MEMORIAL HOSPITAL OF SWEETWATER COUNTY
REGULAR MEETING OF THE BOARD OF TRUSTEES
August 3, 2022
2:00 p.m.
Dial: 301-715-8592
Meeting ID: 880 4116 3036
Password: 918648

AGENDA

I.	Call to Order	Barbara Sowada
	A. Roll Call	
	B. Pledge of Allegiance	
	C. Our Mission and Vision	Ed Tardoni
	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. Taylor Jones Recognition	
VI.	New Business *(Review and Questions/Comments)*	Barbara Sowada
	A. Professional Practice Review Plan *(For Review)*	Kara Jackson, *Director of Quality, Accreditation, Patient Safety & Risk*
	B. Conflict of Interest Annual Disclosure *(For Your Information)*	Barbara Sowada
	C. Miner's Hospital Board Appointment *(For Action)*	Barbara Sowada
	D. MHSC Think Tank Proposal *(For Action)*	Ed Tardoni
	E. September Board of Trustees Meeting Date *(For Action)*	Barbara Sowada
	F. State Land Investment Board Projects *(For Action)*	Ed Tardoni
	G. Credentials Policy *(For Review)*	Kerry Downs, *Director of Medical Staff Services*
VII.	Chief Executive Officer Report	Irene Richardson
VIII.	Committee Reports	
	A. Quality Committee	Taylor Jones
	B. Human Resources Committee	Kandi Pendleton
	C. Finance & Audit Committee	Ed Tardoni
	1. Bad Debt *(For Action)*	
	D. Building & Grounds Committee	Marty Kelsey
	E. Foundation Board	Taylor Jones
	F. Compliance Committee	Kandi Pendleton
	G. Governance Committee	Barbara Sowada
	H. Executive Oversight and Compensation Committee	Barbara Sowada
	I. Joint Conference Committee	Barbara Sowada

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IX. Contract Review — Suzan Campbell, *In House Counsel*

A. Consent Agenda *(For Action)*

1. RQI Online Course
2. True North

B. Contracts Approved by CEO since Last Board Meeting *(For Your Information)*

1. Wolters Kluwer Up-To-Date Agreement

X. Board Education — Barbara Sowada

A. Pandemic Considerations for Maintaining Quality and Safety

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

A. CEO Evaluation *(For Action)*

XV. Adjourn — Barbara Sowada

Our Mission

Compassionate care for every life we touch.

Our Vision

To be our community's trusted healthcare leader.

Our Values

Be Kind

Be Respectful

Be Accountable

Work Collaboratively

Embrace Excellence

Our Strategies

Patient Experience

Workplace Experience

Quality & Safety

Growth, Opportunity & Community

Financial Stewardship

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

July 6, 2022

The Board of Trustees of Memorial Hospital of Sweetwater County met via Zoom in regular session on July 6, 2022, at 2:00 p.m. with Mr. Taylor Jones, President, presiding.

CALL TO ORDER

Mr. Jones called the meeting to order and announced there was a quorum. The following Trustees were present online at the call to order: Mr. Taylor Jones, Mr. Marty Kelsey, Ms. Kandi Pendleton, Dr. Barbara Sowada, and Mr. Ed Tardoni.

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

Pledge of Allegiance

Mr. Jones led the attendees in the Pledge of Allegiance.

Our Mission and Vision

Mr. Jones read aloud the mission and vision statements.

Mission Moment

Ms. Richardson said our community suffered a tragic loss on June 23rd and we express our condolences to the families and their loved ones. There were also serious motor vehicle accidents recently, and our thoughts and prayers are with everyone involved. Ms. Richardson thanked the emergency room physicians, staff, and everyone involved in providing care during these sad and difficult times. She thanked the staff for always taking care of our patients and their families.

AGENDA

The motion to approve the agenda as presented was made by Dr. Sowada; second by Ms. Pendleton. Motion carried.

APPROVAL OF MINUTES

The motion to approve the minutes of the June 1, 2022, regular meeting as presented was made by Mr. Tardoni; second by Mr. Kelsey. Motion carried. The motion to approve the minutes of the June 13, 2022, special workshop as presented was made by Mr. Tardoni; second by Dr. Sowada. Ms. Pendleton abstained, and the motion carried. The motion to approve the minutes of the June 27, 2022, special meeting was made by Mr. Tardoni; second by Dr. Sowada. Ms. Pendleton abstained, and the motion carried.

COMMUNITY COMMUNICATION

There were no comments.

OLD BUSINESS

There were no items for discussion.

NEW BUSINESS

Trustee Reappointment

Mr. Jones thanked the Board of County Commissioners for reappointing Mr. Kelsey to the Board. He said Mr. Kelsey has been a tremendous asset to the Board. Mr. Kelsey said he enjoys working with the group and is looking forward to the future.

Changes to Masking & Visitor Policies

Ms. Kim White, Incident Commander and Director of Emergency Services, provided an update on masking and visitor policies. She said we have continued to monitor the rates of Covid in our community, with patients coming to the Emergency Department, the staff out, etc., through the pandemic. The State and The Joint Commission were recently onsite and shared with us what other facilities are doing. We have taken a great deal of information into consideration and made changes. Ms. White reviewed the changes to the visitor policy, and masking requirements for patients, visitors, and staff. She said we will continue to monitor and can reinstitute precautions if things change. Ms. White said we hope we don't have to return to the stricter guidelines. Mr. Jones thanked Ms. White for the update.

Election of Officers

Dr. Sowada presented a slate of officers provided by the Governance Committee:

President: Dr. Sowada
Vice-President: Mr. Jones
Secretary: Ms. Pendleton
Treasurer: Mr. Tardoni

Dr. Sowada said there were no other recommendations or changes submitted by the deadline of June 15. The motion to approve the officers as presented was made by Ms. Pendleton; second by Mr. Tardoni. Motion carried. Dr. Sowada thanked Mr. Jones for the past three years of his service as Board President. She said he has donated a tremendous amount of his time. Mr. Jones said it has been an interesting and rewarding three years. He said we have collectively come through many things due to a group effort. Mr. Jones thanked everyone for their hard work. He said he feels the President title is a title only and the work is done by everyone. He said good people will do good things. Dr. Sowada said we will formally thank Mr. Jones at the August meeting. She said we have had significant challenges over the past five years. She noted successes and said we may

have differences in leadership styles but we are going in the same direction on the path together. Dr. Sowada presided for the remainder of the meeting.

Committee Assignments

Dr. Sowada announced the committee assignments for the upcoming year:

Building & Grounds:	Mr. Kelsey (Chair) and Mr. Tardoni
Compliance:	Ms. Pendleton (Chair) and Mr. Jones
Executive Oversight:	Dr. Sowada (Chair) and Mr. Jones
Finance & Audit:	Mr. Tardoni (Chair) and Mr. Kelsey
Governance:	Dr. Sowada (Chair) and Mr. Kelsey
Human Resources:	Ms. Pendleton (Chair) and Dr. Sowada
Joint Conference:	Dr. Sowada (Chair) and Ms. Pendleton
Quality:	Mr. Jones (Chair) and Mr. Tardoni
Foundation:	Mr. Jones

Dr. Sowada said we will focus on succession planning and strengthening the pipeline at the Board level. Dr. Sowada said we want people with experience on all committees because this Board works through its committees. She asked the committees to revisit the charters and body of work. Dr. Sowada said she will send an e-mail with the committee information and include the physician names for the Quality and Finance & Audit committees.

Employee Policies

Telecommuting: Ms. Suzan Campbell, In House Counsel, said a policy has been in place. Changes were made to clarify and bring associated forms in line with each other. The new IT Director provided input. The updates were approved by the Human Resources Committee. The motion to approve the policy as presented was made by Ms. Pendleton; second by Mr. Tardoni. Motion carried.

Social Media: Ms. Campbell said the policy was recently approved by the Board. Revisions were made to address some additional issues including not filming or posting videos from the Hospital. The updates were approved by the Human Resources Committee. The motion to approve the policy as presented was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

CHIEF EXECUTIVE OFFICER REPORT

Ms. Richardson reported 817 people have completed the Planetree Person-Centered Care Workshops and 422 people have completed the Communicating With Empathy Workshops. The Patient and Family Advisory Council celebrated their three-year anniversary in May. They are a great group of patients and family members, and we continue to recruit additional members. The next meeting is August 29 and we hope to provide an onsite hospital tour. Ms. Richardson commended the Lab for their recent accreditation survey results. The Joint Commission was onsite for three days in June. 971 elements were reviewed with an excellent outcome. Ms. Richardson recognized Ms. Mary Fischer, Lab Director, Dr. Cielette Karn, Pathology, and all of the staff involved for the excellent survey. Ms. Richardson reported the Wyoming Department of Health

was onsite to conduct a Dialysis Life Safety Survey. She recognized and thanked Dr. Rahul Pawar, Nephrology, Ms. Jamie Webb, Mr. Jim Horan and Ms. Stevie Nosich, Facilities, and the staff for the excellent survey. Ms. Richardson thanked the Board for approving the FY23 budget and thanked the Board of County Commissioners for approving the maintenance and Title 25 budget. She reported we are working with the auditors for the $11.6M Cares Act single audit. The auditors will be onsite the week of August 1 for the annual audit. Ms. Richardson said we continue working with Cerner to resolve some outstanding issues. She said she attended the Wyoming Hospital Association (WHA) Board Retreat at the end of June. The agenda of the WHA and the American Hospital Association includes staffing issues, mental health services, and workplace violence. Ms. Richardson said we are working on a new strategic plan. We continue working on State Land Investment Board (SLIB) grants to submit to the State. We have requested time on the July 19 Board of County Commissioners meeting agenda to review and request matching funds. Ms. Richardson congratulated Mr. Kelsey on his reappointment to the Board and thanked him for his years of work. Ms. Richardson congratulated Dr. Sowada and thanked her for taking the role of President. Ms. Richardson thanked Mr. Jones for his years of service as Board President. She said a lot of things have been unprecedented. His leadership and direction were very good and she said she learned a lot from him. Ms. Richardson invited everyone to participate in the Red Desert Round Up Parade July 30. She said we walked in the Flaming Gorge Days Parade in Green River and received a great response. She said we have a booth at the Sweetwater County Fair and are always looking for volunteers. The Hospital Picnic will be August 13 at Crossroads Park in Rock Springs. The Wyoming Hospital Association annual meeting will be September 7 and 8 in Laramie. The Foundation is hosting a Casino Night event September 17 at Bunning Hall in Rock Springs. Ms. Richardson said she presented the hospital annual report to the Board of County Commissioners June 21. She had asked her leadership team to submit their accomplishments and activities for the year and included that information in the report. Dr. Sowada asked Ms. Richardson to review the PowerPoint presentation for the Board and meeting attendees. Following the presentation, Ms. Richardson thanked staff for everything they have done throughout the year. Dr. Sowada said the report shows the amount of regular everyday work that went on while Covid was going on. She thanked Ms. Richardson for the report.

COMMITTEE REPORTS

Quality Committee

Dr. Sowada said the information is in the packet. She urged Trustees to look at the end of the year summary report in the portal. She said it contains initiatives for each of the departments participating during the year.

Human Resources Committee

Dr. Sowada said the information is in the packet. She drew attention to one of the goals for the coming year to replace travel staff with hospital staff.

Finance and Audit Committee

Mr. Tardoni said his comments are in the packet with one correction to the bad debt information. He said it is 30% higher than what he anticipated. He said there are no capital projects to consider at this time.

Bad Debt: The motion to approve the net potential bad debt of $1,125,418.46 as presented was made by Mr. Tardoni; second by Ms. Pendleton. Motion carried.

Building & Grounds Committee

Mr. Kelsey said the information is in the packet.

Foundation

Ms. Tiffany Marshall, Foundation Executive Director, reported the Foundation has a lot going on. We are participating in Wyoming Gives July 13. A number of non-profit organizations are working together to benefit from online donations on this date. Ms. Marshall said we are excited to announce a Casino Night event September 17. We are working on SLIB grants and Wyoming Workforce grants. We continue working on employee contributions and rewards. The Foundation Board is continuing their work on their strategic plan with three to five different goals in each pillar. They meet again July 28.

Compliance Committee

Mr. Kelsey said the minutes and Chair report are in the packet.

Governance Committee

Dr. Sowada said we have contacted The Governance Institute regarding our survey. The Committee will review materials and the process at the next meeting.

Executive Oversight and Compensation Committee

Dr. Sowada said the end of the year CEO evaluation will be an item for executive session.

Joint Conference Committee

Mr. Jones said there is no information to report.

CONTRACT REVIEW

Contracts Approved By CEO Since Last Board Meeting

Dr. Sowada said there are no contracts requiring approval and asked for any questions/comments on the information in the packet. There were none.

BOARD EDUCATION

Dr. Sowada provided an overview of the iProtean Diversity, Equity and Inclusiveness program. She said CMS (Centers for Medicare and Medicaid Services) is looking at this as part of social determinants of health. She said this is something our Board will keep our eyes on and see where the topic is going. The Trustees provided their input on their review of the iPro program. Ms. Richardson said she thinks we already have some good things built in by being a county memorial hospital. She agreed we need to keep this on our radar.

MEDICAL STAFF REPORT

Dr. Crofts reported things continue to go well with Cerner. The physicians and providers have adopted the technology and are moving forward. Dr. Crofts referenced recent events and said she thinks there are times in healthcare where the nurses, doctors, techs, every person who touches the patients knows how they saved a life. Dr. Crofts said she is grateful to be part of this hospital and this community. Dr. Sowada said it is reassuring to know in times of major trauma everyone knows their important roles. She said we like to make those differences in people's lives.

GOOD OF THE ORDER

Mr. Tardoni said his term on the State Miner's Board expired in June. He said the Board of County Commissioners are directed by law for steps to take to fill spots. First is to invite from the Trustees. Next is considering any application by employees of MHSC. If there are none, then the spot is open to the general public. The next Miner's Board meeting is in September. Mr. Tardoni said it is a real benefit of having someone from the Hospital even though they aren't there to represent the Hospital. They bring a level of knowledge with them. The Miner's Board has governance on a pretty substantial insurance program the State provides for miners.

EXECUTIVE SESSION

Dr. Sowada said there would be an executive session that would last at least an hour. The motion to go into executive session was made by Mr. Jones; second by Ms. Pendleton. Motion carried. Dr. Sowada said the Board would take a break until 4:10 p.m.

RECONVENE INTO REGULAR SESSION

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

ACTION FOLLOWING EXECUTIVE SESSION

Approval of Privileges

The motion to approve the clinical privileges and appointments to the Medical Staff as discussed by Dr. Crofts was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

Credentials Committee Recommendations from June 14, 2022

1. Initial Appointment to Active Staff (2 years)
   - Dr. Anil Aleti, Hospitalist
   - Dr. Nicholas Kanaan, Emergency Medicine (U of U)
2. Initial Appointment to Associate Staff (1 year)
   - Dr. Julie Widdison, Emergency Medicine (U of U)
3. Initial Appointment to Consulting Staff
   - Dr. Donald Anderson, Tele Radiology (VRC)
   - Dr. Joseph Horner, Tele Radiology (VRC)
   - Dr. Jason Mitchell, Tele Radiology (VRC)
4. Reappointment to Active Staff (2 years)
   - Dr. Alicia Gray, Hospitalist

The motion to approve four provider contracts and authorize the CEO to execute the contracts as discussed in executive session was made by Ms. Pendleton; second by Mr. Jones. Motion carried.

Dr. Sowada said it will be best to continue meeting via Zoom due to the 6-feet distancing rule. The group agreed to stay with Zoom in August and reevaluate as issues change.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 5:19 p.m.

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Dr. Barbara Sowada, President

Attest:

_____

Ms. Kandi Pendleton, Secretary

Status **Pending** PolicyStat ID **10579123**

Approved	N/A
Review Due	1 year after approval
Document Area	Medical Staff
Reg. Standards	TJC MS 05.01.01, TJC MS 06.01.05, TJC MS 08.01.01, TJC MS 08.01.03, TJC MS 09.01.01

Professional Practice Review Plan (Medical Staff Peer Review)

Statement of Purpose

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

Plan

I. Goals

The goal of the Professional Practice Review (Medical Staff Peer Review) Plan is to outline processes to:

A. Assist in driving healthcare quality, defined as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge " (Agency for Healthcare Research and Quality [AHRQ], 2018; Institute of Medicine [IOM], 1990). Refer to MHSC's Performance Improvement and Patient Safety (PIPS) Plan

B. Provide a mechanism for review of charts and ongoing evaluation of Practitioner

clinical competence and professional performance through systematic, data-driven processes.

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

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

E. Create a culture of accountability.

F. Assist in organizational process improvement strategies based on identified opportunities and in congruence with MHSC's PIPS Plan and organizational strategic plan.

G. Continuously improve processes to ensure safe, timely, effective, efficient, patient-centered, and equitable care delivery.

II. Definitions

A. Medical Staff: The group of all Practitioners privileged through the organized medical staff process who are subject to the Medical Staff Bylaws, Rules, and Regulations.

B. Professional performance review/peer review: A process that allows the Medical Staff to evaluate an individual's professional practice and/or system issues that may affect the delivery of quality care. The process includes measuring Practitioner professional performance based on metrics as defined by the Medical Staff (see attached Professional Performance Review Indicators), in addition to quality events identified through other processes (see Medical Staff Peer Review Process Flow). The evaluation may identify systems or processes of care that do not adequately protect against foreseeable human error. These system opportunities will be referred to the Performance Improvement and Patient Safety (PIPS) Committee as appropriate for evaluation and improvement interventions.

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

D. Ongoing Professional Practice Evaluation (OPPE): A summary of ongoing data collected for the purpose of assessing a Practitioner's clinical competence and professional behavior.

E. Focused Professional Practice Evaluation (FPPE): A systematic process to ensure there is sufficient information available to evaluate a Practitioner's professional competence. A focused review can be requested by the Credentials Committee, PPEC, or the Medical Executive Committee (MEC). FPPE occurs:

1. When clinical privileges are initially granted to a Practitioner who is new to the organization.
2. As the result of data evaluated during OPPE.
3. When an existing Practitioner requests a new privilege.

