MEMORIAL HOSPITAL OF SWEETWATER COUNTY
REGULAR MEETING OF THE BOARD OF TRUSTEES
August 6, 2025
2:00 p.m.
Hospital Classrooms 1, 2 & 3

AGENDA

I. Call to Order — Kandi Pendleton
   A. Roll Call
   B. Trustee Appointment & Oath of Office — Geoff Phillips, *Legal Counsel*
   C. Pledge of Allegiance
   D. Mission and Vision — Nena James
   E. Mission Moment — Irene Richardson, *Chief Executive Officer*

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

III. Community Communication — Kandi Pendleton

IV. Old Business — Kandi Pendleton
   A. Quarterly Progress Report on Strategic Plans and Goals
   B. Medical Staff Peer Review Plan (formerly Professional Practice Review Plan) *(For Action)* — Stephanie Mlinar, *Quality Director*
   C. Performance Improvement and Patient Safety (PIPS) Plan *(Under Development)*
   D. Patient Safety

V. Consent Agenda *(For Action)* — Kandi Pendleton
   A. Approval of Meeting Minutes
   B. Approval of Bad Debt
   C. Utilization Management Plan — Robin Jenkins, *Director of Care Management*

VI. New Business *(For Review and Questions/Comments)* — Kandi Pendleton
   A. Firearms and Weapons Policy — Geoff Phillips, *Legal Counsel*
   B. Hospital Insurance Policy — Geoff Phillips
   C. Critical Access Hospital – Exposure Control Plan — Dr. Kari Quickenden, *Chief Clinical Officer*; Patty O'Lexey, *Director of Education and Employee Health*

VII. Reports
   A. Chief Executive Officer and Guests Verbal Reports
      1. Chief Executive Officer Report — Irene Richardson
      2. Chief of Staff Report — Dr. Israel Stewart, *Chief of Staff*
      3. County Commissioner Liaison Report — Taylor Jones, *County Commissioner*
   B. Senior Leader and Board Committee Reports
      1. Senior Leader Written Reports
         a. Chief Clinical Officer — Kari Quickenden
         b. Chief Experience Officer — Cindy Nelson
         c. Chief Financial Officer — Tami Love
         d. Chief Nursing Officer — Ann Marie Clevenger

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AGENDA

2. Board Committee Written or Verbal Reports
   a. Governance Committee — Kandi Pendleton
   b. Quality Committee — Nena James
      1) FY25 Annual Performance Improvement & Patient Safety Eval — Stephanie Mlinar
   c. Human Resources Committee — Nena James
   d. Finance and Audit Committee — Craig Rood
   e. Foundation Board Report — Craig Rood
   f. Executive Oversight and Compensation Committee — Kandi Pendleton
   g. Joint Conference Committee — Nena James
   h. Building and Grounds Committee — Marty Kelsey
   i. Compliance Committee — Kandi Pendleton

VIII. Contracts — Suzan Campbell, *In-House Counsel*
   A. Arctic Wolf Security *(For Approval)*
   B. True North *(For Approval)*
   C. Lamar (*For Information, No Action Needed)*
   D. Sweetwater Now *(For Information, No Action Needed)*
   E. The Radio Network *(For Information, No Action Needed)*

IX. Education
   A. VMG Health (formerly Veralon) Mission & Strategy - "The Rural Health Landscape"

X. Good of the Order — Kandi Pendleton

XI. Executive Session (W.S. §16-4-405(a)(ix)) — Kandi Pendleton

XII. Action Following Executive Session — Kandi Pendleton

XIII. Adjourn — Kandi Pendleton

Sent: Wednesday, June 18, 2025 1:19 PM
Subject: Board Appointment

Neil D Malicoat
Green River, WY, 82935

Dear Neil D Malicoat,

During the June 17, 2025 Board of County Commissioner's meeting, you were appointed to fill an unexpired term on the MEMORIAL HOSPITAL OF SWEETWATER COUNTY BOARD. This term will expire on July 1, 2029.

The County Commissioners very much appreciate your serving on this board and your willingness to offer your time, talents, and energy to benefit the community.

The MEMORIAL HOSPITAL OF SWEETWATER COUNTY BOARD will contact you regarding the meeting schedule. However, in the meantime, should you have any questions or concerns, please do not hesitate to contact my office at 307-872-3897 and speak with Sally Shoemaker.

Sincerely,

Keaton D. West, Chair

Sweetwater County

Board of County Commissioners

cc- The MEMORIAL HOSPITAL OF SWEETWATER COUNTY BOARD

Memorial Hospital
OF SWEETWATER COUNTY

OATH OF OFFICE

I, NEIL MALICOAT, do solemnly swear and affirm that I will obey and defend the Constitution of the United States; and the Constitution of the State of Wyoming, and that I will faithfully and impartially discharge and perform the duties of my office as a member of the Board of Trustees of Memorial Hospital of Sweetwater County; that I have not paid or contributed, or promised to pay or contribute, either directly or indirectly, any money or other valuable thing, to procure my appointment; that I have not knowingly violated any law of the State of Wyoming in order to be appointed, or procured my appointment by others in my behalf; and that I will not knowingly receive, directly or indirectly, any money or other valuable thing for the performance or nonperformance of any act or duty pertaining to my position on the Board of Trustees.

_____
Neil Malicoat, Affiant

THE STATE OF WYOMING)
: ss
COUNTY OF SWEETWATER)

The foregoing Oath of Office was acknowledged before me this _____ day of _____, **2025**.

WITNESS my hand and official seal.

_____
Notary Public, State of Wyoming

My commission expires:

Memorial Hospital

OF SWEETWATER COUNTY

OUR MISSION

Compassionate care for every life we touch.

OUR VISION

To be our community's trusted healthcare leader.

OUR VALUES

Be Kind

Be Respectful

Be Accountable

Work Collaboratively

Embrace Excellence

OUR STRATEGIES

Patient Experience

Quality & Safety

Community, Services & Growth

Employee Experience

Financial Stewardship

ORIENTATION MEMO

Board Meeting Date: August 6, 2025

Topic for Old & New Business Items:
Medical Staff Peer Review and Professional Practice
(formerly titled Medical Staff Professional Practice and Peer Review)

Policy or Other Document:

___X__ Revision
_____ New

Brief Senior Leadership Comments:
Revisions made after Joint Conference meeting in 2025.
Language is clearer and the process is easier to follow.
Approved by PPEC and MEC.

Board Committee Action:
The first read for this was in June 2025 at the Board meeting prior to PPEC and MEC approval. The title change and punctuation were the changes made since that review.

Policy or Other Document:

_____ For Review Only
___x___ For Board Action

Legal Counsel Review:

____x__ In House Comments: Reviewed by Suzan
_____ Board Comments:

Senior Leadership Recommendation:
We are almost 3 years behind getting this approved from the last documented approval date. If possible, may we please have this for action?

Status Draft PolicyStat ID 18063944

Approved N/A
Review Due N/A

Document Area Medical Staff
Reg. Standards TJC MS 05.01.01, TJC MS 06.01.05, TJC MS 08.01.01 + 2 more

Medical Staff Peer Review and Professional Practice

Statement of Purpose

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

Plan

I. Objectives

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

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

1. Safe: avoiding harm to patients from the care that is intended to help them.
2. Timely: reducing wait times and sometimes harmful delays for both those who receive and those who give care.

3. Efficient: avoiding waste, including waste of equipment, supplies, ideas, and energy.
4. Effective: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit.
5. Equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
6. Patient-centered: providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

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

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

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

E. ~~Create a culture of accountability.~~Create and participate in a Just Culture. See Just Culture Policy.

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

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

II. Definitions

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

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

C. Medical Staff: The group of all Practitioners privileged through the organized ~~medical staff~~Medical Staff process ~~who~~and are subject to the Medical Staff Bylaws, Rules, and Regulations. ~~Nurse practitioners, physician assistants and other Advance Practice Providers (APP) are considered part of the Medical Staff per MHSC's Bylaws and will be referred to as Practitioners~~See Medical Staff Bylaws and Medical Staff Rules & Regulations.

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

Medical Staff Bylaws.

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

F. Professional Practice Evaluation Committee (PPEC): A multidisciplinary peer review committee authorized to conduct peer review for the Medical Staff. This committee will also function to review and monitor the ongoing evaluation of Practitioner performance trends and provide recommendations and follow-up as appropriate. ~~The Vice Chair of each department (Medicine and Surgery) shall serve on PPEC. Three other Physicians will be appointed by the Chief of Staff to serve on the committee. An Advance Practice Provider shall also be appointed to serve. The PPEC chair shall be selected by the Chief of Staff.~~

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

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

H. ~~Focused professional practice evaluation (FPPE) is~~Focused Professional Practice Evaluation (FPPE): Is a systematic process to ensure the current competency of Practitioners at Memorial Hospital of Sweetwater County. FPPE occurs routinely whenever the Hospital grants new privileges, such as when new privileges are initially granted to a Practitioner who is new to the organization or when an existing Practitioner requests a new privilege. ~~FPPE can also be initiated when a question arises regarding a Practitioner's ability to provide safe, high quality patient care (Triggered FPPE). Triggered FPPE can be requested by the Credentials Committee, the Professional Practice Evaluation Committee (PPEC), or the Medical Executive Committee (MEC).~~ See Focused Professional Practice Evaluation Plan.

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

1. ~~Care Appropriate: Despite a complication, adverse outcome, or other question regarding the quality delivery of care, it is determined that a majority of peers would have responded similarly under similar~~

~~circumstances. This designation adjudicates that there was no clear deviation from standard of practice.~~

2. ~~Improvement Opportunity: Care that involved simple errors in diagnosis, treatment or judgment, or inadvertently doing other than what should have been done: a slip, lapse, or mistake.~~
3. ~~At Risk Behavior: Care that requires education or coaching to prevent recurrence, or behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified.~~
4. ~~Reckless Behavior: Care that suggests reckless disregard of the Practitioner's duty to the patient through gross negligence, general incompetence or actual intent to provide substandard care, or behavioral choice to consciously disregard a substantial and unjustifiable risk.~~

J. ~~Care ratings: System Improvement (as determined by the PPEC or MEC)~~

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

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

L. ~~Medical Staff Quality Reviewer: A group of reviewers appointed to perform an initial case review to determine if the case requires peer review by the PPEC. Reviewer will be appointed each year, by the Chief of Staff.~~

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

N. Medical Staff Quality Reviewer: A reviewer appointed by the Chief of Staff annually to perform initial case reviews on Medical Staff approved Review Indicators.

1. Three will be appointed from the Medicine Department and three from the Surgery Department.
2. In the event a designated Medical Staff Quality Reviewer is unable to fulfill the term, a new reviewer will be appointed by the Chief of Staff, as a replacement.

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

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

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

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

R. Rate Indicators: Medical Staff approved OPPE indicators.

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

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

III. Review Process

A. ~~All reviews will be directly documented within the quality management system.~~

B. ~~Indicators~~

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

1. ~~Rule indicators will initiate a peer review by PPEC. The PPEC will be notified when a rule has been triggered. Additionally, the individual Practitioner will be notified when a rule indicator has been triggered through the process of OPPE.~~

2. ~~Rate indicators will be trended and added to OPPE profiles. The PPEC will review peers with outlier rate indicators twice per year (every 6 months) at a minimum and provide feedback, education, initiate a performance improvement plan, or recommend FPPE with the individual as appropriate. Refer to the OPPE process flow.~~

3. ~~Review indicators will be screened through an initial case review by a designated Medical Staff Quality Reviewer. If the case requires further action, follow-up, or review, it will be reviewed by the PPEC as a peer review case.~~

4. ~~Other quality events will initiate a peer review and be referred directly to PPEC.~~

5. ~~If a sentinel event is identified during the peer review process, the sentinel event policy will be enacted.~~

C. ~~Initial Case Review (performed by Medical Staff Quality Reviewer)~~

1. ~~An initial case review of a quality event will occur by a designated Medical Staff Quality Reviewer if the event is triggered by a review indicator (see attached list of Medical Staff Review Indicators).~~

2. ~~Six Medical Staff Quality Reviewers will be appointed by the Chief of Staff. Three will be appointed from the Medicine Department and three from the Surgery Department. In the event a designated Medical Staff Quality Reviewer is unable to fulfill the term, a new reviewer will be appointed by the Chief of Staff, as a replacement.~~

3. ~~Medical Staff Quality Reviewers will be notified via quality management system of cases needing review as they occur.~~

    a. ~~Review of case and outcome determination is expected to be completed within 2 weeks of notification.~~

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

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

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

D. ~~Peer Review (performed by PPEC)~~

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

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

i. ~~Care Appropriate - case closed/trended~~

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

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

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

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

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

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

b. ~~In the event that PPEC is unable to determine the final outcome, the case will be referred to MEC for evaluation and final determination.~~

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

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

a. ~~System improvement care rating will include the following:~~

i. ~~System Improvement Opportunity - education, follow-up, etc. provided or delegated to appropriate department~~

9. ~~Findings in which nursing, essential services, or other departments are needing to review or follow-up can be referred to the PIPS committee or appropriate individual department as necessary. It is the responsibility of~~

~~the PPEC to communicate this need with appropriate department/ committee. Medical staff input, engagement, and support for resolutions will be expected.~~

E. ~~Patient Complaints and Grievances~~

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

F. ~~Anonymous Referrals~~

1. ~~Cases can be sent to PPEC anonymously by completing the MHSC Peer Review Request Form.~~

G. Referral of Cases

1. All cases that may require peer review by PPEC will be processed through the Quality Department.
    a. Any employee, Medical Staff member, or Committee who may be aware of a case for peer review will contact the Director of Quality or Quality Analyst.
    b. Should the person requesting a peer review wish to remain anonymous, they must clearly indicate this in their request.
    c. The Grievance Committee may send cases for standard of care review to PPEC by notifying the Quality Department. See attachment Grievance Cases Referred to PPEC and MEC.

H. Initial Case Review

1. All cases requiring an initial case review will be processed through the Quality Department.

2. The Medical Staff Quality Reviewers will be notified via the quality management system of cases needing review as they occur.
3. The review of the case and outcome determination is expected to be completed in a timely manner.
4. Initial Case Review Outcome Determination:
    a. Appropriate Care: after careful review, this designation adjudicates that there was no clear deviation from standard of practice. The case will be closed and this outcome determination will be displayed on the Practitioner's OPPE report.
    b. Further Review Needed: after careful review, this designation adjudicates that there may be a deviation from standard of practice, a system improvement opportunity, or when an outcome is undetermined. These cases will be referred to PPEC for evaluation and outcome determination.

I. Peer Review

1. PPEC will meet ten (10) times per year, ideally monthly. They may meet more or less often, as needed, dependent on the volume of cases requiring review by the committee.
2. The PPEC will be provided with a list of patients with case summaries for review from the Quality Department prior to the meeting.
3. It is the responsibility of the PPEC members to review cases prior to the set meeting date for discussion and final outcome determination at the PPEC meeting.
4. Outcome determinations for final conclusions must be made by a consensus of members present at PPEC.
5. The PPEC reserves the right to halt the peer review process for a Practitioner that has separated from the organization for any reason.
    a. Judgment of whether or not the case needs to be reviewed is left up to PPEC.
    b. A letter formulated by the Quality Department will be placed in the separated Practitioner’s peer review file indicating that there is/are unclosed Peer Review case(s) should the Practitioner wish to be recredentialed at a future time.
6. Peer Review Outcome Determination:
    a. Care Appropriate: despite a complication, adverse outcome, or other question regarding the quality delivery of care, it is

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

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

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

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

7. System Improvement Outcome Determination:

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

    b. System improvement opportunities will be delegated to the appropriate department for evaluation and recommendation for next action.

8. If the PPEC is unable to determine the final outcome, the case will be

referred to MEC for evaluation.

J. External Reviews

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

K. ~~Practitioners performing reviews will not review their own cases.~~

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

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

N. ~~The Practitioner whose patient's clinical course of treatment is scheduled for discussion of a possible deviation from standard clinical practice at a Department, Service or Committee meeting, shall be notified in writing from the Department, Service or Committee's chair at least one week prior to the scheduled date of presentation.~~

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

1. ~~The involved Practitioner will be given a brief case summary including the medical record number, encounter number, and reason for review.~~
2. ~~If a case has been sent for external review, a copy of the external review will be provided to the Practitioner involved.~~
3. ~~The involved Practitioner may request the names of the attendees of PPEC~~

~~and MEC where their case(s) were reviewed.~~

4. ~~To protect the integrity of the peer review process, the names or other identifying information of individuals requesting the peer review will not be provided to the involved Practitioner.~~
5. ~~Attendance by the involved Practitioner shall be mandatory. Failure to appear or to secure postponement from the chair may be deemed "unprofessional conduct", and result in corrective action as outlined in Article XVII of the Medical Staff Bylaws. This rule is not to be construed as applying to discussion of cases identified by routine monitoring of patient care.~~
6. ~~Except as explicitly provided in Article XVIII of Medical Staff Bylaws in connection with the exercise of applicable hearing and appeal rights, and notwithstanding anything to the contrary in the Medical Staff Documents, no Practitioner shall have the right to be represented or accompanied by an attorney at any meeting of the Medical Staff, or any committee (standing or ad hoc), Department, or section thereof, or when meeting with any Medical Staff officer.~~
7. The Practitioner whose patient's clinical course of treatment is scheduled for discussion of a possible deviation from standard clinical practice at a Department, Service or Committee meeting, shall be notified in writing from the Department, Service or Committee's chair at least one week prior to the scheduled date of presentation.
    a. The involved Practitioner will be given a brief case summary including the medical record number, encounter number, and reason for review.
    b. If a case has been sent for external review, a copy of the external review will be provided to the Practitioner involved.
    c. The involved Practitioner may request the names of the attendees of PPEC and MEC where their case(s) were reviewed.
    d. To protect the integrity of the peer review process, the names or other identifying information of individuals requesting the peer review will not be provided to the involved Practitioner.
    e. Attendance by the involved Practitioner shall be mandatory. Failure to appear or to secure postponement from the chair may be deemed "unprofessional conduct", and result in corrective action as outlined in Article XVII of the Medical Staff Bylaws. This rule is not to be construed as applying to discussion of cases identified by routine monitoring of patient care.
    f. Except as explicitly provided in Article XVIII of Medical Staff Bylaws in connection with the exercise of applicable hearing and appeal rights, and notwithstanding anything to the contrary in the Medical Staff Documents, no Practitioner shall have the right to be represented or accompanied by an attorney at any meeting

of the Medical Staff, or any committee (standing or ad hoc), Department, or section thereof, or when meeting with any Medical Staff officer.

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

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

Q. Documentation

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

R. For information related to accessing Medical Staff Peer Review Files see (insert link)

IV. OPPE

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

B. The following general competencies are included in OPPE:

1. Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and care at the end of life.
2. Medical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
3. Practice-based Learning: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate and improve patient care practices.
4. Interpersonal & Communication: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families and other members of healthcare interdisciplinary teams.
5. Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward patients, families, colleagues, their profession, and society.

6. Systems-based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare.

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

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

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

F. ~~Ongoing professional practice evaluation (~~OPPE~~)~~ is factored into the decision to maintain, revise, limit, or revoke existing ~~medical staff~~Medical Staff privileges by the Credentials Committee. ~~The organized medical staff are responsible for defining the OPPE process.~~

G. ~~Department Leadership will do the following:~~

1. ~~Perform at least two OPPE's on all designated staff members every 24 months, but not longer than 9 months apart. This will be performed by the Vice Chair of each Department, through their membership on PPEC. If there are negative trends or concerns about an Individual Practitioner, the Vice Chair will communicate that information to the Department Chair.~~
2. ~~Use the types of data and evaluation processes developed by the departments and approved by the organized medical staff.~~

H. ~~While the practitioner is on FPPE, specialty specific OPPE data will be concurrently monitored.~~

I. ~~The following general competencies are included in OPPE :~~

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

practice, an understanding and sensitivity to diversity, and a responsible attitude toward patients, families, colleagues, their profession, and society.

6. Systems-based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare.

J. The Quality Department will be responsible for compiling the OPPE profiles based on data available in MHSC's electronic data systems.

1. OPPE profiles will include Practitioner level metrics for Medical Staff indicators, including rule, rate, and review indicators. Profiles will also include indicators from other quality events that required a review by PPEC.
2. OPPE profile metrics may change and evolve over time based on individual performance and opportunities for improvement and specialty specific indicators. Specialty specific measures will be recommended for inclusion on the OPPE profiles and approved by each specialty, PPEC, and MEC.
3. Other metrics will be included on the OPPE profiles to meet the six (6) general competency categories, including patient experience data, and will include any data showing zero performance.
4. Compile at least two OPPE's on all designated staff members every 24 months, but not longer than 9 months apart.
5. Individual Practitioners will be notified when profile is ready for review.

K. PPEC will be responsible for ensuring consistent implementation of the OPPE process and for reviewing at least two OPPE's on all designated staff members every 24 months, but not longer than 9 months apart.

1. Review is expected to be completed within 30 days of receiving OPPE profiles.
2. Purpose:
    a. To review Practitioner performance, identify trends and intervene when appropriate.
        i. If data is exceeding thresholds, the cases that contributed to the excess rate may be reviewed when indicated.
    b. To request additional information for further review.
    c. Develop individual improvement plans from this process when appropriate.
        i. If improvement plans are not effective in improving performance, recommendation and/or initiation for FPPE may occur.
3. PPEC designated members are expected to communicate feedback and

~~opportunities for improvement with individual Practitioners when appropriate, or communicate with the appropriate Department Chair/Vice Chair for follow-up actions.~~

L. Quality Department Responsibilities:

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

M. PPEC Responsibilities

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

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

V. Authority for Peer Review

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

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

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

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

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

VI. Confidentiality

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

B. **WY Stat § 35-17-103.** Exemption from liability; exception: A professional standard review organization or a society or person rendering services as a member of a professional standard review organization functioning pursuant to this act is not liable either independently or jointly for any civil damages as a result of acts or omissions in his capacity as a member of any such organization or society. Such persons or organizations or societies are not immune from liability for intentional or malicious acts or omissions resulting in harm or any grossly negligent acts or omissions resulting in harm.

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

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

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

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

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

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

Reviewed and Approved:

~~PPEC 9/18/2024~~

~~MEC 10/30/2024~~

PPEC 6/25/2025

MEC 7/22/2025

Board of Trustees ~~12/2/2024~~

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Attachments

- Grievance Cases Referred to PPEC and MEC.pdf
- Medical Staff Peer Review Process Flowsheet 2025.pdf

Medical Staff Professional Practice Rate Indicators 2025.pdf

Medical Staff Professional Practice Review Indicators 2025.pdf

Medical Staff Professional Practice Rule Indicators 2025.pdf

Approval Signatures

Step Description	Approver	Date

Reg. Standards

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

History

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

July 9, 2025

The Board of Trustees of Memorial Hospital of Sweetwater County met in regular session on July 9, 2025, at 2:00 p.m. with Ms. Kandi Pendleton presiding.

CALL TO ORDER

Ms. Pendleton welcomed everyone and called the meeting to order.

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

Officially present during the meeting: Ms. Irene Richardson, Chief Executive Officer; Dr. Israel Stewart, Chief of Medical Staff; Mr. Geoff Phillips, Legal Counsel; and Mr. Taylor Jones, Sweetwater County Commission Liaison.

Trustee Appointment, Reappointment, Oath of Office

Mr. Phillips administered the Oath of Office to Judge James. Ms. Pendleton and the Trustees welcomed her back for the next term of service. Mr. Malicoat was unable to attend the meeting and will complete the Oath of Office at a future meeting.

Election of Officers

Ms. Pendleton reported the Governance Committee met and presented a slate of officers for FY26. The motion to approve the slate of officers as follows was made by Mr. Kelsey; second by Judge James. Motion carried.

President: Ms. Kandi Pendleton
Vice President: Mr. Marty Kelsey
Treasurer: Mr. Craig Rood
Secretary: Judge Nena James

Pledge of Allegiance

Ms. Pendleton led the attendees in the Pledge of Allegiance.

Mission and Vision

Mr. Rood read aloud the mission and vision statements.

Mission Moment

Ms. Richardson shared a recent visit with a couple needing assistance with test results from the Hospital being available to Huntsman before their next visit. Ms. Richardson said a number of staff responded immediately and made sure all of their needs were quickly met. Ms. Richardson thanked the staff and said it was gratifying to see that things went exactly how things are supposed

to go. The couple expressed their appreciation to Ms. Richardson and the Hospital for everything that we do here for the community.

Ms. Pendleton said she had requested permission from a patient to share a story about an experience they had while traveling to another country. The patient was able to return home to the United States but not without the extensive efforts of MHSC staff. Ms. Pendleton said the story shows that we really do have it very good here in Sweetwater County.

Ms. Deb Sutton, Director of Marketing, said we recently had an online review from a patient from Riverton. She said this is the second one out of Riverton in three weeks. The patient said they had to travel in to do a number of things and thanked Central Scheduling for making it possible to get everything done in one day to save them from having extra trips.

AGENDA

Ms. Pendleton asked for requests for any items to be moved from the Consent Agenda to New Business. There were no changes to the Consent Agenda. Ms. Pendleton asked if there were requests for Senior Leader or Board Committee Reports to be moved to New Business. There was a request for the Master Plan Review under Building and Grounds Committee and the Resolution Authorizing Participation in the Wyoming Class under Finance and Audit Committee to be moved. The motion to approve the agenda with the items noted as moved to New Business as requested was made by Judge James; second by Mr. Rood. Motion carried.

COMMUNITY COMMUNICATION

There were no comments.

OLD BUSINESS

Quarterly Progress Report on Strategic Plans and Goals

The next update will be presented to the Quality Committee in July and reported to the Board in August.

Professional Practice Review Plan

The information is still under review.

Patient Safety

The Board education for July is the patient safety topic.

CONSENT AGENDA

The motion to approve the Consent Agenda as presented was made by Mr. Kelsey; second by Judge James. Motion carried. Items approved: Meeting Minutes for June 4, June 9, June 26; Bad Debt; Credentialing Policy; Internal Medicine Privilege Form.

NEW BUSINESS

Committee Assignments

Ms. Pendleton said she sent an e-mail to the Trustees with committee appointments. She said the only change is she is remaining on the Governance Committee with Mr. Kelsey and Mr. Malicoat is assigned to the Human Resources Committee with Judge James. The updated list will be distributed to staff.

Annual Conflict of Interest Disclosure

Ms. Pendleton asked Trustees to complete the annual disclosure form and return to Administration at the end of the meeting.

Utilization Management Plan

Ms. Robin Jenkins, Director of Care Management, provided an overview. She said it is an annual plan requiring annual review and approval. Ms. Jenkins said the proposed changes are largely for clarity. Mr. Kelsey suggested some revisions. Ms. Jenkins said she would make the changes and bring back to the Board in August.

Performance Improvement and Patient Safety (PIPS) Plan

Ms. Stephanie Mlinar, Director of Quality, said there have been many changes to the Plan following work to combine two separate plans into one. She said responsibilities at all levels have been included with a goal to be more concise and clear. Ms. Mlinar said there were a lot of changes and invites questions and feedback. She said the draft has been approved by the Quality Committee and Medical Executive Committee. Mr. Phillips said he wants to make sure the Plan does not conflict with the new governance policy and requested review and discussion at the next Governance Committee meeting.

PIPS Priorities

Ms. Mlinar said the PIPS Committee looks at documentation and strategic priorities. The Committee identified focus items for FY26. Ms. Mlinar reviewed each of the proposed items. Ms. Pendleton said she was excited to see the plan and thinks it is put together well. She said it references many of the things the Board has been discussing. The motion to approve the PIPS Priorities as presented was made by Judge James; second by Mr. Rood. Motion carried.

Master Plan Review

Ms. Richardson said we contracted with the company PACT for a 10-year master plan design. She said Senior Leaders met and developed a plan update. The information was presented to the Building and Grounds Committee. She said the update includes the priorities list developed by Facilities. Ms. Richardson said the Master Plan is a living document and she outlined the priorities and plans. Mr. Rood said it is a great plan. Mr. Kelsey asked if Board approval is being requested. Ms. Richardson said we were not seeking formal approval at this time. Mr. Rood said he understands the Board will be asked to approve each project as presented. Ms. Pendleton said it

would be helpful to see a map to visualize the proposed changes. Ms. Richardson said we have budgeted money for Phase One in the current fiscal year.

Resolution Authorizing Participation in the Wyoming Class

Ms. Tami Love, Chief Financial Officer, reviewed the investment program. She said this is another option for an investment pool for us due to our affiliation with the County. She said Wyo Star has made changes so we have fewer options. Mr. Rood asked if there are concerns Wyoming Class will make similar changes moving forward. Ms. Pendleton said she has utilized Wyoming Class and seen no problems. Mr. Kelsey said he was very impressed with the presentation made at Finance and Audit Committee. The motion to authorize appropriate signing for the resolution to participate in Wyoming Class as presented was made by Mr. Kelsey; second by Judge James. Motion carried.

REPORTS

Chief Executive Officer Report

Ms. Richardson said a reception in the Dr. Pryich Healing Garden will be scheduled to recognize Dr. Barbara Sowada for her service on the Board. Ms. Richardson thanked Judge James for her commitment to serving another term and thanked her for her service. She said we look forward to having Mr. Malicoat join the Board. Ms. Richardson announced Dr. Alicia Gray has resigned as Chief of Staff. Patient care comes first for Dr. Gray. She will continue to serve as the Hospitalist Director and we are grateful for her focus on patients. The Medical Staff Bylaws state the Vice Chair becomes the Chair following a vacancy and that is Dr. Israel Stewart. Dr. David Liu becomes the Vice Chair. The Medical Staff will elect a new Secretary/Treasurer. Ms. Richardson thanked Dr. Gray for her dedication and leadership. Ms. Richardson provided an overview of strategic plan projects. Clifton Larson Allen will be onsite to conduct the audit in early August. Ms. Richardson invited the Trustees to attend the Wyoming Hospital Association Annual Meeting in Laramie September 3-4.She said the Hospital has been very busy and thanked the staff and physicians for their hard work.

Medical Staff Services Chief of Staff Report

Dr. Stewart introduced himself and said he is looking forward to learning more about his responsibilities as Chief of Staff. Ms. Pendleton thanked Dr. Stewart for accepting his new position and for attending the meeting. She said the Board appreciates his time.

County Commissioner Liaison Report

Commissioner Jones thanked Ms. Richardson for the Hospital Week gift and thanked Judge James for applying to remain on the Board. He thanked Ms. Richardson and Ms. Love for their cooperation in the County budget process. He said the Hospital has been good working with the County in past year, as well. He said he reminds the Commissioners the money provided to the Hospital is for maintenance, not for operating expenses. Commissioner Jones thanked the Hospital as a whole. Ms. Pendleton said Commissioner Jones gives great reports and is a great liaison for the Hospital. She said he always keeps important hospital information in the forefront.

CONTRACTS

No action was required and there were no comments.

EDUCATION

Hospital Board Quality & Safety – A Brief Overview

Ms. Mlinar said a short presentation was loaded in the portal. She provided a brief overview and said there is information included about the patient safety structural measure. Ms. Mlinar said we continue to work with being transparent with offering information. She asked the Trustees to complete the questions at the end of the PowerPoint to help us meet the structural measures. She invited Trustees to e-mail the answers to her and she would provide the answer key.

GOOD OF ORDER

Mr. Kelsey said he would like to see FY25 financial information for Unidine.

Mr. Kelsey said the FY26 budget includes a bonus for employees. He said if it is based on success, staff need to recommend some goals/measurements. He said the Board can choose to select to not tie it to anything but he cautioned about being mindful so it's not just continued year after year without a plan. He suggested full Board review and discussion.

EXECUTIVE SESSION

The motion to go into executive session at 3:28 p.m. to discuss litigation and personnel items considered confidential by law was made by Judge James; second by Mr. Rood. Motion carried.

RECONVENE INTO REGULAR SESSION

The motion to leave the executive session and return to the regular session at 5:11 p.m. was made by Judge James; second by Mr. Rood. Motion carried.

ACTION FOLLOWING EXECUTIVE SESSION

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

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

Credentials Committee Recommendations to the Board of Trustees for Granting Clinical Privileges and Granting Appointment to the Medical Staff from June 10, 2025

1. Initial Appointment to Associate Staff (1 year)
   - Dr. Nathan Dreyfus, Emergency Medicine
   - Dr. Julia Ruggieri, Emergency Medicine
2. Initial Appointment to Consulting Staff (1 year)
   - Dr. Marina Bogdanovic, Tele-Psychiatry (QLER)

3. Reappointment to Active Staff (3 year)
    - Dr. Brianne Crofts, General Surgery
    - Dr. Benjamin Jensen, Anesthesia
4. Reappointment to Locum Tenens Staff
    - Dr. Jared Tyler, Anesthesia
5. Reappointment to Consulting Staff (3 year)
    - Dr. Marcela Smid, Maternal Fetal Medicine (U of U)
    - Dr. Lauren Theilen, Maternal Fetal Medicine (U of U)
    - Dr. Matthew Jensen, Tele-Neurology (U of U)
    - Dr. Raminder Nirula, Tele-ICU (U of U)
    - Dr. Michael Caruso, Tele-Radiology (VRC)
    - Dr. Michael Seymour, Tele-Radiology (VRC)
6. Reappointment to Non-Physician Provider Staff (3 year)
    - Julie Scott, Professional Counselor (SWCS)
7. New Business
    - Dr. Ken Holt – Modification of Privileges

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

The motion to approve the severance and release agreement as discussed in executive session was made by Judge James; second by Mr. Rood. Motion carried.

ADJOURNMENT

There being no further business to discuss, the meeting was adjourned at 5:12 p.m.

_____
Ms. Kandi Pendleton, President

Attest:

_____
Judge Nena James, Secretary

ORIENTATION MEMO

Board Meeting Date: August 6, 2025

Topic for Old & New Business Items:
Utilization Management Plan

Policy or Other Document:

___X__ Revision
_____ New

Brief Senior Leadership Comments:
Revised plan for CAH.
Approved by the Utilization Management Committee and MEC

Board Committee Action:
Quality Committee of the Board approved 6/18/2025

Policy or Other Document:

_____ For Review Only
___X___ For Board Action

Legal Counsel Review:

_____ In House Comments:
_____ Board Comments:

Senior Leadership Recommendation:
Draft presented to the Board of Trustees July 9. Updates were requested.
Presented to the Board of Trustees for second read and approval August 6.

Status **Draft** PolicyStat ID **18226754**

Approved N/A

Review Due N/A

Document Area: Care Management & Utilization Management

Reg. Standards: CMS §482.30, TJC LD.04.02.05

Utilization Management Plan

STATEMENT OF PURPOSE

The Utilization Management Plan shall monitor the delivery of patient care to ensure that patients receive optimal quality, cost-effective medical and specialty services at the appropriate utilization and allocation of hospital resources. Utilization Management complies with Centers for Medicare & Medicaid Services (CMS) guidelines and standards for utilization review.

TEXT:

I. **Goals**

The goals of the Utilization Management Committee (UMC) are to:

A. Monitor the utilization of the facility's resources through concurrent and retrospective review to determine:

1. The necessity for admission and continued stay.
2. Appropriate length of stay
3. Timely and appropriate use of diagnostic and therapeutic services

B. Document patterns of resource utilization including under and over utilization of services or inefficient scheduling of resources

C. Ensure the medical record contains the information necessary to:

1. Evaluate medical necessities.
2. Determine the quality and utilization of services needed for the management and progress of the patient.

D. Identify problem areas, establish priorities for investigation, recommend corrective action and monitor action taken.

E. Measure performance against indicators.

II. **Authority**

A. The Medical Staff delegates the responsibility for conducting the Utilization Management Plan (UM) to the UMC which will direct activities to monitor and evaluate the medical necessity of admissions, continued stay, and supportive services.

B. The UM Plan is reviewed by the UMC and is approved by the Medical Executive Committee, Quality Committee and the Board of Trustees

C. The Hospital's Care Management Department functions as the agent of the UMC in conducting concurrent reviews of admissions to the Hospital.

III. **Utilization Management Committee**

The UMC is a subcommittee of the Medical Staff. The UMC, through regular review of utilization information, determines whether under-utilization and, when appropriate, over-utilization of services adversely affects the quality of patient care and recommends appropriate actions to be taken. Information reviewed by the UMC is protected as described in the Hospital Medical Staff Bylaws and State law.

A. The responsibilities of the UMC include but are not limited to:

1. Optimizing medical management of cases to reduce admissions without medical necessity and to minimize hospital stays by reducing avoidable acute care days.
2. Analyzing data and information compiled on utilization management indicators.
3. Recommending corrective action to solve identified problems and monitoring problem resolution
4. Recommending strategies and processes to enhance the quality and efficiency of patient care while controlling cost
5. Providing physician advisor support for the Case Management staff.
6. Providing support and input on educational needs for physicians and other health professionals related to utilization management topics.
7. The Chair of the Medical Staff will appoint a practitioner member and appoint the Practitioner Chair.

B. The committee membership will consist at the minimum of:

1. Practitioners (2) or more and must be doctors-of-medicine or osteopathy.
2. The Committee may be supported by representatives from Administration, Case Management, Patient Financial Services, Nursing Services, Quality, Compliance, Health Information Services and other ancillary departments as deemed necessary.
3. Only physicians and other practitioners are members of the Committee for regulatory purposes.

C. The following individuals are excluded from discussion of cases at the UMC:

1. A practitioner who has been professionally responsible for the care of the

patient or who has direct financial interest in the Hospital.

D. The UMC will meet at least quarterly and shall maintain a permanent record of its proceedings. A summary of UMC activities is reported to the Medical Executive Committee and to the Quality Committee.

IV. Physician Advisor Role (PA)

A. Responsibilities of the PA:

1. Review medical records for selected cases, trends, and regulations.
2. Make recommendations for the utilization of resources and quality care.
3. Determine the medical necessity of admission or continued stays in cases identified by the Case Managers as not meeting approved criteria.
4. Refer for rereview in cases where the attending and the PA cannot reach agreement about medical necessity, appropriateness, and quality.
5. Inform the Case Manager of the quality issue or medical reason for approval or denial of referred cases documenting the clinical rational for all medical necessity determinations whether approved or denied.

V. Methods of review

A. Admissions, continued, and extended stays are performed by the Case Manager regardless of payment source for admissions. In general, reviews are not completed on healthy mothers and newborn babies unless an identified concern about the case necessitates such a review.

B. InterQual will be utilized for admission and continued stay review.

C. Review of admissions may be performed before, at or after the hospital admission and will have a documented InterQual review. The InterQual review will focus on determining if the patient meets admission guidelines for inpatient or observation status.

D. Case Management provides guidance to the medical staff and hospital personnel regarding medical necessity criteria and appropriate level of care determinations.

E. If the admission does not meet medical necessity, the case is referred to the PA for secondary review for level of care determination.

F. If the continued stay review does not meet InterQual criteria and does meet the discharge screens, and the physician is not able to provide additional clinical data to support continued stay, the case may be referred to the PA.

G. Reviews for continued stay and cost outlier cases within a specified time.

VI. Case Management Relationship with Third-Party Payer Organizations

A. The Case Management staff provides/submits clinical review as required by third-party payer contracts under the direction of the nurse case manager.

B. The Case Management staff may facilitate physician to physician communication when appropriate regarding adverse determinations by third party payers.

VII. **Appeal Process**

A. For Medicare patients, the Important Message for Medicare (IMM) will be used as the mechanism to advise the patient and family that they are being discharged. The intention of the notice is to provide the Medicare beneficiary with his or her appeal rights if they believe they are being discharged prematurely. The IMM will be provided to the beneficiary within 2 days of discharge if the length of stay warrants. The IMM will not be routinely provided on the day of discharge. However, if it is delivered on the day of discharge, the beneficiary and a representative will have up to 4 hours to determine if they will accept discharge or appeal it.

B. If the beneficiary and representative appeal the discharge to the Quality Improvement Organization (QIO), the QIO will notify the Hospital of the appeal. If the appeal is lost by the beneficiary and or representative, a Hospital of Non-coverage (HINN) will be provided to the patient explaining why they are being discharged.

VIII. **Discharge Planning**

A. Discharge Planning is initiated for hospital admission at the time of admission or as soon as needs can be determined.

1. It is an ongoing function throughout the patient's hospitalization.
2. Assessment and planning are documented in the EMR.

B. The Case Manager coordinates with the interdisciplinary health care team through the Multidisciplinary Rounds to assess patient needs and plan appropriate disposition.

C. A referral for Case Management assistance can be made by any member of the care team, the patient, and their representative.

IX. **Utilization Management Data**

The efficiency and effectiveness of the Utilization Plan may be measured by the following indicators:

A. Analysis of core Utilization Management measures and trends:

1. Length of stay (LOS)
2. Avoidable days and delays
3. Overall, Medicare 30 days all cause readmission rates.
4. Outliers and extended stay patients
5. Inpatient status less than or equal to 2 midnights
6. Observation status greater than 2 midnights
7. Physician advisor secondary reviews
8. Condition Code 44
9. Provider Liable
10. Number of appeals to the QIO related to discharge and number of HINN letters issued.
11. Focused reviews when applicable

X. Performance Improvement Program (PIPS)

A. PIPS are conducted in accordance with the Quality Improvement Program and Plan, Medical Staff Bylaws and Rules & Regulations

XI. **Evaluation**

A. The Utilization Management Plan is reviewed, evaluated, and revised annually.

1. Review and approval will occur annually by the UMC, the Medical Executive Committee, Quality Committee of the Board, and the Board of Trustees.

XII. **Confidentiality**

A. All medical information and records pertaining to the UMC and Plan shall be considered confidentially governed by the Hospital's confidentiality policy, conducted in compliance with applicable HIPPA regulations according to WY Stat 35-2-910.

REFERENCES

Centers for Medicare and Medicaid Services Hospital Conditions of Participation Federal Register 482.30 (4/18/2025) Retrieved from eCFR :: 42 CFR 482.30 -- Condition of participation: Utilization review.

Tenet Health (November 20, 2024) Retrieved from

https://www.tenethealth.com/docs/global/case-management-policies/comprcc-452-utilization-management-plan.pdf?sfvrsn=2ea1890c_1

Cody Regional Hospital (received 7/2/2025) **Title:** Utilization Management Program and Plan **Department:** Quality **cfox@codyregionalhealth.org**

Date of Origin: 2008

Reviewed and Approved:

Utilization Management Committee 04/30/2025

MEC 05/27/2025

Quality Committee of the Board 06/18/2025

MHSC Board of Trustees

Attachments

Case Management Escalation Process 4.22.pdf

HINN-1 - Preadmission or Admission Hospital -Issued Notice of Noncoverage (HINN) 6.20.docx

Utilization Management Process Flow 4.22.pdf

Approval Signatures

Step Description	Approver	Date
	Irene Richardson: CEO	05/2023
	Tami Love: CFO	05/2023
	Ann Clevenger: CNO	05/2023
	Kari Quickenden: Chief Clinical Officer	05/2023
	Suzan Campbell: General Legal Counsel	04/2023

Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:8/6/2025

Topic for Old & New Business Items:

- Firearms and Weapons Policy

Policy or Other Document:

☒ Revision
☐ New

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

Board Committee Action:

Drafted by Board Legal Counsel and approved by the Governance Committee in July. Presented at the August Board of Trustees meeting for first review.

