MEMORIAL HOSPITAL OF SWEETWATER COUNTY
SPECIAL WORKSHOP OF THE BOARD OF TRUSTEES
October 29, 2020
2:00 p.m.
Dial: 301-715-8592
Meeting ID: 841 6676 2914
Password: 588592

AGENDA

I.	Call to Order	Taylor Jones
	A. Roll Call	
	B. Pledge of Allegiance	
	C. Our Mission and Vision	Marty Kelsey
	D. Mission Moment	Irene Richardson, *Chief Executive Officer*
II.	Agenda *(For Approval)*	Taylor Jones
III.	Community Communication	Taylor Jones
IV.	Old Business	Taylor Jones
	A. Board Policy *(from the Governance Committee)* *(For Approval)*	Barbara Sowada
	1. Maintenance of Board and Board Committee Meeting Minutes	
V.	New Business	Taylor Jones
	A. Termination and Appeals Policy *(For Review)*	Richard Mathey
	B. Rules of Practice *(For Review)*	Richard Mathey
	C. Sentinel Event Policy *(For Review)*	Kara Jackson, *Director of Quality, Accreditation, Patient Safety*
	D. Medical Imaging Project *(For Approval)*	Irene Richardson
	E. SLIB Capital Expenditure Request *(For Ratification)*	Richard Mathey
VI.	Committee Information	
	A. Quality Committee	Marty Kelsey
	B. Human Resources Committee	Ed Tardoni
	C. Building & Grounds Committee	Marty Kelsey
	D. Compliance Committee	Ed Tardoni
	E. Governance Committee	Barbara Sowada
	F. Joint Conference Committee	Richard Mathey
VII.	Executive Session (W.S. §16-4-405(a)(ix))	Taylor Jones
VIII.	Quality Committee Presentation at 4:00 PM	Marty Kelsey
IX.	Action Following Executive Session	Taylor Jones
X.	Good of the Order	Taylor Jones
XI.	Adjourn	

Our Mission

Compassionate care for every life we touch.

Our Vision

To be our community's trusted healthcare leader.

Our Values

Be Kind

Be Respectful

Be Accountable

Work Collaboratively

Embrace Excellence

Our Strategies

Patient Experience

Workplace Experience

Quality & Safety

Growth, Opportunity & Community

Financial Stewardship

Maintenance of Board and Board Committee Meeting Minutes

Statement of Purpose

By law and regulatory requirements, the Board of Trustees of Memorial Hospital of Sweetwater County (Hospital) is responsible for the maintenance and retention of their records. Effective records management includes timely access to accurate and reliable information, assures transparency and accountability to the public, preserves the Hospital's history, and preserves essential information.

Definitions

Board means Board of Trustees of Memorial Hospital of Sweetwater County

Committee means any standing or ad hoc committee of the Board

Custodian means the executive assistant of the CEO, who is responsible for the maintenance, care, and keeping of the public records.

Meeting means any meeting duly convened, constituted and held by the Board; meetings convened by another entity to which the Board has been invited; and any meeting by one of the Board's Committees.

Minutes means the written record of the proceedings of the meeting, including actions, decisions, commitments and major discussion points

Maintenance means the permanent and orderly preservation of minutes in either physical or digital mode

Retention means the time period the minutes are required to be maintained.

Policy

Meeting minutes of the Board are the legal and official record of the Board's actions and provide evidence of the Board's interactions. Meeting minutes of Board Committees also provide a lasting record of actions and decisions by these Committees.

It is the policy of the Board that its meeting minutes and those of its Committees shall be recorded and maintained in a manner that complies with Wyoming State statute and other regulatory requirements pertinent to governmental hospitals.[1]

Procedure

1. There shall be an official record, or minutes, of the proceedings of every meeting.
2. Meeting minutes should include:
    a. Date of the meeting
    b. Time the meeting was called to order
    c. Names of the meeting participants and absentees
    d. Corrections and amendments to previous meeting minutes

[1] W.S. 16-4-401 to 16-4-408 (2011)

e. Additions to the current agenda
f. Whether a quorum is present
g. Motions taken or rejected
h. Voting-that there was a motion and second, and the outcome of the vote
i. Actions taken or agreed to be taken
j. Next steps
k. Items to be held over
l. New business
m. Open discussion or public participation
n. Next meeting date and time
o. Time of adjournment

3. The Board Secretary shall delegate the recording and drafting of Board meeting minutes to the executive assistant of the Chief Executive Officer (CEO).
4. For committees where someone other than the executive assistant of the CEO takes the minutes, the Committee chair is responsible for assuring that the CEO's executive assistant has all the Committee meeting material for the upcoming Board meeting packet.
5. Board meeting minutes are official once they have been approved by the Board and signed by the Board Secretary. Committee meeting minutes are official once they have been approved by Committee members.
6. The minutes of executive sessions are confidential and are in the custody of the executive assistant of the CEO.
7. Public meeting notice, as well as the meeting agenda, handouts and documents that were referred to during the meeting shall be attached to the official copy of the minutes.
8. Storage and retention of all official records of the Board shall comply with Wyoming State statutes[2] and are delegated to the executive assistant of the CEO.
    a. Minutes of all Board meetings shall be permanently retained in physical form.
        i. To protect from damage and destruction, physical copies of the minutes and their attached documents shall be retained in a safe, secure file cabinet in the office of the Hospital's administration.
        ii. Digital copies of the minutes and their attached documents shall be uploaded and retained in the board portal.
    b. Minutes of all Committee meetings shall be retained for three years.
        i. Digital copies of the minutes and their attached documents shall be uploaded and retained in the appropriate Committee section of the board portal.
        ii. The administrative staff associated with the Committee shall be responsible for uploading each month's meeting material into the board portal for storage.
9. Board and Committee minutes are controlled from unauthorized access.
    a. Digital minutes are protected from unauthorized access through passwords.
    b. Access to paper minutes is under the purview of the executive assistant of the CEO.
    c. Minutes that are in the public domain shall be provided for public review without charge on equipment made available by the Hospital in its office. Copies of the minutes may be requested; the Hospital may set a fee to cover costs of copying.

[2] W.S. 17-16-1601 and 17-19-1601 (2011)

10. Official minutes of all Board meetings will be part of the public material on the Board of Trustee's section of the Hospital's website.

Policy Stat #:

Termination and Appeal

General:

This Termination and Appeal policy and procedure applies to all employees of Memorial Hospital excepting employed physicians and other providers. Only the Hospital's Chief Executive Officer (CEO) has the authority to terminate the employment of a Hospital employee and must provide a written directive to the Human Resources Office prior to any termination proceeding.

This Termination and Appeal policy and procedure does not apply to reduction-in-force (layoffs) due to a lack of funds, lack of work or other reasons.

From the time an employee is notified that he/she is being terminated, until all internal appeal avenues have been exhausted, the employee is entitled to continuing regular pay. At the discretion of the Hospital, the employee may be suspended with pay during this period of time, or may continue working. Should an employee resign, however, pay will cease at that time.

Employees may not utilize the Hospital's Conflict Resolution policy to address termination decisions.

Definitions:

At-Will Employee

An employee who works for the Hospital and is in the "Introductory Period", per Hospital policy. It is understood that no consideration has been furnished to the Hospital for the employment of the employee other than the employee's services. Any employee has the right to terminate his/her employment with the Hospital and the Hospital has the same right.

Part Time Employee

An employee who occupies a position where the incumbent is scheduled to normally work less than thirty (30) hours in a work week.

Full Time Employee

An employee who occupies a position where the incumbent is scheduled to normally work thirty (30) hours a week or more.

Termination:

The involuntary termination of an employee by the Hospital's CEO.

Termination of "At-Will" Part Time Employees

Notice of termination shall be provided by the Director of Human Resources, or designee, upon a written directive from the CEO, by registered or certified mail to the last known address of such employee. Proof of such written notice, together with the proof of mailing, shall be kept

and retained in the records of the Hospital. Although one or more steps in the Hospital's Corrective Action Policy may be applied, the Hospital will not necessarily give the employee formal reasons for the termination.

Should the employee believe that the termination decision was based on the exercise of his or her constitutional rights, and/or that he or she has a reasonable expectation of continued employment, and/or that the action to terminate his or her employment would stigmatize him or her, the employee may appeal the decision to the CEO in writing within ten (10) calendar days of notification of termination. The CEO will review the written appeal and may (or may not) determine to interview the employee and/or discuss the matter with supervisory or other personnel. The CEO shall inform the employee of his or her decision in writing. The CEO's decision in this matter is final.

Termination of Non "At-Will" Part Time Employees

Notice of termination shall be provided by the Director of Human Resources, or designee, upon a written directive from the CEO, by registered or certified mail to the last known address of such employee. Proof of such written notice, together with the proof of mailing, shall be kept and retained in the records of the Hospital. The employee shall be provided reasons for the termination by the Hospital.

Should the employee decide to appeal the termination decision, the employee may appeal the decision to the CEO in writing within ten (10) calendar days of notification of termination. The CEO will review the written appeal and may (or may not) determine to interview the employee and/or discuss the matter with supervisory or other personnel. The CEO shall inform the employee of his or her decision in writing. The CEO's decision in this matter is final.

Termination of "At-Will" Full Time Employees

The Director of Human Resources, or designee, having first received a written directive from the CEO, shall terminate the employment of a full time employee who is in the "Introductory Period" upon notification in writing of such decision by registered or certified mail to the last known address of such employee. Proof of such written notice together with the proof of mailing, shall be kept and retained in the records of the Hospital. Reasons for the termination decision shall not be given, other than outlined below.

Should the employee believe that the decision to terminate his or her employment was based on the exercise of his or her constitutional rights, and/or that he or she has a reasonable expectation of continued employment and/or that the action to terminate his or her employment would stigmatize him or her, the following procedure will take place:

1. The employee may request a hearing before an Administrative Hearing Officer by requesting same in writing within ten (10) calendar days of receipt of the termination notice. The request shall be made to the CEO.

2. The CEO shall immediately notify the Board of Trustees' attorney of the request and shall forward the written request for a hearing to him or her. The Board of Trustees' attorney shall then arrange for an Administrative Hearing Officer to conduct a pre-hearing conference as soon as practical.

3. At the request of the Administrative Hearing Officer, the CEO shall submit to the Administrative Hearing Officer his or her reasons for termination. At the same time, the Administrative Hearing Officer shall request the employee to submit to the Administrative Hearing Officer substantial evidence that the termination decision was based upon an exercise of his or her constitutional rights and/or that he or she has a reasonable expectation of continued employment, and/or how the action of termination would stigmatize him or her.

4. After reviewing the reasons for the termination and any evidence submitted by the employee, the Administrative Hearing Officer shall determine that:

    a. Sufficient evidence has been presented by the employee to warrant a formal hearing by the Administrative Hearing Officer. In such case, a hearing will be scheduled and, at the conclusion of the hearing, the Administrative Hearing Officer will submit a written copy of his or her findings, conclusions, and recommendations to the Board of Trustees for a final decision.

    OR

    b. Insufficient evidence has been presented by the employee to warrant a formal hearing by the Administrative Hearing Officer. In such a case, the Administrative Hearing Officer will inform both the CEO and the employee of his or her findings. The CEO shall discuss these findings with the Board of Trustees' attorney and will subsequently make a recommendation to the Board of Trustees for a final decision.

