MAYERS MEMORIAL
HEALTHCARE DISTRICT

Board of Directors
Regular Meeting Agenda
June 26, 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 –May 22, 2024		***Attachment A***	**Action Item**	1 min.
4	**DEPARTMENT/QUARTERLY REPORTS/RECOGNITIONS:**					
	4.1	Resolution 2024.09 –May Employee of the Month		***Attachment B***	**Action Item**	2 min.
	4.2	Patient Access	Amy Parker	***Attachment C***	Report	2 min.
	4.3	HIM	Lori Gibbons	***Attachment D***	Report	2 min.
	4.4	Ambulance	Gonzo Solorio	***Attachment E***	Report	2 min.
5	**BOARD COMMITTEES**					
	5.1	**Finance Committee**				
		5.1.1 Committee Meeting Report: Chair Humphry			Report	5 min.
		5.1.2 May 2024 Financial Review, AP, AR and Acceptance of Financials			**Action Item**	5 min.
		5.1.3 Annual Budget Hearing – Approval of FY2025 Budget – Resolution 2024-10		***Attachment F***	**Action Item**	2 min.
		5.1.4 TCCN Building Upgrades		***Attachment G***	**Action Item**	5 min.

	5.1.5	Radiology PACS Program	***Attachment H***	**Action Item**	5 min.
5.2	**Strategic Planning Committee**				
	5.2.1	Strategic Plan Update 2024-2029 and FY Priorities		Discussion/ **Action Item**	5 min.
	5.2.2	Master Planning Update		Discussion/ **Action Item**	5 min.
5.3	**Quality Committee**				
	5.3.1	June Quality Meeting Committee Report	***Attachment I***	Report	5 min.
6	**NEW BUSINESS**				
6.1	Policies & Procedures: Bedside Mobility Assessment Blood Culture Collection Discharge Planning -- Social Services Emergency Operations Plan: Resources and Assets Food and Nutrition in a Disaster Heat Illness Plan Microbiology Critical Results Core Privileges in Oncology One Step Fentanyl Test Dip Card (Urine) Orthopedic Surgery Core Privileges Register of Surgical Procedures Selection of Blood and Components for Transfusion Slips, Trips and Falls Program Wet Mount		***Attachment J***	**Action Item**	5 min.
6.2	MMHD Board By-Laws Update			**Action Item**	5 min.
7	**ADMINISTRATIVE REPORTS**				
7.1	Chief's Reports – ***Written reports provided. Questions pertaining to written report and verbal report of any new items***		***Attachment K***		
	7.1.1	Chief Financial Officer – Travis Lakey		Report	5 min.
	7.1.2	Chief Human Resources Officer – Libby Mee		Report	5 min.
	7.1.3	Chief Public Relations Officer – Val Lakey		Report	5 min.
	7.1.4	Chief Clinical Officer – Keith Earnest		Report	5 min.
	7.1.5	Chief Nursing Officer – Theresa Overton		Report	5 min.
	7.1.6	Chief Executive Officer – Ryan Harris		Report	5 min.
8	**OTHER INFORMATION/ANNOUNCEMENTS**				
8.1	Board Member Message: Points to highlight in message			Discussion	2 min.
8.2	Board Governance Tool Kit – Strategic Planning			Discussion	5 min.
9	**MOVE INTO CLOSED SESSION**				

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		Hearing (Health and Safety Code §32155) – Medical Staff Credentials **MEDICAL STAFF REAPPOINTMENT** Ivy Nguyen, MD – UC Davis – Neurology David Bissig, MD – UC Davis – Neurology Gary Turner, MD - TCR Earljay Landrito, MD – TCR Farres Ahmed, MD – TCR John Erogul, MD - TCR Ryan Redelman, MD - TCR		
	9.1	Allen B. Mendez, MD - Pathology Todd Guthrie, MD – Orthopedic Surgery Nicholas Schulack, DO – Emergency Medicine Matthew Moore, DO – Emergency Medicine	**Action Item**	5 min.
		MEDICAL STAFF APPOINTMENT Ashley Delaney, DO – Emergency Medicine Stephen Williams, PA – MVHC Bradley Clark, MD – TCR Tikoes Blankenberg – Redding Pathology		
	9.2	Personnel – Govt Code 54957 CEO Evaluation Process	Discussion/ **Action Item**	30 min.
10		**RECONVENE OPEN SESSION**		
11		**ADJOURNMENT: Next Meeting** July 31, 2024		

Posted 06/21/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

Board of Directors
Regular Meeting
Minutes
May 22, 2024 – 1:00 pm
FR Boardroom

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

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

BOARD MEMBERS PRESENT:	**STAFF PRESENT:**
Abe Hathaway, President	Ryan Harris, CEO
Jeanne Utterback, Vice President	Travis Lakey, CFO
Tami Humphry, Treasurer	Theresa Overton, CNO
Jim Ferguson, Director	Valerie Lakey, CPRO
Lester Cufaude, Director	Keith Earnest, CCO
ABSENT:	Sophia Rosal, Lab Manager
	Bridget Bernier, ED Manager
	Moriah Padilla, DON Acute
	Jessica DeCoito, Board Clerk

2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS:**		
3	**APPROVAL OF MINUTES**		
3.1	A motion/second carried; Board of Directors accepted the minutes of April 24, 2024	***Utterback, Humphry***	***Approved by All***
4	**DEPARTMENT/OPERATIONS REPORTS/RECOGNITIONS**		
4.1	A motion/second carried; Karen Mayer was recognized as April Employee of the Month. Resolution 2024-07. Karen consistently goes above and beyond in her role to ensure that our vendors are paid promptly, allowing the hospital to operate smoothly. She is a true unsung hero without our organization, as her hard work often goes unnoticed by many. Karen is always willing to go the extra mile to help her colleagues, even when faced with last-minute challenges. Her dedication and positive attitude are truly admirable, and she deserved to be recognized for her outstanding contributions to our team.	***Humphry, Cufaude***	***Approved by All Cufaude - Y***
4.4	Mayers Healthcare Foundation Quarterly Report: written report submitted. spent the morning with the accountant to prepare the books for tax filing. Golf Tournament sponsorship information will go out soon, so keep your eye out for that. Health Fair information is out and book your calendars for June 22nd – sports physical and mammograms will also be there. Exciting news to share is our 2nd Annual Hospice Gala on January 25th with a chance to win a 1969 Chevy Corvette.		
4.3	Acute: written report submitted. A review of strategic priorities was provided. A steep learning curve for our nursing team and providers to adapt the workflow on providing the correct charge codes to each encounter and service. But with time, the team has been able to work through issues.		
4.4	Emergency Department: written report submitted. Review of strategic priorities. Instead of a 5% decrease, we were able to get to 14% decrease in missed or late charges. Solutions included frequently used charges for the ED team to use for the services and encounters we see in the ED.		

4.5 Lab: written report submitted. Media Lab is a software platform that we use in the lab to help us with meeting our CLIA lab certifications and inspections. Within that platform, we have our policies, competencies, etc. and makes our inspection/survey process much smoother. Sophia has been very busy with creating and implementing policies for the lab.

5 BOARD COMMITTEES

5.1 **Finance Committee**

5.1.1	**Committee Report:** Cash on hand is 250 days. Danielle Olson with the Business Office reported that we have received the LTC payments and awaits the swing bed encounter. Kristi Shultz with Retail Pharmacy provided a report on 340B. We heard from Jack Hathaway on the i2i Population Health program that will be reported on later and brought back to June's meeting.		
5.1.2	**April 2024 Financials**: motion moved, seconded and carried to approve financials.	***Humphry, Utterback***	***Approved by All***
5.1.3	**Board Quarterly Finance Review:** Motion moved, seconded and carried	***Humphry, Cufaude***	***Approved by All***
5.1.4	**I2i Population Health Cost** Benefit **Analysis:** information will be brought to the June Board meeting.		***No Action Taken***
5.1.5	**FY25 Leadership Program:** two proposals brought forward that provide two different types of leadership education. Proposal one would have Jen Miley come onsite quarterly and provide multiple days of in person and one on one education. Proposal two with HLI is a yearlong program that provides monthly, virtual classes to 15 members of our leadership team. The total for both proposals is $70,250 (plus travel).	***Utterback, Ferguson***	***Approved by All***

5.2 **Strategic Planning Committee Chair Utterback:** No Meeting held in May. June 25th, time to be determined.

5.3 **Quality Committee Report:** Discussion on the SNF Survey and how the plan of corrections will be put together. And a brief discussion took place on i2i.

6 NEW BUSINESS

6.1 **Policy & 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	***Utterback, Humphry***	***Approved by All***
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		

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		Hemoglobin – arrow goes through hemoglobin (page 2 of 8) Isolation Precautions – (page 2 of 35): Hand Hygiene "Prior to patient contact (even if gloves are worn" remove? Page number needs to be fixed Safety Management Plan – define the frequencies of regular reports (page 2 of 6) Approved above policies with amendments noted above. Policies not approved are noted with line strike through.		
	6.2	**Community Needs Health Assessment:** Previous assessment conducted in 2022 and information found is included in the packet as an attachment. Health issues identified: mental health, substance abuse, and chronic disease management. Staff will develop plans to work on programs focused on mental health and chronic disease management, while researching pathways and education for substance abuse programs.		
	6.3	**Board Member Elections: Resolution Calling for Election & Specification of the Election Order – Resolution 2024-08** Motion moved, seconded and approved	**Cufaude, Utterback**	**Approved by All**
7	**ADMINISTRATIVE REPORTS**			
	7.1	**Chief's Reports: written reports provided in packet**		
		7.1.1 **CFO:** Ambulance runs are up because we are picking up extra runs from both Burney and Adin. HQAF payments should role in soon, which will bump up our cash on hand.		
		7.1.2 **CHRO:** We have 50 applications on the dashboard for our current openings. In 2027 we will have new regulations that will require us to have RNs on staff and on the floor. We have received 5 applications for our summer internship program. Healthcare Minimum Wage Regulation update came out that would extend the deadline. Regardless, we will move forward and just make the minimum wage increase happen now.		
		7.1.3 **CPRO:** SB 525 – extended through July 1. SB 1423 – Cost Reimbursement, is projected to die. SB 1432 – seismic bill, should get through senate this week, looking like it will be passed. Clinic event today for Women's Health, passed out a booklet broken out by decades and what health concerns should be during each decade. Employee Giving – thank you to our employees who participate. Letter of Opinion received from architects that we should be able to inspect the building as permitted. A request to have another inspection has been sent to the Fire Chief. The scope of work for the TCCN Children's Program is expected to be done by the architects on June 10th with minimal updates needing to be made.		
		7.1.4 **CCO**: We will be reviewing a new PACS system for radiology. This program will allow us to move our images across to providers much easier than through a CD or flash drive. We are interviewing a physical therapist and retail pharmacist, so keep your fingers crossed.		
		7.1.5 **CNO**: CDPH was onsite today for two self-reports in FR and will head to Burney tomorrow for additional self-reports.		
		7.1.6 **CEO:** First Farmers Market was down at the lodge on Friday, May 17th, with a great turnout. He was able to get more vendors signed up that day and will have more markets planned for June, July and August. We have received one CMO application and are excited for this one application to interview. We did have our SNF and Fire Life Safety survey with one big tag, but mostly minor tags. Kudos to our team for their hard work on the surveys. Review of FR Clinic space was provided based on drawings in packet.		
8	**OTHER INFORMATION/ANNOUNCEMENTS**			
	8.1	Board Member Message: Employee of the Month, Health Fair information, Golf Tournament, Gala Date, RHC can see kids, upcoming MTCCN events, Guide to women's health booklet, and next Farmers Market		
	8.2	Board Governance Tool Kit – Board Orientation. Board Clerk and CEO to develop an orientation that includes tours of both facilities.		
9	**MOVE INTO CLOSED SESSION: 4:05 pm**			
	9.1	**Conference with Legal Counsel regarding pending litigation (§ 54956.9)**		Discussion
10	**RECONVENE OPEN SESSION: 4:25 pm**			
11	**ADJOURNMENT: 4:25 PM**			

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

_____ _____

Board Member Board Clerk

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MAYERS MEMORIAL
HEALTHCARE DISTRICT

RESOLUTION NO. 2024-09

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

Zita Biehle

As May 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, Zita Biehle is hereby named Mayers Memorial Healthcare District Employee of the Month for May 2024; and

DULY PASSED AND ADOPTED this 26th day of June 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

MAYERS MEMORIAL HEALTHCARE DISTRICT

Strategic Priorities Report

Department: Patient Access

Pillar: Growth

Priority: Front Desk to check in mobile clinic patients

Summary of Plans & Actions

I recieved training from the clinic's front desk staff on how to check in patients through Cerner and then trained each person in my department on how to do it for the mobile clinic patients.

Strategic Priorities Report

Department: Patient Access

Pillar: Quality Service

Priority: Reduce check-in times

Summary of Plans & Actions

Plan: Improve our comfort level in Cerner to become more efficient and reduce patient wait times.
The average time it took to check in patients in November 2023 was: 7 minutes and 20 seconds. In April the average time was: 2.40

Strategic Priorities Report

Department: Amy Parker

Pillar: Quality Service

Priority: Error Rate Reduction

Summary of Plans & Actions

Plan: Reduce errors that effect other departments daily functions.

Plan: I used Cerner's Discern reports to track each team members errors every month. I shared the results with them individually and provided support and extra education when needed. I used 15 markers of what I felt is the most important information that needs to be captured. As a department our error rate was 27% for the month of November 2023 and by April we were down to 15%. I plan to continue to run the report but I will focus on specific areas of weakness for each individual going forward.

Strategic Priorities Report

Department: Patient Access

Pillar: Quality Service

Priority: HIPAA Training

Summary of Plans & Actions

I coordinated a meeting with Jack Hathaway and the Patient Access Department to address staff concerns. We learned which patient/visitor questions we can answer ourselves and which ones we should direct to someone else.
We moved the visitor check-in kiosk away from the front desk where patients are being checked in.
We have ordered privacy screens that reduce visabilty for anyone other than the person sitting directly in front of the computer screen.

MAYERS MEMORIAL HEALTHCARE DISTRICT

Strategic Priorities Report

Department: HIM

Pillar: People

Priority: Cross train Out-pt coding (labs, x-ray)

Summary of Plans & Actions

Cross train HIM staff members on Out Patient coding for vacation coverage and absence of lead coder. Monitor and work CRC edit list weekly for an end month goal of $150,000 or less.

Completed 9/2023

I have trained Kelcey on out pt coding for lab and xrays as she was currently going to college for HIM and medical coding. She picked up on it very quickly and has now resumed the responsibilty of those encounters for coding. Goal for this next year is to have her certified in coding as well as clinical coding for our own clinic.

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Strategic Priorities Report

Department: HIM

Pillar: People

Priority: Cross train UR nurse in ROI's for utilization reviews

Summary of Plans & Actions

Cross train the UR nurse on ROI's for insurance and pre authorization on admission status in the Cerner system.

Completed 2/2024

The UR nurse Jen was shown how we do the ROI's and tracking in Cerner. Fortunately for us she has worked in Cerner before and is comfortable in what information she sends out and how to use the Cerner system for those releases. We have make sure that we can show a accounting of disclosures on any records we send out if requested by patient or State. The Cerner system is a bit more challenging in being able to run a report on this but it can be done..

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Strategic Priorities Report

Department: HIM

Pillar: People

Priority: Cross train ROI's

Summary of Plans & Actions

Cross train an admission desk staff member the process for completing ROI's in the absence of HIM staff.

Completed 1/2024

We have cross trained one of the admitting staff to learn the process of completing and tracking ROI's that come in to the HIM dept. and she also helps answer the phone when HIM staffing is low or absent.

Strategic Priorities Report

Department: HIM

Pillar: People/Quality

Priority: Cancer registry spreadsheet

Summary of Plans & Actions

Create and maintain a spreadsheet that documents patient MR#, Cancer DX, date reported and encounter reported. We have to keep a running track system for Cancer Registry reporting. This will replace the old Rolo-dex cards.

Completed 11/1/2023

We transferred all previous reported cancer patients from the rolodex cards and created an excel spread sheet. We run the cancer DX report monthly out of Cerner and Paragon (as we still have SNF encounters for LTC in paragon) and compare to our already reported spreadsheet. All new cancer DX patients are reported to Cancer Registry, entered on the spreadsheeet for tracking purposes. THis is to help ensure patients are not lost in the system and are being followed or recieving treatment for their cancer dx wherever they are if they choose to seek treatment.

AMBULANCE DEPARTMENT BOARD REPORT

Background: On June 26, 2023, SEMSA ceased ambulance operations and MMHD took over EMS. Careflight Ground began to help MMHD with the set up and permitting process with S-SV EMS. After a few weeks it was decided to not partner with a third-party and run the ambulance as MMHD ambulance. This move improved morale as there were some staff doubting the success under a third part again. S-SV EMS was great to work with and helped us to get up and running.

Initial challenges: Training for staff, ***FINDING STAFF***, it was difficult to find staff that was a good fit for Mayers with our mission and vision and values. We did not want to settle for just anyone to fill a void. With support from the ELT we were able to accomplish that. We have a great team that works well with each other and other agencies, which reflects well on MMHD.

Training: We started doing in-house in services for our ambulance crews to ensure competencies and be compliant with training regulations. Examples are EVOC (Emergency Vehicle Operations Course), airway management, use of cardiac monitors and AED's, documentation.

Ambulance Billing: MMHD had not been running the ambulance for a few years, so we had to learn how to properly bill again. Charges had to be updated, correct charge codes changed as needed, learn how to input charges in Cerner and work with Cerner to build the correct charge modules for ambulances. To improve this process and reduce delays in getting reimbursement, we have started training other staff to do ambulance billing. This is still a work in progress, but we are making progress.

Future goals: Continue with staff training, plan interdepartmental training, forge and strengthen partnerships with neighboring agencies, continue to track ambulance documentation and billing to improve reimbursements, set goals with the ambulance staff to ensure we continue to provide quality care to our community, participate in public events such as health fairs, disaster trainings, MCI trainings.

Ambulance Calls YTD 06/26/2023-Current: 677, May 24- 17 IFT, 64 calls

RESOLUTION NO. 2024-10

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

WHEREAS, the Governing Board of Directors is responsible for the preparation and adoption of a final budget, which provides a financial plan, including estimated revenues, expenditures and reserves, for operation during the fiscal year July 1 through June 30.

WHEREAS, the budget submitted is required by law to be a balanced operating budget for year July 1, 2024 through June 30, 2025; Total Net Patient Revenue $48,470,485 with a bottom line of $4,482,930.

NOW, THEREFORE, the undersigned certifies and attests that the above resolution was approved at a regular meeting of the Board of Directors, Fall River, California, the 26th day of June 2024.

PASSED AND ADOPTED on June 26, 2024, by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

_____ _____

Date

Abe "Jerry" Hathaway, President
Board of Directors
Mayers Memorial Healthcare District

_____ _____

Date

Tami Vestal-Humphry, Treasurer
Board of Directors
Mayers Memorial Healthcare District

FISCAL YEAR July 1, 2024- June 30, 2025
BUDGET

APPROVED AND ADOPTED AT THE BOARD OF DIRECTORS' REGULAR MEETING
THIS 26th DAY JUNE 2024.

