MAYERS MEMORIAL
HEALTHCARE DISTRICT

Board of Directors
Regular Meeting Agenda
March 26, 2025 @ 1:00 PM
Mayers Memorial Healthcare
Burney Annex Boardroom
20647 Commerce Way
Burney, CA 96013

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.

1	**CALL MEETING TO ORDER**					**Approx. Time Allotted**
2	2.1	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS** Persons wishing to address the Board are requested to fill out a "Request Form" prior to the beginning of the meeting (forms are available from the Clerk of the Board, 43563 Highway 299 East, Fall River Mills, or in the Boardroom). If you have documents to present for the members of the Board of Directors to review, please provide a minimum of nine copies. When the President announces the public comment period, requestors will be called upon one-at-a time, please stand and give your name and comments. Each speaker is allocated five minutes to speak. Comments should be limited to matters within the jurisdiction of the Board. Pursuant to the Brown Act (Govt. Code section 54950 et seq.) action or Board discussion cannot be taken on open time matters other than to receive the comments and, if deemed necessary, to refer the subject matter to the appropriate department for follow-up and/or to schedule the matter on a subsequent Board Agenda.				
3	**APPROVAL OF MINUTES**					
	3.1	Regular Meeting –February 19, 2025		***Attachment A***	**Action Item**	1 min.
4	**DEPARTMENT/QUARTERLY REPORTS/RECOGNITIONS:**					
	4.1	Resolution 2025.02 – February Employee of the Month		***Attachment B***	**Action Item**	2 min.
	4.2	Business Office	Danielle Olson	***Attachment C***	Report	2 min.
	4.3	Rural Health Clinic	Kimberly Westlund	***Attachment D***	Report	2 min.
5	**BOARD COMMITTEES**					
	5.1	**Finance Committee**				
		5.1.1 Committee Meeting Report: Chair Humphry			Report	5 min.
		5.1.2 February 2025 Financial Review, AP, AR and Acceptance of Financials			**Action Item**	5 min.
		5.1.3 Acceptance of Annual Audit Summary			**Action Item**	2 min.
		5.1.4 Board Quarterly Finance Review			**Action Item**	5 min.
	5.2	**Quality Committee**				
		5.2.1 March Quality Meeting Committee Report			Report	5 min.
	5.3	**Strategic Planning Committee**				
		5.3.1 March Strategic Planning Committee Report			Report	5 min.

	5.3.2	**Mayers Memorial Healthcare District Master Plan Construction Project Management Firm:** Recommendation from Strategic Planning & Review Committee to Award Contract		**Action Item**	10 min.
6	**NEW BUSINESS**				
	6.1	Resolution 2025.03- Safety Officer	***Attachment E***	**Action Item**	5 min.
	6.2	Service Excellence Initiative Committee		Discussion	5 min.
	6.3	Review Revised Strategic Plan	***Attachment F***	**Action Item**	5 min.
	6.4	**Policies and Procedures:** Board Compensation & Reimbursement Application for Inspection of Public Records MMH585 Admission Criteria: Length of Stay Expectation Emergency Sewage and Waste Disposal Facility Closure -- Notice in Advance Healthcare Worker Vaccination for Covid 19 – SNF Lippincott Procedures for Clinical Practices LVNs in OPMedical Mass Casualty Incident Plan (MCI) OB-GYN Core Privileges Rapid Response to Clinical Deterioration Requirements For Swing Beds In Critical Access Hospital Sedation Assessment	***Attachment G***	**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 H***		
	7.1.1	Director of Operations- Jessica DeCoito		Report	5 min.
	7.1.2	Chief Financial Officer – Travis Lakey		Report	5 min.
	7.1.3	Chief Human Resources Officer – Libby Mee		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 Education: Chapters 11-15 and Enhancing Board CEO & Med Staff Collaboration		Discussion	10 min.
9	**MOVE INTO CLOSED SESSION**				

9.1	Hearing (Health and Safety Code §32155) – Medical Staff Credentials	**Action Item**

MEDICAL STAFF REAPPOINTMENT

1. Allen Morris, MD
2. Kelsey Sloat, MD
3. Aditi Bhaduri, MD (T2U)
4. Jean-Claude Bassila, MD (T2U)
5. Mustafa Ansari, MD (UCD)
6. Lin Zhang, MD (UCD)
7. Ge Xiong, MD (UCD)
8. Sophie Teng, MD (UCD)
9. Massud Seyal, MD (UCD)
10. David Richman, MD (UCD)
11. Kwan NG, MD (UCD)
12. Ricardo Maselli, MD (UCD)
13. Marc Lenaerts, MD (UCD)
14. Jeffrey Kennedy, MD (UCD)
15. Alexander Duffy, DO (UCD)
16. Charles DeCarli, MD (UCD)
17. Norika Malhado-Chang, MD (UCD)
18. Michelle Apperson, MD (UCD)
19. Sindhura Batchu, MD (UCD)

MEDICAL STAFF APPOINTMENT

1. Shravani Nalla, MD (T2U)
2. Manntej Sra, MD (Vesta)
3. Majid Maybody, MD (Vesta)
4. Caren Armstrong, MD (UCD)
5. Courtney Wusthoff, MD (UCD)
6. Vaishnavi Vaidyanathan, MD (UCD)
7. Neggy Rismanci, MD (UDC)

9.2	Real Estate Update (54956.8) Property: Masonic Lodge, Fall River Mills CA Real Estate Negotiator: Ryan Harris APN: 018-200-006	Discussion/ **Action Item**
9.3	Real Estate Update (54956.8) Property: Fall River Arts, Fall River Mills CA Real Estate Negotiator: Ryan Harris APN: 018-200-044	Discussion
10	**RECONVENE OPEN SESSION**	
11	**ADJOURNMENT:** Next Meeting: April 30, 2025	

Posted: 03.21.2025

MAYERS MEMORIAL HEALTHCARE DISTRICT

Board of Directors
Regular Meeting Minutes
February 19, 2025 @ 1:00 PM
Mayers Memorial Healthcare District
Fall River Boardroom
43563 HWY 299 E
Fall River Mills, CA 96028

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: Jeanne Utterback called the regular meeting to order at 1:00 PM on the above date.

BOARD MEMBERS PRESENT:	**STAFF PRESENT:**
Jeanne Utterback, President	Ryan Harris, CEO
Abe Hathaway, Vice President	Travis Lakey, CFO
Tami Humphry, Treasurer	Valerie Lakey, CPRO
Lester Cufaude, Director	Libby Mee, CHRO
Jim Ferguson, Director	Theresa Overton, CNO
	Keith Earnest, CCO
ABSENT:	Jack Hathaway, Director of Quality
Ashley Nelson, Board Clerk	Jessica DeCoito, Director of Operations

2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS:** NONE.		
3	**APPROVAL OF MINUTES**		
3.1	A motion made and carried; Board of Directors accepted the minutes of January 29, 2025	***Cufaude, Humphry***	***Approved by All***
4	**DEPARTMENT/OPERATIONS REPORTS/RECOGNITIONS**		
4.1	Resolution 2025.01- January 2025 Employee of the Month: Cody Robertson, Maintenance. Cody is a work horse, and he always shows up with a good attitude, even when situation doesn't warrant it. He always brings a smile to every room he walks in. He is one of the hardest workers we have. Congrats to Cody!	***Humphry, Hathaway***	***Approved by All***
4.2	Hospice Quarterly: We are working on full compliance and utilizing the EMR to it's full capabilities to help us meet the compliance. Hospice has been the busiest in decades. Will be traveling to Southern Humboldt to look at the Visiting Nurse Service Program in place there to see how we can set up one here for MMHD community.		
4.3	Mayers Foundation Quarterly: Almost all of the numbers are in for Gala proceeds – we are at about $57,000 this year. Very successful event! Great job!		

	4.4	Quality and Risk: written report submitted in the packet. We will focus our efforts on one measure that we are confident in making to receive funds. As we grow our clinic services, locations and providers, we will only create more opportunities to meet measures and metrics. I am very pleased to receive our Deficiency Report from ACHC survey and we excelled as a team in our survey and work. Kudos to the team!		
	4.5	Skilled Nursing: written report submitted. 78 residents live in both facilities. Introduction of Sharon Lyons, DON SNF – newly onboarded and going through the transition and learning with Arnese and Britany.		
5	**BOARD COMMITTEES**			
	5.1	**Finance Committee**		
	5.1.1	Committee Report: Cash on Hand is 300 days and AR has come down a bit. Director of Revenue Cycle is working on the details inside Cerner to clean up with the help of the Wipfli consultant.		
	5.1.2	January 2025 Financial Review Motion moved, seconded and approved.	***Humphry, Hathaway***	***Approved by All***
	5.1.3	Quarterly Finance Review Motion moved, seconded and approved.	***Humphry, Hathaway***	***Approved by All***
	5.2	**Quality Committee**		
	5.2.1	February Quality Meeting Committee Report: reviewed the ACHC Discrepancy Report that our team is working a Plan of Corrections on, that is due March 1st. We should hear back on our accreditation status within 60 days of the POC being completed.		
6	**OLD BUISNESS**			
	6.1	WanderGuard Door System for SNF- quote Motion moved, seconded and carried	***Hathaway, Humphry***	***Approved by All***
7	**NEW BUSINESS**			
	7.1	Policies and Procedures: Identification of Potential Organ and/or Tissue Donors Medication Administration Physician Assistant Core Privileges for Outpatient Retention and Bladder Scanning Post-Catheter Removal Suicide Risk Assessment and Interventions Columbia Protocol in Non-Behavioral Health Setting Motion moved, seconded and approved with amendments provided by directors.	***Cufaude, Ferguson***	***Approved by All***
	7.2	Real Estate Negotiation: the MMHD Board of Directors has named Ryan Harris, CEO as the Real Estate Negotiator. Motion moved, seconded and carried.	***Humphry, Hathaway***	***Approved by All***
8	**ADMINISTRATIVE REPORTS**			
	8.1	**Chief's Reports: written reports provided in packet**		
	8.1.1	**DOO:** written report submitted. Solar project update: we were able to move the posts behind PT down another 6 ft to lessen the view obstruction. Pile driving was scheduled to begin yesterday but travel and weather conditions have put this on hold for now. Seven groups have shown interest in the Construction Project Management Firm RFP/RFQ Application. Questions have come in and responses are due back this Friday. Applications are due March 7th and you'll vote on a firm at the March 26th Board Meeting.		
	8.1.2	**CFO:** Congrats on a successful audit!		
	8.1.3	**CHRO:** written report submitted. Paycom specialist coming onsite to help us maximize the program. Meeting a potential provider on Friday. This summer we will have a Harvard student, who is local to our area, work with us to learn about the medical field. Congrats on the registry expense decrease.		

	8.1.4	**CPRO:** written report submitted. Worked with the new Mountain Valley's Marketing Coordinator to provide community wide marketing efforts for our medical services in this community. We are working on website updates and district wide brochure. Happy to report that just today we received the approval from the Burney Fire District on TCCN updates and can occupy the building after the county is notified. We are in training phases for Partnership Health's ECM program and use the services in our clinic.
	8.1.5	**CCO**: written report submitted. Happy to report that the ACHC survey tag reported under Imaging, did not actually show up on the official discrepancy report. Foam in and Foam Out campaign is going very well.
	8.1.6	**CNO**: written report submitted. Our CNA training program is back open to us thanks to the work from Jack and Ryan. The team is working on hiring Unit Assistants to get them into the department and then open the class up for June. Posted for Staff Educator position. A lot of work done for our ACHC Survey and kudos to the team for the amazing efforts.
	8.1.7	**CEO:** written report submitted. There has been a great deal of work being done on referral management and workflow efficiencies in the Clinic with the help of Jen Miley. We are excited to see how the areas of opportunities are address to provide necessary efficiencies in our Clinic. Updated Strategic Priorities were provided. This will be an action item for formal approval at our next meeting but the team will work towards the newly revised priorities now.
9	**OTHER INFORMATION/ANNOUNCEMENTS**	
	Wipfli Annual Audit Summary – David Imus, Eric Volk, Dang Ta: Summary presentation of the Required Communication, Financial Statement Review, Financial Analysis, and Accounting Standards update was provided. Another clean audit with no findings and Mayers continues to better its financial ratios to increase financial stability. Thank you to Eric Volk, David Imus, and Dang Ta from Wipfli for the presentation and the work. Thank you to the Wipfli team for helping Mayers get to our financial standings today.	
9.1	Board Member Message: Employee of the Month, all the Foundation event dates, TCCN occupancy, events and dates, February 26-27th Heart Health Awareness event, Audit Summary, CNA Program update.	
9.2	Board Education Ch 6-10: Embracing the differing opinions but honoring the decision of the group. Once direction is provided to CEO, the Board honors that directive, unless there is something of utmost urgency that requires a stop on that directive. Trainings are important but hard to find and hard to meet the timelines. But using educational outlets like reading books and watching webinars are very helpful. Conducting self-assessments are a great way to gauge the SWOT of this board. During the next few major projects in MMHD, it will be a priority to keep the positivity in the environment for our staff but our community as a whole. Direction to get a policy created that provides what parliamentary procedure rules are followed by this Board.	
10	**MOVE INTO CLOSED SESSION:** 3:50 pm	
	Hearing (Health and Safety Code §32155) – Medical Staff Credentials	
10.1	Elliott Wagner, MD Nabeel Dar, MD Walter Uyesugi, DO Ron Mark, MD Tad Tanoura, MD Rajiv Kumar, MD Philip McDonald, MD Justin Pham, MD John Pohl, MD Junsung Rho, MD Roberto Rivera-Morales, MD Amit Sanghi, DO Arjun Sharma, MD Russell Gelormini, MD Anne Glaser, MD	**Approved by All**

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

		Susan Gootnick, MD Grant Holz, MD Sayed Jafery, MD Sampath Alapati, MD Derek Armfield, MD Dennis Burton, MD Abbas Chamsuddin, MD Nilofar Firooznie, MD Michael Gabe, MD Adel Abdalla, MD
	10.2	Conference with legal counsel regarding pending litigation (§54956.9)
	10.3	Conference with Real Estate Negotiators (54956.8) Property: Masonic Lodge, Fall River Mills CA Real Estate Negotiator: APN: 018-200-006
10	**RECONVENE OPEN SESSION:** 4:45 pm	
11	**Adjournment:** 4:45 pmm. Next Meeting is March 26, 2025 in Burney.	