5. If the Administrative Hearing Officer determines that a formal hearing shall be held, he or she will immediately provide the employee the CEO's reasons for termination and will immediately provide the CEO with any evidence submitted by the employee.
    OR

    If the Administrative Hearing Officer determines that a formal hearing is not warranted, upon request, he or she will provide the employee the CEO's reasons for termination.

6. Every reasonable effort shall be made by the Hospital to ensure that these due process proceedings are conducted in a timely manner. The Administrative Hearing Officer shall make a determination as to whether or not a formal hearing is warranted within thirty (30) calendar days from receipt of notice by the Board of Trustees' attorney. Should the Administrative Hearing Officer determine that a formal hearing be conducted, he or she shall notify the Board of Trustees' attorney of same. The Board of Trustees' attorney shall then arrange for a pre-hearing conference as soon as practical. The formal hearing

shall be held within thirty (30) calendar days following the pre-hearing conference. The Hospital shall pay for all administrative costs associated with the hearing including fees charged by the Hearing Officer and transcription services. The parties shall pay their own legal fees, if any. The Hospital's Rules of Practice Governing Hearings shall be followed. Should the Administrative Hearing Officer determine that a formal hearing is not warranted, a recommendation regarding the disposition of the case shall be made to the Board of Trustees within thirty (30) calendar days of the Administrative Hearing Officer's determination.

Termination of Non "At-Will" Full Time Employees

The Director of Human Resources, or designee, having first received a written directive from the CEO, shall terminate the employment of a full time employee who is not in the "Introductory Period", upon notification in writing of such decision by registered or certified mail to the last known address of such employee. Proof of such written notice together with the proof of mailing, shall be kept and retained in the records of the Hospital.

Prior to making the decision to terminate a full time employee in this category, and prior to notifying the employee of the decision, the CEO shall conduct an informal Pre-Determination Opportunity Meeting. The CEO shall notify the employee of the meeting by any appropriate means, giving the employee at least a week's notice. The employee may waive his or her right to participate in the meeting. At the meeting, the Hospital's Director of Human Resources, or designee, shall be in attendance. The employee's supervisor shall also be in attendance, unless the employee plans to attend the meeting and objects to same. The employee is allowed to have a limited number of other individuals attend this meeting and to speak in support of the employee.

At the Pre-Determination Opportunity Meeting, the CEO shall inform the employee that he or she is considering terminating the employee's employment at the Hospital. The CEO's reasons for considering the possible termination shall be shared with the employee. The employee shall be informed that this is an opportunity for the employee to share with the CEO information regarding his or her employment that the CEO can take into consideration prior to making a decision whether or not to terminate the employee.

Subsequent to the Pre-Determination Opportunity Meeting, the CEO shall make a decision. Should the CEO make the decision to terminate the employee, the employee shall be notified as set forth above. If the employee decides to appeal the termination decision, the following procedure will take place.

1. The employee may request a formal hearing before an Administrative Hearing Officer by requesting same in writing within ten (10) calendar days of receipt of the termination notice provided by the Hospital's Human Resources Office. The request shall be made to the CEO.

2. The CEO shall immediately notify the Board of Trustees' attorney of the request and shall forward the written request for a hearing to him or her. The Board of Trustees' attorney shall then arrange for an Administrative Hearing Officer to conduct a pre-hearing conference as soon as practical.

3. Every reasonable effort shall be made by the Hospital to ensure that these due process proceedings are conducted in a timely manner. The hearing shall be held within thirty (30) calendar days following the pre-hearing conference.

4. The Hospital shall pay all administrative costs associated with the hearing including fees charged by the Hearing Officer and transcription services. The parties shall pay their own legal fees, if any.

5. The Hospital's Rules of Practice Governing Hearings shall be followed.

Physicians

An independent (non-employed) physician who raises a constitutional defense to a credentialing or privileging decision by MEC may avail himself of this Termination and Appeal process.

An employed physician who raises a constitutional defense to a credentialing or privileging decision by MEC may avail himself of this Termination and Appeal process.
An employed physician who raises a constitutional defense to an adverse employment action, such as termination under his/her Professional Services Contract, and believes the termination was based on the exercise of his or her constitutional rights, and/or that he or she has a reasonable expectation of continued employment, and/or that the action to terminate his or her employment would stigmatize him or her may avail himself of the Termination and Appeal process.

Memorial Hospital OF SWEETWATER COUNTY

Approved: *N/A*
Review Due: *N/A*
Document Area: *Risk Management*
Reg. Standards: *LD 03.09.01, MS 05.01.01, TJC RI.01.02.01, EP 21*

Sentinel Event Policy

STATEMENT O PURPOSE

It is the goal of the Memorial Hospital of Sweetwater County to provide the safe, high- uality care that our community deserves and e pects from our institution. e must constantly work to reduce the occurrence of serious safety events and Sentinel Events in our facility. hen a Sentinel Event occurs, it is our responsibility to carry out an e peditious and thorough investigation to reduce or eradicate future harm to patients, staff, and facility, as well as report the appropriate event to the necessary federal agencies.

TE T

Definitions

I. **Sentinel Event** - An une pected occurrence involving death or serious physical or psychological injury, or risk thereof. Such events are called "sentinel" because they signal the need for immediate investigation and response. Furthermore, a Sentinel Event can also be described as a patient safety event (not primarily related to the natural course of the patient s illness or underlying condition) that reaches a patient and results in any of the following:

   A. Death

   B. Permanent Harm

   C. Severe Temporary Harm

   D. Any of the following events:

      1. Suicide of any patient receiving care, treatment, or services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the organization s emergency department (ED)

      2. nanticipated death of a full-term infant

      3. Discharge of an infant to the wrong family

      . Abduction of any patient receiving care, treatment, or services

      . Any elopement (that is, unauthorized departure) of a patient from a staffed around-the- clock care setting (including the ED) leading to the death, permanent harm, or severe temporary harm of the patient

      . Administration of blood or blood products having unintended ABO and non-ABO (Rh, Duffy,

Kell, Lewis, and other clinically important blood groups) incompatibilities, hemolytic transfusion reactions, or transfusions resulting in severe temporary harm, permanent harm, or death

7. Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, or services while on site at the organization
8. Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization
9. Surgery or other invasive procedure performed at the wrong site, on the wrong patient, or that is the wrong (unintended) procedure for a patient
10. Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
11. Severe neonatal hyperbilirubinemia (bilirubin 30 milligrams/deciliter)
12. Prolonged fluoroscopy with cumulative dose 1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or 25% above the planned radiotherapy dose
13. Fire, flame, or unanticipated smoke, heat, or flashes occurring during direct patient care caused by equipment operated and used by the hospital. To be considered a sentinel event, equipment must be in use at the time of the event staff do not need to be present
14. Any intrapartum (related to the birth process) maternal death
15. Any event in which it's classification as a Sentinel Event is unclear

E. For further in depth definitions, please review attached document "The Joint Commission Sentinel Event Policy".

II. **Severe Temporary Harm**- critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

III. **Sexual Abuse/Assault** - is defined as non-consensual sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the organization, including oral, vaginal, or anal penetration or fondling of the patients' sex organ(s) by another individual's hand, sex organ, or object. One or more of the following must be present to determine that it is a sentinel event:

A. Any staff-witnessed sexual contact as described above

B. Admission by the perpetrator that sexual contact, as described above, occurred on the premises

C. Sufficient clinical evidence obtained by the organization to support allegations of unconsented sexual contact

IV. **Invasive Procedure**-procedure in which skin or mucous membranes and/or connective tissue are incised or punctured, an instrument is introduced through a natural body orifice, or insertion of foreign material into the body for diagnostic or treatment-related purposes. Examples of invasive procedures include central line and chest tube insertions, biopsies and excisions, and all percutaneous procedures (e.g., cardiac, electrophysiology, interventional radiology).

V. **Occurrence Report** - The online form submitted by staff to the Risk/Compliance Department as described in the Occurrence Reporting procedure

I. **Root Cause Analysis (RCA)** - A comprehensive systemic evaluation of an occurrence in an attempt to identify underlying causes or effects of a serious safety event. An RCA can also be described as an interdisciplinary team analysis to definitively determine the conditions that caused an event, with the understanding that if the undesirable condition where eliminated, changed, or controlled, the event could have been prevented.

II. **Action plan** - The product of a Root Cause Analysis that identifies the strategies that an organization plans to implement to reduce the risk of similar events occurring in the future.

A. An appropriate action plan includes:

1. Identification of changes that can be implemented to reduce risk, or formulates a rationale for not undertaking such changes.
2. The plan should address responsibility for implementation, oversight, pilot testing if appropriate, time lines and methods for measuring the effectiveness of the recommended actions.
3. Action plans will include the adequacy of staffing, including nursing staffing, in its analysis of possible causes

Internal Reporting of Suspected Sentinel Events

I. Identification of a Sentinel Event

A. When a safety event, or occurrence takes place, the first course of action is to stabilize the patient or environment.

B. Following the stabilization, any potential Sentinel Event is to be reported immediately to the Risk/ Compliance Department and/or Administrator On Call (AOC). An individual must also be designated to complete an Occurrence Report.

C. Upon notification, this individual will undertake or direct an initial investigation to determine if the occurrence is indeed a Sentinel Event as defined by this policy. If the event is determined not to be sentinel in nature, it will be addressed in accordance with the established Occurrence Report procedure.

D. If the event is determined to be sentinel in nature, then the Hospital shall respond as noted in this policy.

II. Notification/Communication of Sentinel Events

A. Upon determination that a Sentinel Event has occurred, the Risk/Compliance Department and/or available Administrator On Call will notify key representatives of the Hospital's leadership team.

B. The Risk/Compliance Department or the AOC will also be responsible for notifying the Chief Executive Officer (CEO) and Board President of the sentinel event.

C. Per the Event Disclosure policy, the Risk/Compliance Department, in conjunction with the attending physician, and legal counsel will determine the proper time and method disclosure of the event to the patient and the family.

III. Formation of a Sentinel Event Response Team

A. A team is to be formed to respond to a Sentinel Event. The team should include, but not necessarily be limited to, the following:

1. Appropriate representatives of administration, medical staff, legal, risk, quality, and public relations.

2. Those individuals directly involved in the event

B. The purpose of the team will be to coordinate an investigation into the incident, conduct a root cause analysis, and determine corrective actions to undertake in response to finding and/or identified opportunities for improvement.

I□. Protection from Discovery

A. All activities undertaken by the team should be done under the auspices of the □uality management functions and medical staff □uality assurance / peer review process. Other legal protections are to be implemented as determined by legal counsel.

□. Immediate Remediation

A. The team will undertake those actions necessary to remediate any immediate threat or likelihood of the Sentinel Event recurring.

□I. Investigation of Event/Conducting a Root Cause Analysis

A. The team is to undertake a thorough and credible Root Cause Analysis (RCA) of the Sentinel Event. The RCA should be completed within □□ days of the organization becoming aware of the event.

1. A Root Cause Analysis may also be organized at the re□uest of a leader in any department as a method to delineate cause in an occurrence of lesser significance.

