entities that use one or more contract pharmacies must comply with HRSA's contract pharmacy guidelines. Refer to Contra Costa Health Plan Policies on Contract Pharmacies.

I. 340B covered entities must maintain auditable records that demonstrate compliance with 340B program requirements and are accessible to government auditors, manufacturers or any other party authorized to audit the 340B program.

J. The covered entity must retain ownership of the 340B drugs purchased through the approved wholesaler. Although the 340B inventory is property of the covered entity, it must be kept separate from drugs purchased for inpatient use. Virtual separation of 340B drugs requires tracking and replenishment at the NDC 11-digit level. CCRMC is to maintain separate virtual inventory through a split billing software.

1. In exceptional circumstances when an 11-digit NDC replenishment is not possible (e.g., NDC availability, inner vs. outer NDC packaging), 9-digit NDC level replenishment may be used.

II. *ROLES AND RESPONSIBILITIES*

The following individuals have specific obligations to the 340B program:

A. **Chief Financial Officer:** Responsible as the Authorizing Official and principal officer in charge for the compliance and administration of the program

B. **Fiscal Manager/Director of Compliance**: Responsible as the Primary Contact and for communicating any changes in site eligibility information/status immediately to the Director of Compliance and to the Director of Pharmacy Services

   a. Site registration and accuracy and completeness of information provided to the OPA

   b. Annual site recertification with OPA for all CCRMC 340B-enrolled locations

   c. Submitting change request to the OPA in the event any site registration data is incorrect or if any changes occur

C. **Director of Pharmacy Services**: Accountable agent for 340B compliance at CCRMC and Health Centers

D. **Contra Costa Health Plan Pharmacy Manager**: Accountable agent for 340B compliance at Contract Pharmacies

E. **340B Committee**: CCRMC has established a 340B Committee that is responsible for oversight of the 340B program that meets on a regular basis

III. *ENROLLMENT RECERTIFICATION AND CHANGE REQUESTS*

A. Enrollment

   1. Authorizing Official or Primary Contact identifies upcoming registration dates and deadlines.

   2. Authorizing Official or Primary Contact has available the required documents:

      a. Medicare Cost Report:

         1. Worksheet S, S-2, S-3

         2. Worksheet E, part A

         3. For outpatient facilities:

            a. Worksheet C

            b. Worksheet A

            c. Working trial balance

      b. Certification of ownership status

   3. Authorizing Official or Primary Contact completes registration on 340B OPAIS (https://340bopais.hrsa.gov/).

B. Recertification procedure

   1. Authorizing Official or Primary Contact annually recertifies information on 340B OPAIS.

   2. Authorizing Official or Primary Contact completes the annual recertification by following

the directions in the recertification email sent from HRSA prior to the stated deadline.

3. Authorizing Official or Primary Contact submits specific recertification questions to 340b.recertification@hrsa.gov.

C. Enrollment procedure: New Outpatient Facilities

1. Authorizing Official or Primary Contact determines that a new outpatient service or facility is eligible to participate in the 340B Program.
    a. The criteria used include that the outpatient service is fully integrated into the hospital, appears as a reimbursable service or clinic on the most recently filed Cost Report, has outpatient drug charges and has patients who meet the 340B patient definition.
2. Authorizing Official or Primary Contact completes the online registration process during the registration window.
3. Authorizing Official or Primary Contact will submit any updated Medicare Cost Report information, as required by HRSA.

D. Procedure for Changes to Information in 340B OPAIS

1. Authorizing Official or Primary Contact notifies HRSA immediately of any changes to the Medicare disproportionate share adjustment percentage resulting in a disproportionate share percentage ≤ 11.75%.
    a. Covered Entity will stop the purchase of 340B drugs as soon as it files its cost report with a disproportionate share percentage ≤ 11.75%.
    b. Authorizing Official or Primary Contact will complete the online change request as soon as a change in eligibility is identified.
2. Authorizing Official or Primary Contact will notify HRSA immediately of any changes to Covered Entity information on 340B OPAIS.
3. Authorizing official will complete the online change request as soon as a change in eligibility is identified.

IV. *PATIENT ELIGIBILITY/DEFINITION*

CCRMC ensures that 340B drugs are dispensed/administered/prescribed only to eligible patients by:

A. Validating site eligibility:

1. The hospital and clinic sites listed on the Medicare Cost Report and registered on the OPAIS database are eligible to receive 340B drugs

B. Determining patient status (outpatient vs. inpatient)

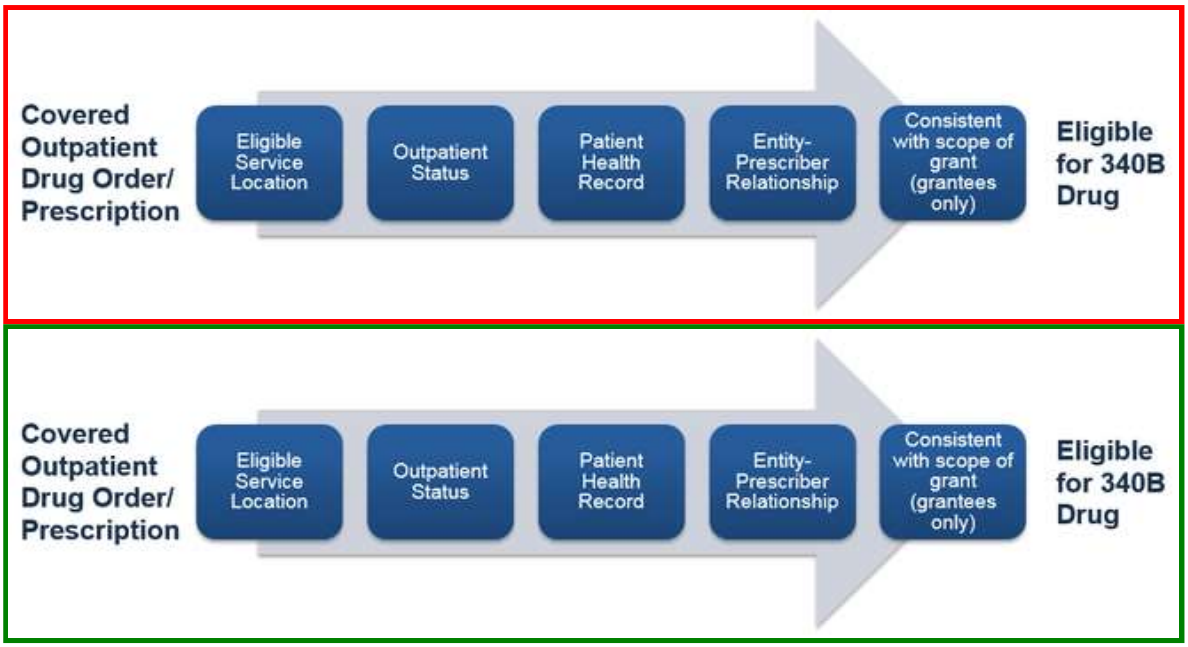
1. Only patients with an outpatient status at the time of medication charge (on administration or dispensation) is eligible to receive 340B drugs
2. Retrospective changes in patient status are not taken into consideration in either direction (e.g. status changing from inpatient to outpatient or outpatient to inpatient).

C. Maintaining records of individual's health care

D. Determining provider's eligibility

1. Prescriber is on the hospital's eligible prescriber list as employed by the entity, or under contractual or other arrangements with the entity, and the individual receives a health care service from a health care professional such that the responsibility for care remains with the entity

E. Determining patient's Medicaid status
    1. Medicaid claims are flagged with appropriate modifiers to prevent duplicate discounts



V. *PREVENTION OF DUPLICATE DISCOUNTS*

CCRMC Hospital and Health Centers is registered with OPA as a "**carved-in**" entity, meaning our entity bills Medicaid for drugs purchased at 340B prices that may be subject to a payment of a Medicaid rebate to the state. Our entity is listed on the Medicaid Exclusion File so that Medicaid knows not to request reimbursement from drug manufacturers for 340B drugs, thus preventing duplicate discounts.

A. To meet the Federal requirements, Medicaid Provider Numbers and/or NPIs are listed on the OPAIS for the parent and each registered child site location.
    1. In addition, out of state Medicaid Programs will not be billed.

