AGENDA

LAST FRONTIER HEALTHCARE DISTRICT

BOARD OF DIRECTORS

Thursday, February 19, 2026, 3:30 pm
Education Room; Alturas, California

Parties with a disability, as provided by the American Disabilities Act, who require special accommodations or aids in order to participate in this public meeting should make requests for accommodation to the Modoc Medical Center Administration at least 48 hours prior to the meeting. Board Agenda packets are available to the public online at www.modocmedicalcenter.org or at the MMC Administration offices.

3:30 pm - CALL TO ORDER – R. Boulade, Chair

1. PLEDGE OF ALLEGIANCE TO THE FLAG OF THE UNITED STATES OF AMERICA – R. Boulade, Chair

2. AGENDA APPROVAL - Additions/Deletions to the Agenda – R. Boulade, Chair

3. PUBLIC COMMENT - *This is the time set aside for citizens to address the Board on matters not on the Agenda or Consent Agenda. Comments should be limited to matters within the jurisdiction of the Board. If your comment concerns an item shown on the Agenda, please address the Board after that item is open for public comment.* ***By law, the Board cannot act on matters that are not on the Agenda.*** *The Chairperson reserves the right to limit the duration of each speaker to* ***three minutes.*** *Speakers may not cede their time. Agenda items with times noted, will be considered at that time. All other items will be considered as listed on the Agenda, or as deemed necessary by the Chairperson.*

4. VERBAL REPORTS

A.) K. Kramer – CEO Report to the Board
B.) E. Johnson – CNO Report to the Board
C.) A. Vucina – CHRO Report to the Board
D.) A. Willoughby – COO Report to the Board
E.) Board Member Reports

5. DISCUSSION

A.) S. Brown – Policy Manual Review Process

REGULAR SESSION

6. CONSENT AGENDA - *Items under the Consent Agenda heading do not require discussion before a vote. If discussion is needed, that item needs to be moved to the Consideration/Action part of the Agenda where discussion is allowed.*

A.) D. King - Adoption of LFHD Board of Directors Regular Meeting Minutes – January 29, 2026, Attachment A
B.) T. Ryan - Medical Staff Committee Meeting Minutes – January 28, 2026 Attachment B

- **Medical Staff Committee Meeting Minutes – November 19, 2025**
- **Committee Reports**
- **Pathology Report**
- **New Business**

C.) E. Johnson – Policy and Procedures Attachment C
PHARMACY/HOSPITAL

7710.25 Counterfeit Drugs and DSCSA

DIETARY ACUTE

8345.26 Calibration of Foodservice Thermometers

SNF-ACTIVITIES

8365.25 Use of Alcohol by Resident or Visitor (5381)

FACILITIES/EOC

8460.26 Bio Hazardous Waste Transportation Maintenance
8460.26 Biomedical Equipment Management
8460.26 Hazardous Materials and Waste Management Plan
8460.26 Performance Improvement Plan
8460.26 Preventative Maintenance
8460.26 Removal of Bio Hazardous Waste
8460.26 Sprinkler Drop Test
8460.26 Use of Electric Wheelchair
8460.26 Use of Spill Kit

SNF-IC

8753-SNF.25 Tuberculosis Screening, Testing and Control at the Skilled Nursing Facility

7.CONSIDERATION/ACTION

A.) K. Kramer – January 2026 LFHD Financial Statement *(unaudited)* **Attachment D**
B.) K. Kramer – Investment Proposal Action **Attachment E**

EXECUTIVE SESSION

9. CONSIDERATION / ACTION

A.) T. Ryan – Medical Executive Committee Minutes & Credentialing Items – January 28, 2026 **Attachment F**
(Per Evidence Code 1157)

- **Medical Executive Committee Minutes & Credentialing Items OPPE 2019B – November 19, 2025**
- **Medical Executive Committee Minutes & Credentialing Items OPPE 2019B – January 28, 2026**

REGULAR SESSION

10. CONSIDERATION / ACTION

A.) T. Ryan – Medical Executive Committee Minutes & Credentialing Items – January 28, 2026
(Per Evidence Code 1157)

- **Medical Executive Committee Minutes & Credentialing Items OPPE 2019B – November 19, 2025**
- **Medical Executive Committee Minutes & Credentialing Items OPPE 2019B – January 28, 2026**

11. MOTION TO ADJOURN – R. Boulade – Chair

POSTED AT: **MODOC COUNTY COURTHOUSE / ALTURAS CITY HALL / MMC WEBSITE / MMC FRONT ENTRANCE - (www.modocmedicalcenter.org) ON February 13, 2026.**

ATTACHMENT A

LFHD BOARD OF DIRECTORS REGULAR MEETING MINUTES (draft) January 29, 2025

REGULAR MEETING MINUTES
LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
Thursday, January 29, 2026, at 3:30 pm
City Council Chambers; Alturas City Hall; Alturas, California

Directors present: **Carol Madison, Paul Dolby, Keith Weber, Rose Boulade, Mike Mason**
Directors absent:
Staff in attendance: **Kevin Kramer, CEO; Edward Johnson, CNO; Adam Willoughby, COO; Jin Lin, Finance Director; Amber Vucina, CHRO; Denise King, LFHD Clerk**
Staff absent:

CALL TO ORDER

Rose Boulade , Chair, called the meeting of the Last Frontier Healthcare District (LFHD) Board of Directors (Board) to order at 3:30 p.m. The meeting was held at the City Council Chambers, located at 200 W. North St., in Alturas, California.

1. PLEDGE OF ALLEGIANCE TO THE FLAG OF THE UNITED STATES OF AMERICA

2. AGENDA – Additions/Deletions to the Agenda

Carol Madison moved that the agenda be approved as presented. **Paul Dolby seconded**, and the motion carried with all present voting "aye."

3. PUBLIC COMMENT

There was no public comment.

4. VERBAL REPORTS

A.) K. Kramer – CEO Report to the Board

New SNF Update

- USDA Loan has closed. Project has been completed.
- Interim loan has been paid off and closed out.
- Swinerton is currently working through a number of warranty issues that have cropped up since we occupied the building, including drain issues, floor cracking, and typical issues that we encounter once we occupy new space.

Provider Recruitment

- We are currently looking for the following permanent providers:
  - Two physicians (one for Canby Clinic and one for Alturas Clinic)
  - A FNP/PA for the Emergency Room
  - A FNP/PA for Canby Clinic
  - A FNP/PA for the Skilled Nursing Facility

Potential Security Incident

- We have had a potential data/security incident and have a team of experts engaged to help us through this. We hope to have some very general communication out to staff and the community this afternoon just making them aware of the fact that we think we have experienced a security incident and that we are currently investigating the matter to find out what data was accessed so that we can respond appropriately.
- We do have cyber security insurance that will assist with these expenses and with connecting us to the right resources as we respond to this potential incident.

Other Items

- Received a complaint from a community member regarding the difficulty of being seen and becoming established in the clinic.
  - This is mostly a provider issue and we need to recruit more providers. We have hired locums providers to help cover the Canby Clinic and Alturas Clinic while we continue to try to find permanent providers for both clinics.
  - We are actively looking independently and with retained firms to find providers to help alleviate this issue.
- Next Board Meeting
  - Three members of our senior leadership team will be gone for our next scheduled board meeting. I am wondering if we could reschedule the meeting to February 12 or February 19. Please let me know if that will work for the rest of you. The Board indicated that February 19 would be the best day for a board meeting next month.

C.) E. Johnson – CNO Report to the Board

Warnerview

- 4-star CMS rating
- Census is currently at 15
- Discharges - Zero
- Gearing up for one of our residents to turn 100 in April.
  - We have a committee getting together to plan this birthday party.
- Respiratory Illness
  - One resident with Rhinovirus

Mountain View

- Census is currently at 37
- Admissions - Zero
- Discharges two (one to death, transfer to U C Davis)
- Respiratory illness
  - Three residents with the flu.
  - Signs have been placed around the facilities and front door regarding masking and hand hygiene. Hand sanitizer stations are at the entrances to the facilities. We are asking visitors at Mountain View if they are sick at the door.
  - Dr. Richert spoke before this meeting, and I will be updating our respiratory virus response/protocol a little:
    - Healthcare personnel with a suspected or confirmed respiratory viral infection, regardless of whether testing is performed, should:
      - Not returning to work until at least 3 days have passed since symptom onset* and at least 24 hours have passed with no fever (without use of fever-reducing medicines), symptoms are improving, and they feel well enough to return to work.
        - If testing is performed that renders a positive result, but HCP is asymptomatic throughout their infection, HCP should not return to work until at least 3 days have passed since their first positive test.
    - Wear a facemask for source control in all patient care and common areas of the facility (including breakrooms) for at least 10 days after symptom onset or positive test (if asymptomatic), if not already wearing a facemask as part of universal source control masking (i.e., not getting the flu vaccine).
    - Perform frequent hand hygiene, especially before and after each patient encounter or contact with respiratory secretions.
      - This 3-day rule is for all areas except for the Skilled Nursing Facilities. They will remain 5 days out and return on day 6.
        - *Where the first day of symptoms is day zero, making the first possible day of return to work on day four.

Acute

- Inpatient – Census 2.23
  - ALOS – 3.63
- Swing – Census 4.00
  - ALOS – 10.33

- Admissions
  - 19 Acute
  - 12 Swing
- Surgeries
  - 26 Surgeries

ER

- 486 patients
- Census Avg 15.7 per day

Ambulance

- 107 runs for the month.

Pharmacy

- 4,331 Scripts filled, an increase from last month.
- Pharmacy is a little concerned about the new employee prescription plan, but they would like everyone to go to mail order for maintenance prescriptions. This will affect our 340b program.

Physical Therapy

- 546 Sessions, a decrease from last month.
- We have an offer out to PTA.

Radiology

- 287 X-rays, an increase of 51 x-rays from last month.
- 126 Ultrasounds, an increase of 53 ultrasounds from last month.
- 182 CT scans, an increase of 22 CT scans from last month
- 45 MRIs, an increase of 24 from last month.

Lab

- 4,721 Test, an increase from last month.

Wound Care Nurse Program

- We have a wound nurse that started in January. She should start seeing patients on her own sometime in February pending Dr. Hagge's return.

Infusion

- Is doing well. Patients are loving the new space.

D.) J. Lin – Finance Director Report to the Board

Accounting

- We received the audited Financial Statement in December.
- W-2s have been released to all employees.
- We are working on 1099s to send out to the vendors by this Friday.

Purchasing

- Still busy stocking inventory for the new departments: Infusion, Mountain View SNF, and Mountain View Dietary.

Floaters

- One of the floaters left for another job opportunity. I am still considering whether we should have a replacement.
- We have 4 floaters total now.

E.) A. Vucina – CHRO Report to the Board

Permanent/Travel Staff

- We currently have 312 total staff
- We have a total of 29 travelers, both Acute and SNF.

Compliance

- Performance Evaluations 82% compliant
- TB 88% complaint
- Physicals 94% compliant

F.) A. Willoughby – COO Report to the Board

Revenue Cycle

- December was another strong month on the revenue cycle front, which was great as December is normally a lower month due to the holidays. Highlights included: $5.1M in revenue, $2.72M in

payments, ADR was 162K, which is a new all-time high, and our AR > 90 was the lowest it has ever been at $2.61M, which represents 27% of overall AR.

- January is shaping up to be a great month as well. We're already over $2.5M in payments and the ADR has increased from last month, which will help our AR days too. We do have a Medicare **credentialing** issue that is affecting about half a million dollars right now. As of 1/1/26, CMS rolled out a new requirement for all providers to sign over their billing rights to the facility they practice at as CMS is saying that hundreds of millions of dollars in duplicate claims were paid out to both the provider directly and the facility directly, which creates "double dipping". So, our Credentialer, Taylor, has been working on getting all the necessary signatures to get this squared away on our end. She has done a good job with this and is just about done gathering the signatures. Our main ED doctors have been taken care of and that's where a bulk of the half million was tied up so R1 can resubmit the claims to Medicare for payment now. January month end would've looked a lot better had this issue not popped up.
- I'm still working with MedEvolve to provide data they need in order for them to compile a deep dive analysis for us. I'm also running an expense analysis to see if it makes sense to engage with them for the long run.

Clinics

- Still working through our clinic improvement project, which has been going well. Virginia Baker, FNP is now seeing patients in Alturas and we have Dr. Kemmer seeing patients in Canby.
- We did find out that Wendy Richardson will be departing in early July with July 2nd being her last day with us so we're working on a backfill plan for her departure as she is our main same day provider. Her and her husband can essentially retire so that is their plan.
- Next month I'll provide an update on the PHP QIP status as we're hoping to graduate their modified QIP program, which will open up the possibility for additional supplemental reimbursement. We should know by then whether or not we scored high enough to graduate.

Maintenance

- Marty and his team are assisting me in getting the ball rolling on the Nagle/299 intersection streetlight. CalTrans/DOT has made the decision that a project isn't warranted at this location so we're just going to do it ourselves. I guess someone has to get seriously injured or killed in order for them to do anything but we want to get ahead of that. Marty and his team have located the Christy Box on the southeast side of Nagle right next to the stop sign that has the 2" conduit that was installed during the new facility project for this future purpose. I'm coordinating with McComb's Electric and Big Dog Electric to get quotes as they will need to physically come out to the site in order to produce those. The other thing we need is an Encroachment Permit in order for us to be permitted to do this. The requirements of that permit will also influence the quote as we will have to comply with the standards they set forth.

IT

- IT has their hands full at the moment with a big development, but I will have more on that next month.
- The ScriptPro switches and servers that I reported on last month have been swapped out with the new ones, which is the first step in fixing the IVR issue we've been having. Once Andy and team weather the current storm, they will be able to work on the IVR issue specifically to get that all squared away.

Marketing

- Marketing is humming along and will be putting out information to the public on the current events when the time is right.

F.) Board Member Reports

- **Carol Madison** – Attended the Joint Conference Meeting – loved it.
- **Paul Dolby –** Attended the Joint Conference Meeting – learned a lot.
- **Mike Mason –** Nothing to report.
- **Rose Boulade –** Attended the Finance Committee Meeting.
- **Keith Weber –** Attended the Finance Committee Meeting.

5. DISSCUSSION

A.) A. Doss – Quality Report to the Board

Alicia Doss, Risk Management Manager, reported to the Board on Partnership's QIP for the clinics.

Alicia also shared a risk management report that included the volumes of event by category from August 2025 through December 2025.

Risk Management Board Report
Facility By Type Summary
For Period 8/1/2025 through 12/31/2025

AMA / LWBS / Elopement	20
EMTALA	2
Equipment / Device Malfunction	4
Fall	37
Fire Hazard	1
Grievance	18
HIPAA / Privacy	9
Hostile Visitor / Patient	23
Incomplete or Missing Orders	6
Incomplete Progress Notes	3
Infection Prevention	4
Information Technology	2
Medication Error	22
Medication Security	12
Missing Content	4
Near Miss / General Patient Care Concern	41
Other Regulatory Issue	7
Other Unsafe Work Condition	23
Patient Abuse / Neglect	4
Patient Care Management	33
Patient Injury	7
Policy Violation	2
Skin Integrity / Pressure Ulcer	8
Suicidal Ideation	1
Untimely Charting	1

REGULAR SESSION

6. CONSENT AGENDA - *Items under the Consent Agenda heading do not require discussion before a vote. If discussion is needed, that item needs to be moved to the Consideration/Action part of the Agenda where discussion is allowed.*

A.) D. King - Adoption of LFHD Board of Directors Regular Meeting Minutes – September 25, 2025

Carol Madison moved that the Consent Agenda be approved as presented, **Keith Weber** seconded, and the motion carried with all present voting "aye."

7. CONSIDERATION/ACTION

A.) E. Johnson – Departmental Manuals

Ed Johnson, CNO presented the Departmental Manuals and answered any questions the Board had on the manuals and review processes.

Paul Dolby moved to approve the **Departmental Manuals**, **Carol Madison** seconded, and the motion carried with all voting "aye."

B.) J. Lin – December 2025 LFHD Financial Statement *(unaudited)*

J. Lin. Finance Director presented the December 2025 LFHD Financial Statement provided in the Board meeting packet and answered the questions the Board had.

Keith Weber moved to accept the December 2025 LFHD Financial Statement as presented, **Mike Mason** seconded, and the motion carried with all present voting "aye."

C.) J. Lin – FYE 2025 Financial Audit

J. Lin. Finance Director presented the FYE 2025 Financial Statement provided in the Board meeting packet and answered the questions the Board had.

Mike Mason moved to accept the FYE 2025 Financial Statement as presented, **Keith Weber** seconded, and the motion carried with all present voting "aye."

D.) K. Kramer – Physician Assistant Wage Change Proposal (Budget Amendment)
Kevin Kramer, CEO, presented the **Physician Assistant Wage Change Proposal (Budget Amendment)** provided in the packet and answered any questions the Board had.

Carol Madison moved to accept **Physician Assistant Wage Change Proposal (Budget Amendment)** as presented, **Paul Dolby** seconded, and the motion carried with all present voting "aye."

E.) K. Kramer – SART Nurse Expansion Proposal (Budget Amendment)
Kevin Kramer, CEO, presented the **SART Nurse Expansion Proposal (Budget Amendment)**provided to the Board and answered any questions the Board had. Carol and Rose were appointed to the Ad Hoc Committee.

Carol Madison moved to accept the **SART Nurse Expansion Proposal (Budget Amendment)**as presented, **Paul Dolby** seconded, and the motion carried with all present voting "aye."

F.) K. Kramer – PA/FNP Emergency Room Coverage Proposal (Budget Amendment)
Kevin Kramer, CEO, presented the **PA/FNP Emergency Room Coverage Proposal (Budget Amendment)** provided in the packet and answered any questions the Board had.

Paul Dolby moved to accept the **PA/FNP Emergency Room Coverage Proposal (Budget Amendment)**as presented, **Mike Mason** seconded, and the motion carried with all present voting "aye."

E.) R - Boulade – Appointment of Board Treasurer
Rose Boulade, Board Chair, appointed **Keith Weber** as the Board Treasurer.

Carol Madison moved to approve **Appointment of Board Treasurer**, and **Mike Mason** seconded and all present voted aye.

F.) R - Boulade – Appointment of Board Members to Committees
Rose Boulade, Board Chair, appointed **Keith Weber** to the Finance Committee, **Mike Mason** to the Quality Council Committee**,** and **Carol Madison** and **Paul Dolby** to the Joint Conference Committee.

Carol Madison moved to approve **Appointment of Board Members to Committees**, and **Mike Mason** seconded and all present voted aye.

Carol Madison moved to close the Regular Session of the Board of Directors, **Keith Weber** seconded, and the motion carried with all voting "aye."

The Regular Session of the Last Frontier Healthcare District Board of Directors was adjourned at 4:48 pm.

ATTACHMENT B

MEDICAL STAFF COMMITTEE MEETING MINUTES

MODOC MEDICAL CENTER
A Public Entity
Healing Hands Close To Home
Last Frontier Healthcare District

DATE: FEBRUARY 19, 2026

TO: GOVERNING BOARD

FROM: T. RYAN – CREDENTIALING AIDE

SUBJECT: MEDICAL STAFF COMMITTEE MINUTES

*The following Medical Staff Committee Minutes were reviewed and accepted at the January 28, 2026, meeting and are presented for Governing Board review:

A. REVIEW OF MINUTES

1. Medical Staff Committee Meeting Minutes – November 19, 2025

B. COMMITTEE REPORTS

1. EOC Committee Meeting Minutes – 09/02/2025
2. ER Committee Meeting Minutes – 12/23/2025
3. Infection Control Committee Meeting Minutes – 01/22/2026
4. Patient Safety/Safe Lifting Committee Meeting Minutes – 01/21/2026
5. Pharmacy and Therapeutics Committee Meeting Minutes – 01/22/2026
6. OP Infusion Committee Meeting Minutes – 12/16/2025
7. Surgery Committee Meeting Minutes – 12/16/2025
8. OP Infusion Committee Meeting Minutes – 01/13/2026
9. Surgery Committee Meeting Minutes – 01/13/2026

C. PATHOLOGY REPORT – 10/31/2025 & 11/01/2025

D. NEW BUSINESS

1. Diet Manual Update – Barbara Howe, RDN
2. Incomplete Records
3. FNP Privilege Form Update
4. Annual MMC Bylaws and Rules Review

MODOC MEDICAL CENTER
A Public Entity
Healing Hands Close To Home
Last Frontier Healthcare District

MEDICAL STAFF COMMITTEE MEETING
November 19, 2025 – Education Building
MINUTES

In Attendance

Matthew Edmonds, MD Chief Medical Officer
Edward Richert, MD Vice Chief Medical Officer
Lisanne Burkholder, MD
Landin Hagge, DO
Barbara Howe, RDN
Valeria González Campos, MS4 (Medical Student)
Kevin Kramer- CEO
Ed Johnson- CNO
Judy Jacoby- Infection Control Nurse
Vahe Hovasapyan- Pharmacist
Alicia Doss- Risk Management
Brandy Morris-Wright- MSC/H.I.M Director
Taylor Ryan- Credentialing Aide

SUBJECT	DISCUSSION	ACTION
I. CALL TO ORDER	After noting that the required members were present to constitute a quorum, the regularly scheduled Medical Staff Committee Meeting was called to order at 1200 by Dr. Edmonds, MD Chief Medical Officer.	
II. CONSENT AGENDA ITEMS	1. The following Minutes were reviewed: A. Medical Staff Committee Meeting of October 29, 2025.	Minutes approved by motion, second, and vote. Forward to Governing Board.
	1. The following Committee Reports were reviewed with no corrections or additions noted: A. Infection Control Committee Meeting for July, August, & September 2025. B. Pharmacy and Therapeutics Committee Meeting Minutes, 10/30/2025. C. Surgery Committee Meeting Minutes, 10/14/2025. D. OP Infusion Committee Meeting Minutes, 11/18/2025. E. Surgery Committee Meeting Minutes, 11/18/2025.	Minutes approved by motion, second, and vote. Forward to Governing Board.
III. PATHOLOGY REPORT	Review of Report, 08/07/2025 & 09/11/2025	Report at next meeting

SUBJECT	DISCUSSION	ACTION
IV. CHIEF MEDICAL OFFICER REPORT (DR. EDMONDS, MD)	Currently, not a whole lot is going on right now, especially with the Holidays here. We had a Provider Meeting last week and we discussed the possibility of bringing in a clinical lead to the Alturas Clinic to assist the PAs, FNPs, MAs, and the Care Coordinators with some of the more technical and clinical things for patient care and provider support. The Providers were pretty excited and had much of their own feedback. That being, we are going to be taking the feedback and working on that to see the best way to implement it moving forward. However, Provider Recruitment has been tough. We did lose one of our Providers to some documentation issues and another temporarily due to some personal issues that are going on, so things are a bit tight right now. Therefore, we have been working around this and rescheduling appointments. With that, there have been lots of overbooking and same-day appointments. Recently, we attended our quarterly board meeting. We got to introduce Lisanne to everybody as well as give them the usual updates so that was a good time. We still have Cardiology in the background. They are probably going to beg off till the New Year before trying to set things up here. However, that will be huge when that happens. It will be a lot of work and a huge adjustment for everybody, but it will benefit us and the community immensely. As we are recruiting and about to hire Virginia FNP in January, we are starting to see more times where there are more than five Providers in the Clinic. We have got an agreement with Jacee and Wendy that they are ok to go down to one room if necessary and Dr. Hagge has also offered to go down to one room as well, if necessary, so that if we keep running into days like this, we can properly function. We have also discussed with Kevin the possibility of utilizing the Wound Care room as an outpatient place to bill from as well as the surgical area as an outpatient place to bill from so that our Surgeon and GI Doctor can actually see their patients over there and possibly free up space in the Clinic. They too may have to double up on offices more than they already are, but for now this is still all up in the air so more to come on that. We do have Dr. Kemmer starting on December 1st, so we have a few days set aside with IT to show	Report at next meeting

SUBJECT	DISCUSSION	ACTION
	him the ropes and Julie's got some really good scheduling ideas for him to be able to pick up Miriam's patients and eventually transition to mine as well, so I think that is all going to go very smooth. We have his office, schedule, and team all ready for him. For the time being, we are going to be pretty light with our PA/FNP supervision as there may only be one Doctor on, so we may have to look ahead at the schedules for Clinic PA/FNPs to ensure coverage.	
V. EMERGENCY ROOM REPORT	Nothing to Report.	
VI. CEO REPORT	Currently, with that Provider recruitment, Dr. Richert and I currently have an interview tomorrow with Kathleen Chesney. She is interested in the Skilled Nursing Facility PA/FNP. We also have initiated a locum position in the Alturas Clinic to try to bridge the gap as well and provide more supervision. Hopefully we receive some applicants here over the next few weeks. On the SNF project front, everything is done as you guys know. Ed's crew has everybody moved in there. On the financial side, the USDA has pushed our close date to from November 20th to December 19th. They just have too much backlog coming off from the federal government shutdown. That being, our intern lender which is Vanguard bought all the anticipation notes from us when we went out to get construction financing so, they are going to extend that financing for us. Their legal team is reviewing the documents right now and is pending approval. We are anticipating signing early next week. It is our best interest to close with the USDA as soon as possible because their interest rate is 3.75% on 24 million versus 6% of what these guys are charging us on the interim financing. With Cardiology, we have not heard from them in a while, but we are going to hold off right now due to all the movements we have going on right now in the Alturas and Canby Clinic.	Report at next meeting
VII. CNO/SNF REPORT	Currently, I am working with Dr. Richert on the admission process for outside people. I am going to get with Kayla today and I should have written out to you guys by tomorrow on what the process is. The hardest part is going to be getting the notes to	Report at next meeting

SUBJECT	DISCUSSION	ACTION
	you guys in Cerner. If they are not in our system, that is where it gets difficult. I will have the final answer to you guys by tomorrow. We are at 36 ½ residents and I say a half because we have one currently in the acute that should be coming back to us soon. We are going to start working down the waitlist. We want to fill up Mountain View first and then we will start over at Warnerview. We do have our second IV Infusion going at Warnerview making a total of two. We are doing it once a day, so we have an RN over there at least eight hours a day, but if we do it more than once, then they must come over to Mountain View because we don't have supervision night shift at this time. If we exceed more than two, we are going to run into pump issues because we only have one, so we had to borrow one from Surgery.	
VIII. PHARMACY REPORT	Currently, not a whole lot is going on right now. We recently got our feedback from the SNF Survey as far as what things will look like moving forward. One thing I wanted to discuss with the Physicians was the Topical NSAID Voltaren 1% Gel. They do want you guys to put in the orders as to how many grams are to be applied with each application and to which location. That being, so you guys are not leaving the decision making to the Nurses.	Report at next meeting
NEW BUSINESS IX. POLICY REVIEW & APPROVAL MEDICAL STAFF OFFICER NOMINATIONS	The following New Business was presented for review/approval: 1. Updated Policies, November 2025 (33) 2. The nominations for Chief of Staff were opened by nominating Dr. Lisanne Burkholder, MD. The nominations for Vice Chief of Staff were opened by re-nominating Dr. Edward Richert, MD. Both physicians have: • Demonstrated understanding of the functions and purposes of the Medical Staff. • Demonstrated the willingness to assure that patient welfare always takes precedence over other concerns. • Demonstrated an understanding and willingness to work towards attaining reasonable policies and requirements.	After review and discussion, a recommendation was made to implement the Updated Policies (33) presented November 2025. The recommendations were ratified by motion, second, and vote. Recommendations will be forwarded to the Governing Board for final approval. After review and discussion, based upon meeting the established criteria/qualifications for Chief of Staff and Vice Chief of Staff, as well know character, current competence, training,

SUBJECT	DISCUSSION	ACTION
	• Demonstrated the administrative ability applicable to the respective office. • Demonstrated the ability to motivate and work with others to achieve the objectives of the Medical Staff and Hospital. • Demonstrated clinical competence in their field of practice. • Are of Active or Limited Active members of the Medical Staff (and remain in good standing as an active Medical Staff member while in office). • Not having any significant conflict of interest. These qualifications have been determined through close observation by members of the Medical Staff, peer evaluation, and participation in Medical Staff functions.	experience and judgment, participation in other Medical Staff functions, the nominations were ratified by motion, second, and vote. Results will be forwarded to the Governing Board for final approval.
X. ADJOURNMENT	The meeting was adjourned at 1240.	

Lisanne Burkholder, MD Chief Medical Officer — Date: 01/28/2026

MODOC MEDICAL CENTER
A Public Entity
Healing Hands Close To Home
Last Frontier Healthcare District

EOC COMMITTEE MEETING
Tuesday, September 2nd, 2025 at 11:00 am
Education Conference Room, Modoc Medical Center

MINUTES

Present:

- Dan Vierra
- Michael Appletoft
- Hao Lin
- Suzanne R. Johnson
- Sandra Brown
- Judy Jacoby
- Jeremy Wills
- Alicia Doss
- Susan Sauerheber
- Jonathan Crnkovic

Absent:

Adam Willoughby
Megan Morris-Wright
Julie Carrillo
Marty Shaffer
Lance P. Chrysler
Raven Sparks
Amber Vucina
Shelly Bailey
Delinda Gover
Ed Johnson
Jay Dunn
Lance P. Chrysler

Subject	Discussion	Action
A. Call to Order		
B. Approval of the Agenda	**M Shaffer** – The EOC Committee meeting was called to order at 11:00 am	Approved
C. Discussion Items		
1. Education/Training	**Ed J.** • Health Stream • Train the Trainer	Absent. Friday meeting to discuss adding modules.
2. Emergency Management	**J Wills** **Emergency Management**	Training is coming up. Staff are required to set up E-3 on computer or cell phone.
3. Fire& Life Safety	**D Vierria** **Fire Drills**	Up to date.
D. New Business		
4. Haz Mat / Waste Management	**D Vierria** Medical Waste **L Chrysler** **Haz Material**	1. Medical waste accumulates normally. 2. Absent.

Subject	Discussion	Action
5. **Medical Equipment/ Training / Safe Medical Device**	**M Shaffer** 1. New Equipment 2. **Medical Devices**	1. We received 1 Omnicell for HA.
6. **Policy & Procedure Manual**	**M Shaffer** 1. **Policy & Procedure**	1. In progress.
7. **Water Management Program Committee Update**	**M Shaffer** 1. **Update on Water Management Program**	Last quarter's water samples were tested, and all results met standards.
8. **Safety**	**A Vucina** 1. **First Aid Injuries** 2. **Claim Injuries** EOC Rounds due for September 2nd. 1. Suzanne J. / Dan V. – SNF floor 2. Susan S. / Marty S. – Acute,ER areas. 3. Shannon K. / Marty s. – Laboratory. 4. Shelly B/ Marty S. – Radiology. EOC Rounds are due in November 4th. 1. Jon C. / Dan V. – Alturas Clinic. 2. Jullie C. / Dan V. – Canby Clinic. 3. Suzann J. / Raven S. – SNF Kitchen. 4. Delinda G. / Michael A. – Surgery area. 5. Vahe H. / Michael A. – Hospital Pharmacy. Code Blue/ Staff Assist testing Surgery/Radiology areas.	1. Absent. SNF: • Glucometers missing date labels • Bugs observed on light fixtures • Soiled linen overflowing • Food at nurses' station missing date labels • Resident rooms untidy • Dust buildup on top of nurses' station ER: • Air vents require cleaning • Ceiling tile with a water spot needs replacement Med/Surg: • Crash cart is required to be plugged into a red emergency outlet • Sharps container overflowing Lab: • Air vents require cleaning • Floors require cleaning • Lab needs an alarm system
9. **Security**	**M. Shaffer** **1. Door Locks / Card Readers** **2. Security Cameras**	1. Wires have been run for Mountain View
10. **Utilities Management**	**D Vierria** **Generators Power Outages** **M Shaffer** 1. **Other Utilities**	1. One power outage since the last meeting.
Adjournment	The next EOC meeting will be held on November 4th , 2025, at 11:00 am in the education conference room.	

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MINUTES

ER COMMITTEE MEETING

On Tuesday 12-23-2025 from 3:00 to 4:00 pm
Modoc Medical Center – 1111 N. Nagle Street
Education Conference Room; Alturas, California

Present:

- Dr. Jay Lai
- Susan Saueheber, Acute/Er Nursing Manager
- Ed Johnson, CNO
- Shannon King
- Walter Dimarucut
- Sandra Brown
- Megan Wright
- Mary Lawrence

Absent:

- Shelly Bailey
- Kevin Kramer, CEO
- Alicia Doss
- Lance Chrysler
- Vahe Hovasapyan

Subject	Discussion	Attachment
1. **Call to Order** – The meeting was called to order by **Susan Sauerheber** at 3:04 pm in the Education Conference Room.		
2. **Agenda Approval**	**Susan Sauerheber** - Changes, additions and/or deletions to the Agenda.	All present approved the presented Agenda.
3. **Minutes of July 31, 2025 ER Committee Meeting**	**Susan Sauerheber** – Presentation of July 31,2025, ER Committee meeting minutes for approval.	All present approved the presented meeting minutes for the July 31, 2025 meeting.
4. Old Business	• See attached Minutes	
5. New Business	• A-Central Supply • B-Lab	

Subject	Discussion	Attachment
	• **C-Zio Patch** • **D-Chantel not being here** • **E-Nora Glucometer- Saren beta hydroxy butyrate (any new equipment as it becomes available) **keep on agenda**	
A.	Central Supply-Minnesota or Blakemore tub kit Placed in ER trauma room, spare Blakemore tube in hallway. This will be available to use if we can't get someone out due to weather or emergency Central Supply-Slit Lamp- The Slit Lamp is here but we have no cart. Marty and Danny are working on a makeshift cart that should work.	
B.	Lab-strep PCR, MRSA PCR, MVP Working on Validation, Gene-Expert, should be up and running in February and interfaced with Cerner. Misc. can be done sooner. Bio-Fire—these do not get paid and are very expensive. Great for Multiple Respiratory issues. We will still use for blood cultures, stool and GI. Lab supplies- Marty to take care of bags New Procedure and Form to order supplies from lab-ER to fill out order form and Lab to bring supplies over. The ER staff is to look at bins and email Order sheet to Walter and Shannon or deliver to Lab. Lab will fill order and bring to ER.	
C.	Zio Patch- halter monitor TRhythm-website-Marty to figure out how to get patches in our ER. Patients responsible for mailing in patch after allotted monitoring time and results provided via TRhythm website.	
D.	Chantel was very thorough and ordered labs on patients all the time. She left no stone unturned with patients. This will most definitely be reflected in the volume produced in the lab unless another physician or the physician group picks up where she left off. (May she rest in peace-may her family have strength and hope through this Holiday season)	
E.	Instrument options coming to America upon approval by FDA, need to keep searching (lab) beta hydroxy butyrate analyzer (like NOVA glucometer)	
5. Roundtable – See attached.		
6. Adjournment	**The next ER Committee Meeting will be TBD in the Education Conf. Room.**	

ER COMMITTEE MEETING

On Thursday 7-31-2025 from 3:00 to 4:00 pm
Modoc Medical Center – 1111 N. Nagle Street
Education Conference Room; Alturas, California

ROUNDTABLE

Dr. Lai- Toco Monitor Price 7k Cart $500-600. Marty still looking into it. Per Susan, put on Aux. wish list as well. Blood Bank orders, he will talk to physicians. Zip patch-heart halter monitor alternative. More user friendly and Marty will look into cost and how to use them in our ER.

Marty L.- Marty will work on the above and look into website for TRhythm. Her and Danny are developing the cart for the Slit lamp. She is doing the bags for ER from now on.

Walter D.- Working on validation and interface with Cerner. Shannon detailing different labs, cost and availability.

Shannon K.- Still a problem with the blood bank orders. Dr. Lai to inform the physicians that if they have questions, to call the lab. All lab staff is willing to help out with the order so that it is processed correctly and can be billed out and paid for. Supplies in ER, Suggested by Shannon and accepted by Committee that a form be created so ER staff can order supplies and Lab will deliver.

Megan W-. Nothing to report, called out

Edward J.- Nothing to report

Susan S.- EMS Transfers are tapping out nursing staff. Between being down one ambulance and nurses going on transfers we have developed the following: --Day transfers-Tami --Night transfers-Kelly
Susan to be called if Kelly unavailable-during Christmas.

Ventilator to be put in use 12/24/2025. Everyone has been trained and we are ready to go.

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MINUTES

INFECTION CONTROL COMMITTEE MEETING

01/22/2026 12:00-1:00 pm
Modoc Medical Center – 1111 N. Nagle Street
Education Conference Room; Alturas, California

Present
- Walter Dimarucut
- Suzanne Johnson
- Ed Johnson
- Amber Vucina
- Sandra Brown
- Judy Jacoby
- Michael Appletoft
- Edward Richert, M.D.
- Jeremy Murray
- Shannon King
- Megan Hays
- Jon Crnkovic

Absent:
- Tim Reynolds
- Susan Saueheber
- Delinda Gover-Perez
- Marty Shaffer
- Raven Sparks
- Lisanne Burkholder, M.D.
- Edward Richert, M.D.
- Alicia Doss

Subject	Discussion	Attachment
1. **Call to Order** – The meeting was called to order by Judy Jacoby at 12:03 pm in the Education Conference Room.		
2. **Agenda Approval**	• See attached Agenda	All present approved the presented Agenda.
3. **Minutes**	• No Prior Minutes to Review/attach	
4. New Business		
A.	• **Agenda items and analysis**	**Attached**
B.	• **SNF'S 4nd quarter IC report**	**Attached**
C.	• Topic review: Review of Strategic Goals, current and accomplished in 2025-2026 Data presentation on blood cultures and	**Details in Attached Agenda**

Subject	Discussion	Attachment
	urine cultures Discussion on employee health concerns and follow-up procedures Wound Care Review of vaccination data Review of identified concerns reports Review of upcoming Action Plan • SNF Provider to Provider Communication is broken. Possible use of steps in Cerner to take proxy authorization from another provider. Culters-results being sent to providers that are not here-possible solution-see attached • We are keeping prior Covid protocols that hold strict standards (newer protocols have lower standards) • Burkholder or Richert must be at IC Committee Meeting. Move the meeting to accommodate their schedule • Need to swap to catch GI issues that are being missed.	**(see attached)**
7. Adjournment	The next Infection Control Committee Meeting will from 4/23/2026 from 12:00 to 1:00 p.m., in the Education Conf. Room.	

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MINUTES

PATIENT SAFETY/SAFE LIFTING COMMITTEE MEETING

1/21/2025 at 1:00 p.m.
Modoc Medical Center – 1111 N. Nagle Street
Education Room, Alturas, California

Present:

- Jay Dunn, Chair
- Ed Johnson, CNO
- Amber Vucina, Chief HR Officer
- Sandra Brown, Admin to CNO
- Megan Hays, DNO
- Jon Crnkovic, Manager Alturas Clinic
- San Juanita Wagner, Staff Development

Absent:

- Julie Carrillo, Manager Canby Clinic
- Susan Sauerheber, ER Nurse Manager
- Megan Morris-Wright, EMS Director
- CeCe Toaetolu, SNF-Nurse Manager
- Judy Jacoby, IC Nurse

Subject	Discussion	Attachment
1. Call to Order – The meeting was called to order by Jay Dunn at 1:03 pm in the Education Room.		
2. **Agenda Approval**	• Jay Dunn approved Agenda items	All present-approved
3. **Minutes**	• 9/2025	Attached
4. Old Business	• See attached Minutes	Attached
5. New Business		
A. **Good Catch Patient Safety Recognition Award**	• **We tell staff that if they see something, to say something. This will be seen as a reward for speaking up.** • **The award will be given as the "Good Catch" occurs. Sandy and Ed to create rules, form and trophy options.**	
B. **Patient Safety Committee**	• **The committee is now named Patient Safety/Safe Lifting Committee** • **We will continue with the same members on the committee.**	
C. **Items to add to the standard agenda**	• **Care Funds-See Attached Memo From Amber V., this year $4,700**	**Attached**

Subject	Discussion	Attachment
	• **Ideas for CARE Funds, the spa bathing chair, a hover jack cart, tilt back shower chair (although it may be too expensive) Cadillac chair (include shipping and tax with all items we wish to submit for approval)**	
Roundtable:		
7. Adjournment	The next Meeting will be 3/18/2025 @ 1:00 at Education Conference Room.	

