MAYERS MEMORIAL
HEALTHCARE DISTRICT

Board of Directors
Regular Meeting Agenda
May 22, 2024 @ 1:00 PM
Mayers Memorial Healthcare District
Fall River Boardroom
43563 HWY 299 E
Fall River Mills, CA 96028

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 –April 24, 2024		***Attachment A***	**Action Item**	1 min.
4	**DEPARTMENT/QUARTERLY REPORTS/RECOGNITIONS:**					
	4.1	Resolution 2024.07 –April Employee of the Month		***Attachment B***	**Action Item**	2 min.
	4.2	Mayers Healthcare Foundation Quarterly	Val Lakey	***Attachment C***	Report	2 min.
	4.3	Acute	Moriah Padilla	***Attachment D***	Report	2 min.
	4.4	Emergency Department	Bridget Bernier	***Attachment E***	Report	2 min.
	4.5	Lab	Sophia Rosal	***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 April 2024 Financial Review, AP, AR and Acceptance of Financials			**Action Item**	5 min.
		5.1.3 Board Quarterly Finance Review			**Action Item**	2 min.

	5.1.4	I2i Population Health Cost Benefit Analysis	***Attachment G***	**Action Item**	5 min.
	5.1.5	FY25 Leadership Program	***Attachment H***	**Action Item**	5 min.
5.2	**Strategic Planning Committee –** No May Meeting.				
5.3	**Quality Committee**				
	5.3.1	May Quality Meeting Committee Report		Report	5 min.
6	**NEW BUSINESS**				
6.1	Policies & Procedures: Page # Policy Name 1-7 Abuse, Neglect, Exploitation and Misappropriation of Property 8-10 Albumin 11-15 Autoclave Control Testing and Maintenance 16-17 Communication-News Media Process-Plan 18-19 Disruption of Services; Fire and Disaster Health Records-SNF 20-23 Emergency and Critical Incident Plan 24-29 Evaluating Quality Control 30-50 Fire Safety Management Plan 51-60 Heat Illness 61-68 Hemoglobin A1C Assay 69-72 Hospice Patients Bill of Rights - Informed Consent MMH686 73-76 Imaging Contrast Policy 77-78 Infant Security 79-85 Infection Prevention Program Plan - LTC 86-124 Isolation Precautions 125 Notice to Patients MMH754 126 Requirements for Transmission-Based Isolation Precautions MMH758 127-130 Safety Emergency and Environment of Care Committee 131-140 Safety Management Plan 141 Shigella Process 142-144 Sliding Fee Discount Program 145-151 Slips, Trips and Falls Program 152-154 Swing Bed Patient Rights 155-157 Surgical Scope of Services		***Attachment I***	**Action Item**	5 min.
6.2	Community Needs Health Assessment		***Attachment J***	Discussion	5 min.
6.3	Board Member Elections: Resolution Calling for Election & Specification of the Election Order – Resolution 2024-08 DRAFT Attached		***Attachment K***	**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 L***		
	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**				

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	8.1	Board Member Message: Points to highlight in message	Discussion	2 min.
	8.2	Board Governance Tool Kit – Board Orientations	Discussion	5 min.
9	**MOVE INTO CLOSED SESSION**			
	9.1	Conference with legal counsel regarding pending litigation (§54956.9)	Discussion	10 min.
10	**RECONVENE OPEN SESSION**			
11	**ADJOURNMENT: Next Meeting June 26, 2024**			

Posted 05/17/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

Board of Directors
Regular Meeting
Minutes
April 24, 2024 – 1:00 pm
FR Boardroom & Microsoft Teams

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 – on the phone for medical reasons	Valerie Lakey, CPRO
ABSENT:	Keith Earnest, CCO
Jim Ferguson, Director	Libby Mee, CHRO
	Dana Hauge, Safety Officer
	Harold Swartz, Radiology
	Susan Garcia, FR Dietary
	Jen Taylor, Burney Dietary
	Jessica DeCoito, Board Clerk

2 CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS:

- Romy Saraquse: submitted online form to speak. Was not available during the meeting for further public comment.
- Bob May, Burney Fire District Chief: Community Center event held a couple of weeks ago. Occupancy of building for proper occupancy and fire inspection needs to be worked out. We need to work together and not be bad mouthed by staff for following the law.

3 APPROVAL OF MINUTES

3.1	A motion/second carried; Board of Directors accepted the minutes of March 24, 2024	***Cufaude, Utterback***	***Approved by All Cufaude - Y***

4 DEPARTMENT/OPERATIONS REPORTS/RECOGNITIONS

4.1	A motion/second carried; Rowan Dietle was recognized as March Employee of the Month. Resolution 2024-06. Rowan has been an amazing member of the team, working diligently on her long list of to do's for the marketing of this district. She has made some amazing marketing flyers and documents for our services and continues to provide outstanding work. She always has a smile on her face and willing to help out wherever help is needed. Thank you, Rowan for your dedication and smiling face!	***Utterback, Humphry***	***Approved by All Cufaude - Y***
4.4	Safety Quarterly: Director Utterback passed along thanks for the "Every 15 Minutes Program" that MMHD and Dana put into the program. Attending a cyber security training tomorrow with IT manager with region. It's going to be very interesting and enlightening. Great work so far on the ACHC work.		

	4.3	Lab: clarification on the goals was provided. There was some confusion about what to submit. Sophia will present at next month's meeting with her specific goals.		
	4.4	Radiology: One study away from completing CT certification.		
	4.5	Food & Nutrition Services: Provided some fun things for our staff to show them how much we appreciate them – goodies, food, bowling, etc. Building morale and approving better communication with the team. Received CDM certification – re-oriented and learned some new things. Attending a conference in Reno to network and learn about food & nutrition service professionals.		
5	**BOARD COMMITTEES**			
	5.1	**Finance Committee**		
		5.1.1 **Committee Report:** AR is up without receiving SNF payments – Partnership has changed their billing program and caused some backlog. A Swing Bed claim has been submitted and we should receive that money by May 10th. Access into DDE has been regranted after their cyber breach. Without these issues, Cerner's transition looks good. Rate increase of 6.5% with 1% increase in the years to come.		
		5.1.2 **March 2024 Financials**: motion moved, seconded and carried to approve financials.	***Utterback, Cufaude***	***Approved by All Cufaude - Y***
	5.2	**Strategic Planning Committee Chair Utterback:** No Meeting held in March		
	5.3	**Quality Committee:** Met on Monday, April 22nd. Discussion on the QIP Measures PY6. Unfortunately, we won't meet this mark due to multiple factors but one major one being not enough patients. We have met up and picked a list of measures we can meet and have buy in from providers and clinic staff to help monitor this. We have a mobile mammography unit coming in for the health fair and we will making sure our patients know of this service that also helps us work towards meeting measure requirements. I2i is a module in Cerner that scrubs our data for us, and we can see this data, analyze in real time to make adjustments in processes, to then help meet our measures for QIP payments.		
6	**NEW BUSINESS**			
	6.1	**Policy & Procedures Summary 4-1-2024**	***Cufaude, Humphry***	***Approved by All Cufaude - Y***
	6.2	**Policy & Procedures:** Medical Staff Bylaws: Article 10 Medical Staff Rules: Rule 1 Alkaline Phosphatase Automated LDL Cholesterol Core Privileges General Surgery Dental Care, Swing Bed Decontamination & Sterilization Discharge Planning Discharge Planning – Patient Choice Emergency Operations Plan 2024 Emergency Operations Plan – Communications Plan Emergency Operations Plan – Crisis Communication Employee Health Program Employee Health Program Appendix 1 Workers Compensation – Employee Injury Employee Injury Packet & Instructions Evacuation & Shelter in Place Plan Fatality Management – Mortuary Services High-Level Disinfection Immediate Use Steam Sterilization Invoking the 1135 Waiver Lockdown Procedures in an Emergency Plan Multi-Disciplinary Plan of Care	***Cufaude, Utterback***	***Approved by All Cufaude - Y***

Operating room Cleaning and Terminal Cleaning
Patient Care Plan – Interdisciplinary Guidelines
Patient Rights, Acute & Swing
Patient Rights Form – English & Spanish
Preparing, Assembling, Wrapping and the Distribution of Sterile Equipment
Restraint Log
Physical Restraint Record Form MMH250
Restraint Log MMH578
Security – Emergency Management Policy
Staff & Patient Tracking During an Emergency Situation
Swing Bed Patient Care Plan Multi-Disciplinary Guidelines
Swing Bed Social Services
Volunteers – Assigning Disaster Responsibilities to Volunteers

6.3	**ACHC Board Bylaws - Workshop** – Board Clerk to send out a date and time option for board workshop	
7	**ADMINISTRATIVE REPORTS**	
7.1	**Chief's Reports: written reports provided in packet**	
	7.1.1	**CFO:** New chart in the finance notes that looks at ER data.
	7.1.2	**CHRO:** Ashley is at the Career Fair in Klamath interacting with some Physical Therapists! Offer out with an NP to hopefully join our hospitalist rotation. Current number of applications for the open roles in HR is at 20. Enterprise Rent a Car would like to work with MMHD on a ride share program – another benefit for our employees that we are researching.
	7.1.3	**CPRO:** 1423 – Dahle: not great for MMHD. In committee today. It's ok for MMHD with the "opt-in" language. Seismic bill has had some updates with deleted language and further extensions through 2033 – Unions are not in favor but there is a lot of support from hospitals. TCCN – continue to work with the county and fire departments on what the proper occupancy for TCCN to hold a children's program will be. An Architect has been hired to do proper drawings and plans for getting the correct occupancy in the building for all of our programs.
	7.1.4	**CCO**: Physical Therapy numbers are trending in the right direction. We are still looking for an additional physical therapist. Mtn. Valley's is excited for our Radiology Manager to be CT Certified.
	7.1.5	**CNO**: Nursing is busy with lots of projects going on. Cerner LTC go live on May 13th. Lippincott is helping us with training/education. Ambulance department is fully staffed. We are working out the logistics with Modoc Medical Center to utilize open spaces in their CNA program for our students.
	7.1.6	**CEO:** Regional CEO meeting with Seneca, Modoc, Plumas, Surprise Valley, Eastern Plumas – looking to revive this partnership and collaboration, with a meeting planned in July. FY24 Priorities: turnover rate goal was less than 17.52% and that has been met with adjusted or unadjusted figures. ACHC Accreditation: we will probably not meet this deadline however, it is allowing us to address patient care and satisfaction, which is our biggest priority. As a group, we collectively feel that even if we take the whole calendar year to prepare for the application, our group wants to continue to work towards this accreditation for the accountability, visibility and overall quality patient care this process is providing us. We are meeting the Finance priority. We will not meet the priority for clinic visits. **FY25 Priorities:** submitted in the written report. Board supports the priorities. Hospital week is coming up and we are very excited for each activity planned on each day.
8	**OTHER INFORMATION/ANNOUNCEMENTS**	
8.1	Board Member Message: Employee of the Month, Upcoming Events: Health Fair & Golf Tourney, Hospital Week. Scholarships are open – submit by May 3rd. Surgery continues.	
8.2	Board Governance Tool Kit – Tour the hospital and annex.	
9	**MOVE INTO CLOSED SESSION**	
9.1	**Hearing (Health and Safety Code § 32155) – Medical Staff Credentials** Staff Status Change:	**Approved by All** **Cufuade - Y**

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Chuck Colas, DO – to Inactive
Saif Siddiqui, MD – to Inactive
Tikoes Blankenberg, MD – to Inactive
Frederic Jones, PhD – to Inactive

AHP Appointment:
Lewis Furber, NP (Pit River)

Medical Staff Appointment:
Dale Syverson, MD – General Surgery
Charles Westin, MD – Radiology
Alexander Vogel, MD – Radiology
Sanford Smoot, MD – Radiology
Masood Siddiqui, DO – Radiology
Shree Shah, MD – Radiology
Dishant Shah, MD – Radiology
Faranak Sadri-Tafazoli, MD – Radiology
Avez Rizvi, MD – Radiology
William Randazzo, MD – Radiology
Teppe Popovich, MD – Radiology
William Phillips, MD – Radiology
Benjamin Park, DO – Radiology
Ellen Johnson, MD – Radiology
Miriam Hulkower, MD – Radiology
James Haug, DO – Radiology
Mark Harshany, MD – Radiology
Jeffrey Grossman, MD – Radiology
Kenneth Edgar, MD – Radiology
Lillian Cavin, MD – Radiology
Courtney Carter, MD – Radiology
Dennis Burton, MD – Radiology
James Brull, DO – Radiology
John Boardman, MD – Radiology
Michael Bevern, MD – Radiology
Robert Berger, MD – Radiology
Troy Belle, MD – Radiology
David Bass, MD – Radiology
Daniel Baker, MD – Radiology
Asif Anwar, MD – Radiology
John Anderson, DO – Radiology
Sandeep Amesur, MD – Radiology
Batook Hussain, MD (UCD) - Neurology

10	**RECONVENE OPEN SESSION**
11	**ADJOURNMENT: 4:04 PM**

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

_____ _____

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Board Member

Board Clerk

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RESOLUTION NO. 2024-07

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

Karen Mayer

As April 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, Karen Mayer is hereby named Mayers Memorial Healthcare District Employee of the Month for April 2024; and

DULY PASSED AND ADOPTED this 22nd day of May 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

MHF

MAYERS HEALTHCARE FOUNDATION

Report to the MMHD Board
May 2024 Regular Board Meeting

Events:

Health Fair – The Mayers Healthcare Foundation Health & Wellness Fair is scheduled for Saturday, June 22, 2024 at the Inter-Mountain Fairgrounds in McArthur. The event will utilize a lot of outdoor space and the Flower Building for the lab draws. We will have the mobile clinic on-site to do sports physicals. We are very excited to announce that there will be a mobile mammography unit at the event as well. The Tri County Community Network Kid Fit Summer Program will kick off at the event with a children's color run. We will once again host the 5K Run/Walk for all ages. Letters have been sent out to community partners and we are very excited about this event.

Golf Tournament – Mark your calendars for August 3, 2024. We are working on preparation for the annual event and will be looking for guidance on what we want the proceeds to benefit.

2nd Annual Gala – Mark your calendars for January 25, 2025.

Thrift Store Update: The Thrift Store continues to do very well under the direction of our volunteers. Many, many hours have been put in by this group to sort inventory and operate the store. Revenues have been improving and the stores is a very busy place! We are excited to announce that we just received notification that we were approved for the Burney Community Fund Grant! This grant will allow the Thrift Store to purchase a Point of Sale and inventory system, get a new road sign and much needed display and storage items.

Volunteers: We will be making a few adjustments with managing the volunteers. MHF staff will now be working on the logistics of the volunteers and MMHD HR staff will continue to handle the compliance piece. We are excited to have recently gained one new volunteer for the Thrift Store.

Awards and Scholarships: Information and applications for the scholarship cycle has been sent out. Both community and internal scholarship cycles received through May 3, 2024. The MHF Board increased the scholarship budget to $20,000 this year and approved doing two award cycles in the budget year. The Scholarship committee met and has awarded $12,500 for the first round including scholarships to three MMHD employees. The remaining $7500 will be awarded in the second application cycle.

MEG (Mayers Employee Giving): The MEG Committee met on April 3 and is happy to announce MEG Department Awards! Thanks to the generosity of thirteen incredible members of

our team who contributed to the Mayers Employee Giving (MEG) fund through payroll deductions over the last year, we have been empowered to make a significant impact on our hospital departments. I am delighted to announce that MEG has decided to award a **total of $11,000** to several hospital departments. This funding will support initiatives in the ***Activities Department, Outpatient Medical, Surgery, Cardiac Rehabilitation, and Clinical Education***. These departments play crucial roles in delivering exceptional care to our patients and advancing our mission of providing quality healthcare services to our community.

It is truly inspiring to see the collective impact of our contributions and the meaningful difference we can make when we come together as a team. Your generosity and dedication to giving back to our hospital are commendable, and I want to express my heartfelt gratitude to each and every one who participated in the MEG fund.

As contributors to the MEG fund, those involved are privileged with the opportunity to decide how these funds will be allocated. From the input and insights of the committee, their decisions help shape the projects and initiatives that receive support, further demonstrating our commitment to enhancing patient care and advancing our hospital's mission.
I am incredibly proud to be part of such a compassionate and generous team.

Additionally, we just launched the Power of 2 Campaign. (See additional attachment)

Finance Pillar

Executive Leader: Theresa Overton, CNO
Director or Manager: Moriah Padilla
Department: Acute Care

Last Updated: 05/08/2024

FY24 (July 1, 2023 - June 30, 2024)	Specific Plan & Estimated Completion Date	Driver	Current Actions
Priority:			
Standardize clinical documentation process to capture a 5% increase in patient charges.	Establish Baseline	Moriah	Obtained FY23 ER Charge data from Travis Lakey. 28,556 total number of charges 13720515 total amount charged
	Establish Process through Cerner for clinical documentation and educate to nursing staff	Moriah Moriah Jed/ Jennie	July: Collaborated with Cerner team to ensure proper charges for department are updated August 7-17th: Validated all charges, communicated issues with Cerner team, completed IT2 August: Completed end user training and included clinical documentation process and education for obtaining charges August: Completed 6 weeks of education to all staff (RN, CAN, WC) that will be working within Cerner. Included charge review and education documentation changes. 10/24: Acute staff meeting to provide additional education/ expectation of reviewing charges
			September: Go live
	Audit accounts and reports for discrepancies	Moriah	Daily Charge Reconciliation Call completed 09/18-10/4. Pulled CDM stats report to compare captured data with charges posted on patient account. Review charges to ensure applicable, appropriateness. Compare to historical data. Communicated several missed charges throughout timespan with Danielle and Cerner team. Super Users for med/surg reviewing charges daily. October - December: Pulled daily charge reconciliation reports. Looked for inappropriate/missed charges. Worked with Bridget/Danielle to rectify issues. Those unable to rectify internal, SR tickets created. As noted below.

			Jan- Present: RCAT Follow Up meeting every Thursday to discuss issues in a collaborative effort. Jan - Present: DNFB report provided by Travis twice a week. Charts reviewed, issues corrected, and appropriate education streamlined as needed.
	Collaborate with Cerner and MMHD team to rectify billing/charges issues.	Moriah SR Ticket 452123905	10/25: Q2Hr Time Generation Error, not allowing proper of specimen collection, not dropping charges. Resolved 01/29/24
		Moriah SR Ticket 453586055	01/29: Not Syncing, charge not dropping. Resolved 01/30/24 10/26: RCAT Committee Meeting to discuss top areas of concern.
		Moriah SR Ticket 4544018665	02/23/24: PSO stop date/time does not align with discharge order. Charges not dropping. Resolved 05/01/24 04/16/2024: Hospitalist placed all Swing bed PSO's on Acute charts. This changed admission times and became additional FINS on this SR ticket. Several accounts added to DNFB due to inability to bill. These orders changed the acute accounts to swing, causing inaccurate bill rates. Included this with this SR ticket, as we were able to discuss via phone on 05/01/24 with Cerner representative on how to rectify these charts.
		Moriah SR Ticket 454410350	01/24/24: Lack of PSO order ability to backdate. The PSO order drops room/board charges. When a provider does not enter this order, you cannot backdate it past 3 days. Cerner closed ticket 2/4/24, stating a global change request needed to be created. They provided no feedback on how to rectify the lack of room/board charges dropping. 2/6/24: Contacted Plumas District Hospital for guidance and was provided education from their Senior Clinical Informatics Specialists on alternative order to allow room/board charges to drop appropriately. This order is called an adjustment inpatient order. 2/6: Email and Education to ward clerks to complete audits at admission for PSO orders and to escalate to leadership team if noted. March - May: Random Chart Audits by Moriah for presence of PSO orders March - May: Emails to providers for accounts on DNFB or noted through audits as having missing orders. Provided full instructions for resolution. See attached.
		Moriah SR Ticket 454890762	04/23/24: Unable to discharge when adjustment order is placed due to lack of PSO order.

			05/06/24: Per Cerner, unable to resolve on tech side. Will be escalating ticket internally.

Priority Ideas for Next Year			

Quality / Service Pillar

Executive Leader: Theresa Overton, CNO
Director or Manager: Moriah Padilla, DON
Department: Acute Care

Last Updated: 05/07/2024

FY24 (July 1, 2023 - June 30, 2024)	Specific Plan & Estimated Completion Date	Driver	Current Actions
Priority:	**Swing Bed Basics for Critical Access Hospitals**		
Complete 100% of the Swing Bed Basics for CAH's and Swing Bed and Beyond through HealthTech (12, 1-hour self paced classes) to enhance our current program to meet ACHC guidelines.	**Class Introduction:**	Moriah Padilla	8/31/23: Initiation of class and introductory assignments
	Module 1: History and Regulation	Moriah Padilla	9/14/23: Completion of Module 1 (Swing Bed History and Regulatory Requirements). Downloaded provided resources, reviewed video presentation, and participated in discussion board. 10/02/2023: Started Module 2 (Swing Bed Criteria and Pre-Admission). 10/02/2023: Scheduled meeting with Marinda on 10/4 to discuss current process for admissions criteria and develop plan for improving our process to meet CMS/ACHC.
	Module 2: Pre-Admission Criteria	Moriah Padilla	10/04/2023: Met with Marinda to discuss below topics, establish work plan. Emailed policy example to Pam Sweet for revision. Reviewed ACHC Manual.
	Swing Bed Pre-Admission Checklist		Pre-admissions checklist: Marinda to adapt our old checklist with HealthTech example to meet the needs of our organization. Implementation Plan: Marinda will complete these with each internal packet to ensure each patient meets eligibility and will include the checklist with the admissions packet provided to Acute Care and uploaded for documentation purposes.
	Admission Criteria & Policy		Pre-admission Criteria Document for local agencies: Marinda to utilize HealthTech example to meet needs of our organization. Discussed plan for local networking and meeting of case management in surrounding hospitals to build understanding of program and work on relationships. 01/16/2024: Document created by Public Relations.

			Policy Revision: Reviewed ACHC manual and utilized HealthTech example to create up to date policy. Completed and submitted to P&P on 10/05/2023.
	Post Acute Services		Post Acute Services Option: IT ticket placed to have CMS links for post acute service options available. Implementation Plan: Marinda to utilize iPad to discuss options and receive patient choice.
	Provider Choice		Post Acute Provider Choice: Completed audit of current swing bed charts to see if post acute provider option is present in documentation. Audit suggests need for process change, education, and re-audit.
	Module 3: Admission Process	Moriah Padilla	10/05/2023: Completion of modules, reviewal of internal admission policies, collaboration with team to identify current processes. 10/06/23: Policy Conversion 12/26/23: Educational Handout/Tool being created to help aid in ensuring we are documenting to the standards of care. Completed Assignment.
	Module 4: Multi Disciplinary POC	Moriah Padilla	10/23/23: Completion of Modules, review of internal policy and procedure, collaboration with team to streamline process 12/23/23: Policy completed and uploaded in MCN March 2023: Several discussions with UR to improve IDT and documentation. Jenna identified appropriate form for documentation within Cerner system. 3/27/24: Jenna emailed new expectations of documentations with instructions to all IDT care team members.
	Module 5: Continuing Care	Moriah Padilla	11/17/2023: Completion of Modules, review of internal policy and procedure, and assignment work. 12/26/23: Completed Policy for Abuse, Neglect, Exploitation, and Misappropriation of Property and uploaded to MCN 12/26/23: completed Policy for Nutritional Care and uploaded to MCN. 12/26/23: Completed Policy for Dental Care and uploaded to MCN. Retired several old policies. 12/26/23: Completed Policy for Social Services.
	Module 6: Discharges	Moriah Padilla	11/17/2023: Completion of Modules, review of internal policy and procedure, and assignment work. 12/26/26: Policy Completed and uploaded to MCN. 02/23/24: Added Pt Centered Discharge Planning in Acute Care to Relias annual re-orientation

Completed 12 modules and all associated coursework to obtain (2) certifications of completion. Revised, updated, and/or added 22 policies to align the Swingbed Program with ACHC and CMS guidelines.

Swing Bed Beyond Basics for Critical Access Hospitals		
Class Introductions		11/22/23: Initiation of class and introductory assignments
Module 1: Navigating Appendix PP		11/22/23: Completion of Modules 12/26/23: Course Assignments and Policy Review
Module 2: Culturally Competent Trauma Informed Care		02/23/24: Completed Module and associated course assignments. 02/23/24: Assigned Trauma Informed Care and Cultural Competence Modules to all RN's on Acute Care and included in yearly training
Module 3: Swing Bed Performance Measures and Reducing Re-admissions		02/23/24: Completed Module, viewed associated videos assigned, and completed discussion work. 3/18/24: Course responses/follow up
Module 4:		3/15/24: Video completed 5/7/24: Policy Requirements Confirmed - see attached 3/18: Course assignment completed
Module 5: Engaging the Team		3/25: Completed Module/ Created MMHD Roles & Responsibilities template 3/26: Discussion with Director of Quality, Jack, about Swing bed Coordinator, Case Manager, and future projects of organization that may align with program needs. 4/27: Emailed example and MMHD template to Jack and Theresa as plan to improve our care management coordination
Module 6: Strategies for Growth		3/29: Module Assignment completed, SWOT completed, Discussion thread completed. Course Completed and finalized!

Priority Ideas for Next Year			
Implement changes to discharge process policy and capture 100% of post acute care choice.			

Finance Pillar

Executive Leader: Theresa Overton, CNO
Director or Manager: Bridget Bernier, Emergency Room Manager
Department: Emergency Department

Last Updated: 04/30/2024

FY24 (July 1, 2023 - June 30, 2024)	Specific Plan & Estimated Completion Date	Driver	Current Actions
Priority:			
5% decrease in the amount of missed or late charges entered by ED nurse or ED techs as evidenced by a decrease in DNFB totals.	Establish a baseline	Bridget	11/19 Assumed the role of Emergency Department Manager, since go live with Cerner have identified several issues with CPT codes and order builds.
			11/19 Utilized the information from Cerner to create a quick reference guide to assist ED staff in appropriately completing ED Tech fees in Cerner.
			11/22 Post conversion call with Cerner to streamline ED Tech fees- Frequently used category added for ease of charging for most common procedures. Added several CPT codes that were not available in the ED Tech View as well as removed some that were not relevant.
			11/28 SR #452673440 Nebulizer added to ED tech fees for use on off shifts and weekends when Respiratory is not in the building. Ticket resolved
			12/5 SR # 452740770 Facility charge ticket and IV stop times not calculating appropriately on all ED patients.
			12/13 Internal RCAT kickoff meeting- completing daily reconciliations of department charges, reviewing discrepancies with Danielle
			12/18 AMA patients cleared all charges for the encounter. Worked directly with Cerner associate to correct this issue.
			1/10 First Staff Meeting as Nurse Manager. Discussed ways to educate and implement better processes on tech charges.
			1/30 Wipfli optimization meeting
			1/31 Meeting with Cerner Solution lead regarding unresolved ticket for Facility charge ticket and IV stop times. Issue resolved during the call, as well as reoptimized the frequently used category based on feedback from the staff.
			2/1 SR# 453660158 Foley catheter not populating a charge in Cerner. Ticket resolved
	DNFB Baseline		2/5 RCAT meeting to include DNFB- Late charges for the ED 7408.00. Plan of correction for late charges- shift to shift chart checks.
			2/21 Monthly staff meeting- More input and training completed on workflow for ED Tech fee charging. First draft of chart checks for review.
			3/13 Monthly staff meeting- pointed education on ED Tech fee charging. Final draft of shift to shift chart check form approved by staff.
			3/18 Chart check instituted. Forms placed on every patient chart by admitting. First chart check completed by the nurse caring for the patient second check completed by the following shift.
			3/18 -4/18 Audits completed. SR#s 453430623, 454870719, 455090225, 4548702252 to correct CPT code errors in changes and naming.
			4/10 Monthly staff meeting- Pointed education on matching ED Tech fees to the Pro Fees to complete the charges for each procedure. Encouraged staff to fix the missing charges at time of recognition to decrease the amount of late charges.
	Captured corrections prior to billed chart		4/18 - 5/14 Audits completed- $8477. 00 in fixed charges that did not result in late charges.
	May DNFB improvements		5/9 DNFB ED late charges $ 758.17. Audit completed and only $113.00 was and ED related charge.
			After implementing the chart corrections, our late charge errors decreased by approximately 14.43%. This exceeds the target of a 5% reduction, indicating a substantial improvement in our accuracy in capturing charges before they become late.

Quality Service Pillar

Executive Leader: Theresa Overton, CNO

Director or Manager: Bridget Bernier, Emergency Department Manager

Department: Emergency Department

Last Updated: 06/29/23

FY24 (July 1, 2023 - June 30, 2024)	Specific Plan & Estimated Completion Date	Driver	Current Actions
Priority:			
Decrease in ligature risk to all ED patients as evidenced by 100% completion of SI/HI risk in triage.	Baseline		Created audit on paragon account for August 2023. See attachement
			Reviewed ACHC and CMS standard for ligature risk assessment and initiatiing standard of care
			12/12/23 Ordered paper scrubs for all 5150 and 1799 holds in the Emergency department to reduce ligature risk from hospital gown.
			1/2/24 Paper Scrubs arrived and were placed in ED supply room.
			1/10/24 ED staff meeting education provided on new supply item - paper scrubs. Indications for use discussed. As well as current process for completing safety checks of all 5150 holds in the ED.
			2/23/24 Email to Cindy Segar-Miller for clarification of ACHC appropriate documentation of suicide risk assessment. Current process meets guidelines.
	Complete full ligature risk assessment to involve Maintanence and Risk Manangement.		5/14/24 Email sent to Dana and Alex with ACHC standards with estimated completion date of 06/15/24
	100% completion of physical restraint skills cometency for all ED staff		Tracking list completed by 6/15/24
	Pointed education to all ED staff on Cerner specific documentation of all 5150 and 1799 hold patients in the Emergency Department		Scheduled for next ED staff meeting
			11/19/23- 5/14/24 Chart Audit- 100% of all ED patients have a suicidal risk assessment completed in triage

MAYERS MEMORIAL HEALTHCARE DISTRICT

People Pillar

Executive Leader: Keith Earnest, CCO
Director or Manager: Sophia Lou Rosal, CLS
Department: Laboratory

Last Updated: 05/08/2024

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**
Accomplish ACHC acrreditation while meeting all deliverables while updating policies and procedures before June 2024	**40%**		Review and revise old policies and procedures. Create new policies and procedures for microbiology, chemistry, serology and accessioning/phlebotomy. 100% completion time will be 3rd quarter of year 2024.	Sophia	Reviewed and revised blood bank and general policies and procedures. Created new policies and procedure in Chemistry, serology, hematology and blood banking. Microbiology and other policies in the laboratory are still on process. 80% of the policies and procedures was submitted to Ms. Pam for review and approval by the committee.	80%	
Every lab employee to complete at least one hour of outside training in a relevant are by June 30, 2024.	**20%**		Employee need to have an access to medialab for continuing education and one CLS will be send to onsite training each year.	Sophia	Created account in Medial Lab and American Proficiency Institute to access the continuing education. Joven is set to go for training in New York in August for Siemens Dimension EXL advance trouble shooting of analyzer. Expenses that may incur will be paid by the Vendor.	100%	
Ensure all laboratory equipment is certified and create a comprehensive inventory documenting the remainign useful life of each machine by June 2024.	**40%**		Request Annual preventive maintenance service agreement for each analyzer. Included to this agreement is unexpected maintance service during analyzer breakdown and malfuntion.	Sophia	Requested Annual Preventive Maintenance service agreement contract signed by Keith and Christopher. PO created by Purchasing department. All service agreement is for renewal every year. Life span of each analyzer depends on the customer's decision or until analyzer is down and unable to used. It is also the customer's discretion when the analyzers will be upgraded based on the Vendor's recommendation. Shifting to another Vendor is acceptable if the services or contract of the previous vendor didn't met the expectations of the customer.	100%	
					Siemens Exl - 2022, Cs2500 - 2020, Sysmex - 2020, Vitek - 2021, Bactec alert - 2021, Biofire - 2020, Triage, Clinitek Minicube, Medtox & Sofia analyzer no records,		

Cost-Benefit Analysis and Board Report on Implementing i2i for DHCS QIP Program

Background

Implementing the i2i Population Health platform has demonstrated significant improvements in quality scores and financial returns for various hospitals, including Franciscan Healthcare and Mammoth Hospital. These improvements are crucial for effectively managing population health and enhancing reimbursement performances under programs like the DHCS QIP (Quality Incentive Program).

Cost Analysis

Initial Costs: Costs include software licensing, implementation, and training. For example, Mayers Memorial Hospital had an initial outlay of $10,652 in fees, with recurring costs of $8,551 monthly [oai_citation:1,Mayers Memorial HD_i2i_Ordering Document_4.29.24.pdf](file-service://file-YQ0Frnsx4yE2Fm4HzRiQazHi).

Operational Costs: Ongoing operational costs involve data integration and system maintenance. Oracle provides implementation services, which might range from $1,500 for estimated expenses to more for comprehensive integration and support [oai_citation:2,Mayers Memorial HD_i2i_Ordering Document_4.29.24.pdf](file-service://file-YQ0Frnsx4yE2Fm4HzRiQazHi).

Benefit Analysis

Quality and Efficiency: Hospitals have reported significant time savings (e.g., 3,016 to 6,032 hours saved at Mammoth Hospital), reduced errors, and improved workflow efficiency through automated data handling and real-time analytics [oai_citation:3,Case_Study_i2i_Mammoth Hospital.pdf](file-service://file-2EDUBZnfWImKGHY2v7glbwfR).

Financial Returns: Enhanced QIP performance leads to higher reimbursements. Mammoth Hospital, for instance, generated over $2 million in new quality revenue and labor savings within two years of i2i implementation [oai_citation:4,Case_Study_i2i_Mammoth Hospital.pdf](file-service://file-2EDUBZnfWImKGHY2v7glbwfR).

Compliance and Reporting: i2i simplifies compliance with state and federal health reporting requirements, reducing manual efforts and associated costs [oai_citation:5,2024_04_08_MAYE_CA_i2i_Overview.pdf](file-service://file-LPTuVL6ae5TaniJoWs7x32Iy).

Grants and Funding: Improved data management capabilities aid in successfully applying for health-related grants, as seen with Franciscan Healthcare securing a hypertension grant [oai_citation:6,Case_Study_i2i_Franciscan Healthcare.pdf](file-service://file-d1haQIFr2BoPe7bm4yoJYf9C).

Likelihood of Success

Considering the evidence from existing implementations, the likelihood of success for enhancing DHCS QIP performance after adopting i2i is high. The platform has consistently shown its ability to improve quality measures, streamline operations, and increase financial gains.

Conclusion

Implementing the i2i Population Health platform offers significant benefits that outweigh the costs, particularly in the context of improving performance in programs like DHCS QIP. The platform's capability to integrate with existing EHR systems, its ease of use, and its robust support for quality management make it a worthwhile investment for enhancing healthcare quality and operational efficiency. Given the substantial improvements reported by similar healthcare institutions, moving forward with i2i is recommended to achieve similar successes in quality improvement and financial performance.

ORACLE

Ordering Document

CPQ-3416524

Mayers Memorial Hospital District
43563 State Highway 299 East
FALL RIVER MILLS CA, 96028
US

Contact
Ryan Harris
5303365511
rharris@mayersmemorial.com

Oracle America, Inc.
500 Oracle Parkway
Redwood Shores, CA
94065

Fee Summary

Fee Description	Net Fees	Monthly Fees	Annual Fees
Professional Services -- Estimated Expenses	1,500.00	0.00	0.00
Recurring Services	0.00	8,551.00	0.00
Professional Services -- Fixed Price	9,152.00	0.00	0.00
Total Fees	**10,652.00**	**8,551.00**	**0.00**

Billing Frequency

Description	% of Total Due	Payment Due
Professional Services - Estimated Expenses	100%	Monthly in arrears
Professional Services - Fixed Price	100%	Upon order execution
Recurring Services	100%	Quarterly in arrears, beginning when access issued

Ordered Items

Professional Services

Professional Services -- Estimated Expenses

Part Number	Description	Estimated Fees
B102173	**Oracle Health Travel and Expenses for Commercial Estimate - Each**	**1,500.00**
	Subtotal	**1,500.00**

Recurring Services

Part Number	Description	Term	Pass-Through Code	Quantity	Unit Net Price	Extended Monthly Fees
B101650	**i2iLinks - Interface** [Mfg Part Num: LINKS]	**111 mo**	**3rd Party**	**1**	**1,495.00**	**1,495.00**
B101651	**i2i PRiZiM (Up To Quantity) - Covered Lives** [Mfg Part Num: PRIZIM]	**111 mo**	**3rd Party**	**7,500**	**0.33**	**2,500.00**
B101652	**i2iTracks (Up To Quantity) - Covered Lives** [Mfg Part Num: TRACKS]	**111 mo**	**3rd Party**	**7,500**	**0.61**	**4,556.00**
					Subtotal	**8,551.00**

Professional Services -- Fixed Price

Part Number	Description	Service Descriptions	Pass-Through Code	Net Fees
B104249	**i2i Implementation - Client** [Mfg Part Num: IMPLEMENTATION]	**Attached**	**3rd Party**	**0.00**
B107551	**i2i Integration**	**Attached**	**--**	**9,152.00**
			Subtotal	**9,152.00**

Permitted Facilities

Name	Street Address	City
Mayers Memorial Hospital District	**43563 State Highway 299 East**	**FALL RIVER MILLS, CA, 96028 US**

A. Terms of Your Order

1. Applicable Agreement

a. This order incorporates by reference the terms of the Cerner Business Agreement LA-0000055438 and all amendments and addenda thereto (the "Agreement"). The defined terms in the Agreement shall have the same meaning in this order unless otherwise specified herein.

Oracle America, Inc. is acting as ordering and invoicing agent for Cerner Corporation. Your order remains between You and Cerner Corporation. All references to "Oracle", "we", "us", or "our" shall refer to Cerner Corporation. We may refer to Client as "You".

2. Fees and Payments

a. Listed above is a summary of net fees due under this order. All fees on this order are in US Dollars.

b. Fees will be invoiced in accordance with the Billing Frequency table above.

c. Oracle may increase the monthly fee for each Ordered Item identified as Licensed Software Support, Equipment support, Sublicensed Software support, Recurring Services, Transaction Services, Professional Services -- Recurring, Application Management Services, and Managed Services in the table(s) above any time following the initial 12 month term after such recurring service fees begin (but not more frequently than once in any 12 month period) by giving You 60 days prior notice of the price increase. The amount of such annual increase will equal 8%. Oracle may also increase the fees at any time during the term if an Oracle third party increases the fees to be paid by Oracle, with such increase being limited to the amount of increase in Oracle's fee to the third party.

d. You agree to pay any sales, value-added or other similar taxes imposed by applicable law that Oracle must pay based on the items You ordered, except for taxes based on Oracle's income.

e. Once placed, Your order shall be non-cancelable and the sums paid nonrefundable, except as provided in the Agreement and this order.

3. Terms Applicable to Ordered Items

a. **Scope of Use.**

You will use the Ordered Items in this order in accordance with the Documentation and subject to the quantity of the item specified in the Ordered Items table(s) above. This order incorporates by reference the scope of use metric, definition, and any rules applicable to the Ordered Item as described in the Oracle Health Definitions and Rules Booklet v031524 which may be viewed at http://www.oracle.com/contracts on the Oracle Health tab.

If the quantity of an Ordered Item is exceeded, You agree to execute a new order setting forth the additional quantity of the item.

Where applicable, scope of use will be measured periodically by Oracle's system tools, or, for metrics that cannot be measured by system tools or obtained through industry available reporting sources (e.g., FTEs or locations), You will provide the relevant information (including records to verify the information) to Oracle at least once per year. You agree that if an event occurs that will affect Your scope of use (such as the acquisition of a new hospital or other new facility), You will notify Oracle in writing of such event no later than 30 days following the effective date of such event so that Your scope of use can be reviewed. Any additional fees due under this section will be payable within 30 days following Your receipt of an invoice for such fees. Any additional monthly fees will begin on the date the limit was exceeded and shall be paid annually (pro-rated for any partial month).

b. **Solution Descriptions.**

Solution Descriptions applicable to each Ordered Item identified as Licensed Software, Recurring Services or Transaction Services in the table(s) above are available on http://www.oracle.com/contracts on the Oracle Health tab. The Solution Description is identifiable by the Part Number in the table(s) above. These Solution Descriptions are incorporated into this order by reference.

c. **Third-Party Products and Services and Pass-Through Provisions.**

Certain products and services are provided by third-party suppliers (the "Third-Party Offerings"). Third-Party Offerings You have ordered, if any, are identified with pass-through code(s) in the Ordered Items table(s) above and will be provided under the applicable terms required by the third-party supplier. Applicable pass-through terms for each supplier are available at http://www.oracle.com/contracts on the Oracle Health tab and are incorporated into this order by reference.

Oracle is not liable under this order for any damages of any kind or nature related to or arising out of the Third-Party Offerings. Oracle does not warrant or provide any indemnities on Third-Party Offerings. To the extent that any third-party pass-through provisions contain liability limitations with respect to the Third-Party Offerings, such limitations state the total maximum liability of Oracle (and then only to the extent that Oracle can collect from supplier for Your benefit) and each supplier with respect to the Third-Party Offerings.

d. **Shared Computing Services.**

You understand that Oracle may deliver the products and services on this order in a Shared Computing Services model. The policies that govern the Shared Computing Services model are available at http://www.oracle.com/contracts on the Oracle Health tab and are incorporated into this order by reference.

e. **Permitted Facilities.**

The Ordered Items in this order are for use by the facilities listed in the Permitted Facilities table(s) above. You may add or substitute Permitted Facilities by amending this order.

4. Recurring Services

a. Unless otherwise set forth herein, all Ordered Items identified as Recurring Services in the table(s) above begin on the date that You are issued access that enables You to activate Your Service.

5. Professional Services

a. **Oracle Health Professional Services Delivery Policies.**

The Oracle Health Professional Services Delivery Policies ("Health PSDP") available at http://oracle.com/contracts on the Oracle Health tab apply to and are incorporated into this order.

b. **Service Descriptions.**

Service Descriptions applicable to each Ordered Item identified as Professional Services in the table(s) above may be found (i) at http://www.oracle.com/contracts on the Oracle Health Tab (where identified as "Online" in the Professional Services table(s)), or (ii) as an attachment to this order (where identified as "Attached" in the Professional Services table(s)). These Service Descriptions are incorporated into this order by reference.

c. **Estimated Fees.**

Fees for Professional Services identified in this order as "Professional Services -- Time and Materials" and "Professional Services -- Estimated Expenses" are estimates intended only to be for Your budgeting and Oracle's resource scheduling purposes and may exceed the estimated totals; these estimates do not include taxes. For Professional Services performed on a time and materials (T&M) basis, You shall pay Oracle for all of the time spent performing such services at the rate specified in the Items Ordered table(s) above, plus materials, taxes and expenses. Actual expenses shall be invoiced as incurred, in accordance with the Billing Frequency table. Once fees for Professional Services reach the estimate and upon amendment to this order, Oracle will cooperate with You to provide continuing Professional Services on a T&M basis.

d. As required by U.S. Department of Labor regulations (20 CRF 655.734), You will allow Oracle to post a notice regarding Oracle H-1B employee(s) at the work site prior to the employee's arrival on site.

6. Order of Precedence

a. In the event of inconsistencies between the terms contained in this order and the Agreement, this order shall take precedence. This order will control over the terms contained in any purchase order.

7. Effective Date

a. If accepting this order electronically, the effective date of this order is the date You click to accept the order. If accepting this order via E-sign, the effective date of this order is the date You adopt and sign. If accepting this order via Download and Sign, the effective date is the date You return the document to Oracle. Otherwise, the effective date is the last signed date stated below.

8. Offer Validity

a. This offer is valid through 31-May-2024 and shall become binding upon execution by You and acceptance by Oracle.

Mayers Memorial Hospital District		Oracle America, Inc.	
Signature		Signature	
Name		Name	
Title		Title	
Signature Date		Signature Date	

i2i Implementation – Client

Part #: B104249
Oracle Health Legacy Part #: IMPLEMENTATION

Supplier Responsibilities	• Design project plan for implementing solutions and services purchased • Perform interface build of disparate systems to supplier solutions (typically, electronic health record (EHR) and practice management (PM) systems). • Perform data integration of source systems (EMR/PM) to supplier solutions. • Configure supplier solutions based on agreed-upon functionality purchased. • Provide go-live training (typically 2-3 days onsite) and ongoing support after launch.

Project	• Supplier project manager will perform a technical readiness assessment (TRA) which is a standard review of client's technical platforms and data sources prior to implementation kickoff. • Project is complete on approval by the Oracle Health monitor. • On average the implementation services take 90-120 days. • On average the implementation services effort is approximately 200-225 labor hours total. • Remote performance will take place at 377 Riverside Drive, #300, Franklin, TN 37064, and at the Client sites as needed.

i2i Integration

Part #: B107551
Cerner Legacy Part #: i2i-90500

Description of Services	Oracle will provide the following Services: • Assist You in achieving project readiness for strategy and solution implementation • Manage and leverage project plan for events and activities associated to implementation • Guide You through design decisions impacting features and workflows • Assist with domain strategy and deployment delivery • Configure extract monitoring within Your environment to support operations • Configure the electronic health record (EHR) extract for one (1) production domain
Your Cooperation / Obligations	You are responsible for the following obligations: • Identify the value objectives that the implementation is supporting • Establish communication plan and deployment strategy • Ensure governance support • Ensure resource availability and experience for design, training, and implementation that aligns with each proposed use case; department-required resources include clinical application analyst, information technology analyst, and project manager • Provide end user activation support for workflows • Localize and deliver necessary end-user training materials, as needed
Assumptions	• Deliverables: o Historical EHR extract delivered to *i2i* o Daily EHR extract delivered to *i2i* • You and Oracle will work on this project concurrently on an agreed upon project timeline. • You shall incur additional fees if services are requested beyond this scope. • Contracting is in place through a value-added reseller agreement or other business relationship with a third-party partner and health system client. • This scope includes assistance for integration of validated *i2i* EHR extract. Any custom integration that sits outside of validation is not supported in this scope of work. • Number of domains: One (1) production • Oracle will provide eight (8) hours of conversion support.

Bill To / Ship To Contact Information

Bill To Contact

Customer Name	Customer Address	Contact Name / Phone / Email
Mayers Memorial Hospital District	43563 State Highway 299 East FALL RIVER MILLS, CA, US 96028	Ryan Harris 5303365511 rharris@mayersmemorial.com

Ship To Contact

Customer Name	Customer Address	Contact Name / Phone / Email
Mayers Memorial Hospital District	43563 State Highway 299 East FALL RIVER MILLS, CA, US 96028	Ryan Harris 5303365511 rharris@mayersmemorial.com

Mayers Memorial Healthcare District

Fall River Mills, CA

Introduction to i2i
April 8, 2024

Matt West
VP Population Health Solutions

Ian Farquhar
Product Solution Consultant

We are i2i Population Health.

We are a population health technology company.

Integrating and aggregating all types of data is our strength.

Creating innovative apps that improve quality and power care coordination is our demonstrated value.

OUR MISSION

Serving Others for Healthy Communities

OUR VISION

Better Care means Better Life

OUR BELIEF

i2i believes that every community and person wants a healthy, happy life.

i2i POPULATION HEALTH

PARTNER SUCCESS STORY

Oracle Health and i2i create extensible value for many customers across diverse settings

i2i POPULATION HEALTH

2019

- Oracle Health and CommunityWorks selected i2i as its only Population Health platform of choice in 2019.
- i2i is the only third-party PHM platform that has a complete and comprehensive data integration with CommunityWorks, Millennium, HealtheIntent, PowerWorks, and Continuum.

THE STRATEGY

- Provide an alternative PHM platform for Cerner CWx, PWx, & State clients
- Enable Medicaid quality program execution for all Cerner clients
- Provide data integration of client's additional solutions & systems

ABOUT US

i2i is the nation's largest population health technology company serving the underserved, safety net market, through community health centers (FQHCs), critical access and community hospitals, primary care associations, and managed care organizations.

With over 23 years of experience spanning forty states and thirty million lives, i2i was ranked #1 by Black Book for end-to-end population health technology in 2020.

ORACLE Cerner

i2i by the Numbers

i2i's two-decades of experience has led to the development of extensive data acquisition and PHM capabilities which create a springboard for future growth opportunities.

350+
Total Provider Customers

100+ (Over 2,000 Interfaces)
EHR & Practice Management Interfaces

30M+
Patients/Members

2,600+
Care Facilities live with i2i Solutions

30
Health Plan Partners
Medicaid Managed Care

40 States with Clients utilizing i2i Population Health solutions

51 Hospitals: Critical Access, Community, & IDNs

22M Medicaid Lives on platform + Other lines of business: Medicare, Commercial, Uninsured

5 Provider Segments: FQHC, Private Clinic, Hospital, IHS, and Behavioral Health

121 Bi-directional Data Exchange with Provider Organizations and Health Plan Partners

i2i POPULATION HEALTH

Why i2i Population Health?