_____
Abe "Jerry" Hathaway, President
BOARD OF DIRECTORS
MAYERS MEMORIAL HEALTHCARE DISTRICT

_____
Tami Vestal-Humphry, Treasurer
BOARD OF DIRECTORS
MAYERS MEMORIAL HEALTHCARE DISTRICT

Budget Prepared By:

MAYERS MEMORIAL HEALTHCARE DISTRICT

(Attachment: FY2025 Operating Budget)

MAYERS MEMORIAL HOSPITAL
OPERATING BUDGET

	Actual YTD May	PROJ ACTUAL FYE '24	BUDGET FYE 2025	DIFF	DIFF %	Notes
REVENUE:						
Medical/Surgical	13,214,714	14,416,052	13,695,250	(720,803)	-5.00%	Acute and Swing Days were higher than normal
Skilled Nursing	14,928,618	16,285,765	16,448,622	162,858	1.00%	Census should increase slightly
OP Services	30,217,165	32,964,179	34,612,388	1,648,209	5.00%	Surgery is going again and we are aiming for a 5% increase in visits
Total Patient Revenue	58,360,497	63,665,996	64,756,260	1,090,264	1.71%	
DEDUCTIONS FROM REVENUE:	FY 23 May Contractuals					
Contractual - Medicare/Medi-Cal	8,511,035	9,284,766	10,213,242	928,477	10.00%	Actually modeling off of past years as this year was an anomoly given the amount of supplementals
Contractual - PPO	3,404,703	3,714,221	3,862,790	148,569	4.00%	Up due to processing more payments from a larger AR
Charity and Other Allowances	115,916	126,454	132,776	6,323	5.00%	Trying to promote Charity, Discounts and Vouchers
Admin Adjmts/Employee Discounts	1,054,954	1,150,859	1,219,911	69,052	6.00%	Up due to our higher AR being worked down
Provision For Bad Debts	755,418	824,093	857,056	32,964	4.00%	Up due to a higher AR
Total Deductions	13,842,026	15,100,392	16,285,775	1,185,383	7.85%	Our average total contractuals are 25% over the last 6 years with Supplemental Payments factored in.
Net Patient Revenues	44,518,470	48,565,604	48,470,485	(95,119)		
OTHER OPERATING REVENUE:	669,074	729,899	737,198	7,299	1.00%	
Net Revenue	45,187,544	49,295,503	49,207,683	(87,820)	-0.18%	
OPERATING EXPENSES:						
Salaries & Wages	20,175,646	22,009,795	23,550,481	1,540,686	7.00%	Up due wage increases and replacing of registry staff
Employee Benefits	4,183,390	4,563,699	4,700,610	136,911	3.00%	Smaller increase due to being self funded
Supplies	3,897,530	4,251,851	4,485,703	233,852	5.50%	Projecting a smaller increase more in line with Pre-Covid years. Also less inpatient days so we should need less supplies there.
Professional Fees	1,335,176	1,456,556	1,675,039	218,483	15.00%	Up due to the addition of Surgery Pro Fees
Acute/Swing Purch Serv	774,546	844,959	760,463	(84,496)	-10.00%	Down due to more employed staff
SNF Purch Serv	3,556,918	3,880,274	3,996,683	116,408	3.00%	Up due to loss of C.N.A program
Ancillary Purch Serv	1,493,966	1,629,781	1,466,803	(162,978)	-10.00%	Down due to more employed staff
Other Purch Serv	1,851,174	2,019,462	2,080,046	60,584	3.00%	Estimate a slight increase due to consultants to try fix our Cerner issues
Repairs	425,880	464,596	487,826	23,230	5.00%	Up due to aging plant and infrastructure
Utilities	1,081,310	1,179,611	943,689	(235,922)	-20.00%	Decrease due to solar
Insurance	606,612	661,758	668,376	6,618	1.00%	Rate increases on the liability side due to more Acute/Swing days and ER visits
Other	1,723,293	1,879,956	1,936,355	56,399	3.00%	Up due to manager training
Depreciation	1,672,769	1,824,838	1,943,453	118,615	6.50%	Increased due to solar project
Bond Repayment Interest	658,418	718,274	861,928	143,655	20.00%	Used actual debt service numbers
Interest	73,113	79,760	80,557	798	1.00%	Based off historical averages
Rental & Leases	107,980	117,796	120,741	2,945	2.50%	Based off historical averages
Total Operating Expenses	**43,617,720**	**47,582,967**	**49,758,752**	**2,175,785**	**4.57%**	Total
Net Operating Revenue or (Loss)	**1,569,825**	**1,712,536**	**(551,070)**	**(2,263,606)**	**-132.18%**	Net Revenue minus Total Operating Expenses
NONOPERATING REVENUES AND EXPENSE:						
District and County taxes	863,000	941,455	1,100,000	158,545	16.84%	This is a historical average. It only shows as an increase because we haven't gotten our June payment yet
Interest Income	834,866	910,763	956,301	45,538	5.00%	Higher due to increased funds
Other Non-operating rev	3,956,624	2,919,313	2,977,699	58,386	2.00%	Forecasting higher revenue in the Retail Pharmacy
Other Non-operating expense	3,255,368	3,551,310	3,728,876	177,566	5.00%	Increased due to forecasted drug costs for the Retail Pharmacy
Total Nonoperating Revenue	**5,654,490**	**4,771,530**	**5,034,000**	**262,470**	**5.50%**	Down due to not having Provider Relief Funds
PROFIT or (LOSS)	**7,224,315**	**6,484,066**	**4,482,930**			Projecting a positive bottom line, using contractuals from past years so the profit numbers in May and projected won't match financial statements

Aspen Street ARCHITECTS
Architecture • Planning • Feasibility Studies

June 16, 2024

Valerie Lakey, Chief Public Relations Officer
Mayers Memorial Hospital
PO Box 459 / 43563 Highway 299E
Fall River Mills, CA 96028
(530) 519-5041

Project Title: **Burney, 37477 Main Street Child-Care Building - Permitting Documents**

Valerie,

Aspen Street Architects (Consultant) is pleased to submit this proposal for professional design services related to the permitting submittal requirements for the previous TCCN Building to accomplish planned change of use and document unpermitted work.

As noted in the Scoping letter, there are 3 permits required.

1. Tenant Improvement permit for the 1991 Addition (Assembly A-occupancy)
    a. Document current unpermitted Lighting Replacement
    b. Provide means to lock/secure the area from access to the original building side
2. Tenant Improvement/change of use 1980 Original Building
    a. Change the use of the 2nd floor from the previous B-occupancy bank use to a B-occupancy office use.
    b. Document the previous unpermitted changes made to the original building side. Which includes the built walls to enclose the entry foyer, the demolition of rooms, and the conversion of the vault into an office.
3. Tenant Improvement permit for the 1980 Original Building side to convert to E-Occupancy Child-Care
    a. To include toilet room additions and remodels.
    b. To include owner requested washer/dryer area.

Scope of Work:

Design services. Consultant to provide design documents and make 3 separate submittals to the local jurisdiction for the 3 permits noted above. Includes sub-consulting engineering as necessary; electrical and mechanical/plumbing design.

Consultant includes a site visit to review existing conditions with engineering subconsultants as needed. Client to provide any available reference documents (already provided available information).

Permit #1 includes electrical for the lighting replacement and required Title 24 energy compliance forms, as well as installation of a new control door between the two building halves and lockable hardware.

Permit #2 includes architectural documentation for the change of use on the 2nd floor, as well as documentation of previous changes (demo and foyer wall installation) and the conversion of the previous bank vault to an office.

Permit #3 includes architectural, electrical and mechanical/plumbing design for the toilet room additions and alterations in the concept floor plan. No exterior changes are assumed. Mechanical design is related to exhaust system changes/additions, it is assumed the existing HVAC systems are adequate. Electrical assumes adequate capacity for the required changes in the existing electrical system.

Consultant to make submittal the local jurisdiction (Shasta County) for plan review and permitting. Client to pay all fees.

Bidding services include responses to questions from contractors. More extensive bidding can be provided if required, as additional services.

Construction Administration (CA) is provided. It is assumed basic CA, limited to responding to contractor RFIs and submittals. Fee is noted as time and materials (T&M), and only actual hours to be billed as needed.

Fee Proposal

Consultant to proceed on a fixed fee basis for design and plan review/approval. Construction Administration to be on a T&M basis, estimated at $7,500. Proposed fee is exclusive of typical reimbursable expenses (required mileage, printing, etc), which will be billed per the attached rate schedule.

		design	agency review	con admin	subtotal
architectural	Aspen Street	$ 25,900	$ 4,440	T&M	$ 30,340
subconsultants					
structural	n/a				$ -
mechanical	Nexus				$ 6,400
electrical	Edge				$ 14,000
subconsultant subtotal					$ 20,400
consultant markup	15%				$ 3,060
Total					**$ 53,800**

This proposal is valid for the next 90 days. Please provide a written authorization to proceed with work if the above meets your approval.

Thank you for considering Aspen Street Architects for this project. We look forward to working with you.

Respectfully,

Nathan A. Morgan
President

Aspen Street Architects, Inc.
Rate Schedule

Hourly Rates for Professional Personnel

Principal/Architect	240.00	Certified Access Specialist (CASp)	200.00
Senior Architect	230.00	Senior Planner	240.00
Architect IV	210.00	Facilities Manager	180.00
Architect III	180.00	Sr Project Manager	185.00
Architect II	160.00	Project Manager	165.00
Architect I	150.00		
Architect Intern II	145.00	Construction Contract Administrator	130.00
Architect Intern I	135.00	Project Administrator	100.00
Sr. Job Captain	135.00		
Job Captain	120.00		
Senior Production	120.00		
Production	105.00		

Consultants Fees Under Contract:

Billed per consultant's invoice, plus 15% coordination fee.

Reimbursable Expenses Not Included in Contract:

Engineering Xeroxes (white 24" x 36")	$ 5.00/each
Engineering Xeroxes (white 30" x 42")	$ 7.50/each
Color Printing (8.5”x11”)	$ 1.50/page
Color Printing (11”x17”)	$ 2.75/page
Photocopies	$ 0.20/each
Data Disc	$ 2.50/each
Report Binding	$ 5.50/each

Miscellaneous reimbursable charges, including but not limited to, photographs, outside printing, maps, renderings, postage and freight will be billed at actual cost plus 15%. Travel expenses will be billed at actual cost plus 15%.

Clients will be billed monthly for services rendered. Payment is due upon receipt of invoice. Invoices which remain unpaid after thirty days are considered past due and subject to a service charge of 1.5% per month, which is an annual rate of 18%. If Client believes a billing error has occurred, or if Client requires additional information regarding an invoice, Client agrees to inform Aspen Street Architects in writing within ten days of invoice date. If Client does not inform Aspen Street Architects of any disputes within ten days, charges will be deemed correct.

The rates will remain in effect until December 31, 2024 and are subject to adjustment thereafter.

June 14, 2024

Valerie Lakey, Chief Public Relations Officer
Mayers Memorial Hospital
PO Box 459 / 43563 Highway 299E
Fall River Mills, CA 96028
(530) 519-5041

Project Title: **Burney, TCCN Building 37477 Main Street, Building Permitting/Scoping**

Valerie,

The subject building was originally built in 1980 as a bank (B-occupancy). In 1991 a use permit and addition project were completed. The use permit conditioned a change of use of the building to a Community Center with Child-Care use, and approved the addition as a Senior Nutrition Center. A subsequent construction project was permitted for the addition and completed. The building has been in use since this time as the Community Center.

Mayers Memorial has recently acquired the building and desires to continue the use of the building as Child-Care and After School Programs, as well as for community events and programs in the addition. It is noted there is office space on the second floor that is related to the Child-Care use.

While applying for the child-care license through the state, the fire inspector performing his required inspection for licensing note that the use of the building was never "officially" changed from the previous bank use to the child-care use. And as such was not permitted for the proposed use. After visits and discussions with both the County Building Department and Local Fire District, the following steps have been determined advisable to allow the desired use.

1. <u>Tenant Improvement permit for the 1991 Addition (Assembly A-occupancy)</u>

    a. Document current unpermitted work – Lighting Replacement in the main dining area. This will require design documents and updated Title 24 (interior lighting) energy compliance forms.
    b. Provide means to lock/secure the area from access to the original building side – as required by the Fire Marshal (FM) due to the use not be permitted.
        i. To achieve this, it is proposed to install a control door at the end of the toilet room hallway to separate the bank side from the A-occupancy, with these toilet rooms accessible from the A-occupancy side.
        ii. Locking hardware will be included, as well as verified on the other 2 existing doors between the two occupancies, so that the original building side can be secured from the A-occupancy side.
    c. Related to this is the FM comment to ensure the fire alarm system is operational. It is recommended that your fire alarm vendor test the system and provide a report.

2. <u>Tenant Improvement/change of use for the 2nd floor Original Building</u>

a. The intent is to change the use of the 2nd floor from the previous B-occupancy bank use to a B-occupancy office use. This is intended to allow the hospital to utilize for office space as desired most promptly.
    i. This will require an analysis of the office use on this floor to include exiting requirements.
    ii. It is also assumed that this project will document the previous unpermitted changes made to the original building side. Which includes the built walls to enclose the entry foyer, the demolition of rooms, and the conversion of the vault into an office.

3. Tenant Improvement permit for the 1980 Original Building side to convert to E-Occupancy Child-Care

    a. Although this was conditioned in the use permit approved in 1991, a subsequent construction project does not appear to have been permitted. Our initial contracted scope at this time is to provide an analysis of the Child-Care requirements and develop a scope for what this project would encompass, and then to provide a design proposal to assist in the permitting.

    b. To convert to a E-occupancy Child-Care use, the main scope elements are:
        i. Children toilet rooms
            1. Add 2 new toilet rooms for pre-school (single occupant).
            2. Add 2 new toilet rooms for K-6th (single occupant).
            3. This includes minor demolition, new framing, finishes, plumbing, mechanical, electrical, lighting, accessories, signage.

        ii. Staff toilet rooms
            1. Modify 2 existing toilet rooms to create 1 accessible staff toilet room on the 1st floor (single occupant).
                a. Other staff toilet rooms are on 2nd level, ok as is (non-accessible)
                b. The 2 existing multi-fixture toilet rooms on the 1st floor are a part of the A-occupancy 1991 Addition and not included in the toilet count for the child-care side.
            2. Modify plan to utilize the remainder of the available space in this area for an owner-requested washer/dryer area.
            3. This includes demolition, new framing, finishes, plumbing, mechanical, electrical, lighting, accessories, signage.

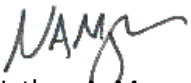
        iii. Fire/Life Safety (FLS) Compliance
            1. It appears from the site visit, review of available information, and Building Standards Code analysis that the building meets the requirements for fire-life safety as is. The Tenant Improvement plans will indicate the requirements for exiting, occupancy separation, and FLS features.
                a. The only item that may be questionable is the Fire Alarm system. It is advisable that your Fire Alarm vendor review the existing system and provide an operational report documenting the system and any issues that may need resolution.

iv. Title 22 Code Requirements

1. It appears from the site visit and review of Title 22, that the space meets the requirements as outlined for Building/Grounds, Outdoor Activity Space, Indoor Activity Space, Storage Space, Fixtures/Furnishing/Equipment/Supplies, and Drinking Water, with the exception of the required toilet rooms as noted. The Tenant Improvement plans will indicate physical items that meet code requirements to assist in jurisdiction and licensing review.

Thank you for considering Aspen Street Architects for this project. We look forward to working with you.

Respectfully,



Nathan A. Morgan
President

Attachments:

Appendix A – Code Review Notes
Appendix B – Concept Floor Pla**n**

APPENDIX A – CODE REVIEW NOTES

Review of the 2022 CA Building Standards Code, Title 24, Part 2 – California Building Code

1. Section 452 School Facilities for Kindergarten Through 12th Grade and Group E Child Care
    a. Section 452.1.1 Location on Property – shall front directly and exit on a public street - compliant
    b. Section 452.1.4 Special Provisions – rooms used for Group E Child-care shall not be located above or below the first story – compliant

2. Table 508.4 Required Separation of Occupancies
    a. Between E (Child-care) and the adjacent A occupancy – no rated separation required – compliant

3. Section 907.2.3 Group E – Fire Alarm
    a. **For new buildings** - An automatic fire alarm system that initiates the occupant notification signal utilizing an emergency voice/alarm communication system meeting the requirements of Section 907.5.2.2 and installed in accordance with Section 907.6 shall be installed in **Group E occupancies** with an occupant load **of 50 or more persons** or containing more than one classroom or one or more rooms used for Group E or I-4 child-care purposes in accordance with this section. Where automatic sprinkler systems or smoke detectors are installed, such systems or detectors shall be connected to the building fire alarm system. One additional manual fire alarm box shall be located at the administration office or location approved by the AHJ.
        i. Building has some sort of fire alarm system now. FM has indicated it needs to be operational. Recommend have FA company review the existing system, and provide operational report.

4. Chapter 10 Means of Egress
    a. Exiting
        i. Table 1006.2.1 Occupant load greater than 49, 2 exits required – compliant
            1. Maximum common path of travel, occupant load greater than 30 = 75 feet – compliant
        ii. 10007.1.1 – Exit Separation, where 2 exits required they shall be placed a distance apart equal to not less than ½ the length of the maximum overall diagonal dimension of the building or area served – this is for the 1st floor - compliant
        iii. Table 1006.3.4 Stories with one exit or access to one exit for other occupancies - 1st story above grade (2nd story) E occupancy maximum occupant load 49, 1 exit allowed – compliant

Title 22, Division 12 Chapter 1 Child Care Center General Licensing Requirements, Article 7. Physical Environment

1. 101238 – Buildings and Grounds

a. Cleaning Solutions, other items that could pose a danger if readily available to children shall be stored where inaccessible to children. Poisons shall be in locked storage areas. Medicines shall be stored separately from items cleaning solutions/etc. Cleaning solutions/etc shall not be stored in food-storage areas or in areas used by or for children.
    i. It is assumed these locations exist and will simply be noted on the plan submittal - Owner to confirm locations

2. 101238.2 – Outdoor Activity Space
    a. Required to have 75/sf per child of outdoor activity space based on licensed capacity. 59 licensed capacity – requires 4,425sf.
        i. Existing yard is approximately 150' x 25' = 11,250 sf – in excess of requirement - compliant
    b. Required to have shaded area
        i. Existing yard has shaded areas, built shade structures - compliant
    c. Permit children to reach the outdoor activity space safely
        i. Staff escorts children to the area
    d. Areas around and under high climbing equipment, swings, slides and other similar equipment shall be cushioned with material that absorbs falls. Sand, woodchips and pea gravel, or rubber mats are permitted.
        i. Appears to have wood chips - compliant
    e. The playground area shall be enclosed by a fence
        i. Has existing fence of proper height - compliant

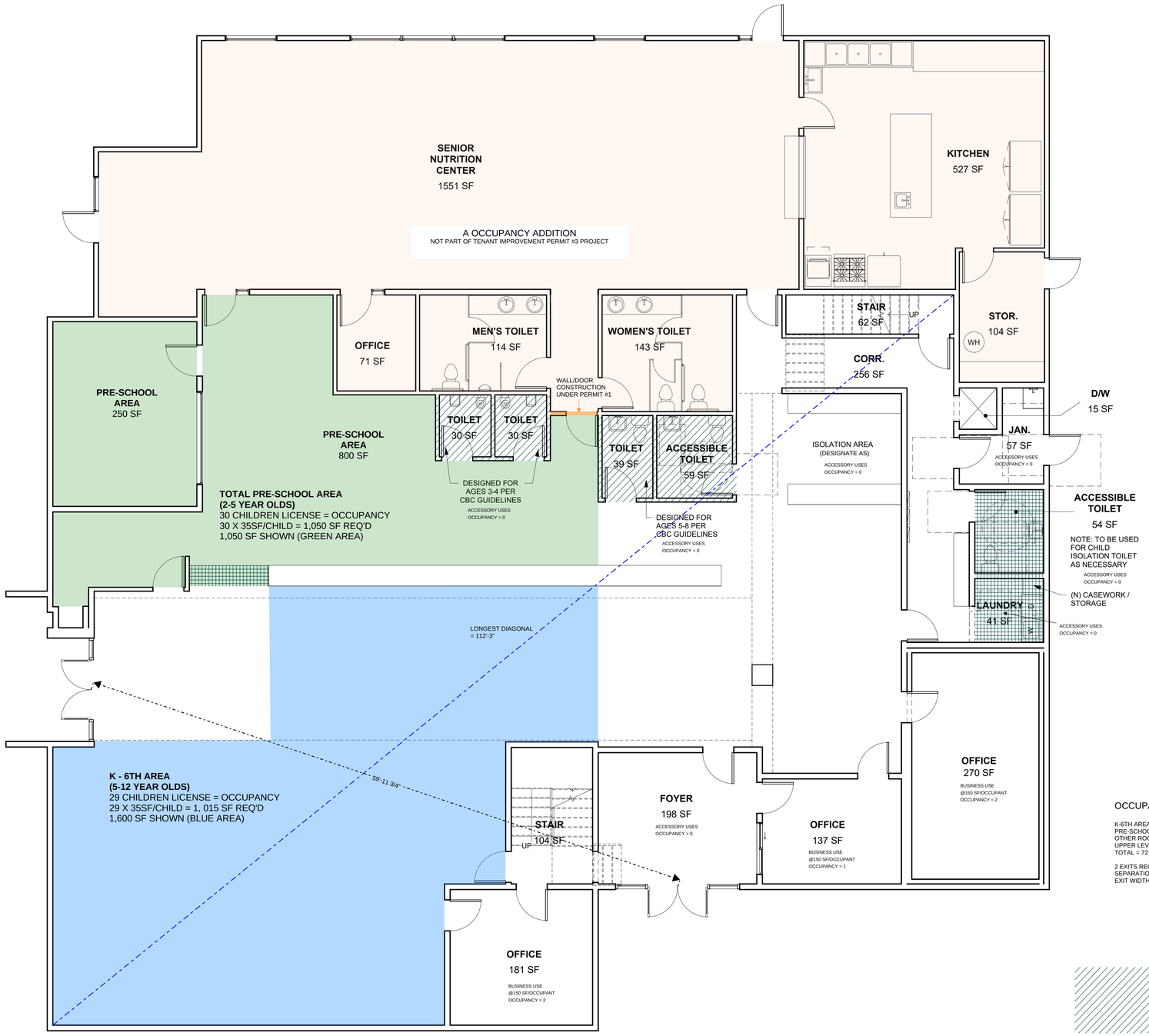
3. 101238.3 – Indoor Activity Space
    a. Required to have 35/sf per child of indoor activity space based on licensed capacity. 59 licensed capacity – requires 2,065sf.
        i. Existing floor space is in excess of 3,600 sf – in excess of requirement - compliant

4. 101238.4 – Storage Space
    a. Each child required to have individual permanent or portable storage space for clothing, personal belongings and/or bedding.
        i. We'll need to indicate on the plan where this is. There appeared to be quite a bit of this.
            1. Owner to confirm locations
    b. There shall be permanent or portable storage space in the playroom for play materials and equipment
        i. We'll need to indicate on the plan where this is. There appeared to be quite a bit of this.
            1. Owner to confirm locations
    c. Napping Equipment stored when not in use
        i. We'll need to indicate on the plan where this is. There appeared to be quite a bit of this.
            1. Owner to confirm locations
    d. Combustibles, cleaning equipment and cleaning agents stored in an area separate from food supplies in locked cabinet or location inaccessible to children.

i. We'll need to indicate on the plan where this is. There appeared to be quite a bit of this.
    1. Owner to confirm locations

5. 101239 – Fixtures, Furniture, Equipment and Supplies
    a. A comfortable temperature for children shall be maintained at all times – betw 68-85 degrees
        i. Will have mechanical indicate this with the existing equipment
    b. Window screen in operable windows
        i. Will provide note on plans
    c. Lamps or lights in all spaces
        i. Will provide note on plans
    d. Faucets used by children for personal care shall deliver hot water – betw 105-120 degrees
        i. Will have mechanical indicate this with the existing and new plumbing
    e. Solid waste shall be stored, located and disposed appropriately
        i. Existing dumpster area will be indicated in parking area
    f. Toilet facilities – based on licensed capacity, one toilet and one handwashing fixture for every 15 children
        i. Pre-school 30 = 2
        ii. K-6th 29 = 2
        iii. Plan on adding 4 separate single use toilet rooms sized for the 2 age groups to meet this requirement
    g. Ill child facilities – there shall be one toilet and handwashing fixture, separate from and in addition to the numbers above, for children who are ill, for use by staff, and for emergency use. This shall be conveniently located to the isolation area.
        i. Intending to convert the existing 2 toilets, to a single accessible toilet room to meet his requirement, as well as the accessible staff toilet requirement.
    h. Playground equipment – securely anchored to ground
        i. Assuming it is and will indicate as such
    i. Materials – all materials and surfaces accessible to children shall be free of toxic substances
        i. Will indicate no hazardous/toxic materials used in the building

ii. 101239.2 - Drinking Water
    1. Drinking water from a noncontaminating fixture or container shall be available in indoor and outdoor activity areas
        a. Need to review what this is in both indoor and outdoor and indicate on plan
        b. Anchored steps or broad based platform if drinking fountain is high
        c. Bottled or portable containers ok



CONCEPT PLAN - PERMIT #3

OCCUPANT LOAD ANALYSIS

K-6TH AREA = 29
PRE-SCHOOL AREA = 30
OTHER ROOMS = 5
UPPER LEVEL = 8
TOTAL = 72

2 EXITS REQUIRED (1ST FLOOR) - PROVIDED
SEPARATION LESS THAN 1/2 LONGEST DIAGONAL DISTANCE
EXIT WIDTH MINIMUM MET

LEGEND

NEW CONSTRUCTION

ALTERATION AREA

1 PROPOSED FLOOR PLAN
3/16" = 1'-0"

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Angels Camp, CA 95222
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www.aspenstreetarchitects.com

NOT FOR CONSTRUCTION

BURNEY TCCN DAY CARE

PROJECT SCOPING
37477 MAIN ST
BURNEY, CA 96013

KEY PLAN

AGENCY APPROVALS

AGENCY NO.