PHARMACY AND THERAPEUTICS COMMITTEE
Minutes
Thursday, January 22, 2026, 2:00:00 PM
Education Conference Room, Modoc Medical Center
Alturas, California

Attendees:

Vahe Hovasapyan	Megan Hays	Edward Richert
Ed Johnson	Alicia Doss	Walter Dimarucut
Suzanne Johnson	Lisanne Burkholder	

Subject	Discussion	Action
1. Call to Order		Called to Order @ 1410
2. Approval of October 2025 Minutes		Minutes Approved
3. Agenda	1. Formulary Changes 2. Policies for Review a. Vasopressin Protocol b. Droperidol Protocol c. Comfort Care 3. Medication Error Report 4. Antimicrobial Stewardship a. New Antibiogram b. Oct – Dec 2025 Report	Vahe Presented the Agenda
New Business		
4. Formulary Changes	Vahe Updated the Committee on the formulary changes: Removing: Medrol Dose Pak Adding: Paroxetine 10mg	Formulary Changes Approved

Subject	Discussion	Action
5. Policies for Review	Vasopressin Protocol Comfort Care Protocol Comfort Care Protocol	Dr. Burkholder approved the Vasopressin protocol for ED use. Droperidol was reviewed with no changes requested, approved. Comfort Care protocol will be renamed to Pain Management in Comfort Care Patients. This protocol will be revised to include information pertaining to pain management of comfort care patients at the SNF, with a focus on the use of concentrated morphine oral solution. This protocol will be revised to include the retail pharmacy and their role in unit dosing morphine oral solution in syringes for easier tracking.
6. Med Error Report for Oct – Dec 2025	Vahe presented the Med Error report for the previous 3 months, noting an uptick in retail pharmacy errors reaching patients and resulting in hospitalizations.	Ongoing education being provided to retail staff regarding error reduction. Monthly pharmacist education series scheduled to discuss workflow improvements and streamline medication dispensing process. Dr. Burkholder has requested ER Committee to bring up messaging PCP when ED providers see a patient and prescribe new meds.
7. Antibiogram for New Year	Vahe presented the Antibiogram for October 2023 – December 2025	Walter Dimarucut's team was able to compile data since the start of Cerner to make a more comprehensive antibiogram. Lab has finished calibrating new MRSA analyzer (PCR) that is much faster.
8. Antimicrobial Stewardship Report	Vahe presented the Antimicrobial Stewardship report for the past 3 months.	The most prevalent infections were UTI in the SNF. The most used antimicrobials were Macrobid and Bactrim for UTI. Next report will include differentiation between UTI treated with culture growth vs UTI treated w/o any cultures.
Adjourn Meeting	Meeting adjourned at 14:50. The Next P & T Committee Meeting will be scheduled for April 23, 2026, @1400.	

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MINUTES

OP INFUSION COMMITTEE MEETING

Tuesday, 12/16/2025 at 8:30-9:30 a.m.
Modoc Medical Center – 1111 N. Nagle Street
Infusion Department, Alturas, California

Present:

- Susan Sauerheber, Committee Chair
- Shirley Hughes, Infusion
- Linda Sawyer, Infusion Nurse
- Delinda Gover-Perez, Surgery Manager
- Sandra Brown, Admin. Assistant
- Lisanne Burkholder, M.D.
- Vahe Hovasapyan, Hospital Pharmacy Manager
- Ed Johnson, CNO

Absent:

- Matthew Edmonds, M.D.

Subject	Discussion	Attachment
1. **Call to Order** – The meeting was called to order by Delinda Gover-Perez at 8:35 am in the Infusion Room.		
2. **Agenda Approval**	No Changes, additions and/or deletions to the Agenda.	All present approved the presented Agenda.
3. **Minutes**	Approved	Attached hereto (11/2025)
4. Old Business	**As noted on Minutes and discussed at 11/2025 OP Infusion Committee Meeting**	
5. New Business		
	• Still concern about checking that labs are done before starting infusion. Shirley and Linda working with spreadsheet to check same.	
	• Vahe has keys to refrigerator. He will make sure Linda has one.	
	• Adam said no to tinting, blinds? Not sure when that will be resolved.	
	• Meds for patients that we are not administering. We need to tell Dr. Torman or any other physician that	

Subject	Discussion	Attachment
	Infusion does not handle meds that they are not administering. Needs to go through Torman's MA or back to outside doctor. Great solution is to have them do the procedure here and then most likely insurance will pay.	
	• Blood drive- consensus is that the Surgery and Infusion areas are not a good fit due to possible contamination. Should look into mobile unit or clinic on a clinic day off.	
	• Issue with true "no show" should be right clicked and action..."no show". When you do this the FIN# is scrapped. On the other hand, if you go in and put reschedule the FIN# is kept.	
	• Quarterly reports from Jin Lin?? Delinda has received 1 report.	
	• Billing has been going well. Quarterly reports are needed still.	
6. Roundtable Do we want to start having roundtable after we do old and new business??? All discussed above		
7. Adjournment	The next OP Infusion Meeting will be Tuesday, 1/13/2026 @ 8:30 a.m. in the Infusion Department	

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MINUTES

SURGERY COMMITTEE MEETING

Tuesday, 12/16/2025, at 8:30-9:30 a.m.
Modoc Medical Center – 1111 N. Nagle Street
Infusion Department Alturas, California

Present:

- Lisanne Burkolder, M.D.
- Delinda Gover Perez, Committee Chair
- Susan Sauerheber, Nursing Manager
- Sandra Brown
- Linda Sawyer, RN
- Ed Johnson, CNO
- Shirley Hughes, Infusion Clerk
-

Absent:

- Edward Richert, M.D.
- Dale Syverson, M.D.
- Kevin Kramer, CEO
- Marty Shaffer, Plant Op Director
- Katrina Murray, Surgery Tech
- Marty Shaffer, Facilities/EOC
- Adam Willoughby, COO
- Krishna Desai
- Jon Crnkovic
- Sidney Barns, Surgery Tech

Subject	Discussion	Attachment
1. Call to Order – The meeting was called to order by Delinda Gover-Perez at 9:11 am in the Infusion Room.		
2. **Agenda Approval**	No Changes, additions and/or deletions to the Agenda.	All present approved the presented Agenda.
3. **Minutes**	See Attached from 11/2025	
4. Old Business	**See attached Minutes**	
5. New Business		
	• Quarterly from Jin Lin… only received one report. Delinda to follow up with Jin Lin on that.	
	• Adam stated that they will not be asking patients to pay anything for anesthesia provider/cost.	

Subject	Discussion	Attachment
	• For Diagnostic procedures (colonoscopy) to make it urgent, there is no urgent box to check in order or comment but the diagnostic code will trigger it. Positive (Shield) blood test also need to be treated as urgent.	
	• Waiting on Kevin to let us know about provider space issues	
	• Problems with laparoscopic equipment. Eric suggested using plumbers tape for CO2 tank issue. We were approved for new ones but won't be certified to be placed into service until at least February. Delinda will use the plumbers tape for January procedures.	
	• Cauterizing machine (2020 model) almost caught on fire Wed. It has been sent out for service.	
	• Acute will be getting ice machine. Delinda will keep putting sign up. Everyone goes in there for ice which she does not mind on non-surgery/procedure days.	
	• Cerner, long-term care orders seem to be fixed for now. We will see	
7. Adjournment	The next Surgery Meeting will be Tuesday, 1/13/2025 @ 8:30 a.m. in the Infusion Room.	

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MINUTES

OP INFUSION COMMITTEE MEETING

Tuesday, 1/13/2026 at 8:30-9:30 a.m.
Modoc Medical Center – 1111 N. Nagle Street
Infusion Department, Alturas, California

Present:

- Susan Sauerheber, Committee Chair
- Shirley Hughes, Infusion
- Linda Sawyer, Infusion Nurse
- Delinda Gover-Perez, Surgery Manager
- Sandra Brown, Admin. Assistant
- Vahe Hovasapyan, Hospital Pharmacy Manager
- Ed Johnson, CNO

Absent:

- Lisanne Burkholder, M.D.

Subject	Discussion	Attachment
1. **Call to Order** – The meeting was called to order by Delinda Gover-Perez at 8:35 am in the Infusion Room.		
2. **Agenda Approval**	No Changes, additions and/or deletions to the Agenda.	All present approved the presented Agenda.
3. **Minutes**	Approved	Attached hereto (12/2025)
4. Old Business	**As noted on Minutes and discussed at 12/2025 OP Infusion Committee Meeting**	
5. New Business		
	• No new or Roundtable items	
	• Phone number correction needed. Sandy to send e-mail to Rylee regarding same ie., 708-8855 (sent).	
	• Sandy to also send message to Rylee regarding advertising? (sent)	
	• Sandy to send message to Jin Lin for last quarter Budget Statements on Anesthesia (sent).	
6. Roundtable Do we want to start having roundtable after we do old and new business???		

Subject	Discussion	Attachment
	All discussed above	
7. Adjournment	The next OP Infusion Meeting will be Tuesday, 2/10/2026 @ 8:30 a.m. in the Infusion Department	

MINUTES

SURGERY COMMITTEE MEETING

Tuesday, 1/13/2026, at 8:30-9:30 a.m.
Modoc Medical Center – 1111 N. Nagle Street
Infusion Department Alturas, California

Present:

- Delinda Gover Perez, Committee Chair
- Susan Sauerheber, Nursing Manager
- Sandra Brown
- Linda Sawyer, RN
- Ed Johnson, CNO
- Shirley Hughes, Infusion Clerk
- Sidney Barns, Surgery Tech

Absent:

- Edward Richert, M.D.
- Dale Syverson, M.D.
- Kevin Kramer, CEO
- Marty Shaffer, Plant Op Director
- Katrina Murray, Surgery Tech
- Marty Shaffer, Facilities/EOC
- Adam Willoughby, COO
- Krishna Desai
- Jon Crnkovic
- Lisanne Burkolder, M.D.

Subject	Discussion	Attachment
1. Call to Order – The meeting was called to order by Delinda Gover-Perez at 9:11 am in the Infusion Room.		
2. **Agenda Approval**	No Changes, additions and/or deletions to the Agenda.	All present approved the presented Agenda.
3. **Minutes**	See Attached from 12/2025	
4. Old Business	See attached Minutes	
5. New Business		
	• Surgery & Anesthesia Budget Statements- Sandy sent request to Jin Lin for same prior to next meeting 2/10/2026.	
	• Medications ordered for Surgical Patients are not being filled in a timely manner. Patients are often still waiting for the medication after they have been	

Subject	Discussion	Attachment
	discharged. Syverson will be asked to ask pharmacy and preferred pain meds for take home in the a.m. This should allow enough time for the meds to be filled prior to discharge.	
	• Laparoscopic equipment, new things need3ed. Potential to consider buying some of Mayer's equipment. Insufflator needs repair. Some of Mayer's equipment might work for us. We sked Syverson to look at it when he is there.	
	• Sandy sent e-mail to Rylee about Advertising.	
7. Adjournment	The next Surgery Meeting will be Tuesday, 2/10/2026 @ 8:30 a.m. in the Infusion Room.	

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PATHOLOGIST ON-SITE VISIT REPORT
DATE OF VISIT: 10/31/2025

During the pathology on-site visit, I spent approximately 6 ½ - 7 hours in the Laboratory, Medical Records, and at Canby Clinic.

While in medical records, I reviewed 12 surgical path reports and compared them with their clinical histories. There were 3 mortality reviews and 1 blood product reviews. There were no issues identified in any of these reports.

While in the laboratory, I spoke Walter concerning the laboratory staffing. The lab is now fully staffed, and the lab is working well together. I spoke with Brenda and she felt that things were going very well in the laboratory and she is happy with her new CLS working companions. There was an issue with being able to do a calculated LDL. When the HDL level was above 100 milligrams for desolator, Cerner is not set up to do the calculations; however, a Manuel calculation can be performed if desired. I examined the Modoc monthly quality control review summary, the Modoc exceptions report, the nova biomedical data exception report for August and June, the QA statistics report for the hemoglobin A1C.

I spoke to Dr. Appel in the Emergency room, and he indicated he had no issues with the laboratory and that the staff generated reliable data which coordinates with the clinical practice

I spoke with some of the ER nursing staff and they felt that the laboratory staff was performing well and had no issues with the new ~~CLS~~'s in the laboratory.

12/17/25
Date

ROBERT JAMES, MD, PhD
CONSULTING PATHOLOGIST

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PATHOLOGIST ON-SITE VISIT REPORT
DATE OF VISIT: 11/1/2025

During the pathology on-site visit, I spent approximately 7 – 7 ½ hours in the Laboratory, Medical Records, and at Canby Clinic.

While in medical records, I reviewed 15 surgical path reports and compared them with their clinical histories. There were 3 mortality reviews and 4 blood product reviews. There were no issues identified in any of these reports.

While in the laboratory, I spoke Walter concerning the laboratory staffing. The laboratory is in a very good situation regarding staff and personnel currently. The results of the recent State inspection are back and there was one deficiency that was quickly addressed and the laboratory should be extremely pleased with the results and as should the hospital staff with the personnel of the laboratory. While on this visit I attended a dinner provided by the hospital celebrating the excellent results of the laboratory during the State inspection and just to show the appreciation the hospital has for the excellent work the people in the lab do. In addition, I review the QC results for glucose for August and September, the XN-550 quality control charge for September, the UA Quantrell level 1 and level 2, Multi stick test for September, the clinic tac urinary quality control level 1 ands level 2 for the siemens multi stick 10 SG strips, the Alcor group coordination report for the mini SED – 291 instrument, the siemens hemostasis QAP program for September, the Sysmex CA-620 maintenance log, the procedure policy for validation for the Vitros 760 instrument. The American Proficiency Institute (API) for chemistry 2025 miscellanies second event kit, the procedure to establish the basic guidelines using the BD BVL Cefinase for beta lactamase disk to determine the presence of the absence of beta lactamase activity, the verification of test ranges for the ortho ranges. The data summary report which needs to be run every 6 months. The Hemostatic new QC log verification receipt, the procedure for establishing a baseline guideline for policy and procedure related to validation and implementation of new law of QC controls in the varies department of the lab. The new urinalysis policy procedure, the 2024 immunology / immunohematology 1st event for the American Proficiency Institute (API), the Istat 6th month CG 4+ calibration verification, the Istat 6th month chemistry chem 8 plus calibration verification.

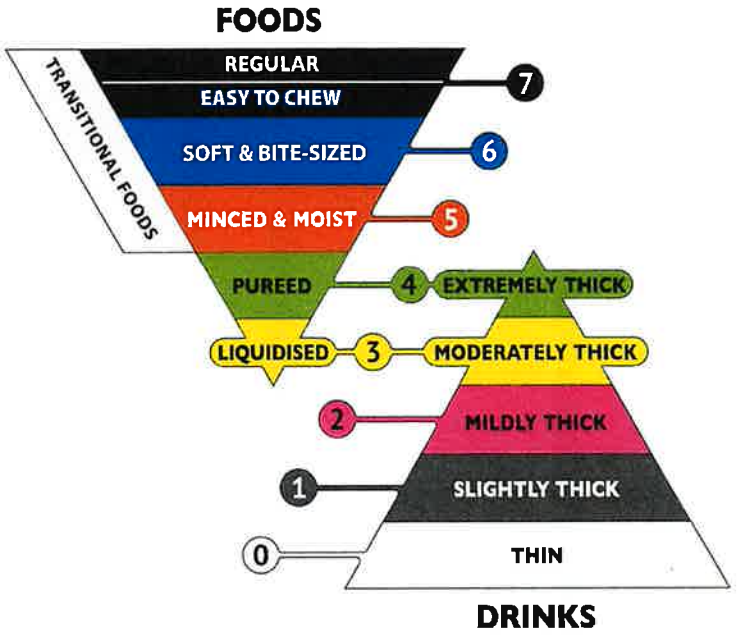
I spoke to Dr. Appel in the Emergency room, and he indicated he was satisfied with the work being done by the laboratory and enjoyed working with the staff.

Robert James 12/17/25

ROBERT JAMES, MD, PhD
CONSULTING PATHOLOGIST

Date

IDDSI FOOD AND DRINK CHART



NEW DIET TEXTURE VERBAGE	DIET CODE	OLD DIET TEXTURE VERBAGE	NEW DRINK TEXTURE VERBAGE	DRINK CODE	OLD DRINK TEXTURE VERBAGE
REGULAR (7)	RG7	REGULAR			
EASY TO CHEW (7)	EC7	CHOPPED			
SOFT & BITE SIZED (6)	SBS6	MECHANIC SOFT			
MINCED & MOIST (5)	MM5	MIXED TEXTURE (combination of multiple food textures)			
PUREE (4)	PU4	PUREE	EXTREMELY THICK (4)	ET4	PUDDING THICK
LIQUIDIZED (3)	LQ3	FULL LIQUID DIET	MODERATELY THICK (3)	MT3	HONEY THICK
			SLIGHTLY THICK (2)	ST2	NECTAR THICK
			THIN (0)		REGULAR LIQUIDS

MISSING DOCS, CHANTELE 12.05.2025				
DOS	Patient	FIN NUMBE	Docum	Notes
12/4/2025	CAIL	60106052	ER	**MISSING**
12/4/2025	HUNTER	60106086	ER	**MISSING**
12/4/2025	REYNOLDS	60106054	ER	**MISSING**

Standardized Procedures and Protocols for Nurse Practitioners

Revised 01/28/202619

Contents

Standardized Protocols for Nurse Practitioners

I. Introduction

These Standardized Procedures and Protocols are established for use by Nurse Practitioners and Physicians at Modoc Medical Center (MMC). They are based on the guidelines established by the Board of Registered Nursing, and on applicable sections of the regulations of Medical Board of California.

The purpose of this document is to:

- Define the scope of practice of Nurse Practitioners (NPs) at MMC
- Meet the required legal guidelines for the provision of health care by Nurse Practitioners
- Promote the highest standard of care for patients at Modoc Medical Center

These Standardized Procedures are to be considered guidelines, not standards of care; they are not intended to replace clinical judgment.

II. General Policy

A. It is the intent of this document to authorize the Nurse Practitioners (NPs) of MMC to implement the Standardized Procedures without the immediate supervision or approval of a physician. It is not the intent to have the NPs independently diagnosing, treating, or managing all patient conditions that may be encountered, but to utilize personal assessment and healthcare management skills in conjunction with the Standardized Procedures and the collegial physician-nurse practitioner relationship in order to meet the healthcare needs of the patient.

B. This agreement provides guidelines for the duties and functions of Nurse ~~Practitioners~~ Practitioners, along with a standardized formulary for their clinical practice. It provides the legal authorization for them to perform those functions and procedures delegated to ~~the~~them by the Supervising Physicians of Modoc Medical Center as described in this document.

III. General Protocol

A. Approval

The Standardized Procedures and Protocols will be approved by the Physicians, NPs. Each physician ~~and NP~~and NP shall sign the Statement of Agreement and Approval upon hire and when the document is revised thereafter to indicate the intent to follow the Standardized Procedures and Protocols, with implied approval of the policies, protocols and procedures in this document.

B. Review and Revision

Review and revision of the Standardized Procedures and Protocols will take place as

necessary or when requested by the signing parties.

C. Setting

The NP will perform these Standardized Procedures in the following locations:

☐ Modoc Medical Center Acute/Swing-Bed Care

☐ Modoc Medical Center Emergency Department

☐ Mountain View Skilled Nursing Facility

☐ Warnerview Skilled Nursing Facility

☐ Canby Family Practice Clinic

☐ Modoc Medical Clinic

Nurse Practitioners may only complete those privileges, ~~which~~which, ~~by~~through education, training and experience, the provider is qualified to perform.

Standardized Procedures may be performed by telephone or electronic means and in other settings when related to the NP practice.

D. Education, Training and Scope of Practice

NPs functioning under the procedures and protocols must have and maintain the following credentials:

- Valid CA license as a Registered Nurse
- Certification by the State of California, Board of Registered Nursing, and as a NP
- Furnishing number from the State of California Board of Registered Nursing.

All new hires after 8/1/2015 must also have and maintain:

- Master's Degree
- National Board Certification in a recognized specialty, or in the process of obtaining such certification
- DEA

E. Evaluation of Clinical Care

Evaluation of the care provided by the NP will be approved in the following forms:

- Initial formal review of clinical work upon hire
- Routine record review as part of the peer review and Quality/Risk/Performance Improvement activities
- Periodic face-to-face review with the Supervising Physician

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F. Patient Records

NPs will be responsible for complete and accurate documentation in the patient record as appropriate in accordance with internal policies and the Medical Staff Bylaws/Rules, as well as State and Federal regulations.

G. Supervision

1. NPs are authorized to perform the Standardized Procedures in this document without the direct or immediate observation, supervision, or approval of a physician, except as may be specified in the individual Healthcare Management Standardized Procedures. Physician consultation is available at all times, either on-site or by electronic means.
2. The Supervising Physician will select for review those cases ~~that~~that, by diagnosis, problem, treatment, or procedure represent the most significant risk to the patient.
3. Supervising Physician Requirements
    a. The Supervising Physician will be available in person or through electronic means at all times that the NP are caring for their patients
    b. The Supervising Physician will consult with the NP on all unusual or serious cases, or anytime that the NP feels that the problem exceeds the scope of practice for NP training and experience. Consultation may include case review, re-examination of the patient or assumption of direct care.
    c. The Supervising Physician will bring to the Chief Medical Officer ~~of Staff~~ any ~~cases~~case in which the quality of care is not in keeping with professional standards.
    d. The Supervising Physician will supervise no more than four (4) nurse practitioners at a time and no more than four (4) physician assistants at one time, but no more than a combined total of six (6).
    e. The Supervising Physician must be available at all times in person, or through telephonic or electronic contact.
    f. The Supervising Physician periodically reviews and signs the medical records of all inpatients cared for by nurse practitioners, clinical nurse specialists, or physician assistants.

H. Consultation

The NP will be managing primary, secondary and tertiary care conditions as outlined in this document. In general, however, physician consultation will be sought for ~~all of~~all the following situations, and others as deemed appropriate in the course of providing care:

- Whenever situations arise which go beyond the intent of the Standardized Procedures or the competence or scope of practice/expertise of the NP
- Whenever patient conditions fail to respond to the treatment or management plan in appropriate time
- For any patient with acute decompensation
- At the request of the patient, NP, or at the request of a physician
- All emergency situations after initial stabilizing care ~~has~~have been provided

Whenever a physician is ~~consulted~~consulted, a notation with the physician's name must

be made in the medical record.

I. Emergency Care and Transportation Procedures
In the event that the Supervising Physician is not immediately available to assume direct care of emergent cases, the NP will:

a. FIRST PRIORITY – Promptly institute Basic Life Support measures to sustain life
b. Summon back up assistance at the outset of any resuscitation effort and call 911
c. NPs competent in and with current ACLS certification may institute ACLS approved emergency procedures, when indicated, per ACLS protocols and MMC guidelines
d. Arrange for transportation of unstable patients, via ambulance, to Modoc Medical Centers Emergency Department. Call the ED at the first opportunity and notify the physician on-call that the patient is being transported, and provide report
e. Document emergency care in the medical record, including times of observations and therapeutic interventions.

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IV. Standardized Procedures and Protocols

Healthcare Management – Primary Care

I. Policy – The NP is authorized to diagnose and treat primary care problems seen in the outpatient setting, such as upper and lower respiratory infections, gynecologic problems, dermatologic conditions, urinary tract infections diagnosis of pregnancy, contraception, minor trauma such as musculoskeletal injuries and stable chronic conditions, such as HTN, thyroid disease, diabetes, arthritis, etc.

II. Protocol –

a. A treatment plan is developed based on the resources listed in this document
b. Lab work and diagnostic studies can be ordered, collected and interpreted
c. Therapies such as physical or occupational therapy, dietary counseling and psychological services can be ordered.
d. All other applicable Standardized Procedures in this document are followed during healthcare management.

Healthcare Management – Secondary Care

I. Policy – The NP is authorized to diagnose and treat secondary care problems under the following protocols.

Definition – This protocol covers the management of conditions for which the diagnosis and/or treatment are beyond the scope of the NPs knowledge and/or skills, and for those conditions that do not respond as expected to treatment. Secondary care problems are unfamiliar, unstable, or complex conditions requiring a specialized level of care. Examples include acute respiratory distress, pneumothorax, unusual or

potentially complicated fractures, full thickness burns or lacerations, emergent chest pain or unexplained abnormal vital signs.

II. Protocol
   a. Communication with the physician regarding the evaluation, diagnosis and/or treatment plan
   b. Management of the patient is either in conjunction with a physician or by complete referral to a physician or secondary care treatment facility
   c. The consultation or referral is noted in the medical record including the name of the physician
   d. Lab work and diagnostic studies can be ordered, collected and interpreted
   e. Therapies such as physical therapy, occupational therapy, dietary counseling and psychological services may be ordered
   f. All other applicable Standardized Procedures in this document are followed during healthcare management.
   g. All general policies regarding review, approval, education, evaluation, patient records, supervision and consultation are in force.

Healthcare Management – Tertiary Care

I. Policy – The NP is authorized to perform initial evaluation and stabilization of tertiary care problems under the following protocol.

   Definition: Tertiary care problems are life-threatening conditions such as shock, respiratory arrest, cardiac arrest and major trauma.

II. Protocol
   a. Initial evaluation and stabilization of the patient may be performed with concomitant notification of and immediate management by a physician.
   b. The name of the physician is noted in the medical record, as well as the name of any other physician or agency to which the patient is referred (e.g., Emergency Department).
   c. All other applicable Standardized Procedures in this document are followed during healthcare management.
   d. All general policies regarding review, approval setting, education, evaluation, patient records, supervision and consultation are in force.

Procedures

I. Policy

The NP may perform the listed procedures under the following protocols.

- Repair of laceration under local anesthesia
- Incision and drainage of lesion under local anesthesia
- Removal biopsy of skin lesions – punch, shave and excisional
- IUD insertion or removal
- Diaphragm fitting
- Joint aspiration or injection

- Nail plate avulsion/nail removal
- Cryotherapy of external lesions
- Intra-lesion injections
- Foreign body removal, except eye
- Foreign body removal, cornea simple
- Minor orthopedic procedures, including casting and fracture reduction
- Needle aspiration
- Application of TCA or Podophyllin

II. Protocols

a. The NP has been trained to perform the procedure(s) and has been observed to perform the procedure(s) satisfactorily by another individual who is competent in that skill
b. The NP is following standard medical technique for the procedures as described in the resources listed in this document
c. All skin lesions and/or biopsied tissue are sent for a pathology report
d. Appropriate patient consent is obtained before the procedure
e. All other applicable standardized procedures in this document are followed during healthcare management
f. All general policies regarding review, approval, setting, education, evaluation, patient records, supervision and consultation are in force.

V. Furnishing Drugs and Devices

I. Policy

The NP is authorized to verbally order, or write a transmittal order for, drugs or devices under the following protocols. Mid-level providers may initiate, alter, discontinue, and/or renew medications.

II. Protocol

a. The NP has a current furnishing number.
b. The drugs and devices ordered are consistent with the provider's educational preparation.
c. The drug or device is appropriate to the condition being treated
d. The drugs or devices ordered are listed in the ~~Formulary, OR~~Formulary OR are per the recommendations in the resources listed in this ~~document, and~~document and are as specified in the Standardized Procedure for furnishing Scheduled Drugs.
e. Patient education is given regarding the drug or device
f. The Statement of Approval and Agreement signed by the NPs will act as the record of NPs authorized to furnish
g. No single physician will supervise more than two (2) NPs at one time, or two (2) PAs at one time
h. A physician must be available at all times in person or through telephonic or electronic contact

i. All other applicable standardized procedures in this document are followed during healthcare management
j. All general policies regarding review, approval, setting, education, evaluation, patient records, supervision and consultation in the standardized procedures are in force.

VI. Furnishing Scheduled Drugs

Patient Specific Protocol

I. Policy

The NP is authorized to Furnish Scheduled controlled substances per the following protocols.

II. Protocols

a. The NP follow the provisions of the standardized procedure for furnishing
b. The NP has registered with the DEA for authority to order schedule II-~~V OR~~V ~~OR~~ schedule III-V controlled substances
c. The scheduled substances that may be ordered are on the list of scheduled drugs in this document
d. The NP Furnishing and DEA numbers are on a secure transmittal order
e. The name, license number, and DEA number of ~~the supervising~~the supervising physician is present on the transmittal order
f. All practice policies on pain management, scheduled drug contracts, DEA requirements, etc. are adhered to
g. Schedule III substances may be ordered when the patient is in one of the following categories and under the following conditions:

CATEGORIES

Respiratory ~~Injury~~ Injury; cough; cancer
Dermatology ~~Shingles~~ Shingles; marked dermal injuries
Musculoskeletal - Severe strain; fracture; arthritis; inflammatory disorders; cancer
GYN - Ovarian cyst; severe dysmenorrhea; cancer
Neurologic - Headache; marked myofascial pain; neuropathy; cancer
EENT - Marked pain from EENT infection/injury; cancer
GU/GI Urinary calculi; pyelonephritis; cancer
Postoperative Pain
Other trauma

CONDITIONS

Acute: Such as cough or painful limited illness

- Limit order for acute conditions to a maximum of 30 days
- No refill without reevaluation

Chronic Conditions: Acute, intermittent, but recurrent pain, e.g., headache, OR continuous chronic pain

- Amount given, including all refills (maximum of 5 in 6 months) is not to exceed a 90-day supply as appropriate to the condition
- Treatment plan must be established in conjunction with a physician and reviewed, with documentation, every 6-12 months.

h. Schedule II substances may be ordered when the patient has one of the following diagnoses and under the following conditions

- Pain from cancer, postoperative pain, trauma
  - Limit order for acute conditions to a maximum of 30-days
  - Long-term use of these drugs must be established in conjunction with a physician and reviewed, with documentation every 6-12 months
  - No refills without re-evaluation

- Attention Deficit Hyperactivity Disorder
  - ADHD diagnosis per criteria and supporting assessment per in-house protocols
  - Treatment plan is per established protocols
  - No refills without re-evaluation

i. All other applicable standardized protocols in this document are followed during healthcare management

j. All general policies regarding review, approval, setting, education, evaluation, patient records, supervision and consultation in these standardized protocols are in force.

CATEGORIES

Respiratory ~~- Injury-~~ Injury; cough; cancer
Dermatology ~~- Shingles-~~ Shingles; marked dermal injuries
Musculoskeletal - Severe strain; fracture; arthritis; inflammatory disorders; cancer
GYN - Ovarian cyst; severe dysmenorrhea; cancer
Neurologic - Headache; marked myofascial pain; neuropathy; cancer
EENT - Marked pain from EENT infection/injury; cancer
GU/GI Urinary calculi; pyelonephritis; cancer

Postoperative Pain
Other trauma

CONDITIONS

Acute: Such as cough or painful limited illness

- Limit order for acute conditions to a maximum of 30 days
- No refill without reevaluation

Chronic Conditions: Acute, intermittent, but recurrent pain, e.g., headache, OR continuous chronic pain

- Amount given, including all refills (maximum of 5 in 6 months) is not to exceed a 90-day supply as appropriate to the condition
- Treatment plan must be established in conjunction with a physician and reviewed, with documentation, every 6-12 months.

LIST OF SCHEDULED DRUGS

SCHEDULE V DRUGS

Cough

- Codeine cough syrup (robitussin AC, others)

Diarrhea

- Diphenoxylate/atropine sulphate (Lomotil)

Pain

- acetaminophen with codeine elixir

SCHEDULE IV DRUGS

Anxiety

- lorazepam (Ativan)
- diazepam (Valium)
- alprazolam (Xanax)
- clonazepam (Klonopin)

Insomnia

- zolpidem (Ambien)
- ~~fluazepam~~flurazepam (Dalmane)

- eszopiclone (Lunesta)
- temazepam (Restoril)
- zaleplon (Sonata)
- chlordiazepoxide (Librium)

Obstructive Sleep Apnea

- modafinil (Provigil)

SCHEDULE III DRUGS

Pain/Cough

- codeine w/ acetaminophen (~~TyCo~~Tyco #3, #4)

SCHEDULE II DRUGS

Pain

- hydrocodone w/ acetaminophen (Vicodin, others)
- hydrocodone w/ ibuprofen (Vicoprofen)
- hydrocodone cough syrup (Hycodan)
- oxycodone
- oxycodone w/ acetaminophen (Percocet)
- morphine
- hydromorphone
- duragesic (Fentanyl)

ADHD

- lisdexamfetamine (~~Vyvanase~~Vyvanse)
- methylphenidate (Ritalin)
- amphetamine & dextroamphetamine (Adderall)

MEDICATION MANAGEMENT

I. Policy
The ~~NP is~~NP is authorized to transmit an order for drugs and devices under the following protocols.

II. Protocols
   a. The drugs and devices ordered are per the recommendation in the resources section in this document
   b. The ordering of drugs or devices may include initiating, altering, discontinuing and/or renewing of prescriptive medications and/or their over-the-counter counter equivalents

c. Medication evaluation can include the assessment of:
   - Other medication being taken
   - Prior medications used for the current condition
   - Medication allergies and contraindications, including appropriate labs and exams.

d. The drug or device is appropriate to the condition being treated:
   - Appropriate dosage
   - Not to exceed upper limit dosage per pharmaceutical references
   - Generic medications are ordered if appropriate

e. A plan for follow-up and refills will be written in the patient chart

f. The prescription will be written in the patient chart, including the name of the drug, strength, instructions, and quantity, and a signature for the NP

g. Consultation with a physician, if made, is noted in the patient chart

h. All other applicable standardized procedures in this document are followed during healthcare management

i. All general policies regarding review, approval, setting, education, evaluation, patient records, supervision and consultation in the standardized protocols are in force.

DISPENSING MEDICATIONS

I. Policy
The NP may dispense pre-packaged prescription drugs and devices under the following protocols.

II. Protocols
a. The ~~NP is~~NP is functioning under a standardized procedure for furnishing
b. Appropriate patient education regarding the drug and/or device is given
c. The drug or device is labeled pursuant to the container labeling requirement, including use of auxiliary labels and childproof containers
d. All appropriate record keeping practices of the dispensary are performed
e. All other applicable standardized procedures in this document are followed during healthcare management
f. All general policies regarding review, approval, setting, education, evaluation, patient records, supervision and consultation in these standardized procedures are in force.

SUPERVISION OF MEDICAL ASSISTANTS

I. Policy
The NP is authorized to supervise medical assistants under the following protocols.

II. Protocols
a. The medical assistants are functioning in a healthcare facility or clinic
b. The tasks performed by the medical assistants are within their scope of practice as defined by Business and Professions codes regulating medical assistants, and the clinic

policies and procedures

c. All other applicable standardized procedures in this document are followed during healthcare management
d. All general policies regarding review, approval, setting, education, evaluation, patient records, supervision and consultation in these standardized procedures are in force.

V. STATEMENT OF APPROVAL

By signing this statement of ~~approval~~approval, we, the below named Nurse Practitioner and ~~Physicians~~Physicians, agree to maintain a collaborative and collegial professional relationship and abide by the provisions of these Standardized Procedures and Protocols

REVIEW:

This document will be reviewed and signed every 24 ~~months. and~~months and amended as needed.

_____ Date:_____
~~Physician Assistant or~~ Nurse Practitioner

_____ Date:_____
Supervising Physician

_____ Date:_____
Supervising Physician

~~_____ Date:_____~~
~~Dr. Parson on behalf of Modoc Emergency Physicians~~
~~Supervising Physician~~

_____ Date:_____
Chief Medical Officer ~~of Staff~~

_____ Date:_____
Administrator

_____ Date:_____
Chair, Governing Board

ADDENDUM A – RESOURCES (To be completed by the NP)

The attached resources are intended to be used in guiding the clinical practice of the NP, and their clinical judgement and decision making. Individual references that will be used should be listed in the Addendum, ~~thoughthough they~~ are not considered inclusive.

MODOC MEDICAL CENTER
MEDICAL STAFF RULES
2026~~5~~
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RULE 1
CATEGORIES OF MEMBERSHIP

1.1 Categories

The Medical Staff shall consist of the following categories. The rules applicable to each staff category are set forth in the corresponding appendix.

	See Appendix
Active Staff	1A
Affiliate Staff	1B
Consulting Staff	1C
Courtesy Medical Staff	1D
Honorary and Retired Staff	1E
Limited Active Staff	1F
Locum Tenens Affiliate Staff	1G
Provisional Staff	1H
Telemedicine Staff	1I
Temporary Staff	1J
Inactive Staff	1K

1.2 Qualifications Generally

Each practitioner who seeks or enjoys staff appointment must continuously satisfy the basic qualifications for membership set forth in the Bylaws and Rules, except those that are specifically waived for a particular category, and the additional qualifications that attach to the staff category to which he or she is assigned. The Governing Body may, after considering the Medical Executive Committee's recommendations, waive any qualification in accordance with Section 2.2-4 of the Bylaws.

1.3 Prerogatives and Responsibilities

1.3-1 The prerogatives available to a medical staff member depending upon staff category enjoyed are:

a. **Admit patients:** Admit patients consistent with approved privileges.

b. **Eligible for Clinical Privileges:** Exercise those clinical privileges that have been approved.

c. **Vote:** Vote on any medical staff matter including Bylaws amendments, officer selection and other matters presented at any general or special staff meetings.

d. **Hold Office:** Hold office in the Medical Staff.

e. **Serve on Committees:** Serve on committees and vote on committee matters.

f. **Physician Advisors:** Serve as Physician Advisor to clinical services and committees

1.3-2 The responsibilities which medical staff members will be expected to carry out in addition to the basic responsibilities set forth in the Bylaws, Section 2.6, Basic Responsibilities of Medical Staff Membership, are to:

a. Medical Staff Functions: Contribute to and participate equitably in staff functions, at the request of the Chief Medical Officer, including: contributing to the organizational and administrative activities of the medical staff, such as quality improvement, risk management and utilization management; serving in medical staff and on hospital and medical staff committees; participating in and assisting with the hospital's medical education programs; proctoring of other practitioners; and fulfilling such other staff functions as may reasonably be required.

b. Consulting: Consulting with other staff members consistent with his or her delineated privileges.

c. Attend Meetings: The members of the Medical Executive Committee shall attend at least four Medical Executive Committee Meetings per year. ~~Attend at least the minimum number of staff and committee meetings specified in the Medical Staff Bylaws.~~

1.3-3 Prerogatives and Obligations of Staff Categories

The prerogatives and obligations of each staff category are described in the table following.

1.4 Qualifications for Staff Category

1.4-1 Assignment and Transfer in Staff Category

a. Medical staff members shall be assigned to the category of staff membership based upon the qualifications identified below. Active staff members who fail to achieve the minimum activity for two consecutive years shall be automatically transferred to the appropriate category. Action shall be initiated to evaluate and possibly terminate the privileges and/or membership of any staff member who has failed to meet activity requirements or recommend transfer to the appropriate category. Any member who has exceeded the maximum activity permitted for two consecutive years shall be deemed to have requested transfer to the appropriate category. The Medical Executive Committee shall approve or recommend assignments and transfers, which shall then be evaluated in accordance with the Bylaws and these Rules. The transfers shall be made at the time of reappointment, or as deemed necessary.

b. In assigning practitioners to the proper staff category, the medical staff shall also consider whether the practitioner participated in other aspects of the hospital's activities by, for example, serving on committees. The Governing Body (on recommendation of the Medical Executive Committee) may rescind an automatic transfer, but only if the practitioner clearly demonstrates that unusual

circumstances unlikely to occur again in his or her practice caused the failure to meet the minimum or maximum requirements.

c. Any Medical Staff member having to discontinue practice at this Hospital for a stated period of one year or more, and/or for a stated purpose, may apply for Inactive Staff status. There shall, however, be no right to Inactive Staff status; any such decision shall be solely within the discretion of the Medical Executive Committee and the Governing Body; and there are no procedural rights associated with a denial of a request for Inactive Staff status. Inactive status is not intended as a mechanism for averting Medical Staff peer review action. The Medical Executive Committee may recommend transferring to Inactive Status in accordance with Rule 1.4-1a, and shall notify the member of the recommendation, and the basis for the recommendation. Upon the return of an Inactive Staff member to active practice in this area, he/she may be eligible for reinstatement to the same Staff category he/she held immediately prior to his/her Inactive status; however, he/she shall then complete an application for reappointment and his/her application will be processed in the same manner as described in Rule 2.9. Pending processing of the reappointment application, the member may be granted temporary Privileges in accordance with Article 5.4.