Provider Organizations leverage i2i to increase revenue and reimbursement

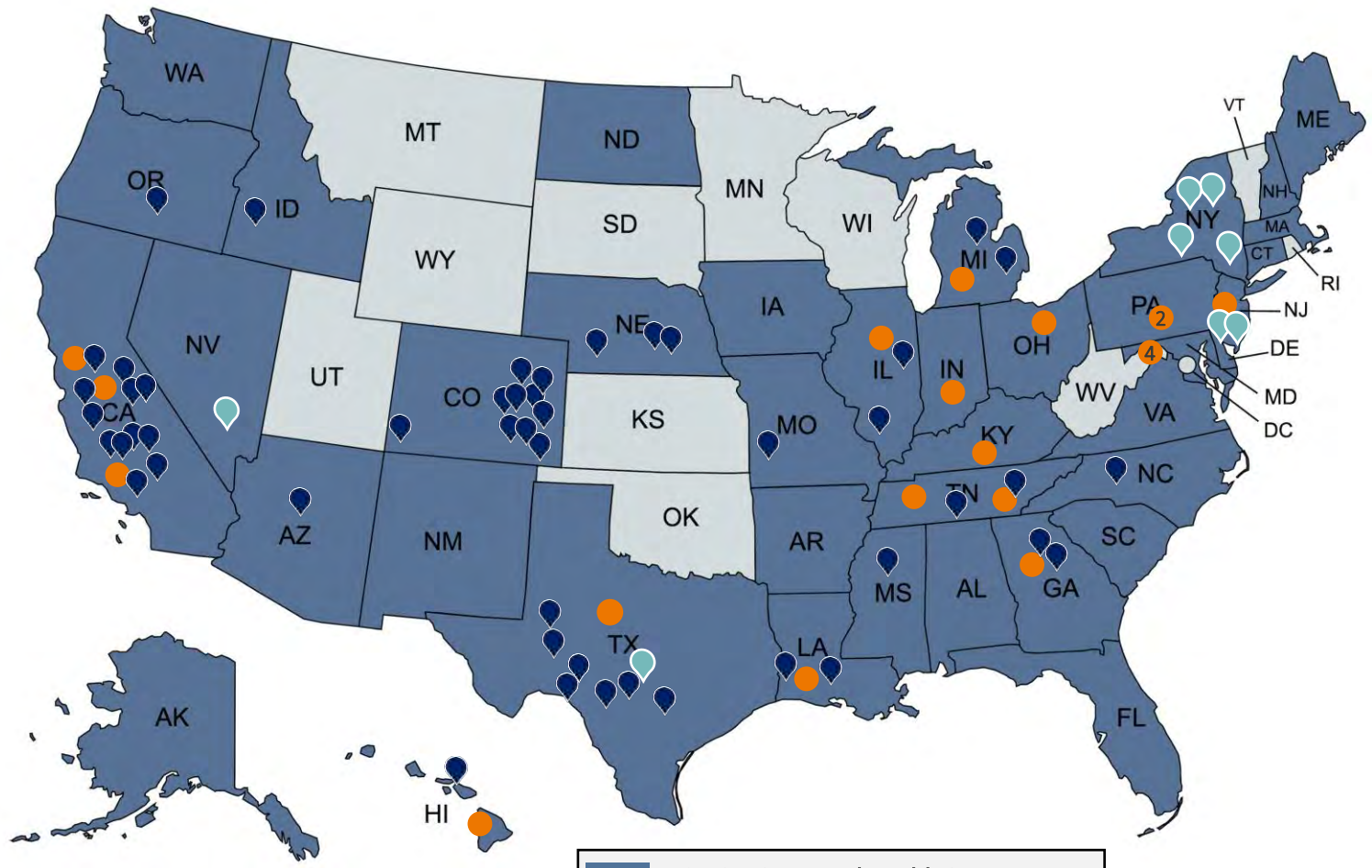
1. New, scalable technology for clinics and hospitals that's easy to use and powerful
   a. ONLY EMR-agnostic software that can connect, integrate and provide hospital access to all data
   b. Do more with less - gives clinic staff the ability to automate state & federal reporting needs

2. Increase revenues & reimbursement by participating & performing in national & state quality programs
   a. Eliminate manual data mining and report building with clinic leaders and costly labor
   b. Know daily, weekly, monthly where the organization stands on metrics and why - provide actions necessary to improve scores
   c. Add new quality programs that are not available today through manual work

3. Better community health and patient engagement with integrated, automated technology
   a. Connect and give instructions to patients through an automated system connected to specific care needs that improve health measures
   b. Reliable and scalable administrative processes that allow clinical (and leadership) teams to focus on other necessary work efforts

i2i POPULATION HEALTH

Advancing Partnerships to Accelerate Community Health Programs



FQHC, PCAs, Rural Health States
Health Plans by State
Critical Access or Regional Hospitals
Behavioral Health Clinics

Health Plans

- aetnaCVSHealth
- Elevance Health
- United Healthcare
- CENTENE Corporation
- CareFirst
- Amerigroup An Anthem Company
- CareSource
- MedStar Health
- BlueCare Tennessee
- AmeriHealth Caritas
- HIGHMARK
- Humana
- ALOHACARE
- L.A. Care HEALTH PLAN
- PRIORITY PARTNERS
- Anthem BlueCross Californi

Strategic Partnerships

- Cerner
- cpsi
- sellers dorsey realize the opportunity
- optmycare
- AMA
- MAPBP

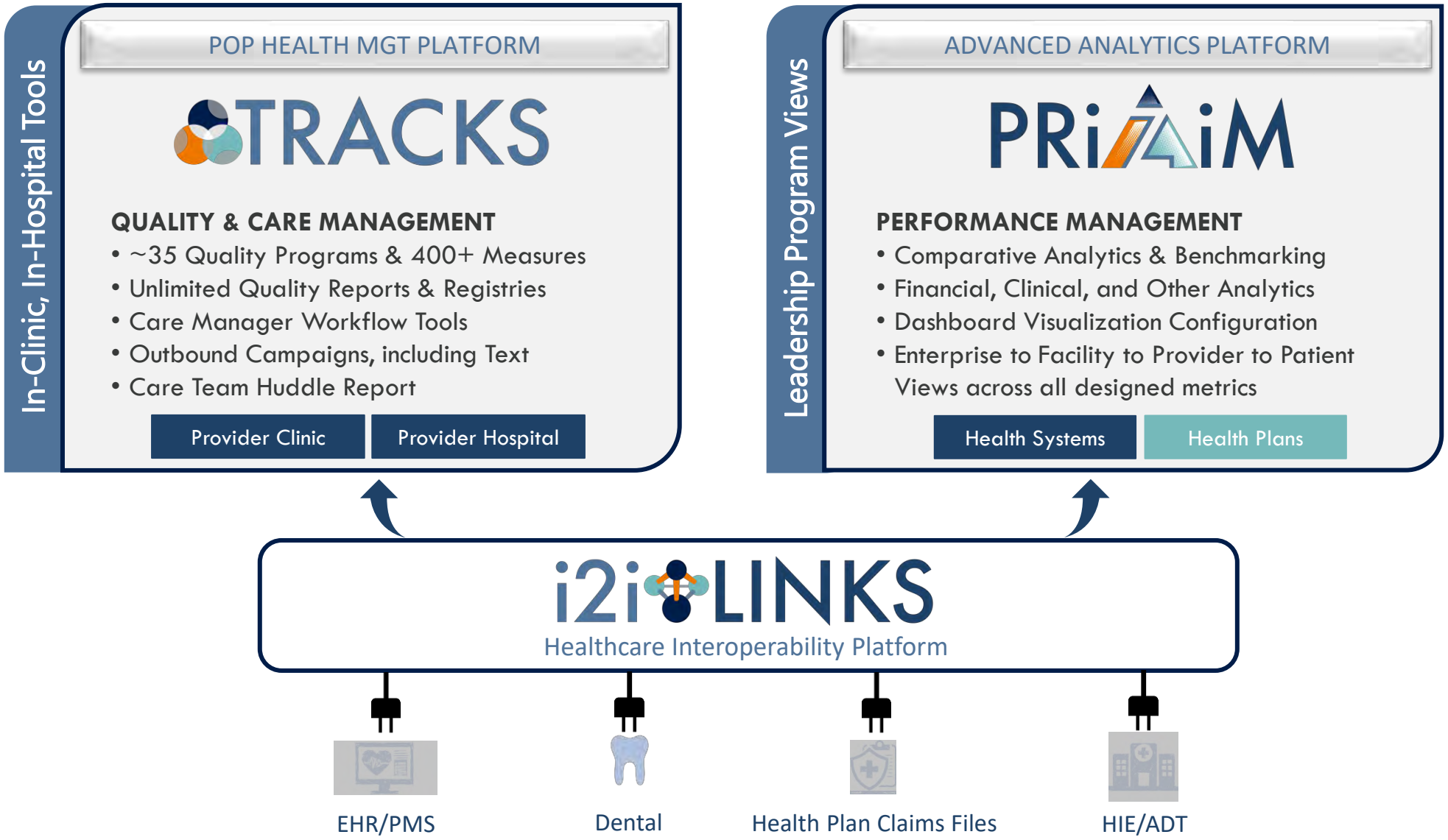
CERTIFIED NCQA HEDIS® MEASURES MY 2022 HEALTH PLAN MEASURES AND ALLOWABLE ADJUSTMENT MEASURES i2i Population Health

VALIDATED NCQA DATA AGGREGATOR VALIDATION VALIDATED DATA STREAM 2023

PREVALIDATED NCQA PATIENT-CENTERED MEDICAL HOME i2iTracks version 7.6 2023 PCMH and PCSP Prevalidation

i2i POPULATION HEALTH

i2i Technology Solutions



Quality Programs and Measures: Automation to Drive Revenue

Increase participation, performance, and reimbursement opportunities

QUALITY ENGINE

Top National & Regional Quality Programs

and others…..

eCQM	MIPS	HEDIS	Uniform Data System (UDS)
Indian Health Service (IHS)	Ryan White	Million Hearts (CDC)	SAMSHA CCBHC
Colorado HTP	PRIME/QIP Medi-Cal	Texas TIPPS/CHIRPS	STARS
MACRA	DSRIP	Healthy People 2030	PRAPARE (SDOH)

i2i TRACKS

Leverage unlimited quality reports OR build your own, quickly

Over 35+ quality programs with user allowed changes

400+ measures

Actionable Care Team dashboards, reports – connected to outreach workflow (email, text)

California State Reporting

- **PRIME Reporting**
  - PRIME Project 1.5: Million Hearts Initiative
  - PRIME Report, Project 1.1: Integration of Behavioral Health
  - PRIME Report, Project 1.2: Ambulatory Care Redesign: Primary Care
  - PRIME Report, Project 1.4: Patient Safety in the Ambulatory Care Setting
  - PRIME Report, Project 1.5: Million Hearts Initiative
  - PRIME Report, Project 1.6: Cancer Screening and Follow-up
  - PRIME Report, Project 2.5: Transition to Integrated Care: Post Incarceration
- **Medi-Cal**
- **QIP Report**
- **Behavioral Health Integration Grant**
- **CCALAC Network Reports**
  - Preventive Care
  - HTN
  - TC3
- **Partnership QIP Report**
- **Comprehensive Pre-Natal Services Program (CPSP)**
- **UDS (for affiliated FQHCs**

Today, i2i has over 90 Clients, representing 35,000 Providers and over 6 million Patient Lives

We have 8 CommunityWorks Clients in CA that have selected i2i as their PHM.

i2i LINKS

Data Activation Interoperability Platform

The foundation for many health systems starts with Data Activation. i2iLINKS integrates data from EHR and PM systems, health plans, health information exchanges, and open-source channels. LINKS is a proven, scalable healthcare interoperability platform with robust and reliable technology architecture.

Data Interoperability

- 68 EHR Interface Adapters thru FHIR, HL7, UPD, CCD, plus
- Health Plan Data Integration
  - Enrollment and Attribution
  - Claims Care Gaps
  - 835 and 837 (and other)
- 7 Health Information Exchanges
- Revenue Cycle Management
- Interactive Patient Care

Data Normalization

- Enterprise Master Patient Index
- Mapping Enumeration Coding
- EHR, PM, Claims & HIE Lexicon Conversions
- Unstructured Data Decoding
- Terminology Code Remediation

Provider & Health Plan Co-Management

CERTIFIED NCQA HEDIS® MEASURES MY 2022 HEALTH PLAN MEASURES AND ALLOWABLE ADJUSTMENT MEASURES i2i Population Health

VALIDATED NCQA DATA AGGREGATOR VALIDATION VALIDATED DATA STREAM 2023

TRACKS — In-Clinic & In-Hospital

- Unmatched Patient Manager (UPM)
  - Integrated enrollment files
  - Attribution by Payer
- Claims Care Gaps

PRiAiM — Health System & Payer

- Financial Analytics
- Member Management
- Quality Performance
  - HEDIS
  - ACO
  - Medicare at Risk

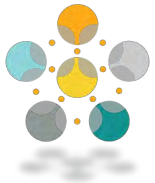
134	# of provider orgs engaged for bi-directional data sharing
30	# of health plans engaged sharing data; enrollment, attribution, claims, and other

i2i POPULATION HEALTH

i2iTRACKS

Care Coordination Quality Management

The i2iTracks platform combines the most comprehensive patient view with actionable insights into user-centered workflows for outreach tasking, and care coordination. Improve quality program performance with our deep EHR and PM integration by leveraging hundreds of measures & registries.



Care Coordination

- Complete Patient 360 Views
- Assess & Assign Care Plans
- View the Care Team Huddle Report
- Create Protocols for High Risk
- Manage Care Teams & Assignments

Quality Management

- Hundreds of quality measures out-of-the-box OR develop your own
- Analytics for risk stratification across measures and programs
- Dynamic, on-demand quality reports

eCQM MIPS ACO HEDIS ***and***
PCMH UDS MSSP SDoH ***more***

Workflow Automation

- Custom Dashboard Designs
- Automate Care Team Worklists
- Integrate Reminders & Alerts
- On-Demand Decision Support
- Build & Launch User Biz Rules

Referral Management

- Simple & insightful referral process
- Submit integrated requests & direct referrals from PCPs to specialists
- Provide a complete patient view
- Cost effective with coordinated care

i2i POPULATION HEALTH

PRiZAiM

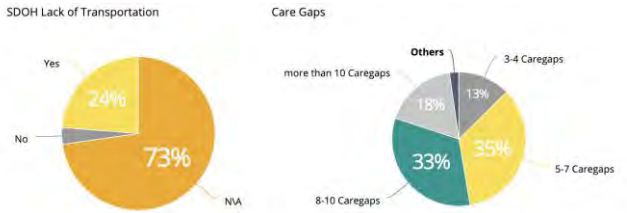
Advanced Analytics Performance Dashboards

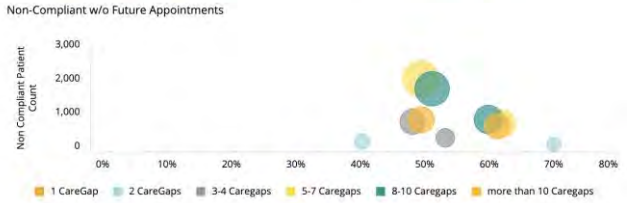
- Enterprise views into clinical, operational, and financial data sets on a single web-based platform (*connected to Tracks*)

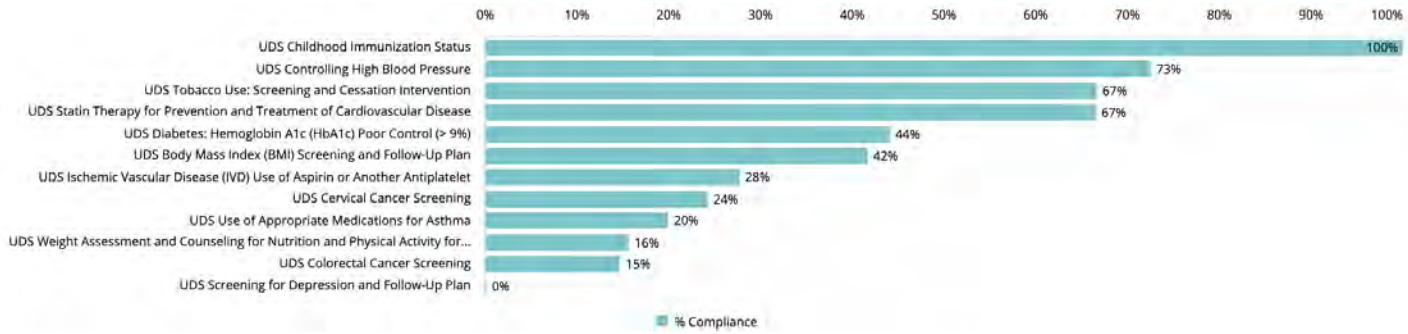
- Performance Dashboards that spotlight insights and recommend actions for….
  - Quality Programs
  - Financial Analytics
  - Inpatient Insights
  - Member Management (Health Plans)
  - SDoH Intelligence
  - Appointment Analytics

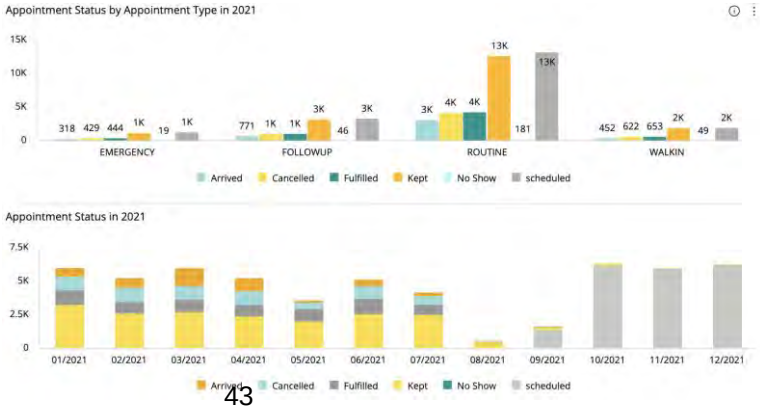
- Dynamic data from your EHR, PM, and health plans with easy-to-use visualizations

MeasureName (Parent)	% Compliant (Goal)	% Compliant (Actual)	% NonComplaint (Without Future Appts)	PatientCount
UDS Childhood Immunization Status	41%	81%	56%	57
UDS Controlling High Blood Pressure	66%	77%	57%	2,492
UDS Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	30%	74%	41%	931
UDS Use of Appropriate Medications for Asthma	70%	63%	53%	52
UDS Statin Therapy for Prevention and Treatment of Cardiovascular Disease	73%	59%	52%	837
UDS Tobacco Use: Screening and Cessation Intervention	89%	53%	54%	3,951
UDS Body Mass Index (BMI) Screening and Follow-Up Plan	74%	30%	55%	6,648
UDS Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	72%	22%	53%	861
UDS Cervical Cancer Screening	56%	20%	55%	2,208
UDS Colorectal Cancer Screening	46%	13%	52%	3,220
UDS Ischemic Vascular Disease (IVD) Use of Aspirin or Another Antiplatelet	82%	12%	50%	394
UDS Screening for Depression and Follow-Up Plan	75%	6%	53%	5,950









i2i Platform Pricing and Implementation

Purchasing made simple with a single-minded focus on our Customers ability to acquire, retain and utilize our platform.

1 Implementation & Support

- 45–90-day Implementation to go-live
- 10 hrs. of client responsibility during implementation
- All customer support handled by i2i

2 Pricing Metrics

- **Data Connections-** LINKS
- **Total # of annualized Patient Lives-** (Total number of unduplicated patients under your organizations care)
- **Minimal up-front fees**
- **Monthly invoicing initiated at First Productive Use (FPU)**

Why purchase a PHM platform?

Delivering population health management capabilities beyond the EHR

Data Activation

- Disparate data systems, unified
- Longitudinal patient record
- Single source of data truth
- Get access to your data to leverage for analytics

Competent

Quality Management

- Manage multiple quality programs
- On-demand, dynamic reports
- Quality measure vault with user design capabilities
- Drill-down from enterprise to patient

Comprehensive

Care Management

- Unlimited, real-time patient searches & registries
- Care gap closure with 360 views
- Automate outreach directly from any Quality Report
- SDOH Analytics

Configurable

Advanced Analytics

- Actionable dashboards by site, by provider & by programs
- Explore, identify, and drive performance improvement actions
- Eliminate unnecessary third-party BI tools with a dynamic platform

Coordinated

i2i POPULATION HEALTH

Value Drivers: ROI
Oracle Health CommunityWorks & i2i Population Health Solutions

Matt West
Vice President,
Population Health Solutions

PARTNER SUCCESS STORY

Oracle Health and i2i create extensible value for many customers across diverse settings

i2i POPULATION HEALTH

2019

- Oracle Health and CommunityWorks selected i2i as its only Population Health platform of choice in 2019.
- i2i is the only third-party PHM platform that has a complete and comprehensive data integration with CommunityWorks, Millennium, HealtheIntent, PowerWorks, and Continuum.

THE STRATEGY

- Provide an alternative PHM platform for Cerner CWx, PWx, & State clients
- Enable Medicaid quality program execution for all Cerner clients
- Provide data integration of client's additional solutions & systems

ABOUT US

i2i is the nation's largest population health technology company serving the underserved, safety net market, through community health centers (FQHCs), critical access and community hospitals, primary care associations, and managed care organizations.

With over 23 years of experience spanning forty states and thirty million lives, i2i was ranked #1 by Black Book for end-to-end population health technology in 2020.

ORACLE HEALTHCARE

Why i2i Population Health?

Critical Access & Community Hospitals leverage i2i to increase revenue and reimbursement

1. New, scalable technology for hospitals that is easy to use and powerful
   a. ONLY AGNOSTIC EMR software that can connect, integrate and provide hospital access to all data
   b. Do more with less - gives hospital staff the ability to automate state & federal reporting needs

2. Increase revenues & reimbursement by participating & performing in national & state quality programs
   a. Eliminate manual data mining and report building with hospital leaders and costly labor
   b. Know daily, weekly, monthly where the hospital stands on metrics and why - provide actions necessary to improve scores
   c. Add new quality programs that are not available today through manual work

3. Better community health and patient engagement with automated technology
   a. Connect and give instructions to patients through an automated system connected to specific care needs that improve health measures
   b. Reliable and scalable administrative processes that allow clinical (and leadership) teams to focus on other necessary work efforts

i2i POPULATION HEALTH

Hospitals secure a ROI within six months, post go-live of i2iTracks

Value is recognized through multiple impact areas key to hospital performance

Quality Management & Reporting
On-demand, actionable, and comprehensive

Care Coordination Workflows
Efficiently integrated care actions to close gaps

Data Activation and Analytics
Complete access to EHR & PM data allows real-time analytics without spreadsheets & BI tools

Culture of Population Health
Provides a scalable technology platform that creates trust across the health system and prepares the organization for value-based care

i2iTRACKS

Leverage unlimited quality reports OR build your own, quickly

Over 35+ quality programs with user allowed changes

400+ measures

Actionable Care Team dashboards, reports – connected to outreach workflow (email, text)

i2i POPULATION HEALTH

CASE STUDY: Improve Quality, Increase Revenue, and Save Time

Significant financial upside opportunities with adoption of Tracks quality & care management

ROI = 5.8 months
Value Drivers
* based on four hospitals ROI data

Critical Access & Community Hospitals

- NPR AVG $30M for one hospital and minimum of one clinic
- Participating in at least 3-4 quality programs at install of Tracks
- Utilizing existing professional staff to assemble quality reports

26%
Average improvement

Quality Program Performance

- Automated and actionable quality reports by program and each measure
- Daily reporting updates to highlight biggest opportunities to improve
- Actions are embedded within software to drive results

ANNUAL ROI $ per hospital & clinic(s)

$64 -104K

12.4
Time Savings (hours/week)

Time is Valuable

- Reallocate valuable labor to original position functions
- With i2iTracks, manual data pulls and analytics are automated - saving time
- Not a reduction of headcount but more time to address care needs of the community

$21 -62K

28%
Increase in Visits

Driving New Revenue

- Leveraging population health registries, reports, and referral management drives visits
- Proactive campaigns specific to screenings, immunizations, etc.
- Care coordination for overdue health assessments, follow-ups, and preventative care

$114 - 209k

3
Additional Quality Programs

Increasing Participation

- 35+ quality programs built-in allows hospital/clinics to participate in new programs
- Prepares and assists in value-based care or ACO programs
- Easy to apply for Grants with i2iTracks solutions

$44 - 79K^

i2i POPULATION HEALTH

^not added to ROI calculation

Closer look at Rural Hospital Group quality programs

Significant financial upside opportunities with adoption of Tracks quality & care management

1 TOP PROGRAMS IDENTIFIED

i2i Offers

- eCQM
- SDoH (PRAPARE)
- MIPS
- STARS

2 AD-HOC PROGRAMS/MEASURES

- CART is an old CMS provided platform for downloading and entering quality data. This will now be automated and more advanced through i2iTracks. No more manual downloads and uploads.
- Performance Improvement or Other Pay for Performance Programs - All can be setup within i2iTracks, individual reports by hospital and by program. Unlimited reporting.
- QBRP/EDTC for Blue Cross or QHI - Quality Reports can be configured and automated for daily review and downloads that can be sent to agency.

3 GROWTH OPPORTUNITIES

- ✓ **HEDIS, Managed Care Organizations**
  - Medicaid programs follow HEDIS quality measures and reports
  - Kentucky, Oklahoma, and Tennessee health plans are utilizing HEDIS to measure and reimburse performance
- ✓ **Value-Based Care Shift**
  - Aetna/CVS, Blue Cross, UnitedHealthcare, and Elevance are starting to create VBC programs in addition to standard Medicare & Medicaid quality programs
  - Participation requires technology to support data extraction needs, quality reports, and analytics
- ✓ **State-Specific Programs, Grants, & Others:** utilizing a PHM platform will provide hospitals the opportunity to apply with accurate data & less time

i2i POPULATION HEALTH

i2i POPULATION HEALTH
Data. Insight. Action.

Franciscan Healthcare
Your health is our passion.

CASE STUDY

Fransciscan Healthcare

ABOUT FRANCISCAN HEALTHCARE

Franciscan Healthcare is a Catholic health system in northeast Nebraska. The health system is a 25-bed critical access hospital with five rural health clinics that offer comprehensive medical care including emergency care, obstetrics, surgical services, and multiple specialty clinics such as cardiology, ENT, dermatology, oncology, ophthalmology, orthopedics, pain, podiatry, and others.

When Franciscan Healthcare hired new CEO Tyler Toline in 2020, the need for more data arose. Toline was interested in actionable data, especially data easily pulled from the EHR to drive decision-making, quality, and performance in a proactive manner. Franciscan Healthcare implemented Cerner CommunityWorks electronic health record (EHR) in 2018. Prior to that the clinics were utilizing paper documentation. CommunityWorks provides a digital record of a patient's health history including clinical and financial data across the continuum of care. What surprised Tyler was that the Cerner system could not easily extract the necessary data quickly and efficiently. The existing reporting process was cumbersome and time-consuming. Staff would manually extract clinical data, place it in a spreadsheet and analyze the data using Excel.

CHALLENGES

Anne Timmerman is the Director of Quality and Safety at Franciscan Healthcare. "One of the first things Tyler requested from me was a list of our diabetic patients, their last A1C result, which physician they saw, and next appointment date. He was surprised that Cerner offered no easy report to extract clinical data. After months of trial and error, Tyler knew we would need to find a different solution to help us achieve the data he was looking to present to the organization," said Timmerman.

Furthermore, Franciscan Healthcare leadership was now looking to utilize EHR data to create quality scorecards and proactively manage population health. ACO data submission and reporting is accomplished by using Health Endeavors software. This requires manual entry of data into its software which is a duplicative process for staff. The software is also unable to obtain real-time quality metrics to provide useful and actionable feedback to providers and care teams.

SOLUTION

Franciscan Healthcare chose to partner with i2i Population Health after learning of i2i at a conference. Being a critical access hospital and rural health clinic, finances and cost-effective solutions are of high importance. It was critical for the solution purchased to be able to work with the existing EHR system, be easily implemented by the organization, include training, and remain efficient.

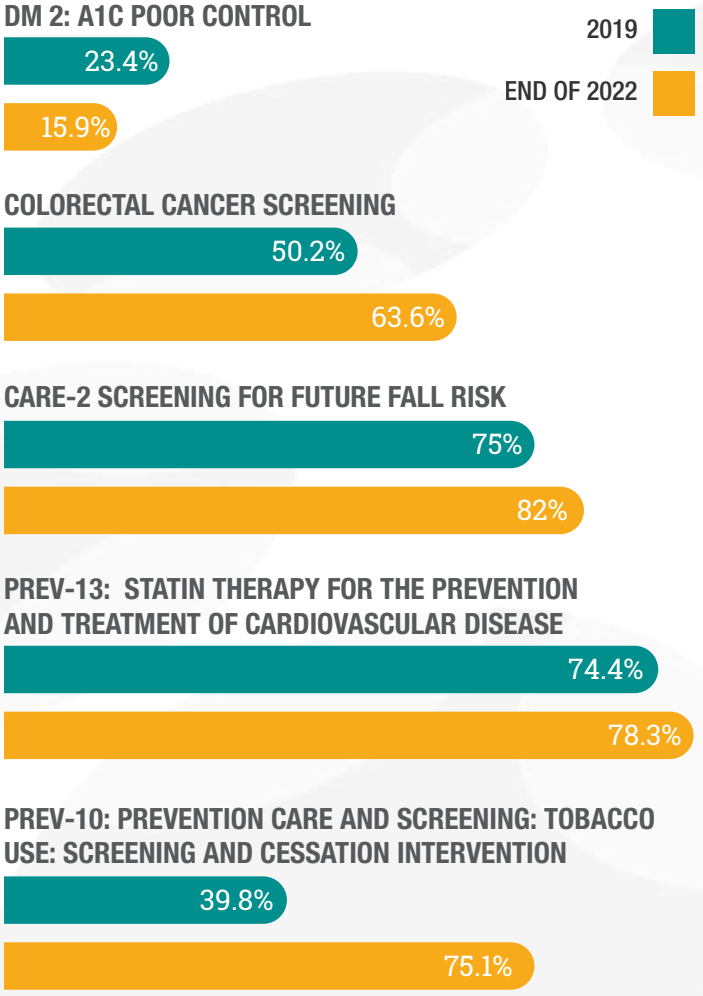
RESULTS

Clinical Director Anastasia Stokely and RN-BC Jen Coufal put i2i to the test by applying for a last-minute hypertension/hyperlipidemia grant. This grant would provide funding for at-home blood pressure monitors for identified patients to participate in remote patient monitoring. Jen was able to quickly pull the information needed for the application from the Cerner EHR utilizing i2i and the grant application was completed and submitted with minimal effort successfully meeting the short deadline.

Additionally, i2i has enabled Franciscan Healthcare to pull ACO data at an individual provider level. This has allowed physicians to improve quality metrics and gaps in documentation of their care. Before i2i, all data shared with providers was aggregated for the organization. After implementing i2i, providers are more actively invested in the quality improvement process.

To support population health efforts, Franciscan Healthcare's clinics use i2i to perform patient searches based on criteria, e.g., an age group with specific insurance plans, chronic diseases and health issues or specific diagnoses or procedures, or how many new and returning patients each outpatient specialist sees each month. Easily accessible reports have enabled Franciscan Healthcare to build programs around population health management, quality improvement, and patient satisfaction.

Using the data from i2i to identify gaps in workflows and reporting, Franciscan Healthcare has been able to demonstrate the following improvements in their clinical quality measures:



After implementing i2i, Timmerman's quality reports are more data-driven. And other created reports, such as patients who have Advance Directives, can be obtained quickly, cross-checked, and easily validated with the patients' EHR.

Daily huddles have been simplified and more productive with better information to share. Providers can review a list of patients they are scheduled to see and, more importantly, view the conditions that require attention, such as overdue vaccines and preventative screenings. Accessing the data in their EHR has empowered Franciscan Healthcare's care teams to provide proactive care to ensure every patient receives the highest quality care.

And lastly, Franciscan Healthcare is utilizing the i2i technology and extracting data for continuous quality improvement. Utilizing these enhanced metrics to build continuous quality improvement plans, Franciscan Healthcare strives to participate in more quality initiatives and apply for more grants.

i2i POPULATION HEALTH
Data. Insight. Action.

ABOUT i2i

i2i is the nation's largest population health technology company serving the underserved, safety net market, through community health centers (FQHCs), critical access and community hospitals, primary care associations, and managed care organizations. With over 23 years of experience spanning forty states and thirty million lives, i2i was ranked #1 by Black Book for end-to-end population health technology in 2020.

The i2i platform powers an advanced data integration and aggregation engine that publishes normalized clinical and administrative data through expansive quality management and care coordination applications.

Improving outcomes through better quality program performance is a core competency of i2i. The mission, Serving Others for Healthy Communities, drives the company's vision, culture, and actions to bring better health solutions to all communities. Recently, i2i was named one of middle Tennessee's Top Workplaces 2021.

Case Study

MAMMOTH HOSPITAL

About Mammoth Hospital

Mammoth Hospital is a 17-bed critical access hospital with 12 outpatient clinics located in Mammoth Lakes, California. In 2007, Mammoth Hospital added a 38,000-square-foot expansion to its existing 20,000-square-foot hospital. The addition included a new emergency department, surgery center, three-bed birthing center, and a fully digital medical imaging department. Mammoth is supported by full-time board-certified medical staff and highly qualified nursing staff throughout the organization. Mammoth is also an official medical provider for the U.S. Ski and Snowboard teams, including specialized orthopedic surgery and rehabilitation programs.

Challenge

In 2020, Mammoth Hospital's Population Health Team hit a brick wall. Oracle Health, CommunityWorks, is the electronic health record (EHR) leveraged by the Mammoth hospital and clinics. While the EHR and revenue cycle systems are core to the clinical and administrative staff operations, Mammoth's population health and quality team workflows and execution relied on numerous Excel spreadsheets to support cumbersome manual processes. Juggling several quality programs and payment processes to meet specific timelines, Mammoth was at extreme risk of falling short in performance goals and losing meaningful reimbursement dollars. Manual data mining and report building took an enormous amount of skilled labor to meet the monthly demands. This opened the door for reporting errors and constrained the organization from transitioning and participating in new quality programs.

Mammoth Hospital Leadership made the decision to invest in a population health technology platform for all quality programs including data analytics, care coordination, and workflow integration to improve quality and enhance reimbursement performance.

Areas of focus included:

- Improving Medicare Shared Savings Program performance across ten (10) quality measures to achieve maximum shared savings
- Enhancing California QIP quality performance across eighteen (18) quality measures to increase reimbursement
- Decreasing reporting errors and realigning clinical and operational labor from manual reporting functions to hospital and clinic job roles
- Increasing quality program participation and performance opportunities with State, Federal, and health plans by leveraging a comprehensive population health platform
- Developing and executing wellness programs that meet community health needs
- Providing regular performance feedback to all levels of operations, clinical, and administrative teams within Mammoth Hospital and Clinics

Solution

Mammoth Hospital chose to partner with i2i Population Health technology. The i2iTracks platform offers a comprehensive patient view with actionable insights into user-centered workflows for outreach tasking, and care coordination.

Improving quality program performance through deep EHR and PM integration was another goal of the i2i relationship incorporating hundreds of quality measures and registries.

Data activation was a foundational element of the i2i Mammoth collaboration. The i2i LINKS solution integrates data from many EHR and PM systems, health plans, and open-source channels. **The combination of LINKS and i2iTracks specifically supported Mammoth through features such as:**

Data Management

i2i unifies disparate data systems to create a longitudinal patient record and a single source of data truth.

Quality Management

i2i scales quality program reporting with dynamic measures that can be customized into hospital and clinic scorecards. This included participating in PRIME, QIP, eCQM, HEDIS, MIPS, and ACO for Mammoth.

Care Coordination

i2i leverages real-time patient searches and registries, care-gap closure, and automated outreach through dashboards, care team huddle views, and quality reports.

Referral Management

i2i's integrated practice management workflows for patient referral orders allows i2iTracks to present easy to use tracking reports for follow-up to reduce network leakage.

i2iTRACKS + i2iLINKS

Results

With i2i in place for nearly two years, Mammoth Hospital has experienced significant improvements in its quality scores across programs such as Quality Incentive Program (QIP) and ACO shared savings. A positive return on investment (ROI) for i2iTracks was achieved in less than three months post go-live and helped Mammoth generate over $2 million in new quality revenue and labor savings.

With i2i's Population Health Platform, Mammoth Hospital gained immediate performance views in real-time to support the overall health of the business combined with the ability to proactively manage community health programs.

Improvements across the hospital and clinics include:

- Time savings between 3,016 and 6,032 hours, supporting reallocation of time to necessary clinical operations and strategic programs
- Fewer errors through the elimination of manual processes
- More effective referral management workflows with real-time alerts and follow-up actions
- Automated outreach programs for patients that drive care gap closure
- Care Team Huddle report to prepare clinical and care management teams for the day
- More precise registries across multiple chronic conditions, providers, locations, and dates
- Improved QIP reporting readiness, leading to accurate revenue cycle processes and significant time savings
- Identified and targeted patient outreach specific to closing gaps in care for high risk members
- Improved management of chronic conditions and support of wellness programs
- Ability to identify opportunities to optimize Medicare patient programs

"With i2i, we went from manually tracking quality measures to an automated PHM platform allowing us to participate in several quality programs. And, we are now able to uncover more opportunities for grants," shared Kate Britton, Population Health Manager, at Mammoth Hospital. Britton further explained that i2iTracks helped Mammoth create provider incentives through simple and effective scorecards that the clinicians love. "There is no doubt that i2i has helped us grow our patient volumes, improve the health of our community, and increase reimbursement levels."

Britton praises how seamless i2i implementation and client support is. "i2i is great! You put in a support ticket, and the team responds quickly," continued Britton. "Whenever we reach out to i2i, they are super helpful. The skill of i2i's training team is exceptional, plus they offer monthly refresher webinars."

When asked which i2iTracks features Mammoth's team likes most, reporting is always at the top of the list.

"You can literally create any report.The sky's the limit!"

"With i2i, Mammoth Hospital has achieved massive time savings and expects an ROI of approximately $12 million over the life of the contract."

Kate Britton, *Population Health Manager*
MAMMOTH HOSPITAL

About i2i

i2i is the nation's largest population health technology company serving the underserved, safety net market, through community health centers (FQHCs), critical access, and community hospitals, primary care associations, and managed care organizations. With over 20 years of experience spanning 40 states and 30 million lives, i2i was granted the 2023 Sector Innovator Award for Population Health by the Acenda Institute.

The i2i platform powers an advanced data integration and aggregation engine that publishes normalized clinical and administrative data through expansive quality management and care coordination applications.

Improving outcomes through better quality program performance is a core competency of i2i. The mission, *Serving Others for Healthy Communities*, drives the company's vision, culture, and actions to bring better health solutions to all communities. Recently, i2i was named one of Middle Tennessee's Top Workplaces 2021.

TOP WORK PLACES

i2i POPULATION HEALTH

377 Riverside Dr. Ste. 300, Franklin, TN 37064 | 615-561-1190 | info@i2ipophealth.com | i2ipophealth.com

April 29th, 2024,

Elite Edge Coaching, LLC
8920 S. 168th Dr., Goodyear, AZ, 85338

Mayers Memorial Healthcare District
PO Box 459|43563
Hwy. 299 E Fall River Mills, California, 96028

Dear Mr. Harris,

Thank you for your interest in partnering with Elite Edge, LLC. I am truly thankful for your consideration of this opportunity for us to work together! Please find outlined below the newly proposed coaching to support you and your team in this work.

Deliverables:

On site coaching visits

Four (4) on site coaching visits to focus on leadership development coaching targeted to support all levels of leadership growth and skill building. These are typically three-hour sessions with the complete leadership team off site for best learning.

Executive Coaching

One on one coaching following the leadership development onsite sessions for leaders. These one on one sessions should be 30 to 45 minutes each and leaders should be scheduled prior to onsite visit for best results.

Term of Agreement: July 1st 2024 – June 30th, 2025

Investment

Quarterly professional fees paid at the following schedule:
$3500.00 July 1, 2024
$3500.00 October 1, 2024
$3500.00 January 1, 2025
$3500.00 April 1, 2025
Total Fees: $14,000.00 plus Travel expenses (airfare and lodging)

Thank you again for considering EEC, and I look forward to hearing back from you and happy to answer any questions you may have. If you agree with this proposal please sign and return to me for signature, and completion and a copy will be sent directly to you.

_____ _____

Ryan Harris, CEO

Jennifer Miley, President

Mayers Memorial
Virtual Leadership Academy
Proposal

Prepared for: Mayers Memorial
April 28, 2024

Prepared by:

7521 Paula Dr.
PO Box 260272
Tampa, FL 33685
813.333.1401

Table of Contents

Dear Ryan,

We are excited to partner with you to design, build and deliver a virtual leadership development program at Mayers Memorial Healthcare District. We understand this is a key initiative and part of your organization's vision and transformation.

We will work with you and your leadership team to customize the development structure, curriculum and experiences that would best support your short-term and long-term goals of developing senior leaders.

We will work with you to customize the experience to meet your leaders' developmental needs, and desired outcomes.

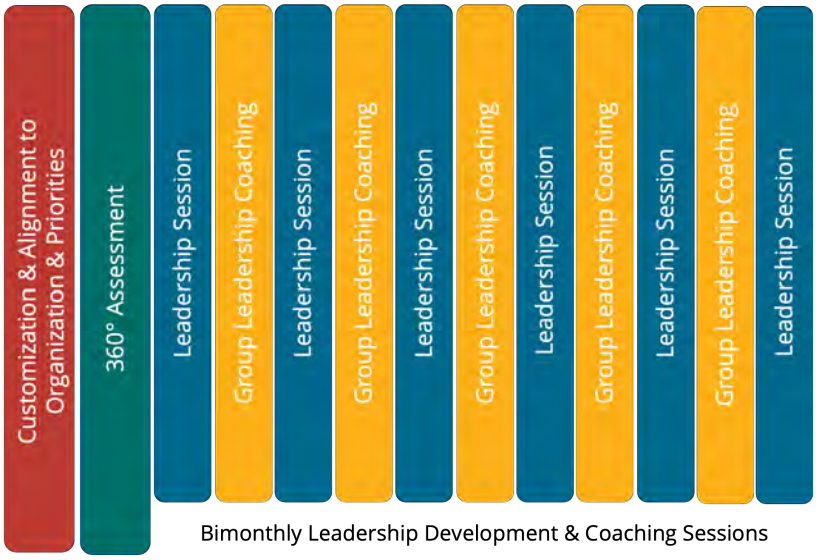
We look forward to your positive consideration and to a great partnership.

Sincerely,

Mo S. Kasti, MS, MBB, MCA
Founder & CEO, HLI

Mayers Memorial Healthcare District
Summary of Services

The proposed academy includes design and customization of a curriculum with cohort learning, 360° assessment, 6 virtual sessions and group leadership coaching.



Leadership Academy Features

1. **Organizational Needs Assessment and Custom Build**

   Based on needs assessment results and organizational priorities, HLI will customize, with Mayers Memorial Healthcare District, content and experiences to leverage the cohort's strengths and address their development areas. HLI may plan and schedule interviews with key leaders during which HLI will discuss current leadership challenges, the strategic plans of the organization, leadership competency model, and skills and characteristics needed for current and future success.

2. **Curriculum Customized**

   Based on the needs assessment results and organizational priorities, HLI will customize, with Mayers Memorial Healthcare District, content and experiences to leverage the cohort's strengths and address their development areas.

3. Self-Assessments (when applicable)

HLI will use a variety of tools to evaluate individual leadership competencies and behaviors that may include communication styles, transformation and change readiness, emotional intelligence, learning styles, time management, teamwork, performance management, and conflict resolution.

4. 360° Assessment Process

HLI will coordinate and launch the 360° Assessment process using the HLI competency profile and/or the Emotional Capital Report ECR 360. The 360° Assessment is a tool designed to provide participants with feedback regarding their leadership strengths and areas of opportunity for personal and professional development. A 360° report provides feedback from the perspective of the people around the participant. Upon completion HLI will provide a confidential 360° Assessment Feedback Report to each participant along with an Aggregate Team Report with collective strengths and weaknesses. Leadership coaches will debrief the individual results with each participant.

5. Development Sessions

6 Virtual development sessions will be held where local and national faculty will deliver hands-on, engaging sessions. All sessions are designed to be experiential, and simulation based to maximize the learning of the participants. Customized case studies, small group discussion, and role-playing learning methodologies are used for deeper learning and development. Suggested topics are provided on the schedule.

6. Professional Program Management

HLI will provide a program manager to lead the design and delivery of the leadership development program including:

- Interviews to determine development needs and building relationship
- Launching assessments
- Designing the curriculum based on interviews and assessment results
- Coordinating virtual sessions where faculty will deliver engaging sessions
- Ensuring that all sessions are designed to be experiential, and simulation based to maximize the learning of the participants.
- Ensuring quality of delivery of the program

- Coordinating progress of the overall development program

7. Group Leadership Coaching

Participants will be organized in learning communities (4-5 per group) to share best practices, solve challenges together and support each other. Each learning community will be assigned an HLI coach. Group coaching involves calls during which the coach assists the participants in identifying priority areas, facilitating the group discussions, deepening the learning from the sessions, and providing ongoing guidance and support.

Mayers Memorial Healthcare District Leadership Academy Samples Schedule and Curriculum				
Day	Date	Time	Session Topic	Location
NA	July 2024	NA	Needs assessment (online survey & phone conversations)	NA
TBD	AUG 2024	8 AM -12 PM	Leading Across Differences in Work Style and Leading Effective Meetings	Online
NA	SEPT 2024	1 Hr TBD	Group Leadership Coaching	Online
TBD	OCT 2024	8 – 10 AM	Enhancing Personal Productivity	Online
NA	NOV 2024	1 Hr TBD	Group Leadership Coaching	Online
TBD	DEC 2024	8 – 10 AM	Effective Delegation and Gentle Accountability	Online
TBD	JAN 2025	1 Hr TBD	Group Leadership Coaching	Online
TBD	FEB 2025	8 – 10 AM	Giving & Receiving Feedback: Facilitating Growth, Improvement and Behavior Change	Online
TBD	MAR 2025	1 Hr TBD	Group Leadership Coaching	Online
TBD	APR 2025	8 – 10 AM	Having the Tough Conversations and Leading Through Conflict	Online
TBD	MAY 2025	1 Hr TBD	Group Leadership Coaching	Online
TBD	JUN 2025	8 – 10 AM	Enhancing Resilience & Well Being/Preventing Burnout Program Graduation	Online

Session Descriptions

Leading Across Differences in Work Style & Personality

Successful leaders are able to tailor their communication to the needs of people with a wide array of styles and personalities – rather than applying a "one size fits all approach." In this session, we will use the DiSC© profile to enhance self-awareness and learn strategies to enable better communication, motivation and influence across diverse styles.

Leading Productive Meetings

One of the key ways organizations generate ideas, coordinate action, and solve problems is through meetings. Unfortunately, only a small percentage of meetings are led in ways that yield meaningful results. In this session, participants will learn skills and strategies for facilitating highly productive meetings and group discussions

Personal Productivity: Managing Commitments and Priorities

Managing the multiple demands that compete for our time and attention can be a challenge, but doesn't have to be. Each of us can enhance our ability to manage these demands and get results. The key is working to manage commitments and priorities.

Effective Delegation and Gentle Accountability

Because of the breadth of the work they oversee, leaders must get work done with and through others. They can no longer just roll up their sleeves and do it all themselves. Success then, requires leaders to be able to delegate well and hold others accountable for results. In the session we'll explore strategies for effective delegation and gentle approaches to holding others accountable

Giving & Receiving Constructive Performance Feedback

When done well, performance communication can improve engagement, resolve problems in a timely manner, increase work satisfaction and loyalty, and accelerate the success of individuals, teams and organizations. Through this session, participants will learn key skills and receiving and giving constructive performance feedback to drive growth and improvement.

Leading Through Conflict & Having the Tough Leadership Conversations

When handled well, conflict can ultimately lead to better ideas, better decisions, and improved relationships. The keys to enabling these results are: knowing which conflicts matter and need to be addressed; the ability to address them in a constructive manner, and the communication skills to assess and clear the issues involved. In this session, participants will learn strategies for engaging in productive negotiations and managing conflict toward lasting resolution.

Enhancing Well Being and Resilience

The pressure to perform in the midst of escalating change and energy demands means organizations are asking more of their physicians and leaders than ever before. Without strategies for managing in this environment inevitably exceed capacity. In this session, we'll explore ways to expand capacity without sacrificing health and happiness.

Proposed Investment

1	Design and Development	INCLUDED
2	Nomination & Selection Process	INCLUDED
3	360° Assessment with 1:1 Debrief Call	INCLUDED
4	Program Management	INCLUDED
5	6 Online sessions (customization, speakers, delivery)	INCLUDED
6	Learning Materials	INCLUDED
7	Group Coaching (3 groups of 5)	INCLUDED
	Mayers Memorial Virtual Leadership Academy Investment	**$4,000/per participant**

Notes:

- Minimum of 15 participants

Optional Investment

Additional Block of Coaching 20 credits	$10,000

A block of coaching credits can be used as needed for support during the duration of the engagement. These hours can be used for on-demand coaching, one-on-one coaching, dyad coaching, executive coaching, small group coaching and/or clinical unit or team coaching.

Coaching Credit Rates

The following credit rates apply to planning, follow up and actual coaching calls as follow:

1. One Hour of Leadership One-on-One Coaching is equivalent to 1 Credit
2. One hour of Dyad Coaching is equivalent to 1.5 Credits
3. One hour of Team/Group Coaching is equivalent to 2 Credits
4. One hour of Executive Coaching is equivalent to 2 Credits
5. Planning time and follow up are equivalent to 1 Credit
6. Missed or cancelled calls are charged at .5 credit

Mayers Memorial Healthcare District Responsibilities

Mayers Memorial Healthcare District would provide an Engagement Liaison (EL) and a Logistics Coordinator (LC) who will act as the liaison between HLI and the participants to ensure the successful implementation of the program. Specific responsibilities are defined in future communication.

Payment Terms

Payment terms are negotiable and spread into two payments.

Our typical payment terms include:

- First 50% payment at the signing of the agreement
- Second 50% payment after session two

Satisfaction Guaranteed

HLI stands behind the quality of our programs and service delivery. Should Mayers Memorial Healthcare District not be satisfied with service delivery during this agreement, we will modify the work to your satisfaction at our own expense.

We look forward to serving Mayers Memorial Healthcare District on this key initiative.

Sincerely,

Mohamad S. Kasti, MS, MBB, MCA
Founder & CEO
HLI

Selection & Client Acceptance

☐ 6 Sessions w/Group Coaching Leadership Academy
☐ Block of Coaching 20 credits

_____

Ryan Harris

Chief Executive Officer

Mayers Memorial Healthcare District

Date:

About The Healthcare Leadership Institute (HLI)

Who We Are

HLI was originally founded in 2005 by the University of South Florida College of Medicine, and College of Nursing and College of Public Health, with the mission to transform healthcare through physician leadership development. We believe that every organization, team and leader is unique, and thus all our solutions are customized to their own distinct visions and needs by leveraging the world's most advanced leadership and innovation practices and a deep bench of experts with practical experiences. HLI has successfully established leadership, strategy, and innovation development programs for physicians, executives, and potential leaders, nationally and internationally.

The Healthcare Leadership Institute was created as a stand-alone division to meet the specific needs of physicians and healthcare professionals leading in an ever-changing healthcare environment. While others may offer structured learning programs on an array of topics including leadership, the Institute is 100% focused on developing professionals in healthcare. The Institute truly engages physicians and healthcare professionals in rigorous, experiential learning that is custom fit for the client, resulting in graduate growth, improved performance, and long-term succession planning. HLI's leadership programs foster a culture of goal setting, collaboration, teamwork, and accountability that are essential to achieve long-term objectives for our client-partners. We live leadership.

Our Mission

We transform healthcare through uncommon leadership development.

Our Services

- Physician and Nursing Leadership Fellowships and Academies
- Physician and Nursing Leadership Development and Coaching
- Leadership Workshops and Retreats
- Leadership Assessments
- Executive Coaching
- High Performance Team Development

What is different about CTI's Healthcare Leadership Institute?

- A credible, academic, and practical program
- On-site program maintains leader productivity
- A high-impact, comprehensive development format
- A customized curriculum for each cohort
- Organization-based projects with a tangible return on investment
- Personalized development plans
- A sustainable transformation in leadership behaviors
- Practical, simulation-based active learning
- Measured results with pre- and post- Assessment process
- Built on years of experience in developing physician leaders
- Documented results in competency and behaviors improvement
- A sustainable leadership networks
- Graduates take on greater leadership roles with confidence
- Continuing Medical Education (CME) credit available (optional)

Healthcare Leadership Institute's Principals

Mohamad (Mo) S. Kasti, M.S., MBB, MCA

Mo Kasti is a distinguished author, thinker, coach, speaker, entrepreneur and family man.

His passion centers around helping executive and clinical leaders elevate their thinking in times of transformation and capitalize on emerging growth opportunities. When terrains are shifting, and outcomes are uncertain, Mo is uniquely equipped to help leaders think outside the box. He is sought after for his expertise in leadership, strategy, innovation, and organizational/cultural transformation.

With more than 28 years in business and healthcare, Mo is an expert in leadership, operations, culture and engagement. His experience includes:

- CEO and Founder of HLI – An Inc. 5000 fastest growing company, specializing in healthcare training, coaching and consulting.
- Executive coach for entrepreneurs, CEOs, healthcare leaders and physician leaders
- COO and CTO of USF Health in Tampa, which includes the largest medical group practice with 1,000 faculty, as well as the medical, nursing and public health schools.
- 10 years as an executive within GE Healthcare System, including operations, sales, marketing, product development, leadership, Lean Six Sigma Master Black Belt
- 10 years in various managerial roles in hospitals in Ohio and Michigan

HLIs professional acknowledgements include: Inc. Magazine's 5000 Fastest-Growing Private Companies; Tampa, Small Business of the Year Finalist; LEAD Top 10 Leadership Partner; LEAD Top 10 Best Executive Coaching Program; LEAD Top 10 Use of Team Building; State of Florida Healthcare Innovation Award; 2015 Florida Companies to Watch; AHA Exclusive Endorsement 2015/2016.

Mo is part of MG100 Top 100 Global Coaches. He recently was named Marshall Goldsmith #1 Healthcare Executive Coach.

He is the author of Physician Leadership: The Rx of Healthcare Transformation on the transformational effects of leadership in medicine and Beyond Physician Engagement: A Roadmap to Partner with Physicians to be ALL IN! Mo next book is on Clinician Experience.