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

_____ Board Member

_____ Board Clerk

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

RESOLUTION NO. 2025-02

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

June Martin

As February 2025 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, June Martin is hereby named Mayers Memorial Healthcare District Employee of the Month for February 2025; and

DULY PASSED AND ADOPTED this 26th day of March by the Board of Trustees of Mayers Memorial Healthcare District by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

_____
Jeanne Utterback, President
Board of Trustees, Mayers Memorial Healthcare District

ATTEST:

_____
Ashley Nelson
Clerk of the Board of Directors

MAYERS MEMORIAL HEALTHCARE DISTRICT

Department Reporting
Managers Meeting and Regular Board Meeting

Manager & Department: Business Office **Reporting Month & Year:** March 2025

Summary:

The Business Office is currently working on getting AR Days to industry standard. We are working with Wipfli to fix errors and understand Cerner workflow better. We went live with Point Click Care for LTC billing in February. Arch Pro coding and billing course completion 5/7

Top Projects (1-3):

AR days at or below the industry standard

Arch Pro Coding and Billing Course

LTC billing out of Point Click Care

Wins (1-2):

5/7 Business Office employees passed the Arch Pro Coding and Billing course to become Certified as a Critical Access Hospital Coding and Billing Specialist.

LTC billing successfully got transmitted this month without a lot of outsourcing help.

Challenge (1):

Working in Cerner and understanding what system capabilities are hindering us from getting AR Days back down to pre-go live with Cerner.

MAYERS MEMORIAL HEALTHCARE DISTRICT

Department Reporting
Managers Meeting and Regular Board Meeting

Manager & Department:
Kimberly Westlund-Rural Health Clinic

Reporting Month & Year:
03/2025

Summary:
The RHC has been in a constant state of growth and change for the last year and will continue into the coming year(s). With change and growth, new challenges present opportunities for process improvement to ensure patient satisfaction. Our goal will always be to provide the highest quality care to our community and surrounding areas.

Top Projects (1-3):

1) Updating referral policies and procedures
2) Luma Health-Luma Health is a software platform that helps healthcare providers improve the patient experience. Patient access: Patients can use Luma to schedule appointments, get reminders, and join waitlists.
Patient Communication: Patients can use Luma to text the office, provide feedback, and chat securely.
Patient Readiness: Luma helps patients prepare for appointments by capturing insurance, documents, and other information.
Patients can use Luma to cancel appointments, reschedule, and more.
3) i2i Population Health- This platform integrates with Cerner and can analyze patient data, identify care gaps, and improve overall patient health outcomes. I2I focuses on data-driven care coordination, quality improvement, chronic care disease management, and patient engagement and compliance.

Wins (1-2):

Referral Process-Implementing new workflows, updating policies, and processes around referrals. With direction from Jen Miley and the help of multiple people, we cleaned up the referral queue from over 700 down to approximately 175. The new processes are working well.

Challenge (1):

Staffing continues to be a constant challenge in the clinic.

MAYERS MEMORIAL
HEALTHCARE DISTRICT

RESOLUTION NO. 2025-06

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

Dana Hauge

As Safety Officer of the District

WHEREAS, the Board of Trustees has asked the CEO to assist the Safety Officer collaboratively by supporting their ability to take any action needed relating specifically to situations that pose an immediate threat to life, health, and/or property; and

WHEREAS, the MMHD Board of Trustees recognizes Dana Hauge for the Safety Officer position and;

NOW, THEREFORE, BE IT RESOLVED that, Dana Hauge is hereby named Safety Officer; and

DULY PASSED AND ADOPTED this 26th day of March 2025 by the Board of Trustees of Mayers Memorial Healthcare District by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

_____
Jeanne Utterback, President
Board of Trustees, Mayers Memorial Healthcare District

ATTEST:

_____
Ashley Nelson
Clerk of the Board of Directors

MAYERS MEMORIAL
HEALTHCARE DISTRICT

Mayers Memorial Hospital District

Strategic Plan
FY2025 – FY2029

Draft Revision (02/24/25 LN)

Message from the Board of Directors

The Mayers Memorial Hospital District Board of Directors is pleased to present this refreshed strategic plan for 2025-2029, building upon the success of our original plan developed in 2016. Since its inception, we have made significant strides in enhancing our facilities and services, including the addition of a new wing featuring a state-of-the-art emergency room, retail pharmacy, rural health clinic, and a mobile clinic. We have also implemented a new electronic medical record system to improve patient care.

As we look to the future, our commitment to delivering exceptional patient care, fostering a safe and motivated work environment for our employees, and being fiscally responsible remains unwavering. This updated plan serves as a guiding framework for the District Board and administration over the next five years. It outlines our goals, objectives, and strategies to ensure that we continue to meet the evolving needs of our community while maintaining our reputation for excellence in patient care.

Introduction

The purpose of this Strategic Plan is to define the critical objectives that the Board of Directors aims to achieve by FYE 2029. This comprehensive plan serves as a bridge, connecting Mayers Memorial Healthcare District's Mission, Vision, and Values to the daily work of our talented and dedicated staff, providing a clear direction and focus for their efforts.

Mission
Leading rural healthcare for a lifetime of wellbeing.

Vision
Build the healthiest rural community through exceptional and accessible care.

Values
I-RESPECT: Integrity, Reliability, Excellence, Stewardship, Partnership, Equity, Compassion, Teamwork

This Plan will outline the strategic pillars and the priorities needed to achieve our Mission, Vision, and Values to ensure success toward those objectives, the risks to the objectives, implementation, monitoring and evaluation.

Strategic Pillars

To progress toward the achievement of our Mission, Vision and Values over the next five years, we will work toward the following five (5) strategic pillars:

1. Quality/Service: At Mayers Memorial Healthcare District, we are committed to delivering exceptional patient-centered care, exceeding expectations, and driving continuous improvement. We will achieve this by:
    a. Providing high-quality, safe, and efficient care that is personalized to the unique needs of each patient.
    b. Fostering a culture of quality and safety through ongoing education, training, and accountability.
    c. Collecting and acting on patient feedback to improve the overall patient experience
    d. Implementing evidence-based practices and guidelines through ACHC to ensure best-in-class care.
    e. Leveraging technology and innovation to streamline processes and enhance outcomes.

Our goal is to be a trusted and respected healthcare partner in our community, known for delivering care that exceeds patient expectations and improves health outcomes.

2. People: At Mayers Memorial Healthcare District, we are committed to fostering a culture of compassion, inclusivity, and growth, where every employee is valued, empowered, and supported to deliver exceptional patient care and achieve their full potential. We will achieve this by:
    a. Recruiting and retaining top talent through competitive compensation, comprehensive benefits, and opportunities for professional development.
    b. Providing ongoing training and education to enhance skills and knowledge.
    c. Encouraging open communication, diversity, and inclusion across all levels of the organization.
    d. Fostering a sense of community and teamwork through recognition and rewards programs.
    e. Embracing innovation and creativity in our work environment.

Our goal is to create a culture that empowers employees to deliver exceptional patient care and achieve their full potential.

3. Growth: At Mayers Memorial Healthcare District, we are committed to driving strategic growth and innovation, expanding our reach and impact, and building a sustainable future for our organization. We will achieve this by:
    a. Developing and executing strategic plans that align with our mission, vision and values
    b. Fostering a culture of innovation.
    c. Investing in cutting-edge technology and infrastructure to drive efficiency and effectiveness.
    d. Building strong partnerships with community stakeholders, payers, and vendors to advance our goals.
    e. Attracting and retaining top talent and providing opportunities for professional growth and development.
    f. Drive consistent departmental growth to achieve a sustainable future.

Our goal is to position Mayers Memorial Healthcare District as a leader in the rural healthcare industry, known for its forward-thinking approach, strategic partnerships, and commitment to driving positive change.

4. Communication: At Mayers Memorial Healthcare District, we are dedicated to fostering a culture of transparency, collaboration, and open communication. We believe that effective communication is essential to building trust, driving understanding, and achieving our goals. We will achieve this by:
    a. Providing timely and clear information to patients, families, and staff about our services, the patient's care, our policies, and initiatives.
    b. Fostering open and respectful dialogue among team members, leadership, and stakeholders.
    c. Utilizing multiple channels to communicate with diverse audiences, including digital media, print materials, and in-person interactions.
    d. Encouraging active listening and feedback from all stakeholders to inform our decisions and actions.
    e. Celebrating successes and learning from setbacks through regular recognition and continuous improvement.

Our goal is to be a model for transparent and effective communication in the healthcare industry, where information flows freely, concerns are heard and addressed, and everyone feels valued and informed.

5. Finance: At Mayers Memorial Healthcare District, we are committed to maintaining a strong financial foundation that supports our mission and enables us to deliver high-quality patient care. We will achieve this by:
    a. Developing and managing budgets that align with our strategic priorities and goals.
    b. Analyzing financial performance regularly to identify areas for improvement and make data-driven decisions.
    c. Maintaining a culture of fiscal responsibility and accountability among all staff members.
    d. Investing in financial systems and processes that support transparency, accuracy, and efficiency.
    e. Building strong relationships with donors, philanthropic organizations, and other funding partners to secure necessary resources.

Our goal is to be a financially sustainable organization that can invest in the future of healthcare, drive innovation, and provide exceptional care to our patients

Success Indicators

FY25

To ensure we achieve our strategic pillars by FYE 2029, we will focus on the following priorities in FY 2025, marking key milestones on our journey toward success. Our annual priorities for FY2026-2029 will be reviewed and approved by the Board of Directors annually to ensure alignment with our long-term goals and continued progress toward achieving our strategic vision.

Priority 1. Quality Service

Specific:

- By June 30, 2025, implement and refine the infection prevention program to achieve a minimum hand hygiene adherence rate of 60% among healthcare workers.

Measurable:

- The success of the goal will be measured by tracking and monitoring hand hygiene adherence rates, with a target of at least 60% compliance rate among healthcare workers.

Achievable:

- This goal is achievable through the implementation of staff education and training programs, promoting a culture of hand hygiene, and regular feedback on adherence rates to encourage improvement.

Relevant:

- The goal is relevant to the Quality Service pillar by fostering a culture of quality and safety through ongoing education, training, and accountability in infection prevention practices.

Time-bound:

- The goal must be achieved by June 30, 2025, to ensure that the enhanced infection prevention program is fully implemented and effective in improving hand hygiene adherence rates.

Priority 2. People

Specific:

- By June 30, 2025, a minimum of 13 leadership team members from the Mayers Memorial Healthcare District, comprising a mix of managers and directors, will complete the Healthcare Leadership Institute Management Training program.

Measurable:

- The success of the goal will be measured by the number of leadership team members who complete the program, specifically at least 13 participants.

Achievable:

- This goal is achievable based on the availability of the program and the interest expressed by the leadership team members.

Relevant:

- The goal is relevant to the People pillar by providing ongoing training and education to enhance skills and knowledge.

Time-bound:

- The goal must be completed by June 30, 2025, to ensure timely completion and evaluation of the program's effectiveness.

Priority 3. Growth

Specific:

- By June 30, 2025, each department within outpatient services (Rural Health Clinic, Laboratory, Radiology, Outpatient Medical, Physical Therapy, Cardiac Rehab, Outpatient Surgery, and Respiratory Therapy) will individually achieve a 5% increase in outpatient visits, charges, or procedures year-over-year, contributing equally (12.5%) to the overall target of 100%.

Measurable:

- Success will be determined by tracking and monitoring outpatient visits, charges, or procedure numbers for each department monthly. Each department's ability to achieve a 5% increase compared to the previous year's figures will be assessed individually.

Achievable:

- This goal is achievable through the implementation of targeted strategies such as marketing campaigns, community outreach initiatives, patient engagement programs, care coordination and staff training to improve patient flow and wait times.

Relevant:

- The goal is relevant to the Growth pillar by driving consistent departmental growth to achieve a sustainable future.

Time-bound:

- The goal must be achieved by June 30, 2025, to ensure that the strategies are fully implemented and effective in driving growth and increasing outpatient visits.

Priority 4. Communication

Specific:

- By June 30, 2025, Mayers Memorial Healthcare District (MMHD) plans to launch an extensive patient satisfaction program with the following objectives:
    1. Establish a baseline for patient experience scores in clinics and the emergency room through surveys conducted by June 30, 2024.
    2. Choose a patient satisfaction program and partner by June 30, 2025.
    3. Develop and implement new clinic workflows, covering scheduling through to referrals, by June 30, 2025.
    4. Establish a dedicated care coordination department by June 30, 2025.
    5. Select and implement a new communication platform.

Measurable:

- We will evaluate progress by collecting patient experience surveys, monitoring the rollout of new workflows, selecting a patient experience vendor, choosing a communication platform, and establishing the care coordination department.

Achievable:

- These objectives are realistic, given thorough strategic planning, effective resource allocation, and collaboration among all stakeholders.

Relevant:

- This initiative supports MMHD's commitment to enhancing patient care and satisfaction, ultimately improving health outcomes in the community.

Time-bound:

- The completion of this goal is targeted for June 30, 2025, with key milestones set for achievement by June 30, 2024.

Priority 5. Finance

Specific:

- By June 30, 2025, MMHD will achieve 50% compliance by meeting one of the California Department of Health Care Services (DHCS) Quality Improvement Program (QIP) measures or 100% compliance by meeting two QIP measures and submit accurate and complete data for audit.

Measurable:

- The success of the goal will be measured by achieving the specified compliance rates with the DHCS QIP measures and submitting accurate and complete data for audit.

Achievable:

- This goal is achievable through a focused effort to review and improve processes, train staff on quality improvement strategies, and implement corrective actions to address any deficiencies or gaps in compliance.