B. Facilitation must be done by 3 or more trained staff members in the following positions:

1. Main facilitator(s)
2. Staff member(s) to maintain the visual media
3. Note taker(s)

C. The RCA must follow the systems involved in the adverse event, not solely the staff or providers involved.

D. All information discussed within the RCA is to be kept confidential within MHSC.

E. Developing and Implementing an Action Plan

1. Once the RCA has been completed, the team is to develop and implement a corrective action plan that will address both direct and root causes as well as □when appropriate -- special and common cause variation. Special cause is a factor that intermittently and unpredictably induces variation over and above what is inherent in the system. It often appears as an e□treme point (such as a point beyond the control limits on a control chart) or some specific, identifiable pattern in data. Common cause is a factor that results from variation inherent in the process or system. The risk of a common cause can be reduced by redesigning the process or system.
2. The action items are given due dates and responsible parties for completion.

F. The notes/information from the RCA is documented in the the attached Appendi□A: "RCA and 2.0 Action Plan □ orksheet" form.

□II. Internal Reporting

A. A summary, void of patient or practitioner identifiable information, of the Sentinel Event, the root cause(s) identified, and the corrective actions taken will be reported to the Patient Safety Committee, □uality Committee of the Board, Medical E□ecutive Committee and to the Board of Trustees. The corrective action plan will also be communicated to other appropriate parties within the organization.

E□ternal Reporting of Sentinel Events

I. Our Hospital has made the decision to voluntarily report Sentinel Events to The □oint Commission for review.

II. The CEO or their designee will be responsible for correspondence with outside agencies in□uiring about sentinel, or other serious safety events. The decision to report a potential Sentinel Event to The □oint Commission for review will be made with prior knowledge of the CEO.

III. A report that complies with The □oint Commission re□uirements will be compiled following the RCA that will be available for e□ternal reporting. This report must include:

   A. Comprehensive Systemic Analysis of the event

   B. Action plans and time-line for completion

I□. Risk/Compliance will prepare report described above and will collaborate with □uality/Accreditation regarding submission of report to The □oint Commission within □□ business days of becoming aware of event.

   A. Should The □oint Commission become aware of a Sentinel Event by reporting from a third party, the official report with follow-up information is re□uired within □□ business days of becoming aware of the event

Confidentiality

I. Record Keeping

   A. A record of the investigation into the Sentinel Event, the subse□uent RCA, and any performance improvement activities undertaken is to be maintained and should be constructed in such a way as to be afforded statutory protection from discovery.

II. □ Y Stat 3□-2-□10. □uality management function for health care facilities□confidentiality□immunity□whistle blowing□peer review.

   A. Subsection A. "Each licensee □hospital, healthcare facility and health services□shall implement a □uality management function to evaluate and improve patient and resident care and services in accordance with the rules and regulations promulgated by the division. □uality management information relating to the evaluation or improvement of the □uality of health care services is confidential. Any person who in good faith and within the scope of the function of a □uality management program participate in the reporting, collection, evaluation, or use of □uality management information or performs other functions as part of a □uality management program with regards to a specific circumstance shall be immune from suit in any civil action based on such functions brought by a health care providers or person to whom the □uality information pertains. In no event shall this immunity apply to any negligent or intention act or omission in the provision of care."

III. All □uality and patient safety data, materials, and information are private and confidential, shall be considered the property of Memorial Hospital of Sweetwater County, and as such is protected by state and federal health care □uality statutes.

I□. Confidentiality shall be maintained based on full respect of the patient's right to privacy and in keeping with hospital policy and state and federal regulations governing the confidentiality of □uality and patient safety work.

□. Information, data results, reports and minutes generated by all □uality management activities will be handled in a manner ensuring strict confidentiality

□I. Confidential information may include but is not limited to: Medical Staff committee minutes, organizational □uality improvement committee minutes, electronic data gathering and reporting, and incident/occurrence reporting □ .S 3□-17-10□

□II. □uality improvement activities will occur in ways that preserve confidentiality of information consistent with policy and established law

Replaces: Sentinel Events, SPP 121

References

I. □nited Regional. (LR□ Healthcare. (August, 2020). *Sentinel Event Policy & Procedure.* □npublished internal document, □nited Regional.

Approval: MEC 0□/22/2020□□uality Committee of the Board 10/21/2020□Board of Trustees

Attachments

Appendi□A: RCA 2.0 and Action Plan □ orksheet (non-fillable)
The □oint Commission Sentinel Event Policy - □pdated 1.2020

FY#	GRANT	DESCRIPTION	AMOUNT
FY21-5	CRF-01	MOBILE LAB 37FT	$ 278,250.00
FY21-6, FY21-7	CRF-10	UVC ROBOTS	$ 248,594.00
FY21-8, FY21-9	CRF-05	LABORATORY EQUIPMENT	$ 227,531.00
FY21-11	CRF-61	MOB ENTRANCE $289,900	deleted
FY21-12	CRF-59	UVG	$ 463,875.00
FY21-13	CRF-77	HVAC	$ 2,314,000.00
FY21-18	CRF-58	MOBILE LAB 26FT	$ 197,250.00
FY21-19	CRF-62	LAB ANALYZERS (2)	$ 366,000.00
FY21-20, FY21-21, FY21-22, FY21-29	CRF-64	WALK-IN CLINIC LAB EQUIPMENT	$ 311,304.00
not capital	CRF-20	PAYROLL	$ 672,894.00
not capital	CRF-63	PAPRS (50)	$ 77,155.00
waiting on request	CRF-60	PRONING BEDS $79,000	$ 39,500.00
		Total approved grants	$ 5,196,353.00

Memorial Hospital
OF SWEETWATER COUNTY

 # Assigned: FY 2021 - 29

Capital Request

Instructions: YOU MUST USE THE TAB KEY *to navigate around this form to maintain the form's integrity.*
Note: When appropriate, attach additional information such as justification, underlying assumptions, multi-year projections and anything else that will help support this expenditure. Print out form and attach quotes and supporting documentation.

Department: Laboratory 700	**Submitted by:** Mary Fischer, MT(ASCP)	**Date:** 10/14/2020

Provide a detailed description of the capital expenditure requested:

The Sysmex UN 2000 includes the UF 5000 fluorescence flow cytometer analyyzer and the UD-10 fully automated urine particle digital imaging device.

Preferred Vendor: Sysmex

Total estimated cost of project *(Check all required components and list related expense)*

1.	Renovation	$
2.	Equipment	$ 79,883.31
3.	Installation	$
4.	Shipping	$
5.	Accessories	$
6.	Training	$
7.	Travel costs	$
8.	Other e.g. interfaces	$ 58,185.00 (service years 2-5)
	Total Costs (add 1-8)	$ 138,068.31

Does the requested item:

Require annual contract renewal? ■ YES ☐ NO

Fit into existing space? ■ YES ☐ NO — Explain:

Attach to a new service? ☐ YES ■ NO — Explain:

Require physical plan modifications? If yes, list to the right: ☐ YES ■ NO

Electrical	$
HVAC	$
Safety	$
Plumbing	$
Infrastructure (I/S cabling, software, etc.)	$

Annualized impact on operations (if applicable): Increases/Decreases

Projected Annual Procedures (NEW not existing)	
Revenue per procedure	$
Projected gross revenue	$
Projected net revenue	$
Projected Additional FTE's	
Salaries	$
Benefits	$
Maintenance	$
Supplies	$
Total Annual Expenses	$
Net Income/(loss) from new service	$

Budgeted Item:
■ YES ☐ NO

# of bids obtained? _____

☐ Copies and/or Summary attached.

If no other bids obtained, reason:

Preferred vendor, obtained as part of the SLIB board grant process

SLIB CRF-0604

Review and Approvals

Submitted by:	Verified enough Capital to purchase	
Department Leader	☐ YES ☐ NO	
Executive Leader	☒ YES ☐ NO	Katie Quickenden 10-15-2020
Chief Financial Officer	☒ YES ☐ NO	10-15-2020
Chief Executive Officer	☒ YES ☐ NO	10-16-2020
Board of Trustees Representative	☐ YES ☐ NO	

OTHER CONSIDERATIONS

The UF5000 offers highly reliable, precise and accurate particle differentiation and counts for urine samples. The analyzer eliminates time consuming hands on review by screening for samples with pathological elements • STAT and routine sample modes for flexibility in loading • Low specimen volume requirements, ideal for pediatric population testing • Powerful blue (488nm) laser which offers enhanced detection and differentiation of particles, especially bacteria • Two new analysis channels, to enhance the specificity and sensitivity of particle detection in urine sediment.

• Five reportable and five flagged parameters • Measures the scatter of depolarized light, improving detection of crystals • Enhanced Waveform Analysis for increased performance in the differentiation of casts • Clear reagent status indication and results display on screen • RFID labeled fluorescent stain reagents for efficient reagent management • Can be used as a standalone analyzer or combined as part of the modular UN-Series.

The UD-10 is a fully automated urine particle digital imaging device that is capable of high-quality detailed digital images of urine particles.

This capital request includes a service agreement for years 2-5.

This capital request was part of the SLIB board grant process awarded in August 2020. This analyzer will be used on all patients including COVID-19 patients to assist with diagnosis of disease or illness.

Submitted by Mary Fischer, MT(ASCP)

Submitted by: Signature

Date

MEMORANDUM

To: Board of Trustees
From: Wm. Marty Kelsey
Subject: Chair's Report…October Quality Committee Meeting
Date: October 24, 2020

Below are some highlights of the October Quality Committee meeting. The meeting minutes given the Board provide more information and detail. The Patient Safety Plan was presented for review and approval. The Quality Committee approved the plan. This plan will also be considered for approval by PIPS, MEC, and the Board of Trustees. Mr. Mathey will discuss the statute associated with confidentiality at the next Quality meeting.

The Sentinel Event policy was presented for approval. It was approved. A sentinel event is an unexpected occurance involving the death or serious physical or psychological injury, or risk thereof. Immediate investigation and response is required. The Joint Commission addresses this policy.

Mr. Corey Worden presented some statistical data relative to how MHSC is doing with respect to the Star Rating system. Mr. Worden said that our rating should be unchanged; but, a new system will probably be in place soon so we will have to see how it impacts the rating.

Dr. Quickenden presented some information on how we evaluate clinical contracts. At the next Quality Committee meeting, there will be an executive session to discuss clinical contracts.

Kara Jackson reviewed the "From the Director" section, highlighting significant achievements and areas of concern.

The Quality staff is preparing for the Board presentation to be held on October 29th at 4:00 p.m.

Quality Committee Meeting
Memorial Hospital of Sweetwater County
October 21, 2020

Present: ***Voting Members:*** Kara Jackson (Quality Director), Dr. Kari Quickenden (CCO), Richard Mathey (Board Member), Irene Richardson (CEO), Marty Kelsey (Quality Board Chair), Leslie Taylor (Clinic Director), Tami Love (CFO), Dr. Banu Symington, Dr. Cielette Karn

Non-voting Members: Gabrielle Seilbach, Karali Plonsky, Corey Worden, Cindy Nelson, Dr. Melinda Poyer (CMO), Ann Clevenger (CNO), Noreen Hove

Absent/Excused: ***Voting Members:***

Non-voting Members: Kalpana Pokhrel

Chair: Mr. Marty Kelsey

Approval of Agenda & Minutes

Mr. Kelsey presented the Agenda for approval. Mr. Mathey motioned to approve, Ms. Richardson seconded the motion. Mr. Kelsey then present last month's Quality Committee Minutes from September 16, 2020 for approval. Dr. Quickenden motioned to approve and Ms. Richardson seconded the motion. Both were approved unanimously.

