MEMORIAL HOSPITAL OF SWEETWATER COUNTY
REGULAR MEETING OF THE BOARD OF TRUSTEES
May 7, 2025
2:00 p.m.
Hospital Classrooms 1, 2 & 3

AGENDA

I. Call to Order — Barbara Sowada
   A. Roll Call
   B. Pledge of Allegiance
   C. Mission and Vision — Nena James
   D. Mission Moment — Irene Richardson, *Chief Executive Officer*

II. Approval of Agenda *(For Action)* — Barbara Sowada
   A. Requests for Consent Agenda items to be removed to New Business
      (If not removed, no questions/discussion)
   B. Requests for Senior Leader or Board Committee Reports to be removed to New Business
      (if not removed, no questions/discussion)

III. Community Communication — Barbara Sowada

IV. New Business
   A. Infection Preventionist Appointment Letter *(For Approval)* — Ann Marie Clevenger, *Chief Nursing Officer*
   B. Infection Prevention Annual Update — Barbara MacDonald, *Infection Prevention*

V. Old Business — Barbara Sowada
   A. Quarterly Progress Report on Strategic Plans and Goals
   B. Behavioral Health Plan *(Still in progress)* — Irene Richardson
   C. Professional Practice Review Plan *(For Review)* — Stephanie Mlinar, *Director of Quality*
   D. CAH - Employee Health Plan *(For Review)* — Ann Marie Clevenger
   E. Patient Safety

VI. Consent Agenda *(For Action)* — Barbara Sowada
   A. Approval of Meeting Minutes
   B. Approval of Capital Expenditure Requests
   C. Approval of Bad Debts
   D. Suspend Policies, Standards, Plans, Procedures/Processes, Guidelines and Forms *(PolicyStat ID 16797170, Active Status)*
   E. Policies from the Governance Committee — Marty Kelsey
      1. Policy for Development, Approval, and Oversight of Policies and Governance Documents at Memorial Hospital of Sweetwater County
      2. MHSC Policy & Governance Document Approval Matrix
      3. Policies, Standards, Plans, Procedures/Processes, Guidelines and Forms *(PolicyStat ID 17862888, Draft Status)*

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VII.	New Business Continued *(For Review and Questions/Comments)*	Barbara Sowada
	A. CAH – Plan of Care & Scope of Services	Marty Kelsey
	B. BOT – Memorial Hospital of Sweetwater County Meeting Guidelines	Marty Kelsey
	C. BOT – Senior Leadership Plan: Filling CEO Absences & Vacancies; Filling Senior Leader Absences & Vacancies; Identifying & Developing Internal Senior Leaders	Marty Kelsey
VIII.	Reports	
	A. Chief Executive Officer and Guests Verbal Reports	
	1. Chief Executive Officer Report	Irene Richardson
	2. Medical Staff Services Chief of Staff Report	Dr. Alicia Gray
	3. County Commissioner Liaison Report	Taylor Jones
	B. Senior Leader and Board Committee Reports	
	1. Senior Leader Written Reports	
	a. Chief Clinical Officer	Kari Quickenden
	b. Chief Experience Officer	Cindy Nelson
	c. Chief Financial Officer	Tami Love
	d. Chief Nursing Officer	Ann Marie Clevenger
	2. Board Committee Written or Verbal Reports	
	a. Joint Conference Committee	Barbara Sowada
	b. Building and Grounds Committee	Craig Rood
	1) For your information – No change to Charter	
	c. Compliance Committee	Kandi Pendleton
	d. Governance Committee	Marty Kelsey
	e. Quality Committee	Barbara Sowada
	f. Human Resources Committee	Kandi Pendleton
	g. Finance and Audit Committee	Marty Kelsey
	h. Foundation Board Report	Craig Rood
	i. Executive Oversight and Compensation Committee	Barbara Sowada
IX.	Education	
	A. A Foundation In Infection Prevention PowerPoint & Quiz	
X.	Good of the Order	Barbara Sowada
XI.	Executive Session (W.S. §16-4-405(a)(ix))	Barbara Sowada
XII.	Action Following Executive Session	Barbara Sowada
XIII.	Adjourn	Barbara Sowada

Memorial Hospital

OF SWEETWATER COUNTY

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

Quality & Safety

Community, Services & Growth

Employee Experience

Financial Stewardship

ORIENTATION MEMO

Board Meeting Date: 5/7/2025

Topic for Old & New Business Items: Letter of Appointment for Infection Preventionist

Policy or Other Document:

_____ Revision
____X__ New

Brief Senior Leadership Comments: Barbara MacDonald, previously the interim infection preventionist has begun full time employment with MHSC as infection preventionist. Seeking approval on recommendation for appointment of Ms. McDonald.

Board Committee Action:

Policy or Other Document:

_____ For Review Only
____X___ For Board Action

Legal Counsel Review:

_____ In House Comments:
_____ Board Comments:

Senior Leadership Recommendation: Approve appointment of Barbara MacDonald as Infection Preventionist at MHSC.

April 23, 2025

MHSC Board of Trustees,

This letter acknowledges that I, Irene Richardson (CEO) of Memorial Hospital of Sweetwater (MHSC), fully support the MHSC Infection Prevention (IP) Program. MHSC is committed to actively promoting and implementing infection prevention and control principles and advancing the objectives set forth by the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid, and The Joint Commission.

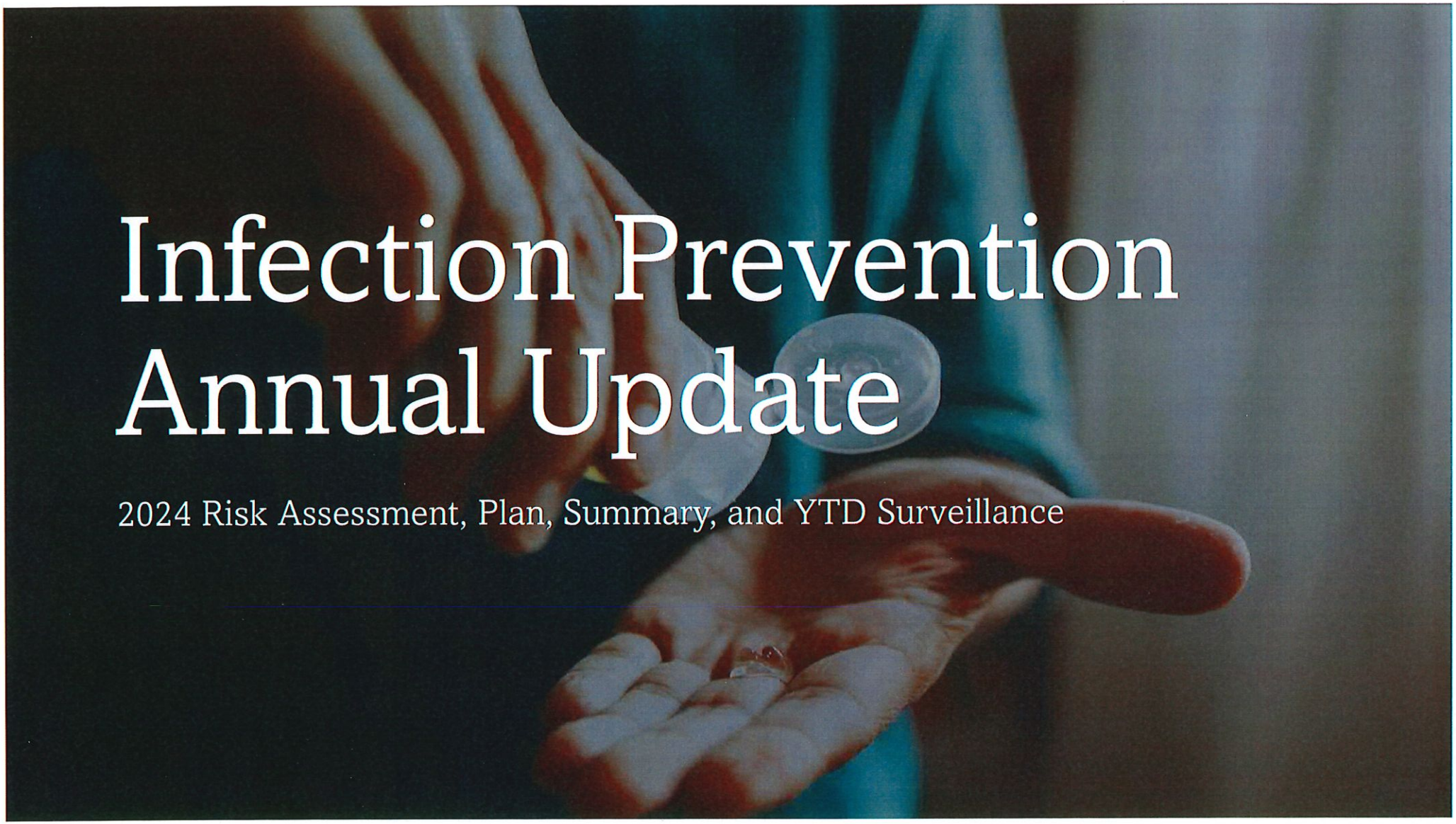
MHSC is committed to ensuring an effective, well-managed infection prevention and control program. To achieve this outcome, Barbara MacDonald RN, CIC, previous Interim Infection Preventionist, has been deemed the person at MHSC with clinical authority over the infection prevention and control program based on the recommendations of medical staff and nursing leadership. Ms. MacDonald began full-time employment at MHSC on February 24, 2025. She reports directly to Noreen Hove MSN, RN, CNOR, and collaborates with Dr. Karn.

I respectfully request that the MHSC Board of Trustees join me in appointing Barbara McDonald as the individual responsible for the infection prevention and control program at the MHSC.

Sincerely,

Irene Richardson, Chief Executive Officer

Joint Commission CAH IC. 01.01.01 EP 1-6: For hospitals that use Joint Commission accreditation for deemed status purposes: An individual(s) who is qualified through education, training, experience, or certification in infection prevention and control is appointed by the governing body to be responsible for the infection prevention and control program. The appointment is based on recommendations of medical staff leadership and nursing leadership.



Infection Prevention Annual Update

2024 Risk Assessment, Plan, Summary, and YTD Surveillance

2024 Brief Summary and Plan

Site	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
SSI									2		3		5
CAUTI								1					1
CLABSI													0
URI													0
PNEU										1			1
VAE													0
PPI									1	1			2
SST													0
Other				1*									1
LabID CDI		2	1										3
LabID MRSA				1									1
Total													
*													14
04 2024	JNT												

- 2024 Trends Observed- C diff HO, now gone to zero
- More SSI's than any other single site, significance difficult to interpret without SIRs or past comprehensive surveillance

Risk Assessment and Plan for 2025 Take Aways:

1. Comprehensive Surveillance
2. Surveillance limited by tools- in progress
3. Infection Prevention practices compliance- reboot auditing, leadership accountability for staff performance

2025 YTD HAI Trend Report- Site

Site	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
SSI	2	1	1										
CAUTI													
CLABSI													
URI			2*										
PNEU	1	1	1										
VAE													
PPI													
SST													
Other													
LabID HO CDI													
LabID HO MRSA													
Total													
*Date	Org	Notes											
3/3/2025	Influenza A	Neg for Flu on admission, 4 days later developed a cough- Flu A. Has ill family, unable to rule out HAI.											
3/8/2025	RSV	CHF pt with fever and RSV pos on day 5, other patients on the unit with RSV.											

Trend Observed- HAI respiratory illness. Expected URI = 0. Expected PNEU = 1-2 per year. (Based on IP experience with similar hospitals.)

SSI- will be able to use NHSN analytics once all procedures are able to be uploaded into NHSN (SIRs).

Good News- no CAUTI or CLABSI for Q1.

2025 YTD HAI Trend Report- Non-SSI Organisms

Organism	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Influenza A			1										
RSV			1										

Trend- respiratory HAIs

Organisms will be tracked over time, both within a year and between years, to look for patterns of significance.

HAI Trend Report – SSI Procedures

Procedure	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
CSEC	1												
NO	1												
SB		1											
AMP			1										

Trends- none observed by procedure YTD.

CSEC- Cesarean Section
NO- Not NHSN Procedure (Why look at these? Track, trend organisms, procedures, surgeons, etc.)
SB- Small Bowel
AMP- Amputation

*1 Rule out SSI incomplete for Q1, waiting to hear back from another facility post transfer.

HAI Trend Report- SSI Organisms

Organism	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
MRSA	1												
Escherichia coli		1											
Cornynebacterium amycolatum		1											
Enterococcus faecalis			1										
Staphylococcus epidermidis			1										

Trends- none observed YTD

What to watch for- MRSA, comprehensive surveillance will reveal the HAI burden of MRSA in our patient population over time

Looking Ahead

- Communicable Disease Reporting Trends- in progress
- Infection Prevention Practice Audits- Hand Hygiene and PPE compliance restarted
- SIR/SUR analytics- in progress

Questions?

Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:5/7/2025

Topic for Old & New Business Items:
Policy – Professional Practice Review Plan
We are proposing a change in the title to "Medical Staff Peer Review and Professional Practice Plan"

Policy or Other Document:

☒ Revision
☐ New

Brief Senior Leadership Comments:

- FPPE used to be part of the Professional Practice Evaluation Plan. However, a new policy was drafted, and it is lengthy, so it was removed from this plan and is now a separate policy.

Board Committee Action:

Review requested for the Professional Practice Review Plan and all attachments

Policy or Other Document:

☒ For Review Only
☐ For Board Action

Legal Counsel Review:

☐ In House Comments:
☐ Board Comments:Click or tap here to enter text.

Senior Leadership Recommendation:
This plan will be taken to PPEC and MEC for review and approval May 2025.

Status **Draft** PolicyStat ID **18063944**

Approved N/A

Review Due N/A

Document Area: Medical Staff

Reg. Standards: TJC MS 05.01.01, TJC MS 06.01.05, TJC MS 08.01.01 + 2 more

Professional Practice Review Plan (Medical Staff Peer Review)

Statement of Purpose

Memorial Hospital of Sweetwater County (MHSC) Medical Staff professional practice review (peer review) process provides a standardized mechanism to measure, assess, improve, and evaluate medical staff member's performance, professionalism, competency, and behaviors through the conduct of peer and chart review. The process involves monitoring and analyzing data, along with identifying trends and/or adverse outcomes, which may impact patient safety and quality of care. This process provides for continuous quality improvement as well as opportunity to address any potential problems in a timely manner. The information identified through this process is also factored into decisions to grant clinical privileges through the credentialing process.

Plan

I. Objectives

The goal of the Medical Staff Peer Review Plan is to outline processes to:

A. Assist in driving healthcare quality by following the Institute of Medicine's six aims (STEEEP):

1. Safe: avoiding harm to patients from the care that is intended to help them
2. Timely: reducing wait times and sometimes harmful delays for both those who receive and those who give care
3. Efficient: avoiding waste, including waste of equipment, supplies, ideas, and energy
4. Effective: providing services based on scientific knowledge to all who

could benefit and refraining from providing services to those not likely to benefit

5. Equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status
6. Patient-centered: providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions

B. Provide a mechanism for review and ongoing evaluation of Practitioner clinical competence and professional performance through systematic, data-driven processes.

C. Identify and resolve Practitioner performance and clinical competency issues.

D. Comply with The Joint Commission standards for Medical Staff Ongoing Professional Practice Evaluation (OPPE).

E. Create and participate in a Just Culture. See Just Culture Policy.

F. Assist in organizational process improvement strategies based on identified opportunities and in congruence with MHSC's Performance Improvement and Patient Safety (PIPS) Plan and organizational strategic plan.

II. Definitions

A. Health Care Quality: A person-centered commitment to excellence, consistently using best practice to achieve the best outcomes for our patients and community. MHSC uses the following terminology interchangeably: quality improvement and performance improvement.

B. Just Culture: A value supported system of accountability between the organization and employee that fosters a fair, learning culture which allows individuals to report adverse events, Good Catches, and hazards in an atmosphere of trust.

C. Medical Staff: The group of all Practitioners privileged through the organized Medical Staff process and are subject to the Medical Staff Bylaws, Rules, and Regulations. See Medical Staff Bylaws.

D. Practitioner: Refers to all members of categories of the Physician Medical Staff, as well as Non-Physician Providers and Advance Practice Providers per the MHSC Medical Staff Bylaws.

E. Professional Performance and Peer Review: A process that allows the Medical Staff to evaluate an individual's professional practice and/or system issues that may affect the delivery of quality care. The evaluation may identify systems or processes of care that do not adequately protect against foreseeable human error.

F. Professional Practice Evaluation Committee (PPEC): A multidisciplinary peer review committee authorized to conduct peer review for the Medical Staff. This committee will also function to review and monitor the ongoing evaluation of Practitioner performance trends and provide recommendations and follow-up as appropriate.

1. The PPEC chair shall be selected by the Chief of Staff.

2. The Vice Chair of each department (Medicine and Surgery) shall serve on PPEC.
3. Three other Physicians will be appointed by the Chief of Staff to serve on the committee.
4. An Advance Practice Provider shall also be appointed to serve.

G. Ongoing Professional Practice Evaluation (OPPE): A summary of ongoing data collected for the purpose of assessing a Practitioner's clinical competence and professional behavior. PPEC's role in OPPE is outlined in Section IV. OPPE.

H. Focused Professional Practice Evaluation (FPPE): is a systematic process to ensure the current competency of Practitioners at Memorial Hospital of Sweetwater County. FPPE occurs routinely whenever the Hospital grants new privileges, such as when new privileges are initially granted to a Practitioner who is new to the organization or when an existing Practitioner requests a new privilege. See Focused Professional Practice Evaluation Plan.

I. Professional Behavior: Adherence to MHSC's Medical Staff Code of Conduct within the Medical Staff Bylaws is expected of each individual member of the Medical Staff at MHSC to promote an environment conducive to providing the highest quality of care.

J. Medical Staff Quality Reviewer: A reviewer appointed by the Chief of Staff annually to perform initial case reviews to determine if the cases require peer review by the PPEC.

K. Conflict of Interest: A Medical Staff member requested to complete a peer review may have a conflict of interest if:
1. They may not be able to render an unbiased opinion.
2. An automatic conflict of interest would result if the Practitioner is involved in any way in the case under review.
3. Relative conflicts of interest are either due to a Practitioner's involvement in the patient's care not related to the issues under review or because of a relationship with the Practitioner involved as a direct competitor, partner, or key referral source.
4. It is the responsibility of the PPEC to determine on a case by case basis if a potential conflict exists and if substantial enough to prevent the individual from participating in the review. If a potential conflict exists, the individual may not participate or be present during peer review discussions or decisions other than to provide specific information requested.

L. Low Volume/No Activity Practitioners or Specialties: Alternate data collection methods may be developed and used as approved by the Professional Practice Evaluation Committee for Practitioners in low volume specialties or specialties in which objective data is unable to be obtained.

M. Peer: An individual practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide

meaningful evaluation of a Practitioner's performance will determine what "practicing in the same profession" means on a case by case basis. (Example: for quality issues related to general medical care, a physician may review the care of another physician. For specialty-specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well-trained and competent in that surgical specialty).

N. Rate Indicators: Medical Staff approved OPPE indicators that will be reviewed by PPEC annually to identify outliers, trends, and provide feedback, education, initiate performance improvement plan, or recommend FPPE with the individual as appropriate. Refer to the OPPE process flow.

O. Review Indicators: Medical Staff approved review indicators that are automatically sent for an initial case review by a designated Medical Staff Quality Reviewer.

P. Rule Indicators: Specific events that are tracked to ensure compliance with established guidelines, policies, and standards, including sentinel events that are automatically sent to the PPEC for peer review. See Sentinel Event Policy.

III. Review Process

A. Referral of Cases

1. All cases that may require peer review by PPEC will be processed through the Quality Department.
    a. Any employee, Medical Staff member, of Committee who may be aware of a case for peer review will contact the Director of Quality or Quality Analyst.
    b. Should the person requesting a peer review wish to remain anonymous, they must clearly indicate this in their request.

B. Initial Case Review

1. Medical Staff approved review indicators are sent for an initial case review by a designated Medical Staff Quality Reviewer.
2. All cases requiring an initial case review will be processed through the Quality Department.
3. Six Medical Staff Quality Reviewers will be appointed by the Chief of Staff. Three will be appointed from the Medicine Department and three from the Surgery Department. In the event a designated Medical Staff Quality Reviewer is unable to fulfill the term, a new reviewer will be appointed by the Chief of Staff, as a replacement.
4. Medical Staff Quality Reviewers will be notified via the quality management system of cases needing review as they occur. The review of the case and outcome determination is expected to be completed in a timely manner.

5. Initial Case Review Outcome Determination:

    a. Appropriate Care: after careful review, this designation adjudicates that there was no clear deviation from standard of practice. The case will be closed and this outcome determination will be displayed on the Practitioner's OPPE report.

    b. Further Review Needed: after careful review, this designation adjudicates that there may be a deviation from standard of practice, a system improvement opportunity, or when an outcome is undertermined. These cases will be referred to PPEC for evaluation and outcome determination.

C. Peer Review

1. PPEC will meet ten (10) times per year, ideally monthly. They may meet more or less often, as needed, dependent on the volume of cases requiring review by the committee.
2. The PPEC will be provided with a list of patients with case summaries for review from the Quality Department prior to the meeting.
3. It is the responsibility of the PPEC members to review cases prior to the set meeting date for discussion and final outcome determination at the PPEC meeting.
4. All reviews from PPEC will be documented directly in the quality management system using a secure log-in by a designated member of the committee or may be transcribed from meeting minutes by Quality.
5. Outcome determinations for final conclusions must be made by a consensus of members present at PPEC.
6. The PPEC reserves the right to halt the peer review process for a Practitioner that has separated from the organization for any reason.

    a. Judgment of whether or not the case needs to be reviewed is left up to PPEC.

    b. A letter formulated by the Quality Department will be placed in the separated Practitioner’s file indicating that there is/are unclosed Peer Review case(s) should the Practitioner wish to be recredentialed at a future time.

7. Peer Review Outcome Determination:

    a. Care Appropriate: despite a complication, adverse outcome, or other question regarding the quality delivery of care, it is determined that a majority of peers would have responded

similarly under similar circumstances. This designation adjudicates that there was no clear deviation from standard of practice. The case is closed and this outcome determination will be displayed on the Practitioner's OPPE report.

b. Improvement Opportunity: care that involved a simple error in diagnosis, treatment or judgment, or inadvertently doing other than what should have been done: a slip, lapse, or mistake. PPEC will determine the appropriate follow-up or may delegate follow-up to another peer. Once follow-up is completed, the case will be closed and this outcome determination will be displayed on the Practitioner's OPPE report.

c. At Risk Behavior: care that requires education or coaching to prevent recurrence, or behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified. Cases with this determination are automatically referred to MEC for final outcome determination and recommendation for the next action.The case is closed upon referral to MEC and this outcome determination will be displayed on the Practitioner's OPPE report.

d. Reckless Behavior: care that suggests reckless disregard of the Practitioner's duty to the patient through gross negligence, general incompetence, or actual intent to provide substandard care, or behavioral choice to consciously disregard a substantial and unjustifiable risk. Cases with this determination are automatically referred to MEC for final outcome determination and recommendation for the next action. The case is closed upon referral to MEC and this outcome determination will be displayed on the Practitioner's OPPE report.

8. System Improvement Outcome Determination:

    a. System Improvement Opportunity: designates an event as resulting at least in part from an opportunity to improve the care system to reduce caregiver errors, mitigate the effects of any future errors, or otherwise better support the care process.This outcome is not Practitioner specific and will not be displayed on the Practitioner's OPPE report.

    b. System improvement opportunities will be delegated to the appropriate department for evaluation.

9. If the PPEC is unable to determine the final outcome, the case will be referred to MEC for evaluation and final determination.

D. Patient Complaints and Grievances

1. A grievance will be entered into the electronic occurrence reporting system.
2. After Grievance Committee reviews the grievance, they may decide to send it through peer review and to MEC. If this is decided, the Quality Department will receive an action with instructions to send the grievance through peer review and the Medical Staff Services (MSS) office will receive an action with instructions to send to MEC. These actions will automatically generate a notification email to both the departments.
3. Quality and the Medical Staff Services Office will ensure that the grievance is sent to the peer review committee (PPEC) before going to MEC.
4. The grievance will also be sent to the Chief of Staff.
5. PPEC will determine whether or not the standard of care was met for the grievance case. Quality will notify Medical Staff Services of PPEC's determination, and MSS will relay that information to MEC.
6. The Chief of Staff will discuss the grievance with the practitioner to obtain their side of the story.
7. Medical Staff Services will request the practitioner's peer review file to determine if he or she had any other grievances (within the past 24 months.) MSS will draft a summary of any grievances for review at MEC.
8. The grievance (and summary of past grievances) will then go to MEC and will be discussed during executive session.
9. MEC will discuss and decide on appropriate action for the grievance. Each complaint will be handled on a case-by-case basis, but here are several possible outcomes:
    a. A letter will be sent to the practitioner informing them that the grievance was determined NOT to be an episode of disruptive behavior. The case will be closed and a copy of the letter will be placed in the practitioner's peer review file. This will not be reported to Quality for tracking on the practitioner's OPPE profile.
    b. A letter will be sent to the practitioner informing them that the grievance was determined to be an episode of disruptive behavior. They will be reminded to follow the code of conduct. The case will be closed and a copy of the letter will be placed in the practitioner's peer review file. This will be reported to Quality for tracking on the practitioner's OPPE profile.
    c. In addition to the disruptive behavior letter, the Chief of Staff may counsel the Practitioner.
    d. MEC can determine that the grievance is serious enough to investigate further, and may initiate corrective action.
10. Once the case is closed, Medical Staff Services will enter any comments

and close the case in the electronic quality management system.

E. External Reviews

1. The PPEC or MEC may require use of external peer review consultation in cases including, but not limited to:
    a. The absence of an appropriate Practitioner able to render an opinion regarding a peer review or FPPE.
    b. The presence of a significant conflict of interest.
    c. Potential for litigation.
    d. Ambiguity, especially when dealing with vague or conflicting recommendations from internal reviewers.
    e. Any case they deem necessary for external review.
2. If a case is sent for external review by in house legal/risk, results of the external review as they pertain to individual Practitioner performance are requested to be presented to the PPEC and entered into MHSC's internal peer review process if indicated. Initial findings and subsequent reporting is the purview of in-house legal.

F. PPEC may request the Practitioner in question to present the case to PPEC before an outcome determination can be made.

1. The Practitioner whose patient's clinical course of treatment is scheduled for discussion of a possible deviation from standard clinical practice at a Department, Service or Committee meeting, shall be notified in writing from the Department, Service or Committee's chair at least one week prior to the scheduled date of presentation.
    a. The involved Practitioner will be given a brief case summary including the medical record number, encounter number, and reason for review.
    b. If a case has been sent for external review, a copy of the external review will be provided to the Practitioner involved.
    c. The involved Practitioner may request the names of the attendees of PPEC and MEC where their case(s) were reviewed.
    d. To protect the integrity of the peer review process, the names or other identifying information of individuals requesting the peer review will not be provided to the involved Practitioner.
    e. Attendance by the involved Practitioner shall be mandatory. Failure to appear or to secure postponement from the chair may be deemed "unprofessional conduct", and result in corrective action as outlined in Article XVII of the Medical Staff Bylaws. This rule is not to be construed as applying to discussion of cases identified by routine monitoring of patient care.

f. Except as explicitly provided in Article XVIII of Medical Staff Bylaws in connection with the exercise of applicable hearing and appeal rights, and notwithstanding anything to the contrary in the Medical Staff Documents, no Practitioner shall have the right to be represented or accompanied by an attorney at any meeting of the Medical Staff, or any committee (standing or ad hoc), Department, or section thereof, or when meeting with any Medical Staff officer.

G. Whenever possible, a Practitioner involved as a member of the MEC, PPEC, or any other ad hoc committee tasked with peer review should vote in only one (1) level of the decision-making process. In situations in which this is not possible, Practitioners are expected to limit their involvement in multiple levels of review.

H. Prior to closing an FPPE cycle, the personnel involved may ask the Quality Department and the Chair of PPEC if there are any open cases for review by PPEC.

I. Documentation

1. All initial case reviews and peer reviews shall be documented directly in the quality management system.
2. Designated member of the committee or medical staff quality reviewers may document notes and final conclusions directly in the quality management system.
3. Notes may be transcribed from meeting minutes or delegated to Quality during meetings for entry in the quality management system.

J. Confidentiality of, and Access to, Medical Staff Peer Review files

1. Refer to Confidentiality of, and Access to Medical Staff and Peer Review Files Policy in PolicyStat. insert link

IV. OPPE

A. The organized Medical Staff are responsible for defining the OPPE process.

B. The following general competencies are included in OPPE:

1. Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and care at the end of life.
2. Medical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
3. Practice-based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate and improve patient care practices.
4. Interpersonal & Communication: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families

and other members of healthcare interdisciplinary teams.

5. Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward patients, families, colleagues, their profession, and society.
6. Systems-based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare.

C. Specialty specific data will be recommended for inclusion on the OPPE report and approved by each specialty, PPEC and MEC.

D. OPPE data from outside organizations may be included in addition to MHSC data for selected specialties as approved by PPEC and MEC.

E. While the practitioner is on FPPE, specialty specific OPPE data may be concurrently monitored.

F. OPPE is factored into the decision to maintain, revise, limit, or revoke existing medical staff privileges by the Credentials Committee.

G. Quality Department Responsibilities:

1. Meet with Medical Staff specialties to determine meaningful data to be included on OPPE reports.
2. Collaborate with other MHSC Departments to collect and validate data for OPPE.
3. Compile the annual OPPE reports
4. Notify individual Practitioners when their report is ready for review.

H. PPEC Responsibilities

1. Ensure consistent implementation of the OPPE process.
2. Complete, at a minimum, one annual review of each Practitioner's OPPE report in the quality management system.
3. Evaluate Practitioner performance, identify trends and intervene when appropriate.
4. PPEC may request additional information from the Quality Department for further review, if a Practitioner's data does not meet the benchmark selected for that indicator.
5. Communicate feedback and opportunities for improvement with individual Practitioners when appropriate.
6. Develop an improvement plan for a Practitioner when appropriate.
7. Evaluate the effectiveness of the improvement plan and recommend initiation of an FPPE when appropriate.
8. Communicate with the appropriate Department Chair/Vice Chair for

follow-up actions when appropriate.

I. Medical Staff Department Leadership are responsible for ensuring completion of any recommended follow up from the PPEC.

V. Authority for Peer Review

A. **WY Stat § 35-2-910. Quality management functions for health care facilities; confidentiality; immunity; whistle blowing; peer review.**

1. (c) No hospital shall be issued a license or have its license renewed unless it provides for the review of professional practices in the hospital for the purpose of reducing morbidity and mortality and for the improvement of the care of patients in the hospital. This review shall include, but not be limited to:

   (i) The quality and necessity of the care provided to patients as rendered in the hospital;
   (ii) The prevention of complications and deaths occurring in the hospital;
   (iii) The review of medical treatments and diagnostic and surgical procedures in order to ensure safe and adequate treatment of patients in the hospital; and
   (iv) The evaluation of medical and health care services and the qualifications and professional competence of persons performing or seeking to perform those services.

2. (d) The review required in subsection (c) of this section shall be performed according to the decision of a hospital's governing board by:

   (i) A peer review committee appointed by the organized medical staff of the hospital.

VI. Confidentiality

A. **WY Stat § 35-2-910.** Quality management functions for health care facilities; confidentiality; immunity; whistle blowing; peer review. Subsection A. "Each licensee [hospital, healthcare facility and health services] shall implement a quality management function to evaluate and improve patient and resident care and services in accordance with the rules and regulations promulgated by the division. Quality management information relating to the evaluation or improvement of the quality of health care services is confidential. Any person who in good faith and within the scope of the functions of a quality management program participates in the reporting, collection, evaluation, or use of quality management information or performs other functions as part of a quality 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 Practitioner or person to whom the quality information pertains. In no event shall this immunity apply to any negligent or intentional act or omission in the provision of care" (Wyoming Laws, 2015).

B. **WY Stat § 35-17-103.** Exemption from liability; exception: A professional standard

review organization or a society or person rendering services as a member of a professional standard review organization functioning pursuant to this act is not liable either independently or jointly for any civil damages as a result of acts or omissions in his capacity as a member of any such organization or society. Such persons or organizations or societies are not immune from liability for intentional or malicious acts or omissions resulting in harm or any grossly negligent acts or omissions resulting in harm.

C. **WY Stat § 35-17-105.** Information of review organizations to be confidential and privileged. All reports, findings, proceedings and data of the professional standard review organizations is confidential and privileged, and is not subject to discovery or introduction into evidence in any civil action, and no person who is in attendance at a meeting of the organization shall be permitted or required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the organization or as to any findings, recommendations, evaluations, opinions or other actions of the organization or any members thereof.

D. 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 quality and patient safety work. All quality and patient safety data and information shall be considered the property of Memorial Hospital of Sweetwater County.

E. Only the following individuals will have access to Practitioner-specific peer review information and only for purposes of evaluation and improvement of the quality of care rendered in the hospital:

    1. The specific Practitioner.
    2. The Chief of Staff for purposes of considering corrective action.
    3. Department chairpersons (for members of their department only) for purposes of initial chart review or considering corrective action.
    4. Members of the PPEC, MEC, and Credentials Committees for purposes of considering corrective action and as part of the appointment/ reappointment process.
    5. Medical staff service professionals supporting the credentialing process and to the extent that the access to this information is necessary for re-credentialing or formal corrective action.
    6. The Quality Department for purposes of tracking peer review processes, OPPE report compilation, and generating reports as requested by parties privileged to the information.
    7. Individuals performing surveys for accrediting bodies with appropriate jurisdiction (i.e. TJC, CMS, DHS, etc.).
    8. The Hospital Chief Executive Officer (CEO) when information is needed to take immediate formal corrective action for purposes of summary suspension by the CEO.

F. No copies of peer review documents will be created and distributed unless

authorized by medical staff policy or bylaws, the MEC, PPEC, Credentials Committee, or by mutual agreement between the Chief of Staff and CEO for purposes of deliberations regarding corrective action on specific cases.

G. No copies of peer review information will be given to other facilities or agencies without specific written authorization from the Practitioner.

Reviewed and Approved:

PPEC 9/18/2024

MEC 10/30/2024

Board of Trustees 12/2/2024

References

Joint Commission Resources. (2024) *Policy Source Hospital: POLH24_MS_Ongoing Professional Practice Evaluation Policy*. Retrieved January, 2024 from https://store-jcrinc.ae-admin.com/assets/1/7/POLH24_MS_Ongoing_Professional_Practice_Evaluation_Policy.docx

Agency for Healthcare Research and Quality [AHRQ]. (2022). *Quality.* https://www.ahrq.gov/topics/quality.html

Institute of Medicine [IOM]. (1990). Medicare: A strategy for quality assurance: Volume II sources and methods. *Institute of Medicine (US) committee to design a strategy for quality review and assurance in Medicare.* Washington (DC): National Academies Press.

The Christ Hospital. (2013). Ongoing professional practice evaluation. Retrieved from https://www.thechristhospital.com/Documents/.../Medical_Staff_Bylaws.pdf.

Adapted for MHSC use, with modifications, with written electronic mail permission from Jeni, Medical Staff Services Manager at The Christ Hospital received March 21, 2017.

The Greeley Company, LLC. (2017). Physician and hospital leadership seminars: Peer review bootcamp. Materials presented at: Peer Review Bootcamp. Physician and Hospital Leadership Seminar; 2017 January 19-21; Desert Springs, CA.

The Greeley Company, LLC. (2019). Physician and hospital leadership seminars: Peer review bootcamp. Materials presented at: Peer Review Bootcamp. Physician and Hospital Leadership Seminar; 2019 March; New Orleans, LA.

Stanford Health Care. (2016). Peer review and focused professional practice evaluation (FPPE) policy for medical staff and advanced practice Practitioners (APPs). Retrieved from https://stanfordhealthcare.org/content/dam/SHC/health-care-professionals/medical-staff/policies/peer-review-and-focused-professional-practice-evaluation-fppe-4-16.pdf

Adapted for MHSC use, with modifications, with written electronic mail permission from Debra, Administrative Director, Medical Staff Services and Pediatric Residency Program at Stanford Health Care received February 27, 2017.

Wyoming Laws. (2021). Title 35, Public Health and Safety. Wyoming Statute W.S. §35-2-910 (1977). Quality management functions for health care facilities; confidentiality; immunity; whistle blowing; peer review. Retrieved from Thomson Reuters WestlawNext.

Attachments

- Medical Staff Professional Practice Indicators 2024 - 2025 UPDATED 9.4.2024.pdf
- Medical Staff Professional Practice- Peer Review Flow- OPPE 2024-2025.pdf

Approval Signatures

Step Description	Approver	Date

Reg. Standards

TJC MS 05.01.01, TJC MS 06.01.05, TJC MS 08.01.01, TJC MS 08.01.03, TJC MS 09.01.01

ORIENTATION MEMO

Board Meeting Date: May 7, 2025

Topic for Old & New Business Items: Policy Stat Document:
Employee Health Plans

Policy or Other Document:

___x___ Revision
_____ New

Brief Senior Leadership Comments: The Joint Commission IC 04.01.01 and 04.01.03 Hospital has a hospital-wide infection prevention and control program for surveillance, prevention, and control of healthcare-associated infections. OSHA 1910.10 occupational exposure to blood and potentially infectious material. Recommendation from the Centers for Disease Control and Prevention (CDC. Combined the Employe Health Plan and the Student, Contractors, and Medical Staff Service contract to one policy.

Board Committee Action:

Policy or Other Document:

__x_____ For Review Only
_____ For Board Action

Legal Counsel Review:

_____ In House Comments:
_____ Board Comments:

Senior Leadership Recommendation:
Approve first read by the Board.

Status **Pending** PolicyStat ID **15508214**

Approved	N/A
Review Due	1 year after approval
Document Area	Employee Health
Reg. Standards	CDC, OSHA 29 CFR 1910.1030, TJC IC 04.01.03 + 1 more

CAH- Employee Health Plan

STATEMENT OF PURPOSE

The primary goal of the Employee Health Plan is to maintain the confidentiality of Memorial Hospital of Sweetwater County (MHSC) staff members' records while promoting a high standard of health, wellness, and safety among all employees. This inclusive plan applies to all employees, medical staff, contractors, students, job shadowers, and volunteers, fostering a unified teamwork approach.

Screening will be performed to ensure compliance with state and federal recommendations and regulations regarding patient care activities, including adherence to the vaccination guidelines set forth by the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA).

DEFINITIONS

- Antibody titer - A laboratory blood test determining immunity or susceptibility to a specific disease
- Bacille Calmette-Guerin (BCG) - A vaccine for tuberculosis (TB) disease
- Communicable Disease - An illness that can spread from one person or animal to another
- FIT Test - A procedure to determine whether a respirator or other protective equipment fits properly and provides an adequate seal
- Hazardous Substance - A material that can cause harm to people, animals, or the environment
- Hepatitis B - Also known as Hep B of HBV, is a viral infection that attacks the liver
- Interferon Gamma Release Assay (IGRA) - a blood test that detects tuberculosis
- Influenza - Flu, seasonal flu, or novel influenza. The flu season is categorized as October through May

- Immunity - The status of being protected from catching a communicable disease because of antibody production, either from a previous disease or an appropriately completed immunization series
- Medical Exemption - permission granted by a health care professional for an individual to be excused from a requirement or obligation due to a medical condition
- Measles, Mumps, Rubella (MMR) - A triple antigen vaccine against measles, mumps and rubella:
    - Measles – Rubeola, red, hard, or ten-day measles
    - Mumps - Also known as infectious parotitis
    - Rubella - Also known as German measles or three-day measles
- Personal Protective Equipment (PPE)
- Staff- All people who provide care, treatment, or services in the organization, including licensed practitioners; permanent, temporary, and part-time personnel; contract employees; volunteers; and health profession students. The *(Contracted staff provided through a written agreement with another organization, agency, or person. The agreement specifies the services or personnel to be provided on behalf of the applicant organization and the fees to provide these services or personnel)* Staff at MHSC:
    - Employed Staff - Full-time, Part-time, PRN, and Temporary
    - Volunteer Staff - Individual who performs service hours to MHSC without promise, expectation, or receipt of compensation for services rendered
    - Permanent Contract Staff - Cardinal and Unidine
    - Temporary Contract Staff - Travelers and Elwood
    - Non - Employed Staff - Students, Shadowers
- Tetanus-Diphtheria-Pertussis (Tdap) - A combination of three vaccines in a single injection
- Titer- Laboratory blood test that measures the amount of a specific type of antibodies in the blood to assist in determining levels of immunity
- Tuberculin Skin Test (TST) - Also known as the Mantoux test, is a diagnostic procedure to detect active or latent tuberculosis (TB) infection
- Tuberculosis (TB) - A bacterial infection caused by the germ Mycobacterium tuberculosis.
- Varicella - Also known as Chickenpox, a highly contagious viral infection caused by the Varicella-zoster virus
- Vaccine Information Statement (VIS) - A sheet from the CDC that explains both the benefits and risks of a vaccine
- Work-Related Injury - An injury that occurs on the job or is caused by something at work

ADMINISTRATION AND MANAGEMENT OF THE PLAN

I. **AUTHORITY**

A. The final authority on employee health issues is the Chief Executive Officer.

1. Except in cases of communicable disease outbreak control, when emergency measures are instituted by Employee Health with approval of the Infection Control Medical Director or their designee, and/or the Infection Control Officer appointed per CMS, with knowledge of the Chief Executive Officer.

II. **RESPONSIBILITIES**

A. The Employee Health Department receives regular guidance from the Infection Control Committee and the Environment of Care Committee.

B. Each department director is responsible for implementing and enforcing the Employee Health Plan.

EMPLOYEE HEALTH REQUIREMENTS

I. **Employed, Volunteer, and Permanent Contract Staff**

A. Health Inventory: All staff are required to complete a Health Inventory Form upon employment. (Form #802926 or #800263).

B. TB

1. All staff must provide documentation of a TST in the last 12 months or a negative IGRA in the past year. If unable to provide documentation, a 2-step TST shall be completed. The first step shall be completed before starting, and the second step shall be completed 1 to 3 weeks after the first step and before patient contact.

a. Staff with a positive TST history will be reassessed annually using the converter form (Form #802691). An experienced primary care provider will determine the frequency of CXR; however, the CDC does not recommend that it be done annually or at a regularly scheduled time.

i. The employee health nurse will inform staff about the signs and symptoms to watch regarding conversion.

ii. If a new staff member has had a previous positive TST, they will need to provide a copy of their last chest X-ray or obtain a two-view (PA/Lateral) chest X-ray.

iii. A chest x-ray and evaluation by an experienced provider will be ordered if symptoms develop (persistent cough, weight loss, anorexia, fever) in a staff with a history of TB or if recently exposed to TB.

b. The employee health provider shall be notified of all positive TST reactions.

c. The Wyoming Department of Health shall be notified of all TB conversions.

d. The hospital is not responsible for any reimbursement for medical care of TST-positive staff at the time of hire.

e. All staff shall be tested for TB at hire and after suspected or confirmed exposure.

f. BCG - Many people born outside the U.S. have been vaccinated with the BCG vaccine. This may cause a false-positive TB Skin Test reaction. There is no reliable way to distinguish a positive TB skin reaction caused by the vaccine or an actual TB infection. TB blood tests IGRA is the preferred test for people who have received the BCG vaccine. BCG does not induce positive results when a TB blood test is used. Staff with documented BCG and a positive TST shall have an IGRA test completed.

C. MMR

1. Required evidence of immunity to Measles, Mumps, and Rubella shall be documented.

a. Documentation of two MMR vaccines or documented laboratory evidence of immunity to all three components.

b. If not immune, staff shall be given MMR vaccinations according to manufacturer guidelines at no cost.

c. In the event of an outbreak, those without documented immunity or vaccine documentation will be excluded from high-risk areas.

D. Varicella (Chickenpox)

1. Required evidence of immunity to Varicella shall be documented.

a. Documentation of two Varicella immunizations or documented titer that proves immunity to Varicella.

b. If no documentation is available and the titer does not prove immunity, the staff shall receive the Varicella vaccine as per CDC guidelines. CDC Chickenpox (Varicella)

E. Hepatitis B

1. The required evidence of immunity to the Hepatitis B virus shall be documented.

a. Immunity will be determined by documented positive antibody for Hepatitis B.

b. If not immune, staff will be given Hepatitis B vaccination according to manufacturer guidelines and the MHSC Hepatitis B Vaccine for Adult Protocol. Adult Hepatitis B Vaccine for Adults Protocol Staff may start working at MHSC if the Employee Health requirements are being met and the CDC guidelines for Hepatitis B vaccine administration are being followed.

c. If the staff has received the maximum number of Hepatitis B vaccines and fails to show immunity, they will be documented as a "non-responder" and counseled on the increased risk in the

event of an exposure.

F. Tdap

1. Documentation of a Tdap within the past 10 years is required.
2. If there is no documentation of Tdap within the past 10 years, a single dose of Tdap will be administered regardless of the time since their last tetanus or diphtheria toxoid (Td) vaccine.
    a. All Employed Staff, Volunteer Staff, and Contracted Permanent Staff will be offered the appropriate booster every 10 years.

G. Respiratory Protection

1. The employee health nurse will evaluate all staff for their need to wear a tight-fitting respirator. If deemed necessary for their job duties, they will complete the OSHA respirator medical evaluation questionnaire (Form #802187) and, if medically able, be tested.
    a. Staff failing fit testing or being unable to be tested will be excluded from patient care areas requiring Airborne Precautions.

H. To meet federal guidelines, the most up-to-date Vaccine Information Statement will be offered to the staff for all vaccine administrations.

STAFF MAY ATTEND ORIENTATION/EDUCATION WHILE AWAITING BLOOD TESTING RESULTS IF NOT IMMEDIATELY AVAILABLE UPON HIRE. NO STAFF WILL BE PERMITTED TO HAVE PATIENT CONTACT UNTIL RESULTS HAVE BEEN VERIFIED BY EMPLOYEE HEALTH.

EMPLOYEE HEALTH REQUIREMENTS

I. ***NON-EMPLOYED STAFF***

A. Students and Shadowers at MHSC will meet basic health requirements and participate in established screening programs outlined by the Employee Health Plan above. Starting July 1, 2025, updated requirements for Hepatitis B proof of immunity or documentation of non-responder will be enforced.

B. The employee health nurse will receive documentation and a copy of the verified immunization records for Students and Shadowers. Verification will be obtained before starting clinical at MHSC.

C. Before their assigned student experience, which has received prior approval from the director overseeing the clinical area and the Senior Leader responsible for the specific department, the following will be completed:

1. The student or instructor will provide contact information in writing to Human Resources before starting the clinical.
2. Students will comply with the Employee Health Plan standards. Students who do not meet these requirements will not be accepted for practice in the hospital.
3. The contracting academic institution is responsible for providing the Employee Health Department with documentation of student compliance

upon request.

4. Students will be involved in case contact workups related to an exposure to a communicable disease and for follow-up if exposed.
5. Students who become ill will be referred to their private provider or to the ED in case of a medical emergency. The student assumes all costs for care and treatment.
6. Letters of attestation are not acceptable for vaccines.
7. Any immunization or titer must be completed before starting at MHSC.
8. Students must have documentation of a current FIT test and approval from their institutes' faculty to take care of a patient on airborne isolation precautions. This will be decided on a case-by-case basis.

II. **CONTRACTED TEMPORARY STAFF**

A. Contracted staff will comply with all requirements of the Employee Health Plan. Starting July 1, 2025, updated requirements for Hepatitis B proof of immunity or documentation of non-responder will be enforced.

B. The employee health nurse will receive documentation with a copy of the verified immunization record for contract personnel or be allowed access to the employee health nurse to review documents. Verification will be obtained before contract personnel begin work at MHSC. Any immunization or titer must be completed before starting at MHSC.

RECORD KEEPING

I. The employee health records are maintained in the Employee Health Department and considered confidential.

II. All people treating, testing, or accessing the staff's health record hold all employee health information in strict confidence.

III. The following people may access the Employee Health Record:

A. Employee Health Department and Infection Control Department

B. The individual staff member with written consent

C. OSHA or other regulatory personnel on site

IV. The format and content of the employee health records are standardized and include the following:

A. Employee Health Inventory for Employed Staff

B. Immunizations and titers

C. Fit test record and OSHA Respirator Medical Evaluation Questionnaire

D. Tuberculin Skin Test (TST) Interferon Gamma Release Assay (IGRA), or Converter's Assessment and Chest X-ray (CXR) record, if applicable

E. Influenza immunization

F. Color Vision for clinical staff upon hire by the Education Department

G. All other work-related documents

V. The employee health nurse maintains health records for all MHSC staff.

VI. Records shall be maintained for 30 years following termination. After 30 years, they will be destroyed.Retention of Hospital Records

VII. **FINANCIAL MANAGEMENT AND RESPONSIBILITY**

A. The Employee Health Department budgets all projected expenses incurred and identified in the Employee Health Plan.

B. Treatment plan expenses, except for worker's compensation claims, delineated by the employee health requirements, are paid for from the Employee Health budget.

C. MHSC will cover the costs of Employed, Volunteer, and Permanent Contracted Staff except for pre-existing conditions (for example, TB infection before hire).

D. Non-Employed and Temporary Contracted Staff will be financially responsible for meeting the plan's requirements before arrival.

MEDICAL EXEMPTIONS

I. All staff must receive all the required vaccines for the safety of their patients and their safety. If the staff member has a stated medical contraindication to vaccination, they shall submit a medical exemption to Employee Health for review and approval by the MHSC Medical Exemption Committee.

A. Medical exemption may include the following:

1. Immune deficiency suppresses immune responses that occur with leukemia and lymphoma, as well as therapy with corticosteroids, antimetabolites, or radiation
2. Pregnancy
3. Allergy

B. Staff will have 30 days from notification of delinquency to comply with the Employee Health Plan.

C. Staff will not be permitted to work past the 30-day notification and will be required to use PTO for time off during this time. If the staff has not complied with this requirement within two (2) weeks of the final notification, the staff will be terminated unless there are approved conditions or situations that prevent the staff from completing the requirement. The Chief Executive Officer must approve all exceptions to terminations.

D. Non-employed and Contract Temporary Staff must submit medical exemptions to Employee Health for review and approval by the MHSC Medical Exemption Committee before starting at MHSC.

ANNUAL REQUIREMENTS

I. Employee Health and Infection Control will conduct an annual TB facility assessment to determine the current TB risk and the need for annual testing.

II. All staff must participate in the Annual Influenza Vaccine Clinic. Annual Influenza Vaccine Program

III. All staff whose job duties require a tight-fitting respirator will be tested annually.

EMPLOYED STAFF ILLNESS OR WORK-RELATED INJURY

I. Staff who become ill before they begin work will notify their supervisor before the designated starting time according to personnel policy. Supervisors shall then notify Employee Health.

II. Staff who report to work ill or become sick will notify their supervisor immediately. At the supervisor's discretion, the staff may be sent to the Employee Health Department. The employee health nurse will determine whether to send the staff home or to the ER for examination by an emergency room physician or private physician.

III. Staff off work because of illness or injury for longer than two days or returning from medical leave of absence may be asked to present a work release signed by their private physician to their supervisor. Staff restricted from work because of a significant communicable disease shall have their work releases evaluated by the employee health nurse before they may return to work. Work releases are to be sent to Employee Health. Employee Health will forward a copy to Human Resources, if not already provided.

IV. It's essential that all staff, regardless of the severity of their injury, complete an Employee Packet / Injury and Exposure (which includes the Wyoming Report of Injury Form) and notify their supervisor. If the employee health nurse is unavailable, the staff should report to the emergency department for an evaluation. Supervisors play a key role in the reporting process. They are responsible for completing the Supervisor Investigation portion of the incident report, ensuring the employee has completed their portion, submitting an incident report in the MHSC reporting system, and returning the packet to the employee health nurse.
It's important to remember that not reporting injuries within 72 hours of their occurrence may have serious consequences. Staff may be ineligible for hospital-funded treatment for injuries' complications. Notification within 24 hours is preferred.

EMPLOYED STAFF EXPOSURE TO COMMUNICABLE DISEASE

I. In the MHSC occurrence reporting system, an incident report will be completed for any staff member who may have been exposed to a communicable disease. The staff's supervisor will fill out the Employee Packet/Injury and Exposure (which includes the Supervisor Investigation of Employee Accident Form) and sign the Worker's Compensation forms. Employee Health performs contact tracing for staff related to exposures. The Infection Preventionist will conduct case contact investigations and provide recommendations aligning with delineated

Infection Control policies.

II. Once the determination, through case contact investigation, of **a staff member's true exposure** to a communicable disease is made, work restrictions will be instituted according to the CDC guidelines.

    A. MHSC follows current CDC guidelines for exposures to communicable diseases, including time off work and job restrictions due to disease.

III. See policy Reporting Communicable Diseases.

EMPLOYED STAFF EXPOSED TO HAZARDOUS SUBSTANCES

I. All staff with routine exposure to hazardous substances, such as chemotherapy medications, will have medical screening, TST, and/or basic laboratory testing performed annually as indicated by the Employee Health Provider.

II. Females who are pregnant or breastfeeding and/or any person actively trying to conceive a child will acknowledge that they are aware of the risks involved with handling hazardous medications. These individuals will wear the appropriate personal protective equipment (PPE) for handling hazardous drugs. The Hazardous Drug Risk Acknowledgement form, Hazardous Drug Risk Acknowledgment, will be signed upon hire or transfer. If possible, staff members may ask to be reassigned.

PERMANENT CONTRACT, TEMPORARY CONTRACT, AND NON-EMPLOYEE STAFF WITH WORK-RELATED INJURY, EXPOSURE TO COMMUNICABLE DISEASE, AND HAZARDOUS SUBSTANCES

I. Staff shall contact and report the event to their academic institute or their agency's Employee Health Department and or Human Resource Department.

    A. Once the determination, through case contact investigation, of **a staff member's true exposure** to a communicable disease is made, work restrictions will be instituted according to the CDC guidelines. Work restrictions may be initiated by a department director with consideration of Employee Health and Infection Control but are enforced by the Infection Control Committee.

    B. MHSC follows current CDC guidelines for exposures to communicable diseases, including time off work and job restrictions due to disease.

    C. See policy Reporting Communicable Diseases.

Employee Health Links- Included but not limited to the following:

Accidental Bloodborne Exposure to Blood and Bodily Fluids

Annual Influenza Vaccine Program

CDC TB Screening- Testing

Chemical and Drug Handlers Health Surveillance History

Hepatitis B Vaccine for Adults Protocol

Employee Packet- Illness/ Injury/ Blood Exposure

Exposure Control Plan

Hazardous Drug Risk Acknowledgment

Hazardous Spill and Exposure Response- Emergency Operation Plan

HIV Post-Exposure Prophylaxis

Reporting Communicable Disease

TB Control Plan

Reporting Communicable Disease

Retention of Hospital Records

Reviewed and Approved:

Infection Control Committee: 4/17/2025

MEC: 4/22/2025

MHSC Board:

REFERENCE:

BCG Vaccine and TB Testing-CDC Guidelines. Retrieved from https://www.cdc.gov/tb/hcp/vaccines/index.html

CDC Chickenpox (Varicella). Retrieved from https://www.cdc.gov/chickenpox/index.html

CDC Management of Potentially Infectious Exposure and Illnesses. Retrieved from https://www.cdc.gov/infection-control/hcp/healthcare-personnel-infrastructure-routine-practices/exposure-managment.html

Frequency of Tuberculosis Screening and Testing for Health Care Personnel/TB Prevention in Health Care Settings. Retrieved from https://www.cdc.gov/tb-healthcare-settings/hcp/screening-testing/

frequency.html

Health Care Workers and Employers-Occupation Safety and Health Administration. Retrieved from https://www.osha.gov/healthcare.

