MAYERS MEMORIAL
HEALTHCARE DISTRICT

Board of Directors
Regular Meeting Agenda
September 23, 2024 @ 1:00 PM
Mayers Memorial Healthcare District
Fall River Boardroom
43563 HWY 299 E
Fall River Mills, CA 96028

Mission Statement
Leading rural healthcare for a lifetime of wellbeing.

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

						Approx. Time Allotted
1	**CALL MEETING TO ORDER**					
2	2.1	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS** Persons wishing to address the Board are requested to fill out a "Request Form" prior to the beginning of the meeting (forms are available from the Clerk of the Board, 43563 Highway 299 East, Fall River Mills, or in the Boardroom). If you have documents to present for the members of the Board of Directors to review, please provide a minimum of nine copies. When the President announces the public comment period, requestors will be called upon one-at-a time, please stand and give your name and comments. Each speaker is allocated five minutes to speak. Comments should be limited to matters within the jurisdiction of the Board. Pursuant to the Brown Act (Govt. Code section 54950 et seq.) action or Board discussion cannot be taken on open time matters other than to receive the comments and, if deemed necessary, to refer the subject matter to the appropriate department for follow-up and/or to schedule the matter on a subsequent Board Agenda.				
3		**APPROVAL OF MINUTES**				
	3.1	Regular Meeting –August 28, 2024		***Attachment A***	**Action Item**	1 min.
4		**DEPARTMENT/QUARTERLY REPORTS/RECOGNITIONS:**				
	4.1	Resolution 2024.13 –August Employee of the Month		***Attachment B***	**Action Item**	2 min.
	4.2	Pharmacy	Keith Earnest	***Attachment C***	Report	2 min.
	4.3	Retail Pharmacy	Kristi Shultz	***Attachment D***	Report	2 min.
	4.4	Cardiac Rehab/PT	Daryl Schneider	***Attachment E***	Report	2 min.
5	**BOARD COMMITTEES**					
	5.1	**Finance Committee**				
		5.1.1 Committee Meeting Report: Chair Humphry			Report	5 min.
		5.1.2 August 2024 Financial Review, AP, AR and Acceptance of Financials			Discussion	5 min.
	5.2	**Quality Committee**				
		5.2.1 September Quality Meeting Committee Report			Report	5 min.
6	**OLD BUSINESS**					

	6.1	Master Planning Update and Budget	***Attachment F***	**Action Item**/ Discussion	10 min.
	6.2	Board By-laws	***Attachment G***	**Action Item**	10 min.
7		**NEW BUISNESS**			
	7.1	Policies and Procedures: Page Number: Policy Name: 41-42 Core Privileges Licensed Marriage & Family Therapist Privileges 43-49 Emergency Exit Plan - Fall River 50-52 Emergency Notification Plan for Skilled Nursing Facilities 53-55 Infectious Disease Core Privileges 56-72 Medical Equipment Management Plan 73-75 Obtaining Surgical Informed Consent 76-78 Perioperative Use Of Sequential Compression Sleeves 79 Separation of Hazardous Materials Storage Areas Policy 80-84 Standing Orders - Administering Phizer-BioNTech Covid 19 Vacci 85-88 Standing Orders - Administering Influenza Vaccine to Adults 89-92 Standing Orders - Administering Pneumococcal Vaccines to Adul 93-94 Using Standing Orders for Administering Vaccines	***Attachment H***	**Action Item**	20 min
	7.3	October Board Meeting Date Change - move from the 30th to 29th in Burney		**Action Item**	2 min.
	7.4	Ignite the Patient Experience	***Attachment I***	Discussion	5 min.
	7.5	Conflict of Interest Policy	***Attachment J***	1st reading/ **Action Item**	5 min.
	7.6	PIN 74 Project- Burney Annex	***Attachment K***	**Action Item**	5 min.
	7.7	I2I Proposal	***Attachment L***	Discussion/ **Action Item**	5 min.
8		**ADMINISTRATIVE REPORTS**			
	8.1	Chief's Reports – ***Written reports provided. Questions pertaining to written report and verbal report of any new items***	***Attachment M***		
	8.1.1	Director of Operations- Jessica Decoito		Report	5 min.
	8.1.2	Chief Financial Officer – Travis Lakey		Report	5 min.
	8.1.3	Chief Human Resources Officer – Libby Mee		Report	5 min.
	8.1.4	Chief Public Relations Officer – Val Lakey		Report	5 min.
	8.1.5	Chief Clinical Officer – Keith Earnest		Report	5 min.
	8.1.6	Chief Nursing Officer – Theresa Overton		Report	5 min.
	8.1.7	Chief Executive Officer – Ryan Harris		Report	5 min.
9		**OTHER INFORMATION/ANNOUNCEMENTS**			
	9.1	Board Member Message: Points to highlight in message		Discussion	2 min.
	9.2	Board Governance Tool Kit – Board Self Assessments		Discussion	5 min.
10		**MOVE INTO CLOSED SESSION**			

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		Hearing (Health and Safety Code §32155) – Medical Staff Credentials **MEDICAL STAFF REAPPOINTMENT** Kelly Kynaston, MD (T2U) – Telemedicine Tom Watson, MD – Active		
	10.1	**MEDICAL STAFF APPOINTMENT** Matthew Kilpatrick, MD – (Redding Pathologists) Pathology Jonathan Hester, MD (TCR) – Radiology Thomas Powierza, MD (TCR) - Radiology	**Action Item**	5 min.
	10.2	Conference with legal counsel regarding pending litigation (§54956.9)	Discussion/ **Action Item**	20 min.
11	**RECONVENE OPEN SESSION**			
12	**ADJOURNEMENT:** Next Meeting October 29, 2024			

Posted: 09/29/2024

Board of Directors
Regular Meeting
Minutes
August 28, 2024 – 1:00 pm
FR Boardroom

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

CALL MEETING TO ORDER: Abe Hathaway called the regular meeting to order at 1:01 PM on the above date.

BOARD MEMBERS PRESENT:	**STAFF PRESENT:**
Abe Hathaway, President	Ryan Harris, CEO
Jeanne Utterback, Vice President	Travis Lakey, CFO
Tami Humphry, Treasurer	Theresa Overton, CNO
Jim Ferguson, Director	Valerie Lakey, CPRO
Lester Cufaude, Director	Keith Earnest, CCO
ABSENT:	Libby Mee, CHRO
	Britany Hammons, ADON SNF
	Lindsey Crum, Hospice
	Samanthan Weidner, Telemedicine
	Katrina Williams, Team Mayers MVP
	Jack Hathaway, Director of Quality
	Jessica DeCoito, Director of Operations

2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS:**		
3	**APPROVAL OF MINUTES**		
	3.1 A motion/second carried; Board of Directors accepted the minutes of July 31, 2024	***Utterback, Humphry***	***Approved by All***
4	**DEPARTMENT/OPERATIONS REPORTS/RECOGNITIONS**		
	4.1 Resolution 2024.12 –July Employee of the Month: Katrina Williams is very deserving of this award. Her work on the safety committee has been instrumental. She is a pharmacy tech and has been a go getter for all of our new Cerner and Pyxis implementations. She is a huge part of our department's success.	***HUMPHRY, FERGUSON***	***Approved by All***
	4.2 Hospice: Great to have our new employee on board. It's been busy with admissions and having a new and energized team member has been helpful. Developing our resources for bereavement, especially with youth.		
	4.3 Mayers Health Foundation Quarterly: written report submitted. $18,000 was made on the golf tournament.		
	4.4 Skilled Nursing Facility: Currently at 77 residents but will be back up at 78 within a few weeks with scheduled admissions. We are working to develop our visits with families and potential residents to meet them in person in their environment. We have hired an interim DON that will be starting on September 9th.		
	4.5 Telemedicine: written report submitted. We are receiving quite a few referrals from Hill Co. Clinic. Telemedicine has been able to connect our community to the specialists they need from the ease of staying local. We are looking into the remote patient monitoring, starting from scratch, and beginning the process of charges will work.		
5	**BOARD COMMITTEES**		

5.1	**Finance Committee**			
	5.1.1	Committee Report: Year end numbers were great. AR report from Danielle was good news – we have received some of the large swing claim, with more anticipated on collection within the next 30 days, brining our AR days down 7. Becker's announced 2024 CFO's to know and we congratulate Travis on his honor. Cash on hand looks good. DHLF came out with a highly likely plan to increase supplemental payments that would give us a large amount, should it pass. Travis will also represent on the HQI Affordability Board.		
	5.1.2	June and July 2024 Financial Review Motion moved, seconded and approved.	***Cufaude, Ferguson***	***Approved by All***
5.2	**Quality Committee**			
	5.2.1	August Quality Meeting Committee Report: met on Monday. Les will now meet on the regular with Med Staff Coordinator to prepare the discussion and approval of credentials prior to the meeting. Updates provided on ACHC and measures. Would like to have a demo of where and how to find MCN training for the whole Board.		
6	**OLD BUSINESS**			
6.1	Master Planning Update and Budget: provided a packet of budget versions. No action taken as it is not ready yet for approval. Just a version for you to see that we are working on updating to cut down the total budget number.			***No action taken***
6.2	Board By-laws: reviewed comments and changes. Motion made, seconded and approved.		***Cufaude, Humphry***	***Approved by All***
7	**NEW BUISNESS**			
7.1	Policies and Procedures		***Humphry, Ferguson***	***Approved by All***

Page Number:	Policy Name:
49	Annual Performance Improvement Project
50-66	Cleaning, Disinfection and Storage of Endoscopes
67	Disposal of Surplus or Excess Properties
68-75	Fire Drill Incident Critique, MMH777
76-86	Hazardous Materials and Waste Plan
87-92	Safe Patient Handling Policy
93-94	Sterile Supplies: Event Related Shelf Life & Storage
95-98	Trash and Biohazardous Waste
99-119	Utility Systems Management Plan
120-123	Physician Orders (policy)-Verbal, Telephone and or Text
124-133	Security Management Plan
134-154	Fire Safety Management Plan
155-180	Fire Safety Response Plan
181-206	Emergency Operations Plan - Utilities Plan

7.2	Fy24 Organization Analysis: Motion moved, seconded and carried.		***Utterback, Cufaude***	***Approved by All***
7.3	September Board Meeting Date Change - move from the 25th to the 23rd, FR. Please add October Board Meeting to Tuesday, October 29th – add to September Board Agenda Motion moved, seconded and approved.		***Utterback, Humphry***	***Approved by All***
8	**ADMINISTRATIVE REPORTS**			
8.1	**Chief's Reports: written reports provided in packet**			
	8.1.1	**DOO:** Updates were provided on projects. Med Gas panel is closed up with scheduling for FS Medical and then IOR & HCAI for final closeout. Temporary Transfer switch project is done and final reports are ready for signature. Fire Alarm project is still a challenge – we are looking for an HVAC company to install duct		

		detectors right now to get us to the next part of the project. Solar project plans were reviewed by the county and Veregy has 10 points of clarification/fixes to make. The well at the lodge was inspected by H2O Pro. It looks like our pump is at 25 GPM where our well is only producing 11 GPM. And the pump power was unstable causing issue. This will get fixed with the hope that no well will need to be drilled.
	8.1.2	**CFO:** Debt schedule for USDA was provided in packet.
	8.1.3	**CHRO:** Attended the CEO Regional meeting and interacted with other HR heads. Gig Workforce was a topic of discussion – this would be a regional group app that would allow us to show open shifts that other facilities RNs, Providers, etc could help cover shifts. Discussion with group also included LVN to RN programs for the new RN ratios for SNFs. Conversation also occurred with what every facility is doing with current covid precautions. Evaluations have been closed out and best response this year. Re-orientation has rolled out with 12 hrs of content.
	8.1.4	**CPRO:** Report submitted.
	8.1.5	**CCO**: 24-25 Covid vaccine has been released and ordered. IP team just received an email from CDPH on our SNF vaccination rate which is above state rate – we are at 54% and state average is 20%. PT lost their registry Physical Therapist and won't be coming. Lab is looking at new equipment that will allow us to test a lot of our current send outs that take days to get results back.
	8.1.6	**CNO**: CDPH was onsite yesterday and today for self-reports. Between CDPH surveyor and our nurse call vendor, we received many compliments on our facility and what we offer our residents.
	8.1.7	**CEO:** CMO offer has been sent out. Medical Director offer has been sent out. And a Clinic Medical Director candidate will be coming out soon for a visit. Shasta Co. Public Health was onsite and had a great collaborative meeting. AI Solution kickoff call took place with Avodah Med. Attended the CEO Regional meeting. Big topic was looking a collaborative partnership with mobile MRI. The group also discussed comparing top 50 products with the current GPOs and seeing where the best deals are. Clinically Integrated Network (system of hospitals) that would maintain independence the leverage of a group negotiating a contract. A lot of great discussion occurred and our next meeting will be in November.
9	**OTHER INFORMATION/ANNOUNCEMENTS**	
	9.1	Board Member Message: Employee of the Month. Golf tournament recap, Denim & Diamonds date, TCCN update, 2024 accomplishments, update on all of our services, Travis' accomplishments for Becker's and HQI.
	9.2	Board Governance Tool Kit: review and discussion took place on Board Assessments.
10	**Move into Closed Session: 4:01 pm**	
	10.1	Hearing (Health and Safety Code §32155) – Medical Staff Credentials ***Approved by All***

MEDICAL STAFF REAPPOINTMENT

Stephen Loos, MD (TCR) – Telemedicine
Shelleen Denno, MD - Hospitalist

MEDICAL STAFF APPOINTMENT

Mark Faltaous, MD (Dir. Radiology) – Telemedicine
Rashmi Hande, MD (Dir. Radiology) – Telemedicine
William Pace, MD (TCR) – Telemedicine
Natalie Nelson, NP – Hospitalist

	10.2	Conference with legal counsel regarding pending litigation (§54956.9)
11	**Reconvene Open Session: 4:30 pm**	
12	**Adjournment: 4:30 pm**	

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

_____ _____

Board Member Board Clerk

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MAYERS MEMORIAL
HEALTHCARE DISTRICT

RESOLUTION NO. 2024-13

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

Tanya Walters

As August 2024 EMPLOYEE OF THE MONTH

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

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

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

NOW, THEREFORE, BE IT RESOLVED that, Tanya Walters is hereby named Mayers Memorial Healthcare District Employee of the Month for August 2024; and

DULY PASSED AND ADOPTED this 23rd day of September by the Board of Trustees of Mayers Memorial Healthcare District by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

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

ATTEST:

_____
Ashley Nelson
Clerk of the Board of Directors

MAYERS MEMORIAL HEALTHCARE DISTRICT

Department Reporting
Managers Meeting and Regular Board Meeting

Manager & Department:

Hospital Pharmacy

Reporting Month & Year:

09/2024

Summary:

Pharmacy continues to work closely with nursing and employee health on many projects. Regulatory compliance and upcoming ACHC accreditation are the areas of focus.

Top Projects (1-3):

1) State Board of Pharmacy Sterile Compounding Annual Inspection. The pharmacy was inspected for sterile compounding on August 7th. The inspector was very helpful is explaining how to navigate the revised USP<797> and state regulations as there are several differences. She had several helpful suggestions and gave good direction on needed policy rewrites. The quality assurance for sterile compounding involves:
   - Certification of the barrier isolator every 6 months.
   - Gowning and garbing competency every 6 months.
   - Media challenge every 6 months.
   - Glove tip testing every 6 months.
   - Surface sampling monthly.

   The action items post inspection:
   - surface sampling policy and results to inspector. Retesting performed 9/11/24.
   - replace glass in the door due to crack.

2) ACHC accreditation.
   - The policy work is largely complete, and we are implementation stage. The policies on adverse drug reactions and chemical restraints require significant implementation. Jack Hathaway has built the reversal agent daily report for adverse drug reaction screening.
   - The ACHC quality project is in the area of drug storage and security. Two months' worth of data is collected and opportunities for improvement identified.
   - Order Sets—each order set built in Cerner must be reviewed and approved annually by the medical staff. Pharmacy & Therapeutics Committee has review with many changes. Medical staff must approve before changes are implemented.
   - Relocation of OPM Pyxis machines. The Pyxis machine was blocking the shut off valve to the sprinklers and ACHC and fire life safety require clearance. Pharmacy and maintenance are working on relocating the machine.

Wins (1-2):

24-25 Covid Vaccines are now available.

Challenge (1):

Flu shot availability (promised early September). Flu shots not yet stocked by wholesaler. (update 9/12--standard flu shots are in. High dose (65+) not yet stocked.)

Attachment D

Department Reporting
Managers Meeting and Regular Board Meeting

Manager & Department:

Kristi Shultz Retail Pharmacy

Reporting Month & Year:

09/2024

Summary:

In the past year, our department has made significant strides in improving our pharmacy services and operations. Key projects like the 340B program transition, enhancements in payer performance efforts, and the rebranding of our OTC area have positioned us for future success. However, the transition to our new TPA has presented several challenges. While many of these issues have been resolved, some remain actively under review. We are diligently working to address these remaining concerns to ensure that our 340B program operates seamlessly and meets our high standards of efficiency and compliance

Top Projects (1-3):

Transition of 340B Program to Hudson Headwaters-
We successfully transitioned our 340B program to our new Third Party Administrator (TPA), Hudson Headwaters. This shift aims to enhance our compliance and efficiency in managing 340B drug pricing and services.
Implementation of Payer Performance Initiatives-
We have significantly advanced our Medication Therapy Management (MTM) services and Comprehensive Medication Reviews (CMRs). These efforts are designed to optimize patient outcomes and improve payer performance metrics.
Rebranding and Reorganization of OTC Area-
We completed a comprehensive rebranding and reorganization of our Over-the-Counter (OTC) area, now featuring the updated Foster and Thrive brand. This initiative is intended to enhance customer experience and streamline product offerings.

Wins (1-2):

Successful IVR System and PocketRX Pharmacy App Implementation-
Our new Interactive Voice Response (IVR) system and PocketRX pharmacy app have been successfully implemented, providing improved communication and convenience for our patients.
DSCSA Compliance Achieved-
We have achieved compliance with the Drug Supply Chain Security Act (DSCSA) as of November 2023 by integrating InfiniTrak. This accomplishment ensures that we meet all necessary regulatory requirements for drug traceability and security.

Challenge (1):

Transition Delay with Old TPA-
The transition to our new TPA was complicated by a delay in the termination of our old TPA. This issue created some operational challenges, which we are addressing to ensure a smooth transition moving forward.

MAYERS MEMORIAL HEALTHCARE DISTRICT

Department Reporting
Managers Meeting and Regular Board Meeting

Manager & Department:

Daryl Schneider, Physical Therapy and Cardiac Rehab

Reporting Month & Year:

09/2024

Summary:

Mayers Memorial Physical Therapy offers a broad scope of services to meet the growing needs of our community including orthopedic, neurologic, and cardiovascular training, hand rehabilitation, pediatric therapy, lymphedema management, ergonomic assessments, balance training, vestibular rehabilitation, and athletic performance enhancement, as well as willingness to attempt treatment on any patient that walks into our clinic.

Top Projects (1-3):

1. Lori Gibbons from HIM, Danielle Olson from Revenue Cycle, Stefanie Hawkins PT and cardiac rehab scheduler and I met to look over differences in Cerner views and collaborated to improve transmitting information on cardiac rehab orders from Referral Management into appropriate FINs in order for HIM to have access to orders for coding. If the referrals are made in Scheduling Book as a scheduled visit, then the visit appears as an "order" now that can be printed and scanned into the charts. This shoud help both HIM with coding and the business office with decreased requests on changing admit dates by utilizing the scheduling book to verify registration. As Cerner does not have a place for cardiac rehab to document, the codes were not being added through documentation. This work around will improve other departments' workflows.
2. In regards to the Medicare Thresholds, we are actively trying to follow a few patients to determine frequency of updates and whether it would capture information from use of their benefits if they were seen in other locations prior to Mayers.
3. Working on getting a permanent PT position filled or a traveler for the time being in order to help reduce wait times.

Wins (1-2):

1. Stefanie Hawkins, PT and cardiac rehab scheduler, was able to find an area in Registration to look up Medicare Threshold amounts. Therapists do not have access to the area and it does not flag the physical therapists when approaching it, but if we have concerns that we are approaching a possible threshold Stefanie is able to look into them.
2. We have a new slot built in our scheduling book ready for when we get a new therapist!

Challenge (1):

1. The wait to be seen in PT and cardiac rehab are still our biggest challenge. Currently physical therapy is approximately a 6 week wait, though those that call and advocate for themselves are getting in sooner, and a monitored patient in phase 2 cardiac rehab is about 5 weeks out to start the program.

Mayers Masterplanning Estimated Project Costs			sf	$/sf	total	notes	only Seismic Required work
Construction							
New Acute Construction	New Addition: Acute & Pharmacy	OSHPD-1	13,697	$ 2,000	$ 27,394,000		$ 27,394,000
	New Addition Site Work	OSHPD-1		lump sum	$ 5,000,000		$ 5,000,000
	Connector Pieces: connection kitchen to resident dining	OSHPD-1	140	$ 1,000	$ 140,000		$ 140,000
New Non-OSHPD	New Addition: Purchasing & Administrative Offices	non-OSHPD	2,025	$ 750	$ 1,518,750		$ 1,518,750
RACS	12-Bed/Pharmacy BLD: Station 3	OSHPD-1	6,000	$ 150	$ 900,000		$ 900,000
	Original Hospital BLD: Station 1	OSHPD-1	6,000	$ 150	$ 900,000		$ 900,000
	SNF BLD: Station 2	OSHPD-1	10,000	$ 100	$ 1,000,000		$ 1,000,000
Remodel Existing Buildings	Remodel Surgery: New Kitchen	OSHPD-1	4,802	$ 1,200	$ 5,762,400		$ 5,762,400
Burney Site	Burney ASC	OSHPD-3	8,433	$ 1,000	$ 8,433,000		$ 8,433,000
	Burney site work	OSHPD-3		lump sum	$ 3,000,000		$ 3,000,000
	Burney Maint Building	non-OSHPD	2,549	$ 150	$ 382,350	metal building	
Construction SubTOTAL					**$ 54,430,500**		**$ 54,048,150**
Construction Contingency		15%			**$ 8,164,575**		**$ 8,107,223**
Admin Costs (Permit/Utility Fees , T&I, Site Survey/Reports/Studies, Legal, PM)		5%			**$ 2,721,525**		**$ 2,702,408**
Design Services		7%			**$ 3,810,135**		**$ 3,783,371**
Equipment (Med, Kitchen, FF&E, Communications)		15%			**$ 8,164,575**		**$ 8,107,223**
Owner Contingency		5%			**$ 2,721,525**		**$ 2,702,408**
subTOTAL					**$ 80,012,835**		**$ 79,450,781**
NPC Milestones	Non-structural eval	OSHPD-1		lump sum	$ 50,000		
TOTAL					**$ 80,062,835**		**$ 79,450,781**

Introba FR Acute Add and Burney RHC/ASC = $5M

SELF FUNDED PROJECTS							
FR Out-Buildings	FR Clinic Building Remodel - combine Finance/Business	non-OSHPD	4,300	$ 50	$ 600,000.00		
Deferred Maintenance	Placeholder - HVAC upgrades, Generator requirements, etc	varies		lump sum	$ 16,000,000.00		
PIN 74 Work - Burney Annex					$ 472,110.00		
Solar Project	FR Solar Project				$ 3,000,000.00		
Self Funded Total					**$ 20,072,110.00**		

MAYERS MEMORIAL
HEALTHCARE DISTRICT

BYLAWS OF THE MAYERS MEMORIAL HEALTHCARE DISTRICT

Revised MARCH 2024

Contents

ARTICLE I PREAMBLE

These District Bylaws are adopted by the Mayers Memorial Healthcare District Board of Directors (the "Board") pursuant to and consistent with Division 23 of the California Health and Safety Code, known as the Local Health Care District Law. These District Bylaws are established to further enable the Board to faithfully exercise its powers and fiduciary duties in accordance with applicable law. All provisions contained herein shall conform to and comply with all applicable federal, state, and local laws and regulations. Medical Staff Rules that have been approved by the Board shall be used to further assist in implementing the responsibilities of the Board.

1.1 Mission. Leading rural healthcare for a lifetime of wellbeing.

1.2 Offices. The principal office of the District is fixed and located within Mayers Memorial Hospital at 43563 Highway 299 East, Fall River Mills, California, 96028. Branch or subordinate offices may be established by the Board at any time or place.

1.3 Definitions.

1.3.1 "Allied Health Practitioner" or "AHP" means an individual, other than a practitioner, whose authority to perform specified patient care services is established by the Medical Staff based upon his / her qualifications and whose functions are delineated by members of the Medical Staff and approved by the Board.

1.3.2 "Board" means the Board of Directors of the District.

1.3.3 "Director" means a duly elected or appointed member of the Board of Directors of the District.

1.3.4 "District" means the Mayers Memorial Healthcare District.

1.3.5 "Facilities" means the Hospital as well as other health care facilities and services operated by the District.

1.3.6 "Hospital" means Mayers Memorial Hospital.

1.3.7 "Medical Staff" or "Staff" means the organized medical staff of Mayers Memorial Healthcare District.

1.3.8 "Medical Staff Bylaws" means the Bylaws of the Medical Staff, as approved by the Board.

1.3.9 "Medical Staff Rules" means the Medical Staff Bylaws, Rules and Regulations, and Policies.

1.3.10 "Practitioner" means a person who is eligible to apply for or who has been granted privileges in the Hospital, or another District Facility.

1.3.11 "Telemedicine" means the provision of clinical services to patients by physicians and practitioners from a distance via electronic communications.

ARTICLE II POWERS AND PURPOSES

The only actions of the Board are those agreed to by a majority of the Board of Directors in publicly noticed meetings that are consistent with all applicable laws and regulations. The Board shall have accountability and authority for those powers as set forth in the Local Health Care District Law Code Sections 32121 through 32138 inclusive, that are necessary for fulfilling the District's mission. These include but are not limited to the following:

2.1 **General.** The Board is the governing body of the District. All District powers shall be exercised by or under the direction of the Board. The Board is authorized to make appropriate delegations of its powers and authority to officers and employees. The Board shall evaluate the performance of the CEO and its own performance. The Board may do any and all things which an individual might do that are necessary or advantageous to the District or the Facilities for the benefit of the communities served by the District, or that are necessary to accomplish any purpose of the District.

2.2 **Dissolution.** Any proposal for dissolution of the District shall be subject to confirmation by the voters of the District in accordance with Cortese-Knox Local Government Reorganization Act of 1985 (Gov. Code, § 56000 et seq.).

2.3 **Authority of District Bylaws**.

2.3.1 **Amendment**. These District Bylaws shall be reviewed biannually at the beginning of even numbered years. They may be changed by an affirmative vote of at least three Directors at a regularly scheduled board meeting.