Relevant:

- The goal is relevant to the Finance pillar to analyze financial performance regularly to identify areas for improvement and make data-driven decisions.

Time-bound:

- The goal must be achieved by June 30, 2025, to ensure that the necessary improvements are made, and data is submitted in a timely manner for audit.

Risk Management Plan for Mayers Memorial Healthcare District (MMHD) Strategic Priorities

Scope:

This risk management plan addresses the five strategic priorities of MMHD, covering People, Quality Service, Growth, Communication, and Finance. The plan aims to identify, assess, and mitigate potential risks that may impact the achievement of these priorities.

Risk Identification:

1. Quality Service:
   - Risk: Technical issues with technology used to track hand hygiene adherence may compromise data accuracy.
   - Risk: Cost of hand hygiene tracking solutions may compromise the use of technology.
   - Risk: Inadequate staff training on infection prevention practices may lead to decreased adherence rates.
2. People:
   - Risk: Insufficient training or lack of buy-in from leadership team members may impact the success of the Healthcare Leadership Institute management training program.
   - Risk: Inadequate employee engagement and motivation may hinder the achievement of program goals.
3. Growth:

- Risk: Competition from other healthcare providers in the region may impact MMHD's ability to increase outpatient visits.
- Risk: Insufficient capacity or resources to accommodate increased patient volume, leading to decreased quality of care and patient satisfaction

4. Communication:
   - Risk: Poor communication between care coordination team members may lead to misaligned goals and ineffective care delivery.
   - Risk: Resistance to change from staff or providers may hinder the implementation of new communication protocols.
5. Finance:
   - Risk: Failure to meet the minimum patient volume requirements for the DHCS QIP measures, resulting in non-compliance and financial loss.

Risk Assessment and Mitigation Strategies:

1. Quality Service:
   - Conduct regular compliance system checks to ensure data accuracy and integrity.
   - Provide ongoing staff training on infection prevention practices and technology use.
   - Establish regular reporting to quality committee to monitor hand hygiene adherence rates and identify areas for improvement.
2. People:
   - Implement a comprehensive onboarding program for leadership team members participating in the Healthcare Leadership Institute management training program.
   - Establish a mentorship program to provide ongoing support and guidance for participants.
   - Conduct regular feedback sessions to ensure employee engagement and motivation.
3. Growth:
   - Conduct market research to identify competitor strengths and weaknesses.
   - Conduct market research on outmigration of services
   - Develop targeted marketing campaigns to attract new patients.
   - Establish partnerships with local organizations to promote MMHD's services.
4. Communication:
   - Develop clear communication protocols, job descriptions and guidelines for care coordination team members.
   - Provide ongoing training and coaching for care coordination team members.
   - Establish a feedback mechanism for patients and staff to provide input on communication effectiveness.
5. Finance:
   - Regularly monitor patient volume and adjust strategies as needed to ensure compliance with QIP measures.

Responsibility and Accountability

The MMHD Strategic Plan is a five-year roadmap set by the Board of Directors, respresenting the collective vision of the public's elected representatives. As such, the Board is accountable to its constituents and responsible for ensuring the success of this plan. This accountability is reflected in two key layers:

Layer 1: Board of Directors to the Public

The Board of Directors, elected by the public, is accountable to its constituents for the success of the Strategic Plan. The public can measure the Board's performance by assessing the progress towards achieving the objectives outlined in this Plan. The Board's accountability to the public serves as a fundamental mechanism to ensure transparency and effective governance.

Layer 2: Chief Executive Officer (CEO) to the Board of Directors

The CEO is accountable to the Board of Directors for implementing the Strategic Plan successfully. The Board has entrusted the CEO with the responsibility to manage and execute each objective outlined in this Plan, as well as identify and mitigate risks associated with these objectives. The CEO is responsible for:

- Assigning management tasks to other managers and teams as needed
- Reporting progress to the Board on a regular basis
- Ensuring that management reporting accurately reflects the implementation status of the plan.

While the CEO may delegate tasks further down the organizational structure, they remain ultimately accountable to the Board for the successful execution of this Plan. This dual-layer accountability structure ensures that both the Board and CEO are committed to delivering on the promises outlined in this Strategic Plan, ultimately benefiting the community served by MMHD.

Ensuring Successful Implementation

For the MMHD Strategic Plan to be successful, it is essential that all layers of management and staff are aware of the Plan and work together to achieve its objectives. To achieve this, we will implement the following key strategies:

Alignment and Communication

- Align departmental annual priorities with the strategic pillars to ensure a unified focus on achieving the plan's objectives.
- Regular management/departmental meetings will emphasize the critical role each staff member plays in contributing to the success of the strategic pillars.
- Foster an open-door policy, encouraging top-down and bottom-up communication throughout the organization.

Risk Management and Transparency

- Regularly review and update risk management plans to identify potential obstacles and develop mitigation strategies.
- Encourage a culture of reporting risks, ensuring that concerns are addressed promptly and effectively.

CEO Communication and Oversight

- The CEO will regularly communicate with all staff regarding the progress of the Strategic Plan, keeping everyone informed of our progress towards achieving our objectives.

Effective Monitoring

- Establish a robust monitoring system to track progress against key performance indicators (KPIs) and make data-driven decisions to adjust our approach as needed.

Monitoring

To ensure this Plan is being implemented successfully, it is necessary to have monitoring mechanisms in place. At the Board level, monitoring consists of reporting yearly by each department manager. At the operational level, monthly reporting will take place to discuss progress and monitor issues on the strategic pillars and priorities. These mechanisms are the responsibility of the CEO and/or other management and staff as designated by the CEO.

The monitoring of this Plan will be done in two layers: first, to the Strategic Planning Committee and second, to the Board of Directors. The reporting requirements of each layer are described in more detail below.

Reporting to the Strategic Planning Committee
The CEO will report to the Strategic Planning Committee at least every other month.

The CEO will provide the Committee with a written report on the progress of each Strategic Pillar. The report will include:

- Tracking on current success indicator.
- Risk management, including the mitigation strategies for unacceptable risks, any changes in risk and reporting of any emerging risks.
- Issues encountered.
- Relevant documentation.

The Committee will determine whether any specific issues in the report from the CEO need to be reported to the Board of Directors.

Reporting to the Board of Directors
In conjunction with the Strategic Planning Committee Board Members, the CEO will provide an overall report every other month to the full Board following the Committee meeting regarding the progress of the Plan. The report will include:

- Overall progress.
- Changes in risk.
- Issues of note as determined by the Committee.

The Board will determine whether any changes in risk level and/or new risks are acceptable or not.

The Board may request additional reporting on any aspect of the Plan as deemed necessary.

Evaluation

It is the responsibility of the Board of Directors to evaluate the overall success of the Plan. This Plan is not static and as such, the Board must evaluate whether any changes are required. At a minimum, the Board will evaluate this Plan annually to determine whether it still meets the needs of the Board.

At the end of the Plan, in 2030, the Board will conduct a thorough evaluation of the success of this Plan. This evaluation will be included in the next iteration of the Strategic Plan as part of the statement from the President of the Board of Directors. The evaluation will include:

- Statement of successes.

- Statement of unanticipated/poorly managed risks.
- Lessons learned.

In addition to the other elements of this Plan described above, a thorough evaluation will lead to even stronger and more successful Strategic Plans in the future, which will ultimately lead to better services for those in the Mayers Memorial Healthcare District.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Board Compensation & Reimbursement	POLICY #
DEPARTMENT/SCOPE:	Page 1 of 2
REVISION DATE:	EFFECTIVE DATE:
AUDIENCE:	APPROVAL DATE:
OWNER:	APPROVER:

POLICY:

Directors shall receive no fee for attending meetings of the District Board of Directors.

The District shall reimburse Directors for actual necessary traveling and incidental expenses incurred in the performance of official duties as Directors, subject to the requirements of these Policies and Procedures and the law.

The following types of occurrences qualify for reimbursement if attended in the performance of official duties as Directors of the board and if prior approval is obtained.

- Training workshops, seminars, and conferences.
- Educational workshops, seminars, and conferences.
- Meetings of or sponsored by ACHD (the Association of California Health Care Districts), by CSDA (the California Special Districts Association), by CHA (California Hospital Association), and by other state or national organizations relevant to the purposes of the District.
- Meetings of local governmental entities and bodies and Ad Hoc committees thereof.
- Meetings of local nonprofit organizations.
- Meetings of community or civic groups or organizations.
- Meetings of advisory groups and Ad Hoc committees organized or conducted by District staff.
- Meetings with District consultants, advisors, and other professionals.
- Any other activity approved by the Board in advance of attendance, whether the request for attendance was initiated by the Board or by a Director.

If there is no Internal Revenue Service rate established for an expense such expense shall not be reimbursed unless the District board approved such expense in a public meeting before the expense was incurred.

No expense shall be reimbursed except pursuant to an expense report meeting the requirements of this Policy and submitted by the Director to (and received by) District staff, within four weeks after the final date of the occurrence in connection with which the expense was incurred. The expense report shall include receipts for all expenses for which reimbursement is being requested.

No reimbursement shall be paid unless, at the next regular meeting of the board following the occurrence for which the expense report was submitted, the Director submitting the expense

SUBJECT/TITLE: Board Compensation & Reimbursement	POLICY #
DEPARTMENT/SCOPE:	Page 2 of 2
REVISION DATE:	EFFECTIVE DATE:
AUDIENCE:	APPROVAL DATE:
OWNER:	APPROVER:

report makes a brief report on the occurrence attended. If the Director is not in attendance at such next regular board meeting, a written report submitted by the Director and read aloud by staff or another Director shall suffice as the required brief report

REFERENCES:

Sequoia Health Care District policy Reimbursable Expenses policy (adopted 6/24/14) Sequoia Health Care District policy Remuneration and Reimbursement (8/24/14)

COMMITTEE APPROVALS:

BOD QI: 5/26/2021

MAYERS MEMORIAL HOSPITAL DISTRICT

The District encourages public participation in the governing process and provides reasonable accessibility to all public records except those documents that are exempt from disclosure by express provisions of law or considered confidential or privileged under the law. The District has 10 days to respond to any request for a copy of public documents by indicating whether or not the documents exist and will be made available. Actual production of the documents may take somewhat longer depending upon their ease of availability and staff workload. You may be notified within the 10 day period that additional time is necessary. To assist us in providing a timely response to your request, please fill out the form below and indicate the specific record/document you wish to review. If you do not know the precise identification of the document, please describe its contents as clearly as possible. Minutes of Board of Directors meetings, annual budget and audits are available on the MMHD website, www.mayersmemorial.com

Name: _____
Address: _____
Telephone: _____ Fax: _____
E-Mail: _____
Record or Document Requested (Please be as specific as possible):
_____
_____
_____

Reason for Request (Optional): _____
_____
_____
Do you wish to purchase a copy of the record(s)? Yes ____ No ____
If Yes, how many copies? ____ Fee for copying: 10 cents per page
Date of Inspection: _____

_____ _____
Applicant's Signature Date of Request

DISTRICT USE ONLY: Is Written Authorization Required? Yes ____ No ____ If so, has written authorization been received and attached? Yes ____ No ____

District Officer's Signature _____

Approvals: BOD: 5/25/22
APPLICATION FOR INSPECTION OF PUBLIC RECORDS MMH585
Attached to policy: Access to Public Records

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Admission Criteria: Length of Stay Expectation	POLICY #COM030
DEPARTMENT/SCOPE:	Compliance/Administration / All Departments	Page 1 of 1
REVISION DATE:		EFFECTIVE DATE: 12/02/2024
AUDIENCE: All Staff		APPROVAL DATE:
OWNER: J. Hathaway		APPROVER: R. Harris

DEFINITIONS:

CAH – Critical Access Hospital
LOS – Length of Stay
CFR – Code of Federal Regulations
ACHC – Accreditation Commission for Health Care

POLICY:

Acute inpatient services must be furnished to patients who present to the CAH for treatment as long as the CAH has an available inpatient bed and the treatment required to appropriately care for the patient is within the scope of services offered by the CAH.

CAHs are expected to provide less complex inpatient services in order to comply with the length of stay requirement that does not exceed 96 hours (42 CFR §485.620(b)).

In accordance with Medicare payment regulations, the CAH is required, for each admitted patient who is a Medicare beneficiary, to have the admitting practitioner certify that the beneficiary may reasonably be expected to be discharged or transferred within 96 hours following admission to the CAH.

CAHs generally are not expected to handle patients requiring complex, specialized inpatient services, such as those services provided by trauma centers or cardiac surgery centers but should be able to handle a range of patient needs requiring inpatient admission.

REFERENCES:

42 CFR § 485.635(b)(1)(ii)
42 CFR § 485.620(b)
ACHC Manual 06.04.01

COMMITTEE APPROVALS:
MEC: 1/27/2025

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Emergency Sewage and Waste Disposal	POLICY #DIA044
DEPARTMENT/SCOPE:	Disaster	Page 1 of 1
REVISION DATE:		EFFECTIVE DATE: 1/22/2025
AUDIENCE: Facilities		APPROVAL DATE:
OWNER: Dana Hauge, SO		APPROVER: R.Harris

Also See: Emergency Operations Plan

POLICY:

Mayers Memorial Healthcare District will take all possible measures, including collaboration with local authorities and utilities, to restore the functionality of our sewage and waste disposal systems as soon as possible.

PROCEDURE:

1. Activate Incident Command System.
2. In the event of a failure of the Fall River Valley Community Services sewage system call Packway Materials, at 530-335-4197, or Big Valley Sanitation, at 530-243-0657, and arrange for continuous pumping of the lift stations.
3. If the failure of the sewer system is located in the facility's infrastructure, staff will use heavy-duty waste disposal bags to collect and contain waste from commodes, adult briefs, etc. Staff will wear proper PPE to perform these duties. The Infection Preventionist will manage the level of PPE needed.
4. Bags containing waste will be stored in the Riverview Garage at the Fall River Campus and in the storage room at the Laundry Facility in Burney. Arrangements will be made for safe and timely removal and disposal of this waste.
5. The Incident Commander will activate the Evacuation P&P if the sewage and waste systems cannot be restored in a timely manner.