He has a Master of Science in Biomedical Engineering and Healthcare Administration from Case Western Reserve University in Cleveland, Ohio, USA and has earned numerous awards as a coach, trainer, and speaker on leadership development. He is certified as a Master Black Belt (MBB) in Lean Six Sigma and Master Change Agent (MCA) in Change Management. Mo is a life-long learner and student of ancient Asian teachings (i.e. Sun Tzu, The Art of War, The Seven Chinese Military Classics, and The Five Rings) as they apply to strategy and leadership.

Mo has faculty appointments in the USF College of Medicine, College of Nursing, College of Engineering, Business School, Honor College, and College of Pharmacy. He has received numerous management awards for outstanding performance and holds several patents. He is a sought-after speaker on strategy, leadership and management transformation, and effective process improvement. Mo has been the keynote speaker and panelist at numerous conferences including the AHA, AMA, AMGA National Conference and ACHE Kentucky.

HLI's Leadership Faculty and Coaches at a Glance

More than 70 national faculty and industry experts from top universities and professional organizations contribute to our leadership programs, including faculty from University of South Florida, Duke University, Emory University, Harvard University, Stanford University, the US Military Academy at West Point, Washington University in St. Louis, General Electric, Lehigh Valley Hospital, and AdventHealth, to name a few. ***This list provides a glance at just a few of our contributing faculty and coaches. For a complete list of faculty and coaches, please visit our website at www.ctileadership.com***

Nate Allen, Ph.D.
LTC, US Army, and Professor of Military Science, Duke University

Wes Avants, MA
Executive Director & Coach, HLI

Ben Bache-Wiig, MD
Chief Clinical Officer & EVP, Allina Health

Jeffrey Bauer, Ph.D.
VP, Forecasting and Strategy, Affiliated Computer Services, a Xerox Company

Stephen Beeson, MD
Author, Physician & Speaker

Ayse Birsel
Co-Founder & Creative Director, Birsel+ Seck

Jeff Black
Principal of Black Sheep

Chester Elton
Author & Speaker

Marshall Goldsmith, Ph.D.
New York Times Bestselling Author & Harvard Business Review #1 Leadership Thinker

Mohamad Kasti, M.S., MBB, MCA
Founder & Chief Executive Officer, HLI

Stephen Klasko, M.D., M.B.A.
Former President & CEO, Thomas Jefferson University and Jefferson Health

David Mish, M.B.A.
Partner and Business Coach, Shirlaws, Inc.

David Nour
Growth Strategist & Thought Leader

Manoj Pawar, MD
Senior Physician Executive

Garry Ridge, MS
CEO, WD-40

Marion Smith, M.S.B., C.P.I.M.
Founder & Lead Executive Coach
Element Consulting

Mark Tribus, M.B.A.
LTC, US Army, and
Professor of Military Science
Duke University

Liz Wiseman
President, Wiseman Group

Margie West, M.Ed., M.A.
Director of Curriculum & Senior Facilitator
HLI

Testimonials

"I just want to thank our leadership for introducing CTI to us at this critical time in our development."
-Kristina Bedynerman, M.D., Lee Health

"The partnership between The Iowa Clinic and the Physician Leadership Institute has provided us with an educational foundation for our physicians to meet the business challenges in today's changing environment. Their experiential approach has allowed a unique connection to how the physicians can immediately apply leadership concepts into their professional and daily lives."
-Ed Brown, CEO, The Iowa Clinic

"I would say the experience of working with CTI has been transformative."
-Kristine Fay, M.H.A., Lee Physician Group

"CTI's Physician Leadership Institute has been a tremendous, phenomenal experience. I would recommend it to any leader."
-LaTrice C. Davis, M.S.H.A.

"I do now admit that listening is the #1 leadership skill."
-Dan Kollmorgen, M.D., The Iowa Clinic

"CTI and its Physician Leadership Institute had a significant and positive impact on our physicians. Not only did they learn essential leadership skills, such as how to collaborate with others and think strategically, they were able to apply those skills immediately to projects that addressed important, real-world objectives for our health system."
-Kim Miller, FACHE, CEO, Beaver Dam Community Hospital

A Few of Our Clients

Awards & Recognition

Inc. Magazine ranked CTI on its annual Inc. 5000, the most prestigious ranking of the nation's fastest-growing private companies – 7 yeas in a row

CTI Named Small Business of the Year Finalist - Top 5 – 2016 & 2019

Top 10 Leadership Partner
Top 10 Best Executive Coaching Program
Top 10 Use of Team Building

The State of Florida
Healthcare Innovation Award

The State of Florida
Healthcare Innovation Award

Florida Companies to Watch 2015 Awardee by GrowFL

The American Hospital Association (AHA) exclusively endorsed Physician Leadership Training and Development Services from The Physician Leadership Institute™(PLI). - 2015

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Abuse, Neglect, Exploitation and Misappropriation of Property	POLICY #
DEPARTMENT/SCOPE:	Swing Bed	Page 1 of 7
REVISION DATE:	EFFECTIVE DATE: 12/27/2023	
AUDIENCE: Swing Bed	APPROVAL DATE: 4/3/2024	
OWNER: M. Padilla		APPROVER: T. Overton

DEFINITIONS

Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all patients, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled using technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

Mental Abuse – Verbal or nonverbal infliction of anguish, pain, or distress that results in psychological or emotional suffering. Includes, but is not limited to, humiliation, harassment, threats of punishment, or deprivation

Physical Abuse – A willful act against a patient by another patient, staff or other individuals. Includes hitting, beating, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment, or restraining without authorization for discipline or convenience.

Emotional Abuse: The willful infliction of mental or emotional anguish by threat, humiliation, or other verbal or nonverbal abusive conduct.

Exploitation: Means taking advantage of a patient for personal gain through the use of manipulation, intimidation, threats, or coercion.

Injuries of Unknown Source: An injury should be classified as an injury of unknown source when BOTH of the following conditions are met:

a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the patient; AND

b. The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time

Involuntary Seclusion: The separation of a patient from other patients or from his or her room or confinement to her or her room (with or without roommates) against the patient's will, or the will of the patient's legal representative. Emergency or short-term monitored separation from other patients will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the patient's needs.

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Misappropriation of Property: Means the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a patient's belongings or money without the patient's consent.

Mistreatment: Inappropriate treatment or exploitation of a patient

Neglect: Failure of the facility, its employees, or service providers to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

Sexual Abuse: Non-consensual sexual contact of any type with a patient. Includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

Verbal Abuse: Refers to any use of oral, written and/or gestured language that includes disparaging and/or derogatory terms to patients or their families, or within their hearing distance, to describe patients, regardless of their age, ability to comprehend, or disability.

Willful: As used in the definition, "abuse" means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

PURPOSE

Describe Mayers Memorial Healthcare District (MMHD) role and responsibility for preventing abuse, neglect, exploitation and misappropriation of property, and the steps for reporting and follow-up.

POLICY

The patient has the right to be free from verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion.

MMHD will ensure that the patient is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the patient's medical symptoms. When the use of restraints is indicated, This Hospital will use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

MMHD will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source, and misappropriation of patient property are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve

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abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegations do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

MMHD will maintain evidence that all alleged violations are thoroughly investigated.

MMHD will prevent further potential abuse, neglect, exploitation, or mistreatment while an investigation is in progress.

MMHD will report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five (5) working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

MMHD has zero-tolerance for any behavior on the part of anyone who could encounter a patient that could be perceived to constitute verbal abuse, sexual abuse, mental abuse, physical abuse, corporal punishment, and/or involuntary seclusion.

MMHD will take immediate disciplinary action, up to and including the immediate termination of employment or contract, for any employee or contractor involved in the abuse of a patient or financial exploitation or misappropriation of the patient's property.

MMHD will not employ or otherwise engage individuals who:

- Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law.
- Have had a finding entered in the State Nurse Aide Registry concerning abuse, neglect, exploitation, mistreatment of patients or misappropriation of their property

Professionally licensed and nurse aide position applicants will have licenses/certifications checked through the State to assure the license/certification is current and in good standing. The data base for OIG, EPLS, State Police Repository, Sex Offenders and/or other data bases that may be required, will also be checked.

All applicants will have a criminal background check completed and will not be hired if the applicant has been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. Any other conviction must be reviewed by the Administrator prior to hiring.

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Pre-employment screening of new employees will include investigations of reference.

MMHD will report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

All new employees will participate in education directed at the identification and prevention of abuse. Abuse prevention will be included in annual mandatory education.

PROCEDURES:

A. Protection

1. The hospital will provide for the immediate safety of patients and take actions to prevent further potential abuse upon identification of suspected abuse, neglect, mistreatment, injuries of unknown origin, or misappropriation of property, while the investigation is in process. Means of providing protection include, but are not limited to:
    a. Removing the alleged perpetrator from patient care areas immediately
    b. Moving patient to another room or unit
    c. Providing 1:1 monitoring as appropriate
    d. Suspending suspected employees pending outcomes of the completed investigation
    e. Initiating discharge process for patients who are a danger to self or others

B. Reporting

1. Employee or Provider

Employees or providers that witness or are informed of mistreatment, neglect, or abuse, including injuries of an unknown source, and misappropriation of patient property, will:

a. Immediately report the allegations of what was witnessed or reported to the charge nurse or supervisor.
b. If the patient acts fearful or emotionally distraught, stay with the patient, and use call light to summon the charge nurse or supervisor.
c. Document the information in the medical record.

2. Charge Nurse or Supervisor

The charge nurse or supervisor will respond immediately upon notification and will:

a. Assess the patient for:
    - immediate safety
    - physical well-being

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- injuries
- emotional distress
- any needed immediate treatment or intervention

b. Take appropriate measures to prevent further potential abuse while the investigation is in progress. Assess the incident (ask appropriate questions to attempt to ascertain what has happened).
c. Preserve any potential evidence (soiled linen, gowns, etc.) in paper or open containers (not plastic or sealed).
d. Notify the Chief Nursing Officer, Administrator or Administrator on-call and the attending physician no later than 2 hours after the allegation has been made if the events that caused the allegation involves abuse including any abusive act or allegation, or results in serious bodily injury.
e. Notify the Chief Nursing Officer, Administrator or Administrator on-call and the attending physician no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.
f. The Administrator will be notified immediately in the event of an abusive act or allegation.
g. Notify officials (including the State Survey Agency, CDPH, and adult protective services where state law provides for jurisdiction in long-term care facilities) no later than two hours after an allegation has been made if the events that caused the allegation involves abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury per the guidelines established in the state reporting guidelines and any other required agency, including the Ombudsman and local law enforcement as required by law. Responsibility for notification to State Survey Agency or other agencies may be assumed by the Chief Nursing Officer (CNO) or Social Services if the CNO or Social Services is available to report within the required timeframes.

3. Chief Nursing Officer or Social Services
   a. Notify the administrator and the attending physician within 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury.
   b. Notify the person legally responsible for the patient or individual(s) that the patient has given permission to share protected health information. This may be delegated to the administrator or the attending physician, depending on circumstances of what has occurred.
   c. Review the process to ensure that the charge nurse or supervisor has followed appropriate procedures, documented the event and that any evidence is secure.
   d. Notify regulatory officials, (including the State Survey Agency, CDPH, and adult protective services where state law provides for jurisdiction in long-term care facilities),

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no later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury if reporting has not already occurred by the Charge Nurse or Supervisor.

C. Alleged Violations by Staff

1. For any alleged violations by a staff member, the following additional steps will be taken:
   a. The Nursing Supervisor, Chief Nursing Officer or Administrator will arrange to remove the involved employee from direct care and contact with all patients pending the outcome of the investigation.
   b. If the incident warrants, the Administrator or Chief Nursing Officer will:
      - Notify law enforcement
      - Notify the Human Resource Director, the employee's supervisor, and the Risk Manager
      - Work with the Human Resource Director and Risk Manager to take appropriate steps to investigate and manage the event according to Hospital policy and procedures, and governing laws. The Risk Manager will be responsible for the coordination of the investigation and ensuring that all appropriate documentation is collected and preserved.

D. Investigation and Reporting

1. Any alleged violations will be thoroughly investigated by the Chief Nursing Officer or Risk Manager.
2. The in-house investigation will be documented and include the date and time of incident, records of statements and interviews of patient, other patients and staff as applicable, steps taken to prevent further abuse, action taken, notifications to state agencies as applicable.
3. The investigation will be reported to the administrator or his or her designated representative within five (5) working days of the incident, and if the alleged violation is verified, appropriate corrective action taken.
4. The Chief Nursing Officer or Director of Quality will report the results of all investigations to officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective actions that were taken.
5. If the incident appears to be a criminal act, the Administrator or designee will also notify the appropriate local law enforcement agencies.

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E. Education

1. All new employees will participate in education regarding the identification and prevention of abuse and their responsibility to report it, as a component of new employee orientation.
2. All employees will complete annual education on the identification and prevention of abuse, including internal reporting.
3. All staff training will be documented and maintained with training records in the facility.

REFERENCES

State Operations Manual. Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs §485.645(d)(3), §483.12(a)(1), (a)(2), (a)(3)(i), (a)(3)(ii), (a)(4), (b)(1), (b)(2), (c)(1), (c)(2), (c)(3), (c)(4))

COMMITTEE APPROVAL

P&P: 4/3/2024

SUBJECT/TITLE:	Albumin	POLICY # LAB1002
DEPARTMENT/SCOPE:	Laboratory - Chemistry	Page 1 of 3
REVISION DATE:	EFFECTIVE DATE: 11/15/2023	
AUDIENCE: Lab	APPROVAL DATE:	
OWNER: Sophia Lou Rosal, CLS		APPROVER: Kevin Davie

DEFINITION:

The ALB method is an in vitro diagnostic test for the quantitative determination of albumin in human serum and plasma.

POLICY:

It is the policy of this department to ensure that all clinical laboratory scientists performing the test adheres to this policy to produce quality laboratory results at all times.

PROCEDURE:

1. **Summary:** Measurements of albumin are used in the diagnosis and treatment of numerous diseases involving primarily the liver or kidneys.

   Albumin is the protein of the highest concentration in plasma. Albumin is formed in the liver and serves as a transport and binding protein for calcium, fatty acids, bilirubin, hormones, vitamins, trace elements and drugs. It's also important in maintaining the colloidal osmotic pressure in both the vascular and extravascular spaces. Decreased concentration can result from liver disease, kidney disease, which allows albumin to escape into the urine, malnutrition or a low protein diet.

   The albumin method is an adaptation of the bromocresol purple (BCP) dye-binding method reported by Carter and Louderback, et al. Because of an enhanced specificity of BCP for albumin, this method is not subject to globulin interference. Multiple wavelength blanking increases sensitivity and minimizes spectral interference from lipemia.

2. **Principles of Procedure:** In the presence of a solubilizing agent, BCP binds to albumin at pH 4.9. The amount of albumin-BCP complex is directly proportional to the albumin concentration. The complex absorbs at 600 nm and is measured using a polychromatic (600, 540, 700 nm) endpoint technique.

3. **Specimen Collection and Handling:** Recommended specimen types are serum and plasma. Separated samples are stable for 8 hours at room temperature, 2 days refrigerated at 2-8ºC. For longer storage, specimens may be frozen for 3 months at -20 ºC or colder.

4. **PROCEDURE:**

   4.1. Materials

   ALB Flex® reagent cartridge, Cat. No. DF13
   Total Protein/Albumin Calibrator, Cat. No. DC31
   Quality Control Materials

SUBJECT/TITLE: Albumin	POLICY OR REFERENCE #
DEPARTMENT/SCOPE: Laboratory - Chemistry	1002
	EFFECTIVE: 11/15/2023
OWNER: Sophia Lou Rosal, CLS	APPROVER: Kevin Davie

4.2. Test Steps

4.2.1. Sampling, reagent delivery, mixing, processing, and transmission of results to LIS are automatically performed by the Dimension® clinical chemistry system. For details of this processing, refer to the Dimension® clinical chemistry Operator's Guide.

4.2.2. The primary tube or sample container must contain sufficient quantity to accommodate the sample volume plus dead volume.

4.3. Test Conditions

Sample Size	5 µL
Reagent 1	Volume 125 µL
Diluent Volume	370 µL
Temperature	37 °C
Wavelength	540, 600 and 700 nm
Type of Measurement	Polychromatic endpoint

4.4. Calibration

Assay Range	0.6 – 8.0 g/dL [6 – 80 g/L]
Calibration Material	Purified human albumin or secondary calibrators such as Total Protein/Albumin Calibrator Cat. No. DC31
Calibration Scheme	3 levels, n = 3
Units	g/dL [g/L] (g/dL x 10) = [g/L]
Typical Calibration Levels	0.5, 4.5, 8.3 g/dL [5, 45, 83 g/L]
Calibration Frequency	Every 90 days for any one lot
A new calibration is required	*For each new lot of Flex® reagent cartridge *After major maintenance or service as Indicated by quality control results *As indicated by laboratory quality control Procedures or when required
Assigned Coefficients	C_0 –1.060 C_1 0.023

4.5. Quality Control

Bio-Rad Liquid Assayed Multiqual two-levels controls are run once daily.

4.6. Results: The instrument calculates the concentration of albumin in g/dL [g/L] using calculation scheme.

Reference ranges are established and maintained in the LIS.
Reference Range: 3.4 – 5.0 g/dL

Repeat all critical values as needed.
Critical Value: Not applicable

SUBJECT/TITLE: Albumin	POLICY OR REFERENCE #
DEPARTMENT/SCOPE: Laboratory - Chemistry	1002
	EFFECTIVE: 11/15/2023
OWNER: Sophia Lou Rosal, CLS	APPROVER: Kevin Davie

4.7. Analytical Measurement Range (AMR): 0.6 – 8.0 g/dL [6 – 80 g/L]

Samples with results above 8.0 g/dL [80 g/L] are reported as "Above Assay Range" and should be repeated with dilution.
Autodilution (AD): Refer to Operator's Guide for details.
Manual Dilution: Make appropriate dilution with Reagent grade water to obtain result within the assay range. Enter dilution factor. Reassay. Resulting readout is corrected for dilution.

Results less than 0.6 g/dL [6 g/L] should be reported as "less than 0.6 g/dL [6 g/L]".

5. Limitations

The instrument reporting system contains flags and comments to provide the user with information regarding the instrument's processing status and potential errors.

A system malfunction may exist if the following 5 test precision is observed:

Concentration	**S.D.**
0.69 g/dL [7 g/L]	> 0.10 g/dL [1.0 g/L]
3.84 g/dL [38 g/L]	> 0.12 g/dL [1.2 g/L]

Interfering substances:
CMPF (3-carboxy-4-methyl-5-propyl-2-furanpropanoic acid) present in sera of patients with renal failure has been reported to give falsely low albumin values.
Lipemia (Intralipid®) at 1000 mg/dL [11.3 mmol/L] and above tripped a test report message; therefore the magnitude of the interference could not be determined.

REFERENCES:

Siemens Dimension Clinical Chemistry System – Flex reagent cartridge kit insert IFU 717013.001-US | April 22, 2019

COMMITTEE APPROVALS:

P&P: 3/6/2024
MEC: 4/4/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Autoclave Control Testing And Maintenance	POLICY # SG 0044
DEPARTMENT/SCOPE: Surgery		Page 1 of 5
REVISION DATE: 4/2/2024 8/18/2017 9/11/2019	EFFECTIVE DATE: 2/6/2016	
AUDIENCE: All Surgical Staff	APPROVAL DATE:4/11/2024	
OWNER: L. Melang		APPROVER: T. Overton

POLICY:

Steam sterilization is the safest method of sterilization available in health care. It is the preferred method of sterilization for those items that can withstand heat and moisture. All central supply personnel are trained and evaluated to operate each autoclave safely and correctly. Temperature, humidity, and vacuum are measured with controls to ensure proper functioning of a sterilizer, ensuring the efficiency of the sterilization process. Mechanical and chemical controls assist in identifying and preventing sterilizer malfunction and operational errors made by personnel.

PROCEDURE:

1. Cleaning:
    a. Autoclaves and racks will be cleaned with a water-dampened cloth. No soaps or abrasives will be used.
    b. Autoclaves and racks will be cleaned daily when the surgery department is open. Both the interior, as well as the exterior of the autoclaves will be cleaned.
2. Operation:
    a. All central supply personnel will refer to the MDT Castle® Autoclave instruction booklet for step-by-step instructions on how to operate the autoclaves.
    b. The MDT Castle® Autoclave instruction booklet will be posted on the wall between Autoclave One and Autoclave Two.
3. Functioning:
    a. Mechanical Controls:
        i. Temperature
            1. Each autoclave is equipped with automatic controls that control all phases of the sterilization process.
            2. When a drop in temperature occurs, or when sufficient temperature is not achieved, the sterilization cycle is automatically aborted.
            3. If a cycle is aborted, all items in that load will be opened and reprocessed. A second sterilization cycle will then be attempted.
            4. If the second cycle is successful, continue normal processes.
            5. If the second cycle is unsuccessful, the autoclave will be taken out of service and warranty personnel will be notified. All items in second load will be opened and reprocessed via a different autoclave or alternative sterilization method.
        ii. Vacuum
            1. A Sterilizer Mechanical Air Removal Test Pack (Bowie-Dick Test) will be processed through a sterilization cycle before the autoclave is put into daily operation. This test is designed to detect residual air in the chamber. Air is a poor conductor of heat, thus an air pocket in the chamber causes sterilization failure.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Autoclave Control Testing And Maintenance	POLICY # SG 0044
DEPARTMENT/SCOPE: Surgery		Page 2 of 5
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AUDIENCE: All Surgical Staff	APPROVAL DATE:4/11/2024	
OWNER: L. Melang		APPROVER: T. Overton

2. One pack will be used for each autoclave.
3. Packs will be placed into autoclave alone. No other items will be run in this cycle.
4. The indicator(s) inside each pack will be checked at the end of the test cycle.
5. If a failed indicator is noted, a second pack will be tested.
6. If a failed indicator is noted upon retest, the autoclave will be taken out of service and warranty personnel notified.
7. If the indicator passes inspection, the autoclave will be put into use for the day.

b. Chemical controls:
Chemical indicators are used to detect failures in packaging, loading, or sterilizer function. Chemical indicator cards or strips are impregnated with a material that changes color when steam initiates a chemical reaction.
   i. A chemical indicator card or "load card" will be placed in every load. All items placed in the load must be listed on the card. The card has an indicator that changes from light to dark when it has gone through a proper cycle.
   ii. Every item that is wrapped for sterilization will be secured with heat sensitive tape. This tape has stripes that change from light to dark, indicating that the package has gone through the heat cycle.
   iii. Vis-a-peel packages have their own indicator spot that changes from light to dark during the heat cycle.
   iv. Before unwrapping or opening a sterile item, the indicators on the item will be checked to make certain they have gone through the heat cycle.
   v. A sterilization indicator will be placed inside, at the center of all wrapped or Vis-a peel packages. Upon unwrapping or opening of the item the contents of the item will be checked and the sterilization indicator will be noted for color change.
   vi. Any chemical indicator, located on the outside or inside of a wrapped or Vis-a-peel package, which does not demonstrate a complete and uniform color change will be considered "failed."
   vii. Any package supporting a failed indicator will be repackaged and reprocessed.

c. Operation Log:
The autoclave control panel provides a printed readout which provides time and temperature information regarding each sterilization cycle. Its recordings are proof that the exposure time of loads has been correct and proper temperature limits have been maintained.
   i. The autoclave control panel printout for each load will be attached to its corresponding load card.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Autoclave Control Testing And Maintenance	POLICY # SG 0044
DEPARTMENT/SCOPE: Surgery		Page 3 of 5
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AUDIENCE: All Surgical Staff	APPROVAL DATE:4/11/2024	
OWNER: L. Melang		APPROVER: T. Overton

ii. Each printout and load card will be bundled and placed into an envelope.
iii. Envelopes will be gathered by month and boxed by year. These records will be maintained in compliance with local, state, and federal regulations.

4. For quality assurance, autoclaves have biological monitoring performed weekly. Biological controls are used to identify and prevent sterilizer malfunction.
    a. Exposure/Incubation:
        i. Place indicator pack into autoclave and process with load.
        ii. Crush the glass ampule in the designated crushing well in the incubator.
        iii. Hold cap and tap until the spore strip at bottom of vial is wet.
        iv. Push the crushed indicator down to firmly seat it in the metal heating block.
    b. Readout procedure:

COMMITTEE APPROVALS:

Surg: 4/11/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

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DEPARTMENT/SCOPE: Surgery		Page 4 of 5
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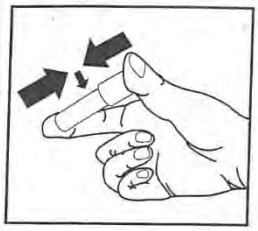
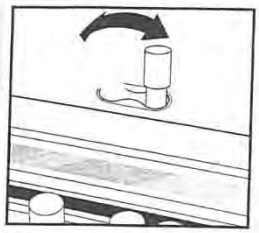
AUDIENCE: All Surgical Staff	APPROVAL DATE:4/11/2024	
OWNER: L. Melang		APPROVER: T. Overton

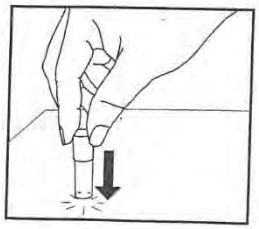
Follow this procedure for every 3M™ Attest™ Rapid Readout Biological Indicator to be read.



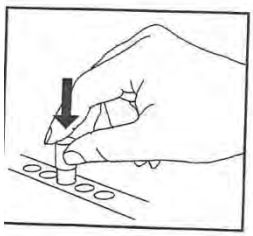
While wearing safety glasses, **CLOSE** the cap of the cooled 3M™ Attest™ Rapid Readout Biological Indicator (BI) by pushing cap down.



CRUSH the glass media ampoule in the Crusher Well built into the top of the 390 Auto-reader.



Holding BI by the cap, **TAP** the bottom of the vial on a tabletop until media wets spore strip at bottom of vial. Do not tap BI on Auto-reader.



PLACE the crushed BI in **color-coded** incubation well. Observe 3M™ Attest™ Auto-reader 390 LCD panel to confirm correct placement of the BI. If the BI is correctl seated, the 3M™ Attest™ Auto-reader 390 LCD panel will display ***, **, * and then remaining minutes of incubation directly below the incubating BI.

RECORD BI result.

WARNING: Do not remove the 3M™ Attest™ Rapid Readout Biological Indicator from the incubation well until the (+) or (-) symbol on the LCD panel indicates the test is complete.

MAYERS MEMORIAL HEALTHCARE DISTRICT

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REVISION DATE: 4/2/2024 8/18/2017 9/11/2019	EFFECTIVE DATE: 2/6/2016	
AUDIENCE: All Surgical Staff	APPROVAL DATE:4/11/2024	
OWNER: L. Melang		APPROVER: T. Overton

c. Dispose broken ampule in the sharp's container.
d. Interpretation:
   Examine the indicator at regular intervals for any color change.
   i. Rapid readout at 3 hours.
   ii. Final readout at 48 hours.
   iii. If color changes to yellow, bacterial growth is present.
   iv. No color change indicates an adequate sterilization cycle.
e. Test Failure: If a yellow color change occurs, a retest must be performed, and all items sterilized in test load must be opened and their biological indicators will be inspected. Once opened, these items are considered unsterilized and will be reprocessed.

REFERENCES:

1. Sterilization. In: *AORN Guidelines for Perioperative Practice*. 2023 ed. Denver, CO. 2023

2.Sterilization and Decontamination Devices 07.04.05. Infection Control. In: *ACHC Accreditation Requirements for Critical Access Hospitals. 2023 ed.*

3. Rothrock JC, McEwen DR, Ann VWS. In: Alexander's Care of the Patient in Surgery. Elsevier; 2023.

4. Steam sterilization. Centers for Disease Control and Prevention. September 18, 2016. Accessed January 5, 2024.
https://www.cdc.gov/infectioncontrol/guidelines/disinfection/sterilization/steam.html.

5. MDT Castle®, M/C Vacuum Steam Sterilizer Operator Manual. Rochester, NY 08/15/1990.

APPROVALS:
Surgery: 9/11/2019

SUBJECT/TITLE:	Communication-News Media Process/Plan	POLICY # DIA020
DEPARTMENT/SCOPE:	Disaster	Page 1 of 2
REVISION DATE:	EFFECTIVE DATE:	
AUDIENCE:	APPROVAL DATE:	
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

PURPOSE

The hospital will seek to maintain a cooperative relationship with the news media and community during an emergency.

PROCEDURE:

- The Incident Commander will appoint a Public Information Officer.
- The Public Information Officer (PIO) shall develop a media relations plan in cooperation with the media to ensure accurate and timely reporting.
- Pre-script risk communication messages for likely incidents shall be created and ready when needed
  - These messages shall be developed in coordination with the Public Health department and other response agencies as appropriate.
  - The Public Information Officer, in coordination with the local Emergency Management Director, other hospitals and public health, shall develop joint communication via Joint Information System (JIS).
  - Joint Information Center (JIC) is a physical location where public information professionals from organizations involved in incident management activities can re-locate to perform critical emergency information, crisis communications and public affairs functions.
  - Do not send out information that is not validated, or that you don't know to be accurate.
- Communication to the community shall include appropriate guidance for all age groups and populations in a timely and effective manner.
- Public education programs include:
  - Direction on what actions should be taken
  - Direction on what actions should not be taken
  - Appropriate details about the incident
  - Actions taken by the hospital and community
- **Only the designated Public Information Officer shall interact with the media.**
- Questions not related to the hospital's response shall be referred to the local or state emergency management agencies.
- When a Joint Information Center (JIC) is established, a hospital representative will be designed to participate in the JIC.
- Communication – News Media
  - Hospital staff will not discuss topics that are outside of their areas of expertise, and **WILL NOT** communicate with the media unless authorized by the Incident Commander and in conjunction with The Public Information Officer.
  - Condition reports, stating the patient's condition only, will be authorized by Nursing Administration. This condition information will be made available to the information desk and Nursing Supervisor. The information on patient conditions is limited to the following:
  - **Good-** The patient is conscious, vital signs are stable, within normal limits. Outlook
  - for recovery is excellent.
  - **Stable-** The patient is conscious but may be uncomfortable, vital signs are stable. The

SUBJECT/TITLE:	Communication-News Media Process/Plan	POLICY # DIA020
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OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

- patient is making satisfactory progress in relation to his/her diagnosis, outlook for
- recovery is favorable.
- **Serious-** The patient's vital signs may be unstable, not within normal limits; the
- patient is acutely ill; the outlook for recovery is questionable.
- **Critical-** The patient has major complications; vital signs are unstable. The outlook
- for recovery is potentially unfavorable.

- Media will only be given permission to interview, tape, film or photograph patients with their expressed permission.
- In the case of minors, consent for interview or release of information to the media must be obtained from parent or guardian.
- Information regarding patients who are unconscious or medically incompetent may only be released with the consent of patient's family or legal guardian in accordance with consent laws.
- Information to be released as a case of public record will only be done by authorized personnel after next of kin have been notified by the appropriate agency. (i.e., persons under arrest or held under police surveillance, persons brought to the hospital by law enforcement or fire department, cases of alleged shooting, stabbing, poisoning, injury by moving vehicle, dog bites and cases reportable to government agencies)
- **NO STATEMENT** will be made regarding the following:
  - HIV or AIDS
  - Suicide or attempted suicide
  - Sexual assault
  - Poisoning
  - Intoxication

Also see:
Emergency Operations Plan
Communications Plan
Crisis Communications Plan

REFERENCES:

Communications Plan
Crisis Communications Plan

COMMITTEE APPROVALS:

SUBJECT/TITLE:	Disruption of Services; Fire and Disaster Health Records- SNF	POLICY # DIA026
DEPARTMENT/SCOPE:	Disaster	Page 1 of 2
REVISION DATE:	EFFECTIVE DATE: 12/17/2018	
AUDIENCE:	APPROVAL DATE:	
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

PURPOSE:

All employees of Mayers Memorial Healthcare District need to be prepared for any emergency or disaster. Long-term residents and patients are the main priority and, in a disaster, or emergency the need for evacuation, or emergency power systems may arise. Resident and patient health records must be kept according to facility policies and the process must be followed to ensure proper care.

GUIDELINES:

NOTE: Common sense must prevail. Use your good judgment to protect patients/personnel first, then
the health records. Make all information available as quickly as possible for continuity of care.
1. Attend all fire and disaster training and drills. You must be fully aware of the evacuation plan for this facility.
2. Disaster Tags are located at each nursing unit. Know the exact location and periodically check to see if they are still there.
3. If current inpatient health records are not moveable racks, maintain large gurney sacks/pillowcases with disaster tags. In the event of a disruption of service insert records in sacks and drag them to a secure area. Electronic records can be faxed, e-mailed, or accessed where needed to provide care.
4. Evacuate health records in order of priority:
a. Current medication records
b. Patient index file
c. Current in-patient health records
d. Current in-patient thinned health records
e. Registers/Indexes
f. Discharged health records
5. Maintain confidentiality of health record information during a disruption of service.

PROCEDURE:

Disruption Of Services; Fire and Disaster Health Records - SNF

Fire/Disaster:
1. Report to triage area per facility plan.
2. Attach disaster tags to each patient brought into/or leaving the facility.
3. Complete as much patient identification information as possible.
4. If time and equipment allow, copy the health record front sheet, current medications, and patient care plan to attach to disaster tags of patients leaving the facility. Do not send original information to the patient.
5. As soon as the disaster is resolved, we can send additional information for continuity of care.
6. Control: Maintain a log of disaster tags as distributed and include patient name, disposition/destination, or retain a copy of the disaster tag and maintain it in alphabetical order by patient name. (Tag should include destination/disposition.)

SUBJECT/TITLE:	Disruption of Services; Fire and Disaster Health Records- SNF	POLICY # DIA026
DEPARTMENT/SCOPE:	Disaster	Page 2 of 2
REVISION DATE:	EFFECTIVE DATE: 12/17/2018	
AUDIENCE:	APPROVAL DATE:	
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

Facility Closure/Change of Ownership/Destruction/Defacement/Lost Health Records:

1. The administrator should call/write Department within 3 business days of the facility's intention to close.
2. The administrator should call/write Department within 3 business days of the transfer of ownership
3. The Administrator should call/write the Department within 3 business days of health record defacements/destruction before termination of the retention period.
4. The health record designee should file all records per regular procedure, making certain that all electronic records are current
5. Lock all lockable file drawers; lock the storage area, desk, and department. Turn keys into the administrator and ensure the administrator has access to all electronic records. IT is to rescind access to electronic records to everyone except the administrator and whomever the administrator designates to have access.
6. The health Records will remain locked in the facility until the Department orders that they be moved.

REFERENCES

Title 22: 72543 (c), (d), (e)(1), (2), (3)
Title 22: 72551 (b)(8), (10)
Title 22: 72553 (b)(10), (11)

COMMITTEE APPROVALS:
Disaster/Safety: 12/17/2018

SUBJECT/TITLE:	Emergency and Critical Incident Plan	POLICY # DIA017
DEPARTMENT/SCOPE: Disaster		Page 1 of 4
REVISION DATE: 5/13/2024	EFFECTIVE DATE: 9/14/2020	
AUDIENCE: All Hospital Staff	APPROVAL DATE:	
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

DEFINITIONS:

Emergency is an unplanned or imminent event that affects or threatens the health, safety or welfare of people, property, and infrastructure, and which requires a significant and coordinated response. The defining characteristic of an emergency event or situation is that usual resources are overwhelmed or have the potential to be overwhelmed. Emergencies may be a specific event with a clear beginning, end and recovery process, or a situation that develops over time and where the implications are gradual rather than immediate.

Emergency management is the coordination of an emergency response and management of recovery. Emergency management hopes to minimize physical and psychological impacts on all parties and to minimize damage to assets, operations, reputation, and staff productivity.

Critical Incident Debriefing (CID) is a preventative health measure to minimize the impact of traumatic events and the development of major psychological health problems such as Post Traumatic Stress (PTS) Disorder.

POLICY:

Mayers Memorial Healthcare District identifies, prevents, and manages disaster and emergencies within its sphere of responsibility and influence, until the arrival of appropriate emergency services. Mayers Memorial Healthcare District will swiftly and effectively respond to emergencies, with the foremost goals of preserving life, protecting the organization's property, and restoring operations as quickly as possible.

A range of emergencies may occur on the premises with the potential to impact on the safety of staff, board members, volunteers, students, visitors and patients, including:

- Natural Hazards
- Technological Hazards
- Human Hazards
- Hazardous Material

Emergency and Critical Incident

PURPOSE:

The purpose of this policy is to ensure Mayers Memorial Healthcare District prepares for and effectively responds to emergencies and critical incidents through the appropriate use of resources. The prevention and effective management of emergency situations and critical incidents can assist in minimizing the negative impact of an unexpected event.
This policy applies to all staff, consumers, volunteers, and Board members.

SUBJECT/TITLE:	Emergency and Critical Incident Plan	POLICY # DIA017
DEPARTMENT/SCOPE: Disaster		Page 2 of 4
REVISION DATE: 5/13/2024	EFFECTIVE DATE: 9/14/2020	
AUDIENCE: All Hospital Staff	APPROVAL DATE:	
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

Position Delegation/Task

Board of Directors

- Develop and Review Emergency and Critical Incident Policy. Compliance with Emergency and Critical Incident Policy.

Management CEO/Manager

- Ensures development and implementation of Emergency and Critical Incident Policy.
- Ensures potential disasters and emergencies are identified, and appropriate emergency management plans are in place.

Safety Officer/ Emergency Preparedness

- Lead responsibility for the implementation of emergency and critical incident procedures, including identification of potential situations, developing, documenting, and communicating response plans, reporting on actual situations, and reviewing policy and procedures following a disaster or emergency.
- Coordinate staff training in emergency and critical incident, such as fire response, building evacuation, etc.

Staff

- Maintain compliance with Emergency and Critical Incident Policy.
- Contribute to the development of emergency and Critical Incident Policy.
- Behave in a way that minimizes the risk of emergencies occurring.

Risk Management

- All staff and volunteers are trained in disaster and emergency response procedures at induction and annually by the Safety Officer or designee.
- Emergency drills, education, and training will occur at least two times per year under the instruction of the Safety Officer or designee through in-person training or Relias.
- Disaster and emergency management plans are reviewed annually and/or following the event of a disaster or emergency.

Implementation

All staff have access to and are familiar with policies and procedures relating to disaster emergency management. Emergency Preparedness documents can be located on the staff INTRANET and in DISASTER BINDERS at the Station 1, Station 2, Emergency Department, Annex Nurse’s Station, and Administration (Safety Officer's office).

Emergency and Critical Incident

All staff have information, which outlines actions to follow for various disasters and emergency situations.

Risk Assessment

Mayers Memorial Healthcare District uses a risk assessment process to identify and control

SUBJECT/TITLE:	Emergency and Critical Incident Plan	POLICY # DIA017
DEPARTMENT/SCOPE: Disaster		Page 3 of 4
REVISION DATE: 5/13/2024	EFFECTIVE DATE: 9/14/2020	
AUDIENCE: All Hospital Staff	APPROVAL DATE:	
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

barriers to effective emergency management.

Preparedness
Emergency Operations Plan: Supports the organization to prepare for potential disasters and emergencies, and is reviewed on an annual basis. Disaster and emergency management plans are reviewed on an annual basis.

Risk Assessment: A Hazards Vulnerability Assessment is completed annually for each campus. This document directs the need for training and education of staff.

HICS: Mayers Memorial Healthcare District will use the Hospital Incident Command System (HICS) for planning, implantation, and documentation of incidents.

Drills: Mayers Memorial Healthcare District will participate in community-wide drills through Shasta County, the State of California, and local community partner groups.

Communication: Mayers Memorial Healthcare District will communicate with staff via a mass notification system, email, and the intranet in case of an emergency. All staff will provide appropriate contact information to ensure they will receive important communications. Back-up communication includes WPS/GETS, satellite phones, HAM Radio and any alternate means necessary.

Expectations of Staff, Board members, and Volunteers
- All staff, Board members, and volunteers are provided with training to ensure they are familiar with the implementation of disaster and emergency management plans.
- All staff, Board members, and volunteers familiarize themselves with emergency evacuation procedures, including their responsibilities and the emergency evacuation assembly point.
- All fire safety activities undertaken by the organization are recorded and reviewed to identify gaps in training, knowledge, equipment, or processes. Fire activities include, but are not limited to, fire safety training, drills, and exercises, records of maintenance, and inventories of equipment kept.
- Where relevant, all staff, and volunteers familiarize themselves with techniques to minimize physical and emotional harm from other people.

Response
When a disaster or emergency arises, the primary aim of the response is to ensure the safety of all people on the premises, preserve life, and protect property.

Recovery
- Mayers Memorial Healthcare District initiates recovery and aims to restore operations as quickly as possible.

SUBJECT/TITLE:	Emergency and Critical Incident Plan	POLICY # DIA017
DEPARTMENT/SCOPE: Disaster		Page 4 of 4
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AUDIENCE: All Hospital Staff	APPROVAL DATE:	
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

- The availability of critical incident debriefing is an essential component of the Organization's approach to emergency management.
- When required, supportive counseling is provided to consumers, staff, volunteers, students and board members who are affected by an emergency or critical incident within two hours of the event (for defusing and mobilization) and then within 48 to 72 hours (for critical incident debriefing).

Emergency and Critical Incident Procedures

Staff, board members, volunteers, and consumers who experience a critical incident related to their involvement with Mayers Memorial Healthcare District should immediately inform where possible their direct supervisor. If this is not possible, they should immediately inform the Safety Officer.

Where required, a meeting will be organized to determine issues and responsibilities relating to:

- Assessing risks and response actions
- Liaison with emergency and other services contact with the affected person's relatives and other supports
- Liaison with other organizations
- Counselling and supporting staff, board members, volunteers, students and consumers not directly involved in, but affected by, the incident.
- Media management (if required)
- Where appropriate Mayers Memorial Healthcare District may be required to provide support to the family in the form of:
  - hiring interpreters
  - planning for hospital/funeral/memorial service/repatriation
  - obtains a death certificate
  - assisting with personal items and affairs including insurance issues

REFERENCES:

Mayers Memorial Healthcare District Emergency Operations Plan

COMMITTEE APPROVALS:

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Evaluating Quality Control	POLICY # LAB3001
DEPARTMENT/SCOPE:	Laboratory - General	Page 1 of 6
REVISION DATE:		EFFECTIVE DATE: 11/16/23
AUDIENCE: Lab		APPROVAL DATE: 4/4/2024
OWNER: Sophia Lou Rosal, CLS		APPROVER: K. Davie

DEFINITIONS:

1. Systematic Errors: Where a shift or drift may have occurred causing the average value to be different from the "true value." Systematic errors can be caused by incorrect calibration, incorrect assay temperature, bad reagents, or malfunctions in the instrument.

2. Random Error: Where scatter of values occurs about the "true value." Random error = standard deviation.

PURPOSE:

Laboratory quality control is all the measures put in place to eliminate the risk of non-conforming outcomes. It involves systems that safeguard the accuracy, reliability, and timeliness of lab results by ensuring the early detection of results or measurement errors and the procedures to rectify them. It should be performed regularly and quality control materials should be treated the same as samples, from the beginning to the end of the run.

Laboratory quality control (QC) ensures that the lab processes and operations run efficiently and guarantees the production of accurate and reproducible results. In addition, the QC measures developed in a lab are the building blocks for the process of certification and accreditation.

Failure to integrate quality control in a laboratory can lead to several negative consequences, including the following:

- Time wastage, as experiments and tests are repeated.
- Budget implications, as more reagents are needed to carry out repeat tests and experiments.
- Unreliable results, which will impact the integrity of the lab and consequently any funding options and certification/accreditation process.
- Loss of customer loyalty and satisfaction.
- Safety concerns due to non-compliance in the absence of quality control mechanisms.
- Delayed diagnosis or unnecessary treatments for patients.

The process of setting up laboratory quality management begins with identifying all the lab processes and practices that are susceptible to inefficiencies, errors, and safety concerns, to build systems that secure them as discussed below.

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Standard:

Criteria used to evaluate acceptable versus unacceptable control values. To explain the Westgard rules Control Rules of quality controls in details.

POLICIES AND PROCEDURES:

1. Multi-Level Control:

    A. Acceptable: If no rule violation occurs (excluding Rule 5A).

    B. Unacceptable: If one or more rule violations occur (excluding Rule 5A). If running two controls and one control is out, then you cannot run patient samples until the error is rectified.

    C. Acceptable: If running three controls and only one control value is out. You must still evaluate why the control is out, and rectify the situation. You can run patient samples.

    ***NOTE:** If a systematic error occurs, 4 1S or 10x, and no random error occurs, patient results may be reported out. See evaluation of shifts and trends.

2. Single-Level Control:

    A. Acceptable: Value must always fall within 2SD.

    B. Unacceptable: If one or more rule violations occur.

3. Qualitative Assay Controls:

    A. Acceptable:

        1. Negative results obtained from the negative control material.

        AND

        2. Positive results obtained from the positive control material.

    B. Unacceptable:

        1. Positive results obtained from the negative control material.

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AND/OR

2. Negative results obtained from the positive control material

Note: If the results are unacceptable you must repeat the controls and the run. No test(s) will be resulted until the controls are acceptable.

3. Control Rules - Decision Criteria:
   A. 1 2S (single level control only): When control observation exceeds two standards deviations (SD) from the mean(x).

   B. 1 3S when one control observation exceeds 3 SD from the mean.

   C. 2 2S when two consecutive control observations, or two of three consecutive observations exceed 2SD on the same side of the mean.

   D. 2 SD when both control values exceed 2 SD from the mean.

   E. 4 1S four consecutive values on one side of the mean farther than 1SD from the mean.

   F. 10x ten consecutive values on one side of the mean.

      1. Shift has occurred when 10 or more consecutive values have been either above or below the mean.
      2. Trend has occurred when 10 or more consecutive values have either increased or decreased in value regardless of the mean.

5. Evaluation of Shifts and Trends:

   Control values must be evaluated and a supervisor notified if any of the control rules 1 1S, 4 1S or 10x is violated.

6. All occurrences of out of control situations and steps taken are documented on the Instrument/QC Action Log.

7. All QC values shall be entered on the appropriate Levy Jennings chart.

8. Recommended action plan for resolving unacceptable quality control situations:

   A. Hold all specimen values and do not report. Notify the floor or physician about the delay.

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B. Check to see if you have run the wrong level of control.

C. Check lot numbers and expiration date of controls, standards and reagents.

D. Examine and troubleshoot the instrument, reagent system and pertinent technical Detail; repeat using the same control vials.

(1) Look for contamination and defects of reagents and disposables: e.g., specimen cups, cuvettes, probes, tubing's, seals, rings, etc.
(2) Check usage dates of reagents and controls.
(3) Check if routine/scheduled preventative maintenance were performed.
(4) Check if calibrations are up-to-date.
(5) For assayed controls, verify the assay sheets for control values (consider: if there is a change in the lot numbers, there will also be a change in the control values).

E. If repeating with the old controls proves unsatisfactory, repeat with new control.

F. If repeating control runs proves unsatisfactory, notify a supervisor and re-examine the procedure. Systematically problem-solve by:

(1) Replacing the controls, standards, reagents, etc., as needed.
(2) Performing the calibration of the instrument or test involved.

G. If all of the above proves unsatisfactory, back-up procedures may need to be considered. This decision should be made jointly by the staff, supervisor and pathologist. In the event where the pathologist or supervisor are not available, the technologist must take the necessary action.

H. Call the instrument hotline for assistance.

Note: These guidelines are designed as a general statement. More detailed information can be found in the written procedure for each test or in the Operator's Manual.

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Evaluating Run Data
2 Controls per run

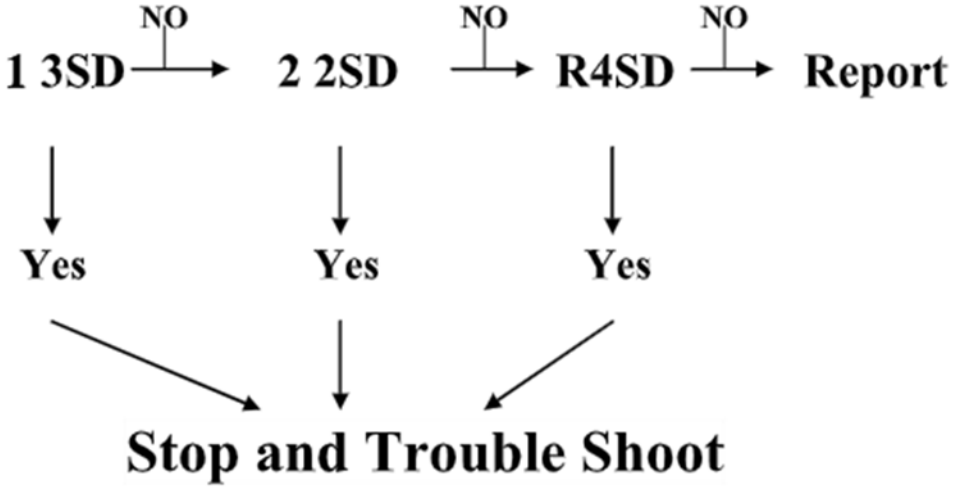
Look at the data.

↓

Is one value > 2SD? If No, report the data

If Yes then

↓



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REFERENCES:

Westgard Quality Control, *Westgard Rules and Multirules Quality Control* Website: westgard.com/multirule.htm | Retrieved on 10/24/2023

University of Texas Medical Branch, *Westgard Rules Policy and Procedures* Website: www.utmb.edu/policies_and_procedures | Retrieved on 10/24/2023

COMMITTEE APPROVALS:

P&P: 3/6/2024
MEC: 4/4/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Fire Safety Management Plan	POLICY # SAF004
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AUDIENCE: All Hospital Staff	APPROVAL DATE:	
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

Also see¨ Fire Safety Response Plan

PURPOSE

The purpose of the Fire Safety Management Plan is to define the program to protect building occupants from fire and the products of combustion.

SCOPE

The Fire Safety Management Program is designed to assure an appropriate and effective response to fire emergency situations that could affect the safety of patients, staff, and visitors or the environment of the hospital. The program is also designed to assure compliance with applicable codes and regulations.

I. FUNDAMENTALS

A. The hospital buildings must be in compliance with law, regulation, and accreditation, including compliance with the 2012 *Life Safety Code*®.

B. Deficiencies with these codes must be corrected as quickly as practical. When deficiencies cannot be corrected immediately, Interim Life Safety Measures (ILSM) are considered and implemented whenever patients are exposed to an increased risk of exposure to fire or products of combustion.

C. The fire alarm, detection and suppression systems must be maintained to ensure reliable performance and meet all applicable codes.

D. Fire safety training is an essential part of fire safety.

II. OBJECTIVES

A. The Fire Plan defines the hospital's methods for protecting patients, visitors, and staff from the hazards of fire, smoke, and other products of combustion and it is reviewed and evaluated annually.

B. The fire detection and response systems are tested as scheduled and the results are forwarded to the Safety Emergency and Environment of Care (SEECC) Committee quarterly.

C. Summaries of identified problems with fire detection and response systems, NFPA code compliance, fire response plans, drills, and operations, in aggregate, are reported to the Safety Emergency and Environment of Care Committee (SEECC) quarterly.

D. The procedures used to review furnishings, draperies, bedding and other new materials for conformance with applicable flammability standards are evaluated at least every three years.

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E. The scope and objectives of this plan, as well as program effectiveness and performance, are evaluated annually.

F. Fire prevention and response training includes the response to the fire, at the scene of the fire and in other locations of the facility, the use of the fire alarm system, processes for relocation and evacuation of patients, if necessary, and the functions of the building in protection of staff and patients. Staff knowledge of these issues is evaluated quarterly.

G. Performance indicators for the Fire Prevention Program are reported to the Safety Emergency and Environment of Care Committee (SEECC) on a quarterly basis.

