MEMORIAL HOSPITAL OF SWEETWATER COUNT□
REGULAR MEETING OF THE BOARD OF TRUSTEES
August 7□2□1□
2:□□ p.m.
Classrooms 1□2 □ 3

AGENDA

I. Call to Order — Taylor □ones

A. Pledge of Allegiance

B. Our Mission and Vision — Richard Mathey

II. Agenda *(For Approval)* — Taylor □ones

III. Minutes *(For Approval)* — Taylor □ones

IV. Community Communication — Taylor □ones

V. Old Business

A. (From the Medical Staff) *(For Approval)* — Dr. □awrence □auridsen, *Medical Staff President*

1. Proposed Changes to Medical Staff Bylaws

B. (From the Human Resources Committee) *(For Approval)* — Ed Tardoni

1. Code of Conduct Policy

C. Outstanding – Not Ready for Board Consideration (Placed on the agenda as a reminder of uncompleted business)

1. Credentialing Policy

VI. New Business

VII. Chief Executive Officer Report — Irene Richardson

VIII. Committee Reports

A. □uality Committee — Barbara Sowada

B. Human Resources Committee — Ed Tardoni

C. Finance □ Audit Committee — Marty Kelsey

1. Capital Expenditure Requests *(For Approval)*
2. Narratives — Tami □ove, *Chief Financial Officer*
3. Bad Debt *(For Approval)* — Ron Cheese, *Director of Patient Financial Services*
4. Finance □ Audit Committee Packet

D. Building □ Grounds Committee — Ed Tardoni

E. Foundation Board — Tiffany Marshall, *Foundation Director*

F. Compliance Committee — Barbara Sowada

G. □oint Conference Committee — Richard Mathey

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AGENDA

IX. Contract Review — Suzan Campbell, *Chief Legal Executive/General Counsel*

A. Contracts Consent Agenda *(For Approval)*
1. Amendment to Affiliation Agreement with □ of □
2. Facility □se Agreement for □ of □ Dermatology
3. NaVectis

B. Contracts Approved by CEO since □ast Board Meeting *(For Your Information)*
1. Check □ist for American Association of Critical Care Nurses
2. Check □ist for Gallagher Employee Engagement Survey
3. Check □ist for Hospice Services Cowboy Cares
4. Check □ist for Mission Health Clinical Agreement
5. Check □ist for Vivor

X. Medical Staff Report — Dr. □awrence □auridsen

XI. Good of the Order — Taylor □ones

XIII. Executive Session (W.S. 16-4-405 (a)(ii), (ix), (x)) — Taylor □ones

XIV. Action Following Executive Session — Taylor □ones

A. Approval of Privileges *(For Approval)*

XV. Adjourn — Taylor □ones

Memorial Hospital

OF SWEETWATER COUNTY

OUR MISSION

Compassionate care for every life we touch.

OUR VISION

To be our community's trusted healthcare leader.

OUR VALUES

Be Kind
Be Respectful
Be Accountable
Work Collaboratively
Embrace Excellence

OUR STRATEGIES

Patient Experience
Quality & Safety
Workplace Experience
Growth, Opportunity & Community
Financial Stewardship

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

July 10, 2019

The Board of Trustees of Memorial Hospital of Sweetwater County met in regular session on July 10, 2019, at 2:00 p.m. with Mr. Richard Mathey, President, presiding.

CALL TO ORDER

Mr. Mathey called the meeting to order and announced a quorum was present. The following Trustees were present: Mr. Taylor Jones, Mr. Marty Kelsey, Mr. Richard Mathey, Dr. Barbara Sowada, and Mr. Ed Bardoni.

Officially present: Ms. Irene Richardson, Chief Executive Officer, and Dr. Lawrence Lauridsen, Medical Staff President.

Mr. Mathey led the audience in the Pledge of Allegiance. Mr. Bardoni read aloud the mission and vision statements.

APPROVAL OF AGENDA

The motion to approve the amended agenda to add approval of a resolution designating a public records person for MHSC was made by Dr. Sowada, second by Mr. Jones. Motion carried.

APPROVAL OF MINUTES

The motion to approve the minutes of the June 5, 2019, regular meeting as presented was made by Mr. Kelsey, second by Mr. Jones. Motion carried.

ELECTION OF OFFICERS AND COMMITTEE ASSIGNMENTS

Dr. Sowada presented names for officers on behalf of the Governance Committee:

President – Mr. Jones
Vice President – Mr. Mathey
Treasurer – Mr. Kelsey
Secretary – Mr. Bardoni

The motion to close nominations and approve the names as presented was made by Mr. Kelsey, second by Mr. Bardoni. Motion carried. Mr. Mathey turned the gavel over to Mr. Jones. He noted the thank you note included in the packet. Mr. Jones thanked Mr. Mathey for all he has done for the Board of Trustees and the Hospital. Mr. Jones thanked the Trustees for voting him in and allowing him to serve.

COMMUNITY COMMUNICATION

Ms. Richardson presented a gift of appreciation to Mr. Mathey on □ehalf of the □oard of □rustees and hospital staff.

Ms. □odi Corley□Clinic Systems □nalyst□reported on the Merit□□ased □ncentive Payment System □M□PS□score for 201□from the Centers for Medicare and Medicaid Services □CMS□.

□r. □auridsen recogni□ed medical staff scholarship recipients Ms. □lyssa □lingensmith from Roc□ Springs and Ms. □oseline □latorre from □reen River. Ms. □e□ Sutton□Mar□eting and Pu□lic Relations □irector□recogni□ed Ms. □iushia □on□ales as the Roc□ Springs High School Health □cademy scholarship recipient.

CENTRAL PLANT UPGRADE ENGINEERS PRESENTATION

Mr. □a□e □levins of Space□□□im□ie and □levins □S□□□□ngineering provided an update on the central plant upgrade pro□ect. □he □id document pac□age is progressing nicely. □he □id opening will □e at the □ugust □uilding and □rounds Committee meeting.

OLD BUSINESS

Quality Assessment Performance Improvement (QAPI) Plan

Ms. □ara □ac□son□□uality □irector□reviewed the information provided in the meeting pac□et. She said we are focusing efforts to □ring in □ean as our □uality improvement methodology. □he motion to approve the □□P□Plan as presented was made □y □r. Sowada□second □y Mr. Mathey. Motion carried. Ms. □ac□son said additional in□depth information will □e provided at the special wor□shop on □uality in □ugust.

NEW BUSINESS

Approval of Proposed Changes to Medical Staff Bylaws

□r. □auridsen reviewed the changes to current □ylaws approved □y the general medical staff on □une 25. Mr. □ones said the □oard will ta□e action at the □ugust meeting.

Resolution Designating a Public Records Person at MHSC

□he motion to approve and adopt the MHSC resolution to designate a pu□lic records person as presented □y Ms. Su□an Camp□ell□Chief □egal □□ecutive and □eneral Counsel□was made □y Mr. Mathey□second □y Mr. □elsey. Motion carried.

CHIEF EXECUTIVE OFFICER REPORT

Ms. Richardson provided a Strategic Plan update. She said we continue to wor□on medical staff □ylaws. □he ne□t am□ulance service discussion is □ugust 5 and we continue to loo□at all options. Ms. Richardson provided a physician recruitment update. □n annual report was presented to the □oard of County Commissioners in □une 1□. □own Halls will □e held the wee□s of □uly 15 and 22.

Ms. Richardson than□ed Mr. □elsey for wal□ing with hospital staff at the □laming □orge □ays Parade in □reen River.

COMMITTEE REPORTS

Quality Committee

Ms. □ac□son announced the Hospital received a □uality award from the Mountain□Pacific □uality Health □MP□H□regional □uality group. □he application focused heavily on the patient e□perience. □ e detailed our wor□with Planetree and care coordination. Ms. □ac□son said another focus was opioid reduction□readmissions□adverse drug reactions□and M□PS. She said a lot of wor□is □eing done across the organi□ation and e□pressed appreciation for everyone's hard work.

Human Resources Committee

Mr. □ardoni said wor□ on the code of conduct has □ecome more comple□. He thin□s we made some progress. □he Committee is reviewing legal re□uirements and implementation procedures for telecommuting.

Finance and Audit Committee

Capital Expenditures: □he motion to approve □□20□1 for hospital we□site redesign and host service as presented was made □y Mr. □elsey□second □y Mr. Mathey. Motion carried. □he motion to approve □□20□2 for intranet upgrades and we□site design as presented was made □y Mr. □elsey□ second □y Mr. □ardoni. Motion carried.

Narratives: Ms. □ove reviewed the narrative highlights included in the meeting pac□et. □ e continue to see an increase in reductions of revenue. Mr. □elsey suggested including more detailed information in reports when there is a discrepancy to e□plain the differences and why. Mr. □elsey than□ed Ms. □ove and her staff for their efforts.

Bad Debt: □he motion to approve the net potential □ad de□t of □1□035□513.□5 as presented was made □y Mr. □elsey□second □y □r. Sowada. Motion carried. Mr. □elsey said we tal□ed a□out adding more metrics regarding what is represented □ehind these num□ers.

Building & Grounds Committee

Mr. □im Horan□□acilities □irector□referenced the minutes from the last meeting in the pac□et. He reported we have □□□ lighting throughout the par□ing lot. □he retaining wall pro□ect is almost complete. □ e e□perienced sprin□ler and water issues. Mr. Horan apologi□ed for the way the grass has loo□ed and said things are turning around. He announced the □uilding and □rounds Committee meeting is moved to □uly 11 to ta□e advantage of meeting with S□□ □ while they are on□site.

Foundation Board

Ms. □iffany Marshall□□oundation □irector□said the golf tournament □ugust 1□at Rolling □reen in □reen River is trending very nicely. □he □onor □ all is still a wor□in□progress. She hopes to have it up □y the end of the year. □he employee campaign third □uarter num□ers are higher than the annual goal and we still have three months to go. □r. □a□e □ohnson has ta□en a step □ac□from service on the □oundation □oard. □ e hope to have a replacement medical staff representative soon. □rustees are invited to attend the Cancer Center 5 □ear Cele□ration on □ugust 22.

Compliance Committee

□r. Sowada reported Mr. Clayton Rada□ovich□□irector of Compliance and Ris□ Management□ continues to wor□on the ris□assessment update. □ e are rolling out □air □ arning software which flags employees inappropriately in others' medical records. OSHA was onsite to look at heat in the laundry. □r. Sowada reported we used a large part of the wor□Mr. □ardoni did when the □oard first came together on the pro□ect to correct the heat issues. □he Code of Conduct review continues.

Mr. □ones announced a ten□minute recess.

Mr. □ones called the meeting □ac□to order at 4:10 p.m.

CONTRACT REVIEW

□he motion to authori□e the C□O to e□ecute the contracts on □ehalf of MHSC as presented was made □y Mr. Mathey□second □y Mr. □ardoni. Motion carried.

MEDICAL STAFF REPORT

□r. □auridsen reported the Medical □□ecutive Committee met □une 1□and the □eneral Medical Staff met □une 25. Ms. Richardson treated the Medical Staff to a □ingo □ight □une 27. □r. □srael Stewart is hosting □ al□□ ith □ □oc □uly 16. □r. □auridsen said we need to meet as the □oint Conference Committee whenever the □oard would li□e to meet. He reported the first half of the new □ylaws are ready for review. □r. □auridsen presented an appreciation gift to Mr. Mathey and than□ed him on □ehalf of the Medical Staff.

GOOD OF THE ORDER

Mr. □ones than□ed Mr. Mathey for the note he included at the □eginning of the meeting pac□et. □he committee assignments will remain the same with the e□ception of Mr. Mathey replacing Mr. □ones on the □inance and □udit Committee. Mr. □ones said he is not a fan of □eeping things the same □ut there is a lot going on right now and we will □enefit from □eeping things moving forward. Mr. □ones said that□as the new President□he will do things different. He as□ed that people not read anything into that. He is not sure what he will do different yet. Mr. □ones said Mr. Mathey did an e□cellent □o□and is to □e commended □ecause of his tremendous commitment of time and effort.

Mr. □elsey as□ed again for staff to wor□with □□. for microphones □ecause the microphone we have on the podium is useless. He as□ed for information on anti□venom supplies at the hospital. Ms. □eslie □aylor□Clinic □irector□reported we have anti□venom on□hand.

Mr. □ardoni said the increases in □ad de□t and reductions in revenue are significant. He said we are not going to compete our way out of it. He as□ed what can we do locally that is under our control. Mr. □ardoni as□ed if the □oard would consider forming an ad hoc committee to see what we can do□something local and under our control to supplement these forces to find a gate in the fences closing in on us. Ms. Richardson agreed we want to loo□at every possi□le option to help us ad□ust to this new norm. She said the aggregate collected on charges for Medicare patients is 33□. Mr. □ones said he does not want to duplicate or create e□tra wor□. He as□ed Ms. Richardson and Ms. □ove to get a group together to discuss.

EXECUTIVE SESSION

□he motion to go into □□ecutive Session for personnel reasons was made □y □r. Sowada□second □y Mr. □elsey. Motion carried.

RECONVENE INTO REGULAR SESSION

□he motion to reconvene the meeting at 5:15 p.m. was made □y Mr. Mathey□second □y □r. Sowada. Motion carried.

ACTION FOLLOWING EXECUTIVE SESSION

Approval of Privileges

□he motion to approve the □une 11□2019□Credentials Committee Recommendations for privileges as presented was made □y □r. Sowada□second □y Mr. Mathey. Motion carried.

1. □nitial □ppointment to □ocum □enens Staff □1year□
   - □r. □anene □lyn□Pediatrics
2. □nitial □ppointment to Consulting Staff □1year□
   - □r. □ipayan Chaudhuri□Cardiovascular □isease □□ of □□
   - □r. □l□ert □□asco□□ele Radiology □□rad□
     - □Rad schedule 1 list of Physicians
3. □nitial □ppointment to □HP Staff □1year□
   - □ac□uelyn □indsey□□□P Oncology
4. Reappointment to Consulting Staff □2 years□
   - □r. Peter Hannon□□ele Stro□e □□ of □□
   - □r. Roger □reedman□Cardiovascular □isease □□ of □□
   - □r. □auren □heilen□Maternal/□etal Medicine □□ of □□
   - □r. Marcela Smid□Maternal/□etal Medicine □□ of □□
5. Reappointment to □ocum □enens Staff □1 year□
   - □r. Mary Murphy□Radiology □□dvanced Medical □maging□
   - □r. □raham □rant□□awad□□i□□mergency Medicine □□ of □□
   - □r. □aylor □elgado□□mergency Medicine □□ of □□
6. Reappointment to □HP Staff □2 years□
   - □onnie Collins□□CS□ □S□ CS□

□he motion to authori□e the C□O to e□ecute a new Chief Medical Officer agreement as presented was made □y Mr. Mathey□second □y □r. Sowada. Motion carried.

ADJOURNMENT

□here □eing no further □usiness to discuss□the meeting ad□ourned at 5:17 p.m.

□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□
Mr. □aylor □ones□President

□ttest:

□□
Mr. □d □ardoni□Secretary

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
Report to the Board of Trustees
On Medical Staff Vote for Proposed Changes to the Medical Staff Bylaws and Rules and Regulations

From the General Medical Staff Meeting of
June 25, 2019

President Mathey and Board of Trustees:

At their most recent General Medical Staff meeting, several changes to the current medical staff bylaws were presented for a vote. MEC decided it was important to make these changes to the current bylaws, while continuing to work on the new bylaws. The following changes were approved and are now being presented, for your approval:

1. FPPE Requirements in Associate Staff Category (bylaws p 10)
   This change is to update the bylaws to match our current policy and process for Focused Professional Performance Evaluation (FPPE).

2. Consultant Documentation in EMR (bylaws p 11) (RR p 30)
   This change is to ensure that a note from all consulting providers is included in the Medical Record.

3. Omissions or Misstatements on application (bylaws p 17, 26) (RR p 3, p 9)
   This change is to advise applicants that they need to disclose all pertinent information on their application, or their privileges can be denied.

4. CME Requirements (bylaws p. 20)
   After some research, it was discovered that there are some situations where the Wyoming Board of Medicine (WBOM) does NOT require physicians to complete Continuing Medical Education (CME). For example, Physicians are not required to submit CME for the first three years after they are granted a Wyoming language. This additional language ensures that our requirements are stricter than those of the WBOM.

5. Credentials Committee action upon Department Chair Denial (bylaws p. 21, 29) (RR p 5, 11)
   This section clarifies the action that Credential's Committee can take, after receiving the recommendation of the Department Chair.

6. Board Certification (bylaws p 36 – 37)
   This language changes the requirement for board certification from seven years to "board certified or board eligible as determined by physician's individual college." Some colleges allow more or less than seven years to become board certified. The medical staff decided that it was best to follow the requirements of each specific college, such as the American College of Obstetricians and Gynecologists, which allows eight years for board certification.

7. Remove General Services Department (bylaws p 42)
   If the board approves this language, Pathology will become part of the Surgery Department and ER and Radiology will become part of the Medicine Department.

3. The Associate Physician Staff

a. The Associate Physician Staff shall consist of Physicians who, following their initial appointment, are being considered for advancement to the Active Physician Staff. The duration of Associate Medical Staff status shall be for one (1) year from such Applicant's initial appointment to the Medical Staff. During this time, the Associate Medical Staff Appointee's performance will be monitored ~~by the Chair of the department in which such Physician is assigned~~ to determine eligibility of such Associate Medical Staff Appointee for appointment to the Active Physician Staff.

b. Monitoring of the Associate Staff member shall be accomplished through Focused Professional Practice Evaluation (FPPE) as provided for in these Medical Staff Bylaws, Rules and Regulations, and policies. ~~The nature and scope of the required observation shall be determined on a department by department basis. Re~~ The Associate Staff Member must successfully complete FPPE to determine their competence to practice the clinical privileges granted. The results of such FPPE shall be considered in conjunction with the Associate Staff Member's application for renewal of clinical privileges.

c. If the Associate Staff Member does not complete FPPE within the required time period, he/she shall not be eligible to apply for renewal of clinical privileges, and his/her grant of clinical privileges shall expire at the end of the initial grant period. This expiration of clinical privileges will not entitle the Associate Staff member to a fair hearing, as their failure to complete FPPE will be interpreted as not meeting threshold criteria.

~~a.~~d. ~~A~~appointments to the Associate Medical Staff may not exceed one (1) full ~~Medical Staff~~ Year (with an additional one (1) Medical Staff Year extension for up to 12 months, for good reason ~~cause~~, as recommended by Credentials Committee and approved by the Medical Executive Committee, at which time failure to remove such provisional status shall be deemed a termination of his/her Medical Staff appointment. An Associate Medical Staff member whose membership is terminated shall have the rights accorded by the Medical Staff Bylaws to an Active Physician Staff member who has failed to be reappointed to the Active Medical Staff.

~~c~~b. The Associate Staff shall be appointed to a specific department, shall be eligible to vote and serve on all Medical Staff committees, and it is recommended that they attend all meetings of the Medical Staff, such Physician's department meetings, and any committee on which such Physician serves. The Associate Staff members shall be ineligible to hold office in this Medical Staff organization. They shall assume all other duties and responsibilities of a Medical Staff member.

4. The Consulting Physician Staff

a. The Consulting Physician Staff shall consist of Physicians of recognized professional ability, experience, and maturity who occasionally come to the Hospital on a pre-defined schedule or to act as a consultant upon request of any credentialed of the Medical Staff.

b. The Consulting Physician Staff must possess expertise or training materially valuable to the Hospital, as such is determined by the MEC, and approved by the Governing Board, not available from active or Associate Staff members. Consulting Physician staff members may admit patients under special circumstances, not to exceed 12 admits per year. Non-admitting Physicians (radiologists, pathologists, emergency Physicians, etc.) working at the Hospital may not engage in more than 50 hours of work, per year.

c. Consulting physicians will provide documentation for the hospital's EMR. This documentation will be entered directly, scanned in, or dictated.

~~c.~~d. Consulting Physician Staff members shall not be permitted to vote or hold office. Consulting Staff members may attend meetings of the Medical Staff and Departments of which he/she is a member and any staff or Hospital educational programs.

~~d.~~e. Consultation shall not be limited to members of this Medical Staff category.

~~e.~~f. Each member of the Consulting Physician Staff expressly authorize the Hospital to monitor and evaluate such member's professional performance in such manners as authorized pursuant to the Rules and Regulations and the Policies, regardless of whether such member comes to or sees patients at the Hospital's facilities.

5. Locum Tenens Staff

This category is for Physicians who provide temporary service to the Hospital. Locum Tenens Privileges may be granted only for a specific period of time, not to exceed twelve (12) months per appointment, and shall automatically expire at the end of the specified period, without recourse by the Practitioner under the Medical Staff Bylaws. Locum Tenens Appointees shall not be eligible to vote or to hold office in the Medical Staff organization. They may, however, attend staff and departmental meetings and any staff or Hospital educational meetings

6. The Affiliate Physician Staff

a. The Affiliate Physician Staff shall consist of Physicians who perform same day/outpatient surgery procedures at the Hospital. Affiliate Staff members shall

and past malpractice insurance carrier(s);

11. a statement whereby the Practitioner agrees that, when an adverse ruling is made with respect to his/her staff membership, staff status and/or privileges, he/she will resort to the administrative remedies afforded by the Medical Staff Bylaws Rules & regulation before resorting to formal legal action;

12. evidence of current, adequate professional liability insurance as determined by the Governing Board;

13. a statement regarding physical/mental health status, including alcohol abuse and/or drug dependency, as permitted by applicable law;

14. satisfactory completion of such continuing education requirements as may be imposed by law, this Hospital, or applicable accreditation agencies and as required by the Wyoming Board of Medicine to maintain licensure;

15. a statement as to whether the Applicant has ever withdrawn his/her application for appointment, reappointment, or clinical privileges, or resigned from a Medical Staff before the final decision of the Governing Board of such entity;

16. information as to whether the Applicant has ever been named as a defendant and/or convicted in a criminal action and details about any such instances;

17. information on the citizenship or visa status of the Applicant; and

18. information regarding whether the Applicant has ever been sanctioned by, or excluded or suspended from participation in Medicare, Medicaid or any other governmental reimbursement programs.

ii. Responsibility of Applicant

iii. The Practitioner shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, health status and other qualifications, and for resolving any doubts about such qualifications. Any material misrepresentation in, or omission from, the application and related documents, shall be grounds for denial of privileges or corrective action regardless of when the misrepresentation or omission is discovered.

3. completion of training programs, specialty, date of completion;

4. the granting of state licenses, dates and history of adverse action;

5. the granting of staff membership and privileges at other institutions and adverse actions;

6. specialty board certifications;

7. querying the National Practitioner Data Bank;

8. at least three references from persons who can provide adequate references pertaining to the Practitioner's professional competence and ethical character; and

9. satisfactory completion of such continuing education requirements as may be imposed by law, this Hospital, or applicable accreditation agencies~~.~~ and as required by the Wyoming Board of Medicine to maintain licensure. Beginning their fourth year after completion of residency or fellowship, Physicians who aren't yet board certified must complete and provide documentation of CME. Physicians who have a lifetime certification and aren't participating in Maintenance of Certification must also provide CME documentation. Documentation must be provided for 20 hours of CME per year, or at least sixty (60) hours of CME within the previous three (3) years.

10. Upon completion of the verification the Medical Staff Services Manager will forward the application to the appropriate staff Departmental Chair.

~~vi.~~vii. Responsibilities of Departmental Chair

The Departmental Chair or his/her designated representative, to which the application is forwarded, will review the application, and within ten (10) working days make a written report to the Credentials Committee on the qualifications of the Practitioner for admission to the Medical Staff as well as for specific privileges requested. In making this report, the Departmental Chair or his/her designated representative shall examine evidence of the character, professional competence, qualifications, health status and ethical standing of the Practitioner, and shall determine, through information contained in the references given and from other sources available to him/her whether the Practitioner has established and meets all of the

necessary qualifications for the Medical Staff category and the clinical privileges requested by him/her.

~~vii.~~viii. Responsibilities of the Credentials Committee

1. The Credentials Committee shall review the Practitioner's application for staff membership as well as for specific clinical privileges along with the report of the Departmental Chair or his/her representative at its first meeting following receipt of all these materials/ documents. The Credentials Committee shall review the Chair's recommendation, and either approve and adopt the Chair's recommendation, in whole or in part, or formulate its own written recommendation, and transmit the recommendation to the Medical Executive Committee.

2. Following review of the Practitioner's application and report of the department Chair or his/her designated representative; the Credentials Committee shall make a recommendation with respect to the Practitioner's appointment and/or clinical privileges. If favorable, it will be submitted, together with all supporting documentation, to the Medical Executive Committee for review and comment, and then to the Governing Board for final action.

~~viii.~~ix. Adverse Recommendation of Credentials Committee

When the recommendation of the Credentials Committee is adverse to the Practitioner either in respect to appointment or clinical privileges, the Medical Executive Committee shall be so advised and the Medical Staff Services Manager shall promptly notify the Applicant by certified mail, return receipt requested. No such adverse recommendation may be forwarded to the Governing Board until after the Applicant has exercised, or has been deemed to have waived, his/her rights to a hearing as provided by Article XIII of these Bylaws.

~~ix.~~x. Favorable Recommendation of Credentials Committee

At its next regular meeting after receipt of a favorable recommendation by the Credentials Committee, along with comments from the Medical Executive Committee, the Governing Board shall act in the matter. If the Governing Board's decision is adverse to the Practitioner in respect to either appointment or clinical privileges, the Medical Staff Services Manager shall promptly notify him/her of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the Applicant has exercised, or has been deemed to have waived, his/her rights under Article XIII of these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer clinical privileges where

ever been sanctioned by, or excluded or suspended from participation in Medicare, Medicaid or any other governmental reimbursement programs

ii. Responsibilities of Allied Health Professional

iii. The Allied Health Professional shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. Any material misrepresentation in, or omission from, the application and related documents, shall be grounds for denial of privileges or corrective action regardless of when the misrepresentation or omission is discovered.

~~iii.~~iv. Appearance, Authorization and Consent

By applying for appointment to the Allied Health Professional staff, each Allied Health Professional thereby signifies:

1. his/her willingness to appear for interviews in regard to his/her application;

2. his/her authorization for the Hospital to consult with members of Medical Staffs of other Hospitals with which the Allied Health Professional has been associated and with others who may have information bearing on his/her competence, character, health status and ethical qualifications;

3. his/her consent to the Hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests as well as his/her moral and ethical qualifications for Allied Health Professional staff membership;

4. his/her release from any liability of all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the Allied Health Professional and his/her credentials; and

5. his/her release from any liability all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the Allied Health Professional's competence,

membership as well as for specific clinical privileges along with the report of the Departmental Chair or his/her representative at its first meeting following receipt of all these materials/ documents. The Credentials Committee shall review the Chair's recommendation, and either approve and adopt the Chair's recommendation, in whole or in part, or formulate its own written recommendation, and transmit the recommendation to the Medical Executive Committee.

2. Following review of the Allied Health Professional's application and report of the Department Chair or his/her designated representative; the Credentials Committee shall make a recommendation with respect to the Allied Health Professional's appointment or clinical privileges. If favorable, it will be submitted, together with all supporting documentation, to the Medical Executive Committee for review and comment, then to the Governing Board for final action.

~~viii.~~ix. Adverse Recommendation of Credentials Committee

When the recommendation of the Credentials Committee is adverse to the Allied Health Professional, either in respect to appointment or clinical privileges, the Medical Executive Committee shall be so advised and the Chief Executive Officer shall promptly notify the Allied Health Professional by certified mail, return receipt requested. No such adverse recommendation may be forwarded to the Governing Board until after the Allied Health Professional has exercised or has been deemed to have waived, his/her rights as provided by Article V of these Bylaws.

~~ix.~~x. Favorable Recommendation of Credentials Committee

At its next regular meeting after receipt of a favorable recommendation by the Credentials Committee, along with comments from the Medical Executive Committee, the Governing Board shall act in the matter. If the Governing Board's decision is adverse to the Allied Health Professional, in respect to either appointment or clinical privileges, the Medical Staff Services Manager shall promptly notify him/her of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the Allied Health Professional has exercised, or has been deemed to have waived, his/her rights under Article XIII of the Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

d. The individual distant site Practitioner holds an appropriate license issued by the State of Wyoming by the appropriate licensing entity.

e. The Hospital maintains documentation of its internal review of the performance of each distant site Practitioner and sends the distant site such performance information for use in the distant site's periodic appraisal of the distant site Practitioner. At a minimum, this information must include:

i. All adverse events that result from the telemedicine services provided by the distant site Practitioner to Hospital patients; and

ii. All complaints the Hospital receives about the distant site Practitioner.

5. Board Certification

Applicants for appointment or re-appointment to the Medical Staff are required to adhere to the following requirements relative to board certification:

a. Board certification or the active pursuit of board certification in the specialty in which the Applicant seeks privileges, conferred by the American Board of Medical Specialties or the American Osteopathic Association is required.

b. In the absence of board certification, an Applicant must have successfully completed a residency training program in conjunction with the specialty in which the Applicant seeks privileges that is approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or from another recognized accredited training program approved by the Governing Board, and must be qualified to pursue and receive board certification.

c. Any physician granted clinical privileges, who does not attain board certification by their individual certifying board's deadline will be determined to not meet threshold criteria.

d. If a physician does not meet threshold criteria for their specialty, their medical staff membership and clinical privileges will be revoked. As this revocation is based solely on the failure of the physician to meet threshold criteria, this will not be reportable, and the Physician will not be entitled to a fair hearing.

e. Physician's eligibility for board certification (board eligible period) expires on a date determined by their individual certifying board. On appointment applications, physicians will be required to indicate the date that their board certification or board eligibility (if not certified) expires. The Medical Staff Office will track these expiration dates.

f. When a Physician's board eligibility lapses and certification has not been achieved, the physician must immediately notify the Medical Staff Office. If their

certifying board allows them to re-establish board eligibility, the candidate must complete all requirements set by their board, and must provide documentation of such, proving that they are once again board eligible or board certified.

~~b. Board certification must be obtained within seven (7) years from completion of residency or fellowship.~~

~~c. Applicants whose board certification has expired or whose board requires recertification must become re-certified as per their specific specialty board requirements.~~

~~d. Applicants who are not board certified and who have been Active, Consulting, or Locum Tenens, Temporary, Physician Staff members of the Hospital for a period of not less than five (5) years prior to March 10, 2004 shall not be required to obtain board certification.~~

~~6. Waiver of Criteria~~

~~a. Any individual who does not satisfy an eligibility criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.~~

~~b. The Board may grant waivers in exceptions cases after considering the findings of the Credentials Committee and the Medical Executive Committee, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.~~

~~c. No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.~~

~~d. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.~~

Section E. AGREEMENT OF APPLICANTS

1. Physicians and Licensed Independent Practitioners seeking appointment or reappointment agree that if an adverse ruling or other decision which is unfavorable to the Application is made with respect to Medical Staff membership, status, and/or clinical privileges, the Applicant must resort to the administrative remedies afforded by these Bylaws in Article XIII before seeking to pursue to any formal legal action.

2. Allied Health Professionals are not members of the Medical Staff and accordingly shall have no recourse to the procedural rights set forth in these Bylaws in Article XIII, but

by a two-thirds (2/3) majority vote of the Medical Staff present at any annual or special meeting at which a quorum is present, but no such removal shall be effective unless and until it has been ratified by the Governing Board . Cause for such removal may be for reasons unrelated to professional capabilities or the exercise of clinical privileges, and may include failing to perform the duties of the position or exhibiting conduct detrimental to the interests of the Hospital. Without further action pursuant to these Bylaws, removal from office does not affect the Medical Staff appointment or clinical privileges of the Physician or Licensed Independent Practitioner so removed.

ARTICLE VIII
CLINICAL DEPARTMENTS

Section A. ORGANIZATION OF CLINICAL DEPARTMENTS

Each department shall be organized as a separate part of the Medical Staff and shall have a Chair and a Vice-Chair. The Chair shall be responsible for the overall supervision of the clinical work within the department. In the absence of the Chair the Vice-Chair shall assume all the duties and have the authority of the Chair. The Medical Staff of Memorial Hospital of Sweetwater County shall be organized into the following departments:

1. Surgery Department

   The Surgery Department shall include those Practitioners primarily engaged in surgical care.

2. Medicine Department

   The Medicine Department shall include those Practitioners primarily engaged in non-surgical medical care.

~~3. General Services Department~~

~~The General Services Department shall include those Practitioners who are primarily based in a clinical area located within the Hospital.~~

Section B. FUNCTIONS OF DEPARTMENTS

1. Responsibilities

   Each clinical department shall:

   a. through the Departmental Chair, recommend to the Credentials Committee written criteria for the assignment of clinical privileges that are consistent with,

l. evidence of current, adequate professional liability insurance as determined by the governing body; and

m. a statement regarding physical/mental health status, including alcohol abuse and/or drug dependency.

n. satisfactory completion of such continuing education requirements as may be imposed by law, this hospital, or applicable accreditation agencies and as required by the Wyoming Board of Medicine to maintain licensure.

2. Responsibility of Applicant

The practitioner shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, health status and other qualifications, and for resolving any doubts about such qualifications. Any material misrepresentation in, or omission from, the application and related documents, shall be grounds for denial of privileges or corrective action regardless of when the misrepresentation or omission is discovered.

3. Applicant Authorization and Consent

By applying for appointment to the medical staff, each practitioner thereby signifies:

a. his/her willingness to appear for interviews in regard to his/her application;

b. his/her authorization for the hospital to consult with members of medical staffs of other hospitals with which the practitioner has been associated and with others who may have information bearing on his/her competence, character, health status and ethical qualifications;

c. his/her consent to the hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests as well as his/her moral and ethical qualifications for medical staff membership;

d. his/her release from any liability of all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating the practitioner and his/her credentials; and

e. his/her release from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the practitioner's competence, ethics, character, health status and other qualifications for medical staff appointment and clinical privileges including otherwise privileged or confidential information.

ethical standing of the practitioner, and shall determine, through information contained in the references given and from other sources available to him/her whether the practitioner has established and meets all of the necessary qualifications for the medical staff category and the clinical privileges requested by him/her.

7. Responsibilities of the Credentials Committee

a. ~~a.~~ The Credentials Committee shall review the practitioner's application for staff membership as well as for specific clinical privileges along with the report of the departmental chairman or his/her representative at its first meeting following receipt of all these materials/ documents.

~~a.~~b. Following review of the practitioner's application and report of the department chairman or his/her designated representative, the Credentials Committee shall make a recommendation with respect to the practitioner's appointment and/or clinical privileges. The Credentials Committee shall review the Chair's recommendation, and either approve and adopt the Chair's recommendation, in whole or in part, or formulate its own written recommendation, and transmit the recommendation to the Medical Executive Committee. ~~If favorable, it will be submitted, together with all supporting documentation, to~~ the Medical Executive Committee will ~~for~~ review and comment, and then forward the credentials file to the governing body for final action.

8. Adverse Recommendation of Credentials Committee

When the recommendation of the Credentials Committee is adverse to the practitioner either in respect to appointment or clinical privileges, the Medical Executive Committee shall be so advised and the Executive Director shall promptly notify the applicant by certified mail, return receipt requested. No such adverse recommendation may be forwarded to the governing body until after the applicant has exercised, or has been deemed to have waived, his/her rights to a hearing as provided by Article XIII of the bylaws.

9. Favorable Recommendation of Credentials Committee

At its next regular meeting after receipt of a favorable recommendation by the Credentials Committee, along with comments from the Medical Executive Committee, the governing body shall act in the matter. If the governing body's decision is adverse to the practitioner in respect to either appointment or clinical privileges, the Executive Director shall promptly notify him/her of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the applicant has exercised, or has been deemed to have waived, his/her rights under Article XIII of the bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer clinical privileges where none existed before.

10. Responsibilities of the Governing Body

the governing body; and

l. a statement regarding physical/mental health status, including alcohol abuse and/or drug dependency;

l. satisfactory completion of such continuing education requirements as may be imposed by law, this hospital, or applicable accreditation agencies.

2. Responsibilities of Allied Health Professional

The allied health professional shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. Any material misrepresentation in, or omission from, the application and related documents, shall be grounds for denial of privileges or corrective action regardless of when the misrepresentation or omission is discovered.

3. Appearance, Authorization and Consent

By applying for appointment to the allied health professional staff, each allied health professional thereby signifies:

a. his/her willingness to appear for interviews in regard to his/her application;

b. his/her authorization for the hospital to consult with members of medical staffs of other hospitals with which the allied health professional has been associated and with others who may have information bearing on his/her competence, character, health status and ethical qualifications;

c. his/her consent to the hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests as well as his/her moral and ethical qualifications for allied health professional staff membership;

d. his/her release from any liability of all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating the allied health professional and his/her credentials; and

e. his/her release from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the allied health professional's competence, ethics, character, health status and other qualifications for allied health professional staff appointment and clinical privileges including otherwise privileged or confidential information.

sources available to him/her whether the allied health professional has established, and meets all of the necessary qualifications, for the allied health professional staff category and the clinical privileges requested by him/her.

7. Responsibilities of the Credentials Committee

a. ~~a.~~ The Credentials Committee shall review the allied health professional's application for allied health professional staff membership as well as for specific clinical privileges along with the report of the departmental chairman or his/her representative at its first meeting following receipt of all these materials/ documents.

b. ~~b.~~

c. Following review of the practitioner's application and report of the department chairman or his/her designated representative, the Credentials Committee shall make a recommendation with respect to the practitioner's appointment and/or clinical privileges. The Credentials Committee shall review the Chair's recommendation, and either approve and adopt the Chair's recommendation, in whole or in part, or formulate its own written recommendation, and transmit the recommendation to the Medical Executive Committee. The Medical Executive Committee will review and comment, and then forward the credentials file to the governing body for final action.

~~Following review of the allied health professional's application and report of the department chairman or his/her designated representative, the Credentials Committee shall make a recommendation with respect to the allied health professional's appointment or clinical privileges. If favorable, it will be submitted, together with all supporting documentation, to the Medical Executive Committee for review and comment, then to the governing body for final action.~~

8. Adverse Recommendation of Credentials Committee

When the recommendation of the Credentials Committee is adverse to the allied health professional, either in respect to appointment or clinical privileges, the Medical Executive Committee shall be so advised and the chief executive officer shall promptly notify the allied health professional by certified mail, return receipt requested. No such adverse recommendation may be forwarded to the governing body until after the allied health professional has exercised or has been deemed to have waived, his/her rights to a hearing as provided by Article XIII of these bylaws.

9. Favorable Recommendation of Credentials Committee

At its next regular meeting after receipt of a favorable recommendation by the Credentials Committee, along with comments from the Medical Executive Committee, the governing body shall act in the matter. If the governing body's decision is adverse to the allied health professional, in respect to either appointment or clinical privileges, the

require written consultation from at least two disinterested, qualified physician consultants.

Section VIII. CONSULTATIONS

A. Responsibilities of Practitioners

The good conduct of medical practice includes the proper and timely use of consultation. Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and treatment, rests with the practitioner who has responsibility for the care of the patient. On the other hand, it is the duty of the organized medical staff, through its departmental chairmen and the Medical Executive Committee, to see that those with clinical privileges do not fail in the matter of consultants as needed.

B. Qualifications for Consultants

Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his area of expertise. Consulting physicians will provide documentation for the hospital's EMR. This documentation shall be entered directly, scanned in, or dictated.

C. Requests for Consultation

1. Recommendations for Consultation

Except in an emergency, consultation is recommended in the following situations:

a. when the patient is not a good risk for operation or treatment;

b. where the diagnosis is obscure after ordinary diagnostic procedures have been completed;

c. where there is doubt as to the choice of therapeutic measures to be utilized;

d. in unusually complicated situations where specific skills of other practitioners may be needed;

e. when requested by the family; and

f. for therapeutic abortions.

D. Responsibilities of Attending Practitioner

The attending practitioner is primarily responsible for requesting consultation when indicated and for calling a qualified consultant. He/she will provide written authorization to permit another attending practitioner to attend or examine his/her patient, except in an emergency.

Memorial Hospital of Sweetwater County Medical Staff Bylaws
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MEMORIAL HOSPITAL OF SWEETWATER COUNTY
MEDICAL STAFF BYLAWS

PREAMBLE

□ H□R□□S□ Memorial Hospital of Sweetwater County (the "Hospital") is a County Hospital organi□ed and acting under the laws of the State of □ yoming□ and

□ H□R□□S□ the purpose of the Hospital is to serve as a general Hospital providing patient care□education and research□and

□ H□R□□S□ □he Practitioners and □llied Health Professionals providing patient care and services recogni□e their overall responsi□ility for the □uality of the professional services provided □y individuals with clinical privileges on the Medical Staff□as well as the responsi□ility to the □overning □oard□ and

□ H□R□□S□ Cooperative efforts of the Medical Staff□□dministration and □overning □oard are necessary to fulfill the Hospital□s aims and goals in providing patient care□education□and research.

□ H□R□□S□ □he Medical Staff □ylaws□Rules and Regulations□and policies and those of the □overning □oard □ylaws are free of conflicting statements.

□H□R□□OR□□ □he Practitioners and □llied Health Professionals who provide professional services at Memorial Hospital of Sweetwater County orga□ ni□e themselves into a Medical Staff□pursuant to the terms hereof □the "Bylaws"), and those other Policies□Rules and Regulations contemplated herein.

DEFINITIONS

1. **ALLIED HEALTH PROFESSIONAL** or **AHP** means an individual other than a licensed Practitioner as defined by these Bylaws who exercises independent judgment within the areas of his/her professional competence and who is qualified to render direct or indirect medical dental or surgical care under the supervision of a Practitioner who has been afforded privileges to provide such care in the Hospital. Such AHP's shall include without limitation Bacteriologists Chemists Clinical Pharmacologists Clinical Psychologists Dental Auxiliaries Nurse Clinicians/Practitioners Certified Lactation Consultants Certified Registered Nurse Anesthetists Other Doctor Scientists Physician Assistants Physiologists and Qualified Therapists (e.g. occupational physical respiratory) anyone who can be licensed or certified by the State of Wyoming.

2. **APPLICANT** means any Practitioner applying for appointment to the Medical Staff or requesting any privileges to perform medical services at the Hospital including without limitation any existing Appointee to the Medical Staff requesting additional privileges or appointment to any department or committee.

3. **APPOINTEE** means a Practitioner duly appointed to and serving as a member of the Medical Staff.

4. **BYLAWS** means these Bylaws and each of its exhibits attachments or other items incorporated herein by reference as each may be amended from time to time.

5. **CHIEF EXECUTIVE OFFICER** means the individual appointed by the Governing Board to act on its behalf in the overall administrative management of the Hospital.

6. **CLINICAL PRIVILEGES** or **PRIVILEGES** means the permission granted to Practitioners to provide patient care and includes access to those available Hospital resources including equipment facilities and Hospital personnel which are necessary to effectively exercise those privileges.

7. **EX-OFFICIO** means serves as a member of a body by virtue of an office or position held and unless otherwise expressly provided without voting rights.

8. **GOVERNING BOARD** or **BOARD** means the Board of Trustees of Memorial Hospital of Sweetwater County.

9. **LIMITED INDEPENDENT PRACTITIONER** or **LIP** means any medical Practitioner other than Physicians who are authorized to practice in Hospitals by the applicable law then existing in Wyoming and is licensed by the State of Wyoming.

10. **INVESTIGATION COMMITTEE** means a committee appointed to investigate a request for corrective action regarding an Appointee pursuant to Article hereunder.

11. **MEDICAL EXECUTIVE COMMITTEE** or **EXECUTIVE COMMITTEE** or **MEC** means the □□ecutive Committee of the Medical Staff□as constituted pursuant to these □ylaws.

12. **MEDICAL STAFF** or **STAFF** means the formal organi□ation of all □icensed Practitioners who attend patients in the Hospital.

13 **MEDICAL STAFF YEAR** means the period from the first day of □anuary to the thirty□ first day of □ecem□er.

14. **PHYSICIAN** means an individual with an M.□. or □.O. degree who is fully licensed and authori□ed to practice medicine in the State of □ yoming.

15. **POLICIES** mean those policies and procedures for the operations and management of the Hospital enacted □y the Medical Staff□the Medical □□ecutive Committee□or the □overning □oard pursuant to these □ylaws.

16. **PRACTITIONER** means any appropriately licensed healthcare professional granted privileges to practice in Hospitals □y the applica□le law in □ yoming applying for□or e□ercising□clinical privileges in this Hospital.

17. **PRESIDENT** means the President of the Medical Staff□who shall also serve as the Chair of the Medical □□ecutive Committee.

1□ **PROFESSIONAL REVIEW ACTIVITY** means any activity of the Hospital with respect to a Practitioner □i□to determine whether an □pplicant or □ppointee may have clinical privileges at the Hospital or mem□ership on the Medical Staff□□ii□to determine the scope of conditions of such privileges or mem□ership□or □iii□to change or modify such privileges or mem□ership.

19. **RULES AND REGULATIONS** mean those Rules and Regulations regarding Medical Staff □ppointees□committees□and other operational matters at the Hospital enacted □y the Medical Staff□the Medical □□ecutive Committee□or the □overning □oard pursuant to these □ylaws.

20. **TELEMEDICINE** means the provision of clinical services to patients □y Practitioners from a distance via electronic communication.

21. **VACANCY** means that period when an appointed or elected position is unoccupied□the time of which is recogni□ed □y the President of the Medical Staff.

ARTICLE I

NAME

The name of this organization shall be the **"Medical Staff of Memorial Hospital of Sweetwater County."**

ARTICLE II
MEDICAL STAFF ORGANIZATION

Section A. PURPOSES

The purposes and responsibilities of the Medical Staff are:

1. To be the formal organizational structure through which the benefits of appointment to the Medical Staff may be obtained by individual Practitioners and the obligations of Medical Staff appointment, including the requirement that appointees work cooperatively with each other and with Hospital staff, may be fulfilled.

2. To serve as the primary means of accountability to the Governing Board for the appropriateness of the professional performance, cooperative behavior, and ethical conduct of appointees; to monitor the patient safety, patient satisfaction and quality of patient care delivered in the Hospital, and to make recommendations thereon to the Board.

3. To establish procedures whereby issues concerning the Medical Staff and the Hospital may be discussed both within the Medical Staff and with the Governing Board and to provide a means through which the Medical Staff may participate in the Hospital's policy-making and planning process.

4. To recommend to the Board action with respect to appointments, staff categories, clinical privileges, specified services for Allied Health Professionals, and corrective action.

5. To ensure that all patients, regardless of race, creed, color, sex, or national origin, admitted to the Hospital or treated in the ambulatory facilities shall receive appropriate patient care, and

6. To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill through educational activities that relate at least in part to the type and nature of care offered by the Hospital, as demonstrated through the Hospital's quality improvement activities and the Medical Staff's focused and ongoing professional practice evaluations.

Section B. GENERAL RESPONSIBILITIES OF APPOINTEES

As a general responsibility of Medical Staff appointment each appointee agrees to participate in the functions performed by departments divisions Medical Staff committees Medical Staff Officers or interdisciplinary Hospital committees as assigned in accordance with these bylaws as approved and upheld by the Governing Board.

1. Responsibilities:

   a. Monitoring and evaluation of care provided and the development and periodic review and amendment of written Policies for special care areas such as medical imaging laboratory pulmonary medicine physical medicine anesthesia emergency outpatient home care and other ambulatory care services and such other areas as directed by the MEC from time to time

   b. Coordination and performance of quality and appropriateness reviews including but not limited to tissue blood usage antibiotic and drug usage medical records and surgical case review participation and cooperation in any investigation and/or the resolution of sentinel events

   c. Coordination cooperation with and performance of utilization review

   d. Provision of continuing education opportunities responsive to quality activity findings new state of the art developments and other perceived needs

   e. Development administration and recommendation of amendments to see and enforce compliance with these bylaws Policies Rules and Regulations of the Medical Staff and Hospital and the enforcement and compliance thereof

   f. Assistance in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those goals

   g. Development and maintenance of drug utilization policies and surveillance of drug usage and

   h. Development of complete admission histories and physical examinations performed and recorded within twenty four (24) hours of inpatient admission. Such reports should include identifying data chief complaint history of present illness significant past medical and surgical history relevant family history social history a review of all systems of the body physical examination significant laboratory results provisional diagnosis and treatment plan. If a complete history has been recorded and a physical examination performed within one week prior to the patient's admission to the Hospital a reasonably durable legible copy of these reports may be used in the patient's Hospital medical record in lieu of the admission history and report of the physical examination provided these reports were recorded by a member of the Medical Staff. In such instances

an interval admission note that includes all additions to the history and any su□se□uent changes in the physical findings must always □e recorded.

Section C. PRINCIPLES OF PRACTICE

□ll health care rendered in this institution shall □e □ased on accepted □iomedical□scientific principles and current information.

ARTICLE III
CATEGORIES OF THE PHYSICIAN STAFF

Section A. THE PHYSICIAN STAFF

□he Physician Staff shall □e divided into Honorary□□ctive□□ssociate□□ffiliate□Consulting□and □ocum □enens Staff categories□as further defined □elow and in the Rules□Regulations□and Policies.

1. □he Honorary Physician Staff

   a. □he Honorary Physician Staff shall consist of Physicians recogni□ed for their outstanding reputations□their noteworthy contri□utions to the health and medical sciences□and their previous service to the Hospital.

   □. Honorary Physician Staff mem□ers are not eligi□le to admit patients to the Hospital. □hey may□however□attend staff meetings and any staff or Hospital education meetings. Honorary Staff Mem□ers shall not □e eligi□le to vote or to hold office in the Medical Staff organi□ation.

2. □he □ctive Physician Staff

   a. □he □ctive Physician Staff shall consist of Physicians who care for patients at the Hospital□who are located within the Hospital's service area□as defined in the Rules□Regulations and/or the Policies□from time to time so as to provide continuous care to their patients□and who assume all the functions and responsi□ilities of mem□ership on the active Physician Staff□including□where appropriate□providing emergency service care and consultation assignments.

   □. Mem□ers of the □ctive Physician staff shall □e appointed to a specific department□shall □e eligi□le to vote□to hold office□to serve on Medical Staff committees and it is recommended that they attend meetings of the Medical Staff□ such as Physician's departmental meeting and any committee meetings on which Physician serves.

3. The Associate Physician Staff

a. The Associate Physician Staff shall consist of Physicians who following their initial appointment are being considered for advancement to the Active Physician Staff. The duration of Associate Medical Staff status shall be for one (1) year from such Applicant's initial appointment to the Medical Staff. During this time, the Associate Medical Staff Appointee's performance will be monitored to determine the eligibility of such Associate Medical Staff Appointee for appointment to the Active Physician Staff.

. Monitoring of the Associate Staff member shall be accomplished through Focused Professional Practice Evaluation (FPPE) as provided for in these Medical Staff Bylaws Rules and Regulations and policies. The Associate Staff Member must successfully complete FPPE to determine their competence to practice the clinical privileges granted. The results of such FPPE shall be considered in conjunction with the Associate Staff Member's application for renewal of clinical privileges.

c. If the Associate Staff Member does not complete FPPE within the required time period he/she shall not be eligible to apply for renewal of clinical privileges and his/her grant of clinical privileges shall expire at the end of the initial grant period. This expiration of clinical privileges will not entitle the Associate Staff member to a fair hearing as their failure to complete FPPE will be interpreted as not meeting threshold criteria.

d. Appointments to the Associate Medical Staff may not exceed one (1) full year with an additional one (1) Medical Staff Year extension for up to 12 months for good reason as recommended by Credentials Committee and approved by the Medical Executive Committee at which time failure to remove such provisional status shall be deemed a termination of his/her Medical Staff appointment. An Associate Medical Staff member whose membership is terminated shall have the rights accorded by the Medical Staff Bylaws to an Active Physician Staff member who has failed to be reappointed to the Active Medical Staff.

e. The Associate Staff shall be appointed to a specific department shall be eligible to vote and serve on all Medical Staff committees and it is recommended that they attend all meetings of the Medical Staff, such Physician's department meetings and any committee on which such Physician serves. The Associate Staff members shall be ineligible to hold office in this Medical Staff organization. They shall assume all other duties and responsibilities of a Medical Staff member.

4. The Consulting Physician Staff

a. The Consulting Physician Staff shall consist of Physicians of recognized professional ability experience and maturity who occasionally come to the Hospital on a predefined schedule or to act as a consultant upon request of any credentialed of the Medical Staff.

□. □he Consulting Physician Staff must possess e□pertise or training materially valua□le to the Hospital□as such is determined □y the M□C□and approved □y the □overning □oard□ not availa□le from active or □ssociate Staff mem□ers. Consulting Physician staff mem□ers may admit patients under special circumstances□not to e□ceed 12 admits per year. □on□admitting Physicians □radiologists□pathologists□emergency Physicians□etc.□wor□ing at the Hospital may not engage in more than 50 hours of wor□□per year.

c. Consulting physicians will provide documentation for the hospital's EMR. This documentation will □e entered directly□scanned in□or dictated.

d. Consulting Physician Staff mem□ers shall not □e permitted to vote or hold office. Consulting Staff mem□ers may attend meetings of the Medical Staff and □epartments of which he/she is a mem□er and any staff or Hospital educational programs.

e. Consultation shall not □e limited to mem□ers of this Medical Staff category.

f. □ach mem□er of the Consulting Physician Staff e□pressly authori□es the Hospital to monitor and evaluate such member's professional performance in such manners as authori□ed pursuant to the Rules and Regulations and the Policies□regardless of whether such member comes to or sees patients at the Hospital's facilities.

5. □ocum □enens Staff

□his category is for Physicians who provide temporary service to the Hospital. □ocum □enens Privileges may □e granted only for a specific period of time□not to e□ceed twelve □12□months per appointment□and shall automatically e□pire at the end of the specified period□without recourse □y the Practitioner under the Medical Staff □ylaws. □ocum □enens □ppointees shall not □e eligi□le to vote or to hold office in the Medical Staff organi□ation. □hey may□however□attend staff and departmental meetings and any staff or Hospital education meetings

6. □he □ffiliate Physician Staff

a. □he □ffiliate Physician Staff shall consist of Physicians who perform same□ day/outpatient surgery procedures at the Hospital. □ffiliate Staff mem□ers shall have a permanent medical office located within the primary geographic area served □y the Hospital.

□. Mem□ers of the □ffiliate Physician Staff shall □e appointed to a specific department□□ut shall not □e eligi□le to vote□hold office□or serve on Medical Staff committees. □ffiliate Physician Staff mem□ers may attend meetings of the Staff and departments of which he/she is a mem□er and any staff or Hospital education

programs. □ffiliate Physician Staff mem□ers are not re□uired to provide emergency service care or ta□e call unless residing in Sweetwater County.

c. □ach mem□er of the □ffiliate Medical Staff is re□uired to provide assurance of immediacy of ade□uate professional care for his/her patients in the Hospital □y □eing availa□le or having availa□le□within a reasona□le period of time□an eligi□le alternate Practitioner with whom prior arrangements have □een made. □ffiliate Physicians that will □e unavaila□le immediately following a patient procedure shall file a Plan of Care outlining plans for continued coverage arrangements. □he Plan of Care shall indicate in writing on the order sheets of the patient's chart the name of an eligi□le alternate Practitioner □same surgical su□specialty□who will □e assuming responsi□ility for the care of that patient or for sta□ili□ing and transferring the patient□if necessary due to complications□during the Physician's a□sence.

d. □he □uality of care rendered □y □ffiliate Physician Staff will □e reviewed □y the same standards applied to □ctive Physicians and they will □e appointed and reappointed according to □rticle □□of these □ylaws□□. and □. of the Rules and Regulations.

ARTICLE IV
LICENSED INDEPENDENT PRACTITIONER

Section A. QUALIFICATIONS

Classes of health care Practitioners□other than Physicians□authori□ed to practice in Hospitals □y the applica□le law in □ yoming□approved □y the □overning □oard□who have □een licensed □y their respective licensing agencies and who desire to provide professional services in the Hospital□are eligi□le to serve as □icensed □ndependent Practitioners on the Medical Staff.

Section B. CONDITIONS OF SERVICE

1. Responsi□ilities

a. □icensed □ndependent Practitioners may admit patients only in con□unction with an □ctive or □ssociate Staff Mem□er. □hey shall □e located within the geographic service area of the Hospital re□uired of □ctive Physician Staff□close enough to fulfill their responsi□ilities and to provide such services as allowed □y their clinical privileges on the Medical Staff. □hey may not hold office.

□. □icensed □ndependent Practitioners may not hold office and/or serve on committees□su□□ect to those limitations provided in these □ylaws□the Rules and Regulations□and/or the Policies.

c. All licensed independent Practitioners within each department may attend department and general Medical Staff meetings.

d. All licensed independent Practitioners will be eligible to vote in the general Medical Staff election of Medical Staff officers.

2. Quality Assurance Appointments Reappointments and Privileges

a. Licensed independent Practitioners will be appointed and reappointed to the Medical Staff in accordance with the same requirements applicable to Physicians pursuant to Article of these Bylaws and the Rules and Regulations and the Policies.

. Licensed independent Practitioners may within the scope of his or her professional licensure certification and practice privileges and consistent with these Bylaws and the Rules and Regulations and the Policies provide patient care services and exercise independent judgment in his or her area of competence and participate directly in the management of patients provided that a Physician Medical Staff member within the appropriate department or specialty has overall responsibility for the care provided to each patient.

c. The quality of care rendered by licensed independent Practitioners will be reviewed by the same standards applied to Physicians pursuant to these Bylaws and the Rules and Regulations and the Policies adopted hereunder.

Section C. PODIATRISTS

1. Podiatrists with appropriate two-year residency training documentation and recommendations will be allowed to perform surgery including and not to extend beyond the midfoot.

2. Podiatrists will be allowed to document his/her portion of the pre-operative physical examination.

3. Any post-operative podiatry patient requiring admission or readmission after surgery will be co-admitted by a qualified MD or DO physician. The podiatrist will be allowed to document his/her portion of the admission/readmission physical exam with the remainder being completed by a qualified MD or DO physician member of the medical staff.

ARTICLE V
ALLIED HEALTH PROFESSIONALS

Section A. QUALIFICATIONS

Classes of health care professionals other than Physicians and licensed independent Practitioners approved by the Governing Board who have been licensed or certified by their respective licensing or certifying agencies and who desire to provide professional services in the Hospital are eligible to serve as Allied Health Professionals.

Section B. CONDITIONS OF SERVICE

Allied Health Professionals are not entitled to the rights privileges and responsibilities of appointment to the Medical Staff. They may only engage in acts within the scope of practice or clinical privileges specifically granted by the Governing Board. They shall be located within the geographic service area of the Hospital required of Active Physician Staff close enough to fulfill their responsibilities and to provide such services under the supervision of Physicians who are presently members of the Medical Staff as further defined in these Bylaws the Rules and Regulations and the Policies.

Section C. LIMITATIONS & GRIEVANCES

Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an Allied Health Professional to the procedural rights set forth in Article III of these Bylaws. An Allied Health Professional who receives an adverse privileging decision may challenge such action by filing a written grievance with the Medical Executive Committee within fifteen (15) days of the action. Within thirty (30) days of receipt of the grievance the Medical Executive Committee will conduct an investigation. The Allied Health Professional will have the opportunity for an interview with the Medical Executive Committee concerning the grievance at which time the Allied Health Professional may present relevant information. Such interview shall not constitute a hearing as established by the Medical Staff Bylaws and shall not be conducted according to the procedural rules applicable to such hearings. The Medical Executive Committee shall make a decision regarding the issue and make a recommendation to the Governing Board. The Governing Board will take final action.

ARTICLE VI
APPOINTMENTS, REAPPOINTMENTS AND PRIVILEGES

Section A. GENERAL

Membership on the Medical Staff of the Hospital is a privilege extended only to Practitioners who continuously meet the qualifications standards and requirements set forth in these Bylaws the Rules and Regulations and the Policies. All appointments reappointments and privileges are recommended by the Medical Staff and are granted by the Governing Board. Appointments to the Medical Staff are made without regard to gender race creed age national origin or disability provided that the

individual is competent to render care consistent with the professional level of □uality and competence esta□lished □y these □ylaws and the Rules and Regulations and the Policies of the Hospital.

Section B. APPOINTMENTS AND REAPPOINTMENTS

1. Medical Staff

   □ll healthcare professionals authori□ed to practice in Hospitals □y the applica□le law in □ yoming□who are licensed to practice in the state of □ yoming and who desire to provide professional services in the Hospital□are eligi□le to apply for appointment to the Medical Staff of the Hospital.

2. □llied Health Professionals

   □ll □llied Health Professionals as defined □y these □ylaws are eligi□le to apply for appointment to the □llied Health Professional Staff of the Hospital.

3. □erms of □ppointment

   □nless otherwise specified□all initial appointments to the Medical Staff and □llied Health Professional Staff will □e for a one □1□year period. Su□se□uent reappointments shall □e for no longer than two □2□ years e□cluding □ocum □enens su□se□uent reappointments□which shall □e for a one □1□year period.

4. Procedure for □ppointment/Reappointment

   a. Medical Staff □ppointment

      i. □pplication:

         □ach application for appointment to the Medical Staff shall □e signed □y the □pplicant□ and shall □e su□mitted on a form prescri□ed □y the □overning □oard after consultation with the Medical □□ecutive Committee. □he application shall re□uire detailed information concerning the □pplicant□s professional □ualifications including:

            1. □ll schools attended and date of degree□

            2. □ll postdoctoral training programs with dates of successful completion□

            3. □ll special training programs with dates of successful completion□

            4. □ll state licenses□licensure dates□and history of adverse actions□if any□

5. □ll staff mem□ership and privileges at other institutions□dates of privileging□and history of adverse or corrective actions□if any□

6. □ statement specifying any circumstances and □udgments and/or settlements of any previous or pending malpractice actions involving the Practitioner□

7. □he names of three medical or healthcare professionals who have personal □nowledge of the □pplicant's current clinical abilities, ethical character□and a□ility to wor□cooperatively with others and who will provide specific written comments on these matters. □he named individuals must have ac□uired the re□uisite □nowledge through recent o□servation of professional practice over a reasona□le period of time and prefera□ly have a current affiliation with an acute care institution and at least one must □e from a colleague in the □pplicant□s specialty. □he references may not □e relatives or have any recently initiated□or impending□professional partnership/financial associations with □pplicant□

□. □ statement that the Practitioner has received or □een given access to□and read the □ylaws and Rules and Regulations of the Medical Staff and that he/she agrees to □e □ound □y the terms thereof if he/she is granted mem□ership and/or clinical privileges and to □e □ound □y the terms thereof without regard to whether or not he/she is granted mem□ership and/or privileges in all matters relating to consideration of his/her application□

9. □nformation as to whether any of the following has ever □een□or is in the process of □eing□denied□revo□ed□suspended□reduced□not renewed□or voluntarily relin□uished:

   a. Staff mem□ership status or privileges at any other Hospital or healthcare institution□

   □. Mem□ership/fellowship in local□ state or national professional organi□ations□

   c. Specialty □oard certification□

   d. □icense to practice any profession in any □urisdiction□

   e. □rug enforcement agency or other controlled su□stances registration□

10. A statement of experience during the most recent five (5) years including a consent to the release of information by his/her present and past malpractice insurance carrier(s).