Mission Moment

Ms. Richardson shared a moment from the Sweetwater feedback page – Shout out to Dr. Barton and his office for treating patient with caring and compassion, living up to our Mission: "Compassionate care for every life we touch".

Mr. Mathey gave a shout out to us – he had a procedure a few weeks ago and prior to procedure all his records from MHSC were easily pulled up. He noted something was obviously working well!

Old Business

The Surveys on Patient safety Culture PowerPoint was shared by Karali Plonsky and Gabriel Seilbach. See attached. Dr. Symington noted concern for anonymity for survey isn't always a guarantee for small departments with specific job descriptions. Ms. Jackson stated that the survey doesn't report on areas with less than 5 comments to preserve that anonymity. She also noted we need to convey that information to staff next time for additional confidence in anonymity. Dr. Symington further questioned could specific areas get a breakdown of results, to help them understand what they need to work on? Ms. Plonsky stated yes – that would be their next move in sharing the results and meetings will be set up. Dr. Karn noted problems with reporting concerns and occurrences is because MIDAS is often difficult to use. Dr. Quickenden responded, by assuring they were aware of the issue and are currently looking into another reporting system.

Ms. Seilbach presented the updated Patient Safety Plan for review and approval. She noted that they developed this plan by evaluating and combining 4 other plans and included key points from The Joint Commission. Our goal with Patient Safety is to create a Just Culture which

allows staff to feel supported and safe as well as empowered to speak up about their errors. Mr. Kelsey commented that in many industries they state "Safety is first", and the doctor's oath states "Do no harm" – so question is who approves the plan? Ms. Jackson noted that this plan will be approved by PIPS, Quality, MEC, and the Board. Once those approvals are garnered the information will be added to the bottom of the document. Mr. Kelsey had a second question regarding confidentiality and the statute that is sited WY Stat 35-2-910 and what it means in layman's terms. Mr. Mathey noted the statute is often misinterpreted and worthy of a 10-15 minute discussion that he would be happy to more fully address at the next Quality meeting. Mr. Kelsey further questioned if there was a clear description of who holds whom accountable in the event of a safety issue? Dr. Quickenden stated the Just Culture algorithm will be utilized in terms of accountability and it starts from the top down. Mr. Kelsey requested a motion to approve the Patient Safety Plan, Mr. Mathey motioned to approve, Dr. Poyer seconded the motion. The motion was unanimously approved.

Quality Reporting Program Results – HACRP Follow-up was presented by Noreen Hove. Ms. Hove noted the question leading to this report was about the penalty we incurred for our C.diff numbers. Ms. Hove worked with Sarah Roth, Infection Preventionist at Tufts Medical Center. Ms. Roth was our previous Infection Preventionist. They looked at our reported numbers and processes and have already placed process improvements, with plans for continued process improvements in place. See attached. Dr. Karn noted that they feel the Lab has already made some of these improvements and will communicate with Ms. Hove prior to C.diff testing to continue to work on rejection processes. Ms. Hove will work with Valerie Boggs, M/S Clinical Coordinator to possibly create a checklist, before sending specimens for testing. Mr. Kelsey questioned how can we ensure improvement processes are being followed? Ms. Hove stated we should see the answer in the decrease of C.diff hospital acquired cases, which is the goal.

New Business

Ms. Jackson and Dr. Quickenden presented the Sentinel Event policy. Wording was taken directly from The Joint Commission (TJC) Sentinel Event policy on the TJC website. We have defined for staff what exactly a sentinel event is and the process for determining one, as well as outlining the reporting process. Mr. Kelsey questioned whether Ms. Richardson, CEO was on the approval path. Ms. Clevenger, CNO noted she and Dr. Quickenden will work to ensure the committees and persons needed for approval will be listed on the document, prior to moving through the Approval process. Mr. Kelsey requested a motion to approve the Sentinel Event policy. Dr. Poyer motioned to approve and Mr. Mathey seconded the motion. Motion was unanimously approved.

Mr. Corey Worden presented the Hospital Compare statistics analysis. Mr. Worden noted he has been working on this document for about a year with quarterly updates, with the idea to look at and predict our Star rating. Based on our best calculations, these current numbers shouldn't change our 4-Star rating.

Ms. Hove presented information on Root Cause Analysis (RCA), which is a process used to "drill down" on adverse or "never" events that occur, i.e. wrong site, wrong surgery. Events that should never happen. Ms. Hove outlined a recent process as an example.

Ms. Quickenden presented Contract review and some of the new tools we have put in place for evaluating contracts. It was noted that the Medical Staff should be included in clinical contract selection and based on that information it was taken to MEC where increased

monitoring parameters put in place. It was also noted at a TJC Breakfast briefing we should be adding clinical and student contracts also for evaluation, i.e. nursing, lab, etc. It was stated that contract discussion is confidential and discussed in Executive session. Mr. Mathey requested we have an Executive session at the next meeting to discuss contracts.

Medical Staff Update

Dr. Poyer reported Medical Staff Updates as Dr. Karn had to leave meeting early. From Medical Staff standpoint we continue to have weekly Covid updates with staff and public health. We continue to have a significant increase in Covid statewide. Wyoming Medical Center has activated Code Orange and have stopped accepting non-emergent transports from outside the community, including stopping elective procedures. MHSC and Sweetwater County have continued to do incredibly well – which is a credit to our facility, laboratory, administration and public health.

From the Director

Ms. Jackson reviewed her Director of Quality Report – Significant Achievements and Progress. See attached.

Meeting Adjourned	The meeting adjourned at 10:00 am
Next Meeting	November 18, 2020 at 08:15 am, via ZOOM

Respectfully Submitted,

_____

Robin Fife, Recording Secretary

Quality Committee of the Board
Quality, Risk, Safety, & Accreditation Summary
October 2020

Three Priorities FY 2021

1. HCAHPS/Patient Experience
2. High Level Disinfection
3. Culture of Safety Survey Results and Action Plans

1) Star Rating
    a. There are seven categories within the Star Rating and they are as follows: mortality, readmission, safety of care, efficient use of medical imaging, timeliness of care, patient experience (see next bullet) and effectiveness of care. Each of these seven categories contain several data metrics. Data within the following categories continues to trend in right direction: mortality. Opportunities for improvement exist within the efficient use of medical imaging category. OP-10 Abdomen CT with and without Contrast – Project Team is working on improvements of process at this time, will continue to monitor. June and July's data within the readmission category has increased, an in-depth analysis of the data has been completed and did not yield any trending gaps in our processes. Case Management and Care Transition continue to monitor the data and their processes. Data for August has decreased, and will continue to monitor. An opportunity for improvement exists within the safety of care category, specifically for the CDI (Clostridioides difficile infection) measure, Infection Preventionist working on improvements with nursing departments and the medical staff.
    b. Within the Timeliness of Care category**,** Ed-2b: ED Median Admit Decision Time to ED Departure Time has seen an increase in the data over the past few months. The most recent month of data has trended down again. The project team is aware and is identifying and developing thresholds for each part of the part of the Patient Flow process. These thresholds have been identified and implemented on September 1st, so will continue to monitor data to see if these improvements were effective. Within the Effectiveness of Care category, we continue to see fluctuations with the data for Core Sep1 – Early Management Bundle, Severe Sepsis/Septic Shock. Scorecards identifying opportunities for improvement continue to be sent to physicians and nurses. Sepsis team developed new visual tool to ensure all elements of bundle are met in a timely manner and rounding and education have taken place. The sepsis project team continues to work towards their new goal related to improving compliance with ordering and obtaining blood cultures within specified timeframe. Improvement work continues for Core OP-23 – Head CT/MRI Results for Stroke Pts within 45 minutes of Arrival.
    c. Patient Experience-HCAHPS: The "Inpatient HCAHPS" is the survey data that affects our Star Rating and Value Based Purchasing reimbursement program. This survey includes OB, ICU, and Med-Surg. Please see the "Introduction to Press Ganey" document for further information.
2) Risk/Safety

a. We recognize that this system is limited. The data brought forth is a work in progress. The falls average is 1.11 falls per month. During investigation of the falls, no recurrent themes are present. Medication errors continue to be the majority of the occurrence reports. During investigations for August (2) and September (2), wrong weights were identified as an issue. The corresponding departments have been notified and are working towards process improvements.
b. Safety – An interdisciplinary team is working to create a new safety committee. Development of charter, agenda, and scheduling recurring meetings is underway. The Patient Safety Plan has been approved by PIPS Committee, and will be taken to MEC, in addition to Quality Committee of the Board, prior to presentation to the Board. The Culture of Safety Survey was administered in June, and results have been analyzed. Results were presented to Leadership in October, and will also be presented during Town Halls in October. Individual department data will be analyzed and presented to departments separately. Improvement work, goals, etc. will be addressed by the Patient Safety Committee. Please see "Culture of Safety Survey 2020 Presentation – Leadership 2.0" in packet for further information.

3) PI Standards
    a. Our PI Standards within the dashboard include data metrics defined by Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC), as well as priorities identified by MHSC on the Performance Improvement and Patient Safety (PIPS) plan.
4) Accreditation
    a. We are currently in our Joint Commission triennial survey window and a survey will may occur in the next several weeks, depending on the COVID 19 situation in our County. CSR Committee continues to meet weekly in order to prepare. Joint Commission rounding and tracers have increased in frequency. There are some standards that need work to come into compliance and this work is underway. "Joint Points" continue to be shared with the hospital and clinics and we have increased the frequency of these as well to five times per week.

Human Resources Committee Meeting
Monday, October 19, 2020
3:00 PM – Zoom meeting
AGENDA

Old Business

I. Approval of minutes
II. Turnover Report - Amber
III. Open Positions –Amy
IV. Employee policies– Suzan
    a. Workplace Violence Prevention policy
    b. Others needing discussion – Suzan

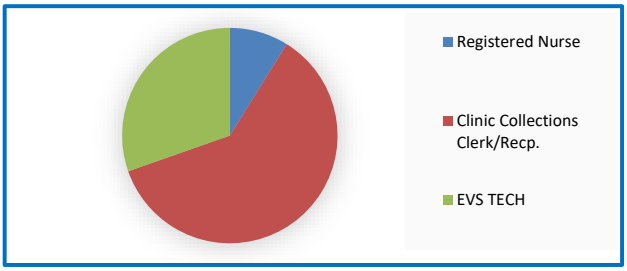
New Business

V. Committee member reports, other discussion(s) – as needed
VI. Determination of Next Meeting Date (Auto-Scheduled for (11/16/20)

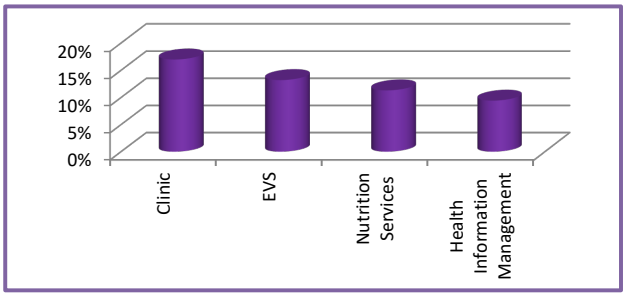
MEMORIAL HOSPITAL OF SWEETWATER COUNTY

2020 Overall Turnover Data (As of 09/30/2020)

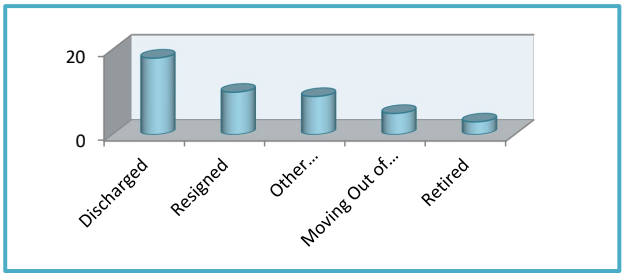
Top Position(s) / Turnover	***2020***	***%***
Registered Nurse	7	6%
Clinic Collections Clerk/Recp.	6	40%
EVS TECH	5	20%