H. The Fire Plan defines the response to fire emergencies on a facility wide basis, at the point of origin and in other areas of the facility, as well as the specific roles and activity should patient relocation or evacuation if necessary. Unit-specific fire plans are evaluated at least tri-annually, or as significant changes take place in those units.

I. The specific roles of physicians and other licensed independent practitioners, volunteers, students, and others are defined, both at the scene of a fire and in other parts of the facility.

J. The role and use of a fire alarm system (where installed) is included in the training. Staff knowledge is evaluated as part of fire drills. The results are reported to the Safety Emergency and Environment of Care Committee (SEECC) at least annually.

K. Staff knowledge of patient relocation, including compartmentalization where provided and equipment which may be used to relocate or evacuate a patient are included in drills. Staff knowledge is evaluated and reported to the Safety Emergency and Environment of Care Committee (SEECC) annually.

L. Fire extinguishers are inspected monthly and maintained annually. They are positioned to be in visible locations and are selected based on the hazards of the area in which they are installed.

M. Automatic fire extinguishing systems, including sprinkler systems and packaged systems, are tested according to applicable NFPA standards. Tests are annual or semiannual, depending on system function.

III. ORGANIZATION AND RESPONSIBILITY

A. The Governing Body receives regular reports on the activities of the Fire Safety Program from the EC Committee. They review reports and, as appropriate, communicate concerns about identified issues and regulatory compliance. They also authorize capital budget expenses to

correct *Life Safety Code* deficiencies. They also provide support to facilitate the ongoing activities of the Fire Safety Program.

B. The CEO receives regular reports on the activities of the Fire Safety Program from the EC Committee. The CEO reviews reports and, as necessary, communicates concerns about key issues and regulatory compliance to the Safety Officer. The CEO collaborates with the Safety Officer/Director of Operations to establish operating and capital budgets for the Fire Prevention Program.

C. The Safety Officer / Director of Operations manages the Fire Safety Program. They identify *Life Safety Code* deficiencies, develop Plans for Improvement, manage the maintenance of fire systems, the fire plan, fire drills, and fire response. The Human Resources department facilitates training of staff, volunteers, and physicians. The Safety Officer / Facilities Manager advises the Safety Emergency and Environment of Care Committee (SEECC) regarding fire safety issues that may necessitate changes to policies, orientation, education, or purchase of equipment.

D. Department heads orient new staff members to the department-specific, job-specific fire safety procedures. Department heads are responsible for ongoing training of their staff in fire safety procedures. When necessary, the Safety Officer or his designee provides department heads with assistance in developing department fire safety procedures.

E. Individual staff members are responsible for learning and following the hospital-wide and departmental fire plans. Individual staff members are also responsible for learning and using emergency reporting procedures for fires and fire hazards.

IV. PROCESSES OF THE FIRE SAFETY MANAGEMENT PLAN

Fire Safety Management Plan (ACHC 03.00.02)

The hospital has developed and maintains a written management plan describing the processes it implements to effectively manage the fire safety environment of patients, staff and others. The management plan is evaluated annually and modified as necessary, based on changes in conditions, regulations and standards and identified needs.

Protecting Patients Staff and Others

The hospital minimizes the potential for harm from fire, smoke, and other products of combustion. The Safety Officer is responsible for managing the program for protecting patients, personnel, visitors and property from fire, smoke, and other products of combustion. The fire protection program includes three phases.

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- The first phase is the design of buildings and spaces to assure compliance with current local, state, and national building and fire codes. All designs are reviewed either by local or state agencies as part of the construction and permitting process.
- The second phase is maintenance of the current building. The Director of Operations is responsible for setting maintenance standards based on applicable codes. The standards are applied through a process of planned maintenance and management of the work completed by The hospital staff and contractors to ensure the end product of all work maintains or improves the level of life safety in each affected area.
- The third phase is an active program of fire prevention, fire safety and fire response training. The Safety Officer manages this phase of the program.
- When flammable germicides or antiseptics are used during surgeries utilizing electro-surgery, cautery, or lasers the following are required:
  - Packaging is nonflammable. -
  Applicators are in unit doses. -
  Preoperative "time-out" is conducted prior to the initiation of any surgical procedure to verify the following:
  - Application site is dry prior to draping and use of surgical equipment.
  - Pooling of solution had not occurred or has been corrected. -
  Solution-soaked materials have been removed from the operating room prior to draping and use of surgical devices. (For full text, refer to NFPA 99-2012: 15.13).

Smoking by Patients

Patients/ Residents are not allowed to smoke on District grounds.

Fire Response Plan (ACHC 03.00.02)

The hospital has a written fire response plan. The written response plan describes the specific roles of staff and licensed independent practitioners at and away from the fire's origin, including when and how to sound alarms, how to contain smoke and fire, how to use a fire extinguisher, and how to evacuate the areas of refuge.

The Fire Response Plan provides clear, specific instructions for staff responding to an emergency. The procedures provide information about notifying appropriate administrative staff of the emergency and actions to take to protect patient safety. Each department head is responsible for maintaining copies of emergency procedures in a continuously accessible location.

Each department head in both patient care and non-patient care areas are responsible for developing and training staff about department specific emergency fire response procedures. Each department head is responsible for providing department and area personnel with an orientation to emergency procedures related to their job. Additional department level training is

provided on an annual basis as part of the continuing education program or on an as needed basis. Each department head is responsible for reviewing department specific Fire Safety Program emergency procedures annually and ensuring their staff participates in fire drills according to The hospital Fire Response Plan.

Fire Plan Elements (ACHC 03.04.01)

- The roles of all employees, medical staff, volunteers, and students at and near the point of fire origin are defined. The basic plan in the hospital is based on the acronym "RACE":

  - **R**escue anyone directly affected by the fire.
  - **A**larm by pulling fire alarm pull stations and calling 1500 for Fall River and 6000 for Burney Campus on the phones.
  - Contain or Close Doors to contain smoke and the products of combustion.
  - **E**xtinguish and as needed prepare to relocate patients.
    - Pull
    - Aim
    - Squeeze
    - Sweep

- The role of all employees, medical staff, volunteers, and students that are away from the origin of the fire are to close the doors and evaluate the situation. If the fire is in a horizontally adjacent area or in an area where they were planning to relocate patients, all personnel should then focus on transferring patients to an alternate location. In other zones, the plans should be reviewed, fire response equipment discussed and checked, the oxygen valves checked for access and the responsibility for shutting off discussed.

- The roles of others, such as students, physicians and other LIP volunteers vary depending on the situation.

  - Most volunteers and other visitors are requested to go into rooms and stay until the drill or emergency is over.
  - Physicians and other LIP, because they are not always available, are asked to:
    1. If with patients, continue to work with the patient. Close the door if practical, but if not, staff will close the doors.
    2. If in another area, such as their office, cafeteria, etc. Stay there until the drill or emergency is over and 'All Clear' is paged.
    3. If in the hall or corridor, go to the nearest patient unit without going thru smoke or fire doors and check in to be available for any medical emergencies

that may occur.

- If a relocation or evacuation is deemed necessary, staff should:
  - Assure patients in the most affected areas are moved first to adjacent zones.
  - Patients are moved using the usual equipment and techniques. Where practical, ambulatory patients should walk or be moved on wheelchairs. Non-ambulatory patients are moved on wheelchairs or gurneys, as appropriate to their condition. Movement on beds is generally the last alternative because of the additional staff necessary to move beds.
  - Patients are moved into rooms in adjacent zones to protect them from smoke and products of combustion that may be in the corridor.
  - If patients must be moved vertically, obtain permission of the Fire Department and use elevators with emergency power to move patients to lower floors.
  - If an evacuation is deemed necessary and the Command Center is activated, then the Emergency evacuation plan is initiated.

Fire Drills (ACHC 03.04.02)

The hospital conducts fire drills regularly. Fire drills are a critical tool to maintain the readiness of staff to respond to a fire emergency and to minimize the likelihood of injury to patients, visitors, and staff. Staff participation is necessary to maintain a level of readiness and staff knowledge of the equipment and procedures they must follow to protect themselves and their patients. To evaluate staff knowledge, drill activities are observed, and staff is questioned about their role and activities during a fire emergency nearby and elsewhere in the building.

Hospital Fire Drills

The hospital conducts fire drills once per shift per quarter in each building defined as a health care occupancy by the Life Safety Code. The hospital conducts quarterly fore drills in each building defined as an ambulatory health care occupancy by the Life Safety Code.

Fire drills are conducted in all hospitals and facilities on each occupied shift each quarter. Drills are evaluated on a randomly selected basis to assure that all elements of the drill activity are exercised in all occupied areas during each alarm activation, not announced as an audible test.

Fire drills are conducted in all areas in which patient care takes place at least once a year. These drills are witnessed, documented, and evaluated to identify improvements that may be made. Additional drills are held as deemed appropriate.

Business Occupancy Fire Drills

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The hospital conducts fire drills at least every 12 months from the date of the last drill in all free-standing buildings classified as business occupancies and an in which patients are seen or treated.

Unannounced Fire Drills

When quarterly fire drills are required, they are unannounced and held at unexpected times and under varying conditions. Fire drills **include transmission of fire alarm signals** and simulation of emergency fire conditions. Note 1: When drills are conducted between 9:00 PM and 06:00AM the hospital may use alternative methods to notify staff instead of activating audible alarms.
Note 2: For full text, refer to NFPA 101-2012: 18/19.717; 7.1; 7.2; 7.3.

Staff Participation in Fire Drills

All staff in the affected areas is required to participate in the drills to the extent the fire plan describes. This includes all hospital staff and all hospital staff in buildings where space is shared with others. Department heads are responsible for ensuring their staff participates in fire drills at the point of fire origin and away from the point of fire origin.

Fire Drill Critiques

The hospital critiques fire drills to evaluate fire safety equipment, fire safety building features, and staff response to fire, and the evaluation is documented. Fire drills are observed and documented on a formatted data collection form and critiqued to identify opportunities to improve and areas where additional training is required.

The results of the critique and evaluation of drills and evaluation of staff knowledge are used to identify improvements needed in training programs, equipment, and administrative compliance issues. Such improvements are included in monitoring activities and the results used to identify the effectiveness of the activities to improve fire safety.

Staff knowledge and response to drills is evaluated by a data collection document that includes:

- How they activate the fire alarm or call a Code Red
- Their containment of fire and smoke, where appropriate
- How they would move patients to areas of refuge (adjacent fire zones)
- How and when to use fire extinguishers
- Specific duties, such as, shut-off of oxygen valves, movement of medical records and other emergency responses.

- What they would do if a building evacuation was announced.

Maintaining Fire-Safety Equipment and Building Features

The hospital maintains fire safety equipment and fire safety building features. The Facilities Manager is responsible for maintenance of the fire alarm and related systems. The activity of the Facilities department is limited to troubleshooting fire alarm malfunction. Corrective and preventive maintenance to the fire alarm is performed by a qualified contractor. The contractor conducts the scheduled maintenance of all components of the fire alarm. The Director of Operations reviews and documents their work with forms developed by the contractor and hospital generated work orders.

**Supervisory Signal Devices **

At least quarterly, the hospital tests supervisory signal devices on the inventory (except valve tamper switches). The results and completion dates are documented. Note 1: For additional guidance on performing tests, see NFPA 72, 2010 edition (Table 14.4.5).
Note 2: Supervisory signals include the following: control valves; pressure supervisory; pressure tank, pressure supervisory for a dry pipe (both high and low conditions), steam pressure; water level supervisory signal initiating device; water temperature supervisory; and room temperature supervisory.
Deficiencies noted on the report are corrected in a timely manner.

**Valve Tamper Switches and Water Flow Devices **

Every quarter the hospital tests valve tamper switches and water flow devices per NFPA 72, 2010 edition (Table 14.4.5) and the completion date of the test is documented. Deficiencies noted on the report are corrected in a timely manner.

**Duct Detectors, Electromechanical Releasing Devices, Heat Detectors, Manual Fire Alarm Pull Boxes, and Smoke Detectors **

Every 12 months, the hospital tests duct detectors, electromechanical releasing devices, heat detectors, manual fire alarm pull boxes, and smoke detectors per NFPA 72, 2010 edition (Table 14.4.5; 17.14) and the completion date of the test is documented. Deficiencies noted on the report are corrected in a timely manner.

**Visual and Audible Fire Alarms **

Every 12 months, the hospital tests visual and audible fire alarms, including speakers per NFPA 72, 2010 edition (Table 14.4.5) and the completion date of the test is documented. Deficiencies noted on the report are corrected in a timely manner.

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**Fire Alarm Equipment for Off-Site Fire Responders **

Every quarter, the hospital tests fire alarm equipment for off-site fire responders per NFPA 72, 2010 edition (Table 14.4.5) and the completion date of the test is documented. Deficiencies noted on the report are corrected in a timely manner.

Main Drain Tests

Quarterly, the hospital tests main drains at system low point or at all system risers per NFPA 25, 2011 edition (Section 13.2.5; 13.3.3.4) and the completion date of the tests is documented. Deficiencies noted on the report are corrected in a timely manner.

Fire Department Connections

Every quarter, the hospital inspects all fire department water supply connections per NFPA 25, 2011 edition (Section 13.7) and the completion date of the tests is documented. Deficiencies noted during inspections are corrected in a timely manner.

Water Flow Tests for Standpipe Systems

Every five years, the hospital conducts water flow tests for standpipe systems per NFPA 25, 2011 edition and the completion date of the tests is documented. Deficiencies noted on the report are corrected in a timely manner.

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Kitchen Automatic Fire Extinguishing Systems

Every six months, the hospital inspects any automatic fire extinguishing systems in a kitchen, per NFPA 96, 2011 edition and the completion date of the tests is documented. Deficiencies noted on the report are corrected in a timely manner.

Portable Fire Extinguisher Inspections

Each portable fire extinguisher is clearly identified, inspected at least monthly per NFPA 10, 2010 edition, and maintained at least annually by a licensed contractor. In addition, extinguisher access is evaluated during ongoing environmental tours.

Fire and Smoke Damper Tests and Inspections

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Each fire and smoke damper is inspected and operated one year after installation at least every six years (with fusible links removed where applicable) per NFPA 80 to verify that they fully close where such dampers may be reached.

Automatic Smoke-Detection Shutdown Devices for Air-Handling Equipment

Every 12 months, the hospital tests automatic smoke-detection shutdown devices for air-handling equipment per NFPA 90A and the completion date of the tests is documented. Deficiencies noted on the report are corrected in a timely manner.

Door Assemblies

The hospital has written documentation of annual inspection and testing of door assemblies by individuals who can demonstrate knowledge and understanding of the operating components of the door being tested. Testing begins with a pre-test visual inspection; testing includes both sides of the opening.

Fire System Device Inventory

The Facilities Manager is responsible for completing a Fire System Device inventory annually. Information on the inventory shall include the device ID number, building, floor, and specific location.

Life Safety Code (ACHC 14.00.01)

Policies have been developed to support the requirements of the Life Safety Code as applicable to health care, business and ambulatory health care occupancies. It is the policy to design new construction and to maintain means of egress to comply with the 2012 edition Life Safety Code (NFPA 101) as well as all other applicable codes. For the Elements of Performance stated in this management plan, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

Life Safety Drawings

The hospital maintains current and accurate drawings denoting features of fire safety and related square footage.

Fire safety features include the following:

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- Areas of the building that are fully sprinklered (if the building is partially sprinklered)
- Locations of all hazardous storage areas
- Locations of all fire-rated barriers
- Locations of all smoke-rated barriers
- Sleeping and non-sleeping suite boundaries, including the size of the identified suites
- Locations of designated smoke compartments
- Locations of chutes and shafts
- Any approved equivalencies or waivers

Protecting Occupants During Periods When the Life Safety Code is Not Met or Periods of Construction

It is the policy to protect occupants during periods when the Life Safety Code is not met or periods of construction. For the Elements of Performance stated in this policy, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

Fire Watch Policy and Notification (14.00.09)

A fire watch is required when "hot work" is being conducted such as cutting, welding or when the fire or fire protection system, such as sprinklers, is inoperative for any four hours in a 24-hour period. Selected staff will conduct the Fire Watch tour at least hourly. The fire department shall be notified any time the fire protection systems are out of service for any four hours in a 24-hour period. The FM Global field engineer shall be notified any time the fire protection systems are out of service for any four hours in a 24-hour period and the Red Tag Permit system shall be implemented.

Interim (Alternative) Life Safety Policy (ACHC 14.00.02)

It is the policy to ensure that the safety of all building occupants is maintained during periods of construction, or when Life Safety deficiencies compromise the level of protection provided by the building. Life Safety deficiencies include but are not limited to issues identified as a Plan for Improvement (PFI), Life Safety deficiencies identified on a state, CMS Life Safety or fire marshal survey or through routine building inspections. Life Safety Standards will be evaluated on all construction projects, and when Life Safety deficiencies exist.

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The Safety Officer is responsible for managing the ILSM program. The program is applied to situations when the assessments of the life safety deficiencies identified in the existing building or occur as part of construction indicate the need.

An assessment tool is used to evaluate each situation to determine if the degree of deficiency warrants ILSM and what specific measures are required to minimize the effects of the deficiency. This is also part of the preconstruction risk assessment process.

The assessment evaluates the risk of non-compliance with each of the elements of the Unit Concept of the Life Safety Code (i.e., smoke and fire walls, floor separation, exiting, building construction, fire alarm system activity). Where any construction or deficiency is identified, the 11 key elements of the ILSM are evaluated and where applicable to the deficiency or construction activity, compensatory activity is implemented.

The Safety Officer is responsible for communicating the findings to appropriate managers, staff, contractors, and senior leaders. In addition, the Director is responsible for monitoring implementation of the ILSM and taking action when they are not being observed.

The schedule of monitoring and documentation is determined on a per project basis. The Safety Officer is responsible for maintaining all ILSM documentation from the onset through elimination of the deficiencies. Regular reports of ILSM programs will be made to the EC Committee.

Building and Fire Protection Features are Designed and Maintained to Minimize the Effects of Fire, Smoke and Heat

It is the policy to design new construction and to maintain building and fire protection features to minimize the effects of fire, smoke and heat to comply with the 2012 edition Life Safety Code (NFPA 101) as well as all other applicable codes. For the Elements of Performance stated in this management plan, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing in accordance with policy LS.02.01.10. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

Maintaining the Integrity of the Means of Egress

It is the policy to design new construction and to maintain building and fire protection features to minimize the effects of fire, smoke and heat to comply with the 2012 edition Life Safety Code (NFPA 101) as well as all other applicable codes. For the Elements of Performance stated in this management plan, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing in

accordance with policy LS.02.01.20. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

Maintaining Building Features to Protect Individuals from the Hazards of Fire and Smoke

It is the policy to design new construction and to maintain existing environments of care to comply with the 2012 edition Life Safety Code (NFPA 101) as well as all other applicable codes. Building features shall be constructed and maintained in accordance with all applicable codes. For the Elements of Performance stated in this management plan, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing in accordance with policy LS.02.01.30. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

Installing and Maintaining Fire Alarm Systems –Health Care Occupancies (LS.02.01.34)

It is the policy to design fire alarm systems and to maintain existing systems in Health Care Occupancies to comply with the 2012 edition Life Safety Code (NFPA 101). Building features and systems shall be constructed, installed, and maintained in accordance with all applicable codes. For the Elements of Performance stated in this management plan, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing in accordance with policy LS.02.01.34. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

Installing and Maintaining Systems for Extinguishing Fires

It is the policy to design systems for extinguishing fires and to maintain existing systems to comply with the 2012 edition Life Safety Code (NFPA 101). Building features and systems shall be constructed, installed, and maintained in accordance with all applicable codes. For the Elements of Performance stated in this management plan, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing in accordance with policy LS.02.01.35. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

Installing and Maintaining Special Features to Protect Individuals from the Hazards of Fire and Smoke

It is the policy to design special features and to maintain existing building features to comply with the 2012 edition Life Safety Code (NFPA 101). Building features and systems shall be

constructed, installed, and maintained in accordance with all applicable codes. For the Elements of Performance stated in this management plan, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing in accordance with policy LS.02.01.40. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

Installing and Maintaining Building Features to Protect Individuals from the Hazards of Fire and Smoke

It is the policy to design and to maintain existing building features to comply with the 2012 edition Life Safety Code (NFPA 101). Building features and systems shall be constructed, installed, and maintained in accordance with all applicable codes. For the Elements of Performance stated in this management plan, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing in accordance with policy LS.02.01.50. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

Installing and Maintaining Operating Features That Conform to Fire and Smoke Prevention Requirements

It is the policy to design and to maintain existing operating features that conform to fire and smoke prevention requirements in accordance with the 2012 edition Life Safety Code (NFPA 101). Building features and systems shall be constructed, installed, and maintained in accordance with all applicable codes. For the Elements of Performance stated in this management plan, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing in accordance with policy LS.02.01.70. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

Maintaining the Integrity of the Means of Egress – Ambulatory Health Care and Business Occupancies

It is the policy to design new construction and to maintain existing environments of care for Ambulatory Health Care and Business Occupancies to comply with the 2012 edition Life Safety Code (NFPA 101) as well as all other applicable codes. For the Elements of Performance stated in this management plan, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing in

accordance with policy LS.03.01.20. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

Maintaining Building Features to Protect Individuals from the Hazards of Fire and Smoke – Ambulatory Health Care and Business Occupancies

It is the policy to design new construction and to maintain existing environments of care in Ambulatory Health Care and Business Occupancies to comply with the 2012 edition Life Safety Code (NFPA 101) as well as all other applicable codes. Building features shall be constructed and maintained in accordance with all applicable codes. For the Elements of Performance stated in this management plan, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing in accordance with policy LS.03.01.30. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

It is the policy that when acquiring furniture, furnishings and related supplies that only fire safe materials will be allowed into the facility. Furnishings in the hospital will be determined from the standpoint of utility, durability, maintaining cleanliness and therapeutic and aesthetic value of color and design. Outside consultants and/or hospital resources will be utilized for interior decorating or interior design services when indicated. It is the policy of that all furniture, curtains, draperies, carpeting, wastebaskets, shelving, and miscellaneous furnishings meet National Fire Protection Association (NFPA) fire safety codes.

Installing and Maintaining Fire Alarm Systems – Ambulatory Health Care Occupancies

It is the policy to design fire alarm systems and to maintain existing systems in Ambulatory Health Care Occupancies to comply with the 2012 edition Life Safety Code (NFPA 101). Building features and systems shall be constructed, installed, and maintained in accordance with all applicable codes. For the Elements of Performance stated in this management plan, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing in accordance with policy LS.03.01.34. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

Installing and Maintaining Systems for Extinguishing Fires – Ambulatory Health Care and Business Occupancies

It is the policy to design systems for extinguishing fires and to maintain existing systems in Ambulatory Health Care and Business Occupancies to comply with the 2012 edition Life Safety Code (NFPA 101). Building features and systems shall be constructed, installed and

maintained in accordance with all applicable codes. For the Elements of Performance stated in this policy, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing in accordance with policy LS.03.01.35. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

Installing and Maintaining Special Features to Protect Individuals from the Hazards of Fire and Smoke – Ambulatory Health Care Occupancies

It is the policy to design special features and to maintain existing building features in Ambulatory Health Care Occupancies to comply with the 2012 edition Life Safety Code (NFPA 101). Building features and systems shall be constructed, installed, and maintained in accordance with all applicable codes. For the Elements of Performance stated in this policy, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing in accordance with policy LS.03.01.40. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

Installing and Maintaining Building Features to Protect Individuals from the Hazards of Fire and Smoke – Ambulatory Health Care Occupancies

It is the policy to design and to maintain existing building features in Ambulatory Health Care Occupancies to comply with the 2012 edition Life Safety Code (NFPA 101). Building features and systems shall be constructed, installed, and maintained in accordance with all applicable codes. For the Elements of Performance stated in this policy, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing in accordance with policy LS.03.01.50. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

Installing and Maintaining Operating Features That Conform to Fire and Smoke Prevention Requirements – Ambulatory Health Care Occupancies

It is the policy to design and to maintain existing operating features that conform to fire and smoke prevention requirements in accordance with the 2012 edition Life Safety Code (NFPA 101) in Ambulatory Health Care Occupancies. Building features and systems shall be constructed, installed, and maintained in accordance with all applicable codes. For the Elements of Performance stated in this policy, construction and system design includes compliance with NFPA 101 – 2012 and all other applicable codes. Routine building inspections and Environmental Tours are conducted to ensure compliance is ongoing in

accordance with policy LS.03.01.50. Corporate, regulatory and accreditation surveys verify compliance and plans of correction are implemented to correct deficiencies.

The organization monitors and improves conditions in the Environment of Care

Reporting of Environment of Care Experience

The Safety Officer makes quarterly reports of problems, failures, and user errors to the EC Committee. The reports summarize findings of incident reports, maintenance and repair activities, hazard notices and recalls and other information of interest.

Collection, Analysis, and Dissemination of Information

The Safety Officer coordinates the collection and analysis of information about each of the EC management programs. The information is used to evaluate the effectiveness of the programs and to improve performance. The information collected includes deficiencies in the environment, staff knowledge and performance deficiencies, actions taken to address identified issues and evidence of successful improvement activities.

Performance Monitoring

The Safety Officer coordinates the performance measurement and improvement process for each of the seven functions associated with management of the EC. The Safety Officer monitors the Fire Safety program performance measurement process.

The Safety Officer is responsible for preparing quarterly reports of performance and experience for the EC Committee. The reports include ongoing measurement of performance, and a summary of problems and deficiencies.

The Director of Operations establishes performance indicators to objectively measure the effectiveness of the Fire Safety program. The Director of Operations determines appropriate data sources, data collection methods, data collection intervals, analysis techniques and report formats for the performance improvement standards. Human, equipment, and program performance are evaluated to identify opportunities to improve the Fire Safety program.

The performance measurement process is one part of the evaluation of the effectiveness of the Fire Safety program. A performance indicator has been established to measure at least one important aspect of the Fire Safety program. The current performance indicator for the Fire Safety program is:

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Please refer to the Physical Environment and Life Safety Performance Plan where Mayers Memorial Healthcare District keeps track of the current Performance indicators. The Plan can be found with the Safety Officer and or the Director of Operations. The Plan will be an appendix to the documents that it references as part of a safe environment initiative.

The performance improvement (PI) indicator shown in the management plan reflects the monitor selected at the beginning of the calendar year. If the goal for the performance improvement indicator is met for two consecutive quarters, this process will be considered as "improved or corrected" and the Safety Emergency and Environment of Care Committee (SEECC) will establish a new PI initiative.

Annual Review and Evaluation of Management Plans

The Safety Officer and designees responsible for the design and implementation of the EC programs perform and review every 12 months of each EC management plan, including a review of the plan's objectives, scope, performance, and effectiveness.

The Safety Officer is responsible for coordinating the annual evaluation of the functions associated with the management of the EC. The Safety Officer is responsible for performing the evaluation of the Safety management program every 12 months.

Annual evaluations examine the scope, objectives, performance, and effectiveness of the Safety program. The annual evaluation uses a variety of information sources including internal policy and procedure reviews, incident report summaries, safety meeting minutes, Safety Committee reports, and summaries of other activities. In addition, findings by outside agencies such as accrediting or licensing bodies, or qualified consultants are used. The findings of the annual evaluation are presented in a narrative report supported by relevant data. The report provides a summary of the Safety management program's performance over the preceding 12 months. Strengths are noted and deficiencies are evaluated to set goals for the next year.

The annual evaluation is presented to the EC Committee. The Committee reviews and approves the report. The deliberations, actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, the Quality Improvement Committee, and other Department Heads as appropriate. Once the evaluation is finalized, the Safety Officer is responsible for implementing the recommendations in the report as part of the performance improvement process.

Patient Safety

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The Safety Officer is responsible for working with the individual who is responsible for patient safety to integrate EC monitoring and response activities into the patient safety program. The integration includes conducting risk assessments to identify environmental threats to patient safety, conducting environmental tours to evaluate patient safety concerns on an ongoing basis, participating in the analysis of certain types of patient safety incidents, participating in the development of material for general and job-related orientation and on-going education.

The organization analyzes identified EC issues.

Environment of Care Committee

Representatives from clinical, administrative and support services participate in the analysis of environment of care data. The multidisciplinary Safety Emergency and Environment of Care Committee (SEECC) considers reports of EC issues at regularly scheduled meetings. The committee evaluates the reports and approves actions to address identified issues.

Management of Environment of Care Information

Designees of each EC function and the Safety Emergency and Environment of Care Committee (SEECC) collaborate to analyze EC issues. The analysis includes ongoing evaluation of performance and aggregate analysis of fire environmental tours, incident reports, maintenance activities, and other issues.

Analysis is used to manage the stability of current programs, assess risks related to new programs, and to identify opportunities for improvement.

Reporting of Environment of Care Activities

The hospital uses the results of data analysis to identify opportunities to improve the environment of care. The Safety Emergency and Environment of Care Committee (SEECC) publishes the minutes of each meeting. The minutes summarize materials presented, issues identified, and actions to be taken. (See also EC.04.01.05.1).

Identification of Performance Improvement Opportunities

Annually, representatives from clinical, administrative, and support services recommend to leaders one or more priority performance improvement activities for the environment of care. The Safety Emergency and Environment of Care Committee (SEECC) identifies performance improvement opportunities. A proposal for improvement is prepared and sent to leadership. The leadership reviews all improvement proposals and determines the priority and need for the proposed improvement.

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Improvement of the Environment of Care

When leadership approves a proposal, appropriate staff or a team is appointed to address the identified issues and to design a process improvement. The team evaluates changes to determine if they resulted in improvements in the environment of care. The staff or team appointed make regular reports to the Safety Emergency and Environment of Care Committee (SEECC) and leadership. The reports address progress toward improvement, including measurement of changes to assure they are effective and sustainable.

Orientation, Training, and Education

All staff shall attend the new employee orientation within 30 days of hire. New employee orientation addresses key issues and objectives of all areas of the Environment of Care, including the role each area and staff play in the overall patient safety program. Employees receive ongoing education annually relative to the environment of care. Competency of education is assessed and documented.

Employees also receive departmental safety orientation at their respective work areas regarding hazards and their responsibilities to patients, visitors, and co-workers. In addition, all staff participates in periodic refresher training in their departments related to the Environment of Care.

All Licensed Independent Practitioners (LIP) receive orientation to the Environment of Care in accordance with the Medical Staff policies and bylaws. Retraining and ongoing education shall be provided to LIPs in accordance with Medical Staff policies and bylaws.

Initial and ongoing education programs include describing and demonstrating methods for reducing and eliminating risks in the Environment of Care, actions to take in the event of an environment of care incident, and how to report environment of care risks.

REFERENCES:

MAYERS MEMORIAL HEALTHCARE DISTRICT

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ACHC Accreditation requirements for Critical Access Hospitals, 2023 edition.. Accreditation Commission for Health Care (ACHC). Chapter 3, *03.04.01,03.04.02,03.04.03,3.04.04,, 03.04.05, 03.04.06 Chapter 14. 14.00.01,14.00.02,14.00.03,14.00.04,14.00.05,14.00.06,14.00.0714.00.08,14.00.09,14.02.01,14.02.02,14 .02.03,14.03.01,14.03.02,14.03.03,140.03.04,14.03.05,14.03.06,14.03.07,14.03.08,14.03.0914.03.11,140 3.12,14.04.01,14.04.02,14.04.03,14.04.04*

NFPA. (2011). *NFPA 99: Health Care Facilities Code, 2012 edition*.
NFPA. (2011). *NFPA 101: Health Care Facilities Code, 2012 edition*.

COMMITTEE APPROVALS:

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With attachments

Attachment 1 Heat Illness Prevention - Guidance for Employees

DEFINITIONS:

Acclimatization: The temporary adaptation of the body to work in the heat that occurs gradually when a person is exposed to it. Acclimatization peaks in most people within four to fourteen days of regular work for at least two hours per day in the heat.

Heat Illness: A serious medical condition resulting from the body's inability to cope with a particular heat load, and includes heat cramps, heat exhaustion, heat syncope, and heat stroke.

Environmental Risk Factors for Heat Illness: Working conditions that create the possibility that heat illness could occur, including air temperature, relative humidity, radiant heat from the sun and other sources, conductive heat sources such as the ground, air movement, workload severity and duration, protective clothing, and personal protective equipment worn by employees.

Personal Risk Factors for Heat Illness: Factors such as an individual's age, degree of acclimatization, health, water consumption, alcohol consumption, caffeine consumption, and use of prescription medications that affect the body’s water retention or other physiological responses to heat.

Potable: A liquid that is suitable and safe to drink.

Preventative Recovery Period: A period, at least five minutes, used to recover from the heat in order to prevent further heat illness.

Shade: Blockage of direct sunlight. Canopies, umbrellas, and other temporary structures or devices may be used to provide shade. One indicator that blockage is sufficient is when objects do not cast a shadow in the area of blocked sunlight.
Shade is not adequate when heat in the area of shade defeats the purpose of shade, which is to allow the body to cool. For example, a car sitting in the sun does not provide acceptable shade to a person inside it, unless the car is running with air conditioning.

PURPOSE:

This Heat Stress Prevention Program for Mayers Memorial Hospital District has been developed to provide Employees with the training and equipment necessary to protect them from heat-related exposures and illnesses. Mayers Memorial Hospital cares for the health, wellness and safety of its employees.
The purpose of this program is to ensure that all MMHD employees, working in outdoor places of employment or in other areas where environmental risk factors for heat illness are present, are protected from heat illness and are knowledgeable of heat illness symptoms, methods to prevent illness, and procedures to follow if symptoms occur.

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The Heat Illness Prevention Program applies to all employees that may be at risk of heat illness and applies to all indoor and outdoor places of employment where environmental risk factors for heat illness are present.

PROCEDURE:

All employees who are or may be exposed to potential heat-related illnesses including indoor and outdoor positions will receive training on the following:

- The environmental and personal risk factors that cause heat-related illnesses; the employer's procedures for identifying, evaluating, and controlling exposures to the environmental and personal risk factors for heat illness
- The importance of frequent consumption of small quantities of water, up to 4 cups per an hour under extreme conditions of work and heat
- The importance of acclimatization; including acclimatization each season as applicable
- The different types of heat illness and the common signs and symptoms of heat illness
- The importance of immediately reporting to the employer, directly or through the employee's supervisor, symptoms or signs of heat illness in themselves, or in co-workers
- The employer's procedures for responding to symptoms of possible heat illness, including how emergency medical services will be provided should they become necessary
- Procedures for contacting emergency medical services, and if necessary, for transporting
employees to a point where they can be reached by an emergency medical service provider
- How to provide clear and precise directions to the work site

High Heat Procedures:

- 70 Degrees- Preparation for training and Procedures for heat illness should begin.
- 80 Degrees- Shade or covered area for cooling off is provided for breaks and meals.
  Employees will be encouraged and allowed to take a preventative cool-down rest break in the shaded or indoor areas as needed to protect themselves from overheating. Shade areas are always available to Mayers Memorial Healthcare District Employees. Shade is defined as a blockage of direct sunlight, where the temperature is lower than in the sun and the employee does not cast a shadow. A vehicle does not constitute shade unless it is running with air-conditioning
- 90 Degrees (or higher) or heatwave conditions-
  Pre-shift meetings should be conducted to
  review prevention measures. Additional water breaks should be scheduled and preparation for a 10-minute preventative rest, cool-down period should be taken every 2 hours in cooling or shade areas. This can incorporate regular breaks and lunch breaks)

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The identified departments as followed are labeled as employees that could be affected by heat within our facility. They have been labeled due to the nature of their work with working both indoors and outdoors, and or near appliances that produce heat.

- Environmental Services
- Dietary- Nutritional Services
- Purchasing
- Engineering/Maintenance Departments
- Ancillary buildings
- Thrift Store and Volunteer services surrounding the store and the donations
- EMS

SUPERVISOR RESPONSIBILITIES

• All supervisors will be provided a copy of this program and training documents prior to the assignment of employees working in environments where heat exposure may occur. All new employees will be trained in procedures at new hire orientations and the policy information will be found on the employee intranet, which is available to all employees.
• Supervisors will be provided with the procedures to follow to implement the applicable provisions of this program.
• Supervisors will be provided with the procedures to follow when an employee exhibits symptoms consistent with possible heat illness, including emergency response procedures.

PROVISION OF WATER

Employees shall have access to potable water. Water should be provided in sufficient quantity from constant sources and or at the beginning of the work shift provide one quart per employee per hour for drinking the entire shift for a total of 2 gallons per employee per 8-hour shift. Employees may begin the shift with smaller quantities of water if effective procedures for replenishment of water during the shift have been implemented to provide employees with one quart or more per hour. Employees are allowed to refill water receptacles as needed at any time and have access to water at all times from faucets or filtered water dispensers throughout the hospital.

ACCESS TO SHADE

Employees suffering from heat illness or believing a preventative recovery period is needed shall be provided access to an area with shade that is either open to the air or provided with ventilation or cooling for no less than five minutes. Such access to shade shall be permitted at all times. Shade areas can include trees, buildings, canopies, lean-tos, or other partial and/or temporary structures that are either ventilated or open to air movement. The interior of cars or trucks is not considered shade unless the vehicles are air-conditioned or kept from heating up in the sun in some other way.

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ACCLIMATIZATION

Supervisors are required to acclimatize employees and allow time to adapt when temperatures rise suddenly an employee's risk for heat illness increase. Acclimatization may also be required for new employees, employees working at temperatures to which they have not been exposed for several weeks or longer, or employees assigned to new jobs in hot environments. Generally, about four to fourteen days of daily heat exposure is needed for acclimatization. Heat acclimatization requires a minimum daily heat exposure of about two hours of work. Gradually increase the length of work each day until an appropriate schedule adapted to the required activity level for the work environment is achieved. This will allow the employee to acclimate to conditions of heat while reducing the risk of heat illness.

It should be noted that new employees are among those most at risk of suffering the consequences of inadequate acclimatization. Supervisors with new employees should be extra vigilant during the acclimatization period, and respond immediately to signs and symptoms of possible heat illness.

PREVENTIVE RECOVERY PERIODS

The purpose of the recovery period is prevention of heat illness. The supervisor is required to provide access to shade for employees who believe they need preventive recovery period from the effects of heat and for any who exhibit indications of heat illness.

Access to shade must be allowed at all times, and employees must be allowed to remain in the shade for at least five minutes. If employees are wearing PPE including but not limited to respirators, face coverings, disposable coveralls, backpack vacuums, arc flash suits, and welding gear they need to be allowed more frequent breaks to prevent overheating. These breaks may need to be longer in order to allow the employees to remove PPE to cool more completely. In addition, activities in hot locations like in the tunnels, some welding or pipe soldering operations will require more frequent breaks where the employees need to leave the area to a cooler area often.

The purpose of the preventive recovery period is to reduce heat stress on the employee. The preventive recovery period is not a substitute for medical treatment.

Emergency Procedures

If an employee has any symptoms of heat illness, first-aid procedures should be initiated without delay. Common early signs and symptoms of heat illness include headache, muscle cramps, and unusual fatigue. However, progression to more serious illness can be rapid, and can include loss of consciousness, seizures, mental confusion, unusual behavior, nausea or vomiting, hot dry skin, or unusually profuse sweating.

Any employee exhibiting any of the above-mentioned symptoms requires immediate attention. Even the initial symptoms may indicate serious heat exposure. If medical

Reporting Requirements

Constant awareness of and respect for heat illness prevention procedures and compliance with all applicable MMHD safety rules is mandatory.

Employees may report any safety concerns to their supervisor.

Supervisors may issue warnings to employees and implement disciplinary actions up to and

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including termination for failure to follow the guidelines of this program.

TRAINING REQUIREMENTS AND COMPETENCY ASSESSMENT

Training shall be provided for all potentially impacted employees, and their supervisors, working where environmental risk factors for heat illness are present. Training information shall include, but not be limited to:

- Environmental and personal risk factors for heat illness
- Procedures for identifying, evaluating, and controlling exposure to environmental risk factors for heat illness
- The importance of frequent consumption of hydrating fluids, up to 1 quart (4 cups of water) per hour, when environmental risk factors for heat illness are present. Particularly when an employee is excessively sweating during the exposure
- The importance of acclimatization
- Different types of heat illness and the common signs and symptoms of heat illness
- The importance of immediately reporting symptoms or signs of heat illness, in themselves or in co-workers, to their supervisor
- Understanding the procedures for contacting emergency medical services, and if necessary, for transporting employees to a point where they can be reached by emergency medical service
- Procedures for ensuring that, in the event of an emergency, clear and precise direction to the work site can and will be provided to emergency responders

Supervisors shall receive training on the following topics before being assigned to supervise outdoor employees.

- The training information required of the employees, detailed above
- Procedures supervisors are to follow to implement the provisions of this program
- Procedures the supervisor shall follow when an employee exhibit symptoms consistent with possible heat illness, including emergency response procedures

Retraining will be required under any of the following conditions:

Annual retraining is encouraged but not required unless one of the conditions listed below is met. Periodically, the safety committee may assign training to teams as an update or to refresh the information as part of the safety initiative. If the training is assigned it is required.

- Changes in the workplace render previous training obsolete or inadequate
- Inadequacies in an employee's knowledge of heat illness prevention indicate that the employee has not retained the required information and heat stress management strategies

SAFE WORK PROCEDURES

Supervisors Responsibilities

The Cal/OSHA standard requires not only that water be provided, but that supervisors encourage employees to drink frequently. Employees must understand that thirst is not an effective indicator of a persons needs for water and it is recommended that individuals drink one quart of

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water, or four 8-ounce cups, per hour when working in hot environments.

Supervisors are responsible for performing the following:

- Give Employees frequent breaks in a cool area away from heat.
- Adjust work practices as necessary when Employees complain of heat stress.
- Oversee heat stress training and acclimatization for new Employees and for employees who have been off the job for some time. All new Employees will be trained as well as current employees electronically, in Relias, and or in person as the need arises and or annually. A period of acclimation will be given to employees -including new employees when the heating season begins. Frequent water breaks and tasks outside/inside away from the heat will be used to help acclimatize.

    - Monitor the workplace to determine when hot conditions arise. The OSHA-HIOS Safety Tool- a mobile app can be used to determine the heat index and or a thermometer will be placed in an appropriate area available to all employees.
    - Increase air movement by using fans where possible.
    - Provide potable water in required quantities.
    - Determine whether Employees are drinking enough water.
    - Make allowances for Employees who must wear personal protective clothing (welders, etc.)
    and equipment that retains heat and restricts the evaporation of sweat.
    - Schedule hot jobs for the cooler part of the day; schedule routine maintenance and repair
    work in hot areas for the cooler times of the day.
    - Make available to all Employees cooling devices (hard hat liners/bibs/neck bands) to help rid bodies of excessive heat.

    Departments shall take one or more of the following steps to ensure employees have access to
    drinking water:

    1. Provide access to drinking fountains
    2. Supply water cooler/dispenser and single service cups
    3. Supply sealed one-time-use water containers

    Drinking water and water dispensers shall meet the following requirements:

    - All sources of drinking water shall be maintained in a clean and sanitary condition
    - Drinking water must always be kept cool. When temperatures exceed 90°F it is recommended that ice be provided to keep the water cool.
    - Potable drinking water dispensers used to provide water to more than one person shall
    be equipped with a spigot or faucet.

Employees/ Staff

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Employees are responsible for performing the following:

- Follow instructions and training for controlling heat stress.
- Be alert to symptoms in yourself and others, and report any symptoms and or hazards immediately to your supervisor.
- Determine if any prescription medications you are required to take can increase heat stress.
- Wear light, loose-fitting clothing that permits the evaporation of sweat.
- When applicable wear light-colored garments that absorb less heat from the sun. Take extra precautions if wearing PPE
- Drink small amounts of water – approximately 1 cup every 15 minutes.
- Avoid beverages such as tea or coffee.
- Avoid eating hot, heavy meals.
- Do not take salt tablets unless prescribed by a physician.
- Review Attachment 1 for additional information to protect yourself and others.

Program Review

The Safety Officer will periodically review this program for compliance with all applicable regulatory standards. Updates will be provided to all employees. All information regarding this plan can be found on the employee intranet in the IIPP Section. All records of reviews will be kept with one or all of the Safety Officers.
All Policies can also be given to employees upon request.

HEAT STRESS DISORDERS

Heat Rash (Prickly Heat)

Symptoms:

- Red blotches and extreme itchiness in areas persistently damp with sweat.
- Prickling sensation on the skin when sweating occurs.

Treatment:

- Cool environment.
- Cool shower.
- Thorough drying.

Heat rashes typically disappear in a few days after exposure. If the skin is not cleaned frequently enough the rash may become infected.

Heat Cramps

Symptoms:

- Loss of salt through excessive sweating.
- Cramping in back, legs, and arms.

Treatment:

- Stretch and massage muscles.
- Replace salt by drinking commercially available carbohydrate/electrolyte replacement

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fluids.

Heat Exhaustion

Heat exhaustion occurs when the body can no longer keep blood flowing to supply vital organs and at the same time send blood to the skin to reduce body temperature.

Symptoms

- Weakness.
- Difficulty continuing work.
- Headache.
- Breathlessness.
- Nausea or vomiting.
- Feeling faint or actually fainting.

Treatment:

- Call 911 or go immediately to the Emergency Department.

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Help the victim to cool off by:

- Resting in a cool place.
- Drinking cool water.
- Removing unnecessary clothing.
- Loosening clothing.
- Showering or sponging with cool water**. It takes 30 minutes to cool the body down once a worker becomes overheated and suffers heat exhaustion**.

Heat Stroke

Heat stroke occurs when the body can no longer cool itself and body temperature rises to critical levels.

Symptoms:

- Confusion.
- Irrational behavior.
- Loss of consciousness.
- Convulsions.
- Lack of sweating.
- Hot, dry skin.
- Abnormally high body temperature.

Treatment:

- Call 911 or go immediately to the Emergency Department.

Provide immediate, aggressive, general cooling.

- Immerse victim in tub of cool water or;
- Place in cool shower; or
- Spray with cool water from a hose; or wrap victim in cool, wet sheets and fan rapidly.
- Transport victim to hospital.

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- Do not give anything by mouth to an unconscious victim.

REFERENCES:

Title 8 California Code of Regulations, General Industry Safety Orders - §3395
Heat Illness Prevention: What you need to know
http://www.99calor.org/_downloads/factsheet.english.pdf
http://www.99calor.org/_downloads/factsheet.spanish.pdf
Heat Illness Prevention enforcement Q&A http://www.dir.ca.gov/dosh/heatIllnessQA.html
Protect Yourself from Heat Illness Cards
http://www.dir.ca.gov/dosh/dosh_publications/HeatIllnessEmployeeEngSpan.pdf
CDC Poster
https://www.cdc.gov/niosh/docs/2016-151/pdfs/fy16_heat-related-illness- poster_2016-151.pdf
CDC Infographic
https://www.cdc.gov/niosh/topics/heatstress/infographic.html
CDC Protect Yourself from Heat Stress Podcast
https://tools.cdc.gov/medialibrary/index.aspx#/media/id/303858
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National Ag Safety Database: Keep Cool
https://nasdonline.org/182/d000004/keep-cool.html

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ATTACHMENT 1

Heat Illness Prevention - Guidance for Employees

Awareness of heat illness symptoms can save your like or the life of a co-worker. The following provides valuable information concerning heat-related illnesses and preventative measures.

- If you are coming back to work from an illness or an extended break or you are just starting a job working in the heat, it is important to be aware that you are more vulnerable to heat stress until your body has time to adjust.
  Let your employer know you are not used to the heat. It takes about 5-7 days for your body to adjust. Your employer will help you acclimatize.
- Drinking plenty of water frequently is vital for Employees exposed to the heat. An individual may produce as much as 2 to 3 gallons of sweat per day. In order to replenish that fluid, you should drink 3 to 4 cups of water every hour starting at the beginning of your shift. Temperature variations could happen indoors as well as outdoors.
- Taking your breaks in a cool shaded area and allowing time for recovery from the heat during the day are effective ways to avoid a heat-related illness.
- Avoid or limit the use of alcohol and caffeine during periods of extreme heat. Both dehydrate the body.
- If you or a co-worker start to feel symptoms such as nausea, dizziness, weakness or unusual fatigue, let your supervisor know and rest in a cool shaded area. If symptoms persist or worsen, seek immediate medical attention.
- Whenever possible, wear clothing that provides protection from the sun but allows airflow to the body. Protect your head and shade your eyes if working outdoors.
- When working in the heat pay extra attention to your co-Employees and be sure you know
  how to call for medical attention.

REFERENCES:
California Code of Regulations, Title 8 (CCR8), Section 3395,

MAYERS MEMORIAL HEALTHCARE DISTRICT

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OWNER: Sophia Lou Rosal, CLS		APPROVER: Kevin Davie

DEFINITION:

The Hemoglobin A1C assay is an in vitro diagnostic test for the quantitative determination of %HbA1C (DCCT/NGSP) and mmol/mol HbA1C (IFCC) in human anticoagulated venous whole blood.

POLICY:

It is the policy of this department to ensure that all clinical laboratory scientists performing the test adheres to this policy to produce quality laboratory results at all times.

PROCEDURE:

1. **Summary:** HbA1C refers to the product of a non-enzymatic reaction between glucose and hemoglobin A1. The human erythrocyte is freely permeable to glucose, which can non-enzymatically combine with hemoglobin to form HbA1C. This non-enzymatic reaction between the alpha-amino group of the N-terminal valine of the hemoglobin beta-chain and glucose takes place to form an unstable aldimine or Schiff base intermediate (labile fraction). This reaction is slow and reversible and occurs at a rate that is proportional to the glucose concentration in the blood. The aldimine intermediate subsequently undergoes a non-reversible Amadori rearrangement to form the stable ketoamine 1-glucofrutovaline product. Since the reaction is driven by the concentration of reactants, the degree of glycosylation (reported as HbA1C relative to the total hemoglobin) is proportional to the average concentration of blood glucose over the circulating life span of hemoglobin in the red cell (approximately 120 days).

   The utility of HbA1C measurements was demonstrated in the Diabetes Control and Complications Trial (DCCT). A significant finding of this study was the direct correlation between glycemic control and patient outcome with respect to long-term complications. Patients with improved glycemic control (i.e., lower HbA1C) showed significantly improved prognosis with respect to micro-vascular complications including neuropathy, retinopathy, and nephropathy.

2. **Principles of Procedure:** The Dimension® Hemoglobin A1C assay measures both HbA1C and total hemoglobin. The HbA1C measurement is based on a turbidimetric inhibition immunoassay (TINIA) principle, and the measurement of total hemoglobin is based on a modification of the alkaline hematin reaction. Using the values obtained for each of these two analytes, the relative proportion of the total hemoglobin that is glycated is calculated and reported. Pre-treatment to remove the labile fraction is not necessary as only the Amadori rearranged form of HbA1C is detected. All hemoglobin variants that are glycated at the beta-chain N-terminus and have epitopes identical to that of HbA1C are measured by this assay.

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Total Hemoglobin Measurement:
Whole blood + lysing agent → Released hemoglobin → hemoglobin derivative (measured at 405 nm)

Hemoglobin A1C Measurement:
hemoglobin A1C + anti-HbA1C Ab → hemoglobin A1C-anti-HbA1c Ab complex
anti-HbA1C Aby (excess) + polyhapten → Ab/polyhapten complex (absorbs at 340 nm)

3. **Specimen Collection and Handling:** Recommended specimen type: Anticoagulated venous whole blood (K2 EDTA; K3 EDTA; sodium fluoride/Na2 EDTA; lithium heparin, or Na Fluoride/K-Oxalate).

