MAYERS MEMORIAL HEALTHCARE DISTRICT

Board of Directors
Regular Meeting Agenda
March 27, 2024 @ 1:00 PM
Mayers Memorial Healthcare District
Fall River Boardroom
43563 HWY 299 E
Fall River Mills, CA 96028
Microsoft Teams Meeting: Click here to join the meeting
Meeting ID: 265 939 691 938 Passcode: fPg2Up
Phone Conference: 1-279-895-6380 Phone Conference ID: 245 148 587#

Mission Statement
Leading rural healthcare for a lifetime of wellbeing.

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

						Approx. Time Allotted
1	**CALL MEETING TO ORDER**					
2	2.1	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS** Persons wishing to address the Board are requested to fill out a "Request Form" prior to the beginning of the meeting (forms are available from the Clerk of the Board, 43563 Highway 299 East, Fall River Mills, or in the Boardroom). If you have documents to present for the members of the Board of Directors to review, please provide a minimum of nine copies. When the President announces the public comment period, requestors will be called upon one-at-a time, please stand and give your name and comments. Each speaker is allocated five minutes to speak. Comments should be limited to matters within the jurisdiction of the Board. Pursuant to the Brown Act (Govt. Code section 54950 et seq.) action or Board discussion cannot be taken on open time matters other than to receive the comments and, if deemed necessary, to refer the subject matter to the appropriate department for follow-up and/or to schedule the matter on a subsequent Board Agenda.				
3	**APPROVAL OF MINUTES**					
	3.1	Regular Meeting –February 28, 2024		***Attachment A***	**Action Item**	1 min.
4	**DEPARTMENT/QUARTERLY REPORTS/RECOGNITIONS:**					
	4.1	Resolution 2024.04 –February Employee of the Month		***Attachment B***	**Action Item**	2 min.
	4.2	Resolution 2024.05 – TCCN Children's Programs		***Attachment C***	**Action Item**	2 min.
	4.3	Purchasing	Rachel Morris	***Attachment D***	Report	2 min.
	4.4	Business Office	Danielle Olson	***Attachment E***	Report	2 min.
	4.5	Rural Health Clinic	Kimberly Westlund	***Attachment F***	Report	2 min.
5	**BOARD COMMITTEES**					
	5.1	**Finance Committee**				
		5.1.1 Committee Meeting Report: Chair Humphry			Report	5 min.
		5.1.2 February 2024 Financial Review, AP, AR and Acceptance of Financials			**Action Item**	5 min.
		5.1.3 Cornerstone Community Bank Signatory Change		***Attachment G***	**Action Item**	2 min.

	5.2	**Strategic Planning Committee –** No March Meeting			
	5.3	**Quality Committee –**No March Meeting			
6	**NEW BUSINESS**				
	6.1	Policies & Procedures: Charity Care Policy HHS Poverty Guidelines – 75% MMH388 Credentialing Policy Indoor-Outdoor Walking Surfaces Irregularities Medication Verification – RHC Safe Ladder Use Surgery, General Core Privileges	***Attachment H***	**Action Item**	5 min.
	6.2	Infection Control Plan	***Attachment I***	**Action Item**	5 min.
	6.3	Medical Staff Bylaws	***Attachment J***	**Action Item**	5 min.
7	**ADMINISTRATIVE REPORTS**				
	7.1	Chief's Reports – ***Written reports provided. Questions pertaining to written report and verbal report of any new items***	***Attachment K***		
	7.1.1	Chief Financial Officer – Travis Lakey		Report	5 min.
	7.1.2	Chief Human Resources Officer – Libby Mee		Report	5 min.
	7.1.3	Chief Public Relations Officer – Val Lakey		Report	5 min.
	7.1.4	Chief Clinical Officer – Keith Earnest		Report	5 min.
	7.1.5	Chief Nursing Officer – Theresa Overton		Report	5 min.
	7.1.6	Chief Executive Officer – Ryan Harris		Report	5 min.
8	**OTHER INFORMATION/ANNOUNCEMENTS**				
	8.1	Board Member Message: Points to highlight in message		Discussion	2 min.
	8.2	Board Governance Tool Kit – Community Engagement		Discussion	5 min.
9	**ADJOURNMENT: Next Meeting April 24, 2024**				

Posted 03/22/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

Board of Directors
Regular Meeting
Minutes
February 28, 2024 – 1:00 pm
Burney Boardroom

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

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

BOARD MEMBERS PRESENT:	**STAFF PRESENT:**
Abe Hathaway, President	Ryan Harris, CEO
Jeanne Utterback, Vice President	Travis Lakey, CFO
Tami Humphry, Treasurer	Theresa Overton, CNO
Lester Cufaude, Director	Valerie Lakey, CPRO
ABSENT:	Keith Earnest, CCO
	Libby Mee, CHRO
	Cassandra LaFave, DON SNF
	Jack Hathaway, Director of Quality
	Alex Johnson, Facilities & Maintenance
	Marrisa Martin, TCCN
	Jessica DeCoito, Board Clerk

2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS:**		
3	**APPROVAL OF MINUTES**		
	3.1 A motion/second carried; Board of Directors accepted the minutes of January 31, 2024	***Utterback, Cufaude***	***Approved by All***
4	**DEPARTMENT/OPERATIONS REPORTS/RECOGNITIONS**		
	4.1 A motion/second carried; Milca Estrada was recognized as January Employee of the Month. Resolution 2024-03. A CNA that went through our program and is now working at the Burney Annex. Very friendly and great team player. Really cares about the residents and a wonderful CNA. Patient and caring. MMHD is very lucky to have Milca as a team player, CNA and caregiver on our team.	***Utterback, Hathaway***	***Approved by All***
	4.2 Hospice Quarterly: written report submitted. Big thank you to the Foundation for the gala and the outpouring of support from our community. Review of the graph: not a great census this winter but had an uptick this past month.		
	4.3 MHF Quarterly: We have 7 Board Members as of now but are looking to meet the 9 required seats in our bylaws. Working on the Health Fair, reinvigorating this event and bringing in TCCN to help them be part of the improved event. The health fair is scheduled for June 22nd. We would really like to commend our foundation board members, volunteers and staff on their big successes in each are they encompass. Our volunteers are doing an amazing job with assuming the responsibility of the Thrift Store – encouragement to get into the store and admire their hard work.		
	4.4 Quality & Risk: written report submitted. We had a provider meeting yesterday to review the QIP program for 2027 and identify measures and metrics that we can have success with on collecting information. Our Quality Program Coordinator will work closely with clinical staff to make sure we are collecting the information and gathering what we need to properly apply and meet the measures we have selected.		

4.5	Skilled Nursing Facility: Written report submitted. We have 3 CNA's who just graduated from our program with 6 signed up for the next session. We are still not allowed to admit residents but continue to work through our improvements and wait for that ok to admit. We anticipate another survey and are working on our trainings and corrections until that survey happens.			
4.6	Maintenance & Engineering: written report submitted. We are working on the physical environment updates in the hospital for preparation of ACHC.			
5	**BOARD COMMITTEES**			
5.1	**Finance Committee**			
	5.1.1	**Committee Report:** Reviewed the January 2024 financials. We are still working on AR. Our cash on hand will dip a bit in the next 30 days. We are beginning to shop our insurance options for some better options.		
	5.1.2	**January 2024 Financials**: motion moved, seconded and carried to approve financials.	***Cufaude, Humphry***	***Approved by All***
	5.1.3	**Board Quarterly Finance Review**	***Humphry, Cufaude***	***Approved by All***
	5.1.4	**Acceptance of Annual Audit Summary**	***Utterback, Humphry***	***Approved by All***
	5.1.5	**Proposal for HVAC Project in FR Dietary:** design proposal was included in your packet. This is just for the architect to work on the design not the construction. Our rough cost looks around $1,000,000 for construction. The units would be set up and designed in such a way that we can reuse them in the master plan. Motion moved, seconded and carried to approve the proposal.	***Utterback, Humphry***	***Approved by All***
	5.1.6	**Solar Project – TPX Upgrade Cost:** findings were that our current transformer is not large enough for the project and will need to be upgraded. We are looking into cutting down the cost of the tie in portion of the project. And we will look into a 3rd party that would tie in to help cut down the cost as well. Motion moved, seconded and carried to approve the upgrade.	***Humphry, Utterback***	***Approved by All***
	5.1.7	**Master Planning Update – FR Rural Health Clinic:** feedback from our patients is that they prefer a brick and mortar clinic space rather than a mobile setting. Our architect looked into converting our current business office space into a RHC in FR. ROM is approx.. $420,000 but could be more than that. The design proposal is $71,000. And we will look into selling the mobile clinic. Staff will look at the communication plan for a change in the master plan. Motion moved, seconded and carried to approve the proposal.	***Utterback, Humphry***	***Approved by All***
5.2	**Strategic Planning Committee Chair Utterback:** No Meeting held in January			
5.3	**Quality Committee:** DRAFT minutes attached. The report from the Director of Quality today covered what we discussed in the last committee meeting. Our ACHC consultant has been awesome to work with. We get weekly milestones and easy, structured and manageable direction/deliverables. Staff is looking into the process efficiencies for our referrals and medical records that our patients need. Staff has already met to discuss our options and looking at the best way to keep our patients satisfaction in referrals and medical record management a priority.			
6	**NEW BUSINESS**			
6.1	**Policy & Procedures:** Ivenix SMART Infusion Pump Use Swing Bed Criteria and Pre-Admission Processes ABO/RH Confirmation of Patient Age Specific Guidelines Automated HDL Cholesterol Automated LDL Cholesterol Cholesterol Collection and Arm Band Policy		***Utterback, Humphry***	***Approved by All***

Public records which relate to any of the matters on this agenda (except Closed Session items), and which have been distributed to the members of the Board, are available for public inspection at the office of the Clerk to the Board of Directors, 43563 Highway 299 East, Fall River Mills CA 96028. This document and other Board of Director's documents are available online at www.mayersmemorial.com.

Critical Values with Read Back
Emergency Release of Blood
Handling and Processing Specimens
High Sensitivity Troponin I Ordering Protocol to Rule Out acute Myocardial Infarction
Laboratory Environment Health and Safety
Loci Thyroid Stimulating Hormone
Loci Vitamin B12
Loci Vitamin D Total Assay
Millipore Water Culture
Total Prostate Specific Antigen
Total Protein
Triglycerides
Uric Acid
Urinary/Cerebrospinal Fluid Protein

	6.2	**Organizational Chart Approval:** drafted changes provided. Motion moved, seconded and approved.	***Cufaude, Utterback***	***Approved by All***
	6.3	**New Board Member Appointment:** Jim Ferguson		
	6.4	**Board Member Education Plans & Options:** ACHD has a Governance Tool Kit that we have access to as members of the organization. We simply provide ACHD with the emails of our Board Members and Chief team members. In the tool kit, we have at our fingertips 6 different topics that are provided in a virtual format. The option is to ask each Board member to watch a section before the Board meeting and have a review session at the board meeting.		
7	**ADMINISTRATIVE REPORTS**			
	7.1	**Chief's Reports: written reports provided in packet**		
		7.1.1 **CFO:** patients are being billed and money is being collected but our systems are talking to each other in the same speed as our staff working on the billing.		
		7.1.2 **CHRO:** We will be reopening the ED Provider position. We are in the final steps of finalizing our CRNA contract. Partnership has some funding in a new program to help us with recruiting providers and we are enrolling now to have that opportunity.		
		7.1.3 **CPRO:** Introduction of TCCN Executive Director, Marrisa Martin. She has hit the ground running and getting the program going. SB 1432 language should be coming out hopefully tomorrow in our Legislative Strategy Group meeting. Provided a presentation virtually in a webinar for ACHD – big thank you for representing MMHD and rural healthcare. Quarterly community event is March 27th at TCCN.		
		7.1.4 **CCO**: The pharmacy fridge is fixed! Met with MVHC CFO on how to help meet the needs of their patients in the out-lining areas. Interim Infection Preventionist has been amazing, jumping right in and taking control. We have posted a position for a Physical Therapist to help meet their volume needs our community is requiring of us. We are seeing out of our district PFT in Respiratory which means our outreach in that service is working.		
		7.1.5 **CNO**: CDPH was onsite this week for an incident that happened in the ED, but a self-reported event. No deficiencies were noted but opportunities for additional training and education. Surgery has 25 referrals right now. We are going live on March 11th.		
		7.1.6 **CEO:** March 4th – Travis, Val and Ryan will be attending the Rural Healthcare Symposium in San Diego. Eager to be there and collaborate with the other facilities on cost-based reimbursement programs. Wipfli will be helping us look at the benefits of going to cost based reimbursement. A meeting with Northern Sierra Section with CHA took place last week. A good take away was regarding ambulance services and how we can get GEMT funding. All Employee Quarterly meeting took place yesterday and one take away was looking at retention programs for our non-licensed staff, where our licensed staff are already in retention programs. ELT will be spending some time looking at the options and will present this to the board as we develop more information. Congrats to Ryan on his completion of his Master's in Business Administration with a concentration in Healthcare Administration.		
8	**OTHER INFORMATION/ANNOUNCEMENTS**			

	8.1	Board Member Message: Employee of the Month, Save the Date for the Health Fair, CNA Program, FR RHC Master Planning change, surgery for colonoscopy and endoscopy services opening on March 11th, solar project construction has begun, quarterly community event	
9		**MOVE INTO CLOSED SESSION: 3:00 PM**	
		Hearing (Health and Safety Code §32155) – Medical Staff Credentials AHP Appointment: Paula Amacker, NP – Oncology (Dignity)	
	9.1	Medical Staff Appointment: Ross Mandeville, MD – Neurologist (Telemed2U) Galen Church, DO – Emergency Medicine	**Approved by All**
10		**RECONVENE OPEN SESSION**	
11		**ADJOURNMENT: 3:25 PM** **Next Meeting March 27, 2024**	

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

_____ Board Member

_____ Board Clerk

Public records which relate to any of the matters on this agenda (except Closed Session items), and which have been distributed to the members of the Board, are available for public inspection at the office of the Clerk to the Board of Directors, 43563 Highway 299 East, Fall River Mills CA 96028. This document and other Board of Director's documents are available online at www.mayersmemorial.com.

RESOLUTION NO. 2024-04

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

Liliana Venegas

As February 2024 EMPLOYEE OF THE MONTH

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

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

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

NOW, THEREFORE, BE IT RESOLVED that, Liliana Venegas is hereby named Mayers Memorial Healthcare District Employee of the Month for February 2024; and

DULY PASSED AND ADOPTED this 27th day of March by the Board of Trustees of Mayers Memorial Healthcare District by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

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

ATTEST:

_____
Jessica DeCoito
Clerk of the Board of Directors

RESOLUTION NO. 2024-05

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

Children's Programs at the Tri County Community Network (a department of MMHD)

WHEREAS, the Board supports the purpose and programs of the Mayers Memorial Healthcare District Tri County Community Network department; and

WHEREAS, the Board, within its power, approves programs within the departments of MMHD, the board hereby supports and approves the children's programs (daycare, after school and preschool) and supports the required licensing processes, and

WHEREAS, the Board, within its power, hereby assigns this department to the Chief Public Relations Officer Division and assigns direct oversight of the children's programs to the credentialed Executive Director position of the TCCN department, and

WHEREAS, the board recognizes the need for proper authorizing signatures on licensing, the board designates the Chief Executive Officer as the first signing authority for required licensing,

NOW, THEREFORE, the undersigned certifies and attests that the above resolution was approved at a regular meeting of the Board of Directors, Burney, California, on the 27th day of March 2024.