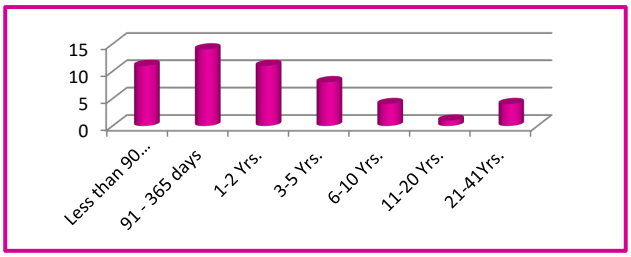
Top Department(s) / Turnover	***2020***	***%***
Clinic	9	17%
EVS	7	13%
Nutrition Services	6	11%
Health Information Management	5	9%



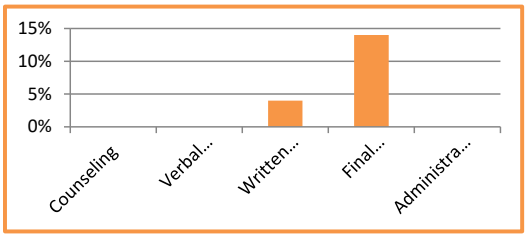
Top Reasons / Turnover	***2020***	***%***
Discharged	18	34%
Resigned	10	19%
Other Employment	9	17%
Moving Out of Area/Relocation	5	9%
Retired	3	6%



Length of Service	***2020***	***%***
Less than 90 days	11	21%
91 - 365 days	14	26%
1-2 Yrs.	11	21%
3-5 Yrs.	8	15%
6-10 Yrs.	4	
11-20 Yrs.	1	
21-41Yrs.	4	8%
Total	***53***	

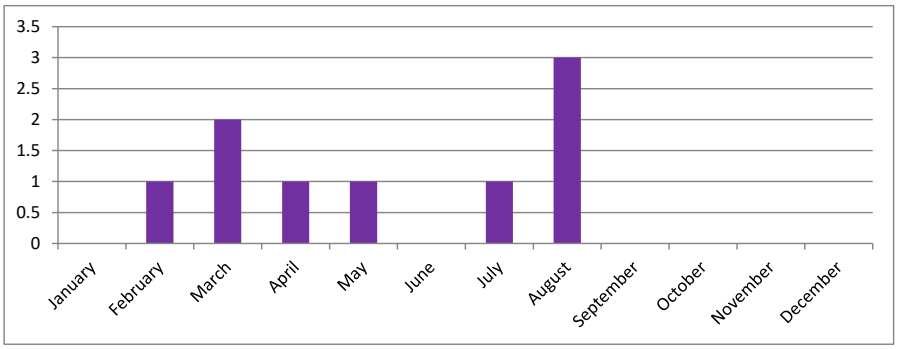


Corrective Action		% Discharged
Counseling		
Verbal Warning		
Written Warning	4%	100%
Final Written Warning	14%	100%
Administrative Leave		



2020 Separations - Clinic

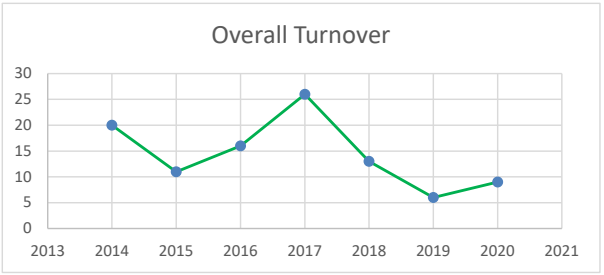
	Separations	New Employees	Total Employees	110
January	0	0	110	
February	1	1	110	
March	2	2	110	
April	1	0	109	
May	1	0	108	
June	0	0	108	
July	1	1	108	
August	3	3	108	
September	0	1	109	
October				
November				
December				
Total				



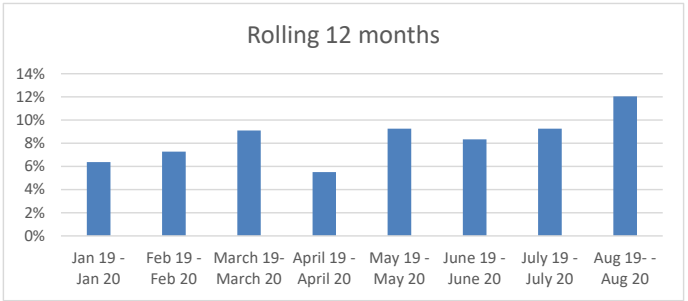
Separations	
Involuntary	5
Voluntary	4
Total	9

Classifications	
RN	1
Classified	8
Total	9

Overall Turnover		
2014	20	26%
2015	11	18%
2016	16	14%
2017	26	23%
2018	13	12%
2019	6	5%
2020	9	8%



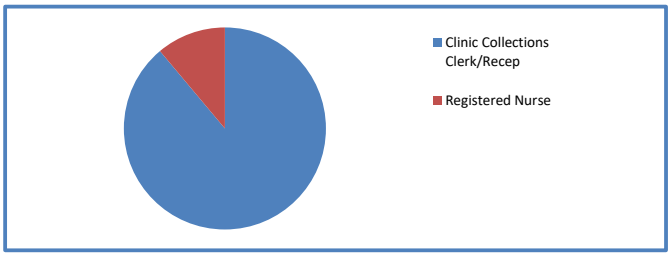
Rolling 12 Months		
Jan 19 - Jan 20	7	6%
Feb 19 - Feb 20	8	7%
March 19- March 20	10	9%
April 19 - April 20	6	6%
May 19 - May 20	10	9%
June 19 - June 20	9	8%
July 19 - July 20	10	9%
Aug 19- - Aug 20	13	12%
Sept 19 - Sept 20	8	7%



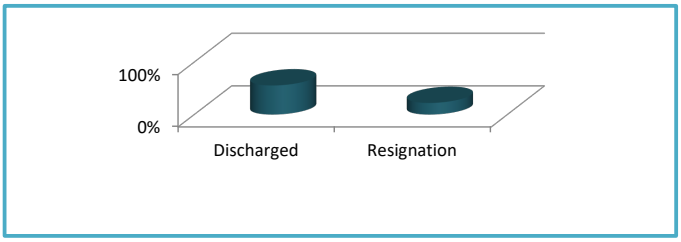
MEMORIAL HOSPITAL OF SWEETWATER COUNTY - CLINIC DATA

2020 Clinic Turnover Data (as of 09/30/2020)

Top Position(s) / Turnover	*2020*	*%*
Clinic Collections Clerk/Recep	6	40%
Registered Nurse	1	5%



Top Reason(s) / Turnover	*2020*	*%*
Discharged	5	56%
Resignation	2	22%



Length of Service	*2020*	*%*
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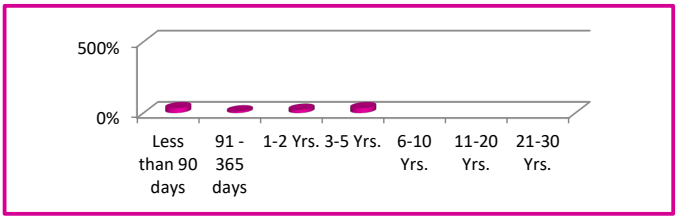
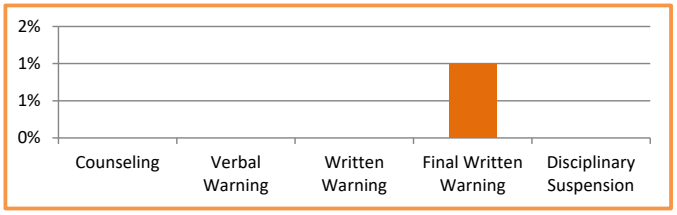
91 - 365 days	1	11%
1-2 Yrs.	2	22%
3-5 Yrs.	3	33%
6-10 Yrs.		
11-20 Yrs.		
21-30 Yrs.		
Total	9	



Corrective Action		
Counseling		
Verbal Warning		
Written Warning		
Final Written Warning	1%	100%
Disciplinary Suspension		



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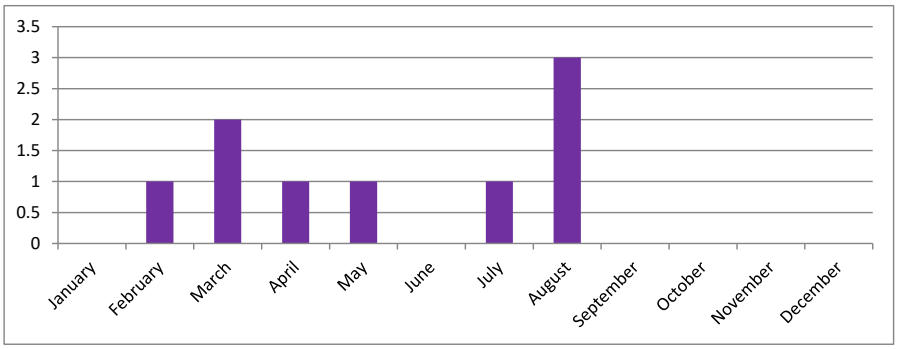
September	0	1	109	
October				
November				
December				
Total				



Separations

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Voluntary	4
Total	9

Classifications

RN	1
Classified	8
Total	9

Overall Turnover

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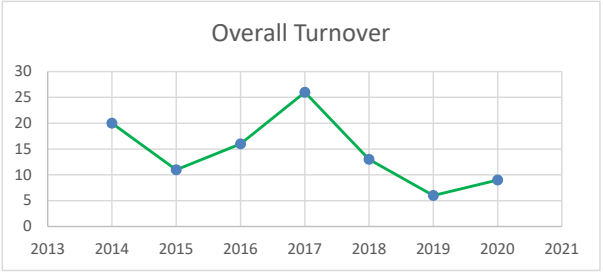

Rolling 12 Months		
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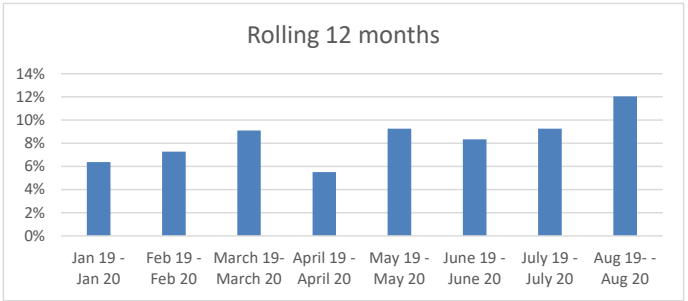
July 19 - July 20	10	9%
Aug 19- - Aug 20	13	12%
Sept 19 - Sept 20	8	7%



