MEMORIAL HOSPITAL OF SWEETWATER COUNTY
REGULAR MEETING OF THE BOARD OF TRUSTEES
August 2, 2023
2:00 p.m.
Classrooms 1, 2 & 3

AGENDA

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

II. Agenda *(For Action)* — Barbara Sowada

III. Minutes *(For Action)* — Barbara Sowada

IV. Community Communication — Barbara Sowada

V. Old Business — Barbara Sowada
   A. Employee Policies *(Remains under review/development, no request for action)*
      1. Workplace Violence Prevention Program
      2. Employee Policy – Non-Discrimination and Anti-Harassment
   B. Board Policy–BOT - Senior Leadership Plan: Filling CEO Absences & Vacancies; Filling Senior Leader Absences & Vacancies; Identifying & Developing Internal Senior Leaders *(For Review)* — Barbara Sowada
   C. Performance Improvement and Patient Safety (PIPS) Plan *(For Action)* — Kara Jackson, *Director of Quality Accreditation, Patient Safety, & Risk*
   D. Infection Control Plan and Annual Evaluation *(For Action)* — Noreen Hove, *Director of Surgical Services, Infection Prevention, & Grievance Coordinator*

VI. New Business *(Review and Questions/Comments)* — Barbara Sowada
   A. Board Policy – Executive Compensation Policy *(For Review)* — Barbara Sowada
   B. Health Equity Plan *(For Action)* — Kara Jackson
   C. FY24 PIPS Priorities *(For Review)* — Kara Jackson
   D. September Board of Trustees Meeting in Green River *(For Your Information)* — Barbara Sowada
   E. Credentials Committee *(For Action)* — Kerry Downs, *Director of Medical Staff Services*
      1. Non-Physician Provider Privilege Form – Outpatient Medicine
      2. Meeting Documentation Form
      3. Privilege Specific FPPE Form

VII. Chief Executive Officer Report — Irene Richardson

VIII. Committee Reports
   A. Quality Committee — Taylor Jones
   B. Human Resources Committee — Kandi Pendleton

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AGENDA

C. Finance & Audit Committee — Marty Kelsey
   1. Bad Debt *(For Action)*

D. Building & Grounds Committee — Marty Kelsey

E. Foundation Board — Craig Rood

F. Compliance Committee — Kandi Pendleton

G. Governance Committee — Barbara Sowada

H. Executive Oversight and Compensation Committee — Barbara Sowada

I. Joint Conference Committee — Barbara Sowada

IX. Contract Review — Irene Richardson
   A. Consent Agenda *(For Action)*
      1. True North Statement of Work
      2. UL Solutions – UL Verification Services
   B. Contracts Approved by CEO since Last Board Meeting *(For Your Information)*
      1. RQI Partners LLC

X. Board Education — Barbara Sowada
   A. Veralon *(formerly iPro)* Credentialing & Privileging Parts 1, 2 & 3 *(For Discussion)*

XI. Medical Staff Report — Dr. Brianne Crofts, *Medical Staff President*

XII. Good of the Order — Barbara Sowada

XIII. Executive Session (W.S. §16-4-405(a)(ix)) — Barbara Sowada

XIV. Action Following Executive Session — Barbara Sowada

XV. 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
Workplace Experience
Growth, Opportunity & Community
Financial Stewardship

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

July 5, 2023

The Board of Trustees of Memorial Hospital of Sweetwater County met in regular session on July 5, 2023, 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: Mr. Marty Kelsey, Ms. Kandi Pendleton, Mr. Taylor Jones, Mr. Craig Rood, and Dr. Barbara Sowada.

Officially present during the meeting: Ms. Irene Richardson, Chief Executive Officer; Dr. Brianne Crofts, Medical Staff President; Mr. Robb Slaughter, County Commissioner Liaison; and Mr. Geoff Phillips, Legal Counsel.

Pledge of Allegiance

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

Our Mission and Vision

Dr. Sowada read aloud the mission and vision statements.

Mission Moment

Ms. Richardson reviewed a recent social media post from someone visiting town who had an accident and shared their positive experiences at the Hospital. Ms. Pendleton shared an experience involving an Air Stream Rally participant who said MHSC is second to none.

AGENDA

Mr. Kelsey requested an amendment to the agenda to table "Board Policy – Success/Talent Management Plan" because it needs more refinement. Dr. Sowada requested reordering two items. The motion to approve the agenda with noted changes was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

TRUSTEE APPOINTMENT

Mr. Phillips administered the Trustee Oath of Office to Mr. Rood. The Trustees welcomed Mr. Rood to the Board. Dr. Sowada asked for introductions around the table as the "Education" portion of the agenda. Each person shared background information as well as their management philosophy.

APPROVAL OF MINUTES

The motion to approve the minutes of the June 6, 2023, regular meeting as presented was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

The motion to approve the minutes of the June 21, 2023, special joint meeting with the Foundation Board of Directors as presented was made by Mr. Jones; second by Mr. Kelsey. Motion carried.

COMMUNITY COMMUNICATION

There were no comments.

ANNUAL CONFLICT OF INTEREST DISCLOSURE

Dr. Sowada said The Joint Commission dictates the Board must complete an annual disclosure. She requested each Trustee complete their form and return it by the end of the meeting.

OLD BUSINESS

There was no old business for discussion or action.

NEW BUSINESS

Election of Officers

Dr. Sowada reviewed the slate of officers proposed by the Governance Committee:
President – Dr. Sowada
Vice President – Mr. Jones
Treasurer – Mr. Kelsey
Secretary – Ms. Pendleton

Dr. Sowada said the Bylaws state there may be nominations from the floor. Following no additional nominations, the motion to approve the officers as presented was made by Mr. Jones; second by Ms. Pendleton. Motion carried.

Committee Assignments

Dr. Sowada reviewed the Committee assignments as follows:
Finance & Audit: Mr. Kelsey, Chair, and Mr. Jones
Building & Grounds: Mr. Kelsey, Chair, and Mr. Rood
Quality: Mr. Jones, Chair, and Ms. Pendleton
Compliance: Ms. Pendleton, Chair, and Dr. Sowada
Human Resources: Ms. Pendleton, Chair, and Mr. Rood
Governance: Dr. Sowada, Chair, and Mr. Kelsey
Executive Oversight & Compensation: Dr. Sowada, Chair, and Mr. Jones
Joint Conference: Dr. Sowada and Mr. Rood

Foundation Liaison: Mr. Rood

Dr. Sowada said the joint meeting of the Trustees and Foundation Board was truly a celebration. She thanked all of the Board members for all they have done all year long. Dr. Sowada referenced the great work being done in the area of quality. She said finance has had hard work especially in the area of Cerner. Dr. Sowada said we honor all of the hard work the committees have done so successfully. Ms. Richardson expressed gratitude for the Trustees. She said they are responsive, involved, committed, and passionate about healthcare in Sweetwater County. She expressed appreciation to Mr. Phillips and Commissioner Slaughter. Ms. Richardson said we have a lot of involvement with everyone working in the same direction.

Infection Preventionist Letter of Approval for Appointment

The motion to approve the letter as presented was made by Mr. Jones; second by Mr. Rood. Motion carried.

Performance Improvement and Patient Safety (PIPS) Plan

Dr. Sowada reported she attended an American Hospital Association webinar the previous week. She said regulations are changing a bit and the full Board must be involved in the area of quality. She said many things required are things we have already done, for example, approving plans. She said The Joint Commission will be looking for documentation in meeting minutes for discussions of quality. Ms. Kara Jackson, Director of Quality, Accreditation, Patient Safety, and Risk, reviewed the PIPS Plan. She said we want patients to have good outcomes and spoke to the Board's fiduciary responsibility of the Hospital and oversight of our PIPS Plan. Ms. Jackson said the Plan outlines the framework, approach, roles and responsibilities of everyone involved. She said we help the Board have oversight. We have monthly PIPS meetings. Some information funnels up through the Quality Committee. A summary of the PIPS Plan results is coming next month. Ms. Jackson reviewed the main changes in the PIPS Plan. Mr. Kelsey said he read the document carefully and said he really likes it. He thanked Ms. Jackson for the work. Ms. Jackson said she has five people in the Quality Department including Ms. Jackson. Staff are set up as liaisons to departments. Dr. Sowada said we have a great team.

Infection Control Plan and Annual Evaluation

Ms. Noreen Hove, Director of Surgical Services, Infection Prevention, and Grievance Coordinator, and Mr. Corey Worden, Infection Prevention, reviewed the information in the meeting packet. Mr. Worden said we did a risk assessment and then developed a plan. It references The Joint Commission and National Patient Safety information. Mr. Kelsey asked about efforts to address sepsis. Mr. Worden said we are focusing as a group including nursing, infection prevention, and quality.

Credentials Committee – Radiation Oncology Privilege Form

The motion to approve the Radiation Oncology Privilege Form as presented was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

CHIEF EXECUTIVE OFFICER REPORT

Ms. Richardson thanked Mr. Rood for agreeing to serve on the Board. She said she and Ms. Tami Love, Chief Financial Officer, plan to provide orientation to Mr. Rood in July. Ms. Pendleton plans to join them. Ms. Richardson announced Ms. Mary Fischer, former Lab Director, has stepped down as she prepares for retirement, and welcomed Ms. Aimee Urbin in the Director role. Ms. Richardson provided an update on our person-centered care culture. She said we continue to work on our critical access designation application with a goal to get this accomplished as soon as possible. Ms. Richardson said she presented a brief annual presentation to the County Commissioners at their June 20 meeting. She will provide a more detailed report at a meeting in July. She said we have so much going on at MHSC. Ms. Richardson said it was nice to meet with the Foundation Board and reflect back on everything we have accomplished together. She said the Foundation Board is a strong supporter of the Hospital and is greatly appreciated. Ms. Richardson invited the Trustees to attend the Wyoming Hospital Association annual meeting August 30 and 31 in Cheyenne. She said we have been very busy and thanked staff for everything everyone is doing. She thanked the Board and Commissioners for their help in keeping our community healthy.

COMMITTEE REPORTS

Quality Committee

Mr. Jones said the information is in the packet.

Human Resources Committee

Ms. Pendleton said the Committee did not meet in June.

Finance and Audit Committee

Mr. Kelsey said the Committee will not meet in July. He said we have some sobering, difficult facts to go over and said hospitals are in trouble across the United States. He thanked Dr. Sowada for sending out articles and information. Mr. Kelsey said Covid did a number on hospitals plus we have very serious inflationary concerns. He said our staff have done a good job and the very best we can. Mr. Kelsey said that for the past eleven months (July 2022 to May 2023) we have had losses each month. He said experts say to have a healthy hospital, we need a positive margin. Mr. Kelsey said we have a plan to work on that and we are going to have to work very hard. He said we lost days of cash since last year and said we will not meet our goal but he knows we are working very hard on it. He said we need to be cognizant of what our finances are. Mr. Kelsey said for the month of May this year, we had our first positive cash flow month of the year. He said our bond covenants are well-controlled. The average age of plant went down about four years. Mr. Kelsey said we have a lot of work to do. He said we are not alone and we are doing better than most. Mr. Kelsey noted the Patient Navigation Team has been working to help with over $2.2M in savings. He noted the self-pay report in the packet and said this information will be included in future meeting packets. Mr. Kelsey said this is a tremendous cost benefit. He commended Mr. Ron Cheese, Patient Financial Services Director, and said the staff deserves a great amount of credit for creating this program. Mr. Cheese briefly reviewed the program that began in FY 2021. He said the staff continue to look for ways to help patients. He said it is something really special to be a part of and said we have helped find over $4M in benefit to our community since it started. Mr.

Kelsey said we need to find ways to report this news. Ms. Love said we continue working on the FY 2024 finance goals. Ms. Richardson said insurance companies and pharmaceutical companies are operating at double digit profit margins while hospitals are operating with negative margins. She said we do not pass those costs on to the patients. She said we need help in the areas that are completely out of our control.

Bad Debt: The motion to approve the net potential bad debt of $1,452,104.96, as presented was made by Mr. Kelsey; second by Mr. Jones. Motion carried.

Building and Grounds

Mr. Kelsey said Committee minutes and his Chair Report are in the meeting packet. He said there is an action item for how we will handle management of the construction project for the lab expansion. He said the recommendation from our architect is for a construction manager at risk program. Mr. Kelsey said Wyoming Statute 16-6-707 outlines the options for hospitals and projects. This appears to be our best shot at getting the project at the price we can live with. Mr. Kelsey said he recommends the actual bidding out of specialty areas that can bid out in open bid. He said that just gives a little more transparency and competitive edge to us. The motion to approve authorizing the staff to work with Plan One to solicit a construction manager at risk associated with the lab expansion project as discussed was made by Mr. Kelsey; second by Mr. Jones. Motion carried. Ms. Richardson said the project must be completed by December 2026. Ms. Love said we hope to break ground in spring 2024.

Foundation

Ms. Tiffany Marshall, Foundation Executive Director, said her report is in the meeting packet. She said the Foundation Board will have their election of officers in July. She reminded everyone to save the date of August 26 for the Casino Night event.

Compliance Committee

Ms. Pendleton said there is information in the packet.

Governance Committee

Dr. Sowada asked for a discussion on whether or not there is a need for a board level policy that gives oversight of expansion of or need for new services. She said the purpose is to have the staff thinking about what is needed for the Hospital in a proactive way and put into words and oversight the need for control plans that can come to the Board. She said it is not about busy work but about lifting the material up. Mr. Kelsey said in addition to feasibility, he thinks we need to also look at appropriateness. Dr. Sowada asked if the Trustees felt this would be useful or not. The Trustees shared their opinions and the majority felt the way it is working now is fine. Mr. Kelsey said he thinks everyone is talking about the same thing and thinks a policy just puts a framework around the process we are already doing. Ms. Richardson said we have the criteria and feels the staff does an excellent job of bringing the pros and cons. Ms. Pendleton said the Committee should bring a policy if they feel it is important. Dr. Sowada said a draft will be brought to an upcoming meeting. She thanked everyone for the discussion.

Executive Oversight and Compensation Committee

Dr. Sowada said she distributed confidential information to the Trustees for review.

Joint Conference Committee

Dr. Sowada said the Committee has not met.

CONTRACT REVIEW

Consent Agenda

Ms. Richardson reviewed the amendment for the University of Utah helipad. The motion to approve the agreement was made by Ms. Pendleton; second by Mr. Jones. Motion carried. Ms. Richardson said we have contacted the County Attorney's office to find out if we need to move the agreement forward to the County Commissioners for their review and approval.

Five agreements were approved since the last regular meeting: Fibertech, Martin Ray Laundry Systems, Radio Network, Sweetwater Now, and WyoRadio.

MEDICAL STAFF REPORT

Dr. Crofts recognized Dr. John Iliya for having 37 years of medical privileges as a general surgeon at MHSC. She said the Medical Staff had a presentation by UMIA, our medical malpractice provider, about documentation and said it was very good because proper documentation is so very important. Dr. Crofts said she was training on the Davinci robot earlier in the day and hopes to begin cases in August. She said Dr. Jamias is preparing, also. Dr. Crofts said we presented scholarship checks the prior week to very deserving students in Sweetwater School District #1 and #2. She said it is very exciting to see.

GOOD OF THE ORDER

Dr. Sowada distributed updated contact information and thanked Mr. Rood for joining the Board.

EXECUTIVE SESSION

The motion to go into executive session at 4:15 p.m. was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

RECONVENE INTO REGULAR SESSION

The motion to leave executive session and return to regular session at 5:51 p.m. was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

ACTION FOLLOWING EXECUTIVE SESSION

Approval of Privileges

The motion to approve the list of clinical privileges and granting appointments to the Medical Staff as reviewed in executive session was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

Credentials Committee Recommendations to the Board of Trustees for Granting Clinical Privileges and Granting Appointment to the Medical Staff from June 15, 2023

1. Initial Appointment to Active Staff (2 year)
   - Dr. Julie Widdison, Emergency Medicine (U of U)
2. Initial Appointment to Consulting Staff (1 year)
   - Dr. Satvik Ramakrishna, Cardiovascular Disease (U of U)
3. Reappointment to Consulting Staff (2 years)
   - Dr. Lauren Theilen, Maternal/Fetal Medicine (U of U)
   - Dr. Marcela Smid, Maternal/Fetal Medicine (U of U)
   - Dr. Peter Hannon, Tele Stroke (U of U)
   - Dr. Michael Seymour, Tele Radiology (VRC)
4. Reappointment to Non-Physician Provider Staff (2 years)
   - Julie Scott, Professional Counselor (SWCS)
5. New Business
   - New Privilege Form
     - Radiation Oncology

The motion to approve the severance agreement for an unnamed employee and authorize the Board President to sign was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

The motion to approve the written findings of fact and conclusions of law for an unnamed employee and authorize the Board President to sign was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 5:52 p.m.

_____
Dr. Barbara Sowada, President

Attest:

_____
Ms. Kandi Pendleton, Secretary

ORIENTATION MEMO

Board Meeting Date: **August 2, 2023**

Topic for Old & New Business Items: **Board policy: Filling CEO Absences & Vacancies; Filling Senior Leader Absences & Vacancies; Identifying & Developing Internal Senior Leaders**

Policy or Other Document:

_____ Revision
____X__ New

Brief Senior Leadership Comments: **This new policy is required by TJC. The policy provides guidelines for the Board in filling CEO absences and vacancies. It also provides guidelines for the CEO to fill senior leadership absences and vacancies, as well as providing a list of key attributes for successful leaders. The CEO was involved in drafting the policy.**

Board Committee Action: **The policy was drafted by the Governance Committee who presents it to the Board for first reading.**

Policy or Other Document:

____X___ For Review Only
_____ For Board Action

Legal Counsel Review:

__NA_____ In House Comments:
___NA____ Board Comments:

Senior Leadership Recommendation: **The Governance Committee recommends that the Board review the policy and recommend any changes at this first reading.**

Status Draft PolicyStat ID 14074422

Approved N/A
Review Due N/A

Document Area Board of Trustees

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
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
    b. The appointment of an interim Senior Leader
    c. The appointment of a search committee
    d. The retention of a consultant to assist with recruiting, interviewing, and selecting a replacement

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.
2. The salary of the Acting or Interim Senior Leader shall be determined by the CEO in consultation with the Executive Oversight & Compensation Committee and approved by the Board.
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
3. Integrity…the desire to be honest and to value ethical & moral principles
4. Humility…the ability to contain one's ego and to acknowledge mistakes
5. Focus…the ability to maintain a positive focus at work and in life
6. The desire to continually improve
7. The ability to understand that leaders are only as strong as their team and

team members

8. Interest in leading by example
9. The ability to effectively motivate others
10. Capacity to work at a high energy level
11. Ability to endure challenging times without undue discouragement
12. Ability to embrace change
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.

Formerly: Hospital Policy - Succession/Talent management Plan - Senior Leadership Plan

Board of Trustees Approval:

Approval Signatures

Step Description	Approver	Date

ORIENTATION MEMO

Board Meeting Date: August 2nd, 2023

Topic for Old & New Business Items:
Performance Improvement and Patient Safety (PIPS) Plan

Policy or Other Document:

___X__ Revision
_____ New

Brief Senior Leadership Comments:
Minimal revisions made to the content of the document. Corrected all "hospital" to read "Hospital" per Board Member recommendation. The following statement was added under the Confidentiality section of the document: "The Joint Commission is an independent contractor. Any event reported to The Joint Commission is performed under the auspice of the Quality Committee". The document is thorough, comprehensive, and meets regulatory standards.

Board Committee Action:
Approved by Quality Committee of the Board

Policy or Other Document:

_____ For Review Only
__X___ For Board Action

Legal Counsel Review:

___X___ In House Comments:
_____ Board Comments:

Senior Leadership Recommendation:
Recommendation for approval.

Status Draft PolicyStat ID 13563708

Approved N/A
Review Due N/A

Document Area: General - Housewide
Reg. Standards: CMS A-0263, CMS A-0273, CMS A-0283, CMS A-0286, CMS A-0297, CMS A-0308, CMS A-0309, CMS A-0411, CMS A-0508, TJC LD.01.03.01, TJC LD.01.05.01, TJC LD.02.01.01, TJC LD.02.02.01, TJC LD.02.04.01, TJC LD.03.01.01, TJC LD.03.02.01, TJC LD.03.03.01, TJC LD.03.04.01, TJC LD.03.05.01, TJC LD.03.06.01, TJC LD.03.07.01, TJC LD.03.09.01, TJC LD.03.10.01, TJC PI.01.01.01, TJC PI.02.01.01, TJC PI.03.01.01,

Performance Improvement and Patient Safety (PIPS) Plan

Mission

Compassionate care for every life we touch

Vision

To be our community's trusted healthcare leader

Values

Be Kind, Be Accountable, Be Respectful, Embrace Excellence, Work Collaboratively

Introduction

Memorial Hospital of Sweetwater County (MHSC) is committed to providing compassionate, high-quality care with a strong culture of safety for the best patient outcomes. Our objective is to support a culture of safety for our patients and staff. This culture allows us to consistently identify opportunities to improve performance and increase safety while maintaining a commitment to responsible stewardship of resources as aligned with MHSC's mission, vision, values, and strategic objectives.

Definitions

Performance improvement – The systematic process of detecting and analyzing performance problems, designing and developing interventions to address the problems, implementing the interventions, evaluating the results, and sustaining improvement.