4. When additional data or reports indicate the need for a focused review.

F. Care ratings: Practitioner (as determined by the PPEC or MEC)

1. Care Appropriate: Despite a complication, adverse outcome, or other question regarding the quality delivery of care, it is determined that a majority of peers would have responded similarly under similar circumstances. This designation adjudicates that there was no clear deviation from standard of practice.
2. Improvement Opportunity: Care that involved simple errors in diagnosis, treatment or judgment, or inadvertently doing other than what should have been done: a slip, lapse, or mistake.
3. At Risk Behavior: Care that requires education or coaching to prevent recurrence, or behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified.
4. Reckless Behavior: Care that suggests reckless disregard of the Practitioner's duty to the patient through gross negligence, general incompetence or actual intent to provide substandard care, or behavioral choice to consciously disregard a substantial and unjustifiable risk.

G. Care ratings: System of care (as determined by the PPEC or MEC)

1. System Improvement Opportunity: Designates an event as resulting at least in part from an opportunity to improve the care system to reduce caregiver errors, mitigate the effects of any future errors, or otherwise better support the care process. This rating will apply whenever a system improvement opportunity is identified, independent of any individual Practitioner's care rating.

H. Professional Behavior: As defined in MHSC's Behavior Standards, the Code of Caring, a high standard of professional behavior, ethics, and integrity is expected of each individual member of the Medical Staff at MHSC in order to promote an environment conducive to providing the highest quality of care. The standards expected to be practiced at MHSC include: Courtesy, Accountability, Respect, Integrity, Nurturing, and Growth. In addition to the Code of Caring, Medical Staff will adhere to the Medical Staff Code of Conduct found within the Medical Staff Bylaws. Violations of the Code of Caring and/or Medical Staff Code of Conduct will be addressed by the Medical Executive Committee.

I. Medical Staff Quality Reviewer: A group of reviewers appointed by each department chair to perform an initial case review screening to determine if the case requires further review by the PPEC.The group of reviewers may rotate every six months.

J. Conflict of Interest: A member of the medical staff requested to perform peer review may have a conflict of interest if they may not be able to render an unbiased opinion. An automatic conflict of interest would result if the Practitioner is involved in any way in the case under review. Relative conflicts of interest are either due to a Practitioner’s involvement in the patient’s care not related to the issues under review or because of a relationship with the Practitioner involved as a direct competitor, partner, or key referral source. It is the responsibility of the PPEC to determine on a

case by case basis if a potential conflict exists and if substantial enough to prevent the individual from participating in the review. If a potential conflict exists, the individual may not participate or be present during peer review discussions or decisions other than to provide specific information requested.

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

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

III. Responsibilities

A. The organized medical staff are responsible for defining the OPPE process.

B. PPEC is responsible for ensuring consistent implementation of the OPPE process and for monitoring compliance with this policy.

IV. Authority for Peer Review

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

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

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

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

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

the hospital.

V. Review Process

A. All reviews will be directly documented within the quality management system, using the appropriate focus study or quality management entry, depending on level of review.

B. Indicators

Different types of indicators are utilized to identify potential quality concerns. The indicator type dictates the action required. See the Medical Staff Peer Review Process Flow. All review indicators and rate thresholds will be reviewed annually, at a minimum, by the PPEC and/or appropriate specialties.

1. Rule indicators will initiate a peer review by PPEC. The PPEC will be notified when a rule has been triggered. Additionally, the individual Practitioner will be notified when a rule indicator has been triggered through the process of OPPE.
2. Rate indicators will be trended and added to OPPE profiles. The PPEC will review peers with outlier rate indicators twice per year (every 6 months) at a minimum and provide feedback, education, initiate a performance improvement plan, or recommend FPPE with the individual as appropriate. Refer to the OPPE process flow.
3. Review indicators will be screened through an initial review by a designated Medical Staff Quality Reviewer. If the case requires further action, follow-up, or review, it will be reviewed by the PPEC as a peer review case.
4. Other quality events will be referred directly to PPEC.

C. Initial Screening (performed by Medical Staff Quality Reviewer)

1. An initial screening of a quality event will occur by a designated Medical Staff Quality Reviewer if the event is triggered by a review indicator (see attached list of Medical Staff Review Indicators).
2. Six Medical Staff Quality Reviewers will be appointed by the Chief of Staff. Three will be appointed from the Medicine Department and three from the Surgery Department. In the event a designated Medical Staff Quality Reviewer is unable to fulfill the term, a new reviewer will be appointed by the Chief of Staff, as a replacement.
3. Medical Staff Quality Reviewers will be notified via secure email of cases needing review as they occur.
    a. Screening of case and outcome determination is expected to be completed within 2 weeks of notification.

4. The initial screening will determine if referral to the PPEC for peer review of the case in question is needed.

    a. If care is appropriate, a summary of findings and final conclusion is documented in the quality management system using the initial review focus study. The case will be documented and trended via the quality management system by the Quality Department. Trended results will be located on the OPPE profiles.

    b. If the case needs further follow-up, investigation, or it is unable to determine appropriateness of care a summary of findings and conclusion of further review needed is documented in the quality management system using the initial review focus study. The case will be documented and referred to the PPEC via the quality management system by the Quality Department. Cases requiring further review may include identification of system of care opportunities. Final conclusions of the review will be located on the OPPE profiles.

D. Peer Review (performed by PPEC)

1. PPEC will meet ten (10) times per year, ideally monthly. They may meet more or less often, as needed, dependent on the volume of cases requiring review by the committee. It is the responsibility of PPEC members to review cases prior to set meeting date for discussion and final outcome determination at PPEC meeting.
2. The PPEC will be provided a list of cases and/or Practitioners for review prior to the meeting.
3. All reviews from PPEC will be directly entered into the quality management system using a secure log-in by a designated member of the committee or may be transcribed from meeting minutes by Quality.
4. A summary of findings will be documented on all cases for review.
5. Outcome determinations for final conclusions must be made by a consensus of members present at PPEC.
6. **The PPEC reserves the right to halt the peer review process for a Practitioner that has been involuntarily terminated. Judgment of whether or not the case needs to be reviewed is left up to PPEC.**
7. The PPEC will review all cases for peer review in which rule indicators are met, those referred by Medical Staff Quality Reviewers following initial screening, as well as cases with risk investigation/review and reported to insurance and cases referred by other departments.

a. Practitioner standard of care rating will include the following outcomes:

i. Care Appropriate - case closed/trended

ii. Improvement Opportunity - education, follow-up, FPPE, etc. provided or delegated to another peer to provide to the Practitioner in question.

a. Case can be closed in the quality management system once education, follow-up, FPPE, etc. is provided and documented with date.

iii. At Risk Behavior - MEC notified of outcome finding and recommendation for next action.

a. Case can be closed after MEC final conclusion is made.

iv. Reckless Behavior - referred to MEC with summary of findings and recommendations for appropriate action.

a. Case can be closed after MEC final conclusion is made.

b. If additional follow-up, referral, etc. is required prior to making a final conclusion the case is kept open and referred to the appropriate department. The case will be closed and trended upon final conclusion.

8. Practitioners exceeding the threshold for rate indicators will be reviewed by PPEC at an every six (6) month evaluation. The cases that contributed to the excess rate will be reviewed when indicated.

a. Individual Practitioners will be notified of exceeding thresholds via the OPPE profile.

b. Additional follow-up, FPPE, education, etc. required for improvement will be determined by the PPEC. These activities may be performed by the appropriate Department Chair or Vice Chair if delegated by the PPEC.

9. Findings in which care is appropriate, yet system of care opportunities are identified is a possibility will be referred to the PIPS Committee for organizational improvement interventions. Medical staff input, engagement, and support for system of care resolutions will be expected. The solution/plan for improvement developed by the PIPS Committee will

be reported back to PPEC as necessary.

10. Findings in which nursing, essential services, or other departments are needing to review or follow-up can be referred to the PIPS committee or appropriate individual department as necessary. It is the responsibility of the PPEC to communicate this need with appropriate department/ committee. Medical staff input, engagement, and support for resolutions will be expected.

E. **Patient Complaints and Grievances**

1. **Patient Complaints/Grievances will be entered into the electronic occurrence reporting system.**
2. **If the Grievance Committee determines a case needs review for behavioral issues, they will forward the case to PPEC, first.**
3. **PPEC will determine whether or not the standard of care was met for the grievance case. The case will then be forwarded to MEC to review for the behavioral issues.**
4. **Medical Staff Services (MSS) will request the practitioner's peer review file to determine if he or she had any other grievances (within the past 24 months.) MSS will draft a summary of any grievances for review at MEC.**
5. **The grievance (and summary of past grievances) will then go to MEC and will be discussed during executive session.**
6. **MEC will discuss and decide on appropriate action for the grievance.**
7. **If the Grievance Committee determines that a case needs to be reviewed for clinical competence, they will follow the steps in section D, above.**

F. External Reviews

1. External reviews can be initiated by Medical Executive Committee after appropriate referral from PPEC and inability to determine a final conclusion.
2. If a case is sent for external review by another department within MHSC results of the external review as they pertain to individual Practitioner performance are requested to be presented to the PPEC and enter into MHSC's internal peer review process if indicated.
3. The PPEC or MEC may require use of external peer review consultation in cases including, but not limited to:
    a. The absence of an appropriate Practitioner able to render an opinion regarding the FPPE.
    b. The presence of a significant conflict of interest.
    c. Potential for litigation.

d. Ambiguity, especially when dealing with vague or conflicting recommendations from internal reviewers.

G. Practitioners performing reviews will not review their own cases.

H. Practitioners serving on PPEC in which their case is being reviewed will not take part in the review process and outcome determination.

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

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

VI. OPPE

A. Ongoing professional practice evaluation (OPPE) is factored into the decision to maintain, revise, limit, or revoke existing medical staff privileges.

B. Nurse practitioners, physician assistants and other Non-Physician Providers are considered part of the Medical Staff per MHSC's Rules & Regulations and will be referred to as Practitioners.

C. Department Leadership will do the following:

1. Perform at least two OPPE's on all designated staff members every 24 months, but not longer than 12 months apart. This will be performed by the Vice Chair of each Department, through their membership on PPEC. If there are negative trends or concerns about an Individual Practitioner, the Vice Chair will communicate that information to the Department Chair.
2. Use the types of data and evaluation processes developed by the departments and approved by the organized medical staff.

D. The following general competencies are included in OPPE :

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

and other members of healthcare interdisciplinary teams.

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

E. The Quality Department will be responsible for compiling the OPPE profiles based on data available in MHSC's electronic data systems.
    1. OPPE profiles will include Practitioner level metrics for Medical Staff indicators, including rule, rate, and review indicators. Profiles will also include indicators from other quality events that required a review by PPEC.
    2. OPPE profile metrics may change and evolve over time based on individual performance and opportunities for improvement and specialty specific indicators. Specialty specific measures will be recommended for inclusion on the OPPE profiles and approved by PPEC.
    3. Other metrics will be included on the OPPE profiles to meet the six (6) general competency categories, including patient satisfaction data, and will include any data showing zero performance.
    4. Profiles will be compiled every six (6) months.

F. Medical Staff Services will be responsible for dispersing the OPPE profiles to individual Practitioners for review every 6 months, at a minimum.

G. PPEC will be responsible for reviewing OPPE profiles every six (6) months, at a minimum.
    1. Review is expected to be completed within 30 days of receiving OPPE profiles.
    2. Purpose is to review Practitioner performance, identify trends and intervene when appropriate.
        a. Request additional information for further review.
        b. Individual improvement plans may be generated from this process.
        c. If improvement plans are not effective in improving performance, recommendation and/or initiation for FPPE may occur.
    3. PPEC designated members are expected to communicate feedback and opportunities for improvement with individual Practitioners when

appropriate, or communicate with the appropriate Department Chair/Vice Chair for follow-up actions.

VII. FPPE

A. Focused professional practice evaluation (FPPE) is a time-limited process to ensure there is sufficient information available to evaluate a Practitioner's clinical competence. It may be initiated on an individual Practitioner in the following situations:

1. When clinical privileges are initially granted to a Practitioner who is new to the organization.
2. An existing Practitioner requests a new privilege or does not have documented evidence of performing a requested privilege.
3. An existing Practitioner requests assistance with an identified improvement opportunity.
4. A question arises regarding a Practitioner's ability to provide safe, high quality patient care. This can be initiated through the following processes, but not limited to:
    a. OPPE trends
    b. Low volume procedures
    c. Sentinel event
    d. Complaint
    e. Variance from acceptable practice patterns
    f. Variance from comparative peer performance data
    g. Recommendations made to Medical Executive Committee

B. Direct observation of the applicant is required, with a few exceptions. Because of staff limitations, direct observation is not required for Locum Tenens Practitioners, but it is recommended. The evaluator may use one or more of the following in addition to direct observation:

1. Chart review.
2. Discussion with other individuals involved in a patient's care (other Practitioners, nurses, surgical assistants, administration, etc.)
3. Monitoring of diagnostic and treatment techniques.
4. Simulation.
5. Proctoring.

C. FPPE plans will contain, at a minimum:

1. An individual designated as responsible for overseeing the plan.
2. Specific criteria that will be monitored.
3. Measures of success.

4. Time frame for the plan.
5. Parameters for extending the plan.
6. Actions that may be taken if the performance is not satisfactory.
7. Method of communicating the evaluation results and recommendations based on results, to appropriate parties.

D. FPPE for initial grant of clinical privileges, existing Practitioner requesting a new privilege, or an individual request for improvement:

1. The Department Chair will oversee the evaluation process for all Practitioners undergoing FPPE. They may evaluate the Practitioner themselves, or they may assign an Active member of the Medical Staff to evaluate the Practitioner. The evaluator should have the same or similar privileges as the Practitioner being evaluated.
2. When the Practitioner's credentials file is reviewed and approved by the Department Chair, the Chair will assign an FPPE evaluator.
3. The Department Chair will develop an FPPE monitoring plan using pre-established department specific criteria. In those instances when no department-specific criteria have been established, the Department Chair will determine the specific privileges to be monitored.
4. The Medical Staff Services Office will send an FPPE letter and evaluation forms to the evaluator, and will copy the Practitioner. The FPPE letter will be sent after the Practitioner's privileges have been approved by the Board of Trustees.
5. The FPPE for initial privileges, or new privileges, should be completed within six (6) months from the date the privileges were granted. The FPPE can be based on volume of cases, instead of a specific time period, if necessary. An evaluation form will need to be completed for each of ten procedures or ten patients for which care was provided. However, as soon as the Practitioner commences clinical activity, all of his/her work is subject to evaluation until the FPPE has been completed and competency evaluated.
6. All FPPE evaluation forms will be turned into the Medical Staff Services Office.
7. The Medical Staff Office will forward a copy of all completed FPPE evaluation forms to the appropriate Department Chair for their review and recommendation.
8. If an event happens in the last month of initial monitoring, the FPPE can be extended for six (6) months or five (5) cases, whichever comes first.
9. If FPPE is found to be unsatisfactory, the Practitioner will be referred to the Credentials Committee for final determination regarding continuation of privileges.

E. Locum Tenens or temporary Practitioners will be required to participate in FPPE.

However, because they are often working when other physicians in their specialty are away, direct observation may not always be possible. In addition, locums Practitioners may only be contracted for a short time period, so the requirement of ten (10) cases in a six (6) month time period is not always practical. The Department Chair will assign an evaluator for locums or temporary Practitioners. If the evaluator is unable to review ten (10) charts, because of inadequate volume, they will review as many charts as possible. They will then document the reason they were unable to review ten (10) charts and forward that information, along with the evaluation forms, to the Medical Staff Office.

F. FPPE for triggered events outside of the initial request for privileges or requested improvement:

1. When a triggered Focused Professional Practice Evaluation is initiated, with the exception for initial request for privileges, the following events shall occur:

    a. The PPEC chairperson shall notify the MEC at the next regularly scheduled MEC meeting that a FPPE is either recommended and/or has been initiated.

    b. The data supporting the necessity for recommendation/ initiation is reviewed and analyzed by MEC for appropriateness.

    c. The involved Practitioner will be given both verbal and written notice by either the chairperson of the PPEC, the Chief of Staff, or the MEC's designee regarding the specific concerns which have been identified and are the basis for initiating the FPPE.

    d. The involved Practitioner will be given access to medical records and other appropriate information necessary to respond to the cases or events, as applicable.

    e. The PPEC will be responsible for assigning an evaluator and for following-up on the FPPE plan with the individual Practitioner.

    f. The PPEC can at any point during the FPPE require the Practitioner under evaluation to address the PPEC in person. A reasonable amount of time will be established by the PPEC for this to occur. Failure of the Practitioner to comply with the requests for additional information or a personal appearance shall be considered a violation of Medical Staff Bylaws and will result in automatic suspension of the Practitioner's privileges.

    g. Prior to reaching a final conclusion, the PPEC may require the involved Practitioner to respond to the committee's concerns by addressing the PPEC in person. It shall be the obligation of the Practitioner being reviewed to fulfill this requirement within a reasonable period of time as may be established by the PPEC. The involved Practitioner shall be strongly encouraged to submit a written response to all identified clinical concerns, as well. Failure of the Practitioner to comply with the requests for additional information or a personal appearance shall be

considered a violation of Medical Staff Bylaws and will result in automatic suspension of the Practitioner's privileges.

h. The conclusions and recommendations of a FPPE shall be recorded in writing and shall include a record of any medical record reviews, interviews, reports, medical literature information utilized, relevant clinical practice guidelines and/or evidence based information which has been used in arriving at the FPPE's conclusions. The recommendations shall include consideration of the need for corrective action, education, additional performance monitoring (internal or external), and/or other actions deemed appropriate by the PPEC.

i. The findings and conclusions of the FPPE evaluation shall be reported to the MEC by the PPEC chairperson or designee at the next regularly scheduled MEC meeting.

j. A triggered FPPE shall be completed within 120 days of initiation when possible, dependent on the nature of the situation. If the PPEC is not able to complete the triggered FPPE within 120 days of initiation, a report will be submitted to the MEC regarding the status and timeliness of the FPPE in progress.

k. Upon completion of the triggered FPPE, PPEC will notify the Practitioner in writing of the results.

l. Correspondence with the Practitioner regarding the monitoring plan, progress reports, and the final report will be included in the Practitioner's peer review file, which are reviewed by the Department Chair and Credentials Committee as part of the appointment/reappointment process.