PASSED AND ADOPTED on March 27, 2024, by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

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

ATTEST:

_____
Jessica DeCoito
Clerk of the Board of Directors

Quality / Service Pillar

Executive Leader: *Travis Lakey, CFO*

Director or Manager: *Rachel Morris*

Department: *Purchasing*

Last Updated: 3/20/2024

Current Year	Specific Plan & Estimated Completion Date	Driver	Current Actions
Priority:			
Implement a new GPO for Hospital. Manage contracts with Vendors and track savings	Weekly Meeting with CHC program Manager, prepping to go live August 4th 2023	Rachel Morris	Went live August 4th, weekly meetings, as of December moved to meetings moved to monthly
	Met with all departments that place weekly supplies from Purchasing. Found savings through CHC	Rachel Morris	10/17/2023-Onboarding with all Departments. CHC on-site
	Updating system with new pricing. Accessing portal for updates in pricing	Rachel Morris and Valerie Harris	Implementation with Medline/CHC, Mayers converting items in our system. Go Live 12/04/2023
	Updating pricing weekly when placing weekly orders	Valerie Harris	Continue to check portal. Receiving reports on savings and rebates from CHC monthly
Working with Director of Nursing to re-organize the storage room in ED. Separating PAR, consumable and Non-Stock items			
	Re-Organized ER Supply Room. Separating Par and Consumable Supplies. Updated in November	Nathan Glazzard	Keeping supplies rotated and check expires and par levels on shelf. Made a Non-stock ER order form for supplies in ER Supply Room
	Updating Order forms with correct par levels and supplies	Nathan Glazzard & Rachel Morris	Communicating with Department manager on par levels and needed supplies in ER, set up monthly meetings with manager
	After Go-Live with Cerner - making sure supplies are correctly chargeable in system for ER staff to Order and bill for supplies	Rachel Morris	Training staff on orders in Cerner and how to locate items in system . Making sure all chargeables were correctly added to Cerner
Implement a quality program and monthly tracking in the Purchasing Department to help track expires and critical items	Do weekly walk throughs of Supply Room, pulling expires and logging expired supplies	All Purchasing Staff	Continue to check supplies as staff stocks and orders.
	Departments going through supplies and returning expired items to Purchasing. Purchasing logs expires, Updating Monthly	All Purchasing Staff	Assisting departments with supplies and making sure supplies are current and rotated weekly
	Donating expired supplies, looking to find new company by April 2024	Rachel Morris	Original company no longer receives expired items. Looking for a new company. Contacted Project C.U.R.E and Matter 360
Priority Ideas for Next Year			

MAYERS MEMORIAL HEALTHCARE DISTRICT

People Pillar

Name: Danielle Olson
Supervisor: Travis Lakey
Department: Business Office

Last Updated: 03/21/2024

FY24 (July 1, 2023 - June 30, 2024)							
Priority:	**Weight**	**Bonus Amount**	**Specific Plan & Estimated Completion Date**	**Driver**	**Current Actions**	**% Complete By FY End**	**Bonus Amount Awarded**
Hospice, Ambulance and Cerner billing all up and running smoothly.					Cerner and MatixCare are all up and running. We have started to see an easier workflow and billing is easier for the billers within the last couple of months. There is some Cerner challenges like splitting Inpatient claims that is a Cerner domain issue that we are working through. MatrixCare was a struggle at first as it is a new billing service that I had to research and figure out how to do. We have started receiving payments and I am hopeful it will become just as easy as the rest of the billing by the end of the year. Ambulance claims are finally dropping correctly and are being billed out. We have not received a payment as of yet. There was a Cerner workflow issue that had to be fixed prior to us being able to bill.		
Priority Ideas for Next Year							

For Completion at Beginning of Fiscal Year		
Name	Signature	Date
Supervisor	Signature	Date
Executive Leader	Signature	Date

CEO Approval at End of Fiscal Year		
Ryan Harris		
CEO	Signature	Date

Quality Service Pillar

Name: Danielle Olson
Supervisor: Travis Lakey
Department: Business Office

Last Updated: 03/21/2024

FY24 (July 1, 2023 - June 30, 2024)							
Priority:	**Weight**	**Bonus Amount**	**Specific Plan & Estimated Completion Date**	**Driver**	**Current Actions**	**% Complete By FY End**	**Bonus Amount Awarded**
Cerner billing clean claims at least 85% by 06/30/2024.					current clean clain rate is ranging between 84-86% There is an error that is coming through Experian that is "error for review" it is holding claims that are "clean" I have a ticket open to remove that error.		
Priority Ideas for Next Year							
AR Days back at industry standard which is 60 days.							
Cerner billing clean claim rate 90-92%							

For Completion at Beginning of Fiscal Year		
Name	Signature	Date
Supervisor	Signature	Date
Executive Leader	Signature	Date

CEO Approval at End of Fiscal Year		
Ryan Harris		
CEO	Signature	Date

Growth Pillar

Name:
Supervisor:
Department: **Last Updated:**

FY24							
Priority:	**Weight**	**Bonus Amount**	**Specific Plan & Estimated Completion Date**	**Driver**	**Current Actions**	**% Complete By FY End**	**Bonus Amount Awarded**
Priority Ideas for Next Year							
I would like to get my CRCR Certification. Which is to become a Certified Revenue Cycle Representative.							

For Completion at Beginning of Fiscal Year

Name	Signature	Date
Supervisor	Signature	Date
Executive Leader	Signature	Date

CEO Approval at End of Fiscal Year

Ryan Harris		
CEO	Signature	Date

Communication Pillar

Executive Leader: Ryan Harris
Director or Manager: Kimberly Westlund
Department: Rural Health Clinic

Last Updated:

FY24 (July 1, 2023 - June 30, 2024)							
Priority:	**Weight**	**Bonus Amount**	**Specific Plan & Estimated Completion Date**	**Driver**	**Current Actions**	**% Complete By FY End**	**Bonus Amount Awarded**
Participate in 1 quarterly and 8 monthly community events as outlined in the community event calendar by FYE24.			Attend and plan/help plan quarterly and monthly community events.	Val Lakey	Attended quarterly meet and greet event.		
				Kimberly	Hosted a booth at the Fall River Elementary back to school night		
				Kimberly/Amanda	Hosted Mayers RHC booth at the community fall festival @ fairgrounds		
			Will be attending the TCCN community helpers event	Kimberly	Hosted mobile clinic grand opening event		
			Will be attending Health Fair in June	Kimberly	Hosted patient appreciation day in RHC		
			Will be attending (2) farmers markets	Mary/Zita/Kimberly	Attended and took BP's at (2) heart health awareness events at local grocery stores		
Priority Ideas for Next Year							

For Completion at Beginning of Fiscal Year

Name	Signature	Date
Supervisor	Signature	Date
Executive Leader	Signature	Date

CEO Approval at End of Fiscal Year

Ryan Harris		
CEO	Signature	Date

Growth Pillar

Executive Leader: Ryan Harris
Director or Manager: Kimberly Westlund
Department: Rural Health Clinic

Last Updated: 7.6.2023

FY24 (July 1, 2023 - June 30, 2024)							
Priority:	**Weight**	**Bonus Amount**	**Specific Plan & Estimated Completion Date**	**Driver**	**Current Actions**	**% Complete By FY End**	**Bonus Amount Awarded**
Continue education by attending 1 Rural Health Clinic specific conference and become a certified rural health clinic professional (CRHCP) by taking and passing the CRHCP exam by FYE 2024.			Will be attending conference in KC	Kimberly			
			Register for CRHCP course	Kimberly	Currently in final stages of course-final exam to be taken the week of APR 22nd-26th.		
Priority Ideas for Next Year							

For Completion at Beginning of Fiscal Year

Name	Signature	Date
Supervisor	Signature	Date
Executive Leader	Signature	Date

CEO Approval at End of Fiscal Year

Ryan Harris		
CEO	Signature	Date

People Pillar

Executive Leader: Ryan Harris
Director or Manager: Kimberly Westlund
Department: Rural Health Clinic

Last Updated: 7.6.2023

FY24 (July 1, 2023 - June 30, 2024)							
Priority:	**Weight**	**Bonus Amount**	**Specific Plan & Estimated Completion Date**	**Driver**	**Current Actions**	**% Complete By FY End**	**Bonus Amount Awarded**
Have an employment turnover rate in the clinic department of less than 17.52% or two employees or less for FY24.			Education Employees on Employee Retention Programs	Kimberly			
			Discuss with Leadership Retention for non clinical staff.				
			Improve coaching to work through issues with staff.				
			Improve onboarding process to reduce turnover.				
Priority Ideas for Next Year							

For Completion at Beginning of Fiscal Year

Name	Signature	Date
Supervisor	Signature	Date
Executive Leader	Signature	Date

CEO Approval at End of Fiscal Year

Ryan Harris		
CEO	Signature	Date

MAYERS MEMORIAL
HEALTHCARE DISTRICT

March 27, 2024

Cornerstone Community Bank
PO Box 889
Red Bluff, CA 96080

Subject: Change in Authorized Signatory
Reference: Mayers Memorial Healthcare District Account

Dear Manager,

The Board of Directors of Mayers Memorial Healthcare District (MMHD) in its meeting held on March 27th, 2024 approved a change to the authorized signatories. Please accept this letter as notification to remove Louis Ward as a signer on the MMHD Account and replace with Ryan Harris, CEO and Travis Lakey, CFO.

If you have any questions, please feel free to reach out at 530-336-5511.

Sincerely,

Abe Hathaway
President, Board of Directors
Mayers Memorial Healthcare District

MAYERS MEMORIAL HEALTHCARE DISTRICT
POLICY AND PROCEDURE
CHARITY CARE POLICY

Page 1 of 4, plus the following attachments
HHS Poverty Guidelines – 75% MMH388
HHS Poverty Guidelines – 400% MMH389

POLICY:

Mayers Memorial Healthcare District realizes the need to provide service to patients who cannot otherwise afford health care. This policy is to provide financial assistance to patients who have health care needs and are uninsured, under-insured, ineligible for a government program, and are otherwise unable to pay for medically necessary care based on their individual needs. A graduated schedule based on the annual HHS Poverty Guidelines, as well as assessment of the patient's monetary assets will be used to determine the qualifying income and asset levels of applicants. Guidelines are subject to change yearly based on the HHS Poverty Guidelines. Understanding this need, the hospital has chosen to fulfill their responsibility to the community by adopting the following Charity Care Policy.

PROCEDURE:

1. **Standard Eligibility Criteria for Participation in the Charity Care Program:**
    a. A patient qualifies for Charity Care if all of the following conditions are met:
        i. The patient does not have private health insurance (including coverage offered through the California Health Benefit Exchange), Medicare, or Medi-Cal as determined and documented by the hospital;
        ii. The patient's injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital;
        iii. The patient's household income does not exceed 75% of the Federal Poverty Level; **and**
        iv. The patient's allowable monetary assets do not exceed $5,000;
            1. In determining a patient's monetary assets, the hospital **shall not** consider: retirement or deferred compensation plans qualified under the Internal Revenue Code; non-qualified deferred compensation plans; the first ten thousand dollars ($10,000) of monetary assets, and fifty percent (50%) of the patient's monetary assets over the first ten thousand dollars ($10,000).
2. **Special Eligibility and Enrollment Exceptions:**
    a. High Medical Costs/Medically Indigent:
        i. A patient whose family income does not exceed 400% of the federal poverty level and their annual out-of-pocket medical expenses for non-elective/medically

necessary services with Mayers Memorial Healthcare District and other health care providers exceed 10% of the patient's family gross income in the prior 12 months, would then be considered as "Medically Indigent" as defined by AB774.

1. For those who have been informally determined to be Medically Indigent, or have incurred high medical costs will be offered to complete a Charity Care application by the Financial Counselor.
2. Supporting documentation to show what medical expenses have been paid in the prior 12 months is required to determine eligibility.

b. Homeless/Indigent Patients:
   i. Patients who are determined to be indigent/homeless by either clinical documentation or are unable to provide sufficient demographic information such as a mailing address, phone number, or residential address will/can be considered for Charity Care.
      1. No application will be required by a patient who has been determined to be indigent/homeless.
      2. Only emergent/medically necessary services will be considered. Should a patient who presents for outpatient services, financial counseling will be done at the time of service.

c. Deceased - No Estate:
   i. Upon receipt of confirmation that a patient is deceased and who has no estate, third party coverage, or spouse, will be automatically eligible for Charity Care upon receipt of the following items.
      1. Notification from county in which patient expired in.
      2. Received copy of death certificate from patient family notifying MMHD of death and no estate exists.
      3. Confirmation that patient does not have a living spouse who would be liable for outstanding/unpaid debt.
      4. Confirmation from another facility of patients' expiration and that no estate or pending probate exist.
      5. Upon notification from collections agency that collections accounts are being cancelled due to deceased/no estate.
      6. Knowledge that patient has expired based on clinical documentation for services provided by MMHD.

d. Administrative Charity Care:
   i. In cases where medically necessary services are provided to a patient who has been screened by the Financial Counselor, and it has been determined that the patient is unable to complete the standard application process due to medical, social, or other documented circumstances, charges may be considered for Charity Care on a case by case basis.
      1. Account(s) should be written up for Charity Care adjustment with all supporting documentation attached and be presented to the Financial Director and Chief Executive Office for approval.