Patient safety - The prevention of errors and adverse effects to patients that are associated with health

care. Patient Safety Plan

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.

Purpose

The Performance Improvement and Patient Safety (PIPS) Plan provides guidelines for collecting, analyzing, and using data to identify, address, and monitor performance to continually improve the quality of care provided by the Hospital. The PIPS Plan encompasses a multidisciplinary and integrated approach and is designed to include Leadership, Medical Staff, employees, and the Board of Trustees to collaboratively identify, plan, implement and sustain improvement. The previously identified parties assess processes, initiate peer review activities, and take appropriate actions that will improve the processes and/or systems, in an effort to improve outcomes within the organization. The PIPS Plan is approved annually by the Board of Trustees. Functions of the PIPS Plan include expressing the foundational concepts that form the basis for MHSC's performance improvement and patient safety efforts. In addition, the PIPS Plan outlines the structure and processes that MHSC has developed as a framework for participation in performance improvement across the organization.

Scope

The PIPS Plan is organization wide and applies to all departments, care, treatment, and services settings (including those services furnished under contract or arrangement). This includes Hospital inpatient and outpatient services, as well as Sweetwater Memorial Clinics. (Appendix 1 – PIPS Committee Reporting Calendar)

Objectives

The objective of the PIPS Plan is to allow for a systematic, coordinated, and continuous approach for improving performance. (Appendix 4 – PIPS Documentation Tool)

I. To guide development and implementation of data collection processes that support performance improvement. Data are fundamental components of all performance improvement processes. Data can be obtained from internal sources (for example, documentation, records, staff, patients, observations, and risk assessments) or external sources (for example, regulatory organizations, insurers, and the community). The purpose of data collection is to ensure that data necessary to identify, address, and monitor areas for improvement are available.

II. To guide development and implementation of data analysis processes that support performance improvement. Collected data must be analyzed to be useful. The purpose of data analysis is to determine the status of the Hospital's quality of care and to inform any plans for improvement.

III. To guide development and implementation of performance improvement processes that

increase safety and quality. All performance improvement activities must be based on relevant data collected and analyzed according to Hospital policies and procedures. Performance improvement is a continual process. Performance improvement aims to ensure that the safest, highest-quality care is provided to all patients at all times.

Organization and Accountability

The PIPS Plan shall involve the coordinated efforts of the Board of Trustees, Senior Leadership Team, Medical Staff, Department Directors, Supervisors, Clinical Coordinators, and staff of the various MHSC departments and committees. Every employee is responsible for participating in performance improvement activities, as appropriate to their job duties. Engagement in quality improvement activities is an expectation at MHSC. Activities are prioritized by the PIPS Committee and Medical Staff, with input from the Quality Committee of the Board.

Board of Trustees

I. The responsibilities of the Board of Trustees, as they relate to the PIPS Plan, include:
   A. Oversee that quality and safety are at the core of the organization's mission
   B. Oversee that quality and safety values are embedded in guiding the organization's strategic plan
   C. Oversee that adequate resources (staff, time, information systems, and training) are allocated to data collection and performance improvement
   D. Oversee the Hospital's ongoing monitoring, maintenance, and improvement efforts for safe, high - quality, and efficient medical care
   E. Monitor appropriate data collection processes, including methods, frequency, and details
      1. By approving the PIPS Plan and accepting dashboard reports and other reports addressing specific metrics, the Board approves data definitions and frequency and detail of data collection. The Board authorizes applicable quality oversight committees to adjust data definitions and data frequency as deemed necessary so long as revisions ensure performance improvement processes are in no way hindered and applicable definitions and frequency are consistent with national, state, or local reporting requirements. Based on its oversight responsibilities and at its discretion, the Board, may at any time require changes in either frequency or detail of data collection.
         a. Frequency of data collection and reporting is determined on a case-by-case basis with consideration to improvement priorities, sample size necessary for adequate review, and resource consideration
   F. Assess the effectiveness of the PIPS Plan
   G. Review and approve the PIPS Plan annually
   H. Participate in education regarding the methods of quality management and performance improvement

I. Receive reports of indicators and performance of processes as outlined in this plan

J. Receive regular reports regarding all departments with direct and indirect patient care services and ensure these are monitored, problems are identified and prioritized, and appropriate action is implemented

Senior Leadership Team

I. The Senior Leadership Team is comprised of the Chief Executive Officer (CEO), Chief Medical Officer (CMO), Chief Nursing Officer (CNO), Chief Clinical Officer (CCO), and Chief Financial Officer (CFO).

II. Oversight of a PIPS Plan capable of continuous improvement is a task accomplished in an environment fostered by Senior Leadership support. The Senior Leadership Team's commitment includes taking accountability for the PIPS Plan's effectiveness and ensuring the PIPS Plan requirements are integrated into organizational processes. In addition, the commitment includes recognizing the importance of meeting patient needs and the various requirements of statutes and regulations that surround and permeate the organization.

III. The responsibilities of the Senior Leadership Team as they relate to the PIPS Plan include:

A. Support the implementation, execution, and oversight of this quality framework

B. Set the scope, priorities, guidelines, and parameters for the PIPS Plan

C. Align the PIPS Plan with strategic priorities

D. Set expectations for using data and information

E. Set priorities for and identify the frequency of data collection and performance improvement that include but are not limited to the following:

1. High-volume processes
2. High-risk processes
3. Problem-prone processes

F. Set priorities for performance improvement based on the following considerations:

1. Incidence
2. Prevalence
3. Severity

G. Prioritize and ensure that adequate resources (staff, time, information systems, and training) are allocated to data collection and performance improvement

H. Update this plan to reflect any changes, including but not limited to, changes in the following:

1. Strategic priorities
2. Internal or external environment (such as patient population, community health metrics, and so on)

I. Ensure the PIPS Plan is cohesive and feasible

J. Periodically approve flexibility and variation in department and committee -

scheduled reports, in extenuating circumstances as necessary

K. Ensure accreditation standards adherence

L. Motivate and support staff to achieve PIPS objectives

M. Evaluate the effectiveness of the Hospital's use of data and information

N. Monitor the effectiveness of the PIPS Plan and the achievement of results

O. Ensure appropriate follow-up of identified corrective actions not resulting in expected or sustained improvement

P. Communicate the PIPS Plan to staff and the community

Quality Department

I. The responsibilities of the Quality Department as they relate to the PIPS Plan include:

A. Serve as a resource for performance improvement, patient safety, patient experience, and regulatory information

B. Educate MHSC staff about the performance improvement process, patient safety, and patient experience

C. Support staff, including Medical Staff, Leadership, and project leaders, in the development and implementation of performance improvement activities, including team building and data analysis

D. Assist with and assure data gathering efforts are valid, reliable, and comprehensive

E. Attend designated Medical Staff committee meetings and facilitate performance improvement processes

F. Provide accurate and reliable data for Ongoing Professional Practice Evaluation (OPPE) profiles for assessment of Medical Staff members

G. Promote consistency in performance improvement activities

Medical Staff

I. The Medical Staff provides expertise in meeting appropriate clinical goals, objectives, and initiatives for patient care. The responsibilities of the Medical Staff as they relate to the PIPS Plan include:

A. Provide clinical input for targets related to clinical outcomes

B. Carry out tasks to meet the objectives of the PIPS Plan

C. Reviews reports to ensure measures are reaching agreed-upon targets in Medical Staff meetings

D. Act upon identified areas for improvement

E. Provide effective mechanisms to measure, assess, and improve the quality and appropriateness of patient care, and the clinical performance of all individuals with delineated clinical privileges, accomplished through Ongoing Professional Practice Evaluations (OPPE), Focused Professional Practice Evaluations (FPPE), and Peer Review Process (refer to Professional Practice Review Process – Medical Staff Peer Review)

Leadership Team

I. The Leadership Team is comprised of department directors, supervisors, and clinical coordinators. The responsibilities of the Leadership Team, as they relate to the PIPS Plan, include:
    A. Utilize performance improvement processes to support MHSC's mission, vision, and values
    B. Participate in the collection and analysis of relevant departmental data
    C. Foster a climate of continuous improvement through measurement, data analysis, identification, and implementation of changes needed to improve and ensure sustainment
    D. Monitor processes known to jeopardize the safety or clinical outcomes of patients
    E. Implement and maintain processes to ensure compliance with applicable requirement(s) or standard(s)
    F. Ensure services provided are consistent with MHSC's values and goal of consistently providing person-centered care
    G. Document improvement initiatives and progress
    H. Present department performance improvement project updates to PIPS Committee as requested and/or scheduled (Appendix 5 - PIPS Reporting Presentation Template)

Project Teams, Staff, and Volunteers

I. The responsibilities of the Project Teams, Department Employees, and Volunteers as they relate to the PIPS Plan include
    A. Participate in data collection and analysis activities as well as performance improvement activities
    B. Identify and utilize approaches for improving processes and outcomes to continuously improve the quality and safety of patient care
    C. Performance improvement project teams may be formed according to employee identification of improvements and prioritization
    D. Document improvement initiatives and progress (Appendix 4 - PIPS Documentation Tool)
    E. Report improvement initiatives to PIPS Committee as requested or scheduled (Appendix 5 - PIPS Reporting Presentation Template)

PIPS Committee Functions

I. The PIPS Committee oversees the establishment, implementation, and monitoring of the PIPS Plan. The core PIPS Committee shall be comprised of Senior Leadership, Director of Medical Office Building Clinics, Director of Acute Care Services, Director of Emergency Services, Infection Prevention, Director of Surgical Services, Director of Medical Imaging, Director of Women's Health, Director of Pharmacy, Director of Cardiopulmonary, Director of Environmental Services, Director of Lab, Director of Nutrition Services, Director of Rehab Services, Director of Care Management, Director of Education, Director of Dialysis, Director of Medical Oncology,

Director of Radiation Oncology, Quality Department, Medical Staff Representative, Security, Emergency Management Coordinator, Family Medicine/Occupational Medicine Clinic Representative and Patient Safety Representative. Other representatives may attend based on identified priorities.

A. Provide an organization-wide program to systematically measure, assess, and improve performance to achieve optimal patient outcomes in a collaborative, multidisciplinary, cross-departmental approach

B. Support activities to promote patient safety and encourage a reduction in preventable harm, in collaboration with the Patient Safety Committee

C. Provide a mechanism to foster collaborative efforts for performance improvement, feedback, and learning throughout the organization while assigning responsibilities and authority for these processes

D. Implement all Centers for Medicare and Medicaid Services (CMS) and other regulatory bodies' quality management and performance improvement standards and maintain accreditation and required certifications

E. Oversee compliance with accreditation standards and support resolution of noncompliance through action plans in coordination with the Continual Survey Readiness Committee

F. Coordinate schedule for department and committee reports

G. Prioritize improvement projects to address processes based on the following:

    1. Focus on high-risk, high-volume, or problem-prone areas
    2. Consider the incidence, prevalence, and severity of the problems in those areas
    3. Affect on health outcomes, patient safety, and quality of care
    4. Additional factors such as resource allocation and accreditation/ regulatory requirements
    5. Utilize a prioritization scoring tool to assist in determining the distinct number of improvement projects annually (Appendix 3 - Proposed Performance Improvement Project Decision Checklist)

H. Ensure performance improvement projects incorporate the needs and expectations of patients and families

I. Monitor the status of identified and prioritized performance improvement projects and action plans by ensuring additional data collection and analysis is performed to assure improvement or problem resolution on a sustained basis

J. Identify corrective actions not resulting in expected or sustained improvement

K. Ensure proper continuation of the cycle of creating, implementing, monitoring, and evaluating improvement efforts

L. Identify annual data elements collected on an ongoing basis to prioritize focus areas for performance improvement

M. Review and approve the PIPS Plan each year prior to submitting to the Quality

Committee of the Board

N. Oversee annual evaluation of performance improvement project priorities and goals

O. Oversee annual evaluation of PIPS Plan objectives, scope, and effectiveness, and evaluate progress towards strategic plan goals related to quality, safety, and patient experience

P. Communicate information concerning quality, patient safety, and patient experience to departments when opportunities to improve exist

Q. Report, in writing, to leadership on issues and interventions related to adequacy of staffing, including nurse staffing. This occurs at least once a year.

R. Report appropriate information regarding quality, patient safety, patient experience, and accreditation to Senior Leadership, Medical Executive Committee (MEC), Quality Committee of the Board, and the Board of Trustees to provide leaders with the information they need in fulfilling their responsibilities concerning the quality and safety of patient care

    1. Specifically, the committee provides data on Multidrug-resistant organisms (MDROs), Central line-associated blood stream infection (CLABSI), Catheter associated urinary tract infection (CAUTI), Clostridioides difficile (CDI), Surgical site infection (SSI) to key stakeholders, including but not limited to the following:

        a. Leaders

        b. Licensed independent practitioners

        c. Nursing staff

        d. Other clinicians

S. Provide reports to the Quality Committee of the Board regarding results of performance improvement activities

Risk/Compliance

I. Risk Management is undertaken by the Quality Department, in collaboration with multiple other departments, to identify, evaluate and reduce risk or loss to patients, employees, visitors, and the Hospital. The PIPS Committee may assist with quality improvement opportunities identified for risk reduction and performance improvement.

Safety

I. MHSC is committed to encouraging, promoting, and supporting a culture of safety throughout the organization. The purpose of the organizational Patient Safety Program is to improve patient safety and reduce risk to patients through an environment that encourages:

    A. Recognition and acknowledgment of risks to patients with regard to medical/health care errors

    B. Initiation of actions to reduce these risks

    C. Internal reporting of what has been found and the actions taken

    D. Focus on processes and systems

E. Minimization of individual blame or retribution for involvement in a medical/health care error

F. Organizational learning about medical/health care error

G. Support for the sharing of knowledge to effect behavioral changes in itself and other healthcare organizations

H. Appropriate communication and transparency to our patients and families

II. Please refer to the Patient Safety Plan for further information. Patient Safety Plan

Methodology

Memorial Hospital of Sweetwater County utilizes processes outlined by the Institute for Healthcare Improvement (IHI) Model for Improvement, developed by Associates in Process Improvement. This model for improvement includes forming a team, setting aims, and establishing measures, along with selecting, testing, implementing, and spreading changes. The Plan, Do, Study, Act (PDSA) Model is used to guide tests of change within and throughout the organization. Specific, Measurable, Achievable, Realistic, and Time-bound (S.M.A.R.T) goals are encouraged to be utilized when appropriate in setting aims and smart objectives. (See Appendix 4-PIPS Documentation Tool and Appendix 7 – IHI's Model for Improvement) Performance improvement teams may use other evidence-based methodologies and tools as appropriate based on the complexity, scope, and scale of the improvement project.

I. Performance improvement project teams will use data to determine how action plans are developed and will define the frequency of data collection

Data

MHSC continually seeks to identify changes that will lead to improved quality and patient safety. Annually, each department/discipline shall develop indicators for performance improvement based on their identified improvement project. Whenever possible, data collection is a shared activity involving staff. The collected data may be organized and analyzed with the assistance of the Quality Department, if necessary.

I. By approving the PIPS Plan and accepting dashboard reports and other reports addressing specific metrics, the Board approves data definitions, along with frequency and detail of data collection. The Board authorizes applicable quality oversight committees to adjust data definitions and frequency of data collection as deemed necessary, so long as revisions ensure performance improvement processes are in no way hindered and applicable definitions and frequency are consistent with national, state, or local reporting requirements. Based on its oversight responsibilities and at its discretion, the Board may, at any time require changes in either frequency or detail of data collection.

A. Frequency of data collection and reporting is determined on a case-by case basis with consideration to improvement priorities, sample size necessary for adequate review, and resources consideration

II. Data Collection

A. The PIPS Committee has identified acceptable data sources for performance

monitoring and improvement activity. Data sources and mechanisms of identifying opportunities for improvement include, but are not limited to:

1. Risk Assessments
2. Reports and/or alerts from governmental agencies (for example, Centers for Disease Control and Prevention, Occupational Safety and Health Administration, Food and Drug Administration)
3. Accreditation reports
4. Regulatory rounds and tracers
5. Culture of Safety survey
6. Occurrence reports and Good Catches identifying patient safety concerns and trends
7. Staff reporting safety or process concerns to their leaders
8. RCA (Root Cause Analysis)
9. FMEA (Failure Mode Effects Analysis)
10. Patient complaints/grievances
11. Patient perception of safety and quality
12. Peer review
13. Ongoing medical record review
14. Audit of clinical contracts
15. Internal audits identifying improvement opportunities
16. Sentinel event reports and Joint Commission Sentinel Event alerts
17. Hospital Quality Improvement Contractor (HQIC)

B. The PIPS Committee collaborates with department managers to perform the following activities:

1. Collect data required by CMS Conditions of Participation and The Joint Commission including measures from:
    a. Inpatient Quality Reporting
    b. Outpatient Quality Reporting
    c. Value Based Purchasing
    d. Hospital Readmission Reduction Program
    e. Hospital Acquired Condition Reduction Program
    f. Quality Payment Program – Merit Based Incentive Payment
    g. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
    h. The Joint Commission ORYX Measures
2. Collect data on the following:

a. Improvement priorities, as identified by leadership
b. Selected outcome indicators (mortality, readmissions, etc.)
c. Procedures, including operative procedures, that place patient at risk of disability or death
d. Clinically significant unexpected postoperative diagnoses, as determined by the medical staff
e. Blood and blood components use
f. Use of restraints
g. Use of seclusion
h. Patient safety issues (ex: falls, self harm)
i. Resuscitative services, including the following elements:
    i. Number and location of cardiac arrests
    ii. Outcomes of resuscitation, such as return of spontaneous circulation (ROSC) and/or survival to discharge
    iii. Transfer to higher level of care
j. Pain assessment and pain management
k. Rapid response to change or deterioration in a patient condition
l. Care or services to high-risk populations (patient falls)
m. National Patient Safety Goals
n. CMS preventable conditions (Hospital-Acquired Conditions)
o. Healthcare-associated infections (SSI, CLABSI, CAUTI, MRSA, MDRO, C.diff)
p. AHRQ Patient Safety Indicators (PSI)
q. Reported and confirmed transfusion reactions
r. Changing internal or external (e.g. Joint Commission Sentinel Event Alerts) conditions
s. MRI incidents/injuries
t. Significant adverse drug reactions
u. Significant medication errors
v. Adverse events or patterns of adverse events during moderate or deep sedation and anesthesia
w. Complications of care

3. Collect data on topics in the following areas:
    a. Environment of care
    b. Infection prevention and control

c. Medication management system

d. Resuscitation performance, including but not limited to the following elements:

i. Frequency of early warning signs being present prior to cardiac arrest

ii. Timeliness of staff response to cardiac arrest

iii. Quality of cardiopulmonary resuscitation (CPR)

iv. Post–cardiac arrest care processes

v. Outcomes following cardiac arrest

e. Organ procurement program (conversion rates)

f. Adequacy of staffing, including nurse staffing, in relation to undesirable patterns, trends, or variations in performance

g. Incidents related to overexposure to radiation during diagnostic computed tomography examinations

4. Include the following information when recording data:

a. Data source

b. Collection frequency

c. Reporting frequency

d. Report audience

e. Responsible department(s)

f. Indicators for intervention

III. Data Reliability and Validity

A. Collected data need to be accurate, complete, and reliable. The PIPS Committee has established the following expectations for any data used to monitor or improve Hospital performance:

1. Data samples will undergo auditing

2. Data sources will be regularly checked using established procedures

3. Re-abstraction will occur on a data sample

IV. Data Analysis

A. The PIPS Committee does the following:

1. Engages the assistance of relevant departmental management and/or staff to collect and analyze data

2. Develops goals and benchmarks in conjunction with stakeholders with attention to past performance, national performance data, external benchmarks, or comparative databases

3. Compares internal data over time to identify levels of performance, pattern or trends in performance, and variations in performance

4. Utilizes statistical tools and techniques to measure, analyze, and display data (e.g., run charts, flow charts and control charts). Preferred PIPS data displays include dashboards, run charts, and control charts, as applicable
5. Analyzes data using methods that are appropriate to the type of data and the desired metrics, which include but are not limited to:
    a. Benchmark: a comparison and measurement of a health care organization's metrics against other national health care organizations. MHSC utilizes the National Average when available.
    b. Target Goal (SMART Goal): targeted goals define interim steps towards the stretch goal. Target goals may change frequently as progress is made toward stretch goal. Target goals help form a concrete plan of action in order to make the stretch goal a reality.
    c. Stretch Goal: inspires us to think big and reminds us to focus on the larger picture. This goal should exceed the benchmark. MHSC utilizes the National Top 10% when available.
6. Analyzes aggregate data to identify opportunities for improvement and actions to improve the quality of processes

Communication

I. To communicate changes made based on data analysis and to sustain improvements, performance improvement is communicated through the following resources (Appendix 6 - Communication Plan):
    A. Quality Committee of the Board
    B. PIPS Committee
    C. Leadership meetings
    D. Medical Staff meetings
    E. Staff meetings
    F. Department white boards, electronic communication, and communication books may be utilized to display results of monitoring and internal performance improvement activities

Confidentiality

I. WY Stat 35-2-910. Quality management function for health care facilities; confidentiality; immunity; whistle blowing; peer review. Subsection A.

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

III. 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.

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

V. Confidential information may include but is not limited to: Medical Staff committee minutes, organizational quality improvement committee minutes, electronic data gathering and reporting, and incident/occurrence reporting

VI. Quality improvement activities will occur in ways that preserve confidentiality of information consistent with policy and established law

VII. The Joint Commission is an independent contractor. Any event reported to The Joint Commission is performed under the auspice of the Quality Committee.