VIII. Confidentiality

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

B. **WY Stat § 35-17-103.** Exemption from liability; exception: A professional standard review organization or a society or person rendering services as a member of a professional standard review organization functioning pursuant to this act is not

liable either independently or jointly for any civil damages as a result of acts or omissions in his capacity as a member of any such organization or society. Such persons or organizations or societies are not immune from liability for intentional or malicious acts or omissions resulting in harm or any grossly negligent acts or omissions resulting in harm.

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

D. Confidentiality shall be maintained, based on full respect of the patient's right to privacy and in keeping with hospital policy and state and federal regulations governing the confidentiality of quality and patient safety work. All quality and patient safety data and information shall be considered the property of Memorial Hospital of Sweetwater County.

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

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

F. No copies of peer review documents will be created and distributed unless authorized by medical staff policy or bylaws, the MEC, PPEC, Credentials Committee, or by mutual agreement between the Chief of Staff and CEO for purposes of

deliberations regarding corrective action on specific cases.

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

Reviewed and Approved:

PPEC 6/22/2022

MEC 6/29/2022

Board of Trustees

References

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

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Attachments

FPPE Department Chair Review

FPPE Evaluation Form

Medical Staff Professional Practice Review Indicators 2020-2021

Medical Staff Professional Practice-Peer Review Process Flow- OPPE 2020-2021

Approval Signatures

Step Description	Approver	Date
	Kara Jackson: Director Quality	Pending

History

Draft saved by Jackson, Kara: Director Quality on 9/20/2021, 4:57PM EDT

Draft saved by Roger, Jennifer: Quality Analyst on 10/4/2021, 1:43PM EDT

Draft saved by Jackson, Kara: Director Quality on 10/5/2021, 4:16PM EDT

Draft saved by Roger, Jennifer: Quality Analyst on 10/6/2021, 12:23PM EDT

Draft saved by Downs, Kerry: Director of Medical Staff Services on 10/15/2021, 6:36PM EDT

Edited by Downs, Kerry: Director of Medical Staff Services on 10/15/2021, 7:03PM EDT

> all changes are highlighted

Draft saved by Roger, Jennifer: Quality Analyst on 10/20/2021, 10:37AM EDT

Draft saved by Jackson, Kara: Director Quality on 10/20/2021, 5:57PM EDT

Draft saved by Downs, Kerry: Director of Medical Staff Services on 11/18/2021, 5:06PM EST

Draft saved by Jackson, Kara: Director Quality on 11/23/2021, 8:01PM EST

Draft saved by Roger, Jennifer: Quality Analyst on 12/1/2021, 9:43AM EST

Draft saved by Jackson, Kara: Director Quality on 12/7/2021, 11:12AM EST

Administrator override by Fife, Robin: Clinical Administrative Assistant on 12/9/2021, 5:09PM EST

> updated the Review Indicators (attached) 2021-2022

Draft saved by Downs, Kerry: Director of Medical Staff Services on 1/26/2022, 4:45PM EST

Edited by Downs, Kerry: Director of Medical Staff Services on 1/26/2022, 4:46PM EST

> Removed vb5

Administrator override by Downs, Kerry: Director of Medical Staff Services on 3/1/2022, 6:15PM EST

> Added VD6 at the request of the PPEC

Draft saved by Downs, Kerry: Director of Medical Staff Services on 6/16/2022, 4:23PM EDT

Comment by Downs, Kerry: Director of Medical Staff Services on 6/16/2022, 4:24PM EDT

> Added section V E - Patient Complaints and Grievances

Comment by Downs, Kerry: Director of Medical Staff Services on 6/30/2022, 12:53PM EDT

> Deleted draft and made changes to policy waiting approval - added section VE - patient complaints and grievances.

Administrator override by Downs, Kerry: Director of Medical Staff Services on 6/30/2022, 12:55PM EDT

> Added section VE - patient complaints and grievances

Draft discarded by Downs, Kerry: Director of Medical Staff Services on 6/30/2022, 12:55PM EDT

Dated this ___, day of _____, 20____

TO: BOARD OF TRUSTEES OF MEMORIAL HOSPITAL OF SWEETWATER COUNTY, ROCK SPRINGS, WYOMING

FROM: _____
BOARD MEMBER

RE: CONFLICT OF INTEREST DISCLOSURE UNDER WYO. STAT. § 6-5-118

TO WHOM IT MAY CONCERN:

The undersigned is a public officer or public servant who either has the authority to decide how public funds are invested or invests public funds on behalf of Memorial Hospital of Sweetwater County.

The undersigned hereby discloses that he or she transacts personal business with the following entities or institutions that provide any services related to the investment of public funds to Memorial Hospital of Sweetwater County or has a financial interest in a security or other investments made by Memorial Hospital of Sweetwater County:

1._____
2._____
3._____

I hereby request that this disclosure be considered my annual disclosure under Wyo. Stat. § 6-5-118 and be made a part of the record of proceedings of the meeting of the Board of Trustees of Memorial Hospital of Sweetwater County at the date and time presented.

Sincerely yours,

Trustee
Board of Trustees Member
Memorial Hospital of Sweetwater County

Resolution Number 1

Entitled: A RESOLUTION AUTHORIZING SUBMISSION OF AN ARPA HEALTH AND HUMAN SERVICES GRANT APPLICATION TO THE STATE LOAN AND INVESTMENT BOARD ON BEHALF OF THE GOVERNING BODY FOR THE

Memorial Hospital of Sweetwater County

FOR THE PURPOSE OF:

The hospital is currently looking to renovate the current laboratory to increase spacing both in the front end where patients are admitted for lab testing as well as in the back end to accommodate the testing equipment that the hospital has purchased to combat the COVID-19 pandemic.

(State Purpose of Project)

W I T N E S S E T H

WHEREAS, the Governing Body for the
Memorial Hospital of Sweetwater County
desires to participate in the HEALTH AND HUMAN SERVICES CAPITAL CONSTRUCTION ARPA GRANTS program to assist in financing this request; and

WHEREAS, the Governing Body of the
Memorial Hospital of Sweetwater County
recognizes the need for the request; and

WHEREAS, the Health and Human Services Capital Construction ARPA Grant program requires that certain criteria be met, as described in the State Loan and Investment Board's Rules and Regulations governing the program, and to the best of our knowledge this application meets those criteria; and

WHEREAS, if any of the disbursed grant funds are later deemed to not comply with the SLIB criteria or the criteria of the American Rescue Plan Act (ARPA), the grant applicant agrees to repay the ineligible grant funds within 15 days of such finding to the Office of State Lands and Investments.

NOW, THEREFORE, BE IT RESOLVED BY THE GOVERNING BODY OF THE
Memorial Hospital of Sweetwater County
that a grant application in the amount of $ 4,350,000.00

(Amount being requested)

be submitted to the State Loan and Investment Board for consideration at the next Board meeting after application processing
to assist in funding the

Laboratory Renovation

(Name of Funds Requested)

BE IT FURTHER RESOLVED, that

Irene Richardson, MHSC CEO; Tami Love, MHSC CFO; Tiffany Marshall, Executive Director of Memorial Hospital Foundation

(Name and Title of Person(s))

are hereby designated as the authorized representatives of the
Memorial Hospital of Sweetwater County
to act on behalf of the Governing Body on all matters relating to this grant application.
PASSED, APPROVED AND ADOPTED THIS

4	day of	August	2022
(Date)		*(Month)*	*(Year)*

(Signature)

Barbara Sowada; Memorial Hospital of Sweetwater County Trustee President

(Name and Title)

Attest:

(Signature)

Cindy Nelson; Executive Assistant to Memorial Hospital CEO

(Name and Title)

Resolution Number 2

Entitled: A RESOLUTION AUTHORIZING SUBMISSION OF AN ARPA HEALTH AND HUMAN SERVICES GRANT APPLICATION TO THE STATE LOAN AND INVESTMENT BOARD ON BEHALF OF THE GOVERNING BODY FOR THE

Memorial Hospital of Sweetwater County

FOR THE PURPOSE OF:

The hospital is currently looking to renovate the Medical Office Building entrance and first floor waiting area to properly accommodate social distancing in the waiting area, minimize unnecessary foot traffic in the area, and expand the entrance area to address the airflow when entering the building.

(State Purpose of Project)

W I T N E S S E T H

WHEREAS, the Governing Body for the
Memorial Hospital of Sweetwater County
desires to participate in the HEALTH AND HUMAN SERVICES CAPITAL CONSTRUCTION ARPA GRANTS program to assist in financing this request; and

WHEREAS, the Governing Body of the
Memorial Hospital of Sweetwater County
recognizes the need for the request; and

WHEREAS, the Health and Human Services Capital Construction ARPA Grant program requires that certain criteria be met, as described in the State Loan and Investment Board's Rules and Regulations governing the program, and to the best of our knowledge this application meets those criteria; and

WHEREAS, if any of the disbursed grant funds are later deemed to not comply with the SLIB criteria or the criteria of the American Rescue Plan Act (ARPA), the grant applicant agrees to repay the ineligible grant funds within 15 days of such finding to the Office of State Lands and Investments.

NOW, THEREFORE, BE IT RESOLVED BY THE GOVERNING BODY OF THE
Memorial Hospital of Sweetwater County
that a grant application in the amount of $ 1,066,000.00

(Amount being requested)

be submitted to the State Loan and Investment Board for consideration at the next Board meeting after application processing
to assist in funding the

Medical Office Building Renovation

(Name of Funds Requested)

BE IT FURTHER RESOLVED, that

Irene Richardson, MHSC CEO; Tami Love, MHSC CFO; Tiffany Marshall, Executive Director of Memorial Hospital Foundation

(Name and Title of Person(s))

are hereby designated as the authorized representatives of the
Memorial Hospital of Sweetwater County
to act on behalf of the Governing Body on all matters relating to this grant application.
PASSED, APPROVED AND ADOPTED THIS

4 *(Date)* day of August *(Month)* 2022 *(Year)*

(Signature)

Barbara Sowada; Memorial Hospital of Sweetwater County Trustee President

(Name and Title)

Attest:

(Signature)

Cindy Nelson; Executive Assistant to Memorial Hospital CEO

(Name and Title)

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
CREDENTIALING POLICY

POLICY:

Practitioners applying for Medical Staff or Non-Physician Professional (NPP) membership and clinical privileges at Memorial Hospital of Sweetwater County (the "Hospital" or MHSC) must submit required application materials. The Hospital will accept and process applications for only those Applicants who can demonstrate that they can fulfill the Minimum Qualifications for membership and criteria for specific privileges requested as outlined in the Medical Staff Bylaws, Rules & Regulations, and applicable clinical privilege forms.

If a Practitioner does not meet the Minimum Qualifications, they are not eligible to apply for Medical Staff membership and clinical privileges. Applications will not be sent to Practitioners in those specialties in which privileges have not been developed, in which services are not offered at the Hospital, or for which there is an exclusive contract arrangement and the potential Applicant is not a part of the group holding the exclusive contract.

The Hospital will consider the application a pre-application until eligibility of the Applicant for Medical Staff membership is established. Upon establishment of eligibility (i.e. Minimum Qualifications are met), the application will become an official application and will be moved forward in the process. An application that is incomplete, or becomes incomplete at any time during the review process, will no longer be processed.

Completed applications shall be reviewed by the Department Chair, Credentials Committee, and their recommendations forwarded to the Medical Executive Committee, whose recommendations shall be acted upon by the Hospital Board of Trustees.

I. Definitions

APPLICANT: A Physician or Non-Physician Provider (NPP) submitting an application for Medical Staff membership and/or clinical privileges at the Hospital.

COMPLETED APPLICATION: A complete application means that all required documentation has been submitted by the Applicant and that:

- All information was verified and there is nothing missing from the file;
- All gaps in time of six months or more are accounted for;
- Any discrepancies between information provided by the Applicant and the information verified by the Hospital have been resolved.

CLINICAL PRIVILEGES: Authorization granted by the Board of Trustees to a Practitioner to provide specific care, treatment, or services in the organization within well-defined limits, based on the following factors: license, education, training, experience, competence, health status, and judgment.

CREDENTIALING: The process of obtaining, verifying, and assessing the qualifications of a Practitioner to provide care or services in, or for, a health care organization.

CREDENTIALS: Documented evidence of licensure, education, training, experience, or other qualifications.

DESIGNATED EQUIVALENT SOURCE: Selected agencies that have been determined to maintain specific item(s) of credential(s) information that is identical to the information at the primary source. An example is: The American Medical Association (AMA) Physician Masterfile for verification of a physician's medical school graduation and postgraduate education completion.

DISTANT SITE: The site where the Practitioner delivering tele-medicine services is located.

ORIGINATING SITE: The location of the patient at the time a tele-medicine service is being furnished.

PRACTITIONER: All Physicians and Non-Physician Providers (NPP's) admitted to the Medical Staff.

PRIMARY SOURCE VERIFICATION: Obtaining verification from the primary source of a Practitioner's credentials; e.g. the Practitioner's academic institution, internship/residency program, hospital affiliations, references, etc.

PRIVILEGING: The process used to determine if credentialed Practitioners are competent to perform their assigned responsibilities, based on training, and evaluation of the individual's credentials and performance.

QUALIFICATIONS: Knowledge, education, training, experience, competency, licensure, registration, or certification related to specific responsibilities.

STAFF or MEDICAL STAFF: The formal organization of all Practitioners who are approved by the Hospital's Board of Trustees to attend patients in the Hospital. Members include Physicians and Non-Physician Providers.

II. Procedure

A. Initial Application Process

Each Practitioner applying for Medical Staff or Non-Physician Provider (NPP) membership and clinical privileges will be given an application packet, including these additional documents:

- Appropriate privilege list(s)
- Employee Health Requirements and Questionnaires
- Consent for Background Check
- Application for Malpractice Insurance (if Practitioner will be employed by MHSC)

B. Burden of Applicant

The Applicant for staff membership and privileges shall have the burden of producing adequate information for a proper evaluation of his/her professional, ethical, and other qualifications for membership and clinical privileges and for resolving any doubts about such qualifications. The Practitioner applying for Medical Staff or NPP membership and clinical privileges, shall provide all

the information required by the application packet to the Medical Staff Office, along with the items listed below.

1. Copy of applicable current Wyoming professional license;
2. Copy of current DEA registration, if applicable;
3. Copy of Wyoming State Board of Pharmacy registration (CSR), if applicable;
4. If employed by the Hospital, the Medical Staff Office will assist the Practitioner with applying for malpractice insurance. If Practitioner is not employed by the Hospital, they will need to provide documentation of current malpractice insurance coverage, showing carrier and carrier contact information, policy number, dates of coverage as well as the amount of coverage. Minimum limit of liability must be $1,000,000/$3,000,000;
5. Contact information (phone, email, and/or fax numbers) for three references who meet the requirements listed in the application for initial appointment. All references shall be able to attest regarding Applicant's suitability for Medical Staff membership, and ability to safely and competently exercise the clinical privileges requested in his/her chosen field;
6. Evidence of TB testing per hospital policy;
7. Documentation of required immunizations;
8. Copy of appropriate Board certification (if applicable), or confirmation of Board-certification eligibility;
9. Copy of curriculum vitae;
10. Copy of government-issued photo identification, i.e. driver's license or passport;
11. Documentation of CME for the past three years, if applicable;
12. Evidence of negative drug test results (for all new Hospital-employed Practitioners);
13. Application fee (submitted with application)
    a. $100 non-refundable application fee for initial appointment; or
    b. $50 non- refundable application fee for reappointment.

C. Initial Granting of Privileges

1. The Medical Staff Office reviews the application, requested privileges, and supporting materials submitted by the Applicant and confirms that the Applicant meets the Minimum Qualifications.
2. The Medical Staff Office reviews the application, requested privileges, and supporting materials submitted by the Applicant and requests any missing items or information. If an application remains incomplete within six (6) months of initial opening, it shall be considered to have been abandoned, and shall be closed permanently. If an incomplete application is closed after six (6) months, this does not give rise to a fair hearing. If an Applicant wants to apply after an incomplete application has been closed, they will be required to submit a new application and application fee.
3. Once all requested information has been submitted by the Applicant, the Medical Staff Office reviews the application to determine if it is complete. When the application is deemed to be a Completed Application, the Medical Staff Office shall be responsible to review the application for veracity. Initiation of the verification process will begin within a reasonable time period after receipt of a Completed Application.
4. The Medical Staff Office (MSO) confirms the information provided by the Applicant using Primary Source Verification, or Designated Equivalent Sources, by doing the following:
    a. Querying the National Practitioner Data Bank (NPDB), Federation of State Medical Boards (FSMB), American Medical Association (AMA), American Osteopathic

Association (AOA), or other applicable medical or surgical specialty board, Office of Inspector General (OIG), Fraud and Abuse Control Information System (FACIS), Excluded Parties Listing System (EPLS).

b. Querying the medical licensing board in each state in which the Practitioner has practiced, and verifying that there have been no successful challenges to licensure, certification or registration. The Practitioner's Wyoming license will be verified at the time of initial granting, expiration/renewal, and reappointment.
c. Entering application information into the credentialing software system.
d. Requesting information regarding any malpractice claims which have been filed or are in process.
e. Verifying education and training;
f. Completing background check;
g. Querying the Practitioner's references to verify that the Practitioner is competent to perform the requested privileges;
h. Querying the Practitioner's current and past hospital affiliations (for the past ten years.)