3. Standard Enrollment Process:

a. An informal determination of Charity Care eligibility will be determined by the Patient Financial Counselor, and the applicant may choose to fill out an application based on the recommendation of the Patient Financial Counselor; however, the recommendation of the Patient Financial Counselor is not required in choosing to fill out the Charity Care Application.

b. Upon being submitted for consideration by the Patient Financial Counselor, all properly submitted applications will be reviewed and considered for implementation within 10 business days.
c. All application packets must be filled out completely and accurately with each of the following required documentation attached to be considered:
    i. Documentation of non-coverage from Medi-Cal for the service on the date performed;
    ii. ii. Documentation of household income, as provided by:
        1. Current W-2 withholding form or Income Tax statement form from the previous year, **or**
        2. Pay stubs from the previous three months
    iii. iii. Documentation of monetary assets, to include:
        1. Most current bank statement, and any additional information or statements on all monetary assets
            a. Statements on retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans **shall not** be included
        2. Signed waiver or release from the patient or the patient's family, authorizing the hospital to obtain account information from financial and/or commercial institutions, or other entities that hold or maintain monetary assets, to verify their value
    iv. Completed Medicare Secondary Payer (MSP) Questionnaire indicating the patient's injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance
d. Any additional accounts with outstanding balances at time of application will be screened for Charity Care eligibility using the same information collected above.
e. Verification of accuracy of application information, including contacting employers for verification of employment, will be made.
f. A letter of either approval or denial will be submitted to each applicant:
    i. The approval letter will include a demand statement for the service in question with adjustments and a balance of zero dollars ($0), and contact information for any questions that may arise;
    ii. The denial letter will include: reason for denial; indication of potential eligibility under the Discount Payment Program, Payment Plan Program, or other self-pay policy; and information and request to contact the Patient Financial Counselor as soon as possible.
g. Any additional services rendered up to a year after the submission date of an approved Charity Care Application will additionally require: updated documentation of non-coverage for the service on the date performed; and a completed MSP Questionnaire indicating the patient's injury is not a compensable injury.
h. Any disputes regarding a patient's eligibility to participate in the Charity Care Program shall be directed to the Business Office Manager and will be resolved within 10 business days:
    i. If it is determined that the patient is ineligible to participate, the number of days spent on dispute resolution shall not be counted toward the minimum 180 days prior to reporting any amount to a credit reporting bureau.

4. Participant Accounts Maintenance:

a. A folder for each Charity Care applicant will be created, and will include the following items:
    i. Patient information and application
    ii. A copy of every correspondence between Mayers Memorial Healthcare District and the participant
    iii. Detailed bills on all accounts to be included in the application
    iv. Adjustment form with adjustments taken on accounts
    v. Any additional notations and pertinent information

5. Availability of the Charity Care Policy:

a. Notice of the Charity Care Policy shall be posted in the following locations:
    i. Emergency department
    ii. Billing office
    iii. Admissions office
    iv. Laboratory
    v. Imaging
    vi. Station III
b. In the event of the hospital providing service to a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, the hospital shall provide a notice to the patient that includes, but is not limited to:
    i. A statement of charges for services rendered by Mayers Memorial Healthcare District; and
    ii. A request that the patient inform Mayers Memorial Healthcare District if the patient has health insurance coverage, Medicare, Medi-Cal or other coverage, and if the patient does not, that the patient may be eligible for such coverage, and can obtain an application for such coverage from Mayers Memorial Healthcare District; and
    iii. A statement that indicates the patient may qualify for Charity Care if they meet the eligibility criteria set forth in this policy; and
    iv. The name and telephone number of the Patient Financial Counselor from whom the patient may obtain information about the Charity Care policy and other assistance policies, and about how to apply for that assistance.

REFERENCES:

The processes and procedures described above are designed to comply with CA SB 1276 (Chapter 758, Statutes of 2014), CA AB 774 (Statutes of 2006) and SB 350 (Chapter 347, Statutes of 2007). Questions regarding SB 1276, AB 774 and SB 350 can be addressed by the Patient Financial Counselor or by California's Office of Statewide Health Planning and Development's website, at http://www.oshpd.ca.gov/hid/products/hospitals/fairpricing/index.html.
http://aspe.hhs.gov/poverty/14poverty.shtml

COMMITTEE APPROVALS:
Chiefs: 3/19/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

2023 HHS POVERTY GUIDELINES

Persons in Family or Household	75% US Poverty Level
1	$ 10,935
2	$ 14,790
3	$ 18,645
4	$ 22,500
5	$ 26,355
6	$ 30,210
7	$ 34,065
8	$ 37,920
For each add'l person, add	$ 3,855

To determine charity eligibility according to income level:

1. Count the number of persons in your family/household
    a. For persons 18 years of age and older, include spouse, domestic partner and dependent children under 21 years of age, whether living at home or not
    b. For persons under 18 years of age, include parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative
2. Calculate the household income
3. On the row corresponding to the number of persons in your family/household above, compare your household income to the amount in the column labeled "75% US Poverty Level"
4. If your household income is less than 75% US Poverty Level amount, your income supports your eligibility for Charity Care.

Note: Pursuant to AB 774 Sect. 127405(2), Mayers Memorial Hospital has established eligibility levels for financial assistance and charity care at less than 350 percent of the federal poverty level as appropriate to maintain its financial and operational integrity. Mayers Memorial Hospital is a rural hospital as defined in Section 124840.

To determine charity eligibility according to total monetary assets:

1. Calculate your total monetary assets (referred to as "ASSETS" in the equation below)
    a. Assets included in retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans **shall not** be included
2. Insert total assets into the following equation:
    a. (ASSETS – 10,000)/2
3. If the remaining amount is less than $5,000, your total asset level supports your eligibility for Charity Care.

Approvals: Chiefs: 3/19/2024
MMH388 Page 1 of 1
HHS POVERTY GUIDELINES – 75%
Attached to policy Charity Care Policy

MAYERS MEMORIAL HOSPITAL DISTRICT

Privileges in General Surgery

Name: _____

General Surgery Core Privileges

Qualifications
To be eligible for core privileges in general surgery, the applicant must meet the following qualifications:

- Documentation of the performance of at least 50 general and/or gynecological surgical procedures total or 25 major general surgical procedures (see accompanying lists) during the past two years or demonstrated successful completion of a hospital-affiliated formalized residency or clinical fellowship in the past two years;

and

- Current certification or active participation in the examination process leading to certification in general surgery by the American Board of Surgery, or the American Osteopathic Board of Surgery; or
- Successful completion of a postgraduate residency in general surgery accredited by the ACGME, AOA, or equivalent.

Staff Status Requested *(please check one)*

- ☐ Active: must admit at least 10 inpatients per year to the Hospital
- ☐ Consulting: may not admit patients to the Hospital
- ☐ Courtesy: may not admit more than 10 inpatients per year to the Hospital
- ☐ Telemedicine Affiliate: may not admit patients to the Hospital

Privileges included in the General Surgery Core
Privileges to evaluate, diagnose, consult, provide pre-, intra-, and postoperative surgical care, and perform surgical procedures for patients above the age of 18 —except where specifically excluded from practice and except for those special procedure privileges listed below—to correct or treat various conditions, and illnesses. Privileges include, but are not limited to, those delineated in the accompanying minor general surgery procedure lists. Practitioner accepts responsibility of exercising those privileges that are requested and approved.

☐ Requested	☐ Recommended	☐ Not Recommended
☐ Recommended with the following modification(s) and reason(s):		

Name _____

Additional Privileges Requested (write in below):

To be eligible for the additional privilege(s) requested, the applicant must demonstrate acceptable experience and/or provide documentation of competence in the privileges requested consistent with the criteria set forth in the medical staff policies governing the exercise of specific privileges.

_____

_____

_____

Recommended/Not recommended with the following modification(s) and reason(s):

_____

_____

_____

Acknowledgement of Practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Mayers Memorial Hospital District, and;

I understand that:

(a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

_____ _____

Applicant Date

Recommendations

We have reviewed the requested clinical privileges and supportive documentation for the above named applicant and recommend action on the privileges as noted above.

_____ _____

Credential Committee Chair/Vice-Chair Date

_____ _____

Medical Executive Committee Chair/Vice-Chair Date

Name _____

CORE PRIVILEGES
GENERAL SURGERY

MINOR

Anorectal Exam under Anesthesia
Anorectal Fistulotomy/Fistulectomy
Breast Biopsy
Colonoscopy
Debride/Repair Minor Injuries/Wounds
Esophagogastroduodenoscopy
Excision Anorectal Lesions (Superficial)
Excision Cutaneous/Subcutaneous Lesions
Excision Oral Lesions
Excision Ingrown Nail
Hemorrhoidectomy
I&D Abscess (Superficial, Perianal)
Incision/Excision Pilonidal Cyst
Liver Biopsy (Percutaneous)
Lymph Node Biopsy
Paracentesis/Thoracentesis
Polypectomy (Nasal/Rectal/Vaginal)
Rectal Biopsy

ANESTHESIA

Local Anesthesia
Analgesia/Sedation - For Procedures
Regional Nerve Block (Hand/Finger, Foot/Toe, Facial)

SUBJECT/TITLE: Medical Staff Credentialing	POLICY #MedStaff001
DEPARTMENT/SCOPE: Medical Staff	Page 1 of 2
	EFFECTIVE: 3/11/2024
AUDIENCE: All Employees	APPROVAL DATE:
OWNER: P. Sweet	APPROVER: J. Hathaway

References and Citations: Mayers Memorial Hospital District Medical Staff Bylaws

1. **SCOPE**
   To establish the policy for verifying and assessing the credentials of the licensed independent practitioners [LIPs] and Allied Health Practitioners [AHPs].

2. Responsible Party / Parties
   Director of Quality and the Chief Executive Officer

3. Credentialing Policy
   Mayers Memorial Healthcare District is dedicated to assessing and verifying the credentials of all licensed or certified licensed independent practitioners on the medical staff. This assessment is done at the time of hire, three months prior to expiration of licenses / certifications, and every 24 months thereafter.

   The procedures are defined and outlined in the Medical Staff Bylaws and Rules and Regulations.

   a) Two categories of medical staff practitioners that require credentialing verification:
      i. Licensed Independent Practitioners [LIP] – individuals permitted by law and the organization to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.
         1) Physicians
      ii. Allied Health Practitioners - Other licensed or certified healthcare practitioners – an individual who is licensed, registered, or certified but not permitted by law to provide patient care services without direction or supervision.
         a) Licensed Clinical Psychologists
         b) Licensed Clinical Social Workers
         c) Nurse Anesthetists
         d) Nurse Midwives
         e) Nurse Practitioners
         f) Physician Assistants
      iii. Primary Source Verification – used to determine the accuracy of a qualification by using the verification system of California License Verification on the Breeze website. All board certifications will be verified via

the AMA Physician Profile. Claims histories are obtained from the malpractice insurance carrier / company.

iv. Secondary Source Verification – another method used to determine the accuracy of a qualification by contacting the original source / granting agency of the license or certification. This may be accomplished via direct correspondence, telephone verification, internet verification, and reports from the credential's verification organization.

b) Initial Appointment and Reappointment of members of the medical staff and Allied Health Practitioners follow all procedures outlined in the Medical Staff Bylaws Article 2 4 – 7; and the Medical Staff Rules 2 and 4.

COMMITTEE APPROVALS:

MEC: 3/18/2024

SUBJECT/TITLE:	Indoor/Outdoor Walking Surfaces Irregularities	Policy #SAF046
DEPARTMENT/SCOPE:	Safety	Page 1 of 2
		EFFECTIVE: 12/18/2023
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

PURPOSE:

Walking Surface Irregularities can be a direct cause for Slips, Trips and Fall hazards as well as for ergonomic working conditions. Mayers Memorial Healthcare District (MMHD) focuses on employee health and safety through safety initiatives and regular screening and risk analysis procedures. Mayers Memorial Healthcare District has a culture that allows for reporting of hazards including walking hazards.

Damaged surfaces that are used for walking can cause hazardous conditions. These occur both indoors and outdoors and must be continuously sought out to prevent accidents. Poorly maintained surfaces such as uneven ground, holes, rocks, and other debris can cause outdoor slips, trips and falls. Indoors the flooring of healthcare facilities must be kept in grand repair to avoid injury from uneven flooring, buckled or warped areas.

Also see P&P Slips Trips and Falls Program.

PROCEDURE:

As part of daily rounds, the applicable departments will look for:

- Loose, warped, blistered, cracked, or buckled flooring.
- Uneven surfaces in doorways, walkways and due to mats or drains.
- Hazards developed from an acute incident including spills and debris.

If there is a hazard to be found immediate action shall take place:

- Section off or remove the offending area by use of cones, signs, or tape.
- Contact maintenance through the ticket system with an urgent request if the hazard cannot be removed easily- such as a mat or piece of debris.

Maintenance will decide the best strategy for remediation including but not limited to:

- Replacement of specific area or removal of hazard and or debris
- Patch or fill cracks indoors greater than ¼ in. or reduce elevation changes more than ¼ in. If outdoors patch or fill cracks greater than ½ in.
- Create Visual cues using Safety Yellow warning paint

SUBJECT/TITLE:	Indoor/Outdoor Walking Surfaces Irregularities	Policy #SAF046
DEPARTMENT/SCOPE:	Safety	Page 2 of 2
		EFFECTIVE: 12/18/2023
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

REFERENCES:

ACHC Accreditation requirements for Critical Access Hospitals, 2023 edition.. Accreditation Commission for Health Care (ACHC). Chapter 3,03.01.01, 03.03.03

Beta Healthcare Group, ESWI Toolkit: Slip, Trip and Fall Prevention, 2021. BETA Healthcare Group [3.2021]

Mayers Memorial Healthcare District Injury and Illness Prevention Program Plan

COMMITTEE APPROVALS:

Safety: 1/24/2024
P&P: 3/6/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Medication Verification	POLICY #RHC001
DEPARTMENT/SCOPE: Rural Health Clinic	Page 1 of 2
	EFFECTIVE: 01/29/2024
OWNER: Kimberly Westlund	APPROVER: R. Harris

DEFINITIONS:

MA - Medical Assistant
Provider - MD, DO, PA, NP

PURPOSE:

The purpose of this policy is to ensure the proper medication(s)/vaccine(s) are being administered.

PROCEDURE:

- The MA draws up a medication(s) or vaccine(s) ordered or authorized by provider. The MA verifies they are drawing up the correct medication(s), dose, and ensuring it is not expired. The MA then brings medication vial(s) and syringe(s) to a provider for verification; the medication(s), dose, and expiration date are being verified again.
- If the provider draws up a medication(s) or vaccine(s), they are verifying the correct medication(s), dose, and expiration date. The provider will take the medication(s) and syringe(s) to another provider, if available. In the event another provider is not available, the medication(s) can be taken to an MA for the second verification. If provider draws up medication(s), justification and route of administration should be disclosed at time of second verification.

REFERENCES:

1. Injectable Medication Administration P&P. Long Term Care-MCN. Date referenced 01/29/2024.
2. Pharmacy Services for Nursing Facilities © 2006 American Society of Consultant Pharmacists and MED-PASS, Inc. (Revised August 2014)
3. Federal: OBRA Regulatory Reference Numbers:); 483.25
4. Federal: Survey Tag Numbers: F332; F333

SUBJECT/TITLE: Medication Verification	POLICY #RHC001
DEPARTMENT/SCOPE: Rural Health Clinic	Page 2 of 2
	EFFECTIVE: 01/29/2024
OWNER: Kimberly Westlund	APPROVER: R. Harris

COMMITTEE APPROVALS:

P&P: 3/6/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Safe Ladder Use	Policy #SAF038
DEPARTMENT/SCOPE: Safety, Facilities, Facility Wide	Page 1 of 2
	EFFECTIVE: 12/8/2023
OWNER: Dana Hauge, Safety Officer	APPROVER: R. Harris

POLICY:

The use of ladders can be a direct cause for Slips, Trips and Fall hazards as well as for ergonomic working conditions. Mayers Memorial Healthcare District (MMHD) focuses on employee health and safety through safety initiatives and regular screening and risk analysis procedures. MMHD has a culture that allows for reporting of hazards including ladders hazards.