Policy or Other Document:

☒ For Review Only
☐ For Board Action

Legal Counsel Review:

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

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

Status Draft PolicyStat ID 18590633

Approved N/A
Review Due N/A

Document Area Administration

FIREARMS AND WEAPONS POLICY

I. INTRODUCTION

This policy establishes rules governing the possession of open and concealed firearms and non-firearm weapons on Memorial Hospital of Sweetwater County ("MHSC" or the "Hospital") property to ensure compliance with W.S. § 6-8-105 and other applicable laws while promoting safety and operational integrity.

A. Statement of Purpose

The purpose of this policy is to protect the safety, security, and clinical integrity of the Hospital by lawfully prohibiting the open carry, display, or wearing of firearms and non-firearm weapons within its facilities or on MHSC Property, and by establishing operational safeguards where concealed carry of firearms is permitted by law but may interfere with patient care, surgical procedures, or staff responsibilities. This policy also aims to reduce the potential risk of injury, liability, and/or property damage, and to ensure compliance with applicable state and federal firearm and weapons laws, as well as Hospital operational and clinical safety requirements.

II. SCOPE, AUTHORITY, LIABILITY AND DEFINITIONS

A. Scope

This Policy applies to all individuals present on MHSC Property, including but not limited to:

1. Employees (full-time, part-time, and temporary);
2. Medical Staff and Allied Health Professionals;
3. Contractors and Vendors performing services on Hospital premises;
4. Volunteers;

5. Students and Interns affiliated with clinical or educational programs;
6. Patients, whether inpatient, outpatient, or in the emergency department;
7. Visitors, Guests, and Members of the Public; and
8. Law Enforcement Officers acting in an official capacity, except where explicitly exempted or restricted under applicable law or Hospital policy.

All individuals on MHSC Property are expected to comply with the requirements of this policy unless expressly exempted under applicable law or as otherwise provided herein.

B. Authority and Legal Background

1. This policy is adopted pursuant to W.S. § 6-8-105(d)(iii), which provides that nothing in the Wyoming Repeal Gun Free Zones Act (HB0172) shall be construed to "prohibit a governmental entity from prohibiting the open carry, display or wearing of a firearm in its facilities or on MHSC Property."
2. As a county memorial hospital and political subdivision of the State of Wyoming, the Hospital is a "governmental entity" under W.S. § 6-8-105(h).
3. The Hospital acknowledges that its ability to regulate concealed carry is limited by Wyoming law, and this policy is designed to conform strictly with W.S. § 6-8-105.
4. This policy is also intended to ensure compliance with federal firearm statutes where applicable.

C. Limitation of Hospital Liability

MHSC assumes no responsibility or liability for the loss, theft, damage, misuse, or discharge of any firearm or non-firearm weapon brought onto MHSC Property, whether by personnel, patients, visitors, or any other individual, except as expressly required by law. Individuals carry and store firearms on MHSC Property at their own risk and are solely responsible for ensuring compliance with this policy and applicable law. Nothing in this policy shall be deemed to create any duty on the part of MHSC to supervise, inspect, or intervene in the actions of individuals lawfully carrying firearms in accordance with this policy or applicable law.

D. Definitions

The following definitions apply throughout this policy unless context clearly indicates otherwise:

1. "Ammunition" means ammunition or cartridge cases, primers, bullets, or propellent powder designed for use in any Firearm.
2. "Concealed Carry" means the possession of a firearm on the person or within the immediate control of the person in a manner not visible to others and compliant with W.S. § 6-8-104.
3. "Firearm" means a loaded or unloaded device, by whatever name known, that is designed to expel a projectile by the action of an explosion, expanding gas, or escape of gas, including devices powered by gunpowder, compressed air, or CO_2 cartridges.
4. "MHSC Property" or "Property of MHSC" includes all land, buildings, structures, vehicles, and

improvements owned, leased, or otherwise controlled by MHSC, including but not limited to clinical, administrative, educational, storage, or parking areas, regardless of whether located on or off the main hospital campus.

5. "Open Carry" means the visible possession, wearing, display, or exposure of a firearm on the person or within immediate reach in a way that is observable by others.
6. "Patient Undergoing a Procedure" means any patient who is sedated, undergoing diagnostic/therapeutic procedures, or receiving care that would require relinquishing control of a firearm.
7. "Personnel" means employees, contractors, students, interns, and any other individuals who regularly perform duties or functions on behalf of MHSC.
8. "Procedural Area" means any room or area where invasive medical, diagnostic, or surgical procedures are performed, or where a patient is receiving care that would reasonably require disarmament or transfer of control over personal items.
9. "Weapon" means any item designed or modified to cause serious bodily injury or death, or to threaten, intimidate, or endanger others. MHSC Security may determine on a case-by-case basis whether an object is considered a weapon under this policy. The definition of Weapon includes, but is not limited to:

- Firearms (as defined herein);
- Ammunition;
- Stun guns and tasers;
- Explosive devices (e.g., grenades, black powder, percussion caps);
- Switchblades, daggers, swords, and knives with blades longer than 4 inches;
- Striking instruments (e.g., batons, metal knuckles, blackjacks);
- Martial arts weapons (e.g., nunchakus, throwing stars);
- Bow-and-arrow weapons, slingshots, and paintball guns; and
- The term does not include folding pocket knives with blades 4 inches or shorter that are not spring-assisted or automatic, nor tools carried for legitimate work, clinical, or utility purposes authorized by MHSC.

III. NON-FIREARM WEAPONS PROHIBITED

A. Possession of Non-Firearm Weapons Prohibited

The possession of any Weapon other than a Firearm, irrespective of whether or not it is openly carried or concealed, is strictly prohibited on MHSC Property, except as set forth herein. This prohibition applies regardless of licensure or concealed weapon permit status. MHSC shall post signage consistent with this prohibition at all public entrances.

This restriction does **not** apply to:

1. Pocket knives with folding blades no longer than 4 inches that are not spring-assisted or automatic. For purposes of this policy, spring-assisted, automatic-opening, or switchblade knives are considered Weapons and are not exempt, regardless of blade length;

2. Tools or instruments necessary for job duties, including maintenance, security, or clinical care, when used appropriately and carried in accordance with Hospital protocols;
3. Hospital Security Personnel authorized by MHSC to carry specific weapons or equipment in the course of their duties, in accordance with Hospital policy and applicable law; and
4. Law enforcement officers acting within the scope of their official duties.

In the event of a violation of the non-firearm weapons prohibition, Hospital Security or Administration shall:

1. Advise the individual that possession of the non-firearm weapon violates Hospital policy;
2. Instruct the individual to immediately remove the weapon from MHSC Property;
3. In extremely rare circumstances where immediate removal is not feasible and no safety risk is present, Security may, at their sole discretion, temporarily retain the item solely to facilitate safe removal from MHSC property. This is not a storage service, and no right to storage is created by this policy;
4. Document the incident in accordance with MHSC procedures;
5. Remove the individual from the premises or notify law enforcement if the individual refuses to comply, poses a safety risk, or violates applicable laws.

Note: Refusal to comply may result in removal from MHSC Property and referral to law enforcement. MHSC reserves the right to take immediate protective action when possession of a prohibited weapon presents a risk to safety, clinical operations, or patient care.

IV. FIREARMS

A. Open Carry Prohibition

General Rule: Open carry of any firearm is strictly prohibited on MHSC Property, regardless of licensure status.

Examples of Prohibited Open Carry:

1. Wearing a holstered handgun visibly on the hip or leg;
2. Carrying a rifle or shotgun in plain view; and
3. Any visible firearm slung over the shoulder or placed on carts or equipment.

Signs shall be prominently posted at all public entrances stating: *"Open Carry of Firearms is Prohibited. Concealed Firearms Permitted Only as Allowed by Law. Possession of Other Non-Firearm Weapons is Prohibited by Hospital Policy."* Signs must be large enough to be clearly legible and comply with W.S. § 6-8-105 and other applicable regulations. Security or Administration may direct individuals to remove prohibited weapons from the premises.

In the event of a violation of the open carry prohibition, Hospital Security or Administration will:

1. Advise the individual that open carry is prohibited on MHSC Property pursuant to this policy and W.S. § 6-8-105(d)(iii);
2. Instruct the individual to immediately remove the firearm from Hospital property or secure it offsite;
3. Offer temporary secure storage only in accordance with the limited circumstances outlined in this policy;
4. Document the incident in accordance with MHSC reporting procedures; and
5. Remove noncompliant individuals from the premises or contact law enforcement if the individual refuses to comply, poses a safety risk, or otherwise violates Hospital policy or applicable law.

B. Concealed Carry Authorization and Limitations

General Rule: Pursuant to the Wyoming Repeal Gun Free Zones Act, codified at W.S. § 6-8-105, MHSC shall not prohibit lawful concealed carry by persons authorized under W.S. § 6-8-104(a)(ii)–(iv), except as expressly permitted by statute and this policy. As stated in W.S. § 6-8-105(b)(iv), "[p]ersons lawfully carrying concealed weapons in Wyoming under W.S. § 6-8-104(a)(ii) through (iv) may carry a concealed weapon in... any public building not otherwise prohibited under W.S. § 6-8-104(t) or regulated under this section."

Patient Care Priority: MHSC recognizes the constitutional and statutory rights of individuals to lawfully carry concealed firearms under W.S. § 6-8-104 and W.S. § 6-8-105. However, in circumstances where the presence of a concealed firearm poses a clear risk to patient care that is supported by clinical judgment, operational necessity, or documented safety policies, clinical integrity, or safety, MHSC reserves the right to impose limited, situational restrictions consistent with the exceptions set forth in state law. In all cases, the safety and welfare of patients, staff, and visitors shall take precedence, and MHSC may restrict firearms only to the extent permitted by law and this policy.

Concealed carry is not permitted in the following limited circumstances where possession of a firearm would interfere with patient safety, clinical integrity, or violate applicable law:

1. **Medical Incapacitation:** When a patient is sedated, undergoing imaging or invasive procedures, or receiving care that renders them physically or mentally unable to maintain immediate control of the firearm.
2. **Sterile or Invasive Procedural Areas:** Concealed carry is not permitted in operating rooms, interventional radiology suites, or other procedural areas where sterile field integrity is required and the individual must relinquish physical control of the firearm due to gowning, sedation, or procedural positioning.
   These restrictions apply only when:
   (a) the individual cannot maintain direct, continuous control of the weapon due to the nature of the procedure; and
   (b) the procedure involves a sterile environment where the presence of the firearm would necessitate a break in sterile protocol.
   This restriction shall not apply where the individual is able to retain the firearm without compromising sterile conditions or requiring assistance from Hospital personnel.

3. **Title 25 Mental Health Holds:** When an individual is undergoing evaluation, detention, or treatment under Title 25 or is otherwise legally prohibited from possessing a firearm.
4. **Other Situational Incapacity:** When an individual, due to unconsciousness, medical treatment, or comparable condition, is unable to maintain immediate control of their firearm and no other exception above applies. In such cases, MHSC shall require temporary offsite removal or secure storage consistent with this policy.

Patient Explanation: MHSC personnel should offer a verbal and written patient-friendly explanation of this policy in advance of any procedure requiring temporary firearm removal.

Volatile Materials Exception: Consistent with W.S. § 6-8-105(d)(vi), concealed carry may be restricted in specific locations where volatile, flammable, or explosive materials are used or stored in sufficient quantities to pose a risk of bodily harm. Such areas shall include clear signage identifying the restricted nature of the space due to material hazards.

Requirements for Affected Patients: Firearms must be secured offsite or transferred to a personal representative (not Hospital staff), or the procedure must be rescheduled.

C. Firearm Storage

Firearm Storage Prohibited: Except as authorized below, no firearms may be stored on MHSC property, including in desks, drawers, lockers, or unattended in vehicles or Hospital rooms.

Temporary Storage – Limited Circumstances Only: In limited circumstances where an individual is physically or mentally unable to remove a firearm from the premises and no immediate personal representative is available:

1. Security may temporarily secure the firearm;
2. A written waiver must be completed acknowledging that: (1) MHSC does not assume liability for loss, theft, or damage; and (2) storage is provided solely as a temporary courtesy in accordance with this policy. If an individual declines to sign the waiver or follow Security's direction, MHSC may deny temporary storage and require immediate removal of the firearm from the premises;
3. An ID verification process will also be required;
4. Only unloaded firearms and separated ammunition will be accepted;
5. Storage beyond 15 days will be deemed abandoned. MHSC will make reasonable attempts to contact the owner before reporting to law enforcement or disposing of the weapon in accordance with the Rock Springs Ordinances.

These storage provisions apply to all individuals on MHSC property, including patients, visitors, and staff. MHSC reserves the right to refuse the temporary storage of any firearm if, in the sole discretion of MHSC staff, it is determined that the temporary storage of the firearm exposes MHSC to the potential risk of injury, property damage, and/or storage is impractical.

D. Disclosure Generally

Hospital personnel shall not inquire into the lawfulness of an individual's concealed carry status unless required by law or in coordination with law enforcement.

E. Disclosure of Concealed Carry Status by MHSC Personnel

MHSC personnel and other authorized individuals are not permitted to disclose the presence of a concealed firearm to patients, visitors, or colleagues unless legally required or during an imminent safety threat. However, disclosure to a supervisor, Hospital Security, or Administration shall be required in specific operational situations, including but not limited to:

1. Entry into sterile procedural areas or behavioral health units where concealed carry is prohibited;
2. Medical treatment, sedation, or incapacity requiring secure storage or disarmament;
3. Requests for temporary firearm storage under this policy;
4. Incidents involving suspected mishandling or exposure of a concealed firearm;
5. Operational needs, where firearm presence may affect staffing, patient assignments, emergency response, or other critical safety protocols, provided such disclosure does not result in restriction of lawful concealed carry rights.

Such disclosures are solely for purposes of safety, compliance, and operational coordination. Information disclosed will be treated confidentially and shared only with those who have a legitimate need to know. Failure to disclose in required situations may result in corrective action in accordance with Hospital policy.

F. Improper Disclosure by Non-Personnel

Patients, visitors, or members of the public who voluntarily disclose the presence of a concealed firearm to Hospital personnel or others may be advised that such disclosure compromises the concealed nature of the firearm and may be treated as a policy violation under this section. Individuals who lawfully carry concealed firearms are expected to do so discreetly, in accordance with state law and Hospital policy. Improper disclosure may be treated as a violation of this policy, even in the absence of visible display or misconduct.

Consistent with this policy, MHSC reserves the right to take appropriate action in response to such disclosures, including:

1. Assessment of the situation by Hospital Security solely for safety purposes;
2. Issuance of verbal or written instruction to refrain from further disclosure;
3. Requirement to immediately remove the firearm from MHSC property or transfer custody to an

offsite representative, if deemed necessary to protect patient care, privacy, or safety;

4. Documentation of the disclosure and response to support ongoing safety planning and policy compliance;
5. Removal from Hospital premises if the individual refuses to comply with directives or presents a continued disruption or safety concern; and
6. Referral to law enforcement where refusal to comply or other conduct gives rise to a reasonable belief that a law or policy has been violated.

G. Exception

Law Enforcement and Security Personnel (applies to Sections IV and V of this policy): This policy does not restrict the lawful possession or use of firearms by licensed law enforcement officers acting within the scope of their official duties, subject to any applicable limitations imposed by Hospital policy or law. If MHSC Security Personnel are authorized to carry firearms as part of their official responsibilities, such authorization and use shall be governed by applicable law and any Hospital policies established by the Hospital. This exception also applies to the general prohibition on non-firearm weapons described above.

H. Employees and Contractors

Concealed Carry by Personnel: Personnel authorized to carry a concealed firearm under Wyoming law must keep the firearm concealed and under their direct control at all times while on MHSC property. When not carried on their person, firearms must be stored in a concealed biometric container or lock box within the individual's immediate control, consistent with W.S. § 6-8-105(d)(vii). The Hospital shall not require that firearms be stored unloaded or separate from their ammunition.

Disciplinary Action: Failure to comply with this policy, including improper storage, disclosure, misuse, or handling of a concealed firearm, may result in disciplinary action, up to and including termination of employment, loss of clinical privileges, or permanent exclusion from MHSC premises or programs. Disciplinary measures shall be based on the nature and severity of the violation and guided by applicable Hospital policies and procedures, including but not limited to:

1. Employees shall be subject to MHSC's Corrective Action Policy.
2. Medical Staff may face revocation, suspension, or modification of privileges in accordance with the Medical Staff Bylaws and credentialing procedures.
3. Contractors, Students, and Interns may be subject to immediate removal from MHSC facilities, termination of assignments or educational placements, and may be barred from future access.

MHSC reserves the right to take immediate protective action, including removal from the premises, in cases where a violation presents an imminent threat to patient or staff safety.

V. REPORTING AND RESPONSE PROCEDURES

Any suspected violation of this policy, or applicable state or federal law regarding firearms or weapons, must be **immediately reported** to Hospital Security or Administration. Hospital Security shall document all reports and actions taken in accordance with internal procedures. If a firearm or weapon is observed or disclosed in violation of this policy, staff should notify Security rather than confront the individual directly.

Hospital Security shall:

1. Instruct individuals to remove the non-firearm weapon or firearm;
2. Remove noncompliant individuals or contact law enforcement;
3. Temporarily secure weapons only as provided above.
4. Offer temporary storage for firearms in accordance with the Firearm Storage section, if appropriate.

Retaliation against any individual who reports a suspected violation in good faith is strictly prohibited and may result in disciplinary action.

Cooperation with Law Enforcement: MHSC personnel and security will cooperate with law enforcement agencies in any investigation involving weapons violations, including providing access to storage areas, video footage, and relevant records, as permitted by law.

VI. POLICY REVIEW AND LEGAL COMPLIANCE

This policy will be reviewed biannually or more frequently upon changes to:

1. State or federal firearm or non-firearm weapon laws;
2. Hospital operations, such as the addition of behavioral health services or chemical storage.

Hospital Legal Counsel shall be consulted to ensure alignment with applicable statutory, regulatory, and operational requirements prior to each review.

VII. SEVERABILITY

If any provision is held unlawful, all other provisions will remain enforceable.

VIII. LEGAL PROTECTIONS

Nothing herein waives any immunity afforded under the Wyoming Governmental Claims Act.

IX. AUTHORITY

W.S. § 6-8-105 (Wyoming Repeal Gun Free Zones Act);
W.S. § 6-8-401 et seq. (Wyoming Firearms Act)

Approval: Board of Trustees 1/3/24

Approval Signatures

Step Description	Approver	Date

Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:8/6/2025

Topic for Old & New Business Items:

- BOT – Hospital Insurance Policy

Policy or Other Document:

☐ Revision
☒ New

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

Board Committee Action:

Drafted by Board Legal Counsel and approved by the Governance Committee in July. Presented at the August Board of Trustees meeting for first review.

Policy or Other Document:

☒ For Review Only
☐ For Board Action

Legal Counsel Review:

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

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

Status Draft PolicyStat ID 18613873

Approved N/A
Review Due N/A

Document Area Board of Trustees

HOSPITAL INSURANCE POLICY

Board of Trustees

STATEMENT OF PURPOSE:

This policy establishes Memorial Hospital of Sweetwater County's (the Hospital) commitment to maintaining comprehensive and adequate insurance coverage to protect its Board of Trustees, Officers, employees, volunteers, contractors, and assets from liability, property loss, and operational risks. It outlines the types of insurance required, the review and procurement process, and procedures for legal compliance and governance oversight. This policy is designed to ensure the Hospital's insurance program aligns with its obligations and potential liabilities under the Wyoming Governmental Claims Act (W.S. § 1-39-101 et seq.).

POLICY STATEMENT

The Hospital shall secure and maintain insurance coverage consistent with applicable laws, contractual obligations, risk tolerance, and industry best practices. Insurance shall include coverage for professional liability (medical malpractice), directors and officers liability, general and auto liability, property loss, cyber events, employment claims, and other insurable risks relevant to the Hospital's operations.

TEXT:

A. Required Insurance Coverages

Professional Liability / Medical Malpractice:

1. Covers claims alleging errors, omissions, or negligence in the delivery of patient care;

2. Applies to the Hospital, its employees, and, where applicable, contracted or privileged providers;
3. Policy limits shall meet or exceed statutory minimums, licensing requirements, and relevant third-party payor or accreditation conditions.

Directors and Officers (D&O) Liability:

1. Covers actual or alleged wrongful acts by Trustees, Officers, and senior management in the performance of their duties.
2. Includes:
   a. Defense costs;
   b. Indemnification reimbursement;
   c. Employment practices liability, if not separately insured;
   d. Regulatory or administrative investigations.
3. Protects against claims where governmental immunity does not apply (e.g., civil rights, retaliation, fiduciary claims).

General Liability: Covers bodily injury, personal injury, and property damage claims arising out of hospital premises, operations, or events.

Property Insurance:

1. Covers buildings, equipment, furniture, and other assets against fire, theft, flood, vandalism, and natural disasters.
2. Shall include business interruption, extra expense, and equipment breakdown coverage when available and cost-effective.

Cyber Liability:

1. Covers breach response, data restoration, ransomware attacks, and liability arising from unauthorized access to protected information.
2. Shall include:
   a. Breach response services;
   b. Regulatory fines and penalties (to the extent insurable);
   c. Notification and monitoring costs;
   d. Public relations/crisis management assistance.

Automobile Liability:

1. Covers Hospital-owned, leased, or rented vehicles.
2. Includes employee use of personal vehicles for business purposes, as appropriate.

Employment Practices Liability (EPLI):

1. Covers claims involving wrongful termination, harassment, discrimination, retaliation, or other employment-related allegations.
2. May be included under D&O or issued as a standalone policy.

Workers' Compensation and Employer's Liability: Covers job-related injuries and illnesses in accordance

with Wyoming law.

Umbrella / Excess Liability: Provides additional coverage beyond the limits of general liability, professional liability, automobile, and D&O policies.

B. Covered Individuals and Entities

Coverage shall extend to:

1. Members of the Board of Trustees;
2. Officers and executive leadership;
3. Department directors and managers;
4. Employees, agents, and volunteers acting within the scope of assigned duties;
5. Students, interns, residents, and trainees participating in authorized clinical or educational programs;
6. Contractors, if specifically required by agreement and approved by the CEO or Risk Manager;
7. Memorial Hospital of Sweetwater County Foundation, including its officers, directors, and authorized volunteers, but only while acting within the scope of their duties in support of the Hospital's mission, and provided such coverage is approved by the Hospital's insurer or risk pool.

Independent contractors and credentialed medical staff shall not be covered unless:

1. The Hospital is required to do so under a written agreement; and,
2. Coverage is approved by the CEO in consultation with legal and risk management.

Third-Party Clinical Personnel Under Hospital Supervision:

Individuals who provide clinical services at the Hospital but are employed by third-party staffing agencies may be deemed "public employees" under the Wyoming Governmental Claims Act if the Hospital exercises significant control over their job duties, conduct, or scheduling. In such cases, the Hospital may be vicariously liable for their actions.

The Risk Manager, in consultation with legal counsel and the Hospital's insurance broker, shall evaluate whether coverage under the Hospital's professional liability policy is appropriate and whether contractual or insurance adjustments are needed to mitigate this risk.

C. Procurement, Oversight, and Review

Insurance shall be secured from carriers with an A.M. Best rating of A- or higher, unless otherwise approved by the Board.

The CEO, in collaboration with the CFO and Hospital legal counsel, shall:

1. Annually assess the Hospital's insurance needs in consultation with the Hospital's broker, typically beginning in January;
2. Determine which coverages, if any, should be marketed to additional carriers;

3. Present recommended changes in limits, deductibles, coverage structure, or carrier selection to the Board of Trustees for review and approval;
4. Conduct an in-person or virtual meeting with the broker during the renewal process to review final coverage options and develop a recommendation regarding carrier selection and policy structure. This meeting is commonly scheduled in April but may occur at another time as appropriate.

Upon completion of this process, the CEO shall present the proposed insurance program to the Board of Trustees for review and final approval.

The Board shall have sole authority to approve:

1. The overall insurance portfolio and carrier selection;
2. Significant changes to policy limits, deductibles, or self-insured retentions;
3. Participation in a risk pool, captive, or self-insurance program;
4. Use of non-admitted (surplus lines) carriers where admitted coverage is unavailable.

Discretionary Board Review:

1. Direct that selected lines of coverage be competitively bid, consistent with procurement law and sound risk management practices;
2. Retain an independent insurance consultant to assist with coverage evaluation or bidding processes.

Post-*Elsner* Liability Exposure Review:

In light of the Wyoming Supreme Court's holding in *Elsner v. Campbell County Hospital District*, the Hospital shall annually review its liability coverage to:

1. Confirm that policies do not exclude or limit coverage for claims involving third-party personnel deemed "public employees" due to Hospital supervision or control;
2. Ensure that contracts with staffing agencies contain adequate indemnification provisions and insurance obligations in light of Elsner;
3. Evaluate whether excess liability or risk pool participation is necessary to mitigate the expanded vicarious liability exposure.

Vendor and Contractor Insurance Requirements:

The Hospital shall require all clinical staffing vendors to:

1. Acknowledge in writing that their personnel may be subject to supervision and control by the Hospital;
2. Provide certificates of insurance listing the Hospital as an additional insured under professional liability policies;
3. Agree to indemnify the Hospital for claims arising from acts or omissions of their employees, except where doing so would violate public policy or statutory limits.

Use of Surplus Lines Carriers: If coverage is unavailable from admitted (licensed) carriers, the Hospital

may, with Board approval, obtain coverage from surplus lines insurers, provided those insurers demonstrate appropriate financial strength and reinsurance support.

D. Risk Pool Participation and Self-Insurance

Where applicable, the Hospital may participate in a public entity risk pool, captive insurer, or self-insured retention arrangement, subject to Board approval. The financial condition, reinsurance support, and claims administration processes of such arrangements shall be reviewed at least annually.

The CEO or CEO designee shall maintain a system for:

1. Prompt reporting and documentation of potential and actual claims;
2. Notification to insurers in accordance with policy conditions;
3. Coordination with outside counsel and claims adjusters;
4. Maintenance of claims records for audit and regulatory purposes.

Material claims shall be reported to the Board of Trustees periodically, subject to legal restrictions and confidentiality needs.

E. Legal Compliance

The Hospital's insurance coverage shall comply with:

1. Wyoming Governmental Claims Act (W.S. § 1-39-101 et seq.)
2. Relevant sections of Wyo. Stat. §§ 33-26, 35-2, and 42 U.S.C. § 1320d (HIPAA)
3. Medicare Conditions of Participation and EMTALA
4. CMS, Joint Commission, and state licensing standards
5. Contractual requirements with insurers, payors, and vendors

F. Indemnification and Immunity

Nothing in this policy waives or modifies the Hospital's governmental immunity under Wyoming law. Indemnification of board members, officers, or employees shall occur only as permitted under the Wyoming Governmental Claims Act, applicable state statutes, and the Hospital Bylaws.

G. Loss Prevention and Risk Education

To minimize insurable risks, the Hospital shall promote proactive loss prevention strategies through training, internal audits, and departmental risk reviews. The Risk Manager shall collaborate with department heads to identify trends, reduce claim exposure, and recommend mitigation strategies.

Board of Trustees Approval:

Approval Signatures

Step Description	Approver	Date

ORIENTATION MEMO

Board Meeting Date: 8/6/2025

Topic for Old & New Business Items: “CAH – Exposure Control Plan”

Policy or Other Document:

__X____ Revision
_____ New

Brief Senior Leadership Comments: The plan was due for review. The terminology and grammar were updated with minor changes. Since this is a “plan,” it is coming for review and approval to the Board of Trustees. It has been approved by the employee health nurse, Director of Education, Deseriee Stofferahn, AGNP-C, Dr. Karn, the Infection Control Committee, and MEC.

Board Committee Action:

Policy or Other Document:

___X____ For Review Only
_____ For Board Action

Legal Counsel Review:

_____ In House Comments:
_____ Board Comments:

Senior Leadership Recommendation: Recommend review and approval.
Ann Marie Clevenger DNP, RN, NEA-BC

Status Active PolicyStat ID 17956684

Approved 06/2025
Review Due 06/2026

Document Area: Employee Health
Reg. Standards: OSHA 29 CFR 1910.1030, TJC EC.02.02.01, TJC IC 04.01.01:

CAH - Exposure Control Plan

STATEMENT OF PURPOSE

To ~~provide guidelines for the development of policies and procedures designed to~~ prevent or minimize the occupational exposure of ~~employees and other patient service providers to blood borne~~staff to bloodborne pathogens (BBP) ~~or~~and other potentially infectious material (OPIM).

~~PLAN:~~

~~Health care~~Healthcare workers face ~~a~~ significant health ~~risk because of~~risks from occupational exposure to infectious diseases and bloodborne pathogens, including ~~hepatitis~~the Hepatitis B virus (HBV), ~~hepatitis~~Hepatitis C (HCV), ~~human immunodeficiency virus~~Human Immunodeficiency Virus (HIV), and other bloodborne pathogens. A consistent approach to managing body fluids and substances from all ~~persons~~individuals is essential to prevent the transmission of infectious agents, whether a causative agent has been identified.

~~A~~Staff shall have access to a copy of the Memorial Hospital of Sweetwater County's (MHSC) Exposure Control Plan and related policies ~~shall be accessible to all employees~~ during the ~~normal~~regular work shift. The ~~Exposure Control Plan~~plan shall be reviewed and updated ~~at least~~ annually ~~and whenever~~, or as necessary, to reflect current literature, new or modified tasks, and procedures ~~which~~that affect occupational exposure.

~~MHSC has made the decision to have all permanent employees~~All clinical staff shall receive initial and annual bloodborne pathogen (BBP) training in accordance with OSHA requirements. Nonclinical staff ~~will~~shall receive ~~a~~ separate BBP education tailored to their specific roles, distinct from the more ~~detailed~~comprehensive BBP training provided to clinical staff ~~BBP education~~.

~~**Methods of Compliance**~~

DEFINITION

- **Bloodborne Pathogens (BBPs):** Pathogenic microorganisms in human blood that can cause disease. These pathogens include, but are not limited to, HBV, HIV, and HCV.
- **Contaminated Laundry/Linen:** Any linen or laundry used or soiled with blood or other potentially infectious materials or may contain sharps.
- **Hand Hygiene:** Handwashing that may include either plain or antiseptic-containing soap and water, or the use of alcohol-based sanitizers (gels, rinses, foams) that do not require water.
- **Occupational Exposure:** Actual or suspected exposure of skin, eye, mucous membrane, or respiratory tract, or parenteral contact with blood or other potentially infectious materials that may result from performing staff's duties.
- **Occupational Safety and Health Administration (OSHA):** The Occupational Safety and Health Administration (OSHA) assures safe and healthful working conditions by setting and enforcing standards and providing training, outreach, education, and assistance.
- **Other Potentially Infectious Material (OPIM):** Includes, but is not limited to, blood, semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, mucous, saliva, pus, urine and stool.
- **Personal Protective Equipment (PPE):** Equipment worn to minimize exposure to infectious agents, including gowns, gloves, masks, face shields, and respirators.
- **Regulated Waste:** Liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and can release these materials during handling; contaminated sharps; and pathological wastes containing blood or other potentially infectious materials.
- **Sharps:** Any object that can penetrate the skin, including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.
- **Standard Precautions:** A set of infection control practices used to prevent the transmission of diseases that can be acquired by contact with blood, body fluids, non-intact skin, and mucous membranes. These measures are to be used when providing care to all individuals.
- **Transmission-Based Precautions:** Infection prevention and control measures to protect against exposure to a suspected or identified pathogen. These precautions are specific and based on the way the pathogen is transmitted. Categories include contact, droplet, airborne, and a combination of these.
- **Staff:** All people who provide care, treatment, or services in the organization, including licensed practitioners, permanent, temporary, and part-time personnel, contract employees, volunteers, and health profession students.The C*ontracted Staff are provided through a written agreement with another organization, agency, or person. The agreement specifies the services or personnel to be provided on behalf of the applicant organization and the fees to provide these services or personnel.* Staff at MHSC:
    - Employed Staff - Full-time, Part-time, PRN, and Temporary personnel
    - Volunteer Staff - An individual who performs service to MHSC without expectation of compensation

- Permanent Contract Staff - Personnel contracted through organizations such as Cardinal and Unidine
- Temporary Contract Staff - Personnel from staffing agencies such as Travelers and Elwood
- Non-Employed Staff - Students, Shadowers

ADMINISTRATION AND MANAGEMENT OF THE PLAN

Methods of Compliance

I. **General**

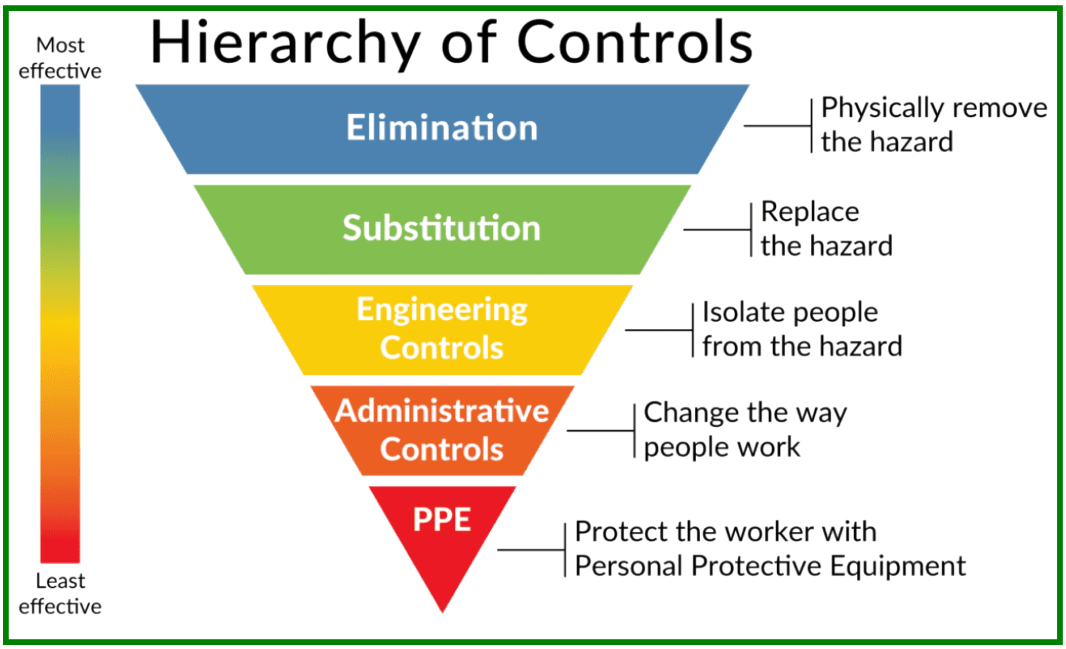
A. All staff shall follow Standard Precautions ~~shall be followed by all employees~~ to prevent contact with blood or other potentially infectious materials (OPIM). Standard Precautions ~~places~~ensure that Personal Protective Equipment (PPE) acts as a barrier ~~of gloves, gown, goggles, face shield and/or mask~~ between potentially infectious body substances, non-intact skin ~~and~~, mucous membranes, and ~~the caregiver~~caregivers.

II. **Engineering and Work Practice Controls**

A. Engineering and work practice controls shall be implemented to eliminate or minimize employee exposure to blood or bloodborne pathogens (BBPs). When occupational exposure persists despite these measures, PPE shall be used ~~to eliminate or minimize employee exposure to blood or bloodborne pathogens~~as an additional safeguard. ~~Where occupational exposure remains after institution of these controls, personal protective equipment shall also be used.~~

B. Engineering controls shall be examined ~~and~~, maintained, or replaced ~~on a regular schedule~~regularly to ensure their effectiveness. CDC Hierarchy of Controls

C. ■



III. Hand Hygiene

A. The World Health Organization (WHO) recommends the "Five Moments of Hand Hygiene" to prevent the spread of infection in healthcare settings. (See attachment) These moments are:

1. **Before touching a patient:** To remove any microorganisms that may be on the healthcare worker's hands.
2. **Before a clean/aseptic procedure:** To ensure the procedure is performed in a sterile environment.
3. **After body fluid exposure:** To remove microorganisms that may have been exposed to body fluids, such as blood, mucus, or vomit.
4. **After touching a patient:** To prevent the transmission of microorganisms from the patient to the healthcare worker.
5. **After touching the patient's surroundings:** To remove microorganisms that may be on objects in the patient's environment, such as bed rails, chairs, or medical equipment.

B. Hand hygiene facilities are ~~provided~~available in all patient care areas, treatment rooms, utility rooms, and restrooms to support infection prevention and control.

C. ~~Employees~~Staff must perform hand hygiene immediately or as soon as possible after ~~removal of~~removing gloves or other ~~personal protective equipment~~PPE to maintain infection control and prevent cross-contamination.

D. ~~Employees~~Staff must wash their hands and any other exposed skin with soap and water, or flush mucous membranes with water, immediately or as soon as possible ~~following~~after contact ~~of such~~with body areas contaminated with blood or ~~other~~

~~potentially infectious materials~~OPIM.

E. Alcohol-based hand sanitizers may be used for hand hygiene if hands are not visibly soiled.

IV. **Sharps**

A. ~~Contaminated needles and other contaminated sharps shall not be recapped unless such action is required by a specific medical procedure.~~

B. Contaminated needles and other ~~contaminated~~ sharps shall not be ~~bent,~~ sheared, clipped, or broken ~~and~~. They shall be dropped into ~~the~~a sharps container without any manipulation.

C. MHSC has a no -recapping policy. If ~~specifically required~~recapping is necessary, a one-handed technique (scoop method) ~~of the cap~~ may be ~~used~~utilized. Needles shall not be recapped, bent, or altered unless medically necessary.

D. Disposable sharps shall be ~~disposed of~~discarded in the appropriate sharps container ~~at the point and time of~~immediately after use~~, or as soon as possible, by the user~~.

E. Contaminated, reusable sharps shall be ~~put~~placed in appropriate containers immediately ~~or as soon as possible~~ after use. ~~The~~These containers shall be puncture -resistant, ~~color coded red or~~ labeled with ~~the appropriate~~a biohazard label, and leak-proof on the sides and bottom.

F. ~~Employees~~Staff shall not handle contaminated ~~needles or contaminated~~ sharps directly~~: perforated~~. Perforated trays, hemostats, forceps, ~~or dustpan and broom~~dustpans, and brooms shall be used~~, depending on the situation's requirements,~~ to prevent direct ~~handling or touching of the~~contact with contaminated sharp.

V. ~~**Environmental Surfaces**~~

~~A. Food, Cosmetics~~

~~1. Eating, drinking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is likelihood of occupational exposure to blood or BBP. **NOTE**: See attachment from The Joint Commission, OSHA and the Wyoming Department of Health regarding their stance on food and drink in clinical work stations.~~

~~2. Units shall perform a unit-specific risk assessment to determine allowable areas for food and drinks.~~

~~a. Food and covered drinks shall be allowed in designated areas where blood or OPIM will not be collected, stored, or processed.~~

~~b. Staff will be subject to corrective action if food and drinks are found in areas where blood or OPIM are collected, stored, or processed.~~

~~3. Food and covered drinks shall be allowed in designated areas where blood or OPIM will not be collected, stored, or processed.~~

4. ~~Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets, or on countertops or benchtops where blood or OPIM is present.~~

5. ~~Only hospital-approved hand lotion may be applied after hand hygiene has been performed.~~

B. ~~Body Fluid Contamination~~

1. ~~All procedures involving blood or OPIM shall be performed in such a manner as to minimize splashing, spraying, splattering and generation of droplets of these substances.~~

2. ~~Splattering or generation of droplets of blood and/or body fluids necessitate the use of eye protection and mask or face shield.~~

3. ~~Environmental cleaning will be done in a manner to minimize splashing, spraying or generation of droplets of blood and/or body fluids.~~

4. ~~Mouth pipetting of blood and OPIM is prohibited.~~

C. ~~Laboratory Specimens~~

1. ~~Specimens of blood or OPIM shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport or shipping.~~

2. ~~Biohazard labeling/color-coding of specimens shall be used for transporting specimens.~~

3. ~~All employees who will have contact with the specimen are trained to handle all specimens as if infected with a BBP.~~

4. ~~Standard Precautions are followed always.~~

5. ~~If the specimen leaves the facility (e.g., during transport, shipment or disposal) a biohazard label or red color-coding is required.~~

6. ~~If outside contamination of the primary container occurs, the primary container shall be placed within a second container which prevents leakage during handling, processing, storage and transport. If shipping outside the facility, the secondary container must have red color-coding, or a biohazard label attached.~~

7. ~~If the specimen could puncture the primary container, the primary container shall be placed within a secondary container which is puncture resistant and meets guidelines previously listed.~~

8. ~~Extracted teeth are subject to containerization and labeling standards.~~

D. ~~Equipment Servicing~~

1. ~~Equipment which may become contaminated with blood or OPIM shall be examined prior to servicing or shipping and shall be decontaminated as necessary.~~

2. ~~Decontamination shall be done in a manner to minimize splashing, spraying or generation of droplets of blood and/or OPIM.~~

3. ~~When it is not possible to decontaminate equipment prior to servicing or shipping (e.g., highly technical or sensitive equipment and/or limited access to contaminated parts), at least partial decontamination, such as flushing lines and wiping the exterior with an approved disinfectant, shall be accomplished.~~

4. ~~A readily observable approved biohazard label shall be attached to the equipment stating which portions remain contaminated.~~

5. ~~This information is conveyed to all affected employees, the servicing representative and/or manufacturer as appropriate, prior to handling, servicing or shipping so that appropriate precautions will be taken.~~

VI. **Environmental Surfaces**

A. Food, Cosmetics

1. Eating, drinking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where occupational exposure to blood or OPIM is likely.

2. Each unit shall determine designated areas for food and drinks.

   a. Food and covered drinks shall be allowed in areas where blood or OPIM will not be collected, stored, processed, or transmitted.

   b. Staff may face corrective action if food and drinks are found in prohibited areas.

3. Food and drink shall not be stored in refrigerators, freezers, shelves, cabinets, or counter tops where blood or OPIM is present or transported.

4. Only hospital-approved hand lotion may be applied after performing hand hygiene.

B. Body Fluid Contamination

1. Procedures involving blood or OPIM must minimize splashing, spraying, splattering, and aerosol generation.

2. Eye protection and masks/face shields must be used when exposure to splattering blood or body fluids is anticipated.

3. Environmental cleaning protocols must be followed to prevent splashing, spraying, or aerosol generation.

4. Mouth pipetting of blood and OPIM is strictly prohibited.

VII. Laboratory Specimens

A. Specimens of tissue, blood, or OPIM shall be placed in a leak-proof container during

collection, handling, processing, storage, transport, and shipping.