2.3.2 **Conflict**. If there is a conflict between the District Bylaws and any other bylaws, the District Bylaws shall be controlling.

2.4 **Facility Operation.** The Board shall be responsible for the operation of all Facilities owned or leased by the District, according to the best interests of public health. The Board shall make and enforce all rules, regulations and bylaws necessary for the administration, government, protection and maintenance of Facilities and District property under their management. The Board may

prescribe the terms upon which patients may be admitted to the Facilities. Minimum standards of operation as prescribed by the Medical Staff Rules shall be established and enforced by the Board.

2.5 Trade Membership. The District may maintain membership in any local, state, national, or global group or association organized and operated for the promotion of the public health and welfare or the advancement of the efficiency of hospital and health care administration, and in connection therewith pay any necessary dues and fees.

2.6 Purpose. The purposes, goals, and objectives of the Board of Directors of Mayers Memorial Healthcare District shall be to:

2.6.1 Support, manage and furnish facilities, personnel, and services; provide diagnosis, medical, surgical and hospital care, outpatient care and other hospital and medically related services to sick, injured or disabled persons; provide well-care programs as appropriate and feasible, without regard to race, color, sex, gender, gender identity, sexual orientation, national origin, or disability.

2.6.2 Provide appropriate facilities and services to best serve the needs of patients.

2.6.3 Improve the standards of health care in the community.

2.6.4 Establish and promote cost-effective health care delivery including timely adaptations to meet evolving Medicare and other regulations mandating data accumulation.

2.6.5 Encourage educational activities related to tendering care to the sick and injured or to the promotion of health, as may be justified by the facilities, personnel, funds, or other resources that are available.

2.6.6 Manage or participate in, so far as hospital policy, circumstances and available funds may permit, activities designed to promote the general health of the community.

2.6.7 Guard against any activity in or on behalf of the Hospital having, or tending to have, an undesirable effect upon the Hospital or the services it renders.

2.6.8 Provide for overall institutional planning, with the participation of the Medical Staff, nursing department, and such other individuals as the Governing Body deems appropriate; and

2.6.9 Maintain a commitment to continued comprehensive quality assurance and quality improvement in all aspects of health care

provided by the Hospital in cooperation with the Medical Staff, CEO, and hospital personnel.

ARTICLE III THE BOARD OF DIRECTORS

The Board shall consist of five (5) Directors, each of whom shall be a registered voter residing in the District and whose term shall be four (4) years. Terms shall be staggered such that three (3) Directors shall be elected in years evenly divisible by four, and two (2) Directors shall be elected in alternating even-numbered years. Elections of the Board Members shall be consolidated with the statewide general election as indicated by Health & Safety Code section 32499.3.

3.1 Responsibilities. The responsibilities and obligations of the Board shall include:

3.1.1 Assuming responsibility for Medical Staff oversight and quality care evaluation as described in Section V of these bylaws. The Board ensures Hospital are provided according to acceptable standards of practice, irrespective of whether the services are provided directly by Hospital employees or indirectly by agreement or arrangement.

3.1.2 Requiring a process designed to assure that all individuals who provide patient care services, but who are not subject to the Medical Staff privilege delineation process, are competent to provide such services, and receiving reports of quality assurance information regarding competency of care providers not subject to the privilege delineation process.

3.1.3 Overseeing quality of professional services as described in these bylaws.

3.1.4 Establishing, maintaining, and supporting, through the CEO and the Medical Staff and its designated committees a comprehensive, hospital-wide program for quality assessment and improvement, receiving reports of performance improvement information on a regular basis from the Medical Staff, and assuring that all aspects of the program are performed appropriately, and that administrative assistance is available to the Medical Staff.

3.1.5 In consultation with the MEC and the CEO, formulating programs for efficient delivery of care, compliance with applicable law (including Medicare regulations and other applicable regulations) and development, review and revision of policies and procedures.

3.1.6 Subject to recommendations formulating programs for efficient delivery of care, compliance with applicable law (including Medicare regulations and other applicable regulations) and development, review and revision of policies and procedures.

3.1.7 Approving bylaws for hospital auxiliary organizations or for any other similar organizations.

3.1.8 Making recommendations to the CEO regarding the kinds and quality of service to be made available at the Hospital when appropriate.

3.1.9 Reviewing and consulting with the CEO concerning the long-range plan for the Healthcare District.

3.1.10 Overseeing of programs for continued medical education for Medical Staff members, and appropriate in-service education programs for District employees, for the purpose of improving clinical and employee performance.

3.1.11 Directly consult with the Chief of Staff or his/her designee, or through a subcommittee appointed by the Board to include the Chief of Staff, on no less than two occasions per year, on matters including but not limited to: the scope and complexity of hospital services offered, specific patient populations served by the hospital, and any issues of patient safety and quality of care. Any urgent request for consultation presented by the Chief of Staff or his/her designee shall be promptly addressed. Appropriate documentation of each consultation shall be maintained accordingly.

3.1.12 Assisting in the accreditation process, including participation in the summation conference. Assisting in maintaining compliance with current accreditation standards set by ACHC, in conjunction with the CEO and the Medical Staff.

3.1.13 Assisting the CEO in establishing medical record policies respecting composition, retention, confidentiality, and other aspects of record keeping. Maintaining confidentiality with respect to the records and affairs of the District, except as disclosure is required by law.

3.1.14 Protecting the economic viability of the District, while ensuring that ethical principles guide the District's business practices.

3.1.15 In cooperation with the CEO and other District employees, approving an annual operating budget; developing a long-term capital expenditure plan for at least a three (3) year period, including the year of the operating budget, and implementation of that plan.

3.1.16 Conducting an annual evaluation of its own activities and performance. And an annual evaluation of the CEO and communicating same to the appropriate corporate officer.

3.1.17 Establishing mechanisms to assure that all patients with the same health care problem are receiving the same level of care in the Hospital.

3.1.18 Designating particular individuals or departments responsible for evaluating and monitoring quality of care in particular patient services and fostering communication between such individuals or departments through establishing timeframes for discussion of these issues. When the Hospital provides a patient care service for which there is no designated department, establishing an appropriate monitoring and evaluation process.

3.1.19 Performing any other functions designated in these bylaws but not specifically referred to in this section.

3.1.20 Subject to recommendation from the Hospice Agency Medical Director and review, approving regulations of the Hospice Agency on an annual basis to ensure compliance with the standards set forth in 42 C.F.R 418 and all other applicable provisions of law (where applicable).

3.1.21 Establishing a process for making decisions when leadership group fails to fulfill its accountabilities.

3.1.22 Ensuring that new or modified processes are well defined and that clinical practice guidelines are considered when such processes are promulgated.

3.1.23 The governing body must be responsible for providing a physical environment that is constructed, arranged, maintained, equipped, and staffed to meet the needs and services required for patients.

3.2 Directors.

3.2.1 **Fiduciary Responsibilities**. Directors have fiduciary responsibilities to the District, and those living in the District trust the Board to act on their behalf.

(a) The duty of care requires that Directors act toward the District with the same watchfulness, attention, caution, and prudence as would a reasonable person in the same circumstances.

(b) The duty of loyalty requires that Directors not place their personal interests above those of the District.

(c) The Board shall respect the privacy of information by not requesting or seeking to obtain information that is not authorized or necessary for conducting the business of the Board. Directors respect confidentiality by not revealing information to others who

are not legally authorized to have it or which may be prejudicial to the good of the District. Directors respect information security by requesting and monitoring policies that protect the privacy of individuals served by or doing business with the District.

3.2.2 Orientation. The Board shall ensure an orientation process that familiarizes each new Director with his or her duties and responsibilities, including the Board's responsibilities for quality care and the Facilities' quality assurance programs. Continuing education opportunities shall be made available to Directors.

3.2.3 Resignation and Removal.

(a) Any Director may resign effective upon giving written notice to the President, the Secretary, or the Board, unless the notice specifies a later time for the effectiveness of such resignation.

(b) The term of any Director shall expire if the Director is absent from three consecutive regular meetings or from three of any five consecutive meetings of the Board and if the Board by resolution declares that a vacancy exists on the Board, except when prevented by sickness, or when absent with permission required by law.

(c) All or any of the Directors may be recalled at any time by the voters following the recall procedure set forth in Division 16 of the Elections Code.

(d) A Director shall cease to hold Committee membership upon ceasing to be a Board member.

3.2.4 Vacancies. When a vacancy occurs on the Board of Directors, the remaining Board Members may fill it by appointment as outlined in Government Code Section 1780.

3.3 Officers.

3.3.1 President. The President shall be the principal officer of the District and the Board, and shall perform all duties incident to the office and such other duties as may be prescribed by the Board including but not limited to:

(a) Serve as the Board’s primary liaison with the Chief Executive Officer, the press, and the public;

(b) Prepare the Board agenda and request necessary support materials for meetings;

(c) Conduct meetings of the Board;

(d) Sign documents as authorized by the Board;

(e) Appoint Directors to Committees subject to approval by a majority of the Board;

3.3.2 Vice President. The Vice President shall serve in the capacity of the President when necessary or as delegated.

3.3.3 Secretary. In coordination with the Board Clerk, the Secretary shall provide for the keeping of minutes of all meetings of the Board. The Secretary shall give, or cause to be given, appropriate notices in accordance with these Bylaws or as required by law and shall act as custodian of District records, reports, and the District's seal.

3.3.4 Treasurer. The Treasurer shall be charged with the safekeeping and disbursal of the funds in the treasury of the District.

3.4 Committees. All Committees, whether Standing or Special (ad hoc) shall be appointed by the President. The chairman of each Committee shall be appointed by the President. All Committees shall only be advisory to the Board unless otherwise specifically authorized to act by the Board. Authorized action requires Committee quorum and a majority vote of appointed members unless such action is approved in writing by the absent members. A Committee chairman may invite additional individuals with expertise in a pertinent area to meet with and assist the Committee. Such consultants shall not vote or be counted in determining the existence of a quorum and may be excluded from any Committee session.

3.4.1 Standing Committees. When it is deemed necessary by the Board, Standing Committees may be appointed by the President with the concurrence of the Board. Standing Committees shall limit their activities to the accomplishment of the task for which they are created and appointed. Members of Standing Committees will serve one-year terms. Standing Committees shall continue in existence until discharged by the Board.

(a) Standing Committees shall be:
  (1) Finance Committee
  (2) Quality Committee
  (3) Strategic Planning Committee

(b) Standing Committee Participation. Other Directors may attend standing Committee Meetings as members of the public but may not participate in the discussions. The President may remove any member at any time or designate other Directors to serve in the

capacity of any absent Committee members. All appointed members of Committees, including ex officio appointments and recognized alternates, shall be voting members and shall count toward establishing a quorum. Additional members from within the district, including appointed members, may be recommended to serve on the committee as a voting member with board approval.

3.4.2 Special (Ad Hoc) Committees. A Special Committee is an advisory committee composed solely of Directors that represent less than a quorum of the Board, does not have continuing authority, and does not have a meeting schedule fixed by resolution or formal action of the Board. Special Committees may be appointed by the President for special tasks as circumstances warrant, and upon completion of the task for which appointed, such Special Committee shall stand discharged. Special Committee action may be taken without a meeting by a writing setting forth the action so taken signed by each member of the committee entitled to vote.

3.5 Meetings. All meetings of the Board and its Standing Committees are conducted in accordance with the Ralph M. Brown Act (the Brown Act). Public comments will be invited and considered at all open meetings and meeting agendas, support materials, and minutes will be available to the public.

3.5.1 Quorum. A majority of the Directors of the Board or Committee members shall constitute a quorum.

3.5.2 Types of Meetings.

(a) An annual organizational meeting shall be held on the first meeting in December at the place designated in a resolution by the Board. This meeting shall include the election of the President, Vice President, and Secretary, as well as the appointment of a Treasurer, and appointment of Standing Committee members.

(b) Regular monthly meetings shall be held on a consistent basis, alternating sites between the Burney and the Fall River Mills campuses, in the boardroom, except as otherwise specified by a resolution of the Board. Meeting dates and times are set at the annual meeting in December and if changed will be legally noticed. In the event the regular meeting date falls on a legal holiday, the meeting shall be held on the following day, except as otherwise specified by a resolution of the Board.

(c) Special Meetings. The Chairman of the Board may call a special meeting on his/her own initiative and shall call a special meeting

at the written request of three (3) members of the Board. The Chairman shall give written notice, delivered either personally, by mail or telefax, to each member of the Board at least three (3) days before the date of the meeting, giving the time and place of the meeting. This notice shall state the business for which the special meeting has been called, and no business other than that stated in the notice shall be transacted. Meetings may be held at any time upon waiver of notice signed by all Board members. Attendance at any meeting without protest of lack of notice shall be deemed a waiver of notice.

3.6 Compensation. The Board shall serve without compensation except that by resolution of a majority vote, the Directors may authorize the payment of up to one-hundred dollars ($100) per meeting for a maximum of six (6) meetings per month as compensation to each Director as authorized by the Local Health District Law (Health & Saf. Code, § 32103). Each Director shall be allowed the Director's actual necessary traveling and incidental expenses incurred by the performance of official business of the District as approved by the Board.

3.7 Conflict of Interest. The best interest of the community and the Healthcare District are served by Board members who are objective in the pursuit of their duties as Board members, and who exhibit that objectivity at all times. The decision-making process of the Board may be altered by interests or relationships which might in any instance, either intentionally or coincidentally, bear on that member's opinion or decision. Therefore, it is considered to be in the best interest of the District for relationships of any Board member which may influence decisions related to the District to be disclosed to all other members of the Board on a regular and contemporaneous basis.

No Board member shall use his/her position to obtain or accrue any benefit. All Board members shall at all times avoid even the appearance of influencing the actions of any employee of the District, except through his/her vote, and the acknowledgment of that vote, as a Board member for or against opinions or actions to be stated or taken by or for the Board as a whole.

Annually, on or before [insert date], each Board member shall file with the Board Secretary a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Board member and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Hospital or its staff, or the Hospital's relationship to the community. A new Board member shall file the written statement immediately upon being appointed to the Board. This disclosure requirement is to be construed broadly, and a Board member should finally determine the need for all possible disclosures of which he/she is

uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to the Hospital.

This disclosure procedure will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

Between annual disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the Board Secretary by the next regularly scheduled Board meeting. The Board Secretary will provide each Board member with a copy of each member's written disclosure at the next Board meeting following filing by the member for review and discussion by the Board.

Board members shall abstain from voting on any issue in which the Trustee has an interest other than as a fiduciary of the District.

A breach of these provisions is deemed sufficient grounds for removal of a breaching member by the remaining members of the Board on a majority vote.

A willful breach of these provisions may result in loss of indemnification under Article III, 3.8.

3.8 Indemnification. All instances of indemnification shall adhere to the California Government Code beginning at Section 825. Nothing contained herein shall be construed as providing indemnification to any person in any malpractice action or proceeding arising out of or in any way connected with the practice of such person's profession.

3.8.1 District Agent Indemnification. The District shall, to the maximum extent permitted by law, indemnify each of its agents against expenses, judgments, fines, settlements, and other amounts actually and reasonably incurred in connection with any proceeding arising from any act or omission occurring within the agent's scope of authority, as determined by the District. A District agent includes any person who is or was a director, officer, employee, or other agent of the District.

3.8.2 Scope of Indemnification. The District may not provide unconditional indemnification to non-employee members of its medical staff involved in litigation arising out of peer review committee activities.

ARTICLE IV DELEGATION OF AUTHORITY

The Board honors the distinction between governance and management and is authorized to make appropriate delegations of its powers and authority to officers and employees at its discretion. The Board shall exercise its responsibilities for oversight by operating at the policy level, setting strategic direction and goals, monitoring key outcomes, and taking corrective action where needed.

4.1 Chief Executive Officer ("CEO"). The District shall employ or contract with a CEO for the Hospital who acts on behalf of the District within the constraints of all District bylaws and policies. The Board delegates to the CEO the authority to perform the following functions:

4.1.1 Operation of the District and Its Facilities. The CEO is responsible for coordination among the Facilities to control costs and to avoid unnecessary duplication in services, facilities and personnel. The CEO is responsible for ensuring the soundness of financial, accounting and statistical information practices including budgets, forecasts, special studies and reports, and proper maintenance of statistical records. The CEO is responsible for data collection as required by governmental, licensing, and accrediting agencies. The CEO shall maintain adequate insurance or self-insurance covering the physical property and activities of the District and the Board. The CEO is responsible for the negotiation and administration of contracts necessary for District operations. The CEO shall maintain all District records including the minutes of Board and Committee meetings.

(a) Negotiating and finalizing professional, consultant and service contracts in accordance with policy.

(b) Developing a plan of organization of the personnel and others concerned with the operation of the Hospital, including establishing and managing such non-Medical Staff departments, as necessary.

(c) Selecting, employing, controlling, and discharging employees, and developing and maintaining personnel policies and practices for the Hospital.

(d) Maintaining physical properties in a good state of repair and operating condition.

(e) Supervising business affairs to ensure that funds are collected and expended to the best possible advantage.

(f) Preparing capital budgets for review with the Board.

(g) Cooperating with the Medical Staff and others concerned with the rendering of professional services, to the end that optimal achievable care may be rendered to patients and identifying the proper mix of programs and services of the Hospital.

(h) Presenting to the Board periodic reports reflecting the activities of the Hospital and the impact of new medical, legal, regulatory and community developments.

(i) Attending all meetings of the Board, and providing orientation for new Board members, senior managers, and leaders of the Medical Staff.

(j) Serving as liaison officer and conveying all communications among the Board, the Medical Staff, the AHP Staff and hospital personnel.

(k) Being responsible for assuring that the Hospital is in conformity with the requirements of planning, regulatory and inspecting agencies, reviewing, advising, and acting promptly upon the reports of such agencies.

(l) Assisting the auxiliary organizations of the Hospital in their policies, management, and services.

(m) With the assistance of the Board as appropriate, promoting hospital functions and programs in the community.

(n) Querying the National Practitioner Data Bank and reporting adverse actions to the Data Bank as required by law.

(o) Identifying a nurse leader at the executive level who participates in decision-making; and

(p) Performing other duties as may be necessary in the best interest of the Hospital.

4.1.2 **Communication**. The CEO shall be liaison among the Board, the Medical Staff, and District personnel.

4.1.3 **Compliance**. The CEO shall assist the Board in planning services and facilities and informing the Board of governmental legislation, regulations and requirements of official agencies and accrediting bodies, which affect the planning and operation of the Facilities. The CEO is to perform as liaison with governmental, licensing, and accrediting agencies, and shall implement actions necessary for compliance.

4.1.4 **Delegation**. The CEO shall designate other individuals by name and position who are authorized to act for the CEO during any period of absence. To the extent the CEO deems appropriate, the CEO shall delegate to management personnel in the Facilities the authority to manage the day-to-day operations of the Facilities, hire and terminate Facility personnel, and administer professional contracts between the District and Practitioners.

4.1.5 **Human Resources**. The CEO is responsible for ensuring the soundness of all personnel. The CEO shall provide the Board and its Committees with adequate staff support.

4.1.6 **Policy Implementation**. By working with Standing and Special Committees of the Board and joint committees of the Medical Staff, the CEO is to participate in the elaboration of District policies.

4.1.7 **Public Relations**. The CEO shall coordinate community relations activities, including public appearances and communications with the media.

4.1.8 **Reporting**. The CEO shall prepare and distribute to the Board and Medical Staff periodic reports on the overall activities of the District, the Hospital or other Facilities, and pertinent federal, state and local developments that affect the operation of District Facilities.

4.1.9 Any other duties the Board may direct from time to time.

4.2 **Medical Staff**. There shall be a Medical Staff for the District established in accordance with legal, regulatory and accreditation requirements, including California Local Healthcare District Law, which is responsible and accountable to the Board for the discharge of those duties and obligations set forth in the Medical Staff Rules and as delegated by the District. The Medical Staff shall be self-governing with respect to the professional work performed in the Hospital and shall have those rights recognized by the California legislature in Senate Bill

1325 (2004). The Board and the Medical Staff shall have the mutual rights and responsibilities as described in that legislation.

4.2.1 The Medical Staff is responsible for and accountable to the Board for the quality of care, treatment and services rendered to patients in the District. The Medical Staff shall implement mechanisms to assure the consistent delivery of quality care such that patients with the same health problem all receive the same level of care. The Medical Staff shall be responsible for investigating and evaluating matters relating to Medical Staff applications, membership status, clinical privileges, and corrective action, except as provided by the Medical Staff Rules. The Medical Staff shall adopt and forward to the Board specific written recommendations, with appropriate supporting documentation, which will allow the Board to take informed action. Board procedures for appeals shall comply with procedures set forth in the Medical Staff Rules and applicable law, including the Local Healthcare District Law (Health and Safety Code Section 32150 et seq.).

4.2.2 The Medical Staff is responsible for the development, adoption, and periodic review of the Medical Staff Rules consistent with these District Bylaws, applicable laws, government regulations, and accreditation standards. The Medical Staff Rules and all amendments shall become effective only upon approval by the Medical Staff and the Board.

4.2.3 Membership in the Medical Staff shall be comprised of physicians, surgeons, dentists, podiatrists, and mid-levels who meet the qualifications for membership as set forth in the Medical Staff Rules and who are duly licensed and privileged to admit or care for patients in the Hospital. Membership shall be a prerequisite to the exercise of clinical privileges in the District, except as otherwise specifically provided in the Medical Staff Rules.

ARTICLE V CREDENTIALED PRACTITIONERS

5.1 Medical Staff Appointment & Clinical Privileges

5.1.1 The Board shall appoint a Medical Staff and see that they are organized into a responsible administrative unit and adopt such bylaws and rules and regulations for government of their practice in the Hospital as the Board deems to be the greatest benefit of patients within the Hospital. In the case of the individual patients, those appointed to the Medical Staff shall have full authority and responsibility for the care of patients, subject only to such limitations as the Board may formally impose and to the bylaws and rules and regulations for the Medical Staff as adopted by the Board. The Medical Staff shall adhere to the highest ethical principles of the medical profession.

5.1.2 All applications for appointment to the Medical Staff shall be in writing and addressed to the CEO in such format as determined by the Hospital and more specifically described in the Medical Staff Bylaws. The application shall be complete and with required information relating to education, licensure, practice, previous hospital experience, professional liability coverage, sanction check, and any history relative to licensure, malpractice experience and/or hospital privileges.

5.1.2.1 Telemedicine
The governing body ensures that, when telemedicine services are furnished to the Hospital's patients through an agreement with a distant-site hospital or distant site entity, the agreement is written and specifies that it is the responsibility of the governing body of the distant-site hospital to meet its physicians or practitioners providing telemedicine services:

(i) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.

(ii) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff.

(iii) Assure that the medical staff has bylaws.

(iv) Approve medical staff bylaws and other medical staff rules and regulations.

(v) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.

(vi) Ensure the criteria for selection are individual character, competence, training, experience, and judgement.

(vii) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship or membership in a specialty body or society.

5.1.2.2 When telemedicine services are furnished to the Hospital's patients through to the Hospital's patients through an agreement with a distant site hospital, the governing body may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site hospital regarding individual distant-site physicians or practitioners. The governing body must ensure, through its written agreement with the distant-site hospital, that the following provisions are met:

(i) The distant-site hospital providing telemedicine services is a Medicare-participating hospital.

(ii) The individual distant-site physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician's or practitioner's privileges at the distant site hospital.

(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State of California; and

(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the Hospital whose patients are receiving the telemedicine services, the Hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such information for use in the periodic appraisal of the individual distant site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant site physician or practitioner to the Hospital's patients and all complaints the Hospital has received about the distant-site physician or practitioner.

5.1.2.3 When telemedicine services are furnished to the CAH's patients through an agreement with a distant-site telemedicine entity, the Board may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site telemedicine entity regarding individual distant-site physicians or practitioners.

5.1.2.4 The Board must ensure, through its written agreement with the distant-site telemedicine entity, that the following provisions are met:

(i) The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii).

(ii) The individual distant-site physician or practitioner is privileged to at the distant-site telemedicine entity providing the telemedicine services, which provides a current list to the Hospital of the distant-site telemedicine entity.

(iii) The individual distant-site physician or practitioner holds a license issues or recognized by the State of California.

(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the Hospital whose patients are receiving the telemedicine services, the Hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant site telemedicine entity such information for use in periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that results from the telemedicine services provided by the distant site physician or practitioner to the Hospital's patients and all complaints the CAH has received about the distant-site physician or practitioner.

5.1.3 At its next regular meeting after receipt of a completed application and a recommendation from the Medical Staff concerning an applicant for Medical Staff appointment, the Board shall act in the matter unless further investigation requires that action be postponed to a later meeting, as provided in the following paragraph.

OPTIONAL: In order to expedite the credentialing process, the Board may appoint a committee consisting of at least two (2) Board members to review the recommendations received from the Medical Staff. If the committee returns a positive decision concerning the practitioner's clinical privileges, the privileges shall be granted, and the full Board shall ratify that decision at its next regular meeting. If the committee returns a negative decision concerning the practitioner's clinical privileges, the matter shall be returned to the MEC for further recommendation prior to final action by the Board.

The expedited process may not be used in the following circumstances:

(1) The applicant submits an incomplete application; or

(2) The MEC makes a recommendation that is adverse or with limitation; or

(3) There is a current challenge or a previously successful challenge to licensure or registration; or

(4) The applicant has received an involuntary termination of Medical Staff membership at another organization; or

(5) The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges; or

(6) There has been a final judgement adverse to the applicant in a professional liability action.

The above circumstances shall require action by the full Board.

5.1.4 At any time in its consideration of such recommendation, the Board may, in its absolute direction, defer final determination by referring the matter to a committee of its choice for further consideration. Any such referral shall state the reasons, therefore, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional meeting be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation, the Board shall act in the matter.

5.1.5 Appointments to the Medical Staff shall not exceed two (2) years, renewable by the Board before the end of the appointment upon formal application.

5.1.6 The Board shall delegate to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to Medical Staff and AHP membership status, clinical privileges, and corrective action, and shall require that the Medical Staff adopt and forward to it specific written recommendations with appropriate supporting documentation that will allow the Board to take informed action. Such delegation, however, does not relieve the Board of its responsibilities in appointing members of the Medical Staff and overseeing the MEC in the appointment and delineation of functions, responsibilities, and prerogatives of AHPs.

5.1.7 Final action on all Medical Staff matters shall be taken by the Board after considering the Medical Staff recommendation, except that the Board shall act on its own initiative if the Medical Staff fails to adopt and submit recommendations within the time periods required by the Medical Staff Bylaws. Board action without a staff recommendation shall be based on the same kind of documented investigation and evaluation of current ability, judgement, and character as is required for Medical Staff recommendations.