Mayers Memorial Healthcare District has a developed plan for the maintenance department and use of ladders throughout all properties under the name Mayers Memorial Healthcare District. All use of ladders shall be governed by the following procedures. All Maintenance Crew Members will be given access to the NIOSH Ladder Safety App through their phones or with the use of a company smartphone.

PROCEDURE:

- Prior to climbing a ladder of any kind, the crew members will inspect the ladder for safety. This will include but not be limited to verifying that: ladder rungs, steps, and cleats are parallel, level, and uniformly spaced when the ladder is in position for use.
- Employees will wear non-slip shoes or appropriate show wear while using ladders.
- Ladders are used only for the purposes for which they were designed.
- Any ladder with defects is immediately tagged “Dangerous. Do Not Use” and taken out of service until repaired or replaced.
- Each crew member will face the ladder when climbing up and down and use at least one hand to grasp the ladder.
- Ladders are used only on stable and level surfaces unless they are secured or stabilized.
- The cap and top step of a step ladder are not used as steps.
- Extension ladders extend at least 3 feet above the upper landing surface.
- All crew members take the ladder safety course upon hire and annually after that with their reorientation packet.
- All ladders will be returned to lower positions as well as stored properly when not in direct use.

SUBJECT/TITLE:	Safe Ladder Use	Policy #SAF038
DEPARTMENT/SCOPE:	Safety, Facilities, Facility Wide	Page 2 of 2
		EFFECTIVE: 12/8/2023
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

SPECIAL CONSIDERATIONS:

Also see Slips Trips and Falls Program and Policy

REFERENCES:

ACHC Accreditation requirements for Critical Access Hospitals, 2023 edition.. Accreditation Commission for Health Care (ACHC). Chapter 3 03.01.01,03.01.08

Slips. Trips, and Falls | NIOSH | CDC. (n.d.). https://www.cdc.gov/niosh/topics/retail/slips.html 5/21/2018 accessed 4/01/2023

COMMITTEE APPROVALS:
Safety: 1/24/2024
P&P: 3/6/2024

SUBJECT/TITLE:	Infection Prevention Control Plan	POLICY #
DEPARTMENT/SCOPE:	Infection Control	Page 1 of 12
REVISION DATE: 3/13/2024 5/18/2022 6/5/2019 1/10/2017	EFFECTIVE DATE: 9/4/2013	
AUDIENCE: All Staff	APPROVAL DATE:	
OWNER: Maria Cuccinello		APPROVER: K. Earnest

I. Introduction

The Infection Prevention and Control (IPC) Plan is a description of the multidisciplinary, systematic, coordinated approach developed by Mayers Memorial Hospital to reduce the risks of acquiring and transmitting infections among patients, employees, physicians, and other licensed independent practitioners (LIP), contract employees, volunteers, students, and visitors in the Hospital.

II. Authority Statement

The Infection Prevention and Control Committee is a medical staff committee and shall have the authority under the medical staff bylaws to institute appropriate control measures, when and if an infectious hazard is identified, or anticipated, that may affect any patient, employee, student, LIP, contract employee, volunteer, faculty, and/or visitor.

Infection Prevention staff are delegated responsibility for execution of the Infection Prevention and Control Plan by the Medical Staff, under the direction of the chairperson of the Infection Prevention and Control Committee. The organization verifies that infection prevention staff have training in the principles and methods of infection prevention and control.

The chairperson and the Infection Prevention staff shall be notified of the potential issue and shall confer with committee members as necessary to institute appropriate control measures. In their absence, an appropriate director or administrator shall assume responsibility for instituting control measures. The Committee also has the authority for routine identification and analysis of the incidence and cause of infectious diseases within the hospital and shall develop and implement processes for the surveillance, prevention, and control of infectious disease.

III. Plan Components

Several considerations are made to guide the activities of the program, including internal and external requirements and activities related to healthcare. Careful consideration is made based on internal and external surveillance activities from the preceding year. An IPC Risk Assessment is completed at least annually to inform and establish program priorities. The IPC Plan is based upon the most current risk assessment (See attached 2024 Infection Control Plan Risk Assessment).

- Maintenance of a sanitary environment.
- Development and implementation of infection prevention and control measures related to organization personnel.

SUBJECT/TITLE:	Infection Prevention Control Plan	POLICY #
DEPARTMENT/SCOPE:	Infection Control	Page 2 of 12
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AUDIENCE: All Staff	APPROVAL DATE:	
OWNER: Maria Cuccinello		APPROVER: K. Earnest

- Mitigation of risks associated with patient infections present upon admission.
- Mitigation of risks contributing to healthcare-associated infections.
- Active surveillance.
- Monitoring compliance with all policies, procedures, protocols, and other Infection Prevention and Control Program requirements.
- Monitoring the following areas: food storage, preparation, serving and dish rooms, refrigerators, ice machines, air handlers, autoclave rooms, venting systems, inpatient rooms, treatment areas, labs, waste handling, surgical areas, supply storage, equipment cleaning, sterilization and high-level disinfection, linen processing facility, etc.
- Plan evaluation and revision of the plan, when indicated.
- Coordination as required by applicable law and regulations with emergency preparedness and public health authorities (e.g., federal, state, and local) to address communicable and infectious disease threats and outbreaks.
- Compliance with reportable disease requirements of applicable public health authorities.
- HAI RISK MITIGATION MEASURES
    - Implementing appropriate prophylaxis to prevent surgical site infection (SSI), including, but not limited to:
        - Protocol for antibiotic prophylaxis:
        - Selection of appropriate antibiotic.
        - Timeliness of antibiotic administration.
        - Appropriate duration and frequency of antibiotic therapy.
        - Strict observance of aseptic technique.
        - Sterilization or high-level disinfection of instruments, as appropriate.
    - Implementing measures to avoid overuse of antibiotics, including consideration of the antimicrobial spectrum, duration, and patient selection.
    - Other organization mitigation measures:
        - Strict hand hygiene protocols among personnel and vendors, including use of alcohol-based hand sanitizers.
        - Measures specific to the prevention of infections caused by organisms that are antibiotic resistant.
        - Measures specific to safe injection and safe infusion practices.
        - Requiring disinfectants and germicides to be used in accordance with the manufacturer’s instructions.
        - Appropriate use of equipment, including air filtration equipment, UV lights, personal protective devices used by personnel (as described in the

SUBJECT/TITLE:	Infection Prevention Control Plan	POLICY #
DEPARTMENT/SCOPE:	Infection Control	Page 3 of 12
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AUDIENCE: All Staff	APPROVAL DATE:	
OWNER: Maria Cuccinello		APPROVER: K. Earnest

OSHA standards), and other equipment used to control the spread of infectious agents.

- Educating patients, visitors, personnel, and others about infections and communicable diseases and methods to reduce transmission in the organization and in the community.
- Prevention and control protocols for those individuals who may present as a risk for the transmission of infectious agents by the airborne or droplet route. For example, the organization may take actions including prompt physical separation, respiratory hygiene/cough etiquette protocols, and appropriate transmission-based precautions based.

IV. Surveillance Activities

The organization must develop and implement interventions to address issues identified through its detection activities, and then evaluate the effectiveness of interventions through further data collection and analysis. The hospital conducts comprehensive monitoring to identify infection risks or communicable diseases. The hospital documents its monitoring/tracking activities, including the measures selected for monitoring, and collection, and analysis methods. Activities are conducted in accordance with recognized infection control surveillance practices.

The activities related to infection prevention surveillance are based on the risk assessment of populations served at the hospital, clinics, high risk/high volume indicators, Centers for Disease Control and Prevention (CDC) definitions of infections, and facility needs based on the annual assessment. County, state, and CDC emerging and reemerging disease reports, as well as reported outbreaks are taken into consideration when planning surveillance activities.

Surveillance and prevention activities are designed to coordinate processes with the related patient care support departments/services (e.g., clinics, sterile processing, environmental services, linen / laundry processing location, microbiology, nursing services, environmental health and radiation, and the maintenance department).

Priority-directed, targeted surveillance is utilized and related to the scope of service. High volume and/or high frequency infectious complications, reoccurrence of previous infection prevention and control issues, and issues that have potential for significant adverse patient outcomes are included in the surveillance process.

SUBJECT/TITLE:	Infection Prevention Control Plan	POLICY #
DEPARTMENT/SCOPE:	Infection Control	Page 4 of 12
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AUDIENCE: All Staff		APPROVAL DATE:
OWNER: Maria Cuccinello		APPROVER: K. Earnest

Utilizing the surveillance data, the IPC staff obtain laboratory relevant culture information from the microbiology system to assist in determining whether or not an infection has occurred and whether or not the infection was healthcare-acquired. In addition, the daily inpatient census is reviewed for current or potential infection-related issues. Methods for determining presence and classification of infection are based on national guidelines and definitions published by the CDC/ National Health Safety Network (NHSN) program. Reports are generated by rate, count and NHSN standardized infection ratio (SIR) and compared to the national benchmarks.

The Infection Preventionist tracks potential / actual bloodborne pathogen exposures and employee vaccination status, through the Employee Health Program.

The IPC Department notifies institutions transferring or receiving patients with infection if culture results are received following the transfer.

VI. IPC Goals and Objective for 2024

A. CLABSI SIR 0.334 or less
B. CAUTI SIR 0.253 or less
C. MRSA Bacteremia LAB-ID SIR 0.39 or less
D. C. difficile SIR 0.212 or less
E. Resistant *Candida auris*
    a. *Include information on C. auris in staff on-hire and annual infection prevention education.*
    b. *Species identification to be performed on all yeast from invasive sources.*
F. Employee influenza immunization 90%
G. Covid-19 employee vaccination required by federal laws.
H. Hand Hygiene Compliance 90%
I. Complete quarterly IC inspections of the following areas:
    a. Dietary: food storage, preparation, serving and dish rooms, refrigerators / freezers, vent hood, and ice machines.
    b. Facility ice machines
    c. Air handlers
    d. Sterilization and high-level disinfection areas, including autoclaves, decontamination, sterilization, high-level disinfection, endoscope processing and storage, and sterile supplies.
    e. Hazardous waste storage areas

SUBJECT/TITLE:	Infection Prevention Control Plan	POLICY #
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AUDIENCE: All Staff		APPROVAL DATE:
OWNER: Maria Cuccinello		APPROVER: K. Earnest

J. Complete monthly IC inspections on a rotating basis, to ensure all areas are inspected two times per year:
    a. All inpatient units, including patient rooms, equipment storage, supply storage, Rural Health Clinic, and procedure rooms.
    b. All outpatient departments including treatment or procedure rooms, equipment storage, and supply storage.
    c. Obstetrics, Labor and Delivery, and Nursery – including procedure rooms, equipment storage and supply storage.
    d. Central supply
    e. Laboratory
    f. Imaging / Radiology
    g. Cardiopulmonary / Respiratory Therapy
    h. Pre-op, surgical suites, and PACU
    i. Waiting areas and visitor restrooms
K. Environmental Maintenance Programs, such as replacement of stained ceiling tiles, , addressing peeling / chipping paint, assessment of air handlers, temperature, and humidity monitoring, etc.
L. Representatives from Linen Services, Environmental Services, IPC Department or other designated individuals conduct an onsite inspection of the linen processing vendor annually, that includes, but is not limited to:
    a. Compliance with facility layout, separation of clean versus soiled linen, ventilation, infection control procedures, and transportation requirements.
    b. Any identified opportunities for improvement during the annual linen site inspection will be recorded in writing and provided to the vendor, with a request for corrective actions, and reported to the Infection Prevention Committee.
    c. The IP will re-visit the linen / laundry processing vendor site to confirm correction of any identified opportunities.
    d. Personnel receiving linen from the vendor will ensure there is separation in the truck / vehicle of clean and dirty linen, and the vehicle used for transport is clean upon arrival.
M. Pre-construction risk assessment [ICRA] and active monitoring of containment and compliance with ICRA.
N. Compliance with Water Quality Testing.
O. Annual TB Fit testing program.
P. Employee Immunization Program – defined in the Employee Health Plan

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Q. Medical Staff and Hospital staff education on how infections are spread and infection prevention strategies
R. Bioterrorism Activity - Monitoring
    a. The IPC Department monitors patient admissions and laboratory data for extraordinary findings that may be evidence of biological weapon activities in the community. The annual risk assessment revealed a high risk for highly pathogenic organisms, such as hemorrhagic fever, etc.
    b. Response to bioterrorism events - In the event of a community event of a large magnitude and isolated patient events, the IPC Department will work with the Safety Manager to ensure appropriate protective equipment is available to the staff.
    c. The IPC Department will communicate with the ED Director, IPC Chair, and state and local health departments as needed, and provide support in monitoring the clinical lab results and reports.
    d. The IPC staff will serve as adjunct members of the Emergency Preparedness Committee.
S. Tuberculosis Control Process – see Tuberculosis Control Plan. While the risk in this geographical area is epidemiologically low, the potential risk of exposure to Mycobacterium tuberculosis is a reality.
T. Exposure Control Plan – see separate Exposure Control Plan. The Exposure Control plan is the focal point of preventing exposure to bloodborne pathogens. It details the plan for reducing exposures to blood and explains what steps to take if an exposure occurs.
U. Regulated Waste Management - the Exposure Control Plan addresses the issue of regulated waste management in accordance with the Occupational Safety and Health Administration (OSHA) and CDC requirements. The Maintenance department and Environmental Services department are responsible for the infectious waste stream and management of infectious waste manifests.

VII. Responsibilities for the Infection Control Program

Medical Director for Infection Prevention and Control - is a Physician, designated as Chairperson of the Infection Prevention and Control (IPC) Committee, and also serves on various hospital and medical staff committees as a representative for IPC. The Medical Director is responsible for leading the IPC committee and for setting the agenda of the IPC Program.

Infection Prevention Staff Core responsibilities:

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- Core responsibilities and time allocations are: 15% allocated to surveillance monitoring, 20% allocated to education/prevention activities, 25% allocated to committee/task force-related issues, 20% allocated to management activities, and 20% allocated to policy review/literature research associated activities. This time appropriation fluctuates depending on the needs of the institution and issues affecting clinical practice, changes in federal legislation, and any suspected outbreak occurrence.
- Education and training:
    - Employees of the IPC Department are preferred to be certified through the Certification Board of Infection Prevention and Control (CBIC). If not certified must have comparable experience, training, and education.
- The IPC Department develops and maintains an IPC Policy and Procedure Manual that includes the Bloodborne Pathogen and Tuberculosis Exposure Control Plans. Policies are reviewed by IPC staff and chair annually and revised, as necessary.
- Wellness promotion activities are provided through Employee Health with recommendations and approval of the IPC Committee.
- Response to outbreaks - The IPC Department investigates all suspected outbreaks, under the direction of the Chairperson of the IPC Committee and in collaboration with appropriate medical and administrative staff. Institutional bylaws authorize the IP Committee Chairperson or his/her designate to take measures to control an outbreak.
- Hospital Infection Preventionist duties include, but are not limited to:

1. Program Management:
    a. Develop, implement, and evaluate the organizational infection prevention program.
    b. Surveillance
    c. Develop an annual surveillance plan based on the population(s) served, services provided, and analysis of surveillance data.
    d. Utilize epidemiologic principles to conduct surveillance and investigations.
    e. Evaluate and modify the surveillance plan as necessary.
    f. Develop, interpret, and assist with implementation of infection prevention and control policies and protocols.
    g. Communicate infection prevention and control information and data to various committees and healthcare workers across the organization as assigned.