PROPOSED FLOOR PLAN

DRAWING TITLE

JOB: 98013.13

SCALE: AS SHOWN

DR. BY:

ISSUED FOR DN

A-100.2

SHEET NO.

PACS Summary

Limitations of the Ambra PACS Solution:

1. Image Exchange Platform Focus:
    - Ambra was primarily designed as an image exchange platform, not a comprehensive PACS system.
    - This limited focus restricts its functionality for managing and correcting patient information and image assignments.
2. Risk of Critical Findings Misassociation:
    - The inability to make corrections within the Ambra system poses a significant risk.
    - Critical findings might inadvertently get associated with the wrong patient, potentially leading to serious clinical implications.
3. Complex Workflow and Error Opportunities:
    - Ambra's workflow involves multiple manual steps, which can be cumbersome.
    - Especially with frequent onboarding of travel technologists, this complexity increases the chances of errors.
4. Lack of Cerner EMR Integration:
    - Ambra's lack of integration with your Cerner EMR hinders efficient access to patient images.
    - Providers cannot seamlessly review images within their primary clinical system.

Benefits of Transitioning to a Dedicated PACS System:

1. Improved Data Accuracy:
    - With our own PACS system, we will have the ability to review and correct patient information and image assignments before radiologists interpret studies.
    - This ensures data accuracy and patient safety.
2. Streamlined Workflow:
    - A dedicated PACS system streamlines our workflow by reducing manual steps.
    - Fewer opportunities for errors lead to better efficiency.
3. Cerner EMR Integration:
    - Integration with Cerner EMR empowers providers to access and view patient images directly within their clinical workflow.
    - Seamless access improves patient care and overall efficiency.
4. In-House Management and Control:
    - Managing our PACS system in-house provides greater control, flexibility, and responsiveness.
    - Relying less on third-party platforms enhances Mayer's autonomy.
5. Electronic Study Sharing:
    - Sending studies electronically to other organizations' PACS systems eliminates the need for burning CDs/DVDs and using FedEx.
    - It's a more efficient and eco-friendly approach.

In conclusion, I believe transitioning to our own PACS system will provide significant benefits to Mayers, including improved patient safety, enhanced clinical workflows, and greater control over our imaging data and processes.

PACS Vendor Comparison:

1. OnePACS:
    - **Pros:**
        - Currently used by our Tele Rads.
    - **Cons:**
        - **Lack of Integration with Cerner:** OnePACS does not integrate with our existing Cerner system, which is a critical requirement.
        - **Inadequate Fulfillment:** It wouldn't fully meet our needs.
2. Fuji Synapse PACS:
    - **Pros:**
        - **Cost-Effective:** Over the long term, Fuji Synapse PACS proves to be more budget-friendly. After year 5 the annual cost drops to $16,416
        - **Integration Potential:** Working with our IT department, Fuji indicated we could use our existing interface. The only way this would not be true is if Fuji needs a segment that we are not currently getting from Cerner. We estimate with about a 90+ percent chance that we will be able to do this without engaging Cerner.
        - **Electronic Study Sharing:** Sending studies electronically to other organizations' PACS systems reduces the need for physical media and shipping.
    - **Cons:**
        - Specific pricing and implementation details require thorough assessment(see table)
3. Sectra PACS:
    - **Pros:**
        - **Viable Option:** Based on the information provided, Sectra PACS seems like another viable choice.
        - **Best in KLAS:** Sectra is ranked #1 in PACS for smaller hospitals.
    - **Cons:**
        - Specific pricing and implementation details require thorough assessment(see table)
        - After year 5, the annual cost will not decrease and we would continue to pay the higher rate of $46K+ annually.

Why Choose Fuji?

- Synapse is Clientless and Zero Footprint with server side rendering of studies, which means there are not thick client software upgrades to manage with all Mayer's workstations, during implementation nor with every upgrade release

- Synapse SAAS is Mayer's owned at the end of the term and only annual support paid post term.
    - Sectra SAAS is paid in perpetuity and therefore TCO increases over time

- Synapse is well proven with Cerner integrations and many sites as well as Cerner CommunityWorks

- Synapse PACS project can start within 30 days of PO. All project professional services hours and training are included in our quotes. Fuji does will not come back and ask for additional money to cover unidentified project professional services and training
    - Sectra is often 12mo+ on projects due to a lack of resources
    - Sectra is now using 3rd party dealers to help with smaller implementations, which means community hospitals gets less trained resources assigned **(technoLOGIX)**
    - Sectra routinely asks for additional project dollars and training dollars and even calls this out in their PACS contract

3.1.4 A Service Ticket that runs over 10 hours will be treated as a project and billed separately

- Synapse has many future expansion opportunities as Mayers grows including Fuji developed Cardiology, 3D and #1 VNA for 5 Consecutive Years
    - Sectra's Cardiology solution is a 3rd Party software made by TomTec, which is owned by Philips Healthcare
    - Fuji coded 3D with over 50 different modules
    - Synapse AI Orchestration is strong and integrated with 45+ AI Vendors

- Fuji has had an AI Orchestrator which we can embed in PACS. We take the vendors AI and drive the PACS worklist priority and AI findings to assist clinicians. We have currently validated 45+ Vendors AI and that is growing. We are happy to validate any AI vendor you are considering.
    - For example:
        - With AIDoc and Fuji PACS - a highly likely stroke can automatically triage stroke team communications and prioritize a Rad to read that study.
        - With Gleamer and Fuji PACS will highlight fractures in the ER and for the Radiologist, which is helpful for hairline fractures and trauma cases
        - Hologic Profound AI with Fuji PACS will assist with early detection of breast cancer

Recommendation

I recommend moving forward with Fuji Synapse PACS. This system offers several key advantages over the Sectra PACS:

- After the fifth year, the cost of ownership drops to approximately $16,000 annually, compared to Sectra's $45,000 annual cost.
- Fuji Synapse integrates seamlessly with Cerner, facilitating smoother information exchange within our organization.
- Fuji Synapse provides greater flexibility for sharing images with external organizations, improving our ability to collaborate with partners.
- With over 45+ AI vendors, Fuji Synapse offers ample opportunities for future expansion and integration of AI technologies.
- Synapse PACS has consistently ranked among the top-performing radiology IT solutions in the Best in KLAS rankings, with a notable 10% performance increase in recent years.

Fuji Synapse

	Year 1	Year 2	Year 3	Year 4	Year 5	**5-Year Total**
Implementation	$ 37,500.00	$ -	$ -	$ -	$ -	**$ 37,500.00**
Training	$ 33,200.00	$ -	$ -	$ -	$ -	**$ 33,200.00**
Back-up	$ 15,568.00	$ -	$ -	$ -	$ -	**$ 15,568.00**
Service	$ 25,736.80	$ 25,736.80	$ 25,736.80	$ 25,736.80	$ 25,736.80	**$ 128,684.00**
Totals	**$ 112,004.80**	**$ 25,736.80**	**$ 25,736.80**	**$ 25,736.80**	**$ 25,736.80**	**$ 214,952.00**

Sectra

	Year 1	Year 2	Year 3	Year 4	Year 5	**5-Year Total**
Implementation	$ 37,500.00	$ -	$ -	$ -	$ -	**$ 37,500.00**
Training	$ -	$ -	$ -	$ -	$ -	**$ -**
Back-up	$ -	$ -	$ -	$ -	$ -	**$ -**
Service	$ 42,600.00	$ 43,440.00	$ 44,340.00	$ 45,240.00	$ 46,140.00	**$ 221,760.00**
Totals	**$ 80,100.00**	**$ 43,440.00**	**$ 44,340.00**	**$ 45,240.00**	**$ 46,140.00**	**$ 259,260.00**

MAYERS MEMORIAL HEALTHCARE DISTRICT

Board of Directors
Quality Committee
Minutes
June 19, 2024 @ 1:00 PM
MMHD FR Boardroom

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

1	**CALL MEETING TO ORDER:** Les Cufaude called the meeting to order at 1:02 pm on the above date.			
	BOARD MEMBERS PRESENT:		**STAFF PRESENT:**	
	Les Cufaude, Director Jim Ferguson, Director		Ryan Harris, CEO Jack Hathaway, Director of Quality Jessica DeCoito, Board Clerk	
	Excused ABSENT:			
2	**CALL FOR REQUEST FROM THE AUDIENCE – PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**			
	None			
3	**APPROVAL OF THE MINUTES:**			
	3.1	Regular Meeting – May 20, 2024	***Hathaway, Ferguson***	**Approved by All**
4	**HOSPITAL QUALITY COMMITTEE REPORT:** ACHC Performance Initiatives were discussed, more information will come in July, with full reports available in August.			
5	**DIRECTOR OF QUALITY:** QAPI Standards Program- Abuse Training is underway for SNF staff. Val is creating a QR code for an anonymous Abuse reporting form for all employees**.** We are the first one in the state (as we know of) that has a QR code created to help staff report when they see abuse. The information is immediately sent to the Ombudsman and the state. We did receive $2,000 in fees for licensing tags from the last survey event. We had a survey in the RHC yesterday (6.18.24) that may result in possible clinic tags: medical records, documentation, medical administration program. The Plan of Corrections for the Fire Life Safety was accepted as well.			
6	**OTHER INFORMATION/ANNOUNCEMENTS:** Ryan- Strategic Planning Workshop will take place next Tuesday, June 25th. The Board will receive clearer documents regarding the priorities and pillars that will be better aligned with to a new strategic plan, that will be discussed and reviewed.			
7	**MOVE INTO CLOSED SESSION ITEMS: 1:43 pm**			
8	**CLOSED SESSION ITEMS**			
	8.1 Hearing (Health and Safety Code § 32155) – Medical Staff Credentials **MEDICAL STAFF REAPPOINTMENT** Ivy Nguyen, MD – UC Davis – Neurology David Bissig, MD – UC Davis – Neurology Gary Turner, MD - TCR Earljay Landrito, MD – TCR Farres Ahmed, MD – TCR John Erogul, MD - TCR Ryan Redelman, MD - TCR Allen B. Mendez, MD - Pathology		***Cufaude, Ferguson***	**Approved by All**

	Todd Guthrie, MD – Orthopedic Surgery Nicholas Schulack, DO – Emergency Medicine Matthew Moore, DO – Emergency Medicine **MEDICAL STAFF APPOINTMENT** Ashley Delaney, DO – Emergency Medicine Stephen Williams, PA – MVHC Bradley Clark, MD – TCR Tikoes Blankenberg – Redding Pathology **STAFF STATUS CHANGE** Pamela Ikuta, DO to Inactive		
7	**ADJOURNMENT:** at 1:50 pm Next Meeting is July 24, 2024 at 1:00 pm		

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Bedside Mobility Assessment		POLICY # MS012
DEPARTMENT/SCOPE: Acute Care		Page 1 of 1
REVISION DATE:	EFFECTIVE: 01/05/2024	
AUDIENCE: All hospital staff	APPROVAL DATE:	
OWNER: M. Padilla		APPROVER: T. Overton

With attachment:
Mobility Screening and Solutions Tool MMH759

PURPOSE:

To ensure that the Bedside Mobility Assessment Tool (BMAT) is used effectively and consistently to identify patient mobility function deficits and guide the healthcare team in selecting equipment to safely handle and mobilize patients.

POLICY:

Bedside Mobility Assessment Tool (BMAT) Implementation:

- The BMAT will be conducted upon admission and during each shift by a registered nurse or licensed vocational nurse.
- BMAT findings will be documented promptly in the electronic health record (EHR).
- BMAT results will be clearly communicated with all staff involved in patient care.

Utilization of BMAT for Patient Mobility Management:

- The BMAT will serve as a tool to identify patient mobility function deficits accurately.
- Results from the BMAT will guide the healthcare team in selecting appropriate equipment for safe patient handling and mobilization.

Safe Patient Handling and Mobilization:

- Staff will ensure the use of appropriate equipment for safe patient handling and mobilization, as indicated by the BMAT results.
- Proper techniques and equipment will be employed to minimize the risk of injury to both patients and healthcare providers.

Communication Protocol for Patient Mobility:

- Patient mobility status, as determined by the BMAT, will be included in shift handoffs.
- During shift handoffs, staff will verbally communicate any changes or updates in the patient's mobility status, including deficits identified and equipment requirements.
- Any modifications in patient handling techniques or equipment usage will be clearly conveyed during shift changes to ensure continuity of care.
- Written documentation of patient mobility assessments and updates will be available in the electronic health record for reference during shift handoffs.

REFERENCES:

Boynton, T., Kumpar, D., & VanGilder, C. (2020). The Bedside Mobility Assessment Tool 2.0. American Nurse Journal[1]

Duke Occupational & Environmental Safety Office. (n.d.). BMAT (Bedside Mobility Assessment Tool)

COMMITTEE APPROVALS:

M/P&T: 5/14/2024
P&P: 6/5/2024
MEC: 6/13/2024

SUBJECT/TITLE:	Blood Culture Collection	POLICY # LAB5003
DEPARTMENT/SCOPE:	Laboratory - Microbiology	Page 1 of 4
REVISION DATE: n/a		EFFECTIVE: 12/22/2023
AUDIENCE: All lab staff		APPROVAL DATE:
OWNER: Sophia Lou Rosal, CLS		APPROVER: Kevin Davie

POLICY

Blood culture is the most important among cultures performed by the microbiology laboratory. Because the procedure is so sensitive, the steps involved must be controlled in the beginning of the pre-analytical stage (collection), to avoid misinterpretation of an associated skin-commensal microorganisms as an agent of infection. Proper technique and guidelines for phlebotomist, nurse and physician has been established to avoid skin contamination of blood cultures.

Blood Culture Collection Tips

- Speedy collection is a set-up for contamination. False positives lead to a delay in diagnosis, unnecessary antibiotics, line removal and replacement, delays in treatment or discharge and increased cost.
- Blood culture by definition MUST BE DRAWN from two sites (two different pheripheral sites).
- It is never acceptable to draw all four bottles from the same site.
- ALWAYS HOLD THE BOTTLE UPRIGHT when inoculating the bottle with blood.
- Immediately transport the blood culture bottles to the laboratory.
- Label the bottles correctly. Labels should not cover the barcode located on the side of the bottle. Labels must include the patient's full name, date of birth, collector's initials and the collection date and time.
- If it is not possible to obtain an adequate amount of blood to inoculate both bottles, the AEROBIC (gray cap) bottle is more critical.

Cleansing Procedure – 2 Steps

A. Blood culture bottle prep

- The rubber septum of blood culture bottles is NOT sterile and must be disinfected. Apply alcohol for 5 seconds and allow to air dry for one minute before inoculation.
- Peripheral draw
    - Draw two sets from two different peripheral sites. One set contains one aerobic and one anaerobic botlle.

B. Peripheral Skin Prep

- Prep skin with Prevantics swab (or other authorized replacement) for 15 seconds on one side of the paddle and 15 seconds on the other side for the paddle for a total of 30 seconds. Use a "back and forth" motion over the 4 inches area; allow to air dry for 30 seconds.

SUBJECT/TITLE: Blood Culture Collection	POLICY # LAB5003
DEPARTMENT/SCOPE: Laboratory - Microbiology	Page 2 of 4
REVISION DATE: n/a	EFFECTIVE: 12/22/2023
AUDIENCE: All lab staff	APPROVAL DATE:
OWNER: Sophia Lou Rosal, CLS	APPROVER: Kevin Davie

- If the site is touched during the drying process, the cleansing process must be repeated.
- Once the peripheral site has been prepped. NEVER re-palpate the venipuncture site again with your gloved finger. The glove is not sterile and will contaminate the site.
- The decontamination action comes from the CONCENTRATING AND DRYING OF DISINFECTANTS. Unless they have dried thoroughly, effective decontamination has not occurred.

C. If there is no central line, it is imperative that two separate peripheral sites be drawn.

- When drawing blood cultures from two peripheral sites, wait for 5 minutes before collecting the second specimen set. Wait 15 minutes if the second culture must be drawn from the same site.

Blood Cultures Obtained From Peripheral Sites (After Disinfection Of Venipuncture Site And Culture Bottles

A. Blood collection set – BD Safety Lok Blood Collection wingset

- Carefully attach a single use opaque vacutainer holder to the luer adapter needle end. Carefully remove needle sheath.
- Gently insert the needle into the patient's vein.
- Observe tubing for good blood return "flash".
- Inoculate the aerobic bottle first.
- Ensure that 5-10mL of blood is inoculated into each bottle (use the fill level marking on the side of the bottle as a gauge). Invert the blood culture bottles 8-10 times to mix.
- Complete collection of further blood tubes for additional laboratory work.
- Activate the safety feature on the Safety Lok Wingset and dispose the entire device, including vacutainer holder into an appropriate sharps container.

NOTE: Always remove the blood culture bottle or vacutainer tubes from the vacutainer holder before pulling the needle from the patient's arm to avoid introduction of air into anaerobic bottle thus jeopardizing anaerobic growth and to avoid bruising of the patient's arm.

B. Syringe – Use blood Transfer Device

- Collect 10-20mL per culture.
- Activate the needle's safety mechanism and remove from syringe.
- Attach a blood transfer device to the syringe.
- Insert the blood culture bottle (aerobic first) into the blood transfer device/syringe assembly. Allow 5-10mL to fill the bottle. Repeat this process for the anaerobic bottle.

SUBJECT/TITLE: Blood Culture Collection	POLICY # LAB5003
DEPARTMENT/SCOPE: Laboratory - Microbiology	Page 3 of 4
REVISION DATE: n/a	EFFECTIVE: 12/22/2023
AUDIENCE: All lab staff	APPROVAL DATE:
OWNER: Sophia Lou Rosal, CLS	APPROVER: Kevin Davie

- Allow the blood to transfer from the syringe to the blood culture bottle using the blood culture vacuum. DO NOT depress the plunger of the syringe.
- Invert the blood culture bottle 8-10 times to mix.
- If additional blood tubes are required for additional laboratory work, repeat procedure using the blood transfer device and following order of draw. Dispose of syringe and transfer device in sharp container.

Additional Information

- Most type of yeast/fungi (e.g aspergillus, candida) will grow in the aerobic bottle. If the physician is suspecting Coccidiodes, Fusarium or Histoplasma or if AFB is being considered, request an AFB/FUNGUS bottle from Labcorp.
- The most important determinant in the isolation of bacteria from blood culture is the volume of the blood cultured. Blood culture can be collected by venipuncture or from intravascular catheters. Us the table below to determine the number of cultures to draw.

Diagnosis	Collection Instructions
Acute Sepsis	Collect two sets of blood cultures, from two different sites. (2 sets = 4 bottles) Begin therapy.
Acute endocarditis	Obtain three sets of blood cultures with three separate venipunctures over 1-2 hours. (3 sets = 6 bottles)
Sub Acute Endocarditis	Obtain three sets of blood culture in day 1 (15 minutes or more apart). (3 sets = 6 bottles) If the cultures are negative 24 hours later, obtain two more sets. (2 sets = 4 bottles)
Antimicrobial therapy, 1-2 weeks prior to admission	Obtain 2 sets of blood cultures on each of three successive days. (2 sets = 4 bottles x 3 days)
Fever of unknown origin	Obtain two sets of blood cultures at least one hour apart, or both sets can be drawn at the same time from two different sites if the patient is to begin therapy. If negative 24-36 hours later, obtain two more sets of blood culture one hour apart.

Types Of Blood Culture Bottles

The table below lists the blood culture bottle in use ay Mayers Memorial Hospital:

SUBJECT/TITLE:	Blood Culture Collection	POLICY # LAB5003
DEPARTMENT/SCOPE:	Laboratory - Microbiology	Page 4 of 4
REVISION DATE: n/a		EFFECTIVE: 12/22/2023
AUDIENCE: All lab staff		APPROVAL DATE:
OWNER: Sophia Lou Rosal, CLS		APPROVER: Kevin Davie

Device	Cap Color	Volume
Bactec Alert FA Plus (Aerobic)	Light Green	5-10 mL
Bactec Alert FN Plus (Anaerobic)	Orange	5-10 mL

Blood Culture Volume

Use the table below to determine the volume of blood to draw.

Age	Device	Total Volume
Adult	1 Bactec Alert FA Plus (aerobic) + 1 Bactec Alert FN Plus (anaerobic)	10-20 mL
8-12 years old	1 Bactec Alert FA Plus (aerobic) + 1 Bactec Alert FN Plus (anaerobic)	10-12 mL

Note: There sets are not interchangeable. If patient is a difficult draw, use the Bactec FA plus (aerobic) bottle only (the culture yield will be decreased).

REFERENCE

Henry Isenberg Editor ASM Press Washington DC., *Clinical Microbiology Procedure Handbook* Current edition.