Appendix 1A
ACTIVE STAFF

The Active Staff shall consist of the members who:

1. Are regularly involved in caring for patients or demonstrate, by way of other substantial involvement in medical staff or hospital activities, a genuine concern and interest in the hospital. Regular involvement in patient care shall mean admitting inpatients or outpatients, referring or consulting on at least eight cases each medical staff year (except that allergists, dentists, dermatologists and psychiatrists need only be involved in at least five cases to maintain Active Staff status).

2. Have been members in good standing of the provisional staff for at least twelve months, unless otherwise determined by the Medical Executive Committee.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	APPLICABLE
Prerogatives	
Admits, Consults & Refers Patients (Inpatients & Outpatients)	Yes
Eligible for Clinical Privileges	Yes
Vote	Yes
Hold Office	Yes
Serve as Physician Advisor on Committees	Yes
Serve on Committee	Yes
Responsibilities	
Medical Staff Functions	Yes
Consulting	Yes
Emergency Room Call	Yes
Attend Meetings	Yes
Additional Particular Qualifications	
Must First Complete Provisional	Yes
Malpractice Insurance	Yes
File Application and Apply for Reappointment	Yes

Appendix 1B
AFFILIATE STAFF

The Affiliate Staff shall consist of members who have not completed full training in their specialty and/or do not meet board certification or eligibility for board examination requirements or who have not met all minimum experience requirements to qualify for full privileges, but who nevertheless appear likely to provide a distinct service to the hospital, the medical staff and the patients. Affiliate Staff members may be granted privileges to co-admit patients, assist in surgery and write progress notes, depending upon the member's training and experience.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	APPLICABLE
Prerogatives	
Admits, Consults & Refers Patients (Inpatients & Outpatients)	Yes, with limitations[1]
Eligible for Clinical Privileges	Yes, with limitations[2]
Vote	No
Hold Office	No
Serve as Physician Advisor to Committees	No
Serve on Committee	Yes
Responsibilities	
Medical Staff Functions	Yes
Consulting	No
Emergency Room Call	Yes, with limitations[3]
Attend Meetings	No
Additional Particular Qualifications	
Must First Complete Provisional or be subject to FPPE (Focused Professional Practice Evaluation)	Yes
Malpractice Insurance	Yes
File Application and Apply for Reappointment	Yes

[1] Limitations: Co-admit only.

[2] Limitations: Assist in surgery; write progress notes, orders must be co-signed by co-admitting practitioner.

[3] Limitations: Must be monitored/co-signed by attending practitioner.

Appendix 1C
CONSULTING STAFF

The Consulting Staff shall consist of practitioners who possess ability and knowledge that enable them to provide valuable assistance in difficult cases.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	APPLICABLE
Prerogatives	
Admits, Consults & Refers Patients (Inpatients & Outpatients)	Yes, with limitations[4]
Eligible for Clinical Privileges	Yes
Vote	No
Hold Office	No
Serve as Physician Advisor Committees	Yes
Serve on Committee	Yes
Responsibilities	
Medical Staff Functions	Yes
Consulting	Yes
Emergency Room Call	Yes
Attend Meetings	No
Additional Particular Qualifications	
Must First Complete Provisional	Yes
Malpractice Insurance	Yes
File Application and Apply for Reappointment	Yes

[4] Limitations: May not admit; consult only.

Appendix 1D
COURTESY MEDICAL STAFF

The Courtesy Medical Staff shall consist of the members who:

1. Admit, refer or otherwise provide services for less than eight patients during each medical staff year.

2. Prior to reappointment, provide evidence of current clinical performance at the hospital where they practice in such form as the Medical Executive Committee may require to evaluate their current ability to exercise the requested clinical privileges.

3. Have completed at least twelve months of satisfactory performance on the provisional staff, unless otherwise determined by the Medical Executive Committee.

4. May vote and serve as Physician Advisor on Committees if the member has served as active status in medical staff for a minimum of five years.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	APPLICABLE
Prerogatives	
Admits, Consults & Refers Patients (Inpatients & Outpatients)	Yes, with limitations[1]
Eligible for Clinical Privileges	Yes
Vote	No/Yes designated[2] voting privileges if 5 yrs active status
Hold Office	No
Serve as Physician Advisor of Committees	No/Yes if 5 yrs active status
Serve on Committee	Yes
Responsibilities	
Medical Staff Functions	Yes
Consulting	Yes
Emergency Room Call	Yes/No
Attend Meetings	No
Additional Particular Qualifications	
Must First Complete Provisional	Yes
Malpractice Insurance	Yes
File Application and Apply for Reappointment	Yes

[1] Limitations: Fewer than eight.

[2] Designated voting privileges if has been on Active Status for 5 years

Appendix 1E
HONORARY AND RETIRED STAFF

The Honorary Staff shall consist of practitioners who are deemed deserving of membership by virtue of their outstanding reputations, noteworthy contributions to the health and medical sciences, or their previous longstanding service to the hospital.

The Retired staff shall consist of Practitioners who have been members of the Medical Staff for at least five years immediately preceding application for, or transfer to, Retired Staff status, and who were in good standing when they retired. Retired Staff members shall not admit or attend patients.

Members of the Honorary and Retired Staff may attend meetings and serve on committees; but they may not vote or hold office in the Medical Staff organization.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	APPLICABLE
Prerogatives	
Admits, Consults & Refers Patients (Inpatients & Outpatients)	No
Eligible for Clinical Privileges	No
Vote	No
Hold Office	No
Serve as Physician Advisor on Committees	Yes
Serve on Committee	Yes
Responsibilities	
Medical Staff Functions	No
Consulting	No
Emergency Room Call	No
Attend Meetings	Yes
Additional Particular Qualifications	
Must First Complete Provisional	No
Malpractice Insurance	No
File Application and Apply for Reappointment	Yes

Appendix 1F
LIMITED ACTIVE STAFF

The Limited Active Staff are qualified to admit and follow their own patients but may not be available on a full-time basis to provide full continuity of care for their patients. Arrangements satisfactory to the Medical Executive Committee and Governing Body must be made by such practitioners to assure complete continuity of care of their patients. This category applies to emergency service physicians working under contract with the hospital who are not scheduled on a regular basis.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	APPLICABLE
Prerogatives	
Admits, Consults & Refers Patients (Inpatients & Outpatients)	Yes
Eligible for Clinical Privileges	Yes
Vote	Yes
Hold Office	No
Serve as Physician Advisor on Committees	Yes
Serve on Committee	Yes
Responsibilities	
Medical Staff Functions	Yes
Consulting	Yes
Emergency Room Call	Yes
Attend Meetings	Yes
Additional Particular Qualifications	
Must First Complete Provisional	Yes
Malpractice Insurance	Yes
File Application and Apply for Reappointment	Yes

Appendix 1G
LOCUM TENENS AFFILIATE STAFF

The Locum Tenens Affiliate Staff shall consist of practitioners who only provide coverage for medical staff members. They may be in residency or fellowship training programs or have completed training.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	APPLICABLE
Prerogatives	
Admits, Consults & Refers Patients (Inpatients & Outpatients)	Yes, with limitations[2]
Eligible for Clinical Privileges	Yes[3]
Vote	No
Hold Office	No
Serve as Physician Advisor on Committees	No
Serve on Committee	Yes
Responsibilities	
Medical Staff Functions	No
Consulting	Yes
Emergency Room Call	Yes/No
Attend Meetings	No
Additional Particular Qualifications	
Must First Complete Provisional or be subject to FPPE	Yes
Malpractice Insurance	Yes
File Application and Apply for Reappointment	Yes

[2] Limitations: May admit or treat patients for the practitioner for whom the Locum Tenens member is covering privilege form.

[3] Must have same range of privileges as the practitioner for whom the Locum Tenens member is covering.

Appendix 1H
PROVISIONAL STAFF

The Provisional Staff shall consist of the members who:

1. Are initial appointees to the medical staff and plan to qualify for, and seek transfer to, the Active, Limited Active, Consulting, Affiliate, or Courtesy Staff in 12 to 36 months.

2. In the ordinary course of events, transferred to Active, Limited Active, Consulting, Affiliate, or Courtesy status after serving at least 12 but not more than 36 months on the Provisional Staff, unless otherwise determined by the Medical Executive Committee. Action shall be initiated by the Medical Executive Committee to terminate the privileges and membership of a provisional member who does not qualify for advancement within 36 months. The member shall not be entitled to any hearing and appeal under Article 14, Hearings and Appellate Reviews, if advancement was denied because of a failure to have a sufficient number of cases proctored or because of a failure to maintain a satisfactory level of activity. The member shall be entitled to the hearing and appeal rights under Article 14, Hearings and Appellate Reviews, if advancement was denied because the member's clinical performance or professional conduct was unsatisfactory.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	APPLICABLE
Prerogatives	
Admits, Consults & Refers Patients (Inpatients & Outpatients)	Yes
Eligible for Clinical Privileges	Yes
Vote	Yes
Hold Office	No
Serve as Physician Advisor on Committees	Yes
Serve on Committee	Yes
Responsibilities	
Medical Staff Functions	Yes
Consulting	Yes
Emergency Room Call	Yes
Attend Meetings	Yes
Additional Particular Qualifications	
Must be subject to FPPE	Yes
Malpractice Insurance	Yes
File Application and Apply for Reappointment	Yes

Appendix 1I
TELEMEDICINE STAFF

1. Telemedicine Definitions
   a. Distant Site is the location at which the telemedicine equipment is located and from which the Telemedicine Provider delivers his/her patient care services.
   b. The Originating Site is the location at which the patient is located.
   c. Telemedicine Provider is the individual provider who uses the telemedicine equipment at the Distant Site to render services to patients who are located at the Originating Site. The Telemedicine Provider is generally a physician, but other health professionals may also be involved as Telemedicine Providers. The Telemedicine Provider would generally contract with (or in the case of non-physicians, be employed by) the entity that serves as the Distant Site.
2. Prerogatives and Responsibilities of the Telemedicine Staff
   The Telemedicine Staff shall consist of Telemedicine Providers who provide diagnostic or treatment services, from the Distant Site to hospital patients at the Originating Site via telemedicine devices. Telemedicine devices include interactive (involving a real time [synchronous] or near real time [asynchronous] two-way transfer of medical data and information) audio, video, or data communications between physician and patient. Telemedicine does not include telephone or electronic mail communications.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	APPLICABLE
Prerogatives	
Admits, Consults & Refers Patients (Inpatients & Outpatients)	Yes, with limitations[4]
Eligible for Clinical Privileges	Yes
Vote	No
Hold Office	No
Serve as Committee Chair	No
Serve on Committee	Yes
Responsibilities	
Must first complete Provisional or be subject to FPPE	Yes
Medical Staff Functions	Yes
Consulting	Yes
Emergency Room Call	No
Attend Meetings	No

[4] The Medical Executive Committee shall recommend the clinical services that may be provided by telemedicine.

Additional Particular Qualifications Must First Complete Provisional or Be Subject to Focused Professional Practice Evaluation for New Privileges	Yes
Malpractice Insurance	Yes
File Application and Apply for Reappointment	Yes

3. Additional Provisions Applicable to Telemedicine Staff
    a. Responsibility to Communicate Concerns/Problems:
        1) There is a need for clear delineation of reporting responsibilities respecting the Telemedicine providers' performance. At the very least, the Medical Staff officials at this hospital must be informed of any practitioner-specific problems that arise in the delivery of services to this hospital's patients.
        2) Additionally, this hospital should communicate to the Medical Staff officials at the Distant Site through peer review channels, any problems that may arise in the delivery of care by the Telemedicine provider to patients at this hospital.
        3) Similarly, when a member of this hospital's Medical Staff is providing telemedicine services to patients at another facility, this hospital's Medical Staff should communicate to the Medical Staff officials at the Originating Site, through peer review channels, any problems that may arise in the delivery of telemedicine services by members of this hospital's Medical Staff.
        4) The Medical Staff may enter appropriate information sharing agreements and/or develop and implement appropriate protocols to effectuate these provisions.
    b. Responsibility to Review Practitioner-Specific Performance:
        1) Special proctoring arrangements may be made for qualified practitioners at the Distant Site to proctor cases performed by new members of the Telemedicine Staff.
        2) Primary responsibility to assess what, if any, practitioner-specific performance improvement and/or corrective action may be warranted rests with the Originating Site. If such an action gives rise to procedural rights at the hospital, the provisions of Bylaws, Article 14, Hearings and Appellate Reviews, will apply.

        Further details are available in the Bylaws, Article 4.3-2(b).

Appendix 1J
TEMPORARY STAFF

Temporary Staff are granted limited privileges jointly by the Chief Executive Officer upon recommendation of the Chief Medical Officer, after review of the applicant's background and a determination of skill level. Temporary Status is for a period of no longer than 120 days. This status is usually assigned to those practitioners that are under contract with the hospital. The practitioner has limited privileges, but is qualified to admit, refer and otherwise provide services to patients and may be on call in the emergency room. The practitioner may apply for active Medical Staff membership.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	APPLICABLE
Prerogatives	
Admits, Consults & Refers Patients (Inpatients & Outpatients)	Yes, with limitations[5]
Eligible for Clinical Privileges	Yes
Vote	No
Hold Office	No
Serve as Physician Advisor Committees	No
Serve on Committee	No
Responsibilities	
Medical Staff Functions	No
Consulting	Yes
Emergency Room Call	Yes
Attend Meetings	Yes
Additional Particular Qualifications	
Must be subject to FPPE	Yes
Malpractice Insurance	Yes
File Application and Apply for Reappointment	Yes

[5] The Medical Executive Committee shall recommend the clinical services that may be provided.

Appendix 1K
INACTIVE STAFF

Inactive staff are members who have discontinued practice at the Hospital for a stated period of one year or more, and/or for a stated purpose. The member may apply for inactive status, or may, at the discretion of the Medical Executive Committee, be transferred to inactive status if deemed appropriate. The decision to grant Inactive Status lies solely within the discretion of the MEC and the Governing Body; and there is no procedural rights associated with a denial of a request for Inactive Staff status. This status applies to all categories of the Medical Staff.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	APPLICABLE
Prerogatives	
Admits, Consults & Refers Patients (Inpatients & Outpatients)	No
Eligible for Clinical Privileges	No
Vote	No
Hold Office	No
Serve as Physician Advisor on Committees	No
Serve on Committee	No
Responsibilities	
Medical Staff Functions	No
Consulting	No
Emergency Room Call	No
Attend Meetings	No
Additional Particular Qualifications	
Must First Complete Provisional	No
Malpractice Insurance	No
File Application and Apply for Reappointment	Yes

RULE 2
APPOINTMENT AND REAPPOINTMENT

2.1 Overview of Process

The following charts summarize the appointment, temporary privileges and reappointment processes. Details of each step are described in Rules 2.2 through 2.9.

APPOINTMENT

Person or Body	*Function*	*Report to*
Medical Staff Coordinator	Verify application information	Medical Executive Committee *(See Rule 2.5)*
Medical Executive Committee	Review applicants' qualifications and make recommendations for appointments and privileges	Governing Body *(See Rule 2.7-3)*
Governing Body	Review recommendations of the Medical Executive Committee; make decision	Final Action *(See Rule 2.7-4)*

TEMPORARY PRIVILEGES

Person or Body	*Function*	*Report to*
Medical Staff Coordinator	Verify key information	Chief Medical Officer (See Rule 2.5 and Bylaws Section 5.5-2)
Chief Medical Officer	Recommend temporary privileges	Chief Executive Officer (See Bylaws Section 5.5-2d.)
Chief Executive Officer	Making decision	Final action *(See Bylaws Section 5.5-2d.)*

REAPPOINTMENT

Person or Body	*Function*	*Report to*
Medical Staff Coordinator	Verify reappointment information.	Medical Executive Committee *(See Rule 2.9-3)*
Medical Executive Committee	Review applicants' performance and reapplication information and make recommendations for reappointments and privileges	Governing Body (See Rule 2.9-5)
Governing Body	Review recommendations of the Medical Executive Committee; make decision	Final Action *(See Rule 2.9-6)*

2.2 Application

2.2-1 Each practitioner who expresses formal interest in a recognized and appropriate category of membership and privileges shall be provided with an application form for medical staff membership. Upon completion by the practitioner, the form shall be returned to the medical staff office signed and dated by attesting to accuracy and completeness of application within 180 days of signature.

2.2-2 The application form shall be approved by the Medical Executive Committee and the Governing Body and once approved, shall be considered part of these rules. The application shall include an agreement to abide by the Medical Staff and Hospital Bylaws, Rules and applicable Policies. The application shall request information pertinent to the applicant's qualifications, such as (but not limited to) information regarding the applicant's education (including participation in continuing medical education), residency, specialty training, the last 5 years of work history (including specifications of gaps in work history), abilities and current competencies, professional affiliations, proffered references (including names and addresses of professional peers, when possible, from the same professional discipline as the applicant who will be able to attest in writing to the applicant's relevant qualifications, experience, abilities, professionalism, and current competencies), relevant health status as further described at Rule 2.3), as well as information regarding possible involvement in professional liability actions, taken within the last 5 years (including but not limited to all final judgments or settlements involving the applicant); previously completed or currently pending challenges involving professional licensure, certification or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure, certification or registration; voluntary or involuntary termination, limitation, reduction or loss of medical staff or medical group membership and/or clinical privileges at any other hospital or health facility or entity; any formal investigation or disciplinary action at another hospital or health facility that was taken or is pending; and information detailing any prior or pending government agency or third party payor investigation, proceeding or
litigation challenging or sanctioning the practitioner's patient admission, treatment, discharge, charging, collection or utilization practices, including but not limited to Medicare or Medi-Cal fraud and abuse proceedings or convictions. The applicant shall also release all persons or entities from any liability that might arise from their investigating and/or acting on the application. The applicant, or applicant's designee, may provide documentation to substantiate his or her qualifications, hospital affiliation or proffered references. It shall be the duty of the Medical Staff office to verify that the documentation provided is true and correct.

2.3 Physical and Mental Capabilities

2.3-1 Obtaining Information

a. The application shall require the applicant to submit a statement attesting that no health problems exist that could affect his or her ability to perform the responsibilities of the Medical Staff membership or exercise of requested clinical privileges. If the applicant does have a health condition and/or requires special accommodation with respect to health condition, he or she shall provide information pertaining to his/her physical and mental health on a separate page of the form, which can be removed from the remaining application and processed separately. Upon receipt of the application, the page addressing

physical and mental disabilities shall be removed and referred to by the Medical Executive Committee.

b. When the medical staff office verifies information and obtains references, it shall ask for any information concerning physical or mental disabilities to be reported on a confidential form, which can be processed separately from the other information obtained regarding the applicant. This information will also be referred to by the Medical Executive Committee.

c. The Medical Executive Committee shall be responsible for investigating any practitioner who has or may have a physical or mental disability or condition that might affect the practitioner's ability to exercise his or her requested privileges in a manner that meets the hospital and medical staff's quality of care standards. This may include one or all the following:

   1) **Medical Examination –** To ascertain whether the practitioner has a physical or mental disability that might interfere with his or her ability to provide care which meets the hospital and medical staff's quality of care standards.

   2) **Interview –** To ascertain the condition of the practitioner and to assess if and how reasonable accommodation can be made.

d. Any practitioner who feels limited or challenged in any way by a qualified mental or physical disability in exercising his or her clinical privileges and in meeting quality of care standards should make such limitations immediately known to the Medical Executive Committee. Any such disclosure will be treated with the high degree of confidentiality that attaches to the medical staff's peer review activities.

2.3-2 Review and Reasonable Accommodations

a. Any practitioner who discloses or manifests a qualified physical or mental disability will have his or her application processed in the usual manner without reference to the condition.

b. The Medical Executive Committee shall not disclose any information regarding any practitioner's qualified physical or mental disability until the Committee (or, in case of temporary privileges, the Medical Staff's representatives who review temporary privilege requests) have determined that the practitioner is otherwise qualified for membership and/or to exercise the privileges requested. Once the determination is made to ensure that the practitioner is otherwise qualified, the Medical Executive Committee may disclose information it has regarding any physical or mental disabilities and the effect of those on the practitioner's application for membership and privileges. Any such disclosure shall be limited as necessary to protect the practitioner's right to confidentiality of health information, while at the same time communicating sufficient information to permit the Medical Executive Committee to evaluate what, if any, accommodation may be necessary and feasible. The Medical Executive Committee and any other appropriate committees may meet with the practitioner to discuss if and how reasonable accommodation can be provided.

c. As required by law, the medical staff and hospital will attempt to provide reasonable accommodation to a practitioner with known physical or mental disabilities, if the practitioner is otherwise qualified and can perform the essential functions of the staff appointment and privileges in a manner which meets the hospital and medical staff quality of care standards. If reasonable

accommodation is not possible under the standards set forth herein, it may be necessary to withdraw or modify a practitioner's privileges and the practitioner shall have the hearing and appellate review rights described in Article 14, Hearings and Appellate Reviews, of the Bylaws.

2.4 Effect of Application

By applying for or by accepting appointments or reappointment to the Medical Staff, the applicant:

2.4-1 Signifies his or her willingness to appear for interviews regarding his or her application for appointment.

2.4-2 Authorizes medical staff and hospital representatives to consult with other hospitals, persons or entities who have been associated with him or her and/or who may have information bearing on his or her competence and qualifications or that is otherwise relevant to the pending review and authorizes such people to provide all information that is requested orally and in writing.

2.4-3 Consents to the inspection and copying, by hospital representatives, of all records and documents that may be relevant or lead to the discovery of information that is relevant to the pending review, regardless of who possesses these records, and directs individuals who have custody of such records and documents to permit inspection and/or copying.

2.4-4 Certifies that he or she will report any subsequent changes in the information submitted on the application form to the Medical Executive Committee and the Chief Executive Officer.

2.4-5 Releases from all liability the medical staff and the hospital and its representatives for their acts performed in connection with evaluating the applicant.

2.4-6 Releases from all liability all individuals and organizations who provide information concerning the applicant, including otherwise privileged or confidential information, to hospital representatives.

2.4-7 Authorizes and consents to hospital representatives providing other hospitals, professional societies, licensing boards and other organizations concerned with provider performance and the quality of patient care with relevant information the hospital may have concerned him or her and releases the hospital and hospital representatives from liability for so doing.

2.4-8 Consents to undergo and to release the results of a medical, psychiatric or psychological examination by a practitioner acceptable to the Medical Executive Committee, at the applicant's expense, if deemed necessary by the Medical Executive Committee.

2.4-9 Signifies his or her willingness to abide by all the conditions of membership, as stated on the appointment application form, on the reappointment application form, and in the bylaws and these rules.

2.4-10 For purposes of this Rule 2.4, the term "hospital representative" includes the Governing Body, its individual Directors/Trustees and Committee members; the Chief Executive Officer, the Medical Staff, all Medical Staff Officers, and/or Committee members having responsibility for collecting information regarding or

evaluating the applicant's credentials; and any authorized representative or agent of any of the foregoing.

2.5 Verification of Information

The applicant shall fill out and deliver an application form to the medical staff office, which shall seek to verify the information submitted. Verification shall encompass, but is not limited to, written verification of peer references, licensure status, training and education, current proficiency with respect to the hospital's general competencies (as applicable to the privileges requested), health status, other evidence submitted in support of the application, and confirmation that the practitioner is the same individual identified in the credentialing documents (by viewing a current, valid picture hospital ID card, or a valid state or agency picture ID card). The application will be deemed complete when all necessary verifications have been obtained from the practitioner that ~~includes , but~~includes, but not limited to, current license, licensing board disciplinary records, specialty board certification status, , verification of prior practice information, current malpractice liability insurance and reference letters, and
verification of current proficiency in the hospital's general competencies (Bylaws, Section 5.2, Criteria for Privileges/General Competencies). Primary verifications that are ran by credentialing personnel include, but not limited to, National Practitioner Data Bank information, Drug Enforcement Administration certificate, if appropriate, NPI (NPPES), OIG Exclusions, CalHHS (S&I List), SAMS.gov, Medicare Opt-Out List, Social Security Death Master File, and other evidence that the applicant submitted in support of the application. Additionally, the Medical Staff office may seek information from other relevant sources, such as the American Medical Association's Physician Masterfile (to verify medical school graduation and residency completion), the American Board of Medical Specialties (for verification of Board certification), the Educational Commission for foreign Medical Graduates (for verification of graduation from a foreign medical school), the American Osteopathic Association Physician Database (for pre and postdoctoral education), and the Federation of State Medical Boards Physician Disciplinary Data Bank (for all actions against a physician's medical license). All information that is verified must be within 180 days of appointment/reappointment date. The medical staff office shall then transmit the application and all supporting materials to the Medical Executive Committee.

2.5-1
The following ongoing monitoring sites are reviewed as follows. A review log for each is kept on an Excel spreadsheet.

a) Office of Inspector General (OIG)- Monthly

b) State-Specific Sanction Lists, CALHHS (S&I List)- Monthly

c) Medicare Opt-Out List- Quarterly

d) SAMS.gov- Quarterly within 180 days of appointment/reappointment date

2.6 Incomplete Application

2.6-1 If the medical staff office is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise significantly incomplete, the medical staff office may delay further processing of the application or may begin processing the application based only on the available information with a decision that further information may be considered upon receipt.

2.6-2 If the processing of the application is delayed for more than 60 days and if the missing information is reasonably deemed significant to a fair determination of the applicant's qualifications, the affected practitioner shall be informed. He or she shall then be given the opportunity to withdraw his or her application, or to request the continued processing of his or her application. If the applicant does not respond within 30 days, he or she shall be deemed to have voluntarily withdrawn his or her application. If the applicant requests further processing, but then fails to provide or arrange for the provision within 45 days or any other date mutually agreed to when the extension was granted (whichever is later) of the necessary information that the practitioner could obtain using reasonable diligence, the practitioner shall be deemed to have voluntarily withdrawn his or her application.

2.6-3 Any application deemed incomplete and withdrawn under this rule may, thereafter, be reconsidered only if all requested information is submitted, and all other information has been updated.

2.7 Action on the Application

2.7-1 Medical Executive Committee Action

a. **Preliminary Recommendation**: At its next regular meeting after receipt of the application and supporting documentation, the committee may personally interview the applicant, and/or consider all relevant information available for review. The Medical Executive Committee shall then formulate a preliminary recommendation as to whether the applicant meets the relevant criteria specified in Article 4, Procedures for Appointment and Reappointment (with respect to membership), and Article 5, Privileges (with respect to privileges). If the preliminary recommendation is favorable, the Medical Executive Committee shall then assess the applicant's health status, and determine whether the applicant is able to perform, with or without reasonable accommodation, the necessary functions of a member of the medical staff.

b. **Final Recommendation:** Thereafter, a final recommendation shall be made, and the Medical Executive Committee shall forward to the Governing Body a written report and recommendations, as follows:

1) **Favorable Recommendation:** Favorable recommendations shall be promptly forwarded to the Governing Body together with the application form and its accompanying information and the reports and recommendations of the Medical Executive Committee as to staff appointment, membership category, clinical privileges to be granted and any special conditions to be attached to the appointment.

2) **Adverse Recommendation:** When the recommendation is adverse in whole or in part, the Chief Medical Officer shall immediately inform the practitioner by special notice, and he or she shall be entitled to such procedural rights as may be provided in Bylaws Article 1, Hearings and Appellate Reviews. The Governing Body shall be

generally informed of but shall not receive detailed information and shall not act on the pending adverse recommendation until the applicant has exhausted or waived his or her procedural rights.

(For the purposes of this section, an adverse recommendation by the Medical Executive Committee is as defined in Article 14, Section 14.2, Grounds for Hearing, of the Bylaws)

3) **Deferral:** The Medical Executive Committee may defer its recommendation to obtain or clarify information, or in other special circumstances. A deferral must be followed up within 60 days of receipt of information with a subsequent recommendation for appointment and privileges, or for rejection for staff membership.

2.7-2 Governing Body Action

a. **On Favorable Medical Executive Committee Recommendation**: The Governing Body shall adopt, reject or modify a favorable recommendation of the Medical Executive Committee, or shall refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for the referral and setting a time limit within which the Medical Executive Committee shall respond. If the Governing Body's action is a ground for a hearing under the Bylaws, Section 14.2, the Chief Executive Officer shall promptly inform the applicant by special notice, and he or she shall be entitled to the procedural rights as provided in the Bylaws Article 14, Hearings and Appellate Reviews.

b. **Without Benefit of Medical Executive Committee Recommendation**: If the Governing Body does not receive a Medical Executive Committee recommendation within the time specified in Rule 2.7-6 below, it may, after giving the Medical Executive Committee written notice and a reasonable time to act, act on its own initiative. If such a recommendation is favorable, it shall become effective as the final decision of the Governing Body. If the recommendation is grounds for a hearing under the Bylaws Article 14.2, the Chief Executive Officer shall give the applicant special notice of the tentative adverse recommendation and of the applicant's right to request a hearing. The applicant shall be entitled to the Bylaws Article 14, Hearings and Appellate Reviews, procedural rights before any final adverse action is taken.

c. **After Procedural Rights**: In the case of an adverse Medical Executive Committee recommendation pursuant to Rule 2.7-3 or an adverse Governing Body decision pursuant to Rule 2.7-4a. or 2.7-4b., the Governing Body shall take final action in the matter only after the applicant has exhausted or has waived his or her Bylaws Article 14, Hearings and Appellate Reviews, procedural rights. The action thus taken shall be the conclusive decision of the Governing Body, except that the Governing Body may defer final determination by referring the matter back for reconsideration. Any such referral should state the reasons, therefore, set a reasonable time limit within which a reply to the Governing Body shall be made, and may include a directive that additional hearings to be conducted to clarify issues which are in doubt. After receiving the new recommendation and any new evidence, the Governing Body shall make a final decision.

d. **Expedited Review:** The Governing Body may use an expedited process for appointment, reappointment or when granting privileges when criteria for that

process are met. The Governing Body may delegate this authority to any other committee of at least two voting members of the Governing Body; however, any final decision of the delegated committee must be subject to ratification by the full Governing Body at its next regularly scheduled meeting. Expedited processing is generally not available if:

1) The practitioner or member submits an incomplete application.

2) The Medical Executive Committee's final recommendation is adverse in any respect or has any limitations.

3) There is a current challenge or a previously successful challenge to the practitioner's licensure or registration.

4) The practitioner has received an involuntary termination of Medical Staff membership or some or all privileges at another organization.

5) There has been a final judgment adverse to the practitioner in a professional liability action.

2.7-3 Notice of Final Decision

The Chief Executive Officer shall give notice of the Governing Body's final decision to the Medical Executive Committee. The Medical Staff Coordinator shall give notice of the Governing Body's final decision to the applicant.

A decision and notice to appoint shall include:

a. The staff category to which the applicant is appointed.

b. The clinical privileges the practitioner may exercise; and

c. Any special conditions attached to the appointment.

If the decision is adverse, the notice to the applicant shall be by special notice, as further described in Section 14.-3-1, Notice of Action or Proposed Action.

2.7-4 Guidelines for Time of Processing

All individuals and groups shall act on applications in a timely and good faith manner. Except when additional information must be secured, or for other good cause, each application should be processed within the following time guidelines:

REVIEWER	TIME FRAMES FOR REVIEW
Medical Staff Office	60 DAYS after all necessary documentation is received
Medical Executive Committee	60 DAYS after receiving application from the Medical Staff Office
Governing Body	45 DAYS after receiving application from the Medical Executive Committee, except when the hearing and appeal rights of Bylaws Article 12, Hearings and Appellate Reviews, apply

These time periods are guidelines and are not directives which create any rights for a practitioner to have an application processed within these precise periods. If action at a particular step in the process is delayed without good cause, the next higher authority may immediately proceed to consider the application upon its own initiative or in the direction of the Chief Medical Officer or the Chief Executive Officer.

2.8 Duration of Appointment

2.8-1 All new staff members shall be appointed to the Provisional Staff and subjected to a period of formal observation and review. Provisional appointments are for not more than 36 months.

2.8-2 Reappointments to any staff category other than Provisional shall be for a maximum period of two years and shall be staggered throughout the year so as to enable thorough review of each member. Changes in staff category may be requested at any time during the reappointment period after requirements of provisional status are met.

2.9 Reappointment Process

2.9-1 Schedule for Reappointment

At least 120 days prior to the expiration date of each staff member's term of appointment, the medical staff office shall provide the member with a reappointment form. Completed reappointment forms shall be returned to the medical staff office at least 30 days prior to the expiration date. Failure, without good cause, to return the form shall result in automatic suspension or resignation as described in Rule 2.9-9.

2.9-2 Content of Reappointment Form

a. The reappointment form shall be approved by the Medical Executive Committee and the Governing Body and once approved, shall be considered part of these rules. The form shall seek information concerning the changes in the applicant's qualifications since his or her last review. Specifically, the form shall request an update of all the information and certifications requested in the appointment application form, as described in Rule 2.2-2, apart from that information which cannot change over time, such as information regarding the member's premedical and medical education, date of birth, and so forth. The form shall also require information as to whether the applicant requests any change in his or her staff status and/or in his or her clinical privileges, including any reduction, deletion or additional privileges. Requests for additional privileges

must be supported by the type and nature of evidence which would be necessary for such privileges to be granted in an initial application.

b. If the staff member's level of clinical activity at this hospital is not sufficient to permit the staff and board to evaluate his or her competence to exercise the clinical privileges requested, the staff member shall have the burden of providing evidence of clinical performance at his or her principal institution in whatever form as the staff may require.

2.9-3 Verification and Collection of Information

The medical staff office shall, in a timely fashion, seek to verify the additional information made available on each reappointment application and to collect any other materials or information deemed pertinent by the Medical Executive Committee. The information shall address, without limitation:

a. Reasonable evidence of current ability to perform privileges that may be requested including, but not limited to, consideration of the members' professional performance, judgment, clinical or technical skills and patterns of care and utilization as demonstrated in the findings of quality improvement, risk management and utilization management activities.

b. Participation in relevant continuing education activities.

c. Level/amount of clinical activity (patient care contacts) at the hospital.

d. Sanctions imposed or pending include, but not limited to, previously successful or currently pending challenges to any licensure or registration (state or district, DEA) or the voluntary relinquishment of such licensure or registration.

e. Health status includes completion of a physical examination or psychiatric evaluation by a physician who is mutually accepted by the affected practitioner and staff, when requested by the Medical Executive Committee and subject to the standards set forth in Rule 2.3 pertaining to Physical and Mental Capabilities.

f. Attendance of required medical staff and committee meetings.

g. Participation as a staff officer and committee member/chair.

h. Timely and accurate completion and preparation of medical records.

i. Cooperativeness and general demeanor in relationships with other practitioners, hospital personnel and patients.

j. Professional liability claim experience, including being named as a party in any professional liability claims and the disposition of any pending claims.

k. Compliance with all applicable Medical Staff and Hospital Bylaws, Rules, and Policies.

l. Professional references from at least one practitioner who is familiar with the member's current qualifications by virtue of having recently worked with the member or having recently reviewed the member's cases.

m. Any other pertinent information including the staff member's activities at other hospitals and his or her medical practice outside the hospital.

n. Information concerning the members of the State Licensing Board and the Federal National Practitioner Data Bank.

o. Information from other relevant sources, such as, but not limited to, the Federation of State Medical Boards Physician Disciplinary Data Bank.

p. Practitioners will be notified in writing if information obtained from primary source verification or other sources significantly differs from what the practitioner provided. The notification is issued within 10 business days of discovering the discrepancy.

The medical staff office shall transmit the completed reappointment application form and supporting materials to the Medical Executive Committee.

2.9-4 Medical Executive Committee Action

a. The Medical Executive Committee shall review all relevant information available and shall forward to the Governing Body its favorable recommendations, which are prepared in accordance with Rule 2.7-3.

b. When the Medical Executive Committee recommends adverse action, as defined in the ~~Bylaws,~~Bylaws section 13.2, either with respect to reappointment or clinical privileges, the Chief Medical Officer shall give the applicant special notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 14.3. The applicant shall be entitled to Article 12, Hearings and Appellate Reviews, procedural rights. The Governing Body shall be informed of, but not act on, the pending recommendation until the applicant has exhausted or waived his or her procedural rights.

c. Thereafter, the procedures specified for applicants in Rule 2.7-4 (Governing Body action), Rule 2.7-5 (Notice of Final Decision) and in the Bylaws Section 4.6 (Waiting Period After Adverse Action), shall be followed. The committee may also defer action; however, any deferral must be followed up within 70 days with a recommendation.

2.9-5 Reappointment Recommendations

Reappointment recommendations shall be written and shall specify whether the applicant's appointment should be renewed; renewed with modified membership category, clinical privileges; or terminated. The reason for any adverse recommendation shall be described. The medical staff may require additional proctoring of any clinical privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring, and such proctoring requirements imposed for lack of activity shall not result in any hearing rights.

2.9-6 Reappointment Recommendations

Reappointment recommendations (including privilege recommendations) shall be written and shall specify whether the member's appointment should be renewed; renewed with modified membership category and or clinical privileges; or terminated. The medical staff may require additional proctoring of any clinical privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring, and such proctoring requirements imposed for lack of activity shall not result in any hearing rights.

2.9-7 No Extension of Appointment

Except as provided at Section 4.3-4, Limitations on Extension of Appointment, if the reappointment application has not been fully processed before the member's appointment expires, the staff member shall refrain from exercising his or her

current membership status and clinical privileges until the reappointment review is complete.

2.9-8 Failure to File Reappointment Application

Failure to file a complete application for reappointment 30 days prior to the expiration of the appointment shall result in the automatic suspension of a practitioner's privileges and prerogatives effective on the date the member's current appointment expires.~~Committee with the approval of the Governing Body.~~ Prior to suspension, the practitioner will be sent at least one letter with special notice warning of the impending suspension. If an application for reappointment is not submitted, completed as required, before the appointment expires, the member shall be deemed to have resigned his or her membership of the medical staff, effective the date his or her appointment expires. Members who automatically resign under this rule will be processed as new applicants should they wish to reapply.

2.9-9 Relinquishment of Privileges

A staff member who wishes to relinquish or limit privileges (other than privileges necessary to fulfill Emergency Room call responsibilities) shall send written notice to the Chief Medical Officer identifying the privileges to be relinquished or limited. A copy of this notice shall be forwarded to the medical staff office for inclusion in the member's credentials file.

RULE 3
STANDARDS OF CONDUCT

3.1 Purpose

The purpose of this Rule is to clarify the provisions of Section 2.7 of the Medical Staff Bylaws, regarding the expectations of all practitioners during all interactions with people at the hospital, whether such persons are colleagues, other health care professionals, hospital employees, patients and/or other individuals. This Rule is intended to address conduct which does not meet the professional standards expected of Medical Staff members. In dealing with incidents of inappropriate conduct, the protection of patients, employees, practitioners and other people at the hospital is the primary concern. In addition, the well-being of a practitioner whose conduct is in question is also of concern, as is the orderly operation of the hospital.

3.2 Examples of Inappropriate Conduct

Examples of common inappropriate conduct include, but are not limited to, the following [6]:

3.2-1 **Verbal abuse:** Verbal abuse is usually in the form of vulgar, profane or demeaning language, screaming, sarcasm or criticism directed at an individual, having the intent or effect of lowering the recipient's reputation or self-esteem. It is often intimidating to the recipient and often causes the recipient or others around him or her to become ineffective in performing their responsibilities (e.g., the individuals become afraid or unwilling to question or to communicate concerns, or to notify or involve either the involved practitioner or others when problems occur). This kind of conduct becomes disruptive at the point where it reaches beyond the bounds of fair professional comment or where it seriously impinges on staff morale.

3.2-2 **Non-communication:** Refusal to communicate with responsible people can be extremely disruptive in the patient care setting. This kind of behavior often results from individual fighting or feuding, or lack of trust. It becomes disruptive at the point where important information should be communicated but it is not. Closely related are incomplete or ambiguous communications. This becomes disruptive when it diverts patient care resources into having to devote substantial and unnecessary time obtaining follow-up clarification.

3.2-3 **Refusal to return calls:** Refusing to return telephone calls from the facility staff can be another form of the problem. Often this type of behavior is a result of what a practitioner feels are repeated, inappropriate phone calls from the facility's staff. However, unless a phone call is returned, the practitioner cannot know the urgency of the matter. The problem becomes disruptive at the point where patient care is placed in unnecessary jeopardy, or when matters that were not initially urgent, and needn't have become urgent, become so because of a refusal to return calls.