- Samples for the A1C method can only be assayed from a sample cup or SSC.
- Samples cannot be assayed directly from primary collection tubes.
- Samples should be mixed gently by inversion (gently invert the tube ten times) or in a rocker mixer prior to pipetting into the sample cup or SSC in order to obtain uniform distribution of the erythrocytes prior to testing. Avoid the formation of foam.
- Samples containing clots should not be used.
- Pipette 200 µL of the whole blood sample into the sample cup or SSC.
- Sample can sit in sample cup on instrument for up to one hour

Samples are stable when stored for no greater than: 3 days at 15–25°C; 7 days at 2–8°C; 4 months at -20°C (freeze only once)

4. **Procedure:**

4.1. Materials

A1C Kit, Cat. No. DF105B: Includes A1C Flex® reagent cartridges
A1C calibrator (5 levels)
Quality Control Materials

4.2. Test Steps

4.2.1. Sampling, reagent delivery, mixing, processing, and transmission of results to LIS are automatically performed by the Dimension® clinical chemistry system. For details of this processing, refer to the Dimension® clinical chemistry Operator's Guide.

4.2.2. The sample container must contain 200 µL whole blood to ensure proper re-mix.

4.3. Test Conditions

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	Cuvette 1	**Cuvette 2**
Sample Volume	3 µL (from sample cup)	19 µL (from cuvette 1)
Hemolyzing Reagent Volume	300 µL	0 µL
Antibody/Buffer Volume	0 µL	320 µL
Polyhapten Volume	0 µL	52 µL
Diluent Volume	147 µL	69 µL
Temperature	37°C	37°C
Test wavelength	340 and 700 nm for hemoglobin A1C 405 and 700 nm for hemoglobin	
Type of Measurement	Turbidimetric for hemoglobin A1C Colorimetric for hemoglobin	

4.4. Calibration

The general calibration procedure is described in your Dimension® Operator's Guide.

Note: The A1C Flex® reagents and calibrators are packaged in a kit. Each kit lot contains matched sets of A1C Flex® reagent cartridges and A1C Calibrators. Do not interchange reagents with different lot numbers.

The system automatically performs the calibration for both Hb and HbA1C.

The Dimension® Hemoglobin A1C assay requires lot-specific scalers which must be entered in the Calibration Set Up screen, prior to calibration. The scaler values are provided on the Flex® reagent cartridge carton. These scalers are applied to all QC and patient results to maintain accuracy. Failure to enter the lot-specific scalers will cause inaccurate results.

The A1C method offers two options for calibration and reporting of results.

Option 1:
• Results reported in %HbA1C using the following equation:

%HbA1C = 100 x HbA1C (g/dL) / Hb (g/dL)

• Calibrator values (g/dL) are required for hemoglobin A1C and total hemoglobin. These values are obtained from the Table of Assigned Values provided in the Dimension® Hemoglobin A1C Calibrator Instructions for Use (IFU).
• Subsequently the Dimension® clinical chemistry system calculates an NGSP standardized %HbA1C result based on the calculation shown below. This calculation provides a %HbA1C value that is standardized to the DCCT study result, which is printed

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on the Dimension® report slip. The values of the polynomial coefficients (b, c and d) may vary by Flex® reagent cartridge lot.

NGSP Standardized %HbA1C = (b x (%HbA1C)2) + (c x %HbA1C) + d

A1C lots are produced under controlled conditions to meet established product specifications. Annually, one lot is tested on each Dimension® model to confirm standardization to the National Glycohemoglobin Standardization Program (NGSP). Copies of certificates may be accessed at www.siemens.com/diagnostics. Additional information concerning NGSP certification may be obtained at www.ngsp.org.

Option 2:
• Results reported in SI unit [mmol/mol]h using the following equation:

mmol/mol HbA1C = 1000 x HbA1C (mmol/L) / Hb (mmol/L)

• Calibrator values (mmol/L) are required for hemoglobin A1C and total hemoglobin. These values are obtained from the Table of Assigned Values provided in the Dimension® Hemoblobin A1C Calibrator IFU.

• Subsequently the Dimension® system calculates an IFCC standardized mmol/mol A1C result based on the calculation shown below. This calculation provides a mmol/mol HbA1C value that is standardized to the IFCC reference system9 , which is printed on the Dimension® report slip. The values of the polynomial coefficients (b, c and d) may vary by Flex® reagent cartridge lot.

IFCC Standardized HbA1C (mmol/mol) = (b x (HbA1C mmol/mol)2) + (c x HbA1C mmol/mol) + d

Calibration	Material Secondary calibrators such as A1C calibrators
Calibration Scheme	2 levels, n=5 for Hbi 5 levels, n=5 for HbA1Ci
Units	% [mmol/mol]
Typical Calibration Levels	5.0–25.0 g/dL [3.1–15.5 mmol/L] Hb 0.25–2.90 g/dL [0.16–1.80 mmol/L] HbA1C
Calibration Frequency	Every 30 days for any one lot
A new calibration is required	• For each new lot of Flex® reagent cartridges. • After major maintenance or service, if indicated by quality control results • As indicated in laboratory quality control procedures • When required by government regulations

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Assigned Coefficients C0 145.6
C1 -147.5
C2 -1.60 C3 1.00
C4 0.5

Scalers See Flex® reagent cartridge carton for lot-specific scaler values.
Calibration cups must be filled with 600 µL of calibrator.

Calibration Acceptance Criteria
The Dimension® Hemoglobin A1C assay requires confirmation of additional calibration guidelines; after calibration is complete, ensure that the following criteria are met:

Data	Acceptance Guideline	Comments
Hemoglobin A1c (A1C) Slope (m)	0.95–1.05	N/A
Hemoglobin A1c (A1C) y-intercept (b)	Close to 0	Not clinically significant
Hemoglobin (HB BV) Accuracy (g/dL [mmol/L])	Mean ± 10%	Average the 5 report results and compare to HB BV data
Hemoglobin (HB BV) SD (g/dL [mmol/L])	≤0.8 (0.5)	N/A
"EX" Coefficient Reproducibility SD Guideline	<0.4 (0.6)	A reflection of the precision of the individual total hemoglobin milliabsorbance values used for the calculation of the "EX" calibration coefficient.

4.5. Quality Control
Bio-Rad Liquichek Diabetes Control two-levels controls are run once daily.

4.6. Results: The instrument calculates the concentrations of total A1C, Hb, and HbA1C using calculation scheme.

Reference ranges are established and maintained in the LIS.
Reference Range: 3.8 %– 5.6 %

Repeat all critical values as needed.
Critical Value: >14.0%

4.7. Analytical Measurement Range (AMR):
Hb: 5.0–25.0 g/dL [3.1–15.5 mmol/L]
HbA1C: 0.25–2.90 g/dL [0.16–1.80 mmol/L]
Calculated HbA1C Ratio (A1C): 3.8–14.0% [18–130 mmol/mol]

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The Hb and HbA1C analyte values can be measured directly from the specimen without any dilution or pretreatment that is not part of the usual analytical process. Hb and HbA1c analyte values outside of the ranges above will trigger a test report message to appear with the Calculated HbA1C Ratio result.

The Calculated HbA1C Ratio range has been validated by Siemens using native whole blood samples. This range may be used for laboratory validation of AMR, if needed.

Samples with results in excess of 14.0% [130 mmol/mol], 25 g/dL [15.5 mmol/L] hemoglobin or 2.90 g/dL [1.80 mmol/L] HbA1C will be reported as "Above Assay Range" and should be repeated on dilution. If the message persists on the diluted sample, report the result as "greater than 14.0% [130 mmol/mol]."

Manual Dilution: Mix one part of clinical laboratory reagent water (CLRW) and one part of well mixed whole blood. Re-assay the dilution mixture to obtain results within the analytical measurement range.

Important: The resulting readout (%HbA1C [mmol/mol]) is the reportable result. The result must not be corrected for dilution as it is a calculated result based on the ratio between HbA1C and Hb. Therefore, a dilution factor must not be used in the Dimension® Hemoglobin A1C assay.

Autodilution (AD): Not available for this method.

Samples with results less than 3.8% [18 mmol/mol], hemoglobin less than 5.0 g/dL [3.1 mmol/L] or HbA1C less than 0.25 g/dL [0.16 mmol/L] will be reported as "Below Assay Range" by the instrument. Dispense a new 200 µL aliquot of whole blood and re-assay the sample. If the message persists, contact your local support provider for assistance.

The instrument reporting system contains flags and comments to provide the user with information regarding instrument processing errors, instrument status information and potential errors in A1C results. Refer to your Dimension® Operator's Guide for the meaning of report flags and comments.

5. Limitations

The instrument reporting system contains flags and comments to provide the user with information regarding the instrument's processing status and potential errors.

The Dimension® Hemoglobin A1C assay has significant interference with fetal hemoglobin (HbF). Samples containing HbF may produce a negative bias (lower than actual results) with

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the Dimension® Hemoglobin A1C assay. Hemoglobin A1C results are invalid for patients with abnormal amounts of HbF, including those with known Hereditary Persistence of Fetal Hemoglobin. For additional information on the interference of the HbF variant, refer to Interfering Substances.

As with any other laboratory procedure, a large discrepancy between the clinical impression and test results usually warrants investigation. Some of the following test limitations should be considered:

The Dimension® Hemoglobin A1C assay is designed only for accurate and precise measurement of mmol/mol HbA1C (IFCC) and %HbA1C (DCCT/NGSP). The individual results for total Hb and HbA1C concentration are not reported.

Patients with hemoglobin concentrations outside of the acceptable range for the Dimension® Hemoglobin A1C assay should be assayed by a test employing a different assay principle.

The Dimension® Hemoglobin A1C assay should not be used to diagnose diabetes during pregnancy. Hemoglobin A1C reflects the average blood glucose levels over the preceding 3 months (the average life span of a red blood cell) and therefore may be falsely low during pregnancy or any other condition associated with recent onset of hyperglycemia and/or decreased red blood cell survival.

The Dimension® Hemoglobin A1C assay should not be used to diagnose or monitor diabetes in patients with the following conditions: hemoglobinopathies except as demonstrated to produce acceptable performance (such as, sickle cell trait), abnormal red blood cell turnover (such as, anemias from hemolysis and iron deficiency), malignancies, and severe chronic hepatic and renal disease.

In cases of rapidly evolving Type 1 diabetes, the increase of HbA1C values might be delayed compared to the acute increase in glucose concentrations. In these conditions, diabetes mellitus must be diagnosed based on plasma glucose concentrations and/or the typical clinical symptoms.

This test should not replace glucose testing for patients with Type 1 diabetes, pediatric patients, or pregnant women.

Any cause of shortened red blood cell survival (for example, hemolytic anemia or other hemolytic diseases, pregnancy, or recent significant blood loss) will reduce the exposure of red blood cells to glucose with a consequent decrease in HbA1C values. Results of HbA1C are not reliable in patients with chronic blood loss and consequent variable erythrocyte lifespan. A system malfunction may exist if the following 5 test precision is observed:

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A1C Concentration % [mmol/mol]	**SD % [mmol/mol]**
5.5 [37]	>0.2 [1.6]
9.6 [81]	>0.3 [4.3]

REFERENCES:

Siemens Dimension Clinical Chemistry System – Flex reagent cartridge kit insert - IFU PN11275287-DE | April/2019

COMMITTEE APPROVALS:
P&P: 3/6/2024
MEC: 4/4/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

INTERMOUNTAIN HOSPICE PATIENT'S BILL OF RIGHTS

Patients have the right to be notified in writing of their rights and obligations before their hospice care begins. Consistent with state laws, the patient's family or guardian may exercise the patient's rights when the patient is unable to do so. Hospice organizations have an obligation to protect and promote the rights of their patients, including the following:

The Intermountain Hospice shall provide care for patients without discrimination including, but not necessarily limited to, the following:

- Patient will be treated without regard to race, color, creed, national origin, handicap, sexual orientation gender or gender identification.
- Employees, volunteers and medical staff will be assigned to patients regardless of race, color, creed, national origin, gender or gender identification.
- All patients shall receive the level of care appropriate to their diagnosis, treatment needs, care planning and all other aspects of patient care regardless of race, color, creed, national origin, sexual orientation or gender identification.
- Medical staff privileges will not be denied nor removed from professionally qualified personnel on the basis of race, color, creed, national origin, handicap, sexual orientation or gender identification.

PATIENTS AND PROVIDERS HAVE A RIGHT TO DIGNITY AND RESPECT

Patients have the right:

- To have a relationship with Hospice that is based on honesty and ethical standards of conduct
- To be informed of procedure they can follow to lodge complaints with Hospice about the care that is, or fails to be furnished, and regarding a lack of respect of person, privacy, or property. To lodge complaints, you may:
    - File a complaint on our web site https:\\mayersmemorial.com,
    - call the Hospice Manager at 530-336-5511 ext.1200,or
    - contact the State of California Dept. of Health Services, Licensing and Certification Division, located at 126 Mission Blvd. Chico, CA 95973 24 hours per day at 1-800-554-0350
- To know of disposition of such complaints
- To voice their grievances without fear of discrimination or reprisal for having done so.
- Complaints concerning advance directive notification and/or implementation can be filed with the state licensing and certification office by using the above 24 hour hotline number.

QUALITY OF CARE

Patients have the right:

- To be cared for by a team of professionals who will provide high quality comprehensive hospice services as needed and appropriate for them and their family (including extended and alternative family);

- To receive appropriate and compassionate care regardless of age, creed, race, gender, gender identification, diagnosis, disability, or the ability to pay for the services rendered;
- To have a clear understanding of availability of and access to hospice services and the hospice team 24 hours a day, seven days a week;
- To be told what to do in case of an emergency;
- To have family and/or other caregivers trained in effective ways of providing care when self-care is no longer possible.
- To be fully informed, as evidence by the patient's or his/her appointed representative's written acknowledgement prior to or at the time of admission of these rights and of all rules and regulations governing patient conduct.
- To be fully informed, prior to or at the time of admission, of services available within hospice and of related charges, including any charges for services not covered under Titles XVIII or XIX of the Social Security Act.
- To be fully informed by a physician of his or her medical condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of his or her medical treatment and to refuse to participate in experimental research.
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
- To be advice of what hospice services are to be rendered and by what discipline, e.g., registered nurse, counselor, chaplain, etc.
- To be advised in advance of any change in treatment.
- To be assured confidential treatment of personal and clinical records and to approve or refuse their release to any individual outside the hospice, except in the case of transfer to another health facility, or as required by law or third-party payment contract.
- To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs.
- To not be subjected to verbal or physical abuse of any kind and to be informed that corporal punishment is prohibited.
- To be informed by the license of the provisions of the law regarding complaints and procedures for registering complaints confidentially, including, but not limited to, the address and telephone number of the local District office of the Department.
- To be informed of the provisions of law pertaining to advanced directives, including but not limited to living wills, durable power of attorney for health care, withdrawal or withholding of treatment and/or life support.
- To be assured the personnel who provide care are qualified through education and experience to carry out the services for which they are responsible.

Hospice shall ensure that:

- All medically related hospice care is provided in accordance with physicians' orders and that a plan of care which is developed by the patient's physician and the hospice interdisciplinary group specifies the services to be provided and their frequency and duration;
- All medically related personal care is provided by an appropriately trained home health aide who is supervised by a nurse.

DECISION-MAKING

Patients have the right:

- To participate in the planning of their care and in planning changes in their care, and to be advised that they have the right to do so;
- To be fully informed regarding their health status in order to participate in the planning of their care;
- To be fully informed regarding the potential benefits and risks of all medical treatments and/or services suggested;
- To refuse services and to be advised of the consequences of refusing care.
- To request a change in caregiver without fear of reprisal or discrimination.

The hospice professional team will:

- Assist the patient and family in identifying which services and treatments will help attain the patient's goals;
- Provide information pursuant to the Patient Self Determination Act about ways to make the patient's wishes known to those caring for him or her.

The hospice or the patient's physician may be forced to refer the patient to another source of care if the client's refusal to comply with the plan of care threatens to compromise the provider's commitment to quality care.

PRIVACY

Patients have the right:

- To confidentiality with regard to information about their health, social, and financial circumstances and about what takes place in the home;
- To expect the hospice to release information only as consistent with its internal policy, required by law, or authorized by the client.

FINANCIAL

Patients have the right:

- To be informed in advance of any fees or charges for which they may be liable;
- To access any insurance or entitlement program for which they may be eligible;
- To have access, upon request to all bills for services they have received regardless of whether the bills are to be paid out-of-pocket or by another party;
- To be informed of the hospice's ownership status and its affiliation with any entities to whom the patient is referred.

PATIENT'S RESPONSIBILITIES

Patients have the right:

- To remain under a doctor's care while receiving hospice services.
- To inform the hospice of any advance directives or any changes in advance directives and provide the hospice with a copy.
- To cooperate with the primary doctor, hospice staff and other caregivers.
- To advise the hospice of any problems or dissatisfaction with patient care.
- To notify of address or telephone number changes or when unable to keep appointments.
- To provide a safe home environment in which care can be given. Hospice Services may be terminated due to conduct such that the patient's or staff's welfare or safety is threatened.
- To obtain medications, supplies and equipment ordered by the patient's physician if they cannot be obtained or supplied by the hospice.
- To treat hospice personnel with respect and consideration.
- To sign the required consents and releases for insurance billing and provide insurance and financial records as requested.
- To accept the consequences for any refusal of treatment or choice of non-compliance.

Patient's Name	Account #
Signature of Patient or Legal Guardian	Date
Signature of Caregiver, Relationship to Patient	Date
Signature of Hospice Representative	Date

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Imaging Contrast Policy		POLICY # IMG-009
DEPARTMENT/SCOPE:		Page 1 of 4
REVISION DATE:	EFFECTIVE DATE: 1/11/2024	
AUDIENCE: Imaging	APPROVAL DATE:	
OWNER: Harold Swartz		APPROVER: K. Davie

PURPOSE:

To ensure patient safety related to contrast administration in the imaging department at Mayers Memorial Healthcare District. Contrast media is used to enhance the visibility on internal structures in some medical imaging studies per ACHC policy 06.06.12.

POLICY:

- A Certified Radiologic Technologist administers the IV contrast used during Computed Tomography (CT). At no time will IV contrast media be administered without an attending Emergency Department physician on the premises.
- The Radiology department follows standardized protocols for IV contrast administration in CT procedures to ensure safety and consistency.
- The following contrast media will be used for image enhancement as determined by the specific exam protocol and clinical judgment.

Contrast Name	Generic	Modality Used	Route
Omnipaque 300	Iohexol	CT	IV
Omnipaque 350	Iohexol	CT	IV
Isovue 320	Iopamidol	CT	IV
Gastrografin(30ml)	diatrizoate meglumine and diatrizoate sodium-solution	CT	Oral
Breeza (16 oz)		CT	Oral
Readi-Cat	barium sulfate	CT	Oral

- Current renal function lab results are required, and if unavailable or older than 30 days, new labs must be performed.
    - The Technologist will utilize the contrast administration form for documentation of contrast administration and screening:
        - If patient is older than 35 years old
        - If the patient is pregnant, status should be determined before receiving ionizing radiation or intravenous contrast medications. The ordering provider should be contacted regarding imaging order if the patient is pregnant to confirm that the test should still be performed.
        - If patient has contrast allergy, ordering provider must be notified to either change to non-contrast study or provide pre-medication strategy.

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AUDIENCE: Imaging	APPROVAL DATE:	
OWNER: Harold Swartz		APPROVER: K. Davie

  - If patient has paraproteinemia syndrome or disease, myeloma, or sickle cell disease, and referring physician still wants to use IV contrast, technologist must document discussion on contrast administration form and in tech notes.
  - If patient has history of asthma, high blood pressure, cardiovascular disease, diabetes, prior kidney disease, or has only 1 kidney and no recent creatinine result, a stat creatinine test and eGFR calculation is required.
  - If patient's recent Creatinine is >2.0, GFR <30, or other contrast/renal function concerns exist, technologist must review with ordering provider and document discussion on contrast administration form and in tech notes.
  - If emergency department provider determines patient is unstable and orders scan before labs are completed, technologist must document on contrast administration form and in tech notes and proceed with exam.
  - A copy of the signed consent for contrast administration shall be uploaded into the patient electronic medical record which will be verified and reviewed by the quality committee.
- It is important to avoid fluid restriction before IV contrast administration. Patients should drink 1-2 glasses of water in addition to their normal intake before and after their CT scan.
- Metformin should be temporarily discontinued or withheld for 48 hours after the procedure.
- Patients on hemodialysis who receive iodinated contrast media should consider undergoing dialysis within 24 hours of the exam.

Vascular Access / Delivery Systems for Iodinated Contrast Media

- Outpatient IV access documentation is included in the contrast administration form, which is scanned into Cerner as part of the patient's medical record.
- IV placement is preferred in the antecubital area with at least a 20G for most exams, but an 18G is required for power injection rates exceeding 4mL/min in arterial and vascular studies. Small hand veins should be avoided. IV catheter shall be checked for patency by flushing with 10mL normal saline before contrast injection.
- PICC lines should not be used unless pressure rated or authorized by written order from physician or radiologist, which must include catheter type, gauge, and placement date.
- Central lines should not be used unless pressure rated or authorized by written order from physician or radiologist, which must include catheter details and placement date.
- All central lines must be accessed and monitored by an RN or practitioner, with the radiologic technologist responsible for selecting and initiating power injection parameters based on protocol and physician order, under direct supervision of the RN or practitioner.

PROCEDURE:

1. Upon registration of the patient, imaging personnel will escort the patient to the CT room.

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OWNER: Harold Swartz		APPROVER: K. Davie

2. Prior to contrast administration, the patient is identified using two identifiers. This information is verified against the exam order.
3. The radiologic technologist shall review the patient's current medications and clinical conditions for contraindication related to IV contrast administration. These include but, are not limited to:
    A. Prior allergic reaction to ionic contrast
    B. Asthma
    C. High blood pressure
    D. Diabetes
    E. Cardiovascular disease
    F. Renal disease
        I. Any contraindications identified by the technologist are documented on the patient's contrast history screening form.
            a. If contraindication has been identified, the ordering provider will be contacted to determine whether we will proceed with contrast.
            b. If the ordering provider is unavailable the exam will be rescheduled until we can get clearance from the ordering provider.
4. The technologist will connect the fluid-filled high-pressure tubing to the catheter hub on the contrast injector and manually progress the contrast through until all air is expelled from the tubing. The tubing is then connected to the patent IV catheter and the injector is programmed.
5. The patency of the IV catheter is checked prior to contrast injection by flushing with a minimum of 10 mL of 0.9% normal saline.
6. During the exam, the radiologic technologist shall remain in the room during the injection for as long as possible before the scan begins.
7. Upon completion of the contrast injection, the catheter is flushed with 10ML 0.9% normal saline, the high-pressure tubing is disconnected, and the IV site is inspected for any swelling or indication of extravasation.
8. An appropriate bandage is applied to the injection site and the patient is instructed to keep pressure on the site for 5 minutes.
9. Patient is instructed to increase fluids for the next 24 hours, that they may eat and drink normally unless otherwise instructed by their nurse or doctor, and to report any unusual symptoms to their provider.
10. The type of contrast and dose information is recorded in the Cerner by the technologist.

Intravenous Extravasations

Injection site is actively monitored with visual observation and palpation to document successful injection and to exclude extravasation. If there is evidence of extravasation including pain, burning, stinging, swelling or tightness:

1. Stop injection immediately if evidence of extravasation (e.g. pain, swelling) occurs.

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2. Remove venous access device.
3. Elevate affected extremity above the heart.
4. Apply ice packs as needed.
5. Patients may be asked to remain for observation.
6. Notify emergency provider for evaluation.
7. Instruct patient to follow up with ordering provider if symptoms persist.
8. Report extravasation through RL6 and notify radiology manager.

SPECIAL CONSIDERATIONS:

Unused/Unadministered contrast will be disposed of per the Waste Management policy.

REFERENCES:

American College of Radiology Manual on Contrast Media 2023 pg. 5-28, 40-53, 87

COMMITTEE APPROVALS:
P&P: 4/3/2024
MEC: 4/4/2024

SUBJECT/TITLE: Infant Security		POLICY # SAF020
DEPARTMENT/SCOPE: Safety		Page 1 of 2
REVISION DATE: 5/13/2024 1/2/2019	EFFECTIVE DATE: 1/2/2016	
AUDIENCE: All Hospital Staff	APPROVAL DATE:	
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

With Attachment
Newborn Identification, *MMH172*

PURPOSE:
To ensure a safe and secure environment for all newborns.
To provide guidelines to properly identify newborns, and protect them from unauthorized removal from the hospital. To facilitate immediate recovery in the event of an abduction or unauthorized removal of a newborn.

POLICY:
Mayers Memorial Healthcare District has written procedures that govern the response to a security incident. (ACHC, 03.02.05)
Babies born to Mayers Memorial Healthcare District will be transferred with the mother. Mayers Memorial Healthcare District does not operate with a nursery or delivery department, however, in case of a birth, this policy shall be used. Hospital staff will instruct the family about their responsibilities regarding infant security. Staff instructions will include that the parents do not hand their newborn to any person not wearing a Mayers Memorial Hospital name badge and if name badge is not present, the parents have every right to refuse or challenge the situation.

PROCEDURE:
Newborns:

1. Identical ID bands will be placed on all newborns and mothers immediately after delivery. Place two (2) bands on the newborn and one (1) on the mother. The number on the plastic bands will be identical for the mother and the newborn.
2. Staff will always check the number on the ID bands, to ensure they match, before giving the newborn to the mother.
3. Newborns will be transported in the halls in a crib by staff wearing appropriate badges, or mother/support person with a matching ID band.
4. Newborns may be left in the patient room with the father or adult member of the immediate family or another adult the mother permits to, without a member of the nursing staff being present. Otherwise, newborns will not be left in a patient's room. If a newborn patient is to go to another department (i.e. Radiology), a nursing staff member will accompany the patient to that department, stay with them at all times, and accompany them back to their room.

INFANT SECURITY CODE: "Code Purple"

1. Witnessed removal of infant or child:
   a. Tell the unauthorized person to stop.
   b. Page "Code Purple & Location" and designate a staff member to call '911'.
   c. Employee Response: When employees hear "Code Purple" paged, employee (s) need to position themselves at the exit door nearest their location and to observe for

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DEPARTMENT/SCOPE: Safety		Page 2 of 2
REVISION DATE: 5/13/2024 1/2/2019	EFFECTIVE DATE: 1/2/2016	
AUDIENCE: All Hospital Staff	APPROVAL DATE:	
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

suspicious people. All exits are to be secured by personnel, and no one is allowed to leave the facility until "all clear" is paged.

d. Notify the Supervisor and Safety Officer.
e. Nursing Supervisor to designate someone to sit with parents.
f. Maintain alert status until a Deputy Sheriff arrives or an "all clear" has been paged.
g. If the abductor is being grievously threatening to the baby or the staff (behavior, brandishing a firearm), do not be confrontational, and let the perpetrator pass.
h. When the perpetrator leaves the facility, note, if possible, the type of vehicle, license number, the color of the car, and the direction taken.

2. Non-witnessed and suspected infant or child abducted:
   a. Call "Code Purple & location" and designate a staff member to call '911'.
   b. Employees are to position themselves by the nearest exit door and observe for suspicious people.
   c. All exits are to be secured by personnel and no one is allowed to leave the facility until an "all clear" is paged.
   d. Alert Nursing Supervisor and Safety Officer.
   e. Nursing Supervisor to designate someone to sit with parents.
   f. Designated group to search all areas of the hospital.
   g. Maintain alert status until the Sheriff arrives or "all clear" has been paged.

REFERENCES:

ACHC Accreditation requirements for Critical Access Hospitals, 2023 edition. Accreditation Commission for Health Care (ACHC). Chapter 3. 03.02.05

Guidelines for Perinatal Care, Sixth Edition

COMMITTEE APPROVAL:

SUBJECT/TITLE: IP Program Plan - LTC	POLICY # IC
DEPARTMENT/SCOPE: Infection Control	Page 1 of 7
REVISION DATE: N/A	EFFECTIVE DATE: 4/25/2024
AUDIENCE: All MMHD	APPROVAL DATE: 4/25/2024
OWNER: M. Cuccinello	APPROVER: K. Earnest

2024 Infection Prevention Program Plan – Long Term Care

I. Introduction

The Infection Prevention and Control (IPC) Plan is a description of the multidisciplinary, systematic, coordinated approach developed by Mayers Memorial Healthcare District (MMHD) 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 long-term care (LTC) setting. All applicable elements of the 2024 Acute Care Infection Prevention Program Plan will be applied to LTC. This document will serve as a *supplement* to the plan in order to address the infection prevention needs specific to the LTC setting.

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 potential issues 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

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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 LTC Infection Control Plan Risk Assessment).

- Maintenance of a sanitary environment.
- Development and implementation of infection prevention and control measures related to organization personnel.
- 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, venting systems, resident rooms, 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 measures to avoid overuse of antibiotics, including consideration of the antimicrobial spectrum, duration, and patient selection.
    - Ensure the prompt identification and containment of transmissible infections.
    - Other organization mitigation measures:
        - Strict hand hygiene protocols among personnel, 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 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.

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- 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

In long-term care, surveillance will be conducted in the following manner:

- Data collection for surveillance will be conducted as follows:
  - Weekly review of the Alert/Infection Charting Log.
  - Daily Cerner results for lab tests.
  - Direct communication to the IP from staff, leaders, or providers.
  - Monthly pharmacy report of antibiotics issued to LTC residents.
- Potential infections will be evaluated using McGeer Criteria, to determine if they meet the surveillance definition.
- Monthly infections will be reported by category: Urinary, Respiratory, Skin and Soft Tissue, and Gastrointestinal.
- Quarterly, infection rates will be calculated per 1000 resident days.
- Data will be reported quarterly via the Infection Prevention Committee (IPC), or more frequently if there are outbreaks or trends of concern.

V. Opportunities for Improvement

In order of priority, the following opportunities for improvement have been identified through a formal, quantified risk assessment. A subcommittee of the IPC, including LTC leaders, have collaborated to develop the plans of action to address each opportunity.

Opportunity	Actions	Who/ How	Progress
Outbreak Prevention / Outbreak Response	Update LTC Alert Charting Log to include infection information.	IP	Done
	Work with IT to create IP Worklist alerts when new meds are prescribed (anti-itch, antibiotic, etc., and certain tests are ordered (flu, COVID, urine CX, etc.)	IP and IT	

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	Ensure there is an established process for prompt reporting and management of infection concerns to LTC leader, to include new cough/ congestion, flu-like symptoms, rash or itch, conjunctivitis, N/V/D. • Ensure there is a process to educate and communicate with all staff, including registry, on these processes and expectations. • Consider implementing a "cheat sheet" or nursing order in Cerner addressing what infection elements to monitor and what to do if identified. • Refer to the "on-call decision tree" on the "cheat sheet" or nursing order, so registry staff have clear direction on the communication process.	LTC leaders/ IP/ Executive leadership team	
	Develop an evidence-based process for the management of HCWs exposed to COVID.	EH/ HR	
	Develop a process to communicate with LTC providers regarding any IP concerns, initiatives, or new processes.	Executive leadership team.	
	Continue to implement the Outbreak Response Team approach at the earliest concern of transmissible infection/ infestation (generally 1 or 2 cases, depending on the transmissibility of the infection). • Team to be led by CCO and/or IP, and in collaboration with LTC leaders; to include providers and all stakeholders.	LTC leadership/ IP/ Executive leadership team	Ongoing
	Consider adding IP to LTC communication threads with provider so that IP can be looped into early s/s infection.	IT/IP	
	Develop a list of standard actions should a resident develop a respiratory infection as a means to support a streamlined process for a prompt and thorough response. Educate leaders on same (charge nurses, nursing supervisors, admin team, etc.)	LTC leaders/ IP	
	Charge nurse or designee to round on isolations on a routine basis (ideally daily) to ensure correct signage is posted. IP to round at least weekly on same.	LTC leaders/ IP	

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	All isolations will have an order for the correct isolation in Cerner to guide in proper signage, communicate with all team members and IP, and to facilitate rounding.	LTC leaders/ IP/ providers	
Antibiotic Stewardship	Standardize review process for antibiotics to promote appropriate use and timely de-escalation. Create an antibiotic stewardship subcommittee to develop sustainable processes. Tools: https://www.ahrq.gov/antibiotic-use/long-term-care/index.html https://www.cdc.gov/antibiotic-use/core-elements/nursing-homes/implementation.html https://www.cdc.gov/antibiotic-use/core-elements/nursing-homes.html	Pharmacy/ quality/ IP/ LTC leaders/ providers/ Lab	
	Provide staff and ***family*** education regarding appropriate indications for antibiotics and risks of over-use.	LTC leadership/ Education/ Pharmacy	
	Educate LTC providers and nurses regarding Loeb's criteria and asymptomatic bacteriuria and appropriate indications for Urine Cx. Ensure review of expectations included in onboarding for interim providers including ARNPs and PAs. https://www.health.state.mn.us/diseases/antibioticresistance/hcp/asp/ltc/asbltc.pdf https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10466199/	Pharmacy/ Education/ CMO	
	In collaboration with quality and antibiotic stewardship subcommittee, develop measures of success. https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/ASP_ToolkitAC_examples.aspx	Pharmacy/ quality/ IP/ LTC leaders/ providers	
LTC UTIs	Continue to implement peri-care competency for CNAs biannually (return demo on mannequin or observed by a superuser).	Nursing education/ IP	

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	Identify residents at high risk for UTI and/or history of recurrent UTI and implement evidence-based strategies to mitigate risk to include increased vigilance of peri-care, fluids as appropriate, mobility, and bowel management. Put in writing; educate nursing, CNAs, families/ residents and providers.	LTC leaders/ IP/ Education	
	Similar to above; develop strategies to mitigate risk of UTI for residents exhibiting *early* signs of possible UTI. (Attempt strategies *prior to* ordering UA/ C&S, under the direction of nursing leaders). Include nursing, CNAs, providers, and families/ residents in education. • Number of UA/ C&S done quarterly, and/or number of UTIs, may be used as a measure of success. • These processes support antibiotic stewardship as well.	LTC leaders/ IP/ Education	
Staff Education Re: IP (includes *C. auris, MDROs,* and transmission-based precautions*)*	IP to be on the standing agenda for staff meetings; review infections, reinforce education, discuss other IP-related topics.	LTC leaders/ IP	
	IP to add IP-related communication to the daily huddle.	LTC leaders/ IP	
	Ensure education re: *C. auris* is provided to all nursing staff and environmental services. Add to annual MDRO education.	Education/ IP	
	Review CMS requirements for enhanced barrier precautions. Create a current list of residents who meet criteria so that compliance can be monitored. Clarify expectations in isolation policy. Provide staff, provider, and family education on same.	IP/ LTC leaders/ education	

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	Provide education to clinical* and EVS staff regarding C-diff and Enhanced Barrier precautions. (Include activities, therapy, nursing, CNAs, and all others who interact with residents.)	IP/ Ed.	
	Letter to residents and families re: EBP: https://www.cdc.gov/hai/pdfs/containment/Letter-Nursing-Home-Residents-Families-Friends-508.pdf	LTC leadership	
	Ensure isolation policy provides clear guidance on steps needed if infection suspected or confirmed. Once updated, educate staff to isolation policy.	IP/ LTC leadership/ Education	
Resident vaccines (flu, COVID, Pneumococcal, RSV)	Continue all current processes.	LTC leaders	
	Determine a standard process for ensuring new residents received recommended vaccines if consent obtained. Consider provider cheat sheet for ordering in Cerner, assistance from pharmacy, or utilizing Cerner prompts.	LTC leaders/ IT/ Pharmacy	

V1. Evaluation

At the end of the year, an evaluation of the plan will be conducted and used for development of the next year's risk assessment and plan.

COMMITTEE APPROVALS:

IC: 4/25/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Isolation Precautions	POLICY: IC 025
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Associated document*: Requirements for Transmission-Based Isolation Precautions* MMH758

Appendices:
Appendix A – *Alphabetical List of Suspected or Confirmed Infections*
Appendix B- *Clinical Syndromes or Conditions Warranting Empiric Transmission-Based Precautions in Addition to Standard Precautions*
Appendix C- *Injection safety*
Appendix D- *Donning and Doffing PPE*

POLICY:
Mayers Memorial Healthcare District utilizes a tiered approach for preventing the spread of infection within our healthcare facilities. With a goal of protecting patients, residents, healthcare workers, and visitors, this policy has been adapted from the Centers for Disease Control and Prevention (CDC) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007).

Standard Precautions:
Standard Precautions are the basic practices that apply to all patient care, regardless of the patient's *suspected* or *confirmed* infectious state, and apply to all settings where care is delivered. These practices protect healthcare personnel and prevent healthcare personnel or the environment from transmitting infections to others.

Transmission-based Precautions:
Transmission-Based Precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent transmission.

Enhanced Barrier Precautions:
Are an infection control intervention designed to reduce the transmission of multidrug resistant organisms (MDRO's) in skilled nursing facilities.

PROCEDURE:

1. **STANDARD PRECAUTIONS-** Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions, non-intact skin, and mucous membranes may contain transmissible infectious agents. The infection prevention practices under Standard Precautions applies to all patients, in any healthcare setting, regardless of suspected or confirmed infection, and states that all patients and residents must be treated as if they are potentially infectious. Whenever there is a chance of exposure to blood or any body fluids, secretions, excretions, mucous membranes, or tissue, personal protective equipment (PPE) is used.

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RECOMMENDATIONS FOR THE APPLICATION OF STANDARD PRECAUTIONS
FOR THE CARE OF *ALL* PATIENTS IN *ALL* HEALTHCARE SETTINGS

COMPONENT	RECOMMENDATIONS
Hand hygiene	Prior to patient contact (even if gloves are worn); prior to aseptic/ clean procedures; after touching patient; after contact with blood or body fluids; after touching patient surroundings or potentially contaminated items; immediately after removing gloves.
Personal protective equipment (PPE) Gloves	For touching blood, body fluids, secretions, excretions, contaminated items; for touching mucous membranes and nonintact skin
Personal protective equipment (PPE) Gown	During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated.
Personal protective equipment (PPE) Mask, eye protection (goggles), face shield	During procedures and patient-care activities likely to generate splashes or sprays of blood, body fluids, secretions, especially suctioning, endotracheal intubation. During aerosol-generating procedures on patients with suspected or proven infections transmitted by respiratory aerosols wear a fit-tested N95 or higher respirator in addition to gloves, gown and face/eye protection.
Soiled patient-care equipment	Handle in a manner that prevents transfer of microorganisms to others and to the environment; wear gloves if visibly contaminated; perform hand hygiene.
Environmental control	Ensure routine care, cleaning, and disinfection of environmental surfaces, especially frequently touched surfaces in patient-care areas.
Textiles and laundry	Handle in a manner that prevents transfer of microorganisms to others and to the environment
Needles and other sharps	Do not recap, bend, break, or handle used needles; if recapping is required, use a one-handed scoop technique only; use safety features when available; place used sharps in puncture-resistant container
Patient resuscitation	Use mouthpiece, resuscitation bag, other ventilation devices to prevent contact with mouth and oral secretions
Patient placement	Prioritize for single-patient room if patient is at increased risk of transmission, is likely to contaminate the environment, does not maintain appropriate hygiene, or is at increased risk of acquiring infection or developing adverse outcome following infection.
Respiratory hygiene/cough etiquette (source containment of respiratory secretions in symptomatic patients, at initial point of encounter e.g., ED triage/ reception areas and clinics)	Instruct symptomatic persons to cover mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacle; observe hand hygiene after soiling of hands with respiratory secretions; wear surgical mask if tolerated or maintain spatial separation, >3 feet if possible.

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Safe injection practices	Adhere to "One Needle, One Syringe, Only One Time." For additional information, refer to Appendix C, or the CDC Infection Safety page: https://www.cdc.gov/injectionsafety/index.html

Lab specimens--should be placed in a container and closed. After collection, the container is placed into a bag that prevents leakage during handling, processing, storage, transport, or shipping and is labeled with a biohazard symbol. If outside contamination of the primary biohazard bag occurs, it should be placed within a second biohazard container.

Blood spills-spills of blood or other body fluids should be removed, and the area decontaminated using the facility-approved blood spill kit. Gloves should be worn during cleaning and decontamination. The manufacturer's directions will be followed for use of the product in cleaning and decontaminating spills. The disinfectant should be EPA registered and have kill data against Hepatitis B and HIV and should be tuberculocidal. Refer to MMHD policy *Blood and Body Fluid Spill Kit, Guide for Use*.

Biomedical waste--Refer to MMHD policy *Medical Waste Management*.

Personal Protective Equipment (PPE)

- PPE is provided to all employees. Each employee is responsible for knowing where the equipment is kept in the department.
- The type of protective barrier(s) should be appropriate for the procedure being performed and the type of exposure anticipated.

2. **TRANSMISSION-BASED PRECAUTIONS-** Transmission-Based Precautions are used when the route(s) of transmission are not completely interrupted using Standard Precautions alone. For some diseases that have multiple routes of transmission, more than one Transmission-Based Precautions category may be used. When used either singly or in combination, *they are always used in addition to Standard Precautions.* See Appendix A for an alphabetized list of recommended precautions for specific suspected or confirmed infections. When Transmission-Based Precautions are indicated, efforts must be made to counteract possible adverse effects on patients (i.e., mood disturbances, perceptions of stigma, reduced contact with clinical staff, and increases in preventable adverse events) in order to improve acceptance by the patients and adherence by HCWs.

A. **CONTACT PRECAUTIONS-** Contact Precautions are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment. Contact precautions should be utilized for all multi drug-resistant organisms and other suspected or confirmed infections as per Appendix A. It should also be used for uncontained draining wounds, lice, scabies, bedbugs, or other infestations.

- **Patient placement**--Patient may be placed in a private room. If a private room is not available, the patient may be placed in a room with a patient(s) who has an active infection with the same organism but with no other infection. When a private room is not available and cohorting is not an option, consider the organism and patient(s) when determining placement. A decision will be made on a case-by-case basis regarding the safety of placing the patient in a room with another patient. Examples of patients who may require a private room include patients with resistant organisms who have copious drainage from a wound, incontinence, poor hygiene, etc.
- **Gloves and hand hygiene--**Hand hygiene should be performed prior to donning gloves. Gloves should be worn when entering the room and while providing care for the patient. Gloves should be changed, and hand hygiene performed, after having contact with infective material (e.g., fecal material, wound drainage) or when going from a "dirty" task to a "clean" task. Gloves should be removed before leaving the patient's room and hand hygiene should be performed immediately. After glove removal and hand hygiene, hands should not touch potentially contaminated environmental surfaces or items.
- **Gowns**--A gown should be worn when entering the room beyond the threshold and removed before leaving the patient's room. After removal of the gown, clothing should not contact potentially contaminated environmental surfaces.

B. **SPECIAL CONTACT PRECAUTIONS**- Used for those patients/ residents with suspected or confirmed infectious diarrhea (e.g., C-diff, norovirus). Special Contact Precautions are the same as Contact Precautions with two exceptions:
   - Soap and water (rather than hand sanitizer) should be used for hand hygiene *after* providing care.
   - An EPA-registered sporicidal (such as an "orange-top" bleach wipe) should be used to disinfect environmental surfaces.

C. **DROPLET PRECAUTIONS-** Droplet Precautions are used in addition to Standard Precautions for patients with infections that can be transmitted by droplets. Droplet transmission involves contact of the conjunctiva or mucous membranes of the nose or mouth of a susceptible person with large-particle droplets containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets may be generated by the patient's coughing, sneezing, talking, or during the performance of procedures, e.g., suctioning.

   - **Patient placement**--Patient may be placed in a private room. If a private room is not available, the patient may be placed in a room with a patient who has an active infection with the same organism but with no other infection. When a private room is not available and cohorting is not an option, maintain spatial separation of at least 3 feet between the infected patient and other patients and visitors, and keep the curtain

closed. Special air handling and ventilation are not necessary, and the door may remain open.

- **Masks**--A procedure mask should be worn to enter the room or cubicle.
- **Gown/ Gloves** – Gown and gloves should be worn as per standard precautions (i.e., if there will be potential contact with respiratory or other secretions.)
- **Transport**--Limit the movement and transport of the patient. If transport is necessary, the patient should wear a procedure mask.

D. **AIRBORNE PRECAUTIONS-** Airborne precautions are used in addition to standard precautions for patients known to or suspected to be infected with a disease spread by very small droplet nuclei (≤ 5mm). These particles are spread through the air and may be carried on air currents or inhaled by another person. Special air handling/ventilation ***is*** needed.

- **Patient Placement--**A private negative pressure Airborne Infection Isolation Room (AIIR) is required. The MMHD AIIR room is located in the emergency department. Per AIA Guidelines this room:
  - Is monitored for negative pressure relative to the surrounding area.
  - Provides a minimum of 12 air exchanges per hour.
  - Has air exhausted directly to the outside via a HEPA filter.
  - Door must remain closed to ensure negative pressure.
- Engineering may place a negative pressure machine in a regular patient room to provide a level of protection for certain airborne-transmissible diseases, such as COVID-19, *however, these rooms do not meet all of the above requirements, and thus are not appropriate for use with higher-risk diseases such as tuberculosis, measles, chickenpox, disseminated zoster, or smallpox.*
- **Respirator--**A fitted N95 respirator should be worn when entering the room. Clean hands upon room exit, *remove respirator when outside the room*, then perform hand hygiene again.
- **Transport--** Limit the movement and transport of the patient. If transport is necessary, the patient should wear a procedure mask.
- **Engineering controls--** Air pressure of the AIIR is electronically monitored continuously via the building management system. System alarms audibly and alerts both nursing staff and maintenance when pressure is lost.

E. **ENHANCED RESPIRATORY PRECAUTIONS**- Use for suspected or confirmed COVID-19.

- **Patient placement –** Place in private room with door closed if safe to do so. Use an airborne infection isolation room (AIIR) for aerosol-generating procedures, if available.
- **Gown and Gloves-** Use gown and gloves.
- **Respiratory protection-** Use an N95 respirator or higher-level respirator.

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- **Eye protection-** Use goggles or face shield for eye protection.
- Gown and gloves should be removed prior to exiting the room. Perform hand hygiene upon exiting room. After hand hygiene, respirator and eye protection are removed outside of room; then repeat hand hygiene.

F. **ENHANCED BARRIER PRECAUTIONS**- Enhanced Barrier Precautions (EBP) are an infection control intervention used in the ***long-term care setting*** to reduce the transmission of drug-resistant organisms.

Enhanced Barrier Precautions require gown and glove use during high-contact care activities for residents known to be colonized or infected with an MDRO, as well as those at increased risk of MDRO acquisition (e.g., residents with *wounds* or *indwelling medical devices*) when contact precautions do not apply. Examples of indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheostomies. Chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers.
****Contact Precautions are recommended if resident has acute diarrhea, draining wounds, or other sites of secretions or excretions that are unable to be covered or contained.**

Examples of high-contact resident care activities requiring gown and gloves us for Enhanced Barrier Precautions include:

- Dressing
- Bathing/showering/ providing hygiene
- Transferring
- Changing linens
- Changing briefs or assisting with toileting
- Device care or use; central line, urinary catheter, feeding tube
- Wound care; any skin opening requiring a dressing

Additionally,

- Residents on Enhanced Barrier Precautions are *not* restricted to their rooms or limited from participation in group activities.
- Enhanced Barrier Precautions are intended to be in place for the duration of the resident stay in the facility or until resolution of the wound or discontinuation of indwelling medical devices placing the patient/resident at higher risk for infection with a MDRO.
- Prevention of MDRO transmission requires more than just proper use of PPE; Other infection control practices such as proper hand hygiene, environmental cleaning, proper handling of wounds and indwelling medical devices are equally important.
- Consideration should be given to the appropriateness of shared bathrooms. Frequently touched surfaces in shared bathroom should be disinfected 2-3 times per day, and after use by affected resident.
- MDROs included in this category in, but are not limited to:

Pan-resistant organisms,
Carbapenemase-producing carbapenem-resistant Enterobacterales*, Acinetobacter baumannii*, and *Pseudomona,s*
Candida auris,
Methicillin-resistant *Staphylococcus aureus (MRSA)*,
ESBL-producing Enterobacterales,
Vancomycin-resistant *Enterococci (VRE)*,
Multidrug-resistant *Pseudomonas aeruginosa*,
Drug-resistant *Streptococcus pneumoniae,*
Clostridium difficile (use bleach wipes)

NEUTROPENIC (PROTECTIVE) PRECAUTIONS - As a general guide, neutropenic (protective) precautions should be initiated for those patients with an absolute neutrophil count (ANC) of less than 1000 cells/ mm^3 (or ANC is dropping and anticipated to be < 1000 in the next 48 hours) as ordered by the provider. For these patients the following precautions apply:

- Perform meticulous hand hygiene before entering room and/or contact with patient.
- Wear gloves when entering room (be sure to remove gloves, perform hand hygiene, and re-don gloves if there is any possibility of contamination or when going from a soiled task to a clean task).
- Wear mask upon entering room.
- Wear a gown *only if* clothing or scrubs may be contaminated.
- Ensure that no ill persons enter the room (staff or visitor).
- Assign staff to minimize the possibility of cross-contamination.
- No dried or live plants or flowers in the room.
- Avoid *non-peelable* fresh fruit or vegetables.
- Minimize invasive procedures/ devices.
- Patient should don surgical mask if leaving room.

3. GENERAL CLINICAL RESPONSIBILITIES FOR ALL TYPES OF TRANSMISSION-BASED PRECAUTIONS.

A. Transmission-based precautions may be initiated by a nurse, a provider, or infection preventionist (IP).
B. All patients placed on isolation precautions will have an isolation order entered into Cerner, as this triggers an alert to infection control and communicates the isolation status to other departments. This may be entered by the provider, nurse, or IP.
C. The caregiver will place the transmission-based precautions sign on the patient or resident door without delay, to alert others to the isolation. Place at eye-level.
D. If the patient/ resident has C-diff, Norovirus, or suspected infectious gastroenteritis, a sign will be placed over the alcohol gel to alert staff and visitors to use soap and water after contact/ care.

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E. Nursing will explain the need for isolation to the patient/ resident and to the family or caregiver as appropriate (within HIPAA guidelines). Education should be documented.
F. Nursing will review the importance of hand hygiene with the patient and with all visitors. Patients and residents will be encouraged/ assisted to perform hand hygiene frequently, particularly after toileting and before meals.
G. Nursing staff is expected to instruct visitors on the proper use of PPE and instruct on, and enforce, proper hand hygiene.
H. Isolation gowns are single use only and should be discarded after each use (or, if using cloth gowns, place in laundry after single use).
I. Use disposable and/or dedicated equipment whenever possible. When this is not possible, ensure that all equipment is thoroughly wiped down using a hospital-approved disinfectant after use and upon removal from the room or the patient environment.
J. The door to Airborne Isolation rooms should be kept closed at all times to maintain negative pressure. The doors on Droplet or Contact Precaution rooms are not required to be kept closed, but it is recommended to partially close the door to allow the isolation sign to be more visible.
K. With the exception of N95 respirators and/or face shields in airborne isolation rooms, PPE should be removed at the door, prior to exiting the room, and hand hygiene performed; the goal is to contain the organism in the room.
L. Dietary staff should refrain from passing trays into isolation rooms unless properly trained in isolation precautions and PPE.
M. **Patient Activities** – Except in extenuating circumstances, and if approved by IP and the provider, patients/residents on *airborne* precautions should remain in their rooms except for necessary medical tests that cannot be performed in the room.
N. Generally, patients and residents on *contact* and/or *droplet precautions* should be encouraged to remain in their room, however, to balance the physical and mental health concerns of isolation, *a charge nurse or nurse leader*, ***in consultation with*** *infection prevention,* can use the "***Five C's***" to assess the appropriateness of allowing these patients/ residents to ambulate in the halls or participate in solo activities outside of the room (go outside, or sit separately in a shared area.)
    a. ***Continent***: Is the patient/ resident continent, or is the incontinence able to be contained?
    b. ***Contained***: Are the patient/ resident's wounds contained (clean, dry dressing)? Can those on droplet precautions be masked?
    c. ***Cognizant***: Is the patient/ resident aware of their MDRO status and how to prevent transmission to others?
    d. ***Compliant***: Is the patient/ resident compliant with recommendations to prevent transmission (such as hand hygiene)?
    e. ***Clean***: Is the patient/ resident clean (bathed, hand hygiene, clean clothing)?