REFERENCES:

ACHC Accreditation requirements for Critical Access Hospitals, 2023 edition. Accreditation Commission for Health Care (ACHC). Chapter 17, 17.00.02,17.00.03, 17.01.01

COMMITTEE APPROVALS:
Disaster/Safety: 2/12/2025
P&P: 3/5/2025

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Facility Closure – Notice in Advance 11.02.09	POLICY #CAH003
DEPARTMENT/SCOPE:	CAH	Page 1 of 3
REVIEW DATE: n/a		EFFECTIVE: 1/15/2025
AUDIENCE: All Hospital Staff		APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

POLICY:

This policy outlines the procedures and responsibilities to be followed in the event of a non-emergency voluntary or involuntary facility closure to ensure compliance with all regulatory requirements, the orderly transfer of residents, and the continuation of patient care throughout the closure process.

PROCEDURE:

The Administrator must ensure that:

- Written notification is provided to the State Survey Agency, the Office of the State Long Term Care Ombudsman, patients of the facility, and the legal representatives of the patients or other responsible parties of the impending closure and a plan for the relocation of residents at least 60 days prior to the impending closure; *or*

- If the Secretary of the Department of Health and Human Services or state terminates the facility's participation in Medicare and/or Medicaid, not later than the date the Secretary determines appropriate.

Patients shall be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice and best interests of each resident.

- Patients and their legal representatives or other responsible parties shall be interviewed to determine each resident's goals, preferences and needs in planning for the services, locations, and setting to which they shall be moved

- Patients shall be offered the opportunity to obtain information regarding their community options, including setting and location. Information provided shall also include the quality of providers and/or services they are considering

- Psychological counseling and/or preparation shall be provided as needed

- Transfer of residents shall take place by the date specified by the State prior to closure

The facility shall not admit any new residents on or after the date on which such written notification of closure has been submitted.

A plan shall be in place that has been approved by the State for the transfer and adequate location of all residents of the facility by the date that has been specified by the State prior to closure.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Facility Closure – Notice in Advance 11.02.09	POLICY #CAH003
DEPARTMENT/SCOPE:	CAH	Page 2 of 3
REVIEW DATE: n/a		EFFECTIVE: 1/15/2025
AUDIENCE: All Hospital Staff		APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

- Assurance shall be given to the state that patients shall be transferred to the most appropriate facility.

Notice of facility closure to patients and their legal or other responsible parties must be provided in a language and manner they understand.

The facility shall maintain ongoing operations and management of the facility and its patients during the closure process that includes:

- Continuation of appropriate staffing and resources to meet the needs of each patient including the provision of medications, services, supplies, and treatments as ordered by the patients physician/practitioner

- Ongoing accounting, maintenance, and reporting of patients personal funds

- Labeling, safekeeping, and appropriate transfer of patients personal belongings, such as clothing, medications, furnishings etc., at the time of transfer or relocation, including contact information for missing items after the facility has closed

The notice must include:

The name, address and telephone number of the State LTC ombudsman

- For patients with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act

- For patients with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of individuals with mental illness established under the Protection and Advocacy for Mentally Ill Individuals Act

- The notice shall also include contact information for the primary facility contact(s) responsible for the daily operation and management of the facility during the facility's closure process

The facility shall not close until all residents are transferred in a safe and orderly manner to the most appropriate setting in terms of quality, services and location, as available and determined

SUBJECT/TITLE:	Facility Closure – Notice in Advance 11.02.09	POLICY #CAH003
DEPARTMENT/SCOPE:	CAH	Page 3 of 3
REVIEW DATE: n/a		EFFECTIVE: 1/15/2025
AUDIENCE: All Hospital Staff		APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

appropriate by the resident's interdisciplinary team after taking into consideration the resident's individual needs, choices and interests.

Each resident's complete medical record information, including archived files, Minimum Data Set (MDS) discharge assessment, and all orders, recommendations or guidelines from the resident's attending physician, shall be provided to the receiving facility or other provider at the time of the resident's discharge or relocation.

REFERENCE:

Accreditation Requirements for Critical Access Hospitals. Accreditation Commission for Health Care, 2023. Standard 11.02.09

Centers for Medicare and Medicaid Services (CMS). (December 22, 2017). An Initiative to Address Facility Initiated Discharges that Violate Federal Regulations. Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-08.pdf

COMMITTEE APPROVALS:
P&P: 2/12/2025

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Healthcare Worker Vaccination for Covid 19-SNF	POLICY # IC041
DEPARTMENT/SCOPE:	Infection Control	Page 1 of 1
REVISION DATE:		EFFECTIVE DATE: 12/5/2023
AUDIENCE: All hospital staff		APPROVAL DATE:
OWNER: K. Stephenson		APPROVER: K. Earnest

POLICY:

Mayer's Memorial Healthcare District ensures compliance with mandates and guidance from: The Centers for Medicare/Medicaid Services (CMS), the Centers for Disease Control (CDC), and the California Department of Public Health (CDPH).

PROCEDURE:

1. Healthcare workers are offered COVID 19 vaccinations through Mayer's Employee Health and through Mayer's Rural Health Clinic in Burney.
2. Healthcare workers are also welcome to receive COVID 19 vaccinations from other providers or pharmacies.
3. It is the responsibility of the healthcare worker to provide evidence of vaccination to Mayer's Human Resources Department.
4. Every Employee has a declination or proof of vaccination on file with Human Resources.
5. The Human Resources Department informs managers/supervisors of healthcare workers who have not provided documentation of vaccination status.

REFERENCES:

Centers for Medicare/Medicaid Services, Guidance for the Interim Final Rule, Medicare and Medicaid programs, Omnibus COVID-19 Healthcare Staff Vaccination, QSO-22-07-ALL, and Attachment A, LTC

COMMITTEE APPROVAL:

IC: 2/14/2025
P&P: 3/5/2025

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Use of Lippincott Procedures for Clinical Practices	POLICY #MS010
DEPARTMENT/SCOPE:	Page 1 of 1
REVISION DATE:	EFFECTIVE DATE: 10/16/2024
AUDIENCE: All Clinical Staff	APPROVAL DATE:
OWNER:	APPROVER:

DEFINITIONS:

Lippincott Procedures: An online resource system providing current clinical procedures and best practices used in healthcare settings.

Computer Downtime: A period when the online Lippincott system is unavailable, necessitating the use of physical manuals.

POLICY:

This policy outlines the use of the Lippincott online resource system as the approved procedure manual for all clinical procedures at Mayers. The purpose of this document is to ensure that clinical staff have access to up-to-date information and maintain compliance with standards set by regulatory bodies. This policy is aligned with ACHC standards and CMS regulations, ensuring that all clinical practices meet established guidelines.

PROCEDURE:

1. **Access:**
    - All clinical staff will have access to the Lippincott Procedures online resource.
    - Training will be provided to ensure effective navigation and utilization of the system.
2. **Availability During Computer Downtime:**
    - Updated physical Lippincott procedure manuals will be supplied to all units and can be utilized during computer downtime to ensure continuous access to clinical procedures.
3. **Procedure Reference:**
    - Clinical staff must use Lippincott for all clinical procedures.
    - Updated physical manuals will be accessible during computer downtime for reference.
4. **Support:**
    - For any issues related to Lippincott access or use, staff should contact the clinical educator for assistance.

COMMITTEE APPROVALS:

P&P: 12/11/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: LVNs in OPMedical	POLICY # OPM830
DEPARTMENT/SCOPE: Outpatient Medical	Page 1 of 2
REVISION DATE:	EFFECTIVE DATE: 11/6/24
AUDIENCE: LVN in OPM only	APPROVAL DATE:
OWNER: M. Peterson	APPROVER: M. Padilla

DEFINITIONS:

LVN's working in Outpatient Medical will work under the full extent of their scope of practice.

POLICY:

LVN's in Outpatient Medical Department (OPM) must work under the supervision of an RN, NP, or provider. The level of supervision required depends on the complexity of the task, the LVN's training and experience, and state regulations. Supervisory roles may include direct oversight or indirect oversight where the LVN reports changes in a patient's condition.

In some cases, RNs and providers may delegate certain tasks to LVNs. The delegation of tasks must consider:

- The LVN's competency and experience.
- The complexity and risk associated with the task.
- The availability of supervision or support.

Some high-complexity tasks, such as invasive procedures, require the supervision of an RN or provider.

PROCEDURE:

- The OPM LVN will be trained on policies and procedures within the scope of the LVN practice. Skills checklist and competencies will be performed and evaluated on high risk selected procedures.

Outpatient Wound Care and other Outpatient Services:

- Wound care
- Ostomy maintenance/education
- Wound VAC placement and maintenance
- PICC line/Central line/IV care and maintenance
- Implanted port/VAD maintenance
- Blood and blood products
- Therapeutic transfusions
- Phlebotomy services
- IV medication administration
- IV hydration
- IM/SQ medication administration

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: LVNs in OPMedical		POLICY # OPM830
DEPARTMENT/SCOPE: Outpatient Medical		Page 2 of 2
REVISION DATE:	EFFECTIVE DATE: 11/6/24	
AUDIENCE: LVN in OPM only	APPROVAL DATE:	
OWNER: M. Peterson		APPROVER: M. Padilla

REFERENCES:

LVN Scope of Practice in California 2024 | NCC Guide Accessed 11/6/2024

COMMITTEE APPROVALS:

OP Med: 2/14/2025
P&P: 3/5/2025
MEC: 3/17/2025

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Mass Casualty Incident Plan (MCI)	POLICY # DIA0064
DEPARTMENT/SCOPE: Disaster	Page 1 of 6
REVISION DATE:	EFFECTIVE: 10/23/24
AUDIENCE: All District Staff	APPROVAL DATE:
OWNER: Dana Hauge, SO	APPROVER: Ryan Harris

DEFINITIONS:

- **Mass Casualty Incident (MCI):** Any incident that produces more casualties than the facility can handle with its usual resources.
- **Incident Command System (ICS):** A standardized hierarchical structure for coordinating incident response.
- **Surge Capacity:** The ability of the healthcare facility to expand quickly beyond normal services to meet increased patient demand during an MCI.
- **Level 1 Surge:** A surge in patients presenting to the Emergency Room which results in significant stress to hospital resources.
- **Level 2 Surge:** Patient surge affecting all local medical providers. This surge requires regularly scheduled planning sessions among all the community medical/health providers, and Emergency Medical Services (OES) to meet the medical needs of the community.
- **Level 3 Surge:** Patient surge countywide and in neighboring counties which results in a lack of capacity to provide medical services. A state of emergency has been declared or is being sought. Regional coordination is necessary to meet the medical needs of the community.
- **Level 4 Surge:** A surge in patients that requires recalibration of EMS and hospital standards of care using pre-approved alternate care protocols and that less-acute hospital patients be triaged from hospitals to appropriate alternate care providers. Regional/Statewide coordination is required.

PURPOSE:

This Mass Casualty Incident (MCI) Plan aims to ensure that Mayers Memorial Healthcare District is adequately prepared to respond to a mass casualty event. This plan provides the framework for internal and external responses to incidents that overwhelm the normal operations of the healthcare system, ensuring that patient care continues, staff and resources are efficiently managed, and safety is maintained. This plan complies with the Accreditation Commission for Health Care (ACHC 17.00.03)

This MCI Plan applies to all hospital staff and departments. It encompasses internal mass casualty incidents (e.g., a fire or explosion within the hospital) and external incidents (e.g., community-wide disasters such as earthquakes, terrorist attacks, or pandemics). The plan is designed to integrate with local, state, and federal emergency response systems and outlines procedures for coordinating with external agencies and other healthcare facilities.

SUBJECT/TITLE: Mass Casualty Incident Plan (MCI)	POLICY # DIA0064
DEPARTMENT/SCOPE: Disaster	Page 2 of 6
REVISION DATE:	EFFECTIVE: 10/23/24
AUDIENCE: All District Staff	APPROVAL DATE:
OWNER: Dana Hauge, SO	APPROVER: Ryan Harris

PLAN ACTIVATION

The MCI Plan may be activated in response to:

- **Internal Incidents:** Fires, explosions, or structural failures within the hospital that result in multiple casualties.
- **External Incidents:** Natural disasters, mass transportation accidents, chemical spills, terror attacks, or pandemics that overwhelm local medical resources.
- Activation authority resides with the Safety Officer, Hospital Administrator, or Incident Commander. Activation triggers include a high volume of casualties or notification from public health or emergency services regarding a mass casualty event in the community.

Emergency medical services (EMS) staff may have good information about the situation, the anticipated number of victims, and the severity of injuries. Mayers EMS services can be reached at extension 1183.

INCIDENT COMMAND SYSTEM (ICS) STRUCTURE

Upon activation, Mayers Memorial Healthcare District will implement the Incident Command System (ICS), ensuring a structured and organized response:

- **Incident Commander (IC):** Responsible for overall command and decision-making.
- **Operations Section Chief:** Directs all tactical operations, including patient care and triage.
- **Planning Section Chief:** Monitors the status of resources and operations, developing action plans.
- **Logistics Section Chief:** Ensures that medical supplies, equipment, and personnel are available.
- **Finance/Administration Section Chief:** Tracks expenses, personnel time, and resource allocation.
- **Public Information Officer (PIO):** Manages communications with the public and media.
- **Liaison Officer:** Serves as the point of contact for coordinating with external agencies (EMS, local hospitals, public health authorities, etc.).

STAFFING

Staffing needs will be discussed within the IC structure. The Planning Chief will be responsible for starting the staffing procedures using the communications systems to gather information on the available staff. The goal will be to implement a staffing ratio increase in appropriate areas to meet the needs of the increased patient population.