[6] The foregoing examples are designed to generally discuss and illustrate common problems. They are not exhaustive. Further, it is recognized that in virtually every case cited above, there will be instances where a member's conduct falls outside the literal description of expected behavior but is nonetheless *not* disruptive. There are circumstances where the exigencies of a situation result in crossing over the lines of acceptable behavior. In most instances, particularly those involved in isolated events, corrective action would not be called for. However, repeated or particularly egregious incidents, extending beyond generally recognized standards of behavior, as judged by professional peers, should be subject to such corrective action as deemed necessary to effectively address the circumstances, up to and including termination of a practitioner's right to practice in the facility in appropriate cases.

3.2-4 Inappropriate communication: It is inappropriate to criticize the facility, its staff, or professional peers outside of official problem-solving and peer review channels. This includes written or verbal derogatory statements to an inappropriate audience, such as patients and families, or statements placed in the medical records of patients. These kinds of communications indiscriminately undermine morale and reputation of the facility and its staff and contribute to inaccurate perceptions of facility quality.

3.2-5 Failure to comply: Failure to comply with the bylaws, policies and procedures of the Medical Staff and the facility can be inadvertent, or it can be willful. Willful failure to comply – i.e., refusal to comply – with rules becomes disruptive at the point that it places the Medical Staff or the facility in jeopardy with respect to licensing or accreditation requirements, complying with other applicable laws, or meeting other specific obligations to patients, potential patients and facility staff. Specific examples include:

a. Refusing to provide information or otherwise cooperate in the peer review process (e.g., refusing to meet with responsible committee members, refusing to answer reasonable questions relevant to the evaluation of patient care rendered in the facility, especially when coupled with an attitude that the committee responsible has no right to be questioning or examining the matter at hand).

b. Refusing to provide information necessary to process the facilities or a patient's paperwork. The facility, its patients and their families have a right to expect timely and thorough compliance with all requirements of the facility, third party payors, regulators, etc., as necessary to ensure smooth functioning of the facility and that patients receive the benefits to which they are entitled.

c. Violating confidentiality rules – e.g., disclosing confidential peer review information outside the confines of the formal peer review process.[7] This has the effect of undermining the peer review process, and jeopardizing important protections that often serve as inducements to assuring ongoing willingness to participate in peer review activities.

d. Refusing to comply with established protocols and standards, including, but not limited to, utilization review standards. Here, it is recognized that from time-to-time established protocols and standards may not adequately address a particular circumstance, and deviation is necessary in the best interests of patient care. However, in such circumstances, the member will be expected to account for the deviation, and in appropriate circumstances, to work cooperatively and constructively toward any necessary refinements of protocol or standards to avoid unnecessary problems in the future.

e. Refusing to participate in or meet Medical Staff obligations can be disruptive when it reaches the point that the individual's refusal obstructs or significantly impairs the ability of the Medical Staff to perform its delegated responsibilities – all of which, in the final analysis, are aimed at facilitating quality patient care.

f. Repeatedly abusing or ignoring scheduling policies, or reporting late for scheduled appointments, surgeries, and treatments, resulting in unnecessary delays in or hurrying of patient care services being rendered to any patient of the facility.

g. Sexual harassment – unwelcome comments or contacts of a sexual nature or characterized by sexual overtones, whether overt or covert, are both illegal and disruptive.

[7] This is not to suggest that individual staff members should not speak up if they feel there are shortcomings in other people's performance or in the quality of care being rendered in the facilities that are not being effectively responded to by the individual(s) in charge. In such instances, the proper reporting would be to the next higher step in the process (e.g., if a supervisor is not effectively dealing with a matter, the Medical Director or facility administrator should be notified; if the Medical Director is not effectively dealing with a matter, the Governing Body's designated representative (usually the CEO) should be contacted; if the CEO is not effectively dealing with a matter, the Chair of the Governing Body should be contacted. All contacts should be factual and professional.

3.2-6 Physical abuse: Offensive or nonconsensual physical contact would generally be deemed disruptive, as would intentionally damage to facility premises or equipment.

3.2-7 Threatening behavior: Threats to another's employment or position or otherwise designed to intimidate a person from performing his or her designated responsibilities or interfering with his or her well-being are generally disruptive.

Examples include threats of litigation against peer review participants or against people who report concerns in accordance with established reporting channels, and threats to another's physical or emotional safety or property.

3.2-8 Combative behavior: Combative behavior refers to that which is constantly challenging, verbally or physically, legitimate and generally recognized authority or generally recognized lines of professional interaction and communication. It becomes disruptive to the point that it results in an inability to acknowledge or to deliver constructive comments and criticism.

3.3 Procedures

3.3-1 Reporting: Any person may report potentially disruptive conduct in accordance with the hospital's usual reporting procedures. The Medical Staff office or other appropriate recipient of a disruptive conduct complaint shall submit a report to the Chief Medical Officer and Chief Executive Officer for investigation. The Chief Medical Officer and Chief Executive Officer may agree to delegate the investigation and any action to an appropriate committee. The Chief Medical Officer and Chief Executive Officer may
agree to consult with the hospital's Human Resources department or other consultants as appropriate.

3.3-2 Investigation

The Chief Medical Officer and Chief Executive Officer, or designated committee, shall ensure that appropriate documentation on each incident of disruptive conduct is acquired to facilitate the investigation process. Such documentation should include:

1) Date and time of the reported disruptive behavior.

2) A statement by the reporting individual of whether the behavior involved a patient in any way, and, if so, information identifying the patient involved.

3) The reporter's account of the circumstances that precipitated the situation.

4) A factual and objective description of the reported disruptive behavior.

5) To the extent known to the reporter, the consequences, if any, of the disruptive behavior relate to patient care or hospital operations.

6) A record of any action taken to address the situation prior to the Medical Staff's investigation as required by the Code of Conduct, including the date, time, place, action and name(s) of those taking such an action.

a. The Chief Medical Officer and Chief Executive Officer, or designated committee, shall conduct an appropriate investigation for each matter reported.

b. If the report of inappropriate conduct is anonymous, then, the Chief Medical Officer and Chief Executive Officer, or designated committee, shall exercise discretion as to whether or not to investigate the matter.

c. The investigation shall take place within 14 calendar days from receipt of a report of inappropriate conduct.

3.3-3 Action

a. Unfounded Report: Based on the investigation, the Chief Medical Officer, Chief Executive Officer, or designee shall dismiss any unfounded report by providing a written explanation of the evidence supporting this conclusion. The report should be maintained in the Medical Staff member's file with the original complaint. The individual who initiated the report of the decision shall be notified of the decision.

b. Confirmed Report: A confirmed report will be addressed as follows: The Chief Medical Officer and Chief Executive Officer, or designee, shall consider a number of variables to determine how best to address each incident of disruptive behavior. These variables shall include, but not be limited to:

1) Degree of disruptiveness

2) Number of incidents (i.e., pattern of disruptive behavior over time)

3) Length of time between incidents of disruptive behavior, if multiple incidents have occurred.

c. Plan for Addressing Disruptive Behavior: Relying on the variables described above as well as the overall intent of Bylaws, Article 2, Section 2.7, Standards of Conduct, the Chief Medical Officer, and Chief Executive Officer, or the designated committee, shall document a plan for addressing disruptive behavior. A copy of the plan shall be included in the individual's file. The plan shall include items (1) below and may include any portion or all of items (2) and (3) below:

1) The Chief Executive Officer, or designee, shall send a letter to the offending individual that describes the inappropriate conduct, explains that the behavior is in violation of Bylaws, Article 2, Section 2.7, Standards of Conduct, notes any patient care or hospital operations implications, explains why the behavior in question is inappropriate, encourages the individual to be more thoughtful or careful in the future, invites the individual to respond, and makes clear that attempts to confront, intimidate, or otherwise retaliate against the individuals who reported the behavior in question is a violation of this Rule and grounds

for further disciplinary action. A copy of Bylaws, Article 2, Section 2.7, Standards of Conduct, and this Rule should be included with the letter. Documentation of both the letter and the individual's response should be included in the individual's file.

2) The Chief Medical Officer, Chief Executive Officer, or the designated committee, and any other number of appropriate participants from the Medical Staff and Governing Body shall initiate a discussion with the offending individual to discuss the inappropriateness of his or her behavior and require that such behavior cease. A copy of Bylaws, Article 2, Section 2.7, Standards of Conduct, and this Rule may be hand delivered to the offending individual and he or she should be advised that the Medical Staff requires compliance with the Bylaws. Each individual or a designated member of a group, (if the group meets with the offending individual), shall send a follow-up letter documenting the content of the discussion and any specific actions the offending individual has agreed to perform. The offending individual should be invited to respond. This letter and any response will be included in the individual's file.

3) The plan may incorporate additional components, including, but not limited to:

i) Warning the offending individual that failure to abide by the terms of the Standards of Conduct shall be grounds for disciplinary action including, but not limited to, suspension and/or actual termination of Medical Staff membership.

ii) Notifying one or all the following individuals of the member's disruptive behavior and any relevant history relating to the member: Chief Medical Officer, Medical Executive Committee and Chief Executive Officer.

iii) Requiring the offending individual to agree to specific corrective actions aimed at eliminating that individual's disruptive behavior. Suggested actions are counseling, leave of absence, written apologies, courses or programs specific to the behavior trait (i.e., anger management) or requiring the offending individual to sign a behavior modification contract. The Chief Medical Officer, Chief Executive Officer or designated committee shall document any corrective action and require the offending individual to sign his or her acceptance of this plan. The plan may clearly delineate the consequences for the offending individual not successfully completing the agreed upon corrective action.

iv) In appropriate circumstances, the plan may provide for immediate suspension and/or action to terminate Medical Staff membership without need of further warning or counseling.

3.3-4 Final Warning: If the Chief Medical Officer, Chief Executive Officer, or designated committee determines that the plan has been unsuccessful, the Medical Executive Committee shall be informed in writing of the offending individual's disruptive behavior, including any relevant history regarding this behavior, and advise the Medical Executive Committee to proceed with a final warning. If the Medical Executive Committee determines

that the offending individual deserves a final warning, the Medical Executive Committee Chair/designee (or the Chief Medical Officer/designee or CEO/designee) shall meet with and advise the offending individual that the disruptive behavior in question is intolerable and must stop. The Chief Medical Officer/designee or CEO/designee will inform the individual that a single recurrence of disruptive behavior shall be sufficient cause to result in his/her suspension and/or termination of Medical Staff membership. This meeting shall not be a discussion but rather will constitute the offending individual's final warning. The offender will also receive a follow-up letter that reiterates the final warning and the consequences of suspension and possible termination of Medical Staff membership and privileges.

3.3-5 **Suspension:** If after the final warning the offending individual engages in disruptive behavior that is deemed to require intervention, the individual's Medical Staff membership and privileges shall be subject to suspension consistent with the terms of the Medical Staff Bylaws and policies and procedures. Additional action may also be taken at this time. Action may be taken to revoke the individual's membership and privileges. The individual may also be found ineligible to reapply to the Medical Staff for a period of at least two years.

3.3-6 **Consequences of a Member's Failure to Comply with the Standards of Conduct**: Members who do not act in accordance with the Standards of Conduct shall be subject to corrective action and/or disciplinary action, up to and including termination of membership and privileges, pursuant to the Bylaws. Any recommendation to restrict, or restriction of Member's membership or privileges shall entitle the member to hearing procedures set forth in the Bylaws.

RULE 4
COMMITTEES

4.1 Committees

The medical staff hereby establishes the following committees. The rules applicable to each committee are set forth in the corresponding appendix. Most Medical Staff Committee functions and activities shall be performed by the Medical Executive Committee. Assigned committee members from the Medical Staff ~~Additional personnel~~ will be required to attend at least 50% of their assigned committee meetings as necessary to fulfill the committee's activities. The Medical Executive Committee retains the prerogative to assign committee activities to separate committees if necessary to accomplish the required duties.

Committee	See Appendix
ρ Bylaws Review	4A
ρ Credentialing Activities	4B
ρ Infection Control Committee	4C
ρ Interdisciplinary Practice Committee	4D
ρ Medical Chart Review/Utilization Review Committee	4E
ρ Pharmacy & Therapeutics Committee	4F
ρ Quality Improvement Committee	4G
ρ Environment of Care Committee	4H
ρ Well-Being Activities	4I
ρ Emergency Services Committee	4J
ρ Policy/Procedure Review Committee	4K

Appendix 4A
BYLAWS REVIEW

1. Composition

Review of the Medical Staff Bylaws shall be a function of the Medical Executive Committee.

2. Duties

The purposes of the Bylaws Review is to assure that the Medical Staff Bylaws and Rules adequately and accurately describe the structure of the medical staff, including but not limited to: the mechanism used to review credentials and to delineate individual clinical privileges; the organization of the medical staff quality improvement activities, including the procedures for conducting, evaluating and revising such activities; the mechanism for terminating medical staff membership; and the fair hearing and appeal procedures. The Bylaws Review shall ensure that the Bylaws and Rules are reviewed at least bi-annually and updated as necessary.

3. Meetings

The committee will meet as necessary for the review or revision of the bylaws as requested by the Chief Medical Officer.

Appendix 4B
CREDENTIALING ACTIVITIES

1. Composition

The Credentialing Activities and responsibilities shall be a function of the Medical Executive Committee.

2. Duties

The Medical Executive Committee shall evaluate or coordinate the evaluation of the qualifications of all applicants for medical staff appointments, reappointment or changes in staff categories. The Committee shall develop recommendations based on its evaluations of each applicant.

3. Meetings

Credentialing Activities shall meet as often as necessary to fulfill the credential functions.

Appendix 4C
INFECTION CONTROL COMMITTEE

1. Composition

a. The Infection Control Committee shall be composed of one staff physician designated as Physician Advisor, Hospital Infection Control Coordinator, the Chief Nursing Officer, Assistant Director of Nursing, and other hospital services as deemed necessary.

b. Representatives from housekeeping, laundry, dietetic services and engineering and maintenance shall be available on a consultative and ad hoc basis.

2. Duties

The Infection Control Committee shall develop and monitor the hospital's infection control program and the staff's treatment of infectious disease, and employee health. The committee shall approve action to prevent or control infections and the infection potential among patients and hospital personnel. At least every two years, the committee shall review and approve all policies relating to the infection control program. The Physician Advisor or his or her designee shall be available for on-the-spot interpretation of applicable rules.

3. Meetings

The Infection Control Committee shall meet every other month and at least quarterly.

Appendix 4D
INTERDISCIPLINARY PRACTICE COMMITTEE

1. Composition

The Interdisciplinary Practice Committee (IPC) shall have an equal number of Mmedical Sstaff Mmembers and Allnd ied Health Professionals.~~nursing staff members. It shall include the CEO and/or his or her designee, the Director of Nursing, registered nurses appointed by the Director of Nursing and the Medical Staff Coordinator. Licensed or certified health professionals other than registered nurses who are performing or who will perform functions under standardized protocols shall be included in the Committee.~~

2. Duties

a. Standardized Procedures

1) The IPC shall be responsible for:

a. Identifying functions and/or procedures which require the formulation and adoption of standardized procedures under Section 2725 of the Business and Professions Code for them to be performed by Allied Health Professionals ~~registered nurses~~ in the facility and initiating the preparation of such standardized procedures in accordance with this section.

b. The review and approval of all such standardized procedures covering practice by Allied Health Professionals ~~registered nurses~~ in the facility.

c. Recommending policies and procedures for the authorization of Allied Health Professionals ~~employed staff registered nurses~~ to perform identified functions and/or procedures. These policies and procedures may be administered by the IPC. ~~or by delegation to the Director of Nursing.~~

2) Each standardized procedure shall:

Be in writing and show dates or dates of approval including approval by the IPC.

Specify the standardized procedure functions which Allied Health Professionals ~~registered nurses~~ are authorized to ~~perform and~~perform under what circumstances.

State any specific requirements which are to be followed by Allied Health Professionals ~~registered nurses~~ performing all or part of the functions covered by the standardized procedure.

Specify any experience, training or special education requirements for performance of the functions.

Establish a method for initial and continuing evaluation of the competence of those Allied Health Professionals~~registered nurses~~ authorized to perform the functions.

Provide for a method of maintaining a written record of those ~~persons~~people authorized to perform the functions.

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Specify the nature and scope of review and/or supervision required for the performance of the standardized procedure functions, e.g. if the function is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated.

Set forth any specialized circumstances under which the Allied Health Professional~~registered nurse~~ is to communicate immediately with the physician concerning the patient's condition.

State any limitations on settings or departments within the facility where the standardized procedure functions may be performed.

Specify any special requirements for procedures relating to patient record keeping.

Provide periodic review of the standardized procedure.

3) If Allied Health Professionals~~nurses~~ have been approved to perform procedures pursuant to a standardized procedure, the names of ~~the nurses approved~~the approved shall be on file in ~~the office of the Director of Nursing~~the Credentialing Office.

b. Credentialing Allied Health Professionals

1) Nurse Practitioners~~Registered Nurses~~:

The IPC shall be responsible for recommending policies and procedures for the granting of expanded role privileges to Nurse Practitioners~~registered nurses~~, whether employed by the facility, to provide for the assessment, planning and direction of the diagnostic and therapeutic care of a patient in a licensed health facility. The policies and procedures will be administered by the IPC, which shall be responsible for reviewing credentials and making recommendations for the granting and/or rescinding of such privileges.

2) Physician Assistant:

A Physician Assistant who practices in a licensed health facility shall be supervised by a physician approved by the Division of Allied Health Professions of the Board of Medical Quality Assurance who is a member of the active medical staff. Physician Assistants shall apply to and be approved by the e~~E~~xecutive c~~C~~ommittee of the medical staff of the facility in which the P~~p~~hysician A~~a~~ssistant wishes to practice.

3. Meetings

The IPC shall meet as often as needed for the purpose of fulfilling the obligations of the duties listed above, but at least biannually.

[1]Subject to implementation of expanded role privileges by AHP's in the hospital

APPENDIX 4E
MEDICAL CHART REVIEW/UTILIZATION REVIEW COMMITTEE

1. Composition

The Medical Chart Review/Utilization Review Committee shall consist of members of the Medical Staff, the Administrator, Utilization Review Coordinator, Medical Records Director, Quality Improvement Coordinator and other hospital staff as deemed necessary.

2. Duties

The Medical Chart Review and Utilization Review Committee has been combined to improve Committee activities and report to the Medical Executive Committee.

a. **Medical Chart Review:** Provide for the review by a multidisciplinary team a sample of records to determine whether they reflect the correct diagnosis, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient and the condition of the patient at discharge. Provide leadership in measuring, assessing and improving medical assessment and treatment, use of medications, use of blood and blood components, operative and other procedures, efficiency of clinical practice patterns, departures from established clinical patterns, coordination of care with other practitioners and hospital personnel, and the accurate, timely, and legible completion of patients' medical records. Recommend actions to be taken as necessary to correct deficiencies identified during the review

b. Utilization Review General Duties: Oversees the review of the medical necessity for admissions, extended stays and services rendered. The Committee addresses over-utilization, under-utilization, and inefficient scheduling and use of resources. Patterns of care will be followed, and focused review may be undertaken as deemed necessary. They shall also work toward maintaining proper continuity of care upon discharge. The Committee shall communicate pertinent data and results of review to the Medical Executive Committee and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety.

c. Utilization Review Plan: The Committees shall establish and follow a Utilization Review Plan, which shall be approved by the Medical Executive Committee and Governing Body and shall comply with applicable federal and state regulations.

d. Evaluation: The Committees shall evaluate the medical necessity of continued hospital services for patients, where appropriate. In making such evaluations, the Committees shall be guided by the following criteria:

1) No practitioner shall have review responsibility for any extended stay cases in which he or she was professionally involved.

2) Each decision that further inpatient stay is not medically necessary shall be made by the medical staff members of the Committee and only after

opportunity for consultation has been given to the attending practitioner by the Committee and full consideration has been given to the availability of hospital facilities and services.

3) All decisions that further inpatient care is not medically necessary shall be given by written notice, in accordance with the written Utilization Review Plan.

e. Liaison: The Committee will act only upon the direct instruction of the Medical Executive Committee as the Liaison Committee for government agencies and third-party providers.

f. Continuity of Care: The Committee shall promote continuity of care upon discharge and supervise the accumulation of data on the availability of health care resources outside the hospital.

3. Meetings

The Committees shall meet quarterly. The Committee shall report matters pertaining to quality improvement to the Quality Improvement Committee as well as the Medical Executive Committee.

Appendix 4F
PHARMACY & THERAPEUTICS COMMITTEE

1. Composition

The Pharmacy & Therapeutics Committee shall consist of a Physician Advisor, Pharmacy Director, Chief Nursing Officer, Assistant Director of Nursing, and other hospital staff as deemed necessary.

2. Duties

Duties of the Pharmacy and Therapeutics Committee shall be to develop, implement and monitor professional policies regarding evaluation, selection, and procurement of drugs comprising the hospital formulary; preparing and dispensing medications; distribution, administration, safety, and effect (including reactions and interactions) of drug usage; review the clinical use of antibiotics; patient education; review of hospital protocols, standing orders, policy/procedures that pertain to patient care; and other matters pertinent to drug use in the facility.

3. Meetings

The Pharmacy and Therapeutics Committee shall meet quarterly.

APPENDIX 4G
QUALITY/PERFORMANCE IMPROVEMENT COMMITTEE

1. Composition

The Quality Improvement Committee shall consist of a Physician Advisor, a member of the Governing Body, the CEO, Performance Improvement Coordinator, Chief Nursing Officer, Director of Nursing. Members of other committees may be requested to participate in the Committee activities as deemed necessary.

Additionally, there shall be a Performance Improvement Committee for the Skilled Nursing Facility, which shall consist of a Physician Advisor, the Performance Improvement Coordinator, the Chief Nursing Officer, the Director of Nursing, Social Services, Social Services Coordinator, MDS Coordinator, Activities Director and any other staff as deemed necessary

2. Duties

Performance Improvement objectives will be focused on the development, maintenance and periodic improvements in systems that influence organizational outcomes. Systems will be designed and redesigned to achieve efficient, reliable outcomes. MMC will participate in ongoing and systematic quality improvement efforts. Quality improvement efforts will focus on care delivery processes and support processes that promote optimal patient outcomes and effective practices. This is accomplished through peer review, clinical outcomes review, variance analysis, performance appraisals, and other quality improvement techniques.

3. Meetings

The Committee shall meet monthly or at least quarterly.

Appendix 4H
ENVIRONMENT OF CARE COMMITTEE

1. Composition

The Environment of Care Committee shall be composed of ~~Physician Advisor,~~ the Chief Nursing Officer, the DON, a member of the Engineering ~~Dept.,,~~Dept., Human Resources, Environmental Services, Ambulance ~~Director,,~~Director, and other staff as deemed necessary.

2. Duties

The Committee is responsible for promoting safety throughout the facility, investigation of accidents/injuries to staff, correlation of disaster planning within the facility, and with outside agencies. To promote surveillance of the facility for compliance with fire and hazardous materials regulations. The Committee shall develop policies and procedures as necessary to comply with new regulations and to ensure that staff receive in-service education on a regular basis.

3. Meetings

The Environment of Care Committee shall meet regularly~~monthly~~, but no less than six~~ten~~ (6~~10~~) times per year. Minutes of the Environment of Care Committee shall be provided to the Medical Executive Committee.

Appendix 4l
WELL-BEING ACTIVITIES

1. Composition

Well-Being Activities shall be fulfilled by the Medical Executive Committee.

2. Duties

a. In accordance with Rule 2.3 on Physical and Mental Capabilities, the Medical Executive Committee shall review the responses from applicants concerning physical or mental disabilities and recommend what, if any, reasonable accommodations may be indicated with the hospital and medical staff's standard of care.

b. The Medical Executive Committee shall also strive to assist in improving the quality of care for patients by helping to resolve matters relating to medical staff members' health, well-being or impairment before they evolve into significant patient care problems.

c. The Medical Executive Committee may receive reports related to the health, wellbeing, or impairment of medical staff members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual medical staff members, the Committee may, upon its own initiative, upon request of the practitioner involved, or upon request of a medical staff officer, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential. If the Chief Medical Officer receives information that demonstrates that the health or impairment of a medical staff member may pose a risk of harm to hospital patients (or prospective patients), a determination for corrective action shall be made to protect the patients.

d. The Medical Executive Committee shall also consider general matters related to the health and wellbeing of medical staff members and develop educational programs or related activities as necessary.

3. Meetings, Reporting and Minutes

The Medical Executive Committee shall meet for the Well-Being Activities as often as deemed necessary. It shall maintain only such records of its proceedings as it deems advisable.

APPENDIX 4J
EMERGENCY SERVICES COMMITTEE

1. Composition

The Emergency Services Committee shall consist of a Physician Advisor, Quality Improvement ~~Coordinator,,~~Coordinator, Chief Nursing Officer, Ambulance Supervisor, and CEO or his/her designee. Other personnel may be requested to participate in the Committee activities as deemed necessary.

2. Duties

The Emergency Services Committee shall be responsible for the evaluation of the quality of emergency services provided within the scope of services available at this facility. This Committee will make recommendations to maintain or improve quality, appropriateness of care and services rendered by monitoring and evaluating processes The Committee shall develop policies and procedures as necessary to comply with new regulations and/or advancement in standard of care, review of concerns/complaints related to care provided in the Emergency Department, or by EMS personnel, and assist in the review of transfers to determine appropriateness of documentation, medical necessity, utilization of services and compliance with EMTALA regulations. The Committee shall also monitor patient safety as related to the provisions of emergency services.

3. Meetings

The Committee shall meet at least quarterly.

Appendix 4K
POLICY/PROCEDURE REVIEW COMMITTEE

1. Composition

The Policy/Procedure Review Committee shall consist of the Performance Improvement Coordinator, Risk Management, the Chief Nursing Officer, at least one member of nursing administration, the Clinic Manager, and when appropriate, other department representatives may be requested to participate in the Committee.

2. Duties

The duties of the Policy/Procedure Review Committee shall be the establishment of policies governing services provided at the facility and for reviewing and recommending policies related to patient care. Based on reports received from the Administrator, Risk Management Committee, Quality Improvement Coordinator, and/or other representatives of the facility, the Committee shall review the effectiveness of policy implementation and shall make recommendations for the improvement of patient care.

3. Meetings and Reporting

The Committee shall review all patient care policies annually and revise as necessary. The Committee shall report recommendations to the Medical Executive Committee following such a review.

RULE 5
CLINICAL SERVICES

5.1 Clinical Services Functions

Each clinical service, through its Physician Advisor and established committees, is responsible for the quality of care within the service, and for the effective performance of the following as relates to the members and Allied Health Professionals (AHP)~~s~~ practicing within the service:

5.1-1 Patient care evaluation, observation and monitoring (including periodic demonstrations of ability), consistent with guidelines developed by the committees responsible for Quality Improvement, Utilization Review, Education and Medical Records, and by the Medical Executive Committee.

5.1-2 Credentials review, consistent with guidelines developed by the Medical Executive Committee.

5.1-3 Corrective action, when indicated, in accordance with Bylaws Article 11, Peer Review and Corrective Action.

5.1-4 Continuing education, consistent with guidelines developed by the clinical service and the Medical Executive Committee.

5.2 Physician Advisor Qualifications

Each Physician Advisor shall:

5.2-1 If required by California hospital licensure regulations, be board certified or board admissible in his or her appropriate specialty. Where certification/admissibility is not required by law, a person with comparable training and experience shall be eligible to serve.

5.2-2 Have demonstrated clinical competence in his or her field of practice sufficient to maintain the respect of the members of his or her service.

5.2-3 Understand the purposes and functions of the staff organization and demonstrated willingness to promote patient safety over all other concerns.

5.2-4 Understand and willingness to work with the hospital toward attaining its lawful and reasonable goals.

5.2-5 Have an ability to work with and motivate others to achieve the objectives of the medical staff organization in the context of the hospital's lawful and reasonable objectives.

5.2-6 Be (and remain during tenure in office) a medical staff member in good standing. Limited Active or Active status is required for the Physician Advisor to participate in the activities of Clinic Director or for Emergency Services/Ambulance Services.

5.2-7 If participating in the activities of Emergency Services/Ambulance Services, hold current ATLS (Advanced Trauma Life Support) certification.

5.2-8 Not having any significant conflict of interest.

5.3 Procedures for Selecting Physician Advisor

5.3-1 All Physician Advisors shall be appointed by the Chief Medical Officer, unless otherwise designated through contracts with the hospital.

5.4 Procedures for Removing Physician Advisor

Removal of a Physician Advisor appointed by the Chief Medical Officer may be initiated by a medical staff member. Removal will take effect upon the approval by majority vote by the Medical Executive Committee. Removal of a Physician Advisor assigned through a hospital contract will be done through action by the Chief Executive Officer.

5.5 Responsibilities of Physician Advisors

5.5-1 Each Physician Advisor shall be responsible for:

a. All clinical activities of the clinical service.

b. All administrative activities of the service (unless otherwise provided by the hospital).

c. Integrating the service into the primary functions of the organization.

d. Developing and implementing policies and procedures that guide and support the provision of services in the unit.

e. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the unit.

f. Recommending the criteria for clinical privileges in the service.

g. Evaluating the qualifications and competence of practitioners and allied health professionals (AHPs) who provide patient care services within the purview of the service.

h. Recommending clinical privileges for each practitioner and AHP desiring to exercise privileges in the service.

i. Maintaining quality control programs, as appropriate and in coordination with the Medical Staff Quality Improvement Committee.

j. Continuously assessing and improving the quality of care and services provided in the service.

k. Making recommendations regarding space and other resources needed by the department.

l. Making recommendations to the relevant hospital authority with respect to off-site sources needed for patient care services not provided by the service or the hospital.

m. Reporting on activities of the medical staff to the Governing Body when called upon to do so by the Chief Medical Officer or the Chief Executive Officer.

n. Performing such additional responsibilities as may be delegated to him or her by the Medical Executive Committee or the Chief Medical Officer.

RULE 6
ALLIED HEALTH PROFESSIONALS

6.1 Overview

6.1-1 The credentialing process for Allied Health Professionals (AHPs) is like that for credentialing medical staff members. However, the Interdisciplinary Practices Committee (IPC), is responsible for overseeing the credentialing of AHPs, subject to approval of the Medical Executive Committee and the Governing Body. The credentialing process for AHPs is summarized at Rule 6.3, below.

6.1-2 Rule 6.4 reflects the basic requirements that all AHPs must meet, and Appendices 6A through 6N set forth requirements that specific types of AHPs must meet in addition to the basic requirements.

6.1-3 Also, the clinical service in which the AHP will exercise privileges has a role in establishing criteria for the exercise of specific privileges in that service, and in evaluating whether the applicant meets the established criteria. The clinical services also have the responsibility for generally supervising AHPs in their service, through their proctoring and peer review mechanisms.

6.1-4 Until the AHP has been granted privileges and assigned to a service, an AHP should not be practicing within the hospital.

6.1-5 This Rule applies to AHP's who practice independently, as well as AHP's who are employees or independent contractors of a Medical Staff member. It does not apply to hospital-employed AHP's.

6.2 Categories of AHPs Eligible to Apply for Practice Privileges

6.2-1 The types of AHPs allowed to practice in the hospital will be ultimately determined by the Governing Body, based upon the comments of the Medical Executive Committee and such other information as may be available to the Governing Body.

a. The following categories may practice independently or as employees or independent contractors of medical staff members:

- acupuncturist
- audiologist
- licensed clinical social workers
- nurse anesthetists
- nurse practitioners
- occupational therapists
- physician's assistants
- registered vascular technologists
- registered nurse first assistants
- respiratory care practitioners
- speech pathologists
- surgical assistants
- surgical nurses

6.2-3 When an AHP in a category that has not been approved as eligible to apply for clinical privileges under Article 6 of the Bylaws requests privileges, the IPC may begin to process an application at the same time the request for recognition of the profession is processed; however, no right to practice in the hospital is thereby created or implied.

6.3 Processing the Application

6.3-1 Applications shall be submitted and processed in a manner parallel to that specified for medical staff applicants in Rule 2, Appointment and Reappointment, except that the applications shall be submitted to the IPC rather than the Medical Executive Committee.

6.3-2 Once the application is determined to be complete, it will be forwarded to the IPC for consideration. The IPC may meet with the applicant and the sponsoring or supervising practitioner (if applicable). The IPC shall evaluate the AHP based upon the standards set forth in Rules 2 and 6.4. The IPC will also ascertain that appropriate monitoring mechanisms are in place (in the clinical service or through the Quality Improvement Committee). Whenever possible, the IPC shall include practitioners in the same AHP category when conducting its evaluation. The IPC shall forward its recommendations to the Medical Executive Committee for review and action.

6.3-3 Thereafter, the application shall be processed by the Medical Executive Committee and Governing Body in accordance with the procedures set forth in Rule 2.7-3 through 2.7-6.

6.4 Credentialing Criteria

6.4-1 Basic Requirements

a. The applicant must belong to an AHP category approved for practice in the hospital by the Governing Body.

b. If required by law, the applicant must hold a current, unrestricted state license or certificate.

c. In addition, hospital independent contractors shall meet all conditions of their contract with the hospital.

d. The applicant must document his or her experience, education, background, training, demonstrated ability, judgment and physical and mental health status with sufficient adequacy to demonstrate that any patient he or she treats will receive care of the generally recognized professional level of quality and efficiency in the community and as established by the hospital, and that he or she is qualified to exercise clinical privileges within the hospital.

e. The applicant must maintain in force professional liability insurance or its equivalent for the privileges exercised in the amounts of at least $1,000,000/occurrence and $3,000,000/aggregate. The requirement may be satisfied through coverage under the hospital insurance, if applicable.

f. The applicant must submit a minimum of three references from either licensed physicians or adequately trained professionals in the appropriate field and who are familiar with his or her professional work and have demonstrated competency.

g. The applicant must have practiced for an average of at least 20 hours per week in his or her field for 18 of the previous 24 months. If the applicant is working in an independent setting, he or she must have completed one year of clinical practice outside of his or training program.

h. The applicant must be determined, based on documented references, to adhere strictly to the lawful ethics of his or her profession, to work cooperatively with others in the hospital setting so as not to adversely affect patient care, to be willing to participate in and properly discharge responsibilities as determined by the medical staff.

6.4-2 Specific Requirements

In addition to meeting the general requirements outlined above, applicants must meet any specific requirements established for his or her category of AHP, as set forth in the applicable appendix:

	See Appendix:
ρ acupuncturists	6A
ρ audiologists	6B
ρ licensed clinical social workers	6C
ρ nurse anesthetist	6D
ρ nurse practitioners	6E
ρ occupational therapists	6F
ρ physician's assistants	6G
ρ registered vascular technologist	6H
ρ registered nurse first assistants	6I
ρ respiratory care practitioners	6J
ρ speech pathologists	6K
ρ surgical assistants	6L
ρ surgical nurses	6M
ρ Licensed marriage and family therapist	6N

6.4-3 Supervising Practitioner Responsibilities

a. Any supervising practitioner or group which employs or contracts with the AHP agrees that the AHP is solely his, her or its employee or agent and not the hospital's employee or agent. The supervising practitioner or group has full and sole responsibility for paying the AHP, and for complying with all relevant laws, including federal and state income tax withholding laws, overtime laws and workers' compensation insurance coverage laws.

b. A supervising practitioner or group which employs or contracts with the AHP agrees to indemnify the hospital against any expense, loss or adverse judgment it may incur because of allowing an AHP to practice at the hospital or as a result of denying or terminating the AHP's privileges.

c. Hospital employed mid-level practitioners may be supervised by appropriately licensed physicians who are otherwise under contract with the hospital to provide such services.

6.5 Provisional Status

All AHPs initially shall be appointed to a Provisional Status for at least twelve months. Advancement from the provisional status will be based upon whether the professional's performance is satisfactory, as determined by the IPC, the Medical Executive Committee and the Governing Body.

6.6 Duration of Appointment and Reappointment

6.6-1 AHPs shall be granted practice privileges for no more than 24 months. Reappointments for the AHP staff shall be processed every other year, in a manner parallel to that specified in Rule 2 for medical staff members.

6.6-2 Applications for renewal of the AHP's privilege and the supervising practitioner's approval must be completed by the AHP and supervising practitioner and submitted for processing in a parallel manner to the reappointment procedures set forth in the Medical Staff Rules.

6.7 Observation

6.7-1 All new AHPs shall be subject to performance evaluation and monitoring, consistent with the provisions of Bylaws Article 7, adapted to the scope of practice and privileges of the AHP.

6.7-2 The IPC shall be responsible for establishing observation programs appropriate to each category of AHP granted privileges. The IPC shall determine the appropriate frequency and methods of initial Focused Professional Practice Evaluation, which may include concurrent or retrospective chart review or consultations. AHPs exercising surgery or anesthesia practice privileges shall be observed during surgery under appropriate supervision of the operating or supervising practitioner.

6.7-3 The proctor or evaluator should be a member in good standing of the medical staff who exercises appropriate clinical privileges; however, in appropriate circumstances, the Chief Medical Officer may assign an appropriately credentialed AHP to serve as the proctor/evaluator. Whenever possible, the proctor/evaluator should not be the sponsoring or supervising practitioner of the AHP being observed.

6.7-4 The Governing Body may approve alternative observation procedures for employees or contract AHPs.

6.8 General

6.8-1 Duties

Upon appointment, each AHP shall be expected to:

a. Consistent with the privileges granted to him or her, exercise independent judgment within his or her areas of competence and, if applicable, within the limits of an approved standardized procedure, provided that a medical staff member who has appropriate privileges shall retain the ultimate responsibility for each patient's care.

b. Participate directly in the management of patients to the extent authorized by his or her license, certificate, other legal credentials, any applicable standardized procedures, and by the privileges granted by the Governing Body.

c. Write orders to the extent established by any applicable medical staff or clinical service policies, rules or standardized procedures and consistent with privileges granted to him or her.

d. Record reports and progress notes on patient charts to the extent determined by the appropriate service, and in accordance with any applicable standardized procedures.

e. Assure that records are countersigned or peer reviewed as follows: (i) all inpatient chart notes are countersigned by the supervising physician; ~~the supervising practitioner, if any, shall countersign all entries except routine progress notes;~~ (ii) all emergency room chart notes are countersigned by the supervising physician; (iii) ~~unless otherwise specified in the rules or specific supervision protocols, all chart entries that require countersignatures must be countersigned within fourteen days after the entry is made.~~up to 5% of clinic chart notes are peer reviewed and signed by a supervising physician.

f. Consistent with the privileges granted to him or her, perform consultations as requested by a medical staff member.

g. Comply with all Medical Staff and Hospital Bylaws, Rules and Policies.

6.8-2 Prerogatives and Status

AHPs are not members of the medical staff and hence shall not be entitled to vote on medical staff. They are expected to attend and actively participate in the meetings of their respective clinical services, to an extent consistent with Medical Staff and Hospital Bylaws, Rules, and Policies.

6.9 Standardized Procedures

6.9-1 Definition

Standardized procedures mean the written policies and protocols for the performance of standardized procedure functions, and which have been developed in accordance with the requirements of state law.

6.9-2 Functions Requiring Standardized Procedures

Standardized procedures are required whenever any registered nurse (including, but not by way of limitation, Nurse Anesthetists, Nurse Practitioners and Nurse Midwives) practices beyond the scope of practice taught in the basic curriculum for registered nurses as contemplated by the California Nurse Practice Act (i.e., whenever special training and/or experience are necessary in order for the nurse to perform the procedure or practice in question).

6.9-3 Development of Standardized Procedures

a. Standardized procedures may be initiated by the appropriate clinical service, the affected AHPs, or sponsoring or supervising practitioners.

b. The IPC is responsible for assuring that standardized procedures are a collaborative effort among administrators and health professionals, including physicians and nurses. Representatives of the category of AHPs that will be

practicing pursuant to the standardized procedures shall be involved in developing the standardized procedures.

c. Each standardized procedure shall:

1) Be in writing and show the date or dates of approval by the IPC.

2) Specify which standardized procedure functions registered nurses may perform and under what circumstances.

3) State any specific requirements which are to be followed by registered nurses in performing standardized procedure functions.

4) Specify any experience, training and/or education requirements for performance of standardized procedure functions.

5) Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions.

6) Provide a method of maintaining a written record of those persons authorized to perform standardized procedure functions.

