MAYERS MEMORIAL HEALTHCARE DISTRICT

Board of Directors
Regular Meeting Agenda
December 6, 2023 @ 1:00 PM
Tri County Community Network
37477 CA-299
Burney, CA 96013

Mission Statement
Leading rural healthcare for a lifetime of wellbeing.

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

						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 –October 25, 2023		***Attachment A***	**Action Item**	1 min.
	3.2	Special Meeting – November 6, 2023		***Attachment B***	**Action Item**	1 min.
4	**DEPARTMENT/QUARTERLY REPORTS/RECOGNITIONS:**					
	4.1	Resolution 2023-15 – October Employee of the Month		***Attachment C***	**Action Item**	2 min.
	4.2	Hospice Quarterly	Lindsey Crum	***Attachment D***	Report	2 min.
	4.3	Mayers Healthcare Foundation Quarterly	Michele King	***Attachment E***	Report	2 min.
	4.4	Clinical Education	Brigid Doyle	***Attachment F***	Report	2 min.
	4.5	Construction Management	John Morris	***Attachment G***	Report	2 min.
5	**BOARD COMMITTEES**					
	5.1	**Finance Committee**				
		5.1.1 Committee Meeting Report: Chair Humphry			Report	5 min.
		5.1.2 October 2023 Financial Review, AP, AR and Acceptance of Financials			**Action Item**	5 min.
		5.1.3 Board Quarterly Finance Review			**Action Item**	2 min.
	5.2	**Strategic Planning Committee –** No November Meeting				

	5.3	**Quality Committee –** No November meeting			
6	**OLD BUSINESS**				
	6.1	BOD Assessment Survey Results	***Attachment H***	Discussion	10 min.
	6.2	Bylaws Review	***Attachment I***	**Action Item**	5 min.
	6.3	MVHC Discussion		Discussion	10 min.
7	**NEW BUSINESS**				
	7.1	Policies & Procedures: 1. Laboratory Staff Competency 2. Quality Assurance Program – Lab 3. STAT List of Tests and Results Reporting Turn Around Time	***Attachment J***	**Action Item**	5 min.
	7.2	Organizational Analysis	***Link***	Review, 1st Reading Discussion/ **Action Item**	10 min.
	7.3	Annual Organizational Process			
		7.3.1 Board Calendar	***Attachment K***	**Action Item**	2 min.
		7.3.2 Officers & Committees – will remain the same for 2024		Information	2 min.
	7.4	Tri Counties Community Network Partnership	***Attachment L***	**Action Item**	10 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 Chief Financial Officer – Travis Lakey		Report	5 min.
		8.1.2 Chief Human Resources Officer – Libby Mee		Report	5 min.
		8.1.3 Chief Public Relations Officer – Val Lakey		Report	5 min.
		8.1.4 Chief Clinical Officer – Keith Earnest		Report	5 min.
		8.1.5 Chief Nursing Officer – Theresa Overton		Report	5 min.
		8.1.6 Chief Operation Officer – Ryan Harris		Report	5 min.
		8.1.7 Chief Executive Officer – Chris Bjornberg		Report	5 min.
9	**OTHER INFORMATION/ANNOUNCEMENTS**				
	9.1	Board Member Message: Points to highlight in message		Discussion	2 min.
10	**MOVE INTO CLOSED SESSION**				
11	**CLOSED SESSION ITEMS**				
	11.1	**Personnel – Govt Code 54957** CEO Applicants Review		Discussion	1 hr.
12	**RECONVENE OPEN SESSION**				
13	**ADJOURNMENT: Next Meeting January 31, 2024**				

Posted 12/01/2023

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

Chief Executive Officer
Chris Bjornberg

MAYERS MEMORIAL HEALTHCARE DISTRICT

Board of Directors
Regular Meeting
Minutes
October 25, 2023 – 1:15 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 1:15 PM on the above date.

BOARD MEMBERS PRESENT:	**STAFF PRESENT:**
Abe Hathaway, President	Chris Bjornberg, CEO
Jeanne Utterback, Vice President	Travis Lakey, CFO
Tami Humphry, Treasurer	Ryan Harris, COO
ABSENT:	Theresa Overton, CNO
Tom Guyn, M.D., Secretary	Keith Earnest, CCO
Lester Cufaude, Director	Valerie Lakey, CPRO
	Libby Mee, CHRO
	Jessica DeCoito, Board Clerk

2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS:**		
3	**APPROVAL OF MINUTES**		
3.1	A motion/second carried; Board of Directors accepted the minutes of September 27, 2023.	***Humphry, Utterback***	***Approved by All***
4	**DEPARTMENT/OPERATIONS REPORTS/RECOGNITIONS**		
4.1	A motion/second carried; Diana Reynoso-Rodriguez was recognized as September Employee of the Month. Resolution 2023-14. Diana started out as an intern with MMHD and now she's with us full time. She has been in the Imaging department for a year now. She always has a great work ethic, a positive attitude and a happy face. She goes above and beyond her role and is always a patient advocate. Congratulations!!	***Utterback, Humphry***	***Approved by All***
4.2	Safety Quarterly: written report submitted. Very exciting to include the community into your Safety and Emergency Preparedness activities and training.		
4.3	Respiratory Therapy: written report submitted. David is currently attending a conference.		
4.4	Physical Therapy: written report submitted. Collecting Patient Satisfaction surveys. Working on a "Walk with a Doc" program to provide to the community, and includes other areas, not just PT – other areas would include Pediatric, Dentistry, Physician Assistants, etc. Developing the Safe Patient Handling program with nursing. Continue to navigate the new Cerner workflows.		
4.5	Employee Housing: written report submitted. Farmer's Market plans changed with a lack of interested farmers but plans are to pick back up in May. Joey will be attending college job shows to help promote MMHD as a place to stay while they work with us. Our occupancy rate is 86% for long term housing and 53% in short term housing.		
5	**BOARD COMMITTEES**		
5.1	**Finance Committee**		

	5.1.1	**Committee Report:** AR has gone up due to Cerner implementation but that was expected. New insurance benefit package will be a self-insured plan – our health and gap plans will remain the same but our vision and dental are changing. Travelers cost has been increasing due to LVN cost in SNF but we are working diligently to get our LVN program up and running by next year to grow our own. Our Acute and ED registry staff numbers have gone down.		
	5.1.2	**September 2023 Financials**: motion moved, seconded and carried to approve financials.	***Humphry, Utterback***	***Approved by All***
	5.2	**Strategic Planning Committee Chair Utterback:** No October Meeting		
	5.3	**Quality Committee:**		
	5.3.1	Draft Minutes attached. Lots of reports available in Cerner to give us the measures and metric data we need. Jack is busy with ACHC Readiness meetings. A new P&P template has been created for everyone to use to update their policies. Physical environment has a list of required improvements in order to meet the ACHC accreditation and our team is currently working on that.		
6	**OLD BUSINESS**			
	6.1	BOD Assessment Survey – Due by November 14th: please add a cheat sheet for the tallying.		
	6.2	By-Laws Review: update the mission statement and provide the updated version for approval at next meeting.		
7	**NEW BUSINESS**			
	7.1	**Policy & Procedure Summary**	***Utterback, Humphry***	***Approved by All***
	7.2	**Policies & Procedures:** 1. Blood Unit Issue/Return 2. Cannabis 3. Core Privileges in Neurology, Telemed 4. Hours of Operation 5. Lab Specimen Collection and Reporting Schedules 6. One Step Fentanyl Test Dip Card (urine) 7. Petty Cash - Clinic	***Utterback, Humphry***	***Approved by All***
8	**ADMINISTRATIVE REPORTS**			
	8.1	**Chief's Reports: written reports provided in packet**		
	8.1.1	**CFO:** New employee health benefit plans have been chosen. Retail Pharmacy has been cleaned up and financials look good. GPO came onsite and met with all the managers and lots of opportunities for savings.		
	8.1.2	**CHRO:** Direct marketing for pharmacists will be taking place. Added the "adjusted" turnover category to the employee stats. New legislation will be phased into the program, while some are sunsetting.		
	8.1.3	**CPRO:** List of legislative bills that passed is being created for each department. 525 – minimum wage bill – is tiered for different organizations/hospitals. June 1st, we have to move our minimum wage to $18. AB 242 gave us the ability to hire physicians, permanently. Website updates are being made. Volunteer Luncheon is November 15th – please join us at the lodge. Gift shop – thank you to Mary Jo McDermott for the help she is giving us. December 13th is our next Quarterly Community Event – Master Planning Review. Met with TCCN about possibility to collaborate with them and the opportunities we have. Check out the Denim & Diamond Gala for tickets, and the Mustang tickets!		
	8.1.4	**CCO**: A new Barrier Isolator has been purchased and installed and certified.		
	8.1.5	**CNO**: Burney Annex has a full census. Surgery – we have lost our interim manager but have transitioned a floor nurse into the Surgery role. We have hired a scrub tech who is very excited. We continue to have conversations with general surgeons to come on board.		
	8.1.6	**COO***:* The Compliance Team survey has been wrapped up. One thing that is awesome, is The Compliance Team will conduct our Patient Satisfaction Surveys. Criteria Docs for Master Plan have been reviewed and we will be setting up a meeting for Strategic Planning for our Board members to review those current drafts.		

	8.1.7	**CEO:** Discussions about working with CHA on possible creation of legislation to benefit California CAH and District hospitals. Discussion about the impacts of AB525 being approved took place. Kudos to our MMHD team in their Cerner transition, and to keep up with all of their responsibilities.	
9	**OTHER INFORMATION/ANNOUNCEMENTS**		
	9.1	Board Member Message: Solar Project, Employee of the Month, ACHD Finance Committee, Denim & Diamonds, Northstate Giving Tuesday, Flu Vaccinations, Mobile RHC, Thank you to Volunteers, Kudos to our MMHD Team as a whole	
10	**MOVE INTO CLOSED SESSION: 2:55 PM**		
		Medical Staff Credentials – Government Code 54962	
	10.1	AHP Reappointment Alexandra Conner, PA – MVHC Practitioner Medical Staff Appointment Edward P. Lane, DO – Pathology Sasikanth Gorantla, MD – Neurology (UCD) Melissa Asmar, MD – Neurology (UCD) Samantha Allen, MD – Neurology (UCD) Medical Staff Reappointment Jinno Magno, MD	**Approved by All**
11	**RECONVENE OPEN SESSION**		
12	**ADJOURNMENT: 3:40 PM** **Next Meeting December 6, 2023**		

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

MAYERS MEMORIAL
HEALTHCARE DISTRICT

Board of Directors
Special Meeting
Minutes
November 6, 2023 – 11:00 pm
FR Boardroom & Teams

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

1 **CALL MEETING TO ORDER:** Abe Hathaway called the regular meeting to order at 11:10 AM on the above date.

BOARD MEMBERS PRESENT:	**STAFF PRESENT:**
Abe Hathaway, President	
Jeanne Utterback, Vice President	
Tami Humphry, Treasurer	
Tom Guyn, M.D., Secretary	
Lester Cufaude, Director	
ABSENT:	

2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS: NONE**		
3	**MOVE INTO CLOSED SESSION 11:11 AM**		
	3.1	Personnel – Government Code 54957 CEO Resignation Discussion took place.	***Approved by All***
4	**RECONVENE OPEN SESSION 12:15 PM**		
5	**CEO RESIGNATION:** Motion moved, seconded and accepted resignation of CEO.		***Approved by All***
6	**NOMINATING COMMITTEE:** Will keep a two-year term on officers and committees.		
7	**OTHER INFORMATION/ANNOUNCEMENTS**		
8	**ADJOURNMENT: 12:20 pm** **Next Regular Meeting December 6, 2023 @ 1:00 pm**		

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

_____ Board Member

_____ Board Clerk

RESOLUTION NO. 2023-15

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

Sarah Skelly

As October 2023 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, Sarah Skelly is hereby named Mayers Memorial Healthcare District Employee of the Month for October 2023; and

DULY PASSED AND ADOPTED this 6th day of December 2023 by the Board of Trustees of Mayers Memorial Healthcare District by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

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

ATTEST:

_____
Jessica DeCoito
Clerk of the Board of Directors

Hospice Quarterly Report

Hospice began using their new EMR system Sept 1 and it has been a fairly smooth transition. We are still working with financing to get all the Medicare clearances needed to fully transition with the billing portions of the new system. We have weekly meetings to make sure that we have continued to document and put in billing correctly. We have also continued to do education with outreach programs and outside clinics to let them know about Hospice and how we can help them and their patients when the time comes for earlier referral. It seems that patients are continuing care longer and reaching out for homeopathic treatments when western medicine is no longer able to do treatments. We will continue to educate practitioners about referrals even if it is just to speak to families about future needs that might arise. The Road Gypsie summer show and shine was a success and Intermountain Hospice was presented with a check for $2200 donation.

Part of our pillar goals is to recruit more volunteers to specially help bring pet therapy to hospice. I have been able to recruit three volunteers who are in the beginning stages of becoming a volunteer. With that we have continued to work with potential animals that can be brought in for therapy. We have been in contact with SNIPP with questions we have had and we have also volunteered hours with SNIPP. Hospice staff also volunteered with the Fall River and McArthur cemetery to put flags on Veterans headstones for Veterans Day. In December the hospice manager and chief clinical officer will be going to Vegas to attend Hospice regulatory bootcamp to get all the 2024 updates for hospice regulations.

Thank you,

Lindsey Crum, RN Hospice Manager

People Pillar

Name: Lindsey Crum
Supervisor: Keith Earnest
Department: Hospice

Last Updated:

FY24 (July 1, 2023 - June 30, 2024)							
Priority:	**Weight**	**Bonus Amount**	**Specific Plan & Estimated Completion Date**	**Driver**	**Current Actions**	**% Complete By FY End**	**Bonus Amount Awarded**
Bring in pet therapy run by volunteer/staff for hospice patients. **Add 3 new volunteers in the area**				Lindsey Crum	Three new volunteer applications placed through Mayers for Hospice on 11/15/23		
Priority Ideas for Next Year 2.							

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

CEO Approval at End of Fiscal Year		
Christopher R Bjornberg		
CEO	Signature	Date

MAYERS MEMORIAL HEALTHCARE DISTRICT

Growth Pillar

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

FY24							
Priority:	**Weight**	**Bonus Amount**	**Specific Plan & Estimated Completion Date**	**Driver**	**Current Actions**	**% Complete By FY End**	**Bonus Amount Awarded**
Increase length of stay to 80% of national average.				Lindsey Crum	Continued education given to the Hospice Medical Director over early admission.		
Priority Ideas for Next Year							

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

CEO Approval at End of Fiscal Year		
Christopher R Bjornberg		
CEO	Signature	Date

Communication Pillar

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

FY24 (July 1, 2023 - June 30, 2024)							
Priority:	**Weight**	**Bonus Amount**	**Specific Plan & Estimated Completion Date**	**Driver**	**Current Actions**	**% Complete By FY End**	**Bonus Amount Awarded**
Complete outreaches quarterly to achieve earlier referral.				Lindsey Crum	Meetings with different outreach programs to educate about hospice		
Priority Ideas for Next Year							

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

CEO Approval at End of Fiscal Year		
Christopher R Bjornberg		
CEO	Signature	Date

Finance Pillar

Name: Lindsey Crum
Supervisor: Keith Earnest
Department: Hospice

Last Updated: 08/04/2023

FY24
(July 1, 2023 - June 30, 2024)

Priority:	Weight	Bonus Amount	Specific Plan & Estimated Completion Date	Driver	Current Actions	% Complete By FY End	Bonus Amount Awarded
1. Create Medicare Advantage admission form process to be used prior to admission into Hospice to receive payment on 70% of Medicare patients.				Lindsey Crum			
				Lindsey Crum			
Priority Ideas for Next Year							

For Completion at Beginning of Fiscal Year

Name	Signature	Date
Supervisor	Signature	Date
Executive Leader	Signature	Date

CEO Approval at End of Fiscal Year

Christopher R Bjornberg		
CEO	Signature	Date

MAYERS HEALTHCARE FOUNDATION

November – December Report to the MMHD Board

Events:

- **MHF "On the Green" –** a check for $18,653.37 was presented to the MMHD Ambulance. This was a result of the successful golf tournament. The amount is 75% of the net proceeds.

- **NSGT –** We participated in NSGT on November 28, 2023. We raised $25,705 from 98 donors! This includes $1000 as a prize for 100% MHF board giving. Laura Beyer headed up the effort and was joined by staff and board members to participate in soliciting donations throughout the day. Thank you to all MHF and MMHD board members and staff who participated and donated.

- **Denim & Diamonds Hospice Winter Gala –** January 27, 2024. We are full steam ahead on plans for the gala! This is going to be an amazing event. The caterer is secured and tickets are available for sale. We have a limited number of sponsored tables and already have some sold. The reverse raffle for the 1965 Mustang is going great and we are selling tickets steadily. We will be doing heavy PR on the event after NSGT. KRCR has agreed to donate the television advertising, which is a big bonus. We will be asking for help in many areas – so stay tuned and mark your calendars!

- **Annual Appeal** – The Annual Appeal went out this month. You can view a copy HERE. Along with the appeals that were sent to each boxholder, we have an additional 300+ going out to past donors outside of our district area. Special thank you to Rowan Dietle who worked very hard to put together this beautiful document.

Thrift Store Update: The Thrift Store will have expanded hours through Christmas.

Staff: Staff continues to go above and beyond! We have had questions about our staff structure and how it works. Simply defined – it is a great team effort and collaboration with MHF and MMHD. We have recently added this definition on our website:

> *The Mayers Healthcare Foundation staff is characterized by a collaborative and part-time structure, with personnel provided by the Mayers Memorial Healthcare District. The team operates in coordination with the foundation's mission and goals, leveraging the expertise and resources of the healthcare district to fulfill its objectives. This collaborative and part-time approach reflects a flexible and efficient workforce dedicated to supporting the foundation's initiatives in the healthcare sector, while focusing on fiscal responsibility.*

Volunteers: MHF hosted a thank you luncheon for the volunteers at the Pit River Lodge on November 15th. It was a beautiful day and there was a great turnout of volunteers. Special thank you to Joey and

Carol for hosting and Shay for organizing. We were also thrilled to have most of the MMHD Executive Leadership and MMHD Board Member Jeanne Utterback present to express thanks to our volunteers. We have been doing a lot of marketing around "volunteers". It is difficult, as many local organizations are looking for volunteers. We were able to get in touch with the Intermountain Volunteers group and become a part of their project.

We have been able to utilize a couple of the volunteers to help at the Mayers Pharmacy Gift Shop to check in inventory, do pricing and keep the displays looking fresh and tidy.

Mayers Employee Giving (MEG): We have started moving forward with relaunching the MEG Program, Michele has teamed up with Ashley Nelson, MMHD Recruiter, who manages the EAT (Employee Action Team) Program with the hospital. We will give presentations to new hires as well as to each facility department to educate and encourage participation of both programs moving forward.

Awards and Scholarships: Letters to the Department Grant recipients were sent. MHF is proud to have awarded $80,480.99 to MMHD departments. These grants needed to be expended by the departments by the end of the year.

Department	Award Amount	Item Description
Acute Care	$5,438.30	VS9 Vital Signs Cart
Ambulance	$4,200.00	Statpacks Medical and Airway Bags
Staff Development	$5,359.40	Geri Auscultation Manikin
Emergency	$10,000.00	MAC7 Electrocardiogram
Food and Nutrition	$7,391.21	Heavy Duty Utility Cart and Meal Delivery Carts
Marketing & Public Relations	$14,800.00	Healthcare Content and Quarterly Newsletter
Skilled Nursing	$15,058.04	Safe patient handling/patient lifts
Cardiac Rehab	$13,937.59	Ambulatory Blood Pressure Monitor, SciFit Recumbent Bike, Defend neoprene coated compact dumbbell set, Fitter Fit Professional Rocker Board
Physical Therapy	$4,296.45	Metron Value Convertible Staircase
TOTAL	**$80,480.99**	

CLINICAL EDUCATION
November 2023
Report to the Mayers Memorial Hospital District Board of Directors

PEOPLE

The Clinical Education Department continues to invest in people and the community by completing its 2nd year of the Nurse Assistant Training Program.

The Clinical Educator in the role of Director of Staff Development supports CNA staff to be successful in gaining recertification every 2 years. The CDPH process is complicated and can be intimidating particularly for the new CNA, and this support is well received and appreciated by staff.

NATP-

QUALITY SERVICE

Clinical Education demonstrates its commitment to quality through ensuring that all staff are licensed and certified per policy.

Certifications/Licenses

- BLS (100% of staff certified per Evercheck)
- ACLS (100% of RN staff certified per Evercheck)
- NRP- 1 new employee and 1 current ED RN requires this training scheduled for 12/14/23.
- PALS-(100% of RN staff certified per Evercheck)

Clinical Education demonstrates its commitment to quality through ensuring that all staff are trained and competent per policy and regulations.

Trainings

The 2023 doubled the number of in class trainings for CNA recertifications as Covid restrictions were removed and CDPH in-class requirements resumed. CNA recertification rate remained 100%.

Trainings for RN staff included Pediatric Respiratory Emergencies, Common Dysrhythmia's, 2 Skills Fair, Working with Difficult People, Stress Reduction, Cultural Competence. The Clinical Educator participated in "Ivenix" new IV pump training for all RN staff.

Grand Rounds-Two Grand Rounds sessions were held in May (Atrial Fibrillation) and July (Treating Hypertension) through a grant from the American Heart Association. These events were well attended by our Medical Staff as well as Nursing and other clinicians.

The Clinical Educator participated in Cerner roll out, consulted with Surgery RN for OR preparedness and opening: ED.

GROWTH

The Clinical Education Department has grown as it welcomes BLS instructor Regina Blowers LVN, ACLS & PALS Instructor Gonzo Solaria EMT and BLS & PALS Instructor Zita Biehle EMT. The addition of instructional staff offers flexibility and cost effectiveness to our training calendar and budget.

COMMUNICATION

Clinical Education seeks to enhance communication of all training offerings by posting schedules in working units, on monitors in clinical areas, announcement through Relias functioning offer an opportunity to enroll online, and email correspondence. **W.I.N.K**. and It **Pays to Know** are used as updates and reminders of trainings and deadlines. Relias has reporting capabilities that automatically remind staff of assigned trainings and reminders to complete. The Clinical Educator audits and send reminders to staff/management periodically.

FINANCE

As the Program Director for the NATP, the clinical educator was given the opportunity to request grant funds for equipment which was awarded. The NATP is in possession of a geriatric-manikin which can assist CNA students to practice and master skills for certification. This multiuse equipment also has functionality for training for all levels of clinicians making it a cost-effective purchase for MMHD.

Respectfully submitted,

Brigid Doyle MSN, RN
Clinical Educator, Director of Staff Development, Program Director NATP

November 29, 2023

People Pillar

Executive Leader: Ryan Harris
Director or Manager: John Morris
Department: Project Management

Last Updated: 7.6.2023

FY24 (July 1, 2023 - June 30, 2024)							
Priority:	**Weight**	**Bonus Amount**	**Specific Plan & Estimated Completion Date**	**Driver**	**Current Actions**	**% Complete By FY End**	**Bonus Amount Awarded**
Complete an in person or e-learning ASHE health care construction workshop by FYE 2024.	**20%**	**$1,000**	Oct-23	Attendance	Completed	100%	
Priority Ideas for Next Year							

For Completion at Beginning of Fiscal Year

Name	Signature	Date
Supervisor	Signature	Date
Executive Leader	Signature	Date

CEO Approval at End of Fiscal Year

Christopher R Bjornberg		
CEO	Signature	Date

Quality Service Pillar

Executive Leader: Ryan Harris
Director or Manager: John Morris
Department: Project Management

Last Updated: 7.6.2023

FY24 (July 1, 2023 - June 30, 2024)							
Priority:	**Weight**	**Bonus Amount**	**Specific Plan & Estimated Completion Date**	**Driver**	**Current Actions**	**% Complete By FY End**	**Bonus Amount Awarded**
Install a data line cable management system with firestopping in the station 1 and 3 space by FYE 2024.	**40%**	**$2,000**	Begin in Acute rooms as available. Move to corridor after rooms are complete.	Census Crew Availability	Construction in progress. Three (3) rooms completed.	100%	
Priority Ideas for Next Year							

For Completion at Beginning of Fiscal Year

Name	Signature	Date
Supervisor	Signature	Date
Executive Leader	Signature	Date

CEO Approval at End of Fiscal Year

Christopher R Bjornberg		
CEO	Signature	Date

Growth Pillar

Executive Leader: Ryan Harris
Director or Manager: John Morris
Department: Project Management

Last Updated: 7.6.2023

FY24 (July 1, 2023 - June 30, 2024)							
Priority:	**Weight**	**Bonus Amount**	**Specific Plan & Estimated Completion Date**	**Driver**	**Current Actions**	**% Complete By FY End**	**Bonus Amount Awarded**
Complete criteria documents with the board of directors' approval by FYE 2024.	**20%**	**$1,000**	Layout in progress. Equipment planner	Equipment planning	Contracting equipment planner.	100%	
			contract being developed. On schedule		Ongoing layout development.		
			to have Criteria Documents completed by				
			FYE 2024.				
Priority Ideas for Next Year							

For Completion at Beginning of Fiscal Year

Name	Signature	Date
Supervisor	Signature	Date
Executive Leader	Signature	Date

CEO Approval at End of Fiscal Year

Christopher R Bjornberg		
CEO	Signature	Date

Communication Pillar

Executive Leader: Ryan Harris
Director or Manager: John Morris
Department: Project Management

Last Updated: 7.6.2023

FY24 (July 1, 2023 - June 30, 2024)							
Priority:	**Weight**	**Bonus Amount**	**Specific Plan & Estimated Completion Date**	**Driver**	**Current Actions**	**% Complete By FY End**	**Bonus Amount Awarded**
Prepare a presentation for and participate in the master planning community event by FYE 2024.	**20%**	**$1,000**	Attend and support community event in December 2023.	Coordinate Plan Presentation	Presentation development.	100%	
Priority Ideas for Next Year							

For Completion at Beginning of Fiscal Year

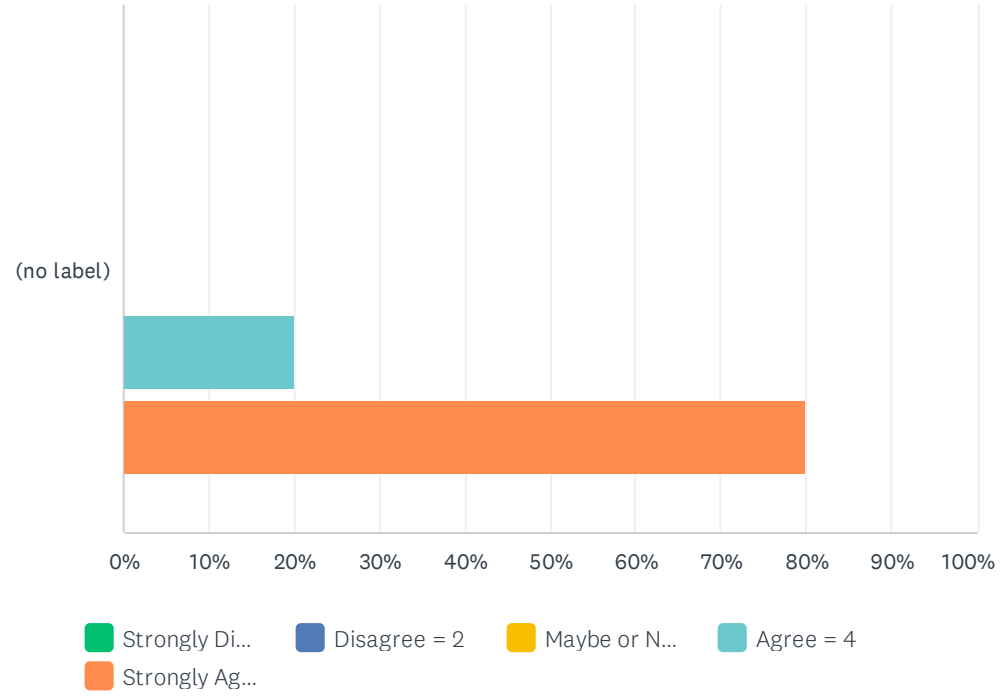
Name	Signature	Date
Supervisor	Signature	Date
Executive Leader	Signature	Date

CEO Approval at End of Fiscal Year

Christopher R Bjornberg		
CEO	Signature	Date

Q1 Our organization has a three to five-year strategic plan or a set of clear long range goals and priorities.