5. The Department Chair reviews the Applicant's file to determine whether he or she meets the established criteria for requested privileges.
6. The Medical Staff Office and/or Department Chair request additional information or materials from the Applicant, if necessary.
7. The Applicant provides any additional information or materials requested by the Medical Staff Office and/or Department Chair.
8. The Department Chair makes written recommendations regarding the requested privileges (for example, approval, modification, denial) to the Credentials Committee.
9. The Credentials Committee reviews the Applicant's file and the Department Chair's recommendations.
10. The Credentials Committee requests additional information or materials, if necessary.
11. The Applicant provides any additional information or materials requested by the Credentials Committee.
12. The Credentials Committee makes written recommendations regarding the requested privileges (for example, approval, modification, denial) to the Medical Executive Committee.
13. The Medical Executive Committee reviews the recommendations of the Credentials Committee at its next regularly scheduled meeting. The Medical Executive Committee may do one of the following:
    a. Recommend, modify, or deny any portion of the requested privileges; or
    b. Return the request to the Credentials Committee for further review.
14. The Board of Trustees acts on recommendations from the Medical Executive Committee regarding the requested privileges at its next regularly scheduled meeting.
15. The Medical Staff Office sends a letter (signed by the CEO) notifying the Applicant of the Board's decision regarding the requested privileges. The letter and a copy of the delineation of privileges is also posted to Policystat, which is accessible to all Hospital Departments. The letter to the Applicant contains the following information:
    a. Specific clinical privileges granted to the Applicant
    b. Staff category to which the Applicant is appointed
    c. Department to which the Applicant is assigned (Surgery or Medicine)
    d. Duration of the individual's appointment to the identified staff category (not to exceed 24 months)

e. Any conditions or restrictions that may apply to the appointment or clinical privileges granted

16. The CEO or designee promptly notifies the Medical Executive Committee (MEC), if the Board of Trustees' decision is inconsistent with the MEC's recommendation, in accordance with Medical Staff Bylaws, Rules & Regulations.
    a. These notifications are made in writing.
    b. The CEO or their designee ensures that all appropriate external agencies, organizations, and other entities receive notification of the decision, as described in the Medical Staff Bylaws, Rules & Regulations.
17. If there is a decision to deny privileges, the CEO or designee promptly provides the Applicant with information on the Fair Hearing and Appeal Policy and its procedures.
18. Except as otherwise determined by the Medical Executive Committee or Board of Trustees, a Medical Staff member applying for appointment or reappointment and clinical privileges, who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment and clinical privileges while under investigation or to avoid an investigation, is not eligible to reapply to the Medical Staff of MHSC for a period of five (5) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such re-application is processed in accordance with the procedures then in effect. As part of the reapplication, the Practitioner must submit such additional information as the Medical Staff and/or Board of Trustees requires, demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

D. Reappointment Process

1. At least ninety (90) days before the expiration of a medical staff appointment or expiration of privileges, the Medical Staff Office shall send a reappointment packet to the Applicant. When the completed application is received, all new information will be verified for accuracy. The Medical Staff Office will also gather information from Quality concerning On-going Professional Performance Evaluation (OPPE), patient experience and/or patient satisfaction scores, and any other pertinent data.
2. The Medical Staff Office only conducts background checks (and drug/alcohol screenings, as applicable) at initial appointment. Thereafter, the process for re-appointment shall be the same as for initial Appointment as to the review and recommendation of the Department Chair, Credentials Committee, and the Medical Executive Committee, and the action of the Board of Trustees.
3. If a Practitioner has requested a leave of absence during the time that his or her privileges are up for reappointment, the process outlined in the Medical Staff Bylaws Article VIII, section 6 (Leave of Absence) and section 7 (Termination of Leave), shall be followed.

E. Credentialing of Tele-Medicine Practitioners

1. All Practitioners who are providing telemedicine services to patients at MHSC, must be granted privileges at MHSC.
2. The Practitioner shall be credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in the Medical Staff Bylaws and Rules & Regulations with the exception that the credentialing information and/or privileging decision from the distant site may be relied upon by the Medical Staff and the Board of Trustees in making its recommendations/decision, provided that the Hospital has entered into a written agreement with the distant site and all of the following requirements are met:
   a. The clinical services offered via a telemedicine link are consistent with commonly accepted quality standards.
   b. The Medical Staff recommends which clinical services are appropriately delivered by Practitioners through a telemedicine link.
   c. The distant site hospital is accredited by the Joint Commission or is a Medicare-participating organization.
   d. The individual distant site Practitioner is privileged at the distant site for those services to be provided to Hospital patients via telemedicine link and the Hospital is provided with a current list of his/her privileges at the distant site.
   e. The individual distant site Practitioner holds an appropriate license issued by the State of Wyoming by the appropriate licensing entity.
   f. The originating site has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the Practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site physician or licensed practitioner from patients, physicians or licensed practitioners, or staff at the originating site. This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law.
   g. When the distant site is a "distant site telemedicine entity" the written agreement shall specify that the distant site telemedicine entity is a contractor of services to the Hospital and, as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable conditions of participation for the contracted services including, but not limited to, 42 C.F.R. 482.12 (a)(1) through (a)(9) with regard to the distant site telemedicine entity Practitioners providing telemedicine services. The written agreement shall further specify that the distant site telemedicine entity's medical staff credentialing and privileging process and standards will, at minimum, meet the standards at 42 C.F.R. 482.12 (a)(1) through (a)(9), as that provision may be amended from time to time.

F. Request of Additional or Modified Privileges

1. The Medical Staff member submits a written request for additional or modified privileges to the Medical Staff Office.
2. The Medical Staff member provides documentation supporting the request, showing competency for the additional or modified privileges, including but not limited to the following:
   - Documentation of training
   - Certificates or licensing
   - Relevant experience
3. The Medical Staff Office will inform the Department Chair, Credentials Committee, MEC, and the Board of Trustees of the request for additional or modified privileges.
4. When a request for additional or modified privileges is submitted, the Medical Staff Office will run a current NPDB query.
5. If the request for additional or modified privileges coincides with the Medical Staff member's reappointment, the reappointment process is followed.
6. The Department Chair reviews the Applicant's file to determine whether he or she meets the established criteria for requested privileges.
7. The Department Chair makes written recommendations regarding the requested privileges (for example, approval, modification, denial).
8. The Credentials Committee reviews the Applicant's file and the Department Chair's recommendations.
9. The Credentials Committee makes written recommendations regarding the requested privileges to the Medical Executive Committee.
10. The Medical Executive Committee reviews the recommendations of the Credentials Committee at its next regularly scheduled meeting.
11. The Medical Executive Committee may do one of the following:
    - Recommend, modify, or deny any portion of the requested privileges; or
    - Return the request to the Credentials Committee for further review.

19. The Board of Trustees acts on recommendations from the Medical Executive Committee regarding the requested privileges at its next regularly scheduled meeting.
20. The Medical Staff Office sends a letter (signed by the CEO) notifying the Applicant of the Board's decision regarding the requested privileges. The letter and a copy of the delineation of privileges is also posted to Policystat, which is accessible to all Hospital Departments. The letter to the Applicant contains the following information:
    - Specific clinical privileges granted to the Applicant
    - Staff category to which the Applicant is appointed
    - Department to which the Applicant is assigned (Surgery or Medicine)
    - Duration of the individual's appointment to the identified staff category (not to exceed 24 months)
    - Any conditions or restrictions that may apply to the appointment or clinical privileges granted

21. The CEO or designee promptly notifies the Medical Executive Committee (MEC), if the Board of Trustees' decision is inconsistent with the MEC's recommendation, in accordance with Medical Staff Bylaws, Rules & Regulations.
    - These notifications are made in writing.
    - The CEO or their designee ensures that all appropriate external agencies, organizations, and other entities receive notification of the decision, as described in the Medical Staff Bylaws, Rules & Regulations.
22. If there is a decision to deny privileges, the CEO or designee promptly provides the Applicant with information on the Fair Hearing and Appeal Policy and its procedures.

G. Temporary Privileges

1. In order to grant temporary clinical privileges pursuant to the Medical Staff Bylaws, the Medical Staff Office will obtain a completed application and privilege delineation form as well as primary source verification of the items listed previously in this policy.
2. The requirements of the Medical Staff Bylaws must be met for any application for temporary Medical Staff membership and clinical privileges.
3. Temporary privileges may be granted only by the Chief Executive Officer in conjunction with the Department Chair and the Chief of Staff.
4. The Practitioner's application for clinical privileges shall go through the ordinary clinical privileging process outlined herein (to the extent the application does not go through this process in the temporary clinical privilege process), as soon as possible after the granting of temporary clinical privileges.
5. The Practitioner shall not be eligible for temporary privileges if:
    a. The Practitioner submits an incomplete application for Medical Staff or NPP membership and clinical privileges;
    b. There is a current challenge or previously successful challenge to the Practitioner's licensure;
    c. The Practitioner has received an involuntary termination of his or her medical staff membership at another hospital;
    d. The Practitioner has received involuntary limitation, reduction, denial or loss of clinical privileges.

III. Reapplication After Initial Appointment or Resignation

A. If a Staff Member's Membership or clinical privileges expire, or the Staff Member resigns, while in good standing, the Staff Member may apply for reappointment to the Medical Staff.
    1. The Practitioner shall be required to provide all information required by the application form most recently approved by the Medical Staff and Board of Trustees. If the Medical Staff Member is reapplying after less than twelve (12) months of non-membership, they will be required to complete a reappointment application. If they are applying after more than 12 months of non-membership, they will be required to complete an application for initial appointment.
    2. If the Staff Member is reapplying after less than 12 months of non-Membership, the Medical Staff Office shall not be required to verify such information as the Practitioner warrants is

accurate, unless the information is of a type identified by the Credentials Committee as lacking sufficient reliability after six (6) months, such as results of a state licensing board query.

3. The Medical Staff Office shall contact the Practitioner's references and verify that each reference is still accurate and unchanged.

IV. Review and Approval of Credentialing Policies

All policies must be reviewed and approved by the Credentials Committee, every two years. With the exception of technical corrections made by MHSC staff related to reorganization, renumbering, punctuation, spelling, or grammar related changes, all policy amendments require Credentials Committee review and approval.

References

Joint Commission Standard MS.06.01.05, EP 4. The hospital has a clearly defined procedure for processing applications for the granting, renewal, or revision of clinical privileges.

Joint Commission Standard MS.06.01.05, EP 5. The procedure for processing applications for the granting, renewal, or revision of clinical privileges is approved by the organized medical staff.

Joint Commission Standard MS.13.01.01 For originating sites only: Physicians or licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.

Joint Commission Standard MS.13.01.03 For originating and distant sites: The medical staffs at both the originating and distant sites recommend the clinical services to be provided by licensed independent practitioners through a telemedical ink at their respective sites.

Memorial Hospital of Sweetwater County Medical Staff Bylaws and *Rules & Regulations*, approved March 2022.

Quality Committee Meeting of July 20th

The mission moment for this meeting was a very complimentary note written about our ICU.

Joint Commission survey was reviewed and it was noted that there were very few findings and the findings were either low or moderate. Out of 970 elements, we only received 9 findings which is a 99.3% overall.

Dialysis survey was discussed briefly as there were no findings.

Safety survey was discussed briefly as well, again there were no findings.

ED-2B will add an additional week of data as the census was too low for accurate analysis.

It was suggested that writings by Don Berwick might be good for review as he shares great information about patient safety.

Quality Committee Meeting
Memorial Hospital of Sweetwater County
July 20, 2022

Present: ***Voting Members:*** Mr. Taylor Jones (Quality Board Chair), Kara Jackson (Quality Director), Dr. Kari Quickenden (CCO), Dr. Melinda Poyer (CMO), Ed Tardoni (Quality Board Member), Dr. Ann Marie Clevenger (CNO), Tami Love (CFO), Leslie Taylor (Clinic Director), Dr. Alicia Gray, Dr. Banu Symington, Irene Richardson (CEO),

Non-voting Members: Cindy Nelson, Jennifer Rogers, Valerie Boggs, Corey Worden,

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

Non-voting Members: Kalpana Pokhrel, Karali Plonsky, Noreen Hove

Guests: Dr. Barbara Sowada (Board of Trustees Chair), Kandi Pendleton (Board of Trustee), Marty Kelsey (Board of Trustee)

Chair: Taylor Jones

Approval of Agenda & Minutes
Meeting was called to order at 8:15 am. Mr. Jones presented the Agenda for approval. Dr. Poyer motioned to approve, Ms. Richardson seconded. Motion carried. Mr. Jones then presented the June 15, 2022 Minutes for approval. Mr. Tardoni motioned to approve and Dr. Quickenden seconded. Motion carried.

Mission Moment
Ms. Nelson shared a note cared Ms. Richardson had received in the mail. This person wanted to thank the ICU staff for the care and kindness their brother and family members received, during a difficult time of family loss.

Mr. Jones related an occurrence from the Commissioner's meeting the previous day, where Ms. Richardson and Ms. Tiffany Marshall, Foundation Director spoke about upcoming renovations to the hospital. A lot of hard work went into the pre-planning and presentation. Mr. Jones also wanted recognize the generosity of the Commissioners. Ms. Richardson reiterated her thanks, and commend our "A-Team"! They have been diligently working together on all these plans and grants for the past few years. The team includes Tiffany Marshall, Tami Love, James Horan – Facilities Director, Gerald Johnston – Project Manager/Maintenance Supervisor, Mary Fischer – Lab Director and Will from PlanOne.

Old Business
No old business to discuss.

New Business
Dr. Quickenden presented an update to the June 15-17 Joint Commission Survey of the Clinical Laboratory. We had only 9 findings, none which were in the high/immediate threat to life category. Many were clerical or EMR records, and with us being so close to the Cerner conversion, they just needed some cleaning up. One was as simple as an address, one was a

humidity log for Environment of Care. Some "clean-up" of the competency process was needed. The others were related to clarification of processes, again some of this was due to the Cerner conversion. The Surveyor noted there are 970 elements, so having only 9 findings is great. Compliments to the lab staff for their hard work.

Dr. Clevenger presented an update to the Wyoming Department of Health Survey of the Dialysis Unit. This survey came out with no recommendations. The only request the Surveyor had was to continue with temperature checks and masks in this area, as these are high risk patients. This was initiated immediately, while the Surveyor was still here. During that same time, we also had a Life Safety Surveyor come to survey for Emergency Operations for Dialysis. That also was cleared without any recommendations.

Medical Staff Update

Dr. Poyer gave the Medical Staff update. Today we have our Joint Physician, Emergency Room and Hospitalist meeting, where we continue to look for improvements in Patient Experience and HCHAPS. We continue to involve the General Medical staff and the Medical Executive Committee (MEC). Dr. Crofts has committed to reviewing each and every question at the next MEC meeting. We are working closely with Dr. Hopkins, to identify the new ED Medical Director. Dr. Poyer noted the request was that this provider has a platform based in improving the patient experience and continued improvement in Quality and Sepsis.

Informational Items for Review/Discussion

Ms. Jackson reviewed the Control Charts and summaries, pulling out points of interest. PC-06, Unexpected Complications of the Term Newborn, had a spike in May. Typically, our control number is 0-1, this month we had 4, of those 3 were moderate complications and 1 was a severe complication. These are being reviewed by Perinatal committee. The severe complication was a transfer to a higher level of care and these automatically become a fallout.

Mr. Tardoni noted his understanding that most of these complications can occur and, in most cases, would require a higher level of care than we at MHSC could provide. Which means transferring is the best choice for the newborn. But that transferring will show up as a "fall out". Dr.'s Quickenden and Clevenger agreed with that assessment.

Dr. Quickenden noted HCAHPS was part of our PIPS priority and we are working on those initiatives and how we are going to tackle them and should have a better update next month.

Mr. Jones questioned any updates from Patient Safety. Ms. Jackson noted this committee was launched 1 year ago and it has gone well. They have brought a lot of data up to committees for reporting. We continue to look for opportunities for improvement.

Dr. Quickenden updated the presented information on Workplace Violence within the Risk Dashboard and Summary. It was questioned last month what type of violence were we encountering, which the committee has been evaluating and breaking out into sub-categorization. In turn they are working with Human Resources to ensure they aren't doing double work.

Mr. Taylor asked about our process for evaluating grievances. Dr. Quickenden and Ms. Richardson both spoke to the fact that every grievance is taken seriously and researched. Each occurrence is evaluated to determine if level of care was met, and whether there was anything

we could do to improve the outcome. Mr. Tardoni noted a grievance is often more valuable than a compliment, as each was an opportunity for learning.

Dr. Quickenden then gave an overview of the Medication Dashboard and Summary. Medication errors continue to be reported up through Synergi, fortunately we haven't had any severe errors. As part of PIPS we are working on barcode medication scanning. We are also working on reducing PYXIS overrides. Additionally, we are looking into a better sign in process for scanning. The current process requires signing in at multiple steps, but a process is available through Cerner that we are working on for next budget.

Mr. Jones stated we have reached the end of our Agenda with plenty of left-over time. He questioned did we cover everything effectively. Mr. Tardoni noted the Informational Items for Review/Discussion are interesting and helps us properly focus on the information. The group agreed the overview of the Informational items was beneficial, and the summaries help to better understand, without missing important information.

Meeting Adjourned The meeting adjourned at 9:16 am

Next Meeting August 17, 2022 at 08:15 am via ZOOM.

Respectfully Submitted,

_____

Robin Fife, Recording Secretary

MEMORANDUM

To: Board of Trustees
From: Wm. Marty Kelsey
Subject: Chair's Report…July Building and Grounds Committee Meeting
Date: July 26, 2022

Medical Imaging Renovation…project is 100% complete!

Pharmacy Chemo Mixing Room…the final plans are completed…just waiting on final sign offs. Cost estimates are being developed.

Dr. Sulentich's Office Renovation…Work won't commence until September due to not all materials being on site.

Building Automation System…project is about half completed. Hopefully the project will be completed by September 1st.

Bulk Oxygen Project…project is progressing slowly. Concern was expressed about getting it done before harsh winter conditions set in. Still waiting on some materials. The existing tank still needs to be removed. A temporary tank will be installed until the permanent tank can be put in place.

Lightning Arrest System…a certified UL installer must be retained to work on this project. A local contractor is apparently trying to get certified. Until a certified installer is retained, a price for the work cannot be obtained. If the ultimate price comes in significantly higher than originally estimated, the Hospital will need to reassess the necessity of the project from a risk management point of view.

OB Shower Project…staff would like to get this project completed this fiscal year.