Immunization of Health Care Personnel -Center for Disease Control and Prevention. Retrieved from https://www.cdc.gov/vaccines/

Medical Surveillance for Health Care Workers Exposed to Hazardous Drugs/ OSHA and Department of Health and Human Services. Retrieved from https://www.cdc.gov/niosh/docs/wp-solutions/2007-117/pdfs/2007-117.pdf

Occupational Safety and Health Administration/ Health Care. Retrieved from https://www.osha.gov/healthcare.

Oncology Nursing Society-Safe Handling of Hazardous Drug. Retrieved from https://www.ons.org/store/books/safe-handling-hazardous-drugs-fourth-edition

The Joint Commission. Retrieved from https://edition.jcrinc.com/

Attachments

- 800263P Employee Health Inventory 03.24R.pdf
- 802187 - OSHA Respirator Medical Evaluation Questionnaire 04.24R.pdf.pdf
- 802769 - Employee Health Requirements 1.24.pdf
- 802926 - Employee Health Inventory for Students-Shadowers- Observer & Volunteer
- 802973 - Employee Health Provider Orders 4.25.pdf

Approval Signatures

Step Description	Approver	Date
	Ann Marie Clevenger: CNO	Pending
Medical Director	Cielette Karn: Laboratory & IP Medical Director, T&B Chair	03/2025
	Patty O'Lexey: Education Director	03/2025
	Nicole Burke: Employee Health Supervisor	03/2025

Reg. Standards

CDC, OSHA 29 CFR 1910.1030, TJC IC 04.01.03, TJC IC.06.01.01 EP 5

Status **Pending** PolicyStat ID **15508214**

Approved	N/A
Review Due	1 year after approval
Document Area	Employee Health
Reg. Standards	CDC, OSHA 29 CFR 1910.1030, TJC IC 04.01.03 + 1 more

CAH- Employee Health Plan

~~INTRODUCTION~~

~~The primary goal of the Employee Health Plan is to provide a high level of health, wellness and safety among hospital employees. Memorial Hospital of Sweetwater County strives to provide a safe working environment by ensuring that all employees are trained in the proper use of machinery, safety precautions and personal protective equipment. Employees will be screened to ensure they meet the minimum employee health standards to perform patient care activities and meet the recommendations of the CDC for vaccination of health care providers. The policy applies to all employees, contract employees, students, shadowers, medical staff, and volunteers (hereafter referred to as the "employee").~~

STATEMENT OF PURPOSE

The primary goal of the Employee Health Plan is to maintain the confidentiality of Memorial Hospital of Sweetwater County (MHSC) staff members' records while promoting a high standard of health, wellness, and safety among all employees. This inclusive plan applies to all employees, medical staff, contractors, students, job shadowers, and volunteers, fostering a unified teamwork approach.

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    - Non - Employed Staff - Students, Shadowers
- Tetanus-Diphtheria-Pertussis (Tdap) - A combination of three vaccines in a single injection
- Titer- Laboratory blood test that measures the amount of a specific type of antibodies in the blood to assist in determining levels of immunity
- Tuberculin Skin Test (TST) - Also known as the Mantoux test, is a diagnostic procedure to detect active or latent tuberculosis (TB) infection
- Tuberculosis (TB) - A bacterial infection caused by the germ Mycobacterium tuberculosis.
- Varicella - Also known as Chickenpox, a highly contagious viral infection caused by the Varicella-zoster virus

- Vaccine Information Statement (VIS) - A sheet from the CDC that explains both the benefits and risks of a vaccine
- Work-Related Injury - An injury that occurs on the job or is caused by something at work

ADMINISTRATION AND MANAGEMENT OF THE PLAN

I. **RESPONSIBILITIES**

A. The employee health department receives regular input from the Infection Control Committee and the Environment of Care Committee. Pertinent policies and procedures must be approved by the appropriate committee before being incorporated or appended to the plan.

B. Each individual department Director is responsible for implementing and enforcing the Employee Health Plan within his/her department.

II. **AUTHORITY**

A. The final authority on employee health issues is the Chief Executive Officer

1. Except in cases of communicable disease outbreak control, when emergency measures are instituted by Employee Health with approval of the Infection Control Physician or designee, and/or the chair of the Infection Control Committee, with knowledge of the Chief Executive Officer

III. **RECORD KEEPING**

A. The employee health records are maintained in the Employee Health Department and are considered confidential records.

B. The following persons may access the Employee Health Record:

1. Employee health nurse or infection control/employee health director
2. Anyone who has WRITTEN consent from the employee
3. The employee with WRITTEN consent
4. OSHA or other regulatory personnel on site

C. The format and content of the employee health record are standardized.

1. Employee Health Inventory (Form # 800263 - attached) or the Employee Health Inventory for Students/Shadower/Observer (Form # 802926 - attached)
2. Immunizations and titers
3. Fit test record and OSHA Respirator Medical Evaluation Questionnaire
4. TST, IGRA or Converter's Assessment/CXR record (if applicable)
5. Influenza immunizations
6. All other work related documents

D. Health records of hospital auxiliaries are maintained by the employee health nurse,

persons who have access to employee health records also have access to the volunteer health records.

E. Records will be maintained for 30 years following termination. After 30 years these records will be destroyed.

IV. **CONFIDENTIALITY**

A. All employee health information is held in strict confidence by all persons treating or testing the employee, or having access to the employee health record.

B. To reduce the possibility of intentional or inadvertent leaks of confidential information, employee identification numbers may be used on all employee health documents and correspondence, unless the document or correspondence is being directed out of the hospital to an equally confidential source.

C. Employee health information may be released only after the employee has signed a Consent to Release of Medical Information.

V. **FINANCIAL MANAGEMENT AND RESPONSIBILITY**

A. All projected expenses incurred by the Employee Health Plan are budgeted by the Infection Prevention Department.

B. Expenses incurred by treatment plans, with the exception of worker's compensation claims, delineated by the employee health requirements, are paid for from the budget of the Infection Prevention Department.

C. New hires, current employees, and volunteer staff costs will be covered by Memorial Hospital of Sweetwater County with the exception of pre-exsisting conditions (for example TB infection prior to hire)

D. Non-employed staff, students, and shadowers will be financially responsible for meeting the requirements of the plan prior to arrival, please see policy #941517

I. **AUTHORITY**

A. The final authority on employee health issues is the Chief Executive Officer.

1. Except in cases of communicable disease outbreak control, when emergency measures are instituted by Employee Health with approval of the Infection Control Medical Director or their designee, and/or the Infection Control Officer appointed per CMS, with knowledge of the Chief Executive Officer.

II. **RESPONSIBILITIES**

A. The Employee Health Department receives regular guidance from the Infection Control Committee and the Environment of Care Committee.

B. Each department director is responsible for implementing and enforcing the Employee Health Plan.

EMPLOYEE HEALTH REQUIREMENTS

I. **Employment**

A. Health Inventory: Employees are required to complete a Health Inventory Form upon employment (Form #802672 or #802926).

B. TB

1. Tuberculin skin test (TST), Annual PPD Converter's Assessment (Form # 802691), plus chest x-ray or IGRA test results if history of past positive reaction are required. TST will be done on all employees at hire, and after a suspected or confirmed exposure to Tuberculosis (TB). All non employed staff will be required to submit annual test results.

a. Employees who have not had a documented TST in the last 12 months, will have a 2 step TST done 1 to 3 weeks after the first, with the first being completed prior to patient contact.

b. Employees who have history of a positive TST will be reassessed annually using the converter form. Frequency of CXR will be determined by an experienced primary care provider, however, annually or at a regularly scheduled time is not recommended by the CDC.

i. Education will be provided by the Employee Health Nurse regarding what signs and symptoms the employee should watch for regarding conversion.

ii. If a new employee has had a previous positive TST, the employee will need to provide a copy of the last chest x-ray or have a two view (PA/Lateral) performed.

iii. A chest x-ray and evaluation by an experienced provider will be ordered if symptoms develop (persistent cough, weight loss, anorexia, fever) in an employee with a history of TB or if recently exposed to TB.

c. The employee health physician will be notified of all positive TST reactions.

d. The Wyoming Department of Health will be notified of all TB conversions.

e. The hospital is not responsible for any reimbursement for medical care of an employee who is TST positive at time of hire.

C. Mumps, Rubella, Rubeola, and Varicella

1. Required immunity to Rubella, Rubeola, Mumps and Varicella will be documented.

a. Laboratory evidence of serologic immunity or 2 MMR and 2 Varicella vaccines.

b. If not immune, employee will be given MMR or Varicella vaccination according to manufacturer guidelines at no cost to the employee.

c. In the event of an outbreak, those without documented immunity or documentation of vaccines will be excluded from high-risk areas.

D. Hepatitis B

1. Required immunity to Hepatitis B virus will be documented.

a. Immunity will be determined by the presence of a 3 dose Hepatitis B vaccination series AND positive serologic immunity.

b. If not immune, employee will be given Hepatitis B vaccination according to manufacturer guidelines at no cost to the employee.

c. If the employee has received the maximum number of hepatitis B vaccine and fails to show immunity the employee will be documented as a "nonresponder" and will be counseled on the increased risk in the event of an exposure.

E. Tetanus, Diptheria and Pertussis

1. A TDAP or TD will be given to all new employees who are not up to date or who have not been immunized for pertussis, especially in areas in contact with children or neonates.

a. All employees will be offered the appropriate booster every 10 years.

F. Respiratory Protection

1. All employees will be evaluated by Employee Health for their need to wear a tight fitting respirator. If deemed necessary for their job duties, they will complete the OSHA respirator medical evaluation questionnaire (Form #802187) and if medically able, will be fit tested. .

a. Employees failing fit testing or unable to be tested will be excluded from patient care areas where Airborne Precautions are required.

G. All employees will receive a Employee Health Requirements checklist (Form # 802672 - attached) prior to hire to aid them in compiling the necessary requirements.

II. **Exemptions**

A. It is mandatory for employees to receive all of the above vaccines for the safety of their patients and for their own personal safety. If the employee has a stated medical contraindication to vaccination they will be evaluated by the employee health physician and may be granted exemption.

1. Medical exemption may include the following:

a. Immune deficiency, suppressed immune responses that occur with leukemia, lymphoma, therapy with corticosteroids, antimetabolites, or radiation.

b. Pregnancy

~~c. Allergy~~

~~B. Employees will have 30 days from notification of a delinquency to comply with the Employee Health Plan.~~

~~C. Employees will not be permitted to work past the 30 day notification and employees will be required to use PTO for time off during this time. If the employee has not complied with this requirement within two (2) weeks of the final notification the employee will be terminated unless there are approved conditions or situations that prevent the employee from completing the requirement. All exceptions to terminations must be approved by the Chief Executive Officer.~~

~~For all vaccine administrations, the most up to date vaccine information statement (VIS) will be offered to the employee at time of administration to meet federal guidelines.~~

I. **Employed, Volunteer, and Permanent Contract Staff**

A. Health Inventory: All staff are required to complete a Health Inventory Form upon employment. (Form #802926 or #800263).

B. TB

1. All staff must provide documentation of a TST in the last 12 months or a negative IGRA in the past year. If unable to provide documentation, a 2-step TST shall be completed. The first step shall be completed before starting, and the second step shall be completed 1 to 3 weeks after the first step and before patient contact.

a. Staff with a positive TST history will be reassessed annually using the converter form (Form #802691). An experienced primary care provider will determine the frequency of CXR; however, the CDC does not recommend that it be done annually or at a regularly scheduled time.

i. The employee health nurse will inform staff about the signs and symptoms to watch regarding conversion.

ii. If a new staff member has had a previous positive TST, they will need to provide a copy of their last chest X-ray or obtain a two-view (PA/Lateral) chest X-ray.

iii. A chest x-ray and evaluation by an experienced provider will be ordered if symptoms develop (persistent cough, weight loss, anorexia, fever) in a staff with a history of TB or if recently exposed to TB.

b. The employee health provider shall be notified of all positive TST reactions.

c. The Wyoming Department of Health shall be notified of all TB conversions.

d. The hospital is not responsible for any reimbursement for medical care of TST-positive staff at the time of hire.

e. All staff shall be tested for TB at hire and after suspected or

confirmed exposure.

f. BCG - Many people born outside the U.S. have been vaccinated with the BCG vaccine. This may cause a false-positive TB Skin Test reaction. There is no reliable way to distinguish a positive TB skin reaction caused by the vaccine or an actual TB infection. TB blood tests IGRA is the preferred test for people who have received the BCG vaccine. BCG does not induce positive results when a TB blood test is used. Staff with documented BCG and a positive TST shall have an IGRA test completed.

C. MMR

1. Required evidence of immunity to Measles, Mumps, and Rubella shall be documented.

a. Documentation of two MMR vaccines or documented laboratory evidence of immunity to all three components.

b. If not immune, staff shall be given MMR vaccinations according to manufacturer guidelines at no cost.

c. In the event of an outbreak, those without documented immunity or vaccine documentation will be excluded from high-risk areas.

D. Varicella (Chickenpox)

1. Required evidence of immunity to Varicella shall be documented.

a. Documentation of two Varicella immunizations or documented titer that proves immunity to Varicella.

b. If no documentation is available and the titer does not prove immunity, the staff shall receive the Varicella vaccine as per CDC guidelines. CDC Chickenpox (Varicella)

E. Hepatitis B

1. The required evidence of immunity to the Hepatitis B virus shall be documented.

a. Immunity will be determined by documented positive antibody for Hepatitis B.

b. If not immune, staff will be given Hepatitis B vaccination according to manufacturer guidelines and the MHSC Hepatitis B Vaccine for Adult Protocol. Adult Hepatitis B Vaccine for Adults Protocol Staff may start working at MHSC if the Employee Health requirements are being met and the CDC guidelines for Hepatitis B vaccine administration are being followed.

c. If the staff has received the maximum number of Hepatitis B vaccines and fails to show immunity, they will be documented as a "non-responder" and counseled on the increased risk in the event of an exposure.

F. Tdap

1. Documentation of a Tdap within the past 10 years is required.
2. If there is no documentation of Tdap within the past 10 years, a single dose of Tdap will be administered regardless of the time since their last tetanus or diphtheria toxoid (Td) vaccine.
    a. All Employed Staff, Volunteer Staff, and Contracted Permanent Staff will be offered the appropriate booster every 10 years.

G. Respiratory Protection

1. The employee health nurse will evaluate all staff for their need to wear a tight-fitting respirator. If deemed necessary for their job duties, they will complete the OSHA respirator medical evaluation questionnaire (Form #802187) and, if medically able, be tested.
    a. Staff failing fit testing or being unable to be tested will be excluded from patient care areas requiring Airborne Precautions.

H. To meet federal guidelines, the most up-to-date Vaccine Information Statement will be offered to the staff for all vaccine administrations.

~~AN EMPLOYEE~~STAFF MAY ATTEND ORIENTATION/EDUCATION WHILE AWAITING BLOOD TESTING RESULTS ~~OF BLOOD TESTING~~ IF NOT IMMEDIATELY AVAILABLE UPON HIRE. ~~AN~~NO STAFF WILL BE PERMITTED TO HAVE PATIENT CONTACT UNTIL RESULTS HAVE BEEN VERIFIED BY EMPLOYEE ~~WILL NOT BE PERMITTED TO HAVE PATIENT CONTACT UNTIL RESULTS HAVE BEEN VERIFIED BY EMPLOYEE~~ HEALTH.

EMPLOYEE HEALTH REQUIREMENTS

I. ***NON-EMPLOYED STAFF***

A. Students and Shadowers at MHSC will meet basic health requirements and participate in established screening programs outlined by the Employee Health Plan above. Starting July 1, 2025, updated requirements for Hepatitis B proof of immunity or documentation of non-responder will be enforced.

B. The employee health nurse will receive documentation and a copy of the verified immunization records for Students and Shadowers. Verification will be obtained before starting clinical at MHSC.

C. Before their assigned student experience, which has received prior approval from the director overseeing the clinical area and the Senior Leader responsible for the specific department, the following will be completed:

1. The student or instructor will provide contact information in writing to Human Resources before starting the clinical.
2. Students will comply with the Employee Health Plan standards. Students who do not meet these requirements will not be accepted for practice in the hospital.
3. The contracting academic institution is responsible for providing the

Employee Health Department with documentation of student compliance upon request.

4. Students will be involved in case contact workups related to an exposure to a communicable disease and for follow-up if exposed.
5. Students who become ill will be referred to their private provider or to the ED in case of a medical emergency. The student assumes all costs for care and treatment.
6. Letters of attestation are not acceptable for vaccines.
7. Any immunization or titer must be completed before starting at MHSC.
8. Students must have documentation of a current FIT test and approval from their institutes' faculty to take care of a patient on airborne isolation precautions. This will be decided on a case-by-case basis.

II. **CONTRACTED TEMPORARY STAFF**

A. Contracted staff will comply with all requirements of the Employee Health Plan. Starting July 1, 2025, updated requirements for Hepatitis B proof of immunity or documentation of non-responder will be enforced.

B. The employee health nurse will receive documentation with a copy of the verified immunization record for contract personnel or be allowed access to the employee health nurse to review documents. Verification will be obtained before contract personnel begin work at MHSC. Any immunization or titer must be completed before starting at MHSC.

RECORD KEEPING

I. The employee health records are maintained in the Employee Health Department and considered confidential.

II. All people treating, testing, or accessing the staff's health record hold all employee health information in strict confidence.

III. The following people may access the Employee Health Record:

A. Employee Health Department and Infection Control Department

B. The individual staff member with written consent

C. OSHA or other regulatory personnel on site

IV. The format and content of the employee health records are standardized and include the following:

A. Employee Health Inventory for Employed Staff

B. Immunizations and titers

C. Fit test record and OSHA Respirator Medical Evaluation Questionnaire

D. Tuberculin Skin Test (TST) Interferon Gamma Release Assay (IGRA), or Converter's Assessment and Chest X-ray (CXR) record, if applicable

E. Influenza immunization

F. Color Vision for clinical staff upon hire by the Education Department

G. All other work-related documents

V. The employee health nurse maintains health records for all MHSC staff.

VI. Records shall be maintained for 30 years following termination. After 30 years, they will be destroyed.Retention of Hospital Records

VII. **FINANCIAL MANAGEMENT AND RESPONSIBILITY**

A. The Employee Health Department budgets all projected expenses incurred and identified in the Employee Health Plan.

B. Treatment plan expenses, except for worker's compensation claims, delineated by the employee health requirements, are paid for from the Employee Health budget.

C. MHSC will cover the costs of Employed, Volunteer, and Permanent Contracted Staff except for pre-existing conditions (for example, TB infection before hire).

D. Non-Employed and Temporary Contracted Staff will be financially responsible for meeting the plan's requirements before arrival.

MEDICAL EXEMPTIONS

I. All staff must receive all the required vaccines for the safety of their patients and their safety. If the staff member has a stated medical contraindication to vaccination, they shall submit a medical exemption to Employee Health for review and approval by the MHSC Medical Exemption Committee.

A. Medical exemption may include the following:

1. Immune deficiency suppresses immune responses that occur with leukemia and lymphoma, as well as therapy with corticosteroids, antimetabolites, or radiation

2. Pregnancy

3. Allergy

B. Staff will have 30 days from notification of delinquency to comply with the Employee Health Plan.

C. Staff will not be permitted to work past the 30-day notification and will be required to use PTO for time off during this time. If the staff has not complied with this requirement within two (2) weeks of the final notification, the staff will be terminated unless there are approved conditions or situations that prevent the staff from completing the requirement. The Chief Executive Officer must approve all exceptions to terminations.

D. Non-employed and Contract Temporary Staff must submit medical exemptions to Employee Health for review and approval by the MHSC Medical Exemption Committee before starting at MHSC.

ANNUAL REQUIREMENTS

I. ~~**Annual Requirements**~~

~~A. An Annual TB Facility Assessment will be conducted by the Employee Health Nurse which will determine the current TB risk, and the need for annual testing.~~

~~B. All Employees are required to take part in the Annual Influenza Vaccine Clinic, Policy #1103869.~~

~~C. All employees whose job duties require the use of a tight fitting respirator will be fit tested annually.~~

II. ~~**Student/Shadowers and Contract Health Requirements**~~

~~A. Refer to Student/Contract Employees/Medical Staff Health Requirements Policy #941517~~

~~B. Costs for volunteers (MHSC Auxiliary members) will be paid by the hospital and follow the same standards as hospital employees~~

III. Employee Health and Infection Control will conduct an annual TB facility assessment to determine the current TB risk and the need for annual testing.

IV. All staff must participate in the Annual Influenza Vaccine Clinic. Annual Influenza Vaccine Program

V. All staff whose job duties require a tight-fitting respirator will be tested annually.

~~EMPLOYEE~~EMPLOYED STAFF ILLNESS OR WORK-RELATED INJURY

1. ~~Employees who become ill before they begin work will notify their supervisor before the designated starting time according to personnel policy. Supervisors will then notify Employee Health.~~
2. ~~Employees who report to work ill, or who become ill at work, will notify their supervisor immediately. At the supervisor's discretion, the employee may be sent to the Employee Health Department. The Employee Health Nurse will determine the need to send the employee home, to the ER for examination by an emergency room physician, or to a private physician.~~
3. ~~Employees off work because of illness or injury for longer than two days, or who are returning to work from a medical leave of absence, may be asked to present a work release signed by their their private physician to their supervisor. Employees restricted from work because of a significant communicable disease will have their work releases evaluated by the Employee Health Nurse or Infection Control, before they may return to work. Work releases are to be sent to Infection Control/Employee Health. In turn, Employee Health will forward a copy to Human Resources, if not already given to HR.~~
4. ~~Any employee with a work-related injury who seeks medical treatment must present a work release or restriction document to their Department Supervisor before returning to work. The Department Supervisor will then forward the document to Employee Health or Human Resources.~~
5. ~~Employees injured on the job – however minor the injury may appear – are encouraged to complete an Employee Packet (which includes Wyoming Report of Injury Form) and notify their~~

~~supervisor who will complete a Supervisors Investigation of an Employee Incident report (Refer to Employee Packet) in its entirety, and report to the Employee Health Department, or Emergency Department if after hours for evaluation. Employees who do not report injuries within 72 hours of occurrence may be ineligible for hospital funded treatment for complications of the injury. Notification within 24 hours is preferred.~~

I. Staff who become ill before they begin work will notify their supervisor before the designated starting time according to personnel policy. Supervisors shall then notify Employee Health.

II. Staff who report to work ill or become sick will notify their supervisor immediately. At the supervisor's discretion, the staff may be sent to the Employee Health Department. The employee health nurse will determine whether to send the staff home or to the ER for examination by an emergency room physician or private physician.

III. Staff off work because of illness or injury for longer than two days or returning from medical leave of absence may be asked to present a work release signed by their private physician to their supervisor. Staff restricted from work because of a significant communicable disease shall have their work releases evaluated by the employee health nurse before they may return to work. Work releases are to be sent to Employee Health. Employee Health will forward a copy to Human Resources, if not already provided.

IV. It's essential that all staff, regardless of the severity of their injury, complete an Employee Packet / Injury and Exposure (which includes the Wyoming Report of Injury Form) and notify their supervisor. If the employee health nurse is unavailable, the staff should report to the emergency department for an evaluation. Supervisors play a key role in the reporting process. They are responsible for completing the Supervisor Investigation portion of the incident report, ensuring the employee has completed their portion, submitting an incident report in the MHSC reporting system, and returning the packet to the employee health nurse.
It's important to remember that not reporting injuries within 72 hours of their occurrence may have serious consequences. Staff may be ineligible for hospital-funded treatment for injuries' complications. Notification within 24 hours is preferred.

EMPLOYED STAFF EXPOSURE TO COMMUNICABLE DISEASE

I. ~~An~~In the MHSC occurrence reporting system, an incident report will be completed for any ~~employee potentially~~staff member who may have been exposed to a communicable disease ~~in the MHSC occurrence reporting system~~.~~The employee~~ The staff's supervisor will ~~complete the gray packet~~fill out the Employee Packet/Injury and Exposure (which includes the Supervisor Investigation of Employee Accident Form) and sign the Worker's Compensation forms~~)~~. Employee Health performs contact tracing for staff related to exposures. The Infection Preventionist will conduct case contact investigations and provide recommendations aligning with delineated Infection Control ~~Nurse will conduct case contact investigations as needed and delineated in Infection Control Policy~~policies.

~~A. Once the determination, through case contact investigation, of **true** exposure of an employee or employees to a communicable disease is made, work restrictions will be instituted according to the CDC guidelines. Work restrictions may be initiated by a department director with consideration of the Infection Control/Employee Health~~

~~Director, but are enforced by the Infection Control Committee.~~

II. ~~Memorial Hospital of Sweetwater County follows current~~Once the determination, through case contact investigation, of **a staff member's true exposure** to a communicable disease is made, work restrictions will be instituted according to the CDC guidelines ~~for exposures to communicable diseases, including time off work, and job restrictions due to disease~~.

A. MHSC follows current CDC guidelines for exposures to communicable diseases, including time off work and job restrictions due to disease.

III. See policy Reporting Communicable Diseases.

~~EXPOSURE~~EMPLOYED STAFF EXPOSED TO HAZARDOUS SUBSTANCES

I. All ~~employees identified as having~~staff with routine exposure to hazardous substances, such as chemotherapy medications, will have ~~a~~ medical screening, TST, and/or basic laboratory testing performed annually as indicated by the Employee Health ~~Physician~~Provider.

II. ~~Females who are pregnant or breast-feeding and/or any person actively trying to conceive a child will be reassigned to duties that do not involve the handling of hazardous medications.~~

III. ~~Link to Chemical and Drug Handlers Health Surveillance History~~

IV. Females who are pregnant or breastfeeding and/or any person actively trying to conceive a child will acknowledge that they are aware of the risks involved with handling hazardous medications. These individuals will wear the appropriate personal protective equipment (PPE) for handling hazardous drugs. The Hazardous Drug Risk Acknowledgement form, Hazardous Drug Risk Acknowledgment, will be signed upon hire or transfer. If possible, staff members may ask to be reassigned.

~~Approval:~~

~~Infection Control Committee - Nov. 7, 2018; HR Committee - February 18, 2019~~

~~REFERENCES:~~

PERMANENT CONTRACT, TEMPORARY CONTRACT, AND NON-EMPLOYEE STAFF WITH WORK-RELATED INJURY, EXPOSURE TO COMMUNICABLE DISEASE, AND HAZARDOUS SUBSTANCES

I. Staff shall contact and report the event to their academic institute or their agency's Employee Health Department and or Human Resource Department.

A. Once the determination, through case contact investigation, of **a staff member's true**

exposure to a communicable disease is made, work restrictions will be instituted according to the CDC guidelines. Work restrictions may be initiated by a department director with consideration of Employee Health and Infection Control but are enforced by the Infection Control Committee.

B. MHSC follows current CDC guidelines for exposures to communicable diseases, including time off work and job restrictions due to disease.

C. See policy Reporting Communicable Diseases.

Employee Health Links- Included but not limited to the following:

Accidental Bloodborne Exposure to Blood and Bodily Fluids

Annual Influenza Vaccine Program

CDC TB Screening- Testing

Chemical and Drug Handlers Health Surveillance History

Hepatitis B Vaccine for Adults Protocol

Employee Packet- Illness/ Injury/ Blood Exposure

Exposure Control Plan

Hazardous Drug Risk Acknowledgment

Hazardous Spill and Exposure Response- Emergency Operation Plan

HIV Post-Exposure Prophylaxis

Reporting Communicable Disease

TB Control Plan

Reporting Communicable Disease

Retention of Hospital Records

Reviewed and Approved:

Infection Control Committee: 4/17/2025

MEC: 4/22/2025

MHSC Board:

REFERENCE:

BCG Vaccine and TB Testing-CDC Guidelines. Retrieved from https://www.cdc.gov/tb/hcp/vaccines/index.html

CDC Chickenpox (Varicella). Retrieved from https://www.cdc.gov/chickenpox/index.html

CDC Management of Potentially Infectious Exposure and Illnesses. Retrieved from https://www.cdc.gov/infection-control/hcp/healthcare-personnel-infrastructure-routine-practices/exposure-managment.html

Frequency of Tuberculosis Screening and Testing for Health Care Personnel/TB Prevention in Health Care Settings. Retrieved from https://www.cdc.gov/tb-healthcare-settings/hcp/screening-testing/frequency.html

Health Care Workers and Employers-Occupation Safety and Health Administration. Retrieved from https://www.osha.gov/healthcare.

Immunization of Health Care Personnel -Center for Disease Control and Prevention. Retrieved from https://www.cdc.gov/vaccines/

Medical Surveillance for ~~Healthcare~~Health Care Workers Exposed to Hazardous Drugs ~~*Department of Health and Human Services* https://www.cdc.gov/niosh/docs/wp-solutions/2013-103/pdfs/2013-103.pdf~~/ OSHA and Department of Health and Human Services. Retrieved from https://www.cdc.gov/niosh/docs/wp-solutions/2007-117/pdfs/2007-117.pdf

Occupational Safety and Health Administration/ Health Care. Retrieved from https://www.osha.gov/healthcare.

~~Healthcare Workers~~Oncology Nursing Society-Safe Handling of Hazardous ~~Drugs Should Be Monitored in Surveillance Program *Oncology Nursing Society* https://www.ons.org/practice-resources/clinical-practice/healthcare-workers-handling-hazardous-drugs-should-be-monitored~~Drug. Retrieved from https://www.ons.org/store/books/safe-handling-hazardous-drugs-fourth-edition

The Joint Commission. Retrieved from https://edition.jcrinc.com/

Attachments

- 800263P Employee Health Inventory 03.24R.pdf
- 802187 - OSHA Respirator Medical Evaluation Questionnaire 04.24R.pdf.pdf
- 802769 - Employee Health Requirements 1.24.pdf
- 802926 - Employee Health Inventory for Students-Shadowers- Observer & Volunteer
- 802973 - Employee Health Provider Orders 4.25.pdf

Approval Signatures

Step Description	Approver	Date

	Ann Marie Clevenger: CNO	Pending
Medical Director	Cielette Karn: Laboratory & IP Medical Director, T&B Chair	03/2025
	Patty O'Lexey: Education Director	03/2025
	Nicole Burke: Employee Health Supervisor	03/2025

Reg. Standards

CDC, OSHA 29 CFR 1910.1030, TJC IC 04.01.03, TJC IC.06.01.01 EP 5

Minutes for April 2 2025 Regular Meeting Draft

MINUTES FROM THE REGULAR MEETING
MEMORIAL HOSPITAL OF SWEETWATER COUNTY
BOARD OF TRUSTEES

April 2, 2025

The Board of Trustees of Memorial Hospital of Sweetwater County met in regular session on April 2, 2025, at 2:00 p.m. with Dr. Barbara Sowada, President, presiding.

CALL TO ORDER

Dr. Sowada welcomed everyone and called the meeting to order.

Dr. Sowada requested a roll call and announced there was a quorum. The following Trustees were present: Judge Nena James, Mr. Marty Kelsey, Ms. Kandi Pendleton, Mr. Craig Rood, and Dr. Barbara Sowada.

Officially present during the meeting: Ms. Irene Richardson, Chief Executive Officer; Dr. Alicia Gray, Chief of Medical Staff; Mr. Geoff Phillips, Legal Counsel; and Mr. Taylor Jones, Sweetwater Board of County Commissioners.

Pledge of Allegiance

Dr. Sowada led the attendees in the Pledge of Allegiance.

Mission and Vision

Mr. Kelsey read aloud the mission and vision statements.

Mission Moment

Ms. Richardson shared a personal mission moment involving the care of a loved one. He was admitted after testing in the Emergency Department. He has a complicated case and comments were shared that everyone providing care was excellent. Ms. Richardson said Dr. Gray took such good care of him. Nursing staff was wonderful. Everyone was great across the board. He told Ms. Richardson he is very grateful and she said she is also grateful.

AGENDA

Dr. Sowada asked for requests for any items to be moved from the Consent Agenda to New Business. There were no changes. Dr. Sowada asked if there were requests for Senior Leader or Board Committee Reports to be removed to New Business. There was a request to move Finance and Audit Committee to New Business. The motion to approve the agenda with the item noted as moved to New Business as requested was made by Judge James; second by Mr. Rood. Motion carried.

Mr. Kelsey clarified why Employee Policies – Access to Personnel Files was included under Old Business this month. He said there was no official document or record of what was passed so he asked for it to be placed on the April agenda to verify approval. Mr. Kelsey said he agrees with all of the changes made by the attorney. Dr. Sowada thanked Mr. Kelsey for bringing this to the Board's attention. Mr. Kelsey also noted we have an official online agenda item in the packet for Approval of Bad Debt under the Consent Agenda.

COMMUNITY COMMUNICATION

There were no comments.

OLD BUSINESS

Quarterly Progress Report on Strategic Plans and Goals

Ms. Richardson gave a shout out to staff and said everyone is on the same page in regard to working on the Strategic Plan. She reviewed the update provided to the Board in the portal and shared updates on each of the Strategic Pillars: Patient Experience, Employee Experience, Quality and Safety, Community Services and Growth, and Financial Stewardship. Mr. Kelsey thanked Ms. Richardson for the very nice report and asked if it would be possible to explore graphing the key metrics for patient satisfaction.

Employee Policies – Access to Personnel Files

The motion to approve the policy as presented was made by Ms. Pendleton; second by Mr. Kelsey. Motion carried.

CONSENT AGENDA

The motion to approve the Consent Agenda as presented was made by Mr. Kelsey; second by Judge James. Motion carried. Items approved: March Meeting Minutes, Capital Expenditure Requests, Bad Debt, Quality Committee Charter Update.

NEW BUSINESS

Behavioral Health Plan

Dr. Sowada said Dr. Ann Marie Clevenger, Chief Nursing Officer, and Ms. Crystal Hamblin, Director of Cardiopulmonary Services, have developed a Behavioral Health Plan, which is a huge project and a big plan. Dr. Sowada said the purpose at the meeting is not to approve/disapprove but to gather information. Dr. Clevenger thanked the group. She provided a summary of how the plan was developed. She said bringing this forward helps to build the clinic and address strategic priorities alignment. Dr. Clevenger said we want to improve access to care. She said Southwest Counseling has made a big impact in providing services and QLER has also helped. She said many staff members across multiple departments have helped develop the plan. Dr. Gray recognized Dr. Clevenger and her team for all the work they have done. She said the physicians recognize there are barriers and are supportive and happy to answer any questions. Dr. Gray reviewed the process acute care patients go through. Mr. Kelsey thanked the group for the presentation. He said he has questions revolving around mental health, our responsibility, and the responsibility of other cunty organizations. The Board requested a workshop to review the information in more detail.

Policies from the Governance Committee

Mr. Kelsey said this journey began about nine months ago. The Committee looked at current policies with staff and proposals were developed. Mr. Kelsey said it became apparent there were

some legal implications and so they involved legal counsel. The information presented is primarily the work of Mr. Phillips. Mr. Kelsey said these are the bedrock or foundational policies that govern how we handle policies at MHSC. He said there are extremely critical legal implications. Mr. Phillips reviewed the process and said we must have a proper separation of powers regarding the development of policies and we must ensure that we identify who is going to be adopting, approving, developing, etc. He said as a government entity we retain our sovereign immunity. The Board has a statutory duty. He said the matrix is really the key. Mr. Kelsey said as we move forward if we run into trouble we can tweak it. He said staff was wonderful with their help to develop the policies. Dr. Sowada thanked everyone involved for their work.

Request from the Medical Staff – Changes to Emergency Medicine Privileges and Pediatric Privileges

Dr. Sowada asked the Board for their pleasure to review or to approve on first review. The motion to approve the Changes to the Emergency Medicine Privileges as presented was made by Ms. Pendleton; second by Judge James. Motion carried. The motion to approve the Changes to the Pediatric Privileges as presented was made by Ms. Pendleton; second by Judge James. Motion carried.

Patient Safety

Dr. Sowada said 20% of each Board meeting should be spent on patient safety. She said how information is brought to the Board will be a work in progress. She said in the late 1990's, a large study was conducted. "To Err Is Human" was a report issued that found there were a number of deaths that occurred due to errors in the practice of medicine. The total study was reviewed again two or three years ago and the numbers hadn't really changed. Dr. Sowada said when Quality Department staff and other staff look at our hospital scores, we show we are doing really well. She said hat's off to everybody. Dr. Sowada said we have a lot in our community to be thankful for including good processes and good people in place.

Finance and Audit Committee

Mr. Kelsey said Mr. Ron Cheese, Patient Financial Services Director, brought to Finance and Audit an update on the revenue cycle project started by Clifton Larson Allen. He said Mr. Cheese did a good job with his report and Mr. Kelsey thinks this is something the entire Board should be aware of. He said the information is available in the portal. Mr. Kelsey asked Trustees to review the information carefully. Mr. Rood said it is a nice report and it is good to see we are making progress. He said we need to stay on top of that. Ms. Tami Love, Chief Financial Officer, said the update will be included monthly in the Finance and Audit Committee meeting packet. Mr. Kelsey said a question was asked at the recent Committee meeting about when will we be all caught up with the old billing. Staff said hopefully by the end of May. Mr. Kelsey suggested by the end of the fiscal year. He said he knows we are submitting piecemeal for a reason and said he thinks that is a good idea. Mr. Kelsey noted net patient revenues were down through February. He said expenditures were also down. Dr. Sowada thanked Mr. Kelsey.

REPORTS

Chief Executive Officer Report

Ms. Richardson thanked everyone for the work done related to Critical Access designation. She said we started in January 2023 and involved the Medical Staff. She said she thinks it really is the best thing we could do for this hospital and our community. Ms. Richardson said many of the OB units have closed around us. She said we are committed to keeping our unit open. We added Dr. Ken Holt and Dr. Cesar Hernandez to our group and they are helping us solidify our presence here. Ms. Richardson said we have been extremely busy and we are grateful to have great providers and great staff. We presented a proposal to the County Commissioners for remodeling of our OB unit with some remaining funds. The Commissioners asked us to explore grant funding. Ms. Richardson asked staff to investigate. The Lab renovation is coming along nicely and we plan to have the work done by the end of the calendar year. Ms. Richrdson said we are very busy right now with annual education, competencies, evaluations, and our operating and capital budget process. As we prepare our budget to submit to the County, we are mindful county revenues are down and we will adjust our budget accordingly. Ms. Richardson said Doctors Day was March 30 and we are celebrating our physicians April 10. She said we are so lucky to have them at MHSC. We will celebrate Hospital Week May 12-16 and a service award banquet event will be held that week. Ms. Richardson will attend the American Hospital Association Annual Meeting in Washington D.C. May 4-6. She said she is honored to have been asked to introduce Senator John Barrasso as one of the speakers. The Wyoming Hospital Association (WHA) CEO and Trustee Spring Meeting will be in Casper May 30. Ms. Richardson will attend the WHA Region 4 CEO Meeting in Afton June 11. The WHA Board Retreat is in Jackson June 12-13. The WHA Annual Meeting will be in Laramie September 3-4. Ms. Richardson ended her report with a huge shout out to staff for their hard work. She said she is happy to be part of it.

Medical Staff Services Chief of Staff Report

Dr. Gray highlighted Dr. Cody Christensen and Emily James, NP, for their great care. She shared some of the recent comments shared by patients and said we are grateful for these great providers. The Medical Staff are reviewing readmission rates and collaborating with the Emergency Department to improve outcomes. We continue to focus on the Pain Task Force. We are working to improve care coordination between departments. Dr. Gray recognized Dr. Banu Symington for her recent appointment as Chair-Elect to the American Society of Clinical Oncology's State Affiliate Council. Dr. Gray said we are all dedicated to improving patient care.

County Commissioner Liaison Report

Commissioner Jones said Dr. Sowada announced she will be stepping away from the Board at the end of June. He asked that anyone interested in serving on the Board complete an application with the County. He said typically the Liaison pre-screens. Commissioner Jones said he believes strongly that Trustees not be afraid to ask questions. The Liaison then makes a recommendation and the Commissioners vote. The more people who apply, the better the selection. Commissioner Jones provided a budget update.

CONTRACTS

Wolters Kluwer

The motion to approve the contract as presented was made by Ms. Pendleton; second by Mr. Kelsey. Motion carried.

EDUCATION

Ms. Pendleton said she thought the *Veralon Community Partnerships: A Strategic Imperative Parts 1 and 2* was very good and timely. Mr. Rood said he thought it was interesting that we look at the money as well as the cause. He agreed it was timely. Dr. Sowada liked the questions the Board should ask about partnerships.

GOOD OF ORDER

Ms. Richardson said a family member wanted her to give a shout out to the Health Information Management Department for all of the requests he has made and they are so responsive and helpful every time.

Mr. Kelsey said he needed to give an admonition to the staff. He said that as a prior CFO, he knows we are always under pressure to add staff. He urges everyone to be very careful and scrutinize every request carefully. He said he will be looking at that closely and cautioned everyone to be mindful and careful.

EXECUTIVE SESSION

The motion to go into executive session at 4:01 p.m. to discuss legal, personnel, contracts, and items considered confidential by law was made by Mr. Rood; second by Mr. Kelsey. Motion carried.

RECONVENE INTO REGULAR SESSION

The motion to leave the executive session and return to the regular session at 5:14 p.m. was made by Ms. Pendleton; second by Mr. Rood. Motion carried.

ACTION FOLLOWING EXECUTIVE SESSION

Pursuant to the notice provided in the agenda, the Board of Trustees held discussions and action was taken.

The motion to grant clinical privileges and appointments to the medical staff as discussed in executive session was made by Judge James; second by Ms. Pendleton. Motion carried.

Credentials Committee Recommendations to the Board of Trustees for Granting Clinical Privileges and Granting Appointment to the Medical Staff from March 11, 2025

1. Initial Appointment to Associate Staff (1 year)
   - Dr. Benjamin Childs, Orthopedic Surgery
   - Dr. Joginder Singh, Medical Oncology
2. Initial Appointment to Consulting Staff (1 year)
   - Paul Crane, Tele-Neuro (U of U)
3. Initial Appointment to Advance Practice Provider Staff (1 year)
   - Mariah Pacheco, Family Nurse Practitioner
4. Reappointment to Active Staff (3 year)
   - Dr. Kurt Hunter, Family Medicine
   - Dr. Wagner Veronese, OB/GYN
   - Dr. David Dansie, Family Medicine
   - Dr. Brytton Long, Family and Occupational Medicine
   - Dr. Jacques Denker, Orthopedics and Sports Medicine
   - Dr. Joshua Binks, Radiation Oncology
   - Dr. Rahul Pawar, Nephrology
   - Dr. Augusto Jamias, General Surgery
5. Reappointment to Consulting Staff (3 year)
   - Dr. Ethan Tumarkin, Cardiovascular Disease (U of U)
   - Dr. Clark Moser, Tele-Neurology (U of U)
   - Dr. Robert Kadish, Tele-Neurology (U of U)
   - Dr. Frank Rembert, Tele-Radiology (VRC)
   - Dr. Jana Wold, Tele-Stroke (U of U)
   - Dr. Stephanie Lyden, Tele-Stroke (U of U)
6. New Business
   - Dr. Name Change
   - Revised Pediatric and Emergency Medicine Privileges

The motion to approve contracts and authorize the CEO to sign as discussed in executive session was made by Judge James; second by Ms. Pendleton. Motion carried.

ADJOURNMENT

There being no further business to discuss, the meeting was adjourned at 5:15 p.m.

_____
Dr. Barbara Sowada, President

Attest:

_____
Judge Nena James, Secretary

Minutes for April 22 2025 Special Meeting Draft

MINUTES FROM THE SPECIAL MEETING
MEMORIAL HOSPITAL OF SWEETWATER COUNTY
BOARD OF TRUSTEES

April 22, 2025

The Board of Trustees of Memorial Hospital of Sweetwater County met in a special meeting on April 22, 2025, at 8:30 a.m. with Dr. Barbara Sowada, President, presiding.

CALL TO ORDER

Dr. Sowada called the meeting to order. The following Trustees were present: Judge Nena James, Ms. Kandi Pendleton, and Dr. Barbara Sowada. Mr. Marty Kelsey attended via Zoom meeting online. Mr. Craig Rood was excused.

Officially present during the meeting: Ms. Irene Richardson, Chief Executive Officer; Mr. Geoff Phillips, Legal Counsel. Dr. Alicia Gray, Chief of Medical Staff, and Mr. Taylor Jones, County Commissioner Liaison, attended via Zoom meeting online.

BEHAVIORAL HEALTH CLINIC PROPOSAL OVERVIEW

Dr. Ann Marie Clevenger, Chief Nursing Officer, asked if everyone had received a copy of her printed information. She provided some background and said it was an organizational decision to move forward with pursuing a behavioral health clinic. She stressed it is really meant to provide an additional service and access to our community. Dr. Clevenger reviewed data of rates and service providers. She reviewed questions from the Board. She reviewed what we are currently doing in detail. Dr. Clevenger reviewed verification of expenses and revenues. She emphasized the return on investment may not be financial. She said, as a healthcare facility, we feel it is the right thing to do for the underserved members of our community. She said collaboration is the key. The process for patients under a Title 25 hold was discussed. They are currently under the care of Hospitalists and are on observation status until medical needs supersede and then admitted as a medical patient. Ms. Tami Love, Chief Financial Officer, said we see an average of 4.8 days per stay. We are projecting to 55 patients this year. Data shows 60% are self-pay, 35% are Blue Cross Blue Shield, and there are some with Medicare or Medicaid. Dr. Clevenger said when someone is here waiting 30-45 days, they were waiting for a bed. When discharged, we often see them back again. Ms. Robin Jenkins, Director of Care Management, said a location we wait for openings is Wyoming Behavioral Institute (WBI). Dr. Gray said most patients go to the Wyoming State Hospital. She said it is very difficult to get patients into WBI. She said it is really up to the State Hospital where these patients go. Dr. Clevenger said the plan to start is two separate clinics and then evaluate. We would like to start small, try to grow to see the impact to our community, and if positive, then enhance an opportunity to bring a psychiatrist. Ms. Love reviewed the financials. She said the insurance is no different through COPIC for providers than what we offer now. Dr. Clevenger said we added one day a week on to our QLER contract. She said that would/could go away. Dr. Sowada asked what problem we are attempting to solve. Is our goal to provide counseling or is it to get people stabilized on their medications? Dr. Clevenger referred to the nurse model and said the focus is on medication management. If we go to a counseling model, we will never have enough providers. Dr. Clevenger said the purpose is to solve a disparity of service. She said providers practice in their realm of practice. Dr. Sowada said the direction we take determines which staff are hired. Ms. Crystal Hamblin, Director of Cardiopulmonary Services, said if it was her as the provider, she would want to focus on medication management. She said she personally

likes to refer to the experts. Ms. Pendleton said she appreciates the starting small approach clarified today. Ms. Jodi Cheese, Specialty Clinics Practice Manager, said the majority of what we are currently doing in the clinics is medication management. Dr. Clevenger referenced working on a Memorandum of Understanding with Southwest Counseling moving forward. Mr. Phillips mentioned additional liability issues with enhanced federal standards related to HIPAA. Ms. Suzan Campbell, In House Legal Counsel, said we would not have any additional liability issues. Dr. Gray said the clinic would be an added benefit to our community. She said medication management appointments sometimes take 1 – 2 months to get so that would be a benefit alone. When asked how long we think it would take to start, the response was 60-90 days. Ms. Pendleton thinks this is step 1. She said we can't get to step 10 without starting at step 1. Commissioner Jones said the County Commissioners will not tell the Board what to do. He said Title 25 is a big thing. Mr. Kelsey said he would like more information on our relationship with Southwest Counseling. He said this presentation has been helpful and is appreciated. He said it is certainly worth discussion, deliberation, contemplation, and thought. Ms. Richardson thanked Dr. Clevenger and the team for the great, informative presentation. She said we want to do everything we can to help our community and address their concerns. She thanked the Board for their questions and agreed this is a very important topic. The Trustees thanked the presenters. Dr. Sowada said the topic will be on the May meeting agenda.

ADJOURNMENT

The meeting adjourned at 9:51 a.m.

_____

Dr. Barbara Sowada, President

Attest:

_____

Judge Nena James, Secretary

Capital Request Summary

Capital Request #

FY25-44

Name of Capital Request:

OSMOPRO MAX

Requestor/Department:

AIMEE URBIN/LABORATORY

Sole Source Purchase: Yes or (No)

Reason:

☐ This Quote/Bid/Proposal contains discount pricing which parties agree not to disclose other than is required by law or court order.

Quotes/Bids/ Proposals received:

	Vendor	City	Amount
1.	ADVANCED INSTRUMENTS	NORWOOD, MA	$64,894.00
2.	FISHER HEALTHCARE	HOUSTON, TX	$59273.17 (does not include training & validation
3.			

Recommendation:

ADVANCED INSTRUMENTS - $64,894.00

Memorial Hospital
OF SWEETWATER COUNTY

	# Assigned: FY 25-44

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.

****

Note: Before ordering equipment requiring sterilization, check with Surgical Services/Central Sterile to ensure we have the proper sterilizing equipment.

Department: Laboratory	**Submitted by:** Aimee Urbin, MLS(ASCP)	**Date:** 2/25/2025

Provide a detailed description of the capital expenditure requested:
The OsmoPRO MAX is a device that measures the concentration of particles in a solution. Providers may order an osmolality test to assess a patient's body water balance, primarily to diagnose conditions like dehydration or overhydration.
Preferred vendor is Advanced Instruments.

Preferred Vendor:

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

1.	Renovation	$ Amount
2.	Equipment	$ 53,975.00
3.	Installation	$ 10,768.50 (includes training/validation
4.	Shipping	$ 150.00
5.	Accessories	$ Amount
6.	Training	$ Amount
7.	Travel costs	$ Amount
8.	Other e.g. interfaces	$
	Total Costs (add 1-8)	$ Total $ 64,894.00

Does the requested item:

Require annual contract renewal? ☒ YES ☐ NO		
Fit into existing space? ☒ YES ☐ NO	Explain: Click or tap here to enter text.	
Attach to a new service? ☐ YES ☒ NO	Explain: Click or tap here to enter text.	
Require physical plan modifications? If yes, list to the right: ☐ YES ☒ NO	Electrical	$ Amount
	HVAC	$ Amount
	Safety	$ Amount
	Plumbing	$ Amount
	Infrastructure (I/S cabling, software, etc.)	$ Amount

Annualized impact on operations (if applicable): Increases/Decreases		**Budgeted Item:**
Projected Annual Procedures (NEW not existing)		☒ YES ☐ NO
Revenue per procedure	$ Amount	# of bids obtained? _____
Projected gross revenue	$ Amount	
Projected net revenue	$ Amount	☐Copies and/or Summary attached.
Projected Additional FTE's		**If no other bids obtained, reason: Fisher Scientific Osmo PRO quote. Training, installation and validation not included in the quote. The OsmoPRO is a less automated platform.**
Salaries	$ Amount	
Benefits	$ Amount	
Maintenance	$ Amount	
Supplies	$ Amount	
Total Annual Expenses	$ Total	
Net Income/(loss) from new service	$ Amount	

Review and Approvals		
Submitted by:	Verified enough Capital to purchase	
Department Leader	☐ YES ☐ NO	
Executive Leader	☐ YES ☐ NO	03/24/2025
Chief Financial Officer	☒ YES ☐ NO	3-17-25
Chief Executive Officer	☒ YES ☐ NO	4-16-25
Board of Trustees Representative	☐ YES ☐ NO	

OTHER CONSIDERATIONS

The Advanced Instruments OsmoPRO MAX is a device that measures the concentration of particles in a solution. A provider may order an osmolality test to assess a patient's body water balance, primarily to diagnose conditions like dehydration or overhydration, by measuring the concentration of particles dissolved in the blood (serum osmolality) or urine, which can indicate issues with fluid regulation and potential problems like kidney dysfunction, diabetes insipidus, or poisoning from substances like antifreeze.

Currently, the analyzer used for this testing is at the end of useful life, purchased in 2012. The current analyzer requires substantial and valuable hands on, manual operation and increased user interaction. Also, it is no longer serviced by the manufacturer. If the analyzer becomes unoperational, we would no longer be able to offer testing. Waiting any longer for the purchase of this analzyer leaves patient care at risk for this vital testing. Typically providers order this testing when patients are in critical condition, requiring fast turnaround time for the best care of the patient.

The OsmoPRO MAX offers great workflow efficiency with complete walkaway testing. Features include continuous sample loading, automated barcode scanning, and "walk-away" testing capabilities, allowing for greater efficiency and reduced user intervention providing faster turnaround time. The purchase of this analyzer will significantly improve productivity in the lab and provide an easy to use platform. The competing quote is from FisherScientific and is a lesser model requiring more hands on. Also, the competing quote only includes the cost of the analyzer and not the validation, installation or the training opportunities. These are valuable services.

Included in the quote is instrument installation, training and validation services. Validation is required per regulatory agencies for any new analyzers. This is an invaluable service, as a resource and consumables are provided for this necessary validation, freeing up staff to work on patient care. Additionally, a one year service agreement with an onsite preventative maintenance visit is included in the pricing.

Submitted by: Signature

Date

Advanced Instruments, LLC
Two Technology Way
Norwood, Massachusetts, 02062
USA

Quotation

Quote Details

Quote Number	00035970
Created Date	2/24/2025
Expiration Date	6/30/2025

General Information

Bill To Name	Memorial Hospital of Sweetwater County	Ship To Name	Memorial Hospital of Sweetwater County
Bill To	1200 College Drive Rock Springs, Wyoming 82901 United States	Ship To	1200 College Drive Rock Springs, Wyoming 82901 United States
Contact Name	Mary Fischer	Prepared By	Stacie Mooney
Email	mfischer@sweetwatermemorial.com	Email	staciem@aicompanies.com
Phone	(307) 352-8364		

Quote Line Items

Part No.	Product	Product Description	Quantity	List Price	Sales Price	Discount (Percentage)	Total Price
OSMOPRO MAX	OsmoPRO MAX Automated Osmometer	The OsmoPRO MAX provides automated liquid handling, continuous sample loading, a self-cleaning fluid management system, touch screen operation, integrated barcode scanners, built-in quality control features, Ethernet and USB connectivity, and an integrated data management system.	1.00	USD 53,975.00	USD 53,975.00		USD 53,975.00
ITV-SKC-PRO MAX	Instrument Installation, Training and Validation Services – OsmoPRO MAX	Instrument Installation, Training & Validation Service includes instrument installation & installation documents, on-site training (two hours) & training document, validation up to 6 hours and required consumables. Validation includes: • Method Comparison: 20 patient serum/plasma & urine samples (10 serum + 10 urine) • Precision/Accuracy: Clinitrol 290 - 5 replicates, Protinol Protein-Based Control (3 levels) & Renol Urine Control (3 levels) – 5 replicates each/per level • Linearity: Osmolality Linearity Set (5 levels) – 5 replicates per level • Summary page & comprehensive report • Certification of validation • Meets CAP and CLIA requirements	1.00	USD 11,965.00	USD 11,965.00	10.00%	USD 10,768.50

Email: orders@aicompanies.com
Web: www.aicompanies.com

ADVANCED INSTRUMENTS

Advanced Instruments, LLC
Two Technology Way
Norwood, Massachusetts, 02062
USA

SC-PROMAX-1YR-PAC	Service Contract, OsmoPRO MAX, 1 Year, Premium Advanced Care	· 3-Day Response Time · One-year on-site service contract · One (1) expedited annual on-site preventive maintenance service is covered under each year of a purchased agreement · One (1) refresher training is offered in conjuntion with annual on-site preventive maintenance visit · Onsite repairs and repair parts covered · Unlimited phone support · Loaner instrument covered	1.00	USD 9,450.00	USD 9,450.00	5.00%	USD 8,977.50
SH1000	Small Instrument Shipping & Handling		1.00	USD 150.00	USD 150.00		USD 150.00

Totals

Subtotal	USD 75,540.00
Total Price	USD 73,871.00
Grand Total	USD 73,871.00

NOTE: If providing a freight account to charge, a separate handling fee will be applied.