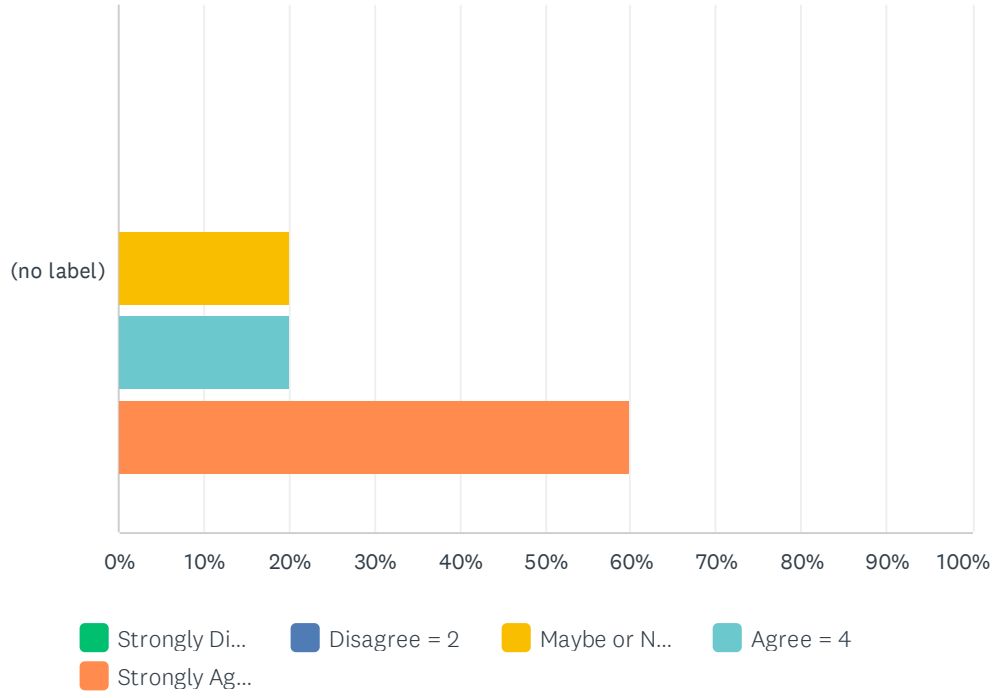
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	20.00% 1	80.00% 4	5	4.80

Q2 The Board’s meeting agenda clearly reflects our strategic plan or priorities.

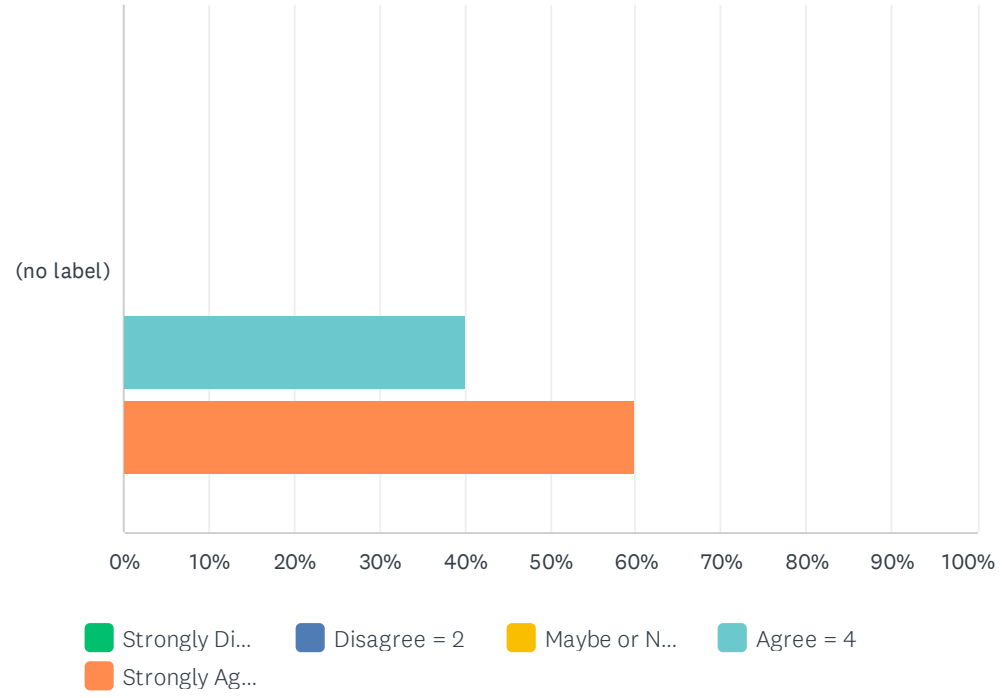
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	20.00% 1	20.00% 1	60.00% 3	5	4.40

Q3 The Board has insured that the organization also has a one-year operational or business plan.

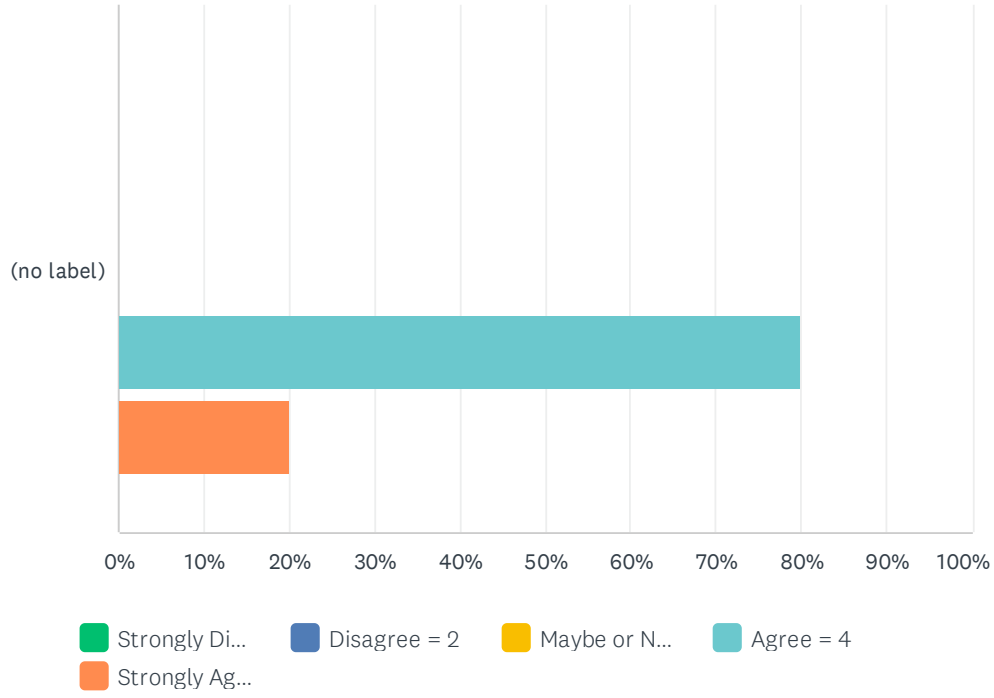
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	40.00% 2	60.00% 3	5	4.60

Q4 The Board gives direction to staff on how to achieve the goals primarily by setting or referring to policies.

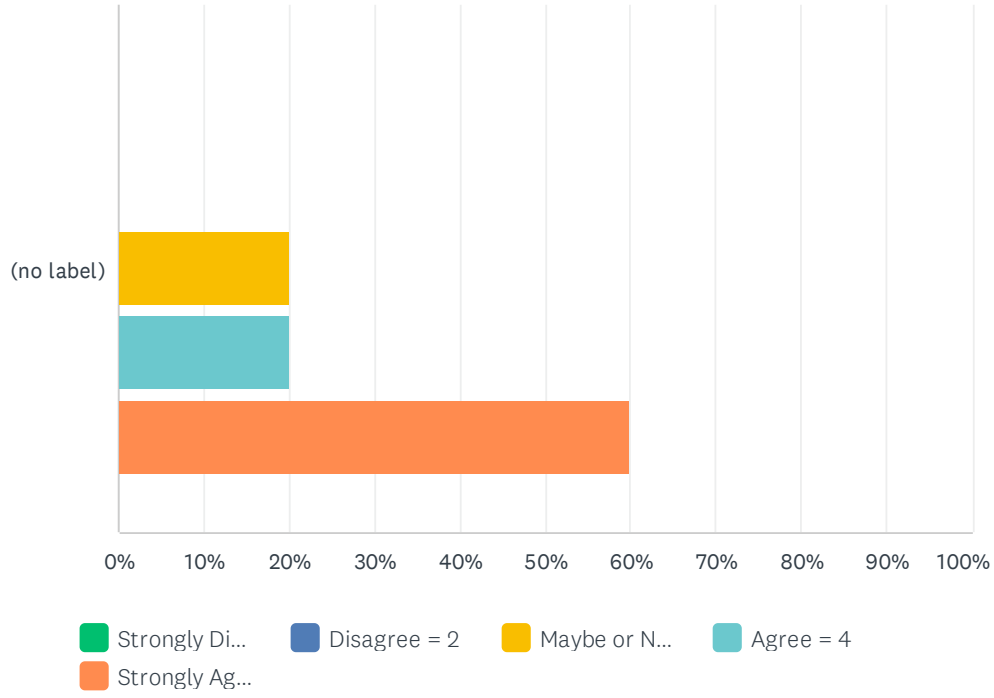
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	80.00% 4	20.00% 1	5	4.20

Q5 The Board ensures that the organization’s accomplishments and challenges are communicated to members and stakeholders.

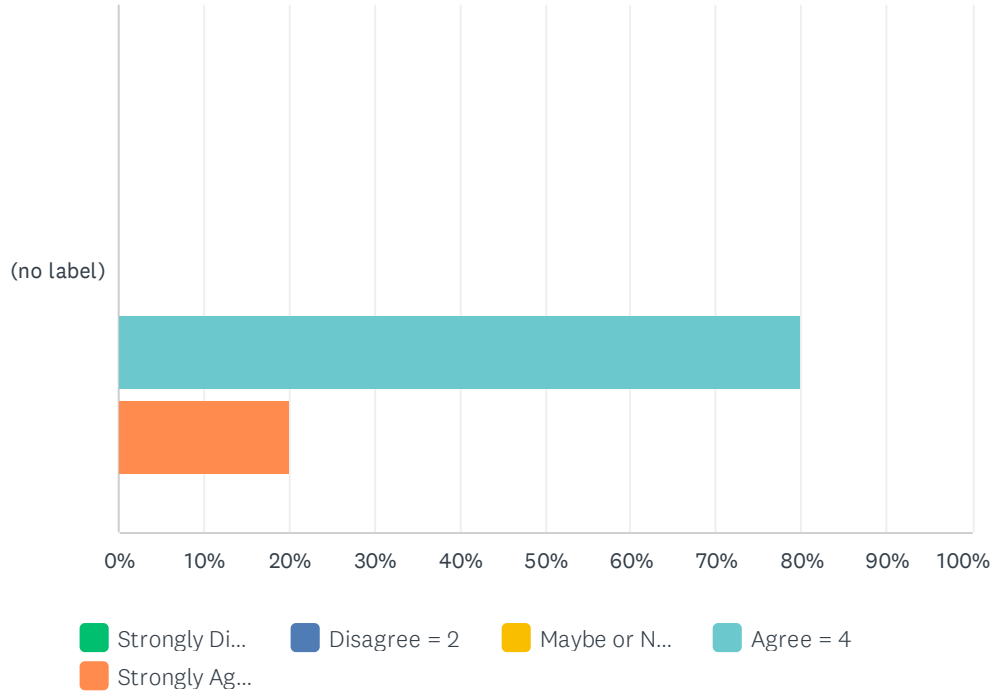
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	20.00% 1	20.00% 1	60.00% 3	5	4.40

Q6 The board has ensured that members and stakeholders have received reports on how our organization has used its financial and human resources.

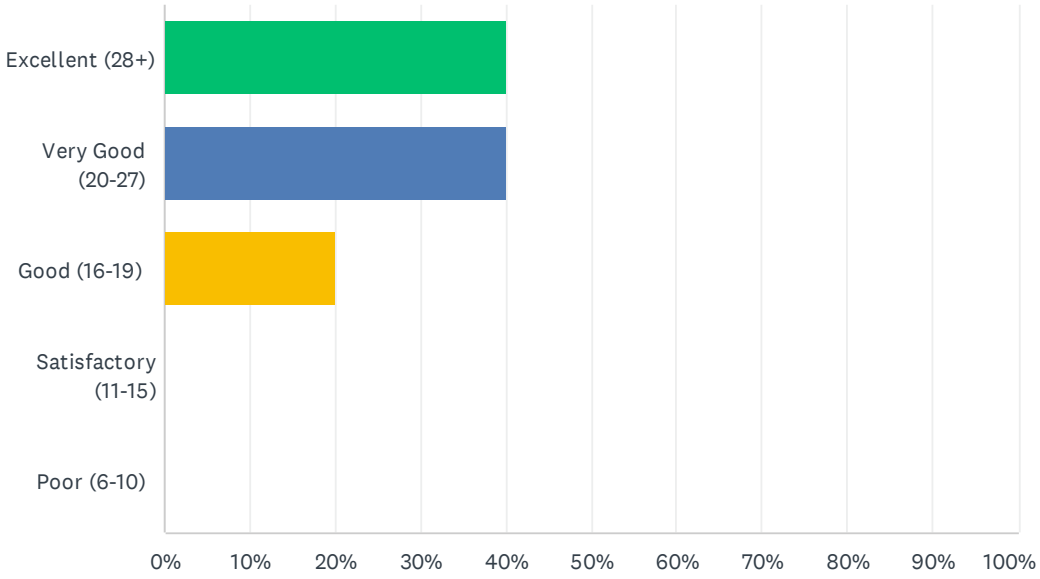
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	80.00% 4	20.00% 1	5	4.20

Q7 Add together your ratings for Section A and select the matching overall rating.

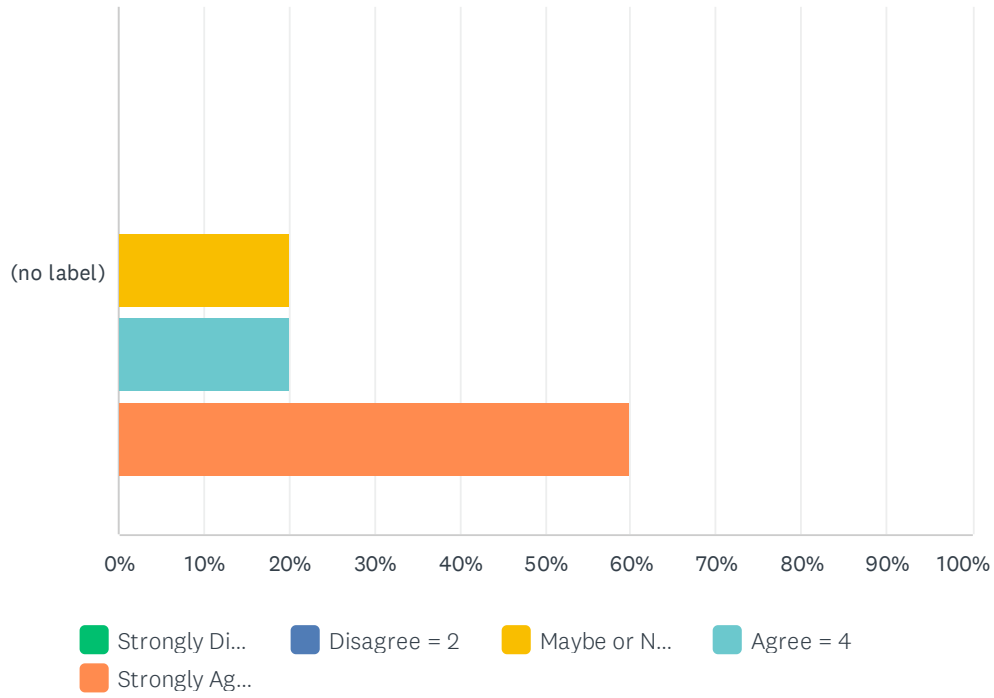
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent (28+)	40.00%	2
Very Good (20-27)	40.00%	2
Good (16-19)	20.00%	1
Satisfactory (11-15)	0.00%	0
Poor (6-10)	0.00%	0
Total Respondents: 5		

Q8 Board members are aware of what is expected of them.

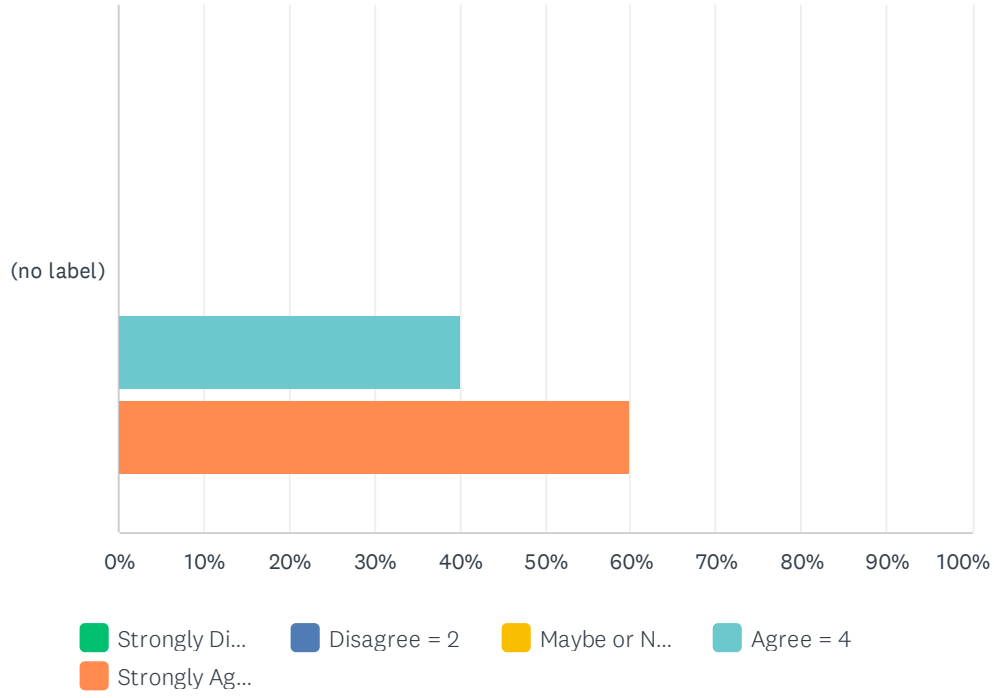
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	20.00% 1	20.00% 1	60.00% 3	5	4.40

Q9 The agenda of board meetings is well planned to that we are able to get through all necessary board meetings.

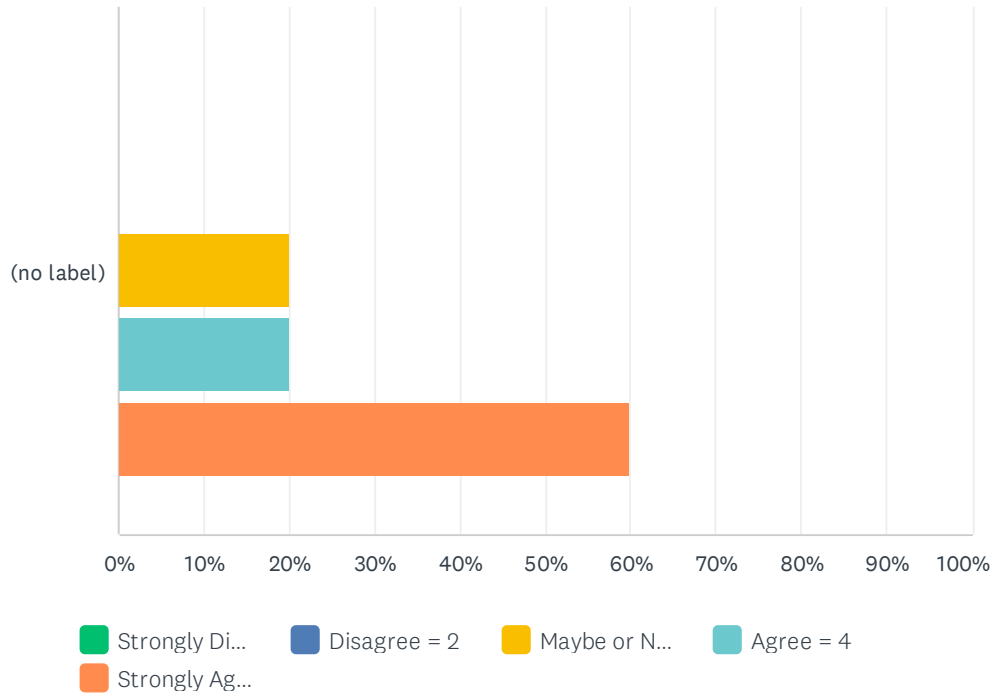
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	40.00% 2	60.00% 3	5	4.60

Q10 It seems like most board members come to meetings prepared.

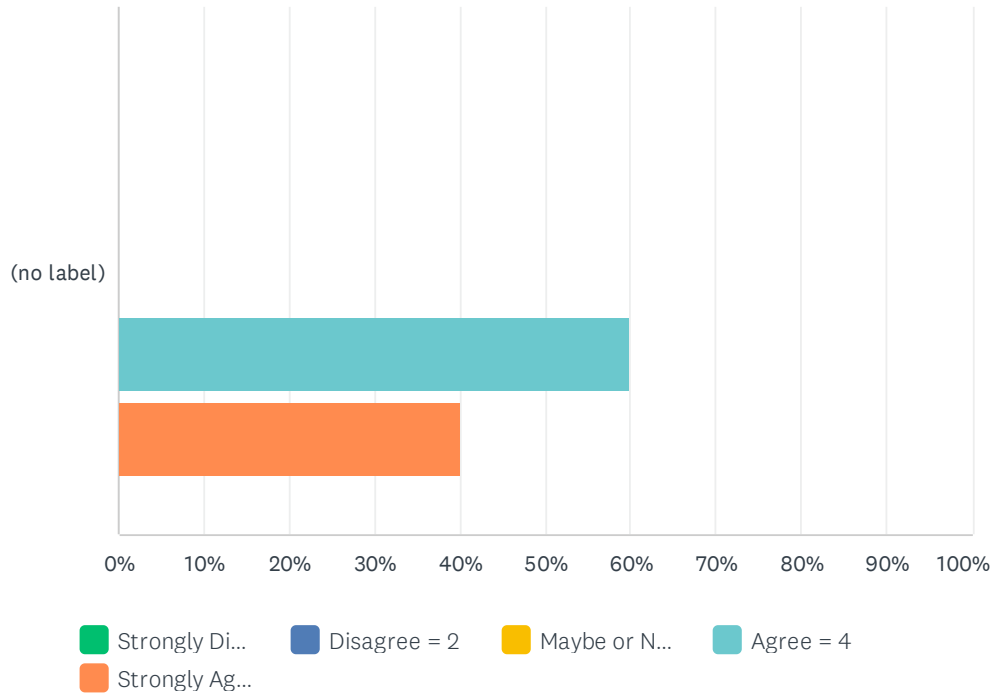
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	20.00% 1	20.00% 1	60.00% 3	5	4.40

Q11 We receive written reports to the Board in advance of our meetings.

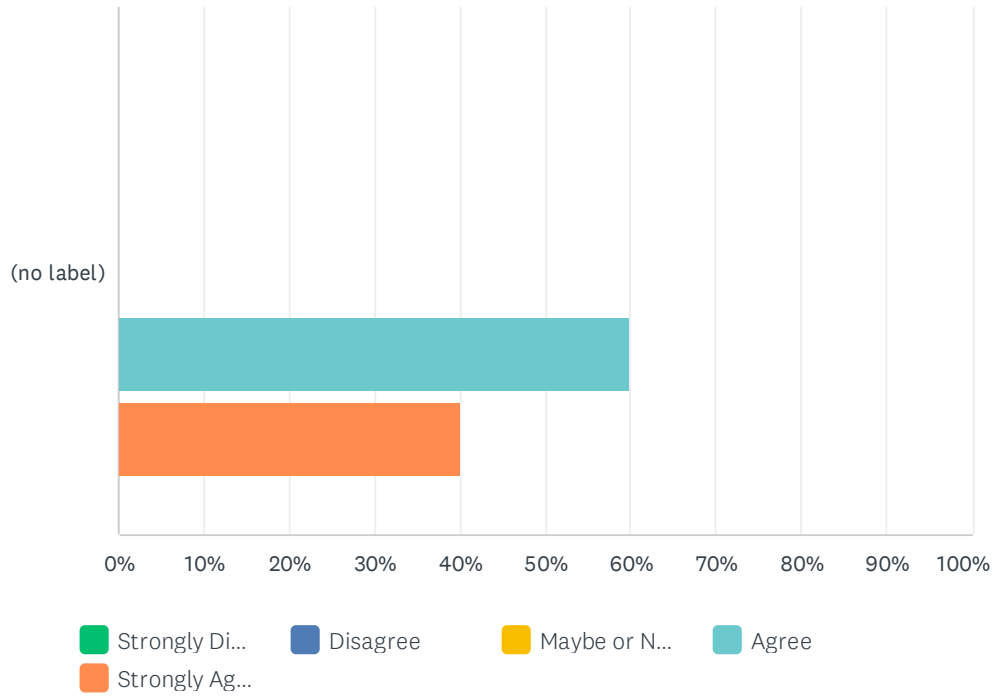
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	60.00% 3	40.00% 2	5	4.40

Q12 All Board members participate in important board discussion.

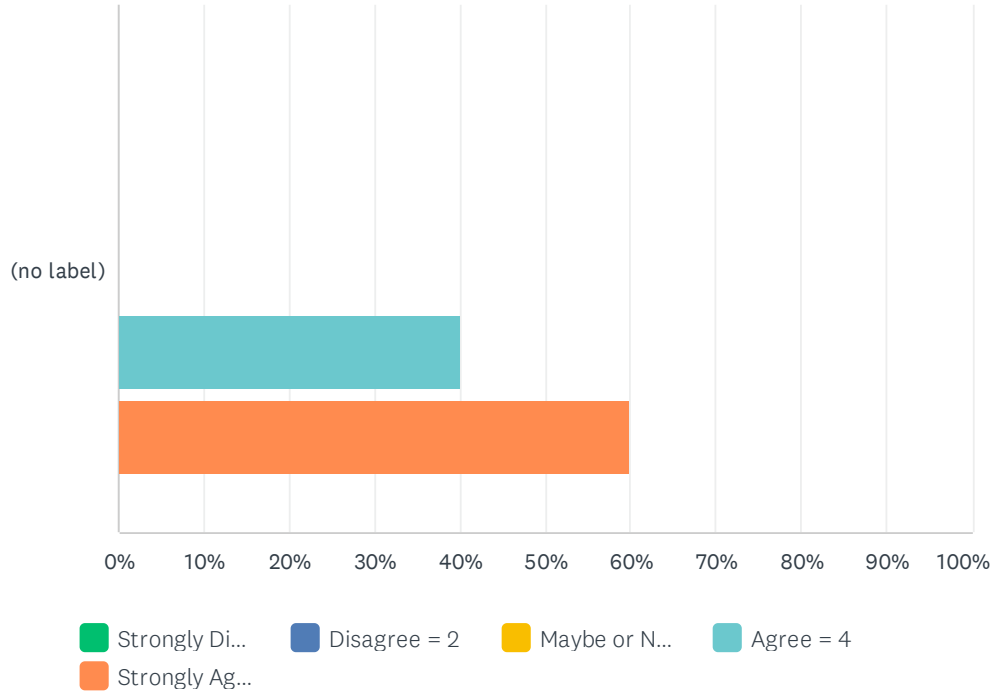
Answered: 5 Skipped: 0



	STRONGLY DISAGREE	DISAGREE	MAYBE OR NOT SURE	AGREE	STRONGLY AGREE	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	60.00% 3	40.00% 2	5	4.40

Q13 We do a good job encouraging and dealing with different points of view.