5.1.8 The CEO shall make available to each applicant for staff membership a copy of the Medical Staff Bylaws, including the Medical Staff Rules and Fair Hearing Plan. The applicant shall sign a statement on the application form declaring that he/she has received and reviewed those documents and that he/she specifically agrees:

(i) to obligate himself/herself, as an appointee to the Medical Staff, to provide continuous care and supervision as needed to all hospital patients for whom he/she has responsibility.

(ii) to abide by all such bylaws, policies and directives of the Hospital and its Medical Staff as shall be in force during the time he/she is appointed to the Medical Staff of the Hospital; and

(iii) to accept committee assignments and such other duties and responsibilities as shall be assigned to him/her by the Board and the Medical Staff.

No appointment or reappointment shall take effect until such a statement has been signed by the individual concerned.

5.1.9 The terms and conditions of membership status and clinical privileges and the procedure to be followed in acting on the same shall be as specified in the Medical Staff Bylaws or as more specifically defined in the notice of individual appointment.

5.1.10 The Board shall make final decisions on all requests for corrective action and shall otherwise participate in the corrective action process as described in the Medical Staff Bylaws.

5.1.11 No aspect of membership status nor specific clinical privileges shall be limited or denied to a practitioner on the basis of race, color, sex, gender identity, sexual orientation, national origin, or disability, or on the basis of any other criterion unrelated to quality patient care at the Hospital District, to professional qualifications, to the hospital's purposes, needs and capabilities, or to community needs. Members of the Medical Staff who also have hospital administrative responsibilities shall be required to meet the same requirements and qualifications for membership on the Medical Staff as do practitioners who do not have an administrative relationship to the Hospital.

All administrative relationships with members of the Medical Staff and others who are not members of the Medical Staff shall be reduced to a written agreement between the individual practitioner and the Hospital. These administrative relationships may be terminated by the CEO following the same procedures utilized for other hospital employees

unless the written agreement provides another method of termination. Should the written agreement provision for termination conflict with the general procedures utilized for other employees, the written agreement shall control.

5.2 Medical Staff Governance

The Board shall adopt bylaws, rules, and regulations establishing the organization and government of the Medical Staff. The bylaws, rules, and regulations shall be developed by the Medical Staff but shall be effective only upon approval by the Board. The power of the Board to adopt or amend Medical Staff Bylaws and Rules and Regulations shall be conditioned upon the Medical Staff's failure to keep current, update or make necessary modifications to its bylaws in a manner that will allow for the maximum possible achievement of the purposes and objectives of the Medical Staff.

The Healthcare District retains the right to rescind any authority or procedures delegated to the Medical Staff, and to recommend amendment or replacement of the Medical Staff Bylaws as necessary for the operation of the Hospital.

The Medical Staff shall review all Medical Staff Rules and Regulations, and, as applicable, departmental policies and procedures, when warranted, provided that such review shall occur at least every two (2) years. The Medical Staff shall recommend changes in such policies and procedures for approval by the Board.

5.3 Categories of Staff Membership

The Medical Staff shall be organized into categories as outlined in the Medical Staff Bylaws. The prerogatives and responsibilities of each staff category shall be outlined in the Medical Staff Bylaws.

5.4 Allied Health Professionals (AHP)

The Board may approve specific clinical privileges for individuals who are not part of the Medical Staff, but who may render patient care services within the Hospital setting.

Each member of the AHP shall be assigned and made accountable to the appropriate clinical section of the Medical Staff, although such assignment will not constitute membership on the Medical Staff.

All applications for appointment to AHP status shall be in writing and addressed to the CEO of the Hospital on such forms as determined by the Hospital. The application shall be processed in the same manner as Medical Staff applications.

The terms and conditions of AHP status, and of the exercise of clinical privileges, shall be as specified in the appropriate section of Medical Staff Bylaws or as

more specifically defined in the notice of individual appointment. AHPs shall not be entitled to the procedures set forth in the Fair Hearing Plan. They shall, however, be entitled to an appearance before a Medical Staff committee designated within the Medical Staff Bylaws, as well as a written appeal to the Board in the event of an adverse action.

ARTICLE VI MEDICAL CARE EVALUATIONS

6.1 Board Responsibility For The Quality Of Professional Services

After considering the recommendations of the Medical Staff and the other health care professionals providing patient care services, the Board shall implement specific review and evaluation activities to assess, preserve and improve the overall quality and efficiency of patient care in the Hospital. The Board, through the CEO, shall provide whatever administrative assistance is reasonably necessary to support and facilitate activities contributing to continuous quality assessment and improvement.

6.2 Medical Records

In order to facilitate the Medical Staff's review and appraisal of the quality and efficiency of the medical care rendered in the Hospital, the Board will assure that the Medical Staff will have access to the services of the Medical Records Department and to any other administrative or technical assistance deemed appropriate.

6.3 Professional Accountability To The Board

The Medical Staff and the other health care professional staff providing patient care services shall conduct and be accountable to the Board for conducting activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Hospital. These activities shall include these functions:

6.3.1 Providing effective Ongoing and Focused Professional Practice Evaluation mechanisms to monitor and evaluate the quality of patient care and the clinical performance of individuals with delineated clinical privileges within the Hospital.

6.3.2 Ongoing review, evaluation, and monitoring of patient care practices through a systematic process of overall quality assessment and improvement, Ongoing and Focused Professional Practice Evaluations.

6.3.3 Delineation of clinical privileges for Medical Staff members, commensurate with individual credentials and demonstrated ability and judgment, and assignment of patient care responsibilities to

other health care professionals consistent with individual qualification and demonstrated ability.

6.3.4 Establishing a process designed to assure that all individuals responsible for the assessment, treatment, or care of patients are competent in the following, as appropriate to the ages of the patients served:

(i) the ability to obtain information and interpret information in terms of the patients' needs.

(ii) a knowledge of cognitive, physical, and emotional growth and development in the particular age group treated; and

(iii) an understanding of the range of treatment needed by the patients.

6.3.5 Providing continuing professional education, shaped primarily by the needs identified through the review and evaluation activities.

6.3.6 Reviewing utilization of the hospital's resources to provide for their allocation to patients in need of them.

6.3.7 Reviewing the competency of care providers who are not subject to the Medical Staff privilege delineation process; and reporting to the governing body of findings with regard to such care providers.

6.3.8 Establishing a process to support the efficient flow of patients, such as a plan concerning the care of admitted patients who are in temporary bed locations; and

6.3.9 Such other measures as the Board may, after receiving and considering the advice of the Medical Staff, the other professional services, and the CEO, deem necessary for the preservation and improvement of the quality and efficiency of patient care.

6.4 Documentation

The Board shall consider and act upon the findings and recommendations from the required review, evaluation, and monitoring activities. All findings and recommendations shall be in writing, signed by the person(s) responsible for conducting the review activities, and supported and accompanied by documentation upon which the Board can take informed action.

ARTICLE VII REVIEW, AMENDMENT & REPLACEMENT

These bylaws shall be reviewed by the Board as needed, but at least every two (2) years, and shall be dated to indicate the time of the last review.

These bylaws may be amended by affirmative vote of two-thirds majority of the members of the Board, providing a full presentation of such proposed amendment shall have been published in the notice of meeting.

ARTICLE VIII Certification, Adoption & Execution

These Bylaws shall not be effective until they have been approved by the Board. The signatures set forth below signify that the foregoing Bylaws are the duly adopted Board of Director Bylaws of the Healthcare District.

It is hereby certified that attached hereto is a true, complete and correct copy of the current Bylaws of the Mayers Memorial Healthcare District, duly adopted by the Board of Directors on [Enter Month/Day], 2024.

_____

Abe Hathaway, President

MAYERS MEMORIAL HEALTHCARE DISTRICT
Delineation Of Privileges

Licensed Marriage & Family Therapist Privileges
(LMFT)

Provider Name: _____

CORE PRIVILEGES - Marriage & Family Therapist

Qualifications: Licensed by the Board of Behavioral Science Examiners,
AND,
Master's Degree in Psychology or Counseling,
AND,
One year multidisciplinary experience as a therapist and/or experience as a master degree therapist.

Individual psychotherapy/adult	Requested	Deferred	Approved
	-----	-----	-----

ADVANCED PRIVILEGES - Marriage & Family Therapist

Qualifications: Applicants must meet the criteria outlined for the Core Marriage & Family Therapist privileges,
AND,
provide documentation of ability to perform the procedures requested via certification by a Training Director regarding experience and demonstrated competence.

Family/couple psychotherapy	Requested	Deferred	Approved
	-----	-----	-----

ACKNOWLEDGEMENT OF THE ALLIED HEALTH PROFESSIONAL:

I have requested only those privileges for which I am qualified to perform, based upon my education, training, current experience and demonstrated performance. I understand that in exercising my practice privileges granted, I am constrained by hospital and medical staff policies and rules, including those outlined in the Allied Health Professional Rules and Regulations.

Signature of AHP:_____ Date: _____

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant. To the best of my knowledge, this practitioner's health status is such that he/she may fully perform with safety the clinical activities for which he/she is being recommended. Therefore, we recommend action on the privileges as noted above.

_____ _____

Approval of the IDP/AHP Committee Chair Date

_____ _____

Approval of Medical Executive Committee Chief of Staff or Vice-Chief of Staff Date

MAYERS MEMORIAL HEALTHCARE DISTRICT

EMERGENCY EXIT PLAN

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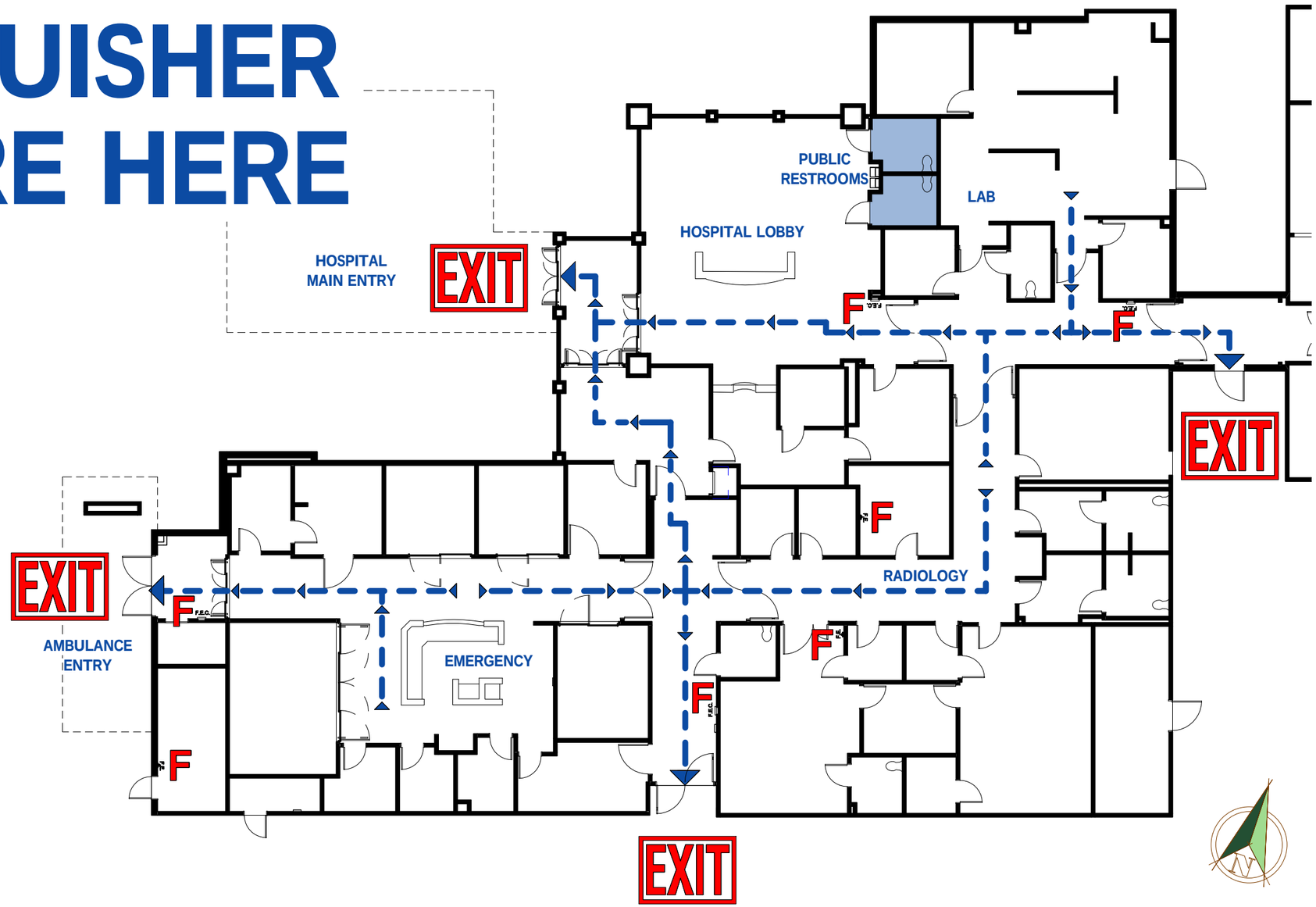
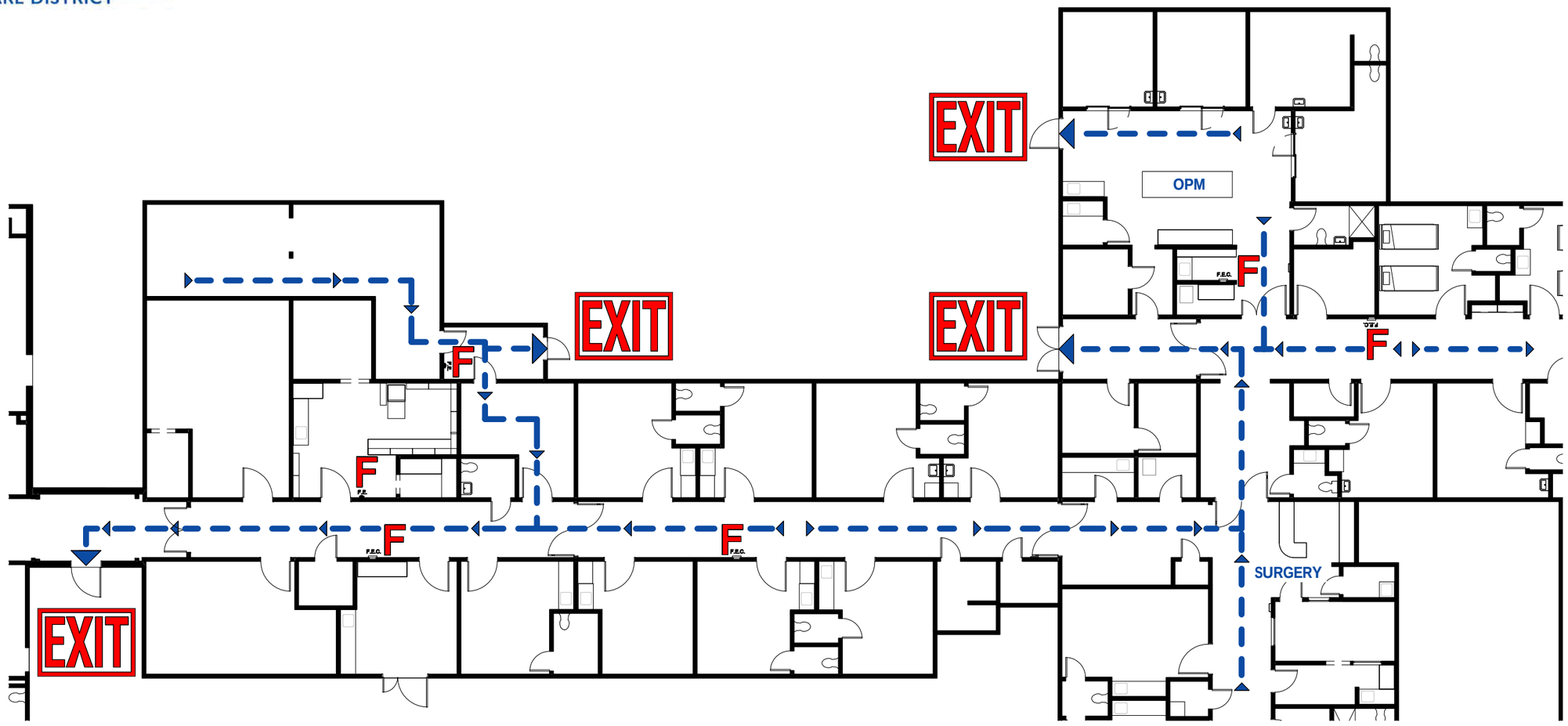


MAYERS MEMORIAL HEALTHCARE DISTRICT

EMERGENCY EXIT PLAN



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HEALTHCARE DISTRICT

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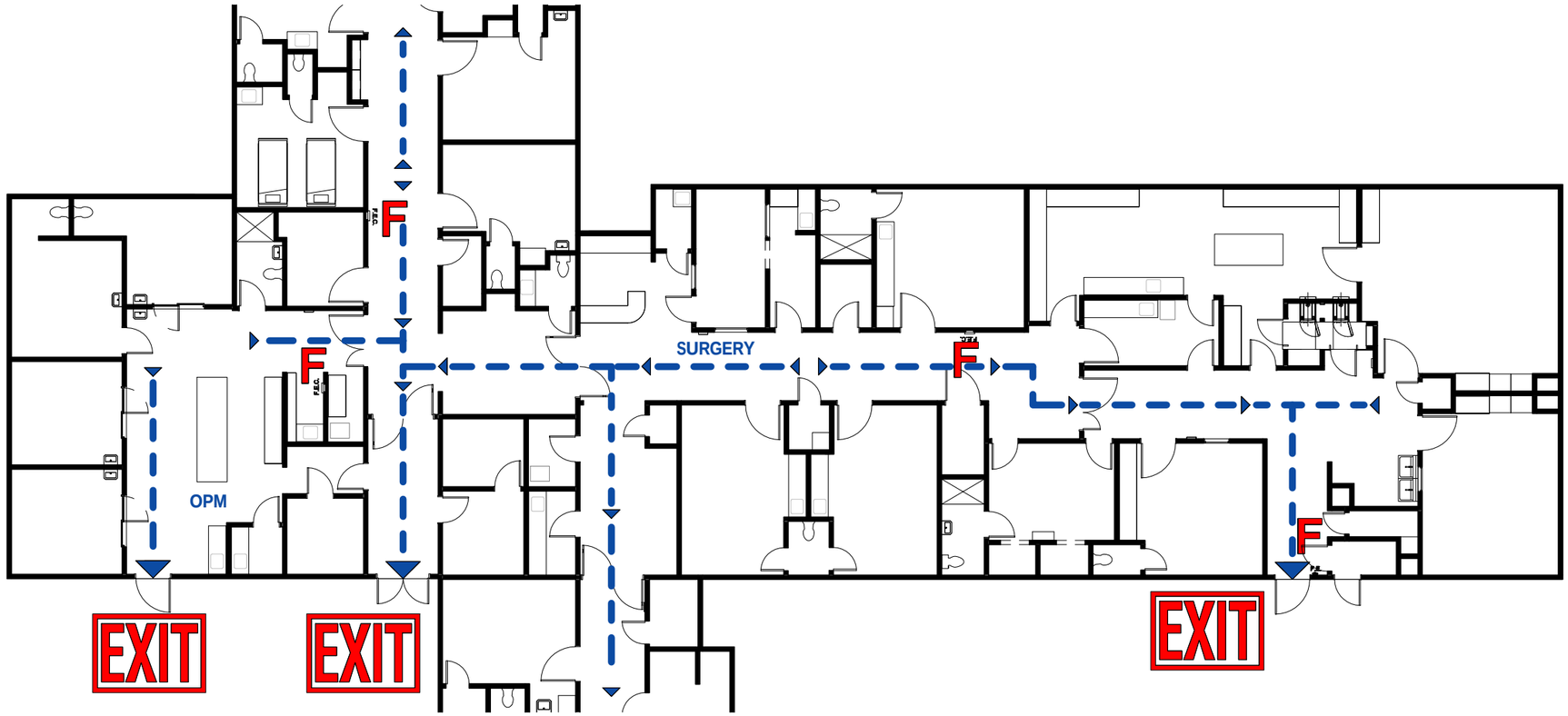

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MAYERS MEMORIAL
HEALTHCARE DISTRICT

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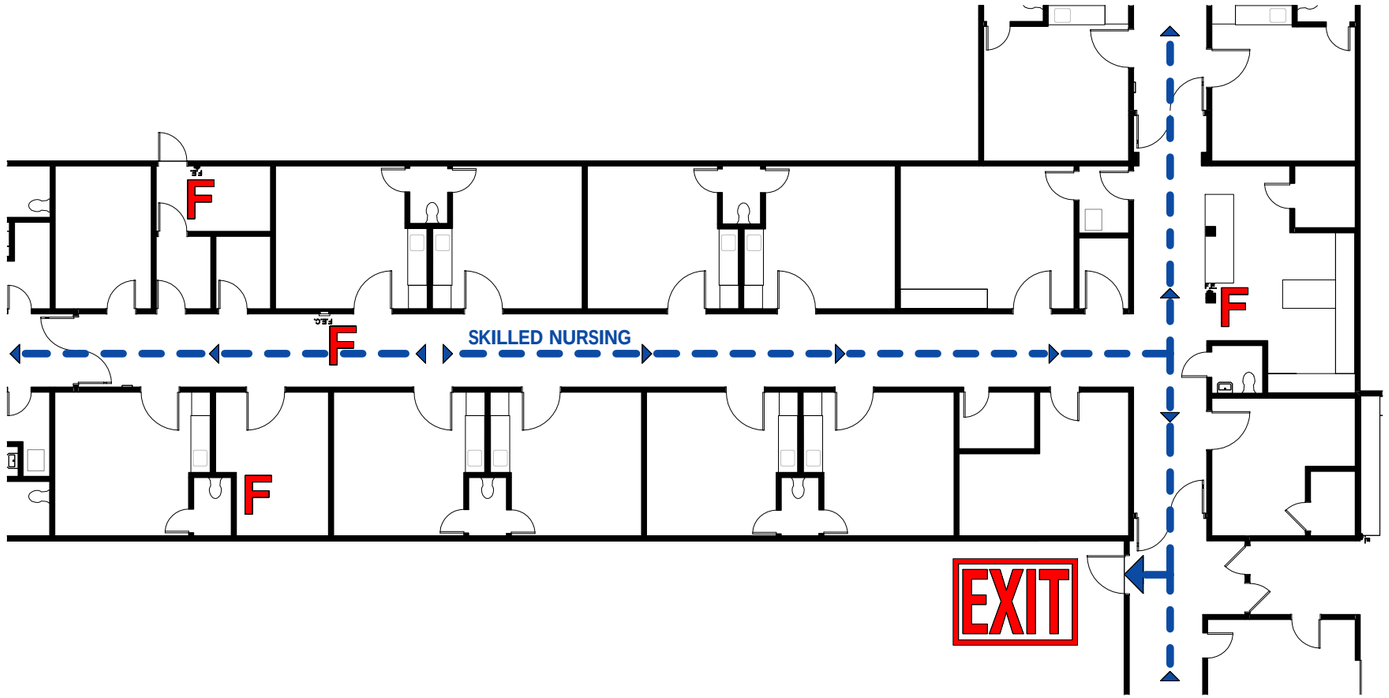

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HEALTHCARE DISTRICT

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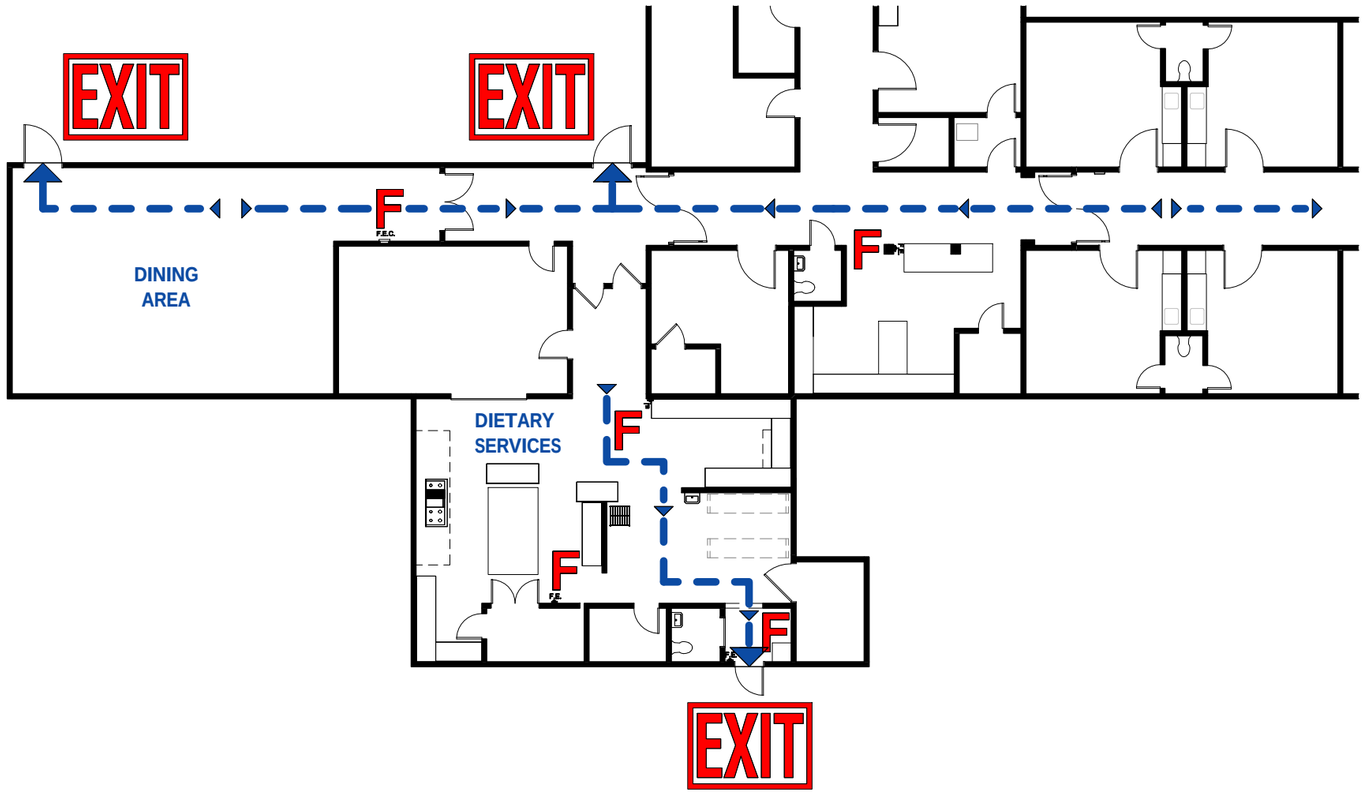