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4. DISCONTINUATION OF ISOLATION PRECAUTIONS

Discontinuation of isolation precautions should be done in consultation with the Infection Preventionist. If it *is* determined to be appropriate to discontinue isolation, the patient must be freshly bathed, moved on to a clean bed, and into a clean room. The isolation sign should remain on the door of the original room until a terminal clean has been completed.

a. In Long-Term Care, the terminal clean may be completed while the resident is out of the room for activities. Upon completion of the terminal clean, the resident can be transitioned to *Enhanced Barrier Precautions* as appropriate.
b. For patients with Clostridium difficile colitis (C-diff), the patient must have, at minimum, completed their full course of treatment and have been ASYMPTOMATIC for at least 48 hours. The decision to discontinue C-diff precautions should also take into account if the patient/ resident is continent of bowel, as they can continue to shed C-diff spores for months after acute infection.

5. CLINIC SETTING – In the clinic setting, staff should follow both Appendix A for suspected or confirmed infections, and Appendix B for presentation of clinical syndromes.

a. If the suspected or confirmed infection or syndrome is spread via droplet or airborne routes, the patient should be immediately masked and guided to perform hand hygiene. The patient should be immediately placed in a private room.
b. After this is completed, consult with the provider and/or infection preventionist for any further directions.

6. OUTPATIENT MEDICAL/ WOUND CARE –

a) Follow standard precautions as outlined on page 2 including the following:
   i. Use gloves for touching blood, body fluids, secretions, excretions, contaminated items; for touching mucous membranes and nonintact skin.
   ii. Use a gown when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated.
   iii. Use mask, eye protection (goggles), face shield during procedures likely to generate splashes or sprays of blood, body fluids, secretions.
b) Contact precautions should be used when managing wounds with active MDRO infection, or history* of MDRO and current evidence of active infection (such as the presence of purulent drainage, etc.) while cultures are pending (p. 20).
   i. *Exception: use contact precautions *consistently and indefinitely* on those with a history of **CRE** or ***Candida auris***.
c) Use contact precautions when managing an abscess or draining wound that cannot be covered, as per Appendix B (p. 32; Add Droplet Precautions for the first 24 hours of appropriate antimicrobial therapy if invasive Group A streptococcal disease is suspected.)

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REFERENCES:

CDC, *Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug resistant Organisms (MDRO's),* Updated; August 1, 2023.

CDC *Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*, Updated July 11, 2023. https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CMS Memorandum*: Enhanced Barrier Precautions in Nursing Homes*. March 20, 2024 https://www.cms.gov/files/document/qso-24-08-nh.pdf

COMMITTEE APPROVALS:

IC: 4/25/2024

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Appendix A – Alphabetical List of Suspected or Confirmed Infections

Link: https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/type-duration-precautions.html

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Abscess Draining, major	Contact + Standard	Duration of illness (DI)	Until drainage stops or can be contained by dressing.
Abscess Draining, minor or limited	Standard		If dressing covers and contains drainage.
Acquired human immunodeficiency syndrome (HIV)	Standard		Postexposure chemoprophylaxis for some blood exposures.
Actinomycosis	Standard		Not transmitted from person to person.
Adenovirus infection (see agent-specific guidance under Gastroenteritis, Conjunctivitis, Pneumonia)			
Amebiasis	Standard		Person-to-person transmission is rare. Transmission in settings for the mentally challenged and in a family group has been reported. Use care when handling diapered infants and mentally challenged persons.
Anthrax	Standard		Infected patients do not generally pose a transmission risk.
Anthrax Cutaneous	Standard		Transmission through non-intact skin contact with draining lesions possible, therefore use Contact Precautions if large amount of uncontained drainage. Handwashing with soap and water preferable to use of waterless alcohol-based antiseptics since alcohol does not have sporicidal activity.
Anthrax Pulmonary	Standard		Not transmitted from person to person.
Anthrax Environmental: aerosolizable spore-containing powder or other substance		Until environment completely decontaminated	Until decontamination of environment complete. Wear respirator (N95 mask or PAPRs), protective clothing; decontaminate persons with powder on them. **Hand hygiene:** Handwashing for 30-60 seconds with soap and water or 2% chlorhexidine gluconate after spore contact (alcohol handrubs inactive against spores.) **Postexposure prophylaxis following environmental exposure:** 60 days of antimicrobials (either doxycycline, ciprofloxacin, or levofloxacin) and postexposure vaccine.

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Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Arthropod-borne viral encephalitides (eastern, western, Venezuelan equine encephalomyelitis; St Louis, California encephalitis; West Nile Virus) and viral fevers (dengue, yellow fever, Colorado tick fever)	Standard		Not transmitted from person to person except rarely by transfusion, and for West Nile virus by organ transplant, breastmilk or trans placentally.
Ascariasis	Standard		Not transmitted from person to person.
Aspergillosis	Standard		Contact Precautions and Airborne if massive soft tissue infection with copious drainage and repeated irrigations required.
Avian influenza (see influenza, avian below)			
Babesiosis	Standard		Not transmitted from person to person, except rarely by transfusion.
Blastomycosis, North American, cutaneous or pulmonary	Standard		Not transmitted from person to person.
Botulism	Standard		Not transmitted from person to person.
Bronchiolitis (see Respiratory Infections in infants and young children)	Contact + Standard	Duration of illness	Use mask according to Standard Precautions.
Brucellosis (undulant, Malta, Mediterranean fever)	Standard		Not transmitted from person to person, except rarely via spermatozoa and sexual contact. Provide antimicrobial prophylaxis following lab exposure.
Campylobacter gastroenteritis (see Gastroenteritis)			
Candida auris, active, history, or colonization.	*Special Contact		Requires contact precautions and special cleaning. Private room only. Refer to the CDC website: https://www.cdc.gov/fungal/candida-auris/c-auris-infection-control.html
Candidiasis, all forms including mucocutaneous	Standard		

Cat-scratch fever (benign inoculation lymphoreticulosis)	Standard		Not transmitted from person to person.
Cellulitis	Standard		
Chancroid (soft chancre) (*H. ducreyi*)	Standard		Transmitted sexually from person to person.
Chickenpox (see Varicella)			
Chlamydia trachomatis Conjunctivitis	Standard		
Chlamydia trachomatis Genital (lymphogranuloma venereum)	Standard		
Chlamydia trachomatis Pneumonia (infants ≤3 mos. of age)	Standard		
Chlamydia pneumoniae	Standard		Outbreaks in institutionalized populations reported, rarely.
Cholera (see Gastroenteritis)			
Closed-cavity infection Open drain in place; limited or minor drainage	Standard		Contact Precautions if there is copious uncontained drainage.
Closed-cavity infection No drain or closed drainage system in place	Standard		
Clostridium botulinum	Standard		Not transmitted from person to person.
Clostridium difficile (see Gastroenteritis, *C. difficile*)	Contact + Standard	Duration of illness	
Clostridium perfringens Food poisoning	Standard		Not transmitted from person to person.
Clostridium perfringens Gas gangrene	Standard		Transmission from person to person rare. Use Contact Precautions if wound drainage is extensive.
Coccidioidomycosis (valley fever) Draining lesions	Standard		Not transmitted from person to person except under extraordinary circumstances.
Coccidioidomycosis (valley fever) Pneumonia	Standard		Not transmitted from person to person except under extraordinary circumstances, (e.g., inhalation of aerosolized endospores during necropsy, transplant of infected lung).
Colorado tick fever	Standard		Not transmitted from person to person.

Congenital rubella	Contact + Standard	Until 1 yr of age	Standard Precautions if nasopharyngeal and urine cultures repeatedly negative after 3 mos. of age.
Conjunctivitis Acute bacterial	Standard		
Conjunctivitis Acute bacterial-*Chlamydia*	Standard		
Conjunctivitis Acute bacterial-Gonococcal	Standard		
Conjunctivitis Acute viral (acute hemorrhagic)	Contact + Standard	Duration of illness	Adenovirus most common; enterovirus 70, Coxsackie virus A24 also associated with community outbreaks. Highly contagious; outbreaks in eye clinics, pediatric and neonatal settings, institutional settings reported.
Corona virus associated with SARS (SARS-CoV) (see Severe Acute Respiratory Syndrome)			
Coxsackie virus disease (see enteroviral infection)			
Creutzfeldt-Jakob disease (CJD, vCJD)	Standard		Use disposable instruments or special sterilization/disinfection for surfaces, objects contaminated with neural tissue if CJD or vCJD suspected; No special burial procedures.
Croup (see Respiratory Infections in infants and young children)			
Crimean-Congo Fever (see Viral Hemorrhagic Fever)	Standard		
Cryptococcosis	Standard		Not transmitted from person to person, except rarely via tissue and corneal transplant.
Cryptosporidiosis (see Gastroenteritis)			
Cysticercosis	Standard		Not transmitted from person to person.
Cytomegalovirus infection, including in neonates and immunosuppressed patients	Standard		No additional precautions for pregnant HCWs.

Decubitus ulcer (see Pressure Ulcer)			
Dengue fever	Standard		Not transmitted from person to person.
Diarrhea, acute-infective etiology suspected (see Gastroenteritis)			

Diphtheria Cutaneous	Contact + Standard	Until off antimicrobial treatment and culture-negative	Until 2 cultures taken 24 hours apart negative.
Diphtheria Pharyngeal	Droplet + Standard	Until off antimicrobial treatment and culture-negative	Until 2 cultures taken 24 hours apart negative.
Ebola virus (see Viral Hemorrhagic Fevers)			**Update:** Recommendations for healthcare workers can be found at Ebola For Clinicians..
Echinococcosis (hydatidosis)	Standard		Not transmitted from person to person.
Echovirus (see Enteroviral Infection)			
Encephalitis or encephalomyelitis (see specific etiologic agents)			
Endometritis (endomyometritis)	Standard		
Enterobiasis (pinworm disease, oxyuriasis)	Standard		
Enterococcus species (see MDRO if epidemiologically significant or vancomycin-resistant)			
Enterocolitis, *C. difficile* (see Gastroenteritis, *C. difficile*)			
Enteroviral infections (i.e., Group A and B Coxsackie viruses & Echo viruses) (excludes polio virus)	Standard		Use Contact Precautions for diapered or incontinent children for duration of illness and to control institutional outbreaks.
Epiglottitis, due to *Haemophilus influenzae* type b	Droplet + Standard	Until 24 hours after initiation of effective therapy	See specific disease agents for epiglottitis due to other etiologies.
Epstein-Barr virus infection, including infectious mononucleosis	Standard		
Erythema infectiosum (also see Parvovirus B19)			

Escherichia coli gastroenteritis (see Gastroenteritis)			
Food poisoning Botulism	Standard		Not transmitted from person to person.
Food poisoning C. *perfringens* or *welchii*	Standard		Not transmitted from person to person.
Food poisoning Staphylococcal	Standard		Not transmitted from person to person.
Furunculosis, staphylococcal	Standard		Contact if drainage not controlled. Follow institutional policies if MRSA.
Furunculosis, staphylococcal Infants and young children	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	
Gangrene (gas gangrene)	Standard		Not transmitted from person to person.
Gastroenteritis	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks for gastroenteritis caused by all of the agents below.
Gastroenteritis Adenovirus	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis Campylobacter species	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis Cholera (Vibrio cholerae)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis C. difficile	Special Contact + Standard	Duration of illness	Discontinue antibiotics if appropriate. Do not share electronic thermometers; ensure consistent environmental cleaning and disinfection with a sporicidal (such as bleach wipes). Use soap and water for hand hygiene.
Gastroenteritis Cryptosporidium species	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.

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Gastroenteritis E. coli Enteropathogenic O157:H7 and other Shiga toxin-producing strains	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis E. coli- Other species	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis Giardia lamblia	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis Noroviruses	Special Contact + Standard		Use Contact Precautions for a minimum of 48 hours after the resolution of symptoms or to control institutional outbreaks. Persons who clean areas heavily contaminated with feces or vomitus may benefit from wearing masks since virus can be aerosolized from these body substances; ensure consistent environmental cleaning and disinfection with focus on restrooms even when apparently unsoiled. Hypochlorite solutions may be required when there is continued transmission. Alcohol is less active, but there is no evidence that alcohol antiseptic handrubs are not effective for hand decontamination. Cohorting of affected patients to separate airspaces and toilet facilities may help interrupt transmission during outbreaks. **Gastroenteritis, Noroviruses Precaution Update [April 2019]** **Update:** The Type of Precaution was updated from "Standard" to "Contact + Standard" to align with Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings (2011)
Gastroenteritis Rotavirus	Contact + Standard	Duration of illness	Ensure consistent environmental cleaning and disinfection and frequent removal of soiled diapers. Prolonged shedding may occur in both immunocompetent and immunocompromised children and the elderly.
Gastroenteritis Salmonella species (including S. typhi)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis Shigella species (Bacillary dysentery)	Standard		Use Contact Precautions for diapered or incontinent personsfor the duration of illness or to control institutional outbreaks.

Gastroenteritis Vibrio parahaemolyticus	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis Viral (if not covered elsewhere)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis Yersinia enterocolitica	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
German measles (see Rubella; see Congenital Rubella)	n/a		
Giardiasis (see Gastroenteritis)	n/a		
Gonococcal ophthalmia neonatorum (gonorrheal ophthalmia, acute conjunctivitis of newborn)	Standard		
Gonorrhea	Standard		
Granuloma inguinale (Donovanosis, granuloma venereum)	Standard		
Guillain-Barré syndrome	Standard		Not an infectious condition.
Haemophilus influenzae (see disease-specific recommendations)			
Hand, foot, and mouth disease (see Enteroviral Infection)			
Hansen's Disease (see Leprosy)			
Hantavirus pulmonary syndrome	Standard		Not transmitted from person to person.
Helicobacter pylori	Standard		
Hepatitis, viral Type A	Standard		Provide hepatitis A vaccine postexposure as recommended.
Hepatitis, viral Type A-Diapered or incontinent patients	Contact + Standard		Maintain Contact Precautions in infants and children <3 years of age for duration of hospitalization; for children 3-14 yrs. of age for 2 weeks after onset of symptoms; >14 yrs. of age for 1 week after onset of symptoms.
Hepatitis, viral Type B-HBsAg positive; acute or chronic	Standard		See specific recommendations for care of patients in hemodialysis centers.
Hepatitis, viral Type C and other unspecified non-A, non-B	Standard		See specific recommendations for care of patients in hemodialysis centers.

Hepatitis, viral Type D (seen only w/ hepatitis B)	Standard		
Hepatitis, viral Type E	Standard		Use Contact Precautions for diapered or incontinent individuals for the duration of illness.
Hepatitis, viral Type G	Standard		
Herpangina (see Enteroviral Infection)			
Hookworm	Standard		
Herpes simplex (*Herpesvirus hominis*) Encephalitis	Standard		
Herpes simplex (Herpesvirus hominis) Mucocutaneous, disseminated or primary, severe	Contact + Standard	Until lesions dry and crusted	
Herpes simplex (Herpesvirus hominis) Mucocutaneous, recurrent (skin, oral, genital)	Standard		
Herpes simplex (Herpesvirus hominis) Neonatal	Contact + Standard	Until lesions dry and crusted	Also, for asymptomatic, exposed infants delivered vaginally or by C-section and if mother has active infection and membranes have been ruptured for more than 4 to 6 hours until infant surface cultures obtained at 24-36 hours of age negative after 48 hours incubation.
Herpes zoster (varicella-zoster) (shingles) *Disseminated* disease in any patient *Localized* disease in immunocompromised patient until disseminated infection ruled out	Airborne + Contact + Standard	Duration of illness	Susceptible HCWs should not enter room if immune caregivers are available; no recommendation for protection of immune HCWs; no recommendation for type of protection (i.e. surgical mask or respirator) for susceptible HCWs.
Herpes zoster (varicella-zoster) (shingles) Localized in patient with intact immune system with lesions that can be contained/covered	Standard	Until lesions dry and crusted	Susceptible HCWs should not provide direct patient care when other immune caregivers are available.
Histoplasmosis	Standard		Not transmitted from person to person.

Human immunodeficiency virus (HIV)	Standard		Postexposure chemoprophylaxis for some blood exposures.
Human metapneumovirus	Contact + Standard	Duration of illness	Assumed to be Contact transmission as for RSV since the viruses are closely related and have similar clinical manifestations and epidemiology. Wear masks according to Standard Precautions.

Impetigo	Contact + Standard	Until 24 hours after initiation of effective therapy	
Infectious mononucleosis	Standard		
Influenza Human (seasonal influenza)			See Prevention Strategies for Seasonal Influenza in Healthcare Settings for current seasonal influenza guidance.
Influenza Avian (e.g., H5N1, H7, H9 strains)			See Interim Guidance for Infection Control Within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease for current guidance.
Influenza Pandemic Influenza (also a human influenza virus)	Droplet + Standard		See Interim Guidance for Infection Control Within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease

Kawasaki syndrome	Standard		Not an infectious condition.

Lassa fever (see Viral Hemorrhagic Fevers)	n/a		n/a
Legionnaires' disease	Standard		Not transmitted from person to person.
Leprosy	Standard		n/a
Leptospirosis	Standard		Not transmitted from person to person.
Lice Head (pediculosis)	Contact + Standard		Further information may be found at CDC's Parasites – Lice.

Lice Body	Standard		Transmitted person-to-person through infested clothing. Wear gown and gloves when removing clothing; bag and wash clothes according to CDC guidance Parasites – Lice .
Lice Pubic	Standard		Transmitted person-to-person through sexual contact. See CDC's Parasites – Lice (accessed September 2018).
Listeriosis (listeria monocytogenes)	Standard		Person-to-person transmission rare; cross-transmission in neonatal settings reported.
Lyme disease	Standard		Not transmitted from person to person.
Lymphocytic choriomeningitis	Standard		Not transmitted from person to person.
Lymphogranuloma venereum	Standard		
Malaria	Standard		Not transmitted from person to person, except through transfusion rarely and through a failure to follow Standard Precautions during patient care.
Marburg virus disease (see Viral Hemorrhagic Fevers)			
Measles (rubeola)	Airborne + Standard	4 days after onset of rash; duration of illness in immune compromised	See Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings Susceptible healthcare personnel (HCP) should not enter room if immune care providers are available; regardless of presumptive evidence of immunity, HCP should use respiratory protection that is at least as protective as a fit-tested, NIOSH-certified N95 respirator upon entry into the patient's room or care area. For exposed susceptibles, postexposure vaccine within 72 hours or immune globulin within 6 days when available. Place exposed susceptible patients on Airborne Precautions and exclude susceptible healthcare personnel.
Melioidosis, all forms	Standard		Not transmitted from person to person.
Meningitis Aseptic (nonbacterial or viral; also see Enteroviral infections)	Standard		Contact for infants and young children.
Meningitis Bacterial, gram-negative enteric, in neonates	Standard		
Meningitis Fungal	Standard		
Meningitis *Haemophilus Influenzae*, type b known or suspected	Droplet + Standard	Until 24 hours after initiation of effective therapy	

Meningitis *Listeria monocytogenes* (See Listeriosis)	Standard		
Meningitis *Neisseria meningitidis* (meningococcal) known or suspected	Droplet + Standard	Until 24 hours after initiation of effective therapy	See Meningococcal Disease below.
Meningitis *Streptococcus pneumoniae*	Standard		
Meningitis *M. tuberculosis*	Standard		Concurrent, active pulmonary disease or draining cutaneous lesions may necessitate addition of Contact and/or Airborne. For children, Airborne Precautions until active tuberculosis ruled out in visiting family members (see Tuberculosis below).
Meningitis Other diagnosed bacterial	Standard		
Meningococcal disease: sepsis, pneumonia, Meningitis	Droplet + Standard	Until 24 hours after initiation of effective therapy	Postexposure chemoprophylaxis for household contacts, HCWs exposed to respiratory secretions; postexposure vaccine only to control outbreaks.
Molluscum contagiosum	Standard		
Monkeypox			See CDC's Monkeypox website for information on infection prevention and control.
Mucormycosis	Standard		
Multidrug-resistant organisms (**MDRO**s) e.g., MRSA, VRE, VISA/VRSA, ESBLs, Carbapenem-resistant *Enterobacteriaceae* [CRE], *Candida auris*, resistant *S. pneumoniae.*	Contact + Standard		Contact precautions for active infection with MDRO or history of MDRO and current infection while cultures are pending. For those with a history of, or are colonized with, an MDRO and do NOT have a current, active infection: Acute care- Use standard precautions. LTC- Refer to section on Enhanced Barrier Precautions. EXCEPTION: Patients and residents with a history of **CRE** or ***Candida auris*** must be placed on contact precautions and consult infection prevention. See also listing under Candida auris on p. 11

Mumps (infectious parotitis)	Droplet + Standard	Until 5 days after the onset of swelling	After onset of swelling; susceptible HCWs should not provide care if immune caregivers are available.
Mycobacteria, nontuberculosis (atypical)		Not transmitted person-to-person.	
Mycobacteria, nontuberculosis (atypical)	Pulmonary	Standard	
Mycobacteria, nontuberculosis (atypical)	Wound	Standard	
Mycoplasma pneumonia	Droplet + Standard	Duration of Illness	

Necrotizing enterocolitis	Standard		Contact Precautions when cases clustered temporally.
Nocardiosis, draining lesions, or other presentations	Standard		Not transmitted person-to-person.
Norovirus (see Gastroenteritis)			
Norwalk agent Gastroenteritis (see Gastroenteritis)			
Orf	Standard		
Parainfluenza virus infection, respiratory in infants and young children	Contact + Standard	Duration of illness	Viral shedding may be prolonged in immunosuppressed patients. Reliability of antigen testing to determine when to remove patients from Contact Precautions uncertain.
Parvovirus B19 (Erythema infectiosum)	Droplet + Standard		Maintain precautions for duration of hospitalization when chronic disease occurs in an immunocompromised patient. For patients with transient aplastic crisis or red-cell crisis, maintain precautions for 7 days.
Pediculosis (lice)	Contact + Standard	Until 24 hours after initiation of effective therapy after treatment	
Pertussis (whooping cough)	Droplet + Standard	Until 5 days after initiation of effective antibiotic therapy	Single patient room preferred. Postexposure prophylaxis for household contacts and HCWs with prolonged exposure to respiratory secretions. Current recommendations can be found at Tdap / Td ACIP Vaccine Recommendations.
Pinworm infection (Enterobiasis)	Standard		

Plague (*Yersinia pestis*) Bubonic	Standard		
Plague (*Yersinia pestis*) Pneumonic	Droplet + Standard	Until 48 hours after initiation of effective antibiotic therapy	Antimicrobial prophylaxis for exposed HCW.
Pneumonia Adenovirus	Droplet + Contact + Standard	Duration of illness	Outbreaks in institutional settings reported. In immunocompromised hosts, extend duration of Droplet and Contact Precautions due to prolonged shedding of virus.
Pneumonia Bacterial not listed elsewhere (including gram-neg. bacteria)	Standard		
Pneumonia *B. cepacia* in patients with CF, including respiratory tract colonization	Contact + Standard	Unknown	Avoid exposure to other persons with CF; private room preferred.
Pneumonia *B. cepacia* in patients without CF (see MDROs)			
Pneumonia *Chlamydia*	Standard		
Pneumonia Fungal	Standard		
Pneumonia *Haemophilus influenzae*, type b Adults	Standard		
Pneumonia *Haemophilus influenzae*, type b Infants and children	Droplet + Standard	Until 24 hours after initiation of effective therapy	
Pneumonia *Legionella spp.*	Standard		
Pneumonia . Meningococcal	Droplet + Standard	Until 24 hours after initiation of effective therapy	See Meningococcal Disease above.
Pneumonia Multidrug-resistant bacterial (see Multidrug-Resistant Organisms)			
Pneumonia	Droplet + Standard	Duration of illness	

Mycoplasma (primary atypical Pneumonia)			
Pneumonia Pneumococcal pneumonia	Standard		Use **Droplet Precautions** if evidence of transmission within a patient care unit or facility.
Pneumonia *Pneumocystis jiroveci* (*Pneumocystis carinii*)	Standard		Avoid placement in the same room with an immunocompromised patient.
Pneumonia *Staphylococcus aureus*	Standard		For MRSA, see MDROs.
Pneumonia *Streptococcus*, group A- Adults	Droplet + Standard	Until 24 hours after initiation of effective therapy	See Streptococcal Disease (group A *Streptococcus*). Use **Contact Precautions** if skin lesions present.
Pneumonia *Streptococcus*, group A Infants and young children	Droplet + Standard	Until 24 hours after initiation of effective therapy	Contact Precautions if skin lesions present.
Pneumonia Varicella-Zoster (See Varicella-Zoster)			
Pneumonia- Viral Adults	Standard		
Pneumonia- Viral Infants and young children (see Respiratory Infectious Disease, acute, or specific virus)			
Poliomyelitis	Contact + Standard	Duration of illness	
Pressure ulcer (decubitus ulcer, pressure sore) infected Major	Contact + Standard	Duration of illness	Until drainage stops or can be contained by dressing.
Pressure ulcer (decubitus ulcer, pressure sore) infected Minor or limited	Standard		If dressing covers and contains drainage.
Prion disease (See Creutzfeld-Jacob Disease)			
Psittacosis (ornithosis) (*Chlamydia psittaci*)	Standard		Not transmitted from person to person.
Q Fever	Standard		
Rabies	Standard		Person to person transmission rare; transmission via transplants has been reported. If patient has bitten another

			individual or saliva has contaminated an open wound or mucous membrane, wash exposed area thoroughly and administer postexposure prophylaxis.
Rat-bite fever (*Streptobacillus moniliformis* disease, *Spirillum minus* disease)	Standard		Not transmitted from person to person.
Relapsing fever	Standard		Not transmitted from person to person.
Respiratory infectious disease, acute (if not covered elsewhere) Adults	Standard		
Respiratory infectious disease, acute (if not covered elsewhere) Infants and young children	Contact + Standard	Duration of illness	Also see syndromes or conditions listed in Table 2.
Respiratory syncytial virus infection, in infants, young children and immunocompromised adults	Contact + Standard	Duration of illness	**Wear mask according to Standard Precautions**. In immunocompromised patients, extend the duration of Contact Precautions due to prolonged shedding.
Reye's syndrome	Standard		Not an infectious condition.
Rheumatic fever	Standard		Not an infectious condition.
Rhinovirus	Droplet + Standard	Duration of illness	Droplet most important route of transmission Outbreaks have occurred in NICUs and LTCFs Add Contact Precautions if copious moist secretions and close contact likely to occur (e.g., young infants)
Rickettsial fevers, tickborne (Rocky Mountain spotted fever, tickborne Typhus fever)	Standard		Not transmitted from person to person except through transfusion, rarely.
Rickettsialpox (vesicular rickettsiosis)	Standard		Not transmitted from person to person.
Ringworm (dermatophytosis, dermatomycosis, tinea)	Standard		Rarely, outbreaks have occurred in healthcare settings, (e.g., NICU, rehabilitation hospital). Use Contact Precautions for outbreak.
Rocky Mountain spotted fever	Standard		Not transmitted from person to person except through transfusion, rarely.
Roseola infantum (exanthem subitum; caused by HHV-6)	Standard		
Rotavirus infection (see Gastroenteritis)			
Rubella (German measles) (also see Congenital Rubella)	Droplet + Standard	Until 7 days after onset of rash	Susceptible HCWs should not enter room if immune caregivers are available. No recommendation for wearing face protection (e.g., a surgical mask) if immune. Pregnant

			women who are not immune should not care for these patients Administer vaccine within 3 days of exposure to non-pregnant susceptible individuals. Place exposed susceptible patients on Droplet Precautions; exclude susceptible healthcare personnel from duty from day 5 after first exposure to day 21 after last exposure, regardless of postexposure vaccine.
Rubeola (see Measles)			

Salmonellosis (see Gastroenteritis)			
Scabies	Contact + Standard	Until 24 hours after initiation of effective therapy	
Scalded skin syndrome, staphylococcal	Contact + Standard	Duration of illness	See Staphylococcal Disease, scalded skin syndrome below.
Schistosomiasis (bilharziasis)	Standard		
Severe acute respiratory syndrome (SARS)	Airborne + Droplet + Contact + Standard "**Enhanced Respiratory Precautions**"	Duration of illness plus 10 days after resolution of fever, if respiratory symptoms are absent or improving	Airborne preferred; Droplet if AIIR unavailable. N95 or higher respiratory protection; surgical mask if N95 unavailable; eye protection (goggles, face shield); aerosol-generating procedures and "supershedders" highest risk for transmission via small droplet nuclei and large droplets.
Shigellosis (see Gastroenteritis)			
Smallpox (variola; see Vaccinia for management of vaccinated persons)	Airborne + Contact + Standard	Duration of illness	Until all scabs have crusted and separated (3-4 weeks). Non-vaccinated HCWs should not provide care when immune HCWs are available; N95 or higher respiratory protection for susceptible and successfully vaccinated individuals; postexposure vaccine within 4 days of exposure protective.
Sporotrichosis	Standard		
Spirillum minor disease (rat-bite fever)	Standard		Not transmitted from person to person.
Staphylococcal disease (*S. aureus*) Skin, wound, or burn Major	Contact + Standard	Duration of illness	Until drainage stops or can be contained by dressing.
Staphylococcal disease (*S. aureus*) Skin, wound, or burn Minor or limited	Standard		If dressing covers and contains drainage adequately.

Staphylococcal disease (*S. aureus*) Enterocolitis	Standard		Use Contact Precautions for diapered or incontinent children for duration of illness.
Staphylococcal disease (*S. aureus*) (Multidrug-resistant see Multidrug-Resistant Organisms)			
Staphylococcal disease (*S. aureus*) Pneumonia	Standard		
Staphylococcal disease (*S. aureus*) Scalded skin syndrome	Contact + Standard	Duration of illness	Consider healthcare personnel as potential source of nursery, NICU outbreak.
Staphylococcal disease (*S. aureus*) Toxic shock syndrome	Standard		
Streptobacillus moniliformis disease (rat-bite fever)	Standard		Not transmitted from person to person.
Streptococcal disease (group A *Streptococcus*) Skin, wound, or burn- Major	Contact + Droplet + Standard	Until 24 hours after initiation of effective therapy	Until drainage stops or can be contained by dressing.
Streptococcal disease (group A *Streptococcus*) Skin, wound, burn- Minor or limited	Standard		If dressing covers and contains drainage.
Streptococcal disease (group A *Streptococcus*) Endometritis (puerperal sepsis)	Standard		
Streptococcal disease (group A *Streptococcus*) Pharyngitis in infants and young children	Droplet + Standard	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A *Streptococcus*) Pneumonia	Droplet + Standard	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A *Streptococcus*) Scarlet fever in infants and young children	Droplet + Standard	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A *Streptococcus*) ***Serious invasive disease***	Droplet + Standard	Until 24 hours after initiation of effective therapy	Outbreaks of serious invasive disease have occurred due to transmission among patients and healthcare personnel. **Add Contact Precautions for draining wound as above**; follow recommendations for antimicrobial prophylaxis in selected conditions.
Streptococcal disease (group B *Streptococcus*), neonatal	Standard		

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Streptococcal disease (not group A or B) unless covered elsewhere Multidrug-resistant (see Multidrug-Resistant Organisms)			
Strongyloidiasis	Standard		
Syphilis Latent (tertiary) and seropositivity without lesions	Standard		
Syphilis Skin and mucous membrane, including congenital, primary, Secondary	Standard		
Tapeworm disease *Hymenolepis nana*	Standard		Not transmitted from person to person.
Tapeworm disease *Taenia solium* (pork)	Standard		
Tapeworm disease Other	Standard		
Tetanus	Standard		Not transmitted from person to person.
Tinea (e.g., dermatophytosis, dermatomycosis, ringworm)	Standard		Rare episodes of person-to-person transmission.
Toxoplasmosis	Standard		Transmission from person to person is rare; vertical transmission from mother to child, transmission through organs and blood transfusion rare.
Toxic shock syndrome (staphylococcal disease, streptococcal disease)	Standard		Droplet Precautions for the first 24 hours after implementation of antibiotic therapy if Group A *Streptococcus* is a likely etiology.
Trachoma, acute	Standard		
Transmissible spongiform encephalopathy (see Creutzfeld-Jacob disease, CJD, vCJD)			
Trench mouth (Vincent's angina)	Standard		
Trichinosis	Standard		
Trichomoniasis	Standard		
Trichuriasis (whipworm disease)	Standard		
Tuberculosis (*M. tuberculosis*) Extrapulmonary, draining lesion	Airborne + Contact + Standard		Discontinue precautions only when patient is improving clinically, and drainage has ceased or there are 3 consecutive negative cultures of

			continued drainage Examine for evidence of active pulmonary tuberculosis.
Tuberculosis (*M. tuberculosis*) Extrapulmonary, no draining lesion, Meningitis	Standard		Examine for evidence of pulmonary tuberculosis. For infants and children, use Airborne until active pulmonary tuberculosis in visiting family members ruled out.
Tuberculosis (*M. tuberculosis*) Pulmonary or laryngeal disease, confirmed	Airborne + Standard		Discontinue precautions only when patient on effective therapy is improving clinically and has 3 consecutive sputum smears negative for acid-fast bacilli collected on separate days. Consult with IP/ health department.
Tuberculosis (*M. tuberculosis*) Pulmonary or laryngeal disease, suspected	Airborne + Standard		Discontinue precautions only when the likelihood of infectious TB disease is deemed negligible, and either 1. there is another diagnosis that explains the clinical syndrome, or 2. the results of 3 sputum smears for AFB are negative. Each of the 3 sputum specimens should be collected 8 -24 hours apart, and at least 1 should be an early morning specimen.
Tuberculosis (*M. tuberculosis*) Skin-test positive with no evidence of current active disease	Standard		
Tularemia Draining lesion	Standard		Not transmitted from person to person.
Tularemia Pulmonary	Standard		Not transmitted from person to person.
Typhoid (*Salmonella typhi*) fever (see Gastroenteritis)			
Typhus Rickettsia prowazekii (Epidemic or Louse-borne Typhus)	Standard		Transmitted from person to person through close personal or clothing contact.
Typhus *Rickettsia typhi*	Standard		Not transmitted from person to person.
Urinary tract infection (including pyelonephritis)	Standard		
Vaccinia			Only vaccinated HCWs have contact with active vaccination sites and care for persons with adverse vaccinia events; if unvaccinated, only HCWs without contraindications to vaccine may provide care.

Vaccinia Vaccination site care (including autoinoculated areas)	Standard		Vaccination recommended for vaccinators; for newly vaccinated HCWs: semi-permeable dressing over gauze until scab separates, with dressing change as fluid accumulates, ~3-5 days; gloves, hand hygiene for dressing change; vaccinated HCW or HCW without contraindication to vaccine for dressing changes.
Vaccinia (adverse events following vaccination) Eczema vaccinatum	Contact + Standard	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material.
Vaccinia (adverse events following vaccination) Fetal vaccinia	Contact + Standard	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material.
Vaccinia (adverse events following vaccination) Generalized vaccinia	Contact + Standard	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material.
Vaccinia (adverse events following vaccination) Progressive vaccinia	Contact + Standard	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material.
Vaccinia (adverse events following vaccination) Postvaccinia encephalitis	Standard		
Vaccinia (adverse events following vaccination) Blepharitis or conjunctivitis	Contact + Standard		Use Contact Precautions if there is copious drainage.
Vaccinia (adverse events following vaccination) Iritis or keratitis	Standard		
Vaccinia (adverse events following vaccination) Vaccinia-associated erythema multiforme (Stevens Johnson Syndrome)	Standard		Not an infectious condition.
Vaccinia (adverse events following vaccination) Secondary bacterial infection (e.g., *S. aureus*, group A beta hemolytic *Streptococcus*)	Standard + Contact		Follow organism-specific (strep, staph most frequent) recommendations and consider magnitude of drainage.
Varicella Zoster	Airborne + Contact + Standard	Until lesions dry and crusted	Susceptible HCWs should not enter room if immune caregivers are available; no recommendation for face protection of immune HCWs; no recommendation for

			type of protection (i.e., surgical mask or respirator) for susceptible HCWs. -In immunocompromised host with varicella pneumonia, prolong duration of precautions for duration of illness. -Postexposure prophylaxis: provide postexposure vaccine ASAP but within 120 hours; for susceptible exposed persons for whom vaccine is contraindicated (immunocompromised persons, pregnant women, newborns whose mother's varicella onset is <5 days before delivery or within 48 hours after delivery) provide varicella zoster immune globulin as soon as possible after exposure and within 10 days. -Use Airborne for exposed susceptible persons and exclude exposed susceptible healthcare workers beginning 8 days after first exposure until 21 days after last exposure or 28 if received varicella zoster immune globulin, regardless of postexposure vaccination.
Variola (see Smallpox)			
Vibrio parahaemolyticus (see Gastroenteritis)			
Vincent's angina (trench mouth)	Standard		
Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses	Droplet + Contact + Standard	Duration of illness	Recommendations for healthcare workers can be found at Ebola For Clinicians. Single-patient room preferred. Emphasize: 1. use of sharps safety devices and safe work practices, 2. hand hygiene; 3. barrier protection against blood and body fluids upon entry into room (single gloves and fluid-resistant or impermeable gown, face/eye protection with masks, goggles or face shields); and 4. appropriate waste handling. Use N95 or higher respirators when performing aerosol-generating procedures. Largest viral load in final stages of illness when hemorrhage may occur; additional PPE, including double gloves, leg and shoe coverings may be used.
Viral respiratory diseases (not covered elsewhere)- Adults	Standard		

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Viral respiratory diseases (not covered elsewhere)- Infants and young children (see Respiratory infectious disease, acute)			
Whooping cough (see Pertussis)			
Wound infections Major	Contact + Standard	Duration of illness	Until drainage stops or can be contained by dressing.
Wound infections Minor or limited	Standard		If dressing covers and contains drainage.
Yersinia enterocolitica Gastroenteritis (see Gastroenteritis)			
Zika	Standard		Reassign pregnant personnel. Refer to CDC website: https://www.cdc.gov/zika/hc-providers/infection-control.html
Zoster (varicella-zoster) (see Herpes Zoster)			
Zygomycosis (phycomycosis, mucormycosis)	Standard		Not transmitted person-to-person.

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APPENDIX B- Clinical Syndromes or Conditions Warranting Empiric Transmission-Based Precautions in Addition to Standard Precautions

Disease	Clinical Syndrome or Condition†	Potential Pathogens‡	Empiric Precautions (Always Includes Standard Precautions)
Diarrhea	Acute diarrhea with a likely infectious cause in an incontinent or diapered patient	Enteric pathogens§	Special Contact Precautions (pediatrics and adult)
Meningitis	Meningitis	*Neisseria meningitidis*	Droplet Precautions for first 24 hours of antimicrobial therapy; mask and face protection for intubation
Meningitis	Meningitis	Enteroviruses	Contact Precautions for infants and children
Meningitis	Meningitis	*M. tuberculosis*	Airborne Precautions if pulmonary infiltrate Airborne Precautions plus Contact Precautions if potentially infectious draining body fluid present
Rash or Exanthems, Generalized, Etiology Unknown	Petechial/ecchymotic with fever (general)	*Neisseria meningitides*	Droplet Precautions for first 24 hours of antimicrobial therapy
Rash or Exanthems, Generalized, Etiology Unknown	Petechial/ecchymotic with fever (general) • If positive history of travel to an area with an ongoing outbreak of VHF in the 10 days before onset of fever	Ebola, Lassa, Marburg viruses	Droplet Precautions plus Contact Precautions, with face/eye protection, emphasizing safety sharps and barrier precautions when blood exposure likely. Use N95 or higher respiratory protection when aerosol-generating procedure performed. Recommendations for healthcare workers can be found at Ebola For Clinicians.
Rash or Exanthems, Generalized, Etiology Unknown	Vesicular	Varicella-zoster, *herpes simplex,* variola (smallpox), vaccinia viruses	Airborne plus Contact Precautions; Contact Precautions only if Herpes simplex, localized zoster in an immunocompetent host or vaccinia viruses most likely
Rash or Exanthems, Generalized, Etiology Unknown	Maculopapular with cough, coryza and fever	Rubeola (measles) virus	Airborne Precautions
Respiratory Infections	Cough/fever/upper lobe pulmonary infiltrate in an HIV-negative patient or a patient at low risk for human immunodeficiency virus (HIV) infection	*M. tuberculosis,* Respiratory viruses, *S. pneumoniae, S. aureus* (MSSA or MRSA)	Airborne Precautions plus Contact precautions
Respiratory Infections	Cough/fever/pulmonary infiltrate in any lung location in an HIV-infected	*M. tuberculosis,* Respiratory viruses, *S.*	Airborne Precautions plus Contact Precautions

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Disease	Clinical Syndrome or Condition†	Potential Pathogens‡	Empiric Precautions (Always Includes Standard Precautions)
	patient or a patient at high risk for HIV infection	*pneumoniae, S. aureus* (MSSA or MRSA)	Use eye/face protection if aerosol-generating procedure performed or contact with respiratory secretions anticipated. If tuberculosis is unlikely and there are no AIIRs and/or respirators available, use Droplet Precautions instead of Airborne Precautions. Tuberculosis more likely in HIV-infected individual than in HIV negative individual
Respiratory Infections	Cough/fever/pulmonary infiltrate in any lung location in a patient with a history of recent travel (10-21 days) to countries with active outbreaks of SARS, avian influenza	*M. tuberculosis,* severe acute respiratory syndrome virus (SARS- CoV), avian influenza	Airborne plus Contact Precautions plus eye protection. If SARS and tuberculosis unlikely, use Droplet Precautions instead of Airborne Precautions.
Respiratory Infections	Respiratory infections, particularly bronchiolitis and pneumonia, in infants and young children	Respiratory syncytial virus, parainfluenza virus, adenovirus, influenza virus, *Human metapneumovirus*	Contact plus Droplet Precautions; Droplet Precautions may be discontinued when adenovirus and influenza have been ruled out
Skin or Wound Infection	Abscess or draining wound that cannot be covered	*Staphylococcus aureus* (MSSA or MRSA), group A streptococcus	Contact Precautions Add Droplet Precautions for the first 24 hours of appropriate antimicrobial therapy if invasive Group A streptococcal disease is suspected

Source: https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/transmission-precautions.html

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Appendix C- Injection safety

Follow CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings (PDF) and CDC's One and Only Campaign for safe injection and medication practice recommendations.

1. Perform hand hygiene and use aseptic technique when preparing and administering medications.
2. Before entry, always disinfect the tops of medication vials with 70% alcohol; allow tops to dry before inserting a needle or device into the vial.
3. Draw up medications in a clean medication area; the designated medication area should not be near areas where contaminated items are placed.
4. Always use needles and syringes for one patient only, including manufactured prefilled syringes and cartridge devices such as insulin pens
5. Enter medication containers with a new syringe and a new needle even when obtaining additional doses for the same patient.
6. Ensure single-dose or single-use vials, ampules, bags or bottles of parenteral solution, fluid infusion and administration sets (for example, intravenous tubing) are used for one patient only!
    - Use single-dose medication vials whenever possible.
        - Read the label on medication vials carefully to determine if it's for single use; if the vial says single-dose, throw it away after it has been accessed
        - Do not save single-dose medications for future use!
        - Discard unused single-dose medications when expired.
7. Limit the use of multi-dose medication vials whenever possible (Refer to "*Use of Multidose Vials"* policy and procedure.
    - A multi-dose vial is recognized by its FDA-approved label.
    - Dedicate multi-dose vials to a single patient whenever possible.
    - If multi-dose vials must be used for more than one patient, restrict the medication vials to a centralized medication area and never take them into the patient treatment area (such as operating room, patient room/cubicle)
    - Discard multi-dose vials when the beyond-use date has been reached.
    - Any time the sterility of the vial is in question, throw it out.
    - Date the multi-dose vial when first opened; discard within 28 days, unless the manufacturer recommends a shorter expiration period.
8. Wear a facemask when placing a catheter or injecting material into the epidural or subdural space (such as during myelogram, epidural, or spinal anesthesia)

Source: Injection Safety Information for Healthcare Providers and Public Health Departments, CDPH, 11/13/2019, https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/InjectionSafetyInfoForHCP_PublicHealthDpt.aspx

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APPENDIX D- Donning and Doffing (https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf)

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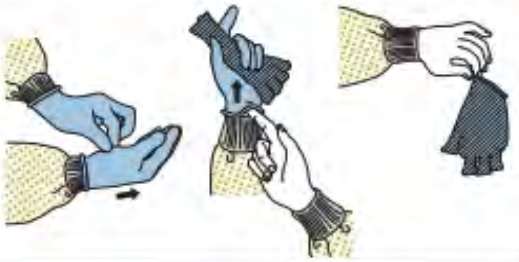
HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container



2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

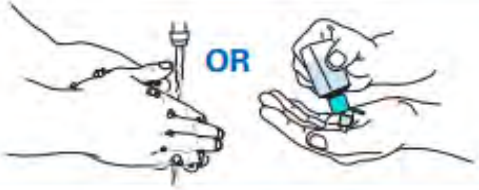
3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

CDC

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HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container

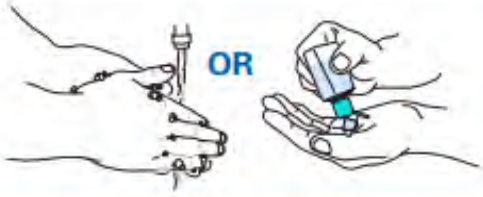
2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

CDC

MAYERS MEMORIAL
HEALTHCARE DISTRICT

NOTICE TO PATIENTS:

This practice serves all patients regardless of ability to pay. Discounts for essential services are offered based on family size and income. For more information, ask at the front desk or visit our website. Thank you.

AVISO PARA PACIENTES:

Esta práctica atiende a todos los pacientes independientemente de su capacidad de pago. Se ofrecen descuentos para servicios esenciales según el tamaño de la familia y los ingresos. Para más información, pregunte en la recepción o visite nuestro sitio web.

Requirements for Transmission-Based Isolation Precautions

Standard Precautions must be used in the care of all patients

	Standard Precautions	Droplet Precautions	Contact Precautions	Airborne Precautions	Enhanced Barrier	Special Contact	Enhanced Respiratory
Private Room	No	Yes, unless cohorted	Yes, unless cohorted	Yes	Yes, unless cohorted	Yes, unless cohorted	Yes, unless cohorted
Mask	Refer to standard precautions listed on p. 2 of Isolation Policy	Yes	No	N95	No	No	N95
Eye Protection		If close contact and patient unable to contain cough.	No	No	No	No	Yes
Gown		If potential contact with respiratory or other secretions.	Yes	No	During high-contact care activities • Bathing, dressing • Transferring • Toileting • Changing linens or briefs • Device care • Wound care	Yes	Yes
Gloves		Yes	Yes	No	Yes, for high-contact care activity	Yes **Use soap & water after care**	Yes
Disinfectant	Caviwipes	Caviwipes	Caviwipes	Caviwipes	Caviwipes *Use bleach wipes for hx C-diff*	PDI Orange-top bleach wipes	Caviwipes
Linen bag	Black	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Dedicated Equipment	No	Yes	Yes	No	If available	Yes	Yes
Transport	No concerns	Surgical mask on patient	Clean linens	Surgical mask on patient.	Clean linens	Clean linens	Surgical mask on patient
Disposable meal tray	No	No	No	No	No	Yes	No
Door closed	No	No	No	Yes (if safe to do so)	No	No	Yes (if safe to do so)
Change curtains on D/C	No	Yes	Yes	Yes	Yes	Yes	Yes

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Safety Emergency and Environment of Care Committee	POLICY # SAF#003
DEPARTMENT/SCOPE: Safety		Page 1 of 4
REVISION DATE:	EFFECTIVE DATE: 12/1/2023	
AUDIENCE: Disaster, Safety	APPROVAL DATE:	
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

POLICY:

The Safety Emergency Environment of Care Committee has been developed to discuss opportunities to improve all issues related to safety, emergency and environment of care existing within Mayers Memorial Healthcare District.

The Safety Emergency Environment of Care Committee is a multidisciplinary team that includes representatives from various areas and levels of the organization. The committee falls under direct responsibility of the Safety Officer and the CEO. Members should have knowledge and authority of the operations within their own area/service. Committee members will represent the district as a whole and will meet at least every two months per *ACHC 03.01.03.*

The committee will also represent other employees and leadership and bring forth concerns from others and report in department meetings findings from the committee. Members shall include both leadership and employees and includes representatives from, but not limited to:

- Administration
- Emergency Management Program Manager
- Clinical and non-clinical staff from key departments/units
- May include representatives from local agencies, i.e., police, fire/emergency medical services, emergency management and public health, as necessary.

PROCEDURE

Mayers Memorial Healthcare District, the Safety Officer and the Safety Emergency and Environment of Care Committee in conjunction with hospital Quality committee will coordinate the overall Safety Program and facilitate good practice. The Safety Emergency and Environment of Care Committee will also oversee and coordinate with Staff Development, safety training/education and hospital safety surveys.

Neither the Safety Emergency and Environment of Care Committee nor the Safety Officer or Committee Chair alone is responsible for facility or individual safety.

The Committee will either meet as one or split into seperate subcommittees dependent on facility need, with the cadence determined by the committee and noted in the minutes. and meet no less than every other month in an in person, or electronic capacity.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Safety Emergency and Environment of Care Committee	POLICY # SAF#003
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OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

DUTIES OF THE SAFETY EMERGENCY AND ENVIRONMENT OF CARE COMMITTEE CHAIRPERSON:

The Safety Committee Chairperson ensures the goals are met within the committee. Duties include, but not limited to the following:

- Facilitate Safety Committee Meetings. Oversee the development of agenda and production of minutes. The meeting minutes written by the committee scribe and kept on the intranet and in a file on Teams and are available upon request.
- Organize the facility wide safety surveys including developing an on-going schedule.
- Advise Management on the development and/or progress of Safety topics or Programs, and serve the purpose of assuring concerns identified by the committee can receive administrative attention in an expeditious manner. *ACHC 03.01.04*
- Facilitate annual review of Safety Policies.
- Attending or recommend attendance of employees at educational workshops.
- Facilitate the development &/or presentation of Employee Safety Training.
- Report to the QA/QI committee, the significant trends, activities, events associated. with Safety and Security.

The CEO must annually appoint the Committee chair, with copies of written appointment available upon request. ***ACHC 03.01.04***

RESPONSIBILITIES OF SAFETY EMERGENCY AND ENVIRONMENT OF CARE COMMITTEE:

Safety and Environment of Care Meetings

A. Develop, implement, and review general Employee and environmental Safety Policies.
B. Partner with department heads regarding policies that are department specific. Return to departments with Safety information to share.
C. Oversees Facility Wide Programs regarding Safety, Security and Environment of Care:
    - Hazard Communication Program
    - Fire Plan Program
    - Disaster Preparedness
    - Safety and Security
    - Workplace Violence Program
    - Ergonomics
    - Safe Patient Handling
D. Review board for employee injury reports, identifying problems, noting trends, make recommendations for solution and training needs.

SUBJECT/TITLE:	Safety Emergency and Environment of Care Committee	POLICY # SAF#003
DEPARTMENT/SCOPE: Safety		Page 3 of 4
REVISION DATE:	EFFECTIVE DATE: 12/1/2023	
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OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

E. Perform a planned, on-going calendar of Facility Safety Surveys. Safety Audits/Surveys as assigned by the Safety Officer. Documentation of findings, corrections and subsequent training courses are kept according to policy.