7) Specify the nature and scope of review and/or supervision required for performance of standardized procedure functions; for example, whether the functions must be performed under the immediate supervision of a physician.

8) Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition.

9) State the limitations on settings or clinical services, if any, in which standardized procedure functions may be performed.

10) Specify patient record keeping requirements.

11) Provide a method of periodic review of the standardized procedures.

d. Standardized procedures shall be reviewed by the IPC and then must be approved by the Medical Executive Committee and the Governing Body.

Appendix 6A
ACUPUNCTURISTS

1. Licensure

Acupuncturists shall be currently certified by the Acupuncture Board.

2. Scope of Practice

a. Acupuncturists may receive privileges to perform the following professional services at the hospital when expressly ordered by the attending physician:

1) Insert needles into the skin to stimulate certain points on the body to prevent or modify the perception of pain or to achieve other clinical objectives. ~~control pain for the purpose of assisting in the treatment of diseases or dysfunctions.~~

2) Administer electroacupuncture, cupping and moxibustion to stimulate a certain point or points on or near the surface of the body to prevent or modify the perception of pain or to achieve other clinical objectives. ~~control pain for purposes of assisting in the treatment of diseases or dysfunctions; and~~

3) As an adjunct to the treatment described above in 1) and 2), prescribe or perform oriental massage, acupressure, breathing techniques, exercise or nutrition (including incorporating drugless substances or herbs as dietary supplements).

b. Acupuncturists shall not perform any procedure at the hospital beyond the scope of acupuncture licensure, including:

1) Making incisions in the skin and manipulating nerve tissue with forceps.

2) Inserting sutures to stimulate a certain point or point on or near the surface of the body.

3) Using ultrasound or diathermy to generate deep heat within body tissues.

4) Using lasers or magnets to stimulate a certain point or point on or near the surface of the body; or

5) Using heat therapy or hydrotherapy to stimulate a certain point or points on or near the surface of the body. (However, an acupuncturist may use heat therapy and hydrotherapy to prepare the patient for acupuncture treatment.)

c. Acupuncturists shall not:

1) Sever or penetrate tissues to excise a needle that has broken subcutaneously; or

2) Treat complications, such as pneumothorax, hematoma or peritonitis, arising from acupuncture.

d. Acupuncturists shall refer to any of the above complications to the attending physician.

e. Acupuncturists shall be responsible for knowing and adhering to all applicable infection control requirements of the hospital and of the Acupuncture Board.

Appendix 6B
AUDIOLOGISTS

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1. Licensure

Audiologists shall be currently licensed by the Speech Pathology and Audiology Examining Committee of the Medical Board of California.

2. Scope of Practice

a. Audiologists may receive privileges to perform the following professional services at the hospital:

1) Determine the range, nature and degree of hearing function related to the patient's communication needs, using instruments such as pure-tone and speech audiometers, and acoustic impedance equipment.

2) Coordinate audiometric results with other diagnostic data, such as educational, medical, social and behavioral information.

3) Differentiate between organic and nonorganic hearing disabilities through evaluation of total response pattern and use of acoustic tests, such as Stenger and electrodermal audiometry; and

4) Plan, direct, conduct or participate in conservation, habilitative and rehabilitative programs, including hearing aid selection and orientation, counseling, guidance, auditory training, speech reading, language habilitation and speech conservation.

b. Audiologists shall not:

1) Perform invasive procedures.

2) Conduct physical examinations.

3) Prescribe medication; or

4) Dispense hearing aids.

Appendix 6C
LICENSED CLINICAL SOCIAL WORKERS

1. Licensure

Licensed Clinical Social Workers shall be currently licensed by the California Board of Behavioral Science Examiners.

2. Scope of Practice

Licensed Clinical Social Workers may receive privileges to perform the following professional services at the hospital pursuant to a medical staff member's order:

a. Counsel and provide psychotherapy of a nonmedical nature to individuals, families or groups.

b. Provide information and referral services and arrange for the provision of social services.

c. Explain or interpret the psychosocial aspects of individual, family or group situations.

d. Use psychosocial methods to assist people to achieve better psychosocial adaptation; and

e. Provide marriage, family and child counseling, provided that the clinical social worker does not advertise that he or she is licensed as a Marriage, Family and Child Counselor.

Appendix 6D
NURSE ANESTHETISTS

1. Licensure and Certification

Nurse Anesthetists shall be currently licensed as a registered nurse in California and currently certified as a Nurse Anesthetist by the California Board of Registered Nursing and the American Association of Nurse Anesthetists.

2. Scope of Practice

a. Nurse Anesthetists may administer anesthesia only upon the direct order of a qualified physician who:~~, dentist or podiatrist who:~~

1) Is a current member of good standing of the medical staff of the hospital.

2) Is acting within the scope of his or her licensure and privileges; and

3) Has personally evaluated the patient in question.

b. Nurse Anesthetists may receive privileges to perform the following professional services at the hospital:

1) Perform a preanesthetic evaluation of the patient, which may involve:

i) Review of the patient's medical records, x-rays, previous experience with anesthesia, and history and physical examination conducted by a physician.

ii) Performance of a physical examination.

iii) Assessment of the patient's emotional status; and

iv) Choice of anesthetic agent.

2) Record the preanesthetic evaluation in the patient's record.

3) Administer regional, local or general anesthesia upon appropriate order and under supervision of the operating or supervising practitioner.

4) Initiate orders with registered nurses and other hospital staff as required for care of the patient.

5) Provide pain management services and emergency procedures including:

i) Endotracheal intubation.

ii) Injection of anesthetic or narcotic substances into epidural, subdural or subarachnoid spaces; and

iii) Injection of somatic or sympathetic nerves with anesthetic agents.

6) Perform postanesthetic evaluation of the patient.

7) Authorize release of an in~~m~~patient from the recovery area to a nursing unit; on the order of a qualified licensed independent

practitioner or rigorously applied criteria approved by the medical staff; and

8) Perform other functions according to standardized procedures adopted by the hospital.

Nurse Anesthetists shall consult with the physician, dentist or podiatrist responsible for the anesthesia, or other qualified physician, when necessary or appropriate.

Appendix 6E
NURSE PRACTITIONERS

1. Licensure and Certification

Nurse Practitioners shall be currently licensed as a Registered Nurse in California and currently certified as a Nurse Practitioner by the California Board of Registered Nursing.

2. Scope of Practice

Nurse Practitioners may receive privileges to perform the following professional services at the hospital:

a. Perform tasks or functions which fall within the customary scope of nursing practice; and

b. Furnish or order drugs or devices (other than controlled substances) to patients under the following conditions:

1) The drug or device is furnished or ordered pursuant to a standardized procedure or protocol which is promulgated by the hospital in accordance with legal requirements.

2) The drug or device furnished or ordered is consistent with the Nurse Practitioner's educational preparation or established (and maintained) clinical competency.

3) The drug or device is furnished or ordered pursuant to a standardized procedure or protocol which is promulgated by the hospital in accordance with legal requirements.

4) The drug or device is furnished or ordered under the supervision of the attending physician, who:

(i) collaborated in the development of the standardized procedure.

(ii) approved the standardized procedure.

(iii) is available by telephone at the time of patient examination by the Nurse Practitioner, and

(iv) supervises no more than four Nurse Practitioners at one time.

5) The drug or device is furnished or ordered pursuant to certification from the Board of Registered Nursing that the Nurse Practitioner has completed:

i) At least six months of physician-supervised experience in the furnishing of drugs or devices; and

ii) A course in pharmacology covering the drugs and devices to be furnished.

6) The drug or device is furnished or ordered under a number issued by the Board of Registered Nursing to the Nurse Practitioner, to be included on all transmittals of orders for drugs or devices.

7) The Nurse Practitioner is registered with the United States Drug Enforcement Administration.

c. Furnish or order Schedule IV or Schedule V controlled substances if, in addition to the conditions above at (b) being met, the drugs or devices are further limited to those drugs agreed upon by the Nurse Practitioner and the supervising physician and specified in the standardized procedure.

d. Furnish or order Schedule III controlled substances if, in addition to the conditions above at (b) and (c) being met, the drugs or devices are furnished in accordance with a patient-specific protocol approved by the treating or supervising physician.

e. Furnish or order Schedule II controlled substances if, in addition to the conditions above at (b), (c), and (d) being met, the following conditions are met:

1) The provision in the protocol for furnishing Schedule II controlled substances addresses the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished; and

2) The Nurse Practitioner completes, as part of his or her continuing education requirements, a course including Schedule II that controls substances that meet the standards of the Board of Registered Nursing.

3) The term "furnish" shall include

i) Ordering a drug or device in accordance with the standardized procedure; and

ii) Transmitting an order of a supervising physician.

f. Perform tasks or functions within the expanded scope of nursing practice as developed in collaboration with physicians and defined in standardized procedures, promulgated by the hospital in accordance with Rule 5.9.

3. Supervision

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a. Nurse Practitioners shall be supervised by a physician who:

1) Is currently licensed by the State of California.

2) Is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting supervision or employment of a Physician Assistant.

3) Is a current member in good standing of the medical staff and practices actively at the hospital; and

4) Meets the requirements set forth in this Appendix 6G.

b. Before the Nurse Practitioner is permitted to perform services at the hospital, the supervising physician shall submit a signed, written request which describes the tasks and functions that the Nurse Practitioner would be performing. Those tasks and functions shall be consistent with the supervising physician's

specialty, with supervising physician's usual and customary practice, and with the patient's health and condition.

c. The supervising physician shall establish the following in writing, together with any necessary documentation:

1) That the supervising physician accepts full legal and ethical responsibility for the performance of all professional activities of the Nurse Practitioner.

2) Those specific duties and acts, including medical screening examinations, that the Nurse Practitioner would be permitted to perform outside of the supervising physician's immediate supervision and control.

3) That the supervising physician is covered by professional liability insurance with limits as determined by the governing board, for acts or omissions arising from supervision of the Nurse Practitioner (the supervising physician shall verify such coverage in a form acceptable to the Medical Staff Executive Committee); and

4) That the supervising physician is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting supervision or the employment of a Nurse Practitioner.

d. The supervising physician shall agree in writing in a form acceptable to the hospital that:

1) He or she shall notify the hospital and its Medical Staff immediately if he or she becomes subject to any disciplinary condition, or an action to impose a disciplinary condition, by the Medical Board of California; and

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2) He or she shall comply with all the Medical Board of California regulations regarding supervision of the Nurse Practitioners.

e. No supervising physician shall have a supervisory relationship with more than four Nurse Practitioners at any one time. (Notwithstanding the foregoing, an emergency physician may have a supervisory relationship with more than four emergency care Nurse Practitioners at any one time, provided that the emergency physician does not oversee the work of more than two such Nurse Practitioners while on duty at any one time.)

f. The supervision of the Nurse Practitioner by the supervising physician shall include all the following:

1) Availability of the supervising physician in person or by electronic communication when the Nurse Practitioner is caring for patients.

2) Establishment of written transport and back-up procedures for the immediate care of patients who need emergency care beyond the Nurse Practitioner's scope of practice for such times when the supervising physician is not on the premises.

3) Establishment of written guidelines for the adequate supervision of the Nurse Practitioner.

i) The minimum content for any such protocol governing diagnosis and management shall include the presence or absence of symptoms, signs and other data necessary to establish a diagnosis or assessment, any appropriate test or studies to order, drugs to recommend to the patient and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the supervising physician, adopted from, or referred to, texts or other sources. Protocols shall be signed and dated by the supervising physician and the Nurse Practitioner. The supervising physician shall review, countersign, and date a minimum sample of five percent of medical records of patients treated by the Nurse Practitioner functioning under these protocols within 30 days. The supervising physician shall select or review those cases which, by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient.

ii) Alternatively, the requirement of adequate supervision of the Nurse Practitioner may be satisfied by alternative mechanisms established by the Medical Board of California.

4) On-site supervision by the supervising physician of any surgery requiring anesthesia other than local anesthesia.

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Appendix 6F
OCCUPATIONAL THERAPISTS

1. Registration

Occupational Therapists shall meet all the following:

Occupational Therapists (OTs) shall be currently licensed as an Occupational Therapist by the California Board of Occupational Therapist and registered by the American Occupational Therapy Association.

2. Scope of Practice

Occupational Therapists may receive privileges to perform the following professional services at the hospital for the purpose of restoring functional capacity to patients, in accordance with the prescription of a medical staff member:

a. Provide the responsible medical staff member with an initial evaluation of the patient's level of function by diagnostic and prognostic testing.

b. Intervene in acute stages of illness or injury to minimize or prevent dysfunction.

c. Use professionally selected self-care skills, daily living tasks and tests, and therapeutic exercise to improve function.

d. Train patients in the performance of tasks modified to the patient's level of physical and emotional tolerance.

e. Provide preventive and protective equipment to promote function and to prevent deformity.

f. Re-evaluate the patient as changes occur and modify treatment goals consistent with those changes.

g. Provide psychological conditioning to prepare the patient for reentry and integration into the community.

h. Use tests to determine the patient's ability in the areas of concentration, attention, thought organization, perception and problem-solving; and

i. Provide prevocational evaluation using specific tasks to determine the patient's potential for vocational performance

Appendix 6G
PHYSICIAN ASSISTANTS

1. Requirements

Physician Assistants shall be currently licensed by the Physician Assistants Examining~~Exa mining~~ Committee of the Medical Board of California.

Physician Assistants who perform all services at the hospital shall be under the direction of a qualified supervising physician.

2. Scope of Practice

a. Physician Assistants may receive privileges to perform the following professional services at the hospital pursuant based on education training, experience and competency, under physician supervision as provided in the practice agreements. Services may include:

1) Take history, perform a physical examination, assess the patient, make a diagnosis, and record the pertinent data in a manner meaningful to the supervising physician.

2) Perform a medical screening examination.

3) Order, transmit an order for and perform or assist in performing laboratory screening and therapeutic procedures under supervising physician, provided that the procedures are consistent with the supervising physician's practice and with the patient's condition.

4) Order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy and nursing services.

5) Recognize and evaluate situations which call for the immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.

6) Administer or provide medication to patient or transmit orally or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication to the patient, subject to the following conditions:

i) Any prescription transmitted by the physician assistant shall be based either on a patient-specific order by the supervising physician or on written protocol approved by the supervising physician which specifies all criteria for the use of a specific drug or device and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued.

ii) Any drug order issued by a Physician Assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in supervising physician's practice.

iii) All Physician Assistants who are to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration.

iv) In compliance with State and Federal prescribing law the PA may order and furnish those drugs and devices, including schedule II through V controlled substances.

7) Instruct and counsel patients regarding matters pertaining to their physical and mental health, such as medications, diets, social habits, family planning, normal growth and development, aging and understanding and managing their diseases.

8) Assist the supervising physician by arranging admissions, making appropriate entries in the patient's medical record, reviewing and revising treatment and therapy plans, ordering, transmitting orders for, performing, or assisting the performance of radiology services, therapeutic diets, physical therapy treatment, ordering occupational therapy treatment, ordering respiratory care services, acting as first or second assistant in surgery under the direct supervision of the supervising physician and providing continuing care to patients following discharge.

9) Facilitate the referral of patients to the appropriate health facilities, agencies and resources of the community; and

10) Perform, outside the personal presence of the supervising physician, surgical procedures which are customarily performed under local anesthesia, which the supervising physician has determined the Physician Assistant has training to perform, and for which the Physician Assistant has privileges to perform.

11) Act as a first or second assistant in surgery under the supervision of the supervising physician.

b. Physician Assistants shall not:

1) Perform any task or function that requires the skill, training, or experience of a physician, dentist or dental hygienist.

2) Determine eye refractions or fit glasses or contact lenses; or

3) Prescribe or use any optical device for eye exercises, visual training or orthoptics (this does not, however, preclude administering routine visual screening tests.)

3. Supervision

a. Physician Assistants shall be supervised by a physician who:

1) I~~s~~t ~~is~~ currently licensed by the State of California.

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2) Is<u>t is</u> not subject to a disciplinary condition imposed by the Medical Board of California prohibiting supervision or employment of a Physician Assistant.

3) Is a current member in good standing of the medical staff and practices actively at the hospital; and

4) Meets the requirements set forth in this Appendix 6G.

b. Before the Physician Assistant is permitted to perform services at the hospital, the supervising physician shall submit a signed, written request which describes the tasks and functions that the Physician Assistant would be performing. Those tasks and functions shall be consistent with the supervising physician's specialty, with supervising physician's usual and customary practice, and with the patient's health and condition.

c. The supervising physician shall establish the following in writing, together with any necessary documentation:

1) That the supervising physician accepts full legal and ethical responsibility for the performance of all professional activities of the Physician Assistant.

2) Those specific duties and acts, including medical screening examinations, that the Physician Assistant would be permitted to perform outside of the supervising physician's immediate supervision and control.

3) That the supervising physician is covered by professional liability insurance with limits as determined by the governing board, for acts or omissions arising from supervision of the Physician Assistant (the supervising physician shall verify such coverage in a form acceptable to the Medical Staff Executive Committee); and

4) That the supervising physician is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting supervision or the employment of a Physician Assistant.

d. The supervising physician shall agree in writing in a form acceptable to the hospital that:

1) He or she shall notify the hospital and its Medical Staff immediately if he or she becomes subject to any disciplinary condition, or an action to impose a disciplinary condition, by the Medical Board of California; and

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2) He or she shall comply with all the Medical Board of California regulations regarding supervision of the Physician Assistant.

e. No supervising physician shall have a supervisory relationship with more than four Physician Assistants at any one time. (Notwithstanding the foregoing, an emergency physician may have a supervisory relationship with more than four emergency care Physician Assistants at any one time, provided that the emergency physician does not oversee the work of more than two such Physician Assistants while on duty at any one time.)

f. The supervision of the Physician Assistant by the supervising physician shall include all the following:

1) Availability of the supervising physician in person or by electronic communication when the Physician Assistant is caring for patients.

2) Establishment of written transport and back-up procedures for the immediate care of patients who need emergency care beyond the Physician Assistant's scope of practice for such times when the supervising physician is not on the premises.

3) Establishment of written guidelines for the adequate supervision of the Physician Assistant.

i) The minimum content for any such protocol governing diagnosis and management shall include the presence or absence of symptoms, signs and other data necessary to establish a diagnosis or assessment, any appropriate test or studies to order, drugs to recommend to the patient and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the supervising physician, adopted from, or referred to, texts or other sources. Protocols shall be signed and dated by the supervising physician and the Physician Assistant. The supervising physician shall review, countersign, and date a minimum sample of five percent of medical records of patients treated by the Physician Assistant functioning under these protocols within 30 days. The supervising physician shall select or review those cases which, by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient.

ii) Alternatively, the requirement of adequate supervision of the Physician Assistant may be satisfied by alternative mechanisms established by the Medical Board of California.

4) On-site supervision by the supervising physician of any surgery requiring anesthesia other than local anesthesia.

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Appendix 6H
REGISTERED VASCULAR TECHNOLOGIST

1. Licensure

An applicant for Registered Vascular Technologist privileges must have a current certificate from the American Registry of Diagnostic Medical Sonographers.

2. Scope of Practice

a. A qualified applicant may be granted privileges to perform the following noninvasive diagnostic vascular tests:

1) Cerebrovascular tests including carotid artery color-flow duplex ultrasonography, vertebrobasilar arterial color-flow duplex ultrasonography, intracranial vascular color-flow duplex ultrasonography, and temporal artery color-flow duplex ultrasonography.

2) Extremity arterial studies including arterial air plethysmography with segmental pressures (upper and/or lower extremities), arterial color-flow duplex ultrasonography, unilateral or bilateral, upper and/or lower extremities, with or without arterial bypass graft(s) or dialysis access shunt:

3) Pelvic and abdominal vascular studies including color-flow duplex ultrasonography of visceral vessels, with or without bypass graft, color-flow duplex ultrasonography of pelvic vessels, with or without bypass graft, testicular/penile color-flow duplex ultrasonography.

4) Venous examinations including color-flow venous duplex ultrasonography (upper and/or lower extremities), photoplethysmography determined venous recovery time:

5) Impotence examinations including penile arterial pneumoplethysmography with penile/brachial systolic pressure index, penile arterial and/or venous color-flow duplex ultrasonography.

Appendix 6l
REGISTERED NURSE FIRST ASSISTANTS

1. Qualifications

An applicant for Registered Nurse First Assistant privileges shall:

a. Be currently licensed as a Registered Nurse in California; and

b. Either:

1) Be currently certified as a "Registered Nurse First Assistant" by the National Certification Board: Perioperative Nursing; or

2) Be a graduate of a Registered Nurse First Assistant program accredited by the National Certification Board: Perioperative Nursing, who is obtaining the necessary clinical experience before taking the certification examination of the National Certification Board: Perioperative Nursing to become a "Registered Nurse First Assistant or

3) Demonstrate sufficient training and experience to ensure the ability to act as a Registered Nurse First Assistant at a level that will ensure that patients receive care of the proper quality.

2. Scope of Practice

a. Registered Nurse First Assistants may receive privileges to perform the following professional services at the hospital under the direct supervision of a physician on the medical staff:

1) Perform the following preoperative services:

i) Conduct patient interviews.

ii) Perform patient assessments.

iii) Perform patient teaching.

iv) Obtain patient histories; and

v) Perform physical examinations.

2) Perform the following intraoperative services:

i) Assist with positioning, preparing and draping the patient.

ii) Provide retraction for adequate exposure.

iii) Use surgical instruments.

iv) Perform dissection.

v) Apply pressure.

vi) Suction the wound area.

vii) Pack sponges or laparotomy pads into body cavities to hold tissues or organs out of the operating field.

viii) Grasp or fixate tissue with screws, staples or other devices.

ix) Suture tissue.

x) Perform knot tying.

xi) Provide hemostasis by clamping bleeding vessels, suturing or tying clamped vessels or cauterizing vessels.

xii) Cauterize tissues.

xiii) Apply Bovie power to instrumentation held by the surgeon when the surgeon is unable to do so.

xiv) Inject medications.

xv) Provide closure of the surgical wound by suturing fascia, subcuticular tissue and skin; and

xvi) Affix and stabilize drains, clean the wound and apply the dressing, and assist in applying casts.

3) Perform the following postoperative services:

i) Remove dressings, sutures, skin staples, drains, chest tubes, and casts.

ii) Perform postoperative assessments.

iii) Perform postoperative teaching; and

iv) Conduct discharge planning.

4) Perform other functions according to standardized procedures adopted by the hospital.

b. Registered Nurse First Assistants shall not function concurrently as a Scrub Nurse or a Circulating Nurse.

Appendix 6J
RESPIRATORY CARE PRACTITIONERS

1. Certification

a. Respiratory Care Practitioners shall hold a current license issued by the Respiratory Care Examining Committee of the Medical Board of California.

b. As used herein, the term "Respiratory Care Practitioner" also includes respiratory therapists and inhalation therapists.

2. Scope of Practice

a. Respiratory Care Practitioners may receive privileges to perform the following professional services at the hospital:

1) Pursuant to a medical staff member's order:

i) Administer medical gases (exclusive of general anesthesia), aerosols, environmental control systems and pharmacological agents related to respiratory care procedures.

ii) Use mechanical or physiological ventilatory support, bronchopulmonary hygiene and cardiopulmonary resuscitation.

iii) Maintain natural airways.

iv) Insert and maintain artificial airways without cutting tissues.

v) Apply diagnostic and testing techniques required for implementation of respiratory care protocols.

vi) Collect blood specimens.

vii) Collect respiratory tract specimens; and

viii) Analyze blood gases and respiratory secretions.

2) Observe patients, make determinations and act, as follows:

i) Observe and monitor signs, symptoms, general behavior and general physical responses to respiratory care treatment or to diagnostic testing.

ii) Determine whether such signs, symptoms and physical responses are abnormal; and

iii) In response to observed abnormalities, report the abnormalities, refer the patient, implement respiratory care protocols, change the treatment regime (pursuant to a prescription of a physician) or initiate emergency procedures, as appropriate.

3) Transcribe and implement written and verbal orders of a physician pertaining to the practice of respiratory care.

b. Respiratory Care Practitioners shall not administer general anesthesia.

Appendix 6K
SPEECH PATHOLOGISTS

1. Licensure

Speech Pathologists shall be currently licensed by the Speech-Language Pathology and Audiology Board.

2. Scope of Practice

a. Speech Pathologists may receive privileges to perform the following professional services at the hospital for the purposes of identifying, preventing, managing, habilitating, rehabilitating, ameliorating or modifying disorders of speech, voice or language:

1) Measure and test as follow:

i) With respect to speech related to articulation, fluency, mastication or swallowing, measure and test the development of patients' articulation, fluency, mastication or swallowing.

ii) With respect to voice involving vocal quality and vocal production, measure and test the development of patients' voice quality and voice production.

iii) With respect to language involving auditory processing, auditory memory, verbal language, written language, visual processing, visual memory, cognition and communication, and nonverbal/aural language, measure and test the development of patients' auditory processing, auditory memory, verbal language, visual processing, visual memory, cognition and communication and nonverbal/aural language.

2) Predict disorders.

3) Counsel patients.

4) Conduct binary pure tone screening for the purpose of determining if the screened individuals need further medical or audiological evaluation; and

5) Perform suctioning in connection with this scope of practice, after compliance with the hospital's training protocols on suctioning procedures.

6) Perform instrumental procedures with the use of rigid and flexible endoscopes to observe the pharyngeal and laryngeal areas of the throat in order to observe, collect data, and measure the parameters of communication and swallowing assessment and therapy, except that the flexible endoscopic procedures may only be performed by a Speech Pathologist who has received, and has available on file, a written verification from an otolaryngologist that meets all legal requirements and the procedure is directly authorized by a certified otolaryngologist and supervised by a physician and surgeon; and

7) Plan, direct, conduct, and supervise programs for identification, evaluation, habilitation, and rehabilitation of the disorders of speech or language described in subparagraph 2.a.l.), above.

b. Speech Pathologists shall not:

1) Perform invasive procedures.

2) Conduct physical examinations; or

3) Prescribe medications.

Appendix 6L
SURGICAL ASSISTANTS

1. Qualifications

a. Surgical Assistants shall hold a certificate from a training program or be able to demonstrate technical training and competence acquired elsewhere, such as in the military service or in previous employment.

b. The term "Surgical Assistant" as used in these standards also includes Operating Room Technicians and Surgical Technicians.

2. Scope of Practice

Surgical Assistants may receive privileges to perform the following professional services at the hospital:

a. Under the direct supervision of medical staff member:

1) Assist in patient transfer from gurney to table.

2) Prepare the operating room for surgery and maintain sterile field and aseptic environment during and after surgery.

3) Scrub for operative procedures and provide the surgeon with instruments necessary for the procedure.

4) Apply pressure.

5) Suction the wound area.

6) Cut sutures.

7) Provide retraction for adequate exposure by hand or with instrumentation.

8) Clamp tissues for non-hemostatic purposes.

9) Apply Bovie power to instrumentation held by the surgeon when the surgeon is unable to do so.

10) Keep track of needles, sponges and other instruments during surgery; and

11) Place skin staples and tie skin sutures.

b. Wrap and sterilize instruments.

c. Monitor electrical and other safety hazards in the operating room; and

d. Assist in cleaning up the operating room following surgery.

Appendix 6M
SURGICAL NURSES

1. Conditions for Granting Practice Privileges to Surgical Nurses

An applicant for Surgical Nurse privileges must have a current, unrestricted California license as either a Registered Nurse or a Licensed Vocational Nurse.

2. Practice Privileges

A qualified applicant may be granted privileges to assist a medical staff member during surgery by performing the functions normally assumed by surgical nurses. Such functions include, but are not limited to, shaving and preparing the patient, arranging instruments and equipment in preparation for surgery, passing instruments during surgery, starting or discontinuing intravenous fluids, monitoring equipment used during surgery and bandaging patients after surgery.

3. Supervision

A nurse granted practice privileges as a Surgical Nurse may not function autonomously and must always act under the direct supervision of a medical staff member when providing direct patient care services.

Appendix 6N
LICENSED MARRIAGE AND FAMILY THERAPISTS

1. Licensure

Licensed Marriage and Family Therapists shall be currently licensed by the California Board of Behavioral Sciences.

3. Scope of Practice

a. Licensed Marriage and Family Therapists may receive privileges to perform the following professional services at the hospital (but only within the context of marital and/or family relationships, including interpersonal and premarital relationships) pursuant to a Medical Staff member's order:

1) Administer and interpret psychological tests.

2) Explain and interpret psychosexual and psychosocial aspects of relationships.

3) Apply psychotherapeutic techniques to assess premarital, couple, family and child relationships to diagnose and treat problems, and to promote healthy functioning; and

4) Counsel patients regarding alcoholism and other chemical substance dependency

Appendix 6O
DIETITIANS

1. Licensure and Certification

An applicant for Dietitian privileges shall:

(a) Hold a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose and has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional or,

(b) meet the requirements if recognized as a "Registered Dietitian" by the Commission on Dietetic Registration.

2. Scope of Practice

Upon referral by a health care provider, a Dietitian is authorized to prescribe dietary treatments, provide nutritional and dietary counseling, conduct nutritional and dietary assessments, develop and recommend nutritional and dietary treatments, including therapeutic diets.

RULE 7 OTHER STAFF RULES

7.1 General Rules

(a) This hospital provides medical care and services to patients presenting to the facility, without discrimination based on race, color, national origin, creed or the ability to pay for such services. Patients with conditions and/or diseases or those needing diagnostic studies not provided in this facility will be referred to appropriate facilities providing such care or diagnostics.

(b) A patient may be admitted to the hospital only by a member of the medical staff. All physicians shall be governed by the official Admitting Policy of the hospital.

(c) A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring physician and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

(d) Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis is given. In case of an emergency such a statement shall be recorded as soon as reasonably possible.

(e) A patient to be admitted on an emergency basis will be cared for by the Hospitalist. ~~who does not have a private physician will be cared for by the contract physician.~~

~~(f) Each member of the staff who does not reside in the immediate vicinity shall name a member of the medical staff who is a resident in the area who may be called to attend to his patients in an emergency, or until he arrives. In case of failure to name such an associate, the Chief Executive Officer or Chief Medical Officer shall have the authority to call any member of the active staff.~~

~~(g)~~(f) To assure continuity of care in patient transfers, the attending practitioner shall be responsible for providing pertinent medical, diagnostic, treatment and identification information. See transfer requirements under emergency services.

~~(h)~~(g) The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and harm to others.

~~(i)~~(h) For protection of the patients, the medical and nursing staff, and the hospital, precautions to be taken in care of the potentially suicidal patient include:

(1) Any patient known or suspected of being suicidal in intent shall be referred, if possible, to other institutions where suitable facilities are available.

(2) When transfer is not possible, the patient may be admitted to a general area of the hospital, as a temporary measure; special observation is desirable.

(i) The attending practitioner shall abide by the hospital's Utilization Review plan, as approved by the Medical Staff, Chief Executive Officer, Governing Body, and CDPH. The patient's medical record must be sufficiently documented to show reasons for continued hospitalization, for review by the Utilization Review Coordinator, or Physician Advisor of the Utilization Review Committee. Documentation must also include plans for post-hospital care.

(j) Patients shall be discharged only on the written order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record. Discharge instructions and/or follow-up care should still be provided as able.

(k) It shall be the responsibility of the attending physician, if possible, to discharge his or her patients by 1400 hours on the day of discharge. It is preferable that the attending physician make the patient aware of his impending discharge the day prior, so that the patient can arrange transportation for the day of discharge.

(l) In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee, within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the medical staff. Policies with respect to the release of the dead body shall conform to local law.

(m) It shall be the duty of all staff members to secure meaningful autopsies whenever indicated due to uncertainty as to the cause of death or for the purposes of counseling family members.

(n) All facility deaths must be assessed for suitability of anatomical gifts. The hospital is required by law to notify our designated donor organization of any death under the age of seventy (70) years which occurs in this facility. The Charge Nurse generally assumes responsibility. See Policy/Procedure of Anatomical Gifts and the hospital's Nursing Policy manual.

(o) This facility has policies and procedures in place to inform and allow patients to formulate advance directives concerning health care decisions. It is expected that physicians will abide by legally formulated directives made by their patients. If the attending physician is ethically unable to do so, the patient should be so notified and referred to another medical practitioner as indicated.

7.2 Medical Records Requirements

(a) The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. The contents shall be pertinent and current.

(b) A complete admission history and physical examination shall be recorded within 24 hours of admission or immediately before in accordance with hospital policy and procedures by a Doctor of Medicine or osteopathy, or, for patients admitted only for oral maxillofacial surgery, by an oral maxillofacial surgeon, who has been granted such privileges by the Medical Staff. This requirement may be satisfied by a complete history and physical that has been performed within the 30 days prior to admission (the results of which are documented in the patient's medical record) so long as an examination for any changes in the patient's condition is completed and documented in the patient's medical record within 24 hours after admission. (See History & Physical Guidelines for details of required elements for Inpatient Services)

(c) This record shall include identification data; chief complaint; personal history; family history; history of present illness; should include pertinent findings resulting from an assessment of all the systems of the body; physical examination; special reports such as consultations; clinical laboratory and radiology services and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings, progress notes.

(d) When the history and physical examination are not recorded at the time of observation or potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending practitioner states in writing that such delay would be detrimental to the patient. In any event, a written entry in the record regarding the patient's history, a pertinent physical examination, and plan of care shall be recorded prior to commencement of the surgical procedure. (See History & Physical Guidelines for details of required elements for Surgical Services)

(e) Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatments. Progress notes shall be written at least daily on critically ill patients and those where there is difficulty in diagnosis or management of the clinical problem.

(f) Operative reports should include a detailed account of the findings of the surgery, as well as the details of the surgical technique. Operative reports shall be written or dictated immediately upon completion of the surgery. Any practitioner with undictated operative reports on the day of operation shall be notified of the deficiency by the medical records office; if this continues to be a problem, the chief of medical staff shall be notified.

(g) Consultations shall show evidence of a review of the patient's record by the consultant. Pertinent findings on examination of the patient, the consultant's opinion as well as recommendations are to be recorded. This report shall be made part of the patient's record. A limited statement such as "I concur" does

not constitute an acceptable report of consultation. When operative procedures are involved the consultation note shall, except in an emergency, be verified on record and be recorded prior to the operation.

(h) The current obstetrical record shall include a pre-natal record. The pre-natal record may be a legible copy of the attending practitioner's office record transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

(i) All clinical entries in the patient's medical record shall be accurately dated/timed and authenticated. Authentication shall mean establishing authorship by written signature or identifiable initials.

(j) An official record of unapproved abbreviations is kept on file in the Medical Staff Rules. See attached appendix 8.0, "Do Not Use" listing.

(k) Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, using diagnoses, which include the relevant ~~are able to be coded by~~ ICD-10~~9~~ codes; symptoms may be acceptable in some circumstances. The final diagnosis shall be dated and signed by the practitioner responsible at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.

(l) A discharge summary shall be dictated within forty-eight (48) hours of discharge. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and result and shall admitting and final diagnosis; any operative procedures performed, present history, physician examination, pertinent findings of laboratory or other special studies, summary of events while in the hospital; plan for discharge including provisions for follow-up care, diet, medications and disposition; condition at discharge; and autopsy report when performed. All summaries shall be authenticated by the practitioner responsible.

(m) Written consent of the patient is required, as outlined in the Medical Records Policy/Procedure Manual, for the release of medical information to people not otherwise authorized to receive this information. Further restrictions on the release of information may exist with certain medical or mental health diagnosis (i.e. HIV, drug and alcohol abuse and mental health problems). The hospital Administration and/or the hospital attorney should be consulted if any problems arise regarding the release of medical information.

(n) Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with court order, subpoena or stature. All records are the property of the hospital and shall not otherwise be removed from campus without the permission of the Chief Executive Officer. In the event of readmission of the patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of medical records from the hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee of the medical staff.

(o) Free access to all medical records of all patients shall be afforded to the members of the medical staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Medical Executive Committee of the medical staff before the records can be studied. Subject to the discretion of the Chief Executive Officer, former members of the medical staff should be permitted free access to information from the medical records of their patients covering all periods during which they attended to such patients in the hospital.

(p) A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Executive Committee.

(q) A practitioner's routine orders, standing orders, and/or protocol for certain conditions, when applicable to a given patient, shall be written in detail on the order sheet of the patient's record, or a copy of the same attached, and shall be timed, dated and signed by the practitioner of the patient.

(r) The patient's medical record shall be complete at the time of discharge, including progress notes, final diagnosis, and dictated clinical resume. Where this is not possible, because final laboratory or other essential reports have not been received at the time of discharge, the chart will remain open and available for the physician to complete. Any deficiencies found in the chart will be noted for correction and the physician will be notified by the medical records staff. The patient's medical record will be available for completion in the medical records office for fourteen (14) days after discharge. Failure to timely complete the medical record shall result in an automatic suspension after a Notice is given as provided in the Medical Staff Rules. The Chief Executive Officer shall be notified of the deficiency, and he/she will give Notice to the staff member of the suspension, which shall remain in effect until the medical record is completed. The Chief Executive Officer may, depending upon circumstances, postpone the suspension for an additional period, not to exceed 30 days total.

(s) All radiology films taken in the x-ray department of this hospital will be interpreted and/or overread by the hospital radiologist. A report on the interpretation will be filed in the patient's medical record and a copy filed in the radiology file. The x-rays taken by the facility staff are considered hospital property and protected in the same manner as other medical records. Consultation between the attending physician and radiologist is encouraged.

7.3 GENERAL CONDUCT OF CARE

7.3-1 Consents:

(a) A general form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admitting officer should notify the attending physician whenever such consent has not been obtained, and it will be his or her responsibility to obtain the consent as soon as possible.

(b) See perioperative section for additional consent information regarding surgical procedures and pharmacy section for information on selected medications and restraints.

(c) An informed consent is to be obtained prior to blood transfusions.

7.3-2 Orders

(a) All orders for treatments shall be in writing. A verbal order shall be in writing if dictated to a duly authorized person functioning within his or her sphere of competence and signed by the attending practitioner (attending or prescribing practitioner is defined as the practitioner that issues the order). All orders dictated over the telephone shall be signed by the appropriately authorized person to whom dictated, with the name of the attending practitioner in his/her own name. The attending or prescribing practitioner shall time, date, and authenticate such orders within 48 hours, failure to do so shall be brought to the attention of the Medical Executive Committee for appropriate action.

A covering practitioner (covering practitioner is defined as the practitioner who has assumed the care of the patient in the absence of the attending or prescribing practitioner) may sign verbal orders of the prescribing physician

(b) The practitioner's orders must be written clearly, legibly, and completely. Orders, which are illegible or improperly written will not be carried out until clarified by the nurse with the physician and rewritten. The use of "renew", "repeat", and "continue" orders are acceptable if the meaning of the order is clear.

(c) All previous orders are canceled when the patient goes to surgery or changes levels of care (i.e. from outpatient to inpatient status or from acute to SNF or vice versa).

7.3-3 Reportable Conditions

(a) There are numerous diseases and conditions where the medical practitioners are responsible for reporting. The reporting regulation varies regarding the agency/format required. Policy/Procedures and required forms are on file in the hospital.

(b) Conditions include, but are not limited to the following:

(1) Abuse reporting: child, sexual, elder, spousal

(2) Infectious Disease: See list in Infection Control Manual

(3) Emergency conditions: animal bites, pesticide exposure, injuries by deadly weapons and/or assault.

(4) Violence against hospital personnel

(5) Pre-hospital exposure to infectious diseases

(6) Injury/Illness from a medical device/or vaccine

(7) Cancer and/or reportable neoplasms

(8) Lapse of consciousness

7.3-4 Pharmacy

(a) All drugs and medications administered to the patient shall be those listed but not limited to the latest edition of: United States Pharmacopeia, National Formulary, American Hospital Formulary Service, A.M.A. Drug Evaluations, or the P.D.R.; drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the "statement of Principles Involved in the Use of Investigational Drugs in Hospitals", and all regulations.

(b) If patients bring their own drugs to the hospital, these drugs shall not be administered, unless they can be identified, and written orders to administer these specific drugs are given by the responsible practitioner. If the drugs that the patient brought to the hospital are not to be used while he is hospitalized, they shall be packaged, sealed and stored in the central pharmacy and are to be returned to the patient at the time of discharge, if such action is approved by the responsible practitioner.

(c) The hospital maintains a pharmaceutical formulary regularly reviewed and approved by the medical staff. Additions and deletions to the formulary are approved by the medical staff through the P&T Committee. Physicians are expected to utilize formulary products whenever possible.