B. To meet the State requirements,
    1. the required claim identifier ("UD modifier") is used on claims to indicate 340B drugs were administered to Medicaid beneficiaries.
    2. drug cost submission on the claim reflects the 340B AAC (Welf. & Inst. Code § 14105.46(d)).
    3. Fee-for-Service and Managed Care Medicaid are carved-out for contract pharmacy claims.

C. The Health Centers do not use Medicaid Fee-for-Service billing.
    1. If patient seen by a licensed practitioner, the billing claim form will list medication claims

with applicable state requirements (as above) as 'information only.' The information only line does NOT have units/quantity or a dollar amount.

2. If patient not seen by a licensed practitioner, the billing claim form will list medication claims with applicable state requirements (as above), a unit/quantity, and a dollar amount. However, the third-party claims scrubber will not send the bill to Medicaid and the medication charges are written off.
3. There are some program-specific exceptions (e.g. Family Pact) that are billed based on the California Medicaid requirements. Charges that do not meet the program-specific requirements may appear on the claim form as required, but are not billed, not sent to the payor, and written off.

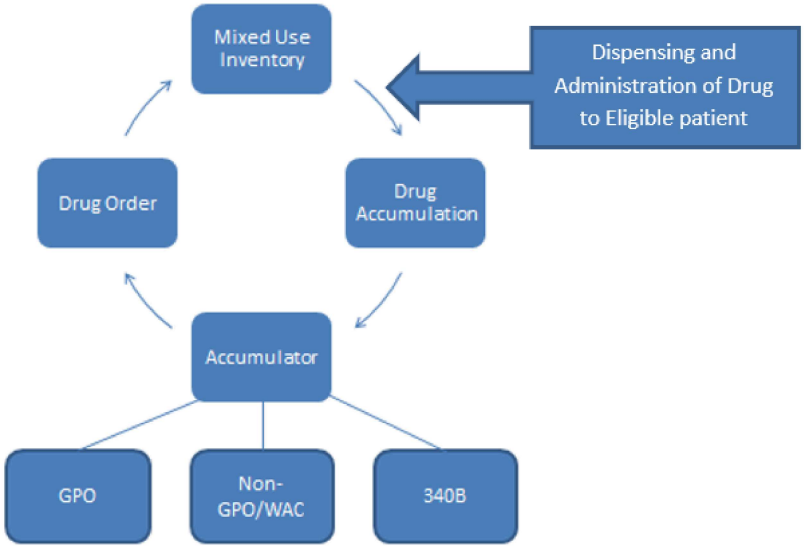
VI. *PROCUREMENT, INVENTORY MANAGEMENT, AND DISPENSING PROCESS*

A. 340B inventory is procured and managed in the following settings:
    1. Hospital pharmacy servicing mixed-use areas of the hospital and providing discharge medications to certain patient populations (at no charge/not billed)
    2. Outpatient pharmacy servicing health center child sites
    3. Contract Pharmacy

B. CCRMC Hospital and Health Centers uses a hybrid (physical and virtual) approach to inventory management.
    1. The parent entity (hospital pharmacy and mixed-use areas of the hospital): uses a ***virtual mixed-used replenishment inventory*** (i.e., neutral) using a split billing software
    2. The parent entity also dispenses discharge medications to patients that are not billed to payers or charged to the patient and therefore are not included on a billing claim form; however, are a part of the virtual inventory.
    3. The outpatient pharmacy and health center child sites use ***physically separated 340B and non-340B inventory.***

C. ***Virtual Mixed-use Inventory Replenishment System*** is maintained at the PARENT ENTITY (hospital pharmacy and mixed-use areas of the hospital)
    1. Split-billing software is used to perform split-billing on medication procurement orders.
    2. Medications administered to specific patient(s) within the hospital are tracked by 11-digit NDC. This information is transmitted to split-billing software with coding indicating patient eligibility for 340B medications.
    3. Medications are charge on administration in the hospital setting, with some exceptions for bulk dispense medications (i.e. topicals, inhalers, etc.) which are charge on dispense. Only medication charges are sent to the split-billing software for accumulation.
    4. Split-billing software accumulates eligible and non-eligible medication administrations and allows for appropriate replenishment. Accumulation occurs at the 11-digit NDC level, and a full package size must be accumulated before replenishment.
        a. In exceptional circumstances when an 11-digit NDC replenishment is not possible (e.g., NDC availability, inner vs. outer NDC packaging), 9-digit NDC level replenishment may be used.

5. Purchasing agent exports daily orders from wholesaler ordering system to split-billing software, which then splits the order based on accumulations of 11-digit NDC into corresponding purchasing accounts (i.e., 340B, GPO, or WAC).
6. Procurement order is then placed with wholesaler and accumulations are automatically reduced accordingly from split-billing software.
7. Upon receipt of the drug shipment, pharmacy personnel verify quantity received with the quantity ordered and identifies/resolves inaccuracies in split-billing software.
8. If/when consignment inventory is acquired, and dispensed to a 340B eligible patient, it will be replenished like all other inventory based on accumulations.
9. If medications are unable to be acquired from usual wholesaler channels, medications may be purchased outside of the accumulation process and obtained directly from secondary or tertiary resources on non-340B/non-GPO accounts when needed to fulfill patient medication orders. If 340B or WAC accounts are unavailable direct from the manufacturer, communication will be retained.



D. ***Physical Inventory*** is maintained at the OUTPATIENT PHARMACY and HEALTH CENTER CHILD SITES
    1. Medication procurement is performed through wholesaler on the **340B account** for facility-administered medication requests from child site locations registered on OPAIS as 340B eligible.
    2. Medication procurement is performed through wholesaler on the **GPO account,** which is separate from the Parent hospital/mixed-use account, for medication requests from off-site non-340B eligible locations.
    3. Drugs procured for off-site non-340B eligible locations are stored in a physically separate location from drugs procured for 340B eligible locations.
    4. Medications are charge on administration in the child sites.
E. Inventory of 340B medications wasted do not go back into the accumulator.
F. Patient-specific waste is defined as waste associated with the unused portion of a dosage form of a drug provided (e.g., dispensed, administered) to a patient. The patient-specific waste may be documented and allocated for accumulation and/or purchased based on the patient's eligibility

status.

G. In a state of emergency CCRMC will continue to ensure it has policies and procedures in place to address the purchasing and dispensing of 340B drugs, and it will continue to keep auditable records.

H. As a hospital subject to the GPO prohibition, if unable to purchase a covered outpatient drug at the 340B price, CCRMC will first try and obtain the drug at WAC. If it is unable to purchase the product at WAC due to shortages, the hospital may use a GPO or GPO private label product (e.g. Novaplus) according to the following circumstances described below.

    1. A suitable alternative is not available for purchase.
    2. The drug is required for a medically necessary treatment.
    3. The manufacturer will not or cannot supply the equivalent drug at 340B or WAC pricing, after hospital has attempted to work with the manufacturer to do so.

I. Documentation maintained includes, but is not limited to, screenshots of the WAC, GPO, and 340B accounts for the product being purchased, showing that no stock is available from CCRMC's Primary Drug Wholesaler, and documentation of communications with manufacturer and/or wholesaler regarding non-availability.

VII. *340B COMPLIANCE MONITORING/REPORTING*

A. Routine and/or random self-audit monitoring will be done by the pharmacy department to assure continued compliance with 340B requirements.

B. CCRMC develops an annual internal audit plan approved by the 340B Oversight Committee.

C. CCRMC has established processes in place to ensure 340B Program compliance and oversight at the contract pharmacy location(s).

D. CCRMC reviews 340B policies and procedures annually.

E. CCRMC reviews the HRSA 340B OPAIS to ensure the accuracy of the information for the parent site, off-site locations, and contract pharmacies annually and as needed.

F. CCRMC reviews the Medicaid Exclusion File (MEF) to ensure the accuracy of the information for the parent site, off-site locations, and contract pharmacies annually and as needed.

G. CCRMC updates the prescriber eligibility files regularly.

H. CCRMC 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 quarterly.

I. CCRMC reconciles dispensing records and Medicaid billing practices to demonstrate that CCRMC practice is following the Medicaid billing question on the HRSA 340B Database.

J. CCRMC 340B Oversight Committee reviews the internal audit results:

    1. Assess if audit results are indicative of a material breach.
    2. CCRMC maintains records of 340B-related transactions for a period of 3 years in a readily retrievable and auditable format.