Quote is provided with standard NET30 terms. If additional extended terms are required, that will lead to an increase in the quoted price. Also, take note that applicable taxes and governmental regulated fees are NOT included in this quote.

Ordering:
Email your order to orders@aicompanies.com

We require the following information to process your order:

- Quote reference number
- Your signed Purchase Order and PO#
- Invoice address
- Delivery address

Terms & Conditions

The quotation is subject to Advanced Instruments standard terms and conditions to the exclusion of any other terms that the customer may seek to impose or incorporate

Click Here to view the Standard Terms

Email: orders@aicompanies.com
Web: www.aicompanies.com

Capital Request Summary

Capital Request #

FY25-53

Name of Capital Request:

STRYKER MAKO RIO ROBOTIC ARM

Requestor/Department:

NOREEN HOVE/SURGICAL SERVICES

Sole Source Purchase: (Yes) or **No**

Reason: converting current rental agreement to purchase

☐ This Quote/Bid/Proposal contains discount pricing which parties agree not to disclose other than is required by law or court order.

Quotes/Bids/ Proposals received:

	Vendor	City	Amount
1.	STRYKER MAKO	FT LAUDERDALE, FL	$626,400.00
2.			
3.			

Recommendation:

STRYKER MAKO - $626,400.00

Memorial Hospital
OF SWEETWATER COUNTY

	# Assigned: FY 25-53

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.

****

Note: Before ordering equipment requiring sterilization, check with Surgical Services/Central Sterile to ensure we have the proper sterilizing equipment.

Department: surgical department 630	**Submitted by:** Noreen Hove	**Date:** 4/23/2025

Provide a detailed description of the capital expenditure requested:
Stryker Robotic Arm System (Mako TM/RIO)

Preferred Vendor:

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

1. Renovation		$ Amount
2. Equipment		$ 626,400.00
3. Installation		$ Amount
4. Shipping		$ Amount
5. Accessories		$ Amount
6. Training		$ Amount
7. Travel costs		$ Amount
8. Other e.g. interfaces		$ Amount
	Total Costs (add 1-8)	$ 626,400.00

Does the requested item:

Require annual contract renewal? ☒ YES ☐ NO		
Fit into existing space? ☒ YES ☐ NO	Explain: Click or tap here to enter text.	
Attach to a new service? ☐ YES ☒ NO	Explain: Click or tap here to enter text.	
Require physical plan modifications? If yes, list to the right: ☐ YES ☒ NO	Electrical	$ Amount
	HVAC	$ Amount
	Safety	$ Amount
	Plumbing	$ Amount
	Infrastructure (I/S cabling, software, etc.)	$ Amount

Annualized impact on operations (if applicable): **Increases/Decreases**		**Budgeted Item:**
Projected Annual Procedures (NEW not existing)		☒ YES ☐ NO
Revenue per procedure	$ Amount	# of bids obtained? _____
Projected gross revenue	$ Amount	
Projected net revenue	$ Amount	☒Copies and/or Summary attached. **If no other bids obtained, reason: This is the robotic system that works with our total joint implants.**
Projected Additional FTE's		
Salaries	$ Amount	
Benefits	$ Amount	
Maintenance	$ Amount	
Supplies	$ Amount	
Total Annual Expenses	$ Total	
Net Income/(loss) from new service	$ Amount	

Review and Approvals		
Submitted by:	Verified enough Capital to purchase	
Department Leader	☒ YES ☐ NO	
Executive Leader	☒ YES ☐ NO	4.23.25
Chief Financial Officer	☒ YES ☐ NO	4.23.25
Chief Executive Officer	☒ YES ☐ NO	4.23.25
Board of Trustees Representative	☐ YES ☐ NO	

OTHER CONSIDERATIONS

The Mako robot was selected last December for a trial lease. This past year Dr. Pedri has utilized it on all of his total knee joint replacements and a select total hip replacement surgeries. The Mako robot allows for shorter recovery times and less pain experienced by patients compared to manual surgery. This equipment has improved precision, shortened the procedure (surgery) time and has cut down on extra people to assist in the operating room. We have had patient come from out of state because we utilize the Mako robot here at MHSC. This model of the Mako will allow for expansion in total joints in the future.

Submitted by: Signature

Date

SECOND AMENDMENT TO EQUIPMENT RENTAL AGREEMENT

This Second Amendment to Equipment Rental Agreement ("***Amendment***") by and between Memorial Hospital of Sweetwater County ("***Customer***") and MAKO Surgical Corp. ("**Stryker Mako**"), and Stryker Sales, LLC (both subsidiaries of Stryker Corporation and collectively referred to herein as "**Stryker**"), is made effective as of the date executed by last party below.

Recitals

WHEREAS, Customer and Stryker Mako entered into that certain Equipment Rental Agreement dated November 28, 2023, (the "***Agreement***"), whereby Customer gained access to a RIO robotic arm interactive orthopedic system (the "***Original System***");

WHEREAS, Customer and Stryker Mako entered into that certain First Amendment to Equipment Rental Agreement dated November 27, 2024 (the "***First Amendment***"), whereby Customer elected to extend the duration of the Rental term; and

WHEREAS, Customer now seeks to purchase from Stryker Mako a new RIO robotic arm interactive orthopedic systems (the "***New System***") pursuant to the terms contained herein and in the Agreement.

Agreement

NOW, THEREFORE, in consideration of the mutual covenants, agreements, representations and warranties contained in the Agreement and this Amendment, the parties hereby agree as follows:

1. Purchase of New System. For good and valuable consideration, the sufficiency and adequacy of which is hereby mutually acknowledged, Stryker Mako agrees to sell and Customer agrees to purchase the New System as set forth in the below table, at the price set forth below (the "**Purchase Price**") and upon the terms and conditions set forth herein and contained in the Agreement. Customer acknowledges that Customer shall be responsible for payment of all applicable federal, state, and local taxes in connection with the purchase of the New System unless a tax exemption, direct pay, or resale certificate is provided to Stryker Mako.

Mako System with Partial Knee, Total Knee, and Total Hip Applications				
QTY.	PART #	EQUIPMENT	List Price	Purchase Price
1	353535	**Stryker Robotic Arm System (MakoTM/RIO®)** Includes:		
1	229999	Mako 4 Robotic Arm		
1	6900-100-000	Stryker Q Guidance System		
1	700002719223	Mako 4 Accessory Kit		
1	700003243335	Mako 4 with JR User Guides		
4	700002606000	Mako MICS 3 Power Tray		
3	210480	MICS 3 Straight Sagittal Saw Attachment		
3	210490	MICS 3 Angled Sagittal Saw Attachment		
3	700002606001	Mako Standard Tray Lid		
3	700002606011	Mako Standard Double Tier Tray Case		
3	700002606012	Mako Knee Tray Top Insert		
3	700002606013	Mako Knee Tray Bottom Insert		
3	700002606014	Mako Knee Tray Kit Laminate	$ 1,635,000.00	$ 900,000.00
1	200681	MAKOplasty® CT Scan Kit		
1	313131	**Mako™ Partial Knee Application** Includes:		
1	100020	RESTORIS® Partial Knee Software License		
1	203997	Surgeon & Surgical Staff Training, Knee (English)		
1	424242	**Mako™ Total Hip Application** Includes:		
1	208114	MAKOplasty® Total Hip Software License		
1	204490	Surgeon & Surgical Staff Training, Hip (English)		
1	212121	**Mako™ Total Knee Application** Includes:		
1	212184	Mako™Total Knee Software License		
1	212249	Surgeon & Surgical Staff Training, Total Knee		
1	Multiple	*Instrument Purchase Conversion		
1	203996	Freight/Installation Fee		
		Limited Time Discount		$ (273,600.00)
		TOTAL		**$ 626,400**

*Instrument Purchase Conversion. The Parties hereby agree that the instrumentation accessed with the Original System shall remain at Customer's facility to be utilized with the Equipment detailed above.

The Parties acknowledge and agree that while Customer, via this Amendment, is purchasing the items and quantities detailed in the chart below at the pricing identified above (referred to herein as "MICS 3 Package"), the MICS 3 Package remains in limited market release and is not yet generally commercially available. Upon the conclusion of Stryker Mako's limited market release, Stryker Mako shall notify Customer of the MICS 3 Package general commercial availability and Customer shall receive the items detailed in the table below, within a commercially reasonable time at no additional cost.

QTY.	PART #	EQUIPMENT
4	700002606000	MICS 3 Power Tray Kit
3	210480	MICS 3 Straight Sagittal Saw Attachment
3	210490	MICS 3 Angled Sagittal Saw Attachment
3	700002606001	Mako Standard Tray Lid
3	700002606011	Mako Standard Double Tier Tray Case
3	700002606012	Mako Knee Tray Top Insert
3	700002606013	Mako Knee Tray Bottom Insert
3	700002606014	Mako Knee Tray Kit Laminate

(a) New System Payment Terms. Customer elects to purchase the New System from Stryker Mako by (i) paying to Stryker Mako the purchase price as set forth in the table above or (ii) entering into a lease or rental agreement with a financing company for purchase of the Equipment at the purchase price set forth the table above. In either case, full payment of the purchase price shall be due to Stryker Mako NET 30 days from date of applicable invoice and Customer shall be responsible for ensuring full payment is made to

Stryker Mako. Customer shall be responsible for ensuring all payments are paid in full, including any open Rental Payments through May 27, 2025.

(b) Software Application Upgrade. The Parties acknowledge and agree that subject to the terms and conditions of this Agreement, Customer's purchase hereunder includes a one-time right to upgrade (the "Upgrade Right") one of Customer's Mako software applications to a new upgraded software application (the "New Application") in the event Stryker Mako makes a new software application generally available for sale within the next twelve (12) months. In the event Stryker Mako makes multiple New Applications available in the next twelve (12) months, the parties acknowledge and agree that the Upgrade Right applies only to the first New Application that Stryker Mako makes generally commercially available. Customer must exercise the Upgrade Right within ninety (90) days of notice from Stryker Mako that a New Application is generally available for sale. Notwithstanding anything contained in the foregoing, Customer acknowledges that nothing contained in this Agreement shall create any obligation on Stryker with respect to developing or releasing any New Application whether during the next twelve (12) months or otherwise and Stryker Mako makes no guarantees or promises with respect to the development or release of any New Application. In the event Stryker Mako makes a New Application available and Customer exercises its Upgrade Right, all references in the Agreement to "Equipment" or "Software" are hereby modified to incorporate and include the New Application such that all terms and conditions of the Agreement shall apply to the New Application, unless Stryker Mako notifies Customer of any required changes to the Software Schedule resulting from the New Application. In the event the Customer validly exercises the Upgrade Right, Stryker shall promptly deliver the New Application to Customer and install the New Application on Customer's Mako Equipment purchased pursuant to this Agreement, and Customer shall immediately cease further use of any superseded software application.

(c) New System Terms and Conditions. The parties agree that, unless expressly stated otherwise in this Amendment, the New System shall be sold and purchased on and subject to the same terms and conditions related to access and use as the Original System as set forth in the Agreement. All references in the Agreement to "Equipment" are modified to incorporate and include the New System such that all terms and conditions of the Agreement shall apply to the Equipment and the New System.

(d) Warranty and Service Agreement. The New System shall be subject to the same Warranty as set forth in Schedule D of the Agreement. Customer's Annual Service Fee shall be $120,000 for the New System, beginning with the first payment due following expiration of the New System Warranty Period.

2. Expiration Date. Stryker Mako shall honor the terms of this Amendment, provided customer executes this Amendment on or before May 27, 2025. Stryker Mako may, in its sole discretion, elect to install the New System following such date, but not later than ten (10) days after the Effective Date.

3. Effect; Conflict. Except as expressly provided herein, all terms and conditions set forth in the Agreement to which this Amendment applies shall remain in full force and effect. In the event of a conflict between this Amendment and the provisions of the Agreement, this Amendment shall be controlling with respect to the subject matter hereof.

4. Counterparts; Electronic Transmission. This Amendment may be executed in counterparts, each of which are deemed to be original, but both of which together constitute one and the same instrument. Copies of signatures sent by facsimile transmission or any other electronic means are deemed to be originals for purposes of execution and proof of this Amendment.

5. Defined Terms. Unless otherwise defined herein, all capitalized terms used herein shall have the same meaning as described in the Agreement.

*****

IN WITNESS WHEREOF, the parties have duly executed this Amendment to be effective as of the day and year signed by the last party below.

CUSTOMER	STRYKER, ON BEHALF OF THE LEGAL ENTITIES LISTED HEREIN
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:5/7/2025

Topic for Old & New Business Items:

- Suspend active “Policies, Standards, Plans, Procedures/Processes, Guidelines and Forms”

Policy or Other Document:

☒ Revision
☐ New

Brief Senior Leadership Comments:
The CEO participates in the Governance Committee and recommends approval.

Board Committee Action:

Recommended suspension at the current time approved by the Governance Committee at their April 21 meeting.

Policy or Other Document:

☐ For Review Only
☒ For Board Action

Legal Counsel Review:

☐ In House Comments:.
☒ Board Comments:.

Senior Leadership Recommendation:
The CEO participates in the Governance Committee and recommends approval.

Status Active PolicyStat ID 16797170

Approved 09/2024
Review Due 09/2026

Document Area: Quality & Risk Management

Reg. Standards: CAH C-0991 §485.631(c)(1), CAH C-1006 §485.635(a), CAH C-1008 §485.635(a)(2) + 4 more

Policies, Standards, Plans, Procedures/Processes, Guidelines and Forms

STATEMENT OF PURPOSE

The purpose of health care policies and procedures is to communicate to employees the desired outcomes for Memorial Hospital of Sweetwater County (MHSC).

I. Documents in the Document Management System, (RLDatix/PolicyStat), are the official operating document until replaced by new approved documents.

II. Policies, Plans, Procedures, Protocols, Standing Orders, Order Sets, Guidelines, Standards and Forms have the following basic objectives:

   A. Serve as written coordinating documents to provide staff with a common point of reference and understanding and to eliminate duplications and discrepancies.

   B. Designate in the "Policy Area" area(s) in which Policies, Plans, Procedures, Protocols, Standing Orders, Order Sets, Guidelines, Standards and Forms apply.

   C. The intent of Protocols, Standing Orders, Order Sets, Guidelines, and Forms is to provide evidence-based guidance in the care and treatment of patients. Protocols, Standing Orders, Order Sets, Guidelines, and Forms are not a substitute for clinical judgment.

   D. Staff may not be formally educated and/or trained on all Protocols, Standing Orders, Order Sets, Guidelines, or Forms.

Definitions:

I. **POLICY-** formal written documents detailing the overall application of a principle or overarching statement. These documents are typically high level statements that provide information across the organization. ***This is the WHY.***

II. **PROCEDURE -** The desired intentional action steps to be taken by specified persons to achieve a

certain objective in a defined set of circumstances. (Ost et al., 2020).***This is the HOW.***

III. **PLAN -** A detailed proposal **of requirements and/or benchmarks,** for doing or achieving that clearly identifies the desired outcome. ***This is the WHAT and WHY.***

IV. **PROTOCOL (CLINICAL) –** Synonymous with PROCEDURE but specific to clinical patient care-related interventions. A series of step-by-step actions, which may include specific medications, that may be implemented as needed to respond to and manage a patient's clinical status in specific and specialized circumstances. Protocols are designed to standardize and optimize patient care based on current evidence-based clinical guidelines or standards of practice. ***This is also the HOW. Refer to Standing Orders, Protocol and Order Sets document.***

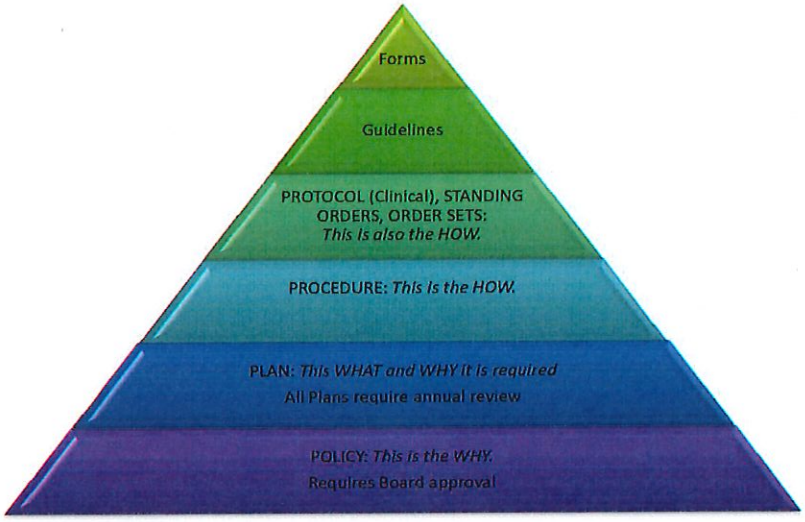
V. **STANDING ORDERS-** Pre-written medication orders and specific instructions from the provider that the nurse, respiratory therapist or other licensed health care professional can administer or implement in clearly defined situations that do not necessitate notification of the provider prior to administration or implementation; universal order in that all patients who meet the criteria for the order receive the same treatment.***This is also the HOW . Refer to Standing Orders, Protocol and Order Sets document.***

VI. **ORDER SETS -** Tool designed to assist providers as they write orders; are diagnosis-specific. ***This is also the HOW . Refer to Standing Orders, Protocol and Order Sets*** document.

VII. **GUIDELINE -** Recommended actions for a specific situation or type of case. A ***guideline*** aims to streamline particular processes according to a set routine or sound practice. (Ost et al., 2020).

VIII. **FORM -** A pre-approved printed document.

IX. **DOWNTIME FORM -** may be used in the event of computer system outages. Due to the complexity of the electronic medical record (EMR) system, downtime forms may not replicate the EMR work flow or match the EMR content.



Drafting New, Revision of, and Review of Policies, Plans, Procedures, Protocols, Standing Orders, Order Sets, Guidelines, Standards and Forms

A. Employees, committees or departments may participate in, or be asked to participate, in this process

B. Process for drafting new document:

1. Verify that no other similar documents exist in the document management system or other hospital document repositories, i.e. PolicyStat, Lippincott
    a. If there is an existing document collaborate with the "owner" to revise
2. Conduct a thorough literature review and include any regulatory standards, state and federal laws, governing professional organizations, i.e. OSHA, CMS, TJC
3. Consider and integrate the most current information/evidence when drafting new, revising existing, or reviewing documents
4. Maintain list of citation references for inclusion in the document
5. Include the following headings when creating the document in PolicyStat or WORD. Only unassigned users should utilize WORD for creation of documents.
    a. Title
    b. Statement of Purpose
    c. Definitions (if applicable)

d. Text - body of document
e. References (if applicable) - using APA format
f. Regulatory Standards (if applicable)
g. Attachments (if applicable)

6. **Assigned document management system users**, i.e. PolicyStat, in addition to above, must also enter
    a. "Policy Area" under "Properties".
        a. For department specific documents select corresponding department from dropbox in "Policy Area"
        b. For documents that include or affect more than one department, choose *Draft Policy* in "Policy Area"
    b. "Approval Work Flow" under "Properties"
        a. For department specific documents select corresponding department from dropbox in "Approval Work Flow"
        b. For documents that include or affect more than one department, choose *Draft Policy* in "Approval Work Flow"

C. Process for Review and/or Revisions of Existing Documents
    1. Verify that no other similar documents exist in the document management system or other organization document repositories, i.e. PolicyStat, Lippincott
        a. If there is an existing document collaborate with the owner of the document to revise
    2. Conduct a thorough literature review, update and include any regulatory standards, state and federal laws, governing professional organizations, i.e. OSHA, CMS, TJC
    3. Maintain list of updated citation references for inclusion in the document

D. Approval Work Flow Process
    1. New or revised Policies, Plans, Procedures, Protocols, Standing Orders, Order Sets, Guidelines, Standards and Forms will be reviewed and/or approved through the designated approval pathway, appropriate to the content of the document
    2. Committee and Medical Staff Committee review and approval will be denoted in the body of the document before the References section
    3. The Board of Trustees approval is required as outlined in "Hospital Policies and Other Documents Requiring Board of Trustees Approval."

E. Medical Staff Committees
    A. To comply with Critical Access§485.635(a)(2) & (4), an advanced practice clinician (APC) will participate on existing Medical Staff committees to review and approve both new and current patient care policies at least biennially. The Medical Staff Committees will consist of:
        1. At least one physician

2. At least one advanced practice clinician
3. Chief Nursing Officer (CNO)
4. Chief Clinical Officer (CCO)
5. Others as needed pertinent to documents requiring review

F. Forms

A. Drafting New or Revising and Reviewing Existing Forms

1. Use the attached **Forms Checklist** for formatting
2. Ensure that all information included on the form is correct, limit abbreviations and do not use unapproved abbreviations. Refer to Abbreviation Usage
3. Forms are to be submitted electronically to the Clinical Administrative Assistant
4. Forms are to be submitted in printed form with the approved #800443 New/ Revised Presentation Sheet:
    a. with the required input and approval of all other departments that use the particular form
    b. to be available in the event of downtime
    c. to be housed within and by the Materials Management Department
5. All forms will contain a form number assigned by the Clinical Administrative Assistant (i.e. 800100)
6. The Clinical Administrative Assistant will assign a barcode to forms for use in the EMR
7. Revision/review date
    a. all forms will include a revision/review date following the form number (i.e. 800100 6/20)
    b. the date will be updated each time a form is revised
    c. if the form is reviewed, but no revisions were made, an "R" denoting review will be added after the form number (i.e. 800100R 6/20)
8. Forms approval process:
    a. The Clinical Administrative Assistant will reformat the document if needed, add the logo and assign a document number to new forms
    b. The author / owner of the form must then obtain the required signatures on the Forms Presentation Sheet and return it to the Clinical Administrative Assistant
    c. The Clinical Administrative Assistant will forward the signed document with copies and email the updated electronic version to the Materials Management Department and to the individual responsible for building (EMR) notes, if applicable

G. Staff and Leadership Responsibilities:

A. Read, become familiar with the information in the available documents on MHSC Intranet

in the document management system. If changes are needed, staff are expected to notify their Director or Leader and follow the relevant process as outlined above.

B. Keep current regarding changes in documents through the document management system and other document repositories , i.e. PolicyStat, Lippincott.

H. Frequency of Reviews of Policies, Plans, Procedures, Protocols, Standing Orders, Order Sets, Guidelines, and Forms

A. Completed at least every two (2) years, upon changing evidence, or as required by regulatory standards.

REFERENCES

Department of Health and Human Services. (2016). Vaccines and immunizations. Retrieved from https://www.hhs.gov/vaccines/nvac/reports-and-recommendations/the-standards-for-pediatric-immunization-practice/index.html

Irving, A. V. (2014, October 13). Policies and procedures for healthcare organizations: A risk management perspective. Patient Safety & Quality Healthcare website. Retrieved on June 6, 2020 from https://www.psqh.com/analysis/policies-and-procedures-for-healthcare -organizations-a-risk-management-perspective.

Melnyk, B. M., Gallagher-Ford, L., Thomas, B. K., Troseth, M., Wyngarden, K., & Szalacha, L. (2016). A study of chief nursing executives indicates low prioritization of evidence-based practice and shortcomings in hospital performance metrics across the United States. Worldviews Evidence Based Nursing, 13(1): 6-14. doi:10.1111/wvn.12133

Ost, K., Blalock, C., Fagan, M., Sweeney, K. M., & Miller-Hoover, S. R. (2020, June). Aligning Organizational Culture and Infrastructure to Support Evidence-Based Practice. Critical Care Nurse, 40(3), 59-63. doi.org/10.4037/ccn20209630963. Retrieved from https://aacnjournals.org/ccnonline

The Joint Commission (TJC). Hospital Accreditation Standards, 2020. MHSC Intranet

Document - Standing Orders, Protocols and Order Sets

Attachments

Forms Check list.pdf

Approval Signatures

Step Description	Approver	Date
	Kari Quickenden: Chief Clinical Officer	09/2024

Ann Clevenger: CNO	09/2024
Suzan Campbell: General Legal Counsel	09/2024
Ann Clevenger: CNO	09/2024

Reg. Standards

CAH C-0991 §485.631(c)(1), CAH C-1006 §485.635(a), CAH C-1008 §485.635(a)(2), TJC LD.04.01.07, EP 1, 2, TJC NR.02.01.01, EP 2, TJC NR.02.02.01, EP 1-5, TJC NR.02.03.01, EP 1-3

Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:5/7/2025

Topic for Old & New Business Items:

- Policy for Development, Approval, and Oversight of Policies and Governance Documents at Memorial Hospital of Sweetwater County
- MHSC Policy & Governance Document Approval Matrix
- Policies, Standards, Plans, Procedures/Processes, Guidelines and Forms

Policy or Other Document:

☐ Revision
☒ New

Brief Senior Leadership Comments:
The CEO participates in the Governance Committee and recommends approval.

Board Committee Action:

Approved by the Governance Committee at their March 17 meeting. Presented at the April Board of Trustees meeting for first review. Presented at the May 7 meeting for second read and approval.

Policy or Other Document:

☐ For Review Only
☒ For Board Action

Legal Counsel Review:

☒ In House Comments:.
☒ Board Comments:.

Senior Leadership Recommendation:
The CEO participates in the Governance Committee and recommends approval.

Status Draft PolicyStat ID 17862650

Approved N/A
Review Due N/A

Document Area Board of Trustees

Policy for Development, Approval, and Oversight of Policies and Governance Documents at Memorial Hospital of Sweetwater County

Board of Trustees

STATEMENT OF PURPOSE:

The purpose of this policy is to establish the framework for the development, approval, and oversight of policies and governance documents at Memorial Hospital of Sweetwater County (the “Hospital”). It ensures that policies and governance documents are aligned with the Hospital's mission, legal obligations, and strategic goals, and outlines the delegation of policy and document development responsibilities to Senior Leaders, In-House Counsel, and designated committees, while maintaining final approval by the Board of Trustees for Hospital-wide policies and governance documents.

SCOPE:

This policy governs Hospital-wide policies and governance documents with significant strategic, legal, or financial implications. Operational documents governed by the Policies, Standards, Plans, Procedures/ Processes, Guidelines, and Forms policy shall adhere to this framework for alignment.

TEXT:

I. Policy Statement

A. The Board of Trustees (the "Board") of Memorial Hospital of Sweetwater County is responsible for the overall management and governance of the Hospital, including

the approval of Hospital policies and governance documents.

B. This responsibility is in accordance with the powers and duties outlined in Wyo. Stat. § 18-8-104, which provides that the Board shall oversee the management and operation of the Hospital, ensuring that all policies and governance documents are consistent with the Hospital's strategic direction, ethical standards, and compliance with legal and regulatory requirements.

C. The Board is not involved in the day-to-day operations of the Hospital. The daily operation of the Hospital is the responsibility of Senior Leadership, who manage and execute operational strategies to meet the Hospital's objectives and ensure compliance with approved policies.

D. The Board recognizes that effective delegation is essential for the efficient operation of the Hospital. While certain responsibilities may be delegated to Hospital management and committees, the Board retains final approval authority over policies and governance documents with legal, financial, strategic, or ethical implications, ensuring alignment with the Hospital's mission, compliance requirements, and governance responsibilities. All such delegations must be consistent with the MHSC Policy & Governance Document Approval Matrix.

E. The Board shall rely on advice and recommendations from qualified professionals, including legal counsel, auditors, and compliance experts, during the review and approval of policies and governance documents. Such reliance demonstrates the Board's commitment to fulfilling its oversight obligations in good faith and with reasonable care.

II. Disclaimer on Delegation of Responsibilities

A. The Board of Trustees reserves the right to modify, alter, or revoke the delegation of responsibilities outlined in this policy at any time to ensure the effective governance and operation of the Hospital.

B. Delegated responsibilities shall be reviewed regularly to ensure compliance with the Board's approved guidelines. Any modifications by the Board shall be documented and communicated to Senior Leaders, committees, and relevant stakeholders.

III. Policy Approval Process

A. Approval responsibilities are set forth in the MHSC Policy & Governance Document Approval Matrix.

IV. Policy Development and Delegation

A. The Board of Trustees delegates the responsibility for the initial drafting and administration of Hospital policies and governance documents to Senior Leaders, In-House Counsel and designated committees.

B. Senior Leaders, In-House Counsel, and committees are tasked with drafting policies and governance documents in their respective areas of responsibility, aligning with the Hospital's operational needs, legal obligations, and best practices.

C. The Compliance Committee, in collaboration with Senior Leaders, shall ensure that policies mitigate identified risks and align with legal and regulatory requirements.

D. All policies, procedures, and governance documents must be maintained in an approved document management system (e.g., PolicyStat). The CEO shall ensure that all policies and governance documents remain current.

E. The Policies, Standards, Plans, Procedures/Processes, Guidelines, and Forms policy outlines additional procedural requirements. The following committees shall be responsible for the development of policies and governance documents within their identified area of coverage:

1. Joint Conference Committee: Develops policies and governance documents related to the collaboration between medical staff and Hospital administration, including clinical practice, Hospital operations, and patient care standards.
2. Building & Grounds Committee: Develops policies and governance documents related to Hospital facilities, maintenance, building and grounds safety, and capital improvement projects.
3. Compliance Committee: Develops policies and governance documents related to regulatory compliance, ethical conduct, risk management, and patient privacy (including HIPAA compliance).
4. Governance Committee: Develops policies and governance documents related to Board governance, organizational structure, Board member duties, and Board policies and documents.
5. Quality Committee: Develops policies and governance documents related to quality assurance, patient safety, performance improvement, and patient satisfaction.
6. Human Resources Committee: Develops policies and governance documents related to employee conduct, hiring, compensation, benefits, performance management, and workplace safety.

F. After committees draft policies and governance documents in their areas, the proposed policies and governance documents shall be submitted to the Board of Trustees for review and approval in accordance with the MHSC Policy & Governance Document Approval Matrix.

G. The Board shall approve or provide feedback on policies and governance documents to ensure alignment with the Hospital's mission, vision, legal obligations, and regulatory compliance. The Board of Trustees may request additional information or revisions from Senior Leaders, In-House Counsel, the Board attorney, or committees before final approval.

V. Delegation of Specific Responsibilities

A. The Board may delegate certain aspects of policy implementation or ongoing policy management to designated committees or Senior Leaders, provided that such policies do not require ongoing Board oversight or modification.

B. Senior Leaders, and In-House Counsel are responsible for ensuring that delegated policies are implemented in accordance with the Board's approved guidelines, and they must report regularly to the Board on the status of policy implementation.

C. The committees shall report to the Board of Trustees on the effectiveness of the policies and governance documents developed within their areas and suggest necessary updates as part of the policy review process. Detailed responsibilities for staff, committees, and Senior Leaders are further elaborated in the Policies, Standards, Plans, Procedures/Processes, Guidelines, and Forms policy to ensure clarity and alignment.

D. The Policies, Standards, Plans, Procedures/Processes, Guidelines, and Forms policy provides detailed guidance on specific delegation responsibilities for drafting and managing operational and clinical documents. These delegations remain valid unless explicitly modified by this policy.

VI. Regular Policy Review

A. All policies and governance documents must be reviewed at least every three years or as required by changing legal, regulatory, or operational conditions.

1. This includes compliance with evolving requirements set forth by the Centers for Medicare & Medicaid Services (CMS), the accrediting organization of MHSC, Critical Access Hospital (CAH) regulations, and other applicable authorities.
2. All reviews must ensure consistency with the Hospital's strategic objectives and the Policies, Standards, Plans, Procedures/Processes, Guidelines, and Forms policy, as well as the Policy and Governance Approval Matrix.
3. The CEO, In-House Counsel, and Senior Leaders are responsible for identifying any policies and governance documents that require updating and shall present proposed updates to the appropriate committees and the Board of Trustees for final approval.

B. Policy reviews shall include legal compliance audits, operational effectiveness assessments, and updates to reflect changes in laws, regulations, or best practices. Reviews must be documented and include recommendations for updates where necessary.

VII. Exclusions from Board Approval

A. The policies and governance documents delegated to Senior Leaders or specific committees without requiring Board approval are set forth in the MHSC Policy & Governance Document Approval Matrix. They generally include the following:

1. Operational policies that do not significantly affect the Hospital's governance, financial stability, or legal compliance (e.g., internal departmental procedures).
2. Routine employee policies related to day-to-day operational functions (e.g., time-off requests, internal scheduling).
3. Specific medical or clinical policies that fall under the scope of the Medical Staff and are governed by the Hospital's Medical Executive Committee.

B. However, even these policies and governance documents must be reviewed periodically by the Board of Trustees to ensure that they remain aligned with the Hospital's objectives and legal compliance.

VIII. Uncertainty in Approval Requirements

A. If there is any uncertainty regarding whether a policy or governance document requires Board approval, Senior Leaders must consult the MHSC Policy & Governance Document Approval Matrix.

B. If the matrix does not clearly resolve the uncertainty, the matter shall be presented to the Board for final determination.

C. When in doubt, the Board's approval should be obtained to ensure full compliance with hospital governance, legal, and regulatory requirements.

IX. Responsibility

A. Board of Trustees:

1. Review and approve Hospital-wide policies and associated governance documents, particularly those that have legal, financial, or ethical implications.
2. Ensure all policies and governance documents align with the Hospital's mission, vision, and strategic goals.
3. Maintain ultimate accountability for the Hospital's compliance with applicable laws and regulations.

B. Chief Executive Officer (CEO):

1. Oversee the development, implementation, and periodic review of Hospital policies and governance documents.
2. Ensure that Senior Leaders and committees follow the established policy approval process.
3. Report to the Board on the status of policy and governance document implementation and any necessary updates.

C. In-House Counsel:

1. Develops, initiates, maintains, and revises policies and procedures for the Hospital related to legal and regulatory matters.
2. Ensures that established policies, processes and application functionality comply with required regulatory standards and support quality initiatives.
3. Ensures compliance with approved policies and procedures.

D. Senior Leader Overseeing Human Resources:

1. Oversee the development of employee policies and associated governance documents in collaboration with the Director of Human Resources and In-House Counsel, ensuring alignment with Hospital objectives and coordination across departments.
2. Review and approve proposed employee policies before submission to the

Board, in accordance with the MHSC Policy & Governance Document Approval Matrix.

3. Ensure ongoing compliance with approved employee policies.

E. Committee Responsibilities: Each committee is responsible for drafting policies and governance documents in their respective areas of oversight, including:

1. Joint Conference Committee: Clinical and administrative collaboration policies.
2. Building & Grounds Committee: Facility management and building and grounds safety policies.
3. Compliance Committee: Legal compliance and risk management policies.
4. Governance Committee: Board governance and organizational policies.
5. Quality Committee: Patient safety and quality improvement policies.
6. Human Resources Committee: Employee management and workplace policies.

NOTE: Committees must ensure that the policies and governance documents they develop comply with the Hospital's legal, regulatory, and operational needs. They are also responsible for reporting to the Board of Trustees on the effectiveness and implementation of policies within their area of responsibility.

F. Senior Leaders:

1. Develop, implement, and manage policies and governance documents within their respective departments or committee areas.
2. Ensure compliance with approved policies and procedures.
3. Provide regular reports on the effectiveness of policies to the CEO and the Board of Trustees.

X. Disclaimers for Unintended Consequences

A. This policy is intended to provide a framework for governance and oversight.

1. The Board recognizes that unforeseen circumstances may arise, and policies may require interpretation or adjustments.
2. Such actions will be taken in good faith, with reasonable care, and in consultation with appropriate experts.

B. The Board acknowledges that, despite best efforts, certain policies or governance documents may, on occasion, be approved by an entity other than the one designated in this policy and the Policy and Governance Approval Matrix.

1. Any such error does not, by itself, invalidate the policy or document, provided it was developed and approved in substantial compliance with legal, regulatory, and governance requirements.
2. When an approval discrepancy is identified, corrective action must be

taken immediately, and the policy must be re-evaluated and re-approved by the appropriate entity within a reasonable timeframe.

3. The Hospital shall maintain a record of such corrective actions to ensure compliance and prevent recurrence.

XI. Wyoming Governmental Immunity Disclaimer

A. Nothing in this policy shall be construed as a waiver of the Hospital's immunity from suit or liability under the Wyoming Governmental Claims Act, Wyo. Stat. § 1-39-101 et seq. The Hospital retains all defenses and immunities afforded under state law, including governmental immunity.

References

· Wyo. Stat. § 18-8-104 (Hospital generally under control of board of trustees)

· Wyoming Governmental Claims Act, Wyo. Stat. § 1-39-101 et seq.

Board of Trustees Approval:

Approval Signatures

Step Description	Approver	Date

Status Draft PolicyStat ID 17868228

Approved N/A
Review Due N/A

Document Area Board of Trustees

MHSC Policy & Governance Document Approval Matrix

Board of Trustees

MHSC Policy & Governance Document Approval Matrix*

Document Type	Approval Responsibility	Rationale
Governance Policies (Bylaws, Credentialing, Compliance, particularly those that have legal, financial, or ethical implications, including duties outlined in Wyo. Stat. § 18-8-104, which provides that the Board shall oversee the management and operation of the Hospital, ensuring that all policies and governance documents are consistent with the Hospital's strategic direction, ethical standards, and compliance with legal and regulatory requirements)	**Board of Trustees**	Ensures alignment with legal and strategic governance responsibilities.
Board Committee Charters	**Board of Trustees**	Defines the authority, scope, and responsibilities of Board committees.
Medical Staff Bylaws & Peer Review	**Board of Trustees**	Required for compliance with medical staff governance and credentialing.
Quality & Patient Safety Programs	**Board of Trustees**	Ensures compliance with the accrediting organization of MHSC CMS, and other regulatory agencies.
Financial & Compliance Policies	**Board of Trustees**	Maintains fiscal responsibility and regulatory adherence.
Strategic Plans	**Board of Trustees**	Aligns hospital goals with long-term sustainability and growth.
Risk Management Policies (Malpractice, Liability, Incident Reporting)	**Board of Trustees**	Addresses patient and legal risks, ensuring compliance with WGCA.
Business Continuity & Disaster Recovery Plans	**Board of Trustees**	Ensures hospital preparedness for system failures, emergencies, and disasters.
Ethics Policies (Conflict of Interest, Code of Ethics)	**Board of Trustees**	High-level policies that mitigate ethical risks.
Informed Consent & Patient Rights Policies	**Board of Trustees**	Aligns with legal standards and patient care rights.
Research & Clinical Trial Policies	**Board of Trustees (if applicable)**	Addresses ethical, legal, and compliance concerns with hospital-affiliated research.
Facility Use & Capital Projects	**Board of Trustees**	Ensures alignment with financial planning and operational capacity.
Vendor & Third-Party Agreements Policies**	**Board of Trustees approval required for contracts exceeding**	Ensures oversight of financial and legal risks.

**Approved in accordance with applicable Wyoming statutes.	**statutory or policy thresholds.** Senior Leaders **may approve routine contracts within delegated authority**	
Critical Access Hospital (CAH) Policies (including CAH-specific patient care policies)	**Board of Trustees (for required oversight) Delegated to Medical Staff Committees for clinical execution**	Required by CMS Conditions of Participation for CAHs and ensures compliance with federal rural hospital regulations.
The accrediting organization of MHSC & CMS Operational Policies (Infection Control, Nursing Procedures)	Medical Executive Committee, Clinical Senior Leadership, Clinical Department Directors	Clinical and operational compliance with accreditation standards.
Departmental Clinical Policies	Senior Leaders **working with** Clinical Department Directors	Ensures medical staff and department oversight.
Routine Administrative Policies (HR, Scheduling, IT)	Senior Leaders **working with HR**	Supports efficient hospital administration.
Employee Governance Policies (e.g., Code of Conduct, Executive Compensation, Whistleblower Protection)	**Board of Trustees**	Aligns with governance, ethics, and leadership expectations.
HR Compliance & Legal Risk Policies (e.g., Anti-Discrimination, Workplace Safety, HIPAA, Harassment Prevention)	**Board of Trustees**	Addresses legal compliance and risk mitigation.
Operational HR Policies (e.g., Employee Benefits, Leave, Hiring, Performance Evaluations)	Senior Leaders **working with HR**	Routine HR functions that do not require Board oversight.
Departmental or Unit-Specific HR Policies (e.g., Scheduling, Dress Code, Remote Work)	Senior Leaders **working with HR**	Ensures department-level flexibility and efficiency.
IT Security & Data Protection Policies	Senior Leaders **working with IT & Compliance**	Protects sensitive hospital data and meets regulatory security requirements.
Electronic Medical Records (EMR) Usage & Downtime Contingency Plans	Senior Leaders **working with IT & Compliance**	Ensures continuity of patient care and compliance with documentation standards.
Telehealth & Remote Patient Care Policies	**Board of Trustees**	Defines telemedicine guidelines, compliance, and liability protections.

* If there is any uncertainty regarding whether a policy or governance document requires Board approval, Senior Leaders must consult the MHSC Policy & Governance Document Approval Matrix. If the matrix does not clearly resolve the uncertainty, the matter shall be presented to the Board for final determination. When in doubt, the Board's approval should be obtained to ensure full compliance with hospital governance, legal, and regulatory requirements. Nothing in this matrix shall be construed as a waiver of the Hospital's immunity from suit or liability under the Wyoming Governmental Claims Act, Wyo. Stat. § 1-39-101 et seq. The Hospital retains all defenses and immunities afforded under state law, including governmental immunity.

Board of Trustees Approval:

Attachments

- 3.7.25Policy & Governance Document Approval Matrix_Page_1.jpg
- 3.7.25Policy & Governance Document Approval Matrix_Page_2.jpg

Approval Signatures

Step Description	Approver	Date

Status **Draft** PolicyStat ID **17862888**

Approved N/A

Review Due N/A

Document Area Quality & Risk Management

Reg. Standards CAH C-0991 §485.631(c)(1), CAH C-1006 §485.635(a), CAH C-1008 §485.635(a)(2) + 4 more

Logo for Memorial Hospital of Sweetwater County

Policies, Standards, Plans, Procedures/Processes, Guidelines and Forms

STATEMENT OF PURPOSE

The purpose of this policy is to provide a foundational framework for the development, approval, maintenance, implementation, and reviewing and revision of operational and clinical policies and documents. To maintain consistency and coherence, this policy governs the creation, review, and approval of operational and clinical policies and documents.

SCOPE

This policy governs the development, approval, maintenance, implementation, and review and revision of operational and clinical policies and documents that support delegated, day-to-day activities of the Hospital.

Integration with Governance Policy

This policy incorporates the approval framework established in the Policy for Development, Approval, and Oversight of Policies and Governance Documents and aligns with the MHSC Policy & Governance Document Approval Matrix. It governs operational and clinical policies, plans, procedures, protocols, and guidelines that support the Hospital's day-to-day functions. If there is a conflict or uncertainty regarding approval authority, the Governance Policy and the Approval Matrix take precedence, except where explicitly stated otherwise. Any uncertainties regarding approval requirements must be escalated to the Board of Trustees, CEO, or Compliance Committee for clarification.

Definitions:

I. **POLICY-** formal written documents detailing the overall application of a principle or overarching statement. These documents are typically high level statements that provide information across the organization. ***This is the WHY.***

II. **PROCEDURE -** The desired intentional action steps to be taken by specified persons to achieve a certain objective in a defined set of circumstances. (Ost et al., 2020).***This is the HOW.***

III. **PLAN -** A detailed proposal **of requirements and/or benchmarks,** for doing or achieving that clearly identifies the desired outcome. ***This is the WHAT and WHY.***

IV. **PROTOCOL (CLINICAL) –** Synonymous with PROCEDURE but specific to clinical patient care-related interventions. A series of step-by-step actions, which may include specific medications, that may be implemented as needed to respond to and manage a patient's clinical status in specific and specialized circumstances. Protocols are designed to standardize and optimize patient care based on current evidence-based clinical guidelines or standards of practice. Protocols are not a substitute for clinical judgment. ***This is also the HOW. Refer to Standing Orders, Protocol and Order Sets document.***

V. **STANDING ORDERS-** Pre-written medication orders and specific instructions from the provider that the nurse, respiratory therapist or other licensed health care professional can administer or implement in clearly defined situations that do not necessitate notification of the provider prior to administration or implementation; universal order in that all patients who meet the criteria for the order receive the same treatment. Standing Orders are not a substitute for clinical judgment. ***This is also the HOW . Refer to Standing Orders, Protocol and Order Sets document.***

VI. **ORDER SETS -** Order sets are pre-established, computerized, diagnosis-specific protocols for the diagnosis and treatment of patients. Order Sets are not a substitute for clinical judgment. ***This is also the HOW . Refer to Standing Orders, Protocol and Order Sets*** document***.***

VII. **GUIDELINE -** Recommended actions for a specific situation or type of case. A ***guideline*** aims to streamline particular processes according to a set routine or sound practice. Guidelines are not a substitute for clinical judgment. (Ost et al., 2020).

VIII. **FORM -** A pre-approved printed document. Forms are not a substitute for clinical judgment.

IX. **DOWNTIME FORM -** may be used in the event of computer system outages. Due to the complexity of the electronic medical record (EMR) system, downtime forms may not replicate the EMR work flow or match the EMR content.

TEXT

I. Drafting, Revising, and Reviewing Policies and Documents

A. Responsible party/parties: Drafting responsibilities for all new documents or revisions are assigned to employees, committees, departments, senior management, or medical staff committees, depending upon the document type.

1. Medical staff policies and documents shall be developed by a medical staff committee or delegated to the appropriate hospital staff in accordance with the MHSC Policy & Governance Document Approval

Matrix.

2. To comply with Critical Access§485.635(a)(2) & (4), an advanced practice clinician (APC) will participate on existing Medical Staff committees to draft, review and approve both new and current patient care policies at least biennially.
3. The Medical Staff Committees will consist of at least one physician and advanced practice provider; the Chief Nursing Officer; the Chief Clinical Officer; and others as needed pertinent to documents requiring drafting, review, or revision.

II. Procedure for drafting or revising policies and documents.
   A. Verify that no other similar documents exist in the document management system or other hospital document repositories, i.e. PolicyStat, Lippincott.
   B. If there is an existing document collaborate with the "owner" to revise.
   C. Conduct a thorough literature review and include any regulatory standards, state and federal laws, governing professional organizations, i.e. OSHA, CMS, TJC.
   D. Consider and integrate the most current information/evidence when drafting new, revising existing, or reviewing documents Ensure alignment with current regulatory standards, legal requirements, and evidence-based practices.
   E. Maintain list of citation references for inclusion in the document.

III. Check list for layout of policies. These headlines must be used. Only unassigned users should utilize WORD for creation of documents.
   A. Title
   B. Statement of Purpose
   C. Definitions (if applicable)
   D. Text – body of document
   E. References (if applicable) using APA format
   F. Regulatory Standards (if applicable)
   G. Attachments (if applicable)
   H. Assigned document management system (PolicyStat) users.
   I. Date of approval and name of approval party.

IV. Check list for maintaining policies and appropriate documents in PolicyStat
   A. Assign document management system users under “Properties”
      1. For department specific policies and documents, select corresponding department from dropbox in “Policy Area.”
      2. Policies and documents that include or affect more than one department, choose “*Draft Policy* in “Policy Area.”
   B. Approval Work Flow” under “Properties”

1. For department specific documents select corresponding department from dropbox in "Approval Work Flow"
2. For documents that include or affect more than one department, choose *Draft Policy* in "Approval Work Flow"

V. Procedure for approval of policies and documents

A. New or revised Policies, Plans, Procedures, Protocols, standing Orders, Order Sets, Guidelines, Standards and Forms shall be reviewed and/or approved through the designated approval pathway, appropriate to the content of the document.

1. Documents that include or affect multiple departments must be reviewed under the "Draft Policy" pathway in the document management system
2. Department-specific documents are reviewed through the designated departmental approval pathway.

B. Medical staff policies shall be reviewed and approved by the appropriate medical staff committee, composed of physicians, the Chief Nursing Officer, the Chief Clinical Officer, and at least one advanced practice provider prior to being submitted to the Board for final review and approval.

VI. Approval responsibilities for all operational and clinical policies, plans, procedures, protocols, guidelines, and forms are detailed in the MHSC Policy & Governance Document Approval Matrix. Any approvals granted outside of the designated pathways outlined in the Matrix must be corrected immediately to maintain compliance with governance and oversight requirements. Procedure for the communication and education of policies and documents

A. The policy/document owner is responsible for the communication of new and revised policies and documents to all relevant stakeholders.

1. Multiple communication channels may be used to inform the affected stakeholders.

B. The policy/document owner is responsible for the training of all relevant stakeholders regarding all new and revised policies and documents.

C. Training records shall be maintained in the relevant stakeholders' personnel files in accordance with regulatory and legal requirements.

D. All approved policies, procedures, and governance documents must be maintained in the Hospital's document management system (PolicyStat, or equivalent). Document owners are responsible for ensuring that:

1. Policies are properly categorized under the correct approval pathway.
2. Outdated policies are archived and replaced with the most recent version.
3. Employees have unrestricted access to required policies for compliance and operational efficiency.

VII. Staff and Leadership Responsibilities:

A. The roles and responsibilities outlined in this policy complement the overarching governance framework and approval processes established in the Policy for Development, Approval, and Oversight of Policies and Governance Documents at

Memorial Hospital of Sweetwater County and the MHSC Policy & Governance Document Approval Matrix.

B. Read, become familiar with the information in the available documents on MHSC Intranet in the document management system. If changes are needed, staff are expected to notify their Director or Leader and follow the relevant process as outlined above.

C. Keep current regarding changes in documents through the document management system and other document repositories , i.e. PolicyStat, Lippincott.

REFERENCES

Department of Health and Human Services. (2016). Vaccines and immunizations. Retrieved from https://www.hhs.gov/vaccines/nvac/reports-and-recommendations/the-standards-for-pediatric-immunization-practice/index.html

Irving, A. V. (2014, October 13). Policies and procedures for healthcare organizations: A risk management perspective. Patient Safety & Quality Healthcare website. Retrieved on June 6, 2020 from https://www.psqh.com/analysis/policies-and-procedures-for-healthcare -organizations-a-risk-management-perspective.

Melnyk, B. M., Gallagher-Ford, L., Thomas, B. K., Troseth, M., Wyngarden, K., & Szalacha, L. (2016). A study of chief nursing executives indicates low prioritization of evidence-based practice and shortcomings in hospital performance metrics across the United States. Worldviews Evidence Based Nursing, 13(1): 6-14. doi:10.1111/wvn.12133

Ost, K., Blalock, C., Fagan, M., Sweeney, K. M., & Miller-Hoover, S. R. (2020, June). Aligning Organizational Culture and Infrastructure to Support Evidence-Based Practice. Critical Care Nurse, 40(3), 59-63. doi.org/10.4037/ccn20209630963. Retrieved from https://aacnjournals.org/ccnonline

The Joint Commission (TJC). Hospital Accreditation Standards, 2020. MHSC Intranet

Document - Standing Orders, Protocols and Order Sets

Attachments

Forms Check list.pdf

Standards Pyramid.jpg

Approval Signatures

Step Description	Approver	Date

Reg. Standards

CAH C-0991 §485.631(c)(1), CAH C-1006 §485.635(a), CAH C-1008 §485.635(a)(2), TJC LD.04.01.07, EP 1, 2, TJC NR.02.01.01, EP 2, TJC NR.02.02.01, EP 1-5, TJC NR.02.03.01, EP 1-3

Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:5/7/2025

Topic for Old & New Business Items:

- CAH – Plan of Care and Scope of Services

Policy or Other Document:

☒ Revision
☐ New

Brief Senior Leadership Comments:
The CEO participates in the Governance Committee and recommends approval.

Board Committee Action:

Approved by the Governance Committee at their April 21 meeting. Presented at the May Board of Trustees meeting for first review.

Policy or Other Document:

☒ For Review Only
☐ For Board Action

Legal Counsel Review:

☐ In House Comments:.
☒ Board Comments:. Geoff Phillips reviewed/developed

Senior Leadership Recommendation:
The CEO participates in the Governance Committee and recommends approval.

I. **GOVERNANCE**BOARD OF TRUSTEES

- The Hospital Board of Trustees' role is to serve as the governing body of the Hospital. In matters of policy development, approval, and governance oversight, the BOT shall act in accordance with the Policy for Development, Approval, and Oversight of Policies and Governance Documents and the MHSC Policy & Governance Document Approval Matrix. These documents establish the framework and delegation of authority for policy approval and governance. In the event of any conflict between this section and either the overarching policy or the Matrix, the terms of the Policy for Development, Approval, and Oversight of Policies and Governance Documents and the Approval Matrix shall govern.
- Board of Trustee (BOT) meetings are open to the public and take place the first Wednesday of every month beginning at 2:00 PM. Hospital Board members also serve on standing board committees that meet at various times, dates and hours of the day.
- Board members are assigned to standing committees by the Board President.
- The BOT is responsible for oversight of the Hospital.
- The BOT responsibilities include making strategic decisions for the organization, hiring and monitoring an effective CEO, ensuring the organization is providing safe, quality care, overseeing the organization's financial well-being, staying educated in health care industry news and best practices, and being a representative of the organization in the community.
- The BOT is not involved in the day-to-day operations of the Hospital. The daily operation of the Hospital is Senior Leaderships' responsibility.
- The Board of Trustees consists of five (5) members who are citizens of Sweetwater County and appointed by the Sweetwater County Commissioners.
- A County Commission liaison attends monthly Board of Trustee meetings and other meetings attended by Board of Trustee members whenever possible.
- BOT'S CONTRACTED SERVICES
    - Legal services
- AFFILIATIONS OR SOURCES OF REFERENCE
    - American Hospital Association (AHA)
    - Wyoming Hospital Association (WHA)
    - Veralon/Iprotean-educational resource for healthcare boards

II. SENIOR LEADERSHIP

- The role of Senior Leadership is to provide overall leadership and management of the Hospital, including the development of strategies related to the delivery of patient care. The plan for the provision of patient care is enacted through the planning, evaluating, directing, coordinating and implementing the services of the organization to meet or exceed the needs of the patient.

- Senior Leadership consists of the Chief Executive Officer, Chief Financial Officer, Chief Clinical Officer, Chief Nursing Officer, and Chief Experience Officer.
- One (1) Executive Administrative Assistant to the Chief Executive Officer and one (1) Administrative Assistant for the Chief Financial Officer, Chief Clinical Officer and Chief Nursing Officer work to ensure that functions within the executive offices are carried out and flow smoothly.
- Administration office hours are from 8:00 AM - 5:00 PM Monday - Friday, with the exception of holidays. However, a member of Senior Leadership serves as Administrator On-Call on a rotating basis to ensure at least one senior leader is available by telephone, in person or email 24 hours a day, 7 days per week, 365 days per year.
- Senior Leadership is accountable for the quality of care, safety and satisfaction of all patients and staff served at the MHSC. Members of Senior Leadership interact with patients and citizens of Sweetwater Country through direct and indirect communication.
- The MHSC contracts with numerous services in order to provide health care services to all persons needing care at the MHSC. The Board of Trustees, Chief Executive Officer and General Legal Counsel are responsible for reviewing, updating and maintaining all contracts, memorandum of understanding and other agreements with contracted services.
- AFFILIATIONS OR SOURCES OF REFERENCE
    - American Hospital Association (AHA)
    - Wyoming Hospital Association (WHA)
    - American Nurses Association (ANA)
    - American Organization of Nurse Leaders (AONL)

III. LEADERSHIP TEAM

- Each clinical and non-clinical area has a director or manager who is responsible for departmental functional activities, operations, quality and patient experience and patient safety initiatives, and for managing the resources of the department to meet the needs of the patient.