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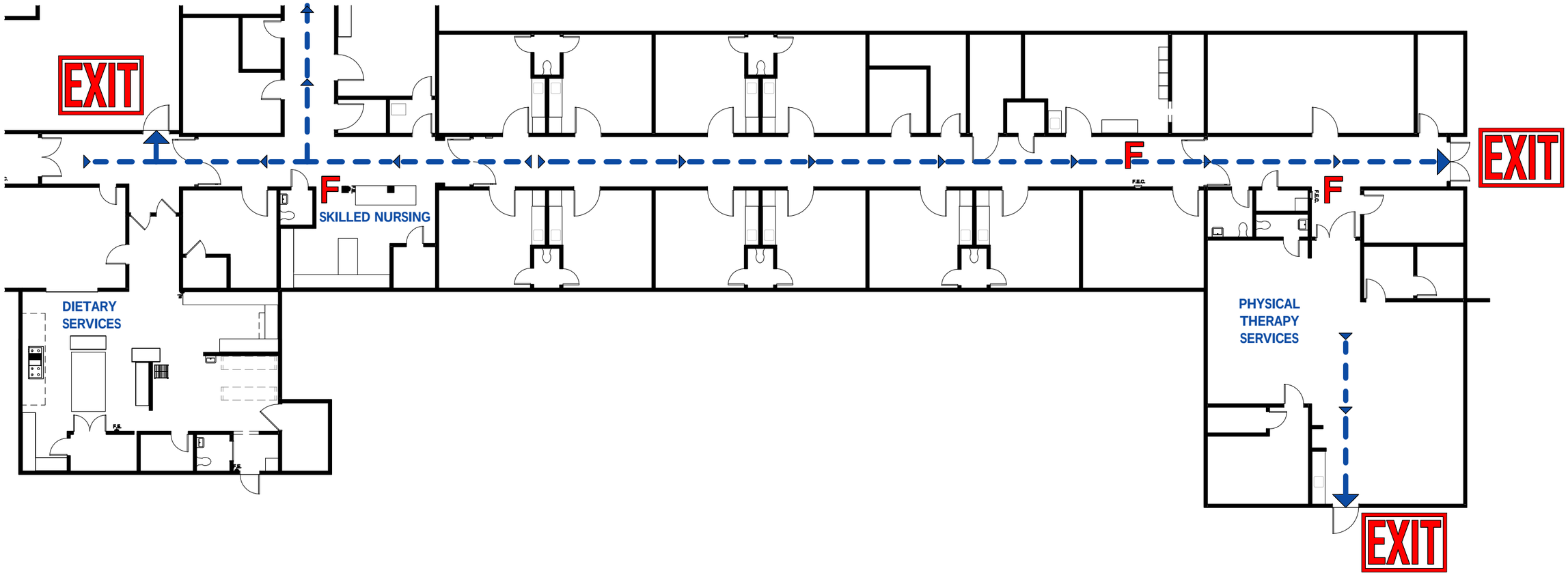
MAYERS MEMORIAL
HEALTHCARE DISTRICT

EMERGENCY EXIT PLAN



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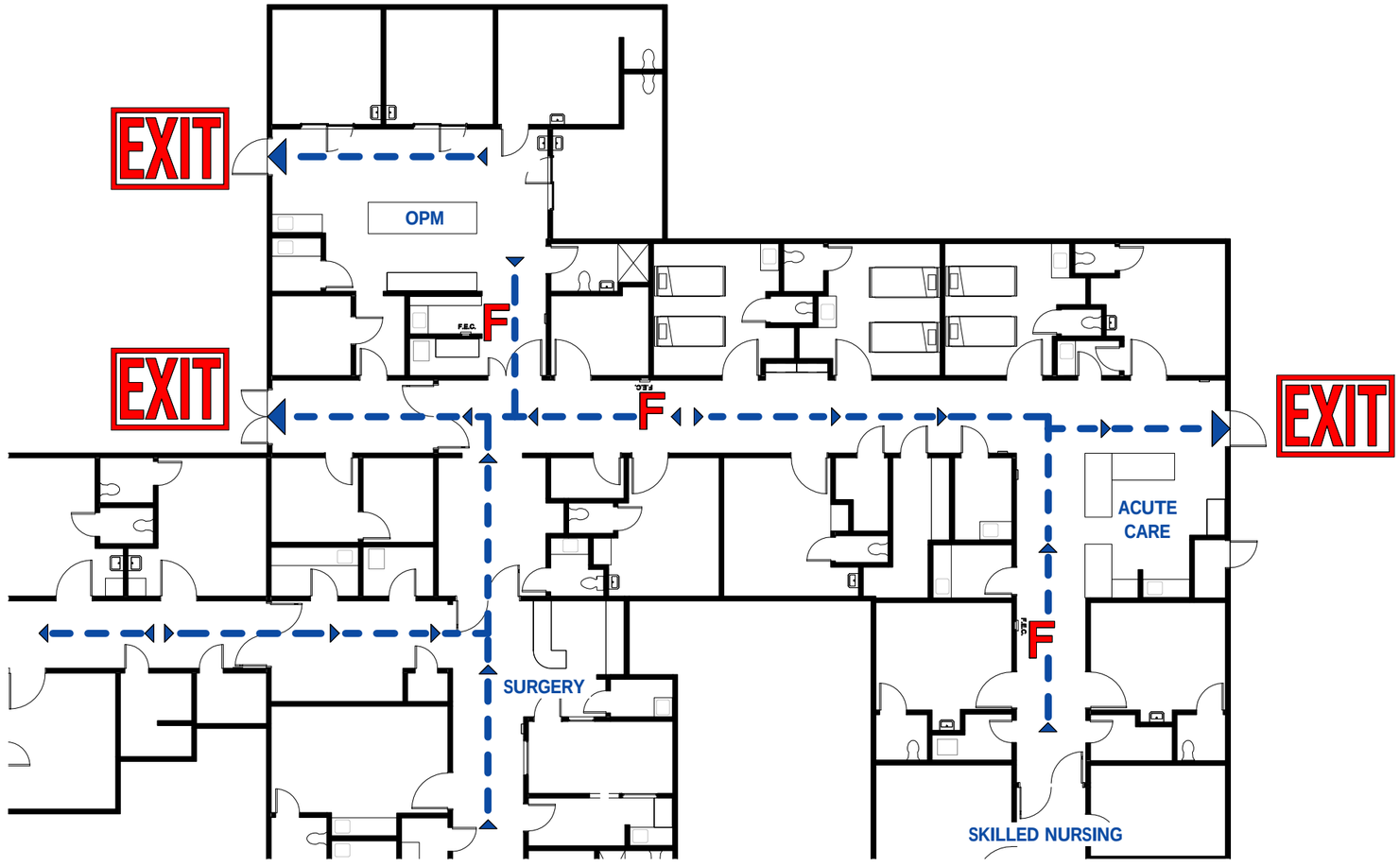
MAYERS MEMORIAL HEALTHCARE DISTRICT

EMERGENCY EXIT PLAN



EXIT **EXIT ROUTE**

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SUBJECT/TITLE:	Emergency Notification Plan for Skilled Nursing Facilities	POLICY # DIA064
DEPARTMENT/SCOPE:	Emergency & Disaster Preparedness	Page 1 of 3
REVISION DATE: n/a		EFFECTIVE: 8/26/2024
AUDIENCE: Skilled Nursing Staff		APPROVAL DATE:
OWNER: Dana Hauge, SO		APPROVER: R. Harris

PURPOSE:

Effective and efficient communication is crucial during emergencies. In the event of an emergency, Mayers Memorial Healthcare District (MMHD) will follow the emergency notification procedures outlined below.

Department managers and nursing leadership need to ensure that their respective departments are well-versed in all emergency communication methods.

Hospital employees are encouraged to keep their personal information updated and to participate in the activation of the plan when necessary. Participation is voluntary, and no personal information will be disclosed without the explicit permission of the involved employee, in line with privacy regulations.

For these procedures, a crisis or emergency is defined as an event or series of events that could have implications for the health or well-being of individuals associated with MMHD, or the hospital itself, extending beyond the routine challenges of daily life and work.

PROCEDURES:

MMHD will promptly notify the staff, patients, and residents (and their designated emergency contacts) using the Emergency Notification System (ENS) upon confirmation of a significant emergency or dangerous situation posing an immediate threat to the health or safety of patients, residents, or employees.

A significant emergency or dangerous situation is confirmed distribute an emergency notification when the designee receives reports or other evidence from community members, local first responders, the National Weather Service, or similar sources, indicating the existence of a significant emergency or dangerous situation for the entire facility or a segment of the facility population.

The MMHD Director of Safety and Security, Safety Officer, or Administration is responsible for issuing an ENS when appropriate. As emergency notification is time-sensitive, the designee will carefully consider the safety of the hospital community, determine the information to be released, and issue an ENS notification based on the evidence available at that time. An ENS message will be disseminated as swiftly as possible and without delay, unless notification will compromise efforts to assist a victim or to contain, respond to, or otherwise mitigate the emergency.

SUBJECT/TITLE:	Emergency Notification Plan for Skilled Nursing Facilities	POLICY # DIA064
DEPARTMENT/SCOPE:	Emergency & Disaster Preparedness	Page 2 of 3
REVISION DATE: n/a		EFFECTIVE: 8/26/2024
AUDIENCE: Skilled Nursing Staff		APPROVAL DATE:
OWNER: Dana Hauge, SO		APPROVER: R. Harris

System Description:

The ENS allows notifications to geographical areas of persons or select persons on or off campus. Messages will be sent to all members of each hospital department based on the location of the crisis. MMHD uses an Emergency Notification System (ENS) to notify patients, residents, and staff when there is a significant emergency or dangerous situation involving an immediate threat to the health or safety of those on campus. The ENS is used to transmit brief, urgent messages to the campus community as quickly as possible.

The following systems are available for emergency notification and are known as MMHD Emergency Notification System (ENS):

- Mass E-mail (MMH Everyone)
- Telephone Call out (Call 'Em All)
- Text Message (Call 'Em All)
- Social Media - Facebook, X
- Intranet Notification
- Overhead Paging (Dial #1500 in Fall River, 6000 in Burney)
- Website

The following is a list of potential situations where the ENS system will be deployed:

- Earthquake
- Gas leak
- Fire
- Power outage
- Terrorist incident
- Armed intruder or active shooter
- Bomb threat
- Civil unrest or rioting
- Explosion
- Approaching extreme weather
- Campus closure
- Other incidents or situations requiring rapid communication

SUBJECT/TITLE:	Emergency Notification Plan for Skilled Nursing Facilities	POLICY # DIA064
DEPARTMENT/SCOPE:	Emergency & Disaster Preparedness	Page 3 of 3
REVISION DATE: n/a		EFFECTIVE: 8/26/2024
AUDIENCE: Skilled Nursing Staff		APPROVAL DATE:
OWNER: Dana Hauge, SO		APPROVER: R. Harris

Recipient obligation:

Recipients of ENS messages must ensure that their emergency contact information is kept up to date with the Hospital. All members of the Hospital community should provide their cellular phone numbers to receive ENS messages via text, which is the fastest form of communication.

Emergency contact information for Skilled Nursing residents will be regularly updated, and ENS notifications will be sent to the point of contact for residents of the Fall River and Burney Skilled Nursing units in case of an emergency."

REFERENCES

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

COMMITTEE APPROVALS:

Safety: 9/4/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

Privileges in Infectious Disease

Name: _____

Qualifications

To be eligible for core privileges in infectious disease, the applicant must meet the following qualifications:

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)- or American Osteopathic Association (AOA)- accredited residency in internal medicine and successful completion of a fellowship in infectious disease.

OR

- Current subspecialty certification or board eligible (with achievement of certification within 1 year) leading to subspecialty certification in infectious disease by the American Board of Internal Medicine or completion of a certificate of special qualifications by the American Osteopathic Board of Internal Medicine

AND

- Inpatient or consultative services for at least 24 patients, reflective of the scope of privileges requested, during the past 12 months, or successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the past 12 months.

Staff Status Requested

☐ Telemedicine Affiliate: may not admit patients to the Hospital

Privileges included in the core

Evaluate, diagnose, consult, and provide care to patients of all ages with infectious diseases of all types and in all organ systems. This includes, but is not limited to, infections of the reproductive organs, infections in solid organ transplant patients, infections in bone marrow transplant recipients, sexually transmitted diseases, HIV/AIDS, infections in travelers, and viral hepatitis, including hepatitis B and C.

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

Name _____

Qualifications for HIV/AIDS Specialists

- Successful completion of an ACGME- or AOA-accredited postgraduate training program in infectious disease and fellowship training or at least 30 category 1 continuing medical education credits in HIV/AIDS-related medicine

OR

- Current certification or board eligible (with achievement of certification within 1 year) leading to subspecialty certification in infectious disease by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine.

AND

- Inpatient or consultative services for at least 10 patients, reflective of the scope of privileges requested, during the past 12 months, or successful completion of an ACGME- or AOA- accredited residency or clinical fellowship within the past 12 months

Privileges included in the HIV/AIDS core

Evaluate, diagnose, consult, and provide care to patients of all ages with HIV/AIDDS and secondary infections and other related medical conditions.

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

<u>Additional Privileges Requested</u> (write in below):

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

_____

_____

_____

Acknowledgement of practitioner

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

_____ _____
Applicant Date

Recommendations

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

_____ _____
Credentials Committee Chair/Vice-Chair Date

_____ _____
Medical Executive Committee Chair/Vice-Chair Date

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Medical Equipment Management Plan	POLICY #
DEPARTMENT/SCOPE:	BioMed, Purchasing, Maintenance, Nursing	Page 1 of 17
REVISION DATE: n/a		EFFECTIVE DATE: 5/22/2024
AUDIENCE: BioMed		APPROVAL DATE:
OWNER: A. Johnson/J. DeCoito		APPROVER: R. Harris

I. PURPOSE

The purpose of the Medical Equipment Management Plan is to support a safe patient care and treatment environment at the hospital by managing risks associated with the use of clinical equipment technology. The program includes processes for selection and maintenance of equipment designed to assure safe and appropriate support of patient care services. The selection and management processes are based on the risks associated with the equipment. The risk management strategies include training, education and competency evaluation of individuals who maintain and use medical equipment and appropriate inspection, testing, maintenance, and repair of that equipment.

II. SCOPE

The Medical Equipment Management Program is designed to assure selection of appropriate medical equipment to support the medical care processes of the hospital and to assure effective preparation of staff responsible for the use or maintenance and repair of the equipment. Finally, the program is designed to assure continual availability of safe, effective equipment through a program of planned maintenance, timely repair, safe storage practices, ongoing education and training and evaluation of all events that could have an adverse impact on the safety of patients or staff.

III. FUNDAMENTALS

A. The sophistication and complexity of clinical equipment continues to expand. Selecting new clinical equipment technology requires research and a team approach.
B. Patient care providers need information to develop an understanding of clinical equipment limitations, safe operating conditions, safe work practices and emergency clinical interventions during failures.
C. Medical equipment may injure patients or adversely affect care decisions if not properly maintained and stored when not in use.

IV. OBJECTIVES

A. To provide a safe environment through proper selection, use, testing and maintenance of Medical Equipment.

B. To maintain an accurate Medical Equipment inventory.

C. To educate users and maintainers of Medical Equipment to help ensure proper use and functioning.
D. To identify deficiencies, failures, and user errors to help prevent injury to patients.
E. To ensure Medical Equipment and staff perform at an acceptable level to limit the potential for patient injury due to equipment failure or misuse.

V. ORGANIZATION AND RESPONSIBILITY

A. The Board of Directors receives regular reports either directly or through another committee (e.g., PI, Risk Management, and Quality Management) of the activities of the Medical Equipment program from the Safety Emergency and Environment of Care (SEEC) Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues and regulatory compliance. The Board provides support to facilitate the ongoing activities of the Medical Equipment program.

B. The CEO receives regular reports of the current status of the Medical Equipment program through the SEEC Committee. The CEO reviews the reports and, as necessary, communicates concerns about key issues and regulatory compliance to the medical staff, nursing, clinical engineering, and other appropriate staff.

C. Beacon Medeas will act as Biomedical Engineering for MMHD. FS Medical and Plant Operations ensures that the biomedical equipment program is implemented in all key clinical areas. Program activities including tracking of rental or leased equipment, warranty repairs, contract services and the activities of specialty contractors providing services to other departments such as radiology, laboratory, respiratory care and surgery and anesthesia are also managed.

   The Biomedical staff implements the medical equipment maintenance program and tracks maintenance provided by original equipment manufacturers and other contractors who provide maintenance and repair services for specific items of equipment.

D. Department heads orient new staff to the department and, as appropriate, to job and task specific uses of clinical equipment. When requested, the Biomedical provider will assist with staff education.
E. Individual staff members are responsible for learning and following job and task specific procedures for safe clinical equipment operation.

VI. PROCESSES OF THE MEDICAL EQUIPMENT PLAN

The organization manages Medical Equipment risks

SUBJECT/TITLE:	Medical Equipment Management Plan	POLICY #
DEPARTMENT/SCOPE:	BioMed, Purchasing, Maintenance, Nursing	Page 3 of 17
REVISION DATE: n/a		EFFECTIVE DATE: 5/22/2024
AUDIENCE: BioMed		APPROVAL DATE:
OWNER: A. Johnson/J. DeCoito		APPROVER: R. Harris

Medical Equipment Management Plan

The hospital has developed and maintains a written management plan describing the processes it implements to effectively manage risks associated with the use of clinical equipment technology. This plan is evaluated annually, and changed as necessary, based on changes in conditions, regulations and standards and identified needs.

Selection and Acquisition

The SEEC Committee has overall responsibility for coordinating the clinical equipment selection and acquisition process. Department heads and others, as appropriate, collaborate to select and acquire medical equipment. Department heads develop recommendations related to equipment to purchase. The Manager of Materials Management coordinates vendor negotiations and ensures clinical equipment considered for purchase meets appropriate standards of performance and safety.

Biomedical Engineering and Plant Operations work with design professionals and clinical staff to identify needs for space and support of new equipment. They also manage the commissioning of new equipment. The commissioning process includes assembly, installation and testing of new equipment.

The managers of clinical departments where new equipment is installed collaborate with Materials Management and equipment suppliers to assure appropriate education and training are provided to all initial users of the equipment and a program for training additional future users is developed.

Capital equipment requests for clinical equipment are included as part of the annual budget process. The CEO has final approval over all new clinical equipment purchases. The Materials Management Department maintains documentation related to the Medical Equipment selection and acquisition process.

Criteria and Inventory

The organization maintains a written inventory of all medical equipment.

SUBJECT/TITLE:	Medical Equipment Management Plan	POLICY #
DEPARTMENT/SCOPE:	BioMed, Purchasing, Maintenance, Nursing	Page 4 of 17
REVISION DATE: n/a		EFFECTIVE DATE: 5/22/2024
AUDIENCE: BioMed		APPROVAL DATE:
OWNER: A. Johnson/J. DeCoito		APPROVER: R. Harris

Written criteria are used to identify risks associated with medical equipment. The risks include equipment function, physical risks associated with use, and equipment history as it relates to patient safety.

The risks identified are used to assist in determining the strategies for maintenance, testing and inspection of medical equipment. In addition, the identified risks are used to guide the development of training and education programs for staff that use or maintain equipment.

All medical equipment is screened at the time of delivery. In addition, appropriate training and testing of new equipment takes place prior to use on patients.

Equipment requiring a program of planned maintenance is listed as part of a maintenance inventory. The list includes equipment maintained by biomedical engineering staff as well as equipment maintained by vendors.

Maintenance Strategies

The hospital identifies high-risk medical equipment on the inventory for which there is a risk of serious injury or death to a patient or staff member should the equipment fail.
Note: High-risk medical equipment includes life-support equipment.

Biomedical Engineering evaluates all equipment used for the diagnosis, treatment, and monitoring of patients to determine the appropriate maintenance strategy, thus assuring safety and maximum useful life. The strategy selected is based on manufacturer recommendations, accreditation or regulatory requirements, local operating experience, and equipment design. The determination of the appropriate strategy is made as part of the initial evaluation of equipment.

Potential strategies include:

- Interval testing, based on specified intervals between tests, inspections, or maintenance activity.
- Run-time based inspections, based on hours of use or other time of use processes. This strategy uses on-board clocks or event recorders to trigger specific tests, inspections, or service.
- Corrective maintenance, based on a request for service or failure of the equipment to pass internal self-tests. Such equipment is subject to an initial test on receipt and asset management.

SUBJECT/TITLE:	Medical Equipment Management Plan	POLICY #
DEPARTMENT/SCOPE:	BioMed, Purchasing, Maintenance, Nursing	Page 5 of 17
REVISION DATE: n/a		EFFECTIVE DATE: 5/22/2024
AUDIENCE: BioMed		APPROVAL DATE:
OWNER: A. Johnson/J. DeCoito		APPROVER: R. Harris

- Other strategies, based on the use of the equipment may include inspection immediate prior to each use, for equipment used infrequently, borrowed, or rented from vendors or others.

Inspection, Testing and Maintenance

The frequency of planned maintenance is determined based on manufacturer recommendations, accreditation or regulatory requirements and local operating experience. The frequency of maintenance is determined at the time of initial evaluation of the equipment and thereafter based on AEM principles.

A work order is used to manage the work for each planned maintenance event. Work orders are issued for maintenance performed by in-house staff and by contractors. Biomedical Engineering manages the work order generation and completion process. Biomedical Engineering technicians perform assigned work orders and return completed work orders to managers. Work done by outside contractors is tracked to assure the work is completed in accordance with the terms of the contract.

In addition, other departments manage performance testing and maintenance of sterilizers and the dialysis water processing system.

Storage of Equipment

- Manufacturer's Instructions for Use (IFUs) are evaluated for specific temperature & humidity requirements prior to establishing storage practices.

The organization's activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers' recommendations:

- Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining must be in accordance with the manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements.
- Medical laser devices
- Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes)
- New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies
  Note: Maintenance history includes any of the following documented evidence:
- Records provided by the hospital's contractors.

- Information made public by nationally recognized sources.
- Records of the hospital's experience over time

AEM Strategies

A qualified individual(s) uses written criteria to support the determination whether it is safe to permit medical equipment to be maintained in an alternate manner that includes the following:

- How the equipment is used, including the seriousness and prevalence of harm during normal use
- Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm
- Availability of alternative or back-up equipment in the event the equipment fails or malfunctions.
- Incident history of identical or similar equipment
- Maintenance requirements of the equipment

AEM Equipment Identification

The organization identifies medical equipment on its inventory that is included in an alternative equipment maintenance program.

Safe Medical Devices Act

The hospital monitors and reports all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990.

The Director of Quality & Risk is responsible for the Safe Medical Devices Act Reporting process.

The Director of Quality & Risk collects information about potentially reportable events through the incident reporting and investigation process. The Directors of Plant Operations, Biomedical Engineering and appropriate clinical staff conduct investigations of clinical equipment incidents to determine if the incident is reportable under criteria established by the Food and Drug Administration.

SUBJECT/TITLE:	Medical Equipment Management Plan	POLICY #
DEPARTMENT/SCOPE:	BioMed, Purchasing, Maintenance, Nursing	Page 7 of 17
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AUDIENCE: BioMed		APPROVAL DATE:
OWNER: A. Johnson/J. DeCoito		APPROVER: R. Harris

The Director of Quality & Risk uses the Sentinel Event Process to investigate and document reportable incidents. The Risk Manager prepares quarterly reports for the Safety Committee on those incidents determined to be reportable. The Risk Manager is also responsible for completing all reports and handling other communications with medical equipment manufacturers and the FDA required by the Safe Medical Devices Act.

Appropriate changes in processes and training are made through the performance improvement process. The changes are communicated to all appropriate staff.

Recalls

The Manager of Materials Management along with the Biomedical staff manage the medical equipment hazard notice and recall process.

Product safety alerts, product recall notices, hazard notices, etc. are received from a variety of external sources. All such notices are routed to Materials Management. Notices are circulated to department heads to determine if the hospital has any of the affected equipment. When a piece or type of equipment subject to a hazard notice or recall is identified, appropriate action is taken to address the hazard.

The Biomedical technicians support the process by using the medical equipment inventory to screen known equipment for matches and by evaluating the relative severity of the risk. When conditions warrant, equipment is removed from service and replaced with a safe, effective substitute. In unusual cases when no substitute is available, the biomedical department provides support to users to ensure the identified hazard is minimized until it can be corrected.

The organization ensures responses to product safety recalls by appropriate organization representatives. Risk Management manages this process in collaboration with Materials Management and key hospital staff. They document the follow-up and report the results to the SEEC Committee on a periodic basis. Critical recalls or alerts are brough to the attention of the Safety Officer upon receipt, and the Safety Officer assists in assuring an effective response.

Equipment Failures

The hospital has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment.

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The head of each department using high risk or other life-critical medical equipment develops and trains staff about the specific emergency procedures to be used in the event of failure or malfunction of equipment whose failure could cause death or irreversible harm to the patient dependent on such equipment.

These emergency response procedures provide clear, specific instructions for staff responding to an emergency and provide information about notifying appropriate administrative staff of the emergency, actions required to protect patients from harm, contacts for spare equipment or repair services and contacts to obtain additional staff to manage the emergency.

Each department head maintains copies of applicable emergency procedures in accessible locations in their departments. Departmental staff receives orientation and ongoing education and training about the emergency procedures.

Each department head reviews the department's specific medical equipment emergency procedures annually.

Diagnostic Quality Control and Maintenance

The hospital identifies quality control and maintenance activities to maintain the quality of the diagnostic computed tomography (CT) images produced. The hospital identifies how often these activities should be conducted.

Medical Equipment is Maintained, Tested, and Inspected)

Biomedical Engineering establishes and maintains a current, accurate and separate inventory of all equipment included in a program of planned inspections or maintenance. The inventory includes equipment owned by the hospital, leased and rented equipment and personally owned equipment.

Performing Safety, Operational and Functional Checks

Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the organization performs safety, operational, and functional checks.

High risk Equipment

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Biomedical Engineering and Plant Operations ensures that scheduled testing of all high-risk equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the safety Committee each quarter. If the quarterly rate of completion falls below 100%, Biomedical Engineering will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

Note: Scheduled maintenance activities for high-risk medical equipment in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate.

Non-High-Risk Equipment

Biomedical Engineering and Plant Operations ensures that scheduled testing of all non-high-risk equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the SEEC Committee each quarter. If the quarterly rate of completion falls below 95%, Biomedical engineering and Plant Operations will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

Note: Scheduled maintenance activities for non-high risk medical equipment in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate.

Performance Testing and Maintenance of Sterilizers (EC.02.04.03.4)

Greg Drummond, DC Technical Service Inc. is/are responsible for testing and maintenance of all types of sterilizers used in MMHD Outpatient Surgery. Records of load testing and regular maintenance are maintained by Sterile Processing Tech and OR Manager. Any improper results are documented as patient safety incidents and reported to the Director of Quality for evaluation and action.