B. All specimens shall be transported in a secondary container such as a biohazard bag.

C. All staff handling specimens must be trained to treat all specimens as potentially infected with BBPs.

D. Standard Precautions shall always be followed.

E. A biohazard label is required when specimens are transported outside the facility (e.g., shipment, or disposal).

F. If a specimen has the potential to puncture its container, it must be placed within a puncture-resistant secondary container.

VIII. Equipment Servicing

A. Equipment that may become contaminated with blood or OPIM shall be examined prior to servicing or shipping and shall be decontaminated as needed.

B. Decontamination shall be done to minimize splashing, spraying, or generation of droplets of blood and/or OPIM. Decontamination procedures shall minimize splashing, spraying, and aerosol generation.

C. When it is not possible to decontaminate equipment prior to servicing or shipping (e.g., highly technical or sensitive equipment and/or limited access to contaminated parts), at least partial decontamination, such as flushing lines and wiping the exterior with an approved disinfectant, shall be accomplished.

D. A highly visible biohazard label must be attached to contaminated equipment, indicating which portions remain contaminated.

E. This information shall be communicated to all affected staff, the servicing representative, and/or manufacturer as appropriate, prior to handling, servicing, or shipping to ensure proper precautions.

~~Personal Protective Equipment (PPE)~~

Personal Protective Equipment (PPE)

I. ~~PPE includes but is not limited to: gloves, gowns, laboratory coats, face shields or masks and eye protection, mouthpieces, resuscitation bags, pocket masks or other ventilation devices.~~

II. ~~PPE is appropriate only if it does not permit blood or OPIM to pass through or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth or other mucous membranes under normal conditions of use and for the duration of time for which the protective equipment will be used.~~

III. ~~Appropriate PPE in appropriate sizes shall be readily accessible at the work site or is issued to the employee.~~

~~A. Hypo-allergenic gloves, glove liners, powderless gloves or other similar alternatives shall be provided if necessary at no cost to the employee.~~

IV. ~~PPE cleaning or reprocessing, laundering and disposal will be done at no cost to the employee.~~

V. ~~Use of PPE~~

A. ~~The type and amount of PPE shall be chosen to protect against contact with blood or other potentially infectious material based upon the type of exposure and quantity of these substances which can be reasonably anticipated to be encountered during the performance of a task or procedure.~~

1. ~~The employee shall wear appropriate PPE except when, in his/her professional judgment, that in the specific instance of its use would have prevented the delivery of health care or would have posed an increased hazard to the safety to the patient, employee or co-worker.~~

2. ~~When an employee makes this judgment, the circumstances shall be investigated and documented to determine whether changes can be instituted to prevent such occurrences in the future.~~

B. ~~All personal protective equipment shall be removed prior to leaving the work area.~~

VI. ~~When personal protective equipment is removed it shall be placed in an appropriately designated area or container for storage, washing, decontamination or disposal.~~

VII. ~~If a garment(s) is penetrated by blood or OPIM, the garment(s) shall be removed as soon as possible.~~

VIII. ~~Personal protective equipment shall be removed in a manner to minimize contamination of personnel or the environment.~~

A. ~~If a pull-over scrub (as opposed to scrubs with snap closures) becomes minimally contaminated, the employee shall remove the pull-over scrub in such a way as to avoid contact with the outer surface, such as rolling up the garment as it is pulled toward the head for removal.~~

B. ~~If the amount of blood is such that the blood penetrates the scrub and contaminates the inner surface, not only is it impossible to remove the scrub without exposure to blood, but the penetration itself constitutes a body fluid exposure. Such a contaminated scrub should be cut to aid removal and prevent exposure to the face.~~

IX. PPE includes but is not limited to gloves, gowns, laboratory coats, eye protection, masks, respirators, mouthpieces, resuscitation bags, pocket masks, and other ventilation devices.

A. PPE must effectively block blood or OPIM from reaching the staff's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the intended duration.

B. Appropriate PPE in appropriate sizes shall be readily accessible at the work site or is issued to staff.

1. Hypoallergenic gloves, glove liners, powder-free gloves, or other alternatives shall be provided at no cost to the staff if needed.

C. PPE cleaning or reprocessing, laundering, and disposal will be done at no cost to staff.

D. Use of PPE

1. The type and amount of PPE shall be chosen to protect against contact with blood or OPIM based upon Transmission-Based Precautions, the type of exposure, and the quantity of these substances that can be reasonably anticipated to be encountered during a task or procedure.

    a. Transmission-Based Precautions supplement Standard Precautions for patients known or suspected to be infected with specific infectious agents requiring additional protective measures.

    b. Staff shall wear appropriate PPE as required unless, in their professional judgment, doing so would interfere with patient care or pose an increased hazard.

    c. When this occurs, the circumstances shall be investigated and documented to determine potential policy modifications.

2. All PPE shall be removed prior to leaving the work area, and hand hygiene shall be performed.

E. Used PPE shall be placed in designated containers for storage, washing, decontamination, or disposal.

F. If a garment is penetrated by blood or OPIM, it shall be removed immediately, and the affected body area shall be cleaned.

G. PPE and contaminated clothing shall be removed in a manner to minimize contamination of personnel or the environment.

1. If a pull-over scrub (as opposed to scrubs with snap closures) becomes minimally contaminated, the staff shall remove it in such a way as to avoid contact with the outer surface, such as rolling up the garment as it is pulled toward the head for removal.

2. If blood penetrates the inner surface, removal without exposure is impossible. Such garments should be cut to aid removal and prevent facial exposure.

X. **Gloves**

A. Gloves shall be worn when it can be reasonably anticipated that the staff may have hand contact with blood, OPIM, mucous membranes, or non-intact skin.

B. Gloves shall be worn during vascular access procedures, including phlebotomy and intravenous line starts.

C. Gloves shall be worn when touching contaminated items or surfaces.

D. Disposable (single-use) gloves must be replaced when contaminated, torn, punctured, or compromised.

E. Disposable gloves shall not be washed or decontaminated for reuse unless an official shortage mandates.

F. Utility gloves may be decontaminated if their integrity is intact but must be discarded if cracked, peeling, torn, punctured or compromised.

G. Gloves are not required for routine injections unless the staff member has open lesions on their hands or risks contact with the patient's body fluids.

XI. **Masks, Eye Protection, and Face Shields**

A. Masks along with eye protection devices such as goggles, glasses with solid side shields, or chin-length face shields, shall be worn whenever splashes, spray, spatter, or droplets of blood or OPIM may be generated and eye, nose, or mouth contamination is reasonably anticipated.

B. Minimum protection consists of a mask combined with either safety glasses (with solid side shields), goggles, or a chin length face shield.

C. Prescription glasses alone do not meet protective standards. Disposable eye shields must be worn over glasses for adequate splash protection.

XII. **Gowns, Aprons, and Other Protective Clothing**

A. Staff shall wear appropriate protective clothing such as gowns, aprons, lab coats, or clinic jackets in situations involving occupational exposure.

1. The level of protection shall match the anticipated degree of exposure throughout the task duration.
2. Protective clothing must prevent blood or OPIM from passing through to skin or clothing.

B. Surgical caps and/or shoe or boot covers shall be worn when gross contamination is reasonably anticipated (autopsies, orthopedic surgery).

C. Home laundering of protective clothing is prohibited to prevent microbial contamination or disease transmission.

D. If a staff member's personal clothing or uniform becomes contaminated, it must be removed immediately, replaced with clean scrubs, and laundered by MHSC. An event report shall be completed for each blood exposure or clothing change.

E. Protective clothing shall be removed prior to leaving the work area.

~~Gloves~~

~~I. Gloves shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood, OPIM, mucous membranes and non-intact skin.~~

~~II. Gloves shall be worn when performing vascular access procedures including phlebotomy and intravenous starts.~~

~~III. Gloves shall be worn when touching contaminated items or surfaces.~~

~~IV. Disposable (single use) gloves such as surgical or exam gloves shall be replaced as soon as~~

practical when contaminated or as soon as possible if they are torn, punctured, or when their ability to function as a barrier is compromised.

V. Disposable (single use) gloves shall not be washed or decontaminated for re-use.

VI. Utility gloves may be decontaminated for re-use if the integrity of the glove is not compromised. However, they must be discarded if they are cracked, peeling, torn, punctured, or exhibits other signs of deterioration or when their ability to function as a barrier is compromised.

VII. Gloves do not need to be worn when only giving routine injections.

Masks, Eye Protection and Face Shields

I. Masks in combination with eye protection devices such as goggles or glasses with solid side shields or chin length face shields, shall be worn whenever splashes, spray, spatter, or droplets of blood or OPIM may be generated and eye, nose, or mouth contamination can be reasonably anticipated.

II. Minimum protection consists of a mask in conjunction with eye glasses with solid side shields, goggles, or a chin length face shield.

III. Prescription glasses may not be used as protective eye wear. The disposable eye shields must be worn over glasses to be considered protective for splash exposure.

Gowns, Aprons, and Other Protective Body Clothing

I. Appropriate protective clothing such as, but not limited to, gowns, aprons, lab coats, clinic jackets, or similar outer garments shall be worn in occupational exposure situations.

II. The protective clothing worn must be appropriate for the task and degree of exposure anticipated for the duration of the task.

III. The protective clothing must prevent blood or OPIM from passing through to reach the employee's skin or work clothes.

IV. Surgical caps and/or shoe covers, or boots shall be worn in instances when gross contamination can reasonably be anticipated (autopsies, orthopedic surgery).

V. Home laundering of protective clothing is not permitted; it could lead to microbial contamination within the home and possible transmission of disease.

VI. If the employee's own personal clothing or uniform becomes contaminated with blood or OPIM during the course or work, the clothing must be removed as soon as possible, replace with clean scrubs, and the personal clothing will be laundered by MHSC. Complete an event report any time an employee has a blood exposure or must change their clothes.

VII. Protective clothing shall be removed prior to leaving the work area.

Environmental Services

I. The work site will be maintained in a clean and sanitary condition. There are written schedules for

cleaning and method of decontamination based upon location within the facility, type of soil present and tasks or procedure being performed in the area.

II. All equipment, environmental and working surfaces shall be cleaned and decontaminated after contact with blood or OPIM.

III. Contaminated work surfaces shall be decontaminated with an appropriate disinfectant after completion of procedures, immediately or as soon as possible when surfaces are overtly contaminated or after any spill of blood or OPIM; and at the end of the work shift if the surface may have become contaminated since the last cleaning.

IV. Protective coverings, such as plastic wrap, aluminum foil, or imperviously backed absorbent paper used to cover equipment and environmental surfaces, shall be removed and replaced as soon as possible when they become overtly contaminated or at the end of the work shift, if they have become contaminated during the shift. Protective coverings used in patient care areas will be changed between patients.

V. All bins, pails, cans, and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or OPIM shall be inspected and decontaminated on a regularly scheduled basis and cleaned and decontaminated immediately or as soon as possible upon visible contamination.

VI. Broken glassware which may be contaminated shall not be picked up directly with the hands. It shall be cleaned up using mechanical means such as a brush and dust pan, tongs, or forceps. Tools used in cleanup must be properly decontaminated or discarded after use and the broken glass placed in a sharps container.

VII. Reusable sharps that are contaminated with blood or OPIM shall not be stored or processed in a manner that requires an employee to reach by hand into the containers where these sharps have been placed.

Regulated Waste

Regulated waste will be properly contained and disposed of, so as not to become a means of transmission of disease to employees, and shall be in accordance with applicable national, state, and local regulations.

Disposal of Contaminated Sharps

I. Shall be discarded immediately or as soon as possible in containers that are closeable, puncture resistant, leak-proof and labeled with the words “Biohazardous Waste” or with the international biohazard symbol and the word “Biohazard”.

II. The sharps container should be easily accessible to staff and located as close as possible to the immediate area where sharps are used or can be reasonably anticipated to be found.

III. The sharps container will be maintained upright throughout use, replaced routinely when 2/3 full and not be allowed to overfill.

IV. When moving containers of contaminated sharps from the area of use, the container will be closed to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

V. If leakage is possible, the sharps container must be placed in a secondary container that is properly labeled, closeable, leak-proof, and constructed to contain all contents during handling, storage, transport or shipping.

VI. Reusable containers will not be opened, emptied, or cleaned manually or in any manner which would expose employees to risk of percutaneous injury.

VII. Retractable needles and other safety needles must be disposed of in a sharps container.

Other Regulated Waste

I. Regulated waste shall be placed in containers which are closable, constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping.

II. Regulated waste shall be put into containers which are labeled with international biological hazard symbol and/or labeled "Biohazard" or colored-coded red.

III. The containers will be closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport or shipping.

IV. If outside contamination of the regulated waste container occurs, it shall be placed in a second container which meets all the same design requirements as the first container. This second container shall be closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport or shipping.

Laundry/Linens

I. Standard precautions shall be used always when handling soiled laundry/linens.

II. Contaminated laundry shall be handled as little as possible with a minimum of agitation. It shall be bagged or containerized at the location where it was used and shall not be sorted or rinsed at the location of use.

III. Linen bags are to be constructed of a material that minimizes the likelihood of soak-through or leakage of fluids to the exterior.

IV. Employees having direct contact with contaminated laundry shall wear protective gloves and any other appropriate PPE to prevent or reduce contact exposure to blood or OPIM.

V. The laundry/linen service department will have written infection control guidelines that address the proper handling of linen.

Compliance

I. Compliance by employees with this standard will be integrated into employee performance review and appraisals.

II. Employees who fail to comply with elements of this Plan will receive additional education about the control of BBP and the intent of this plan.

Hepatitis B Vaccination and Post-Exposure Follow-Up

I. MHSC shall provide the hepatitis B vaccine and vaccination series to all employees who have occupational exposure to blood and/or BBP.

II. Post-exposure evaluation and follow-up shall be provided to all employees who have had a body substance exposure incident.

III. All medical evaluations, hepatitis B vaccine and vaccination series, post-exposure evaluation and follow-up will be:

A. Available at not cost to the employee.

B. Available to the employee at a reasonable time and place.

C. Performed by, or under the supervision of a licensed physician or by or under the supervision of another licensed healthcare professional.

IV. All laboratory tests will be conducted by an accredited laboratory at no cost to the employee.

Hepatitis B Vaccine

I. The employee shall be given the Vaccination Information Sheet on the hepatitis B vaccine; the vaccination series is offered free of charge.

II. Hepatitis B vaccination shall be made available prior to hire during the on-boarding process assignment to all employees who have occupational exposure to blood or BBP unless:

A. The employee has previously received the complete hepatitis B vaccination series and has antibody testing that has revealed the employee is immune.

B. The vaccine is contraindicated for medical reasons

III. The Hepatitis B vaccine with be required for all employees unless medically contraindicated.

Post-Exposure Evaluation

I. Following a report of an exposure incident, Employee Health Services will provide confidential post-exposure care to the employee who is accidentally exposed to blood or OPIM.

II. The Accidental Exposure to Blood and Body Fluids Policy will be followed.

III. Evaluation and follow-up will include:

A. Documentation of the route(s) of exposure and the circumstances under which the exposure occurred.

B. Identification and documentation of the source individual unless that identification is not possible (e.g., needlestick by unmarked syringe):

1. The source individual's blood shall be tested as soon as possible once consent is verified to determine HBV, HCV and HIV infectivity.

2. When the source individual is already known to be infected with HBV or HIV, testing for the source individual's known HBV or HIV status need not be repeated.

3. Results of the source individual's testing shall be made available to the exposed employee and the employee shall be informed of applicable laws and

regulations concerning disclosure of the identity and infectious status of the source individual.

C. Post-exposure prophylaxis, when medically indicated, will be offered as recommended by the updated CDC Guidelines.

D. Counseling of the employee and evaluation of reported illnesses.

IV. Employee Health Services will have:

A. A description of the exposed employee's duties as they relate to the exposure incident.

B. Documentation of the route(s) of exposure and circumstances under which exposure occurred.

C. Results of the source individual's blood testing, if available.

D. All medical records relevant to the appropriate treatment of the employee, including vaccination status, will be maintained in their Employee Health Record.

V. Within 15 days, a written opinion will be provided to the employee.

VI. This written opinion shall be limited to the following information:

A. Whether hepatitis B vaccination is indicated for the employee and has the employee received such vaccination.

B. That the employee has been informed of the results of the evaluation and given a copy of the written opinion.

C. That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

D. All other findings or diagnoses shall remain confidential and shall not be included in the written report.

VII. Exposure records shall be maintained for duration of employment plus 30 years.

Communication of Hazards to Employees

I. Standard Precautions shall be followed always.

II. Warning labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or OPIM, and other containers used to store, transport or ship blood or other potentially infectious material.

III. Red bags or red containers may be substituted for labels.

IV. Containers of blood, blood components, or blood products that are labeled as to their contents and have been released for transfusion or other clinical use are exempted from these labeling requirements.

V. Individual containers of blood or OPIM that are place in a labeled container during storage, transport, shipment or disposal are exempted from the labeling requirements.

Labels and Signs

I. Labels shall display the universal biohazard symbol and the legend **"BIOHAZARD"**

II. Labels shall be fluorescent orange or orange-red, or predominantly so, with lettering or symbols in a contrasting color.

III. Labels shall be affixed to containers by string, wire, adhesive, or other method that prevents their loss or unintentional removal.

IV. Red bags or red containers may be substituted for labels.

V. Containers of blood, blood components, or blood products that are labeled as to their contents and have been released for transfusion or other clinical use are exempted from the labeling requirements.

VI. Individual containers of blood or OPIM that are placed in a labeled container during storage, transport, shipment or disposal are exempted from the labeling requirement.

VII. Labels required for contaminated equipment, shall be in accordance with this standard and shall also state which portions of the equipment remain contaminated.

VIII. Regulated waste that has been decontaminated need not be labeled or color-coded.

Information and Training

I. All employees with occupational exposure to blood or OPIM shall participate in a training program which will be provided at no cost to the employee and during working hours.

II. Training shall be provided at the time of initial assignment to tasks where occupational exposure might occur and at least annually thereafter.

III. Additional training shall be provided when changes such as modification of procedure affect the employee's occupational exposure.

IV. Training shall be appropriate to the education level, literacy and language or the employees.

V. The trainer shall be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address.

Training

I. The training program shall contain at least the following elements:

A. An accessible copy of the regulatory text of the standard and an explanation of its contents.

B. A general explanation of the epidemiology and symptoms of blood borne diseases.

C. An explanation of the modes of transmission of BBP.

D. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and OPIM.

E. An explanation of the use and limitations or methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and PPE.

F. Information on the types, proper use location, removal, handling, decontamination and disposal of PPE; and an explanation of the basis for selection of PPE.

G. Information of the hepatitis B vaccine, including information on efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge.

H. Information of the appropriate actions to take and persons to contact in an emergency involving blood or OPIM.

I. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available.

J. Information on the post-exposure evaluation and follow-up that Sweetwater Memorial is required to provide for the employee following an exposure incident.

K. An explanation of the signs and labels.

L. An opportunity for interactive questions and answers with the person conducting the training session.

Record Keeping

I. **Medical Records**

A. MHSC shall establish and maintain an accurate record for each employee with occupation exposure in accordance with OSHA.

B. This record shall include:

1. Name and social security number of the employee.
2. A copy of the employee's hepatitis B vaccination status including the dates of all hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination.
3. A copy of all results of examinations, medical testing, and follow-up procedures as required by the Standard.

C. The employee's medical records shall be kept confidential and not disclosed or reported without the employee's express written consent to any persona within or outside the workplace except as required by the Standard or as may be required by law.

D. MHSC shall maintain the employee's medical records for at least the duration of employment plus 30 years.

II. **Training Records**

A. Training records shall include:

1. Dates of the training sessions.
2. Contents or a summary of the training session.
3. Names and qualifications of persons conducting the training.
4. Names and job titles of all persons attending the training sessions.

B. Training records shall be maintained for 3 years from the date on which the training occurred.

III. **Availability**

A. All records required to be maintained shall be made available upon request to the employee.

B. Employee medical records shall be provided upon request to the employee or anyone given written consent by the employee.

Definitions

Bloodborne pathogens (BBP): pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, HBV, HIV, and HCV.

Contaminated laundry/linen: any linen or laundry that is used or soiled with blood or other potentially infectious materials or may contain sharps.

Hand hygiene: includes both handwashing with either plain or antiseptic-containing soap and water, or the use of alcohol-based sanitizers (gels, rinses, foams) that do not require the use of water.

Occupational exposure: reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

Occupational Safety and Health Administration (OSHA): ensures safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education and assistance.

Other potentially infectious material (OPIM): includes, but is not limited to, blood, semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, mucous, saliva, pus, urine and stool.

Personal Protective Equipment (PPE): equipment worn to minimize the exposure to infectious agents including items like gowns, gloves, masks and face shields, and respirators.

Regulated waste: liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and can release these materials during handling; contaminated sharps; and pathological wastes containing blood or other potentially infectious materials.

Sharps: any contaminated object that can penetrate the skin, including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

Standard Precautions: a set of infection control practices used to prevent the transmission of diseases that can be acquired by contact with blood, body fluids, non-intact skin, and mucous membranes. These measures are to be used when providing care to all individuals.

Responsibilities

Processes

I. **Environmental Services**

A. The work site will be maintained clean and sanitary condition.

B. All equipment, environmental surfaces, and working surfaces shall be cleaned and decontaminated after contact with blood or OPIM.

C. Contaminated work surfaces shall be decontaminated with an appropriate disinfectant.

D. Broken glassware that may be contaminated shall not be handled directly with the hands. Instead, it shall be cleaned using mechanical means, such as a brush and dustpan, tongs, or forceps. Tools used in cleanup must be properly decontaminated or discarded after use, and the broken glass shall be disposed of in a designated sharps container.

E. Reusable sharps contaminated with blood or OPIM shall not be stored or processed in a manner that requires staff to reach into the container by hand.

F. For further guidance, please refer to PolicyStat's Environmental Services: Housekeeping Care and Cleaning Guidelines and Environmental Services: Contaminated and/or Infectious Trash/Waste Handling and Disposal Procedures.

II. **Regulated Waste**

A. Regulated waste shall be properly contained and disposed of in a manner that prevents disease transmission. Disposal shall comply with all applicable national, state, and local regulations.

III. **Disposal of Contaminated Sharps**

A. Sharps shall be discarded immediately or as soon as possible in closable, puncture-resistant, leak-proof containers labeled with the words “Biohazardous Waste” or with the international biohazard symbol and the word “Biohazard”.

B. Sharps containers shall be easily accessible to staff and located near areas where sharps are frequently used.

C. The sharps container shall be stable, secure, upright throughout use, routinely replaced when 3/4 full and not allowed to overfill.

D. When containers of contaminated sharps are removed, they must be closed securely to prevent spills or protrusion of content during handling, storage, transport, or shipping.

1. If leakage is possible, the sharps container must be placed in a secondary container that is properly labeled, closable, leak-proof, and constructed to contain all content during handling, storage, transport, or shipping.

E. Reusable containers shall not be opened, emptied, or cleaned manually or in a way that exposes staff to percutaneous injury.

F. Retractable needles and other safety needles must be disposed of in a sharps container.

IV. **Other Regulated Waste**

A. Regulated waste shall be placed in closable containers designed to prevent fluid leakage during handling, storage, transport, or shipping.

B. Regulated waste shall be labeled with an international biological hazard symbol and/or the word "Biohazard".

1. The containers will be closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

C. If the outside of a regulated waste container is contaminated, it shall be placed in a second container which meets all the same design requirements as the first container. This second container shall be closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport or shipping.

V. **Laundry/Linens**

A. Standard Precautions shall always be used when handling soiled laundry/linens.

B. Contaminated laundry shall be handled minimally to avoid agitation. It shall be bagged or containerized at the point of use and never sorted or rinsed at the location of use.

C. Linen bags are to be constructed of a material that minimizes the likelihood of soak-through or leakage of fluids to the exterior.

D. Staff having direct contact with contaminated laundry shall wear protective gloves and any other appropriate PPE to prevent exposure to blood or OPIM.

E. The laundry/linen service department shall adhere to the Environmental Services: Linen Handling Procedures Policy to ensure the proper linen management and hygiene compliance.

Compliance

I. Staff compliance with this plan will be integrated into performance reviews and appraisals. Repeated or intentional failure to adhere to the plan may result in disciplinary action, up to and including termination.

II. Hepatitis B Vaccination and Post-Exposure Follow-Up

A. MHSC requires all staff to provide proof of Hepatitis B immunity, documented non-responder status, or an approved medical exemption. (See Employee Health Plan)

B. Post-exposure evaluation and follow-up shall be available to all employees who experience body substance exposure incidents. (See Bloodborne Exposure to Blood and Bodily Fluids)

III. Communication of Hazards to Employees

A. Standard Precautions shall always be followed.

B. Transmission-Based Precautions shall be used in addition to Standard Precautions when necessary to prevent the spread of known or suspected pathogens.

C. Warning labels must be affixed to containers storing:

- Regulated waste
- Refrigerators and freezers containing blood or OPIM
- Other containers used to store, transport, or ship blood or OPIM

IV. **Labels and Signs**

A. Labels shall display the universal biohazard symbol and the legend **"BIOHAZARD".**

1. Labels shall be fluorescent orange or orange-red, or predominantly so, with contrasting lettering or symbols.
2. Labels must be securely affixed with string, wire, adhesive, or another method to prevent accidental removal.

B. Biohazard bags may be substituted for labels.

C. Containers of blood or blood products released for transfusion or clinical use are exempt from labeling requirements.

D. Contaminated equipment must be labeled according to this standard, identifying portions that remain contaminated.

E. Decontaminated regulated waste does not require labeling or color-coding.

V. **Information and Training**

A. All staff with occupational exposure to blood or OPIM shall participate in a training program provided at no cost to the staff and during working hours.

1. Training shall be provided prior to the time of initial assignment to tasks where occupational exposure might occur and annually thereafter.
2. Additional training shall be provided when procedure modifications affect the exposure risks.
3. Training shall be appropriate to the staff's educational level, literacy, and language needs.
4. The trainer must be knowledgeable in the subject matter relevant to workplace hazards.

VI. **Training**

A. The training program shall include, but not limited to, the following elements:

1. Regulatory Standards:
    a. An accessible copy of the regulatory text of the standard and an explanation of its contents.
2. Epidemiology and Disease Awareness
    a. A general explanation of the epidemiology and symptoms of bloodborne diseases.
    b. An explanation of the modes of transmission of BBPs.
3. Exposure Recognition and Prevention:
    a. An explanation of the appropriate methods for recognizing tasks and other activities involving exposure to blood and OPIM.
    b. An explanation of the use and limitations of methods that will

prevent or reduce exposure, including appropriate engineering controls, work practices, and PPE.

4. PPE:
    a. Information on the types, proper use, location, removal, handling, decontamination, and disposal of PPE.
    b. For selecting PPE in different situations.
5. Hepatitis B Vaccine:
    a. Information on the Hepatitis B vaccine, including information on efficacy, safety, method of administration, and the benefits of being vaccinated and MHSC's requirements.
6. Emergency Response:
    a. Information about the appropriate actions to take and people to contact in an emergency involving blood or OPIM.
7. Exposure Incident Protocol:
    a. An explanation of the procedure to follow if an exposure incident occurs, including the reporting requirements and available medical follow-up.
    b. Information on the post-exposure evaluation and follow-up that MHSC is required to provide for the staff following an exposure.
8. Hazard Communications:
    a. An explanation of the signs and labels.
9. Interactive Learning:
    a. An opportunity for interactive questions and answers with the person conducting the training session.

VII. Record Keeping

A. Medical Records

1. MHSC shall maintain accurate medical records for all staff with occupational exposure in compliance with OSHA regulations.
2. This record will include:
    a. Name and Social Security number
    b. Hepatitis B vaccination status
    c. Medical examination results related to BBPs exposure
3. Medical records shall be confidential and only disclosed with the staff's written consent, unless legally required.
4. MHSC shall maintain the staff's medical records for at least the duration of employment plus 30 years.

B. Training Records

1. Training records shall include:

a. Dates and content of training sessions

b. Names and qualifications of trainers

c. Names and job titles of participants

Responsibilities

I. Value Analysis Committee - VAC

A. Oversee the selection and evaluation of safety devices.

II. Oversight Committee

A. MHSC's Infection Control Committee will serve as the Oversight Committee for reviewing the Exposure Control Plan

III. Infection Prevention

A. Review the Exposure Control Plan annually and ~~revise~~consult as needed.

B. Provide ongoing consultation regarding ~~implementation of~~implementing OSHA's Occupational Exposure to Bloodborne Pathogens standard.

C. Assist with the development of educational programs.

D. Consult as needed in situations of non-compliance.

E. Assist with the evaluation ~~when non-compliance is reported~~and selection of safety devices.

F. ~~Assist with the evaluation and selection of safety devices.~~

IV. Employee Health

A. Review and revise the Exposure Control Plan.

B. ~~Review and continue to implement hepatitis~~Oversee the Hepatitis B immunization program and maintain all related records.

C. ~~Review and continue~~Ensure post-exposure follow-up procedures continue and maintain all records.

D. Maintain a sharps injury log and track sharps injury trends, products, and procedures.

E. Evaluate cases of non-compliance and escalate concerns when needed.

V. Department ~~managers~~Managers

A. Ensure and document ~~employee~~staff orientation and annual training.

B. ~~Ensure~~Confirm that PPE and other necessary supplies are available and accessible.

C. Evaluate staff compliance.

D. ~~Ensure suitable training/educational programs are provided by knowledgeable trainers. Training will include the appropriate use of new devices on an ongoing basis, review where engineering controls are currently employed, where the can be updated, and participate in the selection and evaluation of safer medical devices.~~Ensure knowledgeable trainers provide suitable training and educational programs.

- The appropriate use of new devices.
- A review of existing engineering controls and potential updates.

- Participate in the VAC.
- Consultation with Employee Health and Infection Prevention as needed.

E. Ensure ~~that~~the availability of appropriate safety devices ~~are stocked,~~ and staff ~~have been trained to~~training on their use ~~them~~.

F. Evaluate ~~the circumstances surrounding~~ exposure incidents, including an ~~evaluation of '~~assessment of failure of control~~' at the time of the exposure~~ measures, and submit ~~this information~~findings to Employee Health.

VI. ~~Product Selection Committee~~

~~A. Oversee the selection and evaluation of safety devices.~~

VII. ~~Oversight Committee~~

~~A. Hospital Infection Control Committee will serve as the Oversight Committee for the review/revision of the Exposure Control Plan.~~

VIII. ~~Employees~~Staff with ~~occupational exposures~~Occupational Exposure

A. ~~Know what~~Understand which tasks ~~they perform that cause~~pose an occupational exposure risk.

B. Participate in the ~~BBP~~BBPs training ~~module~~modules annually.

C. ~~Conduct all activities in accordance with the~~Follow engineering controls, work practice controls, and ~~use of~~ PPE guidelines in all activities.

D. Report any exposure ~~incident~~incidents to their supervisor and follow up with ~~the appropriate~~an occupational health provider.

E. ~~Participate in the selection and evaluation of safer medical devices when applicable.~~Participate in VAC.

Reviewed and Approved:

Infection Control Committee ~~2/17/2022~~; 7/17/2025 MEC ~~2/22/2022~~; 7/22/2025 MHSC Board;

REFERENCES

OSHA. Federal Register. (~~2012~~2019). Bloodborne Pathogens Standard. 29 CFR 1910.1030. Retrieved from https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051

~~See attachment with information on food and drink in clinical stations from The Joint Commission, OSHA and Wyoming Department of Health, 2019.~~

OSHA Hierarchy of Controls - graphic (2025). Retrieved from https://makesafetools.com/osha-hierarchy-of-controls/

World Health Organization (WHO). (2021) Five Moments for Hand Hygiene. Retrieved from https://cdn.who.int/media/docs/default-source/integrated-health-services-(ihs)/infection-prevention-and-control/hand-hygiene/d_allmoments_a2_en.pdf?sfvrsn=dfebffbf_11&download=true

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(2025). Bloodborne Infectious Disease Risk Factors. Retrieved from Bloodborne Infectious Disease Risk Factors | Healthcare Workers | CDC

Attachments

- Five Moments for Hand Hygiene WHO.pdf
- Hierarchy_of_Controls_02.01.23_form_508_2.pdf

Approval Signatures

Step Description	Approver	Date
	Ann Marie Clevenger: CNO	06/2025
Medical Director	Cielette Karn: Laboratory & IP Medical Director, T&B Chair	06/2025
	Deseriee Stofferahn, MSN, NP-C	06/2025
	Patty O'Lexey: Education Director	05/2025
	Nicole Burke: Employee Health Supervisor	05/2025

Status **Active** PolicyStat ID **17956684**

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Document Area: Employee Health
Reg. Standards: OSHA 29 CFR 1910.1030, TJC EC.02.02.01, TJC IC 04.01.01:

CAH - Exposure Control Plan

STATEMENT OF PURPOSE

To prevent or minimize the occupational exposure of staff to bloodborne pathogens (BBP) and other potentially infectious material (OPIM).

Healthcare workers face significant health risks from occupational exposure to infectious diseases and bloodborne pathogens, including the Hepatitis B virus (HBV), Hepatitis C (HCV), Human Immunodeficiency Virus (HIV), and other bloodborne pathogens. A consistent approach to managing body fluids and substances from all individuals is essential to prevent the transmission of infectious agents, whether a causative agent has been identified.

Staff shall have access to a copy of the Memorial Hospital of Sweetwater County's (MHSC) Exposure Control Plan and related policies during the regular work shift. The plan shall be reviewed and updated annually, or as necessary, to reflect current literature, new or modified tasks, and procedures that affect occupational exposure.

All clinical staff shall receive initial and annual bloodborne pathogen (BBP) training in accordance with OSHA requirements. Nonclinical staff shall receive separate BBP education tailored to their specific roles, distinct from the more comprehensive BBP training provided to clinical staff.

DEFINITION

- **Bloodborne Pathogens (BBPs):** Pathogenic microorganisms in human blood that can cause disease. These pathogens include, but are not limited to, HBV, HIV, and HCV.
- **Contaminated Laundry/Linen:** Any linen or laundry used or soiled with blood or other potentially infectious materials or may contain sharps.
- **Hand Hygiene:** Handwashing that may include either plain or antiseptic-containing soap and water, or the use of alcohol-based sanitizers (gels, rinses, foams) that do not require water.
- **Occupational Exposure:** Actual or suspected exposure of skin, eye, mucous membrane, or

respiratory tract, or parenteral contact with blood or other potentially infectious materials that may result from performing staff's duties.

- **Occupational Safety and Health Administration (OSHA):** The Occupational Safety and Health Administration (OSHA) assures safe and healthful working conditions by setting and enforcing standards and providing training, outreach, education, and assistance.
- **Other Potentially Infectious Material (OPIM):** Includes, but is not limited to, blood, semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, mucous, saliva, pus, urine and stool.
- **Personal Protective Equipment (PPE):** Equipment worn to minimize exposure to infectious agents, including gowns, gloves, masks, face shields, and respirators.
- **Regulated Waste:** Liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and can release these materials during handling; contaminated sharps; and pathological wastes containing blood or other potentially infectious materials.
- **Sharps:** Any object that can penetrate the skin, including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.
- **Standard Precautions:** A set of infection control practices used to prevent the transmission of diseases that can be acquired by contact with blood, body fluids, non-intact skin, and mucous membranes. These measures are to be used when providing care to all individuals.
- **Transmission-Based Precautions:** Infection prevention and control measures to protect against exposure to a suspected or identified pathogen. These precautions are specific and based on the way the pathogen is transmitted. Categories include contact, droplet, airborne, and a combination of these.
- **Staff:** All people who provide care, treatment, or services in the organization, including licensed practitioners, permanent, temporary, and part-time personnel, contract employees, volunteers, and health profession students.The C*ontracted Staff are provided through a written agreement with another organization, agency, or person. The agreement specifies the services or personnel to be provided on behalf of the applicant organization and the fees to provide these services or personnel.* Staff at MHSC:
    - Employed Staff - Full-time, Part-time, PRN, and Temporary personnel
    - Volunteer Staff - An individual who performs service to MHSC without expectation of compensation
    - Permanent Contract Staff - Personnel contracted through organizations such as Cardinal and Unidine
    - Temporary Contract Staff - Personnel from staffing agencies such as Travelers and Elwood
    - Non-Employed Staff - Students, Shadowers

ADMINISTRATION AND MANAGEMENT OF THE PLAN

Methods of Compliance

I. **General**

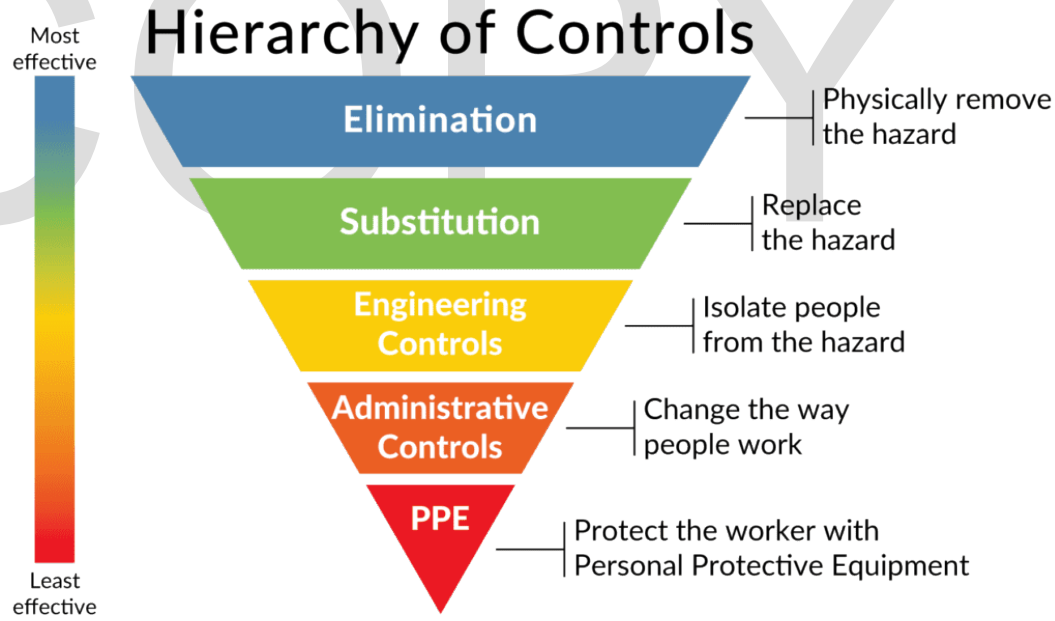
A. All staff shall follow Standard Precautions to prevent contact with blood or other potentially infectious materials (OPIM). Standard Precautions ensure that Personal Protective Equipment (PPE) acts as a barrier between potentially infectious body substances, non-intact skin, mucous membranes, and caregivers.

II. **Engineering and Work Practice Controls**

A. Engineering and work practice controls shall be implemented to eliminate or minimize employee exposure to blood or bloodborne pathogens (BBPs). When occupational exposure persists despite these measures, PPE shall be used as an additional safeguard.

B. Engineering controls shall be examined, maintained, or replaced regularly to ensure their effectiveness. CDC Hierarchy of Controls

C.



III. **Hand Hygiene**

A. The World Health Organization (WHO) recommends the "Five Moments of Hand Hygiene" to prevent the spread of infection in healthcare settings. (See attachment) These moments are:

1. **Before touching a patient:** To remove any microorganisms that may be on the healthcare worker's hands.

2. **Before a clean/aseptic procedure:** To ensure the procedure is performed in a sterile environment.
3. **After body fluid exposure:** To remove microorganisms that may have been exposed to body fluids, such as blood, mucus, or vomit.
4. **After touching a patient:** To prevent the transmission of microorganisms from the patient to the healthcare worker.
5. **After touching the patient's surroundings:** To remove microorganisms that may be on objects in the patient's environment, such as bed rails, chairs, or medical equipment.

B. Hand hygiene facilities are available in all patient care areas, treatment rooms, utility rooms, and restrooms to support infection prevention and control.

C. Staff must perform hand hygiene immediately or as soon as possible after removing gloves or other PPE to maintain infection control and prevent cross-contamination.

D. Staff must wash their hands and any other exposed skin with soap and water, or flush mucous membranes with water, immediately or as soon as possible after contact with body areas contaminated with blood or OPIM.

E. Alcohol-based hand sanitizers may be used for hand hygiene if hands are not visibly soiled.

IV. **Sharps**

A. Contaminated needles and other sharps shall not be sheared, clipped, or broken. They shall be dropped into a sharps container without any manipulation.

B. MHSC has a no-recapping policy. If recapping is necessary, a one-handed technique (scoop method) may be utilized. Needles shall not be recapped, bent, or altered unless medically necessary.

C. Disposable sharps shall be discarded in the appropriate sharps container immediately after use.

D. Contaminated, reusable sharps shall be placed in appropriate containers immediately after use. These containers shall be puncture-resistant, labeled with a biohazard label, and leak-proof on the sides and bottom.

E. Staff shall not handle contaminated sharps directly. Perforated trays, hemostats, forceps, dustpans, and brooms shall be used to prevent direct contact with contaminated sharp.

V. **Environmental Surfaces**

A. Food, Cosmetics

1. Eating, drinking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where occupational exposure to blood or OPIM is

likely.

2. Each unit shall determine designated areas for food and drinks.
    a. Food and covered drinks shall be allowed in areas where blood or OPIM will not be collected, stored, processed, or transmitted.
    b. Staff may face corrective action if food and drinks are found in prohibited areas.
3. Food and drink shall not be stored in refrigerators, freezers, shelves, cabinets, or counter tops where blood or OPIM is present or transported.
4. Only hospital-approved hand lotion may be applied after performing hand hygiene.

B. Body Fluid Contamination

1. Procedures involving blood or OPIM must minimize splashing, spraying, splattering, and aerosol generation.
2. Eye protection and masks/face shields must be used when exposure to splattering blood or body fluids is anticipated.
3. Environmental cleaning protocols must be followed to prevent splashing, spraying, or aerosol generation.
4. Mouth pipetting of blood and OPIM is strictly prohibited.

VI. Laboratory Specimens

A. Specimens of tissue, blood, or OPIM shall be placed in a leak-proof container during collection, handling, processing, storage, transport, and shipping.

B. All specimens shall be transported in a secondary container such as a biohazard bag.

C. All staff handling specimens must be trained to treat all specimens as potentially infected with BBPs.

D. Standard Precautions shall always be followed.

E. A biohazard label is required when specimens are transported outside the facility (e.g., shipment, or disposal).

F. If a specimen has the potential to puncture its container, it must be placed within a puncture-resistant secondary container.

VII. Equipment Servicing

A. Equipment that may become contaminated with blood or OPIM shall be examined prior to servicing or shipping and shall be decontaminated as needed.

B. Decontamination shall be done to minimize splashing, spraying, or generation of droplets of blood and/or OPIM. Decontamination procedures shall minimize splashing, spraying,

and aerosol generation.

C. When it is not possible to decontaminate equipment prior to servicing or shipping (e.g., highly technical or sensitive equipment and/or limited access to contaminated parts), at least partial decontamination, such as flushing lines and wiping the exterior with an approved disinfectant, shall be accomplished.