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Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:5/7/2025

Topic for Old & New Business Items:

- BOT – Memorial Hospital of Sweetawater County Meeting Guidelines

Policy or Other Document:

☒ Revision
☐ New

Brief Senior Leadership Comments:
The CEO participates in the Governance Committee and recommends approval.

Board Committee Action:

Approved by the Governance Committee at their April 21 meeting. Presented at the May Board of Trustees meeting for first review.

Policy or Other Document:

☒ For Review Only
☐ For Board Action

Legal Counsel Review:

☐ In House Comments:.
☒ Board Comments:. Geoff Phillips reviewed/developed

Senior Leadership Recommendation:
The CEO participates in the Governance Committee and recommends approval.

BOT - Memorial Hospital of Sweetwater County Meeting Guidelines

Board of Trustees

STATEMENT OF PURPOSE:

These Guidelines are intended to provide a framework for the preparation, notification, and operation of meetings of the Memorial Hospital of Sweetwater County (Hospital) Board of Trustees (Board) concerning topics not otherwise addressed in the Wyoming Statutes, the By-Laws of the Board, or in the Board Governance Committee Charter. These Guidelines are prepared by the Governance Committee of the Board and are approved by the Board. They may be amended at any time by the Board.

TEXT:

I. Agenda Preparation

A. The Board President, the Chief Executive Officer (CEO), and the Executive Assistant to the CEO meet at least a week before each regular monthly meeting of the Board to prepare the agenda for the meeting.

B. Typically, a less formal meeting is required for the preparation of an agenda for special meetings of the Board.

II. Public Access to the Meeting Packet

A. The meeting packet associated with regular monthly meetings of the Board should be published on the Hospital's website at least two days before the date of the meeting.

B. When possible, the meeting packet for special meetings of the Board should also be published on the Hospital's website in advance of the meeting. It is noted that a meeting packet may not be prepared for every special meeting.

III. Orientation Memo Associated with New and Old Business Agenda Items

A. Prefacing each agenda item under the Old and New Business section of the meeting agenda, staff should prepare a brief "Orientation Memo" designed to orient Board members concerning the agenda item.

B. To ensure consistency, the Executive Assistant to the CEO should develop a template that would be used each time so that the memo format is standardized for every meeting and for each agenda item.

C. The following content for the Memo must include:

1. Date of the Board Meeting
2. Topic
3. If a policy or other document … is it a revision or a new policy/document?
4. Brief Senior Leadership comments (if any)
5. Board Committee action (if applicable)
6. Is the agenda item for review only or for Board action?
7. Legal Counsel Review … In-House Counsel or Board Counsel
8. Senior Leadership Recommendation

IV. Review and Approval of Hospital Policies & Program Documents

A. All review and approval of policies and governance documents by the Board shall be conducted in accordance with the Policy for Development, Approval, and Oversight of Policies and Governance Documents and the MHSC Policy & Governance Document Approval Matrix.

V. As a general practice, new policies and program documents or substantive revisions to existing ones should be presented to the Board for "review only" at the first meeting, with final approval scheduled for a subsequent meeting. This allows Board members time for meaningful review and feedback. Minor or non-substantive revisions may be considered and approved at the same meeting where they are introduced, at the discretion of the Board President, so long as the changes do not alter the legal, financial, or strategic impact of the policy. Medical Staff forms, documents, or clinical policies that have been reviewed and approved by the Medical Executive Committee (MEC), and that do not require additional Board oversight under the Approval Matrix, may be approved by the Board at the same meeting they are first presented. Board Committee Reports

A. Board Committee reports to the Board may be presented by the Committee Chair either in writing or verbally at the discretion of the Committee Chair.

VI. Executive Session

A. Invitations to attend Executive Sessions of the Board are extended by the Board President.

B. The CEO should always be in attendance unless excused for a period of time by the Board President when his/her regular performance evaluation is being conducted or for other reasons associated with his/her performance or compensation.

C. The Executive Assistant to the CEO is typically in attendance to document the discussion. If absent, an Acting Executive Assistant may be present to document the discussion or, alternatively, a taped recording may be substituted.

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Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:5/7/2025

Topic for Old & New Business Items:

- BOT – Senior Leadership Plan: Filling CEO Absences & Vacancies; Filling Senior Leader Absences & Vacancies; Identifying & Developing Internal Senior Leaders

Policy or Other Document:

☒ Revision
☐ New

Brief Senior Leadership Comments:
The CEO participates in the Governance Committee and recommends approval.

Board Committee Action:

Approved by the Governance Committee at their April 21 meeting. Presented at the May Board of Trustees meeting for first review.

Policy or Other Document:

☒ For Review Only
☐ For Board Action

Legal Counsel Review:

☐ In House Comments:.
☒ Board Comments:. Geoff Phillips reviewed/developed

Senior Leadership Recommendation:
The CEO participates in the Governance Committee and recommends approval.

BOT - Senior Leadership Plan: Filling CEO Absences & Vacancies; Filling Senior Leader Absences & Vacancies; Identifying & Developing Internal Senior Leaders

Board of Trustees

STATEMENT OF PURPOSE:

It is important that the Hospital have in place guidelines and a process for filling a short or long term absence of the CEO or filling the vacancy when the CEO leaves the position permanently. This is also true for other senior leadership positions. This policy has two major purposes:
(1) To help the Hospital prepare for CEO or other Senior Leadership absences and permanent departures by bringing order at a time of potential turmoil, confusion, and high stress;
(2) Identifying and developing skills and talent by mentoring promising candidates employed by the Hospital with the potential to fill Senior Leadership positions on a temporary or permanent basis.

DEFINITIONS

Acting: Substitutes during an absence of a Senior Leader

Interim: Fills the role of a Senior Leader when the Leader has departed and a permanent replacement has yet to be appointed

Long Term Absence: One that is expected to last three consecutive months or more

Short Term Absence: One that is expected to last more than one month, but less than three consecutive months

TEXT:

I. ABSENCES OR PERMANENT DEPARTURE OF THE CHIEF EXECUTIVE OFFICER (CE0)

A. Absences (Long or Short Term)

1. In the event of an unplanned absence of the CEO, the Administrator on Call (AOC) shall immediately inform the Board President or designee of the absence. As soon as it is feasible, the Board President or designee shall convene a meeting of the Board of Trustees (Board) to affirm the procedures prescribed in this policy. The Board may make modifications as necessary. If possible, the Board shall consult with the CEO prior to appointing an Acting CEO.

2. In the event of a planned absence of the CEO, the Board shall meet to discuss the matter, consult with the CEO, and appoint an Acting CEO.

3. Normally, one of the following Senior Leaders will be appointed Acting CEO; however, the appointment shall be made at the discretion of the Board.

    a. Chief Nursing Officer

    b. Chief Financial Officer

    c. Chief Clinical Officer

    d. Chief Experience Officer

4. The decision about when the absent CEO returns to Hospital duties shall be determined by the Board President in conjunction with the absent CEO, and approved by the Board. They shall determine a mutually agreed-upon schedule and start date. A reduced work schedule for a short period of time may be allowed with the intention of returning to a full time commitment.

B. Permanent Departure

1. Should the CEO leave Hospital employment for any reason, the Board shall meet as soon as feasible after becoming aware of the departure to discuss the departure, determine a transition plan, and the next steps to take. The Board may, over time, take any one or more of the following actions:

    a. Appoint a permanent replacement

    b. Appoint an interim CEO

c. Appoint a search committee

d. Retain a consultant to assist with recruiting, interviewing, and selecting a replacement

C. Authority and Compensation of the Acting or Interim CEO; Appointment and Compensation of a Permanent CEO

1. The individual appointed as an Acting or Interim CEO shall have full authority for decision making and independent action as a permanent CEO.

2. The salary of the Acting or Interim CEO shall be recommended by the Board Executive Oversight and Compensation Committee and approved by the Board.

3. The appointment and compensation of a permanent CEO shall be made in accordance with prevailing Hospital policies.

D. Board Oversight

1. The Board member(s) responsible for monitoring the work of the Acting or Interim CEO shall be members of the Board Executive Oversight and Compensation Committee.

2. Board members on the Executive Oversight and Compensation Committee should be sensitive to the special support needs of the Acting or Interim CEO in the temporary leadership role. If the Acting or Interim CEO is appointed internally from the ranks of the Senior Leaders, it is recognized that it may not be reasonable to expect the Acting or Interim CEO to perform the duties of both positions for longer than three (3) months. Consequently, in this situation, it may be necessary to fill the Senior Leadership position temporarily until the permanent CEO returns to work or until a new permanent CEO is hired.

E. Communication Plan

1. If prior communication has not occurred, immediately upon transferring the responsibilities to the Acting CEO, Interim CEO, or to the permanent replacement, the Board President shall notify Hospital employees, medical providers, Foundation Board members, key volunteers, and the CEO of the University of Utah Healthcare System of the delegation of authority. The Board President shall also work with appropriate Hospital staff to prepare a local press release.

2. The Acting CEO, Interim CEO, or the permanent replacement shall communicate the temporary or permanent leadership change to state licensing agencies and other constituent groups.

II. ABSENCES OR PERMANENT DEPARTURE OF OTHER SENIOR LEADERS

A. Absences (Long or Short Term)

1. In the event of an absence of a Senior Leader below the level of the CEO, long or short term, planned or unplanned, the CEO may, at his or her discretion, appoint an Acting replacement in consultation with the Executive Oversight & Compensation Committee.

2. The decision about when the absent Senior Leader returns to Hospital duties shall be determined by the CEO in conjunction with the absent Senior Leader. They shall determine a mutually agreed upon schedule and start date. A reduced work schedule for a short period of time may be allowed with the intention of returning to a full time commitment.

B. Permanent Departure

1. If the Senior Leader's departure is permanent, the CEO shall, upon consultation with the Executive Oversight & Compensation Committee, execute a transition plan. The transition plan could, over time, include any one or more of the following actions:

a. The appointment of a permanent Senior Leader

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d. The retention of a consultant to assist with recruiting, interviewing, and selecting a replacement

e. At the discretion of the CEO, that may eliminate the need for reappointment, by consolidating Senior Leader positions or assigning duties and responsibilities to other Senior Leaders.

C. Authority and Compensation of the Acting or Interim Senior Leader; Appointment and Compensation of a Permanent Senior Leader

1. The individual appointed as the Acting or Interim Senior Leader shall have full authority for decision making and independent action as the permanent Senior Leader.

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3. The appointment and compensation of a permanent Senior Leader shall be made in accordance with prevailing Hospital policies.

D. Communications Plan

1. The CEO shall communicate the leadership change with all necessary constituents.

III. IDENTIFYING AND DEVELOPING INTERNAL SKILLS & TALENT

A. Leadership plays an essential role in the success of the Hospital. Change in Senior Leadership positions is inevitable requiring advanced preparation and planning. One of the purposes of this policy is to help the Hospital prepare for Senior Leadership position absences and departures.

B. To implement this objective, members of the Senior Leadership team should actively identify and mentor potential candidates through a deliberative interactive process to foster and develop the traits needed in a Senior Leader. Some of the key traits important in a great leader include:

1. Vision…being a strategic thinker

2. Courage…the ability to take reasonable risks to achieve worthwhile goals

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13. Ability to remain calm, cool and resilient in the face of conflict and criticism

C. Senior Leadership should work together, in a coordinated way, to proactively seek out individuals employed by the Hospital with great leadership potential and provide appropriate and meaningful leadership training opportunities for them throughout the year.

BOT - Senior Leadership Plan: Filling CEO Absences & Vacancies; Filling Senior Leader Absences & Vacancies; Identifying & Developing Internal Senior Leaders

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MHSC Board of Trustees: May 2025

Chief Clinical Officer (CCO) Report

Report prepared and submitted by: Kari Quickenden, Pharm.D., MHSA

1. The Medical Imaging Department of Memorial Hospital of Sweetwater County (MHSC) continues to progress on a project with Huntsman Cancer Institute (HCI) for breast MRI services. The collaboration will enable patients to have their breast MRI exams performed at MHSC and interpreted by a fellowship-trained breast MRI radiologist at HCI. At this point, we have an executed agreement and have successfully pushed images to HCI. The next steps include the MHSC team working with the HCI team to finalize the breast MRI protocols and credentialing/privileging of HCI physicians. A select number of fellowship-trained breast MRI radiologists are working on obtaining their Wyoming licenses. We expect we will be able to begin the service in mid-late summer 2025.
2. The Medical Imaging Department is in the initial stages of the replacement project for the Picture Archiving and Communication System (PACS). The team has started the build process and is on schedule to convert to the new system in the fall of 2025.
3. **Quality-Patient Safety:** Tracie Soller, Director of Medical Imaging, in collaboration with the Medical Imaging Technologists and Dr. Matti, has developed the 2025 Medical Imaging Order Guidelines. The goal of the resource document is to provide ordering guidance and streamline the ordering process for providers. The document is available via a link on the hospital intranet as well as the main hospital website page. The development of this document came out of the Central Scheduling work group, which continues to work on central scheduling-related process improvements. The document is currently available to internal providers, and we are also distributing it to community providers.
4. A team has been working with Cerner on the Unified Consumer Communications (UCC) project. Amy Magana, a Nurse Informaticist, is leading the project. The UCC project will improve patient appointment reminders for hospitals and clinics. The team is currently in the testing phase of the project, with a tentative go-live in early June 2025.
5. **Quality-Patient Safety:** We are excited to welcome Starlyn Kunz to the Quality Department. Starlyn joins the team with six years of experience in employee health and safety. She is already rounding with the team and asking great questions regarding standards and process improvements. Please join us in welcoming Starlyn to MHSC.
6. **Quality-Patient Safety:** The acute care quality reporting programs are officially closed. There will not be complete data submission for Q4 of 2024 due to our transition to Critical Access Hospital (CAH) designation. The Quality Department has notified the quality reporting agencies that we will begin submitting data for January 2025. Press Ganey and Cerne have been updated with this information and are active in the quality system with our new CAH CCN (CMS Certification Number).
7. **Quality-Patient Safety:** Our Patient Safety Committee recently met and restructured its reporting calendar. Beginning in July 2025, Directors will report to the Patient Safety Committee twice per year on their action plans/progress related to their culture of safety survey results. Press Ganey administered the survey in the fall of 2024. We administer the culture of safety survey every two years. As part of our efforts to meet the CMS patient safety structural measures, we are exploring options for a culture of safety pulse survey for the calendar year 2025.
8. **Quality-Patient Safety:** The clinical laboratory is actively performing its interim College of American Pathologists (CAP) self-inspection. CAP is our accrediting organization for the clinical laboratory. The clinical laboratory team has identified a few minor items to correct in the next 30 days as a result of the interim self-inspection.
9. The Sweetwater Regional Cancer Center was awarded a $10,000 grant through the Wyoming Breast Cancer Initiative (WCBI) for a breast boutique. The breast boutique will offer the following complimentary items/services: breast forms and prosthetics, post-surgery bras, recovery garments, compression sleeves and

gloves, wigs, head covers, brushes, shampoo/conditions, scalp care products, cream for radiation burns, educational materials and bra fitting consultations. A few staff members will become certified to perform the bra fitting consultations. The breast boutique will be a valuable service to our oncology patients.

10. I had the opportunity to attend a Survivor Family Night event at the Broadway Theater on 04/24/2025 hosted by the Sweetwater Regional Cancer Center. Approximately 70 community members attended the event. The team provided education and resources. Additionally, community members were able to view a movie to encourage social time with family. The event was possible via grant funding received from WCBI. After the movie, several people took the time to tell the team what a wonderful time they had. Some expressed they rarely get to go to social outings like this with their families, and thus, it meant a lot to them. Several also expressed they attended because they wanted to see the team that had taken care of them. I want to extend a big thank you to the following team members who planned and participated in the event: Tasha Harris, Rita Calzada, Lacey Reddick, Eva Wasseen, Ramona Allen, Bri Schafer, Danielle Hale, Josie Ibarra, Megan Benedict, Stephanie Dupape, Dr. Josh Binks, Dawn Piaia, Kerry Dixon, Heather Sell, and Deborah Defauw.
11. As of 05/01/2025, Deborah Defauw, Director of Rehabilitation Services and Physical Therapist, will have completed half of the required coursework needed to obtain her Certificate of Achievement in Pelvic Health (CAPP) from the American Physical Therapy Association. Pelvic health cards have been given to the SANE team to inform victims of available services if needed. Additionally, Deborah is working with our OB department to provide information for new mothers.
12. The Diabetes Self Management is experiencing significant growth. The team has received 37 referrals since January 2025 vs nine total patients seen in calendary year 2024. I would like to thank the Education Department and the Clinical Dietietians for their work on program.
13. A small group attended the University of Utah Affiliate Symposium 04/17/2025-04/18/2025. The symposium was an excellent opportunity to network with other affiliate hospitals as well as connect with our affiliate colleagues at the University of Utah.

Respectfully submitted,
Kari Quickenden

MHSC Board of Trustees: May 2025
Chief Experience Officer (CXO) Report
Report prepared and submitted by Cindy Nelson, SHRM-SCP, FPCC

Patient Experience Pillar

We continue to utilize our person-centered care culture to improve the patient experience and improve the satisfaction for our patients to provide compassionate care to every life we touch for every patient, every time.

"One of the most sincere forms of respect is actually listening to what another has to say." (Bryant H. McGill)

We continue to focus on Active Listening for our house-wide Compassion Initiative during the second quarter of 2025. Included is data shared with hospital staff April 17. Staff were asked to think about what behaviors or habits they have changed at work to help make improvements happen. We want to make these changes sustainable and keep them going. Karali Plonsky, Patient Experience Director, noted the surveys are from clinical areas so clinical staff have an impact, however non-clinical staff play a profoundly impactful role in each patient's experience.

Department	Baseline % 2024	AIM % (+2%)	Stretch % (+3%)	Year to Date 2025 %	% Change from baseline
OB	74.07	76.07	77.07	**100.00**	+25.93
M/S	64.9	66.9	67.9	**81.82**	+16.92
ICU	71.43	73.43	74.43	**45.45**	-25.98
Inpatient	64.9	66.9	67.9	**75.00**	+10.10
Surgery	90.48	92.48	93.48	**96.72**	+6.24
ED	65.71	67.71	68.71	**69.29**	+3.58
MOB	88.01	90.01	91.01	**89.65**	+1.64
3000	87.77	89.77	90.77	**89.36**	+1.59
MHSC Average	77.48	79.48	80.48	**81.76**	+4.28

Last Updated: 4/17/25

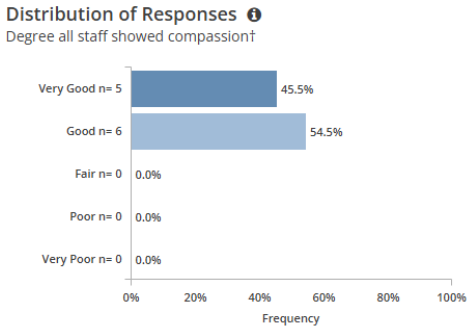
*MHSC's average is not an official number from Press Ganey. Score was identified by adding up all department scores and dividing by the number of departments. The purpose of MHSC's average is to show the importance of everyone working together to improve our patients' experiences.

To help staff understand the data, the following message was shared with staff:

Did you know that the Centers for Medicare and Medicaid (CMS) only look at "top-box" answers? Meaning, they only look at the number of times a patient said their bathroom was "always" kept clean or that our compassion was "very good." Patients get multiple survey response options and only the highest one is counted or shown in the data.

For example, let's look at the section for the ICU (one of our most complimented departments). At first glance, it may appear alarming that ICU's year-to-date percentage for the survey question, "Degree to which all staff showed compassion" seems to be decreasing. But is it actually as alarming as it appears? It's important to understand how we look at these scores to better understand the data.

When we break down the data, we can see the "Distribution of Responses" and see how all of our patients scored us for each question. Below is ICU's Distribution of Responses for this survey question.



We can see that of the 11 patients who returned a survey so far this year, 5 gave us a top-box score of "very good" and 6 of them gave us a score of "good." We had zero patients say "fair, poor, or very poor" . It shows us that while the data may look negative at first glance, when we dig into it, it does not tell the entire story. When we are presented with data like this, it gives us the opportunity to ask ourselves, what's that little bit of extra that I/we can do to help make our patient's experiences even better? What can I do to help?

We continue to share data with staff as well as strategies/solutions to improve to raise awareness and place a focus on the importance of the initiatives we are working on.

Workgroups continue meeting to develop strategies to improve patient experience and patient satisfaction scores in Hospital Environment – Cleanliness & Restfulness (formerly Quietness), Discharge Information, and Care Coordination (formerly Care Transitions). Reports were presented to the Performance Improvement and Patient Safety (PIPS) Committee in April and the updates were included in the April Quality Committee meeting packet.

The Patient & Family Advisory Council (PFAC) met April 21 and the question for discussion was, “How important is it to you that every person introduce themself with their name and department/job title when you are a patient or visiting a patient?” Our activity that night was a tour of the Nutrition Services Department. The presentation for the May 19 meeting is the Top 10 Patient Safety Concerns for 2025 and the CMS Patient Safety Structural Measures, specifically the role of the PFAC in the attestation process for Domain 5. The question for discussion that night is, “What should the Hospital be aware of to improve your care experience?”

<u>Employee Experience Pillar</u>

We continue to work to improve employee retention and employee satisfaction for a happier, healthier staff by weaving our culture throughout HR and management practices to recruit, reward, and retain staff committed to carrying out our mission. Human Resources is coordinating with Nutrition Services to prepare for a delicious Hospital Week 12-16. Efforts are being made to ensure we celebrate all staff on all shifts at all locations.

MHSC Board of Trustees: May 2025

Chief Financial Officer (CFO) Report

Report prepared and submitted by: Tami Love

FINANCIAL SUMMARY - Revenue decreased in March coming in at $22,850,422, under budget by $1.4 million Expenses are staying stable, slightly over budget at $11.2 million. Our bottom line for March was a loss of $178,000. Through three quarters of the fiscal year, our gross revenue is under budget by $2 million, net revenue is under budget by $585k and expenses are under budget by $1.3 million. Revenue is projected to be higher in April, at $23.5 million and with expenses staying stable, the estimated bottom line will be close to break even. Collections are projecting near $17 million as Medicare payments are catching up. We will see all of our financial ratios turn in the right direction in April and expect them to be close to our strategic plan goals for year end.

CRITICAL ACCESS. We released about $18 million in Medicare claims the week of March 6 and were notified on March 17 that the claims had started processing. We started receiving payments the first week of March. We have now released all of the CAH claims and have verified reimbursement at the cost to charge ratio as stated in our Noridian rate letter. With payments starting to come in, we have started to see the positive impact to both Days in AR and Days Cash on Hand in April. We are still waiting on the State for their CAH survey. We continue to look into adding swing beds and have started to research the 340B drug program as we automatically qualify as a CAH. The estimated timeline for 340B is January 2026 as we do need to complete our first year end cost report as a CAH before applying.

CONSTRUCTION PROJECT UPDATE. Several concurrent construction projects are happening at the hospital with the following updates and timelines.

MOB Front Entrance- This is the most recent scheduled project and, the most challenging. The fence around the front parking area of the MOB has been erected as parking lot improvements will begin first. This project will be expanding out the front vestibule roughly 4 feet, moving the double exit/entrance egress doors down, taking out the fireplace and replacing carpet. This project will take roughly 3-4 months to complete and will be in full swing in a couple of weeks.

Medical Imaging Phase II – There have been a few hold-ups with this project. It has been moving forward at a steady pace with all walls completely framed. Electrical is being ran and we are currently waiting for the back ordered VAV boxes that provide heat/cooling for spaces. This project is slated to be complete sometime towards the end of May but could move up depending on how fast the equipment can be installed and implemented.

Laboratory Expansion- This project has the most active and noticeable changes but is still a little behind. The expansion section is slated to be completed mid-September or early October. Once complete, work will move to the second phase of this project, which includes renovation of the existing Laboratory.

MHSC Board of Trustees: 5/2025

Chief Nursing Officer (CNO) Report

Report prepared and submitted by: Ann Marie Clevenger DNP, RN, NEA-BC

1. College Drive: Clinics and Occupational Medicine
    a. The Family Medicine group assists with scheduled days at Wamsutter Clinic twice weekly, caring for patients at Sageview Care Center and Deer Trail. The Walk-In Clinic has regularly scheduled providers who include Family Medicine to assist with patient census and decrease wait times. The clinic also serves as a leader in occupational medicine, including eight companies on retainer and over 75 companies that it serves.
2. Surgical Services and MOB Surgical Clinic
    a. New Procedure
        i. The Surgical Services Team is working with Dr. Hoffman, the Surgery Clinic, including Jodi Cheese, Practice Manager, and the Surgical Services Department to coordinate a plan for trialing a plan of care for a patient considering and who could potentially qualify for a sleeve gastrectomy procedure at MHSC.
3. University of Utah Affiliate Conference
    a. I had the opportunity to attend the University of Utah Affiliate Conference. It provided a wealth of information on the University and what other hospitals in its network of affiliates are working on. They also included their short—and long-range plans for their facilities and growth projections, considering and collaborating on how we, as affiliate organizations, and the University could work together fluidly to keep patients at home for care when possible or expedite transfers when a higher level of care was required.
4. Strategic Initiative:
    a. Quality and Safety
        i. We are meeting to discuss and propose a Nurse Professional Peer Review (NPPR) Committee. It is best practice to have NPPR, which aligns Nursing Excellence and Magnet requirements to improve quality and safety and enhance the nursing profession. We have spoken to the Magnet Director at Cheyenne Regional, who leads this program. We are meeting to further develop. When it starts, we will update you.
    b. Reducing Turnover and Travel Staff Update
        i. I provide leadership education to nursing services leaders monthly. In addition, each month, one leader shares something to enhance leadership skills or lessons learned.
        ii. Nursing Services, with the help of Human Resources, held a Recruitment Brunch on April 28th, 9-11 am, CR 1-3, with 13 graduate nursing students in attendance who were interested in MHSC.
            1. New Grad Application Period May 6- May 16th
            2. Group Leader Interview Panel
            3. The successful applicant's start date is June 30th

4. Nemo (Nursing Education Mini Orientation Residency Program) every Thursday for six weeks to fit into their existing schedules

c. Mental Health Services: The Sweetwater Behavioral Health Clinic (SBHC) Business Proposal was brought to the April Board of Trustees Meeting, where I presented. A Board of Trustees workshop was held on April 22, 2025, with a PPT presentation and coordination of answers to questions posed by Board Members.

Please let me know if you have any additional insight that may be helpful in this report. Thank you for being so supportive of the MHSC teams. Ann

Building and Grounds Committee Meeting
April 15, 2025

The Building and Grounds Committee met in regular session via Zoom on April 15, 2025, at 2:30 PM with Mr. Marty Kelsey presiding.

In Attendance:
Mr. Craig Rood, *Chairman*
Mr. Marty Kelsey, *Trustee*
Ms. Irene Richardson, *CEO*
Ms. Tami Love, *CFO*
Mr. Gerry Johnston, *Director of Facilities*
Mr. Steven Skorcz, *Facilities Supervisor*
Mr. Will Wheatley, *PlanOne Architects*

Mr. Rood called the meeting to order.

Mr. Rood said we did a great job at the Commissioner meeting earlier that day. Ms. Richardson and Mr. Rood both shared a mission moment.

Mr. Rood asked for a motion to approve the agenda. Mr. Kelsey made a motion to approve the agenda. Ms. Richardson seconded; the motion passed.

Mr. Rood called for a motion to approve the minutes for the March 18, 2025, meeting.
Ms. Love moved to approve the minutes. Mr. Johnston seconded; the motion passed.

Maintenance Metrics

Mr. Johnston reported on the March metrics report. He said the average days open are creeping up. We have several flooring repair projects in the queue that we are currently waiting on pricing.

Old Business – Project Review

Medical Imaging Core and X-ray

Mr. Johnston said they are waiting on VAV's for needed valve repairs. The project is moving along nicely and is right on schedule. Siemens was onsite last week for the electrical walk through and review for equipment placement.

Laboratory Expansion project - SLIB

Mr. Johnston reported that internal walls were being framed. They are still a little behind schedule but making way on the total timeline. He has reviewed and signed a few contingency allocations. They did have to make some corrections on the canopy. Mr. Rood asked what type of items are being put through the contingency balance. Mr. Johnston some minor items like door lettering, med gas, ceiling outlets, lighting changes and some corner guard changes. Mr. Rood asked for a list of all contingency change orders be reported at these meetings. Mr. Johnston said they are tracked on the pay applications and the balance is currently at $78,000.

MOB Entrance – SLIB

Mr. Johnston said they will start barricading the parking lot on April 21. He worked with the State for a plan for an emergency exit and path of egress. This will require the front elevator to be taken out of service. They will start by removing the double doors and then demolishing the fireplace.

Master Plan

Ms. Richardson said we are working on the capital budget and discussing what we will be submitting to the County for maintenance next year. There was discussion on being conservative next year on any master plan projects. There are several maintenance projects that should fall under the County maintenance funds. The University of Utah is expected to move out of the Clinic space in October. Mr. Rood commented on Commissioner Jones comment at the Commissioner meeting regarding the hospital being the "most transparent agency" they have.

Tabled Projects

Foundation Area Renovation – Ms. Love said this project is still tabled until a decision is made on what the space will be used for once the Foundation and Legal office move to the new building. There were several options for this space in the master plan recommendations.

County Maintenance Fund

Mr. Kelsey asked for more discussion on the definition of maintenance. Ms. Richardson reviewed what happened at the Commissioner meeting earlier that day. It was decided to use the remaining FY25 funds for the OB project. We have always been very transparent with the money received from the County but there is some disagreement on the definition of what maintenance means per the State statute. The committee discussed the next steps for the County budget request. Mr. Kelsey shared the definition of "major maintenance" from the State statute for county governments. It was decided we would send a list of the projects we plan on doing in the new year to the County, with the budget request.

New Business

The committee charter was reviewed with no need for any changes. The committee approved to move the Building & Grounds Committee charter to the full Board for approval.

Other

The next meeting is scheduled for Tuesday, May 20, 2025; 2:30pm.

Mr. Rood adjourned the meeting at 3:26 pm.

Submitted by Tami Love

Governance Committee Minutes
April 21, 2025
1:30 P.M.

Attendance: Marty Kelsey, Chair; Kandi Pendleton, Member; Irene Richardson, Member; Geoff Phillips, Board Attorney

Mr. Kelsey called the meeting to order at 1;35 P.M.

Moved by Kandi, seconded by Irene to recommend that the Board suspend the following policy at the May meeting of the Board until it can be reviewed and changed so as to not conflict with the Operations Policy due to be approved at the May meeting of the Board. “Policies, Standards, Plans, Procedures/Processes, Guidelines and Forms”. Motion carried unanimously.

Moved by Kandi, seconded by Irene to approve the recommended changes to the following policy and to submit them to the Board for consideration on first reading at the May meeting of the Board. “CAH—Plan of Care & Scope of Services.” Motion carried unanimously.

Moved by Kandi, seconded by Irene to approve the recommended changes to the following policy and to submit them to the Board for consideration on first reading at the May meeting of the Board. “ BOT—Memorial Hospital of Sweetwater County Meeting Guidelines.” Motion carried unanimously.

Moved by Kandi, seconded by Irene to approve the recommended changes to the following policy and to submit them to the Board for action at the May meeting of the Board. “ BOT—Senior Leadership Plan: Filling CEO Absences & Vacancies; Filling Senior Leader Absences and Vacancies; Identifying & Developing Internal Senior Leaders.” Motion carried unanimously.

The Committee discussed education needs. It was determined to perhaps schedule a time in June for a departmental presentation to the Board…such as the Walk-in Clinic.

The meeting was adjourned at approximately 2:00 P.M.

To: Board of Trustees
From: Barbara J. Sowada
Re: Quality Committee Meeting
Date: April 16, 2025
The Quality Committee met April 16th from 8:15 to 9:30 am by Zoom.

Major discussion items were as follows:

1. Star Rating. At the most recent refresh, MHSC has maintained its 4-star rating from CMS.
2. Barbara McDonald provided a thorough Infection Prevention risk assessment, plan, summary, and YTD surveillance. Take-aways for 2025
    a. Comprehensive surveillance
    b. Surveillance limited by available tools, e.g. Cerner
    c. Reboot auditing and leadership accountability for staff
    d. Plan approved by Committee and send to Board with recommend to approve.
3. Surgical Services First Case On Time Start
    a. National benchmark is 90%
    b. Winter average was 53%, March was 70%
    c. Not clear whether this benchmark has value for MHSC
4. Safe use of opioids and discharged on anticoagulant therapy—hospital is doing well on both measures.
5. Sepsis Bundle—fell below the goal for January and February 2025. Reasons for fall out have been identified and are being addressed
6. Increase in workplace violence attributed to one behavioral health patient

Executive Update – MHSC Board Quality Committee Meeting

PROVIDED BY Stephanie Mlinar, Kari Quickenden, Ann Clevenger, Tami Love, Irene Richardson, Cindy Nelson

REPORTING DATE April 2025 Board Quality Committee Monthly Meeting

General Highlights

- Update on the Star Rating Refresh presented. MHSC's star rating will refresh by the end of April. We will maintain our 4-star rating.
- Annual Infection prevention summary, risk assessment and plan reviewed and discussed.
- Review of Surgical Services First Case on Time Starts
- Review of summary for electronically captured clinical measures (eCQMs)

Patient Experience Pillar: Reported to PIPS April 8, 2025

Objective/Initiative (Increase by 3% per year)	Dept.	Baseline (CY 2023)	Target Goal	Stretch Goal	CY 2024 Outcome	Goal Re-evaluation planned	Baseline (CY 2024)	Target Goal (2% increase)	Stretch Goal (3% increase)	**CY 2025 YTD**
Care Transition/Care Coordination (HCAHPS)* --CY 2025 is only reflecting Care Coordination. The Care Transition domain has been discontinued.	Inpatient [MS, ICU, OB]	54.41%	57.4%	58%	52.96%	Re-evaluate goals in Feb '25	MS: 50.17% ICU: 60.18% OB: 57.89% Overall 52.96%	MS: 52.17% ICU: 62.18% OB: 59.89% Overall 54.96%	MS: 53.71% ICU: 63.18% OB: 60.89% Overall 55.96%	MS: 74.29% ICU: 51.28% OB: 91.67% **Overall 70.38%***
Discharge information (HCAHPS)*		86.25%	89.25%	90%	88.72%		MS: 87.49% ICU: 93.59% OB: 88.46% Overall 88.72%	MS: 89.49% ICU: 95.59% OB: 90.46% Overall 90.72%	MS: 90.49% ICU: 96.59% OB: 91.46% Overall 91.72%	MS: 88.46% ICU: 91.67% OB: 100% **Overall 91.94%***
Hospital Environment: Cleanliness sub measurement		74.54%	77.54%	78%	72.24%		MS: 69.01% ICU: 80.85% OB: 77.78% Overall 72.24%	MS: 71.01% ICU: 82.85% OB: 79.78% Overall 74.24%	MS: 72.01% ICU: 83.25% OB: 80.78% Overall 75.24%	MS: 63.33% ICU: 53.85% OB: 75.00% **Overall 59.52%***
Hospital Environment: Quietness sub measurement		64.02%	67.02%	75%	62.55%		MS: 59.76% ICU: 66.67% OB: 73.08% Overall 62.55%	MS: 61.76% ICU: 68.67% OB: 75.08% Overall 64.55%	MS: 62.76% ICU: 69.67% OB: 76.08% Overall 65.55%	MS: 64.29% ICU: 38.46% OB: 75.00% **Overall 54.55%***

Objective/Initiative (Increase by 3% per year)	Dept.	Baseline (CY 2023)	Target Goal	Stretch Goal	CY 2024 Outcome	Goal Re-evaluation planned	Baseline (CY 2024)	Target Goal (2% increase)	Stretch Goal (3% increase)	**CY 2025 YTD**
Degree to which all staff showed compassion (HCAHPS)* ***Survey data may lag by 49 days per CMS reporting guidelines.		73.31%	76.31%	77%	64.90%	Goals evaluated Feb 2025	MS: 64.7% ICU: 71.43% OB: 74.07% Overall 64.90%	MS: 66.7% ICU: 73.43% OB: 76.07% Overall 66.90%	MS: 67.7% ICU: 74.43% OB: 77.07% Overall 67.90%	MS: 82.76%* ICU: 45.45%* OB: 100%* **Overall: 75.00%**
Degree to which all staff showed compassion (non-HCAHPS areas) * ***Survey data may lag	Surgical Services: Emergency Department: Medical Office Building: 3000 College Hill Clinics	Not evaluated at this level in 2024					Surgical Services: 90.71% Emergency Department: 72% Medical Office Building: 88% 3000 College Hill Clinics: 87.79%	Surgical Services: 92.71% Emergency Department: 74% Medical Office Building: 90% 3000 College Hill Clinics: 89.79%	Surgical Services: 93.71% Emergency Department 76% Medical Office Building: 91% 3000 College Hill Clinics 90.79*	Surgical Services: **98.28%*** Emergency Department: **68.60%*** Medical Office Building: **89.73%** 3000 College Hill Clinics: **89.38%***
Sub-measure question chosen to affect compassion question. • OB/MS/ICU specific question "Nurses Attitude Towards Requests" • Surgical Services/ED specific question "Nurse's Response to Questions/Concerns" • 3000/MOB specific question "Concern of Nurse/Asst for problem"	OB	81.40%	84.4%	86.4%	81.48%	These metrics will not be continued for 2025. The focus is the degree to which all staff showed compassion.				
	MS ICU	74.42% 69.66%	77.42% 72.66%	78% 73%	67.88% 76.00%					
	Surgical Services	91.03%	94.03%	96.03%	89.02%					
	ED	70.19%	73.19%	75.19%	68.20					
	MOB Clinics	80.18%	83.18%	85.18%	80.93					
	3000 College Clinics	82.36%	85.36%	85.36%	80.34					
Formal leader training program 4 cohorts x 8 (2hr) sessions = 32 sessions	Leadership Team	NA	100%	N/A	91% [29/32] *TJC visit	Exploring additional training opportunities				
Dedication of one Senior Leadership meeting per month for implementation and management of 3-year strategic plan	Senior Leaders	0	In develop-ment	In develop-ment	NA	NA	NA	12	NA	**2**

Accomplishments	Issues	Impact	Action Plan
Care Coordination			Care transitions provides post-discharge phone calls. Preparing to go home checklist provided to patients prior to discharge. Using active listening initiative for care coordination purposes as well.
Discharge Information	Case management post-acute instructions did not auto populate into discharge instructions	Creates a gap in discharge information that is available for patients	Staff to contact case management prior to printing of discharge instructions to allow for post-acute instructions to print. OB is giving post-partum hemorrhage and preeclampsia instructions to all patients. Increasing discharge phone call follow ups. Speak up campaigns have been shared with patients. The Patient Educator RN targets seeing 40% of the discharges on MS and ICU set to go home. Pre-built folders are ready for education with patients. Pharmacy provided education regarding "communicating about medication to improve patient safety and experience.
Compassion: OB, MS, ICU (inpatient) and Surgical Services, ED, MOB & 3000 clinics (outpatient) **A hospital-wide compassion initiative rolled out. First and second phase: Active listening.**	Occasionally patients or families are verbally or physically abusive or aggressive toward staff. Outpatient settings are more difficult to observe providers interacting with patients and demonstrating active listening.		Scores reviewed with staff for inpatient units. Education provided to staff on what active listening looks like. Ongoing reinforcement of compassion driven patient care, active listening, and timely initiation of patient requests. TeamSTEPPS is used in Surgical Services with crucial conversations if necessary. The Emergency Department is seeing increases in overall top box scores compared to last year. Staff put themselves in the patient's position and use closed-loop communication.
Hospital Environment – Cleanliness:			Updating EVS cards with language of who to ask on the care team for certain cleanliness topics. Inpatient rooms being cleaned twice per day with few exceptions. Toilets will be labeled as sanitized in occupied rooms as well as after patients are discharged. Scheduling additional education for communication regarding cleanliness with patients and visitors. OB has daily C.N.A. checklists for cleanliness. Standing agenda items for cleanliness at staff meetings on MS and ICU.
Hospital Environment – Quietness:			Maintenance repaired loud closing doors. Sleep masks and ear plugs were purchased for patients. Discussed keeping conversations outside of rooms quiet. Signage posted that promotes a quiet hospital environment
Formal leader training:	None identified		Exploring additional Peak Leadership Training Person Centered Care culture leadership training for new leaders Proposing Just Culture training for leaders
Dedication of one **Senior Leader meeting** per month for Strategic Plan	None identified		This is ongoing.
Translation Services PIPS: Evaluating and designing a plan to provide translated signs in Spanish for the hospital, MOB, and 3000 Clinics	Cost prohibitive for FY 2026. Life Safety Codes may limit what can and cannot be hung.	Increase the length of time to project completion.	Follow up with: U of U, Foundation Director, work on wayfinding maps and exploring the cost of a "you are here" sign like in malls or airports.
Grievance PIPS: Completion of actions for investigations and follow up on complaints/grievances	The timing of receipt of a complaint to the next Grievance Committee	May not reach 100% based on timing.	Continue to send information at times that directors are more readily available. Consider looking at metrics for a cut-off time prior to grievance committee having all actions completed.

Accomplishments	Issues	Impact	Action Plan
Improving Phone and Email accuracy PIPS Patient Access for clinics and hospital settings	Some phone numbers and email addresses do not pull to the Patient Experience Survey Vendor Press Ganey	Should MHSC desire to move to an electronic form of surveys, not having phone numbers and emails pull correctly can limit who receives surveys.	The group is reconvening to discuss how information is collected, where it is entered in Cerner the hospital and clinic's electronic health record. Accurate phone numbers and emails also allow patients to access the patient portal to view their medical record and some testing results.
Rehabilitation Services PIPS Physical therapy, Occupational Therapy, Speech Therapy			Providing tele-health services. The Rehabilitation Services Director continues to research and implement access for therapy services via tele-health.

Employee Experience Pillar: Reported to PIPS April 8, 2025

Objective/Initiative	Baseline	Target Goal	Stretch Goal	CY 2024 Outcome	Goal Re-evaluation planned	Target Goal (10%)	Stretch Goal (15%)	**CY 2025 YTD**
Reduce staff turnover by 10% per year, using the current turnover rate.	CY 2023: 21% National Average 2023: 22.7%	10% reduction 18.9%	18%	18%	January 2025	16.2%	15.3%	**17%** (end of Feb)
Improve our employee engagement scores by 3% per year.	Baseline data collected October 2024	NA	NA	3.91	This is our baseline, the next survey in 2026			
Hire a consultant to evaluate and review salaries at a minimum of every three years.	Consultant hired and review completed	NA	NA	Completed	Budgeting for FY 26 review			
Comprehensive program for directors to develop relationships, etc.	NA	100%	NA	91% [29/32] *TJC visit 100% Jan 2025	Exploring additional training opportunities			
Develop plans for success sharing bonuses for employees if goals are reached.	NA	1 sharing bonus	NA	1 sharing bonus 6/2024	June 2025			

Accomplishments	Issues	Impact	Action Plan
Reduce Staff turnover by 10% per year, using the current turnover rate. Additional goal to remain under national staff turnover rate (YTD 22.7%)	None identified		The plan continues to be documented in the tracking system. Cross-trained staff list available and being used for retention. Over 40 nursing staff are cross-trained and competent to provide care in additional units. Recruitment and retention are complex. Individual employees may need to change jobs because of family-related needs. We will continue to do the ER nurse residency and NEMO courses. HR includes stay and exit interviews. They celebrate Employee Appreciation Day, Hospital Week, Bravos, and host a lifestyle page for the website.
Employee Engagement Survey	The goal lists that it will improve by 3% per year. This survey is conducted every 2 years.	A new survey vendor was used for the Employee Engagement Survey. Calculating a percentage increase may prove difficult because a baseline is different between the vendors.	The Employee Engagement survey was completed in October 2024. HR will present overall findings We will be able to look at engagement scores in 2026 if we keep the current schedule and vendor.
Salaries were reviewed with adjustments made at the beginning of FY 2025			Hiring a consultant to review salaries is being budgeted for FY 2026.
Comprehensive program for Directors (also listed under patient experience pillar)			As documented in the Patient Experience Pillar
Success sharing bonus implemented at the end of June 2024			Evaluation of the ability to offer success sharing bonuses will occur in June 2025.
New Hire RN Retention PIPS: Education Department Since June 2024 – 32 new nurses hired and only 2 have separated from the organization giving a 6.25% turnover rate.			We worked with the directors to review the orientation plans, mini residency—nemo, nursing skills day, preceptor training, education opportunities, and cross-training opportunities. Healthy workforce to reduce bullying and bad attitudes. Leadership training. Preceptor pay and travelers to help with staffing and safety. We also offer staff continuing education and other educational opportunities, including specialty classes and U of U training courses. We have also had 19 RNs transfer to other areas, which has provided these nurses with opportunities to learn new skills and explore options at MHSC. Some of these transfers also allow us to build our cross-trained pool. The education dept and the directors have a meeting planned to review and revise any areas of the new hire orientation process/ nemo/ and skills day and have this ready to implement with the new Grads this spring.
Nutrition Services PIPS: Unidine Policy changed to hire certified food handlers or have existing staff become certified			Changing new hire orientation for Unidine to be the same day and occur with MHSC hires.
Person-Centered Care Committee PIPS			Rounding on employees with a goal of visiting with at least 80% of staff monthly.

Accomplishments	Issues	Impact	Action Plan
Medical Staff Services PIPS:			The time to process applications has decreased. We are going to partner with AMA and will utilize their VeriCre platform. VeriCre will interface with our Credentialing Software and will download provider information from the AMA profile. So, when we send out the initial applications, a lot of the information will be pre-populated. We are now sending out on-line applications for reappointments, in addition to the initial applications. We have received positive feedback from the providers who have completed the on-line reappointment applications.
Information Services PIPS: Meeting goal for monthly ticket completion			We hope to bring on a cybersecurity analyst to bring focus and reduce cybersecurity workload. Implement affective AI to reduce workloads while maintaining services and cybersecurity. As technical debt is reduced, and AI is implemented we hope to a more effective workforce, and a slight reduction of workloads.

Quality & Safety Pillar – Last Updated March 14, 2025

Objective/Initiative	Baseline	Target Goal	Stretch Goal	CY 2024 Outcome	Goal Re-evaluation planned	Target Goal	Stretch Goal	**CY 2025 YTD**
C. *Diff*	Baseline data: January 2024 – May 2024: 4 cases	No more than 1 case from 4/1/24 to 3/31/2025	No cases from 4/1/24 to 3/31/2025	0	Re-evaluate goals April 2025			**0**
SEP-1 Bundle Compliance	Calendar year January-May 2024: 72.58%	70% compliance by 6/30/2025	75% compliance by 6/30/2025	75.31%	January 2025	78% By 6/30/2025	83% By 6/30/2025	66.67% CY **76.98% FY25 YTD**
OP23 -Stroke measure: 70% compliance by end of CY 2024, stretch goal 80% (re-evaluate in Jan '25)	Per July 2024 Hospital Compare Report: 67%	70% compliance by end of CY 2024	80% compliance by end of CY 2024	90.91%	January 2025	95% By 6/2025	100% By 6/2025	**100% CY & FY 25 YTD**
Create process improvement position that will require Lean training and be responsible for leading improvement efforts	Position does not currently exist	1 FTE	NA	Not budgeted for FY 2025	January 2025	Interview and hire by June '25	Interview and hire by May 2025	**Candidate will start April 21, 2025**
Create patient and staff education	No nurse educator Using Symplr for staff	1 RN Educator Reintroducing Brown Bags, Prosper Training	NA	Met Met	NA	Continuing with current plan and goals		
100% of clinical staff will complete TeamSTEPPS training by the end of three years (CY 2027)	0%	66%	75%	79%	January 2025	85% of clinical by 6/25	90% Clinical by 6/25	**83%**
In-house legal counsel will provide a "risk management minute" quarterly each year and provide a recording for all staff	0%	8	10	8	NA	12	12	**Meeting goal**
Develop methods that will allow Synergi to categorize reports and create the ability to track and trend data	HIPAA specific cases Using process improvement modules	10% PIPS in Synergi	25%	82.1%	February 2025	Add data stratification for Health equity. 100% of PIPS in Synergi		**100% of PIPS in Synergi**
Utilize Health Equity Plan to promote the highest quality outcomes and safest care for all people	No disparities identified based on stratification of demographics	1 disparity	NA	0 found	February 2025	Meet attestation for Age-Friendly Care 5 Domains		**0**

Accomplishments	Issues	Impact	Action Plan
C. Diff: BioFire testing is available with reflex testing. Meeting goal	None identified	Interdisciplinary review resulted in improved process.	Continued monitoring.
Sep-1 Bundle Compliance: Goal met	Continuing to work through identified process barriers/challenges		Continue weekly OFIs with timely feedback to team members.
OP 23 – Stroke Measure: Meeting goal	None identified		Continued monitoring
Process Improvement position			Interviews were held and candidate to start on April 21st.
Create Staff and Patient Education: Staff education – Prosper training held for evidence-based research regarding suicide prevention offered by community agency Patient education – educator hired, meeting goal	None identified		Staff: Annual education will be completed by the end of March. Several courses offered including Trauma Nurse Certification Course (TNCC), Advanced Cardiac Life Support (ACLS), Advanced Pediatric Life Support (PALS). Multiple other in-house education was provided. Patient: Reviewing health literacy tools. Shadowing at U of U with unit Educator. Evaluating educational tools for patients to include in FY 2026.
Initiative regarding TeamSTEPPS. Attendance Tracking is in place and the activities are open to clinical and non-clinical staff. Current clinical staff 83% completion. Non-clinical staff 19%	None identified	Improve inter-and intradepartmental communication	Three sessions for each of the three levels are available for staff to sign up each month. Monthly report sent to leadership with updates on compliance. Milestone goal for June 2025 – 85% completion rate for clinical staff.
Risk management minutes are being presented at medical staff meetings.	None identified	Provide education for staff, including employed medical staff	In-house legal counsel continues to bring risk management minutes to medical staff meetings.
Synergi report categorization with further development for HIPAA, grievance/complaint, and process improvements	None identified	Further categorization increases tracking and trending capabilities	The Patient Safety Organization (PSO) contract executed, will begin project build within the next two to three months.
Health Equity: AHA HETA assessment completed. Tailored MHSC's HE plans and charter to match resources and strategic goals.	None identified		Align the age-friendly structural measures with health equity efforts.

Regulatory Readiness - Last Updated March 14, 2025

PIPS Projects	Baseline	Target Goal	Stretch Goal	CY 2024 Outcome	Planned updates	Target Goal	Stretch Goal	**CY 2025 YTD**
Emergency Management: All Senior Leaders complete FEMA courses for better understanding of Incident Command Structure	0%	100%	NA	80%	April 2025			
Environment of Care: Evaluating changes for a tobacco free campus	NA	Completed	NA	Signs ordered	April 2025			
PICC Team: PICC line data in Synergi 95% success insertion [1 attempt] Decrease catheter readjustment	NA	100% 95% <5%	NA 100% 0%	100% 89% 4.6%	April 2025			
Trauma Improve hourly GCS charting. Improve hourly VS charting. Improve EMS scene time <20"	38% 54% 78%	65% 75% 85%	75% 85% 90%	44% 75% 82%	April 2025			
Physician Recruitment: Completed contracts	0	67%	75%	67%	April 2025	75%		
Blood Utilization: Consent completed. Order to administer. Transfusion indication	97% 95% 100%	100% 100% 100%	NA NA NA	99% 99% 99%	April 2025			
Code Blue Committee	In development	-----	------	-------	April 2025			
Cardiopulmonary: Ventilator Orders	69%	100%	NA	93%	April 2025	100%	NA	
Sleep Lab: decrease turn around read times	50%	100%	NA	100%	April 2025	100%	NA	
Dietitians: reconciling dietary orders	In development	------	------	------	April 2025			
MS/ICU Critical Values	MS – 98% ICU – 97%	95%	100%	MS – 88% ICU – 94%	April 2025			
BCMA	MS – 93% ICU – 93%	95%	98%	MS – 96.63% ICU – 93.1%	April 2025			
Falls: reduce and maintain fall rate to less than 2.5 per 1000 acute care patient days	CY 2023 5.33 / 1000 patient days	Less than 2.5 / 1000 patient days	Less than 1.5 / 1000 patient days	1.21 / 1000 patient days	April 2025			
OB: unexpected complications of newborn/1000 live births	Severe and Moderate in overall total Overall: 58.51	Overall: 29.4 Severe: 12.8 Moderate: 18.1	Overall: 25 Severe: 12 Moderate: 17	Overall: 51.63 Severe: 29.89 Moderate: 21.79	April 2025			
3000 College Drive: Sample medications	In development	-----	------	------	April 2025			

PIPS Projects	Baseline	Target Goal	Stretch Goal	CY 2024 Outcome	Goal Re-evaluation planned	Target Goal	Stretch Goal	CY 2025 update
Dialysis: Central Venous Catheters 10-15% Increase AV Fistulas to 85-90%	93.15%	90%	95%	92%	April 2025			
Opioid Safety	In development	------	-----	-----	April 2025			
Behavioral Health	In development	------	------	------	April 2025			

Community, Services and Growth Pillar - Last Updated March 14, 2025

Objective/Initiative	Baseline	Target Goal	Stretch Goal	CY 2024 Outcome	Goal Re-evaluation planned	Target Goal	Stretch Goal	**CY 2025 YTD**
Improve and establish outreach to community and outlying areas/ Increase number of community presentations	Baseline data unavailable, goals are being set by each team.							
Community education		7 presentations	8 Presentations	7 presentations	January 2025	Add 6 presentations	Add 8 presentations	**6 total presentations**
Diabetes Education		Training	Whole Process	On target	January 2025	Manage referrals		**13/15 scheduled**
Care for the caregiver		Resources for caregiver	Whole Process	On target	December 2025	Increase community Contact	Have 211 Ambassador	**Meeting goal**
Mental health		Secure mental health services	Whole process	On target	January 2025	Prosper training for MHSC staff	Increasing access to Qler telehealth	**Meeting goal**
Improve from a Google 2-star Rating to a Google 3-star rating by the end of three years	2.3	3	4	4.1	NA	4	4.5	**4.2**
Utilize master plan to identify areas where we can provide outreach to outlying areas	In development	----------	---------	----------	Remains in development			
Develop a strategic communication/marketing plan.	10 testimonial	28	30	39	January 2025			**Adding meet the team profiles**

Accomplishments	Issues	Impact	Action Plan
Community Education goal is to have a total of 7 presentations in 2024 Goal met	Scheduling can sometimes be difficult. Some departments are not as comfortable with public speaking.	None identified at this time	Young at Heart Lunch & Learn-Jan. 28 Rock Springs Chamber of Commerce-Feb. 13 Rock Springs Health Academy- Feb. 13 Currently have planned presentations: School District #1 Retired Teachers-March 3 Rock Springs Health Academy-March 5 Young at Heart Lunch & Learn- April 22
Radiation Oncology is working with in-house translators to provide Spanish documents in the education binder for new patients.	Documents from outside entities are not in Spanish	None identified at this time	Monthly radio spots with KREO
Diabetes Education: Diabetic Self-Management Education (DSME) site change from Public Health to MHSC. There were five referrals in the first week upon the transition from Public Health to MHSC.	None identified at this time	RN patient educator performs the nurse visit, and the Director of Education is the DSME Quality Coordinator. Medical Nutrition Therapy (MNT) continues through MHSC Dieticians. Potential impact to increase appointments as the RN patient educator meets with patients while hospitalized.	Contract renewed. Referrals are being scheduled.
Care for the Caregiver: Care for the Caregiver team members will attend/participate/present at 2 public events to meet the community members we serve, network with other service providers, and build relationships in our community in 2024. Goal exceeded for CY 2024 with 3 events attended.	None identified	None identified	2025: Care for the Caregiver team members will attend/ participate/ present at 4 public events MHSC will have an employee train and be the SWC 211 Ambassador. Caregivers need to know the services and providers available to them in our county and state. The employees of MHSC are the largest group of caregivers in our county and planning is in place for providing support.
Accomplishments	**Issues**	**Impact**	**Action Plan**
Mental Health:			8 hours of telehealth offered for outpatients on Wednesdays. Feedback is positive and patients are returning for further visits.