VIII. *REPORTING 340B NON-COMPLIANCE/ MATERIAL BREACH*

A. A material breach is defined as a discrepancy that results in a negative impact of more than 10% of total 340B purchases in a fiscal year and does not self-correct within six (6) months.

B. The Self-Disclosure for Material Breach will be used to take proper action.

RELATED LINKS:

Non Covered 340B Outpatient Drugs (NCODs) (i.e. exclusions)

Self-Disclosure for Material Breach

REFERENCES:

A. HRSA (Health Resources and Services Administration) Health Resources and Services Administration | HRSA

B. OPA (Office of Pharmacy Affairs) 340B Drug Pricing Program | HRSA

C. 340B Health https://www.340bhealth.org/

D. 340B Prime Vendor Program Managed by Apexus 340B Tools (340bpvp.com)

APPROVALS:

Patient Care Policy and Evaluation Committee: 8/2024
Medical Executive Committee: 8/2024
Joint Conference Committee: 11/2024

Attachments

C. Glossary of Terms

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	06/2025

Shideh Ataii: Director Of Pharmacy Svcs	06/2025

Standards

No standards are associated with this document

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Owner	Shideh Ataii: Director Of Pharmacy Svcs
Area	Pharmacy

Policy for Infusion Pump System

POLICY STATEMENT:

To safely administer prescribed IV fluids, medications, and blood products via the ~~Alaris®~~ Smart Infusion Pump at a precise infusion rate. While smart pump technology helps reduce medication errors and prevent patient injury, it is not intended to replace clinical practices, institutional policies, and vigilant patient monitoring.

- The ~~Alaris®~~ Smart pump will be used to deliver prescribed IV fluids, medications, and blood products at a constant and precise infusion rate, utilizing the appropriate profile ~~and Guardrail® features~~ to enhance safe delivery. All intravenous medications will be ordered by a physician and administered by a registered nurse or qualified licensed vocational nurse. The safety software should be used in every situation except for emergent needs when a delay in initiating therapy could have a deleterious effect on patient care.
- When using this technology, clinicians must continue to practice the "five rights" of medication administration: the right patient, the right drug, the right dose, the right route, and the right time. Clinicians should also have another nurse perform an independent double check with high-risk infusions.
- Pharmacy Department is the system administrator for ~~Alaris®~~Smart infusion pump system at CCRMC and the ~~Guardrails®~~ Drug Libraries are managed by this department.
- The Continuous Quality Improvement (CQI) reports are closely monitored by the Pharmacy Department and reported to MSC, PIC and MEC. Nursing leadership will be notified as deemed appropriate.
- Use of the "~~No Guardrails -~~ Basic Infusion" feature requires permission of the nurse program manager or the nurse supervisor except in emergency situations.

~~**Note:** If basic infusion is used in an emergency situation, Guardrails® must be enabled for that infusion as soon as the immediate critical status stabilizes.~~

- Note: Anesthesia dept. is exempt.

This document was prepared on a multidisciplinary fashion by Pharmacy and Nursing

GUIDELINES:

For detailed procedure/instructions – refer to user manual on each types of pump (i.e., PCA, IV, and syringe pumps)

~~A. Equipment~~

- ~~PC Unit~~
- ~~Infusion Module (Pump, PCA, and/or Syringe)~~
- ~~Intravenous tubing~~
- ~~Intravenous medication, solution, or blood product, as ordered by provider~~

1. ~~Assemble all needed equipment and prime tubing.~~
2. ~~Turn on the PC unit and infusion module to begin programming infusion.~~
3. ~~Enter patient's medical record number (MRN)~~
4. ~~Select the appropriate profile.~~
5. ~~Select one of the following:~~
    - ~~Guardrails® Drugs~~
    - ~~Guardrails® IV Fluids~~
    - ~~No Guardrails - Basic Infusion~~
6. ~~**Guardrails®** *must* be utilized for any medication of IV fluid found within the Drug Library. "No Guardrails **- Basic Infusion**" mode is *only* available for medications or solutions not listed in the library of the clinical profile. No safety software exists in this mode.~~
7. ~~Select the appropriate medication using the pharmacy label as a guide.~~
8. ~~Acknowledge any clinical advisory by selecting "Confirm."~~
9. ~~If you get a Soft Limit alert, STOP, check the settings, check the order, and reprogram the pump. If you still get the Soft Limit alert, you may perform an override, if indicated, and proceed to give the medication.~~
10. ~~If you get a **Hard Limit** alert, **STOP,** check the settings, check the order, and reprogram the pump. If the Hard Limit comes up again, STOP and have a 2nd RN perform an independent double check: verify the order and reprogram the pump. If the hard limit comes up again, STOP and notify the prescriber of the Hard Limit and reprogramming attempt.~~
11. ~~For those IV medications requiring a bolus followed by maintenance infusion, the~~

bolus will be administered from the bag on indicated medications. Please see attachment 2 for a complete list of medications that can be bolused out of the bag".

12. For infusion of secondary medications, the maintenance infusion must be hung with the hanger fully extended for accurate delivery of medications.
13. Refer to the Quick Reference Guide attached to each device, or the User Guide found on each nursing unit and bio-medical for further instructions.

Note: the Alaris pump drug library is approved on an annual basis at the PCP&E Committee meeting

B. Pediatric Considerations

1. Profiles for all pediatric patients will be based on weight, rather than physical area.
    - Peds 15 Kg or less
    - Peds 15.1 Kg to 40 Kg
2. If the patient's weight is >40 kg, utilize the appropriate adult profile (i.e., Critical Care or Med/Surg).
3. The amount programmed into the Volume to be Infused (VTBI) for the Peds ≤ 3 kg patient cannot exceed 100 mL.

C. Special Considerations

1. When a patient transfers from one unit to another, the receiving unit is responsible for checking and/or changing the profile to meet the level of care provided on that unit.
    - To change profile, the PC unit must be powered down and re-booted.
2. Do not use the Alaris® Infusion System near magnetic resonance imaging (MRI).
3. Nursing Managers may utilize compliance rounds for staff re-education, as deemed necessary.

D. Device Management

1. Equipment will be stored in Central Supply and dispensed when called for.

RELATED LINKS:

Policy for Drug Shortages

REFERENCES:

- TJC Standard MM.06.01.01, NPSG.03.05.01
- CMS CoP § 482.13(c), 482.21(c), 482.23(c), 482.25(a)(b), 482.41(c)
- Institute for Safe Medication Practices - Revised and Expanded Guidelines for the Safe Use of Smart Infusion Pumps. 2020.

- ~~CareFusion®, Directions for use, Alaris® System (with Alaris® PC Unit, Model 8015), (manufacturer's guidelines).~~ Manufacturer's guidelines.

APPROVALS:

Clinical Practice Committee:
Patient Care Policy and Evaluation Committee: 3/2022
Medical Executive Committee:
Joint Conference Committee:

Attachments

1: Infusion Pump Data Set Change Request Form

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Shideh Ataii	04/2025

Standards

No standards are associated with this document

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Effective	Upon Approval		
Last Revised	05/2025		
Next Review	3 years after approval		

Policy for Reporting Diversion of Controlled Substances

POLICY STATEMENT:

All known or suspected diversion of controlled substances will be reported to the appropriate authorities, in accordance with County policies and state and federal regulations.

This policy provides guidelines for reporting drug diversion of controlled substances to the appropriate authorities.

GUIDELINES:

A. Known or suspected diversion must be reported immediately to the department head. The department head is responsible for investigating the incident and notifying the Director of Pharmacy.

B. The Director of Pharmacy Services can and will report all thefts by all disciplines to the DEA and the California Board of Pharmacy.
    1. Affected Department Heads will be notified
    2. Information will be provided to affected Department Heads to report to other regulatory agencies as appropriate (e.g. Board of Registered Nursing, Medical Board, etc.)

C. Reporting a Loss
    1. Definition of Significant Loss
        a. Any loss of a controlled substance, regardless of amount, attributed to employee theft
        b. A trend or pattern of losses repeated over a period of time using software

and technology

c. Losses where the aggregate amount discovered in that category, on or after the same day of the previous year, that equals or exceeds the following, as defined by the Board of Pharmacy Title 16 CCR 1715.6:

i. 99 dosage units – for tablets, capsules, or other oral medications

ii. 10 dosage units – for single-dose injectable medications, lozenges, film (such as oral, buccal, and sublingual), suppositories, or patches

iii. 2 dosage units – for multiple-dose injectable medications/vials, medications administered by continuous infusion, or any other multi-dose unit/container not previously described above.