11. A statement whereby the Practitioner agrees that when an adverse ruling is made with respect to his/her staff membership staff status and/or privileges he/she will resort to the administrative remedies afforded by the Medical Staff Bylaws Rules & regulation before resorting to formal legal action.

12. Evidence of current adequate professional liability insurance as determined by the Governing Board.

13. A statement regarding physical/mental health status including alcohol abuse and/or drug dependency as permitted by applicable law.

14. Satisfactory completion of such continuing education requirements as may be imposed by law, this Hospital, or applicable accreditation agencies and as required by the Wyoming Board of Medicine to maintain licensure.

15. A statement as to whether the Applicant has ever withdrawn his/her application for appointment, reappointment, or clinical privileges, or resigned from a Medical Staff before the final decision of the Governing Board of such entity.

16. Information as to whether the Applicant has ever been named as a defendant and/or convicted in a criminal action and details about any such instances.

17. Information on the citizenship or visa status of the Applicant and

18. Information regarding whether the Applicant has ever been sanctioned by or excluded or suspended from participation in Medicare, Medicaid or any other government reimbursement programs.

ii. Responsibility of the Applicant

The Practitioner shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, health status and other qualifications, and for resolving any doubts about such qualifications. Any material misrepresentation in or omission from the

application and related documents shall □e grounds for denial of privileges or corrective action regardless of when the misrepresentation or omission is discovered.

iii. □pplicant □uthori□ation and Consent

□y applying for appointment to the Medical Staff□ each Practitioner there□y signifies:

1. His/her willingness to appear for interviews in regard to his/her application□

2. His/her authori□ation for the Hospital to consult with mem□ers of Medical Staffs of other Hospitals with which the Practitioner has □een associated and with others who may have information □earing on his/her competence□ character□ health status and ethical □ualifications□ including otherwise privileged or confidential information□ provided □y third parties □earing on his or her credentials□and agreement that any information so provided shall not □e re□uired to □e disclosed to him or her if the third party providing such information does so on the condition that it □e □ept confidential□

3. His/her consent to the Hospital□s inspection of all records and documents that may □e material to an evaluation of his/her professional □ualifications and competence to carry out the clinical privileges he/she re□uests as well as his/her moral and ethical □ualifications for Medical Staff mem□ership□

4. His/her release from any lia□ility of all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the Practitioner and his/her credentials□

5. His/her release from any lia□ility all individuals and organi□ations who provide information to the Hospital concerning the Practitioner□s competence□ethics□character□health status and other □ualifications for Medical Staff appointment and clinical privileges including otherwise privileged or confidential information□

6. His/her authori□ation to third parties to release information□ including otherwise privileged or confidential information□as well as reports□ records□ statements□ recommendations and other documents in their possession□□earing on his/her credentials to the Hospital□and consents to the inspection and procurement □y the Hospital of such information□records and other documents□

7. His/her authori□ation to release information a□out such individual to other healthcare entities and their agents□ who solicit such information for the purpose of evaluating the individual□s professional □ualifications pursuant to the individual's re□uest for appointment□reappointment or clinical privileges□

□. His/her authori□ation to maintain information concerning the □pplicant's age, training, board certification□licensure□and other confidential information in a centrali□ed physician data□ase for the purpose of ma□ing aggregate physician information availa□le for use □y the Hospital□

9. His/her authori□ation to release confidential information□including peer review and/or □uality assurance information□o□tained from or a□out the □pplicant or Medical Staff □ppointee to peer review committees of the Hospital for purposes of reducing mor□idity and mortality and for the improvement of patient care□

10. His/her consent to the reporting □y the Hospital of information to the □ational Practitioner □ata □an□ esta□lished pursuant to the Health Care □uality □mprovement □ct of 19□6 which the Hospital □elieves in good faith is re□uired □y law to □e reported□and

11. His/her agreement that the foregoing provisions are in addition to any agreements□ understandings□ covenants□ waivers□ authori□ations or releases provided □y law or contained in any application or re□uest forms.

iv. □iscrimination

□o considerations of se□□race□creed□and/or national origin may □e used in the granting or denying of Medical Staff mem□ership or clinical privileges.

v. Responsi□ilities of the Medical Staff Services Manager

1. □he completed application shall □e su□mitted to the Hospital□s Medical Staff Services Manager. □he Medical Staff Services Manager shall □e responsi□le to review the application for veracity. □he credentialing process re□uires that the Hospital verify in writing and from the primary source□whenever feasi□le□the items listed □elow. □nitiation of the verification process of at least the following items will □egin within a reasona□le time after receipt of a completed application:

2. □egrees conferred□when and the institution□

3. Completion of training programs□specialty□date of completion□

4. □he granting of state licenses□dates□and history of adverse action□

5. □he granting of staff mem□ership and privileges at other institutions and adverse actions□

6. Specialty □oard certifications□

7. □uerying the □ational Practitioner □ata □an□□

□. □t least three references from persons who can provide ade□uate references pertaining to the Practitioner□s professional competence and ethical character□and

9. Satisfactory completion of such continuing education re□uirements as may □e imposed □y law□ this Hospital□ or applica□le accreditation agencies and as re□uired □y the □ yoming □oard of Medicine to maintain licensure. □eginning their fourth year after completion of residency or fellowship□Physicians who are not yet □oard certified must complete and provide documentation of CM□. Physicians who have a lifetime certification and are not participating in Maintenance of Certification must also provide CM□ documentation. □ocumentation must □e provided for 20 hours of CM□ per year□or at least si□ty □60□hours of CM□ within the previous three □3□years.

10. □pon completion of the verification□the Medical Staff Services Manager will forward the application to the appropriate staff □epartment Chair.

vi. Responsi□ilities of □epartment Chair

□he □epartment Chair or his/her designated representative□to which the application is forwarded□will review the application□and within ten □10□ wor□ing days ma□e a written report to the Credentials Committee on the □ualifications of the Practitioner for admission to the Medical Staff as well as for specific privileges re□uested. □n ma□ing this report□the □epartment Chair or his/her designated representative shall e□amine evidence of the character□professional competence□□ualifications□health status□and ethical standing of the Practitioner□ and shall determine□ through information contained in the references given and from other sources availa□le to him/her whether the Practitioner has esta□lished and meets all of the necessary □ualifications for the Medical Staff category and the clinical privileges re□uested □y him/her.

vii. Responsi□ilities of the Credentials Committee

1. □he Credentials Committee shall review the Practitioner□s application for staff mem□ership as well as for specific clinical privileges along with the report of the □epartment Chair or his/her representative at its first meeting following receipt of all these materials/documents. □he Credentials Committee shall review the Chair's recommendation, and either approve and adopt the Chair's recommendation□in whole□or in part□or formulate its own written recommendation□and transmit the recommendation to the Medical □□ecutive Committee.

2. □ollowing the review of the Practitioner□s application and report of the □epartment Chair or his/her designated representative□the Credentials Committee shall ma□e a recommendation with respect to the Practitioner□s appointment and/or clinical privileges. □f favora□le□ it will □e su□mitted□ together with all supporting documentation□to the Medical □□ecutive Committee for review and comment□and then to the □overning □oard for final action.

viii. □dverse Recommendation of the Credentials Committee

□ hen the recommendation of the Credentials Committee is adverse to the Practitioner either in respect to appointment or clinical privileges□the Medical □□ecutive Committee shall □e so advised and the Medical Staff Services Manager shall promptly notify the □pplicant □y certified mail□ return receipt re□uested. □o such adverse recommendation may □e forwarded to the □overning □oard until after the □pplicant has e□ercised□or has □een deemed to have waived□his/her rights to a hearing as provided □y □rticle □ □□□of these □ylaws.

i□ □avora□le Recommendation of Credentials Committee

□t its ne□t regular meeting after receipt of a favora□le recommendation □y the Credentials Committee□ along with comments from the Medical □□ecutive Committee□the □overning □oard shall act in the matter. □f the Governing Board's decision is adverse to the Practitioner in respect to either appointment or clinical privileges□the Medical Staff Services Manager shall promptly notify him/her of such adverse decision □y certified mail□return receipt re□uested□and such adverse decision shall □e held in a□eyance until the □pplicant has e□ercised□or has □een deemed to have waived□his/her rights under □rticle □ □□□of these □ylaws. □he fact that the adverse decision is held in a□eyance shall not □e deemed to confer clinical privileges where none e□isted □efore.

x Responsi□ilities of the □overning □oard

1. □t its ne□t regular meeting after all of the Practitioner's rights under □rticle XIII of the □ylaws have □een e□hausted or waived, the □overning □oard or its duly authori□ed committee shall act in the matter. □he □overning □oard's decision shall □e conclusive e□cept that the □overning □oard may defer final determination □y referring the matter □ac□ to the Credentials Committee for further reconsideration. □ny such referral □ac□ shall state the reasons, therefore, shall set a time limit within which a su□se□uent recommendation to □overning □oard shall □e made, and may include a directive that an additional hearing is conducted to clarify issues which are in dou□t. □t its ne□t regular meeting after receipt of such su□se□uent recommendation, and any new evidence in the matter, if any, the □overning □oard shall ma□e a decision either to provisionally appoint the Practitioner to the Medical Staff or to re□ect him/her for Medical Staff mem□ership.

2. □henever the □overning □oard's decision will □e contrary to the recommendation of the Credentials Committee, the □overning □oard shall su□mit the matter to the □oint Conference Committee for review and recommendation and shall consider such recommendation □efore ma□ing its decision final.

3. □hen the □overning □oard's decision is final, it shall send notice of such decision through the to the Secretary of the Medical Staff, the Chair of the Medical □□ecutive Committee, the Chair of the Credentials Committee and the Chair of the department concerned, and □y certified mail, □eturn receipt re□uested to the Practitioner.

b Medical Staff Reappointment

i. Reappointment □pplication

□ach application for reappointment to the Medical Staff shall □e signed □y the □pplicant and shall □e su□mitted on a form prescri□ed □y the □overning □oard after consultation with the Medical □□ecutive Committee.

ii. Responsi□ilities of the Medical Staff Services Manager

□he reappointment process shall □egin at least ninety (90) days prior to the termination of current appointment and privileges. Re□uests for additional privileges or for change in a staff category shall □e made to the Medical Staff Services Manager at this time with accompanying documentation of further training and/or clinical e□perience. □he Medical Staff Services

Manager shall gather all pertinent information relating to the staff member's professional competence and clinical judgment in the treatment of patients as determined by ongoing peer review and quality assurance activities, his/her mental and physical condition, ethics, conduct, compliance with Hospital and Medical Staff Bylaws, Rules and Regulations, cooperation with Hospital personnel, and shall check all new information for veracity. The Applicant shall report the circumstances and outcome of any malpractice judgments delivered against him/her during the previous appointment period as well as the circumstances of any pending malpractice action against him/her. The Medical Staff Services Manager shall deliver that information to the appropriate Department Chair or his/her designated representative for review within ten (10) working days.

iii. Responsibilities of Department Chair

The Department Chair or his/her designated representative to which the application is forwarded will review the application within ten (10) working days and make a written report regarding the qualifications of the Practitioner to the Credentials Committee. In making his/her report the Department Chair or his/her designated representative shall examine the evidence of the character, professional competence, qualifications, health status and ethical standing of the Applicant and shall determine, through information provided by the Medical Staff Services Manager whether the Practitioner has established and meets all of the necessary qualifications for staff membership and the clinical privileges requested by him/her. Any requested change in the staff category and/or clinical privileges requested by the Practitioner will be supported by evidence of further training and/or clinical competence provided by the Practitioner.

iv. Reappointment Process

Thereafter, the procedure provided for in Section 4(i.) of these Bylaws, relating to an initial appointment should be followed.

c. Allied Health Professional Appointment

i. Application

Each application for appointment to the Allied Health Professional staff shall be signed by the Applicant, and include a statement by a sponsoring Physician who is currently on the MHSC Medical Staff. Said sponsorship shall remain adequate, regardless of the status of the sponsor, until the

e□piration of the □pplicant's term, and shall be submitted on a form prescri□ed □y the □overning □oard after consultation with the Medical □□ecutive Committee. □he application shall re□uire detailed information concerning the □pplicant□s professional □ualifications including:

1. □ll schools and date of degree/registration/ certification□

2. □ll special training programs with dates of successful completion□

3. □ll state licenses□their licensure dates□and history of adverse actions□if any□

4. □ll staff mem□ership and privileges at other institutions□dates of privileging□and history of adverse or corrective actions□if any□

5. □ statement specifying any circumstances and □udgments and/or settlements of any previous malpractice actions□as well as the circumstances of any pending malpractice actions□involving the □llied Health Professional□

6. □he names of at least three persons who have had e□tensive recent e□perience in o□serving and wor□ing with the □llied Health Professional and who can provide ade□uate references pertaining to the □llied Health Professional□s professional competence and ethical character□health status and a□ility to wor□ cooperatively with others and who will provide specific written comments on these matters. □he named individuals must have ac□uired the re□uisite □nowledge through recent o□servation of professional practice over a reasona□le period of time and prefera□ly have a current affiliation with an acute care institution and at least one must □e from a colleague in the □pplicant□s specialty. □he references may not □e relatives or have any recently initiated□or impending□ professional partnership/financial associations with □pplicant□

7. □ statement that the □llied Health Professional has received or □een given access to□and read the □ylaws□Rules and Regulations of the Medical Staff and that he/she agrees to □e □ound □y the terms thereof if he/she is granted mem□ership and/or clinical privileges and to □e □ound □y the terms thereof without regard to whether or not he/ she is granted mem□ership and/or privileges in all matters relating to consideration of his/ her application□

□. □nformation as to whether any of the following has ever □een □or are in the process of □eing □denied □revo□ed □suspended □reduced not renewed □or voluntarily relin□uished:

a. Staff mem□ership status or privileges at any other Hospital or healthcare institution□

□. Mem□ership/fellowship in local□ state or national professional organi□ations □and

c. □icense to practice any profession in any □urisdiction.

9. □ statement of e□perience during the most recent five □5□ years□ including a consent to the release of information □y his/her present and past malpractice insurance carrier□s□□

10. □ statement where□y the □llied Health Professional agrees that□ when an adverse ruling is made with respect to his/her staff mem□ership□staff status and/or privileges□he/she will resort to the administrative remedies afforded □y the Medical Staff □ylaws Rules □ Regulations □efore resorting to formal legal action□

11. □vidence of current□ade□uate professional lia□ility insurance□as determined □y the □overning □oard□and

12. □ statement regarding physical/mental health status□ including alcohol a□use and/or drug dependency□as permitted □y law□

13. Satisfactory completion of such continuing education re□uirements as may □e imposed □y law□ this Hospital□ or applica□le accreditation agencies.

14. □ statement as to whether the □llied Health Professional has ever withdrawn his/her application for appointment□reappointment□or clinical privileges□or resigned from a medical staff □efore the final decision of the □overning □oard of such entity.

15. □nformation as to whether the □llied Health Professional has ever □een named as a defendant and/or convicted in a criminal action and details a□out any such instances□

16. □nformation on the citi□enship or visa status of the □llied Health Professional□

17. □nformation regarding whether the □llied Health Professional has ever □een sanctioned □y□ or e□cluded or suspended from participation in Medicare□ Medicaid or any other government reim□ursement programs.

ii. Responsi□ilities of the □llied Health Professional

□he □llied Health Professional shall have the □urden of producing ade□uate information for a proper evaluation of his/her competence□ character□ethics and other □ualifications□and for resolving any dou□ts a□out such □ualifications. □ny material misrepresentation in□or omission from□the application and related documents□shall □e grounds for denial of privileges or corrective action regardless of when the misrepresentation or omission is discovered.

iii. □ppearance□□uthori□ation□and Consent

□y applying for appointment to the □llied Health Professional staff□each □llied Health Professional there□y signifies:

1. His/her willingness to appear for interviews in regard to his/her application□

2. His/her authori□ation for the Hospital to consult with mem□ers of Medical Staffs of other Hospitals with which the □llied Health Professional has □een associated and with others who may have information □earing on his/her competence□ character□ health status□and ethical □ualifications□

3. His/her consent to the Hospital□s inspection of all records and documents that may □e material to an evaluation of his/her professional □ualifications and competence to carry out the clinical privileges he/she re□uests as well as his/her moral and ethical □ualifications for □llied Health Professional staff mem□ership□

4. His/her release from any lia□ility of all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the □llied Health Professional and his/her credentials□and

5. His/her release from any lia□ility all individuals and organi□ations who provide information to the Hospital in good faith and without

malice concerning the □llied Health Professional s competence□ ethics□character□health status and other □ualifications for □llied Health Professional staff appointment and clinical privileges including otherwise privileged or confidential information.

6. His/her authori□ation to third parties to release information□ including otherwise privileged or confidential information□as well as reports□ records□ statements□ recommendations and other documents in their possession□□earing on his/her credentials to the Hospital□and consents to the inspection and procurement □y the Hospital of such information□records and other documents.

7. His/her authori□ation to release information a□out such individual to other healthcare entities and their agents□who solicit such information for the purpose of evaluating the individual s professional □ualifications pursuant to the individuals re□uest for appointment□reappointment or clinical privileges.

□. His/her authori□ation to maintain information concerning the □llied Health Professional's age□training□licensure□and other confidential information for the purpose of ma□ing aggregate information availa□le for use □y the Hospital.

9. His/her authori□ation to release confidential information□including peer review and/or □uality assurance information□o□tained from or a□out the □llied Health Professional to peer review committees of the Hospital for purposes of reducing mor□idity and mortality and for the improvement of patient care.

10. His/her agreement that the foregoing provisions are in addition to any agreements□ understandings□ covenants□ waivers□ authori□ations or releases provided □y law or contained in any application or re□uest forms.

iv. □iscrimination

□o considerations of se□□race□creed and/or national origin may □e used in the granting or denying of staff mem□ership or clinical privileges.

v. Responsi□ilities of the Medical Staff Services Manager

1. □he completed application shall □e su□mitted to the Hospital s Medical Staff Services Manager who shall □e responsi□le to

review the application for veracity. Initiation of the verification process of at least the following items will begin within a reasonable time after receipt of a completed application:

a. Degree/certification/registration conferred when and the institution

b. Completion of training programs specialty date of completion

c. The granting of state licenses if applicable dates and history of adverse actions

d. Querying the National Practitioner Data Bank and

e. At least three references from persons who can provide adequate references pertaining to the Allied Health Professional's competence and ethical character.

f. On completion of the verification the Medical Staff Services Manager will forward the application to the appropriate Departmental Chair.

vi. Responsibilities of Departmental Chair

The Departmental Chair or his/her designated representative to which the application is forwarded will review the application and within a reasonable time make a report to the Credentials Committee on the qualifications of the Allied Health Professional for admission to the Allied Health Professional staff as well as for specific privileges requested. In making this report the Departmental Chair or his/her designated representative shall examine evidence of the character professional competence qualifications health status and ethical standing of the Allied Health Professional and shall determine through information contained in the references given and from other sources available to him/her whether the Allied Health Professional has established and meets all of the necessary qualifications for the Allied Health Professional staff category and the clinical privileges requested by him/her.

vii. Responsibilities of the Credentials Committee

1. The Credentials Committee shall review the Allied Health Professional's application for Allied Health Professional staff

membership as well as for specific clinical privileges along with the report of the Departmental Chair or his/her representative at its first meeting following receipt of all these materials/ documents. The Credentials Committee shall review the Chair's recommendation, and either approve and adopt the Chair's recommendation, in whole, or in part, or formulate its own written recommendation, and transmit the recommendation to the Medical Executive Committee.

2. Following a review of the Allied Health Professional's application and report of the Department Chair or his/her designated representative; the Credentials Committee shall make a recommendation with respect to the Allied Health Professional's appointment or clinical privileges. If favorable, it will be submitted, together with all supporting documentation, to the Medical Executive Committee for review and comment, then to the Governing Board for final action.

viii. Adverse Recommendation of the Credentials Committee

When the recommendation of the Credentials Committee is adverse to the Allied Health Professional, either in respect to appointment or clinical privileges, the Medical Executive Committee shall be so advised and the Chief Executive Officer shall promptly notify the Allied Health Professional by certified mail, return receipt requested. No such adverse recommendation may be forwarded to the Governing Board until after the Allied Health Professional has exercised or has been deemed to have waived, his/her rights as provided by Article V of these Bylaws.

ix. Favorable Recommendation of Credentials Committee

At its next regular meeting after receipt of a favorable recommendation by the Credentials Committee, along with comments from the Medical Executive Committee, the Governing Board shall act in the matter. If the Governing Board's decision is adverse to the Allied Health Professional, in respect to either appointment or clinical privileges, the Medical Staff Services Manager shall promptly notify him/her of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the Allied Health Professional has exercised, or has been deemed to have waived, his/her rights under Article XIII of the Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

□. Responsi□ilities of the □overning □oard

1. □t its ne□t regular meeting after all of the □llied Health Professional's rights under □rticle □ of the □ylaws have □een e□hausted or waived□the □overning □oard or its duly authori□ed committee shall act in the matter. □he □overning □oard's decision shall □e conclusive e□cept that the □overning □oard may defer final determination □y referring the matter □ac□ to the Credentials Committee for further reconsideration. □ny such referral □ac□ shall state the reasons□therefore□shall set a time limit within which a su□se□uent recommendation to the □overning □oard shall □e made□and may include a directive that additional information is o□tained to clarify issues□which are in dou□t. □t its ne□t regular meeting after receipt of such su□se□uent recommendation any new evidence in the matter□if any□the □overning □oard shall ma□e a decision either to provisionally appoint the □llied Health Professional to the □llied Health Professional staff or to re□ect him/her for □llied Health Professional staff mem□ership.

2. □ henever the □overning □oard's decision will □e contrary to the recommendation of the Credentials Committee□ the □overning □oard shall su□mit the matter to the □oint Conference Committee for review and recommendation and shall consider such recommendation □efore ma□ing its decision final.

3. □ hen the □overning □oard's decision is final□it shall send notice of such decision through the Chief □□ecutive Officer to the Secretary of the Medical Staff□the Chair of the Medical □□ecutive Committee□the Chair of the Credentials Committee and the Chair of the department concerned□and □y certified mail□return receipt re□uested to the □llied Health Professional.

d. □llied Health Professional Reappointment

i. Reappointment □pplication

□ach application for reappointment to the □llied Health Professional staff shall □e signed □y the □pplicant and include a statement □y a sponsoring Physician who is currently on the MHSC Medical Staff. Said sponsorship shall remain ade□uate□regardless of the status of the sponsor□until the e□piration of the □pplicant's term, and shall be submitted on a form prescri□ed □y the □overning □oard after consultation with the Medical □□ecutive Committee.

ii. Responsi□ilities of the Medical Staff Services Manager

□he reappointment process shall □egin ninety □90□ days prior to the termination of current appointment and privileges. Re□uests for additional privileges shall □e made to the Medical Staff Services Manager at this time with accompanying documentation of further training and/or clinical e□perience. □he Medical Staff Services Manager shall gather all pertinent information relating to the □llied Health Professional□s competence and clinical □udgment in the treatment of patients □as determined □y ongoing peer review and □uality assurance activities□□his/her mental and physical condition□ethics□conduct□compliance with Hospital and Medical Staff □ylaws□Rules and Regulations□cooperation with Hospital personnel and shall chec□ all new information for veracity. □he □llied Health Professional shall report the circumstances and outcome of any malpractice □udgment□s□ delivered against him/her during the previous appointment period as well as any malpractice actions pending against him/her. □he Medical Staff Services Manager shall deliver that information to the appropriate □epartmental Chair or his/her designated representative for review.

iii. Responsi□ilities of □epartmental Chair

□he □epartmental Chair or his/her designated representative to which the application is forwarded will review the application □within 30 days□and ma□e a report regarding the □ualifications of the □llied Health Professional to the Credentials Committee. □n ma□ing his/her report the □epartmental Chair or his/her designated representative shall e□amine the evidence of the character□professional competence□□ualifications□health status□and ethical standing of the □llied Health Professional and shall determine□through information provided □y the Medical Staff Services Manager whether the □llied Health Professional has esta□lished and meets all of the necessary □ualifications for the □llied Health Professional staff mem□ership and the clinical privileges re□uested □y him/her. □ny re□uested change in clinical privileges re□uested □y the □llied Health Professional will □e supported □y evidence of further training and/or clinical competence provided □y the □llied Health Professional.

iv. Reappointment Process

□hereafter□the procedure provided for in Section c.□i. paragraphs 7□10 of these □ylaws□relating to the initial appointment shall □e followed.

Section C. REQUESTS FOR CLINICAL PRIVILEGES

Re□uests for clinical privileges will □e considered only when made on the prescri□ed form□and only when all information specified in the Hospital□s description of threshold re□uirements for clinical privileges is provided. □n the event all re□uested information is not provided□the re□uest for clinical privileges will □e considered incomplete and will not □e processed. □he potential □pplicant will □e notified of the nature of incompleteness.

Section D. RECOMMENDATIONS FOR PRIVILEGES

1. Clinical Privileges:

   a. □he clinical privileges of a Practitioner □pplicant recommended to the □overning □oard shall □e □ased upon the following: the □pplicant□s education□training□ e□perience□ demonstrated current competence and □udgment□ references□ utili□ation patterns□health status□and any and all other professional criteria used in evaluating an Applicant's qualifications for Medical Staff appointment;

   □. □vaila□ility of □ualified Physicians or other appropriate □ppointees to provide medical coverage for the □pplicant in case of the □pplicant□s illness or unavaila□ility□

   c. □de□uate levels of professional lia□ility insurance coverage□as determined □y the □overning □oard□with respect to the clinical privileges re□uested□

   d. □he Hospital□s availa□le resources and personnel□

   e. □ny previously successful or currently pending challenges to any licensure or registration□or the voluntary relin□uishment of such licensure or registration□ information concerning any voluntary or involuntary termination or Medical Staff appointment or voluntary or involuntary limitation□reduction or loss of clinical privileges at another Hospital□and

   f. Other relevant information□including a written report and findings □y the Chair of each of the clinical departments in which such privileges are sought.

2. □hreshold Re□uirements

   a. □ll re□uests for clinical privileges will □e □udged on the □asis of esta□lished threshold re□uirements consisting of □aseline criteria specifying the minimum amount of education□training□e□perience□and evidence of competency re□uired.

   □. Recommended threshold re□uirements will □e generated □y the Credentials Committee in consultation with the appropriate □epartment Chair.

Recommended threshold re□uirements will then □e su□mitted to the Medical □□ecutive Committee for comments as well as to the □overning □oard. □ollowing the review of the Credentials Committee recommendations□as well as comments of the Medical □□ecutive Committee□the □overning □oard will then ta□e action to esta□lish final threshold re□uirements.

c. □ll □pplicants will □e provided with the currently approved description of threshold re□uirements for particular clinical privileges re□uested.

d. □ny re□uest for clinical privileges for which there are no e□isting approved threshold re□uirements will □e ta□led for a period not to e□ceed ninety □90□ calendar days. □uring this time□the Credentials Committee shall generate and su□mit recommended re□uirements to the M□C and □overning □oard. Processing of the re□uest will resume when the re□uirements are approved □y the □overning □oard.

3. □urden of Proof

□he □pplicant shall have the □urden of esta□lishing his/her □ualifications for competence to e□ercise the clinical privileges re□uested.

4. □mergency Privileges

□n the case of an emergency□any Physician□to the degree permitted □y his/her license□ and regardless of service or staff status or lac□ of it□shall □e permitted and assisted to do everything possi□le to save the life of a patient□using every facility of the Hospital neces□ sary□ including the calling for any consultation necessary or desira□le. □ hen an emergency situation no longer e□ists□such Practitioner must re□uest his/her privileges necessary to continue to treat the patient. □n the event privileges are denied or he/she does not desire to re□uest privileges□the patient shall □e assigned to an appropriate mem□er of the Medical Staff. □or the purpose of this section□an □emergency□is defined as a condition in which serious□permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

5. □isaster Privileges

□isaster privileges may □e granted when the emergency management plan has □een activated and the Hospital is unable to handle the immediate patients' needs. Such disaster privileges will □e granted in accordance with the Medical Staff Policy for granting disaster privileges.

6. □emporary □ppointments

□emporary □ppointments constitute temporary permissions to attend patients at the Hospital. □emporary □ppointments are distinguished from the privileges of the Hospital in that they are not □ased upon a complete review of credentials and are granted or revo□ed □y the President of the Medical Staff□Chief □□ecutive Officer□and □epartment Chair. □emporary Privileges may □e revo□ed or withdrawn at any time□with or without cause. □emporary Privileges may □e granted only for a specific period of time□and shall automatically e□pire at the end of the specified period□ without recourse □y the Practitioner under the Medical Staff □ylaws. □emporary Privileges are granted only under the following circumstances and su□□ect to the following conditions.

a. Circumstances for □ranting □emporary Privileges. □pon the written concurrent of the Chair of the department where the privilege will □e e□ercised and the President□the Chief □□ecutive Officer may grant a □emporary □ppointment in the following circumstances:

□i. □fter receipt of an application for Medical Staff appointment□ an appropriately licensed □pplicant may □e granted a □emporary □ppointment□for an initial period of si□ty □60□days□with su□se□uent renewal not to e□ceed the pendency of the application □the □emporary □ppointment in such case cannot e□ceed the regular privileges applied for □y the □pplicant□ □n e□ercising such privileges□the □pplicant shall act under the supervision of the Chair of the department to which he or she is assigned or is appointed□

□ii. □pon receipt of a written re□uest□an appropriately licensed □pplicant may □e granted a □emporary □ppointment for the care of one or more specific patients. Such □emporary □ppointments will □e □ased upon a complete review of the application□credentials□and licensure in compliance with the □ylaws□the Rules and Regulations□and the Policies.

7. □elemedicine Privileges

Practitioners who are responsible for the patient's care, treatment, and services via a telemedicine lin□ shall □e credentialed and privileged to do so □y the Hospital in accordance with the □ylaws□accreditation re□uirements□and applica□le law. □f the Hospital has a pressing clinical need and the Practitioner can supply that service through a telemedicine lin□□the Practitioner may □e evaluated for □emporary Privileges in accordance with the procedures set forth in Section 6. Practitioners providing telemedicine services to Hospital patients shall □e credentialed and privileged to do so through one of the following mechanisms:

a. The Practitioner shall be credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in these Bylaws.

b. The Practitioner shall be credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in these Bylaws 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 Governing Board 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:

i. The distant site is a Medicare-certified Hospital or a facility that qualifies as a "distant site telemedicine entity." A "distant site telemedicine entity" is defined as an entity that (i) provides telemedicine services, (ii) is not a Medicare-certified Hospital, and (iii) provides contracted services in a manner that enables Hospitals using its services to meet all applicable conditions of participation, particularly those requirements related to the credentialing and privileging of Practitioners providing telemedicine services to the patients of the Hospital.

ii. When the distant site is a Medicare-certified Hospital, the written agreement shall specify that it is the responsibility of the distant site Hospital to meet the credentialing requirements of 42 C.F.R. 485.616 (c)(1)(i)-(c)(1)(vii), as that provision may be amended from time to time, with regard to the distant site Hospital Practitioners providing telemedicine services, and

iii. 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. 485.616 (c)(1)(i)-(c)(1)(vii), 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. 485.616 (c)(1)(i)-(c)(1)(vii), as that provision may be amended from time to time.

c. 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.

d. The individual distant site Practitioner holds an appropriate license issued by the State of Wyoming by the appropriate licensing entity.

e. The Hospital maintains documentation of its internal review of the performance of each distant site Practitioner and sends the distant site such performance information for use in the distant site's periodic appraisal of the distant site Practitioner. At a minimum this information must include:

i. All adverse events that result from the telemedicine services provided by the distant site Practitioner to Hospital patients and

ii. All complaints the Hospital receives about the distant site Practitioner.

B. Board Certification

Applicants for appointment or reappointment to the Medical Staff are required to adhere to the following requirements relative to board certification:

a. Board certification or the active pursuit of board certification in the specialty in which the Applicant seeks privileges conferred by the American Board of Medical Specialties or the American Osteopathic Association is required.

b. In the absence of board certification an Applicant must have successfully completed a residency training program in conjunction with the specialty in which the Applicant seeks privileges that are approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or from another recognized accredited training program approved by the Governing Board and must be qualified to pursue and receive board certification.

c. Any physician granted clinical privileges who does not attain board certification by their individual certifying board's deadline will be determined to not meet threshold criteria.

d. If a physician does not meet threshold criteria for their specialty their medical staff membership and clinical privileges will be revoked. As this revocation is based solely on the failure of the physician to meet threshold criteria this will not be reportable and the Physician will not be entitled to a fair hearing.

e. Physician's eligibility for board certification (board eligible period) expires on a date determined by their individual certifying board. On appointment applications Physicians will be required to indicate the date that their board certification or board eligibility if not certified expires. The Medical Staff Office will track these expiration dates.

f. When a Physician's board eligibility lapses and certification has not been achieved the physician must immediately notify the Medical Staff Office. If their certifying board allows them to re-establish board eligibility the candidate must complete all requirements set by their board and must provide documentation of such proving that they are once again board eligible or board certified.

Section E. AGREEMENT OF APPLICANTS

1. Physicians and licensed Independent Practitioners seeking appointment or reappointment agree that if an adverse ruling or other decision which is unfavorable to the pplicant is made with respect to Medical Staff membership status and/or clinical privileges the pplicant must resort to the administrative remedies afforded by these ylaws in rticle efore seeking to pursue to any formal legal action.

2. llied Health Professionals are not members of the Medical Staff and accordingly shall have no recourse to the procedural rights set forth in these ylaws in rticle but may file a rievance with the Medical ecutive Committee pursuant to rticle of these ylaws.

Section F. LEAVE OF ABSENCE

1. Medical Staff ppointee may obtain a voluntary leave of absence for good cause for a period not to exceed one 1 year by submitting a written request to the Medical ecutive Committee and the Chief ecutive Officer. ood cause shall include but shall not be necessarily be limited to personal illness death in the family or significant personal problems or hardships. Reasonable notice must be given for a request of leave and there is a reasonable expectation that the cause will be resolved in the time requested. he decision as to whether to recommend a leave of absence resides in the discretion of the Medical ecutive Committee and must be approved by the overning oard.

2. pon proper written request to the Medical ecutive Committee prior to the expiration of the first period a Medical Staff ppointee on leave of absence may request an extension of his/her leave for one 1 additional period not to exceed one 1 year.

3. t least thirty 30 days prior to the termination of the leave or at an earlier time the Medical Staff Member may request reinstatement of his or her clinical privileges by submitting a written notice to that effect to the Chief ecutive Officer for transmittal to the Medical ecutive Committee. he Medical Staff ppointee shall submit a written summary of his or her relevant activities during the leave if the Medical ecutive Committee requests. hereafter the procedure provided in Section of the Medical Staff Rules and Regulations shall be followed.

4. he Medical Staff ppointee may request reinstatement or reappointment as determined by the Medical ecutive Committee. ased on the information provided the Medical

□□ecutive Committee will determine whether the Medical Staff □ppointee will □e reinstated□need to apply for reappointment□or go through the initial appointment process.

5. □ailure□without good cause□to re□uest reinstatement or to provide a re□uested summary of activities as provided a□ove shall □e deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff mem□ership and clinical privileges. □ Practitioner whose Medical Staff mem□ership is so terminated shall □e entitled to the procedural rights provided in □rticle □ □□□of the Medical Staff □ylaws for the sole purpose of determining the issue of good cause. □ re□uest for Medical Staff mem□ership su□se□uently received from a former Staff mem□er so terminated shall □e su□mitted and processed in the manner specified for applications for initial appointments.

ARTICLE VII
OFFICERS

Section A. OFFICERS OF THE MEDICAL STAFF

□he Officers of the Medical Staff shall □e:

1. President
2. □ice□President
3. Secretary

Section B. QUALIFICATIONS OF OFFICERS

Officers must □e mem□ers of the □ctive Physician Staff with □ctive status□at the time of nomination and election and must remain mem□ers in good standing during their term of office. □ailure to maintain such status shall□loss of licensure□or privileges shall immediately create a vacancy in the office involved.

Section C. NOMINATION AND ELECTION OF OFFICERS

1. □omination of Officers

   a. □t least one □1□candidate for each office shall □e nominated □y the □ominating Committee.

   □. □ominations may also □e made from the floor at the time of the annual meeting of the Medical Staff.

   c. □ll nominations can □e made only with the consent of the nominated individual.

2. □lection of Officers

   Officers shall □e elected at the annual meeting of the Medical Staff. □oting shall □e □y secret written □allots□provided□however□if re□uested□Medical Staff mem□ers may use a□sentee □allots and may vote □y phone□e□mail□or □y □.S. mail. □ here there are three □3□or more candidates and no candidate receives a ma□ority□there shall □e successive □alloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a ma□ority vote is o□tained □y one □1□candidate.

Section D. TERM OF OFFICE

□ll Officers shall serve a one □1□year term or until resignation or removal□and shall ta□e office on the first □1st□day of the Medical Staff year□□anuary 1. □f elected□an Officer may succeed himself/herself□for one □1□consecutive□additional one □1□year term. □n the event that an officer vacates his or her office prior to the completion of the term□such vacancy shall □e filled in accordance with Section □□.□

Section E. VACANCIES OF OFFICE

□acancies in office prior to the completion of the term□e□cept for the President and □ice President□shall □e filled □y the Medical □□ecutive Committee. □f there is a vacancy in the office of the President□the □ice President shall serve out the remaining term. □f there is a vacancy in the office of the □ice President□the □ominating Committee shall nominate candidates to fill the office and a special election will □e held. Such nomination and a special election will □e held within thirty □30□days of the vacancy.

Section F. DUTIES OF OFFICERS

1. President

   □he President shall serve as the Chief □dministrative Officer of the Medical Staff. □he President's duties include:

   a. □ct in coordination and cooperation with the Chief □□ecutive Officer in all matters of mutual concern within the Hospital□

   □. Call□preside at□and □e responsi□le for the agenda of all general meetings of the Medical Staff□

   c. Serve as Chair of the Medical □□ecutive Committee□

   d. Serve as an e□□officio mem□er of all other Medical Staff committees and other departments without vote□

e. □e responsi□le for the enforcement of Medical Staff □ylaws□ Rules □ Regulations□for implementation of sanctions where these are indicated□and for the Medical Staff's compliance with the procedural safeguards in all instances where corrective action has □een re□uested against a Practitioner or □llied Health Professional□

f. □ppoint committee mem□ers to all standing□ special and multi□disciplinary Medical Staff committees and su□committees□e□cept the Medical □□ecutive Committee□and interdepartmental committees□

g. Represent the views□policies□needs□and grievances of the Medical Staff and report to the □overning □oard and to the Chief □□ecutive Officer□

h. Receive and interpret the Policies of the □overning □oard to the Medical Staff and report to the □overning □oard on the performance and maintenance of □uality with respect to the Medical Staff's delegated responsi□ility to provide medical care□

i. □e responsi□le for the educational activities of the Medical Staff□

□. □e the spo□esperson for the Medical Staff in its e□ternal professional and pu□lic relations□

□. □ttend all regular □overning □oard meetings.

2. □ice President

□n the a□sence of the President□the □ice President shall assume all the duties and have the authority of the President. He/she shall automatically succeed the President when the latter fails to serve for any reason. He/she may attend all regular Hospital □oard meetings and shall serve as a mem□er of the Medical □□ecutive Committee.

3. Secretary

□he Secretary shall □e responsi□le for giving proper notice of all Medical Staff meetings□ maintaining accurate and complete minutes of all Medical Staff meetings□call Medical Staff meetings on order of the President□and perform such other duties as ordinarily pertains to his/her office. □he Secretary shall attend to all routine and special correspondence. Special Correspondence involving or pertaining to the □ctivities of the Hospital will □e referred to the □overning □oard through the President. □ here there are funds to □e accounted for□the Secretary shall also act as □reasurer and account for all such funds. □he Secretary shall serve as a mem□er of the Medical □□ecutive Committee.

Section G. REMOVAL FROM OFFICE

1. Officers must remain mem□ers of the □ctive Physician Staff in good standing at all times during their term of office. Resignation from the Medical Staff□failure to maintain □ctive status□loss of license□or privileges shall immediately create a vacancy in the office involved.

2. Removal of an officer during his/her term of office may □e initiated□for or without cause□ □y a two□thirds □2/3□ma□ority vote of the Medical Staff present at any annual or special meeting at which a □uorum is present□□ut no such removal shall □e effective unless and until it has □een ratified □y the □overning □oard . Cause for such removal may □e for reasons unrelated to professional capa□ilities or the e□ercise of clinical privileges and may include failing to perform the duties of the position or e□hi□iting conduct detrimental to the interests of the Hospital. □ ithout further action pursuant to these □ylaws□removal from office does not affect the Medical Staff appointment or clinical privileges of the Physician or □icensed □ndependent Practitioner so removed.

ARTICLE VIII
CLINICAL DEPARTMENTS

Section A. ORGANIZATION OF CLINICAL DEPARTMENTS

□ach department shall □e organi□ed as a separate part of the Medical Staff and shall have a Chair and a □ice□Chair. □he Chair shall □e responsi□le for the overall supervision of the clinical wor□ within the department. □n the a□sence of the Chair□the □ice□Chair shall assume all the duties and have the authority of the Chair. □he Medical Staff of Memorial Hospital of Sweetwater County shall □e organi□ed into the following departments:

1. Surgery □epartment

   □he Surgery □epartment shall include those Practitioners primarily engaged in surgical care.

2. Medicine □epartment

   □he Medicine □epartment shall include those Practitioners primarily engaged in non□ surgical medical care.

Section B. FUNCTIONS OF DEPARTMENTS

1. Responsi□ilities

□ach clinical department shall:

a. □hrough the □epartmental Chair□ recommend to the Credentials Committee written criteria for the assignment of clinical privileges that are consistent with□ and su□□ect to□the □ylaws□Policies□Rules and Regulations of the Medical Staff and Hospital. □hose criteria shall include levels of demonstrated current competence□training and e□perience re□uired for granting privileges within the specialties covered □y the department□

□. Monitor and evaluate medical care provided □y mem□ers of the department on a retrospective□concurrent and prospective □asis□which monitoring and evaluation must at least include:

i. □he routine collection of information a□out important aspects of patient care provided in the department and a□out the clinical performance of its mem□ers□and

ii. □he periodic assessment of this information to identify opportunities to improve care and to identify important pro□lems in patient care□and

iii. □ ill routinely review all mortalities□mor□idity□and any significant patient complications□and

c. Recommend□ su□□ect to approval and adoption □y the Medical □□ecutive Committee and □overning □oard□o□□ective criteria that reflect current □nowledge and clinical e□perience to □e used in the monitoring and evaluation of patient care.

d. □ach department shall meet at least three □3□times a year□ideally □uarterly. □ll meetings shall □e held on such day and at such hour as the Chair of the department designates in the call and notice of the meeting.

Section C. QUALIFICATIONS, SELECTION AND TENURE OF DEPARTMENT CHAIR AND VICE-CHAIR

1. □ualifications

□ach □epartmental Chair and □ice□Chair shall □e a mem□er of the □ctive Staff and □e certified □y an appropriate specialty □oard or□through the privilege delineation process□ □e esta□lished to possess compara□le competence.

2. Selection

   Each Departmental Chair and Vice-Chair shall be elected by the Medical Staff members of their respective clinical departments prior to the end of the Medical Staff year.

3. Roles and Responsibilities. Each Department Chair and Vice-Chair shall be responsible and shall perform each of the following:

   a. Clinically related activities of the department.

   b. Administratively oversee related activities of the department, unless otherwise provided by the Hospital.

   c. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.

   d. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department.

   e. Recommending clinical privileges for each member of the department.

   f. Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital.

   g. Integration of the department or service into the primary functions of the organization.

   h. The coordination and integration of interdepartmental and intradepartmental services.

   i. The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

   j. The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

   k. Determination of the qualifications and competence of department or services personnel who are not licensed Independent Practitioners and who provide patient care, treatment, and services.

   l. The continuous assessment and improvement of the quality of care, treatment, and services.

m. The maintenance of quality control programs as appropriate;

n. The orientation and continuing education of all persons in the department or service; and

o. Recommending space and other resources needed by the department or service.

4. Tenure

a. Each Departmental Chair and Vice-Chair shall serve for a one (1) year term effective the first day of the Medical Staff year (January 1) or until resignation or a vacancy is created pursuant to Section 5. If elected, a Department Chair and/or Vice-Chair may succeed himself/herself for one (1) consecutive additional one (1) year term subject to the approval of the Governing Board.

b. If there is a vacancy in the office of the Chair, the Vice-Chair shall serve out the remaining term. If there is a vacancy in the office of the Vice-Chair, a special election will be held within thirty (30) days of the vacancy to elect a successor to serve for the remainder of the term.

5. Removal

a. Department Chairs and Vice-Chairs must remain members of the Active Physician Staff in good standing at all times during their term of office. Resignation from the Medical Staff, failure to maintain active status, loss of license, or privileges shall immediately create a vacancy in the office of Chair or Vice-Chair involved.

b. Each Departmental Chair and/or Vice-Chair may be removed from his or her office with or without cause when initiated by a two-thirds (2/3) majority vote of all active Physician Staff members of the department but no such removal shall be effective unless and until it has been ratified by the Governing Board. Cause for such removal may be for reasons unrelated to professional capabilities or the exercise of clinical privileges and may include failing to perform the duties of the position or exhibiting conduct detrimental to the interests of the Hospital. Without further action pursuant to these Bylaws, removal from office does not affect the Medical Staff appointment or clinical privileges of the Physician so removed.

Section D. ASSIGNMENT TO DEPARTMENTS

□pplicants for appointment and reappointment will re□uest departmental assignments at the time of application. □f any □epartmental Chair feels that the □pplicant□s choice is not appropriate□the Medical □□ecutive Committee will determine the final departmental assignment.

ARTICLE IX
COMMITTEES OF THE MEDICAL STAFF

Section A. COMPOSITION

Medical Staff committees esta□lished to perform one or more of the staff functions re□uired □y these □ylaws□Rules and Regulations shall consist of □ppointees to the □ctive and □ssociate Physician Staff categories and may include□ where appropriate□ □icensed □ndependent Practitioners□ □llied Health Professionals□ and representatives from Hospital management□ nursing□medical records□pharmacy□or social services□and such other departments as are appropriate to the function□s□to □e discharged.

Section B. APPOINTMENT AND TERM

□□cept as otherwise provided□mem□ers of each committee shall □e appointed yearly □y the President of the Medical Staff□in consultation with the Chief □□ecutive Officer. □he Chief □□ecutive Officer and the President of the Medical Staff or their respective designee□s□shall □e mem□ers□e□officio□without a vote□of all committees. □here is no limit to the num□er of one□ year terms committee mem□ers may serve.

Section C. CHAIRS

□ll committee Chairs□unless otherwise provided for in these □ylaws□will □e appointed □y the President of the Medical Staff. □ll such appointments will □e su□□ect to final approval □y the □overning □oard.

1. □erm

   □nitial appointments of the committee Chair□unless otherwise provided for in these □ylaws□ shall □e for a period of one □1□year□after which a Chair may □e reappointed for unlimited one □1□year terms.

Section D. REMOVALS AND VACANCIES

□ll appointed mem□ers and Chair may □e removed and vacancies filled at the discretion of the President of the Medical Staff unless otherwise provided for in these □ylaws.

Section E. MEDICAL EXECUTIVE COMMITTEE (MEC)

1. Composition:

   a. The Medical Executive Committee shall be composed of the officers of the Medical Staff, the Chair of each clinical department and the immediate Past President of the Medical Staff if he or she continues to be a member of the active Medical Staff.

   b. The President of the Medical Staff shall be Chair of the MEC.

   c. The Chief Executive Officer shall be an ex officio member of the Medical Executive Committee, but without a vote, and shall be present at all meetings of the Medical Executive Committee. Members of the Governing Board and the Chief Nursing Officer may attend meetings of the Medical Executive Committee and participate in its discussions, but without a vote.

2. Duties:

   The duties of the Medical Executive Committee shall be:

   a. To represent and to act on behalf of the Medical Staff in all matters, without the requirement of subsequent approval by the staff, subject only to any limitations imposed by these Bylaws, Rules, Regulations, and Policies.

   b. To coordinate the activities and general policies of the various departments.

   c. To receive and to act upon the committee and departmental reports as specified in these Bylaws, and to make recommendations concerning them to the Medical Staff, Chief Executive Officer, and the Governing Board.

   d. To implement policies of the Hospital that affect the Medical Staff, and those policies of the Medical Staff not otherwise the responsibility of the departments.

   e. To provide liaison among the Medical Staff, the Chief Executive Officer, and the Governing Board.

   f. To keep the Medical Staff abreast of applicable accreditation and regulatory requirements affecting the Hospital.

   g. To enforce Hospital and Medical Staff rules in the best interest of patient care and of the Hospital with regard to all persons who hold an appointment to the Medical Staff.

h. To resolve situations involving questions of the clinical competency patient care and treatment case management or inappropriate behavior of any Medical Staff ppointee

i. To be responsible to the overning oard for the implementation of the Hospitals uality assessment plan as it affects the Medical Staff

. To review the ylaws Policies Rules and Regulations and associated documents of the Medical Staff at least once a year and to recommend such changes as may be necessary or desirable

. To act for the organized Medical Staff between meetings of the organized Medical Staff

l. To review clinical pertinence accuracy and timely completion of medical records on a uarterly asis

m. To review the appropriateness of admissions and stays at the Hospital

n. To review processes related to medication use

o. To make recommendations to the President and Chief ecutive Officer on matters of medico administrative nature

p. To make recommendations on Hospital management matters to the Medical Staff the overning oard the President and the Chief ecutive Officer

. To fulfill the Medical Staff's accountability to the Governing Board for the medical care rendered to patients in the Hospital

r. To review the recommendations of the Credentials Committee concerning all applications and to make written comment to the overning oard on the recommendations from the Credentials Committee regarding the appointment assignments to services and delineation of clinical privileges

s. To review periodically all information of Medial Staff ppointees and other Practitioners with clinical privileges including ut not limited to Peer Review nformation and Credentialing ata and as a result of such reviews make recommendations for reappointments and renewal or changes to clinical privileges

t. To take all reasonable steps to ensure professional ethical conduct and competent clinical performance on the part of all appointees of the Medical Staff including the initiation of and/or participation in staff corrective or review measures when warranted and

u. To report at each general Medical Staff meeting.

3. Meetings:

The Medical Executive Committee shall meet at least ten (10) times per year ideally monthly. The Secretary will be responsible for maintaining reports of all meetings which shall include the minutes of the various committees and departments of the staff. Copies of all Medical Executive Committee minutes and reports shall be transmitted to the Chief Executive Officer and the Departmental Chair routinely as prepared.

4. Reports and Recommendations:

Recommendations of the Medical Executive Committee shall be transmitted to the Governing Board with a copy to the Chief Executive Officer. The Chair of the Medical Executive Committee shall be available to meet with the Board or its applicable committee on all recommendations of the Medical Executive Committee. The minutes of all Medical Executive Committee meetings will be reviewed by each Department Chair at his/her departmental meetings.

Section F. CREDENTIALS COMMITTEE

1. Composition:

The Credentials Committee shall consist of the three (3) most recent Past Presidents of the Medical Staff who are still appointees to the active Staff category. The Chair shall be the member who has the most recent consecutive years of service on the committee. If the functions of the committee are threatened by the inability or unwillingness of any of the Past Presidents to serve as determined by the Medical Executive Committee the President of the Medical Staff shall appoint members to the committee to fulfill those terms.

2. Duties:

The duties of the Credentials Committee shall be to:

a. Review the credentials of all applicants for Medical Staff appointments reappointments and clinical privileges to make investigations of and interview such applicants as may be necessary and to submit a written report of its findings and recommendations

□. Review the credentials of all □pplicants who re□uest to practice at the Hospital as □llied Health Professionals□ to ma□e investigations of□ and interview□ such □pplicants as may □e necessary□ and to su□mit a report of its findings and recommendations□

c. □nnually review and recommend amendments to the policies on appointments□ reappointments and clinical privileges as outlined in these □ylaws□Rules and Regulations□and

d. □enerate threshold re□uirements and other criteria for granting of clinical privileges in consultation with the appropriate □epartmental Chair.

3. Meetings:

□he Credentials Committee shall meet at least ten □10□times per year□ideally monthly□ unless there is no □usiness to □e transacted□and shall maintain a permanent record of its proceedings and actions.

4. Reports and Recommendations:

□he Credentials Committee shall report its recommendations to the Medical □□ecutive Committee□the Chief □□ecutive Officer and the □overning □oard. □he Chair of the Credentials Committee shall □e availa□le to meet with the □overning □oard or its applica□le committee on all recommendations that the Credentials Committee may ma□e.

5. Recusal:

Whenever an Applicant's or Medical Staff □ppointee's practice is in direct economic competition with the practice of a mem□er of the Credentials Committee□such mem□er of the Credentials Committee who is in direct economic competition with the □pplicant or Medical Staff □ppointee shall a□stain from voting during proceedings involving the □pplicant or Medical Staff □ppointee. Such a□stention shall □e recorded in the minutes of the meeting.

Section G. JOINT CONFERENCE COMMITTEE

1. Composition:

□he □oint Conference Committee shall □e a standing committee composed of the President□□ice President and Secretary of the Medical Staff□two □2□mem□ers of the □overning □oard□and the Chief □□ecutive Officer□who shall serve as an e□ officio mem□er. □he Chair ship shall □e alternated □etween the □overning □oard Chair and the President of the Medical Staff every two □2□years.

2. □uties:

□he □oint Conference Committee shall provide for medico□administrative liaison with the □overning □oard and the Chief □□ecutive Officer relative to matters of Hospital policy and practice. □ts primary function shall □e to serve as a forum for discussion of matters pertaining to□efficient and effective patient care□credentialing□and identifying those s□ills and values necessary for the future leadership of the Hospital and the Medical Staff. □he □oint Conference Committee shall further endeavor to formulate and enact the mission□core values□and goals of the Hospital and the Medical Staff□as well as perform those functions assigned to it □y these □ylaws□the Rules and Regulations□the Policies□or the □overning □oard from time to time. Such duties include:

a. □o serve as a forum for education and discussion of issues of mutual concern related to patient care□ medical policies□ staffing and resources□ and the relationship □etween the Hospital and mem□ers of the Medical Staff.

□. □o serve as a forum for education and discussion on all matters related to the □uality of care□patient safety□customer service□and organi□ational culture.

c. □o serve as a forum for discussion of issues related to new service lines.

d. □o address trou□lesome issues □efore they □urgeon into conflicts.

e. □o ma□e recommendations to the □overning □oard and the Medical □□ecutive Committee□respectively.

3. Meetings:

□he □oint Conference Committee shall meet at least annually.

4. Reporting □o:

□he □oint Conference Committee shall transmit written of its activities to the □overning □oard and the Medical □□ecutive Committee.

Section H. NOMINATING COMMITTEE

1. Composition:

□he □ominating Committee shall □e composed of one □1□representative from each Medical Staff department. □ach Medical Staff department will elect its representative. □he term of each mem□er will □e for one □1□Medical Staff year.

2. □uties:

   □he □ominating Committee shall nominate Medical Staff officers to □e presented to the Medical Staff at the annual meeting. □he officers shall □e the President□□ice President□ and Secretary.

3. Meetings:

   □he □ominating Committee shall meet as determined □y the committee□□ut at least once a year at least 60 days prior to the annual meeting.

4. Reporting □o:

   □he □ominating Committee shall transmit their nominations in writing to all mem□ers of the Medical Staff at least thirty □30□days prior to the annual Medical Staff meeting.

Section I. SPECIAL COMMITTEES

□he President of the Medical Staff may appoint special committees as the need arises to carry out a specified tas□. □t such time when such special committee has concluded its assigned duty that is upon acceptance of its final report to the Medical □□ecutive Committee□such committee shall □e terminated.

Section J. REMOVAL

1. Committee mem□ers who are □ppointees must remain mem□ers of the Medical Staff in good standing at all times. Committee mem□ers who are □llied Health Professionals must similarly remain in good standing as □llied Health Professional mem□ers in good standing. Resignation from the Medical Staff□failure to maintain such Medical Staff status□loss of license□or privileges shall immediately create a vacancy in the committee.

2. Officers and Chair shall □e su□□ect to automatic removal from a committee upon their resignation or removal from office in accordance with □rticle □ □□Section □ □and □rticle □ □□□ Section□ C□4 and 5□ respectively. □ll other committee mem□ers who are □ppointees of the Medical Staff and □llied Health Professionals may □e removed upon the determination of the Medical □□ecutive Committee□with or without cause□□ut no such removal shall □e effective unless□and until□it has □een ratified □y the □overning □oard. Cause for such removal may □e for reasons unrelated to professional capa□ilities or the e□ercise of clinical privileges and may include failing to perform the duties of the position or e□hi□iting conduct detrimental to the interests of the Hospital. □ ithout further action pursuant to these □ylaws□removal from office does not affect the Medical Staff appointment or clinical privileges of an □ppointee or □llied Health Professional so removed.

ARTICLE X
MEDICAL STAFF MEETINGS

Section A. STAFF MEETINGS

1. Regular Meetings of the Medical Staff

   a. Medical Staff meetings shall □e held at least annually. □lections of Medical Staff Officers will □e held at the annual meeting. □he agenda of such meetings shall include reports of review and evaluation of the wor□ done in the clinical depart□ ments and the performance of the re□uired Medical Staff functions.

   □. □he Medical □□ecutive Committee may provide□□y resolution□for the holding of additional regular meetings of the Medical Staff for transacting such □usiness as may come □efore the meeting. □ll meetings shall □e held on such day and at such hour as the President of the Medical Staff shall designate in the call and notice of the meeting.

2. Special Meetings of the Medical Staff

   a. □he President of the Medical Staff□the □overning □oard□the Medical □□ecutive Committee□the Chief □□ecutive Officer□or not less than one/third □1/3□of the mem□ers of the □ctive and □ssociate Physician staff may at any time file a written re□uest with the President of the Medical Staff that within seven □7□days of the filing of such re□uest□a special meeting of the Medical Staff shall □e called.

   □. □he Medical □□ecutive Committee shall designate the time and place of any such special meeting.

   c. □ ritten or printed notice stating the place□day and hour of any special meeting of the Medical Staff shall □e delivered□either personally□via e□mail□in Physicians' Hospital mail□o□es□or □y placing in the □nited States mail□to each mem□er of the active and □ssociate Staff mem□ers not less than three □3□wor□ing days □efore the date of such meeting□□y or at the direction of the President of the Medical Staff or other persons authori□ed to call the meeting. □f mailed□the notice of the meeting shall □e deemed delivered when deposited□postage prepaid□in the □nited States mail addressed to each staff mem□er at the address as it appears on the records of the Hospital. □otice may also □e sent to mem□ers or other Medical Staff groups who have so re□uested. □he attendance of a mem□er of the Medical Staff at a meeting shall constitute a waiver of a notice of such meeting. □o □usiness shall □e transacted at any special meeting e□cept that stated in the motion calling the meeting.

3. □uorum

□ □uorum will consist of those Physicians □ppointees present at the Medical Staff meeting.

ARTICLE XI
COMMITTEE AND DEPARTMENT MEETINGS

Section A. REGULAR MEETINGS

Committees and □epartments shall provide the time for holding meetings with prior written notice.

Section B. SPECIAL MEETINGS

□ special meeting of any committee or department may □e called □y □the Chair thereof□□y the President of the Medical Staff□Chief □□ecutive Officer□or □y one□third □1/3□of the group□s mem□ership□□ut not less than two □2□mem□ers.

Section C. NOTICE OF MEETINGS

□ ritten or oral notice stating the place□day and hour of any special meeting or of any regular meeting□not held pursuant to resolution□shall □e given to each mem□er of the committee or department either personally□via e□mail□placing in the Physicians' Hospital mail□o□es□or □y placing in the □nited States mail□at least three □3□days prior to the meeting. □f mailed□the notice of the meeting shall □e deemed delivered when deposited in the □nited States mail addressed to the mem□er at his/her address as it appears on the records of the Hospital with postage thereon prepaid. □he attendance of a mem□er at a meeting shall constitute a waiver of notice of such meeting to such mem□er.

Section D. ATTENDANCE REQUIREMENTS

1. □ctive and □ssociate Staff Mem□ers

□ach mem□er of the □ctive and □ssociate Physician Staff□and □icensed □ndependent Practitioners□are strongly encouraged to attend the following meetings□to contri□ute□and to ma□e their voice heard:

a. Clinical departments□

□. Committees□and

c. □dministrative and special committees.

Section E. QUORUM

 uorum will consist of those Physicians with voting privileges present at the Medical Staff meeting.

Section F. MANNER OF ACTION

1. ormal ction:

   he action of a ma ority of the mem ers present at a meeting at which a uorum is present shall e the action of a committee or department.

2. nformal ction:

   o action of a committee or department shall e valid unless ta en at a meeting at which a uorum is present e cept that any actions may e ta en without a meeting if a unanimous consent in writing setting forth the action so ta en shall e signed y each mem er entitled to vote thereat.

Section G. RIGHTS OF EX-OFFICIO MEMBERS

Persons serving under these ylaws as e officio mem ers of a committee or department shall have all rights and privileges of regular mem ers e cept they shall not e counted in determining the e istence of a uorum. hey shall e deemed non voting mem ers of the committee or department unless specified to the contrary in the individual committee or department sections of these ylaws Rules and Regulations or Policies.