D. A highly visible biohazard label must be attached to contaminated equipment, indicating which portions remain contaminated.

E. This information shall be communicated to all affected staff, the servicing representative, and/or manufacturer as appropriate, prior to handling, servicing, or shipping to ensure proper precautions.

Personal Protective Equipment (PPE)

I. PPE includes but is not limited to gloves, gowns, laboratory coats, eye protection, masks, respirators, mouthpieces, resuscitation bags, pocket masks, and other ventilation devices.

A. PPE must effectively block blood or OPIM from reaching the staff's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the intended duration.

B. Appropriate PPE in appropriate sizes shall be readily accessible at the work site or is issued to staff.

1. Hypoallergenic gloves, glove liners, powder-free gloves, or other alternatives shall be provided at no cost to the staff if needed.

C. PPE cleaning or reprocessing, laundering, and disposal will be done at no cost to staff.

D. Use of PPE

1. The type and amount of PPE shall be chosen to protect against contact with blood or OPIM based upon Transmission-Based Precautions, the type of exposure, and the quantity of these substances that can be reasonably anticipated to be encountered during a task or procedure.

a. Transmission-Based Precautions supplement Standard Precautions for patients known or suspected to be infected with specific infectious agents requiring additional protective measures.

b. Staff shall wear appropriate PPE as required unless, in their professional judgment, doing so would interfere with patient care or pose an increased hazard.

c. When this occurs, the circumstances shall be investigated and documented to determine potential policy modifications.

2. All PPE shall be removed prior to leaving the work area, and hand hygiene shall be performed.

E. Used PPE shall be placed in designated containers for storage, washing, decontamination, or disposal.

F. If a garment is penetrated by blood or OPIM, it shall be removed immediately, and the affected body area shall be cleaned.

G. PPE and contaminated clothing shall be removed in a manner to minimize contamination of personnel or the environment.

1. If a pull-over scrub (as opposed to scrubs with snap closures) becomes minimally contaminated, the staff shall remove it in such a way as to avoid contact with the outer surface, such as rolling up the garment as it is pulled toward the head for removal.

2. If blood penetrates the inner surface, removal without exposure is impossible. Such garments should be cut to aid removal and prevent facial exposure.

II. **Gloves**

A. Gloves shall be worn when it can be reasonably anticipated that the staff may have hand contact with blood, OPIM, mucous membranes, or non-intact skin.

B. Gloves shall be worn during vascular access procedures, including phlebotomy and intravenous line starts.

C. Gloves shall be worn when touching contaminated items or surfaces.

D. Disposable (single-use) gloves must be replaced when contaminated, torn, punctured, or compromised.

E. Disposable gloves shall not be washed or decontaminated for reuse unless an official shortage mandates.

F. Utility gloves may be decontaminated if their integrity is intact but must be discarded if cracked, peeling, torn, punctured or compromised.

G. Gloves are not required for routine injections unless the staff member has open lesions on their hands or risks contact with the patient's body fluids.

III. **Masks, Eye Protection, and Face Shields**

A. Masks along with eye protection devices such as goggles, glasses with solid side shields, or chin-length face shields, shall be worn whenever splashes, spray, spatter, or droplets of blood or OPIM may be generated and eye, nose, or mouth contamination is reasonably anticipated.

B. Minimum protection consists of a mask combined with either safety glasses (with solid side shields), goggles, or a chin length face shield.

C. Prescription glasses alone do not meet protective standards. Disposable eye shields must be worn over glasses for adequate splash protection.

IV. **Gowns, Aprons, and Other Protective Clothing**

A. Staff shall wear appropriate protective clothing such as gowns, aprons, lab coats, or clinic jackets in situations involving occupational exposure.

1. The level of protection shall match the anticipated degree of exposure throughout the task duration.
2. Protective clothing must prevent blood or OPIM from passing through to skin or clothing.

B. Surgical caps and/or shoe or boot covers shall be worn when gross contamination is reasonably anticipated (autopsies, orthopedic surgery).

C. Home laundering of protective clothing is prohibited to prevent microbial contamination or disease transmission.

D. If a staff member's personal clothing or uniform becomes contaminated, it must be removed immediately, replaced with clean scrubs, and laundered by MHSC. An event report shall be completed for each blood exposure or clothing change.

E. Protective clothing shall be removed prior to leaving the work area.

Processes

I. **Environmental Services**

A. The work site will be maintained clean and sanitary condition.

B. All equipment, environmental surfaces, and working surfaces shall be cleaned and decontaminated after contact with blood or OPIM.

C. Contaminated work surfaces shall be decontaminated with an appropriate disinfectant.

D. Broken glassware that may be contaminated shall not be handled directly with the hands. Instead, it shall be cleaned using mechanical means, such as a brush and dustpan, tongs, or forceps. Tools used in cleanup must be properly decontaminated or discarded after use, and the broken glass shall be disposed of in a designated sharps container.

E. Reusable sharps contaminated with blood or OPIM shall not be stored or processed in a manner that requires staff to reach into the container by hand.

F. For further guidance, please refer to PolicyStat's Environmental Services: Housekeeping Care and Cleaning Guidelines and Environmental Services: Contaminated and/or Infectious Trash/Waste Handling and Disposal Procedures.

II. **Regulated Waste**

A. Regulated waste shall be properly contained and disposed of in a manner that prevents disease transmission. Disposal shall comply with all applicable national, state, and local regulations.

III. **Disposal of Contaminated Sharps**

A. Sharps shall be discarded immediately or as soon as possible in closable, puncture-resistant, leak-proof containers labeled with the words “Biohazardous Waste” or with the international biohazard symbol and the word “Biohazard”.

B. Sharps containers shall be easily accessible to staff and located near areas where sharps are frequently used.

C. The sharps container shall be stable, secure, upright throughout use, routinely replaced when 3/4 full and not allowed to overfill.

D. When containers of contaminated sharps are removed, they must be closed securely to prevent spills or protrusion of content during handling, storage, transport, or shipping.

    1. If leakage is possible, the sharps container must be placed in a secondary container that is properly labeled, closable, leak-proof, and constructed to contain all content during handling, storage, transport, or shipping.

E. Reusable containers shall not be opened, emptied, or cleaned manually or in a way that exposes staff to percutaneous injury.

F. Retractable needles and other safety needles must be disposed of in a sharps container.

IV. **Other Regulated Waste**

A. Regulated waste shall be placed in closable containers designed to prevent fluid leakage during handling, storage, transport, or shipping.

B. Regulated waste shall be labeled with an international biological hazard symbol and/or the word "Biohazard".

    1. The containers will be closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

C. If the outside of a regulated waste container is contaminated, it shall be placed in a second container which meets all the same design requirements as the first container. This second container shall be closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport or shipping.

V. **Laundry/Linens**

A. Standard Precautions shall always be used when handling soiled laundry/linens.

B. Contaminated laundry shall be handled minimally to avoid agitation. It shall be bagged or containerized at the point of use and never sorted or rinsed at the location of use.

C. Linen bags are to be constructed of a material that minimizes the likelihood of soak-through or leakage of fluids to the exterior.

D. Staff having direct contact with contaminated laundry shall wear protective gloves and any other appropriate PPE to prevent exposure to blood or OPIM.

E. The laundry/linen service department shall adhere to the Environmental Services: Linen Handling Procedures Policy to ensure the proper linen management and hygiene compliance.

Compliance

I. Staff compliance with this plan will be integrated into performance reviews and appraisals. Repeated or intentional failure to adhere to the plan may result in disciplinary action, up to and including termination.

II. Hepatitis B Vaccination and Post-Exposure Follow-Up

A. MHSC requires all staff to provide proof of Hepatitis B immunity, documented non-responder status, or an approved medical exemption. (See Employee Health Plan)

B. Post-exposure evaluation and follow-up shall be available to all employees who experience body substance exposure incidents. (See Bloodborne Exposure to Blood and Bodily Fluids)

III. Communication of Hazards to Employees

A. Standard Precautions shall always be followed.

B. Transmission-Based Precautions shall be used in addition to Standard Precautions when necessary to prevent the spread of known or suspected pathogens.

C. Warning labels must be affixed to containers storing:

- Regulated waste
- Refrigerators and freezers containing blood or OPIM
- Other containers used to store, transport, or ship blood or OPIM

IV. **Labels and Signs**

A. Labels shall display the universal biohazard symbol and the legend **"BIOHAZARD".**

1. Labels shall be fluorescent orange or orange-red, or predominantly so, with contrasting lettering or symbols.
2. Labels must be securely affixed with string, wire, adhesive, or another method to prevent accidental removal.

B. Biohazard bags may be substituted for labels.

C. Containers of blood or blood products released for transfusion or clinical use are exempt from labeling requirements.

D. Contaminated equipment must be labeled according to this standard, identifying portions that remain contaminated.

E. Decontaminated regulated waste does not require labeling or color-coding.

V. **Information and Training**

A. All staff with occupational exposure to blood or OPIM shall participate in a training program provided at no cost to the staff and during working hours.

1. Training shall be provided prior to the time of initial assignment to tasks where occupational exposure might occur and annually thereafter.

2. Additional training shall be provided when procedure modifications affect the exposure risks.
3. Training shall be appropriate to the staff's educational level, literacy, and language needs.
4. The trainer must be knowledgeable in the subject matter relevant to workplace hazards.

VI. **Training**

A. The training program shall include, but not limited to, the following elements:

1. Regulatory Standards:
    a. An accessible copy of the regulatory text of the standard and an explanation of its contents.
2. Epidemiology and Disease Awareness
    a. A general explanation of the epidemiology and symptoms of bloodborne diseases.
    b. An explanation of the modes of transmission of BBPs.
3. Exposure Recognition and Prevention:
    a. An explanation of the appropriate methods for recognizing tasks and other activities involving exposure to blood and OPIM.
    b. An explanation of the use and limitations of methods that will prevent or reduce exposure, including appropriate engineering controls, work practices, and PPE.
4. PPE:
    a. Information on the types, proper use, location, removal, handling, decontamination, and disposal of PPE.
    b. For selecting PPE in different situations.
5. Hepatitis B Vaccine:
    a. Information on the Hepatitis B vaccine, including information on efficacy, safety, method of administration, and the benefits of being vaccinated and MHSC's requirements.
6. Emergency Response:
    a. Information about the appropriate actions to take and people to contact in an emergency involving blood or OPIM.
7. Exposure Incident Protocol:
    a. An explanation of the procedure to follow if an exposure incident occurs, including the reporting requirements and available medical follow-up.
    b. Information on the post-exposure evaluation and follow-up that MHSC is required to provide for the staff following an exposure.
8. Hazard Communications:

a. An explanation of the signs and labels.

9. Interactive Learning:
    a. An opportunity for interactive questions and answers with the person conducting the training session.

VII. **Record Keeping**

A. **Medical Records**

1. MHSC shall maintain accurate medical records for all staff with occupational exposure in compliance with OSHA regulations.
2. This record will include:
    a. Name and Social Security number
    b. Hepatitis B vaccination status
    c. Medical examination results related to BBPs exposure
3. Medical records shall be confidential and only disclosed with the staff's written consent, unless legally required.
4. MHSC shall maintain the staff's medical records for at least the duration of employment plus 30 years.

B. **Training Records**

1. Training records shall include:
    a. Dates and content of training sessions
    b. Names and qualifications of trainers
    c. Names and job titles of participants

Responsibilities

I. Value Analysis Committee - VAC

A. Oversee the selection and evaluation of safety devices.

II. Oversight Committee

A. MHSC's Infection Control Committee will serve as the Oversight Committee for reviewing the Exposure Control Plan

III. Infection Prevention

A. Review the Exposure Control Plan annually and consult as needed.

B. Provide ongoing consultation regarding implementing OSHA's Occupational Exposure to Bloodborne Pathogens standard.

C. Assist with the development of educational programs.

D. Consult as needed in situations of non-compliance.

E. Assist with the evaluation and selection of safety devices.

IV. Employee Health

A. Review and revise the Exposure Control Plan.

B. Oversee the Hepatitis B immunization program and maintain all related records.
C. Ensure post-exposure follow-up procedures continue and maintain all records.
D. Maintain a sharps injury log and track sharps injury trends, products, and procedures.
E. Evaluate cases of non-compliance and escalate concerns when needed.

V. Department Managers
A. Ensure and document staff orientation and annual training.
B. Confirm that PPE and other necessary supplies are available and accessible.
C. Evaluate staff compliance.
D. Ensure knowledgeable trainers provide suitable training and educational programs.
- The appropriate use of new devices.
- A review of existing engineering controls and potential updates.
- Participate in the VAC.
- Consultation with Employee Health and Infection Prevention as needed.

E. Ensure the availability of appropriate safety devices and staff training on their use.
F. Evaluate exposure incidents, including an assessment of failure of control measures, and submit findings to Employee Health.

VI. Staff with Occupational Exposure
A. Understand which tasks pose an occupational exposure risk.
B. Participate in the BBPs training modules annually.
C. Follow engineering controls, work practice controls, and PPE guidelines in all activities.
D. Report any exposure incidents to their supervisor and follow up with an occupational health provider.
E. Participate in VAC.

Reviewed and Approved:

Infection Control Committee; 7/17/2025 **MEC; 7/22/2025**
MHSC Board;

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(2025). Bloodborne Infectious Disease Risk Factors. Retrieved from Bloodborne Infectious Disease Risk Factors | Healthcare Workers | CDC

Attachments

- Five Moments for Hand Hygiene WHO.pdf
- Hierarchy_of_Controls_02.01.23_form_508_2.pdf

Approval Signatures

Step Description	Approver	Date
	Ann Marie Clevenger: CNO	06/2025
Medical Director	Cielette Karn: Laboratory & IP Medical Director, T&B Chair	06/2025
	Deseriee Stofferahn, MSN, NP-C	06/2025
	Patty O'Lexey: Education Director	05/2025
	Nicole Burke: Employee Health Supervisor	05/2025

MHSC Board of Trustees: August 2025

Chief Clinical Officer (CCO) Report

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

1. The Quality Department has completed the FY25 Memorial Hospital of Sweetwater County Annual Performance Improvement and Patient Safety Evaluation.
2. The Quality Department received official notification from QNet, the CMS platform for submission of our quality measures, that our acute care hospital CCN (CMS certification number) was inactivated as of 07/25/2025.
3. The Sweetwater Regional Cancer Center is mapping out a schedule of classes and opportunities for our cancer patients as part of their grant-funded Thrive Well Survivorship program. The first class will be 08/13/205. The class will cover healthy cooking and eating with our clinical dietitian, Josie Ibarra RDN/LDN.
4. The Sweetwater Regional Cancer Center is collaborating with the American Cancer Society to participate in an upcoming initiative focused on developing additional resources to address food insecurity among patients.
5. Dr. Symington has been named a Fellow of the American Society of Clinical Oncology. The title of FASCO is a recognition bestowed upon ASCO members who have shown extraordinary dedication to their voluntary efforts that benefit the Society, the specialty of oncology, and the patients whom ASCO and its members serve.
6. A team in Medical Imaging is working to improve the time to the third next available appointment in MRI and breast care, specifically diagnostic mammography, breast ultrasound, and breast biopsies. We have observed an increase in the time to the third next available appointment in these modalities, attributed to various factors. The MRI technologists and radiologists are collaborating to offer additional evening appointment times and limited Saturday appointments, aiming to improve access and reduce the wait time to the third next available appointment.
7. The NRC (Nuclear Regulatory Commission) was on-site 07/29/2025 for an unannounced survey. We are surveyed by the NRC every three years. The survey resulted in zero findings or citations. The surveyor was highly complimentary of Shelyn Edwards, our nuclear medicine technologist. The surveyor was also complimentary of our contracted medical physicist, who also serves as our radiation safety officer (RSO). As part of the survey process, the surveyor examines equipment for calculating and measuring nuclear medicine doses, assesses radiation safety, observes the technologist practicing radiation safety with patients, and reviews documentation, including the RSO's quarterly documentation. The surveyor commented that "it is obvious that radiation safety is ingrained in your organization".
8. As part of our occupational medicine service, we are working to expand our service to help mine operators meet new medical surveillance requirements under Mine Safety and Health Administration regulations. Under the regulations, which become effective on April 8, 2026, mine operators are required to provide each miner with periodic medical examinations by a healthcare professional. Part of this medical surveillance includes a chest x-ray classified by a B reader certified by the National Institute of Occupational Safety and Health (NIOSH) using the International Labour Office (ILO) classification system. Dr. Matti, Medical Director of Medical Imaging, recently received his NIOSH (National Institute for Occupational Safety and Health) B Reader certification from the U.S. Department of Health and Human Services. At the time of preparing this report, 08/01/2025, there are only 175 certified B-readers in the United States. I want to extend a thank you to Dr. Matti for pursuing this certification.
9. Ortho, the manufacturer of the chemistry analyzers, was on site the week of 07/17/2025 to perform a system optimization. Ortho suggested forming a small lab team to perform weekly and monthly maintenance. They recommended designating a "team" of three to four staff members. They suggested a similar approach for performing calibrations. Aimee, the leads, and Dr. Karn, Medical Director of the Clinical Laboratory, met on 07/28/2025 to discuss logistics so that we can try this approach and see if it reduces the downtime and service issues on the chemistry analyzers. Once the "teams" are designated, Ortho will return to provide additional training.

Respectfully submitted,
Kari Quickenden

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

Patient Experience

We continue working on a compassionate care hospital-wide initiative. Following is MHSC's compassion data shared with staff July 18. We have seen a 4.87% increase for the MHSC average. We are focusing on Personalized Care this quarter. Personalized care means finding out what matters to our patients and getting to know them. We want to have a personalized approach that tailors medical treatment, care plans, and more to the individual characteristics, needs, preferences, and values of each of our patients.

"Degree to which all staff showed compassion"					
Department	**Baseline % 2024**	**AIM % (+2%)**	**Stretch % (+3%)**	**Year to Date 2025 %**	**% Change from baseline**
OB	74.07	76.07	77.07	**91.67**	+17.6
M/S	64.9	66.9	67.9	**81.25**	+16.35
ICU	71.43	73.43	74.43	**65.00**	-6.43
Inpatient	64.9	66.9	67.9	**79.46**	+14.56
Surgery	90.48	92.48	93.48	**90.65**	+.17
ED	65.71	67.71	68.71	**68.00**	+2.29
MOB	88.01	90.01	91.01	**89.93**	+1.92
3000	87.77	89.77	90.77	**89.84**	+2.07
MHSC Average	77.48	79.48	80.48	**82.35**	+4.87

Last Updated: 7/15/25

MHSC Patient & Family Advisory Council (PFAC) highlights from the year include:
- Tour through the Medical Office Building to provide insights to help us improve on wayfinding, signage, and visitor spaces
- Rounding through vacant patient rooms with Environmental Services to provide feedback and suggestions for improving cleanliness and quietness measures
- Identifying a department they feel passionate about to help create partnerships for co-design
- Lab expansion project update to see how their input in the planning stages has been implemented
- Reviewed top patient safety concerns and CMS patient safety structural measures. A PFAC member has volunteered to assist by serving on one of the domain workgroups
- Participated in a process mapping exercise to assist with a central scheduling improvement project
- Tours of the power house area, labor & delivery, nutrition services, and the education department
- PFAC participation in the Person-Centered Care Committee
- PFAC presentation at Young At Heart and on a local radio program

- Review of CEO Annual Report to the Commissioners where they could see the important role they fulfill and how much we value the partnership
- Celebration of 6 years together providing a voice of patients and family members to staff

Future work for the group of 20 includes designing a charter, finding ways to add membership that reflects the demographic of our patient population, and continuing to find ways to partner in co-design opportunities. The next meeting is August 25.

The Patient Experience Director created a new program to provide to new nurses in the N.E.M.O. Program to help connect patient experience in the Strategic Plan and FY26 PIPS Plan. It was well-received and will be incorporated in new employee orientation moving forward. A copy has been loaded in the portal in the Education Workroom for Trustee review.

Human Resources and Employee Experience

The Human Resources Department is developing a Symplr Performance Manager Overview to review with the Human Resources Committee and utilize with the Leadership Team. The Department is working in conjunction with Compliance to develop a HIPAA training refresher. The Department is coordinating the Crisis Prevention Institute (CPI) training kick-off in October. Working with PEAK Consulting for the job description review and performance review update project kick-off in mid-September. We are continuing to gather information on mentoring programs to develop for our staff. The Person-Centered Care Committee is rounding on employees to express appreciation to staff as well as ask questions each month related to engagement and satisfaction. Compiling and reviewing the CEO Town Hall meeting employee feedback to get a "pulse" of engagement in the FY26 PIPS Plan and overall engagement. Wellness Wednesdays for staff and visitors have returned to weekly in the front lobby during the summer.

Nutrition Services

The Nutrition Services Department is preparing to roll out an updated patient menu. New nurse graduates shadowed in the department in July. Patient rounding continues with comments received including, "I can't believe this is hospital food!" Room service "get to know us" delivery cards are being developed to help staff connect with patients as they take orders and deliver meals. The staff are focusing on offering additional information on food line ingredients and have created new offerings like a waffle bar and bagel bar to provide customer satisfaction. The Director has been working on delivery cart improvements to minimize noise in the food delivery process to help improve quiet and restfulness survey results. The staff are focusing on a hand hygiene campaign in July and August.

MHSC Board of Trustees: August 2025

Chief Financial Officer (CFO) Report

Report prepared and submitted by: Tami Love

FINANCIAL SUMMARY. With June being the last month of the fiscal year, there is a delay in financial reports. We will complete June financials once the annual audit has been completed. The auditors from Clifton Larson Allen will be onsite for the week of August 11. They are scheduled to meet with the Finance & Audit Committee Board members as well as the CEO and myself. June projections show revenue down in June, coming in at $23.7 million, under budget by $211,000. Net revenue will be over budget again this month from the decrease in reductions due to Medicare claims being paid at the new CAH rates. Expenses are expected to come in close to the budget of $11.7 million. We will have another positive bottom line for the month and will end the year with a significant gain, around $8.5 million, compared to a gain of $2 million in the budget. We expect to meet most of our year end strategic plan goals.

For July, revenue is projected to $26 million for the month, which will be under budget by $1 million. We have seen lower volumes in both inpatient and outpatient services. Reductions of revenue will include the lower CAH rates and expenses should be close to budget. We should have a break even or slight gain for July. Collections are projecting to $13 million.

CRITICAL ACCESS. We saw the positive impact on both Days in AR and Days Cash on Hand in June and will be close to meeting our year-end goals. We are still waiting for the State survey and continue to operate under a provisional license.

INDUSTRIAL SITE IMPACT FEES. We were notified by the County that Pacific Soda will be fling an amendment to their Industrial Siting Permit in the upcoming months. Due to management changes and the high inflation in Turkey along with the tariffs, Pacific Soda is anticipating construction commencement at the end of 2026. We will not see industrial siting impact fees until the commencement of construction. This change in schedule will impact our FY2026 budget by about $125,000 in impact revenue.

SUPPLY CHAIN. Vizient, our group purchasing organization (GPO), provides access to industry-leading contract portfolios across medical/surgical supplies, pharmacy, capital equipment, and purchased services. This partnership helps drive significant cost savings, improve contract compliance, and streamline our procurement processes. Their stance is to uphold contracts and not increase prices just because of tariffs. We will only see price increases if the items become unavailable and we must find different vendors.

We meet monthly to share insight and make recommendations. Last month we discussed two different agreements that will enhance our savings opportunities by about $30K by requesting a higher tier rate and buying directly from the manufacturer. Vizient monitors our data which gives them insight into our current spending to help us streamline our purchases more efficiently.

MHSC Board of Trustees: 8/6/2025

Chief Nursing Officer (CNO) Report

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

1. Nursing and Cardiopulmonary Annual Report
    a. Please see the provided Nursing and Cardiopulmonary Annual Report. This report was first offered last year. The leaders and teams are proud to share their highlights for the previous year.
2. College Drive:
    a. Misty Cozad, Practice Manager, has collaborated successfully with Tata Chemical to provide an occupational health nurse at their facility. Please welcome Lori Koritnik, RN, who will transition from a PT Nurse on MedSurg to an FT occupational health nurse. (MHSC does provide Occupational Medicine Services to many companies in our region, as well as onsite services with a provider and nurse/medical assistant two days a week at Jim Bridger Power Plant and Wamsutter Clinic)
3. Education/Employee Health:
    a. Community Services and Growth
        i. Community Education
            1. Patty O'Lexey, the Director of Education, has shared the following educational opportunities for July and August.
                a. Second Tuesday of every month- "Stop the Bleed"
                b. Last Tuesday of the month- CPR for the Community
                c. August 21st- ACLS
                d. August 28th- PALS
    a. Drills- The team works with unit leaders to have drills for Rapid Responses/Codes to provide the opportunity to enhance response and skills.
    b. Employee new hires for nursing are participating in weekly check-ins with their leaders, but also at six weeks with the Director of Education, Unit leaders, preceptors, and me to identify areas of concern to impact the orientation process positively. It has been effective in identifying areas where additional education or experience was needed before completing orientation.
4. Emergency Services/Behavioral Health
    a. Process map action items are currently under review. An MOU is drafted for review before sending it to Southwest Counseling Services.
    b. Nursing Informatics created a report in the EMR to pull data to assess the number of patients seen in our clinics who have a mental health diagnosis included in the patient history or current problem list. The data is being evaluated for presentation to the subgroup reviewing the process map action items.
5. Nurse Practice Review Committee (NPRC)
    a. The committee will have its first meeting in August. The committee will be assigned education through our online education program, Symplr, and review the processes and policies created by the subgroup for approval.
6. Rocky Mountain Infectious Disease
    a. Rocky Mountain Infectious Disease (RMID) consult service was discussed at the Medical Executive Committee. Some concerns with the process were identified and

resolved after collaborating with the nurses at RMID. The update was shared with the medical staff via email.

7. Surgical Services/Infection Prevention:
    a. The Surgical Services Team, with guidance from the Director of Surgical Services, Noreen Hove, has an initiative to perform a "pilot" day for Dr. Hoffman to increase the number of cases (scopes) we can perform in a particular block. The scheduled day for the pilot is August 11th.
8. Sustainability Planning
    a. For several years, I have worked with my leaders to identify daily, weekly, and monthly job duties/tasks that are required within their positions. These lists are maintained on an Excel Spreadsheet that includes both direct reports and Clinical Coordinators/Leads for the respective departments. This has helped identify any duplicate data collection and ensure that appropriate work is assigned, as well as items that can/should be delegated. This helped in the past when a leadership position was open and the unit/department was able to function effectively until a new leader could be secured.
9. Transfers
    a. Data has been collected for transfers from the Emergency Department and inpatient services. The data is being assessed for any opportunities for improvement.
10. Women's Services/OB
    a. Megan Guess, Director of Women's Services, along with physician involvement, has met with the Tele-NICU (Neonatal Intensive Care Unit) Team to discuss options for newborn services. We are currently awaiting the draft contract for review.
11. Tele Services
    a. Collaborating with the University of Utah for Tele Services, we are participating in a pilot program to ease access to tele services and expand service availability. This pilot program began on July 29th and includes services in the "Acute Care Line" (ACL), such as endocrinology, infectious disease, nephrology, oncology, pulmonary medicine, urology, and vascular surgery. The Tele Services also include a "MedPic" Service for Ortho and Spine. These services are adjunct to the existing services, including Tele-ICU, Tele-Stroke, Tele-Burn, and Tele-Neurology.
        i. Mental Health Services

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

Memorial Hospital

OF SWEETWATER COUNTY

FY 2025 Annual Report

Nursing & Cardiopulmonary


Courage to Soar

Contents Page

AACN's 2025 Theme


Courage to Soar

Message from Our Chief Nursing Officer

As a professional nurse, it is my honor to be the Chief Nursing Officer at Memorial Hospital of Sweetwater County (MSHC). To see the progress in almost five years while in this role toward meeting our mission for "compassionate care for every life we touch" has been amazing. The passion and desire to provide for each other and our community are unparalleled. As in work and life, time can pass so quickly when we are enjoying what we do and who we do it with. This is evident at MHSC, as demonstrated by the growth, achievements, and successes that align with MHSC's Strategic Pillars and Performance Improvement Process (PIP) Annual Plan, year to year.

According to the American Nurses Association (2024), "The Chief Nursing Officer oversees the system's nursing professional practice and leadership, serving as part of the senior executive leadership team. The CNO is also accountable for overall professional nursing practice across a healthcare organization."

The success in my role as CNO is a result of the knowledgeable and professional leaders and teams that are a part of the MHSC Family. It is with the combined efforts of every individual that we are meeting the goals set within the Patient Experience, Quality and Safety, Community, Services and Growth, Employee Experience, and Financial Stewardship Pillars. To quote Gordon and Fleck (2021, p. 88), "One of the key elements of your journey is surrounding yourself with people who want to go to the same destination. Only by rowing together can we achieve our goals." The steps in meeting our goals are supported through MHSC's vision "to be our community's trusted healthcare leader." I want to thank the leadership and teams throughout the organization for their support.

The Nursing Leadership Team was fortunate to participate in leadership training through Peak Consulting and TeamSTEPPS training by the Quality Department. During a monthly meeting, the team enjoyed reviewing the lessons learned by Gordon and Fleck (2021), as outlined in "Row the Boat." The growth and team building during these activities have been exponential. As evidenced in the subsequent pages of this report, the leadership team has brought this model of lifelong learning to their teams.

Among the many new initiatives that include but are not limited to the Nurse Peer Review Committee, Title 25 Process Mapping, Cross Training Program, Preceptor Program, nationally recognized certifications by specialty, and the development of several unit-based committees, we are making progress in aligning with best practices as identified in the American Nurses Credentialing Center (ANCC) Magnet Program.

Nursing professionals exemplify unwavering commitment and leadership on behalf of the patients they serve (AONL, 2025), which is reflective of this year's theme for Nurses Week, "The Power of Nurses." As we step forward into the year ahead, we look forward to growth and new initiatives that will continue to build on team cohesiveness, expertise, and quality and safety outcomes. Keep dreaming and let's work together to make them a reality, as anything is possible.

AnnMarie Clevenger DNP, RN, NEA-BC

Ann Marie Clevenger, DNP, RN, NEA-BC
Chief Nursing Officer

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- American Nurses Association. (2024, February 13). What is a Chief Nursing Officer/Chief Nurse Executive, American Nurses Association. https://www.nursingworld.org/content-hub/resources/nursing-leadership/chief-nursing-officer/
- American Organization for Nursing Leadership. (2025, May 5). Celebrate the Power of Nurses during National Nurses Week 2025, American Organization for Nursing Leadership. https://www.aonl.org/press-release/Celebrate-the-Power-of-Nurses-during-National-Nurses-Week-2025
- Gordon, J., & Fleck, P.J. (2021). *Row the Boat*. John Wiley & Sons.

Nursing Team (7/9/2025)

- 188 Nurses
- 25 CNAs & Techs
- 20 MAs
- 7 Care Management
- 13 Respiratory Therapists
- 17 Supporting Staff
- 4 House Supervisors
- 12 Administrative Staff

281 = 46% of Hospital Staff

> Just wanted to thank the nurses, doctors and everyone last night (July 12). I have lived here most of my life and our hospital just keeps getting better.
> **–Kelly Souther**

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

Care Delivery

1436
Admissions (excluding Births)

408
Births

14.00
Average Daily Inpatient Census

16,816
ED Visits

1,602
ED Visits Admitted

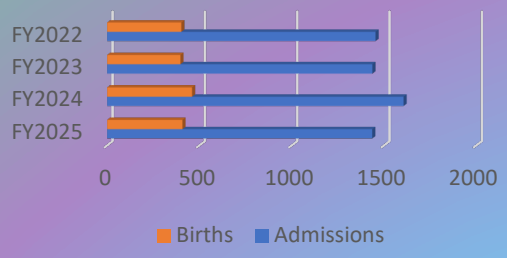
101,584
Outpatient Visits (Non-ED)

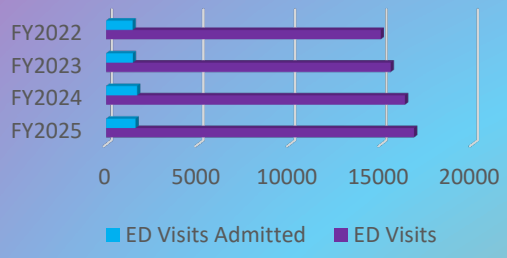
80,475
Clinic Visits

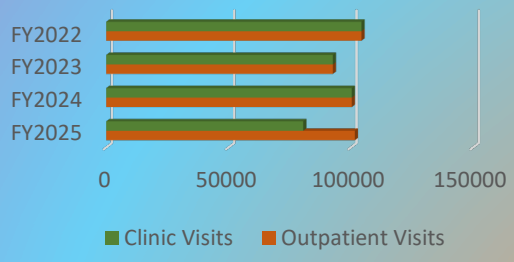
1547
Outpatient Surgeries

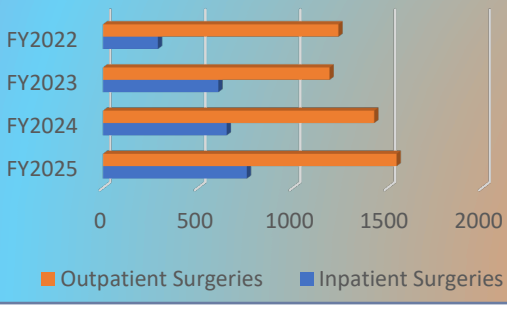
757
Inpatient Surgeries

(FY2025)









The success of our Team is built on the efforts of each individual; this includes our Support Team of House Supervisors and Administrative Assistants. We are stronger together! Thank you to everyone for being part of our Team!

Excellence in Nursing

The DAISY Award for Extraordinary Nurses was created in memory of J. Patrick Barnes who died at 33 of ITP, an auto-immune disease.

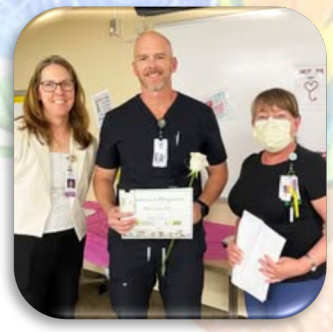
The Barnes Family was awestruck by the clinical skills, caring and compassion of the nurses who cared for Patrick, so they created this international award to say 'thank you' to nurses everywhere.

2025 DAISY Winner: Elizabeth "Liz" Stott, RN

#1 I was completely impressed with Liz's professionalism and caring after my procedure. Her smiling face and concern about my overall wellbeing. She was thorough with instructions and attentive to my needs. I would recommend having my procedure done at Memorial Hospital of Sweetwater County for the service and care I received.

#2 Liz was pleasant, helpful and had a sense of humor. All staff at MHSC were pleasant from check-in to release. I was taken for surgery on time. My wife was kept informed of my progress. Dr. Jensen and Dr. Liu answered all my questions and eased my concerns.

#3 She is a very special person. She is caring and also has a personality that makes you feel at ease. Some nurses in the past were kind of grumpy – not her! She told me everything that I would expect and let me know that it was going to be a little more time to get to the surgery, because a baby was being born and the anesthesiologist had to be there. I told her that a little anesthesia goes a long and please let him know that it takes a long time to come out of it. When we got to the surgery room I told the anesthesiologist to not give me too much. He said the nurse had told him and he said that he would take care of me and not to worry. When I got back to my room the same nurse was there and it was very nice to see her. She made me comfortable and I said she was wonderful. It's always nice to have the same nurse from beginning and end. It's always hard when you have one and when you are done have another one. She walked us to the door of the hospital and again asked if I was OK? I laughed and said yes! She laughed and said yes you are. Thank you very, very much.



Nominees

Shayla Dean (x2)
Delina Singleton
Rochelle Roemer
Santana Chavez (not pictured)

Weston Turner

Adriana De Jesus

Jennifer Warpness

Pictured with Noreen Hove, OR Director; Julia Kershisnik Acute Care Services Director; and Ann Marie Clevenger, CNO.

Acute Care Services: ICU, Medical Surgical, Outpatient Infusion

Statistics CY2024 – ICU

Average Daily Census – **3.94**

****Hours Per Patient Day*** – **16.98**

# of Patients Cared For – **507**

Statistics CY2024 – Medical Surgical

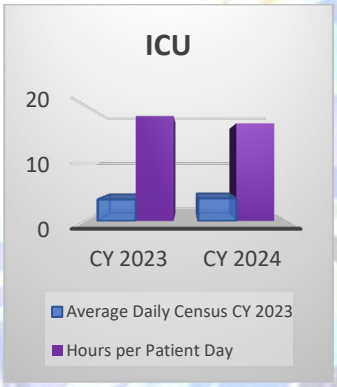
Average Daily Census – **10.68**

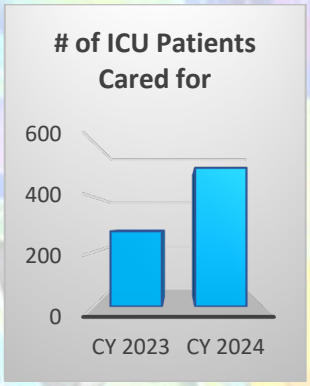
****Hours Per Patient Day*** – **10.18**

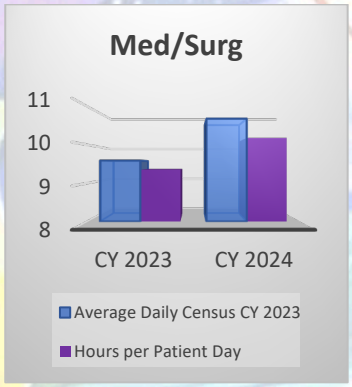
# of Patients Cared For – **1424**

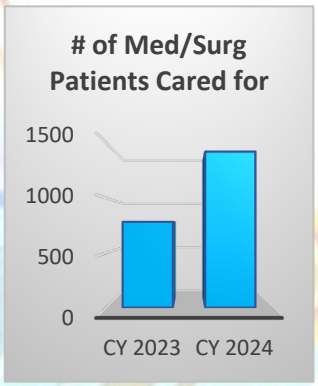
Julia Kershisnik, BSN, RN
Acute Care Services Director

**Hours per patient day (HPPD) is a metric that measures the number of hours of care each patient receives from nursing staff each day.*









The ICU & Medical Surgical Units

culture is built on respect, integrity, service, and caring. The peer-to-peer relationships are grounded in trust, collaboration, and open, honest, communication.

A key measure of the success of both departments is the strength and quality of the collaborative care between staff, providers and supporting departments, which in turn provides the highest quality of care and treatment for our patients.

CY2024 ICU & Medical Surgical Projects included:

Falls Prevention Project: Focused on increased fall prevention education for patients, family members and training for staff. New fall prevention strategies were utilized to reduce the number of patient falls per month. The fall rate per 1000 acute care days decreased from 5.33/1000 days in 2023 to 1.36/1000 days for 2024. New strategies have improved patient safety and reduced risk of falls significantly. Both departments will continue to monitor, provide ongoing education and training, and implement fall prevention strategies to ensure the safety of our patients.

Bar Code Medication Administration **(BCMA) Project:** This project focused on monitoring the compliance of scanning medications and the patient ID band when administering medications. Monthly audits were conducted to track the scanning compliance percentage to ensure the process of medication administration was safe for both staff and patients and consistently followed. Both the ICU and Medical Surgical units improved significantly during the CY 2024 with percentage scoring from 92% to 97%.

Courtesy and Respect Process Improvement Project: Focused on how patients perceive nursing care. Med Surg and ICU have improved scoring for Courtesy and Respect Project from 86.76 % for 2023 to 88.08 for 2024, with a target goal of 93.08%. The departments continue to push forward and meet with staff to assist them in understanding how patients perceive nursing care and the patient experience.

Press Ganey Survey Results: Provide feedback about the care and treatment of patients on both units from patients and family members. The survey responses continue to trend in a positive direction with several staff members being recognized by both name and unit where they work and thanked for the hard work they do each day. The departments will continue to strive to provide the highest quality of compassionate care for patients.

U of U Staff Training Courses: An integral part of increasing the nursing skill set and knowledge base. We have sent several staff members to the U of U for specialized training from PICC line placement to wound care training to ICU level training. Staff have shared the information with their peers and have benefited greatly from these trainings. We will continue to use the U of U training courses to enhance the scope of knowledge and skill sets of the staff.

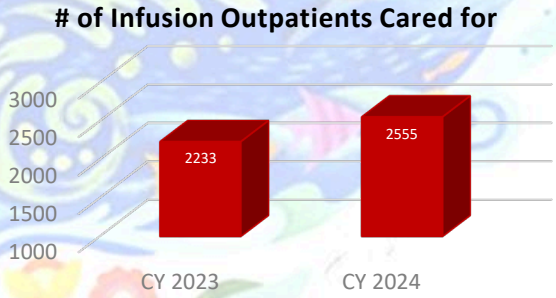
Positive Workplace Culture: A major goal for both the ICU and Med Surg unit. The culture of the workplace is paramount to the satisfaction of staff and interdepartmental collaboration and communication. Through continual education and reinforcement of treating one another with respect and professionalism, the positive workplace culture has flourished.

Outpatient Infusion Department

Statistics – Outpatient Infusion

Monthly Average Number of Visits CY2024 – **213**

# of Patients Cared for CY2024 – **2555**



Outpatient Infusion Services provide a variety of treatments for their patients. The Outpatient nurses have a unique yet comprehensive skill set and perform antibiotic infusions, monoclonal antibody infusions, therapeutic phlebotomy, blood transfusions, wound care, vaccinations, PICC and Port maintenance and therapeutic injections for asthma, osteoporosis, and rheumatoid arthritis.

Outpatient Services is open Monday through Friday but will also see patients on weekends who require ongoing therapy.

The Outpatient Team consists of a unit secretary and four (4) Registered Nurses with three being full-time and one being PRN status.

Press Ganey Survey Results: Provide feedback about the care and treatment of patients on both units from patients and family members. The survey responses continue to trend in a positive direction with several staff members being recognized by both the name and unit where they work and thanked for the hard work they do each day. The departments will continue to strive to provide the highest quality of compassionate care for patients.

Cardiopulmonary Services

Crystal Hamblin, MSN, RN, RRT
Cardiopulmonary Services Director

Patient Care Enhancements

- ***EEG Services***: Successfully launched and operating at full capacity.
- ***Pediatric Suction Clinic***: Now available during Flu/RSV/Cold season—meeting critical seasonal needs.
- ***Impact by the Numbers (FY2025)***:
  - 6,531 Electrocardiograms (EKGs)
  - 3,672 Breathing Treatments
  - 1,049 Outpatient Procedures
  - 388 Sleep Studies

Core Value: Passionate care delivered to every life we touch.

Technology Upgrades

- ***Hamilton C6 Ventilator***: Budget-friendly innovation suitable for all age groups. Offers non-invasive ventilation and heated high-flow oxygen therapy.
- ***Hamilton C1 Transport Ventilator***: Matching Airmed's trusted equipment, ensuring continuity of care for neonates through geriatrics.