2. Reporting to the Board of Pharmacy (BOP)

a. The report must be made no later than thirty (30) days after the date of the discovery of the significant loss defined in section (1) above.

b. The report shall specify the identity, amounts, and strengths of each controlled substance lost, and date of discovery of the loss, for all loses that have made the report necessary.

c. Any loss due to theft, diversion, or self-use of a licensed individual employed by or with the pharmacy shall be made within 14 days of discovery as per B&PC section 4104.

3. Reporting to the Drug Enforcement Agency (DEA)

a. Notice of the theft or significant loss must be provided in writing directly to the local DEA Diversion Field Office within one (1) business day upon discovery.

b. The DEA registrant must keep a copy of the notice for its records.

c. The DEA registrant must complete a DEA form 106 (Report of Theft or Loss of Controlled Substances).

RELATED LINKS:

DEA Form 106: https://apps.deadiversion.usdoj.gov/webforms/dtlLogin.jsp

Board of Pharmacy Online Portal for Reporting Theft or Loss of Controlled Substances: Report Drug Loss - California State Board of Pharmacy

REFERENCES:

A. TJC Standards MM.01.01.03, MM.05.01.11, EC.02.01.01, LD.04.01.11

B. CMS CoP § 482.11(a), 482.13(c), 482.23(c), 482.25(a)(b), 482.41(a)(c)

C. California Board of Pharmacy Law Health and Safety Code 4104, CC&R Title 16 §1715.6

D. DEA Pharmacist's Manual https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-046)(EO-DEA154)_Pharmacist_Manual.pdf

E. Diversion Control Division | Reporting

F. DEA Notification: CFR, Title 21, Sec 1301.76(b)

~~APPROVALS:~~

~~Patient Care Policy and Evaluation Committee: 7/2023~~
~~Medical Executive Committee:~~
~~Joint Conference Committee:~~

Attachments

Tally of Cumulative CII to CV Losses

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Shideh Ataii	05/2025

Standards

No standards are associated with this document

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Last Revised	05/2025
Next Review	3 years after approval
Owner	Shideh Ataii: Director Of Pharmacy Svcs
Area	Pharmacy

Policy for Titrating Medications

POLICY STATEMENT:

It is the policy of this institution to allow orders for medication titration, which is the progressive increase or decrease of the medication dose in response to the patient's clinical status. This policy establishes safety guidelines for medications ordered as titrations.

GUIDELINES:

Every titrated medication order must include:

~~A. The starting dose/rate~~

~~B. The increments the dose/rate must be adjusted~~

~~C. The frequency the dose/rate must be adjusted~~

~~D. The titration goal parameter (i.e. SBP, MAP, RASS, etc.)~~

~~E. A dose/rate limit~~

A. Medication name

B. Medication route

C. Initial or starting dose/rate of infusion

D. Incremental units the dose/rate can be increased or decreased

E. Frequency for incremental doses (how often the dose/rate can be increased or decreased)

F. Maximum dose/rate of infusion

G. Objective clinical endpoint (i.e. SBP, MAP, RASS, etc.). This particular element does not have to

reside in the titration order itself but instead may be a separate order in the medical record

Any orders received missing any of the above elements will not be verified or dispensed by the Pharmacy department.

A. Nursing guidelines are in place for titrated medications.

B. Nursing staff must assess the patient frequently when titrating medications to detect potential problems as early as possible.

C. If medication is titrated off but order is still active, the nurse may restart to meet the titration goal parameter with reference to the last infusion dose/rate or per provider order.

When the patient is rapidly deteriorating and is not responding to standard titration orders, the RN is authorized to increase or decrease a titratable drip more rapidly than prescribed, up to the maximum prescribed dose, or "off", as needed to support the patient's immediate stability. The provider will be notified as soon as reasonably possible~~, and additional orders will~~. All titration adjustments should be ~~instituted as communicated by the provider~~recorded in the medical record including supporting documentation. ~~All titration adjustments should be recorded in the medical record including supporting documentation for deviations in dosing outside the ordered parameters.~~

RELATED LINKS:

Guidelines for Administration of Titratable Medications

REFERENCES:

A. TJC Standard MM.04.01.01

B. CMS CoP § 482.23(c), 482.24(c), 482.25(a)(b)

APPROVALS:

Clinical Practice Committee: 2/18, 5/18, 9/19, 7/20, 7/22
Patient Care Policy and Evaluation Committee: 3/18, 5/18, 11/18, 3/19, 10/19, 7/20, 11/20, 6/21, 3/22, 6/22
Medical Executive Committee: 3/18, 6/18, 4/19, 11/19, 7/20, 11/2020, 6/21, 4/22, 6/22, 8/22
Joint Conference Committee: 9/2022

Approval Signatures

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Joint Conference Committee	John Gioia: Board of Supervisor	Pending

Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	06/2025
	Shideh Ataii: Director Of Pharmacy Svcs	06/2025

Standards

No standards are associated with this document

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Last Approved	N/A	Area	Pharmacy
Effective	Upon Approval		
Last Revised	12/2022		
Next Review	3 years after approval		

Policy for Pharmacy Security

POLICY STATEMENT:

Security of the Pharmacy shall be maintained in accordance with federal, State and local laws. All personnel on duty shall protect Pharmacy assets and records and guard against the theft or diversion of drugs it contains. In addition to ensure that all medications are stored in a secure manner, consistent with all applicable federal and state laws.

GUIDELINES:

Pharmacist is responsible for maintaining the security of the pharmacy.

Locking of Pharmacy Areas:

A. All areas occupied by the Pharmacy shall be capable of being locked by key or combination, to prevent access by unauthorized personnel by force.

B. Keys may only be in the possession of:

    1. Licensed pharmacists employed by CCRMC & HC

C. Locks in the Pharmacy must be rekeyed:

    1. When keys are lost
    2. In case of theft
    3. With changes in personnel, if determined to be necessary

Restricted Access to the Pharmacy (Traffic Control):

A. No person other than a pharmacist, pharmacy technician, intern pharmacist, an authorized officer of the law, or a person authorized to prescribe shall be permitted in the pharmacy wherein controlled substances or dangerous drugs or dangerous devices are stored, possessed, prepared, manufactured, derived, compounded, dispensed, or repackaged.

B. Medical staff, Nursing Services, administrative, Environmental Services and other facility personnel are authorized admission to the pharmacy in relation to their duties and only while **under the supervision of a Pharmacist.**

C. The Pharmacy shall limit nonessential traffic (by medical service representatives, visitors, and others).

D. The Nursing Supervisor may enter the Pharmacy Night Locker **ONLY**, during the hours when no Pharmacist is present only if patient need exists and the medication cannot be obtained elsewhere in the hospital. If the needed medication is only stocked in the Pharmacy and administration to the patient cannot wait until Pharmacy opens, the on-call Pharmacist must be contacted to come in to dispense the medication.

Pharmacy Lock-Up Procedures:

A. Pharmacy lock-up procedures shall ensure that drugs are secure, and that the Pharmacy is free of hazardous conditions. Lock-up procedures shall include, but shall not be limited to, ensuring that:

    1. Controlled drugs are secure
    2. Non-essential lights and electrical equipment are turned off
    3. All doors are locked
    4. The alarm is set

B. The Pharmacy door shall be locked at all times.

C. The Pharmacist will be the only person with a key to the working controlled substance drawers.

D. Pharmacy Administration is in sole possession of the key to circumvent the security of the narcotic vault in the event of a disaster or major system failure in order to provide adequate patient care.

Alarm System:

A. The alarm system for all Pharmacy locations is monitored by Denalact Alarm Company. A list of contact personnel will be provided to them by the Director of Pharmacy and updated as necessary.

B. In the event of an alarm, they will contact the Pharmacist-in-Charge, or Pharmacist designee, from the list. This individual will rectify the situation as appropriate and as necessary.

C. If that person cannot be reached, they will then contact the Director or the Assistant Director of the Pharmacy for resolution of the problem.

Theft or Break-Ins:

A. Any theft, break-in or unexplained loss shall be reported to the Pharmacy Director immediately.

B. The Pharmacy Director shall ascertain the loss and file all necessary reports, in accordance with hospital policy and applicable federal and state laws.