Section H. MINUTES

Minutes of each meeting and special meeting of a committee or department shall e prepared and shall include a record of the attendance of mem ers and the result of the vote ta en on each matter. he minutes shall e signed y the presiding officer and read for approval at the ne t meeting and after such approval is o tained forwarded to the Medical ecutive Committee or as otherwise specified y these ylaws Rules and Regulations and Policies. ach committee and department shall maintain a permanent file of the minutes of each meeting in an accessi le central location in the Hospital approved y the Medical ecutive Committee.

Section I. REQUIREMENTS FOR MANDATORY MEETING ATTENDANCE

1. Re uirements and otice

   Practitioner whose patient s clinical course is scheduled for discussion at a committee or departmental meeting may e re uired y the committee or department Chair to attend

such meeting. The Secretary of the Medical Staff will be notified of the attendance request and then shall give the Practitioner advance written notice of the time and place of the meeting at which his/her attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved the notice to the Practitioner shall so state shall be given by certified mail return receipt requested and shall include a statement that his/her attendance at the meeting at which the alleged deviation is to be discussed is mandatory.

2. Failure to Attend

Failure by a Practitioner to attend any meeting with respect to which he/she was given notice that attendance was mandatory unless excused by the Medical Executive Committee upon a showing of good cause shall result in automatic initiation of a request for corrective action by the committee or Departmental Chair or his/her designee as outlined by Article XII. In all other cases if the Practitioner shall make a timely request for postponement supported by an adequate showing that his/her absence will be unavoidable such presentation may be postponed by the Chair of the involved committee or department or by the Medical Executive Committee if the Chair is the Practitioner involved until not later than the next regular departmental or committee meeting otherwise the pertinent clinical information shall be presented and discussed as scheduled, and Practitioner's absence will result in an automatic initiation of a request for corrective action.

ARTICLE XII
CORRECTIVE ACTION

Section A. CORRECTIVE ACTION

4. Grounds:

Corrective action may be initiated against a member of the Medical Staff whenever there is probable cause that the Practitioner or Allied Health Professional is or was engaged in any of the following:

a. The use of any false fraudulent or forged statement or document or any fraudulent or deceitful practice in the connection with the process of obtaining an appointment or clinical privileges

. The possession of any physical or mental impairment which renders the exercise of their privileges a material risk to patients

c. The performance of any dishonest fraudulent slanderous libelous unethical or unprofessional conduct likely to deceive defraud or harm the public the Medical Staff or the Hospital

d. the habitual use of a drug or intoxicant to such degree as to render one unsafe or unfit to exercise his/her privileges

e. The aiding or abetting of the exercise of privileges in the Hospital by a person not appointed to the Medical Staff by the Governing Board pursuant to these Bylaws

f. The manifest incapacity to exercise privileges

g. Unprofessional or dishonorable conduct which includes but is not limited to the following:

i. any conduct or practice contrary to recognized standards or ethics of the medical profession or any conduct or practice which does or might constitute a danger to the health or safety of a patient Hospital personnel or the public or any conduct practice or condition which does or might impair a Practitioner's or Allied Health Professional's ability to safely and skillfully practice his/her profession

ii. Willful and consistent utilization of medical service or treatment which is inappropriate or unnecessary and/or

iii. Gross negligence gross malpractice or repeated malpractice

h. Inadequate or substandard clinical performance

i. Disruptive behavior as defined in Article III The Medical Staff Code of Conduct and/or

. Failure or refusal to abide by the terms of the current Bylaws or the Rules and Regulations and Policies of the Medical Staff and the Hospital.

. Any restriction limitation or probation of any sort is placed on a Medical Staff Appointee's or Allied Health Professional's license by any licensing or certifying agency or authority unless such action has resulted in automatic termination of the appointment of the Medical Staff Appointee or Allied Health Professional subject to Section C below.

5. Initial Submission of Corrective Action and Initiation of Investigation:

   a. Corrective action against a Practitioner or Allied Health Professional may be requested by a member of the Medical Staff, the President, the Chief Executive Officer, or any member of the Medical Executive Committee or Governing Board.

   b. Requests for corrective action shall be made in writing and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request. Requests for corrective action shall be submitted to the Medical Executive Committee.

   c. The President shall promptly notify the Chief Executive Officer of all requests for corrective action received by himself/herself or the Medical Executive Committee and shall continue to keep the Chief Executive Officer fully informed of all activities in connection therewith.

   d. The President shall consult with the Medical Executive Committee to determine whether such a request for corrective action should be investigated. In the event the Medical Executive Committee determines that the request for corrective action should be investigated, the President shall promptly notify the accused individual(s) that an investigation has begun, unless, under extraordinary circumstances, in the Medical Executive Committee(s) and Chief Executive Officer's judgment, informing the individual would compromise the investigation, or disrupt the operation of the Hospital or Medical Staff.

   e. The initiation of an investigation hereunder shall not preclude the imposition of summary suspension under Section [illegible] below or automatic termination under Section C below at any time.

6. Investigation:

   a. If a determination is made to investigate formally the necessity or advisability of corrective action against a particular Medical Staff Appointee or Allied Health Professional, as the result of an informal investigation or otherwise, the investigation shall be deemed to be conducted by a Body conducting Professional Review Activities and subject to the limitation from liability provided in Section [illegible] of Article [illegible] below.

   b. The Medical Executive Committee shall conduct such investigation itself or at its option, appoint an Investigation Committee to undertake the investigation.

      i. If the Medical Executive Committee elects to appoint an Investigative Committee, the Investigation Committee shall consist of the President,

two (2) Medical Staff Appointees appointed by the President and two (2) Medical Staff Appointees appointed by the Chief Executive Officer. A designee of the Chair of the department to which the affected Medical Staff Appointee is assigned shall serve as a consultant to the Investigation Committee. The President shall serve as Chair of the Investigation Committee.

ii. If an Investigative Committee undertakes the investigation a written report of the investigation shall be forwarded to the Medical Executive Committee as soon as practicable after the conclusion of the investigation.

c. The Medical Executive Committee or the Investigation Committee as the case may be shall have no voting members who are in direct economic competition with the Medical Staff Appointee who is the subject of the investigation. In the event there are not a sufficient number of Medical Staff Appointees who meet such criteria the President along with the Medical Executive Committee may appoint Physicians who are not affiliated with the Hospital who meet such criteria.

d. The Medical Staff Appointee or Allied Health Professional shall be advised of the names of the members of the Medical Executive Committee or if applicable the names of the members of the appointed Investigation Committee within ten (10) days of appointment. If the Medical Staff Appointee or Allied Health Professional who is the subject of the investigation advises the President that he or she believes a member of the Medical Executive Committee or the Investigation Committee should be recused as being in direct economic competition with such Appointee the President shall determine the merit of such contention and if the contention is found to be correct shall appoint a substitute to serve therein.

e. An investigation shall be considered an administrative matter and not an adversarial proceeding. A Medical Staff Appointee or Allied Health Professional who is the subject of an investigation shall not be entitled to have legal counsel present during any meetings or discussions conducted pursuant to the investigation. The Medical Staff Appointee shall have the opportunity to interview with the Medical Executive Committee before the decision is made on whether or not to recommend corrective action.

f. At any time in the Medical Executive Committee's discretion, but in any event, within twenty (20) working days after the receipt of the request for corrective action unless such time is extended upon the written consent of the affected Appointee the Medical Executive Committee shall determine whether or not to recommend corrective action. The recommendation of the Medical Executive Committee may include without limitation the following:

i. Recommending rejection of the request for corrective action;

ii. Recommending a warning, a letter of admonition or a letter of reprimand;

iii. Recommending terms of probation or individual requirements of consultation;

iv. Recommending reduction, suspension or revocation of clinical privileges;

v. Recommending a reduction of staff category or limitation of any staff prerogative directly related to the Practitioner's or Allied Health professional's delivery of patient care; or

vi. Recommending suspension or revocation of staff membership.

7. Procedural Rights:

a. If the Medical Executive Committee has made a proposal to recommend an action for which the Medical Staff Appointee has the right to request a hearing, pursuant to these Bylaws, then notice shall be sent to the Medical Staff Appointee by the Medical Executive Committee by certified mail, return receipt requested. Such notice shall advise the Medical Staff Appointee of his/her procedural rights pursuant to Article XIII, Section C.

b If the Medical Executive Committee proposes to recommend an action for which the Medical Staff Appointee has the right to request a hearing pursuant to these Bylaws, he/she may waive his or her right to a hearing at any time by notifying the Medical Executive Committee in writing. Upon receipt of a waiver of rights to a hearing, or alternatively, upon the expiration of the 30 day period within which the Appointee may appeal the proposed recommendation but fails to do so, then the Medical Executive Committee shall submit the report and its recommendation, together with all supporting documentation, to the Governing Board in writing for final action. In instances in which the Medical Staff Appointee affirmatively waives his or her right to a hearing, the Appointee shall be afforded with an opportunity to interview with the Governing Board before it acts upon the recommendation of the Medical Executive Committee. The Medical Staff Appointee shall promptly be notified of the final action adopted by the Governing Board by certified mail, return receipt requested.

c. If the Medical Executive Committee proposes to recommend an action for which a right to a hearing is not required pursuant to these Bylaws (such as, for instance, with respect to any recommended action with respect to an Allied Health Professional), or alternatively, proposes to reject the request for corrective action,

then the report and its recommendation, together with all supporting documentation, shall be forwarded to the Governing Board in writing for final action. If the Governing Board determines to adopt such Medical Executive Committee recommendation, then the Chief Executive Officer shall provide notice of such final action in writing to the Medical Executive Committee. The Medical Staff Appointee or Allied Health Professional shall promptly be notified of the final action by certified mail, return receipt requested. If the Governing Board proposes to recommend an action that would modify the Medical Executive Committee's recommendation in a manner that would provide a Medical Staff Appointee with the right to request a hearing pursuant to these Bylaws, then the Chief Executive Officer shall promptly notify the Medical Executive Committee in writing of the Governing Board's proposed determination. Notice shall be sent to the Medical Staff Appointee by the Medical Executive Committee by certified mail, return receipt requested advising the Medical Staff Appointee of the proposed action. Such notice shall advise the Medical Staff Appointee of his/her procedural rights pursuant to Article XIII, Section C.

d. Allied Health Professionals do not have procedural rights pursuant to Article XIII of these Bylaws but may pursue the Grievance procedures outlined in Article V, Section C of these Bylaws.

Section B. SUMMARY SUSPENSION

1. Criteria for Initiation:

a. Whenever a Practitioner's or Allied Health Professional's conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the Hospital, either the Chair of the Medical Executive Committee, the Department Chair of any department with respect to Appointees in that department, the Executive Director or his/her designated representative, or the Executive Committee of the staff or Governing Board shall have the authority to summarily suspend the Medical Staff membership status of all or any portion of such clinical privileges of such Practitioner or Allied Health Professional for a period of time not to exceed fourteen (14) days. Such summary suspension shall become effective immediately upon imposition, and the Chief Executive Officer shall promptly give special notice, by certified mail, return receipt requested, or hand delivered with a signed receipt, of the suspension to the Practitioner or Allied Health Professional.

b In the event of any such suspension, the Practitioner's patients then in the Hospital, whose treatment by such Practitioner is terminated by the summary suspension, shall be assigned to another Practitioner by the Departmental Chair or

the President of the Medical Staff. The wishes of the patient shall be considered where feasible in choosing a substitute Practitioner.

2. Medical Executive Committee Action:

As soon as possible after such summary suspension a meeting of the Medical Executive Committee shall be convened to review and consider the action taken. The Medical Executive Committee may modify continue or terminate the terms of the summary suspension.

3. Procedural Rights:

Unless the Medical Executive Committee immediately terminates the suspension and ceases all further corrective action and the Governing Board upholds the Medical Executive Committee's recommendation the Practitioner or Allied Health Professional shall be entitled to the procedural rights as provided in Article III.

Allied Health Professionals do not have procedural rights pursuant to Article III of these Bylaws but may pursue the Grievance procedures outlined in Article V Section C of these Bylaws.

4. Other Action

If the Medical Executive Committee's action is to terminate the suspension and to cease all further corrective action such action shall be transmitted immediately together with all supporting documentation to the Governing Board. The terms of the summary suspension as originally imposed shall remain in effect pending a final decision by the Governing Board which shall be reviewed within seven (7) calendar days of the date the Medical Executive Committee provides its recommendation to the Governing Board.

Section C. AUTOMATIC SUSPENSION OR TERMINATION

1. Termination Events. An appointment to the Medical Staff as well as all clinical privileges shall be automatically terminated upon the occurrence of any of the following events:

   a. A Medical Staff Appointee or Allied Health Professional loses his/her license to practice his/her profession or a restriction or condition of any sort shall be placed upon such license provided however that the placing of an Appointee or Allied Health Professional on probation by the applicable licensing authority shall not be the basis for automatic termination alone without the imposition of restrictions or conditions which in some way restrict the Appointee's or Allied Health Professional license or ability to practice medicine or to treat patients

□. □ailure to report to the Hospital any restriction or condition imposed on or pro□ation with respect to his/her license □y the applica□le licensing authority within thirty □30□ days of the imposition of such restriction□ condition or pro□ation□

c. □ revocation or suspension of the right to prescri□e or administer any controlled su□stances□to prescri□e medications in any manner□or revocation or termination of the □ppointee's Drug Enforcement Administration Number;

d. □ Medical Staff □ppointee or □llied Health Professional who has □een re□uested to appear at a meeting of any committee of the Medical Staff or Hospital in order to discuss proposed corrective action shall fail to appear□

e. Revocation or suspension of the right to □ill Medicare□Medicaid□or any other federal or state healthcare program□or

f. □□clusion from □illing Medicare□ Medicaid□ or any other federal or state healthcare program.

g. □ Medical Staff □ppointee or □llied Health Professional□ who after the imposition of si□ □6□prior suspensions for failure to complete medical records during any Medical Staff year fails to complete medical records in a timely fashion pursuant to the Rules and Regulations and/or Policies of the Medical Staff□

h. □ailure to maintain the minimum professional lia□ility insurance coverage as re□uired □y the □ylaws□the Rules and Regulations□and/or the Policies□unless the Medical Staff □ppointee or □llied Health Professional has timely re□uested a waiver or reduction of such coverage and is awaiting final action on such re□uest□

i. □ailure to comply with the geographic pro□imity re□uirement set forth in re□uired □y the □ylaws□the Rules and Regulations□and/or the Policies□or

□. □ailure to meet any certification or other □ualification to maintain his/her appointment to the Medical Staff pursuant to the □ylaws□ the Rules and Regulations□and/or the Policies.

2. □utomatic Suspension □vents.

□n appointment to the Medical Staff□ as well as all clinical privileges□ shall □e automatically suspended upon the occurrence of any of the following events:

a. □ailure to complete medical records in a timely fashion pursuant to the Rules and Regulations and/or Policies of the Medical Staff □e□cept with respect to his her

patients already in the Hospital and for emergency admissions for forty□eight □4□□ hours following suspension□□his/her rights to admit patients and to consult with respect to patients□and his/her voting rights and office holding prerogatives shall□ after 24 hours written warning of delin□uency□□e automatically suspended until medical records are completed.

□. □n □ppointee's or Allied Health Professional's license□certification or other legal credentials are limited or restricted □y the applica□le authority in a manner that does restrict the □ppointee's or Allied Health Professional's license or ability to practice medicine or to treat patients□then those clinical privileges or specified services that are within the scope of the limitation or restriction shall □e immediately and automatically suspended□for at least the term of such limitation or restriction.

c. □hen an □ppointee's or Allied Health Professional's license□certification or other legal credentials are placed on pro□ation □y an applica□le authority□and such pro□ation does not restrict the □ppointee's license or ability to practice medicine or to treat patients□the □ppointee's voting and office□holding rights pursuant to these □ylaws shall □e automatically suspended for at least the term of the pro□ation.

3. Reinstatement

Reinstatement of a staff mem□er or □llied Health Professional whose mem□ership has □een terminated pursuant to □rticle □□□Section □C□1□g□□or suspended in accordance with □rticle □□□□Sections C □2□□□□and □c□revo□ed □ecause of incomplete medical records as outlined in □rticle □□□Section □. and □rticle □□□Section □. shall □e made only upon application□and all such applications shall □e processed in the same manner as applications for original appointment.

ARTICLE XIII
HEARING PROCEDURE

Section A. LIMITATION

□o □pplicant or Medical Staff □ppointee shall □e entitled as a matter of right to more than one □1□hearing with respect to the su□□ect matter of any proposed adverse recommendation or action giving rise to a hearing right. □llied Health Professionals do not have procedural rights pursuant to □rticle □□□□of these □ylaws □ut may pursue the □rievance procedures outlined in □rticle □□ Section C of these □ylaws.

Section B. APPLICABILITY

1. □eneral

□his article shall apply to all hearings re□uired □y law or these □ylaws with respect to the rights□duties□and privileges of any Practitioner or □llied Health Professional. □he □ yoming □dministrative Procedures □ct applies to all proceedings conducted under these □ylaws and Rules and Regulations□ □ut only to the e□tent the □ yoming □dministrative Procedures □ct is not consistent with these □ylaws and Rules and Regulations.

2. Specific Rights.

□nless waived□ an □pplicant or □ppointee shall □e entitled to a hearing if any professional review □ody proposes □i□ to ma□e a recommendation that any of the following adverse actions □e ta□en with respect to him or her for reasons other than failure to meet minimum o□□ective criteria specified in the Medical Staff □ylaws the Rules and Regulations□and/or the Policies□or □ii□to ta□e any of the following adverse actions without a prior adverse recommendation of any professional review □ody for reasons other than failure to meet minimum o□□ective criteria specified in the Medical Staff □ylaws□the Rules and Regulations□and/or the Policies:

a. □enial of a completed application for initial appointment or reappointment to the Medical Staff for any reason□e□cept where: □i□the application does not meet the minimum o□□ective re□uirements set forth in the Medical Staff □ylaws□or □ii□the □pplicant is re□uesting clinical privileges in a department□su□specialty or service in which the num□er of Medical Staff □ppointees has □een limited in accordance with the Medical Staff □ylaws□the Rules and Regulations□and/or the Policies□

□. Summary suspension or termination from the Medical Staff in accordance with the Medical Staff □ylaws□

c. Revocation or termination of appointment to the Medical Staff□e□cept where continued appointment to the Medical Staff was contingent upon the continuance of a contractual relationship with the Hospital□

d. □enial of re□uested advancement or re□uested change in Medical Staff category□ e□cept for any denial resulting from failure to meet the minimum o□□ective criteria for the re□uested category□

e. □enial of re□uested advancement or re□uested change in Medical Staff category□ e□cept for any denial resulting from a failure to meet the minimum o□□ective criteria for the re□uested category□

f. Reduction in Medical Staff privileges other than i a change from ctive Physician Staff for failure to meet the patient care re uirements set forth in the ylaws the Rules and Regulations and/or the Policies ii or iii any other change in category resulting from a failure to meet the minimum o ective criteria for a particular Medical Staff category

g. enial of re uested clinical privileges or re uested change in clinical privileges e cept where i the pplicant or ppointee is re uesting clinical privileges in a department in which the num er of Medical Staff ppointees has een limited y the ylaws the Rules and Regulations and/or the Policies or ii the pplicant or ppointee fails to meet the minimum o ective criteria for such privileges

h. Reduction in restriction of or failure to renew clinical privileges other than i a temporary restriction in accordance with the ylaws the Rules and Regulations and/or the Policies or ii where such Staff ppointee no longer meets the minimum o ective criteria for such privileges

i. Revocation or suspension summary or otherwise of clinical privileges other than i a temporary suspension as provided y the ylaws the Rules and Regulations and/or the Policies or ii where such ppointee no longer meets the minimum o ective criteria for such privileges and/or

. ny other action or recommendation adversely affecting as such term is defined in Section 431 1 of the Health Care uality mprovement ct of 19 6 any pplicant or ppointee.

3. ctions ot iving Rise to Hearing Rights.

hearing right shall not have arisen in any of the following circumstances:

a. he commencement of an investigation y the Medical ecutive Committee or the appointment of an nvestigation Committee and the commencement of an investigation y such Committee

. he conduct of an investigation into any matter

c. he restriction or summary suspension of an ppointee's clinical privileges for a period of no longer than fourteen 14 days while an investigation is pending

d. he formulation and presentation of any preliminary report of the Medical ecutive Committee to the Chief ecutive Officer or to the officers of the Medical Staff or alternatively the formulation and presentation of any preliminary report of any nvestigation Committee to the Medical ecutive Committee the Chief ecutive Officer or to the officers of the Medical Staff

e. The making of a request or issuance of a directive to an Applicant or Appointee to appear at an interview or conference before the Credentials Committee the Medical Executive Committee any Investigation Committee the President or Chief Executive Officer the Governing Board or any other Body in connection with any investigation prior to a proposed adverse recommendation or action

f. The denial of or refusal to accept an application for initial appointment or reappointment to the Medical Staff i where the application is incomplete ii where the application reflects that the Applicant does not meet the minimum objective requirements for appointment or reappointment or iii where the Applicant is requesting clinical privileges in a department subspecialty or service in which the number of Medical Staff Appointees has been limited in accordance with the Bylaws the Rules and Regulations and/or the Policies

g. The denial or revocation of temporary privileges in accordance with the Bylaws

h. The appointment of a newly appointed Appointee to the Associate Physician Staff

i. Automatic termination or suspension of privileges as provided by Article III Section C of the Bylaws

. The imposition of supervision or observation on an Appointee which supervision or observation does not restrict the clinical privileges of the Appointee or the delivery of professional services to patients

. The issuance of a letter of warning admonition or reprimand

l. Corrective counseling

m. A recommendation that an Appointee be directed to obtain retraining additional training or continuing education

n. The denial of a request for a waiver or reduction of the required minimum liability insurance coverage as provided in the Bylaws the Rules and Regulations and/or the Policies

o. Any change in Medical Staff category resulting from the failure of an Appointee to meet the minimum objective criteria for a specific category or

p. Any recommendation or action not adversely affecting as such term is defined in Section 431(1) of the Health Care Quality Improvement Act of 1986 any Applicant or Appointee or which is not based upon a subjective determination of the professional competence or conduct of the Applicant or Medical Staff Appointee.

Section C. NOTICE

1. Notification to Practitioners and Applicants and Appointees.

Prior to sending a recommendation for corrective action to the Governing Board pursuant to Article (Section 3(f)(iii)(iv)(v) and (vi)) or recommending or taking an adverse action against an Applicant or Appointee pursuant to Section (a)(ove) the Applicant or Appointee shall be notified in writing by the Medical Executive Committee of the following:

a. That adverse action has been proposed to be taken against the Applicant or Appointee

b. The reasons for the proposed action;

c. That the Applicant or Appointee has the right to request a hearing on the proposed action by notifying the Medical Executive Committee in writing via certified mail return receipt requested of such intent within thirty (30) days of receipt of the notice and

d. The rights and procedures to be applied at any such hearing.

2. Notice of Hearing

If a timely request for a hearing is received the Practitioner or Allied Health Professional shall be given written notice stating the following:

a. The place time and date of the hearing which date shall not be less than thirty (30) days nor more than forty-five (45) days after the date of receipt of the notice of appeal from the Applicant or Appointee unless otherwise mutually agreed by the Applicant or Appointee and the Hospital;

b. A list of witnesses if any expected to testify on behalf of the Governing Board or decision-making entity and

c. The Applicant or Appointee's rights at the hearing.

3. □ aiver of Hearing

a. □he Practitioner or □llied Health Professional may waive a hearing at any time □y notifying the Medical □□ecutive Committee, □n writing.

b □f a re□uest for a hearing is not received within (□0) days, or upon receipt of a written notice of waiver, the □pplicant or □ppointee shall □e deemed to have waived all rights to a hearing.

A waiver of a hearing right as to an adverse recommendation also waives a hearing right for the adverse action recommended. □n the case of waiver of a hearing right as to a proposed adverse recommendation □y the Credentials Committee, the Medical □□ecutive Committee or an □nvestigation Committee pursuant to a re□uest for corrective action, or with respect to any other Medical Staff □ody, the □overning □oard shall □e notified that the proposed recommendation is a final recommendation, and the □overning □oard shall ta□e final action on the recommendation. Such report and recommendation, together with all supporting documentation, shall □e su□mitted to the □overning □oard in writing for final action. □n instances in which a Medical Staff □ppointee affirmatively waives his or her right to a hearing arising from a recommendation for corrective action, the □ppointee shall □e afforded with an opportunity to interview with the □overning □oard □efore it acts upon the recommendation of the Medical □□ecutive Committee. □he □pplicant or □ppointee shall promptly □e notified of the final action adopted □y the □overning □oard □y certified mail, return receipt re□uested

c. □he Practitioner shall have an opportunity to interview with the □overning □oard □efore they act on the recommendation of the Medical □□ecutive Committee.

Section D. CONDUCT OF HEARING

1. Hearing □uthority

□ny hearing held pursuant to this □rticle shall □e held □efore either of the following: at the election of the involved □pplicant or □ppointee, which □ody shall □e deemed a □ody conducting Professional Review □ctivities and su□□ect to the limitation from lia□ility provided in Section I of □rticle XIV □elow, or at the election of the involved Practitioner□s)

a. A Hearing Officer appointed □y the □overning □oard, and approved □y the Medical □□ecutive Committee, who is not in direct economic competition with the □pplicant or □ppointee involved; or

□. □ panel of three □3□individuals who are appointed □y the President of the Medical Staff□and approved □y the □overning □oard□and are not in direct economic competition with the □pplicant or □ppointee involved.

2. Rights of □pplicants and □ppointees □t the hearing□the □pplicants and □ppointees shall have the following rights:

   a. □he right to □e represented □y an attorney or another person of the □pplicant or □ppointee's choice□□provided□however□that such □pplicant or □ppointee shall promptly provide the Medical □□ecutive Committee with written identification of the appointed attorney and such attorney's contact information);

   □. □he right to have a record of the proceedings made□copies of which may □e o□tained □y the □pplicants and □ppointees upon payment of any reasona□le charges associated with the preparation thereof□

   c. □he right to call□e□amine and cross□e□amine witnesses□

   d. □he right to present evidence determined to □e relevant □y the hearing authority regardless of its admissi□ility in a court of law□and

   e. □he right to su□mit a written statement at the close of the hearing.

3. Pre□Hearing Procedures and Re□uests for □nformation or □ocuments

   a. □ot later than ten □10□days prior to the scheduled hearing date□the □pplicant or □ppointee will provide written notice to the Medical □□ecutive Committee of the witnesses e□pected to testify on his or her □ehalf at the hearing.

   □. □ot later than ten □10□days prior to the scheduled hearing date□each party will provide to the other party the documents upon which it e□pects to rely at the hearing. □ach party remains under a continuing o□ligation to provide the other party any documents identified after this date□ which the party intends to introduce at the hearing.

   c. □pon re□uest □y either party to the hearing□the hearing officer may re□uire the other party to provide information or produce documents in its/his/her possession□ which the hearing authority concludes in good faith to □e reasona□ly related to the su□□ect of the hearing and not su□□ect to any privilege prohi□iting such disclosure. □f the party who is directed to provide such information or documents fails without good cause to do so□the hearing authority shall have wide latitude in drawing adverse inferences against the party who failed to provide the information or documents re□uested. □he party re□uesting the information or documents shall □e given the opportunity to state to the hearing officer what such

party □elieves the information or documents would have shown if it had □een provided as directed □y the hearing officer. Such statement, if any, shall □e made in writing and included as part of the record. □dditionally, if the information or documents re□uested and directed □y the hearing officer to □e provided are accessi□le □y alternative means, the hearing officer may in his/her discretion direct that the party refusing to provide such information or documents pay the cost of o□taining the information □y such alternative means.

4. Order of Procedure

□o the e□tent practica□le, the hearing shall □e conducted in accordance with the following order of procedure:

a. □he Medical □□ecutive Committee shall ma□e an opening statement e□plaining its position and the evidence it proposes to offer in support of its position.

b □he □pplicant or □ppointee shall ma□e an opening statement □riefly e□plaining their Professional's position and the evidence that he or she proposes to offer in support of his/her position.

c. □he Medical □□ecutive Committee shall present its evidence, including witnesses and e□hi□its. □he □pplicant or □ppointee shall □e entitled to cross-e□amine the witnesses.

d. □he □pplicant or □ppointee shall present his/her evidence, including witnesses and e□hi□its. □he Medical □□ecutive Committee shall □e entitled to cross-e□amine the witnesses.

e. □he Medical □□ecutive Committee may present re□uttal evidence.

f. □he □pplicant or □ppointee may present re□uttal evidence.

g. □he Hearing □uthority may allow the ta□ing of evidence out of order.

h. Oral closing statements may □e made in the same se□uences as the presentation of evidence and the parties shall □e afforded the right to present a written statement at the close of the hearing.

5. Se□uence of Presentation of evidence in □ppointment, Re-□ppointment or □dvancement Cases

□otwithstanding □rticle XIII, Section 3, whenever a hearing relates solely to (i) a denial of appointment or reappointment to the Medical Staff, (ii) re□uested clinical privileges or (iii) re□uested advancement in Medical Staff category or privileges, the □pplicant or

□ppointee shall present his or her evidence first. □fter the first party to present evidence has completed□the other party shall present his/her evidence. □he initial party shall then have the opportunity to re□ut the evidence presented □y the opposing party. □he hearing officer may in its discretion re□uest or allow opening statements□which if made will □e presented □y the parties in the same se□uence as provided for presentation of evidence.

6. □dministration of Oath

□ll persons testifying at any hearing shall □e administered the following oath or affirmation □y a person lawfully entitled to administer oaths□to□wit:

□□o you swear or affirm to tell the truth□the whole truth and nothing □ut the truth in the matter now here pending□□

7. □dmissi□ility of □vidence

a. □he □pplicant or □ppointee shall □e permitted to present evidence determined to □e relevant □y the hearing authority□regardless of its admissi□ility in a court of law. □he hearing authority shall permit the admission of any evidence□which possesses pro□ative value commonly accepted □y reasona□ly prudent persons in the conduct of their affairs. □he hearing authority shall have □road discretion in determining whether evidence proposed to □e introduced is merely cumulative in nature and does not possess pro□ative value in addition to the evidence already admitted□and shall e□clude any such cumulative evidence. □he hearing authority shall give effect to the rules of privilege recogni□ed □y law□to the same e□tent recogni□ed in □udicial proceedings□communications made or documents prepared in anticipation of the hearing provided for in these □ylaws. O□□ections to evidentiary offers may □e made and shall □e noted in the record. Su□□ect to these re□uirements□when a hearing will □e e□pedited and the interests of the parties will not □e pre□udiced su□stantially□any part of the evidence may □e received in written form.

□ □ocumentary evidence may □e received in the form of originals or copies. □□cerpts of documents may also □e received□in the discretion of the hearing officer. □pon re□uest□parties shall □e given an opportunity to compare a copy with the original. □ach party shall □e responsi□le for properly identifying any e□hi□its sought to □e introduced into evidence. □f authenticity is challenged □y the opposing party□such party shall also □e responsi□le for proving the authenticity of the e□hi□it. □he identification or authenticity of any e□hi□it shall □e a matter for determination □y the Hearing Officer.

c. □he Hearing Officer may□in the course of the proceedings□indicate that it will ta□e official notice of any matters as to which it □elieves there can □e no reasona□le dispute. Official notice may also □e ta□en of generally recogni□ed

technical or scientific facts within the Hearing Officer's specialized knowledge. □pon challenge of the propriety of ta□ing such official notice□the Hearing Officer shall set forth in writing and provide the participants to the hearing a □rief statement of the □asis for such official notice of technical or scientific facts. □ny party to the hearing is entitled upon a re□uest made within a reasona□le time thereafter to □e heard as to the propriety of ta□ing official notice.

□. Record of Proceedings

□n all hearings□the proceeding□including all testimony□shall □e reported ver□atim □y stenographic□electronic or other appropriate means as determined □y the □overning □oard or hearing authority.

9. Standard of Proof

a. □he Medical □□ecutive Committee shall have the initial o□ligation to present evidence in support of the proposed adverse recommendation or action giving rise to the hearing□□ut the □pplicant or □ppointee shall thereafter have the □urden of proving□□y clear and convincing evidence□that the adverse recommendation or action lac□s any factual □asis or that such □asis or the conclusions drawn therefrom are ar□itrary□unreasona□le□or capricious.

□. □otwithstanding section 9□a□□whenever a hearing relates solely to a proposed denial of □i□appointment or re□appointment to the Medical Staff□□ii□re□uested clinical privileges or □iii□re□uested advancement in Medical Staff category or privileges□the □pplicant or □ppointee who re□uested the hearing shall have the □urden of proving□□y clear and convincing evidence□□i□that he or she meets the standards for appointment or reappointment to the Medical Staff or for the granting of the clinical privileges or Medical Staff privileges or category re□uested and □ii□that the denial of appointment or reappointment□re□uested clinical privileges or re□uested advancement would □e ar□itrary□unreasona□le and capricious.

10. Recommendations

□pon completion of the hearing□or within a reasona□le time thereafter□not e□ceeding fourteen □14□ days□the hearing authority shall su□mit a written recommendation□ including a statement of the □asis for that recommendation□to □e forwarded to the Medical □□ecutive Committee and the □pplicant or □ppointee□or each party's attorney of record□as applica□le□via certified mail□return receipt re□uested. □n addition□a copy of the written recommendation□together with the entire record□shall □e promptly forwarded to the □overning □oard □y the hearing authority.

11. Re□uest for □ppellate Review

a. □ny party to an original hearing may re□uest an appellate review of the recommendations of the hearing authority to the □overning □oard. Re□uests for an appellate review must □e made in writing □y certified mail□return receipt re□uested□to the □overning □oard□with copies to the other parties involved in the hearing□within seven □7□days of receipt of the recommendation from the hearing authority.

□. □he failure of any party to re□uest an appellate review in a timely manner shall constitute a waiver of the right to appellate review□ and such written recommendation shall □e su□mitted □y the hearing authority to the □overning □oard for a review pursuant to Section 12 of these □ylaws.

12. □ppeal to the □overning □oard □ □ecision

a. □pon receipt of a written notice of appeal□the □overning □oard shall review and consider the hearing authority□s recommendation and findings□and the whole record or any portion stipulated to □y the parties presented during the hearing. □he □overning □oard shall afford all parties an opportunity to file written e□ceptions to and/or support for the written recommendation□shall permit all parties to file a □rief. □t the determination of the □overning □oard□the parties may □e permitted to present oral arguments to the □overning □oard.

□. □he □overning □oard shall□within thirty □30□days after receipt of the re□uest for an appeal of the recommendation of the hearing authority□ma□e and enter a written decision upholding, modifying, or rejecting the hearing authority's recommendation. Such written decision shall include findings of fact and conclusions of law□□ased upon the evidence adduced from the hearing. □he parties shall □e notified in writing of the decision□and a copy of the final decision□ findings of fact and conclusions of law shall □e delivered forthwith to each party or the party□s attorney of record □y certified mail□return receipt re□uested.

13. Governing Board Action When the Hearing Authority's Decision is not Subject to □ppeal.

Where the parties do not provide notice of appeal of the Hearing Authority's recommendation□the □overning □oard shall□within thirty □30□days after receipt of the recommendation of the hearing authority□review and consider the Hearing □uthority□s recommendation and findings□the whole record□and shall thereafter ma□e and enter a written decision upholding□ modifying□ or re□ecting the Hearing □uthority's recommendation. Such written decision shall include findings of fact and conclusions of law□□ased upon the evidence adduced from the hearing. □he parties shall □e notified in

writing of the final decision and a copy of the decision findings of fact and conclusions of law shall e delivered forthwith to each party or the party's attorney of record y certified mail return receipt re uested.

14. Reports to the ational Practitioner ata an

he Hospital or its authori ed representative shall report adverse actions as that term is defined in the Healthcare uality mprovement ct of 19 6 as amended from time to time to the ational Practitioner ata an as re uired y law.

ARTICLE XIV
IMMUNITY

Section A. IMMUNITY FROM LIABILITY

1. Persons Protected.

y applying for and/or accepting appointment to the Medical Staff and y applying for accepting and/or e ercising clinical privileges within the Hospital each pplicant and Medical Staff ppointee e tends a solute immunity to and releases from all claims damages and lia ility whatsoever:

a. he Hospital and any representative thereof for any action ta en or statement or recommendation made y any Hospital representative within the scope of his/her duties as a representative of the Hospital in compliance with the ylaws Rules and Regulations or Policies including disclosures made to other healthcare entities pursuant to the ylaws.

. ny third party for releasing or disclosing information including otherwise privileged or confidential information to any representative of the Hospital concerning any former or current pplicant or Medical Staff ppointee unless such information is false and the third party providing it new it was false.

2. cts Covered.

he immunity provided y the ylaws shall apply to all acts communications reports recommendations or disclosures performed or made in connection with the Hospital's activities, including, but not limited to:

a. pplications for appointment and/or clinical privileges

. Periodic reappraisals for reappointment or for changes in clinical privileges

c. corrective action□

d. Hearings and appellate reviews□

e. Patient care audits□

f. Medical care evaluations□

g. □tili□ation reviews□

h. Other Hospital□staff□department□service□committee and su□committee activities related to monitoring and maintaining □uality patient care and appropriate professional conduct□

i. Matters or in□uiries concerning the credentials□or re□uest for credentials□of any or Medical Staff □ppointee or □pplicant□

□. Matters directly or indirectly affecting patient care or the efficient operation of the Hospital□and

□. Reports to the □ational Practitioner □ata □an□.

Section B. FOR ACTION TAKEN

□n addition to the foregoing□no representative of the Hospital or the Medical Staff shall □e lia□le to a Practitioner or □llied Health Professional for damages or other relief for any action ta□en□ or statement or recommendation made within the scope of his/her duties as a representative of the Hospital or of the Medical Staff□if such representative acts in good faith and without malice in the reasona□le □elief that such acts are in the furtherance of □uality health care□and after a reasona□le effort□under the circumstances□to ascertain the truthfulness of the facts and in the reasona□le □elief that the action□statement or recommendation is warranted □y such facts. □ruth shall □e an a□solute defense in all circumstances.

Section C. FOR PROVIDING INFORMATION

□n addition to the foregoing□□o representative of the Hospital or Medical Staff and no third party shall □e lia□le to a Practitioner or □llied Health Professional for damages or other relief □y reason of providing information□including otherwise privileged or confidential information□to a representative of the Hospital or Medical Staff or to any other healthcare facility or organi□ation of health professionals□concerning a Practitioner or □llied Health Professional who is□or has □een an □pplicant to□or a mem□er of□the Medical Staff□or who did□or does□e□ercise clinical privileges or provide specified services at the Hospital□provided that such representative or third

party acts in good faith and without malice and provided further that such information is related to the performance of the duties and functions of the recipient and is reported in a factual manner.

Section D. REVIEW ACTIVITY IMMUNITIES

□he □overning □oard□any committees of the Medical Staff and/or of the □overning □oard□the President□an □nvestigating Committee□Hearing Officer□or any other person□entity□or □ody who conducts Professional Review □ctivities and any individuals within the Hospital authori□ed to conduct Professional Review □ctivities□here□y constitute themselves as Professional Review □odies as defined in the Health Care □uality □mprovement □ct of 19□6□as amended from time□ to□time□and as defined pursuant to □ yoming law. □ach Professional Review □ody here□y claims all privileges and immunities afforded to it □y said federal and state statutes. □ny action ta□en □y a Professional Review □ody pursuant to these □ylaws or the Rules and Regulations and the Policies shall □e in the reasona□le □elief that it is in furtherance of □uality healthcare □including the provision of care in a manner that is not disruptive to the delivery of □uality medical care at the Hospital□only after a reasona□le effort has □een made to o□tain the true facts of the matter□after ade□uate notice and hearing procedures are afforded to any □pplicant or Medical Staff □ppointee□and only in the reasona□le □elief that the action is warranted □y the facts □nown after a reasona□le effort has □een made to o□tain the facts.

ARTICLE XVIII
AMENDMENTS TO THE BYLAWS

Section A. AMENDMENT UPON INITIATION OF THE MEDICAL STAFF

□ proposed amendment to these □ylaws may □e made □y an □ctive or □ssociate Medical Staff □ppointee. □ny such proposed amendment shall □e referred to the □ylaws Committee□which shall report on it at the ne□t regular meeting of the Medical □□ecutive Committee or at a special meeting called for such purpose. □n addition to the process set forth a□ove□the Medical Staff may directly consider a proposed amendment to these □ylaws upon the written re□uest of at least twenty□five □25□ □of the Medical Staff. Prior to a vote on any proposed amendment□it will □e communicated to the Medical □□ecutive Committee for consideration. □mendments so adopted shall □e effective when approved □y the □overning □oard. □he proposed amendment shall □e mailed to the Medical Staff at least twenty □20□calendar days prior to the Medical Staff meeting at which it is to □e voted upon. □o □e adopted□an amendment shall re□uire a two□thirds □2/3□ vote of the active and associate Physician staff physically present. □mendments so made shall □e effective when approved □y the □overning □oard. □f an amendment is initiated □y the Medical □□ecutive Committee□they shall □e re□uired to follow the same process as a□ove.

Section B. AMENDMENT UPON INITIATION BY GOVERNING BOARD OR CHIEF EXECUTIVE OFFICER

These Bylaws may be amended by the Governing Board at any regular or special meeting of the Governing Board. A copy of each proposed amendment to these Medical Staff Bylaws shall be distributed to each Medical Staff Member at least thirty (30) days in advance of the meeting at which the Governing Board proposes to take final action thereon. Any amendments approved by the Governing Board also shall require approval by the Medical Staff as provided herein. The Governing Board and Chief Executive Officer shall also have the right to propose amendments to the Medical Staff Bylaws; they shall be required to follow the same process above and are subject to approval by both the Medical Executive Committee and/or the Medical Staff as set forth above and the Governing Board.

ARTICLE XV
RULES, AND REGULATIONS AND POLICIES

Section A. CREATION OF RULES, REGULATIONS, AND POLICIES

1. The Medical Staff shall from time to time adopt or assure the adoption of such Rules and Regulations and/or Policies as may be necessary to implement more specifically the general principles found within these Bylaws subject to the approval of the Governing Board. Such Rules and Regulations and Policies shall relate to the proper conduct of Medical Staff activities as well as embody the level of practice that is to be required of each Medical Staff Appointee in the Hospital. Such Rules and Regulations and Policies shall be incorporated and made a part of these Bylaws herein as amended.

2. The Medical Staff hereby delegates to the Medical Executive Committee the authority to propose and adopt Rules and Regulations of the Medical Staff subject to the limitations set forth herein. The Medical Executive Committee will furnish to all members of the Medical Staff for review and comment a written copy of any proposed Rule or Regulation or any amendment thereto at least ten (10) days prior to the meeting at which such matter will be considered; provided however, in the event there is a documented need for an urgent amendment to a Rule or Regulation to comply with law or regulation, the Medical Executive Committee may provisionally adopt and the Governing Board may provisionally approve such urgent amendment without prior notification to the Medical Staff. In such cases, the Medical Staff will be immediately notified by the Medical Executive Committee and the Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment.

3. The Medical Staff hereby delegates to the Medical Executive Committee the authority to propose and adopt Policies for the Medical Staff subject to the limitations set forth

herein. The Medical Executive Committee shall notify the Medical Staff of its approval of a Policy or any amendment thereto.

Section B. APPROVAL OF RULES, REGULATIONS, AND POLICIES

1. The approval of any Rule and Regulation or Policy shall be submitted to a vote of the Medical Staff at the written request of at least twenty-five percent (25%) of the Medical Staff received within thirty (30) days following approval of such Rule and Regulation or Policy or any amendment thereto by the Medical Executive Committee. Such matter shall be considered at a special meeting of the Medical Staff.

2. Notwithstanding and in addition to the foregoing, the Medical Staff may directly adopt a Rule and Regulation or Policy or any amendment thereto at any annual or special meeting to the extent such action is requested in writing by at least twenty-five percent (25%) of the Medical Staff. Notice of such proposed Medical Staff action shall be given to the Medical Executive Committee by the President at least ten (10) days prior to the meeting at which such matter will be considered. Such changes shall become effective when approved by the Governing Board.

3. The Governing Board shall also have the right to propose changes to such Rules and Regulations or Policies subject to approval by both the Medical Executive Committee and/or the Medical Staff as set forth above and the Governing Board.

BYLAWS

These Bylaws together with the appended Rules and Regulations shall be adopted at any regular or special meeting of the active and associate Physician staff shall replace any previous Bylaws Rules and Regulations and shall become effective when approved by the Governing Board of the Hospital.

ARTICLE XVI
DISPUTE RESOLUTION PROCEDURES BETWEEN THE MEDICAL STAFF AND THE MEDICAL EXECUTIVE COMMITTEE

To the extent a conflict arises between at least 25% of the active Medical Staff and the Medical Executive Committee on issues including but not limited to proposed adoption of or amendments to these Bylaws Rules Regulations or Policies the following dispute resolution process shall be followed as determined by the President and Vice President before either the Medical Executive Committee or the Medical Staff takes an action contrary to an action proposed action or position of the other group:

1. The President shall appoint at least two Medical Executive Committee members to represent the Medical Executive Committee. The Medical Staff shall select two at large active Medical Staff members to represent the Medical Staff in connection with the dispute.

2. Such appointed representatives shall meet in good faith to attempt to resolve the dispute.

3. In the event the dispute has not been resolved after at least two meetings of the representatives over at least thirty (30) days, the dispute resolution process will terminate, and the Medical Executive Committee and the Medical Staff may proceed to take such actions as are otherwise authorized by these Bylaws, Rules, Regulations, and Policies.

ARTICLE XVII
MEDICAL STAFF CODE OF CONDUCT

PURPOSE

Memorial Hospital of Sweetwater County's (MHSC) vision is to improve the health of its patients and the well-being of the community by building relationships, exceeding expectations, and enhancing human lives. This vision may be achieved by setting high standards for safety and quality of patient care. The MHSC Medical Staff recognizes that safety and quality of patient care depend on teamwork, communication, and collaboration. The Medical Staff further recognizes that certain behaviors tend to undermine the culture of patient safety and quality that MHSC is committed to, specifically intimidating and disruptive behaviors by members of the health care team that could potentially contribute to medical errors, poor patient satisfaction, preventable adverse outcomes, and increased costs.

This Code of Conduct is intended to:

- Define personal and professional standards of conduct and acceptable behavior for all staff while engaged in business or service with MHSC;

- Prohibit intimidating and disruptive behaviors that can foster medical errors, contribute to poor patient care, preventable adverse outcomes, and increase costs, and

- Encourage and promote teamwork, communication and a collaborative work environment.

In furtherance of this purpose, acts of retribution or consequence to any Medical Staff member or employee who carries out the standards of, or reports violations of this Code of Conduct will not be tolerated. Making knowingly frivolous, false or malicious allegations of violations of the Code of Conduct, however, has the potential to undermine trust and morale in the workplace.

□isciplinary action under the relevant MHSC policy□□ylaws□or Code of Conduct may □e ta□en against anyone found to have made allegations of violations that are □nowingly frivolous□false or malicious.

STANDARDS OF CONDUCT AND PROFESSIONALISM

I. APPROPRIATE BEHAVIOR.

□ll Medical Staff are e□pected and re□uired to engage in □ppropriate □ehaviors that foster collegial and colla□orative relationships□support a health care and wor□place environment that improves patient □uality care□fosters a safety culture□and □e professional□courteous and respectful to all individuals. **Appropriate Behavior is a condition of membership, credentialing and privileging of the Medical Staff.**

□elow is a list of □ppropriate □ehaviors□however□this list is not intended to □e all□inclusive:

- □reat all persons□including patients□families□visitors□employees□trainees□students□volunteers□trustees□and healthcare professionals with respect□courtesy□caring□dignity and a sense of fairness.
- Communicate openly□respectfully and directly with team mem□ers□referring providers□patients□and families in order to promote mutual trust and understanding and optimi□e health services.
- □ncourage□support and respect the right and responsi□ility of all individuals to assert themselves to enhance patient safety and the □uality of care.
- Resolve conflicts in a respectful□non□threatening□constructive and private manner. □□ ait until emotions have cooled□.
- □emonstrate sensitivity and acceptance of diverse □ac□grounds □e.g.□gender□race□age□disa□ility□nationality□se□ual orientation□religion□etc.□.
- □dhere to high ethical standards in patient care□teaching□and conducting research.
- Respect the privacy and confidentiality of all individuals.
- Promptly report adverse events and potential safety ha□ards and encourage colleagues to do the same.
- □illingly participate in□cooperate with and contri□ute to □riefings□de□riefings□and investigations of adverse events.
- □phold the Policies of MHSC and the Medical Staff.

- □tili□e all MHSC facilities□ e□uipment□ and property responsi□ly and appropriately.
- □e fit for duty during wor□time□including on□call responsi□ilities.

II. DISRUPTIVE BEHAVIOR.

Medical Staff are e□pected not to engage in □isruptive □ehavior. □isruptive □ehavior is unaccepta□le and will not □e tolerated.

□isruptive □ehavior is a style of interaction with Physicians□Hospital personnel□patients□family mem□ers□or others that interfere with patient care□causes distress among other staff□and affects the overall morale and the wor□environment.

□isruptive □ehavior can □e either ver□al or physical □e.g.□personally directed ver□al out□ursts□ profanity□condescending attitude□refusal to participate in assigned patient care activities□ physical threats□□laming / name□calling□or throwing o□ects□etc.□□and is accompanied □y strong emotion. **It includes actions that are detrimental to the quality of patient care, disruptive to departmental or facility operations, or in violation of established standards, policies, Bylaws, federal or state law, or local ordinances.**

□□amples of □isruptive □ehavior include□□ut are not limited to:

- □hreatening or a□usive language directed at patients□visitors□nurses□Physicians□ Hospital personnel□leadership□or trustees □e.g.□□elittling□□erating□and/or non□ constructive criticism that intimidates□ undermines confidence□ or implies incompetence without □ustification□.
- □er□al tirades□with or without o□scene/a□usive language.
- □se of profanity or other offensive language directed at an individual.
- □egrading or demeaning comments regarding patients□ families□ nurses□ Physicians□Hospital personnel□the □uality of care provided □y the Hospital□or MHSC leadership or trustees.
- □nappropriate use of cell phones□computers□music players□or other electronic devices in a manner that could □e detrimental to patient care.
- □nappropriate physical contact or actions that are threatening or intimidating to another individual□with or without in□ury □e.g.□throwing e□uipment or supplies at or near others□.
- Ma□ing or posting derogatory or a□usive signs□posters□cartoons□or drawings.
- □isorderly conduct disrupting the performance of assigned functions or department operations.

- □iscrimination □ased on any status protected □y law or MHSC policy □e.g.□race□ color□ national origin□se□□age□religion□disa□ility□status as a protected veteran□ se□ual orientation□gender identity/gender e□pression□etc.□
- Harassment of any type including se□ual harassment□which is defined as ver□al and/or physical conduct of a se□ual nature that is unwelcome and offensive to those individuals who are su□ected to it or who witness it.
- Mental / Physical □mpairment □e.g.□alcohol/drug use□mental impairment that prevents successful completion of □o□duties□etc.□
- □isruption of Hospital performance review functions □e.g.□ peer review□ committee meetings□event reporting□privileging determinations□
- □ntentional and overt □isruption of Hospital meetings.

VIOLATIONS OF THE CODE OF CONDUCT

□ll mem□ers of the Medical Staff are e□pected to adhere to this Code of Conduct□to hold others to the same standards□ and appropriately address concerns. □isruptive□ intimidating□ inappropriate□or unaccepta□le □ehaviors shall □e reported to the appropriate departmental□ administrative□or human resources representative□pursuant to MHSC policies and Medical Staff □ylaws. □ll reports of □isruptive □ehavior will □e addressed.

□n evaluating □isruptive □ehavior□consideration will □e given to whether the □ehavior was a "Disruptive Episode" or the behavior of a truly "Disruptive Practitioner". Disruptive Episodes are evidenced □y infre□uent occurrences and □ehavior out of character for the Practitioner. □ypically□the Practitioner recogni□es and ta□es responsi□ility for his or her unaccepta□le □ehavior. □ Practitioner who is found to engage in a □isruptive □pisode and has not displayed □isruptive □ehavior previously should not □e treated in the same manner as a Physician who is □nown to have fre□uent or multiple □isruptive □pisodes. □isruptive □pisodes will □e addressed □y the President of the Medical Staff□who will discuss the incident with the staff mem□er in a non□threatening manner. □he discussion will □e followed up and documented with a letter summari□ing the conversation. M□C will □e responsi□le for determining if formal corrective action will □e pursued for a disruptive episode.

□ □isruptive Practitioner is a more serious matter and is evidenced after the inception of this document □y fre□uent occurrences and □ehavior that is typical for the Practitioner □ased on repeat documentation of summary letters and as determined by MEC. There will be "zero tolerance" for Disruptive Practitioners who direct disruptive, intimidating, inappropriate□or unaccepta□le □ehavior at any specific individual associated with MHSC □i.e. patients□family mem□ers□Physicians□nurses□staff□volunteers□managers□e□ecutives□trustees or anyone else□

□ny report of □isruptive □ehavior will □e sufficient grounds for immediate action □y the President of the Medical Staff□the Medical □□ecutive Committee or the Chief □□ecutive Officer□ as specified in the Medical Staff □ylaws or other applica□le policies. □ progressive process of

reha□ilitation/discipline is recommended for most situations. However□it is not re□uired if it is □elieved that more immediate action is needed □ased upon the severity of a particular incident. □n addressing concerns or reports of a violation□the corrective actions outlined in MHSC policies and Medical Staff □ylaws will □e followed. □enerally□the following process is suggested □ut not re□uired:

1. □he President of the Medical Staff will discuss the incident with the staff mem□er in a non□threatening manner. □he discussion will □e followed up and documented with a letter summari□ing the conversation. M□C will □e responsi□le for determining if formal corrective action will □e pursued for a disruptive episode.

2. Should the staff mem□er continue to engage in □isruptive □ehavior□the staff mem□er would □e re□uired to meet with the Medical □□ecutive Committee and to sign an agreement specifically defining the □isruptive □ehavior and outlining the ramifications of future disruptive □ehavior. □he discussion will □e followed up and documented with a letter summari□ing the conversation and agreement.

3. Should □isruptive □ehavior continue□any mem□er of the Medical Staff□the Chief □□ecutive Officer of the Hospital□or any mem□er of the □overning □oard may ma□e a re□uest for corrective action to the Medical □□ecutive Committee to intervene with possi□le action□which may include□without limitation□further investigation□limitation□ suspension□or termination of privileges according to the provisions of □rticle □□□of the Memorial Hospital of Sweetwater County Medical Staff □ylaws.

AGREEMENT

□very mem□er of the MHSC Medical Staff must sign and a□ide □y this Code of Conduct. Refusal or failure to comply with the Code of Conduct may result in the immediate and indefinite suspension of privileges at MHSC as per the Medical Staff □ylaws.

MEDICAL STAFF CODE OF CONDUCT
AGREEMENT FORM

□he Memorial Hospital of Sweetwater County □MHSC□Medical Staff has adopted a Code of Conduct□a copy of which is attached. □he purpose of the policy is to identify unaccepta□le □ehavior and the conse□uences of participating in unaccepta□le □ehavior. □understand that my refusal or failure to comply with the Code of Conduct may result in the immediate and indefinite suspension of my privileges at MHSC.

I understand that by failing to sign this Agreement Form indicating my acceptance and agreement to abide by the Code of Conduct, I am choosing to immediately relinquish my clinical privileges at MHSC.

□understand my o□ligations under the MHSC Medical Staff Code of Conduct and here□y agree to a□ide □y the same during my appointment to the MHSC Medical Staff.

ARTICLE XX
PARLIAMENTARY PROCEDURE

□□cept where it may conflict with the procedure stated within these □ylaws□all meetings of the Medical Staff□its departments□sections□and committees shall □e governed in its procedures □y the most recent edition of Ro□ert's Rules of Order□as Revised.

ARTICLE XXI
GOVERNING LAW

□hese □ylaws shall □e governed □y□and construed in accordance with□the Health Care □uality □mprovement □ct of 19□6□as amended from time□to□time□and the laws of the State of □ yoming.

ADOPTION AND APPROVAL

□pproved and adopted □y the Medical Staff of Memorial Hospital of Sweetwater County on this 25th day of □une 2019.

□awrence □auridsen□□O
President of the Medical Staff

□srael Stewart□□O
Secretary of the Medical Staff

□pproved □y the □oard of □rustees of Memorial Hospital of Sweetwater County on this 7th □ay of □ugust 2019.

□aylor □ones
President□MHSC □oard of □rustees

□d □ardoni
Secretary□MHSC □oard of □rustees

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
MEDICAL STAFF RULES & REGULATIONS

Section I. INTRODUCTION

□. Rules and Regulations

1. □sta□lishment and □mendment:

Rules and Regulations shall □e esta□lished to control the conduct of wor□ of the medical staff as a whole. □uthority for esta□lishing and changing rules□regulations or any standing orders□is stated in the □ylaws.

2. Purpose:

Rules shall □e esta□lished which refer to the medical/administrative conduct of staff wor□ in general as well as to specific areas of medical service or clinical activity. □hese may □e recommended □y any department or committee of the medical staff and shall re□uire approval □y the Medical □□ecutive Committee □efore approval of the governing □ody.

3. □pproval:

□o regulations□rules or orders□which in any way limit or conflict with anything in the Hospital or medical staff □ylaws□or which are in conflict with any □nown law or regulation thereof□may □e approved.

Section II. PROCEDURE FOR APPOINTMENT/REAPPOINTMENT

□. Medical Staff □ppointment

1. □pplication:

□ach application for appointment to the medical staff shall □e signed □y the applicant□ and shall □e su□mitted on a form prescri□ed □y the governing □ody after consultation with the Medical □□ecutive Committee. □he application shall re□uire detailed information concerning the applicant□s professional □ualifications including:

a. □he school and date of degree□

□. □ll postdoctoral training programs with dates of successful completion□

c. □ll special training programs with dates of successful completion□

d. □he granting of state licenses□their dates□and history of adverse actions□

e. □he granting of staff mem□ership and privileges at other institutions□

f. A statement specifying any circumstances and judgments and/or settlements of any previous or pending malpractice actions involving the Practitioner.

g. The names of three medical or healthcare professionals who have personal knowledge of the applicant's current clinical abilities, ethical character, health status and ability to work cooperatively with others and who will provide specific written comments on these matters. The named individuals must have acquired the requisite knowledge through recent observation of professional practice over a reasonable period of time and preferably have a current affiliation with an acute care institution and at least one must be from a colleague in the applicant's specialty. The references may not be relatives or have any recently initiated or impending professional partnership/financial associations with the applicant.

h. A statement that the Practitioner has received or been given access to and read the Bylaws Rules and Regulations of the Medical Staff and that he/she agrees to be bound by the terms thereof if he/she is granted membership and/or clinical privileges and to be bound by the terms thereof without regard to whether or not he/she is granted membership and/or privileges in all matters relating to consideration of his/her application.

i. Information as to whether any of the following has ever been or are in the process of being denied revoked suspended reduced not renewed or voluntarily relinquished:

1. Staff membership status or privileges at any other Hospital or healthcare institution.

2. Membership/fellowship in local state or national professional organizations.

3. Specialty board certification.

4. License to practice any profession in any jurisdiction.

5. Drug enforcement agency or other controlled substances registration.

. A statement of experience during the most recent five 5 years including a consent to the release of information by his/her present and past malpractice insurance carriers.

. A statement whereby the Practitioner agrees that when an adverse ruling is made with respect to his/her staff membership staff status and/or privileges he/she will resort to the administrative remedies afforded by the medical staff bylaws rules regulation before resorting to formal legal action.

l. □vidence of current□ade□uate professional lia□ility insurance as determined □y the governing □ody□and

m. □ statement regarding physical/mental health status□including alcohol a□use and/or drug dependency.

n. Satisfactory completion of such continuing education re□uirements as may □e imposed □y law□this Hospital□or applica□le accreditation agencies and as re□uired □y the □ yoming □oard of Medicine to maintain licensure.

2. Responsi□ility of the □pplicant

□he Practitioner shall have the □urden of producing ade□uate information for a proper evaluation of his/her competence□character□ethics□health status and other □ualifications□ and for resolving any dou□ts a□out such □ualifications. □ny material misrepresentation in□or omission from□the application and related documents□shall □e grounds for denial of privileges or corrective action regardless of when the misrepresentation or omission is discovered.

3. □pplicant □uthori□ation and Consent

□y applying for appointment to the medical staff□each Practitioner there□y signifies:

a. His/her willingness to appear for interviews in regard to his/her application□

□. His/her authori□ation for the Hospital to consult with mem□ers of medical staffs of other Hospitals with which the Practitioner has □een associated and with others who may have information □earing on his/her competence□character□health status and ethical □ualifications□

c. His/her consent to the Hospital s inspection of all records and documents that may □e material to an evaluation of his/her professional □ualifications and competence to carry out the clinical privileges he/she re□uests as well as his/her moral and ethical □ualifications for medical staff mem□ership□

d. His/her release from any lia□ility of all representatives of the Hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating the Practitioner and his/her credentials□and

e. His/her release from any lia□ility all individuals and organi□ations who provide information to the Hospital in good faith and without malice concerning the Practitioner s competence□ethics□character□health status and other □ualifications for medical staff appointment and clinical privileges including otherwise privileged or confidential information.

4. □iscrimination

□o considerations of se□□race□creed and/or national origin may □e used in the granting or denying of medical staff mem□ership or clinical privileges.

5. Responsi□ilities of the Medical Staff Services Manager

a. □he completed application shall □e su□mitted to the Hospital□s Medical Staff Services Manager. □he Medical Staff Services Manager shall □e responsi□le to review the application for veracity. □he credentialing process re□uires that the Hospital verifies in writing and from the primary source whenever feasi□le the items listed □elow. □nitiation of the verification process of at least the following items will □egin within five □5□ wor□ing days of receipt of a completed application:

□1□ □egree conferred□when and the institution□

□2□ Completion of training programs□specialty□date of completion□

□3□ □he granting of state licenses□dates□and history of adverse action□

□4□ □he granting of staff mem□ership and privileges at other institutions and adverse actions□

□5□ Specialty □oard certification□

□6□ □uerying the □ational Practitioner □ata □an□□

□7□ □t least three references from persons who can provide ade□uate references pertaining to the Practitioner□s professional competence and ethical character□and

□□□ Satisfactory completion of such continuing education re□uirements as may □e imposed □y law□this Hospital□or applica□le accreditation agencies.