COMMITTEE APPROVALS

P&P: 6/5/2024
MEC: 6/13/2024

SUBJECT/TITLE:	Discharge Planning – Social Services 19.00.01	POLICY #MS031
DEPARTMENT/SCOPE:	Acute	Page 1 of 4
REVISION DATE: n/a	EFFECTIVE DATE: 4/17/2024	
AUDIENCE: All Employees	APPROVAL DATE:	
OWNER: M. Padilla		APPROVER: T. Overton

Discharge Planning is a process used to determine what a patient needs for a smooth transition from one level of care to another within or outside the current setting. Discharge Planning is a continuous process, involving healthcare professionals, the patient and family caregivers.

It is the policy of the hospital to provide an interdisciplinary approach for discharge planning and continuity of care to patients and their families.

I. IDENTIFICATION OF PATIENTS IN NEED OF DISCHARGE PLANNING

A. All patients are screened by nursing services for potential discharge needs upon admission or placement in Observation. Nursing will communicate with the Social Worker those patients with special needs that could impact discharge planning process, e.g., language or communication barriers, visual impairments, etc.

B. The Social Worker will screen all acute care patients in an inpatient status except maternity and normal newborn cases, preferably on the day of admission/observation placement but within no more than one working day, for potential discharge planning needs, utilizing a High-Risk Screening tool. This screen will take place during the initial clinical review for medical necessity and will be in conjunction with the initial screening completed by Nursing in the Admission Assessment process, or later in the stay by request.

C. Screening criteria will include but not be limited to the following:
- Age
- Prior hospitalization
- ED visit history
- Medications
- Principal diagnosis
- Comorbidities
- Functional impairment

II. DISCHARGE PLANNING ASSESSMENT

A discharge planning assessment will be completed by Social Work in the following circumstances:

A. *High-Risk Screening Score*: A comprehensive assessment will be completed by the Social Worker if the screening score is 6 or higher, indicating the patient may require

SUBJECT/TITLE:	Discharge Planning – Social Services 19.00.01	POLICY #MS031
DEPARTMENT/SCOPE:	Acute	Page 2 of 4
REVISION DATE: n/a	EFFECTIVE DATE: 4/17/2024	
AUDIENCE: All Employees	APPROVAL DATE:	
OWNER: M. Padilla		APPROVER: T. Overton

assistance meeting their discharge planning needs.

B. *Physician Order/Healthcare Team Referral*: The physician and/or any member of the healthcare team may make a referral to Social Work for evaluation and discharge plan development when a potential or actual discharge need is identified.

C. *Patient/Family/Caregiver Request*: The patient of family/significant other acting on the patient's behalf can also request an assessment for discharge planning needs.

D. A social worker, or other appropriately qualified personnel will develop, or supervise the development of, the evaluation.

E. The discharge planning evaluation will include, at a minimum:

F. The likelihood of the patient needing post-hospital services and the availability of the services

G. Assessment of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

H. The discharge planning evaluation will be completed in a timeframe no greater than one business day after identification of need by the Social Worker or referral from other sources.

I. The discharge planning evaluation will be documented in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation will be discussed with the patient or individual acting on his or her behalf.

III. DISCHARGE PLAN

A. The discharge plan will be developed by Nursing / Social Work for those patients with a High-Risk Screening Score less than 6, indicating no identified discharge planning needs. When changes are noted in a patient's condition that necessitate interventions for the discharge plan, the Social Worker will be notified of the changes and new referral for services.

B. For those patients with a High-Risk Screening Score of 6 or higher, indicating potential discharge planning needs, the Social Worker will develop the discharge plan, setting expectations for estimated length of stay, goals, anticipated disposition,

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DEPARTMENT/SCOPE:	Acute	Page 3 of 4
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AUDIENCE: All Employees	APPROVAL DATE:	
OWNER: M. Padilla		APPROVER: T. Overton

etc. and arrange for the initial implementation of the discharge plan.

C. The Social Worker will develop the discharge plan with input from the patient and/or caregiver. They will discuss the options available to the patient for post-hospital care services, if indicated. The discharge plan will also reflect the recommendations and contributions of the physician and healthcare team members involved in the patient's care, treatment, and services, as appropriate.

D. Should the patient require post-hospital services, the patient will be given the opportunity to choose their preferred choice of post-hospital provider that can provide the services recommended by the physician in accordance with the policy and procedure specific to offering Patient Choice.

E. The Social Worker will reassess the patient's discharge plan for appropriateness and factors that may impact the patient's continuing care needs.
   - The patient will be involved in planning and preparing for post hospital care. Family members and others will be involved as needed.
   - The discharge plan will be reviewed in the discharge planning rounds and updated by the Social Worker as appropriate.

F. The discharge plan will be documented in the patient's medical record to provide guidance to the healthcare team in preparing the patient for discharge.

IV. TRANSFER OR REFERRAL

A. The hospital will facilitate the transfer or referral of patients when the discharge plan involves a need for continuity of care, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.

B. Transportation arrangements will be completed by the Nurse or Social Worker and communicated to the patient/family and applicable members of the healthcare team. In addition, information regarding the transporting agency and arrangements will be documented in the medical record.

C. Once an order is received to transfer the patient, Nursing will contact the transporting agency to alert them that the patient is ready for pick-up. In addition, Nursing will contact the receiving facility with report on the patient.

SUBJECT/TITLE:	Discharge Planning – Social Services 19.00.01	POLICY #MS031
DEPARTMENT/SCOPE:	Acute	Page 4 of 4
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AUDIENCE: All Employees	APPROVAL DATE:	
OWNER: M. Padilla		APPROVER: T. Overton

V. REASSESSMENT

A. Social Work will reassess the discharge planning process on an on-going basis for those patients with identified needs. This may include a review of discharge plans to determine if the discharge plans meet the needs of patients.

B. This reassessment most commonly takes place in the form of evaluation of readmissions to identify opportunities for improvement in the discharge planning and transitions of care processes.

REFERENCES:

485.642(a)
482.43(a)

COMMITTEE APPROVALS:

P&P: 5/1/2024
BOD: 6/13/2024

Mayers Memorial Healthcare District

EOP: Resources & Assets Plan

Date:

The Resource and Assets Annex has been reviewed by the Safety Officer and the Safety Emergency and Environment of Care Management Committee in compliance with ACHC standards and Center for Medicare & Medicaid Services (CMS).

The RECORD OF CHANGES page provides details of any changes and updates made to this document.

Date reviewed and approved by Safety Emergency and Environment of Care Management Committee: _____

Title_____ Signature_____

Date reviewed and approved by Safety Officer _____

Title_____ Signature_____

RECORD OF CHANGES

Change #	Date	Part Affected	Date Posted	Who Posted
	4/1/24	First Draft Written		Dana Hauge, S.O.

I. PURPOSE

The purpose of this Annex is to provide guidance and outline procedures for efficiently obtaining, managing, allocating, and monitoring the use of resources during emergency situations or when such situations appear imminent. This Annex contains the resources the organization maintains in case of a community disaster / internal emergency and outlines the procedures to replenish the resources.

II. SITUATION & ASSUMPTIONS

A. Situation:

1. The organization is at risk from a number of hazards that could threaten the health and safety of our patients, health care workers (HCWs) and visitors and require the commitment of local resources to contain, control, or resolve.

2. Resource management planning during pre-disaster hazard mitigation activities is designed to lessen the effects of known hazards. Pre-disaster preparedness activities are designed to enhance the facility's ability to respond to a disaster. Throughout an actual response to a disaster or during the post-disaster recovery process, resource management is essential for facility operations. Resources based on sound business practices functioning efficiently during emergency situations shall be in compliance with the framework set forth by the National Incident Management System (NIMS) as well as including certain reporting and coordinating requirements contained in the National Response Framework (NRF).

3. Effective resource management is required for all types of emergency situations. For some emergency situations, available resources will be insufficient for the tasks that may have to be performed. Therefore, other resources may have to be diverted from their day-to-day usage to emergency response. Additionally, resource requests may come from materials management/ supply chain, local healthcare providers, Mayers Memorial Healthcare District EOC, or the local municipality or operating area. It may be necessary to rent or lease additional equipment and purchase supplies in an expedient manner.

4. In responding to major emergencies and disasters, the Incident Commander or the administrator on duty may declare that it is necessary to open and activate certain emergency procedures to protect the health and safety of patients, HCWs, and visitors.

5. When activation of the EOP has been initiated, the Incident Commander may use all available resources to respond to the disaster and temporarily suspend processes relating to purchasing and contracting, if compliance would hinder or delay actions necessary to cope with the disaster. The Chief Financial Officer should provide advice regarding any proposed suspension of purchasing processes. When normal

purchasing and contracting is suspended, it is the responsibility of the Chief Financial Officer to identify processes for emergency purchasing and contracting and provide direction to materials management/supply chain.

B. Assumptions:

1. Much of the equipment and many of the supplies required for emergency operations will come from inventories on hand.

2. Some of the equipment and supplies needed during emergency operations are not used on a day-to-day basis and may have to be obtained through local county, region, and national supply chain resources.

3. Mutual aid agreements will be activated, and resources made available when requested.

4. Some businesses and individuals that are not normal suppliers will be willing to rent, lease, or sell needed equipment and supplies during emergency situations.

5. Once activated, the County EOC/MHOAC/Health Coalition may provide equipment, supplies, personnel, or services during declared disasters. The organization will request resources via the Medical Health Operational Area Coordinator (MHOAC). If local resources are unavailable to meet needs, the local EOC will make a request for state resources.

6. Some community groups and individuals may provide equipment, supplies, personnel, and services during emergency situations.

III. CONCEPT OF OPERATIONS

A. General

1. Resource management, in accordance with the NIMS, involves the application of tools, processes, and systems that allow for efficient and suitable resource allocations during an incident. Resources include personnel and facilities as well as equipment and supplies. In order to facilitate resource management, coordination activities will take place in the HCC.

2. As established in NIMS, resource management is based on four guiding principles:

   - The establishment of a uniform method of identifying, acquiring, allocating, and tracking resources

   - The classification of kinds and types of resources required to support incident management

- The use of a credentialing system linked to uniform training and certification standards

- The incorporation of resources from non-traditional sources, such as the private sector and nongovernmental organizations.

3. As a basis for employing our resources to their greatest capacity during emergency situations, a current inventory of dedicated emergency resources and other resources that may be needed during emergency operations is maintained and updated as needed or at a minimum of annually. A list of resources can be found with the Safety Officer.

4. If all local resources have been committed and are insufficient, assistance will be sought from health care partners and the County HCC and MHOAC. The ICS 213 form delivered by one of the communications modes available and described in the Communications Plan will be used if borrowed resources are necessary. The County EOC/MHOAC/Health Coalition operations center may assist in locating resources.

5. Certain emergency supplies, equipment and services may be needed immediately in the aftermath of an emergency. It is important to maintain records of resources expended in support of emergency operations as a basis for future program and budget planning, and to document costs incurred that may be recoverable from the party responsible for an emergency incident, insurers, or from the state or federal government.

B. Management Operations:

1. The Incident Commander is responsible for managing emergency resources and is assisted by the Logistics Section. The Logistics Section will be expanded to meet the needs of the event per HICS.

2. If the HCC is activated, the Incident Commander shall continue to manage emergency resources committed to the operation. The Logistics Section Chief in the HCC shall monitor resources, manage uncommitted resources, and coordinate with the Incident Commander to determine requirements for additional resources. Departments involved in emergency operations that require additional resources should use the HICS 213 form to communicate their requirements to the Logistics Section in the HCC.

3. If additional resources are required, the Logistics Section Chief shall coordinate with the IC to:

- Activate and direct deployment of additional local resources.
- Establish priorities for the use of available resources.

- Request assistance from the County EOC/MHOAC/Health Coalition.
- Purchase, rent, or lease supplies and equipment.
- Obtain donated resources from businesses, individuals, or volunteer groups.
- Contract for necessary services to support emergency operations.
- Commit such resources to the IC to manage.

4. If the resources above are inadequate or inappropriate for the tasks to be performed, the Logistics Section Chief shall coordinate with the Liaison Officer to prepare a request for resource assistance from the County EOC/MHOAC/Health Coalition using an ICS 213 form and an available communication mode of this plan. The County EOC/MHOAC/Health Coalition may fill the request from resources available to it or forward the request to the County EOC/MHOAC/Health Coalition EOC.

5. The Purchasing Manager is among those initially notified of any developing large-scale emergency. When a warning is available, key suppliers of emergency equipment and supplies should be notified by the Purchasing Manager or their designee that short notice orders may be imminent.

C. Initial Supplies, Equipment and Pharmaceuticals

1. General

The organization maintains supply quantities on site to always support an extended emergency. Supplies with limited shelf life and/or supplies that require continual replenishment will be required from the vendor immediately upon the notification of an emergency. If appropriate, supplies supporting operations for 96 hours should be maintained.

The organization's emergency resources and assets are evaluated on an annual basis or as needed. The inventory includes:

- Personal Protective Equipment (PPE)
- Water
- Food
- Fuel
- Medical and surgical resources
- Pharmaceutical resources

2. Materials Management/Supply Chain (Purchasing Department)

The Purchasing Department is responsible for maintaining both day-to-day hospital supplies and supplies designated for disaster response. The Purchasing Department will generate "current inventory reports" at the time that a Code Triage is initiated and provide them to the Hospital Command Center.

i. Par levels for supplies and equipment are maintained to ensure that the hospitals have a 96-hour supply and ensure self-sufficiency if restocking from vendors is not immediately possible.

ii. Upon activation of the HCC the Purchasing Manager or their designee will run an inventory report and provide it to the Logistics Chief.

iii. The California state required emergency supply of PPE is managed by the Safety Officer and or applicable designee and is kept in the Foundation Building directly across the street and can be accessed by purchasing and facilities. There will be 90 days of PPE available. A list of PPE will be available in a TEAMS file accessible by the Director of Operation, the Purchasing Manager and the Safety Officer.

3. Food and Nutrition Services

Food and Nutrition Services maintains a weekly supply of food inventory to meet the normal operational needs of the hospital including feeding patients, staff, visitors, and others. In addition, it maintains a 96-hour cache of disaster designated food products which consist of prepackaged nonperishable or canned food), emergency food that is readily accessible and will be used to support patients, staff, visitors, and others.

4. Pharmaceutical Services

Pharmaceutical Services maintains an adequate supply of medication to meet the self-sufficiency requirements of 96 hours.

i. Upon activation of the HCC the Chief Clinical Officer and Pharmacist or their designee will run a current narcotic and emergency medication inventory and share information with the Incident Commander and Operations Chief.

ii. In conjunction with the drug wholesaler, a policy and procedure has been developed that identifies the process for ordering and receiving pharmaceutical supplies during an emergency.

5. Environmental Services

Environmental Services maintains no less than 3 bed changes per unit on hand as well as well as other appropriate linens. Mayers Memorial Healthcare District has their own laundry facility. Mayers has an established account with the following linen service that can deliver laundered linen and pick up soiled linen in an expedited manner in case of power failure or other issues that would block the use of our laundry facility. Mayers Memorial Health care District supplies at least 96 hours/ four days of cleaning supplies for normal operations.

Alsco Linen Division- Northern California 1-541-779-3711

D. Ongoing Replenishment of Supplies, Equipment and Pharmaceuticals

For the duration of the emergency – including response and recovery phases – the Operations Section Chief and Staging Manager shall monitor the inventory of supplies (including personal protective equipment), equipment, and pharmaceuticals in the various care areas. Replenishment from storage areas (Central Supply, Storeroom, etc.) shall occur on an as needed basis.

A general inventory of supplies (including personal protective equipment), equipment and pharmaceuticals will be taken in their respective storage areas on at least a daily basis (or more frequently if necessary) for the duration of the emergency. Remaining inventory shall be measured against the rate of consumption that is occurring because of the emergency. When existing inventory of critical supplies (including personal protective equipment), equipment, and/or pharmaceuticals are in danger of reaching insufficient levels, then emergency replenishment from outside vendors will be implemented.

If emergency replenishment from outside vendors is not feasible, the Local Agency EOC should be contacted to facilitate access to, and distribution of, stockpiled supplies, equipment, and pharmaceuticals. Other healthcare organizations should also be contacted to see, if necessary, supplies, equipment, and pharmaceuticals can be made available.

E. Ongoing Replenishment of Non-Medical Supplies

For the duration of the emergency – including response and recovery phases – the Logistics Section Chief and the Infrastructure Branch Director shall monitor the inventory of non-medical supplies. These supplies include, but are not limited to, the following:

- Food
- Water
- Linen
- Fuel for Emergency Power Generators
- Fuel for Vehicles

A general inventory of non-medical supplies will be taken in their respective storage areas on at least a daily basis (or more frequently if necessary) for the duration of the emergency. Remaining inventory shall be measured against the rate of consumption that is occurring because of the emergency. When existing inventory of critical non-medical supplies are in danger of reaching insufficient levels, then emergency replenishment from outside vendors will be implemented.

F. Sustainability of Operations without External Support

It is possible that the nature, scope, and duration of the emergency may preclude outside agencies, vendors, authorities, or other vital entities from assisting the hospital in a timely manner. Outside assistance may not be available for up to 96 hours following the initiation of the EOP.

The hospital has designed its operations so that it can be self-sufficient for a designated time frame depending on resources and assets being affected. The table below summarizes the hospital's ability to be self-sufficient in key areas. Hours of self-sufficiency is based on the following:

- The average amount of resource or asset within the organization at any given time
- The estimated consumption of the resource or asset based on maximum capacity and a full complement of staff

Resource or Asset	Hours Self Sufficient
1. Potable Water	At least 96 hours
2. Food	96 hours
3. Non-Potable Water	96 hours
4. Fuel for Emergency Generators	96 Hours 230 gal. diesel
5. Fuel for Transportation Vehicles	Cardlock fuel station with backup generator power
6. Hygiene and Sanitation Supplies	In supply-7 Days
7. Supplies for Disinfection & Sterilization	In supply only- 4 days
8. Personal Protective Equipment	PPE Supply & Supply- 104 days
9. Linen	Three bed changes and applicable linen, laundry facility and linen deliver.
10. Medical Gases – Oxygen	96 hours
11. Medical Gases – Carbon Dioxide	96 hours for Lab, Surgery
12. Medical Gases - Nitrogen	Surgery
13. Medical Gases – Compressed Air	1506 cubic feet stored
14. Medical Gases - Oxygen cryogenic	380 gallons stored
15. Large Volume Intravenous Fluids	5 Days- 120 hours stored and ready through hospital supply
16. Pharmaceuticals – Analgesics / Narcotics	96 hours- ability to order more pharmaceuticals as needed. Please see Pharmacy Policies for more information
17. Pharmaceuticals – Broad Spectrum Antibiotics	

If critical assets and resources have neared depletion levels, and there is no anticipated assistance from external sources soon, then the HCC will need to decide as to whether operational capability can be sustained. Possible actions include:

- Continuing current operational capability based on anticipated assistance from external sources
- Curtailing or modifying selected operational capability
- Closing and evacuating the facility(s)

Decisions involving curtailment, modification, or halting of operational capability should be made only after close consultation with hospital senior leadership and the County EOC/MHOAC/Health Coalition.

G. **Sharing Resources with other Healthcare Organizations**

Depending on the nature, scope, and duration of the emergency, it may be possible to share resources and assets with other healthcare organizations both within and outside the community. Sharing of resources should be coordinated through County EOC/MHOAC/Health Coalition to ensure that resources are being appropriately requested and being used in the most effective manner.

These assets and resources include, but are not necessarily limited to:

- Personnel
- Beds
- Transportation
- Linen
- Fuel
- Personal Protective Equipment
- Medical Equipment and Supplies

Prior to making such assets and resources available, the hospital must first assure that sufficient assets and resources are maintained on-site to meet its own operational requirements and vendors have the capacity to replenish shared supplies immediately.

H. Volunteers and Other Emergency Staffing Strategies

If personnel from the hospital are going to be shared with another facility, staff will be apprised of the following information:

- Location and type of facility that they are being sent to
- Type of care, treatment, and service they are being asked to provide
- Expected duration of the assignment
- Contact information at the receiving organization.

Staff should be instructed to wear their identification badges. If possible, copies of pertinent documents such as licensure, competencies, etc. should be made and given to staff to take with them to the assigned facility.

A record is maintained of staff who are assigned to other facilities recording date of assignment, facility name and location; contact information and anticipated return. HICS 252 Personnel –Time Sheet may be used.

For equipment and supplies, an accurate inventory should be maintained of what was sent to other facilities and when, so that appropriate reimbursement can occur.

If resources and assets are to be shared outside of the organization's geographic service area, then the Liaison Officer shall coordinate these efforts with the community wide EOC and/or its regional counterpart.

IV. ORGANIZATION & ASSIGNMENT OF RESPONSIBILITIES

A. General:

1. The function of resource management during emergency situations shall be conducted in the framework of our normal emergency organization. Preplanning for resource management operations shall be conducted identifying procedures/processes required to manage resources in an emergency.

2. The Director of Operations may serve as the Logistics Section Chief who will be responsible for planning, organizing, and conducting resource management activities during emergencies. The Logistics Section Chief will be assisted by temporary HCWs as needed.

3. During an emergency or disaster, the Logistics Section Chief will fulfill requests for additional personnel, equipment, and supplies received from departments, identify resources to satisfy such requirements, coordinate external resource assistance, and serve as the primary point of contact for external resources made available to Mayers Memorial Healthcare District.

4. The Logistics Section Chief will assess the availability of supplies and other resource requests received from other facilities and local hospitals. If the requested resources are available after hospital needs are met, the Logistics Section Chief may offer the resource to the requestor and coordinate transportation of the resource. **All requests must be approved by the IC**. All costs associated with the request are recorded and sent to the Finance Section for reconciliation after the event.

B. Task Assignments:

Incident Commander (IC):

- Manages resources committed to an incident.
- The IC establishes a Logistics Section if necessary to manage personnel, equipment, and supply resources committed to the incident
- Monitors the status of available resources and requests additional resources through the Logistics Section at the HCC.

Logistics Section Chief:

- Advises the Incident Commander regarding resource management needs and the priorities for meeting them.
- Provides qualified HCWs at the HCC to track the status of resources -- those assigned, available, or out-of-service.
- Identifies sources for additional resources from public and private entities and coordinates the use of such resources.
- Designates staging locations and temporary storage for equipment and supplies received.
- Monitors potential resource shortages and establishes controls on use of critical supplies.