Reports:

A. The Pharmacy Director shall report controlled substance losses, as appropriate, according to Pharmacy Policy for Reporting Diversion of Controlled Substances.

RELATED LINKS:

Pharmacy Policy for Reporting Diversion of Controlled Substances

REFERENCES:

A. TJC Standard EC.02.01.01

B. CMS CoP § 482.13(c), 482.23(c), 482.25(a)(b), 482.41(a)(b)(c)

C. California Pharmacy Law Business and Professions Code Sections 4116, 4117, 4135

APPROVALS:

Patient Care Policy and Evaluation Committee: 12/2022
Medical Executive Committee:
Joint Conference Committee:

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
	Shideh Ataii: Director Of Pharmacy Svcs	06/2025

Standards

No standards are associated with this document

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Effective	Upon Approval		
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Next Review	3 years after approval		

Policy for Anticoagulation Program in Ambulatory Care

POLICY STATEMENT:

To assess, evaluate and manage patients on Vitamin K antagonist (VKA) therapy or on enoxaparin for bridging as clinically indicated.

All patients on Vitamin K antagonist (VKA) therapy will be referred by a clinician to the Anticoagulation Clinic. The Primary Care Provider (PCP) will be consulted for approval.

The referring provider or a member of the Internal Medical Department will continue management of the patient's anticoagulation needs until:

A. A PCP has been assigned and/or patient is seen by his/her PCP.
B. The trained staff manages care of the patient's needs and will notify the PCP of enrollment into the program.

GUIDELINES:

A. Training: All staff working in anticoagulation clinics will receive training. Prior to assuming independent care of any patients enrolled in this clinic, staff will complete competency training and assessment.
B. Referral: Provider will send an Anti-coagulation referral for both inpatients and outpatients:
    1. For hospitalized patients' referral to anti-coagulation via ccLink should be placed prior to discharge.
    2. PCP will maintain responsibility for the patient's anticoagulation coordination until patient is enrolled in the program.

C. Compliance: Anticoagulation Clinic staff will review new referrals and check for compliance:
    1. Anticoagulation Clinic staff contacts Provider to verify the plan of care as clinically indicated.
    2. Patient must have assigned PCP.
    3. Patients who have not been seen for 2 months or greater must-see PCP and have a new referral written.
    4. When a patient is out of compliance, the Anticoagulation Clinic staff will document justification for the rejection or closing of the active referral.
    5. Presence of a signed consent form by the patient.

D. Exclusion Criteria for Anticoagulation Clinic Enrollment:
    1. Medications not covered or mentioned in this protocol.
    2. Patients who are unknown to our system.
    3. Patients who are transferred to OR are currently in-patients in Skilled Nursing Facility (SNF) and all Contra Costa County detention facilities.
    4. Patients who are in residential and/or alternative care settings unless the patient has a CCRMC provider.
    5. Patients with multiple co-morbidities and highly technical or complex medical care needs (i.e., dialysis patients, anticoagulation therapy is being managed by Cardiology Group, certain blood dyscrasias, etc...)
    6. Patients without an assigned PCP with CCRMC privileges.
    7. Previously enrolled patients who have been discontinued in collaboration with the provider due to non-compliance will not be readmitted without proof of ability to comply. The Anticoagulation Clinic staff will communicate with PCP regarding readmission.
    8. Patients who qualify for therapy with a direct oral anticoagulant (DOAC).

E. Functions of the Anticoagulation Clinic staff:
    1. Receives referrals and enrolls patients into the Anticoagulation Clinic program accordingly.
    2. Monitors lab results and adjusts the VKA dose to keep patient within therapeutic range.
    3. Bridging with enoxaparin if/when indicated.
    4. Provides Patient education (e.g., medication regimen, diet, possible drug complications, lab results, medication dose changes, birth control and pregnancy complications, Coumadin video, and handouts).
    5. Reviews drug interactions (if present), modifies warfarin dose as necessary and notifies PCP.
    6. Gives patient contact information for further questions and education.
    7. Reviews with patient each section of Anticoagulation Patient Agreement and patient

education checklist.

8. Orders next lab test and confirms medication dosage.
9. Reorders medications.
10. Documents medication changes.

F. Medication Management
Warfarin (Coumadin®) [VKAs stands for Vitamin K Antagonists]

1. Therapeutic or target INR range is determined and prescribed by the provider.
2. Recommended therapeutic range for oral Warfarin therapy per CHEST guidelines is as follows (References: CHEST Antithrombotic Guidelines, 2019 AHA/ACC/HRS Update of the 2014 AHA/ACC/HRS Guidelines for the Management of Patients With Atrial Fibrillation)
    a. Optimal Therapeutic INR Range: For patients treated with VKAs, the CHEST consultants recommend a therapeutic INR range of 2.0 to 3.0 (target INR of 2.5) rather than a lower (INR<2.0) or higher (INR 3.0-5.0) range (Grade 1B)
    b. Therapeutic Range for High-Risk Groups: For patients with antiphospholipid syndrome with previous arterial or venous thromboembolism, the CHEST guidelines suggest VKA therapy titrated to a moderate intensity INR range (INR 2.0-3.0) rather than higher intensity (INR 3.0-4.5) (Grade 2B).
3. Adjustment in the dosage:
    a. The percentage change is per visit and the following table should be used as "monitoring guidelines."

Current INR	Goal INR	Percent Change1	Visit2
1.0 - 1.8	2.0 - 3.0	10% weekly increase1	See "f" to follow. Check INR sooner if patient unstable (e.g., anywhere from 3 days to a week)
1.0 - 1.8	3.0 - 4.5	20% weekly increase1	See "e" to follow. Check INR sooner if patient unstable (e.g., in 2 to 3 days)2
1.8 - 2.7	3.0 - 4.5	10% weekly increase1	See "F2a." above
4.0 – 5.7	2.0 – 3.0	20% weekly decrease1	See "F2b." above
4.0 – 5.7	3.0 – 4.5	10% weekly decrease1	See "F2a." above
>5.7	2.0	Hold Coumadin	Follow up in 2 days, then in a

	– 3.5	one day, then 20% weekly decrease1	week. Check for signs and symptoms of bleeding

*Note: In extreme and difficult to treat subtherapeutic patients who have had a recent PE (or DVT) it may be necessary to place them on enoxaparin temporarily to maintain adequate anticoagulated state while optimizing the warfarin dose. Consult with the provider before placing the enoxaparin order in.

Loading Dose for Initiation of Vitamin K Antagonist (VKA) Therapy
For patients sufficiently healthy to be treated as outpatients, CHEST guidelines suggest initiating VKA therapy with warfarin 10 mg daily for the first 2 days followed by dosing based on international normalized ratio (INR) measurements rather than starting with the estimated maintenance dose (Grade 2C) . Since this is Grade 2C, do NOT use this approach for elderly population.
1The percent change is per visit and the table above should be followed as "monitoring guidelines".
2For sub-therapeutic pro-time post-thrombotic episodes recheck the INR in 2-3 days.

b. Patients at either extreme, but still within the accepted therapeutic range, may receive a 5% to 10% dosage adjustment to approach the middle of the therapeutic range when deemed appropriate by the Anticoagulation Clinic staff.

c. A one-time Coumadin booster dose of 5-10 mg depending upon weight and INR is to be given when INR <2.0 for low intensity (INR2-3) or when INR <3.0 for high intensity (INR 3.0 -4.5).

d. Patients with risk factors for bleeding (i.e., varying alcohol intake, drug interactions, Hx of GI bleed, etc.) will be maintained to keep the INR ratio at the low end of the therapeutic range.

e. If adjustments of 20% are made in the weekly dosage, frequent INRs will be done until the INR is stable in the therapeutic range. The risk will be assessed and once the dosage is adjusted the INR will be checked as appropriate. Special attention is required for patient with recent deep vein thrombosis or pulmonary emboli.

f. If minor dosage adjustments (10% or less) are made, the patient will be rescheduled in 2 weeks for INR depending on the stability of the patient's previous INRs and risk factors for bleeding.

g. If the provider makes changes in Coumadin dosage, s/he will notify the Anticoagulation Clinic staff.