References

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The Joint Commission. (2023, Jan). *PI performance improvement plan*. PolicySource hospital and critical access hospital. PolicySource: P&Ps for Compliance with Joint Commission Requirements | Joint Commission Resources (jcrinc.com)

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Approval:

Performance Improvement and Patient Safety Committee – May 9th, 2023

Medical Executive Committee - May 23rd, 2023

Quality Committee of the Board – June 21st, 2023

Board of Trustees –

Attachments

Appendix 1 - Reporting Calendar

Appendix 2 - Committee Reporting Structure

Appendix 3 - Proposed Performance Improvement Project Decision Checklist

Appendix 4 - PIPS Documentation Tool

Appendix 5 - PIPS Reporting Presentation Template

Appendix 6 - Communication Plan

Appendix 7 - IHI Model for Improvement.pdf

Appendix 8 - FY 2023 PIPS Priorities

Approval Signatures

Step Description	Approver	Date

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Performance Improvement and Patient Safety (PIPS) Plan

Mission

Compassionate care for every life we touch

Vision

To be our community's trusted healthcare leader

Values

Be Kind, Be Accountable, Be Respectful, Embrace Excellence, Work Collaboratively

Introduction

Memorial Hospital of Sweetwater County (MHSC) is committed to providing compassionate, high-quality care with a strong culture of safety for the best patient outcomes. Our objective is to support a culture of safety for our patients and ~~workers~~staff. This culture allows us to consistently identify opportunities to improve performance and increase safety while maintaining a commitment to responsible stewardship of resources as aligned with MHSC's mission, vision, values, and strategic objectives.

Definitions

Performance improvement – The systematic process of detecting and analyzing performance problems, designing and developing interventions to address the problems, implementing the interventions, evaluating the results, and sustaining improvement.

Patient safety - The prevention of errors and adverse effects to patients that are associated with health care. Patient Safety Plan

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.

Purpose

The Performance Improvement and Patient Safety (PIPS) Plan provides guidelines for collecting, analyzing, and using data to identify, address, and monitor performance to continually improve the quality of care provided by the Hospital. The PIPS Plan encompasses a multidisciplinary and integrated approach and is designed to include Leadership, Medical Staff, employees, and the Board of Trustees to collaboratively identify, plan ~~provides guidelines for collecting~~, ~~analyzing~~implement and sustain improvement. The previously identified parties assess processes, ~~and using data to identify~~initiate peer review activities, ~~address, and monitor performance to continually~~and take appropriate actions that will improve the ~~quality of care provided by the hospital~~processes and/or systems, in an effort to improve outcomes within the organization. The PIPS Plan ~~encompasses a multidisciplinary and integrated approach, and~~ is ~~designed to~~approved annually by the Board of Trustees. Functions of the PIPS Plan include ~~Leadership, Medical Staff, employees, and the Board of Trustees to collaboratively identify, plan, implement and sustain improvement. The previously identified parties assess processes, initiate peer review activities, and take appropriate actions~~expressing the foundational concepts that ~~will improve the processes and/or systems, in an effort to improve outcomes within the organization. The PIPS plan is approved annually by the Board of Trustees. Functions of the PIPS plan include expressing the foundational concepts that~~ form the basis for MHSC's performance improvement and patient safety efforts. In addition, the PIPS Plan outlines the structure and processes that MHSC has developed as a framework for participation in performance improvement across the organization.

Scope

The PIPS Plan is organization wide and applies to all departments, care, treatment, and services settings (including those services furnished under contract or arrangement). This includes Hospital inpatient and outpatient services, as well as Sweetwater Memorial Clinics. (Appendix 1 – ~~FY 2023~~ PIPS Committee Reporting Calendar)

Objectives

The objective of the PIPS ~~plan~~Plan is to allow for a systematic, coordinated, and continuous approach for improving performance. (Appendix 4 – PIPS Documentation Tool)

I. To guide development and implementation of data collection processes that support performance improvement. Data are fundamental components of all performance improvement processes. Data can be obtained from internal sources (for example, documentation, records, staff, patients, observations, and risk assessments) or ~~from~~ external sources (for example, regulatory organizations, insurers, and the community). The purpose of data collection is to ensure that data necessary to identify, address, and monitor areas for improvement are available.

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Organization and Accountability

The PIPS Plan shall involve the coordinated efforts of the Board of Trustees, Senior Leadership Team, Medical Staff, Department Directors, Supervisors, Clinical Coordinators, and ~~front line~~ staff of the various MHSC departments and committees. Every employee is responsible for participating in performance improvement activities, as appropriate to their job duties. Engagement in quality improvement activities is an expectation at MHSC. Activities are prioritized by the PIPS Committee and Medical Staff, with input from the Quality Committee of the Board.

Board of Trustees

I. The responsibilities of the Board of Trustees, as they relate to the PIPS Plan, include:
   A. Oversee that quality and safety are at the core of the organization's mission
   B. Oversee that quality and safety values are embedded in guiding the organization's strategic plan
   C. Oversee that adequate resources (staff, time, information systems, and training) are allocated to data collection and performance improvement
   D. Oversee the Hospital's ongoing monitoring, maintenance, and improvement efforts for safe, high - quality, and efficient medical care ~~that is in accordance with all applicable laws and accrediting bodies~~
   E. Monitor appropriate data collection processes, including methods, frequency, and details
      1. By approving the PIPS Plan and accepting dashboard reports and other reports addressing specific metrics, the Board approves data definitions and frequency and detail of data collection. The Board authorizes applicable quality oversight committees to adjust data definitions and data frequency as deemed necessary so long as revisions ensure performance improvement processes are in no way hindered and applicable definitions and frequency are consistent with national, state, or local reporting requirements. Based on its oversight responsibilities and at its discretion, the Board, may at any time require changes in either frequency or detail of data collection.
         a. Frequency of data collection and reporting is determined on a case-by -case basis with consideration to improvement

priorities, sample size necessary for adequate review, and resource consideration

F. Assess the effectiveness of the PIPS Plan

G. Review and approve the PIPS Plan annually

H. Participate in education regarding the methods of quality management and performance improvement

I. Receive reports of indicators and performance of processes as outlined in this plan

J. Receive regular reports regarding all departments with direct and indirect patient care services and ensure these are monitored, problems are identified and prioritized, and appropriate action is implemented

Senior Leadership Team

I. The Senior Leadership Team is comprised of the Chief Executive Officer (CEO), Chief Medical Officer (CMO), Chief Nursing Officer (CNO), Chief Clinical Officer (CCO), and Chief Financial Officer (CFO).

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III. The responsibilities of the Senior Leadership Team as they relate to the PIPS Plan include:

A. Support the implementation, execution, and oversight of this quality framework

B. Set the scope, priorities, guidelines, and parameters for the PIPS Plan

C. Align the PIPS Plan with strategic priorities

D. Set expectations for using data and information

E. Set priorities for and identify the frequency of data collection and performance improvement that include but are not limited to the following:

1. High-volume processes
2. High-risk processes
3. Problem-prone processes

F. Set priorities for performance improvement based on the following considerations:

1. Incidence
2. Prevalence
3. Severity

G. Prioritize and ensure that adequate resources (staff, time, information systems, and training) are allocated to data collection and performance improvement

H. ~~Updates~~Update this plan to reflect any changes, including but not limited to, changes in the following:
~~Strategic priorities~~
~~Internal or external environment (such as patient population, community health metrics, and so on)~~

1. Strategic priorities
2. Internal or external environment (such as patient population, community health metrics, and so on)

I. Ensure the PIPS Plan is cohesive and feasible

J. ~~May periodically~~Periodically approve flexibility and variation in department and committee - scheduled reports, in extenuating circumstances as necessary

K. Ensure accreditation standards adherence

L. Motivate and support staff to achieve PIPS objectives

M. Evaluate the effectiveness of the ~~hospital~~Hospital's use of data and information

N. Monitor the effectiveness of the PIPS Plan and the achievement of results

O. Ensure appropriate follow -up of identified corrective actions not resulting in expected or sustained improvement

P. Communicate the PIPS Plan to ~~workers~~staff and the community

Quality Department

I. The responsibilities of the Quality Department as they relate to the PIPS Plan include:

A. Serve as a resource for performance improvement, patient safety, patient experience, and regulatory information

B. Educate MHSC staff about the performance improvement process, patient safety, and patient experience

C. Support staff, including Medical Staff, Leadership, and project leaders, in the development and implementation of performance improvement activities, including team building and data analysis

D. Assist with and assure data gathering efforts are valid, reliable, and comprehensive

E. Attend designated Medical Staff committee meetings and facilitate performance improvement processes

F. Provide accurate and reliable data for Ongoing Professional Practice Evaluation (OPPE) profiles for assessment of Medical Staff members

G. Promote consistency in performance improvement activities

Medical Staff

I. The Medical Staff provides expertise ~~on~~in meeting appropriate clinical goals, objectives, and initiatives for patient care. The responsibilities of the Medical Staff as they relate to the PIPS ~~plan~~Plan include:

A. Provide clinical input for targets related to clinical outcomes

B. Carry out tasks to meet the objectives of the PIPS ~~plan~~Plan

C. Reviews reports to ensure measures are reaching agreed -upon targets in Medical Staff meetings

D. Act upon identified areas for improvement

E. Provide effective mechanisms to measure, assess, and improve the quality and appropriateness of patient care, and the clinical performance of all individuals with delineated clinical privileges, accomplished through Ongoing Professional Practice Evaluations (OPPE), Focused Professional Practice Evaluations (FPPE), and Peer Review Process (~~refer to Professional Practice Review Process – Medical Staff Peer Review~~refer to Professional Practice Review Process – Medical Staff Peer Review)

Leadership Team

I. The Leadership Team is comprised of department directors, supervisors, and clinical coordinators. The responsibilities of the Leadership Team, as they relate to the PIPS Plan, include:

A. Utilize performance improvement processes to support MHSC's mission, vision, and values

B. Participate in the collection and analysis of relevant departmental data

C. Foster a climate of continuous improvement through measurement, data analysis, identification, and implementation of changes needed to improve and ensure sustainment

D. Monitor processes known to jeopardize the safety or clinical outcomes of patients

E. Implement and maintain processes to ensure compliance with applicable requirement(s) or standard(s)

F. Ensure services provided are consistent with MHSC's values and goal of consistently providing person-centered care

G. Document improvement initiatives and progress ~~(Appendix 4 - PIPS Documentation Tool)~~

H. Present department performance improvement project updates to PIPS Committee as requested and/or scheduled (Appendix 5 - PIPS Reporting Presentation Template)

Project Teams, ~~Department Employees~~Staff, and Volunteers

I. The responsibilities of the Project Teams, Department Employees, and Volunteers as they relate to the PIPS Plan include

A. Participate in data collection and analysis activities as well as performance improvement activities

B. Identify and utilize approaches for improving processes and outcomes to continuously improve the quality and safety of patient care

C. Performance improvement project teams may be formed according to employee identification of improvements and prioritization

D. Document improvement initiatives and progress (Appendix 4 - PIPS Documentation

Tool)

E. Report improvement initiatives to PIPS Committee as requested or scheduled (Appendix 5 - PIPS Reporting Presentation Template)

PIPS Committee Functions

I. The PIPS Committee oversees the establishment, implementation, and monitoring of the PIPS Plan. The core PIPS Committee shall be comprised of Senior Leadership, Director of ~~Clinic~~Medical Office Building Clinics, Director of Acute Care Services, Director of Emergency Services, ~~Director of~~ Infection Prevention, Director of Surgical Services, Director of Medical Imaging, Director of Women's Health, Director of Pharmacy, Director of Cardiopulmonary, Director of Environmental Services, Director of Lab, Director of Nutrition Services, Director of Rehab Services, Director of Care Management, Director of Education, Director of Dialysis, Director of ~~Cancer Center~~Medical Oncology, Director of Radiation Oncology, Quality Department, Medical Staff Representative, Security, Emergency Management Coordinator, Family Medicine/~~Emergency Management,~~Occupational Medicine Clinic Representative and Patient Safety Representative. Other representatives may attend based on identified priorities.

A. Provide an organization -wide program to systematically measure, assess, and improve performance to achieve optimal patient outcomes in a collaborative, multidisciplinary, cross-departmental approach

B. Support activities to promote patient safety and encourage a reduction in preventable harm, in collaboration with the Patient Safety Committee

C. Provide a mechanism to foster collaborative efforts for performance improvement, feedback, and learning throughout the organization while assigning responsibilities and authority for these processes

D. Implement all Centers for Medicare and Medicaid Services (CMS) and other regulatory bodies' quality management and performance improvement standards and maintain accreditation and required certifications

E. Oversee compliance with accreditation standards and support resolution of noncompliance through action plans in coordination with the Continual Survey Readiness Committee

F. Coordinate schedule for department and committee reports

G. Prioritize improvement projects to address processes based on the following:

1. Focus on high-risk, high -volume, or problem -prone areas
2. Consider the incidence, prevalence, and severity of ~~problem~~the problems in those areas
3. Affect on health outcomes, patient safety, and quality of care
4. Additional factors ~~include:~~such as resource allocation and accreditation/ regulatory requirements
5. ~~Utilizes~~Utilize a prioritization scoring tool~~. This will~~ to assist in determining the distinct number of improvement projects annually (Appendix 3 - Proposed Performance Improvement Project Decision Checklist)

H. Ensure performance improvement projects incorporate the needs and expectations of patients and families

I. Monitor the status of identified and prioritized performance improvement projects and action plans by ensuring additional data collection and analysis is performed to assure improvement or problem resolution on a sustained basis

J. Identify corrective actions not resulting in expected or sustained improvement

K. Ensure proper continuation of the cycle of creating, implementing, monitoring, and evaluating improvement efforts

L. Identify annual data elements collected on an ongoing basis to prioritize focus areas for performance improvement

M. Review and approve the PIPS Plan each year prior to submitting to the Quality Committee of the Board

N. Oversee annual evaluation of performance improvement project priorities and goals

O. Oversee annual evaluation of PIPS Plan objectives, scope, and effectiveness, and evaluate progress towards strategic plan goals related to quality, safety, and patient experience

P. Communicate information concerning quality, patient safety, and patient experience to departments when opportunities to improve exist

Q. ~~Reports~~Report, in writing, to leadership on issues and interventions related to adequacy of staffing, including nurse staffing. This occurs at least once a year.

R. Report appropriate information regarding quality, patient safety, patient experience, and accreditation to Senior Leadership, Medical Executive Committee (MEC), Quality Committee of the Board, and the Board of Trustees to provide leaders with the information they need in fulfilling their responsibilities concerning the quality and safety of patient care

1. Specifically, the committee provides data on Multidrug-resistant ~~organism~~organisms (~~MDRO~~MDROs), Central ~~Line~~line-associated ~~Blood Stream Infection~~blood stream infection (CLABSI), ~~and~~Catheter associated urinary tract infection (CAUTI), Clostridioides difficile (CDI), Surgical ~~Site Infection~~site infection (SSI) to key stakeholders, including but not limited to the following:
    a. Leaders
    b. Licensed independent practitioners
    c. Nursing staff
    d. Other clinicians

S. Provide reports to the Quality Committee of the Board regarding results of performance improvement activities

Risk/Compliance

I. Risk Management is undertaken by the Quality Department, in collaboration with multiple other departments, to identify, evaluate and reduce risk or loss to patients, employees, visitors, and

the ~~hospital~~Hospital. The PIPS Committee may assist with quality improvement opportunities identified for risk reduction and performance improvement.

Safety

I. MHSC is committed to encouraging, promoting, and supporting a culture of safety throughout the organization. The purpose of the organizational Patient Safety Program is to improve patient safety and reduce risk to patients through an environment that encourages:
   A. Recognition and acknowledgment of risks to patients ~~of~~with regard to medical/ health care errors
   B. Initiation of actions to reduce these risks
   C. Internal reporting of what has been found and the actions taken
   D. Focus on processes and systems
   E. Minimization of individual blame or retribution for involvement in a medical/health care error
   F. Organizational learning about medical/health care error
   G. Support for the sharing of knowledge to effect behavioral changes in itself and other ~~health care~~healthcare organizations
   H. Appropriate communication and transparency to our patients and families

II. Please refer to the Patient Safety Plan for further information. Patient Safety Plan

Methodology

Memorial Hospital of Sweetwater County utilizes processes outlined by the Institute for Healthcare Improvement (IHI) Model for Improvement, developed by Associates in Process Improvement. This model for improvement includes forming a team, setting aims, and establishing measures, along with selecting, testing, implementing, and spreading changes~~, testing changes, implementing changes, and spreading changes~~. The Plan, Do, Study, Act (PDSA) Model is used to guide tests of change within and throughout the organization. Specific, Measurable, Achievable, Realistic, and Time-bound (S.M.A.R.T) goals are encouraged to be utilized when appropriate in setting aims and smart objectives. (See Appendix 4-PIPS Documentation Tool and Appendix 7 – IHI's Model for Improvement) Performance improvement teams may use other evidence-based methodologies and tools as appropriate based on the complexity, scope, and scale of the improvement project.

~~Performance improvement project teams will collect, analyze, document, and report improvements using Lean principles and methodologies (Appendix 4 – PIPS Documentation Tool)~~

I. Performance improvement project teams will use data to determine how action plans are developed and will define the frequency of data collection

Data

MHSC continually seeks to identify changes that will lead to improved quality and patient safety.

Annually ~~and coinciding with the fiscal year~~, each department/discipline shall develop indicators for performance improvement based on their identified improvement project. Whenever possible, data collection is a shared activity involving staff. The collected data may be organized and analyzed with the assistance of the Quality Department, if necessary.

I. By approving the PIPS Plan and accepting dashboard reports and other reports addressing specific metrics, the Board approves data ~~definition~~definitions, along with frequency and detail of data collection. The Board authorizes applicable quality oversight committees to adjust data definitions and frequency of data ~~frequency~~collection as deemed necessary, so long as revisions ensure performance improvement processes are in no way hindered and applicable definitions and frequency are consistent with national, state, or local reporting requirements. Based on its oversight responsibilities and at its discretion, the Board~~,~~ may, at any time require changes in either frequency or detail of data collection.
    A. Frequency of data collection and reporting is determined on a case-by case basis with consideration to improvement priorities, sample size necessary for adequate review, and resources consideration

II. Data Collection
    A. The PIPS Committee has identified acceptable data sources for ~~use in~~ performance monitoring and improvement activity. Data sources and mechanisms of identifying opportunities for improvement include, but are not limited to:
        1. Risk Assessments
        2. Reports and/or alerts from governmental agencies (for example, Centers for Disease Control and Prevention, Occupational Safety and Health Administration, Food and Drug Administration)
        3. Accreditation reports
        4. Regulatory rounds and tracers
        5. Culture of Safety survey
        6. Occurrence reports and ~~good catches~~Good Catches identifying patient safety concerns and trends
        7. Staff reporting safety or process concerns to their leaders
        8. RCA (Root Cause Analysis)
        9. FMEA (Failure Mode Effects Analysis)
        10. Patient complaints/grievances
        11. Patient perception of safety and quality
        12. Peer review
        13. Ongoing medical record review
        14. Audit of clinical contracts
        15. Internal audits identifying improvement opportunities
        16. Sentinel event reports and Joint Commission Sentinel Event alerts

17. Hospital Quality Improvement Contractor (HQIC)

B. The PIPS Committee collaborates with department managers to perform the following activities:

1. Collect data required by CMS Conditions of Participation and The Joint Commission including measures from:
    a. Inpatient Quality Reporting
    b. Outpatient Quality Reporting
    c. Value Based Purchasing
    d. Hospital Readmission Reduction Program
    e. Hospital Acquired Condition Reduction Program
    f. Quality Payment Program – Merit Based Incentive Payment
    g. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
    h. The Joint Commission ORYX ~~Core~~ Measures
2. Collect data on the following:
    a. Improvement priorities, as identified by leadership

    ~~Transfers to other facilities~~
    b. Selected outcome indicators (mortality, readmissions, etc.)
    c. Procedures, including operative procedures, that place patient at risk of disability or death
    d. ~~All~~Clinically significant ~~discrepancies between preoperative and~~unexpected postoperative diagnoses, as determined by the medical staff
    e. Blood and blood components use
    f. Use of restraints
    g. Use of seclusion
    h. Patient safety issues (ex: falls, self harm)
    i. Resuscitative services, including the following elements:
        i. Number and location of cardiac arrests
        ii. Outcomes of resuscitation, such as return of spontaneous circulation (ROSC) and/or survival to discharge
        iii. Transfer to higher level of care
    j. Pain assessment and pain management
    k. Rapid response to change or deterioration in a patient condition
    l. Care or services to high-risk populations (patient falls)

m. National Patient Safety Goals
n. CMS preventable conditions (Hospital-Acquired Conditions)
o. Healthcare-associated infections (SSI, CLABSI, CAUTI, MRSA, MDRO, C.diff)
p. AHRQ Patient Safety Indicators (PSI)
q. Reported and confirmed transfusion reactions
r. Changing internal or external (e.g. Joint Commission Sentinel Event Alerts) conditions
s. MRI incidents/injuries
t. Significant adverse drug reactions
u. Significant medication errors
v. Adverse events or patterns of adverse events during moderate or deep sedation and anesthesia
w. Complications of care

3. Collect data on topics in the following areas:
    a. Environment of care
    b. Infection prevention and control
    c. Medication management system
    d. Resuscitation performance, including but not limited to the following elements~~:~~
        i. Frequency of early warning signs being present prior to cardiac arrest
        ii. Timeliness of staff response to cardiac arrest
        iii. Quality of cardiopulmonary resuscitation (CPR)
        iv. Post–cardiac arrest care processes
        v. Outcomes following cardiac arrest
    e. Organ procurement program (conversion rates)
    f. Adequacy of staffing, including nurse staffing, in relation to undesirable patterns, trends, or variations in performance
    g. Incidents related to overexposure to radiation during diagnostic computed tomography examinations ~~and, if applicable, provision of fluoroscopic services~~

4. Include the following information when recording data:
    a. Data source
    b. Collection frequency
    c. Reporting frequency

d. Report audience

e. Responsible department(s)

f. Indicators for intervention

III. Data Reliability and Validity

A. Collected data need to be accurate, complete, and reliable. The PIPS Committee has established the following expectations for any data used to monitor or improve ~~hospital~~Hospital performance:

1. Data samples will undergo auditing
2. Data sources will be regularly checked using established procedures
3. Re-abstraction will occur on a data sample

IV. Data Analysis

A. The PIPS Committee does the following:

1. Engages the assistance of relevant departmental management and/or staff to collect and analyze data
2. Develops goals and benchmarks in conjunction with stakeholders with attention to past performance, national performance data, external benchmarks, or comparative databases
3. Compares internal data over time to identify levels of performance, pattern or trends in performance, and variations in performance
4. Utilizes statistical tools and techniques to measure, analyze, and display data (e.g., run charts, flow charts and control charts). Preferred PIPS data displays include dashboards, run charts, and control charts, as applicable
5. Analyzes data using methods that are appropriate to the type of data and the desired metrics, which include but are not limited to:
    a. Benchmark: a comparison and measurement of a health care organization's metrics against other national health care organizations. MHSC utilizes the National Average when available.
    b. Target Goal (SMART Goal): targeted goals define interim steps towards the stretch goal. Target goals may change frequently as progress is made toward stretch goal. Target goals help form a concrete plan of action in order to make the stretch goal a reality.
    c. Stretch Goal: inspires us to think big and reminds us to focus on the larger picture. This goal should exceed the benchmark. MHSC utilizes the National Top 10% when available.
6. Analyzes aggregate data to ~~draw conclusions about~~identify opportunities for improvement and actions to improve the quality of processes

Communication

I. To communicate changes made based on data analysis~~,~~ and to sustain improvements, performance improvement is communicated through the following resources (Appendix 6 - Communication Plan):

A. Quality Committee of the Board

B. PIPS Committee

C. Leadership meetings

D. Medical Staff meetings

E. Staff meetings

F. Department white boards, electronic communication, and communication books may be utilized to display results of monitoring and internal performance improvement activities

Confidentiality

I. WY Stat 35-2-910. Quality management function for health care facilities; confidentiality; immunity; whistle blowing; peer review. Subsection A.