□. □pon completion of the verification□the □□ecutive □irector will forward the application to the appropriate staff departmental chairman.

6. Responsi□ilities of □epartmental Chairman

□he departmental chairman or his/her designated representative□to which the application is forwarded□will review the application□and within ten □10□wor□ing days ma□e a written report to the Credentials Committee on the □ualifications of the Practitioner for admission to the medical staff as well as for specific privileges re□uested. □n ma□ing this report□the departmental chairman or his/her designated representative shall e□amine evidence of the character□professional competence□□ualifications□health status and

ethical standing of the Practitioner and shall determine through information contained in the references given and from other sources available to him/her whether the Practitioner has established and meets all of the necessary qualifications for the medical staff category and the clinical privileges requested by him/her.

7. Responsibilities of the Credentials Committee

a. The Credentials Committee shall review the Practitioner's application for staff membership as well as for specific clinical privileges along with the report of the departmental chairman or his/her representative at its first meeting following receipt of all these materials/ documents.

. Following the review of the Practitioner's application and report of the department chairman or his/her designated representative the Credentials Committee shall make a recommendation with respect to the Practitioner's appointment and/or clinical privileges. The Credentials Committee shall review the Chair's recommendation, and either approve and adopt the Chair's recommendation, in whole or in part or formulate its own written recommendation and transmit the recommendation to the Medical Executive Committee. The Medical Executive Committee will review and comment and then forward the credentials file to the Governing Body for final action.

. Adverse Recommendation of the Credentials Committee

When the recommendation of the Credentials Committee is adverse to the Practitioner either in respect to the appointment or clinical privileges the Medical Executive Committee shall be so advised and the Executive Director shall promptly notify the applicant by certified mail return receipt requested. No such adverse recommendation may be forwarded to the governing body until after the applicant has exercised or has been deemed to have waived his/her rights to a hearing as provided by Article III of the Bylaws.

9. Favorable Recommendation of Credentials Committee

At its next regular meeting after receipt of a favorable recommendation by the Credentials Committee along with comments from the Medical Executive Committee the governing body shall act in the matter. If the governing body's decision is adverse to the Practitioner in respect to either appointment or clinical privileges the Executive Director shall promptly notify him/her of such adverse decision by certified mail return receipt requested and such adverse decision shall be held in abeyance until the applicant has exercised or has been deemed to have waived his/her rights under Article III of the Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer clinical privileges where none existed before.

10. Responsi□ilities of the □overning □ody

a. □t its ne□t regular meeting after all of the Practitioner□s rights under □rticle XIII of the □ylaws have □een e□hausted or waived, the governing □ody or its duly authori□ed committee shall act in the matter. □he governing □ody□s decision shall □e conclusive e□cept that the governing □ody may defer final determination □y referring the matter □ac□ to the Credentials Committee for further reconsideration. □ny such referral □ac□ shall state the reasons, therefore, shall set a time limit within which a su□se□uent recommendation to the □overning □ody shall □e made, and may include a directive that an additional hearing is conducted to clarify issues which are in dou□t. □t its ne□t regular meeting after receipt of such su□se□uent recommendation, and any new evidence in the matter, if any, the governing □ody shall ma□e a decision either to provisionally appoint the Practitioner to the medical staff or to re□ect him/her for medical staff mem□ership.

b □ henever the governing □ody□s decision will □e contrary to the recommendation of the Credentials Committee, the governing □ody shall su□mit the matter to the □oint Conference Committee for review and recommendation and shall consider such recommendation □efore ma□ing its decision final.

c. □ hen the governing □ody□s decision is final, it shall send notice of such decision through the □□ecutive □irector to the Secretary of the Medical Staff, the Chairman of the Medical □□ecutive Committee, the Chairman of the Credentials Committee and the chairman of the department concerned, and □y certified mail, return receipt re□uested to the Practitioner.

B. Medical Staff Reappointment

1. Reappointment □pplication

□ach application for reappointment to the medical staff shall □e signed □y the applicant and shall □e su□mitted on a form prescri□ed □y the governing □ody after consultation with the Medical □□ecutive Committee.

2. Responsi□ilities of □□ecutive □irector

□he reappointment process shall □egin at least ninety (90) days prior to the termination of current appointment and privileges. Re□uests for additional privileges or for change in a staff category shall □e made to the □□ecutive □irector at this time with accompanying documentation of further training and/or clinical e□perience. □he □□ecutive □irector shall gather all pertinent information relating to the staff mem□er□s professional competence and clinical □udgment in the treatment of patients □as determined □y ongoing peer review and □uality assurance activities), his/her mental and physical condition, ethics, conduct, compliance with Hospital and medical staff □ylaws, Rules and Regulations, cooperation with Hospital personnel, and shall chec□ all new information for veracity. □he applicant shall report the circumstances and outcome of any malpractice □udgment□s) delivered against him/her during the previous appointment

period as well as the circumstances of any pending malpractice action against him/her. The Executive Director shall deliver that information to the appropriate departmental chairman or his/her designated representative for review within ten (10) working days.

3. Responsibilities of Departmental Chairman

The departmental chairman or his/her designated representative to which the application is forwarded will review the application within 10 working days and make a written report regarding the qualifications of the Practitioner to the Credentials Committee. In making his/her report the departmental chairman or his/her designated representative shall examine the evidence of the character, professional competence, qualifications, health status and ethical standing of the applicant and shall determine, through information provided by the Executive Director whether the Practitioner has established and meets all of the necessary qualifications for staff membership and the clinical privileges requested by him/her. Any requested change in the staff category and/or clinical privileges requested by the Practitioner will be supported by evidence of further training and/or clinical competence provided by the Practitioner.

4. Reappointment Process

Thereafter, the procedure provided for in Section [illegible]. paragraphs 7-10 of these Rules and Regulations relating to the initial appointment shall be followed.

C. Allied Health Professional Appointment

1. Application

Each application for appointment to the allied health professional staff shall be signed by the applicant and include a statement by a sponsoring Physician who is currently on the MHSC medical staff. Said sponsorship shall remain adequate regardless of the status of the sponsor, until the expiration of the applicant's term, and shall be submitted on a form prescribed by the governing body after consultation with the Medical Executive Committee. The application shall require detailed information concerning the applicant's professional qualifications including:

a. The school and date of degree/registration/ certification;

b. All special training programs with dates of successful completion;

c. The granting of state licenses, if applicable, their dates and history of adverse actions;

d. The granting of staff membership and privileges at other institutions;

e. A statement specifying any circumstances and judgments and/or settlements of any previous malpractice actions as well as the circumstances of any pending malpractice actions involving the allied health professional.

f. The names of at least three persons who have had extensive recent experience in observing and working with the allied health professional and who can provide adequate references pertaining to the allied health professional's professional competence and ethical character health status and ability to work cooperatively with others and who will provide specific written comments on these matters. The named individuals must have acquired the requisite knowledge through recent observation of professional practice over a reasonable period of time and preferably have a current affiliation with an acute care institution and at least one must be from a colleague in the applicant's specialty. The references may not be relatives or have any recently initiated or impending professional partnership/financial associations with the applicant.

g. A statement that the allied health professional has received or been given access to and read the Bylaws Rules and Regulations of the medical staff and that he/she agrees to be bound by the terms thereof if he/she is granted membership and/or clinical privileges and to be bound by the terms thereof without regard to whether or not he/ she is granted membership and/or privileges in all matters relating to consideration of his/ her application.

h. Information as to whether any of the following has ever been or are in the process of being denied revoked suspended reduced not renewed or voluntarily relinquished:

(1) Staff membership status or privileges at any other Hospital or healthcare institution.

(2) Membership/fellowship in local state or national professional organizations and

(3) License to practice any profession in any jurisdiction.

i. A statement of experience during the most recent five (5) years including a consent to the release of information by his/her present and past malpractice insurance carrier(s).

. A statement whereby the allied health professional agrees that when an adverse ruling is made with respect to his/her staff membership staff status and/or privileges he/she will resort to the administrative remedies afforded by the medical staff bylaws rules & regulations before resorting to formal legal action.

□. □vidence of current□ade□uate professional lia□ility insurance□as determined □y the governing □ody□and

l. □ statement regarding physical/mental health status□including alcohol a□use and/or drug dependency□

m. Satisfactory completion of such continuing education re□uirements as may □e imposed □y law□this Hospital□or applica□le accreditation agencies.

2. Responsi□ilities of the □llied Health Professional

□he allied health professional shall have the □urden of producing ade□uate information for a proper evaluation of his/her competence□character□ethics and other □ualifications□ and for resolving any dou□ts a□out such □ualifications. □ny material misrepresentation in□or omission from□the application and related documents□shall □e grounds for denial of privileges or corrective action regardless of when the misrepresentation or omission is discovered.

3. □ppearance□□uthori□ation□and Consent

□y applying for appointment to the allied health professional staff□each allied health professional there□y signifies:

a. His/her willingness to appear for interviews in regard to his/her application□

□. His/her authori□ation for the Hospital to consult with mem□ers of medical staffs of other Hospitals with which the allied health professional has □een associated and with others who may have information □earing on his/her competence□ character□health status and ethical □ualifications□

c. His/her consent to the Hospital□s inspection of all records and documents that may □e material to an evaluation of his/her professional □ualifications and competence to carry out the clinical privileges he/she re□uests as well as his/her moral and ethical □ualifications for allied health professional staff mem□ership□

d. His/her release from any lia□ility of all representatives of the Hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating the allied health professional and his/her credentials□ and

e. His/her release from any lia□ility all individuals and organi□ations who provide information to the Hospital in good faith and without malice concerning the allied health professional□s competence□ ethics□ character□ health status and other □ualifications for allied health professional staff appointment and clinical privileges including otherwise privileged or confidential information.

4. □iscrimination

□o considerations of se□□race□creed and/or national origin may □e used in the granting or denying of staff mem□ership or clinical privileges.

5. Responsi□ilities of □□ecutive □irector

a. □he completed application shall □e su□mitted to the Hospital□s □□ecutive □irector who shall □e responsi□le to review the application for veracity. □nitiation of the verification process of at least the following items will □egin within fifteen □15□ wor□ing days of receipt of a completed application:

□1□ □egree/certification/registration conferred□when□and the institution□

□2□ Completion of training programs□specialty□date of completion□

□3□ □he granting of state licenses□if applica□le□dates and history of adverse actions□

□4□ □uerying the □ational Practitioner □ata □an□□and

□5□ □t least three references from persons who can provide ade□uate references pertaining to the allied health professional□s competence and ethical character.

□6□ On completion of the verification□the □□ecutive □irector will forward the application to the appropriate departmental chairman.

6. Responsi□ilities of □epartmental Chairman

□he departmental chairman or his/her designated representative to which the application is forwarded will review the application and within fifteen □15□wor□ing days ma□e a report to the Credentials Committee on the □ualifications of the allied health professional for admission to the allied health professional staff as well as for specific privileges re□uested. □n ma□ing this report□the departmental chairman or his/her designated representative shall e□amine evidence of the character□ professional competence□ □ualifications□health status and ethical standing of the allied health professional□and shall determine□through information contained in the references given and from other sources availa□le to him/her whether the allied health professional has esta□lished□and meets all of the necessary □ualifications□for the allied health professional staff category and the clinical privileges re□uested □y him/her.

7. Responsi□ilities of the Credentials Committee

a. □he Credentials Committee shall review the allied health professional□s application for allied health professional staff mem□ership as well as for specific clinical privileges along with the report of the departmental chairman or his/her representative at its first meeting following receipt of all these materials/ documents.

b □ollowing the review of the Practitioner□s application and report of the □epartment Chairman or his/her designated representative, the Credentials Committee shall ma□e a recommendation with respect to the Practitioner□s appointment and/or clinical privileges. □he Credentials Committee shall review the Chair's recommendation, and either approve and adopt the Chair's recommendation, in whole, or in part, or formulate its own written recommendation, and transmit the recommendation to the Medical □□ecutive Committee. □he Medical □□ecutive Committee will review and comment, and then forward the credentials file to the □overning □ody for final action.

8 □dverse Recommendation of the Credentials Committee

□ hen the recommendation of the Credentials Committee is adverse to the allied health professional, either in respect to the appointment or clinical privileges, the Medical □□ecutive Committee shall □e so advised and the chief e□ecutive officer shall promptly notify the allied health professional □y certified mail, return receipt re□uested. □o such adverse recommendation may □e forwarded to the governing □ody until after the allied health professional has e□ercised or has □een deemed to have waived, his/her rights to a hearing as provided □y □rticle XIII of these □ylaws.

9. □avora□le Recommendation of Credentials Committee

□t its ne□t regular meeting after receipt of a favora□le recommendation □y the Credentials Committee, along with comments from the Medical □□ecutive Committee, the governing □ody shall act in the matter. □f the governing □ody□s decision is adverse to the allied health professional, in respect to either appointment or clinical privileges, the □□ecutive □irector shall promptly notify him/her of such adverse decision □y certified mail, return receipt re□uested, and such adverse decision shall □e held in a□eyance until the allied health professional has e□ercised, or has □een deemed to have waived, his/her rights under □rticle XIII of the □ylaws. □he fact that the adverse decision is held in a□eyance shall not □e deemed to confer privileges where none e□isted □efore.

10. Responsi□ilities of the □overning □ody

a. □t its ne□t regular meeting after all of the allied health professional s rights under □rticle XIII of the □ylaws have □een e□hausted or waived, the governing □ody or its duly authori□ed committee shall act in the matter. □he governing □ody s decision shall □e conclusive e□cept that the governing □ody may defer final determination □y referring the matter □ac□ to the Credentials Committee for further reconsideration. □ny such referral □ac□ shall state the reasons, therefore, shall set a time limit within which a su□se□uent recommendation to the governing □ody shall □e made, and may include a directive that an additional hearing is conducted to clarify issues which are in dou□t. □t its ne□t regular meeting after receipt of such su□se□uent recommendation any new evidence in the matter, if any, the governing □ody shall ma□e a decision either to provisionally appoint the allied health professional to the allied health professional staff or to re□ect him/her for allied health professional staff mem□ership.

b □ henever the governing □ody s decision will □e contrary to the recommendation of the Credentials Committee, the governing □ody shall su□mit the matter to the □oint Conference Committee for review and recommendation and shall consider such recommendation □efore ma□ing its decision final.

c. □ hen the governing □ody s decision is final, it shall send notice of such decision through the □□ecutive □irector to the Secretary of the Medical Staff, the Chairman of the Medical □□ecutive Committee, the Chairman of the Credentials Committee and the chairman of the department concerned, and □y certified mail, return receipt re□uested to the allied health professional.

D. □llied Health Professional Reappointment

1. Reappointment □pplication

□ach application for reappointment to the allied health professional staff shall □e signed □y the applicant and include a statement □y a sponsoring Physician who is currently on the MHSC medical staff. Said sponsorship shall remain ade□uate, regardless of the status of the sponsor, until the expiration of the applicant's term, and shall be su□mitted on a form prescri□ed □y the governing □ody after consultation with the Medical □□ecutive Committee.

2. Responsi□ilities of □□ecutive □irector

□he reappointment process shall □egin ninety (90) days prior to the termination of current appointment and privileges. Re□uests for additional privileges shall □e made to the □□ecutive □irector at this time with accompanying documentation of further training

and/or clinical e□perience. □he □□ecutive □irector shall gather all pertinent information relating to the allied health professional□s competence and clinical □udgment in the treatment of patients □as determined □y ongoing peer review and □uality assurance activities□□ his/her mental and physical condition□ ethics□ conduct□ compliance with Hospital and medical staff □ylaws□Rules and Regulations□cooperation with Hospital personnel and shall chec□ all new information for veracity. □he allied health professional shall report the circumstances and outcome of any malpractice □udgment□s□ delivered against him/her during the previous appointment period as well as any malpractice actions pending against him/her. □he □□ecutive □irector shall deliver that information to the appropriate departmental chairman or his/her designated representative for review.

3. Responsi□ilities of □epartmental Chairman

□he departmental chairman or his/her designated representative to which the application is forwarded will review the application □within 30 days□and ma□e a report regarding the □ualifications of the allied health professional to the Credentials Committee. □n ma□ing his/her report the departmental chairman or his/her designated representative shall e□amine the evidence of the character□professional competence□□ualifications□health status and ethical standing of the allied health professional and shall determine□through information provided □y the □□ecutive □irector whether the allied health professional has esta□lished and meets all of the necessary □ualifications for the allied health professional staff mem□ership and the clinical privileges re□uested □y him/her. □ny re□uested change in clinical privileges re□uested □y the allied health professional will □e supported □y evidence of further training and/or clinical competence provided □y the allied health professional.

4. Reappointment Process

□hereafter□the procedure provided for in Section □□.□C. paragraphs 7□10 of these Rules and Regulations□relating to the initial appointment shall □e followed.

Section III. PROFESSIONAL PRACTICE EVALUATION

□. □valuation of Practitioner’s Performance

1. □he Medical Staff will monitor and evaluate a Practitioner’s professional performance in an o□□ective and evidence□□ased manner □y collecting□ verifying and evaluating data relevant to a Practitioner’s professional performance. □his may □e done in two ways:
    - □ocused professional practice evaluation
    - Ongoing professional practice evaluation

2. □ocused professional practice evaluation is a time□limited evaluation of a Practitioner's clinical competence that may □e done when:

   a. □n initial re□uest for privileges is made □effective □anuary 200□□□

   □. □ Practitioner does not have documented evidence of performing a re□uested privilege□

   c. □ □uestion arises regarding a Practitioner's ability to provide safe, high□□uality patient care□

   d. □□amples of triggers for focused professional practice evaluation include □ut are not limited to:

      1□ □ow volume procedures

      2□ Sentinel event

      3□ Complaint

      4□ □ariance from accepta□le practice patterns

      5□ □ariance from comparative peer performance data

3. Ongoing professional practice evaluation is factored into the decision to maintain□revise□limit or revo□e e□isting privileges. □he following general competencies are included in the ongoing professional practice evaluation:

   - Patient care: Practitioners are e□pected 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
   - Medical/Clinical □nowledge: Practitioners are e□pected to demonstrate □nowledge of esta□lished and evolving □iomedical□ clinical and social sciences□and the application of their □nowledge to patient care and the education of others.
   - Practice□□ased □earning and □mprovement: Practitioners are e□pected to □e a□le to use scientific evidence and methods to investigate□evaluate and improve patient care practices.
   - □nterpersonal and Communication S□ills: Practitioners are e□pected to demonstrate interpersonal and communication s□ills that ena□le them to esta□lish and maintain professional relationships with patients□families and other mem□ers of healthcare teams.
   - Professionalism: Practitioners are e□pected to demonstrate □ehaviors that reflect a commitment to continuous professional development□ ethical practice□an understanding and sensitivity to diversity and a responsi□le attitude toward their patients□profession□and society.

- 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.

3. Focused Professional Practice Evaluation

   a. When a focused evaluation is triggered, an evaluation by an external or internal source may be required. The data supporting the trigger is reviewed and analyzed by the Physician member of the Quality Steering committee.

   b. The Physician member of the Quality Steering committee meets with the Practitioner to discuss the identified issues and obtain his/her input on the issues.

   c. The Physician member of the Quality Steering committee meets with the Medical Executive Committee (MEC) to review the results of the data analysis and input from the Practitioner.

   d. If the MEC determines that monitoring is indicated, it will direct the department chair to develop a monitoring plan in conjunction with the Practitioner, and with the approval of the MEC. The plan will contain, at a minimum:

      (1) The type of monitoring, which may include, but is not limited to one or more of the following:
      - Chart review
      - Direct observation
      - Discussion with other individuals involved in a patient's care
      - Monitoring of diagnostic and treatment techniques
      - Simulation
      - Proctoring

      (2) The individual responsible for overseeing the plan

      (3) The specific criteria that will be monitored

      (4) The measures of success

      (5) The timeframe for the plan, usually 3-12 months, depending on practice volumes and current performance

      (6) Parameters for extending the plan

      (7) Actions that may be taken if the performance is not satisfactory

      (8) Frequency of progress reports to MEC and the Practitioner

e. Upon completion the department chair will report to MEC who will notify the Practitioner of the results.

f. 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 is reviewed by Credentials Committee as a part of the appointment/reappointment process.

Section IV. PROFESSIONAL ASSISTANCE PROGRAM

This policy has been developed to establish a mechanism for education referral investigation and intervention of health issues specific to Physicians and other licensed independent Practitioners and to inform Practitioners and staff members about the Wyoming Professional Assistance Program.

Memorial Hospital of Sweetwater County recognizes that often health professionals ignore their own physical and emotional needs while dedicating their lives to the needs of their patients. They are often reluctant to admit that they need help or that they are experiencing difficulties in coping with potentially impairing conditions.

Memorial Hospital of Sweetwater County has contracted with the Wyoming Professional Assistance Program (WPAP) to assure that Practitioners suffering from illness or impairment are offered assistance to help resolve these problems.

The Wyoming Professional Assistance Program (WPAP) was established in 1997 to provide resources and support to include the identification referral and ongoing monitoring of impaired Wyoming health professionals in order to preserve the personal health and professional talents of the individual and to maintain the economic viability of the Wyoming health care system.

A. Eligibility

All Practitioners with current privileges at Memorial Hospital of Sweetwater County are eligible to use the Wyoming Professional Assistance Program. All Practitioners staff members and contract employees are eligible to make referrals to the WPAP or other MEC approved program.

B. Referral Self Referral Evaluation and Treatment

1. WPAP provides education through informational brochures and inservices to all contracting Hospitals. This education addresses how to recognize signs of impairment how to make a referral self referrals evaluation and intervention.

2. Anyone may call WPAP or other MEC approved program to discuss concerns about a health professional: MHSC staff members colleagues friends family members supervisors employees or any concerned individuals.

3. Health professionals may also call □ P□P (or other M□C approved program) to ma□e a self-referral.

4. □ach call to □ P□P will □e handled promptly. □nformation will □e gathered with discretion and confidentiality. □he identity of the caller is □ept confidential to the ma□imum e□tent possi□le.

5. □f concerns of impairment are validated in telephone or on□site interviews, arrangements will □e made for an informal meeting with the professional who is the o□□ect of concern.

6. Recommendations for a referral to evaluate (and treat, if needed) are most often accepted at the informal level; if the professional accepts evaluation and treatment recommendations, his or her identity remains completely anonymous to the licensing □oard.

7. □ll communications with □ P□P (or other M□C approved program) are protected and confidential. □ P□P assures confidentiality for participants and immunity for all reporting entities and/or individuals in accordance with □ yoming statute.

8 □ P□P provides for early intervention; avoidance of emergency suspensions; assurance that healthcare professionals have met the terms for a safe return to employment; and esta□lishment of an ongoing monitoring system.

9. □ P□P can □e contacted at:

□ yoming Professional □ssistance Program
Post Office Box 1496
Casper, WY 8 2602
307□472- 222
Fax: 307□472- 221
□□mail: wpapro@ □west.net

10. □or individuals that have □een referred to □ P□P, or other M□C approved program, failure to participate in the program or complete the recommended reha□ilitation may result in further action under section XII of the medical staff □ylaws.

Section V. ADMISSION AND DISCHARGE OF PATIENTS

A. □dmission Policy

□he Hospital shall accept all patients for care and treatment.

1. □eneral

a. A patient may □e admitted to Memorial Hospital of Sweetwater County □y Physician mem□ers of its medical staff or other □ualified licensed individuals. □ll Practitioners shall □e governed □y the official admitting policy of the Hospital.

□. The management and coordination of each patient's care, treatment, and services is the responsi□ility of a Practitioner with appropriate privileges. Such Practitioner shall □e responsi□le for the medical care and treatment□for the prompt completeness and accuracy of the medical record□for necessary special instructions□and for transmitting reports on the condition of the patient to the referring Physician and to relatives of the patient. □henever these responsi□ilities are transferred to another Practitioner a note covering the transfer of responsi□ility shall □e entered on the order sheet of the medical record and the transferring Practitioner shall personally notify the receiving Practitioner.

2. □dmission of Patients of □ndependent □imited Practitioners

□hen a patient□s care involves the a□ove listed □ndependent □imited Practitioner the following will apply:

a. Responsi□ilities of □ndependent □imited Practitioner

□1□ □ detailed history □specific□□ustifying Hospital admission□

□2□ □ detailed description of the e□amination □specific□and a preoperative diagnosis where applica□le□

□3□ □ complete operative/procedural report where applica□le□descri□ing the findings and techni□ue□□all tissues□including teeth and fragments□shall □e sent to the Hospital pathologist for e□amination. □n cases of e□traction of teeth□a dentist shall clearly state the num□er of teeth and fragments removed□.

□4□ Progress notes as are pertinent to the patient□s condition□and

□5□ Clinical summary statement.

□. Responsi□ilities of Physician:

□1□ Supervision of the patient's general health status while Hospitali□ed.

□2□ □he discharge of the patient will □e on a written or ver□al order of the Physician mem□er of the medical staff.

3. □mergency □dmissions

a. □□cept in an emergency□no patient shall □e admitted to the Hospital until a provisional diagnosis or valid reason for admission has □een stated. □n the case of an emergency□such statement shall □e recorded as soon as possi□le.

b. In the case of an emergency admission, patients who do not have a private Physician may request any known Physician in the department or service to which he/she needs to be admitted, or be assigned to the on-call Physician member of the active or associate staff on duty in the department or service to which the illness of the patient indicates assignment in accordance with Section VIII, E. of these Rules and Regulations. The chairman of each department shall provide an assignment schedule for attendance to such patients.

4. Physician Coverage

Each member of the medical staff shall provide assurance of immediacy of adequate professional care for his/her patients in the Hospital by being available or having available, within a reasonable period of time, an eligible alternate Practitioner with whom prior arrangements have been made. The alternate must be a member of the medical staff. Failure of the attending Practitioner to meet the above requirements may result in loss of medical staff privileges. Staff members who will be unavailable should indicate, in writing, on the order sheets of the patient's chart, the name of the Practitioner who will be assuming the responsibility for the care of those patients during his/her absence.

5. Patient Placement

No patient's attending Physician or location will be changed without such transfer being approved by all Practitioners involved (change of bed location within one care unit does not apply). Approval for transfer need not be obtained from the responsible Practitioner if the patient's location change is felt to be necessary to control nosocomial infection risk by the Chairman of the Infection Control Committee and the appropriate department chairman (or the President of the Medical Staff if a disagreement between the above two parties occurs, or if one is absent).

6. Involuntary Detention

The admitting Physician shall be held responsible for taking appropriate measures and for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his/her patients might be a source of danger from any cause whatever. All patients admitted or detained under involuntary detention statutes will be admitted to special lock-up rooms unless there are over-riding reasons to do otherwise.

7. Length of Stay

The attending Physician is required to document the need for continued Hospitalization when requested by the Utilization Management Committee and/or the Medical Executive Committee after specific periods of stay and is required to abide by the Utilization Management Plan, which will be approved, by the Medical Executive Committee and the governing body.

□. □ischarges

Patients may □e discharged on a written or oral order of the attending Physician. Should a patient leave the Hospital against the advice of the attending Physician□or without proper discharge□a notation of the incident shall □e made in the patient□s medical record □y the nursing staff and the Physician and□if possi□le□a signed release o□tained from the patient or his/her representative.

C. □eaths and □utopsies

1. □eaths

□n the event of a Hospital death□the deceased shall □e pronounced dead □y a Physician mem□er of the medical staff□or house officer□as designated□within a reasona□le time. □n the case of a DNR patient, the patient may be pronounced dead by Two R.N.'s following the nursing protocol□and the date and time will □e entered in the medical record. □he □ody shall not □e released until a written pronouncement of death entry has □een made in the medical record of the deceased.

2. □utopsies

a. □he Hospital will attempt to secure autopsies in all cases of unusual deaths and cases with medical□legal□and education interest and will inform the medical staff □specifically the attending Physician□of autopsies that the Hospital intends to perform. □ hich include□□ut not limited to the following:

□1□ □nanticipated death□

□2□ □eath during treatment with a new therapeutic trial regime□

□3□ □ntraoperative or intra procedural death□

□4□ □eath occurring within 4□ hours after surgery or an invasive diagnostic procedure□

□5□ □eath incident to pregnancy or within seven days following delivery□

□6□ □eaths where the cause is sufficiently o□scure to delay completion of the death certificate□

□7□ □eaths in infants and children.

□. □n autopsy may □e performed on all patients whose death does not come under the coroner□s □urisdiction only with a written consent□signed in accordance with state law. □ll autopsies shall □e performed □y the Hospital pathologist□the coroner or □y a Physician delegated this responsi□ility. □ hen an autopsy is

performed□provisional anatomic diagnoses shall □e recorded in the medical record within three days□and the complete protocol shall □e made part of the record within thirty □30□days unless e□ceptions for special studies are esta□lished □y the medical staff.

Section VI. MEDICAL RECORDS

□. Practitioner Responsi□ilities

1. □he attending Physician shall □e responsi□le for the preparation of a complete and legi□le medical record for each patient. □his record shall□at a minimum□include a complete admission H□P□all special reports such as consultations and pathology findings□clinical la□oratory results□interpretations of studies performed □y Medical □maging□operative reports□progress notes□autopsy report □when performed□□and a discharge summary.

2. Completion of medical records □y locum tenens Physicians will □e according to policies and procedures developed □y the Medical Records Committee and approved □y the Medical □□ecutive Committee.

3. □ll Physician □ssistant and □urse Midwife inpatient medical record entries shall □e countersigned □y the appropriate Practitioner's authorized, supervising Physician within 4□hours.

□. History and Physical □□amination

□ complete admission history and physical e□amination shall □e performed and recorded within twenty□four □24□ hours of admission. □his report should include identifying data□chief complaint□history of present illness□significant past medical and surgical history□relevant family history□social history□a review of all systems of the □ody□physical e□amination□ significant la□oratory results□provisional diagnosis and treatment plan. □f a complete history has □een recorded and a physical e□amination performed within one wee□ prior to the patient's admission to the Hospital□a reasona□ly dura□le□legi□le copy of these reports may □e used in the patient's Hospital medical record in lieu of the admission history and report of the physical e□amination□provided these reports were recorded □y a mem□er of the medical staff. □n such instances□an interval admission note that includes all additions to the history and any su□se□uent changes in the physical findings must always □e recorded.

C. Readmissions

□ hen a patient is readmitted within thirty □30□days□a □rief interval history and physical may □e recorded in lieu of a full e□am□provided a copy of the most recent Hospitali□ation H□P and discharge summary are placed in the current chart.

□. Surgery

□n ade□uate history and physical shall □e recorded within the chart of each patient within 24 hours prior to surgery unless any delay for recording the history and physical would □e detrimental to the patient.

□. Outpatients

□ach outpatient admission will have a note/report ade□uately descri□ing the medical circumstances surrounding that visit.

□. □wenty □hree and One Half Hour Outpatient Stays

1. Surgical procedures involving anesthesia□done in the OR Suite□re□uire a complete H□P□ operative report and a dictated or written discharge note.

2. Medical outpatient admissions re□uire an H□P □to include chief complaint□pertinent history□and pertinent physical findings□□and a dictated or written discharge note. □ full H□P will □e re□uired if the patient is admitted.

3. O□stetrical outpatient admissions re□uire a prenatal H□P□results□order for discharge and nursing discharge instructions.

4. Chemo or other cycle patients re□uire an initial H□P with the plan of therapy□which will □e valid for one year. □n interval note will □e re□uired if there is any change in condition or if treatment is stopped and started again.

5. O□servation patients will □e treated in accordance with the O□servation/Surgical Outpatient □dmissions Policy.

6. □n all cases in this section □□if the patient □ecomes an inpatient□all re□uirements for inpatient charting must □e o□served.

□. Progress □otes

Pertinent progress notes shall □e recorded at the time of o□servation sufficient to permit continuity of care and transfera□ility. □ henever possi□le each of the patient□s clinical pro□lems should □e clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall □e written at least daily on critically ill patients□and those where there is difficulty in diagnosis or management of the clinical pro□lem. □ll other patients will have progress notes recorded at least every other Hospital day.

H. Operative Reports

 written operative note for oth inpatients and outpatients will e entered in the chart immediately following surgery. hat note will include pre and post operative diagnosis the operation performed surgeons involved anesthesia type and other information pertinent to the immediate postop care of the patient. n addition a comprehensive operative report shall e dictated or written at the conclusion of the procedure which includes findings found at surgery details of surgical techni ue specimen s removed pre and post operative diagnosis surgeon s and assistant s and type of anesthetic used. entists shall record the num er of teeth and/or fragments removed on the operative report. Reports shall e promptly signed y the surgeon and made a part of the patient s current medical record.

. Consents

ll procedures listed elow re uire written consent from the patient or parent/guardian/ne t of in in the case of a minor and ade uate documentation of the procedure or transfer recorded in the chart or dictated within twenty four 24 hours e cept for transfers to another acute care facility (see 3., a. below). In those situations wherein the patient's life is in jeopardy and suita le signatures cannot be obtained, these circumstances should be fully explained on the patient's medical record.

1. eneral nesthesia

ll procedures with general anesthesia regional anesthesia or ier loc .

2. Other

Other procedures not using general anesthesia including ut not limited to:
mniocentesis
rteriography
rthrography
spiration of hematomas or other ody fluid collections cysts purulent
ccumulations etc.
iopsies of all types liver lung s in etc.
one marrow aspiration/ iopsy
ronchography
Chest tu e insertion
Circumcision
Closed reduction of fractures
e ridement ma or urns and wounds
ilation and curettage
lective C cardioversion
ndoscopic procedures esophagogastroduodenoscopy
Sigmoidoscopy colonoscopy ronchoscopy cystoscopy etc.
cision removal or destruction of s in or su cutaneous tissues
Hysterosalpingography

□nvasive vascular line placements □central venous lines, Swan-□an□, catheters, arterial □ines, e□ternal □ugular lines, pacema□ers, etc.)
□irshner wire insertion
Myelography
Paracentesis
Pacement of posterior nasal pac□s
Removal of e□ternal fi□ation devises
Spinal taps
Steinman pin insertion
Suction curettage
□horacentesis
□m□ilical artery catheteri□ation
□asectomy
□enous cutdown
Moderate sedation/analgesia

3. Special Consents

Special consents are re□uired for the following:
□ransfusion of □lood or □lood products
□utopsy
□herapeutic a□ortion
□ll e□perimental treatments and medications
Sterili□ation procedures
Ru□ella vaccine
□ransfer to another acute care facility

a. □henever a patient is transferred to another acute care facility, the attending Physician must e□plain the □enefits versus ris□s of the transfer with the patient and/or parent/guardian/ne□t of □in, in the case of a minor, and sign a certification that he/she has discussed the □enefits versus ris□s of a transfer. □n the event the Physician is unavaila□le at the time of transfer, the certification may □e signed □y the case manager or house supervisor in consultation with the attending Physician. □f the certification is signed □y anyone other than the Physician, the Physician must countersign the certification within twenty□four (24) hours of the transfer.

J Consultations

Consultations shall show evidence of a review of the patient□s record □y the consultant, pertinent findings on e□amination of the patient, the consultant□s opinion and recommendations. □his report shall □e made a part of the patient□s record. A limited statement such as "I concur" does not constitute an accepta□le report of the consultation. □□cept in an emergency, so verified on the record, when operative procedures are involved the consultation note shall □e recorded prior to operation. □See VII, B . of these Rules & Regulations)

□. O□stetrical Records

□he current o□stetrical record shall include a complete prenatal record. □his may □e a legi□le copy of the attending Physician□s office record transferred to the Hospital □efore admission. □n such instances□an interval admission note must □e recorded that includes pertinent additions to the history and any su□se□uent changes in physical findings.

□. □uthentication

□ll clinical entries in the patient□s medical record shall □e accurately dated and authenticated. □uthenticated means to prove authorship□for e□ample□□y written signature or identifia□le initials.

M. Sym□ols and □□reviations

Sym□ols and a□□reviations may □e used only in accordance with the □□reviation □sage Policy.

□. □ischarge Summary

□ discharge clinical summary shall □e recorded within seven □7□days of the date of discharge on all medical records of patients Hospitali□ed. □he discharge summary shall accurately reflect the patient□s reason for admission□clinical course□all operations and procedures performed□findings of various investigations□response to treatment□condition at discharge□recommended activity and diet□medications on discharge□follow□up instructions and final diagnoses.

O. Release of Medical Records

□he written consent of the patient or guardian is re□uired for release of medical information.

P. Removal of Medical Records

Records may □e removed from the Hospital□s □urisdiction and safe□eeping only in accordance with a court order□su□poena or statute. □ll records are the property of the Hospital and shall not otherwise □e ta□en away without the permission of the □□ecutive □irector. □ll records shall □e availa□le for the use of all involved Practitioners.

□. □ccess to Medical Records

□ree access to all medical records of all patients shall □e afforded to mem□ers of the medical staff for □ona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. □ll such pro□ects shall □e approved □y the Medical □□ecutive Committee □efore records can □e studied. □ormer mem□ers of the medical staff shall □e permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

R. □iling of Medical Records

A medical record shall not □e permanently filed until it is completed □y the responsi□le Practitioner or is ordered filed □y the Medical Record Committee.

S. Completion of Medical Records

□ll records shall □e completed within thirty (30) days following the discharge of the patient.

T. □ncomplete Medical Records

1. □mergency □dmissions

□n cases where a mem□er of the medical staff has had his/her privileges suspended □y virtue of incomplete medical records, in accordance with □R□□C□□ XII, Section C. 4. of the □ylaws, and has a patient who re□uires admission to the Hospital, the following will □e applied:

a. □he attending Physician must contact the Hospital admitting office and declare the admission to □e an emergency. Such declarations may □e made ver□ally over the phone to the Hospital admitting personnel, if necessary, □ut must □e set forth in writing on the patient□s chart on admission. □his initial progress note will also contain sufficient medical information to □ustify and support the declared emergency.

b □he Hospital admitting office, when in receipt of a declared and written emergency, will e□pedite such admissions without delay. □hey will then report the following information to the □□ecutive □irector□s office:

(1) □ame of admitting Physician;

(2) Patient□s name, Hospital and room num□er;

(3) □ate and time Physician declared the emergency admission;

(4) □ate and time admitted;

(5) Service to which patient was admitted; and

(6) □dmitting diagnosis;

c. □dministration will forward information pertaining to each emergency admission to the President of the Medical Staff and to the chairman of the department appropriate □y the medical nature of the admission.

d. Administration will cause to be mailed a letter to the admitting Practitioner informing him/her that:

(1) He/she is under suspension for incomplete medical records;

(2) He/she had admitted an emergency patient under Rules & Regulations Section VII.B.;

(3) Unless his/her records are completed within forty-eight (48) hours of the initial emergency admission he/she will not be allowed to admit even emergency cases; and

(4) He/she is responsible upon expiration of the forty-eight (48) hours for making arrangements with another Practitioner to handle such cases or he/she could be exposing himself/ herself as well as the Hospital to subsequent liability.

e. The chairman of the department will review and report the declared emergency admission at the next meeting of the Medical Executive Committee.

f. The President of the Medical Staff shall cause to have investigated any cases which appear to be improper declarations of an emergency for subsequent disciplinary action as deemed appropriate by the Medical Executive Committee; consistent with the existing staff bylaws.

Section VII. GENERAL CONDUCT OF CARE

A. Consent Forms

Procedural consent forms for treatment and/or transfer to another facility shall be prepared by the Hospital taking into account all special procedures. These are to be adopted by the medical staff and governing body.

B. Orders

All orders for treatment (both inpatient and outpatient) shall be in writing, typed or dictated by an authorized Practitioner to an appropriate person. Appropriate persons shall include Registered Nurses (R.N.s) for patient care orders; Medical Imaging Department employees for Medical Imaging orders; clinical lab employees for Clinical Laboratory orders; Certified Respiratory Therapy Technologists (C.R.T.s) and Registered Respiratory Therapists (R.R.T.s) for Respiratory Care orders; Registered Physical Therapists (R.P.T.s) for Physical Therapy orders; Registered Pharmacists or Pharmacy Interns verified by a Registered Pharmacist for

Pharmacy orders□ any Materials Management Personnel for Central Supply orders and Registered □ieticians □R.□.s□ for □ietary orders□ □ll ver□al orders shall □e signed □y the ordering Practitioner or the Physician responsi□le for the patient within forty□eight □4□□hours with the e□ception of restraint and seclusion orders which must □e signed in accordance with SPP 120□and attached protocols□approved □uly 1□□2001.

1. Outpatient Orders □y □on□Hospital Staff Mem□ers

   a. □ny utili□ation of the Hospital□s outpatient diagnostic services assumes eligi□ility for □ yoming State licensure and Memorial Hospital of Sweetwater County staff mem□ership and must □e within the scope of practice ordinarily associated with the Practitioner□s specialty□or his/her allied health professional□s specialty or practice scope. □ ritten documentation of eligi□ility may □e re□uired.

   □. □ny utili□ation of the Hospital□s outpatient therapeutic services re□uires Memorial Hospital of Sweetwater County staff mem□ership or acceptance of an order □y a staff Physician.

2. □llegi□le Orders

   □he Practitioner□s order must □e written clearly□legi□ly and completely. Orders which are illegi□le or improperly written will not □e carried out until rewritten or understood □y the nurse. □he use of □Renew□□□Repeat□□and □Continue Orders□are not accepta□le.

3. Routine and Standing Orders

   Routine and standing orders may □e formulated □y any mem□er of the staff. □hese shall □e approved □y the □orms Committee and the Medical □□ecutive Committee □efore □ecoming effective.

4. Cancellation of Orders

   □ll previous orders are canceled when patients undergo surgery which involves administration of medications by an anesthesiologist or anesthetist, except when a “do not resuscitate” (DNR □□o Code□patient is to have surgery, a “do not resuscitate” □□□R□ order may □e carried out in surgery □y consensual agreement □etween the patient/agent/family□the attending Physician and/or surgeon□and the anesthesiologist. □his agreement will □e documented in the medical record prior to the patient having the planned surgery.

5. Medication Orders

All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopeia National Formulary American Hospital Formulary Service or AMA Drug Evaluations.

a. Drugs brought into the Hospital by patients shall not be administered unless the drugs have been identified and there is a written order from the responsible Practitioner to administer the drugs. If the drugs are not to be used during the patient's Hospitalization they should be packaged and sealed and either given to the patient's designee or stored and returned to the patient at the time of discharge provided such action is approved by the responsible Practitioner.

b. Narcotics sedatives and anticoagulant drugs that are ordered shall automatically be discontinued after ninety six (96) hours. All antibiotics antibacterial drugs and corticosteroids that are ordered shall automatically be discontinued after ninety six (96) hours unless a specific termination date is indicated by the Physician. Drugs should not be discontinued without notifying the Physician. If the order expires during the night medications should be continued until the automatic expiration is called to the attention of the Physician the following morning.

6. Respiratory Therapy Orders

a. Respiratory therapy orders (excluding ventilators) prescribed without time limitation shall be automatically discontinued after three (3) days unless the Physician renews the order. Standby respiratory equipment shall be automatically discontinued after seventy two (72) hours unless the Physician renews the order. Stop order notification stickers shall be placed on the Physician order form in the patient's chart twenty four (24) hours before the automatic stop order is effective.

C. Restraints/Seclusion

Restraints/seclusion the standard practice of medical immobilization and reserving of patients with altered mental status or who are at risk for falls will be implemented in accordance with the Restraint and Seclusion Policy.

D. Unanticipated Outcomes of Treatment

All Practitioners are required to inform the patient (or the patient's family) when treatment outcomes vary considerably from the anticipated results. This information shall be documented in the patient's medical record.

□. □□ortions

□lective or demand a□ortions are not permitted on the premises of the Hospital. □herapeutic a□ortions may □e performed only for the therapeutic purpose of saving the life of the mother and re□uire written consultation from at least two disinterested□□ualified Physician consultants.

Section VIII. CONSULTATIONS

□. Responsi□ilities of Practitioners

□he good conduct of medical practice includes the proper and timely use of consultation. □udgment as to the serious nature of the illness and the □uestion of dou□t as to the diagnosis and treatment rests with the Practitioner who has responsi□ility for the care of the patient. On the other hand□it is the duty of the organi□ed medical staff□through its departmental chairmen and the Medical □□ecutive Committee□to see that those with clinical privileges do not fail in the matter of consultants as needed.

□. □ualifications for Consultants

□ny □ualified Practitioner with clinical privileges in this Hospital can □e called for consultation within his/her area of e□pertise. Consulting Physicians will provide documentation for the Hospital's EMR. This documentation shall □e entered directly□scanned in□or dictated.

C. Re□uests for Consultation

1. Recommendations for Consultation

□□cept in an emergency□consultation is recommended in the following situations:

a. □ hen the patient is not a good ris□for operation or treatment□

□. □ here the diagnosis is o□scure after ordinary diagnostic procedures have □een completed□

c. □ here there is a dou□t as to the choice of therapeutic measures to □e utili□ed□

d. □n unusually complicated situations where specific s□ills of other Practitioners may □e needed□

e. □ hen re□uested □y the family□and

f. □or therapeutic a□ortions.

□. Responsi□ilities of □ttending Practitioner

□he attending Practitioner is primarily responsi□le for re□uesting consultation when indicated and for calling a □ualified consultant. He/she will provide written authori□ation to permit another attending Practitioner to attend or e□amine his/her patient□e□cept in an emergency.

□. Responsi□ilities of □ursing and Chain of Command

□f a nurse has any reason to dou□t or □uestion the care provided to any patient or feels that appropriate consultation is needed and has not □een o□tained□he/she shall call this to the attention of the attending Physician. □f the nurse still has dou□t or □uestions he/she shall call this to the attention of his/her supervisor who in turn may refer the matter to the □ssistant □□ecutive □irector □□ursing. □f warranted□the □ssistant □□ecutive □irector □□ursing will □ring the matter to the attention of the chairman of the department□wherein the Practitioner has clinical privileges□or the President of the Medical Staff. □ here circumstances are such as to □ustify such action□ the departmental chairman or the President of the Medical staff may re□uest a consultation.

Section IX. GENERAL RULES REGARDING SURGICAL CARE

□. Responsi□ilities of Surgery □epartment

□he Surgery □epartment shall esta□lish policies□Rules and Regulations for the surgical suite.

1. Policies□Rules and Regulations

Policies□Rules and Regulations shall □e esta□lished regarding□□ut not limited to□the following:

a. Scheduling operations□

□1□ Priority:

□a□ □efinition of priority time□

□□□ □irst priority□

□c□ Second priority□

□2□ Scheduling periods□

□3□ □ssignment of priority□

□4□ □oss of priority□

□. Reservations for operations□

c. □nformation re□uired to ma□e reservations□

d. Change of schedules□

e. □mergency operations□

f. Re□uirements prior to anesthesia and operation:

□1□ □dentification of the patient□

□2□ Preoperative evaluation and documentation:

□a□ Medical record content□including diagnosis□

□□□ □a□oratory procedures□

□c□ □nformed consent□

□3□ □ime of admission□

□4□ □ime out protocol

g. Starting time of operations□

h. Outpatient operations re□uiring general anesthesia□

i. Care and transport of patients:

□1□ □o the surgical suite□

□2□ □ ithin the surgical suite□

□3□ □o the recovery room□

□. □fficient utili□ation of operating rooms□

□. Contaminated cases□and

c. Conductivity and environmental control.

□. Consents

□ ritten □signed □informed □surgical/procedural consent shall □e o□tained prior to the operative procedure e□cept in those situations wherein the patient□s life is in □eopardy and suita□le signatures cannot □e o□tained due to the condition of the patient. □n emergencies involving a minor or unconscious patient in which consent for surgery cannot □e immediately o□tained from parents□guardian or ne□t of □in□these circumstances should □e fully e□plained on the patient□s medical record.

C. □nesthesia

□he anesthetist shall maintain a complete anesthesia record to include evidence of pre□anesthetic evaluation and postanesthetic follow□up of the patient□s condition. □he pre□anesthesia evaluation is completed and documented □y an individual □ualified to administer anesthesia within 4□hours prior to surgery or a procedure re□uiring anesthesia. □ post□anesthesia evaluation will □e completed no later than 4□hours after a surgery or procedure re□uiring anesthesia services.

□. Re□uirements for Patients Coming to the Operating Room

1. □npatients

a. □ll patients shall have □een admitted through proper channels and have an identification □racelet.

□. □□cept in a life□threatening emergency□all patients shall have as part of their records:

□1□ □ history and physical e□amination□

□2□ Re□uired consultation performed and on the chart prior to surgery□

□3□ □ndicated la□oratory procedures□

□4□ □ preanesthesia evaluation performed □y the anesthesiologist□

□5□ □ properly completed□ signed□ dated and witnessed permission for operation□and

□6□ Preoperative medication and time given.

2. Outpatients

a. Surgical procedures on outpatients shall □e limited to such procedures and patients in which it is deemed that the surgical procedure□ anesthesia□ and medication will in no way □e harmful to the patient □y his/her immediate return to an uncontrolled environment.

□. □ll outpatients shall □e properly admitted to the operating room and identified.

c. □he outpatient record shall include a description of the pathology□ diagnosis□ evidence of preanesthesia evaluation□ operative procedure and condition at discharge.

Section X. EMERGENCY SERVICES

□. Medical Coverage in the □mergency □epartment

□he medical staff shall adopt a method of providing medical coverage in the emergency services area. □his shall □e in accordance with the Hospital□s □asic plan for the delivery of such services□ including the delineation of clinical privileges for all Physicians who render emergency care.

□. □mergency Room Medical Record

□n appropriate medical record shall □e □ept for every patient receiving emergency medical service.

1. Contents of Medical Record

□he medical record shall include:

a. □de□uate patient identification□

□. □nformation concerning the time of the patient□s arrival means of arrival and □y whom transported□

c. Pertinent history of the in□ury or illness including details relative to first aid or emergency care given the patient prior to this arrival at the Hospital□

d. □escription of significant clinical□la□oratory□and roentgenology findings□

e. □iagnosis and treatment given□

f. □he condition of the patient on discharge or transfer□and

g. □inal disposition□including instructions given to the patient and/or his/her family□ relative to necessary follow□up care.

C. □mergency Medicine Physician s Responsi□ility

□ach patient s emergency medical record shall □e signed □y the Practitioner in attendance□who is responsi□le for its clinical accuracy.

□. Hospital s Responsi□ility

□he Hospital shall contract with an independent group of Physicians to provide twenty□four □24□ hours per day□seven □7□days per wee□□primary Physician coverage of the □mergency Room.

□. □mergency Services

1. □reatment of Patients in the □mergency □epartment

□ll patients presenting to the □R will □e evaluated □y the □R Physician on duty□and or the □HP□ in accordance with current □ yoming Statutes□unless specific arrangements have □een made with their private Physician.

2. □dmitting and □npatients

a. □he □mergency Medicine Physicians shall not admit patients to the Hospital on their own and are not permitted to treat inpatients at the Hospital e□cept in acute emergency situations when neither the patient s Physician nor any other □ualified mem□er of the medical staff is availa□le within the time limits dictated necessary □y good medical □udgment.

□. □he □mergency Medicine Physician on duty will respond to all □Code □lues□and he/she may pronounce inpatients dead if re□uested □y the attending Physician.

c. □he □mergency Medicine Physician on duty may assist attending Physicians with the renewal of orders and evaluations of restraint/seclusion patients□as defined □y□and in accordance with the Restraint and Seclusion Policy.

3. Referrals

a. □ll patients□having □een initially treated □y the □mergency Medicine Physician□ shall □e referred for admission and inpatient care or for su□se□uent outpatient care to their private Physician or the appropriate □on□call□Physician. □or patients not re□uiring admission □ut re□uiring outpatient follow□up□each □epartment of the Medical Staff □Medicine□Surgery and □eneral Services□shall formulate a written policy for appropriate and timely follow□up specific to their respective departments and the su□specialties represented therein. □f necessary□follow□up arrangements may □e made with the □mergency Room.

b. All individual department policies for ER outpatient referral shall be approved by the Emergency Services Committee and the Medical Executive Committee before being adopted.

4. "On Call" Lists

a. Each clinical department will be responsible for generating "on call" lists for the various specialties contained within that department, and equitable participation in the "on call" list will be required of all Practitioners on the medical staff. The "on call" lists will be distributed to all nursing units, the Emergency Department, and all medical staff members on a monthly basis by Medical Staff Services.

Departments may excuse individual Practitioners from emergency room call for good cause subject to the approval of the Medical Executive Committee.

b. Senior active staff Physicians may, at their option, choose to not take call, provided they have reached a score of 72 or more (scoring is based on a combination of age and years of service at MHSC.) In order to exercise this clause, Physicians must give at least a one-year notice to the Hospital administration.

F. Policies and Procedures

The Emergency Services Committee shall establish policies, procedures, Rules and Regulations for Emergency Services not covered by the above Section VIII

Section XI. MEDICAL STAFF COMMITTEES

A. Intensive Care Unit Committee

1. Composition:

The Intensive Care Unit Committee shall be composed of a representative of each medical staff department who admits to the Intensive Care Unit, in addition to the head nurse of the Intensive Care Unit. A representative from Administration may also serve on the committee.

2. Duties:

The duties of the Intensive Care Unit Committee shall be to monitor and evaluate the quality of care in the Intensive Care Unit.

3. Meetings:

The Intensive Care Unit Committee shall meet at least three (3) times per year (ideally quarterly) and shall maintain a permanent record of its proceedings and activities.

4. Reports To:

The Intensive Care Unit Committee shall report to the Department of Medicine and the Department of Surgery.

C. Infection Control Committee

1. Composition:

The Infection Control Committee shall be composed of a representative from each of the medical staff departments, a representative from Nursing Services, the Infection Control Coordinator, a representative from Administration and a representative from the clinical labs as ex-officio without a vote.

2. Duties:

The Infection Control Committee shall:

a. Develop a Hospital-wide Infection Control Program and maintain surveillance over the program.

b. Develop a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities.

c. Develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques.

d. Develop written policies defining special indications for isolation requirements.

e. Act upon recommendations related to infection control received from the President of the Medical Staff, the Medical Executive Committee, departments, and other committees.

f. Review sensitivities of organisms specific to the facility and disseminate biannually summaries to the medical staff.

3. Meetings:

The Infection Control Committee shall meet at least three (3) times per year (ideally quarterly) and shall maintain a permanent record of its proceedings and activities.

4. Reports To:

The Infection Control Committee shall report to the Medical Executive Committee.

C. Pharmacy & Therapeutics Committee (P&T)

1. Composition:

The Pharmacy & Therapeutics Committee shall be composed of a representative from each of the medical staff departments as well as a representative from nursing and a representative of the pharmacy service. A representative of Administration may also serve on the committee.

2. Duties:

The Pharmacy & Therapeutics Committee shall:

a. Be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure appropriate clinical results and minimum potential for hazard.

b. Formulate broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use safety procedures and all other matters relating to drugs in the Hospital; and

c. Develop and review annually a formulary or drug list for use in the Hospital.

3. Meetings:

The Pharmacy & Therapeutics Committee shall meet at least three (3) times per year, ideally quarterly, and shall maintain a permanent record of its proceedings and activities.

4. Reports To:

The Pharmacy & Therapeutics Committee shall report to the Medical Executive Committee.

□. Medical Records Committee

1. Composition:

□he Medical Records Committee shall □e composed of one representative from each of the medical staff departments□a representative from nursing services and a representative from Medical Records. □ representative of □dministration may also serve on the committee.

2. □uties:

□he Medical Records Committee shall:

a. □e responsi□le for assuring that all medical records meet the standards for patient care usefulness and □e of historical validity□

□. Conduct a □uarterly review of currently maintained inpatient and outpatient medical records to assure that they properly descri□e the condition and progress of the patient□the therapy provided□the results thereof□and the identification of responsi□ility for all actions ta□en□and that they are sufficiently complete at all times so as to meet the criterion of medical comprehension of the case in the event of transfer of Physician responsi□ility for patient care of the patient□

c. Review patient records to determine the promptness□pertinence□ade□uacy□and completeness thereof□and

d. Ma□e recommendations to □dministration on the inclusion of forms□and their content□for medical records.

3. Meetings:

□he Medical Records Committee shall meet at least once per year or as needed□and shall maintain a permanent record of its proceedings and activities.

4. Reports □o:

□he Medical Records Committee shall report to the Medical □□ecutive Committee.

□. □issue □ □lood Committee □□□□

1. Composition:

□he □issue □ □lood Committee shall □e composed of a representative of each medical staff department and a representative from Pathology □who may also represent the □eneral Services □epartment□. □ representative from □dministration may also serve on the committee.

2. □uties:

□he □issue □ □lood □□□□Committee shall:

a. □evelop policies and procedures for the ordering□distri□ution□handling□use□and administration of □lood and □lood components□

□. □evelop screening mechanisms to identify pro□lems in □lood usage for more intensive evaluation□

c. Review transfusions of □lood and its components or su□stitutes throughout the Hospital for appropriate use□

d. □ducate the medical staff on the appropriate use of □lood and its components or su□stitutes□

e. Review all confirmed □lood transfusion reactions□

f. □evelop policy for handling of all specimens removed during surgery□which specimens can be submitted for "gross examination only," and which specimens do not need to □e su□mitted to the pathologist□

g. □evelop screening mechanisms □ased on predetermined criteria for identifying surgical cases for more intensive review□

h. Perform surgical case review on all procedures□ □oth tissue and nontissue producing□monthly for surgical indications and □uality of individual surgical procedures performed □y individual Practitioners □review of a representative sample of cases is ade□uate□□and

3. Meetings:

□he □issue □ □lood Committee shall meet at least once per year or as needed□and shall maintain a permanent record of its proceedings and activities.

4. Reports □o:

□he □issue □ □lood Committee shall report to the □tili□ation Management Committee.

□. Perinatal Committee

1. Composition:

□he Perinatal Committee shall □e composed of a pediatrician□an o□stetrician□and a representative of the nursing staff of O□/nursery. □ representative from □dministration and a family Practitioner may also serve on the committee.

2. □uties:

□he Perinatal Committee shall:

a. Review records of o□stetric and new□orn patients in meeting the re□uirements of maintaining the □uality standards of patient care□

□. Conduct chart review in the manner of an audit of patient care to determine if the current practice of care and policies are in line with current□valid standards of medical practice□and

c. Review all protocols for o□stetrics/nursery nursing units prior to presentation to other committees or departments.

3. Meetings:

□he Perinatal Committee shall meet at least three □3□times per year□ideally □uarterly□ and shall maintain a permanent record of its proceedings and activities.

4. Reports □o:

□he Perinatal Committee shall report to the □epartment of Medicine and □he □epartment of Surgery.

□. □rauma Committee

1. Composition:

□he □rauma Committee shall □e composed of the □rauma Program Manager□the □mergency Medical □irector□the □rauma Medical □irector□the □R □urse Manager□the □irector of □ursing□ the □irector of □uality and □ccreditation□ the OR □urse Manager□ and representatives from local am□ulance services. □ representative from □dministration□

Medical □maging□ the Clinical □a□□ and local clergy mem□ers may also serve on the committee. □nesthesiologists and other Surgery □epartment mem□ers are also encouraged to attend. □he □rauma Committee may □e chaired □y an □□ Physician or a general surgeon.

2. □uties

□he □rauma Committee shall:

a. □e responsi□le for esta□lishing guidelines for □rauma □eam activation□

□. □nsure that the Hospital meets the necessary re□uirements for trauma designation□

c. □nsure that the Hospital participates in the State □rauma Registry□

d. Participate in □uality improvement evaluation□including the development of the standard of care□and on□going chart review.

3. Meetings:

□he □rauma Committee shall meet at least three □3□times per year□ideally □uarterly□and shall maintain a permanent record of its proceedings and activities.

4. Reports □o:

□he □rauma Committee shall report to the □eneral Services □epartment.

H. Radiation Safety Committee

1. Composition:

□he Radiation Safety Committee shall □e composed of the Radiation Safety Officer□a Physician representative of Medical □maging and representatives from □dministration and □ursing Services. □he chairman shall □e the Medical □maging Physician representative. □nother representative from administration may also serve as e□□officio□ without a vote.

2. □uties:

□he Radiation Safety Committee shall:

a. □e familiar with all pertinent □uclear Regulatory Commission □□RC□regulations□ the terms of the license and its amendments□and

□. □a□e necessary action to maintain compliance with pertinent □RC regulations.

3. Meetings:

The Radiation Safety Committee shall meet annually or semi-annually and shall maintain a permanent record of its proceedings and activities.

4. Reports to:

The Radiation Safety Committee shall report to the Department of General Services.

. Utilization Management Committee

1. Composition:

Physician Members

a. Physician members will be appointed annually by the President of the Medical Staff

. Committee will consist of at least two Physicians

c. One Physician member must be present at each meeting

d. The President of the Medical Staff will appoint the Physician Chair

Non-Physician members may include but are not limited to:

e. Administration

f. Health Information Management

g. Nursing

h. Quality

i. Case Management

. Clinical Documentation Improvement

. Patient Financial Services

l. Other healthcare Practitioners and professionals as necessary

m. Case Management

2. □uties: Please reference the □tili□ation Management plan□per current CMS guidelines.

3. Meetings:

□he □tili□ation Management Committee shall meet at least three times per year□ideally □uarterly□and shall maintain a permanent record of its proceedings and activities.

4. Reports □o:

□he □tili□ation Management Committee shall report to the Medical □□ecutive Committee.

□. □ylaws Committee

1. Composition:

□he □ylaws Committee shall □e composed of a representative of each medical staff department. □ representative from □dministration may serve as e□□officio□without a vote.

2. □uties:

□he □ylaws Committee shall:

a. Conduct an annual review of Medical Staff □ylaws□Rules and Regulations□

□. Su□mit recommendations to the Medical □□ecutive Committee for changes in these documents as necessary to reflect current medical staff practice□and

c. Receive and evaluate for recommendation to the Medical □□ecutive Committee suggestions for modification of the items specified in a. a□ove.