4. Methods of titration:

a. Dosage adjustments are based on WEEKLY DOSAGE, NOT DAILY DOSAGE. Example: T.W.'s INR range is 2.0 - 3.0. He is taking Coumadin 7.5mg every day. He is a very compliant patient and has had a stable diet for a long time. Lately, he has added spinach to his lunch. On 7/3 (Thursday) the INR

came out to be 1.6 how would you adjust for the dosing regimen, so this patient falls back within the therapeutic range?
Answer:

i. Calculate the weekly intake: 7.5 x 7= 52.5mg (total amount taken per week).
ii. Increase the total weekly dose by 10% per protocol: 52.5mg x 10% = 5.25mg.
iii. Patient should be taking: 52.5mg + 5.25mg = 57.75mg per week.
iv. Correct the daily dose to suit the total weekly changes, that is:
    A. Give 10mg tonight, then if stable diet (including spinach or other green, leafy vegetables) is anticipated, have patient: Take 10mg on Wednesday and Sunday (2 days of 10mg) And 7.5mg for the rest of the week (5 days of 7.5mg) Total weekly dosage =57.5mg
        1. Schedule for an INR check one week later (i.e., the following Thursdays).
        2. Days designated for odd dosages will be defined by the anticoagulation clinic staff
        3. Weekly dosage increases or decreases of 5%, 10% and 20% will be approximated as close as possible to the actual value based on tablet strengths available.
        Example: A.B. is on 5mg every day. On 7/21 the INR came out to be 4.3 while his level should remain between the range of 2.0 – 3.0. After asking appropriate questions, you realize that A.B. has recently changed his diet. How do you correct his dosing regimen?
        Answer:
        Calculate the weekly dose: 5mg x7 = 35mg.
        Decrease the weekly dose by 20% per protocol:35mg x 20% =7.0mg
        35mg – 7.0 = 28mg per week
        Change the dosing regimen to 4mg every day.
        Schedule for an INR check next week.

5. INR monitoring:
    a. The next INR follow –up will be scheduled as follows:

GOALS FOR THE NEXT INR	TIME FROM LAST INR
Post discharge to establish therapeutic window	Twice weekly x 1 week (e.g., Monday and Thursday)

Confirm maintenance dose (weekly)	7 -10 days x 2
Routine follow-up	3 – 4 weeks x 2
Very stable with no risks for complications	weeks

b. Frequency of monitoring may change (e.g., may get shortened or extended) based upon clinical judgment of the Anticoagulation Clinic staff.

c. Based on Anticoagulation Clinic staff's judgment and in very stable patients with no risks for complications who understand dietary restrictions and are aware of notifying the anticoagulation clinic of any changes in their diet, drug regimen or use of over the counter (OTC) medicines, the monitoring frequency may even be extended more.

6. See appendix for dosing instructions for the following:
    a. Enoxaparin (Low Molecular Weight Heparin (LMWH)
    b. Unfractionated Heparin (UFH)
    c. Fondaparinux
    d. Vitamin K:
        i. Management of dental procedures.
        ii. Management of general surgery.
7. At CCRMC it is highly recommended NOT to use Enoxaparin in patients with a creatinine clearance <30mL/min. Instead use Unfractionated Heparin.
8. In addition, the use of Fondaparinux is contraindicated if creatinine clearance is <30ml/min.

G. Handling of Patients with complications:
1. VITAMIN K POLICY FOR ANTICOAGULATION CLINIC STAFF (see attached for a copy of the protocol).
2. INRs greater than or equal to 9 or less than or equal to 1.5 with symptoms (and/or within 6 weeks post discharge after a thromboembolic episode) should be referred for a medical assessment in the following order:
    a. Primary Care Provider.
    b. Internal Medicine on call Physician.
    c. Emergency Department.
3. Refer patients with any of the following signs or symptoms of bleeding immediately to their PCP if available or to the Emergency Department:
Bleeding disorders
    a. Melena
    b. Gross hematuria

c. Presence of blood in stools
d. Pulse in excess of 120 beats/min
e. Any findings suggestive of serious hemorrhage
f. Any findings suggestive of thromboembolic episode
g. Dizziness, light-headedness
h. Non-stop bleeding
i. Unusual bruising

Thromboembolic events

a. Chest or leg pain
b. Shortness of breath

H. Handling Anticoagulation prescriptions:

1. Renewal:
    a. The Anticoagulation Clinic staff will authorize refills of anticoagulation medication for patients requesting medications during follow-up calls.
    b. Patients will be given a month supply of medication at a time with 1 refill (optional)
    c. A 60-day supply of medication or less as governed by limitations of the patient's insurance coverage may be given if patient is out of the area for an extended period.
2. New prescriptions:
    a. The Anticoagulation Clinic staff will e-prescribe new prescriptions to the pharmacy identified by the patient.
    b. The initiation of a new prescription must carry appropriate sig as per anticoagulation protocol (i.e., warfarin 0.5 mg PO at bedtime).
    c. Situations for which new prescriptions will be generated include patients enrolled in the Anticoagulation Program who require different Warfarin dosage strengths than previous prescribed for titration of Warfarin.
    d. This authorization is limited to Warfarin prescription for Anticoagulation Clinic patients.
3. Discontinuing patient from program or program completion:
    a. Within one month before planned completion, the Anticoagulation Clinic staff will inform PCP that the patient will be completing the program.
    b. PCP will provide a written response by the planned completion date.
    c. For patients not compliant with treatment, the Anticoagulation Clinic staff will contact the patient, document the conversation, and notify the PCP of the situation.
        i. The Anticoagulation Clinic staff, in collaboration with the

provider, will discuss the noncompliant patient. Then the Anticoagulation Clinic staff and/or the PCP will send the patient a letter disenrolling them from the Anticoagulation program (A-585 during Epic downtime). Upon sending this letter, the patient will be simultaneously discontinued from the anti-coagulation program. The letter will instruct patient to contact their PCP to come up with alternative anti-coagulation therapies.

ii. A copy of letter will be retained in ccLink.

iii. The Anticoagulation Clinic staff will not renew or refill the patient's anticoagulant prescription during the period of non-compliance. The continued management of the patient will be returned to the Provider.

RELATED LINKS:

A. Anticoagulation Consent Form

B. Letter A-585 during Epic downtime

REFERENCES:

A. University of Washington Medical Center

B. CHEST Journal. Antithrombotic Therapy and Prevention of Thrombosis. Evidence- Based Clinical Practice Guidelines

C. TJC 2016 Standard PC.04.01.05, "Before the hospital discharges a patient, it informs and educates the patient about his or her follow-up care, treatment, and services."

D. 2021 NPSG.03.05.01, "Use medicines safely: take extra care with patients who take medicines to thin their blood."

E. E-Learning Module for Anticoagulation Clinic Staff

F. 2019 AHA/ACC/HRS Update of the 2014 AHA/ACC/HRS Guidelines for the Management of Patients with Atrial Fibrillation

APPROVALS:

Patient Care Policy and Evaluation Committee: 12/2013, 8/2017, 9/2021, 10/2021
Ambulatory Policy Committee: 10/2021, 7/2022
Medical Executive Committee: 11/2021, 8/2022
Joint Conference Committee: 9/2022

VITAMIN K POLICY FOR ANTICOAGULATION CLINIC	
INR range	**Management**
• INR above the therapeutic range but <4.5	• Hold or reduce warfarin maintenance dose until the INR returns to the therapeutic range • Monitor more frequently

◦ No bleeding	• Resume Warfarin therapy at a lower dose • If only minimally above the therapeutic range, no dose reduction may be required
INR ≥4.5 but < 9 • No bleeding	Hold warfarin AND if the patient is at increased risk for bleeding: • Administer Vitamin K **2.5 mg PO** under direct observation (Oral is the preferred route of administration SEE footnotes) • When a condition exists that would prevent the patient from taking oral medication, such as vomiting, administer Vitamin K **2.5 mg subcutaneously.** • Recheck INR in 24 hours after Vitamin K administration. • If it is Friday, consult with the patient's primary care physician. • If unavailable, refer the patient to the CCRMC Emergency Department on Saturday for follow-up. If INR is unchanged, repeat Vitamin K administration. • If the INR is higher (SEE BELOW, INR ≥9.0), consult with the patient's primary care physician if you need to. • If unavailable, refer the patient to CCRMC Emergency Department. Continue holding warfarin until the INR returns to the therapeutic range • **RAPID REVERSAL:** **If more rapid reversal is required because the patient requires **urgent surgery**, vitamin K (≤5 mg orally) can be given with the expectation that a reduction of the INR will occur in 24 hours. If the INR is still high, additional vitamin K (2.5 mg orally) can be given **MANAGEMENT OF DOSING WHEN AN INVASIVE PROCEDURE IS REQUIRED:** Refer MD to guidelines
• INR 9	• **INR 9.0 with no bleeding**: Hold warfarin and administer a higher dose of vitamin K **(5 mg orally)** with the expectation that the INR will be reduced substantially in 24 to 48 hours. Check the INR in 24 hours. Monitor the patient more frequently and use additional vitamin K if necessary. Resume therapy at lower dose when INR is in the therapeutic range. Leave a courtesy message for the Primary Care Provider.
• INR >9	• **INR >9: REFER TO ED**

	Note: Notify PCP if patient is referred to ED.
• **ANY** elevated INR with bleeding • **ANY therapeutic** INR with concerning bleed • **ANY** INR < 1.5 with s/sx of clot • **ANY** INR with s/sx of clot.	• **REFER PATIENT TO ED** ***Note: Notify PCP if patient is referred to ED.***

*ORAL Vitamin K comes in 5 mg Tablets. Cutting tablets in half provides 2.5 mg of Vitamin K.