Oxygen Equipment)
Equipment listed for use in oxygen-enriched atmospheres are clearly and permanently labeled (withstands cleaning/disinfecting) as follows:
-Oxygen-metering equipment and pressure reducing regulators, humidifiers and nebulizers are labeled with name of manufacturer or supplier.
-Oxygen-metering equipment and pressure reducing regulators are labeled “OXYGEN-USE NO OIL”.

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–Labels on flowmeters, pressure-reducing regulators, and oxygen-dispensing apparatuses designate the gases for which they are intended.
–Cylinders and containers are labeled in accordance with Compressed Gas Association (CGA) C-7. Note: Color coding is not utilized as the primary method of determining cylinder or container contents. (For full text, refer to NFPA 99-2012: 11.5.3.1).

The Lab inspects, test and maintains laboratory equipment

The Laboratory evaluates analytic measuring equipment and instruments for all critical operating characteristics. This evaluation is documented.

The laboratory evaluates automated volumetric equipment. This evaluation is documented.

The laboratory monitors temperature-controlled spaces and equipment at frequencies established in the laboratory, using manufacturers guidelines. The temperature is documented.

For each instrument or piece of equipment, the laboratory retains a daily, weekly, monthly, quarterly, or semiannual performance testing and function checks for at least two years.

All blood warmers must have a warning system to detect malfunctions and prevent damage to the cellular components. This system should be checked per manufacturer's specifications.

Staff standardize scales used for phlebotomy and blood collection with a container of known mass or volume each day before use and after repairs/adjustments in order to verify that the correct volume of blood is being drawn.

The laboratory evaluates the accuracy of analytical balances using ANSI/ASTM Class standard weights. This evaluation is documented.

Diagnostic Quality Control and Maintenance Evaluation

The hospital maintains the quality of the diagnostic computed tomography (CT) images produced.

CT Dosage Evaluation

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For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist does the following:

- Measures the radiation dose (in the form of volume computed tomography dose index (CTDIvol) produced by each diagnostic CT imaging system for the following four CT protocols: adult brain, adult abdomen, pediatric brain, and pediatric abdomen. If one or more of these protocols is not used by the hospital, other commonly used CT protocols may be substituted.
- Verifies that the radiation dose (in the form of CTDIvol) produced and measured for each protocol tested is within 20 percent of the CTDIvol displayed on the CT console. The dates, results, and verifications of these measurements are documented.
    - Note 1: This element of performance is only applicable for systems capable of calculating and displaying radiation doses.
    - Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
    - Note 3: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to The Joint Commission HR.01.02.01 EP4; HR.01.02.05 EP20; HR.01.02.07 EP's 1 and 2; HR.01.06.01 EP1; LD.03.06.01 EP4).

CT Performance Evaluation

For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist conducts a performance evaluation of all CT imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics:

- Image uniformity
- Slice thickness accuracy.
- Slice position accuracy (when prescribed from a scout image)
- Alignment light accuracy
- Table travel accuracy
- Radiation beam width
- High-contrast resolution
- Low-contrast resolution

- Geometric or distance accuracy
- CT number accuracy and uniformity
- Artifact evaluation
    - Note 1: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to The Joint Commission HR.01.02.01 EP1; HR.01.02.05 EP20; HR.01.02.07 EP's 1 and 2; HR.01.06.01 EP1; LD.03.06.01 EP4).

Image Acquisition Display Monitor Performance Evaluation

For computed tomography (CT), the annual performance evaluation conducted by the diagnostic medical physicist includes testing of image acquisition display monitors for maximum and minimum luminance, luminance uniformity, resolution, and spatial accuracy.

- Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
- Note 2: Medical physicists or MRI scientists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist or MRI scientist. (For more information, refer to The Joint Commission HR.01.02.01 EP4; HR.01.02.05 EP20; HR.01.02.07 EP's 1 and 2; HR.01.06.01 EP1; LD.03.06.01 EP4).
  MMHD does not currently have MRI services provided. When a patient requires MRI services, an appropriate referral will be placed.

Anesthesia Apparatus

The hospital performs equipment maintenance on anesthesia apparatus. The apparatus are tested at the final path to patient after any adjustment, modification, or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas flow and an oxygen analyzer is used to verify oxygen concentration. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. (For full text, refer to NFPA 99-2012: 11.4.1.3; 11.5.1.3; 11.6.2.5; and 11.6.2.6).

Related Code Requirements

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The hospital meets NFPA 99-2012: Healthcare Facilities Code requirements related to electrical equipment in the patient care vicinity. (For full text, refer to NFPA 99-2012: Chapter 10)
Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendment (TIA) 12-5.

The organization monitors and improves conditions in the Environment of Care

Reporting of Environment of Care Experience

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

Collection, Analysis, and Dissemination of Information

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

The Safety Officer coordinates the performance measurement and improvement process for each of the seven functions associated with Management of the EC. Biomedical Engineering and Plant Operations manages the Medical Equipment program performance measurement process.

Biomedical Engineering and Plant Operations is responsible for preparing quarterly reports of performance and experience for the EC Committee. The reports include ongoing measurement of performance, a summary of hazard notices and recalls acted on during the quarter and summary reports of incidents.

Biomedical Engineering establishes performance indicators to objectively measure the effectiveness of the Medical Equipment program. Biomedical Engineering determines appropriate data sources, data collection methods, data collection intervals, analysis techniques and report formats for the performance improvement standards. Human, equipment, and management performance are evaluated to identify opportunities to improve the Medical Equipment program.

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

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

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

Annual Review of Management Plans

The Safety Officer and designees responsible for the design and implementation of the SEEC programs perform an annual review of each EC management plan. The review evaluates the content of the plan to determine if changes in organization structure, scope of services or other changes create a need to update the plan.

The Safety Officer is responsible for coordinating the annual evaluation of the seven functions associated with Management of the Environment of Care. Biomedical Engineering is responsible for assisting the Safety Officer in performing the annual evaluation of the Medical Equipment program.

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

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

Patient Safety

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

The organization analyzes identified SEEC issues and develops recommendations for resolving them

The multidisciplinary SEEC Committee reviews reports of SEEC activities at regularly scheduled meetings. The committee evaluates the reports and approves actions to address identified issues.

The SEEC Committee meets at least bi-monthly to address SEEC, risk management, patient safety, quality, and other business as appropriate.

The SEEC Committee collaborates to analyze SEEC issues. The analysis includes ongoing analysis of performance and aggregate analysis of environmental tours, incident reports, maintenance activities and other issues.

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

The SEEC Committee publishes the minutes of each meeting. The minutes summarize materials presented, issues identified and actions to be taken.

Designees of each SEEC function are responsible for identifying important measures of environmental or patient safety or of program management. The measures are used to

evaluate performance on an ongoing basis, to measure the success of implementation of performance improvement activities and to develop an understanding of processes that are no meeting expectations.

Minutes and relevant supporting materials are communicated to all SEEC and organization leaders. All managers are required to read the materials and respond as appropriate.

When the SEEC Committee identifies performance improvement opportunities, a proposal for improvement is prepared and sent to leadership. The leadership reviews all improvement proposals and determines the priority and need for the proposed improvement.

When leadership approves a proposal for improvement, appropriate staff or a team is appointed to address the identified issues and to design a process improvement. The staff or team appointed make regular reports to the SEEC Committee and leadership. The reports address progress toward improvement, including measurement of changes to assure they are effective and sustainable.

The minutes of the SEEC Committee are presented to the Quality Improvement Committee at its regular meetings. Issues of interest to the Patient Safety Committee are presented for discussion and action as appropriate. The minutes of and issues identified by the Patient Safety Committee are handled in the same manner before the SEEC Committee.

Orientation, Training, and Education

All staff must attend a new employee orientation within 30 days of hire. The new employee orientation addresses key issues and objectives of all seven areas of the SEEC including the role each area and staff play in the overall patient safety program.

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

References

The Joint Commission. (2022). Hospital Accreditation Standards. https://www.jointcommission.org/standards/hospital-accreditation-standards/ HR.01.02.01 EP4; HR.01.02.05 EP20; HR.01.02.07 EP's 1 and 2; HR.01.06.01 EP1; LD.03.06.01 EP4

MAYERS MEMORIAL HEALTHCARE DISTRICT

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AUDIENCE: BioMed		APPROVAL DATE:
OWNER: A. Johnson/J. DeCoito		APPROVER: R. Harris

NFPA 99 Code Development. (n.d.). https://www.nfpa.org/codes-and-standards/nfpa-99-standard-development/99

COMMITTEE APPROVALS:
Safety:

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Obtaining Surgical Informed Consent	POLICY # SG0023
DEPARTMENT/SCOPE:	Surgery	Page 1 of 3
REVISION DATE: n/a		EFFECTIVE DATE: 12/01/2023
AUDIENCE: Surgery Staff		APPROVAL DATE:
OWNER: L. Melang		APPROVER: T. Overton

DEFINITIONS:

Provider: For the purposes of this policy, the provider is a Physician, Surgeon, or Certified Registered Nurse Anesthetist (CRNA).

Informed Consent: The process in which a healthcare provider educates a patient about the risks, benefits, and alternatives of a planned procedure or intervention allowing the patient to make an informed decision regarding His/her care.

PURPOSE:

To define the requirements and process for obtaining informed consent for procedures and surgeries scheduled and performed at Mayers Memorial Hospital in the Surgical Department. Obtaining the patient's verbal and written consent prior to surgery ensures that the patient has sufficient time and information to make an intelligent decision regarding recommended medical procedures or treatments.

POLICY:

Informed consent shall be obtained and documented for all patients undergoing invasive medical procedures or surgeries at Mayers Memorial Hospital District. State and Federal laws grant patients certain rights. Foremost among these is the right for a competent adult to make his or her healthcare decisions. It is the policy of Mayers Memorial Hospital District to provide each patient with sufficient information regarding diagnostic tests, operative procedures, and administration of blood products. Thus, allowing the patient to make an informed decision regarding his/her healthcare.

PROCEDURE:

1. Informed consent will be obtained and documented prior to the patient undergoing premedication.
2. The patient may cross out any part of the authorization that he/she does not wish to authorize; the patient and provider should initial each section crossed out.
3. Informed consent should be presented to the patient in a language that they fully comprehend. The use of a professional medically trained translator service should be arranged if necessary.
4. The Authorization for Diagnostic or Surgical Procedure consent form will be signed by the Patient, Parent, Guardian, Conservator, or other legal patient representative after a full explanation from the involved provider.

MAYERS MEMORIAL HEALTHCARE DISTRICT

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AUDIENCE: Surgery Staff		APPROVAL DATE:
OWNER: L. Melang		APPROVER: T. Overton

5. The Pre-operative and Circulating nurse assesses patient readiness for surgery and directs any significant questions or concerns to the Provider to discuss.
6. Patients are given sufficient time to read the consent form and ask any questions they may have. All signatures must be dated and timed.
7. The signed consent form is placed into the Patient's Surgical chart. The pre-operative nurse and the Circulating nurse confirm the Consent form is complete, accurate and all signatures, dates, and times have been obtained.

The following standards are required for informed consent. Each disclosure must be made in such a way that the patient understands it. The patient must be given a chance to ask questions.

- Name of the facility where the procedure will be performed.
- Name of the Provider(s) who will perform the procedure or other significant surgical tasks.
- Specific procedure(s) to be performed and a general description stated in plain language or layman's terms.
- The location must be unambiguous. Laterality (e.g., left / right), multiple structures (fingers / toes), or multiple levels (spinal) are clearly specified.
- Patient is informed if an intimate exam will be performed.
- Medically significant potential benefits of the procedure
- Medically significant potential risks, side effects, and complications of the procedure or during the recovery which may occur.
- Discussion of patient's goals and the likelihood of the patient achieving these goals
- Medical alternatives for testing or treatment and the risks related to not receiving proposed medical care.
- Authorization for use of anesthesia / sedation for the procedure
- Advanced directive for emergency measures during procedure/treatment and limitation to such directive if any
- Disclosure of involvement or presence of any observers, health care industry representatives, residents, fellows, and other credentialed providers, if applicable.
- Authorization for disposition of tissue or body parts removed during the procedure.
- Disclosure of any independent medical research or significant economic interests the provider has related to performing the procedure, if any.
- The Provider signs the Physical Certification that He/she has discussed the consent form in its entirety with the patient (or the patient's legal representative).

MAYERS MEMORIAL HEALTHCARE DISTRICT

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AUDIENCE: Surgery Staff		APPROVAL DATE:
OWNER: L. Melang		APPROVER: T. Overton

EMERGENCY SITUATIONS:

1. Consent is generally implied when a medical emergency exists. Providers must make all reasonable attempts to seek a qualified medical decision-maker within a reasonable amount of time.
2. An emergency must meet all the following criteria:
   a. The patient's life or health must be in immediate and substantial danger.
   b. The patient is incapable of consenting.
   c. Any potential risks associated with the treatment are outweighed by the potential benefits associated with the procedure.

PROCEDURE PERFORMED NOT ON THE CONSENT FORM:

1. It is the responsibility of the surgeon to inform the circulator of any additional procedures done not listed on surgical consent.
2. The circulating nurse will make a notation in the surgery case log and on the intraoperative record.
3. The surgeon will inform the patient and/or family members of any additional procedures attempted or performed and the reason for the change in procedure.
4. A quality review report will be completed and given to the Quality Director.

REFERENCES:

1. *Code of Federal Regulations. Title 42*. Subpart D – Optional Hospital Services. Condition of participation: Surgical Services. §482.51 (b)(4). Last amended 11/22/2023. eCFR :: 42 CFR Part 482 Subpart D -- Optional Hospital Services. Accessed 12//01/2023.
2. Informed Consent Documentation. In: *AORN Guidelines for Perioperative Practice*. 2023 ed. ; 2023:387-391.
3. Informed Consent 08.00.06. Surgical Services. In: *ACHC Accreditation Requirements for Critical Access Hospitals*. 2023 ed: pg 291-293.

COMMITTEE APPROVALS:

Surgery: 6/6/2024
P&P: 7/3/2024
MEC: 9/4/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Perioperative Use of Sequential Compression Sleeves	POLICY # Surgery 0036
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REVISION DATE: n/a		EFFECTIVE DATE: 12/01/2023
AUDIENCE: Surgery staff		APPROVAL DATE:
OWNER: L. Melang		APPROVER: T. Overton

DEFINITIONS:

VTE: Venous Thromboembolism, blood clots in the veins.

DVT: Deep Vein Thrombosis, a blood clot that forms in a deep vein, often in the lower extremities.

SCD: Sequential Compression Device, a pneumatic compression sleeve placed onto a patient's lower legs that limits venous poling and increases venous return from the legs. SCDs are single patient use.

RATIONALE:

To establish and implement a protocol for the prevention of VTE for the surgical patient. The development of a VTE is a medical condition that can cause disability or death. Undergoing a surgical procedure is a major risk factor for the development of a VTE. The Centers for Disease Control and Prevention, estimates that 60,000 - 100,000 deaths in the United States occur annually from VTE and that "33% of patient deaths related to VTE in the United States occur following a surgical procedure."

POLICY:

Mechanical VTE prophylaxis is used for the prevention of blood clots in the surgical patient. This includes the use of a SCD, early ambulation, and active foot and ankle exercises. The use of Mechanical VTE prophylaxis must be ordered by the Surgeon, per protocol, and implemented by the preoperative nursing staff. The pre-operative nurse evaluates the patient for any contraindications for the use of SCDs.

PROCEDURE:

SCDs are placed on the patient once on the operating room table, PRIOR to induction of Anesthesia. SCDs will remain in use until the patient is able to ambulate after surgery. Early and frequent ambulation is recommended for the Post-operative patient for the prevention of DVT. Once deemed safe for ambulation, the post-operative nurse will encourage the patient to ambulate. Post-operative education will be provided verbally and written for the prevention of DVT.

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Huntleigh Healthcare Flowtron Universal Intermittent Pneumatic Compression System® User Instructions

1. Plug the pneumatic cuff stimulator into a suitable outlet. The pump will go through a self-test and then remain on Standby until required for use.
2. The pump is configured to give the recommended therapy for each garment type and does not require any setting by the nurse.
3. Apply the prescribed garment to the patient by carefully following the directions included in the garment packaging.
4. Connect the snap-lock connection tubing to the garments by pushing firmly together until they click. To remove, press the button on the female end of the connector while simultaneously pulling on the male end.
5. Pump will operate with one or two garments connected. Adjustment is automatic
6. Check that the connection and garment type are confirmed correctly on the display.
7. To start, press and hold the green RUN on the pump. The green power indicator will illuminate, and therapy will begin.
8. To stop, press and hold the green RUN button a second time. The green power indicator will go out and therapy will stop.
9. If the patient is ambulatory, they may walk with the calf garments on. The foot garments must be removed before allowing the patient to stand or walk.
10. When the pneumatic cuff stimulator is discontinued, return the cleaned unit to surgery Central Supply. The garments are single use and may be thrown away.
11. Plug the pneumatic cuff stimulator into a suitable outlet. The pump will go through a self-test and then remain on Standby until required for use.
12. The pump is configured to give the recommended therapy for each garment type and does not require any setting by the nurse.
13. Apply the prescribed garment to the patient by carefully following the directions included in the garment packaging.
14. Connect the snap-lock connection tubing to the garments by pushing firmly together until they click. To remove, press the button on the female end of the connector while simultaneously pulling on the male end.
15. Pump will operate with one or two garments connected. Adjustment is automatic.
16. Check that the connection and garment type are confirmed correctly on the display.
17. To start, press and hold the green RUN on the pump. The green power indicator will illuminate, and therapy will begin.
18. To stop, press and hold the green RUN button a second time. The green power indicator will go out and therapy will stop.
19. If the patient is ambulatory, they may walk with the calf garments on. The foot garments must be removed before allowing the patient to stand or walk.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Perioperative Use of Sequential Compression Sleeves	POLICY # Surgery 0036
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OWNER: L. Melang		APPROVER: T. Overton

20. When the pneumatic cuff stimulator is discontinued, return the cleaned unit to surgery Central Supply. The garments are single use and may be thrown away.

EXCEPTIONS AND CONTRAINDICATIONS:

1. Do not place sequential compression sleeve on a lower extremity that is compromised (eg, infection, injury, open sores, or recent skin graft).
2. If Surgery site is on the lower extremity, do not place SCD on the surgical limb.
3. Known pre-existing DVT
4. Severe leg edema, Heart failure, or Pulmonary edema from congestive heart failure
5. Pediatric patients (under 18 years old).
6. Patients undergoing a GI procedure (EGD or Colonoscopy) or minimally invasive Surgery (superficial incision, procedure lasting < 30 minutes, such as removal of skin mass), do not require sequential compression sleeves.

REFERENCES:

1. AORN Guidelines for Perioperative Practice. 2023
2. Venous thomboembolism. https://www.cdc.gov/ncbddd/dvt/index.html. Accessed December 1st, 2023.
3. Huntleigh Healthcare Flowtron Universal Intermittent Pneumatic Compression System User Manual.

COMMITTEE APPROVALS:

Surgery: 6/6/2024
P&P: 7/3/2024
MEC: 9/4/2024

SUBJECT/TITLE:	Separation of Hazardous Materials Storage Areas Policy	POLICY # SAF065
DEPARTMENT/SCOPE:	Safety	Page 1 of 1
REVISION DATE: n/a		EFFECTIVE: 8/26/2024
AUDIENCE: District wide		APPROVAL DATE:
OWNER: Dana Hauge, SO		APPROVER: R.Harris

POLICY:

The Hospital separates the areas used to store or process hazardous materials and waste from other areas within the hospital. This also includes contaminated linens, medical equipment, and other items in the hospital.

SCOPE:

To prevent the possible contamination of materials, used for patient care or staff services, especially clean linen, supplies, food products, and clinical reagents, all hazardous materials or waste, including radiological, biological, and chemical areas, will be separate from other areas of the hospital.

PROCEDURE:

A. Waste carts containing hazardous materials will be stored separately for other areas in the hospital.

B. Contaminated linens, especially with potentially infectious material such as blood, will be stored separately.

C. Cleaning and disinfecting of contaminated equipment will be conducted separately from clean equipment or supplies.

D. Processing of hazardous waste will be separated from other areas and areas.

E. Clean chemical supplies, such as clinical reagents, are stored separately from other hazardous wastes.

REFERENCES

ACHC Accreditation requirements for Critical Access Hospitals, 2023 edition. Accreditation Commission for Health Care (ACHC). Chapter 3, 03.03.01,.02

COMMITTEE APPROVALS

Disaster/Safety: 9/4/2024

5 Years of Age and Older

Updated (2023–2024 Formula) Pfizer-BioNTech COVID-19 Vaccine

Standing Orders for Administering Vaccine

2023–24 Formula Vaccine Presentation	Age	Diluent	Dose/Injection Amount	Route
Single-dose vial with blue cap and blue label	5 through 11 years	None	0.3 mL/10 μg	Intramuscular (IM) injection
Single-dose vial with gray cap and gray label	12 years and older	None	0.3 mL/30 μg	Intramuscular (IM) injection
Manufacturer-filled syringe	12 years and older	None	0.3 mL/30 μg	Intramuscular (IM) injection

Purpose

To reduce morbidity and mortality from coronavirus disease 2019 (COVID-19) by vaccinating persons who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP).

Policy

Where authorized under state law, standing orders enable eligible nurses and other health care professionals (e.g., pharmacists) to assess and vaccinate persons who meet the criteria in the "Procedure" section below without the need for clinician examination or direct order from the attending provider at the time of the interaction.

Procedure

Assess children 5 years of age and older for vaccination with the 2023–24 Pfizer-BioNTech COVID-19 Vaccine based on the following criteria:

People who are NOT moderately or severely immunocompromised*

COVID-19 vaccination history† (regardless of COVID-19 vaccine formula)	Schedule for administration of 2023-24 Pfizer-BioNTech COVID-19 Vaccine
Unvaccinated	Give 1 dose now.
Any number of previous doses of COVID-19 vaccine, **NOT** including at least 1 dose of 2023–24 COVID-19 vaccine	Give 1 dose at least 8 weeks (2 months) after the previous dose.
Any number of previous doses COVID-19 vaccine, **INCLUDING** at least 1 dose of 2023–24 COVID-19 vaccine	**People 5 through 64 years of age:** No further doses are indicated. **People 65 years of age and older:** Administer 1 additional dose at least 4 months following the previous dose of 2023-24 COVID-19 vaccine.

* Persons with a recent SARS-CoV-2 infection may consider delaying vaccination by 3 months from symptom onset or positive test (if infection was asymptomatic).

† COVID-19 vaccination history refers to previous receipt of dose(s) of Original monovalent (ancestral) mRNA, bivalent mRNA vaccine, Updated (2023–2024 Formula), or a combination of the three, unless otherwise specified; for people ages 12 years and older, Original monovalent Novavax COVID-19 Vaccine doses, alone or in combination with any mRNA vaccine doses; and for people ages 18 years and older, Janssen COVID-19 Vaccine doses, alone or in combination with any mRNA or Original monovalent Novavax vaccine doses.

5 Years of Age and Older

Updated (2023–2024 Formula) Pfizer-BioNTech COVID-19 Vaccine

Standing Orders for Administering Vaccine

People who ARE moderately or severely immunocompromised

COVID-19 vaccination history* (regardless of COVID-19 vaccine formula)	Schedule for administration of 2023-24 Pfizer-BioNTech COVID-19 Vaccine
Unvaccinated	Give a 3-dose initial series. Administer: ▪ Dose 1 now ▪ Dose 2 at least 3 weeks after Dose 1 ▪ Dose 3 at least 4 weeks after Dose 2
1 previous dose of any Pfizer-BioNTech COVID-19 Vaccine (Dose 1)†	Complete series. Administer: ▪ Dose 2 at least 3 weeks after Dose 1 ▪ Dose 3 at least 4 weeks after Dose 2
2 doses of any Pfizer-BioNTech COVID-19 Vaccine (Doses 1 and 2)†	Complete series. Administer: ▪ Dose 3 at least 4 weeks after Dose 2
3 or more doses of Pfizer-BioNTech COVID-19 Vaccine, **NOT** including at least 1 dose of 2023–24 COVID-19 vaccine †	Give 1 dose at least 8 weeks (2 months) after the previous dose.
3 or more doses of Pfizer-BioNTech COVID-19 Vaccine, **INCLUDING** at least 1 dose of 2023–24 COVID-19 vaccine †	▪ **People 5 through 64 years of age:** May receive 1 additional dose at least 8 weeks (2 months) following the previous dose of 2023-24 COVID-19 vaccine. ▪ Further additional dose(s) may be administered, informed by the clinical judgement of a health care provider and personal preference and circumstances. ▪ Administer any further additional doses at least 8 weeks (2 months) after the last 2023-24 COVID-19 vaccine dose. ▪ **People 65 years of age and older:** Administer 1 additional dose at least 8 weeks (2 months) following the previous dose of 2023-24 COVID-19 vaccine. ▪ Further additional dose(s) may be administered, informed by the clinical judgement of a health care provider and personal preference and circumstances. ▪ Administer any further additional doses at least 8 weeks (2 months) after the last 2023-24 COVID-19 vaccine dose.

* COVID-19 vaccination history refers to previous receipt of dose(s) of Original monovalent (ancestral) mRNA, bivalent mRNA vaccine, Updated (2023–2024 Formula), or a combination of the three, unless otherwise specified; for people ages 12 years and older, Original monovalent Novavax COVID-19 Vaccine doses, alone or in combination with any mRNA vaccine doses; and for people ages 18 years and older, Janssen COVID-19 Vaccine doses, alone or in combination with any mRNA or Original monovalent Novavax vaccine doses.

† People who are recommended to receive a multidose mRNA series for initial vaccination (i.e., children ages 6 months–4 years and people who are moderately or severely immunocompromised) should receive all doses from the same manufacturer. However, in the following exceptional situations a different age-appropriate COVID-19 vaccine product may be administered: the same vaccine is not available, the person would otherwise not complete the vaccination series, or the person starts but is unable to complete a vaccination series with the same vaccine due to a contraindication.

5 Years of Age and Older

Updated (2023-2024 Formula) Pfizer-BioNTech COVID-19 Vaccine

Standing Orders for Administering Vaccine

Additional Clinical Considerations

- 2023–24 Pfizer-BioNTech COVID-19 Vaccine may be simultaneously administered with other routinely recommended vaccines. There are additional considerations for simultaneous administration of an orthopoxvirus vaccine and COVID-19 vaccine.
- Persons who have received HCT or CAR-T-cell therapy
  - Revaccinate persons who received doses of COVID-19 vaccine prior to or during HCT or CAR-T-cell therapy, following the current COVID-19 vaccination schedule. Revaccination should start at least 3 months (12 weeks) after transplant or CAR-T-cell therapy.
- For additional details and all clinical considerations, see Interim Clinical Considerations for Use of COVID-19 Vaccines.