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

III. Confidentiality shall be maintained, based on full respect of the patient's right to privacy and in keeping with ~~hospital~~Hospital policy and state and federal regulations governing the confidentiality of quality and patient safety work.

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

V. Confidential information may include but is not limited to: Medical Staff committee minutes, organizational quality improvement committee minutes, electronic data gathering and reporting, and incident/occurrence reporting

VI. Quality improvement activities will occur in ways that preserve confidentiality of information consistent with policy and established law

VII. The Joint Commission is an independent contractor. Any event reported to The Joint Commission is performed under the auspice of the Quality Committee.

References

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Ransom Memorial Health. (March, 2019). *Quality Improvement Plan*. Unpublished internal document,

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Summary of Compliance Concerns & Strategies for Compliance and/or Improvement: Healthcare Strategies. August 2020

The Joint Commission. (~~2022~~2023, Jan). *PI performance improvement plan.* PolicySource hospital and critical access hospital. PolicySource: P&Ps for Compliance with Joint Commission Requirements | Joint Commission Resources (jcrinc.com)

Whitney Matson. (N.A). *Quality Management System Plan*. Unpublished internal document, St. John's Health.

Wyoming Laws. (2015). 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.

Approval:

Performance Improvement and Patient Safety Committee – ~~April 12~~May 9th, ~~2022~~ 2023

~~Quality Committee of the Board – April 20th, 2022~~

Medical Executive Committee ~~–~~ - May ~~24th~~23rd, ~~2022~~2023

Quality Committee of the Board ~~of Trustees~~ – June ~~1~~21st, ~~2022~~ 2023

Board of Trustees –

Attachments

Appendix 1 - Reporting Calendar

Appendix 2 - Committee Reporting Structure

Appendix 3 - Proposed Performance Improvement Project Decision Checklist

Appendix 4 - PIPS Documentation Tool

Appendix 5 - PIPS Reporting Presentation Template

Appendix 6 - Communication Plan

Appendix 7 - IHI Model for Improvement.pdf

Appendix 8 - FY 2023 PIPS Priorities

Approval Signatures

Step Description	Approver	Date
Board of Trustees	Ann Clevenger: CNO	06/2022
Quality Committee of Board	Kari Quickenden: Chief Clinical Officer	06/2022

ORIENTATION MEMO

Board Meeting Date: August 2, 2023

Topic for Old & New Business Items: Second Reading of the Infection Prevention Plan

Policy or Other Document:

_____ Revision
___X___ New (Updated yearly)

Brief Senior Leadership Comments: The Infection Prevention Plan is created with input from the multidisciplinary Infection Control Committee. The Infection Prevention Plan was approved by the Infection Control Committee and PIPS. The presentation at the Board Meeting is for Second Reading.

Board Committee Action: No Board Committee Action was taken.

Policy or Other Document:

_____ For Review Only (First Reading)
____X___ For Board Action

Legal Counsel Review:

_N/A_____In House Comments:
_____ Board Comments:

Senior Leadership Recommendation: The recommendation for the August meeting is for the Infection Prevention Plan to pass through Second Reading. I do recommend ultimate approval of the Infection Prevention Plan to guide infection control initiatives post-approval by the Infection Control Committee and the PIPS Committee.
Ann Marie Clevenger DNP, RN, CNO

INFECTION PREVENTION PLAN FOR CY 2023

(*Based on organization's strategic plan, risk assessment and external requirements*)

Hand Hygiene Risk score 20%	NPSG.07.01.01 EPI IC.01.04.01 GOAL: Hand Hygiene compliance rates to increase by 5 % for each department, with a house wide compliance rate increase of 8% by December 31, 2023 (2022 average 80%)	Number of correct observances divided by number of total observances	• Conduct unit audits at least once weekly, feedback data to unit leadership, review with staff • Provide unit education on hand hygiene, fingernails, approved lotions	• Report HH performance monthly to ICC and other committees as appropriate	• Front Line Staff • Leadership team • Clinical coordinators, supervisors • Environment Services director • Director of Infection Prevention and CNO • Infection Prevention • ICC
Transmission-based Precautions Risk Score 17%	NPSG.07.01.01 TJC: IC.02.01.01 IC.02.02.01 GOAL: Zero Hospital Acquired Infection related to cross contamination	Zero infections related to cross contamination emphasis on MRSA, CDI.	• Educate departments on their roles in the fight against HAI's • Work with pharmacy team and antibiotic stewardship • Work with physician team to identify potential HAI occurrences	• Round on Isolation • Round on PPE use • Validation of education on NetLearning transcripts	• Front Line staff • Clinical leadership • Clinical coordinators, supervisors • Infection Prevention • Pharmacy • Physicians
Contaminated Instruments/ Equipment To Include: **High level disinfection and/or sterilization** Risk Score 15%	IC 01.04.01 EP 1 GOAL: Zero tolerance for improper reprocessing of invasive instruments/equipment (i.e. critical or semi-critical devices requiring sterilization and/or high-level disinfection)	Standardized protocols for sterilization and high-level disinfection followed throughout facility. Maintain use of procedural & unit-based pre-soaking of instruments every time. Rounding/monitoring/surveillance. 1 area each month 100% compliance with goal.	• Competency assessment of staff who perform reprocessing upon hire and annually • Documentation in logs (per policy) on cycle parameters, biological testing, solution concentration, and temperature. • Audit unit pre-soaking/spraying of items with a solution per IFU prior to arrival in SP.	• Departmental monthly monitoring of quality control • Process monitored as part of mock surveys/EOC rounds. • Joint SP/Infection Prevention site visits to locations that reprocess	• Departmental managers • SP • IP • ICC • Front Line staff

Contaminated Equipment **Low Level Disinfection** Risk Score 20%	GOAL: Provide safe and sanitary equipment and environment	Environment of Care results >80% compliance with monitoring and Surveillance. 1 department each month.	• Written clarification of cleaning protocols • Education of staff • Standardization of cleaning products • Education of proper contact times for disinfectants	• Environment of Care results • Rounding reports	• EVS • Departmental managers • Biomedical Engineering • IP • Unit/department staff • ICC
Employee Participation **Fit test Annually** Risk Score 19%	Goal: Have 100% of employees participate in annual fit test.	Employee health to report at IP monthly totals. Each employee is scheduled annually for fit test in birth month. 100 % of employees within their month.	• Each employee is responsible for scheduling fit test with employee health during their birthday month.	• This can be included in the yearly evaluations done by both director and employee • For physicians it can be used as part of their OPPE evaluation	• Employee • Employee Health
Annual Influenza Vaccine 2022-2023 vaccine year Risk Score 9%	IC 02.04.01 EP4 Goal: 95% of Employees vaccinated	Total number of employees vaccinated during flu season.	• Provide education to the importance/value of vaccines related to patient safety • Provide flu vaccination clinics • Continue with mandatory policy for vaccination •	• Monitor monthly by employee health nurse number of employees	• Employee • Employee Health • IP • Directors • Senior Leadership

Add the ratings for each event in probability, risk, and preparedness. The total values, in descending order, will represent the events most in need of organization focus and resources for emergency planning. Determine a value below which no action is necessary. For our hospital, that value is 10.

Approved Infection Prevention Committee: 03/30/2023
Approved MEC: 04/18/2023

ORIENTATION MEMO

Board Meeting Date: **August 2, 2023**

Topic for Old & New Business Items: **Executive Compensation Policy**

Policy or Other Document:

_____ Revision
__X____ New **Board Policy**

Brief Senior Leadership Comments: **Policy provides a procedure for Board of Trustees for determining the compensation of the CEO. The policy represents "best practice" for the Board.**

Board Committee Action: **Policy has been reviewed and approved by the Governance Committee and forward to the Executive Oversight and Compensation Committee that recommends Board approval. Note: the CEO was involved in the discussion of this policy with both Committees and approves of the policy.**

Policy or Other Document:

__X_____ **For Review Only**
_____ For Board Action

Legal Counsel Review:

_____ In House Comments: **NA**
___X____ Board Comments: **Recommend approval**

Senior Leadership Recommendation: **NA**

Status Draft PolicyStat ID 13986061

Approved N/A
Review Due N/A

Document Area Board of Trustees

BOT - Executive Compensation

Board of Trustees

STATEMENT OF PURPOSE:

The intent of this policy is to set forth how Memorial Hospital of Sweetwater County (Hospital) establishes compensation for the Chief Executive Officer (CEO) and for other Senior Leaders. This policy is developed by the Executive Oversight and Compensation Committee (Committee) and is approved by the Board of Trustees (Board).

TEXT:

Salary Determination and Timelines:

I. **Chief Executive Officer**

A. Each year, in January or February, the Hospital shall conduct a salary survey for the position of CEO.

1. At least five comparator hospitals in Wyoming, recommended by the CEO and approved by the Committee, shall be identified and surveyed in an effort to compare the CEO salary at the Hospital with the CEO salary at the comparator hospitals.
2. The results of this survey shall first be provided the Committee then ultimately to the Board.

B. At the April meeting of the Committee each year, the Committee will review the

results of the salary survey and any other relevant information provided by the CEO in advance of the meeting and shall then make a recommendation to the Board regarding the CEO's salary.

NOTE: The Board President may excuse the CEO for a period of time when the Committee discusses his or her salary.

C. The Board shall make a decision on the CEO salary for the upcoming fiscal year in the month of May. The CEO employment contract shall be updated at this time to reflect the agreed-upon salary and shall be approved by the Board.

D. **Criteria for Determining the Salary of the CEO**

1. Desires and other input from the CEO
2. Input from the Committee and Board
3. Length of tenure in position
4. Cost of living data
5. Financial status of the Hospital
6. Anticipated general salary increases, if any, for other Hospital employees
7. Salary survey data

E. The CEO shall be ineligible for any general salary increases provided other employees; however, he/she will be eligible for any one-time bonuses or other one time payments provided other employees.

F. **Executive Sessions:** Salary deliberations associated with the CEO, at both the Committee level and the Board level, may be held in an executive session as deemed appropriate.

II. **Senior Leaders Below the Level of the CEO**

A. For purposes of this policy, the Hospital's Senior Leaders, below the level of the CEO, occupy the following positions:

1. Chief Financial Officer
2. Chief Nursing Officer
3. Chief Nursing Officer
4. Chief Medical Officer
5. Any other Senior Leader position recommended by the CEO and approved by the Board

B. The CEO shall, at his or her discretion, establish salaries for the Senior Leaders consistent with the process used to set salaries for all other Hospital employees.

Board of Trustees Approval:

Approval Signatures

Step Description	Approver	Date

ORIENTATION MEMO

Board Meeting Date: August 2nd, 2023

Topic for Old & New Business Items: Health Equity Plan

Policy or Other Document:

_____ Revision
___X___ New

Brief Senior Leadership Comments: The Health Equity Plan has been developed to outline the organizations' plan for addressing healthcare disparities and to ensure we remain compliant with CMS and TJC Standards. Approval of the Health Equity Plan will be integral during the upcoming TJC survey and hospitals are currently being cited as evidenced in TJC Perspectives Newsletter. Kari Quickenden, CCO

Board Committee Action:
Approved by Quality Committee of the Board

Policy or Other Document:

___X__ For Review Only
_____ For Board Action

Legal Counsel Review:

___N/A_ In House Comments:
___N/A_ Board Comments:

Senior Leadership Recommendation:
I recommend the Board consider approval due to the upcoming TJC survey, although I understand the Board may need additional time to review the document. Kari Quickenden, CCO

Status Draft PolicyStat ID 13252737

Approved N/A
Review Due N/A

Document Area General - Housewide
Reg. Standards TJC NPSG 16.01.01

Health Equity Plan

STATEMENT OF PURPOSE

Consistent with MHSC's mission, vision, and values this plan establishes the parameters of the Hospital's efforts to promote health care equity by addressing disparities in health care. This plan addresses guidelines for identifying, analyzing, addressing, and monitoring disparities in health care among the patient populations served by the Hospital; to minimize inequities; and to increase quality and safety in an equitable fashion for all patients.

Definitions

I. Health care disparities – Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

II. Health equity – A state in which every person can achieve their full health potential, and in which no person is prevented from achieving this potential because of socially-determined circumstances.

III. Health-related social needs (HRSNs) – Health-harming conditions often identified as root causes of disparities in health outcomes.

Responsibilities and Reporting Structure

Leadership is responsible for the following:

I. Establishing the processes by which the Hospital addresses health care disparities

II. Naming a health care equity leader(s) to lead the Hospital's health care equity initiatives

III. Maintaining and implementing this plan and its associated policies and procedures

The Heath Equity Team is chaired by the Chief Clinical Officer and Director of Quality. Please see attached Health Equity Charter for membership and further details.

The health care equity team does the following:

I. Plans, organizes, and leads all activities related to the Hospital's health care equity initiatives, including but not limited to the following:
    A. Assessing patients' health-related social needs (HRSNs)
    B. Identifying health care disparities in its patient population
    C. Responding to identified health care disparities through written action plans

II. Monitors performance related to health care equity action plans and responding when goal(s) are not met or sustained

III. Identifies internal and external stakeholders to serve as resources and partners in the health care equity program and its activities, including but not limited to the following:
    A. Hospital leaders, managers, and staff members
    B. Relevant community organizations
    C. Relevant government agencies

IV. Communicates with internal and external partners and stakeholders about the health care equity program and its activities and progress in reducing identified health care disparities, as appropriate.

Objectives

I. To establish and refine processes for the following:
    A. Collecting information about patients' HRSNs
    B. Providing patients with information about internal and external resources and support services that address their HRSNs
    C. Identifying health care disparities in the Hospital's patient population
    D. Development of not less than one written action plan to address identified health care disparities

II. To describe processes and expectations for orientation and education, performance monitoring, and annual evaluation of this plan and its related policies and procedures.

Processes

I. Collecting Patient HRSNs Information
    A. To identify health care disparities with the goal of reducing or eliminating those disparities, the Hospital must identify who its patients are, what HRSNs they have, and what obstacles they face in accessing care. This is accomplished by collecting information about their HRSNs. This process is ongoing, as relevant factors change frequently in response to social, economic, environmental, organizational, and individual changes. The goal is to connect patients with existing services and inform the Hospital's health care equity initiatives.
    B. The health care equity team performs the following activities:

1. Determines the HRSNs for which patient information will be collected. These might include but are not limited to the following:
    a. Access to transportation
    b. Difficulty paying for prescriptions or medical bills
    c. Education and literacy
    d. Food insecurity
    e. Housing insecurity
    f. Access to child care
2. Determines whether the HRSNs will be collected for all the Hospital's patients or for a representative sample of the Hospital's patients.
3. Creates standardized forms (paper, electronic, or a combination of the two) for collecting identified HRSNs information.
4. Establish and standardize training and competencies for collection of HRSNs information for staff who participate in patient admission and/or assessment
5. Seeks input and feedback on quality of HRSNs information collection processes from staff members, patients, community partners, and other stakeholders.
6. Considers this input and feedback when evaluating the relevance and effectiveness of HRSNs information collection processes.

II. Connecting Patients with Services and Support

A. The Hospital provides patients with information about relevant services and support programs that are available to address their identified HRSNs.

1. The health care equity team performs the following activities:
    a. Identifies existing internal programs and services that are available to help address patients' HRSNs.
    b. Identifies existing partnerships with community-based organizations, programs, and government agencies that are available to help address identified HRSNs.
    c. Maintains a list of identified programs and services, including current contact information and other relevant details, as applicable (MHSC Resource Book)
    d. Reviews the list periodically and updates it when necessary to reflect changes and ensure its accuracy.
    e. Ensures that all relevant staff members have access to the list and are educated and trained on connecting patients with available services or programs, when necessary, based on their assessed HRSNs.
        i. The MHSC Resource Book is located on PolicyStat.

III. Identifying and Addressing Disparities

A. Collected patient demographic data should be used in conjunction with the organization's quality and safety data to identify health care disparities among the various populations the Hospital serves. To identify health care disparities and understand which processes and outcomes vary in the populations served, the Hospital should compare the quality and safety metrics for various demographic groups. The Hospital may focus on areas with known disparities, as identified in evidence-based literature, or it may select measures that affect all its patients. Once disparities are identified, the Hospital should determine which ones to address and create not less than one written action plan to do so.

B. The health care equity team performs the following activities:

1. Determines the demographic characteristics to be used during analysis of HRSNs information. These characteristics may include but are not limited to the following:

a. Age

b. Race and ethnicity

c. Preferred language

C. Compares quality and safety data, including health outcomes when appropriate, for various demographic categories

D. Identifies disparities in quality, safety, and/or health outcomes among the identified demographic groups

E. Determines which disparities to address with a written action plan(s)

F. Develops not less than one written action plan that describes how the Hospital will address at least one identified disparity.

G. Performs evaluation activities related to the action plan(s), as described in the action plan(s). These include but are not limited to the following:

1. Collecting and analyzing relevant data

2. Evaluating the effectiveness of the action(s) in reducing the identified disparity

3. Determining whether additional or different action(s) are necessary to address the identified disparity

4. Revising the action plan(s) as necessary

a. Reports on outcomes of action plan(s) to relevant stakeholders, including but not limited to the following:

i. Hospital leadership

ii. Hospital representatives for safety, performance improvement, community relations, and other groups

5. Reports at least annually on the Hospital's progress to reduce health care disparities to key stakeholders, including but not limited to the following:

a. Leadership
b. Licensed practitioners
c. Staff members

IV. Orientation and Education

A. The Health Equity team is tasked with developing new staff member orientation and job specific training, along with annual education relative to cultural sensitivity and health equity. The information provided will vary depending on the individual's job duties and responsibilities.

V. Performance Monitoring

A. The health care equity team oversees development of appropriate performance monitors for the Hospital's health care equity initiatives. The committee collects and documents data for the identified performance monitors and reports to leadership and, as appropriate, leaders of identified community partners and stakeholders.