SUBJECT/TITLE: Mass Casualty Incident Plan (MCI)	POLICY # DIA0064
DEPARTMENT/SCOPE: Disaster	Page 3 of 6
REVISION DATE:	EFFECTIVE: 10/23/24
AUDIENCE: All District Staff	APPROVAL DATE:
OWNER: Dana Hauge, SO	APPROVER: Ryan Harris

COMMUNICATION PLAN

Communication is critical during an MCI, and the following protocols will be in place:

- **Internal Communication:** Staff will be alerted through overhead announcements, paging systems, and email notifications. All staff should monitor emergency channels during an MCI.
- **External Communication:** The Safety Officer or Liaison Officer will coordinate with local EMS, public health officials, neighboring hospitals, and local authorities. Redundant communication systems (landline, mobile, and radio) will be used to ensure reliable contact with external partners.
- **Public Communication:** The Public Information Officer will release official statements and updates to the media, ensuring accurate and timely information.

It is important to note that the Crisis Communication Plan and the Communication Plan, attached to the Emergency Operations Plan should be used to govern communication in a patient surge or Mass Casualty Event.

SURGE CAPACITY PLAN

In the event of a mass casualty, the hospital will activate its surge capacity protocols to accommodate a sudden influx of patients. The Mayers Memorial Healthcare District Surge Plan will outline the differences between Levels 1, 2, 3 and 4 surges in the case that a patient surge becomes possible.

- **Space:** Non-traditional areas, including conference rooms, lobbies, and parking lots, will be converted into triage and treatment areas. The Emergency Department (ED) will serve as the primary point of care, but additional zones will be designated based on patient volume.
- **Staffing:** Off-duty staff will be called in, and additional personnel from unaffected departments will be reassigned. Volunteers may be used in non-clinical roles.
- **Supplies:** Inventory levels of critical supplies (e.g., oxygen, IV fluids, PPE, medications) will be monitored by the Logistics Section. Arrangements with external vendors and mutual aid agreements with other healthcare facilities will be activated if supplies run low.

TRIAGE AND PATIENT CARE

A standardized triage system will be used to assess and prioritize patients based on the severity of their condition:

SUBJECT/TITLE: Mass Casualty Incident Plan (MCI)	POLICY # DIA0064
DEPARTMENT/SCOPE: Disaster	Page 4 of 6
REVISION DATE:	EFFECTIVE: 10/23/24
AUDIENCE: All District Staff	APPROVAL DATE:
OWNER: Dana Hauge, SO	APPROVER: Ryan Harris

- **Immediate (Red):** Patients who need immediate life-saving interventions.
- **Delayed (Yellow):** Patients with serious injuries that do not require immediate treatment.
- **Minor (Green):** Patients with minor injuries who can wait for care.
- **Deceased (Black):** Patients who are deceased or whose injuries are so severe that survival is unlikely.

Triage zones will be marked, and patients will be triaged upon arrival. Triage tags or wristbands will be used to identify the patient's priority status. Triage tags are kept in the disaster trailer, in the ER, and are with the EMS department as well. Triage flagging is also in the disaster trailer.

EVACUATION PROCEDURES

Evacuation procedures will be initiated if a portion of, or the entire facility becomes unsafe:

- **Partial Evacuation:** Evacuate affected units, moving patients to other areas of the hospital.
- **Full Evacuation:** Transfer all patients to predetermined external locations. The Logistics Section Chief will coordinate transportation with EMS and local agencies. Evacuation routes will be marked, and priority will be given to critical patients.

SUPPLIES

Emergency and Disaster supplies for the incident can be found in inventory sheets. The district maintains a disaster trailer that has supplies for an MCI. Purchasing carries enough supplies for 96 hours and the dietary department has a robust stock of food and water for 96 hours. Please refer to the Emergency Operations Plan Resources and Assets Plan.

Clinical supplies for the ED are managed by that department and can be found within the ER and in purchasing stock areas.

Pharmaceutical Supplies are available within the pharmacy department and the contact numbers for Pharmacy vendors are in the master contact list within the emergency and disaster binder, within the contacts section.

EXTERNAL COLLABORATION

Effective collaboration with external agencies is crucial for a successful MCI response. Mayers Memorial Healthcare District will coordinate with:

- **Emergency Medical Services (EMS):** Collaborating with EMS for patient transport, triage, and on-scene care.

SUBJECT/TITLE: Mass Casualty Incident Plan (MCI)	POLICY # DIA0064
DEPARTMENT/SCOPE: Disaster	Page 5 of 6
REVISION DATE:	EFFECTIVE: 10/23/24
AUDIENCE: All District Staff	APPROVAL DATE:
OWNER: Dana Hauge, SO	APPROVER: Ryan Harris

- **Public Health Authorities:** Coordinating with state and local public health departments for guidance on infection control, vaccination, and patient management.
- **Neighboring Hospitals:** Mutual aid agreements will be activated, allowing patient transfers if capacity is exceeded.

DOCUMENTATION

Proper documentation during an MCI is essential for patient care and after-action reviews:

- **Patient Documentation:** The Planning Section will ensure all patient information, treatments, and outcomes are accurately recorded, even in non-traditional care areas.
- **Incident Documentation:** Each section of the ICS will document its activities and resource use during the MCI. This information will be compiled for an after-action review to improve future responses.
- **Safety Officer:** All documentation will be approved and collected by the Safety Officer and stored within the Emergency Management files. Documentation will be used to write an After-Action Report and that will be submitted to the appropriate committees for review.

SAFETY AND SECURITY

Designated Safety and Security personnel will:

- Secure all hospital entrances and exits to control patient flow.
- Manage crowd control, including family members and media personnel.
- Control traffic so that EMS units are able to move freely, and so that vehicles do not block high-traffic areas needed for the response.
- Security leadership will consider holding or calling back staff and may ask for assistance from facilities and EVS teams to help manage entry and exit points. If extra security is needed the Director of Safety and Security may ask for community volunteers such as firefighters, or local law enforcement.
- Assist in a manner to ensure staff safety by distributing PPE and enforcing infection control protocols (if applicable).

TRAINING AND DRILLS

To maintain preparedness, the hospital will conduct:

- **MCI Drills/Training:** These drills will involve all departments and external agencies to simulate real-life mass casualty scenarios. Staff will be evaluated on their response time, decision-making, and adherence to the ICS. Drills will occur as a part of the emergency

Management Program and will occur according to the HVA and training programs. Annual MCI policy training will be scheduled for applicable employees.

- **Post-Drill Evaluations:** After each drill, an evaluation will be conducted, and any identified areas for improvement will be addressed in subsequent training.

POST-INCIDENT RECOVERY

After the incident is resolved, the following actions will be taken:

- **Demobilization:** The ICS will coordinate the return of resources, equipment, and personnel to regular operations.
- **Psychological Support:** Counseling services will be provided for both staff and patients to address stress, trauma, and burnout following the MCI.

COMPLIANCE AND PLAN MAINTENANCE

This MCI Plan will be reviewed annually and updated as needed to ensure compliance with ACHC standards. Training programs will be revised regularly to address any changes in procedures or technologies.

REFERENCES:

ACHC Accreditation requirements for Critical Access Hospitals, 2023 edition. Accreditation Commission for Health Care (ACHC). 17.00.03

Hospital Mass Casualty Response Plan Considerations.
https://files.asprtracie.hhs.gov/documents/aspr-tracie-mci-response-plan-considerations.pdf

COMMITTEE APPROVALS:

Safety/Disaster: 2/12/2025

MAYERS MEMORIAL HEALTHCARE DISTRICT

Privileges in Obstetrics and Gynecology (OB-GYN)

The Physician will perform procedures in the following locations:

- ☐ MMHD Acute/Swing Bed Care
- ☐ MMHD Skilled Nursing Facility
- ☐ Mayers Rural Health Clinic

Name: _____

Obstetrical and Gynecological Core Privileges

Qualifications

To be eligible for core privileges in OB-GYN, the applicant must meet the following qualifications:

- Current certification or board eligible (with achievement of certification within 2 years of completion of training) leading to certification in OB-GYN.

and

- Successful completion of an Accreditation Council for Graduate Education (ACGME)- or American Osteopathic Association (AOA)- accredited residency in OB-GYN

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 Obstetrics Core
Admit, evaluate, diagnose, treat, and provide consultation to adolescent and adult female patients and/or provide care of the female reproductive system and associated disorders, including major medical diseases that are complicating factors in pregnancy. Assess, stabilize and determine the disposition of patients with emergent conditions consistent with the medical staff policy regarding emergency and consultative call services.

Privileges included in the Gynecology Core
Admit, evaluate, diagnose, treat, and provide consultation and the pre-, intra-, and postoperative care necessary to correct or treat female patients of all ages presenting with injuries and disorders of the female reproductive system and the genitourinary system and non surgically treat disorders and injuries of the mammary glands. Assess, stabilize and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.

NAME:

Additional Privileges Requested (write in below):

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

NAME:

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	Date
_____	_____
Medical Executive Committee Chair or Vice Chair	Date

NAME:

Core Privileges
Obstetrics

- Performance of history and physical examination.
- Amnioinfusion
- Amniocentesis,
- Amniotomy
- Application of internal fetal and uterine monitors
- Cerclage
- Cervical biopsy or conization of cervix in pregnancy
- Hypogastric artery ligation
- Interpretation of fetal monitoring
- Management of high-risk pregnancy, inclusive of such conditions as preclampsia, postdatism, third-trimester bleeding, intrauterine growth restriction, premature rupture of membranes, premature labor, and placental abnormalities
- Management of patients with or without medical, surgical or obstetrical complications for normal labor, including toxemia, threatened abortion, normal puerperal patient, normal antepartum and postpartum care, postpartum complications and fetal demise
- Obstetrical diagnostic procedures, including ultrasonography and other relevant imaging techniques
- Treatment of medical and surgical complications of pregnancy

Core Privileges
Gynecology

- Performance of history and physical examination.
- Aspiration of breast masses
- Cervical biopsy, including conization
- Colpocleisis
- Colpoplasty
- Cycstscopy as part of a gynecological procedure
- Diagnosis and management of pelvic floor dysfunction, including operations for its correction (e.g., repair of rectocele, entercocele, cyctocele, or pelvic prolapse
- Diagnostic and therapeutic dilation and curettage
- Endometrial ablation
- Endometrial biopsy, ultrasound
- Gynecologic diagnostic procedures, including ultrasonography and other relevant imaging techniques
- Hysterosalpingography
- Hysterscopy, diagnostic or ablative, excluding the use of the resection technique
- Incision and drainage of pelvic abscesses
- IUD Placement
- Labarotomy (other than tubal sterilization)
- LEEP procedure
- Manual vacuum aspiration
- Metroplasty

- Myomectomy, abdominal
- Nexplanon placement
- Uterovaginal, vesicovaginal, rectovaginal, and other fistula repair
- Vulva biopsy
- Vulvectomy, simple

NAME:

SUPPORTING DOCUMENTATION
REQUEST FOR SPECIAL PROCEDURE PRIVILEGES

Name: _____Kelsey Sloat, MD_____

Date: _____

Special Procedure Privileges requested:

_____

_____

Training and Education:

Residency Program:

_____

_____

Board Certification:

_____

Certificate obtained at a CME Training Course:

_____

Proctoring:

☐ Proctoring forms on file in Medical Staff Office
☒ Request for proctoring of above procedures

Competency:

I have completed _____(#) of _____ procedures in the past 2 years.

Other:

_____

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Rapid Response to Clinical Deterioration	POLICY #MS035
DEPARTMENT/SCOPE:	Acute Services	Page 1 of 3
REVISION DATE:		EFFECTIVE DATE: 01/22/2025
AUDIENCE: All Clinical Staff		APPROVAL DATE:
OWNER: Moriah Padilla		APPROVER: T. Overton

DEFINITIONS:

Rapid Response Process: A structured system designed to provide immediate intervention and care to patients whose condition is deteriorating, ensuring timely stabilization and escalation of care when necessary.

POLICY:

Mayers Memorial Healthcare District (MMHD) maintains a Rapid Response Process to address the immediate needs of patients showing signs of clinical deterioration. The purpose of this process is to ensure timely assessment, stabilization, and intervention to prevent further decline or adverse outcomes. This policy provides guidelines for initiating and executing the Rapid Response Process, emphasizing flexibility in roles based on staff availability to ensure patient-centered and efficient care.

PROCEDURE:

The rapid response care for a patient can be activated by any healthcare provider or team member when a patient's condition shows signs of deterioration.

Common indicators include but are not limited to:

- Sudden or unexplained changes in vital signs (e.g., increased heart rate, decreased blood pressure, oxygen saturation changes).
- Respiratory distress or failure.
- Acute change in mental status.
- Severe chest pain, dyspnea, or significant lab result changes.
- Clinical concern for patients declines.

Steps for Rapid Response:

1. **Initial Assessment:** The first responder evaluates the patient and initiates immediate interventions as appropriate.
2. **Team Assembly:** Based on the patient's condition and staff availability, additional responders (e.g., respiratory therapist, provider) are called to assist.
3. **Intervention and Stabilization:** Implement diagnostic and therapeutic measures to stabilize the patient.
4. **Communication and Documentation:** Document all actions in the patient's chart and communicate updates to family members as appropriate.
5. **Escalation or Transfer:** If necessary, facilitate the transfer of the patient to a higher level of care.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Rapid Response to Clinical Deterioration	POLICY #MS035
DEPARTMENT/SCOPE:	Acute Services	Page 2 of 3
REVISION DATE:		EFFECTIVE DATE: 01/22/2025
AUDIENCE: All Clinical Staff		APPROVAL DATE:
OWNER: Moriah Padilla		APPROVER: T. Overton

Communication Process:

1. Nursing Staff:
    - Upon recognizing a significant change or deterioration in a patient's condition, the primary nurse contacts:
        - The Nursing Supervisor to assist with stabilization, oversight, and guidance for care outside of their knowledge and comfort level.
        - The Hospitalist for medical assessment and care decisions.

2. Nursing Supervisor:
    - Responds and evaluates patient's clinical condition and provides initial stabilization if needed and coordinates response and delegates tasks as needed.
    - Responds promptly to provide oversight and assistance while encouraging the primary nurse to continue managing the patient's care to promote growth and learning.
    - Remains present to oversee the situation, ensuring proper interventions are implemented and assisting as needed.