SLIB Project(s)…extensive discussion occurred regarding the two possible SLIB projects…Lab Expansion and MOB Entrance Renovation. The Commissioners voted to provide $3 Million in matching funds with the possibility of more if needed. County maintenance funds could be used to help fund the match; however, I urged caution here. We need all the annual maintenance money from the County and we don't want to send a signal that these funds can easily be repurposed into capital construction. Concern was also expressed regarding the MOB Entrance Project…the # 2 priority. We must be careful that attempting to forge ahead with this project does not jeopardize the # priority. Getting adequate matching funds for both may be difficult. A special Finance and Audit Committee is set for August 1st to further discuss this matter and to formulate a recommendation for the full Board to consider on August 3rd.

The Committee determined that no changes were needed to be made to the B & G Charter.

For more detail, please refer to the B & G Committee meeting minutes in the packet.

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
Building and Grounds Committee Meeting
July 19, 2022

The Building and Grounds Committee met in regular session via Zoom on July 19, 2022, at 3:30 PM with Mr. Marty Kelsey presiding.

In Attendance: Mr. Marty Kelsey, *Trustee - Chair*
Mr. Ed Tardoni – *Trustee*
Ms. Irene Richardson, *CEO*
Ms. Tami Love, *CFO*
Mr. Gerry Johnston, *Facilities Supervisor*
Mr. Will Wheatley, *PlanOne Architects*
Ms. Tiffany Marshall, *Guest*

Absent/Excused: Mr. James Horan, *Director of Facilities*

Mr. Kelsey called the meeting to order.

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

Mr. Kelsey asked for a motion to approve the minutes from the June 21, 2022 meeting. Mr. Tardoni made a motion to approve the minutes. Ms. Love seconded; motion passed.

Maintenance Metrics

No discussion.

Old Business – Project Review

Medical Imaging Renovation

Ms. Love reported the final work on the doors had been completed and signed off. The final payment and retainage had been sent and this project is officially completed.

Pharmacy Chemo Mixing Room

Mr. Wheatley sent the revised plan to staff and we are waiting on approval from all parties. The next steps will be to get pricing so we can bring for approval to move forward. Mr. Tardoni and Mr. Kelsey asked to see the drawings before going to the Board for approval.

Dr. Sulentich Office

Mr. Wheatley said A Pleasant Construction reported the delivery of the updated flooring material is still delayed so the start has been pushed to September. The contractor has communicated this to Dr. Sulentich and his team.

Building Automation System

Mr. Johnston said we are at about 50% completion. We are waiting on Harris and Vaughn's to come back onsite, mid-August, to complete.

Bulk Oxygen

Mr. Johnston said they are still waiting on some materials for this project. There has been scheduling discussions with the third party who is doing the wiring of the temporary tank and Airgas regarding the delivery and set up of the temporary tank. This must be complete before the old tank and concrete can be removed. They are looking at July 28-29 for the delivery of the temporary tank. There was discussion about the concern of running into winter conditions. The material is currently being delivered to the contractor. Mr. Kelsey asked about the excavation around the utility lines. Mr. Johnston said none of that will start until the old tank can be removed which can't happen until the temporary tank is installed and working.

Lightning Arrest System

Mr. Johnston said a Wyoming contractor is looking at getting their UL certification and then they will be able to place a bid. Mr. Kelsey had asked Mr. Horan to look at Utah and Colorado for other options. All agreed that a local UL certified and Wyoming licensed contractor would be best.

Tabled Projects

Ms. Love said we would still like to make the OB Showers a priority this fiscal year with our County funds. Mr. Johnston said the powerhouse roof can be done in the spring if funds are available. Mr. Kelsey asked about the current roof. Mr. Johnston said the current roof is ballasted and they would like to replace with a fully adhered roof.

Old Business - Other

SLIB Project

Ms. Richardson said the group went to the County Commissioner meeting today. Ms. Marshall presented to them our projects for SLIB and a request for matching funds. We had a lot of support from the Commissioners and they approved to match $3 million for our projects. ARPA funds can not be used to match SLIB funds so this money will come from other County funds. We would like to submit our applications by August 5 with the due date being August 15. Ms. Marshall shared the presentation with the committee. We have to meet the following timeline regarding matching funds: 33% by 6 months after grant award, 66% with 12 months and 100% by December 30, 2023.

The Foundation meeting is next week and they will be discussing any funds they have available for matching also. Mr. Kelsey thanked Ms. Marshall, on behalf of the Board, for the presentation to the Commissioners. He said it looked optimistic we would have matching funds

for the Lab project as our first priority. Ms. Marshall said she is confident we will have commitment for all of the matching funds. She feels we will be more competitive if we can go in with 100% matching funds available now. We do need to have letters of support from the Commissioners and the Foundation by August 5 to submit with the applications.

Ms. Richardson said we also have our regular County Maintenance funds we can show as matching funds. We could then go back to the County to ask for more to replenish the Maintenance funds. Mr. Kelsey commented on the good discussion and he suggested we have a strategy to present to the Board on August 3rd. We will schedule a special Finance & Audit meeting, after the Foundation meets July 28, to finalize a presentation for the full Board.

New Business

The Committee reviewed the Building & Grounds charter and approved with no changes.

Other

The next meeting will be held August 16, 2022 at 3:30 p.m. Mr. Kelsey adjourned the meeting at 4:45 p.m.

Submitted by Tami Love

Chairs Report

Compliance Committee Meeting, July 2022

Overtime Audit has been completed. Irene and Susan are looking over the information now and will present it to the committee next month and then onto the full board if needed.

Cybersecurity was discussed and will be audited this year. The new IT director will be heavily involved. More discussion will take place in the next several months.

The Compliance Audit will begin soon. Susan presented the monitoring checklist she's going to use as a starting point. She'll update it with specific Memorial Hospital information.

Susan also spoke about the 21 top management risks and what would fall under the compliance committee. The biggest threat and our focus right now is cybersecurity.

Fair Warning Report currently shows possible HIPAA violations from the old legacy system and the new P2Sential system. We had a length discussion about the timeline between the violation and the item being closed. HR will continue to work with the other leaders & directors to get violations dealt with and closed in a timely manner. Susan & Irene also discussed a training or reminder to the staff about HIPAA.

For additional information please refer to the Compliance Packet & Minutes.

Kandi Pendleton

Board Compliance Committee Meeting
Memorial Hospital of Sweetwater County
July 25th, 2022

Present via Zoom: Irene Richardson, *CEO*, Suzan Campbell, *In House Counsel*, Kandi Pendleton, *Trustee-Chair*, Taylor Jones, *Trustee,* April Prado, *Foundation & Compliance*

Minutes

Call to Order
The meeting was called to order at 9:00 am by Kandi Pendleton.
Agenda
The June agenda was approved as written, Irene made the motion and Suzan seconded it. Motion carried.
Meeting Minutes
The meeting minutes from June 2022 were presented. Irene made the motion to approve the minutes as written and Suzan seconded. Motion carried.

Old Business

1. Overtime Audit. Suzan reported that the audit is complete on April's end. Herself, Irene and April will be meeting on Wednesday to finalize it and then it will be presented to this Board. Suzan added that she might not wait until the meeting next month to present it and will more than likely send it out before. It was noted that this Board will have to approve the audit and decide where it goes from there.
2. Cybersecurity Audit. Suzan reported that this will be the next audit that Compliance will be undertaking. She stated that she has already spoken to the I.T. Director, T.J., who is excited and completely onboard for this. It was reported that April will be researching cybersecurity audits and looking for applicable compliance items to audit. Suzan added that we have some great information to work with from insurance and I.T.. She noted that we will be only auditing the compliance side of this, specifically, what insurance we have in place for attacks and what we might need. Kandi said that our employee David Beltran had recently done a presentation on this type of thing and that it was very interesting just how many people would be involved in a cybersecurity attack and how quickly operations could be shut down. She spoke about the example given of ransom being requested and how a whole business was shut down for days. Irene added that we had a situation last year where an employee clicked and added information from an email and we had to work with attorneys and nothing ever fully happened but it was a scare. She continued that the attorneys stated that our multi-factor authentication is a great way to prevent these things. Taylor asked if the hospital was still performing penetration tests and Suzan said that she believes that we are but will check with I.T..

New Business

1- Compliance Audit. Suzan presented a "Compliance Monitoring Checklist" for the Board's information. She explained that she will be using this to find any areas of improvement and as a checklist for items in Compliance. This is just for information and does not need to be approved by the Board.
2- Top 21 Management Risks- Becker's. Suzan reported that this information was found by Irene and herself and is specific to healthcare, coming from Becker's Hospital Review. The

list was presented and Suzan stated that most of the items have already been addressed here but a few will be the responsibility of Compliance and they are; vendor management, physician financial transactions, Emergency Medical Treatment and Labor Act (EMTALA), cybersecurity and ransomware preparedness and new regulations. She continued that this list will be the working for our Compliance Plan when it is reviewed. Taylor asked what physician financial transactions covers. Suzan stated that this is our "Stark Act" and "Anti-kickback Law" and involves who we have physician relationships with, having contracts with them and how patients and business are referred out. She added that it confusing to explain but she has lots of information that she will get out to the Board to better explain it. She added that this has been a big issue in the past but not as much now. She continued that we have to stay on top of it though. Irene stated that Becker's is a national reporting agency and they gather data from lots of facilities. She added that after our assessment, this area received a low impact, low vulnerability score. This means that it calculated really low for impact to the hospital but is still on our radar for review. Suzan reported that the EMTALA issue may move up on the impact scale. She explained that EMTALA provides rights to any person who comes to the emergency department and requires that a triage take place on that person. She continued that the changes to the abortion laws may not cause a huge change with this but it will definitely change it.

Standing Items-Reports

This report was presented and the following items were spoken to,

A. Suzan reported that there is currently no internal or external investigation
B. a. Audits- Suzan reported that the overtime audit is complete.
   b. Cybersecurity review. Suzan reported that the physical plant audit found this as a Compliance area for review. This will be starting September 1st, 2022.
   c. Physical Plant audit- Suzan reported that minus cybersecurity, all other issues identified are being handled in other departments.
C. Hot Line calls- Suzan reported that there were no new reports. She continued that our specialist, Ray, said that getting 4-5 a year is great. Both Suzan and Irene added that the posters are everywhere and that employees have commented about it positively and that Leadership has also been receptive.
D. HIPAA Monitoring/Fair Warning Report- Suzan reported that Fair Warning is now out legacy system and was used for monitoring our old systems. She continued that P2Sentinel is our monitoring system. She explained that all of these have been sent to Amber in H.R. for review and that we are waiting for supervisors to respond. She added that per this committee, the supervisor will be the one doing corrective action and not H.R.. She further explained that Amber is working through them and that more and more will be closing in the near future. Kandi questioned the dates on the top of the report and wanted to know if these were all new reports from that time frame or if these were the open ones in that time frame. April explained that these are the ones that are still open for that time frame. She further explained that there had been issues getting in Fair Warning so we were playing a little bit of catch up but that the reports had been reviewed in H.R. and were mostly waiting for supervisors to decide corrective action. Suzan added that more training was needed to remind employees that they could not access their own record or have their co-worker access it for them. Suzan also reported that we have not received any reports via Synergy, our HIPAA reporting system for patient information being released incorrectly. She stated that this is more concerning that either we are not making any mistakes, or they are not getting reported. Taylor asked for further explanation on our reporting process, stating that

the process seems easy but is not moving. Suzan clarified and stated that he wasn't wrong. She further commented that we are hoping to close the loop on this very quickly. Taylor added that follow-up from Amber is critical and Suzan agreed and added that we are not certain how hard Amber should push supervisors for their corrective actions. Taylor said he felt that she should push as hard as needed and asked if H.R. doesn't have the authority to do corrective action, who does? Suzan stated the committee before had decided that the corrective action should come from the supervisor and not H.R.. She continued that the process needed to be looked at. Taylor clarified that he didn't mean that Amber should do the corrective action but should be the drive in getting it done with no barrier. Kandi asked if there was a time period to have these done and maybe that needed to be addressed. April stated that after reports are received to her, she reviews them and gets them to H.R. within the week. After that, Amber reviews them quickly and gets them to the supervisors. Irene stated that we have educated staff but maybe we should talk to Patty in education about adding a Net Learning chapter for staff to complete. She added that maybe employees don't know that we are monitoring them as much as we are and we could explain it better to them. She said that maybe we could have them sign something stating that they understand and will not get into charts that they shouldn't be in. Suzan added that this was a good idea and we will look into this. She also stated that she hopes to have 90% of these open reports closed before the next meeting.

Next Meeting

The next meeting will be on August 23, 2022 @9:00 am.

Adjournment

The meeting adjourned at 9:40 am

Respectfully Submitted,

_____

April Prado, Recording Secretary

Minutes
Governance Committee Meeting
July 25, 2022

Present: Barbara Sowada, Marty Kelsey, and Irene Richardson

Call to Order: Irene Richardson called the Zoom meeting to order at 2:00 pm

Agenda was approved as written

Minutes had been previously approved

Old Business –

1. Board Self-Assessment survey was discussed. Agreed that the two sections—System Module and Subsidiary Module—be eliminated because the Modules are irrelevant. Also agreed that Question 21 in Board Development section be eliminated because it's confusing.

New Business

1. Will recommend that the Board write letter to County Commissioner recommending that Suzan Campbell be appointed as MHSC's representative to the Miner's Hospital Board.

2. Asked staff for information regarding TJC Leadership requirements for the Board regarding Diversity, Equity, and Inclusion (DE&I). Information was sent to Governance Committee members during meeting. This will be further discussed at August, Governance meeting.

3. Asked whether there is any need for the hospital to have on record any kind of DE&I report comparing hospital staffing against the community's demographics. Irene will explore this and report back at the August meeting.

4. Physician members of Board Committees was discussed with special attention to F&A meeting. Marty will take this to the F&A meeting and report back in September.

5. Governance charter was reviewed. Revision is needed, which Marty will be responsible for drafting the revisions. Will review at August meeting.

6. Due to WHA meeting September 6-9, will recommend that the Board approve changing the September meeting to September 14th.

7. iProtean videos were discussed. Irene suggested videos dealing with physician and staff burnout, patient and staff safety, and HCAHPS scores. Marty suggested strategic planning videos. He also suggested running record kept for all videos that have been watched for Board education. Barbara will make the record and will see what's available in iProtean library for future education.

8. Annual signing of Conflict of Interest document is due. Barbara will work with Cindy to get the document to all Board members for signatures.

The meeting was adjourned at 3:30 pm.

Next meeting is Monday, August 29, 2022, 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: **RQI Online course**

2. Purpose of contract, including scope and description: **The RQI stands for Resuscitation Quality Improvement and it is digital resuscitation portfolio that will include online course (through our learning management system) for BLS (CPR), ACLS (advanced Cardiac Life Support) and PALS(Pediatric Advances Life Support). This contract will also provide the computer simulation station for individual check off. This is a program that will assist our staff with their American Heart Association Required certificates. The annual subscription/ contract would cover the equipment and the seats for this program.**

3. Effective Date: **October 1, 2022**

4. Expiration Date: **three (3) years from Effective Date**

5. Termination provisions: **13.3 Termination for Cause** Is this auto-renew? **No**

6. Monetary cost of the contract: **$46845.60 year one-$42,015.60 year two and $42015.60 year three for total of $130876.80** Budgeted? **Yes**

7. Jurisdiction/Choice of Law provision checked and changed to Wyoming if able to so. **No jurisdiction is New York**

8. Any confidentiality provisions? **Yes 9.2 as to proprietary information of software and resuscitation technology**

9. Indemnification clause present? **Yes mutual indemnification section 11**

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

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

RESUSCITATION QUALITY IMPROVEMENT PROGRAM
MASTER SERVICES AGREEMENT

This Resuscitation Quality Improvement ("RQI") Master Services Agreement ("Agreement") is entered into and effective as of 10/1/2022 ("Effective Date") by and between **RQI Partners, LLC** ("RQIP"), a Delaware Limited Liability Company with its principal place of business at 7272 Greenville Ave., Suite P2020, Dallas, Texas, 75231 and Memorial Hospital of Sweetwater County, having its principal place of business at 1200 College Drive, Rock Springs, WY 82901 ("Customer"). ***RQIP is a partnership between the American Heart Association and Laerdal Medical,*** specifically established to sell, service their Resuscitation Quality Improvement Program for customers on their behalf.

1. Definitions.

"Program" or "RQI" means the Program portfolio as described in Section 2 and the subject of this Agreement.

"HeartCode" means the branded program, or its successors, which forms a part of the RQI Portfolio and delivers a program eLearning activity to enable learners to achieve a traditional AHA course completion ecard.

"System Implementation" or "Implementation" means the satisfactory installation of any equipment to be provided as a part of the service, and proof that the system is operational evidenced by implementation of systems for ten users.

"Order Form" means the ordering document representing purchase of any Services agreed to between the parties signed under this Agreement. The term "Order Form" also includes any subsequent document intended by the Parties to effect a change to the Service, such as a Change Request Form or Order Modification Form.

"Service" means all services ordered by the Customer to be included in RQI Order Forms that are subject of this Agreement.

"Users" means Customer's employees, consultants, contractors, clients or agents who are authorized to use the Service and have been supplied user identifications and passwords by Customer, or by RQIP at Customer's request.

2. Program Description – Resuscitation Quality Improvement (RQI).

The RQI portfolio of Programs is a system developed jointly by the American Heart Association and Laerdal Medical AS to assist in the continuous improvement of resuscitation skills provided by healthcare workers. RQI Partners, LLC, is a joint venture of the American Heart Association and Laerdal Medical Corporation established to sell, service and support the RQI Program.