3. Meetings:

□he □ylaws Committee shall meet as often as necessary at the call of its Chairman□□ut at least annually and shall maintain a permanent record of its proceedings and activities.

4. Reports □o:

□he □ylaws Committee shall report to the Medical □□ecutive Committee.

Section XII. NON MEDICAL STAFF COMMITTEES

In the interest of quality patient care and enhanced communication between the medical staff and the Hospital, it shall be the prerogative of the President of the Medical Staff or his/her designee, in his/her capacity as chief medical officer of the Hospital, to attend, as ex-officio without vote, any and all Hospital assemblies, including, but not limited to, Hospital/staff committees, councils, team meetings, group meetings, department meetings, etc.

Section XIII. ITINERANT SURGERY

Itinerant surgery, as defined by the American College of Surgeons, is prohibited.

Section XIV. HEALTH POLICIES

All medical staff and allied health professionals shall make every reasonable effort to minimize the possibility of a communicable disease being passed to the Hospital staff, patients, visitors or other medical staff and allied health professional members.

ADOPTION AND APPROVAL

□pproved and adopted □y the Medical Staff of Memorial Hospital of Sweetwater County on this 25th day of □une 2019.

□awrence □auridsen□□O
President of the Medical Staff

□srael Stewart□□O
Secretary of the Medical Staff

□pproved □y the □oard of □rustees of Memorial Hospital of Sweetwater County on this 7th □ay of □ugust 2019.

□aylor □ones
President□MHSC □oard of □rustees

□d □ardoni
Secretary□MHSC □oard of □rustees

Memorial Hospital OF SWEETWATER COUNTY

Approved: *N/A*
Review Due: *N/A*
Document Area: *Corporate Compliance*
Reg. Standard:

Code of Conduct

STATEMENT OF PURPOSE

It is the policy of Memorial Hospital of Sweetwater County (MHSC) that all of the business be conducted according to high ethical standards, including compliance with applicable laws, rules, and regulations. This Code of Conduct (henceforth referred to as Code) is integral to the MHSC Compliance Plan and the provision of care and services that is consistent with the mission and vision of MHSC. This Code applies to any and all members of the workforce operating for or within MHSC. This includes employees, providers, volunteers and contractors.

TEXT

I. **General**

A. The underlying principles of these standards are based on common sense, courtesy, ethical and legal conduct that are essential to govern the business of MHSC.

B. It is important that the entire workforce understand these standards and abide by them daily.

II. **PRINCIPLE 1 - Legal Compliance: We will strive to ensure all activity by or on behalf of the organization is in compliance with applicable laws.**

A. Employees and subcontractors are expected to follow these guidelines for compliance with applicable laws. Knowledge (first or second hand) or suspicion of any violation of any law, regulation or rule must be reported to the Compliance Hotline (307 ~ 362 ~ 5291) or other appropriate staff. MHSC employees:

1. Will not solicit, receive or offer to give anything of value to anyone in exchange for referral of patients.
2. Will not accept bribes or kickbacks of any kind intended to induce referrals.
3. Will not make false statements or representations to any person or entity in order to gain or retain participation in a federal program or to obtain payment for any service.
4. Will submit claims for reimbursement accurately and only for services rendered.
5. Will not enter into any agreements with competitors to share or fix prices.
6. Will maintain complete and accurate medical records to support all medical decisions.
7. Will collect all applicable co-payments and deductibles in accordance with acceptable business practices.

8. Will store, dispense and transport all drugs and biologicals in accordance with accepted guidelines.
9. Will adhere to sound environmental and safety practices, including the proper handling of medical or hazardous waste.
10. Will respect our obligations as individuals and as health care providers, and neither express nor imply a promise of performance which we cannot reasonably expect to fulfill.
11. Will assure that all practices of write-offs, discounts, or forgiveness of debt are based solely on justifiable business practices and conform to federal and state statutes.

III. **PRINCIPLE 2 - Quality of Care: We are committed to providing the highest quality of care and delivering services in an ethical manner. MHSC employees:**

A. Will treat patients with dignity, respect, and compassion at all times.

B. Will provide high quality care to patients without regard to race, creed, age, gender, religion, national origin, or disability.

C. Will honor the rights afforded to patients, advocates and family to receive education in a manner that is understandable and to provide informed consent for care.

D. Will honor the right of patients, or their legal designees, to participate in decision making regarding their care, including refusing treatment to the extent permitted by law and being informed of the consequences of such action.

IV. **PRINCIPLE 3 - Confidentiality: We shall strive to maintain the confidentiality of patient and other confidential information in accordance with applicable legal and ethical standards. MHSC employees:**

A. Will protect the confidentiality of patient information in accordance with all applicable laws and regulations.(Such as HIPAA)

B. Will refrain from revealing any personal or confidential information concerning patients or members unless supported by legitimate business or patient care purposes.

C. Information pertaining to our competitive position or business strategies, payment and reimbursement information, and information relating to negotiations with the workforce or third parties should be protected and shared only with those having a need to know such information in order to perform their job responsibilities.

D. Will hold all investigatory information, data, and reports collected and/or made in connection with compliance issues in the highest confidence and not disclose such information outside of the confines of the activities of the Compliance Work Team or Compliance Committee of the Board of Trustees, except as is otherwise required by applicable law.

E. Will ensure that information received in confidence is not used for personal gain and divulge no such information with the intent of giving or receiving an unfair advantage in a personal business transaction.

V. **PRINCIPLE 4 - Valuing The MHSC Workforce: We value our workforce and are committed to their protection and success.**

A. MHSC shall afford all people equal employment and advancement opportunities without regard to age, gender, race, creed, national origin, religion, or disability.

B. No form of harassment or discrimination will be permitted.

C. We shall treat each other with respect, dignity, and fairness.

D. Sexual harassment, sexual advances, request for sexual favors or other verbal or physical conduct of a sexual nature that would create a hostile working environment are absolutely prohibited.

E. We shall exhibit acceptable behaviors that enhance the quality with which we meet the mission of MHSC. Such behaviors include but are not limited to, those that help to promote quality in the work place, integrity, innovation, diversity in the work place and teamwork.

F. We shall refrain from displaying inappropriate behaviors in the work place. Inappropriate behaviors are those that are disruptive to the work environment and interpersonal relationships and surroundings.

VI. **PRINCIPLE 5 - Conflicts of Interest: We shall avoid conflicts or the appearance of conflicts of interest between our private interest and the fulfillment of our duties.**

A. No employee may represent MHSC in any transaction in which he or she or a member of their immediate family has a personal interest.

B. We shall not disclose or use confidential, special or inside information of or about MHSC for personal profit or advantage.

C. MHSC workforce shall disclose all potentially conflicting activities in the annual Conflict of Interest disclosure statement.

D. We shall avoid any real or potential conflicts of interest and disclose, to the fullest extent possible, any significant proprietary or financial interest in any organization with which MHSC does business.

VII. **PRINCIPLE 6 - Business Relationships*:* Business relationships with third parties shall be free from offers or solicitation of gifts or other inducements in exchange for influence or business.**

A. We will not *solicit* tips, personal gratuities or gifts from patients or vendors.

B. No gifts of any kind that are offered by contractors, vendors, suppliers, potential employees, potential contractors, vendors or suppliers, or any other individual or organization, no matter the value, may be accepted by any employee at any time, on or off the work premises. This no-gift policy includes any business courtesy offered such as a product discount or any other benefit if the benefit is not extended to all employees.

1. Exempted from this policy are:

a. Gifts given at conferences, etc. that are offered equally to all attendees.

b. Food and beverages provided at conferences, etc. funded by conference or event supporter.

c. Occasional food items provided to a hospital department where all departmental employees may partake, even if addressed to a singular employee, provided it is of a nominal value.

C. Gifts to, and from, referring physicians must follow Stark monetary guidelines.

D. MHSC will not provide gifts to patients with the intent to induce business or referrals. All gifts provided to patients will follow the Social Security Act provisions.

E. Any questions regarding gifts, and their appropriateness, are to be directed to the Compliance Department.

VIII. **PRINCIPLE 7 - Protection of Assets/Research: All employees will strive to preserve and protect**

the organization's assets by making prudent and effective use of MHSC resources and properly and accurately reporting its financial condition.

A. MHSC has established control standards and procedures to ensure that assets are protected and properly used and that financial records and reports are accurate and reliable.

B. All financial reports, accounting records, research reports, expense accounts, time sheets and other documents must accurately and clearly represent the relevant facts or the true nature of a transaction.

C. All employees are expected to refrain from converting assets of the organization to personal use.

D. All property and business of the organization shall be conducted in the manner designed to further the organization's interest rather than the personal interest of an individual.

E. Employees are prohibited from the unauthorized use or taking of equipment, supplies, materials or services.

F. We shall collect and report scientific research validly and accurately, consistent with the Belmont report provisions.

IX. **Responsibility and Enforcement**

A. All employees must abide by the principles set forth in this Code.

B. Failure to abide by the principles set forth in this Code may lead to corrective action.

C. Any suspected violation of this Code must be reported to the Compliance Officer, the Compliance Hotline, or other authorized reporting mechanism without the fear of retaliation.

D. Reports of suspected violations may be made anonymously.

E. All employees must understand that actions will be taken to uphold and enforce these standards.

F. This standards set for in this Code are integral to the facility compliance program.

G. This Code will be read and acknowledged in writing upon hire and annually.

H. Employee acknowledgements shall be maintained in the employee file housed in Human Resource Department.

REFERENCES

Attachments:

No Attachments

□uality Committee
Consent □genda Summary
□une and □uly 2019

□our Priority/□ocus □reas □**Bolded** in Summary □elow□

1. □□ Patient □low
2. HC□HPS/Patient □□perience
3. Sepsis
4. Hand Off

1□ Star Rating

a. □here are seven categories within the Star Rating and they are as follows: mortality□ readmission□safety of care□efficient use of medical imaging□timeliness of care□patient e□perience □see ne□t □ullet□and effectiveness of care. □ach of these seven categories contain several data metrics. □ata within the following categories continues to trend in right direction: mortality□readmissions□safety of care. □fficient use of medical imaging has mi□ed results. MHSC received our annual facility specific report from CMS for efficient use of Medical □maging □claims □ased measures□ □or OP – □: MR□□um□ar Spine for □ow □ac□Pain measure and OP□10: □□domen C□ □se of Contrast Material□ we are performing a deep dive into data with medical imaging department and H□M director to identify potential opportunities for improvement. □or OP□10□we are pro□ected to continue improvement towards the national average of 7.□□. □ ithin the □imeliness of Care category**, Ed-2b: ED Median Admit Decision Time to ED Departure Time**□is seeing fluctuation□however the last few months have □een trending down□with □9 minutes in May 2019 being the lowest time since we've began this journey in June 2017. □ e have completed two □ean pro□ects for □□ Patient □low and have one □ean pro□ect still in progress. Please see separate □ean Summary on following page for more information. □ ithin the □ffectiveness of Care category□we have fluctuations with the data for **Core Sep1 – Early Management Bundle, Severe Sepsis/Septic Shock,** and have a □ean pro□ect and medical staff plan to improve this data metric. □ e also have fluctuation in data for Core Op 29□Colonoscopy□□ollow up for average ris□patients and we are wor□ing with physician related to this measure.

□ **Patient Experience-HCAHPS:** The "Overall □npatient HC□HPS □ash□oard" is the survey data that affects our Star Rating and □alue □ased Purchasing reim□ursement program. □his survey includes O□□C□□and Med□Surg. □ ithin this survey□we saw a steady decrease in our scores within all □uestions from □3 201□to □1 2019. □ ith □2 2019□the scores are improving again and each department is wor□ing on improvements to □eep this momentum going.

i. Our plan with the new fiscal year is to focus on the "Overall Quality of Care" □uestions score at the □□P□Committee level. Our vendor for HC□HPS provides a statistical analysis of our HC□HPS and targets the three □uestions□□nown as □ey □rivers□within the HCAHPS that will improve our "Overall Quality of

Care" Score. Research has shown that if our patients perceive our "Overall □uality of Care" as excellent, they are more likely to rate us better in all HC□HPS □uestions. □ach department has □een provided with 3 □ey drivers□ specific to their department□and are as□ed to pic□a □ey driver to focus on and incorporate into a □uality improvement pro□ect already occurring in the department. □he Medical Staff have also received the □ey □rivers pertaining to their departments and we are providing simple suggestions for improvement. □he □uality □epartment is also rounding on the floors to assist in educating staff on HC□HPS. □his direction for targeting HC□HPS improvement efforts is □uite new□we are in the process of educating staff□as well as setting goals□and target completion dates. Please see the "Priorities Work Plan" document for further information on interventions.

ii. □ata for Overall □uality of Care □y □epartment
    1. □□: □oal 42.2□ □□2 2019□44.4□ Highest result since □uly 2016.
    2. □C□: □oal 59□ □□2 2019□□□0□ Highest results since □uly 2016
    3. Med/Surg: □oal 60.6□ □□2 2019□□5□1□ □□oted improvements in each of last three □uarters
    4. O□: □oal 71.9□ □□2 2019□□64□ □□mprovement since last □uarter
    5. Surgery: □oal 73.1□ □□2 2019□□77.6□ □e□ceeded goal for □uarter

iii. □□2 2019 data not yet complete

2□ Ris□/Safety

a. Please see separate report/summary.

3□ P□Standards

a. Our P□Standards within the dash□oard include data metrics defined □y Centers for Medicare and Medicaid Services □CMS□and □he □oint Commission □□C□as well as priorities identified □y MHSC on the □uality □ssessment Performance □mprovement □□□P□□plan. □ata is trending in right direction on all metrics e□cept Maternal □eliveries □□ with □a□or □nduction. □ e have completed a □ean pro□ect surrounding the scheduling of inductions and our physicians and O□ department are wor□ing together to ensure we are providing safe care.

4□ □ccreditation

a. Please see separate report/summary.

Quality Committee Meeting
Memorial Hospital of Sweetwater County
July 1, 2019

Present: Cindy Nelson, Dr. Banu Symington, Kara Jackson, Tami Love, Dr. Kristy Nielson, Leslie Taylor, Kari Quickenden, Jodi Corley, Dr. Cielette Karn, Clayton Radakovich, Marty Kelsey, Suzan Campbell, Dr. Barbara Sowada, Irene Richardson,

Visitor: Richard Mathey

Absent/Excused:

Chair: Dr. Barbara Sowada

Approval of Agenda & Minutes

Dr. Sowada called the meeting to order at 8:15 am. Dr. Sowada present the Agenda for appoval, with correction to "III. Approval of November 20, 2013 Minutes" to Old Business. Motion to approve by Mr. Radakovich and seconded by Ms. Richardson. Minutes for May 15, 2019 were presented, motion to approve by Mr. Radakovich, seconded by Dr. Symington. Motions approved.

New Business

Ms. Jackson gave updates on the OPPE. Working on the process and currently waiting for feedback before taking to MEC. A few specialties have already responded and they are working to build those in MIDAS. For those specialties that don't respond, they will be using national standards. We are limited with outside specialties that don't document in our in-house EMR it does not communicate with MIDAS. They are working with Rich Tyler, Director IT and Leslie Taylor, MOB Manager to find ways to pull this information. We will revisit in November.

LEAN project update by Dr. Nielson, 9 of the 11 projects are completed.

Ms. Jackson reminded that the Hospital Compare data is 8-9 months old when it is published. They did an update last month and we are officially listed as a 4-Star facility. Biggest opportunities for improvement is our HCHAPS and MI measures. We have identified and started some improvement projects for MI as of last year. A deep dive of statistics is being reviewed, with plans for provider education. We will review again next month.

Dr. Nielson announced that we have no reportable infections for last month. Additionally, Dr. Nielson announced we have a new locum Infection Preventionist that started this month that will help us to reorganize our Infection Control Department and will also assist with the hiring of a new Infection Preventionist.

Ms. Corley reported the MIPS results, we received a positive 1.57 adjustment.

Ms. Nelson reported that the Planetree Steering Committee met yesterday. There are 5 workgroups each working on different goals. One of the work groups is the Person Centered Care training, we have currently had 112 staff members complete this program. Another group is working to improve patient communication by updating the information in patient rooms that

reminds and advises them on how to "speak up" during morning rounds with the care staff. The team has also, with the help of Housekeeping staff, begun placing small "speak up" notepads in patient rooms, to help patients to record their questions and thoughts.

Ms. Richardson reported on Patient & Family Advisory Council, they have had their third meeting. Typically the agenda starts out with a patient story, both positive and not so positive, and some are from years past. Council advised what they want to see is a focus on the patient. Cleanliness was addressed and one simple change was to increase size of trash cans that appear "full" with just a few items. They are looking into feasibility of upgrading. Comfort of visitor chairs was also addressed, with some samples for testing. The council toured the Med/Surg floor and gave feedback on the whiteboards. They will meet again on August 19th where we will address "what have you heard about us in the community?".

Mr. Radakovich reviewed the CMS Final Rule. Currently our systems don't all communicate, QuadraMed is working to upgrade, but if we had to there are free systems we could access. A work group is forming to evaluate our Quadramed system.

Could it happen here? Dr. Sowada provided "Ten Insights on Reducing Care Variation". Discussion ensued upon the topics. Ms. Jackson stated #"Set the pace based on your capacity to implement, rather than define, standards" spoke to her. We see so many projects starting and follow up or closure is not always there. We are working on circling back and following up, to complete and close loops. Hardwiring those processes is key. Dr. Karn noted #3 "Stop working around pockets of change-resistant physicians" and #4 "Minimize physician involvement in designing standards for routine care" both spoke to her. Involving providers when needed is essential, but not "abusing" their time for areas that they don't affect is important.

Consent Agenda

Dr. Sowada requested any pullout from Consent Agenda? Dr. Sowada questioned the "Data for Overall Quality of Care". Ms. Jackson referred her to the dashboard for the breakdown of statistics.

Ms. Jackson noted we are currently using PRC for our HCHAP scores, but we are assessing other companies (NRC and Press Ganey) to determine if we would be better served with a vendor change. Our contract with PRC ends June 2020 and we need to notify of a change 120 days prior. If we decide to move forward we would be bringing it to the Board by November.

In closing, Ms. Richardson commended our staff for all their hard work. You can see the upward trending in quality within the many statistics we evaluate. Additionally, Ms. Jackson announced that for the third year in a row we have won the "Excellence in Quality" award from Mountain Pacific Quality Health.

Meeting Adjourned The meeting adjourned at 9:45 am

Next Meeting August 21, 2019 at 08:15 am, CR 1 & 2

Respectfully Submitted,

_____

Robin Fife, Recording Secretary

HR Chair Report to the Board for July 2019

The Turnover and Open Positions Reports were reviewed and may be found in the Board Packet.

Code of Conduct

The Board at the May meeting voted to send a provision of the existing code of conduct to the HR committee for review. Specifically Section Principle 6 Item C. The stated section covers the acceptance of vendor gifts by hospital personnel. The HR Committee has completed the assigned review of that section. The committee by majority vote has sent the revised language to the Board with a do pass recommendation. The new section is included in the Board packet. The HR committee also suggests that the Board may want to consider a vote at the August Board meeting. The change involves only the paragraphs in Principle 6. The entire policy has previously been reviewed by the Board .

Telecommuting Agreement

The Chief Legal Officer and the Human Resources Director reviewed a webinar on telecommuting policy. Based on what was learned the Chief Legal Officer drafted a list of requirements that our telecommuting agreement must meet. The committee by majority vote approved the document as the guiding principle for development of the policy. Staff will now start on drafting of the policy.

Human Resources Committee Meeting
Monday, July 15th, 2019
3:00 PM – MOB Conference Room
AGENDA

Old Business

I. Code of Conduct Discussion – Clay Radakovich
II. Turnover Report - Amber
III. Open Positions –Amy
IV. Telecommuting Process Outline – For discussion/comments (sent 7/9)

New Business

I. Committee member reports, other discussion(s) – as needed
II. Determination of Next Meeting Date

Memorial Hospital
OF SWEETWATER COUNTY

Approved: *N/A*
Review Due: *N/A*
Document Area: *Corporate Compliance*
Reg. Standard:

Code of Conduct

STATEMENT OF PURPOSE

It is the policy of Memorial Hospital of Sweetwater County (MHSC) that all of the business be conducted according to high ethical standards, including compliance with applicable laws, rules, and regulations. This Code of Conduct (henceforth referred to as Code) is integral to the MHSC Compliance Plan and the provision of care and services that is consistent with the mission and vision of MHSC. This Code applies to any and all members of the workforce operating for or within MHSC. This includes employees, providers, volunteers and contractors.

TEXT

I. **General**

A. The underlying principles of these standards are based on common sense, courtesy, ethical and legal conduct that are essential to govern the business of MHSC.

B. It is important that the entire workforce understand these standards and abide by them daily.

II. **PRINCIPLE 1 - Legal Compliance: We will strive to ensure all activity by or on behalf of the organization is in compliance with applicable laws.**

A. Employees and subcontractors are expected to follow these guidelines for compliance with applicable laws. Knowledge (first or second hand) or suspicion of any violation of any law, regulation or rule must be reported to the Compliance Hotline (307 ~ 362 ~ 5291) or other appropriate staff. MHSC employees:

1. Will not solicit, receive or offer to give anything of value to anyone in exchange for referral of patients.
2. Will not accept bribes or kickbacks of any kind intended to induce referrals.
3. Will not make false statements or representations to any person or entity in order to gain or retain participation in a federal program or to obtain payment for any service.
4. Will submit claims for reimbursement accurately and only for services rendered.
5. Will not enter into any agreements with competitors to share or fix prices.
6. Will maintain complete and accurate medical records to support all medical decisions.
7. Will collect all applicable co-payments and deductibles in accordance with acceptable business practices.

8. Will store, dispense and transport all drugs and biologicals in accordance with accepted guidelines.
9. Will adhere to sound environmental and safety practices, including the proper handling of medical or hazardous waste.
10. Will respect our obligations as individuals and as health care providers, and neither express nor imply a promise of performance which we cannot reasonably expect to fulfill.
11. Will assure that all practices of write-offs, discounts, or forgiveness of debt are based solely on justifiable business practices and conform to federal and state statutes.

III. **PRINCIPLE 2 - Quality of Care: We are committed to providing the highest quality of care and delivering services in an ethical manner. MHSC employees:**

A. Will treat patients with dignity, respect, and compassion at all times.

B. Will provide high quality care to patients without regard to race, creed, age, gender, religion, national origin, or disability.

C. Will honor the rights afforded to patients, advocates and family to receive education in a manner that is understandable and to provide informed consent for care.

D. Will honor the right of patients, or their legal designees, to participate in decision making regarding their care, including refusing treatment to the extent permitted by law and being informed of the consequences of such action.

IV. **PRINCIPLE 3 - Confidentiality: We shall strive to maintain the confidentiality of patient and other confidential information in accordance with applicable legal and ethical standards. MHSC employees:**

A. Will protect the confidentiality of patient information in accordance with all applicable laws and regulations.(Such as HIPAA)

B. Will refrain from revealing any personal or confidential information concerning patients or members unless supported by legitimate business or patient care purposes.

C. Information pertaining to our competitive position or business strategies, payment and reimbursement information, and information relating to negotiations with the workforce or third parties should be protected and shared only with those having a need to know such information in order to perform their job responsibilities.

D. Will hold all investigatory information, data, and reports collected and/or made in connection with compliance issues in the highest confidence and not disclose such information outside of the confines of the activities of the Compliance Work Team or Compliance Committee of the Board of Trustees, except as is otherwise required by applicable law.

E. Will ensure that information received in confidence is not used for personal gain and divulge no such information with the intent of giving or receiving an unfair advantage in a personal business transaction.

V. **PRINCIPLE 4 - Valuing The MHSC Workforce: We value our workforce and are committed to their protection and success.**

A. MHSC shall afford all people equal employment and advancement opportunities without regard to age, gender, race, creed, national origin, religion, or disability.

B. No form of harassment or discrimination will be permitted.

C. We shall treat each other with respect, dignity, and fairness.

D. Sexual harassment, sexual advances, request for sexual favors or other verbal or physical conduct of a sexual nature that would create a hostile working environment are absolutely prohibited.

E. We shall exhibit acceptable behaviors that enhance the quality with which we meet the mission of MHSC. Such behaviors include but are not limited to, those that help to promote quality in the work place, integrity, innovation, diversity in the work place and teamwork.

F. We shall refrain from displaying inappropriate behaviors in the work place. Inappropriate behaviors are those that are disruptive to the work environment and interpersonal relationships and surroundings.

VI. **PRINCIPLE 5 - Conflicts of Interest: We shall avoid conflicts or the appearance of conflicts of interest between our private interest and the fulfillment of our duties.**

A. No employee may represent MHSC in any transaction in which he or she or a member of their immediate family has a personal interest.

B. We shall not disclose or use confidential, special or inside information of or about MHSC for personal profit or advantage.

C. MHSC workforce shall disclose all potentially conflicting activities in the annual Conflict of Interest disclosure statement.

D. We shall avoid any real or potential conflicts of interest and disclose, to the fullest extent possible, any significant proprietary or financial interest in any organization with which MHSC does business.

VII. **PRINCIPLE 6 - Business Relationships: Business relationships with third parties shall be free from offers or solicitation of gifts or other inducements in exchange for influence or business.**

A. We will not *solicit* tips, personal gratuities or gifts from patients or vendors.

B. Gifts of no more than nominal value may be accepted from vendors, provided they are not intended to influence decision-making of MHSC. Gifts of this nature will be required to follow Anti-Kickback Statute provisions.

C. Gifts to, and from, referring physicians must follow Stark monetary guidelines.

D. MHSC will not provide gifts to patients with the intent to induce business or referrals. All gifts provided to patients will follow the Social Security Act provisions.

E. Any questions regarding gifts, and their appropriateness, are to be directed to the Compliance Department.

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H. Employee acknowledgements shall be maintained in the employee file housed in Human Resource Department.

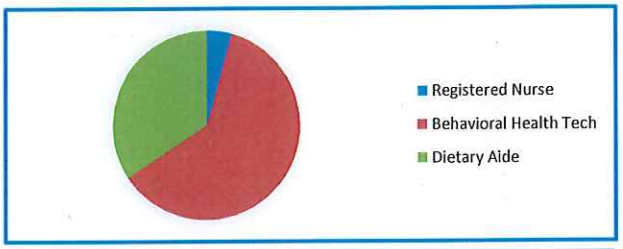
REFERENCES

Attachments: No Attachments

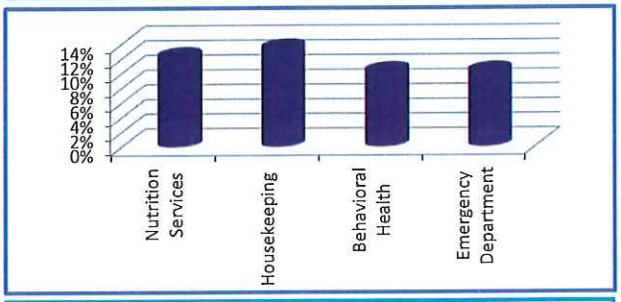
MEMORIAL HOSPITAL OF SWEETWATER COUNTY

2019 Overall Turnover Data (As of 06/30/2019)

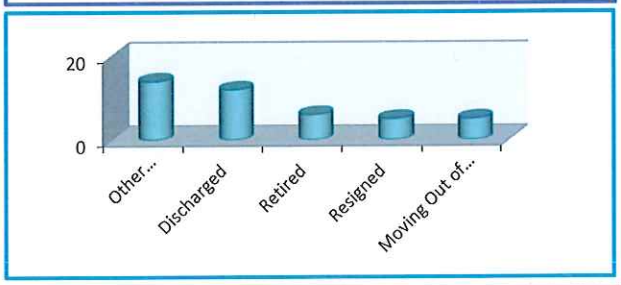
Top Position(s) / Turnover	2019	%
Housekeeper	6	30%
Registered Nurse	6	5%
Behavioral Health Tech	5	71%
Dietary Aide	4	40%



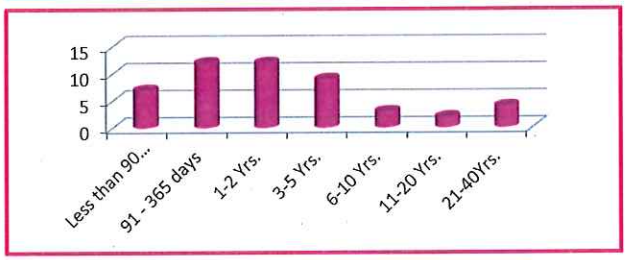
Top Department(s) / Turnover	2019	%
Nutrition Services	6	12%
Housekeeping	6	13%
Behavioral Health	5	10%
Emergency Department	4	10%



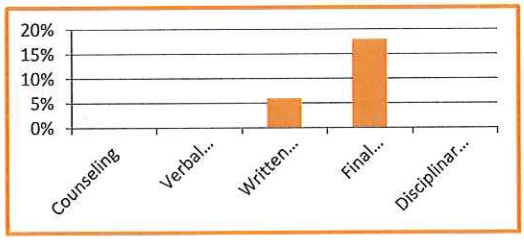
Top Reasons / Turnover	2019	%
Other Employment	14	29%
Discharged	12	24%
Retired	6	12%
Resigned	5	10%
Moving Out of Area/Relocation	5	10%



Length of Service	2019	%
Less than 90 days	7	14%
91 - 365 days	12	24%
1-2 Yrs.	12	24%
3-5 Yrs.	9	18%
6-10 Yrs.	3	6%
11-20 Yrs.	2	4%
21-40Yrs.	4	8%
Total	**49**	

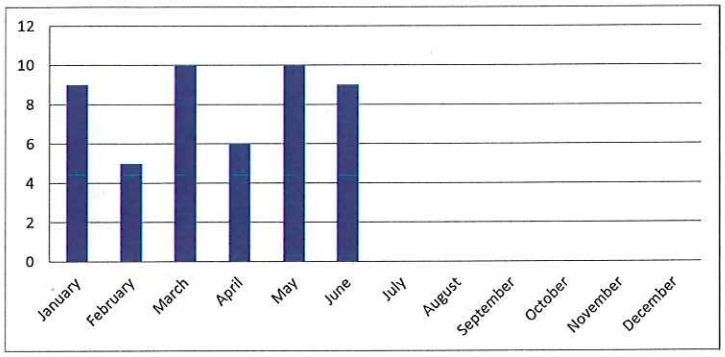


Corrective Action	
Counseling	
Verbal Warning	
Written Warning	6%
Final Written Warning	18%
Disciplinary Suspension	



2019 Separations - Hospital Wide

	Separations	New Employees	Total Employees
			496
January	9	12	499
February	5	9	503
March	10	13	506
April	6	12	512
May	10	5	507
June	9	9	507
July			
August			
September			
October			
November			
December			10%
Total	49	60	



Separations

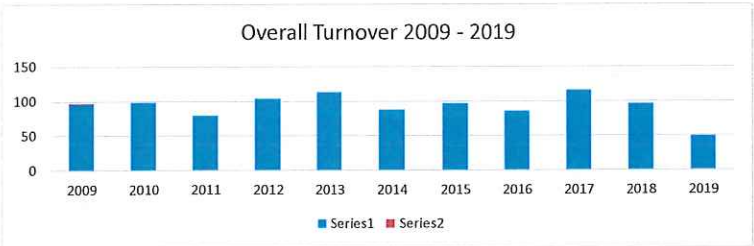
Involuntary	10
Voluntary	39
Total	49

Classifications

RN	6
Classified	43
Total	49

Overall Turnover

2009	96
2010	98
2011	79
2012	104
2013	113
2014	88
2015	97
2016	86
2017	116
2018	96
2019	49

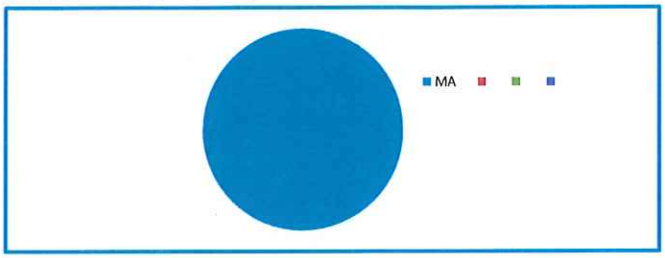


Rolling 12	Separations	%
Jan 18 - Jan 19	123	25%
Feb 18 - Feb 19	125	25%
March 18- March 19	133	26%
April 18 - April 19	117	23%
May 18 - May 19	118	23%
June 18 - June 19	118	23%

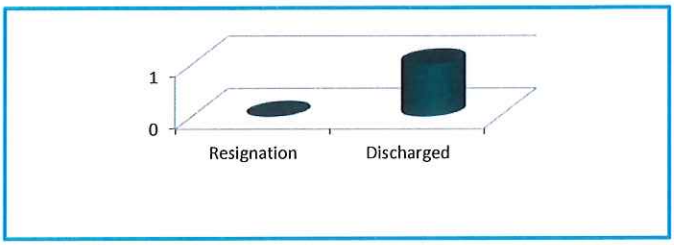
MEMORIAL HOSPITAL OF SWEETWATER COUNTY - CLINIC DATA

2019 Clinic Turnover Data (as of 06/30/2019)

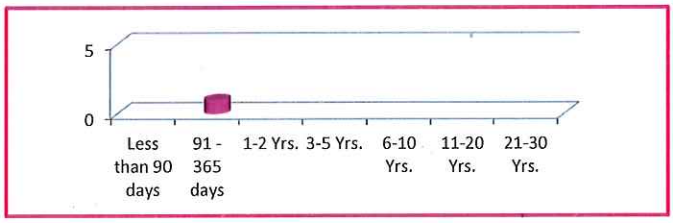
Top Position(s) / Turnover	2019	%
MA	1	8%



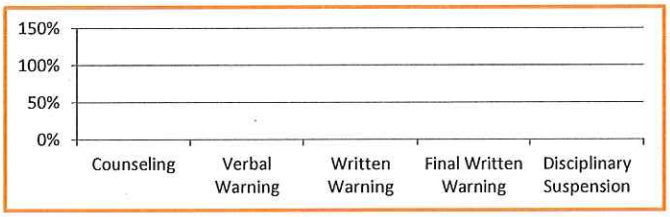
Top Reason(s) / Turnover	2019	%
Resignation	0	
Discharged	1	



Length of Service	2019	%
Less than 90 days		
91 - 365 days	1	
1-2 Yrs.		
3-5 Yrs.		
6-10 Yrs.		
11-20 Yrs.		
21-30 Yrs.		
Total	1	

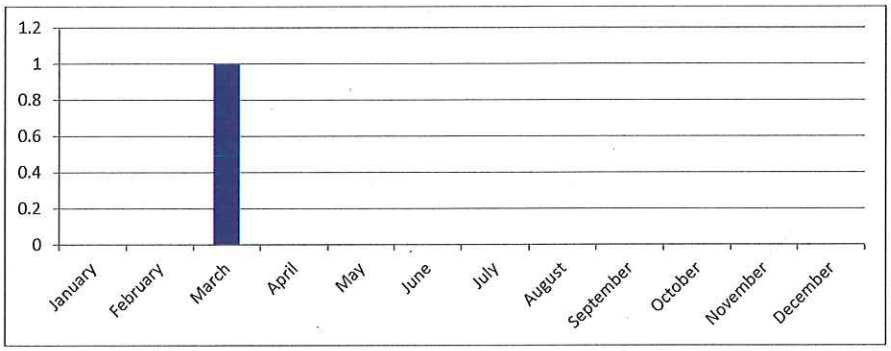


Corrective Action
Counseling
Verbal Warning
Written Warning
Final Written Warning
Disciplinary Suspension



2019 Separations - Clinic

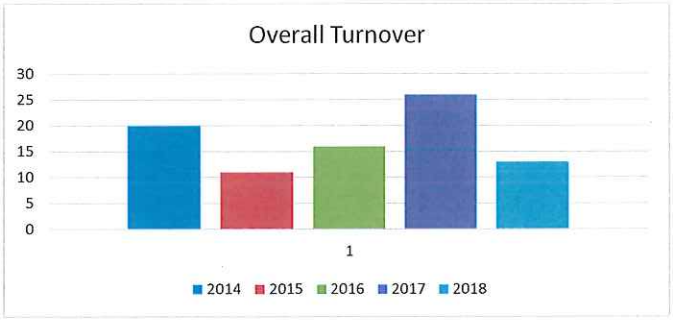
	Separations	New Employees	Total Employees	110
January	0	0	110	
February	0	2	112	
March	1	2	113	
April	0	0	113	
May	0	0	113	
June	0	0	113	
July				
August				
September				
October				
November				
December				
Total				



Separations	
Involuntary	1
Voluntary	0
Total	1

Overall Turnover		
2014	20	26%
2015	11	18%
2016	16	14%
2017	26	23%
2018	13	12%

Classifications	
RN	0
Classified	0
Total	0



Overall turnover starting Sept June 18- June 19	13	12%

Memorial Hospital OF SWEETWATER COUNTY

Job Postings as of 07/05/19

Memorial Hospital OF SWEETWATER COUNTY

Position	Req #	Position Status	Shift: Days / Hours	Position Qualifications
ADMITTING				
Admitting Specialist	2311	PRN	Variable	High School diploma or equivalent required. **Typing test required, complete at Workforce Services**
Admitting Specialist	2312	PRN	Variable	High School diploma or equivalent required. **Typing test required, complete at Workforce Services**
Admitting Specialist	2276	PRN	Variable	High School diploma or equivalent required. **Typing test required, complete at Workforce Services**
BEHAVIORAL HEALTH				
BHT - TEMP	2277	TEMP FT	Variable	High School diploma or equivalent required.
CANCER CENTER (MED/ONC)				
Medical Assistant	2285	Regular Full-Time	Days	High School Diploma or equivalent required. Completion of a certified Medical Assistant Program preferred. BLS certification required within 30 days of hire.
CARDIOPULMONARY				
Respiratory Therapist	2303	Regular Full-Time	Variable	Completion of AMA approved School for Respiratory Therapy. NBRC (National Respiratory Care) license required. Wyoming Respiratory License required. Must have passed National Registry exams.
Respiratory Therapist/Sleep Tech	2289	Regular Full-Time	Nights	Completion of AMA approved School for Respiratory Therapy. NBRC (National Respiratory Care) license required. Wyoming Respiratory License required. Must have passed National Registry exams.
COMMUNICATIONS				
PBX/Operator	2301	Regular Full-Time	Variable	High School diploma or equivalent required. **Typing test required, complete at Workforce Services**
PBX/Operator	2317	Regular Full-Time	Variable	High School diploma or equivalent required. **Typing test required, complete at Workforce Services**
Emergency				
Nursing Unit Secretary	2259	Regular Full-Time	Variable	Current Wyoming Nursing License and hold a current BLS certification.
HOUSEKEEPING				
Housekeeper	2315	Regular Part-Time	Variable	High School diploma or equivalent preferred
Housekeeper	2316	Regular Full-Time	Variable	High School diploma or equivalent preferred
ICU				
Registered Nurse	2318	Regular Full-Time	Variable	Current Wyoming Nursing License and hold a current BLS certification.
INFORMATION SERVICES				
Help Desk Analyst	2310	Regular Full-Time	Days + Call	High school diploma or equivalent and requires an Associates of Science degree or related experience.
MAINTENANCE				
Maintenance Mechanic	2307	Regular Full-Time	Variable	Possession of a high school diploma or equivalent is required. One year experience in general maintenance functions or an associated building trade. Graduation from a trade or technical school specializing in facilities maintenance or a building trade may substitute for one year experience.
MED/SURG				
C.N.A.	2325	Regular Full-Time	Variable	Current Wyoming C.N.A. License and hold a current BLS certification.
MEDICAL IMAGING				
Radiology Technologist (Rad Tech I)	2319	PRN	Variable	Graduate of a recognized program in radiologic technology. Current licensure by the Wyoming Board of Radiologic Technologists and registration by ARRT required. Shall function independently in one (1) imaging modality. BLS certification required.
Radiology Technologist (Rad Tech I)	2320	PRN	Variable	Graduate of a recognized program in radiologic technology. Current licensure by the Wyoming Board of Radiologic Technologists and registration by ARRT required. Shall function independently in one (1) imaging modality. BLS certification required.
Ultrasound Tech	2273	Regular Full-Time	Variable	Must be registered by the ARDMS, RVT, RDCS, or any other accredited ultrasound registry. Must be registered by ARRT if required to work in the role of Radiologic Technologist or other specialized modality, multiple modalities preferred.
Ultrasound Tech	2322	Regular Full-Time	Variable	Must be registered by the ARDMS, RVT, RDCS, or any other accredited ultrasound registry. Must be registered by ARRT if required to work in the role of Radiologic Technologist or other specialized modality, multiple modalities preferred.
NUTRITION SERVICES				
Cook	2302	Regular Full-Time	Variable	High School diploma or equivalent required
Cook	2323	Regular Full-Time	Variable	High School diploma or equivalent required
Dietary Aide	2324	Regular Full-Time	Variable	High School diploma or equivalent preferred
QUALITY				
Quality Analyst Registered Nurse	2286	Regular Full-Time	Days	Current Wyoming Nursing License and hold a current BLS certification. One year as staff nurse required.A minimum of two years of hospital based nursing in any clinical area is required or ability to demonstrate clinical skills from other fields of nursing that may be applicable if related to current practice and clinically pertinent knowledge.

Position	Req #	Position Status	Shift: Days / Hours	Position Qualifications
REHABILITATION				
Speech Therapist	1447	PRN	Days	Masters Degree in Speech Pathology. Certificate of Clinical Competence from American Speech Language and Hearing Association or presently completing clinical fellowship year. Wyoming License in Speech Pathology. BLS certification.
Occupational Therapist	1997	PRN	Days	Minimum of Bachelor's degree in Occupational Therapy. Master's degree in Occupational Therapy preferred. State of Wyoming Occupational Therapist License required. BLS certification.
SURGICAL SERIVICES				
Registered Nurse - PACU	2185	Regular Part-Time	Days + Call	Current Wyoming Nursing License and hold a current BLS certification.
Registered Nurse - Same Day	2321	Regular Full-Time	Days	Current Wyoming Nursing License and hold a current BLS certification.

TELECOMMUTING PROCESS

In order to have an effective telecommuting plan and process at MHSC we will need to develop the following:

1) Process to ensure that any telecommuting request go through HR.

2) Application for telecommuting-needs to be drafted.

3) Telecommuting Policy that outlines:

- Job-related criteria for eligibility for a telecommuting arrangement
- Minimum amount of years of service with MHSC to be eligible for TC
- Performance ratings at a certain level
- May be discontinued at any time with or without advance notice in the employers sole discretion
- Be very clear that the TC Agreement does not create a contract for employment and the employee is subject to MHSC Employee policies and corrective action.
- Job duties/descriptions state whether the position is eligible for TC-not all positions or classifications are suitable for TC
- FLSA requirements for recording worked hours
- Requirements for maintenance of OSHA requirements for home-office provide TC employee with list of what OSHA home office requirements are.
- Availability to come into hospital when needed for meetings
- Confidentially and security addressed-make sure our confidentiality policies cover TC employees and that TC employees are taking reasonable steps to protect MHSC confidential information
- Privacy issues- should MHSC provide work computer and no personal use allowed on this computer-that way we can remotely check it, update it, secure it and employee is clear that it is MHSC computer subject to inspection with no expectation of privacy.
- Differentiate between telecommuting and working from home
- Need to be clear as to which positions can telecommute and which can't so we don't get a discrimination/unfair treatment claim
- Telecommuting could be a reasonable accommodation under ADA
- Workers Comp- add to policy and TC Agreement that injuries that occur while working have to be reported and investigated. Check with Wyoming Workers Comp on TC
- Clock in and out?

4) Telecommuting Agreement- in draft form.

Capital Request Summary

Capital Request #

FY20 - 3

Name of Capital Request:

Harris QCPR 6.3 upgrade with Linux server conversion

Requestor/Department:

Rich Tyler – IT

Sole Source Purchase: Yes or No

Reason: QCPR is our current patient medical record and this request is to upgrade to the latest version

Quotes/Bids/ Proposals received:

	Vendor	City	Amount
1.	Harris Healthcare	Herndon, VA	$88,631.00
2.			
3.			

Recommendation:

Harris Healthcare - $88,631.00

Memorial Hospital
OF SWEETWATER COUNTY

		# Assigned: FY -
Capital Request		
Instructions: YOU MUST USE THE TAB KEY *to navigate around this form to maintain the form's integrity.* **Note:** When appropriate, attach additional information such as justification, underlying assumptions, multi-year projections and anything else that will help support this expenditure. Print out form and attach quotes and supporting documentation.		
Department: IT	**Submitted by:** Rich Tyler	**Date:** 06/26/19
Provide a detailed description of the capital expenditure requested: QCPR electronic health record software update - version 6.3		
Preferred Vendor: Harris Healthcare		
Total estimated cost of project *(Check all required components and list related expense)*		
1. Renovation		$
2. Equipment		$ 39,870.00 upgrade fees
3. Installation		$ 23,000.00 server migration
4. Shipping		$
5. Accessories		$
6. Training		$
7. Travel costs		$ 11,691.00 annual Linux licensing
8. Other e.g. interfaces		$ 14,070.00 annual QCPR support
	Total Costs (add 1-8)	$ 88,631.00
Does the requested item:		
Require annual contract renewal? ■ YES ☐ NO		
Fit into existing space? ■ YES ☐ NO	Explain:	
Attach to a new service? ☐ YES ■ NO	Explain:	
Require physical plan modifications? If yes, list to the right: ☐ YES ■ NO	Electrical HVAC Safety Plumbing Infrastructure (I/S cabling, software, etc.)	$ $ $ $ $
Annualized impact on operations (if applicable): **Increases/Decreases**		**Budgeted Item:**
Projected Annual Procedures (NEW not existing)		■ YES ☐ NO
Revenue per procedure	$	# of bids obtained? 0
Projected gross revenue	$	
Projected net revenue	$	☐ Copies and/or Summary attached.
Projected Additional FTE's		**If no other bids obtained, reason:**
Salaries	$	current EHR to be upgraded
Benefits	$	
Maintenance	$	
Supplies	$	
Total Annual Expenses	$	
Net Income/(loss) from new service	$	
Review and Approvals		
Submitted by: Rich Tyler	Verified enough Capital to purchase	
Department Leader	☐ YES ☐ NO	
Vice President of Operations	☐ YES ☐ NO	
Chief Financial Officer	■ YES ☐ NO	
Chief Executive Officer	☒ YES ☐ NO	
Board of Trustees Representative	☐ YES ☐ NO	

OTHER CONSIDERATIONS

This request is to upgrade our current Quadramed QCPR electronic health record software to the latest version of 6.3. We are currently on version 6.2 and it will stop being supported at the end of 2019. The upgrade project timeline is 15 weeks in duration.

We will also need to migrate our QCPR servers to Linux with this version upgrade. The annual licensing for Linux through Red Hat is $11,691.

Capital upgrade - $39,870.00
Capital migration - $23,000.00
Licensing - $11,691.00
Support - $14,070.00
Total - $88,631.00

Submitted by: Signature

Date

HARRIS HEALTHCARE

Supplemental Service Form

Memorial Hospital of Sweetwater County
1200 College Dr
Rock Springs, WY 82901-5868

Case ID: CAS-280275-W8Y9R2
Client Contact: Rich Tyler
Product: Professional Services
Service: Full-Service Linux Migration
Client Phone: 307-352-8409
Harris Contact: Brian Wahlstrom

STATEMENT OF WORK

Summary: Full-Service AIX to Linux Migration

Details: See attached SOW and steps from ATS Services

COST

Fixed Fee: $23,000
Estimated By: Brett Chambers

This quote will expire on: 8/31/2019

CLIENT ADMINISTRATIVE APPROVAL

Print Name: _____ **Email Address:** _____

Title: _____ **Fax Number:** _____

Signature: _____ **Date:** _____

Email signed Supplemental Service Form to SSFGroup@harriscomputer.com or fax to 703-709-2490

This Supplemental Service Form (SSF) is governed by an existing contract between QuadraMed Affinity Corporation (herein referred to as "Licensor") and Client, except this form is specific. The limit of liability of Client and Licensor is the fee stated in this form. This signed SSF must be returned by the expiration date or the fee is subject to increase. For all services totaling less than $10,000, not including Time and Materials (T&M), 100% of the SSF fee is due and payable upon execution of the SSF. For Services totaling $10,000 or greater but less than $100,000, 50% of the total fee is due and payable upon execution and the remaining 50% of the SSF is due and payable upon completion of the services. For Time and Materials, Licensor will bill Client monthly for services as incurred, unless otherwise specified. Licensor will begin work within sixty (60) days (the Commencement Date) of receipt of the execution payment and the work shall be deemed complete within one-hundred and twenty (120) days after the Commencement Date unless otherwise specified within description section of the SSF. Client will make its required resources available to Licensor on or before the Commencement Date. Any modifications or additions to specifications are subject to additional fees. Client is responsible for any and all fees associated with changes in travel arrangements due to the client's cancellation and/or rebooking of services.

HARRIS HEALTHCARE

QCPR 6.3 Upgrade

Harris Healthcare Pricing Proposal

April 23, 2019

HARRIS HEALTHCARE

April 23, 2019

Rich Tyler
Director of IT
Memorial Hospital of Sweetwater County
1200 College Drive
Rock Springs, WY 82901 USA
(307) 362-3711
rtyler@sweetwatermemorial.com

Subject: QCPR 6.3 Enhancement - Pricing Proposal

Thank you for your interest in QCPR's software v. 6.3, which will become available in Q3-Q4, 2019. This proposal provides high-level information on the new functionality included in this release, an overview of the associated Professional Services as well as pricing.

Harris Healthcare is working with Wolters Kluwer to incorporate their latest drug database **Medi-Span Clinical APIs,** which will bring advanced functionality and enhanced content to QCPR.

Medi-Span Clinical APIs includes improved performance, zero downtime for monthly updates, and additional medication advisory screening alerts. Medi-Span's Route Contraindication, Dosing Ingredient (for Acetaminophen daily dose across medication orders), Duplicate Therapy screening is available from Order Entry and Department Order Review applications.

Below is a comparison table of the advisory alert screening available in the Medi-Span Drug Information Bridge API used until now by US clients and the new Medi-Span Clinical APIs go forward drug database. Medi-Span Clinical APIs offers multiple **new advisory screening capabilities:**

Advisory Screening	*QCPR Order Entry* **Medi-Span DIB (Drug Information Bridge) API**	*QCPR Order Entry and Novus Meds* **Medi-Span Clinical API's**
Prior Adverse Reaction	✓	✓
Drug-Drug	✓	✓
Drug-Food	✓	✓
Drug-Alcohol	✓	✓
Drug-Disease	✓ (SNOMED CT, ICD-9)	✓ (SNOMED CT, ICD-9, ICD-10)
Drug PLAG (Pregnancy, Lactation, Age, Gender)	✓	✓
Dosing	✓ (Age, Weight, BSA, Renal)	✓ (Age, Weight, BSA, Renal)
Route Contraindication	--	✓
Dose Ingredient (Acetaminophen)	--	✓

IV Compatibility	✓	✓
Medication Leaflets, (IPE-ML) *	✓	✓
Duplicate Therapy by Class	--	✓
Latency Screening	--	✓

***Patient Education Medication Leaflets – Lexicomp**:

The Integrated Patient Education–Medication Leaflets (IPE-ML) provide Adult education leaflets in English, Spanish and French language and are available to QCPR customers at no extra cost with Medi-Span Clinical API's (6.3). QCPR clients interested in the full Lexicomp online full subscription can contact Mr. Ryan V. Smith, VP, EMR Partner Development and Clinical Effectiveness, at Wolters Kluwer via email: ryan.v.smith@wolterskluwer.com

As indicated in the above table, Medi-Span Clinical APIs will provide enhanced advisory screening for all QCPR clients ensuring the right medication for the patient. It will also provide product information:

- Therapeutic Classification (Medi-Span TCS)
- Restriction Codes (Controlled Substances)
- Brand / Generic drug relationships
- Active Package Product indicators
- Display the RxNorm numbers

Furthermore, QCPR 6.3 will include key **Patient Demographic enhancements:**

Gender and sex are two, commonly used and **often interchanged**, terms for classifying males and females. The World Health Organization (WHO) defines sex as the biological characteristics that define humans as female or male. While the biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males or females. Gender, on the other hand, is described by the WHO as the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women. The distinction made between patient gender identity and patient birth sex helps to improve the quality of patient care.

In this release, the **Patient Sex data element has been renamed Patient Birth Sex** in the Registration Screen Sequence and QCPR has been enhanced to support additional birth sex options. In addition, the terms gender and sex have been streamlined throughout the application and the word Sex replaces the word Gender in QCPR fields, headers, and columns.

A loop has been created and must be run to rename the Patient Sex data element on registration screens to Patient Birth Sex. The loop ensures backward compatibility as the internal values of (M) Male, (F) Female and (U) Unknown continue to display as options when defining the Patient Birth Sex data element in the Registration Screen Sequence Table.

There is also **a new Patient Gender Identify data element** allowing the documentation of what gender a patient identifies with, independently of their Birth Sex. In addition, new Ethnicity and Race data elements, which both use the Controlled Medical Vocabulary data element for registration, have been added in v 6.3.

Furthermore, QCPR 6.3 will include several other enhancements listed here below. Information that is more detailed will be provided on these, as we get closer to the release date.

Additional enhancements in 6.3:

- **Interoperability** - New C-CDA version 2.1 with enhanced / new C-CDA sections and ability to translate
- **Novus ClinDoc -** Implementation of QCPR Document List within Novus ClinDoc including creation of the C-CDA
- **Novus ClinDoc -** Results Widget - Enhanced vitals, labs and radiology display of results, navigation and selection
- **Order Entry -** Compliance with regulatory requirement for advanced imaging ordering with Appropriate Use Criteria
- **Novus Meds -** Order Entry and Advisory Alert Enhancements
- **ePrescribing -** Upgrade of ePrescribing portal from Rcopia 3 to 4

6.3 Pre-requisite

A new Harris Intermediate Server Medi-Span Clinical (HISMC), middleware server cluster is required for the 6.3 /Medi-Span Clinical APIs upgrade. The HISMC server cluster will provide a High Availability (HA) environment and support zero downtime during "Monthly Updates". The HISMC recommended hardware specifications are found at the end of this document.

Novus Meds (Medication Order Entry + Medication Reconciliation) and Novus ClinDoc (Physician Documentation) both require the Harris Intermediate Server Medi-Span Clinical (HISMC). If you have already implemented either of these modules, the HISMC middleware server cluster discussed above is already in place.

The HISMC server cluster will provide a High Availability (HA) environment and support zero downtime during "Monthly Updates". The HISMC recommended hardware specifications are found at the end of this document.

The 6.3 development work is currently in progress and we will keep you apprised as the functionality is being finalized. Target availability is end of Q3-Q4, 2019. With the upgrade to Medi-Span Clinical API's, there will be a slight increase in your overall annual Medi-Span licensing fees. The Medi-Span fee shown in table is the total new fee, which will replace existing fees you are currently paying.

Please review the attached offering and do not hesitate to contact me if you have any further questions. I look forward to hearing back from you and to the collaborative work ahead.

Sincerely,

Brett A. Chambers
Client Development Leader
Harris Healthcare
800-393-0278 x74297 / bchambers@harriscomputer.com
HQ: Herndon, VA | https://www.harrishealthcare.com/

HARRIS HEALTHCARE

Table of Contents

QCPR 6.3 Pricing Memorial Hospital of Sweetwater County

Software Product / Service	Comment	Pricing	TOTAL
QCPR 6.3 license software enhancement	No software license fee	No extra cost	$0.00
Medi-Span Clinical API (3rd Party Wolters Kluwer) **Annual Fee**	Annual software maintenance fee for Wolters Kluwer license. *New fee is in lieu of current fee you are already paying, not in addition to it.		$14,070 / year
Required **Professional Services/Installation Fees** [1,3] **for total QCPR 6.3 Base Package** **One-time fee**	Includes Planning, Training, Configuration, Testing, End User Training, Go Live Support. Includes ATS time to install HISMC on one Development and 2 Production servers	$36,045 USD	$36,045 USD
Optional **Novus ClinDoc- Training for two enhancement content area** **One-time fee**	Novus Document List Application - Novus ClinDoc to include creation of the C-CDA ClinDoc Result Widget - Enhanced vitals, labs and radiology display of results, navigation and selection.	$1,350 USD	
Optional **Medi-Span Clinical US - Training of Medi-Span Clinical API/HISMC** **One-time fee**	Training of Medi-Span Clinical API/HISMC replacing Medi-Span Bridge API for US clients only	$675 USD	$675 USD
Optional **Novus Meds – Training on Novus Meds Enhancements** **One-time fee**	Training on the enhanced Novus Meds module for Order Entry and Advisory Alert Enhancements - Onsite	$5,400 USD	

Optional **Rcopia 3 to 4 Upgrade** **(US eRX Clients only)** **One-time fee**	Training for current US eRX clients - This is an upgrade to the portal from Rcopia 3 to 4. Onsite	$1,800 USD	$1,800 USD
Optional **Radiology AUC** **One-time fee**	Training on the configuration and use to enable compliance with the regulatory requirement for Advanced imaging ordering with Appropriate Use Criteria - Remote	$1,350 USD	$1,350 USD
Year 1 Total	Medi-Span Clinical API Annual fee year 1 + Professional Services		$53,940
Year 2 and beyond	Annual Service fee	$14,070/year	$14,070/year

Notes:

[1] *See description of Professional Services / Installation fees included below.*

[2] *Pricing expires 8.1.2019*

[3] *Harris Healthcare employee travel and related expenses are billable*

PROFESSIONAL SERVICES DESCRIPTION QCPR 6.3

Scope of Work – Implementation of QCPR 6.3

I. SCOPE STATEMENT

The purpose of this statement of work is to provide education, configuration assistance and support for the Canadian clients to move to 6.3 and from the Medi Span API to the Medi Span Clinical API application for use within QCPR.

II. PROJECT TIMELINE

This engagement will be 15 weeks in duration. If the CLIENT'S timeline extends or delays, additional services would be required under a separate Agreement.

III. PRE-REQUISITES

List any Pre-Requisites pertinent to this engagement

- Hardware for Harris Intermediate Medi-Span Clinical (HISMC) and servers installed
- QCPR version 6.3 in the client Development area
- Room/equipment to perform service offering
- Staff available for education, configuration, testing and go live support.

IV. DELIVERABLES

Harris Healthcare will:

- Provide remote project management support for resource scheduling, issues management, and project reporting.
- Install QCPR version 6.3 for the implementation.
- Conduct remote training for:
  - MS Clinical API
  - Database Configuration for QCPR version 6.3
- Remote support during the client configuration and testing to assist with configuration, issues and testing.
- Dedicated remote go live support during the version go live.

V. ITEMS OUT-OF-SCOPE

Harris Healthcare will not perform the following activities during this engagement:

- Perform, enter/result, or modify patient data or results in the Production environment
- Testing the system
- Report Development/Modification
- Data Conversions
- Interface Development/Modification
- Data Warehouse Development

If above services are requested, a separate Agreement or change control will be required

VI. Risks

Risk for this project may include:

- Failure of project scope to be clearly defined, understood, documented and agreed upon by all parties.
- Lack of adherence to escalation pathway
- Lack of resources with appropriate skills and/or empowered with decision making capabilities committed to the project and available for the duration of the project
- Conflicts with other projects

VII. Requirements of CLIENT Personnel – CLIENT Leadership

- Provide background information on organizations objectives
- Provide appropriate resources to implement application, workflow, process and database changes as necessary to support the project
- Provide appropriate resources to support thoroughly testing the system
- Provide appropriate resources to support Go-Live operations of features and functions

Payment Terms

Upon Execution of the Agreement, Harris Healthcare shall invoice CLIENT based on the following schedule:

License (with install)	Not applicable for this upgrade
Installation, Services and Training	50% upon execution of this agreement 25% the earlier of completion of the Client training for MS Clinical or 6 weeks post execution. 25% the earlier of go live or 14 weeks post execution. Any services requested thereafter are available at Harris Healthcare's current rates
Annual Support	100% annually in advance upon Live
Third-Party Software	100% on Execution
Hardware Purchase through Harris	100% on Execution

Notes: For the purposes of this document, the following definition shall apply: "Execution" means the date Client's representative, so duly authorized, signs this document, accepting the terms set forth.

APPENDIX A

Hardware and Software requirements for Harris Intermediate Medi-Span Clinical (HISMC) HA server needed for Wolters-Kluwer Health® Medi-Span Clinical API

The following two server frames require a High Availability Service Level for Production Environments and may be implemented using Hardware Assisted Virtual Machine Technology to emulate abstract platform-independent Operating System program execution. Virtualization is controlled through an administrative Hypervisor, using Red Hat Enterprise Virtualization (RHEV®), VMware ESXi 6.0®, or Microsoft Hyper-V 2016-CB® compliant with Microsoft Server 64 bit 2016-CB Edition.

Platform requirements for additional Harris Healthcare add on products may be combined across a larger set of server frames when CPU and Memory requirements are maintained in accordance with the design requirements and Service Levels.

Harris Healthcare will utilize the Drug Knowledge Vendor Microsoft SQL Server 2016 SP1 Express-Wolters Kluwer Health® Medispan Clinical® beginning with QCPR 6.2. The product is known as HISMC.

A separate similarly configured server/VM is required for **Non-Production domains**.

CPU	• Dual-Core X86-64 3+ GHz or equivalent VM service level
RAM	• 32 GB or equivalent VM service level
Internal Disk Adapters	• (1) RAID1,5,6,10 controller with 4GB Battery Backup Write Cache
OS Disk Space	• 100 GB Equivalent SATA 10k RPM, Internal, Internal RAID1
Fiber	• (1) 8-Gigabit PCI dual-port fiber channel adapter / **Omit with Internal Disk**
Application Software Disk Space	• 100GB Equivalent SATA 10k RPM, Internal, Internal RAID1,5,6,10, or **Omit with SAN**
OS	• Microsoft Windows Server® 2016-CB 64-bit
VM Partition	• (1)
Network	• Gigabit Full Duplex Ethernet NIC or equivalent VMware service level
Applications	• Microsoft SQL Server 2016 SP1 Express or Microsoft SQL Server 2017 Express Advanced
	• Wolters Kluwer Health® Medi-Span® Services

	• .Net 3.5 SP and updates • .Net 4.5 SP and updates
	• Microsoft Internet Information Server® (IIS) service
	• Microsoft WebPI (Web Platform Installer)
	• NET-SNMP Simple Network Management Protocol (SNMP)

NON-DISCLOSURE AND DISCLAIMER STATEMENT

Any terms and conditions contained in the enclosed documents expire 90 days from the date that Harris Healthcare delivers these documents to the original recipient, unless they are extended or terminated earlier by written notice from Harris Healthcare to the original recipient.