From:	Suzan Campbell
To:	Ed Tardoni; Barbara Sowada; Irene Richardson; Tami Love; Kari Quickenden; Ann Marie Clevenger; Amber Fisk
Subject:	Workplace Violence Prevention Plans
Date:	Monday, October 12, 2020 11:35:27 AM
Attachments:	Preventing Workplace Violence in Healthcare - Worker Safety in Hospitals Occupational Safety and Health Administration.html osha3148.pdf OSHA3826.pdf OSHA3828.pdf OSHA3827.pdf

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Ed and Barbara, at the September HR committee meeting the Workplace Violence Prevention Policy was discussed. Also discussed was the idea that a Workplace Violence Prevention Plan should accompany the Policy when sent for approval . A workplace violence prevention plan is referenced in the policy and it provides the basic tenets of a plan but not the plan itself. I started researching actual prevention plans for hospitals and I found a lot of hospital plans. However, they were very comprehensive and very long (some were 80 pages or more). The more I read various plans the more I realized that this is not something that I should do as legal but needs to come from an ad hoc hospital committee that can put together a plan that works for our hospital. To that end I have attached numerous documents from OSHA regarding Healthcare Workplace Prevention plans so that the committee can see what is entailed in a good plan and then decide how to move forward.
Thanks Suzan

Suzan Campbell, JD
WSB # 5-2644
In House Counsel MHSC
1200 College Drive
Rock Springs, WY 82901
307-352-8162
sucampbell@sweetwatermemorial.com

Memorial Hospital OF SWEETWATER COUNTY

Approved: *07/2018*
Review Due: *07/2021*
Document Area: *Employee Policies*
Reg. Standards:

EMPLOYEE POLICIES - WORKPLACE ANTI-VIOLENCE

PURPOSE

Memorial Hospital of Sweetwater County (MHSC) is committed to providing a safe, violence-free workplace for our employees. MHSC has a zero tolerance policy for violence, threats, intimidation, bullying, or any other acts of aggression or violence. This policy also applies to MHSC off-campus sponsored functions and events.

POLICY

I. All MHSC employees bear the responsibility of keeping our work environment free from violence, threats of violence, intimidation, bullying or other acts of aggression or potential violence.

A. Any employee who witnesses or is the recipient of violence, threats of violence, intimidation, bullying or other acts of aggression that causes the employee to be fearful for his/her safety or the safety of those around her must be promptly reported to her supervisor, the Human Resources Department and Security. No employee will be subject to retaliation, intimidation or disciplined as a result of reporting violent threats, behavior, or other violent actions if the report was made in good faith.

B. Any patient, patient family member or community member engaging in violence, threats of violence, intimidation, bullying or other acts of aggression, at MHSC or any of it's other campuses/property, that causes an employee or patient to be fearful for his/her safety must be promptly reported to Human Resources and Security.

1. All acts will be investigated, and the appropriate action will be taken.
2. Any such act or threatening behavior by an employee may result in disciplinary action up to and including termination.
3. Such acts may also result in criminal prosecution as determined by appropriate law enforcement agencies.

C. MHSC prohibits the possession of "dangerous or deadly weapons" by employees on hospital property at all times, including hospital parking lots and hospital vehicles. A "dangerous or deadly weapon" is one that is likely to cause death or great bodily harm.

1. However, hospital security officers, who have been properly trained and certified to carry and use/discharge a Taser, may carry a Taser while on duty.
2. The hospital reserves the right to inspect all belongings of employees on its premises, including

briefcases, purses and handbags, gym bags, and personal vehicles on hospital property.

D. **Commitment to Safety**

1. Protecting the safety of our employees, patients and visitors is a top priority of MHSC.
2. All MHSC employees have the responsibility to contribute to a safe work environment by using commonsense rules, safe practices and by notifying the employee's supervisor, HR and/or Security when safety and security issues are discovered.

Approved: Board 6.6.18

Attachments

No Attachments

Approval Signatures

Approver	Date
Kristy Nielson: Chief Nursing Officer	07/2018
Irene Richardson: CEO	07/2018
Amber Fisk: HR Director	07/2018
Suzan Campbell: In House Legal Counsel	07/2018

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
Human Resources Committee Meeting – Minutes Draft
Monday - October 19, 2020
Zoom

Trustee Members Attending by Zoom: Barbara Sowada & Ed Tardoni
Members Present by Zoom: Amber Fisk, Irene Richardson, Suzan Campbell
Guests by Zoom: Amy Lucy, Kari Quickenden, Tami Love, Ann Clevenger

Ed called the meeting to order.

OLD BUSINESS

I. **MINUTES APPROVED**:

The motion to approve the September 28, 2020, meeting minutes was made by Barbara, second by Irene. Motion carried.

II. **TURNOVER REPORT**:

Amber reviewed the report reflecting updates through the end of August. She said we had a couple of calculations that were incorrect so the corrected information was included in the Board packet for October. She wanted to make sure everyone had the updated information for review. The Clinic turnover data is based on 110 employees and those that have left within the last month. Amber said we are in a great place especially during Covid. She said the average turnover rate for hospitals in the nation is 26% and during Covid it has gone up closer to 30%. She said we were at 15% pre-Covid and have kept ourselves to 20% or less since June. Amber said we continue to include the breakdown information for reasons and we encourage people to come back if possible. Barbara asked if we are experiencing Covid-fatigue. Amber said she thinks we are seeing a lot of that. She said we are seeing a lot of people asking about our employee assistance program. Amber said we have had so many people reach out with so many resources so we are sending that out to staff as much as possible. Irene shared information from a recent article she read about Covid-fatigue regarding people retiring earlier than planned. She said there are so many changes with Covid and so much risk as well as the financial implications of everything. Mentally, it is draining. Irene referenced the information shared during the Person-Centered Care Workshops and said we don't know how long this will last and we need to give staff the resources they need to take care of themselves. We are trying to wrap our minds around the changes but want to make sure we take care of our staff. Barbara said she trusts leaders are taking care of themselves and each other. Irene said we are trying. Barbara shared the story of the shoemaker. Ed said from the perspective of a civilian, when you look at the numbers, he can understand the disregard for the prevention measures from the general public. He said staff are actually warriors on the front. There have been some victories and he hopes that encourages people moving forward. Irene said she hopes we can ride out this storm because it has been a challenge. Ed said in this day in age our work is not where the office is, it is what we do unless you have direct patient impact. Irene said technology has had an impact.

Irene shared the overall updated turnover information on the screen. Amber said the information is as of September 30. Receptionists are in the higher category. She said the data reflects January 1 through September 30, 2020. Amber said people usually leave between their 91st and 365th day. We have about 530 employees currently. The rolling twelve-month overall rate is 18%. She reminded the Committee the national average with healthcare hospitals is 26% but with Covid has been closer to 30%.

Amber said the rehire rate is 15%. Amber said the Clinic through September is not that different than last month. Ed said we are at 53 separations and it looks like it has tapered off but projecting to be middle-range on losses for the year compared to other years. Amy said she thinks we will be under because we are lower with terminations than we were at this time last year.

III. **OPEN POSITIONS**:

Amy reviewed openings and the current status. She said we have 13 positions open currently: 12 FT and 1 PRN. We have some extra help for the ultrasound positions because they are typically hard to fill. It has been open since June.

IV. **EMPLOYEE POLICIES**:

a. **Workplace Violence Prevention Policy** – Amber said there is a lot of information in the packet sent by Suzan regarding workplace violence. Ed said what he sees is that he doesn't see a bunch of changes from what they considered last time. Suzan has provided information and resources for a plan. Ed said his feeling is what the Committee needs to decide is does that plan have to be submitted to the Board for approval. He knows the policy cites the plan so there should be a plan before we submit the policy to the Board for approval so he is asking how is hospital staff coming along on developing this plan. Suzan said she suggested the HR Committee create a working group and she would provide information but there hasn't been a group started and the plan hasn't been started. Ed said the way he sees it is staff develops the plan and the committee asks questions and refines. He doesn't see using committee time to develop the plan. Barbara agreed and said an ad-hoc committee as Suzan recommended would be very valuable. Irene agreed. Ed said the policy is basically on-hold until such time hospital staff can assure the Committee they have a plan in place. Ed asked Suzan if there is anything in this workplace violence policy before them that she thinks needs consideration today. Suzan said no, there have been no changes. Ed said we are ready to go once the hospital staff is ready to go and says they are ready to talk about the plan. Ed said the 135 pages of information should not go to the board packet. Irene said Amber should form the ad-hoc committee of Senior Leaders, Amber, anyone else from HR, Suzan, and Noreen Hove. There was discussion of including Stevie Nosich and Des Padilla. Barbara suggested David Beltran. Kari suggested a front-line nurse from the ED or ICU. Amber suggested the Clinical Coordinators from those areas. Amber will set up the committee and schedule a Zoom meeting.

b. **Others needing discussion** - Amber said the only other thing she had were a couple of e-mails back and forth with Suzan that we are holding off on.

Political Activity Policy - Ed said the Board sent the policy back to the Committee to look at employees running for public office or being elected to public office. Irene shared on-screen an e-mail from Marty Kelsey to Ed Tardoni and Irene. Ed said we have a lot of things to consider including what our budget will bear. He asked that when it is developed, bring it back to the Committee and he and Barbara will ask questions about it. Barbara clarified the policy is to be expanded to include information for running for office. Barbara said we need to decide what is the best thing for the organization. Irene shared her opinion and said she feels it is like a second job.

V. NEW BUSINESS

None

VI. **COMMITTEE MEMBER REPORTS**:

None.

VII. **NEXT MEETING DATE**:

The next meeting is Monday, November 16, 2020.

Ed thanked everyone for participating. The meeting adjourned at 3:40 PM.

MEMORANDUM

To: Board of Trustees
From: Wm. Marty Kelsey
Date: October 24, 2020
Subject: Chair's Report…October Buildings and Grounds Committee Meeting

Below are some highlights of the October Building and Grounds Committee meeting; the minutes given the Board provide more information and detail.

Regarding the Central Plant Expansion project: Discussion ensued regarding why the project is at least four months behind schedule. About $300,000 is being retained at this time. Still no substantial completion but a preliminary punch list has been achieved. Mr. Blevins stated they have learned a lot of lessons and next contract will include liquidated damages for late completion.

Regarding the HVAC & UV Project: Groathouse Construction, the general contractor, was to be on site last week. The GMP is expected soon. Mr. Blevins gave an overall update on progress, including needed governmental approvals. It was noted that now is a great time to begin a phased remodeling of a portion of medical imaging as this function will be relocated. Mr. Blevins and MHSC staff will present a recommendation to the Board at an appropriate time.

Regarding the Laboratory project, Mr. Blevins stated that schematic design documents should be ready in a few days.

Some discussion occurred regarding the Pharmacy Chemo Mixing Room issue. More reviews will be forthcoming to determine an appropriate course of action.

The Pharmacy Compounding Room project should be started in about two weeks.

The Grounds Lean-To Project is almost done. Waiting on a chain link fence and gate to be installed.

Regarding the fencing around the cooling towers discussed last meeting. It was decided to bid this out as a separate project rather than issue a change order to the contractor.

Mr. Horan reported that since the new chiller plant is up and running, MHSC has experienced a savings of about $8,000 per month in electricity charges.