The Program utilizes a variety of learning tools to assist in competence development through frequent, small quantities of learning activities, including performance feedback and measurement. The Program implemented at Customer site includes some or all the following as specified in an Order Form:

- ***Skills learning activities*** for the practice of resuscitation skills using special simulation learning stations deployed at all locations;
- ***Simulation Stations*** that include all necessary equipment to ensure completion of skills learning activities;
- ***Simulations & Feedback By Telephone*** to allow emergency call takers to improve competence in guiding bystanders through critical resuscitation skills;
- ***Knowledge and decision-making e-learning activities*** and may include interactive web-based and video content;

- ***HeartCode Program*** an e-learning system which provides an alternative method of delivery of traditional AHA healthcare provider and course completion ecard;
- ***Learning management system*** to ensure the suitable management of learning activities within, reporting and administration of the Program;
- ***Debriefing of Case Performance*** to provide guidance on system improvement;
- ***Rolling electronic eCredential maintenance*** system that maintains the electronic credential for Verified Competence, compliance documents for the Customer, and the validity periods;
- ***Get With The Guidelines -Resuscitation*** system for collection of data and measurement of system improvement. Customers electing to engage in the Get With The Guidelines (GWTG) system on an Order Form under this Agreement, must also have completed an American Heart Association Get With The Guidelines Unified Participation Agreement to be eligible in that activity.

3. Service.

3.1. ***Provision of Service.*** Customer agrees that the purchase of User subscriptions for Service is not contingent upon the delivery of any future functionality or features, nor is it dependent upon any oral or written public comments made by RQIP with respect to future functionality or features.

3.2. ***Additional Users.*** User subscriptions for the Service are for named Users and cannot be shared or used by more than one User but, except for HeartCode licenses, may be reassigned by Customer to new Users replacing former Users who have separated from employment, changed job status or function, or otherwise no longer require ongoing use of the Service. HeartCode licenses are considered consumed at User commencement in the Program and may not be assigned. Customer acknowledges that RQIP may conduct usage audits and invoice Customer, and Customer agrees to pay, for any usage above the number of subscriptions specified in Customer's Order Forms, and also adjust future billing rates to the new subscription level indicated by Customer's actual usage. Unless otherwise specified in the relevant Order Form:

(a) the term of the additional User subscriptions shall be coterminous with the expiration of the then current subscription term; and

(b) pricing for the additional User subscriptions shall be the same as that for the pre-existing subscriptions, prorated for the remainder of the then current subscription term.

3.3. ***Administrative Users.*** Each subscription will include a number of User accounts that include limited system administration features, the number of which shall be agreed from time to time between the parties.

3.4. ***Authorized Support Contacts.*** Customer will designate one or more Administrative Users who are authorized to invoke technical support and permit technical support technicians to access and make changes to Customer's Services.

4. Use of the Service.

The Service included in the Fees stated on the Order Form may include:

4.1.*Simulation Learning Stations*- all equipment for skills simulation activities as provided on the Order Form (not including the use of any consumables required to operate the equipment). Except in the case of an out of box failure or product defect, Customer is responsible for replacing manikin faces and lungs, wipes, adult and infant bag, adult and infant clothing. Customer acknowledges that in receiving the Service it does not take title or ownership to any of the equipment provided for the Services under this Agreement.

4.2.*System Implementation* – services to ensure that equipment installed at the Customer's site is operational and that site administrators have been orientated to enable them to manage and operate the provided systems. An Implementation Fee shall be included on the Order Form to cover such establishment charges.

4.3. *Equipment Support* – services to ensure that the provided equipment for the Service remains operational and functional. In the case of failure of equipment RQIP will, as far as commercially reasonable, undertake to repair or replace at its own discretion and expense within five working days of the reported failure.

4.4.*Customer Support* - standard telephone and online support to Customer's Authorized Support Contacts during normal RQIP Support Hours (generally Monday-Friday, 8 a.m. to 8 p.m. and Saturday 10 a.m. to 6 p.m. Eastern time, except holidays), which are subject to change.

4.5. *Software and Data Handling* - use of commercially reasonable efforts to make the Service available 24 hours a day, 7 days a week, except for: (i) planned downtime; or (ii) any unavailability caused by circumstances beyond RQIP's reasonable control, including acts of God, acts of government, flood, fire, earthquakes, acts of terror, strikes or other labor problems (other than those involving RQIP employees), computer, telecommunications, internet service provider or hosting facility failures or delays involving hardware, software or power systems not within RQIP possession or reasonable control, and network intrusions or denial of service attacks.

5. Customer Responsibilities. Customer is responsible for all activities that occur under Customer's User accounts. Customer shall: (a) have sole responsibility for the accuracy, quality, integrity, legality, reliability, and appropriateness of all Customer Data; (b) use commercially reasonable efforts to preserve and care for the Simulation Learning Stations and prevent unauthorized access to, or use of, the Service, and notify RQIP promptly of any unauthorized use; (c) comply with all applicable local, state, federal, and foreign laws in using the Service and not use the Service in a manner that would violate any federal or state laws of the United States; and (d) not move any RQIP equipment beyond the designated facility where it was installed, modify, dispose of, transfer or otherwise devalue the Simulation Learning Stations without prior written approval by RQIP.

6. Fees & Payment.

6.1. *Fees.* Customer shall pay all fees specified in all executed Order Forms. Except as otherwise stated on an Order Form, all fees are quoted and paid in United States dollars. In the case of the Service, and except for Implementation Fees and other services as stated on an Order Form:

(a) fees are based on the number of User subscriptions purchased on the relevant Order Form, not the extent of actual usage;

(b) fees are non-refundable; and

(c) the number of User subscriptions purchased cannot be decreased during the relevant subscription term stated on the Order Form.

6.2. Customer Invoicing & Payment. Customer shall provide complete and accurate billing and contact information to RQIP and notify RQIP of any change to such information. Fees for the Service will be invoiced in advance in accordance with the terms set forth in the relevant Order Form. Unless otherwise stated in the Order Form, charges are due net thirty (30) days from the invoice date. Any payment not received from Customer by the due date may accrue (except with respect to charges then under reasonable and good faith dispute), at RQIP's discretion, late charges at the rate of 1.5% of the outstanding balance per month, or the maximum rate permitted by law, whichever is lower, from the date the payment was due until the date paid.

6.3. *System Implementation and Subscription Fees.* Upon completion of equipment delivery and System Implementation as defined in Section 1 of this Agreement RQIP will initiate immediate billing for the Implementation Fees. Unless otherwise provided on the Order Form, the fees for the subscription, and associated billing, on the Service shall commence on the initiation of the first subscription being activated.

6.4. *Taxes.* Unless otherwise stated, RQIP's fees do not include any local, state, federal or foreign taxes, levies or duties of any nature ("Taxes"). Customer is responsible for paying all Taxes, excluding only taxes based on RQIP's income. If RQIP has the legal obligation to pay or collect Taxes for which Customer is responsible under this section, the appropriate amount shall be invoiced to and paid by Customer unless the Customer qualifies for exemption of some or all of the Taxes and Customer provides RQIP with a valid tax exemption certificate authorized by each appropriate taxing authority.

6.5. *Suspension of Service.* If Customer's account is thirty (30) days or more overdue (except with respect to charges then under reasonable and good faith dispute), in addition to any of its other rights or remedies, RQIP reserves the right to suspend the Service provided to Customer, without liability to Customer, until the overdue amounts are paid in full.

7. Proprietary Rights.

7.1. *Reservation of Rights.* Customer acknowledges that in providing the Service, RQIP utilizes (a) trademarks and service marks; (b) certain audio and visual information, documents, software and other works of authorship; and (c) other technology, software, hardware, products, know-how and other trade secrets, designs, inventions and other tangible or intangible technical material and other intellectual property licensed to RQIP (collectively, "RQIP Licensed IP") and that the RQIP Licensed IP is covered by intellectual property rights licensed to Customer under this Agreement (collectively, "RQIP IP Rights"). Other than as expressly stated in this Agreement, no license or other rights in or to the RQIP Licensed IP or RQIP IP Rights are granted to Customer, and all licenses and rights are expressly reserved.

7.2. *License Grant.* To the extent Customer orders Services under this Agreement, RQIP grants Customer and its Users a worldwide, non-exclusive, non-transferable, non-sublicensable right to access and use the Service in accordance with the terms of this Agreement.

7.3. *Restrictions.* Customer shall not (a) modify, copy or create derivative works based on the Service or RQIP Licensed IP; (b) create Internet "links" to or from the Service, or "frame" or "mirror" any content forming part of the Service, other than on Customer's own intranets; (c) disassemble, reverse engineer, or decompile the Service or RQIP Licensed IP, or access it in order to (i) build a competitive product or service; (ii) build a product or service using similar ideas, features, functions or graphics of the Service; or (iii) copy any ideas, features, functions or graphics of the Service; or (d) permit any use, removal or changes to any branding marks or logos on any components of the Service.

8. Customer Data.

8.1. *General.* As between RQIP and Customer, all data obtained by RQIP from Customer through the provision of the Service, including all data results compiled by RQIP in providing the Service ("Customer Data") is owned exclusively by Customer. Customer Data shall be considered Confidential Information subject to the terms of this Agreement. Customer grants RQIP, the American Heart Association and Laerdal Medical, an unrestricted, royalty-free, irrevocable license to maintain and distribute aggregated compilations of Customer Data

("Aggregated Data") and to use such Aggregated Data for future studies and reports; provided, that the Aggregated Data will not reveal any personal information or the identity of Customer or any information in violation of FERPA (as defined below).

8.2. ***Learning Service Data.*** RQIP may access Customer's User accounts, including Customer Data, solely to respond to service or technical problems or at Customer's request. Customer agrees that RQIP may distribute certain Customer Data to support service, licensing and accreditation organizations for the benefit of Users. RQIP will release the minimum data required to adequately credit Users for educational activities completed.

9. Confidentiality.

9.1. ***Definition of Confidential Information.*** As used in this Agreement, "**Confidential Information**" means all confidential and proprietary information of a party ("**Disclosing Party**") disclosed to the other party ("**Receiving Party**"), whether orally or in writing, that is designated as confidential at the time of disclosure or that reasonably should be understood to be confidential given the nature of the information and the circumstances of disclosure, including the terms and conditions of this Agreement (including pricing and other terms reflected in all Order Forms under this Agreement).Confidential Information expressly includes all proprietary information and details that are generally considered "trade secrets" in the medical education and quality improvement services, medical and health-related technology and resuscitation technology industries. Confidential Information (except for Customer Data) shall not include any information that: (a) is or becomes generally known to the public without breach of any obligation owed to the Disclosing Party; (b) was known to the Receiving Party prior to its disclosure by the Disclosing Party without breach of any obligation owed to the Disclosing Party; (c) was independently developed by the Receiving Party without breach of any obligation owed to the Disclosing Party; or (d) is received from a third party without breach of any obligation owed to the Disclosing Party.

9.2. ***Confidentiality.*** The Receiving Party shall not disclose or use any Confidential Information of the Disclosing Party for any purpose outside the scope of this Agreement, except with the Disclosing Party's prior written permission. Each party agrees to protect the confidentiality of the Confidential Information of the other party in the same manner that it protects the confidentiality of its own proprietary and confidential information of like kind. If the Receiving Party is compelled by law to disclose Confidential Information of the Disclosing Party, it shall provide the Disclosing Party with prior notice of the compelled disclosure (to the extent legally permitted) and reasonable assistance, at Disclosing Party's cost, if the Disclosing Party wishes to contest the disclosure.

9.3. ***Remedies.*** If the Receiving Party discloses or uses (or threatens to disclose or use) any Confidential Information of the Disclosing Party in breach of this Section 9, the Disclosing Party shall have the right, in addition to any other remedies, to seek injunctive relief, restraining order or other equitable relief to prevent breaches of this Section 9, it being specifically acknowledged by the parties that a violation of any of the terms of this Section 9 will cause the Disclosing Party irreparable injury for which adequate remedy at law is not available.

10. Warranties.

10.1. ***General.*** Each party represents and warrants that it has the legal power to enter into this Agreement. RQIP represents and warrants that (i) it will provide the Service in a manner consistent with general industry standards reasonably applicable to the provision of the Service; (ii) it owns or otherwise has sufficient rights to

the Service and the RQIP Licensed IP to grant the rights and licenses granted in this Agreement; and (iii) the Service, RQIP Licensed IP and RQIP Licensed Rights do not infringe any intellectual property rights of any third party.

10.2. ***Non-Exclusion***. RQIP represents and warrants that RQIP, its officers, directors, and employees (i) are not currently excluded, debarred, or otherwise ineligible to participate in the federal healthcare programs as defined in 42 U.S.C. §1320a-7b(f) (the "federal healthcare programs"), (ii) have not been convicted of a criminal offense related to the provision of healthcare items or services and have not been excluded, debarred, or otherwise declared ineligible to participate in the federal healthcare programs, and (iii) are not, to the best of its knowledge, under investigation or otherwise aware of any circumstances which may result in RQIP being excluded from participation in the federal healthcare programs. This shall be an ongoing representation and warranty and RQIP shall immediately notify Customer of any change in the status of the representations and warranty set forth in this section. Any breach of this section shall give Customer the right to terminate this Agreement immediately for cause.

10.3. ***FERPA***. RQIP represents and warrants that it will not disclose any information in violation of the Family Educational Rights and Privacy Act (20 U.S.C. 1232g) and the Family Educational Rights and Privacy Act Regulations (34 CFR Part 99), as amended or otherwise modified from time to time, and that Education Records, as defined by FERPA, shall remain in the ownership of Customer.

10.4. ***Disclaimer***. EXCEPT AS EXPRESSLY PROVIDED IN THIS AGREEMENT, RQIP MAKES NO WARRANTY OF ANY KIND, WHETHER EXPRESS, IMPLIED, STATUTORY, OR OTHERWISE. RQIP SPECIFICALLY DISCLAIMS ALL IMPLIED WARRANTIES, INCLUDING ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW.

11. Mutual Indemnification.

RQIP shall defend, indemnify, save, and hold harmless Customer its trustees, officers, employees and agents from and against any and all judgments, damages, costs and expenses, including reasonable attorney's fees, paid or incurred by Customer to the extent arising out of any claim, action or proceeding for the negligent acts or omissions of RQIP.

Customer shall defend, indemnify, save, and hold harmless RQIP its officers, employees and agents from and against any and all judgments, damages, costs and expenses, including reasonable attorney's fees, paid or incurred by RQIP to the extent arising out of any claim, action or proceeding for the negligent acts or omissions of Customer.

12. Limitation of Liability.

12.1. ***Limitation of Liability.*** EXCEPT FOR LIABILITY ARISING UNDER SECTIONS 6 (PAYMENT OF FEES), 7.3 (RESTRICTIONS), 9 (CONFIDENTIALITY), and 11 (INDEMNIFICATION), IN NO EVENT SHALL EITHER PARTY'S AGGREGATE LIABILITY ARISING OUT OF OR RELATED TO THIS AGREEMENT, WHETHER IN CONTRACT, TORT OR UNDER ANY OTHER THEORY OF LIABILITY, EXCEED THE LESSER OF $50,000 OR THE AMOUNTS ACTUALLY PAID BY AND DUE FROM CUSTOMER UNDER THIS AGREEMENT FOR THE SERVICE.

12.2. ***Exclusion of Consequential and Related Damages.*** EXCEPT FOR LIABILITY ARISING UNDER SECTIONS 9 (CONFIDENTIALITY) and 11 (INDEMNIFICATION), IN NO EVENT SHALL EITHER PARTY HAVE ANY LIABILITY TO THE OTHER PARTY FOR ANY LOST PROFITS, LOSS OF USE, COSTS OF PROCUREMENT OF SUBSTITUTE GOODS OR SERVICES, OR FOR ANY INDIRECT, SPECIAL, INCIDENTAL, PUNITIVE, OR CONSEQUENTIAL DAMAGES HOWEVER

CAUSED AND, WHETHER IN CONTRACT, TORT OR UNDER ANY OTHER THEORY OF LIABILITY, WHETHER OR NOT THE PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF THE DAMAGE.

12.3. ***Limitation of Action.*** Except for actions for non-payment or breach of either party's intellectual property rights, no action (regardless of form) arising out of this Agreement may be commenced by either party more than two (2) years after the cause of action has accrued.

13. Term & Termination.

13.1. ***Term of Agreement.*** The Initial Term of this Agreement begins on the Effective Date and continues for __ months from the Date of the commencement of the first subscription.

13.2. ***Term of User Subscriptions.*** User subscriptions for Services commence on the start date of the first subscription commences and continues for the subscription term specified in the Order Form. The parties may agree to extend the Term of this Agreement, providing that the extension is approved in writing by both parties on an Order Form and states the conclusion date of the extended term and the price for the respective subscriptions and services.

13.3. ***Termination for Cause.*** A party may terminate this Agreement for cause: (a) upon thirty (30) days written notice of a material breach to the other party if the breach remains uncured at the expiration of the cure period; or (b) if the other party becomes the subject of a petition in bankruptcy or any other proceeding relating to insolvency, receivership, liquidation or assignment for the benefit of creditors. Upon any termination for cause by Customer, RQIP shall refund Customer any prepaid fees for the Service for the remainder of the User subscription term after the date of termination. Termination shall not relieve Customer of the obligation to pay any fees accrued or payable to RQIP prior to the effective date of termination.

13.4. ***Effect of Termination.***

(a) ***No Release.*** The expiration or termination of this Agreement, for any reason, shall not release either Party from any obligation or liability to the other party under this Agreement that has already accrued, including any payment obligation, or that accrues between notice of termination and the effective date of termination. Following the termination of this Agreement, RQIP will invoice the Customer for any outstanding fees and expenses due and owing under this Agreement, and the Customer shall pay all such amounts to RQIP in accordance with the payment terms set forth in Section 6.

(b) ***Return of Materials.*** Upon termination of this Agreement, Customer shall:
(i) in accordance with instructions given by either RQIP or its Service Provider, use reasonable care to remove any RQIP Equipment located at the Customer's premises, package all items, and insure and safely return such equipment to the address specified at the expense of the customer;
(ii) provide reasonable cooperation and assistance to and appropriate access by RQIP or its Service Provider for deactivating the Services; and, if applicable, removing equipment; and
(iii) if termination was by RQIP for cause or for convenience by Customer, pay all reasonable fees and expenses related to the deactivation, removal, packaging, shipping and delivery of, and any tangible items related to, the Services, including travel costs if work at Customer's location(s) is required.

13.5. ***Surviving Provisions.*** The following provisions shall survive any termination or expiration of this Agreement: Sections 5 through 9, 11, 12, and 16 and paragraph 13.4.