The recipient of the enclosed documents acknowledges that any information provided by Harris Healthcare in the documents, including but not limited to any estimated, proposed or anticipated equipment, programs, features, services, pricing, work or billable hour amounts, and/or timing, is based on Harris Healthcare's understanding of the purposes for which Harris Healthcare is providing the documents as of the date the documents are provided. While Harris Healthcare believes such information to be reasonably accurate, no guarantees or warranties express or implied, are made at this time. In addition, if any purpose for which the documents are being furnished changes, or if Harris Healthcare ascertains new or additional information which modifies its understanding of any purpose, Harris Healthcare reserves the right to revise any part of the enclosed documents to reflect such change or new or additional information. In any event, no information provided by Harris Healthcare in the enclosed documents shall be binding on Harris Healthcare unless it is included in a final, definitive binding agreement that is formally negotiated and executed by Harris Healthcare and any relevant counterparties.

RED HAT STORE

Bill to

Rich Tyler
1200 College Drive
ROCK SPRINGS, WY 82901 US

3073528409
rtyler@sweetwatermemorial.com

Edit your address

Order summary

Subtotal:	US$11,691.00
Estimated tax:	US$0.00
Estimated total:	**US$11,691.00**

Credit card information

Please enter the first and last name of the person on the card.
Do not use the company name.

* First name

Capital Request Summary

Capital Request #

FY20-5

Name of Capital Request:

GE Optima CT580 RT-16 – FMV lease buyout

Requestor/Department:

Tasha Harris – Radiation Oncology

Sole Source Purchase: Yes or No

Reason: FMV lease buyout of current CT equipment

Quotes/Bids/ Proposals received:

	Vendor	City	Amount
1.	GE HFS, LLC	Brookfield, WI	$225,000.00
2.			
3.			

Recommendation:

GE HFS, LLC - $225,000.00

Memorial Hospital
OF SWEETWATER COUNTY

		# Assigned: FY 20 - 5

Capital Request

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

Department: Radiation Oncology	**Submitted by:** Tami Love	**Date:** 07/08/19

Provide a detailed description of the capital expenditure requested:

GE Optima CT580 RT-16 - FMV lease buyout

Preferred Vendor: GE Healthcare Financing Services

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

1. Renovation		$
2. Equipment		$ 225,000.00
3. Installation		$
4. Shipping		$
5. Accessories		$
6. Training		$
7. Travel costs		$
8. Other e.g. interfaces		$
	Total Costs (add 1-8)	$ 225,000.00

Does the requested item:

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

Annualized impact on operations (if applicable): **Increases/Decreases**		**Budgeted Item:**
Projected Annual Procedures (NEW not existing)		■ YES ☐ NO
Revenue per procedure	$	# of bids obtained? 0
Projected gross revenue	$	
Projected net revenue	$	☐ Copies and/or Summary attached.
Projected Additional FTE's		**If no other bids obtained, reason:**
Salaries	$	FMV lease buyout of current equipment
Benefits	$	
Maintenance	$	
Supplies	$	
Total Annual Expenses	$	
Net Income/(loss) from new service	$	

Review and Approvals

Submitted by: Rich Tyler	Verified enough Capital to purchase	
Department Leader	☐ YES ☐ NO	
Vice President of Operations	☐ YES ☐ NO	
Chief Financial Officer	■ YES ☐ NO	
Chief Executive Officer	☒ YES ☐ NO	
Board of Trustees Representative	☐ YES ☐ NO	

OTHER CONSIDERATIONS

Original 60 month lease date was 04/22/2014. The equipment does not need to be replaced at this time due to limited usage of the machine and no immediate need for new technology. Options included the fair market value purchase of the equipment or the continued leasing on a month to month basis for $8,622/month. Based on usage, we expect this piece of equipment to be useful for another 4-5 years.

Capital $225,000.00

Submitted by: Signature

Date

Asset Management
David Kelsey
(214)483-1527

Quote Number: 5120

May 16, 2019

BOARD OF TRUSTEES OF THE MEMORIAL HOSPITAL OF SWEETWATER COUNTY
WATER COUNTY, P O BOX 1359
ROCK SPRINGS, WY 82902

GE HFS, LLC ("GEHFS") is pleased to submit the following proposal:

Contract Description:	True lease of equipment, account # 9752414001
Equipment Description:	GE OPTIMA CT580 RT-16
End of Term Date:	May 15, 2019
End of Lease Options:	_____ 12 months at $8,622.00 per month, plus applicable taxes. _____ Purchase the equipment for $225,000.00, plus applicable taxes. ** FMV Renewal Options assume that the Lessee is liable for all rents and other charges for periods prior to and including the Amendment August 15, 2019 (the "Amendment Effective Date"), plus applicable taxes and any maintenance service charges, including, to the extent applicable, all rents payable in arrears which relate to any period prior to and including the Amendment Effective Date even if billed after the Amendment Effective Date. GE HFS, LLC shall have the option to withdraw this if all amounts owed by Lessee to GE HFS, LLC have not been received promptly when due. GE HFS, LLC and Lessee agree that a signature affixed to any one of the originals and delivered by facsimile shall be valid, binding and enforceable. In addition to the above you may also return the equipment to GE HFS, LLC. Please refer to your master lease agreement for a complete description of the return requirements.
Terms and Conditions:	All other terms and conditions of the referenced lease contract shall continue in effect.
Documentation Fee:	A documentation fee of $200.00 will be charged to Lessee to cover document preparation, document transmittal, credit write-ups, lien searches and lien filing fees. The documentation fee is due upon Lessee's acceptance of this proposal and is non refundable. This fee is based on execution of our standard documents substantially in the form submitted by us. In the event significant revisions are made to our documents at your request or at the request of your legal counsel or your landlord or mortgagee or their counsel, the documentation fee will be adjusted accordingly to cover our additional costs and expenses.
Required Credit and Tax Information:	1. Year end audited/unaudited financial statements & comparative interim statements. 2. If non taxable entity, a current tax exemption certificate is due upon receipt of accepted proposal
Proposal Expiration:	This proposal and all of its terms shall expire on August 10, 2019 if GE HFS, LLC has not received Lessee's acceptance hereof by such date.

The summary of proposed terms and conditions set forth in this proposal is not intended to be all-inclusive. Any terms and conditions that are not specifically addressed herein would be subject to future negotiations. Moreover, by signing the proposal, the parties acknowledge that: (i) this proposal is not a binding commitment on the part of any person to provide or arrange for financing on the terms and conditions set forth herein or otherwise; (ii) any such commitment on the part of GE HFS, LLC would be in a separate written instrument signed by GE HFS, LLC following satisfactory completion of GE HFS, LLC' due diligence, internal review and approval process (which approvals have not yet been sought or obtained); (iii) this proposal supersedes any and all discussions and

understandings, written or oral between or among and any other person as to the subject matter hereof; and (iv)GE HFS, LLC may, at any level of its approval process, decline any further consideration of the proposed financing and terminate its credit review process. GE HFS, LLC' standard documents will be used.

Except as required by law, neither this proposal nor its contents will be disclosed publicly or privately except to those individuals who are your officers, employees or advisors who have a need to know as a result of being involved in the proposed transaction and then only on the condition that such matters may not be further disclosed. Notwithstanding the foregoing, there is no restriction (either express or implied) on any disclosure or dissemination of the tax structure or tax aspects of the transactions contemplated by this proposal. Further, GE HFS, LLC acknowledges that it has no proprietary rights to any tax matter or tax idea or to any element of the proposal's transaction structure.

You hereby authorize GE HFS, LLC to file in any jurisdiction as GE HFS, LLC deems necessary any initial uniform commercial code financing statements that identify the Equipment or any other assets subject to the proposed financing described herein. If for any reason the proposed transaction is not approved, upon your satisfaction in full of all obligations to GE HFS, LLC, will cause the termination of such financing statements. You acknowledge and agree that the execution of this proposal and the filing by GE HFS, LLC of such financing statements, in no way obligates GE HFS, LLC to provide the financing described herein.

We look forward to your early review and response. If there are any questions, we would appreciate the opportunity to discuss this proposal in more detail at your earliest convenience. Please do not hesitate to contact me directly at (214)483-1527.

Sincerely yours,

By: David Kelsey

Title: Senior Portfolio Manager

Acknowledged and Accepted:

_____
(Legal Name)

By:_____

Title:_____

Date:_____

Fed. ID #:_____

NOTICE

The Federal Equal Credit Opportunity Act prohibits creditors from discriminating against credit applicants on the basis of race, color, religion, national origin, sex, marital status, age (provided the applicant has the capacity to enter into a binding contract), because all or part of the applicant's income derives from any public assistance program, or because the applicant has in good faith exercised any right under the Consumer Credit Protection Act. The federal agency that administers compliance with this law is the Federal Trade Commission, Equal Credit Opportunity, Washington, DC 20580.

WELLS FARGO SAFE Transmission

Welcome **Tami Love**

Upload Files

Upload files

OK **Your files have been successfully uploaded.**

	File Name	Batch ID	Product Folder	Status
1.	ACK17.TXT	16BD7D1DC03	ACH	Uploaded

Return to Upload Files | Print

Capital Request Summary

Capital Request #

FY20-8

Name of Capital Request:

MD-Staff Credentialing & Provider Enrollment Software

Requestor/Department:

Kerry Downs – Medical Staff Services

Sole Source Purchase: Yes or No

Reason:

Quotes/Bids/ Proposals received:

	Vendor	City	Amount
1.	Applied Statistics & Management	Temecula, CA	$41,400 software $0 first year support included $3,500 implementation $44,900 Total
2.	Verity	Louisville, CO	$31,500 software $18,900 annual maintenance $50,400 Total
3.	Cactus - Symplr	Berwyn, PA	$62,035 software $28,330 annual maintenance $90,865 Total

Recommendation:

Applied Statistics & Management – MD-Staff $44,900.00

Memorial Hospital
OF SWEETWATER COUNTY

		# Assigned: FY 20 - 8
Capital Request		
Instructions: YOU MUST USE THE TAB KEY *to navigate around this form to maintain the form's integrity.* **Note:** When appropriate, attach additional information such as justification, underlying assumptions, multi-year projections and anything else that will help support this expenditure. Print out form and attach quotes and supporting documentation.		
Department: Medical Staff Services	**Submitted by:** Kerry Downs	**Date:** 07/22/2019
Provide a detailed description of the capital expenditure requested: MD-Staff credentialing and provider enrollment software.		
Preferred Vendor: Applied Statistics & Management		
Total estimated cost of project *(Check all required components and list related expense)*		
1. Renovation		$ 0
2. Equipment		$ 41,400 (software modules)
3. Installation		$ 3,500 (implementation services)
4. Shipping		$
5. Accessories		$
6. Training		$ Included
7. Travel costs		$ 0
8. Other e.g. interfaces		$
	Total Costs (add 1-8)	$ 44,900
Does the requested item:		
Require annual contract renewal? ■ YES ☐ NO		
Fit into existing space? ■ YES ☐ NO	Explain:	
Attach to a new service? ☐ YES ■ NO	Explain:	
Require physical plan modifications? If yes, list to the right: ☐ YES ■ NO	Electrical HVAC Safety Plumbing Infrastructure (I/S cabling, software, etc.)	$ $ $ $ $
Annualized impact on operations (if applicable): **Increases/Decreases**		**Budgeted Item:**
Projected Annual Procedures (NEW not existing)		■ YES ☐ NO
Revenue per procedure	$ 0	# of bids obtained? 3
Projected gross revenue	$ 0	
Projected net revenue	$ 0	■ Copies and/or Summary attached.
Projected Additional FTE's		**If no other bids obtained, reason:**
Salaries	$	
Benefits	$	
Maintenance	$ 14,900	
Supplies	$	
Total Annual Expenses	$ 14,900	
Net Income/(loss) from new service	$	
Review and Approvals		
Submitted by:	Verified enough Capital to purchase	
Department Leader	☐ YES ☐ NO	
Vice President of Operations	☐ YES ☐ NO	
Chief Financial Officer	☐ YES ☐ NO	
Chief Executive Officer	☒ YES ☐ NO	
Board of Trustees Representative	☐ YES ☐ NO	

OTHER CONSIDERATIONS

Our current credentialing software is Midas Seeker. Midas will end maintenance and product support of Midas+ Seeker as of December 31, 2021. We already have been experiencing problems with Seeker, and anticipate that those problems or glitches will only get worse.

Currently, we have over 180 providers on the medical staff. Credentialing software is essential to the Medical Staff Services office. It provides a way to screen, track, and access information for each of our providers. With automated software, we can continuously screen each provider for new malpractice claims and to make sure they don't have Medicaid/Medicare sanctions. These are Joint Commission requirements.

Our physician privileges are out-of-date, and need to be standardized. MD-Staff offers drag-and-drop privileging, which allows each specialty to select their requested privileges. They are then built into a standardized format.

The on-line application module would allow our providers to apply for privileges on-line. The program also includes "hard-stops," which means that if a provider left a required application field blank, they wouldn't be able to continue or to submit the application until they complete the field. This could help improve our turn-around time and prevent us from having to repeatedly ask for or hunt down required information.

When a provider comes up for reappointment (every two years), the application module would pre-populate their information. They would only need to add any new information, or make changes, sign, and then submit. This would help to alleviate the delay for providers returning their reappointment applications.

The payor enrollment module would pre-populate payor applications and speed up the process of enrolling providers with Medicare, Medicaid, and other commercial insurance companies. This module also helps to track application process and status.

We have to replace our current software. With this web-based system (MD-Staff), we would not only replace it, but we would greatly improve our efficiency and compliance with regulatory requirements; decrease the time it takes to enroll providers with payors; and increase the medical staffs' satisfaction as it pertains to the reappointment process.

MD-Staff is web based. Training will be on-line and the software is deployed through the cloud. So there are no additional shipping, travel, or training costs. They offer 1, 3, and 5 year contracts. After the first year we will be charged an annual cost of $14,900.

Capital $44,900

Submitted by: Signature _____ Date _____

MD-Staff for the Web

Web-Based Credentialing System

Quote for:

Memorial Hospital of Sweetwater County

March 8, 2019

Applied Statistics & Management, Inc.
32848 Wolf Store Road
Temecula, CA 92592, USA

Confidentiality Statement

Contents

Quote #:	AS-2815
Expiration Date:	June 31, 2019
Please direct all inquiries regarding this quote to:	Nino Limatola nlimatola@mdstaff.com D: (951) 553-7618 C: (951) 303-4922

Executive Summary

MD-Staff for the Web

MD-Staff for the Web is a comprehensive credentialing system that includes all of the modules needed to streamline and automate the credentialing process. The foundation for MD-Staff for the Web is an extensive, highly relational database that stores nearly every data element relating to a provider. All of the modules in MD-Staff for the Web are built upon this single powerful database, thus allowing them to work seamlessly with each other. Unlike other credentialing systems, all of the modules are included in MD-Staff for the Web thus drastically reducing overall cost while providing the maximum amount of features.

The web-based version of MD-Staff for the Web is a feature rich enterprise level credentialing system, yet it is still very user friendly and intuitive. Based on our highly successful Windows version of MD-Staff, the web-based version takes usability to a new level by utilizing the most advanced web-based technologies to make the application fast, responsive and easy to understand. Along with being easy to use, MD-Staff for the Web also automates many tedious credentialing processes, thus drastically reducing workloads while increasing accuracy.

MD-Staff for the Web interfaces with numerous online verification sources in order to automate many of the verification processes. Verification can be done directly from MD-Staff for the Web for a single provider or a group of providers, drastically reducing the amount of time spent on verifying provider information. In order to further reduce the workload, batch verifications can be scheduled to run automatically on a monthly or weekly basis. With the ability to schedule automatic verifications, a provider's record can be verified and updated with no user intervention.

ASM

As the health care industry is forever evolving, the demand for advanced and innovative credentialing solutions is increasing. ASM is dedicated to creating software solutions that leverage the latest technologies and methodologies that help to improve the speed and accuracy of the credentialing process.

Customer service is an important component to any software product. ASM provides unparalleled support for all of its software products. Rather than simply providing technical support, ASM focuses on building relationships with its clients to provide the best possible service and support.

Proposed Solutions

Items	*Initial Cost*[1]	*Annual Cost*[1]
[X] **MD-Staff for the Web** • Web-based provider credentialing for One facility and 180 Providers. • Highly relational provider management database • Drag-and-drop privileging • Over 200 built-in reports, custom reports and ad hoc query writer • Online verifications: ABMS© Direct Connect Select, DEA, NPDB, OIG, EPLS/GSA, State Licensure Boards, NPI, etc.[2] • Customizable workflow/alarm module • Pronto electronic questionnaires • Batch mail merges with Microsoft Word • CME, Meetings and Committee modules • Unlimited number of users • Data Warehouse	**$18,900**	**$6,900**
[X] **E>Priv (MD-Staff portal)** • Provides house staff with live read-only access to the MD-Staff database • Displays provider data • Unlimited number of customizable E>Priv displays • Unlimited number of users • Displays photos, scanned documents and signatures	**Included**	**Included**
[X] **Payor Enrollment / Managed Care** • Prepopulate PDF payor applications • Track application process/status • Separate Facility/View for Managed Care • Contracts • Sites • Networks • Entities • Fee Schedules • Library of Reports/Directories	**$5,000**	**$2,000**

[X] **MD-App** • Paperless application • Request / Renew Privileges • Electronic Signatures via DocuSign* or AdobeSign* *Requires separate license and additional fees with DocuSign or AdobeSign • Attestation Questions • Initial and Reappointment Applications • Collect all information needed at one time • Integrates for import/export with MD-Staff	**$12,500**	**$4,000**
[X] **Virtual Committee** • Committee members may review selected records • Initial appointments or reappointments • Accessible from any computer with an internet connection • Committee members can review and comment on records when it is most convenient	**$5,000**	**$2,000**
[X] **MD-Query** • Allows Medical Staff Professionals to quickly and economically create their own "online verification" system • Customized website with your logo • Customized affiliation letter • Email notifications • Employs the latest security protocols • NAMSS-PASS Certified	**Included**	**Included**
[X] **MD-Directory** • Real-time integration with provider database • Public facing provider directory • Cross-browser compatibility	**Included**	**Included**
[X] **Direct Fax ($0.10 per page)** • Fax merge letters directly from MD-Staff • No additional hardware or fax server needed • View the fax status directly in MD-Staff	**$0.10 per page**	**$0.10 per page**

[X] **Implementation Services**[3] MD-Staff and E>Priv • System Configuration • Setup merge templates (up to 20) • Creation of privilege forms (up to 20) • One time, two-phase, data conversion of existing data Payor Enrollment / Managed Care • Map up to 10 additional PDF application forms MD-App • System configuration/customization for one initial and one re-appointment application process. (Note: this does not include configuring any PDF applications to be generated by MD-App, MD-Staff or any other related modules). • Customized website with your logo • Mdapp.com setup • Additional applications, pages or complexity requires a price increase based on a rate of $225 per hour • Hosting in ASM's secure data center Custom Reports • Additional reports/exports/imports requires a separate Statement of Work based on a rate of $225 per hour	**$3,500**	**N/A**
[X] **Training** • 10 hours of online training	**Included**	**N/A**
[X] **Support** • Toll-free Telephone and Email Support • Remote Assistance	**Included**	**Included**
Total Cost (with modules described above)	**$44,900**	**$14,900**

1. The initial cost includes the first year of annual cost(s). The annual cost is due on the anniversary of the due date of the initial cost.
2. Some online verifications require an account with a third party (e.g. ABMS©, NPDB, etc). Therefore, queries performed within MD-Staff involving a third party may incur a cost which is billed by the third party. ASM is not responsible for these costs.

3. Although ASM will make every reasonable effort to migrate all of the data from the source database, ASM cannot guarantee that every data element will convert to the new database.

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WY

NARRATIVE TO JUNE 2019 *PROJECTED* FINANCIAL STATEMENTS

THE BOTTOM LINE. The bottom line from operations for June was a loss of $755,071, compared to a gain of $227,713 in the budget. This yields a -11.9% operating margin for the month compared to 3.0% in the budget. The YTD net operating gain is $141,053, compared to a gain of $1,709,309 in the budget. This represents a YTD operating margin of 0.16% compared with 1.89% in the budget. The total net gain YTD is $1,068,160, compared to $676,294 in the budget. This represents a YTD total profit margin of 1.23% compared to 0.75% in the budget.

REVENUE. Revenue for the month was $13,069,675, under budget by $707,325. Inpatient revenue was under budget by $504,277, outpatient revenue was under budget by $278,971 and the employed Provider Clinic was over budget by $75,923. Year-to-date gross revenue was $164,916,540 compared to $164,984,757; under budget by $68,217.

Net patient revenue for the month was $6,149,721, under budget by $1,161,988. YTD net patient revenue was $93,600,184, under budget by $3,957,079.

Other operating revenue for the year was $3,173,482. This includes County routine maintenance funds, Foundation unrestricted income, cafeteria revenue, occupation medicine industry contracts and collection agency interest income.

Non-operating revenue for the year was $927,106, over budget by $1,960,121. This includes interest income and expense, special purpose taxes, rental income and County capital maintenance funds.

Days in AR were 58.8 combined; 51 in the Hospital and 58 in the Clinic.

REDUCTION OF REVENUE. Deductions from revenue were booked at 52.9% for June and 49.3% year-to-date. Reductions of revenue came in over budget $454,663 for June and ended the year over budget $3,957,079. As June is the last month of the fiscal year, we made the needed adjustment to reductions to increase our allowance estimate on the balance sheet. We had recognized in May that we would need to make this adjustment in June to make sure our AR is reserved adequately for year-end. The audit model for reduction of revenue and balance sheet allowance reserves for year-end calculates to 49.3% for reductions and 47.6% for balance sheet reserves, a difference of 1.7%. The auditors recommend we are within a 2-3% variance. The audit will include a detailed analysis of our reserves which may result in additional adjustments.

- The 3.45% increase in Medicare payor mix this fiscal year resulted in the following:
    - Medicare gross revenue increased $7.4 million from FY18
    - Medicare write offs increased $3.9 million from FY18
    - Medicare collections increased $3.1 million from FY18
    - Medicare accounts receivable at year end increased $824,131 from FY18

- The 4.45% decrease in Blue Cross and Commercial payor mix this fiscal year resulted in the following:
    - Gross revenue decreased $3.9 million from FY18
    - Write offs decreased $732,860 from FY18
    - Collections decreased $4.1 million from FY18
    - Accounts receivable at year end increased $410,512 due to the delayed payments from BCBS

While the combined outcome from the change in our top three payors was only $1 million in cash, the net increase to reduction of revenue was $3.2 million, which directly affected the bottom line. We budgeted FY19 reductions of revenue using FY18 actuals. Reductions were budgeted at 46.9% for FY19 as compared to actual of 46.5% in FY18.

EXPENSES. Total expenses for the month were $7,120,832, under budget by $230,244. YTD expenses came in under budget by $2,055,419. The following are the year-end variances for expense categories in FY19:

Salary & Wages – This expense is under budget by $658,558. Budgeted paid FTEs came in under budget by 7.87.
Fringe Benefits – This expense is under budget by $316,931. Group health claims came in under budget by $247,824. FICA, disability and unemployment also came in under budget while retirement expense was over budget for the year.
Contract Labor – This expense is over budget by $206,643 for the year. Contract labor was used in Behavioral Health, OB, ICU,Surgery, Emergency Room, Laboratory, Ultrasound, Respiratory, Infection Control and BioMed.
Physician Fees – This expense ended the year under budget $14,712.
Other Purchased Services – This expense came in under budget $490,246. Most subcategories came in at or under budget including consulting, advertising, legal fees, bank fees and collection agency. Lab send out testing came in over budget for the year due to the increase in lab volumes.
Supplies – This expense came in under budget $769,229 for the year. Over budget expenses include radioactive materials, lab supplies, blood, implants, med/surg supplies, maintenance and outdated supplies. Expenses under budget include patient chargeables, drugs, minor equipment, office supplies and non med/surg supplies.
Utilities – This expense came in under budget for the year $43,065. All utilities were under budget except telephone and sewer expense.
Repairs and Maintenance – This expense is over budget by $147,347 year to date. Reimbursement from the County maintenance fund of $607,635 was

received during the fiscal year. These funds are reported under other operating revenue and not an offset to expenses.
Insurance – This expense is over budget $13,186.
Other Operating expenses – This expense is under budget $95,601 year to date. Postage, freight, memberships, software and employee recruitment were over budget. Education & travel and physician recruitment came in under budget for the fiscal year.
Leases and Rentals - This expense is over budget $154,824 year to date. Equipment rent lease came in over budget due to the end of term on two leases that are being paid monthly until a fair market value contract is approved.
Depreciation – This expense is under budget $189,078. Capital purchases of $2,662,860 were approved of the $3 million budget. Additionally, the Foundation purchased $179,154 in capital equipment and County funds of $692,064 were used for capital projects.

Collections for the month of June were $7,166,619 and $81,332,164 year-to-date. The Days of Cash on Hand are at 135 in June, up 5 days from last month.

Annual Debt Service Coverage came in at 3.76.

CLINIC. The bottom line for the Provider Clinic for June was a loss of $495,282, compared to a loss of $452,523 in the budget. The YTD net operating loss is $5,521,305, compared to a loss of $5,432,073 in the budget and a loss of $7,220,859 in the prior year.

OUTLOOK FOR JULY. Gross patient revenue is projecting to come in at $14.6m, which is right at budget, net revenue is projecting to $7.3m, which is under budget. Collections are projecting to come in around $6.1m. With expenses expected to come in under budget at $7.4m, we are projecting to a slight loss in the month of July.

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
FINANCE & AUDIT COMMITTEE AGENDA

Wednesday ~ July 31, 2019 4:00 p.m. Classrooms 1 & 2

Voting Members:
Marty Kelsey, Chairman
Richard Mathey
Irene Richardson
Tami Love
Jan Layne

Non-Voting Members:
Ron Cheese
Angel Bennett
Rich Tyler
Dr. Augusto Jamias
Kristy Nielson
Kari Quickenden
Suzan Campbell
Dr. Larry Lauridsen

Guests:
Jeff Smith, Commission
Kerry Downs
Jim Horan
Tasha Harris
Leslie Taylor

I. Call Meeting to Order — Marty Kelsey

II. Approve June 26, 2019 Meeting Minutes — Marty Kelsey

III. Capital Requests FY 20 — Marty Kelsey
A. Central Plant Upgrade project — Tami Love/Jim Horan

IV. Financial Report
A. FY2019 Year-End status — Tami Love
B. FY2020 Reduction of Revenue — Tami Love

V. Old Business
□. □C□S □pdates — Ron Cheese

VI. New Business
□. □ndependent □nsurance Consultant — □ami □ove
□. □inancial □orum □iscussion — Marty □elsey

VII. Adjournment — Marty Kelsey

Finance and Audit Comm Minutes June 26 2019 Draft

M□MOR□□ HOSP□□□ O□S WEETWATE R CO UNTY
□inance & □udit Committee Meeting
□une 26, 2019

□oting Mem□ers Present:
Mr. Marty □elsey, *Trustee - Chair*
Mr. □aylor □ones, *Trustee*
Ms. □rene Richardson, *CEO*
Ms. □ami □ove, *CFO*
Ms. □an □ayne, *Controller*

□on- □oting Mem□ers Present:
Mr. Ron Cheese, *Director of Patient Financial Services*
□r. □risty □ielson, *CNO*
Ms. □ngel □ennet, *Director of Materials*
□r. □arry □auridsen

□on- □oting Mem□ers □□sent:
Ms. Su□an Camp□ell, *Chief Legal Exec/General Counsel*
□r. □ugusto □amias
Mr. Rich □yler, *Director of Information Technology*
Ms. □ari □uic□enden, *CCO*

□uests:
Ms. □eslie □aylor, *Clinic Director*
Ms. □m□er □is□, *Director of Human Resources*
Mr. □oah □ewman, *HR Assistant*
Ms. Deb Sutton, *Director of Marketing & PR*

Call Meeting to Order

Mr. □elsey called the meeting to order.

Approve Meeting Minutes

A motion to approve the meeting minutes of May 29, 2019 as presented was made □y Mr. □ones; second □y Ms. Richardson. Motion carried.

Capital Requests

Ms. Sutton e□plained capital re□uest FY 20- for the we□site redesign and host service. Our current internet is outdated and hard to wor□ on. A patient friendly internet is needed to □etter serve our patients needs. □hree □uotes were o□tained. □he preferred vendor is Scorpion □igital. □hey offered more services and came in with the lowest overall price. Mr. □elsey as□ed if Ms. Sutton had considered hiring a we□master to □e on our staff. Ms. Sutton thought that it was a good idea, □ut that it would delay updating the internet even longer. Ms. Sutton e□plained that this contract is for 3 years. Mr. □elsey as□ed if we had the option to opt out early. Ms. Sutton said that we would only have to give a 30 day notice to terminate the contract. □he motion to approve the re□uest to forward to the full □oard was made □y Mr. □ones; second □y Ms. Richardson. Motion carried.

Ms. □is□presented FY 20- for a we□site design for an intranet upgrade. Ms. □is□e□plained that our current intranet is in need of an upgrade. □t is very hard to administer and the support is very

costly and not very helpful. They have had several suggestions from staff leadership and oard mem ers on the need to update. he motion to approve the re uest to forward to the full oard was made y Mr. ones second y Ms. ayne. Motion carried.

Mr. elsey commented that he was very than ful for the new capital summary. t was very easy to read.

Financial Report

Monthly inance Statements Statistical ata

Ms. ove reviewed the narratives included in the meeting pac et. Mr. elsey as ed Ms. ove to give an e planation of the May financials. Ms. ove e plained that we use a model given to us y the auditors to determine our amount of reduction of revenue. e were off 900 000 in May and too 400 000 of that. e will need to ta e more in une. Mr. elsey noted that the gross revenue is close to udget ut the reduction of revenue is over 1 million for the month. Ms. ove e plained that the pro lems this year with collecting Medicare and lue Cross lue Shield made it difficult in determining our reduction level each month. e have also had a change with the Medicare payor mi increasing and the Commercial and CS decreasing. Mr. ones as ed if we are going to have a 700 000 loss every month. Ms. ove said that une will pro a ly e a out the same loss and she is not sure a out uly yet. Mr. elsey as ed how confident Ms. ove was with the udgeted 4 7 reduction in revenue for 20. Ms. ove said that she thin s it will run closer to 49 . Mr. ones said we need to have a plan if this is the new norm. Ms. aylor e plained that they are currently wor ing on an insurance optimi ation plan to help save money on drugs that the insurance does not cover. Mr. ones as ed how long efore we see the savings. Ms. aylor said they are ust now deciding on what company they want to use.

Mr. elsey said that typically we do not have a inance Meeting in uly. He thin s we need to have one this year. He said that we have a hard time controlling our revenue and that our only control is through the e penses. Mr. ones said that we have already whittled down our e penses. hey would li e to discuss a plan.

Ms. Richardson said that they are thin ing a out shifting the program to include the revenue cycle. She mentioned that other hospitals have done this and it seems to e wor ing for them.

Ms. aylor mentioned that the clinic was down in revenue due to many providers eing out on vacation. She also said that the clinic illing did a great o at ringing the days in R from to 72 to 56. Mr. ones as ed if monthly goals are set for the collectors. Mr. Cheese said that he has goals for his staff and that they meet monthly to discuss.

Mr. elsey as ed if there was an update on the ad de t uestion from last month. Ms. Richardson said that she reached out to yoming Hospital ssociation and that we are not o ligated to follow it. She said that oard mem er d ardoni as ed if we would consider adding the num er of accounts turned the largest amount turned the smallest amount turned and the mean and median to our ad de t reports.

Other □usiness

Mr. Cheese distri□uted the potential □ad de□t information for review.

Mr. Cheese gave an update on □C□S. He said that we called them last □riday and as□ed if we could □e paid □y □une 30th. □C□S e□plained that they are wor□ing the old claims first. Mr. Cheese said that we still have □1.6 million outstanding in old claims. Ms. Richardson said that P□S is wor□ing with □C□S □y showing them claims that should not □e denied. Mr. □elsey suggested to call the □yoming State □nsurance Commission to see if they are aware of the pro□lem. He thin□s there is a need for regulatory oversite.

Mr. □elsey stated that the ne□t meeting will □e □uly 31st.

New Business

□inancial □orum □iscussion

□ ith no further □usiness□the meeting ad□ourned at 5:30PM.

Submitted by Jan Layne

Capital Requests FY 20

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
FINANCE & AUDIT COMMITTEE
CAPITAL EXPENDITURE REQUESTS

WEDNESDAY ~ July 31, 2019

	YTD CAPITAL APPROVED	GRANT OR DONATION REIMBURSED	2020 APPROVED BUDGET	REMAINING YTD BALANCE
As of June 2019	54,475.00	-	3,000,000.00	2,945,525.00

CAPITAL REQUEST #	REQUESTED ITEM/REQUESTOR	CAPITAL AMOUNT TO BE APPROVED	MAINTENANCE SUPPORT COSTS	FREIGHT COSTS	TOTAL AMOUNT	COMMENTS
FY20-3	Harris QCPR 6.3 Upgrade with Linux server conversion Rich Tyler	74,561.00	14,070.00		88,631.00	
FY20-5	GE Optima CT850 RT-16 - FMV lease buyout Tasha Harris	225,000.00			225,000.00	
FY20-8	MD-Staff Credentialing & Provider Enrollment Software Kerry Downs	44,900.00			44,900.00	
	TOTAL AMOUNT REQUESTED	344,461.00	14,070.00	-	358,531.00	

FY20-3 QCPR upgrade 6.3

Capital Request Summary

Capital Request #

FY20 - 3

Name of Capital Request:

Harris QCPR 6.3 upgrade with Linux server conversion

Requestor/Department:

Rich Tyler – IT

Sole Source Purchase: Yes or No

Reason: QCPR is our current patient medical record and this request is to upgrade to the latest version

Quotes/Bids/ Proposals received:

	Vendor	City	Amount
1.	Harris Healthcare	Herndon, VA	$88,631.00
2.			
3.			

Recommendation:

Harris Healthcare - $88,631.00

Memorial Hospital
OF SWEETWATER COUNTY

		# Assigned: FY -
Capital Request		
Instructions: YOU MUST USE THE TAB KEY *to navigate around this form to maintain the form's integrity.* **Note:** When appropriate, attach additional information such as justification, underlying assumptions, multi-year projections and anything else that will help support this expenditure. Print out form and attach quotes and supporting documentation.		
Department: IT	**Submitted by:** Rich Tyler	**Date:** 06/26/19
Provide a detailed description of the capital expenditure requested: QCPR electronic health record software update - version 6.3		
Preferred Vendor: Harris Healthcare		
Total estimated cost of project *(Check all required components and list related expense)*		
1. Renovation		$
2. Equipment		$ 39,870.00 upgrade fees
3. Installation		$ 23,000.00 server migration
4. Shipping		$
5. Accessories		$
6. Training		$
7. Travel costs		$ 11,691.00 annual Linux licensing
8. Other e.g. interfaces		$ 14,070.00 annual QCPR support
	Total Costs (add 1-8)	$ 88,631.00
Does the requested item:		
Require annual contract renewal? ☒ YES ☐ NO		
Fit into existing space? ☒ YES ☐ NO	Explain:	
Attach to a new service? ☐ YES ☒ NO	Explain:	
Require physical plan modifications? If yes, list to the right: ☐ YES ☒ NO	Electrical HVAC Safety Plumbing Infrastructure (I/S cabling, software, etc.)	$ $ $ $ $
Annualized impact on operations (if applicable): **Increases/Decreases**		**Budgeted Item:**
Projected Annual Procedures (NEW not existing)		☒ YES ☐ NO
Revenue per procedure	$	# of bids obtained? 0
Projected gross revenue	$	
Projected net revenue	$	☐ Copies and/or Summary attached.
Projected Additional FTE's		**If no other bids obtained, reason:**
Salaries	$	current EHR to be upgraded
Benefits	$	
Maintenance	$	
Supplies	$	
Total Annual Expenses	$	
Net Income/(loss) from new service	$	
Review and Approvals		
Submitted by: Rich Tyler	Verified enough Capital to purchase	
Department Leader	☐ YES ☐ NO	
Vice President of Operations	☐ YES ☐ NO	
Chief Financial Officer	☒ YES ☐ NO	
Chief Executive Officer	☒ YES ☐ NO	
Board of Trustees Representative	☐ YES ☐ NO	

OTHER CONSIDERATIONS

This request is to upgrade our current Quadramed QCPR electronic health record software to the latest version of 6.3. We are currently on version 6.2 and it will stop being supported at the end of 2019. The upgrade project timeline is 15 weeks in duration.

We will also need to migrate our QCPR servers to Linux with this version upgrade. The annual licensing for Linux through Red Hat is $11,691.

Capital upgrade - $39,870.00
Capital migration - $23,000.00
Licensing - $11,691.00
Support - $14,070.00
Total - $88,631.00

Submitted by: Signature

Date

HARRIS HEALTHCARE

Supplemental Service Form

Memorial Hospital of Sweetwater County
1200 College Dr
Rock Springs, WY 82901-5868

Case ID: CAS-280275-W8Y9R2
Client Contact: Rich Tyler
Product: Professional Services
Service: Full-Service Linux Migration
Client Phone: 307-352-8409
Harris Contact: Brian Wahlstrom

STATEMENT OF WORK

Summary: Full-Service AIX to Linux Migration

Details: See attached SOW and steps from ATS Services

COST

Fixed Fee: $23,000
Estimated By: Brett Chambers

This quote will expire on: 8/31/2019

CLIENT ADMINISTRATIVE APPROVAL

Print Name: _____ **Email Address:** _____

Title: _____ **Fax Number:** _____

Signature: _____ **Date:** _____

Email signed Supplemental Service Form to SSFGroup@harriscomputer.com or fax to 703-709-2490

This Supplemental Service Form (SSF) is governed by an existing contract between QuadraMed Affinity Corporation (herein referred to as "Licensor") and Client, except this form is specific. The limit of liability of Client and Licensor is the fee stated in this form. This signed SSF must be returned by the expiration date or the fee is subject to increase. For all services totaling less than $10,000, not including Time and Materials (T&M), 100% of the SSF fee is due and payable upon execution of the SSF. For Services totaling $10,000 or greater but less than $100,000, 50% of the total fee is due and payable upon execution and the remaining 50% of the SSF is due and payable upon completion of the services. For Time and Materials, Licensor will bill Client monthly for services as incurred, unless otherwise specified. Licensor will begin work within sixty (60) days (the Commencement Date) of receipt of the execution payment and the work shall be deemed complete within one-hundred and twenty (120) days after the Commencement Date unless otherwise specified within description section of the SSF. Client will make its required resources available to Licensor on or before the Commencement Date. Any modifications or additions to specifications are subject to additional fees. Client is responsible for any and all fees associated with changes in travel arrangements due to the client's cancellation and/or rebooking of services.

HARRIS HEALTHCARE

QCPR 6.3 Upgrade

Harris Healthcare Pricing Proposal

April 23, 2019

HARRIS HEALTHCARE

April 23, 2019

Rich Tyler
Director of IT
Memorial Hospital of Sweetwater County
1200 College Drive
Rock Springs, WY 82901 USA
(307) 362-3711
rtyler@sweetwatermemorial.com

Subject: QCPR 6.3 Enhancement - Pricing Proposal

Thank you for your interest in QCPR's software v. 6.3, which will become available in Q3-Q4, 2019. This proposal provides high-level information on the new functionality included in this release, an overview of the associated Professional Services as well as pricing.

Harris Healthcare is working with Wolters Kluwer to incorporate their latest drug database **Medi-Span Clinical APIs,** which will bring advanced functionality and enhanced content to QCPR.

Medi-Span Clinical APIs includes improved performance, zero downtime for monthly updates, and additional medication advisory screening alerts. Medi-Span's Route Contraindication, Dosing Ingredient (for Acetaminophen daily dose across medication orders), Duplicate Therapy screening is available from Order Entry and Department Order Review applications.

Below is a comparison table of the advisory alert screening available in the Medi-Span Drug Information Bridge API used until now by US clients and the new Medi-Span Clinical APIs go forward drug database. Medi-Span Clinical APIs offers multiple **new advisory screening capabilities:**

Advisory Screening	*QCPR Order Entry* **Medi-Span DIB (Drug Information Bridge) API**	*QCPR Order Entry and Novus Meds* **Medi-Span Clinical API's**
Prior Adverse Reaction	✓	✓
Drug-Drug	✓	✓
Drug-Food	✓	✓
Drug-Alcohol	✓	✓
Drug-Disease	✓ (SNOMED CT, ICD-9)	✓ (SNOMED CT, ICD-9, ICD-10)
Drug PLAG (Pregnancy, Lactation, Age, Gender)	✓	✓
Dosing	✓ (Age, Weight, BSA, Renal)	✓ (Age, Weight, BSA, Renal)
Route Contraindication	--	✓
Dose Ingredient (Acetaminophen)	--	✓

IV Compatibility	✓	✓
Medication Leaflets, (IPE-ML) *	✓	✓
Duplicate Therapy by Class	--	✓
Latency Screening	--	✓

***Patient Education Medication Leaflets – Lexicomp**:

The Integrated Patient Education–Medication Leaflets (IPE-ML) provide Adult education leaflets in English, Spanish and French language and are available to QCPR customers at no extra cost with Medi-Span Clinical API's (6.3). QCPR clients interested in the full Lexicomp online full subscription can contact Mr. Ryan V. Smith, VP, EMR Partner Development and Clinical Effectiveness, at Wolters Kluwer via email: ryan.v.smith@wolterskluwer.com

As indicated in the above table, Medi-Span Clinical APIs will provide enhanced advisory screening for all QCPR clients ensuring the right medication for the patient. It will also provide product information:

- Therapeutic Classification (Medi-Span TCS)
- Restriction Codes (Controlled Substances)
- Brand / Generic drug relationships
- Active Package Product indicators
- Display the RxNorm numbers

Furthermore, QCPR 6.3 will include key **Patient Demographic enhancements:**

Gender and sex are two, commonly used and **often interchanged**, terms for classifying males and females. The World Health Organization (WHO) defines sex as the biological characteristics that define humans as female or male. While the biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males or females. Gender, on the other hand, is described by the WHO as the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women. The distinction made between patient gender identity and patient birth sex helps to improve the quality of patient care.

In this release, the **Patient Sex data element has been renamed Patient Birth Sex** in the Registration Screen Sequence and QCPR has been enhanced to support additional birth sex options. In addition, the terms gender and sex have been streamlined throughout the application and the word Sex replaces the word Gender in QCPR fields, headers, and columns.

A loop has been created and must be run to rename the Patient Sex data element on registration screens to Patient Birth Sex. The loop ensures backward compatibility as the internal values of (M) Male, (F) Female and (U) Unknown continue to display as options when defining the Patient Birth Sex data element in the Registration Screen Sequence Table.

There is also **a new Patient Gender Identify data element** allowing the documentation of what gender a patient identifies with, independently of their Birth Sex. In addition, new Ethnicity and Race data elements, which both use the Controlled Medical Vocabulary data element for registration, have been added in v 6.3.

Furthermore, QCPR 6.3 will include several other enhancements listed here below. Information that is more detailed will be provided on these, as we get closer to the release date.

Additional enhancements in 6.3:

- **Interoperability** - New C-CDA version 2.1 with enhanced / new C-CDA sections and ability to translate
- **Novus ClinDoc -** Implementation of QCPR Document List within Novus ClinDoc including creation of the C-CDA
- **Novus ClinDoc -** Results Widget - Enhanced vitals, labs and radiology display of results, navigation and selection
- **Order Entry -** Compliance with regulatory requirement for advanced imaging ordering with Appropriate Use Criteria
- **Novus Meds -** Order Entry and Advisory Alert Enhancements
- **ePrescribing -** Upgrade of ePrescribing portal from Rcopia 3 to 4

6.3 Pre-requisite

A new Harris Intermediate Server Medi-Span Clinical (HISMC), middleware server cluster is required for the 6.3 /Medi-Span Clinical APIs upgrade. The HISMC server cluster will provide a High Availability (HA) environment and support zero downtime during "Monthly Updates". The HISMC recommended hardware specifications are found at the end of this document.

Novus Meds (Medication Order Entry + Medication Reconciliation) and Novus ClinDoc (Physician Documentation) both require the Harris Intermediate Server Medi-Span Clinical (HISMC). If you have already implemented either of these modules, the HISMC middleware server cluster discussed above is already in place.

The HISMC server cluster will provide a High Availability (HA) environment and support zero downtime during "Monthly Updates". The HISMC recommended hardware specifications are found at the end of this document.

The 6.3 development work is currently in progress and we will keep you apprised as the functionality is being finalized. Target availability is end of Q3-Q4, 2019. With the upgrade to Medi-Span Clinical API's, there will be a slight increase in your overall annual Medi-Span licensing fees. The Medi-Span fee shown in table is the total new fee, which will replace existing fees you are currently paying.

Please review the attached offering and do not hesitate to contact me if you have any further questions. I look forward to hearing back from you and to the collaborative work ahead.

Sincerely,

Brett A. Chambers
Client Development Leader
Harris Healthcare
800-393-0278 x74297 / bchambers@harriscomputer.com
HQ: Herndon, VA | https://www.harrishealthcare.com/

Table of Contents

QCPR 6.3 Pricing Memorial Hospital of Sweetwater County

Software Product / Service	Comment	Pricing	TOTAL
QCPR 6.3 license software enhancement	No software license fee	No extra cost	$0.00
Medi-Span Clinical API (3rd Party Wolters Kluwer) **Annual Fee**	Annual software maintenance fee for Wolters Kluwer license. *New fee is in lieu of current fee you are already paying, not in addition to it.		$14,070 / year
Required **Professional Services/Installation Fees** [1,3] **for total QCPR 6.3 Base Package** **One-time fee**	Includes Planning, Training, Configuration, Testing, End User Training, Go Live Support. Includes ATS time to install HISMC on one Development and 2 Production servers	$36,045 USD	$36,045 USD
Optional **Novus ClinDoc- Training for two enhancement content area** **One-time fee**	Novus Document List Application - Novus ClinDoc to include creation of the C-CDA ClinDoc Result Widget - Enhanced vitals, labs and radiology display of results, navigation and selection.	$1,350 USD	
Optional **Medi-Span Clinical US - Training of Medi-Span Clinical API/HISMC** **One-time fee**	Training of Medi-Span Clinical API/HISMC replacing Medi-Span Bridge API for US clients only	$675 USD	$675 USD
Optional **Novus Meds – Training on Novus Meds Enhancements** **One-time fee**	Training on the enhanced Novus Meds module for Order Entry and Advisory Alert Enhancements - Onsite	$5,400 USD	

Optional **Rcopia 3 to 4 Upgrade** **(US eRX Clients only)** **One-time fee**	Training for current US eRX clients - This is an upgrade to the portal from Rcopia 3 to 4. Onsite	$1,800 USD	$1,800 USD
Optional **Radiology AUC** **One-time fee**	Training on the configuration and use to enable compliance with the regulatory requirement for Advanced imaging ordering with Appropriate Use Criteria - Remote	$1,350 USD	$1,350 USD
Year 1 Total	Medi-Span Clinical API Annual fee year 1 + Professional Services		$53,940
Year 2 and beyond	Annual Service fee	$14,070/year	$14,070/year

Notes:

[1] *See description of Professional Services / Installation fees included below.*

[2] *Pricing expires 8.1.2019*

[3] *Harris Healthcare employee travel and related expenses are billable*

PROFESSIONAL SERVICES DESCRIPTION QCPR 6.3

Scope of Work – Implementation of QCPR 6.3

I. SCOPE STATEMENT

The purpose of this statement of work is to provide education, configuration assistance and support for the Canadian clients to move to 6.3 and from the Medi Span API to the Medi Span Clinical API application for use within QCPR.

II. PROJECT TIMELINE

This engagement will be 15 weeks in duration. If the CLIENT'S timeline extends or delays, additional services would be required under a separate Agreement.

III. PRE-REQUISITES

List any Pre-Requisites pertinent to this engagement

- Hardware for Harris Intermediate Medi-Span Clinical (HISMC) and servers installed
- QCPR version 6.3 in the client Development area
- Room/equipment to perform service offering
- Staff available for education, configuration, testing and go live support.

IV. DELIVERABLES

Harris Healthcare will:

- Provide remote project management support for resource scheduling, issues management, and project reporting.
- Install QCPR version 6.3 for the implementation.
- Conduct remote training for:
  - MS Clinical API
  - Database Configuration for QCPR version 6.3
- Remote support during the client configuration and testing to assist with configuration, issues and testing.
- Dedicated remote go live support during the version go live.

V. ITEMS OUT-OF-SCOPE

Harris Healthcare will not perform the following activities during this engagement:

- Perform, enter/result, or modify patient data or results in the Production environment
- Testing the system
- Report Development/Modification
- Data Conversions
- Interface Development/Modification
- Data Warehouse Development

If above services are requested, a separate Agreement or change control will be required

VI. RISKS

Risk for this project may include:

- Failure of project scope to be clearly defined, understood, documented and agreed upon by all parties.
- Lack of adherence to escalation pathway
- Lack of resources with appropriate skills and/or empowered with decision making capabilities committed to the project and available for the duration of the project
- Conflicts with other projects

VII. REQUIREMENTS OF CLIENT PERSONNEL – CLIENT LEADERSHIP

- Provide background information on organizations objectives
- Provide appropriate resources to implement application, workflow, process and database changes as necessary to support the project
- Provide appropriate resources to support thoroughly testing the system
- Provide appropriate resources to support Go-Live operations of features and functions

PAYMENT TERMS

Upon Execution of the Agreement, Harris Healthcare shall invoice CLIENT based on the following schedule:

License (with install)	Not applicable for this upgrade
Installation, Services and Training	50% upon execution of this agreement 25% the earlier of completion of the Client training for MS Clinical or 6 weeks post execution. 25% the earlier of go live or 14 weeks post execution. Any services requested thereafter are available at Harris Healthcare's current rates
Annual Support	100% annually in advance upon Live
Third-Party Software	100% on Execution
Hardware Purchase through Harris	100% on Execution

Notes: For the purposes of this document, the following definition shall apply: "Execution" means the date Client's representative, so duly authorized, signs this document, accepting the terms set forth.

APPENDIX A

Hardware and Software requirements for Harris Intermediate Medi-Span Clinical (HISMC) HA server needed for Wolters-Kluwer Health® Medi-Span Clinical API

The following two server frames require a High Availability Service Level for Production Environments and may be implemented using Hardware Assisted Virtual Machine Technology to emulate abstract platform-independent Operating System program execution. Virtualization is controlled through an administrative Hypervisor, using Red Hat Enterprise Virtualization (RHEV®), VMware ESXi 6.0®, or Microsoft Hyper-V 2016-CB® compliant with Microsoft Server 64 bit 2016-CB Edition.

Platform requirements for additional Harris Healthcare add on products may be combined across a larger set of server frames when CPU and Memory requirements are maintained in accordance with the design requirements and Service Levels.

Harris Healthcare will utilize the Drug Knowledge Vendor Microsoft SQL Server 2016 SP1 Express-Wolters Kluwer Health® Medispan Clinical® beginning with QCPR 6.2. The product is known as HISMC.

A separate similarly configured server/VM is required for **Non-Production domains**.

CPU	• Dual-Core X86-64 3+ GHz or equivalent VM service level
RAM	• 32 GB or equivalent VM service level
Internal Disk Adapters	• (1) RAID1,5,6,10 controller with 4GB Battery Backup Write Cache
OS Disk Space	• 100 GB Equivalent SATA 10k RPM, Internal, Internal RAID1
Fiber	• (1) 8-Gigabit PCI dual-port fiber channel adapter / **Omit with Internal Disk**
Application Software Disk Space	• 100GB Equivalent SATA 10k RPM, Internal, Internal RAID1,5,6,10, or **Omit with SAN**
OS	• Microsoft Windows Server® 2016-CB 64-bit
VM Partition	• (1)
Network	• Gigabit Full Duplex Ethernet NIC or equivalent VMware service level
Applications	• Microsoft SQL Server 2016 SP1 Express or Microsoft SQL Server 2017 Express Advanced
	• Wolters Kluwer Health® Medi-Span® Services

	• .Net 3.5 SP and updates • .Net 4.5 SP and updates
	• Microsoft Internet Information Server® (IIS) service
	• Microsoft WebPI (Web Platform Installer)
	• NET-SNMP Simple Network Management Protocol (SNMP)

NON-DISCLOSURE AND DISCLAIMER STATEMENT

Any terms and conditions contained in the enclosed documents expire 90 days from the date that Harris Healthcare delivers these documents to the original recipient, unless they are extended or terminated earlier by written notice from Harris Healthcare to the original recipient.

The recipient of the enclosed documents acknowledges that any information provided by Harris Healthcare in the documents, including but not limited to any estimated, proposed or anticipated equipment, programs, features, services, pricing, work or billable hour amounts, and/or timing, is based on Harris Healthcare's understanding of the purposes for which Harris Healthcare is providing the documents as of the date the documents are provided. While Harris Healthcare believes such information to be reasonably accurate, no guarantees or warranties express or implied, are made at this time. In addition, if any purpose for which the documents are being furnished changes, or if Harris Healthcare ascertains new or additional information which modifies its understanding of any purpose, Harris Healthcare reserves the right to revise any part of the enclosed documents to reflect such change or new or additional information. In any event, no information provided by Harris Healthcare in the enclosed documents shall be binding on Harris Healthcare unless it is included in a final, definitive binding agreement that is formally negotiated and executed by Harris Healthcare and any relevant counterparties.

RED HAT STORE

Bill to

Rich Tyler
1200 College Drive
ROCK SPRINGS, WY 82901 US

3073528409
rtyler@sweetwatermemorial.com

Edit your address

Order summary

Subtotal:	US$11,691.00
Estimated tax:	US$0.00
Estimated total:	**US$11,691.00**

Credit card information

Please enter the first and last name of the person on the card.
Do not use the company name.

* First name

FY20-5 RadOnc CT FMV

Capital Request Summary

Capital Request #

FY20-5

Name of Capital Request:

GE Optima CT580 RT-16 – FMV lease buyout

Requestor/Department:

Tasha Harris – Radiation Oncology

Sole Source Purchase: Yes or No

Reason: FMV lease buyout of current CT equipment

Quotes/Bids/ Proposals received:

	Vendor	City	Amount
1.	GE HFS, LLC	Brookfield, WI	$225,000.00
2.			
3.			

Recommendation:

GE HFS, LLC - $225,000.00

Memorial Hospital
OF SWEETWATER COUNTY

		# Assigned: FY 20 - 5
Capital Request		
Instructions: YOU MUST USE THE TAB KEY *to navigate around this form to maintain the form's integrity.* **Note:** When appropriate, attach additional information such as justification, underlying assumptions, multi-year projections and anything else that will help support this expenditure. Print out form and attach quotes and supporting documentation.		
Department: Radiation Oncology	**Submitted by:** Tami Love	**Date:** 07/08/19
Provide a detailed description of the capital expenditure requested: GE Optima CT580 RT-16 - FMV lease buyout		
Preferred Vendor: GE Healthcare Financing Services		
Total estimated cost of project *(Check all required components and list related expense)*		
1. Renovation		$
2. Equipment		$ 225,000.00
3. Installation		$
4. Shipping		$
5. Accessories		$
6. Training		$
7. Travel costs		$
8. Other e.g. interfaces		$
	Total Costs (add 1-8)	$ 225,000.00
Does the requested item:		
Require annual contract renewal? ■ YES ☐ NO		
Fit into existing space? ■ YES ☐ NO	Explain:	
Attach to a new service? ☐ YES ■ NO	Explain:	
Require physical plan modifications? If yes, list to the right: ☐ YES ■ NO	Electrical HVAC Safety Plumbing Infrastructure (I/S cabling, software, etc.)	$ $ $ $ $
Annualized impact on operations (if applicable): **Increases/Decreases**		**Budgeted Item:**
Projected Annual Procedures (NEW not existing)		■ YES ☐ NO
Revenue per procedure	$	# of bids obtained? 0
Projected gross revenue	$	
Projected net revenue	$	☐ Copies and/or Summary attached.
Projected Additional FTE's		**If no other bids obtained, reason:**
Salaries	$	FMV lease buyout of current equipment
Benefits	$	
Maintenance	$	
Supplies	$	
Total Annual Expenses	$	
Net Income/(loss) from new service	$	
Review and Approvals		
Submitted by: Rich Tyler	Verified enough Capital to purchase	
Department Leader	☐ YES ☐ NO	
Vice President of Operations	☐ YES ☐ NO	
Chief Financial Officer	■ YES ☐ NO	
Chief Executive Officer	☒ YES ☐ NO	
Board of Trustees Representative	☐ YES ☐ NO	

OTHER CONSIDERATIONS

Original 60 month lease date was 04/22/2014. The equipment does not need to be replaced at this time due to limited usage of the machine and no immediate need for new technology. Options included the fair market value purchase of the equipment or the continued leasing on a month to month basis for $8,622/month. Based on usage, we expect this piece of equipment to be useful for another 4-5 years.

Capital $225,000.00

Submitted by: Signature

Date

Asset Management
David Kelsey
(214)483-1527

Quote Number: 5120

May 16, 2019

BOARD OF TRUSTEES OF THE MEMORIAL HOSPITAL OF SWEETWATER COUNTY
WATER COUNTY, P O BOX 1359
ROCK SPRINGS, WY 82902

GE HFS, LLC ("GEHFS") is pleased to submit the following proposal:

Contract Description:	True lease of equipment, account # 9752414001
Equipment Description:	GE OPTIMA CT580 RT-16
End of Term Date:	May 15, 2019
End of Lease Options:	_____ 12 months at $8,622.00 per month, plus applicable taxes. _____ Purchase the equipment for $225,000.00, plus applicable taxes. ** FMV Renewal Options assume that the Lessee is liable for all rents and other charges for periods prior to and including the Amendment August 15, 2019 (the "Amendment Effective Date"), plus applicable taxes and any maintenance service charges, including, to the extent applicable, all rents payable in arrears which relate to any period prior to and including the Amendment Effective Date even if billed after the Amendment Effective Date. GE HFS, LLC shall have the option to withdraw this if all amounts owed by Lessee to GE HFS, LLC have not been received promptly when due. GE HFS, LLC and Lessee agree that a signature affixed to any one of the originals and delivered by facsimile shall be valid, binding and enforceable. In addition to the above you may also return the equipment to GE HFS, LLC. Please refer to your master lease agreement for a complete description of the return requirements.
Terms and Conditions:	All other terms and conditions of the referenced lease contract shall continue in effect.
Documentation Fee:	A documentation fee of $200.00 will be charged to Lessee to cover document preparation, document transmittal, credit write-ups, lien searches and lien filing fees. The documentation fee is due upon Lessee's acceptance of this proposal and is non refundable. This fee is based on execution of our standard documents substantially in the form submitted by us. In the event significant revisions are made to our documents at your request or at the request of your legal counsel or your landlord or mortgagee or their counsel, the documentation fee will be adjusted accordingly to cover our additional costs and expenses.
Required Credit and Tax Information:	1. Year end audited/unaudited financial statements & comparative interim statements. 2. If non taxable entity, a current tax exemption certificate is due upon receipt of accepted proposal
Proposal Expiration:	This proposal and all of its terms shall expire on August 10, 2019 if GE HFS, LLC has not received Lessee's acceptance hereof by such date.

The summary of proposed terms and conditions set forth in this proposal is not intended to be all-inclusive. Any terms and conditions that are not specifically addressed herein would be subject to future negotiations. Moreover, by signing the proposal, the parties acknowledge that: (i) this proposal is not a binding commitment on the part of any person to provide or arrange for financing on the terms and conditions set forth herein or otherwise; (ii) any such commitment on the part of GE HFS, LLC would be in a separate written instrument signed by GE HFS, LLC following satisfactory completion of GE HFS, LLC' due diligence, internal review and approval process (which approvals have not yet been sought or obtained); (iii) this proposal supersedes any and all discussions and

understandings, written or oral between or among and any other person as to the subject matter hereof; and (iv)GE HFS, LLC may, at any level of its approval process, decline any further consideration of the proposed financing and terminate its credit review process. GE HFS, LLC' standard documents will be used.

Except as required by law, neither this proposal nor its contents will be disclosed publicly or privately except to those individuals who are your officers, employees or advisors who have a need to know as a result of being involved in the proposed transaction and then only on the condition that such matters may not be further disclosed. Notwithstanding the foregoing, there is no restriction (either express or implied) on any disclosure or dissemination of the tax structure or tax aspects of the transactions contemplated by this proposal. Further, GE HFS, LLC acknowledges that it has no proprietary rights to any tax matter or tax idea or to any element of the proposal's transaction structure.

You hereby authorize GE HFS, LLC to file in any jurisdiction as GE HFS, LLC deems necessary any initial uniform commercial code financing statements that identify the Equipment or any other assets subject to the proposed financing described herein. If for any reason the proposed transaction is not approved, upon your satisfaction in full of all obligations to GE HFS, LLC, will cause the termination of such financing statements. You acknowledge and agree that the execution of this proposal and the filing by GE HFS, LLC of such financing statements, in no way obligates GE HFS, LLC to provide the financing described herein.

We look forward to your early review and response. If there are any questions, we would appreciate the opportunity to discuss this proposal in more detail at your earliest convenience. Please do not hesitate to contact me directly at (214)483-1527.

Sincerely yours,

By: David Kelsey

Title: Senior Portfolio Manager

Acknowledged and Accepted:

_____
(Legal Name)

By:_____

Title:_____

Date:_____

Fed. ID #:_____

NOTICE

The Federal Equal Credit Opportunity Act prohibits creditors from discriminating against credit applicants on the basis of race, color, religion, national origin, sex, marital status, age (provided the applicant has the capacity to enter into a binding contract), because all or part of the applicant's income derives from any public assistance program, or because the applicant has in good faith exercised any right under the Consumer Credit Protection Act. The federal agency that administers compliance with this law is the Federal Trade Commission, Equal Credit Opportunity, Washington, DC 20580.