Contraindications:

History of a severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine

Precautions:

History of:

- A diagnosed non-severe allergy to a component of the COVID-19 vaccine
- Non-severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of one COVID-19 vaccine type, if receiving the same vaccine type
- Moderate to severe acute illness, with or without fever
- Multisystem inflammatory syndrome in children (MIS-C) or adults (MIS-A)
- Myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vaccine

Administration

Provide appropriate information material:

- **For 5 through 11 years of age:** Provide all recipients and/or parents/legal guardians with a copy of the current Fact Sheet for Recipients and Caregivers.
- **For 12 years of age and older:** There is currently no VIS. Once a VIS is available it should be used; but providers should not delay use of a vaccine because of the absence of a VIS. See more information on alternative information materials that can be provided.
- Prepare to administer the vaccine following the manufacturer's guidance (ages 5–11 and 12 and older). Choose the correct needle gauge, needle length, and injection site for persons:
  - **5 through 18 years of age:**
    - Needle gauge/length: 22–25 gauge, 5/8*-1-inch
    - Site: Deltoid muscle of arm†
  - **19 years of age and older:** See chart below.
- Administer Pfizer-BioNTech COVID-19 Vaccine by intramuscular (IM) injection:
  - **5 through 11 years:** 0.3 mL/10 μg
  - **12 years and older:** 0.3 mL/30 μg

Sex and Weight of Patient	Needle Gauge	Needle Length	Injection Site†
Female or male less than 130 lbs	22–25	5/8‡–1"	Deltoid muscle of arm
Female or male 130–152 lbs	22–25	1"	Deltoid muscle of arm
Female 152–200 lbs	22–25	1–1.5"	Deltoid muscle of arm
Male 152–260 lbs	22–25	1–1.5"	Deltoid muscle of arm
Female 200+ lbs	22–25	1.5"	Deltoid muscle of arm
Male 260+ lbs	22–25	1.5"	Deltoid muscle of arm

* A 5/8-inch needle can be used if the skin is stretched tightly, and subcutaneous tissues are not bunched.

† Alternately, the anterolateral thigh can be used. A 1- or 1.5-inch needle may be used if administering vaccine in this site, depending on the age of the patient.

‡ Some experts recommend a 5/8-inch needle for men and women who weigh less than 130 pounds. If used, skin must be stretched tightly (do not bunch subcutaneous tissue).

5 Years of Age and Older

Updated (2023-2024 Formula) Pfizer-BioNTech COVID-19 Vaccine

Standing Orders for Administering Vaccine

Document Vaccination

Document each recipient's vaccine administration information:

- **Medical record:** The vaccine and the date it was administered, manufacturer, lot number, vaccination site and route, name and title of the person administering the vaccine.
- **Vaccination record for recipient:** Date of vaccination, product name/manufacturer, lot number, and name/location of the administering clinic or health care professional.
- **Immunization information system (IIS):** Report the vaccination to the appropriate state/local IIS.

Be Prepared to Manage Medical Emergencies

Consider observing persons after vaccination to monitor for allergic reactions and syncope:

- **30 minutes** for persons with:
  - A history of a non-severe, immediate (onset within 4 hours) allergic reaction after a previous dose of one COVID-19 vaccine type, if receiving the same vaccine type
  - A history of a diagnosed non-severe allergy to a component of the COVID-19 vaccine, if receiving the same vaccine type
- **15 minutes:** All other persons

Syncope may occur in association with injectable vaccines. Procedures should be in place to avoid falling injuries and manage syncopal reactions.

Have a written protocol to manage medical emergencies following vaccination.

Health care personnel who are trained and qualified to recognize the signs and symptoms of anaphylaxis as well as administer intramuscular epinephrine should be available at the vaccination location at all times.

Report Adverse Events to the Vaccine Adverse Event Reporting System (VAERS)

For licensed Pfizer-BioNTech COVID-19 vaccines (for people ages 12 years and older), healthcare providers are **strongly encouraged** to report to VAERS:

- Any adverse event that occurs after the administration of a vaccine licensed in the United States, whether or not it is clear that a vaccine caused the adverse event
- Vaccine administration errors, whether or not associated with an adverse event

For Pfizer-BioNTech COVID-19 vaccines given under an EUA (for people 11 years of age and younger) vaccination providers are **required** to report to VAERS:

- Vaccine administration errors, whether or not associated with an adverse event
- Serious adverse events regardless of causality. Serious adverse events per FDA are defined as:
  - Death
  - A life-threatening adverse event
  - Inpatient hospitalization or prolongation of existing hospitalization
  - A persistent or significant incapacity or substantial disruption of the ability to conduct normal life functions
  - A congenital anomaly/birth defect
  - An important medical event that based on appropriate medical judgement may jeopardize the individual and may require medical or surgical intervention to prevent one of the outcomes listed above
- Cases of Multisystem Inflammatory Syndrome (MIS) in children and adults
- Cases of myocarditis
- Cases of pericarditis
- Cases of COVID-19 that result in hospitalization or death

Reporting is also encouraged for any other clinically significant adverse event, even if it is uncertain whether the vaccine caused the event. Information on how to submit a report to VAERS is available at https://vaers.hhs.gov or by calling 1-800-822-7967.

For More Information, Please See:

- Interim Considerations: Preparing for the Potential Management of Anaphylaxis after COVID-19 Vaccination
- CDC's *General Best Practice Guidelines for Immunization*, "Preventing and Managing Adverse Reactions"
- Medical Management of Vaccine Reactions in Children and Teens in a Community Setting
- Medical Management of Vaccine Reactions in Adults in a Community Setting

5 Years of Age and Older

Updated (2023–2024 Formula) Pfizer-BioNTech COVID-19 Vaccine

Standing Orders for Administering Vaccine

Note: For more information/guidance, please contact the immunization program at your state or local health department or the appropriate state body (e.g., state board of medical/nursing/pharmacy practice).

Standing Orders Authorization

This policy and procedure shall remain in effect for all patients of the Mayers Memorial Healthcare District effective 7/9/24 until rescinded or until _____.

Medical director (or ~~other~~ authorized practitioner)

Tom Watson MD / _____ / _____.

Adapted with appreciation from the immunize.org standing orders.

STANDING ORDERS FOR
Administering Influenza Vaccine to Adults

Purpose

To reduce morbidity and mortality from influenza by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

Policy

Where allowed by state law, standing orders enable eligible nurses, pharmacists, and other healthcare professionals to assess the need for vaccination and to vaccinate adults who meet any of the criteria below.

Procedure

1 Assess Adults for Need of Vaccination against Influenza

- All adults are recommended to receive influenza vaccination each year.
- Adults age 65 and older should preferentially receive any one of the following higher dose or adjuvanted influenza vaccines: quadrivalent high-dose inactivated influenza vaccine (HD-IIV4), quadrivalent recombinant influenza vaccine (RIV4), or quadrivalent adjuvanted IIV (aIIV4, Fluad). If none of these three vaccines is available, then any other age-appropriate influenza vaccine should be used.
- Adults who are or will be pregnant during the influenza season. Administer any recommended, age-appropriate quadrivalent IIV (IIV4) or RIV4 to pregnant people in any trimester.
- Adults who do not recall whether they received influenza vaccine in the current vaccination season should be vaccinated.
- Adults who recently received another vaccine, including COVID-19 vaccine, may be administered IIV4 or RIV4 at any time before, after, or simultaneously (on the same day, at separate anatomic sites). Quadrivalent live attenuated influenza vaccine (LAIV4) may be administered without regard to timing of non-live vaccines, but should be administered on the same day or at least 4 weeks apart from an injectable live virus vaccine. Information on coadministration of all vaccines can be found at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html and information on giving 2 or more intramuscular vaccines can be found at www.immunize.org/catg.d/p2030.pdf.

2 Screen for Contraindications and Precautions

Not a contraindication or precaution:
ACIP and CDC do not consider egg allergy of any severity to be a contraindication or a precaution to administration of any influenza vaccine (egg-based or non-egg-based). People with any type of egg allergy may receive any IIV4, RIV4, or LAIV4 that is otherwise appropriate for their age and health status. Safety meaures beyond those recommended for receipt of any vaccine are not recommended. Refer to the current season's ACIP influenza recommendations for additional details at www.cdc.gov/vaccines/hcp/ACIP-recs/vacc-specific/flu.html.

Contraindications for use of all influenza vaccines

- Do not give any egg-based IIV4 to a person who has experienced a serious systemic or anaphylactic reaction to any component of the vaccine (except egg), or to a prior dose of any influenza vaccine (i.e., egg-based IIV, cell culture-based IIV [ccIIV], RIV, or live attenuated influenza vaccine [LAIV]).
- Do not give ccIIV4 to a person who has experienced a serious systemic or anaphylactic reaction to any component of ccIIV4 or to a prior dose of any ccIIV.
- Do not give any RIV4 to a person who has experienced a serious systemic or anaphylactic reaction to any component of RIV4 or to a prior dose of any RIV.

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- Do not give any LAIV4 to a person who has experienced a serious systemic or anaphylactic reaction to any component of LAIV4 or to a prior dose of any influenza vaccine (egg-based IIV, ccIIV, RIV, or LAIV).

For a list of vaccine components, refer to the manufacturer's package insert (www.immunize.org/fda) or go to www.fda.gov/vaccines-blood-biologics/vaccines/vaccines-licensed-use-united-states.

Additional contraindications for use of LAIV4 only

Do not give LAIV4 to a person who:

- is pregnant
- has functional or anatomic asplenia, cochlear implant, or is immunocompromised due to any cause (including immunosuppression caused by medications or HIV infection)
- has active communication between CSF and the oropharynx, nose, or ear or any other cranial CSF leak
- is age 50 years or older
- received influenza antivirals before scheduled vaccination (zanamivir or oseltamivir within 48 hours; peramivir within 5 days; baloxavir within 17 days). If any of these antiviral drugs are taken within 14 days after LAIV4, revaccinate with IIV4 or RIV4.
- is a close contact for a severely immunosuppressed person who requires a protected environment

Precautions for use of all influenza vaccines

- Moderate or severe acute illness with or without fever
- History of Guillain-Barré syndrome within 6 weeks of a previous influenza vaccination

Precautions for use of ccIIV4 and RIV4

- History of a serious systemic or anaphylactic reaction to a previous dose of any egg-based IIV, LAIV, or RIV is a precaution to use of ccIIV4.
- History of a serious systemic or anaphylactic reaction to a previous dose of any egg-based IIV, ccIIV, or LAIV, is a precaution to use of RIV4.

Influenza vaccine contraindications and precautions for persons with a history of serious systemic or anaphylactic reaction to a previous dose of an influenza vaccine are summarized in the table below.

VACCINE ASSOCIATED WITH PREVIOUS SERIOUS OR ANAPHYLACTIC REACTION	AVAILABLE 2023–24 INFLUENZA VACCINES		
	Egg-based IIV4s and LAIV4	ccIIV4	RIV4
Any egg-based IIV or LAIV	Contraindication	Precaution*	Precaution*
Any ccIIV	Contraindication	Contraindication	Precaution*
Any RIV	Contraindication	Precaution	Contraindication
Unknown influenza vaccine	Allergist consultation recommended		

* Use of ccIIV4 and RIV4 in such instances should occur in an inpatient or outpatient medical setting under the supervision of a healthcare provider (HCP) who can recognize and manage severe allergic reaction. HCPs may consider consulting with an allergist to help identify the vaccine component responsible for the reaction.

Precautions for use of LAIV4 only

- Asthma
- Other chronic medical conditions that might predispose the person to complications of influenza infection (e.g., other chronic pulmonary, cardiovascular [excluding isolated hypertension], renal, hepatic, neurologic, hematologic, or metabolic disorders [including diabetes mellitus])

3 Provide Vaccine Information Statements

Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS). Provide non-English speaking patients with a copy of the VIS in their native language, if one is available and desired; these can be found at www.immunize.org/vis. (For information about how to document that the VIS was given, see section 6 titled "Document Vaccination.")

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4 Prepare to Administer Vaccine

For vaccine that is to be administered intramuscularly, choose the needle gauge, needle length, and injection site according to the following chart:

GENDER AND WEIGHT OF PATIENT	NEEDLE GAUGE	NEEDLE LENGTH	INJECTION SITE
Female or male less than 130 lbs	22–25	⅝"†–1"	Deltoid muscle of arm
Female or male 130–152 lbs	22–25	1"	Deltoid muscle of arm
Female 153–200 lbs	22–25	1–1½"	Deltoid muscle of arm
Male 153–260 lbs	22–25	1–1½"	Deltoid muscle of arm
Female 200+ lbs	22–25	1½"	Deltoid muscle of arm
Male 260+ lbs	22–25	1½"	Deltoid muscle of arm
Female or male, any weight	22–25	1½"	Anterolateral thigh muscle

† A ⅝" needle may be used in patients weighing less than 130 lbs (<60 kg) for IM injection in the deltoid muscle only if the skin is stretched tight, the subcutaneous tissue is not bunched, and the injection is made at a 90-degree angle to the skin.

For LAIV, which is administered intranasally, prepare the vaccine according to directions in the package insert.

5 Administer Influenza Vaccine to adults according to the criteria and guidance in the table below:

TYPE OF VACCINE	ADULT AGE GROUP	DOSE	ROUTE	INSTRUCTIONS‡
Inactivated influenza vaccine (IIV4)	All adults	0.5 mL	Intramuscular (IM)	Administer vaccine in deltoid muscle.
IIV4-high dose *(preferred age 65+§)*	65 years and older	0.7 mL	Intramuscular (IM)	Administer vaccine in deltoid muscle.
Adjuvanted inactivated influenza vaccine¶ (aIIV4) *(preferred age 65+§)*	65 years and older	0.5 mL	Intramuscular (IM)	Administer vaccine in deltoid muscle.
Recombinant influenza vaccine (RIV4) *(preferred age 65+§)*	18 years and older	0.5 mL	Intramuscular (IM)	Administer vaccine in deltoid muscle.
Cell Culture-based IIV4 (ccIIV4)	All adults	0.5 mL	Intramuscular (IM)	Administer vaccine in deltoid muscle.
Live attenuated influenza vaccine (LAIV4)	Healthy, younger than age 50 years (except if pregnant)	0.2 mL (0.1 mL into each nostril)	Intranasal spray (NAS)	Spray half of vaccine into each nostril while the patient is in an upright position.

‡ For complete instructions on how to administer influenza vaccine, see "How to Administer Intramuscular and Intranasal Influenza Vaccines" at www.immunize.org/catg.d/p2024.pdf.

§ Adults age 65 and older should receive an adjuvanted (aIIV4) or higher dose (IIV4-HD or RIV4) influenza vaccine. If none is available, any age-appropriate influenza vaccine may be used.

¶ Data on immune response or side effects (reactogenicity) are limited for coadministration of influenza and other vaccines. Available data suggest no significant differences in immune response or reactogenicity when coadministering COVID-19 and influenza vaccines. Available data are mixed on the immune response to influenza vaccination when coadministered with RSV vaccine. Simultaneous administraton of two or more vaccines with adjuvants (aIIV, Heplisav-B, RSV vaccines, Shingrix, Tdap, PCV) may increase the side effects experienced by the patient. When deciding whether to coadminister an influenza vaccine with an RSV vaccine or to coadminister an adjuvanted influenza vaccine with other adjuvanted vaccines, providers should consider the feasibility of the patient returning for additional vaccine doses, risk for acquiring vaccine-preventable disease, vaccine reactogenicity profiles, and patient preferences.

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6 Document Vaccination

Document each patient's vaccine administration information and follow up in the following places:

Medical record: Record the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and address and, if appropriate, the title of the person administering the vaccine. You must also document, in the patient's medical record or office log, the publication date of the VIS and the date it was given to the patient. Note that medical records/charts should be documented and retained in accordance with applicable state laws and regulations. If vaccine was not administered, record the reason(s) for non-receipt of the vaccine (e.g., medical contraindication, patient refusal); discuss the need for vaccine with the patient (or, in the case of a minor, their parent or legal representative) at the next visit.

Personal immunization record card: Record the date of vaccination and the name/location of the administering clinic.

Immunization Information System (IIS) or "registry": Report the vaccination to the appropriate state/local IIS.

7 Be Prepared to Manage Medical Emergencies

Be prepared for management of a medical emergency related to the administration of vaccine by having a written emergency medical protocol available, as well as equipment and medications. For Immunize.org's "Medical Management of Vaccine Reactions in Adults in a Community Setting," go to www.immunize.org/catg.d/p3082.pdf. For Immunize.org's "Medical Management of Vaccine Reactions in Children and Teens in a Community Setting," go to www.immunize.org/catg.d/p3082a.pdf. To prevent syncope, vaccinate patients while they are seated or lying down and consider observing them for 15 minutes after receipt of the vaccine.

8 Report All Adverse Events to VAERS

Report all adverse events following the administration of influenza vaccine to the federal Vaccine Adverse Event Reporting System (VAERS). To submit a VAERS report online (preferred) or to download a writable PDF form, go to https://vaers.hhs.gov/reportevent.html. Further assistance is available at (800) 822-7967.

Standing Orders Authorization

This policy and procedure shall remain in effect for all patients of the Mayers Memorial Healthcare District
NAME OF PRACTICE OR CLINIC

effective 7/8/24 (DATE) until rescinded or until _____ (DATE).

Medical Director TOM WATSON MD (PRINT NAME) / Tom Watson (SIGNATURE) 7/8/24 (DATE)

STANDING ORDERS FOR
Administering Pneumococcal Vaccines (PCV15, PCV20, and PPSV23) to Adults

Purpose

To reduce morbidity and mortality from pneumococcal disease by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

Policy

Where allowed by state law, standing orders enable eligible nurses, pharmacists, and other healthcare professionals to assess the need for vaccination and to vaccinate adults who meet any of the criteria below.

Procedure

1 **Assess Adults for Need of Vaccination** against *Streptococcus pneumoniae* (pneumococcus) infection according to the following criteria:

Routine Pneumococcal Vaccination

Age 65 years or older

Risk-Based Pneumococcal Vaccination

Age 19 through 64 years with any of the following conditions:

- **Non-immunocompromising chronic health conditions:** Alcoholism, chronic heart disease[1], chronic liver disease, chronic lung disease[2], cigarette smoking, diabetes mellitus, cochlear implant, cerebrospinal fluid (CSF) leak
- **Immunocompromising conditions:** Chronic renal failure, congenital or acquired asplenia, congenital or acquired immunodeficiencies[3], generalized malignancy, HIV infection, Hodgkin disease, iatrogenic immunosuppression[4], leukemia, lymphoma, multiple myeloma, nephrotic syndrome, sickle cell disease and other hemoglobinopathies, solid organ transplant

[1] Chronic heart disease includes congestive heart failure and cardiomyopathies

[2] Chronic lung disease includes chronic obstructive pulmonary disease, emphysema, and asthma

[3] Congenital or acquired immunodeficiency include B- (humoral) or T-lymphocyte deficiency, complement deficiencies (particularly C1, C2, C3, and C4 deficiencies), and phagocytic disorders (excluding chronic granulomatous disease)

[4] Iatrogenic immunosuppression includes diseases requiring treatment with immunosuppressive drugs, including long-term systemic corticosteroids, and radiation therapy

2 **Screen for Contraindications and Precautions**

Contraindications

Do not give pneumococcal conjugate vaccine (PCV15, Vaxneuvance, Merck; PCV20, Prevnar20, Pfizer) or pneumococcal polysaccharide vaccine (PPSV23, Pneumovax 23, Merck) to a person who has experienced a serious systemic or anaphylactic reaction to a prior dose of the vaccine or to any of its components. For a list of vaccine components, refer to the manufacturer's package insert (www.immunize.org/fda) or go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.

Precautions

Moderate or severe acute illness with or without fever

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3 Provide Vaccine Information Statements

Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS). Provide non-English speaking patients with a copy of the VIS in their native language, if one is available and desired; these can be found at www.immunize.org/vis. (For information about how to document that the VIS was given, see section 6 titled "Document Vaccination.")

4 Prepare to Administer Vaccine

PCV15 and PCV20 must be given IM. PPSV23 may be administered either intramuscularly (IM) or subcutaneously (Subcut). For vaccine that is to be administered IM, choose the needle gauge, needle length, and injection site according to the following chart:

BIOLOGICAL SEX AND WEIGHT OF PATIENT	NEEDLE GAUGE	NEEDLE LENGTH	INJECTION SITE
Female or male less than 130 lbs	22–25	⅝"*–1"	Deltoid muscle of arm
Female or male 130–152 lbs	22–25	1"	Deltoid muscle of arm
Female 153–200 lbs	22–25	1–1½"	Deltoid muscle of arm
Male 153–260 lbs	22–25	1–1½"	Deltoid muscle of arm
Female 200+ lbs	22–25	1½"	Deltoid muscle of arm
Male 260+ lbs	22–25	1½"	Deltoid muscle of arm
Female or male, any weight	22–25	1"*–1½"	Anterolateral thigh muscle

* Alternative needle lengths may be used for IM injections if the skin is stretched tightly, the subcutaneous tissues are not bunched, and the injection is made at a 90° angle to the skin as follows: a) a 5/8" needle for adults weighing less than 130 lbs (<60 kg) or b) a 1" needle for administration in the thigh muscle for adults of any weight.

If you prefer Subcut injection of PPSV23, choose a 23–25 gauge, ⅝" needle for injection into the fatty tissue over-lying the triceps muscle.

5 **Administer PCV15, PCV20, and PPSV23,** 0.5 mL, by choosing between two options displayed on the following schedules based on the recipient's history of pneumococcal vaccination:

Table 1. Recommendations for adults age 65 years or older

PRIOR VACCINES	OPTION A	OPTION B
None, unknown, or PCV7 only	PCV20	PCV15 followed by PPSV23 in at least 1 year**
PPSV23 only (at any age)	PCV20 at least 1 year after PPSV23	PCV15 at least 1 year after PPSV23
PCV13 only (at any age)	PCV20 at least 1 year after PCV13	PPSV23 at least 1 year** after PCV13
PCV13 (at any age) & PPSV23 before age 65 years	PCV20 at least 5 years after last pneumococcal vaccine dose	PPSV23 #2 at least 5 years after previous PPSV23†
Complete series of PCV13 at any age & PPSV23 at age 65 years or older	May administer PCV20 at least 5 years after most recent pneumococcal vaccination	

**Consider minimum interval (8 weeks) for adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak (CSF).

† For adults with an immunocompromising condition, cochlear implant, or CSF leak, the minimum interval for PPSV23 is at least 8 weeks since last PCV13 dose and at least 5 years since last PPSV23 dose; for others, the minimum interval for PPSV23 is at least 1 year since last PCV13 dose and at least 5 years since last PPSV23 dose.

CONTINUED ON THE NEXT PAGE ▶

Table 2. Recommendations for adults age 19 through 64 years with specified immunocompromising conditions[‡]

PRIOR VACCINES	OPTION A	OPTION B
None, unknown, or PCV7 only	PCV20	PCV15 followed by PPSV23 in at least 8 weeks
PPSV23 only	PCV20 at least 1 year after PPSV23	PCV15 at least 1 year after PPSV23
PCV13 only	PCV20 at least 1 year after PCV13	PPSV23 #1 at least 8 weeks after PCV13, followed by PPSV23 #2 in at least 5 years[§]
PCV13 & 1 dose PPSV23	PCV20 at least 5 years after last pneumococcal dose	PPSV23 #2 at least 5 years after PPSV23 #1 and at least 8 weeks after PCV13[§]
PCV13 & 2 doses PPSV23	May give PCV20 at least 5 years after last pneumococcal dose[§]	

[‡]See list of immunocompromising conditions on page 1.
[§]If PCV20 is not given, CDC recommends that you review pneumococcal vaccine recommendations again when your patient turns 65 years old (see www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf).

Table 3. Recommendations for adults age 19 through 64 years with a cochlear implant or cerebrospinal leak[‖]

PRIOR VACCINES	OPTION A	OPTION B
None, unknown, or PCV7 only	PCV20	PCV15 followed by PPSV23 in at least 8 weeks
PPSV23 only	PCV20 at least 1 year after PPSV23	PCV15 at least 1 year after PPSV23
PCV13 only	PCV20 at least 1 year after PCV13	PPSV23 at least 8 weeks after PCV13[§]
PCV13 & 1 dose PPSV23	May give PCV20 at least 5 years after last pneumococcal dose[§]	

[‖]Recommendations for vaccination in the presence of these conditions differ slightly from other non-immunocompromising chronic health conditions.
[§]If PCV20 is not given, CDC recommends that you review pneumococcal vaccine recommendations again when your patient turns 65 years old (see www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf).

Table 4. Recommendations for adults age 19 through 64 years with a non-immunocompromising chronic health condition[¶]

PRIOR VACCINES	OPTION A	OPTION B
None, unknown, or PCV7 only	PCV20	PCV15 followed by PPSV23 in at least 1 year
PPSV23 only	PCV20 at least 1 year after PPSV23	PCV15 at least 1 year after PPSV23
PCV13 only	PCV20 at least 1 year after PCV13	PPSV23 at least 8 weeks after PCV13[§§]
PCV13 & 1 dose PPSV23	No additional pneumococcal vaccines are recommended at this time.[§§]	

[¶]See list of non-immunocompromising chronic health conditions on page 1. Excluding cochlear implant and cerebrospinal fluid leak (see table 3).
[§§]CDC recommends that you review pneumococcal vaccine recommendations again when your patient turns 65 years old (see www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf).

CONTINUED ON THE NEXT PAGE ▶

6 Document Vaccination

Document each patient's vaccine administration information and follow up in the following places:

Medical record: Document the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. You must also document, in the patient's medical record or office log, the publication date of the VIS and the date it was given to the patient. Note that medical records/charts should be documented and retained in accordance with applicable state laws and regulations. If vaccine was not administered, record the reason(s) for non-receipt of the vaccine (e.g., medical contraindication, patient refusal); discuss the need for vaccine with the patient at the next visit.

Personal immunization record card: Record the date of vaccination and the name/location of the administering clinic.

Immunization Information System (IIS) or "registry": Report the vaccination to the appropriate state/local IIS, if available.

7 Be Prepared to Manage Medical Emergencies

Be prepared for management of a medical emergency related to the administration of vaccine by having a written emergency medical protocol available, as well as equipment and medications. For Immunize.org's "Medical Management of Vaccine Reactions in Adults in a Community Setting," go to www.immunize.org/catg.d/p3082.pdf. To prevent syncope, vaccinate patients while they are seated or lying down and consider observing them for 15 minutes after receipt of the vaccine.

8 Report All Adverse Events to VAERS

Report all adverse events following the administration of pneumococcal vaccine to the federal Vaccine Adverse Event Reporting System (VAERS). To submit a VAERS report online (preferred) or to download a writable PDF form, go to https://vaers.hhs.gov/reportevent.html. Further assistance is available at (800) 822-7967.