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2. Design and Deliver Education
    a. Assess and address learning needs of those served.
    b. Create educational goals, objectives, and strategies using learning principles and available educational tools and technology.
    c. Evaluate the effectiveness of educational programs and learner outcomes.
3. Regulatory Requirements
    a. Comply with regulatory and mandatory reporting requirements at the local, state, and federal levels.
    b. Facilitate compliance with regulatory and accreditation standards.
    c. Stay current on infection prevention and control regulatory and accreditation standards.
4. Quality / Performance Improvement (PI)
    a. Utilize PI methodology as a means of enacting change.
    b. Define the scope of the project and select appropriate PI tools to aid in efficiency, reliability, effectiveness and ensure sustainability of the initiative.
    c. Ensure that customer needs and expectations are considered in the development of and continuous improvement of processes, products, and services.
    d. Monitor and analyze process and outcome measures to evaluate the effectiveness and sustainability.
    e. Participate in QII committees, teams and initiatives as indicated.
5. Occupational Health
    a. Participate in the development/review of occupational health policies and procedures related to IPC.
    b. Assess risk of occupational exposure to infectious disease.
    c. Develop (or assist with) rates and trends of occupational exposures.
    d. Develop (or assist with) immunization and screening programs.
    e. Apply work restrictions and recommendations related to communicable diseases or following exposure.
6. Professional Accountability
    a. Pursue professional growth and development of required knowledge and skills.
    b. Obtain certification in infection prevention – OR – complete relevant comparable annual education.
    c. Advocate for patient safety, health worker safety, and safe practices.

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   d. Participate in an infection prevention and control professional organization/association (i.e.: APIC).
7. Collaboration
   a. Consult and collaborate, as needed, with local, state, and federal public health officials, and community health organizations.
   b. Involve multidisciplinary teams to ensure changes are vetted by all stakeholder groups.
   c. Coordinate emergency preparedness activities, planning and drills for max surge events, including those involving infectious disease, in collaboration with the Emergency Management Manager.
8. Leadership
   a. Utilize principles of influence, leadership and change management.
   b. Work collaboratively with others, providing direction when necessary.
   c. Readily share knowledge and expertise.
   d. Contribute to the development of less-experienced healthcare providers through education and mentorship.
   e. Prepare and deliver infection prevention presentations to external groups.
9. Research and Implementation Science
   a. Evaluate (critically) research and evidence-based practices and incorporate appropriate findings into routine practice.
   b. Integrate evidence-based practices into policies, guidelines, protocols, and educational strategies.
   c. Identify barriers for implementation and develop strategies to minimize or remove barriers.
   d. Implement strategies to sustain efforts such as audit tools and meaningful feedback.
10. IPC Informatics
   a. Be familiar with technology.
   b. Collaborate with IT to create meaningful electronic reports to enhance infection prevention initiatives.
11. Fiscal Responsibility
   a. Consider the financial/safety implications and clinical outcomes when making recommendations, evaluating technology and products, and developing policies and procedures.
   b. Use a systematic approach to evaluate costs, benefits, and efficacy.
   c. Incorporate fiscal assessments into program evaluations and/or reports.

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Infection Prevention Committee

A multidisciplinary medical staff committee oversees the program for surveillance, prevention, and control of infection. The infection prevention and control program is an integral part of the hospital's quality assessment and performance improvement program. The Infection Prevention Committee reports on a quarterly ongoing basis to the Quality Improvement Committee.
The Committee is chaired by the Medical Director of Infection Prevention and Control and appointed by the Medical Staff. Committee membership includes representatives from the medical staff, nursing, Laboratory, Respiratory Therapy, Pharmacy, Imaging / Radiation Safety, Facilities Management, Environmental Services, Employee Health, Dietary, Operating Room and Sterile Processing, hospital administration and persons directly responsible for management of the infection surveillance, prevention, and control program.

- The IPC Committee is a committee responsible to the Medical Executive Committee of the Medical Staff. Its purpose is to monitor infection control practices and support the goals of the IPC Program. Additionally, this Committee provides epidemiological direction and consultation to patient-care providers and staff.
- The IPC Committee, by virtue of the authority vested in its Chairperson by the Medical Executive Committee of the Medical staff, has the authority to institute appropriate control measures when there is reasonable evidence of a danger to patients and personnel. That authority may be given to the designee of the Chairperson. That designee may be the Infection Control Staff or another physician acting for the Chairperson when the Chairperson is not available.
- The IPC Committee meets at least quarterly.
- Under the direction of the Chairperson of the IPC Committee, the Infection Preventionist or designee investigates all suspected outbreaks. This is done in collaboration with appropriate medical and administrative staff. Appropriate corrective actions are made, and findings are documented and reported to the IPC Committee.
- The IPC Committee strives to reduce infection rates by employing continuous quality improvement activities.
- Any cluster of infections or suspected outbreaks in three or more patients or one patient suspected to a hospital-acquired COVID-19 while an inpatient is brought to the attention of the IPC Department and the Chairperson of the IP Committee by active surveillance methods.

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- The IPC Committee appoints subcommittees for special projects or quality improvement.
- Approves the annual infection prevention plan, goals and objectives based on the risk assessment. In addition, the following four factors are considered in the selection and design of the surveillance programs:
    - The surveillance process selected is continuous, ongoing, and effective.
    - Information obtained from surveillance activities improves patient care.
    - Assessment rates are evaluated and are epidemiologically valid.
    - Data are linked to the hospital-wide performance improvement activities.
- Review and approve hospital department policies related to infection prevention and control, including high-level disinfection, sterilization, and disinfection.
- The Infection Prevention Committee reviews and approves all products used by Environmental Services for cleaning and disinfection.
- Data and recommendations are documented in the IP Committee minutes. Any unusual infections or rates that exceed threshold are reported immediately to the IP Committee Chairperson. The Chairperson/designee documents his/her findings and forwards them to the appropriate department director for investigation and correction.
- The IP Committee approves the type and scope of surveillance activities.
- Definitions of infections are based on those established by CDC/NHSN and the State Department of Health.

Microbiology Lab

- Provides the attending physician or physician in charge of the patient with reports of all identified infectious agents. These reports are maintained in the patient's medical record.
- Generates annual reports on the changes in antibiotic susceptibility patterns of culture isolates.
- Notifies the IP Department of positive cultures of highly transmissible organisms.
- Reports select isolates to the State Department of Health according to state requirements.

VIII. Orientation, Education and Coordination with Departments

Annual Training - Training is accomplished at the time of hire and annually thereafter for all hospital employees, at all levels of employment. Medical Staff members receive education during orientation at the time of appointment and annually thereafter.

XII. Annual Review Process

The IPC Plan is updated annually with completion of a risk assessment to identify infection prevention priorities, and as needed, and provides the roadmap for achieving IPC

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goals and objectives. The IPC Plan is supported by the Administration, the medical staff, and the Governing Board.

Infection Prevention in collaboration with microbiology, pharmacy, and medical staff leadership additionally review an antibiogram annually related to susceptibility and resistance patterns of endemic organisms in the patient population.

COMMITTEE APPROVALS:
MEC: 3/18/2024

Article 7 Performance Evaluation and Monitoring

7.1 General Overview of Performance Evaluation and Monitoring Activities

The credentialing and privileging processes described in Bylaws, Article 4, Procedures for Appointment and Reappointment, and Article 5, privileges, require that the Medical Staff develop ongoing performance evaluation and monitoring activities to granting or renewing of privileges are, among other things, detailed, current, accurate, objective and evidence-based. Additionally, performance evaluation and monitoring activities help assure timely identification of problems that may arise in the ongoing provision of services in the hospital. Problems identified through performance evaluation and monitoring activities are addressed via the appropriate performance improvement and/or remedial actions as described in Bylaws, Article 12, performance Improvement and Corrective Action.

7.2 Performance Monitoring Generally

7.2-1 Except as otherwise determined by the Medical Executive Committee and Governing Body, the Medical Staff shall regularly monitor all members' privileges in accordance with the provisions set forth in these Bylaws and such performance monitoring policies as may be developed by the Medical Staff and approved by the Medical Executive Committee and the Governing Body.

7.2-2 Performance monitoring is not viewed as a disciplinary measure, but rather is an information-gathering activity. Performance monitoring does not give rise to the procedural rights described in Bylaws, Article 13, Hearings and Appellate Reviews (unless the form of monitoring is Level III proctoring and its imposition becomes a restriction of privileges because procedures cannot be done unless a proctor is present and proctors are not available after reasonable attempts to secure a proctor).

7.2-3 The medical Staff shall clearly define how information gathered during performance monitoring shall be shared in order to effectuate change and additional action, if determined necessary.

7.2-4 Performance monitoring activities and reports shall be integrated into other quality improvement activities.

7.2-5 The results of any practitioner-specific performance monitoring shall be considered when granting, renewing, revising, or revoking clinical privileges of that practitioner.

7.3 Ongoing Professional Performance Evaluations [OPPE]

7.3-1 The Medical Staff shall recommend, for Medical Executive Committee and Governing Body approval, the criteria to be used in the conduct of Ongoing Professional Performance Evaluations for its practitioners.

7.3-2 Methods that may be used to gather information for Ongoing Professional Performance Evaluations include, but are not limited to:

a. Periodic chart review;
b. Direct observation;
c. Monitoring of diagnostic and treatment techniques;

d. Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing and administrative personnel.

7.3-3 Ongoing performance review data will be used as a measure of competency and shall be factored into the decision to maintain, revise, or revoke a practitioner's existing privilege(s) at the time of reappointment.

7.3-4 Ongoing performance review is completed three times in the three-year appointment period for all members of the medical staff granted clinical privileges, including Allied Health Practitioners.

7.3-5 At least two performance measures are administrative indicators in order to evaluate compliance with medical staff bylaws, rules and regulations, and hospital policies. Examples of administrative indicators include:

a. Admissions
b. Consultations
c. Weeks on Surgery Suspension List
d. Medical record delinquency rate, Admission Suspension list

7.3-6 -At least two performance measures are clinical indicators in order to evaluate current competence of privileges granted. Examples of clinical indicators include:

a. Core measures (sepsis, stroke, etc.).
b. Returns to surgery
c. Surgical complication rate
d. Procedural complication data
e. Cesarean section births, not medically necessary

7.3-7 The sponsoring physician or department chair will complete an evaluation of competency for privileges granted for all mid-level practitioners [NP, PA, CRNA, CNM] that are relevant to their practice.

7.3-8 Practitioners without sufficient volume of patient encounters to perform OPPE may submit patient logs and quality data from other hospitals to be evaluated, as well as focused professional practice evaluation, as described in 7.4(b) below.

7.3-9 The medical staff establish triggers for OPPE measures that trigger the need for focused professional practice evaluation / monitoring. Triggers may be a single incident or evidence of a clinical practice trend. Examples include:

a. A number of adverse events.
b. A number of peer review events with adverse determination.
c. Infection rates are higher than most practitioners.
d. Sentinel or serious safety events.
e. Low volume admissions / procedures over an extended period.
f. Increased length of stay.
g. Frequent / repeat readmission for same issue.
h. Increased number of or trend of complications for same issue.
i. Patterns of unnecessary diagnostic testing / treatments.
j. Failure to follow approved clinical practice guidelines.
k. Patient, family, or staff complaints, substantiated.

7.3-10 To provide security and confidentiality of OPPE data the following may access and review data:

a. Respective department chair
b. Credentials Committee
c. Medical Executive Committee
d. Chief of Staff
e. Personnel working in the Quality Department
f. The individual practitioner for his / her own data and information

7.3-11 OPPE outcome is reviewed by Medical Staff Leadership, the credentials committee, or the Medical Executive Committee with recommendations to the governing body regarding:

a. Implementation of FPPE.
b. Positive OPPE outcome with continuation of current clinical privileges.

7.3-12 Practitioners may review OPPE findings and submit opinions to be considered by the MEC and Governing Board, when results of OPPE trigger FPPE or other actions.

7.4 Focused Professional Practice Evaluation [FPPE]

7.4-1 The focused professional practice evaluation (FPPE) process is designed to be a fair, balanced, and educational approach to ensure the competency of the staff. FPPE is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff. Indications for a Focused Professional Practice Evaluation (FPPE):

a. When granting initial privileges.
b. When granting new privileges to a practitioner with current privileges.
c. For underperformance / quality of care issues.

7.4-2 ~~The Medical Staff is responsible for developing a focused professional practice evaluation process that will be used in predetermined situations to evaluate, for a time-limited period, a practitioner's competency in performing specific privilege(s).~~ The Medical Staff may supplement these Bylaws with policies, for approval by the Medical Executive Committee and the Governing Body, that will clearly define the circumstances ~~when a focused evaluation will occur,~~ what criteria and methods should be used for conducting the focused evaluation, the duration of the evaluation period, requirements for extending the evaluation period and how the information gathered during the evaluation process will be analyzed and communicated.

7.4-3 The department chair is responsible to assign the focused evaluation. The focused evaluation may be defined as either a period of time (e.g., six months) or a specific number of cases. The focused evaluation may be extended, as defined in the bylaws. Data sources for the focused evaluation are defined and may include:

1) Retrospective or concurrent medical record review
2) Direct observation
3) Proctoring, as more fully described at Bylaws, Section 7.4-5.
4) Simulation
5) Discussion with others involved in the care of each patient.
6) External peer review
7) Monitoring clinical practice patterns.

~~7.4-1 Information for a focused evaluation process may be gathered through a variety of measures including, but not limited to:~~
~~a. Retrospective or concurrent chart review;~~
~~b. Monitoring clinical practice patterns;~~
~~c. Simulation'~~
~~d. External peer review;~~
~~e. Discussion with other individuals involved in the care of each patient;~~
~~f. Proctoring, as more fully described at Bylaws, Section 7.4-4, below.~~

7.4-4 A Focused Professional Practice Evaluation shall be used in at least the following situations:

a. All initial appointees to the Medical Staff and all members granted new privileges shall be subject to a period of focused professional practice evaluation in accordance with these Bylaws. Such focused evaluation will generally include a period of Level 1 proctoring in accordance with Bylaws, Section 7.4-5(a), below, unless additional circumstances appear to warrant a higher level of proctoring, as described below.

b. In special instances, focused evaluation will be imposed as a condition of renewal of privileges (for example, when a member requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the member's current competency in that area). Such evaluation will generally consist of Level 1 proctoring in accordance with Bylaws, Section 7.4-45(a)(1) below, unless additional circumstances appear to warrant a higher proctoring level, as described below.

c. When questions arise regarding a practitioner's competency in performing specific privilege(s) at the hospital as a result of specific concerns or circumstances, a focused evaluation may be imposed. Such evaluations may include either Level 2 or 3 proctoring, in accordance with these Bylaws, Section 7.4-54(a)(2) or (3).

d. As otherwise defined in these Bylaws or applicable Focused Professional Practice Evaluation policies.

e. Nothing in the foregoing precludes the use of other Focused Professional Practice Evaluation tools, in addition to or in lieu of proctoring, as deemed warranted by these circumstances.