VI. Annual Evaluation

A. The health care equity leader(s) evaluates the Hospital's health care equity initiatives and this plan, including efficacy, continued relevance, and potential areas for improvement. This evaluation process occurs at the following times:

1. At least annually
2. When there are changes to the Hospital, its services, or its policies and procedures that could impact equitable provision of care
3. When there are changes to the community or patient population that could impact equitable provision of care

B. The results of this evaluation are reported to Hospital leadership, Board of Trustees, and other relevant stakeholders, as applicable

REFERENCES

The Joint Commission. (2023, Jan). *Plan for improving health care equity.* PolicySource hospital and critical access hospital. PolicySource: P&Ps for Compliance with Joint Commission Requirements | Joint Commission Resources (jcrinc.com)

Reviewed and Approved:

Health Equity Team: March 28th, 2023

Medical Executive Committee: June 27th, 2023

Quality Committee of the Board: July 19th, 2023

Attachments

Healthcare Equity Charter.docx

Approval Signatures

Step Description	Approver	Date

ORIENTATION MEMO

Board Meeting Date: August 2nd, 2023

Topic for Old & New Business Items: FY 2024 PIPS Priorities

Policy or Other Document:

_____ Revision
__X__ New

Brief Senior Leadership Comments: Utilized the PI Project Decision Checklist to prioritize and select FY 2024 PI projects. Approved by PIPS Committee and MEC. Kari Quickenden, CCO

Board Committee Action:
Approved by Quality Committee of the Board

Policy or Other Document:

___X__ For Review Only
_____ For Board Action

Legal Counsel Review:

__N/A__ In House Comments:
__N/A___ Board Comments:

Senior Leadership Recommendation:
Recommendation for review, Kari Quickenden, CCO

Memorial Hospital of Sweetwater County
Performance Improvement and Patient Safety Priorities
Fiscal Year 2024

I. FY 2024 Priorities

2024 Priorities	Measurement/ Metric	Baseline	Benchmark/ Goals	AIM Statement & SMART Objective
Financial Performance Responsibility Chief Financial Officer Oversight Committee Finance and Audit Reporting Frequency: Monthly Financial Performance Team Members - All Leadership	Outcome Metric: Operating margin Process Metrics: Revenue Cycle KPIs Monthly Variance Reviews	FY 2023 -5.5% operating margin	Benchmark: 0.10% operating margin Target Goal: 0.03% operating margin	AIM Statement By June 30th, 2024, MHSC will implement measures to improve Financial Performance to achieve a 0.03% operating margin (per the approved FY 2024 budget).
Patient Experience Responsibility - All staff Oversight Committee PIPS Committee Reporting Frequency: Quarterly *Current improvement projects continue Patient Experience Team Members Senior Leadership Patient Experience Coordinator Quality Analyst Director of Quality Additional members to be determined	Met/Not Met	N/A	N/A	AIM Statement By December 31st, 2023, MHSC will design a three-year patient experience strategic plan to improve patient experience at MHSC. AIM Statement By June 30th, 2024, MHSC will begin implementation of patient experience strategic plan to improve patient experience at MHSC.

Memorial Hospital of Sweetwater County
Performance Improvement and Patient Safety Priorities
Fiscal Year 2024

2024 Priorities	Measurement/ Metric	Baseline	Benchmark/ Goals	AIM Statement & SMART Objective
Medication Reconciliation/Medication Lists Improve medication history and medication reconciliation in both outpatient and inpatient areas. <u>Responsibility</u> Director of Pharmacy <u>Oversight Committee</u> PIPS Committee Reporting Frequency: Quarterly <u>Medication Reconciliation/Medication lists Work Group</u> - Chief Nursing Officer - Chief Clinical Officer - Physician Champion(s) - Director of Pharmacy - Director of Emergency Department - Director of MOB Clinics - Family Practice Coordinator - Director of Acute Care Services - Director of Women's Health - Director of Dialysis - Director of Radiation Oncology - Director of Medical Oncology - Director of Education - Informatics	% visits with Medication History Completed % visits with Medication Reconciliation Completed	DA2 Medication Reconciliation – July 2022 to June 2023 **Hospital** <u>Med Hx %</u> ED – 47% ED Hold – 93% ICU – 98% L&D – 96% MedSurg – 99% Nursery – 97% Postpartum – 99% <u>Med Rec %</u> ED – 3% ED Hold – 78% ICU – 90% L&D – 70% MedSurg – 95% Nursery – 96% Postpartum – 98% **Clinic** <u>Med Hx %</u> ENT – 22% Fam&Occ – 40% Gen Surg – 50% Internal Med – 86% Med Onc – 44% Neph – 76% Neuro – 79% OBGYN – 32% Ortho – 9% Peds – 10% Pulmonology – 28% Rad Onc – 32% Urology – 59% Walk-in – 8%	**Hospital & Clinic** Benchmarks and Goals to be determined by Sept 30th, 2023	<u>AIM Statement</u> By June 30th, 2024, the medication safety workgroup will implement measures to improve medication history and medication reconciliation process, to improve patient safety reduce the likelihood of medication errors. • Review Policy/Procedure • Review workflows across the organization • Based on reviews, standardize workflows • Provide education and training • Set benchmarks and goals

**Additional project teams may be added as necessary.

Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:8/2/2023

Topic for Old & New Business Items:
Non-Physician Provider – Outpatient Medicine

Policy or Other Document:

- ☒ Revision
- ☒ New

Brief Senior Leadership Comments:
I marked new and revision because the current privilege form for PA's and NP's is very generic, and not specific to any one specialty. This form is going to replace the old form for any Non-Physician Provider that is practicing outpatient medicine (family medicine, internal medicine, occupational medicine, and geriatrics.) This is just one more of the privilege forms that we are re-doing to make them all standardized.

Board Committee Action:

Approval, if possible. If the Board needs to review it for a month, and would like me to bring it back in September, that's OK. Please just let me know. Thank you!

Policy or Other Document:

- ☐ For Review Only
- ☒ For Board Action

Legal Counsel Review:

- ☒ In House Comments:Suzan has reviewed this form at Credentials Committee and also at MEC.
- ☐ Board Comments:Click or tap here to enter text.

Senior Leadership Recommendation:

Senior Leadership Recommends Approval

Name: _____

Delineation of Privileges
NON-PHYSICIAN PROVIDER – OUTPATIENT MEDICINE

☐ Initial appointment ☐ Reappointment ☐ Modification of Privileges

Applicant: Check the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

To be eligible to request privileges in Medicine, the Non-Physician Provider must meet the following minimum threshold criteria:

LICENSURE / PROFESSIONAL LIABILITY INSURANCE	• Current APRN or PA Licensure in State of Wyoming • Current Wyoming designated DEA Registration and current Wyoming Controlled Substance Registration • Proof of Professional liability insurance in the amounts of: Per Claim: $1,000,000.00 Aggregate: $3,000,000.00
EDUCATION / TRAINING	• Successful completion of a Physician Assistant or Nurse Practitioner program.
CERTIFICATION	• Current Certification by the American Nurse Credentialing Center (ANCC), or the National Commission on Certification of Physician Assistants (NCCPA), or an equivalent nationally recognized body.
CLINICAL EXPERIENCE (INITIAL)	• Demonstrated current competence and provision of care, treatment, or services for an adequate volume of patients in the past 12 months, or completion of masters/post master's degree program in the past 12 months.
CLINICAL EXPERIENCE (REAPPOINTMENT)	• Current demonstrated competence and an adequate volume of experience with acceptable results in the privileges requested, for the past 24 months based on results of quality assessment/improvement activities and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

TRANSITIONAL OVERSIGHT	• All newly privileged Non-Physician Providers are required to have a mentoring physician, regardless of their years of experience. They will also require direct observation of procedures until they have completed the required number for each specific procedure.
	  ◦ NPP's who have no clinical experience, other than during their educational programs, will require mentorship at hospital-owned clinics.
	  ◦ During the first year of mentoring, the Non-Physician Provider will meet with their designated mentor, once per month (at a minimum), for chart review, to discuss cases, or for education.
	  ◦ During the second year of mentoring, the Non-Physician Providers will meet with their designated mentor, at least quarterly (at a minimum).
	  ◦ During the third year of mentoring, the Non-Physician Provider will meet with their designated mentor, at least semi-annually (at a minimum).
	  ◦ Non-Physician Providers with more than three years of experience will not require a minimum number of meetings per year (unless they are new to the hospital), but are encouraged to meet with their mentor, on an as-needed basis.
	  ◦ NPP's who have three or more years of experience, but who are new to the hospital, will require a minimum of four meetings per year, for the first year they have privileges at MHSC.
	  ◦ Documentation of the required number of meetings must be turned into the Medical Staff Services Office with each reappointment application.
	• The levels of mentoring are based on the years of experience and type of privilege requested.
	• The foregoing are general guidelines. Based on individual performance, any NPP may be required to exercise his/her clinical privileges under the mentorship of a physician, whether personal or general, in the discretion of the Medical Executive Committee, and mentorship may be required in the criteria for any specific clinical privilege.
	• All tasks and procedures must be performed by a Non-Physician Provider in a manner that is consistent with the applicable standard of care, Medical Staff Bylaws, Rules and Regulations, and hospital policies and procedures.
	• When a Non-Physician Provider chooses to change from one field of practice to another, they may

Name: _____

TRANSITIONAL OVERSIGHT	be required to provide documentation of additional training and evidence of competence. If starting a new, un-related specialty, the NPP may be required to complete the graduated mentoring steps, listed above, with their new mentoring physician. • NOTE: When a physician in the same specialty isn't available to mentor, a Non- Physician Provider may, in certain circumstances, act as a mentor. The mentoring Non-Physician Provider mentor must be in the same specialty and must have at least 15 years of experience in that specialty. All mentor appointments are subject to approval by the MEC, in its sole discretion.
FPPE	• FPPE criteria will be assigned by the Department Chair during the approval process.
OTHER REQUIREMENTS	• Note that privileges granted may only be exercised at the site(s) and setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document. Site-specific services may be defined in hospital or department policy. • This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

Requested		Board Approval
	PATIENT POPULATION	
☐	Newborns/Infants (birth to 1 year)	☐
☐	Pediatric (age 2 to 21 years)	☐
☐	Adult (18 years or older)	☐
☐	Geriatric (65 and older)	☐
Requested	**Core Privileges: Non-Physician Provider – Outpatient Medicine**	**Board Approval**
☐	Evaluates and treats patients with acute, chronic complaints and health maintenance concerns related to specialty	☐
☐	Obtains complete histories and performs pertinent physical exams with assessment of normal and abnormal findings on new and return patients	☐
☐	Performs or requests and evaluates diagnostic studies as indicated upon evaluation of the patient	☐
☐	Orders and collects specimens for routine laboratory tests, screening procedures, and therapeutic procedures, including blood and blood products	☐
☐	Orders physical therapy, occupational therapy, respiratory therapy, radiology examinations and nursing services	☐
☐	Recognizes and appropriately responds to medical emergencies	☐
☐	Performs designated procedures after demonstrated competency, according to written standardized procedures, where applicable	☐
☐	Obtains informed consent, as indicated	☐
☐	Initiates arrangements for hospital admissions and discharges and completes appropriate paperwork	☐
☐	Provides and coordinates patient teaching and counseling	☐
☐	MEDICATIONS: Administer, order, furnish, or prescribe drugs and provide treatment within the NPP's scope of practice, and consistent with the NPP's skill, training, competence, professional judgment, and policies of MHSC.	☐
☐	CONTROLLED MEDICATIONS OUTPATIENT PRESCRIPTION: Administer, dispense, and prescribe medications in outpatient setting, including narcotics, and provide treatment within the NPP's scope of practice, and consistent with the NPP's skill, training, competencce, and professional judgment.	☐

Name: _____

Special/Non-Core Privileges: Non-Physician Provider – Outpatient Medicine		
Requested	**For all newly privileged NPP's, DIRECT OBSERVATION is required for the privileges listed below, until the minimum number of cases has been reached. NOTE: It is the Non-Physician Provider's responsibility to track the number of cases performed for each privilege. Case logs or other documentation should be submitted to the Medical Staff Services Office.**	**Board Approval**
☐	Aspiration of superficial fluid collection (Minimum of 3 cases required)	☐
☐	Contraceptive – transdermal implant insertion and removal (Brand-Specific Certification and Minimum of 5 cases required)	☐
☐	Cryotherapy for treatment of skin leasions (Minimum of 3 cases required)	☐
☐	Earwax Removal (Minimum of 3 cases required)	☐
☐	Excision of toenail (Minimum of 3 cases required)	☐
☐	Incision and drainage (Minimum of 3 cases required)	☐
☐	Intrauterine Device (IUD) placement and removal (Minimum of 5 cases required)	☐
☐	Joint Injections (Minimum of 3 cases required)	☐
☐	PICC Lines (Documentation of Certification and 5 cases)	☐
☐	Punch biopsy (Minimum of 3 cases required)	☐
☐	Removal of benign skin lesion (Minimum of 3 cases required)	☐
☐	Removal of foreign body (Minimum of 3 cases required)	☐
☐	Trigger point injection (Minimum of 3 cases required)	☐
☐	Urinary Catheterization (Minimum of 3 cases required)	☐
☐	Wound closure – simple (Minimum of 3 cases required)	☐
☐	Wound closure & minor debridement of wounds (Minimum of 3 cases required)	☐

NOTE: To NPPs with current privileges, transitioning to this new privilege form - if you are requesting a procedure that is new to you, or one that you haven't performed since your last appointment, please notify Medical Staff Services that you will need FPPE for that specific privilege.

Name: _____

Non-Physician Provider privileges for Medicine require mentoring from a physician with privileges at Memorial Hospital of Sweetwater County.

- The purpose of this document is to set clear expectations regarding NPP mentorship and to ensure the Non-Physician Provider is a successful member of the Medical Staff.
- It is the responsibility of the Non-Physician Provider (NPP) to seek out guidance, education, and consultation from their mentoring physician in accordance with organizational policies, and the Memorial Hospital of Sweetwater County Medical Staff Bylaws and Rules and Regulations.
- The Administrative team will manage the Non-Physician Provider in terms of pay, vacation and CME approval, performance appraisals, and other employee benefits. Under the guidance of the mentoring physician, Administration will ensure that provider time, patient communication, scheduling, patient access, reception services, patient encounters, prescription processes, order and results processes, technology, revenue cycle, and other resources are properly managed.
- When the Non-Physician Provider is exercising his/her clinical privileges they shall regularly and frequently check in with the Physician Staff member regarding his/her treatment of patients, and outcomes.

ACKNOWLEDGEMENT OF MENTORING PHYSICIAN

As mentoring physician, I will mentor the below named Non-Physician provider (NPP), in accordance with state law, organizational policies, and the Memorial Hospital of Sweetwater County Medical Staff Bylaws and Rules and Regulations. By signing as the mentoring physician, below, I acknowledge that:

- I have reviewed the privilege request of the Non-Physician Provider and agree that the requested privileges are within the skill and scope of the Non-Physician Provider.
- I agree to be readily available by electronic communication or provide an alternate to provide consultation when requested, and to intervene when necessary;
- I agree to assist and/or intervene in the care of any patient when requested by the Non-Physician Provider.
- I agree to mentor the below named individual while they see patients at Memorial Hospital of Sweetwater County or at MHSC Clinics.
- I also agree to notify the Medical Staff Office when I am no longer mentoring this individual.

Non-Physician Provider Signature	Printed Name	Date
Mentoring Physician Signature	Printed Name	Date
Mentoring Physician Signature	Printed Name	Date
Mentoring Physician Signature	Printed Name	Date

Name: _____

ACKNOWLEDGEMENT OF APPLICANT

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and that I wish to exercise at Hospital, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Applicant's Printed Name: _____

Applicant's Signature: _____ Date: _____

DEPARTMENT CHAIR REVIEW

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendations:

☐	Recommend all privileges as requested
☐	Recommend privileges with conditions/modifications (describe):
☐	Do not recommend the following requested privileges (rationale for recommendation):
☐	I assign _____ to complete the initial FPPE evaluations on this Practitioner.

Department Chair's Printed Name _____

Department Chair's Signature: _____ Date: _____

FOR MEDICAL STAFF OFFICE USE ONLY

Credentials Committee approval ***Date:*** _____
Medical Executive Committee Approval ***Date:*** _____
Board of Trustees approval ***Date:*** _____

Privileges Effective From: _____ To: _____

Date Form Approved by Specialty: 06/19/2023
Date Form Approved by Department Chair: 07/11/2023
Date Approved by Credentials Committee: 07/11/2023
Date Approved by MEC: 07/25/2023
Date Approved by Board of Trustees: _____

References

1. Age Limit of Pediatrics; American Academy of Pediatrics; Age Limit of Pediatrics | Pediatrics | American Academy of Pediatrics (aap.org). 2017: 1-14.
2. NIH Style Guide: Age; National Institutes of Health; Age | National Institutes of Health (NIH). September 9, 2022: 1-2.

Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:8/2/2023

Topic for Old & New Business Items:
Non-Physician Provider Meeting Documentation Form

Policy or Other Document:

☐ Revision
☒ New

Brief Senior Leadership Comments:
This form is to be used in conjunction with Non-Physician Provider Privilege forms. It will be used to document meetings with the NPP's mentoring Practitioner. The number of meetings will be based on the NPP's years of experience, and upon the mentor's recommendations.

Board Committee Action:

I'm not sure if this form requires Board approval or not. If not, then I would still like the Board to see the form, as it helps to lay out the process for mentorship of Non-Physician Providers.

Policy or Other Document:

☐ For Review Only
☒ For Board Action

Legal Counsel Review:

☒ In House Comments:Suzan has reviewed this form at both Credentials Committee and MEC.
☐ Board Comments:Click or tap here to enter text.

Senior Leadership Recommendation:
Senior Leadership Recommends Approval

Memorial Hospital
OF SWEETWATER COUNTY

Documentation of Meeting Between
Non-Physician Provider
And
Designated Mentoring Physician

Non-Physician Provider Name:_____

Designated Mentoring Physician Name:_____

NPP's who have no clinical experience, other than during their educational programs, will require mentorship at the hospital and hospital-owned clinics.

- During the first year of mentoring, the Non-Physician Provider will meet with their designated mentor, once per month (at a minimum), for chart review, to discuss cases, or for education.
- During the second year of mentoring, the Non-Physician Providers will meet with their designated mentor, at least quarterly (at a minimum).
- During the third year of mentoring, the Non-Physician Provider will meet with their designated mentor, at least semi-annually (at a minimum).
- Non-Physician Providers with more than three years of experience will not require a minimum number of meetings per year (unless they are new to the hospital), but are encouraged to meet with their mentor, on an as-needed basis.

- NPP's who have three or more years of experience, but who are new to the hospital, will require a minimum of four meetings per year, for the first year they have privileges at MHSC.
- ***Documentation of the required number of meetings must be turned into the Medical Staff Services Office with each reappointment application.***

Date of Meeting:_____

Items Discussed:_____

_____

Comments:_____

_____

_____

_____

_____

Non-Physician Provider's Signature: _____ Date:_____

Designated Mentor's Signature: _____ Date:_____

Please submit completed forms to the Medical Staff Services Office

N 6/2023

Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:8/2/2023

Topic for Old & New Business Items:
Privilege Specific Proctoring Form

Policy or Other Document:

- ☐ Revision
- ☒ New

Brief Senior Leadership Comments:
This form works in conjunction with the Non-Physician Provider Outpatient Medicine Privilege form. The procedures listed on the privilege form require proctoring of a minimum of 3 cases, each. This form will be used to document the proctoring, to ensure that there is a record. The forms will be turned into the Medical Staff Office for review and approval by the applicable department chair.

Board Committee Action:

I'm not 100% sure if this needs Board approval, but if not, I would still like the Board to see the form so that they are aware of the process. But, if it is something that the Board should approve, I'm requesting approval.

Policy or Other Document:

- ☐ For Review Only
- ☒ For Board Action

Legal Counsel Review:

- ☒ In House Comments:Suzan has reviewed this form at Credentials Committee and at MEC.
- ☐ Board Comments:Click or tap here to enter text.

Senior Leadership Recommendation:

Senior Leadership Recommends Approval

Memorial Hospital OF SWEETWATER COUNTY

Privilege Specific Proctoring Form

Provider Being Proctored: ___________________________________ Procedure Performed: _________________________________

To the Proctor: Please use direct observation for each case. Minimum Number of Cases Required:____________________

Case #___ MRN or Patient Name: ______________________________

Evaluation of Patient Care	EXCELLENT	STANDARD	UNACCEPTABLE	N/A
Pre-procedure evaluation/ Clinical judgment				
Diagnostic judgement				
Procedure technique				
Quality of medical record documentation				
Management of procedure time				

Was there unnecessary risk to patient? ____ Yes ____No Were there any complications? ____ Yes ____No
Does this provider need proctored on more than the minimum number of cases? ____ Yes ____No

If yes, please explain: ____

Proctor or Preceptor's Name (please print): _____________________________________ Date:________________________________

Proctor or Preceptor's Signature: ____

Case #___ MRN or Patient Name: ______________________________

Evaluation of Patient Care	EXCELLENT	STANDARD	UNACCEPTABLE	N/A
Pre-procedure evaluation/ Clinical judgment				
Diagnostic judgement				
Procedure technique				
Quality of medical record documentation				
Management of procedure time				

Was there unnecessary risk to patient? ____ Yes ____No Were there any complications? ____ Yes ____No
Does this provider need proctored on more than the minimum number of cases? ____ Yes ____No

If yes, please explain: ____

Proctor or Preceptor's Name (please print): _____________________________________ Date:________________________________

Proctor or Preceptor's Signature: ____

Case #___ MRN or Patient Name: ______________________________

Evaluation of Patient Care	EXCELLENT	STANDARD	UNACCEPTABLE	N/A
Pre-procedure evaluation/ Clinical judgment				
Diagnostic judgement				
Procedure technique				
Quality of medical record documentation				
Management of procedure time				

Was there unnecessary risk to patient? ____ Yes ____No Were there any complications? ____ Yes ____No
Does this provider need proctored on more than the minimum number of cases? ____ Yes ____No

If yes, please explain: ____

Proctor or Preceptor's Name (please print): _____________________________________ Date:________________________________

Proctor or Preceptor's Signature: ____

N 6/2023 ***Please submit completed forms to the Medical Staff Services Office***

July Quality Chair Report

We reviewed PIPS and Star Rating and discussed improvements in those topics.