Staff Training & Development

- ***Certification Achievements***: 12 team members earned advanced life support certifications (CPR, ACLS, PALS, NRP).
- ***Continuous Improvement***:
  - Department in-services
  - Leadership development initiatives
  - Ongoing commitment to professional growth and clinical excellence
- ***Workforce Stability***: Proudly hosting Respiratory Therapy students from LCCC.

Ongoing Projects & Strategic Partnerships

- ***Reducing Contract Labor***: Down to just one contracted traveler—strategic cost control in action.
- ***RT Education Collaboration***: Coordinating training opportunities with Primary Children's Hospital to enhance team expertise.

Care Management

Robin Jenkins, BSN, RN
Care Management Director

Care Management Focuses on "Patient Experience"

It was not lost on the Care Management team when the Strategic Plan Pillar "Patient Experience" was selected for years 2024-2027. As a team our department has always focused on care delivery, placing the patient at the center of resource choice, advocacy, and promotion of self-determination. Care Management had the unique opportunity to apply consistent strategies to elevate our practice that had the potential to improve the discharge and post hospitalization transition by increasing patient understanding of discharge instructions resulting in a decrease in overall stress to an already hectic experience.

How did we tackle refining an overall successful discharge planning approach? We instilled identical practices for each patient encounter every time. Follow along our journey and see how we are accomplishing our goals for an optimum "Patient Experience."

Action Description: ***Care Coordination***

1. Care Transition collected/documented patient experience regarding their understanding, concurrence of goals and satisfaction, related to coordinated resources by the Care Management team.

2. Percentage of patients that received the Healthcare and Human Resource guidebook.

Action Description: ***Discharge Information***

1. Case Management included pertinent discharge planning information to the discharge instructions prior to patient signature.

2. The Case Manager assistant arranged follow-up and specialist referral appointments prior to patient discharge and documented on the patient discharge instructions.

PIPS	Q4 2024	Q 1 2025	Q2 2025
CT post discharge calls	81.2%	91.6%	**100%**
Resource Booklet	NA	NA	**100%**
Discharge Information	75%	73.68%	**81.25%**
F/U appointment	75%	77%	**90%**

2024-2025 Highlights:

1. Daily Case Manager patient whiteboard updates and introduction
2. “Commit to sit” for patient interview/interactions.
3. In addition to the resource booklet, provide a “Prepare to go Home” pamphlet and patient follow-up prior to discharge.
4. Monitoring and tracking of Avoidable Days whereas a patient is hospitalized however no longer meets medical necessity.
5. Obtaining the 96-hour rule from providers to comply with Critical Assess requirements.
6. Assumed the Behavioral Health role as liaison between patient and the County Attorney office.
7. Dedicated Case Manager in the Emergency Department and Obstetrics
8. Adopted “Plans of Safe Care” per state statue for at risk infants.
9. Administer PRAPARE survey Social Determinants of Health for all adult patients in line with Health Equity.
10. Developing “Social Admission” guideline process.
11. Building strong relationships with the Department of Family Services, County Attorney Office, and Wyoming Guardianship Corporation.

Lastly, the Care Management team has experienced tremendous growth while enjoying personal patient experiences and a deep appreciation for the community they serve.

Clinical Informatics

Clinical Informatics is comprised of four staff members:

Kari Quickenden, PharmD, MHSA
Chief Clinical Officer

Bethany Bettolo, RN - American Nurses Credentialing Center (ANCC) Informatics Nursing Board Certification

- Attended report writing and Excel training
- Precepted a master's informatics student

Megan Gilbert, RN - American Nurses Credentialing Center (ANCC) Informatics Nursing Board Certification

- SANE trained this year

Amy Magana, RN

- Attended report writing and Excel training

Electronic Medical Record: Clinical Informatics led the electronic medical record (EMR- Cerner) implementation starting during COVID (2020) and successfully went live throughout the facility in April 2022. Informatics takes the lead with ongoing maintenance within the EMR, in addition to providing support to nursing, providers, and other disciplines throughout the organization daily.

Projects: Several nursing and ancillary department projects were implemented in support of Memorial Hospital of Sweetwater County's mission and vision, as well as in support of improving workflows, patient safety, and optimization of technology. That includes, but is not limited to:

- Spearheaded a cross-functional project (Atera implementation) aimed at improving patient appointment adherence across all hospital/clinic departments.
- Collaborated with dietitians and dietary staff to streamline the patient meal ordering workflow, resulting in smoother operations and improved patient satisfaction.
- Partnered with department leaders to draft a downtime policy and led meetings with various teams to strengthen inter-departmental workflows for downtime readiness.
- Participated in Nursing Education Mini Orientation (NEMO) to assist with promoting nurse retention.
- Successfully submitted regulatory requirements for federally mandated reporting programs for CY2024.
- Supported our quality department to ensure our electronic clinical quality measures (eCQMs) function correctly in Cerner, enabling successful submission to regulatory agencies.
- Performed chart audits to address documentation deficiencies and streamline workflows, supporting staff in improving accuracy and efficiency
- Assisted occupational medicine and infection control to address ongoing issues and assess operational workflows for improvement.
- Serve as a front-line resource for evaluating new products and technologies that may impact clinical efficiency and patient experiences.

Dialysis ★★★★

Juan Rodriguez, BSN, RN
Sweetwater Dialysis Center Director

Statistics

Census FY2025 - **32-39 patients**

- We experienced a lower census due to patients transferring to other units, a lower number of admissions, and deaths.

Treatments FY2025 –

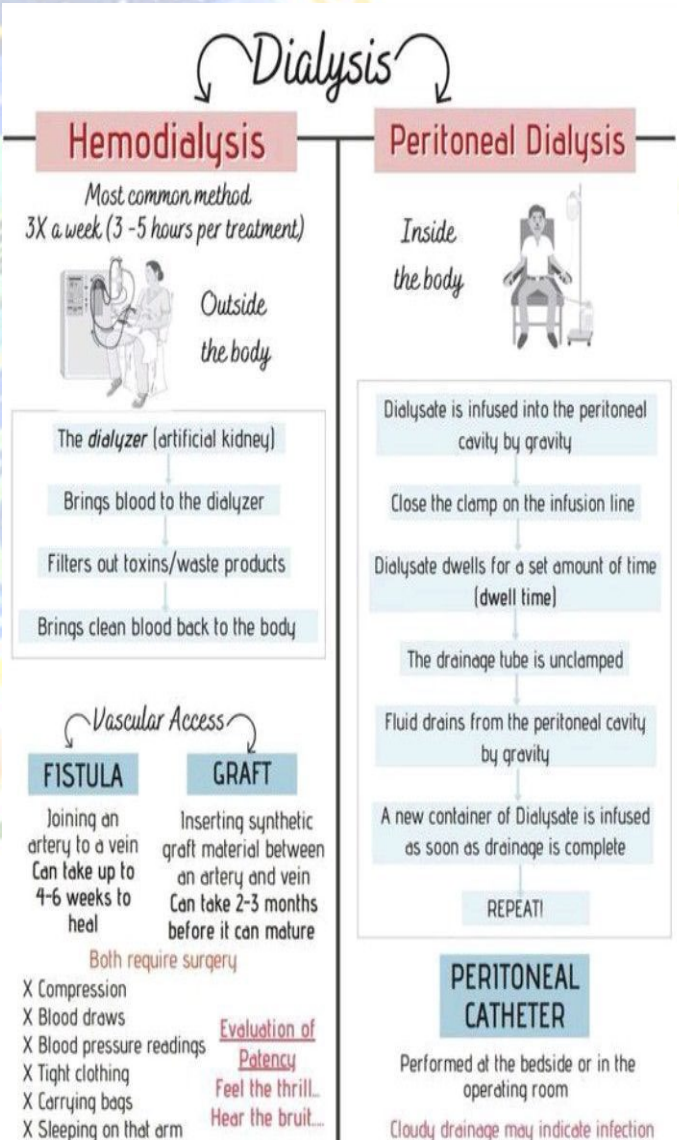
- Treatments ranged from 360 to 460 treatments per month

PD Program experienced a 50 percent drop in Census. We continue to market the program to nearby towns like Pinedale, Wamsutter, and Rawlings.

The Surgical department continues to be a huge benefit for the Dialysis department, giving us the capacity to replace non-working dialysis catheters and the placement of a Peritoneal dialysis catheter, thereby avoiding patient travel to the University of Utah.

FY2025

- Financially, we experienced lower gross income due to low census, which hurt our bottom line. The latter part FY2025 was more promising with a higher census and higher gross income.
- Through the year, we worked to improve our CMS quality scores and improved our **star rating from a three-star rating to a four-star rating.** We continue to improve our clinical outcomes to provide quality care for Rock Springs and the nearby communities.
- During the past year, we have begun assisting our patient community: focusing on Social Determinants of Health to improve their chances of being part of the transplant list. We focused on understanding and addressing the non-medical factors that influence transplant outcomes: income, education, housing, and social support. Addressing these areas will significantly impact patients' chances of receiving a transplant.



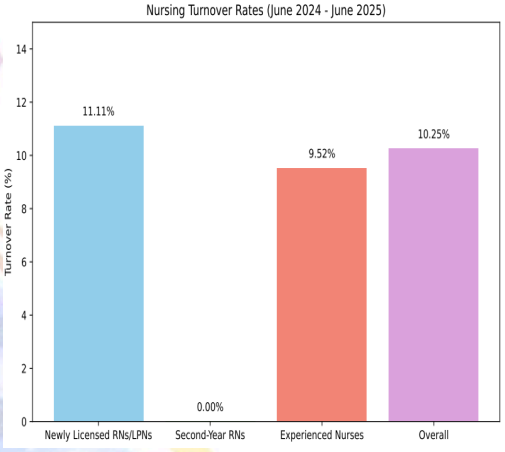
FY2026 Goal

- To achieve CMS QIP 10 % higher than the state and national average and become a 5-star rating unit. We will continue to support nearby communities within a 100-mile radius.
- Reduce the number of blood transfusions and hospitalizations by providing the best care practices and necessary medications.
- Grow our census from thirty-six patients to forty-two patients during FY 2026 and help patients achieve status one on the transplant list.

Education Department

Patty O'Lexey BSN, RN
Director Education
& Employee Health

The Education Department supports new graduates and nursing professionals in their early careers. From June 1, 2024, to June 29, 2025 (excluding hires on June 30, 2025), MHSC set two primary goals: to maintain first-year RN turnover at or below 10%, and to ensure that turnover for newly licensed second-year RNs remained under 20%. Over this period, MHSC hired 18 newly licensed RNs/LPNs, with two separations, resulting in a turnover rate of 11.11%. Of the six newly licensed RNs who began their second year, none left, resulting in a **0%** turnover rate for that group. Additionally, 21 experienced nurses were hired, and two were subsequently separated, resulting in a turnover rate of 9.52% for non-newly licensed hires. In total, 39 nurses were hired during the year, with four separations, leading to an overall turnover rate of 10.25%. This figure excludes nurses who left during this timeframe but were hired before June2024. It's worth noting that one LPN, initially included in this data, later earned her RN and relocated. Six newly licensed RNs were also hired later in the year and are still considered within the "newly licensed" group for this PIPS.



Nursing Education Mini Orientation (NEMO): Mini Residency

Mission: Empower nurses by supporting an environment that allows for the safe development of clinical judgement and critical thinking in an Evidence-Based Practice (EBP) setting.

NEMO aims to facilitate the transition of novice nurses from entry-level to competent professional nurses by supplementing traditional hospital and unit orientations.

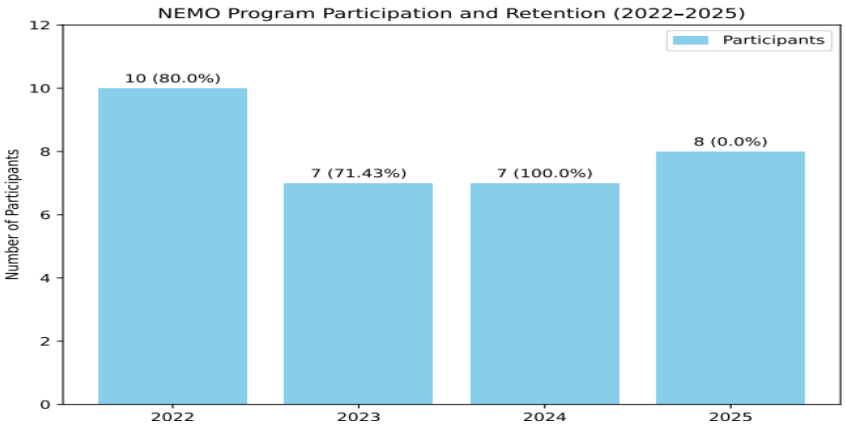
The transition from academia to the hospital setting can be intimidating, stressful, and physically and mentally challenging, which can lead to stress, a lack of confidence, and possibly an inability to retain new nurses. NEMO was developed because MHSC recognized that the new graduate nurses were at risk for burnout and higher turnover rates.

Objectives:

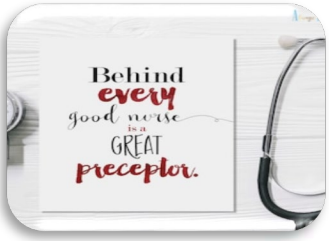
- Develop practical decision-making skills related to clinical judgment and performance.
- Provide clinical leadership at the point of patient care.
- Strengthening commitment to nursing as a professional career choice.
- Incorporate Evidence-Based Practices.
- Demonstrate MHSC's Mission, Vision, and Values

Goals:

- Provide an environment for nurses to refine their skills while ensuring they use the most recent EBP.
- Improve critical thinking.
- Develop the ability to manage outcomes that promote patient safety and quality at the bedside.
- Create an emotional support network by providing a nurturing environment.
- Foster professional development through essential leadership skills, including time management, prioritization, delegation, and patient advocacy.
- Reduce turnover and improve patient experience.



The 2024–2025 period marked the third year of the NEMO (New Employee Mini Orientation) program at MHSC, welcoming seven newly hired nurses into the initiative. One year later, all six nurses are reported to be thriving within their respective departments, demonstrating the program's ongoing success in supporting early-career professionals. Building on this momentum, eight new hires are scheduled to participate in the NEMO program during the 2025–2026 cycle, reflecting MHSC's continued commitment to structured onboarding and long-term nurse retention.



74 RN's have completed preceptor training.

Preceptor Training, Skills Day, cross-training, and multiple continuing education opportunities, including programs through the University of Utah. Around-the-clock House Supervisors were available to assist night and weekend staff. Leadership development was a key focus, with MHSC leaders participating in Peak Consulting's "Team Management: Moving the Needle Forward for Success" training. Additional updates included revisions to the cross-training policy, clarification of internal transfer procedures, and the introduction of a Healthy Workforce training program designed to address bullying and negative behaviors. Looking ahead, MHSC plans to expand cross-training options, explore the development of a float pool, extend Nursing Skills Day, and deepen educational partnerships with the University of Utah to support the nursing team further.

Memorial Hospital of Sweetwater County (MHSC): Supporting Future Healthcare Leaders

Memorial Hospital of Sweetwater County proudly partners with accredited nursing programs to offer students invaluable capstone experiences within a dynamic, patient-centered environment. These hands-on learning opportunities enable emerging professionals to work alongside our dedicated healthcare teams and make meaningful contributions to patient care.

In 2025, MHSC was honored to host a diverse group of student nurses, including:

- **3 Capstone students** from the University of Wyoming
- **1 BSN student** from the University of Wyoming
- **4 BSN students** from Nightingale College
- **1 BSN student** from the University of Utah
- **1 DNP student** from Liberty University
- **2 MSN students** from Liberty University and Western Governors University

Each student brought unique perspectives and skills to our hospital, enhancing the care we provide, while gaining real-world experience that will shape their future in nursing.

Employee Experience

10 Emergency Dept. RN's attended

Splinting Application Course training

8 Ortho Clinic Staff members attended

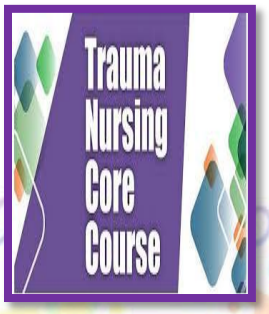
MHSC continues to invest in staff development through robust training and education opportunities, many of which are supported through its ongoing partnership with the University of Utah (U of U). This collaboration provides staff with the opportunity to participate in specialized hands-on training across various clinical departments, including ICU, PACU, ED, PICC Line, and Orthopedic Clinic. Additionally, the University of Utah offers weekly online education to RN staff through its Tele ICU program, which provides clinical insights and instruction on various aspects of critical care nursing.

- **4 Staff members have completed a three-day intensive Clinical Training at the U of U.**
- **1 RN completed P.I.C.C. Line training at MHSC and a two-week training at the U of U.**
- **70+ staff members have participated in weekly Tele ICU Courses with U of U.**
- **18 staff members completed their TNCC certification in February 2025.**

September 2024 Nursing Skills Day – Twenty-one Skills Stations with over 160 staff members attending.

Complementing these academic opportunities, MHSC also facilitates practical, hands-on education through department-driven training and vendor-led demonstrations. Staff have received direct instruction on wound care, ostomy care, wound vac application, and Bridle tube insertion. In fall 2024, Nursing Skills Day was successfully held on September 16–17, featuring over 21 skill stations and more than 160 participants. The event offered a diverse range of training sessions, allowing staff to develop new competencies or reinforce existing knowledge. Throughout the year, casting and splinting classes as well as Trauma Nursing Core Course (TNCC)

certification were also offered, broadening emergency preparedness and orthopedic care skills across nursing teams. Looking ahead, Skills Day 2025 is scheduled for October and promises to feature even more stations and expanded educational opportunities, further advancing MHSC's commitment to professional growth and clinical excellence.



MHSC also continued its commitment to fostering a well-rounded, informed workforce through its ongoing Brown Bag presentation series. These accessible, all-staff sessions covered a wide range of relevant topics spanning clinical education, safety protocols, financial wellness, self-care strategies, and more. Designed to promote cross-disciplinary knowledge and encourage informal learning in a supportive setting, the Brown Bag series offers valuable takeaways while reinforcing a culture of continuous development and staff engagement across the organization.

Monthly Brown Bag presentations included.

- **Workplace Violence**
- **Active Shooter**
- **Alzheimer's – six-week course**
- **Pelvic Floor Dysfunction**

Community Growth:

To further support patient-centered care and align with educational goals, MHSC's Education Department established a new Patient/Family Educator role. A registered nurse was hired into this position to work within the inpatient setting, where they will assess educational needs and provide vital information to both patients and their families throughout the care journey. In alignment with these efforts, the Education Department also became the primary site for the Diabetes Self-Management Education (DSME) program, assuming responsibility for both the quality coordinator and RN roles. This initiative involves close collaboration with MHSC dietitians to deliver comprehensive diabetes education to the community.

Total Referrals for the 2024 calendar year - 18

- **9 Total Registered Dietitian Visits,**
- **7 RN visits,**
- **0 Third Visits (Follow-up visit)**

January to May (2025) – To Date Total Referrals - 34

- **23 Registered Dietitian visits,**
- **22 RN visits,**
- **12 - Third Visits (Follow-up visits) with RD and RN**

Beyond inpatient initiatives, the Education Department remains actively engaged in outreach through community health fairs and the delivery of critical certifications and education, including CPR, ACLS, PALS, Stop the Bleed, and Advance Directive training. These activities help address broader educational needs identified in the region. Furthermore, MHSC continues to strengthen its academic partnerships with numerous schools and universities by hosting students pursuing ADN, BSN, MSN, doctoral, respiratory therapy, and medical imaging programs for clinical rotations, solidifying MHSC's role as both a healthcare leader and a teaching institution.

American Heart Association.
STOP THE BLEED

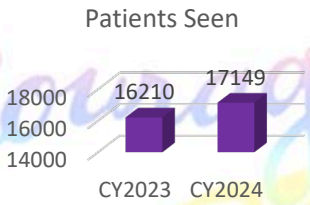
MONTHLY COMMUNITY COURSES

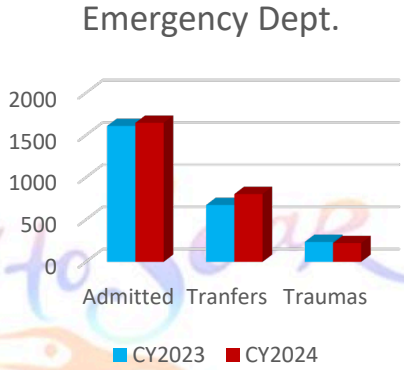
Emergency Department

Statistics

Emergency Care Census CY2024

Total Patients seen: **17,149**
Admitted: **1,646**
Transfers: **803**
Traumas: **222**





Tiffany Uranker, BSN, RN
ED Director

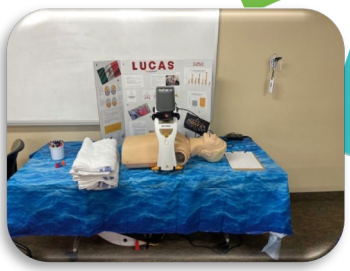
Compliance

- Sepsis Provider Notification above 78% for 8 months
- 100% off ED Hospital Staff have completed TeamStepps

Projects & Accomplishments

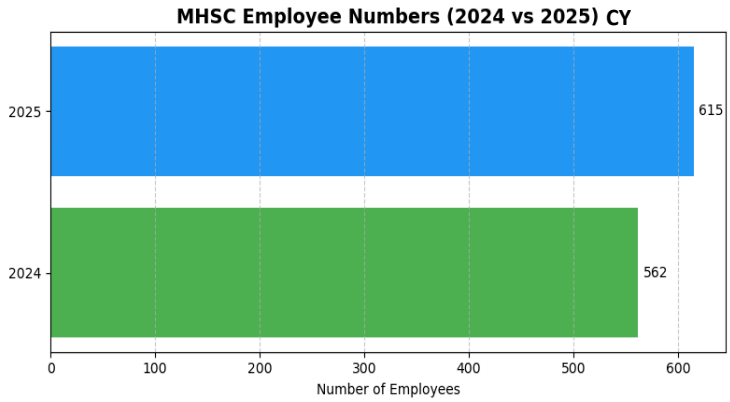
- Multiple staff members completed training for Ultrasound Guided IV with Dr. Opferman ED, MD
- The SANE Team (Sexual Assault Nurse Examiner) is now fully staffed and taking call 24/7 to meet the needs of our patients in their most vulnerable time.
- Code Blue Committee is now working with State on Reporting numbers.
- ER Committee has been formed by multiple Emergency Department Staff members: this will help lead the needs of the Emergency Department and give staff a voice for change.
- Full time Director of Emergency Services and Behavior Health Hired after several months of interim directors.
- Emergency Department Staff completed splinting course that was hosted by Essity, makers of Orthoglass.
- Reduction of Agencies staff from 12 to 5 and this number will decrease when nurses come off orientation

- ED Nurses, Case Managers and OB staff attended the Wyoming Joint Symposium for Women and Children to come together and learn of new ways that we can help vulnerable populations in Wyoming
- ED Leadership and Staff members participated and taught at the annual skills fair, Various skills such as the Lucas Device, Crash Carts, Rapid Transfuser



Employee Health

Employee Health Nurse – Nicole Burke BSN, RN
Director Patty O'Lexey BSN, RN



Mission: To promote and protect the health, safety, and well-being of all hospital staff, ensuring a healthy workforce that can deliver high-quality patient care.

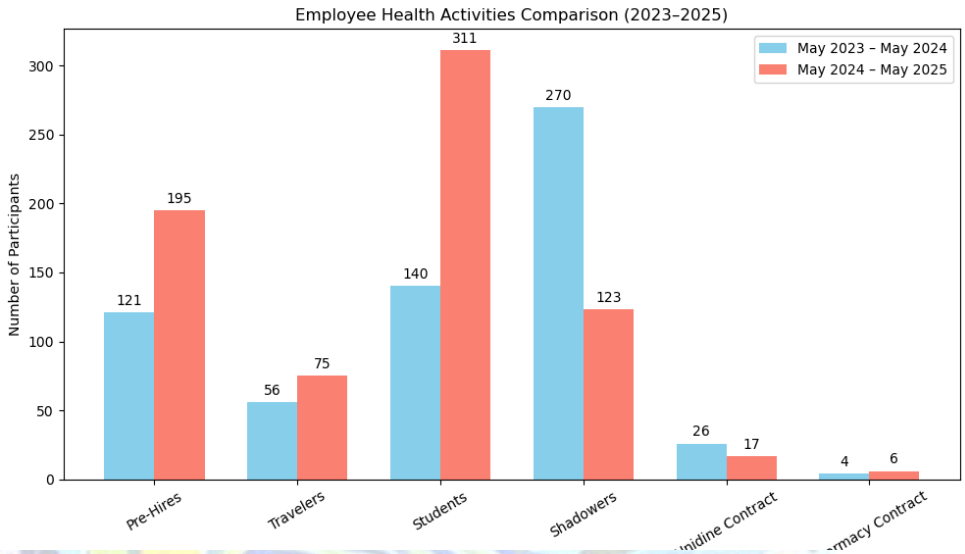
Core Responsibilities

Pre-Employment Health Screenings

- Conduct physical exams, immunization reviews, and TB testing f new hires.
- Ensure employees meet health standards before starting work.

Immunization & Infection Control

- Administer and track required vaccinations (e.g., flu, Hepatitis B, COVID-19).
- Monitor and manage exposure incidents (e.g., needlesticks, airborne pathogens).



Workplace Injury Management

- Provide first aid and coordinate care for on-the-job injuries.
- Manage workers' compensation documentation and follow-up.

Health Surveillance & Monitoring

- Conduct regular screenings (e.g., vaccine, fit testing).
- Monitor employees in high-risk roles or departments.

Return-to-Work Evaluations

- Assess employees returning from medical leave to ensure they are fit for duty.
- Coordinate accommodation if needed.

Wellness & Preventive Programs

- Offer wellness initiatives like flu shot clinics and mental health resources.

Confidential Health Records Management
Maintain secure and confidential employee health records in compliance with HIPAA and OSHA.

Collaboration with HR and Safety Teams
Work closely with Human Resources and Occupational Safety to support employee well-being and regulatory compliance.

Employee Health Collaboration at MHSC
Employee Health works collaboratively with every department at MHSC to promote a safe and well-prepared workforce. We partner closely with Infection Control, Environmental Services, Risk Management, and the Environment of Care teams to ensure all staff receive the training and support they need to perform their duties safely and effectively.

Family Med, Occ Med & Walk-in Clinic

Statistics

Staffing:

- **12 Providers**
- **8 RNs**
- **10 MAs**
- **9 Patient Access Specialists**
- **Practice Coordinator**

Misty Cozad
Practice Coordinator

Patient Visits

CY2022	CY2023	CY2024	CY2025 (to date)
27365	33,313	35319	18,458

←***Just another Busy Day!***

Providers: We have 10 primary care providers and 2 providers that strictly work in the walk-in clinic. Six of the primary care providers rotate through the walk-in clinic throughout the week to ensure double coverage.

Occupational Medicine providers: Dr. Johnson, Dr. Long, Dr. Lauridsen and Mark Sanders, PA-C. There are approximately 30 companies that utilize our occupational medicine services on a consistent basis, with a total panel of 80 companies loaded in our system. Eight companies are fast-tracked to receive 24/7 on call care for employee injuries, drug screens and breath alcohol testing.

- Our providers also staff outside clinics at Jim Bridger Power Plant, Wamsutter Clinic, Sage View Care Center and Deer Trail Assisted Living. Dr. Lauridsen and Deseriee Stofferahn, AGNP provide services on a weekly basis to Sage view Care Center. Deseriee Stofferahn, AGNP goes to Deer Trail Assisted Living monthly.
- Dr. Lauridsen is the medical director for Jim Bridger Power Plant and Sage View Care Center.
- We have 4 DOT certified providers, 8 staff that are NIOSH and CAOHC certified and one nationally certified occupational health nurse.
- Our occupational health teams offer on-site educational clinics, flu and immunization clinics, as well as wellness and ergonomic reviews.

We provide the following services for companies:

- New hire testing
- PFT – pulmonary function test
- FIT – testing respirator checks
- Drug screening
- Audiograms
- Yearly surveillance testing
- All testing complies with OSHA and MSHA federal regulations

Active Shooter Exercise

Projects:

- The nursing staff are assisting in projects that focus on patient experience and improving patient safety.
- Patient Access Specialist are involved in improving the patient experience through eligibility and benefits.
- Both projects are to ensure that patients have the best possible experience in our clinics

Memorial Hospital OF SWEETWATER COUNTY | Family, Internal & Occupational Medicine Clinics of Sweetwater Memorial

Infection Prevention Report

New in 2025!

Comprehensive Surveillance: for HAI; all surgeries for SSI, CAUTI, UTI, CLABSI, BSI, PNEU, VAE, PPI, and all specific types of infections covered by NHSN Chapter 17. Successful surveillance depends on the quality of the tools. Infection Prevention is working closely with Informatics to find and address gaps in the surveillance tools provided by Cerner.

HAI Site Trend Report 2025 YTD

Site	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
SSI	2	1	2	1	1	2							9
CAUTI													
UTI							1						1
CLABSI													
URI			2*										2
PNEU	1	1	1		1								4
VAE													
PPI		1											1
SST													
Other													
LabID HO CDI													
LabID HO MRSA													
Total													17

*Date	Org	Notes
3/3/2025	Influenza A	Neg for Flu on admission, 4 days later developed a cough- Flu A. Has ill family, unable to rule out HAI.
3/8/2025	RSV	CHF pt with fever and RSV pos on day 5, other patients on the unit with RSV.

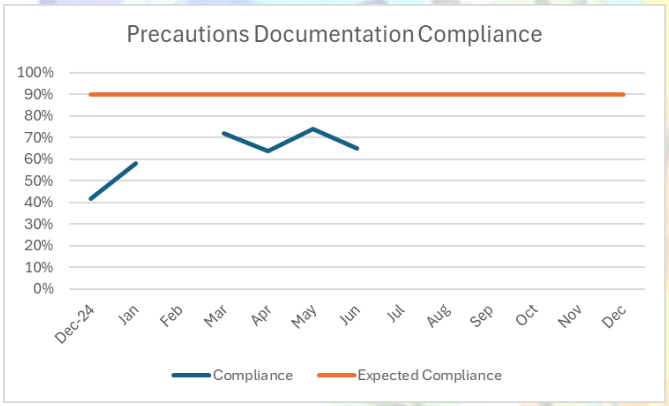
Site Trend- more SSI than any other kind YTD, comparison capabilities pending EHR refinement
Total HAI YTD- 17

Epidemiological Tracking and Trending- new trending tools (above) allow IP to monitor infections over time to detect patterns of epidemiological significance such as organisms, procedures, locations, staff, etc. in common. This allows Infection Prevention to design data driven, evidence-based interventions.

Ongoing Work- Transmission-Based Precautions documentation (JC finding), hand hygiene observation

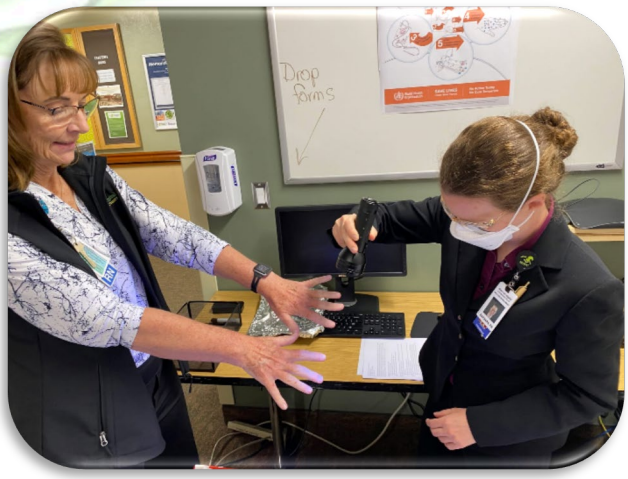
Precautions Documentation:

Initial interventions still ongoing- week-daily audit reported at Leadership Huddle, collaboration with ED and MS/ICU, house-wide education completed. Plateau reached. Next steps: Directors to utilize staff meetings to refocus awareness and elucidate any barriers. Reminder signs to be posted in Triage rooms about implementing and documenting precautions syndromically.



Hand Hygiene: house-wide hand hygiene observations re-initiated. Baseline being established. 18 of 26 departments have reported. Action plans requested for the remainder as the audit structure cannot be one-size-fits-all. Director creativity encouraged.

Education: Infection Prevention provides education for issues du jour for all of MHSC, including the Board of Trustees. Whether it's on-the-spot training provided during Environment of Care Rounding, competency based education for Annual Education requirements, Skills Fairs, or new employee orientation, Infection Prevention creates applicable and accessible support for staff learning.



Right: Patty O'Lexey, Dir. Education and Barbara MacDonald, Infection Preventionist demonstrate a hands-on approach to hand hygiene competency at the 2024 Skills Fair.

Obstetrics

Our OB department serves as an obstetrics triage, antepartum unit, labor and delivery unit, mother baby unit, nursery and special care nursery. Our staff take on many roles and responsibilities but always strive to provide a safe, personalized, compassionate space for our patients. We provide ongoing education throughout the year to our entire department and providers to ensure we remain up to date on the newest evidence and work as a team to care for our patients.

Megan Guess, MSN, RN
Women's Health Director

Statistics (CY2024):

Delivered: 440 newborns Maternity Care: 580 patients *C section rate: 23.8%

**Our c section rate for 2024 is below the national benchmark of 26%.*

OB Annual Education

- University of Utah taught our nursing staff AWHONN Intermediate Fetal Monitoring
- University of Utah taught our nursing and pediatric staff STABLE newborn care
- OB Director, Megan Guess, OB Clinical coordinator, and OB staff RN Jelena Frey provide Neonatal Resuscitation classes to all of MHSC and community partners
- Postpartum hemorrhage, Eclampsia, emergency c section, and shoulder dystocia simulations and drills are completed yearly for all OB Staff and Providers. Other units are invited with several from OR, ED, house supervisors and ICU joining in. This is partnered with Western Wyoming Community College Nursing program to use virtual and manikin simulators to make the experience as real as possible.
- Nursing competencies- these are picked by the staff and include different procedures and skills that are specific to OB. Placement of Intrauterine pressure monitoring devices, amnioinfusion, magnesium sulfate bolus and maintenance to treat preeclampsia, chart audits, NG feeds for newborns, bubble CPAP for newborns, IV placement for newborns, Umbilical catheter placement and care for newborns, hypoglycemia treatment for newborns, and many more are worked on throughout the year to maintain skill and competency.

Community Engagement

OB serves on a community committee for Plans of Safe Care. This partnership involves participation from local community partners such as Southwest Counseling, DFS, WIC, Parent's As Teachers, Early beginnings, and the Child Development Center. This committee works to provide resources and services to families affected by substance exposure.

OB team members attended the Evanston Community Baby Shower to help spread the word that we are here for all our surrounding communities to provide women and newborn services.

Butterfly release - OB team members put together an annual butterfly release and community event to allow families that have experienced pregnancy, neonatal or child loss to come together to support one another.

Prenatal classes- OB offers prenatal classes once per month to expecting mothers and their families. In addition to these classes, OB has partnered with Tinyhood to offer online prenatal classes for families that are unable to attend the in-person classes.

OB provided articles and information to our community newsletter. Each provider spoke to their passion for women's health and what drives them to do what they do.

Person Centered Care

OB provides person centered and family centered care to ensure women have a voice and options when it comes to their delivery and care. We provide various pain management options to laboring mothers including nitrous oxide, meditation, massage, distraction, pain medications and epidurals. We will soon by adding hydrotherapy to our list of choices for pain relief.

The OB unit works closely with the OB clinic, University of Utah Maternal Fetal Medicine and the Pediatric clinic to ensure continuation of care for our patients. The OB providers and Maternal Fetal Medicine providers work together to care for patients with high-risk pregnancy concerns and then work with the patient to decide the safest place for the patient to deliver. This allows patients to seek care close to home but still be overseen by specialists to ensure the mother and newborn's safety.

Quality and Safety Projects

Postpartum Hemorrhage- this project provided education and monitored the use of our postpartum hemorrhage protocol for patients that met criteria. We have hit 100% compliance for several months since starting this initiative.

In addition to our postpartum hemorrhage project, we brought in the Jada system. This is a system that helps in severe postpartum hemorrhage to help decrease blood loss. Specialized education was provided to providers and staff.

HCAHP scores- OB HCAHP scores for compassionate care have increased steadily since 2024. We ended 2024 with a top box score of 74.07% and are currently sitting at 91.67% 😊

Severe hypertension in pregnancy- this project involves getting antihypertensive medication to a patient within 60 minutes of recognizing severe hypertension. This is an ongoing project that has seen steady improvement while working out the different barriers along the way.

New infant security system- OB worked with IT and Facilities to get a new infant security system installed. This new system is state of the art and ensures our newborns are always in their appropriate areas with their families. This system ensures the unit doors remain locked if a newborn is in the area and will alert staff if there are any concerns.

Need Women's Healthcare? **We've Got You Covered.**

MEET THE CARING PROFESSIONALS WHO SERVE THE WOMEN OF SOUTHWEST WYOMING AND BEYOND.

DR. JAVIER HERNANDEZ

"OB/GYN is a complete field with a healthy combination of surgical and medical skills," he said. "Also, it's a happy field. Such happiness comes when delivering healthy babies."

EDUCATION: Universidad Central del Caribe School of Medicine

RESIDENCY: University of New Mexico School of Medicine

DR. KEN HOLT

Of the services Dr. Holt offers, one stands out. "Being part of bringing a new life into the world safely never gets old."

EDUCATION: Kansas City University College of Osteopathic Medicine

RESIDENCIES: University of Kansas Medical Center and University of Missouri-Kansas City School of Medicine

EMILY JAMES, FNP-BC, FAMILY NURSE PRACTITIONER

Board-certified by the American Academy of Nurse Practitioners, she thrives on helping women maximize their health through pregnancy, delivery, and beyond.

EDUCATION: University of Wyoming, and Frontier Nursing University

DR. SAMER KATTAN

Over the years, Dr. Kattan's compassionate care has resulted in multiple Patients' Choice and Compassionate Doctor Recognition awards.

EDUCATION: Lebanese University School of Medicine, Faculty of Medical Sciences

RESIDENCY: Boston Medical Center

STARLA LEETE, CERTIFIED NURSE MIDWIFE

Leete is board certified by the American Midwifery Certification Board. At MHSC, Leete helps women take charge of their physical, mental, and emotional health through education and expert pregnancy, postpartum, and primary gynecologic care.

EDUCATION: Frontier School of Midwifery and Family Nursing

DR. WAGNER VERONESE JR.

Dr. Veronese is known for his exceptional kindness. He takes the time to listen and engage with patients, ensuring they feel heard and understood.

EDUCATION: St. George's University School of Medicine

DR. JEFFERY WHEELER

When not caring for patients, Dr. Wheeler, a Wyoming native, enjoys spending time outdoors with his three children.

EDUCATION: University of Colorado

RESIDENCY: Exempla St. Joseph Hospital

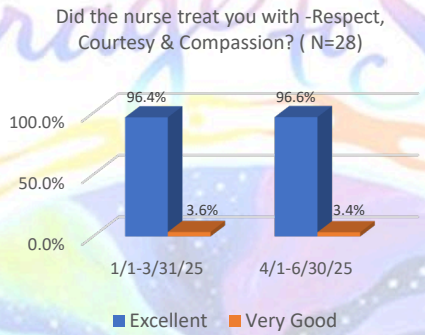
Oncology - Sweetwater Regional Cancer Center (SRCC)

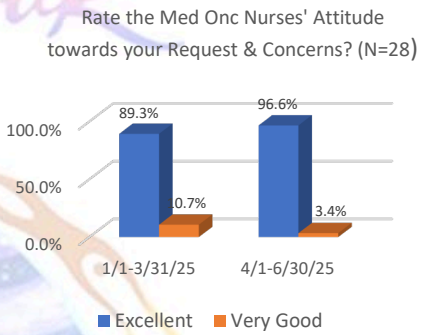
Dawn Piaia, BSN, RN, OCN
Medical Oncology Hematology Director

Medical Oncology Nursing Staff:

- *4 full-time chemotherapy nurses (inc. the director and clinic nurse)*
- *2 PRN chemotherapy nurses*
- *BONUS - 2 chemotherapy nurses are Oncology Certified Nurses.*

Press Ganey Scores





Medical Oncology Department's New PIPS project

Advance directives are important for all patients, but oncology patients have an increased need for end-of-life decisions.

- ***Aim Statement:*** *Medical oncology will AIM for 75% of cancer patients having a completed Advance Directive scanned into the patient's chart.*
  - ***Target Goal*** *(Smart Objective) 75*
  - ***Stretch Goal*** *(AIM Statement) 90*
- ***Measurement/SMART Objective:*** *Patients will be asked, by clinic nurses, during the Infusion/Oncology Admission Assessment, if they have an Advance Directive on file in their chart.*
- *If the patient has an Advance Directive, it will be scanned into Cerner.*
- *Clinic nurses will take classes to improve their knowledge of Advance Directive.*

Stats – FY2024

Clinic Nurse – sees an average of 103 patients or approximately 1,022 total visits each month.
Chemotherapy Nurses – treat an average of 151 patients a month or approximately 1,814 total visits. Nurses administer chemotherapy, immunotherapy, monoclonal antibodies, blood transfusion PORT and PICC maintenance.

About Us

SRCC chemotherapy nurses must maintain education in administering hazardous drugs.

SRCC chemotherapy nurses are highly trained in hypersensitivity reactions. The nurses monitor patients continuously for hypersensitivity reactions when infusing Chemotherapy, Monoclonal antibodies and/or immunotherapy. A hypersensitivity reaction protocol has been developed for the nurses to immediately start the algorithm if needed.

A chemotherapy nurse is training to perform US guided IV insertion.

Medical Oncology is receiving many referrals for both Hematology and Oncology. This has not only increased the number of patients seen in the clinic, but also patients receiving chemotherapy/immunotherapy. Patient acuity levels have also increased due to the complexity of the patients and their chemotherapy/immunotherapy treatment regimen.

From our Patients

The team is so professional, and very knowledgeable. If I have any questions or concerns when I'm home after treatment, every time I called, they gave me additional pertinent helpful information each time. The oncology team is the most helpful and I am amazed at their realm of knowledge and their professionalism and at the same time their more than caring actions.

