

LETTER OF UNDERSTANDING NO. 35

SUBJECT: PATIENT SAFETY STANDARDS

Consistent with the Parties' commitment to ensuring that employees have access to cost effective, quality health care coverage as detailed in Letter of Understanding No. 15, the parties agree that the term "patient safety standards", as set forth in Attachment A and Attachment B of the parties' ~~2005-2008~~ Collective Bargaining Agreement, shall be modified to be defined in its entirety as follows, effective immediately and continuing until the expiration of the Collective Bargaining Agreement.

Patient safety standards refer to nationally recognized criteria for making hospital services safer. A hospital meets patient safety standards if it meets established criteria such as those listed below. The hospital must publicly certify upon request that it meets all criteria and the statements pertaining to standards are accurate and reflect normal operating procedures at the hospital. The criteria include:

A. Criteria for Network Hospital Admissions for Complex Procedures

Evidence-based Hospital Referrals: for patients admitted for one of several complex procedures (coronary artery bypass grafts, percutaneous coronary intervention, abdominal aortic aneurysm repair, pancreatic resection, esophagectomy and high risk deliveries), network hospitals must meet experience criteria, consisting of process, volume, and/or outcome measures, for the performance of the specific procedure. If complex procedures as identified by national standards change in the future, the parties agree that they will meet and discuss the changes.

B. Criteria for Other Network Hospital Admissions

For patients admitted for all other procedures or conditions, network hospitals must meet the following standards:

Computerized Physician Order Entry: Prior to January 1, 2005, the hospital must publicly assure that by January 1, 2005, physicians will enter at least 75 percent of inpatient medication orders via a computer linked to error-prevention software. The software must be capable of alerting physicians to at least 50 percent of common, serious prescribing errors. On and after January 1, 2005, the hospital must publicly assure that it actually fulfills these capabilities.

Intensive Care Unit Staffing: On and after July 1, 2004, the hospital publicly assures that its adult and/or pediatric intensive care unit is managed or co-managed by critical care specialists who:

1. Are present during daytime hours and exclusively provide clinical care in the ICU, and

Best and Final Offer
August 28, 2008

2. At all other times, can return urgent ICU paging calls within five (5) minutes and arrange for a physician or FCCS-certified non-physician specialist to reach ICU patients within five minutes at least 95 percent of the time.

In geographical areas where scientifically rigorous, risk-adjusted outcome comparisons are publicly reported for intensive care unit performance, favorable risk-adjusted outcomes may replace the above criteria for intensive care unit staffing.

Dated: September 4, 2008