Safety/ Emergency Management Meetings

- Developing, evaluating, and revising an "all hazards" Emergency Management Program for Mayers Memorial Healthcare District on an annual basis and as needed
- Conducting the hospital's Hazard Vulnerability Analysis (HVA) on an annual basis.
- Assisting with development or revision of an Emergency Operations Plan (EOP), along with standard operating procedures to address the hazards identified.
- Developing hospital operations plan.
- Ensuring that all staff, including medical staff, receive training and education regarding roles and responsibilities during an emergency/disaster.
- Providing reports to the Incident Commander and the Governing Body
- Providing Emergency Management Program updates and informing staff.
- Reviewing of the hospital's Emergency Management Program and Plans

Program shall include:

- Studying the local community Emergency Management Plan if applicable/available.
- Ascertaining the hospital position and the emergency management mission assigned to it. This mission may include:
    - Caring for emergency/disaster patients in the hospital
    - Responsibility for staffing a Packaged Disaster Hospital (PDH) or first aid station.
    - Providing professional staff to serve outside the community.
- Learning whether the community has negotiated mutual aid agreements with neighboring communities (which may provide for mutual assistance arrangements between hospitals in the participating communities
- Obtaining from state or local Emergency Management offices a current estimate of situations most likely to occur in the community.

Making a general assessment of the hospital's present key resources:

- Physicians
- Nurses
- Beds
- Critical supply and equipment items
- Available space
- Determining the hospital's maximum expansion capability in terms of beds and services, assuming that resources are used with optimum efficiency

MAYERS MEMORIAL HEALTHCARE DISTRICT

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OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

- Estimating, in light of expanded operation, the hospital's key resource requirements during different time intervals, i.e., 15, 30 and 60 days
- Determining the hospital's capabilities and establishing response efforts when the hospital cannot be supported by the local community for at least 96 hours.

- Weighing resources on hand against estimated requirements to determine the extent of resource deficiencies or surpluses
- Estimating the hospital's present capability to provide fallout protection for its' staff, patients, and visitors.
- Evaluating the hospital's ability to provide:
  - Communications
  - Power
  - Food supply
  - Water supply
  - Sewage disposal
- The hospital's Emergency Management Program, which includes the Emergency Operations Plan, shall be submitted to the Governing Body, local Emergency Health Service and the Safety Officer for their approval and recommendations.
- After approval of the hospital's Emergency Operations Plan, copies will be provided to:
  - Governing Body
  - Local Emergency Medical Service
  - Safety Officer
  - Hospital department managers
  - All key participants

- The hospital's Emergency Management Program and Emergency Operations Plan shall be reviewed annually by the above parties to update and implement recommendations.

REFERENCES:

1. ACHC Accreditation requirements for Critical Access Hospitals, 2023 edition. Accreditation Commission for Health Care (ACHC). Chapter 3, *03.01.02, 03.01.03, 03.01.04, 03.01.08*
2. NFPA. (2011). *NFPA 99: Health Care Facilities Code, 2012 edition*.
3. **Tag, C-0912**

COMMITTEE APPROVALS:

Disaster: 4/3/2024
P&P: 5/1/2024

SUBJECT/TITLE:	Safety Management Plan	POLICY # SAF001
DEPARTMENT/SCOPE:	Safety	Page 1 of 10
REVISION DATE: n/a	EFFECTIVE DATE: 12/27/2023	
AUDIENCE: Safety	APPROVAL DATE:	
OWNER: Dana Hauge, Safety Officer		APPROVER: R.Harris

PURPOSE

The purpose of the Safety Management Plan is to define the Safety Program to reduce the risk of injury of patients, staff, and visitors.

SCOPE:

The Safety Management Plan describes the programs used to design, implement, and monitor a program to manage safety for patients, staff and visitors, for the hospital and to assure compliance with applicable codes and regulations.

Please Refer to the IPPP for more Safety Program information

FUNDAMENTALS:

A. Department heads and managers need appropriate information and training to develop an understanding of safe working conditions and safe work practices within their area of responsibility.

B. Safe working conditions and practices are established by using knowledge of safety principles to educate staff, design appropriate work environments, purchase appropriate equipment and supplies, and monitor the implementation of the processes and policies.

C. Safety is dynamic. Regular evaluation of the environment for work practices and hazards are required to maintain a current relevant safety program. The program should change as needed to respond to identified risks, hazards, and regulatory compliance issues.

OBJECTIVES

A. Initial risk assessments are conducted of the buildings, grounds, equipment, staff activity, care of patients and work environment for employees. Additional risk assessments are conducted when substantial changes involving these issues occur.

B. Environmental Tours include all areas of the hospital, required medical practices and clinics. The program includes the facilities, equipment, and all support areas at least annually, and all patient care areas at least semi-annually.

C. All departments have access to current organization wide safety policies and procedures. Departmental safety procedures have been evaluated within the past three years or as new procedure needs arise.

D. The current CEO or designee signs the designation of the Safety Officer, and the Safety Officer's job description is current and reflects the expectations for the responsibility of that position.

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OWNER: Dana Hauge, Safety Officer		APPROVER: R.Harris

E. The individuals assigned to respond to immediate threats to life and health have received appropriate training of their role and resources.

F. The program includes inspections of the campus grounds and the facilities at least annually.

G. There are processes for follow-up to product safety recalls. Summary reports of recalls and hazard alerts are forwarded quarterly to the Safety Emergency and Environment of Care (SEEC) Committee.

H. There is regular monitoring and evaluation of the effect of the no-smoking policies and processes, and where necessary monitoring of the processes designed to correct identified problems or violations.

I. Meaningful, measurable, performance measures are developed and monitored on a periodic basis. Sub-standard performance is corrected in a timely fashion.

ORGANIZATION AND RESPONSIBILITY

A. The Governing Body receives regular reports of the activities of the Safety Program from the multidisciplinary improvement team responsible for the EC – the SEEC Committee. They review reports and, as appropriate, communicate concerns about identified issues and regulatory compliance. They also provide financial and administrative support to facilitate the ongoing activities of the Safety Program.

B. The CEO or other designated leader collaborates with the Safety Officer and EC Committee to establish operating and capital budgets for the Safety Program.

C. The Safety Officer, in collaboration with the committee, is responsible for monitoring all aspects of the Safety Program. The Safety Officer advises the SEEC Committee regarding safety issues which may necessitate changes to policies and procedures, orientation, education, or expenditure of funds.

D. The SEEC Committee coordinates processes within the EC standard. Membership on the committee includes representatives from administration, clinical services, and support services. The SEEC Committee meets at least bi-monthly to receive reports and conducts a timely review of safety issues. Additional meetings may be scheduled at the call of the Safety Officer. Membership of the committee includes representation from clinical staffing, including:

- Nursing
- Support Services
- Facilities Management
- Risk Management

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OWNER: Dana Hauge, Safety Officer		APPROVER: R.Harris

- Environmental Services
- Safety
- Administration
- Human Resources
- Infection Control
- Leadership

Please refer to the Safety Emergency and Environment of Care Committee Policy for more information on the committee structure.

E. The CEO has delegated authority to the Safety Officer and the Nursing Supervisors on duty to take immediate and appropriate action in the event of an emergency situation where there is a clear and present danger that poses a threat to life, a threat of personal injury, or a threat of damage to property.

F. Department heads are responsible for orienting new staff members to the department and as appropriate, to job and task specific safety procedures, and for investigation of incidents occurring in their departments. When necessary, the Safety Officer provides department heads with assistance in developing departmental safety programs or policies.

G. Individual staff members are responsible for learning and following job and task specific procedures for safe operations.

PROCEDURE

The organization plans activities to minimize risks in the environment of care

Management Plan

The Hospital has a library of information regarding inspection, testing, and maintenance of its equipment and systems.
Note: This library includes manuals, procedures provided by manufacturers, technical bulletins, and other information.

Safety Office, Collection, Analysis, and Dissemination of Information

A Safety Officer is designated to coordinate the development, implementation, and monitoring of the safety management activities. The Safety Officer's job is defined by a job description and the CEO or other designee of the CEO, evaluates the performance of the Safety Officer.

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AUDIENCE: All hospital staff	APPROVAL DATE:	
OWNER: Dana Hauge, Safety Officer		APPROVER: R.Harris

The Safety Officer consults with the CEO and SEEC Committee on matters of safety. The Safety Officer reviews changes in law, regulation, and standards of safety; assesses the need to make changes to equipment, procedures, and training and performs other activities essential to implement the EC Programs. The Safety Officer is also responsible for conducting risk assessments and for coordinating the annual review of the safety program.

The Safety Officer manages risk, coordinates risk reduction activities in the physical environment, collects deficiency information, and disseminates summaries of actions and results. (See also 03.01.05). Note: Deficiencies include injuries, problems, or use errors.

The Safety Officer coordinates the collection and analysis of information about each of the EC management programs. The information is used to evaluate the effectiveness of the programs and to improve performance. The information collected includes deficiencies in the environment, staff knowledge and performance deficiencies, actions taken to address identified issues, and evidence of successful improvement activities.

Immediate Threat to Life

The Chief Executive Officer has identified individual(s) who are responsible for intervention whenever conditions pose an immediate threat to life or health or threaten damage to equipment or buildings.

This process is detailed in the Safety Officer Job Description. The objective of the Safety Officer Job Description is to identify and respond to an immediate threat situation before an injury or loss occurs.

The Chief Executive Officer has delegated this authority to the Safety Officer. This individual is empowered to immediately intervene and take appropriate action to mitigate the effects of such situations. Such delegation of authority enables the organization to take swift and decisive action to implement intervention twenty-four hours a day / seven days a week.

Risk Assessment

The Hospital implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities.
Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of poor cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.

The Safety Officer manages the Safety Risk Assessment process.

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The organization conducts an initial proactive risk assessment to evaluate the potential adverse impacts of buildings, grounds, equipment, occupants, and internal physical systems on the safety and health of patients, staff, and other visitors. Further risk assessments would be conducted when major changes to the organization occur.

The goal of performing risk assessments is to reduce the likelihood of future incidents or other negative experiences that have the potential to result in an injury, an accident, or other loss to patients, staff, or hospital assets.

The Safety Officer, Director of Operations or Facilities Manager, individual department heads and other key members of the EC Committee perform the risk assessments.

Use of Risk Assessment Results

The results of the risk assessment process are used to:

- Create new or revised safety policies and procedures.
- Identify new environmental rounds, items for the areas affected.
- Improve safety orientation and education programs.
- Help define safety performance monitoring and indicators.

The organization uses the risks and hazards identified to select and implement changes in procedures and controls to assure the lowest potential for adverse impact on the safety and health of patients, staff, and visitors. The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.

Grounds and Equipment (03.00.01)

The hospital maintains all the grounds and equipment.

The Director of Operations/ Facilities Manager is responsible for managing the hospital grounds and external equipment maintenance process. The Director of Operations/ Facilities Manager is responsible for scheduling and performing maintenance of hospital grounds and external equipment. Hospital staff makes regular rounds of various areas to observe and correct the current condition and safety of hospital grounds and external equipment.

Hospital grounds include lawns, shrubs, trees, sidewalks, roadways, parking lots, lighting, signage, fences, etc. Some external equipment, such as the oxygen storage facility, has established protocols for inspection, testing, or preventive maintenance.

Safety Product Recalls and Hazard Alerts

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OWNER: Dana Hauge, Safety Officer		APPROVER: R.Harris

The organization ensures responses to product safety recalls by appropriate organization representatives. Risk Management manages this process in collaboration with Materials Management and key hospital staff. They document the follow-up and report the results to the EC Committee on a periodic basis. Critical recalls or alerts are brought to the attention of the Safety Officer upon receipt, and the Safety Officer assists in assuring an effective response.

Magnetic Resonance Imaging Patient Safety

Mayers Memorial Healthcare District does not have an MRI machine. If an MRI is ordered the patient will be referred out appropriately.

Computed tomography Scans (CT)

Mayers Memorial Healthcare District does have a CT Scan Machine. The CT scan room is a high priority in safety for both patients and staff. During scans, only the patient is allowed, but radiographers are equipped with an intercom system so that any necessary communication can be handled quickly if needed. Please refer to the CT Radiation Safety Policy.

Smoking Policy

Please refer to the Policy - Smoke and Tobacco-free campus

Patients are not permitted to smoke, however, if there is an exceptional need decided upon by leadership the following would be followed;
If patients are permitted to smoke, the hospital takes measures to minimize fire risk. Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within the site of intentional expulsion (within one foot). When other oxygen delivery equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area of administration (within 15 feet. Solid fuel-burning appliances are not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. (For full text, refer to NFPA 99-2012: 11.5.1.1; Tentative Interim Amendment (TIA) 12-6).

The organization has developed and maintains a policy prohibiting smoking in the buildings and properties controlled by the hospital. This policy prohibits smoking, including electronic cigarettes, in all areas of all buildings and areas of buildings under the organization's control. Out-patients and adolescent patients are never allowed to smoke in buildings controlled by the hospital.

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OWNER: Dana Hauge, Safety Officer		APPROVER: R.Harris

The hospital has identified and maintains processes for monitoring compliance with the policy, and as needed, develops strategies to eliminate the incidence of policy violations when identified. Evidence of smoking is included in Environmental Tours, and where found, improvement activities are in place to identify and eliminate the violations.

Performance Monitoring

The hospital (through its Safety Officer) establishes a process(es) for continually monitoring, internally reporting, and investigating the following:

- Injuries to patients or others within the hospital's facilities.
- Occupational illnesses and staff injuries.
- Incidents of damage to its property or the property of others.
- Security incidents involving patients, staff, or others within its facilities.
- Hazardous materials and waste spills and exposures.
- Fire safety management problems, deficiencies, and failures.
- Medical or laboratory equipment management problems, failures and use errors.
- Utility systems management problems, failures or use errors.

The Safety Officer coordinates the performance measurement and improvement process for each of the functions associated with Management of the EC. The Safety Officer manages the Safety program performance measurement process.

The Safety Officer is responsible for preparing quarterly reports of performance and experience for the EC Committee. The reports include ongoing measurement of performance, a summary of the hazards and problems identified during environmental rounds, and summary reports of incident trends and patterns.

The Safety Officer establishes performance indicators to objectively measure the effectiveness of the Safety program. The Safety Officer determines appropriate data sources, data collection methods, data collection intervals, analysis techniques and report formats for the performance improvement standards. Human, equipment, and management performance are evaluated to identify opportunities to improve the Safety program.

The performance measurement process is one part of the evaluation of the effectiveness of the Safety management program. A performance indicator has been established to measure at least one important aspect of the Safety program.

The performance improvement (PI) indicator shown in the management plan reflects the monitor selected at the beginning of the calendar year. If the goal for the performance improvement indicator is met for two consecutive quarters, this process will be considered as "improved or corrected" and the EC Committee will establish a new PI initiative.

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Environmental Tours and Safety Surveys

The organization conducts regular environmental tours to identify and evaluate environmental deficiencies, hazards, and unsafe practices, security deficiencies, hazardous materials and wastes practices, fire safety problems, medical equipment issues, access to utility system elements and other issues. Staff knowledge shall also be evaluated during the tours.

The organization conducts these environmental tours at least semiannually in all areas where patients are treated, monitored, housed, or served, including in-patient and out-patient care areas. The organization conducts environmental tours at least annually in those areas where patients are not served.

Annual Review and Evaluation of Management Plans

The Safety Officer and designees responsible for the design and implementation of the EC programs perform a review every 12 months of each EC management plan, including a review of the plan's objectives, scope, performance, and effectiveness.

The Safety Officer is responsible for coordinating the annual evaluation of the functions associated with the management of the EC. The Safety Officer is responsible for performing the evaluation of the Safety management program every 12 months.

Annual evaluations examine the scope, objectives, performance, and effectiveness of the Safety program. The annual evaluation uses a variety of information sources including internal policy and procedure reviews, incident report summaries, safety meeting minutes, Safety Committee reports, and summaries of other activities. In addition, findings by outside agencies such as accrediting or licensing bodies, or qualified consultants are used. The findings of the annual evaluation are presented in a narrative report supported by relevant data. The report provides a summary of the Safety management program's performance over the preceding 12 months. Strengths are noted and deficiencies are evaluated to set goals for the next year.

The annual evaluation is presented to the EC Committee. The Committee reviews and approves the report. The deliberations, actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, the Quality Improvement Committee, and other Department Heads as appropriate. Once the evaluation is finalized, the Safety Officer is responsible for implementing the recommendations in the report as part of the performance improvement process.

Patient Safety

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AUDIENCE: All hospital staff	APPROVAL DATE:	
OWNER: Dana Hauge, Safety Officer		APPROVER: R.Harris

The Safety Officer is responsible for working with the individual who is responsible for patient safety to integrate EC monitoring and response activities into the patient safety program. The integration includes conducting risk assessments to identify environmental threats to patient safety, conducting environmental tours to evaluate patient safety concerns on an ongoing basis, participating in the analysis of certain types of patient safety incidents, participating in the development of material for general and job-related orientation and on-going education.

Environment of Care Committee

Representatives from clinical, administrative and support services participate in the analysis of the environment of care data. The multidisciplinary EC Committee considers reports of EC issues at regularly scheduled meetings. The committee evaluates the reports and approves actions to address identified issues.

Designees of each EC function and the EC Committee collaborate to analyze EC issues. The analysis includes ongoing evaluation of performance and aggregate analysis of environmental tours, incident reports, maintenance activities, and other issues.

Analysis is used to manage the stability of current programs, assess risks related to new programs, and to identify opportunities for improvement.

Reporting of Environment of Care Activities

The hospital uses the results of data analysis to identify opportunities to improve the environment of care. The EC Committee publishes the minutes of each meeting. The minutes summarize materials presented, issues identified, and actions to be taken.

Identification of Performance Improvement Opportunities

Annually, representatives from clinical, administrative, and support services recommend to leaders one or more priority performance improvement activities for the environment of care. The EC Committee identifies performance improvement opportunities. A proposal for improvement is prepared and sent to leadership. The leadership reviews all improvement proposals and determines the priority and need for the proposed improvement.

Improvement of the Environment of Care

When leadership approves a proposal, appropriate staff or a team is appointed to address the identified issues and to design a process improvement. The team evaluates changes to determine if they resulted in improvements in the environment of care. The staff or team appointed make regular reports to the EC Committee and leadership. The reports address

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progress toward improvement, including measurement of changes to assure they are effective and sustainable.

Orientation, Training, and Education

All staff shall attend the new employee orientation within 30 days of hire. New employee orientation addresses key issues and objectives of all areas of the Environment of Care, including the role each area and staff plays in the overall patient safety program. Employees receive ongoing education annually relative to the environment of care. Competency of education is assessed and documented.

Employees also receive departmental safety orientation at their respective work areas regarding hazards and their responsibilities to patients, visitors, and co-workers. In addition, all staff participate in periodic refresher training in their departments related to the Environment of Care.

All Licensed Independent Practitioners (LIP) receive an orientation to the Environment of Care in accordance with the Medical Staff policies and bylaws. Retraining and ongoing education shall be provided to LIPs in accordance with Medical Staff policies and bylaws.

Initial and ongoing education programs include describing and demonstrating methods for reducing and eliminating risks in the Environment of Care, actions to take in the event of an environment of care incident, and how to report environment of care risks.

REFERENCES:

1. ACHC Accreditation requirements for Critical Access Hospitals, 2023 edition.. Accreditation Commission for Health Care (ACHC). Chapter 3, 03.01.02, 03.01.03, 03.01.04, 03.01.08
2. California OSHA Compliance Guide, 2020.
3. NFPA. (2011). NFPA 99: Health Care Facilities Code, 2012 edition.
4. Tag, C-0912

COMMITTEE APPROVALS:
Safety: 5/1/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Shigella Process		POLICY #
DEPARTMENT/SCOPE: Lab		Page 1 of 1
REVISION DATE: 3/14/2024	EFFECTIVE DATE: 3/14/2024	
AUDIENCE: Lab Staff	APPROVAL DATE:	
OWNER: S. Rosal		APPROVER: K. Davies

PURPOSE:

In order to detect drug resistant Shigella, Mayers performs cultures and sensitivities on Shigella specimens.

PROCEDURE:

PCR tests that are positive for Shigella are reflexed for culture and sensitivity.

REFERENCE:

Drug-Resistant Shigella (cdc.gov) accessed 3/14/2024

COMMITTEE APPROVALS:
IC: 3/14/2024
MEC: 4/4/2024

SUBJECT/TITLE:	Sliding Fee Discount Program	POLICY #
DEPARTMENT/SCOPE:	Business Office	Page 1 of 3
		EFFECTIVE: 01/01/2024
OWNER: Amber Collins		APPROVER: T. Lakey

POLICY:

Mayers Memorial Healthcare District (MMHD) is committed to providing uncompensated care and discount payment plans to persons who are unable to pay for medically necessary care. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are unable to pay, MMHD strives to ensure that the financial capacity of people who need healthcare services does not prevent them from seeking or receiving medically necessary care. MMHD will not discriminate on the basis of an individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity.

Mayers Memorial Healthcare District realizes the need to provide service to patients who cannot otherwise afford health care. This policy applies to all uninsured or underinsured patients who meet the guidelines of this policy and who agree to its terms. A sliding fee schedule based on the annual HHS Poverty Guidelines will be used to determine the qualifying income 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 Discount Payment Policy.

In order to manage its resources responsibly, the Board of Directors of MMHD establishes the following standards for the provision of uncompensated care services and discount payments.

PROCEDURE:

The following guidelines are to be followed in providing the Sliding Fee Discount Program.

1. Notification: MMHD will notify patients of the Sliding Fee Discount Program by:
   - Payment Policy Summary will be available to all patients at the time of service.
   - Notification of the Sliding Fee Discount Program will be offered to each patient upon admission.
   - Sliding Fee Discount Program application will be included with collection notices sent out by MMHD.
   - An explanation of our Sliding Fee Discount Program and our application form are available on MMHD's website.
   - MMHD places notification of Sliding Fee Discount Program in the clinic waiting areas and emergency room waiting areas.
2. Request for discount: Requests for discounted services may be made by patients, family members, social services staff or others who are aware of existing financial hardship. The Sliding Fee Discount Program will offered for all clinic visits and emergency room patients and for any other medically necessary procedures. Information and forms can be obtained from the Front Desk and the Business Office.
3. Administration: The Sliding Fee Discount Program procedure will be administered through the Director of Revenue Cycle or his/her designee. Information about the Sliding Fee

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OWNER: Amber Collins		APPROVER: T. Lakey

Discount Program policy and procedure will be provided to patients. Staff are to offer assistance for completion of the application. Dignity and confidentiality will be respected for all who seek and/or are provided health care services.

4. Completion of Application: The patient/responsible party must complete the Sliding Fee Discount Program application in its entirety. Staff will be available, as needed, to assist patient/responsible party with applications. By signing the Sliding Fee Discount Program application, persons are confirming their income to MMHD as disclosed on the application form.
5. Eligibility: Discounts will be based on income and family size only.
    a. Family is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. MMHD will also accept non-related household members when calculating family size.
    b. Income includes: gross wages; salaries; tips; income from business and self-employment; unemployment compensation; workers' compensation; Social Security; Supplemental Security Income; veterans' payments; survivor benefits; pension or retirement income; interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources.
6. Income verification: Applicants may provide one of the following: prior year W-2, 90 days previous pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program. Self- declaration of Income may be used. Patients who are unable to provide written verification may provide a signed statement of income.
7. Discounts: Those with incomes at or below 100% of poverty will receive a full 100% discount for health care services. Those with incomes above 100% of poverty, but at or below 200% of poverty, will be charged a nominal fee according to the attached sliding fee schedule. Patients with incomes at or below 400% of poverty may receive a discount according to the attached sliding fee schedule. The sliding fee schedule will be updated during the first quarter of every calendar year with the latest FPL Guidelines.
8. Nominal Fee: Patients with incomes above 100% of poverty, but at or below 200% poverty will be charged a nominal fee according to the attached sliding fee schedule and based on their family size and income. However, patients will not be denied services due to an inability to pay. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment.
9. Waiving of Charges: In certain situations, patients may not be able to pay the nominal or discount fee. Waiving of charges must be approved by MMHD's designated official. Any waiving of charges should be documented in the patient's file along with an explanation.
10. Applicant notification: The Sliding Fee Discount Program determination will be provided to the applicant(s) in writing, and will include the percentage of Sliding Fee Discount

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Program write off, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, MMHD will work with the patient and/or responsible party to establish payment arrangements. Sliding Fee Discount Program applications cover outstanding patient balances for six months prior to application date and any balances incurred within 12 months after the approved date, unless their financial situation changes significantly. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in family income. When the applicant reapplies, the look back period will be the lesser of six months or the expiration of their last Sliding Fee Discount Program application.

11. Refusal to Pay: If a patient verbally expresses an unwillingness to pay or vacates the premises without paying for services, the patient will be contacted in writing regarding their payment obligations. If the patient is not on the sliding fee schedule, a copy of the sliding fee discount program application will be sent with the notice. If the patient does not make effort to pay or fails to respond within 60 days, this constitutes refusal to pay. At this point in time, MCHD can explore options not limited to, but including offering the patient a payment plan, waiving of charges, or referring the patient to collections.
12. Record keeping: Information related to Sliding Fee Discount Program decisions will be maintained and preserved in a centralized confidential file located in the Patient Financial Counselors office, in an effort to preserve the dignity of those receiving free or discounted care.
    a. Applicants that have been approved for the Sliding Fee Discount Program will be documented in MMHD's practice management system, noting names of applicants, dates of coverage and percentage of coverage.
    b. The Business Office Manager will maintain an additional monthly log identifying Sliding Fee Discount Program recipients and dollar amounts. Denials and applications not returned will also be logged.
13. Policy and procedure review: The SFS will be updated based on the current Federal Poverty Guidelines. MMHD will also review possible changes in our policy and procedures and for examining institutional practices which may serve as barriers preventing eligible patients from having access to our community care provisions.

COMMITTEE APPROVALS:

Chiefs: 3/25/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Slips Trips and Falls Program	Policy #SAF036
DEPARTMENT/SCOPE:	Safety	Page 1 of 7
		EFFECTIVE: 12/8/2023
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

DEFINITIONS:

Falls: Occurs when the center of balance of the body is too far off center and balance cannot be maintained. Fall on the same level is to fall into or against objects on that same surface level or onto the surface. Fall to a lower level is a fall below tour walking or working space.

Friction: Friction is the resistance to motion of one object moving relative to another. The coefficient of friction is a measurement of the ratio of the friction to the load and is usually symbolized by the Greek leer mu. It is a direct measure of the slip resistance of a floor under various conditions.

Just Culture: A system of justice that refers to a value-supportive model of shared accountability between leadership and employees. A system that holds organizations accountable for the systems they design and for how they respond to staff behaviors fairly and justly.

Surface microroughness: A measure of the flooring slip resistance which measures the roughness of a floor symbolized by the letters Rz.

Slips: Occur when there is too little friction or traction between footwear and the floor surface, resulting in a loss of balance usually with the upper body moving backwards. A fall may or may not occur as a result.

Trips: Occur when the foot or lower leg hit an object with resultant loss of balance and a forward motion for the upper body. A fall may or may not occur as a result.

POLICY:

A Slip, Trip, and Fall (STF) Program and Policy and applicable procedures are effective in reducing injuries for employees, patients and visitors for Mayers Memorial Healthcare District and was developed on current evidence-based practice and OSHA requirements for Walking-Working Surfaces, standard 190.22, Cal OSHA Code of Regulations Title 8 sub-section 3272-Working Area. Slips, trips, and falls on the same level are a major cause of injury to healthcare workers resulting in the second most common cause of lost work-day injuries in hospitals (Bell er al,2008). The health care industry ranks second out of the top U.S. industries for highest percentage of claim costs with falls on the same level. These injuries are often severe, resulting in broken bones, emergency room visits and lost time from work.

Mayers Memorial Healthcare District (MMHD) places a high value on the safety of its employees and patients. MMHD is committed to supporting employee health, safety, and wellness. Likewise, employees are expected to commit to their own responsibility for health and safety of self, co-workers, and patients, by adhering to the outlined policy.

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DEPARTMENT/SCOPE: Safety	Page 2 of 7
	EFFECTIVE: 12/8/2023
OWNER: Dana Hauge, Safety Officer	APPROVER: R. Harris

This program is a comprehensive approach, based on research, which has demonstrated successful outcomes by using a systems approach to address hazards and the level of the environment, the task, and the human factors. MMHD has a robust IIPP and follows the policies and procedures in accordance with it. All policies and procedures can be found on the employee intranet and or with department managers and appropriate people.
The goal of this policy is to:

A. Provide a safe working environment which, as far as is reasonably practicable, is free from hazards that contribute to STF.
B. Provide for hazard assessments, and where deficiencies are identified, impellent risk reduction action plans that apply timely, best evidence-based principles.
C. Ensure prompt reporting, tracking, and trending of all hazards, injuries and near-misses relating to STF.

Responsibilities:
Mayers Memorial Hospital District (MMHD) Safety and Emergency Management Department and Human Resources are responsible for the development, implementation, and management of the MMHD Slip, Trips and Falls Program. All MMHD directors, managers and supervisors are responsible for implementation of individual components of the plan and for answering employee questions. MMHD employees are responsible for focusing on safety and reporting safety concerns in a timely fashion.
Management is responsible for ensuring that all safety and health policies and procedures are clearly communicated and understood by all employees. The Safety Officer and Chief of Human Resources Officer are responsible for making sure all entitled appropriate or appointed persons are aware and implementing any trainings, communications, evaluations and reports as deemed necessary and part of the safety program procedures and policies. Managers and superintendents are expected to enforce the rules fairly and uniformly and without retaliation.
All employees are responsible for using safe work practices, for following all directives, policies, and procedures, and for assisting in maintaining a safe work environment. Employees may report and are expected to report all hazards and can do so without fear of reprisal and with open communication.

PROCEDURE

Employee Responsibilities:

A. Senior leadership-
   Responsible parties for the STF program include the Safety Officer, Chief Operations Officer and or the Chief of Human Resources Officer. The duties of the above listed positions will include but are not limited to:
   I. Ensure that processes and funds are in place to make the risks associated with slips, trips, and falls including implementing and monitoring this policy.

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II. Oversee responsibility of ensuring regular inspection, maintenance, and repair of walking-working surfaces to keep them in safe condition. If hazards are discovered, resources will be made available to correct the hazard or guard the area to prevent employees, visitors, and patients from using the walking-working surface until the hazard is corrected or repaired by a qualified person.
III. Monitor injury data and action plan completion on slips trips and fall injury at least quarterly.

B. Slip Trip and Fall Prevention Program.
The Safety Officer will oversee continued implementation of the program, along with the champion team that consists of the Environmental Services Manager and the Facilities Manager. Their responsibilities in the role could include:
I. Support and guide the implementation of this policy throughout Mayers Memorial Health Care District.
II. Develop procedures based on evidence-based practice that supports prevention and reduction of slips, trips, and falls.
III. Ensure the evaluators performing walking-working surface evaluations are properly trained.
IV. Ensure that action plans/control measures are implanted in a timely manner.
V. Ensure that a system is in place for employees to report slip, trip and fall hazards.
VI. Ensure accurate records are maintained and provide documentation upon request.
VII. Assist department managers in STF investigation and strategies for prevention and remediation.
1. Monitor the program data on a quarterly basis and provide an annual review which is shared with senior leadership and made available to employees.
2. Ensure that STF prevention principles are considered when renovating or expanding facilities. Choose flooring material that meets slip resistance of 0.6mu on level surfaces and o.6mu on ramps and provides a surface microroughness of greater than 20Rz in areas of high risk for slips.

C. Managers and Supervisors
I. Support and guide implementation of this policy throughout Mayers Memorial healthcare District.
II. Perform walk-through inspections of your area(s) of responsibility to ensure safety of all places of employment, passageways, storerooms service rooms and walking-working surfaces are kept clean.
III. Ensure employees have received appropriate awareness training to understand STF risk and how to participate in prevention measures.
IV. Supervise employees in the compliance of this policy and any procedures regarding slips, trip, and fall prevention.
V. Encourage, monitor, and support employees in timely reporting of slip, trip, and fall injuries, near-misses and hazard reporting in the environment. Follow-up on all reports, identify the root cause(s) and contributing factors then implement control measures.

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D. Employees
   I. All employees will follow this policy and any procedures established which help with elimination of slip, trip and fall injuries and report to their supervisor any barriers which exist that hinder their ability to follow through on these guidelines. ***See appendix- IIPP***
   II. Promptly report to your supervisor/manager any hazards observed which may lead to a STF injury.
   III. Promptly report any STF injury, or near-miss incidents to a supervisor/manager. You also have the option to use RL6 and send a ticket to maintenance through the Fresh Service support desk icon. It is on all desktops and can be found through the employee intranet, as is the RL6 program.
   IV. Give immediate priority to address and correct any contamination (fluid, grease, food etc.) on the floor which could cause employee, patient, or visitor injury. First block the area with a caution sign to barricade, if possible, identify the substance. If water, then wipe or apply absorbent material to the spill. Call environmental services and or maintenance per MMHD policy if the spill is larger or contains other contaminants. ***See blood and body fluid spill kit guide for use, plan for placement of wet floor/caution signs, corridor cleaning.***
      1. Pick up any debris in your work area and keep all pathways clear of hazards to prevent employee, patient or visitor slips, trips, and falls. Observe the 5S procedures and take personal responsibility for decreasing injury through a clean and tidy environment. ***See appendix for 5-S Program***
      2. Attend STF prevention and hazard recognition training as required.

E. Environmental Services and Facilities (housekeeping, maintenance)
   I. Attend training specific to housekeeping on awareness of STF injuries. Demonstrate awareness of risk of employee, patient and visitor injury that can be caused by improper cleaning protocols.
      1. Follow flooring manufacturer recommendations for proper cleaning-product use and dilution procedures for the specific floor type.
      2. Use appropriate caution and barricade signs to protect others from slips and falls after cleaning. Remove signs promptly after floors dry to prevent employees from developing “inattention blindness” or habituation to the warning sign. ***See appendix for Plan for Placement of wet floor/caution signs***
      3. Create cleaning schedules that avoid peak traffic times for wet mopping. Apply dry cleaning methods (sweeping, collecting debris) frequently throughout the day. ***See appendix for cleaning schedules.***
      4. Post in obvious locations throughout the facility the phone number/email address to report floor contaminants that need cleaning (on caution signs, screen savers, intranet, posters). Respond promptly to requests to clean the hazards.

SUBJECT/TITLE: Slips Trips and Falls Program	Policy #SAF036
DEPARTMENT/SCOPE: Safety	Page 5 of 7
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OWNER: Dana Hauge, Safety Officer	APPROVER: R. Harris

Communication
Our system of communication allows for all workers are informed of the Slip, Trips and Falls Program ensuring that employees can comply and are familiar with the rules and maintaining a safe work environment. Methods of communication may include but is not limited to:

- Email Notifications
- Employee Intranet
- Employee TV programming
- Push Text notifications.
- Phone Calls
- Fast Command Service
- In person meetings and or huddles
- Safety Meetings with representatives from each department, with Slips Trips and Falls included with the Ergonomics section, meeting the requirements of T8CCR 3203 (7) (c) (1)-(7) to comply with the communication requirements of subsection (a) (3) of T8CCR

Contacts:
Safety Officer - 336-5511 ext. 1132
Chief of Human Resources - 336-5511 ext. 1206
Chief of Operations- 336-5511 ext. 1191
Health and Wellness/Ergonomics Coordinator – 336-5511 ext. 1132

Mayers Memorial Hospital District
PO Box 459
43563 Highway 299E
Fall River Mills, CA 96028

Program Requirements
A. Hazard Assessment
All areas will be routinely surveyed for STF hazards. Individuals who complete the assessment must be appropriately trained in hazard recognition, proper documentation, and strategies for remediation. Hazards could include chemicals, cleaning agents, hazardous spills, biological spills and other fluids, powders or substances that could be found in a Safety Data Sheet Program.
Refer to Hazmat Program Policies and Procedures/Plans ACHA 03.03.03.
B. Hazard Identification
I. Environmental hazards STF
Examples of environmental hazards involve flooring friction/roughness, lighting, noise-distraction, temperature, weather, surface elevations, visual barriers/obstacles, contaminants to flooring, uneven surfaces, over-crowded and cluttered areas, confined work areas, and unmaintained equipment. Hazards ca be both internal and external at the facility. Safety Data Sheets can be found within minutes using the MSDS program

SUBJECT/TITLE: Slips Trips and Falls Program	Policy #SAF036
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online. All agents or chemicals used in MMHD facilities will have a Safety Data Sheet. ***See appendix for Plan for walking surfaces, 5-S program, Snow, and Ice Plan, Hazmat Program and Procedures/plan***

II. Task-related hazards STF
Examples of task related hazards are load handling, physical exertion, task complexity, social interactions, cleaning protocols, working from heights, working outdoors, and traveling to off-site services (i.e., Home Health).

III. Human Factors/personal related hazards
Examples of human factors mediated risks are communication, fatigue, distraction, interruption, lighting, personality, behavior, perception, visual acuity, contrast sensitivity, body size, age, gender, strength, and health. The Dress code may be found on MCN and with Human Resources

1. Gate Speed: Employees will not run inside or outside the facility while working.
2. Distraction: Employees will not be reading, looking at their cell phone (use headsets), or otherwise be distracted while walking.

C. Safety Hierarchy of Controls
I. Eliminate- physically remove the hazard.
II. Substitution- Replace the hazard with a different product or procedure.
III. Engineering controls- Isolate people from the hazard.
IV. Administrative Controls- Change the way people work
V. Personal Protective Equipment (PPE)- protect the worker from the hazard by use of PPE

D. 5S Workplace Organization and housekeeping. ***See the 5-S Program on the employee intranet.***
MMHD will adhere to the 5S Lean methodology where all employees are responsible for participating in the safety of their area through organization and housekeeping.
I. Sort: Rid the workplace of unnecessary clutter.
II. Straighten/Set in order: Create a work environment that is organized, ergonomic and safe and easy to navigate.
III. Shine: Through cleaning of the work area every day.
IV. Standardize: Set standards for consistency in placement if equipment, tools and content of the department.
V. Sustain; Maintain efforts, with training and communication and continuous process improvement.

E. Training
I. All employees will be trained on hire to recognize the risk of slip trip and fall hazards, procedures for reporting and managing hazards, as well as procedures for injury and near-miss reporting. Periodic refresher training will be offered.
II. ***See the IIPP***

F. Documentation
I. xvii. Proper Documentation will be kept on hazard identification, action items, timeline for remediation and injury logs.

SUBJECT/TITLE: Slips Trips and Falls Program	Policy #SAF036
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II. xviii. MMHD Documentation Process includes keeping personnel records within files for 7 to 10 years and they can be found within Human Resources.
RL6 and Ticket systems kept within the respected programs interface for an indefinite amount of time and may be recalled upon request.

Copies of the Slips Trips and Falls Program will be found in following locations:

- Employee Intranet
- MCN Policies and Procedures
- Human Resources Department, Safety and Emergency Management Department

All employees have access to the material at any time, and if they are unable to obtain an electronic copy, they may ask for a printed version at any time.

G. Program Review
A written review of the STF program will be done by the Slip Trip and Fall Prevention Program Manager/ Administrator and champion team on an annual basis. The review should include analysis of the employee injury data, identification of high-risk areas for STF, implemented solutions for hazard remediation and training compliance. Results of the program review will be shared with senior administrators and made available for employees to view upon request. And on the employee intranet.

REFERENCES:

- ACHC Accreditation requirements for Critical Access Hospitals, 2023 edition.. Accreditation Commission for Health Care (ACHC). Chapter 3, 03.03.03
- Beta Healthcare Group, ESWI Toolkit: Slip, Trip and Fall Prevention, 2021. BETA Healthcare Group [3.2021]
- California OSHA Compliance Guide, 1999
- Mayers Memorial Healthcare District Injury and Illness Prevention Program Plan

COMMITTEE APPROVALS:

SUBJECT/TITLE:	Swing Bed Patient Rights	POLICY #SB007
DEPARTMENT/SCOPE:	Swing Bed	Page 1 of 3
REVISION DATE:	EFFECTIVE DATE: 4/16/2024	
AUDIENCE: Swing Bed IDT		APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

PURPOSE:
To insure the resident's right to dignified experience, self-determination, and communication with and access to persons and services inside and outside of the facility.

Applies To: Interdisciplinary Team

Responsibility/Authority:

POLICY:
The facility prohibits discrimination based on race, color, religion, national origin, disability, age, or sex.

PROCEDURE:
This facility will protect and promote the rights of each resident including the following:

Exercise of Rights:

1. The resident has the right to exercise his/her rights as a resident of the facility and as a citizen of the United States.
2. The resident has the right to be free of interference, coercion, discrimination, or reprisal from this facility in exercising his/her rights.
3. In the case of a resident adjudged incompetent under the laws of the State by a court of competent jurisdiction, the rights o the resident devolve to and are exercised by the resident representative appointed under State Law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. CFR 483.10(b)(7).
4. In the case of a resident who has not been judged incompetent by the state court, any legal surrogate may exercise the resident's rights to the extent provided by state law.

Rights and Services, Notices of:

1. This facility will inform the resident both orally and in writing in a language that the resident's conduct and responsibility during the stay in the facility. Such notification shall be made prior to or upon admission and during the residents stay. Receipt of such information and any amendments to it will be acknowledged in writing.

2. To be informed of, and participate in, his or her treatment. §483.10(c)

3. The resident has the right to be fully informed in language that he/she can understand his/her total health status, including but not limited to his/her medical condition. This includes participation in ethical issues that arise in care. §483.10(c)(1)

4. To be informed, in advance, of changes to the plan of treatment. §483.10(c)(2)(iii)

SUBJECT/TITLE: Swing Bed Patient Rights	POLICY #SB007
DEPARTMENT/SCOPE: Swing Bed	Page 2 of 3
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5. To request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(6)

6. To choose his or her attending physician. §483.10(d)

7. To retain and use personal possession, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(e)(2)

8. To share a room with his or her spouse when married resident live in the same facility and both spouses consent to the arrangement. §483.10(e)(4)

9. To have immediate access to the resident's immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time. §483.10(f)(4)(ii)

10. To have immediate access to others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw *consent at any time.* §483.10(f)(4)(iii)
    a. Any representative of the State.
    b. Physician
    c. The State Long-Term Care Ombudsman.
    d. The agency responsible for the protection and advocacy systems for developmentally disabled individuals.
    e. The agency responsible for the protection and advocacy systems for mentally ill individuals.
    f. The facility must provide access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

11. To send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than the postal services. §483.10(g)(8)

    a. The resident has the right to privacy in receiving communications including the right to:
    b. Send and receive mail promptly that is unopened.
    c. Have access to stationary, postage, and writing implements at the resident's own expense.

12. To be informed at the time of admission, when the resident becomes eligible for Medicaid, and periodically during the resident's stay of items and services included under the State plan for which the resident may not be charged; and those other items and services for which the resident may be charged and the amount of charges for those services. §483.10(g)(17); §483.10(g)(18)

SUBJECT/TITLE:	Swing Bed Patient Rights	POLICY #SB007
DEPARTMENT/SCOPE:	Swing Bed	Page 3 of 3
REVISION DATE:	EFFECTIVE DATE: 4/16/2024	
AUDIENCE: Swing Bed IDT		APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

13. To have personal privacy and confidentiality of personal and medical records. §483.10(h)

14. Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

15. This facility will inform each resident before or at the time of admission and periodically during the resident's stay of services available in the facility and of charges for those services not covered under Medicare.

16. Each resident has the right to be free from verbal, sexual, physical, mental o financial abuse, corporal punishment, and involuntary seclusion.

17. The resident has the right to be free from any physical or chemical restraints, except as authorized in writing by a physician for a specified and limited period of time or when it is necessary to protect the resident from injury to self or to others. Physical or chemical restraint may not be imposed for purposes of discipline or convenience.

18. A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health and safety of the individual or other residents would be endangered; and to receive notice before the resident's room in the facility is changed.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Scope Of Services – Surgical Department	POLICY # SURG 0001
DEPARTMENT/SCOPE:	SURGERY	Page 1 of 3
		EFFECTIVE: 11/15/2023
OWNER: LEANNE MELANG		APPROVER: T. OVERTON

DEFINITIONS:

Sterile field: "The area surrounding the site of incision or perforation of tissue, or the site of introduction into a body orifice that has been prepared for an invasive procedure. The area includes all working areas, furniture, and equipment covered with sterile drapes and drape accessories and all personal sterile attire" [1].

CRNA: Certified Registered Nurse Anesthetist

PURPOSE: To define the scope of surgical services provided by Mayers Memorial Healthcare District, this includes the types of surgical procedures performed, population of patients served, the hours of operation, staffing requirements, and the environment where services are performed.

POLICY:

Endoscopic Gastro-intestinal procedures, minor general, and urological procedures may be performed at Mayers Memorial Healthcare District as defined below starting on page #2. Surgeons and CRNA may only perform procedures or perform duties that they have been granted privileges to perform and that are consistent with their scope of practice and level of professional competency and training. Surgical services are performed in accordance with safe standards of practice in compliance with state and federal laws, regulations, and guidelines.

This scope of Services is reviewed annually by the surgical committee and will be easily accessible for review. All surgical staff ae given annual training on this policy.

Operation services are 9 hours/day from 0700 to 1700 1-3 days a week, 1-2 weeks per month, with no on-call coverage. Services are provided to Adults and geriatric patient populations. All elective surgical procedures are outpatient day procedures, and they are performed under local anesthesia, epidural, regional, general, or monitored sedation by a CRNA.

The surgical team includes at a minimum, a Surgeon, CRNA, Surgical technologist, Circulating Registered Nurse, pre-operative admission nurse, post-operative recovery nurse.

The following procedures may be performed in the surgery department at Mayers Memorial Healthcare District Hospital:

Anoscopy	Colonoscopy Foreign Body Removal

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Scope Of Services – Surgical Department	POLICY # SURG 0001
DEPARTMENT/SCOPE:	SURGERY	Page 2 of 3
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OWNER: LEANNE MELANG		APPROVER: T. OVERTON

Anoscopy Biopsy	Colonoscopy Control Bleeding Stoma
Anoscopy Control Bleeding	Colonoscopy Decompression
Anoscopy Dilatation	Colonoscopy Dilatation
Anoscopy Excision Lesion	Colonoscopy Endoscopic Ultrasound
Anoscopy Foreign Body Removal	Colonoscopy Excision Lesion
Aspiration Fine Needle	Dilatation Endoscopy Biliary Duct
Biopsy Anus	Disimpaction Feces
Colonoscopy	Esophagogastroduodenoscopy
Colonoscopy Biopsy	Esophagogastroduodenoscopy Balloon Dilatation
Colonoscopy Biopsy Stoma	Esophagogastroduodenoscopy Biopsy
Colonoscopy Control Bleeding	Esophagogastroduodenoscopy Control Bleeding
Esophagogastroduodenoscopy Excision Lesion	Excision Lesion
Esophagogastroduodenoscopy Guided Dilatation	Excision Lesion Anus
Excision Cyst	Excision Lesion Facial
Excision Lesion Lower Extremity	Excision Lesion Skin Malignant Lower Extremity
Excision Lesion Rectum	Excision Lesion Skin Malignant Torso
Excision Lesion Skin Benign Head/Neck	Excision Lesion Skin Malignant Upper Extremity
Excision Lesion Skin Benign Lower Extremity	Excision Lesion Transanal Endoscopy Microsurgery Rectum
Excision Lesion Skin Benign Torso	Excision Lesion Trunk
Excision Lesion Skin Benign Upper Extremity	Excision Lesion Upper Extremity
Excision Lesion Skin Malignant Head/Neck	Excision Lipoma Lower Extremity
Excision Lipoma	Excision Lipoma Neck
Excision Lipoma Abdominal Wall	Excision Lipoma Pelvis
Excision Lipoma Back	Excision Lipoma Scalp
Excision Lipoma Breast	Excision Lipoma Shoulder
Excision Lipoma Chest Wall	Excision Lipoma Upper Extremity
Excision Lymph Node	Excision Mass
Excision of Anal Tag	Excision Polyp Rectal
Hemorrhoid Banding	Sigmoidoscopy Control Bleeding
Hemorrhoidectomy	Sigmoidoscopy Diagnostic
Sigmoidoscopy Biopsy	Sigmoidoscopy Dilatation
Sigmoidoscopy Endoscopic Ultrasound	Sigmoidoscopy Excision Lesion
Sigmoidoscopy Flexible	Sigmoidoscopy Removal Foreign Body
Vasectomy	Vasectomy Ligation
Drain Abscess	Placement of wound drain
Simple wound closure	Removal of surgical sutures or staples
Breast biopsy	Excision oral lesions
Liver biopsy (percutaneous)	Lymph node biopsy

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Scope Of Services – Surgical Department	POLICY # SURG 0001
DEPARTMENT/SCOPE:	SURGERY	Page 3 of 3
		EFFECTIVE: 11/15/2023
OWNER: LEANNE MELANG		APPROVER: T. OVERTON

Paracentesis	Excision ingrown finger/ toe nail

Nursing staff are trained and competent to perform physical assessment, laboratory procedures, specimen collection, medication administration, pre-anesthesia evaluation, Iv insertion, pre-induction assessment, safety checklists, time out, instrument and supply identification, post-operative assessment/care, and emergency interventions.

A trained surgical technologist is responsible for assisting with transportation of patients to and from the operating room, equipping the operating room with surgical equipment and supplies, maintaining the sterile field, monitoring the count of surgical instruments, providing the surgeon with necessary medical instruments, participating in the wound closure and application of dressings, cleaning, packaging, inspecting, and sterilizing instruments.

Physical layout of Department consists of 1 Sterile Surgical Procedure room and 1 clean GI procedure room, 1 pre-operative admission room, 1 post-operative recovery room, clean utility equipment storage, a dirty instrument reprocessing room, and a clean packaging room, and a sterile storage supply room. There are 16 beds available on the Acute medical floor should a post-operative patient require observation and care overnight. Access to the surgical suite is only granted to authorized personnel and areas are clearly marked with signage and a red line on the floor to indicate sterile areas.

REFERENCES:

1. 'Sterile Technique' (2023) in *Guidelines for perioperative practice*. Denver, CO: AORN, p. 1047.

2. Code of Federal Regulations.482.51 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-D/section-482.51

3. 08.00.01. Scope of Services. Surgical Services. In: *ACHC Accreditation Requirements for Critical Access Hospitals. 2023 ed.*

COMMITTEE APPROVALS:

Community Needs Assessment for Mayers Memorial Healthcare District

Introduction:

Mayers Memorial Healthcare District is a critical access hospital serving the rural communities of the intermountain area. As a critical access hospital, Mayers Memorial Healthcare District is committed to leading rural healthcare for a lifetime of wellbeing. To better understand the needs of our community, we conduct a comprehensive community needs assessment in 2022.

Demographic Characteristics Fall River Mills 96028:

The demographics report for the 96028 ZIP code provides information on the population, housing, employment, education, and other characteristics of the area. Here are some key findings:

Population:

The population is approximately 1,220 people. Down from its 2007 peak of 1,544.

- The median age is 48, with a slightly higher percentage of seniors) and a slightly lower percentage of children under 18.
- The population is predominantly white (85.3%), with a small percentage of other races.

Housing:

- The median home value is $230,100, which is slightly higher than average compared to the rest of the country.
- The majority of households are owned or have a mortgage (56%).
- Rentals in the area are mostly 2-bedroom apartments or homes.

Employment:

- The median household income is $39,212, which is slightly lower than average compared to the rest of the country.
- The majority of commuters get to work in under 45 minutes.
- The average household income has steady increased over time from $43,545 in 2005 to $57,827 in 2020.

Education:

- 66.4% of the population has a High School Diploma, and 25.8% has post high school degrees.
- The majority of students are enrolled in public schools (89%).

Other characteristics:

- 57% of the area has a husband/wife family household. 27% is made of single-family households.
- 27% of households are with kids.
- There are two nursing homes nearby.

Demographic Characteristics Burney 96013

The demographics report for the 96013 ZIP code provides information on the population, housing, employment, education, and other characteristics of the area. Here are some key findings:

Population:

The population is approximately 3,290 people. Down from its 2007 peak of 4,009.

- The median age is 44, with a slightly higher percentage of seniors and middle-aged adults and a slightly higher percentage of children under the age of 18.
- The population is predominantly white (84.7%), with a small percentage of other races.