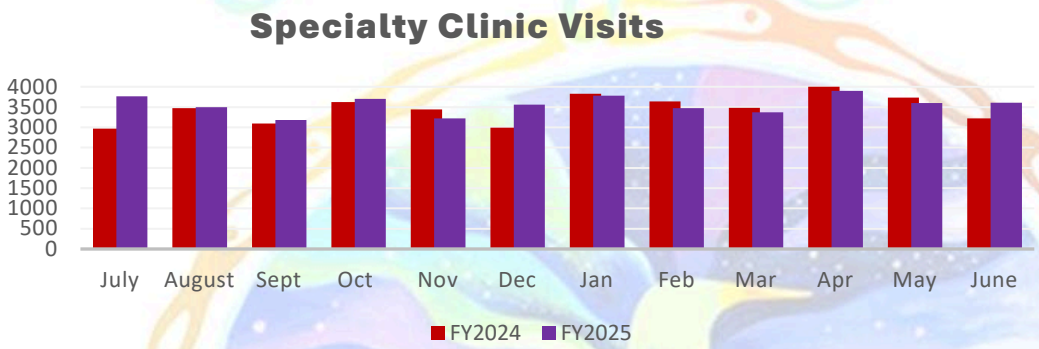
Specialty Clinics

Staffing

- 18 Providers
- 20 Registered Nurses (RN)
- 2 Licensed Practical Nurses (LPN)
- 10 Medical Assistants (MA)
- 2 Nurse Practitioners (NP)
- 1 Certified Nurse Midwife (CNM)

Numbers

- FY 2024 Clinic Visits – 41,611
- FY 2025 Clinic Visits – 42,656



Jodi Cheese
Practice Manager

Updates

- Launched a weekly Behavioral Health telehealth clinic, available every Wednesday.
- Welcomed a new Clinical Coordinator – Stephanie Homan.
- Welcomed a new full time float nurse to assist in all clinics as needed – Julia Samz.
- Welcomed three new part-time doctors to our OB/GYN clinic to help address the shortage of obstetric care in Wyoming.
- Welcomed a new part-time doctor to help assist with our Orthopedic Trauma Service.
- Launched a new appointment reminder system to improve communication with our patients.
- Participated in an improvement program focused on active listening to improve communication between staff and patients.

Education

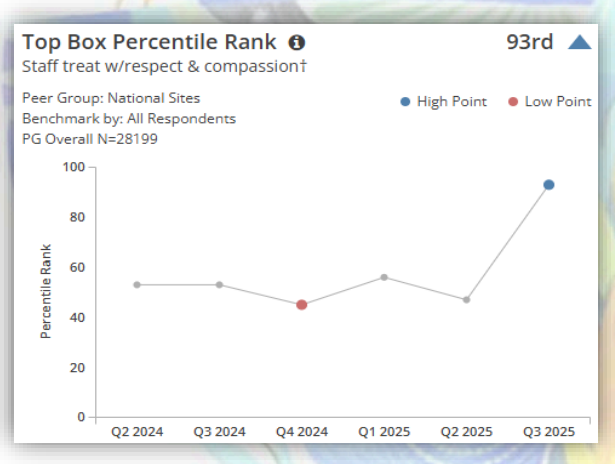
- Jackie DeWitt – trained to do SANE exams
- Two new COPE nurses (Monica Crothers, Rachelle Harris) to help meet the behavioral health needs of our children and adolescents.
- New nurse practitioner – Mariah Pacheco
- Lacy Love – working on her Master of Science in Nursing with a focus on Nursing Leadership
- All orthopedic nurses completed casting training in January.

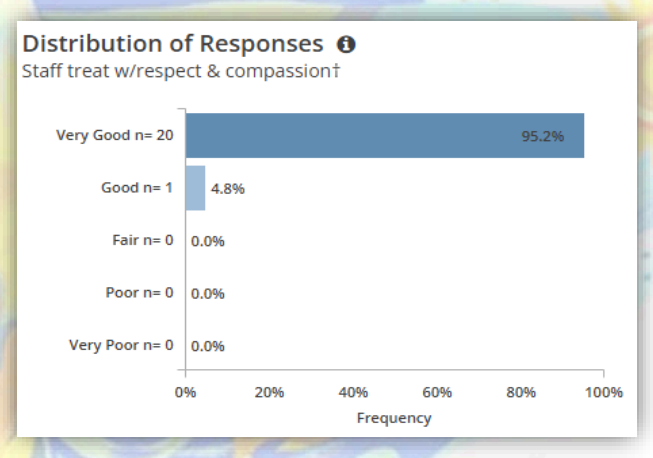
Team Building Activities





Press Ganey Comments





Ondrea has always been a friendly and compassionate nurse.

MONICA ALWAYS REMEMBERS US AND IS VERY KIND.

Christa is the best and helped us so much. Paula is an outstanding nurse.

BRANDIE IS ALWAYS WONDERFUL!

Tara is a great nurse!

Trich is awesome!

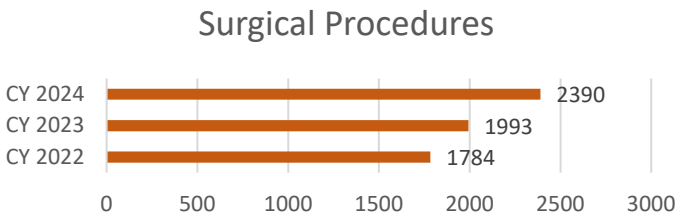
Dr. Jamias is wonderful. My visit was a great experience. His nurse was so fun to chat with about age and the things we go through.

Dr. Christensen's office is the best. Everyone there is more than helpful and just wants the best for you. He brightens everyone's day by just being there for them. I am a better person for knowing Dr. Christensen and all his staff.

Memorial Hospital OF SWEETWATER COUNTY | Specialty Clinics of Sweetwater Memorial

Surgical Services

Noreen Hove, MSN, RN
Surgical Services



We continue to grow with the community and have added three OB/GYN Surgeons, and an Orthopedic Surgeon. These additions allow the Surgical Services Department to provide safe quality care to our community.

In June 2025, we became fully staffed in each of the Surgical Services Department units. Also implementing the first department to take extra new graduate nurses to begin a nursing float pool.

This year the Surgical Services Department focused on "Degree to which staff showed compassion". The base line data was 90.71% with a goal of improvement to 92.71% by December 2025. Currently we are at 92%. The staff are excited to participate and eager to bring this score up as we believe that the Hospital's mission statement, "Compassionate care for every life we touch" embodies the passion of this department.

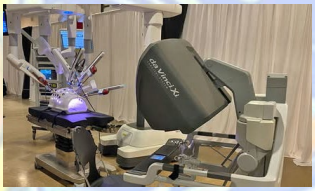
In May during nurse's week, we participated in the DAISY Foundation's celebration of nurses. Of the 8 candidates, the Surgical Department had six nominees, with the Surgical Department winning the Team division and our own Elizabeth Stott receiving the DAISY award for nursing. (See page 4).

Update on Current Services:

The Davinci Robot program is up and running smoothly. This equipment is utilized by all three of the General Surgeons and two of OB/GYN surgeons as well as the new and updated 4.0 MAKO robot for orthopedics.

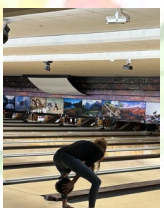
The SAVI SCOUT has been implemented and provides an important service to our breast cancer service line by providing convenience for breast biopsy diagnosis.

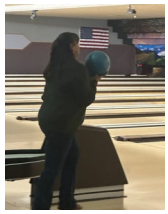
We have extended the service hours for the Same Day Surgery to 6:00 p.m. to accommodate later surgeries so that patients can have quality time to recover before going home.



For Fun:

This year in December the Surgical Services Department went bowling as a team building exercise. The Green River Bowling Alley was an excellent place to celebrate all the positive culture building that has been happening in the Surgery Department.





Community involvement:

Staff have participated in Red Tie Gala; Flaming George Day, Red Desert Round up, and Lighted Christmas Parades; the Truck-or-Treat at Halloween, and the Community Christmas at the hospital.

Career Education:

We continue to collaborate with Western Wyoming Community College to offer clinical experience to the nursing program. This year we have had 5 nursing students choose Surgical Services for their choice clinical.

We have participated in the Health Academy for the last 5 years. Hosting high school students provides the opportunity for those who are interested in healthcare a closer look. This year we incorporated a Farson Highschool student as well and look forward to doing so again this coming school year.


LOOKING
AHEAD
Teamwork
Goal
Leadership
Success
Business
Plan
Vision
Management
Achievement
Mission
Team
Organization
Strategy
Marketing
Successful
Development
Idea
Win
Company
Communication

Patient Experience

Offering a person-centered culture that provides kind and compassionate care to every patient, every time

Overall Goal

Continue to utilize our person-centered care culture to improve the patient experience and improve the satisfaction of our patients

Objective

Provide compassionate care for every life we touch for every patient, every time, aligning with the Mission, Vision and Values of MHSC

Measurement:

"Degree to which all staff showed compassion" - Improve HCAHPS score by 3 percentage points per year

Objective:

Improve patient experience and patient satisfaction scores

Measurement:

Improve HCAHPS scores by 3 percentage points per year in the following measures:
Hospital Environment
Discharge Information
Care Transitions

Strategic Initiatives

Build the capacity of our Directors through a formal training program. This will help create staff accountability to consistently live our mission, vision and values and utilize our service standards across the entire hospital. It will also help increase the engagement of the staff they manage. This will allow the senior leaders to have more time to focus on the strategic priorities of the organization

Dedicate one Senior Leadership meeting per month to the implementation and management of the 3-year strategic plan and working more strategically to communicate, coach, and lead the organization to achieve our overall goal

Quality & Safety

Providing patient-centered care that is evidence-based, reliable, timely, and strives for zero preventable harm, while keeping our patients and employees safe

Overall Goal

Improve CMS Star rating

Objective

Improve safety of care and timeliness of care

Measurement

To be within the top 10% in three measures in the Timeliness of Care domain.

Strategic Initiatives

Create a Process Improvement position that will require Lean training and will be responsible for leading efforts to improve patient safety, facilitate projects in and within departments that can guide continuous process improvement

Create a Patient and Staff Education Program

100% of clinical staff will complete TeamSTEPPS Training by the end of three years

In-house legal counsel will provide a "risk management minute" quarterly each year and provide a recording for all staff to ensure validation that it has been reviewed

Develop method that will allow Synergi to categorize reports and create ability to track and trend data

Utilize the Health Equity plan to promote the highest quality outcomes and safest care for all people.

Community, Services & Growth

Cultivating strong community partnerships and exploring, developing, and offering sustainable and easily accessible services, as we continue to meet and advance healthcare in Southwest Wyoming

Overall Goal

Maintain and improve our community presence, and enhance existing services as well as develop new services

Objective

Advance key areas identified in our community needs assessment

Measurement

Improve and establish outreach to community and outlying areas in the following areas:
Community education
Diabetes education
Care for the caregiver
Mental health

Objective

Improve our reputation in the community and outlying areas

Measurement

Improve from a Google 2-star rating to a Google 3-star rating by the end of three years

Strategic Initiatives

Utilize master plan to identify areas where we can provide outreach to outlying areas
Develop a strategic communication/ marketing plan that will increase the number of presentations for community education, nutrition management, sharing our successes more consistently and effectively and increasing the number of testimonials.
Increase the number of presentations that are made to the community and outlying areas
Increase number of community presentations

MHSC Strategic Plan

Employee Experience
Creating an environment where employees feel appreciated, safe, and supported and providing education and opportunities that will help them grow both personally and professionally

Overall Goal
Improve employee retention and employee satisfaction for a happier, healthier staff

Objective
Weave our culture through our Human Resources and management practices to recruit, reward, and retain staff committed to carrying out our mission

Measurement
Reduce staff turnover by 10% per year, using the current turnover rate
Improve our employee engagement scores by 3% per year

Strategic Initiatives
Hire a consultant to help us evaluate and review salaries at a minimum of every three years

Directors will attend a comprehensive program to further develop relationships across departments and support each other. Training will also include best practices for hiring, evaluating and mentoring staff. Senior Leaders and Human Resources will also learn to model, support and address performance gaps. The training will also include hiring, onboarding, evaluations, recognition, etc.) Training will be complete by the end of 2024.

Develop plan for success sharing bonus for employees if goals are reached

Financial Stewardship
Managing financial resources that will provide for the reinvestment in our people, services, physical facility buildings and grounds and our community

Overall Goal
Improve the organization's overall financial performance

Objective
Improve Revenue Cycle using CliftonLarsenAllen recommendations
Measurement
Improve Days of Cash on Hand by 10% each year for three years
Reduce and maintain Days in A/R to 45 days by the end of 2024
Maintain level of claims denials at state and national benchmarks
Reduce and maintain Days Not Final Billed (DNFB) at five days by the end of 2024

Objective
Work with County Commissioners to build County Maintenance Fund
Measurement
Build the MHSC County Maintenance Fund to $2,000,000 by the end of three years

Objective
Create and maintain (sinking fund, funded depreciation, building fund?)
Measurement
Build and maintain the building fund to the amount of depreciation expense by the end of three years

Objective
Reduce the number of traveler staff and hire permanent staff
Measurement
Decrease the number of Nursing and Respiratory Therapy travel staff by 30%, per year for three years

Strategic Initiatives
Work with the County Commissioners to set annual budget to achieve $2,000,000 goal over three-year strategic plan and still allow for adequate funds in annual budget for routine maintenance

Supplement the building fund from monthly, quarterly or annual contributions from cash flow from operations to achieve the total amount of depreciation expense by the end of three-year strategic plan

Nursing leadership will work with Human Resources to recruit and retain permanent staff and reduce travel staff by 30% per year

Template 2024-2027


Courage to Soar

MHSC Board of Trustees Report

July Report 2025

Business

- After meeting with the Hemsley Charitable Trust, we received a request for a business plan for a PET Scanner. Kayla is working with department leaders to gather information and will continue to work with the Hemsley team.
- WYOGIVES went well! The Foundations application was approved so all donations were boosted by the Hemsley Trust and we had two other match initiatives; donations were almost tripled. We raised over $29,000.
- Waldner House updates are in progress! We hope to have the deck finished by August 15th for our BBQ!
- Working with Tami Love and Gerry Johnston on furnishing needs/ progress for the new building; It looks amazing!

Grants/ Community Donations

- $50,000 donation **Approved** from Wyoming Community Foundation ($25,000 of this was applied in our overall WYOGIVES amount)
- $10,000 Grant **Approved** from Wyoming Cancer Program for a Survivorship Wellness project
- $6,000 ACS **Received** for transportation assistance
- $4,800 Grant **Received** in support for Cancer Survivors during "survivorship night."
- $10,000 Grant **Approved** for Breast Boutique for Breast Cancer patients

Upcoming Events

Waldner House BBQ- August 15th- It's a perfect opportunity to connect with others, share stories, and witness firsthand the impact of your support. Please RSVP to Kayla at kayla.mannikko@sweetwatermemorial.com

Casino Night- August 22nd at the Events Complex, Please take a Save the Date card from the meeting! Scan QR code for tickets/ sponsorships!

Report Submitted By: Kayla Mannikko

Building and Grounds Committee Meeting
July 15, 2025

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

In Attendance:
Mr. Marty Kelsey, *Trustee, Chairman*
Mr. Craig Rood, *Trustee*
Ms. Irene Richardson, *CEO*
Ms. Tami Love, *CFO*
Mr. Gerry Johnston, *Director of Facilities*
Mr. Steven Skorcz, *Facilities Supervisor*
Mr. Wayne Kitchen, *Groathouse Construction*
Mr. Taylor Jones, *SWC Commission Liaison*

Mr. Kelsey called the meeting to order.

Ms. Richardson shared a mission moment.

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

Mr. Kelsey called for a motion to approve the minutes for the June 17, 2025, meeting.
Mr. Rood moved to approve the minutes. Ms. Richardson seconded; the motion passed.

Maintenance Metrics

Mr. Johnston said they saw a slight decrease compared to the normal trend. They lost a staff member at the end of June which impacted some work orders at the end of the month. They are still having issues finding a vendor for flooring issues so have not been able to close those work orders which are significantly past due.

Old Business – Project Review

Medical Imaging Core and X-ray

Mr. Johnston reported flooring was being installed today and then they would complete the ceiling grid. The equipment vendor will be onsite on July 21 to start installing the new x-ray equipment. The closeout is scheduled for July 28 and the State will be here that week for final occupancy approval. Mr. Kitchen said there will be some miscellaneous items to complete after the equipment is installed. Mr. Kelsey asked if this project requires final approval from the State. Mr. Johnston said yes, we will need the State to grant occupancy before we can start training staff on the new equipment. The schedule and contingency list are included in the packet.

Laboratory Expansion project - SLIB

Mr. Johnston said the Laboratory project is moving along with the roof being completed last week and rough ins going in now. The wall between the old and new lab is being discussed and planned for demolition. Mr. Kitchen added they are working with PlanOne for some specific information on tying in the HVAC to the new space. Mr. Kelsey asked him what construction software they use. Groathouse uses Microsoft Project, and schedules are updated weekly. They are also updated on ProCore and they can give anyone access if they want. The current schedule was shared and Mr. Kitchen said it shows where we are now and updates as they complete each step. Mr. Kelsey asked if there are any known surprises like the long delay at the beginning with the sewar tie in. Mr. Kitchen said there is always a risk of delay as they tie into the existing building and infrastructure. Mr. Kelsey also asked about any supply chain issues. Mr. Kitchen said most of the building materials were purchased up front so they wouldn't have any delays. The only issue they are still having is for doors and door hardware. This started with COVID and has not gotten any better. Ms. Love said they are working on the request for the office and lobby furniture which has a placeholder in the capital budget. Mr. Rood asked about setting up a tour of the new space with both the Hospital and Foundation Boards. Mr. Johnston said he would like to wait until the sheetrock is complete and will work with Kayla Mannikko on scheduling. The schedule and contingency list are included in the packet.

MOB Entrance – SLIB

Mr. Johnston said the paving of the new parking and drop area was completed today which will give us back some parking spaces. Once the stairwell is complete, the front entrance will be shut down completely to start on the new entrance. They plan to start that phase by the end of the month. Mr. Kelsey asked how the project is moving along. Mr. Johnston said parking has been the main issue. The schedule and contingency list are included in the packet.

Mr. Kelsey asked if we had investigated getting competing bids for our parking lot maintenance. Mr. Rood shared information for another company last year. Mr. Johnston said they are still finishing up the approved paving projects from last fall but will start looking at competing bids for any new projects. He said he wants to move forward with a slurry seal this year.

OB Renovation – County

Mr. Johnston said PlanOne was onsite to look at scope and they are working on updated drawings. They will need to be submitted to the State for approval before putting out for bids, which could take about four weeks. Mr. Kelsey asked what the timeline was for this project. Ms. Richardson said we do have a working timeline in the Master Plan, and we would like to look at adding the locked unit option to the plans.

Master Plan

Ms. Richardson reviewed the working timeline of the projects. This will be updated as we get more information.

Tabled Projects

Foundation Area Renovation – Mr. Johnston said Plan One is also working with us to get some preliminary plans for moving Patient Financial Services into this space. We will un-table the projects from the Master Plan.

New Business

No new business was brought forward.

Other

The next meeting is scheduled for Tuesday, August 19, 2025; 2:30pm.

Mr. Kelsey adjourned the meeting at 3:00 pm.

Submitted by Tami Love

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: **ARCTIC WOLF SECURITY-Managed Detection and Response to Cyber Threats**

2. Purpose of contract, including scope and description: **Arctic Wolf is a market leader in IT Security Operations. Arctic Wolf's goal is to put security measures in place that will greatly minimize the impact of a cyber-attack. Arctic Wolf will provide a team that works with the IT department to provide 24/7 detection and response and ongoing risk management. Arctic Wolf aims to eliminate blind spots (anywhere a bad actor could get into our system) by providing proactive security assessments to consistently improve the Hospital's security stance and align with HIPAA.**

3. Effective Date: **The effective date is what allows your team to start onboarding/being protected by Arctic Wolf. The effective date is the date of the last signature on the agreement.**

    - **The Contract Start Date is when the billing begins for the annual payment in September.**

4. Expiration Date: **October 1, 2028.** Is this auto renew**? No**

5. Termination provisions: **Either Party may terminate for cause if the other Party commits a material breach of the Agreement. See Section 14. No termination provision for no-cause** Is this auto-renew? **No**

6. Monetary cost of the contract: **Year One $118,640.72; Year Two $118,400.72 Year three $118,400.72 for Total of $355,442.16 (For further detail see CompuNet Quote** Budgeted? **Yes**

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

8. Any confidentiality provisions**? Yes See Section 7.1 of Solution Agreement**

9. Indemnification clause present? **Yes See Section 9 of Solution Agreement**

10. Governmental Immunity Provision added? **Yes Provision 15.15 page13 of 14**

11. Is this contract appropriate for other bids? **Yes, the other bid came in at $190k annually.**

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

Arctic Wolf Solutions Agreement – Frequently Asked Questions

Thank you for reviewing the Arctic Wolf Solutions Agreement. We appreciate your interest in becoming a customer of Arctic Wolf. We hope the below information will help you better understand how Arctic Wolf's security solutions (the "Solution" or "Solutions") contracting model works.

Please note that this information is not considered part of the contract at any time. This is provided for information purposes only.

Who is Arctic Wolf?

- Arctic Wolf is a cybersecurity company that provides security operations Solutions, including managed detection and response, managed risk, and managed security awareness to mitigate our customers' exposure to cyber threats.
- We offer standard, highly configurable, Solutions to our customers which allows us to leverage the power of scale across our customer base to deliver cost effective and operationally efficient Solutions.
- Arctic Wolf's customers may subscribe to and license for the purchased Subscription Term the right to receive and use, in whole or in part, the various Solutions offered by Arctic Wolf. All customers subscribing to a particular Solution are on the same release using the same operational infrastructure and the same security and support operations for such Solution.

Who is the Authorized Partner?

Arctic Wolf leverages its channel partner relationships (its "Authorized Partners") to resell our Solutions to our customers. The Authorized Partner may be selected by you or introduced to you by Arctic Wolf.

The Authorized Partners act as the financial arm in our transactions with you. You contract directly with the Authorized Partner related to purchase and payment of your subscription to our Solutions. The Authorized Partners are not involved in the delivery of our Solutions and, therefore, are not contemplated in the obligations and liabilities within the Solutions Agreement related to the delivery of our Solutions to you. You and the Authorized Partner will have separate contractual terms in place to address the financial aspects of the subscription transaction.

What data do you provide to Arctic Wolf?

Arctic Wolf monitors systems telemetry data received from our customers via the sensors, scanners and agents our customers install within their environment. The systems telemetry data allows us to identify potential security threats that may impact your environment. Systems telemetry data may include names, email addresses, phone numbers, usernames, passwords IP Address, geolocation data, deviceID, and other system log metadata. Arctic Wolf should not receive other more sensitive information, including the content of your business files, your customer's business information, social security numbers, financial information, etc. We trust that our customers have appropriate system and operational controls in place to prevent disclosure of such information to us.

Why does Arctic Wolf reserve the right to change certain terms within the Solutions Agreement?

Like other subscription-based solutions providers, customer-generic terms that apply across our customer base are set forth as url links within the overarching Solutions Agreement. This allows Arctic Wolf to maintain consistency in the Solutions across its customers. To address any customer concerns related to this model, Arctic Wolf: (i) provides that the url terms are last in line from an order of precedence; (ii) agrees that we will not materially decrease the features and functionalities during any customer then-current Subscription Term; (iii) provides notice of the change; and (iv) allows customers to object to any specific modification for the remaining period of their then-current Subscription Term.

Does Arctic Wolf offer service levels?

Arctic Wolf provides for response time service levels. These service levels can be found in the Managed Detection and Response Solutions Terms located at https://arcticwolf.com/terms/. These terms are password protected. Please contact your sales representative for the password.

Does Arctic Wolf offer termination for convenience?

As a subscription Solution, Arctic Wolf does not allow for termination for convenience. Arctic Wolf relies on committed subscription terms, in part, to manage our dedicated CST resource model.

We have special data security requirements. Can we include our security and privacy requirements in the Solutions Agreement?

We are unable to include customer specific data security requirements in our Solutions Agreement. We offer a consistent Solution across our customer base. Arctic Wolf maintains the same IT security controls and processes for all customers. These controls and processes are reflected in our SOC2 Type II Report and its ISO 27001 certification.

Where is the Statement of Work for the services described in the Solutions Agreement?

Arctic Wolf's provides a subscription Solution that, depending on the Solution, is comprised of hardware, software and services. All designated components of the Solution are required to use and receive the Solutions. While services are an important part of the Solution, we do not define the services component of the Solutions as separate "professional services". Unlike a traditional professional service offering, the services do not include deliverables and are not subject to acceptance.

Can we make changes to the Beta Terms?

Because participation in the beta programs is completely voluntary and there is no cost for participation, we do not agree to modifications to the beta terms.

We are a Covered Entity under HIPAA. Can we use our Business Associate Agreement?

Arctic Wolf should not receive PHI during the delivery of the Solutions to you, nor does Arctic Wolf process PHI on your behalf. Accordingly, Arctic Wolf is not a business associate under HIPAA. Arctic Wolf appreciates that certain customers may take a conservative approach and require a business associate agreement (BAA) to cover the exchange of any inadvertently disclosed PHI provided during our relationship. Given this, Arctic Wolf is amenable to execution of its template BAA in which each party's liabilities and requirements are strictly construed to HIPAA requirements and incorporates such terms by url reference in the Solutions Agreement.

(For information purposes only, this FAQ does not form part of any contract)

SOLUTIONS AGREEMENT
(via Authorized Partner)

This Solutions Agreement (the "***Agreement***") is a legal agreement entered into by and between the Customer identified in the signature block below ("***Customer***") and Arctic Wolf Networks, Inc. ("***Arctic Wolf***") and governs any order forms, quotes, or other similarly intended ordering document (however named) executed or accepted by Customer ("***Order Form***") that reference this Agreement or pertains to purchases of an Arctic Wolf subscription. The Order Form will be issued to Customer by an Arctic Wolf authorized partner ("***Authorized Partner***"). This Agreement is effective on the date last executed in the signature block below (the "***Effective Date***"). This Agreement permits Customer to purchase subscriptions to the Solutions, as defined below, identified in the Order Form from its Authorized Partner, and sets forth the terms and conditions under which those Solutions will be delivered. The Agreement consists of the terms and conditions set forth below, any attachments or exhibits identified herein and any Order Forms that reference this Agreement. If there is a conflict between the terms below, the Order Form, or the terms set forth in an URL referenced herein pertaining to the Privacy Notice, Solutions Terms, and Acceptable Use Policy (such URL terms, the "***URL Terms***"), the documents will control in the following order: this Agreement, the Order Form, and the URL Terms. For the avoidance of doubt, any other terms referenced by URL herein (but excluding the URL Terms) shall solely govern the products and services described therein.

In consideration of the mutual covenants and agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. Scope.

1.1 Solutions. Customer will purchase and Arctic Wolf, together with its Affiliates, will provide the specific products and services either separately or as part of a Security Operations Bundle as described at https://arcticwolf.com/terms/bundles-tiers/ (each a "***Solution***" or collectively, "***Solutions***") as specified in the applicable Order Form. For purposes of this Agreement, ***"Affiliate"*** means any company or other entity, which directly or indirectly controls, is controlled by or is under joint control with a party.

A Solution will be comprised of the components ("***Components***") more fully-described within the Solutions Terms located at https://arcticwolf.com/terms/ ("***Solutions Terms***") as may be updated from time-to-time by Arctic Wolf in its sole discretion as needed to accommodate development, implementation, and deployment of new features and functionality and Customer's use and licensing thereof. Notice of any changes will be provided in accordance with Section 13 herein. In no event will any changes materially decrease the Solution features and functionalities that Customer has purchased or subscribed to during the then-current Term.

1.2 License Grant. The Solutions are provided on a subscription basis for a set term designated on the Order Form (each, a "***Subscription Term***") for the one-time costs and subscription fees set forth therein (the "***Fees***"). Provided Customer is compliant with the terms of this Agreement, including payment of Fees, Arctic Wolf grants to Customer a limited, non-transferable, non-sublicensable, non-exclusive right and/or license during the Subscription Term to install, use, and access the Solutions and the applicable Components thereof and any Documentation associated therewith, in accordance with the Solutions Terms. Customer's license and rights to install, access, and use the Solutions and any Documentation associated therewith, is solely for Customer's and its Affiliates' internal business purposes and subject to the additional use restrictions set forth herein and the maximum license numbers, including by server, user, or such other licensing metric designated in the applicable Order Form. "***Documentation***" means user manuals, training materials, product descriptions and specifications, and other printed information relating to the applicable Solution, as in effect and made generally available from Arctic Wolf, but expressly excluding marketing and sales collateral and materials, and proposals in whatever form.

1.3 Future Functionality. Subject to the warranties set forth in Section 10, Customer agrees that it has not relied on the promise of availability of any future functionality of the Solutions or any other future product or service in executing this Agreement or any Order Form. Customer acknowledges that information provided by Arctic Wolf regarding future functionality should not be relied upon to make a purchase decision. Should Arctic Wolf offer additional optional functionality in the future that complement the Solutions, Customer may elect to subscribe to and obtain a license to the optional functionality for an additional fee.

1.4 Except as otherwise provided herein, Customer understands and agrees that the Authorized Partner may not modify this Agreement, except in the event specifically and expressly stated within this Agreement related to pricing, payment, or such other similar financial terms, or make any commitments related to the delivery or performance of the Solutions on Arctic Wolf's behalf and any proposals, marketing collateral, or other similar Solution descriptions shall not apply.

1.5 Beta Solutions.

1.5.1 From time-to-time Arctic Wolf may invite Customer to try, at no charge, Arctic Wolf products, features, or functionality that are not generally available to Arctic Wolf's customers ("Beta Solutions"). Customer may accept or decline any such trial in its sole discretion. Any Beta Solutions will be clearly designated as beta, pilot, limited release, developer preview, non-production or by a description of similar import.

1.5.2 Restrictions and Disclaimers. Beta Solutions are provided for evaluation purposes and not for production use, are not supported, may contain bugs or errors, and may be subject to additional terms. To the full extent permitted by applicable laws, including any foreign consumer protection laws, Beta Solutions are not considered Solutions hereunder and are provided solely and exclusively "AS IS" with no express or implied warranty or terms and conditions, of any kind. TO THE FULL EXTENT PERMITTED BY APPLICABLE U.S. AND FOREIGN CONSUMER PROTECTION LAWS, (THE "CONSUMER PROTECTION LAWS"), CUSTOMER ASSUMES AND UNCONDITIONALLY RELEASES ARCTIC WOLF FROM ALL RISKS ASSOCIATED WITH THE USE OF ANY BETA SOLUTIONS. Arctic Wolf may discontinue the Beta Solutions at any time in its sole discretion and Arctic Wolf will make reasonable efforts to provide Customer with advanced notice of any such discontinuance. Arctic Wolf does not promise or represent that Beta Solutions will be made generally available.

1.5.3 NO DATA RETENTION. ANY DATA ENTERED INTO THE BETA SOLUTIONS MAY BE PERMANENTLY LOST UNLESS CUSTOMER: (i) PURCHASES A SUBSCRIPTION TO THE COMMERCIALLY AVAILABLE VERSION OF THE BETA SOLUTIONS AS MAY BE MADE AVAILABLE BY ARCTIC WOLF; OR (ii) TO THE EXTENT POSSIBLE, EXPORTS SUCH DATA PRIOR TO TERMINATION OF THE BETA SOLUTIONS.

1.5.4 LIMITED LIABILITY. TO THE FULL EXTENT PERMITTED BY LAW, INCLUDING THE CONSUMER PROTECTION LAWS, ARCTIC WOLF'S ENTIRE LIABILITY IN CONNECTION WITH ANY USE OF THE BETA SOLUTIONS WHETHER IN CONTRACT, TORT OR UNDER ANY OTHER THEORY OF LIABILITY, WILL NOT, AS TO ANY INDIVIDUAL CLAIM OR IN THE AGGREGATE, EXCEED $50 USD. IF CUSTOMER DOES NOT AGREE TO THE ALLOCATION OF RISK IN THIS SECTION, ITS SOLE RECOURSE IS TO IMMEDIATELY DISCONTINUE THE USE OF THE BETA SOLUTIONS.

1.5.5. Despite anything to the contrary in this Agreement, Customer acknowledges that (a) Beta Solutions may not be supported and may be changed at any time, including in a manner that reduces functionality, (b) Beta Solutions may not be available or reliable, and (c) Beta Solutions may not be subject to the same security or audits as the Solutions.

1.6 Incident Response Retainers. In the event Customer's Order Form and/or Bundle includes a license to an incident response retainer (either IR JumpStart Retainer or an Incident360 Retainer offering, collectively "Retainer"), Customer agrees that the applicable Retainer Agreement located at https://arcticwolf.com/terms/ pertaining to the specified Retainer shall apply. If Customer is a managed service provider plus Authorized Partner ("MSPP"), MSPP, as Customer, understands that the applicable Retainer Agreement is an agreement between Arctic Wolf and MSPP's end user and MSPP is reselling Retainer to its end user.

1.7 Security Operations Warranty. If Customer's Order Form includes the Arctic Wolf Security Warranty (the "***Service Warranty***"), upon finalization of the Order Form and for initial enrollment in the Service Warranty, Customer will receive a link with an embedded token from Arctic Wolf's third-party warranty provider. CUSTOMER MUST ENROLL IN THE SERVICE WARRANTY, RECEIVE AN ENROLLMENT CONFIRMATION EMAIL, AND AGREE TO THE SUBSCRIBER TERMS LOCATED AT https://arcticwolf.com/terms/subscriber-terms/ (the "***Subscriber Terms***") TO RECEIVE THE SERVICE WARRANTY BENEFIT. Execution or acceptance of the Order Form or this Agreement DOES NOT constitute enrollment in the Service Warranty. Indemnification amounts will be included on the enrollment and are subject to change in accordance with the Subscriber Terms in the event of any change in product subscriptions during the Subscription Term (or any Committed Term, as defined on the Order Form) and re-enrollment in the Service Warranty following the change may be required as more fully set forth in the Subscriber Terms. If the qualifying Order Form is renewed, Customer's initial enrollment in the Service Warranty will continue provided the qualifying indemnification level remains the same.

1.8 Cyber Resilience Assessment ("*CRA*"). Customer's use and license of CRA are governed by the terms set forth in the Cyber JumpStart Subscription Agreement located at https://arcticwolf.com/terms/cyber-jumpstart-portal-subscription-agreement/.

2. Equipment. If the Order Form specifies that Customer will receive Equipment, then Customer is responsible for installing the Equipment at the location(s) identified by the parties and for the implementation of appropriate data protection practices related to the protection of any information included on such Equipment while the Equipment is located within Customer's environment. The Equipment may be included as part of the Solutions and included with the subscription to the Solutions for use by Customer during the Subscription Term. If Customer attempts to install or use the Equipment at a location other than the locations determined by Customer and communicated to Arctic Wolf during onboarding or at any time thereafter, the Solutions may fail to function or may function improperly. In the event Customer installs, uses, or relocates the Equipment, Customer understands it must promptly notify Arctic Wolf so that Equipment deployment information can be updated within Customer's account. Other than normal wear and tear, Customer is directly responsible for the replacement cost of the Equipment associated with any loss, repair, or replacement, including any other ancillary costs, damages, fees, and charges to repair the Equipment. If applicable, Arctic Wolf will ship Equipment to Customer and will pay the freight costs associated with shipping the Equipment to Customer's designated locations. Customer is responsible for all additional costs and expenses associated with shipping the Equipment to its designated locations and, unless otherwise agreed, for the return of the Equipment to Arctic Wolf. Such additional costs and expenses may be reflected on an Order Form, from time-to-time following shipment of the Equipment and will be invoiced by Arctic Wolf or the Authorized Partner. Customer understands and agrees if the Equipment is shipped outside of the United States or Canada (or such other locations identified by Arctic Wolf), Customer is responsible for acting as the importer of record.

3. Professional Services. In the event Arctic Wolf and Customer agree on the delivery of Professional Services, any such Professional Services shall be specified on an Order Form and described in a statement of work which shall reference this Agreement.

4. Reservation of Rights and Ownership. Arctic Wolf owns or has the right to license the Solutions and any associated Documentation ("***Arctic Wolf Technology***"). Customer acknowledges and agrees that: (a) the Arctic Wolf Technology is protected by United States and international copyright, trademark, patent, trade secret and other intellectual property or proprietary rights laws; (b) Arctic Wolf retains all right, title and interest (including, without limitation, all patent, copyright, trade secret and other intellectual property rights) in and to the Arctic Wolf Technology, excluding any rights, title, and interest in any Third Party Products (as defined in Section 10.4 below) which shall be retained by its third party licensor(s), Threat Intelligence Data (as defined in Section 7.3), and any other deliverables, know-how, databases, developed programs, and registered or unregistered intangible property rights related to the foregoing; (c) there are no implied licenses and any rights not expressly granted to Customer hereunder are reserved by Arctic Wolf; (d) the Solutions, excluding any Professional Services, are licensed on a subscription basis, not sold, and Customer acquires no ownership or other interest (other than the license rights expressly stated herein); and (e) Customer has no right to obtain source code related to Software included in any Solutions offered as an on-line, hosted solution.

5. Restrictions, Responsibilities, and Prohibited Use.

5.1 Restrictions. Customer agrees not to, directly or indirectly: (i) modify, translate, copy or create derivative works of the Arctic Wolf Technology except as otherwise expressly permitted under applicable U.S. and international copyright laws ("Copyright Laws") which may not be excluded by agreement between the parties (to the extent that such actions cannot be prohibited because they are necessary to decompile the Solutions to obtain the information necessary to create an independent program that can be operated with the Solutions or with another program ("***Permitted Objective***"), they are only permitted provided that the information obtained by Customer during such activities: is not disclosed or communicated without Arctic Wolf's prior written consent to any third party to whom it is not necessary to disclose or communicate it in order to achieve the Permitted Objective; is not used to create any software that is substantially similar in its expression to the Solutions; is kept secure; and is used only for the Permitted Objective); (ii) reverse engineer, decompile, disassemble, or otherwise seek to obtain the intellectual property contained within Solutions, except as otherwise expressly permitted under the Copyright Laws which may not be excluded by agreement between the parties; (iii) interfere with or disrupt the integrity or performance of the Solutions or the data and information contained therein or block or

disrupt any use or enjoyment of the Solutions by any third party; (iv) attempt to gain unauthorized access to the Arctic Wolf Technology or related systems or networks; (v) remove or obscure any proprietary or other notice contained in the Arctic Wolf Technology, including on any reports or data printed from the Arctic Wolf Technology; (vi) use the Solutions in connection with a service bureau offering or as a service provider whereby Customer operates or uses the Solutions deployed within its environments for the benefit of any unrelated third party (excluding use with Customer's Affiliates, but including any end user or customer of Customer or Customer Affiliates); (vii) use the Solutions to monitor or scan any environments for which Customer has not received consent; or (viii) include material or information that is obscene, defamatory, libelous, slanderous, that violates any person's right of publicity, privacy or personality, or otherwise results in any tort, injury, damage or harm to any person. Customer agrees to abide by the terms of the Acceptable Use Policy at https://arcticwolf.com/terms/acceptable-user-policy, as may be updated from time-to-time in accordance with Section 13 below. If Arctic Wolf, in its reasonable discretion, determines that Customer's use of or access to the Solutions imposes an actual or imminent threat to the security or stability of Arctic Wolf's infrastructure or that Customer is abusing its use of the Solutions in contravention of the terms of this Agreement, Arctic Wolf may, in addition to any other right herein, temporarily suspend Customer's access to the Solutions, without liability except as otherwise provided by applicable laws including Consumer Protection Laws, until such activity is rectified. If commercially practicable, Arctic Wolf shall provide Customer with notice prior to any such suspension and shall work with Customer in good faith to reinstate the Solutions promptly.

5.2 Arctic Wolf Responsibilities. Arctic Wolf shall provide the Solutions Customer subscribes to as identified on an Order Form in accordance with the terms of this Agreement and as further described in the Solutions Terms. Any Software included within the Solutions shall include any updates, upgrades, bug fixes, version upgrades or any similar changes that are made generally available to Arctic Wolf's customers free of charge from time to time during the Subscription Term.

5.3. Customer Responsibilities. Customer is responsible for identifying the administrative users for its account which may include Customer's and its Affiliates' authorized (email authorization sufficient) third party service providers and agents ("***Administrators***"). Each Administrator will receive an administrator ID and password and will need to register with Arctic Wolf. Customer is responsible for registering and updating its Administrators, or notifying Arctic Wolf, as applicable, about changes to Administrators, including but not limited to termination, change of authority, and the addition of Administrators. Customer acknowledges and agrees that (i) Administrators will be able to view all Solutions Data (as defined in Section 7.2) and other traffic and activities that occur on Customer's network and that Customer is responsible for all activities that occur under Administrator accounts, and (ii) Administrators may communicate with Arctic Wolf using chat features within the Solution dashboards and such communications may be monitored and recorded by Arctic Wolf and the third party tool provider for purposes of customer service, quality assurance, and other business purposes set forth in the Privacy Notice located at https://arcticwolf.com/terms/privacy-notice-for-customers/ as may be updated from time to time by Arctic Wolf in accordance with Section 13 ("***Privacy Notice***") and Customer consents to such activity. Administrator IDs are granted to individual, named persons and cannot be shared or used by more than one Administrator but may be reassigned from time-to-time to new Administrators. Notwithstanding anything contrary herein, Customer understands and agrees that transmission of Solutions Data to Arctic Wolf may be impacted by in-country technical issues and requirements. Arctic Wolf will provide reasonable assistance to Customer in such instances but is not liable if the Solutions Data cannot be transmitted outside of such country. Customer is responsible for implementing appropriate internal procedures and oversight to the extent it utilizes the configuration of workflows and processes, including but not limited to containment actions, and similar functionalities in conjunction with the Services. Arctic Wolf may recommend Customer, depending on the scope of the deployment, implement software and services to enable features of the Solutions or to permit increased visibility into Customer's environment. Customer is responsible for making such determinations in its discretion and Arctic Wolf has no liability for Customer's decisions related thereto. Customer acknowledges that any changes Customer makes to its code, infrastructure, or configuration of the Solutions after initial deployment may cause the Solutions to cease working or function improperly or could prevent Arctic Wolf from delivering the Solutions and Arctic Wolf will have no responsibility for the impact of any such Customer changes. Customer understands that depending on the Solution deployed, a Solution may consume additional CPU and memory in Customer's environment while running in production.