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FY20-8 credentialing software

Capital Request Summary

Capital Request #

FY20-8

Name of Capital Request:

MD-Staff Credentialing & Provider Enrollment Software

Requestor/Department:

Kerry Downs – Medical Staff Services

Sole Source Purchase: Yes or No

Reason:

Quotes/Bids/ Proposals received:

	Vendor	City	Amount
1.	Applied Statistics & Management	Temecula, CA	$41,400 software $0 first year support included $3,500 implementation $44,900 Total
2.	Verity	Louisville, CO	$31,500 software $18,900 annual maintenance $50,400 Total
3.	Cactus - Symplr	Berwyn, PA	$62,035 software $28,330 annual maintenance $90,865 Total

Recommendation:

Applied Statistics & Management – MD-Staff $44,900.00

Memorial Hospital
OF SWEETWATER COUNTY

		# Assigned: FY 20 - 8
Capital Request		
Instructions: YOU MUST USE THE TAB KEY *to navigate around this form to maintain the form's integrity.* **Note:** When appropriate, attach additional information such as justification, underlying assumptions, multi-year projections and anything else that will help support this expenditure. Print out form and attach quotes and supporting documentation.		
Department: Medical Staff Services	**Submitted by:** Kerry Downs	**Date:** 07/22/2019
Provide a detailed description of the capital expenditure requested: MD-Staff credentialing and provider enrollment software.		
Preferred Vendor: Applied Statistics & Management		
Total estimated cost of project *(Check all required components and list related expense)*		
1. Renovation		$ 0
2. Equipment		$ 41,400 (software modules)
3. Installation		$ 3,500 (implementation services)
4. Shipping		$
5. Accessories		$
6. Training		$ Included
7. Travel costs		$ 0
8. Other e.g. interfaces		$
	Total Costs (add 1-8)	$ 44,900
Does the requested item:		
Require annual contract renewal? ☒ YES ☐ NO		
Fit into existing space? ☒ YES ☐ NO	Explain:	
Attach to a new service? ☐ YES ☒ NO	Explain:	
Require physical plan modifications? If yes, list to the right: ☐ YES ☒ NO	Electrical HVAC Safety Plumbing Infrastructure (I/S cabling, software, etc.)	$ $ $ $ $
Annualized impact on operations (if applicable): **Increases/Decreases**		**Budgeted Item:**
Projected Annual Procedures (NEW not existing)		☒ YES ☐ NO
Revenue per procedure	$ 0	# of bids obtained? 3
Projected gross revenue	$ 0	
Projected net revenue	$ 0	☒ Copies and/or Summary attached.
Projected Additional FTE's		**If no other bids obtained, reason:**
Salaries	$	
Benefits	$	
Maintenance	$ 14,900	
Supplies	$	
Total Annual Expenses	$ 14,900	
Net Income/(loss) from new service	$	
Review and Approvals		
Submitted by:	Verified enough Capital to purchase	
Department Leader	☐ YES ☐ NO	
Vice President of Operations	☐ YES ☐ NO	
Chief Financial Officer	☐ YES ☐ NO	
Chief Executive Officer	☒ YES ☐ NO	
Board of Trustees Representative	☐ YES ☐ NO	

OTHER CONSIDERATIONS

Our current credentialing software is Midas Seeker. Midas will end maintenance and product support of Midas+ Seeker as of December 31, 2021. We already have been experiencing problems with Seeker, and anticipate that those problems or glitches will only get worse.

Currently, we have over 180 providers on the medical staff. Credentialing software is essential to the Medical Staff Services office. It provides a way to screen, track, and access information for each of our providers. With automated software, we can continuously screen each provider for new malpractice claims and to make sure they don't have Medicaid/Medicare sanctions. These are Joint Commission requirements.

Our physician privileges are out-of-date, and need to be standardized. MD-Staff offers drag-and-drop privileging, which allows each specialty to select their requested privileges. They are then built into a standardized format.

The on-line application module would allow our providers to apply for privileges on-line. The program also includes "hard-stops," which means that if a provider left a required application field blank, they wouldn't be able to continue or to submit the application until they complete the field. This could help improve our turn-around time and prevent us from having to repeatedly ask for or hunt down required information.

When a provider comes up for reappointment (every two years), the application module would pre-populate their information. They would only need to add any new information, or make changes, sign, and then submit. This would help to alleviate the delay for providers returning their reappointment applications.

The payor enrollment module would pre-populate payor applications and speed up the process of enrolling providers with Medicare, Medicaid, and other commercial insurance companies. This module also helps to track application process and status.

We have to replace our current software. With this web-based system (MD-Staff), we would not only replace it, but we would greatly improve our efficiency and compliance with regulatory requirements; decrease the time it takes to enroll providers with payors; and increase the medical staffs' satisfaction as it pertains to the reappointment process.

MD-Staff is web based. Training will be on-line and the software is deployed through the cloud. So there are no additional shipping, travel, or training costs. They offer 1, 3, and 5 year contracts. After the first year we will be charged an annual cost of $14,900.

Capital $44,900

Submitted by: Signature _____ Date _____

MD-Staff for the Web

Web-Based Credentialing System

Quote for:

Memorial Hospital of Sweetwater County

March 8, 2019

Applied Statistics & Management, Inc.
32848 Wolf Store Road
Temecula, CA 92592, USA

Confidentiality Statement

Contents

Quote #:	AS-2815
Expiration Date:	June 31, 2019
Please direct all inquiries regarding this quote to:	Nino Limatola nlimatola@mdstaff.com D: (951) 553-7618 C: (951) 303-4922

Executive Summary

MD-Staff for the Web

MD-Staff for the Web is a comprehensive credentialing system that includes all of the modules needed to streamline and automate the credentialing process. The foundation for MD-Staff for the Web is an extensive, highly relational database that stores nearly every data element relating to a provider. All of the modules in MD-Staff for the Web are built upon this single powerful database, thus allowing them to work seamlessly with each other. Unlike other credentialing systems, all of the modules are included in MD-Staff for the Web thus drastically reducing overall cost while providing the maximum amount of features.

The web-based version of MD-Staff for the Web is a feature rich enterprise level credentialing system, yet it is still very user friendly and intuitive. Based on our highly successful Windows version of MD-Staff, the web-based version takes usability to a new level by utilizing the most advanced web-based technologies to make the application fast, responsive and easy to understand. Along with being easy to use, MD-Staff for the Web also automates many tedious credentialing processes, thus drastically reducing workloads while increasing accuracy.

MD-Staff for the Web interfaces with numerous online verification sources in order to automate many of the verification processes. Verification can be done directly from MD-Staff for the Web for a single provider or a group of providers, drastically reducing the amount of time spent on verifying provider information. In order to further reduce the workload, batch verifications can be scheduled to run automatically on a monthly or weekly basis. With the ability to schedule automatic verifications, a provider's record can be verified and updated with no user intervention.

ASM

As the health care industry is forever evolving, the demand for advanced and innovative credentialing solutions is increasing. ASM is dedicated to creating software solutions that leverage the latest technologies and methodologies that help to improve the speed and accuracy of the credentialing process.

Customer service is an important component to any software product. ASM provides unparalleled support for all of its software products. Rather than simply providing technical support, ASM focuses on building relationships with its clients to provide the best possible service and support.

Proposed Solutions

Items	*Initial Cost*[1]	*Annual Cost*[1]
[X] **MD-Staff for the Web** • Web-based provider credentialing for One facility and 180 Providers. • Highly relational provider management database • Drag-and-drop privileging • Over 200 built-in reports, custom reports and ad hoc query writer • Online verifications: ABMS© Direct Connect Select, DEA, NPDB, OIG, EPLS/GSA, State Licensure Boards, NPI, etc.[2] • Customizable workflow/alarm module • Pronto electronic questionnaires • Batch mail merges with Microsoft Word • CME, Meetings and Committee modules • Unlimited number of users • Data Warehouse	**$18,900**	**$6,900**
[X] **E>Priv (MD-Staff portal)** • Provides house staff with live read-only access to the MD-Staff database • Displays provider data • Unlimited number of customizable E>Priv displays • Unlimited number of users • Displays photos, scanned documents and signatures	**Included**	**Included**
[X] **Payor Enrollment / Managed Care** • Prepopulate PDF payor applications • Track application process/status • Separate Facility/View for Managed Care • Contracts • Sites • Networks • Entities • Fee Schedules • Library of Reports/Directories	**$5,000**	**$2,000**

[X] **MD-App** • Paperless application • Request / Renew Privileges • Electronic Signatures via DocuSign* or AdobeSign* *Requires separate license and additional fees with DocuSign or AdobeSign • Attestation Questions • Initial and Reappointment Applications • Collect all information needed at one time • Integrates for import/export with MD-Staff	**$12,500**	**$4,000**
[X] **Virtual Committee** • Committee members may review selected records • Initial appointments or reappointments • Accessible from any computer with an internet connection • Committee members can review and comment on records when it is most convenient	**$5,000**	**$2,000**
[X] **MD-Query** • Allows Medical Staff Professionals to quickly and economically create their own "online verification" system • Customized website with your logo • Customized affiliation letter • Email notifications • Employs the latest security protocols • NAMSS-PASS Certified	**Included**	**Included**
[X] **MD-Directory** • Real-time integration with provider database • Public facing provider directory • Cross-browser compatibility	**Included**	**Included**
[X] **Direct Fax ($0.10 per page)** • Fax merge letters directly from MD-Staff • No additional hardware or fax server needed • View the fax status directly in MD-Staff	**$0.10 per page**	**$0.10 per page**

[X] **Implementation Services**[3] MD-Staff and E>Priv • System Configuration • Setup merge templates (up to 20) • Creation of privilege forms (up to 20) • One time, two-phase, data conversion of existing data Payor Enrollment / Managed Care • Map up to 10 additional PDF application forms MD-App • System configuration/customization for one initial and one re-appointment application process. (Note: this does not include configuring any PDF applications to be generated by MD-App, MD-Staff or any other related modules). • Customized website with your logo • Mdapp.com setup • Additional applications, pages or complexity requires a price increase based on a rate of $225 per hour • Hosting in ASM's secure data center Custom Reports • Additional reports/exports/imports requires a separate Statement of Work based on a rate of $225 per hour	**$3,500**	**N/A**
[X] **Training** • 10 hours of online training	**Included**	**N/A**
[X] **Support** • Toll-free Telephone and Email Support • Remote Assistance	**Included**	**Included**
Total Cost (with modules described above)	**$44,900**	**$14,900**

1. The initial cost includes the first year of annual cost(s). The annual cost is due on the anniversary of the due date of the initial cost.
2. Some online verifications require an account with a third party (e.g. ABMS©, NPDB, etc). Therefore, queries performed within MD-Staff involving a third party may incur a cost which is billed by the third party. ASM is not responsible for these costs.

3. Although ASM will make every reasonable effort to migrate all of the data from the source database, ASM cannot guarantee that every data element will convert to the new database.

FY2019 Year-End status

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WY

<u>NARRATIVE TO JUNE 2019 *PROJECTED* FINANCIAL STATEMENTS</u>

THE BOTTOM LINE. □he □ottom line from operations for □une was a loss of □755□071□compared to a gain of □227□713 in the □udget. □his yields a □11.9□ operating margin for the month compared to 3.0□ in the □udget. □he □□□ net operating gain is □141□053□compared to a gain of □1□709□309 in the □udget. □his represents a □□□ operating margin of 0.16□ compared with 1.□9□ in the □udget. □he total net gain □□□ is □1□06□□160□compared to □676□294 in the □udget. □his represents a □□□ total profit margin of 1.23□ compared to 0.75□ in the □udget.

REVENUE. Revenue for the month was □13□069□675□under □udget □y □707□325. □npatient revenue was under □udget □y □504□277□outpatient revenue was under □udget □y □27□□971 and the employed Provider Clinic was over □udget □y □75□923. □ear□to□date gross revenue was □164□916□540 compared to □164□9□4□757□under □udget □y □6□□217.

□et patient revenue for the month was □6□149□721□under □udget □y □1□161□9□□. □□□ net patient revenue was □93□600□1□4□under □udget □y □3□957□079.

Other operating revenue for the year was □3□173□4□2. □his includes County routine maintenance funds□□oundation unrestricted income□cafeteria revenue□occupation medicine industry contracts and collection agency interest income.

□on□operating revenue for the year was □927□106□over □udget □y □1□960□121. □his includes interest income and e□pense□special purpose ta□es□rental income and County capital maintenance funds.

□ays in □R were 5□.□com□ined□51 in the Hospital and 5□in the Clinic.

REDUCTION OF REVENUE. □eductions from revenue were □oo□ed at 52.9□ for □une and 49.3□ year□to□date. Reductions of revenue came in over □udget □454□663 for □une and ended the year over □udget □3□957□079. □s □une is the last month of the fiscal year□we made the needed ad□ustment to reductions to increase our allowance estimate on the □alance sheet. □ e had recogni□ed in May that we would need to ma□e this ad□ustment in □une to ma□e sure our □R is reserved ade□uately for year□end. □he audit model for reduction of revenue and □alance sheet allowance reserves for year□end calculates to 49.3□ for reductions and 47.6□ for □alance sheet reserves□a difference of 1.7□. □he auditors recommend we are within a 2□3□ variance. □he audit will include a detailed analysis of our reserves which may result in additional ad□ustments.

- The 3.45% increase in Medicare payor mix this fiscal year resulted in the following:
    - Medicare gross revenue increased $7.4 million from FY18
    - Medicare write offs increased $3.9 million from FY18
    - Medicare collections increased $3.1 million from FY18
    - Medicare accounts receivable at year end increased $2,241,131 from FY18

- The 4.45% decrease in Blue Cross and Commercial payor mix this fiscal year resulted in the following:
    - Gross revenue decreased $3.9 million from FY18
    - Write offs decreased $732,160 from FY18
    - Collections decreased $4.1 million from FY18
    - Accounts receivable at year end increased $410,512 due to the delayed payments from BCBS

While the combined outcome from the change in our top three payors was only $1 million in cash the net increase to reduction of revenue was $3.2 million which directly affected the bottom line. The budgeted FY19 reductions of revenue using FY18 actuals. Reductions were budgeted at 46.9% for FY19 as compared to actual of 46.5% in FY18.

EXPENSES. Total expenses for the month were $7,120,132 under budget by $230,244. YTD expenses came in under budget by $2,055,419. The following are the year end variances for expense categories in FY19:

Salary & Wages – This expense is under budget by $65,155. Budgeted paid FTEs came in under budget by 7.07.
Fringe Benefits – This expense is under budget by $316,931. Group health claims came in under budget by $247,124. FICA disability and unemployment also came in under budget while retirement expense was over budget for the year.
Contract Labor – This expense is over budget by $206,643 for the year. Contract labor was used in Behavioral Health ORs CCU Surgery Emergency Room Laboratory Ultrasound Respiratory Infection Control and BioMed.
Physician Fees – This expense ended the year under budget $14,712.
Other Purchased Services – This expense came in under budget $490,246. Most sub categories came in at or under budget including consulting advertising legal fees Plan fees and collection agency. Lab send out testing came in over budget for the year due to the increase in lab volumes.
Supplies – This expense came in under budget $769,229 for the year. Over budget expenses include radioactive materials lab supplies blood implants med/surg supplies maintenance and outdated supplies. Expenses under budget include patient chargeables drugs minor equipment office supplies and non med/surg supplies.
Utilities – This expense came in under budget for the year $43,065. All utilities were under budget except telephone and sewer expense.
Repairs and Maintenance – This expense is over budget by $147,347 year to date. Reimbursement from the County maintenance fund of $607,635 was

received during the fiscal year. □hese funds are reported under other operating revenue and not an offset to e□penses.

Insurance – □his e□pense is over □udget □13□1□6.

Other Operating expenses – □his e□pense is under □udget □95□601 year to date. Postage□freight□mem□erships□software and employee recruitment were over □udget. □ducation □ travel and physician recruitment came in under □udget for the fiscal year.

Leases and Rentals - □his e□pense is over □udget □154□□24 year to date. □□uipment rent lease came in over □udget due to the end of term on two leases that are □eing paid monthly until a fair mar□et value contract is approved.

Depreciation – □his e□pense is under □udget □1□9□07□. Capital purchases of □2□662□□60 were approved of the □3 million □udget. □dditionally□the □oundation purchased □179□154 in capital e□uipment and County funds of □692□064 were used for capital pro□ects.

Collections for the month of □une were □7□166□619 and □□1□332□164 year□to□date. □he □ays of Cash on Hand are at 135 in □une□up 5 days from last month.

□nnual □e□t Service Coverage came in at 3.76.

CLINIC. □he □ottom line for the Provider Clinic for □une was a loss of □495□2□2□ compared to a loss of □452□523 in the □udget. □he □□□ net operating loss is □5□521□305□ compared to a loss of □5□432□073 in the □udget and a loss of □7□220□□59 in the prior year.

OUTLOOK FOR JULY. □ross patient revenue is pro□ecting to come in at □14.6m□ which is right at □udget□net revenue is pro□ecting to □7.3m□which is under □udget. Collections are pro□ecting to come in around □6.1m. □ ith e□penses e□pected to come in under □udget at □7.4m□we are pro□ecting to a slight loss in the month of □uly.

MHSC Combined Financial Statements 063019 Preliminary

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WY

Unaudited Financial Statements

for

Twelve months ended June 30, 2019

Certification Statement:

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

Certified by:

Tami Love

Chief Financial Officer

MEMORIAL HOSPITAL OF SWEETWATER COUNTY **PAGE 1**
ROCK SPRINGS, WY
Twelve months ended June 30, 2019

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MEMORIAL HOSPITAL OF SWEETWATER COUNTY

EXECUTIVE FINANCIAL SUMMARY

Twelve months ended June 30, 2019

BALANCE SHEET

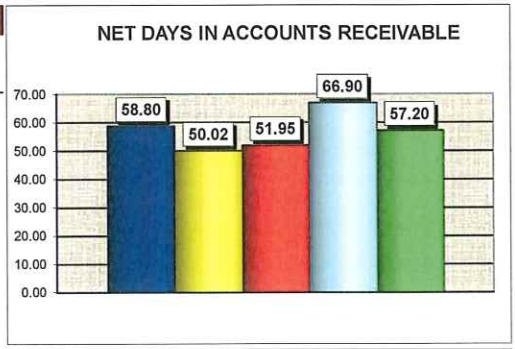
	YTD 6/30/2019	Prior FYE 6/30/2018
ASSETS		
Current Assets	$29,841,920	$32,985,887
Assets Whose Use is Limited	22,466,542	16,103,800
Property, Plant & Equipment (Net)	63,726,102	68,224,600
Other Assets	234,709	247,062
Total Unrestricted Assets	**116,269,273**	**117,561,349**
Restricted Assets	256,963	426,203
Total Assets	**$116,526,235**	**$117,987,552**
LIABILITIES AND NET ASSETS		
Current Liabilities	$7,491,981	$9,791,188
Long-Term Debt	27,858,240	27,915,983
Other Long-Term Liabilities	747,408	1,070,720
Total Liabilities	**36,097,629**	**38,777,891**
Net Assets	80,428,606	79,209,661
Total Liabilities and Net Assets	**$116,526,235**	**$117,987,552**

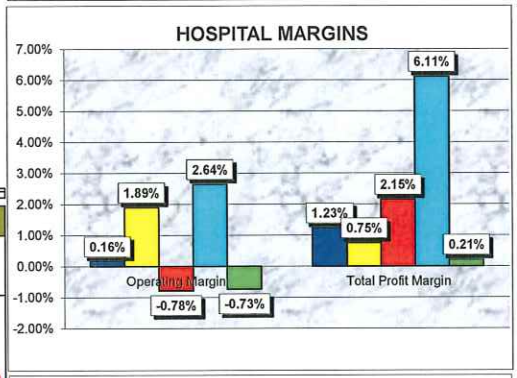
STATEMENT OF REVENUE AND EXPENSES - YTD

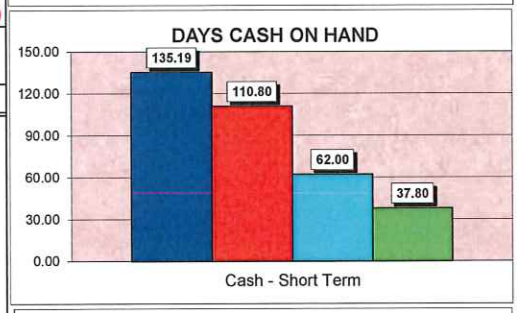
	06/30/19 ACTUAL	*06/30/19 BUDGET*	*YTD ACTUAL*	*YTD BUDGET*
Revenue:				
Gross Patient Revenues	$13,069,675	$13,777,000	$164,916,540	$164,984,757
Deductions From Revenue	(6,919,954)	(6,465,290)	(81,316,356)	(77,427,494)
Net Patient Revenues	6,149,721	7,311,709	83,600,184	87,557,263
Other Operating Revenue	216,040	267,080	3,173,482	2,840,078
Total Operating Revenues	**6,365,762**	**7,578,789**	**86,773,666**	**90,397,341**
Expenses:				
Salaries, Benefits & Contract Labor	3,942,675	4,014,215	48,206,318	48,975,163
Purchased Serv. & Physician Fees	849,198	832,253	8,437,374	8,942,332
Supply Expenses	866,426	1,152,219	13,044,020	13,813,249
Other Operating Expenses	881,137	783,258	9,736,213	9,559,521
Bad Debt Expense	0	0	0	0
Depreciation & Interest Expense	581,397	569,130	7,208,688	7,397,767
Total Expenses	**7,120,832**	**7,351,076**	**86,632,613**	**88,688,032**
NET OPERATING SURPLUS	**(755,071)**	**227,713**	**141,053**	**1,709,309**
Non-Operating Revenue/(Exp.)	116,526	(17,336)	927,106	(1,033,015)
TOTAL NET SURPLUS	**($638,545)**	**$210,377**	**$1,068,160**	**$676,294**

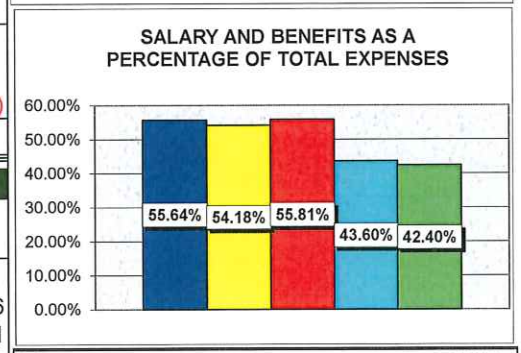
KEY STATISTICS AND RATIOS

	06/30/19 ACTUAL	*06/30/19 BUDGET*	*YTD ACTUAL*	*YTD BUDGET*
Total Acute Patient Days	299	342	4,597	4,234
Average Acute Length of Stay	2.7	2.4	2.9	2.6
Total Emergency Room Visits	1,282	1,326	16,246	16,361
Outpatient Visits	7,363	6,370	87,445	76,842
Total Surgeries	156	151	1,935	2,081
Total Worked FTE's	405.91	427.27	414.01	427.27
Total Paid FTE's	462.19	464.23	456.36	464.23
Net Revenue Change from Prior Yr	-15.82%	0.22%	-0.39%	3.77%
EBIDA - 12 Month Rolling Average			8.20%	10.07%
Current Ratio			3.98	
Days Expense in Accounts Payable			26.30	









MEMORIAL HOSPITAL OF SWEETWATER COUNTY	
Budget	06/30/19
Prior Fiscal Year End	06/30/18
WYOMING	All Hospitals
< $90M Net Rev.	Rural

FINANCIAL STRENGTH INDEX - 0.73

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

Key Financial Ratios

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WY
Twelve months ended June 30, 2019

⇩ ⇧ **- DESIRED POSITION IN RELATION TO BENCHMARKS AND BUDGET**

		Year to Date 6/30/2019	Budget 6/30/2019	BB+ Credit Rating	BBB- Credit Rating	Prior Fiscal Year End 06/30/18	WYOMING All Hospitals (See Note 1)	National Rural < $90M Net Rev. (See Note 2)
Profitability:								
Operating Margin	⇧	0.16%	1.90%	0.10%	0.30%	-0.78%	2.64%	-0.73%
Total Profit Margin	⇧	1.23%	0.76%	0.80%	1.00%	2.15%	6.11%	0.21%
Liquidity:								
Days Cash, All Sources **	⇧	135.19	129.76	91.30	129.00	110.80	62.00	37.80
Net Days in Accounts Receivable	⇩	58.80	50.02	52.40	51.80	51.95	66.90	57.20
Capital Structure:								
Average Age of Plant (Annualized)	⇩	12.38	12.58	15.10	11.20	10.19	9.50	12.40
Long Term Debt to Capitalization	⇩	26.29%	25.75%	48.20%	41.60%	26.19%	16.80%	10.00%
Debt Service Coverage Ratio **	⇧	3.76	3.97	1.80	2.30	3.15	N/A	2.64
Productivity and Efficiency:								
Paid FTE's per Adjusted Occupied Bed	⇩	7.86	8.43			8.43	6.60	4.63
Salary Expense per Paid FTE		$84,711	$86,892			$85,976	$62,436	$48,150
Salary and Benefits as a % of Total Operating Exp		55.64%	56.43%			55.81%	43.60%	42.40%

Note 1 - 2017 Ingenix report (2015 median data), for all hospitals within the state regardless of size.
Note 2 - 2017 Ingenix report (2015 median data), for all U. S. hospitals that match this type and size.
****Bond Covenant ratio is 75 Days Cash on Hand and 1.25 Debt Service Coverage**

Balance Sheet - Assets

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Twelve months ended June 30, 2019

	Current Month 6/30/2019	Prior Month 5/31/2019	ASSETS Positive/ (Negative) Variance	Percentage Variance	Prior Year End 6/30/2018
Current Assets					
Cash and Cash Equivalents	$10,487,324	$9,433,560	$1,053,763	11.17%	$14,404,653
Gross Patient Accounts Receivable	24,217,308	24,998,623	(781,315)	-3.13%	21,199,648
Less: Bad Debt and Allowance Reserves	(11,526,497)	(11,243,092)	(283,405)	-2.52%	(9,770,080)
Net Patient Accounts Receivable	12,690,811	13,755,531	(1,064,720)	-7.74%	11,429,568
Interest Receivable	0	0	0	0.00%	0
Other Receivables	1,461,609	1,676,567	(214,958)	-12.82%	1,957,332
Inventories	2,917,250	2,797,819	119,431	4.27%	2,829,223
Prepaid Expenses	2,284,926	2,149,646	135,280	6.29%	2,365,112
Due From Third Party Payers	0	0	0	0.00%	0
Due From Affiliates/Related Organizations	0	0	0	0.00%	0
Other Current Assets	0	0	0	0.00%	0
Total Current Assets	**29,841,920**	**29,813,123**	**28,797**	**0.10%**	**32,985,887**
Assets Whose Use is Limited					
Cash	19,800	9,472	10,328	109.04%	12,573
Investments	0	0	0	0.00%	0
Bond Reserve/Debt Retirement Fund	0	0	0	0.00%	0
Trustee Held Funds - Project	3,059,212	2,946,177	113,035	3.84%	3,034,341
Trustee Held Funds - SPT	168	0	168	0.00%	3,452,951
Board Designated Funds	4,752,127	4,736,425	15,702	0.33%	1,300,000
Other Limited Use Assets	14,635,235	14,566,338	68,897	0.47%	8,303,935
Total Limited Use Assets	**22,466,542**	**22,258,412**	**208,130**	**0.94%**	**16,103,800**
Property, Plant, and Equipment					
Land and Land Improvements	2,957,673	2,957,673	0	0.00%	2,928,057
Building and Building Improvements	38,215,213	38,215,213	0	0.00%	38,041,246
Equipment	110,985,975	110,760,277	225,699	0.20%	108,303,077
Construction In Progress	762,258	754,256	8,002	1.06%	1,010,882
Capitalized Interest	0	0	0	0.00%	0
Gross Property, Plant, and Equipment	152,921,119	152,687,418	233,701	0.15%	150,283,261
Less: Accumulated Depreciation	(89,195,017)	(88,613,620)	(581,397)	-0.66%	(82,058,661)
Net Property, Plant, and Equipment	**63,726,102**	**64,073,798**	**(347,696)**	**-0.54%**	**68,224,600**
Other Assets					
Unamortized Loan Costs	234,709	235,738	(1,029)	-0.44%	247,062
Other	0	0	0	0.00%	0
Total Other Assets	**234,709**	**235,738**	**(1,029)**	**-0.44%**	**247,062**
TOTAL UNRESTRICTED ASSETS	**116,269,273**	**116,381,071**	**(111,798)**	**-0.10%**	**117,561,349**
Restricted Assets	256,963	256,837	125	0.05%	426,203
TOTAL ASSETS	**$116,526,235**	**$116,637,908**	**($111,673)**	**-0.10%**	**$117,987,552**

Balance Sheet - Liabilities and Net Assets

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Twelve months ended June 30, 2019

	LIABILITIES AND FUND BALANCE				
	Current Month 6/30/2019	Prior Month 5/31/2019	Positive/ (Negative) Variance	Percentage Variance	Prior Year End 6/30/2018
Current Liabilities					
Accounts Payable	$3,176,158	$3,242,791	$66,633	2.05%	$4,934,966
Notes and Loans Payable	0	0	0	0.00%	0
Accrued Payroll	1,481,176	897,025	(584,151)	-65.12%	910,902
Accrued Payroll Taxes	0	0	0	0.00%	0
Accrued Benefits	2,114,225	2,194,990	80,765	3.68%	1,702,057
Accrued Pension Expense (Current Portion)	0	0	0	0.00%	0
Other Accrued Expenses	0	0	0	0.00%	0
Patient Refunds Payable	0	0	0	0.00%	0
Property Tax Payable	0	0	0	0.00%	0
Due to Third Party Payers	0	0	0	0.00%	0
Advances From Third Party Payers	0	0	0	0.00%	0
Current Portion of LTD (Bonds/Mortgages)	323,414	313,097	(10,317)	-3.30%	1,810,631
Current Portion of LTD (Leases)	0	0	0	0.00%	0
Other Current Liabilities	397,008	288,798	(108,211)	-37.47%	432,632
Total Current Liabilities	**7,491,981**	**6,936,701**	**(555,281)**	**-8.00%**	**9,791,188**
Long Term Debt					
Bonds/Mortgages Payable	28,181,654	28,176,149	(5,505)	-0.02%	29,726,614
Leases Payable	0	0	0	0.00%	0
Less: Current Portion Of Long Term Debt	323,414	313,097	(10,317)	-3.30%	1,810,631
Total Long Term Debt (Net of Current)	**27,858,240**	**27,863,052**	**4,812**	**0.02%**	**27,915,983**
Other Long Term Liabilities					
Deferred Revenue	0	0	0	0.00%	0
Accrued Pension Expense (Net of Current)	0	0	0	0.00%	0
Other	747,408	812,389	64,981	8.00%	1,070,720
Total Other Long Term Liabilities	**747,408**	**812,389**	**64,981**	**8.00%**	**1,070,720**
TOTAL LIABILITIES	**36,097,629**	**35,612,142**	**(485,487)**	**-1.36%**	**38,777,891**
Net Assets:					
Unrestricted Fund Balance	77,035,006	76,993,747	(41,259)	-0.05%	74,388,532
Temporarily Restricted Fund Balance	1,959,119	1,959,119	0	0.00%	1,959,119
Restricted Fund Balance	366,321	366,195	(125)	-0.03%	465,216
Net Revenue/(Expenses)	1,068,160	1,706,705	N/A	N/A	2,396,794
TOTAL NET ASSETS	**80,428,606**	**81,025,766**	**597,161**	**0.74%**	**79,209,661**
TOTAL LIABILITIES AND NET ASSETS	**$116,526,235**	**$116,637,908**	**$111,673**	**0.10%**	**$117,987,552**

Statement of Revenue and Expense

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WY
Twelve months ended June 30, 2019

	CURRENT MONTH				
	Actual 06/30/19	Budget 06/30/19	Positive (Negative) Variance	Percentage Variance	Prior Year 06/30/18
Gross Patient Revenue					
Inpatient Revenue	$2,440,090	$2,944,366	($504,277)	-17.13%	$2,691,073
Outpatient Revenue	9,137,727	9,416,699	(278,971)	-2.96%	8,882,234
Clinic Revenue	1,351,020	1,224,976	126,045	10.29%	1,252,867
Specialty Clinic Revenue	140,838	190,959	(50,122)	-26.25%	179,865
Total Gross Patient Revenue	13,069,675	13,777,000	(707,325)	-5.13%	13,006,039
Deductions From Revenue					
Discounts and Allowances	(5,748,563)	(5,582,034)	(166,530)	-2.98%	(4,273,304)
Bad Debt Expense (Governmental Providers Only)	(1,035,734)	(712,436)	(323,297)	-45.38%	(1,232,693)
Medical Assistance	(135,657)	(170,821)	35,163	20.59%	(419,740)
Total Deductions From Revenue	(6,919,954)	(6,465,290)	(454,663)	-7.03%	(5,925,738)
Net Patient Revenue	6,149,721	7,311,709	(1,161,988)	-15.89%	7,080,301
Other Operating Revenue	216,040	267,080	(51,039)	-19.11%	482,048
Total Operating Revenue	**6,365,762**	**7,578,789**	**(1,213,027)**	**-16.01%**	**7,562,349**
Operating Expenses					
Salaries and Wages	3,046,743	3,169,867	123,124	3.88%	2,975,968
Fringe Benefits	767,821	800,311	32,490	4.06%	694,860
Contract Labor	128,111	44,037	(84,074)	-190.92%	46,590
Physicians Fees	450,449	366,038	(84,412)	-23.06%	443,327
Purchased Services	398,748	466,216	67,468	14.47%	439,285
Supply Expense	866,426	1,152,219	285,793	24.80%	1,010,111
Utilities	95,714	94,217	(1,497)	-1.59%	98,439
Repairs and Maintenance	425,390	389,533	(35,857)	-9.21%	369,736
Insurance Expense	40,019	61,649	21,631	35.09%	61,525
All Other Operating Expenses	232,721	165,749	(66,971)	-40.41%	270,617
Bad Debt Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Leases and Rentals	87,293	72,110	(15,183)	-21.06%	100,598
Depreciation and Amortization	581,397	569,130	(12,267)	-2.16%	952,632
Interest Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Total Operating Expenses	**7,120,832**	**7,351,076**	**230,244**	**3.13%**	**7,463,688**
Net Operating Surplus/(Loss)	**(755,071)**	**227,713**	**(982,783)**	**-431.59%**	**98,660**
Non-Operating Revenue:					
Contributions	0	0	0	0.00%	0
Investment Income	58,715	78,984	(20,269)	-25.66%	18,869
Tax Subsidies (Except for GO Bond Subsidies)	168	0	168	0.00%	51,516
Tax Subsidies for GO Bonds	0	0	0	0.00%	0
Interest Expense (Governmental Providers Only)	(109,246)	(113,824)	(4,578)	4.02%	(197,203)
Other Non-Operating Revenue/(Expenses)	166,888	17,504	149,384	853.43%	12,052
Total Non Operating Revenue/(Expense)	**116,526**	**(17,336)**	**133,861**	**-772.18%**	**(114,766)**
Total Net Surplus/(Loss)	**($638,545)**	**$210,377**	**($848,922)**	**-403.52%**	**($16,106)**
Change in Unrealized Gains/(Losses) on Investments	41,259	(55,000)	96,259	-175.02%	0
Increase/(Decrease in Unrestricted Net Assets	**($597,286)**	**$155,377**	**($752,663)**	**-484.41%**	**($16,106)**
Operating Margin	**-11.86%**	**3.00%**			**1.30%**
Total Profit Margin	**-10.03%**	**2.78%**			**-0.21%**
EBIDA	**-3.73%**	**10.51%**			**14.48%**

Statement of Revenue and Expense

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Twelve months ended June 30, 2019

	YEAR-TO-DATE				
	Actual 06/30/19	Budget 06/30/19	Positive (Negative) Variance	Percentage Variance	Prior Year 06/30/18
Gross Patient Revenue					
Inpatient Revenue	$35,773,430	$35,312,721	$460,709	1.30%	$34,175,110
Outpatient Revenue	112,470,048	112,826,906	(356,858)	-0.32%	107,307,650
Clinic Revenue	14,651,051	14,488,014	163,036	1.13%	13,972,715
Specialty Clinic Revenue	2,022,011	2,357,116	(335,105)	-14.22%	2,293,788
Total Gross Patient Revenue	164,916,540	164,984,757	(68,217)	-0.04%	157,749,263
Deductions From Revenue					
Discounts and Allowances	(67,828,387)	(66,828,411)	(999,976)	-1.50%	(62,156,442)
Bad Debt Expense (Governmental Providers Only)	(11,253,830)	(8,549,236)	(2,704,594)	-31.64%	(9,004,156)
Medical Assistance	(2,234,140)	(2,049,847)	(184,293)	-8.99%	(2,218,712)
Total Deductions From Revenue	(81,316,356)	(77,427,494)	(3,888,862)	-5.02%	(73,379,310)
Net Patient Revenue	83,600,184	87,557,263	(3,957,079)	-4.52%	84,369,953
Other Operating Revenue	3,173,482	2,840,078	333,404	11.74%	2,739,634
Total Operating Revenue	**86,773,666**	**90,397,341**	**(3,623,675)**	**-4.01%**	**87,109,587**
Operating Expenses					
Salaries and Wages	37,637,273	38,295,831	658,558	1.72%	37,359,892
Fringe Benefits	9,547,767	9,864,697	316,931	3.21%	9,875,453
Contract Labor	1,021,278	814,634	(206,643)	-25.37%	1,432,609
Physicians Fees	4,011,304	4,026,017	14,713	0.37%	3,084,279
Purchased Services	4,426,070	4,916,315	490,245	9.97%	5,154,203
Supply Expense	13,044,020	13,813,249	769,229	5.57%	12,811,145
Utilities	1,094,313	1,137,378	43,065	3.79%	1,119,148
Repairs and Maintenance	4,787,481	4,640,135	(147,347)	-3.18%	4,421,777
Insurance Expense	750,289	737,102	(13,187)	-1.79%	738,768
All Other Operating Expenses	2,083,327	2,178,928	95,601	4.39%	2,297,931
Bad Debt Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Leases and Rentals	1,020,803	865,979	(154,824)	-17.88%	837,070
Depreciation and Amortization	7,208,688	7,397,767	189,079	2.56%	8,064,970
Interest Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Total Operating Expenses	**86,632,613**	**88,688,032**	**2,055,419**	**2.32%**	**87,197,246**
Net Operating Surplus/(Loss)	**141,053**	**1,709,309**	**(1,568,256)**	**-91.75%**	**(87,659)**
Non-Operating Revenue:					
Contributions	0	0	0	0.00%	0
Investment Income	293,052	122,819	170,233	138.60%	162,873
Tax Subsidies (Except for GO Bond Subsidies)	193,149	0	193,149	0.00%	3,614,005
Tax Subsidies for GO Bonds	0	0	0	0.00%	0
Interest Expense (Governmental Providers Only)	(1,285,361)	(1,365,882)	80,521	-5.90%	(1,501,858)
Other Non-Operating Revenue/(Expense)	1,726,266	210,048	1,516,218	721.84%	209,434
Total Non Operating Revenue/(Expense)	**927,106**	**(1,033,015)**	**1,960,121**	**-189.75%**	**2,484,453**
Total Net Surplus/(Loss)	**$1,068,160**	**$676,294**	**$391,866**	**57.94%**	**$2,396,794**
Change in Unrealized Gains/(Losses) on Investments	215,748	(55,000)	270,748	-492.27%	0
Increase/(Decrease) in Unrestricted Net Assets	**$1,283,908**	**$621,294**	**$662,614**	**106.65%**	**$2,396,794**
Operating Margin	**0.16%**	**1.89%**			**-0.10%**
Total Profit Margin	**1.23%**	**0.75%**			**2.75%**
EBIDA	**8.67%**	**10.07%**			**12.78%**

Statement of Revenue and Expense - 13 Month Trend

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

	Actual 6/30/2019	Actual 5/31/2019	Actual 4/30/2019	Actual 3/31/2019	Actual 2/28/2019	Actual 1/31/2019
Gross Patient Revenue						
Inpatient Revenue	$2,440,090	$2,841,644	$2,956,480	$3,361,712	$3,219,822	$3,505,789
Inpatient Psych/Rehab Revenue						
Outpatient Revenue	$9,137,727	$9,721,418	$9,778,210	$10,025,117	$9,455,323	$9,655,343
Clinic Revenue	$1,351,020	$1,229,230	$1,411,951	$1,460,747	$1,009,031	$1,069,404
Specialty Clinic Revenue	$140,838	$170,624	$169,268	$175,633	$127,930	$207,546
Total Gross Patient Revenue	$13,069,675	$13,962,917	$14,315,908	$15,023,209	$13,812,107	$14,438,082
Deductions From Revenue						
Discounts and Allowances	$5,748,563	$6,036,217	$5,968,334	$6,429,282	$5,729,959	$5,973,406
Bad Debt Expense (Governmental Providers Only)	$1,035,734	$1,106,128	$1,112,048	$925,904	$861,776	$1,068,211
Charity Care	$135,657	$410,835	$154,144	$75,643	$39,094	$9,144
Total Deductions From Revenue	6,919,954	7,553,180	7,234,527	7,430,829	6,630,829	7,050,760
Net Patient Revenue	$6,149,721	$6,409,737	$7,081,381	$7,592,380	$7,181,278	$7,387,322
Other Operating Revenue	216,040	445,830	339,098	152,004	120,379	263,747
Total Operating Revenue	**6,365,762**	**6,855,566**	**7,420,479**	**7,744,384**	**7,301,657**	**7,651,070**
Operating Expenses						
Salaries and Wages	$3,046,743	$3,155,561	$2,977,715	$3,305,068	$3,088,986	$3,186,722
Fringe Benefits	$767,821	$1,000,635	$933,863	$988,234	$665,091	$865,517
Contract Labor	$128,111	$64,948	$98,792	$97,501	$74,652	$69,678
Physicians Fees	$450,449	$418,232	$350,665	$341,727	$356,528	$385,122
Purchased Services	$398,748	$375,159	$413,790	$381,623	$317,228	$389,034
Supply Expense	$866,426	$1,064,799	$1,078,865	$1,123,055	$1,129,337	$1,157,310
Utilities	$95,714	$86,783	$83,836	$90,794	$82,401	$104,011
Repairs and Maintenance	$425,390	$513,170	$428,617	$417,236	$375,266	$415,540
Insurance Expense	$40,019	$37,934	$68,473	$67,452	$67,452	$68,029
All Other Operating Expenses	$232,721	$190,218	$98,643	$84,278	$158,971	$175,580
Bad Debt Expense (Non-Governmental Providers)						
Leases and Rentals	$87,293	$112,094	$79,258	$84,907	$83,369	$94,749
Depreciation and Amortization	$581,397	$575,850	$596,566	$592,419	$593,713	$604,188
Interest Expense (Non-Governmental Providers)						
Total Operating Expenses	**$7,120,832**	**$7,595,383**	**$7,209,082**	**$7,574,294**	**$6,992,995**	**$7,515,479**
Net Operating Surplus/(Loss)	**($755,071)**	**($739,816)**	**$211,397**	**$170,090**	**$308,662**	**$135,591**
Non-Operating Revenue:						
Contributions						
Investment Income	58,715	143,065	10,344	20,255	13,010	3,652
Tax Subsidies (Except for GO Bond Subsidies)						
Tax Subsidies for GO Bonds	168	274	828	4,161	1,627	2,132
Interest Expense (Governmental Providers Only)	(109,246)	(100,442)	(99,953)	(111,832)	(100,799)	(101,257)
Other Non-Operating Revenue/(Expenses)	166,888	59,675	29,196	327,170	9,719	1,027,547
Total Non Operating Revenue/(Expense)	**$116,526**	**$102,572**	**($59,584)**	**$239,753**	**($76,443)**	**$932,074**
Total Net Surplus/(Loss)	**($638,545)**	**($637,244)**	**$151,812**	**$409,844**	**$232,219**	**$1,067,665**
Change in Unrealized Gains/(Losses) on Investments	41,259	174,489				
Increase/(Decrease in Unrestricted Net Assets	**($597,286)**	**($462,755)**	**$151,812**	**$409,844**	**$232,219**	**$1,067,665**
Operating Margin	**-11.86%**	**-10.79%**	**2.85%**	**2.20%**	**4.23%**	**1.77%**
Total Profit Margin	**-10.03%**	**-9.30%**	**2.05%**	**5.29%**	**3.18%**	**13.95%**
EBIDA	**-2.73%**	**-2.39%**	**10.89%**	**9.85%**	**12.36%**	**9.67%**

Actual 12/31/2018	Actual 11/30/2018	Actual 10/31/2018	Actual 9/30/2018	Actual 8/31/2018	Actual 7/31/2018	Actual 6/30/2018
$2,955,935	$3,151,638	$3,043,704	$2,499,813	$2,459,161	$3,337,641	$2,691,073
$9,010,217	$8,820,378	$9,273,432	$8,246,354	$9,927,413	$9,424,838	$8,882,234
$1,254,113	$1,134,169	$1,361,778	$1,076,083	$1,193,552	$1,094,250	$1,252,867
$180,950	$104,902	$116,899	$146,133	$215,242	$266,047	$179,865
$13,401,215	$13,211,087	$13,795,813	$11,968,383	$13,795,368	$14,122,776	$13,006,039
$5,230,019	$5,351,709	$5,646,755	$4,581,170	$5,240,990	$5,891,982	$4,273,304
$557,421	$986,087	$706,393	$1,072,535	$972,129	$849,465	$1,232,693
$653,219	$60,045	$273,186	$135,091	$202,867	$85,215	$419,740
6,440,659	6,397,840	6,626,333	5,788,796	6,415,986	6,826,662	5,925,738
$6,960,556	$6,813,247	$7,169,480	$6,179,587	$7,379,382	$7,296,114	$7,080,302
220,308	254,511	173,401	678,067	159,188	150,909	482,048
7,180,863	**7,067,758**	**7,342,881**	**6,857,654**	**7,538,570**	**7,447,023**	**7,562,349**
$3,269,823	$2,935,437	$3,318,255	$3,014,576	$3,132,114	$3,206,273	$2,975,968
$717,581	$746,950	$702,719	$648,010	$825,597	$685,749	$694,860
$65,504	$74,832	$80,488	$45,634	$87,004	$134,135	$46,590
$388,350	$342,975	$268,744	$239,881	$211,428	$257,203	$443,327
$360,563	$350,678	$354,072	$342,090	$366,075	$377,009	$439,285
$1,032,789	$1,097,604	$1,103,598	$1,060,199	$1,133,975	$1,196,063	$1,010,111
$88,476	$96,033	$88,710	$90,628	$104,407	$82,521	$98,439
$320,266	$415,236	$348,112	$351,939	$417,795	$358,916	$369,736
$68,606	$68,606	$67,412	$66,217	$66,217	$63,871	$61,525
$140,791	$250,438	$225,179	$138,767	$193,415	$194,326	$270,617
$75,445	$87,400	$86,440	$85,136	$72,008	$72,703	$100,598
$619,201	$597,556	$599,007	$604,823	$621,957	$622,012	$952,632
$7,147,397	**$7,063,744**	**$7,242,736**	**$6,687,899**	**$7,231,993**	**$7,250,778**	**$7,463,688**
$33,467	**$4,014**	**$100,145**	**$169,755**	**$306,577**	**$196,245**	**$98,661**
5,279	3,333	10,560	4,652	14,772	5,416	18,869
183,959						51,516
(116,158)	(101,983)	(102,369)	(127,030)	(102,944)	(111,348)	(197,203)
13,517	23,880	15,965	16,934	14,644	20,631	12,052
$86,597	**($74,770)**	**($75,844)**	**($105,445)**	**($73,528)**	**($85,301)**	**($114,766)**
$120,063	**($70,756)**	**$24,301**	**$64,310**	**$233,049**	**$110,943**	**($16,105)**
$120,063	**($70,756)**	**$24,301**	**$64,310**	**$233,049**	**$110,943**	**($16,105)**
0.47%	**0.06%**	**1.36%**	**2.48%**	**4.07%**	**2.64%**	**1.30%**
1.67%	**-1.00%**	**0.33%**	**0.94%**	**3.09%**	**1.49%**	**-0.21%**
9.09%	**8.51%**	**9.52%**	**11.30%**	**12.32%**	**10.99%**	**13.90%**

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WY
Twelve months ended June 30, 2019

	CASH FLOW	
	Current Month 6/30/2019	Current Year-To-Date 6/30/2019
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net Income (Loss)	($638,545)	$1,068,160
Adjustments to Reconcile Net Income to Net Cash Provided by Operating Activities:		
Depreciation	581,397	7,208,688
(Increase)/Decrease in Net Patient Accounts Receivable	1,064,720	(1,261,243)
(Increase)/Decrease in Other Receivables	214,958	495,723
(Increase)/Decrease in Inventories	(119,431)	(88,028)
(Increase)/Decrease in Pre-Paid Expenses	(135,280)	80,186
(Increase)/Decrease in Other Current Assets	0	0
Increase/(Decrease) in Accounts Payable	(66,633)	(1,758,808)
Increase/(Decrease) in Notes and Loans Payable	0	0
Increase/(Decrease) in Accrued Payroll and Benefits	503,386	982,442
Increase/(Decrease) in Accrued Expenses	0	0
Increase/(Decrease) in Patient Refunds Payable	0	0
Increase/(Decrease) in Third Party Advances/Liabilities	0	0
Increase/(Decrease) in Other Current Liabilities	108,211	(35,623)
Net Cash Provided by Operating Activities:	**1,512,782**	**6,691,496**
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of Property, Plant and Equipment	(233,701)	(2,710,189)
(Increase)/Decrease in Limited Use Cash and Investments	(197,802)	(6,355,516)
(Increase)/Decrease in Other Limited Use Assets	(10,328)	(7,227)
(Increase)/Decrease in Other Assets	1,029	12,353
Net Cash Used by Investing Activities	**(440,802)**	**(9,060,578)**
CASH FLOWS FROM FINANCING ACTIVITIES:		
Increase/(Decrease) in Bond/Mortgage Debt	5,505	(1,544,960)
Increase/(Decrease) in Capital Lease Debt	0	0
Increase/(Decrease) in Other Long Term Liabilities	(64,981)	(323,312)
Net Cash Used for Financing Activities	**(59,476)**	**(1,868,272)**
(INCREASE)/DECREASE IN RESTRICTED ASSETS	**41,259**	**320,025**
Net Increase/(Decrease) in Cash	**1,053,763**	**(3,917,329)**
Cash, Beginning of Period	9,433,560	14,404,653
Cash, End of Period	**$10,487,324**	**$10,487,324**

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WY
Twelve months ended June 30, 2019

Current Month					Year-To-Date			
Actual 06/30/19	Budget 06/30/19	Positive/ (Negative) Variance	Prior Year 06/30/18	STATISTICS	Actual 06/30/19	Budget 06/30/19	Positive/ (Negative) Variance	Prior Year 06/30/18
				Discharges				
111	142	(31)	123	Acute	1,593	1,605	(12)	1,964
111	142	(31)	123	Total Adult Discharges	1,593	1,605	(12)	1,964
27	35	(8)	37	Newborn	435	481	(46)	678
138	177	(39)	160	Total Discharges	2,028	2,086	(58)	2,642
				Patient Days:				
299	342	(43)	346	Acute	4,597	4,234	363	5,992
299	342	(43)	346	Total Adult Patient Days	4,597	4,234	363	5,992
37	50	(13)	58	Newborn	696	833	(137)	827
336	392	(56)	404	Total Patient Days	5,293	5,067	226	6,819
				Average Length of Stay (ALOS)				
2.7	2.4	0.3	2.8	Acute	2.9	2.6	0.2	3.1
2.7	2.4	0.3	2.8	Total Adult ALOS	2.9	2.6	0.2	3.1
1.4	1.4	(0.1)	1.6	Newborn ALOS	1.6	1.7	(0.1)	1.2
				Average Daily Census (ADC)				
10.0	11.4	(1.4)	11.5	Acute	12.6	11.6	1.0	16.4
10.0	11.4	(1.4)	11.5	Total Adult ADC	12.6	11.6	1.0	16.4
1.2	1.7	(0.4)	1.9	Newborn	1.9	2.3	(0.4)	2.3
				Emergency Room Statistics				
134	152	(18)	128	ER Visits - Admitted	1,729	1,669	60	1,798
1,148	1,174	(26)	1,291	ER Visits - Discharged	14,517	14,692	(175)	14,716
1,282	1,326	(44)	1,419	Total ER Visits	16,246	16,361	(115)	16,514
10.45%	11.46%		9.02%	% of ER Visits Admitted	10.64%	10.20%		10.89%
120.72%	107.04%		104.07%	ER Admissions as a % of Total	108.54%	103.99%		91.55%
				Outpatient Statistics:				
7,363	6,370	993	6,405	Total Outpatients Visits	87,445	76,842	10,603	82,276
135	111	24	94	Observation Bed Days	1,466	1,313	153	1,239
3,865	4,143	(278)	4,104	Clinic Visits - Primary Care	49,633	49,064	569	52,397
425	412	13	546	Clinic Visits - Specialty Clinics	4,864	5,069	(205)	6,877
15	27	(12)	30	IP Surgeries	292	351	(59)	416
141	124	17	133	OP Surgeries	1,643	1,730	(87)	1,819
				Productivity Statistics:				
405.91	427.27	(21.36)	396.00	FTE's - Worked	414.01	427.27	(13.26)	407.02
462.19	464.23	(2.04)	443.35	FTE's - Paid	456.36	464.23	(7.87)	451.20
1.2466	1.2409	0.01	1.4521	Case Mix Index -Medicare	1.2963	16.2814	(14.99)	1.1562
0.7701	0.8591	(0.09)	0.8282	Case Mix Index - All payers	0.7574	10.5813	(9.82)	0.8739

Accounts Receivable Tracking Report

MEMORIAL HOSPITAL OF SWEETWATER COUNTY PAGE 12
ROCK SPRINGS, WY
06/30/19

	Current Month Actual	Current Month Target
Gross Days in Accounts Receivable - All Services	53.30	50.05
Net Days in Accounts Receivable	58.80	51.95
Number of Gross Days in Unbilled Revenue	3.74	3.0 or <
Number of Days Gross Revenue in Credit Balances	0.00	< 1.0
Self Pay as a Percentage of Total Receivables	30.51%	N/A
Charity Care as a % of Gross Patient Revenue - Current Month	1.04%	1.24%
Charity Care as a % of Gross Patient Revenue - Year-To-Date	1.35%	1.24%
Bad Debts as a % of Gross Patient Revenue - Current Month	7.92%	5.17%
Bad Debts as a % of Gross Patient Revenue - Year-To-Date	6.82%	5.18%
Collections as a Percentage of Net Revenue - Current Month	116.54%	100% or >
Collections as a Percentage of Net Revenue - Year-To-Date	97.29%	100% or >
Percentage of Blue Cross Receivable > 90 Days	28.72%	< 10%
Percentage of Insurance Receivable > 90 Days	15.85%	< 15%
Percentage of Medicaid Receivable > 90 Days	36.43%	< 20%
Percentage of Medicare Receivable > 60 Days	14.76%	< 6%

Variance Analysis

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WYOMING

Twelve months ended June 30, 2019

Monthly Variances in excess of $10,000 as well as in excess of 10% explained below.
Year-To-Date Variances in excess of $30,000 as well as in excess of 5% explained below.

	Current Month		Year-to-Date	
	Amount	%	Amount	%
Gross Patient Revenue	(707,325)	-5.13%	(68,217)	-0.04%

Gross patient revenue is under budget for the month and under budget year to date. Patient statistics under budget include Discharges, ER visits and Clinic visits.
Average Daily Census is 10.0 in June which is under budget

Deductions from Revenue	(454,663)	-7.03%	(3,888,862)	-5.02%

Deductions from revenue are over budget for June and over budget year to date.
They are currently booked at 53% for June and 49% year to date. This number is monitored closely each month and fluctuates based on historical write-offs and current collection percentages.

Bad Debt Expense	(323,297)	-45.38%	(2,704,594)	-31.64%

Bad debt expense is booked at 8% for June and 7% year to date.

Charity Care	35,163	20.59%	(184,293)	-8.99%

Charity care yields a high degree of variability month over month and is dependent on patient needs. Patient Financial Services evaluates accounts consistently to determine when charity adjustments are appropriate in accordance with our Charity Care Policy.

Other Operating Revenue	(51,039)	-19.11%	333,404	11.74%

Other Operating Revenue is under budget for the month and is over budget year to date.

Salaries and Wages	123,124	3.88%	658,558	1.72%

Salary and Wages are under budget and remain under budget year to date.

Paid FTEs are underr budget by 2.04 FTEs for the month and under 7.87 FTEs year to date.

Fringe Benefits	32,490	4.06%	316,931	3.21%

Fringe benefits are under budget in June and remain under budget year to date.

Contract Labor	(84,074)	-190.92%	(206,643)	-25.37%

Contract labor is over budget for June and over budget year to date. Behavioral Health, ICU, Central Sterile, ER, Infection Control, Cardio and Ultrasound are over budget for the month.

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WYOMING

Twelve months ended June 30, 2019

Monthly Variances in excess of $10,000 as well as in excess of 10% explained below.
Year-To-Date Variances in excess of $30,000 as well as in excess of 5% explained below.

	Current Month		Year-to-Date	
	Amount	%	Amount	%
Physician Fees	(84,412)	-23.06%	14,713	0.37%
Physician fees are over budget in June and remain under budget year to date. ER, Radiation Oncology, Hospitalists, Locums and Locum Radiology are over budget in June.				
Purchased Services	67,468	14.47%	490,245	9.97%
Purchased services are over budget for June and under budget year to date. Services over budget Behavioral health, OR, Lab, Pet Scan, Pharmacy and Dr. Liu.				
Supply Expense	285,793	24.80%	769,229	5.57%
Supplies are under budget for June and remain under budget year to date. Line items over budget include Oxygen, Radioactive materials, Lab supplies, Blood, Other Med Supplies, Contrast and Outdated supplies .				
Repairs & Maintenance	(35,857)	-9.21%	(147,347)	-3.18%
Repairs and Maintenance are over budget for June and over budget year to date.				
All Other Operating Expenses	(66,971)	-40.41%	95,601	4.39%
This expense is over budget in June and under budget year to date. Other expenses over budget are Postage, Education & Travel, Pharmacy Floor Direct and Foundation Other.				
Leases and Rentals	(15,183)	-21.06%	(154,824)	-17.88%
This expense is over budget for June and remains over budget year to date.				
Depreciation and Amortization	(12,267)	-2.16%	189,079	2.56%
Depreciation is under budget for June and remains under budget year to date.				
BALANCE SHEET				
Cash and Cash Equivalents	$1,053,763	11.17%		
Cash increased in June. Cash collections for June were $7.2 million. Days Cash on Hand increased to 135 days.				
Gross Patient Accounts Receivable	($781,315)	-3.13%		
This receivable decreased in June.				

Variance Analysis

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WYOMING
Twelve months ended June 30, 2019

Monthly Variances in excess of $10,000 as well as in excess of 10% explained below.
Year-To-Date Variances in excess of $30,000 as well as in excess of 5% explained below.

	Current Month Amount	Current Month %	Year-to-Date Amount	Year-to-Date %
Bad Debt and Allowance Reserves	(283,405)	-2.52%		
Bad Debt and Allowances increased.				
Other Receivables	(214,958)	-12.82%		
Other Receivables decreased in June due to payment from the county				
Prepaid Expenses	135,280	6.29%		
Prepaid expenses increased due to the normal activity in this account.				
Limited Use Assets	208,130	0.94%		
These assets increased due to the payment on the bonds				
Plant Property and Equipment	(347,696)	-0.54%		
The decrease in these assets is due to the increase in Capital equipment and the normal increase in accumulated depreciation.				
Accounts Payable	66,633	2.05%		
This liability decreased due to the normal activity in this account.				
Accrued Payroll	(584,151)	-65.12%		
This liability increased in June. The payroll accrual for June was 7 days.				
Accrued Benefits	80,765	3.68%		
This liability decreased in June with the normal accrual and usage of PTO .				
Other Current Liabilities	(108,211)	-37.47%		
This liability increased due to the monthly interest payment on the bonds.				
Other Long Term Liabilities	64,981	8.00%		
This liability decreased due to the normal monthly lease payments.				
Total Net Assets	597,161	0.74%		
The net loss from operations for June is $755,070				

B□G Chair Report to the Board for □uly 2□1□

The B□G Committee meeting was held □uly 11th□earlier than normal□to allow members to meet with the engineering group handling the Central Plant Upgrade Pro□ect.

Retaining Wall Pro□ect

This project has been completed.

Central Plant Upgrade Pro□ect

Committee members met with the engineers and reviewed the mechanical status of the project.

We are at the stage where the project will go out to bid. It is appropriate to consider if there are cost savings that may be realized. The following actions were approved by the committee:

1. Equipment quality is to be preserved. The intent of a 30 year project life stands. Savings related to lower quality equipment were discussed but such actions would result in a 15 year project life.

2. The committee agreed that we should identify two to three items, in the construction bid package, as optional additions to the base bid. □im Horan was directed to work with the engineers to define what those would be. Two possibilities are connection of the chillers to emergency power and extended grading of the area around the Central Plant Building. Both of these items are worth doing and are related to function of the Central Plant. However we have operated without them and they were not detailed as part of the original project scope.

Next B□G Committee Meeting

The next meeting will be held on August 20, 2019.

Board Compliance Committee

Minutes

July 24, 2019

Present: Ed Tardoni, Irene Richardson, Clayton Radakovich, Suzan Campbell

Excused: Barbara Sowada

Guest: Richard Mathey

Ed called the meeting to order.

Minutes and agenda were approved as written.