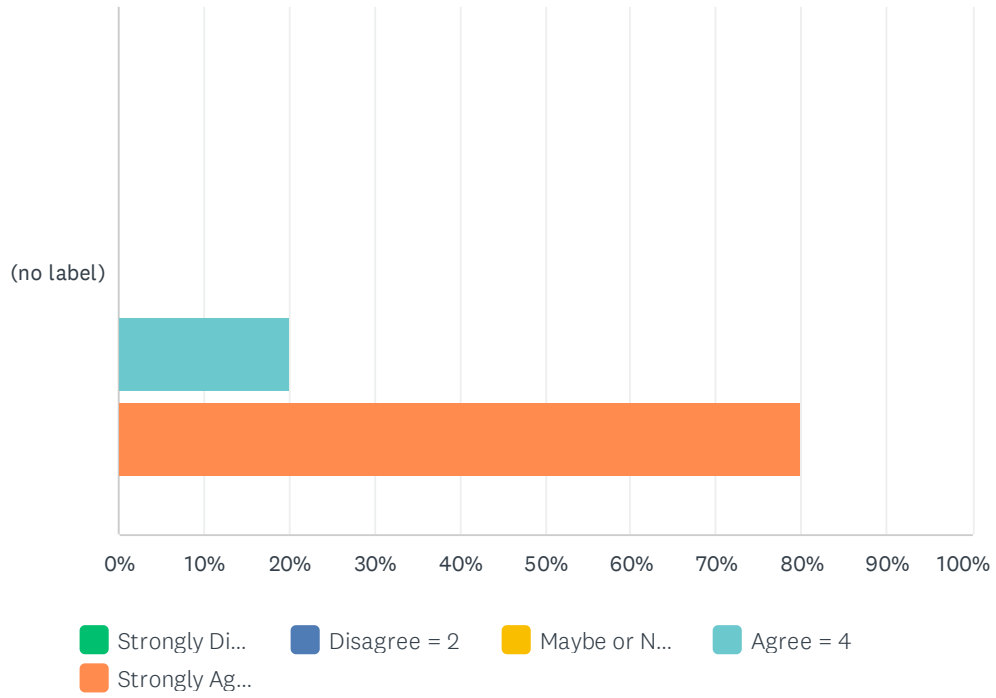
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	40.00% 2	60.00% 3	5	4.60

Q14 We all support the decisions we make.

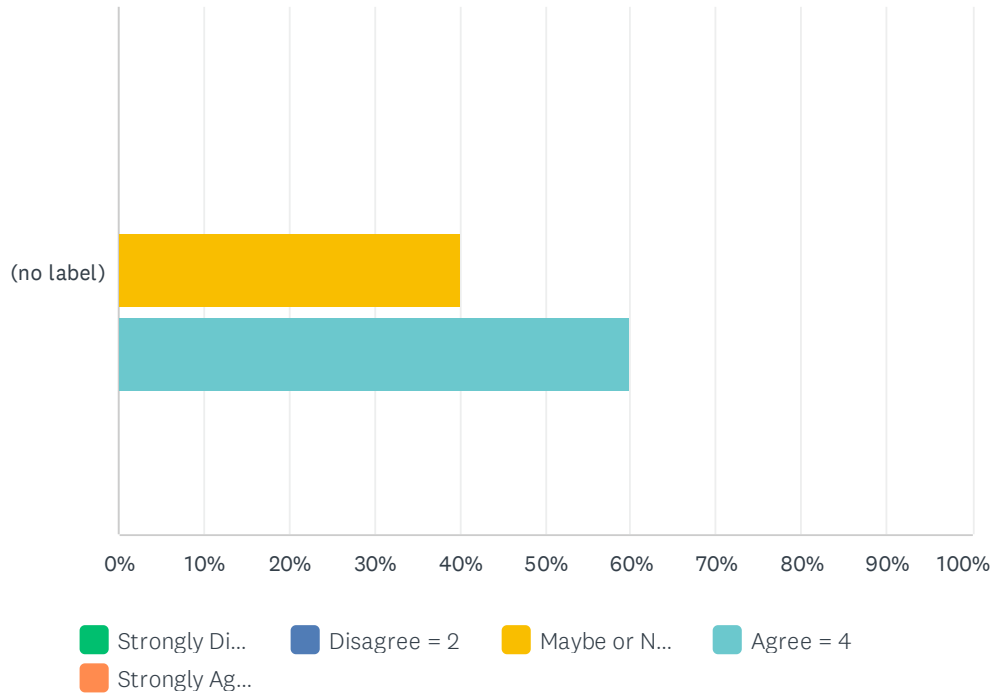
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	20.00% 1	80.00% 4	5	4.80

Q15 The Board has taken responsibility for recruiting new board members.

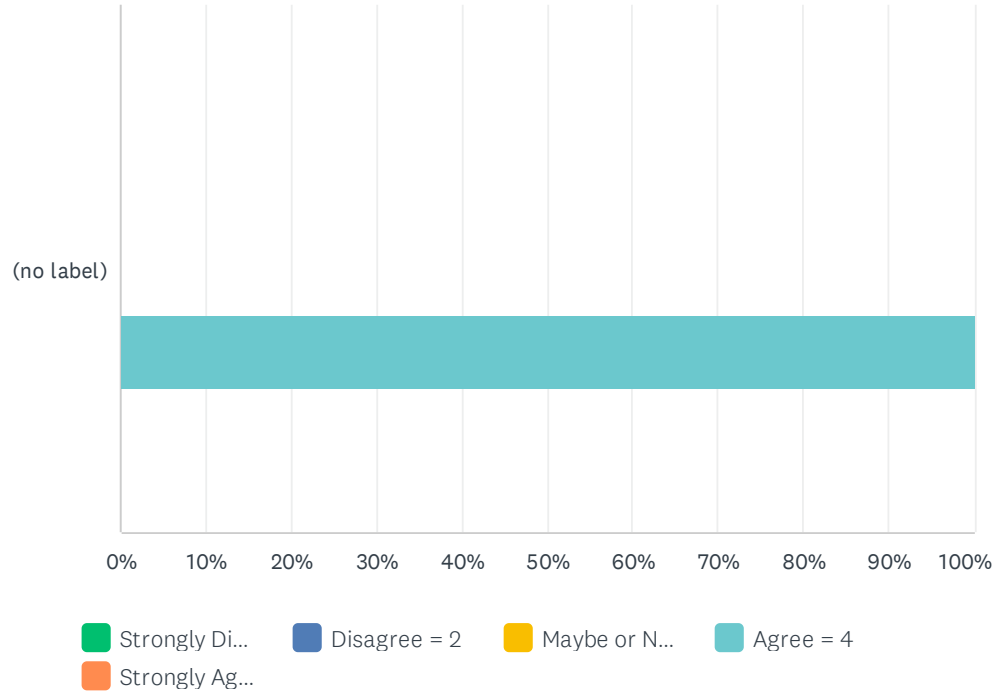
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	40.00% 2	60.00% 3	0.00% 0	5	3.60

Q16 The Board has planned and led the orientation process for new board members.

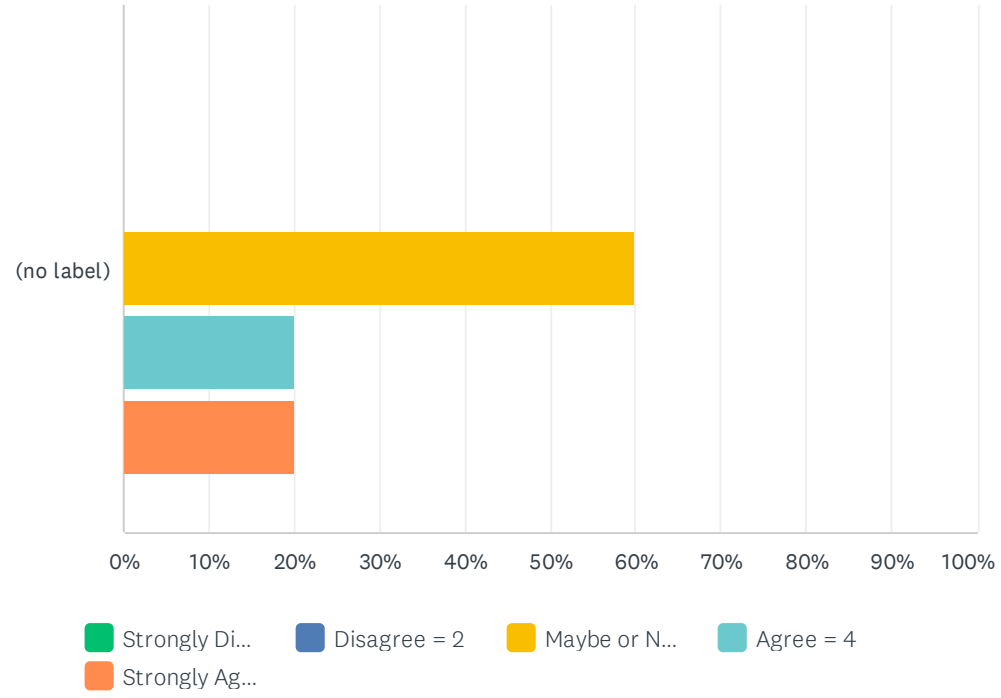
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	100.00% 5	0.00% 0	5	4.00

Q17 The Board has a plan for director education and further board development.

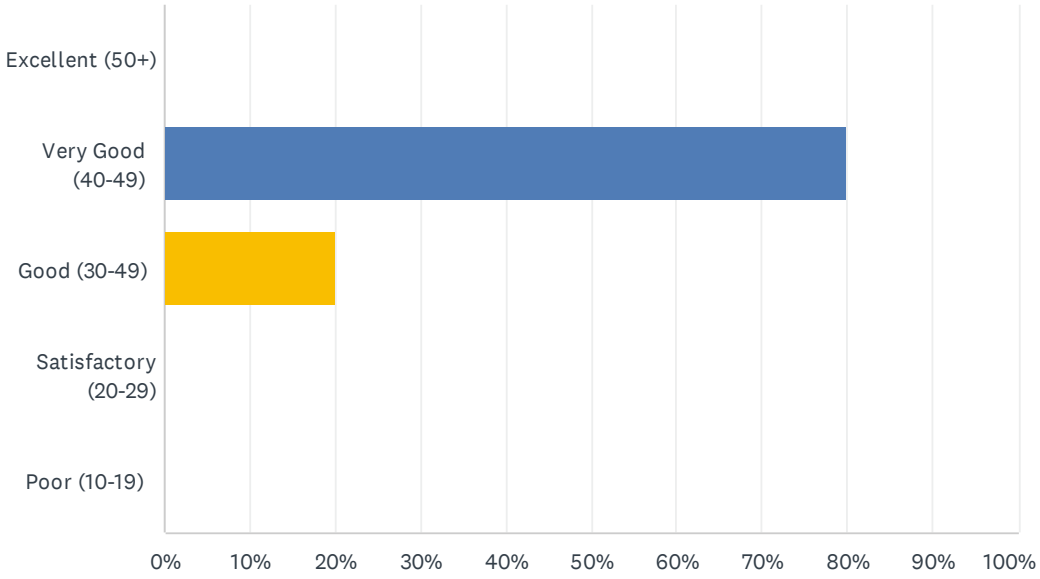
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	60.00% 3	20.00% 1	20.00% 1	5	3.60

Q18 Add together your ratings for Section B and select the matching overall rating.

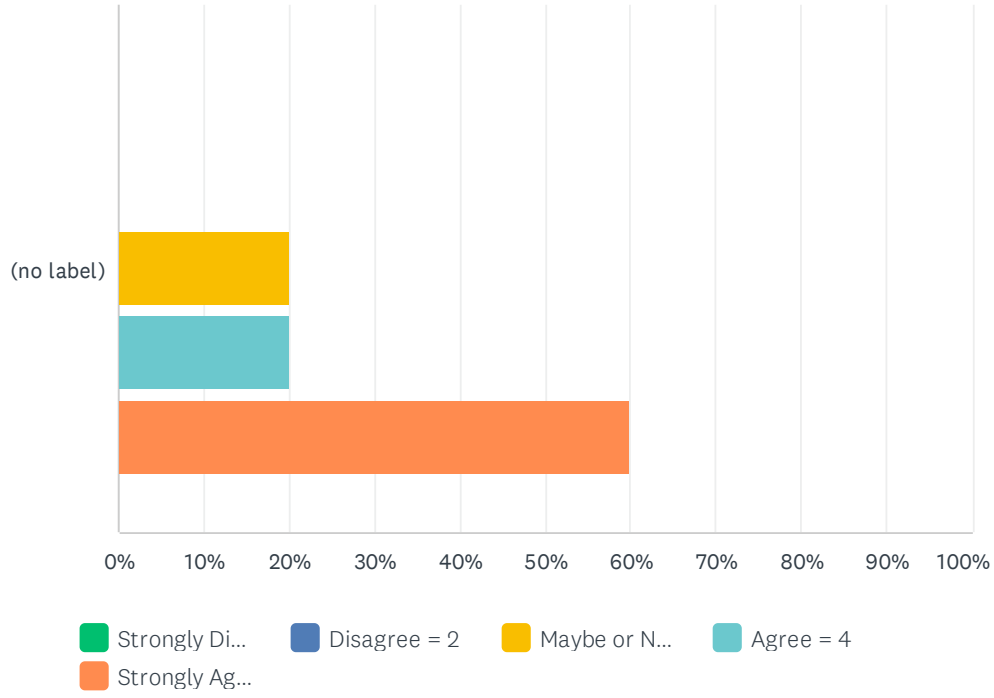
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent (50+)	0.00%	0
Very Good (40-49)	80.00%	4
Good (30-49)	20.00%	1
Satisfactory (20-29)	0.00%	0
Poor (10-19)	0.00%	0
Total Respondents: 5		

Q19 There is a clear understanding of where the Board's role ends and the CEO's begins.

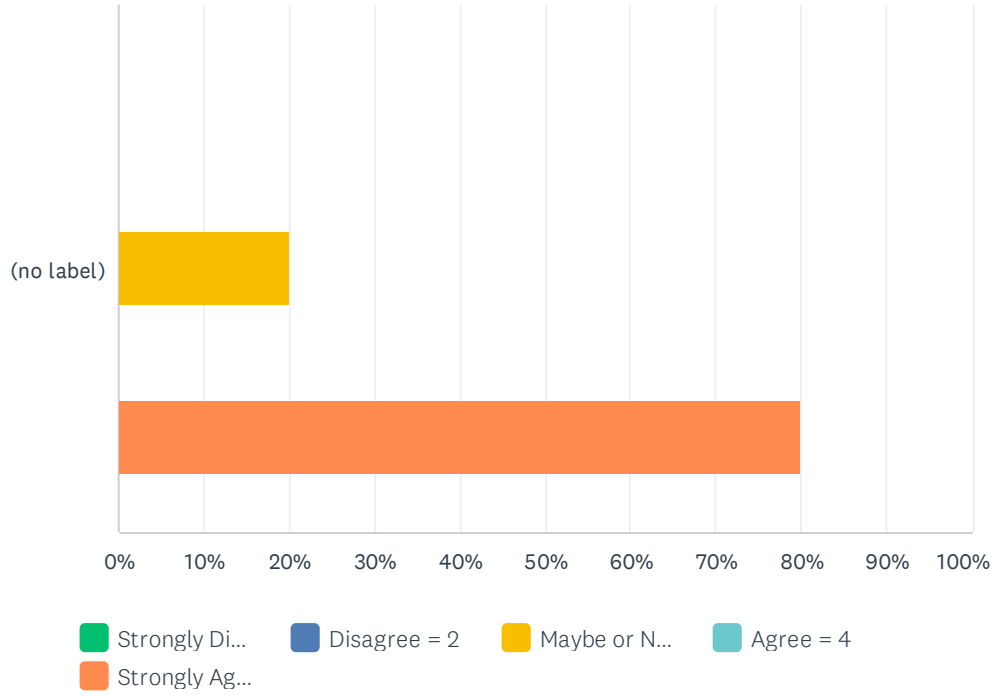
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	20.00% 1	20.00% 1	60.00% 3	5	4.40

Q20 There is good two-way communication between the Board and the CEO.

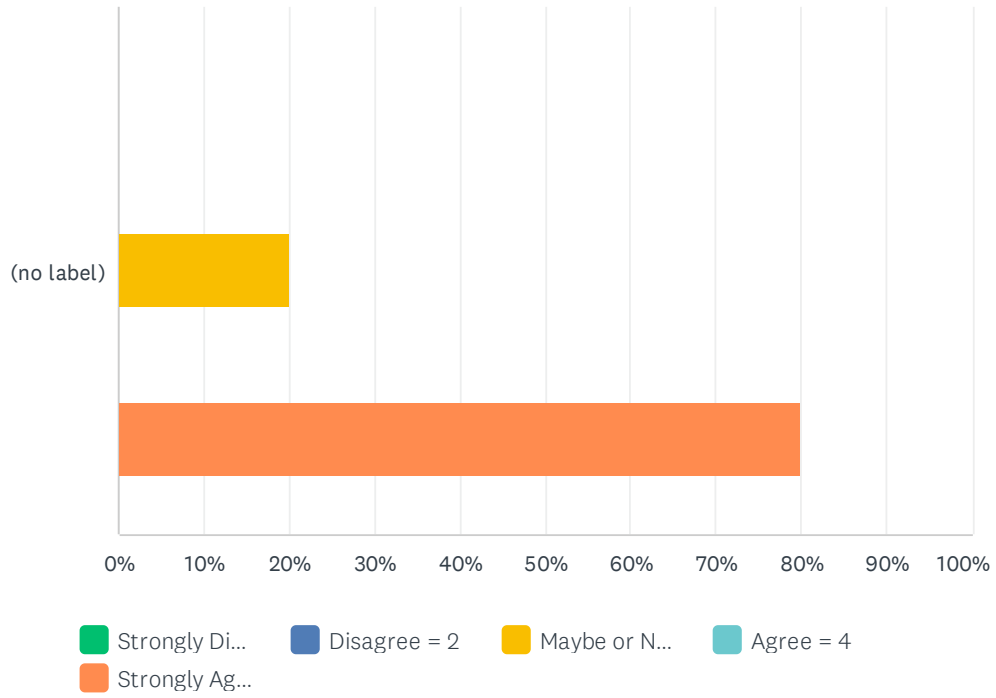
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	20.00% 1	0.00% 0	80.00% 4	5	4.60

Q21 The Board trusts the judgement of the CEO.

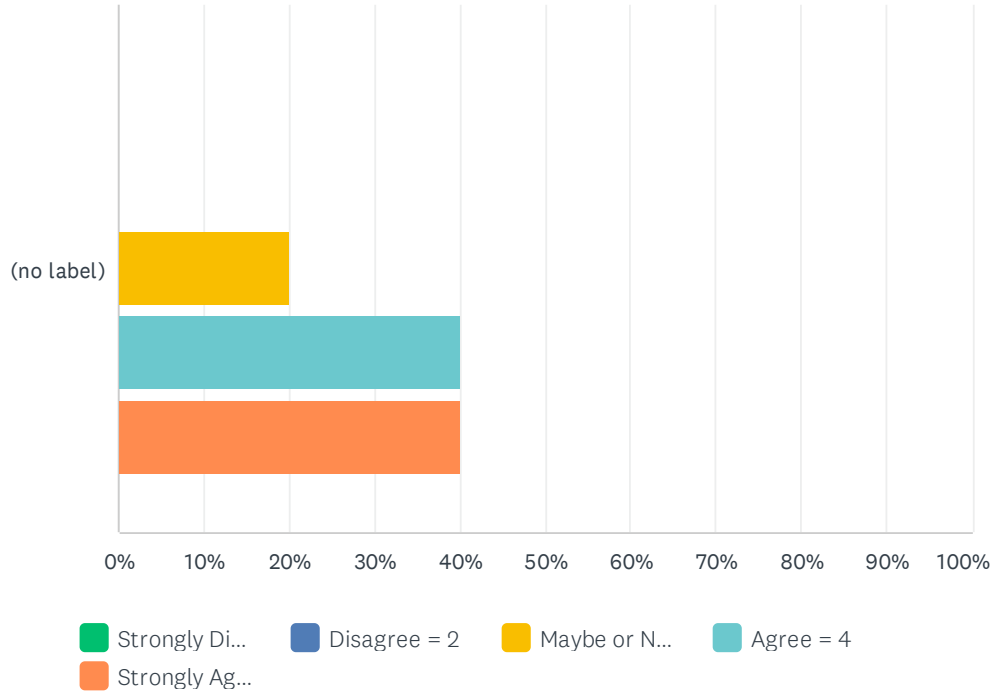
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	20.00% 1	0.00% 0	80.00% 4	5	4.60

Q22 The Board provides direction to the CEO by setting new policies or clarifying existing ones.

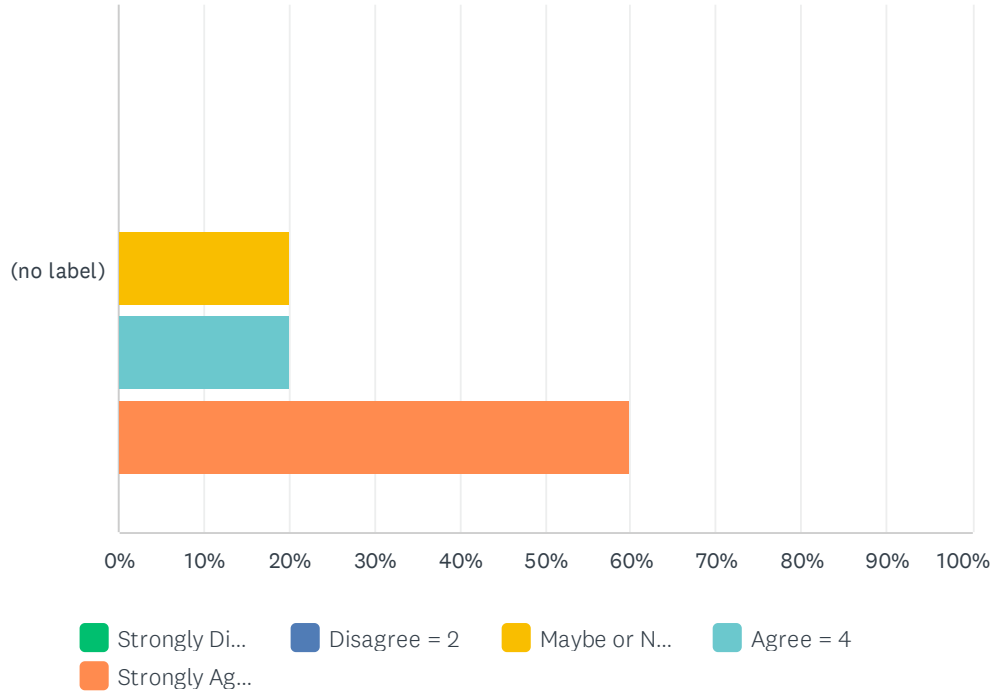
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	20.00% 1	40.00% 2	40.00% 2	5	4.20

Q23 The Board has discussed and communicated the kinds of information and level of detail it requires from the CEO on what is happening in the organization.

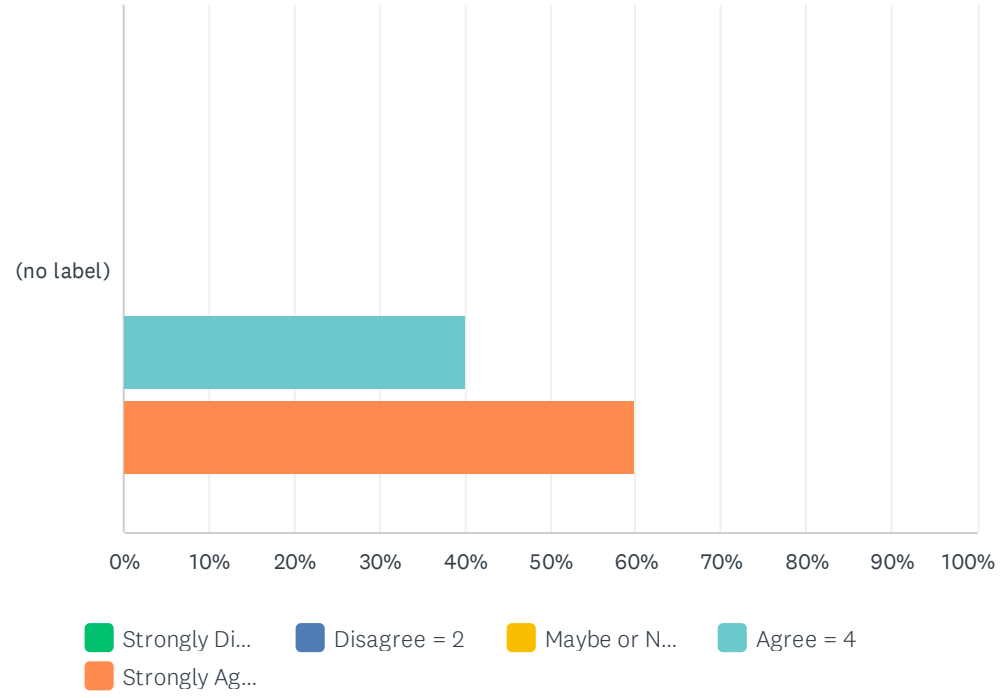
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	20.00% 1	20.00% 1	60.00% 3	5	4.40

Q24 The Board has developed formal criteria and a process for evaluating the CEO.

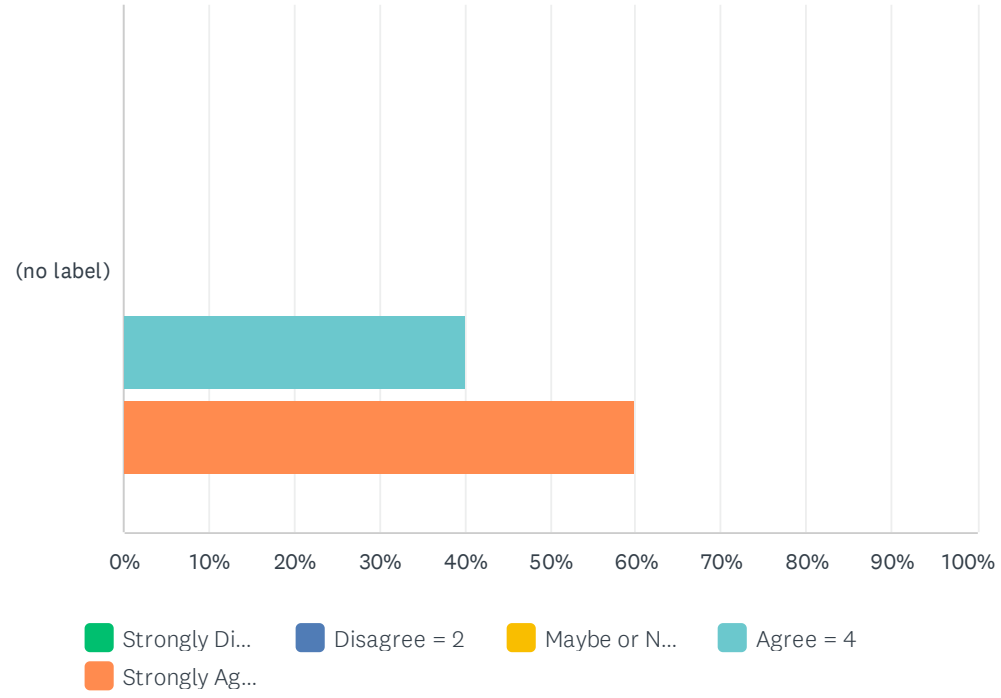
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	40.00% 2	60.00% 3	5	4.60

Q25 The Board, or a committee of the Board, has formally evaluated the CEO within the last 12 months.

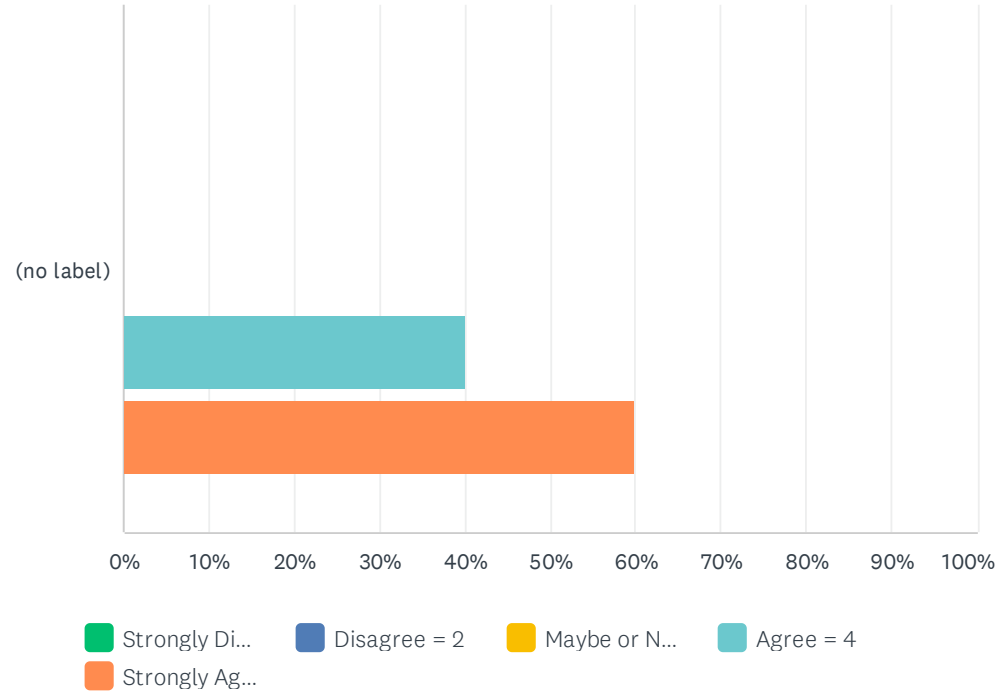
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	40.00% 2	60.00% 3	5	4.60

Q26 The Board evaluates the CEO primarily on the accomplishment of the organization’s strategic goals and priorities and adherence to policy.