5.4 Anti-corruption. In no event shall Arctic Wolf be obligated to take any action (including the shipping of any product or the provision of any service) or omit to take any action that Arctic Wolf believes in good faith would cause it to be in violation of any U.S. or international laws or regulations, including, without limitation, the U.S. Foreign Corrupt Practices Act (the "***FCPA***") or UK Bribery Act 2010. Neither party will (i) attempt to, directly or indirectly, improperly influence the sale or purchase of products by payments or other actions contrary to law or regulation, or (ii) take any action or permit or authorize any action that would violate or cause a party to violate the FCPA, the UK Bribery Act, or other applicable anti-corruption laws or regulations. Neither party will, for the purpose of influencing any act or decision to obtain or retain business or direct business to any person, pay, offer or promise to pay, or authorize the payment of, directly or indirectly, any money or anything of value to or for the use or benefit of any of the following: (a) any government official (including any person holding an executive, legislative, judicial or administrative office, whether elected or appointed, or any representative of any public international organization, or any person acting in any official capacity for or on behalf of any government, state-owned business or public organization); (b) any political party, official thereof, or candidate for political office; or (c) any other person if a party or any respective partner, officer, director, employee, agent, representative or shareholder of such party knows or has reason to suspect or know that any part of such money or thing of value will be offered, given, or promised, directly or indirectly, to any of the above-identified persons or organizations. Each party acknowledges and agrees that none of its officers, directors, employees, agents or representatives is a government official or employee or an official or employee of any department or instrumentality of any government, nor is any of them an officer of a political party or candidate for political office, who will share directly or indirectly any part of the sums that may be paid pursuant to performance of this Agreement; and each party agrees to immediately notify the other party should the foregoing change during the term of this Agreement. Each party represents and warrants that neither this Agreement nor the performance of or exercise of rights under this Agreement is restricted by, in conflict with, requires registration or approval or tax withholding under, or will require any termination or expiration, compensation, or any compulsory licensing under, any applicable law or regulation of any country or other governmental entity, and each party will not make any claim to the contrary (each party is relying on this representation and warranty, among other provisions of this Agreement, in entering this Agreement and would not enter this Agreement in its absence).

5.5 Trade Controls. Customer understands that the Solutions may be subject to the export control, economic sanctions, customs, import, and anti-boycott laws, regulations, and orders promulgated or enforced by Canada, the United States, the United Kingdom, Customer's jurisdictions of incorporation and operations, and any other country or governmental body having jurisdiction over the parties to this Agreement

("Trade Controls"). Customer shall ensure that the Solutions are not re-exported, provided or transferred to any person or entity listed on any restricted or prohibited persons list issued by Canada, the United States, the United Kingdom, Germany, or any governmental authority of any applicable jurisdiction, including but not limited to the Bureau of Industry and Security's Denied Persons, Entity, or Unverified List or the Office of Foreign Assets Control's Specially Designated Nationals and Blocked Persons List, Foreign Sanctions Evaders List, or Sectoral Sanctions Identifications List, or the UK Consolidated List of Financial Sanctions Targets (collectively, the "***Restricted Persons Lists***"). Customer represents and warrants that it and its shareholders, members, partners, or other owners are not listed on, or owned 50% or more, collectively or individually, by anyone on a Restricted Persons List. Customer shall not use the Solutions (a) for a military application, wherever located; or (b) with knowledge or reason to know that the Solutions will be used for nuclear, chemical, or biological weapons proliferation or (c) for any other end use or by any end user otherwise prohibited by applicable Trade Controls. Upon request by Arctic Wolf, Customer will complete and provide an end use certificate in the form requested by Arctic Wolf. Arctic Wolf may suspend and/or cancel the export, delivery, and or servicing of the Solutions, if: (i) Arctic Wolf has not received requested end-user certifications; (ii) Arctic Wolf has not received any government approvals required to comply with Trade Controls; or (iii) Arctic Wolf believes that such activity may violate any Trade Controls. If the Solutions are resold or transferred in violation of any Trade Controls or the provision of this Agreement, Arctic Wolf shall not be obligated to provide any warranty service or technical support for such Items.

5.6 Public Entity Customers. If Customer is a public entity, Customer acknowledges and agrees this Agreement is the sole set of terms governing the delivery of the Solutions to Customer and for the avoidance of doubt, any terms related to the acceptance of any services or work product shall not apply. The terms of any request for proposal(s), request for information, invitation to qualify, purchasing agreement or cooperative contract, or any other similar agreement Customer is using to purchase the Solutions (as defined above) from an Authorized Partner do not apply to Arctic Wolf. Further, Customer understands, and hereby consents, that Solutions Data may be accessed and processed by Arctic Wolf and its non-US Affiliates and their non-US citizen employees and resources and Arctic Wolf's authorized third-party service providers in the United States, Europe, Canada, Australia, or other locations around the world. Notwithstanding anything contrary in any other agreement or purchasing contract, Customer understands and agrees that during the Subscription Term, Arctic Wolf will maintain security controls and processes no less restrictive than those set forth in its SOC 2 Type II report and ISO 27001 certification. Customer is responsible for determining if Arctic Wolf's controls and processes comply with Customer's data handling and security policies.

Customer represents that in purchasing the Solutions, (i) Customer is not relying on Arctic Wolf for performance of a federal prime contract or subcontract and (ii) Customer is not receiving federal funds to purchase the Solutions. If Customer does intend to rely on Arctic Wolf Solutions to fulfill its obligations under a federal prime contract or subcontract or utilize federal funds to purchase the Solutions, Customer agrees to provide Arctic Wolf advance written notice of that intention, and Arctic Wolf shall have the option to terminate this Agreement.

Arctic Wolf Technology is a "commercial item", "commercial computer software" and "commercial computer software documentation," pursuant to DFARS Section 227.7202 and FAR Sections 12.211-12.212, as applicable. All Arctic Wolf Technology is and was developed solely at private expense and the use of Arctic Wolf Technology by the United States Government are governed solely by this Agreement and are prohibited except to the extent expressly permitted by this Agreement.

Customer represents it has the requisite authority to enter into and perform its obligations under this Agreement.

6. Fees, Payment, Taxes, and Audit. Pricing for the Solutions will be specified on an Order Form.

6.1 Fees, Payment, & Taxes. Customer will purchase the Solutions through the Authorized Partner. The Order Form and/or invoice containing terms related to fees, payment, taxes, audit, and any other related terms shall be between Customer and the Authorized Partner. Customer will pay any owed amounts to the Authorized Partner, as agreed between Customer and Authorized Partner. Customer agrees that Arctic Wolf may suspend or terminate Customer's use of the Solutions upon ten (10) days' written notice to Customer if Arctic Wolf does not receive payment of Fees from the Authorized Partner. The amounts paid by Authorized Partner to Arctic Wolf for Customer's use of the Solutions under this Agreement will be deemed the amount actually paid or payable under this Agreement for purposes of calculating Arctic Wolf's liability under Section 11. Customer's renewal pricing will be communicated to Customer by the Authorized Partner in accordance with the terms Customer has with the Authorized Partner or by Arctic Wolf prior to the renewal Subscription Term. If, in limited circumstances, Arctic Wolf invoices Customer directly for any fees, including but not limited to renewal subscription fees, incidental charges, such as international shipping costs, the following terms will apply:

All fees are payable in the currency set forth in the Order Form (or applicable invoice) and are non-cancelable and non-refundable EXCEPT AS REQUIRED BY CONSUMER PROTECTION LAWS, ARCTIC WOLF IS NOT OBLIGATED TO REFUND ANY FEES OR OTHER PAYMENTS ALREADY PAID, AND ANY CANCELLATION BY CUSTOMER WILL TAKE PLACE AT THE END OF THE APPLICABLE SUBSCRIPTION TERM, UNLESS ARCTIC WOLF OTHERWISE AGREES IN WRITING. Late payments shall bear interest at a rate equal to the maximum rate permitted by law. If Customer fails to make any payments due under this Agreement or an applicable Order Form, Arctic Wolf shall notify Customer of such nonpayment. If a payment that is due remains unpaid for ten (10) days after Arctic Wolf provides Customer with notice of such nonpayment, Arctic Wolf may cease providing the Solutions without any liability to Arctic Wolf. The amounts payable to Arctic Wolf are exclusive of any sales tax, use tax, excise tax, VAT, GST, HST, or similar taxes ("***Indirect Taxes***"). Customer is solely responsible for payment of all Indirect Taxes. If Customer is required to pay any Indirect Taxes, Customer shall pay such Indirect Taxes with no reduction or offset in the amounts payable to Arctic Wolf hereunder and Customer will pay and bear such additional amount as shall be necessary such that Arctic Wolf receives the full amount of the payment required as if no such reduction or offset were required. If Arctic Wolf has the legal obligation to pay or collect Indirect Taxes for which Customer is responsible, Customer authorizes Arctic Wolf to charge Customer for such amount. If Customer believes that Arctic Wolf has billed Customer incorrectly, Customer must contact Arctic Wolf no later than thirty (30) days after the closing date on the first billing statement in which the error or problem appeared to receive an adjustment or credit. Inquiries should be directed to Arctic Wolf's customer support department.

6.2 Audit. During the term of this Agreement and for one year thereafter, Customer shall provide Arctic Wolf, or its designated representative, promptly upon request with appropriate records requested by Arctic Wolf to verify Customer's compliance with the Agreement, including specifically its license numbers as set forth on an Order Form. Arctic Wolf, at its option, may require that an executive officer of Customer

certify in writing to Customer's compliance with this Agreement and disclose the scope of use of the Solutions by Customer. If, because of such audit, Arctic Wolf determines that Customer has exceeded the number of licenses subscribed to by Customer on an Order Form, Arctic Wolf will notify Customer of the number of additional licenses, along with the associated Subscription Fees prorated through the end of the then-current Subscription Term, and Customer will remit payment for such Subscription Fees in accordance with this Section 6.

7. Confidentiality; Data.

7.1 Confidentiality. Either party (as a "***Discloser***") may disclose confidential and proprietary information, orally or in writing ("***Confidential Information***") to the other party (as a "***Recipient***"). Confidential Information (a) shall be marked with a restrictive legend of the Discloser or, (b) if orally or visually disclosed to Recipient by Discloser, or disclosed in writing without an appropriate letter, proprietary stamp, or legend, shall be confidential if it would be apparent to a reasonable person that such information is confidential or proprietary. This Section 7 will supersede any non-disclosure agreement by and between the parties (whether entered before, on, or after the Effective Date) and such agreement will have no further force or effect with respect to Confidential Information defined herein. Confidential Information of Arctic Wolf includes the following: any pricing, trade secrets, know-how, inventions (whether or not patentable), techniques, ideas, or processes related to the Arctic Wolf Technology; the design and architecture of the Arctic Wolf Technology; the computer code, internal documentation, and design and functional specifications of the Arctic Wolf Technology; Arctic Wolf's security and privacy due diligence material such as SOC2 reports, security and privacy questionnaire responses & memos; and any intellectual property and know-how included in the problem reports, analysis, and performance information related to the Arctic Wolf Technology, and Threat Intelligence Data. Confidential Information of Customer may include the following:

(i) If the MA or MA+ Solution is deployed: First name, last name, corporate email address, phone number, job title, address, and organization hierarchy (collectively, "***Point of Contact information"***); User setup details (User email, work title, and name), Solution metrics related to such Users, including a Users' learning status, training scores, and Phishing results associated with such Users' use of the Solution (collectively "***Learner Data***"); if the Arctic Wolf Email Report Button is deployed by Customer, information pertaining to phishing email(s) self-reported by a User and includes or may include name of User, email address of User, json web token, full content of email, and version data (collectively, "***Phishtel Data***"); and Customer created and owned content, if any; and

(ii) If MDR and/or MR Solutions are deployed: Points of Contact Information (as defined in Section 7.1(i) above) and Solutions Data (as defined in Section 7.2 below).

Each party agrees to hold the other party's Confidential Information in strict confidence, not to disclose such Confidential Information to third parties not authorized by the Discloser to receive such Confidential Information, and not to use such Confidential Information for any purpose except as expressly permitted hereunder and as described in the Privacy Notice. Each party agrees to take commercially reasonable steps to protect the other party's Confidential Information and to ensure that such Confidential Information is not disclosed, distributed, or used in violation of the provisions of this Agreement. The Recipient may disclose Confidential Information only: (a) with the Discloser's prior written consent; or (b) to those employees, officers, directors, agents, consultants, third party service providers, and advisors with a clear and well-defined "need to know" purpose who are informed of and bound by confidentiality obligations no less restrictive than those set forth in this Section 7. Notwithstanding the foregoing, the Recipient may disclose Confidential Information to the extent required by law; however, the Recipient will give, to the extent legally permissible and reasonably practical, the Discloser prompt notice to allow the Discloser a reasonable opportunity to obtain a protective order and such Confidential Information disclosed to the extent required by law shall otherwise remain confidential and subject to the protections and obligations of this Agreement. For the avoidance of doubt, Arctic Wolf may share Customer's name with Customer's services providers to assist Customer in the resolution of technical issues pertaining to the Solutions. To the extent legally required, Arctic Wolf may report any violations of law pertaining to Customer's use of the Solutions. The Discloser agrees that the foregoing confidentiality obligations shall not apply with respect to any information that the Recipient can document is: (i) rightfully in its possession or known to it prior to receipt from the Discloser without an obligation of confidentiality; (ii) has become public knowledge through no fault of the Recipient; (iii) rightfully obtained by the Recipient from a third party without breach of any confidentiality obligation; or (iv) independently developed by employees of the Recipient who had no access to Discloser's Confidential Information. Upon expiration or termination of this Agreement for any reason, and except as otherwise provided in Section 14 below, each party shall promptly destroy all copies of the other party's Confidential Information and copies, notes or other derivative material relating to the Confidential Information. Notwithstanding the foregoing, and subject to the Privacy Notice, Arctic Wolf may retain Contract Account Information which may include Customer name, contact first name and last name, corporate email address, phone number, job title, address, and organization hierarchy following termination of this Agreement for its internal business purposes.

7.2 Solutions Data. "***Solutions Data***" means, depending on the Solution deployed, the operational system log data and any other information provided by Customer in furtherance of its use of the Solutions and which Customer may elect to submit to Arctic Wolf through the Solutions, including, but not limited to operational values, event logs, and network data such as flow, HTTPS, TLS, DNS metadata, cursory inventory data, operating systems and versions, users and groups from Active Directory, system level inventory, event data, and network vulnerability data, but excluding Threat Intelligence Data (as defined below). As between the parties, Customer shall retain all right, title, and interest (including all intellectual property rights) in and to the Solutions Data (excluding any Arctic Wolf Technology used with the Solutions Data). Customer hereby grants Arctic Wolf, during the term of the Agreement, a non-exclusive, worldwide, royalty-free right to collect, use, copy, store, transmit, modify, and create derivative works of the Solutions Data to provide the Solutions to Customer. The location of the storage of raw Solutions Data within Arctic Wolf's third-party service providers' data centers will be as set forth in the Solutions Terms.

7.3 Threat Intelligence Data. "*Threat Intelligence Data*" means any malware, spyware, virus, worm, trojan, or other potentially malicious or harmful code or files, URLs, DNS data, public IP addresses, network telemetry, commands, processes or techniques, tradecraft used by threat actors, metadata, or other information or data, in each case that is potentially related to unauthorized third parties associated therewith and that: (i) Customer provides to Arctic Wolf in connection with this Agreement, or (ii) is collected or discovered during the course of Arctic Wolf providing Solutions, excluding any such information or data that identifies Customer or to the extent that it includes Personal Information (as defined below) of the data subjects of Customer (but including personal information of threat actors or as otherwise provided in the Privacy Notice).

8. Data Privacy.

8.1 Personal Information. Point of Contact Information, Solutions Data, Learner Data, and Phishtel Data (or any other Confidential Information provided by Customer) may include information that identifies, relates to, describes, is reasonably capable of being associated with

or linked to a particular individual, whether directly or indirectly ("***Personal Information***"). Customer is responsible for the lawfulness of any such Personal Information and Arctic Wolf's receipt, use, and processing of it under the Agreement. Customer represents and warrants that, where it provides Personal Information to Arctic Wolf or requests Arctic Wolf collect or process such information, it (1) has complied with any applicable laws relating to the collection or provision of such information, (2) possesses any consents, authorizations, rights and authority, and has given all required notices to individual data subjects as are required to transfer or permit Arctic Wolf to collect, receive, or access any Personal Information, and (3) to the extent required by applicable law, has informed the individuals of the possibility of Arctic Wolf processing their Personal Information on Customer's behalf and in accordance with its instructions.

8.2 European Union and United Kingdom General Data Protection Regulation. If and to the extent Customer submits to Arctic Wolf personal data (as that term is defined under the General Data Protection Regulation and its UK equivalent ("***GDPR***")) of individuals located in the European Economic Area or United Kingdom, the Arctic Wolf Data Processing Agreement available at https://arcticwolf.com/terms/dpa/, as may be updated by Arctic Wolf from time-to-time in accordance with its terms (the "***DPA***"), shall be executed by Customer and upon execution and return to Arctic Wolf in accordance with its terms will be incorporated into this Agreement. It is Customer's sole responsibility to notify Arctic Wolf of requests from data subjects related to the modification, deletion, restriction and/or objection to processing of personal data. Customer represents and warrants that any processing of personal data in accordance with its instructions is lawful.

8.3 California Consumer Privacy Act. The parties acknowledge and agree that Arctic Wolf is a service provider for the purposes of the California Consumer Privacy Act, as supplemented by the California Privacy Rights Act (collectively, the "***CCPA***") and may receive personal information (as defined by the CCPA) from Customer pursuant to this Agreement for the provision of certain purchased or licensed cybersecurity operations solutions and/or services as chosen by Customer and reflected on an Order Form (the "***Business Purpose***"). The parties agree to always comply with the applicable provisions of the CCPA in respect to the collection, transmission, and processing of all personal information (as defined by the CCPA) exchanged or shared pursuant to the Agreement. Arctic Wolf shall not (i) sell any such personal information; (ii) retain, use or disclose any personal information provided by Customer pursuant to this Agreement except as necessary for the specific purpose of performing and/or delivering the Business Purpose to Customer pursuant to this Agreement or as permitted by the CCPA, as well as any support and other ancillary services (including, without limitation, services to prevent or address service or technical problems) related to the Solutions; (iii) retain, use, or disclose such personal information for a commercial purpose other than performing the Business Purpose unless otherwise explicitly permitted under the Agreement; (iv) retain, use, or disclose such personal information outside of the direct business relationship between Customer and Arctic Wolf for the Business Purpose unless otherwise permitted under the Agreement; or (v) combine any such personal information with personal information that it receives from or on behalf of any other person(s) or collects from its own interaction with the consumer, provided that Arctic Wolf may combine personal information to perform any purpose as defined in and as permitted under the CCPA. Arctic Wolf further agrees that it will: (i) comply with all applicable obligations under the CCPA and Arctic Wolf will provide the same level of privacy protection as is required by the CCPA; (ii) allow Customer to take reasonable and appropriate steps to help to ensure that Arctic Wolf uses personal information in a manner consistent with Customer's obligations under the CCPA; and (iii) allow Customer, upon notice, to take reasonable and appropriate steps to stop and remediate unauthorized use of personal information. The terms "personal information," "consumer", "service provider," "sale," "share," and "sell" are as defined in Section 1798.140 of the CCPA. Arctic Wolf certifies that it understands the restrictions of this Section 8.3 and will comply with them and will notify Customer if Arctic Wolf decides that it can no longer meet its obligations under the CCPA. It is Customer's sole responsibility to notify Arctic Wolf of any requests from consumers (as defined in the CCPA) seeking to exercise rights afforded in the CCPA regarding personal information received or processed in connection with the Solutions. Arctic Wolf agrees to provide reasonable cooperation to Customer in connection with such requests.

8.4 Canadian Privacy Laws. If and to the extent Customer submits to Arctic Wolf personal information (as that term is defined under applicable Canadian privacy laws, being all applicable federal, and provincial laws and regulations relating to the processing, protection or privacy of personal information ("**Privacy Laws**"), of individuals located in Canada, Customer agrees that it is solely responsible for and shall obtain from all such individuals, all required consents and/or provide all required notifications, regarding the collection, use, disclosure, and processing of their personal information by Arctic Wolf/Arctic Wolf's subcontractors/third party service providers (which may be located outside of Canada), and/or the transfer by Customer of such individual's personal information to Arctic Wolf/Arctic Wolf's subcontractors/third party service providers (which may be located outside of Canada). Upon request of Customer, Arctic Wolf will inform Customers of the locations to which the personal information is transferred and processed by Arctic Wolf and/or its subcontractors/third party service providers.

Customer retains control of the personal information and remains solely responsible for its compliance with Privacy Laws and for the processing instructions it gives to Arctic Wolf. The parties agree that this Agreement, together with Customer's use of the Solution in accordance with this Agreement, constitutes Customer's instructions to Arctic Wolf in relation to the processing of such personal information. Subject to Section 8.1 of this Agreement, Arctic Wolf will only process the personal information to the extent, and in such a manner, as is necessary for the performance of the Solutions. Arctic Wolf will reasonably assist Customer with meeting the Customer's compliance obligations under applicable Privacy Laws, considering the nature of Arctic Wolf's processing and the information available to Arctic Wolf.

Arctic Wolf shall:

- Comply with its obligations as a third-party service provider/mandatory under applicable Privacy Laws, including by implementing appropriate technical, physical and organizational measures to safeguard the personal information;
- Periodically conduct audits of its information security controls for facilities and systems used to deliver the Solutions and make relevant audit reports available to Customer for review. The Customer will treat such audit reports as Arctic Wolf's Confidential Information;
- Within seventy-two (72) hours of discovery notify Customer of any unauthorized or unlawful access to or processing of the personal information;
- Limit access to those employees who require the personal information access to meet Arctic Wolf's obligations under this Agreement and ensure that all employees are informed of the personal information's confidential nature;
- Notify Customer if it receives any complaint, notice, or communication that directly or indirectly relates to the personal information processing or to either party's compliance with Privacy Laws, and provide its full co-operation and assistance in responding to such complaint, notice or communication; and

- Upon Customer's request, provide the Customer a copy of or access to all or part of the Customer's personal information in its possession or control in the format reasonably agreed to by the parties.

8.5 Australian Privacy Laws. If and to the extent Customer submits to Arctic Wolf personal information (as that term is defined in the Australian *Privacy Act 1988* (Cth)) on your behalf, as agent for you, Arctic Wolf will only handle your personal information for the purpose of performing the Solutions, in accordance with the Privacy Notice or as required by applicable law, and ensuring you have access to your Solutions Data in accordance with this Agreement. Customer will maintain effective control of how Solutions Data is handled by retaining the right to access, changing and retrieving Solutions Data, limiting others' use of Solutions Data and specifying security measures that are used in relation to Solutions Data as set forth in this Agreement, including the Privacy Notice.

8.6 South African Privacy Laws. If and to the extent Customer submits to Arctic Wolf personal information (as that term is defined in the Protection of Personal Information Act, 4 of 2013) of individuals located in South Africa, Customer agrees that it is solely responsible for and shall obtain from all such individuals, all required consents and/or provide all required notifications, regarding the collection, use, disclosure, and processing of their personal information by Arctic Wolf/Arctic Wolf's subcontractors/third party service providers (which may be located outside of South Africa, and/or the transfer by Customer of such individual's personal information to Arctic Wolf/Arctic Wolf's subcontractors/third party service providers (which may be located outside of South Africa). Upon request of Customer, Arctic Wolf will inform Customers of the locations to which the personal information is transferred and processed by Arctic Wolf and/or its subcontractors/third party service providers. Arctic Wolf will only handle personal information for the purpose of performing the Solutions and ensuring Customer has access to its Solutions Data in accordance with this Agreement. Customer will maintain effective control of how Solutions Data is handled by retaining the right to access, changing, and retrieving Solutions Data, limiting others' use of Solutions Data. Arctic Wolf shall take appropriate, reasonable technical and organizational security measures to prevent the loss of, damage to or unauthorized destruction of personal information, and the unlawful access to or processing of personal information.

9. Indemnity.

9.1 Arctic Wolf's Indemnity. Subject to Section 9.3, Arctic Wolf will defend and indemnify Customer from any unaffiliated third-party claim or action to the extent based on the allegation that the Solutions infringe any intellectual property right (patents, utility models, design rights, copyrights and trademarks or any other intellectual property right) having effect in the United States, Canada, Australia, United Kingdom, Switzerland, South Africa, and the European Union. Arctic Wolf will pay any settlements that Arctic Wolf agrees to in writing signed by an authorized officer of Arctic Wolf or final judgments awarded to the third-party claimant by a court of competent jurisdiction. The foregoing obligations do not apply with respect to the Solutions, or portions or components thereof, that are: (a) not provided by Arctic Wolf; (b) combined with other products, processes or materials that are not reasonably contemplated by the Documentation where the alleged infringement relates to such combination; (c) modified other than with Arctic Wolf's express consent; (d) used after Arctic Wolf's notice to Customer of such activity's alleged or actual infringement; or (e) not used by Customer in strict accordance with this Agreement or the published Documentation. The indemnification obligations set forth in this Section 9.1 are Arctic Wolf's sole and exclusive obligations, and Customer's sole and exclusive remedies, with respect to infringement or misappropriation of third-party intellectual property rights of any kind.

9.2 Customer Indemnity. Subject to Section 9.3, Customer agrees to defend and indemnify Arctic Wolf from any third-party claim or action brought against Arctic Wolf to the extent based on Customer's alleged breach of Sections 5 or 8. Customer agrees to pay any settlements that Customer agrees to in a writing signed by an authorized officer of Customer, or final judgments awarded to the third-party claimant by a court of competent jurisdiction.

9.3 Procedures. Each party's indemnification obligations are conditioned on the indemnified party: (a) providing the indemnifying party with prompt written notice of any claim, provided that the failure to provide such notice shall only limit the indemnifying party's obligation to indemnify to the extent that the failure prejudices the indemnifying party in its defense of the claim; (b) granting the indemnifying party the sole control of the defense or settlement of the claim; and (c) providing reasonable information and assistance to the indemnifying party in the defense or settlement of the claim at the indemnifying party's expense. Notwithstanding the foregoing, the indemnifying party (i) may not make an admission of fault on behalf of the other party without written consent, (ii) any settlement requiring the party seeking indemnification to admit liability requires prior written consent, not to be unreasonably withheld or delayed, and (iii) the other party may join in the defense with its own counsel at its own expense.

9.4 Options. If Customer's use of the Solutions has become, or in Arctic Wolf's opinion is likely to become, the subject of any claim of infringement, Arctic Wolf may at its option and expense: (a) procure for Customer the right to continue using and receiving the Solutions as set forth hereunder; (b) replace or modify the Solutions to make them non-infringing; (c) substitute an equivalent for the Solutions; or (d) if Arctic Wolf, in its sole discretion, determines that options (a)-(c) are not reasonably practicable, terminate this Agreement and refund any pre-paid unused Fees as of the effective date of termination.

10. Warranty and Warranty Disclaimer.

10.1 Solutions Warranty. ARCTIC WOLF WARRANTS THAT DURING THE SUBSCRIPTION TERM AND PROVIDED THAT CUSTOMER IS NOT IN BREACH OF THIS AGREEMENT OR AS OTHERWISE PROHIBITED BY CONSUMER PROTECTION LAWS INCLUDING ANY CUSTOMER RIGHTS UNDER SUCH CONSUMER PROTECTION LAWS THAT: (I) THE SOLUTIONS PROVIDED UNDER THIS AGREEMENT DO NOT INFRINGE OR MISAPPROPRIATE ANY INTELLECTUAL PROPERTY RIGHTS OF ANY THIRD PARTY; (II) THE SOLUTIONS SHALL SUBSTANTIALLY PERFORM AS DESCRIBED IN THE DOCUMENTATION; AND (III) IT WILL COMPLY WITH ALL INTERNATIONAL, PROVINCIAL, FEDERAL, STATE AND LOCAL STATUTES, LAWS, ORDERS, RULES, REGULATIONS AND REQUIREMENTS, INCLUDING THOSE OF ANY GOVERNMENTAL (INCLUDING ANY REGULATORY OR QUASI-REGULATORY) AGENCY APPLICABLE TO ARCTIC WOLF AS IT PERTAINS TO ITS OBLIGATIONS AND THE DATA REQUIRED FOR THE PERFORMANCE OF THE SOLUTIONS DESCRIBED HEREIN. IN THE EVENT OF ANY BREACH OF THIS SECTION 10.1, ARCTIC WOLF SHALL, AS ITS SOLE LIABILITY AND CUSTOMER'S SOLE REMEDY (OTHER THAN ARCTIC WOLF'S INDEMNIFICATION OBLIGATIONS IN SECTION 9.1 ABOVE, OR OTHERWISE PROHIBITED BY CONSUMER PROTECTION LAWS OR PROVIDED IN SECTION 10.3 OF THIS AGREEMENT), REPAIR OR REPLACE THE SOLUTIONS THAT ARE SUBJECT TO THE WARRANTY CLAIM AT NO COST TO CUSTOMER OR IF ARCTIC WOLF IS UNABLE TO REPAIR OR REPLACE, THEN ARCTIC WOLF WILL REFUND ANY PRE-PAID FEES FOR THE SOLUTIONS, OR PARTS THEREOF, SUBJECT TO THE

WARRANTY CLAIM. EXCEPT FOR THE WARRANTIES DESCRIBED IN THIS SECTION, THE SOLUTIONS ARE PROVIDED WITHOUT WARRANTY, TERMS, OR CONDITIONS OF ANY KIND, EXPRESS OR IMPLIED, AND ANY WARRANTIES OF TITLE. CUSTOMER ACKNOWLEDGES THAT THE SOLUTIONS ARE PROVIDED "AS IS" AND FURTHER ACKNOWLEDGES THAT ARCTIC WOLF DOES NOT WARRANT THAT: (A) THE OPERATION OF THE SOLUTIONS WILL BE UNINTERRUPTED, OR ERROR FREE; OR (B) THE SOLUTIONS ARE NOT VULNERABLE TO FRAUD OR UNAUTHORIZED USE. CUSTOMER IS RESPONSIBLE AND ARCTIC WOLF SHALL HAVE NO RESPONSIBILITY FOR DETERMINING THAT THE USE OF THE SOLUTIONS COMPLIES WITH APPLICABLE LAWS IN THE JURISDICTION(S) IN WHICH CUSTOMER MAY DEPLOY AND USE THE SOLUTIONS.

10.2 No Guarantee. CUSTOMER ACKNOWLEDGES, UNDERSTANDS, AND AGREES THAT ARCTIC WOLF DOES NOT GUARANTEE OR WARRANT THAT IT WILL FIND, LOCATE, OR DISCOVER ALL OF CUSTOMER'S SYSTEM THREATS, VULNERABILITIES, MALWARE, AND MALICIOUS SOFTWARE, OR THAT ALL SUCH SYSTEM THREATS, VULNERABILITIES, MALWARE, AND MALICIOUS SOFTWARE CAN OR WILL BE CONTAINED OR UNCONTAINED IN THE DELIVERY OF THE SOLUTIONS. CUSTOMER ACKNOWLEDGES THAT CERTAIN FEATURES AND ACTIVITIES PERFORMED BY ARCTIC WOLF AND MORE FULLY DESCRIBED IN THE SOLUTIONS TERMS COULD POSSIBLY RESULT IN INTERRUPTIONS OR DEGRADATION TO CUSTOMER'S SYSTEMS AND ENVIRONMENT AND ACCEPTS THOSE RISKS AND CONSEQUENCES. CUSTOMER ASSUMES ALL RISKS ASSOCIATED WITH ANY THIRD-PARTY SYSTEMS (NOT INCLUDING THIRD PARTY PRODUCTS AS DEFINED IN SECTION 10.4 BELOW) OR SERVICES, INCLUDING ANY CLOUD IAAS AND SAAS SYSTEMS, TOOLS, AND/OR ENVIRONMENTS AND ANY DIAGNOSTIC TOOLS, API'S, AND OTHER SUCH INTEGRATIONS, THAT CUSTOMER USES OR DEPLOYS IN CONNECTION WITH THE DELIVERY OF THE SOLUTIONS.

10.3 Open Source Warranty. Customer acknowledges that certain components of the Solutions ("Open Source Components") may be covered by so-called "open source" software licenses, which means any software licenses approved as open source licenses by the Open Source Initiative (or any substantially similar licenses). Arctic Wolf hereby represents and warrants that all Open Source Components in the Solutions will be provided to Customer by Arctic Wolf hereunder in a manner compliant with their applicable open source licenses. To the extent required by the licenses covering third party Open Source Components, the terms of such licenses will apply to such Open Source Components in lieu of the terms of this Agreement. To the extent the terms of the licenses applicable to third party Open Source Components prohibit any of the restrictions in this Agreement with respect to such Open Source Component, such restrictions will not apply to such Open Source Component.

10.4 Third-Party Products. Third-Party Products (as defined in this Section 10.4) may carry a limited warranty from the third-party publisher, provider, or original manufacturer of such Third-Party Products. To the extent required or allowed, Arctic Wolf will pass through to Customer or directly manage for the benefit of Customer's use of the Third-Party Products as part of the Solutions (such decision to be made in Arctic Wolf's discretion), the manufacturer warranties related to such Third-Party Products. "Third-Party Products" means any non-Arctic Wolf branded products and services (including Equipment, and any operating system software included therewith) and non-Arctic Wolf-licensed software products, including Open Source Components.

10.5 Customer Warranties. Customer represents and warrants that it shall: (i) be responsible for ensuring the security and confidentiality of all Administrator IDs and passwords; (ii) use commercially reasonable endeavors to prevent unauthorized access to, or use of, the Solutions; (iii) notify Arctic Wolf promptly upon discovery of any unauthorized use of the Solutions or any breach, or attempted breach, of security of the Solutions; (iv) not violate any international, provincial, federal, state and local statutes, laws, orders, rules, regulations and requirements applicable to Customer's performance of its obligations herein, including those of any governmental (including any regulatory or quasi-regulatory) agency, Trade Control laws, and regulations and the FCPA and UK Bribery Act 2010; (v) not use the Solutions or transfer any Solutions Data to Arctic Wolf for any fraudulent purposes; and (vi) implement safeguards within Customer's environment to protect the Solutions, including specifically, the Equipment, from the introduction, whether intentional or unintentional, of: (1) any virus or other code, program, or sub-program that damages or interferes with the operation of the Equipment or halts, disables, or interferes with the operation of the Solutions; or (2) any device, method, or token whose knowing or intended purpose is to permit any person to circumvent the normal security of the Solutions. Customer authorizes Arctic Wolf to perform Services (and all such tasks and tests reasonably contemplated by or reasonably necessary to perform the Services) on network resources with the internet protocol addresses or other designated identifiers identified by Customer. Customer represents that, if Customer does not own such network resources, it will have obtained consent and authorization from the applicable third party to permit Arctic Wolf to provide the Services on such third party's network resources.

11. Limitation of Liability.

11.1 TO THE FULL EXTENT PERMITTED BY LAW AND SUBJECT TO SECTION 11.2 BELOW, FOR ANY CAUSE RELATED TO OR ARISING OUT OF THIS AGREEMENT, WHETHER IN AN ACTION BASED ON A CONTRACT, TORT (INCLUDING NEGLIGENCE AND STRICT LIABILITY) OR ANY OTHER LEGAL THEORY, HOWEVER ARISING, ARCTIC WOLF WILL IN NO EVENT BE LIABLE TO CUSTOMER OR ANY THIRD PARTY FOR: (A) DAMAGES BASED ON USE OR ACCESS, INTERRUPTION, DELAY OR INABILITY TO USE THE SOLUTIONS, LOST REVENUES OR PROFITS, LOSS OF SOLUTIONS, BUSINESS OR GOODWILL, LOSS OR CORRUPTION OF DATA, LOSS RESULTING FROM SYSTEM FAILURE, MALFUNCTION OR SHUTDOWN, FAILURE TO ACCURATELY TRANSFER, READ OR TRANSMIT INFORMATION, FAILURE TO UPDATE OR PROVIDE CORRECT INFORMATION, SYSTEM INCOMPATIBILITY OR PROVISION OF INCORRECT COMPATIBILITY INFORMATION, BREACHES BY AN AUTHORIZED PARTNER, OR BREACHES IN CUSTOMER'S SYSTEM SECURITY; OR (B) ANY INDIRECT, SPECIAL, INCIDENTAL, OR CONSEQUENTIAL DAMAGES; OR (C) ANY AMOUNTS THAT EXCEED THE TOTAL FEES PAID OR PAYABLE BY CUSTOMER FOR THE SOLUTIONS THAT ARE THE SUBJECT OF THE CLAIM PERTAINING TO THE TWELVE (12) MONTH PERIOD IMMEDIATELY PRIOR TO THE EVENT WHICH GIVES RISE TO SUCH DAMAGES. THESE LIMITATIONS SHALL APPLY WHETHER OR NOT ARCTIC WOLF HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES AND NOTWITHSTANDING ANY FAILURE OF ESSENTIAL PURPOSE OF ANY LIMITED REMEDY. BOTH PARTIES UNDERSTAND AND AGREE THAT THE LIMITATIONS OF LIABILITIES FOR EACH PARTY SET FORTH IN THIS AGREEMENT ARE REASONABLE AND THEY WOULD NOT HAVE ENTERED INTO THE AGREEMENT WITHOUT SUCH LIMITATIONS. THE FOREGOING LIMITATIONS OF LIABILITY IN THIS SECTION 11, WITH RESPECT TO ARCTIC WOLF AUSTRALIAN CUSTOMERS, ARE SUBJECT TO THE *COMPETITION AND CONSUMER ACT 2010 (CTH) SCH 2* AND SECTION 11.2 OF THIS AGREEMENT.

11.2 FOR CUSTOMERS DEEMED "CONSUMERS" AS DEFINED BY THE *COMPETITION AND CONSUMER ACT 2010 (CTH) SCH 2,* SECTION 11.1 IS REPLACED IN ITS ENTIRETY WITH THE FOLLOWING:

TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW ARCTIC WOLF SHALL NOT BE LIABLE TO CUSTOMER (UNDER ANY THEORY OF LIABILITY, WHETHER IN CONTRACT, STATUTE, TORT OR OTHERWISE) FOR: (A) ANY LOST PROFITS, REVENUE, OR SAVINGS, LOST BUSINESS OPPORTUNITIES, LOST DATA, OR SPECIAL, INCIDENTAL, CONSEQUENTIAL, OR PUNITIVE DAMAGES, EVEN IF ARCTIC WOLF HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES OR LOSSES OR SUCH DAMAGES OR LOSSES WERE REASONABLY FORESEEABLE; OR (B) AN AMOUNT THAT EXCEEDS THE TOTAL FEES PAID OR PAYABLE BY CUSTOMER FOR THE SOLUTIONS THAT ARE THE SUBJECT OF THE CLAIM DURING THE TWELVE (12) MONTH PERIOD IMMEDIATELY PRIOR TO THE EVENT WHICH GIVES RISE TO SUCH DAMAGES. THESE LIMITATIONS WILL APPLY NOTWITHSTANDING ANY FAILURE OF ESSENTIAL PURPOSE OF ANY REMEDY SPECIFIED IN THESE TERMS. MULTIPLE CLAIMS SHALL NOT EXPAND THE LIMITATIONS SPECIFIED IN THIS SECTION 11.2. THIS SECTION 11.2 DOES NOT SEEK TO LIMIT OR EXCLUDE THE LIABILITY OF ARCTIC WOLF OR ITS AFFILIATES IN THE EVENT OF DEATH OR PERSONAL INJURY CAUSED BY ITS NEGLIGENCE OR FOR FRAUD OR FOR ANY OTHER LIABILITY FOR WHICH IT IS NOT PERMITTED BY LAW TO EXCLUDE. TO THE EXTENT APPLICABLE, THIS PROVISION MUST BE READ SUBJECT TO THE *COMPETITION AND CONSUMER ACT 2010 (CTH) SCH 2*.

12. Term and Renewal. This Agreement shall be in effect for the Subscription Term specified in the Order Form. Unless otherwise set forth on the Order Form, the Subscription Term for the Solutions, in its entirety, will automatically renew at the end of the initial Subscription Term for the same period of time as the initial Subscription Term, but in no event more than a twelve (12) month term, and subject to the then-current terms and price at the time of renewal; provided however, if either party would like to opt out of automatic renewal of the Subscription of the Solutions or reduce Subscription scope, then such party must notify the other party no less than sixty (60) days prior to the expiration of the then-current Subscription Term.

13. Updates. Arctic Wolf reserves the right to modify this Agreement, the URL Terms, and the Documentation in Arctic Wolf's sole discretion or as otherwise set forth in the respective URL Terms. Should Arctic Wolf make any modifications, Arctic Wolf will post the amended terms on the applicable URL links, update the ***"Last Updated Date"*** within such documents, and notify Customer via email or such other direct written communication method implemented by Arctic Wolf from time-to-time. Customer may notify Arctic Wolf within 30 days after the effective date of the change of its rejection of such change. If Customer notifies Arctic Wolf of its rejection during such thirty (30) day period, then Customer will remain governed by the terms in effect immediately prior to the change until the end of Customer's then-current Subscription Term. However, any subsequent renewal of the Subscription Term will be renewed under the then-current Agreement, URL Terms, and/or Documentation for such applicable Solutions, unless otherwise agreed in writing by the parties.

14. Termination. Either party may terminate this Agreement for cause if the other party commits a material breach of this Agreement, provided that such terminating party has given the other party ten (10) days advance notice to try and remediate the breach. Upon termination, Customer agrees to cease all use of the Arctic Wolf Technology, installed or otherwise, and permanently erase or destroy all copies of any Arctic Wolf Technology, including all Content and virtual Equipment, that are in its possession or under its control and promptly remove and return all physical Equipment to Arctic Wolf. Except as otherwise required by law, Arctic Wolf will remove, delete, or otherwise destroy all copies of Confidential Information in its possession upon the earlier of the following: (A) for MDR and MR Solutions, (i) the return of the Equipment, if applicable, to Arctic Wolf, or (ii) one hundred-twenty (120) days following expiration or termination, and (B) for the MA Solution, within one hundred twenty (120) days of expiration or termination. Notwithstanding anything contrary in this Agreement, should Customer fail to return any Equipment within ninety (90) days following discontinuation of use of the Equipment or termination or expiration of this Agreement, Customer will be liable for the replacement cost of the Equipment, which shall be due and owing upon receipt of the invoice from Arctic Wolf or the Authorized Partner, and Customer shall be liable for any breach of the Confidential Information and Arctic Wolf Technology contained within the unreturned Equipment. Should Customer elect to have the Confidential Information defined in Section 7.1(i) and (ii) above returned upon expiration, it is the Customer's responsibility to work with Arctic Wolf to ensure such information is returned prior to destruction. Sections 6 through 13, 14, and 15 will survive the non-renewal or termination of this Agreement.

15. Miscellaneous.

15.1 Except as otherwise provided herein, all notices, requests, consents, claims, demands, waivers and other communications hereunder shall be in writing and shall be deemed to have been given: (a) when delivered by hand (with written confirmation of receipt); (b) on the next business day after the date sent, if sent for overnight delivery by a generally recognized international courier (e.g., FedEx, UPS, DHL, etc.) (receipt requested); or (c) on the date sent by e-mail (with confirmation of transmission) if sent during normal business hours of the recipient, and on the next business day if sent after normal business hours of the recipient. Such communications must be sent to the respective parties at the addresses set forth on the signature page hereof (or at such other address for a party as shall be specified in a notice given in accordance with this Section 15). For contractual purposes, Customer (1) consents to receive communications in an electronic form via the email address it provides herein or via the Customer Portal; and (2) agrees that all agreements, notices, disclosures, and other communications that Arctic Wolf provides electronically satisfies any legal requirement that those communications would satisfy if they were on paper. This Section does not affect Customer's non-waivable rights.