Housing:

- The median home value is $138,900 which is slightly less than average compared to the rest of the country.
- The majority of households are owned or have a mortgage (54%).
- Rentals in the area are mostly 2-bedroom apartments or homes.

Employment:

- The median household income is $37,629, which is slightly lower than average compared to the rest of the country.
- The majority of commuters get to work in under 30 minutes.
- The average household income has steady increased over time from $38,155 in 2005 to $52,746 in 2020.

Education:

- 71.6% of the population has a High School Diploma, and 16% have post high school degrees.
- The majority of students are enrolled in public schools (67%).

Other characteristics:

- 50% of the area has a husband/wife family household. 28% is made of single-family households.
- 28% of households are with kids.
- There are two nursing homes nearby.

Demographic Characteristics McArthur 96056:

The demographics report for the 96056 ZIP code provides information on the population, housing, employment, education, and other characteristics of the area. Here are some key findings:

Population:

The population is approximately 1300 people. Down from its 2007 peak of 1519.

- The median age is 50, with a slightly higher percentage of seniors and middle-aged adults and the percentage of children under the age of 18 is small compared to other areas of the country.
- The population is predominantly white (81.9%), with a small percentage of other races.

Housing:

- The median home value is $215,100 which is higher than average compared to the rest of the country.
- The majority of households are owned or have a mortgage (59%).
- Rentals in the area are mostly 2-bedroom apartments or homes.

Employment:

- The median household income is $46,187, which is slightly lower than average compared to the rest of the country.
- The majority of commuters get to work in over 45 minutes.
- The average household income has steady increased over time from $48,589 in 2005 to $64,829 in 2020.

Education:

- 58.7% of the population has a High School Diploma, and 31.8% have post high school degrees.
- The majority of students are enrolled in public schools (100%).

Other characteristics:

- 61% of the area has a husband/wife family household. 23% is made of single-family households.
- 24% of households are with kids.
- There are two nursing homes nearby.

Healthcare Needs Based on 2022 CHNA:

- **Chronic Disease Management:** Patients with chronic diseases such as diabetes, hypertension, and heart disease require more comprehensive care and management.
- **Mental Health:** There is a shortage of mental health providers in the area, leading to delays in accessing care for individuals with mental health issues.
- **Substance Abuse:** The community struggles with substance abuse, particularly opioid addiction, and requires more effective treatment options.
- **Access to Care:** Rural residents face barriers in accessing healthcare services due to limited transportation options, lack of providers, and long distances to travel.
- **Health Literacy:** Some patients struggle with understanding health information and navigating the healthcare system due to limited health literacy.
- **Diet/Obesity:** The community has a high prevalence of obesity and related diet-related health issues, such as type 2 diabetes and heart disease.

- **Tobacco Use:** Tobacco use is prevalent in the community, with many residents smoking or using other tobacco products.
- **Pediatrics:** Pediatric health services are limited in the area, making it difficult for parents to access care for their children.

Opportunities based on 2022 CHNA:

- **Collaboration:** Partnering with local healthcare providers and community organizations to improve access to care and reduce health disparities.
- **Telehealth:** Implementing more telehealth services to increase access to care and reduce transportation barriers.
- **Health Education:** Providing health education programs and materials to improve health literacy and empower patients to take an active role in their care.
- **Mental Health Services:** Expanding mental health services, including counseling and therapy, to address the growing need in the community.
- **Community Outreach:** Conducting outreach efforts to educate patients about available healthcare services and encourage them to seek care.

Strategies:

- **A focus on Telehealth:** Implement telehealth services to increase access to care and reduce transportation barriers.
- **Start Mental Health Services:** Start mental health services, including counseling and therapy, to address the growing need in the community.
- **Health Education Program:** Develop a health education program to improve health literacy and empower patients to take an active role in their care.
- **Community Outreach:** Conduct outreach efforts to educate patients about available healthcare services and encourage them to seek care.
- **Collaborate with Community Organizations:** Partner with local community organizations to provide resources and support for patients with chronic diseases.
- **Diet/Obesity Program:** Develop a diet/obesity program to address the high prevalence of obesity and related diet-related health issues in the community.
- **Tobacco Cessation Program:** Put more focus on a tobacco cessation program to help residents quit smoking or using other tobacco products.
- **Pediatric Services:** Hire a pediatrician to provide more comprehensive care for children in the community.
- **Substance Abuse Treatment & Prevention:** Consider providing substance abuse treatment options, including medication-assisted treatment (MAT), behavioral therapy, and support groups. Implement substance abuse prevention programs, including education and outreach efforts, to reduce the risk of substance abuse in the community.

Recommendations:

- Develop a comprehensive plan to address the identified healthcare needs of the community.

- Allocate resources to support the implementation of telehealth services, mental health services, diet/obesity programs, tobacco cessation programs, pediatric services, substance abuse treatment options and health education programs.
- Collaborate with local healthcare providers, community organizations, and stakeholders to ensure effective implementation of programs.
- Monitor progress and evaluate outcomes regularly to ensure that programs are meeting their intended goals.
- Continuously assess the needs of the community and adapt programs accordingly.

Conclusion:

The community needs assessment for Mayers Memorial Healthcare District highlights the need for improved access to care, mental health services, diet/obesity programs, tobacco cessation programs, pediatric services, substance abuse treatment options, and health education programs in the rural communities we serve. By implementing these strategies, we can improve the overall health and well-being of our patients and contribute to a healthier community.

Priorities for future CHNA.

Methodology:

Future community needs assessment will be conducted through a combination of literature review, focus groups, and surveys. The following sources will be consulted:

- Literature Review: A review of existing research and reports on the healthcare needs of the communities served by Mayers Memorial Healthcare District.
- Focus Groups: Three focus groups were conducted with community members, healthcare providers, and stakeholders to gather information on their perceptions of the healthcare needs of the community.
- Surveys: A survey will be administered to 200 patients and 10 healthcare providers to gather information on their experiences with healthcare services and perceived needs.

Recommended questions for the next community healthcare need assessment:

Health Status:

- What are the leading causes of death and disease in the community (e.g., heart disease, cancer, diabetes)?
- What are the most common health conditions affecting the community (e.g., hypertension, obesity, mental health issues)?
- Are there any disparities in health outcomes by demographic characteristics (e.g., racial/ethnic groups, socioeconomic status)?

Health Behaviors:

- What are the most common health behaviors practiced by community members (e.g., smoking, physical activity, healthy eating)?
- Are there any health behaviors that are particularly prevalent among specific sub-populations (e.g., youth, seniors)?
- Are there any barriers to practicing healthy behaviors (e.g., lack of access to healthcare services, transportation issues)?

Environmental Factors:

- What are the environmental factors that may impact health outcomes in the community (e.g., air and water quality, noise pollution, proximity to hazardous waste sites)?
- Are there any environmental factors that disproportionately affect specific sub-populations (e.g., low-income communities, communities of color)?
- Are there any initiatives or programs in place to address these environmental factors?

Social Determinants:

- What are the social determinants of health that may impact health outcomes in the community (e.g., education level, employment status, housing quality)?
- Are there any social determinants that disproportionately affect specific sub-populations (e.g., low-income individuals, communities of color)?
- Are there any initiatives or programs in place to address these social determinants?

Healthcare Access:

- What are the primary sources of healthcare for community members (e.g., hospital emergency department, primary care physician, community health center)?
- Are there any barriers to accessing healthcare services (e.g., lack of insurance, transportation issues, language barriers)?
- Are there any initiatives or programs in place to improve access to healthcare services?

Healthcare Quality:

- What are the quality metrics for healthcare services in the community (e.g., patient satisfaction, healthcare outcomes, patient safety)?
- Are there any disparities in healthcare quality by demographic characteristics (e.g., racial/ethnic groups, socioeconomic status)?
- Are there any initiatives or programs in place to improve healthcare quality?

Community Perceptions:

- What are the perceptions of community members regarding their health and healthcare services?
- Are there any concerns or priorities that community members have regarding their health and healthcare services?
- Are there any initiatives or programs in place to address these concerns or priorities?

Data Sources:

- What data sources will be used to collect information for this CHNA (e.g., government reports, surveys, focus groups)?
- Are there any limitations or biases associated with these data sources?
- How will data from multiple sources be integrated and analyzed?

MAYERS MEMORIAL
HEALTHCARE DISTRICT

RESOLUTION NO. 2024-08

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

Resolution Ordering Board of Directors Election; Consideration of Elections; and Specifications of the Election Order

WHEREAS, California Elections Code requires a general district election be held in each district to choose a successor for each elective officer whose term will expire in December (December 6, 2024) following the election to be held on Tuesday, November 5, 2024; and

WHEREAS, other elections may be held in whole or in part of the territory of the district and it is to the advantage of the district to consolidate pursuant to Elections Code section 10400; and

WHEREAS, Elections Code section 10520 requires each district involved in a general election to reimburse the county for the actual costs incurred by the county elections official in conducting the election for that district; and

WHEREAS, Elections Code section 13307(e) requires that before the nominating period opens the district board must determine whether a charge shall be levied against each candidate submitting a candidate's statement to be sent to the voters and,

WHEREAS, Elections Code section 12112 requires the election official of the principal county to publish a notice of the election once in a newspaper of general circulation in the District;

NOW, THEREFORE, IT IS ORDERED that an election be held within the territory included in this district on the 5th **day of November, 2024,** for the purpose of electing members to the board of directors of said district in accordance with the following specifications:

Specifications of the Election Order

1. The Election shall be held on Tuesday, the 5th day of November, 2024. The purpose of the election is to choose members of the board for the following seats:

Current Members of Vacant Seats:	Term Length:
Jerry "Abe" Hathaway	4 years
Tami A Humphry	4 years
James Robert Ferguson III	4 years

2. The District has determined that the estimated cost for the optional Candidate Statement will be paid for by the:
   Circle One: District Candidate

   The Candidate's Statement will be limited to 200 words. The estimated cost shall be paid at the time of filing Declaration of Candidacy.

3. The District directs that the County Registrar of Voters of the principal county publish the Notice of Election in a newspaper of general circulation that is regularly circulated in the territory.

4. This Board hereby requests and consents to the consolidation of this election with other elections which may be held in whole or in part of the territory of the district, pursuant to Elections Code section 10400.

5. The District will reimburse the county for the actual cost incurred by the county elections official in conducting the general district election upon receipt of a bill stating the amount due as determined by the elections official.

6. The Clerk of this Board is ordered to deliver copies of this Resolution to the Registrar of Voters.

7. THE FOREGOING RESOLUTION WAS ADOPTED upon motion of Director (Name). Seconded by Director (Name), at a regular meeting on this day of (Date, 2024), by the following vote:

AYES: 5
NOES: 0
ABSENT: 0
ABSTAIN: 0

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

ATTEST:

_____
Jessica DeCoito
Clerk of the Board of Directors

MAYERS MEMORIAL HEALTHCARE DISTRICT

Operations Report
May 2024

Statistics	April YTD FY24 *(current)*	April YTD FY23 *(prior)*	April Budget YTD FY24	Variance
Surgeries ➢Inpatient ➢Outpatient	 0 0	 0 0	 TBD TBD	
Procedures** *(surgery suite)*	0	0	TBD	
Inpatient	1782	1529	1470	253
Skilled Nursing Days	24100	23959	22846	141
Emergency Room	3582	3575	3541	7
OP Visits (OP/Lab/X-ray)	12537	13180	11937	643
Hospice Patient Days	282	840	1024	558
PT	1693	2017	2104	324

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

Human Resources

May 2024

Submitting by Libby Mee – Chief Human Resource Officer

Staffing, Recruitment and Retention

The Human Resource staff currently supports 308 active employees.

The team continues to work with specialized companies to provide additional recruitment resources for our Chief Medical Officer, Rural Health Clinic Provider, Pharmacist, Infection Prevention, Hospitalist/NP, Physical Therapist, Radiology Tech, and Skilled Nursing positions. The team has received an application and are in communications with a potential Physical Therapist.
We are currently utilizing interim professional in the Pharmacist and Infection Prevention roles.

We have received 5 applications for our 2024 High School Summer Internship program. The committee is scheduled to meet to review the applications and will be setting up interviews. Selected students will begin employment in June.

Leadership Academy

To support our recently approved FY25 Pillar goal of providing Mayers leadership with additional training, we have been working with the Healthcare Leadership Institute (HLI) and Jen Miley with Elite Edge Coaching.
The HLI provided the certification program that the Mayers Executive team participated in last year. The proposed program would allow, over the next year, for 15 of Mayers leaders team members to participate in virtual and group leaning and coaching sessions.
Please see attached for a full proposal of the Mayers specific Virtual Leadership Academy.
In addition to the HLI, we would like to continue to work with Jen Miley. Jen's proposal includes 4 on site coaching visits to focus on leadership development coaching targeted to support all levels of leadership growth and skill building. These training are typically three-hour sessions, off-site, with the complete leadership team. Jen would then remain on-site for the rest of the day to provide one on one coaching to designated members of the leadership team.

Employee Health, Wellness and Benefits

Work Related injury and Illness

For the year, there as has been 2 reportable work-related injury resulting in 5 days away from work. There has been 4 first aide injuries, with no days away from work.
We continue to provide accommodated work duties to previously injured staff members, so their lost time does not have to be paid through insurance.

Employee Assistance Programs

A topic that was brought up multiple times in my recent conferences were robust Employee Assistance Programs. It was reported that about 3-4% of employee's utilize available EAP programs.

Currently, we have a 22% employee usage of our Modern Health app, providing mental health resources to staff. Over half of our eligible staff members are using our Wellable app, providing overall personal health support.

Miscellaneous

ACHC

I am continuing my work on updating orientation, training, competency, and compliance content to meet ACHC standards. Additionally, I am updating content related to employee annual physicals, FIT testing, and TB skin testing.

HR position restructuring

I have successfully filled my HR Generalist opening and am now working on reviewing applications for my HRIS/Employee Benefits Specialist position. This position will train with a current staff member that is nearing retirement.

2024 Healthcare Minimum Wage

Effective June 1, 2024, the healthcare minimum wage will increase to $18.00 per hour. We have finalized our model to meet compliance of this regulation and will begin sending out Personal Action forms to staff. All Mayers employees, that are not under a contract, will receive an annual increase at this time. We will also be adjusting and updating our wage scale accordingly.

Training and Conferences

I recently attended the National Rural Health Association (NRHA) annual conference with a few other MMHD leaders. We head presentations from HRSA Rural Health Division, CDC's Office of Rural Health and the president of the American Medical Association.

I attended breakout sessions on:

- Rural Leader Burnout: Prevalence, Causes and Implications
- Strategies to Bolster the Rural Physician Workforce
- Rural Hospital CEO Recruitment and Retention Program
- Nurse Preceptor Development
- State Level Strategies to Advance Value Base Care
- High Value Retention Strategies for Rural Healthcare

I am looking forward to implanting concepts and ideas learned at this event.

EMPLOYEE STATISTICS

2024 Fiscal Year

366

Total Employees
for the year

RETENTION VS. LOSS

84

People hired/rehired

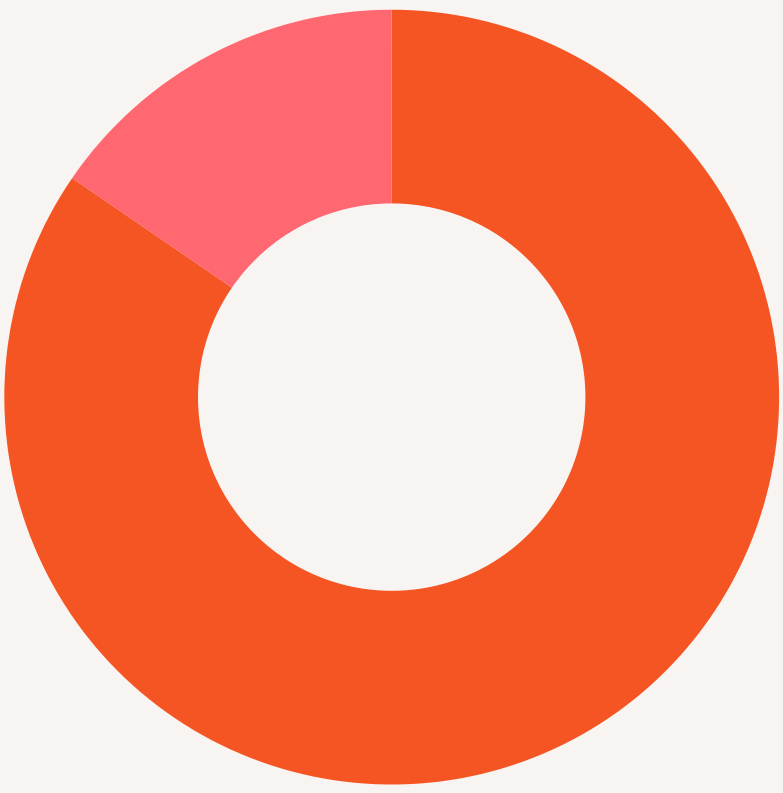
47

people terminated their employment

ADJUSTED TURNOVER STATS:

Goal turnover for FY 24 is 17.52%

Adjusted Turnover
13.99%



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

Positions:	# available:
Activities Aide	1
***Chief Medical Officer**	1
Emergency Room RN I	2
Employee Benefit/HRIS Specialist	1
Employee Health Nurse	1
Environmental Services Aide	1
Executive Assistant to the Chief Nursing Officer	1
Hospice Home Health Aide	PER DIEM
Hospice RN	1
***Independent Retail Pharmacist**	1
***Infection Prevention RN**	INTERIM STARTED 5/5
***Nurse Practitioner (Acute)**	1
Maintenance Worker	1
Med Surg Acute RN	1
Outpatient Medical RN/LVN	1-PT
***Pharmacist**	1
***Physical Therapist**	1
***Radiology Tech**	1
Rural Health Clinic Med Director	1
Skilled Nursing CNA	12 FT, 4 PT
Skilled Nursing LVN	11 FT, 2 PT
Skilled Nursing RN	3

Chief Public Relations Officer – Valerie Lakey
May 2024 Board Report

Legislation/Advocacy

State Budget: The governor released an early look at the May revision of his proposed 2024-25 budget on May 10. The most notable shift was the diversion of the MCO funds away from new commitments made in previous budgets. The team is analyzing the effect of this shift and will provide more information on the Tuesday call. Look for a CHA summary early next week, as well. The Legislature is ramping up the budget subcommittee process to consider the governor's revised plan in hopes of meeting the June 15 deadline to pass the budget.

Legislature: The appropriations committees are working to finish their work by the May 17 deadline to pass bills to the floors. Bills must advance to the next house by May 24.

Assembly Bill (AB) 977 (Rodriguez, D-Pomona)

AB 977 would extend the penalties for violence committed against first responders to all health care workers who provide services within emergency departments.

Status: June 4 hearing in the Senate Public Safety Committee

Senate Bill (SB) 895 (Roth, D-Riverside)

SB 895 would require the California Community Colleges to develop a Baccalaureate Degree in Nursing Pilot Program at 15 community college districts in order to offer a bachelor of science in nursing degree. It would also require the Legislative Analyst's Office to evaluate the effectiveness of the pilot, which would end on Jan. 1, 2034.

SB 1061 (Limón, D-Santa Barbara)

SB 1061 would prohibit consumer credit reporting agencies from including medical debt in consumer credit reports and would also prohibit a health care provider from furnishing information regarding a medical debt to a consumer credit reporting agency. The bill also requires hospitals to maintain a database of all litigation resulting from an individual's medical debt.

SB 1423 (Dahle, R-Bieber

SB 1423 would require Medi-Cal to reimburse outpatient, inpatient, and skilled-nursing 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.

SB 1432 (Caballero, D-Merced

SB 1432 is CHA's proposal to address the 2030 seismic requirement. The bill would extend the 2030 deadline, address additional post-earthquake disaster preparedness requirements for hospitals, assess opportunities for financial support, require the state to assess the financial and access impacts of the 2030 requirement, and address rural hospitals' unique concerns.

AB 869 (Wood, D-Healdsburg)

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.

AB 1001 (Haney, D-San Francisco)

AB 1001 would require general acute care hospitals to adopt behavioral health emergency service policies related to minimum staffing requirements, response times, and data management and reporting. This bill would establish the Behavioral Health Emergency Response and Training Fund to support staffing increases in public and nonprofit general acute care hospitals.

Public Relations/Marketing

The Planting Seeds, Growing Our Own assemblies at the three local elementary schools were a bit hit. Staff went to Big Valley, Burney and Fall River and presented a skit to the students. All students were also treated to a tote bag and pencil. This is always a great event. Thank you to the staff who participated and to Mary Rainwater and Marrisa Martin who organized the events.

May 22 (Board Meeting Day) there will be a Women's Health event at the clinic. Also, during the month of May we have been giving all female patients a Guide to Women's Health booklet. We are currently working on a booklet for Men's Health. Click HERE for a digital copy of the booklet.

Changes, additions, and corrections have either been made, and for the ones that require the webhost to complete, have been submitted for the Mayers, Hospice and Foundation websites as well as the employee Intranet.

If you are in the facility, be sure to check out the Internal and public facing televisions that are full of information for staff and the public. Rowan Dietle does a great job keeping this system up to date and providing relevant information.

We implemented a new system for marketing requests from departments and staff. We get many requests each week and the new process will ensure that nothing is missed and that requests are prioritized.

We have been working to promote the health fair and the mobile mammogram unit.

The employee storefront should launch next week. Employees will be able to purchase MMHD branded items. We can also provide staff gifts through the platform and will be able to change the products quarterly.

Our ad is up and running at the Fall River DMV.

Mayers Healthcare Foundation

Events:

- **Health Fair** – The Mayers Healthcare Foundation Health & Wellness Fair is scheduled for Saturday, June 22, 2024 at the Inter-Mountain Fairgrounds in McArthur. The event will utilize a lot of outdoor space and the Flower Building for the lab draws. We will have the mobile clinic on-site to do sports physicals. We are very excited to announce that there will be a mobile mammography unit at the event as well. The Tri County Community Network Kid Fit Summer Program will kick off at the event with a children's color run. We will once again host the 5K Run/Walk for all ages. Letters have been sent out to community partners and we are very excited about this event.

- **Golf Tournament** – Mark your calendars for August 3, 2024. We are working on preparation for the annual event and will be looking for guidance on what we want the proceeds to benefit.

Thrift Store Update: The Thrift Store continues to do very well under the direction of our volunteers. Many, many hours have been put in by this group to sort inventory and operate the store. Revenues have been improving and the stores is a very busy place! We are excited to announce that we just received notification that we were approved for the Burney Community Fund Grant! This grant will allow the Thrift Store to purchase a Point of Sale and inventory system, get a new road sign and much needed display and storage items.

Volunteers: We will be making a few adjustments with managing the volunteers as there was a resignation in the MMHD Human Resources Department. MHF staff will now be working on the logistics of the volunteers and MMHD HR staff will continue to handle the compliance piece. We are excited to have recently gained one new volunteer for the Thrift Store.

Awards and Scholarships: Information and applications for the scholarship cycle has been sent out. Both community and internal scholarship cycles are open with the deadline for applications being May 3, 2024. Once applications are received and reviewed, we will schedule a meeting of the scholarship committee.

MEG (Mayers Employee Giving): The MEG Committee met on April 3 and is happy to announce MEG Department Awards! Thanks to the generosity of thirteen incredible members of our team who contributed to the Mayers Employee Giving (MEG) fund through payroll deductions over the last year, we have been empowered to make a significant impact on our hospital departments. I am delighted to announce that MEG has decided to award a **total of $11,000** to several hospital departments. This funding will support initiatives in the ***Activities Department, Outpatient Medical, Surgery, Cardiac Rehabilitation, and Clinical Education***. These departments play crucial roles in delivering exceptional care to our patients and advancing our mission of providing quality healthcare services to our community.

It is truly inspiring to see the collective impact of our contributions and the meaningful difference we can make when we come together as a team. Your generosity and dedication to giving back to our

hospital are commendable, and I want to express my heartfelt gratitude to each and every one who participated in the MEG fund.

As contributors to the MEG fund, those involved are privileged with the opportunity to decide how these funds will be allocated. From the input and insights of the committee, their decisions help shape the projects and initiatives that receive support, further demonstrating our commitment to enhancing patient care and advancing our hospital's mission. I am incredibly proud to be part of such a compassionate and generous team.

Additionally, we have just launched the Power of 2 Campaign.

Tri County Community Network

We are working through some of the challenges we have encountered with TCCN. After meeting with the building department and fire department, we were able to "get on the same page" going forward. Aspen Street was on site the first week of May and did a complete evaluation of the building. In addition to them providing scope of work, they also evaluated the space which has the proper occupancy. We have obtained the requested "Opinion Letter" from the architects regarding the occupancy in the remodel/addition space and the upstairs. Since the occupancy and use in those spaces will not change, we will request a fire inspection and be able to move forward with the community programs we have planned and also put support staff in office space upstairs.

Overall, we are making progress and the center will be done correctly and be able to serve the community well. We are hopeful to have programs up and going in June. We will be bringing the plan for the Children's Program space to the board within the next two months.

Children's Programs

- We met with the architects and are moving forward with bringing the children's program portion of the building up to code. We will have a report on the scope of work soon. Initial thoughts after the visit where that the work would not be too extensive.
- Kid Fit will begin June 22nd and will continue through the summer with six fun and free events for children of all ages. This is a grant funded program.

Grants

- TCCN did not receive the grant from the McConnel Foundation to purchase equipment for the children's programs as well as other programs that will be developed in the coming year. We are currently pursuing other options for funding the purchase of furniture for the senior services.
- Bright Futures has started again! Our new advocate, Kiely has hit the ground running and is working to expand the program. She has started tiny tunes in Round Mountain and Baby Bonding Time at the Burney Library. More events for children 0-5 will be added in the coming weeks. This is also a grant funded program that provides great resources to our community.
- A meeting is scheduled with PSA 2 to explore funding our planned senior services.

Partnerships

- We are continuing to partner with SMART to bring employment services to our area.
- HHSA will be hosting a smoking cessation class in June. Flyers will be distributed to all clinics in the area and posted on social media.
- We are working with Partnership Health Plan to bring services related to Cal Aim to the center, which will in turn benefit the clinic and other services at MMHD.

Community Events

- A men's health BBQ and hands only CPR training will be held in the event room on June 13th @ 5pm. This will be the MMHD quarterly community event.
- A dementia and aging workshop will be held in the event room on June 25th @ 12pm. This event will be advertised on our social media platforms.
- Kid Fit Color run will be held at the fairgrounds on June 22nd in conjunction with the health fair.

Gift Shop

There are lots of great items in stock at the gift shop! Gifts for dads and grads!

March Board Report
Clinical Division
5/15/2024

Laboratory

- Sophia Rosal, CLS, Laboratory Manager, will be reporting pillar goals.

Imaging

- The conversion of ultrasound high level disinfection from Cidex to Tristel ULT is complete. The Tristel is as effective, less toxic, and more environmentally friendly.
- Harold Swartz, Radiology Manager, will test for CT certification on June 7th
- CT System had annual service on May 14th. They will return later in the week to service the X-ray/Fluoro system.
- The physicist will be onsite at the end of May for Annual Physics testing of the CT and X-ray/Flouro machines.

Physical Therapy

- Daryl Schneider, PT manager, has been working with Dignity Health Medical Group North State to correct their referral form that has Mayers correct address but wrong fax and phone number on their physical therapy facilities list. Their form does not indicate that we accept Partnership Healthcare.
- We are scheduling an interview with a permanent physical therapist.
- Referrals as of 5/15/24: Of the 42 referrals, 17 have evaluations scheduled and 19 have been contacted for scheduling at least twice. Wait time 4-5 weeks with post-op and urgent referrals receiving priority (last month 43 referrals with 14 of those scheduled).

Cardiac Rehab

- Zita Biehle and PT staff participated in training the Girls Scouts on hands only CPR, first aide, and how to call 911.
- Zita also participated in the "Growing Our Own" outreach to the elementary schools.
- Mirrors have been installed in the dumbbell area of cardiac rehab to provide cardiac rehab participants with visual feedback.
- Cardiac rehab received grant funding through MEG to purchase three new sets of hand weights.

Hospital Pharmacy

- Policies are being updated for ACHC compliance.
- Pharmacists are documenting interventions through CERNER as part of the record.

Retail Pharmacy

- Kristi Shultz, Associate Manager, has renewed our rural rate contract with ExpressScripts and will go into effect by the end of May. ExpressScripts dropped our previous rural rate contract without notice.
- Hospital Insurance update: After our meeting on 05/08/24, CarelonRx Representatives confirmed updating the hospital insurance formulary accurately to prevent incorrect approval of non-formulary medications with high copays. This update allows us to submit prior authorizations for formal approval with correct pricing. We are awaiting guidance from CarelonRx to address wrongly approved claims.
- Hudson Headwaters: Kristi Shultz, and Alesha Johnson, pharmacy tech, are meeting weekly with Hudson Headwaters (our 340B intermediary). The program settings have been updated to prevent missed claims. Missing inventory is being received for the annual return. We are auditing 6,000+ historic claims and conducting daily reports for compliance.

Infection Prevention

- Amy Marisnski, RN, has joined Mayers as our interim Infection Preventionist. We have enjoyed having Maria Cuccinello, RN, in the interim position and she helped Mayers navigate several outbreaks. We appreciate that she has positioned us in a great place to move forward. She has positioned Mayers well to move forward.
- The Infection Prevention Plan for SNF has been approved.
- Covid vaccinations for the SNF residents in Burney were completed May 3rd.
- Policies regarding high level disinfection of endoscopy equipment are complete to ACHC standards. The next area of focus is laundry process and the ACHC consultant has provided sample checklists.
- District wide hand washing competencies are almost complete; 264 employees out of 208 have demonstrated competency.
- Jack Hathaway is our NHSN administrator. We are working with Cerner to report our Antibiotic Use and Resistance (AUR) data federally. Failure to submit 6 consecutive months of data could result is a 1% claw back of CMS payments.

Respiratory Therapy

- Maryann Worthan, RT, will be testing at the end of the month to become a certified pulmonary function technologist.
- We are learning how to have charge codes built. Opportunities to capture more respiratory charges have been identified.
- The new ABG machine from Nova-Biomedical is validated and is in use. The interface is yet to go live, and we are waiting on Nova to complete the last steps.

NURSING SERVICES BOARD REPORT

May 2024-Reporting for April

CNO Board Report

- Cerner Go-Live on hold. Working with Cerner on build for meeting compliance for state regulation.
- CDPH Survey May 6-9th. Awaiting 2567.
- Reported registry CNA to CDPH for 5-suspected instances of abuse on one shift. Reported one fall with fracture. Pending CDPH review
- Hospital Week has been a success with staff.
- ACHC regulations being reviewed with Quality and Acute Departments. Work continues towards restructuring policies and procedures with direction from ACHC consultant.
- OPS had increase of referrals. Scheduled 3 days for next couple of months for increased referrals.

SNF

- Census- (79) Fall River- 33 Burney Annex- 26 Memory Care- 20. This leaves 3-female beds, 2-male beds in Burney 2-femaile,
- Working with Modoc Medical Center to accept staff from Mayers to enter their NATP program. Awaiting schedule. We have 6-unit assistants ready to enter.
- Continuing to struggle with staffing in-house nurses. Medifis and NPH are meeting our needs at this time to maintain staffing ratios.
    - Longtime traveling RN accepted FT position.
    - LVN completed orientation, working FT position in Fall River.
    - Hired a NOC LVN FT weekends in Fall River.
- SNF Cerner implementation continues.
    - Cerner go live on hold at this time. Meeting with administration and Cerner to determine moving forward with go live to meet standards of care.
- Norovirus at Fall River; Two residents, minimized widespread with IP standards and staff surveillance.
- One GI case at St. 2, resident on extended barrier precautions.
- Safe Patient Handling Training scheduled for training in SNF.
- Rekeying Burney Annex

Acute

- April 2024 Dashboard
    - Acute ADC 1.96, ALOS 4.06
        i. High ALOS caused by patient with Medicare Advantage plan
    - Swingbed ADC 3.8, ALOS 10.94
    - OBS Days: 7

- April Staffing: Required 8 FTE RN/LVN's, 2 PTE RN's, 4 FTE CNA's & 2 FTE Ward Clerks
    - Utilizing 1 FTE Medifis, 2 FTE NPH RN, & 1 PTE NPH RN/LVN
    - Open positions: 1 FTE RN
    - 1 RN on orientation and newly hired RN to start orientation mid-May
- Updates:
    - Reviewing RCAT report and collaborating with the team to rectify patient chart issues, ensuring compliance and accuracy in medical records management.
    - Collaborating on the planning stage for the implementation of ACHC focused policies, emphasizing teamwork to ensure compliance and educational readiness for seamless integration across the organization.
    - Collaborating with providers to address and resolve chart issues, ensuring accuracy and compliance with regulatory standards.
    - Utilizing AHRQ toolkits and resources to review the discharge planning process collaboratively, aiming for alignment with ACHC standards and optimizing patient care outcomes.

Emergency Services

- April 2024 Dashboard
    - Total treated patients: 370
    - Inpatient Admits: 16
    - Transferred to higher level of care: 28
    - Pediatric patients: 64
    - AMA: 0
    - LWBS: 2
    - Present to ED vis EMS: 48

- April Staffing: Required 8 FTE RN, 2 PTE RN's, 2 FTE Tech's
    - Utilized 2 FTE contracted travelers.
    - ED Manager covering gaps in shifts coverage between travelers. She continues her temporary role as Clinical Project Manager for the Cerner implementation.
        - LTC testing and validation event April 16th – 18th.
        - LTC End User Training event April 29th thru May 3rd
    - Open positions: 1 FTE Noc RN and 1 FTE Days RN

- Updates:
    - Reviewing, updating, and reformatting policies to meet ACHC guidelines.
    - Centering staff education around updated ACHC guided policies
    - 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 to be held on October 21st, Staff to drive the topic content of this education to make it more meaningful and applicable to our patient population.
    - TNCC Class to be held on October 16th and 17th.

- Continue to improve chart check processes to increase captured revenue and avoid late charging, while improving charting standards.

Outpatient Surgery

Census Report: April

Referrals Received	**26**				
Procedures Performed	**04/8/2024**	**04/9/2024**	**04/10/2024**		
Colonoscopy	**4**	**7**	**3**		
EGD	**1**	**0**	**3**		
Colonoscopy/ EGD Combo					
Other	**0**	**0**	**0**		
Total cases Performed	**5**	**7**	**6**	**Monthly Total:**	**18**

Note: 28-pending referrals

- Received grant for Olympus co2 insufflator will decrease pt post op discomfort.
- Kim Myers working independently in scrub tech role. Utilizing Modoc team for additional support and training. Kim is working through her online training for certification.
- Leanne completing employee competencies and trainings.

Ambulance Services

- Ambulance Runs—
  - April-55 ambulance runs.
  - Transfers-13.
- We hired and our training our new full-time paramedic, so as of June, we will be staffed with a paramedic 7 days a week.

- The crews are doing a much better job with their documentation which should result in better reimbursements.
- Mayers ambulance participated in Every 15 Minutes project with our local agencies.

Outpatient Medical

- Census:
    - April- 90 patients.
- Manually running statistics until we can find some good reports. Finance reports are getting closer to what our census is. High acuity patients currently 5 wound vacs and 7 new patients in one day
- Still needing a part time nurse in OPM to fill position. It has been one month without the position filled. Interview and offer extended to a candidate.

Respectfully Submitted by Theresa Overton, CNO

Chief Executive Officer Report
Prepared by: Ryan Harris, CEO

ACHC Accreditation
We have made significant progress in our ACHC accreditation process, with approximately 60% of our implementation roadmap now complete. Moving forward, we will shift our focus from documentation to education, as we prepare staff on the changes and prepare for the upcoming survey. This will enable us to ensure a smooth transition and ensure compliance with the new standards.

Provider Search Update
Over the past month, we have successfully onboarded a new nurse practitioner. In addition, we are actively seeking to fill several key positions, including a Chief Medical Officer (CMO), a nurse practitioner specializing in acute care, a Rural Health Clinic (RHC) Medical Director and physician. We are also looking forward to conducting an interview with a promising physical therapy applicant in the near future.

Construction Projects Update
The Master Planning project remains on track to be completed by the end of the fiscal year 2024. Our team is actively working on equipment planning and layout for the Criteria Docs, which is an ongoing process. The Burney Fire Alarm project is progressing well, with the duct detector scope approved. The remaining tasks on this project include tying the exhaust fan shut off into the alarm panel and finalizing the closeout. We are also making progress on the solar project, with vegetation management set to begin on June 1st. The contractor will mobilize on July 8th. Additionally, we have made significant strides in our discussions with stakeholders regarding the Fall River Clinic project. After reviewing various options, we have narrowed down the choices and included a concept design in this month's board packet for review.

Conference Attendance
I recently attended the National Rural Health Association (NRHA) Annual Conference, accompanied by our Chief Human Resources Officer (CHRO) and Chief Clinical Officer (CCO). The conference highlighted the pressing issue of rural hospital CEO and leadership burnout, with alarming statistics on CEO turnover rates and industry exits. The event emphasized the numerous challenges facing rural healthcare providers and the limited solutions to address them. This reinforced the need for innovation in order to overcome these challenges in our community. During the conference, I focused on the importance of rural physician workforce development and the role of rural residency training. As a result, I will be exploring the Programs In Medical Education (Rural Prime) Program through the University of California, Davis, as well as the California Oregon Medical Partnership to Address Disparities in Rural Education & Health (COMPADRE) program offered jointly by UC Davis and Oregon Health & Science University.

Surveys

This past month, our skilled nursing facility underwent two important surveys: our relicensing survey and our Fire Life Safety survey. I am pleased to report that both surveys had outstanding results, with a limited number of tags or deficiencies. However, one tag on the relicensing survey has raised concerns among our leadership team, and we are currently conducting a thorough investigation into the matter. We are taking immediate action to address the issue and prevent it from happening again in the future. We are eagerly awaiting the receipt of the 2567 forms for both surveys and view this as an opportunity to further improve our organization and enhance our quality of care.

Hospital week

This past week, the healthcare district has been filled with excitement and joy as we celebrated hospital week with remarkable participation from our staff. I was thrilled to hear that everyone has been thoroughly enjoying the festivities, and I'm grateful for the opportunity to bring our staff together in such a positive way. Our residents also had a fantastic time at the classic car show, and I'm delighted that they were able to participate and engage with the community. I would like to extend my sincere gratitude to everyone who contributed to making this week a success, including our staff and the community members who kindly brought their cars to share with us. It's truly a testament to the incredible teamwork and dedication that goes into making our hospital a special place. I'm proud to celebrate our staff's amazing work and achievements.

Collaboration

In the past month, The Mayers leadership team had the opportunity to engage in meaningful discussions with the leadership team from Pit River Health to explore potential collaboration opportunities. We have agreed to meet quarterly to continue this conversation and have identified several areas where we can work together. We also have identified liaisons between the two organizations to ensure a smooth process. I am excited about the potential for collaboration and look forward to continuing this work with them.

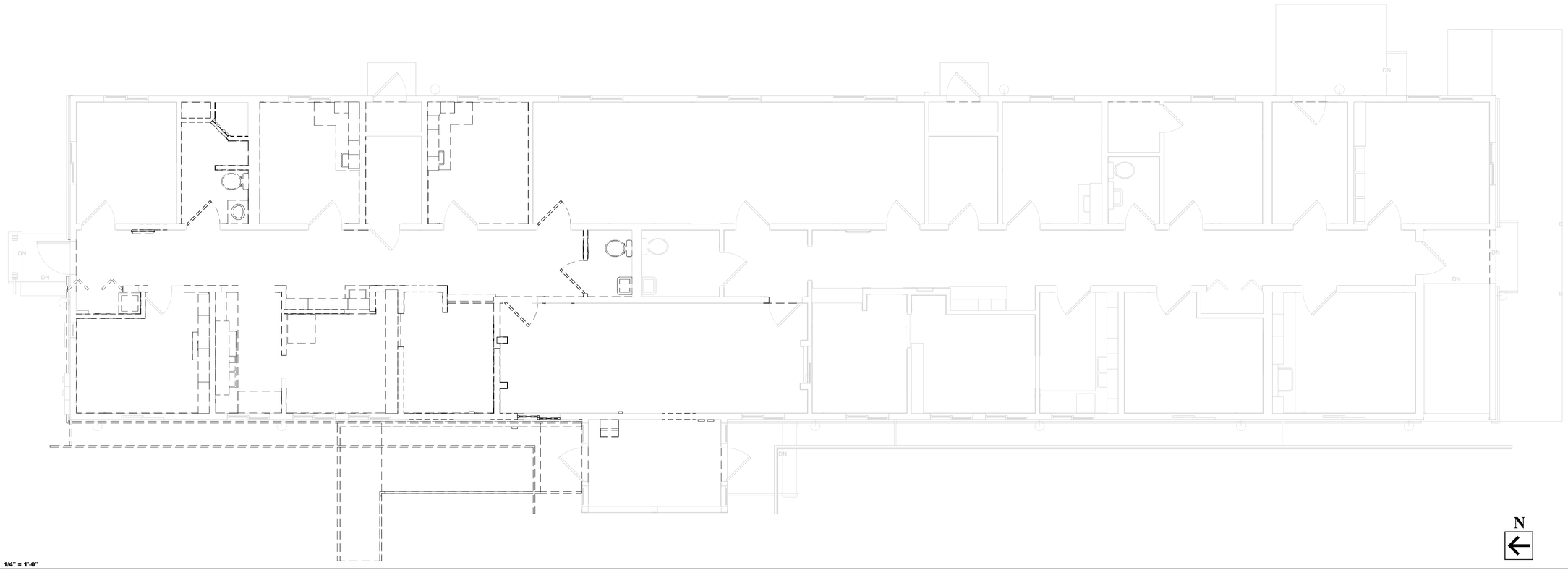
Additionally, I recently met with Chief May of Burney Fire District, which was a productive meeting focused on ensuring collaboration between our two organizations for the benefit of our community. I appreciate Chief May's time and willingness to meet with me, and we have both agreed to meet every other month to continue our discussion.

Furthermore, I am pleased to report that the CEO group, comprising CEOs from Surprise Valley, Modoc Medical Center, Mayers Memorial Healthcare District, Seneca, Plumas, and Eastern Plumas, will be starting a quarterly meeting in July. This initiative aims to increase collaboration among our facilities and enhance our collective impact on the healthcare community in Northern California.

Cerner

In recent weeks, I collaborated closely with our Skilled Nursing leadership and implementation teams and decided to postpone the scheduled go-live on May 13. The Cerner Skilled Nursing solution presents numerous challenges that could require staff to resort to workarounds, revert to paper-based processes in some cases, and potentially lead to future deficiencies. I have

opted to delay the implementation to allow Cerner the opportunity to address these issues and offer solutions that prioritize the safety of our staff and residents. The team came together this past week, and we had a productive meeting with Cerner on solutions. While there is still work to be done before I am comfortable with moving forward, I was encouraged by the meetings results.



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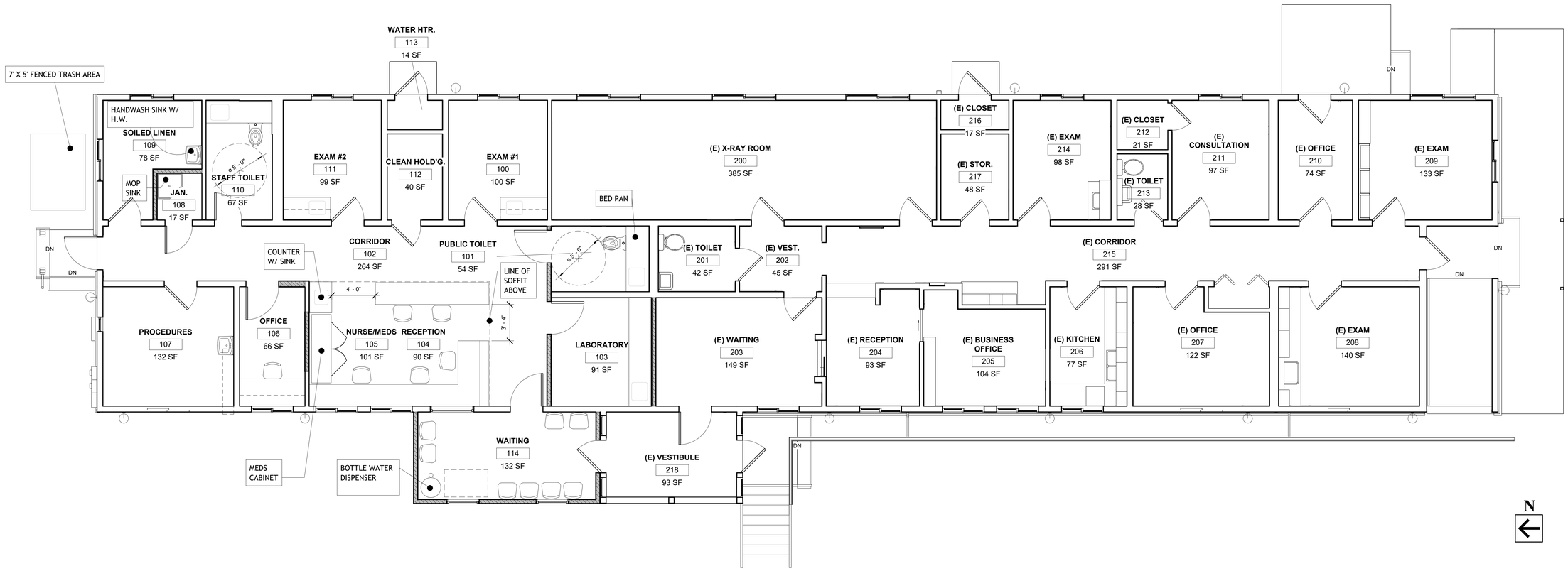
2 DEMOLITION PLAN



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1 PROPOSED FLOOR PLAN

OPTION (2) ON 5-6-24

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KEY PLAN

AGENCY APPROVALS

AGENCY NO.

PROPOSED FLOOR PLAN
DEMOLITION PLAN

DRAWING TITLE

JOB: 98013.12

SCALE: AS SHOWN

DR. BY: RN

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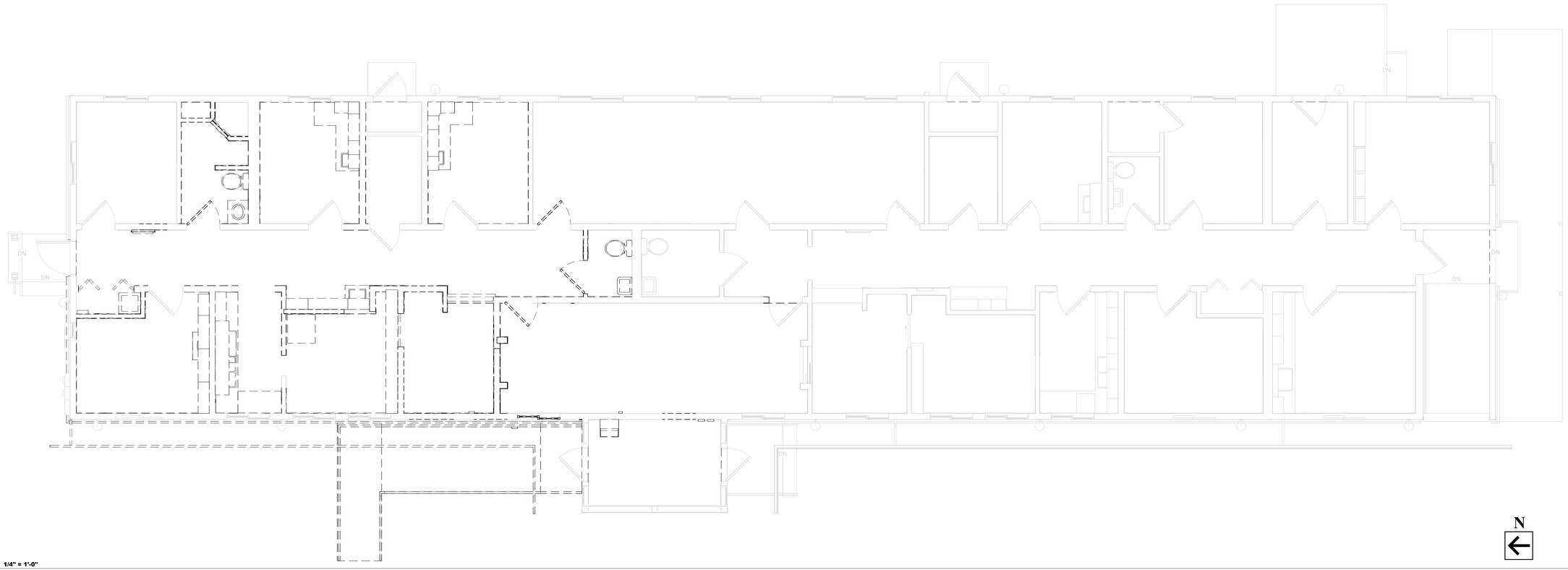

SCALE: 1/4" = 1'-0"

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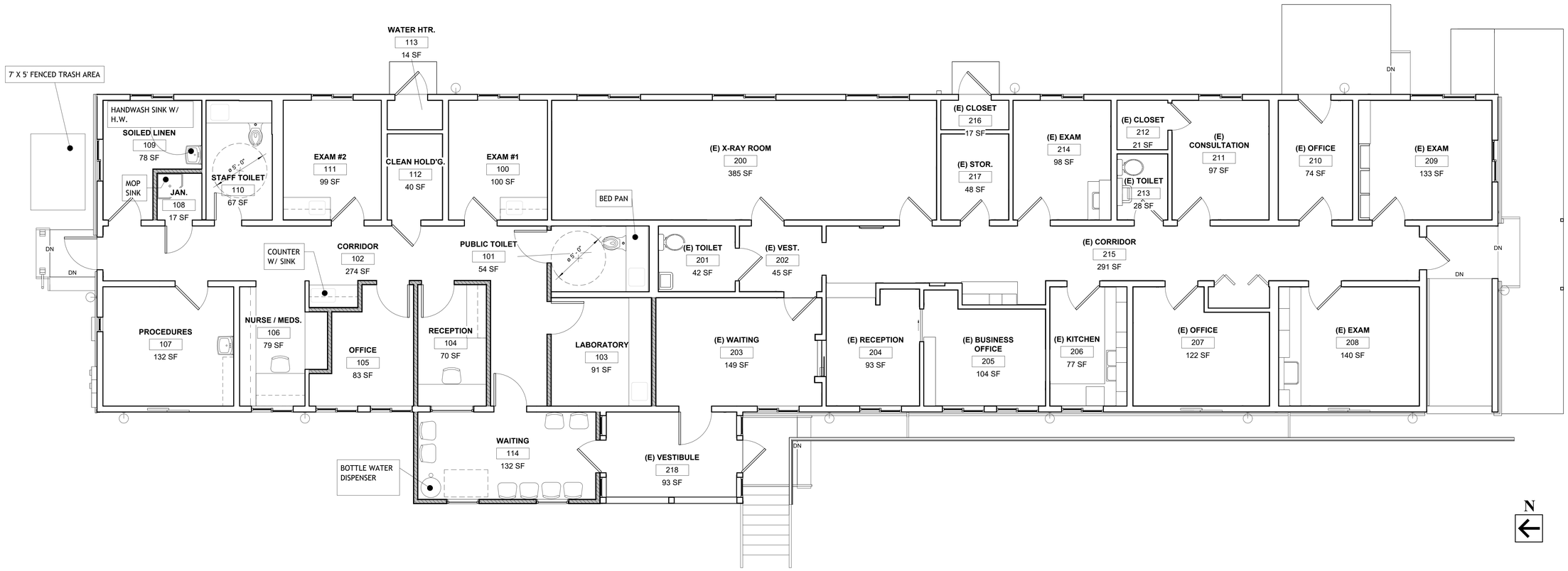

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1 PROPOSED FLOOR PLAN

OPTION (1) ON 4-30-24

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