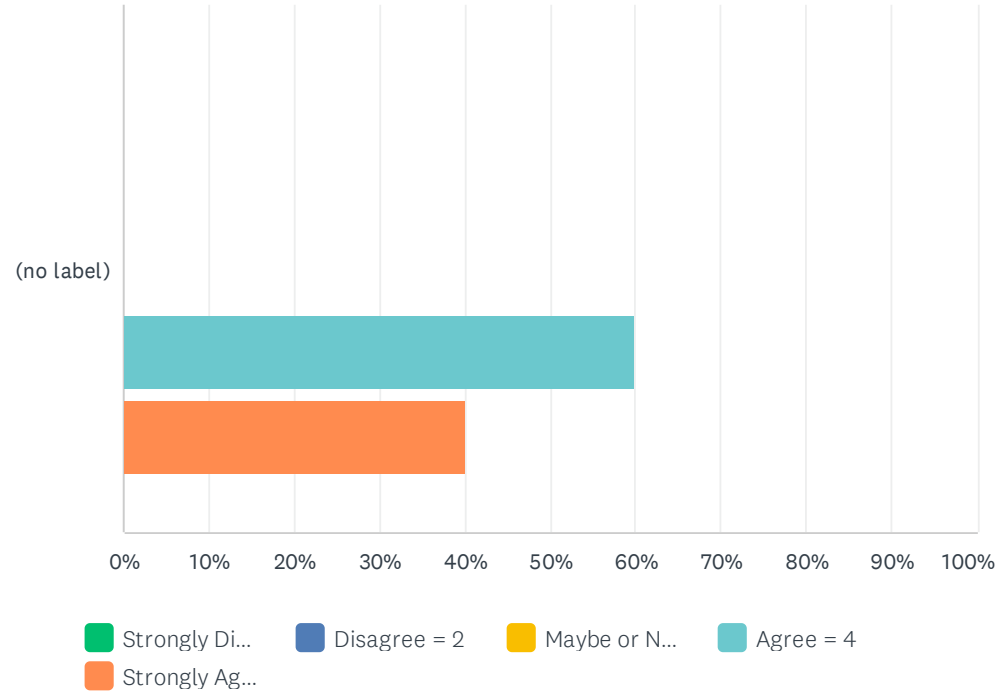
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	40.00% 2	60.00% 3	5	4.60

Q27 The Board provides feedback and shows its appreciation to the CEO on a regular basis.

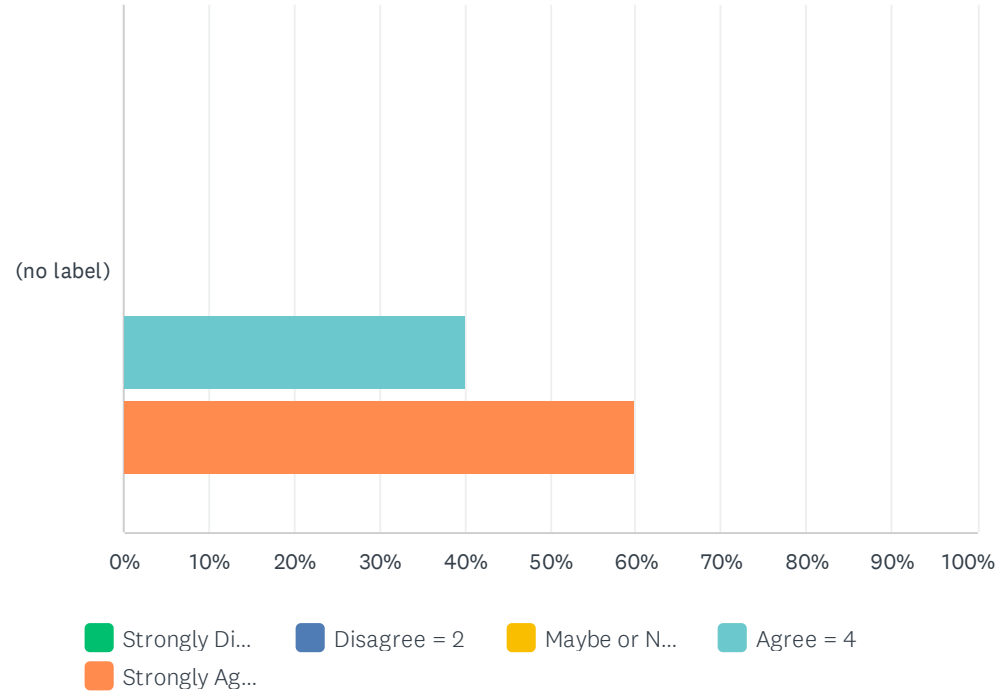
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	60.00% 3	40.00% 2	5	4.40

Q28 The Board ensures that the CEO is able to take advantage of professional development opportunities.

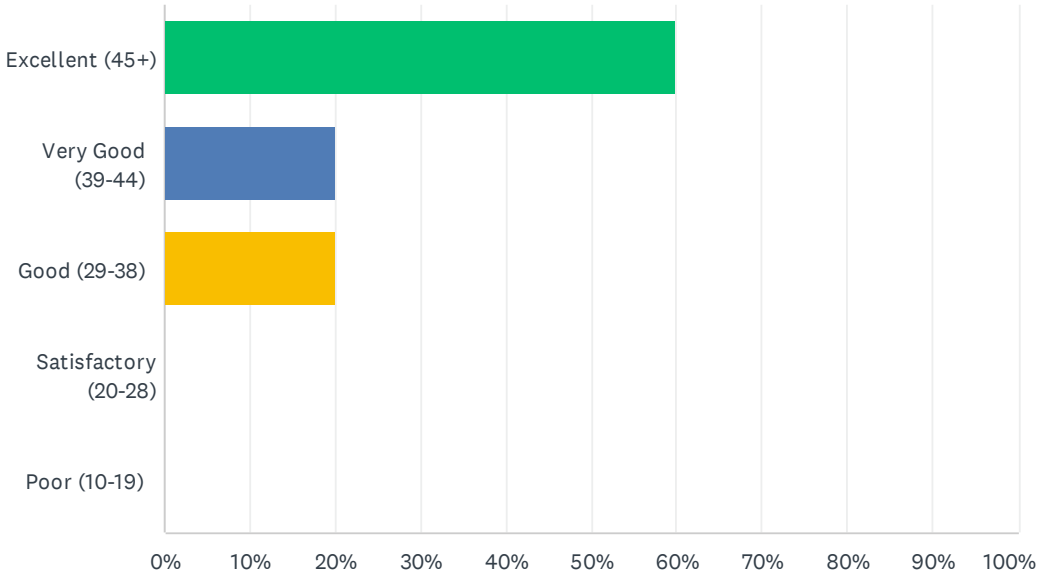
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	40.00% 2	60.00% 3	5	4.60

Q29 Add together your ratings for Section C and select the matching overall rating.

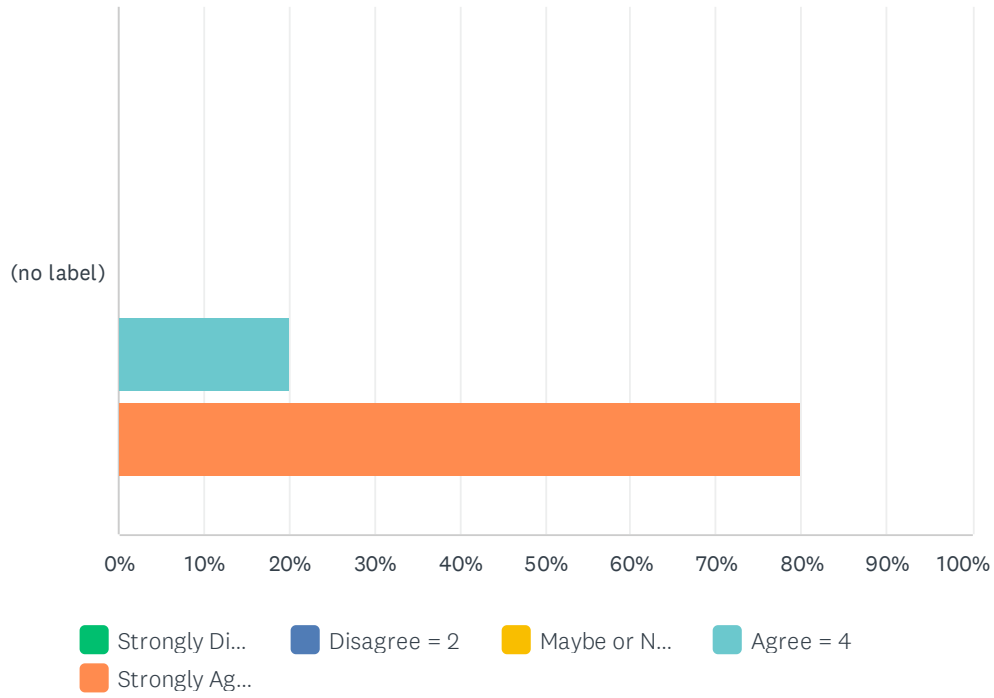
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent (45+)	60.00%	3
Very Good (39-44)	20.00%	1
Good (29-38)	20.00%	1
Satisfactory (20-28)	0.00%	0
Poor (10-19)	0.00%	0
Total Respondents: 5		

Q30 I am aware of what is expected of me as a Board member.

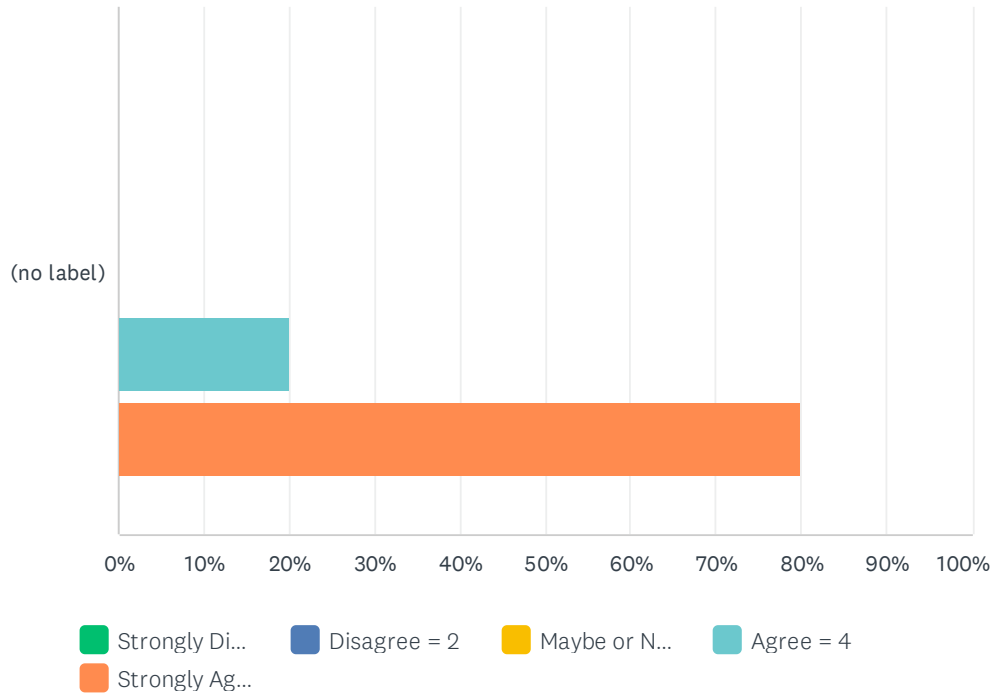
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	20.00% 1	80.00% 4	5	4.80

Q31 I have a good record of meeting attendance.

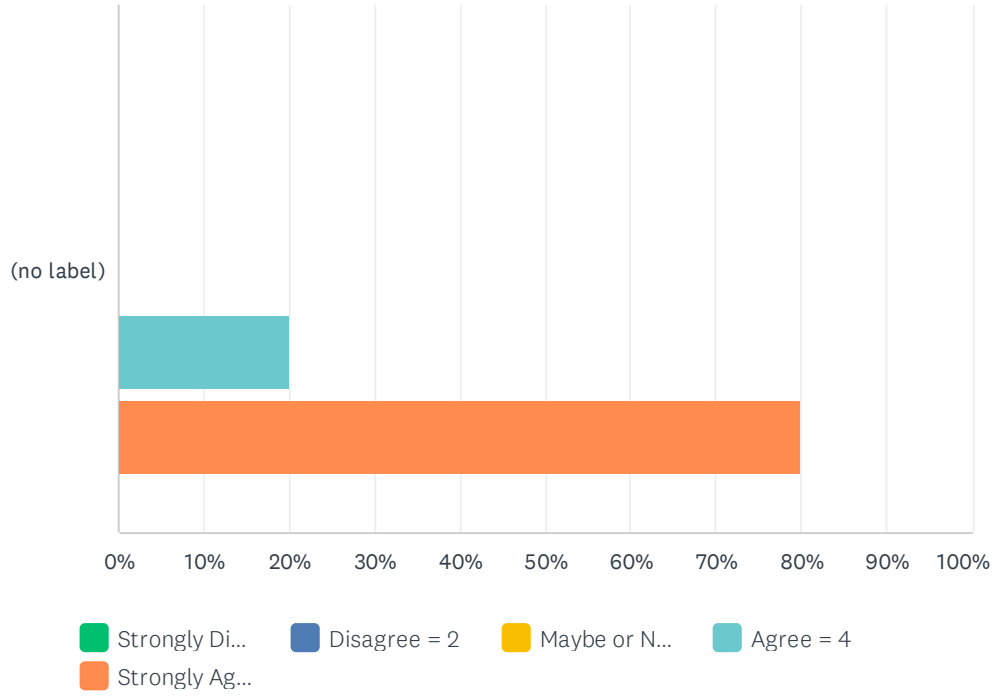
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	20.00% 1	80.00% 4	5	4.80

Q32 I read the minutes, reports and other materials in advance of our Board meetings.

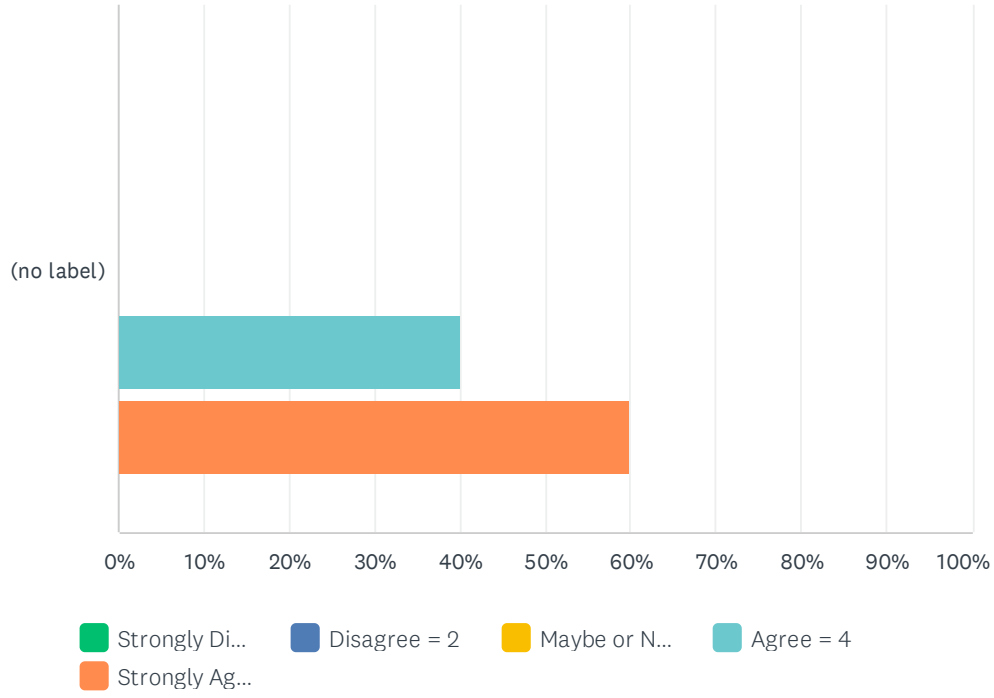
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE =5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	20.00% 1	80.00% 4	5	4.80

Q33 I am familiar with what is in the organization’s by-laws and governing policies.

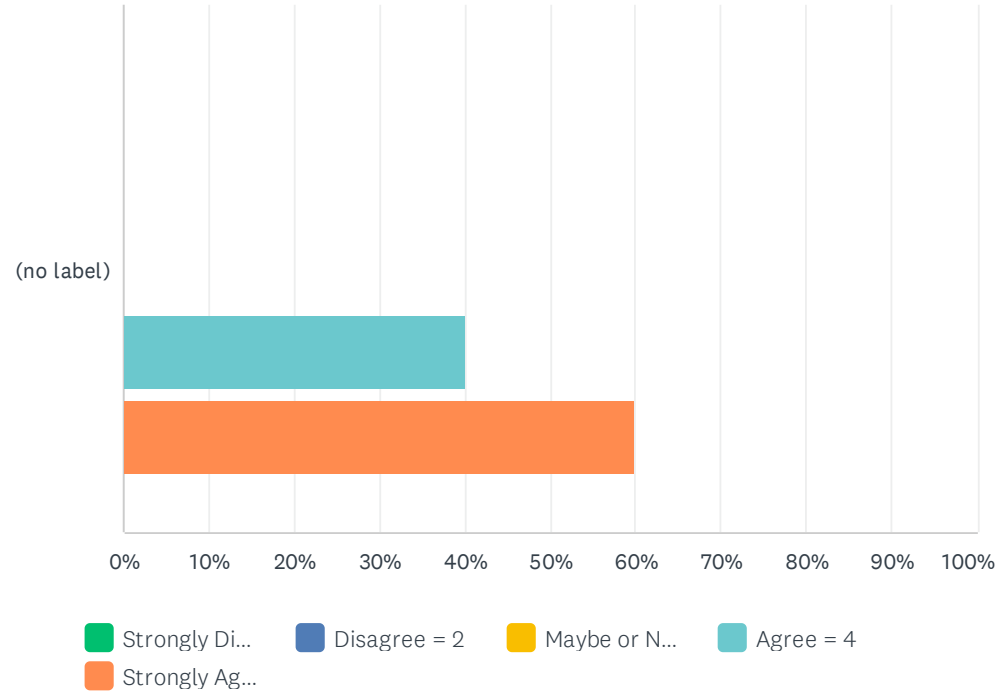
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	40.00% 2	60.00% 3	5	4.60

Q34 I frequently encourage other Board members to express their opinions at Board meetings.

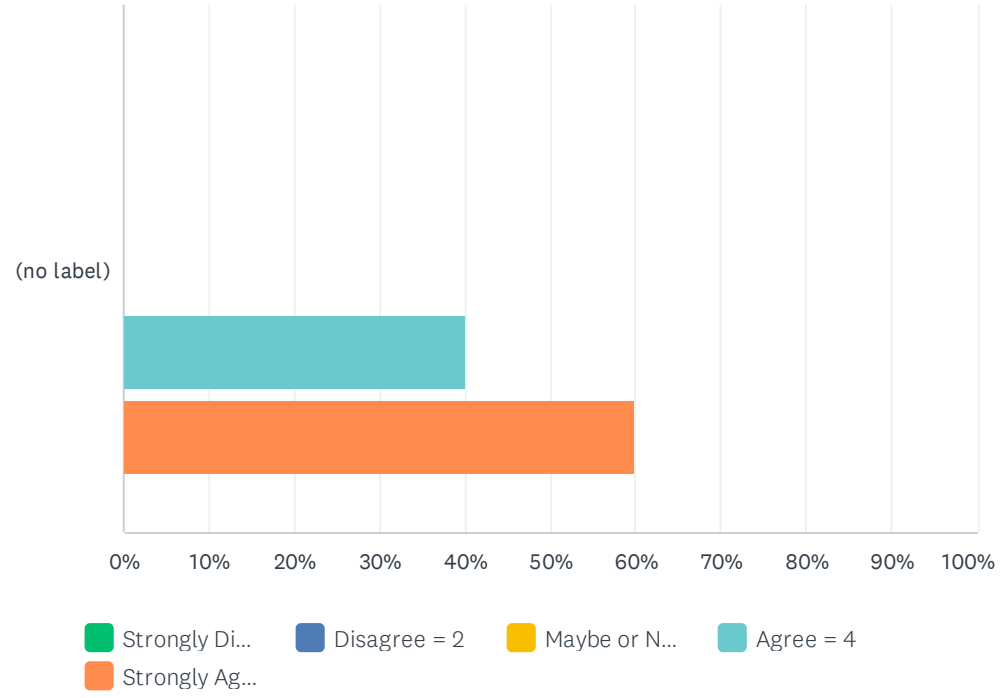
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	40.00% 2	60.00% 3	5	4.60

Q35 I am encouraged by other Board members to express my opinions at Board meetings.

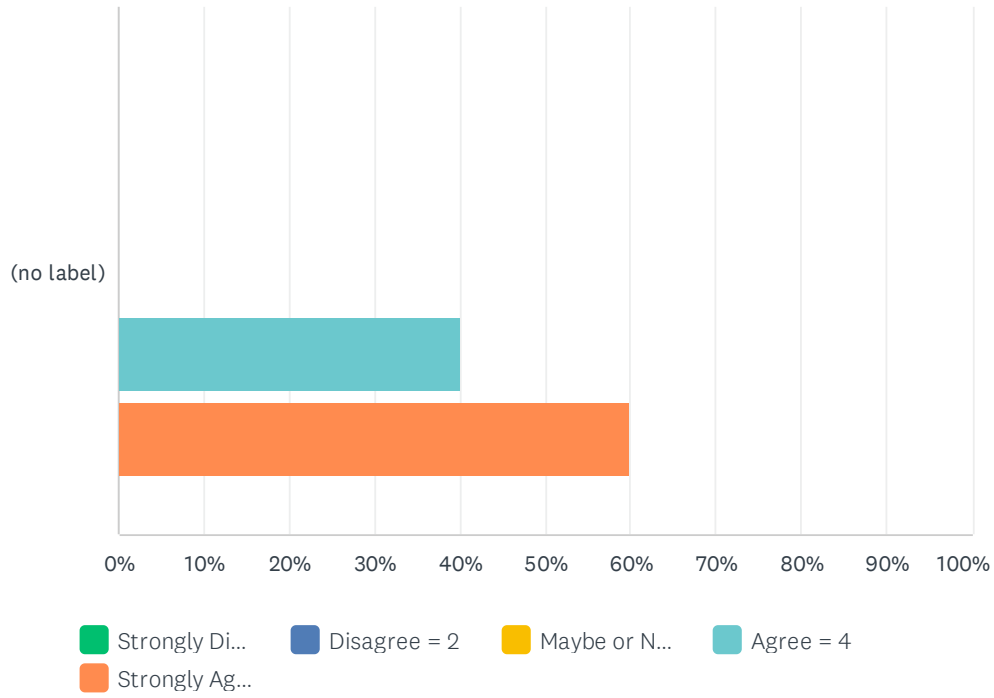
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	40.00% 2	60.00% 3	5	4.60

Q36 I follow through on things I have said I would do.

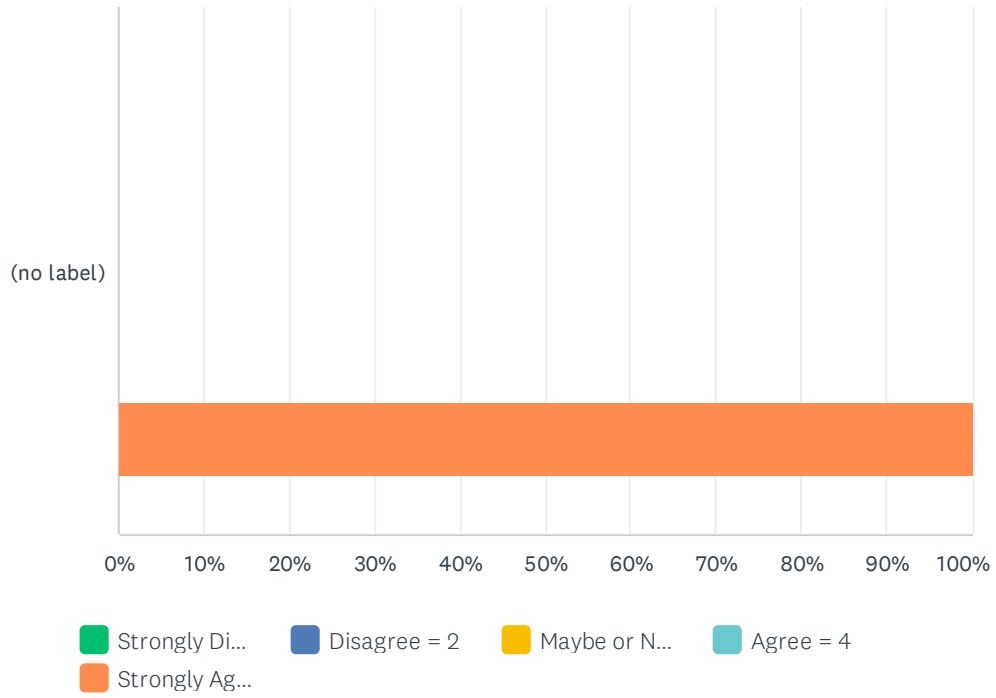
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	40.00% 2	60.00% 3	5	4.60

Q37 I maintain the confidentiality of all Board decisions.

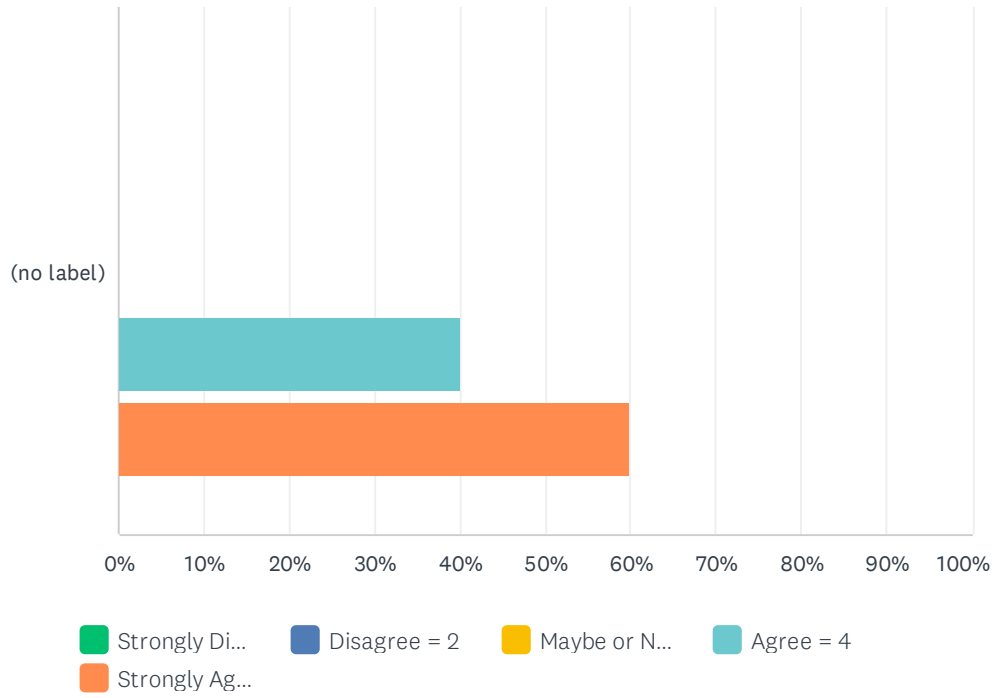
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 5	5	5.00

Q38 When I have a different opinion than the majority, I raise it.