The hospital pharmacist is to be notified when a non-formulary item is needed, and the facility will make all attempts to obtain the product if no therapeutic equivalent is available.

(d) The medical staff has approved the use of substitution with generic equivalents. The prescriber does have the option to specify brand items for a particular order.

(e) The facility has an Automatic Stop order policy for medication orders which fail to specify the duration of therapy. Stop orders are outlined in the acute pharmacy manual of the facility. It is the responsibility of nursing to notify the physician of the same.

(f) The hospital does not have licensure for dispensing pharmaceuticals. Limited supplies of medication are available after hours for the patient's needing medication when local pharmacies are closed. The policy regarding dispensing is outlined in the hospital pharmacy manual. Schedule II medications may be administered but shall never be dispensed from the facility.

(g) Adverse drug reactions and medication errors shall be reported to the hospital pharmacist and/or nursing administration. All ADR's and medication errors are reviewed by the medical staff through the P&T Committee.

(h) Informed consent is required prior to administration of anti-psychotic medication unless an emergency condition exists. In skilled nursing patients this includes all psychotropic medications as well as restraints.

7.3-5 Consults

(a) Except in emergencies, consultation is required in the following situations:

(1) In all primary cesarean sections (in an emergency a telephone consultation may be obtained and recorded).

(2) When the patient is not at a good risk for operation or treatment.

(3) Where the diagnosis is obscured after ordinary diagnostic procedures have been completed.

(4) Where there is doubt as to the choice of therapeutic measures to be utilized.

(5) In unusually complicated situations where specific skills of other practitioners may be needed.

(6) In instances in which the patient exhibits severe psychiatric symptoms.

(7) When requested by the patient or his family.

a) The attending practitioner is primarily responsible for requesting consultation when indicated and for calling a qualified consultant. Any qualified practitioner with clinical privileges in this facility can be called for consultation within his area of experience and competency. She/he will provide written authorization to permit another attending practitioner to attend or examine the patient, except in an emergency.

b) If a nurse has any reason to doubt or question the care provided to any patient or believes that the appropriate consultation is needed and has not been obtained, she/he shall call this to the attention of the Director of Nurses. If warranted, the Director of Nurses may bring the diagnosis to the attention of the Chief Medical Officer. Where circumstances are such as justifying such an action, the Chief Medical Officer may himself or herself request a consultation.

c) Any telephone consultation shall be recorded as a progress note in the patient's medical record by the attending practitioner as to the nature of the consultation and with whom the telephone consultation was held. An attempt will be made to obtain written consultation whenever possible.

7.3-6 Perioperative Services

(a) Except in severe emergencies, the preoperative diagnosis and required laboratory or other diagnostic reports must be recorded in the patient's medical record prior to any surgical procedure. If not recorded, the procedure may be canceled. In an emergency, the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of the procedure.

A current or recent history and physical examination shall be on the chart prior to the time scheduled for an operation unless the attending surgeon states in writing that a delay would constitute a hazard to the patient. A history and physical completed more than 24 hours prior to the surgery shall require an update to the interval period and a revaluation of the patient's physical status.

Any practitioner operating on a patient, other than the admitting practitioner, shall write a consultation note which must be included with the operative report.

(b) In scheduling an operative case, the surgeon shall inform the scheduling nurse of the type of operation to be performed, the type of anesthesia to be used, and the anesthetist who will be administering it.

(1) Emergency procedures will have priority.

(2) Whenever possible, diabetics shall be scheduled as the first case in the morning in elective surgical cases to facilitate control of blood sugar, insulin dosage, etc.

(c) The operative permit must be signed by one or both patients' parents before the procedure, if the patient is a minor. An operative permit must be signed by the patient before any procedure or operation, unless extenuating circumstances are present, i.e., the patient is unable to write, injury or loss of function of the writing hand, psychiatric cases, etc. In such cases, the permit must be signed by the patient's conservator or health care designee. If not present, authorization may be obtained by telephone, heard by the attending physician and the witness. Extenuating circumstances are governed by state law, and the hospital attorney should be consulted, if in doubt.

(d) The operative permit shall designate the name(s) of operating surgeon, the admitting physician, the operative procedure, and the type of anesthetic contemplated. The most recently revised hospital form is to be used.

(e) Prior to the patient signing the surgical consent, the surgeon shall inform the patient of the nature and reason for the procedure, any alternative treatment available, as well as the possible outcome and adverse results that may occur due to the procedure to be performed. This shall be documented in the patient's record.

(f) Additional information and/or consents are required for selected procedures done in this facility. Procedures include but are not limited to sterilization, breast surgery, and hysterectomy.

(g) The anesthetist shall be present, in sufficient time before the operation, to have the patient anesthetized by the time the attending surgeon has scheduled the case. No anesthetic shall be administered by someone other than a physician or certified registered nurse anesthetist. A complete anesthesia record shall be filled out and shall include an evaluation and post anesthesia follow-up of the patient's condition.

(h) The surgeon and surgery staff are responsible for seeing that all tissue and foreign objects removed in surgery are handled in accordance with Surgery Policy. The hospital pathologist shall make examinations as he may consider necessary to arrive at a tissue diagnosis, and his original, authenticated report shall be made part of the patient's medical record.

(i) The hospital's operating room manual delineates operative cases which require an assistant. The surgeon is responsible for obtaining an assistant who is qualified and has hospital privileges for such procedures. The surgeon is responsible for notifying the surgery supervisor who the assistant will be. The assistant is required to stay in the operating room suite until the peritoneum is closed.

(j) A patient admitted for dental care is a dual responsibility involving the dentist and physician member of the medical staff.

(1) Dentist's responsibilities:

(i) A detailed history justifying hospital admission.

(ii) A detailed description of the examination of the oral cavity and a preoperative diagnosis.

(iii) A complete operative report, describing the findings and technique. In cases of extraction of the teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to the hospital's pathologist for examination.

(iv) Progress notes that are pertinent to the oral condition.

(v) Clinical resume (discharge summary)

(2) Physician's responsibility:

(i) A medical history pertinent to the patient's general health.

(ii) A physical examination to determine the patient's condition prior to anesthesia and surgery.

(iii) Supervision of the patient's general health status while hospitalized.

(3) The discharge of the patient shall be on the written order of the dentist, a member of the medical staff.

7.3-7 Emergency Services

(a) Staffing and Responsibility

(1) The Chief Medical Officer shall have overall responsibility for emergency medical care.

(2) The duties and responsibilities of all personnel serving within the emergency area shall be defined in a procedure relating specifically to this service. The contents of such a manual shall be developed by a committee of the medical staff, including representatives from the nursing service and the Chief Executive Officer or designee.

(b) Clinical Record

(1) An appropriate medical record shall be kept for every patient receiving emergency services and being incorporated in the patient's hospital record. The record shall include:

(i) Adequate patient information.

(ii) Information concerning the time of the patient's arrival, means of arrival, and by whom transported.

(iii) The pertinent history of the injury or illness include details related to first aid or emergency care given to the patient prior to his arrival at the hospital.

(iv) Description of significant clinical, laboratory, and roentgenologic findings.

(v) Diagnosis

(vi) Treatment given

(vii) Condition of the patient on discharge or transfer

(viii) Final disposition, including instructions given to the patient and/or his family, relative to necessary follow-up care.

(2) Each patient's emergency medical record shall be signed by the practitioner in attendance, who is responsible for its clinical accuracy.

(c) Medical Screening

(1) All patients who are presented to the hospital, and who request examination and treatment for an emergency medical condition or active labor, shall be evaluated for the existence of an emergency medical condition or, where applicable, active labor. This screening must not be delayed inquiring about the individual's method of payment or insurance status.

(2) Medical screening examinations and emergency services shall be provided in compliance with all applicable provisions of state and federal law, and hospital policies and procedures respecting emergency medical services.

(3) If it is determined that a patient has a life threatening emergent medical condition, only a physician may provide further examination and treatment to stabilize the condition or make the determination to transfer the patient to another facility, unless otherwise determined by the physician and allowed under hospital policies.

(4) This facility has qualified physicians and other mid-level providers on staff authorized to complete the medical screen.

(d) Transfers

(1) Patients are transferred from this facility to another acute care hospital only on the order of the attending physician, only with the permission of the patient or the patient's legal representative and only after acceptance of the patient by the receiving hospital and receiving physician, only upon initiation of the attending physician.

(2) The risks of transfer and the risk of non-transfer must be explained to the patient and/or legal representative prior to receipt of written consent. These risks are to be documented on the transfer form.

(3) Pertinent medical information must be sent to the receiving facility to include but not to be limited to the following:

(i) Chief complaint and history of present illness.

(ii) Pertinent physical findings.

(iii) Results of diagnostic studies.

(iv) Medical indication for transfer.

(v) Consent from patient or legal representative.

(4) If the patient is not stabilized prior to transport, the physician must clarify that based on the patient's condition, the medical benefits

of the transfer of the patient to another medical facility outweighs the risks.

(5) EMTALA regulations define the obstetrical patient in labor as unstable until after delivery of the baby and placenta.

7.3-8 Disaster Plan

(a) There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the hospital's capabilities in conjunction with other emergency facilities in the community. It shall be developed by a committee which includes at least one member of the medical staff, the Director of Nursing Service, and a representative from hospital administration.

(b) The disaster plan should make provision within the hospital for:

(1) Availability of adequate basic utilities and supplies including gas, water, food, and supportive supplies.

(2) An efficient system of notifying and assigning personnel.

(3) Unified medical command under the direction of a designated physician, or designee.

(4) Conversion of all usable space into clearly defined areas for efficient triage, for patient observation, and for immediate care.

(5) Prompt transfer, when necessary, and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care.

(6) A special disaster medical record, such as an appropriately designed tag, that accompanies the patient as he is moved.

(7) Procedures for the prompt discharge or transfer of patients in the hospital who can be moved without jeopardy.

(8) Maintaining security to keep relatives and curious people out of the triage area.

(9) Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will help to provide organized dissemination of information.

(c) All physicians and other medical personnel shall be assigned to posts and it's their responsibility to report to their assigned stations. The Chief Medical Officer in the hospital and Chief Executive Officer of the hospital will work

as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the hospital to another, or evacuation from the premises, the Chief Medical Officer will authorize movement of patients. All policies concerning direct patient care will be a joint responsibility of the Chief Medical Officer and the Chief Executive Officer of the hospital. A written report and evaluation of all drills shall be made.

(d) The disaster plan should be rehearsed at least twice a year, preferably as a part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the medical staff, as well as administrative, nursing, and other hospital personnel. Actual evacuation of the patients is optional. A written report and evaluation of all drills shall be made.

(e) The Chief Medical Officer is empowered to give temporary privileges to physicians licensed in the state of California to practice medicine, when a true emergency exists, and the services of additional medical practitioners are needed. A copy of the physician's license is to be made if time permits, a call to the medical board to verify licensure is preferred.

7.3-9 Perinatal Services

(a) OB patients are admitted to the facility only on the order of the attending physician or associate. During the labor process, the attending physician is readily available to discuss concerns with nursing staff or to assess the patient's progress when requested.

(b) The attending physician must at least be readily available when labor induction or augmentation is initiated and/or in progress.

(c) The facility is required by law to assess the OB patient and newborn for signs of substance abuse and to document and follow-up on positive findings. Medical practitioners are also required to assess signs of domestic violence and to offer assistance/referral as indicated. Domestic violence is a reportable condition.

(d) Labor is defined by Federal Law (EMTALA) as including the "latent or early phase of labor and continuing throughout the delivery of the placenta". Labor is considered an emergency medical condition unless a physician certifies that after a reasonable period of observation that the woman is in false labor.

(e) The facility has policies regarding newborn care reviewed and approved by the medical staff and found in the hospital OB manual. Medical staff members caring for newborns are expected to abide by these policies. Policy includes but is not limited to the following:

(1) Newborn security and visitation

(2) Newborn identification

(3) Newborn screening program

(4) Oxygen administration

(5) Vitamin K and prophylactic ophthalmic administration

(6) Exposure to infectious gas

(7) Discharge/transfer and adoptions

7.3-10 Medical Staff Meetings

The chief of the medical staff shall call regular meetings of the staff. The members shall be notified of the time, place, and agenda in advance.

ATTACHMENT C

POLICY AND PROCEDURES

MODOC MEDICAL CENTER
A Public Entity
Healing Hands Close To Home
Last Frontier Healthcare District

MEMORANDUM

DATE: 2/19/2026
TO: Last Frontier Healthcare District Board of Directors
FROM: Policy Committee
SUBJECT: **Review of Departmental Policies and**

The following information regarding Departmental Policies is submitted for your review:

Review of Departmental Policies (see attached):

PHARMACY/HOSPITAL

7710.25 Counterfeit Drugs and DSCSA

DIETARY ACUTE

8345.26 Calibration of Foodservice Thermometers

SNF-ACTIVITIES

8365.25 Use of Alcohol by Resident or Visitor (5381)

FACILITIES/EOC

8460.26 Bio Hazardous Waste Transportation Maintenance
8460.26 Biomedical Equipment Management
8460.26 Hazardous Materials and Waste Management Plan
8460.26 Performance Improvement Plan
8460.26 Preventative Maintenance
8460.26 Removal of Bio Hazardous Waste
8460.26 Sprinkler Drop Test
8460.26 Use of Electric Wheelchair
8460.26 Use of Spill Kit

Review of Department Policies (see attached)

SNF-IC

8753-SNF.25 Tuberculosis Screening, Testing and Control at the Skilled Nursing Facility

To complete approval of the above-listed Policies, please sign and date where indicated on the attached Excell Spreadsheet.

Thank you for your time and attention to the above.

Respectfully submitted:

Sandra A. Brown
Administrative Assistant to CNO
1111 N. Nagle Street
Alturas, CA 96101
(530) 708-8808

Enc.

PHARMACY/HOSPITAL

REFERENCE #	7710.25	EFFECTIVE
SUBJECT:	7710.25 COUNTERFEIT DRUGS AND DSCSA	REVISED 11/2025
DEPARTMENT:	PHARMACY - HOSPITAL	

PURPOSE:

The purpose of this Policy is to ensure the safety of the pharmaceutical supply chain.

AUDIENCE:

Pharmacy Wide

TERMS AND DEFINITIONS:

- **DSCSA**: Drug Supply Chain Security Act
- **NDC**: National Drug Code
- **FDA**: Food and Drug Administration

- **Counterfeit drug:** A drug that is illegally manufactured and falsely represents a legitimate drug, often containing incorrect or harmful ingredients, or no active ingredient.
- **Illegitimate product:** A drug that has credible evidence showing it is counterfeit, diverted, stolen, intentionally adulterated, or is otherwise unfit for distribution.
- **Suspect product:** A drug for which there is reason to believe it is an illegitimate product.
- **Dispenser:** A pharmacy, hospital pharmacy, or other authorized person who dispenses prescription drugs.
- **Transaction Information (TI):** Documentation that includes the product's name, strength, dosage, NDC, container size, number of containers, lot number, and transaction dates.
- **Product Identifier (PI):** A standardized graphic and numeric identifier on a drug package that includes the NDC, serial number, lot number, and expiration date.

POLICY:

The following is the Policy of Modoc Medical Center with regard to procurement and receiving procedures

- **Authorized trading partners:** All prescription drugs must be purchased only from wholesale distributors or manufacturers licensed and verified by the California State Board of Pharmacy and the FDA.
- **Product documentation:** Upon receipt of any prescription drug, staff must verify that the shipment matches the information on the invoice. This information must be retained for at least six years.

- **Visual inspection:** The designated receiving staff must visually inspect all incoming products for signs of damage, tampering, or counterfeiting, including:
    - Unusual or suspicious packaging (e.g., poor quality printing, different fonts, foreign language)
    - Missing, covered, or altered expiration dates or lot numbers
    - Suspicious product identifiers or barcodes
    - Broken or tampered-with seals and security features
    - Changes in a medication's size, shape, color, or taste

Identification and quarantine of suspect products

- **Immediate quarantine:** Any product identified as "suspect" must be immediately removed from active stock, physically segregated in a secure, labeled area, and prevented from being dispensed.
- **Designated contact:** The hospital pharmacist is the designated staff member responsible for overseeing the quarantine process and subsequent investigation.
- **Documentation:** All observations and details regarding the suspect product will be documented, including:
    - Date the product was quarantined
    - Full product name, strength, and NDC
    - Lot number and expiration date
    - Description of the suspicious features or circumstances

Response and disposition of illegitimate products

- **Removal from supply chain:** Illegitimate products must be permanently removed from the pharmacy's inventory and the supply chain. This should be done in a manner that prevents them from being re-entered into commerce.
- **Destruction or return:** Follow the instructions received from the manufacturer, regulatory agencies, or reverse distributor for the proper disposition of the illegitimate drug. All disposals must be documented.

REFERENCES:

None

ATTACHMENTS:

None

DIETARY ACUTE

REFERENCE #	~~8345.25~~8345.26	EFFECTIVE: 2025~~1/2/2026~~
SUBJECT:	8345.2~~5~~65 CALIBRATION OF FOODSERVICE THERMOMETERS	REVISED 01/2026
DEPARTMENT:	DIETARY - ACUTE	

PURPOSE:

The purpose of this policy is to ensure that all foodservice thermometers provide accurate temperature readings ~~in order~~ to maintain food safety, prevent foodborne illness, and ~~comply with regulation~~meet regulatory requirements.

AUDIENCE:

All dietary department foodservice workers including cooks, dietary aides, & management.

TERMS/DEFINITION:

Calibration – The process of configuring an instrument to provide a result for a sample within an acceptable range.

POLICY:

It is the policy of Modoc Medical Center Acute Dietary Department to calibrate all foodservice thermometers used on a daily basis prior to meal service.

PROCEDURE:

The food service thermometers will be calibrated every morning prior to starting meal service for the day. Thermometers will be calibrated using the ice point method:

1. Fill a container with crushed ice.
2. Add cold water to create a slushy mixture
3. Insert the thermometer probe without touching sides or bottom.
4. Wait until the reading stabilizes.
5. Adjust to 32°F (0°C)
6. Remove from service if unable to adjust

REFERENCES:

FDA Food Code
CDC Food Safety Guidelines
Joint Commission Standards
CMS Conditions of participation

ATTACHMENTS:

None

SNF-ACTIVITIES

REFERENCE #	8365.25	EFFECTIVE 12/1989
SUBJECT:	8365.25 USE OF ALCOHOLIC BEVERAGES BY RESIDENT OR VISITOR	REVISED 12/2025
DEPARTMENT:	SKILLED NURSING FACILITIES	

PURPOSE

The purpose of this policy is to maintain a safe level of resident care and prevent any disorderly conduct and/or accidents resulting in hospital or staff liability.

AUDIENCE:

Department Wide

POLICY

It is the policy of Modoc Medical Center (MMC) and the Skilled Nursing Facilities (SNFs) that all visitors are prohibited from consuming alcoholic beverages on the facility premises at any time. Residents are permitted to consume alcoholic beverages only in accordance with written physician's order.

PROCEDURE

- Obtain a written order from the residents attending physician specifying the amount and frequency for the resident's alcoholic beverage consumption, e.g. one beer, three times daily with meals.
- If a resident is found to be non-compliant by the nursing staff, the attending physician will be notified immediately and requested to discontinue the alcoholic beverage order.
- Under no circumstances are visitors allowed to consume any alcohol at any MMC facility.
- If a visitor is found to be non-compliant by the nursing staff, they will be asked to leave the facility's premises immediately. If the visitor(s) refuse to leave the premises, the local law enforcement agency will be contacted for assistance.

REFERENCES

None

ATTACHEMNTS

None

FACILITIES/EOC

REFERENCE #	8460.268450.25	EFFECTIVE 3/1993
SUBJECT:	8450.25 BIO- HAZORDOUS WASTE TRANSPORTATION/ MAINTENAN8460.26CE25 BIO- HAZORDOUS WASTE TRANSPORTATION/ MAINTENANCE	REVISED 01/20262/2025
DEPARTMENT:	ENGINEERINGFACILITIES	

PURPOSE:
The purpose of this policy is to provide an effective and safe means of transporting Bio-hazardous Waste in accordance with OSHA guidelines.

AUDIENCE:
Facility Wide

TERMS/DEFINITION:
OSHANoneOccupational Health and Safety Administration.

POLICY:
It is the policy of Modoc Medical Center (MMC) to provide a safe means for Bio- Hazardous Waste Transportation as it pertains to maintenance and housekeeping personnel.

PROCEDURE:
CLINIC:

- The Bio-Hazardous Waste from the Clinic is placed in the Bio-Hazardous Waste Room in universally accepted labeled rigid containers with lids.
- The maintenance staff inspect the container for leakage/spillage prior to transporting. The waste is then transported via the maintenance vehicle to the hospital Bio-Hazardous Waste room.

HOSPITAL:

- The Bio-Hazardous Waste from the hospital is taken to the hospital Bio-Hazardous Room by the housekeeping department personnel and placed in the labeled rigid containers with lids.
- The maintenance staff inspects the containers for leakage /spillage prior to transporting to the medical waste freezer where it is held until transported to the medical waste treatment center.

TRANSPORTING TO THE MEDICAL WASTE FREEZER:

- The rigid containers are transported by maintenance staff via the maintenance vehicle to the medical waste freezer where it is held until transported to the medical waste treatment center.
- Elbow length protective rubber gloves are worn to remove the Bio- Hazardous Waste bags from the rigid containers to the medical waste freezer.
- The protective gloves and containers are then washed with a germicidal solution. The clean containers are then returned to the Bio-Hazardous Waste Room and stored separately from contaminated containers.

REFERENCES:
None

ATTACHMENTS:
None

REFERENCE #	8460.25	EFFECTIVE 10/2020
SUBJECT:	8460.25 BIOMEDICAL EQUIPMENT MANAGEMENT	REVISED 1/2026
DEPARTMENT:	FACILITIES	

PURPOSE:
The purpose of this policy is to ensure that all mechanical and electrical patient care equipment used at Modoc Medical Center (MMC) is carefully evaluated for safety, function, and properly maintained before it is put into use.

AUDIENCE:
Facility Wide

TERMS/DEFINITION:
NONE

POLICY:
It is the policy of MMC to evaluate all mechanical and electrical patient care equipment prior to use, based on function, physical risks associated with clinical use, maintenance requirements, and equipment incidents. All incoming and existing equipment meeting the evaluation criteria are included in the equipment management program. An inventory of equipment included in the program and equipment maintenance records documenting all maintenance on equipment is kept by the Engineering department.

PROCEDURE:
All biomedical equipment is evaluated on function, risk, maintenance requirements, and equipment. history. Each piece of equipment is assigned ~~as~~ an equipment management number.

Equipment function for a piece of equipment is categorized as follows:

- Therapeutic
- Diagnostic
- Analytical
- Miscellaneous

The physical risk associated with use of a piece of equipment is evaluated ~~on~~by the following criteria:

- Patient death
- Patient or operator injury
- Inappropriate therapy or misdiagnosis
- No significant risks

Maintenance requirements for the piece of equipment are categorized according to the following criteria:

- Extensive: includes equipment that requires routine alignment, calibration or extensive parts replacement.
- Above Average: includes equipment that needs only performance verification and safety training.

- Average: includes equipment that receives only a visual inspection, basic performance test, and safety testing is minimal.
- Below Average: includes equipment given preventative maintenance a minimum of once every six months.
- Minimal: includes equipment given preventative maintenance annually.

Equipment history and incidents involving injuries or deaths will be used to assist in evaluating equipment. All equipment not included in the equipment management program will undergo a preventative maintenance inspection annually. The Engineering department will maintain an inventory of all equipment included in the equipment management program. The inventory will include each piece of equipment's function value, risk value, maintenance value, equipment management number and preventative maintenance interval. All incoming equipment will be compared to an included device list. Equipment evaluation results shall be reviewed by the Safety Committee. Any changes to the Equipment Management Program must be coordinated and approved by the Safety Committee.

REFERENCES:

~~none~~None

ATTACHMENTS:

~~none~~None

REFERENCE #	8460.26	EFFECTIVE 3/2012
SUBJECT:	8460.26 HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN	REVISED 01/2026
DEPARTMENT:	FACILITIES	

PURPOSE:
The purpose of this policy is to ~~describe the methods~~outline the procedures for handling hazardous materials and waste at Modoc Medical Center (MMC) through effective risk assessment and management ~~for Modoc Medical Center (MMC)~~strategies.

AUDIENCE:
Facility Wide

TERMS/DEFINITION:
None.

POLICY:
It is the policy of Modoc Medical Center (MMC) to safely handle hazardous materials and waste to ~~minimizing~~ minimize the risk of harm.

FUNDAMENTALS:

The scope of the hazardous materials and waste management program is determined by the materials in use and the waste generated by the hospital.

Hazardous materials, waste, and their associated hazards—defined as required by law, regulation, Material Safety Data Sheets (MSDS), guidelines, good-practice recommendations, or similar documents—are identified within the organization's inventory. ~~The hazardous materials and waste and the associated hazards defined as required by law or regulation in Material Safety Data Sheets (MSDS), guidelines, good-practice recommendations, or similar available documents are identified in the organization's inventory.~~

To ensure protection from hazards, all staff who use or are exposed to hazardous materials and waste must be educated about the nature of these hazards and trained to utilize the provided equipment for safe handling and use when working with or near such materials. ~~Protection from hazards requires all staff that use or are exposed to hazardous materials and waste to be educated as to the nature of the hazards and to use equipment provided for safe use and handling when working with or around hazardous materials and waste.~~

Rapid, effective response is required in the event of a spill, release, or exposure to a hazardous material or waste.

ORGANIZATION & RESPONSIBILITY:

The Chief Executive Officer (CEO) receives regular reports of the activities of the HazMat Program from the Environment of Care Committee (EOC Committee) which is responsible for Physical Environment issues.

The CEO, or other designated leader, collaborates with the Safety Officer to establish operating~~,~~ and capital budgets for the HazMat Program.

The Safety Officer, in collaboration with the committee, is responsible for monitoring all aspects of the HazMat Program. The Safety Officer advises the EOC Committee regarding HazMat issues which may necessitate changes to policies and procedures, orientation or education, or expenditure of funds.

Individual staff members are responsible for learning and following job and task-specific procedures for HazMat operations. Department heads are responsible for orienting new staff members to the department and, as appropriate, to job and task specific HazMat procedures. They are also responsible for the investigation of incidents occurring in their departments. When necessary, the Safety Officer provides department heads with assistance in developing departmental HazMat programs or policies.

OBJECTIVES:

The Objectives for the Hazmat Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance measures, Infection Control/Environmental Services reports and environmental tours. The Objectives for this Plan are as follows:

- Create a comprehensive list of all chemicals ~~on~~ in the facility.
- Ensure proper labeling of all hazardous materials containers to insure proper precautions for use and spill response.
- Assess the effectiveness of the MSDS access process and ensure the availability of MSDS to the departments.

PERFORMANCE ACTIVITIES:

The performance measurement process is a key component in evaluating the effectiveness of the HazMat program. Specific performance measures have been established to assess at least one critical aspect of the program. ~~The performance measurement process is one part of the evaluation of the effectiveness of the HazMat program. Performance measures have been established to measure at least one important aspects of the HazMat program.~~

The performance measure for the HazMat program is:

- 95% staff knowledge on how to obtain an MSDS

HAZMAT PROCESSES:

Hazardous Materials and Waste Inventory

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MMC maintains an inventory of hazardous materials and waste, including biological, radiological, chemotherapeutic, and chemicals. Department heads are responsible for maintaining the inventories of hazardous materials and waste used, stored, or generated for each of their respective departments and forwarding this inventory as well as any updates to the Director of Purchasing. The Director of Purchasing manages the inventories received from each department and evaluates for completeness with assistance from the appropriate staff, including the Safety Officer.

Information about the hazards and emergency responses related to these materials and wastes is always accessible to staff, patients, and visitors through resources such as Material Safety Data Sheets (MSDS), Centers for Disease Control (CDC) guidelines, and Nuclear Regulatory Commission (NRC) regulations. This information can be retrieved via various methods, including the Internet, fax, or online servers. Additionally, to ensure constant availability, a hard copy of the MSDS for each material is identified in the inventory maintained by the owning department. ~~Information identifying the hazards and emergency responses associated with these materials and wastes are available to staff, patients, and visitor at all times from such resources as Material Safety Data Sheets (MSDS) sheets, Centers for Disease Control (CDC) Guidelines, and Nuclear Regulatory Commission (NRC) regulations. Various methods for retrieving the information are available from the Internet, fax, and/or online servers. To ensure availability at all times, a hard copy of the MSDS associated with the material is identified on the inventory in the owning Department.~~

Spills and Exposures

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The Purchasing Director is responsible for developing and maintaining emergency procedures for the Hazardous Materials and Waste program. In the event of a spill, the Material Safety Data Sheet (MSDS) for the specific material must be promptly retrieved, and the appropriate procedures must be followed. ~~The Purchasing Director develops and maintains emergency procedures for the Hazardous Materials and Waste program. In the case of a spill, the Material Safety Data Sheet for that material shall be quickly obtained and proper procedure followed.~~

Staff, including housekeeping personnel, are trained to identify spills that are unsafe to manage and are instructed to promptly notify their manager or the Safety Officer. Staff are advised to prioritize safety, avoiding the handling of chemical spills beyond their level of training or the available personal protective equipment. Extreme caution should be exercised to prevent self-contamination. Hands must always be washed thoroughly before and after any contact. ~~Staff, including housekeeping staff, is trained to recognize the potential for a spill that is not safe to handle, and to contact their manager, and/or the Safety Officer. Staff is cautioned to err on the side of safety, and not to handle chemical spills that exceed their training, or the personal protection they have available. Use extreme care to prevent contamination to self. Always wash hands before and after contact.~~

If you discover a hazardous chemical spill, you should:

- Take measures to isolate the area to keep individuals away from the spill
- Contact your supervisor or manager and describe the spill to him or her
- Help locate information about the chemical using safety data sheets

Your supervisor or manager will assess the situation using Modoc Medical Center's criteria and decide whether emergency responders are needed. Your manager may ask you to contact your organization's operator and identify the location of the spill and ask for the initiation of a code orange, indicating a hazardous chemical spill.

If your department is not the site of the hazardous spill but you hear the initiation of a code orange, you should:

- Report to your supervisor or manager for instructions about securing your work area to prevent unauthorized access to areas with hazardous conditions
- Prepare to assist with evacuations as needed
- Keep hallways clear to allow emergency responders access throughout the organization
- Ensure that all ~~I~~incidents involving spill kits~~,~~ or ~~a response from any outside agency~~responses from external agencies are documented on Incident Report Forms.

Minor Spills

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A minor (incidental) spill refers to a situation that can be safely addressed by the staff involved, using their training and personal protective equipment. Such spills typically impact a small area and require only a limited number of staff to temporarily vacate the area until the cleanup is complete.~~A minor (incidental) spill is one that can be cleaned up by the staff involved, with their training and personal protective equipment. A relatively small area is affected and only a relatively small number of staff may need to leave the area until the spill is cleaned up.~~

Follow the ~~P~~procedure below for minor spills:

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- Put absorbent supplies from the spill kit on the spill if the material is in liquid form (and if this can be done safely)

- Call in staff from Plant Operations and Environmental Services
- Take appropriate action to remove the hazard
- Clean up the area
- Do not use respiratory protective equipment unless you are trained in its safe use
- Departmental staff will be oriented and inserviced in the use of the spill kit, evacuating the area and alerting Emergency Response staff
- Additional information or assistance on minor spill cleanup may be obtained from the Safety Officer

A spill that exceeds the capability of the immediate staff to neutralize and clean up requires a response from outside the facility. In these cases, the area may be evacuated, ventilation controlled, and the Regional HAZMAT Team is called. The Regional HAZMAT Team takes control of the site and cleans up or arranges for it to be cleaned up. Once determined safe, hospital staff finish the cleanup and recovery.

Major Spill

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A major spill has occurred under the following conditions:

- A life-threatening condition exists, or the condition requires the assistance of Emergency Response staff
- The condition requires the immediate evacuation of all employees from the area or the building
- The spill involves quantities greater than two (2) liters
- The contents of the spilled material ~~is~~are unknown
- The spilled material is highly toxic, biohazardous, radioactive or flammable
- You feel physical symptoms of exposure

Follow the ~~P~~procedure below for major spills:

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- Do not inhale, if possible, and quickly determine what was spilled
- Evacuate the staff in the area and close all doors

- Notify people in the immediate area, department supervisor and Safety Officer. Report name of spilled chemical (if known), amount spilled, and location. If flammable, state that the material is flammable
- Stand by the area of spill to direct Emergency Response staff. If any special hazard exists, i.e., flammability, corrosiveness, toxic fumes, notify emergency staff
- Re-enter area only after spill has been eliminated

Hazardous Chemical Risks Formatted: Underline

MMC has established and maintains processes for identifying, selecting, handling, storing, transporting, using, and disposing of hazardous chemical materials and waste from receipt or generation through use and/or final disposal. The department leadership assures their safe selection, storage, handling, use, and disposal. The department is responsible for evaluating MSDS for hazards before purchase of departmental supplies to assure they are appropriate and the least hazardous alternative practical for the purpose. The department managers work with the Safety Officer and appropriate individuals, such as the Infection Control Preventionist, to develop procedures for handling of hazardous materials. The following procedures are observed:

- Chemical materials are identified and ordered by department leadership. Appropriate storage space is maintained by each department and reviewed as part of environmental tours in that area. Chemical materials are maintained in labeled containers, and staff ~~is~~are trained in understanding MSDS, and in the appropriate and safe handling of the chemicals they use.
- Chemical waste is held in the generating department~~,~~ until the arrival of the licensed contractor. The contractor lab packs the chemicals, completes the manifest and removes the packaged waste. A disposal copy of the manifest is returned to verify legal disposal of the waste.

Radioactive Risks Formatted: Underline

MMC does not offer radiological therapy services; however, it has established policies and procedures to address patients who may require radiological precautions (e.g., implanted isotopes) after receiving therapy at external facilities. Consequently, MMC does not currently address the selection and use of such materials, as they are not applicable to its operations. Department leadership ensures the safe storage, handling, and disposal of these materials.~~MMC does not provide radiological therapy services but does maintain policies and procedures for the sake of addressing patients who may present after having received radiological therapy at an external location which would require the use of radiological precautions (i.e. implanted isotopes). As such MMC does not specifically address selection and use at this time as they are not appropriate to our facilities. The department leadership assures their safe storage, handling, and disposal.~~

- Radioactive waste is held in an appropriate storage facility until decayed to background, then handled as the underlying hazard of the materials for disposal. The Director of Plant Operations manages the waste and determines when it is no longer considered a radioactive hazard.

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Hazardous Energy Sources

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Hazardous energies are generated by various equipment, including ionizing devices such as X-rays and CT scanners, as well as non-ionizing devices like surgical lasers. Currently, MMC does not utilize non-ionizing equipment beyond computer-related devices, which pose no significant risk except in cases of extreme tampering; therefore, their use is not specifically addressed. The management of hazardous energies is handled as follows:~~Hazardous energies are produced by, but not limited to, both ionizing equipment such as X-Rays and C.T.s and non-ionizing equipment like surgical lasers. MMC does not currently have any non-ionizing equipment aside from computer related equipment which poses no risk except in incidences of extreme tampering and as such use is not addressed. The proceeding is addressed through:~~

- Equipment Selection: Hazardous energy source equipment is selected in accordance with the capital equipment acquisition policy outlined in the Medical Equipment Management Plan.~~selection is addressed through the capital equipment acquisition policy in accordance with the Medical Equipment Management Plan.~~

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- Equipment Use: The use of hazardous energy source equipment is addressed through regular maintenance under the Medical Equipment Management Plan, security measures detailed in the Security Management Plan (ensuring such equipment is located in secure areas), and department-specific policies and procedures regarding safety.~~Hazardous energy source equipment use is addressed through maintenance in accordance with the Medical Equipment Management Plan, security through the Security Management Plan as the only hazardous energy equipment on the grounds is located in areas identified as secure areas, and finally through department specific policy and procedure with regard to safety.~~

Hazardous Medication Risks

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MMC has implemented processes to minimize risks related to the disposal of hazardous medications. While MMC does not offer chemotherapy services, it has established policies and procedures to address the needs of patients who may require precautions after receiving chemotherapy at external facilities. Therefore, the selection and use of chemotherapeutic medications are not specifically addressed, as they are not applicable to MMC's operations.~~MMC has established and maintains processes for minimizing risks associated with disposal of all hazardous medications. MMC does not provide chemotherapy services but does maintain policies and procedures for the sake of addressing patients who may be present after having received chemotherapy at an external location which would require the use of precautions.~~

~~As such MMC does not specifically address selection and use of chemotherapeutic medications at this time as they are not appropriate to our facilities.~~

Hazardous Gas and Vapor Risks

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Department heads~~,~~ (with assistance from the Director of Plant Operations) are responsible for developing processes which minimize the risk associated with selecting, handling, storing, transporting, using, and disposing of hazardous gases and vapors in their respective areas. Hazardous gas and vapor producing chemicals and procedures have been mostly eliminated from the workflow of MMC. The only remaining vapors are generated in surgery, but they are negligible due to the room's high-efficiency exhaust system, which prevents any accumulation. Therefore, monitoring is not conducted.~~The only vapors otherwise generated are done so in surgery in no appreciable amount as the room is heavily exhausted, not allowing any buildup. As such monitoring is not conducted.~~

Permits, Licenses, Manifests and MSDS

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MMC has obtained and maintains permits and licenses for handling and disposal of hazardous ~~wastes~~waste from the designated federal, state, and municipal agencies, ~~and~~as well as material safety data sheets for the chemical waste and hazardous medications waste. Each load of hazardous waste removed from the facility is documented by a manifest, as mandated by federal or state agencies. The manifests have multiple copies, and a copy is left at the time the hazardous waste is removed. Another copy travels with the waste and is returned to the hospital once the ~~wastes have~~waste has been legally disposed of, to document the completion of the activity. These copies are matched~~,~~ to ~~assure~~ ensure that no load has been lost or misplaced, and are kept for the record.

Refer to MSDS, EPA, federal, state and local regulations for clean-up and disposal guidelines of individual hazardous materials and waste.

REFERENCES:

1. Medical Consultants Network Inc. MCN. (2005). www.mcnhealthcare.com

ATTACHMENTS:

None.

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REFERENCE #	8460.26	EFFECTIVE 3/2015
SUBJECT:	8460.26 PERFORMANCE IMPROVEMENT PLAN	REVISED 1/2026
DEPARTMENT:	FACILITIES	

PURPOSE:

In keeping with the facility's mission, Engineering Services in a systematic, collaborative, and continuous approach will endeavor and deliver optimal service in an environment of minimal risk.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
None

POLICY:

There is a planned, continuous ongoing systematic process to monitor and evaluate the quality of the services provided in the ~~D~~department.

When problems and opportunities to improve services are identified, action is taken, and the effectiveness of that action is evaluated.

~~When opportunities to improve services are identified, action is taken, and the effectiveness of that action is evaluated.~~

The primary goal of the Engineering Services Performance Improvement Plan is to improve performance within the department to positively impact patient care. To facilitate this goal, emphasis is placed upon" dimensions of performance" including:

- Efficacy
- Appropriateness
- Availability
- Timeliness
- Effectiveness
- Continuity
- Safety
- Efficiency

- Respect and caring

PROCEDURE:
Scope of Activities:

The Performance Improvement Committee will work together with the Director of Engineering Services to create, implement, and evaluate the program within the department. As part of the facility's Performance Improvement Plan, overall responsibility for monitoring and evaluating Engineering Services is assigned to the Director of the Department and the Performance Improvement Committee.

The Engineering Services Department provides and is responsible for a verity of services including the following:

- Repair of equipment and utility system.
- Plant and grounds maintenance.
- Review of equipment and utility failures, incidence reports, user errors and component failures.
- Equipment evaluation.
- Management of the Preventive Maintenance Program.
- Utility and ~~E~~equipment ~~U~~use and ~~S~~safety ~~E~~education and ~~T~~training ~~P~~programs.
- Review of health alerts and medical device recalls.
- State and Federal regulations compliance.
- Construction and planning.
- Life Safety.

Methodology:

A quality strategy will be established for each of the major functions listed above. This is accomplished by identifying the key components of the function, the expected ~~outcomes~~outcomes, and the specific performance standards.