Standing Orders Authorization

This policy and procedure shall remain in effect for all patients of the Mayers Memorial Hospital District
NAME OF PRACTICE OR CLINIC

effective 7/8/24 (DATE) until rescinded or until _____ (DATE).

Medical Director TOM WATSON, MD (PRINT NAME) / Tom Watson MD (SIGNATURE) 7/8/24 (DATE)

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Using Standing Orders for Administering Vaccines	POLICY #PH036
DEPARTMENT/SCOPE:	Pharmacy	Page 1 of 2
REVISION DATE: n/a		EFFECTIVE DATE: 7/9/2024
AUDIENCE: All Clinical Staff		APPROVAL DATE: 9/4/2024
OWNER: K. Earnest		APPROVER: K. Earnest

With Attachments:

2023-2024 Phizer-BioNTech Covid 19 Vaccine Standing Orders
Standing Orders for Administering Influenza Vaccine to Adults
Standing Orders for Administering Pneumococcal Vaccines (PCV15, PCV20, and PPSV23) to Adults

DEFINITIONS:

Standing Orders authorize nurses, pharmacists, and other appropriately trained healthcare personnel, where allowed by state law, to assess a patient's immunization status and administer vaccinations according to a protocol approved by a medical director in a healthcare setting, a physician, or another authorized practitioner. Standing orders work by enabling assessment and vaccination of the patient without the need for clinical examination or direct order from the attending provider at the time of the interaction. Standing orders can be established for the administration of one or more specific vaccines to a broad or narrow set of patients in healthcare settings such as clinics, hospitals, pharmacies, and long-term care facilities.

BACKGROUND:

Who recommends standing orders for vaccination?
The Community Preventive Services Task Force (Task Force): The Task Force recommends standing orders for vaccinations based on strong evidence of effectiveness in improving vaccination rates:

1. in adults and children,
2. when used alone or when combined with additional interventions, and
3. across a range of settings and populations.

Read the full Task Force Finding and Rationale Statement at www.thecommunityguide.org/findings/ vaccination-programs-standing-orders.

The Centers for Disease Control and Prevention (CDC): CDC's Advisory Committee on Immunization Practices (ACIP) specifically recommends standing orders for influenza and pneumococcal vaccinations and several other vaccines (e.g., hepatitis B, varicella). See Use of Standing Orders Programs to Increase Adult Vaccination Rates: Recommendations of the ACIP. MMWR 2000;49 (No. RR-1) at www.cdc.gov/mmwr/preview/mmwrhtml/rr4901a2.htm

What are the elements of a standing order?

1. Who is targeted to receive the vaccine;
2. How to determine if a patient needs or should receive a particular vaccination (e.g., indications, contraindications, and precautions);

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Using Standing Orders for Administering Vaccines	POLICY #PH036
DEPARTMENT/SCOPE:	Pharmacy	Page 2 of 2
REVISION DATE: n/a		EFFECTIVE DATE: 7/9/2024
AUDIENCE: All Clinical Staff		APPROVAL DATE: 9/4/2024
OWNER: K. Earnest		APPROVER: K. Earnest

3. Procedures for administering the vaccine (e.g., vaccine name, schedule for vaccination, appropriate needle size, vaccine dosage, route of administration);
4. Provision of any federally required information (e.g., Vaccine Information Statement);
5. How to document vaccination in the patient record;
6. A protocol for the management of any medical emergency related to the administration of the vaccine; and
7. How to report possible adverse events occurring after vaccination.

Who is authorized to administer vaccines under standing orders?
Each of the 50 states separately regulates physicians, nurses, pharmacists, and other health-related practitioners. For further information about who can carry out standing orders in your state, contact your state immunization program or the appropriate state body (e.g., state board of medical/nursing/pharmacy practice).

Who is authorized to sign the standing orders?
In general, standing orders are approved by a medical director in a healthcare setting, a physician, or another authorized practitioner. State law or regulatory agency might authorize other healthcare professionals to sign standing orders.

What should be done with the standing orders after they have been signed?
Signed standing orders should be kept with all other signed medical procedures and protocols that are operational in one's clinic setting. A copy should also be readily available for clinic staff who operate under those standing orders.

Do standing orders need to be renewed (e.g., yearly)?
Generally, standing orders will include an implementation date as well as an expiration date. Periodic review of standing orders is important, because vaccine recommendations may change over time.

REFERENCES:

www.immunize.org/catg.d/p3066.pdf accessed 7/9/2024

COMMITTEE APPROVALS:

P&P: 9/4/2024

II. Day 1: Discovery Day (continued)

1. Facility Tour

We would like to take a facility tour with the CEO or a member of your Executive/Senior Management team. This should take no longer than 30 minutes.

2. Frontline Staff *(Focus Group #1)*

No managers, supervisors, or team leaders are to be present. Participants must be frontline staff only. Ideally participants should represent all departments and disciplines with at least 2 to 3 Nurses. Please be sure to include a representative from Maintenance, Housekeeping, and from any off-site facilities such as your Clinics and/or Long-Term Care. *(8 - 12 people maximum)*

3. Department Head (all Non-Clinical Leaders) *(Focus Group #2)*

This focus group is to be with your current or past Customer Service Committee as well as individuals involved in projects or teams to improve employee and/or physician satisfaction. If you do not have a Service Excellence Council we would like to meet with all non-clinical leaders/individuals who have been actively engaged in improving patients, employee, and physician satisfaction for the past year, especially your Department Heads. *(8 - 14 people)*

4. Board, Physicians, and Advanced Care Practitioners (ACPs) Briefing *(Focus Group #4)*

This is a working lunch focus group with the CEO, all Board members, Medical Providers, Physicians, and Advanced Care Practitioners, who are available. The purpose is to brief and update them on Patient Experience, HCAHPS, and Healthcare Reform and seek their input on their perceptions of how the hospital is doing. *(Whoever is available)*

5. Nurse/Clinical Leaders *(Focus Group #3)*

Please schedule a focus group meeting with your CNO/DON and their leadership.
Please ensure that they are provided with their most recent patient satisfaction scores for their department/unit. *(8 - 12 people)*

6. Administration/Senior Management/C-Suite Team Debrief

This debrief is with every member of your Administration/Senior Management/C-Suite team.

If any of these individuals are not available, please set up an appointment phone call in advance.
For everyone's convenience it would be appreciated if you could book a small board/meeting room for the team with refreshments, decaf coffee, coffee, tea, diet sodas, and water available. *(Same as the earlier Focus Groups if possible)*

III. Day 2: Inspiration Day

A. Planning the Seminars

Please use the following guidelines when planning the Morning Seminar and afternoon Executive Briefing:

1. Confirm or estimate number of attendees for both sessions and book an appropriate sized room that permits participants the option to join via Zoom from:
   - Their office
   - Their home
   - Alternative additional meeting room(s)
2. Please ensure a 20-minute meet and greet prior to the start time of the Morning Seminar that allows for appropriate social distancing
3. Please provide continental breakfast for the morning seminar and healthy snacks/refreshments for the Executive Briefing (including regular and decaf coffee), for those attending onsite
4. LCD Projector, screen, sound equipment, plus appropriate audio cord to link our laptop to your sound system, flipchart with markers, and or your laptop Zoom application link to the LCD projector
5. Wireless lavaliere microphone (if more than 40) if our Expert Implementation Team member is onsite
6. Bar stool

B. Morning Seminar: Ignite the Patient Experience™ Attendees

1. Including Leaders at every level, Administrators, Directors, Managers, Supervisors, Program Managers, Physicians, and Advanced Care Practitioners
2. Hospital Board Members
3. Foundation Board Members
4. Volunteer/Auxiliary Leaders
5. Union Representatives
6. Frontline staff and as many key influencers as you can free up
7. Cross section of community leader and business people
8. Every Leader is encouraged to bring along 1 or 2 frontline staff from their department

C. Executive Briefing: Hardwiring a 5 Star Patient Experience™ Luncheon Seminar Attendees

1. This includes Administrators / Executive / Senior Management ONLY
2. CEO/COO, CFO, and CNO/DON must be in attendance
3. Please also invite Board Members and allow for a 15 minute debrief following the Executive Briefing seminar, after the CLS ITPE Expert Implementation Team has left
4. CLS will video record its Live Streaming presentations

D. Video Option

For the convenience of Administrators who are unable to attend, you have permission to videotape both presentations provided Custom Learning Systems is given a copy within 14 days and the original is not duplicated without written consent.

C-SUITE, EXECUTIVE TEAM AND BOARD, YOU ARE INVITED...

IGNITE
THE PATIENT EXPERIENCE™

Service Excellence Initiative

Hardwiring a Five Star Experience™

MISSION:

To provide key decision-makers with education and insights to assess the value and relevance of the Service Excellence Initiative™, and to achieve a breakthrough opportunity to significantly increase employee retention and patient satisfaction.

YOU WILL LEARN HOW TO

- Utilize the Service Excellence Initiative™ to transform your culture to become the Employer and Provider of Choice.
- Evaluate the link between patient satisfaction and employee morale/ retention.
- Discover for yourself the vital importance of "Meeting Your Customers' Expectations" as a system for significantly improving your patient satisfaction survey results.
- Overcome resistance to change and achieve a renaissance in employee morale through frontline empowerment and management accountability.
- Define a "preferred culture" and the impact it would have on your marketing strategy and competitiveness.
- Make an informed choice to partner with Custom Learning Systems.

ATTENDEES SAY IT BEST

"We were very excited, now we're ignited!"

– Brian Martin CEO
Westholt Medical Services

"For us the Ignite presentation was a mix of inspiration and aspiration."

– Kathy Hull CEO/President
Illini Community Hospital

"The CLS Service Excellence Initiative is putting feet on our prayers."

– Sonja Bachus CEO
Greater Baden Medical Services

Date: **Wednesday, Nov 20, 2024**

Presentation: **Board, Physicians & CEO (includes Lunch)**

Location: **Fall River Boardroom**

RSVP by: **Monday, Nov 11, 2024**

RSVP to: **Lisa Zaech**

Custom Learning Systems
1.800.667.7325 www.customlearning.com

CONFLICT OF INTEREST CODE

FOR

MAYERS MEMORIAL HEALTHCARE DISTRICT

I

Adoption

In compliance with the Political Reform Act of 1974, California Government Code § 81000, et. Seq., the Mayers Memorial Healthcare District, hereby adopts this Conflict of Interest Code, which shall be applicable to all designated employees of the Mayers Memorial Healthcare District, as specifically required by California Government Code § 87300.

This Code has the force and effect of law. Designated employees violating this Code are subject to the sanctions provided in Chapter 11 of the Political Reform Act. Government Code § 91000, et. seq.

II

Designated Employees

Government Code § 87302 (a) requires that persons (including Governing Board Members) who occupy positions within the Mayers Memorial Healthcare District, which involve the making, or participation in the making, of decisions, which may foreseeably have a material effect on any financial interest, shall be designated employees.

All persons who hold the positions enumerated in Section III, below, are designated employees and must disclose all economic interests set forth in the Section.

III

Designated Positions

Persons occupying the following positions are designated employees and must disclose the following economic interests. The manner of reporting reportable items shall be as provided by Government Code § 87200.

Board of Directors, District Chief Executive Officer, District Chief Operations Officer, District Chief Financial Officer, District Chief Nursing Officer, District Chief Public Relations Officer, District Chief Clinical Officer, District Chief Human Resources Officer, District Medical Officer, District Chief of Staff, District Directors and *consultants shall disclose:

1. Investments in any business of the type which, within the last two years, has contracted with this district to provide services, supplies, materials, machinery or equipment. See Government Code §§ 82034, 87103, 87206.

2. Income from any source of the type within the last 12 months, has contracted with the District to provide services, supplies, materials, machinery or equipment to the District. See Government Code §§ 82030, 98103, 87207.

3. Interests in real property, located in whole or in part within two miles of any site owned or used by the District or any land owned, used or contemplated for use by the District including any leasehold, beneficial or ownership interest or option to acquire such interest in real property. See Government Code §§ 82033, 87103, 87206.

IV

Statement of Economic Interests – Filing

A. Initial Statement:

An initial statement shall be filed by each designated employee within 30 days after the effective date of this Conflict of Interest Code disclosing investments in business entities and interests in real property made reportable by Section III, above. All new designated employees shall file statements not less than ten days before assuming office or, if subject to confirmation, ten days before being confirmed, unless an earlier assumption of office is required by emergency circumstances. Government Code § 87302 (b).

V

Statement of Economic Interests – Filing (continued)

A. Annual Statement:

Thereafter, each designated employee shall file an annual statement during the month of January, disclosing reportable investments in business entities, interests in real property, and income held or received in the period since the closing date of the employee's previously filed statement and December 31st.

B. New Positions:

Designated employees appointed, promoted, or transferred to designated positions within the agency shall file initial statements disclosing property within 30 days after assuming office. Government Code § 87302 (b).

C. Leaving Office:

Any designated employee whose employment with the Mayers Memorial Healthcare District is terminated, voluntarily or involuntarily shall, within 30 days after termination, file a statement disclosing reportable investments in business entities, interest in real property, and income, covering the period between the closing date of the previous statement of economic interests and the termination date.

D. Filing with the Agency:

The statement shall be filed with the person acting as the filing officer for the agency, who is the Chief Executive Officer. In the case of Directors, the filing officer shall make and retain a copy of the statement and transmit the original to the code reviewing body within five days of receipt.

VI

Manner of Reporting

The manner of reporting reportable interests shall be on forms provided by the District pursuant to Government Code § 87206 and 87207.VII.

VII

Disqualification

A designated employee must disqualify himself or herself from making or participation in the making of any decisions which will foreseeably have a material financial effect, distinguishable from its effect on the public generally, on any reportable economic interest (except gifts of less than $250) or on the principal residence of the filer, or upon any business entity in which the designated employee holds a position of management or is a director, officer, partner, sole owner, trustee, or employee. No member shall be prevented from making or participating in the making of any decisions to the extent his or her participation is legally required for the decision to be made.

VIII

Definitions

Unless otherwise indicated, the definitions contained in the Political Reform Act of 1974, Government Code § 81000, et. seq., the Regulations of the Fair Political Practices Commission adopted pursuant thereto, and any amendments to the Act and Regulations are incorporated into this Conflict of Interest Code.

IX

Effective Date of Code

This Conflict of Interest code shall become effective 30 days after approval by the Fair Political Practices Commission.

The proposed Conflict of Interest Code specifically enumerates each of the positions within the agency, which involve the making or participation in the making of decision, which may foreseeably have a material financial effect on any financial interest.

APPENDIX

Designated Position	Assigned Disclosure Categories
Board of Directors	1, 2
Chief Executive Officer	1, 2
Chief Financial Officer	1, 2
Chief Operating Officer	1, 2
Chief Nursing Officer	1, 2
Chief Clinical Officer	1, 2
Chief Public Relations Officer	1, 2
Chief Human Resources Officer	1, 2
Chief Medical Officer	1, 2
Chief of Staff	1, 2
Director of Nursing	1, 2
Director of Clinical Services	1, 2
Director of Tri County Community Network	1, 2
Director of Operations	1, 2
Director of Quality and Risk Management	1, 2
Director of Safety & Security	1, 2

Disclosure Categories

Category 1:

Investments and business positions in any business entities and sources of income of the type which, within the last two years, has contracted with this District to provide services, supplies, materials, machinery or equipment.

Category 2:

Interests in real property, located in whole or in part within two miles of any land owned, used or contemplated for use by the District.

*Consultants shall be included in the list of designated employees and shall disclose pursuant to the broadest disclosure category in the code subject to the following limitations:

The Executive Officer may determine in writing that a particular consultant, although a "designated position", is hired to perform a range of duties that are limited in scope and thus, is not required to fully comply with the disclosure requirements described in this section. Such written determination shall include a description of the consultant's duties and, based on that description, a statement of the extent of the disclosure requirements. The Executive Officer's determination is a public record and shall be retained for public inspection in the same manner and location as this Conflict of Interest Code.

_____

Ryan Harris, MBA
Chief Executive Officer
Mayers Memorial Healthcare District

_____

Date

MMHD Burney Annex
Pin 74 Project

Estimated Costs		Notes
Aspen Street Architects Inc.	$ 122,110.00	
Generator with belly tank	$ 125,000.00	est. range $100-125K
Exterior Lighting at generator	$ 15,000.00	est. range $10-15K
Concrete pad/bollards or fencing	$ 20,000.00	est. range $15-20K
ATS (pad or wall mounted)	$ 25,000.00	For the pad -- est. range $20-25K
Feeders between generator/ATS	$ 30,000.00	est. range - $25-30K -- If generator is located on other side of building, might be around $80-125K, would look into 480V generator and step down transformer to 208Y/120V
Distribution/panelboards serving AC loads	$ 20,000.00	est. range - $15-20K
Re-feed AC units from new panelboards	$ 15,000.00	est. range - $10-15K
Totals (high end)	**$ 372,110.00**	
With contingency	$ 100,000.00	suggested to escalate with contingency by at least $100-150K
Total	**$ 472,110.00**	

ORACLE

Attachment L

Budgetary Quote

Quote #
CPQ-3416524

Quote Valid Until
30-NOV-2024

Currency
USD

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

Contact
5303365511
Ryan Harris
rharris@mayersmemorial.com

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

Account Manager
Matt J Wilson
matt.j.wilson@oracle.com

Fee Summary

Fee Description	Net Fees	Monthly Fees	Annual Fees
Recurring Services - New Service	--	6,051.00	--
Professional Services -- Fixed Price - New Order	9,372.00	--	--
Professional Services -- Estimated Expenses - New Order	1,500.00	--	--
Total Fees	**10,872.00**	**6,051.00**	**0.00**

Ordered Items

Recurring Services

Part Number	Description	Term	Pass-Through Code	Quantity	Unit Net Price	Extended Monthly Fees
B101650	**i2iLinks - Interface** [Mfg Part Num: LINKS]	36 mo	3rd Party	1	1,495.00	1,495.00
B101652	**i2iTracks (Up To Quantity) - Covered Lives** [Mfg Part Num: TRACKS]	36 mo	3rd Party	7,500	0.6075	4,556.00
					Subtotal	6,051.00

Professional Services

Professional Services - Fixed Price

Part Number	Description	Pass-Through Code	Net Fees
B104249	**i2i Implementation - Client** [Mfg Part Num: IMPLEMENTATION]	3rd Party	0.00
B107551	**i2i Integration**	--	9,372.00
		Subtotal	9,372.00

Professional Services - Estimated Expenses

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

This pricing example is provided for evaluation purposes. This quote is intended to further our discussions, it is not eligible for acceptance by you and is not a part of a binding contract between us for the products and/or services specified. User minimums and licensing rules may apply to the products specified. If you would like to purchase the products and/or services specified in this draft quotation, please ask Oracle to issue you a formal Quote (which may include an Oracle agreement if you do not already have an agreement with Oracle) for your acceptance and execution and return to Oracle. Your order will be effective only upon Oracle's acceptance of the formal Quote (and the Oracle agreement, if required).

Director of Operations Report
Prepared by: Jessica DeCoito, DOO

Facilities, Engineering, Other Construction Projects

- Our Criteria Document meetings continue to take place weekly. We met internally to review the budget provided by Aspen Street and examine where we could make changes to lower the cost and align with the budget figure we have set.
- Fall River Rural Health Clinic drawings are scheduled to be received the week of September 16th. At that point they will be submitted to the county for approval. After final review, we will engage with legal counsel to begin our RFQ/RFP process.
- The Solar Project is still in a holding pattern. This past week, the panels were scheduled to be delivered onsite. We have not received final approval from Shasta Co. but have stressed the urgency to get these plans approved to get the project work going before the winter months.
- The Burney Fire Alarm Panel project has made significant strides this past month. Duct detectors were installed, and wiring was completed. We are currently working on scheduling Shasta Controls to finalize connections to HVACs, hopefully for the 23rd. We then can begin our closeout processes.
- Our temporary automatic transfer switch project repair has been completed and closed out with all regulatory parties.
- FS Medical was onsite Monday, September 16th, to finalize the inspection on the med gas panel. The panel passed all the required testing, and there is a small issue with supporting some of the existing conduit that houses the signal wires coming from the oxygen yard. Maintenance completed the required supports on September 17th, and the IOR will do his final inspection on his next trip to inspect the fire panel in Burney. The panel is fully operational.
- On Wednesday, September 11th, a water leak was identified outside the ambulance garage. The Maintenance team quickly went into action to discover the leak and set up a plan for repair at 12:30 pm. Luckily, the ambulance garage was the only department affected by this leak. However, to repair the leak, the team had to shut the water off to the entire hospital, which occurred around 3:00 pm. Maintenance notified all hospital departments of shut off and supplied each area with water jugs before the water was shut off. In addition, the Maintenance team provided overhead pages providing departments with 5-minute notifications and a final notification. The team repaired the leak, and the hospital was back up and fully functioning by 6:23 pm that night. Maintenance checked in with departments before they departed for the night and notified each station to call the Maintenance on-call number if any other issues arise. A big thank you to our Maintenance team for jumping in and tackling this leak.

Dietary

- On Thursday, September 5th, our Dietary team had a well-deserved break from their usual routine to enjoy a special lunch at Pit River Lodge. Susan and Jen prepared the delicious food and drinks, while Joey Marchy crafted the dessert. The assortment of treats was a

heartfelt gesture to show our appreciation for their hard work. It's not every day that we get to turn the tables and provide lunch for them. This day was dedicated to celebrating and recognizing their efforts. A big thank you to our Dietary Team for your unwavering commitment to delivering nutritious meals to our patients and residents.

- We are replacing equipment on the Burney Kitchen refrigerator. This will mitigate the interruption of workflows, loss of food supplies and unit downtime.

Employee Housing

- The lodge's water issues have been minimized. Joey and the Maintenance team worked to clean out all the tanks and, with the help of Fall River Valley Community Services District, provide proper treatment for better water quality.
- H2O Pro provided a quote for replacing the current pump end with a new 5 HP 10 GPM pump end with existing motor and flow restrictor set to original depth of 316' on the existing 2" schedule 80 drop pipe. This should hopefully fix our problems.

MMHD Burney Annex
Pin 74 Project

Estimated Costs		Notes
Aspen Street Architects Inc.	$ 122,110.00	
Generator with belly tank	$ 125,000.00	est. range $100-125K
Exterior Lighting at generator	$ 15,000.00	est. range $10-15K
Concrete pad/bollards or fencing	$ 20,000.00	est. range $15-20K
ATS (pad or wall mounted)	$ 25,000.00	For the pad -- est. range $20-25K
Feeders between generator/ATS	$ 30,000.00	est. range - $25-30K -- If generator is located on other side of building, might be around $80-125K, would look into 480V generator and step down transformer to 208Y/120V
Distribution/panelboards serving AC loads	$ 20,000.00	est. range - $15-20K
Re-feed AC units from new panelboards	$ 15,000.00	est. range - $10-15K
Totals (high end)	**$ 372,110.00**	
With contingency	$ 100,000.00	suggested to escalate with contingency by at least $100-150K
Total	**$ 472,110.00**	

Human Resources Department Report

September 2024

Submitted by Libby Mee, Chief Human Resource Officer

Staffing, Recruitment, and Retention

- **Current Workforce**: Our Human Resources/Payroll/Benefits department supports 312 active employees.
- **Ongoing Recruitment Efforts**: We are collaborating with specialized recruitment agencies to find suitable candidates for key positions including Chief Medical Officer (CMO), Emergency Department Providers, Rural Health Clinic Provider, Pharmacist, Infection Prevention, Hospitalist/NP, Physical Therapist, and Skilled Nursing positions. Interim professionals are currently fulfilling roles in Pharmacist, Infection Prevention, Hospitalist, and Skilled Nursing Director of Nursing positions.
- **Expanded Recruitment Resources**: To address the challenge of finding candidates for the Retail Pharmacy Pharmacist position, we have engaged an additional recruitment firm to broaden our search.
- **Active Interviews and Site Visits**: We have conducted additional interviews and site visits for permanent CMO, Clinic Director positions, Infection Prevention RN, and Physical Therapist roles. We are also interviewing candidates for Food and Nutrition Services department positions. Updates of these applicants will be provided in the monthly meeting.
- **High School Volunteer Program**: We are hosting three junior volunteers from Fall River High School. Two students interested in Nursing will shadow our Nursing department, while a third student interested in Human Resources and Business will shadow the administrative team.

Miscellaneous Updates

- **ACHC Accreditation**: We are nearing completion of HR-related content for our ACHC accreditation and are monitoring compliance with updated education and training requirements. Implementation of the Kahuna compliance software system is progressing, which will enhance our ability to track and monitor compliance across various learning systems. We are also planning a site visit to Tahoe Forest to address remaining questions about HR ACHC content.
- **Annual Compliance**: Employees are currently completing their Annual Re-Orientation content via Relias. In October, they will undergo Employee Health compliance, including annual physicals, TB screenings, FIT testing, and updating immunization records.
- **California Hospital Association Site Visit**: I recently met with members of the California Hospital Association to discuss our plan to create an in-house nursing program. The conversation highlighted potential challenges but also the significant value of

establishing such a program in rural facilities. Ongoing discussions with CHA and the Board of Nursing will be crucial for the success of this initiative.

- **Gig/Shared Workforce**: We are exploring a system/app with local rural hospitals to share Per Diem staff. This initiative could help fill open shifts without relying on external registry services. I plan to present this proposal at the next regional quarterly CEO meeting to discuss its feasibility and potential implementation steps.

Pillar Goal – Communication

- **Patient Satisfaction Program**: I am excited to serve as an executive sponsor for the communication pillar related to the development of our patient satisfaction program. I look forward to providing updates as we implement the project.

MAYERS MEMORIAL HEALTHCARE DISTRICT

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

Positions:	# available:
***Acute Hospitalist**	1- POSITION CURRENTLY BEING FILLED BY INTERIM
***Director of Skilled Nursing**	1- POSITION CURRENTLY BEING FILLED BY INTERIM
Hospice Home Health Aide	1- PER DIEM
***Independent Retail Pharmacist**	1- POSITION CURRENTLY BEING FILLED BY INTERIM
***Infection Prevention RN**	1- POSITION CURRENTLY BEING FILLED BY INTERIM
***Pharmacist**	1
***Physical Therapist**	1- POSITION CURRENTLY BEING FILLED BY TRAVELER
Rural Health Clinic Med Director/Physician	1
Skilled Nursing CNA	16
Skilled Nursing LVN or RN	14
Skilled Nursing Charge Nurse	1

Chief Public Relations Officer – Valerie Lakey
September 2024 Board Report

Legislation/Advocacy

Now we wait to see what the governor signs or vetoes. Here are a few highlights. After everything is finalized, I will have a complete report.