Accomplishments	Issues	Impact	Action Plan
Improve Google Star Rating Meeting and exceeding the goal	None identified		
Utilize Master Plan: no update at this time, planning in progress			Senior leaders will meet to discuss priorities.
Marketing plan is focusing on nutrition and sharing our successes, on target to meet goal	None identified		
Chronic Care Management is working toward increasing Medicare annual wellness visits. Goal is exceeded as of 12/4/2024.	None identified		

Financial Stewardship Pillar - Last Updated March 14, 2025

Objective/Initiative	Baseline	Target Goal	Stretch Goal	CY 2024 Outcome	Goal Re-evaluation planned	Target Goal	Stretch Goal	**CY 2025 YTD**
Improve Days of Cash on Hand by 10% each year for three years	1/1/24 = 110.9	FY25 = 119	125	110 days	No change, inline to meet FY goal	FY26 = 131, FY27 = 144		**102**
Reduce and maintain Days in A/R to 45 days by the end of 2024	CY 24 Jan-Jul Average 63 days	54 days	45 by 12/31/27	75 *estimated With Medicare claims removed from A/R, the estimated 58 days	Change target goal to 54 days by FY25	54 days by 6/30/25		**81.29**
Maintain the level of claims denials at state and national benchmarks	CY 24 Apr-June 24.7%	(target goal <15% by end of FY 2025)	<12% by end of FY25	14%	Goal may be reevaluated once clear reporting is available	Less than 15% by June 30, 2024	(7%)	**11%**

Objective/Initiative	Baseline	Target Goal	Stretch Goal	CY 2024 Outcome	Goal Re-evaluation planned	Target Goal	Stretch Goal	**CY 2025 YTD**
Reduce and maintain Days Not Final Billed (DNFB)	CY 24 Jan-Aug Average 10.1 days	5 days	< 5 days by end of FY25	31.7 (with Medicare claims removed from DNFB, the number is estimated at 4.79 days)	Due to CAH conversion, held Medicare claims have overstated this ratio. Once claims are billed, we should be on track to meet goal.	On hold until letter received from Noridian		**32** **With Medicare claims removed 5.6 days**
Build the MHSC County Maintenance Fund to $2,000,000 by the end of three years / Work with the County Commissioners to set annual budget to achieve $2,000,000 goal over three-year strategic plan and still allow for adequate funds in annual budget for routine maintenance	7/1/2024 $500,000 rolled over	$2,000,000 by the end of three years	Intermediate goal - $1 million by 06/30/25	Funds cannot be rolled over until the end of the fiscal year.	Pending property tax legislation			
Build and maintain the building fund to the amount of depreciation expense by the end of three years / Supplement the building fund from monthly, quarterly, or annual contributions from cash flow from operations to achieve the total amount of depreciation expense by the end of three-year strategic plan	6/30/2024 $7,000,000	amount of depreciation expense by the end of three years	Intermediate goal - $8 million by 06/30/25. $9 M by 6/30/26. $10 M by 06/30/27 and 12/31/27. Stretch - $12M by 12/31/27	$7,447,000 as of 12/31/24	No change	Intermediate goal - $8 million by 06/30/25. $9 M by 6/30/26. $10 M by 06/30/27 and 12/31/27.	Stretch - $12M by 12/31/27	**$7.4 million**
Decrease the number of Nursing and Respiratory Therapy travel staff by 30%, per year for three years Nursing leadership will work with Human Resources to recruit and retain permanent staff and reduce travel staff by 30% per year	CY 2023 RT/RN staff 17 total	RT/RN Staff 11.9 total	RT/RN Staff 11 total	21 total 1 RT and 20 RN	January 2025	RT/RN staff 11 total	RT/RN Staff 9 total	**16 total** **1 RT and 15 RN**
Additional goal contract staff expenditure total less in total for CY 2024 compared to CY2023	CY 2023 Jan- Dec $4,233,263.17	NA	NA	CY 2024 (Jan-Nov) *Dec financials not ready $3,795,535.48	January 2025			

Accomplishments	Issues	Impact	Action Plan
Improve days of cash on hand	Slow release of billing with CAH Medicare Number	Altering the current amount of days of cash on hand	
Reduce and maintain Days in A/R	Slow release of billing with CAH Medicare Number	Altering current number of days in AR	
Maintain the level of claims denials	No identified issues		
Reduce and maintain Days Not Final Billed: DNFB split into HIM and PFS cases	Slow release of billing with CAH Medicare Number	Altering current number of days in AR	
Build the MHSC County Maintenance Fund		Pending property tax legislation may change this initiative	Request for carryover funds will be made in April 2025
Accomplishments	**Issues**	**Impact**	**Action Plan**
Build and maintain the building fund: receipt of QRA funds helped replenish the building fund.	Conversion to Critical Access billing held since Oct. 1		
Decrease the number of Nursing and Respiratory Therapy travel staff**:** Contracted with Linked-In Targeted adds with Indeed Targeted Facebook adds	National staffing shortages. Colleges are not seeing the same level of enrollment or limited capacity for students.	Not having travel staff for Med Surg, this will have 3 RNs for day/night shift and limit bed capacity to 15 patients.	Continue to "grow our own" through scholarships. Cross-training Preceptor incentive NEMO program for new nurses to have mentors
Alignment of individual departmental performance improvement projects (PIPS) has identified two additional areas for financial stewardship.	None identified		Surgical Services – working on endo room turnover times, nearing goal Patient Navigation – working on a self-pay project, meeting goal

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

NARRATIVE TO MARCH 2025 FINANCIAL STATEMENTS

THE BOTTOM LINE. The bottom line from operations for March is a loss of $177,968 compared to a gain of $426,540 in the budget. This yields a -1.61% operating margin for the month compared to 3.67% in the budget. The year-to-date operating gain is $1,878,096 compared to a gain of $1,976,861 in the budget. The year-to-date operating margin is 1.84%, compared to 1.92% in the budget.

Year-to-date, the total net gain is $4,017,377, compared to a total net gain of $4,754,703 in the budget. This represents a profit margin of 3.95% compared to 4.61% in the budget.

REVENUE. Revenue decreased again in March coming in at $22,850,422, under budget by $1,420,499. Inpatient revenue is $3,617,679 under budget by $834,971 and outpatient revenue is $19,232,743, under budget by $585,528. Year-to-date, gross revenue is under budget by $2,070,206 and net operating revenue is under budget by $1,392,106. The largest percentage variances for revenue to budget comparison came from the following hospital departments:

Nuclear Medicine – 19%
Medical Oncology – 56%
Cardiac Rehab – 77%
Behavioral Health – 201%
Pet Scan – 38%
Dietitians – 106%

Sleep Lab – (22%)
Echocardiography (22%)
Specialty Clinics – (23%)

REDUCTION OF REVENUE. Deductions from revenue are estimated at 52.3%, slightly under budget for the month. The year-to-date reduction of revenue is 52.9%, right on budget. At the end of March, we were holding $18 million in unbilled Medicare claims plus another $8 million of claims being held by Medicare as they process the new billing number. Total AR decreased by $2.5 million as we started to see old and new Medicare claims process. Changes by payer are below:

Medicare – decrease $4,218,000
Medicaid – increase $1,439,000
Blue Cross – increase $1,039,000
Commercial – decrease $165,000
Government – increase $21,000
Self-Pay – decrease $975,000
Worker's Comp – decrease $4,000

Total collections for the month came in much higher this month, at $10.5 million, 94% of net patient revenue, below the monthly goal. Year-to-date collections increased to 89.7% of net patient revenue. The goal for collections as a percentage of net revenue is ≥ 100%.

NET OPERATING REVENUE. Total net operating revenue is $11,036,439 in March and $101,822,950 year-to-date, under budget by $1,392,106. Other operating revenue in

March includes county maintenance, occupational medicine revenue and cafeteria revenue.

RATIOS. Annual Debt Service Coverage is 5.74 for March. Days of Cash on Hand decreased by two days to 94 days for March. Daily cash expense decreased slightly to $337,900 year-to-date. Net days in AR increased to 72.38 days.

VOLUME. Inpatient discharges, patient days and births were under budget for March. The average daily census (ADC) decreased to 12.6, under the budget for the month, and average length of stay (LOS) decreased to 2.9, right at budget. ER visits, Outpatient visits and Clinic visits came in over budget, Surgeries were under budget.

EXPENSES. Total expenses came in close to budget, at $11,214,406, over budget by $34,339. Expenses remain under budget for the year by $1,293,341. The following line items were over budget in March:

Salaries & Wages – Salaries were over budget in March but remain under budget year-to-date. Paid FTEs are under budget 11.32 in March and 22.36 year-to-date.

Contract Labor - Contract labor for Medical Floor, Surgical Services, and Ultrasound are over budget in March. There is unbudgeted contract labor cost in Laboratory, Respiratory, and Physical Therapy as we continue to recruit permanent staff.

Physician Fees – Hospitalist locum fees and Sleep Lab and Cardiopulmonary physician fees were over budget for March.

Other Purchased Services – Advertising, bank card fees, collection agency, imaging services, IT professional fees and department management services were all over budget for the month.

Repairs and Maintenance – Annual Microsoft licensing support contracts were trued up in March.

Other Operating Expenses – Physician recruitment, employee recruitment and pharmacy floor expenses were over budget in March.

Leases and Rentals – Equipment leases were over budget due to the extension of the surgery Mako lease contract, with the plan to purchase before year end.

Depreciation and Amortization – Amortization expenses are over budget in March for GASB lease adjustments.

PROVIDER CLINICS. Revenue for the Clinics decreased slightly in March, coming in at $3,007,057, under budget by $252,739 for the month but remaining over budget year-to-date by $112,506. Clinic volumes decreased slightly from February to 6,955

visits. Total Clinic expenses for March are $2,250,701, over budget by $26,317 for the month and under budget by $85,882 year-to-date. Salaries, supplies, professional liability, pharmacy floor and depreciation are over budget for March.

OUTLOOK FOR APRIL. Gross patient revenue is projected higher in April at $23.9 million, right at the budget of $23.9 million. Inpatient admissions, patient days and births are expected to be close to budget for the month. LOS is currently lower at 2.3 days and the average daily census is at 11.7. Outpatient visits, including ER visits, Clinic and Surgeries are all projected over budget for the month, with Lab and Imaging slightly under budget.

Collections are projecting significantly higher in April, around $14 million as we start to see Medicare payments coming in. We expect to keep deductions of revenue stable as we work through delayed Medicare claims. Expenses are expected to come in at budget in April. With the higher revenue in April, the estimated bottom line for April should be a slight gain for the month.

CRITICAL ACCESS. We released about $18 million in Medicare claims the week of March 6 and were notified on March 17 that the claims had started processing. We started receiving payments in the first week of March. We have released all of the CAH claims and have verified reimbursements at the cost to charge ratios as stated in our Noridian rate letter. With payments starting to come in, we have started to see the positive impact to both Days in AR and Days Cash on Hand in April. We are still waiting on the State for their CAH survey.

Strategic Plan - Finance Pillar. The objectives of the finance pillar of the new Strategic Plan were created around the Clifton Larsen Allen revenue cycle paired advisory support project. We will continue to track the issues from CLA project and share with the Committee. The Strategic Plan objectives are also tracked on the Financial Goal graphs included in the Finance packet and on stoplight reports which report through the Quality Committee.

For fiscal year 2025, we continue to focus on the following revenue cycle metrics:

- Days Cash on Hand
- DNFB Days – Discharged Not Final Billed Days
- Total Days in AR
- Denials
- Accounts Receivable aging – Total and By Payer
- Cash Collections

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WY

Unaudited Financial Statements

for

Nine months ending March 31, 2025

Certification Statement:

To the best of my knowledge, I certify for the hospital that the attached financial statements do not contain any untrue statement of a material fact or omit to state a material fact that would make the financial statements misleading. I further certify that the financial statements present in all material respects the financial condition and results of operation of the hospital and all related organizations reported herein.

Certified by:

Tami Love

Chief Financial Officer

TABLE OF CONTENTS

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

EXECUTIVE FINANCIAL SUMMARY

Nine months ending March 31, 2025

BALANCE SHEET

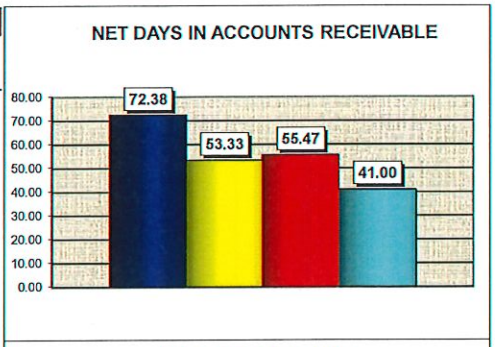
	YTD 3/31/2025	Prior FYE 6/30/2024
ASSETS		
Current Assets	$46,753,143	$43,911,479
Assets Whose Use is Limited	23,345,024	23,098,589
Property, Plant & Equipment (Net)	72,809,720	74,279,500
Other Assets	844,176	898,060
Total Unrestricted Assets	**143,752,063**	**142,187,628**
Restricted Assets	561,084	474,171
Total Assets	**$144,313,147**	**$142,661,800**
LIABILITIES AND NET ASSETS		
Current Liabilities	$15,552,843	$16,058,606
Long-Term Debt	22,284,375	23,506,667
Other Long-Term Liabilities	10,108,538	10,833,425
Total Liabilities	**47,945,756**	**50,398,698**
Net Assets	96,367,391	92,263,102
Total Liabilities and Net Assets	**$144,313,147**	**$142,661,800**

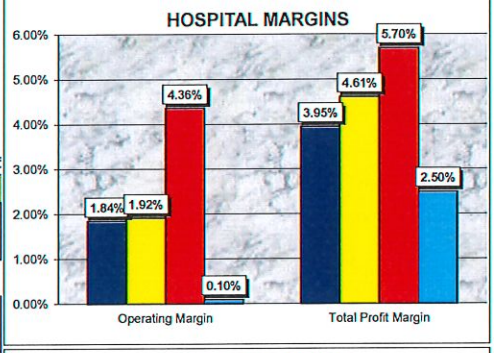
STATEMENT OF REVENUE AND EXPENSES - YTD

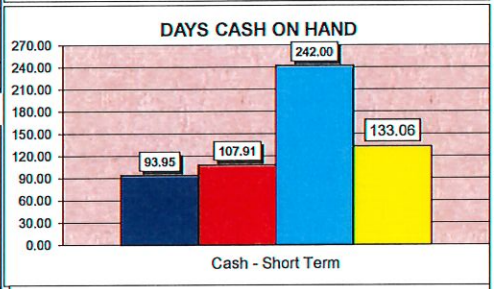
	03/31/25 ACTUAL	*03/31/25 BUDGET*	*YTD ACTUAL*	*YTD BUDGET*
Revenue:				
Gross Patient Revenues	$22,850,422	$24,270,920	$213,638,765	$215,708,971
Deductions From Revenue	(11,943,818)	(12,838,089)	(113,088,974)	(114,311,492)
Net Patient Revenues	10,906,603	11,432,832	100,549,791	101,397,479
Other Operating Revenue	129,835	173,775	1,273,159	1,817,576
Total Operating Revenues	**11,036,439**	**11,606,606**	**101,822,950**	**103,215,056**
Expenses:				
Salaries, Benefits & Contract Labor	6,391,569	6,257,888	56,020,605	56,444,459
Purchased Serv. & Physician Fees	1,217,391	1,054,598	10,667,706	9,947,541
Supply and Drug Expenses	1,605,265	1,991,732	16,832,980	17,634,715
Other Operating Expenses	1,085,838	1,003,263	8,418,817	9,226,556
Bad Debt Expense	0	0	0	0
Depreciation & Interest Expense	914,343	872,586	8,004,747	7,984,923
Total Expenses	**11,214,406**	**11,180,067**	**99,944,854**	**101,238,195**
NET OPERATING SURPLUS	**(177,968)**	**426,540**	**1,878,096**	**1,976,861**
Non-Operating Revenue/(Exp.)	33,546	1,001,344	2,139,281	2,777,843
TOTAL NET SURPLUS	**($144,422)**	**$1,427,884**	**$4,017,377**	**$4,754,703**

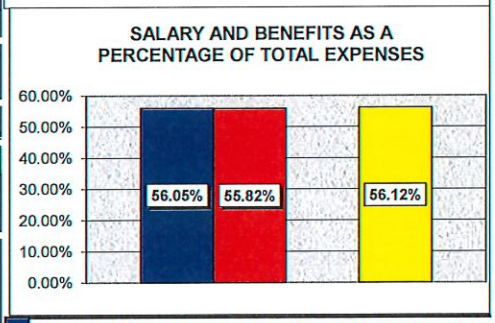
KEY STATISTICS AND RATIOS

	03/31/25 ACTUAL	*03/31/25 BUDGET*	*YTD ACTUAL*	*YTD BUDGET*
Total Acute Patient Days	391	432	3,424	3,810
Average Acute Length of Stay	2.9	3.0	3.2	3.2
Total Emergency Room Visits	1,367	1,265	12,722	12,124
Outpatient Visits	8,455	8,153	76,418	74,682
Total Surgeries	182	199	1,801	1,625
Total Worked FTE's	510.28	521.15	498.50	521.15
Total Paid FTE's	559.77	571.09	548.73	571.09
Net Revenue Change from Prior Yr	1.63%	6.88%	4.99%	6.42%
EBIDA - 12 Month Rolling Average			9.77%	9.65%
Current Ratio			3.01	
Days Expense in Accounts Payable			33.97	









MEMORIAL HOSPITAL OF SWEETWATER COUNTY	
Budget	03/31/25
Prior Fiscal Year End	06/30/24
CLA $50-$100M Net Revenue	6/30/2020

FINANCIAL STRENGTH INDEX - 0.92

Excellent - Greater than 3.0 Good - 3.0 to 0.0
Fair - 0.0 to (2.0) Poor - Less than (2.0)

Key Financial Ratios

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Nine months ending March 31, 2025

⇩⇧ - DESIRED POSITION IN RELATION TO BENCHMARKS AND BUDGET

		Year to Date 3/31/2025	Budget 6/30/2025	Prior Fiscal Year End 06/30/24	CLA $50-$100 MM Net Revenue (See Note 1)
Profitability:					
Operating Margin	⇧	1.84%	1.47%	4.36%	0.10%
Total Profit Margin	⇧	3.95%	4.61%	5.70%	2.50%
Liquidity:					
Days Cash, All Sources **	⇧	93.95	133.06	107.91	242.00
Net Days in Accounts Receivable	⇩	72.38	53.33	55.47	41.00
Capital Structure:					
Average Age of Plant (Annualized)	⇩	12.46	11.59	11.61	12.00
Long Term Debt to Capitalization	⇩	19.19%	17.97%	20.74%	27.00%
Debt Service Coverage Ratio **	⇧	5.74	3.60	5.84	2.80
Productivity and Efficiency:					
Paid FTE's per Adjusted Occupied Bed	⇩	7.13	8.14	6.76	NA
Salary Expense per Paid FTE		$106,624	$106,348	$105,036	NA
Salary and Benefits as a % of Total Operating Exp		56.05%	56.12%	55.82%	NA
Employee Benefits %		30.04%	30.75%	30.97%	22.98%
Supply Expense Per Adj. Discharge		$2,525	$2,865	$2,510	$1,270

	YTD - Actual 3/31/2025	Prior FYE 6/30/2024
Other Ratios:		
Gross Days in Accounts Receivable	87.42	64.59
Net Revenue per Adjusted Discharge	$15,275	$14,822
Operating Expenses per Adj. Discharge	$14,993	$14,176

Note 1 - 2020 CLA Benchmark-$50M-$100M net patient service revenue

****Bond Covenant ratio is 65 Days Cash on Hand and 1.0-1.25 Debt Service Coverage**

Balance Sheet - Assets

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WY
Nine months ending March 31, 2025

	Current Month 3/31/2025	Prior Month 2/28/2025	ASSETS Positive/ (Negative) Variance	Percentage Variance	Prior Year End 6/30/2024
Current Assets					
Cash and Cash Equivalents	$9,451,801	$10,287,915	($836,114)	-8.13%	$12,428,264
Gross Patient Accounts Receivable	68,369,970	70,901,971	(2,532,001)	-3.57%	50,557,292
Less: Bad Debt and Allowance Reserves	(41,416,501)	(43,971,237)	2,554,736	5.81%	(30,463,009)
Net Patient Accounts Receivable	26,953,470	26,930,734	22,735	0.08%	20,094,283
Interest Receivable	0	0	0	0.00%	0
Other Receivables	5,328,524	4,790,339	538,184	11.23%	6,209,096
Inventories	3,123,440	3,141,310	(17,870)		3,137,536
Prepaid Expenses	1,895,908	1,609,806	286,103	17.77%	2,042,300
Due From Third Party Payers	0	0	0	0.00%	0
Due From Affiliates/Related Organizations	0	0	0	0.00%	0
Other Current Assets	0	0	0	0.00%	0
Total Current Assets	**46,753,143**	**46,760,104**	**(6,961)**	**-0.01%**	**43,911,479**
Assets Whose Use is Limited					
Cash	134,546	130,332	4,214	3.23%	(123,123)
Investments	0	0	0	0.00%	0
Bond Reserve/Debt Retirement Fund	0	0	0	0.00%	0
Trustee Held Funds - Project	1,051,019	1,156,199	(105,180)	-9.10%	1,585,606
Trustee Held Funds - SPT	0	0	0	0.00%	0
Board Designated Funds	7,544,581	7,518,547	26,034	0.35%	7,021,234
Other Limited Use Assets	14,614,878	14,614,878	1	0.00%	14,614,873
Total Limited Use Assets	**23,345,024**	**23,419,955**	**(74,931)**	**-0.32%**	**23,098,589**
Property, Plant, and Equipment					
Land and Land Improvements	4,583,118	4,583,118	0	0.00%	4,583,118
Building and Building Improvements	51,845,600	51,819,938	25,662	0.05%	51,482,921
Equipment	141,792,252	140,337,661	1,454,591	1.04%	138,741,400
Construction In Progress	4,353,465	3,711,893	641,572	17.28%	1,630,998
Capitalized Interest	0	0	0	0.00%	0
Gross Property, Plant, and Equipment	202,574,435	200,452,609	2,121,826	1.06%	196,438,437
Less: Accumulated Depreciation	(129,764,715)	(128,882,062)	(882,653)	-0.68%	(122,158,937)
Net Property, Plant, and Equipment	**72,809,720**	**71,570,547**	**1,239,173**	**1.73%**	**74,279,500**
Other Assets					
Unamortized Loan Costs	844,176	850,163	(5,987)	-0.70%	898,060
Other	0	0	0	0.00%	0
Total Other Assets	**844,176**	**850,163**	**(5,987)**	**-0.70%**	**898,060**
TOTAL UNRESTRICTED ASSETS	**143,752,063**	**142,600,769**	**1,151,294**	**0.81%**	**142,187,628**
Restricted Assets	561,084	554,373	6,710	1.21%	474,171
TOTAL ASSETS	**$144,313,147**	**$143,155,143**	**$1,158,004**	**0.81%**	**$142,661,800**

Balance Sheet - Liabilities and Net Assets

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WY
Nine months ending March 31, 2025

	LIABILITIES AND FUND BALANCE				
	Current Month 3/31/2025	Prior Month 2/28/2025	Positive/ (Negative) Variance	Percentage Variance	Prior Year End 6/30/2024
Current Liabilities					
Accounts Payable	$6,597,635	$5,540,929	($1,056,707)	-19.07%	$5,686,582
Notes and Loans Payable	0	0	0	0.00%	0
Accrued Payroll	1,858,147	1,341,175	(516,972)	-38.55%	2,304,822
Accrued Payroll Taxes	0	0	0	0.00%	0
Accrued Benefits	3,372,150	3,341,412	(30,738)		3,113,427
Accrued Pension Expense (Current Portion)	0	0	0	0.00%	0
Other Accrued Expenses	0	0	0	0.00%	0
Patient Refunds Payable	0	0	0	0.00%	0
Property Tax Payable	0	0	0	0.00%	0
Due to Third Party Payers	0	0	0	0.00%	0
Advances From Third Party Payers	0	0	0	0.00%	0
Current Portion of LTD	2,725,551	2,898,295	172,745	5.96%	3,386,824
Other Current Liabilities	999,360	1,107,832	108,472	9.79%	1,566,951
Total Current Liabilities	**15,552,843**	**14,229,642**	**(1,323,200)**	**-9.30%**	**16,058,606**
Long Term Debt					
Bonds/Mortgages Payable	25,009,926	25,317,876	307,950	1.22%	26,893,490
Leases Payable	0	0	0	0.00%	0
Less: Current Portion Of Long Term Debt	2,725,551	2,898,295	172,745	5.96%	3,386,824
Total Long Term Debt (Net of Current)	**22,284,375**	**22,419,581**	**135,205**	**0.60%**	**23,506,667**
Other Long Term Liabilities					
Deferred Revenue	0	0	0	0.00%	0
Accrued Pension Expense (Net of Current)	0	0	0	0.00%	0
Other	10,108,538	10,000,818	(107,721)	-1.08%	10,833,425
Total Other Long Term Liabilities	**10,108,538**	**10,000,818**	**(107,721)**	**-1.08%**	**10,833,425**
TOTAL LIABILITIES	**47,945,756**	**46,650,041**	**(1,295,716)**	**-2.78%**	**50,398,698**
Net Assets:					
Unrestricted Fund Balance	89,833,683	89,833,683	0	0.00%	82,391,633
Temporarily Restricted Fund Balance	1,959,119	1,959,119	0	0.00%	1,959,119
Restricted Fund Balance	557,211	550,501	(6,710)	-1.22%	470,299
Net Revenue/(Expenses)	4,017,377	4,161,798	N/A	N/A	7,442,051
TOTAL NET ASSETS	**96,367,391**	**96,505,102**	**137,711**	**0.14%**	**92,263,102**
TOTAL LIABILITIES AND NET ASSETS	**$144,313,147**	**$143,155,143**	**($1,158,004)**	**-0.81%**	**$142,661,800**

Statement of Revenue and Expense

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Nine months ending March 31, 2025

	CURRENT MONTH				
	Actual 03/31/25	Budget 03/31/25	Positive (Negative) Variance	Percentage Variance	Prior Year 03/31/24
Gross Patient Revenue					
Inpatient Revenue	$3,617,679	$4,452,649	($834,971)	-18.75%	$4,236,296
Outpatient Revenue	16,225,685	16,558,474	(332,789)	-2.01%	15,459,637
Clinic Revenue	3,007,057	3,259,797	(252,739)	-7.75%	3,031,288
Specialty Clinic Revenue	0	0	0	0.00%	0
Total Gross Patient Revenue	22,850,422	24,270,920	(1,420,499)	-5.85%	22,727,221
Deductions From Revenue					
Discounts and Allowances	(10,170,301)	(11,164,715)	994,414	8.91%	(10,397,914)
Bad Debt Expense (Governmental Providers Only)	(1,711,294)	(1,434,320)	(276,974)	-19.31%	(1,508,964)
Medical Assistance	(62,223)	(239,053)	176,830	73.97%	(89,904)
Total Deductions From Revenue	(11,943,818)	(12,838,089)	894,270	6.97%	(11,996,782)
Net Patient Revenue	10,906,603	11,432,832	(526,228)	-4.60%	10,730,439
Other Operating Revenue	129,835	173,775	(43,940)	-25.29%	128,902
Total Operating Revenue	**11,036,439**	**11,606,606**	**(570,168)**	**-4.91%**	**10,859,341**
Operating Expenses					
Salaries and Wages	4,708,174	4,571,610	(136,565)	-2.99%	4,151,633
Fringe Benefits	1,352,195	1,435,279	83,084	5.79%	1,751,548
Contract Labor	331,200	251,000	(80,200)	-31.95%	284,184
Physicians Fees	450,781	360,246	(90,535)	-25.13%	243,692
Purchased Services	766,610	694,352	(72,258)	-10.41%	773,560
Drug Expense	845,045	1,015,114	170,068	16.75%	823,901
Supply Expense	760,219	976,618	216,399	22.16%	853,767
Utilities	105,079	130,590	25,511	19.54%	123,306
Repairs and Maintenance	476,252	467,144	(9,108)	-1.95%	359,588
Insurance Expense	104,197	107,291	3,094	2.88%	71,334
All Other Operating Expenses	341,109	276,903	(64,206)	-23.19%	216,298
Bad Debt Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Leases and Rentals	59,201	21,335	(37,866)	-177.48%	48,301
Depreciation and Amortization	914,343	872,586	(41,757)	-4.79%	885,626
Interest Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Total Operating Expenses	**11,214,406**	**11,180,067**	**(34,339)**	**-0.31%**	**10,586,737**
Net Operating Surplus/(Loss)	**(177,968)**	**426,540**	**(604,507)**	**-141.72%**	**272,604**
Non-Operating Revenue:					
Contributions	0	0	0	0.00%	0
Investment Income	60,251	19,357	40,895	211.27%	52,083
Tax Subsidies (Except for GO Bond Subsidies)	0	0	0	0.00%	0
Tax Subsidies for GO Bonds	0	0	0	0.00%	0
Interest Expense (Governmental Providers Only)	(77,888)	(70,472)	7,417	-10.52%	(71,778)
Other Non-Operating Revenue/(Expenses)	51,183	1,052,459	(1,001,276)	-95.14%	593,094
Total Non Operating Revenue/(Expense)	**33,546**	**1,001,344**	**(967,798)**	**-96.65%**	**573,399**
Total Net Surplus/(Loss)	**($144,422)**	**$1,427,884**	**($1,572,305)**	**-110.11%**	**$846,003**
Change in Unrealized Gains/(Losses) on Investments	0	0	0	0.00%	0
Increase/(Decrease in Unrestricted Net Assets	**($144,422)**	**$1,427,884**	**($1,572,305)**	**-110.11%**	**$846,003**
Operating Margin	**-1.61%**	**3.67%**			**2.51%**
Total Profit Margin	**-1.31%**	**12.30%**			**7.79%**
EBIDA	**6.67%**	**11.19%**			**10.67%**

Statement of Revenue and Expense

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WY
Nine months ending March 31, 2025

	YEAR-TO-DATE				
	Actual 03/31/25	Budget 03/31/25	Positive (Negative) Variance	Percentage Variance	Prior Year 03/31/24
Gross Patient Revenue					
Inpatient Revenue	$34,708,819	$39,202,271	($4,493,452)	-11.46%	$37,295,164
Outpatient Revenue	151,737,942	149,427,202	2,310,740	1.55%	139,732,412
Clinic Revenue	27,192,003	27,079,498	112,506	0.42%	24,574,773
Specialty Clinic Revenue	0	0	0	0.00%	0
Total Gross Patient Revenue	213,638,765	215,708,971	(2,070,206)	-0.96%	201,602,349
Deductions From Revenue					
Discounts and Allowances	(94,838,704)	(99,251,132)	4,412,428	4.45%	(92,520,452)
Bad Debt Expense (Governmental Providers Only)	(17,849,671)	(12,908,880)	(4,940,790)	-38.27%	(12,494,882)
Medical Assistance	(400,599)	(2,151,480)	1,750,881	81.38%	(1,162,882)
Total Deductions From Revenue	(113,088,974)	(114,311,492)	1,222,518	1.07%	(106,178,216)
Net Patient Revenue	100,549,791	101,397,479	(847,688)	-0.84%	95,424,133
Other Operating Revenue	1,273,159	1,817,576	(544,417)	-29.95%	1,562,093
Total Operating Revenue	**101,822,950**	**103,215,056**	**(1,392,106)**	**-1.35%**	**96,986,225**
Operating Expenses					
Salaries and Wages	40,274,474	40,950,706	676,232	1.65%	36,814,285
Fringe Benefits	12,099,852	12,545,553	445,701	3.55%	11,284,370
Contract Labor	3,646,278	2,948,200	(698,078)	-23.68%	3,033,345
Physicians Fees	4,046,323	3,394,116	(652,207)	-19.22%	2,658,739
Purchased Services	6,621,383	6,553,425	(67,958)	-1.04%	5,870,979
Drug Expense	8,857,509	9,136,024	278,515	3.05%	8,672,664
Supply Expense	7,975,472	8,498,691	523,219	6.16%	7,837,290
Utilities	1,041,855	1,155,133	113,278	9.81%	1,075,589
Repairs and Maintenance	3,587,595	4,072,355	484,761	11.90%	3,614,886
Insurance Expense	895,686	965,617	69,931	7.24%	623,462
All Other Operating Expenses	2,525,982	2,750,015	224,033	8.15%	2,245,021
Bad Debt Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Leases and Rentals	367,699	283,436	(84,264)	-29.73%	326,243
Depreciation and Amortization	8,004,747	7,984,923	(19,823)	-0.25%	7,831,255
Interest Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Total Operating Expenses	**99,944,854**	**101,238,195**	**1,293,341**	**1.28%**	**91,888,129**
Net Operating Surplus/(Loss)	**1,878,096**	**1,976,861**	**(98,765)**	**-5.00%**	**5,098,097**
Non-Operating Revenue:					
Contributions	0	0	0	0.00%	0
Investment Income	546,735	174,209	372,527	213.84%	353,653
Tax Subsidies (Except for GO Bond Subsidies)	0	0	0	0.00%	0
Tax Subsidies for GO Bonds	0	0	0	0.00%	0
Interest Expense (Governmental Providers Only)	(647,111)	(645,388)	(1,723)	0.27%	(555,924)
Other Non-Operating Revenue/(Expense)	2,239,657	3,249,022	(1,009,365)	-31.07%	1,221,327
Total Non Operating Revenue/(Expense)	**2,139,281**	**2,777,843**	**(638,561)**	**-22.99%**	**1,019,056**
Total Net Surplus/(Loss)	**$4,017,377**	**$4,754,703**	**($737,326)**	**-15.51%**	**$6,117,152**
Change in Unrealized Gains/(Losses) on Investments	0	0	0	0.00%	0
Increase/(Decrease) in Unrestricted Net Assets	**$4,017,377**	**$4,754,703**	**($737,326)**	**-15.51%**	**$6,117,152**
Operating Margin	**1.84%**	**1.92%**			**5.26%**
Total Profit Margin	**3.95%**	**4.61%**			**6.31%**
EBIDA	**9.71%**	**9.65%**			**13.33%**

Statement of Revenue and Expense - 13 Month Trend

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

	Actual 3/31/2025	Actual 2/28/2025	Actual 1/31/2025	Actual 12/31/2024	Actual 11/30/2024	Actual 10/31/2024
Gross Patient Revenue						
Inpatient Revenue	$3,617,679	$3,352,717	$4,614,671	$3,452,968	$3,449,680	$3,942,476
Inpatient Psych/Rehab Revenue						
Outpatient Revenue	$16,225,685	$16,835,749	$16,547,834	$17,310,090	$17,514,374	$17,231,477
Clinic Revenue	$3,007,057	$3,101,927	$3,082,203	$3,035,731	$2,897,570	$3,305,125
Specialty Clinic Revenue	$0	$0	$0	$0	$0	$0
Total Gross Patient Revenue	$22,850,422	$23,290,393	$24,244,707	$23,798,789	$23,861,624	$24,479,078
Deductions From Revenue						
Discounts and Allowances	$10,170,301	$10,412,140	$10,734,129	$10,310,868	$10,536,882	$11,073,864
Bad Debt Expense (Governmental Providers Only)	$1,711,294	$1,874,592	$1,883,492	$2,085,286	$1,931,492	$2,142,747
Charity Care	$62,223	$22,474	$0	$43,958	$196,269	$16,694
Total Deductions From Revenue	11,943,818	12,309,206	12,617,621	12,440,113	12,664,643	13,233,305
Net Patient Revenue	$10,906,603	$10,981,187	$11,627,087	$11,358,676	$11,196,982	$11,245,773
Other Operating Revenue	129,835	94,606	155,214	135,830	112,512	149,639
Total Operating Revenue	**11,036,439**	**11,075,793**	**11,782,301**	**11,494,506**	**11,309,494**	**11,395,412**
Operating Expenses						
Salaries and Wages	$4,708,174	$4,318,369	$4,566,303	$4,498,489	$4,538,204	$4,414,210
Fringe Benefits	$1,352,195	$1,347,844	$1,603,417	$1,168,648	$1,388,682	$1,324,180
Contract Labor	$331,200	$326,025	$421,623	$380,117	$429,054	$454,213
Physicians Fees	$450,781	$510,272	$504,153	$615,730	$480,276	$372,688
Purchased Services	$766,610	$679,822	$902,276	$676,971	$759,193	$758,597
Drug Expense	$845,045	$921,807	$1,097,040	$973,483	$1,172,392	$980,355
Supply Expense	$760,219	$872,534	$865,849	$1,010,481	$806,083	$899,196
Utilities	$105,079	$118,660	$124,009	$114,124	$111,144	$122,431
Repairs and Maintenance	$476,252	$406,347	$388,570	$421,801	$352,225	$414,564
Insurance Expense	$104,197	$102,247	$99,766	$99,122	$100,220	$97,214
All Other Operating Expenses	$341,109	$248,371	$273,245	$221,366	$249,418	$292,699
Bad Debt Expense (Non-Governmental Providers)						
Leases and Rentals	$59,201	$37,770	$33,862	$42,299	$33,335	$35,124
Depreciation and Amortization	$914,343	$877,351	$879,381	$885,148	$884,329	$884,208
Interest Expense (Non-Governmental Providers)						
Total Operating Expenses	**$11,214,406**	**$10,767,420**	**$11,759,494**	**$11,107,778**	**$11,304,556**	**$11,049,677**
Net Operating Surplus/(Loss)	**($177,968)**	**$308,374**	**$22,807**	**$386,729**	**$4,937**	**$345,735**
Non-Operating Revenue:						
Contributions						
Investment Income	60,251	55,248	62,133	61,976	34,611	86,954
Tax Subsidies (Except for GO Bond Subsidies)						
Tax Subsidies for GO Bonds	0	0	0	0	0	0
Interest Expense (Governmental Providers Only)	(77,888)	(67,140)	(74,030)	(75,865)	(69,734)	(70,257)
Other Non-Operating Revenue/(Expenses)	51,183	562,205	1,041,386	25,444	436,535	20,369
Total Non Operating Revenue/(Expense)	**$33,546**	**$550,312**	**$1,029,490**	**$11,555**	**$401,412**	**$37,066**
Total Net Surplus/(Loss)	**($144,422)**	**$858,686**	**$1,052,297**	**$398,284**	**$406,350**	**$382,802**
Change in Unrealized Gains/(Losses) on Investment	0	0	0	0	0	0
Increase/(Decrease in Unrestricted Net Assets	**($144,422)**	**$858,686**	**$1,052,297**	**$398,284**	**$406,350**	**$382,802**
Operating Margin	**-1.61%**	**2.78%**	**0.19%**	**3.36%**	**0.04%**	**3.03%**
Total Profit Margin	**-1.31%**	**7.75%**	**8.93%**	**3.46%**	**3.59%**	**3.36%**
EBIDA	**6.67%**	**10.71%**	**7.66%**	**11.07%**	**7.86%**	**10.79%**

Actual 9/30/2024	Actual 8/31/2024	Actual 7/31/2024	Actual 6/30/2024	Actual 5/31/2024	Actual 4/30/2024
$4,229,582	$3,815,950	$4,233,097	$3,753,329	$4,873,910	$3,666,923
$15,461,921	$16,307,549	$18,303,263	$16,025,677	$17,065,942	$16,587,785
$2,766,032	$3,030,522	$2,965,835	$2,909,994	$3,098,260	$3,244,931
$0	$0	$0	$0	$0	$0
$22,457,535	$23,154,021	$25,502,195	$22,689,001	$25,038,111	$23,499,639
$10,445,910	$10,358,617	$10,795,994	$10,263,890	$11,795,527	$11,571,869
$1,865,917	$1,630,927	$2,723,923	$2,000,964	$1,283,539	$1,043,471
$15,333	$36,283	$7,366	$241,325	$57,087	$2,736
12,327,160	12,025,826	13,527,282	12,506,179	13,136,153	12,618,076
$10,130,375	$11,128,195	$11,974,912	$10,182,821	$11,901,958	$10,881,563
68,378	91,198	335,946	305,556	131,038	163,765
10,198,753	**11,219,393**	**12,310,859**	**10,488,378**	**12,032,996**	**11,045,328**
$4,421,373	$4,667,572	$4,141,780	$4,693,168	$4,203,693	$4,125,869
$1,138,750	$1,687,786	$1,088,350	$1,105,022	$1,677,550	$1,369,376
$393,537	$501,556	$408,954	$475,083	$543,862	$370,248
$294,647	$373,229	$444,547	$451,969	$389,941	$288,730
$739,663	$724,260	$613,991	$727,936	$691,394	$792,911
$904,747	$771,034	$1,191,605	$918,152	$1,125,459	$1,022,725
$984,579	$853,023	$923,507	$620,399	$956,733	$958,145
$116,368	$112,884	$117,156	$107,637	$122,860	$118,540
$337,361	$447,570	$342,905	$446,822	$367,427	$380,073
$97,214	$97,214	$98,493	$62,095	$135,140	$72,832
$308,900	$280,875	$310,000	$260,091	$253,110	$271,601
$40,673	$51,789	$33,647	$42,332	$36,108	$37,629
$889,405	$900,391	$890,190	$920,211	$946,935	$887,647
$10,667,216	**$11,469,184**	**$10,605,124**	**$10,830,915**	**$11,450,213**	**$10,696,326**
($468,463)	**($249,791)**	**$1,705,735**	**($342,537)**	**$582,783**	**$349,002**
49,266	63,735	72,561	133,266	282,618	56,673
0	0	0	0	0	0
(68,858)	(77,005)	(66,334)	(125,580)	(68,089)	(91,263)
16,560	20,984	69,457	515,404	15,619	17,003
($3,032)	**$7,713**	**$75,684**	**$523,090**	**$230,148**	**($17,587)**
($471,495)	**($242,078)**	**$1,781,419**	**$180,553**	**$812,931**	**$331,415**
0	0	0	59,257	272,726	0
($471,495)	**($242,078)**	**$1,781,419**	**$239,810**	**$1,085,657**	**$331,415**
-4.59%	**-2.23%**	**13.86%**	**-3.27%**	**4.84%**	**3.16%**
-4.62%	**-2.16%**	**14.47%**	**1.72%**	**6.76%**	**3.00%**
4.13%	**5.80%**	**21.09%**	**5.51%**	**12.71%**	**11.20%**

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Nine months ending March 31, 2025

	CASH FLOW	
	Current Month 3/31/2025	Current Year-To-Date 3/31/2025
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net Income (Loss)	($144,422)	$4,017,377
Adjustments to Reconcile Net Income to Net Cash Provided by Operating Activities:		
Depreciation	914,343	8,004,747
(Increase)/Decrease in Net Patient Accounts Receivable	(22,735)	(6,859,187)
(Increase)/Decrease in Other Receivables	(538,184)	880,573
(Increase)/Decrease in Inventories	17,870	14,096
(Increase)/Decrease in Pre-Paid Expenses	(286,103)	146,392
(Increase)/Decrease in Other Current Assets	0	0
Increase/(Decrease) in Accounts Payable	1,056,707	911,053
Increase/(Decrease) in Notes and Loans Payable	0	0
Increase/(Decrease) in Accrued Payroll and Benefits	547,710	(187,953)
Increase/(Decrease) in Accrued Expenses	0	0
Increase/(Decrease) in Patient Refunds Payable	0	0
Increase/(Decrease) in Third Party Advances/Liabilities	0	0
Increase/(Decrease) in Other Current Liabilities	(108,472)	(567,591)
Net Cash Provided by Operating Activities:	**1,436,714**	**6,359,507**
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of Property, Plant and Equipment	(2,153,516)	(6,534,967)
(Increase)/Decrease in Limited Use Cash and Investments	79,145	11,234
(Increase)/Decrease in Other Limited Use Assets	(4,214)	(257,669)
(Increase)/Decrease in Other Assets	5,987	53,884
Net Cash Used by Investing Activities	**(2,072,599)**	**(6,727,518)**
CASH FLOWS FROM FINANCING ACTIVITIES:		
Increase/(Decrease) in Bond/Mortgage Debt	(307,950)	(1,883,565)
Increase/(Decrease) in Capital Lease Debt	0	0
Increase/(Decrease) in Other Long Term Liabilities	107,721	(724,887)
Net Cash Used for Financing Activities	**(200,229)**	**(2,608,452)**
(INCREASE)/DECREASE IN RESTRICTED ASSETS	**(0)**	**(0)**
Net Increase/(Decrease) in Cash	**(836,114)**	**(2,976,463)**
Cash, Beginning of Period	10,287,915	12,428,264
Cash, End of Period	**$9,451,801**	**$9,451,801**

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Nine months ending March 31, 2025

Current Month					Year-To-Date			
Actual 03/31/25	Budget 03/31/25	Positive/ (Negative) Variance	Prior Year 03/31/24	STATISTICS	Actual 03/31/25	Budget 03/31/25	Positive/ (Negative) Variance	Prior Year 03/31/24
				Discharges				
135	142	(7)	142	Acute	1,083	1,209	(126)	1,209
135	142	(7)	142	Total Adult Discharges	1,083	1,209	(126)	1,209
45	50	(5)	50	Newborn	297	351	(54)	351
180	192	(12)	192	Total Discharges	1,380	1,560	(180)	1,560
				Patient Days:				
391	432	(41)	432	Acute	3,424	3,810	(386)	3,810
391	432	(41)	432	Total Adult Patient Days	3,424	3,810	(386)	3,810
84	80	4	80	Newborn	489	569	(80)	569
475	512	(37)	512	Total Patient Days	3,913	4,379	(466)	4,379
				Average Length of Stay (ALOS)				
2.9	3.0	(0.1)	3.0	Acute	3.2	3.2	0.0	3.2
2.9	3.0	(0.1)	3.0	Total Adult ALOS	3.2	3.2	0.0	3.2
1.9	1.6	0.3	1.6	Newborn ALOS	1.6	1.6	0.0	1.6
				Average Daily Census (ADC)				
12.6	13.9	(1.3)	13.9	Acute	12.5	13.9	(1.4)	13.9
12.6	13.9	(1.3)	13.9	Total Adult ADC	12.5	13.9	(1.4)	13.9
2.7	2.6	0.1	2.6	Newborn	1.8	2.1	(0.3)	2.1
				Emergency Room Statistics				
150	143	7	143	ER Visits - Admitted	1,215	1,264	(49)	1,264
1,217	1,122	95	1,122	ER Visits - Discharged	11,507	10,860	647	10,860
1,367	1,265	102	1,265	Total ER Visits	12,722	12,124	598	12,124
10.97%	11.30%		11.30%	% of ER Visits Admitted	9.55%	10.43%		10.43%
111.11%	100.70%		100.70%	ER Admissions as a % of Total	112.19%	104.55%		104.55%
				Outpatient Statistics:				
8,455	8,153	302	8,153	Total Outpatients Visits	76,418	74,682	1,736	74,682
273	134	139	134	Observation Bed Days	1,677	1,242	435	1,242
6,426	5,858	568	5,858	Clinic Visits - Primary Care	54,773	54,407	366	54,407
529	514	15	514	Clinic Visits - Specialty Clinics	5,191	4,746	445	4,746
45	53	(8)	53	IP Surgeries	561	476	85	476
137	146	(9)	146	OP Surgeries	1,240	1,149	91	1,149
				Productivity Statistics:				
510.28	521.15	(10.87)	474.23	FTE's - Worked	498.50	521.15	(22.65)	463.09
559.77	571.09	(11.32)	518.35	FTE's - Paid	548.73	571.09	(22.36)	512.41
1.4600	1.4500	0.01	1.4500	Case Mix Index -Medicare	1.4956	1.4896	0.01	1.4078
1.2800	1.0600	0.22	1.0600	Case Mix Index - All payers	1.2944	0.6731	0.62	1.1867

Accounts Receivable Tracking Report

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

03/31/25

	Current Month Actual	Current Month Target
Gross Days in Accounts Receivable - All Services	87.42	64.59
Net Days in Accounts Receivable	72.38	55.47
Number of Gross Days in Unbilled Revenue	31.15	3.0 or <
Number of Days Gross Revenue in Credit Balances	0.00	< 1.0
Self Pay as a Percentage of Total Receivables	14.38%	N/A
Charity Care as a % of Gross Patient Revenue - Current Month	0.27%	0.98%
Charity Care as a % of Gross Patient Revenue - Year-To-Date	0.19%	1.00%
Bad Debts as a % of Gross Patient Revenue - Current Month	7.49%	5.91%
Bad Debts as a % of Gross Patient Revenue - Year-To-Date	8.36%	5.98%
Collections as a Percentage of Net Revenue - Current Month	96.30%	100% or >
Collections as a Percentage of Net Revenue - Year-To-Date	79.24%	100% or >
Percentage of Blue Cross Receivable > 90 Days	4.85%	< 10%
Percentage of Insurance Receivable > 90 Days	25.33%	< 15%
Percentage of Medicaid Receivable > 90 Days	13.54%	< 20%
Percentage of Medicare Receivable > 60 Days	42.25%	< 6%

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WYOMING
Nine months ending March 31, 2025

Monthly Variances in excess of $10,000 as well as in excess of 10% explained below.
Year-To-Date Variances in excess of $30,000 as well as in excess of 5% explained below.

	Current Month		Year-to-Date	
	Amount	%	Amount	%
Gross Patient Revenue	(1,420,499)	-5.85%	(2,070,206)	-0.96%

Gross patient revenue is under budget for the month and under budget year to date. Patient statistics under budget in March were surgeries and patient days.
Average Daily Census is 12.6 in March which is under budget by 1.3

Deductions from Revenue	894,270	6.97%	1,222,518	1.07%

Deductions from revenue are under budget for March and over budget year to date.
They are currently booked at 52.3% for March and 53.0% year to date. This number is monitored closely each month and fluctuates based on historical write-offs and current collection percentages.
More detail included in the narrative.

Bad Debt Expense	(276,974)	-19.31%	(4,940,790)	-38.27%

Bad debt expense is booked at 7.5% for March and 8.4% year to date.

Charity Care	176,830	73.97%	1,750,881	81.38%

Charity care yields a high degree of variability month over month and is dependent on patient needs. Patient Financial Services evaluates accounts consistently to determine when charity adjustments are appropriate in accordance with our Charity Care Policy.

Other Operating Revenue	(43,940)	-25.29%	(544,417)	-29.95%

Other Operating Revenue is under budget and under budget for the year.

Salaries and Wages	(136,565)	-2.99%	676,232	1.65%

Salary and Wages are over budget in March and are under budget year to date.

Paid FTEs are under budget by 11.32 FTEs for the month and under 22.36 FTEs year to date.

Fringe Benefits	83,084	5.79%	445,701	3.55%

Fringe benefits are under budget in March and under budget year to date.

Contract Labor	(80,200)	-31.95%	(698,078)	-23.68%

Contract labor is over budget for March and over budget year to date.
Med Floor, Recovery room, Lab, Respiratory and Ultrasound are over budget for the month.

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WYOMING
Nine months ending March 31, 2025

Monthly Variances in excess of $10,000 as well as in excess of 10% explained below.
Year-To-Date Variances in excess of $30,000 as well as in excess of 5% explained below.

	Current Month Amount	Current Month %	Year-to-Date Amount	Year-to-Date %
Physician Fees	(90,535)	-25.13%	(652,207)	-19.22%
Physician fees over budget in March and over budget year to date. Hospitalists, Sleep Lab, Locums and Cardiovascular are over budget in March.				
Purchased Services	(72,258)	-10.41%	(67,958)	-1.04%
Purchased services are over budget for March and under budget year to date. Expenses over budget are collection fee's, bank fee's, dept. mgmt service and other purchased services.				
Supply Expense	216,399	22.16%	523,219	6.16%
Supplies are under budget for March and under budget year to date. Line items over budget include radioactive materials, food, maintenance supplies, contrast and minor equipment.				
Repairs & Maintenance	(9,108)	-1.95%	484,761	11.90%
Repairs and Maintenance are over budget for March and under budget year to date.				
All Other Operating Expenses	(64,206)	-23.19%	224,033	8.15%
This expense is over budget in March and under budget year to date. Other expenses over budget are education & travel and employee recruitment.				
Leases and Rentals	(37,866)	-177.48%	(84,264)	-29.73%
This expense is over budget for March and is over budget year to date				
Depreciation and Amortization	(41,757)	-4.79%	(19,823)	-0.25%
Depreciation is over budget for March and is over budget year to date				
BALANCE SHEET				
Cash and Cash Equivalents	($836,114)	-8.13%		
Cash decreased in March. Cash collections for March were $10.5 million. Days Cash on Hand decreased 94 days.				
Gross Patient Accounts Receivable	($2,532,001)	-3.57%		
This receivable decreased in March due to higher collections				

Variance Analysis

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WYOMING

Nine months ending March 31, 2025

Monthly Variances in excess of $10,000 as well as in excess of 10% explained below.
Year-To-Date Variances in excess of $30,000 as well as in excess of 5% explained below.

	Current Month Amount	Current Month %	Year-to-Date Amount	Year-to-Date %
Bad Debt and Allowance Reserves	**2,554,736**	**5.81%**		
Bad Debt and Allowances decreased.				
Other Receivables	**538,184**	**11.23%**		
Other Receivables increased in March due to QRA.				
Prepaid Expenses	**286,103**	**17.77%**		
Prepaid expenses increased due to the normal activity in this account.				
Limited Use Assets	**(74,931)**	**-0.32%**		
These assets increased due to the bond accrual				
Plant Property and Equipment	**1,239,173**	**1.73%**		
The increase in these assets is due to the the normal increase in accumulated depreciation.				
Accounts Payable	**(1,056,707)**	**-19.07%**		
This liability increased due to the normal activity in this account.				
Accrued Payroll	**(516,972)**	**-38.55%**		
This liability increased in March. The payroll accrual for March was 8 days.				
Accrued Benefits	**(30,738)**			
This liability increased in March with the normal accrual and usage of PTO.				
Other Current Liabilities	**108,472**	**9.79%**		
This liability decreased for March due to the payment of interest on the bonds				
Other Long Term Liabilities	**(107,721)**	**-1.08%**		
This liability increased with the addition of new leases				
Total Net Assets	**370,822**	**0.14%**		
The net loss from operations for March is $177,968				

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WY

PROVIDER CLINICS

Unaudited Financial Statements

for

Nine months ending March 31, 2025

Certification Statement:

To the best of my knowledge, I certify for the hospital that the attached financial statements do not contain any untrue statement of a material fact or omit to state a material fact that would make the financial statements misleading. I further certify that the financial statements present in all material respects the financial condition and results of operation of the hospital and all related organizations reported herein.