The following items were discussed:

1. Old Business
    a. Risk Assessment Update: Clayton said the report in the packet reflects half of the risk assessment. The facility's vulnerability involves what do we have in place to monitor. We can turn the assessment into a compliance plan. We were incredibly optimistic about completing the risk assessment in a couple of months. Irene said the compliance work team invites input from numerous departments. Clayton said there are three sections left to complete. The arbitrary numbers are meant to point you in the right direction. Irene said the higher the score, the higher the risk.
    b. Fair Warning Update: Clayton said this is the last time he will report at this committee meeting because we went live with QuadraMed and the information will be reported elsewhere. Our electronic medical records flag when an unauthorized user enters the chart. We have been operating on suspected user access. Fair Warning puts a watchdog on all systems. We will see a spike and then hopefully a decrease when people see evidence we are doing what we said we would do. The intent is to target inappropriate access. HIPAA privacy violations usually follow breaches. Fair Warning is inappropriate access.

2. New Business
    a. June Compliance Report: Clayton reported the 2019 investigations are complete and have been reviewed with the work team. When we receive notice of a breach, Human Resources is notified and they complete the process. Clayton does not update the report to show completion until he receives notification that action is complete. We did not receive any compliance hotline calls in May or June. The routine credentialing process audit is underway. We do not see any issues. We are looking at the process before information is submitted to the Credentials Committee. The audit is listed in the Credentials Committee Charter to review annually. We set up a control mechanism and audit that mechanism.
    b. Code of Conduct Follow-Up: Clayton said that, following approval, we are ready to adjust our education and signature sheets.

Ed asked Richard for his observations. Richard said he is impressed with the progress that has been made and thinks we are headed in the right way. Ed asked Clayton to give the work group the message that what they have done is good and appreciated. Ed thanked Clayton, also.

Next Meeting: Wednesday – August 28, 2019 at 3:00 pm

Meeting was adjourned.

Submitted by Cindy Nelson

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: **AMENDMENT TO AFFILIATION AGREEMENT WITH U OF U**

2. Purpose of contract, including scope and description: **this amendment was given to us last year. Our board approved it and, as far as I can tell, it went to the commissioners for their approval but we never received a signed copy back from them so I am starting the approval process over. Affiliation agreement amendment 1-- adds a new without cause termination section to allow for 90 days without notice (original affiliation agreement only had for cause) 2-- adds governmental immunity language for MHSC.**

3. Effective Date: **When signed by Board and County commissioners**

4. Expiration Date: **original affiliation agreement term is for 5 years**

5. Termination provisions: **with this amendment will have a without cause termination provision with 90-day's notice** Is this auto-renew? **No**

6. Monetary cost of the contract: **None** Budgeted? **NA**

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

8. Any confidentiality provisions? **Not in amendment**

9. Indemnification clause present? **Not in amendment**

10. Is this contract appropriate for other bids? **NA**

11. Is County Attorney review required? **Yes John DeLeon has this amendment and the original affiliation agreement.**

AMENDMENT TO
AFFILIATION AGREEMENT

This Amendment to Affiliation Agreement (the "Amendment") is made and entered into as of the 12 day of September 2018, by and between the University of Utah, a body politic and corporate of the State of Utah, on behalf of its University of Utah Health ("UUH"), and Memorial Hospital of Sweetwater County ("Affiliate").

RECITALS

A. UUH and Affiliate entered into that certain Affiliation Agreement dated November 21, 2017 (the "Agreement"); and

B. University and Affiliate wish to amend the Agreement with respect to the frequency of Operations and Quality Council meetings, term and termination, and certain other matters.

AGREEMENT

NOW THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. The fourth sentence of Section 2.1 of the Agreement (Governance) is deleted in its entirety and replaced with the following:

The members of the Operations and Quality Council shall meet as needed.

2. Section 5.4 of the Agreement (Effect of Termination on SOWs) is renumbered as Section 5.5.

3. A new Section 5.4 (Termination – Without Cause) is added, which shall read as follows:

Termination — Without Cause. Either party may terminate this Agreement, without cause, upon not less than ninety (90) days advance written notice to the other.

4. Section 11 is replaced with the following language:

Each party to the agreement shall assume the risk of any liability arising from its own conduct. No party agrees to indemnify any other party. MHSC is a governmental entity and hereby expressly reserves its governmental immunity, pursuant to W.S. 1-39-101 et. seq. University is a governmental entity and hereby expressly reserves its governmental immunity, pursuant to Utah Code Ann., Section 63G-7-101 et seq. (the "Act"). Nothing in this Agreement shall be construed as a waiver by the University of any protections, rights, or defenses applicable to the University under the Act, including without limitation, the provisions of Section 63G-7-

604 regarding limitation of judgments. It is not the intent of either party to incur by contract any liability for the operations, acts, or omissions of the other party or any third party and nothing in this Agreement shall be so interpreted or construed.

5. This Amendment shall not be deemed to amend or modify the Agreement in any manner except as specifically provided for herein. Each of the definitions set forth in the Agreement shall apply to the defined terms used in this Amendment. The Agreement, as amended by this Amendment, shall be and remain in full force and effect, and enforceable in accordance with its terms.

[Signatures on following page.]

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their duly authorized representatives effective as of the day and year first written above.

UNIVERSITY OF UTAH
("UUH")

By: _____

Name: _____

Title: _____

MEMORIAL HOSPITAL OF
SWEETWATER COUNTY
("Affiliate")

By: _____

Name: _____

Title: _____

This Agreement must be presented to the Sweetwater County Commission for approval as is required by W.S. 8-8-301. Such approval is required prior to this Agreement being effective.

SWEETWATER COUNTY COMMISSIONERS

By: _____
Reid West, Chairman

ATTEST:

_____
Dale Davis, Clerk

AFFILIATION AGREEMENT

This **AFFILIATION AGREEMENT** (the "Agreement") is made and entered into effective as of November 21, 2017 (the "Effective Date"), by and between the University of Utah, a body politic and corporate of the State of Utah, on behalf of its University of Utah Health ("UUH") and Memorial Hospital of Sweetwater County ("Affiliate"). The above parties shall individually be referred to as a "Party" and collectively as "Parties." This Agreement must be presented to the Sweetwater County Commission for approval as is required by W.S. 18-8-201 and/or 18-8-301. Such approval is required prior to this Agreement being effective.

WHEREAS, UUH is a research, academic, and patient care organization that integrates clinical and hospital care with research and education, and has deep tertiary clinical resources and a reputation as a recognized leader in the provision of quality healthcare services; and

WHEREAS, Affiliate operates a general acute care hospital and other health care facilities and services; and

WHEREAS, UUH desires to make available to the patients of Affiliate advanced clinical care and research, multi-disciplinary approaches to patient care, and various educational opportunities for Affiliates' physicians and staff; and

WHEREAS, the Parties desire to enter into this Agreement to enhance the quality and breadth of patient care provided in the region, to achieve both clinical and operational efficiencies through a seamless and accountable network for patient care, and to improve patient, physician and staff access to the unique services of UUH through an affiliation (the "Affiliation"); and

WHEREAS, the Parties desire that this Agreement may lead to the establishment of other related agreements between the Parties in the future and in furtherance of their respective missions.

NOW, THEREFORE, in consideration of the foregoing premises, and the mutual covenants and promises contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereby agree as follows:

1. SERVICES

During the term of this Agreement, the Parties may enter into statements of work ("SOWs") covering specific services, programs and other arrangements ("Projects") to be provided by the Parties in furtherance of the Affiliation. Each SOW shall be identified as addenda to this Agreement, signed by the appropriate Parties, and shall be attached hereto and be deemed and treated for all purposes as part of and subject to the terms of this Agreement unless otherwise provided in the SOW.

2. OPERATIONS AND QUALITY COUNCIL

2.1 Governance. UUH and Affiliate shall establish an Operations and-Quality Council that will be co-chaired by administrative representatives from UUH and

Affiliate. UUH and Affiliate shall each appoint one (1) physician from its respective medical staff to serve as a member of the Operations and Quality Council. The Operations and Quality Council shall be responsible for oversight and guidance of the overall relationship and development of the Affiliation, developing SOWs, monitoring the various activities and Projects, providing regular communication channels between UUH and Affiliate, vetting future opportunities, and handling disputes that may arise, as outlined in Section 13.4 below. The members of the Operations and Quality Council shall meet at least quarterly. Meetings may be convened in person, telephonically, or electronically.

2.2 Projects and SOWs. With respect to the Projects, the Operations and Quality Council will: (i) review all SOWs for each Project, including any amendments and modifications, and submit them for the appropriate approval of the Parties; (ii) have access to and review records relating to the progress of the Projects; and (iii) have access to all reports, recommendations and other materials produced as a result of the Projects.

2.3 Communications. The Operations and Quality Council will facilitate and oversee regular communications between various counterparts of the Parties (i.e. the CEOs, clinical managers, media relations teams, legal, finance departments, etc.).

2.4 Future Opportunities. In furtherance of the Affiliation, each Party will endeavor to present opportunities for discussion and consideration. The Operations and Quality Council will review all potential joint opportunities and present them to the CEOs of each Party, when warranted.

3. FINANCIAL RESPONSIBILITIES

The financial responsibilities for the Projects shall be specified in the financial terms of each SOW.

4. FIRST RIGHT OF REFUSAL

The Parties recognize the clinical value and efficiencies in providing services on a collaborative basis as an integral part of furthering the Affiliation. To that end, during the term of this Agreement, Affiliate shall offer UUH first right of refusal for services not provided by Affiliate. If Affiliate wishes to outsource any such services to any entity or person other than UUH, Affiliate shall first notify UUH of Affiliate's intent to outsource these services and provide to UUH a copy of the third party offer to perform the services, including without limitation the scope of services, price and other material terms and conditions thereof. UUH may exercise the right to perform those services at the price and upon the terms of the offer by providing Affiliate with written notice of such election within sixty (60) days after UUH's receipt of the offer. These restrictions shall not apply to any agreements, which were entered into prior to the Effective Date.

In the event the Parties wish to negotiate additional exclusivity provisions specific to a particular Project, those terms must be included in the respective SOW and approved by the Parties.

5. TERM AND TERMINATION

5.1 Initial Term. The initial term of this Agreement shall commence on the Effective Date and continue for an initial term of five (5) years (the "Initial Term"), unless sooner terminated as hereinafter provided. The term of any individual SOW shall be as set forth in the SOW. One year prior to expiration of the Initial Term, the Parties shall review the Projects that have been performed, the development of the Affiliation and the appropriate renewal term of this Agreement.

5.2 Termination — for Cause. Either party may terminate this Agreement for cause, in the event the other party breaches any material term of this Agreement and fails to cure such breach within thirty (30) days of receiving written notice of breach

5.3 Termination — Immediate. This Agreement may be terminated immediately by any Party by providing written notice to the other Party, upon the occurrence of an event involving the other Party that is likely to have a material adverse effect in the aggregate upon the noticing Party's operations, reputation, perception in the marketplace, or financial well-being.

5.4 Effect of Termination on SOWs. The expiration or earlier termination of this Agreement shall not result automatically in the termination of the SOWs, except to the extent that any such SOW specifically provides therein for automatic termination upon the expiration or termination of this Agreement. Unless specified in the SOW, the Parties shall agree upon appropriate wind-down procedures and timelines for the termination of each Project.

6. INTELLECTUAL PROPERTY

6.1 Deliverables. The Project final reports and other deliverables delineated in the SOWs (the "Deliverables") shall be owned by the Party performing the services in developing the Deliverables, or if jointly developed, shall be jointly owned based upon each Party's relative contribution. Each Party hereby grants to the other Party, a non-exclusive, irrevocable, paid-up license to use all Deliverables developed by the developing Party under any SOW. The Party performing the services shall retain sole ownership of all other intellectual property it creates, including rights to all standard operating procedures, methods, software programs, source codes, object codes, templates, methodologies, ideas, techniques, and know how that were previously developed, conceived, or reduced to practice by or on behalf of the Party performing the services and utilized in the course of providing the services under this Agreement and any SOW. In the event the Parties wish to grant any additional assignment of ownership of intellectual property by any Party in the course of a Project, those terms must be included in the respective SOW and approved by the Parties.

6.2 Trademarks; Use of Brand. The Parties agree to work cooperatively to develop a communications plan to communicate this Affiliation. Such plan shall address each Party's use of the other Party's trademarks and brand names. No Party will use another Party's names or marks without advance written approval. The Parties agree that

use of each other's names and marks shall be permitted only so long as this Agreement remains in effect.

7. REPRESENTATIONS AND WARRANTIES OF THE PARTIES

7.1 UUH. UUH is a duly organized and validly existing entity in good standing under the laws of the State of Utah. The execution, delivery, and performance of this Agreement by UUH and all other agreements referenced herein, or ancillary hereto, and the consummation of the transactions contemplated herein by UUH are within its powers, are not in contravention of law or of the terms of its organizational documents, have been duly authorized by all appropriate corporate action, and will neither conflict with, nor result in any breach or contravention of, any contract, agreement, instrument or understanding to which it is a party or by which it is bound.

7.2 Affiliate. Affiliate is a duly organized and validly existing entity in good standing under the laws of the State of Wyoming. The execution, delivery, and performance of this Agreement by Affiliate and all other agreements referenced herein, or ancillary hereto, and the consummation of the transactions contemplated herein by Affiliate is within its powers, are not in contravention of law or of the terms of its organizational documents, have been duly authorized by all appropriate action, and will neither conflict with, nor result in any breach or contravention of, any contract, agreement, instrument or understanding to which it is a party or by which it is bound.

8. COMPLIANCE

By entering into this Agreement, the Parties specifically intend to comply with all applicable laws, rules, and regulations, including: (i) the Federal Anti-Kickback Statute (42 U.S.C. § 1320a-7(b)), (ii) the Physician Self-Referral law, also referred to as the "Stark Law" (42 U.S.C. §1395nn); and (iii) all applicable antitrust laws. Each Party shall ensure that it operates an effective compliance program. Accordingly, no part of any consideration paid hereunder is intended to be a prohibited payment for the recommending or arranging for the referral of business or the ordering of items or services; nor are the payments intended to induce illegal referrals of business. In the event that any part of this Agreement is determined to violate federal, state, or local laws, rules, or regulations, the Parties agree to negotiate in good faith revisions to the provision or provisions which are in violation. In the event the Parties are unable to agree to new or modified terms as required to bring the entire Agreement into compliance, any Party may terminate this Agreement on sixty (60) days written notice to the other Party.

9. TAX EXEMPT STATUS

The Parties shall take no action pursuant to this Agreement, a SOW, or Project that will jeopardize the tax-exempt status or not be in keeping with the governmental status of it or the other parties, as the case may be. If any term or condition of this Agreement is determined to jeopardize the tax-exempt status of any Party or not be in keeping with its governmental status, as the case may be, the Parties shall negotiate in good faith revisions to the terms or conditions at issue. In the event that the Parties are unable to agree to new or modified terms as required

within thirty (30) days, then the affected Party shall have the right to terminate this Agreement immediately.

10. INSURANCE

Throughout the term of this Agreement, each of the Parties shall secure and maintain, where appropriate, commercial general liability insurance, professional liability insurance, property insurance, workers compensation insurance, and such other insurance coverage or properly reserved self insurance, in such forms and amounts as may be reasonable and appropriate in the performance of the obligations assumed hereunder. Upon request, each Party shall provide the other with certificates of proof of the insurance coverage required herein.

11. INDEMNIFICATION

Each Party shall be liable only for its own acts or omissions, or those of its authorized employees, officers, and agents while engaged in the performance of any obligations under this Agreement or any SOW, and neither Party shall have any liability whatsoever for the acts or omissions of the other Party, their employees, officers, or agents. UUH is a governmental entity under the Governmental Immunity Act of Utah, Utah Code Ann., Section 63G-7-101 et seq., as amended (the "Act"). The Parties agree that the Act shall apply with respect to this Agreement and any SOW, and nothing in this Agreement or any SOW shall be construed as a waiver by UUH of any protections, rights, or defenses applicable to UUH under the Act, including without limitation, the provisions of Section 63G-7-604 regarding limitation of judgments. It is not the intent of UUH to incur by contract any liability for the operations, acts, or omissions of the other Party or any third party and nothing in this Agreement shall be so interpreted or construed.

12. MANAGED CARE CONTRACTING.

Unless otherwise set forth in writing, each Party shall be responsible for its own managed care contracting. Affiliate shall use commercially reasonable efforts to facilitate the inclusion of UUH in all managed care networks in which it participates for the purpose of allowing for reimbursement of UUH services for the beneficiaries of those plans. In addition, each Party shall use commercially reasonable efforts to facilitate the inclusion of the other Party in the managed care plans in which it participates so as to facilitate seamless delivery of patient care for the communities it serves.

13. MISCELLANEOUS.

13.1 Access to Information and Disclosure of Information. To the extent permitted by law, the Parties may, from time to time, provide to one another information reasonably needed for their cooperative endeavors and for each Party's financial accounting and reporting, audit, reimbursement, administration, and prosecution and defense of claims. Each Party shall maintain the confidentiality of the other Party's Confidential Information. Without limiting the foregoing, all data and information that is not generally known to the public, furnished by any Party to any other Party in connection with the performance of each Party's duties and obligations under this Agreement, which is identified as confidential or which the receiving Party should reasonably know to be confidential and proprietary (collectively, "Confidential

Information") shall be kept confidential and shall remain and be deemed to be the exclusive property of the Party furnishing Confidential Information and shall not be used by the other Party for any purpose other than those set forth in this Agreement and any SOW. In the event that this Agreement terminates, each Party shall either destroy or return all Confidential Information in its possession, including all copies, extracts, summaries, and analyses thereof, to the Party furnishing Confidential Information, except to the extent that such Party is required to maintain any such Confidential Information pursuant to any applicable laws, rules or regulations. The Party returning Confidential Information agrees that it shall continue to hold such Confidential Information in strict confidence and not use such Confidential Information for any purpose whatsoever following termination of this Agreement. Anything in this Agreement to the contrary notwithstanding, the Parties acknowledge that any information filed for public record shall not be considered to be Confidential Information hereunder. In the event that any Party becomes subject to any legal or regulatory process pursuant to which disclosure of Confidential Information is sought, such Party will give the other Party prompt notice thereof and provide such parties with a reasonable opportunity at its own expense to seek a protective order or other appropriate remedies with respect thereto and will disclose such Confidential Information in connection therewith only to the extent that such Confidential Information is legally required to be disclosed. Affiliate acknowledges that UUH is subject to the Utah Government Records Access and Management Act, Section 63G-2-101, *et. seq.*, Utah Code Ann. ("GRAMA"), as amended; that certain records in connection with this Agreement may be subject to public disclosure; and that UUH's confidentiality obligations shall be subject in all respects to compliance with GRAMA. Pursuant to Section 63G-2-309 of GRAMA, any confidential information (other than patient information) provided to UUH that Affiliate believes should be protected from disclosure must be accompanied by a written claim of confidentiality and a concise statement of reasons supporting such claim. This Section 13.1 shall survive the termination of this Agreement.

13.2 Public Announcements. The Parties will develop a media and marketing plan for the announcement of the Affiliation. No Party hereto shall release, publish, or otherwise make available to the public in any manner whatsoever any information or announcement regarding the transactions herein contemplated without the prior written consent of the Parties, except for information and filings reasonably necessary to be directed to governmental agencies to fully and lawfully effect the transactions herein contemplated or required in connection with securities and other laws. If there is such a disclosure to a government agency or otherwise required by law, the disclosing Party shall notify the other Party in advance and give the other Party the opportunity to comment on the disclosure.

13.3 Confidentiality of Terms. The terms of this Agreement and all SOWs, in particular any provisions regarding the compensation paid by any Party, shall remain confidential and shall not be disclosed by UUH or Affiliate, without the prior written consent of the other Party, except as necessary for the performance of this Agreement or any applicable SOW, or as required by law, including without limitation, GRAMA. If any Party becomes subject to compulsory process to disclose the terms of this Agreement, a SOW or the substance of any related negotiations, such Party shall resist

such disclosure and shall provide the other Party with immediate oral and written notice of such process. The obligations under this Section 13.3 shall survive termination of this Agreement. Nothing in this Agreement will negate the requirements of the Wyoming Statutes regarding public meetings (W.S. 16-6-401 et seq.)

13.4 Dispute Resolution. The Parties shall negotiate all matters of joint concern in good faith, with the intention of resolving issues between them in a mutually satisfactory manner. If a disagreement between the Parties cannot be resolved through informal discussions, or a Party believes that the relationship is not progressing in a mutually beneficial manner, the declaring Party shall present the dispute to the Operations and Quality Council, specifying the nature and cause of the dispute and the action that the declaring Party deems necessary to resolve the dispute. The Operations and Quality Council shall use good faith efforts to resolve the dispute. If a dispute is not resolved by the Operations and Quality Council within (30) days, the Operations and Quality Council shall present the dispute to each Party's Chief Executive Officer. The Chief Executive Officers shall engage in good faith discussions to further attempt to resolve the dispute. If a dispute is not resolved by the Chief Executive Officers within thirty (30) days, any Party may pursue all other available remedies. If other remedies are pursued by Affiliate, it must be with the knowledge and approval of Affiliate's Board of Trustees. The Parties agree that all aspects of the dispute resolution process shall be conducted in confidence.

13.5 Waiver of Breach. The waiver by any Party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to constitute, a waiver of any subsequent breach of the same or any other provision hereof.

13.6 HIPAA Compliance. The Parties agree to reasonably cooperate with each other in order to ensure compliance by each of them with the federal Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and any current and future regulations promulgated under either the HITECH Act or HIPAA, including without limitation the federal privacy standards, the federal security standards, and the federal standards for electronic transactions, all as may be amended from time to time, and all collectively referred to herein as "Confidentiality Requirements." Each party agrees to enter into any further agreements as necessary to facilitate compliance with Confidentiality Requirements, including, if necessary, a Business Associate Agreement in a form substantially similar to the form attached hereto as Exhibit A.

13.7 Compliance with Laws. Each Party shall comply, at its own cost and expense, with the provisions of all applicable federal, state, county and municipal laws, ordinances and regulations pertaining to the performance and provision of its services under this Agreement as they exist now and as they may be amended from time to time ("Applicable Laws"). In the event of any notice of a violation of the Applicable Laws, or an investigation into an alleged violation, each Party will promptly notify the other Party in writing of such notice. Each Party shall take all measures necessary to promptly remedy any violations(s) of any Applicable Law.

13.8 Excluded Provider Representation and Warranty. Each Party represents and warrants that it: (i) is not currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320A-7B-(f) (the "Federal health care programs"); and (ii) is not under investigation or otherwise aware of any circumstances which may result in it being excluded from participation in the Federal health care programs. This shall be an ongoing representation and warranty during the term of this Agreement. The Parties shall immediately notify one another of any change in the status of the representation and warranty set forth in this section.

13.9 Governing Law. This Agreement shall be governed by the laws of the State of Utah.

13.10 Amendments. This Agreement may be amended from time to time by mutual agreement of the Parties, but no such amendment shall be effective until it is incorporated into a formal written agreement, duly approved and executed by each of the Parties.

13.11 Independent Contractor Relationship. The Parties agree that they shall at all times be and act as independent contractors with respect to one another and that employees of a Party performing services under this Agreement are not and shall not be deemed to be employees of any other Party. No relationship of employer-employee, partner-partnership, principal-agent, or joint venturers is created by this Agreement.

13.12 Third Party Beneficiaries. This Agreement is not intended, and shall not be deemed or construed, to confer upon any person or entity, other than the Parties hereto, any right or interest, including, without limiting the generality of the foregoing, any third party beneficiary status or any right to enforce any provision of this Agreement.

13.13 Assignment; Change in Control. The Parties acknowledge that each is relying on the particular performance of the other to accomplish the unique goals and purposes of this Agreement. Because of this reliance and because this Agreement involves the close cooperation and continued involvement of the Parties, no assignment, pledge, encumbrance or transfer by any Party or successor to any Party to this Agreement of any interest, in whole or part, in this Agreement shall be valid or effective without the prior written consent of the other Party. In addition, upon a Change in Control of a Party, the continued participation of that Party in this Agreement shall be subject to the written consent of the other Parties. For the purposes of this Agreement, the term "Change in Control" means, whether accomplished in a single transaction or series of related transactions, (i) the acquisition by, or conveyance or other transfer to, a third party of more than fifty percent (50%) of the voting rights, stock, membership interest or similar ownership or control interest in a Party, (ii) the sale, transfer or other disposition of all or substantially all of the assets of a Party; or (iii) the merger, consolidation or other reorganization of a Party if, immediately following such merger, consolidation or reorganization, a controlling interest in the issued and outstanding voting securities or interests of the surviving, consolidated or reorganized entity are held by persons other than those holding voting rights, voting securities, membership interests or other interests of the Party, as of the Effective Date. Any consent required under this Section 13.13 may

be granted or denied at the sole and absolute discretion of the Party from whom such consent is requested.

13.14 Entire Agreement. This Agreement, together with all Exhibits and Schedules hereto, represents the entire agreement of the Parties with respect to the subject matter hereof, and supersedes any previous agreements between the Parties relating to the same subject matter.

13.15 Notices. Any notice, approval or consent required or permitted under the terms of this Agreement shall be in writing and sent by certified mail, postage prepaid, return receipt requested, or by nationally recognized overnight delivery service, addressed to each Party, or to such other address as either may designate by written notice to the other, as follows:

To Affiliate: Memorial Hospital of Sweetwater County
1200 College Drive
Rock Springs, WY 82901
Attn: CEO

To UUH: University of Utah Hospitals and Clinics
Hospital Administration
50 North Medical Drive, RM W1200
Salt Lake City, Utah 84132
Attn: CEO

Notices are effective upon written receipt if delivered by hand or by overnight delivery, or three (3) days after the date of postmark if sent by certified mail.

13.16 Severability. In the event any provision of this Agreement is held to be invalid, illegal or unenforceable for any reason and in any respect, such invalidity, illegality, or unenforceability shall in no event affect, prejudice, or disturb the validity of the remainder of this Agreement, which shall be and remain in full force and effect, enforceable in accordance with its terms.

13.17 Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original and all of which, taken together, shall constitute one and the same document.

[Signatures on following page.]

IN WITNESS WHEREOF, the duly authorized representatives of the Parties hereto have executed this Agreement as of the Effective Date.

UNIVERSITY OF UTAH
UNIVERSITY OF UTAH HEALTH

By: Dan Lundgren
Name: Dan Lundgren
Title: Chief Operating Officer, I

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

By: Richard Mathey
Name: Richard Mathey
Title: Pres., BOT

SWEETWATER COUNTY COMMISSIONERS
By: Reid O. West
Reid West, Chairman

ATTEST:
Dale Davis, Clerk

THE STATE OF WYOMING COUNTY SEAL CLERK SWEETWATER COUNTY

Exhibit A

Business Associate Agreement

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: **FACILTY USE AGREEMENT FOR U OF U DERMATOLOGY**

2. Purpose of contract, including scope and description: **use agreement with U of U for office space for a dermatologist. We will give them access to 3 medical exam rooms one day per month and 2 days with advance notice.**

3. Effective Date: **when approved by MHSC Board of Trustees and BOCC.**

4. Expiration Date : **3 years from effective date**

5. Termination provisions: **either party with 30-day's notice** Is this auto-renew? **No**

6. Monetary cost of the contract: **U of U will pay MHSC $100.00 per room per clinic visit. Also compensate the use of our receptionist at $16.00 per hour.** Budgeted? **NA**

7. Jurisdiction/Choice of Law provision checked and changed to Wyoming if able to so. **Wyoming (state where premises are located)**

8. Any confidentiality provisions? **NA**

9. Indemnification clause present? **Yes Section 5**

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

11. Is County Attorney review required? **Yes County attorney has this agreement and will have his opinion to MHSC prior to August 6th meeting**

FACILITY USE AGREEMENT

For Dermatology Services

This Facility Use Agreement (the "***Agreement***") is entered into and effective on the date of the last signature executing this Agreement by and between Memorial Hospital of Sweetwater County ("***Facility***") and the University of Utah, a body politic and corporate of the State of Utah, on behalf of its University of Utah Health ("***University***").

RECITALS

A. Facility is a provider of health care services to patients in the area of Rock Springs, Wyoming and wishes to improve the availability of Dermatology Services in the area;
B. University is an academic medical center located in Salt Lake City, Utah and, in furtherance of its academic and health care missions, wishes to provide Dermatology Services and related health care services to patients in the Rock Springs, Wyoming area; and
C. University and Facility wish to contract for the use of clinic space at Facility.

AGREEMENT

NOW, THEREFORE, in consideration of the foregoing, and mutual agreements set for below, the parties agree as follows:

1. Use of Premises. Facility grants to University the right to use three (3) medical exam room(s) and associated common areas located within Facility's office space at 1200 College Dr, Rock Springs, WY 82901 on a time share basis (the "***Premises***"). The Premises shall be available for exclusive use by University beginning with one to one (1) day per month and expanding to two days per month during such days pursuant to a written schedule agreed upon by the parties in advance (the "***Clinic***"). For purposes of this Agreement the Premises shall be available for use by University between the hours of 8 a.m. to 5 p.m. on each day that the University is scheduled to see patients at the Clinic. University may use the Premises for purposes of providing patient consultations and exams, and related health care services to patients of University ("***Services***"). The parties may, by written mutual agreement adjust the scope of Services, number of hours and/or days of use of the Premises as necessary to meet patient demand for Services at the Clinic.

2. Facility Services and Supplies.
   2.1. Support Staff Services. Facility shall furnish University with limited support staff services (the "***Support Services***") which shall include the use of Facility's regularly employed receptionist, and other support staff while University is providing care at the Facility during the agreed upon Clinic times.
   2.2. Supplies. Facility shall provide standard exam room furnishings with exam table and applicable basic exam supplies (including, but not limited to, exam table paper, paper towels, pillows, warm blankets, rubber gloves, and hand sanitizer).

3. University Responsibilities.
   3.1. Reserved Exam Rooms. University will pay Rent in accordance with Section 3.2 below for reserved exam rooms on a scheduled Clinic day; provided that University may revise the number of reserved exam rooms up to thirty (30) days prior to the scheduled Clinic day without penalty. In the event, University providers are unable to use a reserved exam room due to circumstances outside of the University's reasonable control, including, without limitation, civil commotion, war, third-party transportation delays, governmental regulations or controls, a casualty event, or acts of God, University will not be obligated to pay Rent for the reserved but unused exam room(s).
   3.2. Rent. University agrees to compensate Facility for the use of the Premises, Support Staff Services, and standard supplies provided hereunder (the "***Rent***") at the rate of $100 per room per Clinic during the term of this Agreement. University also agrees to compensate Facility for the use of a Receptionist at the rate of Sixteen Dollars ($16) per hour. Facility shall invoice University monthly for all Rent accrued during the preceding month. Invoices shall be paid by University within thirty (30) days of receipt. All Rent shall be paid by University by check payable to "Memorial Hospital of Sweetwater County" and shall be delivered or mailed to Facility at 1200 College Dr, Rock Springs, WY 82901.
   3.3. Clinical Staff. University shall provide all clinical staff required to provide Services while University is providing care at the Facility.
   3.4. Scheduling. University shall be responsible for scheduling patients, including obtaining patient demographics and insurance information.
   3.5. Clinic Cancellation. If necessary, due to circumstances beyond University's reasonable control, University may cancel a scheduled Clinic upon at least [48] hours advance notice to Facility and University shall have no obligation to pay Rent for any such cancelled Clinic.
   3.6. Billing and Collections. University shall be solely responsible for billing and collections for all Services provided by University at the Clinic, including both technical and professional fees. Facility shall not bill or collect any technical or professional charges for the Services.

4. Term and Termination. The term of this Agreement shall commence on the effective date and continue for an initial term of three (3) year. Either party may terminate this Agreement, with or without cause, upon thirty (30) days' prior written notice to the other.

5. Indemnification.
   5.1. Indemnification by Facility. Facility shall defend, indemnify and hold harmless University, its officers, employees and agents, from and against all liability, damages, judgments, expenses, losses or costs incurred, including reasonable attorneys' fees, to the extent caused by any negligent error, act or omission of Facility, or any breach of this Agreement by Facility.
   5.2. Indemnification by University. University is a governmental entity and is subject to the Governmental Immunity Act of Utah, Section 63G-7-101 et seq. Utah Code Ann., as

amended (the "***Act***"). Subject to the Act, University shall defend, indemnify and hold harmless Facility from and against all expenses, losses or costs incurred, including reasonable attorneys' fees, to the extent caused by any negligent error, act or omission of University, or any breach of this Agreement by University. Nothing in this Agreement shall be construed as a waiver of any rights or defenses applicable to University under the Act, including without limitation, the provisions of Section 63G-7-604 regarding limitation of judgments.

6. Insurance.
   6.1. Professional Liability Insurance. University and Facility shall each maintain at all times during the term of this Agreement, professional liability insurance in the minimum amount of $1,000,000.00 for each occurrence, and $3,000,000.00 in the annual aggregate covering their respective employees, agents, and representatives against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with professional services provided by their respective employees. Upon request, each party shall provide the other with evidence of such coverage.
   6.2. General Liability Insurance. Facility shall also maintain Commercial General Liability insurance with per occurrence limits of at least $1,000,000.00 and general aggregate limits of at least $2,000,000.00. Such insurance policies shall be endorsed to be primary and not contributing to any other insurance maintained by the University.

7. Authorization to Grant Use of Premises. Facility represents and warrants to University that Facility has obtained all necessary approvals from any owner, landlord, lessor, lessee, lender or other person with any rights in the Premises or the Clinic which may be necessary to authorize Facility to grant to University the rights granted herein.

8. Patient Records. All patient medical records shall be confidential and neither party shall disclose any such records to any person except as permitted by law. The parties acknowledge that each is a "covered entity" under the Health Insurance Portability and Accountability Act ("***HIPAA***"). Each party represents and warrants to the other that it is in compliance with privacy provisions of HIPAA as found under 45 CFR, parts 160 and 164: Standards of Privacy or Individually Identifiable Health Information, commonly known as the "Final Privacy Rule". Each party shall indemnify and hold the other party harmless from any liability, costs, awards, judgments, penalties or fees (including reasonable attorney's fees) arising out of a breach of its confidentiality to other obligations under this Section 8. The University shall own and retain all medical records.

9. Health and Human Services Records. Pursuant to 42 U.S.C. Section 1395x (V) (1) (I), with respect to any services furnished under the terms of this Agreement the value or cost of which is Ten Thousand Dollars ($10,000.00) or more over a twelve-month period, until the expiration four (4) years after termination of this Agreement, University and Facility shall each make available upon request to the United States Department of Health and Human Services, the United States Comptroller General, and their representatives, a copy of this Agreement and such other books,

documents and records as are necessary to certify the nature and extent of the costs of the services provided under this Agreement for which payment may be made under the Medicare program.

10. Miscellaneous.
    10.1. Relationship of the Parties. In assuming and performing the obligations of this Agreement, Facility and University are each acting as independent parties and neither shall be considered or represent itself as a joint venture, partner, or employee of the other. Neither Facility nor University shall use the name or any trademark of the other in any advertising, letterhead, sales promotion or other publicity matter without the prior written approval of the other.
    10.2. Entire Agreement. This Agreement constitutes the entire agreement between the parties regarding the subject matter hereof and supersedes any other written or oral understanding of the parties. This Agreement may not be modified except by written instrument executed by both parties.
    10.3. Compliance.
        10.3.1. The parties agree that it is not the purpose of this Agreement to exert any influence over the reason or judgment of any party with respect to the referral of patients or other business between the Facility and University, but that it is the parties' expectation that any referrals which may be made between the parties shall be and are based solely upon the medical judgment and discretion of the patient's physician. The parties further agree and acknowledge that the Rent is (i) set forth in advance; (ii) consistent with fair market value in an arms-length transaction; (iii) does not take into account the volume or value of any referrals or other business generated between the parties; and (iv) would be reasonable even if no referrals were made between the parties. Facility and University enter into this Agreement with the intent of conducting their relationship and implementing the Agreement in full compliance with applicable federal, state and local law.
        10.3.2. Each party warrants and represents that such party, its officers, directors, and any employees or subcontractors providing goods or services under this Agreement are not currently excluded, debarred, or otherwise ineligible to participate in federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) or to provide goods to or perform services on behalf of the federal government as either a contractor or subcontractor. This shall be an ongoing representation and warranty during the term of this Agreement and each party shall immediately notify the other of any change in the status of the representation and warranty. Either party may immediately terminate this Agreement for cause in the event of a breach of this section or as a result of any material change in status of the representation and warranty.
    10.4. Governmental Immunity
    Each party to the agreement shall assume the risk of any liability arising from its own conduct. No party agrees to indemnify any other party. MHSC is a governmental entity and hereby expressly reserves its governmental immunity, pursuant to W.S. 1-39-101 et.

seq. University is a governmental entity and hereby expressly reserves its governmental immunity, pursuant to Utah Code Ann., Section 63G-7-101 et seq. (the "Act"). Nothing in this Agreement shall be construed as a waiver by the University of any protections, rights, or defenses applicable to the University under the Act, including without limitation, the provisions of Section 63G-7-604 regarding limitation of judgments. It is not the intent of either party to incur by contract any liability for the operations, acts, or omissions of the other party or any third party and nothing in this Agreement shall be so interpreted or construed.

10.5. Notices. Any notice or other communication required under this Agreement shall be in writing and delivered to the respective addresses given below, or to such other address as either party shall designate in writing:

In the case of University:

University of Utah School of Medicine
Department of Dermatology
30 North 1900 East 4A330
Salt Lake City, Utah 84132
Attn:

In the case of Facility:

Memorial Hospital of Sweetwater County
1200 College Dr.
Rock Springs, WY 82901
Attn:

10.6. Governing Law. This Agreement shall be interpreted and construed in accordance with the laws of the state in which the Premises are located, without application of any principles of choice of laws. Notwithstanding the application of the laws of another state, University does not waive any rights or defenses available to it under the laws of the State of Utah, including without limitation, the Governmental Immunity Act of Utah.

10.7. Counterparts; Electronic & Facsimile Execution. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original but all of which together shall constitute but one and the same instrument. The exchange of copies of this Agreement and of signature pages by facsimile transmission or in PDF format via email shall constitute effective execution and delivery of this Agreement as to the Parties and may be used in lieu of the original Agreement for all purposes. Signatures of the Parties transmitted by facsimile or in PDF format via email shall be deemed to be their original signatures for all purposes.

[Signature Page to Follow]

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their duly authorized representatives effective as of the day and year first written above.

UNIVERSITY OF UTAH
("UUH")

By: _____

Name: _____

Title: _____

MEMORIAL HOSPITAL OF
SWEETWATER COUNTY
("Affiliate")

By: _____

Name: _____

Title: _____

This Agreement must be presented to the Sweetwater County Commission for approval as is required by W.S. 8-8-301. Such approval is required prior to this Agreement being effective.

SWEETWATER COUNTY COMMISSIONERS

By: _____
Reid West, Chairman

ATTEST:

_____
Dale Davis, Clerk

Contract Check List

This checklist 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 and pursuant to the **CONTRACTS REQUIRING BOARD APPROVAL POLICY** this contract requires board approval as it is a consulting contract.

1. Name of Contract: **NaVECTIS GROUP-CONSULTANT**

2. Purpose of contract, including scope and description: **The consultant will teach staff how to work with patients to optimize their insurance benefits and will teach staff how to access patient advocate foundations and professional foundation groups to help with medical costs if not insured.**

3. Effective Date and term: **August 1, 2019**

4. Expiration Date: **1 year with auto renew for 1 year terms**

5. Termination provisions: **terminate with 90 days written notice by either party for any reason 30 days for breach** Is this auto-renew? **yes**

6. Monetary cost of the contract: **Sixteen Thousand Dollars ($16,000.00) for first year- Eight Thousand Dollars for year 2 on until terminated. We will pay for one on-site visit. Will include airfare to SLC from Michigan; car rental and hotel august 12 and 13. The remainder of the consulting will be done by phone, Skye etc. Only one in person visit.** Budgeted**? No but cost of consultation will be recouped through patient insurance optimization.**

7. Jurisdiction/Choice of Law provision checked and changed to Wyoming if able to so. **Wyoming is choice of law venue**

8. Any confidentiality provisions? **Yes section 4**

9. Indemnification clause present? **Yes section 6**

10. Is this contract appropriate for other bids? **Other providers were contacted but this one provided services needed at reasonable price**

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

CONSULTING AGREEMENT

THIS CONSULTING AGREEMENT (the **"Agreement"**) is entered into effective as of the 1st day of August, 2019 **"Effective Date"**) by and between **CFCS, LLC, d/b/a The NaVectis Group**, a Michigan limited liability company, with an address of P.O. Box 185, Caledonia, Michigan 49316 (**"Consultant"**) and Memorial Hospital of Sweetwater County **("Hospital")**, an nonprofit corporation, with an address of 1200 College Drive, Rock Springs, WY 82901.

RECITALS:

WHEREAS, HOSPITAL desires to engage Consultant to assist HOSPITAL in implementing its Patient Financial Navigation Program (the **"Program"**), as set forth in the Agreement; and

WHEREAS, Consultant desires to provide such services to HOSPITAL pursuant to the terms of this Agreement.

NOW THEREFORE, in consideration of the mutual promises contained in this Agreement and intending to be legally bound, the parties agree as follows:

1. **Services.**

   1.1 HOSPITAL hereby engages Consultant, and Consultant agrees to perform the services described in Exhibit A (the **"Services"**), attached hereto and incorporated herein by reference. To the extent practicable, Consultant shall be permitted to perform the Services remotely, by use of telephone, e-mail, or otherwise. Unless otherwise specifically agreed to in writing by HOSPITAL, all Services will be performed by Dan Sherman, MA, LPC.

   1.2 Each party acknowledges that this Agreement shall in no way be construed or interpreted to be an exclusive arrangement between Consultant and HOSPITAL, and both parties are, and shall remain, free to contract with and/or provide services to third parties.

   1.3 Consultant represents and warrants that: (a) the Services will be performed in a professional and workmanlike manner; and (b) Consultant will perform the Services in compliance with all Joint Commission standards, HOSPITAL policies and procedures, applicable laws, rules, and regulations. Consultant further represents and warrants that Consultant will not knowingly employ, hire for employment or continue to employ any unauthorized alien within the State of Wyoming.

   1.4 While on HOSPITAL or HOSPITAL affiliate premises, Consultant will comply with HOSPITAL's safety and security procedures and will conform to certain rules of conduct that HOSPITAL may have in effect.

2. **Compensation.** HOSPITAL will pay Consultant the fees specified in the Exhibit A for Consultant's performance of Services according to the terms of this Agreement. Additionally, HOSPITAL will reimburse Consultant for the following "reasonable expenses" actually incurred by Consultant: (a) travel expenses to and from all work sites (all flight reimbursement shall be for coach seats); (b) meal

expenses if lodging is necessary not to exceed the sum of $75 per day, or the standard IRS Per diem meal expense, whichever is greater; (c) lodging expenses if overnight stay is appropriate (in hotels designated by HOSPITAL for its out of town consultants); and (d) miscellaneous travel-related expenses, including, without limitation, parking and tolls incurred. Consultant shall submit written documentation and receipts itemizing the dates on which expenses are incurred. All amounts not paid within thirty (30) days of the due date set forth in Exhibit A shall bear interest from the date the amount was due at the rate of twelve percent (12%) per annum or the maximum rate allowed by law, whichever is less.

3. **Term and Termination.** The term of this Agreement will begin on the Effective Date and will continue for a term of twelve (12) months (the **"Initial Term"**). The Agreement will automatically renew for one (1) additional twelve (12) month term unless HOSPITAL notifies the Consultant of its intention to terminate the contract at least thirty (30) days in advance of the expiration of the Initial Term. At the expiration of the second twelve (12) month term, if HOSPITAL does not terminate the Agreement sooner, the Agreement may only be extended upon mutual written consent of the parties. This Agreement may be terminated at any time by either party for any reason without cause with ninety (90) days advance written notice and if the other party breaches any of its obligations under this Agreement and such breach continues for thirty (30) days after such other party receives written notice thereof. HOSPITAL may immediately terminate this Agreement in the event that Consultant's conduct, in the sole discretion of HOSPITAL, could affect the quality of professional care provided to HOSPITAL or its affiliates patients or be prejudicial or adverse to the best interest and welfare of HOSPITAL or its affiliates' patients. In the event of any termination of this Agreement, HOSPITAL shall pay Consultant for all Services actually performed through the date of termination and shall reimburse Consultant for all expenses which have either been incurred by Consultant through such date or cannot be cancelled or otherwise avoided. In the event this Agreement is terminated during the first twelve months of the Initial Term, the parties shall be prohibited from entering into an arrangement for the Service with each other until after the expiration of the first 12 months of the Initial Term.

4. **Ownership and Confidentiality.**

   4.1 Consultant agrees and acknowledges that all right, title and interest, including all intellectual property rights, in and to any reports, presentations, technical information and inventions created by Consultant in connection with the performance of Services, shall be owned by HOSPITAL and shall be considered works made by Consultant for hire for the benefit of HOSPITAL.

   4.2 Consultant acknowledges that HOSPITAL has invested and will continue to invest significant time and resources in the research, development, and advancement of the HOSPITAL and HOSPITAL's affiliates' business, which investment has and will result in creation of proprietary and confidential information and materials (hereinafter **"Confidential Information"**). Confidential Information includes but is not limited to technical information regarding HOSPITAL products, including data, know-how, trade secrets, and documentation; HOSPITAL procedures, processes, methods, and research agendas; proprietary information received by HOSPITAL from a third party under license or otherwise; and non-technical information of HOSPITAL such as pricing policies, customer and supplier lists, and financial information. Confidential Information shall not include information which Consultant can establish (a) was, as of the Effective Date,

generally known to the public; (b) became generally known to the public after the Effective Date other than as a result of the act or omission of Consultant; (c) was rightfully known by Consultant prior to Consultant's learning or receiving same from HOSPITAL; (d) is or was disclosed by HOSPITAL to third party generally without restrictions on use and disclosure; (e) was lawfully received by Consultant from a third party without that third party's breach of any agreement or obligation of trust; (f) was independently developed by Consultant and Consultant can show, by documentation, that it was developed without any reference to Confidential Information; or (g) is disclosed pursuant to the order of a court or other government body or as required by law.

4.3 Consultant agrees not to: (a) use the Confidential Information for Consultant's own benefit or the benefit of any third party; (b) disclose or permit disclosure of the Confidential Information to a third party; or (c) use the Confidential Information for any purpose other than in connection with providing Services under this Agreement. Consultant will deliver to HOSPITAL at any time upon request, and in any event, upon the termination or expiration of this Agreement, all Confidential Information in Consultant's possession or control, whether in electronic or hard copy form.

5. **Independent Contractor.** Consultant will act solely as an independent contractor in performing services for HOSPITAL. Consultant will be solely responsible for payment of all taxes associated with fees earned; HOSPITAL shall not withhold any taxes from payments made. Consultant will not be deemed an employee, agent, partner, or joint venture of HOSPITAL and shall not be entitled to any benefits provided by HOSPITAL to its employees. Consultant and HOSPITAL agree and acknowledge that Consultant shall have no authority whatsoever to bind HOSPITAL in any matter. Consultant hereby waives and releases HOSPITAL from any liability or responsibility for maintaining workers' compensation insurance and from any liability resulting from injury to the person or property of Consultant and the person or property of any third party in connection with the performance of the services. Consultant hereby further represents and warrants to HOSPITAL that it is not entitled to and will not take any tax position that is inconsistent with being a service provider with respect to the services provided by Consultant to HOSPITAL under this Agreement.

6. **Indemnification; Limitation of Liability; Insurance.**

6.1 Consultant shall indemnify, defend, and hold HOSPITAL and its affiliates harmless from and against any and all losses, claims, suits, damages, liabilities and expenses (including, without limitation, reasonable attorneys' fees) of any nature or kind whatsoever arising out of or resulting from, directly or indirectly: (i) Consultant's breach of this Agreement, including, without limitation, breach of any representation, warranty, or covenant of such party in this Agreement; (ii) any alleged negligent or intentional acts or omissions of Consultant, its agents or employees, based upon, arising out of or attributable to the performance or non-performance of their respective obligations under this Agreement; and (iii) conduct by Consultant which negatively affects the quality of professional care provided to HOSPITAL or HOSPITAL's affiliates' patients or jeopardizes the best interests and welfare of HOSPITAL, HOSPITAL's affiliates' patients, and HOSPITAL visitors. Upon notice, Consultant shall resist and defend, at its own expense, any such claim or action. Said indemnity is in addition to any other rights HOSPITAL may have against Consultant. HOSPITAL shall indemnify and hold harmless Consultant from and against all claims, liabilities, actions and expenses (including costs of defense, settlement and reasonable

attorneys' fees) which Consultant incurs as a result of death, bodily injury, damage to property, or violation of any governmental law, to the extent cause by the negligence and/or willful misconduct of HOSPITAL.

6.2 NEITHER PARTY SHALL BE LIABLE FOR ANY INDIRECT, CONSEQUENTIAL, SPECIAL OR PUNITIVE DAMAGES IN CONNECTION WITH THIS AGREEMENT, EVEN IF IT HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

7. **Insurance.** Consultant shall maintain in effect at all times during the term of this Agreement the following insurance, against all losses, claims, demands, proceedings, damages, costs, charges, and expenses for injuries or damage to any person or property arising out of or in connection with this Agreement which are the result of the fault or negligence of Consultant, its affiliates, and/or subcontractors:

(a) Commercial General Liability Insurance (including special form/broad form property damage liability, contractual liability, premises/operations, products liability, and personal injury coverage), on an occurrence form, in the amount of at least One Million Dollars ($1,000,000.00) combined single limit covering personal injury and property damage, One Million Dollars ($2,000,000.00) in the aggregate.

(b) Professional Liability Insurance in minimum amounts of $2,000,000.00 per occurrence and $2,000,000.00 in the aggregate.

8. **Miscellaneous.**

8.1 This Agreement (including, without limitation, its exhibit) sets forth the entire understanding of the parties and supersedes all prior agreements, both oral and written, between the parties with respect to the subject matter hereof. This Agreement shall be binding upon and inure to the benefit of the parties and their respective successors and lawful assigns, and no party may assign this Agreement without the prior written consent of the other party.

8.2 Except as otherwise expressly provided in this Agreement, all covenants, agreements, representations and warranties, express and implied, shall survive the execution of this Agreement.

8.3 This Agreement shall not be amended or modified except by an instrument in writing signed by both parties. No waiver of either party's rights under this Agreement will be valid unless given in a signed writing.

8.4 All notices which are required to be given by either party to the other hereunder shall be deemed to have been duly given when personally delivered or made in writing and sent by overnight mail addressed to the other party at the addresses set forth above or to such other address as either party may notify the other party in writing.

8.5 If any portion of this Agreement is found to be invalid or unenforceable for any reason, any court or other tribunal adjudicating the rights and duties of the parties under this Agreement shall alter, modify, or strike portions of the Agreement so that it will be enforceable to the fullest extent permitted by law. If any provision of this Agreement is

held, in whole or in part, to be invalid, the remainder of such provision and this Agreement shall remain in full force and effect.

8.6 The terms and conditions of this Agreement shall be governed, construed, interpreted, and enforced in accordance with the laws of the State of Wyoming, without regard to its conflict of laws principles. Any and all actions concerning any dispute arising under this Agreement shall be filed and maintained in the Courts lying and being in the county of Sweetwater, State of Wyoming.

8.7 Both parties expressly stipulate that, to the extent permitted by law, any documents contemplated pursuant to this Agreement may be executed and become effective by affixing their signature in the appropriate location and transmitting such document to the other party using traditional, electronic, or facsimile methods of transmission. Any such electronic or facsimile transmitted signature shall be deemed and carry the legal significance of an original signature.

8.8 This Agreement may be signed in counterparts, and transmitted by facsimile or Adobe PDR file, each of which shall be deemed to be an original, with the same effect as if the signatures thereto and hereto were upon the same instrument.

8.9 This Agreement, and the rights of the parties hereunder, may not be assigned by either party, without the prior written consent of the other party, which consent shall not be unreasonably withheld; provided, however, that each party hereby consents to any assignment to any successor of the other party due to acquisition, merger, consolidation, or reorganization, provided that any such assignment shall not alter the terms of the Agreement without the written consent of the non-assigning party.

8.10 Consultant shall not use or publicize HOSPITAL or any HOSPITAL affiliate's name, marks, or logo, whether in marketing material, press releases, or otherwise, without HOSPITAL's prior written consent.

8.11 None of the provisions of this Agreement is intended to create, nor shall be deemed or construed to create, any relationship between the parties other than that of independent parties contracting with each other for the purpose of effecting the provisions of this Agreement. The parties are not, and shall not be construed to be in a relationship of joint venture, partnership or employer-employee. Consultant shall neither have nor exercise any control or direction over the methods by which HOSPITAL and its affiliates and their respective employees perform any Services. Neither party shall have the authority to make any statements, representations or commitments of any kind on behalf of the other party.

IN WITNESS, WHEREOF, the parties have executed this Agreement effective as of the Effective Date.

CFCS, LLC

Date: _____

By:_____
Dan Sherman, MA, LPC
Its: President

Memorial Hospital

Date: _____

By:_____

Its: _____

EXHIBIT A

SCOPE OF CONSULTING SERVICES AND COMPENSATION

1. During the Term, Consultant will provide up to two (2), eight (8) hour days "training" to HOSPITAL, as requested by HOSPITAL on reasonable advance notice. The training will be provided to one (1) Financial Navigator who will provide Financial Navigation Services within HOSPITAL. In addition, during the Term, HOSPITAL and its affiliates will have access to Consultant for up to one hundred (100) hours of off-site Services. This will average to two (2) hours a week, but is expected to be more during the first six (6) months of Program implementation and less for the remaining Term of this Agreement. The Consultant is to dedicate a total of two hundred sixteen (216) hours of consulting time for the full two years of the contract. It is also understood that Consultant will not be available two (2) weeks out of the calendar year for vacation purposes. Consultant will provide a minimum four (4) week notice of any vacation time taken. Consultant shall provide the following Services to HOSPITAL at the times specified above:

a. Assist HOSPITAL and its affiliates in improving its Financial Navigation Program by developing awareness of cost saving and revenue generating programs consisting of:

i. Co-pay assistance programs;
ii. Patient assistance/replacement programs;
iii. Medicare Analysis/Optimization Program
iv. Premium assistance; and
v. Marketplace Enrollment Insurance Optimization.

b. Assist HOSPITAL and its affiliates in the development and training of staff for the purpose of the implementation of the Financial Navigation Program.

c. Upon request of the program manager, the Consultant will hold monthly conference calls with the Financial Navigator and the Program manager for the first three (3) months of Program implementation and then quarterly conference calls for the remaining months of the Program. The Consultant will review performance of the financial navigator and provide guidance for improvement (if found necessary) during these conference calls.

d. Assist HOSPITAL and its affiliates in the implementation of tracking methodology for the purposes of understanding the financial efficacy of the Financial Navigation Program at HOSPITAL affiliates facilities.

e. HOSPITAL acknowledges that Consultant is not providing legal services under this Agreement.

2. In consideration of Consultant's performance of Services hereunder, HOSPITAL shall pay Consultant as follows:

Program Fees. As compensation for the Services provided by Consultant during the Term, HOSPITAL shall pay the consultant the amount of Sixteen Thousand Dollars ($16,000) for the first year of the program, and Eight Thousand Dollars ($8,000) for the second year of the Agreement, if HOSPITAL desires to extend the Agreement for another twelve (12) month period. HOSPITAL will also pay reasonable expenses as outlined in section 2 of the Agreement. The parties acknowledge and agree that the fees for the Services provided by Consultant constitute reasonable compensation and fair market value, and compensation is provided without regard to the volume or value of referrals between the parties. Payment shall be due

to Consultant within thirty (30) days of HOSPITAL receiving an accurate, undisputed invoice of fees and expenses.

3. ROI Guarantee: NaVectis will guarantee a ROI of 5:1 scale on gross savings listed in section 1. a) i-v. Therefore, NaVectis guarantees that the program will generate a minimum of $80,000 in savings per year. If the program does not generate a 5:1 ROI during any year of the Term, NaVectis will refund the Hospital all amounts paid by Hospital pursuant to the Agreement. The ROI guarantee is based upon HOSPITAL implementing and utilizing all five principles listed in section 1. a) i-v.

   The ROI will be calculated based upon the following formulas:

   a. Co-Pay Assistance Programs. Net revenue will be 33% of the grants received from the co-pay assistance programs that your patients will be enrolled in.

   b. Patient Assistance Programs / Drug Replacement Programs. Net savings will be actual cost of each pharmaceutical product that you receive from pharmaceutical companies.

   c. Medicare Analysis/Optimization. $4,000 will be added to the net revenue for each individual who improves their Medicare plan.

   d. Premium Assistance Program. Net revenue will be the total payments received from the third party payer minus the premiums paid for the policy.

   e. Marketplace Enrollment Insurance Optimization. The decrease in out of pocket responsibility will be added to the net revenue for each individual who improves their Marketplace policy based upon the counsel of the Financial Navigator

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: **AMERICAN ASSOCIATION OF CRITICAL CARE NURSES E-LEARNING LICENSE**

2. Purpose of contract, including scope and description: **AACN E-learning really is award-winning. CNO can tell by the way the nurse charts and takes care of patients and asks questions if he/she has taken these e-learning courses or not. This e-learning program is even more important as we have an ICU of very, very inexperienced nurses. AACN's e-learning system's up-to-date, interactive, and evidence-based didactic education easily blends into your existing orientation plans. AACN's 24/7 customer support, comprehensive reports, and progress tracking tools make implementation straightforward. Continuing education hours are provided by module to support this flexibility**

3. Effective Date: **Date executed by MHSC**

4. Expiration Date: **36 months from effective date**

5. Termination provisions: **not addressed in quote** Is this auto-renew? **No**

6. Monetary cost of the contract: **$5500.00 for 3 year site license renewal. (Under initial Agreement this e-learning license was $8600.00. With new software in HR we are able to cut back on learning through this company).**

Budgeted? **YES**

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

8. Any confidentiality provisions? **In Master Agreement section 5**

9. Indemnification clause present? **Yes section 10 Master Agreement indemnification for AACN and MSHC**

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

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

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: **GALLAGHER EMPLOYEE ENGAGEMENT SURVEY**

2. Purpose of contract, including scope and description: **Part of the strategic plan pillar for workplace experience is an employee engagement survey. In addition, MHSC would like to apply to be an Employer of Choice and part of the application process is completion of an employee engagement survey. HR/Employee engagement best practice is to conduct an engagement survey every 2 years (minimum). Our last engagement survey was in 2016.**

3. Effective Date: **When proposal is agreed to and accepted by MHSC**

4. Expiration Date: **survey proposal calls for survey and then follow up with HR on interpretation and analyses of survey Once that is completed to satisfaction of MHSC proposal is completed**

5. Termination provisions: **Once we accept and begin the process of survey we will need to pay for the survey and follow up services** Is this auto-renew? **NO**

6. Monetary cost of the contract: **$16,490.00** Budgeted? **YES**

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

8. Any confidentiality provisions? **NA**

9. Indemnification clause present? **NA**

10. Is this contract appropriate for other bids? **HR contacted other companies who provide engagement surveys. Selected this one due to proposal and services provided.**

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

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: **HOSPICE SERVICES COWBOY CARES**

2. Purpose of contract, including scope and description: **creates an agreement with Cowboy Cares to allow hospice patients to be admitted for inpatient care for pain control or symptom management. We agree to make inpatient beds and services available for use by hospice patients. We have the same arrangement with other hospice providers.**

3. Effective Date: **When signed by CEO**

4. Expiration Date: **one year from effective date**

5. Termination provisions: **30 days written notice by either party** Is this auto-renew? **Yes**

6. Monetary cost of the contract: **The Medicare reimbursement rates are listed as Appendix A-1,A-2, A-3. Appendix A3 #3 refers to the most common inpatient reason-general inpatient. The reimbursement is 80% of the rate paid to Cowboy Cares from Medicare for an inpatient stay (changes annually). MHSC will bill Cowboy Cares directly as we cannot bill separately once a patient is on hospice. Cowboy Cares will then reimburse MHSC 80% of the rate we receive. Once a patient selects hospice services, the agency they chose is responsible for all cost associated to the hospice diagnosis.** Budgeted? **NA**

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

8. Any confidentiality provisions? **Yes**

9. Indemnification clause present? **Yes**

10. Is this contract appropriate for other bids? **NA**

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

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: **Mission Health clinical Agreement**

2. Purpose of contract, including scope and description: **MHSC will provide specimen collection and laboratory services for Mission Health. We will also transport the specimens to our lab for testing. This agreement has been in place since 2016 but expires in August 2019 so we are renewing.**

3. Effective Date: **date of last signature becomes effective date**

4. Expiration Date: **3 years from effective date**

5. Termination provisions: **either party with 30 day's written notice**
Is this auto-renew? **No**

6. Monetary cost of the contract: **Mission Health will pay us $260.00 per month for transport and courier services. MHSC also has the sole right to bill patients for lab services.** Budgeted? **NA**

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

8. Any confidentiality provisions? **No**

9. Indemnification clause present? **No**

10. Is this contract appropriate for other bids? **NA**

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

Contract Check List

This checklist 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. Contract is under $25000.00 so may be signed by CEO. Board will be advised that contract was signed.

1. Name of Contract: **VIVOR**

2. Purpose of contract, including scope and description: **software program that helps clinic, cancer center and hospital find programs to find programs related to drug companies to reduce costs of drugs for patients and increase reimbursement. Cost is based on assisting approximately 300 patients. If patient base increases substantially there will be no increase in additional charge the first year but will increase contract cost in subsequent years.**

3. Effective Date: **when signed by MHSC CEO**

4. Expiration Date: **one year from effective date**

5. Termination provisions: **30 day written notice by either party** Is this auto-renew? **Yes for one-year terms**

6. Monetary cost of the contract: **$12,000.00 year**
Budgeted? **No will recoup the cost for this contract in medication cost savings.**

7. Jurisdiction/Choice of Law provision checked and changed to Wyoming if able to so. **Company is in Delaware so that is jurisdiction**

8. Any confidentiality provisions? **Yes section 11**

9. Indemnification clause present? **Yes section 10**

10. Is this contract appropriate for other bids? **Looked at one other recommended company and cost was much, much more.**

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