TREATMENT of DVT/PE with LMWH, Enoxaparin (Lovenox®)

A. The ***exclusion*** criteria for selection of pts for the treatment of DVT with enoxaparin are:
   - Pregnancy
   - Acute clinical symptoms of PE (supported by VQ scan)
   - Hx of 2 or more DVT or PE
   - Acute GI bleeding
   - Acute hemorrhagic stroke
   - Active coagulopathy

   Enoxaparin therapy in morbidly obese patients as well as Renal failure cases are explained in Special circumstances section (E)

B. ***The expected outcome for usage of LMWH is as follows:***
   1. Therapeutic equivalent outcomes with no increase in bleeding complications
   2. To decrease length of hospital stay with LMWH treatment plan

C. ***LMWH treatment plan for Uncomplicated DVT documented by U/S or Venography and dosing regimen:***

   If you have an otherwise healthy individual, no significant co-morbid conditions, no suspicion of PE
   1. Place the patient on 1 mg/kg SQ enoxaparin Q12h as outpatient
   2. Start patient on coumadin on the same day
   3. Follow the heparin to coumadin protocol (i.e., ***inpatient*** **WARFARIN DOSING GUIDELINES**)

4. Patient can self-administer ***SQ enoxaparin (LMWH) Q12h for 4 to 7 days*** (the average duration of administration in different clinical trials is between 7 to 10 days)
5. Overlap LMWH and coumadin at least 5 days
6. Continue ***therapy with Coumadin (target INR 2-3) for 3 months (based upon your clinical judgment)***
7. ***Daily*** monitoring while on LMWH is required. In general, caution must be exercised through appropriate monitoring of the patient's clinical status and coagulation profile during the time when both Antithrombotic agents are used concomitantly
8. Once placed on Coumadin, monitor INR accordingly (When **enoxaparin** is **D/C**'ed, patients can be referred to the anticoagulation clinic for Coumadin monitoring)

TREATMENT of DVT with LMWH, Enoxaparin (Lovenox[?])
Significant co-morbid condition which may affect ability to care for self or complicated therapy

1. Admit, treat with continuous infusion standard heparin **OR *place the patient on 1 mg/kg SQ enoxaparin Q12 h.***
2. Start patient on coumadin on the same day. Follow the heparin to coumadin protocol (i.e., ***inpatient*** **WARFARIN DOSING GUIDELINES**)
3. When stable, discharge with outpatient regimen as above (Number 4-8)

D. ***Possible Adverse effects with enoxaparin:***

- Either ***minor bleeding*** (e.g., increased bruising***)*** or ***major bleeding*** (e.g., internally)
- Allergic reactions
- Pain and irritation at injection site

E. ***Special circumstances:***
Obesity: Low molecular weight heparin requires anti-factor Xa monitoring for patients with body weight >120 kg.
Use the *Actual Body Weight (ABW)* in dosing enoxaparin for weight as high as 120 kg (i.e., 120 kg is the cut off). Consider IV heparin as an alternative agent when needed.
NOTE: If you intend to use enoxaparin in patients who do not fit in the above categories, e.g., weight >120 kg, the **anti-Xa** will be used to guide proper dosing. The anti-Xa test will be obtained using **outside** lab facilities. The expected therapeutic range for anti-Xa is 0.5-1.2 anti-Xa units. Check for anti-Xa activity 4 hours (when the peak occurs) after administration of the dose. In morbidly obese individuals once the right dose is determined, the anti-Xa activity test is no longer necessary. The turnaround time for obtaining anti-Xa test results is about 48 hours. Use traditional (standard) heparin dosing when appropriate. Always remember that in case of enoxaparin-induced bleeding, you can only neutralize the anti-factor Xa activity up to **60%** by protamine sulfate. There is **no** antidote for 100% reversal!

Pregnancy*:* FDA category: B
Definition of Category B: Either animal-reproduction studies have not demonstrated a fetal risk but there are no controlled studies in pregnant women or animal-reproduction studies have shown adverse effect (other than a decrease in fertility) that was not confirmed in controlled

studies in women in the first trimester (and there is no evidence of a risk in later trimesters). As anti-Xa testing is not an in-house test, CCRMC anticoagulation team recommends against administration of this drugs in patients with CLcr of less than 30 ml/min.

Renal Impairment:
Although package insert states that no dose adjustment is recommended in patients with moderate (creatinine clearance 30–50 mL/min) and mild (creatinine clearance 50–80 mL/min) renal impairment, the CHEST supplement recommends against the use of enoxaparin when CLcr<30 ml/min (i.e., using Cockroft and Gault). At CCRMC we follow CHEST supplement recommendations (http://journal.publications.chestnet.org/). The content could be retrieved via iSite →Library. All renally impaired patients should be observed carefully for signs and symptoms of bleeding.
Per Package Insert, in patients with renal impairment, there is an increase in exposure of enoxaparin sodium. All such patients should be observed carefully for signs and symptoms of bleeding. Because exposure of enoxaparin sodium is significantly increased in patients with severe renal impairment (creatinine clearance <30 mL/min), a dosage adjustment is recommended for therapeutic and prophylactic dosage ranges. No dosage adjustment is recommended in patients with moderate (creatinine clearance 30–50 mL/min) and mild (creatinine clearance 50–80 mL/min) renal impairment. The recommended prophylaxis and treatment dosage regimens for patients with severe renal impairment (creatinine clearance <30 mL/min) are described in Table 1below (see next page).

Table 1

Dosage Regimens for Patients with Severe Renal Impairment (creatinine clearance <30mL/ minute)

Indication	Dosage Regimen
Prophylaxis in abdominal surgery	30 mg administered SC once daily
Prophylaxis in hip or knee replacement surgery	30 mg administered SC once daily
Prophylaxis in medical patients during acute illness	30 mg administered SC once daily
Inpatient treatment of acute deep vein thrombosis with or without pulmonary embolism, when administered in conjunction with warfarin sodium	1 mg/kg administered SC once daily
Outpatient treatment of acute deep vein thrombosis without pulmonary embolism, when administered in conjunction with warfarin sodium	1 mg/kg administered SC once daily
Prophylaxis of ischemic complications of unstable angina and non-Q-wave myocardial infarction, when concurrently administered with aspirin	1 mg/kg administered SC once daily
Treatment of acute ST-segment elevation myocardial infarction in patients <75 years of age, when administered in conjunction with aspirin	30 mg single IV bolus plus a 1 mg/kg SC dose followed by 1 mg/kg administered SC once daily.
Treatment of acute ST-segment elevation myocardial infarction in geriatric patients ≥75 years of age, when administered in conjunction with	1 mg/kg administered SC once daily (**no** initial bolus)

aspirin	

Geriatric Patients and Geriatrics with Acute ST-Segment Elevation Myocardial Infarction

Dosage in Geriatric Patients: At dosages used for prophylaxis the incidence of bleeding complications is similar between elderly and younger patients. When used for treatment of venous thromboembolism, elderly experience a greater incidence of bleeding complications. Elderly patients weighing less than 45 kg or those predisposed to renal dysfunction should be closely monitored.