Certified by:

Tami Love

Chief Financial Officer

TABLE OF CONTENTS

Key Financial Ratios

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Nine months ending March 31, 2025

- DESIRED POSITION IN RELATION TO BENCHMARKS AND BUDGET

	Month to Date 3/31/2025	Year to Date 3/31/2025	Prior Fiscal Year End 06/30/24	MGMA Hospital Owned Rural
Profitability:				
Operating Margin	-28.43%	-25.35%	-23.84%	-36.58%
Total Profit Margin	-28.43%	-25.35%	-23.84%	-36.58%
Contractual Allowance %	42.92%	44.20%	44.34%	
Liquidity:				
Net Days in Accounts Receivable	47.19	45.58	42.14	39.58
Gross Days in Accounts Receivable	41.91	39.81	36.55	72.82
Productivity and Efficiency:				
Patient Visits Per Day	207.29	199.90	198.57	
Total Net Revenue per FTE	N/A	$192,512	$206,194	
Salary Expense per Paid FTE	N/A	$162,802	$176,010	
Salary and Benefits as a % of Net Revenue	105.04%	102.44%	103.17%	91.26%
Employee Benefits %	21.67%	21.14%	20.86%	6.10%

Statement of Revenue and Expense

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Nine months ending March 31, 2025

	CURRENT MONTH				
	Actual 03/31/25	Budget 03/31/25	Positive (Negative) Variance	Percentage Variance	Prior Year 03/31/24
Gross Patient Revenue					
Clinic Revenue	3,007,057	3,259,797	(252,739)	-7.75%	3,031,288
Specialty Clinic Revenue	0	0	0	0.00%	0
Total Gross Patient Revenue	3,007,057	3,259,797	(252,739)	-7.75%	3,031,288
Deductions From Revenue					
Discounts and Allowances	(1,290,761)	(1,423,389)	132,628	9.32%	(1,305,169)
Total Deductions From Revenue	(1,290,761)	(1,423,389)	132,628	9.32%	(1,305,169)
Net Patient Revenue	1,716,297	1,836,408	(120,111)	-6.54%	1,726,120
Other Operating Revenue	36,136	41,485	(5,349)	-12.89%	37,502
Total Operating Revenue	**1,752,433**	**1,877,893**	**(125,460)**	**-6.68%**	**1,763,622**
Operating Expenses					
Salaries and Wages	1,512,850	1,500,382	(12,468)	-0.83%	1,402,323
Fringe Benefits	327,894	446,399	118,505	26.55%	402,575
Contract Labor	0	0	0	0.00%	0
Physicians Fees	160,009	169,383	9,375	5.53%	95,316
Purchased Services	2,977	3,430	453	13.21%	8,021
Supply Expense	31,316	17,523	(13,793)	-78.71%	15,937
Utilities	990	1,159	169	14.59%	888
Repairs and Maintenance	5,529	6,219	689	11.08%	4,634
Insurance Expense	43,000	30,615	(12,385)	-40.45%	22,391
All Other Operating Expenses	154,954	92,678	(62,276)	-67.20%	74,051
Bad Debt Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Leases and Rentals	4,993	4,822	(172)	-3.56%	3,072
Depreciation and Amortization	6,189	4,408	(1,780)	-40.39%	6,673
Interest Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Total Operating Expenses	**2,250,701**	**2,277,017**	**26,317**	**1.16%**	**2,035,880**
Net Operating Surplus/(Loss)	**(498,267)**	**(399,125)**	**(99,143)**	**24.84%**	**(272,258)**
Total Net Surplus/(Loss)	**($498,267)**	**($399,125)**	**($99,143)**	**24.84%**	**($272,258)**
Change in Unrealized Gains/(Losses) on Investments	0	0	0	0.00%	0
Increase/(Decrease in Unrestricted Net Assets	**($498,267)**	**($399,125)**	**($99,143)**	**24.84%**	**($272,258)**
Operating Margin	**-28.43%**	**-21.25%**			**-15.44%**
Total Profit Margin	**-28.43%**	**-21.25%**			**-15.44%**
EBIDA	**-28.08%**	**-21.02%**			**-15.06%**

Statement of Revenue and Expense

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Nine months ending March 31, 2025

	YEAR-TO-DATE				
	Actual 03/31/25	Budget 03/31/25	Positive (Negative) Variance	Percentage Variance	Prior Year 03/31/24
Gross Patient Revenue					
Clinic Revenue	27,192,003	27,079,498	112,506	0.42%	24,574,773
Specialty Clinic Revenue	0	0	0	0.00%	0
Total Gross Patient Revenue	27,192,003	27,079,498	112,506	0.42%	24,574,773
Deductions From Revenue					
Discounts and Allowances	(12,019,574)	(11,833,113)	(186,461)	-1.58%	(10,736,364)
Total Deductions From Revenue	(12,019,574)	(11,833,113)	(186,461)	-1.58%	(10,736,364)
Net Patient Revenue	15,172,429	15,246,385	(73,955)	-0.49%	13,838,409
Other Operating Revenue	358,701	373,365	(14,664)	-3.93%	391,412
Total Operating Revenue	**15,531,130**	**15,619,750**	**(88,619)**	**-0.57%**	**14,229,821**
Operating Expenses					
Salaries and Wages	13,134,257	13,249,122	114,864	0.87%	12,092,240
Fringe Benefits	2,775,981	2,685,062	(90,920)	-3.39%	2,485,327
Contract Labor	0	0	0	0.00%	0
Physicians Fees	1,564,593	1,623,850	59,257	3.65%	1,095,850
Purchased Services	20,197	30,908	10,711	34.65%	58,320
Supply Expense	248,896	247,170	(1,727)	-0.70%	208,898
Utilities	8,780	10,430	1,650	15.82%	9,420
Repairs and Maintenance	64,108	55,967	(8,141)	-14.55%	44,006
Insurance Expense	294,022	275,535	(18,487)	-6.71%	197,147
All Other Operating Expenses	1,257,040	1,291,111	34,072	2.64%	1,118,307
Bad Debt Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Leases and Rentals	42,645	43,394	749	1.73%	38,877
Depreciation and Amortization	57,061	40,914	(16,147)	-39.47%	62,908
Interest Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Total Operating Expenses	**19,467,581**	**19,553,462**	**85,882**	**0.44%**	**17,411,298**
Net Operating Surplus/(Loss)	**(3,936,451)**	**(3,933,713)**	**(2,738)**	**0.07%**	**(3,181,477)**
Total Net Surplus/(Loss)	**($3,936,451)**	**($3,933,713)**	**($2,738)**	**0.07%**	**($3,181,477)**
Change in Unrealized Gains/(Losses) on Investments	0	0	0	0.00%	0
Increase/(Decrease) in Unrestricted Net Assets	**($3,936,451)**	**($3,933,713)**	**($2,738)**	**0.07%**	**($3,181,477)**
Operating Margin	**-25.35%**	**-25.18%**			**-22.36%**
Total Profit Margin	**-25.35%**	**-25.18%**			**-22.36%**
EBIDA	**-24.98%**	**-24.92%**			**-21.92%**

Statement of Revenue and Expense - 13 Month Trend

MEMORIAL HOSPITAL OF SWEETWATER COUNTY **PAGE 5**
ROCK SPRINGS, WY

	Actual 3/31/2025	Actual 2/28/2025	Actual 1/31/2025	Actual 12/31/2024	Actual 11/30/2024
Gross Patient Revenue					
Clinic Revenue	$3,007,057	$3,101,927	$3,082,203	$3,035,731	$2,897,570
Specialty Clinic Revenue	$0	$0	$0	$0	$0
Total Gross Patient Revenue	$3,007,057	$3,101,927	$3,082,203	$3,035,731	$2,897,570
Deductions From Revenue					
Discounts and Allowances	($1,290,761)	($1,371,053)	($1,370,087)	($1,367,918)	($1,274,277)
Total Deductions From Revenue	($1,290,761)	($1,371,053)	($1,370,087)	($1,367,918)	($1,274,277)
Net Patient Revenue	$1,716,297	$1,730,874	$1,712,115	$1,667,813	$1,623,294
Other Operating Revenue	$36,136	$36,852	$42,000	$36,932	$39,322
Total Operating Revenue	**1,752,433**	**1,767,726**	**1,754,116**	**1,704,745**	**1,662,616**
Operating Expenses					
Salaries and Wages	$1,512,850	$1,436,447	$1,457,053	$1,531,022	$1,465,903
Fringe Benefits	$327,894	$333,664	$420,452	$249,304	$286,506
Contract Labor	$0	$0	$0	$0	$0
Physicians Fees	$160,009	$228,117	$71,558	$289,487	$181,437
Purchased Services	$2,977	$1,299	$3,185	$1,579	$1,505
Supply Expense	$31,316	$19,057	$27,592	$27,236	$19,206
Utilities	$990	$1,070	$1,070	$426	$971
Repairs and Maintenance	$5,529	$8,733	$2,868	$12,958	$7,713
Insurance Expense	$43,000	$31,297	$31,941	$31,297	$31,297
All Other Operating Expenses	$154,954	$99,388	$135,844	$108,182	$108,064
Bad Debt Expense (Non-Governmental Providers)					
Leases and Rentals	$4,993	$4,990	$3,978	$6,881	$4,221
Depreciation and Amortization	$6,189	$6,188	$6,188	$6,374	$6,374
Interest Expense (Non-Governmental Providers)					
Total Operating Expenses	**$2,250,701**	**$2,170,251**	**$2,161,730**	**$2,264,747**	**$2,113,197**
Net Operating Surplus/(Loss)	**($498,267)**	**($402,525)**	**($407,614)**	**($560,002)**	**($450,581)**
Total Net Surplus/(Loss)	**($498,267)**	**($402,525)**	**($407,614)**	**($560,002)**	**($450,581)**
Change in Unrealized Gains/(Losses) on Investments	0	0	0	0	0
Increase/(Decrease in Unrestricted Net Assets	**($498,267)**	**($402,525)**	**($407,614)**	**($560,002)**	**($450,581)**
Operating Margin	**-28.43%**	**-22.77%**	**-23.24%**	**-32.85%**	**-27.10%**
Total Profit Margin	**-28.43%**	**-22.77%**	**-23.24%**	**-32.85%**	**-27.10%**
EBIDA	**-28.08%**	**-22.42%**	**-22.88%**	**-32.48%**	**-26.72%**

Actual 10/31/2024	Actual 9/30/2024	Actual 8/31/2024	Actual 7/31/2024	Actual 6/30/2024	Actual 5/31/2024	Actual 4/30/2024	Actual 3/31/2024
$3,305,125	$2,766,032	$3,030,522	$2,965,835	$3,098,260	$3,244,931	$3,031,288	$3,252,627
$0	$0	$0	$0	$0	$0	$0	$0
$3,305,125	$2,766,032	$3,030,522	$2,965,835	$3,098,260	$3,244,931	$3,031,288	$3,252,627
($1,573,472)	($1,123,349)	($1,323,509)	($1,325,148)	($1,247,082)	($1,596,933)	($1,305,169)	($1,437,969)
($1,573,472)	($1,123,349)	($1,323,509)	($1,325,148)	($1,247,082)	($1,596,933)	($1,305,169)	($1,437,969)
$1,731,653	$1,642,683	$1,707,013	$1,640,687	$1,851,177	$1,647,998	$1,726,120	$1,814,659
$44,944	$37,318	$44,317	$40,879	$41,325	$48,843	$37,502	$44,208
1,776,597	**1,680,001**	**1,751,330**	**1,681,566**	**1,892,502**	**1,696,841**	**1,763,622**	**1,858,867**
$1,484,489	$1,472,901	$1,447,522	$1,326,070	$1,487,393	$1,445,111	$1,402,323	$1,417,161
$292,369	$245,580	$373,923	$246,291	$379,342	$326,956	$402,575	$352,833
$0	$0	$0	$0	$0	$0	$0	$0
$183,517	$128,010	$142,605	$179,854	$183,150	$110,473	$95,316	$184,805
$2,324	$2,679	$3,262	$1,386	$818	$7,543	$8,021	$4,886
$18,420	$51,523	$34,125	$20,422	$25,558	$40,409	$15,937	$20,431
$635	$1,048	$1,723	$848	$1,754	$815	$888	$890
$3,251	$3,374	$6,285	$13,396	$19,503	$4,634	$4,634	$2,942
$31,297	$31,297	$31,297	$31,297	$31,297	$22,391	$22,391	$22,391
$179,591	$149,112	$134,426	$187,477	$143,924	$143,679	$74,051	$126,422
$4,176	$5,617	$3,716	$4,072	$4,322	$4,400	$3,072	$5,937
$6,485	$6,485	$6,485	$6,292	$6,547	$6,372	$6,673	$6,773
$2,206,553	**$2,097,628**	**$2,185,370**	**$2,017,404**	**$2,283,608**	**$2,112,782**	**$2,035,880**	**$2,145,470**
($429,957)	**($417,627)**	**($434,039)**	**($335,839)**	**($391,106)**	**($415,941)**	**($272,258)**	**($286,604)**
($429,957)	**($417,627)**	**($434,039)**	**($335,839)**	**($391,106)**	**($415,941)**	**($272,258)**	**($286,604)**
0	0	0	0	0	0	0	0
($429,957)	**($417,627)**	**($434,039)**	**($335,839)**	**($391,106)**	**($415,941)**	**($272,258)**	**($286,604)**
-24.20%	-24.86%	-24.78%	-19.97%	-20.67%	-24.51%	-15.44%	-15.42%
-24.20%	-24.86%	-24.78%	-19.97%	-20.67%	-24.51%	-15.44%	-15.42%
-23.84%	-24.47%	-24.41%	-19.60%	-20.32%	-24.14%	-15.06%	-15.05%

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Nine months ending March 31, 2025

Current Month					Year-To-Date			
Actual 03/31/25	Budget 03/31/25	Positive/ (Negative) Variance	Prior Year 03/31/24	STATISTICS	Actual 03/31/25	Budget 03/31/25	Positive/ (Negative) Variance	Prior Year 03/31/24
				Outpatient Statistics:				
6,426	5,858	568	5,858	Clinic Visits - Primary Care	54,773	54,407	366	54,407
529	514	15	514	Clinic Visits - Specialty Clinics	5,191	4,746	445	4,746
				Productivity Statistics:				
97.47	97.78	(0.31)	80.59	FTE's - Worked	92.28	97.78	(5.50)	80.73
107.79	107.45	0.34	90.91	FTE's - Paid	107.47	107.45	0.02	91.12

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
CASH DISBURSEMENT SUMMARY FOR MARCH 25

PAYMENT SOURCE	NO. OF DISBURSEMENTS	AMOUNT
OPERATIONS (GENERAL FUND/KEYBANK)	572	9,542,568.45
CAPITAL EQUIPMENT (PLANT FUND)	3	712,771.20
CONSTRUCTION IN PROGRESS (BUILDING FUND)	5	659,930.61
PAYROLL MARCH 13, 2025		2,059,597.36
PAYROLL MARCH 27, 2025		2,013,197.36
TOTAL CASH OUTFLOW		$10,915,270.26
CASH COLLECTIONS		10,503,362.00
INCREASE/DECREASE IN CASH		**-$411,908.26**

PLANT FUND CASH DISBURSEMENTS
FISCAL YEAR 2025

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002665	7/11/2024	VERATHON MEDICAL	7,020.00	BLADDER SCANNER		
002666	7/11/2024	WYOELECTRIC, INC	27,700.00	ELECTRICAL HD X-RAY ROOM		
002666	7/11/2024	WYOELECTRIC, INC	4,522.00	UPS FOR IT EQUIPMENT		
002667	7/18/2024	CDW GOVERNMENT LLC	24,263.27	UPS FOR MHSC DATA CENTER		
002674	7/25/2024	CDW GOVERNMENT LLC	1,183.69	UPS FOR MHSC DATA CENTER		
002675	7/25/2024	PEDIA PALS, INC.	2,517.50	PEDIATRIC BED		
002676	7/25/2024	FOLLETT CORPORATION	5,375.54	ICE/WATER MACHINE FOR SAME DAY SURGERY		
		JULY TOTALS			72,582.00	72,582.00

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002677	8/7/2024	WYOELECTRIC, INC	4,954.40	BACKUP UPS UNIT FOR IT		
002678	8/7/2024	INTERMOUNTAIN TRIMLIGHT (WEST HARRISON ENTERPRISES INC)	18,456.00	TRIMLIGHT SYSTEM ADDITION		
002679	8/16/2024	RADIOMETER AMERICA INC	14,150.00	ABL90 FLEX PLUS ANALYZER		
002680	8/22/2024	MEDICAL POSITIONING, INC	12,239.00	ULTRASCAN TABLE		
002681	8/22/2024	PEDIA PALS, INC.	2,517.50	PEDIATRIC BED		
002682	8/29/2024	COMPUNET, INC.	1,250.00	STORAGE FOR DAVINCI VIDEOS		
002683	8/29/2024	DATEX-OHMEDA,INC.	37,190.44	FETAL MONITORS		
002684	8/29/2024	WAXIE SANITARY SUPPLY	10,543.29	AUTOMATIC SCRUBBERS		
		AUGUST TOTALS			101,300.63	173,882.63

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002677	9/12/2024	KARL STORZ ENDOSCOPY-AMERICA	31,042.82	INTUBATION SCOPE		
002678	9/12/2024	PACIFIC WATER INC	58,516.50	CONTROL HEADS FOR SOFT WATER SYSTEM		
002679	9/12/2024	ALLIED AWNING & RENTAL	56,556.58	DIGITAL ELECTRONIC MESSAGING SIGN-HOSPITAL		
002680	9/19/2024	DELL COMPUTER CORPORATION	15,057.70	DELL LAPTOPS		
002681	9/26/2024	INTERMOUNTAIN TRIMLIGHT (WEST HARRISON ENTERPRISES INC)	18,456.00	TRIMLIGHT SYSTEM ADDITION		
		SEPTEMBER TOTALS			179,629.60	353,512.23

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002690	10/9/2024	BC GROUP INTERNATIONAL INC.	6,810.00	FLOW ANALYZER		
002691	10/9/2024	US MED-EQUIP, LLC	8,195.00	BLADDER SCANNER		
002692	10/31/2024	DELL COMPUTER CORPORATION	15,941.60	DELL LAPTOPS AND MONITORS		
002693	10/31/2024	GUARD RFID	2,500.00	INFANT SECURITY SYSTEM		
002694	10/31/2024	WYOELECTRIC, INC	2,127.00	UPS FOR IT EQUIPMENT		
		OCTOBER TOTALS			35,573.60	389,085.83

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002695	11/14/2024	GUARD RFID	34,281.00	INFANT SECURITY SYSTEM		
002696	11/14/2024	OLYMPUS AMERICA INC	47,643.37	PEDIATRIC COLONSCOPE		
002697	11/14/2024	WYOELECTRIC, INC	24,590.00	DIGITAL MESSAGING SIGN - HOSPITAL		
		NOVEMBER TOTALS			106,514.37	495,600.20

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002698	12/5/2024	AMERI-TECH EQUIPMENT COMPANY	13,180.36	SNOW PLOT		
002699	12/5/2024	MERIT MEDICAL SYSTEMS, INC	65,515.00	SAVI SCOUT CONSOLE		
002700	12/5/2024	VERATHON MEDICAL	6,000.00	VERATHON GLIDE SCOPE		
002701	12/12/2024	R & D SWEEPING & ASPHALT MAINTENANCE, LC	25,525.00	PARKING LOT REPAIRS		
002702	12/12/2024	VERATHON MEDICAL	36,608.00	VERATHON GLIDE SCOPE		
002703	12/24/2024	HOLOGIC, INC.	69,350.00	MINI C-ARM		
		DECEMBER TOTALS			216,178.36	711,778.56

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002704	1/16/2025	GUARD RFID	1,115.00	INFANT SECURITY SYSTEM		
002705	1/16/2025	R & D SWEEPING & ASPHALT MAINTENANCE, LC	74,810.00	PARKING LOT REPAIRS - 3000 COLLEGE DRIVE		
002706	1/16/2025	JC JACOBS CARPET ONE	9,843.99	FLOORING - STRESS ROOM		
		JANUARY TOTALS			85,768.99	797,547.55

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002707	2/6/2025	GUARD RFID	5,490.00	INFANT SECURITY SYSTEM		
002708	2/7/2025	CONVERGINT TECHNOLOGIES	5,756.98	BEHAVIORAL HEALTH CAMERAS		
002709	2/20/2025	COMPUNET, INC.	19,525.00	MICROSOFT INTUNE		
002710	2/20/2025	MERGE HEALTHCARE SOLUTIONS, INC	257,801.84	PACS VNA MIGRATION, REPORTS, VOICE RECOGNITION		
		FEBRUARY TOTALS			288,573.82	1,086,121.37

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002711	3/6/2025	DELL COMPUTER CORPORATION	12,242.80	LAPTOPS		
002712	3/13/2025	DELL COMPUTER CORPORATION	29,174.40	LAPTOPS		
002713	3/20/2025	SIEMENS MEDICAL SOLUTIONS USA	671,354.00	X-RAY SYSTEMS		
		MARCH TOTALS			712,771.20	1,798,892.57

CONSTRUCTION IN PROGRESS (BUILDING FUND) CASH DISBURSEMENTS
FISCAL YEAR 2025

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001240	7/18/2024	GROATHOUSE CONSTRUCTION,	44,113.25	LAB EXPANSION		
WF DEBT SERVICI	7/31/2024	WF DEBT SERVICE	185,523.05	WF DEBT SERVICE		
		JULY TOTALS			229,636.30	229,636.30

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001241	8/1/2024	CITY OF ROCK SPRINGS	4,495.00	MOB RENOVATION		
001242	8/7/2024	PLAN ONE/ARCHITECTS	53,858.00	MOB RENOVATION		
001242	8/7/2024	PLAN ONE/ARCHITECTS	29,879.06	MEDICAL IMAGING SUITE RENOVATION		
001242	8/7/2024	PLAN ONE/ARCHITECTS	4,232.90	LAB EXPANSION		
001243	8/7/2024	ROCKET MINER	355.67	MOB RENOVATION		
001244	8/29/2024	GROATHOUSE CONSTRUCTION,	138,013.00	LAB EXPANSION		
WF DEBT SERVICI	8/16/2024	WF DEBT SERVICE	185,523.05	WF DEBT SERVICE		
		AUGUST TOTALS			416,356.68	645,992.98

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001245	9/12/2024	CITY OF ROCK SPRINGS	14,255.00	MRI PHASE 2		
001246	9/12/2024	A. PLEASANT CONSTRUCTION, I	87,352.86	LAB EXPANSION		
001247	9/12/2024	PLAN ONE/ARCHITECTS	7,694.00	MOB ENTRANCE/ADA PARKING RENO		
001247	9/12/2024	PLAN ONE/ARCHITECTS	5,691.25	MRI PHASE 2		
001247	9/12/2024	PLAN ONE/ARCHITECTS	12,537.90	LAB EXPANSION		
001247	9/12/2024	PLAN ONE/ARCHITECTS	3,510.56	ONCOLOGY SUITE RENOVATION		
WF DEBT SERVICI	9/18/2024	WF DEBT SERVICE	185,460.15	WF DEBT SERVICE		
		SEPTEMBER TOTALS			316,501.72	962,494.70

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001248	10/3/2024	GROATHOUSE CONSTRUCTION,	134,813.00	LAB EXPANSION		
001249	10/9/2024	PLAN ONE/ARCHITECTS	5,871.16	LAB EXPANSION		
001250	10/24/2024	WESTERN ENGINEERS & GEOLC	132.00	LAB EXPANSION		
001251	10/31/2024	GROATHOUSE CONSTRUCTION,	272,578.00	LAB EXPANSION		
WF DEBT SERVICI	10/16/2024	WF DEBT SERVICE	185,460.15	WF DEBT SERVICE		
		OCTOBER TOTALS			598,854.31	1,561,349.01

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001252	11/7/2024	PLAN ONE/ARCHITECTS	9,451.51	LAB EXPANSION		
001253	11/26/2024	GROATHOUSE CONSTRUCTION,	400,246.00	LAB EXPANSION		
001254	11/26/2024	A. PLEASANT CONSTRUCTION, I	39,873.40	ONCOLOGY SUITE RENOVATION		
WF DEBT SERVICI	11/19/2024	WF DEBT SERVICE	185,460.15	WF DEBT SERVICE		
		NOVEMBER TOTALS			635,031.06	2,196,380.07

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001255	12/5/2024	WESTERN ENGINEERS & GEOLC	1,499.00	LAB EXPANSION		
001256	12/12/2024	PLAN ONE/ARCHITECTS	7,579.22	LAB EXPANSION		
001257	12/19/2024	GROATHOUSE CONSTRUCTION,	319,491.00	LAB EXPANSION		
001258	12/24/2024	WESTERN ENGINEERS & GEOLC	3,995.00	LAB EXPANSION		
WF DEBT SERVICI	12/19/2024	WF DEBT SERVICE	185,460.15	WF DEBT SERVICE		
		DECEMBER TOTALS			518,024.37	2,714,404.44

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001259	1/2/2025	PLAN ONE/ARCHITECTS	1,422.81	MRI PHASE 2		
001259	1/2/2025	PLAN ONE/ARCHITECTS	1,923.50	MOB ENTRANCE		
001259	1/2/2025	PLAN ONE/ARCHITECTS	4,232.90	LAB EXPANSION		
001260	1/9/2025	A. PLEASANT CONSTRUCTION, I	43,616.40	ONCOLOGY SUITE RENOVATION		
001261	1/9/2025	GROATHOUSE CONSTRUCTION,	220,740.00	LAB EXPANSION		
001262	1/16/2025	INSULATION INC.	1,924.36	MRI PHASE 2		
001263	1/23/2025	WYLIE CONSTRUCTION INC.	1,800.00	LAB EXPANSION		
001264	1/29/2025	WESTERN ENGINEERS & GEOLC	2,132.00	LAB EXPANSION		
WF DEBT SERVICI	1/16/2025	WF DEBT SERVICE	185,460.15	WF DEBT SERVICE		
		JANUARY TOTALS			463,252.12	3,177,656.56

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001265	2/6/2025	INSULATION INC.	1,504.36	MRI PHASE 2		
001266	2/6/2025	PLAN ONE/ARCHITECTS	12,079.21	LAB EXPANSION		
001267	2/20/2025	GROATHOUSE CONSTRUCTION,	209,514.00	LAB EXPANSION		
WF DEBT SERVICI	2/11/2025	WF DEBT SERVICE	185,460.15	WF DEBT SERVICE		
		FEBRUARY TOTALS			408,557.72	3,586,214.28

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001268	3/6/2025	WESTERN ENGINEERS & GEOLC	3,189.50	MOB ENTRANCE		
001269	3/13/2025	PLAN ONE/ARCHITECTS	8,506.21	LAB EXPANSION		
001270	3/20/2025	GROATHOUSE CONSTRUCTION,	344,380.00	LAB EXPANSION		
001271	3/20/2025	GROATHOUSE CONSTRUCTION,	119,914.00	MRI PHASE 2		
WF DEBT SERVICI	3/17/2025	WF DEBT SERVICE	183,940.90	WF DEBT SERVICE		
		MARCH TOTALS			659,930.61	4,246,144.89

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
3/31/2025

Amount	Description
47,481.71	**Advertising Total**
12,103.98	**Blood Total**
3,500.00	**Building Lease Total**
30,505.72	**Café Management Total**
2,708.44	**Cellular Telephone Total**
67,791.87	**Collection Agency Total**
7,029.02	**Computer Equipment Total**
16,130.00	**Consulting Fees Total**
738,435.87	**Contract Maintenance Total**
345,044.75	**Contract Personnel Total**
17,076.76	**Credit Card payment Total**
29,965.95	**Dental Insurance Total**
10,169.83	**Dialysis Supplies Total**
3,584.51	**Education & Travel Total**
10,525.00	**Employee Recruitment Total**
15,179.26	**Employee Vision Plan Total**
78,961.94	**Equipment Lease Total**
6,636.60	**Food Total**
10,302.79	**Freight Total**
667.89	**Fuel Total**
3,963.26	**Garbage Collection Total**
589,446.20	**Group Health Total**
607,659.86	**Hospital Supplies Total**
15,040.98	**Implant Supplies Total**
423.00	**Instruments Total**
37,677.73	**Insurance Premiums Total**
65,799.40	**Insurance Refund Total**
114,315.79	**Laboratory Supplies Total**
36,035.18	**Legal Fees Total**
635.76	**Linen Total**
54,253.57	**Mainetenance Supplies Total**
1,090.00	**Marketing & Promotional Supplies Total**
1,800.00	**Membership Total**
4,195.00	**Membership Dues Total**
3,199.84	**MHSC Foundation Total**
4,200.18	**Minor Equipment Total**
261.00	**Monthly Pest Control Total**
6,190.89	**Non Medical Supplies Total**
14,794.85	**Office Supplies Total**
8,022.38	**Other Employee Benefits Total**
6,731.39	**Other Purchased Services Total**
4,144.00	**Patient Refund Total**
366.48	**Payroll Deduction Total**
6,894.82	**Payroll Garnishment Total**
4,000,000.00	**Payroll Transfer Total**
43.50	**Petty Cash Total**
1,107,367.10	**Pharmacy Management Total**

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
3/31/2025

83,887.88	**Physician Recruitment Total**
16,500.00	**Physician Retention Total**
228,021.89	**Physician Services Total**
21,666.69	**Physician Student Loan Total**
1,370.00	**Postage Total**
599.89	**Professional Service Total**
1,043.89	**Proficiency Testing Total**
21,607.23	**Radiology Material Total**
15,690.89	**Reimbursement - CME Total**
20,052.66	**Reimbursement - Education & Travel Total**
524,372.90	**Retirement Total**
7,200.00	**Sponsorship Total**
330,518.12	**Surgery Supplies Total**
4,980.88	**Surveys Total**
3,419.60	**Title 25 Total**
2,182.08	**Translation Services Total**
150.00	**Uniform Total**
108,299.44	**Utilities Total**
2,650.36	**Waste Disposal Total**
9,542,568.45	**Grand Total**

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
03/31/2025

Check Number	Date	Vendor Check Name	Amount	Description
205094	3/27/25	BIG THICKET BROADCASTING	3,277.00	Advertising
205096	3/27/25	BRIDGER VALLEY PIONEER	600.00	Advertising
205129	3/27/25	KEMMERER GAZETTE	3,135.00	Advertising
204808	3/13/25	LAMAR ADVERTISING	450.00	Advertising
205131	3/27/25	LAMAR ADVERTISING	2,160.00	Advertising
204951	3/20/25	PILOT BUTTE BROADCASTING	650.00	Advertising
205147	3/27/25	PILOT BUTTE BROADCASTING	650.00	Advertising
205148	3/27/25	PINEDALE ROUNDUP	1,100.00	Advertising
204835	3/13/25	ROCKET MINER	19.56	Advertising
204962	3/20/25	ROYAL FLUSH ADVERTISING	319.50	Advertising
204725	3/6/25	ROYAL FLUSH ADVERTISING	6,287.00	Advertising
204726	3/6/25	SCORPION HEALTHCARE LLC	9,218.00	Advertising
204845	3/13/25	THE RADIO NETWORK	6,265.65	Advertising
205169	3/27/25	TRUE NORTH CUSTOM PUBLISHING	13,350.00	Advertising
205182	3/27/25	VITALANT	4,616.45	Blood
204853	3/13/25	VITALANT	7,487.53	Blood
204993	3/21/25	CURRENT PROPERTIES, LLC	3,500.00	Building Lease
205173	3/27/25	UNIDINE CORPORATION	30,505.72	Café Management
204747	3/6/25	VERIZON WIRELESS, LLC	2,708.44	Cellular Telephone
204892	3/20/25	COLLECTION PROFESSIONALS, INC	42.00	Collection Agency
204780	3/13/25	COLLECTION PROFESSIONALS, INC	102.75	Collection Agency
204864	3/14/25	EXPRESS RECOVERY SERVICES	57,896.87	Collection Agency
204854	3/13/25	WAKEFIELD & ASSOCIATES, INC.	9,750.25	Collection Agency
205100	3/27/25	CDW GOVERNMENT LLC	556.66	Computer Equipment
204885	3/20/25	CDW GOVERNMENT LLC	1,558.24	Computer Equipment
204658	3/6/25	CDW GOVERNMENT LLC	3,514.18	Computer Equipment
204673	3/6/25	DELL COMPUTER CORPORATION	68.00	Computer Equipment
204903	3/20/25	DELL COMPUTER CORPORATION	1,331.94	Computer Equipment
205120	3/27/25	GO RURAL	15,000.00	Consulting Fees
205142	3/27/25	PACT STUDIOS, LLC	1,130.00	Consulting Fees
204641	3/6/25	ALCOR SCIENTIFIC INC	1,780.00	Contract Maintenance
204874	3/20/25	ATERA NETWORKS INC.	38,700.00	Contract Maintenance
205095	3/27/25	BISCOM	2,169.94	Contract Maintenance
204659	3/6/25	CERNER CORP	4,375.00	Contract Maintenance
204661	3/6/25	CLOUDLI COMMUNICATIONS INC.	69.27	Contract Maintenance
204778	3/13/25	CLOUDLI COMMUNICATIONS INC.	78.39	Contract Maintenance
205105	3/27/25	COMPUNET, INC.	250.00	Contract Maintenance
204781	3/13/25	COMPUNET, INC.	3,093.75	Contract Maintenance
204893	3/20/25	COMPUNET, INC.	6,004.09	Contract Maintenance
204894	3/20/25	CONSUMER FUSION INC.	5,175.00	Contract Maintenance
205119	3/27/25	FRONT RANGE MOBILE IMAGING, INC.	4,916.12	Contract Maintenance
204909	3/20/25	GE HEALTHCARE	10,178.00	Contract Maintenance
204796	3/13/25	GREENSHADES SOFTWARE	204.60	Contract Maintenance
204686	3/6/25	GREENSHADES SOFTWARE	1,281.16	Contract Maintenance
204798	3/13/25	HARMONY HEALTHCARE IT	2,575.00	Contract Maintenance
204915	3/20/25	HARMONY HEALTHCARE IT	7,727.00	Contract Maintenance
205122	3/27/25	HARMONY HEALTHCARE IT	7,727.00	Contract Maintenance
204918	3/20/25	HOLOGIC, INC.	885.07	Contract Maintenance

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
03/31/2025

204691	3/6/25	HOLOGIC, INC.	6,102.75	Contract Maintenance
204920	3/20/25	INOVALON PROVIDER INC.	1,010.64	Contract Maintenance
204946	3/20/25	NETDAIS	10,500.00	Contract Maintenance
204947	3/20/25	ORACLE AMERICA, INC.	18,461.25	Contract Maintenance
204824	3/13/25	ORACLE AMERICA, INC.	209,872.87	Contract Maintenance
204827	3/13/25	PHILIPS MEDICAL SYSTEM N.A.CO	1,016.67	Contract Maintenance
205145	3/27/25	PHILIPS MEDICAL SYSTEM N.A.CO	1,366.67	Contract Maintenance
204954	3/20/25	QUADRAMED	17,750.00	Contract Maintenance
205151	3/27/25	QUADRAMED	81,518.37	Contract Maintenance
204722	3/6/25	REMI CORPORATION	3,233.36	Contract Maintenance
204723	3/6/25	RENAL SERVICES EXCHANGE, INC.	1,326.00	Contract Maintenance
204724	3/6/25	RL DATIX	421.00	Contract Maintenance
204837	3/13/25	SIEMENS MEDICAL SOLUTIONS USA	1,773.83	Contract Maintenance
205155	3/27/25	SIEMENS MEDICAL SOLUTIONS USA	3,874.76	Contract Maintenance
204965	3/20/25	SIEMENS MEDICAL SOLUTIONS USA	12,109.32	Contract Maintenance
204931	3/20/25	UKG KRONOS SYSTEMS LLC	2,457.00	Contract Maintenance
205174	3/27/25	UNITED AUDIT SYSTEMS, INC.	6,541.50	Contract Maintenance
205178	3/27/25	VARIAN MEDICAL SYSTEMS, INC	212,000.00	Contract Maintenance
205183	3/27/25	WYODATA SECURITY INC.	1,865.00	Contract Maintenance
204855	3/13/25	WYODATA SECURITY INC.	1,935.00	Contract Maintenance
EFT000000009057	3/13/2025	STATE FIRE DC SPECIALTIES	6,120.00	Contract Maintenance
EFT000000009061	3/27/2025	STATE FIRE DC SPECIALTIES	5,470.00	Contract Maintenance
W/T	3/6/2025	ZENITH	420.42	Contract Maintenance
W/T	3/20/2025	TRIZETTO FEE	6,128.84	Contract Maintenance
W/T	3/20/2025	TRIZETTO FEE	247.68	Contract Maintenance
205089	3/27/25	ASPEN MOUNTAIN MEDICAL CENTER LLC	27,723.55	Contract Maintenance
204908	3/20/25	FOCUSONE SOLUTIONS LLC	77,060.75	Contract Personnel
205117	3/27/25	FOCUSONE SOLUTIONS LLC	78,652.00	Contract Personnel
204790	3/13/25	FOCUSONE SOLUTIONS LLC	88,516.75	Contract Personnel
204681	3/6/25	FOCUSONE SOLUTIONS LLC	94,705.25	Contract Personnel
204836	3/13/25	SARAH ROTH	720.00	Contract Personnel
205154	3/27/25	SEPPIE PHYSICAL THERAPY, LLC	5,390.00	Contract Personnel
W/T	3/3/2025	UMB BANK PAYMENT	17,076.76	Credit Card payment
204785	3/13/25	DELTA DENTAL	29,965.95	Dental Insurance
204682	3/6/25	FRESENIUS USA MARKETING, INC.	3,883.15	Dialysis Supplies
204791	3/13/25	FRESENIUS USA MARKETING, INC.	5,683.43	Dialysis Supplies
205124	3/27/25	HENRY SCHEIN INC	89.14	Dialysis Supplies
204688	3/6/25	HENRY SCHEIN INC	514.11	Dialysis Supplies
204963	3/20/25	RQI PARTNERS, LLC	2,197.65	Education & Travel
205158	3/27/25	SODEXO, INC & AFFILIATES	1,386.86	Education & Travel
205084	3/27/25	ALTITUDE ANALYSIS	650.00	Employee Recruitment
204933	3/20/25	LINKED IN CORPORATION	9,607.00	Employee Recruitment
205161	3/27/25	STATE OF WYOMING	130.00	Employee Recruitment
205184	3/27/25	WYOMING PUBLIC HEALTH LAB	138.00	Employee Recruitment
204748	3/6/25	VISION SERVICE PLAN - WY	7,511.07	Employee Vision Plan
205181	3/27/25	VISION SERVICE PLAN - WY	7,668.19	Employee Vision Plan
204884	3/20/25	CAREFUSION SOLUTIONS, LLC	20,990.00	Equipment Lease
204896	3/20/25	COPIER & SUPPLY COMPANY	903.46	Equipment Lease
204911	3/20/25	GE HEALTHCARE FINANCIAL SERVICES	373.62	Equipment Lease

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
03/31/2025

204793	3/13/25	GE HEALTHCARE FINANCIAL SERVICES	7,472.32	Equipment Lease
204809	3/13/25	LEAF	2,800.00	Equipment Lease
204934	3/20/25	MAKO SURGICAL CORP	23,950.00	Equipment Lease
204717	3/6/25	PITNEY BOWES INC	605.86	Equipment Lease
204830	3/13/25	PITNEY BOWES INC	798.77	Equipment Lease
205156	3/27/25	SIEMENS FINANCIAL SERVICES, INC	6,577.77	Equipment Lease
204966	3/20/25	SIEMENS FINANCIAL SERVICES, INC	9,756.01	Equipment Lease
204979	3/20/25	US BANK EQUIPMENT FINANCE	1,021.13	Equipment Lease
205175	3/27/25	US BANK EQUIPMENT FINANCE	1,036.84	Equipment Lease
204849	3/13/25	US BANK EQUIPMENT FINANCE	2,676.16	Equipment Lease
204677	3/6/25	F B MCFADDEN WHOLESALE	6,636.60	Food
204678	3/6/25	FED EX	135.54	Freight
204906	3/20/25	FED EX	312.03	Freight
205115	3/27/25	FED EX	495.37	Freight
204788	3/13/25	FED EX	963.97	Freight
205168	3/27/25	TRIOSE, INC	1,368.24	Freight
204742	3/6/25	TRIOSE, INC	2,535.39	Freight
204978	3/20/25	TRIOSE, INC	4,492.25	Freight
204832	3/13/25	BAILEY ENTERPRISES	667.89	Fuel
EFT000000009058	3/13/2025	WWS - ROCK SPRINGS	3,963.26	Garbage Collection
W/T	3/7/2025	BLUE CROSS BLUE SHIELD 02/28/2025	274,272.91	Group Health
W/T	3/7/2025	HEALTHEQ 3/7/25	4,494.03	Group Health
W/T	3/14/2025	BLUE CROSS BLUE SHIELD	294,737.35	Group Health
W/T	3/20/2025	FURTHER FLEX 3/19/25	124.87	Group Health
W/T	3/6/2025	FURTHER FLEX 3/5/25	223.52	Group Health
W/T	3/14/2025	HEALTHEQ 3/14/25	8,610.86	Group Health
W/T	3/10/2025	HEALTHEQ 3/21/25	6,615.41	Group Health
W/T	3/10/2025	HEALTH EQ FEE	367.25	Group Health
204871	3/20/25	AESCULAP INC	278.68	Hospital Supplies
204643	3/6/25	AMBU INCORPORATED	153.00	Hospital Supplies
205086	3/27/25	APPLIED MEDICAL	264.00	Hospital Supplies
204646	3/6/25	APPLIED MEDICAL	708.00	Hospital Supplies
204768	3/13/25	APPLIED MEDICAL	870.00	Hospital Supplies
204873	3/20/25	ARTHREX INC.	401.50	Hospital Supplies
204647	3/6/25	ARTHREX INC.	2,134.00	Hospital Supplies
205088	3/27/25	ARTHREX INC.	2,293.50	Hospital Supplies
204769	3/13/25	ARTHREX INC.	2,674.00	Hospital Supplies
204649	3/6/25	B BRAUN MEDICAL INC.	426.64	Hospital Supplies
205092	3/27/25	B BRAUN MEDICAL INC.	533.71	Hospital Supplies
204878	3/20/25	B BRAUN MEDICAL INC.	2,540.75	Hospital Supplies
204876	3/20/25	BARD MEDICAL	222.00	Hospital Supplies
204648	3/6/25	BARD MEDICAL	3,095.41	Hospital Supplies
204771	3/13/25	BAXTER HEALTHCARE CORP/IV	411.00	Hospital Supplies
204877	3/20/25	BAXTER HEALTHCARE CORP/IV	5,502.78	Hospital Supplies
204651	3/6/25	BELMONT MEDICAL TECHNOLOGIES	2,233.00	Hospital Supplies
204900	3/20/25	C R BARD INC	780.52	Hospital Supplies
204667	3/6/25	C R BARD INC	1,940.60	Hospital Supplies
204656	3/6/25	CARDINAL HEALTH/V. MUELLER	67,484.30	Hospital Supplies
204882	3/20/25	CARDINAL HEALTH/V. MUELLER	131,529.94	Hospital Supplies

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
03/31/2025

204776	3/13/25	CARDINAL HEALTH/V. MUELLER	154,502.88	Hospital Supplies
205099	3/27/25	CAREFUSION 2200 INC	1,200.00	Hospital Supplies
204662	3/6/25	COASTAL LIFE SYSTEMS,INC.	219.98	Hospital Supplies
204889	3/20/25	COASTAL LIFE SYSTEMS,INC.	219.98	Hospital Supplies
205106	3/27/25	CONE INSTRUMENTS	190.81	Hospital Supplies
205111	3/27/25	DIAGNOSTIGA STAGO INC	1,822.03	Hospital Supplies
204675	3/6/25	DIAGNOSTIGA STAGO INC	2,202.96	Hospital Supplies
204676	3/6/25	DJ ORTHOPEDICS, LLC	107.12	Hospital Supplies
204680	3/6/25	FISHER & PAYKEL HEALTHCARE, INC	803.87	Hospital Supplies
204912	3/20/25	GENERAL HOSPITAL SUPPLY CORPORATION	241.00	Hospital Supplies
204684	3/6/25	GENERAL HOSPITAL SUPPLY CORPORATION	520.00	Hospital Supplies
205123	3/27/25	HEALTHCARE LOGISTICS INC	77.12	Hospital Supplies
204916	3/20/25	HEALTHCARE LOGISTICS INC	105.00	Hospital Supplies
204799	3/13/25	HEALTHCARE LOGISTICS INC	798.28	Hospital Supplies
204687	3/6/25	HEALTHCARE LOGISTICS INC	834.18	Hospital Supplies
204917	3/20/25	HOLLISTER	61.65	Hospital Supplies
204805	3/13/25	J & J HEALTH CARE SYSTEMS INC	530.40	Hospital Supplies
205127	3/27/25	J & J HEALTH CARE SYSTEMS INC	6,793.92	Hospital Supplies
204696	3/6/25	J & J HEALTH CARE SYSTEMS INC	8,560.19	Hospital Supplies
204923	3/20/25	J & J HEALTH CARE SYSTEMS INC	27,045.27	Hospital Supplies
204929	3/20/25	KARL STORZ ENDOSCOPY-AMERICA	- 6,629.50	Hospital Supplies
204806	3/13/25	KARL STORZ ENDOSCOPY-AMERICA	12,959.00	Hospital Supplies
204807	3/13/25	KCI USA	732.62	Hospital Supplies
204704	3/6/25	KCI USA	2,119.99	Hospital Supplies
205141	3/27/25	M V A P MEDICAL SUPPLIES, INC.	8.99	Hospital Supplies
204943	3/20/25	M V A P MEDICAL SUPPLIES, INC.	128.00	Hospital Supplies
205136	3/27/25	MARKET LAB, INC	764.95	Hospital Supplies
204812	3/13/25	MASIMO AMERICAS, INC.	220.00	Hospital Supplies
204706	3/6/25	MASIMO AMERICAS, INC.	660.00	Hospital Supplies
205137	3/27/25	MASIMO AMERICAS, INC.	880.00	Hospital Supplies
204935	3/20/25	MASIMO AMERICAS, INC.	1,750.00	Hospital Supplies
204813	3/13/25	MCKESSON MEDICAL-SURGICAL	193.43	Hospital Supplies
204707	3/6/25	MCKESSON MEDICAL-SURGICAL	724.29	Hospital Supplies
205138	3/27/25	MCKESSON MEDICAL-SURGICAL	1,847.80	Hospital Supplies
204814	3/13/25	MEDELA LLC	615.16	Hospital Supplies
204936	3/20/25	MEDI-DOSE INCORPORATED	132.45	Hospital Supplies
204815	3/13/25	MEDLINE INDUSTRIES INC	13,297.07	Hospital Supplies
204937	3/20/25	MEDLINE INDUSTRIES INC	24,659.17	Hospital Supplies
204708	3/6/25	MEDLINE INDUSTRIES INC	74,971.98	Hospital Supplies
204818	3/13/25	MES	80.95	Hospital Supplies
204944	3/20/25	NATUS MEDICAL INC	193.00	Hospital Supplies
204948	3/20/25	OVATION MEDICAL	809.10	Hospital Supplies
204826	3/13/25	PERFORMANCE HEALTH SUPPLY INC	30.15	Hospital Supplies
204716	3/6/25	PERFORMANCE HEALTH SUPPLY INC	53.62	Hospital Supplies
204721	3/6/25	RADIOMETER AMERICA INC	1,360.43	Hospital Supplies
204959	3/20/25	RESMED CORP	475.00	Hospital Supplies
205153	3/27/25	RESPIRONICS	165.00	Hospital Supplies
204838	3/13/25	SMITHS MEDICAL ASD INC	346.50	Hospital Supplies
204969	3/20/25	STERIS CORPORATION	572.38	Hospital Supplies

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
03/31/2025

204841	3/13/25	STERIS CORPORATION	2,035.40	Hospital Supplies
204732	3/6/25	STERIS CORPORATION	2,166.04	Hospital Supplies
204976	3/20/25	TECHNICAL SAFETY SERVICES, LLC	10,432.50	Hospital Supplies
205167	3/27/25	TRI-ANIM HEALTH SERVICES INC	496.82	Hospital Supplies
204977	3/20/25	TRI-ANIM HEALTH SERVICES INC	1,323.16	Hospital Supplies
204741	3/6/25	TRI-ANIM HEALTH SERVICES INC	1,427.32	Hospital Supplies
204846	3/13/25	TRI-ANIM HEALTH SERVICES INC	3,893.11	Hospital Supplies
205170	3/27/25	TSI INCORPORATED	185.00	Hospital Supplies
204746	3/6/25	UTAH MEDICAL PRODUCTS INC	87.72	Hospital Supplies
205177	3/27/25	UTAH MEDICAL PRODUCTS INC	346.29	Hospital Supplies
205179	3/27/25	VERATHON INC.	681.80	Hospital Supplies
204852	3/13/25	VERATHON INC.	1,385.84	Hospital Supplies
204980	3/20/25	WAXIE SANITARY SUPPLY	25.00	Hospital Supplies
204749	3/6/25	WAXIE SANITARY SUPPLY	618.50	Hospital Supplies
EFT000000009051	3/6/2025	HARDY DIAGNOSTICS	266.63	Hospital Supplies
EFT000000009052	3/6/2025	IN PRO CORPORATION	367.10	Hospital Supplies
EFT000000009054	3/13/2025	HARDY DIAGNOSTICS	767.26	Hospital Supplies
EFT000000009059	3/20/2025	HARDY DIAGNOSTICS	459.87	Hospital Supplies
205108	3/27/25	COULMED PRODUCTS GROUP, LLC	2,969.76	Implant Supplies
204669	3/6/25	CTM BIOMEDICAL, LLC	5,091.50	Implant Supplies
205143	3/27/25	PARAGON 28 INC.	3,009.00	Implant Supplies
204949	3/20/25	PARAGON 28 INC.	3,970.72	Implant Supplies
204888	3/20/25	CIVCO MEDICAL INSTRUMENTS	423.00	Instruments
204745	3/6/25	PROVIDENT LIFE & ACCIDENT	37,677.73	Insurance Premiums
205044	3/25/25	INSURANCE REFUND	19.91	Insurance Refund
205038	3/25/25	INSURANCE REFUND	230.90	Insurance Refund
205037	3/25/25	INSURANCE REFUND	314.67	Insurance Refund
205079	3/27/25	INSURANCE REFUND	850.00	Insurance Refund
204996	3/25/25	INSURANCE REFUND	660.60	Insurance Refund
205070	3/25/25	INSURANCE REFUND	2,844.30	Insurance Refund
205039	3/25/25	INSURANCE REFUND	18.33	Insurance Refund
205091	3/27/25	INSURANCE REFUND	3,868.40	Insurance Refund
205054	3/25/25	INSURANCE REFUND	15.30	Insurance Refund
205053	3/25/25	INSURANCE REFUND	18.00	Insurance Refund
205067	3/25/25	INSURANCE REFUND	53.38	Insurance Refund
205064	3/25/25	INSURANCE REFUND	2,342.67	Insurance Refund
205055	3/25/25	INSURANCE REFUND	3,287.28	Insurance Refund
205065	3/25/25	INSURANCE REFUND	1,118.40	Insurance Refund
205046	3/25/25	INSURANCE REFUND	1,272.99	Insurance Refund
205040	3/25/25	INSURANCE REFUND	25.00	Insurance Refund
205068	3/25/25	INSURANCE REFUND	1,764.70	Insurance Refund
205052	3/25/25	INSURANCE REFUND	184.56	Insurance Refund
205063	3/25/25	INSURANCE REFUND	18.02	Insurance Refund
205049	3/25/25	INSURANCE REFUND	416.29	Insurance Refund
205042	3/25/25	INSURANCE REFUND	118.75	Insurance Refund
205041	3/25/25	INSURANCE REFUND	8,511.66	Insurance Refund
205056	3/25/25	INSURANCE REFUND	578.60	Insurance Refund
205057	3/25/25	INSURANCE REFUND	21.66	Insurance Refund
205059	3/25/25	INSURANCE REFUND	35.70	Insurance Refund

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
03/31/2025

205058	3/25/25	INSURANCE REFUND	54.48	Insurance Refund
205060	3/25/25	INSURANCE REFUND	78.92	Insurance Refund
205061	3/25/25	INSURANCE REFUND	78.92	Insurance Refund
204995	3/25/25	INSURANCE REFUND	350.61	Insurance Refund
205062	3/25/25	INSURANCE REFUND	367.57	Insurance Refund
205069	3/25/25	INSURANCE REFUND	94.05	Insurance Refund
204858	3/13/25	INSURANCE REFUND	438.68	Insurance Refund
205066	3/25/25	INSURANCE REFUND	529.15	Insurance Refund
205050	3/25/25	INSURANCE REFUND	640.30	Insurance Refund
205047	3/25/25	INSURANCE REFUND	33,699.50	Insurance Refund
205043	3/25/25	INSURANCE REFUND	195.78	Insurance Refund
205045	3/25/25	INSURANCE REFUND	37.17	Insurance Refund
205048	3/25/25	INSURANCE REFUND	355.05	Insurance Refund
205051	3/25/25	INSURANCE REFUND	289.15	Insurance Refund
204819	3/13/25	METABOLIC NEWBORN SCREENING	4,252.04	Laboratory Services
205164	3/27/25	SUMMIT PATHOLOGY	24,725.24	Laboratory Services
EFT000000009060	3/27/2025	ARUP LABORATORIES, INC.	500.00	Laboratory Services
204644	3/6/25	ANAEROBE SYSTEMS	102.60	Laboratory Supplies
204652	3/6/25	BIOMERIEUX, INC.	16,686.00	Laboratory Supplies
204775	3/13/25	CANCER DIAGNOSTICS, INC	292.00	Laboratory Supplies
204886	3/20/25	CEPHEID	2,728.00	Laboratory Supplies
204777	3/13/25	CEPHEID	11,753.60	Laboratory Supplies
205101	3/27/25	CEPHEID	17,146.20	Laboratory Supplies
205116	3/27/25	FISHER HEALTHCARE	2,104.89	Laboratory Supplies
204679	3/6/25	FISHER HEALTHCARE	4,491.36	Laboratory Supplies
204907	3/20/25	FISHER HEALTHCARE	4,914.41	Laboratory Supplies
204789	3/13/25	FISHER HEALTHCARE	16,999.42	Laboratory Supplies
205133	3/27/25	LIFELOC TECHNOLOGIES	37.38	Laboratory Supplies
204816	3/13/25	MERCEDES MEDICAL	164.88	Laboratory Supplies
204829	3/13/25	PIPETTE.COM	831.00	Laboratory Supplies
204839	3/13/25	STATLAB MEDICAL PRODUCTS	105.05	Laboratory Supplies
204844	3/13/25	SYSMEX AMERICA INC.	923.62	Laboratory Supplies
204737	3/6/25	SYSMEX AMERICA INC.	1,687.77	Laboratory Supplies
204847	3/13/25	TYPENEX MEDICAL, LLC	213.84	Laboratory Supplies
205171	3/27/25	TYPENEX MEDICAL, LLC	248.68	Laboratory Supplies
EFT000000009050	3/6/2025	BIO-RAD LABORATORIES	2,773.01	Laboratory Supplies
EFT000000009053	3/13/2025	BIO-RAD LABORATORIES	634.80	Laboratory Supplies
204693	3/6/25	HUSCH BLACKWELL LLP	837.00	Legal Fees
204828	3/13/25	PHILLIPS LAW, LLC	16,870.70	Legal Fees
205146	3/27/25	PHILLIPS LAW, LLC	18,327.48	Legal Fees
205159	3/27/25	STANDARD TEXTILE	635.76	Linen
204924	3/20/25	JC JACOBS CARPET ONE	2,571.19	Maintenance Supplies
205081	3/27/25	AGILITI SURGICAL EQUIPMENT REPAIR INC.	595.00	Maintenance & Repair
204657	3/6/25	CARRIER COMMERCIAL SERVICE	2,434.00	Maintenance & Repair
204690	3/6/25	HIGH SECURITY LOCK & ALARM	39.00	Maintenance & Repair
204925	3/20/25	JIM'S UPHOLSTERY	2,800.00	Maintenance & Repair
204715	3/6/25	PACIFIC STEEL HIDES FURS RECYC	368.04	Maintenance & Repair
204825	3/13/25	PARTSSOURCE	55.76	Maintenance & Repair
204950	3/20/25	PARTSSOURCE	884.72	Maintenance & Repair