3. Hospitalist:
    - Assumes responsibility for overseeing patient care within their scope of practice.
    - Provide evaluation and recommendations for treatment plans for deteriorating patients.
    - Can contact the Emergency Department (ED) Provider in the following situations:
        - If the patient's care requires intervention outside of their expertise or for additional assistance in managing treatment.
        - If the deterioration of the patient requires immediate clinical oversight, and the on-call provider requires time to arrive at the facility.
4. ED Provider
    - Collaborate with the team in decision-making about next steps, including medication management, diagnostics tests, and potential transfer to higher level of care, as indicated by needs.

5. Respiratory Therapists:
    - May be called if deterioration requires.
    - Provides immediate airway management, oxygenation support, and ventilatory assistance if necessary.
    - Offers assessments and intervention in cases of respiratory compromise, such as when the patient's oxygen saturation drops, or respiratory distress is evident.

SUBJECT/TITLE:	Rapid Response to Clinical Deterioration	POLICY #MS035
DEPARTMENT/SCOPE:	Acute Services	Page 3 of 3
REVISION DATE:		EFFECTIVE DATE: 01/22/2025
AUDIENCE: All Clinical Staff		APPROVAL DATE:
OWNER: Moriah Padilla		APPROVER: T. Overton

6. Pharmacy Representative (when available)
    - Can provide immediate pharmacological consultation and assist with medication adjustments during RRT interventions.
    - Helps ensure safe and effective drug regimens are followed.

Collaboration and Support:

- The Primary Nurse, Nursing Supervisor, and Hospitalist collaborate to ensure timely and appropriate care.
- The Nursing Supervisor ensures that bedside nurses are supported but remain engaged in the patient's care, reinforcing education, and practical application.
- The ED Hospitalist is available as a consultative resource to address complex or critical needs.

Documentation:

- All clinical changes, communications, and interventions are documented in the patient's medical record.
- Notes must reflect the identified changes, actions taken, and the patient's response to interventions.

A verbal debriefing session may be conducted following a rapid response to evaluate the team's effectiveness and to address any issues or concerns.

REFERENCES:

Lippincott Nursing Procedures. 9th ed., Wolters Kluwer, 2023

Lippincott Nursing Practice. 12th ed., edited by Sandra M. Nettina and Christine Nelson-Tuttle, Wolters Kluwer, 2024.

Accreditation Commission for Health Care. *ACHC Accreditation Requirements for Critical Access Hospitals: 2023 Edition*. Accreditation Commission for Health Care, 2023. Standard 05.02.01.

COMMITTEE APPROVALS:

P&P: 3/5/2025
MEC: 3/17/2025

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Requirements For Swing Beds in Critical Access Hospital 11.00.00 & 11.00.01	POLICY #CAH002
DEPARTMENT/SCOPE:	A Critical Access Hospital	Page 1 of 2
REVISION DATE:		EFFECTIVE: 1/15/2025
AUDIENCE: All Staff		APPROVAL DATE:
OWNER: Moriah Padilla		APPROVER: T. Overton

DEFINITIONS:

Swing-bed requirements apply to any resident discharged from a critical access hospital (CAH) and admitted to a swing-bed for skilled nursing services. The requirements for acute-care CAHs also apply to swing-bed residents.

Swing bed certification is limited to the CAH itself and does not include any distinct part rehabilitation or psychiatric units. Swing bed services shall be provided in CAH distinct part units.

Swing-bed concept allows a CAH to use beds interchangeably for either acute-care or post-acute care.

Swing-bed residents receive a skilled nursing facility (SNF) level of care, and the CAH is reimbursed for providing a SNF level of care; however, swing-bed residents are not SNF residents.

Swing-bed residents in CAHs are considered to be inpatients of the CAH.

POLICY:

This CAH shall meet the following requirements in order to be granted an approval from CMS to provide post-CAH SNF care and to be paid for SNF-level services.

- The facility has been certified as a CAH by CMS under § 485.606(b)
- The CAH has a Medicare provider agreement
- The total number of beds that may be used at any time for furnishing swing-bed services or acute inpatient services does not exceed 25 beds. MMHD is licensed for 10 beds.
- The CAH meets the swing-bed CoP on Resident Rights; Admission, Transfer, and Discharge Rights; Freedom from Abuse, Neglect and Exploitation; Patients Activities; Social Services; Comprehensive Assessment, Comprehensive Care Plan, and Discharge Planning; Specialized Rehabilitative Services; Dental Services; and Nutrition

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Requirements For Swing Beds in Critical Access Hospital 11.00.00 & 11.00.01	POLICY #CAH002
DEPARTMENT/SCOPE:	A Critical Access Hospital	Page 2 of 2
REVISION DATE:		EFFECTIVE: 1/15/2025
AUDIENCE: All Staff		APPROVAL DATE:
OWNER: Moriah Padilla		APPROVER: T. Overton

There is no length of stay restriction for any CAH-based swing bed resident.

- Note: There is no Medicare requirement to place a swing bed resident in a nursing home and there are no requirements for transfer agreements between CAHs and nursing homes.

- Note: While there is no length of stay limit for residents in swing bed status, the intended use for swing beds is for a transitional time period to allow the resident to fully recover to return home or while awaiting placement into a nursing facility.

The CAH shall document in the resident's medical record efforts made for nursing facility placement.

Medicare beneficiaries shall have a qualifying three (3) day inpatient stay in a participating CAH prior to admission to a swing bed. The three (3) day qualifying stay does not need to be in the same CAH as the swing-bed admission.

The CAH shall provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident according to their individual needs.

REFERENCES:

Accreditation Requirements for Critical Access Hospitals. Accreditation Commission for Health Care, 2023. Standard 11.00.00 & 11.00.01

Centers for Medicare and Medicaid Services (CMS). (2023, February 3). *State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities.* 483.40(d). CMS. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Centers for Medicare and Medicaid Services (CMS). (2018, August 31). *Guidance to Hospitals and Critical Access Hospitals Surveyors Addressing Revisions to Swing-Bed Requirements*. CMS. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/QSO18-26-Hospital-CAH

COMMITTEE APPROVALS:

P&P: 2/12/2025

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Sedation Assessment	POLICY # MS076	
DEPARTMENT/SCOPE:	Acute	Page 1 of 2	
REVISION DATE:		EFFECTIVE DATE:	10/16/2024
AUDIENCE:	All Nursing Staff	APPROVAL DATE:	
OWNER:	Moriah Padilla	APPROVER:	T. Overton

DEFINITIONS:

Opioid Analgesics: Medications used to relieve pain that can cause sedation and respiratory depression.

High Risk Adults: Patients at increased risk for oversedation due to age, pre-existing respiratory conditions, and concurrent sedative use.

Pasero Opioid-Induced Sedation Scale (POSS): A scale used to assess sedation levels and determine necessary interventions for patients receiving opioids.

POLICY:

Mayers Memorial Hospital is committed to providing safe and effective care to patients receiving opioid analgesics. This policy outlines the requirements for sedation assessment to prevent oversedation and respiratory depression, thereby ensuring patient safety. Adherence to the following standards is mandated:

PROCEDURE:

1. **Assessment Schedule:**
   - Sedation assessments will be performed when the system-generated order populates for high-risk adults or if ordered by the physician.
     - **Initial Assessment:**
       - Assess sedation levels every 1 hour for the first 12 hours.
       - Assess sedation levels every 2 hours for the next 12 hours.
       - Assess sedation levels every 4 hours for the following 24 hours.
     - **Ongoing Assessment:**
       - After the initial 24 hours, assessments may continue every 4 hours as clinically indicated for patients on opioid patches. Sedation assessments can also be performed during pain reassessment if clinically indicated.
   - For patients on continuous opioid infusion or with altered mental status:
     - Sedation assessments may be conducted more frequently based on clinical judgment and specific physician orders.
2. **Sedation Assessment Using the Pasero Opioid-Induced Sedation Scale (POSS):**
   - Document the sedation level according to the following scale:
     - **(S)** Sleep, easy to arouse – Acceptable; no action necessary; may increase opioid dose if needed.
       - Awake and alert – Acceptable; no action necessary; may increase opioid dose if needed.
     - **(2)** Slightly drowsy, easily aroused – Acceptable; no action necessary; may increase opioid dose if needed.

SUBJECT/TITLE:	Sedation Assessment	POLICY # MS076
DEPARTMENT/SCOPE:	Acute	Page 2 of 2
REVISION DATE:		EFFECTIVE DATE: 10/16/2024
AUDIENCE:	All Nursing Staff	APPROVAL DATE:
OWNER:	Moriah Padilla	APPROVER: T. Overton

- **(3)** Frequently drowsy, arousable, drifts off to sleep during conversation – Unacceptable; monitor closely; decrease opioid dose by 25% to 50% or notify prescriber.
- **(4)** Somnolent, minimal or no response to verbal and physical stimulation – Unacceptable; stop opioid; administer naloxone; notify prescriber.

3. **Documentation:**
   - Document all sedation assessments and promptly in the Electronic Health Record (EHR).
4. **Naloxone Administration:**
   - If a patient shows signs of life-threatening opioid-induced sedation or respiratory depression, administer naloxone 0.4mg and observe the patient's response.
   - The dose may need to be repeated based on the patient's condition and response.
   - Contact the provider for further evaluation and instructions.

SPECIAL CONSIDERATIONS:

- This policy should be read in conjunction with the Pain Management Policy.

REFERENCES:

- Centers for Medicare & Medicaid Services. "42 CFR §482.23 - Nursing Services." *Electronic Code of Federal Regulations*, 2024. www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/section-482.23.
- Pasero, Christine, and L. Michelle McCaffery. *Pain Assessment and Pharmacologic Management.* 2nd ed., Mosby, 2011.
- The Joint Commission. "Patient Safety Goals." *The Joint Commission*, 2023. www.jointcommission.org/standards/patient-safety-goals.
- U.S. Department of Health & Human Services. "State Operations Manual (SOM), Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals." *CMS*, 2024. www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospital.pdf.
- World Health Organization. "WHO Guidelines for the Pharmacological and Radiotherapeutic Management of Cancer Pain in Adults and Adolescents." *World Health Organization*, 2020. www.who.int/publications/i/item/9789241550310.

COMMITTEE APPROVALS:

M/P&T: 1/24/2025
P&P: 3/5/2025
MEC: 3/17/2025

Director of Operations Report
Prepared by: Jessica DeCoito, Director of Operations

Facilities, Engineering, and Other Construction Projects

- The plans for TCCN Phase 3 are still under review by the county. Certificates of Occupancy for Phase 1 and 2 have been received from the Burney Fire District.
- We have received comments from the third-party reviewer for the FR Rural Health Clinic regarding the toilet rooms. The reviewer insists that we provide separate male and female bathrooms, despite the code allowing for a single toilet room for up to three exam rooms. The architects are working directly with the county for clarification on this issue.
- PIN 74 has been submitted to HCAI and is currently under review. We expect to receive feedback within the next couple of weeks.
- The engineers requested panel reading and photos of the breakers for the Fire Smoke Dampers project, which have been provided. We anticipate an update on the project status soon.
- A meeting is scheduled for March 20th to review the engineers' and architects' findings regarding the potential addition of SNF beds into the acute care space once the new acute building is completed. An update will be provided at the Board meeting.
- The response to our request for a Construction Project Management Firm for the Master Plan has been the most positive we've received. The Strategic Planning Committee will review the submitted proposals, with a Notice of Intent to Award scheduled for Monday, March 24th. The board’s approval of the recommendation will follow at the next Board meeting.
- The Solar Project has encountered another setback. The excavator contractor has been removed from the project, and a replacement is being sought. Soil conditions have proven problematic, prompting a review of the pile-driving method to possibly switch to cast-in-place. Veregy has submitted a request for an extension, proposing a new final completion date of August 8th, which is currently under consideration.
- On March 7th, Maintenance and IT successfully relocated the Finance team to TCCN, including Accounts Payable, Payroll, Employee Benefits, the Accountant, and the Controller. Additionally, the Safety Officer, Chief Clinical Officer, and Ambulance Manager were moved to the Administration building. Renovations have started on the old doctor’s sleeper room to create space for Employee Health and Infection Control. The Activities room in Fall River has been remodeled to incorporate a new shelving and cabinet system, along with accommodation for the Activities team. More office relocations are planned for the coming months as additional plans unfold.

Employee Housing

- Joey secured an estimate for installing UV filters and updating the water filtration system at the lodge. The estimate has been approved and forwarded to Your H20 Pro for scheduling.

ACHC

- A team from our organization attended the ACHCU Conference in Dallas during the first week of March. Valuable information was gathered, particularly regarding changes in standards that take effect this year. Dana, Alex, and I are already working on making necessary updates to our programs to align with these new standards.
- We have submitted our Plan of Corrections for the identified deficiencies and are awaiting further feedback from the surveyors for any additional clarifications or recommendations regarding our plan.

IT

- The IT Department has been busy with a variety of projects for the district. We are setting up interfaces for Radiology to link to archive programs, integrating Mobile MRI, and implementing new lab machines. Efforts are also underway to clean up our Frontier contract, decommission outdated technology, update existing systems, and create a document repository that all IT employees can use as a resource.

Human Resources

March 2025

Submitted by: Libby Mee, Chief Human Resource Officer

Employee Support and Recruitment

The Human Resources, Payroll, and Benefits department currently serves **296 active employees**. We are working on several recruitment and retention initiatives, with **21 specific requisitions posted** and **45 vacant positions** to be filled.

Springtime is a busy period for Career and Hiring events, and members of MMHD are scheduled to attend multiple fairs over the coming months.

The HR and Payroll team also **audit**s employee status and working hours quarterly. This audit ensures that employees are working the appropriate number of hours to maintain their designated status and identifies staff who do not meet the minimum required hours or are out of compliance.

We are beginning communications with local high schools in our district to market our **annual Summer Internship Program**, which provides paid opportunities for local graduates pursuing a healthcare career. Applications for this program will be due in early May.