14. General Terms for Order Forms

14.1. ***Governance Of Order Forms*** - An Order Form and the use of the Service(s) ordered shall be governed in all cases by this Master Services Agreement between RQIP and Customer. An Order Form shall state the date of the Agreement, any services or changes to be covered by the Order Form, pricing for any services to be provided under the Order Form, and any special conditions. Any additional terms and conditions specific to the Service(s) shall not be effective until the Order Form is signed by authorized representatives of both parties. If an Order Form is to be agreed between the parties at the time of signing this Agreement, it shall be included as Exhibit A and shall be considered authorized by the signing of this Agreement.

14.2. ***Subscriptions On Order Forms*** - The number of active users in the Program subscriptions may be assessed on the first day of each calendar quarter, and additional users beyond the quantity in the Master Services Agreement (MSA) and/or any Order Form(s) shall be added to such MSA and Order Form(s) and subject to billing at the point assessed. The Order is intended by both parties to run for the full term for each Service in the Order Details, and the parties acknowledge by signing the Order Form that they are aware of the current expiration date of the Agreement and the provisions for renewal and termination.

15. General Provisions.

15.1. ***Relationship of the Parties.*** This Agreement does not create a partnership, franchise, joint venture, agency, fiduciary or employment relationship between the parties.

15.2. ***Notices.*** All notices under this Agreement shall be in writing and given to the party's address first written above, and shall be deemed to have been given, unless returned due to delivery problems, upon the earliest of: (a) personal delivery; (b) written confirmation of receipt by the other party; (c) the second business day after mailing; (d) the second business day after sending by confirmed facsimile; or (e) the second business day after sending by email.

15.3. ***Publicity.*** Neither party may issue press releases relating to this Agreement without the other party's prior written consent. Either party may include the name and logo of the other party in lists of customers or vendors in accordance with the other party's standard guidelines.

15.4. ***Waiver and Cumulative Remedies.*** No failure or delay by either party in exercising any right under this Agreement shall constitute a waiver of that right. Other than as expressly stated in this Agreement, the remedies provided in the Agreement are in addition to, and not exclusive of, any other remedies of a party at law or in equity.

15.5. ***Severability.*** If any provision of this Agreement is held by a court of competent jurisdiction to be contrary to law, the provision shall be modified by the court and interpreted so as best to accomplish the objectives of the original provision to the fullest extent permitted by law, and the remaining provisions of this Agreement shall remain in effect.

16. Assignment. Neither party may assign any of its rights or obligations under this Agreement, whether by operation of law or otherwise, without the prior express written consent of the other party. Notwithstanding the foregoing, either party may assign this Agreement together with all rights and obligations under this Agreement, without consent of the other party, in connection with a merger, acquisition, corporate reorganization, or sale of all or substantially all of its assets . Any attempt by a party to assign its rights or obligations under this Agreement in breach of this section shall be void and of no effect. Subject to the foregoing, this Agreement shall bind and inure to the benefit of the parties, their respective successors and permitted assigns.

17. **Governing Law and Venue.** This Agreement shall be governed exclusively by the internal laws of the State of New York, without regard to its conflicts of laws rules. The state and federal courts located in the Borough of Manhattan, New York shall have exclusive jurisdiction to adjudicate any dispute arising out of or relating to this Agreement. Each party consents to the exclusive jurisdiction of these courts. Each party also waives any right to jury trial in connection with any action or litigation in any way arising out of or related to this Agreement.

18. **Entire Agreement.** This Agreement, including all exhibits and addenda and all Order Forms signed under this Agreement, constitutes the entire agreement between the parties, and supersedes all prior agreements, proposals or representations, written or oral, concerning its subject matter. No modification, amendment, or waiver of any provision of this Agreement shall be effective unless in writing and signed by the parties. In the event of any conflict between the provisions in this Agreement and any exhibit or addendum, or Order Form, the terms of the exhibit, addendum or Order Form shall prevail to the extent of any inconsistency. Notwithstanding any language to the contrary within it, no terms or conditions stated in a Customer purchase order or in any other Customer order documentation (excluding Order Forms) shall be incorporated into or form any part of this Agreement, and all such terms or conditions shall be null and void.

19. **Counterparts.** This Agreement may be executed in counterparts, either in physical or digital form, which, taken together, shall form one legal instrument.

AGREED

RQI Partners, LLC	**XXXX**
By: _____	By: _____
Print Name: _____	Print Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Exhibit A

Target Go Live:

RQI RESUSCITATION QUALITY IMPROVEMENT

An American Heart Association and Laerdal Program

The ratio of learners to BLS instructors per class?	6	
The number of classes/year for the total number of BLS learners	29	
The average hourly salary for a BLS instructor?	$25.00	
The average hours your BLS instructor spends on each BLS class?	1.00	
Estimated annual cost of instructor time for BLS classes		**$725**
What is the average hourly salary for your BLS learners?	$25.00	
How many hours do your learners spend in a BLS class?	1.00	
Do you pay substitutes while learners are in training?	No	
Estimated annual cost of learner time for BLS classes		**$4,313**
What costs do you pay for third-party classroom BLS training?		
What costs do you pay for online BLS training courses?		$7,439
ACLS Estimates		
Your estimated number of annual ACLS learners (from QuickQuote tab)	55	
The ratio of learners to ACLS instructors per class?	6	
The number of classes/year for the total number of ACLS learners	10	
The average hourly salary for a ACLS instructor?	$25.00	
The average hours you ACLS instructor spends on each ACLS class?	4.00	
Estimated annual cost of instructor time for ACLS classes		**$1,000**
What is the average hourly salary for your ACLS learners?	$35.00	
How many hours do your learners spend in a ACLS class?	3.00	
Do you pay substitutes while learners are in training?	No	
Estimated annual cost of learner time for ACLS classes		**$5,775**
What costs do you pay for third-party classroom ACLS training?		
What costs do you pay for online ACLS training courses?		$9,845
PALS Estimates		
Your estimated number of annual PALS learners (from QuickQuote tab)	55	
The ratio of learners to PALS instructors per class?	6	
The number of classes/year for the total number of PALS learners	10	
The average hourly salary for a PALS instructor?	$25.00	
The average hours you PALS instructor spends on each PALS class?	4.00	
Estimated annual cost of instructor time for PALS classes		**$1,000**
What is the average hourly salary for your PALS learners?	$35.00	
How many hours do your learners spend in a PALS class?	3.00	
Do you pay substitutes while learners are in training?	No	
Estimated annual cost of learner time for PALS classes		
What costs do you pay for third-party classroom PALS training?		
What costs do you pay for online PALS training courses?		$9,845
General CPR-related Cost Estimates		
What are your lost training costs due to annual turnover rate?	25%	$7,274
What are your hourly costs for training rooms?		$0
What is your annual cost of books and other materials used for CPR training?		
What are your annual cost of CPR card processing?		
Any other costs related to CPR training?		
Total estimated annual cost of CPR training		**$52,991**

C. This is the current cost of your CPR training based on A or B above	$52,991 (Estimated)	
D. This is the annual cost for the RQI Program from the QuickQuote 2020 tab	$42,016	
E. This is the difference between the RQI Program and your current costs	$10,975	

Notes regarding the figures stated above

$5,775

	Day	$2,500.00	$2,500.00	$ -
				$ 4,830.00

Stations & Fees

P/N	Description	Units	UOM	Unit Price	Disc Price	Ext Price
Select required stations from below:						
15-3248	RQI Simulation Skills Station - ENTER # SELECTED	1	Each	$0.00	$0.00	$ -
EQUIP-1001	RQI-P GO Simulation Station - ENTER # SELECTED		Each	$0.00	$0.00	$ -
	Total Stations Selected	1				
	# of Stations Included based on Subscriptions and Licenses	1				
15-3242	Additional Simulation Station Fee (Selected less Included)	-	Annual	$2,500.00	$2,500.00	$ -
Annual Station Fees						$ -
Total Contract Amount - Station Fees						$ -

of Stations Included based on Subscriptions and Licenses

RQI Provider Subscriptions	1
HeartCode Complete Licenses	-
Total Stations	1

Total Contract Amount by Type

RQI Subscriptions	$ 126,046.80
HeartCode Licenses	
Minimum Engagement Fee	$ -
RQI-P GO	$ -
Reference Library	$ -
Implementation Services	$ -
Stations Fees	$ -
Total Contract Amount	$ 4,830.00
	$ -
	$ 130,876.80

Total Contract Amount by Year

Total Year 1 Amount, including upfront fees	$ 46,845.60
Total Year 2	$ 42,015.60
Total Year 3	$ 42,015.60
Total Year 4	$ (0.00)
Total Year 5	$ -
Total Contract Amount	$ 130,876.80
	$ -

Sales Tax is State-dependent and will be added to invoice as required.
This Quick Quote provides an estimate only; refer to the formal Quote for actual pricing.

Quote Expiration: 60 days from quotation date

COST COMPARISON 2020

July 6, 2022

A. Enter your total annual training costs for BLS, ACLS and PALS here: ***Note: use either this section A above OR section B below; not both***

B. If you do not know your total annual training costs then use the estimator below
Note: use either section A above OR this section B; not both **Subtotals**

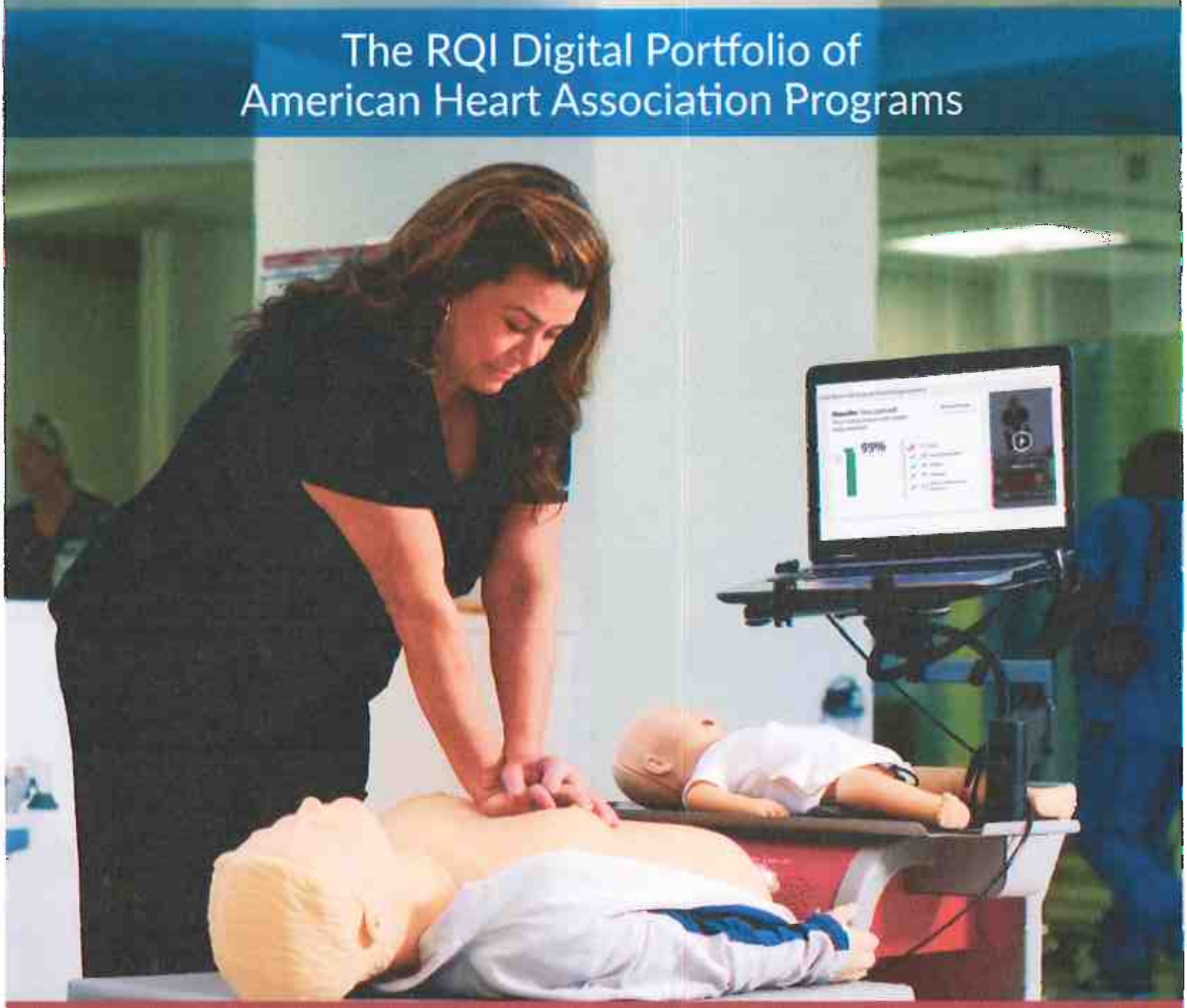
Your estimated number of annual BLS learners (from QuickQuote tab) 173

American Heart Association.

RQI RESUSCITATION QUALITY IMPROVEMENT
An American Heart Association and Laerdal Program

Laerdal
helping save lives

The RQI Digital Portfolio of American Heart Association Programs



Resuscitation and education science of the American Heart Association featuring 2020 Guidelines and innovative True Adaptive™ learning

Resuscitation Quality Improvement®
RQI PROVIDER - RQI ALS - RQI PALS - RQI RESPONDER - RQI FOR NRP®

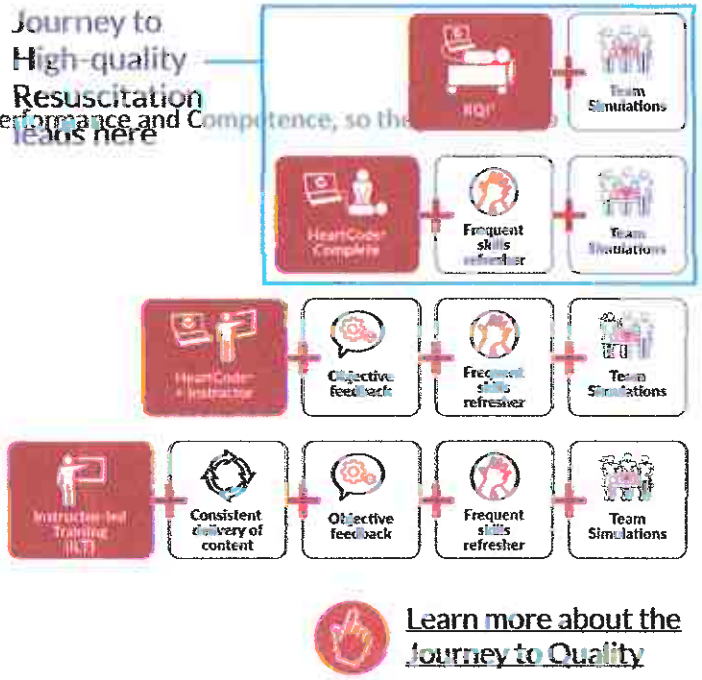
HeartCode® Complete
BLS - ACLS - PALS

THETIMEFORDIGITALTRANSFORMATIONISNOW

Look for this symbol to find interactive features

The American Heart Association (AHA) digital resuscitation portfolio is the preferred solution to uniquely and efficiently deliver safe and effective CPR quality improvement.

Our digital programs – deeply rooted in the latest resuscitation science – lead healthcare organizations on an immediate journey to high-quality and verified CPR competence to maximize lifesaving outcomes.



Learn more about the Journey to Quality

Efficient

- Operational efficiencies save time for learners and administrators
- Reduces costs for your organization

Effective

- Mastery learning, complete with deliberate practice and manikin feedback
- Verifies skills to perform and master the 5 key elements of High Quality CPR

Individual, Safe

- AHA digital solutions eliminate the need for classroom resuscitation learning
- Safe, distanced education, individualized to each learner

Lifesaving

ROI Community Members continue to experience improved cardiac arrest outcomes as their patients reliably receive high-quality CPR.

Begin your Journey to Quality with American Heart Association Digital Programs

respond with lifesaving High-Quality CPR in the most critical moments of a patient's life.

Together, we can help save more lives using the latest AHA resuscitation and education science and implementation design

UTSTEIN Formula for Survival

X

X

= SURVIVAL

Medical Science

Healthcare providers rely on AHA science and Guidelines for their clinical care decisions. Our digital programs incorporate science updates straight from the source, simultaneously with publication. Now, through our digital technology, it is possible to immediately update and disseminate the latest ILCOR and AHA updates into course materials in a single click.

Educational Efficiency

2020 AHA Education Science forms the blueprint for the instructional design of our digital portfolio. Learners achieve Verified Performance and Competence – and the full confidence required to save a life. The new HeartCode and RQI 2025 programs include the most significant educational advancement: True Adaptive™ Learning, a personalized adaptive algorithm for the most effective path to Mastery.

Local Implementation

Ensure consistency for every learner while simultaneously reducing the logistical challenges of traditional training models. The digital platform manages learners and data, and provides access to the AHA Reference Library: the full scope of eBooks, clinical tools, courses and eCredentials. Ongoing, dedicated support at every hospital location is provided through our Impact Management teams.

Based on Utstein's Formula for Survival, the AHA Digital Portfolio is powered by:

- ILCOR
- *AHA Guidelines for ECC and CPR*
- Continuous Evidence Reviews
- Education Statement
- Debriefing & Feedback
- Low-dose, High-frequency
- Contextual Learning
- RQI Analytics
- Valid Assessment
- RQI Platform & Technology Integration
- Mobile Responsive Design
- Automatic Guidelines Updates
- Get With The Guidelines®-Resuscitation
- New Digital AHA Reference Library
- Dedicated Support of Your RQI Impact Manager

AHA Reference Library

Give your providers digital access to lifesaving information with this cost-efficient option

- *2020 Handbook of ECC*
- *ACLS and PALS Drug Reference Guide*
- Algorithms
- BLS, ACLS, PALS eBooks

Learn more about the Reference Library

INNOVATION

for the quality of the learner experience and to dramatically improve the quality of resuscitation care

Powerful, Unique Education Technology – *Personalized to Each Learner*

True Adaptive™ Learning powered by Area9® Rhapsode
Advanced adaptive algorithm adjusts in real-time based on the learner's progress to tailor and customize each learning experience to the individual student. Even though it's instructorless, it's completely personalized.