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
03/31/2025

204953	3/20/25	PURE PROCESSING LLC	176.99	Maintenance & Repair
204718	3/6/25	PURE PROCESSING LLC	1,222.00	Maintenance & Repair
204851	3/13/25	VEOLIA WTS SERVICES USA, INC.	2,130.65	Maintenance & Repair
204869	3/20/25	ACE HARDWARE	45.96	Maintenance Supplies
205080	3/27/25	ACE HARDWARE	213.87	Maintenance Supplies
204890	3/20/25	CODALE ELECTRIC SUPPLY, INC	2,643.30	Maintenance Supplies
205104	3/27/25	CODALE ELECTRIC SUPPLY, INC	3,302.76	Maintenance Supplies
204663	3/6/25	CODALE ELECTRIC SUPPLY, INC	3,540.77	Maintenance Supplies
204779	3/13/25	CODALE ELECTRIC SUPPLY, INC	4,804.31	Maintenance Supplies
204685	3/6/25	GRAINGER	37.84	Maintenance Supplies
205121	3/27/25	GRAINGER	249.54	Maintenance Supplies
204794	3/13/25	GRAINGER	1,006.73	Maintenance Supplies
204913	3/20/25	GRAINGER	1,180.09	Maintenance Supplies
204801	3/13/25	HOME DEPOT	107.82	Maintenance Supplies
205125	3/27/25	HOME DEPOT	728.02	Maintenance Supplies
204919	3/20/25	HOME DEPOT	811.36	Maintenance Supplies
204692	3/6/25	HOME DEPOT	1,424.78	Maintenance Supplies
204802	3/13/25	INSULATION INC.	16,843.00	Maintenance Supplies
204942	3/20/25	MOUNTAIN STATES SUPPLY CO.	1,341.89	Maintenance Supplies
205140	3/27/25	MOUNTAIN STATES SUPPLY CO.	1,813.18	Maintenance Supplies
204822	3/13/25	NAPA AUTO PARTS	363.97	Maintenance Supplies
204713	3/6/25	NAPA AUTO PARTS	517.03	Maintenance Supplies
204831	3/13/25	PURPLE LIZARDS, LLC	1,090.00	Marketing & Promotional Supplies
204756	3/6/25	MOUNTAIN STATES EMPLOYERS COUNCIL	1,800.00	Membership
205085	3/27/25	ANN CLEVENGER	115.00	Membership Dues
204645	3/6/25	ANN CLEVENGER	135.00	Membership Dues
204795	3/13/25	GREEN RIVER CHAMBER OF COMMERCE	70.00	Membership Dues
204914	3/20/25	GREEN RIVER CHAMBER OF COMMERCE	1,000.00	Membership Dues
204940	3/20/25	MHSC MEDICAL STAFF	200.00	Membership Dues
204710	3/6/25	MHSC MEDICAL STAFF	700.00	Membership Dues
205185	3/27/25	WYAMSS	50.00	Membership Dues
204994	3/21/25	WYAMSS	250.00	Membership Dues
204751	3/6/25	WYAMSS	1,675.00	Membership Dues
204709	3/6/25	MHSC-FOUNDATION	524.32	MHSC Foundation
205075	3/25/25	MHSC-FOUNDATION	1,329.01	MHSC Foundation
204761	3/11/25	MHSC-FOUNDATION	1,346.51	MHSC Foundation
204804	3/13/25	IOPI MEDICAL LLC	2,300.00	Minor Equipment
205165	3/27/25	SUPERIOR AUDIOMETRICS, LLC	675.00	Minor Equipment
204850	3/13/25	US MED-EQUIP, LLC	227.76	Minor Equipment
205176	3/27/25	US MED-EQUIP, LLC	997.42	Minor Equipment
204739	3/6/25	TERMINIX OF WYOMING	261.00	Monthly Pest Control
204880	3/20/25	BROWN INDUSTRIES INC	741.70	Non Medical Supplies
205097	3/27/25	BROWN INDUSTRIES INC	4,218.00	Non Medical Supplies
204926	3/20/25	J.J. KELLER & ASSOCIATES, INC.	308.34	Non Medical Supplies
204703	3/6/25	KAYLA MANNIKKO	622.85	Non Medical Supplies
204743	3/6/25	TURN UP THE VOLUME DJ SERVICES	300.00	Non Medical Supplies
205113	3/27/25	ENCOMPASS GROUP, LLC	2,355.06	Office Supplies
204967	3/20/25	STANDARD REGISTER COMPANY	650.50	Office Supplies
204730	3/6/25	STANDARD REGISTER COMPANY	1,975.44	Office Supplies

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
03/31/2025

204968	3/20/25	STAPLES BUSINESS ADVANTAGE	1,571.21	Office Supplies
204731	3/6/25	STAPLES BUSINESS ADVANTAGE	3,069.84	Office Supplies
205160	3/27/25	STAPLES BUSINESS ADVANTAGE	5,172.80	Office Supplies
204738	3/6/25	TELUS HEALTH (US) LTD	1,533.00	Other Employee Benefits
204754	3/6/25	YOUNG AT HEART SENIOR CITIZENS CENTER	1,970.00	Other Employee Benefits
204897	3/20/25	THE CORPORATE GIFT SERVICE INC	4,519.38	Other Employee Benefits
205118	3/27/25	FOOD SERVICE RESOURCES	2,532.72	Other Purchased Services
204689	3/6/25	HERITAGE FORD OF VERNAL	146.67	Other Purchased Services
204820	3/13/25	MOMENTS BY TAYLOR PHOTOGRAPHY	1,800.00	Other Purchased Services
205188	3/28/25	QUICK RESPONSE TAXI	38.00	Other Purchased Services
204757	3/6/25	QUICK RESPONSE TAXI	107.00	Other Purchased Services
204989	3/21/25	QUICK RESPONSE TAXI	151.00	Other Purchased Services
204810	3/13/25	QUICK RESPONSE TAXI	157.00	Other Purchased Services
204727	3/6/25	SEWER PROS LLC	150.00	Other Purchased Services
204752	3/6/25	WYOTEL, INC	1,185.00	Other Purchased Services
205083	3/27/25	ALLEGION ACCESS TECHNOLOGIES	464.00	Other Purchased Services
205032	3/25/25	PATIENT REFUND	169.00	Patient Refund
205033	3/25/25	PATIENT REFUND	1,204.12	Patient Refund
204997	3/25/25	PATIENT REFUND	339.15	Patient Refund
205023	3/25/25	PATIENT REFUND	5.00	Patient Refund
204859	3/13/25	PATIENT REFUND	5.00	Patient Refund
205030	3/25/25	PATIENT REFUND	10.78	Patient Refund
205029	3/25/25	PATIENT REFUND	15.00	Patient Refund
205005	3/25/25	PATIENT REFUND	20.00	Patient Refund
205021	3/25/25	PATIENT REFUND	20.00	Patient Refund
205010	3/25/25	PATIENT REFUND	20.00	Patient Refund
205034	3/25/25	PATIENT REFUND	20.00	Patient Refund
205020	3/25/25	PATIENT REFUND	21.18	Patient Refund
205008	3/25/25	PATIENT REFUND	25.00	Patient Refund
204862	3/13/25	PATIENT REFUND	25.00	Patient Refund
205014	3/25/25	PATIENT REFUND	25.00	Patient Refund
205011	3/25/25	PATIENT REFUND	25.00	Patient Refund
205009	3/25/25	PATIENT REFUND	30.00	Patient Refund
205028	3/25/25	PATIENT REFUND	30.00	Patient Refund
205026	3/25/25	PATIENT REFUND	34.91	Patient Refund
205027	3/25/25	PATIENT REFUND	34.91	Patient Refund
205015	3/25/25	PATIENT REFUND	35.00	Patient Refund
205018	3/25/25	PATIENT REFUND	35.00	Patient Refund
205019	3/25/25	PATIENT REFUND	35.00	Patient Refund
205003	3/25/25	PATIENT REFUND	35.00	Patient Refund
205007	3/25/25	PATIENT REFUND	40.00	Patient Refund
205012	3/25/25	PATIENT REFUND	40.00	Patient Refund
205036	3/25/25	PATIENT REFUND	40.00	Patient Refund
205031	3/25/25	PATIENT REFUND	42.80	Patient Refund
205022	3/25/25	PATIENT REFUND	42.89	Patient Refund
205025	3/25/25	PATIENT REFUND	44.92	Patient Refund
204857	3/13/25	PATIENT REFUND	47.50	Patient Refund
205006	3/25/25	PATIENT REFUND	50.00	Patient Refund
205000	3/25/25	PATIENT REFUND	50.34	Patient Refund

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
03/31/2025

205002	3/25/25	PATIENT REFUND	51.00	Patient Refund
205013	3/25/25	PATIENT REFUND	51.74	Patient Refund
205001	3/25/25	PATIENT REFUND	57.15	Patient Refund
204860	3/13/25	PATIENT REFUND	62.43	Patient Refund
204861	3/13/25	PATIENT REFUND	68.54	Patient Refund
205024	3/25/25	PATIENT REFUND	71.60	Patient Refund
205035	3/25/25	PATIENT REFUND	73.00	Patient Refund
204999	3/25/25	PATIENT REFUND	100.00	Patient Refund
205017	3/25/25	PATIENT REFUND	105.90	Patient Refund
205004	3/25/25	PATIENT REFUND	124.53	Patient Refund
204863	3/13/25	PATIENT REFUND	521.49	Patient Refund
205016	3/25/25	PATIENT REFUND	239.12	Patient Refund
204764	3/11/25	UNITED WAY OF SOUTHWEST WYOMING	183.24	Payroll Deduction
205078	3/25/25	UNITED WAY OF SOUTHWEST WYOMING	183.24	Payroll Deduction
204759	3/11/25	CIRCUIT COURT 3RD JUDICIAL	314.45	Payroll Garnishment
205073	3/25/25	CIRCUIT COURT 3RD JUDICIAL	329.63	Payroll Garnishment
204758	3/11/25	CIRCUIT COURT 3RD JUDICIAL	331.77	Payroll Garnishment
205071	3/25/25	CIRCUIT COURT 3RD JUDICIAL	343.44	Payroll Garnishment
205072	3/25/25	CIRCUIT COURT 3RD JUDICIAL	359.61	Payroll Garnishment
204867	3/18/25	DISTRICT COURT THIRD JUDICIAL DIST	727.46	Payroll Garnishment
205074	3/25/25	DISTRICT COURT THIRD JUDICIAL DIST	1,181.66	Payroll Garnishment
204760	3/11/25	DISTRICT COURT THIRD JUDICIAL DIST	1,181.90	Payroll Garnishment
204762	3/11/25	STATE OF WYOMING DFS/CSES	600.91	Payroll Garnishment
205076	3/25/25	STATE OF WYOMING DFS/CSES	600.91	Payroll Garnishment
204763	3/11/25	TX CHILD SUPPORT SDU	461.54	Payroll Garnishment
205077	3/25/25	TX CHILD SUPPORT SDU	461.54	Payroll Garnishment
W/T	3/25/2025	PAYROLL 7	2,000,000.00	Payroll Transfer
W/T	3/1/2025	PAYROLL 6	2,000,000.00	Payroll Transfer
204941	3/20/25	MHSC - PETTY CASH	43.50	Petty Cash
204883	3/20/25	CARDINAL HEALTH PHARMACY MGMT	5,712.00	Pharmacy Management
205098	3/27/25	CARDINAL HEALTH PHARMACY MGMT	1,101,655.10	Pharmacy Management
204660	3/6/25	CESAR J. HERNANDEZ	10,589.16	Physician Recruitment
204887	3/20/25	CESAR J. HERNANDEZ	25,000.00	Physician Recruitment
204705	3/6/25	DR. KEN HOLT	25,000.00	Physician Recruitment
204800	3/13/25	HOLIDAY INN EXPRESS - LONE TREE HOSPITALITY, LLC	5,102.00	Physician Recruitment
204639	3/3/25	MARIAH PACHECO	15,000.00	Physician Recruitment
204990	3/21/25	THE PRESERVE AT ROCK SPRINGS	1,958.33	Physician Recruitment
204774	3/13/25	BRYAN PARADISE	1,238.39	Physician Recruitment
204674	3/6/25	DESERIEE STOFFERAHN	15,000.00	Physician Retention
204987	3/21/25	DR. ELIZABETH CONGDON	1,500.00	Physician Retention
204870	3/20/25	ADVANCED MEDICAL IMAGING, LLC	25,559.00	Physician Services
204664	3/6/25	COMPHEALTH,INC.	63,097.93	Physician Services
204783	3/13/25	CURATIVE TALENT, LLC	13,911.00	Physician Services
204670	3/6/25	CURATIVE TALENT, LLC	17,487.77	Physician Services
205109	3/27/25	CURATIVE TALENT, LLC	36,240.31	Physician Services
204901	3/20/25	CURATIVE TALENT, LLC	38,702.80	Physician Services
204719	3/6/25	QLER PHYSICIAN MEDICAL GROUP, P.A.	17,670.00	Physician Services
204750	3/6/25	WEATHERBY LOCUMS, INC	15,353.08	Physician Services
204984	3/21/25	AIDVANTAGE	2,500.00	Physician Student Loan

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
03/31/2025

204988	3/21/25	GREAT LAKES	1,666.67	Physician Student Loan
204985	3/21/25	MOHELA	1,666.67	Physician Student Loan
204986	3/21/25	MOHELA	2,500.00	Physician Student Loan
205110	3/27/25	MOHELA	3,333.34	Physician Student Loan
205139	3/27/25	MOHELA	5,000.00	Physician Student Loan
204991	3/21/25	US DEPARTMENT OF EDUCATION	3,333.34	Physician Student Loan
204992	3/21/25	US DEPT OF EDUCATION	1,666.67	Physician Student Loan
204952	3/20/25	POSTMASTER	1,370.00	Postage
205114	3/27/25	CE BROKER	510.64	Professional Service
205180	3/27/25	VERISYS INC.	89.25	Professional Service
204891	3/20/25	COLLEGE OF AMERICAN PATHOLOGY	1,043.89	Proficiency Testing
204910	3/20/25	GE HEALTHCARE INC	2,003.20	Radiology Material
204683	3/6/25	GE HEALTHCARE INC	3,004.80	Radiology Material
204792	3/13/25	GE HEALTHCARE INC	6,159.60	Radiology Material
205144	3/27/25	PHARMALOGIC WY, LTD	9,317.63	Radiology Material
205149	3/27/25	PINESTAR TECHNOLOGY, INC.	1,122.00	Radiology Material
204875	3/20/25	AUGUSTO JAMIAS	1,933.00	Reimbursement - CME
204655	3/6/25	BRIAN BARTON, PA-C	1,143.74	Reimbursement - CME
204786	3/13/25	DESERIEE STOFFERAHN	991.17	Reimbursement - CME
204711	3/6/25	DR MICHAEL BOWERS	225.00	Reimbursement - CME
204881	3/20/25	DR. BRYTTON LONG	888.00	Reimbursement - CME
204672	3/6/25	DR. DAVID DANSIE	1,054.96	Reimbursement - CME
204902	3/20/25	DR. DAVID LIU	4,012.00	Reimbursement - CME
204904	3/20/25	DR. ELIZABETH CONGDON	777.94	Reimbursement - CME
204700	3/6/25	DR. JOSHUA BINKS	340.00	Reimbursement - CME
204932	3/20/25	DR. KYLE HOFFMAN	225.62	Reimbursement - CME
205126	3/27/25	ISRAEL STEWART, DO	502.96	Reimbursement - CME
204695	3/6/25	ISRAEL STEWART, DO	749.26	Reimbursement - CME
204927	3/20/25	JOCELYN PALINEK	2,652.24	Reimbursement - CME
204964	3/20/25	SHAWN ROCKEY, PA-C	195.00	Reimbursement - CME
204640	3/6/25	AIMEE URBIN	309.92	Reimbursement - Education & Travel
204654	3/6/25	BRANDIE MORRELL	125.00	Reimbursement - Education & Travel
205102	3/27/25	CESAR J. HERNANDEZ	408.77	Reimbursement - Education & Travel
205103	3/27/25	CINDY NELSON	3,272.05	Reimbursement - Education & Travel
204899	3/20/25	CRAIG ROOD	48.18	Reimbursement - Education & Travel
204671	3/6/25	DANIELLE TURNER	550.00	Reimbursement - Education & Travel
204784	3/13/25	DEBBIE PARKINS	234.21	Reimbursement - Education & Travel
204865	3/17/25	DR. JANENE GLYN	1,584.22	Reimbursement - Education & Travel
205130	3/27/25	DR. KEN HOLT	1,090.71	Reimbursement - Education & Travel
204957	3/20/25	DR. RASHEEL CHOWDHARY	2,986.80	Reimbursement - Education & Travel
204866	3/17/25	DR. WILLIAM SARETTE	2,332.44	Reimbursement - Education & Travel
204922	3/20/25	IRENE RICHARDSON	291.69	Reimbursement - Education & Travel
204698	3/6/25	JODI CHEESE	996.97	Reimbursement - Education & Travel
204699	3/6/25	JOE MANSFIELD	42.66	Reimbursement - Education & Travel
205128	3/27/25	JULIANNE FORRESTER	839.69	Reimbursement - Education & Travel
204701	3/6/25	KAITLYN ICE	550.00	Reimbursement - Education & Travel
204928	3/20/25	KANDI PENDLETON	160.70	Reimbursement - Education & Travel
204702	3/6/25	KARI QUICKENDEN	134.16	Reimbursement - Education & Travel
205134	3/27/25	LINDSEY O'TOOLE	375.12	Reimbursement - Education & Travel

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
03/31/2025

205135	3/27/25	MARIANNE SANDERS	2,269.61	Reimbursement - Education & Travel
204811	3/13/25	MARINA MONTOYA	550.00	Reimbursement - Education & Travel
204823	3/13/25	NENA JAMES	80.00	Reimbursement - Education & Travel
205162	3/27/25	STEPHANIE DUPAPE	202.92	Reimbursement - Education & Travel
204840	3/13/25	STEPHANIE DUPAPE	291.84	Reimbursement - Education & Travel
204734	3/6/25	SUZAN CAMPBELL	325.00	Reimbursement - Education & Travel
W/T	3/10/2025	PCS CONT 2/27/25	155,694.42	Retirement
W/T	3/10/2025	PCS MATCH 2/27/25	101,401.99	Retirement
W/T	3/24/2025	PCS MATCH 3/13/25	105,459.18	Retirement
W/T	3/24/2025	PCS CONT 3/13/25	161,817.31	Retirement
204767	3/13/25	AMERICAN LEGION TOM WHITMORE POST 28	500.00	Sponsorship
204653	3/6/25	BOY SCOUTS OF AMERICA-CROSSROADS OF THE WEST COUNCIL	500.00	Sponsorship
204797	3/13/25	GREEN RIVER BABE RUTH	250.00	Sponsorship
204697	3/6/25	JAE FOUNDATION	200.00	Sponsorship
204821	3/13/25	MULEY FANATIC FOUNDATION	1,000.00	Sponsorship
204958	3/20/25	RED DESERT ROUNDUP RODEO	3,100.00	Sponsorship
204975	3/20/25	SWEETWATER COUNTY CHILD DEVELOPMENTAL CENTER	650.00	Sponsorship
204735	3/6/25	SWEETWATER COUNTY ROLLER DERBY	500.00	Sponsorship
204736	3/6/25	SWEETWATER MUSIC KEYS	250.00	Sponsorship
205172	3/27/25	UINTA COUNTY PUBLIC HEALTH	250.00	Sponsorship
204868	3/20/25	ACADEMY OF LYMPHATIC STUDIES	198.00	Surgery Supplies
204872	3/20/25	ALI MED INC	295.66	Surgery Supplies
204765	3/13/25	ALI MED INC	532.57	Surgery Supplies
205082	3/27/25	ALI MED INC	595.35	Surgery Supplies
204642	3/6/25	ALI MED INC	843.99	Surgery Supplies
205087	3/27/25	ARMSTRONG MEDICAL INDUSTRIES	135.60	Surgery Supplies
204772	3/13/25	BECTON DICKINSON	1,009.91	Surgery Supplies
205093	3/27/25	BECTON DICKINSON	1,465.50	Surgery Supplies
204650	3/6/25	BECTON DICKINSON	2,501.25	Surgery Supplies
204879	3/20/25	BECTON DICKINSON	3,221.54	Surgery Supplies
204773	3/13/25	BLUE ENDO	284.51	Surgery Supplies
204668	3/6/25	C2DX, INC.	900.00	Surgery Supplies
204665	3/6/25	CONMED LINVATEC	677.75	Surgery Supplies
204895	3/20/25	COOPER SURGICAL	135.38	Surgery Supplies
205107	3/27/25	COOPER SURGICAL	1,457.31	Surgery Supplies
204666	3/6/25	COOPER SURGICAL	2,068.91	Surgery Supplies
204898	3/20/25	COVIDIEN SALES LLC, DBA GIVEN IMAGING	2,440.17	Surgery Supplies
204782	3/13/25	COVIDIEN SALES LLC, DBA GIVEN IMAGING	11,722.72	Surgery Supplies
204905	3/20/25	EQUASHIELD LLC	3,552.32	Surgery Supplies
204921	3/20/25	INSTRAMED INC.	109.00	Surgery Supplies
204803	3/13/25	INTUITIVE SURGICAL INC.	5,922.00	Surgery Supplies
204694	3/6/25	INTUITIVE SURGICAL INC.	197,159.68	Surgery Supplies
205166	3/27/25	JOHNSON & JOHNSON HEALTHCARE	7,232.40	Surgery Supplies
204817	3/13/25	MERCURY MEDICAL	51.84	Surgery Supplies
204938	3/20/25	MERCURY MEDICAL	212.31	Surgery Supplies
204939	3/20/25	MERIT MEDICAL SYSTEMS, INC	5,505.00	Surgery Supplies
204712	3/6/25	NANOSONICS, INC	128.00	Surgery Supplies
204714	3/6/25	NEOGEN CORPORATION	340.10	Surgery Supplies
204945	3/20/25	NEOGEN CORPORATION	970.34	Surgery Supplies

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
03/31/2025

204833	3/13/25	RHYTHMLINK INTERNATIONAL LLC	917.90	Surgery Supplies
204960	3/20/25	RHYTHMLINK INTERNATIONAL LLC	1,211.70	Surgery Supplies
204728	3/6/25	SHEATHING TECHOLOGIES, INC.	95.15	Surgery Supplies
205157	3/27/25	SMITH & NEPHEW ENDOSCOPY INC	2,078.24	Surgery Supplies
204729	3/6/25	SMITH & NEPHEW ENDOSCOPY INC	3,899.00	Surgery Supplies
204970	3/20/25	STRYKER ENDOSCOPY	288.35	Surgery Supplies
205163	3/27/25	STRYKER ENDOSCOPY	288.35	Surgery Supplies
204733	3/6/25	STRYKER ORTHOPAEDICS	10,609.00	Surgery Supplies
204971	3/20/25	STRYKER ORTHOPAEDICS	19,562.30	Surgery Supplies
204843	3/13/25	STRYKER ORTHOPAEDICS	32,403.34	Surgery Supplies
204973	3/20/25	SURGICAL DIRECT	588.68	Surgery Supplies
204974	3/20/25	SURGISHOP	3,000.00	Surgery Supplies
204753	3/6/25	XODUS MEDICAL, INC.	398.00	Surgery Supplies
204856	3/13/25	XODUS MEDICAL, INC.	398.00	Surgery Supplies
204983	3/20/25	XODUS MEDICAL, INC.	398.00	Surgery Supplies
205186	3/27/25	XODUS MEDICAL, INC.	1,194.00	Surgery Supplies
205187	3/27/25	ZIMMER BIOMET	756.00	Surgery Supplies
204755	3/6/25	ZIMMER BIOMET	763.00	Surgery Supplies
205150	3/27/25	PRESS GANEY ASSOCIATES, INC	4,980.88	Surveys
204848	3/13/25	UNIVERSITY MEDICAL BILLING	3,419.60	Title 25
205132	3/27/25	LANGUAGE LINE SERVICES	2,182.08	Translation Services
204740	3/6/25	TRENTON MCKENZIE	150.00	Uniform
204766	3/13/25	ALL WEST COMMUNICATIONS	5,971.73	Utilities
204770	3/13/25	AT&T	52.51	Utilities
205090	3/27/25	AT&T	322.15	Utilities
205152	3/27/25	CENTURY LINK	1,219.81	Utilities
204956	3/20/25	CENTURY LINK	2,535.21	Utilities
204720	3/6/25	CENTURY LINK	4,228.94	Utilities
205112	3/27/25	DISH NETWORK LLC	97.64	Utilities
204955	3/20/25	DOMINION ENERGY WYOMING	33,658.43	Utilities
204834	3/13/25	ROCK SPRINGS MUNICIPAL UTILITY	11,739.35	Utilities
204961	3/20/25	ROCKY MOUNTAIN POWER	48,408.49	Utilities
204981	3/20/25	WHITE MOUNTAIN WATER & SEWER DISTRICT	65.18	Utilities
204842	3/13/25	STERICYCLE,INC.	2,650.36	Waste Disposal
			9,542,568.45	

Memorial Hospital of Sweetwater County
County Voucher Summary
as of month ending March 31, 2025

Vouchers Submitted by MHSC at agreed discounted rate		
July 2024	$45,604.93	
August 2024	$0.00	
September 2024	$41,031.27	
October 2024	$0.00	
November 2024	$36,972.81	
December 2024	$35,266.04	
January 2025	$0.00	
February 2025	$44,725.43	
March 2025	$0.00	
April 2025		
May 2025		
June 2025		
County Requested Total Vouchers Submitted	$203,600.48	
Total Vouchers Submitted FY 25		$203,600.48
Less: Total Approved by County and Received by MHSC FY 25		$203,600.48
Total Vouchers Pending Approval by County		$0.00

FY25 Title 25 Fund Budget from Sweetwater County	$471,488.00
Funds Received From Sweetwater County	$203,600.48
FY25 Title 25 Fund Budget Remaining	$267,887.52
Total Budgeted Vouchers Pending Submittal to County	$0.00

FY25 Maintenance Fund Budget from Sweetwater County	$1,675,536.00
County Maintenance FY25 - July	$267,590.41
County Maintenance FY25 - August	$0.00
County Maintenance FY25 - September	$0.00
County Maintenance FY25 - October	$0.00
County Maintenance FY25 - November	$80,048.00
County Maintenance FY25 - December	$0.00
County Maintenance FY25 - January	$157,445.10
County Maintenance FY25 - February	$0.00
County Maintenance FY25 - March	$88,648.87
County Maintenance FY25 - April	
County Maintenance FY25 - May	
County Maintenance FY25 - June	
	$593,732.38
FY25 Maintenance Fund Budget Remaining	$1,081,803.62

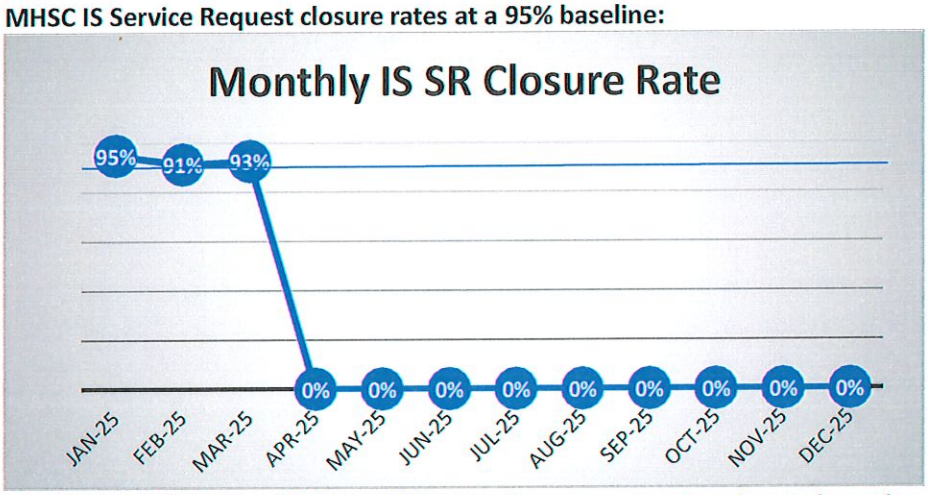
IS Report March 2025

By Terry (TJ) Thompson, IS Director

MHSC IS service environment:

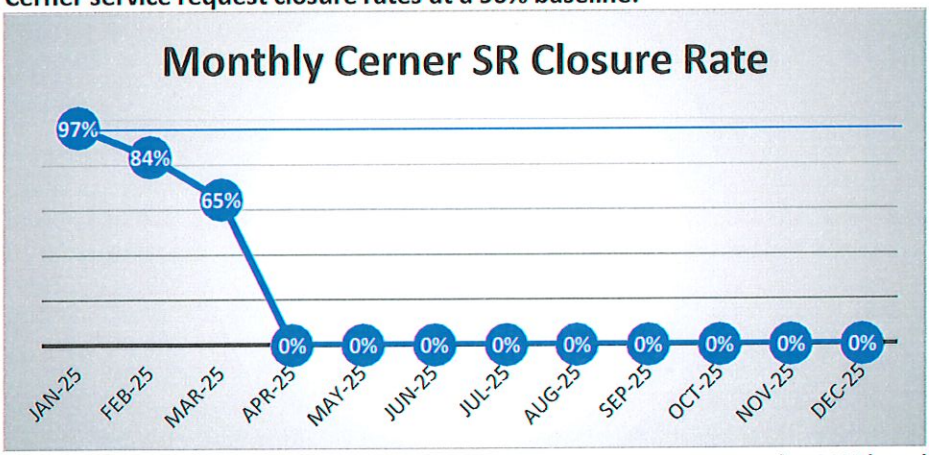
- 1158 computer user accounts
- 100 portable devices, Cell Phones, and iPads
- 790 Desktop systems, Laptops, and Desktops
- 562 VoIP Telephony devices
- 164 Servers, 158 being virtual systems.
- 86 Networking Nodes
- 103 Wireless devices
- 18 Uninterrupted Power Supplies

MHSC IS Service Request closure rates at a 95% baseline:



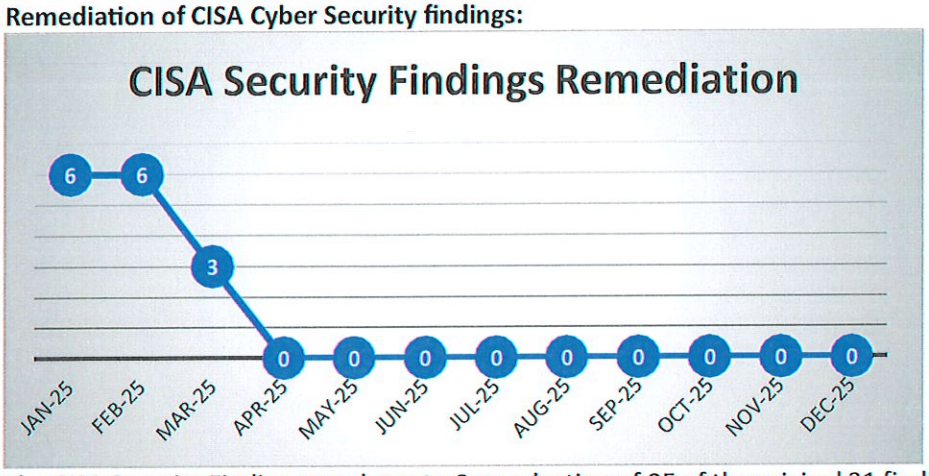
Service Desk 93% of our 95% monthly meantime to restore baseline. Where the service desk closed 717 of the 936 service tickets opened, 162 of which are still pending. This was primarily due to staff PTO

Cerner service request closure rates at a 90% baseline:



Cerner is at dropped to an 65% of the weekly meantime to restore the 90% baseline. Cerner closed 11 of the 24 service requests of which 7 are pending, leaving 6 SR opened.

Remediation of CISA Cyber Security findings:



The CISA Security Findings are down to 6, a reduction of 25 of the original 31 findings.

The remaining seven CISA security findings are known as heavy lift issues which require a restructuring of MHSC systems and network where we must make infrastructure changes without outages. We are slowly making these changes and will continue to monitor the remaining CISA issues. With the new Intune configuration, we are seeing improvement with system security. We were able to move to our public IP space removing the FatPipe systems reducing our vulnerability down to three.

Below is the latest CISA Cyber Hygiene Report Card, which is performed weekly. CISA is scanning MHSC 44 external public IP addresses for vulnerabilities. We have 44 scanned addresses, with 8 hosts and 14, we hope to have many of these security findings remediate. Where two hosts have 2 medium and 0 low vulnerabilities. This is due to the completed migrating to our new public IP addressing range, which requires coordination with multiple parties.

2025-03-29

CYBER HYGIENE

REPORT CARD

Memorial Hospital of Sweetwater County

0 Hosts with unsupported software

0 Potentially Risky Open Services

0% No Change in Vulnerable Hosts

CISA CYBER+INFRASTRUCTURE

HIGH LEVEL FINDINGS

LATEST SCANS

January 21, 2025 — March 29, 2025
Completed host scan on all assets

March 26, 2025 — March 29, 2025
Last vulnerability scan on all hosts

ASSETS OWNED

44
No Change

ASSETS SCANNED

44
No Change
100% of assets scanned

HOSTS

5
Decrease of 1

SERVICES

9
Decrease of 1

VULNERABLE HOSTS

1
No Change
20% of hosts vulnerable

VULNERABILITIES

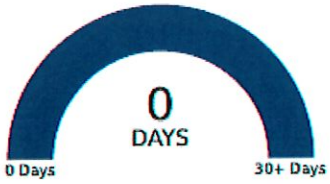
2
No Change

VULNERABILITIES

SEVERITY BY PROMINENCE

VULNERABILITY RESPONSE TIME

MAX AGE OF ACTIVE CRITICALS



MAX AGE OF ACTIVE HIGHS

POTENTIALLY RISKY OPEN SERVICES

RDP* 0	FTP 0
Telnet* 0	RPC 0
SMB* 0	SQL 0
LDAP 0	IRC 0
NETBIOS 0	Kerberos 0

None Open | Open, No New | Newly Opened

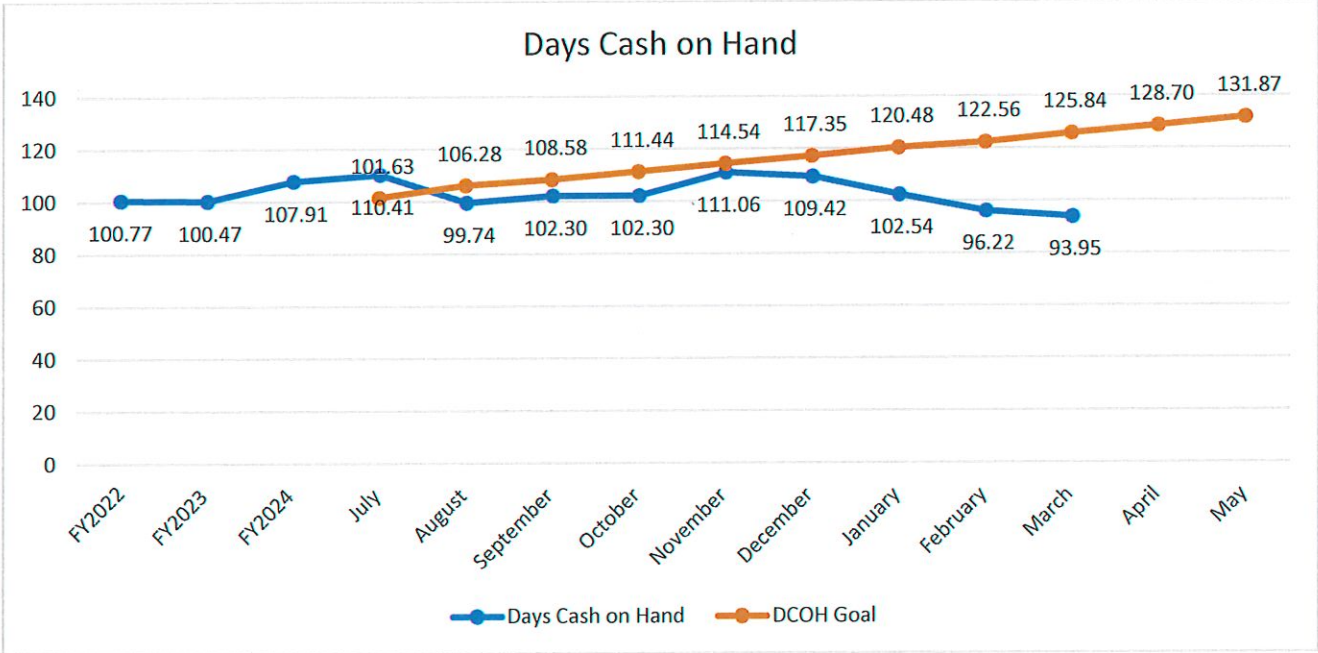
Service counts are best guesses and may not be 100% accurate. Details can be found in "potentially-risky-services.csv" in Appendix G.

**Denotes the possibility of a network management interface.*

Strategic Plan – Finance Pillar Goals – Fiscal Year 2025. The revenue cycle goals for fiscal year 2025 have been created in conjunction with the objectives of the finance pillar of the new Strategic Plan. For fiscal year 2025, we will continue to focus on the following revenue cycle metrics: Days Cash on Hand (DCOH), Days in Accounts Receivable (AR), Cash Collections, Claims Denial Rate, Discharged Not Final Billed Days (DNFB), and Accounts Receivable aging. We have included prior fiscal year data for reference when available.

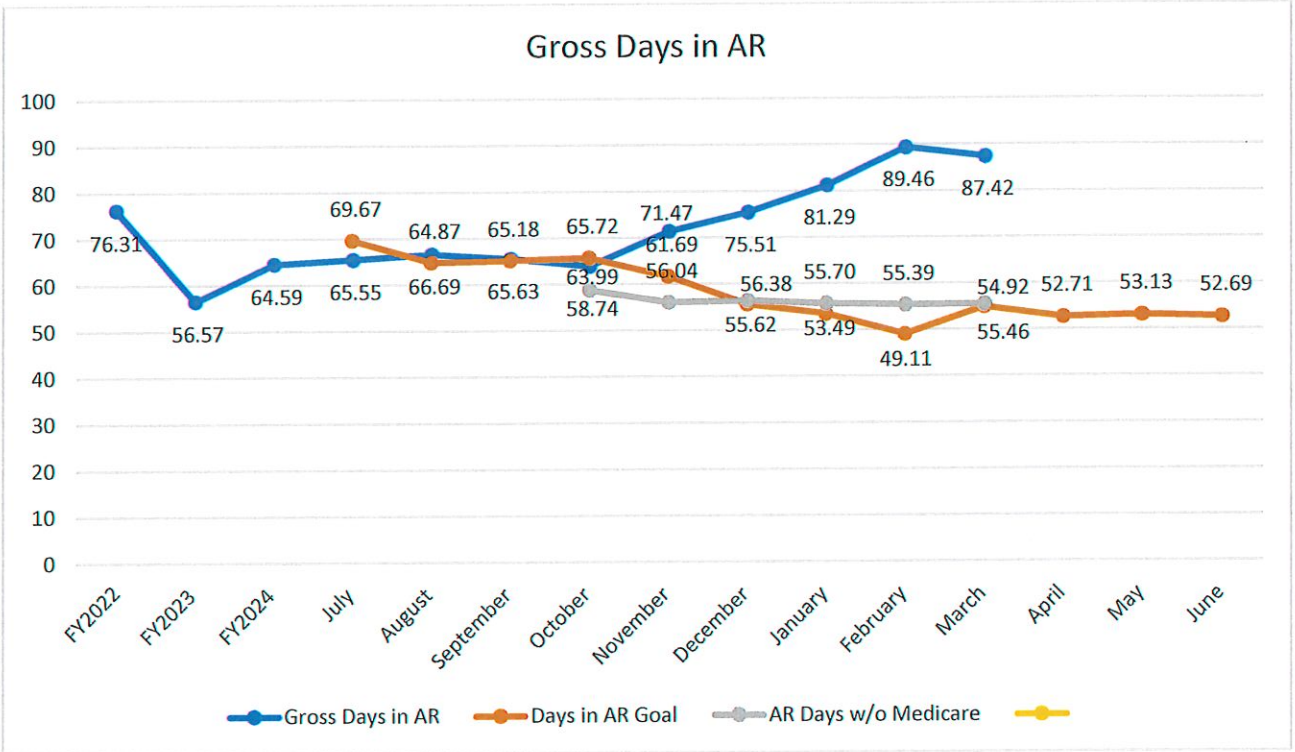
- **Days Cash on Hand** represents the number of days the hospital can operate without cash receipts utilizing all sources of cash available. We have set interim goals of 109 days for September, 117 days for December, 126 days for March and 133 days for year end.

    - There was a decrease of two days in DCOH, coming in at 94, below the goal for the month. Cash collections were $10.5 million, under budget but higher than previous months as we started to see delayed Medicare payments come in. Daily cash expense decreased to $337,900 in March.

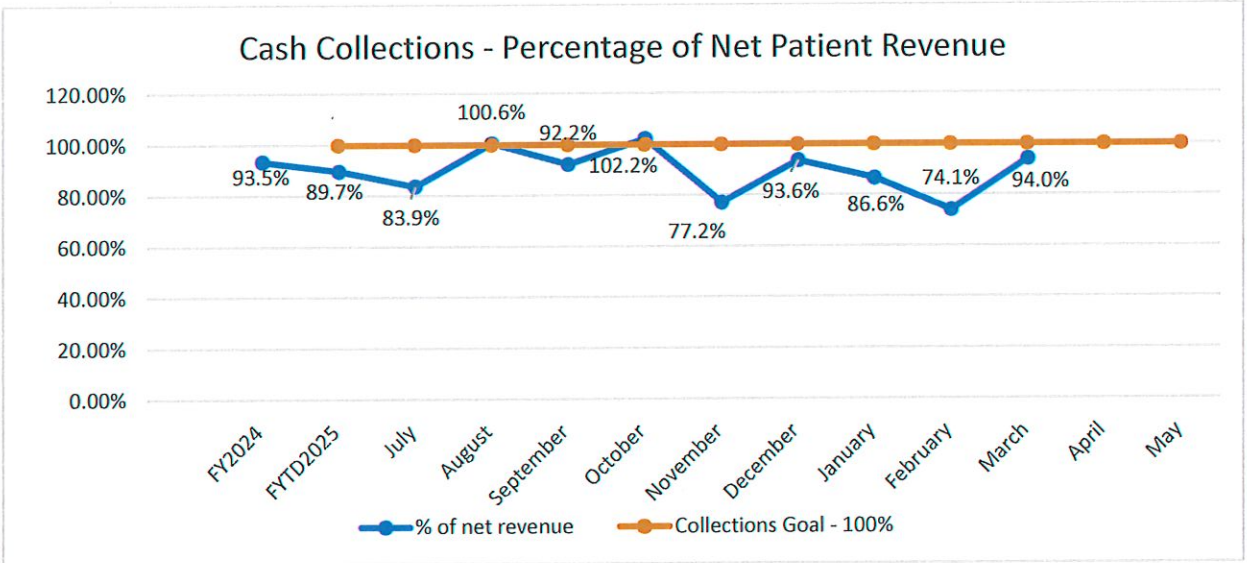


- **Days in Accounts Receivable** represents the number of days of patient charges tied up in unpaid patient accounts. We have set interim goals of 65 days for September, 56 days for December, 55 for March and 53 by year end.

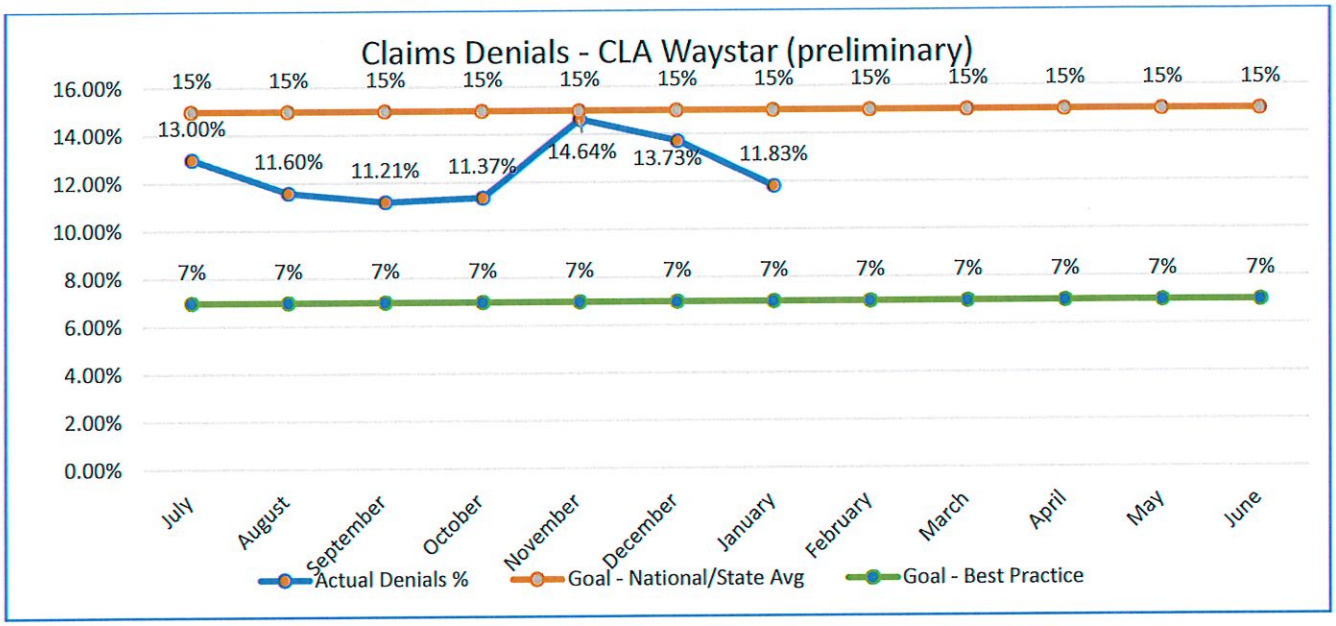
    - Days in AR decreased in March Medicare started processing delayed claims, coming in at 87.42 significantly over the goal of 55. Gross AR decreased by $2.5 million from February and Medicare AR is currently down by another $8 million since March 31st. **When the estimated Medicare outstanding AR is removed, Days in AR are estimated at 55 in March.**



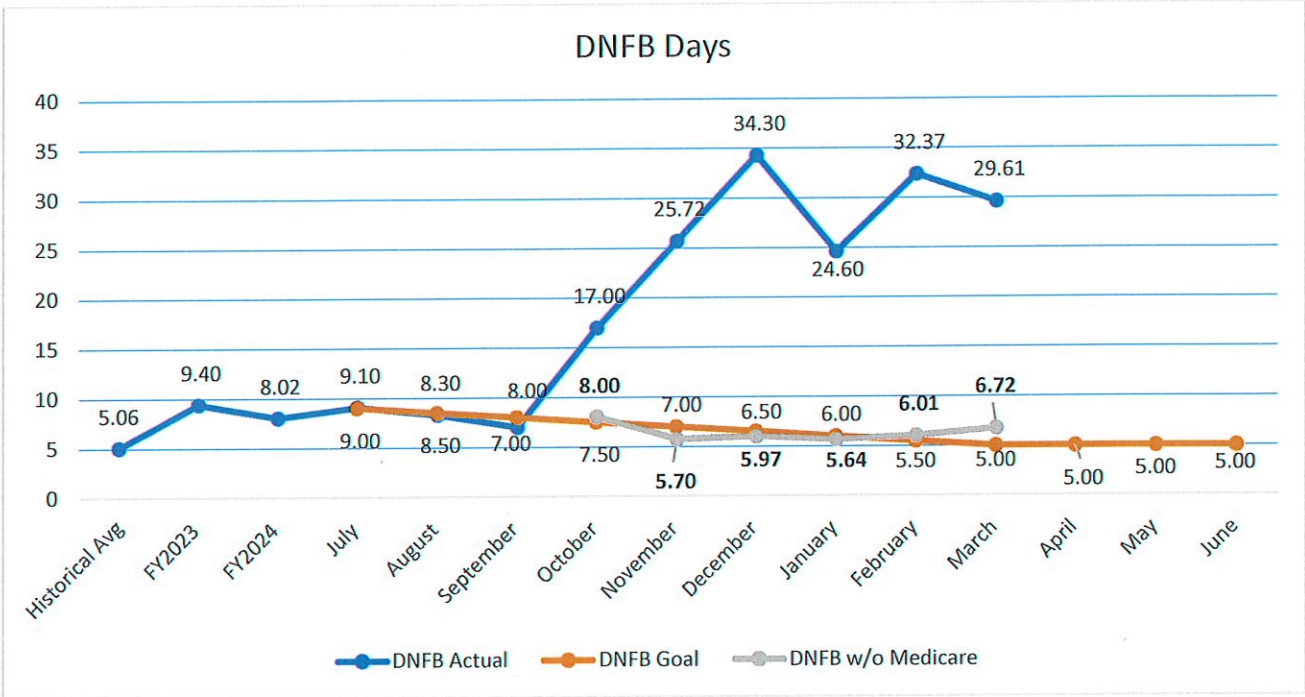
- **Cash Collections –** The goal for cash collections is 100% or > than net patient revenue.
    - Cash collections for March were higher, at $10.5 million, or 94% of net patient revenue, below the goal for the month but increasing the year-to-date percentage to 89.7%. **The lack of Medicare payments since November has impacted this ratio as Medicare payments average $2.5 million per month.**



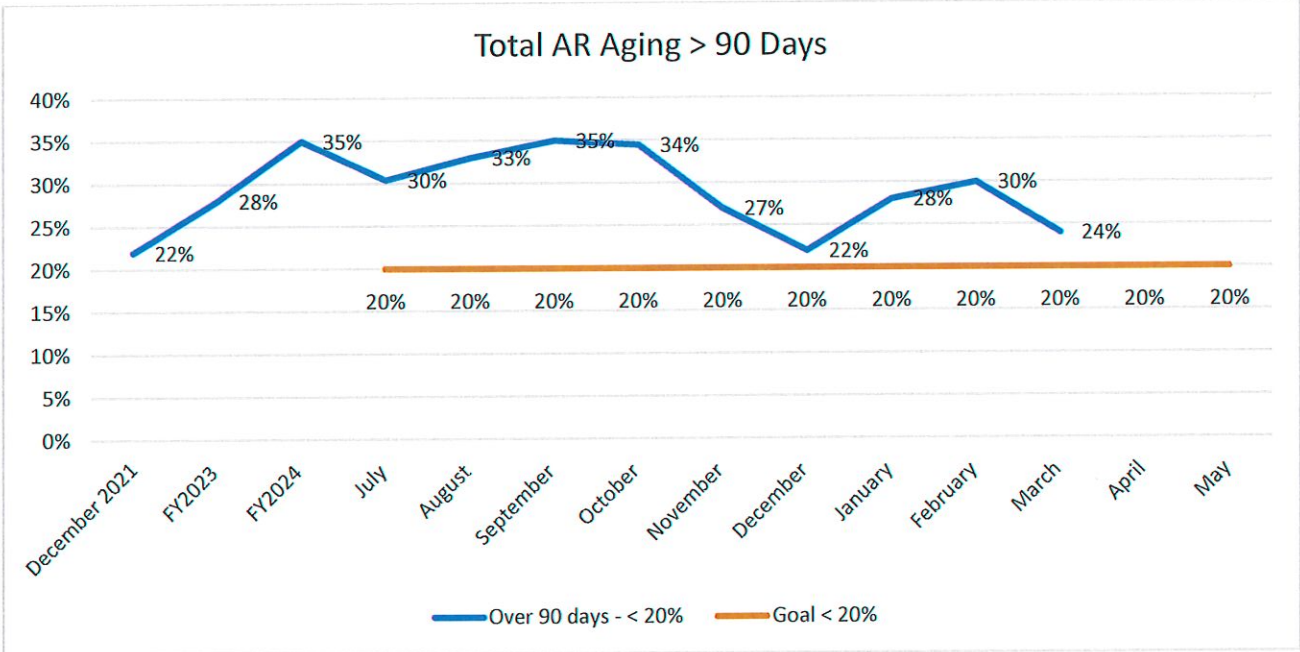
- **Denial Rate** – The denial rate is the percentage of all submitted claims denied by payers. A lower denial rate means improved cash flow. Current state and national benchmarks are at 15%. We have set interim goals of 20% for September, 17% for December, 15% for March and maintaining 15% by year end. Due to meeting the goal, we have added a stretch goal of 7%.
    - We continue to work with CLA and their new software and can report preliminary numbers through January, coming in at 11.83%.