The internal and external customers and their needs will be identified. Customers include anyone who receives Engineering-related services directly or indirectly.

Incorporate Performance Improvement (PI~~I~~) principles into training programs.

By developing a spirit of ownership staff members should develop responsibility for their positions and a commitment to quality and the facility.

Teamwork will be promoted within the department and facility wide.

Input from the staff members on how they can improve Engineering Services will be encouraged.

A complaint tracking system will be developed and maintained to track all types of complaints from staff and other customers.

Traditional monitoring and evaluation of activities along with quality audits will be conducted.

Improvement teams that focus on specific problems will have the responsibility of investigating all aspects of a process and recommending the best quality action plan. The team shall then implement the action plan and monitor the result to look for continual ways to improve the processes.

Develop and Measure Performance Indicators:

Example Indicators:

- Preventative ~~M~~maintenance ~~P~~procedures current within thirty days.
- Documented need for equipment monitoring.
- Employees educated ~~on~~ on the need to comply with lock out ~~procedure~~procedures.
- Work order response initiated within 48 hours.
- 24-hour turnaround time on repairs.
- Interpersonal communication skills.
- Damage to equipment due to negligence.

- Timely submission of statistics.
- Customer/~~S~~staff satisfaction surveys.
- Occurrence of overtime.
- ~~Utilities~~Utilities of user errors.
- Equipment unscheduled down time/failure
- Employee awareness of departmental equipment and utilities operations. Equipment not available for PM repair.
- Phantom problems (non-reproduced complaints). Equipment back (recall) within one month.

Set Benchmarks and Thresholds:

As data is collected over a period of time, the Engineering Services Department will establish levels or benchmark points that will trigger review. The ~~D~~department is always striving for an opportunity for improvement in these services.

Collect Data:

The Engineering ~~S~~service ~~S~~staff will collect data for each aspect of care. The data is collected on an ongoing basis. The data is collected to prevent any potential problems. The data sources include the following:

- Statistical data.
- Worksheets and ~~W~~workorders.
- Meeting ~~M~~minutes.
- Direct ~~O~~observation.
- Patient/~~S~~staff ~~C~~complaints and/or ~~S~~surveys.

Data shall be reviewed quarterly by the Department and the Performance Improvement Committee. The Engineering Services employees will review the findings to determine whether a problem or

opportunity for improvement in the service exists. This evaluation may include analysis of patterns or trends in providing services that relate to specific shifts, staff, skills, and/or structure.

Take Actions to Improve Services:

If evaluation identifies a problem or opportunity for improvement, the staff evaluates and determines the appropriate action and forwards that recommendation to the individual or group with the authority to act. Some possible actions include the following:

- System problems: Change in communication channels, changes in organizational structure, adjustments in ~~staffing~~staffing, and changes in equipment or chart forms.
- Knowledge problems: ~~Inservice~~In-service education, continuing education, and circulating informational material.
- Behavior problems: Informal, or formal counseling, changes in assignment, and disciplinary action.

Assess the Effectiveness of the Action and Document Improvement:

The monitoring and evaluation do not end when actions are taken. Not only do the Engineering Services staff continue to monitor the performance indicators for future opportunities for improvement, but the staff will also determine whether the actions taken are successful in improving the service. The results of continued monitoring and evaluation provide the information to make that determination.

If services do not improve within the expected time, the staff will reexamine the performance indicator and take further action. This follow-up is essential to the monitoring and evaluation process.

Communicate Relevant Information to the Organization Wide Performance Improvement Program:

To "close the loop" of the monitoring and evaluation process the following information is reported to the ~~organization~~organization's wide Performance Improvement Committee.

- Findings/cConclusions
- Recommendations.
- Actions.
- Results of actions taken.

The Engineering Service Performance Improvement Plan will be assessed for its effectiveness and consistency with the Facility's Plan. The assessment is conducted by the Department and the Performance Improvement Committee and forwarded to the Governing Body.

REFERENCES:

None

ATTACHMENTS:

None

Engineering Services Performance Indicators

Engineering Services Performance Indicators	Benchmark/ Threshold	JAN	FEB	MAR	APR	MAY	JUN	JLY	AUG	SEP	OCT	NOV	DEC	AVG
Plant Operations & Clinical Engineering:														
# of PMs Scheduled														
% PMs Completed on Time														
# of Equipment Incidents Reported														
# of User Errors Identified														
# Equipment Incidents with Adverse Outcomes														
# Utility Failures or Interrupts														
# of Medical Device Incidents														
% of Customer Satisfaction AVG <4														
# of Equipment Not Available for PM OR Repair														
LIFE SAFETY:														
Number of Fire Drills Conducted														
# of Staff Able to Demonstrate Knowledge of Their Responsibilities During Drill														
Percent Fully Operational Fire Doors														
Percent Circuit Tests Completed														
AVG Staffing														
AVG Daily Census														

Engineering Services Customer Satisfaction Survey

Work order # _____ was completed for your area on ___/___/___. This work order consisted of : _____, and was ordered by: _____, Dept. _____, cost center # _____.
In order to evaluate our services and where we might improve we would appreciate your feedback.

Rating: Strongly Agree = 5, Agree = 4, Slightly Agree = 3, Disagree = 2, Strongly Disagree = 1, Does Not Apply = N/A

1. Your equipment problems were solved effectively.	
2. The service was performed promptly.	
3. If applicable, we contacted you to schedule service at a convenient time.	
4. You were kept adequately informed as to delays in services (e.g. parts on order, manpower shortages, etc.)	
5. The work was performed in a professional/courteous manner.	
6. After the work was completed, the work area was free of debris and clutter.	
7. Work did not interfere with the safe operation of your department.	
8. In general, the work was conducted in a safe manner.	
9. The work was completed within your time expectations.	
10. We provided a reasonable and cost-effective solution to your work request.	
11. We appropriately appraised you of the cost of work where applicable.	

Comments: (Please comment on any rating <4)

_____

_____

_____

Other Comments That May Help Us Improve the Quality of Our Service.

Thank You for Your Assistance in Helping Us Provide the Quality Service We Are Striving For. Please Return This Form to The Director of Engineering.

To be completed by Engineering Department:

Average rating (average of all questions not answered by N/A) _____

Department Director contacted regarding the attached? Yes__ No__

Processed by: _____ Date: _____

REFERENCE #	8460.26	EFFECTIVE 3/2015
SUBJECT:	8460.26 PREVENTATIVE MAINTENANCE	REVISED 01/2026
DEPARTMENT:	FACILITIES	

PURPOSE:
The purpose of this policy is to ensure that Modoc Medical Center(MMC) maintains a well-organized and effective Preventative Maintenance (PM) Program for its equipment.

AUDIENCE:
Facility Wide

TERMS/DEFINITION:
None

POLICY:
It is the policy of ~~Modoc Medical Center~~MMC ~~is~~ to maintain a comprehensive ~~Preventative Maintenance~~PM Program which includes a written testing and maintenance program for all equipment included in the program at established intervals of ~~A~~annually, ~~S~~semi-~~A~~annually, and ~~Q~~quarterly. It is the responsibility of the Director of Engineering to keep the ~~Preventative Maintenance~~PM Program accurate and ongoing.
Documentation of the ~~Preventative Maintenance~~PM Program is in the Engineering Office.
Equipment included in the program shall meet one or more of the following criteria:

- ~~The equipment is e~~Essential for life support.
- ~~The equipment h~~Has a higher-than-normal incident risk during routine operation.
- ~~The equipment~~ Requires a more intensive maintenance schedule, because of its complexity.
- ~~The equipment~~ Is ~~is~~ supplied or maintained by an outside vendor.

PROCEDURE:

- At the beginning of each week, the Director of Engineering or his/her designee issues the scheduled maintenance work orders to the ~~Chief Engineer or the Chief Biomedical Engineer~~Engineer personnel.
- Maintenance is performed in accordance with the instructions included in the work order. The assigned ~~engineer~~staff ~~shall~~will document the maintenance, including any pertinent observations, on the work order. When maintenance and documentation is completed ~~the engineer~~, the staff will returns the work order to the Engineering Department/~~Service~~ office.
- If scheduled maintenance cannot be performed (i.e., parts not available), the reason is documented on the work order and returned to the Engineering Department/~~Service~~ office. The work order is placed under "outstanding jobs", which will later be compiled as part of ~~30 or 60 day~~30- or 60-day report.

- If equipment must be removed from the user area for more than one day, the engineer shall prepare a corrective maintenance order. One copy will be given to the department from which the equipment was removed.
- If scheduled maintenance is to be performed by an external vendor, the Engineering Department~~/Service~~ contacts the vendor and instructs the vendor to pick up the equipment, perform the maintenance as detailed in the work order, document the maintenance and any associated work done on the work order, and return the equipment within 30 days.
- Annually, the Engineering Department~~/Service~~ will distribute a report to each department director regarding work done for that cost center.

REFERENCES:

None

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ATTACHMENTS:

None

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~~**ATTACHMENTS:**~~

REFERENCE #	8460.26	EFFECTIVE 07/1987
SUBJECT:	8460.26 REMOVAL OF BIO-HAZAR4DOUS WASTE/SHARPS	REVISED 01/2026
DEPARTMENT:	FACILITIES	

PURPOSE:
The purpose of this policy is to properly remove bio-hazardous waste/sharps from facility departments.

AUDIENCE:
Facility Wide

TERMS/DEFINITION:
None

POLICY:
It is the policy of Modoc Medical Center (MMC) to maintain the proper removal of bio-hazardous waste/sharps from facility departments.

PROCEDURE:

Lab

- Equipment needed
    a. Rigid, puncture resistant, covered container.
    b. Bio-Hazardous bag, if needed.
    c. Rigid, puncture resistant covered bucket, if needed
- Housekeeping personnel will wear gloves while handling any Bio-Hazardous waste.
- All Bio-Hazardous materials are to be placed in the rigid puncture resistant container unless otherwise specified. If the Red Bio-Hazardous bags are used, tie off and place inside a rigid puncture resistant container.
- Assure that the cover is secure on the container before removing the container to the Bio-Hazardous waste room.
- Transport all the containers carefully to the bio-Hazardous waste room. If using a rigid bucket, carry by the handle.
- Place the covered container in the container provided for bio-Hazardous waste material. If using a rigid bucket, uncover the container, remove the Red Bio-Hazardous bag and place immediately in the container provided for Bio-Hazardous waste material. Maintenance transports the Bio-Hazardous waste to the waste freezer where it is to be held until transported to Medical Waste Treatment Center.

- Obtain a replacement container and ~~replace~~replace it in the appropriate area and if ~~used~~used, return the rigid bucket to the lab.

Emergency Room/Clinic

- Equipment needed

  a. Rigid, puncture resistant, covered

  b. Container Bio-Hazardous waste bag

- Housekeeping personnel will wear gloves while handling any bio-hazardous waste.
- Tie off the bio-hazardous plastic bag.
- Transport the bag to the hazardous waste room and place the bio-hazardous plastic bag in the container provided for bio-hazardous materials. Maintenance transports the bio-hazardous waste to the bio-hazardous waste freezer ~~where~~where it is held until transported to the medical waste treatment center.
- Reline the bag stand with a bio-hazardous bag.

INFECTIOUS/GLASS WASTE

- Equipment needed:

  a. Rigid, puncture resistant, covered container is to be constructed to house all contents and prevent leakage of contents.

  b. Bio-hazardous plastic liner.

- Procedure for bio-hazardous waste procedure.

DISPOSABLE SHARPS CONTAINER

- Housekeeping personnel shall wear gloves while handling any bio-hazardous waste.
- Secure the cover on the container.
- The container is taken to the bio-hazardous waste room, where it is then taken to the bio-hazardous waste freezer by maintenance.
- Obtain a replacement container and ~~place~~place it in the appropriate area.

REFERENCE #	8460.26	EFFECTIVE 07/1987
SUBJECT:	8460.26 REMOVAL OF BIO-HAZAR4DOUS WASTE/SHARPS	REVISED 01/2026
DEPARTMENT:	FACILITIES	

REFERENCES:
None

ATTACHMENTS:
None

REFERENCE #	8460.26	EFFECTIVE 3/2015
SUBJECT:	8460.26 SPRINKLER DROP TEST	REVISED 01/2026
DEPARTMENT:	FACILITIES	

PURPOSE:
The purpose of this policy is to ensure the proper functioning and reliability of the sprinkler system and associated alarms at Modoc Medical Center.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
None.

POLICY:
It is the policy of Modoc Medical Center (MMC) to check the sprinkler alarms audible signal as well as to flush the sprinkling system out. This test will be performed quarterly.

PROCEDURE:

- Notify alarm company of test.
- Open inspectors test valve.
- Note length of time required to activate alarm.

When drop test is complete, test_____ switch, close OSY valve. Check with alarm company to verify that alarm was transmitted.

REFERENCES:
None

ATTACHMENTS:
None

REFERENCE #	8460.25	EFFECTIVE
SUBJECT:	8460.25 USE OF ELECTRIC WHEELCHAIRS	REVISED
DEPARTMENT:	FACILITIES	

PURPOSE:
The purpose of this policy is to ensure the safe and appropriate use of electric wheelchairs within the facility.

AUDIENCE:
Facility Wide

TERMS/DEFINITION:
None

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POLICY:
It is the policy of Modoc Medical Center (MMC) to ensure that electric wheelchairs are used by those who truly need them, reducing the risk of accidents, preserving the safety of residents and staff, and managing resources responsibly.

PROCEDURE:
Electric wheelchairs are a valuable mobility aid for individuals with significant physical impairments, particularly those who are paralyzed or unable to move independently. However, the use of electric wheelchairs by residents who are not medically required to use them can present several safety risks for both the user and others in the facility.

We would like to clarify the guidelines regarding electric wheelchair use and emphasize the following points:

Medical Necessity

Electric wheelchairs are intended primarily for individuals who are paralyzed or have severe mobility limitations that prevent them from using a manual wheelchair effectively or safely. For residents who retain sufficient upper body strength and mobility, manual wheelchairs are often the safer and more appropriate choice. Using a manual wheelchair encourages physical activity and helps maintain muscle strength, which is important for overall health and well-being.

Safety of Fellow Residents

One of the main concerns with the use of electric wheelchairs by individuals who do not have a medical need for them is the potential risk to other residents. Electric wheelchairs are larger, faster, and harder to control than manual chairs, especially in busy or crowded areas. In our facility, there are narrow hallways, common areas, and dining rooms that are shared spaces. The use of electric wheelchairs in these areas can inadvertently cause accidents, such as collisions with other residents or objects, potentially leading to falls or injuries.

Safety of Staff Members

REFERENCE #	8460.25	EFFECTIVE
SUBJECT:	8460.25 USE OF ELECTRIC WHEELCHAIRS	REVISED
DEPARTMENT:	FACILITIES	

The safety of our staff members is equally important. Electric wheelchairs can be difficult to maneuver, and staff members must assist residents in various tasks, such as transportation to activities, meals, or medical appointments. When electric wheelchairs are used unnecessarily, the risk of injury to both residents and staff increases. Additionally, staff must ensure that proper training is provided on how to handle different types of mobility aids to ensure everyone's safety.

Limited Availability of Electric Wheelchairs

To ensure that residents who truly need electric wheelchairs have access to them, we must manage their availability carefully. If electric wheelchairs are used by individuals who do not require them, this may limit access for those who have more significant mobility needs.

Mobility

We encourage residents who can use manual wheelchairs to do so, as this promotes independence and mobility while minimizing safety risks.

Moving Forward

We respectfully ask that all residents, families, and guardians understand that the use of electric wheelchairs in our facility is restricted to those who are medically required to use them, such as individuals who are paralyzed or have similar conditions. For others, manual wheelchairs or other mobility aids will be the recommended option, unless otherwise advised by a healthcare Doctor.

We are committed to providing the best care possible in a safe and supportive environment. If you have any questions or concerns about this policy, please feel free to contact the Facilities Director.director.~~r.~~

REFERENCES:

"Power struggles: Many problems and some solutions related to ... - CALTCM." https://www.caltcm.org/index.php?option=com_content&view=article&id=79:power-struggles--many-problems-and-some-solutions-related-to-power-wheelchairs-in-ltc&Itemid=111.

ATTACHMENTS:

Power struggles: Many problems and some solutions related to power wheelchairs in LTC

REFERENCE #	8460.25	EFFECTIVE
SUBJECT:	8460.25 USE OF ELECTRIC WHEELCHAIRS	REVISED
DEPARTMENT:	FACILITIES	

~~REFERENCES:~~

~~"POWER STRUGGLES: MANY PROBLEMS AND SOME SOLUTIONS RELATED TO ... - CALTCM." HTTPS://WWW.CALTCM.ORG/INDEX.PHP?OPTION=COM_CONTENT&VIEW=ARTICLE&ID=79:POWER-STRUGGLES--MANY-PROBLEMS-AND-SOME-SOLUTIONS-RELATED-TO-POWER-WHEELCHAIRS-IN-LTC&ITEMID=111.~~

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~~ATTACHMENTS:~~

~~POWER STRUGGLES: MANY PROBLEMS AND SOME SOLUTIONS RELATED TO POWER WHEEL~~

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REFERENCE #	8460.25	EFFECTIVE
SUBJECT:	8460.25 USE OF ELECTRIC WHEELCHAIRS	REVISED
DEPARTMENT:	FACILITIES	

by Rebecca Ferrini, MD

Power wheelchairs are increasingly being requested and used by long term care facility residents. Residents often enter the facility with a power chair or scooter and hope to continue to use this vehicle while in the facility These chairs offer increased mobility and autonomy, but bring potential problems of fires, accidents, storage, repairs, and elopements, posing risk to the user, the other ~~residents~~residents, and the ~~facility as a whole~~facility. Some facilities choose to prohibit power chairs, but for residents with extremely limited mobility and intact cognition (such as a young quadriplegic) this practice severely impairs quality of life and functional status. Others have 1. implemented mandatory safety checks, 2. individualized driving assessments, 3. patient agreements and 4. other policies to promote safety. One way to manage the chairs is to assure that residents and staff understand that the storage and use of the chair in the facility is a privilege, not a right, and that this privilege will be revoked if there are significant safety risks. Requiring a physician order (obtained only after the mechanical safety check and the driving assessment) is one way to assure safe operation. Driving assessments can be done with observation (skilled therapy or registered nurses can conduct this) and/or with a computerized wheelchair simulation program (~~e.g.~~e.g., wheels…) and should be repeated periodically and with any adverse wheelchair event. Problems can arise with power wheelchairs—such as use of the chair to leave the facility and purchase contraband for oneself or others, getting "stuck" in the community and needing help getting back, broken chairs, operating chairs too fast for conditions and how to "take away ~~"a~~"a chair from a resident with advancing dementia. Educating staff about their responsibilities to promote safety is important—for instance, staff should not place residents with delirium, sedation or intoxication in the chairs and should assure that those who operate t a motor vehicle while taking sedating medications are monitored and counseled on the risks. The facility can exert "control" over the situation through establishment of rules for operation and storage and enforcing them. We have developed a toolkit to help facilities think about the use of power chairs and better manage the risk associated with these chairs. This tool kit includes:

- A resident agreement about the use of the power chairs
- A sample policy on power wheelchairs
- A safety check for power wheelchairs
- A quick list of problems and solutions related to power wheelchair operation.
- OPTIONAL—borrowed power wheelchair agreement and policy if the facility chooses to "loan out" chairs that have been donated

This information was presented at the California Association of Long Term Care Medicine annual meeting as a poster called "Power struggles, many problems and some solutions related to the use of power wheelchairs in LTC"

Further questions can be directed to rebecca.ferrini@sdcounty.ca.gov

Additional resources:

Good things about Power Chairs

- They let people go faster and get to places than they otherwise could not.
- Can really enhance the quality of life of those with disabilities.

- Promote autonomy by correct positioning allowing ~~self-feeding~~self-feeding, for example.
- Can save staff time in transport, feeding, mobility

Bad things about power wheelchairs

- They let people go faster and get to places than they otherwise could not.
- Consume staff resources in checking, charging, fixing, ~~loading~~loading, and unloading, cleaning
- People pile stuff in the back of them or store things near them that can be hazardous
- Big liability possibility--staff damages it, people use it unsafely, batteries catch fire, elopement,
- Many staff have no idea how to do something mechanical.
- They break down and need fixing
- post-manufacturing modifications carry risk of liability
- they are the lifeline of a resident, but easily broken
- The batteries ~~have to~~must be charged--that risks fires
- They are bulky and need storage
- Everyone wants one
- Once people have them, they feel entitled to them
- It is hard to tell exactly when they can no longer operate them safely--there is a gray area of danger to the person and those around them.
- Cannot evacuate with electric wheelchair if fire department has water hose on the floor electric wheelchair will not go over them, also cause obstruction for evacuation.

Facility role and responsibilities

1. Require MD order and take it seriously
2. Establish mechanism for initial and ONGOING safety check to reduce risk of fires.
3. Require functional assessment with computer program and observation (initial and ongoing)
4. Require wheelchair agreement
5. Limit use in your facility
6. Promote staff accountability: don't put someone in the chair who is sick, confused,...

How much control the facility can exert have depends on who owns the chair and how much help the resident needs to get into and use it.

Facility owns chair, resident needs help –HIGH DEGREE OF FACILITY CONTROL

Resident owns chair, requires at least some staff assistance –MODERATE DEGREE OF FACILITY CONTROL

Facility owns chair, resident does not need any staff help to transfer–MODERATE DEGREE OF FACILITY CONTROL

Resident owns chair, can transfer himself into it, needs no help at all—LITTLE, BUT SOME FACILITY CONTROL (storage, in-facility operation)

REFERENCE #	8460.26	EFFECTIVE
SUBJECT:	8460.26 USE OF SPILL KITS	
DEPARTMENT:	FACILITIES	REVISED 01/2026

PURPOSE:
The purpose of this policy is to outline the procedures for handling liquid spills around the hospital environment to ensure safety, minimize environmental impact, and comply with regulatory standards. Spill kits are essential tools for managing liquid spills, including oils, chemicals, and hazardous substances.

AUDIENCE:
All Staff

TERMS/DEFINITION:
None.

POLICY:
It is the policy of Modoc Medical Center (MMC) to provide comprehensive guidelines for managing liquid spills.

PROCEDURE:
Spill Kit Components

Each spill kit should include the following components:

- **Absorbents**
  - **Pads:** For placing directly on spills to absorb liquids quickly.
  - **Socks:** To encircle spills and contain liquids, preventing further spread. Ensure ends overlap to create a leak-proof barrier.
  - **Pillows:** To absorb larger volumes of liquid when placed on top of spills.
  - **Loose Granules:** For sprinkling over spills, especially useful on rough or uneven surfaces.
- **Personal Protective Equipment (PPE)**
  - **Goggles:** To protect eyes from splashing hazardous liquids.
  - **Gloves:** Nitrile gloves to protect hands from hazardous materials.
  - **Coveralls and Respiratory Protection:** As needed based on the type of spill.
- **Containment Tools**
  - **Booms:** Larger absorbents used to contain and manage spills.
  - **Barriers:** To create physical barriers around spills.
- **Sealing and Disposal Materials**

- **Waste Bags:** For sealing and disposing of contaminated materials.
- **Ties and Labels:** For securing and identifying waste.

- **Instruction Sheets and Guides**
  - **Instructions:** Easy-to-follow guides on effective and safe use of the spill kit.
- **Optional Add-ons**
  - **Dikes:** To create barriers that prevent spills from spreading.
  - **Drain Covers and Floor Drain Plugs:** To prevent spills from entering drainage systems.
  - **Berms:** To catch spills from leaking equipment.

Spill Response Procedure

1. **Assess the Situation**
   - Determine the type and volume of the spilled liquid and identify potential hazards.
2. **Wear PPE**
   - Don appropriate personal protective equipment before engaging in spill response.
3. **Contain the Spill**
   - Use brooms, barriers, or dikes to contain the spill and prevent further spread.
4. **Deploy Absorbents**
   - Place absorbent pads, socks, or pillows on and around the spill to absorb the liquid.
5. **Clean Up**
   - Press down on absorbents to maximize liquid absorption, replace saturated materials as needed, and ensure the spill area is thoroughly cleaned.
6. **Proper Disposal**
   - Seal used absorbents and contaminated materials in waste bags. Label and dispose of waste according to hospital and regulatory guidelines.
7. **Decontaminate**

- Clean the spill area with appropriate cleaning agents to ensure no hazardous materials remain.

8. **Restock the Spill Kit**
   - Replace used or depleted components to ensure the kit is fully stocked and ready for future spills.

5. Training and Drills

- **Training:** All staff members involved in spill response must receive training on spill kit use, safety procedures, and proper disposal practices.
- **Drills:** Regular spill response drills should be conducted to ensure readiness and compliance with this policy.

6. Inventory and Maintenance

- **Spill Kit Inventory:** Regularly check and update the inventory of spill kits to ensure they are equipped with the necessary components for the types of liquids handled in the hospital.
- **Maintenance:** Inspect and restock spill kits periodically and replace any expired or damaged materials.

7. Documentation

- **Material Safety Data Sheets (MSDS):** Maintain up-to-date MSDS for all liquids used or stored in the hospital. Ensure they are easily accessible for reference during spill response.

Contact Information

Hazmat contractor

-Gray Mar 24/7 Emergency Response Contact 866-Graymar 866-472-9627, 695 Edison Way, Reno Nv. 89502

-Micheal Rudley ANCON 856-417-6025, 1057 Los Alamitos Blvd, Los Alamitos, CA, 90720

REFERENCES:

"Learn How to Use Spill Kits - Spill Containment Blog." 18 Aug. 2023, https://www.absorbentsonline.com/spill-containment-blog/learn-how-to-use-spill-kits/.

ATTACHMENTS:

~~none~~None

SNF-IC

REFERENCE #	8753-SNF.25	EFFECTIVE
SUBJECT:	8753-SNF.25 TUBERCULOSIS SCREENING, TESTING AND CONTROL AT THE SKILLED NURSING FACILITIES	REVISED 12/2025
DEPARTMENT:	INFECTION CONTROL-SKILLED NURSING FACILITIES	

PURPOSE:

The purpose of this policy is to define the process for Tuberculosis screening, testing and control for residents at the MMC Skilled Nursing Facilities (SNF'S).

AUDIENCE:
Facility Wide

TERMS/DEFINITION:
TST or Mantoux: Tuberculin Skin Test (TST), also known as the Mantoux test, is used to assess whether a person has been infected with tuberculosis (TB) bacteria.

Latent Tuberculosis Infection (LTBI): TB bacteria can live in the body without making a person sick. This is called Latent TB Infection (LTBI). People with LTBI have no symptoms, usually have a positive TB skin test reaction or positive TB blood ~~test~~test, and generally do not feel sick. They usually have a normal chest x-ray and negative sputum smear.
They cannot spread TB bacteria to ~~others.~~others. ~~But~~ but they may develop TB disease if they do not receive treatment for latent TB infection.
Many people who have latent TB infection never develop TB disease.

TB Disease: TB bacteria become active if the immune system cannot stop them from growing. When TB bacteria are actively multiplying in the body, this is called TB disease. People with TB disease may spread the bacteria to others.
Symptoms may include: A bad cough that lasts 3 weeks or longer, pain in the chest, coughing up blood in sputum, weakness or fatigue, weight loss, decreased appetite, chills, fever, and/or night sweats.

TST converter: refers to the situation where an individual's TST result changes from negative to positive within a 24-month period

BCG vaccine: Bacille Calmette-Guérin (BCG) is a vaccine for tuberculosis (TB) disease. This vaccine is not generally used in the United States. The vaccine can cause a false-positive TB skin test reaction.

CXR: Chest X ray

CAIR: California Immunization Registry

POLICY:
It is the policy of Modoc Medical Center (MMC) to screen all residents of the Skilled Nursing Facilities (SNF's) for the presence of inactive or active TB per regulatory guidelines (Title 22, section 72523) and to initiate appropriate follow up care as may be indicated.

PROCEDURE:

Admission TST and/-or CXR

All new admissions to MMC Skilled Nursing Facilities are required by CCR, Title 22, Section 72523 to be screened for tuberculosis.

All residents will be screened within 72 hours of admission, using the assessment questionnaire in their EMR chart.

A two-step TST (done 14 days apart) and/or CXR will be initiated per Provider orders unless:

1. The anticipated stay is less than five days.

2. There is written documentation of a positive TST.

3. There is written documentation of a negative two step TST within 90 days.

4. There is a history of active TB infection in the medical record.

5. There is a CXR in the medical record that has been done within 90 days of admission that is read specifically to TB.

6. Has had a negative TST documented within the previous 12 months (in this case a single TST will be given)

Symptom-screen Questionnaire Guidelines

A CXR should be obtained as soon as possible after admission, per Provider orders, if the resident is symptomatic (i.e., resident has one or more unexplained symptoms identified on the assessment questionnaire).

Unless there is documentation of CXR obtained within 90 days prior to admission, a CXR should also be obtained (instead of TST) if the resident has any of the following:

1. History of active TB disease.
2. Documented history of a positive TST.
3. Positive TST on admission.
4. History of BCG vaccination.
5. An adequate symptom assessment cannot be obtained.

If either the symptom screen questionnaire or the CXR suggests the possibility of active pulmonary TB disease, the resident will immediately be medically evaluated.

Annual TST and Screening:

Residents who have a negative TST on admission will have an annual screening and TST. Residents with positive TST on admission should have an annual symptom screen questionnaire. A routine annual CXR or TST is not recommended for those with positive TST on admission. However, a CXR should be obtained if a resident with negative TST on admission subsequently develops positive TST (converts).

A CXR is required every 3 years and read specifically to TB for residents unable to receive an annual TST.

Post-exposure Resident Screening Program

Following notification of the local health department and CDPH, at minimum all residents exposed to a confirmed case of active pulmonary and/or laryngeal TB disease should receive a symptom screen questionnaire assessment.

Symptomatic residents should have a CXR immediately and have a medical evaluation.

Asymptomatic residents whose most recent TST was negative should be tested as follows:

1. If TST was negative within three months prior to the last exposure date, test the resident 8-10 weeks following the last exposure date.

2. If TST was negative more than three months prior to the last exposure date, apply TST as soon as possible. If the new TST is negative, then reapply the TST 8-10 weeks following the last exposure date.

Resident TST Conversions

TST converters should have a CXR within 7 days if asymptomatic, and within one day if symptomatic. The radiology request should state that the resident is a recent converter. The medical director shall determine any course of treatment.

Residents with Suspected Active TB Disease

If active TB disease is suspected in a resident, the SNF Facility where that resident resides should:

1. Transfer the resident as soon as possible to an acute care hospital with negative pressure isolation.

2. Restrict the resident to a single room with a closed door until the transfer is complete.

3. Instruct the resident to wear a mask that covers the nose and mouth, if possible, until the transfer is complete.

4. Notify the receiving hospital and transportation service of the diagnosis prior to transfer.

5. Notify the resident's family member or conservator.

6. Notify local public health and DHS within one working day.

7. Employees should be instructed to wear an N95 respirator when entering the resident's room.

Administering and Reading TST:

1. Inject 5 tuberculin units (TU) purified derivative (PPD) solution to forearm (palm-side-up) about 2-4 inches below the elbow. Avoid areas of skin with veins, sores, rashes, scars, or excess hair. PPD antigen should be injected just beneath the skin surface.
2. Document date and time of TST placement, person who placed TST, location of injection site and lot number.
3. The test is to be read within 48-72 hours by appropriately trained personnel and recorded (in mm induration) in the resident's medical record. If a qualified Nurse reads a positive PPD, a Provider must confirm the results.
4. Residents with reactions greater than or equal to 10mm should have a Provider contacted to over read the positive result.
5. QuantiFERON testing could be performed on residents that are allergic to PPD solution at the discretion of the Provider.

Resident Record Keeping

All TST and CXR results will be recorded in the resident's medical record and reported to CAIRs per regulation. (AB1797)

The SNF's infection control nurse will monitor for correct documentation.

Skilled Nursing Facilities (SNF's) Employees

All SNF's employees will follow the MMC Employee Health Tuberculosis control program policies.

The SNF's may also follow, as needed, the MMC Tuberculosis program policies for other items that may not have been addressed in this policy.

REFERENCES:

Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Division of Tuberculosis Elimination. Core Curriculum on Tuberculosis: What the Clinician Should Know. 4th ed. 2004. Online edition available at: http://www.cdc.gov/tb/pubs/corecurr/. Accessed May 1,2009.

Jensen PA, Lambert LA, lademarco MF, et al. Guidelines for preventing the transmission of Mycobacterium tuberculosis in health-care settings, 2005. MMWR Recomm Rep 2005;54:1-141.

Occupational Safety and Health Administration. Occupational safety and health standards, subpart I—personal protective equipment. Respiratory protection. Title 29, Code of Federal Regulations 2003. Section 1910.134.

CDHS/CTCA Joint Guidelines: Prevention and Control of Tuberculosis in California Long-Term Health Care Facilities October 2005 State of California Department of Health Service

Clinical Guidelines | Tuberculosis (TB) | CDC

TB Guidelines and Regulations

AB 1797 Immunization Registry FAQs

ATTACHMENTS:

CDPH-CTCA Joint Guidelines - CTCA
Latent Tuberculosis Infection: A Guide for Primary Health Care Providers (cdc.gov)

Department	Contact	Name
PHARM-HOSP	Vahe Hovasapyan	7710.25 COUNTERFEIT DRUGS AND DSCSA.docx
DIETARY ACUTE	Sharon Raabe	8345.26 Calibration of Foodservice Thermometers.docx
SNF-ACTIVITIES	Kayla Wood	8365.25 Use of Alcohol by Resident or Visitor (5381).docx
FACILITIES/EOC	Hao Lin	8460.26 Bio Hazardous Waste Transportation Maintenance.docx
FACILITIES/EOC	Marty Shaffer	8460.26 BIOMEDICAL EQUIPMENT MANAGEMENT.docx
FACILITIES/EOC	Marty Shaffer	8460.26 HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN.dotx
FACILITIES/EOC	Marty Shaffer	8460.26 PERFORMANCE IMPROVEMENT PLAN.docx
FACILITIES/EOC	Marty Shaffer	8460.26 PREVENTATIVE MAINTENANCE.docx
FACILITIES/EOC	Marty Shaffer	8460.26 REMOVAL OF BIO HAZARDOUS WASTE.docx
FACILITIES/EOC	Marty Shaffer	8460.26 SPRINKLER DROP TEST.dotx
FACILITIES/EOC	Marty Shaffer	8460.26 USE OF ELECTRIC WHEELCHAIR.docx
FACILITIES/EOC	Marty Shaffer	8460.26 USE OF SPIL KITS.docx
SNF-IC	Suzanne R. Johnson	8753-SNF.25 TUBERCULOSIS SCREENING, TESTING AND CONTROL AT THE SKILLED NURSING FACILITIES.

DATED: _____

BOARD OF DIRECTORS APPROVAL BY:_____

ATTACHMENT D

LFHD FINANCIAL STATEMENT

January 2026

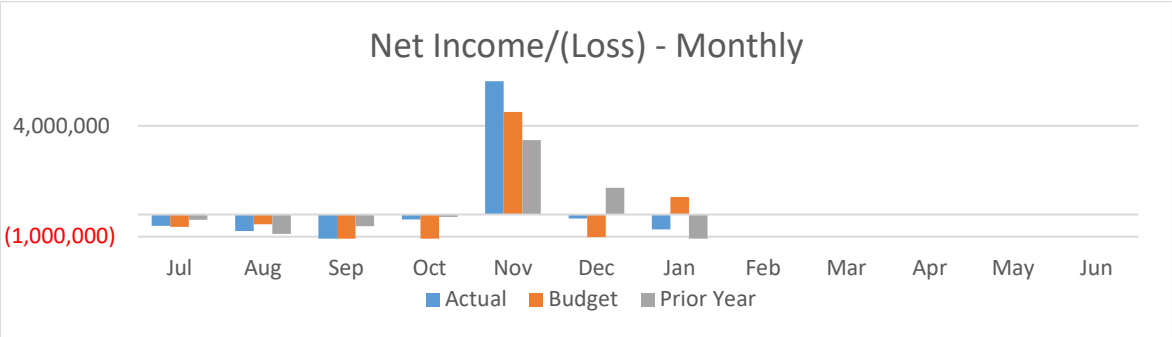
(unaudited)

Modoc Medical Center
Financial Narrative
For the Month of January 2026

Prepared by Jin Lin, Finance Director

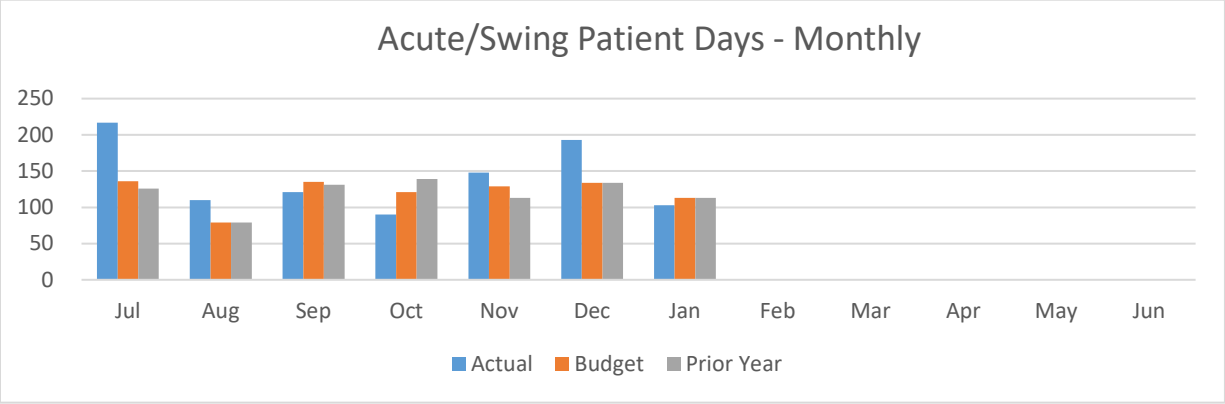
Summary

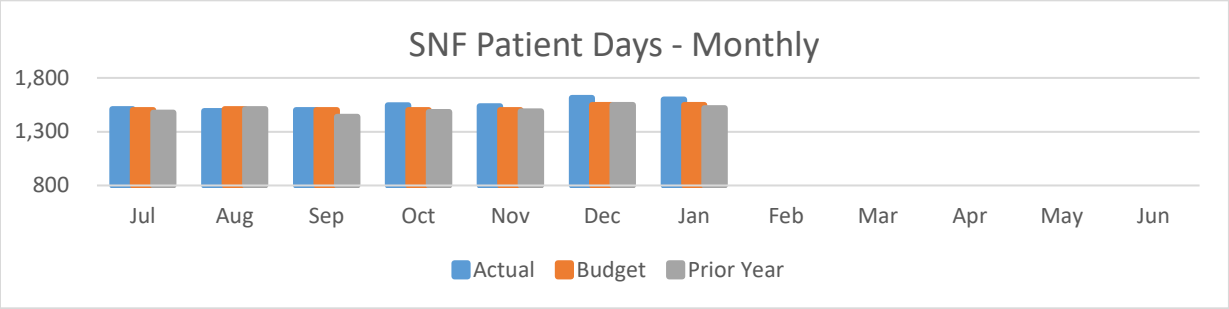
During the month of January, Modoc Medical Center reported a loss from operations of $672K, underperforming the budget that anticipated an operating loss in January of $616K. Inpatient revenue was under the budget by $129K in January. Outpatient revenue was under budget by $406K for the month. Total patient revenue was $4.6 million, under budget of $534K. Modoc Medical Center reported a total net loss of $672K for the month, underperforming the budget that anticipated an overall budget income for the month of $784K, and this difference is due to the non-operating property tax revenue we budgeted in January in the amount of $1.3 million.