Learner-Centric Design

Contextual Content and Design
Dedicated tracks for pre-hospital providers, designed in collaboration with the pre-hospital experts of the Resuscitation Academy

Responsive Design – Mobile and Tablet Support
RQI and HeartCode Complete eLearning sessions can now be accessed on your phone or tablet

All eLearning is Accessible
Courses designed to be inclusive to learners with visible and invisible disabilities

WCAG 2.1 AA compliant

Languages for a Global Community

Courses Available in Multiple Languages
Chinese, English, German, Italian, Japanese, Portuguese, Spanish

Solution for Learners on the Move

RQI-P GO Modular Solution
A more portable version of the RQI Simulation Station, complete with a tablet interface in lieu of a laptop. Compatible with both RQI and HeartCode Complete.

"Implementing new programs based on evidence-based practice in CPR allows us to be flexible and adjust our programs based on the new research."

~Damara Stone, Clinical Education Coordinator, Tahoo Forest Health System

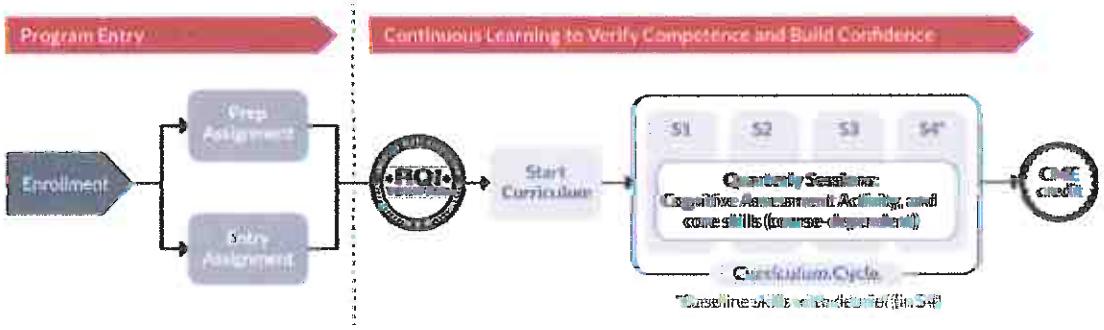
VERIFIED COMPETENCE

Resuscitation Quality Improvement (RQI) 2025

Verified CPR competence is the highest standard of care. The RQI portfolio of Provider, ALS, PALS, Responder, and RQI for NRP* curriculum delivers verified competence through quarterly cognitive and skills simulation sessions, and does so at a lower cost than traditional CPR programs.

- **Quality improvement**– increases competence and confidence resulting in improved patient outcomes
- **Low-dose, high-frequency quarterly learning** improved cognitive retention and recall, critical elements of mastery learning
- **Analytics**– meaningful performance data and quality metrics at the organization and learner level
- **RQI eCredential**– verifies the learner has demonstrated competency in high-quality resuscitation skills after each session
- **Learning platform**– delivered through RQI 1Stop or the existing LMS

RQI Learner Journey



VERIFIED PERFORMANCE

HeartCode Complete 2025

The AHA's HeartCode Programs for BLS, ACLS, and PALS deliver quality resuscitation training through a more flexible delivery method. This method gives providers and administrators more control of their time, schedules, and resources. By combining comprehensive online learning with hands-on skills practice and testing, HeartCode delivers consistent, quality resuscitation training across a healthcare organization at a pace that is right for every individual.

- **Verified Performance**– digital programs from the AHA ensure learners will achieve mastery of CPR skills
- **Biannual training**– standardized training regiment to keep your staff continually compliant
- **AHA eCard**– verifies the learner has completed their cognitive learning and hands-on skills session
- **Learning Platform**– delivered through RQI 1Stop or the existing LMS

HeartCode Learner Journey

*The Neonatal Resuscitation Program (NRP) is developed by the American Academy of Pediatrics for the care of the newborn at birth, available June 2021.

	RQI	HeartCode Complete
Adult & Infant Cognitive	RQI Healthcare Provider, RQI ALS and RQI PALS, RQI for NRP*	HeartCode BLS, HeartCode ACLS, HeartCode PALS
Adult & Infant Skills	Conducted on RQI Simulation Station	
Frequency	Quarterly sessions	Every two years
Analytics	Dashboard view of CPR skill performance in detail over a period of time that can be viewed by the organization, department, or individual	N/A
GWTG®-R	Essential Data set available – included in RQI	N/A
Credentialing	RQI eCredential – issued as part of the AHA's RQI program and represent the gold standard of quality for learners who have verified competence through active and ongoing participation in RQI	An AHA BLS/ACLS/PALS eCard (for each applicable course completion)
RQI-P Go Compatibility	Yes	
Non-medical Personnel CPR Training Program	**Responder program** is designed to prepare healthcare employees who are not directly involved in patient care to respond effectively and efficiently to a cardiac arrest victim	
AHA Guidelines and Programs	AHA science and the AHA Guidelines are updated within the curriculum in real-time	
Availability	RQI is available from RQI Partners	HeartCode Complete is available from RQI Partners or Laerdal Medical
Access to Learning	• RQI1Stop Learning Platform • RQI Technical Partners' LMS • Your Organization's LMS	

*RQI for NRP available June 2021

RQ MMUNITY

Learn more about the RQI Community

A communi ed on resuscitation quality and improving patient outcomes.

ou become a n of this community upon enrollment in our digital programs, specifically RQI HeartCode C e. Our commitment to the RQI Community is ensuring that your organization capable to e arting with implementation and partnering into the future for your success.

digital tfo the RQI Community provide healthcare providers and organizations a end-to- d s that includes:

Lea er a a management through integration with Lear g l ement and Human Resource Information Mana me tems.

A team res s and personnel to support the initial setup an ict of program.

Support f n c ted Impact Managers who work closely wi or tions for overall success.

Immediate cce rogram updates and science changes fr n t A.

Online Us N - The RUN Online is your source for resources uic and peer-to-peer support — available at your fi ert

> *"I know we weren't your only customer, but you made me feel that we were."*
>
> ~Stephanie Profitt, MSNEd, RN, CHSE, Learning Business Partner and Resuscitation Quality Coordinator, Intermountain Health

TRANSFORMING RESUSCITATION FOR LIFE

Our digital programs lead healthcare organizations on an immediate journey to high-quality resuscitation and verified CPR competence as the new standard of care. **Verified Competence saves lives.**

"Low-dose, high-frequency, case-based psychomotor CPR training resulted in improved in-hospital clinical CPR quality."

–Panchal et al, *Resuscitation*, 2019

Read the article

"Resuscitation Quality Improvement gave me the skills I needed when I least expected it. It's priceless."

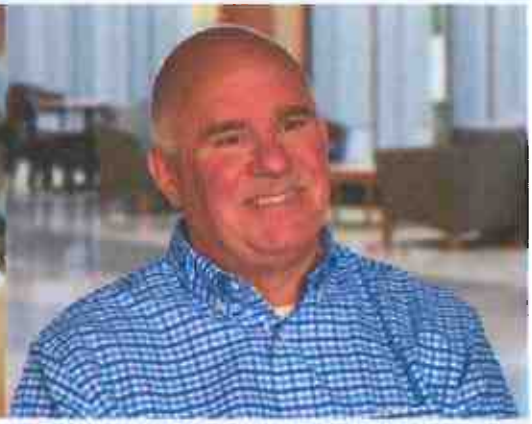
–Tamicka Jones, BSN, RN, TCRN, UAB Hospital

Hear the story

"At 17 minutes and 43 seconds, we had a heart rate thanks to the skills I learned through RQI and our teamwork. I am so grateful for the innovation that RQI has brought to our hospital"

–Mariah Snyder, BSN, RN, C-ELWB, CLE, NICU at CHOC Children's at Mission Hospital

Read the story



"I believe that Resuscitation Quality Improvement helped save my life."

–Michael Lovelace, RN, UAB Hospital

Hear the story

American Heart Association.

RQI Resuscitation Quality Improvement

An American Heart Association and Laerdal Program

Laerdal helping save lives

RQIPartners.com

1/21KM

RESUSCITATION QUALITY IMPROVEMENT

An American Heart Association and Laerdal Program

Quote Expiration: 60 days from quotation date

Quick Quote 2022

Date of Quote	Wednesday, July 6, 2022
Customer Name	Memorial Hospital of Sweetwater County
Street Address	1200 College Drive
City State, ZIP	Rock Springs, WY 82901
Contact	Patty O'Lexey
LMS Provider	Net Learning
Quote type -REQUIRED FOR CALCULATIONS	New
Contract Term (# of months) -REQUIRED FOR CALCULATIONS	36
Target Go-Live Date (Enter first day of the month)	10/1/2022

RQI Subscriptions

P/N	Description	Units	UOM	Unit Price	Disc Price	Ext Price
20-3500	RQI Healthcare Provider	345	Annual	$83.00	$73.04	$ 25,198.80
20-3501	RQI Healthcare Provider ALS	110	Annual	$91.00	$76.44	$ 8,408.40
20-3502	RQI Healthcare Provider PALS	110	Annual	$91.00	$76.44	$ 8,408.40
15-3229	RQI Responder Subscription		Annual	$26.00	$26.00	$ -
15-3512	Get With The Guidelines Resuscitation Subscription	345	Annual	$5.00	$0.00	$ -
Total Annual RQI Subscriptions						$ 42,015.60
Contract Amount - RQI Subscriptions						$ 126,046.80

HeartCode Licenses

P/N	Description	Units	UOM	Unit Price	Disc Price	Ext Price
20-3550	HeartCode BLS Complete		License	$58.00	$58.00	$ -
20-3551	HeartCode ACLS Complete 20-3552 HeartCode PALS Complete		License	$182.00	$182.00	$ -
20-3553	HeartCode BLS Online Part 1		License	$193.00	$193.00	$ -
20-3554	HeartCode ACLS Online Part 1 20-	-	License	$32.50	$32.50	$ -
3555	HeartCode PALS Online Part 1 Total		License	$151.00	$151.00	$ -
Contract Amount - HeartCode			License	$151.00	$151.00	$ -
						$ -

Minimum Engagement Fee

P/N	Description		Ext Price
	Total Annual RQI Subscriptions		$ 42,015.60
	Total Annual HeartCode		
Total Annual RQI and HeartCode Fees		Annual	$ -

Minimum Annual Subscription Value		$ 42,015.60
00-XX	**Annual Minimum Engagement Fee**	$ -
Total Contract Amount - Minimum Engagement Fee		$ -
		$ -

RQI-P GO

P/N	Description	Units	UOM	Unit Price	Disc Price	Ext Price
20-3503	RQI-P-GO		Annual	$10,000.00	$10,000.00	$ -
Total Contract Amount - RQI-P GO						$ -
Select combination of 100 for each RQI-P Go	20-3500 RQI Healthcare Provider					
20-3501	RQI Healthcare Provider ALS					
20-3502	RQI Healthcare Provider PALS					
15-3229	RQI Responder Subscription					
20-3550	HeartCode BLS Complete		Annual	$0.00	$0.00	$ -
20-3551	HeartCode ACLS Complete		Annual	$0.00	$0.00	$ -
20-3552	HeartCode PALS Complete Total Subscriptions Selected		Annual	$0.00	$0.00	$ -
EQUIP-1001	RQI-P GO Simulation Station - ENTER # SELECTED		Annual	$0.00	$0.00	$ -
			Annual	$0.00	$0.00	$ -
			Annual	$0.00	$0.00	$ -
			Annual	$0.00	$0.00	$ -
		-				
			Each	$0.00	$0.00	$ -

P/N	Description	Units	UOM	Unit Price	Disc Price	Ext Price
		No				
	Digital Reference Library (From Above)	-				
	Digital Reference Library (Exisitng Learners)					
20-3510	Digital Reference Library - Total	-	Annual	$4.00	$4.00	$ -
Total Contract Amount - Reference Library						$ -

Activation Services

P/N	Description	Units	UOM	Unit Price	Disc Price	Ext Price
SERV-0001	New Activation Fees	345	Subscribers	$14.00	$14.00	$ 4,830.00
SERV-0001	Additional Activation Fees		Subscribers	$14.00	$14.00	$ -
SERV-0011	Standard Implementation for RQI Responder	-	Subscribers	$14.00	$0.00	$ -
SERV-ADJ	We Can Help Credit			-$3,500.00	-$3,500.00	$ -
SERV-0002	Identity Management Integration		Integration	$15,000.00	$15,000.00	$ -
SERV-0003	Additional Identity Management Integration		Day	$1,500.00	$1,500.00	$ -
SERV-0004	Virtual Custom Configuration Services		Day	$1,500.00	$1,500.00	$ -
SERV-0005	In-Person Custom Services & Integration					
Total Contract Amount - Implementation Services						

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**

2. Purpose of contract, including scope and description: **True North will prepare, produce and distribute the hospital's newsletter two times a year. The newsletter will be mailed to all households in Sweetwater county and some households in Uinta, Lincoln, Sublette and Carbon Counties. The SOW also includes blog content. The blog will publish two times a month for twelve months. The blog content will be published on the website and social media. The purpose of the content is to create brand and service awareness. The blog is an addition to the print media which will target online audiences more frequently.**

3. Effective Date: **When approved by Board**

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

5. Termination provisions: **by either party with minimum of 30 days' notice after October 31, 2023 after not less than one full year of work.**

6. Monetary cost of the contract: **Newsletter is $40,166.40 annually- The blog cost is $18,360. Total cost of the agreement over three years is $175,579.00 ($20,083.20 x 2 = $40,166.40 per year for newsletter). $4,590 x 4 = $18,360 per year for blog content. Total per year= $58,526.40 X3 years= $175,579.200.**

Postage for mailing the newsletter approximately $12,567.60 annually and not figured into the annual cost of the SOW.

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. Print Publication
    a. Print newsletter publication development and execution
        i. Two issues per year
        ii. Eight (8) pages each including front and rear cover, 80# gloss text, 8.125"x10.75" trim size
        iii. Each issue will be mailed to a demographic target address list developed by True North Custom according to the following:
            1. All households in Sweetwater County, WY
            2. Households with a household income of $30,000 or more in Unita, Lincoln, Sublette and Carbon County, WY and Daggett County UT
        iv. True North Custom will provide custom content, design, print and execute shipment for each issue
        v. Each issue includes two (2) proofs. Additional revision cycles can be added at an hourly rate of $165 and will impact time to launch relative to extensiveness of the changes
        vi. Use of stock photography only unless other photos are provided by client
        vii. Includes bulk shipment of 25 non-mailing quantity per issue to client
        viii. True North Custom will develop, maintain and manage address mailing list according to agreed upon specifications
    b. Annual total: $40,166.40
        i. Estimated quantity of 34,910 newsletters sent two times per year for an estimated total of 69,820 per year
        ii. Estimated postage / shipping costs, billed in addition upon mailing (non-profit rate): $12,567.60

2. Blog Content Strategy
    a. Components
        i. Approximately 2 custom pieces of content per month (24 pieces per year)
            1. To include a mix of standard articles (400-500 words), standard articles with interview, feature articles (800-1000 words), feature with interview, super-feature (1500 words), super-feature with interview, infographics and light assessments or quizzes 2. Total custom content cost: $18,360 ii. Each includes SEO components, post headline and link description/CTA
        iii. Each includes a recommended image number from Memorial Hospital of Sweetwater County custom library or preferred stock photo library iv. Content planning and strategy support to include ~12 recommended blog

topics per quarter, of which TNC would execute approximately 6, all aligned with local consumer needs and Memorial Hospital of Sweetwater County priority service

lines

v. Quarterly planning meetings and performance review discussions
vi. TNC collaboration with client team on content deployment
vii. Flexibility will be offered if the content plan varies from 2 posts per month. A budget tracker will be used and provided to Memorial Hospital of Sweetwater County to track utilization throughout the year.

RATE AND PAYMENT TERMS.

1. Pricing Total for 3 year agreement: $175,579.20 ($58,526.40 per year)
    a. $20,083.20 to be billed twice per year for newsletter publication with first payment due on contract execution
    b. $4,590 to be billed on a quarterly basis for blog content strategy with first payment due on contract execution
2. Postage to be billed separately upon execution based on then current rates. Estimate at the time of execution is $12,567.60 annually ($6,283.80 per issue).
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. Prices are based on current market rates and subject to adjustments.
6. Client acknowledges it is agreeing to subscribe to, pay for, and cooperate in the production of, the Total Statement of Work Amount above for the term period. Contract may be terminated by either party in writing with a minimum of 30 days notice after October 31, 2023 after not less than one (1) full year of work as outlined above. This agreement is non - transferable and non - refundable.
7. 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***	
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 Contracts: **Wolters Kluwer for UpToDate subscription service**

2. Purpose of contract, including scope and description: **UpToDate is a search engine for medical journals, articles and newest research. Doctor to doctor - peer reviewed practice guidelines used for patient decision -making. Benefit for our physicians. They really use it a lot. Report from Wolters Kluwer is that use is at 96% by our physicians. The annual cost is based on the number of providers. We are paying for 50 providers (7 more than last year as we are allowing ED physicians to access this year moving forward).**

3. Effective Date: **August 1, 2020**

4. Expiration Date: **1 year**

5. Rights of renewal and termination: **Yes with at least 30-day notice prior to expiration of the current term** Is this auto-renew? Yes **August 1**

6. Monetary cost of the contract and is the cost included in the department budget? **2020-2021 our subscriber number was 43 – this caused the additional annual cost to increase to $22,823. Addition of seven (7) providers for 2021-22 has increased annual cost to $26,175.00 TOTAL 2021-2022 ANNUAL COST $26,175.00**

7. Jurisdiction/Choice of Law provision checked and changed to Wyoming if able to so? **Not changed to Wy. Massachusetts law as this is a Mass. Based Company that has contracts in all states.**

8. Any confidentiality provisions? **Yes as to intellectual property rights, product design and we will keep it confidential for 3 years after termination of the agreement. Not the agreement itself.**

9. Indemnification clause present? **No**

10. Is this contract appropriate for other bids? **No**
11. In-house Counsel Reviewed: **Yes**
12. Is County Attorney review required? NA