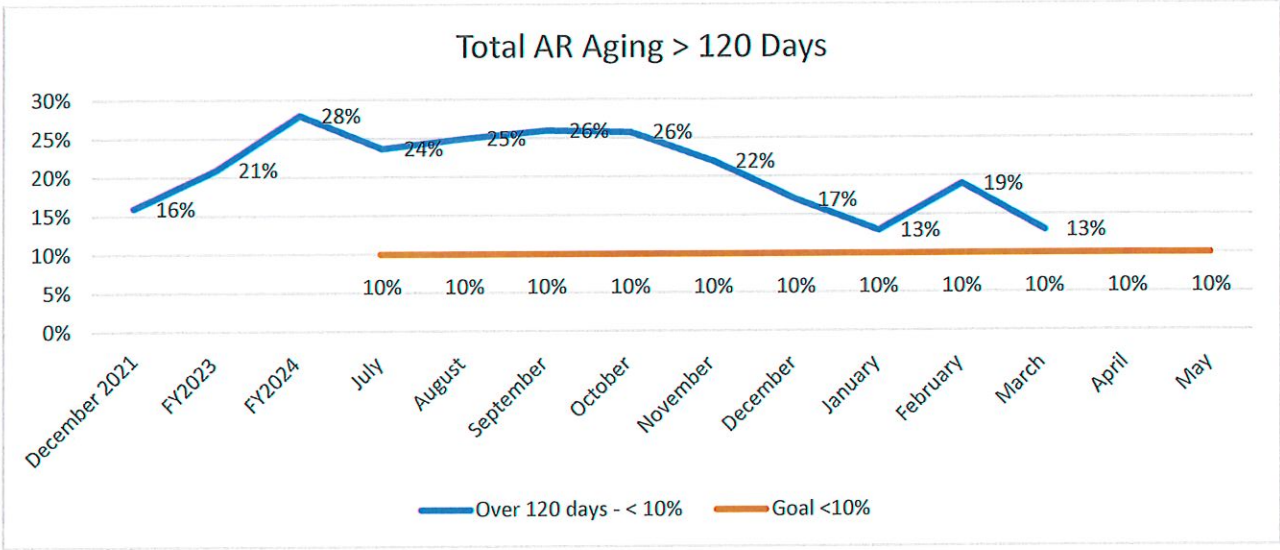
- **DNFB Days – Discharged Not Final Billed days**. Patient accounts that have been discharged but not billed. DNFB includes billing holds, corrections required, credit balances, waiting for coding, ready to bill and standard delay which are accounts held for 3 days before being released for billing. This allows for all charges to be posted, charts documented, and coding completed. The goal for DNFB days is 5 days by the end of the fiscal year.
    - DNFB Days decreased to 29.61 days in March as we started to release new Medicare claims in March. At the end of March, we were still holding about $18 million in CAH claims. By the third week of April, all Medicare claims had been billed and DNFB decreased to 8.85 days. **When removed, DNFB is estimated at 6.7 days for the month, just above the goal of 5 days.**



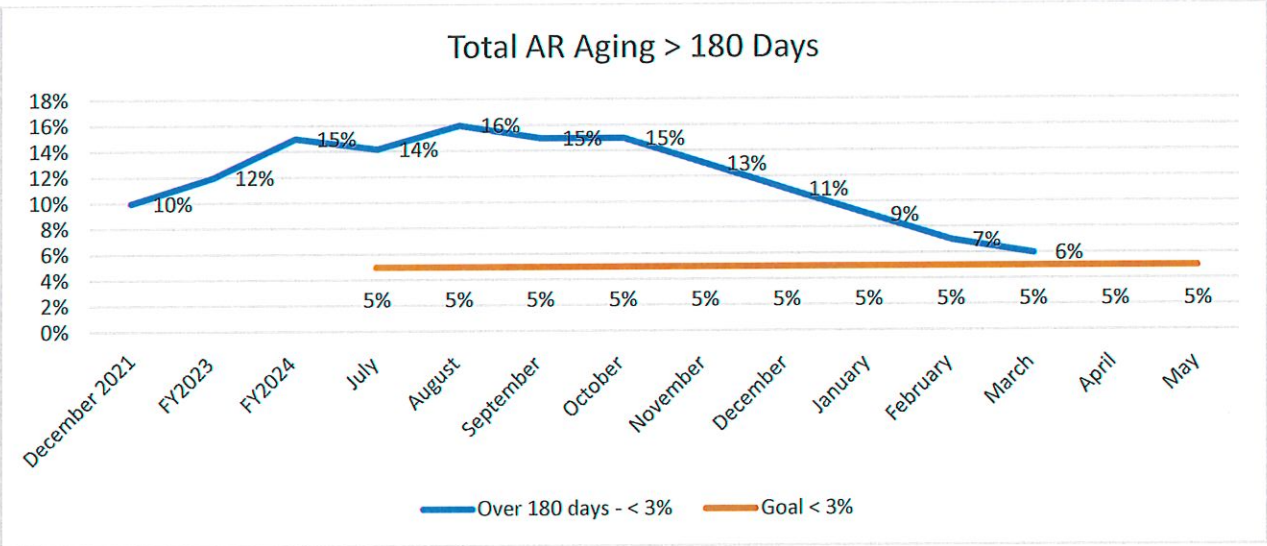
- **Total Accounts Receivable aging** – Goals were set based on national benchmarks received from CLA. These aging ratios are being impacted by the Medicare claims delay. Held claims are currently in 0-30 days but released claims for Medicare fell into aging based on the discharge date of the patient account, with some being over 120 days old.



- Days over 90 days decreased to 24% for March.



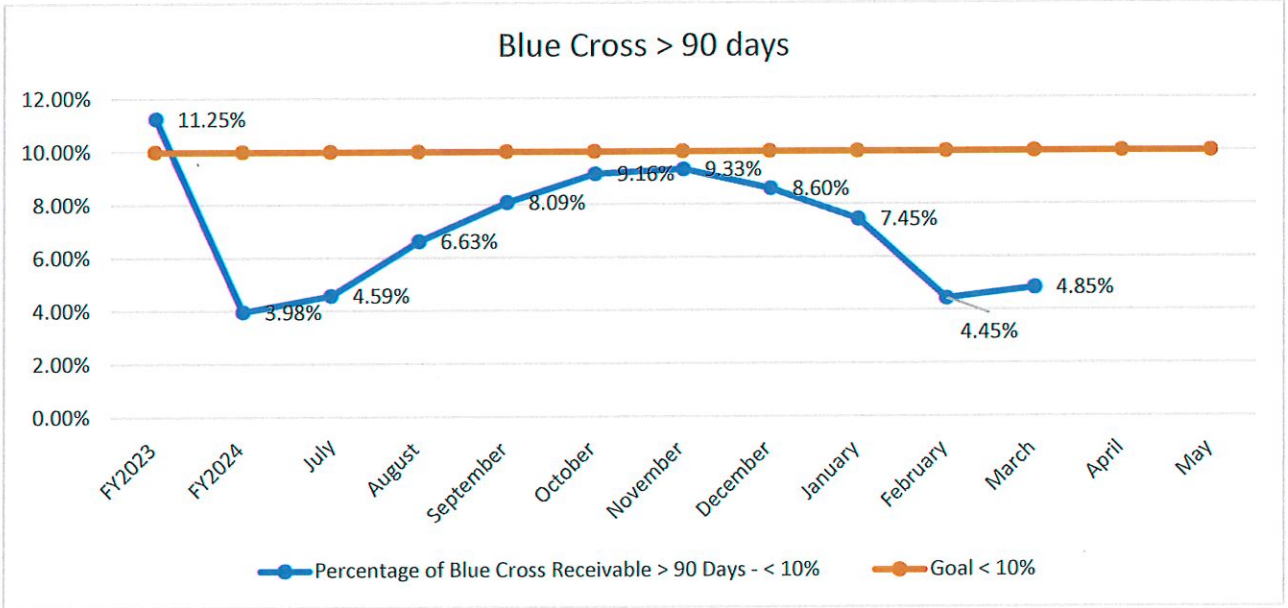
- Days over 120 days decreased to 13% for March.



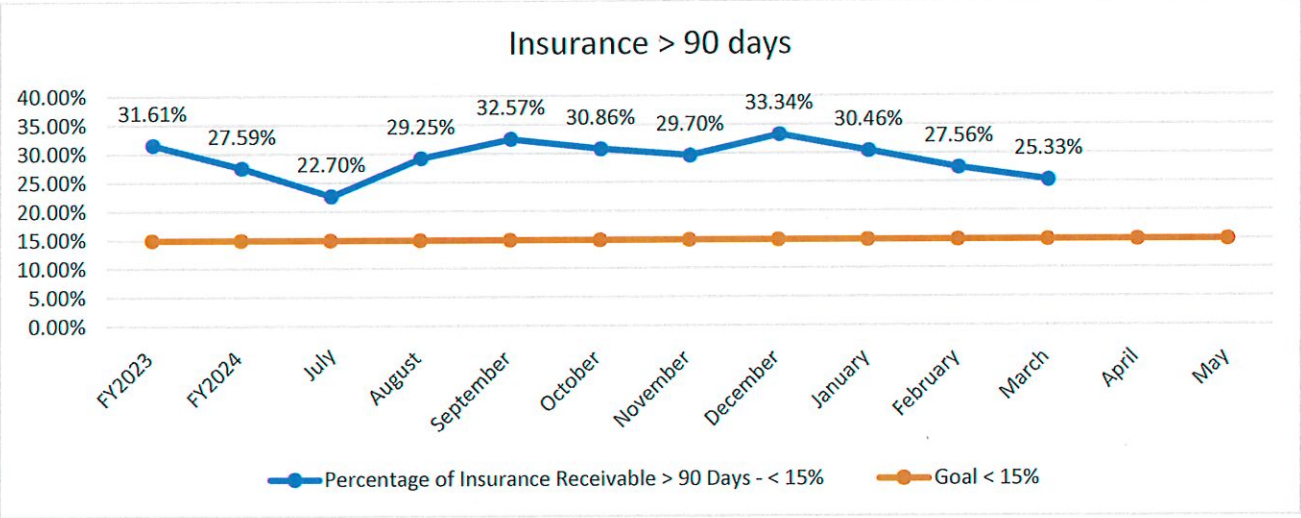
- Days over 180 days decreased to 6% for March.

- **Days in AR by Payer** – These metrics show more detail of the aging AR by payer. We saw a decrease in the aging AR for Blue Cross, Commercial and Medicare with Medicaid staying right at the goal. These goals are as follows:

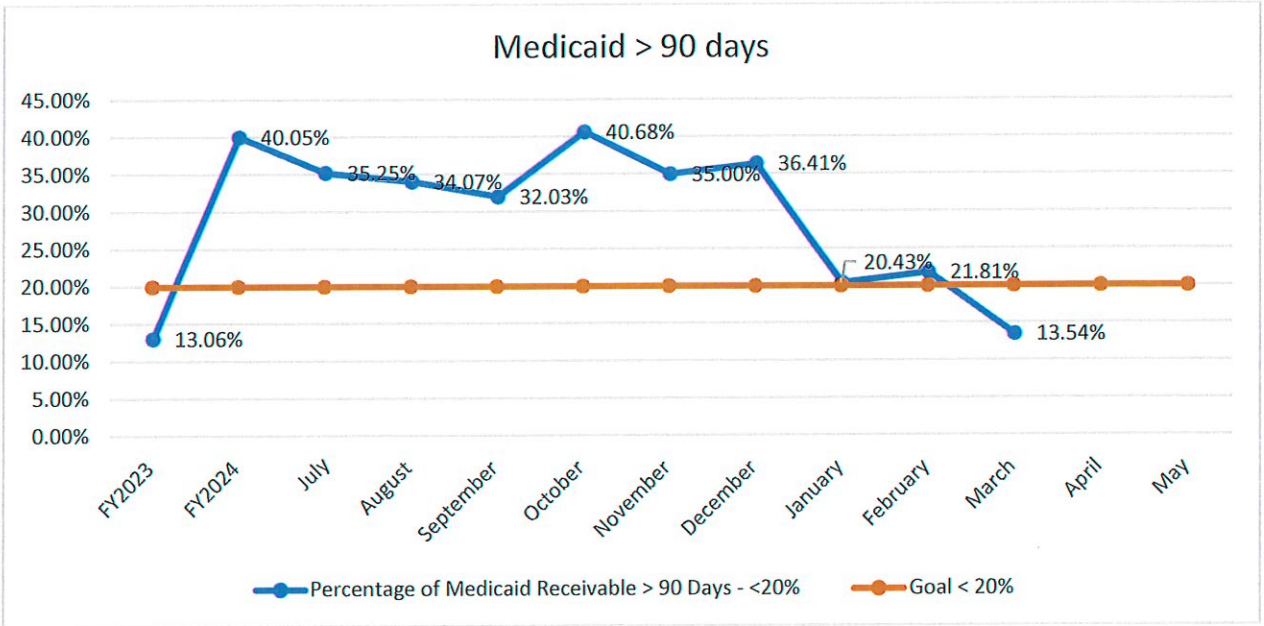
  - BCBS Days in AR > 90 days less than 10%
  - Insurance Days in AR > 90 days less than 15%
  - Medicaid Days in AR > 90 days less than 20%
  - Medicare Days in AR > **60 days** less than 6%
  - Self-Pay Days in AR > 90 days less than 30%



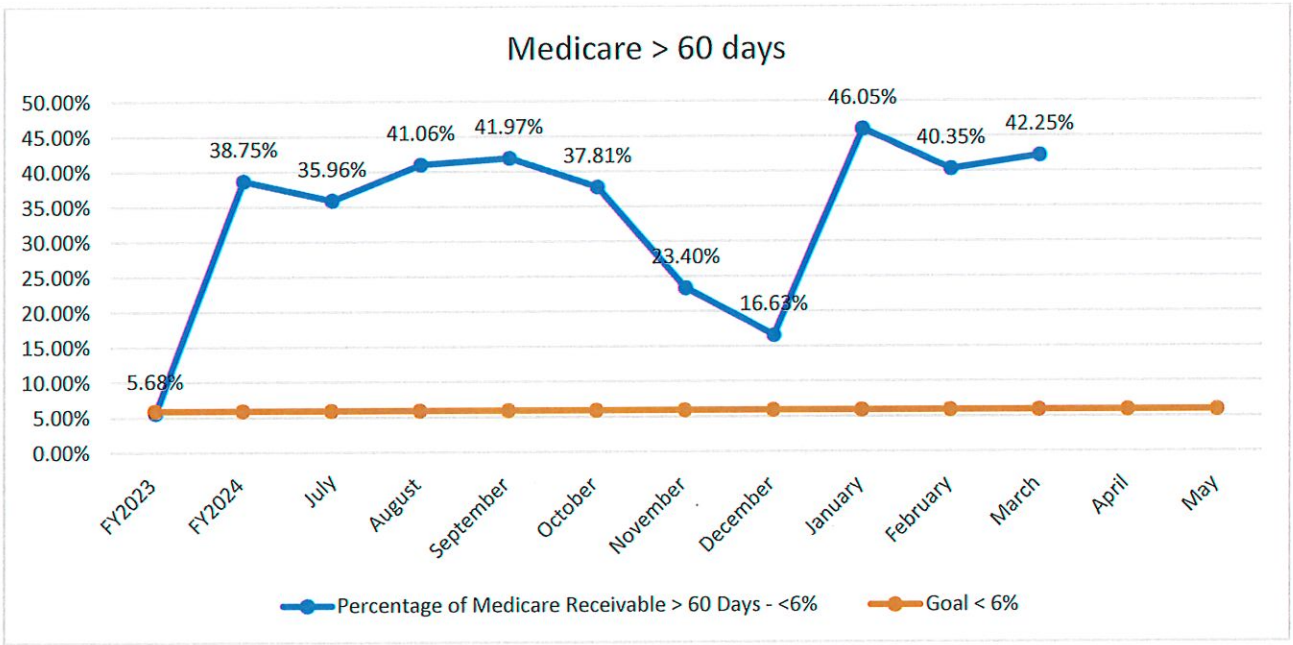
- Blue Cross aging remains under the goal of 10%, at 4.85% in March.



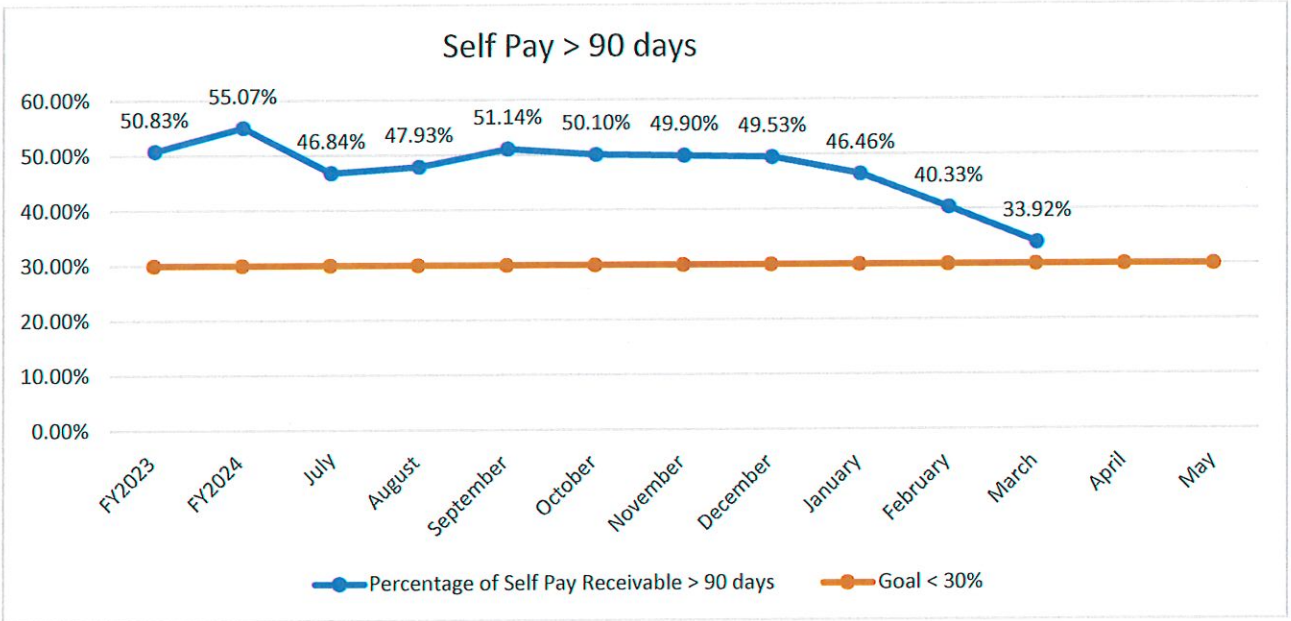
- Commercial aging continues to make progress and decreased to 25.33% for March, still over the 15% goal. We began the temporary outsourcing of aging account follow-ups in early February.



- Medicaid aging decreased in March to 13.54%, under the goal of 20%.



- Medicare increased in March to 42.25%, over the 6% goal. The release of the held Medicare claims immediately aged at over 60 days.



- In March, aging continued to decrease, down to 33.9%. We continue to see great results with the new payment plan program started in mid-February.

Self Pay Plan
Information and Results
April, 2025

PAYZEN PMT ARRANGEMENTS		CURRENT MONTH	FY 25	AVG RETURN %
	NUMBER OF ACCTS	340	1191	
	ACCT BALANCES	$218,227.35	$780,541.42	
	PMTS RECEIVED	$146,660.95	$518,890.25	66.48%

	FY22	FY23	FY24	FY25
SELF PAY DISCOUNTS	1,353,208.58	780,098.39	844,366.51	557,014.44
FY 25 ESTIMATE			844,366.51	742,685.92
MARCH DISCOUNT AMT				84,363.84

*This 20% discount is generated by sending the first private pay statement to the guarantor for a specific account.

	FY22	FY23	FY24	FY25
HARDSHIP PROGRAM	3,164.60	61,124.87	183,310.54	94,215.59
50% DISCOUNT MARCH				6,153.43

*This 50% discount opportunity has been offered during conversation with patients after we have identified through conversation that the patient has no insurance and that the total balance of the account will be a hardship for the patient to pay.

TOTAL SELF PAY PAYMENTS	HOSPITAL	CLINIC
FY 20	8,093,427.44	
FY 21	7,763,867.42	
FY 22	7,359,544.59	
FY 23	7,816,556.16	1,393,371.32
FY 24	8,289,382.17	1,633,256.43
FY 25	7,719,849.06	2,156,231.65

Self Pay Plan
Information and Results

TOTAL SELF PAY REVENUE	HOSPITAL	CLINIC
FY 20	13,566,281.12	
FY 21	14,306,425.74	
FY22	14,129,092.76	
FY 23	14,426,972.88	1,161,887.99
FY 24	14,058,581.93	1,365,896.47
FY 25	11,118,738.94	1,159,036.02

MEDICAL ASSISTANCE	
FY20	2,579,929.74
FY21	2,890,990.97
FY22	1,534,631.43
FY23	2,382,483.18
FY 24	1,488,871.52
FY 25	388,458.13

PATIENT NAVIGATION	FY23	FY24	FY25
FREE OR REPLACEMENT MEDICATION	285,333.00	235,364.00	138,759.00
COPAY ASSISTANCE	51,976.00	80,886.00	72,491.00
INSURANCE MAXIMUMIZATION	1,058,933.00	2,591,935.00	1,571,874.00
PREMIUM ASSISTANCE	823,191.00	664,667.00	226,561.00
TOTAL COST SAVINGS AND COLLECTED REVENUE	2,219,433.00	3,572,852.00	2,009,685.00
TOTAL EXPENSE TO RUN PATIENT NAVIGATION DEPT FY22	162,690.00	166,757.25	226,762.69
GOAL - 2 EMPLOYEES AT 1.5 MILLION EACH	976,140.00	2,441,376.00	3,000,000.00
TOTAL AMOUNT WE NEED TO ACHIEVE OUR GOAL FY 25	1,243,293.00	1,131,476.00	-1,217,077.69

*NOTE: Cost savings of free and/or replacement drug is the actual MHSC cost of products that we acquired for the patient and would have been considered uncollectable.

MEMO: April 28, 2025

TO: Finance Committee

FROM: Ronald L. Cheese – Director Patient Financial Services

SUBJECT: Preliminary April 2025 Potential Bad Debts Eligible for Board Certification

Potential Bad Debts Eligible for Board Certification

Cerner Accounts	$	2,100,000.00
Hospital Accounts Affinity	$	00.00
Hospital Payment Plans Affinity	$	00.00
Medical Clinic Accounts EMD's	$	00.00
Ortho Clinic Accounts EMD's	$	00.00
Total Potential Bad Debt	$	2,100,000.00
Accounts Returned	$ -	45,000.00
Net Bad Debt Turned		$2,055,000.00
Recoveries Collection Agency Cerner	$	- 185,000.00
Recoveries Collection Agency Affinity	$	- 42,000.00
Recoveries Payment Plans Affinity	$	- 600.00
Medical Clinic Recoveries EMD's	$	- 4,000.00
Ortho Clinic Recoveries EMD's	$	- 100.00
Total Bad Debt Recoveries		$- 231,700.00
Net Bad Debt Less Recoveries		$ 1,823,300.00

Projected Bad Debt by Financial Class

Blue Cross and Commercial	$	450,000.00
Medicare	$	35,000.00
Medicare Advantage	$	25,000.00
Self Pay	$	1,300,000.00

Issue	Definition/Impact	Action Plan	Status
Outstanding AR Legacy systems	Legacy system AR needs to be resolved so full attention can be placed on Cerner.	3-29: Legacy AR continues to decline but deadlind of March 31 will not be met. 05-03:Legacy AR remains outstanding with a total of 89K in Affinity. The Patient Financial Services Director has asked that the commercial AR be reviewed for a final time. Target date to stop working Legacy AR is 5/31/24 5-31: System remains open 6-30: Affinity has been closed as of 7/1. Archiving of system set up to take place with Harmony. Remaining credit balances will be worked from spreadsheet. EMDs is closed. 08-31: Email sent to CFO and PFS Director but update unavailable at time of reporting. 09-30: It is estimated that $50K remains outstanding in Affinity Legacy. Plan to move employee balances onto payment plans and be taken out of AR. Deatlind for this has not been set. 3-25: Affinity AR is $42K The commercial accounts have been reviewed and we will move the remainder of Self-Pay to Payment Plans upon getting access to the system after the archive is complete. We are treating the Self-Pay as payment plans as most is from employees and we are performing payroll deduct.	In Progress MHSC update: Legacy systems are not accessible as they complete the archival project . Employee balances make up most of payments through payroll deductions. Affinity AR is $42K including one self pay account for in excess of $30K. The commercial accounts have been reviewed. March - Due to several take-backs on accounts that had zeroed, the March Affinity A/R closed at $47,438.75 which includes the one self-pay account totaling over #30,000.

Issue	Definition/Impact	Action Plan	Status
Lack of understanding regarding patient AR work Ques.	Continued increase in patient AR.	03-29: Gain understanding of patient AR workflow within Cerner. Manage outstanding patient AR from aging report. 05-03: Feedback received from Cerner. CLA to collaborate with PFS Director and team to begin drafting policy and procedure. 05-31: Additional follow up questions submitted to Cerner and P&P is in progress. 06-30:Changes in workflows have been established to avoid duplication of work by allowing two team members to send patient to collections. The policy and procedures are underway as progress is made on patient accounts. 08-31: Draft policy and procedure have been developed and will be reviewed with PFS Director. In Collections Preview dollars have decreased $1.6M from 5/30/24 to 8/25/24 and Past Due Self Pay dollars have decreased $1.6M from 6/13/24 to 8/25/24. 09-30: Numbers have continued to decline. PFS Director to begin providing monthly reports on what has been submitted to bad debt vs. what has been collected since since training and focus has been placed on patient balances. 10-31: PFS Director has obtained numbers from collection agency. Dashboard to be updated. 12-31: Update to Dashboard outstanding. 3-25:Dashboard is updated monthly and is current.	Process and workflow is complete. Education has been provided in reference to AR Work Ques and employee productivity has improved with this knowledge. Workflows have been created and the Dashboard of collection agency collections is updated monthly. This item is complete. As a side note, we have become so knowledgable about the work ques, we have built ques into the Method I and Method II workflows.
Re-structuring of Business Office phone tree.	Alleviate phone volume from insurance billers.	03-29: Established phone tree structure and provided to IT in February. Waiting for set up to be completed. 05-03:New phone tree that was set to take efect on 5/1 is not working as it was desinged; therefore, IT will need to review and correct set up. Additional work will also need to be completed by IT before remote worker can be incorporated into the phone tree tree through TEAMS application. Both items should be priority items to alleviate phone calls that the billers receive so they can dedicate their time to outstanding AR. 05-31: The phone tree is not working as designed. PFS Director is working with IT to resolve. PFS Director has been asked to escalate to upper management if resolution is not found in early June as this is affecting the billing team's productivity. 06-30: The phone tree is now working in PFS as designed with one remote team member still needing to be connecctd to the team, through Microsoft Teams application. Target date of completion is July 2024. After completion, team members will have additional assistance with answering phones. 07-31:Remote worker awaiting connection to phone tree. Escalated to CFO.	In Progress. Additional telephone system components are going to be installed by IT personnel next Fiscal Year to allow the phone tree to be used by remote worker. Also, with the hiring of an employee May 5th, we will have a full staff.

Issue	Definition/Impact	Action Plan	Status
Outstandng DNFB that exceeds industry best practice of less than or equal to 4 days.	Reduce backlogs of DNFB accounts waiting to be processed due to HIM Coding, incomplete documentation, and billing.	03-25:DNFB accounts total $9.6M, which includes a 3ay suspense period of $2.2M, HIM-Coding of $2.1M, and $5.3M due to procesing concerns by Business Office. It was reported DNFB reports are monitored once per month by Business Office. It was agreed DNFB accounts must be worked daily. Leadership in HIM will be trained on how to generate the DNFB report and HIM and PFS will work the weekly reports. Additionally PFS leadership will collaborate closely with billers to ensure daily tasks are prioritized and includes addressing outstanding billing holds due to DNFB. Weekly recurring meetings established with CLA to review progress made towards prioritization accounts for processing. 05-01:DNFB of 5+ days has decreased from $7.6M on 4/24 to $6.4Mon 4/30. A workgroup which meets weekly has been extablished by CLA to focus on strategy for reducing the dollars outstanding. 06-30: Junes avg DNFB was 10 days 08-31: August avg DNFB was 10 days 09-30: Sept avg DNFB was 9 days 10-31: Oct avg DNFB was 14 days due to holding Medicare claims for Crittical Access billing.	In Progress 03-25 DNFB Days total 29.93 days of which $19,180,490.56 or 24.59 days of Medicare claims are awaiting billing to to our Critical Access designation. 04-22: DNFB days have been reduced to $6,900,258.97 or 8.85 days. All claims that were previously being held for Medicare billing have been submitted. That 8.85 days is the total of all financial classes. As you can see, this is down from 29.93 last month. It is very important to note that These numbers are directly correlated to collections 30-45 days later. Our Gross Days in AR dropped last month from 89 to 87 and we are expecting our highest ever collections this month at over $13 million dollars.

Issue	Definition/Impact	Action Plan	Status
Prior Authorization	Reduce Denials and Accountability	12-31: Met with Registration Supervisor to review what has been discussed in the pst regarding prior authorizations and Central Scheduling. Utilization of phone volume report and tracking of work is a crucial step in understanding volumes and need. A productivity tracking and note spreadsheet was provided and reviewed so this can be implemented as soon as possible.	In Progress We have utilized our Quality personnel and are in the process over the last several months of completely discussing and revamping worflows of the entire department. The project has brought people in from Administration as well as the departments that utilize the service. We are in the process of training four new employees to ensure we are able to handle the tremendous volume of tests that require scheduling and prior authorization. Prior authorization errors have dropped drastically. We are tracking productivity through phone volume reports. Account edits for accuracy contiue to be at the top of our priority list. The team created a "How to Order Medical Imaging" Cheat Sheet

Issue	Definition/Impact	Action Plan	Status
Balancing	Improve Accuracy	12:31: Met with PFS Director regarding status of payment posters balancing with Fiscal each month as this has been an ongoing issue. PFS Director to discuss witih Fiscal to ensure P&Ps put in place are bing followed and are working.	In Progress We set up meetings with the two Cash Posters, the accountants, and the Controller. We identified the errors that were occurring and how they could be corrected. We changed Clinic workflows to submit cash daily. We balance each day and accuracy has improved tremendously which has assisted in very few balancing issues. We continue to work to improve our accuracy and workflows. We have written a policy and that policy is in the process of being reviewed by all personnel associated with the project.

Issue	Definition/Impact	Action Plan	Status
ERA/EFT	Productivity	12-31: Met with PFS Director regarding status of ERA/EFT payer set up because this was discussed with CLA during the last several onsite visits. This is currently in process but not yet completed. After this has been completed there should be an increase in productivity and a reduction in manual work.	In Progress We now have all major insurance carriers along with VA, Medicare and Medicaid set up to send payments and then remits electronically with the last two major players being Aetna and Tricare for Life. In the last month, we have fully implemented Tricare for Life and we received notice this week that Aetna should start sending ERA's prior to May 1st. Recently, we received paper checks from fom small players like RCI, UHC Wyoming, Freedom Life Insurance, and Lumico Life that we are trying to get set up as we have enough business with them that it would make it worth our while. By having the transactions electronically sent to us, we are able to automatically post the transactions.
Late Charges	Decrease Write Offs and Increase Efficiencies	12:31: Met with PFS Director to discuss labs entering late charges and the amount of re-work and or write offs it causes. New hire within lab department was to start on 12.2 with late charges taking priority. Currently meeting(s) with the lab have not taken place.	In Progress We continue to work with the Lab personnel in an effort to decrease the number of late charges that are submitted to us for billing. The new employee has been amazing and we have worked to decrease the number of late charges. We have made great progress but additional efforts are needed. We have provided additional Cerner access to allow her to identify if an account has been billed and she is now able to place a hold on the account until she is able to charge. Lab personnel are now working the charges on a daily basis instead of monthly. This has drastically reduced late charges. The Lab person indicates that she now has a very good grasp of the system.

Current Projects/Outcomes since CLA Not Listed Above	Definition/Impact	Action Plan	Status
Days in Accounts Receivable peaked out at 89. Last month we closed at 87 and this month I believe our A/R will be down to approximately $55,800,000. down from $68,370,570 and our Gross Days in A/R will be around 71. With our projected collections to be the highest ever this month, approximately $13,000,000.00, we should see our Days of Cash on Hand grow. We continue to build our Medicare billing system so that we can bill Method II. We should begin testing in the next couple weeks. We are projecting to flip the switch on Method II billing on July 15th in Cerner for July 1.			
The Central Scheduling department continues to wrap up our Cerner project, UCC, that will allow us to provide patients with call reminders, texts, emails, or calls. We will provide a thank you for scheduling with us 15 minutes after the patient schedules, a reminder 7 days out, a reminder at 2 days out with the option to cancel, reschedule, or confirm. In addition, the patient will be provided with access to their prep instructions at that time. If the patient confirms the appointment, they will receive one more reminder the day prior to the scheduled service. The patient will also have access to a communication board. Go live is May 27th.			
We continue to work with PayZen to address our ever increasing self-pay Accounts Receivable. We have now set up $746,884.96 in payment plans with PayZen while receiving payments of $498,291.24 or 66.7%. These are accounts that would have been tied up in our Accounts Receivable for a very long time.			

A FOUNDATION IN INFECTION PREVENTION

Patient Safety Competency Curriculum for the Board of Trustees of Memorial Hospital of Sweetwater County

OBJECTIVE

MEET THE PATIENT SAFETY STRUCTURAL MEASURE FOR BOARD-LEVEL EDUCATION

2d. Our hospital requires implementation of a patient safety curriculum and competencies for all clinical and non-clinical hospital staff, including C-suite executives and individuals on the governing board, regular assessments of these competencies for all roles, and action plans for advancing safety skills and behaviors.

This course will:

- Provide a solid understanding of the underlying principles in Infection Prevention
- Support critical evaluation of MHSC performance
- Develop the ability to ask informed questions by providing updates on the state of the science

Shifting the focus from

What to How and Why

When someone is asked to do something “because I told you to” without context, the opportunity for ownership is removed.

If instead, a person chooses to do something because of what they know and understand, it’s theirs!

If I know why, I comply.

Infection Prevention education has historically focused on a long list of “what” at the expense of the learner’s need to know why.

The Transmission Of Infectious Disease

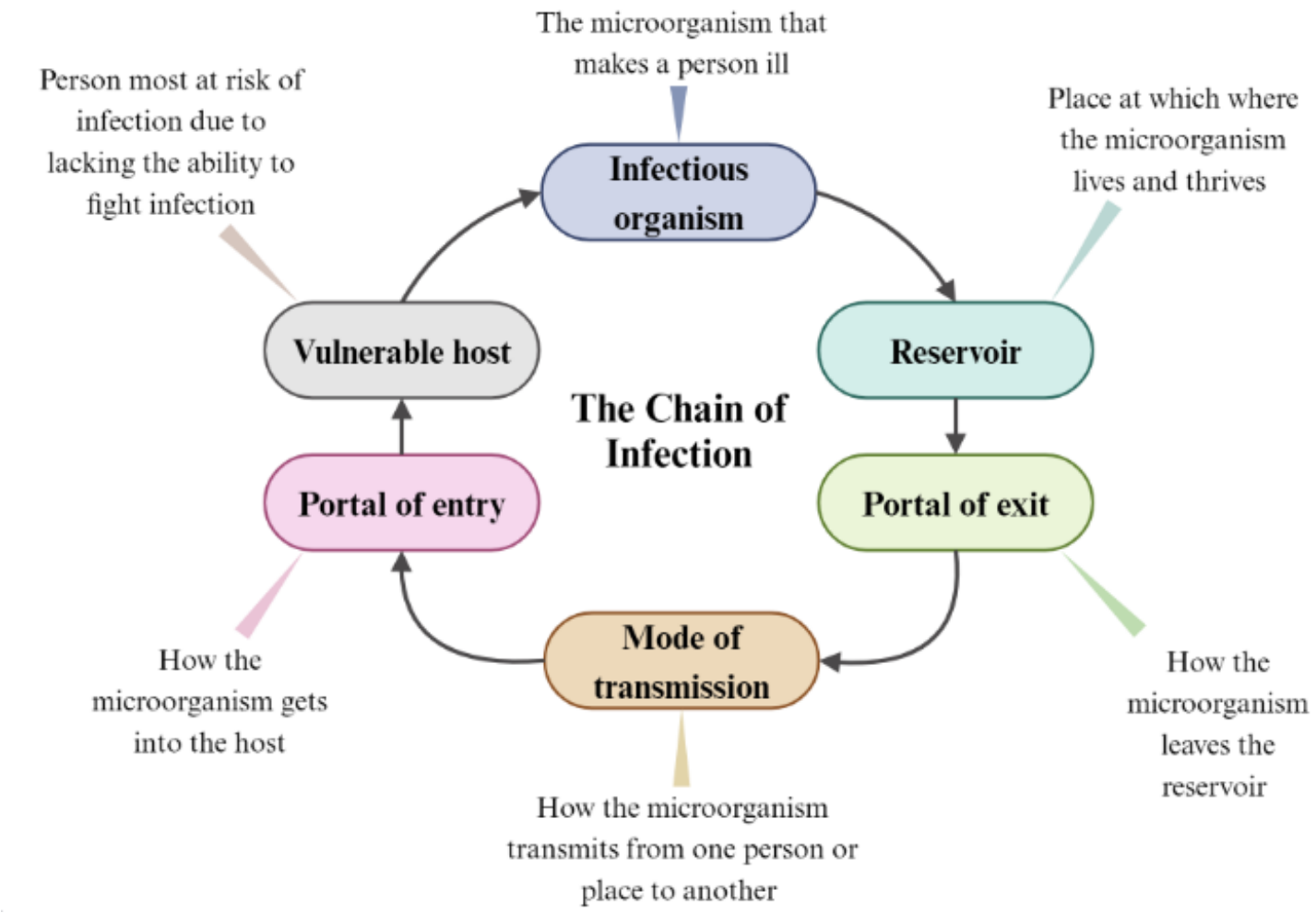
To prevent the spread of infectious disease, it's essential to understand how transmission happens: not by magic or bad luck.

Microbes travel as far as you can throw them or carry them.

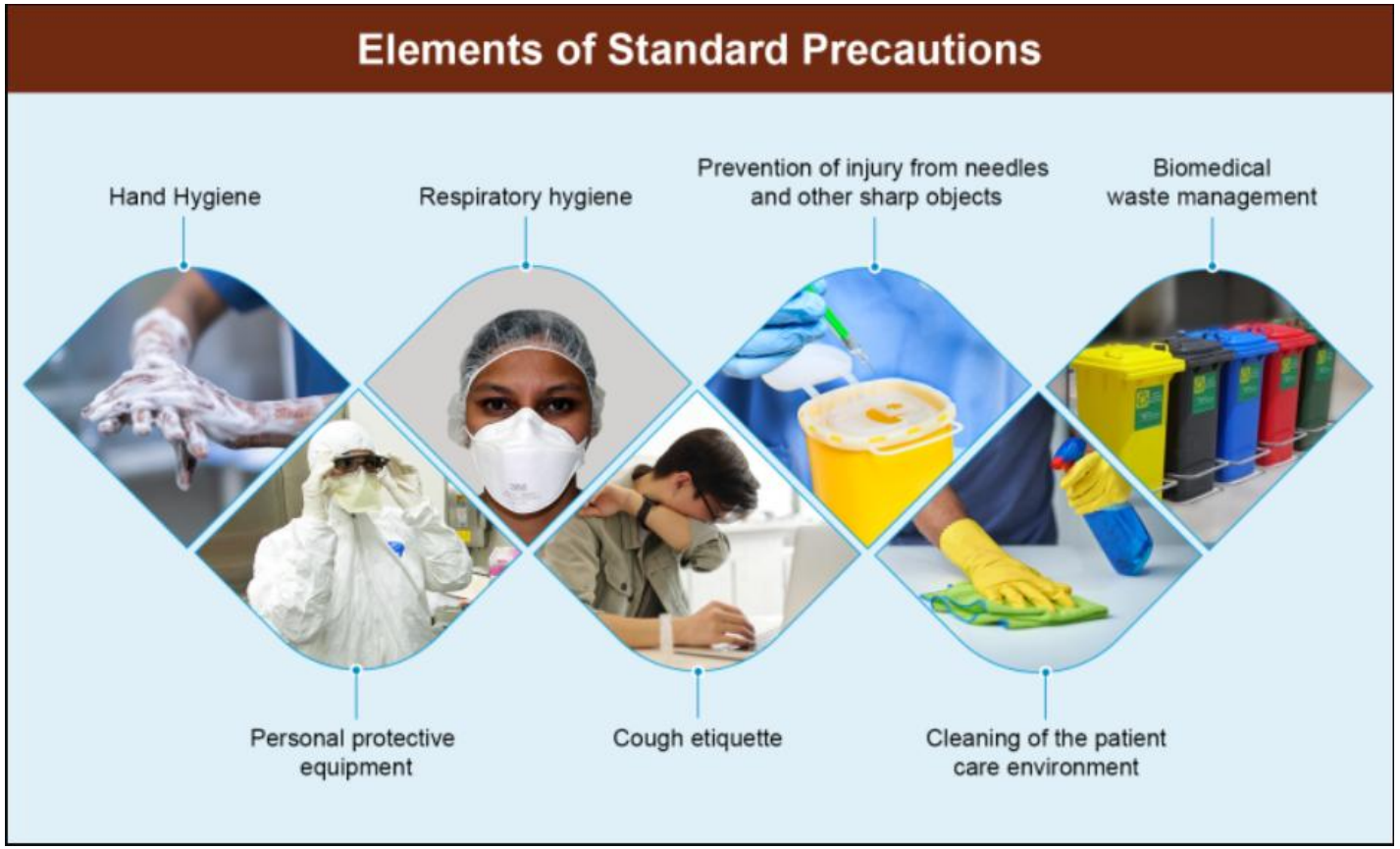
The transfer of microbes is instantaneous upon contact.

CHAIN OF INFECTION

Break any link in the chain and an infection is prevented.



STANDARD PRECAUTIONS



- Primary objective: keep the goo off of you, if you do get it on you, wash it off
- The same applies to the environment
- All patients are considered potentially infectious

TRANSMISSION-BASED PRECAUTIONS

Transmission-Based Precautions: interventions designed to prevent the spread of a specific known or suspected pathogen

- Contact
- Contact Enteric
- Droplet
- Aerosol
- Airborne Contact
- High-Consequence Pathogen

Preventing Infection- How Precautions Apply In Community Life

Preventative Action	Mechanism of Transmission	Chain-link Broken
Immunization	Multiple- disease dependent	Vulnerable Host
Wearing a mask/face covering	Contact, Droplet	Portal of Entry (personal protection)
Wearing a mask/face covering	Droplet, Aerosol, Airborne	Portal of Exit (source control)
Washing fruits and vegetables	Contact	Reservoir
Washing hands as soon as you get home	Contact	Mode of Transmission and Reservoir
Staying home when you are sick	Multiple- disease dependent	Portal of Exit (source control)
Adhering to safe food temperature guidelines when cooking	Contact Enteric	Infectious Organism and Mode of Transmission (inhibiting microbial growth- cold; killed organisms- heat)

Preventing Infection- How Precautions Apply In The Hospital

Preventative Action	Mechanism of Transmission	Chain-link Broken
Immunization	Multiple- disease dependent	Vulnerable Host
Wearing a mask in a coughing patient's room	Contact, Droplet	Portal of Entry (personal protection)
Masking a coughing patient at triage	Droplet, Aerosol, Airborne	Portal of Exit (source control)
Cleaning high-touch surfaces	Contact	Reservoir
Putting a patient in an AIIR (negative pressure room)	Airborne (also use for Aerosol when available)	Mode of Transmission (avoid measles in the HVAC system)
Sterilization of instruments	Contact	Infectious Organism (if none present, they can't cause infection)
Hand Washing	Contact	Infectious Organism and Mode of Transmission (organism not carried on hands from one place to another)

THE WHY OF IT:

"I never get sick, I don't need to wear PPE."

MYTH: if I don't feel sick, I can't spread germs.

Humans have more microbial cells living on us and in us than we have human cells and we can transmit them, benign or pathogenic alike.

FACT: many microbes can spread without the source knowing they are ill or that they have are spreading a pathogen.

IT’S ALL ABOUT THE PATIENTS


A case of the sniffles which is inconvenient for you might kill them.

When patients are in the hospital, they are particularly vulnerable because of their illness or condition. Worse, they are also in an environment which concentrates many kinds of illness in one place, unlike in the community. This double whammy is the reason we are fastidious about preventing germs from spreading.

Remember, it’s not about us and what makes our jobs easier.

It’s not about us at all.

It’s about them!

Sources Of Risk In A Hospital/Community System

A Bidirectional Relationship

What impacts the community impacts the hospital and what impacts the hospital impacts the community.

Predictable Risks In The Hospital- If we can predict it, we can address it.

- Staff: presenteeism, unwashed hands
- Equipment: failure to clean equipment (stethoscopes, IV pumps, lab draw caddies)
- Medical devices: natural barriers to microbial entry compromised by central lines, urinary catheters, ventilators
- Environment: contamination from sink drains, uncleaned over-bed tables, uncleanable or compromised furniture
- Procedures: deposition of microbes into a surgical wound, skin antisepsis failure, mistake during aseptic technique
- Utility Contamination: Legionella species in the water system, dust from the HVAC system inhaled
- Construction: debris entering the HVAC system, uncontained debris contaminating the environment and equipment

Mitigation-

How Do We Prevent Infection?

Effective prevention begins with knowing what's going on

Comprehensive Surveillance- if you don't look, you miss stuff

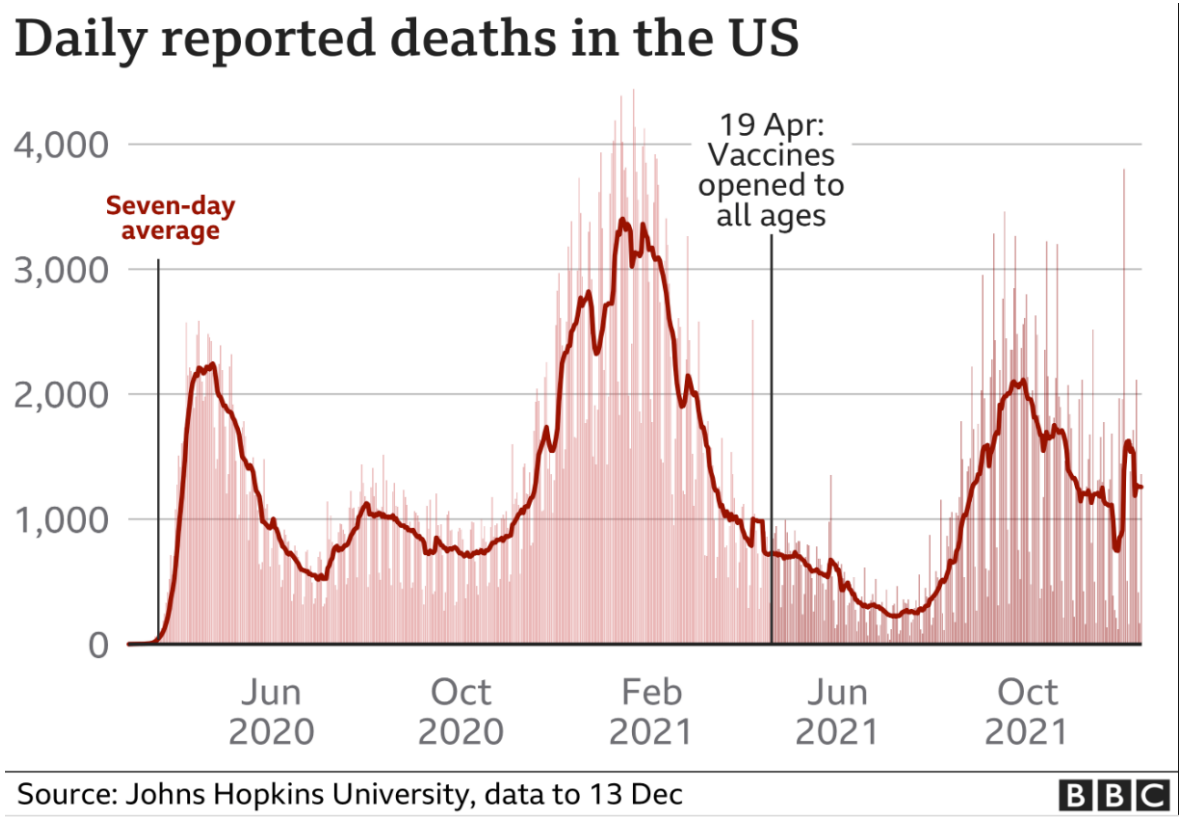
New to MHSC- all positive diagnostics for infectious disease, all NHSN* definitions, syndromic presentations, etc.

Environment of Care rounding is part of comprehensive surveillance.

Thorough surveillance supports evidence-based interventions and comparison to national benchmarks.

*NHSN (National Healthcare Safety Network)- a non-regulatory system for gathering nation-wide data from healthcare entities run by CDC which CMS (regulatory) uses to evaluate compliance with performance metrics.

Tracking And Trending- Epidemiology



Monitoring the occurrence of infections over time allows Infection Prevention to distinguish between background incidence and a worrisome up-tick requiring intervention beyond the basic measures already in place (typical containment strategies like Standard Precautions).

MHSC has implemented epidemiological tools such as epidemic curves, trend reports, and line listing. These support reporting requirements to local public health as well as regulatory reporting requirements.

Interventions- What do we do when we find a problem?

The quality of the intervention depends first on the quality of the data, then:

1. Regulatory compliance
2. Nationally recognized standards of practice
3. Literature reviews
4. Peer consultation- professional bodies such as APIC

Innovation and creativity- with all of the above in place, Infection Prevention seeks to advance the science when they see opportunities to do so.

IP Creativity- Hand Washing Video from Alameda Health System

Interpretation: How Do You Evaluate An Infection Prevention Program?

Define what constitutes a problem:

HAI (Healthcare Associated Infection): determined by rigorous application of NHSN definitions and considered to be associated with the inpatient encounter

CAI (Community Associated Infection): defined within the NHSN framework as infections likely to have originated prior to the inpatient encounter

These definitions are used by CMS in various programs and metrics including pay for performance and other financially linked incentives. Misapplication (knowing/intentional) of these definitions is considered Medicare fraud.

In practical terms, this means that the NHSN definitions determine what is and is not an HAI. Providers do not adjudicate HAI determinations and diagnosis does not apply unless provider diagnosis is a specifically included criterion of an HAI definition (uncommon). Consider how this differs from HAC (Healthcare Associated Condition) definitions in Quality workflows.

INTERPRETATION: COMPARISON AND NATIONAL BENCHMARKING

SIR (Standardized Infection Ratio) - a risk-adjusted calculation which allows hospitals to compare their observed over expected performance to their peers with 1 being average for infections.

SUR (Standardized Utilization Ratio) - a risk-adjusted calculation which allows hospitals to compare their observed over expected performance to their peers with 1 being average for device utilization.

These ratios replace rates as the standard benchmarking tool for Infection Prevention purposes. They are useful because they compare like with like and level the playing field.

(Pharmacy is now using NHSN for Antimicrobial Stewardship purposes and also has standardized ratios for their work.)

Our goal: SIRs and SURs of less than 1, the lower the better.

AUDITING- KEEPING TABS ON CLINICAL PRACTICE

Infection Prevention monitors more than just HAIs:

1. MDRO (Multi-Drug Resistant Organisms)
2. Hand Hygiene
3. Transmission-Based Precautions Compliance
4. Blood Culture Contamination
5. Antimicrobial Stewardship
6. EVS Auditing
7. Water Systems

And more…

Infection Prevention Assessment Of MHSC

Annual Risk Assessment and Plan-

Each Year Infection Prevention generates a set of documents which provide the interpretation of Infection Prevention metrics, an evaluation of the previous year's work, and the proposed interventions for the coming year.

These are living documents which are updated as needed.

On The Horizon

Current Concerns:

Measles – ongoing outbreaks (1st US deaths in 10 years)

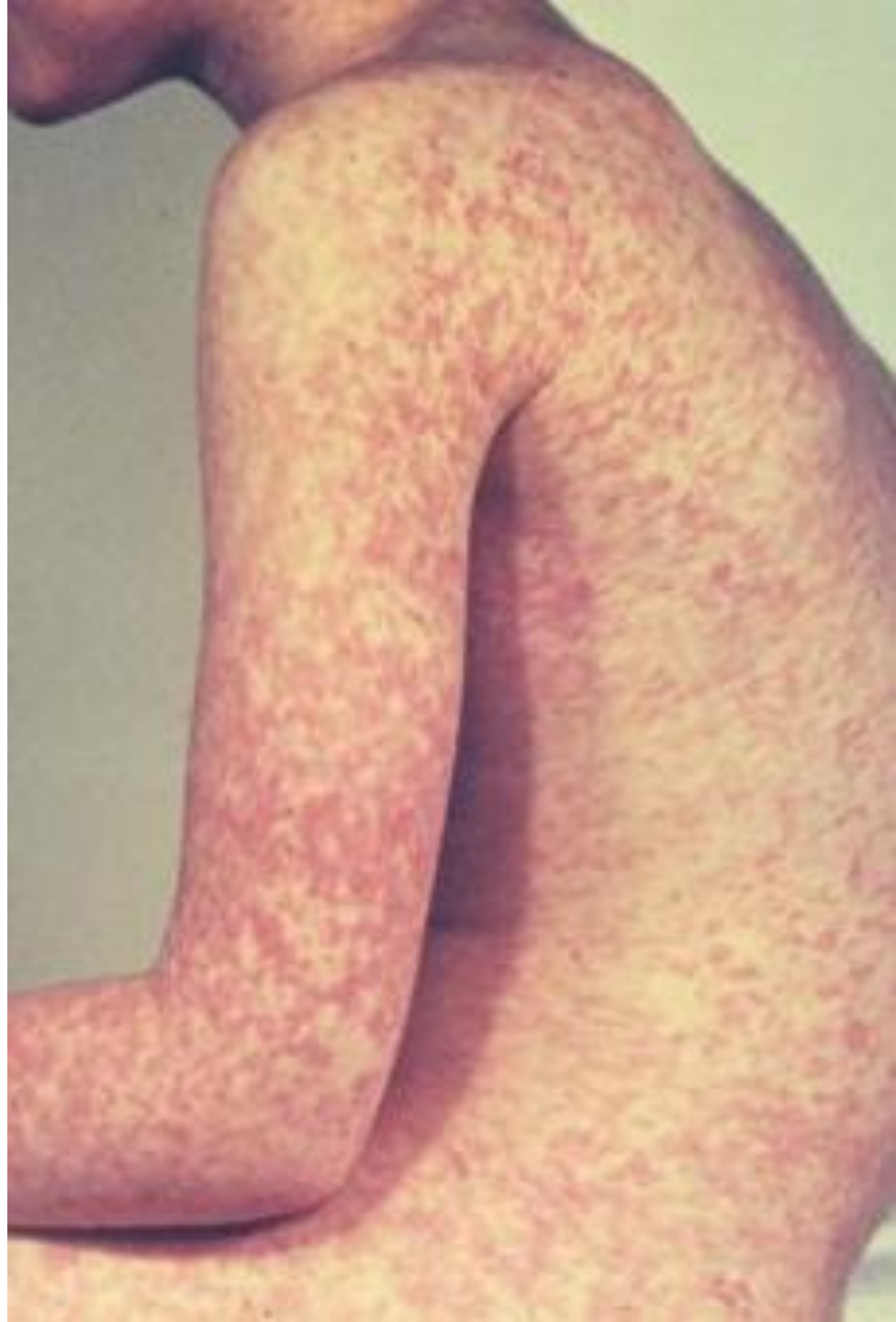
Avian Influenza (Bird Flu, HPAI, H5N1- no consistent nomenclature yet)- economic concern for the moment, risk of transitioning into a human pathogen with pandemic potential

Tuberculosis- ongoing outbreak

Pertussis- ongoing outbreak

Mpox- ongoing outbreaks globally, uncontained

Candida auris- newer MDRO to the US healthcare setting, high mortality, difficult to clean out of the environment



SUMMARY: KEY TAKE AWAYS

1. An Infection Prevention program's effectiveness depends on its data which is only as good as its surveillance.
2. Infection Prevention is a team sport- the best intervention in the world with fail without the participation of everyone.
3. Infection Prevention is a Return On Investment (ROI) department. HAIs are expensive and so are issues with the physical plant. Through surveillance, of the people and the facility, Infection Prevention ultimately saves the hospital money.

PS: Competency based learning requires assessment- your post-test is coming soon!

Infection Prevention Foundations Quiz

1. Do you have to be symptomatic (feel ill, know you're sick) to transmit microbes?
    a. Yes
    b. No
2. What do we call an infection that meets an NHSN definition and occurred under our care?
    a. Nosocomial infection
    b. Healthcare Associated Infection
    c. Hospital Acquired Infection
3. SIR (Standardized Infection Ratio) is a ratio of the number of observed infections over the number of expected infections, which is risk adjusted.
    a. True
    b. False
4. Why do we now use SIR and SUR instead of rates?
    a. Because CDC wanted to make things more complicated.
    b. Because rates don't facilitate peer-to-peer comparison and aren't risk adjusted (including by setting). For example, it doesn't make sense to compare a critical access hospital to a 1000 bed teaching hospital or to a nursing home.
5. Why is it useful to compare our SIRs and SURs to a national average?
    a. CMS uses these metrics in their programs including those with financial consequences.
    b. If we only ever compare ourselves to our own past, we might be doing very well and never know it, and thus waste resources that could be applied to another opportunity.
    c. We might be doing very poorly and not realize it because we have made steady improvements over time. This could lead to taking our foot off the gas when more work is warranted.
    d. All of the above.