MEMOR□□ HOSP□□□ O□S□ EE□□ □□ER CO□□□□
□uilding and □rounds Committee Meeting
Octo□er 20□2020

□he □uilding and □rounds Committee met in regular session via □oom on Octo□er 20□2020□at 3:30 PM with Mr. Marty □elsey presiding.

□n □ttendance:
Mr. Marty □elsey□*Trustee - Chair*
□r. □ar□ara Sowada□*Trustee*
Ms. □rene Richardson□*CEO*
Ms. □ami □ove□*CFO*
Mr. □im Horan□*Facilities Director*
Mr. □erry □ohnston□*Facilities Supervisor*
Mr. □a□e □levins□*ST&B Engineering*
Ms. □eslie □aylor□*Clinic Director*

Mr. □elsey called the meeting to order.

Ms. Richardson made a motion to approve the agenda. Mr. Horan seconded□motion passed.

□r. Sowada made a motion to approve the minutes from the Septem□er 15□2020 meeting□Ms. Richardson seconded□motion passed.

Maintenance Metrics

Mr. Horan presented the maintenance metrics. □ll metrics have □een standard and steady. Overtime is e□pected to increase with the arrival of the winter months. □he □acilities department is slightly over □udget each month □ut we continue to su□mit re□uests for reim□ursement from our County Maintenance fund.

Old Business – Project Review

Central Plant E□pansion

Mr. □levins said the preliminary punch list was issued to the Contractor. Su□contractors are onsite this wee□to wor□through the punch list. He said he would also □e onsite this wee□and will chec□ in with □H□. His Site O□servation Specialist will also □e onsite to review the pro□ect. He said □H□is pushing the su□s to □e done □y the end of the month. Harris still needs to run through the functional testing of the controls. □r. Sowada as□ed why the su□contractors were so slow. Mr. □levins said they struggled to find pipefitters in the mar□et once we as□ed them to ramp up. She as□ed if our e□perience with these su□contractors will □e considered with future pro□ects. Mr. □levins said there have □een lessons learned and we will □e including li□uidated damages in future contracts. Mr. □elsey than□ed Mr. □levins for his report.

S□□□/C□RES □ct Pro□ects

H□□C □ □□C – Mr. □levins provided an update. □he general contractor□□roathouse□will □e onsite this wee□ to discuss mo□ili□ation and to meet with staff regarding e□pectations. He said su□mittals are □eing reviewed as they come in. □ e did receive a response from the State for the permitting and have a few minor issues to respond □ac□. □he as□estos report came □ac□and we will need a□atement on the roof area. □he City of Roc□Springs should release the electrical permit □y the end of this wee□. Mr. □levins said we are e□pecting the □MP from □roathouse soon. Mr. □elsey as□ed a□out items we can purchase directly. Mr. □levins responded the air handler unit was the only item to □e direct purchased and the hospital has already made that purchase. □he architect and engineer fees will also □e direct purchases of the owner. Mr. Horan as□ed if a□out considering remodeling a portion of Medical □maging as these areas will □e relocated for this pro□ect. □r. Sowada as□ed for a recommendation to the Committee and Ms. Richardson commented we would highly recommend moving forward with a phased remodel of the areas. She said we have preliminary cost figures and have the funds availa□le. Mr. □elsey agreed it was a perfect time to loo□at this pro□ect and would li□e to see a recommendation to the □oard. Mr. □levins said he will need to tal□to Plan One □rchitects to review scope overlay with the current pro□ect. He also gave □roathouse a courtesy heads up of the possi□ility of the new pro□ect and that the ceiling scope may change.

MO□ Entrance – Mr. □elsey said the decision was made to put this pro□ect on hold. Ms. Richardson said we may revisit if S□□□ changes their rules and timelines.

□a□oratory – Mr. □levins said the architect schematic design documents should □e ready □y the end of this wee□. He is wor□ing with □ ill □ heatley of Plan One to loo□at options for the H□□C unit servicing this area.

Pharmacy Chemo Mi□ing Room – Mr. Horan and Mr. □levins met with staff and it was agreed to wait until the new year to start this pro□ect. Mr. □elsey as□ed if it was determined there is no imminent danger to □ustify □ringing in an industrial hygienist at this time. Mr. □levins there has not □een an analysis done at this time. Ms. Richardson and Mr. □levins agreed we would circle □ac□around and loo□at our contacts to ma□e this happen.

Pharmacy Compounding Room – Mr. □ohnston said the doors have □een ordered. Once we are notified of shipping□we will start. He estimates a start date in a□out two wee□s.

□rounds □ean□□o – Mr. Horan said we are waiting on the chain lin□fence and gate to □e installed. □ e should □e a□le to close this pro□ect out □y the ne□t meeting.

Mr. □elsey as□ed a□out the status of the potential change order on the Central Plant for fencing. Mr. Blevins said he didn't want to move forward with that under the current BHI contract. □t was decided to wor□with Mr. □ heatley on a design and we would □id it out as a separate pro□ect.

Emergency Room Outside □rainage – Mr. □ohnston said they will start either this □hursday or ne□t wee□. □t will ta□e a□out four days to complete and they will also □e wor□ing on some concrete replacement at 3000 College Hill.

□a□led Pro□ects

□ul□O□ygen Renovation and □rading – Mr. Horan said there is nothing new to add at this point.
Replacement Roofing for Power House – Mr. Horan said this is still on for the spring.
O□ □athtu□s to Showers – Mr. Horan said this is still on hold.

New Business

Mr. □elsey as□ed if our snow removal e□uipment is ready to go. Mr. Horan said yes and they are pleased to have the new □ean□□o to store the e□uipment. He also mentioned he did include a new truc□in the capital □udget for this year.

Ms. Richardson as□ed a□out the need to have the S□□□ grant capital re□uests □rought to this Committee for approval. Mr. □elsey and □r. Sowada agreed they would not need to come to □uilding □ □rounds as they will □e ratified at the □oard meeting.

Mr. □elsey than□ed Mr. □levins and the staff for all the wor□put into these pro□ects. He said he would li□e to come up for a tour of the pro□ects.

Mr. Horan said since the new chiller plant up and running□we have seen savings of □8□000 per month. □ e will also □e receiving an incentive of □□0□000 from Roc□y Mountain Power once the pro□ect is complete. He will □ring the graphs showing the trac□ing to the ne□t meeting. □ e are actually using less electricity now then prior to □uilding our MO□.

□he ne□t meeting will □e held □ovem□er 17 at 3:30 p.m.

□r. Sowada made a motion to ad□ourn. Ms. Richardson seconded□motion passed.

Submitted by Tami Love

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

BUILDING & GROUNDS COMMITTEE AGENDA

Tuesday ~ October 20, 2020 3:30 p.m. Zoom teleconference

Voting Board Committee Members: Marty Kelsey, Chairman Dr. Barbara Sowada

Voting Staff Committee Members: Irene Richardson, Tami Love, Jim Horan

Non-voting Members: Gerry Johnston, Stevie Nosich, Jake Blevins – ST&B, Jeff Smith, County Commissioner Liaison

1. **Call Meeting to Order** **Marty Kelsey**
2. **Approve Agenda** **Marty Kelsey**
3. **Approve Minutes – September 15, 2020** **Marty Kelsey**
4. **Maintenance Metrics** **Jim Horan**
    a. Work orders
    b. Amount of overtime for month
    c. Budget variance
5. **Old Business** **Jim Horan**
    a. Project Review
        i. Central Plant expansion
        ii. SLIB/CARES Act Projects
            1. HVAC/UVG
            2. MOB Entrance
            3. Laboratory
        iii. Pharmacy Chemo Mixing room
        iv. Pharmacy Compounding room
        v. Grounds lean-to
        vi. Emergency Room outside drainage
    b. Tabled projects
        i. Bulk Oxygen renovation and grading
        ii. Replacement roofing for power house
        iii. OB Bathtubs to Showers
6. **New Business** **Marty Kelsey**
7. **Next meeting schedule** **Marty Kelsey**
    a. November 17, 2020 Classroom 1 or Zoom; 3:30P – 4:30P
8. **Adjournment** **Marty Kelsey**

Compliance Probe Audit of the Guest Relations Process

Purpose:

Evaluate the equitable, efficient response to patient grievances from intake to resolution.

Introduction:

A probe audit has been conducted for compliancy in MHSC's process of grievance resolution. This process is outlined in MHSC policy "Guest Relations Policy and Procedure" (PolicyStat ID 3112659). It should be noted that this policy was replaced in July 2020, by "Grievance Process" (PolicyStat ID 7972705). This audit specifically focuses on section II "Procedure", part C subsection 1a, 3, 4, 5f iii, 6 and 7 which will be discussed in detail below.

Method and Sample:

Data for this audit was collected from the MIDAS+ Care Management, Patient Relations tab. 110 grievances were in the system for calendar year 2019. Using the website Calculator.net, 30 random numbers were drawn. Those numbers were then matched to the corresponding grievance in the MIDAS system. Each grievance was audited using the "Grievance Policy Compliancy" checklist found in our compliancy manager program, Healthicity. The checklist consists of 8 questions directly related to compliancy with the policy "Guest Relations and Procedure".

Objective:

1. After auditing the qualifying grievances, determine what percentage are compliant in the following areas;
    a. Documentation that the patient was contacted within one (1) business day of lodging their grievance. (Section II, part C, subsection 1a)
    b. Resolution of the grievance in 7-10 business days. (Section II, part C, subsection 3)
    c. Resolution of the grievance in 30 days. (Section II, part C, subsection 3)
    d. If a resolution could not be made in 30 days, the patient is notified regularly of this. (Section II, part C subsection 4)
    e. Review of the grievance by the Grievance Committee. (Section II, part F, subsection 5iii)
    f. The patient is notified of the resolution via their preferred method of contact. (Section II, part C, subsection 7)
    g. A resolution letter was sent to the patient. (Section II, part C, subsection 8)
    h. If a letter was not sent, documentation of the reason. (Section II, part C, subsection 8)
    i. Documentation of the resolution letter. (Section II, part C, subsection 8)

Results:

Of the 30 grievances reviewed, 100% (30/30) were contacted within one business day. 46.7% (14/30) were resolved within 7-10 business days and 63.3% (19/30) were resolved in 30 days. 20% (2/11) of the grievances had documentation indicating weekly correspondence when a resolution took longer than 30 days. 90% (27/30) of the grievances were reviewed by the Grievance Committee. 93.3% (28/30) of the grievants were notified of the resolution via their preferred method of contact. A resolution letter was

sent to 76.7% (23/30) of the grievants. Of the 7 that did not receive a letter, 3 requested no follow up, 3 had no information on file and 1 was not sent at the request of the Grievance Committee. 76.6% (23/30) of the grievances had the resolution letter documented in MIDAS and 23.4% (7/30) did not. These letters could exist in a file on the hard drive, but that was not reviewed.

Findings:

Based on the results of this audit, MHSC is compliant more often than not in resolving patient grievances. Given that a new policy has since been implemented, this audit will be marked a passing grade with no further recommendations at this time.