Employee Health

Last month's notes mentioned that the **CHRO** and **Director of Safety and Security** met with our **Director of Risk and Employee Safety** from BETA. This meeting reviewed injuries and exposures over the past five years. BETA continues to be very impressed by our low injury volume and safety culture.

Upon reviewing the data, we identified **the highest exposure area of resident/patient handling-related injuries** by Certified Nurse Assistants in Skilled Nursing Facilities. These statistics make sense, as this is the largest department at Mayers, with the most employees.

On a positive note, since implementing our recent **Safe Patient Handling and Mobility** employee safety wellness initiative, we have only reported **one patient handling injury**.

Conference and Education

The CHRO recently attended the annual **AHA Rural Leadership Conference**, where valuable knowledge and tools were gained related to strengthening the rural healthcare workforce, advancing sustainability in rural health, enhancing collaboration between boards, CEOs, and medical staff, and staying updated on regulations from Washington and AI in rural healthcare.

In April, the HR team will also attend the **American Society for Health Care Human Resources Administration** annual conference. This will be our second time attending, and we are excited about the recently posted agenda. Much of the department's success from the past year resulted from programs, education, resources, and contacts made at last year's conference.

Managers' Toolkits

To provide additional training and education to our leadership team, the HR Team is presenting a **"Manager Toolkit"** session at the monthly Managers' meeting. These sessions are designed to retrain and provide resources on the various responsibilities of being an MMHD leader, as they support staff and ensure compliance with regulations to offer the best patient and resident care.

To date, managers have received toolkits on the following topics:

- **Harassment, Discrimination, and Retaliation Prevention**
- **Discipline and Corrective Action**
- **Payroll Responsibilities**

March Board Report
Clinical Division
3/18/2025

- The ACHC survey revealed inefficiencies in our Policy and Procedure review and approval process. I am reworking it. The new process will have fewer layers and meet the regulations.
- I had the opportunity to attend the AHA Rural Hospital Conference in San Antonio. I took several lessons from the conference on foundation, Medicare Advantage, visiting nurse services, and relationships with elected officials.
- Interviews for the Director of Clinical Services are scheduled and plan to be completed by April 4. The goal is to onboard this position as soon as possible.
- I am excited to improve our patient experience through the Service Excellence Initiative.

Retail Pharmacy

- The Digital Pharmacist platform has ceased updating its reports and dashboard. As a result, we are transitioning to the Lumistry® platform, which offers similar features but with enhancements that better align with our pharmacy's needs. Key benefits include a fully customizable app, the ability to send bulk messages with filtering options, delivery confirmations, and pickup and refill reminders.
- We have successfully negotiated a new contract with Telnet, our contract pharmacy provider.
- We have received three external audit proposals for our 340B program, which are under review.
- We have had issues obtaining signatures at the drive-thru window when picking up a package. Insurance companies require digital signatures. Jeff Miles, IT manager, has implemented a new tablet that will maintain connectivity.

Hospital Pharmacy

Cerner

- I am processing open tickets for high-risk medications and continuous infusions. I am currently working on propofol and heparin. Insulin is also in the work queue. As progress has been slow, outstanding tickets have been escalated.
- There is a backlog in obtaining charge codes for medications administered in the Rural Health Clinic.

Humana Insurance Audit

- We had an insurance audit for prescriptions dispensed to skilled nursing residents. We have corrected the issues.

Sterile Compounding

- The barrier isolation was recertified on March 12. Biological results are pending.
- A registry pharmacist will complete his onboarding for sterile compounding by March 21. This will allow him to mix IVs while Keith Earnest is off-campus.

Infection Prevention

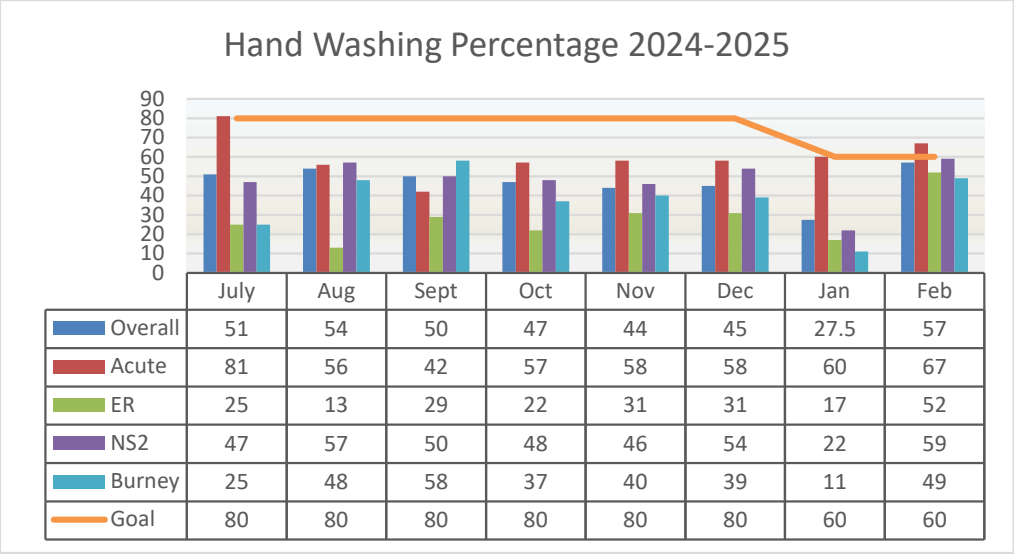
Blood Culture Contamination Rates

- Kristen Stephenson, RN, Infection Preventionist, is investigating the cause of the spike in the blood culture contamination rate. She found several deviations from the process. She has created a standard work and is working with the ER and lab managers to educate staff on the process.

Blood Contamination Rate	
Month	**Cont Rate**
Jan	3.51%
Feb	3.17%
Mar	2.86%
Apr	1.92%
May	0.00%
Jun	4.30%
Jul	1.92%
Aug	3.70%
Sep	0.00%
Oct	0.00%
Nov	5.26%
Dec	13.33%
Jan25	18.52%
Feb25	3.13%

Hand Washing

- February Handwashing Campaign: Valentine's Day—themed stickers reminded staff to foam in and foam out. The campaign, along with an increased number of observations by the executive team and individual coaching, showed improvement in all areas.



	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Overall	51	54	50	47	44	45	27.5	57
Acute	81	56	42	57	58	58	60	67
ER	25	13	29	22	31	31	17	52
NS2	47	57	50	48	46	54	22	59
Burney	25	48	58	37	40	39	11	49
Goal	80	80	80	80	80	80	60	60

Laboratory

Integration

- Kevin Davie facilitates the integration process between the lab and Point Click Care (the electronic medical record used in SNF). Cerner's integration proposal is anticipated by March 21.

Procalcitonin

- It is scheduled to go live the week of March 24. Results and billing will be manual until the Cerner interface is built. Charges are built in Cerner.

Quantiferon Analyzer

- Validation, policy and procedure, and training are complete.
- The Cerner portion is split between two consultants. One will build the charge codes, and the other will create the interface.

Respiratory Therapy

RT Manager Position

- This position has been difficult to fill. Two candidates have not arrived for their on-site interviews, and a third candidate is in the interview process.

Staffing

- An offer has been sent to a Respiratory Traveler with a potential start date of April 1. We are awaiting their acceptance.

Equipment Proposal

- Kevin Davie, DAS, completed a proposal for two transport ventilators and is awaiting feedback from other managers. These ventilators could be used in the ER and on ambulances. Current ventilators are used on ambulances but are not specifically designed for this use.

Cardiac Rehab

- Cardiac Rehab staff are enjoying the new chairs purchased through an award by Mayers Healthcare Foundation.
- Zita Biehle, Cardiac Rehab Coordinator, and Dr Lindsay Frye, Cardiologist, have revised the referral form. Dr Frye is distributing the referral form to cardiology offices in Redding.

Imaging

- Echo updates:
  - The Cerner build is complete.
  - There is a new issue with the unit not holding the network connection – working with Jeff and Mindray to resolve the issue.
  - I'm working with Dr. Lindsay Fry directly on templates and worksheets. We will have a paper process while we explore interface options.
- MRI Updates:
  - A Cerner ticket was submitted to add the MRI studies to Cerner.
  - Building protocols for each MRI exam.
  - Exams are being added to our PACS system for MRI.
- Fuji PACs Updates:
  - Completed transfer of 75K+ studies over to Fuji.
  - Jeff Miles in IT is working with Cerner to generate a URL in Fuji that will display images along with the report.
- Vesta Radiology:
  - Vesta Radiology is our new teleradiology group. They will take over remote imaging readings on March 31.
  - A handful of test studies have been successfully transmitted to Vesta to ensure a smooth transition.
- Ultrasound—onboarding of Dr Sloat:
  - A probe for transvaginal studies has been ordered.
  - Started building out new orders for Dr Sloat to perform bedside ultrasounds.
  - Working with Mindray on connecting the ultrasound machine to the clinic wifi so studies are sent to PACS.
- We have completed the E-Signature forms for Contrast Consent and Pregnancy Consent. Patients sign the consent on the iPad, and the form drops into the patient's chart automatically.
- Harold Swartz, Imaging Manager, and his team have worked to streamline imaging processes. Prior processes consisted of up to 50 steps to complete after each exam; the new process has automated several steps, reducing the manual steps to around 5.

NURSING SERVICES BOARD REPORT

March 2025-Reporting for February

- SNF DON continues Orientation with interim DON. Focus on policy and survey readiness.
- Acute Services commended for their hard work with ACHC survey and POC.

SNF

February 2025 Dashboard

Capacity

- Resident Census= Seventy-Seven (77)
  - Fall River= Thirty-Four (34)
  - Burney= Twenty-Three (2) general resident population and
  - Burney Memory Care= Twenty (20) residents
- One (1) female internal resident is pending review for Memory Care admission.
- Three (3) external candidates on the Memory Care waitlist

Staffing

- We have met regulatory staffing requirements for the month.
- The high percentage of agency utilization is a primary challenge, complicating hardwiring new implementations. To address this, we have:
  - Hired eight (8) new team members: two (2) Charge Nurses, two (2) Unit Assistants, and four (4) LVNs and
  - continue discussions with Nurses in Professional Healthcare (NPH) to engage in aligning registry training and review role shift duties, ensuring consistency and effectiveness across the board.
  - We will continue aggressively screening, interviewing, and job-offering viable candidates.

Updates

- **Staff Development**
  - Preparation**:** We completed 76 of 94 Policy & Procedures revisions this month.
  - Departmental Education: This month, CNA realignment orientation was conducted, achieving an impressive 93% compliance, further solidifying the commitment to exceeding the annual priority goal of eighty percent (80%).
  - Departmental Education: LVN realignment orientation is scheduled for 3/19-3/21/25 this month. All permanent LVNs are scheduled to attend.
  - Departmental Compliance: All job descriptions were reviewed, revised, and discussed with the employee during realignment training for signature(s).

- **Regulatory**
  - Wander Guard Alert System upgrade(s) Board of Directors approved- Thank you.
  - CDPH reinstated Mayers Memorial Healthcare District's collaboration with the Shasta College CNA program.
  - Seventy-six (76) of Ninety-four (94) policies were revised in preparation for the California Department of Public Health (CDPH) 's projected May-June survey.
  - No CDPH Visits this month. One Ombudswoman visit this month (awaiting conclusion)
  - Nine (9) pending self-reports submitted between September 2024 and March 17, 2025, are awaiting review by the CDPH. These include alleged resident-to-resident verbal and physical abuse, staff-to-resident verbal abuse, and a case of medication diversion.
- **Family Engagement**
  - Families well attended the Valentine's Candlelight Dinner.
  - Fourteen (14) resident families RSVPed for the monthly Family Council Meeting.

<u>Acute</u>

February 2025 Dashboard

- Acute ADC: 1.71
- Acute ALOS: 4.43
  - Medicare ALOS 2.77
- Swingbed ADC: 4.46
- Swingbed ALOS: 9.59
- OBS Census Days: 16

February Staffing

- **Staffing Requirements:** Our department's optimal staffing requirements include 8 FTE RNs, 2 PTE RNs, 4 FTE CNAs, and 2 FTE Ward Clerks. Currently, we are down 3 FTE RNs. We have successfully hired two newly graduated RNs for the Med/Surg unit—one has begun her 12-week Orientation, while the second is scheduled to start on March 17. Additionally, we have extended a final RN offer and are awaiting acceptance.
- **Utilization of Registry Staff:** We utilized 1 FTE NPH RN and 2 FTE Contracted RN

Updates

- **ACHC Accreditation:** This month, we completed our ACHC survey, which required extensive collaboration across the organization. We then developed a comprehensive Plan of Correction, ensuring all identified improvements were

addressed through policy revisions, workflow adjustments, and targeted education. These efforts reinforce a culture of continuous improvement and ensure high-quality, standardized Care remains at the forefront of our practice.

- **Auditing on the Unit to Maintain Compliance:** We revamped our audit process to align with the Plan of Correction and improve data collection for Safety and Quality reporting. The Charge Nurse now leads real-time audits, helping identify areas for improvement and guide targeted education. This month focused on individualized care plans, reinforcing patient-centered documentation, and adherence to best practices.
- **Zoll Defibrillator Implementation:** This month, we officially began the implementation phase, collaborating with the Zoll Educator and Deployment Engineer to coordinate IT integration, device setup, and education planning. Internally, we focused on workflow adjustments and standardizing processes to ensure a smooth transition. Education is scheduled for April, with full implementation to follow.
- **Education:** In alignment with CMS and ACHC regulations, we are developing competency validation events for all RN staff to ensure compliance and reinforce essential clinical skills. The class is growing and will launch in April, supporting our commitment to high-quality patient care.