7.4-5 Proctoring

a. Overview of Proctoring Levels

1) Level 1 proctoring shall be considered routine and is generally implemented as a means to review initially requested privileges in accordance with the Bylaws, Section 7.4-3(a), above and for review of infrequently used privileges in accordance with Bylaws, Section 7.4-3(b), above.
2) Level 2 proctoring is appropriate in situations where a practitioner's competency or performance is called into question, in accordance with Bylaws, Section 7.4-3(c), above, but where the circumstances do not involve a "medical disciplinary" cause or reason or where the proctoring does not constitute a restriction on the practitioner's privilege(s) (i.e., the practitioner is required to participate in proctoring, and to notify either the proctor or other designated individual(s) prior to providing services, but is permitted to proceed without the proctor if one is not available).
3) Level 3 proctoring is appropriate in situations where a practitioner's competency or performance is called into question due to a "medical disciplinary" cause or reason in accordance with Bylaws, Section 7.4-3(c), above and where the form of proctoring is a restriction on the practitioner's privilege(s) (because the practitioner may not perform a procedure or provide care in the absence of the proctor). Upon imposition of Level 3 proctoring, that practitioner is afforded such procedural rights as provided at Bylaws, Article13, hearings and Appellate Reviews.

b. Overview of Proctoring Procedures

1) Whenever proctoring is imposed, the number (or duration) and types of procedures to be proctored shall be delineated.
2) During the proctoring, the practitioners must demonstrate they are qualified to exercise the privileges that were granted and are carrying out the duties of their Medical Staff category.
3) In the event that the new applicant has privileges at a neighboring hospital where members of this hospital's Medical Staff are familiar with the member to be proctored, and familiar with that neighboring hospital's peer review standards, privileging and proctoring information from the neighboring hospital may, at the discretion of the Medical Executive Committee, be acceptable to satisfy a portion of the focused professional practice evaluation required for this hospital.

c. Proctor: Scope of Responsibility

1) All members who act as proctors of new appointees and/or members of the Medical Staff are acting at the direction of and as an agent for the Medical Executive Committee and the Governing Body. When possible, no business relationship shall exist between proctor and proctored.

2) The intervention of a proctor shall be governed by the following guidelines:

A member who is serving as a proctor ~~does not~~ may act as a supervisor of the member or practitioner he or she is observing. His or her role is to observe and record the performance of the member or practitioner being proctored, and report his or her evaluation to the Credentials Committee

A proctor is not mandated to intervene when he or she observes what could be construed as deficient performance on the part of the practitioner or member being proctored.

In an emergency situation, a proctor may intervene, even though he or she has no legal obligation to do so.

d. Completion of Proctoring

1) The member shall remain subject to such proctoring until the medical Executive Committee has been furnished with:

a. A report signed by the Director of the department to which the member is assigned describing the types and numbers of cases observed and the evaluation of the member's performance, a statement that the member appears to meet all of the qualifications for unsupervised practice in the hospital, has discharged all of the responsibilities of the Medical Staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and

b. A report signed by the Director of such other department(s) in which the member may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the member's performance and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

e. Effect of Failure to Complete Proctoring

1) Failure to Complete Necessary Volume. Any practitioner or member undergoing Level 1 or level 2 proctoring who fails to complete the required number of proctored cases within the time frame established in the Bylaws and Rules shall be deemed to have voluntarily withdrawn his or her request for membership (or the relevant privileges), and he or she shall not be afforded the procedural rights provided in Bylaws, Article 13, Hearings and Appellate Reviews. However, the Chief of Staff has the discretion to extend the time for completion of proctoring in appropriate cases subject to ratification by the Medical Executive Committee. The inability to obtain such an extension shall not give rise to procedural rights described in Bylaws, Article 13, Hearings and Appellate Reviews.

2) Failure to Satisfactorily Complete Proctoring. If a practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, he or she may be terminated (or the relevant privileges may be revoked), and he or she shall be afforded the procedural rights as provided in Bylaws, Article 13, Hearings and Appellate Reviews.

3) Effect on Advancement. The failure to complete proctoring for any specific privileges shall not, by itself, preclude advancement from provisional staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the specified privileges. The specific privileges may be voluntarily relinquished or terminated, pursuant to Bylaws, Section 7.4-4(e)(1) or (2) if proctoring is not completed thereafter within a reasonable time.

7.4-6 The Medical Staff defines the methods to resolve performance issues. The methods may include:

a. Necessary education.
b. Additional proctoring / assisting for defined privileges.
c. Counseling.
d. Physician / practitioner assistance programs.
e. Suspension of specific privileges.
f. Revocation of specific privileges.
g. The improvement plan will be documented and include who is accountable, and how the improvement will be measured and documented.

7.4-7 FPPE outcome: the Medical Staff leadership submit recommendation to the governing body regarding:

a. The need to continue FPPE.
b. Continuation or limiting of the privilege.
c. Successful completion of FPPE and progression to routine OPPE monitoring.

7.4-7 Practitioners may review FPPE findings and determinations and submit opinions to be considered by the MEC and Governing Board.

2.4-7 Authorizes and consents to hospital representatives providing other hospitals, professional societies, licensing boards and other organizations concerned with provider performance and the quality of patient care with relevant information the hospital may have concerning him or her, and releases the hospital and hospital representatives from liability for so doing.

2.4-8 Consents to undergo and to release the results of a physical or mental health examination by a practitioner acceptable to the Medical Executive Committee, at the applicant's expense, if deemed necessary by the Medical Executive Committee.

2.4-9 Signifies his or her willingness to abide by all the conditions of membership, as stated on the appointment application form, on the reappointment application form, and in the Bylaws and these Rules.

2.4-10 For purposes of this Rule 2.4, the term "hospital representative" includes the Governing Body, its individual Directors/Trustee and committee members; the Chief Executive Officer, the Medical Staff, all Medical Staff officers and/or committee members having responsibility for collecting information regarding or evaluating the applicant's credentials; and any authorized representative or agent of any of the foregoing.

2.5 Verification of Information

2.5-2 **General:** The applicant shall fill out and deliver an application form to the Medical Staff office, which shall seek to verify the information submitted. Verification shall encompass a complete application, which ;includes, but is not limited to,

A. Licensure History: current license(s), licensure sanction(s), state(s) of current practice or intended practice, and all previous licenses held.
B. Medical Education and Postgraduate Training
C. Malpractice Insurance and History: 5-year history.
D. Specialty Board Status: (if applicable).
E. Sanctions or Disciplinary Actions: actions taken by healthcare facilities, specialty boards, federal or state agencies, malpractice carriers.
F. Criminal History: felony convictions/ criminal history (7-10 years).
G. Healthcare Employment History: healthcare related employment/ appointment history (work history).
H. Professional References: current competence and peer recommendations/references, ability to perform privileges requested (health status).
I. Primary Source Verification (PSV) from State Licensing Agency (Agencies), the Drug Enforcement Administration, and query from the National Practitioner Data Bank (NPDB).
J. Information regarding previously successful and/or currently pending challenges to any license, and/or voluntary or involuntary relinquishment of license.
K. Results from search of OIG Medicare / Medicaid Exclusion databank, Federation of State Medical Boards (FSMB) Disciplinary Action Databank or Fraud and Abuse Control Information Systems (FACIS).

L. If telemedicine is used, review the process for validation of licensure and validate it is being enforced.
M. Primary Source Verification (PSV) includes AMA Physicians Profile, AOA Official Osteopathic Physician Profile, and Educational Commission for Foreign Medical Graduates (ECFMG), as applicable.
N. Documentation regarding training and education sufficient to support requested privileges; evidence of continuing educational activities every two years may be requested.
O. Evidence of professional liability insurance including current certificates showing professional liability insurance for the privileges requested in the amounts of at least $1,000,000/occurrence and $3,000,000/aggregate.
P. Malpractice litigation history from insurance carrier.
Q. National Practitioner Data Bank (NPDB) query on professional liability actions resulting in final settlements or judgments within the past 5 years.
R. Documentation regarding specialty board status.
S. If certified by a member of ABMS, verify with the AMA Physician Profile.
T. Health Status
U. Current proficiency / competency with respect to the hospital's general competencies [as applicable to the privileges requested].
V. Verification of identification confirming the practitioner is the same individual identified in the credentialing documents [by viewing picture identification card, valid picture hospital ID card, or a valid state or federal agency picture ID card].

Note: re-applicants, peer review via routine review (e.g., OPPE, ~~clinical peer review, medical records review, c~~credential's ~~function, Medical Executive Committee) will suffice.~~e However, clinical competence review must be a component of recredentialing.

- Applicants must provide documentation regarding clinical activity (from residency or from facilities where the applicant has been practicing medicine) and competency for consideration of privileges requested.
- Re-applicants must provide recommendations from the department volume is low, this may require review of procedure logs/ competency from other institutions to verify competency) including:
    - Scope of specific privileges based upon recent experience and
    - Recommendations from quality assurance committee and/or other staff committees based upon peer review findings.

~~written verification of peer references, licensure status, training and education, current proficiency with respect to the hospital's general competencies (as applicable to the privileges requested), health status, other evidence submitted in support of the application, and confirmation that the practitioner is the same individual identified in the credentialing documents (by viewing a current, valid picture hospital ID card or a valid state or federal agency picture ID card). The application will be deemed complete when all necessary~~

~~verifications have been obtained, including, but not limited to, current license, licensing board disciplinary records, specialty board certification status, National Practitioner Data Bank and OIG Medicare/Medicaid Exclusions information, Drug Enforcement Administration certificate, if appropriate, verification of all practice from professional school through the present, current malpractice liability insurance and reference letters, verification of current proficiency in the Hospital's general competencies (Bylaws, Section 5.2, Criteria for Privileges/General Competencies), and other evidence that the applicant submitted in support of this/her application. Additionally, the Medical Staff office may seek information from other relevant sources, such as the American Medical Association's Physician Masterfile (for verification of a physician's medical school graduation and residency completion), the American Board of Medical Specialties (for verification of a physician's board certification), the Educational Commission for Foreign Medical Graduates (for verification of a physician's graduation from a foreign medical school), the American Osteopathic Association Physician Database (for pre- and post-doctoral education), the Federation of State Medical Boards Physician Disciplinary Data Bank (for all actions against a physician's medical license).~~

2.5-3 **Primary Source Verification for Disaster Privileges:** With respect to volunteer practitioners who may be permitted to exercise privileges or perform functions when the hospital's disaster plan has been activated and the organization is unable to handle the immediate patient needs:

A. Primary source verification of licensure must occur as soon as the disaster is under control or within 72 hours from the time the volunteer practitioner presents him- or herself to the hospital, whichever comes first. If primary source verification of a volunteer practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the all of the following must be documented:
   i. Reason(s) it could not be performed within 72 hours of the practitioner's arrival;
   ii. Evidence of the practitioner's demonstrated ability to continue to provide adequate care, treatment, and services; and
   iii. Evidence of the hospital's attempt to perform primary source verification as soon as possible.

B. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer practitioner cannot be completed within 72 hours of the practitioner's arrival, it must be performed as soon as possible.
   (Note: Primary source verification of licensure is not required if the volunteer practitioner has not provided care, treatment, or services under the disaster privileges.)

2.6 Incomplete Application

2.6-1 If the Medical Staff office is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise significantly incomplete, the Medical Staff office may delay further processing of the application, or may begin processing the application based only on the

MAYERS MEMORIAL HEALTHCARE DISTRICT

Operations Report
March 2024

Statistics	January YTD FY24 *(current)*	January YTD FY23 *(prior)*	January Budget YTD FY24	Variance
Surgeries ➢Inpatient ➢Outpatient	 0 0	 0 0	 TBD TBD	
Procedures** *(surgery suite)*	0	0	TBD	
Inpatient	1365	1263	1149	102
Skilled Nursing Days	19355	19027	18245	328
Emergency Room	2840	2902	2812	62
OP Visits (OP/Lab/X-ray)	9945	10699	9180	754
Hospice Patient Days	282	789	895	507
PT	1289	1627	1671	338

*Note: numbers in RED denote a value that was less than the previous year.
**Procedures: include colonoscopies

Human Resources

March 2024

Submitting by Libby Mee – Chief Human Resource Officer

Staffing and Recruitment

The Mayers Human Resource staff currently supports 301 active employees, and the recruitment team has 25 job requisitions posted, in efforts to fill 41 open positions.
We are currently working with specialized companies to provide additional recruitment resources for our Emergency Medical Director/Physician, Pharmacist, Infection Prevention, Hospitalist/NP, Physical Therapist, Radiology Tech, and Skilled Nursing positions.
The team have received candidates and are conducting interviews and/or site visits for the Provider, Pharmacist, Infection Preventionist and Hospitalist positions.

Fairs and Recruitment Events

Representatives from MMHD are scheduled to attend the below fairs and events in efforts to recruit employment applicants:

- Smart Center Job Fair in Redding – March 26th
- Shasta College Nursing Division – March 28th
- Oregon Institute of Technology – April 24th

At the end of the fiscal year, we will have attend 11 fairs or events.

Employee Health, Wellness and Benefits

Work Related injury and Illness

For the year, there as has been 1 reportable work-related injury resulting in 3 days away from work. There has been 2 first aide injuries, with no days away from work.
All 3 injuries occurred in the Skilled Nursing Facility.

Miscellaneous

Annual Employee Compliance

We are nearing our window for our employee Annual Compliance. Employee's will complete their Annual Re-Orientation content in the months of April and May, their Employee Health content in the months of May and June, with their annual evaluations in the month of June and July. The HR team is currently working with our ACHC consultant and MMHD leadership to be sure content and policies are up to date.

Rural HR Peer Group Meeting

On Friday March 29, 2024- I will be traveling to Seneca Healthcare District in Chester for an in-person meeting with my local CHA HR counterparts. This is a group that I communicate with often that I am looking forward to meeting everyone in person.

HR position restructuring

Due to a recent resignation and the preparation for a retirement, we will be adding some new team members to the HR team. We have posted a position for the Human Resource Generalist and will be posting for a Human Resource Information Specialist/Benefit Administrator and an Employee Health Nurse. The Employee Health position will be a shared position with the Infection Prevention team.