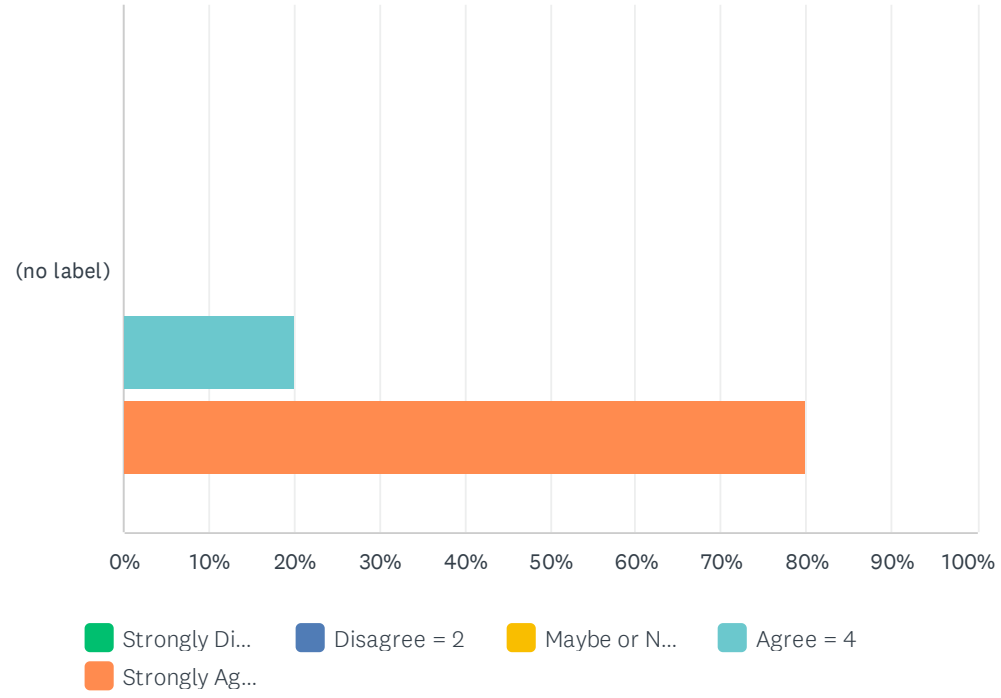
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	40.00% 2	60.00% 3	5	4.60

Q39 I support Board decisions once they are made even if I do not agree with them.

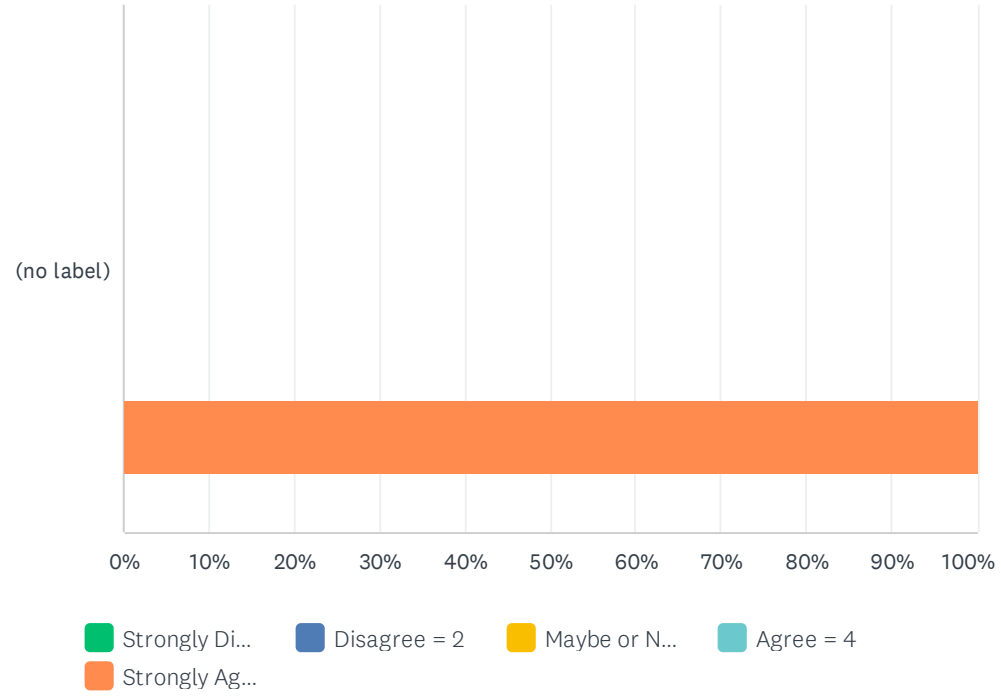
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	20.00% 1	80.00% 4	5	4.80

Q40 I promote the work of our organization in the community whenever I have a chance to do so.

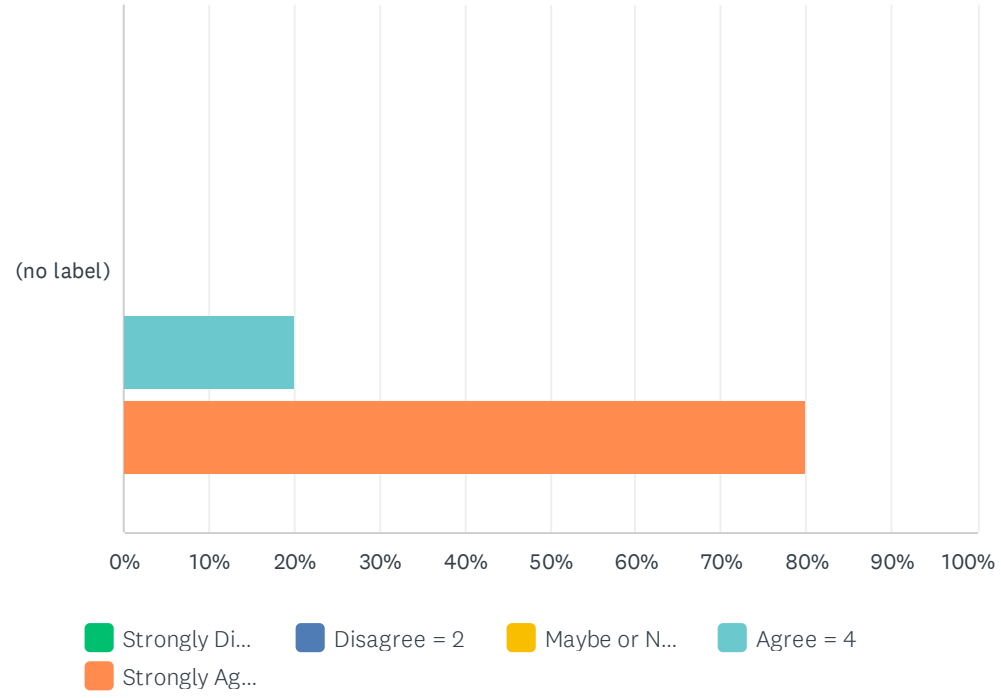
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 5	5	5.00

Q41 I stay informed about issues relevant to our mission and bring information to the attention of the Board.

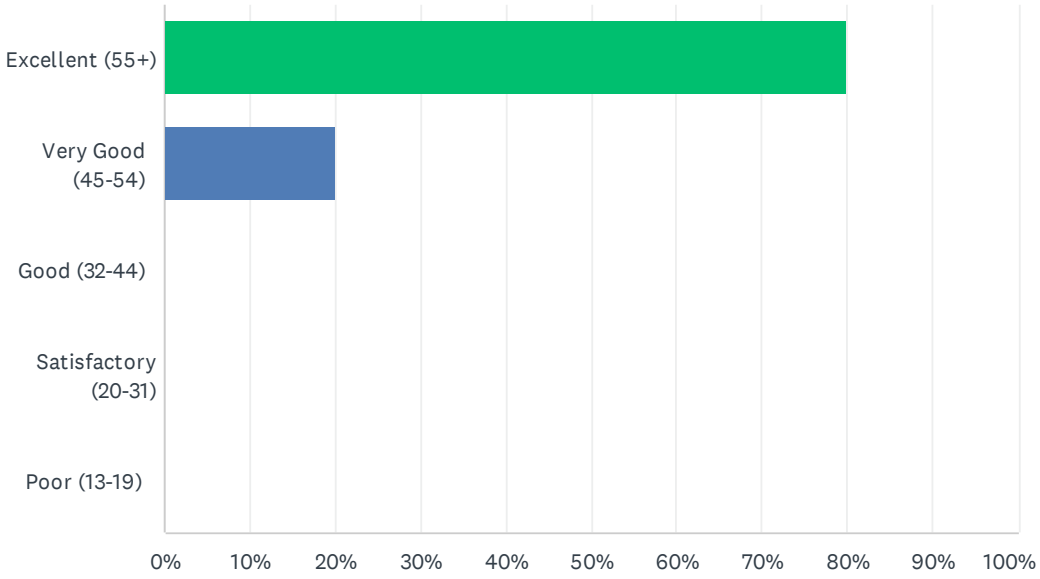
Answered: 5 Skipped: 0



	STRONGLY DISAGREE = 1	DISAGREE = 2	MAYBE OR NOT SURE = 3	AGREE = 4	STRONGLY AGREE = 5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	20.00% 1	80.00% 4	5	4.80

Q42 Add together your ratings for Section D and select the matching overall rating.

Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent (55+)	80.00%	4
Very Good (45-54)	20.00%	1
Good (32-44)	0.00%	0
Satisfactory (20-31)	0.00%	0
Poor (13-19)	0.00%	0
Total Respondents: 5		

BYLAWS OF THE MAYERS MEMORIAL HEALTHCARE DISTRICT

REVISED DECEMBER 2023

TABLE OF 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 "Board" means the Board of Directors of the District.

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

1.3.3 "District" means the Mayers Memorial Healthcare District.

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

1.3.5 "Hospital" means Mayers Memorial Hospital.

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

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

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

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

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 the 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.

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 Directors.

3.1.1 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 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.

3.1.2 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.

3.1.3 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.

3.1.4 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.

3.2 Officers.

3.2.1 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;

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

3.2.3 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.

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

3.3 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.

3.3.1 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.

3.3.2 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.

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

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

3.4.2 **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.

3.5 **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.

3.6 **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.

3.6.1 **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.

3.6.2 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.

3.7 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:

3.7.1 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.

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

3.7.3 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, that 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.

3.7.4 **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.

3.7.5 **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.

3.7.6 **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.

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

3.7.8 **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.

3.7.9 Any other duties as the Board may direct from time to time.

3.8 **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, that 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.

3.8.1 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, that 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.).

3.8.2 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.

3.8.3 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.

CERTIFICATION

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 December 6, 2023.

_____ _____

Abe Hathaway, President Date

MAYERS MEMORIAL HEALTHCARE DISTRICT

POLICY AND PROCEDURE

LABORATORY STAFF COMPETENCY

PURPOSE:

- The Lab Director (or Designee), Lab Manager, and designated CLS and/or Phlebotomist shall assess staff competence.
  - This individual shall be qualified by education, experience and knowledge related to the skill being reviewed.
    - See the qualifications for this individual in CLIA '88 regulations under Subpart M: Personnel for Non-Waived Testing, §493.1351 - §493.1495.
    - In the situation in which neither the Director, Manager, or testing personnel qualify to provide technical consultation, the laboratory shall engage the services of a qualified person (either part-time or full-time) for this service. This technical consultant does not have to be onsite for when tests are being performed, but must be available for consultation and should spend sufficient time in the laboratory to supervise the technical performance of staff in his/her specialty.

- Competencies assessments shall include the following:
  - Direct observations of routine patient test performance, including:
    - Patient preparation, if applicable
    - Specimen collection, handling, processing and testing
  - Monitoring, recording and reporting of test results
  - Review of intermediate test results or worksheets, quality control, proficiency testing and preventive maintenance performance
  - Direct observation of performance of instrument maintenance function checks and calibration
  - Test performance as defined by laboratory policy (i.e., testing previously analyzed specimens, internal blind testing samples, external proficiency, testing samples)
  - Problem-solving skills as appropriate to the job

- New staff competency shall be assessed at least two times during the first year of employment. The assessment shall be on all tests the staff member performs.

- This assessment shall be documented in the staff member's HR file.
  - All staff member's competency shall be assessed for all laboratory tests he/she performs on an annual basis.

- All competency assessments shall be documented in the staff members HR file

- Staff competency shall also be assessed when a new test, methodology or instrumentation is introduced to the laboratory.

- Staff competency shall be assessed when the duties of the staff member change.

- Proficiency Testing:
  - Competency testing will include API proficiency testing or other CMS approved Proficiency Testing Program on a rotating schedule for all technologists.
  - Clinical Laboratory in house examinations will be done annually for all CLS and Phlebotomists.
  - A passing grade of at least 80% must be achieved.
  - When a lab employee fails an examination in any area of the Clinical Laboratory, he/she will be retested in that area after being in-serviced by the Lab Manager or Designee.
  - If a second failure occurs, the technologist will be placed on probation for 30 days with additional in-servicing and then retested.
  - If a third failure occurs, the CLS and/or Phlebotomist will be suspended.

PROCEDURE:

1. ORIENTATION:

All new employees are required to attend the New Employee Orientation Program hosted by the hospital. The Human Resources Department will notify all employees of the date they are scheduled to attend at the time they are being processed as a "new hire". Attendance at Orientation is mandatory.

The Clinical Laboratory conducts an orientation program that also must be completed the first day in the department. This program consists of all work-related duties, Safety, and expectations of the new employee. A check-list will be provided to guide the employee through the orientation and to insure that all pertinent areas are adequately covered.

The new employee will go through a thorough training program of each area of the laboratory. Prior to the new employee being allowed to work on their own, the new employee must be successfully signed-off in each area of the laboratory.

In cases of unexpected circumstances, when new employee is not comfortable or feel that he/she still cannot perform the laboratory testing in each section, extension of probationary period may apply. Laboratory manager will re-evaluate the new employee's training and progress. However, inability to adequately demonstrate proficiency of the above stated will result in termination of employment. **Extension of probationary period will only apply in new hire full time employee**.

Reorientation is conducted annually (Month of March) through the Competency Program explained below.

2. IN-SERVICE:

Employee in-service and education is provided whenever a new procedure is adopted or whenever there is evidence that a system or procedure can be improved through change.

In-service and education may be conducted by the Medical Director, the Lab Manager, or any of the various CLS, Certified Healthcare Workers, and Phlebotomists as well as any qualified product vendor.

In-service may also be provided by the hospital or from qualified hospital staff such as the Infection Control Nurse, or other department Directors/Managers, or their qualified staff.

In-services, including a safety in-service and education, are conducted each month at the monthly General Laboratory Meeting. A quiz for the educational and safety in-service is required to be completed and handed in by all personnel.

3. CONTINUING EDUCATION:

Continuing Education is required by law for all licensed Clinical Laboratory Scientists. CLS must keep up the minimum required CEU's to keep their license valid.

- Continuing Education subject matter for CLS should be directly related to daily work requirements or interdisciplinary issues which may help to improve current systems. Copies of documentation will be kept in the individual files.

4. COMPETENCY:

CLIA 88 has mandated that laboratory personnel regularly demonstrate competency in the performance of all levels of laboratory procedures which they are responsible for.

In consideration of this regulation, the laboratory at Mayers Memorial Hospital will periodically require all personnel to demonstrate adequate knowledge of, or practical ability to effectively perform each of the procedures required by their position description.

Under this policy, the Laboratory Manager and assigned lab personnel will, on an annual basis (March of each year), conduct periodic surveys in which they will ensure the competence of the staff through the use of Orientation/Competency Checklists and through the Laboratory subscribed Proficiency Testing Program.

An Orientation/Competency Checklist has been designed for each department and or analyzer in the Laboratory. When a new employee is hired and annually thereafter, he/she will be required to demonstrate competency in each of the items on the checklist. When the proctor

is satisfied that he/she has met the level of competency required to perform effectively, he/she will sign off the task in the checklist. If the employee needs further in-service in a particular area, the supervisor will comment to that effect and follow-up on any required in-service for that employee.

The Laboratory subscribed proficiency testing program (API) materials arrive at different intervals throughout the year. As these samples arrive, they will be given to various different testing staff, which will then perform the required tests, give them to the Lab Manager or designee to review, and then report them to API. As the results are received, they will be reviewed by the supervisor and the testing staff for "accuracy" and documented as such. The results will be discussed at each monthly Lab Meeting.

If a member of the testing staff should fail to demonstrate competency in a given area, that employee is required to seek in-service for that area on his or her own time and expense. Once that in-service has been completed, that employee will be re-surveyed. However, until the employee can demonstrate competence in that area of testing, he/she will be suspended from working in that area of testing. If after re-testing, he/she still fails to meet requirements, that employee may be subject to disciplinary action, up to and including termination.

REFERENCES:

1. Cms.gov/regulations-and guidance/legislation/clia/downloads/clia_compbrochure_508.pdf
2. Regulation maybe found at: http://wwwn.cdc.gov/clia/regs/toc.aspx

COMMITTEE APPROVALS:
P&P: 11/15/2023

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

QUALITY ASSURANCE PROGRAM
LAB

PURPOSE:

In accordance with the hospital's philosophy of the provision of quality patient care, the Quality Assurance Program in the Clinical Laboratory Department will utilize predetermined criteria to provide for ongoing monitoring of the quality and appropriateness of patient care services provided by the department. The Medical Director and the Laboratory Manager will be responsible for the implementation and overall effectiveness of the program.

I-ASSIGN RESPONSIBILITY:

The Laboratory Manager will write the Performance Improvement (P.I.) Plan, delineate the Scope of Care, identify important aspects of care, develop indicators, establish thresholds for evaluation and, along with laboratory personnel, collect and organize data. The Laboratory Director is responsible for evaluating care and for taking action when the levels of care are not up to standard. The Laboratory Manager will assess the actions taken and document improvement as required, and communicate monitoring and evaluation activities to the appropriate committees as required.

II-SCOPE OF CARE:

The Laboratory provides services to both in and outpatients on a daily basis, 24 hours a day for inpatients. Hospitalized patients receive bedside service as requested by the physician or practitioner while the outpatient services are performed on specimens collected in the laboratory, or at the clinic.

Laboratory services range from Urinalysis to routine Chemistry and Hematology testing, to Microbiology, Clinical Microscopy, Serology and Blood Bank services.

Within the department itself, all lab staff collect and process samples in preparation for the Technologist to perform the requested test. Once the result has been entered and verified in the Laboratory Information System (LIS), or manually, a report is transmitted to the nursing station either through the LISND Electronic Health Record (EHR) or by hand.

In general, the Laboratory provides testing and blood products to the physician or practitioner for the purpose of diagnosis and therapy as needed in order to expedite the healing process and promote the well being of the patient in a timely manner. To that extent, the Laboratory will provide services as requested within reason and only when there appears to be a blatant deviation from reasonable expectations or utilization will there be questions.

III-KEY CUSTOMERS:

Key laboratory customers are patients, physicians and other healthcare providers, visitors, and the nursing staff. For outpatient services such as a physician's office or a clinic, the key customers are the same.

Key suppliers for the laboratory will often involve the various vendors of reagents and supplies used in the laboratory, but also includes services like Admitting, and may also include physicians, nurses, and others who at times assist in the specimen collection process.

IV-MAJOR CLINICAL FUNCTIONS:

1. Appropriateness of Laboratory Tests Ordered:

The laboratory will monitor appropriateness of patient care and laboratory services through the QI and Case Management standards established by the hospital.

Criteria and guidelines for monitoring various areas of service and testing such as vital signs, laboratory results, medications, etc. have been established.

Through intervention and consultation on the part of the Pathologist, the laboratory will ensure that lab testing is in the best interest of the patient and that testing is indeed appropriate for each case in which intervention is deemed necessary.

Patient records are periodically reviewed for appropriate utilization patterns and inappropriate trends are noted and reported to the proper committees. The laboratory acts as a resource for helping to determine appropriateness in individual situations.

The laboratory calculates the number of tests per patient day by dividing the number of tests performed by the adjusted patient days for the month. This number may be of value in identifying trends or changes in test order practices and may provide information about efficiency.

2. Quality (Accuracy) of Laboratory Results:

The laboratory will monitor the utilization and documentation of all Quality Control measures utilized for specialized equipment within the Department with appropriate actions documented when problems are identified.

The laboratory will enroll in certified proficiency testing programs as directed by local and national authorities. Results of these tests will be reviewed as they are received and made available as required.

Quality Control policies for laboratory testing are in place as required by local and national authorities. These policies are strictly followed and compliance monitored on an ongoing basis.

3. Timeliness of Laboratory Testing:

Laboratory testing will be available 7 days per week, 24 hours per day in order to provide efficient service and optimal turn-round at all times. Verified results of laboratory testing are reported immediately in the LIS (on manual forms as a back-up) and onto the EHR to insure efficient and effective communication of results to the physician.

4. Specimen Collection and Processing:

Phlebotomy for collection of blood samples will be performed by trained and licensed Phlebotomists, and other trained personnel. This service is available all hours of the day, 7 days per week. There are established and documented outpatient collection hours and days.

Samples are appropriately labeled with all pertinent patient information at the bedside or wherever collected, and transported to the lab immediately. Specimens are prepared for testing by the phlebotomist immediately after collection and are properly stored until ready for testing.

5. Provision of Blood and Blood Products:

The laboratory will provide blood and blood products to patients as required on an emergency and routine basis 7 days per week, 24 hours per day.

All procedures for transfusion of blood and blood products are American Association of Blood Banks approved and reviewed specifically by the Laboratory Manager, and overseen by the Lab Medical Director.

Blood and blood products will be provided by certified blood bank facilities locally, or where necessary, to keep an optimal stock in-house as required.

V-INDICATORS & THRESHOLDS:

Volume Indicators

1. Total Number of Tests:

This figure will be an indicator of the total workload processed by the laboratory on a daily, weekly and monthly basis. It can be trended to indicate changes in volume and analyzed with respect to percentage of testing being performed outside this laboratory. These figures can be used for justification or explanation for changes in staffing and are used in calculating daily productivity. Data is downloaded from Cerner Millenium.

Threshold: Staffing and budget in the laboratory is based upon workload (billable tests) which is monitored daily. When workload increases, additional FTE's (or granted Overtime) can be utilized to assist in operations. If the workload decreases, the Laboratory Manager evaluates and determines

the appropriate staffing required for maintaining quality performance. Staffing adjustment is made based on their assessment.

2. Total Number of Hours Worked:

The total number of hours worked is monitored in conjunction with the total number of tests performed. This data can provide valuable information used to determine adequate staffing levels in the laboratory and help in controlling the budget.

Threshold: Operating budget is set based upon projected workload and the proper staffing mix of CLS and Phlebotomists. A monthly productivity/FTE report will be generated and reviewed, and the staffing mix adjusted accordingly.

3. Total Number of STAT Orders:

This figure will be an indicator of whether the laboratory services are being properly used. It may indicate need for new instrumentation or it may indicate tests that were ordered late and hence, caused delays in patient discharge. It may also uncover need for more pre-admission testing.

Threshold: On the average, STAT testing comprises about 20% to 30% of the daily workload. Data will be evaluated on a monthly basis. When there is a fluctuation in STAT testing of more than 2% an explanation will be sought, and action will be taken based on the findings. Stat order volume can be downloaded through Cerner Millenium. **Go to Cerner Mellinium App > Discern Analytics 2 Prod > Published Report > Laboratory > Community Works Standard > Choose order volume –Summary or Order volume Detail Go to Cerner Mellinium App > Discern Analytics 2 Prod > Published Report > Laboratory > Community Works Standard > Choose order volume –Summary or Order volume Detail**

4. Total Units of Blood Used:

This figure may be an indicator in a change in the population of patients or the type of patients and may indicate a change in the service that may be provided. Data will be acquired from the blood bank log monthly and evaluated.

Threshold: The laboratory monitors the number of crossmatches ordered, number of PRBC units transfused, and the number of blood products transfused. The Blood Bank average crossmatched to transfused ratio (CT Ratio) should be less than 2.0. When the CT Ratio exceeds 2.0, an investigation will be conducted and reported accordingly. **Number of blood unit tranfused can be download through Cerner Millenium. Go to**

Cerner Millenium App > Pathnet BB Transfusion: Report Selection App

5. Referral Testing:

An indicator of laboratory self-sufficiency, it measures the physician test menu requirements versus the in-house testing capabilities.

Threshold: Data and order patterns will be acquired from monthly revenue and reference lab usage reports (reviewed by the Laboratory Manager) and examined for opportunities to either expand the in-house testing menu, or send testing out. The total volume of referred tests will be tracked monthly. Approximately 6-10% of testing will be referred to contract laboratories. Should this number increase/decrease, the Laboratory Manager or designee identifies the frequently requested test(s), and acts upon that information.

6. Venipuncture's:

Phlebotomy services performed by the laboratory are an important part of the overall success of the final result and to the patient's impression of laboratory services. When a phlebotomist has a problem collecting a sample from a given patient, the supervisor (or Senior CLS) is notified to assess the situation. He/she may perform the phlebotomy or assigns an "expert" for the task. No patient should be punctured more than 3 times by the same phlebotomist.

Threshold: About 20% of venipunctures are reviewed each month. The reason for redraws is investigated, e.g., hemolysis, clots, "hard-sticks", etc. If the number of redraws exceeds 5%, the supervisor investigates and may initiate corrective steps such as use of butterfly needles or phlebotomy staff retraining.

6. Patient Days:

This number is provided by the accounting department and is used in calculating test utilization which is discussed below.

Quarterly Indicators:

1. Customer Complaints:

Our customers are the purpose of our business. We value their input greatly and follow-up on all customer complaints is immediate and complete.

Threshold: One customer complaint may lead to a policy change. Customer complaints, verbal or written are investigated by the Laboratory Manager, or designee. Corrective steps are taken to resolve the

complaint and documented in the Lab Communication Log, and laboratory monthly meeting minutes.

2. STAT Turn-Around Time:

The ability of the laboratory to process STAT requests immediately is essential to good hospital care. STAT lab testing takes first priority and may require shifts in specimen collection, processing, and testing. TAT reports can be downloaded through Cerner Millenium. **Go to Cerner Mellinium App > Discern Analytics 2 Prod > Published Report > Laboratory > Community Works Standard > Choose the TAT detail**

Threshold: STAT turn-around-time is 1 hour from the time of specimen collection to reporting. STAT Turn-Around-Time (TAT) is monitored periodically, examined monthly and reported on a quarterly basis. The laboratory strives to achieve as quick a TAT as possible in every case. When the TAT exceeds 1 hour, processes will be reevaluated and opportunities for improvement will be implemented.

3. Test Utilization:

Through intervention and consultation on the part of the Pathologist, the laboratory will ensure that lab testing is in the best interest of the patient and that testing is indeed appropriate for each case in which intervention is deemed necessary.

Threshold: Patient records are reviewed for appropriate utilization patterns and inappropriate trends are noted and reported to the proper committees. The laboratory acts as a resource for these committees helping to determine appropriateness in individual situations.

4. Proficiency Testing (PT) Survey Deficiencies:

An indicator of whether or not the laboratory testing abilities are adequate, accurate and proficient in accordance with the variety and degree of testing services offered. Quarterly proficiency testing will be performed in all sections in which testing is performed, data will be compiled and analyzed from the service providing the samples and reports will be reviewed and recorded as they are received. Results of proficiency testing will be reported and documented in the monthly laboratory meeting minutes.

Threshold: CLIA and CMS require corrective action when proficiency falls below 80% for a given analyte, or 100% for blood bank. The laboratory investigates each deficiency, plans the corrective steps necessary and documents as required. The Laboratory Medical Director and Laboratory Manager review, and sign off on all PT survey results.

5. Below are some of the other quality indicators that are monitored and reported quarterly. When a set threshold is exceeded, investigation is initiated and necessary corrective steps taken.

    a. Patient Identification at the time of collection: About 30 collections are observed for compliance and reported quarterly. Performance Expectation: 100%

    b. Critical Results Call Back: All critical (panic) results must be called and read back by the responsible RN and/or requesting physician. Performance Expectation: 100%.

    c. Blood Culture Contamination Rate: Monitored monthly and performance expectation is less than 3%.

    d. Patient Identification: All patients (100%) must be positively identified before specimen collection. Two (2) patient Identifiers are: name and medical record or account number. Performance Expectation: 100%

VI-DATA COLLECTION AND ORGANIZATION:

The source for the data collected in the above indicators will almost always involve the Laboratory Information System, manual recording of data, and other related departments. Sample size for each indicator is specifically indicated in the quarterly report.

VII-EVALUATION:

All data will be collected, analyzed and acted upon by the Laboratory Manager and/or designee. He/she will report the findings to appropriate hospital committees as directed.