<u>Emergency Services</u>

February 2025

- Total treated patients: 402
- In-patient Admits: 19
- Transferred to a higher level of Care: 20
- Pediatric patients: 73
- AMA: 5
- LWBS: 1
- Present to ED vis EMS: 66

Staffing:

- Required: 8 FTE RNs, 2 PTE RNs, 2 FTE Techs, 1 PTE Tech
- Utilizing 3 FTE contracted RNs
  - Two Day RNs to cover two LOAs
  - One Noc RN to cover until NOC FTE completes Orientation
- ED Manager also serves as:
  - Clinical Project Manager for Cerner
  - Learning Coordinator
    - Assigning learning journeys to new contracted and hired staff
  - Ongoing resources for clinical areas in the facility
  - Collaborating with internal teams on referral processes
  - Weekly meetings to address open SRs

Open Positions:

- FTE NOC: Position filled, with Orientation planned for a minimum of 6 months

- 1 FTE Tech position: Interviews currently in progress

Updates:

- Centering staff education around ACHC guidelines:
  - Policy signs off each month, of new or amended policies.
  - High risk/ low volume procedures education to begin March 1st with final sign off evaluations scheduled in April.
  - Ongoing education on ACHC plan of corrections
- Continued education and daily auditing of charts to reduce late charges, increase captured revenue, and improve documentation standards.
- In partnership with MHOAC, enrolled in the California Hospital Bed Capacity Project, set for Fall 2024 implementation:
  - Aimed at automating bed reporting, improving patient outcomes, enhancing emergency coordination, and optimizing hospital resources without adding administrative burdens.

Ambulance

- 69 ambulance requests
- 17 Transfers

Staffing:

- We hired a new per diem EMT, who is completing her ambulance orientation.
- Now fully staffed

Updates:

- The Zoll products are on hold until the rep comes to do the initial setup and biomed.
- All Ambulances are up and running.

Surgery

Referrals:

30 - Referrals received
22 - Scheduled (4 canceled/ or No show to Procedure)
3 - Rejected (BMI > 45, Medically complex, Procedure not performed or requesting consultation)
0 – Pending insurance clearance
5 - Called patient and unable to reach or the patient does not want to schedule at this time.
0 – Needs Nurse review
11 – Outstanding/ Pending referrals received before February

Outstanding/Pending Reason breakdown:

3 - Previously scheduled and canceled (unable to reach, needs medical clearance, or the patient does not want to reschedule at this time).
8 – Unable to reach patient or patient does not want to schedule currently.

Procedures Performed	**February 2025**

Colonoscopy	10
EGD	3
Colonoscopy/ EGD Combo	1
Total cases Performed	**Monthly Total: 14**

- **Endoscopy Procedures**: We continue to perform endoscopy procedures for three days each month.
- **Sterile Instrument Reprocessing:** A Certified Scrub/ Sterile Processing Tech sterilizes Surgical instruments two days per week for the Emergency Department and the Outpatient Medical Department. However, our steam sterilizers remain down due to low water hardness after a new filtration system was installed.
- **Staffing**: The team includes a Surgeon/ Endoscopist, an Independent contractor CRNA, one Full-Time OR Circulator/Manager, Pre-op/PACU RNs (shared staff from Acute/ED), and one Full-Time Certified Scrub/Sterile Processing Tech.
- **Surgeon's Contract** was renewed with Mayers Memorial Hospital District.
- **Part-time Endoscopy Technician Position:** The position approved to hire and train Part-time endoscopy to support the Surgeon and tech during procedure days. Awaiting posting for position from H. R. to begin recruitment.
- **Training and Certification**: The Surgery Manager is preparing for the CNOR certification exam. The new Pre-op nurses started training to float from the Acute floor.
- **ACHC Survey 2/3-2/5:** The Surgery/ Central Sterilization Department received **3** Citations for standards not met:
    1. **08.03.06 Equipment safety:** On review of Anesthesia Records, the number of the used anesthesia machine was not documented.
        - POC: The anesthesia record document has been revised, and the CRNA will be educated when she is here in March.
    2. **08.01.00: Anesthesia Risk and Evaluation:** On review of Anesthesia records 2/5 records were missing documentation of post-op evaluation.
        - POC: The anesthesia record document has been revised, and the CRNA will be educated when she arrives in March.
    3. **06.10.08 Patient and safety: Safe setting:** Unsecured needles found in perioperative drawers.
        - **POC:** All needles have been relocated to locking cabinets; nurses will be given education in March and access to keys during procedures.

***Facilities received Survey citations related to Surgical suite air exchange and humidity levels.**

<u>Outpatient Medical</u>

February 2025

- Census OPM:

    - February 109 patients
- Luma Health with RHC for the automated calling of patients beginning conversations
- Continued work on policies and quality reporting up to date on policies and quality reporting. Working more with the new Lippincott
- Always looking for more privileged providers to sign with MMHD
- OPM will be included in the ED and Acute "skills" dates to teach some skills stations and have OPM staff attend appropriate stations and complete competencies needed still
- Safety meeting conducted in OPM for fire safety by MMHD safety team
- Appreciative of Hospice staff willing to come in and help in OPM when available at times

Social Services

February 2025

We had 3 Long-Term care admits.

2- at the Burney Campus

1-at the Fall River Campus

Updates:

- The LTC team will meet with Mountain Valleys in March to discuss the admission process for our LTC. This will help with workflow and collaboration for our community members.
- We will have three more admissions to our LTC facilities in March.
- I have received many calls and referrals for placement in our LTC, specifically for Memory Care.
- Acute Care has had a high census in recent weeks.
- I want to focus on finding a home health agency that could service the Intermountain area.

Clinical Education

February 2025

Certification/Licenses

- BLS training: 6 staff members attended on February 26, 2025. The next scheduled BLS class is on March 26, 2025.
- PALS and NRP begin on March 25. Working with Moriah, Zita, and Barb to disseminate information to the currently enrolled staff members
- ACLS class is scheduled for April 28, 2025
- ASLS is a new training and certification which is scheduled for June 24, 2025

Updates

- Safe Patient Handling and Mobility--We meet for SPHM Refresher Training at various times to accommodate staff.
- CNA CEU classes—February 12, 2025--Infection Prevention/Control, Patient Safety, and CNA Professionalism. February 27, 2025--Nutrition and Hydration

Ongoing Projects

- Assisting as necessary with SNF pillars/goals
- Updating and maintaining class content to comply with CDPH
- Preparing for CNA skills fair validation and SPHM
- Continual collaboration with the team regarding the orientation roll for MMHD staff and Registry/Contract/Traveling staff is needed.
- CDPH Orientation and SPHM training for newly hired/rehired staff
- Collaboration with the team for our upcoming CNA class

Respectfully Submitted by Theresa Overton, CNO

Chief Executive Officer Report
Prepared by: Ryan Harris, CEO

ACHC Accreditation
The team is actively collaborating with ACHC to revise our correction plan. Leadership and I met with ACHC on March 19 to review our plan and discuss recommended changes. Once finalized, the ACHC reviewer will submit it for consideration and approval of our accreditation.

Provider Search Update
We have no posted provider positions and are not working with any recruiters for provider placements. We await responses from some of our existing providers regarding changes to their coverage, the possibility of new providers accepting offers, and working with student loan repayment programs to see if we qualify for some candidates as a qualifying site.

Collaboration
The CEO group representing Modoc, Seneca, Mayers, Plumas, and Eastern Plumas is currently collaborating with legal counsel regarding the MRI owned by their organization. The Heritage group MRI, which will serve as a temporary solution until our unit is ready, is scheduled to be onsite during the week of March 25. We have experienced delays due to the licensing process for the unit, which is similar to what we encountered for our mobile clinic, a process that took over six months to finalize. Based on this timeline, I anticipate that we will be able to start seeing patients in the mobile MRI sometime this summer.

I am collaborating with fellow Hospital CEOs to advocate for exemptions for Critical Access and District hospitals from the Build America, Buy America Act (BABAA). Many facilities struggle to find products that comply with this act, resulting in delays and increased project costs. We are currently reaching out to legislators to gain support for this initiative. While we are not yet affected by this act, it could significantly impact our upcoming construction projects.

Strategic Priorities Update
Efforts are ongoing regarding the F25 strategic priorities as we aim to finalize our current projects. This month, the Executive Leadership Team convened to discuss next year’s priorities and generated ideas for potential new priorities for FY26. These concepts will be presented to the board's strategic planning committee in March to ensure we are on the right path for potential future goals.

Travel
Over the past month, I have been traveling extensively with our executive team to attend the American Hospital Association Rural Health Conference and the California Hospital Association (CHA) Rural Symposium. Many sessions focused on policy issues and the current landscape in Washington, particularly regarding potential changes impacting Medicaid and Medicare and other legislative developments that may affect

rural hospitals. One session interested me in addressing collaboration among CEOs, medical staff, and boards. I have brought several suggestions from this session and others to discuss with our team. We also had attendees at the CHA finance meeting and the ACHC University conference. During the CHA Rural Symposium, I also had the opportunity to meet with our new Assemblymember. I am in the process of scheduling a site visit with her and our team.

Construction Projects
The solar project has faced delays due to weather conditions and encountering a hard pan. Once the weather improves, the contractor will pilot the holes with an auger and install the posts. We have also received proposals from project management firms interested in acting as the owner's representative for our upcoming construction projects. We are also waiting on county approval of our rural health clinic project.

Service Excellence Initiative
On March 18, the executive leadership team convened with Customer Learning Systems to develop the project plan for the first year of our three-year service excellence initiative. In this meeting, we reviewed the entire program, established timelines and assigned responsibilities, and clarified the roles of our leadership, management, and staff. As the day progressed, it became clear that this initiative would be transformative for our healthcare district, but it would also require significant effort from everyone involved. I am excited to start this journey of enhancing our organization for our patients, community, and staff.

Tri-County Community Network update
See the attached report.

Tri-County Community Network Update
February 10, 2025

Children's Programs

1. **Bright Futures**
   - Events like Tiny Tunes and Story Time maintain strong attendance.
   - TK classes in Big Valley, Fall River, Burney, and Round Mountain regularly host Story Time and Tiny Tunes. The program serves over 100 children and caregivers each month.
   - On March 10th and 13th, Bright Futures hosted a try foods day at Fall River and Burney elementary schools. Over 60 children from the TK and Kindergarten classes attended from each site.

2. **BOTVIN Life Skills Training (LST)**
   - LST has been implemented in both elementary schools. Sixth-grade students are completing their 8-week program, learning self-esteem, decision-making, and the dangers of smoking. This last set of learners will complete the course on April 30.
   - Two hundred 4th to 6th graders will participate in the program, which is funded by the Shasta County Asset Forfeiture grant.

Grants/Grant Programs

1. **Lunch with Community Helpers**
   - TCCN received a $700 grant from First 5 Shasta to host this event during the Week of the Young Child.
   - This year's event will be held on Monday, April 7. The classes from Fall River Elementary have not yet committed to coming, so we may have fewer attendees this year.
   - The event will provide a safe, educational space where children (ages 0-5) can engage with local law enforcement and emergency personnel. Parents and caregivers will also learn about community programs and services.

2. **Backpacks to Home Food Pantry**
   - In collaboration with FRJUSD, TCCN applied for a $2,588 grant to launch a food pantry for students.
   - If awarded, the program will deliver $862 worth of food three times between August 2025 and May 2026.
   - FRJUSD will oversee sustainability efforts, with Burney Elementary and

Burney High School hosting food drives.

3. **Kid Fit**
    - If funded, six Kid Fit events will occur from June to August 2025, promoting family health and educating on Adverse Childhood Experiences (ACEs). Events include a Color Run, Take Me Fishing, a Community Concert, Water Wars, Art in the Park, and Family Swim Night.
    - PGE donations will support a Jr. Intern position within the program, providing leadership and data collection experience.

4. **Shasta Substance Use Coalition**
    - TCCN has joined the newly formed coalition, which is developing strategies to address youth substance use in Shasta County.
    - An MOU was signed in early March. TCCN has committed to supporting the coalition to ensure that our youth receive the same opportunities from this grant as their counterparts in the Redding area.
    - Funding will come from the county's Opioid Settlement funds, though TCCN's specific funding allocation is currently unknown.

    .
5. **Enhanced Care Management (ECM) Partnership**
    - TCCN and MMHD collaborate with HANC and Partnership HealthPlan of California to implement ECM services.
    - A one-year, $102,000 contract will support operational costs, including training and billing processes.
    - A case manager has been hired and will undergo 60 days of training. By April, they will begin seeing clients in collaboration with the Rural Clinic.
    - As of March 12, the partnership has approved TCCN's paperwork. We are waiting to begin the onboarding process.

6. **Mindful Connections Program**
    - Unfortunately, due to an accidental oversight by MMD's grant writer, Laura Beyer, the deadline for the federal HRSA grant was missed, and the grant was not submitted.
    - TCCN will be pursuing other funding sources as they become available.

7. **Mayers Health Foundation CPR Training**
    - TCCN received nearly $9,000 to provide CPR training to 12th graders in FRJUSD.
    - With support from Zita Biehle, 50 students will be trained, increasing lifesaving skills and interest in medical careers and strengthening community ties with MMHD.
    - Training started in early March. So far, 24 students have been certified in

CPR; the remaining seniors will be trained by April 22.

Partnerships

1. **SMART Employment Services**
    - TCCN continues its Partnership with SMART to bring employment services to the area.
    - "Pop-up" employment centers will resume in the spring, while referral services will be available during winter.

2. **IMAGE (Intermountain Action Growth and Education) Revitalization**
    - The last IMAGE meeting on March 11 saw increased attendance and productivity.
    - A community needs survey is in development, with questions finalized at the meeting. Currently, members are recruiting community partners to help us administer the survey. The first set of surveys will be launched in May of 2025.

Website Updates

1. The TCCN website continues to expand, with weekly updates to the community calendar and event promotions on social media.
2. Over the next two months, the learning library will grow, job listings will be posted, and monthly health observances will be highlighted.

Community Events

1. **Bright Futures Weekly Events** – Ongoing for children aged 0-5.
2. **BOTVIN Life Skills Training** – Every Tuesday at Burney Elementary and every Wednesday at Fall River Elementary through May.
3. **Senior Sip and Social** – Every Thursday through May 2025.
4. **Lunch with Community Helpers** – Scheduled for April 7.

Intermountain Community Center Building Update

1. The building's offices and event spaces are OPEN!
2. Plans for the children's program portion of the building have been submitted to the county.