EMPLOYEE STATISTICS

2024 Fiscal Year

337

Total Employees
for the year

RETENTION VS. LOSS

64

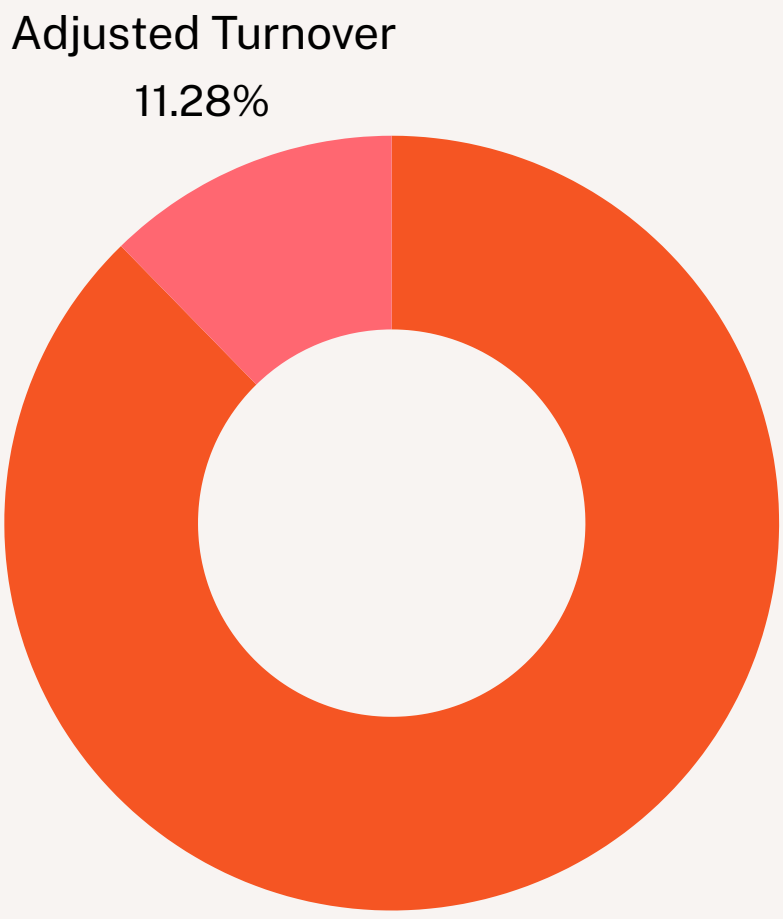
People hired/rehired

38

people terminated their employment

ADJUSTED TURNOVER STATS:

Goal turnover for FY 24 is 17.52%



Bolded *= Actively Recruiting*
**= Top Priority*

Positions:	# available:
Activities Aide	1
Bright Futures Family Advocate	1
***Emergency Dept Medical Director**	1
***Emergency Dept Physician**	PT OR FT
Emergency Room RN I	1
Environmental Services Aide	1
Food and Nutrition Aide	1
Hospice Home Health Aide	PER DIEM
***Independent Retail Pharmacist**	1
***Infection Prevention RN**	1
Lead Early Childhood Educator	1
Med/Surg Acute RN	PER DIEM & FT
Medical Assistant (RHC)	1
***Nurse Practitioner (Acute)**	1
***Nurse Practitioner (SNF)**	1
***Pharmacist**	1
***Physical Therapist**	1
***Radiology Tech**	1
Skilled Nursing CNA	10: 2 PER DIEM, 1 PT, 7 FT
Skilled Nursing RN	3

***BOLDED**= Actively Recruiting*
**= Top Priority*

Positions:	# available:
***Skilled Nursing LVN**	9: 1 PER DIEM, 2 PT, 6 FT
Skilled Nursing Charge Nurse	1
System Administrator	1

Chief Public Relations Officer – Valerie Lakey
March 2024 Board Report

Legislation/Advocacy

The Legislative process is in full swing. Bills are finding places in committees as they move through the process. There are many bills we are following. Here is a summary:

The **Office of Health Care Affordability** (OHCA) is at the top of the list as the OHCA staff-proposed 3%, five-year spending growth target. In January, **OHCA staff released** a proposed 3% annual spending growth target for 2025-29; it would be non-enforceable in 2025 but in later years could result in performance improvement plans and financial penalties for hospitals that fail to meet the target. The OHCA board is required to finalize the initial target by June and may do so as early as its March 25 meeting or as late as its May 22 meeting. Notably, OHCA's mandate is twofold: to rein in spending growth, but without sacrificing quality of or access to health care. As proposed, the spending growth target would undoubtedly have a negative impact on health care statewide. Ahead of the OCHA board's decision on a final target, CHA is advocating for a modified, one-year spending growth target. The OCHA board meets March 25. Talking Points have been provided by CHA.

SB 1423 would require Medi-Cal to reimburse outpatient services provided by critical access hospitals at rates equal to the hospitals' costs. This bill also includes a parallel **budget request** to fund the proposed reimbursement model.

Pending a hearing in the Senate Health Committee

SB 1432 is CHA's proposal to address the 2030 seismic requirement. While currently a placeholder bill, the proposal's key components will include extending the 2030 deadline, addressing additional post-earthquake disaster preparedness requirements for hospitals, assessing opportunities for financial support, requiring the state to assess the financial and access impacts of the 2030 requirement, and addressing rural hospitals' unique concerns.

Introduced on Feb. 16. Pending a Senate policy committee referral.

AB 869 would prioritize certain smaller hospitals for the existing Small and Rural Hospital Relief Program, which is funded by the e-cigarette tax. This would allow them to get assessments for the cost of retrofitting their hospital and give certain smaller rural hospitals and certain district hospitals a five-year extension of the 2030 seismic deadline. It would also allow certain smaller rural and district hospitals, if they have experienced a financial hardship, an indefinite extension beyond 2035, until funds are appropriated by the state.

In Senate Health Committee

AB 2297 would prohibit hospitals from considering patients' monetary assets when determining eligibility for charity care or discount payments or imposing a time limit on eligibility. There is also another Charity Care type bill – **SB1061** which would prohibit hospitals from reporting medical debt to credit reporting agencies, regardless of patient's ability to pay.

April 2 hearing in the Assembly Health Committee. To be heard in the Assembly Judiciary Committee.

SB 963 would require general acute care hospitals with emergency departments (EDs) to create a human trafficking system available at the ED that would allow patients to self-identify as a victim of human trafficking. The hospital would also be required to collect information on the total number of patients who self-identify as victims, their age, and their racial demographics.

Pending a hearing in the Senate Health Committee

AB2975 amends the labor code and aims to have hospitals provide metal detectors. Language is still vague, but we are following closely.

Public Relations/Marketing

There are many marketing and public relations projects happening. March had a focus on surgery, colorectal cancer screening and nutrition month. We have continued a monthly marketing focus for the clinic. This month postcards were sent out to 50–60-year-olds reminding the patient of the importance of colorectal cancer screening.

The Quarterly even is scheduled for March 27th at the TCCN Community Center from 5:00 – 6:00 pm. We will focus on the programs and plans fort the Community Center while also emphasizing Nutrition Month with healthy snacks provided by the Burney F & NS crew.

We are beginning work with HR on the Planting Seeds and Growing Our Own projects. Information on the internship program will be going out soon and we will be working with the local elementary schools on the annual programs.

We will begin advertising on the DMV screen in Fall River and we are looking into ads on the Safeway carts.

Other projects include the updates on all our websites (MMHD, MHF, Hospice and Intranet), which is taking longer than expected. We are building a new website for TCCN, along with their social media. Updating the admissions packet, Surgery and Respiratory Therapy brochures and PR and HR recruiting materials.

Mayers Healthcare Foundation

- **The Annual Appeal** brought in over $20,000. The Annual Appeal went out to all local boxholders as well as an additional 300 to out of the area people. We have seen many donations from the appeal. The appeal also contributed greatly to the success of the gala as the appeal forms were used to send in gala purchases as well as share what the Foundation has done over the last year as a non-profit.
- **Denim & Diamonds Hospice Winter Gala** – January 27, 2024. A truly wonderful event, supported by community members from Burney, Fall River, McArthur, & Big Valley. We sold out the dinner, and all 10 sponsor tables. We sold 481 tickets for the 1965 Mustang. Roughly $35,000 was netted

with this event. We held a committee meeting in Feb to review the event to make it even better next year. Thank you to all the MHF team, board and volunteers for the time and effort put in to make this such a great evening.

- **Health Fair** - We had a planning meeting in February and have secured June 22, 2024, date at the Inter-Mountain fairgrounds. We are looking into a completely new and refreshed event starting with moving to the flower building and having a large majority of the venders outside.
- **Golf Tournament -** August 3, 2024 has been secured with Fall River Valley Golf and Country Club. We are starting the planning stages of this event as well.
- **MEG -** The Mayer Employee Giving program is a program in which Mayer employees can donate to the foundation from their payroll checks every pay period. These funds are used to support the different needs of the departments. We will be having a thank you luncheon for the 2023 employee donors on April 3rd at which time we will select where to spend the 2023 donations. We are currently working to create a campaign pitch that will engage contributions to this program more fully. Please note these funds come unrestricted and throughout the year. Presentation have been given to new hires already as well as some department staff meetings.
- **Thrift Store –** We have one month under our belt with the store being ran by volunteers. Things have been going very well and revenue for the first month was close to $7000. The store looks beautiful, and the volunteers are very invested in making it successful. Thank you to these committed volunteers! Please help spread the word that we could use more volunteers and if anyone is doing any spring cleaning, donations are welcome!
- **Grants & Scholarships –** We have applied for a few grants to support the SNF Music & Memory Program, repairs at TCCN and needed items for the Thrift Store. The scholarship cycle for area students and MMHD staff will begin in April.
- **MHF Board –** The MHF board will be considering approval of two need board members to fill out our board.

Tri County Community Network

- **Building Improvements** – Painting has been completed for both the children's program, the upstairs office space, and the event room. Lights and ceiling tiles have been installed in the children's program area and the whole space already feels brighter and cleaner.
- **Agency Collaborations** - TCCN has already begun partnering with other agencies to bring much-needed services to our area. The SMART Business Center will begin offering monthly employment services starting April 4 and will continue until October or when the weather makes travel difficult. Health and Human Services has agreed to offer a smoking cessation class at the end of May. As soon as the flyer is approved by both us and HHSA, we will begin promoting the class. HHSA is also offering to host a six-week parent/ family nutrition class starting in September called "Around the Table". Parents/ caregivers will learn about nutrition, how relationships with food affect health, and practice techniques for a mindful approach to eating. TCCN is also currently looking for someone to be trained by HHSA to provide exercise classes for our seniors.
- **Grants** - Grant requests have been written to fund programs, equipment purchases, and training opportunities. A grant request has been submitted to the Burney Regional Foundation to fund our annual Kid Fit program. The Burney regional foundation has funded this summer program for kids in the past and we are optimistic that they will fund the program again this year. A grant request has been submitted to the McConnell Foundation to purchase new equipment for the children's program and furniture for the front foyer. Finally, a request has been submitted to the

Redding Rancheria Fund to pay for Parent Café training for some of our staff and possibly staff from other organizations as well such as Head Start or Pit River Health.

- **Staff** - The job openings for Lead Educator and Bright Futures have closed and interviews for both positions will be held next week. Hopefully we will find two amazing candidates!
- **Licensing** - After several meetings and emails with Community Care Licensing, it has become evident that we will need to apply for new childcare licenses for our children's programs. There is a great deal of work involved with the process, but we are still hopeful that we can keep our June 10th opening date.
- **Events** - Our quarterly event will be held in the TCCN event room on March 27th. The community has been invited to attend to learn about what programs and services will be offered. Our annual Lunch with Community Helpers event is scheduled for April 11th and 300 children, caregivers, and community helpers are expected to attend.

Gift Shop

We have received a lot of new inventory for the Mayers Pharmacy Gift Shop. There are a lot of spring items, easter candy and goodies for kids! Please stop by and take a peek and the beautiful displays.

March Board Report
Clinical Division
3/20/2024

Laboratory

- Final validation for CERNER auto-verification process is scheduled for 3/20. Abnormal lab results will be reviewed by a CLS per the normal process.
- Cerner is unable to produce an antibiogram. We are looking at how to extract the data to make an antibiogram that is useful to our providers.
- Siemans (the company who manufactures many of our laboratory analyzers) offers free offsite training and reinforcement to customer's CLS staff on their machines. Mayers will be taking advantage of this training for the first time.

Imaging

- Harold Swartz, Imaging manager, and Kim Elliot, ultrasound tech, are working with infection prevention in evaluating new cost effective Tristel HLD® system to replace the Cidex® system in ultrasound. Cidex® is our current probe disinfection system. Cidex® should be only be used with a vent hood due to toxic nature of vapors.
- Amanda Benson will be able to apply to test for CT certification in the next 4 weeks. Harold will be testing either at the same time or shortly after.
- We now have high dose alerts set up on the CT unit based on national benchmarks. The alert will notify staff if there is excessive radiation for each exam prior to starting. This allows the technique to be adjusted before the scan is begun.
- We have pricing and proposals from two PACS vendors. We are currently working with Fuji Synapse and Sectra. We are working with CERNER on several considerations before a vendor will be proposed.

Physical Therapy

- The gas line to the PT building was compromised effecting heat and hot water. The maintenance team worked to restore hot water.
- Shay Marquez completed 100 intern hours and Alex Winn completed 40 intern hours. They will be applying to Physical Therapy graduate programs in April.

Cardiac Rehab

- The new exercised bike purchased through an award from Mayers Healthcare Foundation was put in use February 21st and has been very well received.
- We have tested the home blood pressure monitoring and will "go live" in April. Policy and procedures around the devices and their limitations are being written.

Hospital Pharmacy

- The barrier isolator has been recertified for airflow. Biological testing results takes several weeks for results but has been completed.
- Pharmacy is working with Infection Prevention and Skilled Nursing Leadership on how to better treat and prevent recurrence of c.diff infections.
- Time is spent everyday working through Cerner tickets to make the EHR work the best.

Retail Pharmacy

- Kristi Shultz, Associate Manager, has been working with Mayers Finance Department to minimize medication adjustments due to formulary changes with the hospital's new insurance.
- Kristi Shultz and Alesha Johnson attended the Liberty software ENGAGE training conference where they were given hands-on experience and in-depth insights on our software. Our goal is to maximize the functionality of the system we already have.

Infection Prevention

- The Infection Prevention Plan has been approved in Infection Control Committee and Medical Staff Committee and is at the board of directors for final approval.
- Review of policies to meet ACHC and other standards is in process with a focus on high level disinfection of endoscopy equipment.
- The Burney Skilled Facility had two cases of a skin infection. Immediate and aggressive actions were taken to prevent spread to other residents. As of March 20 no spread had occurred.
- Actions were taken in the Fall River Skilled Facility with an abundance of caution to isolate a COVID infection to a single resident. The guidelines for Covid mitigation in the healthcare setting are ambiguous as the emergency order has expired.