Health Equity Plan was reviewed under new business in the meeting, and we were requested to approve the plan and move it to the BOT for approval as we expect an audit, and it would be helpful to have this in place.

Due to some lengthy discussions, we did not have time to discuss more than a couple of informational items. We also had an Executive Session that used up some of our planned time.

Chair Report

Human Resources Committee Meeting – July 2023

Items to take note of -

- ✓ Half way through the year our turnover number is 38. Not exact math but on pace to be 76 for the year compared to 102 in 2022 and 129 in 2021.
- ✓ Open positions numbers are continuing to decrease.
- ✓ Staff continues to work at reducing the number of contract staff, and we are seeing improvements.

For detailed information please see the reports and minutes of the meeting.

Kandi Pendleton

MEMORANDUM

To: Board of Trustees
From: Wm. Marty Kelsey
Subject: Chair's Report…July 2023 Building and Grounds Committee Meeting
Date: July 26, 2023

Oncology Suite…hopefully the contractor will be on site to commence work sometime in August.

Building Automation System…Balancing work still not completed; the Climate Control System needs adjustment.

Bulk Oxygen/Landscaping Project…The new riser was built and installed and the pad was poured. Completion is anticipated sometime this fall…preferably before the ground freezes.

Medical Imaging X-Ray and Core…MHSC is waiting on Plan One for documents.

Laboratory Renovation Project…Tami indicated that Plan One desires to get the plans and specifications to about 65% completed before a search process for a CMAR is commenced.

Lightning Arrest System…Supply chain issues persist; can't begin project until the supplies arrive on site.

Foundation Lab Construction Grant…Staff is working on options for the Board to consider. No follow-up on Trustee Tardoni's request last month that a legal opinion be secured regarding the use of County maintenance funds.

U of U Suite in the MOB…No plans yet so no progress.

MOB Entrance Project…Some discussion about this possible project but no decisions have been made at this time.

Central Scheduling Space…No progress at this time.

Master Plan…Some discussion about the need for Campus Master Plan. When asked, rene said this possible endeavor has not been budgeted in the FY 2024 budget.

As usual, for more detailed information, please refer to the B & G minutes.

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
Building and Grounds Committee Meeting
July 24, 2023

The Building and Grounds Committee met in regular session via Zoom on July 24, 2023, at 2:30 pm with Mr. Marty Kelsey presiding.

In Attendance: Mr. Marty Kelsey, *Trustee - Chair*
Ms. Irene Richardson, *CEO*
Ms. Tami Love, *CFO*
Mr. James Horan, *Director of Facilities*
Mr. Gerry Johnston, *Facilities Supervisor/Project Manager*
Dr. Barbara Sowada, *Trustee (guest)*
Mr. Robb Slaughter, *County Commission Liaison*

Absent: Mr. Craig Rood, *Trustee*

Mr. Kelsey called the meeting to order.

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

Mr. Kelsey asked for a motion to approve the minutes from the June 20, 2023, meeting. Mr. Horan made a motion to approve the minutes. Ms. Richardson seconded; motion passed.

Maintenance Metrics

Mr. Johnston presented the metrics for June 2023. He said the average days overdue is higher than normal and he will talk to the team. Mr. Kelsey asked if there are any difficult projects impacting the metrics. Mr. Johnston said there are some projects that require closing down patient areas, so it is sometimes difficult to schedule around the patients. Mr. Kelsey asked about staffing in the department. Mr. Johnston said they have one open position for grounds/maintenance mechanic they are currently interviewing for. They did not receive many applicants but hope to have a decision by the end of the week.

Old Business – Project Review

Oncology Suite renovation

Mr. Johnston said the contractor is working with subs to finalize the schedule and mobilize. They hope to be able to get started mid-August. He has been talking to some vendors about some of the needed equipment.

Building Automation System

Mr. Johnston said they are still trying to get the contractor here for the final balance. It is expected to take 2 full weeks to balance the system so scheduling has been an issue. They have seen some failures with new CRCs installed in storage spaces. They are losing connection to the main system

and going offline. Mr. Kelsey asked that we keep the pressure on the contractor to get this completed.

Bulk Oxygen

Mr. Johnston said the new riser and water line are complete and we are just waiting for final testing before we turn it on. The concrete pad was poured last week and is curing. The drain pans will be poured today and then they can finish the grading. The water needs to be tested by the City of Rock Springs and then DEQ reviews the process of the water testing. After the concrete has been cured, the equipment can be set with an expected completion date of the end of August or mid-September. Mr. Johnston said he is staying on top of the contractor to make sure the project keeps moving.

Lightning Arrest System

Mr. Horan has nothing new to report as they are still having issues with the supply chain. These are specialty parts so not stocked regularly. Wyolectric is waiting to hear on the ship date of the supplies.

Medical Imaging Core and X-ray

Mr. Johnston said we have not received an update on plans from PlanOne at this time.

Laboratory Renovation

Mr. Horan said we are confirming with SLIB regarding the CMAR option approved for this project. We want to make sure we are following the grant documents. Mr. Wheatley sent an email with an update. The engineering team should have their coordination documents in the next week. This will allow Plan One and the Hospital to review the proposed duct passageways. They would like to have a 65% package at minimum before seeking a CMAR for preconstruction services. This would allow advertising in September/October so we can proceed to a GMP no later than January, as planned. There was discussion of needing to have the architect at these monthly meetings to answer questions, and agreement we may need to work around their schedules. Mr. Kelsey asked if there had been a final decision on the second floor of the Lab project. Ms. Richardson said nothing has changed from the initial plan drawings. It will include Foundation, Legal and other office space, and storage as planned for in the grant application.

Capital Construction Grant for Foundation Area

Mr. Horan said the timeline is the same for the main Lab. There is still some discussion of what we will use this space for. Mr. Horan said it could take a few months to make the decision. We are looking at proceeding with a Master Plan which will impact any of these decisions about moving services, offices, etc.

County Maintenance Fund

Mr. Kelsey asked if we had received a legal opinion on the state statute regarding the maintenance fund. Ms. Richardson said she had a conversation with Mr. Slaughter and will also send to Mr.

Geoff Philips for an opinion. Mr. Slaughter said he would talk to County attorneys and other commissioners regarding the fund. He thinks we should be able to get the money for some of these projects as long as we let them know what we are using the funds for.

University of Utah MOB Space

Mr. Johnston reported we are still waiting for the final plans from PlanOne for approval by the State.

MOB SLIB Entrance

Ms. Richardson said the area is very congested with the busy clinics in that location and the doors need to be widened. She said it isn't the highest priority, but we do need to have it and have the grant for half of the project. She said we will come up with a recommendation for the priority presentation.

Central Scheduling Space

Mr. Johnston said there was a delay while the State and City decided who has local authority. The decision finally came back to the City of Rock Springs. The project was approved last week by the State, and he is working on getting all of the contractors rescheduled and asbestos testing scheduled. He is hoping to have contractors start next week.

New Business

Ms. Love started the discussion about a possible Master Plan being completed for the Hospital. She explained the background of how the Foundation has been asked about our Master Plan as she works on grant funding and donations. Ms. Richardson said we met with an architect company referred by Plan One this morning that works with healthcare facilities to show us what the process would look like. We will include the Board and Commissioners as we work through the process of the 5–10-year plan. It will be a living document we can reference and change as our strategic plan changes. Mr. Kelsey asked that we do our research on firms and confirmed that this was not included in the budget.

Other Business

The next meeting is scheduled for Tuesday, August 15, 2023, at 2:30 pm.

Mr. Kelsey adjourned the meeting at 3:18 pm.

Submitted by Tami Love

MHSC Board of Trustees Report

Please see the accompanying report that was provided to the Foundation Board of Directors at the monthly meeting on 7/27/23. The report was provided by Ms. Marshall and outlines June's activities.

The Foundation established a Finance Committee to review and discuss the implementation of an Investment Policy. This discussion came up as the Foundation has had some recent opportunities to invest in CDs with high APRs. The Finance Committee met and is currently working on the rough draft Investment Policy. The Committee also made a motion to the board to vote via electronic survey to close old CD investments at two local banks that were getting minimal returns and to deposit into the Foundation's Money Market Account which currently has a 3.5% interest rate. Upon approval, Ms. Marshall was directed to close those accounts totaling $1,428,393.38 for future investment opportunities.

In addition, at the 7/27/23 meeting, the board voted Mr. Matt Jackman into his second term. There was discussion regarding Mr. Craig Rood's second term as he was appointed the MHSC Trustee Liaison. Ms. Marshall and/or Mr. Jackman will contact Mr. Rood to review that discussion.

Board elections were also held and the Foundation officers for July 2023- June 2024 are as follows-

- President- Matt Jackman
- Vice President- Justin Spicer
- Secretary- Becky Costantino
- Treasurer- Gina Harvey

As a reminder, the Foundation's Casino is next month, August 26th. The event will take place in the Atrium at Western Wyoming Community College. Tickets are $75 each with include 50 gaming chips. Visit MHSCFoundation.com to purchase tickets and to see available Sponsorships.

Report Submitted By: Tiffany Marshall

July 28, 2023

Executive Director Report

PROVIDED BY Tiffany Marshall

REPORTING DATE July 2023 Foundation Monthly Board Meeting

MONTH IN REVIEW

- Hosted Employee Contribution and Rewards Week for Staff
  - Hosted daily activities to thank staff for contributing to the Employee Contribution and Rewards program.
    - Special Thanks to Commerce Bank of Wyoming for Grilling!
    - Approximately 165 donate per pay period, 200 total staff donations prior to week, 50 additional signups.
- Spent time with Family Medicine group to understand how things are going over there in their building and if they have any needs.
- Hosted prelim meeting with architect from Denver to discuss the frameworks of developing a master plan for MHSC.
- Met with Finance Committee– updating draft policy.

CURRENT PROJECTS

- Guardian Angel Program
  - April continues to promote the program to staff through Department meetings.
  - Currently working on collateral redesign
- TV Upgrade Project
  - When IT started implementation, ran into TV configuration issue. Currently working on resolving that.
- Testimonial Project
  - Still working to record and finalize schedule. **Need to reschedule for some board members.**
- Monthly Giving Program
  - Kick-off call for implementation 7/26.
- Donor Database Conversion
  - Currently scrubbing historical data for import
- Digital Foundation Newsletter
  - Confirmed vendor and approved contract. Working on design and implementation will be once data conversion is complete.

FUTURE DATES

- **Casino Night– August 26, 2023– WWCC Atrium**
- Dr. Russell James– UW– August 7, 2023
- Wyoming Hospital Association– August 30–31, 2023– Cheyenne
- Aspen Academy For Healthcare Philanthropy– Oct. 2–4, 2023– Lansing, MI

FUNDING REQUESTS

- Wheelchairs– Cancer Center is asking for 4 new wheelchairs.
  - Approximate cost– $2,500 each
- Music– Nuclear Medicine– asking for iPad and speaker
  - Approximate cost– $1,500–$2,000

Board Compliance Committee Meeting
Memorial Hospital of Sweetwater County
July 24, 2023

Present via Zoom: Suzan Campbell, *In House Counsel;* Irene Richardson, *CEO;* Kandi Pendleton, *Trustee-Chair;* Barbara Sowada*, Trustee;* Cindy Nelson, *Administration Scribe.*

Call to Order

The meeting was called to order by Kandi Pendleton.

Agenda

The July agenda was approved as written, Barbara made the motion and Irene seconded it.

Meeting Minutes

The meeting minutes from the June 26, 2023, meeting were presented. Irene made the motion to approve the minutes as written and Suzan seconded. Motion carried.

New Business

The Committee reviewed a Board and Compliance Oversight video from OIG. Suzan reviewed highlights included in the meeting packet. Kandi suggested taking one of the questions listed in the video and discuss at each monthly meeting. She also suggested adding the link to resources for review by other Trustees in the future. https://youtu.be/fndbDclELds

Old Business

Suzan referenced the HIPAA/Registration Audit Report in the meeting packet. She said April Prado completed the audit by observing the registration and admitting process in different departments. The audit originated from a concern brought forward by a patient as well as questions from the registration staff related to the process in the new E.H.R. system. Suzan said an area to work on is HIPAA notices postings. Suzan said she will add a required sentence to the information regarding notification. She said we do not have a written procedure for training of staff in that area so we are working on developing in writing. Kandi asked for more information on the process for pictures in the new system. Suzan said she will follow up and see where we are with that and report back. Barbara shared a personal experience involving ABNs (Advance Beneficiary Notice of Non-coverage) and Suzan said we will follow up on that with April and Cerner. Kandi said she is glad we did the audit because it has useful information. Overall, she feels it shows we are doing what we need to do. Kandi said we appreciate the time and effort it took to complete the process.

Summary Report

Suzan said she includes these reports to show what she is working on each month.

A. HIPAA-Suzan said the report in the packet reflects the incidents reported to us through our flagging software or reported by people. She said we are working on developing training for all staff. Irene suggested NetLearning and requirements to complete including a signed acknowledgement.

B. Exclusion Report-Suzan said we are required to verify monthly that none of our providers are excluded by Medicare. Suzan said this is included in their contracts.

Additional Discussion

Kandi asked for follow up on the performance improvement plan forms discussion. Suzan said the requested changes have been made. Suzan said she is looking at other hospitals to see what their forms look like to see what other improvements we can make. Suzan said if an employee refuses to sign the form, HR notes in the document that it was reviewed by the employee and the employee refused to sign but they are still required to operate under the plan.

Barbara said a periodic audit of whether the Board is following the credentials process correctly is required. Suzan said it has been three to four years since we completed the last audit. Barbara suggested we complete the audit again this year.

Next Meeting

The next meeting is scheduled for August 28, 2023 @ 9:00am.

Adjournment

The meeting adjourned at 9:45am

Respectfully Submitted,

Cindy Nelson, Recording Scribe

Minutes
Governance Committee
July 25, 2023

Present: Irene Richardson, Marty Kelsey, and Barbara Sowada
Zoom meeting called to order at 1:00 pm
Agenda approved as written
Minutes had been previously approved

Old Business

1. **Criteria for Senior Leadership Compensation policy.** Reviewed draft. Action: Submit policy to Executive Compensation & Oversight Committee with recommendation to approve and forward to Board for first reading at August meeting.
2. **Approval Process for Expansion of and/or an Addition to Hospital Services policy.** Pros and cons of policy discussed. Action: Table policy until August meeting.
3. **Succession Planning policy**. Reviewed. Action: Forward to Board for first reading at August meeting.

New Business

1. **Board Committee Charters.** Discussed need to review charters annually and revise as needed. If charter is not changed, no action needed. If charter is revised, revised charter needs to be brought to full board for approval. Action: Marty will remind Committee chairs to include charter review in upcoming meeting agenda.
2. **Discussion** of proposed mental health services, the hospital is exploring. No action taken.
3. **Education Offering.** August board education will be Iprotean video on physician credentialing.

Meeting adjourned at 3:00 pm.

Next meeting is August 21, 2023 at 2:00 PM by zoom

Respectfully submitted,

Barbara J. Sowada, Ph.D.

Contract Check List

This check list summarizes the purpose, cost and other contract provisions contained in the contract and assures that the contract has been reviewed by both the CEO and In-House Legal Counsel.

1. Name of Contract**: TRUE NORTH STATEMENT OF WORK**

2. Purpose of contract, including scope and description**: MHSC has a master agreement with True North for our newsletter and blog. This is a SOW to that MSA for a monthly e-newsletter which will be available through email subscription to patients who have opted in to receive the newsletter. True North will prepare and produce the e-newsletter.**

3. Effective Date**: 8/31/2023**

4. Expiration Date: **Three (3) years from effective date** Is this agreement auto renew? **No**

5. Termination provisions: **No termination provisions in this SOW**

6. Monetary cost of the contract**: Cost of the SOW is $34,300.00 ($11,500.00 year one; $22,800.00 total for years two and three) Marketing automation costs are estimated to be $3750.00 annually billed separately upon execution based on usage.**

   Budgeted? **Yes**

7. Jurisdiction/Choice of Law provision checked and changed to Wyoming if able to so**. NA**

8. Any confidentiality provisions? **No**

9. Indemnification clause present**? No**

10. Is this contract appropriate for other bids? **No**

11. Is County Attorney review required? **No**

TRUE NORTH
CUSTOM

Statement of Work

Memorial Hospital of Sweetwater County

INTRODUCTION. This Statement of Work provides the business terms and details of the specific engagement described herein.

SERVICES SPECIFICATIONS; RATE AND PAYMENT SCHEDULE. Client hereby engages True North to prepare, produce and distribute the outlined services (collectively, the "***Services***"), as described and set forth in the "***Specifications"*** section of this statement of work. The frequency, payment terms, and other related terms are also set forth in the ***"Rate and Payment Terms"*** section.

DELIVERABLES / SPECIFICATIONS

1. eNewsletter Development and Execution
    a. Create and develop a monthly eNewsletter to client provided, opted-in email list
    b. eNewsletter will feature blogs and articles currently being produced by True North Custom or client separate from this SOW
    c. eNewsletter to include up to 2 existing TNC blogs created under existing SOW and one block of text from Client up to 100 words (for upcoming event information, new service promotion or similar), template design, and monthly deployment. Deviations to be scoped upon execution
    d. List Management: Any additions to the current eNewsletter mailing opt-in list will include a one-time $300 list management fee.
    e. True North will facilitate additions to eNewsletter list by providing code for Client to use on website for additional sign-ups which will be added to the subscriber list
    f. eNewsletter to include a maximum of 2 proofs. Additional proofs to be billed upon request
    g. eNewsletter planning meetings, topic collaboration, and performance review discussions will be incorporated into existing account meetings
    h. Total Cost: $34,300
        i. One-time template development: $2,500
        ii. eNewsletter creation and deployment (issues 1-12 @ $750 each): $9,000
        iii. eNewsletter creation and deployment (issues 13-36 @$950 each): $22,800
        iv. HIPAA compliant marketing automation tool billed separately based on actual usage cost (estimated below).

TIMING Total budget to be utilized by 8/31/2026.

RATE AND PAYMENT TERMS.

1. Total Statement of Work: $34,300
    a. Initial payment due on SOW execution: $4,750
    b. Three (3) additional payments of $2,250 billed quarterly (September 2023 - August 2024)
    c. Eight (8) additional payments of $2,850 billed quarterly (September 2024 - August 2026)
2. Marketing automation costs to be billed separately upon execution based on usage.

Estimate at the time of execution is $3,750 annually ($937.50 quarterly)

3. Payment Terms are net 30 days from invoice date.
4. Work beyond the defined scope of Services shall be mutually agreed to in writing, invoiced to and paid by Client as incurred at the then-current billing rates (currently $165/hour). Client acknowledges they are responsible for all state sales/use taxes that may be related to this work.
5. Client acknowledges it is agreeing to subscribe to, pay for, and cooperate in the production of, no less than the Total Statement of Work Amount above for the term period. This agreement is non - transferable and non - refundable.
6. Additional tactics and / or campaign components can be added either as an addendum to this statement of work or as a separate statement of work.

AGREED:

Memorial Hospital of Sweetwater County	***TRUE NORTH CUSTOM*** ***1301 Riverfront Parkway, Suite 101*** ***Chattanooga, TN 37402***
By: _____	*By:* _____
Name: _____	*Name:* *Michael Andres*
Title: _____	*Title:* *True North Chief Financial Officer*
Date: _____	*Date:* _____

Contract Check List

This check list summarizes the purpose, cost and other contract provisions contained in the contract and assures that the contract has been reviewed by both the CEO and In-House Legal Counsel.

1. Name of Contract: **UL SOLUTIONS -UL VERIFICATION SERVICES**

2. Purpose of contract, including scope and description: **Master License and Service Agreement from UL is underlying master agreement for any software suites purchased from UL. The SOW is for employee health software suite. Currently, employee health does not have a software program for tracking employee health documentation. This software will provide ability for employee health to track all employee related information and allow staff to sign on and view their records.**

3. Effective Date: **July 5, 2023 is effective date of MSA. License term is August 1, through July 31, 2026**

4. Expiration Date: **Three years August 1 through July 31 for software license.**

5. Termination provisions: **Can only terminate the MSA for material breach with notice and opportunity to cure or bankruptcy/cease operations. The SOW does not have its own termination provisions, so it relies on MSA if we want to terminate prior to July 31, 2026.** Is this auto-renew? **No**

6. Monetary cost of the contract: **see attached** Budgeted?

7. Jurisdiction/Choice of Law provision checked and changed to Wyoming if able to so. **Requires attempt to reach a solution without litigation and if not able to do then arbitration.**

8. Any confidentiality provisions? **Yes Section 7 of MSA**

9. Indemnification clause present? **Yes Section 11 of MSA**

10. Is this contract appropriate for other bids? **Different software programs were looked in to but this one had what employee health needs.**

11. Is County Attorney review required? **No**

Here are the one-time and annual costs as they appear in the payment schedule section:

Product or Service	Invoice Date	Amount Due
Single Sign On Solution via Ping Identity (on-going)	August 2023	$2,800.00
PureOHS™ Surveillance (on-going)	August 2023	$2,940.00
PureOHS™ Case Management (on-going)	August 2023	$3,143.00
PureOHS™ Clinical Suite (on-going)	August 2023	$3,962.00
PureOHS™ Employee & Supervisor Views (on-going)	August 2023	$1,652.00
PureOHS™ SSO Implementation (One-Time)	August 2023	$1,800.00
PureOHS™ Implementation and Training - Supervisor and Employee Views (One-Time)	August 2023	$4,000.00
PureOHS™ System Access Initial Setup (one-time fee)	August 2023	$3,500.00
PureOHS™ Implementation and Training – Surveillance, Clinical Suite and Case Management (One-Time)	August 2023	$11,000.00
PureOHS™ State Immunization Registry Implementation (one-Time	August 2023	$5,400.00

The implementation and setup costs include everything from the SSO Implementation to each of the modules and the state immunization registry totaling $25,700. These fees are "one time" and would occur only in the first year.