SB 1432 was CHA's proposal to address the 2030 seismic requirement. Specifically, the bill would have provided up to an additional five years, depending on the project timeline, at the discretion of the Department of Health Care Access and Information. The bill would have also required the state to consider the complexity of a seismic construction project and the impacts on healthcare access when determining an extension to the 2030 requirement. THE GOVERNOR VETOED the bill. The Legislature passed — without a single "no" vote from the Assembly or Senate. This is very disappointing after significant effort went into this bill.

AB 869 would allow certain rural hospitals and district hospitals to delay the 2030 deadline by up to three years and an additional two years depending on their financial need or if they are experiencing construction delays. Transparency and accountability measures are also included. Amendments taken in the Senate Appropriations Committee add distressed hospitals. The bill is pending the governor's signature.

AB 2975 would require the Division of Occupational Safety and Health (better known as Cal/OSHA) Standards Board to amend the existing Workplace Violence Prevention in Health Care standards to require weapons detection screening monitored by trained non-patient care personnel at a hospital's main public entrance, emergency department entrance, and labor and delivery entrance, if separately accessible to the public. Amendments taken in the Senate Appropriations Committee require the Cal/OSHA Standards Board to amend the standard by 2027 instead of 2025, among other amendments. Pending the governor's signature.

Grants

Laura Beyer has recently expanded her role beyond grants for MHF to overseeing grants across the board for MHF, TCCN, and MMHD, including the ongoing MMHD SHIP and FLEX grants. This will help with overall coordination, oversight, and compliance with grant requirements across all entities. Val, Laura, and Marrisa attended a grant training seminar hosted by HCAI last month that provided basic training and more advanced tips and support.

We have been focusing on researching various grant opportunities for both programmatic and operational funds. A few potential opportunities are currently being pursued, including a cybersecurity grant through CalOES, behavioral health facilities through the CA Department of Health Care Services, and some private foundation funds.

If you hear of other potential opportunities, please forward them for review. To help with oversight and streamlining, Laura will also work on better organizing past and ongoing grant information so that access is easier, common documents are readily and quickly available, and consistency is ensured across the three entities.

Internally, the annual departmental awards round and fall employee scholarships round will be announced soon and North State Giving Tuesday is coming up soon.

Public Relations/Marketing

Inter-Mountain Fair Booth Preparation: The Inter-Mountain Fair was a success. The indoor booth turned out great and was staffed by many MMHD employees. The Mobile Clinic served as a great GIANT BILLBOARD and first aid station. Thank you to all who helped. MMHD also sponsored the hand washing stations at the fair again this year.

Department Marketing: We are focused on meeting with outpatient department managers to strategize marketing to meet this year's strategic goals and QIP measures. We have a solid plan in place. Targeted marketing will be utilized for much of the QIP work. We have established lists in the areas of needed mammograms, colonoscopies, and well-child visits.

Commercial Spot: The commercial is complete. View it here: https://youtu.be/irfGLI7x7Ns

Community: We are planning a Thank-you mixer for local providers on October 9th. It will be an opportunity for service department managers to meet with providers in an informal setting.

We participated in the California Special District Associations Special Districts tour representing District Hospitals. This event included 30 staffers from the legislature.

Strategic Goals: This division is working on the Communication and Growth Pillars. In addition to marketing, we are reviewing surveys and working with a consultant to develop a plan.

Mayers Healthcare Foundation

Golf Tournament
The department benefiting from the Golf Tournament is TCCN. The MHF policy awards 75% of the event's net profits. TCCN will receive $13,408.22

Denim & Diamonds Hospice Winter Gala (January 25, 2025)

Tickets for Dinner and 1968 are now available. This is sure to be another great event! CLICK HERE for Information.

MEG Fund - We now have 34 employees who regularly give to the Mayers Employee Giving Fund.

Department Grant Awards – The Department Grant Award Cycle has begun. Managers will have the opportunity to apply for grants that will be awarded before the end of the year.

MHF is implementing a new donor software, which will save us 4500 annually. We are in the process of setting up the program and transitioning from Donor Perfect.

Tri-County Community Network

Children's Programs

Bright Futures began establishing a strong presence in the Inter-Mountain Community in August and September. Notably, this month, they are preparing for a free Child Car Seat Safety event on September 19. This event is a cross-agency collaboration with First 5 Shasta, Shasta Public Health Services, the Burney Fire District, and Pit River Health Services.

September also marks the start of Tiny Tunes being introduced to Elementary School T-K programs in Fall River, Burney, Big Valley, and the Shasta Head Start program in Burney. Bright Futures continues to provide services to Round Mountain's preschool program, the Munik'chun Daycare, and both Burney and Fall River Libraries. Numbers continue to increase at public events, and Bright Futures is serving an estimated 120 children and their families monthly.

Triple P parenting support services are now available with Bright Futures' Family Advocate Kiely. TCCN will advertise these services on all social media platforms, at parenting events, and through the FRJUSD community connectors.

BOTVIN Life Skills Training (LST) begins at both Fall River Elementary and Burney Elementary on September 17 and will continue through the spring. LST will teach resiliency skills such as understanding advertising, making smart choices, identifying healthy relationships, and building self-advocacy skills. An estimated 220 4th-6th graders will benefit from this grant. This program is funded through a generous grant from the Shasta County Asset Forfeiture grant. The grant will be used to purchase curriculum, provide mileage reimbursement, and cover an educator stipend.

Grants/Grant Programs

TCCN continues collaborating with Pathways to Hope to bring Parent Cafés to the area. The first café was offered on August 8 at the Word of Life Church in Burney, where 10 parents and guardians enjoyed dinner and an evening of sharing their parenting journeys. September's café saw similar numbers and continues to receive positive feedback. Marrisa and Kiely will also join Pathways to Hope in December for training to host Parent Cafés. Funding for the training comes from the Community Foundation of the North State.

The Community Foundation of the North State awarded TCCN a $10,000 grant as of June 17. The funds must be spent by December 31. The grant will be used to purchase new furniture for the Intermountain Community Center front foyer, host a weekly coffee hour for seniors, and provide health education workshops for the community.

TCCN is partnering with the Mt. Senior Center to offer a weekly coffee hour at their facility. The event will be free to seniors 60 and older and open to the public. The program will be partially funded through this grant, with future funding pursued through the Redding Rancheria Fund.

Back-to-school night events were hosted at both FRE and BES to promote children's health and increase well-child appointments at the Rural Health Clinic. Grant funds will be used to purchase raffle prizes for both events. The Burney Back-to-School night was held on Thursday, September 12, and 22 children were signed up by their parents for a well-child visit at the MMH clinic.

TCCN is collaborating with MMHD departments to schedule events promoting outpatient services.

Partnerships

TCCN is continuing its partnership with SMART to bring employment services to our area. They will be providing services from our temporary offices in McArthur. Three people attended on September 5 and received employment support. The SMART representative said the four-hour "pop-up" event was a success.

TCCN is partnering with the Healthy Brain Initiative to offer classes focused on healthy aging and self-care for caregivers. Samantha Weidner presented the benefits of telemedicine at the September 12 event, which was a collaboration between TCCN, the Healthy Brain Initiative, and the Sierra Senior Living Apartments. Ten seniors attended and received information on healthy living for the brain and an introduction.

TCCN is restarting IMAGE (Intermountain Action Growth and Education). The second IMAGE meeting was held on Tuesday, September 10. More community stakeholders attended, and it was very productive. A plan has been formulated to administer a community needs assessment. The agenda for the November meeting will include creating a rough draft of the questionnaire and compiling a list of community stakeholders to help administer the assessment.

Website

The new website has been launched. It features a community calendar, a health spotlight, employment/housing information, a learning library, and more!

Community Events

Bright Futures is offering multiple weekly events for children ages 0-5.

September 19 – Car seat safety event at the Burney Fire District, in collaboration with Pit River Tribe, First 5 Shasta, and Shasta Public Health.

September 19 – Fall River Elementary School back-to-school night.

BOTVIN Life Skills Training will be held every Monday and Tuesday at Fall River Elementary School and every Wednesday and Thursday at Burney Elementary until May.

September 28 – Healthy Brain Initiative collaboration at TCCN temporary offices.

Intermountain Community Center Building Update

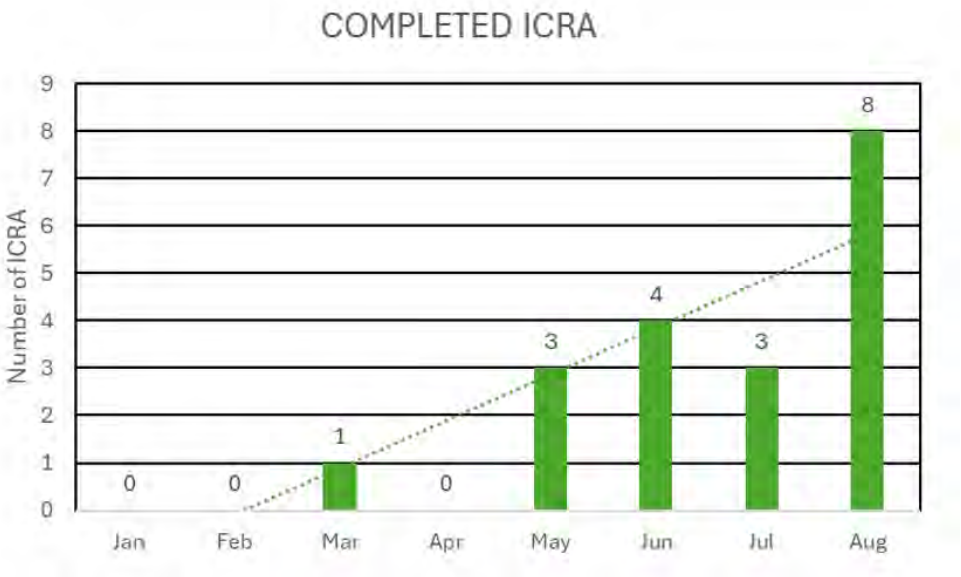
Plans for phases one and two of construction have been submitted to the Burney Fire Department for approval. Phase one includes building a door to separate the event area from the children's program area. Phase two includes permitting for previous construction and using all office space.

September Board Report
Clinical Division
9/13/2024

The managers are excited to participate in an upcoming provider outreach. Hospital Pharmacy, Retail Pharmacy, Physical Therapy, and Cardiac Rehab have their annual board report this month and are not included in this report.

Infection Prevention

- We are adding Profend® Nasal Decolonization to formulary. This product decolonizes MRSA, allowing patients to be removed from contact precautions. We are working on a decolonization protocol. The MRSA screening process has been simplified to align with the applicable statutes.
- Antibiogram is complete and approved. It will be distributed the week of September 16th.
- Appropriate masking was recently put in place at NS2 skilled nursing for COVID-positive staff members. Masking has been lifted and no residents were infected.
- Erin Glebe, LVN, Employee Health Nurse, continues educating managers and staff on employee illness via the Mayers Minute and WINKs. The Infection Control Committee reviewed and approved the Employee Health (EH) Infection Prevention Program.
- Amy Marinski, Infection Preventionist, worked with a representative of PDI to provide in-services to environmental services personnel. PDI manufactures many of our cleaning supplies. Amy is performing quality assurance and training for environmental services personnel with verification by fluorescence.
- Kudos to the maintenance staff for embracing IP standards. When construction or repairs are made, an Infection Control Risk Assessment is completed to protect patients/residents/staff from potential infection or contamination. Some measures to control infection include draping and the use of the HEPA cart.



- Rowan Dietle, marketing, and Amy have made a hand-washing logo for Mayers as we continue championing handwashing.

Laboratory

- We are moving forward with the Quantiferon Gold TB PCR. The analyzer will test for tuberculosis and chlamydia in-house in about an hour. Tuberculosis screening is needed for:
    - Employees, volunteers, and residents annually.
    - Outpatient medical patients are treated with immunomodulators, specifically abatacept.
    - Patients with suspicion for TB. Patients must stay in a negative pressure room in the ER before going to the floor until TB is ruled out.
    - Employees in the education sector.
- Sophia Rosal, CLS, laboratory manager, is working with infection prevention and nursing to reduce the blood culture contamination rate through staff tracking, general training, and one-on-one training.

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	
Oct	
Nov	
Dec	

Respiratory Therapy

- The interface between the Nova ABG machine and CERNER is live for arterial samples. This has been a 5-month process. Jeff Miles, Mayers IT manager, is working to complete the validation for venous and capillary samples.
- The department will be working with marketing and public relations on outreaches to the agriculture and timber sector for mask fittings.
- The department is geared up for annual all-employee mask fittings in October.

Imaging

- Fuji PACS for implementation is on track. Weekly implementation calls have started between Harold Swartz, Imaging manager, Jeff Miles, IT manager, and Fuji. The test server is in place, and a backup server will be available soon. Harold is attending training the week of October 13. The target go-live is mid-November.
- We had some issues with credentialling Nighthawk radiologists. The problem has been resolved.
- The ACR CT accreditation is on track. One additional CT image has been requested and provided in the review process.

NURSING SERVICES BOARD REPORT

September 2024-Reporting for August

CNO Board Report

- Welcome our new Interim DON. We are very excited to have her working with us!
    - Evaluating the reporting guidelines for the Star Rating for SNF.
- Have consulted with Libby in HR regarding Safe Patient Handling Program. Discussed the level to which our facility wants to participate. Currently, we have met the compliance of this mandate. We will assure compliance with new-hire orientation and yearly skills fair.
- Awaiting CDPH self-report findings.

SNF

Monthly Board Report

- Census- (78) Fall River- 33 Burney Annex- 25 Memory Care- 20
- Two Unit Assistants started the CNA at Modoc. One Unit Assistant completed the CNA program on 9/14 and is pending a test date.
- Continuing to struggle with staffing in-house nurses. Medifis and NPH are meeting our needs at this time to maintain staffing ratios and RN coverage.
    - Continuing with recruitment efforts.
- SNF Billing and Coding have been working on capturing provider visits in Cerner to allow for proper charge captures.
- CDPH Surveyor visited Burney Facility this month to review self-reports. Awaiting potential Tag communication regarding resident elopement. Several self-reports pending review.

Acute

August 2024 Dashboard

- Acute ADC: 1.52
- Acute ALOS: 3.875
- Medicare ALOS: 2.7
- Swingbed ADC: 2.61
- Swingbed ALOS: 8.92
- OBS Days: 4

August Staffing

- **Staffing Requirements:** We have successfully filled all key positions, requiring 8 full-time equivalent (FTE) RN/LVNs, 2 part-time equivalent (PTE) RNs, 4 FTE CNAs, and 2 FTE Ward Clerks to maintain optimal department operations.

- **Utilization of NPH Staff:** We are currently utilizing 0 FTE NPH RN/LVN. The occasional shift is being filled when our per diems are unavailable. We started the month with 2 FTE NPH RN/LVNs but reduced this to 0 by the end of the month.
- **Orientation Completion:** Fortunately, our final orientee completed orientation a couple of weeks early, confident in the skills learned and ready to work independently. This early completion has helped fill some critical staffing gaps that arose unexpectedly.

Updates

- **ACHC Accreditation Progress:** We continue to advance our ACHC accreditation efforts by implementing the revised policies we've focused on over recent months. We are now developing and delivering comprehensive education courses across multiple platforms, including live sessions scheduled for October and early November. This approach is designed to ensure in-depth staff training and reinforce adherence to ACHC standards.
- **Audit Tool for PI Measures:** The audit tool for tracking ACHC-required PI measures is now in its second month of use. Focused training has been conducted on key elements, resulting in continued improvement in compliance. The audit process has also identified areas for further education, particularly in charting and workflows, offering important opportunities to enhance both adherence and operational efficiency.

Emergency Services

August 2024 Dashboard

- Total treated patients: 379
- Inpatient Admits: 18
- Transferred to higher level of care: 24
- Pediatric patients: 64
- AMA: 2
- LWBS: 3
- Present to ED vis EMS: 42

August Staffing: Required 8 FTE RN, 2 PTE RN's, 2 FTE Tech's

- Utilized 2 FTE contracted travelers.
- ED Manager covering gaps in shifts coverage between travelers. She continues her role as Clinical Project Manager for Cener
    - Several high-level calls with Wipfli consultants
    - Continued resource for the clinical areas in the facility
- **Open positions**:
    - FTE Days- Lillian Consiglio started her 6-month orientation in the ED this month.
        - Working with SRMC to develop and implement a shadow process in the ED.
    - FTE NOC- OPEN

Updates:

- Centering staff education around ACHC guidelines
    - Policy sign offs each month.

    - 8-hour in person education scheduled for 10/30 and 11/6
- Trauma Nurse Core Course (TNCC) Class to be held on September 16th and 17th.
- Continue to improve chart check processes to increase captured revenue and avoid late charging, while improving charting standards.
- 8-hour de-escalation training scheduled for 10/9 and 10/10
- In alignment with ACHC standards, we have completed a comprehensive Ligature Risk Assessment and Mitigation Plan, developed in collaboration with safety, facilities, and departmental staff.
- In partnership with MHOAC, we have enrolled in the California Hospital Bed Capacity Project, set for implementation in Fall 2024. This initiative is designed to automate bed reporting, enhance patient outcomes, improve emergency coordination, and optimize hospital resource utilization without adding administrative burdens.

Ambulance Services
For the month of August:

- 57 ambulance calls.
- 5 transfers.
- 1 day of coverage for Burney FD for a 12-hour period, on August 29th.
- Jr High School Rodeo-
    - We provided ambulance standby coverage.
- Fair-
    - We provided ambulance coverage for several events.
    - no serious injuries or issues encountered.
- We had our yearly SSV EMS ambulance inspections. All went well with no issues of concern encountered.

Outpatient Surgery
August:

- 19 - Referrals received
    - 6 - Scheduled
    - 6 - Rejected (BMI > 45, Medically complex, or Procedure not performed)
    - 1 - Pending insurance clearance
    - 1 - Called patient and unable to reach or patient does not want to schedule at this time
    - 5 - Needs Nurse review
- 14 - Outstanding/ Pending referrals received prior to July
    Pending Reason breakdown:
    - 8 - previously scheduled and cancelled (unable to reach or patient does not want to reschedule at this time).
    - 6 – Unable to reach patient or patient does not want to schedule at this time.

Procedures Performed	**08/26/2024**	**08/27/2024**	**08/28/2024**		
Colonoscopy	**3** **(4 scheduled, 1 patient No-show**	**3** **(4 scheduled, 1 cancelled patient did not stop taking Plavix)**	**2** **(3 scheduled, 1 patient cancelled by her PCP due to abnormal EKG)**		
EGD	**1**	**0**	**0**		
Colonoscopy/ EGD Combo	**1**	**0**	**1**		
EGD + balloon dilation	**0**	**1**	**0**		
Total cases Performed	**5**	**4**	**3**	**Monthly Total:**	**12**

- Referrals continue to come in from local clinics, 19 referrals were received in August. 5 were rejected for General Surgery procedures or requiring a clinic evaluation.
- **Department Development:** Continuing work to meet ACHC, AORN, and AIMI standards of practice.
- AC #17 in OR 2 was repaired with a new compressor and is in working order. Discussing possibility of opening OR #2 for minor surgical procedures as it meets Air exchange requirements. We rejected 5 General Surgery referrals in August as we are not currently able to accommodate these procedures.

Outpatient Medical

- Our part-time employee is in the process of training and doing extremely well. She is completing competencies in OPM and continues to learn.
- Census OPM:
    - August 96 patients

  - July 104 patients
  - June 91 patients
- Conducted MMHD commercial with the direction of Val's team. The commercial involved Dr Magno, a patient and OPM staff to increase census.
- Continue to work with Tara from Wipli. She has been a great help, and we are currently working on a few process flow issues with the referral process and blood orders. We are looking forward to having her onsite for real-time issues being worked on.
- OPM Pyxis machine has been the challenge now. Due to high temperatures the Pyxis was removed from OPM. We met with Pharmacy, Maintenance, and others to come up with a plan for the future placement of OPM Pyxis. Where it currently resides has a water valve and can't stay there due to ACHC requirements. Maintenance is working on the plan to get the work on the team's schedule. The pharmacy team worked with Pyxis and was able to get our patients properly populated in the system. There is still a ticket in because we are unable to find OPM patients in other Pyxis machines.
- Continued work on policies. Working more with the new Lippincott.
- Worked with HR and DON to plan for upcoming maternity leave coverage. We have a plan in place and will need to have the part-time current employee start by getting up-to-speed training.
- Needing more privilege providers for OPM. Mercy oncology is mostly locums which is a challenge with orders for OPM. MVHC has had a lot of changes in their provider staffing. Two providers left this last month. I have gotten feedback that the provider portal is not easy, and a lot of the questions don't pertain to mid-level clinical staff. I believe it is imperative as a hospital to gain more privilege providers if we want to increase our census by 5% in the Outpatient setting.
- A meeting is set up soon to work on marketing for OPM.
- The OPM manager will be attending a provider appreciation when details arise.
- IP infection prevention is working on utilizing ultraviolet light to help lower the risk of microbes in OPM, especially after high census days such as wound clinic.

Social Services

August 2024

We had 4 new LTC admissions in August.

3- admissions to our Fall River Campus

1- Admission to our Burney Campus

Updates:

- I have been asked to serve as a representative for the County on the Older Adult Policy Council. This would help keep Eastern Shasta County on the radar when offering services to our older population.
- I have started working on my Pillar Goals this last month.
- Our new DON for skilled has started her work here. She will be a wonderful addition to our team.

Activities

August 2024

- Over the past month the residents went out to lunch at Jose's family dinner in Redding, Ca, they went on a trip to alpine for Frosties, Hereford ranch to look for evidence of the season changing by looking at the trees along the way. We also saw cows, horses, and deer on that trip.
- The residents enjoyed fun at the fair this year. They checked out the exhibits, showed animals, ate some fair food and brought some back for the people eagerly waiting at the facility.
- The activity department met up with a senior who is doing her senior project with the staff and residents at the annex. The plans are for her to assist with the family holiday events as well as assist the activity department with portions of their 2025 priorities if needed.

Respectfully Submitted by Theresa Overton, CNO

Chief Executive Officer Report
Prepared by: Ryan Harris, CEO

ACHC Accreditation
We are making ongoing progress toward our ACHC accreditation, concentrating on education. While there are still some outstanding tasks to address, we have made sufficient strides to proceed with our application submission on October 15th.

Provider Search Update
We are making steady progress in filling our provider openings. We have extended an offer to a CMO candidate and await their acceptance. Additionally, we have a hospitalist and an ER physician who are interested in joining our team. We are also scheduled to host a medical director and clinic provider on September 20th. If everything proceeds as planned, this will complete our medical staff.

Collaboration
- Collaboration with Tahoe Forest
    - I am coordinating with Louis Ward, CEO at Tahoe Forest, to arrange a visit for our ACHC team to their campus. As an ACHC accredited facility, Tahoe Forest provides an excellent opportunity to collaborate and address outstanding ACHC challenges within our divisions and departments.
- CHA and California Hospital Council
    - Mayers Leadership recently met with the California Hospital Association (CHA) and the California Hospital Council to enhance relationships and discuss ongoing and new issues. This meeting proved productive and offered valuable insight for their staff regarding the operations of critical access hospitals, which will aid their advocacy efforts.
- Modoc Medical Center
    - On Thursday, the District's Facilities and Engineer Manager and Chief Public relations officer (CPRO) and I attended the topping-out ceremony for Modoc Medical Center to express our support. The event was well-attended, and the overall sentiment was enthusiasm for the new building and its anticipated impact on the local community.
- Mountain Valley Health Center
    - Shannon Gerig, CEO of Mountain Valley Health Center (MVHC), and I had our first call together since I assumed my new role. Our conversation lasted longer than scheduled, as we had numerous topics to address. Key discussion points included offering them assistance with housing for urgent needs, the possibility of MVHC providing emergency dental services to our residents, and the potential

expansion to hygiene services in the future. We also explored opportunities for collaboration on grants and other initiatives to support our communities.

Conferences
Our Chief Nursing Officer, Clinic Manager, and I will attend the National Rural Hospital Association (NRHA) conference on Rural Health Clinics and Critical Access Hospitals from September 23 to 27. They will travel to the conference on Monday the 23rd, while I will join on Tuesday the 24th. This conference, focusing on Rural Health Clinics and Critical Access Hospitals, offers some of the best content in the field. Our team is eager to return with new insights and relationships to benefit our organization.

U.S. Department of Agriculture Meeting
On Wednesday September 11, Travis and I met with USDA representatives to discuss our ongoing project and explore potential funding opportunities. Leveraging his extensive experience with the USDA funding process, Travis has laid the groundwork for our application. We have also scheduled meetings with various banks to discuss additional funding sources. A key requirement was identified during this meeting, as we need to obtain three denial letters from these banks before the USDA considers our application. Our current finances could position us to secure both USDA and private funding, which will be crucial for the successful execution of our projects.

Plumas Healthcare District Meeting
The District's Director of Quality and I had a productive meeting with the Plumas Healthcare District (PDH) clinic manager and QIP manager. This meeting provided valuable insights into the I2I model and its effectiveness in meeting QIP standards at their clinics. Currently, Jack and I are focusing on strategies to reduce the costs and duration of the I2I contract, preparing for future discussions on how this tool has made PDH successful in QIP and how it could positively impact our program.

Patient Experience Priority
We are pleased to announce that Jen Miley will facilitate the priority initiative for the patient experience. Our initial focus will be improving referral processes to enhance patient experience through optimized operational protocols. The District's CHRO and Chief Human Resources Officers will serve as executive sponsors to ensure continuous progress toward the initiative's success. Additionally, our "Ignite the Patient Experience" event is coming up in November, aligning with our broader operational goals. Jack and his quality team are doing fantastic work to drive this important initiative forward.

ConferMED
Our Telehealth Coordinator, Clinic Manager, and I have decided to expand our telehealth services to all patients and specialties through ConferMED, a nonprofit telehealth organization based in Middletown, CT, specializing in asynchronous telehealth (eConsults) designed to enhance access to specialty care for medically underserved populations. This initiative will give patients timely access to specialty consultations without unnecessary face-to-face visits. By

facilitating rapid care access, it will reduce travel costs and healthcare-related risks, ultimately leading to improved patient outcomes. Additionally, our primary care providers will benefit from quick specialist insights, boosting their confidence and ability to deliver quality care that aligns with our patient experience objectives. Kim and her team are working with internal stakeholders from IT to billing to ensure a smooth transition before moving forward.

Regional Ambulances Services

This week, we received notice from the Sierra-Sacramento Valley EMS Agency (SSV) that Southern Cascades Ambulance has ended its ALS ambulance service as of August 31, 2024. It's concerning to see the discontinuation of ALS operations in our area, as this not only negatively impacts the residents they serve but also creates additional strain on other providers required to step in and cover the void. This situation has the possibility of threatening our capacity to maintain our services in the future, ultimately affecting the communities within our District.