For treatment of acute ST-segment elevation myocardial infarction in geriatric patients ≥75 years of age, **do not use an initial IV bolus**. Initiate dosing with **0.75 mg/kg SC every 12 hours (maximum 75 mg for the first two doses only, followed by 0.75 mg/kg dosing for the remaining doses)**. No dose adjustment is necessary for other indications in geriatric patients unless kidney function is impaired.

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Shideh Ataii	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17987470**

Origination	05/2004
Last Approved	N/A
Effective	Upon Approval
Last Revised	10/2022
Next Review	3 years after approval
Owner	Shideh Ataii: Director Of Pharmacy Svcs
Area	Pharmacy

Policy for Bioterrorism Preparedness

POLICY STATEMENT:

In the event of a bioterrorist attack, the HEICS plan would be activated, and those plans and procedures would become operational. CCRMC would work very closely with the Public Health Department in managing and treating the victims. All hospitals in the county play an important part in being prepared. Each facility has been asked to keep a specified amount of medications in stock, and in date, at all times. We have been charged with having enough medication to treat or prophylaxis 50 people for 10 days for any chemical or biological agent that could be used. CCHS has prepared a flip chart as a quick reference guide in the management and treatment for exposure to the most likely agents.

GUIDELINES:

Pharmacy will post a CCHS Bioterrorism Quick Guide posted for reference in the event a bioterrorism event is announced.

The Pharmacy will cooperate fully with the coordinating agency. In the event of a bioterrorist attack, the Public Health Department would be in charge and would have the authority to commandeer medication or personnel. In addition, Public Health has authority over the federal 'PushPack' and 'Chempack' supplies. (See the attachment for the 'Chempack' Activation Flowchart.)

The Pharmacy will keep a stock supply, as requested, of medications that would be used to treatment or prophylaxis of 50 people for 10 days. This stock can include inpatient stock, stock from the outpatient pharmacy.

The CCHS Bioterrorism Quick Guide and the attached chart may be used as a resource for treatment options in the event of an exposure or outbreak of disease.

On a routine basis, inventory will be taken, and expiration dates will be checked. All medications necessary to bring stock up to the required level will be ordered. Soon-to-expire medications should be rotated through working stock to minimize wastage.

REFERENCES:

A. CCRMC Policies and Procedures (Disaster Manual)
B. TJC Standards EM.02.01.01, EM.02.02.03, EM.02.02.07, MM.03.01.03
C. CMS CoP § 482.12(f), 482.23(c), 482.25(a)(b), 482.41(c), 482.55
D. CCHS Bioterrorism Quick Guide
E. The Center for Disease Control: www.bt.cdc.gov/Agent/Agentlist.asp

APPROVALS:

Patient Care Policy and Evaluation Committee: 10/2022
Medical Executive Committee:
Joint Conference Committee:

Attachments

A: Disaster Preparedness Medication Stock

B: Chempack Activation Flowchart

C: Bioterrorist Attack: Treatment & Prophylaxis

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [TT]	05/2025
	Shideh Ataii	04/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18353070

Origination	N/A	Owner	Michael De Peralta: Respiratory Care Services Mgr
Last Approved	N/A	Area	Respiratory
Effective	Upon Approval		
Last Revised	N/A		
Next Review	2 years after approval		

Policy For Neonatal High Flow Nasal Cannula

POLICY STATEMENT:

The Respiratory Care Practitioner will deliver high flow nasal cannula as ordered using hospital-approved equipment. High-flow nasal cannula oxygen therapy delivers a heated and humidified blend of air and oxygen at flow rates surpassing a patient's inspiratory demand. High-flow nasal cannula oxygen therapy is administered to critically ill neonates with respiratory failure due to its comfort, simplicity in setup, and low incidence of nasal trauma. High flow nasal cannula may be initiated in the delivery room, ~~NICU~~level II nursery, or emergency room.

RELATED LINKS:

Procedure for Neonatal High Flow Nasal Cannula

REFERENCES:

A. *GUIDELINE FOR THE USE OF HIGH FLOW NASAL CANNULA OXYGEN THERAPY (OPTIFLOW OR AIRVO) IN CHILDREN WITH BRONCHIOLITIS OR AN ACUTE RESPIRATORY ILLNESS*. (n.d.). https://apps.worcsacute.nhs.uk/KeyDocumentPortal/Home/DownloadFile/1726

B. Huang, Y., Zhao, J., Hua, X., Luo, K., Shi, Y., Lin, Z., Tang, J., Feng, Z., Mu, D., & Evidence-Based Medicine Group, Neonatologist Society, Chinese Medical Doctor Association (2023). Guidelines for high-flow nasal cannula oxygen therapy in neonates (2022). *Journal of evidence-based medicine*, *16*(3), 394–413. https://doi.org/10.1111/jebm.12546

C. Contra Costa County Health Services Nursing Department Policy for Nursing Care of the Infant Receiving Oxygen Therapy.

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
	Michael De Peralta: Respiratory Care Services Mgr	06/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18240367

Origination	08/2014	Owner	Michael De Peralta: Respiratory Care Services Mgr
Last Approved	N/A	Area	Respiratory
Effective	Upon Approval		
Last Revised	07/2025		
Next Review	2 years after approval		

Policy for Continuous Nebulizer Therapy

POLICY STATEMENTT:

The Respiratory Care Practitioner will initiate continuous nebulizer therapy as ordered and monitor the patient until the therapy ends. To provide standardization guidelines for the administration of continuous nebulization therapy (CNT).

~~PURPOSE STATEMENT:~~

~~To provide standardization guidelines for the administration of continuous nebulization therapy (CNT).~~

RELATED LINKS:

Procedure for Continuous Nebulizer Therapy

REFERENCES:

A. Fleisher, G., & Ludwig, S. (2010). Textbook of Pediatric Emergency Medicine (6th ed.). Philadelphia, Pennsylvania: Lippincott, Williams, & Wilkins.

B. Peters, S. (2007, January). Continuous bronchodilator therapy. Chest, 131(1), 286-9. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/17218588

APPROVALS:

Approved By PCP&E
Approved by Med Executive Committee

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	07/2025
	Michael De Peralta: Respiratory Care Services Mgr	06/2025

Standards

No standards are associated with this document

File #: 25-3041 **Agenda Date:** 7/28/2025 **Agenda #:** 6.

Advisory Board: Medical Services (CCRMC) Joint Conference Committee
Subject: Regulatory Review (information only)
Presenter: Roberto Vargas, MPH, CPHQ, LSSBB, Director of Safety and Performance Improvement

Information:

A. Regulatory Review (informational only) - review of recent regulatory activity

Recommendation(s)/Next Step(s):

A. Regulatory Review - **Informational only**

Regulatory Review

Contra Costa Regional Medical Center and Health Centers
Joint Conference Committee

July 28, 2025

Roberto Vargas, Director of Safety &
Performance Improvement

CONTRA COSTA HEALTH

Regulatory Surveys - past 9 months

- The Joint Commission, Laboratory Accreditation Survey
  - Survey Date: November 2024
    - Status: Corrective Action Plan approved by TJC

Summarized Findings	Corrective Action
Gaps in result reporting	Implemented revised SOPs for result reporting workflows
Missing Initial/annual competency validation	Launched new tracker to manage annual competency validation
Calibration and proficiency testing gaps	Established a recurring calibration and proficiency testing schedule

- California Department of Public Health, Diagnostic Imaging Survey
  - Survey Dates: May 5–6, 2025
    - Status: Corrective Action Plan approved by CDPH

Summarized Findings	Corrective Action
Outdated dental and CT equipment inventory log	Updated inventory records
Missing fluoroscopy QC checks for 2023–24	Implemented QC log review protocol
Outdated list of credentialed providers	Updated list and corrected to required formatting

Regulatory Surveys - past 9 months

- Contra Costa Health Plan-Department of Health and Human Services, Facility Site Review + Physical Accessibility Review
  - Survey Date: February – May 2025, Clinics: Martinez, North Richmond, West County, Antioch, Pittsburg
    - Status: Corrective Action Plan approved by CCHP and DHCS

Summarized Findings	Corrective Action
Missing emergency contact info posted in clinic	Updated contacts list designed annual tracking process
Eye charts are not height adjustable	Ordered new eye charts for WCHC and all other clinical areas as needed
Hazardous waste was stored without warning signs	Installed new signs and audited other areas needing new signage

- Baby Friendly USA – waiting on final report
  - June 10-11
- Committee on Cancer – waiting on final report
  - June 12