Logistics Section Staff**:**

- Determines the most appropriate means for satisfying resource requests.
- Locates needed resources using resource and supplier lists and obtains needed goods and services.
- Coordinates resource transportation requirements.
- Arranges delivery of resources, to include settling terms for transportation, specifying delivery location, and providing point of contact information to shippers.
- Provides physical distribution of resources, to include material handling.
- Identifies temporary storage facilities or staging areas are arranged and activated as directed.
- Tracks the location and status of resources.

Finance Section Chief:

- Oversees the financial aspects of meeting resource requests, including record keeping, budgeting for procurement and transportation.
- Advises department leadership on record keeping requirements and other documentation necessary for fiscal accountability.

Liaison Officer:

- Coordinates with the [City/County] EOC and the [County] Public Health Department.
- All departments will coordinate emergency resource requirements with the Logistics Section staff. All communications with the Logistics Section staff are on an ICS 213 form to allow tracking of requests.

V. DIRECTION, CONTROL AND COORDINATION

A. General:

1. The Safety Officer is responsible for developing and maintaining this Annex.

2. The Safety Officer and or Director of Operations establish general policies for resources and assets.

3. Senior Leadership members are responsible for knowing and following the procedures outlined in this Annex.

B. Continuity:

Each hospital department shall establish a contact list of their emergency vendors and suppliers as needed in the department.

VI. ADMINISTRATION AND LOGISTICS

A. Plan Development, Maintenance & Distribution

This Annex will be reviewed and maintained on a regular basis, but at least annually in accordance with the EOP. The Safety Officer shall ensure that all revisions of the Resources and Assets Plan annex are current, and its attachments are updated. This Annex assumes governance over all Mayers Memorial Health care facilities.

B. Maintenance of Records:

All records generated during an emergency will be collected and maintained in an orderly manner, so a record of actions taken is preserved for use in determining response costs, settling claims, and updating emergency plans and procedures.

Vital resource management records should be protected from the effects of the disaster to the maximum extent feasible. Should records be damaged during an emergency, professional assistance in preserving and restoring those records should be obtained as soon as possible.

C. Training:

Individuals who will be performing resource management duties in the HCC shall receive training on their required duties and the operating procedures for those duties.

D. Resource Data:

1. The Hospital Leadership will coordinate with the Safety Officer/ Emergency Management Coordinator to keep current the list of available emergency resources.

2. The Director of Operations and Purchasing Manager will coordinate with the Safety Officer/ Emergency Management Coordinator to keep current information on the planning factors and sources of essential disaster supplies. See attachment 1

3. Vendor Rosters (HICS 258) are maintained and attached to this annex as well as copies of Memorandums of Understanding with vendors and suppliers providing service to the hospital.

VII. ATTACHMENTS

Attachment 1	Essential Disaster Supplies Planning Considerations
Attachment 2	Hospital Water Requirements
Attachment 3	Disaster Contact/ Purchasing Vendor Roster

ATTACHMENT 1 - RESOURCES
ESSENTIAL SUPPLIES PLANNING FACTORS

1. Planning Factors

A. Water (Potable and Non-Potable)

1) Emergency drinking water is usually provided in the form of bottled water. Bottled water is available from a variety of sources already palletized and ready to ship. The water stored is for one gallon of water per day per resident/patient/staff.
2) Facility water requirements for Mayers Memorial Healthcare District have been determined utilizing the CDC Emergency Water Supply Planning Guide for Hospitals and Healthcare Facilities.
3) Fall River has seven hundred ten gallons in hot water tanks throughout the facility. The potable hose is stored in the dietary hall storeroom.
The Burney Annex has four hundred gallons in hot water tanks.
The potable hose is stored in the hot water tanks storage located back of hospital outside of the dietary department back door.

Additional arrangements for water supplies have been made with the Burney Water District and Burney Fire Department for the Annex and Fall River Community Services District and the Fall River Fire Department for Fall River facility. Arrangements have been made with Rays Market, Safeway, Us Foods, Sysco of Sacramento and K&K Distributing.
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B. Ice

1) Ice is needed to preserve food and medicines.
2) The planning factor for ice is one 8-to-10-pound bag per person per day.
3) Mayers Memorial has ice machines available in owned facilities that are on different power grids, and the ice can be transported as needed. Mayers is also able to use local resources to get ice if needed in an emergency.

C. Portable Toilets

1) The general planning factor is 8 to 10 toilets per one hundred people. In areas where people are widely dispersed, additional toilets may be needed to keep the travel distance to sanitary facilities reasonable.
2) When planning to request portable toilets, the contract should include the requirement to service the portable toilets on a regular basis. Mayers Memorial works with Big Valley Sanitation for portable toilets and handwashing Stations.

3) Portable toilets should be sited at least one hundred feet from any water source or cooking facility. To prevent disease, it is desirable to have hand-washing facilities near toilets.

D. Food

1) Shelter and mass care facilities and mobile feeding units aim to provide at least two, and preferably three, simple meals per day – cereal, sandwiches, and soup. When requesting feeding service, provide not only an estimate of the number of people that need to be fed, but also indicate the number of those who are infants and children 1 to 3 years of age if there are any in the facility at the time of an emergency, so that suitable food can be provided.

2. Supply Chain

A. Purchasing is on-site and is available to stock supplies as needed.
B. Par levels of clinical supplies are based on three days of usage at capacity
C. Purchasing will help with supplying materials after hours and on weekends when an emergency event or disaster occurs.
D. The vendor list and the primary item list are available and are located with the Purchasing manager, the Safety Officer and or in the physical binder and is updated annually.

3. Pharmaceuticals

- Mayers Memorial Healthcare District has a patient pharmacy within the hospital facility and a retail pharmacy offsite.
- The pharmacy can purchase emergency supplies through vendors to help meet 96 hours of pharmaceutical supply needs.

4. Linen

- Linen is washed and delivered Monday through Friday from our own laundry facility.
- Two days' worth of linen is kept on the nursing units and an additional day's worth is kept in the linen storerooms throughout the facility.

5. Nutrition Services

Fall River Facility
Burney Facility

- Produce is delivered three times weekly Tuesday, Wednesday, and Friday
- Dairy products are delivered twice weekly, Tuesday and Friday
- Meat and dry goods are delivered Wednesday

- NS has paper plates, napkins, plastic utensils, and disposable cups to last 3 days if water curtailed
- NS keeps about 396 gallons of plain water (in liters) on hand (each case has six gallons)

Burney Facility

- Produce is delivered three times weekly Tuesday, Wednesday, and Friday
- Dairy products are delivered twice weekly, Tuesday and Friday
- Meat and dry goods are delivered Wednesday
- NS has paper plates, napkins, plastic utensils, and disposable cups to last 3 days if water curtailed
- NS keeps about 396 gallons of plain water (liters) on hand (in each case has six gallons)

6. Clinics

Cardio-Vascular Rehab, Physical Therapy, Retail Pharmacy, and the Rural Healthcare Clinic have only juice and crackers on hand and would need additional nourishment if required to shelter in place.

7. Diesel Fuel (additional info in Annex 5 – Utilities)

8. Delivery Locations

A. Mayers Memorial Healthcare District receives supplies at the following locations:

Fall River Facility

1) Facility Loading Dock, located on the back side of the hospital and is clearly marked.

Burney Facility

2) The facility loading area is on the back side of the Burney facility and is clearly marked.

SUGGESTED EMERGENCY AND DISASTER MENU

DAY 1-4

Diabetic	Low Sodium	Regular/Grind	Puree
BREAKFAST			
		4 oz Juice 1 ea. Breakfast Bar & Cereal 1 ea. Protein Bar 8 oz Milk	4 oz Juice 1 ea.-Soaked Br. Bar & Cereal 6 oz Puree Entree 8 oz Milk
LUNCH			
	LS Baked Beans LS Crackers	8 oz Ravioli/Chili 5 crackers 4 oz Beets	3 oz Puree Entree 5 Soaked crackers 4 oz Puree vegetable
Diet Jello		1 ea. Cookies 4 oz Fruit 8 oz Milk	1 ea.-Soaked cookies 4 oz Applesauce/juice 8 oz Milk
DINNER			
	LS Tuna LS Crackers	3 oz Chicken/Tuna 5 Crackers 4 oz Three Bean Salad	3 oz Puree Entree 5 Soaked crackers 4 oz Puree vegetable
Diet pudding		4 oz Fruit 1 ea. Pudding cup 8 oz Milk	4 oz Applesauce/Juice 1 ea. Pudding cup 8 oz Milk
SNACK			
Crackers & Peanut Butter		1 ea. Crackers/Cookies	Juice Soaked crackers/cookies

Juice	10	48	
Breakfast Bar	9	48	
Cereal	5	96	
Protein Bar	5/6	48/32	
Milk	2	600	
Ravioli	3	72	
Chili	3	72	
Baked Beans Low Sodium	1	72	
Crackers	2	290	
Crackers Low Sodium	1	166	
Beets	4	132	
Cookies	4	120	
Fruit	7	132	
Chicken	3	192	
Tuna	2	96	
Three Bean Salad	4	132	
Pudding Cup	9	48	
Puree Entrée	2	60	
Puree Vegetable	3	45	
Applesauce Cups	2	72	
Diet Pudding/Diet Jello	4	48	
Peanut Butter Cups	2	36	
Goldfish Crackers	1	300	
Animal Crackers	1	150	
Crystal Light	1	12/gal	
V8 Juice	2	48	
V8 Juice Low Sodium	2	48	
Jevity	2	8/1.5 lt	
Peanut Butter Tub	1	71/2 TB	
Jelly	1	12/20oz	
Thickener	Six cans		
Mayonnaise	1	1 gal	
Salt/Pepper	Ziploc	400	
Sugar/Splenda	Ziploc	400	
Kit, Cutlery	4	100	
Straws	4	100	
To Go Boxes	5	100	
Garbage Bags	1	100	
Gloves	6	250 ea.	
Gallon Jars	6	ea.	

Can Openers	6	ea.	
Plastic Glasses	2	12/70	
Spoons/Serving Spoons			
Paper Towels	1	12 rolls	
Napkins	2	250/pack	
Potholders	12	ea.	
Dish Bins	6	ea.	
Mixing/Servings Bowls			
Test Strips	1	ea.	
Sanitizer	1	ea.	
Colanders	6	ea.	

Calculations for Potential patients/residents' staff and volunteers or people seeking shelter

4/15/24

Servings= 100 people per day (residents/staff)
Puree=15
Diabetic=15
Low Sodium=10
500 gallons of water= 1 gallon per day per person (and 80-100 gallons to prepare milk)

HOSPITAL WATER REQUIREMENTS
Patient and Staff Needs

Water Supply	
Fall River Facility	4/11/2024
500gallons	
Burney Facility	4/11/2024
396 gallons	4 Days for residents and staff needs

Food & Nutrition Vendor Contacts

K & K Distributing	317 W. Carlos/Box 144 Alturas Ca. 96101	Ken and Donna Roberts	(888) 233-5174	kkdistr@gmail.com
Rays Market	43622 HWY 299E Fall River Mills, Ca 96028	Shelly Agee	(530)554-1057	mgr52@ckmarket.com
Safeway	37264 Main St. Burney Ca. 96013	Andrew Jackson	(530)335-3212	s4178c90@safeway.com
Sysco	7062 Pacific Ave. Pleasant Grove, Ca. 95668	Garret Butler	(800) 797-2627	Garret.butler@sysco.com
US Foods	4455 Winters St. McClellan, Ca. 95652	Janette Cull	O 800-682-1282 M 530-524-2605	Janette.cull@usfoods.com

ATTACHMENT 3

DISASTER CONTACTS ROSTER
Please see Purchasing Manager for Full Vendor List

MMHD Emergency Preparedness Master Contact List

Company	Contact	Phone	Email	Resources
				Construction
ASPR		202-205-8114		
Belfor Property Restoration		800-930-0011		Chemical Spill
Bieber Fire Department		530-294-5720		
Big Valley Sanitation		530-243-0657		Portable Toilets
Burney Fire District	Bob May	530-335-2212		non potable water, fire, EMS
Burney Veterans Hall		530-335-4971		Facilities
Burney Water District		530-335-3582		
CA State Emergency Mgmnt		916-845-8510		
Cal Fire	Brian Noel		brian.noel@fire.ca.gov	
CDC		800-232-4636		
CDF Helitach		530-294-5251		
CDF/Cal Fire	Station 14	530-335-2203		
CDPH		800-554-0350		Licensing
CHP		530-335-4581		Law Enforcement
Citizen's Patrol		530-336-7380		Security
CMS				
Don Harbert Oil		530-336-5033		Fuel
EPA		916-323-2514	866-EPA-WEST	
Fall River Fire Department		530-336-6177		non potable water, fire
Fall River JUSD		530-335-2483		Buses
Fall River Veterans Hall		530-336-5341		Facilities
FBI	Sacramento	916-481-9110		
FEMA		510-621-7250		Recovery
Fort Crook Lodge	Jim Crockett	530-335-3866		Facilities
FR Seventh Day Adventst Church	Bob Parrish	530-336-7104		Facilities
FRM Airport		530-245-6844		
FRM Community Services District		530-336-5263		Water, Sewer
Frontier Communications		800-921-8102		Phone, Internet
Glenn Spalding		530-945-5979		Construction
Hat Creek Construction		530-335-5501		Heavy Equipment
Hill-Rom		530-510-5972		Beds

Safety Officer, Disaster Coordinator: Dana Hauge, 530-604-8073

MMHD Emergency Preparedness Master Contact List

Company	Contact	Phone	Email	Resources
Hiway Garage		530-336-5532		Towing
Hovis Hardware		530-335-5471		Hardware
Intech Mechanical		916-797-4900		HVAC, Mechanical
Intermountain Community Center				Facilities
Inter-Mountain Fair	Bailey Van Riet, manager	530-336-5695		Facilities
McArthur Fire Department		530-336-5026		non potable water
MMHD	Dana Hauge	530-604-8073	dhauge@mayersmemorial.com	Safety Officer, Disaster Coord.
MMHD	Valerie Lakey		vlakey@mayersmemorial.com	CPRO, PIO
MMHD	Ryan Harris	530-383-2044	lward@mayersmemorial.com	CEO
MMHD	Jessica Decoito	530-917-4842	jdecoito@mayersmemorial.com	Director of Operations
MMHD	Keith Earnest	530-304-7594	kearnest@mayersmemorial.com	CCO, Pharmacy
MMHD	Travis Lakey	530-949-1780	tlakey@mayersmeorial.com	CFO, Insurance
MMHD	Theresa Overton	530-941-5874	toverton@mayersmemorial.com	CNO, SNF,
MMHD	Nurse Supervisor	Ext. 1185		HICS
MMHD	Station 1	Ext. 1111		Phone Tree
MMHD	Tom Watson	530-524-8016		Chief of Staff
Modoc Medical Center		530-233-5131		
Montgomery Creek Fire Dept		530-337-6779		Fire
MVHC	Fall River	530-336-6535		
MVHC	Burney	530-335-5457		
MVHC	Bieber	530-294-5241		
Norcal Respiratory		530-246-1200	hello@norcalrespiratory.com	Oxygen
Packway		530-335-6138		Heavy Equipment
Peterson Power System		866-796-5610		Generators
PGE		530-335-5640	800-743-5000	Electric, Gas
PHI		800-423-5993	530-255-6290	EMS Flight
Pit River Tribe		530-335-5421		
Rays Market		530-336-5575	541-469-3113	Bottled Water
REACH		800-338-4045		EMS Flight
Red Cross		530-673-1460		
Remote Satellite Radio		707-545-8199		Radios
Safeway	Andrew Jackson, Casey Averil	530-335-3212		Bottled Water

Safety Officer, Disaster Coordinator: Dana Hauge, 530-604-8073

MMHD Emergency Preparedness Master Contact List

Company	Contact	Phone	Email	Resources
Shasta Co. Sheriff		530-245-6165		Law Enforcement
Shasta County Coroner		530-225-5551		
Shasta County Public Health		530-225-5591		
Soldier Mountain Fire Dept		530-336-6613		Fire
Ed Staub & Sons		530-336-6138		Fuel
Valley Hardware		530-336-5583		Hardware
Warren Consulting Engineers		916-985-1870		Structural

Safety Officer, Disaster Coordinator: Dana Hauge, 530-604-8073

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Food & Nutrition in a Disaster		POLICY # DIA021
DEPARTMENT/SCOPE: Disaster		Page 1 of 6
REVISION DATE: N/A	EFFECTIVE DATE: 4/29/2024	
AUDIENCE: Disaster, Safety	APPROVAL DATE:	
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

With attachments:

Menus
Stock Items
Calculations in accordance with # of people feeding x 96 hours

POLICY:

The Mayers Memorial Healthcare District (MMHD), Emergency Operations Plan (EOP) establishes and provides the guidance and framework that will enable hospital leaders and staff to effectively prepare for and respond to any and all hazards or disasters that may impact hospital operations, threaten patient care, or impede the safety and wellbeing of patients, hospital staff and visitors. The EOP is designed to respond to single and multiple emergencies for an extended length of time without reliance on community support. Therefore, the organization has planned for managing the six critical areas of emergency response, so that it can assess needs and prepare staff or healthcare workers (HCW) to respond to potential events regardless of cause.

In accordance with ACHC and NFPA with guidance from FEMA programs Mayers Memorial Healthcare District carries ninety-six (96) hours of subsistence needs to be used in case of an emergency or disaster. Food and Nutrition Services Department will carry the appropriate amount of food, water and applicable tools as stated in the highest regulation.

MMHD will meet the nutritional needs of patients, visitors, and staff while sheltered in place, or evacuated to other locations. During an emergency event, the facility may experience a disruption in one of multiple services such as:

1. Loss of water, gas, fuel, or electricity.
2. Equipment failure, e.g., dishwashing machines, pumps, refrigeration, cooking appliances.
3. Disruption with the delivery and grocery and food preparation items.

Nutritional Services anticipates possible disruptions and prepares strategies for ensuring continuity of services, including;

1. Alternative methods for heating food and water used for cooking.
2. Written agreements with food suppliers for priority grocery delivery in the event of a disruption with the supply of food products. The written agreements are updated per ACHC standard 17.01.01.

Food, drinking water, paper products, and utensils needed to feed the patients, staff, and visitors for ninety- six hours (96). Calculation parameters are documented and MMHD stores 96 hours of:

1. Fresh and Frozen Foods

2. Dairy Products
3. Drinking Water
4. Paper Products
5. Special dietary requirements, e.g., diabetic, Kosher, and vegetarian.

Foodstuffs are stored in the Riverview building garage in Fall River Mills and in the office off the Activities room in Burney.

PROCEDURE:

1. All employees will be oriented and updated according to the facility policy on the disaster plan, location of the emergency food supply and use of emergency menus. In accordance with the Emergency Operation Plan and ACHC Standards. (ACHC 17.00.03, 17.01.02)
2. A 4-day (96 hour) menu will be used. It can be served hot or cold depending on the availability of electricity, BBQ equipment, etc. Fresh or frozen items should be used first before canned items. NFPA 12.5.3.3.3
3. Emergency food supplies will be maintained at all times. It is suggested that items be stored away from the kitchen area. Rotate emergency foods into the menu every 6 months or per expiration date.
4. In the event of a disaster food service employees should do the following:
    a. Contact the dietary service supervisor and the consultant dietitian.
    b. Immediately turn off all water supply faucets and gas lines. Conserve water from the hot water heater and toilet tanks. Toilets should not be flushed until the state of the sewer system and water availability is known.
    c. Inventory the freezer and refrigerator items. Use these items first to help prevent waste from spoilage.
    d. Keep freezer and refrigerator doors closed at all times to prevent unnecessary temperature drop.
    e. If power is available, hot bread, vegetables, etc., can be added to menu. Hot beverages may be served if water and power are available.
5. All residents will be served a regular diet except:
    a. Residents with food allergies should receive appropriate substitutions.
    b. Residents with chewing or swallowing dysfunction should have food mashed or chopped.
    c. Residents on thickened liquids should be given thickened beverages.
    d. Residents on enteral feedings should have a 4-day supply of enteral formula.
6. Residents receiving pureed foods:
    a. Juice may be substituted for puree fruit or vegetables.
    b. Keep canned puree meat on hand for residents requiring smooth puree textures.
    c. Mash regular food items as much as possible.
    d. Soak cereals, cookies, crackers, breads, etc. in liquid until mushy.

e. Pudding may be used for medication pass for all dysphagia consistencies.

7. Recommended water needs for **four** days:
   NFPA 12.5.3.33
   a. Four-gallons drinking water per resident or projected staff member/visitor (one gallon per day per person) must be stored on the facility properties.
   b. Rotate emergency water every 6 months or per expiration date.