VIII-TAKING ACTION:

When an opportunity to improve patient care and/or services is identified or becomes a necessity, an action plan will be established. Subsequent action may include simple verbal counseling, continuing education, a new policy/procedure, a change in a current policy, procedure or process, disciplinary action, etc.

IX-ASSESSMENT AND DOCUMENTATION:

Corrective actions taken must be assessed for effectiveness by continued monitoring and evaluation of the Important Aspects of Care and Indicators. If actions taken do not have an effect, or do not show improvement in quality of care further action must be taken. Effectiveness of actions will be documented in the quarterly reports.

The Performance Improvement (P.I.) plan will be assessed for effectiveness on an annual basis by the Laboratory Manager who will make recommendations to appropriate committees for

retaining or deleting current indicators, or for the addition of new indicators. The committees review the Laboratory Manager's assessment and recommendations and approve or deny them based on their evaluation.

X-COMMUNICATION:

Results of the various monitors and assessments will be communicated to the staff through the regular staff meetings. These same findings will be reported to the Quality Improvement Committee, the Department of Medicine, ED, and Surgery Committees (If they exist) on a quarterly basis.

REFERENCE:

Center for Medicare and Medicaid Services, *CLIA Interpretive Guidelines for Laboratories* | Website: cms.gov/medicare/quality/clinical-laboratory-improvement-amendments/guidelines/laboratories | Retrieved on 10/21/2023

Cerner Millenium, *Solution Training Resources – CommunityWorks Reference Pages – Cerner Wiki* | Retrieved on 10/21/2023

Labcorp Reference Laboratories, Introduction to Specimen Collection | Website: labcorp.com/resource/introduction-to-specimen-collection |Retrieved on 10/24/2023

COMMITTEE APPROVALS:
P&P: 11/15/2023

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

STAT LIST OF TESTS AND RESULT REPORTING TURN AROUND TIME

POLICY:

To ensure that results are reported timely to optimize patient care and patient outcomes. To define the tests that can be ordered on a STAT basis and the interval of time between when sample is received in the laboratory and the results are reported.

PROCEDURE:

The following tests are available on a STAT basis at Mayers Memorial Hospital (MMH) at all time. Strict adherence to this policy is of paramount importance for the efficient, cost-effective delivery of laboratory services. STAT testing is not limited to the list below. If the clinician insists, perform the test. Consult the Pathologist for unlisted STAT test(s) requested by providers. Also refer to policy #1146 (Handling Unusual Test Requests from Physicians) in the Lab Policy and Procedure Manual.

Turn Around Time for tests in the Clinical Laboratory

- **STAT –** one hour or less from when the sample was received in the laboratory.
- **ASAP –**Two hours or less from when the sample was received in the laboratory.
- **ROUTINE** – Four hours from when the sample was received or as schedule for the next run.

Chemistry Test Available on a STAT basis

- Chemistry Panels (BMP, CMP, LFT, Cardiac, Lactic, Ammonia and Renal).
- Therapeutic Drugs/BNP/High Sensitivity Troponin I
- Toxicology

Hematology/Serology/Clinical Microscopy and Body Fluids Tests Available on STAT Basis

- CBC/Hemogram/H&H and Manual Differential if warranted/Retic
- CSF/Body Fluid Cell Count
- PT/PTT/D-Dimer
- Urinalysis and Microscopic if warranted
- Qualitative Pregnancy Test
- Mono Test
- Strep Screen
- Influenza
- Covid-19 Antigen Rapid Testing
- Other Serological tests deemed necessary

Microbiology Tests Available on a STAT Basis

- Wet Mount
- Gram Stain
- Respiratory PCR, Gastrointestinal PCR, and Meningitis PCR
- WBC Fecal Smear

Transfusion Services Tests Available on STAT basis

- Compatibility Testing (Crossmatch)
- *Atypical Antibody Detection/Antibody Identification
- Direct Coombs Test
- Emergency release of blood products
- ABO Group and Rh Typing
- Red blood cells
- Platelets
- Fresh Frozen plasma
- Cryoprecipitate

Note: *The one hour STAT applies only if the product is available in the laboratory and there are no complications such as an unexpected antibody. In those cases, blood products may need to be brought from Vitalant or a sample blood sent to Vitalant Reference Laboratory for further testing. The nursing unit will be contacted as soon as possible and notified of the delay and options available. If necessary the Pathologist may need to be consulted for the best course of action to meet the patient care needs. The Pathologist may need to speak to the ordering physician to discuss how to accommodate the needs of the patient.

Note: *Tests may be sent-out to the reference laboratory for confirmation or further workup and may take longer than a 1-hour turnaround time.

Other tests performed in-house that the clinician insists that they need STAT should be ran, documented in the Lab Communication Log for review by the Lab Manager and/or Lab Director.

Reporting of STAT Results

STAT results for inpatients and outpatients are available through the HIS (Hospital Information System – CERNER). Laboratory staff who report critical values verbally or telephone will request "read back" from the receiving party and will provide confirmation that the results were read-back accurately in accordance with the Joint Commission's *National Patient Safety Goal on Effectiveness in communication among care givers.*

REFERENCE:

CAP Commission on Laboratory Accreditation Checklist, *Laboratory Accreditation Manual, 2018* | Retrieved from www.lsom.uthsca.edu/pathology/wp-content/uploads/sites/94/2019/03/Laboratory-Accreditation-Manual-2018.pdf

The Joint Commission *Comprehensive Accreditation Manual for Pathology and Clinical Laboratory Series* 2023 Edition.

COMMITTEE APPROVALS:

P&P: 1/15/2023

January 31st	February 28th	March 27th	April 24th
Safety Q IT Facilities & Engineering Infection Control	Hospice Q MHF Q Quality & Risk SNF BOD Q Finance Review	Business Office Rural Health Clinic Purchasing Annual Audit Summary	Safety Q Lab Radiology FNS
May 29th	**June 26th**	**July 31st**	**August 28th**
Hospice Q MHF Q Acute ED BOD Q Finance Review	Patient Access HIM EVS Ambulance Budget Adoption	Safety Q Surgery Outpatient Medical Hazard Vulnerability Assessment	Hospice Q MHF Q SNF Telemedicine 401K Annual Report BOD Q Finance Review
September 25th	**October 30th**	**November**	**December 4th**
Pharmacy Retail Pharmacy Cardiac Rehab/PT Bylaws Review BOD Assessment Process	Safety Q Respiratory Therapy Employee Housing Construction Nominating Committee	NO Regular BOD Meeting	Hospice Q MHF Q Clinical Education Officers & Committees Board Calendar Org Analysis BOD Q Finance Review

** Risk as needed ** **Subject to Change**

Overview Report

MMHD and TCCN Proposed Agreement

Introduction and History

Mayers Memorial Healthcare District granted the real property on which TCCN operates in 1998. At that time MMHD assisted TCCN in obtaining their corporate and non-profit status. Former CEO, Judi Beck worked collaboratively with Cindy Dodds to establish the TCCN.

At the time the grant deed was awarded to TCCN, there were provisions that required TCCN to provide wellness and other socially needed services to the communities it served, or the real property would come back to MMHD.

Over the years, TCCN has provided many services, including Day Care, Food & Nutrition, Workforce and Education trainings, etc. Just recently, largely as a result of COVID and the restricted ability to provide some services, TCCN has had some financial, workforce and program challenges. TCCN was able to recently obtain grants to assist, but further employee challenges have led the board to look at other options.

MMHD has again, been working in collaboration with TCCN to find solutions for the community center to continue to serve the Intermountain Communities. At the direction of the MMHD board and after several meetings with the TCCN Board, research, and legal assistance, we believe we have a solution to fit the needs of the community center while allowing MMHD to expand billable services and invest in the Burney end of our District.

This report outlines the key components of the agreement between Mayers Memorial Healthcare District (MMHD) and Tri County Community Network (TCCN). The agreement focuses on the transfer of operational control of billable services and operations, the return of real property to MMHD, bylaw revisions, and the delineation of responsibilities related to 501(c)3 status, grant funds, and donations.

Actions:

- TCCN to make bylaw revisions – these have been reviewed by attorney. The main changes and additions are as follows and have been approved by the TCCN board contingent on MMHD Board action.

Section 1.Purpose. Under the direction and guidance of Mayers Memorial Healthcare District (MMHD), the specific purpose of this Corporation is to establish and maintain support for any entity which is organized for purposes of providing improved health care, community wellness and services in Shasta, Modoc and Lassen Counties, and within the MMHD District boundaries (attachment 1) situated in California and which has established its tax exempt status under Section 501(c) (3) of the Internal Revenue Code, or the corresponding provisions of any future United States Internal Revenue Law, or which is exempt from income taxation under any other provisions of the Internal Revenue Code and corresponding California law.

MMHD shall maintain responsibility for operational income and expense as related to billable services and general operations outside of donation and grant funded projects. Staff shall be employees of MMHD and eligible for corresponding salary and benefits.

Real Property Transfer:

As part of the agreement, real property currently under the purview of TCCN is slated to be returned to MMHD. This transfer is a crucial step in streamlining the operational control of services and facilities, ensuring a cohesive and unified approach to healthcare provision.

TCCN Board approved a resolution to begin the process of transferring the real property back to MMHD at a board meeting November 27, 2023.

501(c)3 Status and Board Governance:

While MMHD takes operational control, TCCN is committed to maintaining its 501(c)3 status. The Board of TCCN will retain governance over grant funds and donations, ensuring transparency, accountability, and compliance with regulatory requirements. This structure maintains the integrity of TCCN's nonprofit status and its ability to secure funding for community initiatives.

Services Exploration:

Several services are earmarked for exploration under the new collaborative framework:

- **Daycare and Afterschool Programs**: MMHD and TCCN will explore the continuation of daycare and afterschool programs, catering to the needs of the community. Additionally, reduced-fee services will be offered to MMHD employees, fostering a supportive work environment.
- **Reimbursable Partnership Health Plan Services**: The collaboration will delve into the provision of reimbursable health plan services, enhancing accessibility and affordability for the community.
- **Workforce Programs**: Joint efforts will be made to develop workforce programs that address the healthcare needs of the community, focusing on skill development and employment opportunities.
- **Collaboration with School District**: MMHD and TCCN will explore collaboration opportunities with the local school district, fostering synergies in educational and health-related initiatives.

MMHD Benefits and Use:

MMHD will be able to reduce negative cost report effect of non-hospital space by utilizing over 50% of the space for hospital related activity. For example, office space, potential employee benefits by offering discounted daycare to MMHD employees and providing care-based services from the center.

Finance and Staffing:

MMHD will maintain fiscal responsibility for operational needs and all related billable services. Staff of the TCCN programs will be MMHD staff. Initially, a director will be hired to work with MMHD to build, expand and reinvigorate services. Once services, programs and daycare, preschool and after school program needs are determined we will determine what staff will be needed. TCCN will be in the CPRO Division.

We have been working on insurance and other necessary items related to the property coming back to MMHD.

Timeline:

With approval of the MMHD Board on December 6, 2023 – we hope to begin the process of hiring a director, evaluating the programs, looking at the needs of the property and evaluating use of space, proceeding the with grant deed transfer, securing insurance (tentatively set for January 1, 2024) and re-establishing programs. The TCCN board will continue to oversee and monitor grant fund programs including Bright Futures and others currently being researched.

It is hoped we can kick-off a re-building process at the beginning of the year.

Conclusion:

The MMHD and TCCN agreement marks a strategic alliance aimed at optimizing the delivery of healthcare, wellness, social and education services to the community. The outlined provisions for real property transfer, bylaw revisions, governance structures, and service exploration set the stage for a comprehensive and integrated approach to community health and well-being. The commitment to maintaining TCCN's nonprofit status ensures sustainability and the opportunity to seek grant funding, while the exploration of new services reflects the shared vision of addressing diverse community needs.

The collaboration will be a benefit to the community and have a positive reflection on MMHD in serving the Burney Community. This partnership will take MMHD and TCCN back to their origin, when the two organizations worked together to form this community resource.

Statistics	**September YTD FY24** *(current)*	**September YTD FY23** *(prior)*	**September Budget YTD FY24**
Surgeries ➢Inpatient ➢Outpatient	 0 0	 0 0	 TBD TBD
Procedures** *(surgery suite)*	0	0	TBD
Inpatient	656	810	476
Emergency Room	1411	1598	1522
Skilled Nursing Days	9669	9534	9237
OP Visits (OP/Lab/X-ray)	4581	6163	4502
Hospice Patient Days	221	624	597
PT	584	829	935

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

**Procedures: include colonoscopies

Human Resource

December 2023

Submitting by Libby Mee – Chief Human Resource Officer

Staffing and Recruitment

CEO Search

With the recent voluntary resignation of current CEO, Christopher Bjornberg, we have posted the vacant position on all our available job boards. At the time of this report, we have received interest from over 50 applicants. The HR department will continue to work closely with the board to review applicants as we move into the interview process.

Potential Nurse Visitation Day

Our Retention and Recruitment Specialist, Ashley, has had a very busy season attending career fairs at many local businesses and educational institutions. With all the point of contacts that she has established, she is now working on hosting a "Nurse Visitation Day". The intention would be to provide an opportunity for interested applicants to come onsite, meet team members, visit the lodge, and gain insightful information about what potential employment would look like at the district.

Employee Health, Wellness and Benefits

Insurance Renewal and Open Enrollment

There has been an extensive amount of work being done over the past few months, as we have made changes to our employee health benefits insurance broker and rebuild our benefit programs due to the serve increase in premiums with our previous program. We completed our employee open enrollment period on December 1, and are now working on getting accurate enrollment information out to the program vendors. I am excited about the changes that have been made, and the support that we have available with our new broker. I am looking forward to our continued communications with staff as we market our robust benefit programs.

We are also watching our engagement scores on our Wellable and newly implemented Modern Health App in our Employee Assistance Programs.

Work Related injury and Illness

For 2023, we have had 11 reportable claims and 13 first aide claims resulting in 64 days away from work.

We are also continuing to standardize our response to employees with COVID so they better align with how we manage any other employee illness and exposure.

Paycom

We recently had our Client Relations Representative from Paycom on site for a visit. He spent the day with the HR Generalist and Payroll and Benefit Administrator. Together they previewed our current system and has helped identify items that were not set up appropriately or areas of the system we could be more efficient. The team has communicated frustrations and concerns that we have had with the system since implementation, and the Rep is going to continue to work closely with the team until we are satisfied with our set up and usage.

Events/Conferences

I had the privilege of attending the Annual Summit for the Trust Edge Leadership Institute with a group of MMHD Team members. The Institutes primary focus is helping companies build a high-performing workplace with the application of an 8-pillar framework built around trust. The two-day summit hosted over 25 impactful presenters from the industries of Tech, AI, Military, Food Service, NFL, MLB, NBA, Business, Philanthropy, Government, Entertainment, Broadcasting and National Ambassadors. The summit provided an abundant amount of personal and professional resources that I look forward to implementing with the HR, leadership and MMHD team.

The Institute also offers certifications programs and resources, like employee engagement dashboards, that we are considering implementing as well.

EMPLOYEE STATISTICS

As of November 27 2023

293

Total employees

25

Open Requisitions

37

Available Positions

PAYCOM:

79

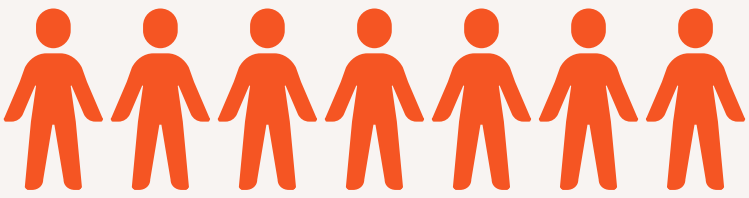
Active Applications

RECRUITING AGENCIES:

4

Active applications

RETENTION VS. LOSS



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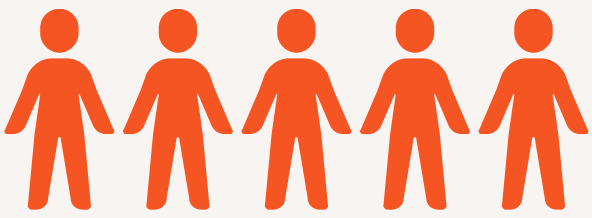
People hired/rehired
Oct 19-Nov 27

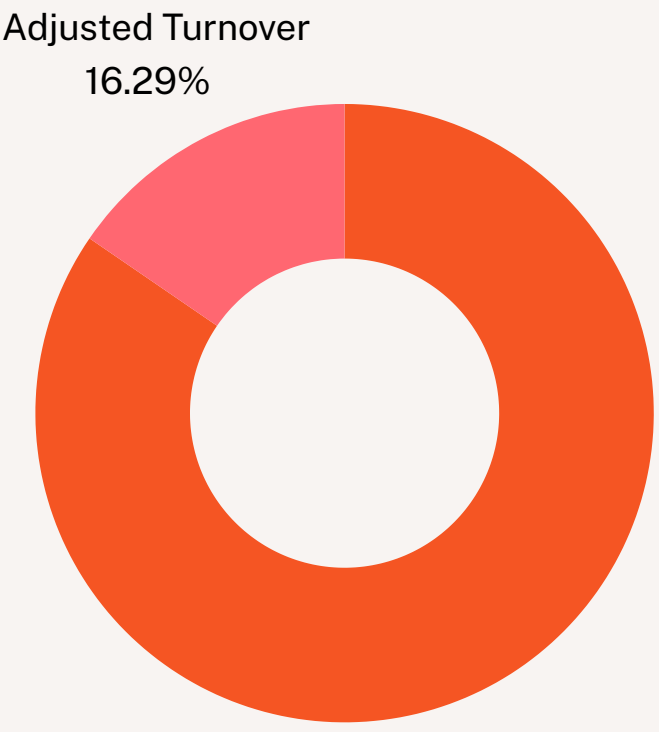


5

people terminated their employment
Oct 19-Nov 27

ADJUSTED TURNOVER STATS FOR JAN-NOV: 58 TERM OVER 356

Goal turnover for FY 24 is 17.52%



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

Positions:	# available:
Activities Aide	1
Admin Assistant to Chief Public Relations Officer	1
CEO	1
Clinical Lab Scientist	PER DIEM
***Emergency Dept Medical Director**	1
***Emergency Dept Mid Level**	FT OR PT
***Emergency Dept Physician**	FT OR PT
Emergency Room RN I	1
Environmental Services	1
Hospice Home Health Aide	PER DIEM
***Independent Retail Pharmacist**	1
Med/Surg Acute Charge Nurse	1

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

Positions:	# available:
***Pharmacist**	1
Physical Therapy Assistant	1
***Radiology Tech**	2
Rural Healthcare EMT	PER DIEM
Rural Healthcare Paramedic	1 FT, 1 PER DIEM
***Skilled Nursing RN**	3
***Skilled Nursing CNA**	10
***Skilled Nursing LVN**	11
Skilled Nursing Charge Nurse	1
Skilled Nursing Unit Assistant	OPEN FOR NEXT ROUND OF CNA CLASSES
Quality Data Analyst	1

Chief Public Relations Officer – Valerie Lakey
November/December 2023 Board Report

Legislation/Advocacy

The legislative session has adjourned until January 3, 2024. Below are some "two-year" bills that can be revisited next year. Bills that are still in their original house must pass to the second house by the end of January, and the deadline to introduce new legislation is February 16, 2024.

Assembly Bill (AB) 1156 (Bonta, D-Oakland) - Oppose
AB 1156 would create a rebuttable presumption in the workers' compensation system that an infectious disease, respiratory disease, cancer, PTSD, musculoskeletal injury, or respiratory disease, including COVID-19 and its variants, arose out of work for any hospital direct patient care worker.

AB 1316 (Irwin, D-Thousand Oaks) – Sponsored by CHA
AB 1316 would require that Medi-Cal managed care plans pay hospital emergency departments for serving Medi-Cal beneficiaries experiencing a mental health crisis. It would also ensure people who need access to a mental health inpatient bed are transferred promptly to the care they need.

AB 403 and AB 666 (Arambula, D-Fresno) - Oppose
AB 403/AB 666 would set forth new or expanded requirements for community benefits. They would require the Department of Health Care Access and Information to define "community," redefine the term "community benefit," and expand the definition of "vulnerable populations." The bills would also require that a community health needs assessment include the needs of the vulnerable populations and include a description of which vulnerable populations are low or moderate income. Community health needs assessments would have to be updated at least once every two years, and hospitals would be required to coordinate with a local health department. AB 403/AB 666 would also increase the fine for not submitting a community benefit plan from $5,000 to $25,000.

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

There are many more two-year bills which we will be following. We are once again represented on the ACHD Advocacy Committee and CHA's Legislative Strategy Group.

Public Relations/Marketing

We assisted the Respiratory Department in putting together packets and information to take to the local providers and clinics. We are doing the same for Imaging. We have designed and will publish a full-page clinic ad this month highlighting our providers and services.

We are planning the quarterly event which will be December 13th from 5:00 – 6:00 pm in the MMHD Lobby. It will feature the Master Plan and refreshments will be provided. Advertising has been initiated for this event.

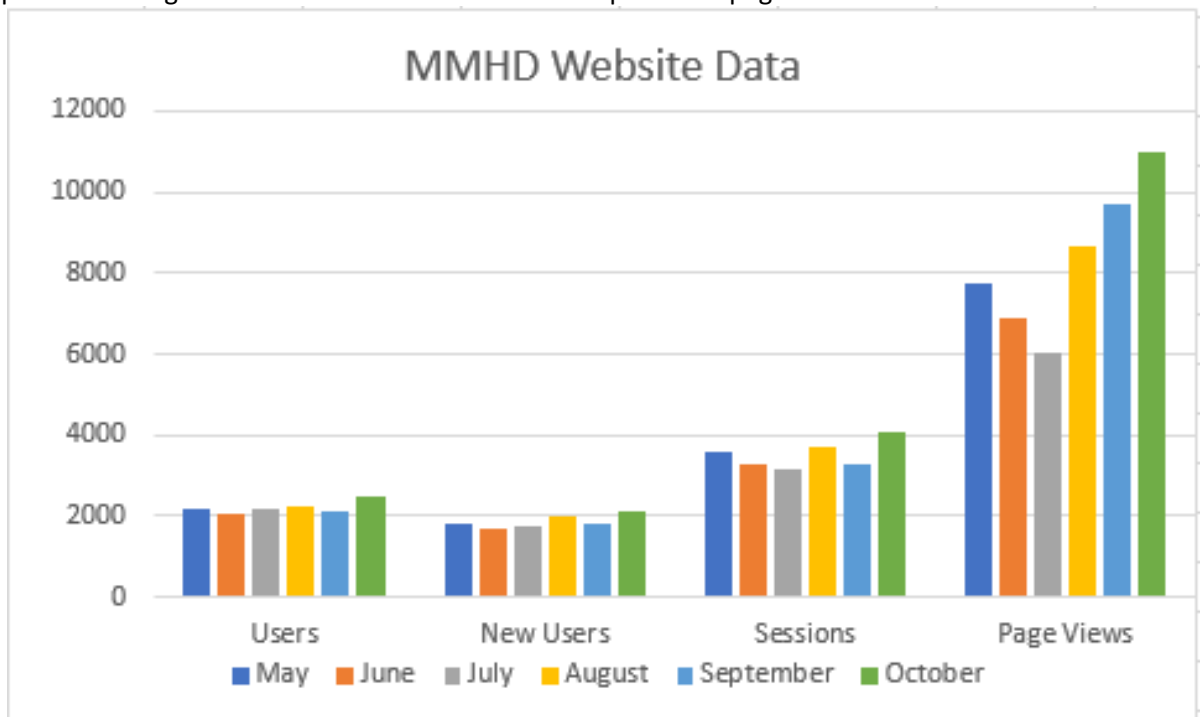
We are making updates and changes to both the MMHD and MHF websites.

We were involved in the annual Block F Tournament at Fall River High School. We had a table set up and gave out water bottles with our logo and "We Support Our Local Athletes".

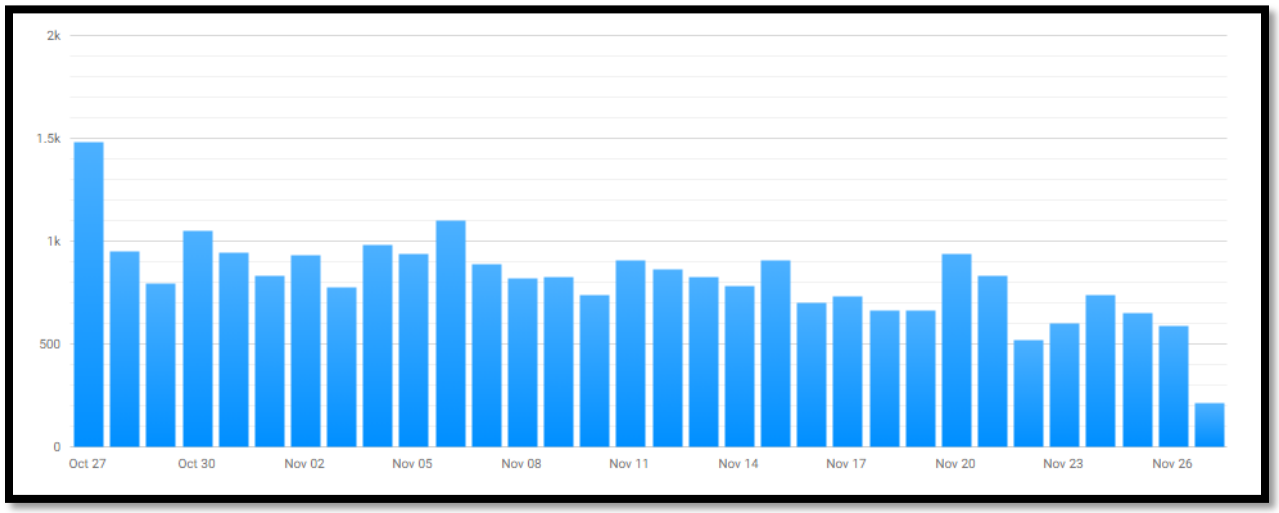
Our second quarterly digital newsletter will go out on December 13th and will feature articles about our Employee Safety, Solar Project and Mobile Clinic.

We have been working with SNF and Hospice to complete holiday projects, flyers and other public relations information.

We have seen an increase in web traffic as well as an increase in clicks on our social media links. These posts are designed to drive traffic to our various department pages on the website.



We saw good numbers on our AudioGo ad for employment needs.



Foundation

MHF North State Giving Tuesday was a great success raising over $25,000 .

The Denim and Diamonds Gala is scheduled for Saturday, January 27, 2024, at the Ingram Hall at the Inter-Mountain Fairgrounds. Jared Hovis will be the featured entertainment. The foundation has announced the exciting reverse raffle for a 1965 FORD MUSTANG. This event will support Hospice and other healthcare service needs of MMHD.

See more about the Foundation in the full and separate MHF report.

Tri County Community Network

Travis Lakey and I have been doing the leg work on the TCCN project. We have agreements in place with TCCN and you will find an overview in this packet and the project listed as an action item on your agenda.

Overall, both MMHD and TCCN see this as a great opportunity to provide services to our community and do some much needed rebuilding. For MMHD, this is a golden opportunity to support the Burney end of our district and enhance services through the community center.

Gift Shop

We have a lot of new inventory at the Gift Shop. There are many gift items and a wide Christmas selection. Revenue has been consistent, and the gift shop items move quickly. We have been fortunate to have a couple of volunteers to help with checking in and staging inventory. We encourage you to stop by and do some local shopping!

November Board Report
Clinical Division
11/28/2023

Respiratory Therapy

- The new ABG machine from Nova-Biomedical has being validated and is in use. Since go live, technicians have been out twice for repairs. This machine is not interfaced to Cerner yet but a work order has been submitted.
- Respiratory therapy staff visited local clinics including Mountain Valley's Clinics and Pit River Clinic to promote the PFT program. The visits have resulted in a round of PFT referrals. They also visited local employers promoting pulmonary screening. David Ferrer, RT, manager, will be performing onsite pulmonary screening at Dica-lite in December.

Laboratory

- The CLIA license renewal and accompanying documentation is ready for submission and has been sent to Dr. Morris for his signature.
- The urine tox screen machine was down for a week. Specimens were sent to Modoc for testing.
- Some reagents are on back order, specifically the reagent for HbA1C and we are borrowing from neighboring hospitals until Mayers receives our allocation.