Respiratory Therapy

- The new ABG machine from Nova-Biomedical is validated and is in use. The interface results field is not populating for each test and the specimen labels are not printing in the correct area. We continue to work with Cerner to get this interface live.
- Respiratory therapy is getting a daily report of smokers admitted to Mayers Med-Surg and Swing beds through Cerner. We are working that every smoker admitted receives smoking cessation education.
- Maryann Worthan ventilator and high flow oxygen training to staff and Modoc Medical Center in Alturas.
- All four Resmed ventilators are back in service. Two are set up as ventilators and two are set up as biPAP (one for adults and one for infants). The Resmed ventilator is preferred over the Vision ventilator for patient transport because the Vision ventilators run through the ambulance oxygen stores faster.

NURSING SERVICES BOARD REPORT

March 2024

CNO Board Report

- Mar. 18th received notification from CMS that due to the findings of Dec. 20thth, we are prohibited from offering or conducting a NATP for two years from Jan. 17, 2024.
- The Burney facility had two suspected cases of scabies. The general population were all treated prophylactically, and extensive cleaning was completed. No further transmission was noted. This was a collaboration with the Infection Control task force.
- One Covid case in SNF-Fall River with no further transmission.
- Cerner build in progress for SNF with integration testing Mar. 18-21. Go-live date pushed back to May 13th to assist with increased training to staff and to allow for Cerner staff on site.
- ACHC regulations being reviewed with Quality and Acute Departments. Work in progress restructuring policies and procedures. Work continues weekly with the consultant.
- OPS opening went very well. The staff did an amazing job and it was well organized by our OR manager Leanne Melang. We will be increasing to 3 days next month to accommodate increased referrals.

SNF

- Census- (76) Fall River- 32 Burney Annex- 25 Memory Care- 19
    - Admits continue to be on hold for the SNF A waiting list has been created by facility social workers for when admissions are again allowed.
    - Once the admissions hold is lifted, we will start in person visit screening for those on the wait list.
- Three students completed the nurse aid training program on February 21st.
    - There are 6 Unit Assistants ready to enter the next CNA class.
    - The next class date will be determined around implementation of Cerner.
- We have 4 CNAs that will need to retest due to lack of continuing education hours.
    - 4 CNA's have expired in March 1 will expire in April, and 1 in May.
- Continuing to struggle with staffing in-house nurses. Medifis and NPH are meeting our needs at this time to maintain staffing ratios.
    - We have sent an offer letter to a Medifis RN to become in-house staff and are awaiting a response.
    - Our new LVN will complete her orientation on the 26th of March and will be full time in Fall River.
- SNF Cerner implementation continues.
    - We completed CareTracker/MDS training the week of 3/4/24.
    - We will complete integration testing on 3/18/2024.
    - Cerner has agreed to push out our implementation to 5/13/24 and provide on-site support.

    - We have had meetings with both Modoc and Senneca LTC regarding Cerner workflows. Valuable information was gained to mitigate potential issues during implementation.
- The Burney facility has had two suspected cases of scabies.
    - Both residents have been treated.
    - 23 residents have received prophylactic treatment.
    - Employees have also been offered prophylactic treatment.
    - A letter was sent out to all resident families.
- The Fall River Facility had one case of Covid diagnosed on 3/13/24.
    - The facility in collaboration with infection prevention has implemented appropriate measures to prevent transmission including contact tracing and testing of exposed employees and residents.

Acute

- February 2024 Dashboard
    - Acute ADC 2.55, ALOS 3.52
    - Swingbed ADC 4.07, ALOS 23.6
    - OBS Days: 6
- February Staffing: Required 8 FTE RN/LVN's, 2 PTE RN's, 4 FTE CNA's & 2 FTE Ward Clerks
    - Utilizing 1 FTE Medifis, 1 FTE NPH RN, & 1 PTE NPH RN/LVN
    - Open positions: 1 FTE RN, Per Diem staff cover PTE
    - Hired 1 RN to start orientation mid-march
- Updates:
    - Continuing to work through Cerner SR tickets, will be meeting with Wipfli consultant at end of month for additional education and assistance.
    - Reviewing DNFB report to identify patient accounts that require additional work to process through billing. Identifying all issues, providing education to staff to prevent future occurrences.
    - Working on Swing Bed Course, collaborating with team, and adjusting policies/workflows to better align with CMS guidelines and ACHC Standards.
    - Completed ACHC assigned tasks by consultant, updating policies, and collaborating with other MMHD teams as needed.

Emergency Services

- February 2024 Dashboard
    - Total treated patients: 390
    - Inpatient Admits: 24
    - Transferred to higher level of care: 23
    - Pediatric patients:
    - AMA: 3
    - LWBS: 1
    - Present to ED vis EMS: 43
- February Staffing: Required 8 FTE RN, 2 PTE RN's, 2 FTE Tech's

    - Utilized 1 FTE contracted travelers
    - ED Manager continues with the temporary role of Project Manager for Cerner and key player in workflow changes, financial revenue review, and superuser, in addition to support the SNF Cerner launch.
    - Open positions: 1 FTE Noc RN
- Updates:
    - Monitoring department workflows, identifying gaps, and working towards building skills fair and in-service courses to promote quality of care and meet ACHC guidelines.
        - 8-hour CEU course planned on the 25th for ED RN's was cancelled and to be rescheduled
        - TNCC Class to he held locally – Tentative Dates: August or October
    - Monitoring patient charges for errors in CPT codes. Working with MMHD team and Cerner to correct issues and reformat processes to ensure proper capturing of clinical work.
    - Identifying quality reporting requirements and building streamlined process for obtaining accurate, efficient data
    - Reviewing DHNP report to identify patient accounts with financial concerns, correcting issues, and educating staff as needed.

Outpatient Surgery

- UPDATE: Surgery opened Mar. 11th. Mon=6 scopes/Tues=4 scopes (one cancelled).
- February Dashboard
    - Unit Closed – Scheduled opening March 11th
- Updates:
    - Finalized contract with MMC to have Dr. Syverson on-site 1 week/month.
    - Finalized MMHD contract with S. Davidson, CRNA.
    - Worked with Cerner to complete build for surgery platform, negotiated having Cerner representative on-site for go-live.
    - Finalized go-live case schedule, staffing, and completed Cerner education with 100% of staff working March shifts.
    - Worked through last minute preparations to ensure compliance and readiness for surgery to re-open.
    - Surgical technician is continuing to work through her program. Currently sharing her time between pharmacy and OPS. Continued traveling to MMC for on-site hands-on experience but due to obligations in pharmacy, this has been a slow process with minimal hours completed. She will start full-time in April.

Ambulance Services

- Ambulance Runs-- 66 ambulance runs for the month of February. 14 of those were transfers.
- We did interview a Paramedic and have made a job offer. Waiting for a response from the candidate.

- We participated in vehicle extrication training with the local fire departments. This will increase awareness and safety at these types of scenes.

Outpatient Medical

- Census is:
  - January 130 patients.
  - February 118 patients.
- Manually running statistics until we can find some good reports. Finance reports are getting closer to what our census is.
- Working toward following up on Cerner tickets/revenue issues/tracking open issues. 3rd party consultant coming onsite to go over issues in March.
- Continue to run reports and work with finance.
- Fully staffed.
- Still need help capturing wound care reports documenting pressure injuries for the hospital. I have not been successful setting this up.
- Had a demo with Tissue Analytics which is an app that works with Cerner to have photos and reports that documents the standards of measuring wounds. Waiting for pricing.

CLINICAL EDUCATION

- **TRAINING CALENDAR**
  - **UPDATE**: Clinical Educator is working with 5 CNA staff needing to be scheduled for retesting with CDPH for recertification.
  - 2 CNA's testing this 3/21
  - 2 CNA waiting CDPH approval to retest for certification.
  - 1 CNA awaiting certification processing by CDPH.
  - Currently working with 3 CNA staff to renew with all criteria met.
  - BLS training- 4 participants next scheduled training 3/26
  - PALS recertification training 3 participants 3/5 and 1 on 3/12
- **Mandatory CNA 8-hour training** includes 2 hours of "CNA Professionalism" with content regarding renewal requirements, regulatory requirements, CDPH renewal forms as handouts, instructions read and discussed, renewal period discussed, participants completed the forms as practice regardless of renewal date, quiz and attestation regarding renewal requirements and accurate filing validated.
- **Mandatory New CNA Orientation** 16-hour training includes "CNA Professionalism" included with content regarding renewal requirements, regulatory requirements, CDPH renewal forms as handouts, instructions read and discussed, renewal period discussed, participants completed the forms as practice regardless of renewal date, quiz and attestation regarding renewal requirements and accurate filing validated.
- **CDPH POC training for C Diff**
  - 94% of MMHD staff (not on leave) completed. Training is ongoing.

    - 14 registry staff completed training and training is ongoing. Working with staffing and registry for accuracy.
- **Nurse Assistant Training Program (NATP)**
    - Currently on hold due to CMS findings.
- **Special Project**
    - **UPDATE:** Information continues to be gathered from trusted SNF sources to create Registry process for training, competency assessment compliance

Respectfully Submitted by Theresa Overton, CNO

Chief Executive Officer Report

Prepared by: Ryan Harris, CEO

ACHC Accreditation

Our partnership with our ACHC Consultant has entered its second month, during which they have been compiling our application packet as we continue to submit our work. Once the packet is ready, we will proceed with our survey. In addition to addressing the mandatory application items, we are also diligently working on fulfilling all Condition of Participation requirements to guarantee a successful and smooth survey process.

Provider Search Update

We are currently in the process of reviewing applications that we have received for our ER physician, hospitalist, and Infection prevention positions. We are also anticipating applications for our Clinic Medical Director, Physician, Pharmacist and Physical Therapist roles with shifts in recruitment efforts for those.

Skilled Nursing Update

Last month I reported that the California Department of Public Health (CDPH) conducted a follow-up on our Immediate Jeopardy (IJ) tag. We received positive feedback from CDPH regarding our response and dedication to resolving root cause analysis issues. The team's exceptional efforts in crafting the response and conducting root cause analysis were commended, but it is essential to ensure accountability in the future. However, this month we received discouraging news from CMS indicating fines totaling $95,781.00 and the requirement to forfeit our Nursing Aid Training Program (NATP/CNA Program) due to federal law prohibiting approval of such programs for facilities that have incurred certain penalties within the past two years. We are continuing to explore options on how to save our NATP program but time to do so is limited.

Director Of Operations

I am pleased to announce that after conducting a thorough search and numerous interviews, it became clear that one candidate stood out as the best fit for our organization. Jessica DeCoito demonstrated exceptional knowledge of our operations departments, hospital operations in general, and proved to be the most well-rounded candidate. For these reasons, Jessica will be taking over the responsibilities of Facilities and Engineering, IT, F&NS, EVS, Housing, and RD starting April 1st as the Director of Operations. I am excited to continue working with Jessica in her new role.

Construction Projects Update

Master Planning is on track for completion by the end of FYE 2024. Equipment planning and layout for Criteria Docs is ongoing. The Burney Fire Alarm project is progressing with duct detector scope approval and design underway for an estimated completion date of 4/22. Solar project construction start may be delayed until June due to transformer replacement, but completion is still expected by the end of December or January 2025. It has been confirmed by PG&E that expanding the scope to include another property would reset the application

process, resulting in a shift from NEM2.0 to NEM3.0 for the project. This change would decrease savings by around 60%, far exceeding the cost of replacing the transformer. The Fall River Acute MedGas construction is set to be completed in April, with Fall River Kitchen and Fall River Clinic projects scheduled for kickoff in May/June 2024. Various other projects and maintenance tasks are also in progress, such as firestopping/cable management, door repairs, Admin Building transformer relocation, and mobile clinic maintenance. Quotes are being obtained for miscellaneous arborist/vegetation management work on the grounds as well.

Priorities
The team is diligently focused on finalizing our FY24 Priorities while keeping an eye on the future. We have already met to establish the priorities for FY25. To ensure their alignment with our objectives, they will be further refined and adjusted over the next month to optimize our efforts.

Surgery
The initial week of surgeries following our reopening on March 11th was a success, and I am excited to see the ongoing expansion and progress within the department.

Compliance Team Accreditation
The Rural Health Clinic underwent its reaccreditation survey on Tuesday, March 19th with the Compliance Team. Kim and her team performed exceptionally well during the survey, leading to a successful outcome. I'm pleased to report that patient interviews with the surveyor were overwhelmingly positive, and the surveyor was impressed with our clinic and the quality of care we offer to our community.

Pit River Health
I signed a letter of support on behalf of MMHD to endorse a Partnership Health grant for Pit River Health's new Tribal Perinatal Health Program. I have also extended an invitation to their leadership to meet at the hospital to enhance our relationship and community support, which they have accepted. I am eager to engage with other community stakeholders to promote collaboration among partners for the benefit of our communities.

Improving Patient Satisfaction
We initiated our patient satisfaction enhancement project with the Executive Leadership Team to enhance patient satisfaction through a program focused on improving communication, referrals, medical records, and scheduling efficiency. This will involve implementing a care coordination team to enhance efficiency and provide individualized care, as well as introducing patient satisfaction surveys to monitor progress and promote ongoing improvement. The goal is to align this initiative with one of our 2025 strategic pillars.

Retention
We are currently adjusting our retention bonus program to include all employees, not just clinical employees. Our plan is to have the details of the program be completed by FYE24 with a one-year lookback to ensure alignment with when the other program was initiated.

Telemedicine Program Update as of March 6th, 2024
Respectfully submitted by Samantha Weidner for Ryan Harris, CEO and Kimberly Westlund, Clinic Manager

We have completed a total of 2,829 live video consults since August 2017 (start of program).

Endocrinology:

- Dr. Bhaduri saw 24 patients in February. She continues to be our most productive, consistent provider.
- We've had 991 consults since the start of this specialty in August 2017.

Nutrition:

- Jessica saw five nutrition patients in February.
- We've had 205 consults so far since we started this specialty in November 2017.

Psychiatry:

- Dr. Granese saw eight patients in February.
- We've had 699 consults since the beginning of the program in August 2017.

Infectious Disease:

- Dr. Siddiqui did not have any scheduled appointments in February but has 5 upcoming in March.
- We've had 118 consults since the start of this specialty in September 2017.

Neurology:

- Dr. Mandeville saw three patients in February. Currently, he is only able to see Partnership patients. We are still waiting for the completion of the CMS credentialing.
- We've had 464 consults since the start of the program in November 2018.

Rheumatology:

- Dr. Tang saw seven patients in February.
- We've had 120 consults since the start of the program in May 2020.

Nephrology:

- Dr. Bassila saw one patient in February.
- We've had 25 consults since the start of the program in April 2023.

Talk Therapy:

- We began talk therapy services with Ryan McNeel, LCSW in mid-April 2023. Currently he sees five patients a week and this service has been going well.

Cerner Update-

We recently discovered that the Telemedicine claims have not been processed correctly since going live with Cerner in September. The diagnosis codes are not dropping on the claims. Kimberly and I have been spending an hour each day manually adding in the diagnosis codes to each encounter. We have processed through November 2023 as of this morning.