The ongoing fees (annually for years 1-3) are slightly different as there is an annual state immunization registry fee which is not present in the first year. The total year 1 fees would include the one-time implementation and setup fees as well as the annual ongoing fees for a total year 1 of $40,197.00 of which $25,700.00 are one-time implementation costs. Year 2 and 3 fees would be $16, 657.00 per year. (See pages 3 and 4 of SOW).

MASTER LICENSE AND SERVICE AGREEMENT

This Master License and Service Agreement ("**Agreement**") is effective July 05, 2023 ("**Effective Date**") and is entered into by and between the UL entity listed in the Statement of Work ("**UL**") and Memorial Hospital of Sweetwater County ("**Client**").

1. LICENSE. UL is a provider of various services (each a "**Service**" and collectively the "**Services**") identified in Statements of Work (a "**SOW**") executed in accordance with Section 2. In consideration for payment to UL of applicable license or service fees, UL grants to Client and Affiliates a non-exclusive, non-transferable License to access and use Services listed in an SOW in accordance with the terms and conditions of this Agreement and such SOW. "**Affiliate**" means an entity that, directly or indirectly, controls, is controlled by, or is under common control with, another entity where "**control**" means the power to direct or cause the direction of an entity's affairs, whether by means of holding shares, possessing voting power, exercising contractual powers or otherwise (and "**controls**" and "**controlled**" will be construed accordingly). The terms of this Agreement will apply to Affiliates to the extent they access and/or use the Services.

2. STATEMENTS OF WORK. Client and its Affiliates may execute SOWs with UL pursuant to this Agreement. Each SOW shall automatically incorporate the provisions of this Agreement. A SOW may by express wording only modify or vary the terms of this Agreement. If there is any conflict or inconsistency between the terms and conditions of this Agreement and those of a SOW, the terms of this Agreement shall prevail.

3. FEES, CHARGES AND TAXES. Each SOW will set out fees payable, expense reimbursement terms, and applicable payment terms. If a valid invoice is not paid within thirty (30) days from the date it is due, UL may suspend access to the Services until such invoice is paid. If UL terminates the Agreement or a SOW for non-payment, Client shall reimburse UL's costs of collection (including legal fees). Client acknowledges that the Service may include a timing mechanism that causes it to cease functioning if Client has not renewed its license to the same prior to the expiry of the term of the applicable SOW.

4. CLIENT RESPONSIBILITIES AND PERMITTED USE. UL will determine how the Services are performed, subject to the specifications set out in each SOW. Client shall: (i) designate appropriate resources and cooperate with UL to support timely provision of the Services; (ii) ensure its own systems, computer hardware and software are and remain compatible with any UL's Service specifications; and (iii) promptly notify UL of any unauthorized access and use of Client's account and is solely responsible for keeping its passwords and account information secret and for all acts that occur if it fails to do so. No rights, other than those expressly granted herein, in or to the Service and Service Content are granted to Client. Client may not modify, copy (except for disaster recovery purposes), provide to any non-Affiliate third party (except for contractors not reasonably deemed competitor of UL (a "Permitted Third Party")), sell or transfer, Services and any Service Content, in whole or in part. Client shall not decompile, disassemble, reverse engineer, or in any way derive source code from the Service or Service Content. Unless otherwise provided in a SOW: (i) on payment of the applicable fees only Client, Affiliates and its or their employees and Permitted Third Party may access and use the Service solely on behalf of such Client or Affiliates; and (ii) no rights to use the Services in a time-sharing, service bureau or reseller capacity are granted.

5. INTELLECTUAL PROPERTY RIGHTS OF UL. The IP Rights in and to the Services and Service Content are and shall remain the property of UL and its licensors. "**IP Rights**" means all intellectual and industrial property rights of any kind whatsoever including patents, supplementary protection certificates, rights in know-how, trade-marks, designs, models, design rights, rights to prevent passing off or unfair competition and copyright (whether in drawings, plans, specifications, designs and computer software or otherwise), database rights, any rights in any invention, discovery or process, and applications for and rights to apply for any of the foregoing together with all renewals, extensions, continuations, divisions, reissues, re-examinations and substitutions. "**Service Content**" means the computer code, operating instructions, graphics, designs, proprietary scripts, underlying technology, third party content, information and/or other material (whether in written, graphical, or other form) comprised in the Services.

6. INTELLECTUAL PROPERTY RIGHTS OF CLIENT. Client retains all rights, title and interest in and to any data, logos, trademarks, trade name, service marks, or any other graphics, designs or pictures input into the Service by Client, an Affiliate, their employees and contractors (or by UL on their behalf), or incorporated as part of a Service (collectively, "**Client Data**"). Except for the limited purpose of fulfilling its obligations to Client under this Agreement, UL has no rights in Client Data. In addition to Client's ownership of Client Data, and in connection with any applicable UL course development services (if ordered pursuant to an SOW), Client will own (i) the text version of custom courses that UL develops for Client using UL proprietary formats and (ii) the text provided by Client that is included within any UL proprietary course content. UL may retain any Client Data on its network systems in accordance with UL's business continuity policies after expiry or termination of this Agreement or the applicable SOW and will, on reasonable request and without charge, return it to Client within that time.

7. CONFIDENTIALITY. The parties acknowledge that by reason of their relationship under this Agreement, they may receive or have access to (such party being a "**Recipient**") certain information and materials concerning the other party's (such party being a "**Discloser**") business, technology, and/or products (including the Services and all terms and conditions and pricing set forth in this Agreement and any SOW) that is confidential and of substantial value to the other party, which value would be impaired if such information were disclosed to third parties ("**Confidential Information**"). Except as provided herein, the Recipient agrees that it will not use in any way for its own account or the account of any third party, nor disclose to any third party, any such Confidential Information, except as needed to provide the contracted Services under this Agreement, and will protect the confidentiality of such information with the same degree of care which it uses to protect its own confidential information, using no less than a reasonable degree of care. Such use and non-disclosure obligations shall not apply to information which (a) was already rightfully known to Recipient prior to the Discloser disclosing it; (b) is in or has entered the public domain through no breach of this Agreement or other wrongful act of Recipient; (c) has been rightfully received from a third party not under obligation of confidentiality; (d) has been approved for release by Discloser's written authorization; (e) is required to be disclosed by law; or (f) was independently developed by Recipient, as evidenced by documentation, without reference to or reliance on Discloser's Confidential Information. Upon expiration or termination of this Agreement or an SOW, Recipient shall promptly destroy all documents and information, however recorded, which contain Discloser's Confidential Information; provided that Recipient shall be permitted to maintain one (1) copy in an encrypted archived computer system backup that was made in accordance with its corporate business continuity or disaster recovery procedures. UL will process Client's personal data in accordance with the "GDPR Processor Terms" set forth in Exhibit A attached hereto and incorporated by reference. Neither party may make any public announcement or press release about the existence or terms of this Agreement without the other party's prior written approval and consent.

8. UL WARRANTIES. UL warrants to Client that: (a) it will provide Services with reasonable skill and care and in accordance with the applicable specifications in each SOW; (b) it has full power and authority to enter into this Agreement and each SOW; (c) the Services, when used in accordance with the terms and conditions of this Agreement and the applicable SOW, do not to its knowledge infringe the IP Rights of any third party; and (d) it will comply with all applicable laws and regulations in the performance of its obligations hereunder. UL does **not** warrant that: (a) the Services provided pursuant to this Agreement will be uninterrupted or error free; (b) that Client will obtain any specific results by using the Services; (c) the opinions or findings it provides in connection with the Services will be recognized or accepted by third parties or represent legal, medical or other regulatory advice. UL makes no warranty, guarantee or representation, either express or implied, regarding the merchantability or fitness for a particular purpose of the Services or suitability or fitness of the Services for the purposes of compliance with any and all administrative, regulatory, or governmental requirements.

9. CLIENT WARRANTIES. Client warrants that: (a) it and its Affiliates (as the case may be) have full power and authority to enter into this Agreement and each SOW; (b) it will comply with all applicable laws and regulations in the performance of its obligations hereunder; (c) it is authorized under such laws to provide UL with any personal data and has obtained any necessary consent or other requirements for UL to process such personal data; (d) Client Data and materials provided to UL by or on behalf of Client ("**Client Materials**"), do not infringe the IP Rights of any third party.

10. LIMITATION OF LIABILITY. Nothing in this Agreement or any SOW shall operate to limit or exclude UL's liability for fraud and fraudulent misrepresentation, or for any matter for which it would be illegal to exclude or to attempt to limit or exclude liability. In no event shall UL be liable for any loss of profits, sales, business (in each case whether direct or indirect) or any indirect, special, exemplary, incidental, or

consequential damages, or any claims or demands brought against Client, even if UL has been advised of the possibility of such claims or demands. The aggregate liability of UL to Client for all claims related to the Services and this Agreement, including any cause of action sounding in contract, tort, or strict liability, shall not exceed the fees paid to UL in the twelve (12) months preceding the claim.

11. INDEMNIFICATION. UL shall indemnify Client and its Affiliates, and their respective directors, officers, employees and agents for any and all claims, damages or liability whatsoever, including payment of reasonable attorneys' fees and costs, suffered or incurred by Client in connection with any claim that the Services infringe the IP Rights of any third party ("**IP Claim**"). This indemnity obligation is subject to Client promptly notifying UL within thirty (30) days of any IP Claim, granting UL the authority to defend, compromise or settle the claim, and providing UL with any information relevant to such claim. UL shall have no liability for any IP Claims that are based on (i) Client's modification of the Service where the same was not pre-authorized in writing by UL or (ii) use of the Service in a manner not permitted by this Agreement or the applicable SOW. This Section constitutes UL's entire obligation to Client with respect to any IP Claim. Client shall indemnify UL and its Affiliates, and their respective directors, officers, employees and agents for any and all claims, damages or liability whatsoever, including payment of reasonable attorneys' fees and costs, suffered or incurred by UL in connection with: (i) any claim that the Client Data and/or Client Materials infringe the IP Rights of any third party; (ii) any claims or actions brought by third parties arising out of, or related to, Client's own corporate training measures, programs initiatives .

12. TERM AND TERMINATION. This Agreement shall commence on the Effective Date and unless earlier terminated in accordance with this Section, will terminate on expiry or earlier termination of all SOWs. Each SOW shall set out its duration. Either party may terminate this Agreement or an SOW by notice in writing if the other party either: (a) commits a material breach of this Agreement or a SOW and, where capable of remedy, fails to remedy such breach within 30 days of being given written notice identifying the breach, requiring it to be remedied and stating that failure to remedy it will result in termination under this Section 12; or (b) ceases productive operations or becomes or is declared insolvent or bankrupt, the subject of any proceedings relating to liquidation, insolvency or for the appointment of a receiver or similar officer for it (or to any analogous proceedings), makes an assignment for the benefit of all or substantially all of its creditors, or enters into an agreement for the composition, extension, or readjustment of all or substantially all of its obligations. In addition to the foregoing and without limiting other rights, UL may terminate this Agreement with immediate effect, and without notice to Client, in the event Client breaches any UL IP Rights.

13. TERMINATION CONSEQUENCES.

On expiry or termination of the Agreement or any SOW: (a) the rights of each party accrued before such termination shall not be affected; (b) Client's right to use and access the Service shall cease and Client shall promptly remove, delete, and uninstall all copies of any Client-hosted Services; (c) all payment obligations accrued by Client up to the date such termination takes effect will be immediately due and payable unless termination is a result of UL's uncured breach where in such case Client shall only be obligated to pay fees for Services provided up to the date of termination and be entitled to receive a prorated refund of any unused prepaid fees; and (d) the following provisions shall remain in full force and effect: Sections 3 (Fees, Charges, and Taxes), 5 (Intellectual Property Rights of UL), 6 (Intellectual Property Rights of Client), 7 (Confidentiality), 8 (UL Warranties), 9 (Client Warranties), 10 (Limitation of Liability), 11 (Indemnification), 13 (Termination Consequences), 16 (Dispute Resolution and Governing Law), 18 (Audit Rights; Services Not Hosted By UL) and 19 (Miscellaneous).

14. ENTIRE AGREEMENT. This Agreement and the SOWs (as amended or varied from time to time) embodies the entire understanding between UL and Client with respect to the subject matter hereof and supersedes any and all prior understandings and agreements, oral or written, relating thereto. Under no circumstances will any preprinted, additional, or different terms or conditions in requests for proposals, requests for quotations, purchase orders or other business documents govern any Services, this Agreement or any SOW. No use of trade or other regular practice or method of dealing between the parties shall be used to modify, interpret, supplement, or alter in any manner the terms of this Agreement or an SOW.

15. NOTICES. All notices hereunder shall be deemed to have been given when delivered to the addresses of the parties set out in the relevant SOW by personal delivery, facsimile (confirmed by copy sent by certified mail), overnight carrier, or by registered post, return receipt requested, postage prepaid.

16. DISPUTE RESOLUTION AND GOVERNING LAW. In the event of any dispute, claim, question, or disagreement arising from or relating to this Agreement of SOW or the breach thereof, the parties shall use their best efforts to settle the dispute, claim, question, or disagreement. To this effect, they shall consult and negotiate with each other in good faith and attempt to reach solution satisfactory to both parties. If they do not reach such solution within a period of 60 days, then, upon notice by either party to the other, all disputes, claims, questions, or differences shall be finally settled by arbitration administered by the American Arbitration Association in accordance with the provisions of its Commercial Arbitration Rules, provided, however, that any such arbitration shall be held in Chicago, Illinois and the arbitrator shall apply Illinois law.

17. ASSIGNMENT. This Agreement or SOWs may not be assigned or transferred by either party (by operation of law or otherwise) without the prior written consent of the other party; provided, however, that either party may, without the prior consent of the other, assign all of its rights under this Agreement to (i) an Affiliate, (ii) a purchaser of all or substantially all of its stock or assets, or (iii) a third party participating in a merger or other corporate reorganization in which the assigning party is a constituent corporation. This Agreement will be binding upon and inure to the benefit of the parties and their respective successors and permitted assigns.

18. AUDIT RIGHTS. Each SOW shall specify the Service license grant. UL or its designee(s), at UL's sole cost and expense, during regular business hours at Client's or an Affiliate's offices and in such a manner that does not interfere with their normal business activities, and with thirty (30) days prior written notice, shall have the right to inspect and audit Client or an Affiliate's compliance with the terms of their license grant. If an audit reveals that Client's use of the Services has exceeded its license grant permitted under the applicable SOW, or Client-hosted Services were not uninstalled or deleted upon termination of expiration in accordance with Section 13, UL shall be permitted to invoice Client or the applicable Affiliate license fees for their actual usage of the Services. If any audit discloses underpayments of three percent (3%) or more of the amount of license fees Client or any Affiliate should have paid to UL for their actual usage, the audited party shall bear all costs incurred by UL to conduct the audit.

19. MISCELLANEOUS. UL is an independent contractor and is not an employee, partner, joint author or joint venturer of Client or its Affiliates. The rights and remedies under this Agreement and any SOW may not be enforced by anyone other than the parties hereto. The failure of a party to enforce any right or claim under, or provision of, this Agreement or a SOW shall not be deemed to be a waiver of such right, claim, or provision. This Agreement and each SOW may not be modified except by a writing signed by authorized representatives of both parties. If any provision of this Agreement or any SOW is declared or found to be illegal, unenforceable or void, then both parties shall be relieved of all obligations arising under such provision. If the remainder of this Agreement or SOW is not affected by such declaration or finding and is capable of substantial performance, then each provision not so affected shall be enforced to the extent permitted by law. Neither party shall be liable to the other for any delay or failure to perform due to acts of god or causes beyond its reasonable control. Performance times shall be considered extended for a period of time equivalent to the time lost because of any such delay. In this Agreement and in any SOW: (a) where an agreement or consent of a party is required, such agreement or consent shall not be unreasonably withheld or delayed; and (b) words denoting the singular include the plural and vice versa.

20. INSURANCE. During the term of this Agreement, UL agrees to maintain, at its own expense, insurance in quantities and types sufficient to meet its obligations hereunder. All policies shall be issued by financially secure companies. Should any of the policies be cancelled before the expiration date thereof, notice will be delivered to Client in accordance with the policy provisions. Upon request, UL shall provide Client a memorandum of insurance evidencing coverage.

21. COUNTERPARTS; SIGNATURES. This Agreement may be executed in counterparts, each of which shall be deemed to be an original instrument, but all such counterparts together shall constitute one and the same instrument. Facsimile or electronic transmissions of counterparts displaying facsimile or electronic, or electronically reproduced copies, of signatures shall be accepted and binding with the same force and effect as "wet signed" originals of the counterpart.

The parties have caused their duly authorized representatives to execute and enter into this Agreement as of the Effective Date.

UL ENTITY LISTED IN THE STATEMENT OF WORK

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

By:	_____	By:	_____
Name:	_____	Name:	_____
Title:	_____	Title:	_____
Date:	_____	Date:	_____

Exhibit A

GDPR Processor Terms

1. DEFINITIONS. "Data Protection Legislation" shall mean, the applicable laws, decisions, codes of practice and guidance of a competent institution supervising or regulating data protection, the Processing of Personal Data and privacy of EU residents including the General Data Protection Regulation (EU) 2016/679 and the Privacy and Electronic Communications (EC Directive) Regulations 2003 (as may be amended by the proposed Regulation on Privacy and Electronic Communications).

2. DATA PROTECTION. References in these Terms to Data Subjects, Personal Data, Process, Processed, Processing, Data Controller or Data Processor, where capitalized, shall have the meanings in the Data Protection Legislation.

3. COMPLIANCE WITH LAWS. UL shall not cause Client to breach any obligation under the Data Protection Legislation. UL shall notify Client without undue delay, if in the delivery of the Services as an experienced supplier of the Services, it or they identify any potential areas of actual or potential non-compliance with the Data Protection Legislation.

4. AUTHORITY. Client authorizes UL to Process the Personal Data during the term of the Agreement as a Data Processor (on its and its Affiliates behalf) for the purposes of providing the Services only. Client's users input Personal Data into the Service and control the type of Personal Data and categories of data subjects whose Personal Information resides in the Service.

5. SUB-PROCESSING. Client acknowledges and agrees that (a) UL Affiliates may be retained as Sub-Processors; and (b) UL may engage third-party Sub-Processors in connection with provision of the Services. UL has entered into a written agreement with each Sub-Processor containing data protection obligations no less protective than those in this Agreement with respect to the protection of Customer Data to the extent applicable to the nature of the services provided by such Sub-Processor. UL shall remain responsible for all acts or omissions of the Sub-Processor as if they were its own.

UL shall make available to Client the current list of Sub-Processors for the Services. Such Sub-Processor list shall include the identities of those Sub-Processors and their country of location, available at the following UL sites: www.ulehssustainability.com/dataprotection, https://msc.ul.com/en/gdpr/, and www.ulehssustainability.com/en/gdpr-compliance-zone (the "Data Protection Site"). The Data Protection Site has a mechanism for Client to subscribe to notifications of new Sub-Processors for each applicable Service, and if Client subscribes, UL shall provide notification of a new Sub-Processor(s) before authorizing any new Sub-Processor(s) to Process Personal Data in connection with provision of the applicable Services.

Client may object to UL's use of a new Sub-Processor by notifying UL promptly in writing within ten (10) business days after receipt of UL's notice in accordance with the mechanism set out above. In the event Client objects to a new Sub-Processor, as permitted in the preceding sentence, UL will use reasonable efforts to make available to Client a change in the Services or Client's use of the Services to avoid Processing of Personal Data by the objected-to new Sub-Processor. If UL is unable to make available such change within a reasonable period of time, which shall not exceed thirty (30) days, Client may terminate the applicable SOW with respect only to those Services that cannot be provided by UL without use of the objected-to new Sub-Processor by providing written notice to UL.

6. UL OBLIGATIONS. UL shall (and shall procure that any Authorized Sub-Processor shall):

6.1. process the Personal Data only on documented instructions from Client, including transfers of Personal Data to a third country or an international organization. This Agreement and any SOW shall be considered documented instructions for UL to process the Personal Data as needed to provide the contracted services. Client acknowledges and agrees that UL makes available a list of transfers to third countries on its Data Protection Site. Client's use of the contracted services shall constitute documented instructions from Client allowing such transfers.

6.2. without prejudice to section 6.1 above, UL shall ensure that Personal Data will only be used to the extent required to provide the Services.