Imaging

- The Imaging Department has been working with public relations in creating a brochure and customer service questionnaire for the clinics we support. We will be visiting all the local clinics to introduce ourselves to the community.
- Harold Swartz, imaging manager, has created required radiology policies for ACHC preparedness
- Radiation Safety is a big component of compliance and Harold has developed quality metrics to support radiation safety.
- Recruitment for radiology tech continues and Harold worked with human resources to find new agency.
- Harold is reviewing the charge master and removing tests that are not performed on site and reviewing reimbursement. One change has already been made with is the difference between a $600 and $2300 test.

Physical Therapy

- Daryl Schneider, PT manager, is meeting with Rey Pesina, Rehab director for Plumas District Hospital on Friday, December 1 to learn from his experience with Cerner and outpatient PT. The goal is to improve performance and efficiency.
- Stefanie Hawkins, PT and Cardiac Rehab scheduler, has helped train two staff members in other departments on Cerner's *Appointment Book* and *Scheduling* module.
- The department is trialing new acoustic panels for sound dampening in the gym.

Cardiac Rehab

- Zita Biehle is officially the Cardiac Rehab Program Coordinator. Trudi Burns has retired and we appreciate Trudi's year of service.

- Balance boards purchased through a foundation grant are in place and in use. In addition to balance exercise in cardiac rehab, fall risk and home fall prevention education is available to patients.
- Dr. Watson is acting medical director for cardiac rehab. This allows us to intake monitored patients sooner as Dr. Watson can sign the orders. Getting signed orders faxed back from doctors' offices results in delays. We are currently at capacity with monitored patients and have a waiting list.
- October has 9 Holter monitor patients which is the most in any month in 2023.
- We are anxiously awaiting the arrival of the equipment awarded by the foundation. Zita has negotiated with the arm bike company to get free shipping and a second seat. We are excited to start the ambulatory blood pressure program.

Hospital Pharmacy

- The plan of corrections for the automated dispensing machine license was submitted and accepted. The licensed Pyxis® machine is the one in the ER. Pyxis® competency training is almost complete for all nursing staff and is complete for pharmacy staff.
- The pharmacy is compliant with the Drug Supply Chain Security Act (DSCSA) and is submitting all the required information through the Infinitek® platform.
- The pharmacy has been short staffed as a pharmacy technician is out on maternity leave.

Retail Pharmacy

- Hydrocodone/APAP 10/325 is on nationwide backorder with no published release date. We have been working with local clinics on alternatives, so patient's pain regimens do not experience interruptions.
- The pharmacy went live with the phone interactive voice response. We chose to use Kristi Shultz's voice and not a mechanical voice. The phone system that allows customers to order refills over the phone by prescription number. Customers will be able to order refills via phone 24 hours and not just when the pharmacy is open. The refills directly appear in the pharmacy computer system.
- The pharmacy went live with our new 340B TPA, Hudson Headwaters, on 11/1/2023
- The first round of customer satisfaction surveys wraps up December 1st. We will receive the data in December and make improvements. Kristi Shultz, CPhT, business manager, is working with marketing on making the survey format more accessible to customers who may not be as computer efficient.

NURSING SERVICES BOARD REPORT

November, 2023

CNO Board Report

- CDPH came to investigate 11/16/23, 1-complaint in Acute and 2-complaints in ED. When they left, it was stated "No deficient practice". We will await their final report.
- ACHC regulations being reviewed with Quality and Acute Departments. Work in progress restructuring policies and procedures.
- I attended the Trusted Leadership Summit along with 4-other C-members. It was very informational and inspirational regarding Trust within your organization and self.

SNF

- Census- (81) Fall River- 32 Burney Annex- 28 Memory Care- 21
    - Fall River – 2 Female bed, 2 Male beds, 1 Hospice or 2 M/F available.
    - Burney – Full
- 4-NATP students will complete their on-the-floor orientation by November 20th.
    - One student resigned due to her family relocating.
- Currently we have 5 Unit Assistants ready to enter the next CNA class tentatively scheduled for January.
- Continuing to struggle with staffing in-house nurses. Medifis and NPH are meeting our needs at this time to maintain staffing ratios.
    - We have signed two new LVN Medifis contracts to help decrease NPH usage due to their high cost.
    - Shasta College reached out with a VN student that is interested in precepting in Burney. The student has expressed intent to apply after gaining licensure.
    - SNF & Acute Director attended the Shasta College Job Fair on November 2nd.
    - Hired per-diem LVN. She is currently in the second semester of the RN program at Shasta College. Will work in SNF during school with the intent to transfer to Acute after completing her RN licensure.
- CDPH was here to review six self-reports. Five ended without deficiency and one with possible deficiency. The CMS-2567 (Written statement of deficiencies) is pending.
- SNF Cerner implementation is on track to start at the end of November.

Acute

- October 2023 Dashboard
    - Acute ADC 2.06, LOS 2.78
    - Swingbed ADC 3.16, LOS 9.8
- October Staffing: Required 8 FTE RN/LVN's, 2 PTE RN's, 4 FTE CNA's & 2 FTE Ward Clerks
    - Utilizing 1 FTE Medifis, 1 FTE NPH RN, & 1 PTE NPH RN/LVN
    - Open positions: 1 FTE RN and 2 PTE
    - 1 FTE RN & Per Diem RN scheduled to start orientation this month
- Updates:

- Collaborating with Cerner Super Users to streamline workflows and educate staff as needed.
- Reviewing Statistical Data to identify gaps, and work with appropriate team members to rectify issues.
- Working on Swing Bed Course, collaborating with team, and adjusting policies/workflows to better align with CMS guidelines and ACHC Standards.
- Reviewing, updating, and reformatting policies to meet ACHC guidelines.

Emergency Services

- October 23 Dashboard
  - Total treated patients: 369
  - Inpatient Admits: 23
  - Transferred to higher level of care: 13
  - Pediatric patients: 62
  - AMA: 2
  - LWBS: 10
  - LPTT: 0
  - Present to ED vis EMS: 57
- October Staffing: Required 8 FTE RN, 2 PTE RN's, 2 FTE Tech's
  - Utilized 2 FTE contracted travelers
  - RN Supervisor continues with temporary role of Project Manager for Cerner and key player in workflow changes, financial revenue review, and superuser.
  - Open positions: 1 FTE Noc RN
  - 1 FTE RN scheduled to start orientation in December
- Updates:
  - Bridget Bernier has accepted the ED Manager Role effective 11/20/23
  - Reviewing, updating, and reformatting policies to meet ACHC guidelines.
  - Monitoring department workflows, identifying gaps, and working towards building skills fair and in-service courses to promote quality of care and meet ACHC guidelines.
  - Monitoring patient charges, CPT codes, and documentation in Cerner system, identifying concerns, creating new workflows, and educating staff as needed.

Outpatient Surgery

- Leanne Melang has stepped into the OR Manager Role effective 11/6/23
- The department remains closed, delayed for HVAC testing and possible facility improvements. Unknown date for opening.
- Letters sent to local referring clinics and patients who have been referred to surgery informing them of the delay in opening.
- Recruitment strategies are going well. Recent site visit with General Surgeon completed.
- A surgical technician has been hired and has started independent study for technician program.
- Evaluating gaps in department and have been streamlining process for workflows.
  - Reviewing, updating, and reformatting policies to meet ACHC guidelines.

Ambulance Services

- Ambulance Runs-- 69 ambulance runs for the month of October.
- We had our ambulance gurneys serviced on all 3 ambulances. Some minor parts were replaced and they remain in great shape.
- Billing: we have encountered some issues with Cerner regarding ambulance billing. Since Mayers was not operating the ambulance when Cerner was originally purchased, they are having to build in options for us. We are in the process of getting this issue resolved with Cerner so as to not fall too behind. We have a rep that will be here this week to help with this.
- We did an Emergency Vehicle Operators Course. This included training in laws regarding ambulance driving, safe driving in inclement weather, and a driving skills obstacle course.

OPM

- We are still not capturing all the Inpatient visits at this point. Roughly we are 108 this month. Unable to capture (at this time) procedures conducted.
- Working with Travis or Jack or how to run statistical reporting for OPM
- Working toward mastering Cerner documentation and work flows and following up on Cerner tickets/revenue issues.
- Marketing: Would like to send constant reminders to discharge planners at Redding hospitals. There is a constant turnaround of discharge planners and they are unaware of our services. Starting to work on plan for this.
- Working with Mercy Oncology and Pit River to renew OPM Privileges.
- ACHC policy updates

Clinical Education Report

- TRAINING CALENDAR
    - 2024 Clinical Training Calendar in draft form will be available to Nursing leaders with a projected completion date of 12/1/23 for publication to all staff by email, departmental postings, Relias registrations (with the ability to send reminders to all registered), WINK, It Pays to Know, and local monitors. The calendar will include 3 classes of 8-hour trainings for CNA staff to meet regulations for recertification. The staff will be scheduled by manger and scheduling staff. The CNA staff has expressed their approval of this process in recent classes with the DSD and Instructor.
    - ALL staff requiring BLS, ACLS and PALS are currently certified, and 2024 trainings are being planned and scheduled. Two new Instructors have been added Gonzo Solaria (ACLS, PALS, NRP) and Regina Blowers (BLS)
    - A NRP training is scheduled on 12/14 for new employees and current staff requiring recertification.
    - CNA Skills Fair on October 23, 24, and November 8 went smoothly. Skills Fairs are scheduled on the 2024 calendar for April and October with staff prescheduled.

    - Beta Safe Patient Handling Skills Fair is scheduled for 11/16 with multiple skills assessed such as PPE use, lift use, transfers.
- Nurse Assistant Training Program (NATP**)**--The NATP is expected to resume on January 2nd with an orientation and classes on 1/9.
- Credentia Testing for NATP--The last NATP class has 100% success on testing.

Karen Harvey has requested additional testing for students in Shasta, Lassen and Modoc County. We will continue to work with her in a collegial manner for the benefit of all.

- Mayers Foundation Grant Funds-We continue to wait for our highly anticipated manikin purchased with funds awards by the MHF to utilize in our Skills Fairs.
    - This manikin will allow training on over 35 nursing a medica procedures. The training will allow student and practitioners to practice, attain and maintain clinical competency in medical and nursing assessments, treatments, and care. It will be useful in demonstration and validation of skills competency during training, orientation and annually.

Respectfully Submitted by Theresa Overton, CNO

Chief Operating Officer Report
Prepared by: Ryan Harris, COO

California Hospital Association & MMHD meeting

On November 29th, I had the privilege of participating in a meeting organized by the California Hospital Association, which brought together their staff and the leadership of MMHD. This meeting proved to be highly beneficial, as it provided an opportunity for me to express my insights and concerns on various important topics.

One major issue I highlighted during the meeting was the challenges faced in meeting seismic requirements within rural areas. We had a thorough discussion on the unique circumstances and limitations experienced by hospitals in remote regions, shedding light on the need for customized strategies and solutions. I also emphasized the potential negative impact of allocating significant funds towards seismic compliance, which could result in reduced access and quality of healthcare services in rural communities.

Another critical topic on my agenda was the potential consequences of not guaranteeing supplemental payments for hospitals beyond a single year. These payments play a vital role in feasibility studies to meet seismic compliance, as they form part of the hospitals' operating income. If there is uncertainty surrounding these payments for the entire loan period, it poses a significant risk to the organization.

By ensuring a guaranteed supplemental payment, hospitals would have a stable financial foundation to sustain their operations. However, if these payments are not assured and there is a possibility of the programs being canceled without a viable replacement, it creates a concerning situation. In such circumstances, our state would face the challenge of having seismically compliant hospitals throughout the state standing after a major earthquake event but lacking the staff to provide medical treatment.

During the meeting, I emphasized the importance of securing continued availability of these supplemental payments for the stability and functionality of hospitals. Without a reliable source of supplemental income, the ability to attract and retain staff, as well as provide quality healthcare services, would be severely compromised.

Additionally, I highlighted the rising healthcare construction costs in our state. Engaging in thoughtful discussions, we examined the factors contributing to this surge and discussed the potential strategies to alleviate its impact.

During these discussions, I drew a comparison between the construction cost of the Golden 1 Center, which was $715 per square foot, and our new buildings, which amounted to $1400 per square foot. It was remarkable to note that both projects were constructed around the same time and adhered to the same building codes. Surprisingly, despite its more impressive structural design, the Golden 1 Center proved to be significantly less expensive in terms of cost per sq. ft.

This striking disparity prompted me to delve into the underlying reasons for such discrepancies within our state compared to others. Identifying and understanding these factors is crucial in order to implement measures that address rising costs and ensure cost-effective healthcare construction projects in the future.

Finally, I addressed the impact of the Department of Health Care Access and Information (HCAI) and the Inspector of Records on construction costs. I thoroughly reviewed how these organizations and individuals contribute to increased expenses in projects.
During the analysis, I proposed that certain projects may not require as much state oversight as others. For instance, small fire alarm projects may not necessitate state inspections unlike larger-scale hospital construction projects. In light of this, I suggested that the state should consider relinquishing jurisdiction back to local authorities for such projects, which would enhance construction efficiency and reduce costs.
Additionally, I raised concerns about the inspector of record model, particularly in rural areas where inspectors charge inflated travel times. Often, these inspectors demand eight hours of travel time for a single inspection, resulting in costs exceeding $1000 before conducting any inspections or paperwork. I highlighted the unique nature of the hospital-IOR relationship, where hospitals pay and contract with the IOR, but they ultimately work for HCAI. I stressed that this relationship causes duplicate inspections between the IOR and HCAI field staff, leading to delays and unnecessary expenses, inflating costs in healthcare construction.

Facilities, Engineering, Other Construction Projects

- Significant advancements have been made to the Criteria documents in the past month, as evidenced by the developed design and the engagement of an equipment planner. The inclusion of the equipment planner in the project allows for the scheduling of time with each department to ensure sufficient space for the design. Furthermore, the board will find preliminary drawings included in this month's board packet, demonstrating the current progress of the work.
- The Burney Fire Alarm Panel project is still in progress, although it has been faced with unexpected delays due to unforeseen conditions. Mayers is collaborating with HCAI and the contractor to address additional field reviews. On November 28th, Mayers conducted an on-site visit along with the contractor and HVAC support to determine the need for additional scope of work. It is likely that further tie-ins of mechanical equipment will be necessary. A call has been scheduled for December 1st to outline the next steps required to advance towards the completion of construction. We have engaged with a mechanical engineer to write an argument that what the IOR and HCAI is requesting is not required by code.
- Regrettably, progress on the Fall River Dietary, Dining, and DON (Director of Nursing) office AC project has been delayed due to other projects taking precedence this month.
- I am pleased to inform the board that the contractor for our solar project has officially been engaged and is now under contract. An initial kickoff meeting has already been completed, and we have established a regular cadence of weekly meetings to closely monitor progress. The contractor is currently focused on the design and procurement phase of the project. In order to ensure that we adhere to all necessary property lines and setbacks, we have also contracted a surveyor. This surveyor will conduct a thorough survey to accurately locate the property markers, thereby guaranteeing that we are in full compliance with property boundaries.
- We are currently making progress on our fire penetration and policy requirements for ACHC accreditation.

- A team of Engineers, Architects, and equipment planners will be visiting both locations on December 17th to assess our dietary casework project. Following this site visit, a scope will be developed.
- Please see the attached comments from EDGE in regard to the scope of our AB2511 work that needs to be completed at our Burney LTC.
- A team of Engineers, Architects, and equipment planners will be visiting both locations on December 17th to assess our dietary casework project. Following this site visit, a scope will be developed.
- I have some unfortunate news regarding the air exchange test for the operating room (OR). Initially, we were informed by Calstar that the results were satisfactory, meeting the required 16 air exchanges per hour for the code year in which our surgery building was constructed. However, Alex received the report last Friday and it revealed that the OR did not pass, achieving only 12.49 in OR#1 and 14.49 in OR#2. This significant difference is a concerning issue regarding our air flow. As a consequence, Surgery will not be able to reopen until we address this air exchange problem. Since ACHC (Accreditation Commission for Health Care) will be handling our accreditations in the future, we approached them to discuss the possibility of conducting only scopes. They informed us that they follow the 2008 ASHRA table for their surveys, which requires 20 air changes per hour for surgeries and 15 air exchanges per hour for endoscopy procedures. They would consider allowing us to demonstrate that the requirement at the time of construction was 16 for surgeries and 6 for endoscopy if we could provide the building code information. However, this is only applicable if there have been no modifications or adjustments made to the mechanical systems or the space. Unfortunately, our as-built drawings do not align with the current space configuration, and there is no record of any permitted work being carried out in this area. With this information, we would have to meet the 20/15 air exchange requirement to meet ACHC standards, which neither of our current units can achieve. Looking ahead, it seems that replacing the HVAC units will be necessary for us to meet the required air exchanges and carry out surgeries or scopes in this space. However, this will be a costly project for an area that we do not intend to use for surgery in the long term.

IT

- The IT department remains actively engaged in collaborating with various departments to address the challenges encountered during the Cerner integration process.
- We have initiated the Citrix performance evaluation project, which aims to conduct a thorough assessment of our Citrix environment and its underlying infrastructure. This evaluation will address issues that have resulted in a diminished user experience and will provide recommendations for long-term resolutions. It will also establish a strategic technology roadmap to ensure stability, scalability, and security of the environment. Additionally, a monitoring tool will be implemented to proactively address any issues, preventing end users from experiencing any disruptions.

Food and Nutritional Services

- I am pleased to report that the F&NS department is now fully staffed. This is a significant achievement, as it marks the first time since my tenure that both kitchens have all positions filled. Consequently, we have successfully removed the dietary staff position from our website.
- We are delighted to report that we recently hosted our first Candlelight Dinner for residents and their families since the onset of the COVID-19 pandemic. This event proved to be an outstanding success, bringing immense joy and happiness to all attendees.
- The Food and Nutritional Services department is eagerly anticipating serving all individuals at the upcoming Resident & Family Social and Resident & Staff Social events scheduled for December.

Rural Health Clinic

- We have recently introduced infant circumcision services, removing the necessity for community members to seek the procedure elsewhere. This convenient offering is designed to benefit our community by providing localized access to this medical service.
- The clinic remains committed to integrating the new Cerner workflows, improving billing efficiency and accurately coding encounters using ATOS.
- In FY23, our advanced practice providers surpassed their productivity standards, whereas the MDs did not. Although the excess from the APP providers was unable to compensate for the difference, we submitted a waiver due to the COVID-19 pandemic and the inclusion of Dr. Magno.

Environmental Services

- Environmental Services is fully staffed.

Employee Housing

- On November 14th a routine water test at the lodge revealed trace number of coliforms. As a precautionary measure, a boil water notice was issued by the county. After a deep shock and multiple rounds of testing we received a negative test result on November 27th. We are currently working with J&J pumps on a water disinfection and filtration system to prevent future issues.

Telemedicine: Please refer to the attached report.

EDGE Electrical Consulting, Inc.
1801 7th Street, Suite 150, Sacramento, CA 95811 | 916.256.2460
1151 Harbor Bay Parkway, Suite 123A, Alameda, CA 94502 | 510.634.7200
18301 Von Karman Avenue, Suite 850, Irvine, CA 92612 | 949.566.8699
EDGE-eConsulting.com

November 17, 2023

Nate Morgan
Aspen Street Architects
494 North Main Street, PO Box 370
Angels Camp, CA 95222

Project Title: Mayers Memorial SNF HCAI PIN 74 Study
Proposal # K389

The existing skilled nursing facility for Mayer Memorial Health in Burney, CA was built in 1994 and is approximately 29,600 sq. ft. The following report will outline proposed modifications to the electrical system, to provide to comply with HCAI PIN 74. The existing facility is served by a 125kW/156.00kVA, 208Y/120V diesel stand-by generator. The emergency system is a non-segregated emergency power system.

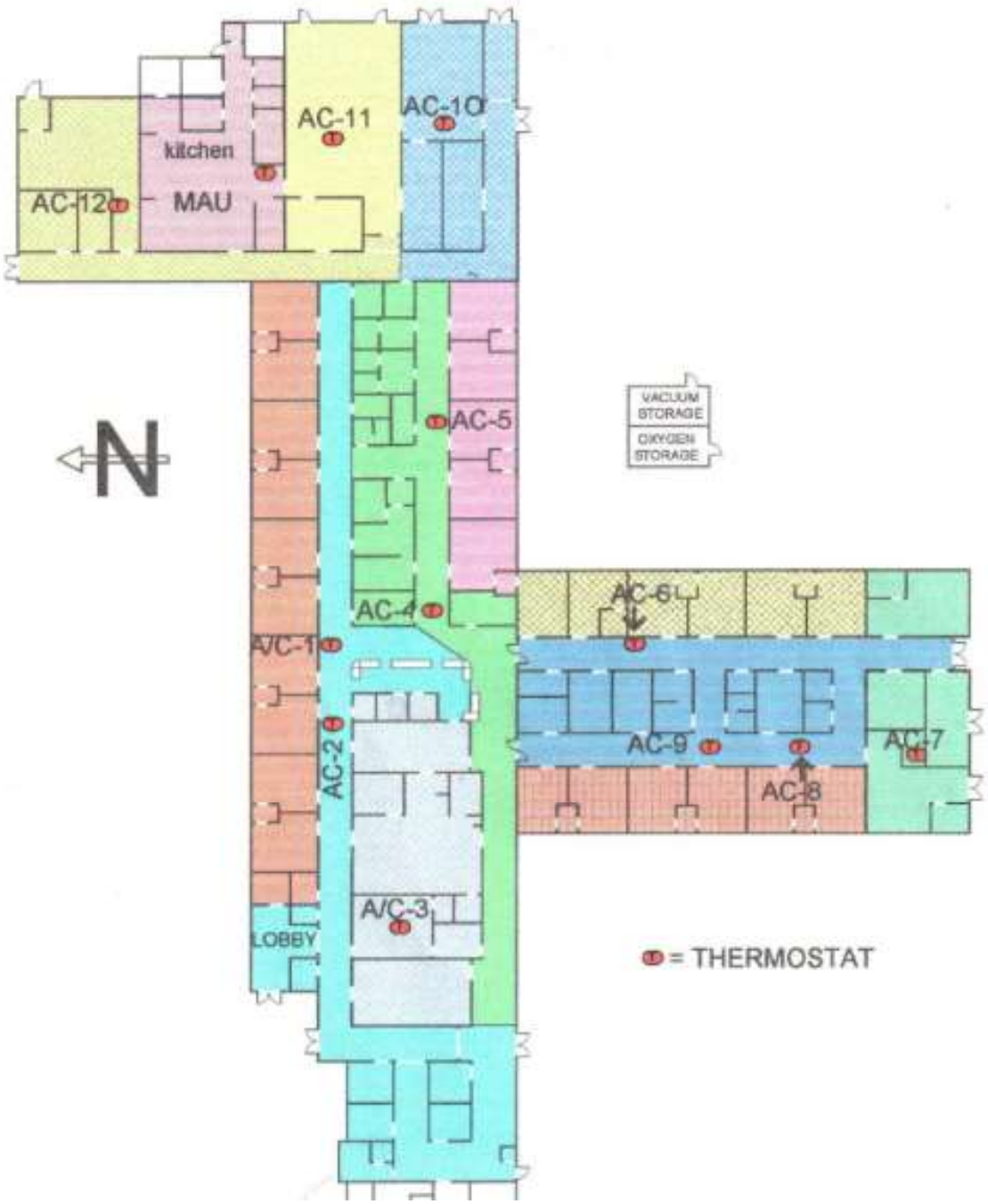
The emergency stand-by generator fuel consumption per the record drawings is 9.5 gallons/hour (gph) at full load with a 230-gallon base tank. Assuming 90% usable fuel in the tank, 207-gallon, there will be 21 hours of run time at full load for the 125kW/156.00kVA diesel stand-by generator. PIN-74 requires a minimum of 96 hours of fuel storage. Owner can provide another above ground fuel tank to supplement the existing base tank to meet the 96 hours of fuel storage per PIN-74 or have arrangements for fuel delivery during normal power utility outages per PIN-74. If Owner elects to have fuel delivery during power outages, it must be approved by the California Department of Public Health (CDPH). Due to the remote location of the facility and inclement weather during the winter season, fuel delivery may not be available.

While this scoping report is for PIN 74, PIN 70 will need to be addressed. PIN 70 requires circuit breakers that are part of the essential electrical system to be coordinated per CEC 517.31(G), overcurrent protective devices shall be coordinated for faults above 0.1 seconds. As PIN 74 requires equipment to be on emergency power, a coordination study for circuit breaker will need to be performed to confirm compliance with PIN 70. All options proposed for relocating AC units to emergency power do not conclude compliance with PIN 70. A coordination study should be performed prior to start of the design to confirm relocation of normal AC unit circuit to emergency power panels will conform to PIN 70.

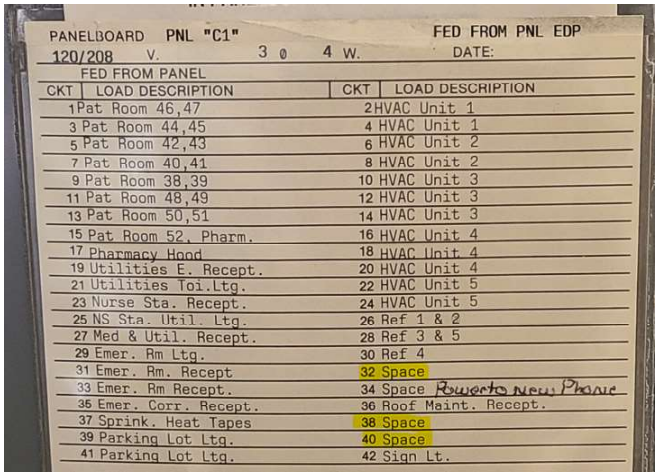
Currently AC units' fans are connected to emergency power at the facility. The compressor units are connected to normal power. To provide cooling in the resident space during a utility power outage, the compress circuit will need to be put on emergency power. AC units 1, 5, 6, and 8 that serve patient rooms have been selected to be used to provided cooling to the residential space per PIN 74. AC units 1, 5, 6, and 8 compressor circuits will need to be removed from normal power and re-circuited to emergency power, see AC zoning map. When AC unit circuits are relocated to emergency power panels, j-boxes, pullboxes, and disconnects need to be relabeled. If the AC units share conduits with other normal power circuits, a new home run will need to be provided to the emergency panel to keep normal and emergency power circuits separate.

This report does not address the heating requirements as the HVAC units are natural gas, but all AC units fans serving the patient rooms are on emergency power.

AC Zoning Map:

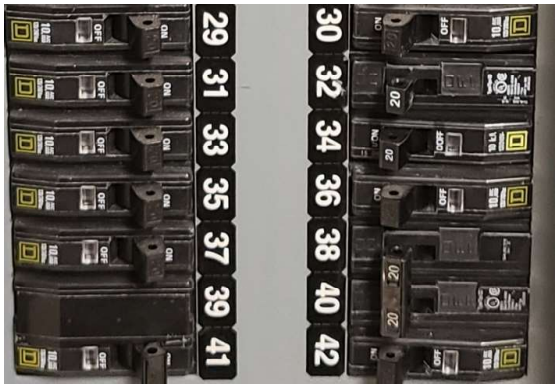


AC units 1 and 5 are served by normal power Panel 'N4'. Emergency power Panel 'C1' is the closest panel to Panel 'N4' but has no space for additional circuit breakers. Panel index indicates 3 spaces (circuits 32, 38, and 40), but all 3 circuit breakers are on. Even if circuit 32, 38, and 40 were verified as spares, Panel 'C1' would only allow one AC unit connection.

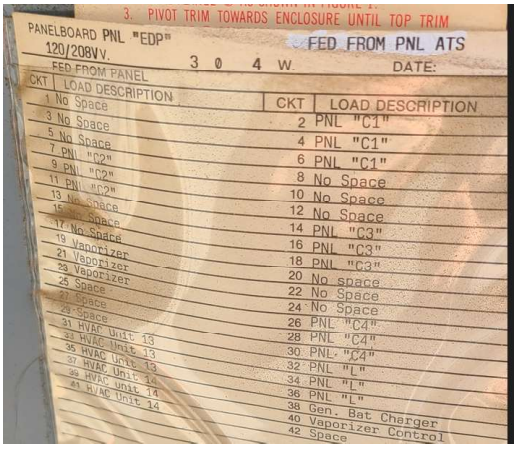


PANELBOARD PNL "C1" FED FROM PNL EDP
120/208 V. 3 Ø 4 W. DATE:
FED FROM PANEL

CKT	LOAD DESCRIPTION	CKT	LOAD DESCRIPTION
1	Pat Room 46,47	2	HVAC Unit 1
3	Pat Room 44,45	4	HVAC Unit 1
5	Pat Room 42,43	6	HVAC Unit 2
7	Pat Room 40,41	8	HVAC Unit 2
9	Pat Room 38,39	10	HVAC Unit 3
11	Pat Room 48,49	12	HVAC Unit 3
13	Pat Room 50,51	14	HVAC Unit 3
15	Pat Room 52, Pharm.	16	HVAC Unit 4
17	Pharmacy Hood	18	HVAC Unit 4
19	Utilities E. Recept.	20	HVAC Unit 4
21	Utilities Toi.Ltg.	22	HVAC Unit 5
23	Nurse Sta. Recept.	24	HVAC Unit 5
25	NS Sta. Util. Ltg.	26	Ref 1 & 2
27	Med & Util. Recept.	28	Ref 3 & 5
29	Emer. Rm Ltg.	30	Ref 4
31	Emer. Rm. Recept	32	Space
33	Emer. Rm Recept.	34	Space Relocate New Phase
35	Emer. Corr. Recept.	36	Roof Maint. Recept.
37	Sprink. Heat Tapes	38	Space
39	Parking Lot Ltg.	40	Space
41	Parking Lot Ltg.	42	Sign Lt.