REFERENCES:

ACHC Accreditation requirements for Critical Access Hospitals, 2023 edition. Accreditation Commission for Health Care (ACHC). Chapter 17.01.02

NFPA 12.5.3.3.3

COMMITTEE APPROVALS:
Disaster: 5/1/2024
P&P: 6/5/2024

Mayers Memorial Healthcare District
SUGGESTED EMERGENCY AND DISASTER MENU

DAY 1-4

Diabetic	Low Sodium	Regular/Grind	Puree
BREAKFAST			
		4 oz Juice	4 oz Juice
		1 ea Breakfast Bar & Cereal	1 ea Soaked Br. Bar & Cereal
		1 ea Protein Bar	6 oz Puree Entree
		8 oz Milk	8 oz Milk
LUNCH			
	LS Baked Beans	8 oz Ravioli/Chili	3 oz Puree Entree
	LS Crackers	5 crackers	5 Soaked crackers
		4 oz Beets	4 oz Puree vegetable
Diet Jello		1 ea Cookies	1 ea Soaked cookies
		4 oz Fruit	4 oz Applesauce/juice
		8 oz Milk	8 oz Milk
DINNER			
	LS Tuna	3 oz Chicken/Tuna	3 oz Puree Entree
	LS Crackers	5 Crackers	5 Soaked crackers
		4 oz Three Bean Salad	4 oz Puree vegetable
		4 oz Fruit	4 oz Applesauce/Juice
Diet pudding		1 ea Pudding cup	1 ea Pudding cup
		8 oz Milk	8 oz Milk
SNACK			
			Juice
Crackers & Peanut Butter		1 ea Crackers/Cookies	Soaked crackers/cookies

Mayers Memorial Healthcare District Emergency Stock

Items	#Cases	#Servings per case
Juice	10	48
Breakfast Bar	9	48
Cereal	5	96
Protein Bar	5/6	48/32
Milk	2	600
Ravioli	3	72
Chili	3	72
Baked Beans Low Sodium	1	72
Crackers	2	5/290
Crackers Low Sodium	1	166
Beets	4	132
Cookies	4	120
Fruit	7	132
Chicken	3	192
Tuna	2	96
Three Bean Salad	4	132
Pudding Cup	9	48
Puree Entrée	2	60
Puree Vegetable	3	45
Applesauce Cups	2	72
Diet Pudding/Diet Jello	4	48
Peanut Butter Cups	2	36
Goldfish Crackers	1	300
Animal Crackers	1	150
Crystal Light	1	12/gal
V8 Juice	2	48
V8 Juice Low Sodium	2	48
Jevity	2	8/1.5 lt
Peanut Butter Tub	1	71/2 TB
Jelly	1	12/20oz
Thickener	6 cans	
Mayonnaise	1	1 gal
Salt/Pepper	Ziploc	400
Sugar/Splenda	Ziploc	400
Kit, Cutlery	4	100
Straws	4	100
To Go Boxes	5	100
Garbage Bags	1	100
Gloves	6	250 ea.

Gallon Jars	6	Ea.
Can Openers	6	Ea.
Plastic Glasses	2	12/70
Spoons/Serving Spoons		
Paper Towels	1	12 rolls
Napkins	2	250/pack
Potholders	12	Ea.
Dish Bins	6	Ea.
Test Strips	1	Ea.
Sanitizer	1	Ea.
Colanders	6	Ea.

Calculations for Potential patients/residents' staff and volunteers or people seeking shelter

4/15/24

Servings= 100 people per day (residents/staff)
Puree=15
Diabetic=15
Low Sodium=10
500 gallons of water= 1 gallon per day per person (and 80-100 gallons to prepare milk)

SUBJECT/TITLE: Heat Illness Plan		POLICY # SAF035
DEPARTMENT/SCOPE: Safety		Page 1 of 10
REVISION DATE: n/a	EFFECTIVE DATE: 5/15/2024	
AUDIENCE: All hospital staff	APPROVAL DATE:	
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

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.

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)

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.

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.

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 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

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

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 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.

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.
- 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
Heat & Illness Prevention Policy
Page 17 of 17
National Ag Safety Database: Keep Cool
https://nasdonline.org/182/d000004/keep-cool.html

COMMITTEE APPROVALS

Disaster: 5/20/2024

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,

SUBJECT/TITLE:	Microbiology Critical Results	POLICY # LAB5002
DEPARTMENT/SCOPE:	Laboratory - Microbiology	Page 1 of 2
REVISION DATE: n/a		EFFECTIVE: 12/21/2023
AUDIENCE: All lab staff		APPROVAL DATE:
OWNER: Sophia Lou Rosal, CLS		APPROVER: Kevin Davie

POLICY

Transmission-based precautions are used in addition to Standards precautions with patients known or suspected to be infected or colonized with highly transmissible and epidemiologically important pathogens for which additional precautions beyond Standard Precautions are needed to interrupt transmission.

Appropriate individuals (e.g. attending physician, nurse supervisor or nurse) are promptly notified by telephone when results of certain tests exceeds critical limits. This notification is documented in the LIS.

NOTE: Before calling microbiology critical results, the CLS will determine if the patient is currently an inpatient, outpatient or has been discharged. If discharged, the CLS will identify the patient's PCP in CERNER (enter patient name in power chart to look for the PCP and then go to provider lookup to search for the PCP contact information) and call the microbiology critical results to the PCP's office. If the patient is still in house, then the results should be called to the appropriate department. Critical outpatient laboratory values (positive blood cultures, MRSA, etc) will be reported to ER nurse at ext 1144 after hours.

The Table below slits Microbiology critical values that will be called to the nursing unit and/or physician office or ER department after hours.

Test	**Call**
Blood Cultures	All positives
Gram stains and cultures – sterile site (e.g CSF, Body Fluids)	All positives
STAT gram stains	All specimens submitted
AFB smears (Labcorp)	All positives
AFB Identification (Labcorp)	All positives
MDRO culture isolates – any source CRE (Carbapenem – resistant Enterobacteriaceae) MRSA (Methicillin-resistant Staphylococcus aureus) VRE (Vancomysin-resistant Enterococcus) ESBL (Extended-Spectrum Beta-Lactamase) MDRO (Multiple drug-resistant organisms) Acinetobacter baumannii (isolates that show drug resistant)	All positives
Significant fungal isolates	All Cultures positive for: Cryptococcus neoformans Coccidiodes Histoplasma/Blasto Candida auris

SUBJECT/TITLE:	Microbiology Critical Results	POLICY # LAB5002
DEPARTMENT/SCOPE:	Laboratory - Microbiology	Page 2 of 2
REVISION DATE: n/a		EFFECTIVE: 12/21/2023
AUDIENCE: All lab staff		APPROVAL DATE:
OWNER: Sophia Lou Rosal, CLS		APPROVER: Kevin Davie

Enteric bacterial pathogens	All Cultures positive for: Salmonella species Shigella species E. coli 0157:H7 Campylobacter jejuni/species
Giardia EIA	All positives
Rotavirus	All Positives
C. difficile Toxin	All positives
Rapid RSV Antigen	All positives
SARS Covid 19	All Detected (positives)
Influenza A and B Antigen	All positives
Rapid Group A Strep	All positives
Culture – Group A Strep from throat	All positives
Culture – Group A Strep from wound site	All positives
Culture – Group B Strep isolates – NBICU	All positives
VZV/HSV 1 & 2 smear	All Positives
Culture – Group B Strep, GYN Patients	All positives
GC/Chlamydia	All Positives
Biofire Filmarray Repiratory, GI, Meningitis Panel	All Positives

Infection Control Department

The following critical values, when requested on an inpatient, are called to the Infection Control; Cassandra LaFave at 1230 extension.

- Positive AFB smears on sputum or bronchial wash.
- Positive C difficile results
- Positive influenza virus either from culture or rapid antigen typing.
- MDRO isolates (CRE, VRE, MRSA, ESBL, Acinetobacter baumannii). Notification of outpatient clinics for critical values

  During regularly scheduled hours (Monday-Friday 08:00am-05:00pm) results should be given to a nurse or provider in any of the clinics. If after hours, Call Emergency Department at 1144.

COMMITTEE APPROVALS:
P&P: 6/5/2024
MEC: 6/13/2024

MAYERS MEMORIAL HOSPITAL DISTRICT

Privileges in Oncology

Name: _____

Oncology Core Privileges

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

- Documentation or attestation of the management of oncologic problems for at least 50 patients as the attending physician (or post doctoral fellow) during the past two years **and**
- Current certification or active participation in the examination process leading to certification in oncology by the American Board of Internal Medicine, or the American Osteopathic Board of Internal Medicine; or
- Successful completion of a postgraduate residency in oncology accredited by the ACGME, AOA, or equivalent.

Staff Status Requested

☒ Consulting: may not admit patients to the Hospital

Privileges included in the Oncology Core

* Order outpatient treatment.

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

Additional Privileges Requested (write in below):
To be eligible for the additional privilege(s) requested, the applicant must demonstrate acceptable experience and/or provide documentation of competence in the privileges requested consistent with the criteria set forth in the medical staff policies governing the exercise of specific privileges (**see attached "Supporting Documentation Form"**).

_____
_____
_____

Acknowledgement of Practitioner

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

I understand that:

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

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

_____ _____

Applicant Date

Recommendations

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

_____ _____

Credential Committee Chair/Vice-Chair Date

_____ _____

Medical Executive Committee Chair/Vice-Chair Date

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	One Step Fentanyl Test Dip Card (Urine)	POLICY # LAB9001
DEPARTMENT/SCOPE:	Laboratory - Serology	Page 1 of 4
REVISION DATE: n/a	EFFECTIVE DATE: 11/15/2023	
AUDIENCE: All lab staff	APPROVAL DATE:	
OWNER: Sophia Lou Rosal, CLS		APPROVER: Kevin Davie

DEFINITION:

The One Step Fentanyl Test Dip Card (Urine) is a rapid chromatographic immunoassay based on the principle of competitive binding. Drugs which may be present in the urine specimen compete against the drug conjugate for binding sites on the antibody.
During testing, a urine specimen migrates upward by capillary action. Norfentanyl, if present in the urine specimen below 10 ng/mL, will not saturate the binding sites of the antibody coated particles in the Test Dip Card. The antibody coated particles will then be captured by immobilized Norfentanyl and a visible colored line will show up in the region. The colored line will not form in the test line region if the Norfentanyl level exceeds 10 ng/mL because it will saturate all the binding sites of anti-fentanyl antibodies.
A drug-positive urine specimen will not generate a colored line in the test line region, while a drug-negative urine specimen or a specimen containing a drug concentration less than the cut-off will generate a line in the test line region. To serve as a procedural control, a colored line will always appear at the control line region indicating that proper volume of the specimen has been added and the membrane wicking has occurred.

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.

MATERIALS

1. Individually packed single dip card
2. Specimen collection container/cup
3. Timer
4. Package insert

SPECIMEN REQUIREMENTS:

1. Urine collected at any time of the day may be used.
2. Urine specimens must be collected in clean, dry containers.
3. Perform testing immediately after specimen collection. Do not leave specimens at room temperature for prolonged periods. Urine specimens maybe stored at 2-8 degrees Celsius for up to 2 days. For long term storage, specimens should be kept below -20 degrees Celsius.
4. Bring the specimens to room temperature prior to testing. Frozen specimens must be completely thawed and mixed well prior to testing. Avoid repeated freezing and thawing of specimens.

5. If specimens are to be shipped, pack them in compliance with all applicable regulations for transportation of etiological agents.

PROCEDURE:

A. Allow the test device, and urine specimens to come to room temperature (15-30 degrees Celsius or 59-86 degrees Fahrenheit) prior to testing.
1. Remove the test device from the foil pouch and use as soon as possible. Label the device with patient or control identifications.
2. Remove the cap from the test device.
3. With the arrow pointing toward the urine specimen, immerse the sample tip vertically in the urine specimen for at least 10-15 seconds.
4. Replace the cap back on the device and place the device on a flat surface.
5. Read results at 5 minutes. **Do not interpret results after 10 minutes.**

INTERPRETATION OF RESULTS

NEGATIVE: Two lines appear. One color should be in the control region (C), and another color line in the test region (T). This negative result indicates that the drug concentration is below the detectable level.

NOTE: The intensity of the color in the test region (T) may vary depending on the concentration of the analytes present in the specimen. Therefore, any shade of color in the test region (T) should be considered negative. This is a qualitative test only and cannot determine the concentration of analytes in the specimen.

POSITIVE: One color line appears in the control region (C). No line appears in the test region (T). This positive result indicates that the drug concentration is above the detectable level.

INVALID: Control line fails to appear. Insufficient specimen volume or incorrect procedural techniques are the most likely reasons for the control line failure. Review the procedural and repeat the test using a new test dip card. If the problem persists, discontinue using the lot immediately and contact your distributor.

QUALITY CONTROLS

A procedural control is included in the test. A red line appearing in the control region (C) is considered an internal procedural control. It confirms sufficient specimen volume, adequate membrane wicking and correct procedural technique.

SUBJECT/TITLE:	One Step Fentanyl Test Dip Card (Urine)	POLICY # LAB9001
DEPARTMENT/SCOPE:	Laboratory - Serology	Page 3 of 4
REVISION DATE: n/a	EFFECTIVE DATE: 11/15/2023	
AUDIENCE: All lab staff	APPROVAL DATE:	
OWNER: Sophia Lou Rosal, CLS		APPROVER: Kevin Davie

Kova Detectable Liquid Control Urine is used as external control. It consists of negative control and positive control. External controls are performed every new lot reagent material and every first day of the month.

STORAGE AND STABILITY

1. The kit can be stored at room temperature or refrigerated (2-30 degrees Celsius /36-86 degrees Fahrenheit until the expiry date printed on the pouch.
2. The test dip card must remain in the sealed pouch until use.
3. The kit should be kept out of direct sunlight.
4. DO NOT FREEZE.
5. Do not use beyond the expiration date.

PRECAUTIONS

1. Do not use after the expiration date indicated on the package. Do not use the test if the foil pouch is damaged. Do not reused the test.
2. The test dip card should remain in the sealed pouch until use.
3. Avoid cross-contamination of specimen by using a new specimen collection container for each specimen obtained.
4. Read the entire procedure carefully prior to testing.
5. All specimens should be considered potentially hazardous and handled in the same manner as infectious agent.
6. Humidity and temperature can be adversely affecting results.
7. The used test dip card should be discarded according to federal, state and local regulations.

LIMITATIONS

1. The One Step Fentanyl Test Dip Card (Urine) provides only a qualitative, preliminary analytical result.
2. This assay provides a preliminary analytical test result only. A more specific alternative chemical method must be used to in order to obtain a confirmed analytical result. Gas chromatography/mass spectrometry (GC/MS) and liquid chromatography / mass spectrometry / tandem mass spectrometry (LC-MS/MS) have been established as the preferred confirmatory method by the National Institute on Drug Abuse (NIDA). Clinical consideration and professional judgement should be applied to any test result, particularly when preliminary positive results are indicated.
3. It is possible that technical or procedural errors, as well as other interfering substances in the urine specimen may cause erroneous results.
4. Adulterants, such as bleach and/or alum, in urine specimens may produce erroneous results regardless of the analytical method used. If adulteration is suspected, the test should be repeated with another urine specimen.

SUBJECT/TITLE:	One Step Fentanyl Test Dip Card (Urine)	POLICY # LAB9001
DEPARTMENT/SCOPE:	Laboratory - Serology	Page 4 of 4
REVISION DATE: n/a	EFFECTIVE DATE: 11/15/2023	
AUDIENCE: All lab staff	APPROVAL DATE:	
OWNER: Sophia Lou Rosal, CLS		APPROVER: Kevin Davie

5. A positive result indicates presence of the drug or its metabolites but does not indicate level of intoxication, administration route or concentration in urine.
6. A negative result may not necessarily indicate drug-free urine. Negative results can be obtained when the drug is present but below the cut-off level of the test.
7. Test does not distinguish between drugs of abuse and certain medications.

REFERENCES:

One Step Urine Fentanyl Test Dip Card product package insert

COMMITTEE APPROVALS:

P&P: 5/1/2024
BOD: 6/13/2024

MAYERS MEMORIAL HOSPITAL DISTRICT

Privileges in Orthopedic Surgery

Name: _____

Orthopedic Surgery Core Privileges

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

- Documentation of the performance of at least 100 orthopedic procedures during the last two years or successful completion of a hospital-affiliated formalized residency or clinical fellowship in the past two years;

and

- Current certification or active participation in the examination process leading to certification in orthopedic surgery by the American Board of Orthopedic Surgery or the American Osteopathic Board of Orthopedic Surgery; or
- Successful completion of an ACGME- or AOA-accredited residency in orthopedic surgery.

Staff Status Requested *(please check one)*

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

Privileges included in the core
Privileges to evaluate, diagnose, consult, and provide non-surgical and surgical care to patients of all ages—except as specifically excluded from practice and except for those special procedure privileges listed below—to correct or treat various conditions, illnesses, and injuries of the musculoskeletal system. Privileges include, but are not limited to, those delineated in the accompanying orthopedic surgery procedure list. Practitioner accepts responsibility to supervise CRNA administering anesthesia while exercising those privileges that are requested and approved.

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

Special Procedures Privileges

To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth in the medical staff policies governing the exercise of specific privileges (**see attached "Supporting Documentation Form"**).

Procedure (Check if requested) →	√	**Criteria**	**Recommend?** **Yes**	**No**
Use of fluoroscopy		*		
Assist in Surgery				

* Requires current California State Fluoroscopy Operator Certificate.

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

_____

_____

_____

Additional Privileges Requested (write in below):

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

_____

_____

_____

Acknowledgement of Practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Mayers Memorial Hospital District, and;
I understand that:
(a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

_____ _____

Applicant Date

Recommendations

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

_____	_____
Credential Committee Chair or Vice-Chair or Vice Chair	Date
_____	_____
Medical Executive Committee Chair or Vice-Chair	Date

CORE PRIVILEGES
ORTHOPEDIC SURGERY

GENERAL

Amputation, Major (Above Knee, Below Knee, Transmetatarsal, Below Elbow, Above Elbow)
Amputation, Minor (Finger, Toe)
Amputation Revision
Arthrocentesis
Arthrodesis/Arthrotomy
Arthroplasty
Arthroscopy
Bone Biopsy
Bone Graft
Bone Manipulation
Bone Resection
Bursectomy
Cast Application/Change
Cheilectomy
Closed Reduction Fracture with/without Cast
Closed Reduction Internal Fixation
Closed Reduction External Fixation
Condylectomy
Excision Bone Spur
Excision Calcium Deposits
Excision Epicondyle
Excision Exostosis
Excision Ganglion
Excision Osteochondroma
Insertion/Removal nails/plates
Insertion/Removal plates/screws
Insertion/Removal Steinman pin/K-wire
Ligament Repair
Nerve Repair
Open Reduction/Fixation
Osteotomy
Percutaneous Pinning
Removal of Loose Bodies
Skin Graft
Synovectomy
Tendon Repair/Transplant
Tendon Sheath Exploration

ARM/HAND

Acromioplasty
Carpal Tunnel Release
DeQuervain's Release
Dupuytren's Contracture Release
Finger Joint Prosthesis
Subacromial Shoulder Decompression
Trigger Finger Release
Ulnar Nerve Transposition

FOOT
Bunionectomy
Excision Morton's Plantar Neuroma
Hallux Valgus Correction
Hammer Toe Correction
Heel Cord Lengthening
Tarsal Tunnel Release

LEG/HIP
Femoral Rodding
Hip Nailing
Intramedullary Nailing
Total Hip Replacement

KNEE
ACL Repair
Excision Baker's Cyst
Meniscal Repair
Meniscectomy
Patellectomy
Total Knee Replacement

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Register of Surgical Procedures	POLICY # Surg0037
DEPARTMENT/SCOPE:	Surgery	Page 1 of 1
REVISION DATE:	12/01/2023 9/29/2016 10/9/2018	EFFECTIVE DATE: 6/19/2012
AUDIENCE: Surgery		APPROVAL DATE: 4/11/2024
OWNER: L. Melang		APPROVER: T. Overton

DEFINITIONS:

EMR: Electronic medical records

PURPOSE:
To define the requirements for maintaining a detailed log of procedures and surgeries scheduled and performed at Mayers Memorial Healthcare District in the Surgical Department.

POLICY:
In accordance with Federal Code of Regulations §482.51 (b)(5), Mayers Memorial Hospital District maintains a complete and up-to-date register of all procedures and surgeries that are scheduled and performed in the surgical department. The register log is populated through the ***Cerner*** EMR scheduling and case documentation and reports are accessed using ***Discern Analytics 2.0***. Log is updated in real time per EMR case documentation. Report of log is generated and printed monthly and as needed by the surgery manager. The log contains the following information as applicable:

MRN #
FIN#
Patient name
Date of birth
Age
Encounter type
Surgeon
Location
Anesthesia type
Primary procedure
Other procedures
Specialty
Anesthesia Care Provider
Case attendees
Pre-op diagnosis
Post-op diagnosis
Wound class
Surgical start and stop times
Anesthesia Start and stop times
In Room and out of room times

REFERENCES:

1. Code of Federal Regulations. Title 42. Subpart D – Optional Hospital Services. Condition of participation: Surgical Services. §482.51 (b)(4). Last amended 11/22/2023. . eCFR :: 42 CFR Part 482 Subpart D -- Optional Hospital Services. Accessed 12//01/2023.
2. Operating Room Register 08.00.08. Surgical Services. In: *ACHC Accreditation Requirements for Critical Access Hospitals*. 2023 ed: pg 294.

COMMITTEE APPROVALS:
Surg: 4/11/2024

SUBJECT/TITLE:	Selection of Blood and Components for Transfusion	POLICY # LAB4024
DEPARTMENT/SCOPE:	Laboratory – Blood Bank	Page 1 of 3
REVISION DATE: n/a		EFFECTIVE: 01/23/2024
AUDIENCE: All Lab Staff		APPROVAL DATE:
OWNER: Sophia Lou Rosal, CLS		APPROVER: Kevin Davie

POLICY

Blood and blood components are selected for transfusion based on the ABO and Rh group of the recipient and the donor unit ABO/Rh blood container label.

A. Red blood cell components must be compatible with the patient's ABO antibody.

B. Plasma components must be ABO compatible with the patient's ABO antigens.

C. Platelets components may or may not be compatible with the patient's ABO antigens.

D. The ABO/Rh type of Cryoprecipitate may be ignored in adult recipients.

Red blood cell containing components selected for a recipient with unexpected antibody must be serologically anti-IgG crossmatch compatible and also have been demonstrated to lack antigens corresponding to that patient's clinically significant antibody.

A. **Whole blood**
Recipients shall receive ABO group specific whole blood unit.

B. **Packed Red Blood Cells**
Recipients shall receive ABO group-specific or ABO group-compatible Red Blood Cell components.

C. **Rh Positive Recipients**
Rh positive recipients may receive either Rh positive or Rh-negative whole blood or Red blood cell components.

D. **Rh Negative Recipients**
Rh negative recipients may receive Rh negative Whole Blood or Red Blood Cell components.

E. **The recipient has clinically significant antibodies present or a history of the same:**
If possible, the units to be transfused to a patient with a clinically significant antibody must be screened and found to be negative for the corresponding antigen. The units must also be compatible with the recipient's serum using an antiglobulin crossmatch.

If it is not possible to screen units for the antigen corresponding to the patient's antibody, units will be selected for transfusion according to Blood Center of the Pacific (BCP) guidelines.