15.2 Unless Customer directs otherwise by sending an email to Arctic Wolf at legal@arcticwolf.com, which direction may be given at any time, Customer agrees that Arctic Wolf may list Customer's company name and/or logo (in accordance with any trademark guidelines Customer may provide) as an Arctic Wolf customer within its customer lists and for use with Arctic Wolf's partners in a manner that does not suggest Customer's endorsement of any specific Arctic Wolf Solution.

15.3 The parties to this Agreement are independent contractors. Neither party has the authority to bind the other party without the express written authorization of the other party. Nothing herein may be construed to create an employer-employee, franchisor-franchisee, agency, partnership, or joint venture relationship between the parties. Each party shall be primarily liable for the obligations of its respective Affiliates, agents, and subcontractors.

15.4 This Agreement shall inure to the benefit of and be binding upon the respective permitted successors and assigns of the parties. Customer shall not be entitled to assign or otherwise transfer any of its rights and/or duties arising out of this Agreement and/or parts thereof to third parties, voluntarily or involuntarily, including by change of control, operation of law or any other manner, without Arctic Wolf's express prior written consent.

Any purported assignment or other transfer in violation of the foregoing shall be null and void. No such assignment or other transfer shall relieve the assigning party of any of its obligations hereunder.

15.5 The rights and obligations of the parties under this Agreement shall not be governed by the provisions of the 1980 U.N. Convention on Contracts for the International Sale of Goods or the United Nations Convention on the Limitation Period in the International Sale of Goods, as amended. The governing law and exclusive venue applicable to any lawsuit, settlement, or other dispute arising in connection with the Agreement will be determined by the location of Customer's principal place of business ("**Domicile**"), as follows:

Domicile	Governing Law	Venue
United States (including, D.C. and its inhabited territories)	Delaware	Kent County, Delaware
Canada	Ontario	Toronto
United Kingdom, Europe Union, Iceland, Switzerland, Norway, Africa, Australia, New Zealand	England & Wales	London

The parties hereby irrevocably consent to the personal jurisdiction and venue as shown above. Unless prohibited by governing law or venue, or otherwise inapplicable, each party irrevocably agrees to waive jury trial. In all cases, the application of law will be without regard to, or application of, conflict of law rules or principles. Any dispute, controversy, or claim (including non-contractual disputes, controversies, or claims) arising out of or relating to this Agreement, the breach thereof, or its subject matter or formation, shall be referred to and finally determined by arbitration within the venue in the table above in English and in accordance with the JAMS International Arbitration Rules then in effect. Any judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Notwithstanding the foregoing, each party shall have the right to institute an action in a court of proper jurisdiction for preliminary injunctive relief pending a final decision by the arbitrator(s), provided that a permanent injunction and damages shall only be awarded by the arbitrator(s). In any action or proceeding to enforce rights under this Agreement, the prevailing party shall be entitled to recover costs and attorneys' fees.

15.6 To the extent permitted by law, each party agrees that regardless of any statute or law to the contrary, any claim or cause of action arising out of or related to this Agreement must be filed within one year after such claim or cause of action arose.

15.7 No failure or delay by any party in exercising any right, power or privilege hereunder shall operate as a waiver thereof nor shall any single or partial exercise thereof preclude any other or further exercise thereof or the exercise of any other right, power or privilege. The rights and remedies under this Agreement are cumulative and are in addition to and not in substitution for any other rights and remedies available at law or in equity or otherwise.

15.8 If any provision of this Agreement is held invalid or unenforceable by any court of competent jurisdiction, the other provisions of this Agreement will remain in full force and effect. Any provision of this Agreement held invalid or unenforceable only in part or degree will remain in full force and effect to the extent not held invalid or unenforceable. The parties agree to replace such void or unenforceable provision of this Agreement with a valid and enforceable provision that will achieve, to the extent possible, the economic, business, and other purpose of such void or unenforceable provision. Arctic Wolf does not accept, expressly or impliedly, and rejects and deems deleted any additional or different terms or conditions that Customer presents, including, but not limited to, any terms or conditions contained in Customer's purchase order, or other such document, or established by trade usage or prior course of dealing.

15.9 This Agreement (including the URL Terms, and Order Form, and any other exhibit attached hereto) constitutes the parties' entire agreement with respect to the subject matter hereof and supersedes any prior or contemporaneous agreement or understanding by and among the parties with respect to such subject matter, whether oral or written, provided that to the extent Customer uses any Arctic Wolf products, services, features, and/or functionalities ("New Products") subject to terms not included in the Agreement, the relevant terms in effect at the time of first use at https://arcticwolf.com/terms/ shall be deemed to govern use of such New Products unless the parties agree otherwise in writing. Each party acknowledges that in entering into this Agreement it does not rely on any statement, representation, assurance, or warranty (whether made innocently or negligently) that is not set out in this Agreement. Each party agrees that it shall have no claim for innocent or negligent misrepresentation or negligent misstatement based on any statement in this Agreement. Except as otherwise provided herein, this Agreement may only be amended, modified, or supplemented only by an agreement in writing signed by each party.

15.10 In the event that Arctic Wolf receives personal healthcare information in the delivery of the Solutions, the parties agree to comply with the Business Associate Addendum (***"BAA"***) located at https://arcticwolf.com/terms/business-associate-addendum/ or such other equivalent agreement/addendum as required under applicable health information/privacy laws. In the event the parties have entered into a BAA or equivalent agreement in relation to protected health information, the parties intend for both this Agreement and BAA or equivalent agreement to be binding upon them and the BAA or equivalent agreement is incorporated into this Agreement by reference.

15.11 The parties have participated mutually in the negotiation and drafting of this Agreement. In the event an ambiguity or question of intent or interpretation arises, this Agreement will be construed as if drafted mutually by the parties and no presumption or burden of proof will arise favoring or disfavoring any party by virtue of the authorship of any of the provisions of this Agreement.

15.12 The parties have agreed that this Agreement as well as any notice, document or instrument relating to it be drawn up in English only; *les parties aux présentes ont convenu que la présente convention ainsi que tous autres avis, actes ou documents s'y rattachant soient rédigés en anglais seulement.*

15.13 Each party agrees that this Agreement and any other documents to be delivered in connection herewith may be electronically signed, and that any electronic signatures appearing on this Agreement or such other documents are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility. 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 one and the same instrument.

15.14 Subject to the rights of Authorized Partners as expressly set out in the terms of this Agreement, this Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement. The rights of the parties to rescind or vary this Agreement are not subject to the consent of any other person.

15.15. Governmental Immunity: Pursuant to Wyo. Stat.§ 1-39-104 (a) Memorial Hospital of Sweetwater County and the Board of Trustees of Memorial Hospital of Sweetwater County expressly reserve sovereign immunity by entering into this Agreement and specifically retain all immunities and defenses available to them as sovereigns.

[signature page to follow]

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives on the Effective Date.

Arctic Wolf Networks, Inc.:	**Customer:**
Signed:	**Signed:**
Name: Andrew Hill	**Name:** _____
Title: Chief Legal Officer & General Counsel	**Title:** _____
Date: _____	**Date:** _____
Notice Address: PO Box 46390 Eden Prairie, MN 55344 Attn: General Counsel legal@arcticwolf.com	**Notice Address:**

Managed Detection and Response
Solution Terms

This Managed Detection and Response – Solution Terms ("***Solutions Terms***") describes the Managed Detection and Response Solution (the "***Solution***"). The Solution, if purchased by Customer as evidenced by Customer's election on an Order Form, will be provided in accordance with the terms set forth herein and the Solutions Agreement (the "***Solutions Agreement***") made by and between Customer and Arctic Wolf Networks, Inc. ("Arctic Wolf"). Any capitalized terms not otherwise defined herein shall have the meaning set forth in the Solutions Agreement.

Solution. The Solution may be licensed separately or as part of a Security Operations Bundle as more fully described at https://arcticwolf.com/terms/bundles-tiers/ (each a "Bundle") and includes the following Components:

Component	
Software	The object form of any software, including any operating system software included in the Equipment, and add-ons offering enhanced features and functionality made generally available to Arctic Wolf customers from time-to-time
Equipment	Virtual appliances or physical sensors
Services	Support, onboarding services, and services provided by Security Services, all as described herein, and Cyber Resilience Assessment ("***CRA***")
Platform	One (1) vSensor 100 series Unlimited data ingestion Access to the Unified Portal (fka Customer Portal) Use of the Arctic Wolf Agent ITSM Ticketing Integrations (if elected by Customer) 90-day Log Retention (unless another retention period is purchased by Customer and set forth on an Order Form)

The Solution is delivered by the Security Services team which is comprised of two (2) teams: (1) the Concierge Security™ Team ("***CST***"), and (2) the Security Operations Center ("***SOC***").

Specific features and functionality provided as part of the Solution include:

- collection of Solutions Data and Points of Contact Information, including Customer's system logs, from Customer's systems using Equipment,
- analysis by Arctic Wolf Security Services of both Equipment and log data through the correlation of Solutions Data with threat and vulnerability information,
- scanning of Customer's internal and external systems,
- escalation of Security Incidents (as defined below) in need of attention by Customer as set forth herein,
- advisory recommendations intended to improve Customer's security robustness,
- calculation of Customer's Security Score, as more fully described below,
- Access to additional modules, if licensed by Customer as reflected on an Order Form (as more fully described below)[1],
- Response Actions[2] (as more fully described below),
- Cyber Resilience Assessment ("***CRA***") subject to the terms set forth at https://arcticwolf.com/terms/cyber-jumpstart-portal-subscription-agreement/, and
- regular summary Executive Dashboard reports, as described herein and the Documentation.

NOTE: The performance of the Solution, including specifically, notification of Emergencies or Security Incidents, as defined below, will not commence until after initial deployment is complete. The performance of (i) remediation services for Security Incidents (as defined below), (ii) the re-imaging of Customer's systems, or (iii) change of policy settings is outside the scope of the Solution.

Data Transfer. Any Equipment provided by Arctic Wolf to Customer is physically or virtually deployed to monitor Customer's system traffic. Such system traffic is augmented with additional sources of log data, as required, to deliver the Solution. Except as otherwise set forth in the Solutions Agreement, all such system traffic information is deemed Solutions Data. Essential log sources will be determined by Customer and Arctic Wolf during the onboarding process following the Order Form Effective Date.

Any Solutions Data and Points of Contact Information will be securely transmitted to Arctic Wolf in accordance with the Agreement. The Solution operates redundantly with Customer's High Availability (HA) specifications to minimize potential service interruptions. Hosting providers used by Arctic Wolf to deliver the Solution may experience service interruptions and service outages outside the control of Arctic Wolf. If such a hosting provider issues an outage notice that could materially impact delivery of the Solutions, Arctic Wolf will use commercially reasonable efforts to promptly notify Customer about the outage and communicate the planned recovery time provided by the hosting provider.

Solutions Data and Points of Contact Information may include personal or confidential information. Customer will provide any such personal or confidential information in accordance with the terms of the Solutions Agreement.

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[1] Existing Arctic Wolf MDR Customers may be, subject to authorization by Arctic Wolf, eligible to license Log Search capabilities only. In such event, Log Search will be included on an Order Form.
[2] Response Actions were formerly referred to as Host Containment Actions.

Data Retention. Arctic Wolf will store Solutions Data and Points of Contact Information for the Data Retention period specified in Customer's then-current Order Form. Solutions Data and Points of Contact Information may be returned to Customer in accordance with the terms of the Solutions Agreement.

Data Storage. Arctic Wolf will store raw Solutions Data and Points of Contact Information in the platform location set forth on an Order Form.

Updates & Upgrades. Automated maintenance and update cycles to the Equipment will be performed remotely by Arctic Wolf Security Services. Arctic Wolf will provide any services related to the replacement or upgrades of the Equipment. Any costs related to such Equipment replacement or upgrades will be in accordance with the Solutions Agreement.

Security Incidents. The CST supporting Customer is available 8:00 am to 5:00 pm (based on the time zone within which the CST is located), Monday through Friday (excluding holidays) and will provide Concierge Security™ Tier support in accordance with the Concierge Security™ Tier selected by Customer, as applicable. The SOC is available 24 hours a day, 7 days a week, including holidays. Customer may schedule specific activities with their CST, in accordance with Customer's Concierge Security™ Tier, as applicable, by contacting the Arctic Wolf SOC at security@arcticwolf.com. Arctic Wolf Security Services will acknowledge any schedule request submitted by Customer to security@arcticwolf.com within one (1) hour of receipt of such request. Arctic Wolf Security Services will provide an estimate of response time determined by scope, size, and urgency.

Arctic Wolf Security Services will notify and escalate to Customer any Security Incidents discovered by Arctic Wolf within two (2) hours of Arctic Wolf's discovery of such Security Incident. Arctic Wolf standard Security Incident notification process is through a ticket to the Customer; however, Arctic Wolf and Customer may agree to alternate notification processes. Security Incident notifications will include a description of the Security Incident, the level of exposure, and a suggested remediation strategy. Customer is responsible for implementing, in its sole discretion, any remediation strategies identified by Arctic Wolf. Customer may request validation by Arctic Wolf that any such implemented remediation strategies are working as expected.

Emergencies. Following transition from the deployment team to the CST, Customer and the CST will agree on and document which Security Incidents will be defined as an ***"Emergency"***. Emergencies will typically include the discovery of ransomware and other alerts that could cause degradation/outage to Customer's infrastructure security. Arctic Wolf will escalate Emergencies to Customer within thirty (30) minutes of Arctic Wolf's discovery of the Emergency.

Any Emergency identified by Customer can be escalated to Arctic Wolf's Security Services by calling: 1-888-272-8429, option 2 or by calling the toll-free number based on the location from which you are calling found at https://arcticwolf.com/toll-free/. Customer must describe the Emergency in the initial call and Arctic Wolf will respond within 5 minutes. In addition, with respect to any urgent inquiries, Customer may contact Arctic Wolf's Security Services by calling: 1-888-272-8429, option 2 or using the applicable toll-free number for the location from which Customer is located as set forth at https://arcticwolf.com/toll-free/.

Ticketing Integration (included in the Platform component of the Solutions). At Customer's election and based on configurations and permissions collected from Customer, Arctic Wolf may employ an integration to transfer data into and out of Customer's third-party ticketing system, provided Arctic Wolf supports integrations to such systems.

Scans. On a monthly basis, Arctic Wolf will use the Solution to conduct external vulnerability assessment scans of Customer's environment. As part of these scans, vulnerability and exploit information will be normalized and correlated with other data sources to determine Customer's Security Score and prioritization of any identified remediation strategies. Arctic Wolf will deliver to Customer a summary security report that includes Security Incident and Emergency notification activities on a monthly and quarterly basis.

Coverage Score (fka Configuration Score or Security Score). Customer's Coverage Score is provided as part of the Solution for illustrative and informational purposes only and may be used by Customer for internal benchmarking. The Coverage Score is based on certain information related to the results of the Solution within Customer's environment and is compiled using the Solutions Data made available to Arctic Wolf in conjunction with its delivery of the Solution. Customer's Coverage Score will be communicated in Customer's summary reports in addition to being available on Customer's online Executive Dashboard. Customers may elect to compare their Coverage Score against industry averages from organizations in the same industry vertical to assess how Customer is performing against industry norms.

Response Actions. Arctic Wolf may, if agreed with Customer, using commercially reasonable efforts, perform response actions, including application/removal of host containment, enable/disable user accounts, block URLs, modify deny lists and iprules, retrieve files, kill processes, and run files or scripts, as described below (collectively, "***Response Actions***"), provided that Customer has deployed the Arctic Wolf Agent, such other agreed upon third party agents, and/or configured the appropriate integrations. In the event Customer has deployed multiple agents, including the Arctic Wolf Agent, within its environment, Arctic Wolf will attempt to contain first using the Arctic Wolf Agent. Based on (i) information provided by Customer to its CST following initial deployment, (ii) a mutually agreed upon response and escalation process set forth in Customer's onboarding document, as updated upon agreement by Customer and its CST during the Subscription Term, and (iii) Arctic Wolf is provided appropriate access to applicable third party security applications, if any, within Customer's environment, the Security Services team may remotely isolate a Customer endpoint device(s), network appliance, or user account that shows evidence of compromise or other suspicious activity. When the Security Services team identifies certain indicators of attack on an endpoint, network device, or user account, the Response Action will be initiated systematically, in accordance with the agreed upon response and escalation process, and subject to the requirements set forth herein, to rapidly quarantine the suspected compromised system or account.

The indicators of attack that may drive Response Actions include those relating to ransomware (and other types of advanced malware), malicious command-and-control (C2) activity, or active data exfiltration attempts.

The endpoints, network, or user accounts participating in the Response Actions will receive a notification and the Response Actions will be detailed in an incident ticket. If using the Arctic Wolf Agent, the Customer Portal will display the Customer endpoints that are currently in a contained state. Security Services team is available to Customer to answer questions or provide detailed information on any endpoints, network, and/or user accounts participating in the Response Action.

Pre-requisites for Response Actions –

Customer must:

- Complete a checklist in partnership with its CST, which will include further definition, including but not limited to the scenarios where Arctic Wolf will and will not perform Response Actions including specific information regarding which endpoints/servers, network appliances, and/or user accounts where Response Actions will and will not be performed, the times of day for Response Actions to occur, notification and escalation preferences related to Response Actions (If parties have not defined the Response Actions pertaining to Customer endpoints, network, and/or user accounts, Arctic Wolf will take Response Actions in accordance with Arctic Wolf's standard response and containment policy);
- Provide Arctic Wolf with technical permissions to allow Arctic Wolf to perform Response Actions within Customer's environment (Customer understands that should Arctic Wolf have invalid access or is blocked from initiating Response Actions, Arctic Wolf will be unable to provide the agreed upon Response Actions);
- Implement appropriate internal procedures and oversight to the extent Customer utilizes the configuration of workflows and processes, including but not limited to Response Actions and other similar functionalities; and
- Enable software or services, in Customer's discretion, to permit necessary visibility into Customer's environment to perform Response Actions.

Active Directory Deception. If licensed and implemented by Customer either as a standalone or bundled feature within the Solution, Customer may deploy Active Directory Deception ("AD Deception"). With AD Deception, Customer creates, configures, and maintains Active Directory decoy account(s) intended to act as a deception trap within Customer's network.

The Active Directory decoy account is not intended to participate in normal business activities and should not log-in to Customer's system. The Active Directory decoy account is intended to provide a high-fidelity mechanism for detecting abnormal activity yielding no false positives. If a decoy account is deployed by Customer, Customer is responsible for creating, configuring, and maintaining the decoy account. The naming of the decoy account should follow Customer's account naming conventions. Arctic Wolf will provide reasonable guidance and assistance to Customer in the configuration of such decoy accounts. Customer will provide Arctic Wolf details of the decoy account to Arctic Wolf for monitoring. Customer understands that any changes to the decoy account configurations may impact the security of Customer's environment.

Microsoft US Government Community and High US Government Community Environment Monitoring. In the event Arctic Wolf monitors applications for Customer within the Microsoft US Government Community environment or US Government Community High environment (each a "GCC environment") as part of the delivery of the Solutions, Customer understands and agrees as follows:

1. Arctic Wolf is not FedRAMP compliant.
2. Only Arctic Wolf supported and integrated applications will be monitored in the GCC environment.
3. Solutions Data (i) may be accessed by Arctic Wolf, its Affiliates, and any third-party providers, from locations outside the United States, and (ii) may be accessed by persons who are not United States citizens;
4. Arctic Wolf does not require access to or delivery of Customer's Controlled Unclassified Information ("CUI") and in the event information classified as CUI is provided, Arctic Wolf may immediately cease ingestion of Customer Solutions Data without further liability to Customer;
5. Arctic Wolf will provide reasonable cooperation to Customer in the event of a data breach involving Solutions Data including, but not limited to assistance in responding to any government or regulatory inquiries;
6. Certain Microsoft log sources may be in beta and, consequently, Arctic Wolf makes no representations as to the delivery of the Solutions related to any such beta Microsoft log sources; and
7. Customer will immediately notify Arctic Wolf of non-consent or any change in consent and any monitoring of Customer's GCC environment will immediately cease without further liability to Arctic Wolf.

Additional Modules.

- **Cloud Detection and Response ("CDR").** Customers may license CDR for Amazon Web Services (AWS), Microsoft Azure, and any such other cloud IaaS and SaaS environments that Arctic Wolf may agree to monitor. Customer's election to license such CDR feature will be set forth on an Order Form. If licensed as part of the Solution, Arctic Wolf will provide detection and response for the respective IaaS and SaaS environments as described herein. Arctic Wolf is not responsible for any software and/or application changes made by the cloud IaaS and SaaS providers which affect or impair the CDR feature.

- **Data Explorer**. Customer may elect to license the Data Explorer feature. Should Customer subscribe to such feature, Data Explorer will be included on an Order Form. Data Explorer allows Customer to access historical data for quick, ad-hoc investigations and self-service reporting. Customer may identify and remediate risk in Customer's environment and may take appropriate actions when needed depending on results. Data Explorer includes (i) access to the prior ten (10) days of event and analyzed data, and (ii) Log Search[3] which permits Customer to query its retained Solutions Data in 30-day increments.

[3] Legacy customers licensing Log Search are entitled to Log Search only.

- **Data Explorer – Lite**. Customers licensing MDR as part of a Bundle will receive Data Explorer - Lite which includes access to the prior three (3) days of event data.

  For purposes of Data Explorer and Data Explorer-Lite, analyzed data includes parsed, normalized, and enriched data processed by the Arctic Wolf platform, however, not all logs ingested by Arctic Wolf will be parsed, normalized, or enriched. Event data is a collection of analyzed observations Arctic Wolf finds to be interesting from a security standpoint.

- **Application and SaaS Integrations.** Customers may license application and SaaS integrations as may be offered by Arctic Wolf. Customer's election to license such integration will be set forth on an Order Form. If licensed as part of the Solution, Arctic Wolf will provide detection and response for the respective integrated environments as described herein. Arctic Wolf is not responsible for any software and/or application changes made by the third-party application provider which affect or impair the integration with such third-party application.

- **Threat Intelligence.** Customers may license Threat Intelligence as an additional feature and enable it within the Unified Portal under the Security Bulletins tab in the reporting section. Threat Intelligence is available in a "Plus" version as well as the base offering with the parameters as described below:

Capability / Description	Base	Plus
Threat Reports - Security research intelligence reports generated by the Arctic Wolf Threat Research team.	Monthly	Monthly
Video Briefings - Security research intelligence briefings across multiple topics and delivered by the Arctic Wolf Threat Research team.	Not included	Quarterly
Downloadable IOC Intelligence - Feed of potentially malicious indicators of compromise (IOCs) including, but not limited to, IP's, domains, URL's and file hashes. The data within this feed can be downloaded and used in third party security tools like firewalls and EDR services to block potentially malicious activities.	Not included	Included

CompuNet

Jason Salisbury
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Quote #: JS267694

Arctic Wolf/ Security Package (3 Year/No Onboarding/Annual Pay)

Quote Information:

Quote #: JS267694

Version: 3
Quote Date: 07/22/2025
Expiration Date: 08/08/2025

Prepared for:

Memorial Hospital of Sweetwater County

Terry (TJ) Thompson
307-362-3711
tthompson@sweetwatermemorial.com

Bill To:

Memorial Hospital of Sweetwater County

Tina Frulla
1200 College Drive

Rock Springs, WY 82901
tfrullo@sweetwatermemorial.com

Ship To:

Memorial Hospital of Sweetwater County

Terry (TJ) Thompson
1200 College Drive

Rock Springs, WY 82901

Security (Year 1)

Manufacturer Part Number	Product Details	Qty	List Price	Price	Ext. Price
NET45 Terms.					
AW-PLUS-USER-GOLD	Arctic Wolf Plus User License - Gold (MDR, MR) (9/22/2025 - 9/21/2026)	900	$321.00	$86.86	$78,174.00
AW-PLUS-SERVER-GOLD	Arctic Wolf Plus Server License - Gold (MDR, MR) (9/22/2025 - 9/21/2026)	172	$321.00	$86.86	$14,939.92
AW-MDR-1YR	Arctic Wolf MDR Log Retention - 1 year (9/22/2025 - 9/21/2026)	1072	$14.40	$4.07	$4,363.04
AW-MDR-EXPLR	Arctic Wolf MDR Data Explorer (9/22/2025 - 9/21/2026)	1072	$40.00	$11.29	$12,102.88
AW-MDR-2XX-S	Arctic Wolf 200 Series Sensor (9/22/2025 - 9/21/2026)	2	$3,000.00	$847.06	$1,694.12
AW-MDR-O365	Arctic Wolf MDR Office 365 user license (9/22/2025 - 9/21/2026)	900	$22.50	$6.35	$5,715.00
AW-CTI-TI	Arctic Wolf Threat Intelligence (9/22/2025 - 9/21/2026)	1	$5,000.00	$1,411.76	$1,411.76
AW-PLATFORM-BASE	Arctic Wolf Aurora Platform (9/22/2025 - 9/21/2026)	1	$15,000.00	$0.00	$0.00
AW-OB	Arctic Wolf Onboarding	1	$12,241.94	$0.00	$0.00
AW-SHP	Arctic Wolf Sensor/Scanner Shipping	2	$120.00	$120.00	$240.00
				Subtotal:	**$118,640.72**

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jsalisbury@compunet.biz
Quote #: JS267694

Security (Year 2)

Manufacturer Part Number	Product Details	Qty	List Price	Price	Ext. Price
August to September Free. NET45 Terms.					
AW-PLUS-USER-GOLD	Arctic Wolf Plus User License - Gold (MDR, MR) (9/22/2026 - 9/21/2027)	900	$321.00	$86.86	$78,174.00
AW-PLUS-SERVER-GOLD	Arctic Wolf Plus Server License - Gold (MDR, MR) (9/22/2026 - 9/21/2027)	172	$321.00	$86.86	$14,939.92
AW-MDR-1YR	Arctic Wolf MDR Log Retention - 1 year (9/22/2026 - 9/21/2027)	1072	$14.40	$4.07	$4,363.04
AW-MDR-EXPLR	Arctic Wolf MDR Data Explorer (9/22/2026 - 9/21/2027)	1072	$40.00	$11.29	$12,102.88
AW-MDR-2XX-S	Arctic Wolf 200 Series Sensor (9/22/2026 - 9/21/2027)	2	$3,000.00	$847.06	$1,694.12
AW-MDR-O365	Arctic Wolf MDR Office 365 user license (9/22/2026 - 9/21/2027)	900	$22.50	$6.35	$5,715.00
AW-CTI-TI	Arctic Wolf Threat Intelligence (9/22/2026 - 9/21/2027)	1	$5,000.00	$1,411.76	$1,411.76
AW-PLATFORM-BASE	Arctic Wolf Aurora Platform (9/22/2026 - 9/21/2027)	1	$15,000.00	$0.00	$0.00
				Subtotal:	**$118,400.72**

Security (Year 3)

Manufacturer Part Number	Product Details	Qty	List Price	Price	Ext. Price
August to September Free. NET45 Terms.					
AW-PLUS-USER-GOLD	Arctic Wolf Plus User License - Gold (MDR, MR) (9/22/2027 - 9/21/2028)	900	$321.00	$86.86	$78,174.00
AW-PLUS-SERVER-GOLD	Arctic Wolf Plus Server License - Gold (MDR, MR) (9/22/2027 - 9/21/2028)	172	$321.00	$86.86	$14,939.92
AW-MDR-1YR	Arctic Wolf MDR Log Retention - 1 year (9/22/2027 - 9/21/2028)	1072	$14.40	$4.07	$4,363.04

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Quote #: JS267694

Security (Year 3)

Manufacturer Part Number	Product Details	Qty	List Price	Price	Ext. Price
AW-MDR-EXPLR	Arctic Wolf MDR Data Explorer (9/22/2027 - 9/21/2028)	1072	$40.00	$11.29	$12,102.88
AW-MDR-2XX-S	Arctic Wolf 200 Series Sensor (9/22/2027 - 9/21/2028)	2	$3,000.00	$847.06	$1,694.12
AW-MDR-O365	Arctic Wolf MDR Office 365 user license (9/22/2027 - 9/21/2028)	900	$22.50	$6.35	$5,715.00
AW-CTI-TI	Arctic Wolf Threat Intelligence (9/22/2027 - 9/21/2028)	1	$5,000.00	$1,411.76	$1,411.76
AW-PLATFORM-BASE	Arctic Wolf Aurora Platform (9/22/2027 - 9/21/2028)	1	$15,000.00	$0.00	$0.00
				Subtotal:	**$118,400.72**

Quote Summary

Description	Amount
Security (Year 1)	$118,640.72
Security (Year 2)	$118,400.72
Security (Year 3)	$118,400.72
Total:	$355,442.16

Taxes, shipping, handling and other fees may apply. We reserve the right to cancel any order arising from pricing or other errors. If Customer is purchasing a subscription-based product, Customer agrees to pay all charges for the complete term of the subscription. By signing below or issuing a Purchase Order, Customer agrees to CompuNet's standard terms and conditions, which can be reviewed https://compunet.biz/terms-and-conditions/, provided, that if Customer and CompuNet are parties to a currently effective Master Product Purchase and Services Agreement (MSA), the terms and conditions of such MSA shall control and shall supersede these standard terms and conditions. Your electronic signature, per the Electronic Signature Act, is considered equivalent to your signed and faxed signature, and allows you to accept and place your order. This Quote becomes binding and noncancelable upon Customer's return to CompuNet of acceptance. A copy of this acceptance and the attached proposal document will be sent to your email address to complete your order acceptance. You are NOT required to electronically sign your order, you may fax or email your signed proposal to your Account Executive.

CompuNet

Jason Salisbury
(208) 286-3019
jsalisbury@compunet.biz

Quote #: JS267694

Memorial Hospital of Sweetwater County

Signature: _____

Name: _____

Title: _____

Date: _____

PO Number: _____

Contract Check List

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

1. Name of Contract**: TRUE NORTH**

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

3. Effective Date: **August 6, 2025**

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

5. Termination provisions: **By either party with minimum of 30 days' notice after October 31, 2026 after not less than one full year of work.**

6. Monetary cost of the contract: **Newsletter is $41,292.41 annually- The blog cost per year $18,600.00. Total cost of the agreement over three years is $179,677.23 or $59892.41 per year.**

Postage costs for mailing the newsletter will be billed separately but are approximately $12,567.60 annually.

Budgeted? **Yes**

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

8. Any confidentiality provisions? **No**

9. Indemnification clause present**? Yes Mutual**

10. Governmental Immunity provisions**? Yes**

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

11. Is County Attorney review required?

TRUE NORTH

Statement of Work

Memorial Hospital of Sweetwater County

TERMS

- SOW effective date 8/6/2025 with funds to be utilized by 8/11/2028
- Governmental Immunity: Pursuant to Wyo. Stat.§ 1-39-104 (a) Memorial Hospital of Sweetwater County and the Board of Trustees of Memorial Hospital of Sweetwater County expressly reserve sovereign immunity by entering into this Statement of Work and specifically retain all immunities and defenses available to them as sovereigns.
- Mutual Indemnification: Each Party agrees to indemnify, defend, and hold harmless the other Party and its officers, directors, employees, agents, and representatives from and against any and all third-party claims, damages, losses, liabilities, regulatory fines, penalties, costs, and reasonable attorneys' fees arising directly from work associated with this SOW.

RATE AND PAYMENT TERMS.

1. Pricing Total for 3 year agreement: $179,677.23 ($59,892.41 per year)
    a. $20,646.20 to be billed twice per year for newsletter publication with first payment due on contract execution
    b. $4,650 to be billed on a quarterly basis for blog content strategy with first payment due on contract execution
2. Postage to be billed separately upon execution based on then current rates.
3. Payment Terms are net 30 days from invoice date.
4. Work beyond the defined scope of Services shall be mutually agreed to in writing, invoiced to and paid by Client as incurred at the then-current billing rates (currently $180/hour). Client acknowledges they are responsible for all state sales/use taxes that may be related to this work.
5. Prices are based on current market rates and subject to adjustments.
6. Client acknowledges it is agreeing to subscribe to, pay for, and cooperate in the production of, the Total Statement of Work Amount above for the term period. Contract may be terminated by either party in writing with a minimum of 30 days notice after October 31, 2026 after not less than one (1) full year of work as outlined above. This agreement is non - transferable and non - refundable.
7. Additional tactics and / or campaign components can be added either as an addendum to this statement of work or as a separate statement of work.

AGREED:

Memorial Hospital of Sweetwater County		***TRUE NORTH AGENCY***	
By:	_____	*By:*	_____
Name:	_____	*Name:*	*Michael Andres*
Title:	_____	*Title:*	*True North Chief Financial Officer*
Date:	_____	*Date:*	_____

TRUE NORTH

Statement of Work

Memorial Hospital of Sweetwater County

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

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

DELIVERABLES / SPECIFICATIONS

1. Print Publication
    a. Print newsletter publication development and execution
        i. Two issues per year
        ii. Eight (8) pages each, including front and rear cover, 80# gloss text, 8.125"x10.75" trim size
        iii. Each issue will be mailed to a demographic target address list developed by True North according to the following:
            1. All households in Sweetwater County, WY
            2. Households with a household income of $30,000 or more in Unita, Lincoln, Sublette and Carbon County, WY, and Daggett County UT
        iv. True North will provide custom content, design, print, and execute shipment for each issue
        v. Each issue includes two (2) proofs. Additional revision cycles can be added at an hourly rate of $180 and will impact time to launch relative to the extent of the changes
        vi. Use of stock photography only unless other photos are provided by client
        vii. Includes bulk shipment of 25 non-mailing quantity per issue to client
        viii. True North will develop, maintain and manage address mailing list according to agreed upon specifications
    b. Annual total: $41,292.41
        i. Estimated quantity of 34,910 newsletters sent two times per year for an estimated total of 69,820 per year

2. Blog Content Strategy
    a. Components
        i. Approximately 2 custom pieces of content per month (24 pieces per year)
            1. Short to medium articles (500-800 words)
        ii. Each includes SEO components, post headline and link description/CTA
        iii. Each includes a recommended image number from Memorial Hospital of Sweetwater County custom library or preferred stock photo library
        iv. Content planning and strategy support to include ~12 recommended blog topics per quarter, all aligned with local consumer needs and Memorial Hospital of Sweetwater County priority service lines
        v. Quarterly planning meetings and performance review discussions
        vi. True North collaboration with client team on content deployment
        vii. Flexibility will be offered if the content plan varies from 2 posts per month. A budget tracker will be used and provided to Memorial Hospital of Sweetwater County to track utilization throughout the year.
    b. Annual custom content cost: $18,600

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: **Lamar**

2. Purpose of contract, including scope and description: **Billboard advertising. Contract includes all three RS digital billboards (2 on Dewar/1 on Elk), as well as Hwy 191 static billboard.**

3. Effective Date: **8/15/25 for digital. 8/4/25 for Hwy 191.**

4. Expiration Date: **8/16/26 for digital. 8/2/26 for Hwy 191.**

5. Rights of renewal and termination. **Contract can be cancelled with written permission from Lamar.** Is this auto-renew? **No**

6. Monetary cost of the contract and is the cost included in the department budget? **$45,812 ($3,060 monthly for digital and 464 monthly for static). Yes, it is budgeted.**

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

8. Any confidentiality provisions? **No**

9. Indemnification clause present? **N/A**

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: **SweetwaterNow**

2. Purpose of contract, including scope and description: **Digital advertising includes Top Billboard banner on SweetwaterNow.com, the Birth Page sponsorship on SweetwaterNow.com and Facebook, and GRHS & RSHS sports story sponsorships.**

3. Effective Date: **Aug. 1, 2025**

4. Expiration Date: **One year after effective date.**

5. Rights of renewal and termination. **Advertiser (MHSC) has the right to terminate this contract by written notice to SweetwaterNow within 30 days of termination date.** Is this auto-renew? **NO**

6. Monetary cost of the contract and is the cost included in the department budget? **Annual cost:** $39,576, a $4,776 increase over last year. Billed at **$3,298 per month**. Budgeted? **YES**

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

8. Any confidentiality provisions? **NO**

9. Indemnification clause present? **NO**

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

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

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: **The Radio Network**

2. Purpose of contract, including scope and description: **Radio advertising. Contract covers 104 ad spots on KYCS, KUGR, KFRZ, KZWB and KFZE. Plus, eight months for Green River and Rock Springs sports coverage; three ads per game.**

3. Effective Date: **Aug. 1, 2025**

4. Expiration Date: **One year from effective date.**

5. Rights of renewal and termination. **Advertiser (MHSC) has the right to terminate this contract within 30 days of termination date.** Is this auto-renew? **No**

6. Monetary cost of the contract and is the cost included in the department budget? **Contract covers 104 ad spots on KYCS, KUGR, KFRZ, KZWB and KFZE at $583.33 per station for 12 months. Added cost of $250 x 8 months for Wolves Coverages. Monthly invoices remain the same as 2024-25. Total annual cost is $37,000.** Budgeted? **Yes**

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

8. Any confidentiality provisions? **No**

9. Indemnification clause present? **No**

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

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

The Rural Health Landscape

Key Takeaways

1. Rural healthcare organizations must adopt innovative approaches to meet the unique needs of their communities

2. Partnering with social services and public health initiatives allows organizations to address patient needs holistically, reducing reliance on emergency room visits

3. Rural organizations can keep their independence while still working cooperatively through a clinically integrated network that provides shared services

4. Advanced technologies such as AI, robotics, and automation are important investments in rural healthcare systems, enhancing both patient care and recruitment/retention efforts

5. While transition and change may be challenging, they are essential for ensuring the organization's continued growth and success in the current healthcare landscape

The Rural Health Landscape

TRANSCRIPT

What are some strategies and opportunities for addressing the challenges faced by rural healthcare systems?

The rural landscape today is quite challenging. At the same time, there's a lot of opportunities for us to advance and move into the future and do some things a little bit differently.

The challenges that we face that include financial sustainability, workforce challenges, being able to recruit people to our communities, really the burden of regulation and mandates and so forth. And the list really, you know, goes on.

A lot of times I would say that we will see what is broken and fragmented in a community in the E.R., because that becomes the go to place, that becomes the safe place where I think a lot of people believe we'll solve those problems. And we try, but many of those things aren't part of the work that we would typically do. However, we can engage and be a catalyst for change using these other organizations and coming together collectively.

So, as we look at putting some relationships together or tapping into the other resources in the community, like a community hub that is a virtual platform that connects, for example, county public health, social service agencies, workforce transportation and so forth, really looking at what are the needs holistically for a patient to be successful and thriving in our communities?

I think another opportunity that's out there is a clinically integrated network that's virtual. We have the opportunity with technology these days to have virtual organizations. And so in my state, for example, we have 18 hospital organizations, all of which are independent, which is an important cultural value for each of us.

We believe that being independent and being able to focus on our community's respective needs is really fundamental to who we are and the missions that we serve. But we can come together collectively as an organization, like a cooperative, to address certain kinds of issues and needs.

That might be contracting with payers, which actually makes it easier and better for payers as well as our organizations. It might be shared services. Oftentimes we don't have the need for, a Department of Legal, for example, or, certain kinds of HR functions or other types of support, types of needs. And so we can share that amongst all of ourselves, and we can do it quite effectively, on a virtual platform.

So if we think, you know, more broadly, if we, if we kind of push ourselves to think more creatively to, to, to share in, we don't have to lose our identity. We don't have to lose who we are, and our missions for our respective organizations. But there's a lot of different ways that we are going to have to change and the time is now, because the current state is not going to support us any longer. So the opportunities that are out there are as big or as broad as we can make them.

What role should the Board play in driving innovation within a rural healthcare system?

As we think about innovation, particularly in rural health care organizations, I think it's a critical time for us to really broaden our thinking, in our approaches and be very open to new ways of doing things

The demographics and geography are always challenges for rural health care organizations. So this is a natural place for innovation to step in. Some of the opportunities that are out there, are things like AI, and there are many ways that that's already in play. And it doesn't even cost a whole lot to be able to do that. We're seeing this come in to help our doctors and our nurses and our clinicians. Things with documentation. Summary of information, extracting data, really pulling in all of this information that before somebody had to data mine, or manually pull together, has now become very quick and very easy for our clinicians to be able to do.

I think there's other advances that are a little bit more costly, things such as robotic surgery. And that's fits into our, our rural facilities, our rural hospitals. It's a great technology. It's how new young surgeons are being trained. But there is an expense for that, or just other types of, medical advances that have, been coming forward in probably in the world of, pharmaceuticals primarily. Again, a little bit more costly on the upfront right now, but big changes and keeping people out of the hospital or out of the ER, and really helping with health and well-being.

We also have, you know, a lot of back office, if you will, type systems that I think really pull things together and make the experience a little bit more self-serve for patients, and easier to access, engage, around their own health, their own health care, whether that's, you know, the portals getting into their electronic medical records, apps to be well, scheduling, billing, communication with providers, looking for data, results, or test results. All of that is at, like, really a fingertip.

So health care is not caught up maybe the on some of these technology things yet. But it is opening up and it's opening up fast. And I think you know having these discussions also with our boards talking about what is that future state of health care look like, how does automation, how does technology, how do these tools really advance our ability to deliver care. And by the way, help us with our financial sustainability and some of the workforce challenges, because this can also, it's not replacing jobs or telling people we don't have jobs for them. There are people out there. So what it does is it ensures that the work can continue, quite actively, and basically support everyone as we go forward.

How can Boards engage in this future state work?

With as much disruption as is occurring in the rural health landscape, I think right now is a real critical time for board engagement and discussion, and collaboration really, with the CEO.

I think, you know, today's environment is one that really can be categorized by change. But what's good about this is that board members come from a variety of different types of backgrounds. They come from different industries, different sizes of business,

Board members bring a wealth of experience and that can bring to bear, you know, some good discussion at the board level, collectively, that can help a CEO really think through like next steps and where to go from here.

It's important for board members, especially in rural communities where we're really trying to protect, you know, our hospitals, our assets, those kinds of things. I think it's really important that, we sort of step back and sort of discern are we trying to stay in the past or are we really trying to move to the future?

So a particular model that I believe really resonates well with rural health care is population health. And in that we are looking holistically at patients, you know, what's going on across the whole continuum of their life. And how do we enhance that? How do we understand what's going on and how do we help put the pieces together so that people are thriving in the community?

And in this model, there's a lot of data that we look at. We are actually trying to keep people out of the hospital and out of the ER, reducing the overall cost of health care, which as we know, is a big drumbeat across the country.

And in doing that, we are having to change a lot of things in our own paradigms of thinking and health care delivery.

And those were conversations we had to have with our board about moving to this model. We were going to contract differently with our government payers, Medicaid at the state, Medicare, at the federal level. And then also as we got into it, some of our commercial payers, as we looked at other populations to do this work with, there is a big impact, as you were transitioning into this new model on our providers, on our staff, on our financials, on our quality, on our patient experience.

But this is a time of transition and change. And in that people can get very uncomfortable. And it's really important that the board understands that it is going to take some time for that transition to happen. But when we also see the outcomes where people really are thriving, lives are impacted very positively, that people are really taking control and ownership for their own health status. They're really rewarding, stories and impacts that we have, which is really what we are about as a healthcare organization.