6.3. ensure that any person authorized to process the Personal Data: (a) have committed themselves to appropriate contractual confidentiality obligations or are under an appropriate statutory obligation of confidentiality; (b) Processes the Personal Data solely on instructions from Client; and (c) are appropriately reliable, qualified and trained in relation to their Processing of Personal Data;

6.4. implement (and assist Client to implement) technical and organizational measures to ensure a level of security appropriate to the risk presented by Processing the Personal Data, in particular from accidental or unlawful destruction, loss, alteration, unauthorized disclosure of, or access to Personal Data transmitted, stored or otherwise processed (together, a "Data Security Breach");

6.5. notify Client without undue delay (and in any event no later than 48 hours) after becoming aware of a Data Security Breach. Where, and in so far as, it is not possible to provide the information at the same time, the information may be provided in phases without undue further delay;

6.6. provide reasonable assistance to Client in: (a) responding to requests for exercising the Data Subject's rights under the Data Protection Legislation, including by appropriate technical and organizational measures, insofar as reasonable; (b) reporting any Data Security Breach to any supervisory authority or Data Subjects and documenting any Data Security Breaches; (c) taking measures to address the Data Security Breach, including, where appropriate, measures to mitigate its possible adverse effects; and (d) conducting privacy impact assessments of any Processing operations and consulting with any applicable supervisory authority or appropriate persons accordingly; and

6.7. securely delete or return all Personal Data to Client after the end of the provision of services relating to processing in accordance with the Agreement.

7. INFORMATION PROVISION. UL shall make available to Client all information necessary to demonstrate compliance with the obligations laid down in this Exhibit and allow for and contribute to audits, including inspections, conducted by Client or another auditor mandated by Client. Client shall reimburse UL for any time expended for any audit at UL's current professional services rates, which UL will make available to Client upon request. Before the commencement of any such audit, Client and UL shall mutually agree upon the timing, scope and duration of the audit in addition to the reimbursement rate for which Client shall be responsible. All reimbursement rates shall be reasonable, taking into account the resources expended by UL. UL shall immediately inform the controller if, in its opinion, an instruction infringes the Data Protection Legislation or other data protection provisions.

Statement of Work

UL Solutions Entity:	UL Verification Services Inc.
UL Solutions Entity Address:	333 Pfingsten Road, Northbrook, IL 60062-2096, USA
Client Name:	Memorial Hospital of Sweetwater County
Client Address:	1200 College Dr Rock Springs, Wyoming, 82901-5868 United States
Client Representative:	Nicole Burke (nburke@sweetwatermemorial.com)
Account No:	2879619
SOW No:	2000065341
UL Solutions Representative:	Nicholas Teply (nick.teply@ul.com)

This Statement of Work No. 2000064499 ***("SOW")***, entered into by and between UL Verification Services Inc. ("UL Solutions") and Memorial Hospital of Sweetwater County ("Client"), is effective as of the date last signed by the parties ("Effective Date") and is subject to the Master License and Service Agreement effective _____, 2023 between the parties ("Agreement"). Except as specifically defined herein, each capitalized term used in this SOW shall have the same meaning as is assigned to it in the Agreement.

Summary of Products and Price

Software	**Total**
License Term: August 01, 2023 - July 31, 2026	
Single Sign On Solution via Ping Identity	$8,400.00
PureOHS™ Surveillance - 700 Employees	$8,820.00
PureOHS™ Case Management - 700 Employees	$9,429.00
PureOHS™ Clinical Suite - 700 Employees	$11,886.00
PureOHS™ Employee & Supervisor Views - 700 Employees	$4,956.00
PureOHS™ State Immunization Registry Interface Annual License – Year 2 & 3	$4,320.00
Licensing Total	$47,811.00

Professional Services	Total
PureOHS™ SSO Implementation	$1,800.00
PureOHS™ Implementation and Training - Supervisor and Employee Views	$4,000.00
PureOHS™ System Access Initial Setup (one-time fee)	$3,500.00
PureOHS™ Implementation and Training - Surveillance and Clinical Suite & Case Management	$11,000.00
PureOHS™ State Immunization Registry Implementation	$5,400.00
Professional Services Total	$25,700.00

Grand Total	**$73,511.00**

Invoicing and Payment

1. Invoicing payment terms: Due On Receipt
2. UL Solutions accepts check, ACH, credit card or wire. If Client chooses to pay by credit card, such payments will be subject to a 3.5% processing fee.
3. The fees quoted to you are exclusive of any transaction related tax that may apply to such proposal. If the proposal is subject to Tax (Sales tax, Goods Services or VAT) we will reflect such tax amounts on your invoices. If you are exempt from such taxes, please provide substantiation of your exemption to UL Solutions prior to your first billing.
4. Before we begin Services, we may require you to make a deposit (to be credited against the total charges).
5. If Client requires UL Solutions to register as a vendor via a third party vendor management portal or to participate in a third party purchasing solution, and such registration or participation is required by Client as a condition for UL Solutions to receive payments, fees invoiced by UL Solutions shall be adjusted to include any fees UL Solutions incurs as a result of UL Solutions registering with such Client required third party portal or purchasing solution.
6. If Client requires a purchase order to be generated and issued as a condition of payment, Client must provide a purchase order that covers the entire Term to UL Solutions *no later than ten (10) days* following execution of this SOW. Client and UL Solutions agree and acknowledge that the Services under this SOW shall not commence until such purchase order has been received. UL Solutions shall not be liable for any delay in Services resulting from Client's delay or failure to provide a valid purchase order as required herein. Under no circumstance will any preprinted, additional, or different terms or conditions in requests for proposals, requests for quotations, purchase orders or other business documents govern any Services, the Agreement or this SOW. No use of trade or other regular practice or method of dealing between the parties shall be used to modify, interpret, supplement, or alter in any manner the terms of the Agreement or this SOW.
7. Client will reimburse reasonable expenses incurred in the performance of Services and will be invoiced when incurred. Reasonable expenses shall include, but not limited to, airfare, lodging, meals, and ground transportation. Additional travel expenses, including but not limited to airline, lodging, and ground transportation cancellation fees

and/or penalties incurred by UL Solutions as a result of any such cancellation or rescheduling will be borne solely by Client.

Payment Schedule

Professional Services & Software Payment Schedule		
Product or Service	**Invoice Date**	**Amount Due**
Single Sign On Solution via Ping Identity	August 2023	$2,800.00
PureOHS™ Surveillance	August 2023	$2,940.00
PureOHS™ Case Management	August 2023	$3,143.00
PureOHS™ Clinical Suite	August 2023	$3,962.00
PureOHS™ Employee & Supervisor Views	August 2023	$1,652.00
PureOHS™ SSO Implementation	August 2023	$1,800.00
PureOHS™ Implementation and Training - Supervisor and Employee Views	August 2023	$4,000.00
PureOHS™ System Access Initial Setup (one-time fee)	August 2023	$3,500.00
PureOHS™ Implementation and Training – Surveillance, Clinical Suite and Case Management	August 2023	$11,000.00
PureOHS™ State Immunization Registry Implementation	August 2023	$5,400.00
Total Fees Year 1		***$40,197.00***
Single Sign On Solution via Ping Identity	August 2024	$2,800.00
PureOHS™ Surveillance	August 2024	$2,940.00
PureOHS™ Case Management	August 2024	$3,143.00
PureOHS™ Clinical Suite	August 2024	$3,962.00
PureOHS™ Employee & Supervisor Views	August 2024	$1,652.00
PureOHS™ State Immunization Registry Interface Annual License	August 2024	$2,160.00
Total Fees Year 2		***$16,657.00***
Single Sign On Solution via Ping Identity	August 2025	$2,800.00
PureOHS™ Surveillance	August 2025	$2,940.00
PureOHS™ Case Management	August 2025	$3,143.00
PureOHS™ Clinical Suite	August 2025	$3,962.00
PureOHS™ Employee & Supervisor Views	August 2025	$1,652.00
PureOHS™ State Immunization Registry Interface Annual License	August 2025	$2,160.00

Professional Services & Software Payment Schedule	
Total Fees Year 3	*$16,657.00*
Total Professional Services & Software Fees	**$73,511.00**

During the Term, UL Solutions shall provide Service Availability In accordance with the terms found in this document along with Technical Support In accordance with the terms found in this document.

Professional Services Details

Adobe Acrobat Document

1. PROJECT SUMMARY

PureOHS is a web-based enterprise Electronic Medical Record (EMR) application used to support an organization's employee health initiative in critical areas such as regulatory compliance and surveillance programs.

The UL Professional Services team will work with the Client's team to implement PureOHS, according to the Client's workflow, as supported by the existing PureOHS application, to manage their employee health program.

2. DELIVERABLES

This section defines items that are within scope for this SOW. Any items not specifically identified as in-scope are assumed to be out of scope.

2.1 In-Scope Summary (details in section 2.2)

- System Access Database Setup for PureOHS
- Implementation & Training Services for Surveillance, Clinical Suite, Case Management, and Supervisor & Employee Views
- People & Organizational Groups Import
- State Immunization Registry Implementation (1 State)
- Single Sign-On (SSO) Implementation

2.2 In-Scope Details

2.2.1 System Access Database Setup

- Setup of a single environment in UL's hosted datacenter
  - Production environment
  - Temporary test and training environments will be available for the duration of implementation only

2.2.2 Implementation & Training Services – Surveillance, Clinical Suite, Case Management, and Supervisor & Employee Views

- Includes Employee Demographics, Companies, Dashboards, Programs, and required dependent data such as encounters and fulfillments
- Implementation Management
  - Project management and delivery as described in the Project Approach section

- PureOHS Configuration Services for Surveillance, Clinical Suite, Case Management, and Supervisor & Employee Views
  - Evaluation of current business processes to include:
    - Identify and understand current workflows and organizational health practices, policies, and procedures
  - User Configuration
    - Setup of manually created users
    - Setup of permissions
  - Surveillance Programs
    - Program requirements
    - Program notifications
    - Program enrollment/inclusions
    - Surveillance compliance tracking
  - Encounters
    - Lookup sets (tables) and order templates
    - Available order templates, which include: Immunizations, Exam/Tests, Document Upload, Declinations, Disease History, DOT Physicals, Hearing, Injuries, Labs, Respirator Fit Testing & Clearance, Titers, and Tuberculosis
    - Encounter order sets
    - Document settings
    - Exam result options
    - Medical staff and clinics
    - Advanced charting and iForms
  - Appointments
    - Review appointments
    - Appointment slots and time blocks
    - Reminder notification emails
    - Dashboard scheduling tool
  - Events
    - Enter vaccine inventory
    - Enter tuberculosis inventory
    - Build events
  - Case Management
    - Lookup set items
    - Injury/illness related encounters
    - Define case number format
  - Dashboards & Reports
    - Surveillance
    - Respirator
    - Injury/illness
    - Disease tracking
    - Organization saved report templates
    - User saved report templates
  - Device Connectivity Assistance
    - Devices must be supported by PureOHS at time of implementation
  - Employee & Supervisor Views
    - Creation of custom permissions for employees and supervisors
    - Set up users for views
    - Identify and configure Dashboard widgets
    - Testing of dashboard widgets and views

- Configuration Acceptance Testing
  - Guide client through configuration testing for Encounters, Surveillance and Case Management
- Training & Go Live Support
  - Online training for a single group of up to 5 users
  - Onsite training is available at an additional charge
  - Dedicated remote Go Live support for 1 day
- Implementation follow-up for 30 days following completion of end user training
  - Includes access to UL project manager to address Client questions
  - Does not include modifications to configurations, surveillances, encounters, or reports
    - Any system changes, including changes to surveillances and encounters, after training will require a separate Statement of Work.
  - Formal transition to Customer Support at the end of 30-day follow-up period
- Does not include creation of electronic forms (eForms), which must be purchased separately

2.2.3 People and Organizational Groups Import

- Import file must comply with specifications as described in Attachment A
- A single, one-time, or recurring People and Organizational Groups Import from Client's HR database, as supported by existing PureOHS application through SFTP
- Import will be run for the test, pre-production, and production environments during the implementation
- UL Responsibilities
  - Provide PureOHS standard file specifications, including encryption instructions
  - Provide Secure File Transfer Protocol (SFTP) account
  - Assist Client with testing of import file(s) until import is successful
  - Assist in troubleshooting import issues (may require remote access to client environment)
- Client Responsibilities
  - Provide data from HR database according to provided import file specifications in Attachment A
  - Encrypt patient data containing PHI to UL requirements
  - Work with UL resources to resolve import errors until successful (several test imports may be needed with adjustments made to data formatting, etc.)
  - Manage import after first successful import run

2.2.4 State Immunization Registry Implementation (1 State)

- Configuration of the PureOHS application for a single state immunization registry interface
- Implementation services and end user training
  - End User Training provided online

2.2.5 Single Sign-On (SSO) Implementation

- Implementation Management of Single Sign-On for production environment
- Setup in SAML 2.0 format
- Client must provide the following information prior to start of implementation:
  - Federation Metadata URL or file
  - Unique Username Field should match PureOHS username
  - Initiation Type SP
- Does not include SSO implementation for any PreProd, training or test environments

2.3 Out of Scope

- Historical data conversion and/or import services
- Custom eForm development, which must be purchased separately
- Implementation services for any modules not stated as in-scope in section 2.2

- Any items not specifically identified as in-scope are assumed to be out of scope

3. PROJECT APPROACH

3.1 Required Project Resources

3.1.1 Resource Notes

- Resources described below are typical for projects of this scope
- An individual contributor may fill the role and responsibility of more than one resource
- Client will determine, and make available, the appropriate resources to complete the project based on their specific company policies and procedures
- Both Client and UL resources should be available throughout the project to address project-related questions within a reasonable timeframe

3.1.2 UL Resources

- Project Manager:
  - Management of project & UL resources
- Configuration Specialist:
  - Requirement gathering & system configuration
- Training Specialist:
  - Application training for client system administrators
- Implementation Analyst:
  - People and Organizational Groups Import

3.1.3 Client Resources

- Client Project Manager
  - Delivery of required Client inputs to PureOHS by the date(s) agreed to in the project plan and formatted as required in UL templates
  - Client resource attendance for configuration, testing and training sessions
  - Timely sign-off on the system
- Client SME(s)
  - Active and regular participation in the implementation process, minimum 5 hours per week
  - Obtain an expert understanding of the application to assist with peer troubleshooting and training
  - Maintain configuration post go-live with the system administrator
- Client System Administrator
  - Active and regular participation in the implementation process, minimum 5 hours per week
  - Make decisions on PureOHS workflow during implementation
  - User creation and maintenance
  - Make decisions on PureOHS workflow changes as needed/requested by users
  - Review all UL production releases and work with SME(s) to update configuration and train staff on new enhancements and features
  - Work with UL support on any user needs or concerns following go-live
  - Work with internal Client resources on technical issues such as HR import errors or updates, immunization registry and SSO
- Client HR/IT Resource
  - Responsible for network related and hardware needs, such as:
    - Wi-Fi connectivity issues
    - Internal email and web browser security specifications
    - Printer/scanner set-up and connectivity
    - New PC or tablet set-up & maintenance
    - Health equipment device connectivity (respirator fit, audiograms, vision, etc.)

- Work with internal System Administrator on technical issues such as HR import errors or updates, immunization registry and SSO

3.2 Project Governance

- Governance is set in place at project kickoff and will stay intact throughout the project lifecycle
- UL requires the Client to provide a designated Project Manager or single point of contact to manage Client resources
- The UL Project Manager is responsible for managing the project, and will collaborate with the Client's Project Manager
- The UL Project Manager will create and maintain a project schedule with mutually agreed milestones, considering dependencies between project deliverables, including other related SOW's, resource availability, holidays, major system upgrade (release) blackouts, etc.
- The UL Project Manager will arrange necessary project calls and ensure alignment of stakeholders within UL
- Roles and responsibilities will be discussed during project kickoff and are found in the Project Workbook
- Client is responsible for ensuring completion of deliverables and decision making in line with agreed schedule, as well as alignment of Client stakeholders
- Issues that cannot be resolved by the core project team will be escalated by the UL Project Manager to UL Professional Services management

3.3 General Assumptions

The scope for this project, including timing, resources, and fees, was developed based upon the following assumptions. Should any of these assumptions change, then the project design, resource requirements, schedule and/or fees may change.

- Any additions by Client to the project scope, delays by Client in completing its responsibilities hereunder or set forth in the project schedule, or suspensions of the project by Client, may result in an extended schedule and/or additional fees and will trigger the Change Order Process. In some cases, it is possible that a small project delay will have a significant impact on the project schedule.
- Should problems or events occur which may delay the target deadline, UL will promptly advise the Client of the situation and project impact. If UL substantially contributed to such problems or events, UL will take all commercially reasonable actions to minimize the delay.
- This project shall conform to the UL platform deployment process and schedule.
- UL is only responsible for design, development, and maintenance efforts within the PureOHS application and infrastructure. Client is responsible for any design, development and maintenance efforts associated with Client systems and infrastructure.
- Validation and User Acceptance Testing are the responsibility of the Client. UL will not perform the Client's User Acceptance Testing.
- UL will provide a Secure File Transfer Protocol (SFTP) secure file sharing site for the transferring of Client data files during this project.
- Client will provide written approval of project acceptance and completion within five (5) business days following release to production.
- The PureOHS application, project configuration, deliverables and materials from UL will be provided in the English language only.
- UL templates may be used for information required to be provided by the client.
- All work will be conducted in the UL environment during UL's normal business hours of 8:00 AM to 5:00 PM Central Time, Monday through Friday.

4. CHANGE REQUESTS

To ensure the project progresses with minimal delays and added expense, change requests should be resolved quickly. The Parties agree to follow the Change Request Process as defined in this section.

4.1 A Change Request shall be defined as:

- Activities which Client or UL requests to add to, or remove from this project, but shall not include clarifications to existing activities
- Any action or omission which leads to a need to revise a planned schedule, resource(s), scope, or deliverable(s)
- Any Client or UL responsibility which is not met and impacts project progress, and/or
- Any revision requested to an already approved configuration, program, surveillance, or other completed work product

4.2 Change Initiation

Change Request as defined above must be documented and may be initiated by either the Client or UL by using the Change Request form. Change Requests shall be submitted by the requesting party to the primary point of contact for the other party for review, validation, and approval.

4.3 Change Validation

Change Requests will be classified as either 'Within Scope' or 'Out of Scope' as defined below.

Within Scope

- If the Client and UL mutually determine that the proposed Change Request is within the scope of this SOW, no further action is required within the Change Request Process.

Out of Scope

- If the Change Request is not within the scope of this SOW, the financial and schedule impact must be determined.

4.4 Change Resolution

Change Requests must be documented and approved by both the Client and UL before work will be initiated.

Within Scope

- Appropriate direction will be provided to project staff by both the Client and UL.

Out of Scope with No Additional Fee

- UL will prepare a formal Change Order document to define all additions and deletions from the current SOW and submit to the Client for review. Authorized parties from both UL and the Client must sign the Change Order document to initiate work on the change request.

Out of Scope with Additional Fee

- UL will prepare a separate Statement of Work with associated fees and invoice schedule and submit to the Client for review. Authorized parties from both UL and the Client must sign the Change Order document to initiate work on the new SOW.

Change Request Dispute

- If there is disagreement between the Client and UL project teams regarding a change request, it will be brought to their respective management for resolution.

Except for those Services listed in this section that contain their own expiration disclaimer within their description, Services and associated contracted hours will expire either (a) twelve (12) months from the date this SOW is

executed by the parties, or (b) upon the expiration of the annual period applicable to the Services, whichever last occurs. To the extent the Services under this SOW are included in a contract having a multi-year term and are not utilized by Client prior to their expiration, such Services will not carry over into subsequent periods and no credit or refund shall apply.

Counterparts; Signatures

1. This SOW may be executed in counterparts, each of which shall be deemed to be an original instrument, but all such counterparts together shall constitute one and the same.
2. Facsimile or electronic transmissions of counterparts displaying facsimile or electronic, or electronically reproduced copies, of signatures shall be accepted and binding with the same force and effect as "wet signed" originals of the counterpart.

IN WITNESS WHEREOF, the parties have caused their duly authorized representatives to execute this SOW as of the dates indicated below.

UL Solutions:		Memorial Hospital of Sweetwater County:	
By:	_____	By:	_____
Name:	_____	Name:	_____
Title:	_____	Title:	_____
Date:	_____	Date:	_____

Contract Check List

This check list summarizes the purpose, cost and other contract provisions contained in the contract and assures that the contract has been reviewed by both the CEO and In-House Legal Counsel.

1. Name of Contract: **RQI Partners LLC**

2. Purpose of contract, including scope and description: **Hospital needs additional licenses for nurses to receive NRP training (neonatal resuscitation program). The hospital already has the program in place but we ran out of licenses so this is only to purchase additional licenses for nurses and three licenses for trainers.**

3. Effective Date: **When accepted by MHSC**

4. Expiration Date: **NA**

5. Termination provisions: **in MSA from RQI but not in the sales quote**
Is this auto-renew? **NA**

6. Monetary cost of the contract: **$2247.00** Budgeted? **yes**

7. Jurisdiction/Choice of Law provision checked and changed to Wyoming if able to so. **Not in the quote**

8. Any confidentiality provisions? **None in quote**

9. Indemnification clause present? **Not in the quote**

10. Is this contract appropriate for other bids? **No**

11. Is County Attorney review required? **No**