If only a "type & screen" was requested, the appropriate number of units negative for the corresponding antigen must be ordered from Vitalant and saved in the blood bank refrigerator for the patient in case a crossmatch is requested.

F. **Blood administered after Non-Group Specific Transfusion.**
It is safe to transfuse group specific blood to a patient following administration of non-ABO group specific blood if the crossmatches are compatible.

If incompatible crossmatches are encountered due to ABO incompatibility, continue using Red blood cells of the alternate compatible ABO group which was transfused first.

G. **Patient's ABO Group is unknown, or patient has an unresolved ABO discrepancy and there is an immediate need to transfuse:**
When the patient's ABO group is unknown, Group O Red Blood Cells may be transfused. **(NEVER use whole blood)**

H. **Emergency Release of Blood**
Issue O negative Red Blood Cells, uncrossed or crossmatch incomplete if there is no time to perform a type, antibody screen and crossmatch. The physician MUST sign a waiver form (Emergency Release of Blood Form). Obtain and test a specimen from the patient and switch to group and type specific red blood cells as soon as possible so as to avoid depletion of the O Negative units in stock.

I. **Selection of other components:**

1. **Fresh Frozen Plasma**
FFP shall be ABO compatible with the recipient's red blood cells. Never use historical blood type to select FFP for a patient; the patient must be typed from his current admission. If this is not possible, give group AB FFP. *The Rh type is not a factor is selecting FFP.*

2. **Plateletpheresis**
ABO matched plateletpheresis are preferred. If ABO compatible platelets are not available, any ABO type may be issued.

3. **Cryoprecipitate**
ABO/Rh type is NOT a factor in selecting cryoprecipitate. All blood types are acceptable.

SUBJECT/TITLE:	Selection of Blood and Components for Transfusion	POLICY # LAB4024
DEPARTMENT/SCOPE:	Laboratory – Blood Bank	Page 3 of 3
REVISION DATE: n/a		EFFECTIVE: 01/23/2024
AUDIENCE: All Lab Staff		APPROVAL DATE:
OWNER: Sophia Lou Rosal, CLS		APPROVER: Kevin Davie

REFERENCES

Association for the Advancement of Blood and Biotherapies, *Standard for Blood Banks and Transfusion Services*, current edition.

Association for the Advancement of Blood and Biotherapies, *Technical Manual*, 20th Edition. Website: https://www.aabb.org/docs/default-source/default-document-library/publications/technical-manual-20th-edition-methods-and-appendices.docx?sfvrsn=8c9876fe_2 | Retrieved on 01/24/2023

COMMITTEE APPROVALS:

P&P: 6/5/2024
MEC: 6/13/2024

SUBJECT/TITLE:	Slips Trips and Falls Program Plan	POLICY # SAF036
DEPARTMENT/SCOPE:	Safety	Page 1 of 7
REVISION DATE: n/a		EFFECTIVE: 12/8/2023
AUDIENCE: All hospital staff		APPROVAL DATE: 5/6/2024
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.

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.
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.

SUBJECT/TITLE:	Slips Trips and Falls Program Plan	POLICY # SAF036
DEPARTMENT/SCOPE:	Safety	Page 2 of 7
REVISION DATE: n/a		EFFECTIVE: 12/8/2023
AUDIENCE: All hospital staff		APPROVAL DATE: 5/6/2024
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

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:
   - Ensure that processes and funds are in place to make the risks associated with slips, trips, and falls including implementing and monitoring this policy.
   - 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.

- 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:
    - Support and guide the implementation of this policy throughout Mayers Memorial Health Care District.
    - Develop procedures based on evidence-based practice that supports prevention and reduction of slips, trips, and falls.
    - Ensure the evaluators performing walking-working surface evaluations are properly trained.
    - Ensure that action plans/control measures are implanted in a timely manner.
    - Ensure that a system is in place for employees to report slip, trip and fall hazards.
    - Ensure accurate records are maintained and provide documentation upon request.
    - Assist department managers in STF investigation and strategies for prevention and remediation.
    - Monitor the program data on a quarterly basis and provide an annual review which is shared with senior leadership and made available to employees.
C. Ensure that STF prevention principles are considered when renovating or expanding facilities. Choose flooring material that meets slip resistance measures decided upon by facilities and safety designee.
D. Managers and Supervisors
    - Support and guide implementation of this policy throughout Mayers Memorial healthcare District.
    - 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.
    - Ensure employees have received appropriate awareness training to understand STF risk and how to participate in prevention measures.
    - Supervise employees in the compliance of this policy and any procedures regarding slips, trip, and fall prevention.
    - 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.
E. Employees

- 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***
- Promptly report to your supervisor/manager any hazards observed which may lead to a STF injury.
- 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.
- 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.
    2. Attend STF prevention and hazard recognition training as required.

F. 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.

- Follow flooring manufacturer recommendations for proper cleaning-product use and dilution procedures for the specific floor type.
- 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.
- Create cleaning schedules that avoid peak traffic times for wet mopping. Apply dry cleaning methods (sweeping, collecting debris) frequently throughout the day.
- 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 Plan	POLICY # SAF036
DEPARTMENT/SCOPE:	Safety	Page 5 of 7
REVISION DATE: n/a		EFFECTIVE: 12/8/2023
AUDIENCE: All hospital staff		APPROVAL DATE: 5/6/2024
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

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 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 online. All agents or chemicals used in MMHD facilities will have a Safety Data Sheet. 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). 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

- Eliminate- physically remove the hazard.
- Substitution- Replace the hazard with a different product or procedure.
- Engineering controls- Isolate people from the hazard.
- Administrative Controls- Change the way people work
- Personal Protective Equipment (PPE)- protect the worker from the hazard by use of PPE

.

D. Training

- 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.
  See the IIPP

E. Documentation

- Proper Documentation will be kept on hazard identification, action items, timeline for remediation and injury logs.
- 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

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.

SUBJECT/TITLE:	Slips Trips and Falls Program Plan	POLICY # SAF036
DEPARTMENT/SCOPE:	Safety	Page 7 of 7
REVISION DATE: n/a		EFFECTIVE: 12/8/2023
AUDIENCE: All hospital staff		APPROVAL DATE: 5/6/2024
OWNER: Dana Hauge, Safety Officer		APPROVER: R. Harris

F. 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:
Safety: 6/5/2024

SUBJECT/TITLE: Wet Mount		POLICY # LAB5001
DEPARTMENT/SCOPE: Laboratory - Microbiology		Page 1 of 4
REVISION DATE: n/a	EFFECTIVE: 12/13/2023	
AUDIENCE: All lab staff	APPROVAL DATE:	
OWNER: Sophia Lou Rosal, CLS		APPROVER: Kevin Davie

PURPOSE

Direct wet mount of vaginal, urethral, penile discharge or first voided urine may be used to detect the presence of white blood cells, yeast/ fungal elements, trichomonas, and clue cells. Identification of Trichomonas vaginalis organisms allow the diagnosis of symptomatic infections. Trichomonas vaginalis infections are primarily diagnosed by detection of live motile flagellates from direct saline wet mounts. Vaginal Candidiasis can often be diagnosed by the clinical characteristics and direct examination of vaginal secretions; observation of yeast/fungal elements in the wet mount may aid in the diagnosis.

POLICY

A wet mount specimen is used to detect the presence of white blood cells, yeast, trichomonas and clue cells from typically a vaginal swab, although penile and urethral swabs and first voided may also be tested.

PROCEDURE

Reagents / Materials

1. Capped tubes with 0.5 to 1 mL of sterile saline
2. Disposable glass or plastic pipettes
3. Glass slide and cover slips
4. Microscope

Specimen Requirements

1. Vaginal discharge
2. Urethral discharge
3. Penile discharge
4. First voided urine with or without prostatic massage

Note: Specimen of choice is a swab placed in a tube containing a small amount of (0.5-1mL) if sterile saline.

Specimen Stability

1. A direct wet mount specimen should be delivered to the laboratory immediately and examined within one hour of the collection.

SUBJECT/TITLE: Wet Mount		POLICY # LAB5001
DEPARTMENT/SCOPE: Laboratory - Microbiology		Page 2 of 4
REVISION DATE: n/a	EFFECTIVE: 12/13/2023	
AUDIENCE: All lab staff	APPROVAL DATE:	
OWNER: Sophia Lou Rosal, CLS		APPROVER: Kevin Davie

- If the sample is received in > 1 hour post collection, report **"Unable to R/O Trichomonas". Time since collection is more than 1 hour.**

2. Reject refrigerated specimens

Specimen Preparation

1. Vigorously mix the swab(s) in and out of the saline making sure to collect all the material adhering to the side of the tube.
2. Remove the swab from the saline and depress onto a clean, dry microscope slide expressing a small amount of fluid.
3. Coverslip the sample and examine under a microscope using the 40X objective.

Quality Control

Check the direct-mount reagents each time they are used. The sterile normal saline solution should be clear, with no visible contamination.

PROCEDURE FOR DIRECT EXAM

The specimens should be delivered to the laboratory immediately. Test should be performed immediately upon receipt of the specimen.

1. Apply the patient's specimen to a small area on a clean microscope clide.
2. Immediately before the sample dries, add 1 -2 drops of saline with a pipette. If urine sediment is used, the addition of saline may not be necessary.
3. Mix the saline and the specimen together with the pipette tip.
4. Cover specimen with the no. 1 coverslip.
5. Examine the wet mount with the low power (10x) objective and low light.
6. Examine the entire coverslip for motile flagellates. Suspicious objects can be examined with the high power (40X) objective.
    - The organism is usually slightly lager than a PMN, and you should see the flagellar movement.

SUBJECT/TITLE: Wet Mount	POLICY # LAB5001
DEPARTMENT/SCOPE: Laboratory - Microbiology	Page 3 of 4
REVISION DATE: n/a	EFFECTIVE: 12/13/2023
AUDIENCE: All lab staff	APPROVAL DATE:
OWNER: Sophia Lou Rosal, CLS	APPROVER: Kevin Davie

Result Interpretation

Follow the steps below to interpret the examination of a direct wet mount specimen;

If	Then
Trichomonas vaginalis	Trichomonas is usually slightly larger than a PMN and you should see the flagellar movement. Observe motility for the jerky, non-directional movement. Four anteriorly directed flagella. One posteriorly located flagella along the outer margin of the undulating membrane, which trends only half the distance to the posterior end of the body.
Yeast cells	Budding yeast and/or hyphae/ pseudohyphae show regular points of constriction, resembling sausage links. If necessary, perform gram stain to confirm.
Clue cells	Squamous epithelial cells covered with coccobacillary rods obliterating the border of the cell. Indicative of Gardnerella vaginalis If necessary, perform gram stain to confirm.
PMN cells	Indicative of bacterial infection

Semi-quantitative reporting for microscopic exam when the cells and/or organisms present:

1-4 per slide (40X)	1-4 per hpf (40X)	5-10 per hpf (40X)	>10 per hpf (40X)

- If motile flagellates (axostyle and undulating membrane) are seen, the the trophozoites of Trichomonas vaginalis are present. Report out as “Trichomonas seen”
- If no motile flagellates are seen, report the specimen as “No Trichomonas seen”.
- Presence of yeast and > few WBC should be reported in CERNER.

SUBJECT/TITLE: Wet Mount		POLICY # LAB5001
DEPARTMENT/SCOPE: Laboratory - Microbiology		Page 4 of 4
REVISION DATE: n/a	EFFECTIVE: 12/13/2023	
AUDIENCE: All lab staff	APPROVAL DATE:	
OWNER: Sophia Lou Rosal, CLS		APPROVER: Kevin Davie

Limitations

- Specimen should be transported to the laboratory ASAP due to the viability of the Trichomonas motility.
- Calgi swabs are not recommended due to the tight adherence of the specimen to the swab.
- Wet mounts have been reported to detect Trichomonas vaginalis in 75-85% of infected patients only.
- If the patient has Trichomonas hominis intestinal infection and the urogenital specimen becomes contaminated with the fecal material, a false positive Trichomonas vaginalis result may be reported since both organisms are similar in shapes.

REFERENCES

Murry, PR et al. *Manual of Clinical Microbiology*, current edition

2020 American College of Physicians. *The Medical Laboratory Evaluation Program; Wet Mount Examination*. Philadelphia, PA 19106-1572

COMMITTEE APPROVALS:

P&P: 6/5/2024
MEC: 6/13/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

Operations Report
June 2024

Statistics	May YTD FY24 *(current)*	May YTD FY23 *(prior)*	May Budget YTD FY24	Variance
Surgeries ➢Inpatient ➢Outpatient	 0 0	 0 0	 TBD TBD	
Procedures** *(surgery suite)*	0	0	TBD	
Inpatient	1989	1656	1623	333
Skilled Nursing Days	26531	26342	25192	189
Emergency Room	4174	3952	3881	222
OP Visits (OP/Lab/X-ray)	13784	14503	13324	719
Hospice Patient Days	894	879	1103	15
PT	1905	2235	2314	330

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

Human Resources

June 2024

Submitting by Libby Mee – Chief Human Resource Officer

Staffing, Recruitment and Retention

The Human Resource/Payroll/Benefit department currently supports 300 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.
We have received interested CMO, Radiology Tech and Director of Nursing applicants.
We are currently utilizing interim professional in the Pharmacist and Infection Prevention roles. Once current staff is orientated, we will be fully staffed, and will eliminate long term registry use, in our Emergency Room and Med/Surg Acute

We are happy to host 5 Interns this summer from our Planting Seeds and Growing Our Own program. Students will gain hands-on knowledge in our nursing, IT, Lab, Physical Therapy and Imaging departments. The Interns will also volunteer time with our Foundation.

Leadership Academy

We have fully executed agreements with our support partners for the Leadership Academy for next fiscal year.
Jen Miley, with Elite Edge Coaching, will be on-sight for her first quarterly training in August.
We have selected 15 managers to participate in the first Healthcare Leadership Institute cohort. The group will have a kick off/orientation webinar June 27th and then will settle into monthly sessions throughout the remainder of the program.

Employee Health, Wellness and Benefits

Work Related injury and Illness

For the year, there as has been 3 reportable work-related injuries, resulting in 5 days away from work. There has been 4 first aide injuries, with no days away from work.
In the past month, we have returned 2 employees back to their primary duties that were previously off work or working accommodated duties due to their work related injuries.

Miscellaneous

ACHC

I am continuing my work on updating orientation, training, competency, and compliance content to meet ACHC standards. We are evaluating a Skills Management system that would validate skills data, helping us track and assess employee skills competency.

Annual Employee Evaluations
We have opened our annual Employee Evaluation period. Through the month August, department managers will evaluate employees on established competencies.

HR position restructuring
The HR team continues to change, as our current payroll clerk has formalized her intent to retire. I am reevaluating the department position structure and job descriptions and will be posting and interviewing for vacant positions.

Training and Conferences
I am scheduled to attend a mid-year Labor and Employment Law seminar hosted by Hanson Bridgett in Sacramento. We will review new employment law and discuss implications of these laws to our workplace.

EMPLOYEE STATISTICS

2024 Fiscal Year

359

Total Employees
for the year

RETENTION VS. LOSS

87

People hired/rehired

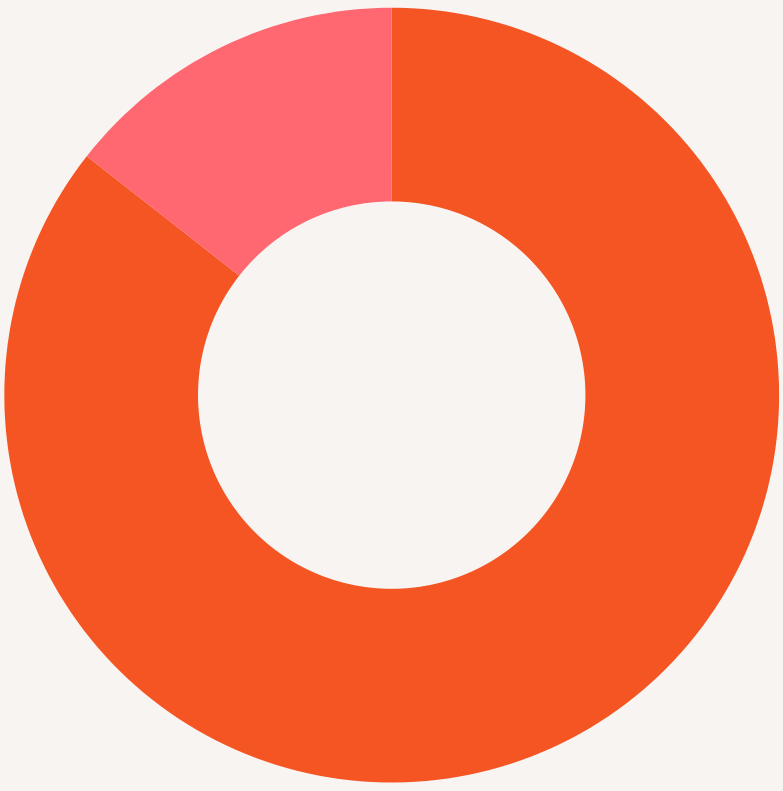
48

people terminated their employment

ADJUSTED TURNOVER STATS:

Goal turnover for FY 24 is
17.52%

Adjusted Turnover
13.37%



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

Positions:	# available:
***Chief Medical Officer**	1
Controller	1
***Director of Skilled Nursing**	1
Emergency Room RN I	2
Employee Health Nurse	1
Environmental Services Aide	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
Med Surg Acute Charge Nurse	1
***Pharmacist**	1
***Physical Therapist**	1
Retail Pharmacy Clerk	1
Rural Health Clinic Med Director	1
Rural Health Clinic Med Assistant	1
Skilled Nursing CNA	12 FT, 4 PT
Skilled Nursing LVN	11 FT, 2 PT
Skilled Nursing RN	3
Skilled Nursing Charge Nurse	1

Chief Public Relations Officer – Valerie Lakey
June 2024 Board Report

Legislation/Advocacy

The Legislature has passed its version of the 2024-25 budget by the June 15 deadline. It represents legislative budget priorities as negotiations between the Legislature and governor continue. Additional budget changes resulting from these negotiations will occur through subsequent budget bills and budget "trailer bills" over the coming weeks. All bills related to the 2024-25 budget must be approved prior to the start of the new budget year on July 1.

AB 2975 would require the Division of Occupational Safety and Health (better known as Cal/OSHA) Standards Board to amend the existing Workplace Violence Prevention in Health Care regulation to require metal detection screening monitored by trained security personnel at a hospital's main public entrance, emergency department entrance, and labor and delivery entrance, if separately accessible to the public. ***Oppose unless amended.***

SB 963 would require general acute care hospitals with emergency departments (EDs) to create a human trafficking system available at the ED that would allow patients to self-identify as a victim of human trafficking or domestic violence. CHA was successful in securing amendments that would limit hospital and staff liability for complying in good faith with the provisions of the law. ***Support***

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. ***Oppose unless amended.***

AB 2297 would prohibit hospitals from considering patients' monetary assets when determining eligibility for charity care or discount payments or imposing a time limit on eligibility. ***Oppose unless amended*** – Senate Judiciary June 25

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 is contingent upon a state budget appropriation and includes a parallel budget request to fund the proposed reimbursement model.

SB 1432 is CHA's proposal to address the 2030 seismic requirement. The bill would extend the 2030 deadline to 2033, with up to an additional five years depending on the project. The bill would also address additional post-earthquake disaster preparedness requirements for hospitals, assess opportunities for financial support, and require the state to assess the financial and access impacts of the 2030 requirement. ***Support*** – In Assembly Health June 25

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. ***Support*** – In Senate Health June 26

Federal Bills

H.R. 7931: Preserving Emergency Access in Key Sites Act To amend title XVIII of the Social Security Act to update the fee schedule for ambulance services provided by critical access hospitals.

H.R.8244 - Ensuring Seniors' Access to Quality Care Act To amend titles XVIII and XIX of the Social Security Act ensure appropriate approval for certain skilled nursing facility and nursing facility nursing aide training and competency evaluation programs under the Medicare and Medicaid program.

Public Relations/Marketing

We completed the booklet for Men's Health month. Click HERE for a digital copy of the Women's Health booklet.

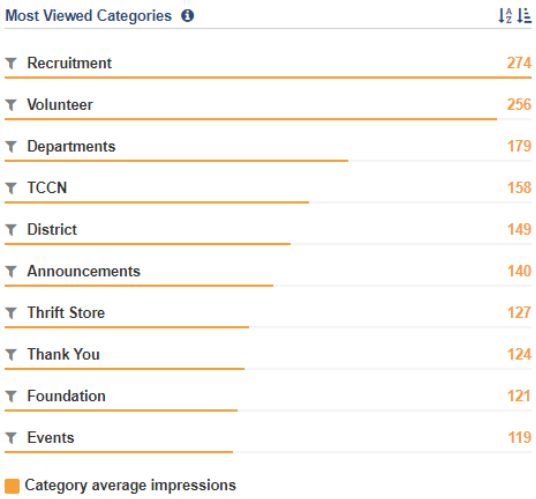
The employee storefront is active and has some great items available for purchase. Employees will be able to purchase MMHD branded items. We can also provide staff gifts through the platform and will be able to change the products quarterly.

We put together marketing "Boxes" for departments to use at events. This will ensure consistency of branding and make sure that we are represented well wherever we go. We have 12 departments who were represented in the health fair. We will also be attending the Pit River Health Fair.

We completed all 12 monthly events and 4 quarterly events for FY24 and are excited about the way these went. Many thanks to the departments that helped and participated. We were very successful in keeping Mayers in the public eye and have built our email list through the events.

We started tracking categories on our social media. This is an overview from January 1 – May 31, 2024:

Recruitment performed better than any other category.
This post type is 55.4% more engaging.
You've posted content with this category 157 times in this time range.



Mayers Healthcare Foundation

Health Fair – This report was written as we prepare for the Health Fair and it will have happened before we have the board meeting. We are excited about the scheduled participation of 12 MMHD Departments and 14 community partners. At the time of this report there are 21 Mammogram appointments scheduled, with more paperwork packets out there that should be turned in.

You can purchase vouchers online and use them at the Mayers lab in Fall River Mills or Burney until July 5, 2024.