Grievance Policy Compliancy

Answer Summary

ID	Question
1712	Is it documented that the patient was contacted within 24 hours of placing their grievance? 100% Yes
1713	Was this grievance reviewed by the Grievance Committee and is this documented in MIDAS? 90% Yes, Yes 10% No, No
1714	Was the grievance resolved within 7-10 business days? 46.7%Yes, 53.3%No
1715	Was the grievance resolved within 30 days? 63.3% Yes, 36.7% No
1719	If no, was adequate contact maintained with the patient (at least once a week)? 20% Yes, 16.7% No, 63.3% Not Applicable
1716	Was the patient notified about the resolution via their preferred method of contact? 93.3% Yes, 6.7% Not Applicable
1717	Was a resolution letter sent to the patient? 76.7% Yes, 23.3% No
1720	If a letter was not sent, what reason was given? 10% No info on file, 10% Patient requested no follow up, 3.3% Committee requested no follow up.

ID	Question
1718	Is the resolution letter documented in MIDAS? 76.6% Yes, 23.3% No

Reports for Board Compliance Committee 10-22-2020

1. 9 behavioral health patients. 0 were in seclusion or restrains. The flow sheet has been created and is working well. Added to the flow sheet will be suicide risk assessment, only 5 of the 9 patients in September had a completed suicide risk assessment completed.

2. There were 4 HIPPA violations reportable for the month of September. 2 came from Fairwarning, 1 was a HIPAA violation with remediation, and one was dismissed. 2 were reported to HR by staff with appropriate remediation. There has been a glitch with getting Suzan notified. I believe that has been resolved, but will continue to monitor it.

3. The Grievance Committee reviewed 6 cases. Each of the cases were reviewed and resolved in a timely manner.

4. Ongoing Audits by April Prado
    a. Denial Management
    b. Peer review OPPE, FPPE

Compliance Work Plan
FY 2020-2021

Prepared By:
Compliance Work Team
Updated 6/2020
Approved 6-24-2020 by Board Compliance Committee

□he following ris□s were identified □y priority areas during the 201□Compliance Ris□ □ssessment. □his assessment was performed □y the Compliance □ or□ □eam□a multidisciplinary group dedicated to compliance with legal and regulatory compliance. □ hat follows is the wor□plan for the calendar year 2020 that aims to address the largest compliance ris□areas. □his wor□plan may change throughout the year in response to previously un□nown ris□s.

1. Identify Compliance Risk Areas/Emerging Risks
Ris□Score – 210
Ris□Choice – Mitigate

Mitigations:

Education – Educate staff mem□ers on reporting ris□s and the availa□ility of the Compliance Hotline. □his will □e completed □y □irector of Compliance and Ris□Management in con□unction with the □irector of Human Resources. □as□is due □y □ecem□er of 2020.
Education will □e completed □y the □irector of Compliance and Ris□Management in con□unction with the Safety Committee chair.
10/22/2020 update this will □e included in annual education

□udits – □ive pro□e audits will □e completed in 2020□2021 □y Compliance □uditor in various topics using the Compliance Manager audit format. One pro□e audit is to □e completed each □uarter□with a fifth one completed in any □uarter of the year. □opics can □e randomly selected□or □e selected □y the wor□group if concern is noted on any of the topics. □hese audits will □e presented to the □oard Compliance Committee.
10/22/2020 2 have □een completed□
Chec□list – □he wor□group and Compliance Committee will complete the Measuring Compliance Program Effectiveness guide □y □pril 2020. Completion of this chec□list will li□ely create further actions.
□am loo□ing for the chec□list
10/22/2020 chec□list presented in 7□22□2020 meeting

2. Medical Malpractice Claim Submission
Ris□Score – 210
Ris□Choice – □ccept/Mitigate

Mitigations:

□nsurance ris□audit is currently □eing performed □y □pplied Ris□Solutions. □he original plan was to audit the su□mission □uarterly. □fter discussion with legal□the new plan is to

await the results of the ris audit and create a new wor flow ased on the results. nternal audits will e scheduled following this step.
am wor ing with Su an on this.
Still wor ing with pplied Ris Solutions.

3. Professional Services Billing
Ris Score – 208
Ris Choice – Mitigate

Mitigations:

or roup ormation – he Revenue Cycle eam was created internally to monitor various aspects of revenue cycle. hey have een tas ed with forming a standardi ed process for appropriate professional services illing.

Process ormation – standardi ed process for professional services illing is eing created to ensure common practice among the various providers.

udits – Once the process has een formed audits will e scheduled uarterly to e performed y the Compliance uditor.
his is a current audit.
10/22/2020 presented /24/2020

4. New Software Implementation
Ris Score – 1 5
Ris Choice – Mitigate

Mitigations:

Process ormation – he department will formulate a general process for the implementation of new software programs.
his is eing done y Rich yler. am waiting for his response.
10/22/20202 present at this meeting
udits – nternal audits will e performed on each implementation of new software in 2020 y the esta lished process.

his will egin with implementation of new software.

5. Coding Training and Education
Ris Score – 154
Ris Choice – Mitigate

Mitigations:

Process ormation – H M irector has created a new education process for oncoming staff. Current staff has een educated to this new orientation plan.

□udits – One□time audits will □e performed when a new employee is hired to this department. □urnover is low in the department which does not present many opportunities. □ e should □e a□le to do an audit in the near future.
10/22/2020 H□M to report 11/2020

6. HIPAA Privacy and Security Regulations
Ris□Score – 144
Ris□Choice – Mitigate

Mitigations:

Education □Educate staff mem□ers H□P□□ Privacy and Security Regulations at staff meetings. □his will □e completed □y □irector of Compliance and Ris□Management in con□unction with the □irector of Human Resources. □as□is due □y □ecem□er of 2020. □his education will □e incorporated into new hire as well as annual education.

Monitoring – Monitoring will continue via reporting and the □air□ arning automated system. More systems are □eing added to □air□ arning monitoring.
10/22/2020 □ or□ing with □□ and H□M to stream line a process.

□udit – H□P□□ Security Ris□□udit is □eing performed □y a third party organi□ation. □ctions will follow this audit.
□his was put on hold □ecause of CO□□□ □1□and will resume as a□le. □ e are continuing to monitor through □airwarning as well as Healthicity for compliance. Health □nformation Management □H□M□is doing the investigations. □he □irector of Compliance and Ris□ management will meet at least monthly□□this can □e done via telephone□□to discuss potential H□P□□ violations.
10/22/2020 □his was accomplished □am waiting for an official report. □ e have two thirds of the report□this should □e completed □y ne□t meeting.

7. Denial Management
Ris□Score – 143
Ris□Choice – □ccept

Mitigations:

□udits – □uarterly audits are to □e performed on the esta□lished Patient □inancial Services process for monitoring denials. □he audits will □e due the last day of each □uarter and will □e performed □y the Compliance □uditor.
□his is currently □eing audited and will □e presented to the □oard Compliance Committee when completed.

10/22/2020 currently wor□ing on

8. Recovery Audit Contractor Readiness
Ris□Score – 135
Ris□Choice – Mitigate

Mitigations:

Process □ormation – □he Revenue Cycle □eam has □een tas□ed with creating a process for the efficient/accurate response to R□C audits.

□udit – Semi□annual audits will □e performed on the process for R□C audit readiness. □his will □e contingent upon the presence of a R□C audit. □he audits will □e performed □y the Compliance □uditor and □e due at the last day of the second and fourth □uarter. □his helps us to find out if we are prepared for R□C audit.
10/22/2020 □pril will reach out to □ami to see what needs to □e loo□ed at.

9. Patient Grievances and Guest Relations
Ris□Score – 132
Ris□Choice – □ccept

Mitigations:

Process □ormation – □ew process/group was formulated in Septem□er of 201□to facilitate more standardi□ed and efficient resolution of patient grievances. □his process was revamped in □anuary to accommodate transition to the new □irector of Compliance and Ris□/Management.

Policy □pdate – □acility policy will □e updated to reflect the new process.

□udits – □uarterly audits will □e performed internally on this esta□lished process. □he audits will □e due □y the last day of each □uarter and □e performed □y a mem□er of the wor□team. □udits will □e performed □y the Compliance □uditor
10/22/2020 included in this meeting pac□et

10. Business Continuity and Disaster Recovery
Ris□Score – 130
Ris□Choice – Mitigate

Mitigations:

□udits – □ third party H□P□□ Security audit will □e performed and report provided.

□esting – Penetration testing will □e performed using a third party organi□ation. □ctions will li□ely follow this event.
□his process was put on hold □ecause of CO□□□1□and will resume as soon as a□le. Current wor□within the different units are commencing to secure downtime procedures are effective in case any one of the EMR's are highjacked.

10/22/2020 Still on hold

11. Anti-Kickback Law
Ris□Score – 126
Ris□Choice – Mitigate

Mitigations:

Policy □pdate – □he Code of Conduct will □e updated to include □ehavior management standards as well as an e□panded e□planation of the □nti□□ic□□ac□re□uirements. □his will □e due □y the last day of □pril 2020. □raft is to □e completed □y the □irector of Compliance and Ris□Management and approved □y all appropriate committees. Su□an has as□ed to wor□ on this pro□ect.

12. Workers Compensation Claim Submission
Ris□Score – 121
Ris□Choice – □ccept

Mitigations

□udits – □ semi□annual audit will □e performed □y the Compliance □uditor on this process. □his will □e contingent upon the presence of claims. □hese will □e due on the last day of the second and fourth □uarters.
10/22/2020 □ue □ecem□er

13. Patient Safety Program
Ris□Score – 120
Ris□Choice – Mitigate

Mitigations:

Committee □ormation – □he Safety Committee has □een formed to ta□e a comprehensive view of safety concerns. □his is an evolving committee and is moving forward.
10/22/2020 □a□riell S. was chair of this committee and her last day is the 22nd. □ re□uest for replacement has □een filed with HR and □uality will continue with the culture of safety plan. □his was presented on 10/21/2020 to the □uality □oard.

14. Stark Law – Education and Policy
Ris□Score – 117
Ris□Choice – Mitigate

Mitigations:

Process □ormation – □n□house counsel has □een tas□ed with creating a standardi□ed process for proactively addressing Star□concerns through policy□contracts□and education.

15. Contract Staff v. Employed Staff
Ris□Score – 110
Ris□Choice – □ccept

Mitigations:

□udits – Semi□annual audits on the process for re□uesting/o□taining contract staff will □e performed □y the □nternal □udit Specialist. □hese will □e due on the last day of the first and third □uarter.
□n audit was performed for the physicians, "Compliance pro□e audit of the Credentialing Process for MHSC Practitioners□and was presented in the □ovem□er 18□201□ □oard pac□et.

□he ne□t audit will □e done for employed vs. contract clinical staff□ie. □ursing□radiology□ respiratory.
10/22/202 □uality has indicated this shall □e done every two years.

Memorial Hospital of Sweetwater County
Governance Committee Meeting
October 9, 2020
Zoom Meeting

Voting Members Present: Richard Mathey, Irene Richardson, and Barbara Sowada
Non-voting Members Present: Suzan Campbell

Call Meeting to Order

Richard Mathey called meeting to order at 2:00 pm.

Discussion

Agenda was created during the meeting.
Minutes of last month's meeting had previously been approved.
New Business

1. Revision of Bylaws was initiated. Chapter VII-Medical Staff was reviewed and revisions suggested. Suzan will research questions that arose during the discussion and bring the revised draft of this section to the next Governance Committee meeting.

With no further business, the meeting was adjourned at 3:30 pm.

Submitted by Barbara J. Sowada, Ph.D.