Patient Volumes

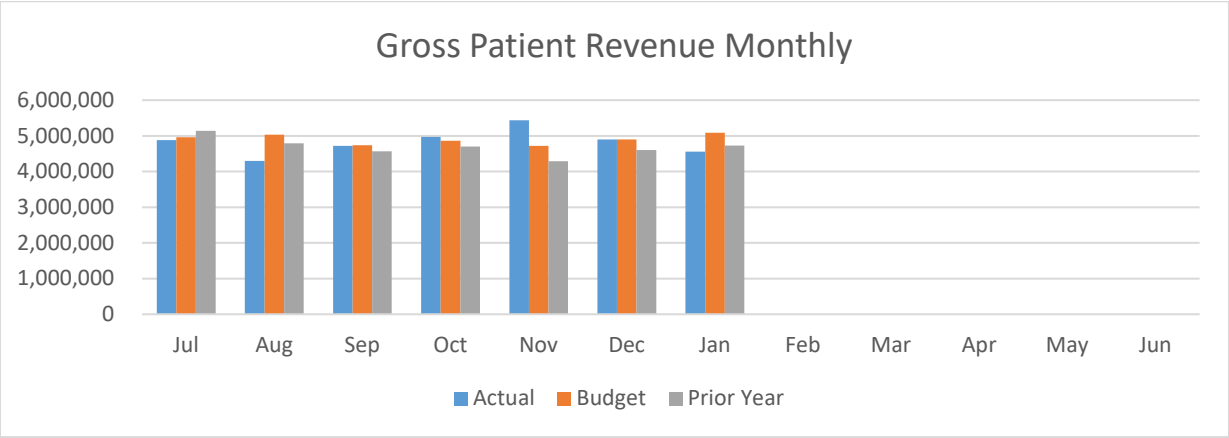
Combined Acute Days were below budget for the month by 10 days. SNF Patient Days were 1,598 for the month. Overall Inpatient and SNF Days were above budget by 38 days (1,701 actual vs. 1,663 budget). Most outpatient visits were below budget, and some of the data might be affected by Cerner service down. We will update this later if needed.

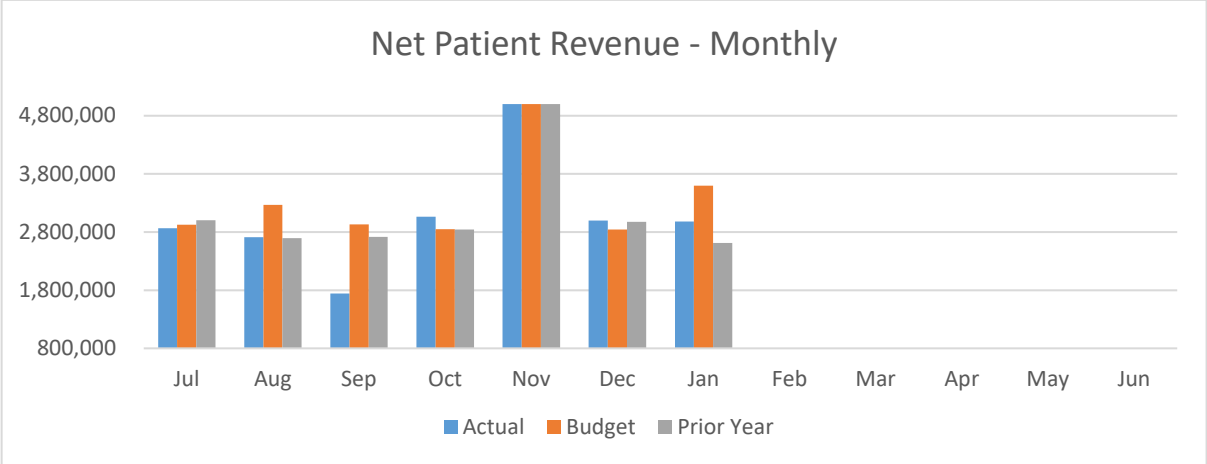




Revenues

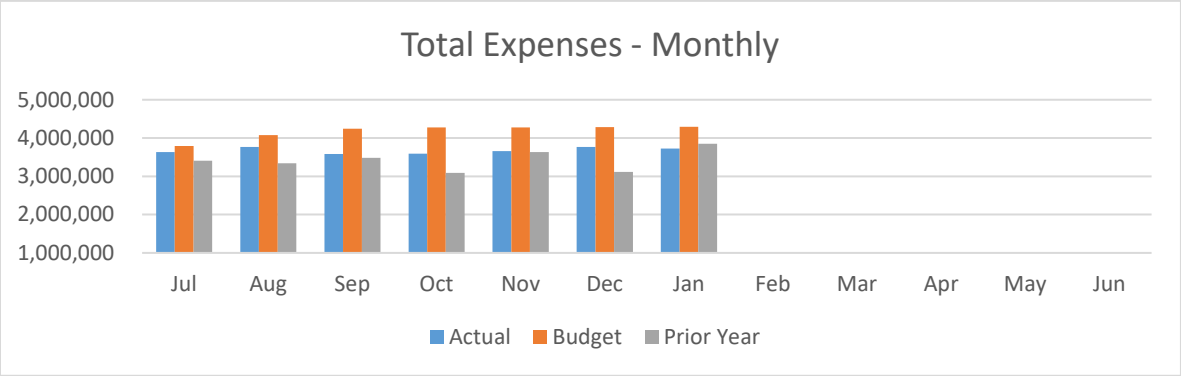
Gross revenue was under budget of $534K, and net revenue was lower than budget in the month of January. Gross Patient Revenues were $4.6 million, compared to the budget of $5.1 million. Inpatient Revenue was $1.3 million compared to the budget of $1.4 million; and Outpatient Revenue was $3.3 million compared to the budget of $3.7 million. Total deductions from revenue were $1.6 million, compared to budget of $1.5 million. Net patient Revenue was $3 million, compared to budget of $3.7 million.





Expenses

Total operating expenses were $3.7 million this month, which is $570K lower than budgeted operating expenses. The decrease was mainly in Payroll, Purchased Services, and Supplies.

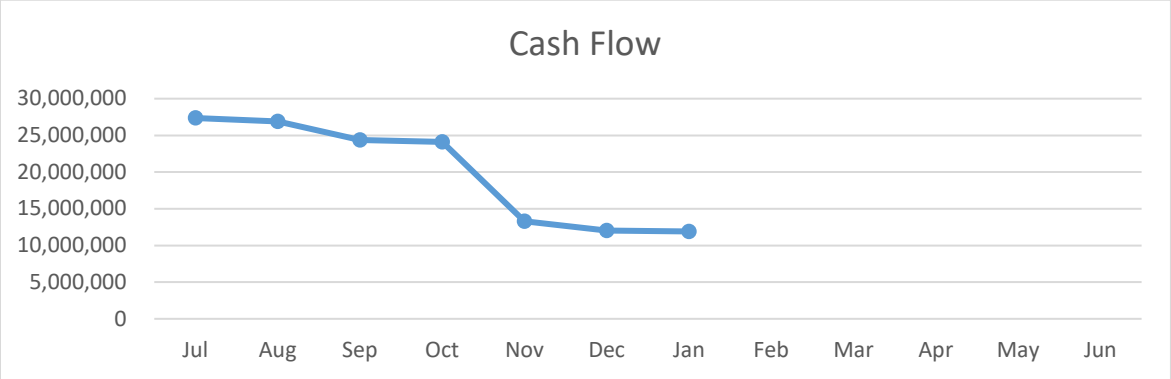


Non-Operating Activity

Non-Operating expenses for the month were as follows: accrued Interest expense from USDA Loan was $83K. Interest income of $54K was earned from CDs. The retail pharmacy showed an income of $38K. Total non-operating net income for the month was $323, which was under the budget.

Balance Sheet

Cash decreased in January by $125K to $11.9 million. The total current liabilities were $3.9 million. Days in Cash totaled 92. Days in AP totaled 10. Days in AR totaled 63. The current ratio was 8.7. Net AR as a percentage of gross AR was 42.31%.



Modoc Medical Center
Income Statement
For the month of January 2026

	Month	Jan-26 Budget	Variance	Prior Year Month	2026 YTD	2026 YTD Budget	Variance	Prior Year YTD
Revenues								
Room & Board - Acute	487,727	579,203	(91,476)	572,229	3,921,057	4,540,921.38	(619,864)	4,391,273
Room & Board - SNF	788,361	825,395	(37,034)	825,009	6,281,673	5,812,800.19	468,873	5,576,668
Total Inpatient Revenue	1,276,088	1,404,598	(128,510)	1,397,238	10,202,730	10,353,722	(150,991)	9,967,940
Outpatient Revenue	3,277,230	3,682,854	(405,624)	3,332,377	23,797,552	23,943,387	(145,835)	22,858,056
Total Patient Revenue	4,553,317	5,087,452	(534,134)	4,729,615	34,000,282	34,297,108	(296,827)	32,825,996
Bad Debts (580000,580011,58010(	125,304	(33,792)	159,096	933,401	691,279	(120,596)	811,875	(1,062,183)
Contractuals Adjs	1,433,103	1,508,631	(75,528)	1,113,784	6,085,573	7,093,918	(1,008,345)	6,173,020
Admin Adjs (5930002-593001,598(	14,809	16,897	(2,088)	72,126	1,058,760	118,279	940,481	3,781,364
Total Revenue Deductions	1,573,217	1,491,736	81,480	2,119,311	7,835,613	7,091,601	744,011	8,892,201
Net Patient Revenue	2,980,101	3,595,715	(615,615)	2,610,305	26,164,669	27,205,507	(1,040,838)	23,933,796
% of Charges	*65.4%*	*70.7%*	*-5.2%*	*55.2%*	*77.0%*	*79.3%*	*-2.4%*	*72.9%*
Other Revenue	73,163	83,638	(10,474)	82,810	301,937	734,652	(432,714)	268,583
Total Net Revenue	3,053,264	3,679,353	(626,089)	2,693,114	26,466,607	27,940,159	(1,473,552)	24,202,379
Expenses								
Salaries	1,631,191	1,788,352	(157,161)	1,473,038	12,143,368	12,430,493	(287,125)	10,388,475
Benefits and Taxes	490,351	545,539	(55,187)	347,775	2,720,554	3,654,411	(933,857)	2,246,881
Registry	281,118	284,982	(3,863)	373,696	1,562,640	1,994,872	(432,232)	1,974,839
Professional Fees	397,137	427,550	(30,413)	596,966	2,829,768	2,758,160	71,608	2,759,603
Purchased Services	141,891	238,451	(96,561)	260,472	954,380	1,630,371	(675,991)	1,242,516
Supplies	274,420	413,265	(138,845)	402,088	2,484,019	2,895,667	(411,647)	2,417,148
Repairs and Maint	24,202	36,991	(12,788)	(110)	282,330	264,284	18,047	228,307
Lease and Rental	7,171	4,541	2,629	7,981	21,592	31,801	(10,209)	37,333
Utilities	64,486	79,256	(14,770)	64,353	471,943	554,793	(82,850)	491,698
Insurance	65,808	45,821	19,986	45,671	281,336	320,749	(39,413)	323,019
Depreciation	270,835	343,633	(72,798)	177,600	1,541,062	2,115,525	(574,463)	1,245,171
Other	76,929	86,686	(9,757)	97,281	530,605	605,033	(74,427)	567,976
Total Operating Expenses	3,725,539	4,295,067	(569,528)	3,846,812	25,823,599	29,256,157	(3,432,558)	23,922,965
Income from Operations	(672,275)	(615,714)	(56,561)	(1,153,698)	643,008	(1,315,999)	1,959,006	279,414
Property Tax Revenue	0	1,339,079	(1,339,079)	0	1,345,292	1,596,367	(251,075)	1,339,079
Interest Income	54,192	107,670	(53,479)	135,345	561,943	753,693	(191,750)	769,681
Interest Expense	(82,881)	(155,543)	72,662	(221,487)	(1,379,393)	(939,108)	(440,285)	(976,147)
Gain/Loss on Asset Disposal/Forter	0	0	0		0	0	0	0
Retail Pharmacy Net Activity	37,725	117,526	(79,801)	17,811	756,719	845,511	(88,792)	218,781
DISTRICT VOUCHERS AND OTHER	(8,713)	(9,450)	737	(9,450)	(28,706)	(54,137)	25,431	(54,355)
Total Non-Operating Revenue	323	1,399,283	(1,398,960)	(77,782)	1,255,855	2,202,326	(946,470)	1,297,040
Net Income/(Loss)	(671,952)	783,569	(1,455,521)	(1,231,480)	1,898,863	886,327	1,012,536	1,576,454
EBIDA	(318,236)	1,282,744	(1,600,980)	(832,392)	4,819,318	3,940,960	878,358	3,797,772
Operating Margin %	-22.0%	-16.7%	-5.3%	-42.8%	2.4%	-4.7%	7.1%	1.2%
Net Margin %	-22.0%	21.3%	-43.3%	-45.7%	7.2%	3.2%	4.0%	6.5%
EBIDA Margin %	-10.4%	34.9%	-45.3%	-30.9%	18.2%	14.1%	4.1%	15.7%

Modoc Medical Center
Income Statement Trend

	Jan-25	FYE 2025 YTD July-Jan	FYE 2026 YTD July-Dec	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Revenues										
Room & Board - Acute	572,229	4,391,273	3,921,057	685,444	529,453	467,429	452,283	571,794	726,928	487,727
Room & Board - SNF	825,009	5,576,668	6,281,673	841,152	893,655	878,216	946,063	942,003	992,223	788,361
			0							
Total Inpatient Revenue	1,397,238	9,967,940	10,202,730	1,526,595	1,423,108	1,345,645	1,398,346	1,513,797	1,719,151	1,276,088
Outpatient Revenue	3,332,377	22,858,056	23,797,552	3,351,869	2,878,680	3,369,321	3,571,943	3,919,351	3,429,157	3,277,230
Total Patient Revenue	4,729,615	32,825,996	34,000,283	4,878,465	4,301,788	4,714,967	4,970,289	5,433,148	5,148,309	4,553,317
Bad Debts	933,401	(1,062,183)	691,279	84,182	101,595	192,942	68,244	223,030	(104,018)	125,304
Contractual Adjs	1,113,784	6,173,020	6,085,573	1,918,848	1,481,549	1,894,197	1,731,019	(4,281,656)	1,908,514	1,433,103
Admin Ajds	72,126	3,781,364	1,058,760	12,361	24,241	884,264	109,742	(331,083)	344,426	14,809
Total Revenue Deductions	2,119,311	8,892,201	7,835,613	2,015,392	1,607,384	2,971,403	1,909,004	(4,389,709)	2,148,922	1,573,217
Net Patient Revenue	2,610,305	23,933,796	26,164,670	2,863,073	2,694,403	1,743,564	3,061,284	9,822,857	2,999,387	2,980,101
% of Charges	*55.2%*	*72.9%*	*77.0%*	*58.7%*	*62.6%*	*37.0%*	*61.6%*	*180.8%*	*58.3%*	*65.4%*
Other Revenue	82,810	268,583	301,937	37,741	14,505	34,509	66,379	33,683	41,958	73,163
Total Net Revenue	2,693,114	24,202,379	26,466,607	2,900,814	2,708,908	1,778,073	3,127,663	9,856,540	3,041,345	3,053,264
Expenses										
Salaries	1,473,038	10,388,475	12,143,368	1,785,419	1,690,354	1,684,758	1,729,366	1,843,644	1,778,637	1,631,191
Benefits and Taxes	347,775	2,246,881	2,720,554	377,349	382,644	340,699	374,615	375,762	379,134	490,351
Registry	373,696	1,974,839	1,562,640	262,589	207,040	199,454	240,036	196,051	176,352	281,118
Professional Fees	596,966	2,759,603	2,829,768	379,442	488,717	373,455	441,028	281,514	468,475	397,137
Purchased Services	260,472	1,242,516	954,380	58,880	209,739	118,558	152,633	139,926	132,753	141,891
Supplies	402,088	2,417,148	2,484,019	397,284	344,376	403,531	351,006	411,097	302,305	274,420
Repairs and Maint	(110)	228,307	282,330	32,193	80,938	55,206	30,158	25,319	34,313	24,202
Lease and Rental	7,981	37,333	21,592	2,393	1,683	2,205	3,241	3,151	1,749	7,171
Utilities	64,353	491,698	471,943	59,208	60,628	56,867	54,083	65,332	111,339	64,486
Insurance	45,671	323,019	281,336	43,282	44,241	43,413	20,745	20,745	43,103	65,808
Depreciation	177,600	1,245,171	1,541,062	183,888	183,829	177,432	182,003	228,214	314,861	270,835
Other	97,281	567,976	530,605	70,025	77,764	135,953	16,174	67,717	86,043	76,929
Total Operating Expenses	3,846,812	23,922,965	25,823,599	3,651,953	3,771,953	3,591,532	3,595,087	3,658,471	3,829,064	3,725,539
Income from Operations	(1,153,698)	279,414	643,009	(751,139)	(1,063,045)	(1,813,459)	(467,424)	6,198,068	(787,719)	(672,275)
Property Tax Revenue	0	1,339,079	1,345,292	0	61,179	0	0		1,284,113	
Interest Income	135,345	769,681	561,943	214,143	104,327	43,952	84,301	31,985	29,043	54,192
Interest Expense	(221,487)	(976,147)	(1,379,393)	(83,144)	(82,545)	(81,291)	(81,800)	(82,675)	(885,057)	(82,881)
Gain/Loss on Asset Disposal/Fortera		0	0	0	0	0	0			
Retail Pharmacy Net Activity	17,811	218,781	756,719	93,595	235,880	40,127	246,607	(4,584)	107,370	37,725
DISTRICT VOUCHERS AND OTHER	(9,450)	(54,355)	(28,706)	(7,186)	(8,218)	(7,451)	(2,202)	(4,834)	9,897	(8,713)
Total Non-Operating Revenue	(77,782)	1,297,040	1,255,855	217,408	310,623	(4,663)	246,906	(60,108)	545,366	323
Net Income	(1,231,480)	1,576,454	1,898,864	(533,731)	(752,421)	(1,818,122)	(220,518)	6,137,961	(242,352)	(671,952)
EBIDA	(832,392)	3,797,772	4,819,319	(266,700)	(486,048)	(1,559,399)	43,285	6,448,850	957,566	(318,236)
Operating Margin %	-42.8%	1.2%	2.4%	-25.9%	-39.2%	-102.0%	-14.9%	62.9%	-25.9%	-22.0%
Net Margin %	-45.7%	6.5%	7.2%	-18.4%	-27.8%	-102.3%	-7.1%	62.3%	-8.0%	-22.0%
EBIDA Margin %	-30.9%	15.7%	18.2%	-9.2%	-17.9%	-87.7%	1.4%	65.4%	31.5%	-10.4%

Modoc Medical Center
Balance Sheet
For the month of January 2026

	Unaudited 1/31/2026	Unaudited 12/31/2025	Unaudited 11/30/2025	Unaudited 10/30/2025	Unaudited 9/30/2025	Unaudited 8/31/2025	Unaudited 7/31/2025	Unaudited 6/30/2025
Cash	207,906	932,650	537,100	1,377,232	537,347	364,654	133,445	1,343,671
Investments	10,469,699	8,412,132	6,112,326	16,085,319	17,212,464	18,491,661	19,210,474	25,133,123
Designated Funds	1,227,911	2,686,203	6,657,936	6,640,065	6,621,947	8,039,751	8,016,285	7,993,985
Total Cash	11,905,516	12,030,984	13,307,362	24,102,615	24,371,758	26,896,066	27,360,203	34,470,779
Gross Patient AR (Patient AR-	9,883,144	9,031,770	9,100,176	8,191,503	8,552,822	9,637,386	10,084,488	10,432,654
Allowances	(5,702,060)	(5,353,141)	(5,408,452)	(4,812,248)	(5,100,262)	(5,197,898)	(5,333,160)	(5,933,536)
Net Patient AR	4,181,084	3,678,629	3,691,724	3,379,255	3,452,561	4,439,488	4,751,329	4,499,118
% of Gross	*42.3%*	*40.7%*	*40.6%*	*41.3%*	*40.4%*	*46.1%*	*47.1%*	*43.1%*
Third Party Receivable	15,407,444	16,752,736	14,961,623	1,930,757	2,423,387	2,423,387	1,955,578	1,955,578
Other AR	1,329,133	1,521,565	1,455,046	920,000	784,190	842,542	674,415	636,825
Inventory	712,446	692,837	683,165	753,237	760,880	737,889	688,927	685,089
Prepaids	347,674	420,697	457,912	441,445	489,130	433,931	495,492	487,234
Total Current Assets	33,883,298	35,097,448	34,556,832	31,527,309	32,281,906	35,773,303	35,925,944	42,734,623
Land (120000-120900)	713,540	713,540	713,540	713,540	713,540	713,540	713,540	713,540
Bldg & Improvements (12110	104,953,797	104,953,797	104,953,797	47,945,861	47,927,861	47,927,861	47,927,861	47,927,861
Equipment (124100-124204)	16,546,581	16,546,581	16,369,150	14,495,515	14,495,515	14,495,515	14,495,515	14,495,515
Construction In Progress (125	1,851,590	1,727,082	3,897,901	59,316,095	59,132,300	57,511,960	57,155,087	56,547,764
Fixed Assets	124,065,507	123,940,999	125,934,388	122,471,011	122,269,216	120,648,876	120,292,003	119,684,680
Accum Depreciation	(21,994,976)	(21,723,943)	(21,408,884)	(21,180,479)	(20,998,278)	(20,820,655)	(20,636,628)	(20,452,542)
Net Fixed Assets	102,070,532	102,217,056	104,525,503	101,290,532	101,270,938	99,828,222	99,655,375	99,232,138
Other Assets	0	0	0	0	0	0	0	0
Total Assets	135,953,830	137,314,504	139,082,335	132,817,841	133,552,844	135,601,525	135,581,319	141,966,761
Accounts Payable	1,269,905	1,498,228	3,344,913	3,542,040	3,561,738	3,714,391	3,222,888	8,745,420
Accrued Payroll	1,885,373	1,792,561	1,579,475	1,332,074	1,904,474	1,716,038	1,513,818	1,241,389
Patient Trust Accounts	11,195	11,195	11,118	11,016	10,906	10,906	10,556	10,580
Third Party Payables	554,000	554,000	554,000	554,000	554,000	554,000	554,000	554,000
Accrued Interest								
Current Portion Liabilities	163,368	163,368	24,163,368	24,163,368	24,163,368	24,163,368	24,163,368	24,163,368
Other Current Liabilities/Accr	18,753	479,328	437,402	361,244	283,740	400,082	321,529	519,110
Total Current Liabilities	3,902,594	4,498,679	30,090,276	29,963,741	30,478,226	30,558,785	29,786,158	35,233,868
Long Term Liabilities	55,446,481	55,473,000	31,473,000	31,473,000	31,473,000	31,623,000	31,623,000	32,027,000
Total Liabilities	59,349,075	59,971,679	61,563,276	61,436,741	61,951,226	62,181,785	61,409,158	67,260,868
Fund Balance	74,705,892	74,705,892	74,705,892	74,705,892	74,705,892	74,705,892	74,705,892	71,480,156
Current Year Income/(Loss)	1,898,863	2,636,933	2,813,167	(3,324,793)	(3,104,275)	(1,286,153)	(533,731)	3,225,737
Total Equity	76,604,755	77,342,826	77,519,060	71,381,099	71,601,617	73,419,739	74,172,161	74,705,893
Total Liabilities and Equity	135,953,830	137,314,504	139,082,336	132,817,840	133,552,844	135,601,524	135,581,319	141,966,761
Days in Cash	92	81	58	151	151	176	180	330
Days in AR (Gross)	63	57	50	53	55	61	64	66
Days in AP	10	12	27	29	29	34	29	80
Current Ratio	8.68	7.80	1.15	1.05	1.06	1.17	1.21	1.21
Net AR as a percentage of grc	42.31%	40.73%	40.57%	41.25%	40.37%	46.07%	47.12%	43.13%
Check	(0)	0	(0)	0	(0)	0	0	(0)

STATEMENT OF CASH FLOWS

January-26

	CURRENT MONTH	FISCAL YEAR YTD
CASH FLOWS FROM OPERATING ACTIVITIES		
NET INCOME	-671,952	1,898,863
ADJUSTMENTS TO RECONCILE NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
DEPRECIATION EXPENSE	271,033	1,542,434
CHANGE IN PATIENT ACCOUNTS RECEIVABLE	-502,455	318,034
CHANGE IN OTHER RECEIVABLES	1,537,725	-14,144,174
CHANGE IN INVENTORIES	-19,609	-27,357
CHANGE IN PREPAID EXPENSES	73,023	139,560
CHANGE IN ACCOUNTS PAYABLE	-294,442	-7,475,515
CHANGE IN ACCRUED SALARIES AND RELATED TAXES	92,811	643,983
CHANGE IN OTHER PAYABLES	-460,575	-500,357
NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES	697,511	-19,503,393
CASH FLOWS FROM INVESTMENT ACTIVITIES		
PURCHASE OF EQUIPMENT/CIP	-124,508	-4,380,825
CUSTODIAL HOLDINGS	0	614
NET CASH PROVIDED (USED) BY INVESTING ACTIVITIES	-124,508	-4,380,211
CASH FROM FINANCING ACTIVITIES		
Current Libility	0	-24,000,000
Long Term Liability	-26,519	23,419,481
NET CASH PROVIDED (USED) BY FINANCING ACTIVITIES	-26,519	-580,519
CASH AT BEGINNING OF PERIOD	12,030,984	34,470,779
NET INCREASE (DECREASE) IN CASH	-125,468	-22,565,260
CASH AT END OF PERIOD	11,905,516	11,905,516

MODOC MEDICAL CENTER

"KEY STATISTICS"

Twelve Months Ending, January 31st, 2026

	Jan-26		Dec-25		Nov-25		Oct-25		Sep-25		Aug-25		Jul-25		Jun-25		May-25		Apr-25		Mar-25		Feb-25		FY 26 YTD	FY 25 YTD	12 Mos.
	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.			
Patient-Days																											
Adults/Peds	49	***56***	69	***64***	56	***83***	52	***75***	47	***86***	49	***48***	53	***90***	47	***57***	51	***76***	64	***137***	49	***63***	48	***68***	375	482	634
Swing	54	***57***	124	***70***	92	***46***	38	***76***	74	***49***	61	***31***	164	***36***	87	***50***	46	***71***	28	***89***	45	***84***	73	***82***	607	350	886
SNF	1,598	***1,550***	1,615	***1,535***	1,536	***1,500***	1,546	***1,500***	1,500	***1,599***	1,493	***1,511***	1,509	***1,478***	1,412	***1,301***	1,465	***1,446***	1,340	***1,463***	1,408	***1,550***	1,377	***1,413***	10,797	10,456	17,799
Total "Patient Days"	***1,701***	***1,663***	***1,808***	***1,669***	***1,684***	***1,629***	***1,636***	***1,651***	***1,621***	***1,734***	***1,603***	***1,590***	***1,726***	***1,604***	***1,546***	***1,408***	***1,562***	***1,593***	***1,432***	***1,689***	***1,502***	***1,697***	***1,498***	***1,563***	**11,779**	**11,288**	**19,319**
ADC																											
Adults/Peds	1.58	1.81	2.23	2.06	1.87	2.68	1.68	2.42	1.57	2.77	1.58	1.55	1.71	2.90	1.57	1.84	1.65	2.45	2.13	4.42	1.58	2.03	1.71	2.19	1.74	2.24	1.74
Swing	1.74	1.84	4.00	2.26	3.07	1.48	1.23	2.45	2.47	1.58	1.97	1.00	5.29	1.16	2.90	1.61	1.48	2.29	0.93	2.87	1.45	2.71	2.61	2.65	2.82	1.63	2.43
SNF	51.55	50.00	52.10	49.52	51.20	48.39	49.87	48.39	50.00	51.58	48.16	48.74	48.68	47.68	47.07	41.97	47.26	46.65	44.67	47.19	45.42	50.00	49.18	45.58	50.22	48.63	48.76
Total "Average Daily Census"	***54.87***	***53.65***	***58.32***	***53.84***	***56.13***	***52.55***	***52.77***	***53.26***	***54.03***	***55.94***	***51.71***	***51.29***	***55.68***	***51.74***	***51.53***	***45.42***	***50.39***	***51.39***	***47.73***	***54.48***	***48.45***	***54.74***	***53.50***	***50.42***	**54.79**	**52.50**	**52.93**
ALOS																											
Adults/Peds	2.72		3.63		3.50		3.06		2.94		3.50		3.12		3.36		3.00		3.20		2.45		2.82		3.21	3.23	3.09
Swing	10.80		10.33		9.20		7.60		14.80		8.71		13.67		10.88		4.60		7.00		4.09		12.17		10.84	7.45	9.33
Admissions																											
Adults/Peds	18	17	19	19	16	8	17	20	16	28	14	14	17	27	14	17	17	23	20	19	20	19	17	18	117	149	205
Swing	5	6	12	9	10	10	5	5	5	8	7	5	12	6	8	7	10	12	4	10	11	10	6	10	56	47	95
SNF	2	2	-	2	5	2	-	2	-	2	1	1	5	4	3	5	4	4	1	1	2	-	-	2	13	14	23
Total "Admissions"	***25***	***25***	***31***	***30***	***31***	***20***	***22***	***27***	***21***	***38***	***22***	***20***	***34***	***37***	***25***	***29***	***31***	***39***	***25***	***30***	***33***	***29***	***23***	***30***	**186**	**210**	**323**
Discharges																											
SNF	1		2		1		1		-		1		2		4		1		1		3		4		8	11	21
																									-	-	-
Days in Period	31		31		30		31		30		31		31		30		31		30		31		28		215	215	365
																									-	-	-
Amulatory Service Statistics																									-	-	-
Emergency Visits	485	440	486	510	474	421	550	474	471	476	494	525	487	464	460	464	481	552	482	553	496	523	482	427	3,447	3,428	5,848
Ambulance Runs Visits	73	87	107	93	90	93	78	91	94	83	82	87	106	81	75	81	77	113	75	108	93	104	95	87	630	629	1,045
Clinic Visits	805	970	772	684	808	813	837	923	791	809	827	857	959	772	574	772	1,081	902	827	1,229	727	1,016	790	1,156	5,799	5,541	9,798
Canby Clinic Visits	222	290	290	251	202	264	233	268	210	225	248	325	312	301	232	301	261	274	233	331	257	217	243	169	1,717	2,085	2,943
Canby Dental	178	185	145	147	129	171	183	200	195	180	169	210	169	171	192	171	136	237	163	286	142	200	133	123	1,168	1,076	1,934
Observation Admits	7		1	5	5	4	2	2	-	5	1	6	2	2	5	2	5	5	4	5	3	4	2	2	18	26	37
Observation Care Hours	293.2	96	23.6	158	121.2	106	115.0	159	-	128	26.2	193	145.3	50	169.3	50	218.2	160	89.5	131	74.0	143	93.9	54	724	777	1,369
																									-	-	-
Ancillary Services Statistics																									-	-	-
Surgeries	4	10	3	11	4	2	3	3	10	4	3	2	2	4	5	4	11	8	2	5	3	3	4	14	29	41	54
Endoscopies	21	28	23	20	23	21	35	20	21	25	24	17	17	24	25	24	19	30	21	19	21	26	20	14	164	123	270
Surgery & Recovery Minutes	632	682	658	731	577	462	1,016	566	716	498	638	501	414	642	802	642	869	1,064	767	574	623	611	666	666	4,651	3,937	8,378
Anesthesia Minutes	904	1,058	912	1,326	933	745	1,427	898	1,089	793	1,014	565	667	946	1,404	946	1,392	1,556	864	1,076	960	943	1,020	1,047	6,946	6,235	12,586
Laboratory Tests		4,591	4,721	4,427	4,454	4,269	4,680	5,079	4379	4,805	4772	4,534	5241	4,112	4816	4,112	4543	4,832	4631	4,914	4648	4,348	4648	4,980	28,247	32,766	51,533
Radiology-Diagnostic Proc		282	287	256	236	261	307	285	244	267	267	283	330	300	266	300	297	293	257	297	262	254	301	249	1,671	1,938	3,054
Ultrasounds Proc		92	126	86	73	53	138	106	112	99	114	99	156	102	82	102	83	85	94	89	88	61	105	102	719	570	1,171
CT Scans Proc		127	182	145	160	152	149	152	168	128	181	167	196	139	150	139	150	173	138	195	168	130	153	163	1,036	1,104	1,795
MRI Proc			45		21	15		-				28		26	-	26		18		-	-	30	-	18	66	46	66
Physical Therapy Sessions	469	569	1,269	429	859	542	880	552	851	573	967	677	1,232	775	817	775	551	718	756	770	889	600	517	624	6,527	4,261	10,057
Retail Pharmacy-Scripts	4,449	2,687	4,331	2,586	3,841	2,377	5,035	2,663	4,016	2,394	3,555	2,594	3,441	2,351	3,248	2,351	3,309	2,689	2,969	2,598	2,513	2,548	2,354	2,463	28,668	18,211	43,061
Dietician Consults																											

MODOC MEDICAL CENTER

"FULL TIME EQUIVALENT REPORT"

Twelve Months Ending: January 31st, 2025

Department	Jan-26	Dec-25	Nov-25	Oct-25	Sep-25	Aug-25	Jul-25	Jun-25	May-25	Apr-25	Mar-25	Feb-25	12 Mo Ave		
Med / Surg	18.35	16.90	17.36	15.63	15.21	16.15	15.37	16.06	16.47	14.81	14.77	14.50	15.97	1.45	0.08
Comm Disease Care													#DIV/0!	0.00	#DIV/0!
Swing Beds													#DIV/0!	0.00	#DIV/0!
Long Term - SNF	59.65	37.41	64.09	59.56	56.28	57.55	55.38	53.39	55.93	53.24	54.82	54.32	55.14	22.24	0.37
Mountainview - SNF	10.26	31.66											20.96	#####	(2.09)
Emergency Dept	12.26	11.60	12.19	12.93	12.49	14.13	10.59	12.51	12.64	11.62	14.17	13.95	12.59	0.66	0.05
Ambulance - Alturas	10.55	11.55	10.79	10.86	11.31	12.65	12.06	12.31	12.50	12.53	11.96	11.34	11.70	-1.00	(0.09)
Clinic	17.92	17.28	19.78	19.45	20.43	19.71	20.32	19.93	20.31	19.52	18.89	18.54	19.34	0.64	0.04
Canby Clinic	9.04	10.54	11.49	12.06	11.47	10.55	10.89	9.80	10.95	10.66	12.18	10.39	10.84	-1.50	(0.17)
Canby Dental	4.43	4.66	5.11	4.75	4.86	4.33	3.85	4.37	5.29	4.80	3.72	3.66	4.49	-0.23	(0.05)
Surgery	3.67	4.33	5.05	4.12	3.97	3.93	4.11	3.70	3.98	4.01	4.21	3.97	4.09	-0.66	(0.18)
IRR													#DIV/0!	0.00	#DIV/0!
Lab	8.65	8.51	8.90	8.94	9.08	9.07	8.21	8.74	8.78	9.32	9.15	9.09	8.87	0.14	0.02
Radiology	6.05	6.86	7.13	5.37	5.05	5.67	5.85	3.65	4.12	4.45	4.35	4.52	5.26	-0.81	(0.13)
MRI													#DIV/0!	0.00	#DIV/0!
Ultrasound	1.70	1.39	1.33	1.37	1.31	1.28	1.33	1.13	1.27	1.36	1.29	1.31	1.34	0.31	0.18
CT	1.34	1.51	1.81	1.29	1.62	1.72	1.67	1.47	2.10	1.93	1.92	1.84	1.69	-0.17	(0.13)
Pharmacy	2.01	2.05	2.00	1.96	2.16	1.83	1.33	1.09	1.17	1.24	1.30	1.33	1.62	-0.04	(0.02)
Physical Therapy	6.30	6.61	7.38	6.40	4.84	6.75	6.88	6.41	5.46	5.74	6.19	6.34	6.28	-0.31	(0.05)
Other PT													#DIV/0!	0.00	#DIV/0!
Dietary	19.07	13.72	16.43	12.85	12.25	13.15	14.01	11.48	12.87	13.82	13.99	13.37	13.92	5.35	0.28
Dietary - MV SNF	2.33	5.89											4.11	-3.56	(1.53)
Dietary Acute	7.35	7.48	7.08	8.43	8.17	7.77	6.76	7.36	7.81	7.69	8.39	7.60	7.66	-0.13	(0.02)
Laundry	1.01	1.00	1.10	1.00	1.01	1.03	1.01	0.90	1.02	1.01	1.02	0.97	1.01	0.01	0.01
Activities	5.21	5.11	5.72	5.67	4.74	4.64	4.43	4.41	4.50	4.12	3.59	3.76	4.66	0.10	0.02
Social Services	2.16	1.79	1.97	2.02	1.82	1.95	1.43	1.65	2.12	1.97	2.04	1.95	1.91	0.37	0.17
Purchasing	3.01	3.01	3.01	2.92	3.00	3.01	3.01	3.02	2.96	3.11	3.16	3.18	3.03	0.00	-
Housekeeping	16.81	17.10	15.12	13.97	13.67	14.00	13.78	13.94	13.82	14.45	14.52	14.87	14.67	-0.29	(0.02)
Maintenance	6.03	6.06	5.93	6.05	5.80	5.16	5.82	5.99	5.96	5.99	6.04	5.96	5.90	-0.03	(0.00)
Data Processing	4.16	4.07	4.87	4.68	4.69	4.73	4.58	4.63	4.68	4.76	4.26	4.05	4.51	0.09	0.02
General Accounting	4.21	4.14	3.92	3.94	3.71	3.99	3.92	3.40	3.38	3.64	3.89	3.97	3.84	0.07	0.02
Patient Accounting	9.48	9.13	9.30	8.46	7.67	7.17	8.25	8.95	8.85	9.86	8.98	7.76	8.66	0.35	0.04
Administration	3.21	3.38	3.37	3.49	3.43	3.53	3.40	3.65	3.25	3.41	3.32	3.46	3.41	-0.17	(0.05)
Human Resources	2.89	2.99	3.01	2.97	2.85	2.92	1.98	2.01	2.00	2.01	2.01	2.01	2.47	-0.10	(0.03)
Medical Records	8.52	8.58	8.70	7.76	7.96	8.30	8.51	8.51	8.57	8.70	8.74	8.62	8.46	-0.06	(0.01)
Nurse Administration	2.93	2.91	2.78	3.07	3.02	3.02	2.88	2.80	3.05	3.11	3.02	2.51	2.93	0.02	0.01
In-Service	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.94	0.87	1.01	1.00	0.99	0.00	-
Utilization Review	1.44	1.48	1.49	1.49	1.44	1.48	1.41	1.44	1.49	1.39	1.47	1.48	1.46	-0.04	(0.03)
Quality Assurance	0.50	0.50	0.50	0.51	0.50	0.50	0.50	0.51	0.50	0.50	0.50	0.51	0.50	0.00	-
Infection Control	0.59	0.59	0.61	0.69	0.64	0.64	0.39	0.70	0.46	0.61	0.48	0.60	0.58	0.00	-
Retail Pharmacy	7.15	6.41	6.39	6.67	6.17	5.94	4.96	4.50	5.03	4.96	4.13	4.15	5.54	0.74	0.10
TOTAL	**281.24**	**279.20**	**276.71**	**262.33**	**253.62**	**259.25**	**249.87**	**245.41**	**254.23**	**251.21**	**253.48**	**246.88**	**259.45**	2.04	0.01

Jan thru Feb 3,113.43

ATTACHMENT E

INVESTMENT PROPOSAL

LAST FRONTIER HEALTHCARE DISTRICT
A Public Entity

Investment Proposal-2-19-2026

A couple of weeks ago we received our supplemental reimbursement funds from the voluntary rate range program. We received a little over $17 million from that program. We have placed those funds into our money market account but would like to recommend investing some of those funds in other investment types to gain a little more interest income off of them. We propose investing $8 million in mortgage securities and $8 million in Equity Linked CDs with a three year term. Mortgage securities are currently yielding 5.50% and Equity Linked CDs are yielding 5.58%. Both can be liquidated early with no penalties if we need to cash down the road. The Equity Linked CDs would just be paid at the current market value of those CDs on the market if we needed to liquidate those early.

Both of these investment types have been recommended by Jason Layland, our investment broker with CWS. If we were to invest these funds as indicated above, it would give us the following investment portfolio, rounded to the nearest 100,000:

- Mortgage Securities $12,000,000
- Money Market $5,000,000
- LAIF $600,000
- Equity Linked CDs (3 years) $8,000,000

This total portfolio mix would be compliant with our investment policy and allow us to keep some of our cash reserves in liquid accounts, such as the money market and LAIF accounts. It is our recommendation that the Board approve this investment strategy. Thank you for your consideration of this item. Jason Layland should be present at our Board meeting if you have any further questions on these investments.

Presented By: Kevin Kramer
Date: 2/13/2026