Vouchers purchased at the Health Fair June 22 will receive a 10% discount and will be entered in a drawing. Vouchers purchased on-site at the Health Fair can also be used until July 5, 2024.

A wide variety of community partners sharing information about nutrition, exercise, spiritual wellness, low-cost lab tests, health screenings and emergency services are there to share information to help you achieve optimal health and wellness.

Golf Tournament
Online registration is open NOW! Don't miss your chance to secure a spot in the 2024 Mayers Healthcare Foundation Annual 'On the Green' Fundraiser Golf Tournament! Proceeds from this year's tournament benefit Mayers Tri County Community Network, which will enable the department to provide valuable resources and services to our Intermountain communities. Don't miss out on the fun! Last year's event raised over $18,000 for the ambulance.

Thrift Store Update
The Thrift Store continues to thrive with donations, sales, and support of the volunteers. The store averages between $400-$500/day with many repeat customers. This time of year also sees a lot of new visitors.

We have had a little trouble with the swamp cooler on the building and have had to close early a couple of days and close entirely one day. The maintenance team is working to remedy the issue and had provided some portable units in the interim.

We have purchased many new display and storage items, ordered a new road sign, and have found a Point-of-Sale systems – all of which are being purchased with our $7000 grant from the Burney Regional Community Foundation.

Volunteers
We met to establish a new process for onboarding new volunteers. There are a couple of new volunteer applications that would like to help in the Skilled Nursing.

Awards and Scholarships

The Mayers Healthcare Foundation is proud to announce the Spring 2024 Mayers Employee Development Scholarship (MEDS) awardees. A big congrats to our recipients!

- Kelcey Easley: **$1,000** for RHIT Certification & Coding Specialist Certificate from the American Health Information Management Association
- Alexandria Jarnaghan: **$800** for nursing studies at Shasta College

- Jennifer Insley: **$800** for nursing studies at Lassen College
- In addition, Alexandria and Jennifer are being awarded **$700** each from the Julie McCullough Memorial Scholarship Fund for a total award amount of **$1,500** each.

The Foundation also awarded an additional **$8,500** to ten community members for their healthcare-related fields of study for a total scholarship award amount of **$12,500**! Congratulations to: Diana Sofia Gonzalez-Green, Dayanara Vega, Jaiden Ford, Kylie Miller, Hailey Schweback Valdez, Reina Reynoso, Peyton Estes, Madison Hamilton, Ciera McClung and Francie Ferguson.

MEG (Mayers Employee Giving)

With the introduction of the Power of 2 Campaign, the Mayers Employee Giving has grown from $148.87 a month to 34 employees giving $385.30 per month. This program is a great way for staff to invest in the departments of MMHD and make the decision as to where the funds are spent. Thank you to all who participate.

Tri County Community Network

Children's Programs

- Kid Fit will begin June 22nd and will continue through the summer with six fun and free events for children of all ages. Our first event will coincide with the Health Fair and we are hoping to see a large crowd. Kid Fit is funded through Community Foundation of the North State
- Bright Futures is back and is offering a full list of fun activities and events to families with children 0-5. Kiely is working on her certification for level 4 of Triple P parenting support. She will be able to offer 1-1 parent support in July. Bright Futures is funded through First 5 Shasta.

Grants/ Grant Programs

- A grant is being written through the Shasta County Asset Forfeiture program to purchase the materials necessary to bring the research proven Botvin program to our local schools. The Botvin Program has been proven to reduce the use of drugs in teens by teaching coping strategies, good decision-making skills, and how to build healthy relationships.
- Redding Rancheria accepted the grant request to train 2-3 people in hosting Parent Cafes. Parent Cafes are events where parents can come together and support each other through the journey of parenting. TCCN is working with Pathways to Hope and First 5 Shasta to schedule that training.
- TCCN was chosen by the Community Foundation of the North State to receive a $10,000 grant. The grant is to be used to support existing programs offered by the non-profit and support the community services that we are already providing. TCCN is grateful and honored to be chosen! Val and Marrisa will be meeting this week to discuss how to best utilize this generous grant.

Partnerships

- TCCN is continuing to partner with SMART to bring employment services to our area. They will be providing their employment services from our temporary offices in McArthur.
- TCCN is partnering with the Healthy Brain Initiative to bring a series of classes to our community. The focus is on healthy aging and self-care for caregivers. TCCN will be offering referrals to our Nutritionist at the September event.
- Marrisa met with representatives from Cal Works to support their efforts in finding business who will support the volunteer efforts of their clients.

Website

- The new website is currently being built and will be a robust community education tool and include a community calendar. The website will include videos and information that align with health observances, education and support for parents, community resources, and a community calendar.

Community Events

- 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.
- Kid Fit "Take me Fishing" event will be on Thursday June 27th from 5-7pm
- Bright Futures is hosting events three to four days a week in Round Mountain, Burney, and Fall River. A schedule can be found on the Mayers Tri County Community Network Facebook page.

Building Update

After last month's board meeting, we had thought the letter from the architect stating the event space as well as the upstairs space was compliant, and we would just need a fire safety inspection. After asking for an inspection, we received an email from the Shasta County Building and a letter from the Burney Fire Protection District. The opinion of Shasta County was that we could use the event space pending the BFD inspection. The BFD opinion differed. The bottom line is that we had to vacant the building and there are several things we need to do for the building to be occupied. We met with Aspen Street and have a plan broken up into three parts. This will allow us to use the event space, office space, address unpermitted work from the past, become fire and life safety compliant and ultimately get the building occupancies correct. We will bring the proposal to you for approval.

In the meantime, it is important for all of us to remember that TCCN does not live in a building. It lives in the thirty years of service and dedication of the people who have come before us. And it continues to live in the vision, grit, and imagination of the people who to show up today. These challenges will only make the foundation of our programs better. We are currently working to building relationships and partnerships with community organizations and businesses to help us host events, etc. In the long run, this will benefit the foundation of our TCCN programs. We are temporarily in the McArthur offices and continue to work on community programs. The Bright Futures and Kid Fit programs (all grant funded) are thriving and we have many other projects on tap.

March Board Report
Clinical Division
6/18/2024

Imaging

- Harold Swartz passed his test for CT certification. Once his certification documents are issued Harold can start the process to submit our American College of Radiology accreditation for CT.
- Annual physics testing is complete with no deficiencies.
- The imaging department is participating in health fair June 22.
- We have hired a new tech to fill one of our open tech roles. He is scheduled to start at the end of July.

Physical Therapy and Cardiac Rehab

- We are seeking a registry therapist until we can hire a physical therapist. Daryl Schneider, PT Manager, has reached out to the five physical therapy applicants with at least two phone calls. No phone calls have been returned.
- Physical Therapy and Cardiac Rehab will have a table at the health fair June 22.
- The Physical Therapy department is excited to have summer interns in the department.
- Cardiac Rehab has added posters for stretching. Seventy-five percent of maintenance patients have added stretching to their regimens.
- Dignity Health Medical Group, North State, has updated their physical therapy referral form with Mayers correct information.

Hospital Pharmacy

- Shortages of lorazepam and epinephrine have resolved.
- Our DEA inventory is scheduled for the end of the month.
- Policies for sterile compounding are being revised due to updates to USP <797>.

Retail Pharmacy

- Kristi Shutlz and Alesha Johnson have successfully completed the historical claim audits on 06/03/2024. The audit covered more than six thousand claims. Our 340B Third Party Administrator (TPA) is diligently working to complete our audits submitted by the end of June. We are receiving replenishment as they complete the claim captures.
- A meeting with our 340B Contract Specialty Pharmacy, Premier Pharmacy/Polaris RX is scheduled for July 2nd at RHC. Brian Mason, Vice President of PolarisRX requested to discuss our current contract relationship, explore ways to enhance our 340B contract relationship and perform a formulary review with Kimberly Westland and Myself. He recently took on this position and would like an opportunity to collaborate to avoid potential termination.
- We are working with our partners in local clinics on opioid safety.

- We are working with other clinics in the community to ensure prescriptions are received at the retail pharmacy and not the hospital pharmacy.

Infection Prevention

- Amy Marisnski, RN, Infection Preventionist, has been collaborating with engineering and project management regarding ICRA risk assessments and procedures.
- Annual TB risk assessment is being completed and procedures for employee health updated. ACHC compliance will be complete with this year's employee annual compliance.
- Isolation signs have been updated and issued. Amy is finding old signs and taking them out of use. Nursing staff has been provided with a quick reference guide for the new isolation signs.
- To facility hand hygiene additional hand sanitizer dispensers have been placed outside the rooms at NS1.
- Infection prevention and nursing staff at the Burney Skilled Nursing facility are working to contain a Rhinovirus outbreak. Amy completed all the required reporting to the state and county.

Laboratory

- CLIA Compliance: Sophia has successfully led the clinic's CLIA compliance efforts
- The laboratory team is actively preparing for the upcoming health fair this weekend.
- IT is working to implement a Stat Monitoring TV system. This system will assist lab personnel in timing certain tests accurately, ensuring optimal turnaround times.

Respiratory Therapy

- Maryann Worthan, RT, is now a certified pulmonary function technologist!
- Mayers Pulmonary Function lab is now registered with the American Thoracic Society.
- Maryann Worthan and David Ferrer are OSHA Respirator Fit Testing certified. Fit testing is required as part of the tuberculosis control plan and ACHC.
- Pulmonary screening will be performed in the clinic lobby and at Mayers Health Fair.

NURSING SERVICES BOARD REPORT

June 2024-Reporting for May

CNO Board Report

- Cerner Go-Live on hold. Continue to work with experienced Cerner experts on build for meeting compliance for state regulation. Mayers superusers and Managers working together gaining knowledge that was not previously shown.
- ACHC regulations being reviewed with Quality and Acute Departments. Work continues towards restructuring policies and procedures with direction from ACHC consultant.
    - Education plan is in progress.

SNF

- Census- (79) Fall River- 35 Burney Annex- 25 Memory Care- 19
    - Burney – 4 Female beds, 1 Male bed (1 Male and 1 Female bed on hold due to resident behaviors)
    - Fall River – 1 Female bed, 1 Male bed (Male scheduled for admit 6/26/24)
- We have 2 CNAs that will need to retest due to lack of continuing education hours.
- Continuing to struggle with staffing in-house nurses. Medifis and NPH are meeting our needs at this time to maintain staffing ratios.
    - Continuing with recruitment efforts. Nurse Facilities Tour scheduled for 6/18/24.
    - SNF Cerner Training continues.
        - Cerner is currently providing extra training to SNF Superusers to address team implementation concerns.
    - The Burney facility has two positive cases of Rhino Virus.
        - Three other residents are symptomatic.
        - Outbreak has been reported by IP to the appropriate authorities.

Acute

- May 2024 Dashboard
    - Acute ADC 2.48, ALOS 4.86
        i. High ALOS was caused by a patient with a Medicare Advantage plan with at 17-day LOS.
    - Swingbed ADC 4.19, ALOS 10.36
    - OBS Days: 11
- May Staffing: Required 8 FTE RN/LVN's, 2 PTE RN's, 4 FTE CNA's & 2 FTE Ward Clerks
    - Utilizing 2 FTE NPH RN, & 1 PTE NPH RN/LVN
    - 1 RN on orientation and newly hired RN to start orientation mid-June
    - The department is fully staffed, and all trainees expected to be completed with orientation by September 2024!
- Updates:

- Received education from our ACHC Consultant on restraint protocols, enhancing our understanding and proficiency in this crucial area. Furthermore, we actively engaged with stakeholder groups to develop comprehensive education and implementation strategies, fostering a collaborative approach towards effective restraint management.
- Collaborated with the billing team on rectifying accounts flagged in the RCAT reports. By working closely together, we aim to address discrepancies efficiently and ensure accurate billing practices, thus enhancing overall financial integrity and compliance.
- Refined competency checkoff lists and skills assessments. By prioritizing this initiative, we aim to streamline the evaluation process, ensure staff proficiency, and maintain high standards of performance across all levels of our organization in accordance with ACHC Standards.

Emergency Services

- May 2024 Dashboard
  - Total treated patients: 418
  - Inpatient Admits: 19
  - Transferred to higher level of care: 29
  - Pediatric patients: 82
  - AMA: 0
  - LWBS: 9
  - Present to ED vis EMS: 50
- May 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 role as Clinical Project Manager for Cerner.
    - Several high-level calls with Cerner for LTC
    - Continued resource for the clinical areas in the facility
  - Open positions: 1 FTE NOC
    - FTE Days to be filled on Aug 20th by Lillian Consiglio
    - Offer Pending acceptance for FTE NOC
- **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 for RNs 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

May 2024

Referrals Received	**24**				
	Total Pending (does not include rejected referrals)	**Patient Cancelled and needs to reschedule**	**Called patient and no call back or insurance pending**	**Pending RN/ anesthesia Review**	**Rejected** **(BMI >45, Medically complex, procedure not performed etc)**
Referrals pending scheduling (Includes referrals received previous months)	28	5	13	10	8
Procedures Performed	**05/6/2024**	**05/7/2024**	**05/8/2024**		
Colonoscopy	**6**	**5**	**5**		
EGD	**1**	**1**	**1**		
Colonoscopy/ EGD Combo			**1**		
Other	**0**	**0**	**0**		

Total cases Performed	**7**	**6**	**7**	**Monthly Total:**	**20**

- We continue to perform Endoscopy procedures 1 week per month (3 days).
- Dale Syverson, MD, Shannon Davidson, CRNA, Per diem Pre-op/ PACU RN (shared staff from Acute/ ED), Endoscopy techs: Mayers and Modoc Medical staff.
- Referrals continue to come in from local clinics with cases typically scheduled 1-6 weeks out. We are hearing very positive patient feedback regarding minimal wait time for procedures and the convenience of our location.
  *Redding Endoscopy Center is currently scheduling patients in January 2025
- **Scrub Tech training and Certification**: The partnership with Modoc Medical Center has continued with Scrub Tech receiving hands-on training for endoscopy procedures and scope re-processing, set-up for surgical cases and began Scrubbing-in to assist during General Surgery cases at Modoc. She travels to Modoc medical 2 days per week when we are not performing cases at Mayers. She works Per diem at the Retail Pharmacy.
  - She is 80% complete with independent study Scrub Tech Certification training.
- **Billing:** All surgery procedure charges remain unpaid due to incomplete Cerner build of Pro-fees. SR ticket was placed in early April when this was discovered, and multiple attempts have been made by Billing and IT department to complete this build. The team continues to escalate the issue with Cerner. All procedures have been coded but are pending Pro-fees.
- **Department Development:** Continuing work to meet ACHC standards of practice through approval of policies and procedures, standardizing training and competencies, and tracking quality measures. Preparing community education and department promotional resources for upcoming health fair and local clinics.

Ambulance Services

- **See Board Report—Manager to Report at Meeting**

Outpatient Medical

- Census:
  - May- 118 patients.
- Interview and offer extended to a candidate. This person is going through orientation now. Looking forward to the new employee and training asap
- Budgets turned in. Was able to ask questions and work well with Finance.
- Working on finalizing next FY priorities and turning in previous year priorities

- Meeting with IT today to work on capabilities of running healing rate and pressure injury reports for PI in the Cerner system. This has been a huge challenge to run reports in Cerner.
- Working on health fair education for the public.
- Planning for OPM inventory since it is a hardship to see patients and conduct inventory some years, especially with 1.75 employees.
- Continue to work as MMHD team on SR tickets for example Inpatient wound consult charges are not in the system. IT is working these challenges with finance.
- Continue to work with Bridget, IT, Pharmacy and Cerner on ways to streamline the OPM ordering process in Cerner.

TRAINING CALENDAR

- One CNA staff has not recertified in May and is expired. This CNA has not reached out to education and working nursing leadership.
- Trauma Nurse Core Curriculum (TNCC) for ED certification scheduled training is full in September with a wait list initiated for those outside of the ED.
- **Certification Trainings in May**
    - BLS training- 3 participants were recertified in May. Next scheduled training 6/18.
    - Mandatory Abuse and Dementia specific trainings were held on May 10 &24th with participants.
- **Other Training(s)**
    - Safe Patient Handling (SPH) with Beta consultation and Regina Blowers roll out of Staff Awareness program via Relias Platform. Live Q & A were held on May 1, 3, 22, 28. SPHM trainings for clinical and non-clinical staff were held on Attendance rosters are being calculated currently. SPHM trainings will be in June.
- **Abuse: Plan of Correction**
    - Training has been attached to the Safe Patient Handling and Mobility training and held on.
- **Special Project**
    - Lippincott Learning Platform was assigned to Acute and ED staff on May 21, 2024, and learners continue to reach out for support and express satisfaction with the platform. Will continue to support and report user stats in July.
        - Meetings with Lippincott Support Josh Ensley continues with content for Abuse POC being created in the platform to extend to registry and contract staff and will be downloaded into the platform relative to Cerner, ACHC and CDPH training requirements.
        - Registry process for training, competency assessment compliance in planning meetings with Lippincott Team continue for roll out of Education Platform for registry staff continue. This platform will allow unlimited user spaces for Registry Staff to complete competency assessments and demonstrate compliance for ACHC, CDPH/LTC regulations.

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 80% of our implementation roadmap now complete. While our focus is still on education we are also transitioning to the next phase, which focuses on enhancing the quality of our physician group through OPPE (Ongoing Professional Practice Evaluation), FPPE (Focused Professional Performance Evaluation), and peer review.

Provider Search Update

Our HR team continues to make great progress in our clinical staffing efforts. The search for our Chief Medical Officer (CMO) is ongoing, and we have several applicants we are reaching out to for interviews. We are looking forward to rescheduling the hospitalist interview originally set for June 18th once we've confirmed their availability. Our HR team is also actively seeking a physical therapist and refining our compensation packages for clinic physician and medical director positions to ensure we're offering the best possible opportunities to attract the best candidates. I am grateful for the hard work and dedication of our HR team, who are working diligently to bring in the best talent for our organization. We appreciate their tireless efforts to find the right candidates and look forward to announcing exciting new additions to our team in the near future.

Construction Projects Update

The Master Planning project remains on track to be completed by the end of fiscal year 2024. Our team is currently focused on equipment planning and layout for the Criteria Docs, which is an ongoing process that will be discussed further at our upcoming strategic planning workshop. The Burney Fire Alarm project is making progress, with the goal of completing it by July 1st. However, there have been some delays in the solar contractor's mobilization process, which includes vegetation management and equipment mobilization. The contractor has provided new dates for these tasks, contingent on permitting: July 15th for vegetation management and August 5th for equipment mobilization. We are also addressing an emergency project to repair the automatic transfer switch (ATS) at our Burney facility, which malfunctioned during a recent PG&E outage and had to be manually operated, posing a life-safety risk. To mitigate this risk, we have installed a temporary ATS until the repairs are completed, which is being carried out in collaboration with all relevant regulatory agencies.

Strategic Planning Workshop

We are thrilled to be hosting our Strategic Planning Workshop with the Board of Directors on June 25th, and the Executive Leadership team is eager to collaborate with you. A substantial amount of preparation has gone into making this event a success, and we are looking forward to a productive and engaging discussion. We are excited to share our progress and insights with you and look forward to your input which will be invaluable in shaping our future direction.

Surveys
Both the Skilled Nursing Facility relicensing survey and Fire Life safety 2567 plan of corrections have now been accepted. Small fines were levied for tags associated with the relicensing survey.

Pillar Goals and Priorities
The Executive Leadership team and I over the past month reviewed our leadership team's performance in FY24 and explored potential objectives for the upcoming FY25. These meetings allowed us to pinpoint several key areas for improvement. We have outlined a plan to implement these enhancements starting in July, which will drive progress and growth for our leadership team.

Collaboration
The CEO group, consisting of leaders from Surprise Valley, Modoc Medical Center, Mayers Memorial Healthcare District, Seneca, Plumas, and Eastern Plumas, had to be rescheduled for August. Additionally, my meeting with Chief May of Burney Fire was rescheduled for September, and our forthcoming meeting with Pit River Health is being rebooked. Notably, a meeting with the MVHC CEO is being planned for July which I am looking forward to.

Cerner
Although our Long-Term Care (LTC) Cerner implementation remains on hold, we have continued to schedule multiple meetings to address the current issues and explore potential solutions. As of now, no definitive decision has been made regarding the future direction of our LTC system, with both options - moving forward with Cerner LTC and staying with our current PCC system - still under consideration.

Thriving Together Initiative
Progress has been made on our Thriving Together initiative, aimed at revitalizing our long-term care facilities. To date, we have successfully installed planters and planted a garden, with the enthusiastic participation of our residents. Next month, we plan to take the next step by acquiring and installing fish tanks in both facilities, further enhancing the initiative's impact. This is just the beginning of our journey to infuse life and vitality into our facilities, with many more innovative ideas in the future.

Rural Health Clinic
As of this report, we have surpassed our goal of 25 and achieved 27 mammograms scheduled for the health fair, a testament to the RHC and foundations efforts. Additionally, I am pleased to announce that I will be meeting with the RHC Manager and Telemedicine Coordinator to explore the potential of integrating remote patient monitoring telehealth solutions into our telemedicine program. I look forward to providing further updates on this initiative in future reports."

Employee Meetings
Our recent all-employee meetings were highly successful, with excellent attendance and overwhelmingly positive feedback from staff. The announcement of our all-employee bonus program going into effect July 1st, was particularly well-received, and the announcement of our enforcement of our current tobacco-free campus policy, effective July 1st, was surprisingly well-accepted by employees.

Additionally, our leadership team had a productive retreat at the lodge on Tuesday, which included a management meeting, team-building games, and a barbecue. The event was a huge success, with all attendees having a great time. Our leadership team appreciated the opportunity to bond and collaborate, and I believe the retreat helped to strengthen our leadership team's dynamic.

Ignite the Patient Experience
I am thrilled to report that our outstanding Quality department won the Ignite the Patient Experience event provided by Custom Leaning Systems, a two-day event taking place in November at our location, with a value of over $30,000. What's even more exciting, we will not incur any costs for this event, making it a significant bonus for our organization. This free event is particularly noteworthy as it aligns closely with our proposed patient experience goal for Fiscal Year 2025.