Emergency distribution Panel 'EDP' has space for one 3 pole breaker per panel schedule. Panel 'EDP' is a Square D NEHB panel, is discontinued, and no longer supported by the Manufacture. There are additional blank spaces on Panel 'EDP', but panel index indicates they are not spaces. For example, poles 2, 4, and 6 is a 100 Amp breaker feeding Panel 'C1', and poles 1, 3, and 5 are blank space, but panel index indicates no space. The 100 Amp breaker may be impeding into pole space 1, 3, and 5. This is typically for all 90 and 100 Amp circuit breakers in Panel 'EDP'. See pictures below. Therefore, we are assuming that these spaces are not available to accommodate new breakers.



3. PIVOT TRIM TOWARDS ENCLOSURE UNTIL TOP TRIM
PANELBOARD PNL "EDP" FED FROM PNL ATS
120/208V V. 3 Ø 4 W DATE:
FED FROM PANEL

CKT	LOAD DESCRIPTION	CKT	LOAD DESCRIPTION
1	No Space	2	PNL "C1"
3	No Space	4	PNL "C1"
5	No Space	6	PNL "C1"
7	PNL "C2"	8	No Space
9	PNL "C2"	10	No Space
11	PNL "C2"	12	No Space
13	No Space	14	PNL "C3"
15	No Space	16	PNL "C3"
17	No Space	18	PNL "C3"
19	Vaporizer	20	No space
21	Vaporizer	22	No Space
23	Vaporizer	24	No Space
25	Space	26	PNL "C4"
27	Space	28	PNL "C4"
29	Space	30	PNL "C4"
31	HVAC Unit 13	32	PNL "L"
33	HVAC Unit 13	34	PNL "L"
35	HVAC Unit 13	36	PNL "L"
37	HVAC Unit 14	38	Gen. Bat Charger
39	HVAC Unit 14	40	Vaporizer Control
41	HVAC Unit 14	42	Space

A new 100 Amp panel will need to be added to Panel 'EDP' to accommodate the AC units 1 and 5 for emergency power to comply with PIN 70. Since the Panel 'EDP' has been discontinued, an aftermarket breaker will need to be located, if possible, to match the existing type and available interrupt current rating. The new 100 Amp panel should be installed inside the building to accommodate any future equipment and/or receptacles; it is assumed that the new 100A/3P breaker to feed the new panel will take up the width of the panel. One of the existing HVAC loads in Panel 'EDP' will need to be relocated into the new panel. HVAC Unit 14, 15 Amp, 3-Pole circuit breaker is the most feasible with the existing conditions at circuits #38, 40, and 42. Circuit 40 is a spare breaker and circuit 42 is a space. Circuit 38 will need to be moved to one of the spaces in Panel 'EDP' to facilitate the new circuit breaker. See picture below.

AC units 6 and 8 are served by normal power Panel ‘N5’. Emergency power Panel ‘C2’ is the closest panel to Panel ‘N4’ and will provide emergency power to AC units 6 and 8. There is sufficient space Panel ‘C2’ to accommodate AC units 6 and 8.

30-day load readings per PIN 38, due to significant motor loads on the existing panels, will need to be performed on Distribution Panel ‘EDP’ and Panel ‘C2’ to confirm available capacity on emergency power.

Existing patient rooms have emergency power at the headwalls to provide emergency power during utility outages for life saving equipment. No additional power is required at patient locations.

PIN 74 requires lifesaving equipment AED, Crash Carts, etc. to be on emergency power. Owner will need to identify locations of lifesaving equipment that will need emergency power. There is space in Panel ‘C2’ if coordination of circuit breakers per PIN 70 is met.

The medical gas for the Burney SNF is housed in a separate building. The medical gas building is served by emergency power Panel ‘C4’. All medial gas is served by emergency power. Med gas alarm panel needs to be confirmed to be on emergency power. There is space in Panel ‘C2’ for med gas alarms if coordination of circuit breakers per PIN 70 is met.

The outdoor switchboard ‘MSB”, ATS, and ‘EDP’ appear to be in good condition, but is approaching 30 years of service and the manufacture does not support the existing equipment and all components are discontinued. The last maintenance done on the switchboard ‘MSB’ was on 9-9-20 by Sigal per sticker on switchboard. Owner should consider replacement of switchboard.

Telemedicine Program Update as of November 8, 2023
Respectfully submitted by Amanda Harris for Tommy Saborido, MD and Kimberly Westlund, Clinic Manager

<u>We have completed a total of 2,616 live video consults since August 2017 (start of program).</u>

Endocrinology:
- Dr. Bhaduri saw 29 patients in October. This has been her busiest month ever!
- We've had 909 consults since the start of this specialty in August 2017.

Nutrition:
- Jessica saw three nutrition patients in October.
- We've had 191 consults so far since we started this specialty in November 2017.

Psychiatry:
- Dr. Granese saw only three patients in October, his lightest month ever.
- We've had 669 consults since the beginning of the program in August 2017.

Infectious Disease:
- Dr. Siddiqui did not have a block in October.
- We've had 109 consults since the start of this specialty in September 2017.

Neurology:
- Dr. Usmanova saw five patients in October
- We were notified last week that Dr. Usmanova's service will end at the end of October. We are working on getting a new Neurology NP credentialed in a timely manner to avoid a break in services.
- We've had 461 consults since the start of the program in November 2018.

Rheumatology:
- Dr. Tang saw six patients in October.
- We've had 98 consults since the start of the program in May 2020.

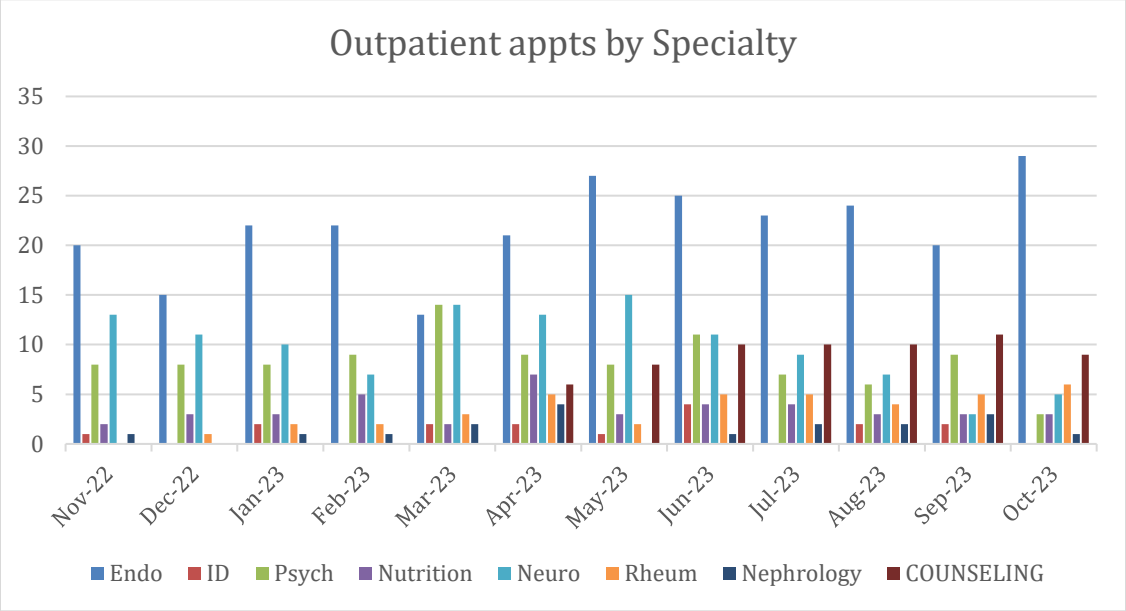
Nephrology:
- Dr. Bassila saw just one patient in October.
- We've had 18 consults since the start of the program in April 2023.

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

Telemedicine Coordinator position:
- Amanda Harris will transition services over to Samantha Weidner permanently in February 2024.

Telemedicine Program FY 22-23 Goals:

- The FY 22-23 Telemedicine Program Goals were to increase total visits by 5% and add a new specialty. We were able to increase total visits by 9% by fiscal year end and added two new specialties – Nephrology and Talk Therapy.



Telemedicine Program Update as of December 1, 2023
Respectfully submitted by Amanda Harris for Tommy Saborido, MD and Kimberly Westlund, Clinic Manager

<u>We have completed a total of 2,663 live video consults since August 2017 (start of program).</u>

Endocrinology:

- Dr. Bhaduri saw 25 patients in November. She continues to be our most productive, consistent provider.
- We've had 929 consults since the start of this specialty in August 2017.

Nutrition:

- Jessica saw four nutrition patients in November.
- We've had 195 consults so far since we started this specialty in November 2017.

Psychiatry:

- Dr. Granese saw nine patients in November.
- We've had 678 consults since the beginning of the program in August 2017.

Infectious Disease:

- Dr. Siddiqui saw two patients in November.
- We've had 111 consults since the start of this specialty in September 2017.

Neurology:

- There were no neurology consults in the month of November. We were in the process of credentialing an NP Neurologist and that fell through while in process. Pam has now completed the process for temporary privileges for another Neurologist, Dr. Mandeville, and we are working on getting him added to Cerner so that we can begin scheduling patients. We have 11 new referrals (both internal and external) and multiple follow-up appointments waiting for this to be completed.
- We've had 461 consults since the start of the program in November 2018.

Rheumatology:

- Dr. Tang saw five patients in November.
- We've had 100 consults since the start of the program in May 2020.

Nephrology:

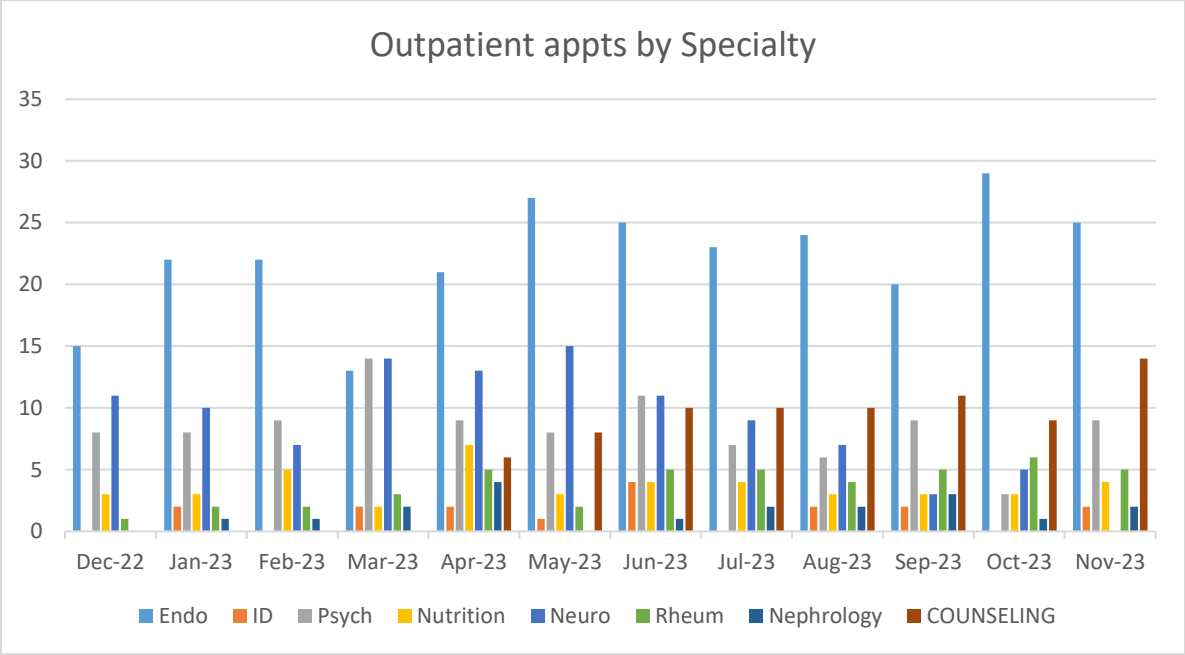
- Dr. Bassila saw two patients in November.
- We've had 20 consults since the start of the program in April 2023.

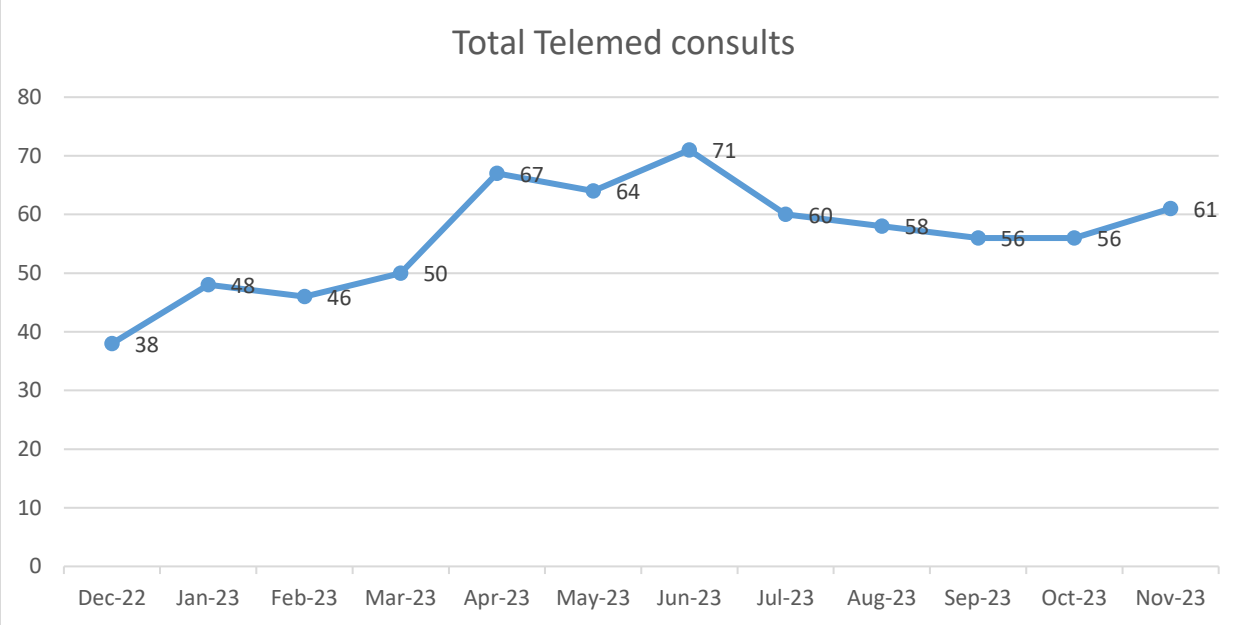
Talk Therapy:

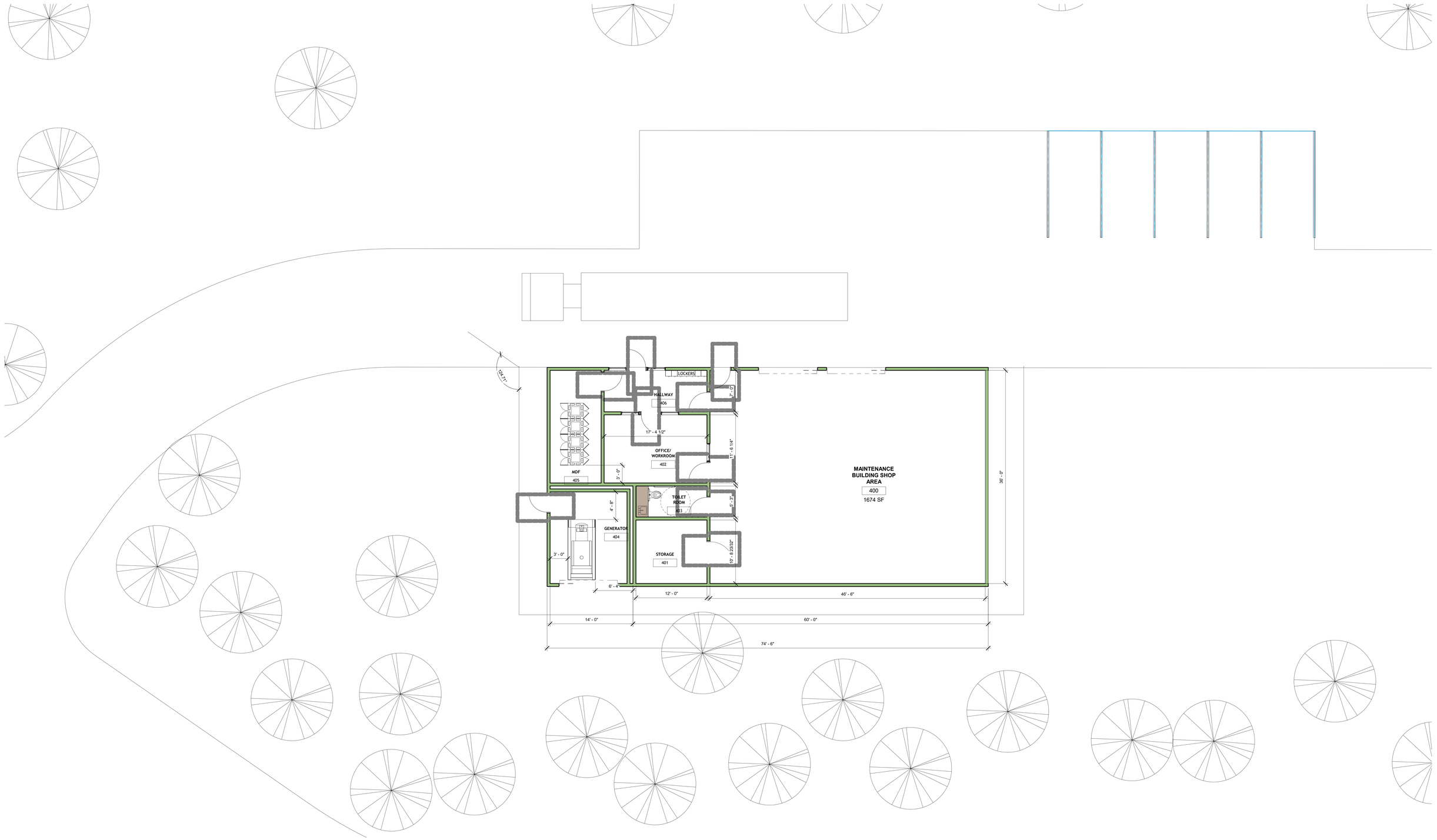
- We began talk therapy services with Ryan McNeel, LCSW in mid-April 2023. Currently he sees three patients a week and this service has been going well.

Telemedicine Coordinator position:

- Amanda Harris will transition services over to Samantha Weidner permanently in February 2024.







1 OVERALL ENGINEERING FLOOR PLAN
3/16" = 1'-0"

Aspen Street
ARCHITECTS

CRITERIA DOCUMENTS

ENGINEERING BUILDING

Scale: 3/16" = 1'-0"

MMH
Always Caring... Always Here.

Aspen Street ARCHITECTS

CRITERIA DOCUMENTS

BURNEY ASC/RHC OVERALL PLAN Copy 1

Scale: 3/16" = 1'-0"

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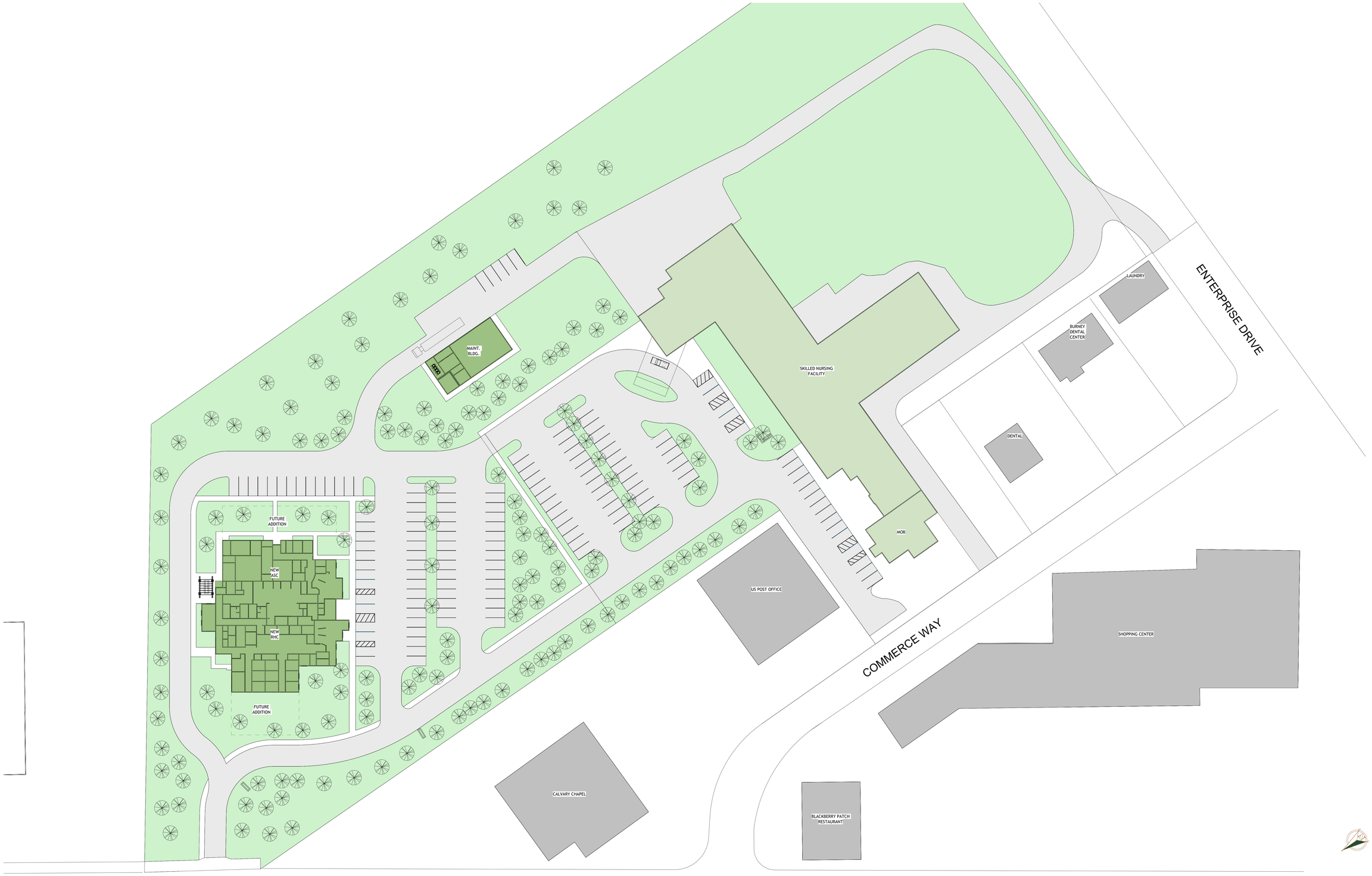

1 Site
1" = 30'-0"

Aspen Street ARCHITECTS

CRITERIA DOCUMENTS

BURNEY ASC/RHC OVERALL SITE PLAN

Scale: 1" = 30'-0"

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1 DIETARY REMODEL
1/4" = 1'-0"

Aspen Street ARCHITECTS

CRITERIA DOCUMENTS

DIETARY REMODEL

Scale: 1/4" = 1'-0"

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1 OVERALL PLAN NEW ADDITION - AREA 1
1/4" = 1'-0"

Aspen Street ARCHITECTS

CRITERIA DOCUMENTS

NEW ADDITION - AREA 1

Scale: 1/4" = 1'-0"

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1 OVERALL PLAN NEW ADDITION - AREA 2
1/4" = 1'-0"

Aspen Street
ARCHITECTS

CRITERIA DOCUMENTS

NEW ADDITION - AREA 2

Scale: 1/4" = 1'-0"

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Always Caring... Always Here.

CEO REPORT NOVEMBER 2023

The month has been a little bit crazy with the holiday and everything else going one. The team has been hard at work like always and there is much to cover.

- Many in our executive team attended The Trusted Leadership Summit this last month. I feel it was very good. There's a lot of great information that we were able to glean from that and bring back to the facility. I think we are going to have some conversations about becoming trust certified so that we continue to move in this direction. The other interesting thing they came from that is they have a dashboard that we could use for patient satisfaction. I think we're going to look at this and see if we could use this going forward instead of going with another outside entity that may not quite fit our needs.

- This month was the Becker's CEO+CFO conference. The presentation I gave on rural health went well. Lot of good feedback from audience members as well as our moderator. After my session Jack and I spoke with a gentleman about the geriatric outpatient mental health program they have. Travis and I spoke with them the next week and we're very optimistic about the ability to bring them on board and provide that service in our area. It will be a great help for a long-term care resident as well as residents within the community. It doesn't make a lot of money, but it should never lose us any money. We're getting more information and will be meeting with them again the Tuesday before we have our board meeting. Hopefully I'll be able to give you more of an update then.

- We did have a general surgeon come out and explore the community. He's the general surgeon that we're looking at teaming up with Modoc to bring on. He liked the area he like the facilities and he liked what we were doing. We sent an offer to him, and he responded to me and let me know that he is in the talks with one other group that he'll be meeting with in the next couple weeks and after that time he will make his decision. This is exciting to know that we have a potential option here.

- On the flip side of that we were made aware that we have an air exchange issue in the OR. The group that did the test initially told us it was fine and then when they gave us the test results this last week, we were notified that both OR1 and OR2 were too low. We're in the process of seeing what we can do to get that fixed and get the air exchange rate to the appropriate level. The timing of this of course is not that great given the

information I just provided to you about the surgeon but we're going to continue to push forward and do what we can to get it fixed and hope that they are minor issues. Stay tuned.

- We had State come into the building on an unannounced visit to look at two things in the ER and one thing on the acute side. There were some complaints made about improper discharges and a couple of items not handled appropriately in the ER. At this point time the surveyor gave us the impression that we will not be tagged on anything. We know for certain that is the case for the two issues that came in for on the ER. The inappropriate discharge, it was missing some discharge paperwork, but we explained the situation and they were going to check with their supervisor to make sure we were okay. So, there's still potential that could result in a tag but as it stands right now, she does not think so.

- We're having a couple provider issues that the team is working through right now. We're hoping to get them resolved here soon. I will keep you posted on this as well and hopefully I'll have more information for you to go over the board meeting.

- We had a water issue down at the lodge. Our water testing revealed the presence of a small number of Coliforms in the water. Essentially you can wash your hands and take a shower and so forth, but we must boil the water to drink it or use it for any consumption. We have done several things to mitigate the issue including shocking the system. We found out that it's coming from the tanks or at least from the tank to the lodge. The shock happened on Monday and yesterday we sent out a new sample to be tested. We heard back on the 27th that we were clear and good to go.

- We currently have three cases of norovirus in the Fall River long-term care. We are working very closely with infection control and continuing to monitor that situation. On top of this, we also have one case of scabies at the Burney long-term care. There is a pretty big clean up going on down there right now to ensure that that doesn't spread past the one resident. So far, the Stafford doing well with these situations.

- We had the final meeting with TCCN. We presented our plan and what it would look like. They voted to accept our plan and we will be presenting the plan for your approval at this board meeting.

- A majority of our executive team met with many of the team with CHA. This meeting when very well. I think they cam out of the meeting wit a better understanding of smaller rural hospitals and how we are not the same as our urban counter parts. They CHA team thanked us for coming out and they heard things from our team that helped them think of how to present things differently so that our legislators can better understand rural.

- Finally, we are in the process of open enrollment into our new benefits. It's pretty exciting. Everyone is eager to see how this first year goes and what that will mean to us as we move forward. I'm pretty optimistic about our ability to keep cost down as we move forward. This will help us with retention as well.